Department of Public Health & Social Services

Medically Indigent Program

Performance Audit
October 1, 2004 through September 30, 2009

OPA Report No. 10-03
June 2010

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EXECUTIVE SUMMARY
Department of Public Health and Social Services' Medically Indigent Program
Report No. 10-03, June 2010

The Department of Public Health and Social Services' (DPHSS) Medically Indigent Program (MIP) was established by Public Law 17-83 in December 1984, and is 100% locally-funded to provide health care access for those persons who lack sufficient income. The Administrator of the Bureau of Health Care Financing serves as the MIP Administrator and oversees the program.

This audit was conducted as part of our efforts to periodically examine and report on major programs of the government of Guam. Our audit findings indicate that DPHSS could not provide reasonable assurance – nor could we conclude -- that the $67.3 million (M) expended for MIP between FY 2005 and 2009 entirely benefited eligible recipients. We found that the MIP pro-rata share of labor cost appears to be absorbed by other public assistance programs, and management of DPHSS' Certification Division has not complied with applicable laws to establish effective checks and balances over the program. We found separation of duties, independent review, and monitoring of MIP applications were lacking. The lack of independent review is exacerbated by the Automated Guam Program Assistance (AGUPA) system's inability to allow the automatic transfer or sharing of applicants' information.

Government of Guam Spent $67.3M on MIP Benefits
Between October 1, 2004 and September 30, 2009, the government of Guam spent $67.3M on MIP benefits. MIP benefit recipients are required to seek primary care services at DPHSS' Southern (Inarajan) or Northern (Dededo) clinics. For services the clinics cannot provide, DPHSS physicians refer MIP recipients to an outside provider. Medical referrals during this period cost the government of Guam $61.7M. Medical services rendered at the DPHSS clinics totaled $5.6M, which are not covered by MIP appropriations, but are absorbed by the department's budget.

MIP Labor Costs Appears to be Absorbed by Other Programs
Historically, the annual MIP appropriations are used to fund program benefits. We found that the administrative cost of MIP was last funded in FY 2004. In fiscal years 2002, 2003, and 2004, labor-related costs of $467,817, $335,876, and $48,185, respectively, were charged to the MIP. We were unable to identify MIP labor-related costs for fiscal years 2005 through 2009 in the AS400 financial system. However, we determined that $303,165 was the pro-rata share that should have been charged to MIP in FY 2009, but instead these costs appears to be absorbed by other public assistance programs.

Lack of Control Processes to Ensure Only Eligible Applicants are Approved
Contrary to 10 G.C.A. § 2904(b), the Certification Division management did not establish a system of internal controls over the application process. Applications are accepted, processed, and approved by Eligibility Specialists without independent review. Absent adequate separation of duties and independent review, the risk is high for errors or fraud to occur and go undetected. In addition, erroneous or false information could be recorded in the AGUPA system and go uncorrected, resulting in an applicant being deemed eligible for MIP benefits when in fact he/she is not.

The Certification Division has not complied with the 10 G.C.A. § 2905(e) requirement to establish a system of quality review to assure the validity and accuracy of MIP applications. We tested 38 MIP case files with transactions totaling $421,790. Of these, 37 cases or 97% totaling $417,605, did not contain adequate support for MIP eligibility. We found a lack of verification documents, such as proof of disability, verification of employment, and check stubs. Case files were not consistently organized and there was no standard filing system or checklist. In addition, there were two missing original case files, but temporary case files were subsequently provided. According to the Certification Administrator, quality reviews are not conducted due to the lack of supervisory staff.

Our findings are similar to those from the government of Guam Single Audits since FY 2000, in which external auditors expressed concerns over eligibility verification. Since 2000, the Certification Division has not utilized the Income Eligibility Verification System (IEVS) to determine income and resource eligibility, due to programming issues with their current system. Not utilizing the IEVS impedes the Certification Division from independently assessing whether or not recipient income and resource information are accurate.

Some MIP Benefits Are More Generous than Government of Guam Health Care Plans

In comparison to the government of Guam health care plans, MIP benefits cover up to three roundtrip airfares as medically necessary, offer up to three times more coverage days for skilled nursing facility services, have no maximum cap for hemophilia-related blood products, and no lifetime cap. The highest instance of MIP cost paid during our audit scope occurred in FY 2009, when $394,787 was spent for one recipient. In FY 2009, MIP benefits to the top 20 users totaled $5.5M, representing 52% of the total $10.5M MIP benefits paid.

Lack of Periodic MIP Narrative Reports

Although not required by law, DPHSS does not produce annual or biennial narrative reports on the state of the MIP. Such reports would outline program benefits, concerns, costs in relation to types of medical conditions, and the impact of benefit payments on limited MIP funding. The MIP's performance can be assessed and issues of concern can be better addressed if periodic reports were made to policy makers and the public.

Conclusion and Recommendations

Because of inadequate separation of duties and lack of independent review of MIP applications, DPHSS management could not provide reasonable assurance that the $67.3M spent on MIP between fiscal years 2005 and 2009 was properly spent. We recommend that the DPHSS Director direct management to: (1) identify and properly allocate MIP administrative costs; (2) establish a standard filing organization system and a standard checklist for all public assistance programs; (3) develop secondary and tertiary review processes; (4) formulate a committee to assess and make recommendations on how to implement the IEVS and improve the current information system by December 31, 2010; and (5) expand the MIP demographics report to include narrative information on the state of MIP to the Governor and the Legislature.

The Director substantively agreed with our recommendations and disagreed with some of the findings. Refer to the Management Response section of the report for details.

Doris Flores Brooks, CPA, CGFM
Public Auditor

Introduction

This report presents the results of our audit of the Department of Public Health and Social Services' (DPHSS) Medically Indigent Program (MIP). This audit was conducted as part of our efforts to periodically examine and report on major programs of the government of Guam. Our audit objectives were to determine:

1. The direct cost of the MIP over the five-year period from October 1, 2004 through September 30, 2009;
2. Whether MIP has effective internal controls in place to ensure that applicants certified into the program are eligible recipients and managed in accordance with applicable legal requirements; and
3. How MIP benefits compared with those of the government of Guam health insurance plans.

The scope, methodology, and prior audit coverage are detailed in Appendices 2 and 3.

Background

The MIP is a 100% locally-funded program established by Public Law (P.L.) 17-83 in December 1984 to provide hospital access and medical services to those who lack sufficient income and cannot afford to pay for health care. The program is intended as the last resort for those in need. Services provided by federal or other local programs are to be utilized first. MIP is administered by the Bureau of Health Care Financing. Applicants must meet the following standards to be eligible: (1) general eligibility; (2) program residency requirements; (3) income limitations; and (4) resource limitations.

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

Eligible individuals may qualify for MIP participation for periods from six months to one year. Certifications for one year are issued to applicants whose household members are all at least 55 years old or have at least one household member with a permanent disability. See Appendix 4 for more information on MIP mandates and legal requirements. Apart from MIP, the government of Guam offered three health care plans for FY 2009 from one provider.

Results of Audit

Our overall findings indicate that DPHSS management cannot provide assurance that the $67.3 million (M) spent on MIP from October 1, 2004 to September 30, 2009 was expended entirely for the benefit of eligible recipients. Our audit found that:

- The pro-rata share of MIP administrative costs appears to be absorbed by other public assistance programs. We estimated that $303,165 was the pro-rata share of MIP that was charged to other programs in FY 2009.
- DPHSS's Certification Division has not established sufficient internal controls, such as separation of duties and independent review and monitoring of MIP applications.
- We tested 38 MIP case files with transactions totaling $421,790. Of these, 37 cases, or 97% totaling $417,605, did not contain adequate support to conclude that applicants were eligible. Findings included missing original case files and lack of verification documents, such as a household member's disability, employment status, and check stubs.
- The current Automated Guam Program Assistance (AGUPA) information system lacks interface capability that would allow Eligibility Specialists to automatically transfer or share applicants' information. Additionally, the Certification Division has not utilized the IEVS to verify income and resource eligibility since 2000, which impedes the division from independently assessing whether or not recipient income and resource information are accurate.
- Some MIP benefits are more generous than the government of Guam health care plans. MIP benefits cover up to three roundtrip airfares, offer up to three times more coverage days for skilled nursing facility services, have no maximum cap for hemophilia-related blood products, and no lifetime cap.
- Although not mandated, DPHSS does not produce annual or biennial narrative reports to inform the public on the state of the MIP, its program benefits, risks, concerns, and the impact of benefits on limited funding.

Government of Guam Spent $67.3 Million on MIP Benefits

Effective May 1, 2004, all MIP participants were required to seek primary care services at DPHSS' Southern (Inarajan) or Northern (Dededo) clinics. The appropriation for MIP covers the costs for services that DPHSS cannot provide. In such cases, MIP recipients must be referred by a DPHSS primary care physician to an outside provider.

Although the MIP appropriation does not cover services rendered at DPHSS clinics, DPHSS internally tracks these costs. For the period of our audit, the cost of medical referrals to outside providers totaled $61.7M. In total, the government of Guam spent $67.3

million on MIP benefits with 92% spent for services referred to outside providers and 8% of the cost were services provided by DPHSS. See Table 1 for illustration.

Table 1: MIP Costs Per Fiscal Year

Fiscal Year	Paid MIP Referred Claims[1] (A)	DPHSS's Internal MIP Costs[2] (B)	Total MIP Cost (C) = (A) + (B)
2005	$13,121,430	$749,822	$13,871,252
2006	$12,018,476	$774,032	$12,792,508
2007	$17,165,993	$1,205,858	$18,371,851
2008	$ 8,872,614	$1,364,926	$10,237,540
2009	$10,549,620	$1,458,798	$12,008,417
TOTAL:	**$ 61,728,133**	**$ 5,553,437**	**$ 67,281,569**
Percentage:	**92%**	**8%**	**100%**

According to the MIP Administrator, the three most costly medical conditions are hemophilia, end-stage renal disease treatment for diabetes patients, and congenital heart disease. Patients with these conditions are referred to outside providers because DPHSS is unable to provide the services. Although only a handful of MIP participants have these conditions, treatments are very expensive. Refer to Table 3 for the top 20 MIP referred client costs between FY 2005 and 2009.

Based on DPHSS' internal tracking, the department spent $5.6M for providing clinic services to MIP recipients. Of this amount, $2.5M was for pharmaceuticals. The remaining $3.1M was for providing various services and treatments, such as hypertension and diabetes patients, routine maternity and child health care, and contraceptive management.

Top 20 MIP Benefit Recipients

The top 20 recipients accounted for 26% or $16.1M of the total MIP cost from FY 2005 to FY 20009. In FY 2009 alone, the top 20 recipients accounted for 52% or $5.5M of the total MIP costs for that year, of which $394,787 was spent for one individual. In descending order, Table 2 illustrates the cost per recipient per fiscal year. As the total costs per individual per fiscal year may vary, it should be noted that the rankings represented below may not necessarily represent the same recipient for each fiscal year.

Table 2: Top 20 MIP Benefit Recipients by Cost

Rank	2005	2006	2007	2008	2009	TOTAL
1	$196,312	$247,915	$284,928	$260,492	$ 394,787	$989,646
2	$181,532	$212,526	$272,078	$191,237	$ 378,324	$857,373
3	$171,963	$190,477	$188,172	$187,587	$ 337,343	$738,198
4	$149,749	$190,197	$179,621	$175,204	$ 328,616	$694,770

[1] Data obtained from corresponding annual government of Guam audited financial statements, except for the FY 2009 data, which is unaudited.

[2] Data obtained from Bureau of Primary Care Services Administrator.

Rank	2005	2006	2007	2008	2009	TOTAL
5	$131,166	$189,455	$174,820	$152,769	$ 320,539	$648,209
6	$122,305	$187,182	$167,223	$145,138	$ 317,760	$621,848
7	$115,275	$178,275	$136,748	$141,969	$ 317,661	$572,267
8	$112,643	$174,084	$135,138	$135,302	$ 315,696	$557,167
9	$103,754	$156,224	$134,240	$129,157	$ 289,235	$523,375
10	$91,090	$141,947	$129,198	$121,105	$ 265,137	$483,340
11	$88,498	$138,724	$128,792	$101,517	$ 256,011	$457,531
12	$88,442	$136,119	$124,026	$99,673	$ 246,820	$448,259
13	$86,507	$134,559	$118,570	$94,129	$ 244,797	$433,765
14	$83,422	$129,964	$116,180	$90,752	$ 237,185	$420,318
15	$82,972	$129,575	$107,518	$89,785	$ 230,168	$409,851
16	$79,857	$124,675	$102,310	$78,622	$ 212,140	$385,465
17	$76,940	$120,036	$100,661	$75,235	$ 209,156	$372,872
18	$73,474	$112,855	$92,977	$72,608	$ 206,545	$351,914
19	$72,937	$107,896	$82,412	$72,301	$ 196,927	$335,546
20	$69,516	$105,927	$82,285	$71,381	$ 187,788	$329,109
Top 20 MIP Total:	**$2,178,353**	**$3,108,612**	**$2,857,896**	**$2,485,962**	**$5,492,633**	**$16,123,457**
MIP Total Cost:	**$13,121,430**	**$12,018,476**	**$17,165,993**	**$8,872,614**	**$10,549,620**	**$61,728,133**
% of Top 20:	**17%**	**26%**	**17%**	**28%**	**52%**	**26%**

MIP Labor Costs Appears to be Absorbed by Other Public Assistance Programs

One of DPHSS management's concerns is that MIP is an unfunded mandate; no appropriation is made to administer the program. According to the MIP Administrator, funding for MIP personnel is requested annually, but due to the department's budget ceiling the request is removed from DPHSS' annual budget request to the Legislature.

Historically, the annual appropriations for MIP are used to fund program benefits. We reviewed the MIP Payment Revolving Fund account in the AS400 financial system and confirmed that there were no labor-related costs from FY 2000 to 2009. Based on our review of the MIP and Catastrophic Illness Assistance Administrative account, the AS400 financial system indicated that there were some labor-related costs. Specifically, we found that the administrative cost of MIP was last funded in FY 2004. In fiscal years 2002, 2003, and 2004, labor-related costs of $467,817, $335,876, and $48,185, respectively, were charged to MIP. We did not find MIP labor-related costs for fiscal years 2005 through 2009 in the AS400 financial system.

DPHSS management's position is that budget authorizations after FY 2003 did not allow for MIP's administrative costs, including personnel costs to be charged to MIP appropriations. Between fiscal years 2003 and 2009, the department's annual budget

indicated that amounts appropriated for MIP were from "*the General Fund to the Medically Indigent Program Payment Revolving Fund.*" We saw nothing in the budget stipulations specifically restricting MIP appropriations only to program benefits and not allowing for administrative costs. We suggest that the Director consider allocating a portion of the annual MIP appropriation towards the program's administration, such as labor costs, using historical data of MIP-related labor expenses.

Pooling Arrangement by Caseload

The Certification Division is a one-stop center for processing and determining applicant eligibility for new and renewal applications for local and federal public assistance programs, i.e., Medicaid, Supplemental Nutrition Assistance Program ("Food Stamps"), Cash Assistance, and MIP. [3]

Eligibility Specialists are not assigned exclusively to a specific public assistance program. Instead, they handle all applications and determine which program applicants qualify for, testing first for the federally-funded programs. If applicants do not qualify for federal assistance, their applications are then tested for MIP, the only locally-funded program.

In our interviews, it took an inordinate amount of time to understand and determine the cost allocation pooling arrangement as DPHSS. After several discussions, we learned that personnel costs should be charged on the pooling arrangement based on the percent of caseloads (for the Certification Division) and claims (for the Claims Division) processed. According to the 2003 Cost Allocation Plan, costs for each reporting quarter are allocated based on case count percentages for the different programs for the same period. The plan also noted that expenditures for MIP are direct costs and chargeable 100% to local funds.

FY 2009 MIP Salaries Pro-Rata Share was $303,165

In FY 2009, MIP was appropriated $15,822,907. With 12,274 clients referred to outside providers, the administrative costs for MIP should be relatively significant. However, we saw no salaries being charged to MIP appropriations. Based on the pooled processing arrangement, we estimated that MIP's pro-rata share of labor costs in FY 2009 of $303,165 appear to be absorbed by other public assistance programs.

- As of September 2009, the Certification Division had 21 Eligibility Specialists and three Eligibility Supervisors. The Eligibility Administrator was unable to quantify the cost for MIP work performed by Eligibility Specialists, so we analyzed the Specialists' salaries against the percentage of the FY 2009 MIP caseload. Based on the Administrator's caseload statistics, the 21 Eligibility Specialists spent an average of 43% of their time processing Food Stamps certification and re-certifications, 30% for Medicaid, 19% for MIP, and 8% for Cash Assistance. The specialists' salaries totaled $635,795, thus we calculated that 19% of their time equaled $122,657, which should have been charged to MIP appropriations as its pro-rata share of administrative costs.

[3] In 1999, the MIP eligibility processing was moved from the Bureau of Health Care Financing Administration (Claims Division) to the Bureau of Economic Security Administration (Eligibility Division).

- The Claims Division personnel are paid from the Medicaid program, which is 50% federally funded and 50% locally matched. According to the MIP Administrator, Claims personnel's time spent for processing MIP claims are charged as part of the 50% local match. Based on the FY 2009 quarterly claims statistics and labor cost allocation reports provided by the MIP Administrator, Claims Specialists spent an average of 21% of their time processing MIP claims. The MIP labor cost for the first quarter was $47,660; second quarter $53,267; third quarter $46,040; and fourth quarter $33,541. Correspondingly, FY 2009 personnel costs incurred for MIP claims activities of $180,508 should have been charged to MIP appropriations.

The above condition exists because management failed to properly report and allocate programs costs. Therefore, we recommend that the DPHSS Director identify and properly allocate MIP's pro-rata share of administrative costs for FY 2009.

Lack of Control Processes to Ensure Only Eligible Applicants are Approved

Pursuant to 10 G.C.A. § 2904(b), the MIP Administrator is responsible for establishing and managing a system to prevent fraud by participants and providers. Management's duty in any organization is to ensure that an adequate system of checks and balances (i.e., internal controls) is designed and in place so that goals and objectives are met, resources are safeguarded and used economically and efficiently, errors are detected, and fraud is mitigated.

Internal control plays an important role in fraud prevention. Although a weak system of internal controls does not guarantee fraud, it does provide a fertile environment for fraud to occur. Common control weaknesses include: lack of separation of duties, lack of independent checks, and lack of proper authorization on documents and records.

The Certification Division's one-stop processing and lack of impendent check on applicant's eligibility determination clearly indicates weak internal control design.

Segregation of Duties and Independent Quality Reviews Needed

The Certification Division's Eligibility Specialists currently have complete control over inputting, processing, and approving applicant eligibility. This practice does not separate incompatible duties or allow for independent checks and proper monitoring. The following is the Certification Division's current process for determining eligibility:

1. An Eligibility Specialist meets with the applicant and obtains readily available information. DPHSS's "Interview Reminder Sheet" lists the documents required for the four public assistance programs, which include:
    - Identity: Driver's license, Guam ID, Passport.
    - Social Security card
    - Citizenship Status: Birth Certificate, Naturalization Certificate, Permanent Residency Card, Certificate of Citizenship, US Passport, etc.

- Earned Income: Current month's pay check stubs, employment verification, 1040 Form, or statement of self-employment earnings.
- Unearned Income: Award letters from Social Security, Veterans Administration, or Retirement Income.
- Residency/Household Composition: Mayor's verification, landlord's statement, GHURA contract, statement of living arrangement.
- Deductible Expenses: Rent or mortgage receipts, lease agreement, utility bills.
- Resources: Current checking and/or savings account statements, stocks and bonds statements, vehicle registrations, etc.

2. The Eligibility Specialist then inputs the obtained information into the AGUPA system and determines whether or not the applicant is eligible for the public assistance program(s) applied for. MIP applicants are required to meet the residency, income, and resource requirements outlined in Appendix 4.

In addition, 10 G.C.A. § 2905(e), requires that a quality review of a sufficient sample size of applications should be conducted to assure the validity of all applications. The Eligibility Administrator stated that due to the lack of supervisory staff, random quality control reviews are not performed. Conversely, the Claims Division has a Quality Assurance Coordinator who conducts daily quality control reviews of MIP claims. The MIP Administrator also conducts secondary and post-reviews of processed claims with high dollar amounts, and returned or adjusted claims.

The current process is without an adequate system of checks and balances (i.e., internal controls). As such, it is possible for an applicant, whether intentionally or unintentionally, to provide inaccurate information and for the Specialist to make decisions based on inaccurate data. Error or fraud would not be detected on a timely basis. If the Income Eligibility Verification System (IEVS) were utilized, the determination of resource and income eligibility would be more reliable and efficient. Any differences signal the need for further examination and explanation, and could affect current or prior eligibility or benefit levels. Refer to the Inadequate Information System section of this report for more discussion.

In terms of effective internal controls, the Eligibility Division should, at a minimum, consider the following application process:

1. A checklist of requirements for each assistance program and a filing system for case files should be standardized. At intake, an Eligibility Specialist meets with the applicant and obtains the required information and documents according to the checklist for the program(s) being applied for. These are then arranged in a specific order in the applicant's new or existing case file. Standardizing the checklist and filing system will help caseworkers unfamiliar with program requirements, and serve as a primary reference for determining eligibility. Since Eligibility Specialists are not dedicated to a specific public assistance program, a uniform process would be an important tool in error management and mitigation. The checklist should be continuously developed for improved efficiency and as program requirements change.

2. The same Eligibility Specialist verifies the information through various government information databases, such as motor vehicle registration, property, employment, and income tax records. This individual then documents the verification and includes it in the applicant's file. As noted earlier, the use of IEVS would make the resource and income eligibility determination process more efficient and reliable.

3. A second Eligibility Specialist then inputs the verified information into the AGUPA system. Separating the intake and input processes serves as a review to ensure the accuracy and completeness of the information gathered by the first Eligibility Specialist.

4. A supervisor(s) or other designated individual(s) should conduct independent reviews of at least 1% of cases per month to ensure quality and accuracy of determinations made, and compliance with public assistance program requirements. This independent or tertiary review allows supervisors to track staff workloads, the timeliness and accuracy of determinations, policy compliance, case activities, as well as to pinpoint program violations and areas of potential fraud.

For example, the State of Montana employs a three-tiered review process. County public health supervisors review at least two cases per caseworker per month for accuracy and completeness. The regional public health staff complete additional case reviews. The Program Compliance staff of the state's Quality Assurance Division focuses their attention on various federal compliance areas and incorporates independent verification of case information through home visits, contacts with relevant banking/financial institutions, etc.

Unsupported MIP Certifications

We tested 38 MIP case files, with transactions totaling $421,790, to determine compliance with general, residency, income, and resource eligibility standards, as outlined in 10 G.C.A. § 2905.[4] We were unable to conclude that 37 cases, representing transactions totaling $417,605, were eligible for MIP benefits. Of the 38 cases, we found the following:

A) Test of Program Residency Requirements, 10 G.C.A. § 2905.2:

1) 16 case files, or 42%, with transactions totaling $340,437, did not contain the required Guam driver's license, current vehicle registration, and other documentation, such as employment verification, children's school enrollment, voter registration, or evidence that the applicant is receiving public assistance on Guam.

2) 34 case files, or 89%, with transactions totaling $382,617, did not contain a signed "MIP Affidavit of Guam Residency" as required by DPHSS.

[4] The general eligibility standards were tested as part of the residency and income eligibility standards as the requirements were similar.

B) Test of Income Eligibility Standards, 10 G.C.A. § 2905.4:

1) Six case files, or 16%, with transactions totaling $182,060, did not contain documentation that applicants were either unemployed or did not have current month's pay stubs.

2) In one case file, the last check stubs were for 2000, and there was no physician certification deeming the applicant physically or mentally disabled and unable to work.

C) Test of Resource Eligibility Standards, 10 G.C.A. § 2905.5:

1) 27 case files, or 71%, with transactions totaling $408,041, contained no documentation to validate and independently verify applicants' balance claim on liquid resources, i.e., savings and checking accounts.

2) 18 case files, or 47%, with transactions totaling $401,592, did not contain verification of applicant claims not to own real property or have personal investments.

3) 19 case files, or 50%, with transactions totaling $205,020, contained no verification as to the number of vehicles applicants claimed to own. Under the law, a single-parent household may own one vehicle and a two-parent household may own two. Any other vehicles would be evaluated at fair market value.

Although Eligibility Specialists have access to the Department of Revenue and Taxation's vehicle registration and real property records, we found only five instances in which vehicle registration and three instances in which real property records were verified and on file.

D) Other Issues Noted:

1) Two case files did not contain evidence that the applicants had MIP coverage for 2008 and 2009. The latest MIP renewal applications found in the file were dated April 2006 and July 2006, respectively.

2) Two case files were missing, but DPHSS subsequently provided temporary case files for our review. However, these files lacked the documents necessary to conclude that the applicants qualified for MIP.

3) Case files were not organized in a consistent and orderly fashion. Some files contained more documentation than others, such as statements of living arrangement, mayor's certification, Guam Housing and Urban Renewal Authority certification, utility bills, etc. Most case files lacked copies of bank statements, vehicle registration, driver's license, school enrollment, and doctor's disability certification, yet renewals were granted. A uniform filing system and checklist would make files better organized and user-friendly, thus missing required documents would be more apparent.

4) A service provider was paid over $171,000 in FY 2009 for services to just one MIP recipient. However, we question the recipient's eligibility because the case file lacked several required documents, such as pay stubs or other evidence of income for 2008 and 2009.

5) There was no evidence of supervisory approval in the 38 case files reviewed. Only two files contained evidence of a Quality Control review, and only because both were initially denied. Although DPHSS management claims that supervisory reviews are regularly conducted, such reviews were not documented in the case files.

Refer to Appendix 4 for the MIP Residency, General, Income and Resource Standards criteria.

Due to the lack of supervisory review and approval, as well as of established internal controls in the processing of eligibility for public assistance, there is no reasonable assurance that approved MIP applications are in fact for eligible recipients. To ensure that MIP benefits are rendered to eligible recipients, we recommend that the DPHSS Director direct the Chief of the Division of Public Welfare, the MIP Administrator, and the Eligibility Administrator to:

1. Establish a standardized filing system and checklist for all public assistance program requirements for Eligibility Specialists to check off and record as they obtain and verify applicant eligibility information. This checklist should also have a section for an independent review acknowledgment.

2. Comply with 10 G.C.A. § 2904(b)(10) and § 2905(e), by establishing and training staff on a uniform eligibility determination process through which information is obtained, verified, and entered into the AGUPA system by separate individuals. In addition, a Supervisor or other designated individual should independently review at least 1% of cases per month for compliance with the established standard filing system and checklist. The reviews allow supervisors to track staff workloads, the timeliness and accuracy of determinations, policy compliance, case activities, and pinpoint program violations and areas of potential fraud.

OPA Findings Similar to Previously Reported Single Audit Findings

Our findings are similar to those reported in the government of Guam Single Audits since FY 2000. In those audits, concerns were expressed over the verification of eligibility for DPHSS' Medical Assistance Program (MAP or Medicaid) and Cash Assistance Program. MAP and Cash Assistance benefits are 100% federally funded. The Single Audit findings cited (1) the lack of documentation that the Income Eligibility Verification System (IEVS) was used to verify MAP and Cash Assistance eligibility; (2) there were no case files provided for some requested files; and (3) case files lacked certain verification documents such as school verification, birth certificate, verification of employment, check stubs, etc. Weak internal controls over record keeping were contributing factors noted in the Single Audit findings. See Appendix 3 for prior Single Audit finding details.

Inadequate Information System

The current AGUPA information system lacks interface capability that would allow Eligibility Specialists to automatically transfer or share applicants' information. For instance, when an applicant with a family of five qualifies for three public health assistance programs, information about each member must be entered into the AGUPA system three separate times. This process is grossly inefficient and leaves room for data entry errors.

Additionally, the Certification Division has not utilized the IEVS to verify income and resource eligibility since 2000 due to programming issues with AGUPA system. IEVS is a federally-operated computerized information system that matches data against several agency data bases to verify certain types of income and/or property.

These matches use the applicant's name and Social Security number to obtain information about wages and unemployment, disability, and Social Security benefits, among others. Information retrieved from the IEVS is compared against the information provided by the applicant. Any differences signal the need for further examination and explanation and could affect current or prior eligibility or benefit levels.

Of the 38 case files we tested, 27, or 71%, with transactions totaling $408,041, did not contain independent verification of the cash/investment resources claimed by the applicant. Verification could have been made through copies of the most current bank statements, absent the IEVS. For the past 10 years, DPHSS management has proposed solutions such as: (1) switching from the AGUPA system to the PAGU system in FY 2005; (2) adopting the IPASS system in FY 2006; and (3) implementing the PH Pro system in FY 2009. As of this report date, the IEVS has yet to be implemented. According to the Certification Administrator, there are plans to have the IEVS in their system, but it is dependent on funding.

Failure to obtain the IEVS impedes the Certification Division from independently assessing the accuracy of recipients' income and resource information. We recommend that the DPHSS Director form a committee to include the Chief of the Division of Public Welfare, the MIP Administrator, the Eligibility Administrator, and other appropriate persons. This committee should evaluate the AGUPA interface issues and make recommendations by December 31, 2010 on how to implement the IEVS, improve the current information system, improve efficiency of the application processing, and track staff workloads and case activities, i.e., interface capability allowing the automatic transfer or sharing of applicants' information, and generation of monthly or quarterly reports to equalize workload allocation and track staffing needs.

Some MIP Benefits are More Generous than Government of Guam Health Care Plans

To better understand the MIP and how its benefits fare with other health-care providers, we compared them with those of the government of Guam's 2009 health plans. We found that MIP benefits are more generous in some areas. For example, MIP covers medically necessary roundtrip airfares for three persons, offers up to three times more coverage days

for skilled nursing facility services, has no maximum cap for hemophilia-related blood products, and has no lifetime cap. Most common lifetime limits are for $1M or $2M for employer provided health insurance according to a study conducted by Price Waterhouse Coopers.

Table 3: Health Care Benefits Comparison

Health Care Benefits	MIP	Government of Guam Health Plans
Lifetime Maximum Cap: The accumulated total that an individual's plan will pay over his/her lifetime.	None Established.	$1,000,000
Roundtrip Airfare: Afforded to participants requiring medical treatments or procedures unavailable in Guam.[5]	Covers airfare for three- MIP patient, a guardian, and medical escort. Additional medical escorts may be approved at the discretion of the DPHSS Director as medically necessary.	Covers airfare for the two-patient and a medical escort.
Hemophilia-Related Blood Products: Hemophilia is an inherited bleeding disorder characterized by prolonged or spontaneous bleeding.	No maximum cap.	$50,000 maximum per plan year.
Skilled Nursing Facility: A nursing facility provides daily skilled nursing care and/or rehabilitation staff involvement.	180 days maximum per plan year	60 days per plan year

MIP Compared to Hawaii Managed Care

Hawaii Quest, the state's medically indigent program, provides health coverage through managed care plans for income eligible Hawaii residents. Managed care is the system which controls the cost of services, manages the use of services, and measures the performance of health care providers. Managed care health plans typically determine whether a doctor is qualified before joining the care network. Annual patient surveys and chart reviews are also done to maintain the quality of care.

Eligible Hawaii Quest participants choose a medical plan and a dental plan to serve themselves and their family members who are in the program. Participants can select from among six providers: AlohaCare, Hawaii Medical Services Association, Kaiser Permanente,

[5] Benefit requires prior authorization. The Bureau tracks medical costs associated with off-island care, while airfare costs are tracked by the Department of Administration (DOA).

Kapiolani Health Hawaii, Queen's Hawaii, and StraubCare. Self-employed participants, whose income does not exceed 100% of the federal poverty level, and their spouse are each required to pay 50% of the Hawaii Quest monthly premium.

In contrast, Guam's MIP Administrator manages operations, enrolls participants, reviews, and processes claims. MIP participants cannot pick their medical and dental plans or choose a physician as provided by a care health plan. Instead, MIP participants receive medical and dental treatments at the Public Health clinics in Dededo, Mangilao, or Inarajan, or from a list of participating outside providers upon referral.

MIP Reports Do Not Address Significant Issues

Pursuant to 10 G.C.A. §2904(c), the DPHSS Director, in consultation with the MIP Administrator, is mandated to update and revise the MIP benefits periodically, based on an annual review of enrollment, utilization and claims payment, and operating expenses. Since the creation of MIP in December 1984, its benefits and eligibility criteria have undergone three revisions: in 1986 by P.L. 18-31, in 2000 by P.L. 25-163, and in 2004 by P.L. 27-30. The updates addressed the health issues from the community, especially from those individuals who cannot afford health insurance. The 2003 changes added new services, placed caps on certain services, limited comprehensive services, and required co-insurance.

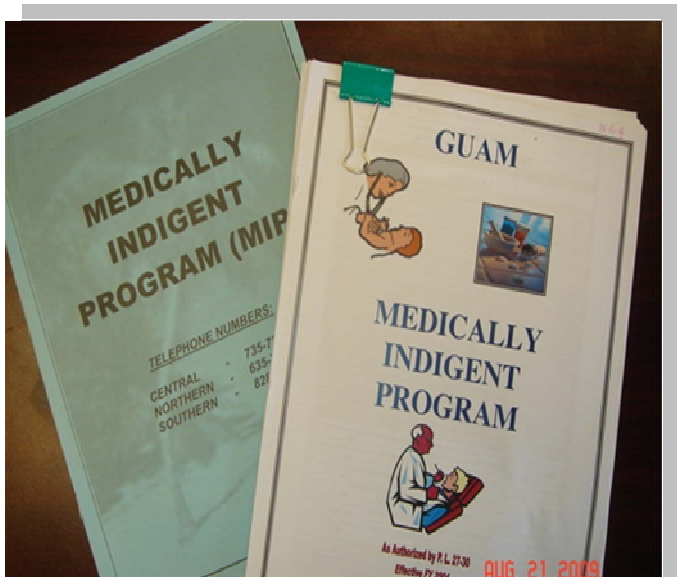

Image 2: MIP Handbook and Procedures last updated in 2004 pursuant to P.L. 27-30.

The MIP Administrator stated that revising and updating the benefits, particularly if changes involved reductions to existing benefits, could raise public objection since the program was created to "increase access to quality health care for individuals who lack sufficient financial resources to meet the costs of medical care."

The Administrator added that if MIP services were reduced, clients would be forced to turn to Guam Memorial Hospital Authority (GMHA) for their medical needs. As Guam's only public hospital, GMHA is obligated by law to provide services, regardless of a patient's origin, condition, or ability to pay. Whether services are provided through MIP or by GMHA, the government of Guam ultimately bears the cost.

Although DPHSS does not produce annual or biennial narrative MIP reports, the MIP Administrator generates quarterly demographics reports, off-island expenditure reports, and claims expenditure reports by service type. These are generated regularly and are submitted to the Legislature. However, the reports do not address significant program issues, specifically risks or concerns of the program. Expanding the MIP reports to include

narrative information on services provided, shifting medical needs, and risks or potential concerns, such as staffing limitations, that the program has experienced or foresees, would give management a tool to better manage MIP. In addition, elected officials can better assess the performance of MIP and issues of concern can be addressed. Such reports deliver useful information as to the program's performance and limitations, as well as the staffing and operational challenges of administering the program.

In order to align MIP benefits with the changing health care needs and shifting population of the indigent population, we recommend that the DPHSS Director expand the MIP demographics report to include narrative information on the state of MIP and submit them to the Governor and the Legislature. The report should include, but not be limited to: an overview of MIP's services and its costs, the identification of the shifting medical needs of the indigent population, risks or potential concerns that the program has experienced or foresees, and staffing operational challenges. Such information would (1) assist the MIP Administrator and DPHSS Director in providing an analysis of the true cost of MIP each fiscal year including the administration costs of administering the program, (2) assist the administration and legislators in making critical decisions concerning the MIP, and (3) inform the public about MIP's costs and benefits.

Conclusion & Recommendations

Because of a lack of effective internal controls over the application process, we were unable to conclude that the $67.3M spent for MIP from October 1, 2004 to September 30, 2009 was expended entirely for the benefit of eligible recipients. We conclude that the pro-rata share of MIP's administrative labor costs ($310,280 for FY 2009) appears to be absorbed by other public assistance programs, and that MIP management did not establish effective internal controls to prevent errors and fraud as required by law. We found that some MIP benefits are more generous than the government of Guam health care plans and that there is no lifetime cap on MIP participation.

To ensure that MIP benefits are rendered to eligible recipients, we recommend that the DPHSS Director direct the Chief of the Division of Public Welfare, MIP Administrator, and Eligibility Administrator to:

1) Identify and properly allocate MIP's pro-rata share of administrative costs as of FY 2009;

2) Establish a standard filing system and checklist for all public assistance program requirements that Eligibility Specialists can check-off as they obtain and verify applicant eligibility information as part of all case files. This checklist should also have a section for an independent review acknowledgment;

3) Comply with 10 G.C.A. § 2904(b)(10) and § 2905(e), by establishing and training staff on a uniform eligibility determination process where at least an Eligibility Specialist obtains and verifies eligibility information, a second specialist inputs the information into the AGUPA system, and a Supervisor or other designated individual independently reviews at least 1% of cases per month using the established standard filing system and checklist to document their review;

4) Formulate a committee, to include the Chief of the Division of Public Welfare, MIP Administrator, Eligibility Administrator, and other appropriate persons, to evaluate why the AGUPA lacks interface, and make recommendations by December 31, 2010 on how to implement the IEVS and improve the current information system to allow for efficient processing of public assistance applications and for management to track staff workloads and case activities; and

5) Expand the MIP demographics report to include narrative information on the state of MIP and submit them to the Governor and the Legislature.

Management Response & OPA Reply

A draft report was transmitted to DPHSS on May 7, 2010, for their official response. On May 12, 2010, OPA met with DPHSS officials to discuss the findings and recommendations. A request was granted to DPHSS for a one-week extension to submit their management response. On May 28, 2010, the Director submitted a four-page response in which he substantively agreed with the audit, but partially disagreed with some findings and did not address two of the five audit recommendations. Refer to Appendix 5 for the DPHSS' management response.

Based on the Director's response, we have amended one recommendation relative to the identification and proper allocation of MIP administrative costs. Listed below are synopses of DPHSS response to certain areas of our report.

- **Finding #2 - Segregation of Duties and Independent Quality Reviews Needed:** DPHSS asserts that it has always been standard practice for Eligibility Specialist Supervisors to conduct case file reviews on all public assistance programs. However, we did not find any documentation within the case files we reviewed that such supervisory reviews are regularly conducted; thus, this finding remains. DPHSS did not address the recommendation to establish a standardized filing system and checklist for all public assistance program requirements.

- **Finding #3 – Unsupported MIP Certifications:** DPHSS asserts that supporting documents are in file for some of the cases in questions (e.g. the Affidavit, receipts). However, of the 38 case files we reviewed, we were unable to conclude that 37 cases were eligible for MIP benefits as they did not have documentation that eligibility requirements were met. In addition, all 37 case files had multiple eligibility requirements discrepancies, i.e., no copy of check stubs, social security card, Guam driver's license, current registration, etc. For these reasons, the finding remains.

  DPHSS did not address the audit recommendation to comply with 10 G.C.A. § 2904(b)(10) and § 2905(e), by establishing and training staff on a uniform eligibility determination process where at least an Eligibility Specialist obtains and verifies eligibility information, a second specialist inputs the information into the AGUPA system, and a Supervisor or other designated individual independently reviews at least 1% of cases per month using the established standard filing system and checklist to document their review. Such reviews allow supervisors to track staff workloads, the timeliness and accuracy of determinations, policy compliance, case activities, and pinpoint program violations and areas of potential fraud.

Management Response & OPA Reply

The legislation creating OPA requires agencies to prepare a corrective action plan to implement audit recommendations, to document the progress of the implementation of the recommendations, and to endeavor to have implementation completed no later than the beginning of the next fiscal year. Accordingly, our office will be contacting DPHSS to establish target dates and titles of officials responsible for implementing the recommendations.

We appreciate the cooperation and assistance shown by the Director of DPHSS, Chief of the Division of Public Welfare, MIP Administrator, Eligibility Administrator, Bureau of Primary Care Services Administrator, and Department of Administration.

OFFICE OF PUBLIC ACCOUNTABILITY

Doris Flores Brooks, CPA, CGFM
Public Auditor

Appendix 1:

Classification of Monetary Amounts

	Questioned Costs
MIP Labor Costs Appears to be Absorbed by Other Public Assistance Programs	$ 310,280
Unsupported MIP Certifications	$ 417,605
TOTAL:	**$ 727,885**

Appendix 2:

Scope and Methodology

The objectives of our audit were to gather and evaluate evidence to determine (1) the direct cost of MIP for the five-year period from October 1, 2004 through September 30, 2009; (2) whether MIP has effective internal control processes in place to ensure that applicants certified into the program are eligible recipients; and (3) whether the 2009 MIP benefits are comparable with those of the government of Guam health insurance plans.

The audit scope included the review of applicable MIP laws, rules and regulations, policies, prior audit findings, costs associated with MIP, and other pertinent information beginning October 1, 2004 and ending September 30, 2009. The scope to verify MIP labor cost funding in the AS400 financial system was extended to FY 2000 to obtain the history and trend. For the purpose of the MIP costs and statistics, i.e., MIP participants by gender, age, and ethnicity, we relied on the reports provided by DPHSS's Bureau of Health Care Financing between October 1, 2005 and September 30, 2009. However, we did not verify the accuracy of the statistical information provided.

To accomplish our objectives, we performed the following:

- Interviewed key DPHSS and Department of Administration (DOA) officials. Our process included a walkthrough of MIP eligibility and claims procedures and DOA's MIP claims payment processing procedures.
- Gained an understanding of the policies, procedures, applicable laws and regulations pertaining to MIP eligibility and claims processing, by reviewing applicable public laws, the 2006 MIP Policies and Procedures, and management's compliance with such requirements.
- Tested 38 case files with transactions totaling $421,790 to determine whether eligibility requirements were met.
- Compared MIP health care benefits with those of the three government of Guam 2009 health care plans.
- Accessed the AS400 system to obtain and analyze MIP costs and reviewed the government of Guam annual audited financial statements.

We conducted this audit in accordance with the standards for performance audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States of America. These standards require that we plan our audit objectives 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.

Appendix 3:

Prior Audit Coverage

Government of Guam Financial Audits

Applicable excerpts relative to the MIP and medical assistance programs (MAP) noted by the government of Guam Single Audits are listed below.

FY 2008:

All 190 cases (totaling $1,969,415) tested lacked documentation or support that the IEVS was used to verify eligibility. Of the 190 cases tested, the following was noted:

- 19 cases totaling $195,203 lacked sufficient data to substantiate eligibility.
- 37 cases totaling $193,773 had no case files.

Total Questioned Costs for FY 2008: $388,976

FY 2007:

All 139 cases tested lacked documentation or support that the Income and Eligibility Verification System (IEVS) was used to verify eligibility. Of the 139 cases tested, the following was noted:

- 21 cases lacked sufficient data to substantiate eligibility. No questioned costs associated or noted.
- Seven cases had no case files. No questioned costs noted.

Total Questioned Costs for FY 2007: $0

FY 2006:

All 103 cases tested lacked documentation or support that the IEVS was used to verify eligibility. DPHSS asserted that compliance with the IEVS is not required by MAP. However, since no documentation from the grantor affirming DPHSS's stance was provided, the finding remains. DPHSS noted that AGUPA does not have the capability to do IEVS matching. However, the new anticipated "IPASS" computer system will address this deficiency.

Total Questioned Costs for FY 2006: $0

FY 2005:

All 121 cases tested lacked documentation or support that the IEVS was used to verify eligibility. Required eligibility documents, such as application worksheets, Social Security cards, proof of citizenship, employment verification, and recertification forms, should be maintained on file. Furthermore, the IEVS shall be used to verify eligibility using wage information available from such sources as Social Security Administration, the Internal Revenue Service, etc. DPHSS noted that the new "PAGU" computer system being implemented will correct this deficiency.

Total Questioned Costs for FY 2005: $25,671.

Appendix 4:

Medically Indigent Program Mandates

The following are MIP mandates and requirements pursuant to 10 G.C.A. Chapter 2.

MIP Guidelines and Operational Responsibilities

The DPHSS Director, in consultation with the MIP Administrator, shall promulgate, subject to the Administrative Adjudication Law, a process for the periodic updating and revision of MIP benefits based upon an annual review of MIP enrollment, utilization and claims payment, and operating expenses, § 2904(c).

The DPHSS Director, in consultation with the MIP Administrator, shall establish Guam MIP income guidelines and annually review and adjust pursuant to the Administrative Adjudication Law, § 2904(d).

The MIP Administrator has full operational responsibility with duties to include:

- Defining eligibility for financial assistance with health care costs;
- Development of implementation and operational plans for MIP;
- Development of a complete system of accounts and controls for MIP, including provisions designed to ensure that covered health services provided are not used unnecessarily or unreasonably; and
- Establish a system for Quality Reviews of a sufficient sample size of applications to assure the validity of all applications.

MIP Application Procedures

To be eligible, an applicant shall meet additional standards for eligibility according to the following four criteria: (1) general eligibility requirements; (2) program residency requirements, (3) income limitations, and (4) resource limitations, § 2905(a).

General Eligibility Requirements:

An applicant must be a person who is, or would be legally obligated to pay for medical services rendered to such person, but through indigence or other financial circumstances, is unable to pay for such services, **AND**

- Is not eligible for Medicare, Medicaid coverage under Title XVIII or XIX of the Social Security Act or the State Children's Health Insurance Program under Title XXI of the Balanced Budget Act of 1997; **OR**
- Has neither private medical insurance coverage nor the financial ability to pay for medical insurance coverage, or for necessary medical services as determined by the Program; **OR**

- Has Medicare, Medicaid or private medical insurance coverage, but such coverage is inadequate to cover the cost of medically required treatment and such person is otherwise qualified for the Program as a result of inadequate income or resources. § 2905.1.

Program Residency Requirements:

- Applicants shall produce a Guam rent, mortgage receipt, or utility bill in order to establish beyond a reasonable doubt proof of residency of no less than six months. In addition, applicants shall produce one of the following: (a) a current Guam motor vehicle driver's license; (b) a current Guam motor vehicle registration; (c) a document showing that the applicant is or was employed on Guam, and if currently unemployed, an applicant shall provide a document showing that the applicant has registered with a public or private employment service on Guam; (d) evidence that the applicant has enrolled the applicant's children in a school on Guam; (e) evidence that the applicant is receiving public assistance on Guam; **OR** (f) evidence of registration to vote on Guam, § 2905.2(b)(1).
- Applicants signs an affidavit attesting that all of the following applies to the applicant: (1) does not own or lease a residence outside of Guam; (2) does not own or lease a motor vehicle registered outside of Guam; (3) is not receiving public assistance outside of Guam; and (4) the applicant is actively seeking employment on Guam, if the applicant is able to work and is not employed, § 2905.2(b)(2).

Income Eligibility Standards:

- Guam MIP Income Guidelines shall be used to determine income eligibility in the calculation of income. Payments for medical insurance or Medicare premiums shall be excluded, § 2905.4(a).
- If an applicant applying for assistance under MIP has gross income exceeding the income limitation by an amount not greater than $300, the applicant may still be eligible for partial coverage, § 2905.4(b).

Resource Eligibility Standards:

- Household total resources shall not exceed $2,000, § 2905.5(c).
- The following will be included in determining liquid resources: cash on hand, checks or savings account amount, stocks or bonds, and shares in credit union wages, § 2905.5(d).
- Cash resources that will be used for medical treatment-related expenditures are exempted in determining liquid resources, § 2905.5(e).

- Entire value of one licensed vehicle shall be excluded for one parent households and two vehicles for two parent households. All other vehicles shall individually be evaluated at fair market value, § 2905.5(f).
- Real property is excluded in determining household resources when it is their primary home, § 2905.5(g).

Effective date of coverage is the first day of the month of application that the individual has been deemed eligible for MIP, § 2905(b).

Failure to report changes in an eligible household within 10 calendar days, which would have resulted in ineligibility, making false or misleading statements or withholding information, shall result in the head of household and spouse (if any) to be suspended from MIP participation for three months for the first occasion; and six months for the second and subsequent occasions, § 2906(n).

GOVERNMENT OF GUÅHAN

DEPARTMENT OF PUBLIC HEALTH and SOCIAL SERVICES
DIPATTAMENTON SALUT PUPBLEKO YAN SETBISION SUSIAT
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FELIX P. CAMACHO
Governor

MICHAEL W. CRUZ, M.D.
Lieutenant Governor

J. PETER ROBERTO, ACSW
Director

MAY 2 8 2010

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Doris Flores Brooks, CPA, CGFM
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238 Archbishop Flores Street
Hagatna, Guam 96910

Dear Ms. Brooks:

Hafa Adai! First of all, thank you and your audit team for the Performance Audit of the Department's Medically Indigent Program (MIP) and the opportunity to meet to discuss the findings.

Attached are the department's responses to the audit findings and recommendations. Please note that the findings brought light to severe issues that the Division of Public Welfare has dealt with for a number of years i.,e., an inadequate automated eligibility system, lack of funding for administrative costs, and the need to strengthen program controls and processes. It is our hope that by moving forward with your office's recommendations the future of the MIP administration is strengthened and provides accordingly for the less fortunate community of our island.

Again, thank you and your audit team for working with our staff to ensure that the review presents an accurate depiction of the MIP operations. It is our hope that this would assist us in obtaining the much needed funding to improve operations.

Should you have any questions or concerns, please contact Ms. Linda Ann T. Susuico, Chief Human Services Administrator, Division of Public Welfare at 735-7274 or email at linda.susuico@dphss.guam.gov.

Senseramente,

J. PETER ROBERTO, ACSW

Attachment

Telephone No.: 1.671.735.7399 • 1.671.735.7102 * Fax No.: 1.671.734.5910

DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES

MANAGEMENT AUDIT RESPONSE

Medically Indigent Program (MIP)
October 1, 2004 through September 30, 2009

May 2010

DPHSS Management Response

The department does not necessarily agree with the overall findings indicating that DPHSS could not provide an assurance that $67.3 million spent on MIP for the period 10/01/2004 through 9/30/2009, was expended entirely for the benefits of eligible recipients. Provided are our responses to your audit findings.

Finding #1. **The pro-rata share of MIP administrative costs is being absorbed by other federally funded public assistance programs. It is estimated that $310,280 was the pro-rata share of MIP that was charged to the other programs in FY 2009.**

Audit Recommendation:

Properly allocate the $310,280 for MIP's pro-rata share of_administrative costs as of FY2009 and cease charging MIP's pro-rata share of labor costs to the other public assistance programs.

Department Response: Agree.

The audit recommendation acknowledges that 100% local MIP allocation goes toward benefits to serve the medically indigent population, currently serving 12,274 clients. The cost share with other federally administered health care programs will provide the necessary staffing to address both caseload and day to day operations. Should we allocate $310,280 from the MIP approved budget of $15,822,907, this would be $310,280 less for benefits to the MIP recipients. Hence, it would be suggested that a percentage be ADDED to the baseline costs pro-rated for MIP.

The finding that the department had not allocated funds for the administrative costs of the program as a result of the ceiling provided to administer the 100% local funded program has been and continues to be sufficient only to cover the costs of the medical services i.e., benefits, provided to our MIP recipients. The request for administrative costs had been repeatedly zeroed out from the budget request. . Although it is very clear that because the number of MIP recipients is sizeable, i.e., 12,274 clients, we do need to staff the certification and claims sections to ensure that the program is sustained to process the cases and the clear the claims.

Finding #2. **DPHSS' Certification Division has not established sufficient internal controls, such as separation of duties and independent review and monitoring of MIP applications.**

Audit Recommendation:

Establish a standard filing system and checklist for all public assistance program requirements that Eligibility Specialists can check-off as they obtain and verify applicant eligibility information a part of all case files. This checklist should also have a section for an independent review acknowledgement.

Response: Disagree and agree.

Disagree in that in conformity with federal requirements, it has always been standard practice for Eligibility Specialist Supervisors (ESS) to conduct case file reviews on all the public assistance programs i.e., Medicaid, Temporary Assistance to Needy Families (TANF), Adult (Aid to the Blind, Old Age Assistance, and Aid to the Permanent and Totally Disabled), and Supplemental Nutrition Assistance Program (SNAP). Case files are randomly selected from the various programs to include the MIP Program, the ES Supervisors will now be required to document and acknowledge all cases that were reviewed to substantiate the completion of an independent review and monitoring of MIP applications and case determinations.

Agree in that the department needs to move quickly to transition from the current Agupa Eligibility System to the new development PHPro Eligibility System which is designed and programmed with internal edits to ensure accurate case determination; and monitors the time frame for the processing of the cases.

Finding #3. **We tested 38 MIP case files with transactions totaling $421,790. Of these, 37 cases, or 97 % totaling $417,605, did not contain adequate support to conclude that applicants were eligible. Findings included missing original case files and lack of verification documents, such as of a household member's disability, employment status, and check stubs.**

Audit Recommendation:

Comply with 10 G.C.A. § 2904(b)(10) and § 2905(e), by establishing and training staff on a uniform eligibility determination process where at least an Eligibility Specialist obtains and verifies eligibility information, a second specialist inputs the information into the Agupa System, and a Supervisor or other designated individual independently reviews at least 1% of cases per month using the established standard filing system and checklist to document their review.

Response: Disagree to some extent.

In reviewing the cases selected for MIP Audit, it was noted that supporting documents are in file for some of the cases in question (e.g. the Affidavit, receipts). We agree that for most of the cases, the affidavit as required in Public Law 27-30 has not been complied with. However, it is our position that the recipients' affixed signature on the sections of public assistance application pertaining to their acknowledgement of responsibilities, penalty warning and client certification that they have bee informed of their rights and responsibilities, substantiates that this portion of the P.L. has been complied with. Furthermore, proof of identity is normally verified, but not made a copy for file.

Finding #4. **The current Automated Guam Program Assistance (AGUPA) information system lacks interface capability that would allow Eligibility Specialists to automatically transfer or share applicants' information. Additionally, the Certification Division has not utilized the IEVS to verify income and resource eligibility since 2000, which impedes the Division from independently assessing whether or not recipient income and resource information are accurate.**

Audit Recommendation:

Formulate a committee, to include the Chief of the Division of Public Welfare, MIP Administrator, Eligibility Administrator, and other appropriate persons, to evaluate why the Agupa lacks interface and make recommendations by December 31, 2010 on how to implement the IEVS and improve the current information system to allow for efficient processing of public assistance applications and for management to track staff workloads and case activities.

Response: Agree.

The Agupa System is a failing system that has made it very difficult for workers to process cases both timely and accurately. In regards to the IEVS system, the division is working with its current and new development contractors to program a system that will link into the IEVS data system and start a routine verification for unreported or underreported income, Social Security Number, Social Security benefits and other wages related information. Transmission test files have already been sent and received indicating successful transmissions. The division continues to work with the SSA and their vendors to obtain hit files and translate for users use. This further supports the decision to transition from the failing current Agupa system to the new development PHPro system.

Finding #5. **Some MIP benefits are more generous than the government of Guam health care plans and federally-funded Medicare. MIP benefits cover up to three**

roundtrip airfares, offer up to three times more coverage days for skilled nursing facility services, have no maximum cap for hemophilia-related blood products, and no lifetime cap.

Response: Agree to some extent.

While it is correct to say that some of the MIP benefits are more generous than other health insurance, the program should not be compared to other Guam health care plans nor the federally-funded Medicare program, because of dissimilar financial classification among the insured. MIP is a medical assistance program to assist low income individuals to pay for medical needs. Revising the benefits of the program to emulate the private insurance coverage would force the MIP eligibles to **not** seek physician services at the initial onset of their illness and until their condition is worsen requiring medical treatment at Guam Memorial Hospital Authority (GMHA) or other primary care physician. This_would definitely be much more costly to the entire community of tax payers and the Government in general. Furthermore, MIP covers roundtrip airfares only after obtaining prior approval for medically necessary treatments not available on island and justified by their physician.

Finding #6. **Although not mandated, DPHSS does not produce annual or biennial narrative reports to inform the public on the state of MIP, its program benefits, risks, concerns, and the impact on limited funding.**

Response: Disagree to a certain extent.

The department, as required by the legislature, provides quarter and annual MIP reports which are also posted on the DPHSS website. The reports contain demographics and expenditures on program benefits and different types of medical services covered by the program. The department recognizes your finding, however, as a means to market the importance of the program's purpose for its existence. Hence, the MIP quarter and annual reports may be expanded to include narratives that would educate the entire community and legislature of the issues and costs in running the program.

Do you suspect fraud, waste, or abuse in a government agency or department? Contact the Office of the Public Auditor:

- **Call our HOTLINE at 47AUDIT (472-8348);**
- **Visit our website at www.guamopa.org;**
- **Call our office at 475-0390;**
- **Fax our office at 472-7951;**
- **Or visit us at the PNB Building, Suite 401 In Hagåtña**

All information will be held in strict confidence.