DEPARTMENT OF PUBLIC HEALTH & SOCIAL SERVICES – MEDICAID PROGRAM – PROVIDER ELIGIBILITY – PART 1

Performance Audit
October 1, 2019 through September 30, 2022

OPA Report No. 25-03
February 2025

OFFICE OF PUBLIC ACCOUNTABILITY
GUAM

Department of Public Health & Social Services Medicaid Program-Provider Eligibility – Part I

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Table of Contents

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to revalidations of providers' enrollments once every five years, in which the providers' eligibilities were already outdated and could be potentially no longer valid.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.

Benjamin J.F. Cruz
Public Auditor

Introduction

Our office is conducting a three-part performance audit series of the Department of Public Health and Social Services (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 1 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. For Part I – Providers Eligibility, our objectives are to determine whether:

1. DPHSS' database on Medicaid providers is updated and accurate;
2. The selection and revalidation process and approval procedures of Medicaid providers are in accordance with standard procedures and are effective;
3. Active Medicaid providers possess medical licenses and other documents required by the federal, local laws & regulations and guidelines.

Our audit scope encompasses October 1, 2019 to September 30, 2022, or Fiscal Year (FY) 2020 through FY 2022. See Appendix 1 for objectives, scope and methodology.

Background

Guam's Medicaid program was established in its current form in 1975, but Guam legislation dates back to the creation of Medicaid on July 30, 1965. United States (U.S.) Public Law 89-97 established the Medicaid program and provided Puerto Rico, the U.S. Virgin Islands, and Guam with a Federal Medical Assistance Percentage (FMAP) match of 55% under the Social Security Act Section 1905(b) (42 U.S.C. §1396d(b)) in 1965. In 1967, Congress passed an annual federal cap of $900,000 in U.S. Public Law 90-248.

Image 1: Bureau of Health Care Financing information board in the DPHSS Mangilao office.

Guam Medicaid State Plan

The Guam Medicaid State Plan is a detailed agreement between DPHSS and the federal government, outlining the Medicaid program's administration on the island. The Plan specifies eligibility, benefits, reimbursement mechanisms, and operational procedures. The Plan shows that DPHSS, a line agency of the Government of Guam (GovGuam), has been the single State Agency designated to administer or supervise the administration of Medicaid at least since 1977.

Bureau of Health Care Financing Administration

The DPHSS - Division of Public Welfare (DPW) - Bureau of Health Care Financing Administration (BHCFA) was established to administer the Guam Medicaid Program and the Guam Medically Indigent Program. The Administrator has full operational responsibility for the Program subject to supervision by the Chief Human Services Administrator of the Division of Public Welfare.

BHCFA's mission is to administer local and federal health care programs to (1) assist low income individuals and families who are uninsured or have inadequate insurance coverage and (2) ensure that the quality of health care is available and accessible both on-island and off-island. The BHCFA takes charge of the development of implementation and operation plans for the Medicaid program, which includes reasonable access to hospitalization, medical, dental and behavioral health care services for members. It also performs the contract administration, certification, and oversight of Providers and the development and management of a Provider payment system. The staff composition of the DPW-Medicaid Assistance Program Administration includes the Claims Specialist, Claims Processing and Utilization Review Officer (CPURO), Program Coordinator, Quality Control Reviewer, Quality Improvement Coordinator and their staff. Regular audits are conducted to ensure compliance and strict adherence to federal and local regulations and prevent misuse of funds.

Medicaid Program Provider Eligibility

According to Title 42 of the Code of Federal Regulations (CFR), providers must first enroll and be credentialed to ensure that they meet qualifications and regulatory standards. Once approved, providers can deliver services to Medicaid beneficiaries and must maintain accurate and updated documentation. Providers receive detailed remittance statements, and can appeal their denied claims.

Guam Medicaid program provider eligibility is regulated under Title 42 CFR to ensure that only qualified providers participate in the program. Below are the guidelines for provider eligibility and responsibilities:

1. Licensed and Credentialed
    - Providers must be appropriately licensed, registered, or certified to practice in their respective fields under Guam law. This includes doctors, nurses, dentists, pharmacists, therapists, and other healthcare professionals.
    - Facilities – such as hospitals, clinics, nursing homes, and pharmacies – must also have the required licenses to operate in Guam.
2. Enrollment with Medicaid
    - Providers must enroll in the Guam Medicaid program to offer services to Medicaid recipients. Enrollment includes submitting an application, agreeing to comply with Medicaid rules, and providing all required documentation.
    - During the enrollment process, providers must be able to demonstrate their qualifications, licenses, and other credentials.
3. Compliance with Federal and Territorial Regulations
    - Providers must comply with federal Medicaid rules, including standards set by the Centers for Medicare & Medicaid Services (CMS), as well as local regulations established by DPHSS.

- Providers must adhere to ethical billing practices, maintain proper patient records, and meet quality-of-care standards.

4. Accepting Medicaid Payment Terms
    - Providers must agree to accept Medicaid payment as full payment for services provided to Medicaid recipients. They cannot charge Medicaid patients for services the program covers, except for nominal co-payments where allowed.
    - Providers must also follow the specific billing procedures and reimbursement rates set by the Guam Medicaid program.
5. Participation Agreement
    - Providers are required to sign a participation agreement that outlines their responsibilities, including adhering to all Medicaid rules, maintaining records, and cooperating with audits or investigations.
    - Providers must notify the Medicaid program of any changes to their practice, such as changes in licensing, ownership, or billing practices.
6. No Prior Exclusion from Medicaid/Medicare
    - Providers excluded, suspended, or terminated from Medicaid, Medicare, or any other federal healthcare program for fraud, abuse, or other violations are ineligible to participate in Guam's Medicaid program.
    - Routine background checks are often conducted to verify that providers do not have a history of violations that would disqualify them from participation.
7. Specialty Services and Provider Types
    - Different rules may apply for specific providers, such as behavioral health specialists, pediatricians, dental providers, and long-term care facilities. Providers offering specialized services might need to meet additional requirements, such as specialized certifications or training.
    - There are general rules and requirements, and additional specifics could apply based on changes in regulations, provider type, or Medicaid program updates. Healthcare providers should contact DPHSS or refer to the Guam Medicaid State Plan for exact and detailed information.

Medicaid Program Provider Revalidation

Title 42 CFR requires that Medicaid providers periodically revalidate their enrollment information with the Medicaid program to ensure that they meet enrollment and participation requirements. Key points from this regulation include:

1. Periodic Revalidations
    - Providers must revalidate their enrollment at regular intervals, which are set by CMS or the state Medicaid agency. The revalidation period is generally every five years, but it may vary for different types of providers.
2. Provider Enrollment Requirements
    - The regulation specifies that providers must meet certain criteria to remain enrolled in the Medicaid program. This includes submitting updated information, supporting documentation, and undergoing background checks or other screenings.
3. Screening and Risk Assessment
    - Providers may be subject to different levels of screening based on their risk category (limited, moderate, or high), as determined by CMS or the state Medicaid agency.

4. Sanctions for Noncompliance
    - If providers fail to submit their revalidation applications or provide the necessary documentation, they risk losing their Medicaid billing privileges or having their enrollment status revoked.

See Appendix 2 for details of laws and regulations.

GovGuam Reimbursements to Medicaid Providers - $399.6M

During FY 2020 through 2022, 218 healthcare providers participated in Guam's Medicaid program, encompassing on-island and off-island services across various healthcare sectors. These providers offer services in birthing center, optical, dental, pharmacy, intermediate care facility, etc., and long-term care reflect the diverse needs of Guam's Medicaid beneficiaries. Provider claims are submitted electronically through the Public Health Professional (PH Pro) System or via paper claim submission. Each claim undergoes compliance review by the Claims Specialist and CPURO before reimbursement. Payment for these services is based on pre-rates outlined in the Medicaid fee schedule, with a breakdown of reimbursed Medicaid claims by healthcare sector (illustrated in Table 1). See Appendix 3 for a complete list of DPHSS-approved and eligible Medicaid providers and Medicaid reimbursement.

Table 1: Reimbursed Medicaid Claims Per Fiscal Year

Provider Category	FY 2020	FY 2021	FY 2022	Total payments to providers (FY2020-FY2022)
On-Island Hospital	$73,821,704.08	$51,674,496.27	$83,469,244.46	$208,965,444.81
Uncategorized*	$13,298,028.41	$17,324,213.60	$20,792,506.60	$51,414,748.61
Pharmacy	$15,938,004.86	$14,274,226.02	$16,283,418.18	$46,495,649.06
Physician / Clinic Service / Other Medical Service	$10,988,245.01	$10,252,680.31	$13,817,218.09	$35,058,143.41
Dental	$7,266,503.94	$7,099,905.13	$10,632,122.02	$24,998,531.09
Dialysis	$4,420,236.12	$1,177,646.30	$8,816,122.22	$14,414,004.64
Radiology	$2,969,658.51	$2,515,141.52	$2,930,732.75	$8,415,532.78
Laboratory	$968,512.09	$902,725.01	$1,112,670.70	$2,983,907.80
Home Health Services	$870,177.41	$840,366.62	$697,814.98	$2,408,359.01
Ambulatory Surgical Center	$620,360.56	$574,399.11	$615,081.42	$1,809,841.09
Medical Transportation	$307,667.80	$355,318.30	$547,354.20	$1,210,340.30
Birthing Center	$324,209.31	$310,051.12	$295,407.24	$929,667.67
Optical	$94,013.93	$82,241.00	$129,224.50	$305,479.43
Behavioral Health Facility	$96,282.48	$17,330.55	$58,045.69	$171,658.72
Intermediate Care Facility (MIP Only)	$0.00	$0.00	$0.00	$0.00
Total:	**$131,983,604.51**	**$107,400,740.86**	**$160,196,963.05**	**$399,581,308.42**

*Uncategorized – There are 68 healthcare providers not categorized/listed under the current DPHSS website categorized as "Approved Medicaid/MIP Providers". See Appendix 3 for details.

Results of Audit

Our audit of GovGuam's 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 processes and procedures related to eligibility screening, approval, and revalidation. 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 potential inclusion of unqualified or fraudulent providers.

Our review of documents and information provided by the BHCFA covering FY 2020 through FY 2022, relative to 28 (or 13%) of 218 Providers, revealed deficiencies relative to the following:

I. Recordkeeping and Storage
   1. Lack of Standard Operating Procedures (SOP) for file maintenance & storage;
   2. Lack of centralized scanned file system or digital record repository system; and
   3. Lack of centralized database for Medicaid Providers.

II. Medical Provider List (MPL)
   1. Inactive Medicaid Providers Continue to Receive Medicaid Payments;
   2. Active Medicaid Providers' National Provider Identification (NPI) with Undetermined Expiry; and
   3. Active Physicians with Expired Licenses or Certificates.

III. Medicaid Provider Eligibility Screening and Revalidation Processes
   1. Lack of Medicaid Provider Enrollment Application Checklist
   2. Absence of and significant deficiencies in Medicaid Providers' Application and Agreement (PAA) and Revalidations; and
      a. Medicaid payments made to non-participating providers without PAAs.
      b. Medicaid providers were not revalidated for over eight to 10 years;
      c. Off-island Medicaid providers' PAAs not revalidated after five years until present;
      d. Medicaid Providers' PAAs were revalidated several days after revalidation due dates;
      e. Medicaid payments made prior to current approved PAAs; and
      f. PAAs without effectivity dates or effectivity prior to approval dates.
   3. Numerous issues on missing documents, insufficiently completed documents, and other non-compliance issues.

IV. Medicaid Providers' Licenses and other Federal and Local Regulation requirements
   1. Medicaid providers and/or participating physicians lack or have expired medical and/or drug enforcement administration licenses;

2. Current Medicaid providers do not have NPIs; and
3. PAA lacked listing of licensed physicians.

I. Recordkeeping and Storage

The requirement for Medicaid state agencies to retain Medicaid provider records is primarily governed by 42 CFR § 431.107-Required Provider Agreement, which relates to keeping records and furnishing information for all providers of services (including individual practitioners and groups of practitioners). Additionally, Title 10 Guam Code Annotated (GCA) § 2904(b) (15)-Division of Public Welfare states that 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 years. These records must also be available at the request of the Secretary of the U.S. Department of Health and Human Services or its successor agency. Additionally, § 2905.2 (3) states that the Program shall maintain its own copies of the application submitted to the Program.

Guam Medicaid State Plan Section 4.7 (Maintenance of Record) states that the Medicaid agency maintains or supervises the maintenance of records for the efficient operation of the Plan, including records regarding applications, determination of eligibility, etc., necessary for reporting and accountability and retains the records in accordance with federal requirements.

Both DPHSS and Medicaid providers must comply with the five-year record retention period of the original eligibility documents submitted for operational efficiency and to facilitate eligibility revalidations.

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

The file of physical records of the sampled Medicaid providers, maintained by BHCFA, raised significant concerns due to their lack of organization and incompleteness. The following issues were identified:

- Outdated information: The file included outdated information about the provider (such as expired licenses), and some current eligibility documents are not in the file.
- Inconsistent filing: The filing of documents was inconsistent and poorly structured, with various types of essential records (such as agreements, medical licenses, W-9 forms, and drug enforcement licenses, etc.) mixed and not properly grouped.
- Inclusion of irrelevant documents: Files contain irrelevant documents (such as claim payments) that were not necessary for determining provider eligibility.
- Illegibility of key documents: Several documents were found to be illegible, either due to poor-quality copies or deterioration over time.

Overall, the current state of recordkeeping and storage could stem from inadequate staffing, staff and supervisors' turnovers, the ineffective orientation of an efficient filing system, or lack of SOP relative to document filing and storage.

2. Lack of centralized scanned file system or Digital Record Repository system

We requested documents relative to the providers' eligibility in May 2024, of which some were delivered via email on October 9, 2024 following our preliminary findings meeting.

During our subsequent meeting, we learned that BHCFA did not have a centralized repository for scanned provider documents. Documents were retrieved from different sources, such as the officer's desktop, PH Pro system, etc., as explained by the CPURO. Moving forward, according to BHCFA supervisors, they are aggressively pursuing the scanning of all Medicaid providers' files to the PH Pro system once upgraded.

A centralized digital repository will improve BHCFA's operational efficiency and mitigate compliance risks and potential audit findings. The DPHSS Director highlighted the need for supporting documentation to fully validate Medicaid providers' eligibility status. Likewise, we 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.

A digital repository system allows for the centralized storage, management, and retrieval of all provider documentation, ensuring that records are easily accessible and well-organized. By digitizing these records, the risks associated with lost, incomplete, or improperly maintained files are minimized. Additionally, compliance with federal and state record retention requirements is more effectively managed. Moreover, a digital records repository can streamline the audit process, improve workflow efficiency, and enhance overall transparency within the Medicaid program.

3. **Lack of Centralized Database for Medicaid Providers**
   Currently, BHCFA is unable to maintain a database for all its Medicaid providers that can automatically generate the current and accurate information from one consolidated file as of a certain period. Information includes the following:
   - Provider name;
   - Category of service;
   - Address and contact information;
   - Date of PAA approval by approving official;
   - Date of PAA effectivity, termination, and revalidation;
   - Business license effective and expiry date;
   - Medical License effective and expiry date;
   - Drug Enforcement License effective and expiry date;
   - Billing Agent; and
   - Total Medicaid reimbursements as of a certain period.

BHCFA management explained that the PH Pro system can generate specific information needed, but not consolidated information for all its Medicaid providers as of a certain period. Furthermore, the BHCFA officers will refer this centralized database to the system vendor for possible extraction of data.

A robust database contains a record of the expiration of Medicaid provider eligibility documents, medical licenses, and other relevant documents that could automatically generate consolidated Provider information needed to monitor the continuous Medicaid provider eligibility and subsequent revalidations.

Overall, the current state of document storage and safekeeping needs immediate attention to ensure that the physical records, documentary evidence, and an updated and accurate database are properly maintained and safeguarded.

To achieve effective monitoring and review of Medicaid providers' eligibility documents for revalidation or potential termination, expired licenses, ocular inspections, and total Medicaid reimbursements, which provide a tool in BHCFA's decision-making and examiners' review processes, we recommend the following:

a) Formulate and implement an SOP on file maintenance and storage, including clear guidelines for systematic filing, scanning, and safekeeping of physical and digital records.
b) Adopt an effective digital records repository system or centralized scanned file system by utilizing the capabilities of the existing PH Pro system or any other BHCFA-preferred system.
c) Create/establish a consolidated Medicaid provider information database.

II. Medical Provider List (MPL)

Instead of a complete listing of all Medicaid providers with pertinent information, BHCFA submitted MPLs for sampled providers generated from the PH Pro system. Accordingly, MPLs contain all Guam registered and eligible Medicaid providers BHCFA manages. An MPL is a document that contains information such as the name of the Medicaid provider, provider status (either "Active" or "Inactive"), provider 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 their corresponding license numbers and expiration dates. Our review of sampled MPLs to determine the profile of Medicaid providers and their affiliated physicians providing Medicaid services noted the following:

1. "Inactive" Medicaid Providers Continue to Receive Medicaid Payments

From the MPL composed of 218 Medicaid providers, we randomly searched for Inactive Medicaid providers and found six off-island providers who still received Medicaid payments for FY 2020 through FY 2022 despite their "**Inactive**" status reflected in the MPL. The MPL did not contain information on the effectivity of Providers' inactive status and whether they were reactivated as of April 2024. Additionally, some of the "active" Medicaid providers and affiliated physicians within the MPLs had expired licenses during FYs 2020 to 2022. See Table 2 for details.

Table 2: Inactive Medicaid Providers Receiving Medicaid Payments

Medicaid Provider(s)	Findings	Remarks
Provider #22	Provider ML# SRL2202622 expired March 31, 2022; no license from April 1, 2022, to September 30, 2022. Five physicians' MLs expired between 2019 and 2021.	Received Medicaid payments totaling $27K in FY 2022.
Provider #23	Provider ML #SRL220983 expired February 28, 2022; no ML from March 1, 2022 to September 30, 2022. The sole physician's (active) ML expired on September 30, 2021.	Received Medicaid payments totaling $335 in FY 2022.
Provider #1	Provider ML#SRL1704351 expired June 30, 2017; no ML from July 1, 2017 to September 30, 2022.	Received Medicaid payments totaling $5K in FY 2021 and $44K in FY 2022.
Provider #28	Provider ML #M1868 expired on December 31, 2019; no ML from January 1, 2020 to September 30, 2022.	Received Medicaid payment totaling $3K in FY 2020.
Provider #24	Provider ML #SRL2028836 expired September 30, 2020; no ML from October 1, 2020 to September 30, 2022. Six physicians have licenses that expired between 2018 and 2022; of those, five have expired CSRs, two have expired MLs, and one has an expired DEA license.	Received Medicaid payments totaling $44K in FY 2021 and $89K in FY 2022.
Provider #26	Provider ML #05D6087565 expired on June 5, 2021; no ML from June 5, 2021 to June 5, 2022.	Received Medicaid payments totaling $7K in FY 2022.

According to BHCFA supervisors, the providers who changed business locations were tagged or labeled "Inactive" within the MPL. This triggers the closing out of their old DPHSS-issued Identification (ID) No. and begins the issuance of a new ID number, the provider needs to distinguish its new location. They are still active in Medicaid claim payments. However, this prevents BHCFA from paying subsequent Providers' billings after changes in their original business locations.

We recommend that "Inactive" Medicaid Providers be appropriately tagged and adequately identified in the MPL, to preclude misinterpretations by the users resulting in potential non-payment or duplicate payments.

2. **Active Medicaid Providers' National Provider Identification (NPI) with Undetermined Expiry Dates**
   Several Medicaid providers' NPIs show undeterminable expiry dates (i.e., December 31, 9999) listed within the MPL. The findings include expired licenses of two providers on December 31, 2010, and March 31, 2022, indicating that the MPL had not been updated to reflect renewed MLs. See Table 3 for details.

Table 3: Active Providers with Expired/Undetermined License Expiry

Medicaid Provider(s)	License Number	Expiry
Provider #2	#FNP	December 31, 2020
	#96-0001695 (NPI)	December 31, 9999*
Provider #7	#960001695 (NPI)	December 31, 9999*
Provider #16	#SRL 2202553	March 31, 2022
Provider #18	#26-1421311 (NPI)	December 31, 9999*
Provider #19	#26-14213111 (NPI)	December 31, 9999*

*****Notes unknown calendar year

3. Active Physicians with Expired Licenses or Certificates

On specific MPLs for certain providers, some physicians were labeled as "Active" despite having expired MLs listed on the MPLs. Two Medicaid providers only had NPIs listed on the MPL and did not have MLs. Additionally, renewed licenses that expired within FY 2020-2022 appeared not to have been updated with new expiry dates in the MPLs generated on April 14, 2024. See Table 4 for details.

Table 4: Medical Providers List of Expired Licenses

Medicaid Provider(s)	Name of Physicians & Status	Type of License	Expiration	Remarks
Provider #2 Provider #3 Provider #4 Provider #5 Provider #6	Physician #1	IM #DO-54	December 31, 2019*	Also listed within Provider #2, #3, #4, #5, #6.
	Physician #2	ML#M-675	December 31, 2019*	Also listed within Provider #2, #3, #4, #5, #6.
	Physician #3	ML#M2148	December 31, 2019*	Also listed within Provider #2, #3, #4, #5, #6.
	Physician #4	ML#1181	December 31, 2019*	Also listed within Provider #2, #3, #4, #5, #6.
	Physician #5	NPI#1508862269	n/a	**No license number and no expiration noted**. Also listed within Provider #2, #3, #4, #5, #6.
	Physician #6	NPI#1588603252	n/a	**No license number and no expiration noted**. Also listed within Provider #2, #3, #4, #5, #6.
Provider #18	Physician #7	ML#M 1555	December 31, 2019*	n/a
Provider #1	Physician #8 through Physician #53	ML, DEA. & CSR	Between **2015 to 2020**	All Provider #1 Sections

* BHCFA subsequently provided digital copies of the renewed expired licenses.

Since the information on the MPLs was extracted from the PH Pro System, it denotes that some providers' information on the PH Pro system has not been 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. If the MPL records are valuable and significant to the BHCFA operations, we recommend that information be updated in the PH Pro system to generate updated and accurate MPLs.

III. Deficiencies in the Medicaid Provider Eligibility Screening and Revalidation Processes

Our evaluation of DPHSS-BHCFA's screening, approval and revalidation processes of Medicare provider applicants appeared ineffective and noncompliant with federal and state/local requirements. Specifically:

1. Lack of Medicaid Provider Enrollment Application Checklist

42 CFR §§431.107 & §455.410 states the Medicaid agency is required to have an **agreement** with each provider or organization furnishing services. These agreements are critical elements of the Medicaid enrollment control environment because they are legal documents, and the **provider's signature "legally and financially binds** [the] provider to the laws, regulations, and instructions

of the Guam Medicaid program." The stipulation in the CFR mandates specific requirements for establishing and maintaining provider agreements within Medicaid programs.

To apply for eligibility in the Guam Medicaid Program, a Medicaid provider applicant is required to execute and submit a PAA. The PAA must be approved by the DPHSS Director and contain information on its effective and termination dates to be filled in by the BHCFA. If the DPHSS Director approves the application during the month, the application becomes effective on the 1st day of said month.

Before June 2023, there was no Medicaid Provider Application Checklist (attached to the PAA), which enumerates the documents and information the applicant Provider must submit. Therefore, we cannot ascertain the effectiveness of Medicaid provider applicants' screening, evaluation, and approval process from FY 2020 to 2022. However, in June 2023, a checklist (BHCFA Form 08-02 revised June 2023) was added to the PAA, which facilitated BHFCA's determination of absent required documentation and justified the reasonableness of its approval decision. See Appendix 4 for a sample of the PAA and checklist.

Based on the examination of 28 sampled providers, we identified deficiencies and non-conformance issues relative to the PAA.

2. Absence of and Significant Deficiencies in the Medicaid PAA and Revalidations

a. *Medicaid Payments to "Non-Participating" Providers without PAAs*

Provider #27 and Provider #29 did not have previous and current PAAs, which should evidence the provider's applications and approvals for enrollment in the Medicaid Program. These off-island providers were identified as **"non-participating**" per the DPHSS list of Medicaid Assistance Program recipients for FY 2020-2022 electronically provided by BHCFA. Additionally, all the required documents such as ML, DEA license, official pictures and signature identification (passport, medical license, and driver's license), and other documents specified in the PAA checklist 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. The absence of these required documents/agreements indicates that Provider #27 and Provider #29 were ineligible to be enrolled in the Medicaid Program, in that they are non-compliant with the regulatory standards that entitle them to render Medicaid services or receive Medicaid payments. Furthermore, DPHSS records identifying these Medicaid Providers as non-participating raised additional concerns about the validity of the payments made to them. The total Medicaid payments received by these Providers from FY 2020 through FY 2022 amounted to $8.5K. See Table 5 below.

Table 5: "Non-Participating" Medicaid Providers

Medicaid Provider(s)	Total Medicaid Payments (FY 2020 ~ FY 2022)
Provider #28	$6,630
Provider #30	$1,846
Totals	**$8,476**

In the MPL, Provider #27 (Emergency Service) has no information except a vendor number, vendor account, and an off-island phone number. For Provider #29, it was labeled as a "Non-Participating Provider", and had information such as an NPI number, "active" status as a professional corporation and individual, and a physician and surgeon license expiring on January 26, 2026. The provider does not have a physical document on file; thus, information on the "Medical Provider List" cannot be validated.

Per BHCFA, the lack of eligibility requirements was based on an email from a representative CMS dated September 2013, citing 2 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." Additionally, in Attachment 3.1A of the Guam State Plan, Guam is required to reimburse a hospital that is providing emergency services even if a Letter of Agreement has not been signed or certification documents have not been submitted to Medicaid.

To ensure the propriety of Medicaid claims and reimbursements, we recommend that BHCFA identify Medicaid providers consistently utilized for "emergency services" in its records and require them to submit a completed and signed PAA, which is mandatory for all healthcare providers.

b. Medicaid Providers 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 SOPs for provider enrollment and screening. All providers, regardless of the industry they belong to, are subject to this regulation, which includes both the initial application and renewal processes for those seeking to participate in the Medicaid Program.

42 CFR § 455.414, Subpart E indicates that the state Medicaid agency must revalidate the enrollment of **all provider types at least once every five years.** Additionally, based on item #12 of the PAA, the agreement has to be revalidated at least once every five (5) years.

Our review found eight (8) Medicaid providers who received Medicaid payments for FY 2020 through 2022 had prior years' approved PAAs, which were not revalidated for approximately eight (8) to ten (10) years. Additionally, we could not determine the revalidation due dates of the four (4) Medicaid providers since they either have no prior PAAs, or no approval dates indicated on their PAAs. Consequently, their eligibilities are already **outdated and could potentially no longer be valid.** We questioned the total Medicaid payments amounting to $233.8M for these 12 Medicaid Providers for FY 2020 through 2022.

Furthermore, all Medicaid Providers' physicians with MLs and other documents on file did not submit their official pictures or signature identification documents such as passports, medical licenses, driver's licenses, or DEA licenses. There is no listing on file to determine that these physicians rendered services in the prior years; thus, there has been a need to submit these requirements since then. See Table 6 for details.

Table 6: **Medicaid Providers Were Not Revalidated for Over Eight to Ten Years**

Medicaid Provider(s)	Type of Services	PAA Last Approval Date	Latest PAA Approval Date (Renewal)	Years without Revalidated PAAs	Other Documentary Deficiencies or Comments	Total Medicaid Payments (FY 2020 to FY 2022)
Provider #1	Facility Services & Professionals	None	November 23, 2022	Undeterminable	None	$130,294,151
Provider #2	Outpatient Services	November 7, 2008	May 11, 2023	Nov. 2013-May 2023=10 years	No official pictures or signature authentication documents	$78,671,294
Provider #3	Skilled Nursing Services	November 7, 2008	May 11, 2023	Nov. 2013-May 2023=10 years	Same comment as Provider #2	
Provider #4	General Acute Care	November 7, 2008	May 11, 2023	Nov. 2013-May 2023=10 years	Same comment as Provider #2	
Provider #5	Hospitalist	November 7, 2008	May 11, 2023	Nov. 2013-May 2023=10 years	Same comment as Provider #2	
Provider #6	Emergency Medical Services	November 7, 2008	May 11, 2023	Nov. 2013-May 2023=10years	Same comment as Provider #2	
Provider #7		November 7, 2008	May 11, 2023	Nov. 2013-May 2023=10years	Same comment as Provider #2	
Provider #8	Pharmacy	**No prior PAA**	October 12, 2022	Undeterminable	No PAA covering FY 2020 through FY 2022.	$11,549,334
Provider #16	Pharmacy	**No prior PAA**	October 12, 2022 (Renewal)	Undeterminable	Same comment as Provider #8	$ 3,428,043
Provider #20	Dialysis Facility	November 4, 2009	January 27, 2023	November 2014-January 2023= 9 years		$ 2,764,283
Provider #30	Individual Medical Provider	November 30, 2016	None	Undeterminable	The approved PAA does not have effectivity and termination dates.	$329.16
Provider #13	Facility	December 5, 2012	May 1, 2023	December 5, 2012 – May 1, 2023 = 11 years		$7,106,615.31
					Total:	**$233,814,049.47**

The lack of approved initial PAA and subsequent PAA revalidation once every five years, as well as proof of Medicaid eligibility and enrollment, could have repercussions on the Medicaid program and its beneficiaries. This deficiency hampers program administrators' ability to perform an effective initial verification of qualifications and eligibilities and re-verification for the required

every five-year revalidation. Furthermore, this could lead to the potential inclusion of unqualified or fraudulent Medicaid providers.

c. Off-island Medicaid Provider PAAs were not Revalidated after Five Years Until Present

42 CFR § 455.414, Subpart E stated that the state Medicaid agency must revalidate the enrollment of all provider types at least once every five years. Additionally, based on item #12 of the PAA (Form 08-02 revised June 2022), the agreement has to be revalidated at least every five years.

The PAAs of four off-island providers – specifically Provider #31, Provider #34, Provider #33, and Provider #11 – were not revalidated five years after their approvals until the present. PAAs on file were approved by the DPHSS Director between 2008 and 2016 and were due for revalidations between 2013 and 2021. However, no revalidation documents were on file, nor subsequently submitted to OPA. See Table 7 for details.

Table 7: Medicaid Providers PAAs not Revalidated

Medicaid Provider(s)	Previous Approval Date	Revalidation Due Date	Total Medicaid Payments after Revalidation Due Date (FY 2020 ~ FY 2022)
Provider #31	November 30, 2016	November 30, 2021	$141.03
Provider #34	May 14, 2013	May 14, 2018	$29.60
Provider #33	August 10, 2015	August 10, 2020	$78.58
Provider #11	October 27, 2008	October 27, 2013	$7,250,768.72
		Totals	**$7,251,017.93**

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 continuously received Medicaid payments even after the revalidation due dates without performing immediate re-screening for revalidations. Revalidations were done from approximately 146 days to 535 days after the revalidation due dates. We did not determine how many payments were made after the revalidation due dates, as these will be addressed in Part III of this audit. See Table 8 for details.

Table 8: PAA Revalidations Several Days after Revalidation Due Dates

Medicaid Provider(s)	Previous PAA Approval Date	Estimated PAA Revalidation Due Date	Current PAA Approval Date	Elapsed Time
Provider #1	March 11, 2016	March 11, 2021	February 19, 2022	345 days
Provider #20	December 1, 2016	December 1, 2021	January 27, 2023	422 days
Provider #18	December 1, 2016	December 1, 2021	January 27, 2023	422 days
Provider #19	December 1, 2016	December 1, 2021	January 27, 2023	422 days
Provider #21	December 1, 2016	December 1, 2021	January 27, 2023	422 days
Provider #17	December 1, 2016	December 1, 2021	January 27, 2023	422 days
Provider #12	May 3, 2017	May 3, 2022	September 26, 2022	146 days
Provider #14	November 7, 2016	November 7, 2021	April 26, 2023	535 days

Medicaid Provider(s)	Previous PAA Approval Date	Estimated PAA Revalidation Due Date	Current PAA Approval Date	Elapsed Time
Provider #15	November 7, 2016	November 7, 2021	April 25, 2023	534 days
Provider #25	November 7, 2016	November 7, 2021	April 26, 2023	535 days

Overall, non-compliance with the revalidation requirements can lead to the re-engagement of providers who may not meet or are 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 Payments Prior to Current Approved PAAs

Medicaid providers received Medicaid payments for FY 2020 through FY 2022 after their revalidation due dates and prior to the approval of their current PAAs. For two providers, there is no evidence of previously approved PAAs on file. See Table 9 for details.

Table 9: Medicaid Payments Prior to Current PAA Approvals

Medicaid Provider(s)	Type of Services	Previous PAA Approval Date	Revalidation Due Date	Current Application Approval Date	Total Medicaid Payments (FY 2020 ~ FY 2022)
Provider #2	Outpatient	November 7, 2008	November 7, 2013	May 11, 2023	Payments included in Table 6
Provider #3	Skilled Nursing Unit	November 7, 2008	November 7, 2013	May 11, 2023	Same comment
Provider #4	Inpatient Services	November 7, 2008	November 7, 2013	May 11, 2023	Same comment
Provider #5	Professionals	November 7, 2008	November 7, 2013	May 11, 2023	Same comment
Provider #6	Emergency Room	November 7, 2008	November 7, 2013	May 11, 2023	Same comment
Provider #7	Urgent Care	November 7, 2008	November 7, 2013	May 11, 2023	Same comment
Provider #9	Pharmacy	No Prior PAA	Undeterminable	October 12, 2022	Payments were made in FY 2020 ~ FY 2022
Provider #16	Pharmacy	No Prior PAA	Undeterminable	October 12, 2022	Same comment

Payments to Medicaid providers without duly approved or revalidated PAAs can undermine the trust in the Medicaid program, potentially affecting its ability to attract and retain qualified and competent providers and thereby impacting the overall effectiveness of services provided to Medicaid beneficiaries.

To achieve an effective and efficient initial screening and revalidation processes, we recommend strict compliance to the eligibility initial screening, documentation and revalidation requirements per local and federal laws and regulations and guidelines.

f. PAAs Without Effectivity Dates or Effectivity Prior to Approval Dates

The PAAs of six Medicaid providers are missing effectivity dates or contain effectivity dates that were earlier or way after the DPHSS Director approval dates. Effectivity dates determine when a

Medicaid provider's services can be rendered and paid. In the absence of effectivity dates, we considered the approval dates as the effective start dates. See Table 10 for details.

Table 10: PAAs without Effectivity Dates

Medicaid Provider(s)	Current PAA Approval Date	Current PAA Effective Date
Provider #1	March 11, 2016	February 19, 2022
Provider #9	October 12, 2022	None
Provider #16	October 12, 2022	None
Provider #20	January 27, 2023	None
Provider #14	September 6, 2022	None
Provider #13	January 3, 2022	September 1, 2021

We recommend that BHCFA ensure that dates in the PAAs are completely and accurately filled in to avoid inaccurate or improper payments.

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 specific documents and information required to be submitted by applicant providers as part of the enrollment review and screening process. This includes evidence such as certifications and medical licenses; official pictures; and signature identification documents such as a passport or driver's license. Other basic requirements include Business National Providers Identifiers (NPIs), Business License (BL), and Federal W-9 Form (Request for Taxpayer Identification Number and Certification).

Some Medicaid Providers had incomplete documentation or information on documents with discrepancies or deficiencies. Specifically:

- No NPI document. NPIs without Enumeration dates (effectivity dates)
- DEA license expired, and no renewal of such license was submitted.
- Providers' PAAs (Form 08-02 revised June 2023) were not signed off by BHCFA staff to signify completion of an application.
- Lack of data for BHCFA to fill in: effective date, termination date, Provider ID No., Vendor ID No., Portal provider User ID.
- No BLs for certain calendar years.
- Provider's name on the BL differs from the PAA.
- Missing documentation for healthcare employees/medical professionals' pictures and signatures.
- No Department of Administration Vendor Record & electronic fund transfer Establishment Request Form and voided check or personalized deposit slip.
- Clinical Laboratory Certificate of Waiver expired December 20, 2020. No renewal for subsequent calendar years.
- Business Associate Agreement/Service Contract Agreement with billing agents, missing four pages and signature page, thus not signed.
- Certificate of Tax Exemption on file was dated March 12, 1993. No annual renewal until CY 2022, as required by the Business Privilege Tax rules.

- No W-9 Form
- Missing page 2 of the PAA, which contained the information of the billing agent and the provisions/conditions that the applicant Medicaid Provider agrees and has to comply.
- Lack of claims information: category of service; type of provider: either facility, group, or individual.

Please refer to Appendix 5 for details.

To achieve an effective Medicaid provider screening and approval process, we recommend strict compliance with documentary requirements and completeness in filling in PAA forms. If the document does not apply to the applicant provider, such should be marked "not applicable" or include disclosures when necessary.

IV. Medicaid Provider Licenses and other Federal & Local Regulation Requirements

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

Some Medicaid providers and/or affiliated physicians providing Medicaid services lacked MLs and/or had expired MLs or DEA licenses and were without documented renewals on file. These physicians were not listed in the PAAs. See Table 11 for details.

Table 11: Medicaid Providers and or Physicians without ML or DEA Licenses

Medicaid Provider(s)	License Owner	Type & License No.	Issued	Expiry	Remarks
Provider #1	License Owner #1	n/a	n/a	n/a	Information not provided. No ML for undetermined period
	License Owner #2	n/a	n/a	n/a	Same comment.
Provider #20	License Owner #3	ML	October 7, 2019	December 31, 2021	No renewal; No ML from January 1, 2022 to September 30, 2022.
	License Owner #4	ML	October 7, 2019	December 31, 2021	No renewal; No ML from January 1, 2022 to September 30, 2022.
Provider #17	License Owner #5	DEA	n/a	February 29, 2019	No renewal. No ML from March 1, 2019 to September 30, 2022.
	License Owner #5	ML	n/a	December 31, 2019	No renewal; No ML from January 1, 2020 to September 30, 2022.
Provider #19	License Owner #5	ML	n/a	December 31, 2017	No renewal; No ML from January 1, 2018 to September 30, 2022.
	License Owner #5	DEA	n/a	February 28, 2019	No renewal. No ML from March 1, 2019 to September 30, 2022.
Provider #18	License Owner #5	DEA	n/a	December 31, 2017	No DEA License from January 2018 to September 30, 2022.
Provider #21	License Owner #5	ML	n/a	n/a	Information not provided. No ML for undetermined period
	License Owner #5	DEA	n/a	n/a	Same comment.
Provider #8	License Owner #6	DEA	February 03, 2022	March 31, 2025	No DEA license from January 1, 2020 to January 30 2022.

Medicaid Provider(s)	License Owner	Type & License No.	Issued	Expiry	Remarks
Provider #10	License Owner #7	DEA	January 07, 2019	September 30, 2021	No DEA license from October 1, 2021 to September 30, 2022.
	License Owner #8	ML	September 23, 2021	September 30, 2023	No ML from January 1, 2020 to September 232 2021.
	License Owner #9	ML	n/a	September 30, 2023	No ML for undetermined period.
Provider #14, Provider #15, & Provider 25	License Owner #10	ML	n/a	September 30, 2023	Same comment.
	License Owner #11	ML	n/a	September 30, 2023	Same comment.
Provider #30	License Owner #12	DEA	March 18, 2015	April 30, 2018	No renewal; No DEA Certificate.
	License Owner #12	ML	n/a	December 31, 2017	No ML for undetermined period.
Provider #31	License Owner #13	ML	n/a	October 31, 2017	No ML for undetermined period.
	License Owner #13	DEA	n/a	n/a	No DEA Certificate for FY 2020-2022.
Provider #32	License Owner #14	ML	n/a	n/a	No ML for FY 2020-2022.
	License Owner #14	DEA	n/a	n/a	No DEA Certificate for FY 2020-2022.
Provider #33	License Owner #15	ML	n/a	March 31, 2017	No ML for undetermined period.
	License Owner #15	DEA	October 16, 2012	August 31, 2015	No DEA Certificate for from September 1, 2015 to September 30, 2022.
Provider #34	License Owner #16	ML	n/a	n/a	No ML for FY 2020-2022.
	License Owner #16	DEA	n/a	n/a	No DEA Certificate for FY 2020 thru 2022.

With the absence of MLs or DEA licenses, a Medicaid provider or physician could not be authorized to perform medical services; therefore, they are not eligible as Medicaid providers and are ineligible to receive Medicaid payments. We recommend strict compliance with the submission of required licenses and updating of expired ones to be qualified to render Medicaid services.

2. Current Medicaid Providers do not have NPI documents.

In 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, Provider #12 and Provider #25, did not submit NPI documents, although their NPI numbers were indicated in their PAAs. See Table 12 for details.

Table 12: Medicaid Providers Lack NPI Numbers

Medicaid Provider(s)	NPI No.	Effectivity	Expiry	Remarks
Provider #12	1609912229	n/a	n/a	No NPI document
Provider #25	1285283382	n/a	n/a	No NPI document

3. PAAs lacked the list of licensed physicians.

The PAA lacked pertinent details such as names and licenses of all their physicians who were providing services, nor was a separate listing of these physicians provided. Additionally, PAAs did not include the addendum agreement for negotiated reimbursement rate/per diem rate, which is essential for establishing the agreed-upon rates for reimbursement and per diem. See Table 13 for details.

Table 13: PAA Lacks List of Licensed Physicians

Medicaid Provider(s)	Deficiencies
Provider #1	• PAA has no list of all licensed physicians.
	• No addendum agreement for negotiated reimbursement rate/per diem rate.

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. We recommend filling in the details of affiliate physicians in PAA forms or providing a separate list of these physicians. We suggest completing the addendum and agreement in the PAA.

Conclusion and Recommendations

Our performance audit of GovGuam – DPHSS Medicaid Program-Provider Eligibility-Part I is primarily intended to provide feedback on whether Medicaid providers' eligibility and revalidation processes and procedures were in accordance with local and federal laws and regulations. GovGuam's Medicaid Program disbursed/paid a total of $399.6M to the 218 participating on-island and off-island Medicaid providers. Our review of documents, information and related processes relative to the 28 sampled Medicaid providers revealed several issues and deficiencies relative to: a) Recordkeeping and storage; b) Medical Provider List (MPL); c) Medicaid Provider eligibility screening and revalidation process; and d) Medicaid providers' licenses and other federal and local regulations requirements. Specifically, these deficiencies relate to the lack of SOP on file maintenance and storage, digital repository system, and consolidated Medicaid provider database; and an appearance of ineffective and inefficient eligibility screening, approval and revalidation processes and procedures.

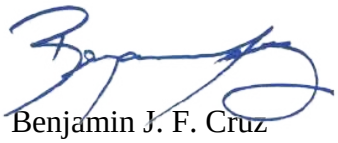
As a result, we questioned $241.1M in Medicaid Provider payments – primarily due to noncompliance with local and federal regulations in regards to revalidations of Providers' enrollments once every five years, in which the Providers' eligibilities were already outdated and could be potentially no longer valid. The lack of revalidations once every five years could lead to potential inclusion of unqualified or fraudulent providers.

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. Relative to these findings, we made the following nine recommendations which DPHSS management has promptly provided us their action plans to implement:

1. To achieve an effective monitoring and review of Medicaid providers' eligibility documents for revalidation or potential termination, which provides a tool in BHCFA's decision-making and examiners' review processes, we recommend the following:
    a. Formulate and implement an SOP on file maintenance and storage, which includes clear guidelines for systematic filing, scanning, and safekeeping of both physical and digital records.
    b. Adopt an effective digital records repository system or centralized scanned file system by utilizing the capabilities of the existing PH Pro system or any other BHCFA preferred system.
    c. Create/establish a consolidated Medicaid provider information database.
2. Inactive Medicaid providers be appropriately tagged and properly identified in the MPL to preclude misinterpretations by the users resulting in potential non-payment or duplicate payments.
3. If the MPL records are valuable and significant to the BHCFA operations, information be updated in the PH Pro system to generate updated and accurate MPLs.
4. To ensure the propriety of Medicaid claims and reimbursements, BHCFA identifies in its records Medicaid providers consistently utilized "emergency services" and requires them to submit a completed and signed PAA, which is mandatory for all healthcare.

5. To achieve an effective and efficient initial screening and revalidation processes, we recommend strict compliance with local and federal laws and regulations and guidelines.
6. Strict compliance with documentary requirements and completeness in filling in PAA forms. If the document does not apply to the applicant provider, such should be marked "not applicable" or include disclosures, when necessary.
7. BHCFA ensures that dates in the PAAs are completely and accurately filled in to avoid inaccurate or improper payments.
8. Strict compliance with the submission of required licenses and updating of expired ones to be qualified to render Medicaid services.
9. Filling in the details of affiliate physicians in PAA forms or provide a separate list of these physicians. We suggest to complete the addendum and agreement in the PAA.

We acknowledge the combined dedicated efforts exerted by the officials and staff of the DPHSS-DPW-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 standard, and many others. We appreciate DPHSS' commitment to ensuring that Guam's Medicaid Program fulfills the health care needs of its people.



Benjamin J. F. Cruz
Public Auditor

Classification of Monetary Amounts

Finding Description	Questioned Cost*	Potential Savings	Unrealized Revenues	Other Financial Impact	Total Financial Impact
I. Recordkeeping and Storage					
1. Lack of Standard Operating Procedure on File Maintenance and Storage	$0	$0	$0	$0	$0
2. Lack of Centralized Scanned File System or Digital Record Repository System	$0	$0	$0	$0	$0
3. Lack of Centralized Database for Medicaid Providers	$0	$0	$0	$0	$0
Subtotal	$0	$0	$0	$0	$0
II. Medical Provider List (MPL)					
1. "Inactive" Medicaid Providers Continue to Receive Medicaid Payments	$0	$0	$0	$0	$0
2. Active Medicaid Provider National Provider Identification (NPI) with Undetermined Expiry Dates	$0	$0	$0	$0	$0
3. Active Physicians with Expired Licenses or Certificates	$0	$0	$0	$0	$0
Subtotal	$0	$0	$0	$0	$0
III. Deficiencies in the Medicaid Provider Eligibility Screening and Revalidation Processes					
1. Lack of Medicaid Provider Enrollment Application Checklist	$0	$0	$0	$0	$0
2. Absence of and Significant Deficiencies in the Medicaid PAA and Revalidations	$0	$0	$0	$0	$0
a. Medicaid Payments to "Non-Participating" Providers without PAAs	$0	$0	$0	$0	$0
b. Medicaid Providers Were Not Revalidated for over Eight (8) to Ten Years	$233,814,049	$0	$0	$0	$0
c. Off-island Medicaid Provider PAAs were not Revalidated After Five Years Until Present	$7,251,018	$0	$0	$0	$0
d. Medicaid Providers' PAAs were Revalidated Several Days after Revalidation Due Dates	$0	$0	$0	$0	$0
Subtotal	$241,065,067	$0	$0	$0	$0

**Note – Based on the Office of Inspector General Report Recommendation Definition, Costs are questioned because of an alleged violation of a provision; costs not supported by adequate documentation; or a finding that the expenditure of funds for the intended purpose is unnecessary or unreasonable.*

Classification of Monetary Amounts

Finding Description	Questioned Cost*	Potential Savings	Unrealized Revenues	Other Financial Impact	Total Financial Impact
e. Medicaid Payments Prior to Current Approved PAAs	$0	$0	$0	$0	$0
f. PAAs Without Effectivity Dates or Effectivity Prior to Approval Dates	$0	$0	$0	$0	$0
3. Numerous Issues on Missing Required Documents, Insufficiently Completed Documents and other Non-Compliance Issues	$0	$0	$0	$0	$0
Subtotal (Cont'd)	$241,065,067	$0	$0	$0	$0
IV. 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	$0	$0	$0	$0	$0
2. Current Medicaid Providers do not have NPI documents	$0	$0	$0	$0	$0
3. PAAs Lacked the List of Licensed Physicians	$0	$0	$0	$0	$0
Subtotal	$0	$0	$0	$0	$0
Total	**$241,065,067**	$0	$0	$0	$0

**Note – Based on the Office of Inspector General Report Recommendation Definition, Costs are questioned because of an alleged violation of a provision; costs not supported by adequate documentation; or a finding that the expenditure of funds for the intended purpose is unnecessary or unreasonable.*

Management Response and OPA Reply

A preliminary findings report (for discussion purposes only) was presented to DPHSS on September 16, 2024. A preliminary discussion meeting was held on September 23, 2024 to discuss DPHSS' response to OPA preliminary findings and clarify data and information provided by DPHSS. A subsequent meeting was held with a DPHSS representative on October 7, 2024 to clarify and validate with updated data and documents and other relevant information.

In November 2024, we provided a final report to DPHSS for their official response. For fair reporting, updated data and documents were considered and incorporated in this draft final report sent to DPHSS.

Per DPHSS request, an audit exit conference was held on December 6, 2024 (via Zoom) to discuss their initial response. In their December 2024 management response letter, DPHSS generally agreed with our findings and recommendations and had provided the actions taken based on audit recommendations. See Appendix 6 for DPHSS official management response.

The legislation creating OPA requires agencies to prepare a corrective action plan to implement audit recommendations, document the progress in implementing the recommendations, and endeavor to have implementation completed no later than the beginning of the next fiscal year. Accordingly, we will contact the Legislature to provide the target dates and title of the official(s) responsible for implementing the recommendations.

We appreciate the cooperation and assistance given to us by the DPHSS Director, management, and staff during this audit.

OFFICE OF PUBLIC ACCOUNTABILITY

Benjamin J.F. Cruz
Public Auditor

Appendix 1:

Objective, Scope, & Methodology

Objectives

Our audit objectives are to determine whether:

1. DPHSS database on Medicaid providers is updated and accurate;
2. The selection and revalidation process and approval procedures of Medicaid providers are in accordance with the standard procedures, and are effective;
3. Active Medicaid providers possess medical licenses and other documents required by the federal, local laws & regulations and guidelines.

Scope

The audit team reviewed the initial eligibility and revalidations of enrollment of Medicaid program providers, focusing on their documented qualifications and compliance with program requirements and local and federal laws and regulations governing the program. The time period covered is October 1, 2019 to September 30, 2022 or Fiscal Year (FY) 2020 through 2022.

Methodology

To accomplish our objectives, we performed the following:

1. Identified and reviewed applicable GovGuam and federal laws, rules and regulations, DPHSS guidelines, SOPs and other relevant reports and documents to be used as the audit criteria.
2. Identified and reviewed prior OPA performance audits, agency internal audit reports, and other relevant publications.
3. Performed an analysis of data provided to determine trends, outliers and anomalies to formulate potential findings within the context of audit objectives.
4. Issued a Survey Briefing Report with the Public Auditor's "Go" decision to proceed to fieldwork.
5. Utilized judgmental sampling in selecting providers and provider eligibility documents for review and verification for potential deficiencies and non-compliance.
6. Formulated the initial/preliminary findings as a basis for discussion with the DPHSS representatives and management.
7. Met with DPHSS representatives to discuss the preliminary findings, conducted other subsequent meetings for clarification, and validated subsequent data provided.
8. Met with DPHSS Director and other DPHSS representatives for an exit conference to discuss draft final report findings.
9. Provided final draft report subject QAR and Cold Read processes.

We conducted this audit in accordance with Generally Accepted Government Auditing Standards. These standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Title 10 Guam Code Annotated

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

(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:

(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.

§ 2905.2. Program Residency Requirements.

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

(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.

Title 42—Public Health
42 CFR Part 431 Subpart C

§ 431.107 Required provider agreement.

(a) Basis and purpose. This section sets forth State plan requirements, based on sections 1902(a)(4), 1902(a)(27), 1902(a)(57), and 1902(a)(58) of the Act, that relate to the keeping of records and the furnishing of information by all providers of services (including individual practitioners and groups of practitioners).

(b) Agreements. A State plan must provide for an agreement between the Medicaid agency and each provider or organization furnishing services under the plan in which the provider or organization agrees to:

(1) Keep any records necessary to disclose the extent of services the provider furnishes to beneficiaries;

(2) On request, furnish to the Medicaid agency, the Secretary, or the State Medicaid fraud control unit (if such a unit has been approved by the Secretary under § 455.300 of this chapter), any information maintained under paragraph (b)(1) of this section and any information regarding payments claimed by the provider for furnishing services under the plan;

(3) Comply with the disclosure requirements specified in part 455, subpart B of this chapter; and

(4) Comply with the advance directives requirements for hospitals, nursing facilities, providers of home health care and personal care services, hospices, and HMOs specified in part 489, subpart I, and § 417.436(d) of this chapter.
(5)
(i) Furnish to the State agency its National Provider Identifier (NPI) (if eligible for an NPI); and
(ii) Include its NPI on all claims submitted under the Medicaid program.

§ 440.170 Any other medical care or remedial care recognized under State law and specified by the Secretary.

(e) Emergency hospital services. "Emergency hospital services" means services that—

(1) Are necessary to prevent the death or serious impairment of the health of a beneficiary; and

(2) Because of the threat to the life or health of the beneficiary necessitate the use of the most accessible hospital available that is equipped to furnish the services, even if the hospital does not currently meet—

(i) The conditions for participation under Medicare; or

(ii) The definitions of inpatient or outpatient hospital services under §§ 440.10 and 440.20.

42 CFR Part 455 Subpart E

§ 455.410 Enrollment and screening of providers.

(a) The State Medicaid agency must require all enrolled providers to be screened under to this subpart.

(b) The State Medicaid agency must require all ordering or referring physicians or other professionals providing services under the State plan or under a waiver of the plan to be enrolled as participating providers.

(c) The State Medicaid agency may rely on the results of the provider screening performed by any of the following:

(1) Medicare contractors.

(2) Medicaid agencies or Children's Health Insurance Programs of other States.

(d) The State Medicaid agency must allow enrollment of all Medicare-enrolled providers and suppliers for purposes of processing claims to determine Medicare cost-sharing (as defined in section 1905(p)(3) of the Act) if the providers or suppliers meet all Federal Medicaid enrollment requirements, including, but not limited to, all applicable provisions of 42 CFR part 455, subparts B and E. This paragraph (d) applies even if the Medicare enrolled provider or supplier is of a type not recognized by the State Medicaid Agency.

§ 455.412 Verification of provider licenses.
The State Medicaid agency must—

(a) Have a method for verifying that any provider purporting to be licensed in accordance with the laws of any State is licensed by such State.

(b) Confirm that the provider's license has not expired and that there are no current limitations on the provider's license.

§ 455.414 Revalidation of enrollment.
The State Medicaid agency must revalidate the enrollment of all providers regardless of provider type at least every 5 years.

Appendix 3:

Reimbursed Medicaid Claims Per FY 2020~FY 2022

FY 2020	
Medicaid Provider(s)	**Total Paid Amounts for FY 2020**
PROVIDER 1	$47,043,625.85
PROVIDER 4	$18,293,407.29
PROVIDER 9	$4,267,077.62
PROVIDER 8	$4,061,831.18
PROVIDER 5	$3,036,513.77
PROVIDER 6	$2,584,554.43
PROVIDER 13	$2,507,487.08
PROVIDER 12	$2,193,945.30
PROVIDER 37	$1,972,721.59
PROVIDER 36	$1,780,877.50
PROVIDER 38	$1,717,490.37
PROVIDER 10	$1,606,755.01
PROVIDER 2	$1,461,827.41
PROVIDER 11	$1,268,368.75
PROVIDER 17	$1,193,640.37
PROVIDER 15	$1,093,878.61
PROVIDER 14	$1,073,782.90
PROVIDER 39	$1,061,284.81
PROVIDER 19	$1,024,667.10
PROVIDER 44	$1,006,747.19
PROVIDER 50	$1,003,706.59
PROVIDER 41	$968,512.09
PROVIDER 16	$967,205.54
PROVIDER 3	$960,717.05
PROVIDER 40	$920,126.00
PROVIDER 18	$903,636.06
PROVIDER 45	$814,613.13
PROVIDER 42	$808,061.06
PROVIDER 49	$804,840.67
PROVIDER 51	$770,488.39
PROVIDER 52	$765,410.33
PROVIDER 20	$749,604.56
PROVIDER 84	$648,196.46
PROVIDER 47	$646,680.97
PROVIDER 53	$646,447.19
Subtotal	**$112,628,730.22**

FY 2020	
Medicaid Provider(s)	**Total Paid Amounts for FY 2020**
PROVIDER 54	$574,136.55
PROVIDER 64	$563,939.96
PROVIDER 58	$563,340.00
PROVIDER 21	$548,688.03
PROVIDER 59	$487,775.58
PROVIDER 56	$480,184.92
PROVIDER 62	$474,406.69
PROVIDER 48	$452,157.06
PROVIDER 60	$450,482.44
PROVIDER 7	$441,058.28
PROVIDER 101	$434,322.72
PROVIDER 69	$423,021.28
PROVIDER 66	$406,339.48
PROVIDER 65	$393,757.26
PROVIDER 43	$381,517.22
PROVIDER 70	$360,948.77
PROVIDER 57	$352,158.04
PROVIDER 71	$348,560.81
PROVIDER 61	$342,222.84
PROVIDER 23	$340,058.91
PROVIDER 67	$339,845.47
PROVIDER 106	$336,500.00
PROVIDER 73	$324,209.31
PROVIDER 63	$318,732.50
PROVIDER 80	$313,755.29
PROVIDER 76	$297,956.40
PROVIDER 114	$284,960.31
PROVIDER 78	$282,129.04
PROVIDER 83	$273,849.01
PROVIDER 77	$268,123.63
PROVIDER 93	$266,846.57
PROVIDER 82	$257,549.78
PROVIDER 22	$244,177.99
PROVIDER 86	$240,498.54
PROVIDER 79	$240,162.97
PROVIDER 81	$229,538.83
Subtotal	**$13,337,912.48**

FY 2020	
Medicaid Provider(s)	**Total Paid Amounts for FY 2020**
PROVIDER 88	$222,480.06
PROVIDER 74	$218,143.50
PROVIDER 112	$214,989.04
PROVIDER 117	$191,835.90
PROVIDER 92	$179,391.70
PROVIDER 98	$178,480.10
PROVIDER 90	$178,071.54
PROVIDER 102	$173,592.38
PROVIDER 95	$163,471.95
PROVIDER 87	$158,694.98
PROVIDER 94	$152,094.48
PROVIDER 104	$146,784.70
PROVIDER 99	$145,953.87
PROVIDER 115	$142,186.75
PROVIDER 89	$141,568.58
PROVIDER 96	$135,387.84
PROVIDER 97	$131,708.83
PROVIDER 46	$126,237.97
PROVIDER 103	$122,576.95
PROVIDER 107	$121,679.61
PROVIDER 123	$114,845.96
PROVIDER 24	$112,750.96
PROVIDER 124	$110,355.24
PROVIDER 113	$109,394.99
PROVIDER 136	$107,982.23
PROVIDER 130	$96,282.48
PROVIDER 109	$91,845.59
PROVIDER 105	$91,239.72
PROVIDER 142	$89,007.14
PROVIDER 110	$81,418.46
PROVIDER 111	$77,698.24
PROVIDER 75	$76,604.38
PROVIDER 148	$75,043.25
PROVIDER 126	$73,069.74
PROVIDER 120	$71,564.96
PROVIDER 121	$63,996.89
Subtotal	**$4,688,430.96**

FY 2020	
Medicaid Provider(s)	**Total Paid Amounts for FY 2020**
PROVIDER 134	$60,432.20
PROVIDER 127	$59,934.06
PROVIDER 155	$59,849.19
PROVIDER 133	$59,553.87
PROVIDER 138	$54,078.91
PROVIDER 122	$53,530.18
PROVIDER 128	$48,838.93
PROVIDER 154	$41,371.22
PROVIDER 137	$38,972.51
PROVIDER 164	$38,692.40
PROVIDER 135	$38,378.16
PROVIDER 25	$38,284.86
PROVIDER 100	$37,017.98
PROVIDER 132	$36,717.83
PROVIDER 141	$33,503.77
PROVIDER 125	$32,830.40
PROVIDER 131	$32,562.94
PROVIDER 140	$31,931.40
PROVIDER 171	$31,201.72
PROVIDER 147	$30,495.26
PROVIDER 144	$30,127.42
PROVIDER 108	$29,942.77
PROVIDER 172	$28,016.85
PROVIDER 146	$27,957.48
PROVIDER 143	$24,414.63
PROVIDER 149	$23,976.89
PROVIDER 175	$23,115.38
PROVIDER 139	$20,000.63
PROVIDER 161	$18,857.70
PROVIDER 158	$18,819.43
PROVIDER 160	$17,035.29
PROVIDER 163	$16,238.57
PROVIDER 116	$15,129.54
PROVIDER 165	$13,915.51
PROVIDER 174	$13,437.91
PROVIDER 152	$12,881.20
Subtotal	**$1,192,044.99**

FY 2020	
Medicaid Provider(s)	**Total Paid Amounts for FY 2020**
PROVIDER 159	$12,648.13
PROVIDER 153	$11,662.31
PROVIDER 168	$11,490.76
PROVIDER 170	$10,936.15
PROVIDER 166	$9,613.40
PROVIDER 190	$6,873.90
PROVIDER 162	$6,236.13
PROVIDER 184	$6,153.26
PROVIDER 185	$5,925.67
PROVIDER 183	$5,631.00
PROVIDER 173	$5,563.36
PROVIDER 182	$5,416.26
PROVIDER 188	$4,580.76
PROVIDER 186	$3,324.24
PROVIDER 178	$3,106.88
PROVIDER 29	$3,014.50
PROVIDER 193	$2,764.60
PROVIDER 189	$2,436.83
PROVIDER 200	$2,216.50
PROVIDER 192	$2,100.00
PROVIDER 197	$1,500.00
PROVIDER 194	$1,332.40
PROVIDER 28	$1,137.44
PROVIDER 169	$1,032.68
PROVIDER 205	$989.04
PROVIDER 206	$975.89
PROVIDER 207	$959.05
PROVIDER 208	$888.86
PROVIDER 195	$857.29
PROVIDER 167	$827.11
PROVIDER 151	$770.88
PROVIDER 198	$750.01
PROVIDER 210	$587.33
PROVIDER 191	$559.65
PROVIDER 31	$329.16
PROVIDER 211	$313.85
Subtotal	**$135,505.28**

FY 2020	
Medicaid Provider(s)	**Total Paid Amounts for FY 2020**
PROVIDER 204	$310.41
PROVIDER 213	$153.72
PROVIDER 201	$145.86
PROVIDER 32	$141.03
PROVIDER 33	$121.38
PROVIDER 34	$78.58
PROVIDER 35	$29.60
PROVIDER 26	$0.00
PROVIDER 27	$0.00
PROVIDER 30	$0.00
PROVIDER 55	$0.00
PROVIDER 68	$0.00
PROVIDER 72	$0.00
PROVIDER 85	$0.00
PROVIDER 91	$0.00
PROVIDER 118	$0.00
PROVIDER 119	$0.00
PROVIDER 129	$0.00
PROVIDER 145	$0.00
PROVIDER 150	$0.00
PROVIDER 156	$0.00
PROVIDER 157	$0.00
PROVIDER 176	$0.00
PROVIDER 177	$0.00
PROVIDER 179	$0.00
PROVIDER 180	$0.00
PROVIDER 181	$0.00
PROVIDER 187	$0.00
PROVIDER 196	$0.00
PROVIDER 199	$0.00
PROVIDER 203	$0.00
PROVIDER 209	$0.00
PROVIDER 212	$0.00
PROVIDER 214	$0.00
PROVIDER 215	$0.00
PROVIDER 216	$0.00
Subtotal	**$980.58**

FY 2020	
Medicaid Provider(s)	**Total Paid Amounts for FY 2020**
PROVIDER 217	$0.00
PROVIDER 218	$0.00
PROVIDER 219	$0.00
PROVIDER 220	$0.00
PROVIDER 221	$0.00
PROVIDER 222	$0.00
PROVIDER 223	$0.00
PROVIDER 224	$0.00
PROVIDER 225	$0.00
PROVIDER 226	$0.00
PROVIDER 227	$0.00
PROVIDER 228	$0.00
PROVIDER 229	$0.00
Subtotal	**$0.00**

Total of Medicaid Claims for FY 2020	**$131,983,604.51**

Appendix 3:

Reimbursed Medicaid Claims Per FY 2020~FY 2022

FY 2021	
Medicaid Provider(s)	**Total Paid Amounts for FY 2021**
PROVIDER 1	$30,423,619.49
PROVIDER 4	$15,110,384.41
PROVIDER 11	$4,174,742.99
PROVIDER 10	$4,132,378.06
PROVIDER 9	$3,503,445.25
PROVIDER 8	$2,591,909.49
PROVIDER 5	$2,554,812.60
PROVIDER 12	$2,253,741.25
PROVIDER 13	$2,165,413.53
PROVIDER 6	$1,849,873.36
PROVIDER 37	$1,525,533.07
PROVIDER 46	$1,471,067.35
PROVIDER 36	$1,337,490.54
PROVIDER 39	$1,244,787.40
PROVIDER 16	$1,150,231.12
PROVIDER 43	$1,131,908.33
PROVIDER 15	$1,109,701.34
PROVIDER 14	$1,108,061.38
PROVIDER 38	$1,056,246.36
PROVIDER 2	$994,681.83
PROVIDER 45	$911,944.06
PROVIDER 41	$902,725.01
PROVIDER 40	$892,448.00
PROVIDER 42	$848,457.54
PROVIDER 50	$815,920.36
PROVIDER 49	$755,480.00
PROVIDER 47	$735,771.79
PROVIDER 52	$681,137.46
PROVIDER 44	$657,212.44
PROVIDER 3	$642,143.72
PROVIDER 48	$625,730.61
PROVIDER 59	$544,105.49
PROVIDER 54	$509,854.77
PROVIDER 56	$498,756.72
PROVIDER 53	$486,638.00
PROVIDER 60	$458,051.42
Subtotal	**$91,856,406.54**

FY 2021	
Medicaid Provider(s)	**Total Paid Amounts for FY 2021**
PROVIDER 61	$442,341.66
PROVIDER 57	$428,606.62
PROVIDER 65	$426,146.55
PROVIDER 62	$419,349.70
PROVIDER 51	$410,245.06
PROVIDER 63	$393,671.33
PROVIDER 66	$385,231.18
PROVIDER 68	$378,606.25
PROVIDER 69	$370,180.89
PROVIDER 18	$369,343.26
PROVIDER 58	$347,560.00
PROVIDER 64	$332,179.45
PROVIDER 67	$330,985.26
PROVIDER 70	$318,843.70
PROVIDER 73	$310,051.12
PROVIDER 78	$304,911.83
PROVIDER 71	$304,823.60
PROVIDER 83	$289,860.60
PROVIDER 81	$285,474.49
PROVIDER 19	$271,534.46
PROVIDER 118	$270,952.32
PROVIDER 82	$264,868.62
PROVIDER 74	$255,113.55
PROVIDER 79	$249,633.58
PROVIDER 75	$249,103.60
PROVIDER 77	$242,205.51
PROVIDER 76	$238,012.72
PROVIDER 17	$221,917.54
PROVIDER 22	$201,042.63
PROVIDER 89	$194,670.70
PROVIDER 87	$179,969.00
PROVIDER 97	$179,511.10
PROVIDER 93	$178,007.80
PROVIDER 88	$177,351.60
PROVIDER 20	$162,097.72
PROVIDER 102	$160,420.06
Subtotal	**$10,544,825.06**

FY 2021	
Medicaid Provider(s)	**Total Paid Amounts for FY 2021**
PROVIDER 99	$155,049.41
PROVIDER 90	$154,135.48
PROVIDER 21	$152,753.32
PROVIDER 94	$152,046.98
PROVIDER 108	$147,746.54
PROVIDER 95	$147,508.02
PROVIDER 96	$147,351.01
PROVIDER 86	$146,031.20
PROVIDER 98	$142,696.33
PROVIDER 23	$142,078.31
PROVIDER 92	$140,597.62
PROVIDER 105	$140,413.81
PROVIDER 24	$133,410.46
PROVIDER 80	$132,997.58
PROVIDER 125	$126,213.17
PROVIDER 110	$126,203.20
PROVIDER 103	$117,863.75
PROVIDER 104	$114,332.24
PROVIDER 109	$107,862.19
PROVIDER 111	$101,761.75
PROVIDER 122	$99,541.35
PROVIDER 7	$98,980.86
PROVIDER 113	$93,111.65
PROVIDER 100	$87,187.85
PROVIDER 116	$85,554.14
PROVIDER 112	$80,089.22
PROVIDER 120	$75,297.39
PROVIDER 121	$73,791.24
PROVIDER 131	$70,148.97
PROVIDER 124	$69,470.49
PROVIDER 107	$68,063.37
PROVIDER 126	$65,320.05
PROVIDER 115	$63,348.80
PROVIDER 123	$56,889.45
PROVIDER 138	$55,293.25
PROVIDER 132	$53,335.94
Subtotal	**$3,924,476.39**

FY 2021	
Medicaid Provider(s)	**Total Paid Amounts for FY 2021**
PROVIDER 128	$52,323.28
PROVIDER 134	$50,477.03
PROVIDER 139	$47,126.01
PROVIDER 127	$46,224.53
PROVIDER 144	$45,178.51
PROVIDER 141	$44,858.21
PROVIDER 25	$43,695.49
PROVIDER 133	$43,184.91
PROVIDER 26	$41,733.06
PROVIDER 137	$38,651.79
PROVIDER 135	$35,549.21
PROVIDER 167	$33,860.01
PROVIDER 85	$32,866.03
PROVIDER 151	$29,244.71
PROVIDER 140	$28,316.22
PROVIDER 143	$27,558.65
PROVIDER 147	$24,538.82
PROVIDER 146	$24,068.47
PROVIDER 169	$23,967.56
PROVIDER 176	$20,953.10
PROVIDER 161	$20,807.84
PROVIDER 158	$19,219.47
PROVIDER 153	$18,979.98
PROVIDER 142	$17,933.19
PROVIDER 130	$17,330.55
PROVIDER 159	$17,255.39
PROVIDER 162	$16,128.28
PROVIDER 136	$13,916.07
PROVIDER 160	$13,643.41
PROVIDER 180	$13,321.10
PROVIDER 166	$12,690.01
PROVIDER 163	$12,229.73
PROVIDER 168	$12,137.98
PROVIDER 178	$11,676.36
PROVIDER 150	$11,296.77
PROVIDER 149	$10,596.82
Subtotal	**$973,538.55**

FY 2021	
Medicaid Provider(s)	**Total Paid Amounts for FY 2021**
PROVIDER 173	$9,763.23
PROVIDER 154	$9,527.29
PROVIDER 170	$9,475.35
PROVIDER 152	$8,709.03
PROVIDER 119	$7,596.33
PROVIDER 174	$7,262.82
PROVIDER 183	$5,630.87
PROVIDER 165	$5,539.26
PROVIDER 182	$5,250.94
PROVIDER 155	$4,237.69
PROVIDER 194	$3,827.50
PROVIDER 185	$3,251.17
PROVIDER 193	$2,547.00
PROVIDER 186	$2,495.23
PROVIDER 191	$2,471.31
PROVIDER 148	$2,260.55
PROVIDER 192	$2,251.48
PROVIDER 202	$1,802.52
PROVIDER 184	$1,665.60
PROVIDER 203	$1,530.76
PROVIDER 197	$1,394.09
PROVIDER 201	$1,011.51
PROVIDER 198	$716.08
PROVIDER 212	$456.76
PROVIDER 195	$454.78
PROVIDER 204	$215.27
PROVIDER 175	$115.49
PROVIDER 211	$19.77
PROVIDER 207	$14.64
PROVIDER 84	$0.00
PROVIDER 101	$0.00
PROVIDER 106	$0.00
PROVIDER 114	$0.00
PROVIDER 117	$0.00
PROVIDER 164	$0.00
Subtotal	**$101,494.32**

FY 2021	
Medicaid Provider(s)	**Total Paid Amounts for FY 2021**
PROVIDER 171	$0.00
PROVIDER 172	$0.00
PROVIDER 190	$0.00
PROVIDER 188	$0.00
PROVIDER 29	$0.00
PROVIDER 189	$0.00
PROVIDER 200	$0.00
PROVIDER 28	$0.00
PROVIDER 205	$0.00
PROVIDER 206	$0.00
PROVIDER 208	$0.00
PROVIDER 210	$0.00
PROVIDER 31	$0.00
PROVIDER 213	$0.00
PROVIDER 32	$0.00
PROVIDER 33	$0.00
PROVIDER 34	$0.00
PROVIDER 35	$0.00
PROVIDER 27	$0.00
PROVIDER 30	$0.00
PROVIDER 55	$0.00
PROVIDER 72	$0.00
PROVIDER 91	$0.00
PROVIDER 129	$0.00
PROVIDER 145	$0.00
PROVIDER 156	$0.00
PROVIDER 157	$0.00
PROVIDER 177	$0.00
PROVIDER 179	$0.00
PROVIDER 181	$0.00
PROVIDER 187	$0.00
PROVIDER 196	$0.00
PROVIDER 199	$0.00
PROVIDER 209	$0.00
PROVIDER 214	$0.00
PROVIDER 215	$0.00
Subtotal	**$0.00**

FY 2021	
Medicaid Provider(s)	**Total Paid Amounts for FY 2021**
PROVIDER 216	$0.00
PROVIDER 217	$0.00
PROVIDER 218	$0.00
PROVIDER 219	$0.00
PROVIDER 220	$0.00
PROVIDER 221	$0.00
PROVIDER 222	$0.00
PROVIDER 223	$0.00
PROVIDER 224	$0.00
PROVIDER 225	$0.00
PROVIDER 226	$0.00
PROVIDER 227	$0.00
PROVIDER 228	$0.00
PROVIDER 229	$0.00
Subtotal	**$0.00**

Total Medicaid Claims for FY 2021	**$107,400,740.86**

Appendix 3:

Reimbursed Medicaid Claims Per FY 2020~FY 2022

FY 2022	
Medicaid Provider(s)	**Total Paid Amounts for FY 2022**
PROVIDER 1	$52,826,905.75
PROVIDER 4	$21,149,986.11
PROVIDER 8	$6,130,877.91
PROVIDER 9	$3,778,811.52
PROVIDER 6	$3,703,270.10
PROVIDER 5	$3,407,079.29
PROVIDER 10	$2,952,856.88
PROVIDER 12	$2,769,543.25
PROVIDER 13	$2,433,714.70
PROVIDER 36	$2,368,984.94
PROVIDER 17	$1,962,459.85
PROVIDER 18	$1,866,460.07
PROVIDER 20	$1,852,580.23
PROVIDER 2	$1,845,633.01
PROVIDER 19	$1,830,861.47
PROVIDER 11	$1,807,656.98
PROVIDER 55	$1,605,429.67
PROVIDER 48	$1,393,702.36
PROVIDER 37	$1,364,983.16
PROVIDER 14	$1,353,076.78
PROVIDER 15	$1,327,477.96
PROVIDER 42	$1,323,186.16
PROVIDER 16	$1,310,606.05
PROVIDER 21	$1,303,760.60
PROVIDER 43	$1,268,318.83
PROVIDER 40	$1,259,557.00
PROVIDER 38	$1,181,655.53
PROVIDER 47	$1,132,718.28
PROVIDER 41	$1,112,670.70
PROVIDER 44	$1,082,293.88
PROVIDER 46	$1,054,925.85
PROVIDER 51	$1,049,221.83
PROVIDER 45	$1,017,857.38
PROVIDER 72	$1,015,448.68
PROVIDER 39	$986,854.46
PROVIDER 49	$834,042.24
Subtotal	**$136,665,469.46**

FY 2022	
Medicaid Provider(s)	**Total Paid Amounts for FY 2022**
PROVIDER 68	$789,452.11
PROVIDER 57	$781,315.87
PROVIDER 52	$760,170.62
PROVIDER 61	$688,455.87
PROVIDER 54	$687,757.39
PROVIDER 53	$668,305.48
PROVIDER 58	$624,550.00
PROVIDER 56	$617,358.21
PROVIDER 85	$601,663.49
PROVIDER 60	$592,558.19
PROVIDER 75	$579,637.93
PROVIDER 63	$575,378.78
PROVIDER 50	$534,915.51
PROVIDER 3	$532,379.37
PROVIDER 91	$514,871.35
PROVIDER 22	$511,202.13
PROVIDER 67	$502,638.23
PROVIDER 59	$471,341.50
PROVIDER 62	$470,461.33
PROVIDER 74	$445,980.01
PROVIDER 65	$422,179.67
PROVIDER 66	$399,188.53
PROVIDER 70	$398,945.17
PROVIDER 71	$381,454.34
PROVIDER 64	$354,985.00
PROVIDER 80	$331,792.04
PROVIDER 69	$322,814.95
PROVIDER 100	$319,252.09
PROVIDER 77	$312,089.15
PROVIDER 79	$307,667.30
PROVIDER 73	$295,407.24
PROVIDER 76	$294,044.56
PROVIDER 119	$244,326.78
PROVIDER 87	$239,513.39
PROVIDER 81	$234,617.42
PROVIDER 82	$218,602.26
Subtotal	**$17,027,273.26**

Appendix 3:

Reimbursed Medicaid Claims Per FY 2020~FY 2022

FY 2022	
Medicaid Provider(s)	**Total Paid Amounts for FY 2022**
PROVIDER 86	$218,152.85
PROVIDER 78	$216,067.15
PROVIDER 89	$202,979.38
PROVIDER 90	$202,477.91
PROVIDER 96	$195,166.50
PROVIDER 92	$190,211.19
PROVIDER 94	$185,314.15
PROVIDER 95	$178,082.49
PROVIDER 116	$177,289.95
PROVIDER 129	$173,070.22
PROVIDER 103	$168,017.70
PROVIDER 83	$167,520.31
PROVIDER 105	$160,069.08
PROVIDER 97	$155,841.90
PROVIDER 88	$145,914.65
PROVIDER 99	$144,620.09
PROVIDER 108	$138,752.82
PROVIDER 104	$136,202.47
PROVIDER 98	$134,419.41
PROVIDER 107	$133,808.06
PROVIDER 111	$118,719.29
PROVIDER 109	$111,499.60
PROVIDER 121	$101,487.70
PROVIDER 120	$94,962.57
PROVIDER 145	$93,286.00
PROVIDER 110	$92,229.40
PROVIDER 25	$88,868.74
PROVIDER 113	$86,153.06
PROVIDER 122	$84,907.08
PROVIDER 127	$84,419.28
PROVIDER 126	$82,069.34
PROVIDER 117	$81,661.34
PROVIDER 102	$79,400.70
PROVIDER 132	$77,032.64
PROVIDER 128	$73,145.47
PROVIDER 115	$72,665.08
Subtotal	**$4,846,485.57**

Appendix 3:

Reimbursed Medicaid Claims Per FY 2020~FY 2022

FY 2022	
Medicaid Provider(s)	**Total Paid Amounts for FY 2022**
PROVIDER 123	$65,731.85
PROVIDER 131	$64,877.69
PROVIDER 150	$64,570.40
PROVIDER 93	$62,430.42
PROVIDER 125	$62,342.36
PROVIDER 26	$62,080.48
PROVIDER 156	$61,903.66
PROVIDER 157	$61,315.26
PROVIDER 140	$61,079.40
PROVIDER 130	$58,045.69
PROVIDER 143	$57,380.98
PROVIDER 139	$57,370.40
PROVIDER 135	$55,852.66
PROVIDER 124	$51,447.55
PROVIDER 137	$49,723.77
PROVIDER 27	$46,237.87
PROVIDER 152	$45,447.63
PROVIDER 151	$43,948.30
PROVIDER 149	$41,569.99
PROVIDER 146	$39,124.71
PROVIDER 141	$37,676.04
PROVIDER 133	$36,821.94
PROVIDER 153	$34,313.53
PROVIDER 159	$27,742.36
PROVIDER 23	$26,636.97
PROVIDER 134	$26,571.69
PROVIDER 147	$25,003.52
PROVIDER 160	$22,509.32
PROVIDER 144	$21,745.57
PROVIDER 158	$20,378.42
PROVIDER 177	$20,256.72
PROVIDER 162	$17,466.15
PROVIDER 179	$17,258.18
PROVIDER 165	$16,315.56
PROVIDER 138	$16,238.10
PROVIDER 154	$13,887.22
Subtotal	**$1,493,302.36**

Appendix 3:

Reimbursed Medicaid Claims Per FY 2020~FY 2022

FY 2022	
Medicaid Provider(s)	**Total Paid Amounts for FY 2022**
PROVIDER 166	$12,912.27
PROVIDER 181	$12,768.26
PROVIDER 170	$11,728.04
PROVIDER 173	$11,621.37
PROVIDER 168	$10,677.13
PROVIDER 161	$10,480.15
PROVIDER 163	$10,294.44
PROVIDER 169	$8,094.54
PROVIDER 187	$7,992.55
PROVIDER 136	$6,655.12
PROVIDER 174	$5,777.92
PROVIDER 28	$5,492.80
PROVIDER 189	$4,568.61
PROVIDER 178	$4,359.11
PROVIDER 7	$3,990.83
PROVIDER 196	$3,715.87
PROVIDER 195	$3,474.67
PROVIDER 142	$3,471.44
PROVIDER 191	$3,247.39
PROVIDER 188	$3,117.43
PROVIDER 186	$2,992.13
PROVIDER 199	$2,549.21
PROVIDER 184	$2,528.13
PROVIDER 30	$1,845.88
PROVIDER 182	$1,784.05
PROVIDER 192	$1,694.51
PROVIDER 198	$1,344.04
PROVIDER 185	$1,071.90
PROVIDER 201	$1,054.44
PROVIDER 204	$900.48
PROVIDER 183	$836.17
PROVIDER 209	$594.12
PROVIDER 24	$335.16
PROVIDER 167	$257.77
PROVIDER 211	$162.00
Subtotal	**$164,389.93**

FY 2022	
Medicaid Provider(s)	**Total Paid Amounts for FY 2022**
PROVIDER 197	$42.47
PROVIDER 118	$0.00
PROVIDER 112	$0.00
PROVIDER 176	$0.00
PROVIDER 180	$0.00
PROVIDER 155	$0.00
PROVIDER 194	$0.00
PROVIDER 193	$0.00
PROVIDER 148	$0.00
PROVIDER 202	$0.00
PROVIDER 203	$0.00
PROVIDER 212	$0.00
PROVIDER 175	$0.00
PROVIDER 207	$0.00
PROVIDER 84	$0.00
PROVIDER 101	$0.00
PROVIDER 106	$0.00
PROVIDER 114	$0.00
PROVIDER 164	$0.00
PROVIDER 171	$0.00
PROVIDER 172	$0.00
PROVIDER 190	$0.00
PROVIDER 29	$0.00
PROVIDER 200	$0.00
PROVIDER 205	$0.00
PROVIDER 206	$0.00
PROVIDER 208	$0.00
PROVIDER 210	$0.00
PROVIDER 31	$0.00
PROVIDER 213	$0.00
PROVIDER 32	$0.00
PROVIDER 33	$0.00
PROVIDER 34	$0.00
PROVIDER 35	$0.00
PROVIDER 214	$0.00
PROVIDER 215	$0.00
Subtotal	**$42.47**

FY 2022	
Medicaid Provider(s)	**Total Paid Amounts for FY 2022**
PROVIDER 216	$0.00
PROVIDER 217	$0.00
PROVIDER 218	$0.00
PROVIDER 219	$0.00
PROVIDER 220	$0.00
PROVIDER 221	$0.00
PROVIDER 222	$0.00
PROVIDER 223	$0.00
PROVIDER 224	$0.00
PROVIDER 225	$0.00
PROVIDER 226	$0.00
PROVIDER 227	$0.00
PROVIDER 228	$0.00
PROVIDER 229	$0.00
Subtotal of Medicaid Claims	**$0.00**

Total of FY 2022 Medicaid Claims	**$160,196,963.05**

Total of Medicaid Claims FY 2020~2022	**$399,581,308.42**

Appendix 3:

Reimbursed Medicaid Claims Per FY 2020~FY 2022-Uncategorized Providers

Uncategorized Provider(s)	
Medicaid Provider(s)	**Total Paid Amounts for FY 2020~2022**
PROVIDER 8	$12,784,618.58
PROVIDER 10	$8,691,989.95
PROVIDER 11	$7,250,768.72
PROVIDER 15	$3,531,057.91
PROVIDER 43	$2,781,744.38
PROVIDER 46	$2,652,231.17
PROVIDER 52	$2,206,718.41
PROVIDER 55	$1,605,429.67
PROVIDER 58	$1,535,450.00
PROVIDER 70	$1,078,737.64
PROVIDER 22	$956,422.75
PROVIDER 84	$648,196.46
PROVIDER 85	$634,529.52
PROVIDER 91	$514,871.35
PROVIDER 23	$508,774.19
PROVIDER 100	$443,457.92
PROVIDER 101	$434,322.72
PROVIDER 106	$336,500.00
PROVIDER 107	$323,551.04
PROVIDER 114	$284,960.31
PROVIDER 117	$273,497.24
PROVIDER 118	$270,952.32
PROVIDER 24	$246,496.58
PROVIDER 122	$237,978.61
PROVIDER 129	$173,070.22
PROVIDER 131	$167,589.60
PROVIDER 138	$125,610.26
PROVIDER 26	$103,813.54
PROVIDER 144	$97,051.50
PROVIDER 145	$93,286.00
PROVIDER 157	$61,315.26
PROVIDER 162	$39,830.56
PROVIDER 164	$38,692.40
PROVIDER 166	$35,215.68
Uncategorized Subtotal	**$51,168,732.46**

Appendix 3:

Reimbursed Medicaid Claims Per FY 2020~FY 2022-Uncategorized Providers

Uncategorized Provider(s)	
Medicaid Provider(s)	**Total Paid Amounts for FY 2020~2022**
PROVIDER 167	$34,944.89
PROVIDER 169	$33,094.78
PROVIDER 171	$31,201.72
PROVIDER 172	$28,016.85
PROVIDER 176	$20,953.10
PROVIDER 179	$17,258.18
PROVIDER 184	$10,346.99
PROVIDER 187	$7,992.55
PROVIDER 188	$7,698.19
PROVIDER 189	$7,005.44
PROVIDER 190	$6,873.90
PROVIDER 28	$6,630.24
PROVIDER 191	$6,278.35
PROVIDER 196	$3,715.87
PROVIDER 29	$3,014.50
PROVIDER 198	$2,810.13
PROVIDER 199	$2,549.21
PROVIDER 200	$2,216.50
PROVIDER 201	$2,211.81
PROVIDER 30	$1,845.88
PROVIDER 202	$1,802.52
PROVIDER 203	$1,530.76
PROVIDER 204	$1,426.16
PROVIDER 205	$989.04
PROVIDER 206	$975.89
PROVIDER 208	$888.86
PROVIDER 210	$587.33
PROVIDER 212	$456.76
PROVIDER 31	$329.16
PROVIDER 32	$141.03
PROVIDER 33	$121.38
PROVIDER 34	$78.58
PROVIDER 35	$29.60
Uncategorized Subtotal	**$246,016.15**

Total Uncategorized for FY 2020~2022	**$51,414,748.61**

Appendix 4:

Provider's Application and Agreement and Checklist

GUAM MEDICAID AND MIP PROVIDER APPLICATION AND AGREEMENT CHECKLIST	
☐	Copy of the Taxpayer Identification Number (TIN) / Federal Employer Identification Number (FEIN).
☐	Copy of business license at the physical location and must match business name on the Federal W-9 Form. If on-island provider, copy of the fictitious certicate, certificate of exemption or business license and must match business name on the Federal W-9 Form.
☐	Completed Federal W-9 Form. The business name, mailing address, and TIN / FEIN.
☐	Completed DOA Vendor Record & EFT Establishment Request Form w/ Voided Check or Personalized Deposit Slip.
☐	Copy of Business National Provider Identifier (NPI - 10 Digits)
☐	Copy of Professional National Provider Identifier (NPI - 10 Digits), and medical and DEA license.
☐	If Facility: ☐ Facility ☐ Professional ☐ Both
☐	If Pharmacy: Additional, DEA license for controlled substance drugs
☐	If Laboratory: Additional, Clinical Laboratory Improvement Amendments (CLIA) Certificate
☐	If Radiology: ☐ Technical ☐ Professional ☐ Both
☐	Copy of Medicare Certification / Approval Letter: When enrolled in the Medicare Program and for dual eligible recipients
☐	Billing Agent: Additional, Business Associate Agreement / Service Contract Agreement.

Government of Guam
DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
DIPATTAMENTON SALUT PUPBLEKO YAN SETBISION SUSIAT
BUREAU OF HEALTH CARE FINANCING ADMINISTRATION

GUAM MEDICAID AND MEDICALLY INDIGENT PROGRAM (MIP)
PROVIDER APPLICATION AND AGREEMENT

I HEREBY APPLY TO PARTICIPATE AS A PROVIDER AND REQUEST FOR ASSIGNMENT OF A VENDOR NUMBER FOR THE PAYMENTS, PROVIDER IDENTIFICATION NUMBER FOR THE CLAIMS, AND PROVIDER USER IDENTIFICATION NAME AND PASSWORD FOR THE PORTAL.

PROVIDER NAME: _____

BUSINESS/CORPORATION NAME: _____

Doing Business As (D.B.A.): _____

TIN/EIN: _____ NPI #: _____

*BUSINESS LICENSE #: _____

BUSINESS LICENSE TYPE : _____

* Guam Business License is required, GCA Title 11 Chapter 70, when engaging in/conducting a business on Guam.

BUSINESS PHYSICAL ADDRESS: _____

_____

BUSINESS MAILING ADDRESS: _____

_____

EMAIL: _____

TEL: _____ FAX: _____

CONTACT INFORMATION

NAME: _____ TITLE: _____

EMAIL: _____

TEL: _____ FAX: _____

PLEASE LIST PARTICIPATING PHYSICIANS OR HEALTH PROFESSIONALS PROVIDING SERVICES AND THEIR REQUIRED INFORMATION, AND PROVIDE A COPY OF CURRENT LICENSE/CERTIFICATE INCLUDING DEA LICENSE, NPI, CURRICULUM VITAE AND DIPLOMA.

NAME	SPECIALTY	NPI#	MEDICAL LICENSE / CERTIFICATE #	ISSUE DATE	EXP DATE

BHCFA Form 08-02 (v2 Feb. 2022) GUAM MEDICAID AND MIP PROVIDER APPLICATION AND AGREEMENT Page 1 of 3

O **BILLING AGENT: Provide a copy of the Business Associate Agreement / Service Contract Agreement.**

BILLING AGENT BUSINESS NAME: _____

STAFF NAME: _____ STAFF TITLE: _____

EMAIL: _____ TEL: _____ FAX: _____

O **EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) PROGRAM PROVIDER:** The EPSDT (age 20 yrs and below) comprehensive and preventive health care services must be performed by licensed physician and services are in accordance to the EPSDT program guidelines, policies, procedures and regulation.

The PROVIDER agrees:

1. To adhere to professional standards of medical or paramedical care and / or services and to comply with the Program's policies and procedures pertinent to the Provider's performance under this agreement;
2. To keep and permit access to such records as are necessary to disclose fully the extent of the services provided to the Medicaid / MIP recipients.
3. To disclose full and complete information regarding ownership and business transactions at the request of the Department, the Secretary of the Department of Health and Human Services, or the Bureau of Investigations and Benefits Recovery Unit.
4. To furnish the Department and the Secretary of the Department of Health and Human Services any information regarding payments claimed for services provided to eligible Medicaid / MIP recipients in accordance with the Medicaid State Plan, the Territorial laws and Government of Guam Rules and Regulations, as the Department or the Secretary may from time to time
5. To accept the established Guam Medicaid / Medically Indigent Programs reimbursement rates and payments as full payment and not to bill, accept or retain payment from patients or relatives for any additional amount other than the required co-payment and co-shares and payments for non-covered services;
6. To utilize patient's medical insurance resources, including but not limited to Medicare, private insurance, and insurance provided by employers and unions, before submitting claims to the Medicaid / MIP;
7. To submit all charges within one (1) year after service date except for Medicaid and MIP with Third Party Liability (TPL) which should be submitted within sixty (60) additional days from the receipt date of the TPL payments/statements;
8. To submit all claims/bills to the following address:
   DPHSS Bureau of Health Care Financing Administration
   155 Hesler Place
   Hagatna, Guam 96910
   Telephone Number: (671) 300-7330 / 7338 / 7335
   Fax Number: (671) 300-7354
9. To assume total responsibility for collecting required patient co-payments, co-insurances and other patient liabilities;
10. To have in effect for hospitals, a Utilization Review Plan to assure the necessity of admission, length of stay, and the level of care appropriateness as required by 42 CFR 456.80 and 456.100.
11. To abide by the provisions of the Civil Rights Act of 1964, specifically stating that "no persons in the United States shall, on the grounds of race, creed, color, national origin, or handicapping condition, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal Financial Assistance;
12. That this agreement may be terminated by a 30-day written notification by the Director of the Department of Public Health & Social Services (DPHSS) and a change of ownership, and revalidated at least every 5 years;
13. That violation of any of the terms in this agreement may result in withholding of payment, suspension/termination from participation, or as in accordance with the terms of 42 CFR 455;
14. That all claims for services rendered to Medicaid / MIP recipients are provided by qualified, licensed health professionals;
15. That retroactive provider certification shall be limited to the first day of the third month from date the completed application has been credentialed. The month in which the completed application was received shall be counted as the first month. Upon approval for participation, Bureau of Health Care Financing Administration (BHCFA) will notify via email along with your vendor number, provider identification number, and provider user identification name and password, and orientation as requested;
16. To provide the BHCFA any operation updates as soon as changes are in effect to include the list of physicians or any health professionals affiliated within group practice and renewal, termination or suspension of licenses and certificates.
17. That claims reconciliation are limited to three (3) years from the date of service.

The DEPARTMENT agrees:

1. To reimburse Provider for covered services in accordance with the program covered benefits.
2. To process all "clean" claims within forty-five (45) days after receipt of invoices from Provider. Clean claims are claims that can be processed without obtaining additional information and/or documentation from the Provider of the service.
3. To reimburse the Provider for program recipient's deductible, coinsurance, and/or co-payment from the recipient's primary insurance/Third Party Payor, not to exceed the programs fee schedule for the service.

I have read the agreement/conditions of the Guam Medicaid and MIP Provider Agreement and fully understand and agree to the terms and conditions provided therein.

AUTHORIZED OFFICIAL'S NAME	TITLE
AUTHORIZED OFFICIAL'S SIGNATURE	DATE

DEPARTMENT APPROVAL

ARTHUR U. SAN AGUSTIN, MHR AUTHORIZED DPHSS'S NAME	DPHSS DIRECTOR TITLE
AUTHORIZED DPHSS'S SIGNATURE	DATE

FOR BHCFA USE ONLY

EFFECTIVE DATE: _____ TERMINATION DATE: _____

PROVIDER ID #: _____ VENDOR #: _____

PORTAL PROVIDER USER ID NAME / PASSWORD: _____

Appendix 5:

Medicaid Healthcare Provider Noncompliance Issues

Medicaid Provider(s)	Noncompliance Issues
Provider #12	• Provider name on the business license differs from PAA. • Missing documentation for healthcare employees' pictures and signatures. • PAA not signed off by Bureau of HCFA staff indicating completion
Provider #16	• PAA not signed off by DPHSS staff indicating completion. • No BL for January 2, 2021 to January 1, 2022 and January 1, 2022 to December 7, 2022. • No Department of Administration Vendor Record & Electronic Funds Transfer (EFT) Establishment Request Form and voided check or personalized deposit slip. • Clinical Laboratory Certificate of Waiver expired November 7, 2017. No renewal from 2018 to 2022.
Provider #17	• Data for BHCFA to fill in did not indicate the effective date and termination date. • No voided check or personalized deposit check on file. • Clinical Laboratory Certificate of Waiver expired December 20, 2020. No renewal from 2021 to 2023.
Provider #19	• No voided check or personalized deposit check on file. • Clinical Laboratory Certificate of Waiver expired December 20, 2020. There is no renewal from 2021 to2023.
Provider #1	• Employer Identification Number (EIN) was dated May 24, 2014 and Taxpayer Identification Number (TIN) was dated April 1, 2022, but the earliest PAA on file was dated/approved November 23, 2022. • No BL from 2018 to 2022. • Business Associate Agreement/Service Contract Agreement with billing agents, missing with four pages and signature page, thus not signed. • NPIs for 4 physicians without enumeration (effective) dates.

Appendix 5:

Medicaid Healthcare Provider Noncompliance Issues

Medicaid Provider(s)	Noncompliance Issues
Provider #2, Provider #3, Provider #4, Provider #5, Provider #6, Provider #7	• Certificate of Tax Exemption on file was dated March 12, 1993. No annual renewal until calendar year (CY) 2022, as required by the Business Privilege Tax rules. • No W-9 Form (Request for Taxpayer Identification Number and Certification) • Page 2 of the PAA, which contained the information of the billing agent and the provisions/conditions that the applicant Medicaid Provider agrees and has to comply is missing.
Provider #9 & Provider #16	• PAA lacks the following information: o Claims Information: category of service; type of provider: either facility, group, or individual. o Data for BHCFA to fill in: effective date, termination date, Provider ID No., Vendor ID No., Portal provider User ID.
Provider #20	• No BL for CY January 1, 2021 to January 1, 2022 and January 1, 2022 to December 7, 2022. • The PAA does not contain the list of participating physicians or health professionals providing services and the required information on their specialty, medical license issue date and expiry, and DEA license.
Provider #18	• No voided check or personalized deposit check on file. • The Clinical Laboratory Certificate of Waiver expired December 20, 2020. There is no renewal from CY 2021 to 2023
Provider #21	• No vendor record nor voided check or personalized deposit check on file. • No Clinical Laboratory Certificate. • No BL from January 2020 through January 2022. On file is a BL dated November 22, 2022.

Medicaid Provider(s)	Noncompliance Issues
Provider #8	• EIN/TIN #95-37777340 for PAA dated April 5, 2023 and No. #951690977 for another PAA dated April 5, 2023. • No vendor record nor voided check or personalized deposit check on file. • No BL.
Provider #10	• Data for BHCFA to fill in the PAA did not indicate the effective date and termination date. • Two PAAs have different DPHSS director approval dates: November 14, 2022 and June 7, 2023. Both were signed by the Medical Provider on November 14, 2022. The PAA dated November 14, 2022 had missing information. • W-9 on file dated September 4, 2021 is for a different named provider: Fast Access Specialty Therapeutics, LLC. which is not a registered Medical Provider per DPHSS record.
	• Vendor record does not have a date. No voided check or personalized deposit check on file. • All participating physicians or health professionals providing services did not have official pictures and signature identification documents such as passport, medical license, and driver's license. • No BL.
Provider #11	• Data for BHCFA to fill in the PAA and its addendum did not indicate the effective date and termination date. • No BL. • No Vendor record, and the EFT Establishment Request Form does not have a date. No voided check or personalized deposit check on file. • All participating physicians or health professionals providing services did not have official pictures and signature identification documents such as passport, medical license, and driver's license.

Appendix 5:

Medicaid Healthcare Provider Noncompliance Issues

Medicaid Provider	Noncompliance Issues
Provider #12	• Data for BHCFA to fill in the PAA and its addendum did not indicate the effective date and termination date. • No BL from July 1, 2017 to June 15, 2022.
Provider #14, Provider #15, Provider #25	• No Certificate of Exemption of Business License from September 16, 2017 to September 30, 2023.
Provider #14, Provider #15	• PAA without effectivity date and termination date not filled in by BHCFA, but the PAA was approved. • No BL for September 1, 2020 through August 7, 2022.
Provider #2	• BL had expired on April 30, 2021, but was renewed only on April 2, 2022, or was late by over 11 months. • No voided check or personalized deposit check on file.
Provider #30	• No Guam BL, needed also for an off-island provider. • No Federal Form W-9. • Vendor Record form was not signed by the requesting department. • No official pictures and signature identification documents such as passport, medical license, and driver's license.

Appendix 5:

Medicaid Healthcare Provider Noncompliance Issues

Medicaid Provider(s)	Noncompliance Issues
Provider #31	• No Guam BL, needed also for an off-island provider. • No copy of any Provider or Authorized Official's picture and signature identification (Passport, ML, Driver's License). • No Federal Form W-9. • Vendor Record form was not signed by the requesting department. • No voided check or personalized deposit check on file.
Provider #32	• No EIN/TIN. • No copy of any Provider or Authorized Official's picture and signature identification (Passport, Medical License, Driver's License). • No Federal Form W-9. • No DOA Vendor Record/EFT Establishment Request Form and no voided check and personalized deposit slip.
Provider #33	• No Business License. • No Federal Form W-9. • No copy of any Provider or Authorized Official's picture and signature identification (Passport, ML, Driver's License). • No DOA Vendor Record/EFT Establishment Request Form and no voided check and personalized deposit slip.

Appendix 6:

DPHSS Management Response

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

LOURDES A. LEON GUERRERO
MAGA'HÅGAN GUÅHAN
GOVERNOR OF GUAM

JOSHUA F. TENORIO
SEGUNDO MAGA'LÅHEN GUÅHAN
LT. GOVERNOR OF GUAM

THERESA C. ARRIOLA, MBA
DIRECTOR

PETERJOHN D. CAMACHO, MPH
DEPUTY DIRECTOR

TERRY G. AGUON
DEPUTY DIRECTOR

DEC 19 2024

Benjamin J.F. Cruz
Public Auditor, Office of the Public Accountability
Suite 401 DNA Building
238 Archbishop Flores Street
Hagatna, Guam 96910

Subject: **Audit Response – DPHSS Provider Eligibility – Part 1**
Re: Performance Audit: October 1, 2019, through September 30, 2022

Hafa Adai Mr. Cruz:

Please find DPHSS response to the audit findings as it relates to the Medicaid Program, Provider Eligibility, Part 1.

The Bureau of Health Care Financing Administration team has provided a corrective action plan response detailed in Attachment 1 as it references the following deficiencies identified in the report:

I. Record keeping and Storage
II. Medical Provider List (MPL)
III. Medicaid Provider Eligibility Screening and Revalidation Process
IV. Medicaid Providers' Licenses and other Federal and Local Regulation requirements

Should you have any questions or concerns, please contact Ms. Rachelle Paulino, Acting Chief Human Services Administrator at (671) 300-7334, or Ms. Terry T. Ascura, Human Services Program Administrator, BHFCA.

Sincerely,

RECEIVED
OFFICE OF PUBLIC ACCOUNTABILITY
BY: Fred
DATE: 12/20/2024
TIME: 8:29

THERESA C. ARRIOLA. MBA
Director, Department of Public Health & Social Services

Attachment

155 Hesler Place, Hagatna, Guam 96910
www.dphss.guam.gov

DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
Division of Public Welfare
Bureau of Health Care Financing Administration
Corrective Action Plan Response

No.	Recommendation	Deficiency Resolved?	Actions	Planned Completion	Lead
1.	To achieve effective monitoring and review of Medicaid providers' eligibility documents for revalidation or potential termination, which provide a tool in BHCFA's decision-making and examiners review processes, we recommend the following:	See Items 1.a.-1.c. below.	See Items 1.a.-1.c. below.	See Items 1.a.-1.c. below.	See Items 1.a.-1.c. below.
1.a.	a. Formulate and implement an SOP on file maintenance and storage, which includes clear guidelines for systematic filing, scanning, and safekeeping of both physical and digital records.	No.	i. Establish SOP on file maintenance and storage. ii. Implement SOP on file maintenance and storage.	i. SOP approved by January 31, 2025. ii. Begin implementing SOP February 1, 2025.	i. J. Janssen ii. A. Estrada
1.b.	b. Adopt an effective digital records repository system or centralized scanned file system by utilizing the capabilities of the existing PH Pro system or any other BHCFA preferred system.	No.	i. Establish a network drive to serve as an interim repository for scanned documents. Scan and file all provider documents. ii. Develop a draft advance planning document (APD) to provide a framework to analyze needs, goals, and objectives, develop alternatives, and conduct market research, develop feasibility analyses, and analyze alternatives.	i. Set up network drive by March 31, 2025. Scan and file all legacy provider documents by September 30, 2025. ii. Complete work on draft APD by June 15, 2025.	i. J. San Nicolas ii. J. Janssen
1.c.	c. Create/establish a consolidated Medicaid provider information database.	No.	i. Work with the MES vendor to either generate a specific report	i. Extract data from existing database to csv	i. A. Estrada ii. J. Janssen

PAGE 1 OF 4

			on providers or extract data from the existing database to csv format and track/update changes on the csv database file as provider information changes. ii. Develop an APD to provide a framework to analyze needs, goals, and objectives, develop alternatives, and conduct market research, develop feasibility analyses, and analyze alternatives.	format by January 31, 2025. Format/update changes for providers from February 1, 2025. ii. Complete work on draft APD by June 15, 2025.	
2.	"Inactive" Medicaid providers should be appropriately tagged and properly identified in the MPL, whatever BHCFA considers appropriate, to preclude misinterpretations by the users resulting in potential non-payment or duplicate payments.	No.	**a.** Request that the MES vendor establish an edit(s) in PH/Pro to prevent processing of claims with inactive providers. **b.i.** The MES vendor will program the edit into PH/Pro; ii. Identify staff with override privileges for the edit. iii; Update the Claims Processing SOP accordingly.	**a.** Submit request by January 15, 2025. **b.** MES vendor completes edit in PH/Pro, staff identified for override privileges, and SOP updated by August 31, 2025.	**a.** A. Estrada. **b.i.** MES vendor; ii. A. Estrada; iii. J. Janssen.
3.	If the MPL records are useful and significant to the BHCFA operations, we recommend that information be updated in the PH Pro system to generate updated and accurate MPLs.	No.	**a.** Establish review process via SOP on entry into PH Pro to ensure new or renewed providers are correctly added to PH Pro system. Implement the review process. **b.** While scanning and filing legacy provider documents per 1.b.i., review MPL records on PH Pro to ensure	**a.** SOP approved by January 15, 2025. Begin implementing by January 16, 2025. **b.** Complete review of legacy MPL records by September 30, 2025.	**a.** A. Estrada **b.** A. Estrada

PAGE 2 OF 4

			legacy data has been input correctly.		
4.	To ensure the propriety of Medicaid claims and reimbursements, we recommend that BHCFA identify in its records Medicaid providers consistently utilized for "emergency services" and require them to submit a completed and signed PAA, which is mandatory for all healthcare providers.	No.	**a.** Establish a list of Medicaid providers which are consistently utilized for emergency services in the previous fiscal year. Revisit annually thereafter. **b.** Submit a PAA to the providers. Revisit at least twice a year.	**a.** List established by January 15, 2025. b. PAA submitted to list by January 31, 2025. Resubmitted to providers which have not signed PAA by July 31, 2025.	**a.** R. Carpela b. Administrator
5.	We recommend strict compliance to the eligibility initial screening, documentation, and revalidation requirements.		**a.** Entry into an agreement with the Guam Health Professional Licensing Office (GHPLO) to authorize BHCFA access to credentials and supporting documentation for providers. **b.** Update SOP for provider payment to require screening for credential/licenses before payment is made. **c.** Submission of a provider memorandum stating that failure to provide updated credentials/licenses before their expiration may result in withholding of payments, suspension/termination from participation as provided in the PAA.	**a.** Finalize the draft Memorandum of Agreement between BHCFA and GHPLO by January 31, 2025. **b.** Update SOP by March 15, 2025. **c.** Submit provider memorandum by March 31, 2025. **d.i.** Meet with representatives of UJG to explore potential for agreement by January 31, 2025. If feasible, implement agreement by June 30, 2025. ii.	**a.** Administrator b. Janssen **c.** Administrator **d.** Administrator **e.** J. Janssen
6.	To achieve an effective Medicaid provider screening and approval process, we recommend strict compliance with documentary requirements and completeness in filling in PAA forms. If the document is not applicable to the applicant provider, such should be marked "NA" or include disclosures when necessary.				
7.	We recommend that BHCFA ensure that dates in the PAAs are completely and accurately filled in to avoid inaccurate or improper payments.				
8.	We recommend strict compliance with the submission of required licenses and updating of expired ones to be qualified to render Medicaid services.				
9.	We recommend filling in the details of affiliate physicians in PAA forms or providing a separate list of these				

PAGE 3 OF 4

	physicians. We suggest to complete the addendum and agreement in the PAA.		**d.i.** Explore the options of incorporating a background check aligned with federal Medicaid regulations and Guam's specific health care infrastructure which includes but are not limited to a potential agreement between BHCFA and Unified Judiciary of Guam (UJG) to grant access to staff to Criminal Justice Information System (CJIS) to facilitate a background check on new or renewing providers; otherwise, procure a vendor to conduct a background check for all new/renewing providers. e. Establish an SOP for provider enrollment, which incorporates strict compliance for completeness/accuracy in filling in PAA forms, initial screening (including but not limited to a background check), documentation (including but not limited to professional credentials) and revalidation (including but not limited to reviewing the status of providers NPI during each renewal period).	If not feasible, contract with a vendor for start date of October 1, 2025. **e.** Establish SOP by June 30, 2025.	

PAGE 4 OF 4

Appendix 7:

Status of Audit Recommendations

No.	Addressee	Audit Recommendation	Action Required	Status
1.	DPHSS-BCF Management	To achieve an effective monitoring and review of Medicaid providers' eligibility documents for revalidation or potential termination, which provide a tool in BHCFA's decision-making and examiners review processes, we recommend the following: a. Formulate and implement an SOP on file maintenance and storage, which includes clear guidelines for systematic filing, scanning, and safekeeping of both physical and digital records. b. Adopt an effective digital records repository system or centralized scanned file system by utilizing the capabilities of the existing PH Pro system or any other BHCFA preferred system. c. Create/establish a consolidated Medicaid provider information database.	Provide a corrective action plan with the responsible official/s and timeline of implementation.	Corrective Action Plan was provided
2.	DPHSS-BCF Management	"Inactive" Medicaid providers should be appropriately tagged and properly identified in the MPL, whatever BHCFA considers appropriate, to preclude misinterpretations by the users resulting in potential non-payment or duplicate payments.	Provide a corrective action plan with the responsible official/s and timeline of implementation.	Corrective Action Plan was provided
3.	DPHSS-BCF Management	If the MPL records are useful and significant to the BHCFA operations, we recommend that information be updated in the PH Pro system to generate updated and accurate MPLs.	Provide a corrective action plan with the responsible official/s and timeline of implementation.	Corrective Action Plan was provided
4.	DPHSS-BCF Management	To ensure the propriety of Medicaid claims and reimbursements, we recommend that BHCFA identify in its records Medicaid providers consistently utilized for "emergency services" and require them to submit a completed and signed PAA, which is mandatory for all healthcare providers.	Provide a corrective action plan with the responsible official/s and timeline of implementation.	Corrective Action Plan was provided
5.	DPHSS-BCF Management	We recommend strict compliance to the eligibility initial screening, documentation, and revalidation requirements per local and federal laws and regulations and guidelines.	Provide a corrective action plan with the responsible official/s and timeline of implementation.	Corrective Action Plan was provided
6.	DPHSS-BCF Management	To achieve an effective Medicaid provider screening and approval process, we recommend strict compliance with documentary requirements and completeness in filling in PAA forms. If the document is not applicable to the applicant provider, such should be marked "NA" or include disclosures when necessary.	Provide a corrective action plan with the responsible official/s and timeline of implementation.	Corrective Action Plan was provided

Appendix 7:

Status of Audit Recommendations

No.	Addressee	Audit Recommendation	Action Required	Status
7.	DPHSS-BCF Management	We recommend that BHCFA ensure that dates in the PAAs are completely and accurately filled in to avoid inaccurate or improper payments.	Provide a corrective action plan with the responsible official/s and timeline of implementation.	Corrective Action Plan was provided
8.	DPHSS-BCF Management	We recommend strict compliance with the submission of required licenses and updating of expired ones to be qualified to render Medicaid services.	Provide a corrective action plan with the responsible official/s and timeline of implementation.	Corrective Action Plan was provided
9.	DPHSS-BCF Management	We recommend filling in the details of affiliate physicians in PAA forms or providing a separate list of these physicians. We suggest to complete the addendum and agreement in the PAA.	Provide a corrective action plan with the responsible official/s and timeline of implementation.	Corrective Action Plan was provided

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

ACKNOWLEDGEMENTS

Key contributions to this report were made by:
Benjamin J.F. Cruz, Public Auditor
Maria Thyrza D. Bagana, CGFM, CFE, Accountability Auditor III - Team Supervisor
Frederick D. Jones, CICA, CFE, Accountability Auditor II - Team Auditor-in-Charge
Melissa E. Ngiralmau, Accountability Auditor I - Team Member
Kristin Fausto, Intern
Abigail Naputi, Intern

MISSION STATEMENT

We independently conduct audits and administer procurement appeals to safeguard public trust and promote good governance for the people of Guam.

VISION

The Government of Guam is the standard of public trust and good governance.

CORE VALUES

Objective
To have an independent and impartial mind.

Professional
To adhere to ethical and professional standards.

Accountable
To be responsible and transparent in our actions.

REPORTING FRAUD, WASTE, AND ABUSE

- Call our HOTLINE at 47AUDIT (472.8348)
- Visit our website at www.opaguam.org
- Call our office at 475.0390
- Fax our office at 472.7951
- Or visit us at Suite 401 DNA Building in Hagåtña

All information will be held in strict confidence.

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