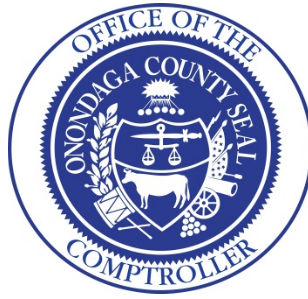


# Medical Assistance Program Single Audit Report
# 2013 Program Year

## Introduction

The Onondaga County Comptroller's Audit Division conducted an audit of Onondaga County's Medical Assistance Program (Medicaid) for the 2013 program year. Medicaid is the largest federally funded assistance program through the Department of Health and Human Services. According to the Medicaid Cluster Compliance Supplement, "The objective of Medical Assistance Program (Medicaid of Title XIX of the Social Security Act, as amended, (42 USC 1396 *et seq*.)) is to provide payments for medical assistance to low –income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children." Once a state opts to create a Medicaid program, it must abide by federal rules. The federal government partially funds the program and establishes mandatory and optional program characteristics. These characteristics relate to who is eligible and what services must be given. But in each case, the federal rules allow the states considerable flexibility. New York offers coverage to virtually all optional populations and covers almost all optional services. Medicaid eligibility is based on both "categorical (e.g., families and children, aged, blind, and disabled) and financial (e.g., income/resources) status" and requirement criteria is defined in the federally approved State plan. Redetermination of eligibility must be completed at least every twelve months. A large part of audit testing surrounded these eligibility and recertification requirements, as this is the County's main focus in the Medicaid program. New York State heads up many of the other program requirements and those elements are audited on the state level.

## Areas of Best Practice

While conducting the audit, it was noted the County Medicaid office follows a case supervisory review process on intake and undercare case determinations. Each seasoned intake and undercare worker has two of their cases reviewed by a supervisor on a monthly basis. All cases determined by new employees are reviewed. Employees also attend various training sessions throughout the year as the regulations for Medicaid are constantly changing and they need to stay ahead of modifications.

There were two Community second-level reviews for the month of November that were not completed until the end of January 2014. The Department completed in excess of 120 annual second level reviews in compliance with Department procedures. Audit recommends the level two reviews be completed more timely which possible.

## Documentation of findings/issues

1. In one instance, a budget was produced for each month of a recipient's authorization period to ensure they were eligible for all months included. It was noted the resource amounts were the same on each budget within the WMS system, yet should have changed accordingly with the monthly resource information provided. This error caused no changes to the eligibility determinations as the recipient was under the $14,250 resource threshold allowed by the program in all instances. The case was completed by Chronic Care but was actually a Community case. This contributed to one snapshot date being used for resources, which is a more standard practice on the Chronic Care side.
2. One instance was discovered in which the resources calculation was incorrect because an irrevocable burial trust was mistakenly backed out of the recipient's resource amount twice. The recipient was over the resource limit and instructed to pay the overage to the nursing home as Medicaid is the payer of last resort. The miscalculation resulted in questioned cost from the recipient to Medicaid in the amount of $3,445. Note: Management was notified of this and because a recertification had not been completed for this recipient, they were able to notify the nursing home and will be recouping the funds.
3. It was noted an application did not contain the signature of the intake worker determining eligibility, as they had been out on extended medical leave. Upon audit discovery, the intake Supervisor completed a level I case supervisory review and verified the original eligibility of the recipient was correct. The supervisor then signed the application themselves to avoid any further issue with the case.
4. There were five instances noted, one from Community and four from Chronic Care, in which the recertification was not completed by the appropriate deadline and the Department did not have a valid reason as to why. The cases had been extended several times with minimal communication attempts made to the recipients and only completed after having been selected for audit testing. There were no changes to eligibility noted.
5. There were six instances noted, all from Chronic Care, in which the recertification was not completed by the appropriate deadline and the Department did not have a valid reason as to why. The cases had been extended several times with minimal communication attempts made to the recipients. The recertifications are still pending and the most recent action seems to be initiated by the cases selection for audit testing.