

**Office of the Comptroller
Field Audit Bureau**



**Nassau County Department of Social Services
Medical Assistance (Medicaid) Unit**

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NASSAU COUNTY
OFFICE OF THE COMPTROLLER

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* We gratefully acknowledge the contribution of Michael S. Kornfeld, former Communications Director, to this audit.

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Background

Medicaid began in 1965¹ as a jointly funded program of the federal and state governments to provide medical services for eligible needy individuals and families.² The U.S. Department of Health and Human Services' Centers for Medicare and Medicaid Services administers the Medicaid program in cooperation with state governments. Although there are broad national guidelines, each state establishes its own eligibility rules and payment rates for providers.

Medicaid in New York State is administered by the New York State Department of Health (DOH) and is governed by the state Social Services Law, New York State Code of Rules and Regulations (NYCRR Title 18) and various DOH policy directives.³ The Nassau County Department of Social Services (DSS) processes Medicaid applications under the state guidelines.

DSS administers the county's mandated functions as a social service district.⁴ DSS processes Medicaid applications to assess applicant eligibility and monitors changes in eligibility status. It also monitors the county's allocated Medicaid-costs and disbursement of funds to the state. During May 2002, DSS Medicaid cases numbered approximately 45,500.

New York is one of 20 states that require local governments to participate in funding Medicaid. New York's required local government Medicaid contribution level is much higher than that required by other states. The U.S. Advisory Commission on Intergovernmental Relations noted that New York State's counties contribute 85 percent of the total local contributions nationwide.

Federal funding to New York State is at 50 percent (the same as ten other states). However, federal funding can be as high as 76.6% for Mississippi and 75 percent for West Virginia.

Medicaid costs in New York are primarily paid according to the following formula: 50 percent federal contribution, 25 percent New York State, and 25 percent local (county) share. There are exceptions for long-term and nursing home care for which the state pays 40 percent of the costs and the counties contribute 10 percent, as well as for federal non-participating programs, for which the state and the counties each incur 50 percent of the costs.⁵ Nassau County's average funding-share is about 18 percent of overall Medicaid costs.

Nassau County's Medicaid expenditures are significant and constitute the single largest mandated cost-component of the county's budget. The last four years' actual costs are

¹ Social Security Act of 1965, Public Law. No. 87-97, 79 Stat. 343 (1965). (codified as amended at 42 U.S.C. §§1396 et. Seq. (2002)).

² Congress appropriates Medicaid funding "(f) or the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care.... The sums made available ...shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for medical assistance." Id.

³ Social Service Law §§363 et. seq. (McKinney 2002)

⁴ N.Y. Social Service Law §365 (McKinney 2002).

⁵ New York State covers certain undocumented aliens who are not covered under federal Medicaid. For these expenditures, the state requires Nassau and other counties to pay 50 percent of the costs.

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summarized below:

	1999	2000	2001	2002
Gross Payments	\$921,082,611	\$953,535,902	\$1,004,669,667	\$1,095,872,318
State/Federal Funding	\$752,067,576	\$778,683,796	\$820,338,013	\$874,891,978
County's Share	\$169,015,035	\$174,852,106	\$184,331,654	\$220,980,340*

*Does not include New York State Indigent Care adjustment estimated to be \$19 million

In addition, county administrative costs were \$10.3 million in 2000 and \$11 million in 2001 (see Attachment A and B for Medicaid cost by category and funding source). For 2002, Nassau County's share of \$221 million represents a 31 percent increase over 1999's cost of \$169 million.

According to the New York State Association of Counties (NYSAC), Medicaid has become the largest single appropriation in every county budget. NYSAC has calculated that municipalities' contributions will be in excess of \$4 billion, larger than the total Medicaid program in 30 individual states.

Medicaid costs, more than any other mandated expenditures, are driven by factors beyond local control. While the state directs and administers the program, the counties' function is eligibility processing.

Objectives, Scope and Methodology

The audit objectives were to examine the various functions performed by the DSS Medicaid unit during 2000-2002 and to determine whether DSS operations adhere to New York State regulations. Auditors reviewed eligibility processing procedures -- including income verification, case management, spend-downs, managed care, spousal refusal, re-certification issues, payment of COBRA premiums, the fair-hearing process, estate recoveries, federal non-participating issues and the eligibility-determination time -- and examined a sample case file. In addition, the auditors distributed a questionnaire to the caseworkers /seeking their concerns, daily problems encountered and recommendations for improvement. The departmental structure of the DSS Medicaid unit and management controls within the unit were reviewed to identify areas of weakness and where potential cost savings could be achieved through more efficient and effective operations. The audit concluded, however, that many important cost-control measures require state initiatives.

This audit was conducted in accordance with generally accepted government auditing standards. These standards require that the audit be planned and performed to obtain reasonable assurance that the audited information is free of material misstatements. An audit includes examining documents and other available evidence that would substantiate the accuracy of the information tested, including all relevant records and contracts. It includes testing for compliance with applicable laws and regulations, and any other auditing procedures necessary to complete the examination. We believe that the audit provides a reasonable basis for the audit findings and

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recommendations.

Major Findings and Recommendations

DSS determines financial eligibility through the use of a Resource File Integration System (RFI), which is part of the state's computerized welfare management systems. The state's RFI is inadequate for determining compliance with federal income-eligibility levels. While federal and state guidelines require that "all income and its availability be verified and documented," RFI checks W-2 income and unemployment-insurance benefits from New York State only and does not contain any information on income reported on federal 1099 tax forms. The income information in the RFI is often outdated.

In 2001, New York State made \$1 billion in Medicaid vendor-payments on behalf of Nassau County (vendors paid include managed care companies, hospitals, physicians, pharmacies and other providers). The county does not review these payments. The federal government's General Accounting Office estimates that as much as 10% of all healthcare expenditures in the United States are lost each year due to fraud and abuse. The state comptroller's office has performed numerous Medicaid audits of the state's Department of Health. These audits indicate a number of weaknesses in the administration of the Medicaid program.⁵ In view of the inadequacies identified by GAO and OSC, we recommend that the county acquire or develop a system for payment oversight.

Currently, DSS receives more than 2,000 Medicaid applications a month. In addition, DSS must re-certify the total caseload each year. During May 2002, DSS had approximately 45,500 active Medicaid cases representing approximately 57,200 individual recipients. As of June 2002, the administrator of the Nassau County Medicaid Unit reported average caseloads for Community Medicaid of 958 cases and 166 new cases pending per worker; for long-term care, there were 1,028 cases and 69 new certification cases pending per worker. Responses to a questionnaire distributed by the comptroller's office to Medicaid unit workers indicate that individual caseloads may be higher than the official estimates listed above. Excessive caseloads and the resultant lack of investigative time increase the risk of ineligible applicants being approved. Moreover, the failure to thoroughly review new information may result in ineligible recipients retaining their eligibility status. Long-term cases -- which require significant paperwork and research -- may be particularly impacted.

State guidelines require that case documentation be sufficient to establish an audit trail and support the application. They also require that an auditor reviewing the eligibility determination be able to obtain the documents upon which the decision was based. A test examination of case documentation performed by the auditors found several instances of lack of compliance -- including a lack of documentation concerning income, residency, medical receipts and health insurance coverage.

The audit revealed that caseworkers use weak standards for determining whether an applicant is a resident of Nassau County (detailed in this report under eligibility processing - residency). This situation could be alleviated if DSS required more complete residency information, as is the case

⁵ State Comptroller reports discussed in the Vendor Payment Review section of this report.

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in neighboring Suffolk County.

Under certain conditions, Medicaid allows for the payment of a claimant's existing medical premiums where it may be cost effective to do so. We examined five Medicaid COBRA⁶ cases for compliance with state directives. None of the cases tested contained Health Insurance Cost Appraisal Program (HICAP) reports, which are state computer-generated recommendations as to whether it is cost effective to make COBRA payments in lieu of Medicaid payments. When the auditors requested five state HICAP reports, three out of five recommended that DSS not pay the premiums. Yet DSS continues to pay the premiums for all five. If the claimants were enrolled in a managed-care plan providing services to Medicaid recipients during the 18-month period for which DSS made COBRA payments, the cost would have been \$39,188 less for the three recipients. One case examined had no caseworker notes in the file since 1994, yet DSS has continued to pay the HMO premiums for this claimant. In two cases examined, the input-authorization screens had errors in effective coverage dates; both cases were erroneously given a 48-year authorization (period of coverage).

DSS is required to offer individuals with excess income the opportunity to reduce it by either: (1) paying the amount by which their income exceeds the medically needy income-level ("pay-in"); (2) submitting incurred expenses to DSS ("spend-down"); or (3) a combination of both. A review of the procedures in place at the department revealed several weaknesses in spend-down and pay-in oversight functions. For example, caseworkers can and do receive cash payments. It is a severe control weakness to have the same person authorizing coverage and receiving cash. Caseworkers authorize Medicaid coverage based on spend-downs or pay-ins for which there is no audit-trail documentation. In addition, DSS processes pay-in refunds based on caseworker notations without documentation.

In an effort to control and manage costs, New York State and Nassau County obtained a federal waiver to enroll Medicaid participants in managed-care plans. However, New York State has guaranteed managed-care companies a six-month premium per participant. Lack of coordination between New York Medicaid CHOICE (the contractor for the managed-care program) and the county regarding the re-certification process can result in Medicaid recipients being prematurely assigned to a managed-care program prior to the completion of re-certification. This has greatly increased the risk of unnecessary premium payments being made to managed-care providers (i.e., six-month premiums being paid on behalf of individuals who do not qualify and will never use the insurance). In addition, DSS cannot regularly check whether recipients are incarcerated.

New York State Social Services Law section 366.3(a) allows for spouses to financially disassociate themselves and refuse to support the other spouse; this is commonly referred to as "Spousal Refusal." The social service district may then attempt recovery from the community spouse. An audit by the New York State Office of Temporary and Disability Assistance⁷ criticized the performance of Nassau County DSS in identifying and pursuing the recovery of excess resources in these cases. The state estimated that this resulted in a potential loss in excess of \$3 million. More than 400 cases were referred to the DSS legal department from the Medicaid unit in a 26-month period, and only 20 letters were sent as a first step in the legal proceedings. With a possible recovery of several million dollars, there is an urgent need for expediting the

⁶ Consolidated Omnibus Budget Reconciliation Act of 1985

⁷ Nassau County DSS Medicaid Chronic Care Excess Resources Spousal Refusal Review, March 1999

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legal process and hiring additional attorneys.

Medicaid clients challenging DSS decisions can have a fair hearing conducted by an administrative law judge. Nassau County currently funds several outside legal organizations to represent clients at fair hearings. However, DSS is represented by a caseworker-supervisor at the fair hearings. We recommend that appropriate legal staff be assigned.

The resource and recovery unit is supposed to maximize DSS revenue by establishing claims against recipient assets. The unit performs these functions by investigative and legal proceedings; however, this unit does not have access to the computerized records maintained by the county clerk or the surrogate's court, which greatly delays the process.

Many asset-recovery checks received by DSS are not deposited by the accounts section on a timely basis. One recent check for \$92,622.17 took 28 days to be deposited.

The New York Code of Rules & Regulations (NYCRR) Title 18 section 360-2.4 (a) requires a Social Service District to determine an applicant's Medicaid eligibility within 45 days of the date of his/her application. Nassau County is currently making these determinations in about 70 days. As a result of this serious violation, clients may not be able to access necessary health care services. The Department must assign adequate resources to expedite processing.

When reviewing the organizational structure of the Medicaid unit, we noted that many employees' responsibility centers were incorrectly listed in the county computer systems (NUHRS and NIFS). Titles and job descriptions used in Medicaid have not been updated in more than 20 years. In addition, the organizational charts do not accurately reflect current functional lines of authority -- particularly in the Medicaid area. We recommend that the department prepare corrected organizational charts with more logical and efficient lines of authority.

The DSS Medicaid unit is understaffed. Caseloads are excessive and do not permit proper case management; the legal unit is understaffed; workers operate with inadequate technology to process eligibility; and accounting systems, check lists and forms are outdated.

DSS receives federal and/or state reimbursement of up to 75% of the salaries and benefits of most DSS positions. Therefore, the lack of trained staff saves only a few thousand dollars per employee. Yet inadequate staffing adds to operational inefficiencies and may be resulting in significant losses to the county.

The auditors distributed a Medicaid Caseworker Questionnaire to obtain employee perspectives of the problems encountered daily and of steps that could be taken to provide more efficient and effective Medicaid services to county residents. Many suggestions and comments were received. Understaffing was cited as the most serious problem facing the Medicaid unit. Caseworkers reported that their caseloads exceed 1,000 each. Client folders for the 47,000 active cases are stored in the record room. It can take weeks for caseworkers to receive a requested folder. Lack of office equipment was cited, as well as workers' need for individual -- rather than shared -- access to the state's Welfare Management System (WMS) terminals. Due to a lack of computers, workers must manually prepare correspondence to attorneys, clients, banks, etc. and log client

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information. Photocopying machines are few in number, often out of service, old and slow. Preprinted notices and forms sent to clients are outdated, triggering additional telephone calls and extra work for the caseworkers.

Although the county will need the state's cooperation in adopting new policies and procedures to address many control weaknesses mentioned in this report, it is imperative that operational efficiencies be addressed, the application process be streamlined, and complicated procedures be computerized. Federal and state databases should be accessed before requiring applicants to submit burdensome documentation.

Department Executive Summary Response

The Medicaid program is administered on the federal level by the U.S. Department of Health and Human Services' Centers for Medicare and Medicaid Services, and on the state level by the New York State Department of Health. The role of the local Department of Social Services is determination of eligibility under state guidelines. As such, Medicaid costs are dictated predominantly by factors beyond the control of the local Department of Social Services.

The findings and recommendations in the draft report fall into two main categories: those issues requiring a policy change on the state or federal level, and issues under the purview of Nassau County. We have grouped the findings and recommendations together as our comments regarding corrective action to be taken and responsibility for effectuating change are similar.

Issues Related to State and Federal Policy and Procedures

The findings that relate to State and Federal requirements often relate to issues of documenting eligibility. The State has, on several occasions, indicated that the Department should not implement eligibility requirements that create an unnecessary burden on the client. In fact, the State conducted a training attended by Nassau County Department of Social Services eligibility staff in May 2002 on just this issue. The training was called "Lighten Up", and focused on the need to avoid excessive over-documentation and only require the minimum necessary documentation. Specific to the residency issue, a State administrative directive (93 ADM-29) indicates that statements from an individual with knowledge of the applicant confirming the applicant resides in the county are sufficient documentation of residency. This directive also states that excessive documentation should be avoided.

Findings related to identifying cost-effectiveness of maintaining private health insurance are also related to State/Federal policy. At the State level for many of these clients, there is not a cost-effectiveness requirement for eligibility. The Department will pilot the Health Insurance Cost Appraisal (HICAP) Report to identify whether it should be implemented on an ongoing basis. Regarding the issue of "premature enrollment" in managed care, Federal and State requirements are clear that there be a 6 month guaranteed period of eligibility. The State's computer system will not permit the enrollment of an individual into managed care unless they have at least 6 months of eligibility.

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The Comptrollers report details the antiquated Welfare Management System. Certainly, this tool is outdated and could be more useful in determining eligibility. The State should update this system to make it more useful. The Department has volunteered to be a pilot site for the State in their development of an electronic eligibility system.

Local Issues under the purview of the Department of Social Services

Several of the findings reflect the need for increased staff of the Department. Specific recommendations are made to increase the number of welfare examiners and legal staff. To some extent these issues will be ameliorated by the addition of 25 temporary clerical staff (many of whom will be assigned to Medicaid), 24 new welfare examiners (14 of whom are in training through June, 2003) and 3 new attorneys.

There are several other initiatives that the Department is implementing to bring caseloads down. These are procedural in nature and include: use of a simplified state-provided application form for community cases, receipt of a waiver from New York State Department of Health to eliminate face-to-face interviews for re-certification, entering into agreements with area hospitals to outstation welfare examiners to process cases at no cost to the County, deputizing provider staff at skilled nursing facilities to take Medicaid applications and conduct face-to-face interviews for nursing home cases, and directed overtime projects towards Medicaid programs at greatest risk. Additionally, to improve process the Department is forming a dedicated unit to process and maintain spend-down.

In a related vein, several findings relate to technology and data access. The Department is taking several proactive steps to improve these issues: the Department is exploring the cost effectiveness of placing a PC on each workers desk, staff have been trained to use the State's new Medicaid Data Warehouse, the County office of Printing and Graphics has implemented a schedule for the replacement and upgrading of photocopiers in the Department over a three-year period. The Department will be submitting a request to the County Clerk and Surrogate's court to allow computerized access to public records required by workers to assist in eligibility determinations.

DSS Conclusion

Since the time of the audit, we believe that we have already addressed many of these findings that have been identified in the audit to a considerable degree. The two items that remain partially open (1 and 13) are outside the jurisdiction of the County to change. In both cases, they are ongoing systemic issues that we are working with the State to resolve. Several proactive initiatives have been implemented, including the restructuring of staffing patterns, and utilizing technology to make improvements to the system.

Auditor's Comment on Department's Executive Summary Response

We note that the department has acted on many of our recommendations. With regard to the residency issue, the above citation from the 93-ADM-29 that the department used to justify the lack of proper residency verification applies only in certain cases (specifically, estranged teenagers and homeless individuals).

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A cost benefit determination for health insurance should have been in place since 1984 as directed by 84ADM-19. HICAP should be considered an indispensable tool and its utilization maximized.

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Introduction

Background

Title XIX of the Social Security Act, enacted in 1965, establishes a program in conjunction with the states to provide medical care for individuals and families with low income and resources. The U.S. Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS), administers the Medicaid program in cooperation with state governments. It is jointly financed by the federal and state governments and administered by the states. Within federally established guidelines, each state:

- determines how the program is administered;
- establishes eligibility rules;
- determines the type, amount, and duration of benefits; and
- sets payment rates for service providers.

The Medicaid program varies considerably from state to state. Federal law does not require local governments to contribute to Medicaid funding; in most states, the state government assumes all responsibility for the non-federal share. According to HHS, New York and 19 other states require local governments to share in financing. According to HHS' data, there are many formulas for the local match. New York mandates that local governments reimburse the state weekly for their share of Medicaid costs in their counties.

Funding from the federal government is called Federal Medicaid Assistance Percentage (FMAP) and varies from state to state, with the lowest FMAP being 50%. The highest is 76.62% for Mississippi; West Virginia is at 75%. Ten other states have the lowest at 50%. New York State's FMAP is 50%, to which the state and counties both contribute 25%. There are some exceptions: notably, for long-term care and nursing homes, the state pays 40% and the counties 10%; for undocumented aliens whom the federal government does not cover, New York and the counties share costs equally at 50%; and for some medical personnel costs, the county pays 12.5%.

According to the New York State Association of Counties (NYSAC), "no other state burdens its localities as much as New York State." NYSAC reports that localities in New York State will pay \$4 billion as their share of Medicaid costs in 2002. This amount is larger than the total Medicaid costs incurred in 30 other states. In a July 1994 report on local government responsibilities in health care, a federal advisory commission on intergovernmental relations noted that New York State's counties contribute 85% of the total local contributions nationwide.

According to the New York State Citizens Budget Commission, Medicaid expenditures in New York are double the national average and almost double those in California. This spending by New York is not due to serving proportionately more people. When comparisons as a percentage of the rest of the country are made, New York's state and local expenditures for Medicaid are 241% of the national average, while the number of beneficiaries is only 20% higher and New York's share of the poverty population is only 12% above the national average. New York's expenditures are higher because of a more extensive benefit package (i.e., coverage of dental, optometry, transportation expenses), greater use of covered services (i.e., more physician or

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hospital visits) and higher rates paid per unit of service.⁸

The New York State legislature enacted the Health Care Reform Act of 2000⁹ as amended¹⁰, which includes many new programs (such as Family Health Plus) and reduces eligibility requirements. This will substantially increase the county's future funding requirements. NYSAC estimates this increase alone to be \$16.9 million for Nassau County for the three-year period 2001-2003.

Providing medical care funding for Nassau County residents who are otherwise unable to pay is of critical importance. The Medicaid program, however, must become more cost-effective and oversight must be improved to ensure the best use of taxpayers' dollars.

Objectives of Audit

Our objectives in performing this audit were to examine the various functions performed by the DSS Medicaid unit, determine whether DSS operations adhere to state regulations, and identify areas of weakness and in which cost savings can be achieved through more efficient and effective operations.

Scope & Methodology

The Medicaid program in New York State operates under the auspices of the state's Department of Health (DOH) and is subject to various policy directives initiated by the department. While state policies govern Medicaid, the Nassau County Department of Social Services (DSS) processes Medicaid applications and wire transfers the county's share of the Medicaid funding to the state each week. New York State has retained an outside contractor, Computer Sciences Corporation, to process vendor payments. DSS is responsible for administering the county's mandated functions as a social service district. DSS processes Medicaid applications, assesses applicant eligibility and monitors changes in eligibility status. It also monitors the county's allocated costs and disburses funds to the state. As previously noted, during of May 2002, there were some 45,500 active Medicaid cases representing approximately 57,200 individuals. Nassau County's expenditures are significant and are the single largest mandated cost in its budget. The county's share of Medicaid costs totaled \$359 million during 2000-2001.

We examined eligibility processing, income verification, case management, spend-downs, managed care, spousal refusal, re-certification issues, payment of COBRA premiums, the fair hearing process, estate recoveries, federal non-participating issues and medical assistance determination time. Case files were tested during the reviews of eligibility processing and case management. The departmental structure and management controls of the DSS Medicaid unit

⁸ "Budget 2000 Project Social Welfare Spending", New York State Citizens Budget Commission, 2000

⁹ New York State Health Care Reform Act 2000

¹⁰ Amendment to New York State Health Care Reform Act 2000 A.9610/S.6084

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were reviewed. In addition, we distributed a questionnaire to caseworkers eliciting their concerns, daily problems encountered and recommendations for improvements.

Findings and Recommendations

Eligibility Processing

Background

Pursuant to New York State Medicaid eligibility guidelines and procedures, which are explained to county DSS welfare examiners during required two-week training sessions in Albany, examiners meet with clients, review their completed State Medicaid applications, along with required supporting documentation, and determine their Medicaid eligibility.

The New York State Medicaid Reference Guide requires that the documentation be sufficient to establish an audit trail and support the application. Consequently, an auditor reviewing the eligibility determination should be able to obtain the documents upon which the decision was based. The auditors performed a test examination of case documentation and found several control weaknesses and inconsistencies.

Financial Eligibility (Income Verification)

Medicaid is a federal program for low-income persons in need of health and medical care, and applicant eligibility is based primarily on income and other resources.

Audit Finding (1):

The Medicaid Reference Guide requires that “All income and its availability [be]...verified and documented in the case record. When information cannot be verified, the attempts to verify are documented.” Nassau County primarily performs income verifications through the use of a state Resource File Integration (RFI) financial eligibility system, which is part of the state’s computerized welfare management systems. The state system is limited in its ability to properly verify income, and DSS is aware of these limitations.

The RFI system income check is inadequate because:

- The state system can only check employment income and unemployment compensation information from New York State. Therefore, a client could be working or receiving unemployment compensation in another state and be determined to be eligible for Medicaid in New York.
- IRS Form 1099 information is not available for state income-eligibility verifications.
- Income information is from the prior quarter and may be up to five-months old.

In addition, pursuant to a recent Medicaid-related amendment to the New York Health Care Reform Act of 2000, the state no longer requires social security number

Findings and Recommendations

documentation in connection with applications. Therefore, if an applicant enters an erroneous social security number, income cannot be properly verified.

Recommendations:

The department should assure that caseworkers are in compliance with the Medicaid Reference Guide for income verifications. They cannot continue to rely on an inadequate income- verification system. DSS must find other methods to obtain necessary information and/or urge the state to upgrade its information-gathering systems. The department should also work with the state to pursue additional upgrades and modifications to ensure appropriate income verification, including the development of a computer program to assess eligibility.

Department's Response:

The State's administrative directive, 93ADM-29, requires that eligibility workers request verification from applicants for all income listed on the application. In addition, if a Resource File Integration (RFI) indicates income in the previous quarter, the applicant is required to clarify this. We do not rely solely on RFI, but rather consider the applicant as the primary source of documentation. In addition, the Department, as well as other local social service departments have informed the New York State Department of Health (NYSDOH) of the need to upgrade the Welfare Management System to interface with other automated systems to provide more current eligibility information (UIB, Tax and Finance, Worker's Compensation, etc.). Financial management of funds is also explored in the eligibility process. Clients that document expenses without income are denied if they fail to provide satisfactory documentation. The County has been seeking access to Federal and State data sources to improve our eligibility verification review. In spite of the County's concerted effort to obtain access, these data are often not available to the County. As an example, use and disclosure of the 1099 information has been severely restricted by IRS directive. In the past, the State provided this information to the County electronically. It is no longer available.

Auditor's Comment:

Because the inability to access 1099 data appears to be based on New York State's past failure to store IRS tapes securely, the County should try to obtain this data directly from the IRS or encourage the State to address the lack of security so that the IRS will resume the availability of the information.

The department should reiterate to its caseworkers the requirement to be in compliance with the state directives and that they should document the procedures in the files with respect to income verification.

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Vendor Payment Review

Audit Finding (2):

Vendor payments for the entire state are made through an agency under contract with the state, Computer Science Corporation (CSC). The state comptroller has the authority to review these payments, including those made on behalf of Nassau County. The state comptroller's office has performed numerous Medicaid audits and has made several significant findings. The state comptroller's website lists 28 audits relating to Medicaid system issues during the last two and one-half years. Some of the significant findings are summarized below:

- Three audit reports indicated the state used inadequate procedures that resulted in millions (\$33m, \$20.2m, \$12.9m) in Medicaid payments that should have been paid by Medicare or were paid by both Medicare and Medicaid.¹¹ (Medicare Part A is to be taken into account before any Medicaid is paid on behalf of an individual).
- A 1999 audit found that the computerized Medicaid Management Information System lacked controls to detect providers that bill for more than 24 hours in a day on behalf of the same Medicaid recipient. This report identified more than \$5.9 million in overpayments to private-duty nursing providers.¹²
- A report covering the year ended March 31, 2000 found that \$32 million may have been overpaid because third-party insurance coverage was not taken into account, claim forms were incorrectly completed by providers or the reimbursed treatment may not have been medically necessary.¹³
- Although the Medicaid-reimbursement rates for a hospital inpatient stay are to cover all associated costs, an audit found as much as \$16.9 million was paid to emergency rooms or clinics for a day that the patient was hospitalized.¹⁴
- A 1999 report found there was an inadequate control process for handling claims that were not processed through the computerized system. The report indicates that there were such weak controls for the accounting of these off-line payments that errors could occur without detection.¹⁵

¹¹ OSC Report 2000-F-10 Medicaid Claims Paid for Medicare Part A Eligible Recipients

OSC Report 99- F-53 Accuracy of Medicare information for Medicaid Recipients

OSC Report 2000-D-4 Medicaid Claims Paid in 1999 for Medicare Part A Eligible Recipients

¹² OSC Report 99-S-16 Private Duty Nursing Services for Medicaid Recipients

¹³ OSC Report 99-D-2 Medicaid Claims Processing Accuracy

¹⁴ OSC Report 2000-F-9 Medicaid Clinic and Emergency Room Claims Paid During a Recipients Hospital Stay

¹⁵ OSC Report 98-S-57 Medicaid Off-line Payments and Recoveries

Findings and Recommendations

- One audit in 2000 found between \$33 million and \$37.1 million was paid for duplicate reimbursement claims for school and pre-school supportive-health services, while there were other potential overpayments related to services that may have been provided more frequently than recommended.¹⁶
- An audit of NAMI deductions (a client's monthly contribution to the cost of nursing home care based on Net Available Monthly Income) found a variance between NAMI on claims filed and on the Welfare Management System provider files. The Medicaid Management Information System is unable to adjust claims affected by retroactive NAMI changes, and the nursing home providers also fail to adjust prior claims. Local districts use the Welfare Management System's Medicaid Budget and Eligibility (MABEL) subsystem to determine the recipients' NAMI once a year and then update the Welfare Management System's principal provider file with relevant information. There is no direct link between MABEL and the provider file.¹⁷
- A report issued in 1999 found that significant improvements were needed in Medicaid's accounts-receivable system. This report found that the main and supporting receivable records were not reconciled, unpaid accounts were too old to recover through legal action and records had not been updated when health-care providers changed ownership.¹⁸

The General Accounting Office estimates as much as 10 percent of all healthcare expenditures in the United States are lost each year due to fraud and abuse.

New York State currently requires Nassau and other New York counties (with some exceptions) to contribute a 25% share--an amount equal to the State's--of Medicaid costs. Although the state comptroller's audits document multi-million-dollar problems, and abuse is estimated at 10 percent, the county does not review vendor payments.

Recommendations:

The county executive's Multi-Year Financial Plan provides for a consultant to be hired to establish a county Medicaid payment-review system. An initial investment of approximately \$500,000 will be required, with the anticipation of a possible four-year recovery of \$17 million. Given the amount of monies that could be recovered, we recommend that this initiative be considered as quickly as possible

¹⁶ OSC Report 2000-S-1 Controlling Medicaid Payments for School and Preschool Supportive Health Services

¹⁷ OSC Report 99-S-49 NAMI Deductions from Nursing Home Medicaid Claims

¹⁸ OSC Report 99-S-34 Medicaid Accounts Receivable

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Department's Response:

New York State is the payment agent for Medicaid vendor payments made on behalf of Nassau County and all other counties. Data on these payments have not historically been available to Nassau County for review and analysis. A Request for Proposal (RFP) process was conducted, the County has selected a vendor to analyze data regarding Medicaid utilization that will now be provided by NYSDOH. The contract for this service has been approved and service will commence shortly. Nassau County is the first county to have access to the State Medicaid Data Warehouse, and DSS employees are currently undergoing a 3-day training to enhance our Medicaid cost savings initiative.

Auditor's Comment:

The two contracts the department has entered into will aid in Medicaid cost reduction in mainly third party liability areas but will not address vendor payment review.

With the recent accessibility to the State Medicaid Data Warehouse, the department can now initiate appropriate reviews to ensure propriety of the vendor payments.

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Case Management

Audit Finding (3):

Caseloads should be kept to manageable levels to help ensure that caseworkers give adequate care to each case and make proper eligibility determinations. Nassau County caseloads are excessive. As previously noted, the total caseload reported by DSS as of May 2, 2002, was approximately 45,500 active Medicaid cases representing 57,200 individuals. As of October 2002 (the last date available), statewide statistics showed Nassau County as having 71,549 total Medicaid-eligible residents.

The official statistics reported by the head of the Nassau County Medicaid unit listed average caseloads -- as of June 2002 -- as follows:

Community Medicaid

New certifications	166	cases pending per worker
Undercare	958	cases per worker

Long-term care

New certifications	69	cases pending per worker
Undercare	1028	cases per worker

We distributed a questionnaire to workers in the Medicaid unit seeking their comments on procedures, problems encountered and suggestions for improvement. The overriding concern expressed by caseworkers was the enormous caseloads. The individual numbers reported by the responding caseworkers indicated caseloads that are even higher than the official estimates previously listed.

Long-term care cases require a tremendous amount of work and documentation due to the three- year “look back” into bank accounts, pensions, life insurance, etc., for resource verification. Proper processing of these cases requires that time be devoted to each case. DSS receives more than 2,000 applications and opens more than 1,000 new cases a month, in addition to re-certifications.

Excessive caseloads increase the risk of ineligible applicants being approved due to the lack of investigative time per case. All income and resources should be investigated. In addition, due to excessive caseloads, re-certification at one-year intervals is the first attention most cases are given. The caseworkers should be monitoring and reviewing cases during the year. The state posts “flags” to the Welfare Management System on the case screen, which are only seen if action is taken on the case. A RFI “flag” indicates a change in the client’s financial status requiring further case investigation. If caseworkers do not open cases during the course of a year, they do not see important flags.

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In addition to having excessive caseloads, workers are not being provided with the requisite tools to do their jobs effectively. The state's Medicaid Reference Guide was designed for local social service districts. Its purpose is to assist districts in determining Medicaid eligibility for applicants/recipients. An extensive caseworker resource, it is arranged in four sections: categorical factors, income, resources and other eligibility factors. Every caseworker is supposed to, but does not, have a copy of the Medicaid Reference Guide. Ideally, it should be available online or on CD-ROM to allow for updates.

Additionally, caseworkers do not have access to personal computers. They handwrite external and internal correspondence.

Some caseworkers must share computer terminals that connect to the Welfare Management System. This access is essential to case management.

Recommendation:

The county should bring caseloads to acceptable risk-levels.

Caseworkers should be provided with the necessary tools to do their jobs. The Medicaid Reference Guide should be available to every caseworker.

All caseworkers should have access to the Welfare Management System and a personal computer.

Department's Response:

Since July 2002, the Department has hired 24 Welfare Examiners and additional part-time and temporary clerical staff for the Medicaid program. Of those, 14 are in training through June 2003. When the training period concludes in June 2003, these trainees will be prepared to assume full caseloads. It is anticipated that this additional staff will help bring caseloads to more manageable levels. The Department is evaluating the cost of providing a personal computer for all examiners in Medicaid. Computer software is in place that would permit a worker to access the Welfare Management System through a personal computer. The ability to obtain this additional hardware will better enable workers to perform their job duties.

There are several other initiatives that the Department is implementing to bring caseloads down. These are procedural in nature and include: use of a simplified state-provided application form for community cases, receipt of a waiver from New York State Department of Health to eliminate face-to-face interviews for re-certification, entering into agreements with area hospitals to outstation welfare examiners to process cases at no cost to the County, deputizing provider staff at skilled nursing facilities to take Medicaid applications and conduct face-to-face interviews for nursing home cases, and

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directed overtime projects towards Medicaid programs at greatest risk. . The Department is fully committed to bringing down processing times. In summary, the Department has taken several proactive measures to increase staff and improve workflow in order to reduce application processing time.

Auditor's Comment:

We concur with the corrective action taken by the department.

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Departmental Structure

Audit Finding (4):

We reviewed the Medicaid unit's organizational structure. Several issues need attention by DSS management.

The Medicaid responsibility center is listed in the Nassau Integrated Financial System (NIFS) and the Nassau Unified Human Resource System (NUHRS) as responsibility center 2400, Medical Assistance or the Medicaid Unit. Responsibility centers are organizational units of accountability for financial purposes and to delineate lines of management authority. We obtained a list of the employees on the county payroll who are cited as working for the Medicaid responsibility center 2400 and found the following inconsistencies:

- 18 employees listed do not work for the director in the Medicaid unit.
- Six employees who work in the Medicaid unit were, instead, listed as being employed in the legal, MMIS, food stamps, resources, public assistance and office services responsibility centers. This included the director's administrative assistant, who was listed under Systems Administration.

These apparently incorrect responsibility center listings could have major implications, including ineffective management control and possible omissions with regard to claiming salaries for federal and state funding. The DSS accounting executive states that he files for reimbursement using state job "function codes" and does not use the county NIFS (accounting) or NUHRS (payroll) system. DSS uses a WANG personnel system for reimbursement. Reconciliations are not performed to ensure the salary amounts claimed for reimbursement correspond with salaries paid because DSS cannot get NIFS reports.

The organizational charts submitted to the budget office during the last several years do not accurately reflect current functional lines of authority, particularly with respect to the Medicaid unit. The auditors obtained these charts and gave them to the Medicaid director so he could insert the appropriate supervisors in each subsection. He prepared a revised organizational chart reflecting accurate grouping, correct unit numbers and the supervisory head of each.

The supervisor handling resource and recoveries (filing of liens and estate recovery) for Medicaid is a welfare resources supervisor whose responsibility center is listed as the accounting section. Her supervisor is a Food Stamp supervisor (food stamps is a different responsibility center). In addition, DSS employs one full-time doctor and two part-time doctors who constitute the "Medical Review Team." They work to determine disability to increase the 'federal share of Medicaid'. These doctors are part of resource and recovery (accounting responsibility center) and report to a Social Welfare Examiner Supervisor I.

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We compared civil service titles in DSS’s Medicaid unit to titles in two other social services districts – Suffolk and Westchester. Titles and job descriptions used in the Nassau County Medicaid unit have not been updated in more than 20 years. Although the job descriptions and qualifications were similar in all three counties, the starting salaries in Nassau were almost \$10,000 less than those in the other two counties. Although the disparities were less evident after two years on the job, salaries in Nassau were still several thousand-dollars less than those in the other two counties. This competitive disadvantage is a likely reason for the county’s inability to attract and retain Medicaid workers.

<u>Nassau County</u>	<u>Westchester County</u>	<u>Suffolk County</u>
Social Welfare Examiner I (Starting salary \$21,756)	Eligibility Clerk (\$29,880)	Social Services Examiner I (\$31,451)
Social Welfare Examiner II (\$26,436)	Eligibility Examiner (\$38,800)	Social Services Examiner II (\$35,835)
Social Welfare Examiner Supervisor I (\$33,287)	Assistant Supervising Eligibility Examiner (\$42,900)	Social Services Examiner III (\$42,569)
Social Welfare-Examiner Supervisor II (\$39,565)	Supervising Eligibility Examiner (\$45,800)	Social Services Examiner IV (\$50,608)
Social Welfare Examiner Supervisor III (\$43,087)		Social Services Examiner V (\$55,071)

In addition to updating job descriptions and keeping salaries competitive to attract and retain employees in these positions, the other counties, unlike Nassau, have removed the term, “Welfare,” from all their titles.

In Westchester, the starting position was changed so that new employees do not have to begin employment with interview responsibility. This enables workers to gain Medicaid knowledge and experience before interacting directly with clients. Nassau should consider such a change.

Medicaid examiners’ salaries in Nassau are lower than those in surrounding areas. Most positions in the Department of Social Services are 75-percent reimbursable through federal and state funding. Therefore, the department’s current lack of adequately trained staff saves only a few thousand-dollars per employee ($\$31,451 - \$21,756 = \$9,695 \times 25\% = \$2,424$). Yet, if one of these underpaid workers approves just one applicant from among their 1,000-person caseloads who does not qualify, the medical costs of prescriptions or surgery can well exceed the salary differential.

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Recommendations:

DSS management should identify the correct work locations for all 1,017 of its employees.

DSS management should ensure employees and salaries are correctly coded in the Nassau County reporting systems for both human resources and accounting (NIFS & NUHRS) and that state reimbursement claims are reconciled with those contained in the county's accounting systems.

Job descriptions should be updated and old terminology removed. Changes in job functions between the titles, as done in Westchester, should be considered in an effort to more properly train and retain employees. Salary levels should be examined to attract qualified workers.

Corrected organizational charts should be prepared. Once obtained from sub-units, they should be integrated into an accurate departmental structure with logical and compatible functional lines of authority.

Department's Response:

Accounting and the Human Resources Department at DSS are reviewing the coding of employees and salaries. Corrections to county systems will be made as necessary. However, the state claims that request reimbursement of the Federal and State share of employee salaries is generated by the use of functional codes. These codes are carefully reviewed annually and signed off as to accuracy by supervisory and administrative staff. The State is making changes to this system as well. The Department has worked on a multi-district task force with the New York State Civil Service Department to update job descriptions and examinations in the Welfare Examiner job series to more accurately reflect current responsibilities. These codes will be modified based on findings of the task force. Organizational charts are being reviewed to ensure they accurately reflect current work locations, department structure and functional lines of authority. Additionally, staff attrition has resulted in staff performing additional functions and assuming responsibilities in multiple program areas. In summary, the coding issues raised do not impact the department obtaining the appropriate reimbursement from the State and Federal government. The County is updating internal codes and organizational charts to ensure that they accurately reflect the Department structure. These two systems will be compared to ensure congruence.

Auditor's Comment:

We concur with the corrective action taken by the department.

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Eligibility Processing - Residency issues

The auditors examined eligibility processing in 28 case files. The original sample was selected by the outside auditors for their year end work plus three random cases added mid year. Of those 28, 3 or 11%, demonstrated weaknesses in the residency verification procedures.

Audit Finding (5):

During audit testing, we found an instance in which an applicant whose case had been closed in New York City applied at the Nassau County DSS. A former resident of Queens, the applicant claimed residence in Massapequa and produced a statement with a Massapequa address stating the applicant was given free “use of a room.” If a Medicaid applicant’s income/resources exceeds the eligibility requirement, he or she can pay in or spend down to the eligibility amount by providing incurred medical expenses. This recipient did this and continued to send in receipts from a Queen’s pharmacy over an additional five-month period for which she stated she was living in Nassau County. The applicant also stated she was now paying \$500 a month in rent, further reducing her income to an eligible level. After receiving benefits for one year, DSS sent her re-certification notice to Massapequa, labeled “return-service requested.” It was returned by the post office to DSS with a Queens forwarding address listed. The caseworker closed the case as a returned re-certification (failure). A few weeks later, the caseworker reinstated the client and told the auditors that the Medicaid recipient called and told her she now lived in Levittown and was having her social security checks sent there. The auditors asked the caseworker why there was no notation or documentation in the file to reflect this Levittown address; the caseworker replied: “it must be in filing.” When the auditors returned twice to see if the file contained any notation or documentation, the entire case file was missing. It was still missing during a subsequent visit.

Contributing factors in this example of insufficient residency verification and documentation were as follows:

- In the above case, the statement regarding residency was on a sheet of loose-leaf paper. The file did not indicate any attempt to determine if the claimant was a relative of the property owner. Auditor inquiry has determined that other districts contacted have developed a detailed questionnaire to determine residency, while this testing indicates Nassau caseworkers accept phone calls and notes.
- Nassau County caseworkers do not perform field visits to ascertain residency, although their civil service job description states that their typical duties include “mak[ing] field visits for the purpose of certifying eligibility as required.” Unlike Suffolk, Nassau County also does not have a special team to do so. When the auditor discussed the problem of applicants’ residency varying between Nassau County and New York City with DSS, the response was that the crossover of recipients goes both ways and that it will even out. DSS’ lack of concern about this crossover issue seems

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misplaced.

- New York City does not use the state's Welfare Management System because its caseload is too voluminous for the system to handle. Nassau County can get limited information regarding cases closed in the city but that requires a little extra work by the caseworker. If New York City were on the Welfare Management System, county caseworkers could see codes that indicate the case may have been closed due to fraud, etc. There is no evidence in this file that the caseworker made any attempt to properly verify residency initially, nor the new residence at re-certification, nor that she performed any follow-up with New York City DSS.

Another case contained a residency statement from a Nassau resident declaring that his son and his pregnant wife from California were living with him. The file documentation listed the applicant as a "physician of medicine". The case file stated no RFI, (i.e. New York State would have no information on income and resources from California) and both he and his pregnant wife were given Medicaid coverage.

The auditor spoke to the state DOH and was apprised that residency is again verified at re-certification (a year later). The state feels that because the re-certification documents are sent to the local address with "return-service requested", if the client is no longer a resident the documentation will be returned to Nassau County. DOH believes receipt of the material is proof of residency.

The auditor sent a "return service requested" envelope to the California address, as a test, so it should have been returned. The envelope contained a note asking the applicant to call upon receipt and the applicant did call the auditor. When the auditor told the client it was a test of the "return- service requested" feature to determine if the applicant received it in California or if it was forwarded to New York, he answered New York. Accordingly, either the postal service's "return-service requested" service used to verify residency forwards mail, or the applicant received the letter in California. In either case, the residency-verification procedure is weak. After the auditor received the call, auditor follow-up indicated that "per client request" the case was closed in the Welfare Management System.

Another method of residency verification used by caseworkers is the address listed for the receipt of a social security check. In one case examined, in which the applicant's case was recently closed in New York City, the applicant's social security check was delivered to a post office box. This does not verify residence.

Recommendation:

The department must address the lack of proper controls regarding verification, documentation and investigation of residency issues. As part of the controls, it could develop a housing verification form similar to Suffolk County's (a copy of which was provided to the department) and perform home visits where necessary to verify residence.

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Department's Response:

The Department operates according to requirements for residency verification as defined in the State's administrative directive 93 ADM-29, page 9, item #7 which indicates that statements that an applicant resides in the county from an individual with knowledge of the applicant is sufficient for documenting residency. This ADM also states on page 4 (B) that excessive documentation must be avoided. The Department has been advised by New York State Department of Health that information obtained via telephone, if no written verification is available, must be accepted. From page 4 item B (3) "the district worker must try to verify the information presented through telephone calls or other means without requiring written verification." In May 2002, Medicaid eligibility staff attended training sessions conducted by NYSDOH staff entitled "Lighten Up". This training was designed to reinforce with staff the need for minimum necessary documentation, as opposed to excessive over documentation. Copies of NYSDOH Administrative Directives and other reference materials provided to staff during these training sessions are attached. In summary, the County is consistent with the State requirements regarding documentation and verification. The State has reinforced with Social Service districts the need for minimum necessary documentation.

Auditor's Comment:

93ADM-29 addresses excessive documentation in the area of established information. Once a person's date of birth and social security number has been established in WMS, it is excessive to document it again. However, varying information such as residency must be verified. The ADM reference to statements from an individual with knowledge of the applicant being sufficient for documenting residency applies to difficult circumstances, such as estranged teenagers or homeless individuals not as a standard procedure. Examples of acceptable forms of residency verification are cited in the ADM.

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Third-Party Health Insurance Payments

Audit Finding (6):

When cost effective and when certain other conditions are met, Medicaid will pay a claimant's health-insurance premiums.¹⁹ Health insurance payments pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") generally will not exceed 18-36 months; other third-party insurance payments, such as for AIDS clients, may be made for years. When the auditor requested COBRA cases to test compliance with state directives, DSS was unable to determine which clients were on COBRA continuation or other third-party insurance coverage. For several years, DSS has used a "catch-all code" for all third-party insurance payments in BICS (the state computerized payment system) instead of codes identifying the category: COBRA, AIDS, Medicare supplements, etc. This compromises the controls necessary for properly monitoring and assessing COBRA payments.

Five cases were examined for compliance with state directives and for documentation of the cost-effective determination performed. Several problems were noted.

- There were no Health Insurance Cost Appraisal (HICAP) reports in any of the five cases examined. A HICAP report, generated by a state DOH computer software program, recommends whether it is cost-effective to make COBRA payments in lieu of Medicaid payments. This is a tool that should be used for claimants under age 65 who are not on Medicare and who do not have pre-existing medical conditions. The software uses average Medicaid costs by region and compares it to estimated cost-information from the insurance policy. Following an auditor's request, it took less than five minutes to generate each of these reports.
- Three out of these five state HICAP reports recommended that DSS not pay the COBRA premiums. Because DSS had not run these calculations, it continues to pay the premiums. The difference in cost for just these three cases was \$39,188.
- Only one case folder out of the five examined contained the medical plan description. According to a state directive,²⁰ this is a necessary component to determine the scope and depth of the insurance coverage to be used as a comparison. Medicaid is the payer of last resort; although DSS pays the insurance premiums, the Medicaid client is issued a Medicaid card to cover items not included on the insurance plan. A cost-effective determination cannot be properly made if DSS does not know what is covered under the premiums it is deciding to pay.
- One case folder did not contain any caseworker notes in the file since 1994, yet the

¹⁹ NYCRR Title 18 360-7.5

²⁰ 82 ADM-20 Enrollment in Employer Group Health Insurance as a condition of Eligibility for Assistance, as it relates to the cost benefit determination of such policies.

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HMO premium-billings for this claimant are still being paid. Nassau County currently offers five different managed-care plans that were not offered in 1994, all of which cost half the amount DSS is paying for this claimant's plan.

- A state directive²¹ requires that COBRA continuation coverage not exceed 102% of the applicable group health insurance premium (or 150% of the premium for extended coverage, 19-29 months for disabled individuals). None of the files examined contained premium documentation from the former employers to monitor and ensure that premium payments were still within 102% of the former health plan's group rate.
- State Medicaid directives do not allow COBRA payments to be made by Medicaid unless the client's former employer employed more than 75 employees. There was no documentation in any of the folders that the caseworkers had made this inquiry before granting COBRA coverage.
- One case out of the five examined did not contain any medical or pharmacy bills as required by state directive. This directive is designed to ascertain the claimant's medical history so as to predict future costs in determining the cost effectiveness of paying health insurance versus placing the client in a managed care plan.
- In two cases examined, the input-authorization screens had errors in effective-coverage dates. The input-authorization screen for payment stated coverage was to begin 01/01/02 effective to 12/31/49 for both cases, a 48-year authorization.
- One of the cases examined where the HICAP recommended DSS not pay the premiums concerned a care-at-home case in which the child was the only Medicaid-eligible member of the family. In this case, the father's business paid for family coverage health insurance and DSS reimbursed the full family-premium to the mother.

COBRA coverage is only temporary (usually for a maximum period of 18 months). When the cost effectiveness is marginal, it may not pay to have the DSS staff initiate the process of monthly premium payments because the claimant will shortly be put on Medicaid or managed care.

Recommendations:

DSS should prepare a COBRA-continuation checklist to distribute to caseworkers that incorporates all the state administrative directives and guidelines and that would satisfy the requirements of a sufficient audit trail. This, at a minimum, should include:

- Use of the HICAP computer to assist caseworkers in conducting cost-effective evaluations.

²¹ 91 ADM-53

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- Modifying the Benefit Issuance Control System (BICS) reporting system by separating third-party health insurance payments into categories, so as to enable tracking and monitoring of the cost and participants.

Securing proper documentation of claimants' medical health plan benefits (placed in the case folder as required by the directive).

- Obtaining health insurance-premium statements from prior employers' health insurance plans to verify that the billings do not exceed the 102% / 150% thresholds.
- Reviewing claimants' medical and pharmacy bills for cost effectiveness for as long a period of time as possible when performing the evaluation and maintaining same in the file as required by the state.

In addition, DSS procedures should include a requirement that all case folders be maintained and updated periodically to help ensure continued cost effectiveness and monitor any changes in circumstances.

Department's Response:

Two administrative directives from the State relate to this item. COBRA continuation is addressed in 91ADM-53 and AIDS Continuation in 91ADM-54. While the COBRA Continuation program requires a cost-effective evaluation, the AHIP (AIDS Health Insurance Program) does not. Both programs are identified in the Welfare Management System by use of a specific coverage code -17. The cases reviewed by the Comptroller's Office included AHIP patients – there is no cost-effectiveness evaluation required for these cases as part of eligibility. Further, one of the cases examined was a Care at Home case. These are severely handicapped children with extensive medical needs and costs. Paying the full family premium is allowable and cost effective, as it does not approach the Medicaid expenses for a child in this program. In the case of the COBRA Continuation program, this premium payment is not an alternative to Medicaid. Individuals applying for COBRA are considered at 100% Federal Poverty Level, and therefore, without COBRA they would have no coverage at all. In most instances, payment of premiums to maintain private coverage is eventually cost effective due to the very high cost of acute care. In summary, a cost-effective evaluation is not required for all cases. The Department however will pilot the HICAP program to see if improvements in cost-effectiveness evaluation can be achieved in those cases that require it. If long term cost savings can be realized, the Department will implement utilization of HICAP on a regular basis.

Auditor's Comment:

A cost benefit determination for health insurance should have been in place since 1984 as directed by 84ADM-19, and addressed in all updated ADM's. To better support COBRA

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cost-effectiveness, HICAP generated reports should be considered an indispensable tool and utilized to the fullest extent possible.

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Medicaid Spend-Down & Pay-In Processing

Audit Finding (7):

According to the state's Medicaid Resource Guide, "Local Social Service Districts are required to offer individuals with excess income the opportunity to reduce their excess income by pre-paying to the district the amount by which their income exceeds the medically needy income level or the Public Assistance standard of need, whichever is higher." This is called a Pay-In. In addition, clients with medical expenses and an income above the eligibility level can spend-down the amount that exceeds the eligibility level. This requirement is met by either paying the overage amount; submitting incurred medical bills to DSS; or via a combination of the preceding two. A review of the procedures in place at the department revealed the following weaknesses:

- Caseworkers can and do receive cash payments. Having the same person who authorizes coverage also be responsible for receiving cash poses a severe control weakness. Individual cash pay-ins noted by the auditor have reached monthly highs of \$1,158. In Suffolk County, a separate unit handles this function.
- Invoices and receipts used to receive coverage are not accounted for in the case folder. For example, case files do not contain documentation as to what clients did to satisfy their spend-downs/pay-ins (submitted spend-down medical invoices, pay-in cash or a combination of the two). DSS workers claim that it is too cumbersome and time consuming to put this information in the clients' folder. Clients have received coverage authorization for which there is no traceable documentation that they met the spend-down/pay-in requirement.
- There is no record of the coverage authorized by caseworkers. Caseworkers are authorizing coverage based on spend-downs or pay-ins for which there is no audit-trail documentation. Also nonexistent is a total record of what caseworkers are authorizing and how much money should be collected on a monthly basis. An accounting of total cash plus credited medical bills should be prepared to reconcile with the total coverage authorized in the Welfare Management System for spend-down/pay-in clients.
- When a client pays-in for coverage and does not use any coverage that month, the state requires that the client be entitled to a refund of his or her pay-in. DSS deposits the pay-ins in an agency account to be held for a one-year period. The auditor noted that DSS authorizes a refund based on a notation by the caseworker without any documentation regarding the reason for the refund; neither the caseworker nor the supervisor signs any document. The client is not even required to fill out a refund request.

The pay-in instructions distributed by Nassau County were examined. They contain several irregularities, including:

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- The cover sheet lists the former DSS commissioner, who retired in 1999.
- DSS is attaching an outdated (2/89) state form DSS 4038. The state issued a new version of this form in 1995. This detailed narrative explains medical-assistance eligibility for applicants with excess income.
- The instructions direct the client to send payments and medical receipts to the “Pay-In Program Unit.” There is no Pay-in Program unit in DSS. As a result of our inquiry, we learned that the mailroom forwards the pay-in mail to the cashier in the accounts department. However, when a client who normally spends-down (sends in receipts to the caseworker) has a month to pay-in or do a combination of the two procedures, s/he automatically mails the money to the caseworker.
- The instructions have an attachment III, although there is no attachment I or II.

Recommendations:

Proper documentation of all spend-downs and pay-ins should be maintained for all monthly coverage granted.

The collection and application of spend-down/pay-in monies should be kept separate from case- management responsibilities in a separate unit accountable for full collection.

Refund requests should be in writing from the client and properly authorized and documented.

Pay-in instructions should be clarified and updated.

Department’s Response:

Department policy is that Medicaid eligibility workers do not accept cash from clients. Clients who wish to make cash payments are directed to the Department cashier located on the 3rd floor to make a payment and obtain a receipt, which is then presented to the eligibility worker. In addition, the Department is formulating a new unit to centralize the processing of Medicaid spend-down cases. This new unit will receive and review receipts from clients indicating they have satisfied their spend-down. Systems support will be required to calculate spend-down amounts, validate receipts, and transmit information to the Welfare Management System to authorize coverage. In summary, this new unit will provide the checks and balances to ensure that spend-down cases are properly documented and receive appropriate coverage.

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Auditor's Comment:

We concur with the corrective action taken by the department.

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Managed Care

Background

New York State received permission from the federal Department of Health and Human Services (HHS) to enroll Medicaid recipients in managed care. HHS, however, imposed three conditions in exchange for allowing mandated managed care: (1) managed care must be cost-effective; (2) the client's rights and benefits are to be protected; and (3) clients are to be educated regarding their rights and responsibilities.

The Managed Care Program expands the number of health-care providers and makes preventive services available to Medicaid clients. The state adopted this program to curb costs by reducing excessive hospital and emergency-room visits. However, clients with Medicare or spend-downs are not eligible for managed care. During the audit period, Nassau County employees had the option of selecting one of six managed-care companies -- United Health Care, Vytra, HIP, Fidelis, Health First and Affinity. A cost-savings analysis covering the period July 1, 2000 – June 30, 2001, prepared by an outside actuary retained by the state, indicates that Nassau County saved \$3.4-million by offering managed-care options. In addition, the DOH has been monitoring and performing surveys to ensure clients' rights and benefits are protected. Nassau County uses a company called New York Medicaid CHOICE through a state contract. This company, a division of Maximus, provides education and enrollment.

Audit Finding (8):

Some health care services, including three high-cost items, are not included in managed care. The client is given a Medicaid card -- in addition to the managed-care card -- to obtain services such as prescriptions, the use of home-health care aides and dental braces. Some managed care plans also do not cover medical transportation, over-the-counter drugs and long-term home-health care. For items not covered by managed care, the client uses a Medicaid card.

Issues noted during the review of managed care include:

- New York State has afforded managed-care providers a six-month guaranteed initial-enrollment period. The premature assigning of clients to a managed care program by Medicaid CHOICE prior to a completed re-certification increases the risk of unnecessary premium payments to program providers. A client's case may end up requiring a spend-down and, therefore, not be eligible for managed care. In such an event, the managed-care company would have received a six-month premium for an individual who does not qualify and will never use the insurance. In addition, Medicaid is often not notified of a client's death or of his/her moving out of state until re-certification. In such instances, Medicaid also would have overpaid premiums.

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- Incarcerated Medicaid clients are not entitled to Medicaid benefits because the institution provides medical services. DSS manually checks for local and state incarceration and does not have any information on facilities in neighboring counties. This raises the possibility of unnecessary premium-payments being made to managed-care companies for incarcerated individuals.
- New York Medicaid Choice provides education and conducts enrollment in Nassau County for managed care plans. On the literature Medicaid choice provided to clients for two different managed care plans regarding non-participating medical transportation, the contact phone number listed is for the Suffolk County Department of Social Services. Nassau County DSS was not aware of this error in the client-information packet. The auditor advised the managed-care director to correct the phone number.

Recommendations:

Controls should be developed to prevent premature enrollment in managed-care programs before eligibility has been fully determined, thus eliminating the possibility of monthly premium-payments to managed-care companies for clients who are no longer eligible.

The department should obtain access to data systems containing client information, matching and updating information on residency, death, and incarceration. Ideally, a state prison database should be automatically scanned for the Welfare Management System.

Department's Response:

In all cases where a client is enrolled in a Medicaid managed care program, there is a six month guaranteed period for the provider. This is period is identified in Federal and State program descriptions which provide for a six- month guaranteed eligibility period for clients enrolled on managed care. In the local system, Clients are not enrolled in managed care until ongoing eligibility has been established. Even if New York Medicaid Choice, the State's contracted enrollment broker assists a client with the selection of a provider, less than 6 months prior to their re-certification, actual enrollment is pended until the system shows a six-month period of eligibility has been established. Once eligibility has been established and a client has been enrolled in a managed care plan, should a change in circumstances occur which would result in the client's loss of eligibility, they are still guaranteed the balance of six months coverage from date of enrollment. Regarding the issue of matching the inmates in the correctional center, the Department does have an automated process for matching inmate data with our eligibility files. The Department is working with the Correctional Center to conduct this match more frequently. In summary, State computer systems ensure the necessary safeguards are in place to prevent premature enrollment prior to eligibility determination.

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Auditor's Comment:

We concur with the corrective action taken by the department.

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Spousal Refusal / Estate Recovery

Background

New York State Social Services Law section 366 3(a) allows for spouses to financially disassociate themselves or refuse to support the other spouse; this is commonly referred to as “Spousal Refusal.” The local Social Services District must initiate court action to recover the excess resources of the community spouse of a long-term care recipient. Pursuant to State Medicaid regulations,²² the community spouse of an institutional spouse cannot have more than \$74,820 - \$89,280 in resources, (exclusive of one house and one car of any value) and \$2,232 monthly income without incurring a contributory spend-down. An institutional spouse cannot have resources of more than \$5,300.

The New York State Medicaid Office has unsuccessfully sought to have critical wording in the state law modified from “absent or refusal of spouse” to “absent and refusal of spouse.” The senior attorney for the state Medicaid Office claims that if this change were enacted, it “would ameliorate the spousal-refusal provision by skewing it in favor of Medicaid” and make it easier to pursue these cases.

Audit Finding (9):

A March 1999 audit by the New York State Office of Temporary & Disability Assistance criticized the performance of Nassau County DSS in identifying and pursuing the recovery of excess resources in spousal-refusal cases. The office estimated a potential loss of more than \$3 million because legal action had not been initiated to recover excess resources owned by community spouses at the time an application for Medicaid was filed. Nassau County hired an attorney to pursue these complicated and time-consuming legal matters. The attorney has since left the county, leaving no one at DSS to perform this function. More than 400 cases have been referred to the DSS legal unit from the Medicaid unit over a 26-month period. For these cases, 20 letters were sent as a first step in the legal proceedings. However, conditions that hinder recovery include:

- The county is rarely notified when a recipient dies. When an institutionalized spouse dies, the DSS legal unit could place a lien on his/her resources (i.e. property, life insurance). However, the institution or the family rarely notifies Nassau County DSS. In fact, most often it is not known to DSS until the time of annual re-certification.
- The DSS legal unit cannot run a financial check because there is no way to register the community spouse’s social security number into the New York State RFI system.
- Even if DSS filed a petition immediately upon opening a case, it would not be able to go to court to present a statement of assistance granted for at least five months. Nursing homes do not bill until the second month after opening, and the microfiche

²² Source: Assistant General Counsel, New York City Health & Human Resources

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does not come back from the state's Medicaid Management Information System, the state computerized payment and information reporting system, for two to three months.

When Nassau County DSS hired an entry-level attorney to address spousal refusal, the attorney was up against experienced legal specialists in elder-care matters including the former chief counsel to the department. Consequently, the risk of losing cases based on the insufficient knowledge of the state's complicated social-service law of the county's legal counsel greatly increases.

In addition, recent examination of nearby municipalities' successes in this arena does not indicate substantial recoveries. For example, New York City has 10 lawyers, two paralegals and one clerical worker assigned to the issue of "spousal refusal" and its estimated annual collections are \$1,335,000. A June 2000 audit by the New York State Office of Temporary and Disability Assistance cited Suffolk County as having successfully initiated a program to recover excess resources in long-term cases. However, the report acknowledged that Suffolk collected \$204,370 based on 15 of the 101 cases identified during a five-year period.

These recovery procedures are very labor-intensive and time-consuming. The eligibility worker must first properly document and identify the recovery; recoveries can drag on for years in the courts, and the county would only retain 10 percent of the dollars recovered. In addition, these recoveries cannot be predicted nor determined to be cost-beneficial. Failure to notify the county when long-term care recipients die hinders recovery from the estates. The current decentralized process provides little incentive for counties to pursue estates since they only receive 10 percent of the proceeds, compared with 40 percent for the state. Since the state receives 40 percent of the recovery, it should assume responsibility for this function instead of passing it on to the counties.

Recommendations:

The department should address the state audit finding to recover excess income and resources of community spouses of long-term recipients. Experienced legal staff should be hired to initiate appropriate court actions and initiate recommended procedures including:

- Centralizing this responsibility in one unit.
- Developing a methodology to negotiate agreements.
- Preparing district forms for use by eligibility staff for proper documentation of the refusal to support.
- Prioritizing cases.

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- Generating a computerized (legal) notification to spouse.

Although the state has been critical of the county with respect to this issue, the county only receives 10 percent of the recoveries on these cases and has little incentive to devote county resources. The administration should request that our state legislators consider drafting legislation that would require the state to assume this function. The state receives 40 percent of the benefits, while incurring none of the costs associated with these cases.

Department's Response:

The Department has hired 2 Attorneys to work with the Medicaid program in the area of spousal refusal. To date, over 100 letters have been sent to community spouses offering them the opportunity to enter into a voluntary agreement with the Department for lump sum and/or monthly payments. Procedures and forms have been developed for use by eligibility staff to refer cases to the legal unit. Clients and their attorney's have been contacting the Department to make arrangements for lump sum payments from excess resources and monthly payments resulting from excess income. In summary, the County has been conducting an expanded program to collect these dollars. The resulting recoveries will range from 10-25% of the gross dollars with the bulk of the resources going to the State and Federal government. In reference to the recommendation regarding centralization of spousal refusal efforts, the Department believes that the eligibility portion of the process is best conducted by eligibility workers. The responsibility for recovering excess income and resources has been centralized in the Department's legal unit. The Department agrees that the State and/or Federal government should assume this role.

Auditor's Comment:

We concur with the corrective action taken by the department.

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Fair Hearings

Audit Finding (10):

A fair hearing is a client's chance to tell an administrative law judge for the New York State Office of Temporary and Disability Assistance why a DSS decision about his or her case is wrong. Upon the conclusion of the hearing, the state issues a written decision stating whether the local social service district was right or wrong. These hearings are closed to the public; however, the auditors obtained the outcome statistics for the Nassau County Department of Social Services for a recent one-year period.

During this period (May 31,2001-April 30,2002), 706 hearings resulted in the following:

Agency withdrawal	370
Agency action correct	126
Reversals (Agency failure)	73
Agency remand codes	52
Other	<u>85</u>
	706

The agency actions were upheld more often than they were reversed. However, the extremely high number of withdrawals indicates further investigation by DSS may be needed into the specifics of the withdrawals to determine any patterns for which improvements could be made.

Nassau County also provides funding to several organizations that will represent clients at fair hearings if they desire; these include the Legal Aid Society, the Nassau County Bar Association - public defender program and Nassau/Suffolk Law Services. However, in Nassau County, DSS is represented by a caseworker-supervisor at the fair hearings, without the support of any legal staff. Discussions with the state supervisor for the administrative law judge revealed that most of the smaller counties are represented at the hearings by attorneys, while the larger counties have staffs headed by attorneys available for the hearings.

Other problems were revealed during the review of the fair-hearing processes. There is no regulatory limit to the number of postponements an individual can request. "New York's aid continuing" provision states that as long as clients request the fair hearing within 10 days of the notice to change or terminate benefits, they will get full benefits until the hearing. For example, if an individual receiving 24-hour home care has home-care benefits reduced because the DSS registered nurse determined the client only needs help several hours a day, the client can request a fair hearing. The client can postpone the hearing indefinitely and continue to receive around-the-clock care. If the client finally loses after the hearing, there is no provision under state law for recovery of the extra care the client received during postponements. Although some of the state client-publications

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report that clients may have to pay this back, both the DSS and the state supervisor for the administrative law judges note that Medicaid does not allow for the repayment. Again, there is need for legal staff intervention in the matter of clients' continual postponements.

Recommendations:

The department should hire an attorney to oversee the fair-hearing process, represent the county when needed at hearings and provide legal counsel regarding all Medicaid-eligibility issues.

The department should perform a review of the withdrawals made in the previously mentioned test-period to determine if procedures can be improved

The department should raise questions in cases in which there's an appearance of unreasonableness in the granting of postponements.

Department's Response:

An additional attorney has been hired since September 2002 to provide counsel to eligibility workers, on an as-needed basis in fair hearings. The data indicate that the County has represented itself well by using caseworkers. In February, for issues decided only 4 of 40 decisions rendered founded the Departments eligibility determination incorrect. Further, a review of fair hearing withdrawals is being conducted to ascertain reasons for withdrawal and actions that could be taken to avoid the scheduling of unnecessary hearings. In some cases, clients request postponements and adjournments on an ongoing basis to continue services for which they are no longer eligible. Contact has been made with the New York State Office of Temporary and Disability Assistance to develop a mechanism for a review of cases where there is an appearance of unreasonableness in the granting of postponements or adjournments. In summary, the Department has had success in utilizing eligibility workers to represent at fair hearings, as the focus of the hearings is eligibility determinations and not legal issues. The additional resources in legal provide for guidance and assistance as needed with respect to fair hearings.

Auditor's Comment:

We concur with the corrective action taken by the department.

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Resource and Recoveries Account:

Background

The resource and recovery unit seeks to maximize revenues for DSS by establishing claims against the assets of recipients (i.e. estate claims, liens, deeds, bonds, mortgages, and other assignment of assets). The unit performs these functions through investigative and legal proceedings.

Audit Finding (11):

Although this unit takes in several million dollars annually, there is no running record of the total amounts that are subject to recovery. There is no control total available on the potential funds to be collected. However, even if this information were compiled, in many instances the amounts collected constitute settlements for amounts that are less than the liens. This unit's function is to perform investigative and legal procedures for resource recovery, yet no investigators or legal staff are employed or affiliated with this unit.

Since this unit does not have access to the surrogate's court and county clerk's computerized records, its employees must manually research records maintained by these offices for the recovery of assistance funds.

Checks are not being deposited on a timely basis. One of the more recent deposits examined, a check for \$92,622.17, was received on April 1, 2002. Although the recovery unit granted approval to make the deposit on April 5, 2002, the accounts section did not deposit the check until April 29, more than three weeks later.

The auditors noted one check on which an employee's name was listed twice on the front and DSS once. This check was for \$172,994.

The accounting system for recoveries produces extremely voluminous documents that are difficult to handle. This DSS system does not drop zero balances and, consequently, all entries remain on record.

Recommendations:

A legal professional should review this unit to determine the most efficient way to recover monies. This review should include computer access to the records in both the county clerk's office and the surrogate's court for obtaining information on judgments, mortgages and the filing of liens.

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The department should address the account section's deposit process to ensure the timely deposit of cash receipts, particularly the large deposits.

The department should instruct individuals to make checks out to "Nassau County DSS Cashier" or a particular unit, not to an individual employee.

The accounting-system database should be modified to allow for the purging of zero balances.

Department's Response:

An additional attorney hired by the Department is now available to provide technical assistance on a case-by-case basis to Resource and Recovery staff regarding the most effective manner to recover monies due to the Department. The Department is preparing a formal request to the Office of the County Clerk asking for computer access to the records maintained by that office which may be of assistance in recovering monies for the county. The Department will also initiate contact with a representative of the Surrogate's Court asking for similar access.

The Accounts Unit has procedures in place to allow for the timely deposit of asset-recovery (69A Trust Account) checks. As part of the procedure, staff is advised that the original check is to be retained in the Accounts Unit. A photocopy of the check is utilized to request authorization to deposit from the Resource and Recovery Unit. In the particular incident cited, the transmittal sheet granting authorization to deposit the check was misrouted and not received by Accounts. In reviewing a regularly produced Outstanding Resource Check Report, Accounts became aware that the photocopied check and authorization to deposit was never received in their Unit. Once advised of this, the Resource and Recovery Unit completed another replacement authorization to deposit form and the check was deposited upon receipt of this form. This replacement authorization should have been marked "DUPLICATE". Procedures have been modified to advise staff of this requirement.

Department policy is that checks to the Department should not be made out in the name of any employee. An attempt is made to obtain a replacement check in instances where an employee is listed as payee.

In summary, in the area of resources and recoveries the Department has taken several steps to improve recovery of monies owed the Department. Legal staff has been added to consult with staff on the most effective means to recover money and steps have been taken to develop the appropriate linkages to the County Clerk and the Surrogates Court.

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Auditor's Comment:

Audit documentation received from DSS accounts differs from the duplicate documentation provided with the response. As both show a delay between the authorization and the deposit, we reiterate our recommendation that DSS accounts deposit cash receipts timely.

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Medical Assistance Determinations

Audit Finding (12):

Title 18 of the New York State Code of Rules & Regulations (NYCRR) section 360-2.4 (a) requires a Social Services District to determine an applicant's eligibility within 45 days of the date of the medical assistance application. Disability eligibility is to be determined within 90 days of filing. Nassau County is currently making these determinations in about 70 days. The director of the Medicaid unit estimates that about 20 percent of its cases involve disabilities. In addition, some delay occurs when clients request additional time to secure needed documentation. DOH is aware that Nassau County is taking too long to process -- approve or disapprove -- these applications.

Although disability does account for some of the longer determinations in Nassau County, the main reasons for this long processing time have been detailed in the previous sections. These include high caseloads per caseworker; inadequate provision of computers and other tools to do the job; check lists; inadequate state income-verification systems, and outdated eligibility-processing systems. The addition of Family Health Plus and other state modifications have also increased the workload, slowing down the process.

Some municipalities use the medical assistance-application completion time as performance indicators, with appropriate time frames set for community eligibility, hospital and nursing home. It is important that Nassau County Medicaid-eligibility determinations be processed correctly with appropriate investigations performed in a timely manner.

Failure to provide clients in need of Medicaid services with timely decisions is a serious breach of New York State regulations.

Recommendation:

The department should make the necessary improvements to bring the county into compliance with the New York State time-frame regulations. Alleviating the high caseload will help caseworkers make accurate medical assistance determinations in a timely manner.

Department's Response:

As stated in our comments regarding finding #3, the additional staff hired since July, 2002 will assist to bring application timeframes in line with state guidelines. In addition, the Department has implemented several initiatives designed to reduce application processing time such as targeted overtime to reduce application backlogs in PCAP and

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Family Health Plus, receipt of a waiver from NYSDOH to eliminate the requirement for a face to face interview at the time of recertification, the use of a state provided simplified application form for community Medicaid, entering into agreements with hospitals and nursing facilities to pay the local share for the out stationing of examiners for the purpose of taking Medicaid applications and conducting the face to face interview, and the development of a call management system to handle routine telephone calls and requests for information that do not require the involvement of the case manager thus providing more time for workers to process cases. The February reports from the State have already indicated a slight reduction in application processing time. In summary, as outlined above and in the response to Finding #3, the Department has taken several proactive steps to resolve this issue.

Auditor's Comment:

We concur with the corrective action taken by the department.

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Management Control Initiatives

Background:

Government Auditing Standards dictate that management establishes internal controls to safeguard public resources. These standards require the auditor to obtain an understanding of the management controls that are relevant to the audit. These controls include the plans, methods, and procedures to ensure that its goals are met. They also include controls over program operations, validity and reliability of data, compliance with laws and regulations and the safeguarding of resources.

Audit Finding (13):

Nassau County is currently dependent on the New York State Welfare Management System and the New York State Health Department to implement controls on Medicaid expenditures. Although Nassau County's annual Medicaid expenditures are nearly \$200 million, the senior staff at the Department of Social Services is hindered in establishing effective management controls.

This is a statewide problem. The New York Public Welfare Association, Inc., which represents all 58 local social services districts in the state, recently concluded:

- New York is the only state requiring such a large Medicaid contribution by its counties.
- Medicaid is the single largest fiscal burden for counties.
- Because federal and state laws and policies govern Medicaid, funding for the program should rest with those levels of government.
- New York should take steps to assume the full responsibility for the non-federal share of Medicaid.
- The local share must be immediately capped to guard against increases in local property taxes.
- The state should cover the full non-federal share of the expansion of Medicaid, including Family Health Plus. The state should place the additional costs for the administration outside of the administrative cap. Under the current cap, local departments of social services are unable to increase their staffing to administer state mandates.
- Family Health Plus is expected to cost \$441 million gross, with \$114 million of these costs to be borne by the counties.

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- If the state cannot afford the full non-federal share of expanding programs, then it should not expand them.
- Counties need true administrative relief. While much is being done to make it easier for people to apply -- such as allowing self-attestations -- little is being done to make the determination process easier.
- The association is very concerned that the changes in HCRA 2002 (i.e., the elimination of the face-to-face interviews at the time of Medicaid re-certification, attestation for non-long-term care services, and dropping the requirement to see the social security card) will require expensive new methods to counteract fraud.
- An electronic eligibility system is needed to support the complicated and excessive eligibility rules and programs with which caseworkers must now contend.

Recommendations:

The antiquated Welfare Management System is an inadequate tool to exercise control over public funds flowing to the Medicaid program. This leaves localities in New York State out of compliance with government standards required to protect local resources. An electronic eligibility system is needed immediately. The administration should review these issues and urge our state legislators to propose legislation to lessen some of the Medicaid funding burden that currently falls on counties.

Department's Response:

Enhanced computer support is essential to assist workers in accurate determination of eligibility. The Department is in discussion with NYSDOH to gain access to an improved electronic eligibility system that would provide for greater control and accountability in the Medicaid program. This system was developed by the New York City system that would need to be modified by the State. Nassau County has volunteered to pilot this system as it is developed. In summary, the Department agrees with the recommendation in this area and is exploring means of developing new systems with the State at low cost to the County.

Auditor's Comment:

We concur with the corrective action taken by the department.

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Summary of Responses -Medicaid Caseworker Questionnaire

Audit Finding (14):

A questionnaire was distributed to obtain employees' perspectives on the problems encountered daily and to ascertain what steps might be taken to provide Medicaid services to Nassau County residents more efficiently and effectively. Responses to this questionnaire reveal the following conditions, which require management's attention:

- Understaffing was overwhelmingly cited as the most pressing problem facing the Medicaid unit. Coupled with this was the complaint of excessive caseloads. Undercare workers reported being responsible for overseeing more than 1,000 cases each.
- Folders for the 47,000 active cases are stored in the record room located in the basement of the Social Services building. Caseworkers must request these folders in order to conduct case management; receipt can sometimes take weeks. Many times, caseworkers have to retrieve their own folders and occasionally even sort the mail; this is indicative of a serious lack of support staff.
- Lack of office equipment was also cited as a severe problem. Although all caseworkers need access to the state's Welfare Management System, many workers have to share these terminals today. Due to a lack of computers, workers must manually log information and handwrite correspondence to attorneys, clients, banks, etc.
- Photocopiers are few in number, antiquated and often out of service. DSS has only 47 photocopiers for 1,017 employees. Some 70 percent of the copiers were acquired in either 1994 or 1997.
- Pre-printed notices and forms sent to clients are outdated and in need of revision. Many clients cannot understand them, prompting additional phone calls and extra work for the already overburdened caseworkers.
- As mentioned previously, computer access to public records is not available to enable caseworkers to more efficiently perform their duties.
- Overcrowding poses the problem of lack of privacy and high noise-level in both the interview area and the office area. Since telephone activity is high in this type of work, the noise level and overcrowding is exacerbated. Interviews are being scheduled by an outside agency without consideration of the caseworkers' schedules. Clients have to speak through a slot in a glass window, making it very difficult for the caseworker to hear them.

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Recommendations:

The department should review its staffing requirements and ascertain the correct level to adequately perform the Medicaid function.

All employees should have Welfare Management System terminal access, a quiet work environment and the standard office equipment needed to perform their jobs -- such as photocopiers and computers.

Standard inquiry responses should be put on an automated telephone response system.

Department's Response:

Increased staffing and the need for additional computer equipment have been discussed in earlier findings. Should staffing and application levels remain constant, it is our belief that the current staff will be sufficient to bring caseloads and time frames into acceptable levels. Service requests have been submitted to retrofit the glass partitions in the interview booth to allow for improved communication between worker and client. The County office of Printing and Graphics has implemented a schedule for the replacement and upgrading of photocopiers in the Department over a three-year period. The Department will be submitting a request to the County Clerk to allow computerized access to public records required by workers to assist in eligibility determinations. The legislature has recently approved a contract for the provision of temporary clerical support. This clerical staff will assist workers in obtaining necessary case records and other routine clerical tasks. In summary, the County is in the process of implementing the necessary activities to provide staff with the tools they require to complete their jobs. This includes updating equipment and software, access to data, and access to paper records. In the long-term the Department's physical plant deficiencies will be addressed through the relocation of the Department of Social Services as part of the County's real estate consolidation initiative.

Auditor's Comment:

We concur with the corrective action taken by the department.