

**MEDICAID
INSTITUTE**
AT UNITED HOSPITAL FUND

The Role of Local Government in Administering Medicaid in New York

About the Medicaid Institute at United Hospital Fund

Established in 2005, the Medicaid Institute at United Hospital Fund provides information and analysis explaining the Medicaid program of New York State. The Medicaid Institute also develops and tests innovative ideas for improving Medicaid's program administration and service delivery. While contributing to the national discussion, the Medicaid Institute aims primarily to help New York's legislators, policymakers, health care providers, researchers, and other stakeholders make informed decisions to redesign, restructure, and rebuild the program.

About United Hospital Fund

United Hospital Fund is a health services research and philanthropic organization whose mission is to shape positive change in health care for the people of New York. We advance policies and support programs that promote high-quality, patient-centered health care services that are accessible to all. We undertake research and policy analysis to improve the financing and delivery of care in hospitals, clinics, nursing homes, and other care settings. We raise funds and give grants to examine emerging issues and stimulate innovative programs. And we work collaboratively with civic, professional, and volunteer leaders to identify and realize opportunities for change.

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Executive Summary

Medicaid in New York is a complex and multifaceted program serving more than four million beneficiaries at an annual cost of nearly \$45 billion — nearly 30 percent of the state's health care economy. Its effective and efficient administration is both vital and enormously challenging. Part health insurance company, part social safety net, Medicaid requires both sensitivity to the health and welfare of the most vulnerable New Yorkers and the administrative acumen to manage shifting eligibility among millions of beneficiaries, and payments and oversight for thousands of health care providers and plans. If New York's Medicaid program were a private business, it would be a Fortune 50 company;¹ if it were a private insurance company, it would rank in the top ten in covered lives in the nation.²

In many respects Medicaid in New York is at a crossroads. Given dropping rates of employer-sponsored health insurance coverage, Medicaid has become the health insurer of last resort for a growing number of working New Yorkers. Medicaid enrollment has increased 50 percent since 2000. At the same time both the demand for and cost of long-term care services has escalated dramatically, with annual Medicaid spending on home health care and personal care rising on average 9 percent and 8 percent, respectively, during the period from 2002 to 2007. With the downturn in the economy and an aging population, New York's reliance on Medicaid for access to health care is likely to increase further — at exactly the moment when state revenues that fuel the program will be in decline. Furthermore, Medicaid is likely to be a vital part of any health insurance reform effort at the state or national level — both as a platform for further expansion and as a safety net under new initiatives and programs.

This report is the third in a series published by the Medicaid Institute at United Hospital Fund examining the administration of Medicaid in New York. The first report, *Administration of Medicaid in New York State: Key Players and Their Roles*, examined the role of state government in the administration of Medicaid.³ It concluded that as New York pursues a range of reforms — such as enrolling more eligible individuals, and improving quality and efficiency in service delivery — the ability to develop and implement successful policies will depend in large part on Medicaid's administrative structure. This report's recommendations are reflected in the 2007 reorganization of the State Department of Health, which consolidated Medicaid oversight under a new Office of Health Insurance Programs.

The second report, *Understanding the New State/County Paradigm: The 2005 New York Medicaid Cap Legislation*, documented state legislation that capped the financial contribution to Medicaid required from counties. The report found that by limiting the financial exposure of local governments, the cap not only reduces their share of Medicaid costs over time, it shields local government from significant fiscal impact related to changes in state

Medicaid policy, such as enrollment expansions. The report concludes that the local cap legislation represented the single biggest change in Medicaid financing since the program's inception in 1966.

The current report builds on the first two in the series, examining the roles played by local government in the administration of a Medicaid program that is newly organized at the state level and has dramatically reduced the fiscal impact of policy changes on local government. It delineates the role of local government in the administration of Medicaid in four parts.

- First, it reviews the federal authority granted to states and state authority granted to local government to administer the program.
- Second, it delineates how New York's local governments structure their administration of Medicaid, including resources dedicated to this infrastructure.
- Third, it assesses the key responsibility areas and associated tasks undertaken by local governments.
- Fourth, it analyzes the implications of these responsibilities and the supporting infrastructure on the ability to meet Medicaid's programmatic goals.

The purpose of this report is to document existing practice related to the local administration of Medicaid and to observe the primary, overarching benefits and challenges associated with this structure. This report does not make specific recommendations, but seeks to set the stage for a larger discussion about how Medicaid can best be administered to meet its programmatic goals efficiently, effectively, and with equity and integrity.

The report concludes that, while local governments shoulder significant administrative and financial responsibility for the implementation of Medicaid in New York, the distribution of core programmatic functions across 58 local governmental entities contributes to fractured governance, diffuse authority, and a disjointed operational infrastructure within the program. Among the significant observations that are set forth in the report are the following:

Decentralization of Responsibility for Administration: New York administers Medicaid through a decentralized approach with fifty-seven county governments and the City of New York (referred to collectively as local government). Within local government, local departments of social services (LDSSs, or local districts) hold primary responsibility for Medicaid. The role of local government within Medicaid's administrative infrastructure is a result of both the historical financial contributions of local government to Medicaid expenditures, and the program's origins as a welfare program.

The largest areas of responsibility held by local districts are (1) determining and monitoring the eligibility of Medicaid recipients; (2) oversight of long-term care services and programs, particularly personal care services. LDSSs also are responsible for implementing transportation services; third-party, estate, and other recoveries; and fraud and abuse prevention and detection. The complexity and volume of work associated with these functions has increased significantly in recent years, increasing the burden on local districts that have struggled to keep pace.

Notwithstanding the challenges faced by local districts, certain aspects of program administration benefit from local participation. Linked to the broader community and the local social services safety net, and benefiting from proximity to beneficiaries and providers, local governments, particularly in smaller counties, are well positioned to provide direct services to vulnerable beneficiaries and to be responsive to local needs.

Divided Authority, Conflicting Priorities, and Limited Accountability: As the “single state agency” charged under federal law with overseeing Medicaid, the New York State Department of Health (SDOH) is responsible for articulating a programmatic vision, setting policy, and ensuring compliance with state and federal requirements. However, the statewide operational infrastructure for putting these policies and priorities into action falls under the wholly separate authority of the 58 local governments. The local agency officials charged with implementing Medicaid report directly to and are held accountable by their county executives or legislatures (or, in New York City, by the Mayor). It is local elected officials, not SDOH, who are ultimately responsible for oversight, hiring and firing of supervisors and staff, use of physical space, equipment and technology purchasing decisions, and other administrative tasks.

These two entities — SDOH and local elected officials — often have wholly different policy priorities and programmatic goals related to administering Medicaid. Historically, counties’ approach to Medicaid administration has been deeply influenced by the local financial contributions to the program. While local Medicaid contributions are capped at 2005 levels plus an annual inflation adjustment of no more than 3 percent, Medicaid remains the single largest budget item in counties throughout the state, and local governments remain highly sensitive to Medicaid costs. For example, local officials report a reluctance among county officials to hire additional Medicaid staff, citing local political sensitivity to worker headcount, skepticism that the county cap will remain, and the fact that counties ultimately hold responsibility for the pension and retirement benefits of new workers.

While SDOH has historically accorded a high degree of deference to local government in Medicaid administration, greater consolidation of Medicaid responsibility at the state level and recent efforts to initiate statewide program reforms have led to a more assertive state role. State and county officials both acknowledge that state efforts to promote these goals have sometimes run afoul of local priorities and practices. For example, current efforts by SDOH to increase Medicaid coverage among eligible but uninsured New Yorkers has come into conflict with practices in some counties that may limit Medicaid enrollment — an area over which local governments have direct control.

Finally, when conflicts arise, few tools exist to force a resolution. While SDOH is legally accountable for oversight of local Medicaid administration, it lacks formal enforcement mechanisms to impose its will over local government actions. Instead, state officials are left to negotiate resolution of disputes with each of the 58 local government units.

Variation in Program Administration: Considerable variation exists in the implementation of the Medicaid tasks across local districts affecting both how the tasks are carried out and programmatic outcomes. This variation affects program goals and objectives and can produce program inefficiencies and increased costs on the part of state and local governments. For individual recipients, it raises issues of equity, often limiting access to services or coverage. This variation can result in liability for the state, creating a substantial risk of potential litigation from consumers and enforcement actions from the federal government.

Local variation stems from multiple factors. Resource constraints at the local level plague counties that face rising caseloads and the increased complexity in administering eligibility determinations. Outdated laws and regulations, along with antiquated information systems, result in inefficiencies and confusion on Medicaid-related tasks. Finally, diffuse monitoring and weak enforcement tools at the state level undermine a consistent and coherent administrative approach among local districts. However, these challenges are compounded — and the ability to address them is compromised — by Medicaid's diffuse governance and disjointed operational infrastructure.

Medicaid has never been more important to the health of New York's citizenry or economy than it is today, nor have the challenges to it been so great. As policymakers chart a path for future, it will be crucial to ensure that Medicaid is governed, administered, and operated in a coherent and consistent manner that promotes efficiency, effectiveness, and equity.

Methodology

This report was informed by two primary sources: 1) legal and regulatory research related to Medicaid; and 2) interviews with state and local officials and stakeholders. The legal and regulatory research consisted of a review of federal and state statute and regulations governing Medicaid. Where relevant, official state documents were also reviewed.

Interviews were conducted with officials from the following agencies:

- New York State Department of Health
- Office of the Medicaid Inspector General
- Office of Mental Retardation and Developmental Disabilities
- Office of Alcoholism and Substance Abuse Services
- Office of Mental Health
- Erie County Department of Social Services
- Greene County Department of Social Services
- Nassau County Department of Social Services
- Onondaga County Department of Social Services
- Rockland County Department of Social Services
- Tioga County Department of Social Services
- New York City's Human Resources Administration

In addition, interviews were conducted with representatives from the following organizations:

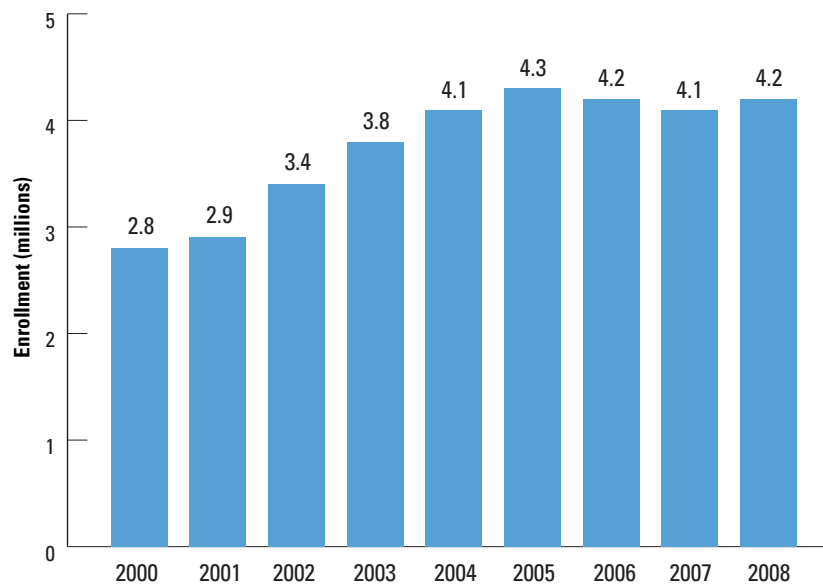
- Empire Justice Center
- Home Care Association of New York State
- Medicaid Matters of New York
- New York Public Welfare Association
- New York State Association of Counties
- Regional Center for Independent Living — Rochester
- Visiting Nurse Service of New York

Relevant literature was reviewed, integrated, and cited in the report, where applicable.

Medicaid in New York

Medicaid is a crucial source of health coverage and services for New Yorkers. A means-tested public health insurance program, it provides health coverage for low-income children and adults, as well as acute and long-term care services and support for low-income disabled and elderly people. While originally implemented as part of the social welfare safety net, Medicaid has adapted over the years, and today provides coverage for a growing number of working New Yorkers without employer-sponsored coverage. Medicaid enrollment in New York State has grown by 50 percent since 2000, from 2.8 to 4.2 million people.⁵ Today, Medicaid is the single largest health insurer in the state.

Figure 1
Total Monthly Medicaid Enrollment (June), New York State, 2000 – 2008



Medicaid holds enormous influence over New York's economic well-being. With annual expenditures approaching \$45 billion, Medicaid is the second-largest item in New York's state budget after education and the largest item in every county's budget.⁶ With half of New York's program funded by the federal government, Medicaid accounts for most of the federal funds flowing into New York. Indeed, Medicaid payments to health care providers and insurance plans account for nearly 30 percent of New York's health care economy.⁷

The effective and efficient administration of Medicaid is both vital and enormously challenging. Medicaid functions both as the state's largest health insurer and as a critical part of New York's social safety net. Successful implementation requires sensitivity to the needs of the most vulnerable New Yorkers — the homebound, homeless, and institutionalized, and those with mental illness, chronic conditions, and physical disabilities —

as well as the administrative acumen to manage shifting eligibility among millions of beneficiaries and payments and oversight for thousands of health care providers. If Medicaid in New York were a private business, it would be a Fortune 50 company;⁸ if it were a private insurance company, it would rank in the top ten in covered lives in the nation.⁹

Within federal guidelines, states administer Medicaid and set the rules governing eligibility, covered benefits, and provider reimbursement. In New York, the State Department of Health (SDOH) is responsible for program administration. However, since the program's inception, New York's 58 local departments of social services have served as the front door for applicants — accepting, processing and denying applications, communicating with beneficiaries, and determining access to needed services. In the pages that follow, the administrative responsibilities of New York's local governments are examined in detail, beginning with the legal authority underpinning their activities.

Legal and Regulatory Authority Governing Local Administration of Medicaid

While enabling authority for counties' administrative role begins with federal statute, state law and regulation provide the origins for local governments' responsibilities in Medicaid administration. The sections below chart the authority at the federal and state levels that undergird New York's existing, locally run Medicaid administrative structure.

Federal

Federal law and regulation mandate overall Medicaid program parameters but provide states flexibility in program administration. In order to participate in Medicaid, states must have a federally approved "state plan" that meets stringent federal standards.¹⁰ Among those standards is the requirement that states designate a single state agency to administer or supervise the administration of the state plan.¹¹

Federal regulations also require the state plan to be in operation statewide, under equitable standards for assistance and administration that are mandatory throughout the state. Federal regulations mandate that states have in place methods for informing local offices of state policies, standards, procedures, and instructions, as well as for examining operations in local offices, among other requirements.¹² States that agree to comply with these and other federal rules are entitled to a federal contribution to offset the total cost of Medicaid in their state. In New York, the federal government's contribution is generally 50 percent.¹³⁻¹⁴

State

New York statute and regulation designate SDOH as the “single state agency” responsible for the overall administration of New York Medicaid. As such, SDOH oversees the development and implementation of the state plan and issues necessary regulations to ensure compliance.¹⁵

SDOH may delegate to other state agencies, localities, or private entities any of its administrative responsibilities other than the issuance of policies, rules, or regulations.¹⁶ State law grants authority to 58 local governments to “provide medical assistance to eligible persons residing in their counties.”¹⁷ In practice, state and local officials describe the division of authority this way: state government sets the policy; local government determines how to implement the policy. And indeed, state regulation catalogues the extensive delegation of local governments’ implementation authority. In describing the functions for which the local governments are responsible in this report, the appropriate statutory or regulatory authority is cited where applicable. A summary of these laws and regulations is available in an appendix published electronically on the United Hospital Fund website (www.uhfnyc.org).

The existing legal framework for New York Medicaid is not always reflective of the manner in which Medicaid is actually administered by local government or state agencies. Administration of the Medicaid program by localities has evolved over many years; the statutes and regulations from which the state and local governments derive their authority to administer the program have not always kept pace. Some requirements set out in statute and regulation, for instance, have been phased out or rendered obsolete.¹⁸ One example is the requirement that local governments submit to the state a “local medical plan.”¹⁹ The requirement was put forth in 1971 when local governments were responsible for reviewing and paying provider claims, which is now centralized through Medicaid Management Information System (MMIS) payments. Accordingly, the local medical plan requirement was designed to ensure local governments applied sound medical principles to payment decisions. Because this task was eliminated as a locally held responsibility, local governments have not been required to submit medical plans in decades. The requirement, however, remains on the books.²⁰

Administrative Structure of Medicaid in New York

SDOH holds primary responsibility for administering Medicaid in New York; however, aspects of New York Medicaid’s governance and administrative infrastructure are spread across a variety of state agencies and divisions as well as 58 local governments. The roles of the many agencies and offices involved at the state level, as well as the roles of local government, are detailed below, accompanied by a brief overview of the staffing and administrative costs associated with New York’s federated administrative structure.

State Agency Role

Until 1996, the State Department of Social Services was responsible for administering all public assistance programs in the state, including Medicaid. In that year, responsibilities for Medicaid were transferred to SDOH and those that crossed programs (those that related to Medicaid as well as cash assistance and food stamps, for instance) were divided up among SDOH, Office for Temporary and Disability Assistance (OTDA), and other state agencies through Memoranda of Understanding (MOUs) that govern to this day.²¹ In 2007, the State Department of Health consolidated oversight and management of the Medicaid program within a new Office known as the Office of Health Insurance Programs (OHIP). OHIP is the primary administrative agency in New York responsible for the administration of Medicaid. It is responsible for oversight of all eligibility-related functions, as well as rate setting and payment, oversight of providers and health plans, and quality initiatives. OHIP also is the main point of interface with other state agencies charged with Medicaid-related tasks. Long-term care issues within Medicaid fall under a separate division within SDOH, the Office of Long-Term Care (OLTC). The two offices (OHIP and OLTC) work collaboratively to ensure coordination.

Key state agencies involved and their respective Medicaid-related functions include the following:²²

- State Department of Health (SDOH)
 - Conducts global implementation, oversight, and monitoring of Medicaid²³
- Office of the Medicaid Inspector General (OMIG)
 - Oversees the state's fraud and abuse activities for the Medicaid program; the Medicaid Inspector General reports directly to the Governor
 - Oversees the Special Education program (School and Preschool Supportive Health Services)
- Office for Temporary and Disability Assistance (OTDA)
 - Manages the Welfare Management System (WMS), the state's eligibility information system used by local government and other state agencies to collect and review applicants' eligibility information
 - Administers and oversees the fair hearing process, through which Medicaid (and public assistance) applicants and recipients can challenge determinations made by state and local agencies (e.g., finding an applicant ineligible)
- Office of Mental Retardation and Developmental Disabilities (OMRDD)
 - Oversees programs for individuals with development disabilities
 - Conducts Medicaid eligibility and service determinations for individuals with developmental disabilities (described further in the "Key Responsibilities" section)

- Office of Mental Health (OMH)
 - Oversees programs for individuals with mental illness
 - Conducts Medicaid eligibility and service determination for individuals with mental illness (described further in the "Key Responsibilities" section)
- Office of Alcoholism and Substance Abuse Services (OASAS)²⁴
 - Oversees programs for individuals with substance abuse disorders
- Office of Children and Family Services (OCFS)
 - Oversees the foster care program and related programs

Local Government Role

The primary local government agency responsible for Medicaid administration is the local department of social services (LDSS). Medicaid is one of several social services programs for which they are responsible, including public/cash assistance, food stamps, home energy assistance, child support enforcement, employment training and services, foster care, and adult/child protective services.²⁵ The 57 counties outside New York City each have their own LDSS. The five counties representing New York City share one LDSS, called the Human Resources Administration (HRA).²⁶

The LDSS is an important arm of county government in New York. Where it falls within a county's larger administrative structure depends on how a county's government is organized. Generally, New York county governments are led by an elected county executive or appointed manager, who appoints the commissioner of the LDSS.^{27, 28} In 10 counties throughout New York, however, administrative control and oversight are maintained by the legislature.²⁹

Though they play a supporting role, other local government agencies and officials also handle Medicaid-related tasks.

- The involvement of local departments of health (LDOH) varies by county. In New York City, for example, the local department of health and mental hygiene holds and oversees the contracts held with Medicaid managed care plans. In other counties, the LDSS may collaborate with the LDOH to assign nurses to conduct long-term care assessments or to provide case work for long-term care waiver programs.
- Local mental hygiene units participate in Prior Approval Reviews (PARs), applications by health care providers to become an OMH-licensed provider of mental health services.³⁰ Based on a review of the applications, local mental hygiene units contemplate the potential impact of the respective providers on Medicaid and make recommendations to OMH.
- Local district attorneys aid in the pursuit of Medicaid fraud and abuse, in collaboration with the LDSS, OMIG, and the State Attorney General.

- In addition, several county-operated nursing homes and public hospitals serve Medicaid beneficiaries. In these cases, the facilities operate as a discrete unit within local government and interface with Medicaid as a health care provider.

Administrative Cost and Staffing

The total cost of administering Medicaid in New York in 2007 was nearly \$1.3 billion, which includes spending by all state and local agencies that implement Medicaid-related tasks,³¹ representing less than 3 percent of all program spending in 2007. More than 70 percent of all administrative costs spent at the state and local level in fiscal year 2007–8 are attributable to county administrative costs (administrative costs spent by state behavioral health agencies are not included in this total).³² See Appendix for county-specific administrative costs.

Medicaid administration costs, which include costs attributable to contractors, vary markedly by county. In state fiscal year (SFY) 2007–8, total administration costs in all 57 counties outside of New York City totaled \$325 million — less than HRA’s costs alone.^{33, 34, 35} Yet the size of a county’s Medicaid program does not fully explain differences in local costs. Table 1 displays the total administrative costs for New York State, New York City and select counties. Within this group representing both upstate and downstate counties, administrative costs per enrollee range from \$171 to \$397. This wide variation in part reflects the autonomy with which each county makes hiring decisions.

Further analysis is required to determine the impact of administrative costs on county performance — for example, whether lower costs are linked to higher efficiency, or whether there is a correlation between compliance with outcome measures and Medicaid administrative tasks. The ability to perform such an analysis is constrained by limited availability of metrics to assess county performance and the lack of publicly available data where indicators do exist.

Table 1.
Total LDSS Administrative Costs, by Select Counties³⁶

Region	Total Administrative Cost	Total Number of Medicaid Enrollees	Average Administrative Cost per Enrollee
New York State	\$789M	4,097,918	\$193
New York City	\$464M	2,710,280	\$171
Rest of State	\$325M	1,387,638	\$234
Erie	\$31.4M	145,494	\$216
Greene	\$2.7M	6,814	\$397
Nassau	\$26.0M	106,859	\$243
Onondaga	\$13.1M	67,022	\$196
Rockland	\$14.7M	49,088	\$300
Tioga	\$1.4M	7,130	\$196

Table 2 lists total full-time equivalents (FTEs), including contractors, dedicated to Medicaid administration for New York City, the rest of the state, and New York State overall. (A list of every county’s number of FTEs by staff category is in Appendix A.) Generally, the bulk of a county’s administrative spending, which includes LDSS staff salary and non-salary expenditures (e.g., office space, equipment), is dedicated to eligibility determination and recertification personnel. More than 5,300 local government employees around New York work on Medicaid-related tasks, most (95 percent) of whom are dedicated primarily to eligibility determination and recertification (including those who supervise eligibility workers and administrative personnel for the Medicaid program). The remaining 5 percent are dedicated to policy and planning and other activities by skilled professional medical personnel, such as medical directors or social workers and the clerical staff that support them. Activities conducted by these personnel can include medical reviews and individual assessments on the level of care needs for Medicaid recipients. Not included in these totals is staff time spent by health care providers (outside of LDSS) on activities related to eligibility and planning, such as long-term care assessments.

The number of eligibility workers ranges from 1 in Hamilton County to more than 2,300 in New York City.³⁷ Forty-six percent of the state’s total staff dedicated to Medicaid is employed at HRA in New York City. The staff-to-recipient ratio is far lower in New York City (one staff member to every 1,110 recipients) than in the rest of the state (one staff member to every 482 recipients). Staff-to-recipient ratios differ widely by county: whereas Washington County employs one staff member per 293 beneficiaries, Erie County has one staff member per 485 beneficiaries.

Table 2.
Total Local Staff Assigned to Medicaid, by Region (April 2007 – April 2008)³⁸

Region	Eligibility Workers	Policy Planning/ Skilled Professional Medical Personnel	Total Annual FTEs
New York State	5,029	287	5,316
NYC	2,303	138	2,441
Rest of State	2,726	149	2,875

Note: FTEs include contractors. Total FTE numbers may not add up due to rounding.

Local Medicaid staff across the state are unionized. Except in two counties (Monroe and Suffolk) and the five counties of New York City, local government employees are generally members of the Civil Service Employees Association (CSEA). CSEA is a local 1000 affiliate of the national American Federation of State, County and Municipal Employees (AFSCME) and also represents state and school district employees, child care providers, retirees, and some private sector employees.

Generally, all local government employees except Commissioners are members of CSEA, including LDSS staff. Local government employees in New York City are affiliated with DC-37, a local affiliate of AFSCME. Medicaid examiners are typically a member of DC-37, while caseworkers are affiliated with local offshoots of this union. Local government employees in Monroe County are members of a local affiliate of Industrial Union of Engineers (IUE), a union that sits under the umbrella of the national AFL-CIO. Local government employees in Suffolk County are members of an independent local union known as the Suffolk County Association of Municipal Employees.³⁹

Financial Structure of Medicaid in New York

In addition to the administration of Medicaid, New York State and the 58 local governments share responsibility for funding the non-federal portion of its Medicaid expenditures. New York State is one of the few states that have always required a local contribution for Medicaid,⁴⁰ paying for a significant share of Medicaid expenditures not covered by the federal government with these local contributions. In 2003, Medicaid constituted the largest budget item in every county and its cost to local government was equivalent to 73 percent of the property taxes they collected that year.⁴¹ In 2005, local governments paid for 17 percent of total Medicaid costs, with the state paying 33 percent.⁴² And for each new beneficiary they helped enroll, counties faced a direct marginal cost in the form of a higher Medicaid local share payment.

After years of bitter protest and significant advocacy from the counties, legislation in 2005, effective January 2006, capped local contributions at calendar year 2005 costs adjusted by an annual trend factor of no more than 3 percent.⁴³ The cap applies to both administrative expenditures related to operations of Medicaid and program expenditures for beneficiary services.⁴⁴ Beginning in 2008, counties were allowed to choose to contribute, as their local share for Medicaid costs, a fixed percentage of local sales taxes as a substitute for costs capped by a trend factor. To date, one county has chosen this route (Monroe).⁴⁵ The cap has succeeded in reducing counties' overall Medicaid costs: in SFY 2007–8, counties, in the aggregate, paid \$128 million less (2 percent less on average) than they would have in the absence of the cap.^{46, 47} Because of the cap, the local share of costs will continue to decline over time.

The cap, however, did not shrink local government responsibilities in administering Medicaid, nor did it change the administrative structure underlying Medicaid. Local governments' historical role in Medicaid cost-sharing had and continues to have a significant impact on the local administration of Medicaid. Recognizing the significant financial contribution of the local counterparts, state officials historically have accorded a fair degree of deference to LDSSs. Further, years of concern about the burden of Medicaid on the local tax base and the resulting local political sensitivity has influenced the culture and approach of many LDSSs. Even today, LDSSs continue to be highly conscious of cost in administering the program. For example, county officials are often hesitant to approve new hires, citing local political sensitivity to worker head count, skepticism that the county cap will remain, and the fact that counties ultimately hold responsibility for the pension and retirement benefits of new workers.

Nevertheless, the cap has helped to insulate local governments from the financial consequences of changes in state Medicaid policy. For example, the cap safeguards county budgets from dramatic increases in cost due to eligibility expansions. And, for the first time since the program's inception in 1966, local governments no longer face a direct financial disincentive to enroll eligible Medicaid beneficiaries.

State Oversight of Local Government in the Administration of Medicaid

SDOH's supervisory function in Medicaid can be assigned to four main categories: 1) policy development and implementation guidance; 2) information systems development and management, 3) training and technical assistance; and 4) program monitoring and oversight.

Policy Development and Implementation Guidance

SDOH is statutorily responsible for setting policy and providing implementation guidance for the administration of Medicaid in New York, and has created a formal structure for communicating with LDSSs.⁴⁹ In addition to the state's statutory and regulatory framework, SDOH communicates Medicaid policy through several forms of written policy guidance, including Administrative Directives (ADMs), General Information System (GIS) Messages, and Informational Letters (INFs).⁵⁰

ADMs are the most comprehensive of all policy guidance and are used to communicate the existence of a new or revised policy, as well as to communicate SDOH's interpretation of existing or new laws and regulations.⁵¹ GISs are shorter, more nimble policy guidance documents used in lieu of ADMs when the goal is to communicate a small amount of typically supplementary information. Lastly, INFs are used to elaborate on existing policy.⁵² INFs are generally issued, for example, when an ADM already exists on a subject but requires clarification.⁵³

All policy guidance must go through a formal clearance process before release to the LDSSs.⁵⁴ This process consists of internal review by various SDOH divisions, depending on the subject matter, as well as review by SDOH's Division of Legal Affairs.⁵⁵ External agencies (e.g., OTDA), also may review as necessary.⁵⁶ These policy guidance documents are distributed to LDSSs, via an e-mail and hard-copy distribution list.⁵⁷ They are considered statements of record and are catalogued for future reference on the SDOH website after they have been released.⁵⁸ However, they are not posted in a manner that allows for searching; they are simply archived on the website by year of release.⁵⁹

One step down in the policy guidance hierarchy are “Dear Commissioner Letters” and general e-mails to LDSSs. These communications do not require the same level of clearance before release but are distributed in the same manner as the policy guidance above.⁶⁰ Dear Commissioner Letters and e-mails are not policy statements and are not made available on the SDOH website.⁶¹ They are used, instead, to communicate informally with LDSSs. For example, SDOH may inform LDSSs of a technical glitch in its information system via e-mail.⁶²

Finally, SDOH manages the Medicaid Reference Guide (MRG), which serves to translate official policy guidance into a useful format for state staff and LDSS and is generally used as a desk reference. It is available both electronically and as a hard copy. Other program-specific reference manuals also exist, including those specific to the Long-Term Home Health Care and Traumatic Brain Injury waiver programs. The MRG is not updated regularly and has gone for long periods without being updated.⁶³

Information Systems Development and Management

In addition to policy guidance, LDSSs rely on state-developed and managed information systems to perform their multitude of Medicaid functions, particularly related to eligibility and application processing.⁶⁴ The state's primary tool for managing eligibility and application processing for the Temporary Assistance for Needy Families (TANF), Medicaid, food stamps, adult services, and home energy assistance benefits programs is a system known as the Welfare Management System (WMS).⁶⁵ The system is managed by OTDA — not SDOH — reflecting its origin as a tool of the welfare program.⁶⁶

It is widely accepted that WMS is outdated, user-unfriendly, and ill-equipped to facilitate the business processes, services, case management, and performance tracking required of a complex health insurance program like Medicaid in New York.⁶⁷ In an attempt to increase its utility, counties report developing local information system overlays and work-arounds, resulting in a patchwork quilt of system designs where instead a single, uniform, interoperable infrastructure should exist.

WMS has become increasingly complex over the 20-plus years of its existence, reflecting an ongoing series of programming additions and edits applied in an additive fashion with each new programmatic or policy change.⁶⁸ Further, this system is actually two systems that function entirely separately: There is a WMS system specific to New York City, with unique functionalities, and another WMS system for counties in the rest of the state. This can cause some duplication issues when Medicaid recipients move around the state.⁶⁹ The existence of duplicate systems dates back to the initial development of WMS, when HRA was already using its own customized computerized system to assist with eligibility and application processing in New York City.⁷⁰ The WMS system installed throughout the rest of the state was different than the one installed at HRA, featuring less automation of rules and entries, and more flexibility in entering codes and related values.⁷¹

Both WMS systems consist of a number of subsystems. These include:

- MABEL: The Medicaid Automated Budgeting and Eligibility Logic system, which serves as a budgeting tool for eligibility determination;⁷²
- CNS: The Client Notification System, which creates customized notices for beneficiaries regarding required enrollee action, eligibility determination, and other matters;⁷³ and
- RFI: The Resource File Integration System, which contains third-party databases used by eligibility workers to verify eligibility.⁷⁴ RFI compares individuals in WMS against individuals in state and federal database systems such as the Wage Reporting System. It should be noted that while RFI provides a way to verify information provided by applicants against data captured in RFI (e.g., wage data, unemployment data, bank records, and new hire information) the system does not enable verification of other types of income, residence, identity, or citizenship.⁷⁵

Separate from WMS is eMedNY, the state's MMIS, which receives enrollment information for those determined eligible for Medicaid from WMS, but which principally serves as the system that processes all Medicaid claims and payments for services.⁷⁶ SDOH's Division of Systems manages eMedNY.⁷⁷

eMedNY provides a single point of entry for client eligibility verification, processing prior approvals, claim history inquiries, entry of third-party health insurance, Medicare coverage information, Medicare Buy-In, daily processing of financial reporting, and other tracking and monitoring systems.⁷⁸ eMedNY is an enormous undertaking and is managed by a third-party entity, Computer Sciences Corporation (CSC), as well as SDOH staff. Together, 550 staff from both CSC and SDOH are assigned to use this system to process claims, as well as oversee, manage, and troubleshoot it.⁷⁹

Training and Technical Assistance

Given the complexity of Medicaid's rules and policies, SDOH provides local government staff with fairly extensive training. All new Medicaid workers are required to attend a New Worker Institute training session, facilitated by the State University of New York (SUNY) at Buffalo through a contract with SDOH. This two-week session reviews the requirements and responsibilities for Medicaid eligibility, renewal, and enrollment processing. LDSS long-term care staff attend a Chronic Care Institute, which initiates these workers into the local involvement in long-term care programs.⁸⁰ On an ongoing basis, LDSSs may request training on any topic of their choice, which SUNY-Buffalo will facilitate on behalf of SDOH.⁸¹ SDOH also provides on-site training in the use of the many state-developed information systems, described above.⁸²

Further, OMIG provides training to LDSS staff involved in fraud and abuse detection and prevention, with a particular focus on increasing local data analysis capability as well as using claims data to better identify fraud and abuse.⁸³ Finally, to supplement SDOH training, LDSSs often prepare and deliver their own topical training sessions.⁸⁴

Through various divisions within SDOH, the state also provides ongoing technical assistance. State staff, called local district liaisons, provide on-site and remote assistance to counties on specific issues, described further in the "Key Responsibilities" section.⁸⁵ Within SDOH, both OHIP's Division of Coverage and Enrollment and the Office of Long-Term Care employ some local district liaisons. Division of Coverage and Enrollment staff hold monthly calls with LDSS eligibility supervisors to review new policies and initiatives and to address specific topical issues.⁸⁶ In addition, LDSS staff often contact the specific divisions within SDOH that oversee their particular responsibility area, such as SDOH's Division of Legal Affairs and OHIP's Division of Provider Relations and Utilization Management, for answers to questions and clarifications on policy. State and local officials both acknowledge the challenges of responding to the large volume of inquiries from local districts. LDSSs note that obtaining a prompt response to time-sensitive inquiries can be a particular problem.

LDSSs have formed eight regional consortiums to exchange best practices, inviting topical speakers and discussing issues germane to the group at regional meetings held every two to three months.⁸⁷ SDOH staff attend these meetings to provide guidance, but agendas are set by the LDSSs themselves.⁸⁸ Finally, organizations like the New York State Public Welfare Association, which represents all 58 LDSSs, host regular meetings and conferences designed to support LDSSs in their administration of the Medicaid program and the other social services for which they are responsible.⁸⁹

Despite the multiple forums for training, state and local officials note that developing and maintaining institutional knowledge and front-line staff competency is a constant struggle. The complexity of the tasks, evolving rules, and the sheer volume of work makes this especially difficult in smaller counties with less specialization. Loss of staff due to retirement or attrition can be devastating to counties, as it takes years to fully grasp the plethora of Medicaid rules and processes.

Program Monitoring and Oversight

SDOH oversees all local agencies involved in the administration of Medicaid, including the LDSSs. In this role, the agency has instituted numerous oversight and monitoring activities specific to program areas, as follows.

Performance indicators: SDOH has recently developed a local district performance indicator report, which aggregates enrollment, case processing, expenditures, and administrative information for each of the 58 counties. Specific information tracked includes the total number of applications processed and duration of each case's submission to eligibility determination; days that Medicaid and Family Health Plus cases are overdue for recertification; long-term care program expenditures; amount of recoveries; and total Medicaid staff per county.

Case record reviews: SDOH staff conduct periodic on-site visits for quality assurance. Issues identified are subject to a corrective action plan delivered to each county, whose implementation is then overseen by SDOH.

- The Division of Managed Care (within OHIP) conducts tri-annual case record reviews for managed care eligibility determination and enrollment for every district. During these reviews, issues such as late recertification are addressed, marketing materials are reviewed, and educational and enrollment procedures are assessed.
- The Office of Long-Term Care conducts annual case record reviews for personal care recipients for each district. Case records are reviewed, including assessments and level of care determinations.
- The Office of Long-Term Care conducts annual case record reviews for the Care at Home Medicaid waiver program. Each year, these reviews are held on-site at 10 LDSSs, which are rotated each year.

Processing reports: SDOH's Division of Coverage and Enrollment (within OHIP) produces monthly processing reports to gauge average time from application submission to eligibility determination and enrollment for every county. State regulations require that applications be processed within a designated time frame: 45 days for most applicants, 30 days for pregnant women and children, and 90 days for people with a disability.⁹⁰ These reports are then shared with counties and discussed as necessary.

Separate from SDOH's oversight activities, the New York State Office of the State Comptroller (OSC) has the authority to audit state agencies and all local governments in New York to determine whether state program funds are used efficiently and goals and objectives are achieved. To that end, OSC has conducted numerous audits of New York Medicaid, which have involved a review of local government activities and which have implications for program oversight by SDOH. For example, a recent OSC audit found that thousands of case files had invalid or missing Social Security numbers. As a result, SDOH was required to follow up with LDSSs regularly to verify that all files which required such a number had one and that local districts make use of reports from WMS that verify these numbers.

Further, SDOH has enabled LDSSs to review their own performance by creating the "Commissioner's Dashboard," which features data on all public assistance programs, including Medicaid. The Commissioner's Dashboard, which is managed globally by OTDA but to which SDOH contributes input, provides LDSS commissioners with longitudinal performance reports using data from WMS (e.g., reports on application processing time) and the Medicaid Data Warehouse. Because these reports are longitudinal, they enable the commissioners to compare one month against another over a period of years, identifying trends. They may be used to improve performance and to develop messages for other branches of county government. SDOH has access to these reports for each county and uses them as a tool to monitor aggregate county performance.

Finally, the federal government conducts oversight and monitoring of the Medicaid program. The Centers for Medicare & Medicaid Services' (CMS) primary oversight is directed towards the state Medicaid agency, under the framework of the federal-state partnership of the Medicaid program. Any CMS and local agency interaction, therefore, occurs in connection with federal oversight of state administration and operations. Examples of these instances in New York include evaluation of local government activities during focused Medicaid financial management reviews of the state and evaluation of local district eligibility procedures as part of a nationwide study following the de-linking of Medicaid from welfare. The Payment Error Rate Measurement (PERM) process was developed by CMS to measure improper payments

in Medicaid and the Children’s Health Insurance Program (SCHIP).⁹¹ State Medicaid programs are reviewed every three years under PERM; New York State’s next review will occur in FFY 2011. Beyond CMS, the Government Accountability Office (GAO) and the U.S. Department of Health and Human Services Office of the Inspector General (OIG) also have broad oversight authority over management and operation of the Medicaid program and can evaluate local agencies through the course of their targeted audits.⁹²

These efforts notwithstanding, the perception among consumers, LDSSs, and many within SDOH is that monitoring of LDSSs is largely reactive, with interventions occurring only after errors are reported. State officials report having few tools with which to pursue enforcement when problems are identified. For small, technical discrepancies, collaborative problem-solving is typical. However, where more fundamental or persistent problems arise, or where there is disagreement among state and local officials about programmatic requirements, state officials report few options or enforcement tools to reach resolution. This has been a source of frustration for consumer groups and providers, who report that litigation is often necessary to force county compliance. For example, two counties (Suffolk and Erie) have been the subject of recent litigation in direct response to application processing delays.

Key Responsibilities of Local Departments of Social Services

Local governments hold enormous responsibility in two key areas within Medicaid: eligibility and long-term care. In addition, they play an important role in other programmatic areas, including transportation; third-party, estate, and other recoveries; and fraud and abuse prevention and detection.

While local governments have always played a principal part in executing Medicaid-related tasks in New York, the nature of their tasks has evolved considerably over the years. Medicaid has broadened and diversified, adding several programs targeting specific enrollment groups with unique eligibility criteria. Medicaid eligibility rules have become more complex, including the financial eligibility rules for long-term care programs. The creation of multiple service configurations providing long-term care has compounded this complexity. The establishment of Medicaid managed care has added a layer to the enrollment process, while facilitated enrollment has modified the interaction between LDSSs and Medicaid enrollees, reducing the amount of face-to-face interaction local districts have with beneficiaries. Further, enrollment in Medicaid has significantly increased over the last ten years, substantially increasing LDSSs’ workload. Finally, fundamental changes in the state’s approach to fraud prevention and program integrity — prompted by both the creation

of OMIG and county cap rules that limit the ability of local governments to benefit from anti-fraud efforts — has upended existing local initiatives in this area.

These changes have had implications for LDSSs and state Medicaid officials. Local districts have struggled to keep pace with both the increasing difficulty and volume of their work. While policy changes are dictated by state officials, LDSSs must manage implementation of those policies with the administrative resources dictated by local government officials. As many local officials are reluctant to authorize new hiring, LDSS staff must often carry the added burden without additional resources. For their part, state Medicaid officials report frustration with sometimes reluctant or even recalcitrant county officials, who may not share state priorities or goals for implementing Medicaid in their districts. With each new policy initiative, state and local officials are left to debate where the line between policymaking (the acknowledged purview of the state) and implementation (the responsibility of local government) falls.

In the following section, LDSS Medicaid-related tasks and responsibilities are described in more detail, along with their statutory and regulatory basis, the oversight and technical assistance provided by SDOH, and observations particular to each task area.

Eligibility/Renewal

Background

By far, the most important area of responsibility for local districts is eligibility: it accounts for the vast majority of local staff and it is a function that must be performed for all enrollees at least once every year. Fifty-eight local departments of social services are responsible for the enrollment and oversight of more than four million beneficiaries. The variation in the number served by local districts is staggering. Home to two-thirds of enrollees statewide, New York City serves nearly 20 times the number of beneficiaries as Erie County—which has the second-highest enrollment of any county in the state; Erie in turn serves 20 times as many beneficiaries as Greene County. Table 3 depicts a snapshot of Medicaid enrollment statewide and among select counties, by enrollment category.⁹³

**Table 3.
Medicaid Enrollment, Select Counties, January 2008**

County	Children	Adults	Family Health Plus	Aged	Blind and Disabled	Other	Total (Sum of Columns)	Percentage of Total Enrollment
New York State	1,586,038	883,288	543,687	380,311	677,594	27,000	4,097,918	100%
New York City	1,046,098	619,603	406,370	247,358	367,671	23,180	2,710,280	66%
Erie	55,253	29,731	15,029	10,627	34,687	167	145,494	4%
Nassau	36,815	15,419	14,815	15,810	22,998	1,002	106,859	3%
Onondaga	27,146	12,612	6,161	5,639	15,431	33	67,022	2%
Rockland	24,898	9,613	5,051	4,210	5,086	230	49,088	1%
Tioga	2,815	1,552	678	677	1,407	1	7,130	<1%
Greene	2,453	1,323	650	712	1,672	4	6,814	<1%

Medicaid is not a monolithic program: it has multiple entry pathways and offers numerous program “tracks” with services tailored for different populations. Associated with these programs are different eligibility criteria, enrollment processes, and benefit packages. Typically, Medicaid coverage falls into two categories: “community Medicaid” and “long-term Medicaid.” Community Medicaid enrollees are eligible for all Medicaid services except care provided in a skilled nursing facility and community-based long-term care.⁹⁴ Long-term Medicaid enrollees are eligible for all Medicaid-covered services, including facility- and community-based long-term care services. New York State’s major Medicaid programs and eligibility categories are described in Table 4.

Table 4.
Targeted Medicaid Programs/Eligibility Categories, New York State

Program	Description	Target Population	Year of Enactment
Community Medicaid for Adults	Comprehensive health insurance coverage for adults including ambulatory care, inpatient and emergency services, and prescription drugs	Adults who meet household income and other requirements	1965
Community Medicaid for Children	Same as above	Children under age 19 who meet expanded household income and other requirements	1965
Medicaid Long-Term Care	Community Medicaid plus long-term care services	Individuals who require long-term care and meet more rigorous asset requirements	1965
Spend-Down	Community or Long-Term Medicaid	Medically needy individuals with income too high to qualify for Medicaid and high medical bills	1965
Prenatal Care Assistance Program	Enhanced prenatal care, education, labor, and delivery services for pregnant women	Pregnant women up to expanded income limits	1990
Refugee Medical Assistance	Medically necessary services for refugees	Uninsured single and childless couples with refugee status who meet income and other eligibility criteria	1995
Medicare Savings Program	Premium assistance for qualified Medicare beneficiaries	Medicare enrollees who meet specific income limits or other requirements	1998
Family Planning Benefits Program	Family planning services only	Women and men of childbearing age who meet expanded income limits	2000
Family Health Plus	Similar to Community Medicaid but implemented exclusively through managed care organizations and with some benefit limits	Adults age 18-64 with household income above Medicaid income eligibility requirements	2000
Medicaid Cancer Treatment Program	Medically necessary services for individuals with cancer or precancerous conditions	Uninsured individuals who meet age and expanded income limits with breast, cervical, colorectal, or prostate cancer	2000
Medicaid Buy-In Program for Working People with Disabilities	Medicaid coverage	Adults with disabilities who are working and have income too high to qualify for Medicaid up to certain income limits	2002
Family Health Plus Premium Assistance	Allows Family Health Plus to pay for employer-sponsored insurance for eligible individuals where cost-effective	Adults 18-64 who meet the eligibility criteria for Family Health Plus	2007
Family Health Plus Buy-In	Allows employers to purchase Family Health Plus coverage for employees	Adults age 18-64 employed at participating businesses	2007
Home and Community-Based Waiver Programs (e.g., Long-Term Home Health Care Program, Care at Home, Traumatic Brain Injury, Nursing Home Transition and Diversion Waiver)	Enhanced "waivered" services for individuals with a nursing home level of need and physical or developmental disabilities, receiving care in homes and communities	Varied	Varied

Tasks

Local districts serve as the front door to Medicaid in New York, completing a host of tasks related to eligibility screening and enrollment for new applicants, as well as renewal, the annual process where eligibility is re-evaluated. These tasks are described in detail in Table 5.

**Table 5.
Medicaid Eligibility Tasks, Local Departments of Social Services**

Task Category	Related LDSS Task
Eligibility Screening	<ul style="list-style-type: none"> • Provide an “opportunity to apply” in LDSS offices. Many counties also “outstation” enrollment workers in the community⁹⁵ • Collect and review applications and relevant documents • Conduct a face-to-face interview and provide information about the program, including on managed care plans, to applicants^{96, 97, 98} • Receive applications from facilitated enrollers • Verify information provided on application⁹⁹ <ul style="list-style-type: none"> -Income/Resources¹⁰⁰ -Citizenship -Assets -Disability (for long-term Medicaid) • Assess eligibility for Medicaid through the Spend-Down program¹⁰¹ • Assess eligibility for various Medicaid programs in a timely manner^{102, 103} • Assess eligibility for public assistance programs such as food stamps and TANF and make referrals • Send a notice of determination to applicants indicating approval or denial and right to a fair hearing^{104, 105} • Input and manage new recipient information into state-managed information systems (e.g., WMS) • Represent the county in fair hearings when determinations are appealed¹⁰⁶
Ongoing Maintenance	<ul style="list-style-type: none"> • Monitor recipients’ cases on an ongoing basis • Terminate coverage when recipients are found to be no longer eligible¹⁰⁷
Renewal	<ul style="list-style-type: none"> • Send a renewal package to recipients every year (or contract out this function to a third party)¹⁰⁸ • Process renewal applications (verifying accuracy of information, determining continued eligibility) • Send a notice of determination to recipients indicating approval or denial and right to a fair hearing
Managed Care	<ul style="list-style-type: none"> • Contract with managed care plans (New York City only)¹⁰⁹ • Distribute information about managed care and assess whether applicant is exempt or excluded from managed care enrollment¹¹⁰ • Automatically enroll individuals who qualify for managed care but have not chosen a plan¹¹¹ • Monitor managed care plan marketing activities¹¹² • Monitor managed care plan provider networks¹¹³

Managed Care — Eligibility and Enrollment

In 1997, New York moved to a mandatory managed care enrollment system, which is now the primary delivery vehicle for 64 percent of Medicaid enrollees. The establishment of Medicaid managed care created new local district responsibilities, including informing beneficiaries of available plans, connecting new enrollees to plans, and, in New York City, contracting with and monitoring managed care organizations.

States are permitted to delegate certain enrollment functions to contracted third-party entities. Currently, 14 counties use Maximus, a private, for-profit entity, to provide education to Medicaid applicants, process enrollments for Medicaid managed care, and mail materials to new and recertified Medicaid recipients. Maximus operates a toll-free call center to answer questions from applicants and recipients from all 14 counties. Often, Maximus staff are located within the LDSS and coordinate with LDSS staff on these functions. Contracts with Maximus are held and costs for their services are borne by the state, not the county.

Recent Developments in the Eligibility Process

Significant changes in Medicaid eligibility rules in the past ten years have had a major impact on the eligibility responsibilities of local districts: the de-linking of Medicaid from cash assistance, the implementation of facilitated enrollment, and the expansion of eligibility levels under Medicaid.

Spotlight: Contracting with Managed Care Plans in New York City

Originally, all local districts held their own contracts with managed care organizations. To standardize oversight of these contracts, legislation was passed that shifted this responsibility to the state for all contracting, except in New York City. Today, New York City is the only local district that contracts directly with health plans. While the Human Resources Administration is primarily responsible for Medicaid-related tasks, including eligibility screening and enrollment in Medicaid managed care, the City Department of Health and Mental Hygiene (NYC DOHMH) holds the health plan contracts.

NYC DOHMH oversees plans' adherence to the managed care contract as well as plan reporting responsibilities that include public health indicators and operational reports at the request of the agency. Further, the contract requires plans to conduct designated education activities and quality initiatives based on DOHMH priorities. NYC DOHMH also has the authority to review managed care plans' marketing materials and approach.

These activities are carried out by NYC DOHMH in parallel to SDOH's own oversight efforts, which are conducted on a statewide basis by the Office of Managed Care within OHIP. As a result, the two agencies have duplicative and sometimes conflicting reporting requirements, priorities, and standards.

Source: Medicaid Managed Care and Family Health Plus Contract. Appendix N. April 1, 2008; Personal communication, staff at SDOH Division of Managed Care, July 2008.

With the passage of the Personal Responsibility and Work Opportunity Act in 1996, federal law formally severed the link between Medicaid and cash benefits. At the time, nearly three out of four Medicaid beneficiaries in New York obtained Medicaid as part of a package of benefits that included cash assistance and food stamps. With the implementation of strict new rules for cash assistance and an uptick in the economy, New York’s welfare rolls began to plummet.

In the years that followed, New York undertook a targeted effort to link low-income working families with Medicaid benefits. After New York expanded eligibility (e.g., through the creation of Family Health Plus) and invested in enrollment initiatives, state and local officials watched as Medicaid enrollment surpassed the losses due to welfare reform and set new records for program participation. Between 1996 and 2007, the number of Medicaid enrollees also receiving cash assistance dropped by 50 percent, and the number of beneficiaries receiving Medicaid as a stand-alone health benefit more than tripled (see Table 6). In contrast to 12 years ago, most beneficiaries today seek Medicaid not as an adjunct to other benefits, but as a discrete health insurance program.

**Table 6.
Medicaid and Public Assistance Enrollment (1996 and 2007)¹¹⁴**

	January 1996	January 2007
Medicaid and Public Assistance	2,223,985 (72%)	1,292,404 (31%)
Medicaid Only	859,924 (28%)	2,835,412 (69%)

New York’s facilitated enrollment (FE) program was established in 2000 to enable community-based organizations and managed care plans to provide assistance with eligibility, enrollment, and renewal for public health insurance programs.¹¹⁵ Facilitated enrollers are generally situated in community-based locations (such as community centers, hospitals, and health centers) and primarily assist individuals with new enrollment in Medicaid (including Family Health Plus) and Child Health Plus. Today, FEs serve as the first point of contact for about half of all applicants for community Medicaid statewide, and most are employed by Medicaid managed care plans. They collect and help process applications, which are then sent to LDSS eligibility staff for final review. LDSSs hold the ultimate responsibility for making eligibility determinations, and throughout the year are charged with case maintenance. Applicants applying for long-term Medicaid are not permitted to apply through facilitated enrollers.¹¹⁶

In combination, these changes have resulted in a subtle shift away from the welfare model of direct client interaction, and towards a more administrative model within LDSSs. Several counties report that facilitated enrollment has reduced the amount of face-to-face interaction that local districts have with Medicaid enrollees. However, facilitated enrollment, they counter, has not diminished their eligibility-related responsibilities because of a dramatic increase in application volume. Each application requires verification of eligibility information and applicant follow-up on missing documents.

The extraordinary complexity associated with Medicaid eligibility rules is widely acknowledged. For instance, for recertification alone, workers must become familiar with 77 different codes associated with denial of re-enrollment during recertification.¹⁷ Eligibility rules and documentation requirements for immigrant groups are particularly complex, requiring workers to master challenging legal definitions, such as Persons Residing Under the Color of the Law (PRUCOLs). This complexity has only been compounded with the creation of new Medicaid programs targeted to specific populations, each with its own eligibility criteria.

In recent years, SDOH has introduced some streamlining initiatives, with the goal of increasing enrollment of eligible but uninsured individuals and reducing the burden and enrollment complexities. These initiatives include the establishment of the facilitated enrollment program, self-attestation of income at renewal, elimination of the face-to-face interview required during recertification, allowance of mail-in renewals, and the state's pending application to the federal government for 12-month continuous eligibility for Medicaid and Family Health Plus enrollees. While these initiatives have removed barriers to enrollment for families, they have sometimes added to local government responsibilities. For instance, self-attestation of income requires LDSS case workers to verify income information through data systems, and follow up with beneficiaries on any discrepancies.

Given this high level of complexity, the volume of Medicaid applications, and the responsibility associated with each application, state and local officials agree that local governments are perpetually burdened by inadequate human and capital resources. A considerable number of retirements, compounded by low government salaries and strenuous workloads, has contributed to high turnover in LDSSs. This turnover results in a loss of institutional knowledge of Medicaid rules and guidelines. While LDSSs have sought to increase their staffs to respond to this volume growth in recent years, new hires require approval from reluctant county executives and legislatures.

State and local officials agree that the underlying goals prompting the recent policy changes have not been universally embraced by county officials. With the de-linking of Medicaid and welfare, state officials began a migration away from the prevailing idea that participation in Medicaid was to be discouraged — a welfare program reserved for only for those in the most desperate need. Today, recognizing the benefits of preventive care and having embraced the goal of universal coverage, state officials have articulated a desire to ensure that the one million uninsured New Yorkers eligible for Medicaid are enrolled in the program. Support for this goal among county governments is mixed. Some local districts have welcomed the opportunity to provide coverage to local citizens, while others, skeptical about the continuance of the county cap, have raised concerns about the potential long-term costs. Still others have questioned the state’s methods, arguing that streamlined eligibility systems leave the program vulnerable to fraud. This clash of visions has been a source of frustration for state and local officials alike, and has contributed to variation in program administration at the local level.

SDOH Interaction / Oversight

The division within OHIP charged with oversight of local government eligibility activities is the Division of Coverage and Enrollment. A separate Division of Managed Care within OHIP oversees all managed care activities, including Managed Long-Term Care, described later in this report.

To provide on-the-ground support and technical assistance, the Division of Coverage and Enrollment employs 17 local district liaisons — eight assigned to New York City alone and nine assigned to the 57 counties apart from New York City. Each liaison may be responsible for as many as eight different local departments of social services. The local district liaison is the LDSS’s first go-to person on troubleshooting matters related to eligibility. They provide technical assistance for implementation of policy and program changes; policy clarification on new initiatives; and assistance with information system issues, both on-site and remotely. Local district liaisons also field and respond to all consumer complaints directed at the districts they oversee.¹¹⁸ Outside of the liaisons, the interaction between OHIP and local districts depends on the task, function, and division.¹¹⁹

The Division of Coverage and Enrollment and Division of Managed Care hold monthly conference calls with eligibility staff to discuss new policy initiatives and respond to specific eligibility issues from the local districts. For oversight and monitoring, the divisions use tools described earlier in this report, such as on-site case reviews and local district performance reports, to identify issues of timeliness and adherence to protocol, and issue corrective action letters or plans as necessary.

Oversight of eligibility activities at 58 LDSSs proves to be enormously challenging. The activities of the many entities involved — facilitated enrollers, enrollment brokers, and LDSS eligibility staff — are difficult to coordinate. For example, facilitated enrollers are chosen by and contract with SDOH, with oversight from OHIP’s Division of Coverage and Enrollment. Yet they must work closely with local districts, who are responsible for making the final eligibility decision. Several districts have complained that the quality of FE applications are poor, failing to comply with standards and protocols, which then requires the LDSS to do additional, duplicative follow-up with families. FEs counter that local districts impose additional requirements that are not required under state rules and that these requirements vary considerably across county lines. State officials report finding validity in both complaints, and have developed various mechanisms to monitor and mediate such disputes across the state.

Oversight by two OHIP divisions, technical assistance from multiple on-the-ground liaisons and interaction with other state agencies such as OTDA and OCFS can compound confusion at the local level. Further, while OHIP has access to some performance metrics that allow them to gauge outcomes at the local level (e.g., timeliness of application processing), they lack the necessary enforcement tools and incentive mechanisms to ensure compliance at the local level. The state also lacks the authority to impose operational changes — such as staffing levels — in response to emerging problems or needs. Finally, while state and local officials agree in principle about the division of authority — the state sets policy, the district determines how to implement it — the line between policy and implementation is not always clearly defined.

Centralization of Tasks

New York State has attempted to relieve some of the burden on local districts and improve efficiency through the centralization of specific Medicaid-related tasks. The enacted 2008-2009 state budget allocated funds to create a centralized statewide enrollment center (EC) to help process applications for certain Medicaid programs and renewals for most Medicaid programs. The EC has implications for LDSS workflow and, in some cases, could relieve LDSSs of some of their traditional responsibilities.

Proposed EC functions currently include: 1) operating a statewide telephone and mail-in renewal system for Medicaid, Family Health Plus, and Child Health Plus B; and 2) administering the Family Health Plus Premium Assistance Program. In the future, the EC may be expanded to include: 1) key responsibilities within the Family Health Plus Buy-In Program, which include fiscal, oversight, renewal, and educational responsibilities; 2) management of web-based renewal; and 3) processing of applications for some Medicaid programs.

The establishment of the Enrollment Center has been one attempt by the state to standardize operations for some Medicaid-related tasks. While one of its goals is to lessen the burden on eligibility workers for renewal of certain enrollees, a principal objective has been to bring a greater degree of consistency to renewal determinations across the state. However, the proposed EC tasks represent some of the less complex tasks LDSSs handle, prompting some local districts to observe that the greatest programmatic challenges will be left in counties' hands. The EC does not eliminate local agencies' responsibility for renewing Medicaid long-term care recipients. In addition, some LDSS staff and labor representatives have expressed concern that the EC could result in job losses among county employees. Since the EC will not be implemented until early 2010 at the earliest, the impact on LDSS workflow remains to be seen. It will be necessary, however, for LDSSs to be partners in implementation to prevent duplicative renewals and ensure the EC is able to operate smoothly.¹²⁰

Behavioral Health Agency Role in Eligibility

The EC is not the first instance of the state assuming direct responsibility for enrollment. SDOH has delegated to the Office of Mental Retardation and Developmental Disabilities (OMRDD) and the Office of Mental Health (OMH) responsibility for Medicaid eligibility and enrollment for certain populations.¹²¹ This delegation permits agencies with expertise in behavioral health to provide enrollment assistance to the populations with which they are closely familiar.

By way of this delegated responsibility, OMRDD operates District 98, a distinct "local district" with responsibility for handling Medicaid eligibility screening and enrollment for residents of state and some voluntary facilities, including individuals with "Chapter 621 status." Individuals with this status are those that have had at least five years of continuous inpatient services provided by a residential facility (e.g., intermediate care facility). For these individuals, there is no local share in Medicaid costs.

To conduct eligibility assessments and facilitate application processing, staff at OMRDD agencies known as Revenue Support Field Offices operate as Medicaid workers and have access to the same state databases as LDSS workers (e.g., WMS and eMedNY).¹²² OMRDD also has 13 Developmental Disability Service Organizations (DDSOs) around the state that serve as extensions of the state agency. Among other responsibilities, DDSOs conduct disability determinations for Medicaid-eligible individuals to identify what level of service they need.¹²³ DDSOs also conduct eligibility determinations for OMRDD Medicaid waivers and monitor the Medicaid eligibility process handled by the LDSSs.^{124, 125}

Similarly, OMH has established District 97. Staff at OMH Field Offices conduct Medicaid eligibility and facilitate application processing using tools similar to those used by LDSS workers (e.g., WMS and eMedNY). Populations that OMH screens for Medicaid eligibility include:

- Inpatients in OMH psychiatric centers
- Residents of state-operated family care homes
- Residents of state-operated community residences (including all OMH-licensed, state-operated transitional residences)
- Residents of state-operated residential care centers for adults
- Children in voluntary-operated residential treatment facilities
- Children in voluntary-operated family-based treatment homes
- Children in teaching family community residences

Long-Term Care

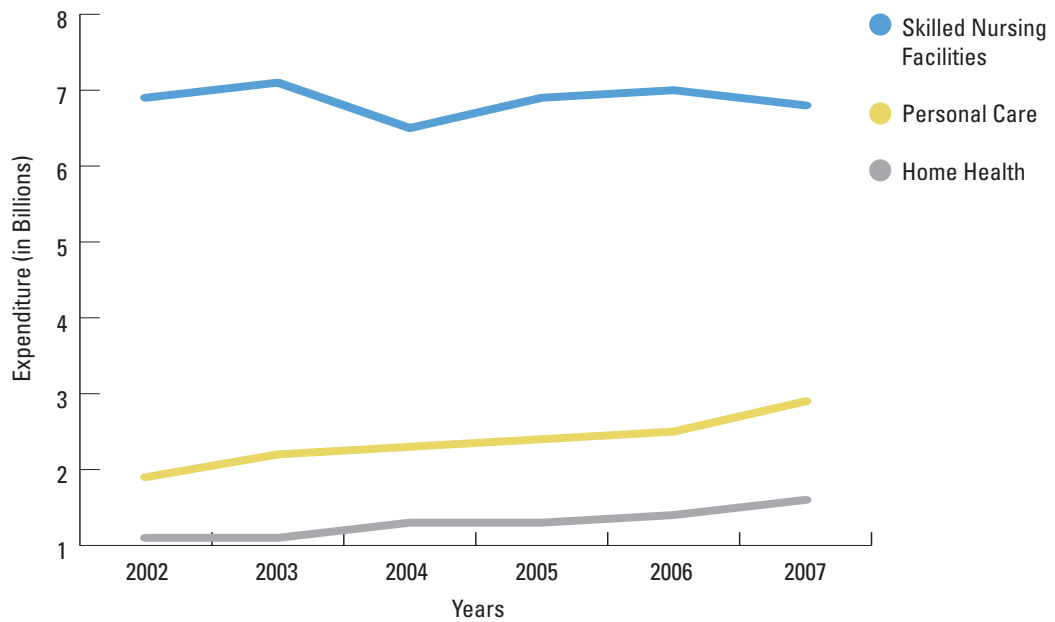
Background

As the largest payer of long-term care services in New York, Medicaid plays a crucial role in ensuring that disabled and elderly New Yorkers have access to necessary residential and community-based long-term care services.¹²⁶ Expenditures for long-term care statewide have risen in recent years. While expenditures for skilled nursing facility care remained relatively stable from 2002 to 2007, annual Medicaid spending on home health care and personal care increased over the same period by an average of 9 percent and 8 percent, respectively¹²⁷ (Figure 2) — despite the fact that the number of Medicaid beneficiaries receiving these services declined over the same period.¹²⁸ From 2006 to 2007 alone, personal care expenditures rose by 16 percent (from \$2.5 billion to \$2.9 billion) and home health expenditures rose by 15 percent (from \$1.4 billion to \$1.6 billion). Together, these two service areas account for \$4.5 billion — more than 10 percent of all Medicaid spending on services.

At a minimum, states are required under federal Medicaid law to provide access to skilled nursing facilities and home health services to long-term care recipients eligible for skilled nursing care.¹³⁰ In addition, New York has elected to provide additional services designed to enable the elderly and people with disabilities to remain safely in their homes and in the community, in accordance with federal mandates through Medicaid waivers; case management; respiratory care; pediatric nursing care; inpatient pediatric psychiatric care; personal care; private duty nursing; hospice; and intermediate care for mentally retarded populations.¹³¹

The combination of the increasing cost and importance of long-term care services within Medicaid has prompted state officials to embark upon a statewide reform effort. SDOH, in coordination with other state agencies, is currently exploring ways to restructure the state's long-term care delivery system to promote efficiency in service delivery to the state's most vulnerable New Yorkers.

Figure 2
Annual Statewide Expenditures, by Long-Term Service Category (2002-7)¹²⁹



Tasks

Local districts historically have played a significant and involved role in the approval and oversight of long-term care services. Far more so than community Medicaid, long-term care is viewed by local districts as part of the social services safety net, largely because of the vulnerability of the beneficiaries themselves. LDSSs, particularly upstate, note that their proximity to beneficiaries facilitates provider dispatch to beneficiaries' homes to conduct on-site assessments and monitoring of beneficiaries' safety, and their relationships with and knowledge of local providers are useful to their provider contracting and monitoring responsibilities. In many counties, long-term care services are implemented in concert with the county's adult and child protective services. Before the implementation of a reduced local share of long-term care expenditures and a cap on local district contributions to Medicaid, the high cost of long-term care services also encouraged a more robust local role.

Within long-term care, local districts are responsible for three principal areas: eligibility screening, program determination, and approval of services.

Eligibility: As in community Medicaid, LDSSs screen elderly, disabled, and chronically ill applicants for eligibility in Medicaid long-term care. Though many of the responsibilities for eligibility mirror those described in the previous section, eligibility standards related to assets are far more rigorous and comprehensive for Medicaid long-term care.

Programs: Due to the diversity of needs among long-term care recipients, New York State has developed and implemented numerous long-term care programs, many of which are home and community-based waivers administered through Medicaid. There is considerable overlap in the services offered, and local districts are charged with helping determine which program is most appropriate for the applicant.

Services: Long-term care beneficiaries can obtain services either through a long-term care program or directly from the provider. The LDSS has the largest role in oversight of personal care services. Workers assess and approve the level of care needed; then they communicate with providers (through information systems) and to beneficiaries (through notices) the amount of services for which they are eligible. LDSSs also are responsible for contracting, oversight, and rate setting for personal care service providers. The major long-term care programs and services are listed in Table 7.

Eligibility

Eligibility rules for Medicaid long-term care are more stringent than those of community Medicaid. LDSS workers must obtain from Medicaid long-term care applicants written documentation of resources, including cash, any assets that can be converted to cash (such as stocks and bonds), and property.^{133, 134} Case workers also must determine whether the applicant transferred assets for less than fair market value during a “look-back” period.¹³⁵ If such an asset transfer is found, the applicant is ineligible for Medicaid for a specified period.¹³⁶ The “look-back” period is significantly longer for Medicaid long-term care applicants requiring institutionalization than for those applying for community Medicaid.¹³⁷ This requires sophisticated investigation and review of past financial transactions by local district workers. Some resources are disregarded when considering eligibility for Medicaid. The rules governing the asset disregards and transfers are the subject of intense interest to elder law attorneys and their clients, and LDSSs report extraordinary efforts by front-line administrative staff to stay a step ahead of the evolving body of law.

**Table 7.
Select Medicaid Long-Term Care Programs and Services**

Program / Service	Target Population
Program ¹³²	
Long-Term Home Health Care Program (“Lombardi”)	Individuals who would otherwise be eligible for admission to a nursing home but prefer to be cared for in their home or community
Managed Long-Term Care / Program for All-Inclusive Care for the Elderly (PACE)	Coordinated long-term care for individuals with a nursing home level of need requiring long-term care services and cared for in home and community-based settings; PACE programs also coordinate acute care services for enrollees
Care at Home I and II Waiver	Long-term care and support services delivered to children with disabilities under 18 in their homes
Traumatic Brain Injury Waiver	Care for individuals with a traumatic brain injury delivered in homes and communities
Nursing Home Transition and Diversion Waiver	Skilled nursing and support services delivered to individuals being discharged from nursing homes or those at risk for institutionalization
Bridges to Health Waiver	Long-term care services delivered to children in foster care
Service	
Personal Care	Care provided to individuals who require assistance with activities of daily living — such as eating, dressing and bathing--and instrumental activities of daily living, such as housekeeping (Note: Personal care also is considered a program, as it includes service coordination provided by county workers)
Consumer-Directed Personal Assistance	Personal care services delivered to individuals who hire, train and supervise personal care aides themselves (or with the help of a proxy)
Personal Emergency Response System (PERS)	Electronic system installed in an individual’s home that provides an alert to the PERS provider, emergency medical services, or the police when the individual is in an emergency situation
Home Health Aide Services	Part-time, intermittent health care and support services to individuals who need intermediate and skilled health care
Private Duty Nursing	Skilled nursing care generally delivered in an individual's home or community

Financial eligibility criteria are more generous for the disabled, and as a result many long-term care enrollees require a disability determination to be eligible for Medicaid. Twenty-four counties have elected to conduct disability determinations for Medicaid long-term care applicants (including both small counties such as Greene and Schoharie and larger counties like Erie and Monroe, as well as New York City). In these cases, the determination is conducted by LDSS case workers; for the remaining 34 counties, disability determinations are handled by SDOH. For districts that do so, these disability determinations often involve an in-depth review of doctors' orders and beneficiaries' medical conditions in order to make the determination.

Program Determination

Within Medicaid, long-term care services may be delivered through one of several specialized programs designed to coordinate service delivery to various groups of beneficiaries. New York State operates seven home and community-based waivers that offer enhanced long-term care services for targeted eligibility groups. For some of these waivers (Care at Home III, IV, and VI; OMRDD Waiver for Adults and Children with Developmental Disabilities; and OMH Waiver for Children with Serious Emotional Disturbances), local districts play a minimal role and thus are not discussed below. Primary responsibility for these waivers is held by OMRDD field offices and DDSOs and by OMH field offices.

In several counties, Community Alternative Services Agencies (CASAs) are an arm of local government, employing case managers and nurses and charged with processing program referrals, conducting assessments, and developing plans of care for individuals who require personal care services. Reflecting its size, New York City has multiple CASAs. Outside of determination and enrollment in distinct long-term care programs, LDSS workers handle discrete tasks within each program to ensure that enrollees are able to receive the services they need. Table 8 details these tasks.

The myriad of long-term care programs with considerable overlap in available services and eligibility requirements often makes it difficult to discern which program is best suited for an individual recipient. In addition, there is not a centralized mechanism or consistent framework for assessing individuals and referring them to the appropriate program. Consumer advocates, local districts, and provider groups indicate that program referrals typically are driven more by the provider relationship than by any objective standard. Most beneficiaries enrolled in long-term care programs come to the LDSS through a provider referral requesting the beneficiary be enrolled in the particular program in which the provider participates. For instance, if the referral originates from a Long-Term Home Health Care Program provider, the beneficiary will likely be enrolled in that program. Stakeholders report that those who do not come with a referral to a specific program typically end up

enrolled in personal care. Some providers have raised concerns that CASAs' involvement in personal care shifts the balance of long-term care services toward personal care in some counties. CASAs are required to screen and refer Medicaid beneficiaries to the long-term care program for which they are best suited; reportedly, however, in some districts CASAs rarely refer beneficiaries to programs other than personal care, the program over which they have the most direct control. All acknowledge that the long-term care referral system is an area ripe for improvement.

**Table 8.
Medicaid Tasks By Long-Term Care Program**

Program	Category of Task	Related LDSS Tasks
Long-Term Home Health Care Program	Eligibility	<ul style="list-style-type: none"> • Receive referral for program, typically through provider • Dispatch nurse to recipient's home/setting to conduct assessment and determine level of care needed, using program-specific assessment tools and criteria, in coordination with referring provider (in New York City, HRA nurse and case manager visit recipient's home)¹³⁸
	Budgeting	<ul style="list-style-type: none"> • Monitor the total cost for all Long-Term Home Health Care Program recipients in district and ensure that all service expenditures for individual enrollees in county fall under 75 percent of equivalent care for the enrollees, were it to be provided at a regional nursing home.¹³⁹
Managed Long-Term Care ¹⁴⁰	Eligibility / Service Authorization	<ul style="list-style-type: none"> • Review assessments conducted by managed long-term care plan and approve level of care determination • Certify all other information provided by plan for accuracy
	Maintenance	<ul style="list-style-type: none"> • If eligible, input applicant's eligibility information into prepaid capitation system (PCP), which generates roster sent to MLTC plans and allow capitated payments to be delivered
Home and Community-Based Waiver Programs	<u>Care at Home I and II:</u> ¹⁴¹ Eligibility / Service Authorization	<ul style="list-style-type: none"> • Collect and review initial assessments and make an eligibility determination • Conduct prior authorization of state plan services • Enter recipient restriction code into eMedNY to authorize level of approved services, maintain case file
	<u>Traumatic Brain Injury/Nursing Home Transition and Diversion:</u> Service Authorization	<ul style="list-style-type: none"> • After Medicaid application is processed and applicant is enrolled in program, approve state plan services, in coordination with Regional Resource Development Centers (see below)
	<u>Bridges to Health:</u> Eligibility, Maintenance, Service Authorization, and Case Work/Referrals	<ul style="list-style-type: none"> • Identify potentially eligible children for the program and refer them to the Health Care Integration Agency (HCIA) • Enter recipient restriction code into eMedNY to authorize level of approved services, maintain case file • Conduct ongoing maintenance of foster care case and monitoring of access to services • Authorize case management services • Make referrals and arrangements for children disenrolled from the waiver program

Two home and community-based waiver programs have unique administrative structures that merit discussion: the Traumatic Brain Injury Waiver (TBI) and the Nursing Home Transition and Diversion Waiver (NHTDW). Though these are smaller waiver programs (with enrollment under 5,000 for TBI and under 100 for NHTDW), their unique administrative structure is worth noting. Instead of delegating tasks to the LDSSs, nine regional non-profit entities around the state are responsible for most tasks related to enrollment and service authorization. These regional bodies, known as Regional Resource Development Centers (RRDCs), are typically non-profit, community-based organizations that contract with SDOH and act as a single point of entry for the program. RRDC staff oversee assessments, develop plans of care, and authorize services for program enrollees. LDSSs play a supportive role in these two waiver programs, screening applicants for Medicaid eligibility, processing enrollment, and relaying a roster of new enrollees to the RRDC.

Service Authorization

LDSSs conduct prior approval of service authorization for long-term care within Medicaid, except for those beneficiaries enrolled in managed long-term care plans. Prior approval is “the process of evaluating the aspects of a plan of care which may be for a single service or an ongoing series of services in order to determine the medical necessity and appropriateness of the care requested.”¹⁴³

The level of authority LDSSs have in service authorization varies by service. All LDSSs handle prior approval for personal care services. They are responsible for conducting intake, making social and clinical assessments, and determining the level of care needed. In counties that use CASAs, case workers at these agencies are responsible for assessments, program referrals, and level of care determinations for personal care. For private duty nursing, seven counties have elected to conduct prior approval; in all other counties (including New York City), SDOH conducts prior approval.

Outside of long-term care programs such as home and community-based waivers and the Long-Term Home Health Care Program, local districts are minimally involved in the approval of home health care services. In these cases, home health care is generally requested on a short-term basis for beneficiaries discharged from nursing homes and hospitals to home and community settings. Generally, providers work directly with certified home health agencies (CHHAs) to determine the level of services and arrange for care without the need for prior approval or direct involvement from LDSSs. Where CHHAs are county-owned and operated, local district staff may play a larger role in approval of home health services.

Adult and child protective services often work in tandem with Medicaid long-term care to ensure the health and safety of long-term care beneficiaries. Adult protective services typically sit within a separate arm of the LDSS and coordinate efforts to intervene when personal care services are inadequate to meet the needs of at-risk Medicaid enrollees. Conversely, adult protective services often rely on personal care services to supplement the array of social services supports offered to their clients. Table 9 details the tasks required of local district workers for each type of long-term care service.

Personal Care

Though local districts hold a myriad of responsibilities with respect to long-term care, their level of responsibility is by far the most significant for personal care services. Within the realm of personal care, local districts are charged with authorizing services as part of a plan of care, linking beneficiaries to other needed health and social services, holding contracts with providers, setting reimbursement rates with state-determined regional caps, and conducting quality assurance activities. Some counties describe a case work function, in which LDSS staff help coordinate care for personal care recipients.

Local districts' approaches to these tasks vary widely. Some counties employ or contract with staff to conduct unannounced visits to home and community settings in which personal care is delivered. These home visits are intended to verify that the plan of care is adhered to and that the personal care aide is able to meet all the needs of the individual served. Citing the proximity of LDSSs to beneficiaries and their involvement in authorizing personal care services, LDSSs view their involvement in quality assurance as important and necessary. However, consumer advocates and some state officials raise concerns about equity and efficiency given the dramatic variation in the operation of personal care services throughout the state.

Consumer advocates and state officials note in particular the enormous variation in authorization of home care services, particularly personal care. In general, New York City is thought to offer more generous access to personal care services overall than the rest of the state. The example is often cited of a beneficiary who moves from New York City to upstate New York and finds his personal care hours drastically reduced despite no change in his condition or social supports. However, state officials note considerable variation in service authorization even within the New York City limits, with rates of service use and costs per recipient sometimes varying significantly among adjacent neighborhoods.

**Table 9.
Medicaid Tasks, Long-Term Care Services**

Service	Category of Task	Related Tasks
Personal Care	Service Authorization	<ul style="list-style-type: none"> • Conduct intake, social, and clinical assessments to assess need and level of care required (generally conducted by a nurse) • Assessment includes need for PERS¹⁴⁵ • Design plan of care, enter information into eMedNY • In New York City, assessments are reviewed and level of care is determined by medical review team (instead of solely by nurse or case worker) • Conduct reassessments to determine level of care every six or 12 months¹⁴⁶ • Involve local professional director in determination of level of care when nurse and LDSS disagree
	Case Work/ Referrals	<ul style="list-style-type: none"> • Ensure that personal care recipient has access to all needed services; make referrals as necessary
	Provider Contracting	<ul style="list-style-type: none"> • Release requests for proposals; select and maintain contracts with personal care providers (including PERS providers)¹⁴⁷
	Rate Setting	<ul style="list-style-type: none"> • For personal care rates, OHIP's Division of Health Care Financing sets a ceiling for the reimbursement rates to providers and LDSSs set a county-specific rate beneath that ceiling. (LDSSs used to set their own rates, but no longer can do so.)¹⁴⁸ • The exception is New York City, which sets its own personal care reimbursement rates, subject to the approval of the Division of Health Care Financing.¹⁴⁹ New York City sets provider-specific rates.
	Monitoring/Quality Assurance	<ul style="list-style-type: none"> • Conduct home visits to monitor providers' adherence to plan of care¹⁵¹ • Ensure that personal care aides have level of training needed to serve beneficiaries¹⁵²
Consumer-Directed Personal Care	Service Authorization	<ul style="list-style-type: none"> • Assist in completing assessment, if necessary¹⁵³ • Authorize adult or child protective services, if necessary
Home Health Care	Service Authorization	<ul style="list-style-type: none"> • For county-operated CHHAs, LDSSs employ nurses to conduct on-site assessments (at beneficiaries' homes or in hospitals before discharge) <ul style="list-style-type: none"> -In counties with voluntary CHHAs, local districts play a minimal role, since CHHAs themselves play a large role in authorization of services. • Nurses determine appropriate level of care and processes prior approval • Enter authorization into eMedNY to ensure that providers are limited to provide and bill for that amount of services • Involve local professional director when CHHA and physician disagree on whether to discontinue case¹⁵⁴
Private Duty Nursing	Service Authorization	<ul style="list-style-type: none"> • At county's discretion, conduct prior approval. (Seven counties have elected to conduct their own prior approval: Broome, Chemung, Erie, Oneida, Schenectady, Tompkins, and Westchester. These counties are permitted to conduct this task through a letter of designation with OHIP.) • LDSSs that conduct prior approval must do the following: <ul style="list-style-type: none"> -Review physician's written orders for nursing care -Review assessment conducted by a nurse -Determine level of service (e.g., number of hours per week) an individual qualifies for -Enter that number into eMedNY to ensure that providers give and bill for that amount of services
	Rate Setting	<ul style="list-style-type: none"> • SDOH sets a ceiling and LDSSs can set the rate beneath that ceiling. LDSSs can seek exemptions for the ceiling for specialized situations.¹⁵⁶
Case Management	Service Provision/ Operator	<ul style="list-style-type: none"> • Provide case management services, in counties where no case management agencies are available¹⁵⁷
Facility-Based Skilled Nursing	Service Provision/ Operator	<ul style="list-style-type: none"> • In some counties, operate skilled nursing facilities

**Table 10.
Personal Care Services, by County (FFY 2005)**

Region	Total Personal Care Expenditures	Number of Personal Care Recipients
New York State	\$2.3B	101,800
New York City	\$1.9B	73,100
Erie	\$20M	2,100
Greene	\$1M	100
Nassau	\$94M	3,900
Onondaga	\$9M	1,000
Rockland	\$10M	600
Tioga	<\$1M	100

Recent data on personal care issues illuminate this point. Whereas the number of hours approved in New York City per personal care recipient per year was 1,977 in 2007, it was 887 for the rest of the state in the same year. Further, the dollars spent per person per year differs drastically for New York City recipients, compared with those in the rest of the state (\$33,873 and \$17,321, respectively).¹⁵⁸ This variation is attributable to a number of factors, including regional variation in population, wages, availability of other local social supports, clinical norms, availability of workforce to serve beneficiaries, and the involvement or sophistication of consumer advocates. However, it also reflects variation in interpretation of rules across county lines. For instance, counties and stakeholders note that while beneficiaries in New York City are able to obtain 24-hour personal care, many upstate counties have internal policies prohibiting 24-hour care. This variation raises questions about the equity of Medicaid service delivery statewide.

SDOH Interaction / Oversight

Because of the breadth of long-term care services delivered in New York, SDOH established an Office of Long-Term Care (OLTC) in 2007, which is separate from the Office of Health Insurance Programs and is led by its own Deputy Commissioner. OLTC holds primary responsibility for oversight of long-term care services, as well as other duties, and works closely with OHIP leadership.

Spotlight: New York City and Personal Care

New York City has a unique organizational structure to review and approve services for personal care. An “Assessment Team” made up of an HRA nurse and case manager conduct the initial steps in the assessment for personal care. The nurse makes a home visit, conducts an assessment, and confers with the case manager to recommend a level of care. If the case manager and nurse disagree, the case is referred to the local medical director (known as a “local professional director” in the regulations) who makes a decision. The case then goes to HRA’s medical review team, an entity not in the regulations but created by New York City as an additional layer of review to ensure appropriate approvals.

Once the approved number of hours is determined, New York City uses its own information system into which the number of hours and duration are entered, known as HALO. HALO links to eMedNY, the system that providers use to bill for services. New York City contracts directly with personal care providers through the Mayor’s Office of Contracts, though HRA is responsible for their oversight and monitoring.

Despite this structure, New York City acknowledges significant challenges in managing its large personal care program, including significant variation in hours of authorized care within the City. HRA notes that efforts to improve the system have been stymied by challenges in fair hearings and the courts. HRA contends that hearing officers from OTDA, which administers fair hearings, are often unfamiliar with personal care state policy goals and expectations emanating from SDOH, which can undermine the City’s efforts to implement reform.

Source: Personal communication, staff at Human Resources Administration, September – October 2008.

Interaction between LDSSs and SDOH on long-term care matters is determined by the topic.³⁵⁹

- For provider enrollment issues, LDSSs contact OHIP’s Division of Provider Relations and Utilization Management.
- For personal care and private duty nursing rate settings issues, as well as payment for county-operated skilled nursing facilities, LDSSs contact OHIP’s Division of Health Care Financing.
- For issues related to managed long-term care, LDSSs contact the OHIP’s Division of Managed Care.
- For all other matters, LDSSs contact their OLTC local district liaison or the Office of Long-Term Care.

Like the Division of Coverage and Enrollment, the Office of Long-Term Care has local district support liaisons who primarily handle personal care issues assigned to a collection of districts. Currently five liaisons serve all LDSSs on personal care and consumer-directed personal assistance program issues statewide. Responsibilities of these liaisons include: reviewing case records, responding to specific issues at the LDSS level, providing process assessment/evaluation to LDSS on program operations with corrective action plans, if applicable.

For many programs, SDOH conducts an annual review of a sample of cases at LDSSs to ensure the appropriateness of authorizations and plans of care.

- For personal care, the Office of Long-Term Care conducts annual on-site monitoring to ensure compliance and review authorizations of services. (The Office of Long-Term Care is currently assembling a computerized tool to facilitate electronic process reviews of LDSS.)
- For Care at Home, the Office of Long-Term Care chooses 10 percent of cases from a selection of counties (rotated each period of case reviews) and conduct on-site quality assurance.

After these reviews, SDOH makes recommendations, issues corrective action plans, and requires the LDSSs to respond. Follow-up monitoring is conducted by SDOH to ensure the corrective action plans are implemented. However, state oversight of long-term care program determination and service authorization is retroactive and often occurs 1-2 years after beneficiaries have been enrolled and services have been delivered.

Finally, several counties noted significant concerns with the lack of state guidance and oversight in the consumer-directed personal assistance program (CDPAP). As with personal care, LDSSs are responsible for the assessment and approval of CDPAP services, provider contracting and program oversight. However, LDSSs note that the lack of regulations, ADMs, and general guidance from SDOH in this area has led to confusion and frustration over what standards should apply and what authority LDSSs have to intervene in the provision of services. (At the time this report was written, SDOH noted that CDPAP regulations are in development.)

To improve efficiency in prior authorization of personal care and other services, and given that New York City incurs the large majority of personal care expenditures for Medicaid, the 2009-10 enacted budget authorized the Department of Health to establish two long-term care assessment centers — one in an upstate county or region and another in New York City. Initially, the centers will be pilot projects, effective January 1, 2010, and concluding three years later. The centers will be responsible for activities related to the assessment of a person's need for, and the authorization of, long-term care services and programs for personal care, consumer-directed personal assistance services, assisted living program, the long-term home health care program, and managed long-term care.

Other Programmatic Areas

Three additional programmatic areas in which local districts play a key role are transportation, third-party and estate recovery, and fraud and abuse detection and prevention.

Transportation

Assurance of transportation to and from health care providers is a federal Medicaid requirement.¹⁶⁰ More than 110,000 Medicaid recipients statewide use transportation services; two-thirds of them reside in New York City. Though statewide transportation expenditures make up less than 1 percent of total Medicaid spending, local districts hold considerable responsibility over the availability of this service and it is thus worth noting in this report. Table 11 highlights transportation costs for select counties and New York State overall.

Table 11.
Medicaid Expenditures, Select Counties (FFY 2007)¹⁶¹

County	Transportation
New York State	\$332.0M
New York City	\$222.0M
Erie	\$9.4M
Greene	\$408.0K
Nassau	\$11.8M
Onondaga	\$8.6M
Rockland	\$1.8M
Tioga	\$368.0K

Through statute, New York State delegates the responsibility of prior authorization of transportation services to local districts, which approve both transportation and the amount for which a recipient is eligible.¹⁶² (“Prior authorization” is similar to prior approval but indicates the necessity of approval for services that do not require review by a medical professional.) LDSSs must ensure that transportation services are approved and utilized efficiently and that transportation is approved only for “essential medically necessary services.” Local governments are permitted to contract out prior authorization to a third-party entity, and several counties do so to remove the burden of coordination and prior authorization from their staff workload. Contracting this function out also limits the need for counties to hire additional staff dedicated to this task.

Local governments set reimbursement rates for transportation services, subject to approval by SDOH's Division of Financial Planning and Policy.¹⁶³ Local governments are permitted to set one reimbursement rate for all providers in the county, or to set provider-specific rates. Transportation providers generally bill SDOH through eMedNY for services rendered; however, in some counties, transportation vendors bill and are reimbursed by the LDSS. Local governments reimburse Medicaid recipients for any out-of-pocket expenditures incurred (e.g., use of public transportation).¹⁶⁴ In New York City, for instance, methadone treatment centers, outpatient psychiatric clinics, and substance abuse clinics dispense MetroCards (payment cards to use on public transportation) and submit monthly bills to and get reimbursed by HRA. For the expenses they incur, the LDSSs bill SDOH and are reimbursed.¹⁶⁵

Two primary divisions within SDOH OHIP interact with LDSSs on transportation-related issues: the Division of Financial Planning and Policy (DFFP) and Division of Provider Relations and Utilization Management (DPRUM). DFFP approves negotiated rates for transportation set by counties while DPRUM oversees enrollment of transportation providers and holds contracts with transportation providers.

New York City's transportation approval system operates differently from those in other counties. New York City has little involvement in prior authorization; instead, health care providers order transportation services for recipients to and from essential medical services. Both the 2008-09 and 2009-10 executive budgets included proposals to reduce variation in prior authorization of transportation services in New York City. The proposals sought to move prior authorization for transportation services in New York City to SDOH and to allow SDOH to contract prior authorization for these services in New York City out to a third-party entity. They were, however, never enacted into law.¹⁶⁶ Though state and local officials agree that maintaining local involvement in transportation approval is efficient because of local government's proximity to regional transportation resources, wide variation in approval of transportation in geographically similar counties is common. Lack of concrete rules to guide approval likely promotes this variation.

Third-Party, Estate, and Other Recoveries

LDSSs play an important role in payment recoveries from both Medicaid recipients and third-party insurers in which recipients are enrolled. Since Medicaid is the “payer of last resort,”¹⁶⁷ states must seek payment for services rendered to Medicaid recipients who are also enrolled in private or other insurance before billing Medicaid.¹⁶⁸ Any services or expenses delivered to Medicaid recipients and not covered by the third-party payer will be paid for by Medicaid.

The state has delegated this responsibility to LDSSs. Recovering payment from third-party payers generally requires the verification of recipients’ coverage and payment collection from the third-party payer. Third-party payment recoveries are quite common. A 2006 federal report found that approximately 12 percent of Medicaid recipients in New York State also had private coverage.¹⁶⁹ In some counties, including New York City and Erie, third-party payment recoveries are automated using eMedNY.

Recoveries may also be made from Medicaid recipients. States and LDSSs are permitted to recover expenses from Medicaid recipients in the following instances:¹⁷⁰

- After the death of a Medicaid recipient who was older than 55 when he or she was enrolled in Medicaid, if there is no surviving spouse or dependent or disabled child.¹⁷¹
- From liens on estates of deceased Medicaid recipients to “prevent the estate from being settled and the property distributed to the recipient’s heirs before all claims against it, including Medicaid’s, are satisfied.”¹⁷²
- From an estate of a permanently institutionalized individual.¹⁷³
- After a Medicaid recipient receives a personal settlement or injury award.¹⁷⁴
- From legally responsible relatives who refuse to make their income available to the Medicaid recipients.¹⁷⁵

In New York State, the responsibility for payment recoveries listed above is delegated to LDSSs.¹⁷⁶ Through federal law, states can recover from estates the full cost of all Medicaid expenses for services delivered to the deceased individual. States have the option to recover expenses from the estates of other populations, but are exempted from doing so while the individual is living and for children under 21. From estates, LDSS must recover the cost of long-term care, prescription drug, and inpatient hospital services.

Under the 2005 cap legislation, the counties are required to seek payment recoveries but are not permitted to keep a share of these recoveries unless their locally incurred expenses fall under the cap.¹⁷⁷ Since very few counties have, to date, incurred expenses that fall under this cap, most recoveries retrieved at the local level are delivered to the state.

No single SDOH Division oversees recoveries. LDSSs tend to consult SDOH's Division of Legal Affairs with issues and troubleshooting. LDSSs report their recoveries to SDOH's Fiscal Management Group through their monthly claims reports.

Counties vary in how actively they pursue third-party and estate recoveries. Though they are mandated by state law to conduct recoveries, their incentive to do so is minimal since they rarely are able to keep a share of the estate recoveries. Some SDOH staff note that the aggressiveness with which recoveries are pursued often depends on the LDSS Commissioner's enthusiasm for this task.

Fraud and Abuse

Two recent initiatives have put a special focus on fraud and abuse: the state-authorized fraud and abuse demonstration project and the requirements under the Federal-State Health Reform Partnership waiver.

The 2005 legislation that created the county cap also enabled a statewide demonstration project targeting the reduction of fraud and abuse in Medicaid. Under OMIG's oversight, twelve counties currently participate in this program as designated agents of the state, with OMIG holding a Memorandum of Understanding with each county delineating their roles.¹⁷⁸ The purpose of the demonstration is to identify and refer provider fraud in Medicaid. Local districts are permitted to bring actions that hold providers accountable for criminal fraud related to the Medicaid program.

One component of counties' responsibilities in fraud and abuse prevention and detection is at the front end: preventing ineligible individuals from enrolling in the program. Counties consider their role in the eligibility screening process critical to identifying and eliminating potential fraud and abuse by consumers. Counties are authorized under state law to identify provider fraud and abuse are entitled to up to 15 percent of recoveries obtained from any audit referred to OMIG where criminal fraud is identified.¹⁷⁹ Some counties contract out to third parties audit functions and data mining related to provider fraud.

The nature of interaction between LDSSs and the state is unique when it comes to fraud and abuse. SDOH plays a minimal role in overseeing fraud and abuse activities at the local level. LDSSs are responsible for pursuing fraud and abuse activities, but they must coordinate with the local district attorney, the State Attorney General's Medicaid Fraud Control Unit, and OMIG when consumer or provider fraud is suspected. In fraud and abuse cases, OMIG's primary relationship at the local level is with LDSS, but the agency also interacts with local district attorneys.

When a county identifies potential fraud, it collects all relevant information and refers the case to OMIG. OMIG reviews the documentation and makes a determination whether or not to pursue it. Affirmative pursuits are then referred by OMIG to the State Attorney General's Medicaid Fraud Control Unit, which may choose to pursue the case in collaboration with the local district attorney. Cases that OMIG determines are not pursuable may be referred back to the county; LDSSs have the flexibility to determine whether or not to proceed. In some cases, OMIG may issue a provider audit.¹⁸⁰

The number of state and local parties involved in fraud and abuse activities in New York State can lead to confusion, lack of communication, and delays in fraud detection and investigation. Further, some counties report that rigid protocols and guidelines stymie counties in their fraud- and abuse-prevention activities. State and local officials acknowledge, however, that because these initiatives are relatively new and therefore in transition, more time is needed to allow the systems to settle into place. Finally, state officials note that many counties, having lost the financial incentive to conduct fraud and abuse prevention and detection activities under the county cap, are seeking to classify even the most basic efforts as a demonstration.

Fraud and abuse detection activities are critically important due to the potential fiscal impact on the state. The Federal-State Health Reform Partnership waiver in New York State provides up to \$1.5 billion in federal funds over five years from savings the state incurred through the transition of Medicaid recipients to managed care. The receipt of these funds is subject to "special terms and conditions," including that New York State must increase its fraud and abuse recoveries a total of \$611 million by the end of the waiver period in 2011. Failure to do so will result in a financial penalty, with more serious implications for state funds and minimal exposure to local counties.¹⁸¹

Implications

By any standard, Medicaid in New York is a massive program: it provides health insurance to more than one in five New Yorkers, incurs a total cost of nearly \$45 billion, and accounts for nearly one-third of the state's health care economy. The importance of Medicaid to the health of New Yorkers, the health care industry, and the state's economy is only likely to increase. Recent state initiatives to expand eligibility and develop targeted programs have led to significant growth in the number of New Yorkers who rely on Medicaid for health coverage and services, and nearly a million more are eligible for the program but remain uninsured. For this reason, Medicaid is seen as a fundamental building block in the state's universal coverage efforts. Yet, as Medicaid in New York has grown and evolved, the state-local administrative structure formed to implement the program has stood still, locked in the mold of an antiquated welfare bureaucracy. As a result, Medicaid in New York is not currently equipped to ensure effective and efficient program implementation.

In recent years, several fundamental programmatic and policy changes have been launched in New York that, to a large extent, have transformed Medicaid's underlying purpose and characteristics. With the de-linking in 1996 of Medicaid from public welfare, global oversight of Medicaid was shifted to the State Department of Health, opening the door for Medicaid to be viewed and managed as a health care program. While the numbers of New Yorkers relying on cash assistance plummeted, Medicaid has been increasingly seen as crucial to the provision of health insurance for low-income individuals, including a growing number of working New Yorkers. With expansions in eligibility for children and adults, and the creation of specialized programs targeting populations in need of long-term care and other specialized services, a dramatic increase in both the volume of applications and eligible beneficiaries, and, in turn, program costs, followed. Efforts to streamline enrollment, including the creation of Facilitated Enrollment and changes in application and eligibility rules, have made the program more accessible to eligible families and individuals.

The burden of implementing these changes has fallen disproportionately on local districts, expanding their workload and stretching local resources. These new initiatives also were replete with complexity, requiring local eligibility workers to master complicated guidelines for multiple programs. State-operated information technology systems were moderately updated to assist enrollment, yet these systems were developed years ago, remain antiquated, and ultimately fall far short of the task. Local districts have not had adequate guidance and oversight, leaving them without the support necessary to address the challenges before them.

In response to an outcry from local governments, in 2005 the state legislature enacted a cap on local contributions to relieve county governments of part of the heavy fiscal impact of Medicaid's rising costs. This represented a potential turning point in Medicaid's underlying financial structure. Though counties still contribute substantial financial resources to Medicaid expenditures, there is more predictability in their annual costs. More importantly, as the state implements new policy and administrative initiatives, local governments are shielded from any increased financial burden. Finally, local governments no longer face a financial disincentive to enroll eligible New Yorkers in coverage.

Yet, throughout these changes, the administrative role of local districts in implementing Medicaid has remained largely unchanged. As state Medicaid policies evolved, the need for local districts to adapt their operations increased. However, the underlying administrative structure — which divides responsibility for program implementation among 58 local entities, each serving two masters, a county executive/legislature and the state — has persevered. The results of this arrangement have been divided accountability, muddled priorities, and enormous variation in program implementation. While all agree that it is the state's responsibility to set policy and the local government's responsibility to implement it, there is no bright line between the two. This challenge is further complicated by profound skepticism among county officials that the cap on county Medicaid expenditures will remain.

The mismatch between the program's fragmented administrative structure and the evolution of Medicaid in New York is likely to be further amplified as the state seeks to implement new and increasingly ambitious reforms to the program's operations. In 2007, in an effort to streamline Medicaid's administrative structure at the state level, the State Department of Health established the Office of Health Insurance Programs and the Office of Long-Term Care. The intent of this revised structure is to consolidate oversight and management of Medicaid and promote a more coherent and integrated approach to implementation.

The newly reconfigured SDOH has launched several reform initiatives, many of which depend on local government to achieve success. First, the state has undertaken a concerted effort to enroll in Medicaid (and the Children's Health Insurance Program) one million uninsured but eligible New Yorkers. This effort will result in a further dramatic increase in applications and enrollment, and will test competing visions among state and local officials about how best to provide program access while preserving program integrity. Second, the state is engaged in a wide range of efforts to improve the quality and efficiency of care, including efforts to reform the provision of long-term care services to ensure equitable and appropriate access to care. Lastly, with significant federal funds hanging in the balance, the prevention and detection of Medicaid fraud has never been more integral to Medicaid's success. Yet coordination of this effort with local government has been strained by misaligned incentives under the county cap, and a degree of confusion about the division of responsibilities.

While local governments shoulder significant administrative and financial responsibility for the implementation of Medicaid in New York, the distribution of core programmatic functions across 58 local governmental entities contributes to fractured governance, diffuse authority, and a disjointed operational infrastructure within the program. The local governments' significant role in implementing Medicaid in New York is driven by history: by both their longstanding financial contributions and their historical link to public assistance. However, while Medicaid has evolved considerably in its size, function, and purpose, the underlying administrative infrastructure has not kept pace.

Of course, this is not the only challenge facing Medicaid's administrative infrastructure. Resource constraints at the state level have led to insufficient oversight and guidance of local districts. Limited staff resources at the local level have left workers overwhelmed with the increasing volume and complexity of their tasks. Outdated laws and regulations, inadequate guidance, and antiquated information systems result in inefficiencies and confusion. Diffuse monitoring and weak enforcement tools at the state level undermine a consistent and coherent administrative approach. These challenges are compounded — and the ability to address them compromised — by Medicaid's fragmented governance and disjointed operational infrastructure.

Medicaid has never been more important to the health of New York's citizenry or economy than it is today, nor the challenges to it so great. As policymakers chart a path for future, it will be crucial to ensure that Medicaid is governed, administered, and operated in a coherent and consistent manner that promotes efficiency, effectiveness, and equity. Addressing the fundamental structural flaws inherent in New York's state-local administrative structure will be central to achieving that vision.

Appendix A
Administrative Cost and Medicaid Staff, by County, State Fiscal Year 2007–8

Region	Total Medicaid Administrative Costs	Eligibility Workers	Policy and Planning Workers	Total Annual FTEs	FTEs per 1,000 Enrollees
New York State	\$788.8M	5,029	287	5,316	1.3
NYC	\$463.6M	2,303	138	2,441	0.9
Rest of State	\$325.2M	2,726	149	2,875	2.1
ALBANY	\$8.2M	64	5	68	1.9
ALLEGANY	\$1.0M	18	1	19	2.3
BROOME	\$8.4M	70	2	72	2.2
CATTARAUGUS	\$3.2M	35	0	35	2.6
CAYUGA	\$2.9M	26	0	26	2.1
CHAUTAUQUA	\$4.8M	47	9	56	2.2
CHEMUNG	\$2.7M	21	0	21	1.2
CHENANGO	\$1.4M	16	0	16	1.7
CLINTON	\$2.5M	24	3	27	2.0
COLUMBIA	\$2.5M	27	1	28	3.9
CORTLAND	\$1.7M	15	0	15	1.8
DELAWARE	\$1.7M	14	3	17	2.6
DUTCHESS	\$7.6M	46	0	46	2.0
ERIE	\$31.4M	298	2	299	2.1
ESSEX	\$2.0M	19	2	21	4.0
FRANKLIN	\$2.5M	22	1	23	2.8
FULTON	\$2.0M	20	7	27	2.4
GENESEE	\$1.4M	15	0	15	1.9
GREENE	\$2.7M	17	5	22	3.3
HAMILTON	\$250K	1	0	1	2.1
HERKIMER	\$2.1M	29	0	29	2.5
JEFFERSON	\$3.6M	38	0	38	2.2
LEWIS	\$638K	10	0	10	2.3
LIVINGSTON	\$1.9M	19	0	19	2.8
MADISON	\$1.5M	19	0	19	2.1
MONROE	\$13.4M	84	7	91	0.8
MONTGOMERY	\$1.7M	25	1	27	2.8
NASSAU	\$26.1M	194	4	199	1.7
NIAGARA	\$5.9M	58	0	58	1.9
ONEIDA	\$9.0M	75	18	93	2.3
ONONDAGA	\$13.2M	123	0	123	1.8
ONTARIO	\$3.1M	32	1	33	3.0
ORANGE	\$9.5M	76	0	76	1.6
ORLEANS	\$1.1M	15	0	15	2.1
OSWEGO	\$2.6M	30	0	30	1.4
OTSEGO	\$1.7M	22	0	22	2.7
PUTNAM	\$2.6M	21	0	21	4.9

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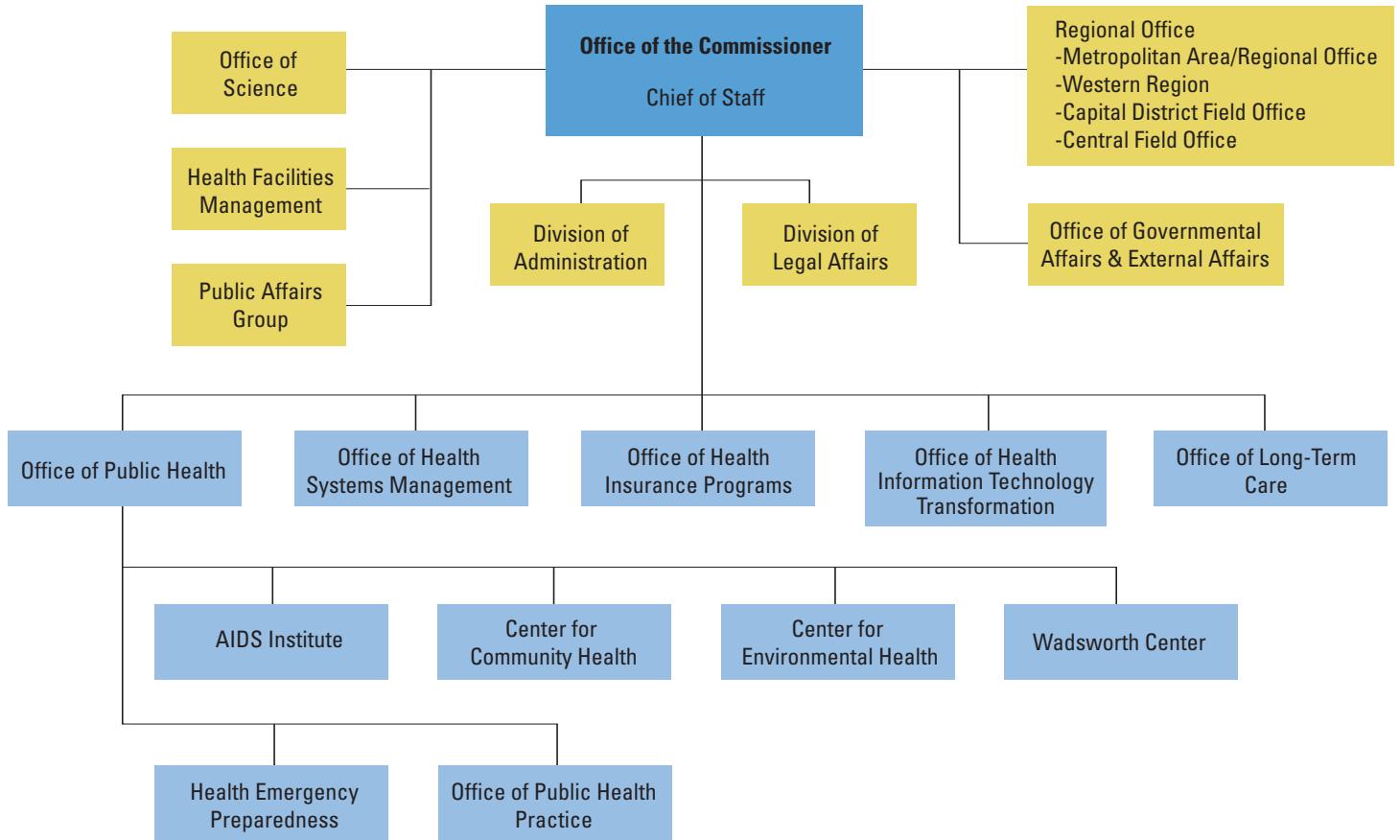
Appendix A**Administrative Cost and Medicaid Staff, by County, State Fiscal Year 2007–8** (continued)

Region	Total Medicaid Administrative Costs	Eligibility Workers	Policy and Planning Workers	Total Annual FTEs	FTEs per 1,000 Enrollees
RENSSELAER	\$1.8M	31	0	31	1.5
ROCKLAND	\$14.7M	105	3	107	2.2
ST. LAWRENCE	\$3.4M	51	4	55	2.8
SARATOGA	\$3.2M	41	0	41	2.4
SCHENECTADY	\$1.3M	23	2	25	1.2
SCHOHARIE	\$911K	13	0	13	3.1
SCHUYLER	\$1.5M	7	0	7	2.4
SENECA	\$3.6M	17	1	18	4.3
STEUBEN	\$2.7M	27	0	27	1.6
SUFFOLK	\$42.3M	263	42	305	2.5
SULLIVAN	\$3.2M	34	0	34	2.7
TIOGA	\$1.4M	10	1	11	1.5
TOMPKINS	\$3.2M	24	6	30	2.9
ULSTER	\$6.3M	63	6	69	3.2
WARREN	\$2.2M	26	0	26	3.5
WASHINGTON	\$1.9M	25	4	30	3.4
WAYNE	\$3.2M	39	0	39	3.8
WESTCHESTER	\$36.2M	217	8	225	2.2
WYOMING	\$1.2M	16	0	16	3.7
YATES	\$590K	7	0	7	1.9

Notes: FTEs include contractors. Note that while FTE figures are for SFY 2007-8, enrollment figures used to calculate FTEs per 1,000 enrollees are from CY 2007. Total FTE numbers may not add up due to rounding.

Source: Manatt Health Solutions analysis of data provided by the New York State Department of Health Fiscal Management Group. Data on number of contractors in New York City (included in New York City FTEs) from the Human Resources Administration.

Appendix B
New York State Department of Health Organizational Chart, May 2008



Notes

- ¹ According to the 2008 list of Fortune 500, New York Medicaid would rank 49th based on revenue alone. http://money.cnn.com/magazines/fortune/fortune500/2008/full_list/. Accessed April 30, 2008.
- ² Atlantic Information Systems, Inc., Health Plan Enrollment Data, 2007. Available at http://www.aishealth.com/MarketData/MCEnrollment/MCEnrol_mc01.html. Accessed April 3, 2008.
- ³ Bachrach D, K Lipson, and K Bhandarkar, 2006. *Administration of Medicaid in New York State: Key Players and Their Roles*. New York: United Hospital Fund. Bachrach D and M Burghardt, 2006. *Understanding the New State/County Paradigm: The 2005 New York State Medicaid Cap Legislation*. New York: United Hospital Fund.
- ⁴ Birnbaum M, 2008. *Medicaid in New York: A Primer. Revised and Updated 2008*. New York: Medicaid Institute at United Hospital Fund.
- ⁵ Medicaid Institute at United Hospital Fund analysis of NYS DOH enrollment reports.
- ⁶ Bachrach D and M Burghardt, 2006. *Understanding the New State/County Paradigm: The 2005 New York State Medicaid Cap Legislation*. New York: United Hospital Fund. Personal communication, staff at New York Association of Counties, December 2008.
- ⁷ Birnbaum M, 2008. *Medicaid in New York: A Primer. Revised and Updated 2008*. New York: Medicaid Institute at United Hospital Fund.
- ⁸ According to the 2008 list of Fortune 500, New York Medicaid would rank 49th based on revenue alone. http://money.cnn.com/magazines/fortune/fortune500/2008/full_list/. Accessed April 30, 2009.
- ⁹ Atlantic Information Systems, Inc., Health Plan Enrollment Data, 2007. Available at http://www.aishealth.com/MarketData/MCEnrollment/MCEnrol_mc01.html. Accessed April 3, 2008.
- ¹⁰ 42 USC § 1396a(a).
- ¹¹ 42 USC § 1396a(a)(5), 1396a(a)(4).
- ¹² 42 USC § 1396a and 42 CFR § 431.50.
- ¹³ 71 Fed. Reg. 69209 (Nov. 30, 2006).
- ¹⁴ The recently enacted American Recovery and Reinvestment Act temporarily increases by 6.2 percentage points state FMAP rates, increasing New York's base federal share to 56.2 percent. States experiencing poor economic conditions as indicated by a significant rise in unemployment receive additional assistance. See Lav IJ, E Park, J Levitis, and M Broaddus, "Recovery Act Provides Much Needed Targeted Medicaid Assistance to States.", Center on Budget and Policy Priorities (February 13, 2009). Available at <http://www.cbpp.org/2-13-09sfp.htm>. Accessed April 30, 2009.
- ¹⁵ NYSSL § 363-a(2) and (3).
- ¹⁶ 42 CFR 431.10(e).
- ¹⁷ NYSSL § 364(1)(a), (b), (c).
- ¹⁸ Personal communication, staff at SDOH Division of Coverage and Enrollment, December 2008.
- ¹⁹ Personal communication, staff at SDOH Division of Legal Affairs, November 2008; NYSSL § 365-B and 18 NYCRR § 501.1
- ²⁰ Personal communication, staff at SDOH Division of Legal Affairs, November 2008.
- ²¹ Personal communication, staff at SDOH Division of Coverage and Enrollment, December 2008.
- ²² Except for OHIP and OLTC, which are part of SDOH, all the offices listed in this section are independent of each other; the Commissioner of each reports directly to the Governor. Other agencies whose populations served are often eligible for Medicaid and therefore play a role in Medicaid-related tasks include the State Education Department, which administers special education; and the state Office for the Aging, which oversees the statewide single point of entry initiative.
- ²³ When Medicaid and welfare programs were de-linked in 1996, oversight of Medicaid was shifted to the State Department of Health. Oversight of public assistance programs fell under the Office of Temporary Disability Assistance. In addition, special education is currently overseen by OMIG; foster care is overseen by the Office for Children and Family Services.
- ²⁴ OASAS does not have an eligibility function comparable to OMH and OMRDD. Eligibility screening and enrollment for Medicaid-eligible individuals served by OASAS providers are handled by local departments of social services.
- ²⁵ Personal communication, staff members of various LDSSs interviewed for this report, July–November 2008.
- ²⁶ NYSSL § 61.
- ²⁷ County executives and managers oversee the administration of all county administrative units.
- ²⁸ Personal communication, staff of Tioga County DSS, August 2008.
- ²⁹ Personal communication, staff of LDSS interviewed for this report, July–November 2008.
- ³⁰ Personal communication, staff at OMH, August 2008.
- ³¹ Analysis of Centers for Medicaid and Medicare Services. HCFA-64 Report. FY 1997 and FY 2007.
- ³² Per SFY 2007–8 Medicaid administrative expenditures for SDOH central office and LDSSs provided by SDOH Fiscal Management Group, December 2008.
- ³³ Manatt Health Solutions analysis of data taken from FY 2007–8 county-submitted RF2A claim worksheets provided by New York State Office of Temporary and Disability Assistance.
- ³⁴ Administration costs include costs related to training and to administration of the Working Disabled Buy-In Program.
- ³⁵ Manatt Health Solutions analysis of data taken from FY 2007–8 county-submitted RF2A claim worksheets provided by New York State Office of Temporary and Disability Assistance.
- ³⁶ Manatt Health Solutions analysis of data taken from FY 2007–8 county-submitted RF2A claim worksheets provided by New York State Office of Temporary and Disability Assistance. Enrollment numbers from SDOH, Monthly Average Number of Medicaid Eligibles by Category of Eligibility by Social Service District, January 2008.

- ³⁷ Manatt Health Solutions analysis of FTE data provided by New York State Office of Temporary and Disability Assistance based on "Schedule D" county claim forms for FY 2007–8.
- ³⁸ Manatt Health Solutions analysis of FTE data provided by New York State Office of Temporary and Disability Assistance based on "Schedule D" county claim forms for FY 2007-8.
- ³⁹ Personal communication, staff at Cornell School for Industrial and Labor Relations, December 2008.
- ⁴⁰ Kaiser Family Foundation. *The Medicaid Resource Book*. July 2002.
- ⁴¹ Bachrach D and M Burghardt, 2006. *Understanding the New State/County Paradigm: The 2005 New York State Medicaid Cap Legislation*. New York: United Hospital Fund.
- ⁴² Birnbaum M, 2008. *Medicaid in New York: A Primer. Revised and Updated 2008*. New York: Medicaid Institute at United Hospital Fund.
- ⁴³ For calendar year 2006, the trend factor was 3.5 percent. For calendar year 2007, the trend factor was 3.25 percent (non-compounded, so the number off the 2005 base was 6.75 percent). Starting in 2008, the annual trend became a non-compounded 3 percent.
- ⁴⁴ Bachrach D and M Burghardt, 2006. *Understanding the New State/County Paradigm: The 2005 New York State Medicaid Cap Legislation*. New York: United Hospital Fund.
- ⁴⁵ Personal communication, staff at the New York Association of Counties, December 2008.
- ⁴⁶ Personal communication, staff at the New York Association of Counties, December 2008.
- ⁴⁷ It should be noted that eight counties did not experience a reduction in costs payable to the state as a result of the cap.
- ⁴⁸ Personal communication, staff at the National Association of Counties, December 2008.
- ⁴⁹ NYSSL § 363-a(2) and (3).
- ⁵⁰ Personal communication, staff at SDOH Division of Coverage and Enrollment, December 2008.
- ⁵¹ Personal communication, staff at SDOH Division of Coverage and Enrollment, December 2008.
- ⁵² Personal communication, staff at SDOH Division of Coverage and Enrollment, December 2008.
- ⁵³ Personal communication, staff at SDOH Division of Coverage and Enrollment, December 2008.
- ⁵⁴ Personal communication, staff at SDOH Division of Coverage and Enrollment, December 2008.
- ⁵⁵ Personal communication, staff at SDOH Division of Coverage and Enrollment, December 2008.
- ⁵⁶ Personal communication, staff at SDOH Division of Coverage and Enrollment, December 2008.
- ⁵⁷ Personal communication, staff at SDOH Division of Coverage and Enrollment, December 2008.
- ⁵⁸ Personal communication, staff at SDOH Division of Coverage and Enrollment, December 2008.
- ⁵⁹ See the SDOH Library of Official Documents at http://www.health.state.ny.us/health_care/medicaid/publications/.
- ⁶⁰ Personal communication, staff at SDOH Division of Coverage and Enrollment, December 2008.
- ⁶¹ Personal communication, staff at SDOH Division of Coverage and Enrollment, December 2008.
- ⁶² Personal communication, staff at SDOH Division of Coverage and Enrollment, December 2008.
- ⁶³ Personal communication, staff at SDOH Division of Coverage and Enrollment, December 2008.
- ⁶⁴ Personal communication, staff at LDSS interviewed for this report, August-December 2008.
- ⁶⁵ New York State Office of Temporary and Disability Assistance website: <http://www.otda.state.ny.us/MAIN/swms/default.asp>. Accessed December 5, 2008.
- ⁶⁶ New York State Office of Temporary and Disability Assistance website: <http://www.otda.state.ny.us/MAIN/swms/default.asp>. Accessed December 5, 2008.
- ⁶⁷ Personal communication, staff at LDSS interviewed for this report, July–December 2008.
- ⁶⁸ New York State Office of Temporary and Disability Assistance website: <http://www.otda.state.ny.us/MAIN/swms/default.asp>. Accessed December 5, 2008.
- ⁶⁹ New York State Office of Temporary and Disability Assistance website: <http://www.otda.state.ny.us/MAIN/swms/default.asp>. Accessed December 5, 2008.
- ⁷⁰ Personal communication, staff at SDOH Division of Coverage and Enrollment, December 2008.
- ⁷¹ New York State Office of Temporary and Disability Assistance, Request for Proposal for the SWMS Functional Roadmap. March 10, 2008.
- ⁷² SDOH, Division of Coverage and Enrollment, Office of Health Insurance Programs, Request for Proposal for "The Enrollment Center." RFP No: 080804239. Released October 14, 2008.
- ⁷³ SDOH, Division of Coverage and Enrollment, Office of Health Insurance Programs, Request for Proposal for "The Enrollment Center." RFP No: 080804239. Released October 14, 2008.
- ⁷⁴ SDOH, Division of Coverage and Enrollment, Office of Health Insurance Programs, Request for Proposal for "The Enrollment Center." RFP No: 080804239. Released October 14, 2008.
- ⁷⁵ SDOH, Division of Coverage and Enrollment, Office of Health Insurance Programs, Request for Proposal for "The Enrollment Center." RFP No: 080804239. Released October 14, 2008.
- ⁷⁶ Personal communication, staff at SDOH Division of Systems, July 2008.
- ⁷⁷ Personal communication, staff at SDOH Division of Systems, July 2008.
- ⁷⁸ SDOH, Division of Coverage and Enrollment, Office of Health Insurance Programs, Request for Proposal for "The Enrollment Center." RFP No: 080804239. Released October 14, 2008.
- ⁷⁹ Personal communication, staff at the SDOH Division of Systems, July 2008.
- ⁸⁰ Personal communication, staff at SDOH Division of Coverage and Enrollment, December 2008.
- ⁸¹ Personal communication, staff at SDOH Division of Coverage and Enrollment, December 2008.
- ⁸² Personal communication, Staff at SDOH Division of Systems.
- ⁸³ Executive Order Number 140.1: Establishing the Office of the Medicaid Inspector General.
- ⁸⁴ Personal communication, staff at SDOH Division of Coverage and Enrollment, December 2008.
- ⁸⁵ Personal communication, staff at SDOH Division of Coverage and Enrollment, December 2008.

- ⁸⁶ Personal communication, staff at SDOH Division of Coverage and Enrollment, July 2008.
- ⁸⁷ Personal communication, staff at SDOH Division of Coverage and Enrollment, December 2008.
- ⁸⁸ Personal communication, staff at SDOH Division of Coverage and Enrollment, December 2008.
- ⁸⁹ Personal communication, staff at the New York State Public Welfare Association, October 2008.
- ⁹⁰ 18 NYCRR § 360-2.4.
- ⁹¹ The PERM process was established by the Improper Payments Information Act of 2002 (IPIA, P.L. 107-300).
- ⁹² E-mail conversation with Sue E. Kelly, Associate Regional Administrator-Division of Medicaid and Children's Health, CMS, November 7, 2008.
- ⁹³ This chart excludes enrollees in long-term care Medicaid.
- ⁹⁴ SDOH. *Medicaid Reference Guide*, page 303.5.
- ⁹⁵ 42 CFR § 435.904.
- ⁹⁶ 18 NYCRR § 350.3(2)(b). Disabled, elderly or chronically ill individuals may appoint a designated representative to appear on their behalf at the face-to-face interview. For pregnant women and children whose parents are applying for Medicaid, the face-to-face interview can be conducted by a prenatal care provider or another designated entity. (SDOH. *Medicaid Reference Guide*, page 367.)
- ⁹⁷ 18 NYCRR § 350.7.
- ⁹⁸ 18 NYCRR § 360-6.3.
- ⁹⁹ SDOH. *Medicaid Reference Guide*, page 369.
- ¹⁰⁰ Workers must determine the amount of income an applicant receives, earned and unearned, as well as that of his or her spouse (if applicable). This can include wages (earned), as well as unemployment insurance benefits, social security payments, dividends, and rental income (unearned). For some populations, certain types of income is "disregarded" or not counted. Disregards can include child support payments for a blind or disabled child from an absent parent or health insurance premiums paid to the applicant. There are more than 50 categories of income disregards that LDSS workers must take note of. Further, income rules differ for SSI-related children. Once information on this income is collected, eligibility workers must adhere to a state-prescribed "budgeting methodology" to ultimately determine whether the applicant's income falls within a particular income limit. (SDOH. *Medicaid Reference Guide*, pages 174-182 and 186-189.)
- ¹⁰¹ Applicants with income above current Medicaid eligibility limits but with high medical bills may qualify for Medicaid through the Spend-Down program. To qualify, individuals are permitted to subtract from their income the amount they spend on medical bills. To determine eligibility, local districts are responsible for gathering receipts and payments from applicants and tracking spend-down enrollees' continued eligibility on a monthly basis. The process requires local districts to manage large volumes of paper receipts and payments, as well as intensive interaction with Medicaid beneficiaries. (New York Social Services Law §366(2)(b)(3)(a).)
- ¹⁰² SDOH. *Medicaid Reference Guide*, page 365.1.
- ¹⁰³ 18 NYCRR § 360-2.4.
- ¹⁰⁴ 18 NYCRR § 360-2.5.
- ¹⁰⁵ 42 CFR § 205.
- ¹⁰⁶ 18 NYCRR §§ 358-4, 358-6.
- ¹⁰⁷ NYSSL § 366-a.; 18 NYCRR § 360-2.7.
- ¹⁰⁸ 18 NYCRR § 360-2.2(e); New York City transmits data to Vanguard, which generates and mails out recertification packets to individuals in the city.
- ¹⁰⁹ Personal communication, staff at SDOH, July 2008. Contracts in New York City are held by the New York City Department of Health and Mental Hygiene. For managed care plans that operate in all other counties outside of New York City, contracts are held by SDOH.
- ¹¹⁰ NYSSL § 364J.
- ¹¹¹ NYSSL §364J.
- ¹¹² Personal communication, staff at SDOH, July 2008.
- ¹¹³ Personal communication, staff at SDOH, July 2008.
- ¹¹⁴ SDOH/OHIP Official Longitudinal Eligibility File.
- ¹¹⁵ Lawler K and AM Costello, 2005. *Community-Based Facilitated Enrollment: Meeting Uninsured New Yorkers Where They Are*. New York: Children's Aid Society and Children's Defense Fund.
- ¹¹⁶ SDOH. *Medicaid Reference Guide*, page 365.1.
- ¹¹⁷ Cornell University ILR School, 2008. *Suggestions for Redesigning the Renewal Process for NYS Health Insurance Programs*. (Final draft prepared for the NYS Office of Health Insurance Programs, October 7, 2008.)
- ¹¹⁸ Personal communication, staff at SDOH Division of Coverage and Enrollment, July 2008.
- ¹¹⁹ Personal communication, staff at SDOH Division of Coverage and Enrollment and Division of Managed Care, July 2008.
- ¹²⁰ SDOH, Division of Coverage and Enrollment, Office of Health Insurance Programs, Request for Proposal for "The Enrollment Center." RFP No: 080804239. Released October 14, 2008.
- ¹²¹ NYSSL § 365.7
- ¹²² Personal communication, staff from OMRDD, August 2008.
- ¹²³ Personal communication, staff from OMRDD, August 2008.
- ¹²⁴ Personal communication, staff from OMRDD, August 2008.
- ¹²⁵ Personal communication, staff from OMRDD, August 2008.

- ¹²⁶ National figures from Kaiser Family Foundation, December 2007. *Medicaid and Long-Term Care Services and Supports Fact Sheet*.
- ¹²⁷ Medicaid Institute at United Hospital Fund analysis of CMS 64 data.
- ¹²⁸ Office of Health Insurance Programs, SDOH analysis of data from Medicaid DataMart.
- ¹²⁹ Medicaid Institute at United Hospital Fund analysis of CMS Financial Management Reports (Form 64).
- ¹³⁰ Centers for Medicare and Medicaid Services. *Medicaid Program General Information: Technical Summary*. Available at: http://www.cms.hhs.gov/MedicaidGenInfo/03_TechnicalSummary.asp. Accessed April 30, 2009.
- ¹³¹ Burke C, 2007. Medicaid and Long-Term Care: Where New York Stands, Where It Should Sit. Presentation, May 10, 2007.
- ¹³² There are additional home and community-based waivers that are co-administered by State Department of Health and Office of Mental Retardation and Developmental Disabilities, and Office of Mental Health. For these waivers, the primary role the LDSS plays is conducting eligibility screening and enrollment in Medicaid.
- ¹³³ SDOH. *Medicaid Reference Guide*, page 250.
- ¹³⁴ SDOH. *Medicaid Reference Guide*, page 367.
- ¹³⁵ SDOH. Administrative Directive. Deficit Reduction Act of 2005 – Long-Term Care Medicaid Eligibility Changes. July 20, 2006.
- ¹³⁶ The look-back period for long-term care is currently transitioning from 36 months for typical asset transfers, to 60 months for all transfers, to be completed February 2011. The community Medicaid look-back period is 12 months. (SDOH. *Medicaid Reference Guide*, page 361.)
- ¹³⁷ SDOH. *Medicaid Reference Guide*, pages 303.5 and 353-358.
- ¹³⁸ There are instances when providers can bypass the LDSS; in such cases, once a beneficiary is discharged from a hospital, a provider can enroll him or her in the LTHHCP and subsequently prepare and send application paperwork to the LDSS for processing.
- ¹³⁹ Personal communication, staff at SDOH, July 2008; 18 NYCRR § 505.21.
- ¹⁴⁰ LDSS holds similar responsibilities for the Program for All-Inclusive Care for the Elderly (PACE). For individuals whose applications were received by the LDSS by the 20th of the month, the LDSS must enroll these applicants by the 1st of the following month.
- ¹⁴¹ For Care at Home III, IV, and VI, OMRDD's DDSOs are primarily responsible for administrative tasks related to this waiver. However, since Medicaid eligibility is involved, DDSOs and LDSSs coordinate to ensure that applicants' Medicaid eligibility is processed.
- ¹⁴² 18 NYCRR § 360.6-4.
- ¹⁴³ SDOH. *Information for All Providers. General Policy*. Version 2008-2. September 1, 2008.
- ¹⁴⁴ 18 NYCRR § 505.14.
- ¹⁴⁵ 18 NYCRR § 505.33.
- ¹⁴⁶ 18 NYCRR § 505.14.
- ¹⁴⁷ 18 NYCRR § 505.14.
- ¹⁴⁸ Personal communication, staff at SDOH, July 2008.
- ¹⁴⁹ Personal communication, staff at SDOH, July 2008; 18 NYCRR § 505.14.
- ¹⁵⁰ Personal communication, staff at SDOH, July 2008.
- ¹⁵¹ 18 NYCRR § 505.14.
- ¹⁵² 18 NYCRR § 505.14.
- ¹⁵³ NYSSL § 365-f.
- ¹⁵⁴ *Catanzano v. Wing*. U.S. Court of Appeals for Second Circuit. 103 F.3d 223 (1996).
- ¹⁵⁵ 18 NYCRR § 505.8.
- ¹⁵⁶ Personal communication, staff at SDOH, July 2008.
- ¹⁵⁷ 18 NYCRR § 505.16.
- ¹⁵⁸ SDOH, Office of Health Insurance Programs, DataMart.
- ¹⁵⁹ Personal communication, staff at SDOH, July 2008.
- ¹⁶⁰ 42 CFR § 431.53.
- ¹⁶¹ Data on expenditures obtained from the SDOH Fiscal Management Group. Data on number of users obtained from SDOH Average Monthly Medicaid Beneficiaries for Categories of Service by Category of Eligibility, CY 2007.
- ¹⁶² NYSSL § 365-h.
- ¹⁶³ Personal communication, staff at SDOH Division of Financial Planning and Policy, July 2008.
- ¹⁶⁴ Personal communication, staff members of various LDSSs interviewed for this report, July-November 2008.
- ¹⁶⁵ Personal communication, staff members of various LDSSs interviewed for this report, July-November 2008.
- ¹⁶⁶ New York State 2008-09 Executive Budget, January 2008; New York State 2009-10 Executive Budget, December 2008.
- ¹⁶⁷ Centers for Medicare and Medicaid Services. Third Party Liability. Available at <http://www.cms.hhs.gov/ThirdPartyLiability/>. Accessed April 30, 2009.
- ¹⁶⁸ 42 CFR part 433, subpart D.
- ¹⁶⁹ Government Accountability Office. Medicaid Third Party Liability: Federal Guidance Needed to Help States Address Continuing Problems. September 2006. GAO-06-862.
- ¹⁷⁰ SDOH. *Medicaid Reference Guide*, pages 476-480.
- ¹⁷¹ US Department of Health & Human Services. Office of Assistant Secretary for Policy & Evaluation. Medicaid Estate Recovery. April 2005.
- ¹⁷² US Department of Health & Human Services. Office of Assistant Secretary for Policy & Evaluation. Medicaid Estate Recovery. April 2005.

¹⁷³ 18 NYCRR § 360-7.11.

¹⁷⁴ SDOH. *Medicaid Reference Guide*, pages 476-480.

¹⁷⁵ SDOH. *Medicaid Reference Guide*, pages 476-480.

¹⁷⁶ SDOH. *Medicaid Reference Guide*, pages 476-480.

¹⁷⁷ Personal communication, staff at SDOH Division of Legal Affairs, September 2008.

¹⁷⁸ Participating counties are Albany, Broome, Chautauqua, Dutchess, Erie, Monroe, Nassau, Orange, Rensselaer, Rockland, Suffolk and Westchester.

¹⁷⁹ NYS Social Services Law § 145-b.

¹⁸⁰ Executive Order Number 140.1: Establishing the Office of the Medicaid Inspector General; Bachrach D and M Burghardt, 2006. *Understanding the New State/County Paradigm: The 2005 New York State Medicaid Cap Legislation*. New York: United Hospital Fund.

¹⁸¹ Centers for Medicare and Medicaid Services. Federal State Health Reform Partnership. Special Terms and Conditions. Available at http://www.health.state.ny.us/health_care/managed_care/appextension/health_reform_partnership/docs/special_terms_and_conditions.pdf. Accessed April 30, 2009.

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This report is the third in a series examining the administration of Medicaid in New York. The two preceding papers, described below, may be found at the United Hospital Fund website, www.uhfny.org.

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As New York pursues a range of reforms, the ability to develop and implement successful policies will depend in large part on Medicaid's administrative structure; the recommendations in this report are reflected in the 2007 reorganization of the State Department of Health.

2006

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