Nassau County
Office of the Comptroller
Field Audit Bureau

Nassau County Department of Social Services: Personal Care Services Program for Medicaid Recipients

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NASSAU COUNTY
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Executive Summary

Background

The Nassau County Department of Social Services ("DSS") Home Health Care unit ("unit") administers the Personal Care Services Program ("PCA"). The program provides housekeeping, meal preparation, bathing, toileting, and grooming services to Medicaid eligible residents who are in need of these services. Local social service districts contract with home care agencies that employ aides to provide services. The New York State Department of Health ("NYS-DOH") oversees the local social service districts' administration of the program.

During 2002, Nassau County had contracts totaling about $87 million per year with 41 personal care agencies to provide these services. The NYS-DOH establishes the billing rates for each agency based on financial data submitted by each agency directly to the state.

Audit Scope, Objective and Methodology

In conducting this audit of the DSS PCA, the auditors reviewed:

- NYS-DOH's finding that DSS had failed to meet state cost savings targets and the penalty levied by NYS-DOH;
- compliance with state directives;
- DSS staffing;
- assessments of the clients' needs for services, including levels and hours of care; and
- management tools in place to monitor costs.

Audit methodologies included interviews with DSS employees, inquiries to the NYS-DOH and other social service districts, comparisons to other county's experience ("comparable counties"),[1] examination of departmental documents, including case folders, internal documents and management control data summaries. This report addresses the audit test period of January 2002 through December 2003.

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

[1] The comparable counties represent the five counties in New York State with the highest number of Medicaid eligible individuals. These counties are Erie, Suffolk, Monroe, Westchester and Nassau. The comparisons do not include New York City.

auditing procedures necessary to complete the examination. We believe that the audit provides a reasonable basis for the audit findings and recommendations.

Summary of Significant Findings and Recommendations:

Nassau County had the highest home care cost per recipient of any county in the state both in the target base period of 1996 -1997 and in the period of 2002-2003. NYS-DOH penalized Nassau County over $2.4 million for failing to meet savings targets for the periods July 1, 2001 to March 31, 2002, and July 1, 2002 to March 31, 2003, money that could have been better spent for case tracking systems, cost control consultants, or additional personnel.

We compared the experience of the five counties in New York State (excluding New York City) with the highest number of Medicaid eligible individuals to determine the cost of providing personal care as well as the cost of a more expensive alternative, skilled nursing facility care. We found that:

- Nassau's spending on all forms of long term care was the highest of the five counties, $13 million higher than Suffolk County even though Nassau's medicaid eligible population of aged, blind or disabled enrollees is 13% lower than Suffolk's.

- Nassau was providing personal care or skilled nursing facility care to a larger percentage of the aged, blind or disabled medicaid eligible population than any of the five comparable counties. Nassau provides service to 31.4% of this population as compared to 28.3% in Westchester and 25.9 % in Suffolk.

- While Nassau County ranks fifth in the number of Medicaid eligible individuals, we have the highest number of clients receiving personal care services. In comparing the five counties we noted that, on average, the other counties provide personal care services to approximately 1.5% of these individuals as compared to 5% in Nassau County.

In addition to Nassau County having the highest number of Medicaid clients receiving personal care services among the comparable counties, we found that Nassau provides double the number of weekly care hours per client (51 hours) as Suffolk (26 hours) and Erie Counties (22 hours) and 40% more than Westchester County (35 hours).

Nassau County commissioned a report by the "Center for Government Research" on Nassau County's DSS Home Care Program.[2] The report, issued in June 2000, estimated that if DSS reduced the number of hours allocated per patient per week by one hour,

[2] The Center for Government Research, Inc., ("CGR"), is an independent, nonprofit research and management consulting organization located in Rochester and Albany N.Y. that serves the public interest by performing analysis and problem solving for public policy challenges.

savings to the county would be $228,000. "If DSS could reduce the average hours per patient, per week, to the mid 20's, as has been done in Westchester, Suffolk, and Erie counties, annual savings would approach $45 million, with a County share savings of $4.5 million."[3]

Physician's written orders, based upon a physical examination, are required for DSS to provide services. NYS regulations require the physician to date the orders within 30 days of the physical examination; however we found that 40% of the forms accepted were not dated within this period. The unit should have returned for correction or denied these defective orders. The unit must properly examine these forms and ensure compliance with state regulations before initiating services.

DSS uses nurses hired under contract from the Nassau Health Care Corporation ("NHCC") to perform nursing assessments, case management, social assessments and clerical functions. This is an inefficient use of nursing skills and financial resources. DSS could achieve efficiencies by utilizing caseworkers and clerical staff, who are paid far less than nursing staff, to perform case management, social assessments and clerical functions.

New York State Regulations[4] require physician's orders to form the basis of authorizations for Personal Emergency Response Services ("PERS"). DSS has been providing clients with emergency communication equipment based upon the contract nurses' judgment, rather than the required physicians' orders.

Initial nursing assessments are not being performed timely. The unit is required to perform initial nursing assessments within five working days of receipt of the request for services, as stated in 18 NYCRR 505.14. DSS should explore all methods to ensure that the department has an adequate number of nurses to clear the large backlog of assessments and to perform reassessments in a timely manner.

DSS relies on an antiquated Wang system and inefficient manual records for case management. We found a number of areas where computerization would help achieve operational efficiencies:

- The DSS Wang computer system is not linked to the state welfare management system ("WMS"). As a result, DSS has allowed services to commence for clients' that were not Medicaid eligible and has allowed services to continue after the clients' cases have closed;
- Useful management reports to track clients are lacking;
- Essential records have not been computerized. The unit keeps many manual logs whereby case numbers and names have to be manually copied and the retrieval of information is dependent on manual searches;

[3] The Center for Government Research Inc., A Review of the Nassau County Department of Social Services Home Care Program, vi, (June 2002)
[4] New York State DSS Regulations[4] Title 18 NYCRR 505.14 (3) (a)

- Manual calculations are performed for hourly authorizations and entered into the system without supervisory review; and
- Consumer directed program hours must be entered into the system in whole hours and, therefore, assessment hours are rounded up. This rounding results in clients receiving more hours of medical care than necessary.

Medicaid recipients can obtain similar personal care services directly through the New York State Certified Home Health Aid Services ("CHHA"). DSS does not have the resources necessary to ensure that PCA services are not being duplicated by CHHA.

Department's Response:

The matters covered in this report have been discussed with officials of the department during the audit. On August 19, 2004, we submitted a draft report to department officials with a request for comments. The department's comments, received on September 10, 2004, and our response to those comments, are included as an addendum to this report.

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Background

Introduction:

The DSS Home Health Care Unit is comprised of three overall service segments: the personal care aide program ("PCA") unit, which includes the consumer (Medicaid client) directed personal assistance program ("CDPAP"); certified home health aide services ("CHHA"); and long term home health care program ("LTHHCP"). This report primarily addresses PCAs, the fastest growing segment.

Nassau County DSS contracts with 41 agencies to provide Medicaid eligible persons with personal care services as required by the New York State Social Services Law[5]. The services provided include housekeeping, meal preparation, bathing, toileting, and grooming. Personal care services, as stated in New York State DSS Regulations,[6] "can be provided only if the services are medically necessary, and the social services district reasonably expects that the patient's health and safety in the home can be maintained by the provision of such services…." Personal care services are provided to Medicaid recipients with varying nutritional and environmental needs to allow them to remain in their homes, thereby avoiding institutionalization. These are not intended to provide a substitute for skilled nursing needs, which fall under a separate health care program.

Comparative Analysis

Using information provided in the NYS-DOH "Category of Service Report" for December 2002, we have compared Nassau County personal care data with the other four comparable counties in New York State. These comparisons reveal a striking disparity in the number of personal care recipients and the weekly hours of care provided to each recipient by Nassau County when compared to other counties. This disparity was noted by the New York State Department of Health, (See finding #3 regarding the state penalty for failure to meet savings targets set by NYS).

[5] New York State Social Services Law §365-a 2 (e) and §365-f.
[6] New York State Regulations, DSS, Title 18 NYCRR 505.14 (4)

Personal Care Recipients and Cost of Services

Audit Finding (1):

Although Nassau County ranked fifth among the comparable counties in New York State in the number of clients on Medicaid during 2002, it had the highest number of clients receiving personal care services. On a percentage basis, while about 4.9% of Nassau County's Medicaid eligible individuals receive Personal Care, the next highest county, Westchester, had only 2.2% of its Medicaid recipients receiving personal care. Of Nassau's aged and blind or disabled Medicaid eligibles, about 10.5% received personal care services, as compared to 6.8 % in Westchester.

Personal care, however, is only one component of long term health care. DSS maintains that although Nassau County spends more than comparable counties on personal care, this results in DSS spending less on personal care's alternative, skilled nursing facility care. In response to DSS's claim, we performed an analysis of all long term care costs for 2002 and found that:

- Nassau's total spending on long term care was the highest of the five counties at $442 million, $13 million higher than Suffolk County, even though Suffolk had 36,809, or 13% more Medicaid enrollees likely to use long term care services (those classified as aged or blind and disabled) than the 32,671 in Nassau County.

- While the department's strategy may mitigate skilled nursing facility costs to some extent, the schedule below shows that Nassau provides long-term care services of one kind or another (predominantly personal care) to a greater percentage of its aged or blind and disabled Medicaid population than comparable counties. Nassau County was providing either personal care or skilled nursing facilities to 31.4% of Medicaid enrollees most likely to use long term care services. This compares to 28.3% and 25.9% receiving care in Westchester and Suffolk County, respectively.

Medicaid Eligible Individuals Receiving Personal or Skilled Nursing Facility Care

Year Ended December 31, 2002

	Medicaid Eligible Individuals		Long Term Care Recipients								
			Personal Care			Skilled Nursing Facilities			Combined		
				Percentage of			Percentage of			Percentage of	
County	Total Eligibles	Aged, Blind or Disabled Eligibles	Recipients	Total Eligibles	Aged, Blind or Disabled Eligibles	Recipients	Total Eligibles	Aged, Blind or Disabled Eligibles	Personal Care and Skilled Nursing Facilitiy Care Recipients	Total Eligibles	Aged, Blind or Disabled Eligibles
Erie	118,795	39,521	1,935	1.6%	4.9%	7,434	6.3%	18.8%	9,369	7.89%	23.7%
Suffolk	90,228	36,809	1,740	1.9%	4.7%	7,796	8.6%	21.2%	9,536	10.57%	25.9%
Monroe	94,039	28,357	287	0.3%	1.0%	5,076	5.4%	17.9%	5,363	5.70%	18.9%
Westchester	87,766	28,928	1,965	2.2%	6.8%	6,234	7.1%	21.6%	8,199	9.34%	28.3%
Nassau	70,498	32,671	3,430	4.9%	10.5%	6,830	9.7%	20.9%	10,260	14.55%	31.4%

In addition to Nassau County having the highest number of Medicaid clients receiving personal care services, Nassau's cost is the highest of comparable counties for personal care services and consumer direct personal care services ("CDPAP"). CDPAP is a personal care program subdivision that allows the client to recruit, interview, hire, supervise, train and dismiss personal assistants. The following chart details the dollars spent on personal care services for 2002 by comparable counties.

County	Expenditure
Monroe	$ 4,329,720
Erie	18,960,119
Suffolk	23,355,229
Westchester	35,519,736
Nassau	86,730,464

We also found that DSS allows more personal care service hours per client, per week, than any of the four counties with the largest Medicaid populations. *

Weekly Hours of Personal Care Service Granted
Year Ended December 31, 2002

County*	Client PCA Service Average Hours per Week
Erie	22
Suffolk	26
Westchester	35
Nassau	**51**

*** Monroe** County was excluded from this analysis due to its insignificant number of PCA recipients.

The county's high personal care costs are preliminary driven by the weekly hours of care granted as compared to the other counties. Nassau County commissioned a June 2000 report by the "Center for Government Research", www.cgr.org , to identify problems with Nassau County's DSS Home Care Program and to recommend solutions. In that report, the Center noted that the number of care hours granted by Nassau County were extremely high and that significant savings could be achieved if the hours granted were reduced. Westchester County provided an average of 35 hours PCA care per week and 40.9% of the Medicaid eligible elderly population receives skilled nursing facility care. By contrast, Nassau County provided an average of 51 hours care per week and has 37.8% of the Medicaid eligible elderly population in skilled nursing facilities. Based upon these percentages it appears that, to some extent, the number of weekly hours granted can be reduced without significantly increasing dependence on skilled nursing facilities for long term health care.

Audit Recommendations:

DSS should:

- DSS should undertake a study to determine if there is a relationship between the manner in which it determines eligibility for personal care services and the greater percentage overall than in comparable counties of elderly and blind or disabled Medicaid eligibles receiving long term care of one kind or another, and, accordingly, whether it is appropriately determining eligibility for these services.

- undertake a study or pilot program to determine whether a reduction in the number of care hours granted would result in:
  a. an overall savings, or an
  b. increase in skilled nursing facility costs that more than offset the personal care savings achieved.

- adopt the recommendations of the Center for Government Research, including;
  a. modifying the approach used to determine hours for new clients,
  b. re-visiting the hours currently allocated to current clients, and
  c. setting performance goals to provide a more efficient number of PCA hours for current clients.

Lack of Management Reports for Control and Performance Monitoring

Audit Finding (2):

DSS does not produce adequate management reports to monitor existing caseloads and productivity. DSS management has acknowledged that there are currently no monthly management reports detailing the individual number of hours of PCA/CDPAP care per client. Based on NYS-DOH information, Nassau County personal care programs have generated expenditures of approximately $99 million in 2002. These programs have grown substantially in the last 2 years (in particular CDPAP expenditures). Without effective reporting controls, DSS management cannot effectively monitor the cost and provision of services per client.

A program administrator at the NYS-DOH, and program administrators from other counties (Westchester, Erie, and Suffolk), advised the auditors that costs could be reduced by gradual hourly reductions in services and through development of shared aid sites. Shared aid sites represent a location where there is a cluster of aid recipients. Efficiencies can be achieved because one aid can provide service to more than one client. DSS does not have reports detailing the hours of service per client nor have address tracking software that enables them to develop sites for shared aids.

The Center of Government Research[7], in a June 2002 report titled "A Review of the Nassau County Department of Social Services Home Care Program", estimated that a reduction of one hour per week per patient could save the county $228,000." Additionally, the report states, "If DSS could reduce the average hours per patient, per week, to the mid 20's, as has been done in Westchester, Suffolk, and Erie counties, annual savings would approach $45 million, with a County share savings of $4.5 million."

The Center of Government Research's report states "without the means to track and monitor cases electronically, the job becomes prohibitively time consuming. We strongly recommend that DSS implement tracking software, which would allow for data-driven performance indicators, better tracking of patients, better oversight of providers and aides, the ability to monitor the Long Term Home Health Care program, and a substantial reduction in the time spent on paperwork, and other clerical functions. It is difficult to estimate the dollars to be saved from automation, but other counties believe that automation allows them to reduce staff, monitor cases much more efficiently, and identify problems much earlier".

[7] See supra no. 2

Audit Recommendation:

DSS should immediately investigate the implementation of client/patient-tracking systems and develop monitoring reports that will detail the number of hours, type of service, approval and assessment periods, etc.

New York State Imposed Penalty for failure to meet Targeted Savings

Audit Finding (3):

New York State Public Health Law requires that the NYS-DOH establish a home care services saving target for each social service district.[8] If the local district's costs for that period exceed the savings cost target, then the NYS-DOH imposes a penalty (target savings intercept) to penalize the county for not meeting its goal.

In discussions with NYS-DOH personnel, they have identified Nassau County as having the highest cost per recipient in home care of any county in the state in both the target's base period (7/1/96-3/31/97) and during the target period (7/1/02-3/31/03).

The NYS-DOH imposed penalties on Nassau County for failure to meet these savings incentive targets. During the audit period the penalties imposed were:

Target Period	Amount
July 2002-March 2003	$1,125,775*
July 2001-March 2002	$1,274,400
	$2,400,175

* Nassau County DSS was credited $99, 083 for actual savings against the original intercept.

The targets were imposed to provide incentives for social service districts to utilize care services that meet the recipients home care service needs in the most cost-effective and cost-efficient means available. DSS was able to meet the target savings imposed by the state for the period July 1996 through March 2000 and again for the period July 2003 through March 2004. DSS is discussing its options in response to the imposition of the July 2001 – March 2002 and July 2002 – March 2003 penalties for by the NYS-DOH with the County Attorney.

The Center for Government Research Inc., in its June 2000 report, made several cost saving recommendations, including:

- developing a long-term care policy and comprehensive plan for the county;
- improving management tools for oversight;
- using home care programs more efficiently: and
- using licensed provider agencies more efficiently.

The County should have:

- adopted the recommendations of the Center for Government Research
- hired a consultant to recommend ways to reduce costs;

[8] The N.Y. Health Care Reform Act of 2000, 1999 N.Y. Laws 1, at § 43.

- purchased case tracking software to automate DSS's inefficient manual personal care record keeping assessment systems; and
- hired additional case management personnel.

Had DSS undertaken these initiatives previously, it could have saved substantial sums in personal care costs and penalties.

We note that penalties are 100% county funded, whereas funds spent on consultants, systems and additional personnel may be eligible for federal (50%) and state (25%) cost sharing. A $1.0 million consulting contract would only have cost the county $250,000 and possibly enable DSS to avoid a $1.2 million penalty each year. Additional personnel could be hired with 75% of the costs borne by the state and federal governments.

Audit Recommendations:

To avoid penalties in the future, DSS should consider implementing the cost savings recommendations of the New York State DOH and the Center for Government Research. The $2.5 million spent on penalties could have been better utilized to fully computerize operations and/or to hire a Medicaid cost reduction expert to make efficiency recommendations to improve both the delivery of personal care services and the administration of the PCA unit.

Physician Orders

Audit Finding (4):

In order for a client to receive PCA services, s/he must visit a physician and have a physical examination. State regulations[9] require the medical professional[10] to complete the physician's order (DSS form 517) within 30 calendar days after the medical examination of the patient. In addition, the medical professional is strictly prohibited from recommending the hours and days of service and NYS DSS Administrative Directive 92-ADM-48[11] states that physician orders are to be returned to the physician with an explanation of the regulatory requirement if hours are specified. The state directive provided a sample cover letter for this purpose.

We performed testing to determine if DSS is monitoring for compliance with this important first step in securing home health care. We examined 100 randomly selected files (out of 2,600 cases) to ensure that the physician's orders met the requirements of the state regulations. We noted exceptions in 40 of the 100 files examined.

This error rate indicates that DSS is improperly approving home health care services based on inadequate physicians' orders, possibly as often as 40% of the time. The types of exceptions noted were:

- Completion of the physician's order form later than 30 days after the exam- Seventeen forms examined had this exception, some as long as eight to eleven months after the date of the exam.

- Physician's order form incomplete, no date of exam. - Eleven forms

- Physician's order form incomplete, no signature date - Four forms

- Physician's order forms contained prohibited information- On eight forms the physician recommended the hours and days of personal care service. DSS should have been rejecting these forms because these recommendations are prohibited by state directive. The physician's form is to state the patient's medical condition and needs, and the social service district's nursing assessments should evaluate functions and tasks required by the patients and determine the hours and days of service

[9] New York State Regulations, DSS, Title 18 NYCRR 505.14 (3) (a)
[10] The physicians order must be completed by a licensed physician, a physician's assistant, a special assistant or a nurse practitioner and signed by a physician.
[11] 1992 New York State Department of Social Services No.92 ADM-48, (Dec. 1, 1992)

The New York State Department of Health has prohibited certain providers from prescribing Medicaid services. It has provided a Web site[12] listing 1,552 providers that are not allowed to order services for Medicaid Recipients. DSS has not checked any prescribers against the listing to ensure that they are not accepting prescriptions from prohibited providers.

Audit Recommendations:

DSS should review the physician's order documents to ensure that data required by state regulations is complete, timely and accurate. Forms without the required information should be returned to the doctor for proper completion. Forms that were not completed within 30 days of the medical examination should also be returned to the doctor. The forms are invalid because a client's medical condition could have changed.

The physician prescribing the care should be matched against the list of prohibited providers found on the New York State Department of Health Medicaid fraud Web site.

[12] http://w3.health.state.ny.us/dbspace/provider.nsf?OpenDatabase&Expand View

Physician Orders Form

Audit Finding (5):

NYS DSS Administrative Directive 92 ADM-48 explains the requirements for the "physicians' orders for personal care" as found in the regulations.[13] The directive also provides a recommended physicians order form for personal care and related instructions to the physician. However, each county may develop its own forms and instructions.

We compared the form used by DSS to the form used by two other counties (Erie and Westchester) and the form recommended by NYS DSS. Nassau County requires the doctor to provide minimal information on the patient's condition as compared with the other counties.

Information requested on at least two of the other three forms, but not on Nassau County's form, included:

- Physician's License number;
- Physician's provider number;
- Patient Prognosis;
- Patient's Mental Status (indicators for check off);
- Sensory Impairment;
- Specific medications, dosage and instructions;
- Self Administered Medications;
- Continent Issues;
- Ambulation capabilities;
- Ability to use a personal emergency response device; and
- Recommend PCA Services.

DSS also does not utilize an instruction sheet as recommended in the directive. The state provided a "sample physician order" which contained accompanying instructions to the physician with extensive directions on how to complete the medical form. On the sample provided by the state, the physician provides the standard medical diagnosis code, as s/he is responsible for the diagnosis. DSS nurses must identify the diagnosis code because the code is not on the physicians form and add it to the assessment. The nurse's time would be better utilized assessing care requirements, rather than researching diagnosis codes.

The DSS physician order form also does not state the exact department within DSS where the form should be returned, nor the 30-day requirement. The lack of clear instruction may have led to forms being misdirected. For several cases, we noted that DSS date stamped the physician's order form as received on two separate dates, several months apart. The unit explained that there were two received dates on one form because the

[13] New York State Regulations, DSS, Title 18 NYCRR 505.14 (b) (3) (i) and (g) (30 (ii)

form had been date stamped as received at another DSS department, months before. Suggesting the form to be sent by fax, and "to the attention of" in the mailing address, would alleviate this problem.

The state's recommended form also contains a sample certification statement to be signed by the medical provider. It reads:

> "I certify that this patient can be cared for at home, and that I have accurately described his or her medical condition, needs and regimens, including any medication regimens, at the time I examined him or her. I understand that I am not to recommend the number of hours of Personal Care Services this patient may require. I also understand that this physician's order is subject to the New York State Department of Social Services regulations at parts 515, 516, 517, and 518 of Title 18 NYCRR, which permit the Department to impose monetary penalties on, or sanction and recover overpayments from, providers or those prescribing of medical care, services or supplies when medical care, services or supplies that are unnecessary, improper or exceed the patient's documented medical condition are provided or ordered."

The county form does not contain a certification statement.

Audit Recommendations:

a. DSS should revaluate its physician's order form and consider including the state's recommendations concerning the physician's assessment of medical diagnosis and patient functionality. In addition, a detailed instruction sheet should be developed, similar to the state directive sample, which provides guidance to the physician filling out the form.

b. DSS should consider the insertion of a certification statement on the physician's order form, informing the medical provider of its obligations under the state regulations. Alternatively, this information should be included in the instructions to the form.

c. The instructions should be clear as to specifically where in DSS to return the form by mail and or by facsimile. The DSS Home Health Care Unit would then be able to immediately return and resolve issues concerning incomplete forms, were completed 30 days past the examination date, or contain information prohibited by the regulations.

DSS Compliance with Nursing Assessment Regulations

Background

After the physician's order is received, the next step in the process is for the social service district to perform an assessment of the individual.[14] Two types of assessments are required. The first is a nursing assessment that includes:

- a review and interpretation of the physician's order;
- the primary medical diagnosis code;
- an evaluation of the functions and tasks required by the patient;
- the degree of assistance required for each function; and
- and development of the plan of care.

The second step is a social assessment that evaluates the potential contribution of informal caregivers such as family and friends. The social services district then notifies the individual of the services that will be provided.

Audit Finding (6):

Initial Nursing Assessment

18 NYCRR 505.14 requires initial nursing assessments to be completed within 5 working days after receipt of the request for services. We tested to determine if DSS complied with this state regulation. A test of 25 cases found that 13 assessments were not performed within the five days as follows:

- Nine cases assessed 6-19 days after receipt
- Three cases assessed 60-76 days after receipt
- One case was assessed 151 days after receipt

Re-Assessment

NYS DSS Regulations, 18 NYCRR 505.33 require that re-assessments of cases be performed every six-months. Medical conditions may change rapidly and a clients care needs may increase or decrease. Without timely reassessment, the client may not receive the proper level of care. The department will be notified by the personal care provider contracted by DSS if the client needs additional care. However, the personal care provider agency would not necessarily let DSS know if the client needs less hours of care.

The department readily admitted that they are not performing reassessments on time and therefore we did not perform any testing. The department generates a monthly list

[14] New York State Regulations, DSS, Title 18 NYCRR 505.14 (3) (a)

entitled “PCA with Clients Reauthorization Overdue”. As of June 3, 2003, this list contained 810 client names.

Audit Recommendations:

The unit should perform initial nursing assessments within five working days as required by state regulations.

Nursing re-assessments should be performed in a timely manner to ensure that Nassau County is not providing personal care services based on medical conditions that may have changed.

Social Assessments

Audit Finding (7):

In addition to the nursing assessment, state regulations require that professional staff of the local social service district perform a social assessment on forms approved by the State. This social assessment includes an evaluation of the potential contribution of informal caregivers. In Nassau County, contract nurses perform social assessments at the same time they perform the nursing assessment. The use of a contract nurse, rather than a caseworker is inefficient for two reasons:

1. Professional caseworkers earn about half of what contract nurses are paid ($30,000 versus $70,000); and
2. The social assessment should be used in conjunction with the nursing assessment to determine the best plan of care.

DSS's method of using the same person to perform both the nursing and social assessment removes objectivity that would be gained by having separate employee's opinions. According to the Supervising Head Nurse and the Director of Medical Services, the family present at the assessment routinely pressures the nurse into granting more hours. With a second employee present at the client's home, it will likely be easier to resist the family pressure, and the two employees can develop the correct plan of care. Better uniformity in assessments could be achieved by using trained caseworkers.

Audit Recommendations:

For economical efficiency and better objectivity, DSS should consider using caseworkers to perform social assessments. This would allow the higher paid nurses to fulfill the state requirement of completing the initial nursing assessments within 5 working days.

Case Management

Audit Finding (8):

The New York State Department of Social Services Administrative Directive "Personal Care Services- Scope and Procedure" states, "…proper case management is the mechanism by which services are provided in a coordinated basis**".** It also states that the case manager should assure the following records are obtained, developed and maintained:

1. Physician's orders
2. Nursing assessment
3. Social assessment
4. Determinations of the local (social service district's) medical director
5. Summary of service requirements
6. Notifications of services authorized

DSS uses contract nurses to perform case management. Contract nurses, who earn more than double the salary of caseworkers, should be using their specialized skills to perform nursing assessments, rather than performing case management. (DSS's contract with the Nassau Health Care Corporation calls for the Center to provide up to 32 nurses. However, because of a nursing shortage, they have provided only 20 nurses.)

Nurses interviewed by the auditor collectively stated that they are required to spend a large amount of their valuable time performing clerical duties.

Audit Recommendations:

DSS should evaluate the possibility of hiring or transferring caseworkers to the unit so that cases can be properly managed and so that nurses can concentrate on clearing the backlog of nursing assessments.

Inadequate Office Systems / Lack of Operations Manual

Audit Finding (9):

Contract nurses stated that not only are they performing case management functions, but performing routine clerical duties as well. This is due to a shortage of clerical staff and inadequate office systems.

Nurses reported having to re-copy redundant information from form to form, manually address envelopes, and stamp forms. Productivity is hindered because nurses share computers and telephones. Nurses' time is also spent answering numerous telephone calls that should be answered by a receptionist and routed to a case worker, social worker or to the PCA agency. In part, this is because PCA clients are not provided with an adequate guidelines manual to answer their questions or a contact sheet to provide guidance on where to direct their telephone calls.

Much of this work could be accomplished by clerical staff that earn much less than nurses are currently earning. Proper use of technology, such as laptops, scanners and integrated systems, could eliminate much of the redundancy and manual effort.

Ideally, doctor's offices should fax medical forms directly to the unit to ensure timely delivery to the correct department. However, with a caseload of 2,600, the unit's only fax machine was reported as being always busy.

Audit Recommendations:

DSS should consider providing nurses with laptop computers preloaded with linked form templates, eliminating the need for re-copying redundant information. In addition, information recorded in the field should be entered directly into the system through the laptop.

Clerical staff should answer and route telephone calls to individuals who can most effectively assist the caller. Queries that should be answered by clerical staff or PCA agencies should not be directed to the nurses.

The unit should provide PCA clients with a care recipient's manual including:

- a telephone contact sheet;
- the caseworker's name;
- answers to frequently asked questions, indicating who to contact;
- PCA agency contacts; and
- a complaint line to DSS/PCA agency.

DSS should consider providing the unit with a high volume fax machine and/or several dedicated fax lines.

DSS should explore computerization of the intake of pertinent information (via scan) from the physician's order form, such as the doctor's name, date of exam, clients' name, dates, etc. The computer should be used to account for the receipt of the form and to generate the nursing assessment form. Computerization would also facilitate matching the physician's authorizing signature against the list found on the New York State Department of Health Medicaid fraud Web site listing of 1,552 providers that are not allowed to order services for Medicaid Recipients.

Information obtained through scanning forms should be used as a permanent searchable archive.

Manual Calculations of Hours Authorized for Input Screens

Audit Finding (10):

PCA calculations of care needed from the nursing assessments are initially based on hours and days. To schedule personal care with the service providers these hours and days must be converted into quarter hours for input into DSS's Wang system. (Consumer Directed (CDPAP) is entered in whole hours with no manual calculation.)

The DSS clerk must perform the various calculations with a hand-held calculator to convert hours of service needed to quarter hour increments and then must enter the results on the PCA entry screen. The DSS clerk interviewed by the auditor stated that after the data is input into the computer system, there is no review of that data input (authorization of PCA hours) by management. Rather, DSS generates a Personal Care Agency Prior Approval roster and sends it directly to the PCA provider. The clerk stated that the PCA provider compares the Prior Approval Roster printout to the nursing task plan hours. The provider catches errors in which the numbers of care hours are understated. It is unlikely that the provider would notify DSS when the hours authorized are overstated.

CDPAP hours are calculated by rounding-up to the next full hour due to internal computer program limitations and the lack of a necessary NYS-DOH quarter-hour incremental billing code. These limitations lead to an over-authorization of service hours.

Audit Recommendations:

DSS should request an enhancement by DSS Information Technology to modify and automate the input screen so that the days and hours of PCA service entered are automatically converted to quarter hours for authorization of service hours.

DSS should apply to NYS-DOH for a quarter-hour incremental billing code.

DSS should work with I/T to modify the data input screens to accept quarter hours for CDPAP services to eliminate the need for rounding up and incurring excess hours of service cost.

Possible Duplication between NYS provided Home Health Care & County Personal Care Services

Audit Finding (11):

Certified Home Health Agencies ("CHHA") services include PCA, home health aide, skilled nursing, physical, occupational and speech therapy services to patients through New York State rather than the local social service districts. Personal care services provided by DSS should not duplicate the CHHA services. DSS should determine if CHHA services are furnished to Medicaid Home Care patients before establishing a new or revised DSS Care Plan.

The state has no mechanism in place to notify local social service districts of clients receiving CHHA services. Patients may be receiving duplicate services through a CHHA assigned by the state and through Home Care services authorized by DSS. Medicaid can be simultaneously billed for both services. According to the DSS Medical Services Director, duplication of services is most frequently discovered by chance.

We contacted Suffolk and Erie County Social Service Districts. They have the following two procedures in place to detect duplicate billings:

1. They make direct inquiry on the physician's order form to determine who is receiving CHAA services; and
2. use MMIS state billing records to determine which patients have billing for both CHAA and county PCA services.

The unit does not utilize either method.

Audit Recommendations:

In order to detect and prevent duplicated services and costs DSS should:

- Establish procedures to detect and prevent duplicated services and costs to the County;
- revise the Physician Orders Form 517 for home care services to inquire of the doctor as to whether CHHA services have been requested; and
- establish a computerized file matching process to periodically compare MMIS billing records to PCA service records to identify clients who receive both services.

Lack of Legal Representation at Fair Hearings

Audit Finding (12):

If the unit denies a Medicaid client's request for services, or reduces the number of care hours granted, the client can request a DSS Fair Hearing. Statistics for the past year (September 2002 – 2003) indicate that there were 183 fair hearing requests. The state allows "aid continuing" until a final determination is reached through the fair hearing process. Because the fair hearing process is often delayed, DSS often continues to pay for daily PCA services at levels that may be higher than necessary until fair hearing decisions are rendered.

The fair hearing data provided by the department indicated that in approximately 80% of the cases (147 cases out of 183 total hearing requests) DSS decisions were upheld. Either DSS received a "correct as made" decision, or the client withdrew the request for a fair hearing.

While legal counsel usually represents clients, DSS relies upon nurses and the unit's director for representation. The County's use of nurses as representation differs sharply with some other social service districts that use legal representation. Attorneys would most likely be better able to prevent unnecessary delays in hearings. There is little or no cost benefit in relying on nurses because nursing salaries are as high as the salary of legal staff.

Audit Recommendations:

DSS should discuss with the county attorney how to obtain legal representation for the County at Fair Hearings. Nurses should be present only when their in person, "expert testimony" is required.

DSS Departmental WANG System not linked with State Welfare Management System

Audit Finding (13):

The unit utilizes a WANG data system to keep track of PCA authorizations. The system does not always reflect the proper Medicaid status of PCA clients currently receiving services when compared to the state's WMS (Welfare Management System) system. The DSS supervising head nurse indicated that there have been cases in which the status of a PCA client was classified as active in the WANG system, and services provided, when they were classified as no longer eligible for benefits in the WMS system. This could result in DSS providing PCA services to ineligible clients.

After the auditors discussed this control weakness with the Director of Medical Services, she instituted a manual log of closed cases. Recently, DSS's Information Technology Department provided a temporary solution by preparing a spreadsheet of closed cases. These stop-gap processes are labor intensive, and not error-proof or timely.

Audit Recommendations:

The unit's systems should be linked to the WMS so that PCA services are discontinued to clients whose Medicaid cases have closed. DSS Information Technology Department should regularly data match the status field on WANG system database to the state WMS system to confirm the correct Medicaid status and produce exception reports. Alternatively, DSS should consider replacing the Wang System with a system capable of direct interface with the WMS.

Nurse, Nurse Supervision, and Unit Supervision Staffing

Audit Finding (14):

DSS has a contractual arrangement with the Nassau Health Care Corporation (NHCC) to provide a maximum of 32 registered nurses ("RNs"). NHCC is presently supplying approximately 20, due to a nursing shortage. The DSS Director of Medical Services states that they have limited control over the work performance and ability to influence enforcement actions against the contract nurses. The Director believes that if the nurses were on the county payroll, DSS would have more flexibility and could impose greater accountability in the performance of the Department's work.

The County only pays about 14% of the cost of the nursing staff because the federal and state governments fund 72% and 14%, respectively. Because the county only pays a portion of an RN's salary, it would be beneficial to hire additional RN's, as either employees or contracted workers so that the assessments and re-assessments can be performed on a timely basis. Any variation of part-time and flexible hours should also be explored to attract nurses in an environment with a nursing shortage.

The Suffolk County Medical Services Director informed us that, in 1991, Suffolk County had problems similar to Nassau County's with its personal care programs. Following cost control task force recommendations, the county hired additional in-house nurses who became familiar with all the different regulations. As a result, the county was able to greatly reduce its care hours and program costs.

DSS's Medical Services Director also has supervisory responsibility for the medical transportation unit and the adult protective services unit, including the homeless. A more focused attention to the high cost personal care area may benefit the county.

Audit Recommendations:

DSS should evaluate the feasibility of hiring full time and/or part time and flex time nurses vs. using contracted nurses to perform state regulated assessments.

DSS should consider using a separate supervisor for the personal care area, to more effectively monitor productivity, review case management and provide guidance to the nursing staff.

DSS Personal Emergency Response Service (PERS)

Audit Finding (15):

Personal Emergency Response Services (PERS) provide and maintain electronic communication equipment in the homes of clients. This equipment signals a monitoring agency for help when either activated by the client, or after a predetermined period, if a timer mechanism has not been reset. DSS provides PERS as a cost-effective means of providing emergency communication capability to approximately 500 PCA clients. The costs incurred for PERS services were approximately $107,000 and $131,000 in calendar years 2002 and 2001, respectively, based on NYS-DOH Provider Ranking Lists.

Nurses use their judgment of the patient's situation to determine if the unit should provide PERS. This is contrary to NYS DSS NYCRR Regulations Section 505.33 (c) (2), and directives, which state, "an initial authorization for PERS must be based on a physician's order and a comprehensive assessment of the person." This necessity for PERS was one of the missing items on the Nassau County physicians form as mentioned in audit finding (5).

At the time of the audit, nurses were responsible for monitoring the PERS contractor's performance. This monitoring consisted of checking to see if the equipment was working properly while they were at the residence performing reassessments. The auditors reviewed the contract and also contacted the DSS designated PERS provider, which stated that the 2003 rates were $19 and $30, for monthly subscriber services and installation, respectively. However, the PCA unit responsible for monitoring contract billing issues was apparently unaware of the contractual rates and informed us that the rates were $25 for both monthly subscriber services and installation.

As a further indication of lax monitoring, the contractor informed the auditors of significant billing issues that have not been resolved or addressed by the DSS home health care unit. According to the contractor, numerous attempts to contact DSS management went unanswered. DSS denied that such a situation occurred. However, in an effort to address these claims, DSS held a meeting with the contractor and began to resolve rate change and retroactive billing issues.

Recommendations:

Procedures should be modified to adhere to state regulations by requiring a physician's order before providing PERS services. DSS should revise the physician's order form to include the health care provider's PERS recommendation.

DSS management should monitor the PERS contract services as to the billing roster and billing rates and resolve discrepancies within a reasonable period with the PERS provider.

Appendix 1

NEW YORK STATE MEDICAID PROGRAM
AVERAGE MONTHLY MEDICAID ENROLLEES
BY COUNTY AND AGE GROUP
FEDERAL FISCAL YEAR 2002

COUNTY	TOTAL AVERAGE MONTHLY ENROLLEES	AGE GROUP 0 - 20	21 - 64	65+
ALBANY	30,580	14,712	12,050	3,818
ALLEGANY	6,501	3,143	2,632	726
BROOME	22,866	11,046	8,837	2,983
CATTARAUGUS	10,490	5,031	4,098	1,361
CAYUGA	8,734	4,411	3,117	1,207
CHAUTAUQUA	20,002	9,723	8,003	2,276
CHEMUNG	13,197	6,585	5,151	1,461
CHENANGO	7,124	3,704	2,570	850
CLINTON	10,078	4,544	4,275	1,259
COLUMBIA	5,901	2,709	2,237	954
CORTLAND	6,355	3,326	2,339	690
DELAWARE	5,002	2,403	1,795	803
DUTCHESS	17,683	8,185	6,543	2,955
ERIE	115,630	54,916	46,657	14,056
ESSEX	3,941	1,677	1,561	703
FRANKLIN	6,261	2,825	2,451	986
FULTON	8,461	4,064	3,323	1,073
GENESEE	5,232	2,565	1,932	735
GREENE	5,173	2,514	1,982	678
HAMILTON	354	147	133	73
HERKIMER	8,073	3,954	2,921	1,198
JEFFERSON	13,809	6,706	5,491	1,613
LEWIS	3,570	1,786	1,331	454
LIVINGSTON	5,322	2,701	2,047	574
MADISON	6,168	3,112	2,237	819
MONROE	90,314	46,794	34,277	9,244
MONTGOMERY	7,106	3,461	2,605	1,039
NASSAU	70,400	29,918	24,599	15,883
NIAGARA	23,134	10,980	9,513	2,642
ONEIDA	32,856	15,406	12,962	4,488
ONONDAGA	53,751	28,147	19,932	5,672
ONTARIO	7,868	3,794	3,018	1,056
ORANGE	38,408	21,091	13,264	4,053
ORLEANS	5,155	2,782	1,865	508
OSWEGO	16,070	8,469	6,220	1,382
OTSEGO	5,735	2,749	2,109	877
PUTNAM	2,949	987	1,295	668
RENSSELAER	15,956	7,518	6,310	2,128
ROCKLAND	31,606	17,472	10,045	4,088
ST. LAWRENCE	15,183	7,020	6,222	1,940
SARATOGA	11,574	5,357	4,485	1,732
SCHENECTADY	16,661	8,180	6,481	2,000
SCHOHARIE	3,377	1,721	1,175	481
SCHUYLER	2,270	1,072	884	314
SENECA	3,361	1,676	1,284	402
STEUBEN	12,899	6,144	5,320	1,435
SUFFOLK	87,374	41,151	31,565	14,658
SULLIVAN	9,705	4,707	3,686	1,313
TIOGA	4,747	2,415	1,723	609
TOMPKINS	7,310	3,637	2,907	766
ULSTER	17,134	7,662	6,921	2,552
WARREN	5,827	2,578	2,387	862
WASHINGTON	6,317	3,067	2,410	839
WAYNE	7,708	3,889	2,803	1,016
WESTCHESTER	83,828	41,025	29,240	13,563
WYOMING	3,274	1,604	1,214	456
YATES	2,510	1,232	941	338
NEW YORK CITY	2,224,159	1,029,764	910,518	283,877

ON-LINE SURS INFORMATION
SOURCE: RETRIEVAL SYSTEM
QUESTIONS: CONTACT LINDA DUBUBEE or DEBRA

Appendix 2

New York State Medicaid Program
Personal Care Services - By Age Group
County by County
Federal Fiscal Year 2002

COUNTY	0 - 20		21-64		65+	
	Dollars	Recipients	Dollars	Recipients	Dollars	Recipients
STATEWIDE	31,722,763	2,115	334,116,669	20,921	1,224,085,072	65,245
NEW YORK CITY	17,649,150	1,075	248,218,972	13,405	1,075,968,749	51,705
UPSTATE	14,053,012	1,038	85,781,049	7,503	148,114,466	13,539
ALBANY	159,398	11	1,723,908	155	1,822,853	289
ALLEGANY	0	0	151,542	53	342,024	95
BROOME	318,532	44	988,140	245	1,185,078	329
CATTARAUGUS	25,635	4	354,160	99	401,378	139
CAYUGA	0	0	215,409	59	420,487	141
CHAUTAUQUA	137,080	19	1,149,410	242	1,389,592	337
CHEMUNG	115,841	9	483,436	138	664,032	227
CHENANGO	0	0	170,218	49	265,431	104
CLINTON	45,257	5	747,080	106	933,747	209
COLUMBIA	127,821	4	377,214	22	74,410	26
CORTLAND	43,455	2	174,941	44	275,287	75
DELAWARE	30,463	7	336,147	55	342,587	112
DUTCHESS	170,550	18	1,293,637	215	2,920,344	308
ERIE	806,134	74	8,323,977	722	9,005,245	1,139
ESSEX	21,625	3	194,798	40	380,341	117
FRANKLIN	76,547	9	744,172	107	1,799,208	241
FULTON	344,654	20	631,590	64	1,232,326	161
GENESEE	329	1	228,696	43	148,068	42
GREENE	0	0	190,641	29	166,634	62
HAMILTON	17,553	1	18,680	7	68,435	21
HERKIMER	47,941	5	176,973	63	175,726	124
JEFFERSON	61,523	7	368,741	90	380,923	124
LEWIS	2,900	1	450,573	34	346,924	94
LIVINGSTON	8,032	1	50,441	17	135,349	40
MADISON	33,714	2	177,835	17	76,569	19
MONROE	957,620	48	2,525,881	145	371,197	94
MONTGOMERY	168,483	19	431,403	65	772,544	111
NASSAU	3,027,853	139	25,277,339	901	59,596,050	2,390
NIAGARA	214,097	20	1,267,181	154	1,653,717	230
ONEIDA	71,657	11	1,061,056	241	620,494	300
ONONDAGA	217,167	26	3,389,354	433	2,335,688	514
ONTARIO	0	0	304,737	46	228,204	86
ORANGE	1,489,171	128	2,468,121	200	3,170,364	321
ORLEANS	0	0	8,989	16	25,370	19
OSWEGO	170,705	22	429,535	107	454,995	145
OTSEGO	159,595	12	369,825	39	318,808	81
PUTNAM	78,677	8	370,216	21	1,444,624	74
RENSSELAER	122,696	10	1,216,565	156	507,787	134
ROCKLAND	291,936	22	1,355,274	85	3,374,354	252
ST. LAWRENCE	437,484	36	1,207,004	224	2,467,056	402
SARATOGA	144,505	15	279,918	25	415,132	66
SCHENECTADY	263,650	10	738,825	86	346,693	104
SCHOHARIE	0	0	311,812	34	569,030	62
SCHUYLER	568	1	89,296	16	219,920	36
SENECA	0	0	715	3	2,000	10
STEUBEN	59,286	5	337,095	48	95,010	60
SUFFOLK	1,147,658	71	6,567,563	478	14,181,002	1,191
SULLIVAN	208,524	7	1,214,149	91	1,134,720	97
TIOGA	60,055	9	265,107	30	52,788	41
TOMPKINS	36,311	8	358,170	105	419,826	124
ULSTER	163,560	11	3,038,813	275	4,646,869	366
WARREN	392,556	29	304,830	65	584,673	110
WASHINGTON	144,086	15	235,905	41	297,132	65
WAYNE	8,136	1	254,491	48	431,564	98
WESTCHESTER	1,405,810	103	10,238,282	564	22,244,085	1,298
WYOMING	15,612	4	110,090	30	89,251	46
YATES	570	1	31,149	16	90,521	37

Source: DOH/OMM County x County Medicaid Reference Statistics, FFY 2000 - 2002.
Contact: Linda Dupuree or Debra Southworth at (518) 473-2230 with any questions.

Appendix 3

Audit Finding (1) - Personal Care Recipients and Cost of Services

First and foremost, it is important to state that it is Nassau County policy to maintain the elderly and infirm in their homes, where they have raised their families and built their memories, where they are most comfortable, for as long as possible.

The auditors have compared the number of recipients receiving Personal Care Services (PCS) to several other counties. Taken out of context, the comparable numbers would make it appear that providing home care to a large number of recipients is inappropriate and indicates a flaw in the Department's PCS program administration. What was not included in the auditor's findings was information provided during the audit, which depicts the entire home care picture. To ignore this information produces a misleading conclusion.

The Comptrollers Office had obtained a comparative analysis from the State about Personal Care costs for various Counties, including Suffolk. The analysis indicated that Nassau's costs in 2002 were almost quadruple Suffolk's costs. If they had included the number of clients they would have found them to be about equal (FFY 2000 Nassau 5,879, Suffolk 5,627).

The very significant cost differential for Personal Care costs between the two counties is due to the number of hours and shifts given to each client (FFY 2000 Units of Service Nassau per user 191.63, Units of Service Suffolk per user 99.29). While this is a very simple answer to the cost difference between Nassau and Suffolk it is like looking at a tree and ignoring the forest.

Personal Care is one form of Medicaid service for individuals needing Long Term Care. Other forms of care include home health care, assisted living arrangements, nursing home without walls, and nursing homes. In fact, long-term care spans a continuum of care from the least restricted (and less costly) environment at home to the most restricted (most costly) nursing homes. To see the "forest" consider the following table:

	FFY1990	FFY2000
NASSAU TOTAL	**$237,013,141**	**$400,729,413**
Nursing Homes	**$176,385,391**	**$288,954,838**
Non-Institutional Total	**$60,627,750**	**$111,774,575**
Personal Care	$54,873,342	$84,572,607
Home Care	$1,876,409	$5,441,784
LTHHC	$3,877,999	$21,581,039
	FFY1990	FFY2000
SUFFOLK TOTAL	**$209,562,370**	**$357,919,897**
Nursing Homes	**$159,056,427**	**$315,984,442**
Non-Institutional Total	**$50,505,943**	**$41,935,455**
Personal Care	$40,905,312	$19,324,632
Home Care	$1,351,148	$11,628,858
LTHHC	$8,248,465	$10,981,965

Database: NYSDOH/OMM Reference File

Nassau's long term care cost increased 69% over the ten year period while Suffolk's increased 71%. Nassau's nursing home costs **increased by 64%** while Suffolk's **increased 99%**. While it is true that Nassau's Non-Institutional costs increased by 64% and Suffolk's declined by 17% one must remember that nursing home costs are easily double that of non-institutional care. Suffolk is actually spending more on nursing homes than Nassau. To really understand this surprising fact consider the following table:

CENSUS 1990 AND 2000 By Age

	1990	2000
NASSAU COUNTY	1,287,348	1,334,544
Under 18 years	280,698	329,079
18 to 64 years	823,751	804,651
65 years and over	182,899	200,814
SUFFOLK COUNTY	1,321,864	1,419,369
Under 18 years	326,588	370,081
18 to 64 years	853,559	881,730
65 years and over	141,717	167,558

Even in 2000, Nassau has approximately 33,000 more elderly (65 and over, of which 19,000 were 75 and over) than Suffolk. According to the New York State 2000 Census, the percentage increase of residents over the ages of 75 from 1990 to 2000 is 12% higher for Nassau than Suffolk. The complexity and extent of medical needs increase with age. This was not considered in reviewing population data.

If one were to consider per capita elderly Medicaid spending for Nassau, $1,996 and Suffolk, $2,136 the argument is clear that it is better to spend more on non-institutional care than nursing homes from the dollar standpoint and the quality of life issue.

This is consistent with county policy to permit those needing long term care to remain in their own homes as long as possible, and the Federal Olmstead Decision that requires such action.

Auditor's Follow-up:

We agree with DSS that it is important to examine the "entire health care picture." We also agree that it is important to maintain the elderly in their homes, and that nursing home care should not be the care option of first resort. We disagree with DSS's claim, however, that the county's overall Medicaid long-term care costs compare favorably to other counties. DSS suggests that we have exaggerated the costs of Medicaid personal care by not placing these costs in the context of the entire cost to the county of Medicaid long-term care for the elderly. When that occurs, DSS argues, Nassau's costs compare favorably to Suffolk's. DSS claims that "per capita elderly Medicaid spending" for Nassau is $1,996 as compared to $2,136 in Suffolk.

We believe, however, that DSS's calculation is incorrect. DSS apparently determined the per capita elderly "Medicaid" spending based upon the elderly population of each

county, not on Medicaid eligibles. An analysis using only the Medicaid eligible population shows that Nassau spends $6,273 on long term care per capita Medicaid eligible individual, or 31% more that the $4,758 spent by Suffolk. With 25,909, or 26% fewer overall Medicaid eligible individuals than Suffolk, Nassau spent $442 million on long term care as compared to Suffolk's $429 million.

The difference in the percentage of population over 65 in Nassau and Suffolk (14.43% vs. 11.49%) or 25% more over 65 elderly, is not enough to explain the disparity in spending. Moreover, Appendix 1 indicates that the average number of "monthly Medicaid enrollees" over the age of 65 in Nassau is only 8.02% more than in Suffolk, 15,883 vs. 14, 658.

DSS argues that our analysis should include the cost of skilled nursing facilities, which is a more expensive alternative to personal care, and that Suffolk is spending more on skilled nursing facilities ($381 million) than Nassau ($318 million). In fact, Suffolk County spends more on skilled nursing facilities because it has 14% more individuals housed in skilled nursing facilities than Nassau County (7,796 vs. 6,830).

It is relevant to consider the percentage of the Medicaid eligible population receiving benefits when comparing costs. 9.7% of Nassau County's Medicaid eligible population is housed in skilled nursing care facilities while Suffolk County houses only 8.6%. When combining personal care and skilled nursing facilities, 14.6% of Nassau's Medicaid eligible population receives either form of care, 37% higher than Suffolk's 10.6% even though Nassau has an elderly population only 25% higher than Suffolk's. The department's granting of services to a higher percentage of the eligible population, and granting higher levels of personal care services, has resulted in Nassau's costs being significantly higher than Suffolk's, despite a substantially lower Medicaid eligible population, and despite a difference in elderly population that does not explain these higher costs.

Comparable counties to Nassau are subject to the same court decisions and state regulations that govern Nassau's DSS. Given similar program objectives and legal environments, DSS has not adequately explained why:

- *Nassau provides an average of 51 hours per week on PCA services, while Suffolk provides 26 hours per week; Westchester, 35 hours, and Erie, 22 hours.*

- *4.9% of Nassau's Medicaid eligible population receives Personal Care services while the percentages for Westchester, Suffolk and Erie County's are 2.2%, 1.9% and 1.6% respectively.*

- *Medicaid eligible per capita total long term care personal care costs are 31% higher than Suffolk.*

Audit Finding (2) - Lack of Management Reports for Control and Performance Monitoring

During 2003, the Department developed a tracking program that provides information on the cost and number of hours of service provided to recipients in the Personal Care Services program. The Department is continuing to further expand the capabilities of this management tool.

The Department has regularly explored geographic areas that could be served as a shared aide site. Over the past 3 years we have added 4 shared aide sites. Information is solicited from our PCS providers, as well as periodic reviews of our caseload lists. There are no additional prospects at this time for expansion of shared aide sites. The client's ability to choose to receive PCS through the Consumer Directed Personal Assistance Program (CDPAP) has impeded our ability to expand our shared-aide sites as fully as we would like to. (Clients participating in CDPAP may not be included in a shared-aide program.)

The Department has conducted a full review of all cases prior to the audit's completion. We cannot, by regulation, reduce hours in an arbitrary and capricious manner. As was indicated to the auditors during their audit of home care, reductions effected in the other counties cited by the auditors were taken prior to changes in legislation and numerous class action litigations that now constrain this Department in its attempts.

Although the Department has already instituted automated management tools for both the PCS program and the Long Term Home Health Care Program, we will pursue more comprehensive systems to determine if they would be feasible for use in Nassau.

Auditor's Follow-up:

DSS states that they developed a tracking program during 2003 that "provides information on the cost and number of hours of service provided to recipients in the personal care Services program." The auditors are pleased with this progress as there was no service hour information appearing on the monthly management reports reviewed during the audit.

We concur with the corrective actions taken to institute management tools and to pursue more comprehensive systems.

Audit Finding (3) - New York State Imposed Penalty for failure to meet Targeted Savings

Attached please find a copy of a memo dated February 9, 2004 to Arda Nazerian, Chief of Staff, which details the significant legal and regulatory obstacles that exist in achieving Medicaid home care savings. This information was made available to auditors, but no reference to its content is contained in the draft report.

Three additional points must be made:

- The County Attorney is contemplating litigation to stop the assessment of a Home Care Savings Target, due in part to the issues raised in the memo.
- The Department was successful in its efforts in reducing program expenditures in its Title XX Homemaking program in 2004 because of the absence of such legal and regulatory restrictions referenced in the memo.
- No home care penalties will be assessed against Nassau County by the State of New York for 2004. It is not clear why the state initially imposed a penalty then withdrew it. The County Attorney has asked the state to provide its computation of prior year penalties; something the State to date has declined to provide.

In reference to the Center for Government Research report recommendations cited by the auditors, the following actions had been implemented at the time of the audit:

- The Department had developed management tools and will continue to improve and refine these tools
- The Department has reduced its provider base as recommended in the CGR report to allow for greater administrative oversight.
- The Department, as stated previously, is exploring enhancement of our current case tracking system.

Auditor's Follow-up:

The information included in the referenced February 9, 2004, letter from the commissioner to the chief of staff was not provided to the auditors. We note that the letter is dated after the conclusion of the audit field work. We are pleased that DSS is actively pursuing alternative methods to stop the imposition of the target savings penalty; however, this does not preclude DSS from continuing to implement cost savings methodologies.

With reference to the Center for Government Research report, the auditors are pleased to see that DSS is implementing some of its suggested reforms.

Audit Finding (4) - Physician Orders

The Department has initiated corrective action prior to the audit findings to insure that Physician Order forms (517) were as complete as possible. Currently accepted forms include information cited in the audit findings. In addition, the cover letter that accompanies a 517 form clearly advises physicians of the regulatory provisions for completion of the form. A distinct cover letter is used by the Medicaid eligibility staff when providing a 517 to the applicant for completion by their physician. It prompts the physician not to complete the form until the applicant has been determined eligible for Medicaid. This will help to reduce the number of grossly outdated 517 forms forwarded to the Medical Services Unit.

Clerical staff are reviewing the forms more carefully and returning them for appropriate completion before assignment to a nurse.

The Medical Services Unit currently matches the prescribing physician's name against the New York State Department of Health's (NYS-DOH) list of prohibited providers. Manually cross-referencing is time consuming, therefore the Department will include in its exploration of systems, one that can accommodate an interface with the NYS-DOH's fraud web site.

Please note, that although the Department may have technically been providing PCS to clients based on incomplete physician's orders; all forms returned for correction did return to the Department corrected/completed without change to the client's medical information or ultimately any change to the nurses' assessments.

Auditor's Follow-up:

Although we are pleased that the Unit's clerical staff is now placing greater emphasis in reviewing the physician form 517's for deficiencies, we again emphasize that DSS should adhere to state regulations and only provide medically necessary care that is indicated by the physician form. Our audit test found an error rate of 40% (performed by randomly selecting 100 forms from the 2600 active case files). This error rate indicates that DSS needs to take immediate corrective action. The auditors did not observe corrected Form 517's returned by doctors; we only observed 517's that were, at a maximum, 8-11 months late, without dates of examinations indicated, and without proper signatures.

We concur with the corrective actions taken by the Medical Services Unit to match prescribing physician's names against the NYS DOH list of prohibited providers

Audit Finding (5) - Physician Orders Form

a. Much of the information included in the NYS-DOH's suggested 517 form is included in the DMS1 that is completed at the time of initial assessment for PCS. (It should be noted that the original recommended form included in Administrative Directive 92 ADM-48 included orders for CHHA services as well as PCS. Information relevant only to CHHA services was included in the form.) The 517 form currently in use by this Department and approved for use by the NYS-DOH includes the Physician's License and/or Provider number, patient's mental status and patient prognosis. The form is accompanied by a cover letter that highlights those areas of importance and provides basic instruction to the physician. It is extremely rare that a 517 is completed without a written diagnosis along with the diagnoses code, therefore, this is a non-issue. When this does occur, the form is returned to the physician for correction.

b. The Department has, upon recommendation of the Comptroller's office included information from the certification statement in the cover letters that accompany the 517 forms, whether issued by a Medicaid eligibility worker or a Medical Services clerk.

c. The issue of outdated 517 forms was a result of the consumer submitting the form at the outset of their Medicaid application, not of the misrouting of the form. If the application process took several months, the 517 form aged accordingly. A separate cover letter for the 517 form was developed for the Medicaid eligibility area prior to the release of these audit findings. The cover letter specifically instructs the physician and consumer that the form must not be completed and submitted until the consumer has established Medicaid eligibility. The cover letter currently includes direction as to where to submit the form, even though this has not been a problem.

Auditor's Follow-up:

DSS indicates that they followed our recommendation and included language from the certification statement in the cover letter. We believe that stronger accountability can be established by including the certification statement in the form signed by the physician.

The response states 517 forms were outdated because "If the application process took several months, the 517 form aged accordingly." It should be clarified that the auditors found multi-year versions of Form 517 submitted, some dating back as far as 1979.

We concur with the corrective actions taken by DSS to add the physician's license number/ MMIS provider number, patient's mental status and patient prognosis, to the Form 517.

Audit Finding (6) - DSS Compliance with Nursing Assessment Regulations

Initial Nursing Assessment

Assessments are often not conducted within the 5 working days mandated by the State regulations as a result of a request by the client and/or their representative. Often the client's relative or representative may request to be present at the assessment interview and schedule an appointment outside of the mandated 5 business days to meet their own scheduling needs. In the 4 cases cited that were grossly outside of the 5-day mandate, the issue was the use of an outdated 517 form rather than the nurse's failure to conduct an initial assessment in a timely fashion. This has been corrected with the revised 517 cover letters and closer review of the form by staff prior to assignment for assessment.

The Department agrees that despite an improvement in the re-assessment backlog, timely completion of re-assessments continues to pose a challenge given our continued shortage of nurses. Please note however that it is rare for a client's medical condition to improve unless the illness or disability was temporary in nature. In those instances, the Department will authorize care for a period less than 6 months and these re-assessments are given priority. The Department continues its efforts to recruit additional nursing resources to the limit stated in our contract with the Nassau Health Care Corporation.

Auditor's Follow-up:

The auditor's concur that this problem could have been caused by both the client requesting appointments beyond the 5 business days and outdated physician forms. Therefore the department's revised cover letter and closer review of the form by the clerical staff will address the issue. However, all nurses should also be reminded not to rely on outdated physician forms when performing their assessments.

Audit Finding (7) - Social Assessments

Completion of a social assessment generally takes no more than 15-20 minutes of the nurse's time. This Department assigns the social assessment to our nurses, as the nurse has the medical training to determine if the client could be safely assisted and/or maintained by those persons indicating their ability to assist with the client's medical needs. The audit implies that the nurses permit the families' pressure to influence their recommendations of PCS hours. Although it is true that advocates and/or family members may exert pressure for the nurse to recommend hours requested rather than hours required, the nurses are trained professionals and do not require casework support to prevent them from losing their objectivity. It should be noted that there is an internal review system in place utilizing a reviewing RN and the Medical Director to ensure that the service recommendations are appropriate.

Auditor's Follow-up:

With the department's continual shortage of nurses, any functions that could be performed by either a case worker or a social worker should be transferred from the nurses. This would free the nurses to perform only nursing assessments until such time that the department is adequately staffed with nurses and the nursing assessment back log is eliminated. Social workers are trained to assess the social implications of the home environment and the safety of the client. With the combined opinions of these two disciplines, a more objective assessment of the necessary service hours could be obtained.

Audit Finding (8) - Case Management

Although the recommendation of hiring or transferring caseworkers to case manage the PCS cases is worthy of future consideration, the present resource level of the Department does not allow for the required staff.

Auditor's Follow-up:

The department stated they will give this future consideration. It would be cost effective to hire additional caseworkers to perform this function as opposed to contract nurses because nurses earn substantially more than caseworkers. In addition, the nurses could then concentrate on resolving the nursing assessment backlog.

Audit Finding (9) - Inadequate Office Systems/Lack of Operations Manual

The Department agrees that ideally, nursing staff would benefit from a software program designed to enhance productivity. We are exploring software programs that will provide nurses with the ability to complete assessments and the attendant forms in a more efficient manner. The procurement or development of such a program is dependent upon the availability of IT staff and County resources.

Calls are routinely screened by clerical staff and forwarded when identified as appropriate for other areas of the agency or referred to provider agencies. The remainder of the calls go to the nurse whose function is to case manage the client in receipt of PCS. Often times even though the issue may be one of Medicaid eligibility or problems with an aide, this information is relevant to the delivery of appropriate PCS and therefore should be shared with the nurse case manager. Clients are provided appropriate contact telephone numbers, however they often will call the staff member they feel most comfortable with, even though they know someone else has responsibility for the issue they wish to discuss and they know how to reach that person. Consumer Directed Program (CDPAP) participants often call with questions about the program even though they have received printed materials from both the Department and the CDPAP provider with the information at issue. The Department will continue to provide telephone numbers to the clients at the home assessment. Clerical support staff will continue to screen calls.

The Department currently has two fax lines available to support Medical Services. The Department is implementing a project to image all records and documents. This project will include forms and other documents utilized in the PCS program.

Auditor's Follow-up:

The nurses the auditors spoke with stated that a lot of their time is spent performing clerical and case management duties, such as telephone calls and copying documents. We reiterate it would be cost effective for caseworkers, who earn about half of a nurse's salary, to manage the cases. This would free up the nurses to perform necessary medical assessments. We encourage the department to implement the software programs mentioned in the response as quickly as possible to assist nurses in efficiently performing their jobs. We are pleased that the department will now be imaging standardized forms.

Audit Finding (10) - Manual Calculation of Hours Authorized for Input Screens

The Department has considered systems enhancements to automate conversion of quarter hours for authorizations of PCS service hours. This issue should be incorporated into a total PCS systems enhancement. The Department will incorporate this recommendation as it moves towards a total PCS program modification. The routine review of Automated Time and Leave Reports ensures that the providers are not billing hours in excess of those authorized.

The Department applied to the NYS-DOH for a quarter-hour incremental billing code in March 2004 and is waiting processing of this request.

Modification of the input screen to accept quarter hours for CDPAP services would not be necessary. Use of a code designated by NYS-DOH for this purpose would be sufficient. The Department will proceed to adjust authorizations accordingly when the code is made available. It should be noted that the client must receive a legal notice advising them of the Department's intent to reduce their authorized hours and is afforded the opportunity to request a Fair Hearing and receive aid continued.

Auditor's Follow-up:

We concur with the corrective actions taken by the department to expedite computer system enhancements to the PCS system, such as elimination of manual calculations and tracking of PCA service hours. These enhancements will be an important tool in the monitoring of service hours and costs.

Audit Finding (11) - Possible Duplication between NYS provided Home Health Care & County Personal Care Services

During the initial assessment, re-assessment or reinstatement of PCS services, nursing staff routinely inquires if the client is in receipt of CHHA or any other home care services. This has proved a more effective method to determine if the client is in receipt of services than to query the physician if CHHA or other services were requested. (Clients may have more than one physician. CHHA services may have been ordered by another physician without the PCS ordering physician's knowledge. Therefore, the client would be the definitive answer initially.) The nurse makes the assumption that any client assessed for PCS services may have been referred to other home care programs or may be in receipt of CHHA services and therefore addresses this issue at the assessment interview.

The NYS Database has been made available to the Department and is being used for random MMIS billing comparisons. In addition, prior to the release of the auditors' findings, the Department procured the services of a consultant to provide us with an electronic file-matching program that is capable of comparing MMIS billing records to PCA service records to identify clients who may be receiving duplicative services.

Auditor's Follow-up:

We concur with the corrective actions taken by the department.

Audit Finding (12) - Lack of Legal Representation at Fair Hearings

It is a Department-wide practice to use program staff that is most knowledgeable about the regulations and procedures in their area to represent the Department at Fair Hearings. In most instances the significant testimony required at the Fair Hearing requires medical knowledge, training and observation, which are skills possessed by registered nurses. The Department has always utilized its legal staff when necessary. Recently, four (4) additional County Attorneys have been added to the Department of Social Services Legal department.

Auditor's Follow-up:

We are pleased that DSS has hired 4 additional deputy county attorneys. We recognize the role of nurses at certain times at fair hearings. Nevertheless, because DSS clients are usually represented by counsel at fair hearings, we believe the county is best served by also having legal counsel.

Audit Finding (13) - DSS Departmental WANG System not linked with State Welfare Management System

The WANG system database is matched on a daily basis to the state WMS system. As the Department investigates overall systems enhancements, improvements to this process will be explored.

Auditor's Follow-up:

We concur that the department should investigate overall systems enhancements and improvements.

Audit Finding (14) - Nurse, Nurse Supervision, and Unit Supervision Staffing

The Department agrees that ideally, full-time nurses hired by the Department would likely ensure improved accountability. Efforts to recruit additional nursing personnel are ongoing. However, we experience difficulty in hiring additional nursing personnel at this time:

- There is a severe nursing shortage in the County and the country in general.
- The starting salary that the County offers is not competitive in the market place.
- Part-time nurses pose the same issues of transience that part-time support staff have. (The Department hired 3 part-time nurses in 2003. Only one remains on staff.)

In response to the recommendation that the Medical Services Director should have responsibility limited to the home care area, administration of this program is similar to other areas of the Department where Directors are assigned multiple areas of responsibility.

Auditor's Follow-up:

The department should continue to explore different ways to increase the number of staff nurses.

Audit Finding (15) - DSS Personal Emergency Response Service (PERS)

Recommendations were offered by the audit staff based upon a misinterpretation of the PCS regulations. Per NYCRR 18§505.33, Personal Care Services require a Physician's Request and an assessment. PERS is a component of PCS that may be authorized by the Department if deemed necessary and appropriate. According to the NYS-DOH PERS authority, a physician may not request PERS, just as they may not request specific hours of care.

Again, auditors were in error in stating that the nurses and PCA support staff were solely responsible for monitoring the PERS provider. The nurse's check on reliability of equipment and the provider's quality of service at the time of re-assessment of the client is only part of the Department's monitoring of the PERS provider. It is not necessary that the PCA support staff have knowledge of the current PERS rate, as they are not involved in rate negotiations, nor do they need to input this information to ensure proper payment to the provider.

The 'significant unresolved billing issues' that the PERS contractor cited to the auditors were not a result of lax monitoring on the part of the Department, but rather lax billing practices on the part of the contractor. Although regular meetings were conducted and numerous phone contacts made with the contractor prior to and during the audit period, no significant billing issues were brought to the attention of the Director or Supervisor prior to statements made to the audit staff. Many of the billing issues will remain unresolved due to the contractor's failure to follow prescribed MMIS billing procedures.

Auditor's Follow-up:

As stated in our report, New York State regulations, NYCRR 505.33 (c) (2), require that "an initial authorization for PERS must be based on a physician's order and a comprehensive assessment of the person," and that "a social services district may authorize PERS only when the comprehensive assessment indicates that PERS would be appropriate for the person because…" Both must occur in order for an initial authorization of PERS service to be authorized.

DSS response states they contacted a NYS DOH PERS authority and that a physician may not request PERS. This opinion appears in contradiction to the above regulation. We request that DSS legal department obtain clarification from NYSDOH in writing.

If the unresolved PERS billing errors were the fault of the vendor, then we concur. However we feel the management of the unit should have known the current rates being billed to DSS.

COUNTY OF NASSAU

Inter-Departmental Memo

To: Arda Nazerian, Chief of Staff
Office of the County Executive

From: Robert Sherman, Commissioner
Department of Social Services

Date: February 9, 2004

Subject: New York State Legislative Agenda 2004:
Elimination of Home Care Savings Target

Section 43 of Chapter 1 of the Laws of 1999 directed the New York State Department of Health to establish local social services district Medicaid home care savings targets.

Home care services as defined by the statute include all Personal Care Services, Long Term Health Care Program Services and Home Health Services that exclude short stays (less than 60 days).

To determine the savings target, a base formula was created using the group's median per recipient home care expenditures and developing a district specific expenditure for those counties whose home care expenditures per recipient exceeded the group's median. The district specific expenditure per recipient is multiplied by the number of home care recipients in the district in the base period. The product of that calculation is trended forward to each target period to account for the projected price and recipient changes. Additional minor adjustments are made and a target rate for each effected district is determined each year.

The total annual savings target assigned to Nassau County in 2000, 2001, 2002 and 2003 was $1,274,400 each year. The Department achieved the target savings in 2000, but failed to achieve the target savings in subsequent years, leading to an intercept of $457,217 in 2001 and $1,274,400 in 2002 and 2003.

Historically, Nassau County has attempted to keep the elderly in their homes, where they've lived their lives, raised their children, and established their memories, rather than institutionalize them. As a result, Nassau has higher per capita home care costs, but lower per capita nursing home costs. While we have been successful in reducing home care costs within the past few years, we have not been able to meet the savings target due to

conflicting programs, regulations and court decisions:

- **The Olmstead Decision** issued by the Supreme Court in 1999, affirmed that individuals with disabilities have the right to receive services in the most integrated community based setting appropriate to their needs. The population targeted is primarily those persons currently disabled sufficiently to qualify for Nursing Home placement. Reintegration of this population into the community will produce an increase in high cost, per recipient home care authorizations, in direct conflict with the home care savings target.

- **Certified Home Health Aide Services** - the program is State supervised and monitored. The Department has no control over the assessment and approval of the amount of care authorized; yet we are expected to control costs. In addition, Federal Prospective Payment System legislation enacted in October 2000 directs Certified Home Health Agencies to bill minimal care, lower cost cases to Medicare and higher cost cases to Medicaid. **CHHA costs have grown every year and are a direct factor in our failure to reach our target.**

- **Fiscal Assessment** - this provision of the Personal Care Services regulation required local districts to conduct an assessment to determine if the cost of services to maintain a client at home were greater than 90% of the cost to maintain the client in a residential placement. If so, the district was required to initiate action to discontinue services at home. This provision of the regulation expired June 30, 1999 and was not renewed by the State. The elimination of this provision, along with uncontrollable CHHA costs, seriously impacts on our ability to achieve program savings.

- **The Mayer Decision** - prohibits the reduction of hours for clients requiring continuous care (24 hours per day) unless there is a change in the client's medical condition or social situation indicating they no longer require the previously authorized care hours.

- **The Rodriguez Litigation**, recently settled on the State level and pending settlement on the County level, requires the local districts to consider the client's unscheduled and recurring care needs when determining the amount of hours of Personal Care Service to be authorized. In essence, it requires the assessing County to document and justify any care plan authorizing less than 24 hour care to an individual who requires assistance with unscheduled needs (toileting, ambulating and transferring).

- **Fair Hearing Procedures** - clients and/or their representatives are permitted unlimited adjournments which delay hearing decisions. Clients are in receipt of Aid-Continuing service during this period, prohibiting the Department from reducing or eliminating services. In addition, the Varshavsky decision requires that homebound clients be seen in the home before a fair hearing decision is rendered. This, in effect, requires two scheduled hearings. The client receives

Aid-Continuing during this process, which includes increasing hours if the hearing was requested as a result of the client's request for increased hours and the Department's denial of same.

- **Consumer Directed Personal Assistance Program (CDPAP) –** Over the past 3 years there has been a marked increase in the number of recipients opting for CDPAP. This program not only averages a higher per hour rate than our traditional Personal Care Services cases, but also draws clients participating in our cost efficient shared aide sites. Increased participation in CDPAP inhibits our ability to open new shared aide sites and maintain the existing ones.

- **Demographics**

  There has been an increase of more than 40% of the 75 and older population in Nassau County in the past 10 years. This increase is higher than any other county in New York State, outside of New York City. It would not seem an unreasonable conclusion that the age of the Medicaid population we are servicing has also increased, along with their medical needs.

As a result of these restricting factors, most of which commenced after the implementation of the savings target, the County Attorney is currently assessing the feasibility of instituting litigation against the State of New York to stop the imposition of a Home Care Savings Target.

The proposed 2004-2005 New York State budget includes a provision to increase the savings target by $11 million dollars from $33 million to $44 million. Based on the current formula, the additional increase to Nassau County is approximately $425,000, raising Nassau's target to approximately $1.7 million per year. This is part of the Governor's so-called 10-year takeover of Long Term Care costs.

I will be talking to officers of the Nassau County Chapter of the Home Care Providers Association in the near future to enlist their assistance. Please contact me if you require further information.

RS:cb

cc: Jack Gallagher, Deputy County Executive
Lorna Goodman, County Attorney
Mary Curtis, Director of Quality Assurance