Nassau County
Office of the Comptroller

Limited Review of the Nassau County Department of Social Services Medicaid Administration Unit

George Maragos
Comptroller

January 28, 2013

NASSAU COUNTY
OFFICE OF THE COMPTROLLER

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Introduction

Total Medicaid in Nassau County costs taxpayers about $1.7 billion per year. The County's portion of this federal, state, and local program is about $221 million. The New York State ("NYS") Health Department administers this program with the assistance of the counties, which are primarily responsible for eligibility determinations

Background

As of May 2010, in anticipation of healthcare reform, the NYS Department of Health eased Medicaid eligibly documentation standards. Our audit tests Nassau County's Department of Social Services Medicaid Unit's adherence to the NYS standards and noted the following findings.

Summary of Significant Findings:

- Medicaid determinations were not made by DSS within the required NYS guidelines. In 2010, the Medicaid Unit made Medicaid eligibility determinations for 23,183 cases that it opened. For 2,482 cases or 10.7% of the cases, the determinations were made over 45 days after the applications were received. For 582 cases or 2.5% of the cases, the determinations were made after 90 days.
- Residents that moved out of state were still covered. We identified thirteen cases where the recipient continued to receive benefits after they left New York State. Total benefits amounted to $29,315. The benefits were in the form of insurance premiums for Managed Care Plans that the Medicaid Unit enrolled the recipients in.
- Income is difficult for DSS to verify. We identified one case that had inconsistencies and did not have adequate documentation explaining income. The case involved a 43 year old female residing with her father.
- DSS failed to save money by dis-enrolling Medicare recipients. An audit of the DOH's Medicaid Program by the NYS Office of the State Comptroller ("OSC")[1] found that Nassau County would have saved $959,306 by paying the recipients' coinsurance and deductible amounts rather than having paid their Managed Care premiums.
- Some recipients had multiple identification numbers. An OSC audit[2] found that statewide, 9,848 recipients were enrolled into Medicaid with multiple identification numbers costing $17.3 million.

[1] "Unnecessary Managed Care Payments for Medicaid Recipients with Medicare", New York State Office of the State Comptroller, audit report 2010-S-75, April 2012.
[2] "Inappropriate Medicaid Payments for Recipients with Multiple Identification Numbers and No Social Security Numbers", New York State Office of the State Comptroller, audit report 2010-S-29, July 2012.

Summary of Significant Recommendations:

The Medicaid Unit should:

A.) file disenrollment forms and obtain refunds due from insurance carriers in a timely manner for clients that have moved out of state.

B.) review all required documentation for inconsistencies regarding income and shelter expenses before determining client eligibility for Medicaid benefits;

C.) make every effort to ensure that eligibility for all cases is determined within the 45 or 90-day limits required by state law;

D.) ascertain why Medicare eligible recipients were not dis-enrolled from the Medicaid Managed Care Plans; and

E.) take steps to minimize the potential for the issuance of multiple identification numbers to the same recipient, including using the appropriate WMS reports and online tools.

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The matters covered in this report have been discussed with officials of the Department of Social Services Medicaid Administration Unit during this review. On December 4, 2012, we submitted a draft report to the Department of Social Services for its comments. The Department of Social Services' comments and our responses to those comments are included as Appendix B to this report.

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Background

Medicaid is a jointly funded, federal-state health insurance program for low-income and needy people. In New York State, the County governments also provide funding. Medicaid covers children, the aged, blind, and/or disabled and other people who are eligible to receive federally assisted income maintenance payments. The U.S. Department of Health and Human Services' Center for Medicare and Medicaid Services oversees state administration of Medicaid.[3]

Medicaid in New York State is administered by the NYS Department of Health ("DOH"), and is governed by the State Social Services Law, NYS Code of Rules and Regulations ("NYCRR Title 18"). The Nassau County Department of Social Services ("DSS") Medicaid Administration Unit ("Medicaid Unit") processes Medicaid applications following these regulations.

The Medicaid Unit processes Medicaid applications to assess applicant eligibility and monitors changes in eligibility status. In 2010, the Medicaid Unit opened 23,183 cases. There are a number of ways that Medicaid applications are received by the Medicaid Unit. Some come from Facilitated Enrollers that work for Managed Care providers and are trained by New York State. Others come from Deputized Workers, who are workers that work for Medicaid providers that have a Memorandum of Understanding with Nassau County and work at various providers such as hospitals, community based agencies, and clinics, and assist in the application process.

Total Medicaid expenditures for the years 2004 through 2010 and the federal, state, and county share of the expenditures were as follows:

Medicaid Expenditures for Years 2004 - 2011

Year	Gross Expenditures	Federal	State	County	Federal %	State %	County %
2004	$1,348,010,574	$677,918,186	$418,502,458	$251,589,925	50.29%	31.05%	18.66%
2005	$1,457,929,904	$709,907,368	$471,602,922	$276,419,615	48.69%	32.35%	18.96%
2006	$1,451,945,784	$700,494,469	$533,634,714	$217,816,601	48.25%	36.75%	15.00%
2007	$1,432,446,673	$693,205,373	$521,215,292	$218,026,009	48.39%	36.39%	15.22%
2008	$1,486,919,481	$718,783,162	$540,181,872	$227,954,747	48.34%	36.33%	15.33%
2009	$1,626,332,624	$784,683,351	$638,132,959	$203,516,312	48.25%	39.24%	12.51%
2010	$1,694,803,759	$807,434,623	$687,552,293	$199,816,843	47.64%	40.57%	11.79%
2011	$1,798,834,611	$846,775,379	$726,179,565	$225,879,667	47.07%	40.37%	12.56%

The Medicaid Unit provided a listing of Medicaid expenditures in 2010 by the category of service. Categories included skilled nursing facility, inpatient, physician services, and other categories (see Appendix A).

As of May 2010, Medicaid applicants can apply or be recertified for Medicaid by mailing in an application. Face-to-face interviews are no longer required. In addition, applicants need only

[3] http://www.socialsecurity.gov/disabilityresearch/wi/medicaid.htm.

supply a statement from another person to prove the applicant's identity, marital status, residence, household composition, age, or absent parent information. Official documents from third party agencies such as driver's licenses, marriage certificates, rent receipts, or birth certificates are not required.

The Medicaid Unit is required to make their determination of eligibility within 45 days, or 90 days in cases of disability applications.

According to the Director of DSS' Office of Investigations ("OI"), 1,184 Medicaid applications were referred to the DSS Office of Investigations in 2010 and 944 applications were referred in 2011.

Audit Scope, Objectives, and Methodology

The audit period was the years 2010 and 2011. The audit objectives were to:

1.) Examine the various functions performed by the DSS Medicaid unit;
2.) Determine whether DSS operations adhere to NYS regulations;
3.) Review eligibility processing procedures, which include:
    a.) Income verification;
    b.) Case management;
    c.) Managed care;
    d.) Fair-housing process; and
    e.) Estate recoveries.
4.) Examine the departmental structure of the unit;
5.) Review management controls; and
6.) Identify potential cost savings that can be achieved through more efficient and effective operations.

An audit includes examining documents and other available evidence that would substantiate the accuracy of the information tested, including all relevant records. It includes testing for compliance with applicable laws and regulations, and other auditing procedures necessary to complete the examination. We believe that this audit provides a reasonable basis for our conclusions.

Audit Finding (1):

Thirteen Out of State Medicaid Recipients Were Still Receiving Benefits

New York State's policy of allowing for self-attestation of residency and income is a significant control weakness that contributed to our finding that Nassau County is still paying for residents that moved out of state.

New York State lists the forms of documentation that are acceptable for the main eligibility factors,[4] which pertain to:

- Identity/Marital Status/Residence/Age/Absent Parent Information
- Citizenship/Social Security number
- Earned/Unearned Income
- Resources, i.e., Bank accounts, and other assets (required for applicants 65 or older)
- Expenses for shelter, health insurance, bills
- Disabled/Incapacitated/Pregnant status.

Official third party documentation, such as a U.S. passport to prove citizenship, or NYS Department of Labor correspondence to prove unearned income, is required. However, per New York State, the applicant may provide a statement from another person, or self-attest to income. As of October 20, 2011, the Medicaid Unit was managing 93,807 active cases. Ninety-eight of these cases listed out-of-state addresses. We examined all 98 of these cases to determine whether out-of-state providers were legitimately providing Medicaid services, or whether the recipient moved out of state, in which case benefits should cease. We identified thirteen cases where the recipient continued to receive benefits after they left the state. Total benefits amounted to $29,315. The Public Assistance Reporting Information System ("PARIS") identified some of these cases as out-of-state. PARIS is the system that matches recipients receiving assistance in two or more jurisdictions. The benefits were in the form of insurance premiums for Managed Care Plans in which the Medicaid Unit enrolled the recipients.

Audit Recommendation:

The Medicaid Unit should file disenrollment forms and obtain refunds due from insurance carriers in a timely manner for clients that have moved out of state.

Audit Finding (2):

The Medicaid Unit Met State Standards with Regard to Income Documentation

The tool provided to DSS by NYS for income verification is extremely limited. It only recognizes state and local government employment, not business income.

[4] New York State Form LDSS-2642.

Auditors reviewed eligibility-processing procedures, which included the documentation obtained from applicants to verify various eligibility factors such as identity, residence, income, and other eligibility factors; case management; Managed Care enrollment; Fair-Hearing process; resource recovery; and the time taken to make eligibility determinations. Auditors also examined the department's structure, caseloads, and management controls.

The Medicaid Unit uses the Resource File Integration ("RFI"), a New York State Welfare Management System ("WMS") subsystem to verify resource information provided by the applicant. The information provided by this system is usually six months old. RFI matches resources with other state and federal sources from five databases: Wage Reporting System, New York State Directory of New Hires, Unemployment Insurance Benefits, Beneficiary Earning and Data Exchange, and Financial Institution Recipient Match. Since WMS does not have access to the New York State Department of Taxation and Finance database, the applicant's incomes from most employers cannot be matched by RFI or verified by the Medicaid Unit.

We examined 101 case files for adequate documentation supporting eligibility factors such as citizenship, residence, and income. We identified one case that had inconsistencies and did not have adequate documentation explaining income. The case involved a 43 year old female residing with her father. On December 16, 2010, the client submitted her first Medicaid application and claimed shelter expenses of $200 per week. The Medicaid Unit denied the case. The client applied again on May 18, 2011 and three budgets were prepared.

- The first budget was for the period February 2011 and showed the only income to be unemployment income of $405 a week.
- The second budget was for the period March 2011 and showed the same unemployment income amount.
- The third budget was for April 2011 and showed that the client had no income since unemployment stopped on March 6, 2011.

The Medicaid Unit opened the case. On her reapplication, the client produced a lease agreement with her father listing $350 per week rent. The client appeared to have insufficient income to meet her shelter expenses and claimed inconsistent shelter expenses.

Although we identified only one case that did not have adequate documentation, the Department of Social Services' Office of Investigations stated most fraud found pertains to the hiding of income by the applicant and the submission of false documentation. Some examples of fraud that were referred to the District Attorney's Office in 2012 included:

- A 51-year-old Great Neck man falsely reported that he was a part-time security guard for a retail store and falsified records to indicate that his family paid $750 in monthly rent, in order to illegally qualify for $40,722 in Medicaid benefits. A DSS investigation revealed that the man actually owned a successful clothing store in Manhattan and owned a home in Great Neck purchased in 2006 for $856,000;
- A 52-year-old Merrick man illegally obtained $42,322 in Medicaid and Food Stamps benefits after concealing income he received from several businesses that he owned. Despite reporting that he was either unemployed or working as a day laborer at various

times, a DSS investigation revealed that the man and his family owned four businesses, a $613,000 home in Merrick, a 2010 Cadillac and a 2011 Chevy Camaro;

- A 52-year-old Plainview woman and her husband failed to report their true income, resulting in $33,618 in illegally obtained Medicaid benefits; and
- A 56-year-old East Meadow man failed to disclose his true income and falsely stated that he was working part-time at a pizzeria in order to illegally qualify for $15,844 in Medicaid and Food Stamps benefits. A DSS investigation revealed that the pizzeria that the man reportedly worked for does not exist and that he is employed as an "Executive Chef" at an upscale restaurant.

All of these cases were referred to the Nassau County District Attorney's Office for criminal fraud prosecution, and full restitution.

Audit Recommendations:

The Medicaid Unit should review all required documentation for inconsistencies regarding income and shelter expenses before determining client eligibility for Medicaid benefits. The case of the 43-year-old female discussed above should be referred to the Office of Investigations.

Audit Finding (3):

The Medicaid Unit Did Not Make Eligibility Determinations in about 11% of Cases within the Required 45-Day State Limit

The social services district must determine an applicant's eligibility for Medicaid within 45 days of the date of application, or in the case of applications for disability, within 90 days of the application, or in some cases within 30 days of the application.[5]

In 2010, the Medicaid Unit made eligibility determinations for 23,183 cases that they opened. We based our evaluation of the length of time to make determinations on the registration date, which is the date that the Medicaid Unit received the application. For 2,482 cases or 10.7% of the cases, the determinations were made over 45 days after the applications were received. For 582 cases or 2.5% of the cases, the determinations were made after 90 days. Cases on average were disposed of within 24 days of the registration date. The largest number of days taken was 322 days.

The risk exists that DSS could become the subject of a lawsuit for not determining eligibility within state time limits.

We met with the Suffolk County Medicaid Unit to compare their operations and staffing with the Nassau County Medicaid Unit. A report provided by the Nassau Medicaid Unit provided the following information:

[5] NYCRR Title 18, Section 360-2.4(a)

Medicaid Statistics for June 2012		
	Nassau	**Suffolk**
Average number of employees in department	100	450
Active Cases	97,990	119,080
Opened cases June 2012	3,664	5,672
Pending applications	6,885	7,451
Pending applications over 30 days old	2,098	300
Rejected cases June 2012	3,231	5,858
Cases reopened	2,137	3,111
Cases denied	829	2,221
Cases withdrawn	265	11

Throughout the audit, the Medicaid Unit administration cited understaffing as a serious concern. As the chart above shows, the Suffolk Medicaid Unit has more than four times the staff of the Nassau Medicaid Unit with only 22% more cases than the Nassau Medicaid Unit.

Audit Recommendations:

The Medicaid Unit should make every effort to ensure that eligibility for all cases is determined within the 45 or 90-day limits required by state law.

DSS should consider hiring additional staff to meet their obligations, as the cost of additional workers is reimbursed 75% from other sources, Federal (50%) and state (25%). This reimbursement covers both salary and fringe benefits.

Audit Finding (4):

The Department of Social Services ("DSS") Paid Managed Care Premiums for Medicare Eligible Recipients

The New York State Department of Health ("DOH") refers to Medicaid recipients who also have Medicare coverage as dual eligibles. As a payor of last resort, Medicaid only pays a dual eligible recipient's coinsurance and deductible amounts. Dual eligible recipients should not be enrolled in managed care plans, as the premium payment for managed care exceeds what Medicaid would pay for a recipient's coinsurance and deductibles.

An audit of the DOH's Medicaid Program by the New York State Office of the State Comptroller[6] found that over a three-year period ending May 31, 2010, Nassau County's DSS would have saved $959,306 by paying the recipients' coinsurance and deductible amounts rather

[6] "Unnecessary Managed Care Payments for Medicaid Recipients with Medicare", New York State Office of the State Comptroller, audit report 2010-S-75, April 2012.

than having paid their Managed Care premiums. Approximately 200 managed care cases per year were not switched to the coinsurance and deductibles payments.

Although New York State has a contract with MAXIMUS[7], and one of its responsibilities is to dis-enroll Managed Care recipients when they become eligible for Medicare, the primary responsibility for dis-enrolling dual eligible clients belongs to the Managed Care Unit within the Medicaid Unit. The Managed Care Unit cited understaffing as a serious concern.

Audit Recommendation:

The Medicaid Unit should ascertain why Medicare eligible recipients were not dis-enrolled from the Medicaid Managed Care Plans.

Audit Finding (5):

The DOH Made Inappropriate Medicaid Payments for Recipients with Multiple Identification Numbers

An audit of DOH's Medicaid Program by the NYS Office of the State Comptroller[8] found that for the three years ended May 31, 2010, DOH overpaid approximately $17.3 million in Medicaid in New York State because 9,848 recipients were enrolled into Medicaid with multiple identification numbers. Upon further investigation, it was determined that $303,087 of this amount pertained to Nassau County recipients. The State's Welfare Management System ("WMS") produces reports identifying persons who are already enrolled in Medicaid. However, the reports are not useful in checking for a duplicate recipient identification number when a Social Security number is not recorded in connection with an already established identification number. Local social service personnel were often not aware of online tools in WMS that can be used.

Audit Recommendations:

The Medicaid Unit should take steps to minimize the potential for the issuance of multiple identification numbers to the same recipient, including using the appropriate WMS reports and online tools. This should include verifying applications submitted through emergency rooms and facilitated enrollees.

[7] MAXIMUS is an enrollment contractor for government insurance programs.
[8] "Inappropriate Medicaid Payments for Recipients with Multiple Identification Numbers and No Social Security Numbers", New York State Office of the State Comptroller, audit report 2010-S-29, July 2012.

2010 Nassau County Medicaid Claims and Dollar Amount by Category of Service

(Source: eMedNY database: Dollar amounts are based on date of payment; DSS Medicaid Unit)

Category of Service	Claims	$ Amount
Grand Total	6,586,330	$1,673,555,212.47
SKILLED NURSING FACILITY	268,666	$358,277,494.86
CAPITATION PROVIDER (Managed Care premiums)	954,123	$300,127,977.07
OMRDD WAIVER SERVICES	598,273	$266,923,476.55
INPATIENT	37,785	$194,925,138.68
VENDOR PERSONAL CARE SERVICES (Personal Care Aides)	771,148	$125,213,213.36
DRUGS	1,298,482	$100,708,086.61
INTERMEDIATE CARE FACILITY/ DEVELOPMENTALLY DISABLED	45,555	$67,602,634.00
DIAGNOSTIC & TREATMENT CENTER SERVICES (FREE-STANDING CLINIC)	318,213	$39,122,700.07
HOSPITAL BASED OUTPATIENT SERVICES	240,406	$35,360,617.22
OMH REHABILATATIVE SERVICES (Office of Mental Health)	24,399	$27,205,104.88
HOME CARE PROGRAM	191,483	$22,541,622.70
CASE MANAGEMENT SERVICES	67,403	$16,531,207.76
PHYSICIAN SERVICES	673,856	$14,287,862.95
HOME HEALTH AGENCY PROFESSIONAL SERVICES	115,044	$13,288,730.67
DAY CARE	87,170	$11,552,638.01
LONG TERM HOME HEALTH CARE	111,751	$11,517,550.46
SUPPORTIVE HEALTH SERVICES	83,434	$8,633,390.09
INVALID COACH	83,437	$7,806,441.43
HOSPICE	2,649	$7,058,056.84
MEDICAL APPLIANCE, EQUIPMENT, SUPPLY DEALER	101,455	$6,201,349.00
HOSPITAL REGISTRY LPN	24,207	$5,846,138.24
DENTAL SERVICES	64,067	$5,187,318.38
CHILD CARE AGENCIES-MEDICAL PER DIEM	3,751	$3,509,889.45
HHA/MED/SRG SUP&DUR MED EQP (HHA CONTRS SVCS-VNDR SBMTS BILL	16,545	$3,432,643.06
ASSISTED LIVING PROGRAM (ALP).	39,651	$3,146,487.64
LPN	10,563	$2,341,498.94
ORDERED AMBULATORY OTHER THAN LABS	15,035	$2,140,503.21
TAXI	51,043	$1,860,313.65
RN	7,249	$1,749,006.06
NURSING REGISTRY RN	6,612	$1,648,729.26
AMBULANCE - EMERGENCY	28,676	$1,410,663.11
CLINICAL PSYCHOLOGY SERVICES	25,779	$1,111,707.57
TRANS DAY TREATMENT	27,545	$922,681.33
ORDERED AMBULATORY (OTHER THAN LABS)	11,023	$912,619.29
PHARMACY MEDICAL SUPPLIES, EQUIPMENT AND APPLIANCES	14,345	$525,193.59
RESIDENTIAL TREATMENT FACILITY	77	$464,562.03
LABORATORY (FREE-STANDING)	37,203	$423,280.34
DEFAULT CATEGORY OF SERVICE (PROFESSIONAL CMS MEDICARE CROSSOVER)	19,891	$400,056.02
LABORATORY (HOS-BASED) ORDERED AMBULATORY	17,252	$208,353.30
PODIATRY SERVICES	36,108	$188,399.35
BRIDGES TO HEALTH WAIVER	324	$185,393.36
AUDIOLOGIST/HEARING AID DEALER	4,685	$172,535.77
NURSE PRACTITIONER	10,331	$130,556.99
PHARMACY	565	$117,994.33
OPTOMETRIST (SELF EMPLOYED)	6,361	$113,292.82
MENTAL RETARDATION, OUTPATIENT SERVICES	637	$112,942.94
OPTICAL ESTABLISHMENT WITH SALARIED OPTOMETRIST	4,624	$93,860.53
EYEGLASS MATERIALS-UPSTATE	8,796	$92,978.00
PERSONAL EMERGENCY RESPONSE SERVICES (PERS).	3,841	$76,444.25
PHYSICAL THERAPIST	8,005	$69,400.96

2010 Nassau County Medicaid Claims and Dollar Amount by Category of Service

(Source: eMedNY database: Dollar amounts are based on date of payment; DSS Medicaid Unit)

Category of Service	Claims	$ Amount
HEARING AID DISPENSER	649	$27,020.96
OCCUPATIONAL THERAPIST	1,290	$10,061.46
CLINICAL SOCIAL WORKER SERVICES	465	$9,931.57
CHIROPRACTIC SERVICES	2,860	$5,478.44
OPTICIAN (OPHTHALMIC DISPENSER) SELF- EMPLOYED	355	$4,754.54
PHYSICIAN GROUP	614	$4,631.14
EYE PROSTHESIS FITTER	31	$3,874.67
SPEECH PATHOLOGIST	109	$2,661.22
SVE; MIDWIFE	15	$2,357.34
THERAPY GROUP SERVICES	190	$1,419.90
OPTICAL ESTABLISHMENT WITHOUT SALARIED OPTOMETRIST	75	$936.09
AN OPTICAL ESTABLISHMENT OWNED BY AN OPTOMETRIST(S) OR AN OP	43	$566.79
MULTI TYPE GROUP SERVICES	56	$296.25
OXYGEN AND RELATED EQUIPMENT DEALER	11	$253.02
AUDIOLOGIST	20	$150.72
PODIATRIST GROUP	15	$34.18
CLINIC PHARMACY	4	$29.70
LABORATORY ORDERED AMBULATORY	4	$13.64
DENTAL GROUP	1	$3.86

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January 3, 2013

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Dear Ms. Watson:

Enclosed are the Department of Social Services' comments on the Office of the Comptroller's draft Limited Review of the Nassau County Department of Social Services Medicaid Administration Unit.

Thank you for the opportunity to comment.

Sincerely yours,

John E. Imhof, PhD
Commissioner

cc: Paul Broderick
Mary Brosnan
Janet McShea
Marjorie Krohn
Brendan Roche
Douglas Russell
Rudolf Carmenaty
Carl Dehaney
Karen Garber

General remarks/corrections

The Nassau County Comptroller's review was for the calendar years 2010 and 2011.

The New York State Office of State Comptroller audit cited in the report issued in April 2012 is for the period of **May 2007 – May 2010**. The policies, procedures, application forms and tools for processing Medicaid applications at that time were essentially different than those for the period of the Nassau County Comptroller's audit

The audit's Summary of Significant Findings states "In 2010, the Medicaid Unit made Medicaid eligibility "determinations" for 23,183. In the Background section (p.1) the report states "In 2010, the Medicaid Unit "opened" 23,183 cases". According to New York State Department of Health figures, there were 48,008 determinations made in Nassau during 2010.

Auditor's Follow-up:

The number of Medicaid determinations of 23,183[9] was obtained from a file provided by the Department of Social Services listing Medicaid cases opened in 2010 with the dates that determinations were made. It does not include determinations of cases that were not opened.

Audit Finding (1)

Thirteen Out of State Medicaid Recipients Were Still Receiving Benefits

The Medicaid Program has a highly effective process in place for recovering any and all "overpayments" in the Medicaid program. Of the 93,807 active cases, thirteen cases (.014%) received medical benefits after moving out-of-state. The Department has already recovered $8,766.90 of the stated $29,315.

The Nassau Medicaid unit uses the Public Assistance Reporting Information System ("PARIS") to identify the out-of-state cases. The finding states that the PARIS system identified *"some"* of these cases as out-of-state. The findings do not state how many of the 13 cases and, if Nassau had knowledge of those cases.

The existing Medicaid policies and procedures have consistently and successfully minimized overpayments. The Medicaid program continues to aggressively pursue reimbursement for expenses associated with individuals who relocate or who are otherwise not qualified for the Medicaid program.

[9] Medicaid case type 20 only; does not include SSI cases which are automatically eligible, or FHP which has different criteria.

Auditor's Follow-up:

Control systems need to be improved to ensure the more timely identification of clients that move out of state, so that reimbursement of their Medicaid Managed Care premiums can be obtained. At the time of our audit fieldwork, the Medicaid Unit had not yet obtained any reimbursements from the 13 cases identified during the audit. We reiterate our recommendation that the Medicaid Unit should file disenrollment forms and obtain refunds due from insurance carriers for the remaining balance of unrecovered funds

Audit Finding (2)

The Medicaid Unit Met State Standards with Regard to Income Documentation

Agreed.

Audit Finding (3)

The Medicaid Unit Did Not Make Eligibility Determinations in about 11% of Cases within the Required 45 Day State Limit

Not all Medicaid applications have a 45-day time requirement. Depending on the case "type" the processing can be 30, 45 or 90 days. The New York State Department of Health does not track the different "types" of applications. Therefore, it is impossible to track the accurate due date on each and every Medicaid application. There are also several exceptions to the "State limits" for processing times:

NYS DOH requires that the Department provide the applicant with extended time, in some instances beyond the processing due date, to better serve the applicant, but therefore automatically resulting in an unavoidable extended application completion time which is charged to the Department and excludes the justification(s) for the delay(s)

If an applicant has participated in the Fair Hearing process the result may be a "re-opening" of the case at the time of the Fair Hearing decision thereby automatically inflating the "number of days to process" the application with once again the delayed application processing time being charged to the Department

An applicant who has submitted and been denied a Temporary Assistance (TA) case is automatically considered a Medicaid applicant. However, the application for Medicaid may already be beyond the 45 days when the application is received to be processed as an MA application. The NYS DOH has advised that in those instances, the Medicaid application should

be processed as soon as possible after the TA denial. (General Information Message No. 12MA021entitled "Time Periods for Determining Medicaid Eligibility for Applicants Denied Temporary Assistance")

The Audit Findings state the timeliness of the application processing though it does not specify the "type of case" and whether the 11% of the cases made after 45 days were considered timely due to the case type (chronic care, disability, long term care) or the above exceptions. Therefore, the finding assumes that all the applications were not processed timely, when the applications could have been within the required processing time period had there not been some of the exceptions noted above. The scope of the audit did not seek further clarification as to the specific reasons for any application delays.

In order to better track the timing of the different application types, in mid 2012, Nassau County developed a proprietary tracking system to better track the application "type" and due date.

Auditor's Follow-up:

We reiterate our recommendation that the Medicaid Unit make every effort to ensure that eligibility is determined within the proper time limits based on the type of case. In the case of those exceeding the 45 or 90 day limits, the Medicaid Unit should determine how many of these cases do not meet the requirements for the allowable exceptions to the time limits.

We concur with the Medicaid Unit's development of a proprietary tracking system to better track the application type and due date.

Audit Finding (4)

The Department of Social Services ("DSS") Paid Managed Care Premiums for Medicare Eligible Recipients

The NYS Comptroller June 2007 – May 2010 audit, "Unnecessary Managed Care Payments for Medicaid Recipients with Medicare" does not include any reference to a finding "*that over a three-year period ending May 31, 2010, Nassau County's DSS would have saved $959,306 by paying the recipients' coinsurance and deductible amounts rather than having paid their Managed Care premiums*."

The NYS audit also states that "*The unnecessary Medicaid managed care premiums occurred because of delays in posting recipients' Medicare Data to eMedNY (Medicaid's automated claims processing and payment system) and because recipients were not disenrolled timely from managed care plans once their Medicare data was posted to eMedNY.*

Nassau County staff cannot directly post the recipients Medicare Date to eMedNY. As for the delay in timely disenrolling clients, The New York State Department of Health issues a monthly "Report of Dually Eligible Recipient's enrolled in Mainstream Managed Care". It is Medicaid's practice and procedure to immediately review and cancel any recipient's enrollment from the Managed Care Plan. The Medicaid program can only review and take action on the information on the report. In the cases cited, the recipients were not on the report. As a result, any figurative cost avoidance figure should be assigned to the New York State Department of Health and NOT to the Department of Social Services.

Also, the policies, procedures and application forms during the time frame of the NYS audit, 2010 – 2011, are essentially different than those during the May 2007 – May 2010 audit.

The 2007 – 2010 NYS Comptroller's audit report also states that "*The enhancements implemented in **September 2011** have eliminated the previous delays in posting the Medicare eligibility data received from CMS, and have improved the overall integrity of the Medicare data maintained in eMedNY.*

The Department will continue to immediately remove any recipients listed on the NYS Department of Health "Report of Dually Eligible Recipient's enrolled in Mainstream Managed Care".

Auditor's Follow-up:

The amount of $959,306 of "unnecessary managed care payments for Medicaid recipients with Medicare" was obtained directly from officials at the New York State Office of the State Comptroller. It is the responsibility of the local Medicaid Units to dis-enroll Medicare eligible recipients from managed care plans. The $959,306 represents managed care premiums that were paid because disenrollment was not performed timely.

Audit Finding (5)

The DOH Made Inappropriate Medicaid Payments for Recipients with Multiple Identification Numbers

The finding states that "*Local social service personnel were often not aware of online tools in WMS that can be used.*" It is not clear if this is a Nassau County issue or statewide? Nassau cannot identify any additional tools that staff is not aware of.

The finding states that "*DOH overpaid approximately $17.3 million in Medicaid in New York State because 9,848 recipients were enrolled into Medicaid with multiple identification*

numbers". The audit further explains that "*402 recipients of the 9,848 received their multiple identification numbers from the 58 counties outside of New York City*".

As stated in the audit findings, local social service personnel does not have access to a comprehensive centralized system to avoid duplicate recipient identification numbers.

As example, when a recipient moves to any of the New York City boroughs, and does not advise Nassau of the move, he or she will be entered into a proprietary NYC system for Medicaid. That system assigns the recipient a set of Client Identification Numbers different from those used by the NYS DOH.

NYS DOH has already taken a number of steps since 2011, to reduce the potential of duplicate CINS, including but not limited to modifying the "Access NY" application.

Also, the NYS DOH has taken measures through their Enrollment Broker, Maximus, to prevent the registration of new clients without screening for an existing NYS DOH Client Identification Number.

The Department has continually partnered with the NYS Office of Medicaid Inspector General to recover any overpayments made to Medicaid Managed Care Plans when more than one Managed Care Premium payment has been made to the same plan.

Auditor's Follow-up:

We concur with the steps taken to prevent inappropriate Medicaid payments for recipients with multiple identification numbers.