MEDICAID STATE MANAGEMENT REPORT

Guam Title XIX Program

April 30, 1979 - May 7, 1979

BUREAU OF PLANNING
GOVERNMENT OF GUAM
P.O. BOX 2950
AGANA, GUAM 96910

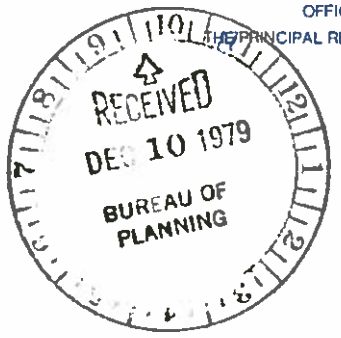
U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Health Care Financing Administration

Medicaid Bureau, Region IX

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
REGIONAL OFFICE
50 UNITED NATIONS PLAZA
SAN FRANCISCO, CALIFORNIA 94102

OFFICE OF
THE PRINCIPAL REGIONAL OFFICIAL

DEC 5 1979



Ms. Betty Guerrero, Director
Bureau of Planning
P.O. Box 2950
Agana, Guam 96910

Dear Ms. Guerrero:

One of the important initiatives of the Department of Health, Education and Welfare is to work closely with the States and U.S. Territories to improve the Medicaid Program. I believe you will agree that it is in the public interest to strengthen program administration and to improve health services to the poor whenever opportunities exist. Toward this end, a State Assessment Team from the HEW Regional Office examined the Medicaid Program in the Territory of Guam and a report has now been transmitted to Mr. Franklin S. Cruz, Director of the Department of Public Health and Social Services, as head of the Single State Agency for Medicaid.

I am pleased to provide you with a copy of this assessment report. For your information, the first section (pages 2-4) of the report, entitled Management Overview, gives you a concise picture of the Guam Medicaid Program. The next step in the assessment process calls for the development of a corrective action plan to address the findings and recommendations. We will again be working together with Guam in this regard.

I hope the enclosed copy of the report will be useful to you. Should you have any comments or questions related to it, please do not hesitate to let me know.

Sincerely,

Michael W. Murray

Michael W. Murray
Principal Regional Official

Enclosure

MEDICAID STATE MANAGEMENT REPORT

Guam Title XIX Program

April 30 - May 7, 1979

Team Leader: Charles A. Woffinden

Team Members:

Regional Office
Medicaid Bureau: Frances Contreras
Winston Barton
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Office of Program Integrity: Norman Siegel

BUREAU OF PLANNING
GOVERNMENT OF GUAM
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Date of Publication

November 1, 1979

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
HEALTH CARE FINANCING ADMINISTRATION
100 VAN NESS AVENUE
SAN FRANCISCO, CALIFORNIA 94102

MEDICAID BUREAU

Franklin S. Cruz, Director
Department of Public Health and
Social Services
Government of Guam
P.O. Box 2816
Agana, Guam 96910

Dear Mr. Cruz:

We are hereby transmitting a copy of the Medicaid State Management Report on Guam's Title XIX program. Included at the end is your response to the findings and recommendations of our assessment.

In the near future, we will be discussing with you the development of a Corrective Action Plan based upon the corrective action steps you outlined in your response. The plan format will show each action step you plan to take, and the anticipated completion date for each action.

Copies of the Assessment Report and your response are being sent to our Central Office, selected Congressional Representatives, the Governor, selected members of the Guam Legislature and other interested parties.

We want to thank you for the help and cooperation of your staff in completing this review.

Sincerely yours,

Lawrence L. McDonough
Regional Medicaid Director

Philip Nathanson
Regional Administrator

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INTRODUCTION

The Medicaid program was authorized by Congress under Title XIX of Public Law 89-97, Social Security Amendments of 1965. It was designed to provide Federal matching funds for use by States in State administered health care programs for the indigent. It succeeded earlier welfare linked medical care programs, most notably the Kerr-Mills program of medical assistance for the aged. State participation in the program is optional, although at the present time, all States except for Arizona have implemented a Medicaid program in some form. The District of Columbia, Puerto Rico, Guam, the Virgin Islands and, soon, the Northern Mariana Islands also provide Medicaid coverage. The Guam Medicaid program was implemented through Guam legislation and became effective on November 1, 1967.

It is important to note that both the extent of covered services and the criteria for program eligibility under the Medicaid program vary significantly from State to State because each State program is separately developed and administered at the State level within broad guidelines established by the Federal government. The State also exercises significant control over the Medicaid program through the funding process as the State legislature sets the scope and level of payments through its appropriation of funds for the program.

In addition, the ratio of federal matching funds to State and local funds varies from State to State depending upon the per capita income of each State. In no case may the Federal matching rate be less than 50 percent or more than 83 percent of the cost of matchable services in a particular State. The federal matching rate for Guam is 50 percent. In 1978, Guam's population was approximately 125,000. More than 6,100 persons received Medicaid during that year. Total Medicaid expenditures for FY 1978 amounted to nearly $2.4 million. In accordance with its matching rates, Guam claimed Federal funds equal to approximately half this amount. However, since the Federal Social Security Act places a $900,000 ceiling on Guam's Federal Medicaid funds, nearly $1.5 million of the total Medicaid costs were paid solely by the Government of Guam.

The overall responsibility for the Federal administration of the Medicaid program resides with the Secretary of the Department of Health, Education and Welfare. Within the Department, this responsibility has been delegated to the Health Care Financing Administration (HCFA). At the State level the Medicaid program is administered by a designated single State agency. In accordance with the guidelines established by Congress, HCFA works with the single State agencies toward effective management of the Medicaid program. The Guam program is administered by the Government of Guam, Department of Public Health and Social Services.

The purpose of this report is twofold: To evaluate the single State agency's administration of the Medicaid program on Guam and to assist Guam toward improvement in the overall management of its Medicaid program. The report is in no way meant to reflect upon Guam's performance in any areas outside of the Medicaid program. Assessment reports are directed to HCFA Central Office and Regional Offices, the State's Governor and top management, Federal and State Legislative offices and any provider or consumer groups which were involved in assessment activities.

This report encompasses 14 major functional areas in the Medicaid operation. Each of these 14 areas is separately discussed in detail:

A. Administration and Management
B. Eligibility
C. Claims Processing
D. Provider Enrollment
E. Utilization Control
F. Long Term Care
G. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
H. Family Planning
I. Sterilization
J. Abortion
K. Financial Management and Reimbursement
L. Drug Reimbursement
M. Third Party Liability
N. Fraud and Abuse

The field work for the Guam State Medicaid Assessment was conducted during the period April 30 through May 7, 1979. The review was conducted by a five-member team composed of staff of the Region IX Medicaid Bureau and Office of Program Integrity. Team members met with various levels of staff from the Department of Public Health and Social Services (DPHSS), as well as others associated with the Guam Medicaid program (e.g., providers, legislators and fiscal staff from the Division of Accounts) to observe whether Guam has procedures in place to run the program and, if so, how well they are operating. Documentation and fact finding were the core of the assessment technique, though many subjective observations and analyses were also necessary.

This report has been divided into two parts so that the various audiences to which it is directed will easily be able to extract needed information. Part I is a management overview of Guam's Medicaid program. It includes very limited descriptive information, and a general evaluation of the program from a management perspective. Part I is designed for legislators and others who wish to obtain an overall picture of Guam's program. Part II contains detailed descriptive information on each functional area reviewed. It also includes a series of very specific findings and recommendations for use by the Region IX and Guam single State agency staff in making needed program changes.

The comments of the Guam Department of Public Health and Social Services are included in their entirety as an appendix.

MANAGEMENT OVERVIEW

MANAGEMENT OVERVIEW

The primary conclusion reached by the assessment team as a result of its in-depth review of the Guam Medicaid program is that the program is seriously undermanaged. At the present time, only two percent of total Medicaid expenditures go toward management activities. The nationwide average for such costs is approximately eight percent, and a figure of six percent is generally considered to be a minimum maintenance level for management functions. The problem of undermanagement is most serious in the areas of staffing and systems.

A critical staffing shortage in the Guam Medicaid program has severely impaired its ability to operate effectively and to meet basic regulatory requirements in a number of program areas. Nearly every program area is gravely understaffed, and even where positions have been allocated, a large number of vacancies exist, often for long periods of time. With the exception of EPSDT, Family Planning, Sterilization and Abortion, every section in Part II of this report cites staffing shortages as a primary reason for failure to carry out essential functions.

In addition to severe staffing shortages, Guam is also suffering from serious deficiencies in its claims processing system. Although claims volume in Guam certainly does not necessitate implementation of a full Medicaid Management Information System (MMIS), some form of automation would appear to be essential to efficient, cost effective program operation. However, at the present time, Guam has no automated claims processing system for Medicaid. Instead, day to day processing is performed manually by the understaffed Medicaid Unit, with responsibility for most hand editing given to a single billing clerk. The speed and accuracy of processing have suffered as a consequence, and the Guam Medicaid program may therefore be paying many bills which should not be paid.

General financial management problems can also be attributed to the system. Other program areas, notably fraud and abuse control and utilization control, have been adversely affected. Most significantly, the system is not providing the information and data management needs to make decisions on how to operate the program. These deficiencies simply cannot be corrected unless Guam implements an automated system. Reports from States with automated systems show that from 10 to 15 percent of total program dollars can be saved through cost avoidance. Based on this percentage, Guam's annual program expenditures are probably at least $240,000 higher than they should be.

The following specific findings indicate the magnitude of Guam's staffing and systems problems and the compelling nature of the situation:

(1) The Utilization Control program is not working effectively. Guam has no overall policy, plan or procedures for controlling the utilization of services.

(2) Reviews to determine medical necessity, appropriateness and quality of care are not being conducted.

(3) Recoveries are not being made from third parties, resulting in monetary shortfalls to the program. Some State agencies recover significant amounts of money annually through their third party recovery activities. Last year, Guam recovered nothing. A conservative estimate of dollar loss due to inactive third party recovery efforts in Guam would be about two percent of program dollars, or approximately $50,000.

(4) A fraud and abuse control program, including methods of detecting, investigating and resolving cases, has not been established.

(5) Accounting and financial data are in a state of disorder. The Department of Public Health and Social Services (DPHSS) has little control over, or knowledge about, Medicaid expenditures.

(6) The claims processing system is inadequate. The present manner of processing claims results in an inability on the part of DPHSS to (a) adequately maintain master files of eligibles and providers; (b) use these files to verify eligibility or reimbursement rates; (c) detect duplicate payment; (d) produce service utilization profiles; (e) produce program operations or statistical reports; (f) detect third party liability; or (g) detect fraud and abuse on a pre- or post-payment basis.

(7) Most of the formulas currently in use for reimbursing providers should be reevaluated so that providers may be paid accurately, fairly, and economically.

Each of these findings, as well as many others in Part II, reflect a need for DPHSS to take extraordinary action. Immediate action is important not only because Guam may be spending a significant amount of funds inappropriately, but also because in its present situation, Guam cannot even track how and where Medicaid funds are being spent. This state of affairs is clearly harmful to Guam's self-interest insofar as health care funding is concerned. One of the goals of this assessment was to determine if the $900,000 federal funding level was adequate. However, so little data is available that such a determination cannot be made.

In order to correct the deficiencies outlined here, the Medicaid Unit needs the following four additional staff members:

(1) one person specializing in utilization control and provider relations;

(2) one accounting and claims processing specialist;

(3) one reimbursement specialist; and

(4) one person specializing in fraud and abuse and third party liability.

In addition, three new eligibility workers are needed to adequately handle the Medicaid caseload. The cost of maintaining this additional staff, as is outlined in Part II, could very probably be offset by savings that normally accrue to a properly managed Medicaid program.

Most importantly, however, the Governor, the Legislature and senior level management of the Department of Public Health and Social Services must focus attention on the Medicaid Program to assure that improvements in program management are made. Unless additional staff resources are provided to make certain that the Guam Medicaid Program meets all Federal requirements, compliance proceedings will have to be initiated and withholding of certain portions of Federal financial participation may be necessary.

A. GENERAL ADMINISTRATION AND MANAGEMENT

ADMINISTRATION AND MANAGEMENT

I. OPERATIONAL DESCRIPTION

A. Organization

Guam's Medicaid program is administered by the Department of Public Health and Social Services (DPHSS), which is the Title XIX single State agency. The Director of DPHSS is appointed by the Governor and must be confirmed by the Guam Legislature. The Director reports directly to the Governor of Guam. At the time of the review, Ricardo C. Duenas was serving as Acting Director of DPHSS, but since that time, Franklin S. Cruz has been confirmed as Director of the Department.

Within DPHSS, there are several divisions or units involved in Medicaid activities. The Social Services Division, headed by Cathy Illarmo, is responsible for Medicaid eligibility and related functions. These activities are described in detail in the eligibility portion of this assessment. This Division also used to include the Medicaid Unit; however, within the past year, the Medicaid Unit has been moved to the Division of Public Health and Sanitation. At the time of the assessment, this Division was headed by Acting Chief Public Health Officer Jim Gillan, but DPHSS is presently advertising for a permanent Chief Public Health Officer.

The Medicaid Unit is headed by the Medicaid supervisor, Dr. Eduvina Loria, who has been in Medicaid and has held this position since July 1978. Her staff includes a billing officer, an assistant billing clerk, an EPSDT coordinator, a general helper and a clerk typist. This unit, with its staff of six persons, is responsible in part or in full for the following Medicaid activities:

(1) Statistical Reporting
(2) Provider Enrollment
(3) EPSDT
(4) Prior Authorization
(5) Third Party Liability Collections
(6) Claims Editing and Processing
(7) Utilization Review and Control
(8) Monitoring of Abortions and Sterilizations
(9) Medical Review
(10) Fraud and Abuse
(11) Monitoring of Spenddown Requirements
(12) Budget preparation for the unit
(13) Recovery and Assignments
(14) PSRO

Although the Medicaid Unit is responsible for all of the areas listed above to a greater or lesser extent, serious staffing

limitations have caused the unit to focus almost entirely on claims processing and prior authorization activities. Most other program activities are either severely limited in scope or nonexistent. All of these program areas are discussed in detail elsewhere in this report.

In addition to the administration functions handled by the Social Services Division and the Medicaid Unit, there are certain major administrative activities conducted outside DPHSS. The Division of Accounts within the Office of Administration is deeply involved in Medicaid because of its resposibility for claims payment and federal claiming.

B. Personnel

1. Staffing Recruitment and Hiring

The three key managerial staff in the Medicaid program during the assessment have considerable experience in health related fields but virtually no experience in Medicaid. The former Acting Director of DPHSS, Ricardo Duenas, was in this position from January 1979 until June 1979. He formerly held the position of Director of Personnel at Guam Memorial Hospital and prior to that time, worked for the Department of Education. Since the assessment, he was replaced by Franklin Cruz. Mr. Cruz was Director of DPHSS about four years ago but returned to school to obtain a Doctorate of Education.

The Acting Chief Public Health Officer, Jim Gillan, has had considerable experience in the health field although he has had no Medicaid experience. He has held his present position since April 1979. Prior to that time, he was the Administrator of Emergency Medical Services. He has also worked for the local Health Planning Agency and as Guam's Hill-Burton officer. He has a master's degree in political theory from the College of William and Mary.

The Medicaid Supervisor, Dr. Eduvina Loria, has held her present position since June 1978. She was a practicing physician in the Philippines but has not completed the requirements necessary to practice medicine in the United States. Prior to becoming Medicaid Supervisor, she was Chief of the Communicable Disease Control Unit in DPHSS. She has had no previous Medicaid experience.

All staff engaged in Medicaid activities within DPHSS are employed full-time. Those employed in CETA positions are considered full-time temporary employees. Although federal financial participation (FFP) is available at either 50 or 75 percent for Medicaid staff, Guam's budget documents show all Medicaid personnel costs as a local contribution. No FFP is claimed for personnel costs.

Guam implemented a new civil service merit system effective June 1, 1979. Under the previous system, a new employee was placed on six months probation. The employee could be fired within the first six months without being informed as to the reason for loss of employment. However, once probation was passed there was virtually no way to fire an employee. Under the new system, performance evaluations will be conducted four times each year. Three of these evaluations will be informal and the final one will be formal. Evaluations will be based on job factors, and measurable performance standards will be developed for rating purposes. These performance standards will also be used for priority layoffs, demotions, training, and merit increases (which have been virtually automatic). Staff said the new system will be a good work-planning tool, but that its effectiveness as a management tool will depend upon how it is used by managers.

Most employees are covered by the civil service merit system. The DPHSS Director and Deputy Director, as well as the Director's private secretary, are not covered. Further, some technical employees such as physicians are not covered, although this is primarily so Guam can be competitive in salaries. Finally "helpers" and CETA employees are not fully covered under civil service.

The Personnel Office, which is located in the Office of Administration, is responsible for recruiting for all Departments, including DPHSS. Recruiting has been a serious problem for DPHSS. Mr. Gillan's administrative secretary position has been vacant since October 1978, and a Medicaid outreach worker position has been vacant since February 1979. Staff indicated that, while they are not displeased with the service provided by the Personnel Office, that office is not operating as efficiently as it should be. Several problems were cited:

a. The Personnel Office certifies the top three names on a list for interviewing. Medicaid has no input into the testing process which determines who will be certified. Technical staff, such as physicians, are certified based on a paper review and DPHSS has no input into the scoring criteria. Although the agency is not required to hire those certified, and can request a new list, persons not selected may be certified to the agency several times before being dropped from a list.

b. Position reclassification and creation of new positions can take a year.

c. Salaries are competitive within Guam itself, but are not competitive with the States or with the Federal government. Therefore, contract hiring from the mainland is now rare.

2. Affirmative Action

Staff interviewed believe DPHSS has a good ethnic balance, but there is no significant effort within the agency to ensure that hiring practices meet the specific requirements of Guam's Affirmative Action Plan. This review found no evidence of discrimination toward any groups.

3. Training

There is no staff training program in DPHSS. The Division of Social Services has done some intra-divisional training on eligibility issues, with some assistance from Regional Office Quality Control Staff. Further discussions of these training efforts can be found in the eligibility portion of this report. However the staff of the Medicaid Unit, which approves claims for payment and is generally responsible for Guam's Title XIX program, have received virtually no training. Dr. Loria was recently sent to the Regional Office and to the annual Medicaid Directors' Conference for some on-the-job-training. However, this type of activity is rare primarily because of fiscal constraints.

4. Office Conditions

DPHSS is housed in a relatively new building. Since the building is air conditioned, it has no windows. However, the air conditioning frequently breaks down and is only marginally effective when it is working. During the week of this assessment, the air conditioning was not operating about half the time and since there are no windows in the bulding, the temperature was well into the 90s. The humidity factor made conditions even more uncomfortable. For the comfort and convenience of applicants, eligibility intake on these days was conducted in the lobby where doors could be opened. However, such a practice afforded applicants virtually no privacy. Eligibility factors were discussed within earshot of many people.

Generally eligibility intake is conducted in the offices of the Social Services Division. The location of the Division at the back of the building on the second floor makes it necessary for applicants to walk through many other office areas to reach the intake area. There is no security in the building and the public appears to have relatively free access to any office. This policy appears to open the door to breaches of confidentiality as well as to aggravate the working situation for employees who may need quiet, uninterrupted working time.

The space available to Medicaid Unit staff is extremely limited. The EPSDT coordinator, billing officer, assistant billing clerk, helper and clerk typist sit within three to four feet of each other, just outside Dr. Loria's office. The billing officer

hand edits and processes thousands of dollars worth of claims daily in that setting. The noise factor as well as tendency toward distractions undoubtedly impinge on her ability to perform this task effectively.

There is no space in the Medicaid Unit for record storage. Dr. Loria keeps most records in her office on tables or in folders. She has been unable to obtain additional file cabinet space. Not only does this situation aggravate her working conditions, but also creates a potential threat to confidentiality.

C. Management

1. Work Planning

DPHSS has no system for establishing objectives and setting priorities. Staff has no time for work planning. Dr. Loria has no time to plan or to administrate and will never have time to do so under present conditions. Priorities in the Medicaid Unit are set based on the number of telephone calls from irate providers who have not been paid.

2. Correspondence Control

According to DPHSS staff, all correspondence is logged and controlled. However, it should be noted that the letter from the Regional Office confirming the assessment schedule never reached DPHSS. It was sent air mail special delivery from the Regional Office on April 13, 1979, and arrived April 17, 1979 in Guam. The Post Office notified DPHSS three times that the letter, addressed to Mr. Duenas, should be claimed. It was finally returned to the Regional Office unclaimed. The assessment team also noted that many Action Transmittals and other federal correspondence never reach the Medicaid Unit. It is the concensus of the assessment team that correspondence is not flowing among staff in an efficient and timely manner.

D. Recipient/Provider Input

1. Medicaid Advisory Committee

The Medicaid Advisory Committee, which consists of both recipients and providers, is basically non-operative on Guam. The Chief of the Social Services Division is responsible for ensuring that the committee functions properly, but she has been unable to maintain sufficient membership or interest in the committee. She is hopeful that the committee will again begin functioning effectively in the near future.

2. Other Recipient Input

With the exception of the Medicaid Advisory Committee, there are

no organized groups on Guam which represent the interest of recipients. Guam has no welfare rights or legal aid groups. However, they do have a public defender who will assist recipients. There is also an Office of Consumer Counseling and the Office of the Suruhano. The latter is further described in the eligibility portion of this assessment.

II. FINDINGS AND RECOMMENDATIONS

A. Compliance Issues

1. Medicaid Advisory Committee

Finding: The Medicaid Advisory Committee is non-operative on Guam.
CFR Citation: 42 CFR 431.12
Recommendation: DPHSS must ensure that the Medicaid Advisory Committee begins functioning as required in federal regulation.

2. Training

Finding: DPHSS has no program of training for Medicaid staff. Medicaid staff is seriously undertrained.
CFR Citation: 42 CFR 432.30
Recommendation: DPHSS must develop and implement a training program for Medicaid personnel as required in federal regulation.

B. Problem Areas

1. Office Conditions

a. Air Conditioning

Finding: The air conditioning system in the DPHSS building is inadequate, causing working conditions which are detrimental to efficient and effective program operation and creating situations which result in breaches of confidentiality.
Recommendation: The Government of Guam should allocate sufficient funds to fully repair or replace the air conditioning system in the DPHSS building. The concensus of the assessment team is that the working conditions created by the failure of the air conditioning system is serious enough to warrant the recommended expenditure.

b. Public Accessibility of Working Areas

Finding: There are virtually no limits on where the public can go within the DPHSS building. This

impinges on the staff's ability to complete their work efficiently and creates a potential for breaches of confidentiality.

Recommendations: (1) Intake or other applicant/recipient contact should occur on the first floor or in areas directly accessible from outside the building. (2) Public and non-public areas within the building should be designated and monitored informally.

c. Working Space

Finding: The working area allocated to the Medicaid Unit is inadequate.

Recommendation: Additional office space should be allocated to the Medicaid Unit. Serious consideration should be given to moving the entire unit to space now available in the old Guam Memorial Hospital.

d. Record Storage Space

Finding: The Medicaid Unit has insufficient office space and insufficient file cabinet space for record storage.

Recommendation: Additional office space for record storage and at least one additional full size file cabinet should be allocated to the Medicaid Unit. (See recommendation above relating to GMH.)

2. Management

a. Resources Devoted to Management

Finding: The Guam Title XIX program is understaffed and therefore undermanaged. Approximately two percent of Guam's Medicaid expenditures are spent on administration and management. The national average percentage of Medicaid funds spent on administration and management is approximately eight percent.

Recommendation: A considerable amount of additional staff should be allocated to the Medicaid Unit. In addition, new information and claims processing systems are essential to improve administration. The cost of administration and management should equal at least five to six percent of total Medicaid costs in order to correct the serious problem of undermanagement of the Guam Medicaid program.

b. Correspondence Receipt and Distribution

Finding: There is no effective system for tracking and routing correspondence. Special delivery mail is sometimes not claimed; Action Transmittals and other federal correspondence are not always routed to the Medicaid Unit; and information in general does not flow smoothly down the chain of command.

Recommendation: The State agency should take steps to improve its mail pick-up and delivery system.

B. PROGRAM MANAGEMENT

1 - ELIGIBILITY

The Medicaid program is generally designed to provide medical assistance to individuals who meet some or all of the requirements for receiving cash benefits under a Federal grant program. In Guam, persons who meet part or all the conditions of the following programs may be eligible for Medicaid: Aid to Families with Dependent Children (AFDC), Old Age Assistance (OAA), Aid to the Blind (AB) and Aid to the Permanently and Totally Disabled (APTD). These individuals are identified and classified by the program under which they may be eligible for a cash grant. These classifications are referred to as "coverage groups". States which implement a Medicaid program must provide medical assistance to certain groups of individuals; these are mandatory coverage groups, and include primarily those persons actually receiving cash benefits. Federal regulations also provide various options to States should they wish to extend medical assistance to groups of individuals who are not actually receiving cash assistance but who meet the basic non-financial requirements of one of the cash grant programs. These are optional coverage groups.

I. OPERATIONAL DESCRIPTION

A. Coverage Groups

Guam is required by federal regulations to provide Medicaid to five mandatory coverage groups. However, one of these groups, individuals under 21 who are ineligible for AFDC because of age or school attendance requirements (42 CFR 436.115), is not being covered under Guam's program.

In addition to the mandatory coverage groups, Guam covers the following optional categorically needy groups, as listed in 42 CFR:

--436.210 - Individuals who would be eligible for but are not receiving cash assistance.

--436.211 - Individuals who would be eligible for cash assistance except for their institutional status.

--436.220 - Individuals who would be eligible for AFDC if child care costs were paid from earnings.

--436.222(b)(1) - Individuals under 21 in foster care supported in whole or in part by public funds.

--436.230 - Essential spouses of aged, blind or disabled individuals receiving cash assistance.

Guam also has opted to cover medically needy persons, and covers all required groups except those individuals under 21 who meet medically needy financial eligibility requirements and who are ineligible for AFDC because they do not meet age or school attendance requirements (42 CFR 436.310(b)).

B. Organization

Medicaid eligibility determination is the responsibility of the Division of Social Services, which reports directly to the Director of DPHSS. Within the Division of Social Services, the Assistance Payments Unit (APU) is specifically responsible for making eligibility determinations for a number of Federal public assistance grant programs. The Food Stamp and Social Services programs are handled in separate units. The APU supervisor is presently on long-term sick leave, and the assistant supervisor is supervising the 28 staff members in the Unit. The APU's eligibility activities are conducted by APU staff in three locations on Guam, including the Central Office in Mangilao, and two satellite offices: the Southern Area Health Center in Inarajan and the eligibility office in Dededo, north of Mangilao.

Staffing

There are no caseload standards for APU eligibility staff, known as Assistance Payments Workers (APWs). Rather, caseloads are based on

the APW's level of experience and on the reality of the number of active cases. At the time of the review there were four vacancies in the APU, so caseloads were averaging between 300 and 400 cases per worker. The Guam Legislature recently commissioned a study on caseloads, which concluded that the average caseload in the 50 states is about 100 cases per worker. However, with Guam's present staffing situation, it cannot even hope to approach this figure in the forseeable future.

Caseload assignments are handled differently in each of the three offices, depending on the number of staff available. In the central office in Mangilao which has most of the caseload, eligibility functions are broken into intake and review. Mangilao has one full-time intake worker who assists applicants with forms and other procedural eligibility requirements. The intake worker determines which applications are for what programs, and distributes the applications to workers accordingly. These workers do the actual eligibility determinations. In Mangilao, one APW is responsible for all Medicaid cases, as well as some AFDC cases. This worker's caseload is presently about 300 cases.

In the Dededo office, there is also one intake worker. This worker assists applicants with required forms and procedures, then refers each case to one of four reviewers for purposes of eligibility determination. In Dededo, however, no single APW specializes in a specific program or programs. All APWs do eligibility determinations for all programs, including Guam's local General Assistance program. Each APW has a caseload of about 250 cases.

In the Southern Area Health Center in Inarajan, there is only one APW. Therefore, this worker does both intake and eligibility determination for all APU programs.

Staff turnover in the APU is quite low, although this is not the case in some other DPHSS units. In the APU, the ratio of supervisors to workers runs between 1:3 and 1:4.

D. Training

Very little outside training in available to Guam staff. The staff mentioned that Region IX staff have provided some quality control training, and commented that the Federal Corrective Action Program has stimulated some training. However, virtually no funds are available for other than in-house training. The APU supervisor recently completed a comprehensive cash grant and Medicaid eligibility manual, and began conducting in-house training sessions in April on the information contained in the manual. In the supervisor's absence, the assistant supervisor is continuing these sessions. APU supervisors see the sessions as a positive step toward improving the eligibility determination process in Guam. The Chief of the Division of Social Services indicated that the quality control findings made by the Guam QC staff have not yet been made available to the eligibility staff and that, therefore, no training has been developed as a result of QC findings.

E. Policy Development and Dissemination

Eligibility policy is formulated primarily by unit supervisors within the APU. Supervisory meetings are held regularly, usually weekly, during which the supervisors themselves may develop policy recommendations, or may provide reactions to policy changes proposed by the Division Chief or the Director. All policy changes must be approved by the Director. In the past, such changes were transmitted to staff through informational memoranda. With the development of the new public assistance manual, changes are transmitted via additions to or deletions from the manual.

F. Public Information

DPHSS makes an effort to provide public information about the Medicaid program, although that effort is quite minimal. Two Medicaid pamphlets, one describing the Federal program and one discussing Guam's program are available in all three eligibility offices. The pamphlets are available only in English and are not routinely distributed to applicants, but can be picked up by the applicants which in the office. In general, informational materials that are available are written in simple language, and appear to be relatively easy to understand. The APU also does a limited amount of outreach work. One APW is assigned to visit the local senior citizen's center on a regular basis. Further, each APW is permitted to spend half a day each week making home visits. Weekly visits to the local hospital are also made.

G. New Applications and Redeterminations

The application process is Guam begins with an interview in one of the three eligibility offices. Generally, applicants are handled on an appointment basis, although the APU will accept walk-in applicants in an emergency situation. As described above, applicants are interviewed by an intake worker in both Mangilao and Dededo, and applications forwarded to reviewers who do eligibility determinations. In Inarajan, both functions are performed by one APW. The regular intake day for the APU is Thursday, and on that day, reviewers will assist the intake worker in prescreening applicants. Under this system, applicants never wait more than one week for an interview. Applicants in an emergency situation can usually be interviewed by the intake worker immediately.

The application itself is a multipurpose form which is used for all APU programs. Property and income information is verified as part of the application process. Residency information is discussed with the applicant, but is not verified. Aliens are required to show an Alien Registration Receipt Card ("Green Card") or other documentation of lawful presence in order to be approved for Medicaid. Normally, eligibility determination is completed within one week of the date of application. However, at the time of the assessment, the Mangilao office was backlogged more than one month primarily because one APW had left the Department and had not yet been replaced. In any case, the effective date of eligibility is the date of application. Changes in circumstances which may affect eligibility are to be reported to DPHSS immediately. However, this requirement is printed only on the notice of action and is not otherwise discussed with the applicant.

Guam's procedures call for redeterminations to be conducted every five months for all AFDC-related cases, and for all ABD-related cases involving a spenddown. The redetermination period is 11 months for all ABD-related cases which do not involve a spenddown. However, time constraints did not permit the assessment team to evaluate the Department's performance with regard to this redetermination schedule. Eligibility decisions on applications and reapplications are made by the APW and are not subject to a second party review.

H. Issuance and Control of Medicaid Cards

Guam uses three types of Medicaid cards. The first is for AFDC-related non-spenddown eligibles, and the second is for ABD-related non-spenddown eligibles. The third "card" is actually not a Medicaid card but an authorization to receive services. This authorization is used by eligibles with a spenddown and is discussed in further detail on page 21. The first two types of cards are mailed out on a monthly basis. The third type is issued to the eligible individual on an as-needed basis.

An individual with no spenddown receives the Medicaid card within three days of the date eligibility was established. If the individual requires a service prior to receipt of the card, the APU gives that individual a note stating that he or she is eligible to receive services. There is no mechanism in place to ensure that an individual who is no longer eligible does not use a still valid card.

I. Hearings and Appeals

Both the application and the notice of action contain statements advising the applicant or eligible of the right to petition for a fair hearing. The individual may petition for a fair hearing up to 90 days following the date of the notice of action. When an applicant or eligible has a complaint, the Department first attempts to resolve the matter through a conference with the APW. If the complaint is not resolved, the matter may be brought to the attention of the APU supervisor. Most problems are resolved in this manner. However, if the individual is not satisfied, he or she may petition for a fair hearing. In this case, the APW must assist the individual in filling out the petition form and in preparing for the hearing. Additional assistance is available to the petitioner through the office of the Suruhano, the ombudsman for the Government of Guam. This individual assists Guamanian residents in overcoming governmental problems.

The fair hearing is scheduled by the Chief of the Division of Social Services, who also acts as the fair hearing officer. The Director of DPHSS signs off on all fair hearing decisions. The petitioner receives Medicaid during the fair hearing process, if he or she was receiving Medicaid prior to the DPHSS action which resulted in the petition for a fair hearing. In such cases, if the petitioner is later determined ineligible, no recoupment of funds is made. If the individual is dissatisfied with the fair

hearing decision, the case can be brought before the Superior Court of Law. In such cases, the effective date of eligibility is the date so ordered by the court. Although the fair hearing process in Guam appears to be well developed and workable, in fact only one individual has actually petitioned for a fair hearing under the Medicaid program during the past two years. In this case, the decision was in favor of the petitioner.

J. Retroactive Coverage

In Guam, the three-month retroactive Medicaid coverage provisions of federal law are being applied inconsistently and usually incorrectly. In both Mangilao and Dededo, retroactive coverage is automatically approved for all persons determined eligible for Medicaid. Eligibility for retroactive coverage is based on current month eligibility information. The Guam public assistance manual specifies that such retroactive coverage is available for 90 days prior to the date of application. In Inarajan, three-month retroactive coverage is being determined on a monthly basis, using eligibility information from the month for which retroactive eligibility is being determined.

K. AFDC-Four Months Continued Coverage

Four-month continuing coverage is being provided inconsistently and perhaps incorrectly in Guam. Four-month continuing cases cannot be separately identified from cash grant cases, and there is no control mechanism to ensure either that Medicaid is not extended beyond the four-month period, or that other eligibility criteria are still being met. Further, staff in Mangilao and Dededo offices are unclear as to the criteria for receiving four-month continuing coverage. When interviewed, several different staff members said they granted this coverage for any person discontinued from AFDC unless the reason for discontinuance was because the AFDC mother married. The APW is Inarajan was aware of the employment criteria associated with this coverage, and applied those criteria correctly. Interviews with quality control staff indicated that they correctly understand four-month continuing coverage requirements. However, they said a four-month continuing case has never been pulled in the quality control sample, so they do not know if it is being granted on the correct basis.

L. Third Party Liability

Third party coverage information is collected on the application form. However, the information is not collected systematically from all applicants. The third party coverage item on the application form specifies that applicants for medical assistance only must provide third party information. Applicants for cash grants are not required to complete this item, even though they receive Medicaid. Information that is collected in this manner is keypunched as part of the monthly eligibility listing, a copy of which is provided to the Medicaid Unit for billing purposes. Funds collected by a Medicaid eligible from a third party payor cannot be used to meet the spenddown requirement. The Medicaid card for ABD-related non-spenddown eligibles contains some third party information. However, the AFDC-related card contains no such information.

M. Institutionalized Persons

Guam provides very little long-term institutional care. The island has a small skilled nursing facility which, at the time of its last medical review, housed only three SNF patients. The income standard used for an institutionalized person is the same as the income standard for a person living at home. If the institutionalized person has a spouse at home, income is divided for eligibility purposes beginning the first of the month following the month the person entered the institution. Resources are not divided.

N. Spenddown

Guam utilizes a spenddown procedure for medically needy persons. Spenddown is computed on a monthly basis, using the income and resource criteria which apply to the related cash grant program. Financial eligibility in general, and spenddown in particular, are computed on the blank back side of a "computation sheet" used for all APU programs. The Food Stamp Program uses a more detailed worksheet, but the APU has not developed such a worksheet for its programs. Once the spenddown is computed, the spenddown amount is keypunched as part of the monthly eligibility listing. The Medicaid Unit then becomes responsible for tracking whether the spenddown was met, and for issuing authorizations for service for spenddown eligibles. The APU does not keep track of whether or when an individual meets the spenddown. There are two ways for an individual to prove that a spenddown has been met. First, the provider can submit a claim to the Medicaid Unit, and the billing clerk will then authorize payment of the amount of the claim above the spenddown amount shown on the eligibility listing. Second, the spenddown eligible can bring a service receipt to the Medicaid Supervisor in Mangilao each time he or she needs a medical service, and the Medicaid Supervisor will issue an authorization for the service. If the eligible fails to obtain such authorization the spenddown will be deducted each time a provider submits a claim for service. Only spenddown eligibles must go to Mangilao to obtain written authorization for every service. All other eligibles, including other medically needy individuals, receive a regular card on a monthly basis. Only services covered under Guam's Medicaid program may be applied toward the spenddown.

II. FINDINGS AND RECOMMENDATIONS

A. Positive Practices

1. Public Assistance Manual -- During the past year, DPHSS staff have devoted considerable time and effort to the development of a comprehensive public assistance manual. Although the manual is not yet complete, it should eventually prove to be a useful tool in identifying eligibility problems and achieving consistency in eligibility determinations in all APU offices. APU supervisors have already begun conducting training sessions for APWs using information contained in the manual.

2. Appointment Schedule -- The procedure for scheduling non-emergency intake interviews is well organized and workable. It ensures that staff focus their full attention on applicants on intake day, while allowing relatively uninterrupted time for processing applications on other days. Emergency applicants can be interviewed immediately and no applicant need wait more than one week for an interview.

B. Compliance Issues

1. Individuals Under 21 Not in School or Training

Finding: Guam is not providing Medicaid to individuals under age 21 who do not meet AFDC age or school attendance requirements, in accordance with its Title XIX State Plan.

CFR Citation: 42 CFR 436.115 and 42 CFR 436.310

Medicaid must be provided to both categorically needy and medically needy individuals under age 21 who are ineligible for AFDC because of age or school attendance requirements.

Recommendation: DPHSS must amend its eligibility determination process to ensure that these groups are covered.

2. Who May Apply

Finding: In the case of married couples living together, the Mangilao and Dededo offices are requiring the husband to complete the application form. Only in Inarajan is the wife permitted to complete the application form.

CFR Citation: 45 CFR 206.10(a)(1)

Each individual wishing to do so shall have the opportunity to apply for Medicaid without delay.

Recommendation: DPHSS must permit anyone who wishes to apply for Medicaid to complete the application form.

3. Three-Month Retroactive Coverage

Finding: DPHSS is automatically providing three-month retroactive coverage to all persons determined eligible in a current month, without regard to eligibility information for retroactive months . DPHSS permits retroactive coverage for only 90 days prior to the date of application, although eligibility determinations in Guam's various cash grant programs are made on a full-month basis.

CFR Citation: 45 CFR 206.10(a)(6)(ii)

Medical assistance must be made available no later than the third month prior to the month of application if the individual would have been eligible on the date he or she received medical services.

Recommendations:

(a) DPHSS must determine whether or not an individual was actually eligible for retroactive coverage during the three retroactive months, including computation of any spenddown requirements.

(b) The public assistance manual should specify that coverage is available for three months rather than 90 days.

(c) Since Guam's cash grant programs are based on full-month eligibility, Medicaid eligibility must also be provided on a full-month basis. Thus, retroactive coverage must be made available to applicants for three full months prior to the month of application.

4. Resource Limitations Based on Family Size

Finding: Guam has set resource limits of $1000 in personal property and $3000 in real property, regardless of family size.

CFR Citation: 42 CFR 436.840

The standards for liquid assets must increase by family size.

Recommendation: DPHSS must establish resource standards which increase by family size and are at least equal to the most liberal resource standards used to determine eligibility under one of the Federal cash grant programs.

5. Income Standard for the Institutionalized

Finding: Guam applies the same income standard for an institutionalized individual as is applied for an individual living at home.

CFR Citation: 42 CFR 436.813

The agency must use a lower income standard for institutionalized persons than for persons at home. The lower standard must be reasonable in amount for clothing and personal needs.

Recommendation: Guam must apply a lower income standard for an institutionalized individual in determining eligibility and spenddown. For States with SSI, this income standard, or personal needs allowance, must be at least $25. However, since Guam has no SSI program, the amount of the institutionalized income standard must simply be reasonable in amount for clothing and personal needs. Within Guam's OAA, AB and APTD programs, a precedent for such an allowance has already been set. Eligibles in these programs are permitted to retain $15 for personal needs when they are in foster care. Income in excess of the $15 is applied toward the cost of foster care. Therefore, Guam may also wish to use the $15 figure as the income standard for institutionalized Medicaid eligibles, since the purposes of this income standard and the foster care allowance are quite similar.

6. Application of Non-Covered Care Toward Spenddown

Finding: DPHSS does not permit the cost of non-Medicaid-covered services to apply toward meeting spenddown requirements.

CFR Citation: 42 CFR 436.831(c)(1)(ii)

In determining income eligibility, DPHSS must deduct from income expenses incurred for necessary medical and remedial services that are recognized under Guam law but not included in the Medicaid State Plan.

Recommendation: DPHSS must permit the cost of medical services not reimbursable under Medicaid to apply toward meeting the spenddown. DPHSS may set reasonable limits on the amounts of such medical expenses (see 42 CFR 436.831(b)(2)).

7. $10 Cutoff on Spenddown Requirement

Finding: DPHSS is not requiring individuals with a spenddown of $10 or less to meet that spenddown.

CFR Citation: 42 CFR 436.831(d)

After incurred medical expenses are deducted from income, countable income must be equal to or less than the income standard. There is no provision in Federal regulation for allowing individuals to

retain even nominal amounts of money above the income standard.

Recommendation: DPHSS must require all persons with a spend-down to meet the full spenddown. It would be acceptable to round down to the next lowest dollar figure in determining the spenddown amount.

C. Problem Areas

1. Staffing Levels and Caseload Standards

Finding: Staffing levels in the APU are totally inadequate to handle the present caseload. Caseload levels are running between 300 and 400 cases per worker. This level makes it virtually impossible to ensure consistently accurate eligibility determinations.

Recommendation: Increase the number of eligibility staff to reasonable levels. More detailed discussion of staffing problems and recommended solutions can be found in the Administration and Management section.

2. Third Party Data Collection

Finding: Procedures for collecting third party liability information during the application process are inadequate. Medical Assistance Only applicants are required to provide such information but cash grant applicants, who comprise most of the Medicaid population, are not required to do so.

Recommendations:

(a) All cash grant and Medicaid applicants should be required to provide third party liability information upon application.

(b) More detailed information should be key-punched on the eligibility listing to further assist the Medicaid Unit in its collection efforts.

(c) Both the AFDC-related card and the ABD-related card should provide space for showing all types of third party information, and this information should be typed on the card by the APU prior to issuance.

3. Medicaid Eligibility Worksheet

Finding: The computation form now used for Medicaid eligibility determinations is inadequate. The material printed on the form does not carry the worker through the eligibility computation, which can result in inconsistent and inaccurate determinations. In fact, the computation is actually done on the back, blank side of the form.

Recommendation: The APU should develop a computation worksheet which takes the worker through each step of the eligibility computation process. The Food Stamp form used on Guam may serve as a model. In addition, the Regional Office can supply DPHSS with examples of worksheets used in other states.

4. Inconsistent Application of Eligibility Factors

Finding: Eligibility factors are being applied inconsistently from office to office on Guam. Inconsistencies regarding three-month retroactive coverage, four-month continuing coverage, and who may complete the application form have already been identified in this report.

Recommendation: The APU should intensify its efforts to provide training to APWs in all offices so that every worker understands the eligibility determination process. Only through a stepped-up training and communication program can the problem of inconsistency between offices be eliminated.

5. Reporting Changes in Circumstances

Finding: 42 CFR 206.10(a)(2)(ii) requires that the State Agency adopt procedures to assure that Medicaid eligibles report changes in circumstances which may affect eligibility on a timely basis. Applicants are informed of this requirement to report any changes in circumstances only on the Notice of Action form. The requirement is not discussed with the applicant and, although one reminder was sent out in the past, there is no regular procedure for ensuring that eligibles are kept fully aware of this reporting responsibility. This is of particular concern on Guam because, according to Guam quality control staff, non-reporting of real property and non-reporting of income account for the major portion of eligibility errors.

Recommendations:

(a) DPHSS staff should emphasize reporting requirements during the intake interview.

(b) A regular reminder system should be developed to ensure that ongoing eligibles are kept informed of their reporting responsibilities. One vehicle for accomplishing this might be a printed statement on the card itself.

6. Quality Control Cooperation Requirements

Finding: Applicants are not being informed during the intake interview of their responsibility to cooperate with

quality control reviewers if their case is selected as part of a quality control sample.

Recommendation: DPHSS staff should begin informing applicants during the intake interview of their responsibility to cooperate with quality control reivewers.

7. Spenddown Procedure

Finding: The spenddown procedure used on Guam is totally inadequate.

(a) There is no good system for tracking whether or when the spenddown was met.

(b) Spenddown eligibles must obtain prior authorization for every service, whereas categorically needy eligibles and other medically needy eligibles need prior authorization only for services subject to prior authorization under Guam's Title XIX State Plan. The practice, which may result in differences in the amount, duration and scope of benefits for different groups of medically needy eligibles, is in conflict with 42 CFR 440.240(b).

Recommendation: A new spenddown procedure should be developed which will track when spenddown requirements are met, and will eliminate any differences in amount, duration and scope between spenddown and non-spenddown medically needy eligibles.

2 - PROVIDER ENROLLMENT

I. OPERATIONAL DESCRIPTION

A. Statewide Coverage

In Guam, most of the 31 physician/Medicaid providers are located in the Western part of Guam in the village of Tamuning. Dentists (6) are a little more dispersed but not significantly so. Guam also has Medicaid providers in the following areas: Optometric, Pharmaceutical, Laboratory, and Medical Supplies and Equipment. Provider Agreements exist with one acute hospital and one Skilled Nursing Facility as well as with the Public Health Department Home Health Program, Inarajan Family Health Center, Family Planning, and Speech and Hearing. Off-island agreements exist with Queens Hospital in Honolulu and University of California/San Francisco Hospital.

If there is a need to verify the professional credentials of any applicant, it is done through local associations and the Public Health Department which licenses all health professionals.

B. Enrollment Procedures

An applying provider has only to request providership verbally. The applicant is then sent a provider agreement to sign. Once an agreement is properly signed and dated it is in force until one or another of the parties wish to terminate the agreement. Annual agreements are signed with both Guam Memorial Hospital Acute and Skilled Nursing Facilities.

The Provider Agreement includes the provisions of 42 CFR 431.107, which requires a certification statement on checks and claims, and the claim form includes the provision of 42 CFR 455.22, which refers to Federal penalties for fraudulent acts and false reporting.

A new provider does not receive any information regarding coverage limitations and reimbursement policies and procedures. Often, providers do not receive any orientation to the program until they have made their first billing error. The Medicaid Unit has very limited information regarding a provider's participation in Medicare and is not notified of a provider's termination by the Bureau of Medicare.

Providers are assigned a number in consecutive order starting with number one. There are no special numbering sequences to differentiate types of practices (group vs. solo) or providers (physicians vs. labs). In organizations such as clinics, group practices, and out-patient hospital facilities, individual physicians are identified for purposes of verifying services. Verifying physicians and physicians who bill through the above types of facilities are monitored closely through claims and not checked against an alphabetical listing. The reasons for this is that Medicaid staff are very familiar with all providers, since they constitute such a small group and it is easy to learn each provider's characteristics. The most current alphabetical listing of providers was

published May 1, 1979. The only requirement for becoming a provider is to be licensed. Since the Department of Public Health issues most professional licenses, they notify the Medicaid Unit of any revocations. There is no Provider Master File and there is no plan to develop one until the Medicaid Unit begins to develop a computerized system.

C. Provider Relations and Education

For the purposes of this assessment two providers were interviewed; a pharmacist who was the former President of the Pharmacist Association and a physician currently the President of the Medical Society. Both these providers stated there is very little contact between Medicaid and providers. Providers are not informed of policy changes nor are they consulted regarding policy changes. Both providers felt the under present policies, there are many opportunities for abuse by both recipients and providers. One provider also felt that recipients are not aware of the services that are available to them and will often become angry or embarrassed if denied services. The recipient will sometimes leave in anger and not take advantage of the service to which he is entitled.

II. FINDINGS AND RECOMMENDATIONS

Finding: There is general lack of written procedures to carry out a more comprehensive program of provider enrollment. This lack of procedures serves to prevent the education and involvement of providers in the program and stymies the growth of the program.

Recommendation: Guam should hire more staff in order to reduce the Medicaid Supervisor's workload. This would allow her to become more involved in developing policy manuals that would improve provider enrollment and relations.

3 - UTILIZATION CONTROL

I. OPERATIONAL DESCRIPTION

A. Prior Authorization

Guam requires prior authorization for certain services, including dental services, eyeglasses, durable medical equipment, off-island treatment, sterilizations and abortions, and for all services for medically needy individuals with a spenddown. Guam Medicaid staff do not know how these services were selected for prior authorization but they continue to be prior authorized because they appear in the State Plan. Dr. Eduvina Loria, Medicaid Unit supervisor, is responsible for making all prior authorization decisions. She personally reviews each request and uses her own medical judgment to determine whether the request should be granted. There are no written guidelines to assist her in this activity, nor does the agency maintain a precedent file of prior authorization decisions.

Claims for services which must be prior authorized usually arrive with the written prior authorization attached. Dr. Loria sometimes gives telephone authorization, but the claim for services will not be processed without written prior authorization. The only exception to this requirement is that, if the physician certifies that there was an emregency situation, the claim will be processed without prior authorization.

Dr. Loria said providers are aware of all prior authorization requirements. However, Medicaid eligibles, not providers, are responsible for obtaining the required prior authorization. Generally, an eligible who needs a service will hand carry the physician's prescription to Dr. Loria in her office in Mangilao and wait while Dr. Loria provides written authorization.

B. Pre-Admission Procedures for Long Term Care

In Guam, there is only one Skilled Nursing Facility (SNF) and that facility is a part of Guam Memorial Hospital. Because the hospital has its own Utilization Review Committee, the Medicaid Unit does not become involved in the evaluation of a patient's need for SNF care prior to admission. Instead, the hospital itself determines the appropriate level of care and length of stay for potential SNF patients. Only during medical review does the State Agency monitor the patient's continued need for institutional care. Further discussion of the medical review procedure can be found under Part D of this Section.

C. Utilization Review

Guam Memorial Hospital (GMH) has a functioning Utilization Review program, but that program is not monitored by the Guam Title XIX program. Since GMH is a Medicare provider, monitoring does take place, but the single State agency makes no attempt to tap into Medicare's monitoring system. In essence, the Guam single State

agency is not involved in the hospital UR program. The only utilization control activity which the State agency performs in connection with GMH is a review of charts of Medicaid patients, which Dr. Loria performs to assure herself that the patient needs hospital care, even though the hospital UR committee has already made such a determination. The single State agency has no plans to develop a UR monitoring program at the present time.

The GMH UR coordinator and the accredited records technician provided the assessment team with much of the UR information for this report. The hospital uses written level of care criteria, specifically the Pacific PSRO guidelines. Level of care determinations are carried out within 24 hours of admission, except that for patients admitted on weekends or holidays, the review may occur a day later.

If a patient no longer needs inpatient care, the State will still pay for administratively necessary days. GMH must simply send a form to the State agency saying the patient needs a lower level of care but cannot be moved. The hospital then bills the agency at the SNF rate but keeps the patient in the acute facility. GMH staff said this is necessary because the State agency will not pay for such patients at the acute rate. The situation is complicated by the fact that the unavailability of SNF beds is largely the result of those SNF beds being filled by intermediate care facility (ICF) level patients and board and care patients. ICF care is not covered under Guam's State Plan.

The hospital has conducted a number of Medical Care Evaluation (MCE) Studies during the past two years, on such subjects as myocardial infarction, pneumonia and ulcers. The Joint Commission on the Accreditation of Hospitals recently surveyed GMH and found that the hospital had performed many more such studies than were actually required. Most of the data for the studies are collected from computer reports, which include abstracts on discharged patients. For the SNF, a MCE study was recently done on strokes, and at least one SNF MCE study is done annually.

D. Medical Review

The single State agency does an annual medical review on the patients in the SNF. The Medical Review Team consists of a physician, a registered nurse and a social worker. Dr. Loria also participates as an observer. All three working team members are employees of DPHSS and assist the Medicaid Unit annually in its medical review acitvities. The SNF has 16 beds, but many of these are filled with ICF or board and care patients. During the last medical review in December 1978, only three Medicaid SNF patients were present in the facility. The entire review took one day, during which time the team physician saw each patient. Dr. Loria has received no training or instruction as to the functions and purpose of the team.

At the time of this assessment, the medical review reports from the December review had not yet been signed by the Director. It should be noted that although the State agency performs its annual medical

review functions as required, no level of care changes have ever been recommended, insofar as State agency staff are aware. Furthermore, no complaints of poor care or mistreatment have ever been received by the State agency.

E. Utilization Control (General)

Guam's Utilization Control program is not working effectively at the present time. The primary problem is lack of staff in the single State agency. This, in combination with inadequate training, has resulted in a total inability on the part of the Medicaid Unit to ensure that appropriate services are being rendered to Medicaid patients.

F. Professional Standards Reveiw Organization (PSRO)

Guam presently is not operating under a PSRO. The single State agency has submitted a draft Memorandum of Understanding (MOU) to the Pacific PSRO, based on Hawaii's MOU, but no further action had occurred at the time of the assessment. Insofar as GMH is concerned, final approval of its UR plan was pending at the time of this assessment, and the hospital survey had already been done. The hospital had planned to begin phasing in the PSRO for the acute level of care in early June for Medicare patients. Action will be delayed for Medicaid patients until an MOU is signed.

II. FINDINGS AND RECOMMENDATIONS

Compliance Issue

Findings: The Guam Title XIX program does not have in effect an acceptable utilization control program. Guam is therefore out of compliance with all Federal regulations regarding the responsibility of the single State agency to monitor and control utilization of services.

(1) There are no written criteria for administering the prior authorization program, and in fact, the staff is not even aware of the rationale for requiring prior authorization.

(2) There is no screening or monitoring of care being received by long term care patients, except for the medical review function. Furthermore, no one on the Medicaid staff understands the purposes and functions associated with the medical review function.

(3) The single State agency is not monitoring the hospital utilization review committee as is required under Federal regulation and is instead duplicating much of the UR committee's activities through its chart reviews.

(4) Guam has no overall policy, plan, or procedures for controlling utilization of services by Medicaid eligibles.

CFR Citation: 42 CFR 456,Subparts A and B

Recommendation: DPHSS must develop a utilization control system which will meet the requirements in the above citation. Failure to come into compliance could result in a substantial reduction in Federal financial participation.

4 -LONG TERM CARE

I. OPERATIONAL DESCRIPTION

The Guam Medicaid program's long term care services include one Skilled Nursing Facility (Guam Memorial Hospital) and one alternative care service (Public Health Department's Home Health Agency). Guam does not provide an Intermediate Care Facility (ICF) level of care and has no future plans to include this service in the State plan. The Public Health Department has no licensing and certification unit. Instead, the Skilled Nursing Facility (SNF) and the Home Health Agency (HHA) are surveyed and certified for Federal participation by the Region IX staff of the Health Care Financing Administration/Health Standards and Quality Bureau. When the SNF and HHA are certified, HSQB informs them by letter and they in turn inform the Medicaid single State agency, DPHSS, which issues a provider agreement. However, HSQB does not directly inform DPHSS when it issues certifications. There is no formal agreement between DPHSS and HSQB regarding their roles in the survey and certification process.

DPHSS is usually kept informed about policy development and policy changes in the area of long term care by HCFA/Medicaid staff, who also monitor the issuing of the annual provider agreements.

Medical-Social Review (MSR) Team findings of problems and deficiencies are not shared with the HSQB staff, who conduct the annual SNF surveys. The latest Medical-Social Review was conducted December 12, 1978. The report does not include a social worker's evaluation. This report was not shared with the SNF. Survey reports prepared by HSQB are not shared with DPHSS and are not made available to the public.

A. Definition of Level of Care and Placement of Patients

Guam has adopted the Title XVIII definitions for the skilled level of care. The physician admitting a patient to a SNF must certify in the patient record that the admission to SNF level of care is appropriate. Most patients are admitted to the SNF from Guam Memorial Hospital's acute facility, which has a close affiliation with the SNF and is very aware of the number of available beds. The public is not made aware of the number of available beds through any organized procedure.

Guam does not monitor procedures for safeguarding patient funds. Such monitoring is done only by HSQB at the time of survey and certification.

Guam Memorial Hospital provides a level of care known as ICF care. However, the Guam Medicaid program does not include ICF care as a covered service under its Medicaid State Plan, and therefore, no FFP is made available for this service.

B. Home Health Agencies and Alternative Health Care Settings

The sole certified Home Health Agency (HHA) in Guam is run by the Public Health Department. This agency is certified for both Titles XVIII and XIX, and it serves the entire Island of Guam. Services are available to all age groups, the the agency accepts payment for all third party payers. This HHA offers the required services of nursing, home health aides, and medical supplies and equipment, as well as one optional service, social services. Family Health Plan (a prepaid health plan) provides home health care for its own enrollees. This is the only other form of home health care available on Guam.

During the January-March 1979 quarter, the Public Health Department HHA provided services to 34 Title XIX patients. Total expenditures for HHA services rendered to Title XIX patients in FY 1978 were $16,775, which represents 1021 nursing visits. Although claims for these services are submitted, actual money payments are not made. Instead, the Public Health Department HHA prepares an annual budget which includes the cost of services rendered to Title XIX patients.

In its review of HHA services, the assessment team identified a problem with the provision of medical supplies and equipment to Title XIX patients. It appears that providers are refusing to provide such supplies and equipment to Title XIX patients who have in hand both a valid prescription and a Medicaid card, on the assumption that such supplies are not covered services. The HHA staff may then send patients to Guam Memorial Hospital for these supplies, which causes further hardship.

II. FINDINGS AND RECOMMENDATIONS

1. Finding: There is a lack of communication about cerification status between DPHSS and HCFA/HSQB.

   Recommendation: DPHSS and HSQB should develop a procedure to exchange information regarding their activities in Long Term Care, e.g., certification reports, MSR team reports and providers agreements; and a procedure should be established to make available to the public information regarding certification and number of beds.

2. Finding: The MSR team reports do not include a social work evaluation of the patients' needs. Also, MSR team reports should not include patient names when they are being forwarded to HEW.

   Recommendation: DPHSS should ensure that all MSR team reviews include a social worker evaluation and comments regarding the patient evaluation. All patient names should be removed from MSR team reports when sent to another agency. The MSR team should not hesitate to make comments on facility standards while making these reviews. These comments can be shared with the HSQB certification team for in-depth review.

3. Finding: Medicaid recipients receiving HHA services are having difficulty obtaining medical supplies and equipment.

   Recommendation: DPHSS should inform all providers that medical supplies are covered under the plan and that they must be provided to Medicaid eligibles.

5 -EPSDT

I. OPERATIONAL DESCRIPTION

The EPSDT program in Guam has undergone innumerable changes. In September of 1976 there began a concerted effort to organize the EPSDT program and develop a system to meet the informing, screening, diagnosis and treatment requirements of EPSDT. Since 1976 there have been staff assigned to monitor the program as well as staff to perform outreach and followup. Staffing, however, has not remained stable over the period of time, which has caused a lack of continuity in the program.

In January 1978 the administration of the Medicaid program was placed under the Chief Public Health Officer of the Department of Public Health and Social Services. The Chief Public Health Officer has ultimate responsibility for the administration of Medicaid. A Medicaid Supervisor administers the day-to-day operations of Medicaid. The EPSDT coordinator, under the supervision of the Medicaid Supervisor, implements EPSDT requirements, prepares all statistical reports, and performs the outreach and follow-up portion of the program.

Currently EPSDT screening services are provided by three pediatricians who have agreed to provide these services on a rotating basis. Guam is exempted from the Federal free choice of provider provision and may limit provider resources in this manner. The Public Health Department may become a screening provider to serve the village of Inarajan, a relatively isolated area where most medical services are not available.

Diagnosis and treatment can be provided by any one of the screening providers or any authorized Medicaid provider.

A. Budget

There are an estimated 3,000-3,500 Medicaid eligible children on Guam. The Guam EPSDT Program screens about 14 to 20 children a month and 6 to 9 children are found to have referrable conditions. The expenditure for screening averages about $200 a month. There is no special EPSDT budget that is accounted for apart from other Medicaid funds. Providers bill for EPSDT services in the same way as for all other Medicaid services except that, for screening, they must attach a screening report.

B. Program Procedures

Informing - On intake, EPSDT services are described to the applicant, including when and where the service may be obtained. A request is documented, along with the recipient's choice of provider, and forwarded to the Medicaid Unit by the Intake Unit. If the recipient wishes the service, he is again informed by the Medicaid Unit with a letter containing the name of the physician with whom he may make an appointment.

This form letter is also used to inform all recipients once annually in writing as well as to remind families of re-screening.

Screening - After the recipient is informed, it is up to him to make a screening appointment. The EPSDT coordinator then waits 60 days from the date of eligibility for a screening card to be sent back by the screening provider. If a screening card is not received in 60 days, then a follow-up letter or phone call is made to ascertain the reason the screening did not take place, and the recipient is offered assistance in rescheduling.

Diagnosis and Treatment - Once a screening card is received in the Medicaid office, it is reviewed for completeness and for follow-up on diagnosis and treatment. If diagnosis and treatment are not needed, the screening card is marked with the re-screening date and filed for periodicity notification. If the card indicates that treatment is required, the EPSDT coordinator contacts the parent to see if an appointment has been made. The coordinator will record the appointment time and will follow-up with the parent two days after the scheduled appointment to see if the appointment was kept. This activity is all recorded on the back of the screening record. Diagnosis and treatment for vision and dental conditions are provided by the Public Health Department. Prior authorization is required for eye glasses and extensive dental work.

II. FINDINGS AND RECOMMENDATIONS

1. Inconsistent Informing Procedures

a. Finding: After interviewing the staff of three different intake units, it was found that none of the units were informing according to established procedure or documenting a screening request, but were instead telling applicants that the Medicaid Unit would contact them. This, however, was not happening; consequently applicants were not being fully informed.

Recommendation: The established procedure should be reviewed by social services and Medicaid to insure that the procedure meets Federal requirements. Training sessions should be held for all intake workers to inform them of the new procedures; follow-up sessions should be held to see if the procedure has been internalized. The procedure should also be incorporated into the procedure manual used by all intake workers.

b. Finding: The informing letter sent by Medicaid (Appendix B, Part 5, Attachment 5) must be rewritten. The letter describes EPSDT as a required rather than a voluntary service. The letter does not offer transportation services.

Recommendation: The letter must be rewritten using Federal informing requirements as a guide.

2. Continuity of Care

Finding: Recipients who request EPSDT services are assigned to a screening provider alphabetically, according to the first letter of their last name. There is no consideration given to the possibility that a recipient may have received care from a pediatrician other than the one to whom he is assigned, thus breaking continuity of care.

Recommendation: Attempts should be made to keep recipients with their previous provider.

6 - FAMILY PLANNING

I. OPERATIONAL DESCRIPTION

Federal funding is available at 90 percent matching for family planning services. However, Guam does not claim for such services at the 90 percent rate. Rather, all services including family planning are claimed at the 50 percent rate.

Provider reimbursement is basically the same for family planning services as for other services in Guam. Some Medicaid eligibles receive these services from their own physicians in the private sector while others are examined, counseled and treated by the Maternal and Child Health - Family Planning (MCH-FP) Unit. Those patients seen in MCH-FP who request a sterilization procedure are referred to physicians in the private sector for the actual sterilization procedure. Both private providers and the MCH-FP Unit bill the Medicaid Unit for services rendered to Medicaid eligibles using appropriate RVS codes.

II. FINDINGS AND RECOMMENDATIONS

Problem Area

Finding: Guam is not identifying and claiming for family planning services at 90 percent Federal financial participation (FFP) as permitted under Title XIX of the Social Security Act, Section 1903(a)(5).

Recommendation: Guam should identify and claim for family planning services at 90 percent FFP. Failure to identify all funds which could be claimed if Guam's $900,000 ceiling were lifted will make it difficult to determine whether or not Guam is actually in need of additional Federal Medicaid funding. Further discussion of this general claiming problem can be found in the section of this report on Financial Management.

7 -STERILIZATION

I. OPERATIONAL DESCRIPTION

On November 8, 1978, the Department of Health, Education and Welfare (DHEW) issued new regulations (42 CFR 441.250-441.259) effective March 8, 1979, governing Federal funding for sterilizations. Under these new regulations, States are required to adopt a federally designed informed consent form containing all the elements of informed consent. Although most other requirements for sterilization remained unaltered, three significant changes were made:

1) The waiting period was extended from 72 hours to 30 days.
2) Hysterectomies were prohibited as a sterilization procedure for family planning purposes.
3) It was mandated that recipients undergoing a sterilization procedure be orally informed of all information necessary to meet the "informed consent" requirements for that procedure.

DPHSS has developed a program for monitoring and controlling sterilizations in accordance with Federal requirements. Prior authorization is required for all sterilizations. In March, the Medicaid Unit changed the required waiting period from 72 hours to 30 days in accordance with Federal requirements. Claims for payment are theoretically not processed without both the prior authorization and informed consent forms attached.

In Guam, all Medicaid recipients who request a sterilization must first be counseled by the Maternal and Child Health - Family Planning (MCH-FP) unit. If the recipient wishes to pursue the sterilization, he or she must hand-carry a note to the Medicaid supervisor from the MCH-FP social worker or nurse requesting prior authorization. MCH-FP then makes a referral to the recipient's personal physician or, if the individual has no physician, to an acceptable physician in the private sector. Only tubal ligations and vasectomies are billed to Medicaid as family planning services. Hysterectomies are not reimbursable for family planning purposes either under Medicaid or under Guam's Title X program.

Although, the DPHSS procedures for monitoring sterilizations appear to be acceptable, the agency has had significant implementation problems. The MCH-FP Unit uses its own consent form for both Medicaid and non-Medicaid patients (Appendix B, Part 7, Attachment 1). However, the Medicaid Unit must meet Medicaid informed consent requirements, and during the assessment, it was discovered that the Medicaid Unit was using the incorrect informed consent form (Appendix B, Part 7, Attachment 2). It was also determined that the Medicaid Unit has no criteria for determining when a sterilization is done for family planning purposes and is therefore subject to 90 percent FFP. Finally, it was discovered that some claims are being processed without informed consent forms. The assessment team reviewed all obstetrical-gynecological claims for sterilizations submitted to and paid by Guam since October, 1977. The most common sterilization

procedure, tubal ligation, was identified by the Hawaii Relative Value Study codings 58700, 58600, and 58605, and in some instances by the wording "tubal ligation." (Only the primary physicians' claims were considered.) Amounts of payment were checked by multiplying Guam's reimbursement conversion factor (.7) times the Hawaii Relative Value. Nine claims were found with an unacceptable consent form with total payments of $2230. Seven were found minus any consent form with total payments of $1750. Since the grand total is $3980, the amount of $1990 Federal share has been overpaid and will have to be disallowed from Guam's quarterly claims for Federal financial participation.

II. FINDINGS AND RECOMMENDATIONS

A. Compliance Issues

1. Finding: DPHSS is not using the correct "informed consent" form.
   CFR Citation: 42 CFR 441.258
   Recommendation: DPHSS must immediately begin using the required "informed consent" form for all sterilizations.

2. Finding: DPHSS is claiming FFP for sterilizations in cases where a copy of the "informed consent" form is not submitted with the claim.
   CFR Citation: 42 CFR 441.256
   Recommendation: DPHSS must not claim FFP for sterilizations in cases where the required "informed consent" form is not attached to the claim for payment.

B. Problem Area

Finding: DPHSS has no criteria for determining when a sterilization has been performed for family planning purposes. Sterilizations for family planning purposes can be claimed at 90 percent FFP. Other sterilizations must be claimed at 50 percent.

Recommendation: DPHSS should develop criteria for determining when a sterilization is performed for family planning purposes. This should be done in connection with the recommendation that Guam begin claiming 90 percent FFP for all family planning services. Discussion of this recommendation can be found in the section of this report on Family Planning.

8 - ABORTION

I. OPERATIONAL DESCRIPTION

Before August 5, 1977, the Department of Health, Education and Welfare would provide Federal financial participation for all abortions. Federal matching of State expenditures was available at 90 percent FFP for abortions performed for family planning purposes and 50 percent FFP for all others.

On August 5, 1977, the so-called Hyde Amendment to the DHEW Appropriations Act for FY 77 became effective and prohibited FFP for all abortions except those which were considered necessary to save the life of the mother. However, on December 1, 1977, the DHEW Appropriations Act for FY 78 expanded the number of exceptions to the prohibition of expenditures for abortion to include:

1. those instances where severe and long lasting physical health damage would result if the fetus were carried to term, when determined by two physicians.

2. those instances where the person was a victim of rape or incest, when such an incident is promptly reported to a law enforcement or public health agency, as well as,

3. those instances where the life of the mother would be endangered if the fetus were carried to term (see 42 CFR 441.200-441.208).

Guam observes the funding limitations on abortions imposed by the Federal Government and satisfies the regulatory requirements in 42 CFR 441, subpart E. Although no abortions have been paid for by Guam Medicaid, the Medicaid supervisor established procedures to prevent payment for any abortion (billed as an abortion) that does not meet the Federal criteria (life endangering, severe and long-lasting damage, rape or incest) and documentation requirements. An educational session on abortions was held for Guam providers.

II. FINDINGS AND RECOMMENDATIONS

The only problem in the abortion area is the potential for an abortion to pass through the claims processing system disguised as another surgical procedure such as a D&C (dilation and curettage) or a hysterectomy. Guam Medicaid would not be alert to this because of the insufficient information generally provided on claims and the lack of any systematic means for detecting such procedures on either a prepayment or postpayment basis. This needs to be addressed broadly as recommended in the fraud and abuse segment of this report.

GOVERNMENT OF GUAM
AGANA, GUAM 96910

OCT 9 1979

Mr. Lawrence L. McDonough
Regional Medicaid Director
Department of Health, Education,
and Welfare
Health Care Financing Administration
Regional Office
100 Van Ness Avenue
San Francisco, CA 94102

Dear Mr. McDonough:

Enclosed is the department's comments to the Guam Medicaid Management Assessment. It is our hope that your department will continue in its assistance to our local Medicaid program in order to improve the overall management.

Sincerely yours,

FRANKLIN S. CRUZ, Ed.D.
Director of Public Health
and Social Services

Enclosure

OCT 15 3 55 PM '79
MEDICAID BUREAU
HCFA/IX

PART I - MANAGEMENT OVERVIEW

The Department agrees with the statements made in this section regarding the serious undermanagement of the program. Efforts to increase the staffing during the past three years have been curtailed due to the general state of the local economy. The Department was required to operate below a certain ceiling as imposed by the local Bureau of Budget, Management and Research.

In addition to the shortage of personnel, with the departure from the island of three key personnel who have knowledge in Medicaid, the department is forced to start from "scratch." Recruitment for the Medicaid program supervisor position has been frstrated by the lack of local expertise in the field.

The Department, with the concurrence and support of the Governor's office will be preparing and submitting a supplemental budget request to address the staffing problem. Furthermore, request for HCFA's assistance in establishing procedures within the various components of the program will be made.

The Department is extremely concerned about the issues raised. However, the Department must call on the assistance of HCFA, the Governor's office and the Legislature in order to make the necessary corrective actions indicated. The Department cannot operate alone in this matter.

A. GENERAL ADMINISTRATION AND MANAGEMENT

II. FINDINGS & RECOMMENDATIONS

A. Compliance Issues

1. Medicaid Advisory Committee

Finding: The Medicaid Advisory Committee is non-operative on Guam.

CFR citation: 42 cfr 431.22.

Recommendation: DPH&SS must ensure that the Medicaid Advisory Committee begins functioning as required in federal regulation.

DPH&SS Comments: The Social Services Advisory Committee members were sworn in by the Governor on June 22, 1979. This committee is charged with the responsibility of advising the principal policy setting and administrative officials of the Division on all programs including Medicaid.

The first meeting was on August 23, 1979. The committee meets monthly as specified in its bylaws. (Appendix attachment 1 & 2)

2. Training

Finding: DPH&SS has no program of training for Medicaid staff.

Medicaid staff is seriously undertrained.

CFR citation: 42 cfr 432.30.

Recommendation: DPH&SS must develop and implement a training program for Medicaid personnel as required in federal regulation.

DPH&SS Comments: The Department agrees with this finding. Due to budgetary constraints,

training activities are at a minimum, other than intra-Divisional training.

In October 1979, the Division will recruit for a Social Service Supervisor III, who will function as the the Staff Development Officer for the Division. A Divisional staff development plan, to include Medicaid, will developed three months after recruitment. However, due to budgetary constraints and lack of local expertise in Medicaid matters, technical assistance from the Regional Office will be requested at a later time. A request listing training needs will be mailed by November 1, 1978.

B. Problem Areas

1. Office Conditions

a. Air Conditioning

Finding: The air conditioning system in the DPH&SS building is inadequate, causing working conditions which are detrimental to efficient and effective program operation and creating situations which result in breaches of confidentiality.

Recommendation: The Government of Guam should allocate sufficient funds to fully repair or replace the air conditioning system in the DPH&SS building. The consensus of the assessment team is that the working conditions system is serious enough to warrant the recommended expenditure.

DPH&SS Comments: Air conditioning problem has been resolved. On August 6, 1979, temporary equipment was installed pending the installation of the permanent equipment in November 1979.

b. Public Accessibility of Working Areas

Finding: There are virtually no limits on where the public can go within the

DPH&SS building. This impinges on the staff's ability to complete their work efficiently and creates a potential f or breaches a confidentiality.

Recommendation: (1) intake or other applicant/recipient contact should occur on the first floor or in areas directly accessible from outside the building.

DPH&SS Comments: The programs of the Department of Public Health and Social Services are all involved in the provision of services, therefore, it is not possible to house everyone one the first floor of a two-story structure. The Northern area and Southern area centers are housed in one story structures.

(2) public and non-public areas within the building should be designated and monitored informally.

DPH&SS Comments: The Division of Social Services have clearly designated public area Vs non-public areas. All visitors to the division report to a reception area where clients are screened and referred to the appropriate program.

During the assessment this was not being followed since the staff were located in temporary work areas due to the air conditioning problem.

c. Working Space

Finding: The working area allocated to the Medicaid Unit is inadequate.

Recommendation: Additional office space should be allocated in the Medicaid Unit.

Serious consideration should be given to moving the entire unit to space now available in the old Guam Memorial Hospital.

DPH&SS Comments: An alternate work space has been made available to the unit as of August 6, 1979. There is adequate space for all the present employees.

However, when additional staff is authorized by the Legislature, additional workspace will be needed. The GMH Administrator will request the GMH board to allow the program to utilize the recently vacated areas. Furthermore, the Department will explore the possibility of acquiring underused government owned building to house the staff.

d. Record Storage Space

Finding: The Medicaid Unit has insufficient file cabinet space for record storage.

Recommendation: Additional office space for record and at least one additional full size file cabinet should be allocated to the Medicaid Unit.

DPH&SS Comments: The present work space, as of August 6, 1979, has adequate room for storage. The lack of file cabinets will continue to be a problem until January 1980. File cabinets on order will require 90 days for delivery.

2. Management

a. Resources Devoted to Management

Finding: The Guam Title XIX program is understaffed and therefore under-managed. Approximately two percent of Guam's Medicaid expenditures are spent on administration and management. The national average percentage of Medicaid funds spent on administrative and management is approximately eight percent.

Recommendation: A considerable amount of additional staff should be allocated to the Medicaid Unit. In addition, new information and claims processing

systems are essential to improve administration. The cost of administration and management should equal at least five to six percent of total Medicaid costs in order to correct the serious problem of undermanagement of the Guam Medicaid program.

DPH&SS Comments: The department strongly agrees that the program is undermanaged. Efforts to increase staffing has been disapproved by the local budget office and the Legislature due to financial constraints. The present $900,000 federally funded ceiling has affected the local legislative decision in the amount of local dollars appropriated for the program.

The Department, with the approval of the Governor's office will prepare a supplemental budget request for additional staff and other administrative needs for the three components of the program by November 1, 1979.

The department agrees on the need for new information and claims processing systems. Due to the present federal ceiling the Department must resort to outside sources. A request for assistance in the identification, acquisition and adaptation of an appropriate Automatic Data Processing System for the Guam Medicaid Program has been made to HCFA, Region IX. (Appendix, Attachment 3).

b. Correspondence Receipt and Distribution

Finding:	There is no effective system for tracking and routing correspondence. Special delivery mail is sometimes not claimed; Action Transmittals and other federal correspondence are not always routed to the Medicaid Unit; and information in general does not flow smoothly down the chain of command.
Recommendation:	The State agency should take steps to improve its mail pick-up and delivery system.
DPH&SS Comment:	As of June 1979, new procedures were developed and implemented in the receipt and distribution of correspondence. Furthermore, key staff positions are presently filled thus assuring that the mail is picked up daily and that screening and distribution is done promptly.

1 - ELIGIBILITY

I. OPERATIONAL DESCRIPTION

Staffing:

DPH&SS Comments: The Assistance Payment Service reorganized its caseload assignment as of July 1979. Assistance Payment Service workers in each center are responsible for eligibility determination for all programs including Medicaid. The average caseload per worker is about 300 cases each.

Training: Assistance Payment Service is continuously conducting in-house staff training sessions. The next session is scheduled the second week of October to reemphasize the Medicaid Management Assessment and other recent changes of the other Public Assistance Programs.

Public Information: In addition to being permitted to spend half a day each week making home visits, workers do make visits to the senior citizen's center and weekly visits to the local hospital.

New Applications & Redetermination: The backlog of Medicaid cases has been resolved by the recent change in caseload assignment. As mentioned earlier, workers are now responsible in making eligibility determination of all programs and conducting redetermination likewise.

Issuance and Control of Medicaid Cards: Assistance Payment Service staff will be informed of the issuance and control of medicaid cards through the training session scheduled October 1979. Ineligible recipients will be advised in their "Notice of Action" letter that the effective date of their case termination invalidates further use of the medicaid card. Ineligible recipients will be required to surrender their cards to the Department.

Hearings & Appeals: When an applicant or recipient has a complaint, the first attempt is to discuss the matter with the Assistance Payment Service worker. If complaint is not resolved, the matter may be brought to the attention of the Assistance Payment Service Supervisor. If this attempt fails, the complainant will be required to file a petition for a fair hearing. In this case, Assistance Payment Service must assist the individual in filling out the request and preparing for the hearing. The administrator of the Division of Social Services is the fair hearing officer.

Retroactive Coverage: This issue has been resolved through a training session held in May 1979 following the medicaid assessment in April 1979. Assistance Payment Service workers are adhering to the appropriate procedure for retroactive coverage.

All three branches are aware and should resolve the inconsistent and incorrect applicability of this coverage.

AFDC-Four Months Continued Coverage: This area has been addressed in the training session of May 1979 and will be re-emphasized on the next training session the second week of October 1979.

Medicaid cards will be issued not to exceed the four month coverage. Assistance Payment Service is currently reviewing a code to be used on the monthly IBM printout to identify this type of class. The code will be printed on the IBM printout by January 1, 1979.

Third Party Liability: The application form on page 3 will be revised to include a section where public assistance applicants can indicate if they currently have health coverage. Revision of the form will be made when the present supply runs out.

In the meantime, Assistance Payment Service workers will be trained to ensure that applicants provide this information.

II. FINDINGS AND RECOMMENDATIONS

B. Compliance Issues

1. Individuals under 21 Not in School or Training

Findings: Guam is not providing Medicaid to individuals under age 21 who do not meet AFDC age or school attendance requirements, in accordance with its Title XIX State Plan.

CFR Citation: 42 CFR 436.116 & 42 CFR 436.310

Medicaid must be provided to both categorically and medically needy individuals under age 21 who are ineligible for AFDC because of age or school attendance requirements.

Recommendation: DPHSS must amend its eligibility determination process to ensure that these groups are covered.

DPH&SS Comments: The Department agrees to the finding. Eligibility determination has been amended to ensure that these individuals are covered.

The Assistance Payment Service staff have been advised of this mandatory group coverage through a training session in May 1979, a week following the medical assessment. The next training session scheduled the second week of October 1979 will re-emphasize this area.

This policy is currently in effect on all new applications being received and will be applied on ongoing cases during redetermination interviews.

2. Who May Apply

Finding: In the case of married couples living together, the Mangilao and Dededo offices are requiring the husband to complete the application form. Only Inarajan is the wife permitted to complete the application form.

CFR Citation: 45 CFR 206.10(a)(1)

Each individual wishing to do so shall have the opportunity to apply for Medicaid without delay.

Recommendation: DPHSS must permit anyone who wishes to apply for Medicaid to complete the application form.

DPH&SS Comments: The Department agrees to the finding. On November 1, 1979, a memorandum will be issued to all Assistance Service staff to implement this requirement beginning on applications receive November 1, 1979.

3. Three-Month Retroactive Coverage

Finding: DPHSS is automatically providing three-month retroactive coverage to all persons determined eligible in a current month, without regard to eligibility information for retroactive months. DPHSS permits retroactive coverage for only 90 days prior to the date of application, although eligibility determination in Guam's various cash grant programs are made on a full-month basis.

CFR Citation: 45 CFR 206.10(a)(6)(ii)

Medical assistance must be made available no later than the third month prior to the month of application if the individual would have been eligible on the date he or she received medical services.

Recommendations: a) DPHSS must determine whether or not an individual was actually eligible for retroactive coverage during the three retroactive months, including computation of any spenddown requirements.

b) The public assistance manual should specify that coverage is available for three months rather than 90 days.

c) Since Guam's cash grant programs are based on full-month eligibility, Medicaid eligibility must also be provided on a full-month basis. Thus, retroactive coverage must be made available to applicants for three full months prior to the month of application.

DPH&SS Comments: The Department agrees to the finding. This issue was addressed in a training session in May 1979 and will be re-emphasized during the next training session this month (October).

4. Resource Limitations Based on Family Size

Finding: Guam has set resource limits of $1,000 in personal property and $3,000 in real property, regardless of family size.

CFR Citation: 42 CFR 436.840

The standards for liquid assets must increase by family size.

Recommendation: DPHSS must establish resource standards which increase by family size and are at least equal to the eligibility under one of the Federal cash grant programs.

DPH&SS Comments: The Department is presently developing the standard for medicaid but we are required to meet the local adjudication act and clearinghouse procedures.

The activity regarding the proposed standard will begin in November. We hope the new standard will be effective March 1980.

5. Income Standard for the Institutionalized

Finding: Guam applies the same income standard for an institutionalized individual as applied for an individual living at home.

CFR Citation: 42 CFR 436.813

The agency must use a lower income standard for institutionalized persons than for persons at home. The lower standard must be reasonable in amount of clothing and personal needs.

Recommendation: Guam must apply a lower income standard for an institutionalized individual in determining eligibility and spenddown. For States with SSI, this income standard, or personal needs allowance must be at least $25. However, since Guam has no SSI program, the amount of the institutionalized income standard must simply be reasonable in amount for clothing and personal needs. Within Guam's OAA, AB and APTD programs, a precedent for such an allowance has already been set. Eligibles in these programs are permitted to retain $15 for personal needs when they are in foster care. Income in excess of the $15 is applied toward the cost of foster care. Therefore, Guam may also wish to use the $15 figure as the income standard for institutionalized Medicaid eligibles, since the purposes of this income standard and the foster care allowance are quite similar.

DPH&SS Comments: Policies will be developed and the requirement of the local adjudication act must be met. We hope the developed policies will be in effect March 1980.

6. Application of Non-Covered Care Toward Spenddown

Finding: DPHSS does not permit the cost of non-Medicaid-covered services to apply toward meeting a spenddown requirements.

CFR Citation: 42 CFR 436.831(c)(1)(ii)

In determining income eligibility DPHSS must deduct from income expenses incurred for necessary medical and remedial services that are recognized under Guam law but not included in the Medicaid State Plan.

Recommendation: DPHSS must permit the cost of medical services no reimbursable under Medicaid to apply toward meeting the spenddown. DPHSS may set reasonable limits on the amounts of such medical expenses (see 42 CFR 436.831(b)(2)).

DPH&SS Comments: A survey will be designed and conducted by June 1, 1980. From this survey, reasonable limits on the amount of such medical expenses will be set. The same process will be followed to meet the Government of Guam administrative procedures.

7. $10 Cutoff on Spenddown Requirement

Finding: DPHSS is not requiring individuals with a spenddown of $10 or less to meet that spenddown.

CFR Citation: 42 CFR 436.831(d)

After incurred medical expenses are deducted from income, countable income must be equal to or less than the income standard. There is no provision in Federal regulation for allowing individuals to retain even nominal amounts of money above the income standard.

Recommendation: DPHSS must require all persons with a spenddown to meet the full spenddown. It would be acceptable to round down to the next lowest dollar figure in determining the spenddown amount.

DPH&SS Comment: We agree to the finding. This problem will be addressed in the scheduled staff training sessions as previously mentioned. All applications received and approved beginning January 1980 with spenddown of $10 or less will be required to meet that spenddown.

C. Problem Areas

1. Staffing Levels and Caseload Standards

Finding: Staffing levels in the APU are totally inadequate to handle the present caseload. Caseload levels are running between 300 and 400 cases per worker. This level makes it virtually impossible to ensure consistently accurate eligibility determinations.

Recommendation: Increase the number of eligibility staff to reasonable levels. More detailed discussion of staffing problems and recommended solutions can be found in the Administration and Management section.

DPH&SS Comment: We are aware of the lack of personnel to effectively and efficiently handle the present caseload level of 300 and 400 cases per worker. The need for additional staff will be addressed in a supplemental request to be transmitted by November 1979.

2. Third Party Data Collection

Finding: Procedures for collecting third party liability information during the application process are inadequate. Medical Assistance Only applicants are required to provide such information but cash grant applicants, who comprise most of the Medicaid population, are not required to do so.

Recommendation: a) All cash grant and Medicaid applicants should be required to provide third party liability information upon application.

b) More detailed information should be key-punched on the eligibility listing to further assist the Medicaid Unit in its collection efforts.
c) Both the AFDC-related card and the ABD-related card should provide space for showing all types of third party information, and this information should be typed on the card by the APU prior to issuance.

DPH&SS Comment: The agency disagrees on the finding. All cash grant and medicaid applicants are required to provide third party liability information upon application except that the present application form does not contain a section to indicate this. Revision of the application will be made to ensure that this information is pursued.

Additionally, current information key punched on the eligibility listing is sufficient to assist the Medicaid Unit in its collection efforts.

3. Medicaid Eligibility Worksheet

Finding: The computation form now used for Medicaid eligibility determinations is inadequate. The material printed on the form does not carry the worker through the eligibility computation, which can result in inconsistent and inaccurate determinations. In fact, the computation is actually done on the back, blank side of the form.

Recommendation: The APU should develop a computation worksheet which takes the worker through each step of the eligibility computation process. The Food Stamp form used on Guam may serve as a model. In addition, the Regional Office can supply DPHSS with examples of worksheets used in other states.

DPH&SS Comment: The agency agrees on the finding. Corrective action plan includes:

1) Reviewing the Food Stamp form as recommended.

2) Developing a computation worksheet in the interim.

3) Request that regional office supply DPH&SS with examples of worksheets used in other states upon receipt of report.

4) Use of computation worksheet will be implemented by March 1980.

4. Inconsistent Application of Elgibility Factors

Finding: Eligibility factors are being applied inconsistently from office on Guam. Inconsistencies regarding three-month retroactive coverage, four-month continuing coverage, and who may complete the application form have already been identified in this report.

Recommendation: The APU should intensify its efforts to provide training to APWs in all offices so that every worker understands the eligibility determination process. Only through a stepped-up training and communication program can the problem of inconsistency between offices be eliminated.

DPH&SS Comment: APS staff are aware of the eligibility factors through a training session in May 1979. The next training session will re-emphasize the eligibility determination process.

Recent training session of all three APS centers have eliminated inconsistent and incorrect applicability of policies

5. Reporting Changes in Circumstances

Finding: 42 CFR 206.10(a)(2)(ii) requires that the State Plan adopt procedures to assure that Medicaid eligibles

report changes in circumstances which may affect eligibility on a timely basis. Applicants are informed of this requirement to report any changes in circumstances only on the Notice of Action form. The requirement is not discussed with the applicant and, although one reminder was sent out in the past, there is no regular procedure for ensuring that eligibles are kept fully aware of this reporting responsibility. This is of particular concern on Guam because, according to Guam quality control staff, non-reporting of real property and non-reporting of income account for major portion of eligibility errors.

DPH&SS Comment: The Department agrees on the finding. Recent training sessions stressed the importance of emphasizing reporting requirements during intake interviews with applicants and recipients.

In addition, flyers will be sent out quarterly as a reminder of reporting responsibilities. The first flyer was sent out with the October 1st Public Assistance checks.

The present supply of medicaid cards is expected to last to the end of the year. By January 1980, new order of medicaid cards will contain a printed statement for reporting change.

6. Quality Control Cooperation Requirements

Finding: Applicants are not being informed during the intake interview of their responsibility to cooperate with quality control reviewers if their case is selected as part of a quality control sample.

Recommendation: DPHSS staff should begin informing applicants during the intake interview of their responsibility to cooperate with quality control reviewers.

DPH&SS Comment: Recent staff training sessions have addressed this problem and will be re-emphasized in the October training session as scheduled. We will be revising our "Notice of Action" letter to include the section of quality control requirement.

7. Spenddown Procedures

Finding: The spenddown procedure used on Guam is totally inadequate.

a) There is no good system for tracking whether or when the spenddown was met.

b) Spenddown eligibles must obtain prior authorization for every service whereas categorically needy eligibles and other medically needy eligibles need prior authorization only for services subject to prior authorization under Guam's Title XIX State Plan. The practice, which may result in differences in the amount, duration and scope of medically needy eligibles, is in conflict with 42 CFR 440.240(b).

Recommendation: A new spenddown procedure should be developed which will tract when spenddown requirements are met, and will eliminate any differences in amount, duration and scope between spenddown and non-spenddown medically needy eligibles.

DPH&SS Comment: The current procedure being utilized by the Medicaid unit seems appropriate.

APS and Medicaid Unit are jointly reviewing other procedures for efficient trackdown when spenddown requirements are met. Procedures should be developed by June 1980.

2 - PROVIDER ENROLLMENT

II. FINDINGS AND RECOMMENDATIONS

Finding:	There is general lack of written procedures to carry out a more comprehensive program of provider enrollment. This lack of procedures servces to prevent the education and involvement of providers in the program and stymies the growth of the program.
Recommendation:	Guam should hire more staff in order to reduce the Medicaid Supervisor's workload. This would allow her to become more involved in developing policy manuals that would improve provider enrollment and relations.
DPH&SS Comments:	The Department agrees with these findings. The Department is presently preparing a supplemental budget request to cover additional positions for the Medicaid Program. The additional request will be transmitted to the Legislature by November 1, 1979. Written procedures to cover provider recruitment, education and orientation will be prepared and implemented by January 1, 1980.

3 - UTILIZATION CONTROL

II. FINDINGS AND RECOMMENDATIONS

Compliance Issue

Findings: The Guam Title XIX Program does not have in effect an acceptable utilization control program. Guam is therefore out of compliance with all Federal regulations regarding the responsibility of the Single State agency to monitor and control utilization of services.

(1) There was no written criteria for administering the prior authorization program, and in fact, the staff is not even aware of the rationale for requiring prior utilization.

(2) There is no screening or monitoring of care being received by long term care patients, except for the medical review function. Furthermore, no one on the Medicaid staff understands the purposes and functions associated with the medical review function.

(3) The Single State agency is not monitoring the hospital utilization review committee as is required under Federal regulation and is instead duplicating much of the UR committee's activities through its chart reviews.

(4) Guam has no overall policy, plan, or procedures for controlling utilization of services by Medicaid eligibles.

CFR Citation: 42 CFR 456, Subparts A and B

DPH&SS must develop a utilization control system which will meet the requirements in the above citation. Failure to come into compliance could result in a substantial reduction in Federal financial participation.

DPH&SS Comments: The Department agrees with these findings. A request to HCFA for technical assistance for the development of utilization control system will be made by November 1, 1979.

4 - LONG TERM CARE

II. FINDINGS AND RECOMMENDATIONS

1. Findings: There is a lack of communication about certification status between DPHSS and HCFA/HSQB.

   Recommendation: DPHSS and HSQB should develop a procedure to exchange information regarding their activities in Long Term Care, e.g., certification reports, MSR team reports and providers agreements; and a procedure should be established to make available to the public information regarding certification and number of beds.

   DPH&SS Comments: Procedures will be developed to foster communication between the Department and HSQB regarding Long Term Care activities.

   Furthermore, program procedures will include a component for documentation of information to provider and the public regarding certification and number of beds by January 1, 1980.

2. Finding: The MSR team reports do not include a social work evaluation of the patients' needs. Also, MSR team reports should not include patient names when they are being forwarded to HEW.

   Recommendation: DPHSS should ensure that all MSR team reviews include a social worker evaluation and comments regarding the patient evaluation. All patient names should be removed from MSR team reports when sent to another agency. The MSR team should not hesitate to make comments on facility standards while making these reviews. These comments can be shared with the HSQB certification team for in-depth review.

   DPH&SS Comments: Written procedures for the Medical-Social Review process will be developed by September 1, 1980.

3. Finding: Medicaid recipients receiving HHA services are having difficulty obtaining medical supplies and equipment.

Recommendation: DPHSS should inform all providers that medical supplies are covered under the plan and that they must be provided to Medicaid eligibles.

DPH&SS Comments: A letter will be sent to all providers informing them that medical supplies are covered under the plan by October 8, 1979.

Furthermore, this matter will be covered in procedure section regarding plan coverage and provider activity.

II. FINDINGS AND RECOMMENDATIONS

1. Inconsistent Informing Procedures

a. Finding: After interviewing the staff of three different intake units, it was found that none of the units were informing according to established procedure or documenting a screening request, but were instead telling applicants that the Medicaid Unit would contact them. This, however, was not happening; consequently, applicants were not being fully informed.

Recommendation: The established procedure should be reviewed by social services and Medicaid to insure that the procedure meets Federal requirements. Training sessions should be held for all intake workers to inform them of the new procedures; follow-up sessions should be held to see if the procedure has been internalized. The procedure should also be incorporated into the procedure manual used by all intake workers.

DPH&SS Comments: A review of the existing EPSDT procedure will be made and appropriate revisions will be initiated as warranted. Furthermore, this matter will be included in the training sessions for the assistance payment unit. Completion date: January 1, 1980.

b. Finding: The informing letter sent by Medicaid (Appendix B, Part 5, Attachment 5) must be rewritten. The letter describes EPSDT as a required rather than a voluntary service. The letter does not offer transportation services.

Recommendation: The letter must be rewritten using Federal informing requirements as a guide.

DPH&SS Comments: The informing letter sent by Medicaid regarding EPSDT will be rewritten to include the description that the program is voluntary. Completion date: October 31, 1979.

2. Continuity of Care

Finding: Recipients who request EPSDT services are assigned to a screeing provider alphabetically, according to the first letter of their last name. There is no consideration given to the possibility that a recipient may have received care from a pediatrician other than the one to whom he is assigned, thus breaking continuity of care.

Recommendation: Attempts should be made to keep recipients with their previous provider.

DPH&SS Comment: The procedure to assign clients alphabetically to screening providers has been modified as of September in order to preserve continuity of care.

At the time of enrollment in the EPSDT Program, caretakers are asked whether the child/ren have a regular physician. All efforts are made to assure that continuity is preserved.

6 - FAMILY PLANNING

II. FINDINGS AND RECOMMENDATIONS

Problem Area

Finding:	Guam is not identifying and claiming for family planning services at 90 percent Federal financial participation (FFP) as permitted under Title XIX of the Social Security Act, Section 1903(a)(5).
Recommendation:	Guam should identify and claim for family planning services at 90 per cent FFP. Failure to identify all funds which could be claimed if Guam's $900,000 ceiling were lifted will make it difficult to determine whether or not Guam is actually in need of additional Federal Medicaid funding. Further discussion of this general claiming problem can be found in the section of this report on Financial Management.
DPH&SS Comments:	The Department has informed the financial management system of the correct FFP rate for family planning activities. A system to readily identify these expenditures will be developed by July 1, 1980.

II. FINDINGS AND RECOMMENDATIONS

A. Compliance Issues

1. Finding: DPH&SS is not using the correct "informed consent" form.

CFR Citation: 42 CFR 441.258.

Recommendation: DPH&SS must immediately begin using the required "informed consent" form for all sterilizations.

DPH&SS Comments: The Department agrees. The department has begun using the required "informed consent" form as of May 1979. (Appendix, Attachment 4).

2. Finding: DPH&SS is claiming FFP for sterilizations in cases where a copy of the "informed consent" form is not submitted with the claim.

CFR Citation: 42 CFR 441.256.

Recommendation: DPH&SS must not claim FFP for sterilizations in cases where the required "informed consent" form is not attached to the claim for payment.

DPH&SS Comments: Department will not claim FFP for sterilization where the required "informed consent" form is not attached to the claim for payment.

This procedure will be included in the proposed program manual. The bill processors have been informed. The provider will also be informed by letter October 31, 1979.

B. Problem Area

Finding: DPH&SS has no criteria for determining when a sterilization has been performed for family planning purposes. Sterilizations for family planning purposes can be claimed at 90 percent FFP. Other sterilizations

must be claimed at 50 percent.

Recommendation: DPH&SS should develop criteria for determining when a sterilization is performed for family planning purposes. This should be done in connection with the recommendation that Guam begin claiming 90 percent FFP for all family planning services. Discussion of this recommendation can be found in the section of this report on Family Planning.

DPH&SS Comment: A criteria for determining when a sterilization is performed for family planning purposes will be developed by June 1, 1980.

8 - ABORTION

II. FINDINGS AND RECOMMENDATIONS

This concern will be addressed in the Utilization Control and Fraud and Abuse procedure.

1 - CLAIMS PROCESSING

II. FINDINGS AND RECOMMENDATIONS

1. Finding: The Agency's eligibility file consists of a monthly printout of those persons who receive an AFDC, OAA, AB or APTD payment. Only basic case information is available on this printout, such as case number, name, address, grant amount and supposedly a code to indicate third party liability The Agency does request third party liability information, but less than 10 percent of those listed on the printout has such a code. The codes obviously do not include all those with potential third party resources. Also, neither retroactive nor continuing eligibility is indicated.

Recommendation: The public assistance eligibility process should be changed to require third party resource information and to train eligibility workers to peruse that information. The office that produces the eligibility printout should be requested to re-program to produce retroactive and continuing eligibility data. The printout should be redesigned to make it easier to use by Medicaid processing. It should also include more information on client characteristics.

DPH&SS Comment: TPL information is presently being obtained by the eligibility workers. Procedure to address retroactive and continuing eligibility data will be developed and implemented by January 1, 1980. Until such time that the Assistance Payment implement a comprehensive ADP system collection of client characteristics is impossible.

2. Finding: There are only 66 providers of medical services on Guam. They include thirty physicians, six dentists, one hospital, two eye specialists, eight opticians, nine pharmacies, three laboratories, three medical suppliers and four PHSS offices.

It would seem easy to keep track of provider participation and limitations of these providers. However, during the assessment, no written information was available. The "claim processing" person is expected to know who is a certified provider and what services they can perform.

Recommendation: Written guidelines should be developed to indicate which services a provider can perform. An effort should be made to verify that providers are properly licensed to perform those services.

DPH&SS Comment: The Department agrees. Written guidelines regarding provider recruitment and screening will be developed to include information regarding licensures and authorized services to be provided.

These procedures will be included in the manual under provider recruitment and orientation.

3. Finding: Actual processing of Medicaid claims by the Agency has many perplexities. A count of claims volume could not be determined; however, at least $600,000 worth of unpaid cliams were found on one desk in the Medicaid Unit. The entire Medicaid expenditures in FY 78 were only $2.4 million, which meant that one fourth of the total volume was waiting to be processed. A spot check indicated that some claims were over eight months old. In addition to this problem manual verification, pricing and edit procedures were less than desirable. The Hawaii Relative Value Scale (HRVS) tables are used to determine the allowable charges for a service. A complicated mathematical weighting procedure is manually used for all procedure codes. Even though most of the allowable charges are memorized by the individual reviewing the claims, it may take up to two hours to review one claim if there are 30 to 40 procedures, such as those on hospital claim. The duplicate payment checking procedure is totally indadequate. At the time of the review, a CETA employee

was responsible for checking duplicate payments which involved a visual observation of the provider's file for three or four prior months.

Recommendation: The obvious recommendation would be to automate the claims processing system which is discussed in the Management Overview section. Short of automation, the claims processing activities should be streamlined. A brief in-house study could determine the most efficient and effective method to process claims. The study would probably indicate a need for two or three additional staff.

DPH&SS Comment: The Department has requested HCFA assistance in the identification, acquisition and implementation of an appropriate ADP system for Guam's medicaid program. A written response has not been received from the Regional Office.

The Department is presently recruiting for the position of Computer System Analyst III under the Assistance Payment Section. This person will be available to federal representatives who will be providing technical assistance to the Department regarding an ADP system for Medicaid. It is hoped that the availability of such person in the Department will facilitate the adaptation and implementation of the acquired system.

4. Finding: Statistical profiles of utilization patterns were non-existent. The agency does not at any given time know how much was paid to whom for what service.

Recommendation: Although it may prove difficult, the Agency should try to keep profiles on its providers. An additional staff person should probably be hired to manually prepare the profiles, but national data on providers indicate that this is an area to discover overpayment and potential fraud and abuse.

DPH&SS Comment: The Department agrees. From June to September 1979, a CETA employee was assigned the task of collecting data regarding utilization patterns. Unfortunately, he was terminated from the CETA program. In the event a replacement occurs, the activity will resumed.

5. Finding: Management and administration reporting is almost non-existent. The few reports that are produced do not provide management data necessary to properly manage the program. The agency is technically out of compliance in that it cannot produce required Federal statistical reports.

Recommendation: It is virtually impossible to meet some of the Federal reporting requirements without an automated system. Until such a system is implemented, management should determine what data it needs to manage the program and provide the means to the Medicaid Unit to provide that information.

DPH&SS Comment: The Department agrees. The Department will determine what data it needs to manage the program and devise ways of acquiring the data.

January 1, 1980.

2 - THIRD PARTY LIABILITY (TPL)

II. FINDINGS AND RECOMMENDATIONS

1. Finding: Data gathering activities during the application process are discussed in the eligibility section of the report; however, it should be noted again here that third party information is not being collected systematically from all applicants. Data that is being collected is inadequate and incomplete.

   Recommendation: Eligibility workers should be instructed to pursue all avenues of potential third party resources. The agency should change its eligibility report to allow for additional reporting and updating of new information.

   DPH&SS Comment: The Department agrees. Instructions were given to the eligibility workers to pursue information gathering regarding TPL during staff meeting in May 1979. This matter will be addressed in the eligibility manual by March 1, 1980.

   The Department will revise the application form by January 1, 1980, or when the present supply runs out.

2. Finding: Inadequate third party information is available to the Medicaid Unit. The only information provided is a one digit code on the eligibility report.

   Recommendation: The agency should provide a complete eligibility file to the Medicaid Unit. In addition, the agency should see that the unit receives a current and accurate list of individuals on buy-in.

   DPH&SS Comment: The Department is presently providing eligibility information to Medicaid via the computer printout. There are existing procedure to cover buy-in activities.

3. Finding: The present provider claim forms do not provide space for third party information.

Recommendation: The agency should redesign its claim forms to include third party information and require all providers to seek that information from beneficiaries.

DPH&SS Comment: The Department will redesign its billing form to include TPL information by June 1, 1980. Request will be made to other state programs requesting samples of their billing forms. November 1, 1980.

All providers will be informed of the necessity to seek Third Party Liability information and to make appropriate changes by November 1, 1979.

Furthermore, this matter will be addressed in the provider enrollment information January 1, 1980.

4. Finding: No apparent effort is being made by the Medicaid Unit to verify third party liability.

Recommendation: The claims processor should be provided written instructions on what types of claims may have third party liability, e.g., auto accidents, worker's compensation, etc.

DPH&SS Comment: Procedures regarding the TPL will be developed by, March 1, 1980, to include written instructions or what type of claims may have TPL.

5. Finding: Separate third party files are not maintained in the Assistance Payment Unit or the Medicaid Unit. Therefore, no check can be made against them.

Recommendation: A third party file should be established at the time the application is taken or a redetermination is made. The file should then be updated periodically as appropriate. This file should be provided to the Medicaid Unit at least on a monthly basis.

DPH&SS Comment: The Department disagrees. It does not see the necessity of developing a

separate file. The Medicaid and Quality Control Sections can obtain information regarding third party liability from the computer listings.

6. Finding: The agency does not have a system of third party edits built into its claim processing review.

Recommendation: Every claim should pass some type of third party edit. Edit procedures should be developed and provided to the claim processor.

DPH&SS Comment: Edit procedures will be included in the TPL plan to be completed by March 1, 1980.

7. Finding: Currently the Medicaid Supervisor is personally responsible for third party recovery along with all other duties. She does not have the time or staff to adequately pursue third party recovery.

Recommendation: It is critical that the third party function not be slighted as it is now. The agency should assign someone on a part time basis to be responsible for third party recovery. The agency should also request technical assistance and begin immediately to implement TPL Plan. The plan should not only look a future claims, but at all potential TPL claims for the past three years.

DPH&SS Comment: The Department agrees with the need to assign someone to perform TPL function. However, it is unable to do so due to staffing shortage.

Furthermore, there is a lack of expertise on-island regarding this matter. The Department will request for technical assistance for the development of a TPL Plan and for training of the medicaid, eligibility and Quality Control staff. Letter of request will be made by November 1, 1979.

3 - FINANCIAL MANAGEMENT AND REIMBURSEMENT

A memorandum was sent to the Department of Administration requesting their comments for this section (Appendix, Attachment 6). At the time of this writting, the Department has not received a reply. The following are DPH&SS comments.

II. FINDINGS AND RECOMMENDATIONS

1. Finding: Most financial management activities of all agencies in Guam are the responsibility of Office of the Administration(OA). Within this office is the Division of Accounts which has several units including "General Accounting" which is responsible for Federal reporting. One person in that unit is responsible for all Federal reporting of Medicaid (Title XIX), Family Assistance (Titles IV-A and XVI), Social Services (Title XX) and Food Stamps. This person is expected to provide accounting service to all of these programs.

Recommendation: It is physically impossible for one person to adequately cover all the programs noted above. Guam is small, but it has the same Federal requirements and receives as many instructional materials as any large states. DPHSS should have an accountant on its staff in addition to the OA accountant to monitor its Federal grants. Thousands of Federal dollars are lost each year because of inadequate claiming, e.g., no 75% FFP has been claimed since March of 1976. At least $5,000 in additional FFP could have been claimed in FY 76 for Medicaid administration. over $8,000 could have been claimed in FY 77. This does not include losses of 90% FFP for Family Planning. Guam did not reach its $900,000 ceiling during either of these years.

DPH&SS Comment: The Department agrees that one person should not be required to prepare all the Federal reports for the Division of Social Services. The Department is extremely concerned about the failure to claim the proper amounts of Federal match.

2. Finding:

Guam is not meeting its Federal financial reporting requirements. The State is required to submit complete HCFA-64's and HCFA-65's quarterly. The State is only submitting summary reports which show total expenditures. Technically, the State is out of compliance and could have its grant awards withheld.

Recommendation:

As noted in the Claims Processing section of this report, it is physically impossible to generate the required financial reports without an automated claims processing system. Guam should request a waiver on the reporting requirements until it automates its system. Federal law requires appropriate documentation and accounting of federal funds. Therefore, if a waiver were granted, it would be for a limited period of time which means that Guam must give top priority to meeting these requirements.

DPH&SS Comment:

The Department will discuss request of waiver with Department of Administration. Request for waiver will be sent by December 1, 1979.

3. Finding:

Reimbursement findings are located throughout this report, specifically in the Drug Reimbursement and Claims Process sections. Basically, physicians are reimbursed using procedure codes from the 1970 Hawaii Relative Value Scale (HRVS). A predetermined dollar value (by the DPHSS) is assigned to the procedure codes. Currently, this value is seven (7) dollars and has not been changed in the last several years. Reimbursement for the four or five SNF patients is on an as billed basis. The hospital is also reimbursed on an as billed basis; however, charges for ancillary services are limited and reduced if necessary. The hospital is supposed to be charging at the Medicare rate, but an audit has not been done to verify this. There has never been hospital adjustments made at the end of the year.

One other disturbing finding is that in October, 1978, Guam Memorial Hospital (GMH) was advanced $200,000 to cover unpaid claims. The agency apparently processed claims up to $200,000 during October-December 1978 to cover the advance and made no further payments until the advance was cleared. (It was not possible during the limited time of the assessment to delve more deeply into this transaction.)

Recommendation: a) An inhouse study should be conducted to determine if current weighting procedures of the HRVS are appropriate and/or need updating. b) An audit of GMH must be conducted. This should be in conjunction with the Medicare auditor. c) A full report should be provided to HCFA on the $200,000 GMH transaction.

DPH&SS Comment: a) An inhouse study will be conducted to determine if current weighting procedure of HRVS are appropriate and/or need up-dating by October 1, 1980.

b) Preparation for audit of Guam Memorial Hospital will be initiated by September 1, 1980. HCFA will be contacted as to procedure and possibility of including Medicaid issues with the Medicare audit.

c) A report regarding the $200,000 Guam Memorial Hospital transaction will be prepared by June 1, 1980.

4. Finding: The Medicaid Agency's accounting and financial management control section is inadequate. There is an apparent feeling among management that since Guam is now spending over its ceiling, it should not be overly concerned as to how expenditures are made from an FFP viewpoint since they are spending all the Federal dollars. Expenditures over the last two years varied from $38,730 in one quarter to over $1,057,000 in another quarter. The DPHSS has little control or even knowledge as to when and how much Medicaid expenditures are made each quarter.

Recommendation: The DPHSS should hire a financial management specialist in addition to the accountant recommended previously to oversee all its Federal accounts. This person should see that the State and Federal dollar is maximized e.g., the $900,000 ceiling is based on expenditures during the quarter, not on when the service is provided. If it appears the agency will exceed the Federal ceiling during the last quarter of a year, payments could be held until after the beginning of the FY. In contrast, in FY 77, the agency did not use $81,000 of FFP that it could has used if it has speeded up payments during the last part of FY 77. Additionally, internal financial management reports are either nonexistent or unusable. Management must develop an adequate reporting system before it can expect to control the Medicaid Program.

DPH&SS Comment: The Department agrees. The need for a staff person to monitor financial expenditure will be requested in the supplemental request.

The Department will develop financial reporting system by March 1, 1980.

4 - DRUG REIMBURSEMENT

II. FINDINGS AND RECOMMENDATIONS

A. Compliance Issues

1. Finding: The State agency has not conducted a dispensing fee study.

   CFR Citation: 42 CFR 447.333

   Recommendation: The State agency must conduct a dispensing fee study. Guildelines provided to the Medicaid Supervisor at the assessment exit conference could be used for such a study.

   DPH&SS Comment: A pharmacutical survey was initiated in Jun 1979. However, completion was not achieved due to the resignation of previous supervisor.

   A dispensing fee survey design will be developed by May 1, 1980. Survey to be completed by August 1, 1980.

2. Finding: The State agency has not established a drug monitoring program. Further information on this issue may be found in the findings and recommendations in the Fraud and Abuse section of this report.

   CFR Citation: 42 CFR 456.3 and 456.23

   Recommendation: As a foundation for a drug monitoring program, some modications should be made to Guam's claims form in order to provide adequate information to conduct reviews and to ensure proper pricing:

   A) Customary charge information should be included. The present claims form encourages providers to total the "AWP" (average wholesale price) and the $2.75 dispensing fee. Hypothethically, a pharmacy's usual and customary charge could be less, and therefore Medicaid could pay less.

B) Spaces should be included for quantity, dosage, days supply, and number of refills.

Guam should examine the recommendations in each section of the assessment concerning claims forms and submit proposed modifications to the regional office for approval.

DPH&SS Comment: Monitoring procedures will be addressed in Fraud and Abuse Policies and Procedures, November 1, 1980.

As of August, 1979, the "Medicaid Billing Form" was revised to include quantity, dosage, etc. (Appendix, Attachment 5).

B. Problem Areas

1. Finding: There is a need to update "Estimated Acquisition Costs" to take into account shipping costs unique to Guam and present ingredient costs including any discounts. "AWP" does not take into consideration any discounts.

Recommendation: DHEW regularly publishes invoice level costs that could be adopted as EAC's by selecting an appropriate percentile.

DPH&SS Comment: Matter will be addressed after Drug Survey, September 1, 1980.

2. Finding: There is a need to establish a minimum and maximum quantity of drug units that will be paid by the program. Due to the current lack of controls, drugstore may bill unusually small quantities and obtain multiple or excessive dispensing fees. This would occur in situations of following scanty physicians' prescriptions (at no fault of the drugstore) or of improper splitting of larger ones.

Recommendation: The State agency should promulgate written policy and notify providers.

DPH&SS Comment: Matter will be addressed after Drug Survey, September 1, 1980.

3. Finding: Guam does not limit the number of prescriptions a recipient can receive per month without prior authorization.

Recommendation: The need exists for Guam to limit the number of prescriptions a recipient can receive per month without prior authorization. Although this could involve additional administrative costs to the program in implementation, savings could be realized in actual prescription payments. Recipients would further be deterred from shopping for numerous prescriptions that might be potentially hazardous in combination. In an overall sense, such controls would provide added guarantees to a drug monitoring program that assures recipients receive medically necessary drugs in appropriate doses.

DPH&SS Comment: The Department agrees. Policy formulation, administrative procedures will be initiated by April 1, 1980.

4. Finding: Guam does not have any written policies on which drugs it will or will not pay for.

Recommendation: At some point Guam should consider adopting a formulary approach as used by some mainland States. This need be nothing more than incorporating portions of formularies currently in usage around the country. Savings are to be realized if Guam identifies those drug products it will not pay for and excludes those with very limited or no therapeutic value. Particular attention should be given to "over the counter" preparations.

DPH&SS Comment: The Department will request information regarding policies in other states and assistance from HCFA.

Will formulate policy by November 1, 1980.

5 - FRAUD AND ABUSE

I. OPERATIONAL DESCRIPTION

The Department agrees with the operational description. The Department will not be able to implement a Fraud and Abuse Program without additional staff and/or an ADP System.

II. FINDINGS AND RECOMMENDATION

B. Compliance Issues

1. Finding: Guam does not established the criteria for identifying suspected fraud (or abuse) cases, or methods for investigating these cases; nor has Guam developed procedures for referring suspected fraud to the State attorney general's office. This include having a staff position available to make friend to make referrals and work such cases.

CFR Citation: 42 CFR 455.13

Recommendation: Guam would have difficulty in meeting this and other Federal requirements without additional staffing. Having procedures in place could not make much sense if the procedures could not be put to use. The State should create at least one position (e.g., post-payment review specialist), possibly a position requiring some medical background, to handle all postpayment review activities, with fraud and abuse control as one aspect of the duties. This would give impetus to the development of workable procedures and guidelines necessary for an efficient fraud and abuse control system.

So that the procedures are appropriate, Guam should seek technical assistance from its attorney general, information from mainland States on their procedures, and input from the Region IX Office of Program Integrity.

Once Guam can assess the extent of potential fraudulent activities, it will be in a better position to determine any further need for a professional investigator; perhaps a departmental investigator for all programs would be appropriate if there is less than a full-time need in Medicaid.

DPH&SS Comment: The Department agrees with this finding. The need for additional staff will be addressed by the supplemental budget request.

Letters will be sent to Mainland agencies requesting sample of Fraud and Abuse policies and procedures and technical assistance will be requested of HCFA.

Completion date October 1, 1980.

2. Finding: Guam has submitted only one set of quarterly reports since the fraud regulation was enacted. For monitoring purposes we require the reports even if no review or investigation have been conducted.

CFR Citation: 42 CFR 455.17

Recommendation: Guam should submit such reports timely to the Region IX Office of Program Integrity.

DPH&SS Comment: The quarterly reports will be sent regularly effective January 1, 1980.

3. Finding: Guam does not have a method for verifying with recipients whether services billed by providers were rendered. Recipients are therefore not likely to provide much information on possible fraud or abuse.

CFR Citation: 42 CFR 255.20

Recommendation: The State agency should refer to the "Program Regulation Guide" on the subject. (Also see recommendation for compliance issue number 1.)

DPH&SS Comment: The Department is unable to address this problem presently. If staffing needs and an ADP System is utilized, it will be addressed by October 1, 1980.

4. Finding: Guam has not notified providers of the provisions of section 1909 of the Act that provide Federal penalties for fraudulent acts and false reporting.

CFR Citation: 42 CFR 455.22

Recommendation: For new providers a notice could be included in the same mailing with the provider agreement. Those providers presently participating could be notified by separate letters.

DPH&SS Comment: The Department agrees. A letter will be sent to all providers informing them of penalties for fraudulent acts and false reporting by November 1, 1979. The revised "Medicaid Billing Form" includes a statement regarding penalties for fraudulent billing (Appendix, Attachment 5). Implemented August 1979.

5. Finding: Guam does not have a surveillance and utilization control program for practitioner services or a postpayment review process to identify and examine exceptional (aberrant) providers. These requirements are inextricably related to the need for efficient fraud and abuse control. Further information on this issue can be found in the Utilization Control Section of this report.

CFR Citation: 42 CFR 456.3 and 456.23

Recommendation: In addition to the recommendation in compliance issue number 1 for a post-payment review specialist, the following is also recommended as a foundation for a surveillance and utilization control program:

A) A new claims form with information such as the description of service, diagnosis, and place of service, that would provide the means to conduct the necessary postpayment reviews to detect patterns of unnecessary care, overutilization, etc. The State agency should submit a proposal to the Regional Office for approval.

B) Readily available payment data for the Medicaid section. The Business Office should routinely supply Medicaid with summary data on amounts paid to specific providers.

The State agency should then phase into its claims processing system the necessary procedures and guidelines for the identification and examination of each aberrant provider. Expertise and training may be available from mainland Medicaid programs. Many States and fiscal agents have written guidelines that may be adaptable for Guam's program.

DPH&SS Comment: The Department is unable to address these recommendations at this time. Please refer to comments No. 1.

C. Problem Areas

1. Finding: The Single State agency is inadequately staffed. There is no person in a position to handle the overall program. integrity activities. Although the Medicaid Supervisor has responsibility in this area, she does not have adequate time to address it because of the overwhelming workload assigned to her. This finding has a significant bearing on the ability of the State agency to correct almost all other deficiencies.

Recommendation: Same as for compliance issue Number 1.

DPH&SS Comment: Please refer to response No. 1, Compliance Issues.

2. Finding: The claims processing system in general does not have the capability to identify potential fraud and abuse. (Also refer to the claims processing section.)

Recommendation: As suggested in the claims processing section, Guam should implement basic systems change. From a program integrity standpoint, the State agency should establish written guidelines to identify a potential fraud or abuse issue. This include written definitions of fraud and abuse as well as screening and handling procedures. (See also recommendations in fraud and abuse section.)

DPH&SS Comment: Please refer to response to No. 1, Compliance Issues.

3. Finding: There is a need to establish formal procedures for the recovery of overpayments.

Recommendation: The State agency should develop procedures for the calculation and collection of overpayments which afford the debtor adequate due process. HCFA Action Transmittal 77-105 would be useful for reference.

DPH&SS Comment: The Department agrees. Procedures will be developed by July 1, 1980.

4. Finding: There is a need to establish, formalize, and refine administrative procedures for fraud and abuse control in such matters as suspensions, terminations, peer review, prior authorization, warning, prepayment review, etc. At present there are only minimal guidelines for suspension and termination outlined in the State Plan.

Recommendation: The State agency should refer to HCFA Action Transmittal 77-105 for guidance in the development of such procedures and utilize those portions applicable or appropriate for Guam Medicaid.

DPH&SS Comment: The Department agrees. Procedures will be developed by July 1, 1980.

5. Finding: There is a need for an arrangement with the local medical association to review providers with abusive billing procedures.

Recommendation: The State agency should enter into an agreement with the association for this purpose.

DPH&SS Comment: The Department will explore the appropriateness of this recommendation with the Guam Medical Society.

6. Finding: There are indications that Guam Medicaid is losing excessive sums of money to abusive billing practices. How excessive the abuses are is unknown, since there is no surveillance system. This finding is based partly on a review of claims submitted by a number of providers suggesting the existence of such practices as the following:

- Upgrading of procedure code(HRVS) generating bills for services more comprehensive than actually performed
- Billings for unusually small quantities of drugs to obtain multiple or excessive dispensing fees
- Billings of full charges for multiple surgeries at the same operation session
- Billings for component parts of all inclusive procedures (e.g., follow-up hospitals visits separated from the surgery)
- Lab tests performed and billed but not ordered by physicians (brought to our attention through a complaint by one of Guam's providers - this may not involve Title XIX recipients)

Some of the elements of Guam's program, in themselves, also give adequate cause to believe abuses are excessive. Claims are processed very slowly and reimbursement levels are low. Most significantly, as noted by the medical association, providers on Guam realize they are not being checked and therefore have reason to feel secure in

cheating, if inclined to do so.

DPH&SS Comment: The Department agrees. Please refer to compliance issue #1.

7. General Recommendation: On the assumption that Guam hires a postpayment review specialist it is recommended that this specialist visit the Region IX Office of Program Integrity, HCFA, and/or one of the mainland States for training and technical assistance.

DPH&SS Comment: The Department agrees, however, the Department's request for off-island travel for Fiscal Year 1980 was denied by the Legislature. Assistance from HCFA will be made when staff are on board.

APPENDIX

1) Advisory Committee Listing (Attachment 1)

2) Advisory Committee By-laws (Attachment 2)

3) Letter to HCFA regarding ADP (Attachment 3)

4) Sterilization Consent Form (Attachment 4)

5) Medicaid Billing Form (Attachment 5)

6) Memorandum to Department of Administration request

Attachment 1

SOCIAL SERVICES ADVISORY COMMITTEE

Vivian Dames - Chairperson
Ernesto A. Cid - Vicechairperson

Members

Teresita Alegarbes
Sr. Mary Concepta
Celi Paternia
Maria Ulloa
Ana Peredo
Flora Mendoza
Francisco Feja
Mr. Daniel Bears
Rev. John Burke
Lourdes P. Camacho
Carlos Diaz

Mae S. Bass)
Dr. Leon Concepcion) withdrew their membership

Attachment 2

BYLAWS

OF

SOCIAL SERVICES ADVISORY COMMITTEE

ARTICLE I

Name

The name of the committee shall be: Social Services Advisory Committee and it is sometimes referred to in these bylaws as the "Committee."

ARTICLE II

Purposes

The purposes for which the Committee is formed are those set forth in the certain executive order issued by the Honorable Paul M. Calvo, Governor of Guam, on the _____day of_____, 197___, namely, to advise the principal policy setting and administrative officials of the Division of Social Services of the Government of Guam and to meaningfully participate in policy development and program administration for the said division.

ARTICLE III

Membership

Section 1. Members. The membership composition of the Committee shall be fifteen (15) members in number, out of which five (5) persons or one-third shall be selected from the recipient group, that is to say, that portion

of the population of the Territory of Guam which receives services directly from the Division of Social Services of the Department of Public Health and Social Services, or representatives of that group; three (3) members selected from government agencies; three (3) members from service providers; and four (4) members from the community at large.

Section 2. Term. Members shall serve for terms of two (2) years and new members shall be designated after each term or upon resignation.

Section 3. All members shall be appointed by the Governor of the Territory of Guam.

ARTICLE IV

Officers And Their Election

Section 1. Officers. The officers of the Committee shall be: a chairperson, a vice-chairperson, and a secretary.

Section 2. Designation. The chairperson and the vice-chairperson shall be selected by a vote of the Committee and shall be members in good standing of the Committee. The secretary shall be an employee of the Division of Social Services of the Department of Public Health and Social Services and shall be designated to serve in that capacity by the Administrator or an administrator of the Division of Social Services of the Department of Public Health & Social Services.

Section 3. Term. Officers shall serve for a term of one year except that should an officer miss two regular meetings of the Committee without furnishing the Committee or the Administrator of the Division of Social Services with a satisfactory reason for his or her absences his or her office shall be deemed vacant and an election shall be held at the next regular meeting of the Committee for a successor to his or her position.

Section 4. Eligibility. A person shall not be eligible to serve more than two consecutive terms in the same office.

Section 5. Vacancy. A vacancy occurring in any office shall be filled for the unexpired term by a person elected by a majority vote of the remaining members of the Committee.

ARTICLE V

Duties of Officers

Section 1. Chairperson. The chairperson shall preside at all meetings of the Committee and shall perform such other duties as may be prescribed in these bylaws and assigned to him/her by the Government of Guam or the Administrator of the Division of Social Services of the Department of Public Health and Social Services or by the Committee and shall coordinate the work of the Committee with the said Department in order that the purposes of the Committee may be promoted.

Section 2. Vice-chairperson. The vice-chairperson shall act as aid to the chairperson and shall perform the duties of the chairperson in the absence or disability of that officer to act.

Section 3. Secretary. The secretary shall record the minutes of all meetings of the Committee and shall perform such other duties as may be designated to him/her by the chairperson or the Administrator of the Division of Social Services.

ARTICLE VI

Meetings

Section 1. Regular meetings. Regular meetings of the Committee shall be held at least once a month at a location to be designated by the Committee.

Five (5) days notice shall be given of any change in this date.

Section 2. Special meetings. Special meetings may be called by the Committee, by the chairperson, by the Administrator of the Division of Social Services, or by the Governor of Guam, five (5) days notice having been given.

Section 3. Quorum. A majority of the members of the Committee shall constitute a quorum for the transaction of business at any meeting.

ARTICLE VII

Standing and Special Committees

Section 1. Creation. The committee may create standing sub-committees as it may deem necessary to promote the purposes and carry on the work of the Committee. The term of the chairperson of any such committee shall be for one year and until the election and qualification of his successor.

Section 2. Power to create and appoint. The power to form special committees and appoint their members rests with the Committee.

Section 3. Ex-officio members. The chairperson and the Administrator of the Division of Social Services shall be members ex-officio of all such committees.

ARTICLE VIII

Amendments

These bylaws may be amended, repealed, or altered in whole or in part by a majority at any regular or special meeting of the Committee.

CERTIFICATE OF SECRETARY

I, the undersigned, certify that:

(1) I am the presently designated secretary of the Social Services

Advisory Committee of the Division of Social Services, Department of Public Health and Social Services, Government of Guam; and

(2) The above bylaws consisting of eight Articles are the bylaws of this Committee as adopted at a meeting of the Committee held on September 10, 1979.

IN WITNESS WHEREOF, I have subscribed my hand this_____day of September 1979.

_____
SECRETARY, Social Services Advisory Committee

ATTEST:

_____
CHAIRPERSON, Social Services Advisory Committee

Adopted September 10, 1979.

_____
ADMINISTRATOR, Division of Social Services, Department of Public Health and Social Services

Attachment 3

Mr. Lawrence L. McDonough
Regional Medicaid Director
Department of Health, Education,
and Welfare
Health Care and Financing Administration
100 Van Ness Avenue
San Francisco, California 94102

Dear Mr. McDonough:

We are requesting your office's assistance in the identification and acquisition of an appropriate Automated Data Processing System for the Guam Medicaid Program and technical assistance for the adaptation and implementation of said system. Our efforts to obtain a federal grant for this purpose was denied. Furthermore, the present $900,000 federal ceiling has hampered our efforts to obtain additional amounts from our local legislature.

During a visit to San Francisco in June, the Social Services Administrator met with members of your staff regarding this matter. Your staff share our concerns and indicated that your agency is in the process of identifying and acquiring a system appropriate for Guam's use. Furthermore, provisions of technical assistance by your agency for the adaptation and implementation of said system on Guam was also discussed. A tentative time frame was discussed. We would like to know whether the prearranged initiation time for the project of September or October 1979 is possible?

In view of Guam's limited Medicaid funding, we are appreciative of any and all assistance you can provide us regarding this matter.

Sincerely yours,

FRANKLIN S. CRUZ, Ed.D.
Director of Public Health
and Social Services

cc: SSAdministrator
DDirector
File
9/5/79
CI:mf

Attachment 4-A

DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
GOVERNMENT OF GUAM
AGANA, GUAM 96910

Medicaid Section

JUN. 15 1978

STEPS TO FOLLOW REGARDING STERILIZATION

1) Any client male or female wishing to be sterilized should see his/her physician for advice.

2) The physician advises the client of the advantages, disadvantages or risk of the sterilization procedure in terms of his/her health.

3) The physician sends the client to the Central Office of the Department of Public Health and Social Services in Mangilao, MCH (Maternal and child Health) Section for counselling if he/she chose to be sterilized.

4) An MCH Social Worker counsels the client and explains to him/her that alternative methods of birth control are available, and that sterilization is considered to be an irreversible procedure.

5) In case that the client does not read, write or understand the English language an interpreter is called to help. The interpreter reads and explains to the patient the contents of the consent form and interpretes the counselling.

6) After counselling, if the client sitll chooses to be sterilized, he/she is requested to sign his/her name on the space provided and date it.

7) The counsellor and the interpreter likewise sign their names and date on the appropriate spaces provided.

8) After signing the consent form the client is advised to bring it to the Medicaid Office for prior authorization.

9) The prior authorization together with the three (3) copies of signed consent is sent to the physician who will perform the sterilization procedure.

10) The patient is advised to see her physician 30 days after his/her consent is signed or anytime after 72 hours if the three (3) circumstances of the last paragraph (2) of the form arises.

11) After the sterilization procedure, the physician completes the physician's statement portion and signs and dates it.

12) The physician gives to the client the patient's copy, retains the physician's copy for his file and submits to Medicaid office the copy for the State Agency Program.

The program copy and the prior authorization should be attached to the bills when submitting to Medicaid office.

DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
GOVERNMENT OF GUAM
AGANA, GUAM 96910

NOTICE: **YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.**

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from _____
Doctor or Clinic

When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least 30 days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by Federally funded programs.

I am at least 21 years of age and was born on _____ (Month/Day/Year), I, _____, hereby consent of my own free will to be sterilized by _____ by a method called _____.

My consent expires 180 days from the date of my signature below. I also consent to the release of this form and other medical records about the operation to: Representatives of the Department of Health, Education, and Welfare, or employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

_____ _____ _____ _____ _____
Signature (Month) (Day) (Year)

You are requested to supply the following information, but it is not required: (Race and ethnicity designation, please check)

( ) Black (not of Hispanic origin) ( ) Asian or Pacific Islander ( ) White (not of Hispanic origin)
( ) Hispanic ( ) American Indian or Alaskan native

INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____ _____ _____ _____
Signature (Month) (Day) (Year)

STATEMENT OF PERSON OBTAINING CONSENT

Before _____ signed the consent form, I explained to him/her the nature of the sterilization operation
Name of Individual

_____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

_____ _____ _____ _____
Signature of Person Obtaining Consent (Month) (Day) (Year)

_____ _____
Facility Address

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon _____ on _____
Name of Individual to be Sterilized (Date of sterilization operation)

I explained to him/her the nature of the sterilization operation _____ the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears to be mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraph: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least 30 days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested).

( ) Premature delivery. Individual's expected date of delivery: _____

( ) Emergency abdominal surgery. (Describe circumstances)

_____

_____ _____ _____ _____
Physician's Signature (Month) (Day) (Year)

OSSH 1148 (2/79)

1st Copy — MEDICAID 2nd Copy — MCH - FP 3rd Copy — PHYSICIAN 4th Copy — PATIENT

Attachment 5

(1) IDENTIFICATION NO. _____

MEDICAID BILLING FORM

(2) PROVIDER NO. _____

(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)
column 1	column 2	column 3	column 4	column 5	column 6	column 7	column 8	column 9	column 10	column 11	column 12
MEDICAID NUMBER	RECIPIENT'S NAME	AGE	VILLAGE	BRAND NAME OF DRUG	DRUG STRENGTH	NUMBER TABS PILLS /CAPS DISPENSED	DRUG COST & DISPENSING FEE	HRVS	PHYSICIAN'S NAME	SERVICE DATE	TOTAL COST

CERTIFICATION: "This is to certify that the foregoing information is true, accurate, and complete."

"I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws".

(15) TOTAL _____

(16) _____
Signature of Provider and/or Certifying Officer

(17) _____
DATE

(18) _____
Name and Title of Provider

(19) _____
Address

(20) _____
Telephone Number

INSTRUCTIONS TO FILL OUT BILLING FORM

(1) IDENTIFICATION NO. - Write the identification number as follows:

(a) The first number applies to the service month.
(b) The second number applies to the month the bill was signed and/or certified.
(c) The third number applies to the number of pages of bills for the particular service month.

(2) PROVIDER NO. - Write the provider number issued by the Medicaid Office.

(3) COLUMN 1 - Write the Medicaid number of the recipient accordingly by categories. Example: In one form, if the first patient falls under category 10, then as many patients serviced in the same month under this category can be posted as the form can accommodate.

(4) COLUMN 2 - Write the recipient's name including the middle initial.

(5) COLUMN 3 - Fill in the date of birth of the patient.

(6) COLUMN 4 - Write the village where the recipient is currently residing.

(7) COLUMN 5 - Write the brand name of the drug.

(8) COLUMN 6 - Write the strength of the drug. Example: ampicillan cap 250 mg. ampicillan suspension 125mg/tsp.

(9) COLUMN 7 - Write the total number of caps, tabs, or pills dispensed; Number of fluid ounces per bottle and number of bottles dispensed.

(10) COLUMN 8 - Write the price of the drug dispensed plus the dispensing fee of $2.75.

(11) COLUMN 9 - Write the proper HRVS Code of the particular service rendered.

(12) COLUMN 10 - Write the name of the servicing physician and/or provider.

(13) COLUMN 11 - Write the month, day, and year the service was rendered.

(14) COLUMN 12 - Write the total cost of the service for each patient.

(15) - Write the sum total cost of services for all the patients listed.

(16) - Signature of provider and/or certifying officer. Original signature of the provider and/or certifying officer is required.

(17) - Indicate the date the bill was signed.

(18) - Type or print in ink the full name of the provider.

(19) - Enter provider's address.

(20) - Enter Provider's telephone number.

Attachment 6

MEMORANDUM

To: Director of Administration

From: Director of Public Health and Social Services

Subject: Guam Medicaid Management Assessment

Attached are pages 50-52 of the audit report covering the section on Financial Management and Reimbursement. We would appreciate your response to the portions covering your area of responsibilities in order that it will be included in this Department's official response. In order to meet the allotted response deadline, I would appreciate receiving your comments by September 28, 1979.

If you have any questions, please contact the Social Services Administrator at 734-2941.

Your assistance in this matter is greatly appreciated.

FRANKLIN S. CRUZ

Attachments

cc: SSAdministrator
DDirector
File
9/7/79

CI;Mf