Medical Assistance Program Single Audit Report
2014 Program Year

Introduction

The Onondaga County Comptroller's Audit Division conducted an audit of Onondaga County's Medical Assistance Program (Medicaid) for the 2014 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.

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.

Areas of Best Practice

While conducting the audit it was noted in reviewing the bank statements of a client that the client received a lump sum payment of $5,130 in the month after applying for and becoming eligible for Medicaid. Per Medicaid regulations, a client is responsible for reporting any change in income. The Medicaid office is referring this case to legal for failure to report this income. This is not a finding but best practice would be for the Medicaid department to follow up on clients that are expected to receive automobile accident settlements to make sure they did not receive unexpected settlements that could affect their Medicaid eligibility.

Documentation of findings/issues

1. In one instance, it was found that a client's income was a pension from a different country. When the case worker calculated the exchange rate for the dollar value of this pension, they used the net of the monthly pension instead of the gross monthly pension. This caused the monthly income of the client to be less than it actually was. This error caused no changes to the eligibility determination but it is a finding due to using the incorrect income amount for calculating eligibility.