The State of South Carolina
General Assembly
Legislative Audit Council
A Management and Performance
Review of the South Carolina
Department of Social Services

February 21, 1985

# THE STATE OF SOUTH CAROLINA

# GENERAL ASSEMBLY

# LEGISLATIVE AUDIT COUNCIL

# A MANAGEMENT AND PERFORMANCE REVIEW

# OF THE SOUTH CAROLINA

# DEPARTMENT OF SOCIAL SERVICES

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## MAJOR FINDING

During the course of this audit, the Legislative Audit Council examined numerous problems at the Department of Social Services (DSS). These problems include:

- The Child Protective Services program needs improvement. Child abuse and neglect investigations are inadequate, treatment plans are not being used and family court requirements are not being met. Casework has been inadequate in this area (see p. 12).

- A delay in automation of the Child Support Enforcement Program has cost approximately $1.9 million annually in collection of child support payments (see p. 33).

- DSS management has been ineffective in collecting child support payments owed the agency through its Tax Intercept programs. The agency could have collected over $3 million more with an adequate Tax Intercept Program in 1983 (see p. 35).

- DSS has not adequately collected funds owed the agency from providers and clients. Over $6.6 million in deliquent debts is outstanding from doctors, dentists, hospitals, nursing homes and clients (see p. 53).

- The agency faces federal penalties in the Food Stamp, AFDC and Medicaid programs because of excessive errors. These penalties could cost the State over $6 million in program and administrative funds (see p. 67).

- Management has not ensured that Medicaid problems identified in the 1982 Audit Council report have been corrected (see p. 78).

- Medicaid management has not implemented cost containment measures in the Medicaid program. One measure proposed by DSS staff could save over $500,000 annually in drug costs without reducing services. Other measures to save funds in the physician, hospital and lab programs have not been implemented by management (see p. 83).

- Medicaid management has not improved its Third Party Liability Program. Deficiencies previously brought to the attention of agency management cost the program at least $3 million annually in lost Medicaid program funds (see p. 89).

- DSS management has not complied with the Assistance to Minority Business Act. The agency has not ensured that minorities are afforded the opportunity to fully participate in the State's procurement process (see p. 119).

Most of these problems existed prior to the hiring of the present commissioner in November 1983 and appointment of the new chairman in April 1984, and the agency has taken corrective action in some areas. Recommendations issued in the 1981 Audit Council report on the Child Development Program have been addressed by the Department. Also, DSS has performed well in investigating food stamp and AFDC fraud cases.

However, there has been a lack of oversight to ensure that deficiencies identified by DSS, federal and State officials are corrected. Questions arose as to whether State office DSS has authority over county DSS operations. According to State law and an Attorney General's opinion, the State DSS office has authority over all county DSS operations and, therefore, authority to ensure corrective actions are implemented.

Additionally, two Board members have poor attendance records and another has elected to abstain from voting because of a possible conflict of interest. One county Board chairman, an attorney, has represented DSS clients in legal suits against his county DSS office. Also, the State Board, improperly and possibly in violation of the State Appropriation Act and Title 42, Section 431 of the Code of Federal Regulations, added over 200 drugs to the Medicaid formulary. These drugs cost the Medicaid program approximately $600,000 in FY 83-84. The Board delayed action on an automated application and reporting system, costing the Food Stamp Program approximately $2.6 million in program savings.

The Attorney General has not taken advantage of federal funds available for investigation and prosecution of those suspected of Medicaid fraud. Better deterrents to keep providers from abusing the Medicaid program are needed, as are specific State laws making it a crime to defraud the Medicaid program.

Approximately $6 million in program funds could be saved annually if the Council's recommendations are implemented. Savings of approximately $6 million were foregone and cannot be recouped. Approximately $7 million in delinquent debts is owed the agency, the amount of which is collectible is uncertain. Also, in 1982 the Council found that at least $4.3 million was spent annually to keep intermediate patients in more costly skilled beds. This problem has not been resolved.

Effective July 1, 1984, the administration of Medicaid and the Social Services Block Grant Program was transferred to the new State Health and Human Services Finance Commission. As a result of this transfer, correction of some problems outlined in this report will be the responsibility of the new agency. Some problems will require that steps be taken by both agencies.

## RECOMMENDATIONS

THE DEPARTMENT OF SOCIAL SERVICES AND STATE HEALTH AND HUMAN SERVICES FINANCE COMMISSION SHOULD IMPLEMENT A SYSTEM FOR MONITORING AND ENSURING THAT DEFICIENCIES IDENTIFIED BY AGENCY, FEDERAL AND OTHER STATE OFFICIALS ARE CORRECTED. THIS SYSTEM SHOULD BE MONITORED BY THE AGENCIES' INTERNAL AUDITORS, WITH REPORTS ISSUED TO THEIR BOARDS AND THE PUBLIC. A PROGRESS REPORT CONCERNING CORRECTIVE ACTION SHOULD BE SUBMITTED TO THE GENERAL ASSEMBLY WITHIN ONE YEAR.

THE DEPARTMENT OF SOCIAL SERVICES AND HEALTH AND HUMAN SERVICES FINANCE COMMISSION SHOULD TAKE STEPS TO CORRECT APPLICABLE PROBLEMS AND WORK TOGETHER TO CORRECT PROBLEMS FOR WHICH THEY ARE JOINTLY RESPONSIBLE.

# CHAPTER I

# HISTORY AND ORGANIZATION

## Introduction

South Carolina's first attempt at establishing a modern welfare program was undertaken in 1870. In that year, the State Legislature enacted the "Poor Law" which provided for the establishment of "Poor Houses" or "Poor Farms" in each County. Today, the Department of Social Services serves over 135,000 individuals through the operation of Public Assistance Programs, and nearly 450,000 persons participate in the Food Stamp Program. The aim of the Department of Social Services is to promote the unified development of welfare activities and agencies of the State and local governments so that each may function as an integral part of a general system.

## History

The "Poor Law" remained in effect until 1915 when, because of defects in the law, the lack of enforcement and inadequate funding, it was replaced by the State Board of Charities and Corrections. The State Board of Charities and Corrections was similarly replaced in 1920 by the State Board of Public Welfare. This agency provided limited services to the needy in South Carolina until 1927, when it was abolished as an economy measure.

During the Depression years, many social oriented programs were implemented to assist the nation in its recovery; among these was the Emergency Relief Administration. As an outgrowth of this agency, the temporary Department of Welfare was established in 1935. Under this

new department, all but three of the 46 counties had local welfare offices to serve the public. From this beginning, the permanent Department of Public Welfare was built.

In 1937 with Act 560, the South Carolina Legislature approved the establishment of the permanent State Department of Public Welfare and a State Board of Public Welfare. The Department functioned under this name until 1972, when the General Assembly changed the name to the Department of Social Services.

Organization and Function

The South Carolina Department of Social Services is one of the State's largest agencies. In FY 83-84, it had 3,986 approved, full-time equivalent positions. The Department is organized into the State Office, located in Columbia, and 46 county offices to serve the residents of each county.

At the State Office level, the Department is organized into five functional areas, each headed by a Deputy Commissioner. These areas include: Assessment; Children's Services; Human and Economic Services; Fiscal and Data Systems; and Administrative Services. The Deputy Commissioners each report directly to the Commissioner. The Commissioner reports to the State Board of Social Services, and serves as the chief executive officer and administrative head of the Department.

The Department of Social Services provides services to the public at the county level. The Department provides aid in three broad categories: money payments, food assistance, and social services. The largest of the money payment programs is the Aid to Families with

Dependent Children (AFDC) Program. The purpose of this State and federally funded program is to assist children under the age of 18 who are in financial difficulty because of death, absence from home, or physical or mental incapacity of a parent. In FY 82-83, 49,687 families were served.

The Food Stamp Program is provided to ensure that low-income families will have the opportunity to receive improved nutrition by increasing the families' food purchasing power. The food coupons are funded with 100% federal funds and the administrative cost is shared on an approximately 50/50 basis between the State and federal governments. In FY 82-83, Food Stamp benefits totalling $219,460,780 were distributed to a monthly average of 146,613 households.

A wide range of social services are provided by the Department. These services include Children and Family Services, Adoption Services, Adult Services and Refugee Resettlement, among others. It is also the Department's responsibility to collect child support payments from absent parents through the Child Support Enforcement Section. In addition, the Department of Social Services is responsible for the licensing of agencies and homes engaged in the care of children, day care and adult residential care facilities.

Act 83, Section 2 of 1983, provided for the creation of the State Health and Human Services Finance Commission (HHSFC). The Commission has the responsibility for administering Title XIX of the Social Security Act (Medicaid), including the Early Periodic Screening, Diagnostic and Treatment Program (EPSDT), and the Community Long-Term Care System. HHSFC will also administer the Social Services Block Grant Program. Additionally, the Commission will serve as the South Carolina

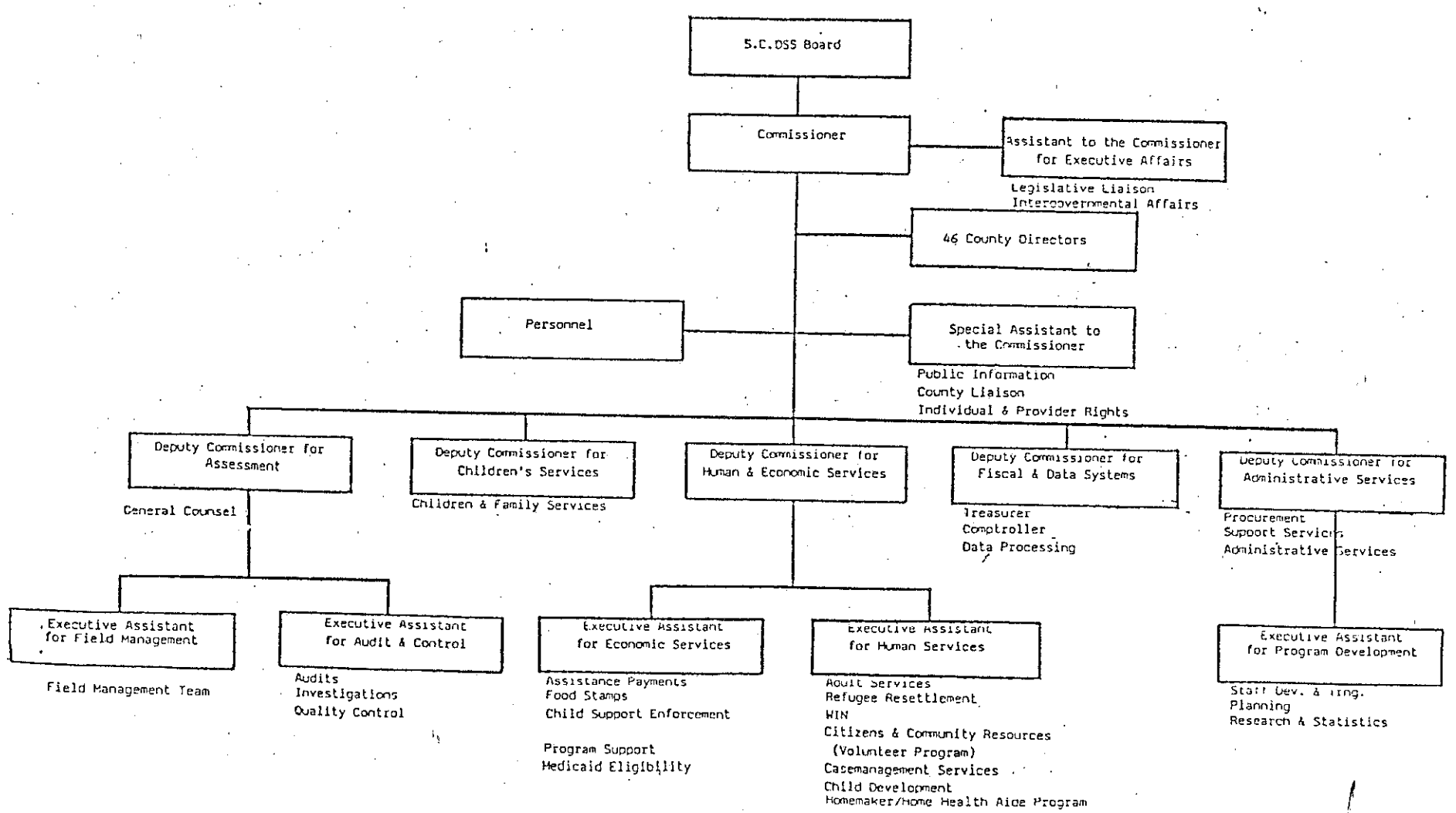
Center for Health Statistics to operate the Cooperative Health Statistics Program.

DSS Board and HHSFC Commission Membership

The members of the South Carolina Board of Social Services are elected by the General Assembly and consist of a chairman elected from the State at large and one commissioner elected from each congressional district. The members serve for a term of four years and until their successors have been duly elected and qualified. No member of the General Assembly is eligible to serve on the Board.

Six of the seven members of the State Health and Human Services Finance Commission are elected by the General Assembly. One member is elected from each Congressional district, and the chairman is appointed by the Governor from the State at large. The terms of the members are for four years and until their successors are elected and qualify, except for three initial members who serve for two years each. No person may be elected who has a conflict of interest and no member may serve more than two consecutive terms.

# ORGANIZATION CHART OF THE DEPARTMENT OF SOCIAL SERVICES

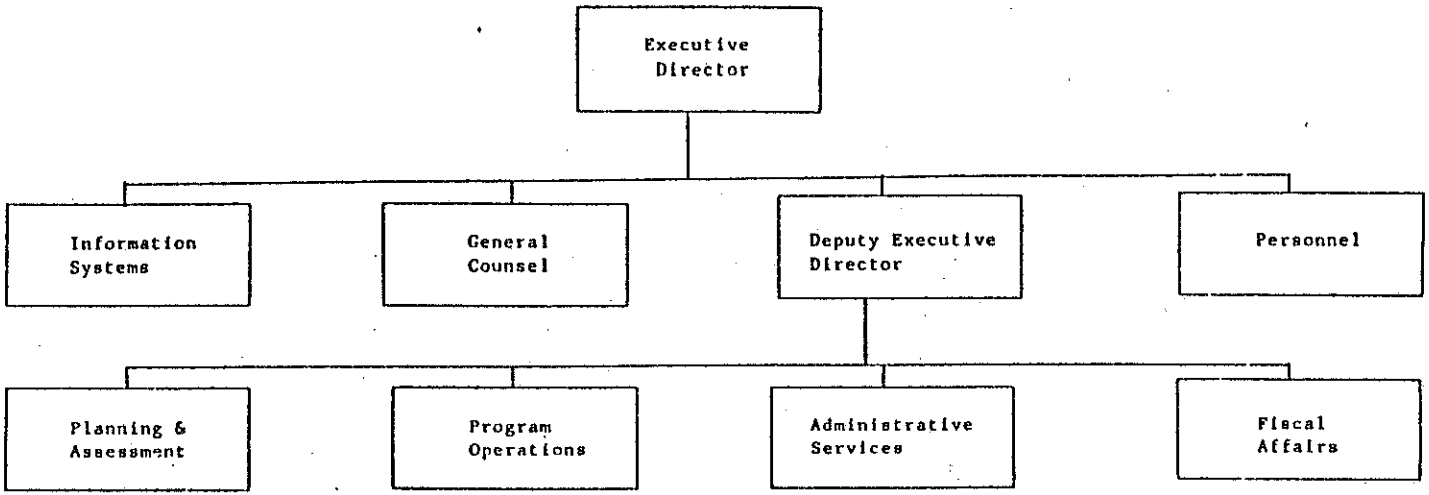



Source: Department of Social Services, Personnel , July 16, 1984.

# ORGANIZATION CHART

# OF THE

# HEALTH AND HUMAN SERVICES FINANCE COMMISSION




Source: Health and Human Services Finance Commission, January 28, 1985.

TABLE 1

DEPARTMENT OF SOCIAL SERVICES SOURCE AND APPLICATION OF FUNDS

FY 78-79 to FY 82-83

| | FY 78-79 | FY 79-80 | FY 80-81 | FY 81-82 | FY 82-83 |
|---|---|---|---|---|---|
| Total Personnel | 4,386 | 4,688 | 4,560 | 3,927 | 3,791 |
| Expenditures | | | | | |
| Personal Services | $ 43,752,775 | $ 50,647,502 | $ 56,234,706 | $ 54,323,160 | $ 54,449,422 |
| Other Operating Expenses | 31,654,818 | 34,769,942 | 30,004,664 | 15,462,226 | 14,851,812 |
| Special Items | 2,068,850 | 2,256,646 | 1,915,089 | 10,787 | 9,180 |
| Public Assistance Payments | 377,774,147 | 474,178,548 | 564,132,356 | 586,648,874 | 593,850,899 |
| Aid to Subdivisions | 738,732 | - | 1,297,975 | 16,592,339 | 19,238,349 |
| Employee Fringe Benefits | 7,257,349 | 8,457,527 | 9,502,635 | 9,580,453 | 10,103,257 |
| Debt Service | - | - | - | - | 15,535 |
| TOTAL EXPENDITURES | $463,246,671 | $570,310,165 | $663,087,425 | $682,617,839 | $692,518,454 |
| Revenues | | | | | |
| State General Fund | $ 87,932,541 | $109,058,043 | $125,858,522 | $127,496,413 | $123,888,177 |
| Federal Funds | 362,300,021 | 442,795,268 | 515,509,071 | 527,147,575 | 527,249,881 |
| Other Funds | 13,014,109 | 18,456,854 | 21,719,832 | 27,973,851 | 41,380,396 |
| TOTAL REVENUES | $463,246,671 | $570,310,165 | $663,087,425 | $682,617,839 | $692,518,454 |

Source: South Carolina State Budget, State Budget and Control Board.

## CHAPTER II

## CHILD PROTECTIVE SERVICES AND CHILD SUPPORT ENFORCEMENT

### Child Protective Services

The DSS State Office has not ensured that child protective services (CPS) are adequately delivered in each county. The Audit Council's review of compliance with the Child Protection Act and DSS policy showed inadequate investigations and treatment for child abuse and neglect cases.

The Audit Council reviewed 406 CPS case records, from 1981 to 1983, in eight counties. The sample included 168 indicated (substantiated) cases of child abuse or neglect, 199 unfounded cases and 39 cases with insufficient documentation to determine DSS's finding. Approximately 44% of the cases reviewed involved physical neglect, 35% involved physical abuse and 9% involved sexual abuse. The following are several problems identified in the Council's review.

### Investigations of Abuse/Neglect Cases

A review of DSS's Child Protective Services records revealed several problems which affect the adequacy of DSS investigations. Investigations were inadequate to determine the existence of abuse or neglect, cases were not investigated within 24 hours of being reported and case assessments were inadequate.

#### Investigations Inadequate to Determine Abuse/Neglect

The Audit Council found cases where investigations conducted by DSS were inadequate to determine if abuse or neglect occurred. In

13% (49 of 385) of the cases reviewed, there was no contact with the family; in 26% (99) of the cases, there was no contact with outside sources; and, in 28% (109) of the cases, there was no follow-up with the family. In addition, the Council identified cases where a report of suspected abuse or neglect was made, but DSS did not initiate an investigation. The following are examples of inadequate investigations:

- Seven reports were received, from November 1981 to April 1984, that the parents beat, slapped and kicked their three young children, causing bruises and cuts that required stitches. The parents are also reported to neglect and verbally abuse their children. The county did not investigate the first two reports of physical abuse on the family. The third, fourth, and fifth reports were investigated and substantiated for abuse. However, after the fourth report, the county did not contact the family. No investigation by the county followed the sixth and seventh reports of physical abuse to determine if abuse occurred again.

- From 1978 to 1983, nine reports of sexual abuse were made. The female child had been sexually abused from age 5 to 11 by her father, adult men in the neighborhood, and by a man living in her home. Her mother was accused of physically neglecting her children. The first report of sexual abuse in January 1978 was not investigated by DSS for 30 days, then there was only one home visit. There were repeated reports of sexual abuse and neglect of the child, but no action was taken until the November 1981 sexual abuse report. The child was placed in a children's home at one point, but put back home by DSS over the objections of the children's home. Following her placement back home, there was another sexual abuse report, but DSS did not remove the child because the perpetrator was not a relative. The case was still open as of May 1984 and this child and two other girls remain in her mother's home.

The DSS Child Protective Services Manual sets guidelines for gathering information during a CPS investigation. DSS policies require detailed accounts of the caseworker's initial contact with the family, contacts with outside sources and follow-up contacts with the family. In addition, Section 20-7-650(C) of the South Carolina Code of Laws, requires that DSS begin an appropriate and thorough investigation of each report of child abuse or neglect within 24 hours of the receipt of such report.

Non-Compliance with Investigative Requirements

DSS is not investigating protective services cases within 24 hours of receiving a report of abuse or neglect, as required by law. In 22% (89 of 406) of the cases reviewed by the Council, there was no evidence that investigations were initiated within 24 hours of receipt of the report. Further, in 25% (103) of the cases reviewed, there was no evidence that a case determination (substantiated or unfounded) is not made in 60 days, the case is automatically dropped for "want of an investigation." The following are two examples of non-compliance with the 60-day requirement:

- A report of physical abuse and mental injury, that a father was beating his daughter, was received in July 1983. The case was closed unfounded, "for want," in January 1984 because an investigation had not been conducted. The record contained two prior physical abuse and neglect reports from 1980 and 1981 on this family.

- A report was received on March 4, 1983 for possible physical neglect and sexual abuse. DSS did not contact the parent of the children, and after 60 days, on May 12, unfounded the case "for want" because there was no investigation.

Section 20-7-650 (C) of the South Carolina Code of Laws requires:

> Within twenty-four hours of the receipt of a report of suspected child abuse or neglect the agency shall commence an appropriate and thorough investigation to determine whether a report of suspected child abuse or neglect is 'indicated' or 'unfounded.' The finding shall be made no later than sixty days from the receipt of the report.

Section 20-7-650(E)(3) states that if there is no finding within 60 days, then the report will be classified "unfounded for want of an investigation."

Inadequate Case Assessments

In 27% (111 of 406) of the cases reviewed, there was no assessment summary found in the case record. There was some form of an assessment

in the narrative record in 34% (140) of the cases, but this usually consisted of a brief statement. In 38% (156) of the cases reviewed, the Council found case assessments in the format required by DSS Policy.

The CPS Policy Manual states:

> Upon completion of the investigation, a social assessment must be written on a separate paper, apart from the narrative record...This should include a summary of the factual information drawn from the initial report and the contacts with the family and other sources.

It adds that attention should be directed toward areas of difficulty in social functioning, strengths and weaknesses of the family. There must be a specific statement as to the status of the case (indicated/unfounded) based on and documented by the assessment. Also, an assessment summary must be completed for each report of abuse or neglect. This summary lists the factors used to assess whether the report is founded. For example, one county uses the Protective Services Assessment Summary form from the foster care manual.

In addition, in 59% (241) of the cases reviewed, there was no evidence that DSS contacted the alleged perpetrator to inform him/her of DSS's assessment of the case, as required by law. DSS Policy and Section 20-7-690(C) of the South Carolina Code of Laws requires that the alleged perpetrator be informed of the findings of the investigation.

The State Office has not ensured consistent compliance with its requirements for adequate assessments. The State Office conducted CPS program reviews in four of the counties (from November 1981 to November 1983) that the Council reviewed. In all four of these counties, the State Office found problems with the assessment process, and the problems were still present during the Council's review.

There is no consistent supervisory review of all cases in the counties. This is partly due to the lack of a standard check-off list to ensure that all critical steps are covered in conducting protective services investigations.

One DSS State Office report states that when not all available information is assessed to diagnose the actual causes of abuse or neglect, there is cause for concern that families will continue to abuse or neglect their children after DSS completes its investigation. This results in continuing danger of abuse to the children. In instances where case determinations are made after only one contact with the family, not enough information is gathered and workers can make the wrong determination about abuse of children.

Another program review finds that weak assessment summaries can have a negative impact on the CPS process from assessment to the close of the case. Without an adequate assessment, the patterns of abuse and neglect cannot be assessed to determine family strengths and weaknesses or the extent and pervasiveness of the family's problems that are causing the abuse. Inadequate assessments can result in misdiagnosed cases with children remaining in danger of further abuse and neglect.

RECOMMENDATIONS

THE STATE OFFICE MUST ENSURE THAT CONSISTENT, ADEQUATE INVESTIGATIONS ARE CONDUCTED STATEWIDE. CPS SUPERVISORS SHOULD REVIEW EACH CASE PRIOR TO THE CASE DECISION TO ENSURE THAT WORKERS ARE GATHERING AND ASSESSING ALL AVAILABLE INFORMATION. A

STANDARD CHECK-OFF LIST SHOULD BE DEVELOPED TO ENSURE THAT ALL CRITICAL STEPS ARE COVERED IN CPS INVESTIGATIONS.

THE PROTECTIVE SERVICES ASSESSMENT SUMMARY FORMAT SHOULD BE USED IN ALL REPORTS OF SUSPECTED ABUSE/ NEGLECT. THIS FORMAT SHOULD BE USED AS AN INTERVIEW GUIDE WHICH WOULD PROVIDE STRUCTURE AND FOCUS TO THE ASSESSMENT PROCESS.

DSS SHOULD ENSURE THAT ALLEGED PERPETRATORS ARE INFORMED OF THE FINDINGS OF CHILD PROTECTIVE SERVICES INVESTIGATIONS AS REQUIRED BY LAW.

Treatment Plans

In the majority of substantiated child neglect and abuse cases reviewed, DSS did not develop treatment plans for client rehabilitation, as required by DSS policy and State law.

In cases where abuse or neglect was substantiated by DSS, 59% (100 of 168) of cases reviewed had no treatment plan. Less than 15% (25) of substantiated abuse and neglect cases reviewed had separate treatment plans, with 26% (43) referring to some type of plan for treatment in the record. In three of the eight counties reviewed, more than 70% of the substantiated cases did not contain treatment plans. The following are some examples of cases reviewed.

- In December 1980, DSS substantiated a case of educational and physical neglect. DSS closed the case in March 1981 when the mother said she would accept homemaker services. No treatment plan was completed. In August 1981, DSS substantiated physical abuse after the father hit his nine-year-old son on the head with a wooden plank, requiring 15 stitches. In September 1981, an aunt told DSS the father had left town and she was keeping the boy. DSS closed the case since the child was no longer in the home of parents. No treatment plan was provided. In September 1982, DSS received a report that the boy's home was filthy, children were roaming the neighborhood, babies were neglected, one teenager was pregnant and school attendance was poor. DSS substantiated medical, physical and educational neglect. But DSS did not provide a treatment plan as required. The caseworker made visits to the home between October 1982 and April 1983 and then closed the case stating: "The children now have all their shots, two boys are in (correctional) institutions in Columbia, and ____, age 14 may be pregnant and has dropped out of school." Case closed.

- In June 1983, DSS received a report of physical and medical neglect of an infant. DSS substantiated the case, with the case assessment summary making recommendations for treatment "to monitor family situation due to risk to ____'s physical well-being." The case was transferred to the treatment unit in August 1983. At the first treatment visit, in September 1983, the caseworker informed the client's mother (infant's grandmother) that the caseworker was going on maternity leave and that the client should call the CPS supervisor if she had any problems. (The client was not at home during this visit.) No treatment plan or service agreement was completed. No contact was made with the family until five months later, in February 1984. The case was still open as of the May 1984 Audit Council review.

DSS State Office program reviews of three counties reviewed by the Audit Council noted deficiencies in completion of treatment plans as early as 1981. From one State Office review: "Most records reviewed... did not include case plans with a description of problems and their history or the exact nature of proposed services and why it was thought they would benefit the client." From another: "Caseworkers are especially weak in this area (case planning and treatment) of the CPS process."

According to the DSS Child Protective Services Manual, treatment planning consists of developing a plan to establish a safe environment for the child. The manual requires that the treatment plan be written

"on a separate paper, preferably of a different color so that it is clearly identifiable." The plan should include:

1. Goals
2. Types of intervention with respect to goals
3. Reasons for intervention
4. Resources to be used
5. Expectations of client and worker
6. Treatment Advisory Team recommendations

The South Carolina Code of Laws also requires case planning by DSS. Section 20-7-650(h) requires that in cases of physical, mental or sexual abuse DSS notify the family court of services offered. The burden of proof is on the agency to justify that the services are reasonable.

Section 20-7-762 states: "... upon a finding that the child shall remain in the home and that protective services shall continue, the Family Court shall review and approve a treatment plan designed to alleviate any danger to the child and to aid the parents so that the child will not be endangered in the future." Section 20-7-764 requires a similar plan from DSS when the child has been removed from the home.

The county CPS staffs have not followed the agency's written policy on treatment plans. Although DSS State Office reviews have identified deficiencies in completion of treatment plans and recommended corrective action, the State Office has not ensured that these problems are corrected.

The American Humane Association handbook for CPS caseworkers states that without a case plan, the caseworker is using a "trial and error approach to treatment." There are no criteria for evaluating why the treatment worked or failed to work. A 1983 State Office program review noted: "Positive change in family dysfuntion is not obvious in most records because treatment is not planful, purposeful, goal oriented,

and time structured." Without service planning, child protective services may be reactive and fail to alleviate the abuse/neglect situation, leaving the child in an unsafe environment.

RECOMMENDATION

THE DSS STATE OFFICE MUST ENSURE THAT COUNTY OFFICES FOLLOW STATE PROCEDURES FOR THE COMPLETION OF TREATMENT PLANS IN ABUSE/NEGLECT CASES.

Service Agreements

Written service agreements were not used in most child protective services cases reviewed by the Audit Council. In cases where abuse or neglect was substantiated by DSS, 88% (148 of 168) of the cases reviewed did not contain service agreements.

The service agreement is a structured way of formalizing the plan for treatment, which requires the signatures of the caseworker and the family. The service agreement identifies problems, states goals developed to overcome the problems, lists specific objectives to be achieved in meeting the goals and specifies time frames in which to complete the objectives. A signed, written agreement not only enhances communications but also helps monitor rehabilitation of the family.

Written service agreements are required to be used by DSS foster care workers. A 1982 DSS review noted that parent-agency service agreements, such as those used in foster care, have the potential for improving casework practices in child protective services abuse/neglect

cases. However, the DSS child protective services procedures manual does not address the use of service agreements.

By not using service agreements in child protective services cases, caseworkers are not taking advantage of an effective treatment tool. For example, in one educational neglect case reviewed, no improvement was seen for the first six months of intervention by DSS. A service agreement was then completed with the signatures of the caseworker and the family, and the treatment goals were thereafter achieved. In another educational neglect case in the same county, the narrative shows that the caseworker planned to complete a service agreement, but never did so. This educational neglect situation, which had occurred for approximately four years, was not corrected, and DSS eventually closed the case with no resolution of the problem.

RECOMMENDATION

DSS SHOULD ESTABLISH GUIDELINES FOR THE USE OF WRITTEN SERVICE AGREEMENTS IN CHILD PROTECTIVE SERVICES CASES. CASEWORKERS SHOULD BE ENCOURAGED TO USE SERVICE AGREEMENTS IN ALL SUBSTANTIATED CHILD PROTECTIVE SERVICES CASES.

Required Hearings

Family Court hearings are not regularly held, as required by law, to review child protective services provided by DSS. Section 20-7-650(H) of the South Carolina Code of Laws requires the Family Court to schedule

a hearing to be held within 90 days after DSS notifies the Court that protective services are being provided for physical, mental, or sexual abuse. These hearings are held to determine whether DSS had "reasonable cause" to initiate protective services and whether the services are "...reasonable in light of the agency's justification for intervention."

DSS records sampled indicate these hearings were not held, as required by law, in 73% (47 of 64) of substantiated cases of physical, mental, and sexual abuse. In one county, 94% (17 of 18) of required hearings were not held, while in another county, all (2 of 2) required hearings were held.

There are several reasons why hearings are not being held. In 55% (35 of 64) of substantiated cases of physical, mental, and sexual abuse sampled, DSS did not notify the Family Court, as required by Section 20-7-650(H) of the South Carolina Code of Laws and Policy 712.21 of the Department's Child Protective Services Manual. DSS records also show cases where the Family Court was notified of substantiated abuse but there was no evidence that required hearings were held.

Without Family Court notification and review of substantiated cases of child abuse, there is reduced judicial oversight of the protective services provided by DSS. Without judicial oversight, caseworkers may be less likely to follow through on treatment designed to protect children from abuse and neglect.

RECOMMENDATIONS

DSS AND THE FAMILY COURTS MUST ENSURE THAT HEARINGS ARE HELD AS REQUIRED BY LAW FOR THE REVIEW OF PROTECTIVE SERVICES PROVIDED BY DSS.

## DSS SHOULD ENSURE THAT THE FAMILY COURT IS PROPERLY NOTIFIED AS REQUIRED BY LAW WHEN PROTECTIVE SERVICES ARE INITIATED FOR PHYSICAL, MENTAL, AND SEXUAL ABUSE.

### Family Court Orders

Four of eight counties reviewed had no system for monitoring compliance with judicial orders from the Family Court affecting the Department or its clients. In these counties, individual caseworkers were responsible for monitoring compliance with orders. However, one county with a formal system monitored judicial orders centrally to ensure compliance with all orders.

The Audit Council found cases where there was no evidence that Family Court orders were followed. The following are descriptions of two such cases.

- DSS substantiated a case of sexual abuse of a 10-year-old girl by her stepfather. Eight months later, the girl was taken into protective custody by police after her mother hit her with a belt, inflicting bruises. The Family Court permitted the mother to retain custody of her daughter but ordered DSS to monitor the home. However, there was no evidence of further contact with the family by the Department after the Court Order.

- DSS substantiated a case of physical abuse of two girls, ages nine and 13, by their father who threw them against a wall after threatening them with a gun. The Family Court ordered the parents to get mental health counseling, cooperate with DSS, restrain from fighting and restrain from abusing their children. The Court also ordered that the children be taken into protective custody if these conditions were not met. One month later, the Department found that the parents were physically fighting and that the father had beaten one daughter with a belt, but did not request that officials take the children into protective custody. Two years later, the father was arrested for hitting his wife and shoving one daughter against a wall. The Family Court placed a restraining order against him. Five months later, the Department received a report of physical neglect of the girls by their mother, but there was no evidence of an investigation.

Also, in March 1984, DSS was charged with contempt of court for failure to follow a Family Court order issued in Richland County.

Section 20-7-480 of the South Carolina Code of Laws states that abused and neglected children should be protected through "...fair and equitable procedures, compatible with due process of law..." The Family Court's role in ensuring protection through due process is effective only if DSS monitors judicial orders.

When Family Court orders are not followed, the actions necessary to prevent future incidents of abuse and neglect of children may not occur, resulting in injuries which were preventable.

RECOMMENDATION

IT IS NECESSARY THAT DSS ESTABLISH A SYSTEM FOR COUNTIES TO MONITOR FAMILY COURT ORDERS AFFECTING THE DEPARTMENT OR ITS CLIENTS. THIS SYSTEM SHOULD INCLUDE A MEANS OF ESTABLISHING ACCOUNTABILITY FOR COMPLIANCE.

Abuse/Neglect Records

The Audit Council's review found inconsistent recordkeeping practices for child protective services files. In addition, documentation was not adequate to follow the progress of some cases.

For example, in 18% (74 of 406) of the cases reviewed, there was no narrative record or narrative summary, or the record was inadequate to follow the progress of the case. In one county, 65% (13 of 20) of

the cases had no narrative record or an inadequate record. In 24% (13 of 54) of the cases in one county, the status of the case (substantiated/unfounded) was not clear from the record. Overall, in almost 10% (39 of 406) of cases reviewed, the status of the case was not clear.

The eight counties reviewed used a variety of forms and methods to document child protective services cases. For example:

- Counties used various county-developed methods to document case assessments and treatment plans. Some counties had specific forms, with standard data to be documented. One county developed a family relationship diagram as a quick reference aid in treatment.

- Some counties sent form letters informing families that services were being provided by DSS or that DSS had completed its investigation.

- One county used a checklist to ensure that all phases of an investigation were completed as required.

- Some counties used a daily narrative to document the progress of cases. The review found cases in which these straight narratives contained unnecessary detail. For example, from one case: "Worker ...took her to the bus station to leave for ____. The bus was scheduled to leave at 9:40 a.m., and we waited until about 12:30 p.m. before a bus came. The bus had a flat tire in _____ and it took awhile to find someone who was able to change the tire..."

A 1982 DSS State Office program review noted problems in excessive documentation: "...information is not summarized in any of the records... caseworkers are using valuable time in recording unnecessary detail every contact with the client." Case control forms (chronological listings of contacts) and interview summary forms used by some of the counties reviewed by the Audit Council reduced unnecessary documentation.

The DSS Child Protective Services Manual requires clear, relevant documentation of every phase of the investigative and treatment process. For example, Policy 710.32 states "There must be a specific statement as to the status of the case (substantiated/unfounded) based on and documented by the assessment."

Recordkeeping should be consistent across the entire program regardless of the specific county handling the case. Standard forms can help ensure completion of required documentation while reducing unnecessary detail.

The DSS central office has not ensured adequate, uniform documentation of county child protective services cases. Although the CPS Manual sets guidelines for child protective services cases, there is no standard checklist for counties to follow to ensure compliance with the guidelines.

Without consistent recordkeeping practices by the counties, records and/or investigative practices could vary by geographic area or the local directors' viewpoints. The State cannot ensure that the program is fully accountable to agency policy and the community in providing a uniform response to child abuse and neglect cases.

RECOMMENDATIONS

THE STATE OFFICE SHOULD ENSURE THAT CHILD PROTECTIVE SERVICES RECORDS ARE MAINTAINED IN ACCORDANCE WITH AGENCY POLICY.

THE STATE OFFICE SHOULD DEVELOP A CHECKLIST OF REQUIRED DOCUMENTATION AND STANDARD FORMS FOR THE CHILD PROTECTIVE SERVICES PROCESS TO BE USED BY THE COUNTIES.

Records Not Destroyed

Records of unfounded Child Protective Services reports are not destroyed as required by law. There is no uniformity of record retention in the counties reviewed, resulting in inconsistent protection of the privacy and rights of alleged perpetrators. In addition, in one county, the security of CPS records was not assured.

In one of the counties reviewed by the Council, unfounded cases older than three years are destroyed, but identifying information was not deleted in all cases between one and three years old. After one year, in another county, the unfounded cases are removed from the general files to a locked file cabinet in the director's office. The identifying information is removed only when the file is to be reviewed. After three years, the files are destroyed. The policy in a third county is to destroy unfounded cases three years from the date of the last report. However, cases older than three years were on file and contained identifying information.

There was a lack of concern for the security of CPS records in one county reviewed by the Council. CPS records were kept in an unlocked file cabinet, in a room with a door which opened to the outside of the building. Several times during the Council's review in May 1984, the door to the outside was unlocked and open with no one safeguarding the records.

Decision making on cases needs to be consistent across the entire program regardless of the specific unit or county handling the case. Title XX Case Management Procedures require that unfounded cases older than three years be destroyed. Section 20-7-650(F) of the South Carolina Code of Laws requires "The names, addresses and all identifying characteristics of all persons named in all unfounded reports shall be

destroyed one year from the date that the last report has been determined to be unfounded; provided, however, that all information in any such report which is unnecessary for auditing purposes shall be destroyed immediately upon a determination that such report is unfounded and the remaining information shall be kept confidential except for auditing purposes." CPS Policy 710.6 reiterates the requirements of the Code.

Inconsistent implementation of this policy results in varied protection of the rights and privacy of individuals investigated for possible child abuse and neglect and has implications on confidentiality. In addition, some counties could be in violation of the law.

The State Office has not ensured clear, consistent implementation of its policy on record retention in the counties. Counties have various interpretations of State law, CPS policies and Title XX Case Management Procedures and are implementing this policy in various ways. One county official said that it is too time consuming to implement the law accurately.

RECOMMENDATION

THE STATE OFFICE SHOULD CLARIFY THE PROPER PROCEDURES FOR RECORD RETENTION TO ENSURE CONSISTENCY. LOCAL DSS AGENCIES SHOULD ENSURE THE SAFETY AND CONFIDENTIALITY OF CPS RECORDS.

## Additional Child Protective Services Issues

During its review, the Audit Council noted additional problems which affect the adequacy of Child Protective Services.

### Caseload Analysis

In 1983, caseloads for CPS "intake and assessment" workers varied by more than 67% among the eight counties reviewed. Intake and assessment is the process in which the worker determines whether a case of abuse/neglect is substantiated. In that year, new cases per worker, by county, ranged from 85.7 to 143.2 (see Table 2). To ensure a consistent level of child protective services, caseloads should be approximately equal.

TABLE 2

CASELOADS PER FULL-TIME EQUIVALENT

INTAKE AND ASSESSMENT WORKER

BY COUNTY FOR 1981-1983

| County | 1981 | 1982 | 1983 | Average[1] 1981-1983 | % Change 1981-1983 |
|---|---|---|---|---|---|
| 1 | 204.5 | 159.1 | 143.2 | 168.9 | -30.0 |
| 2 | 100.0 | 115.0 | 104.0 | 106.2 | 4.0 |
| 3 | 91.7 | 93.3 | 85.7 | 90.0 | - 6.5 |
| 4 | 86.7 | 110.7 | 95.1 | 97.1 | 9.7 |
| 5 | 136.0 | 129.0 | 132.3 | 132.4 | - 2.7 |
| 6 | 82.3 | 89.0 | 103.0 | 91.4 | 25.1 |
| 7 | 142.0 | 109.2 | 114.2 | 119.2 | -19.6 |
| 8 | 127.1 | 96.3 | 94.7 | 106.0 | -25.5 |
| Average[1] | 109.5 | 101.2 | 98.7 | 102.9 | -9.8 |

[1]This is a weighted average computed by dividing total cases by total full-time equivalent workers.

Source: CPS intake logs and county department staff, June-July 1984.

## Training and Certification

Child Protective Services "intake and assessment" workers are required to be initially certified by the State Office and to take continuing education courses to maintain valid certification. However, neither the State nor the county offices maintain training and certification records which are adequate for determining whether CPS workers are certified (see p. 117).

## Agreements With Law Enforcement Agencies

The eight counties reviewed reported that they have good working relationships with the local law enforcement agencies. However, the counties have not developed written procedures or policies regarding coordination of services between DSS and law enforcement agencies. One county had a limited written agreement which addresses emergency protective custody. State law and DSS policy require that procedures and guidelines be established between law enforcement agencies and DSS to facilitate the referral of child protection cases. A State Office CPS program review recommends that written agreements be established so services can be provided in an appropriate, orderly manner, with each agency sure of their responsibilities.

## Agreements/Policies With Schools

Three of the counties reported problems with their school district's methods for reporting child abuse and neglect cases. Teachers are required to go through an internal chain of command to make a child abuse or neglect referral. These reports are screened by the schools

and those that are not perceived to be significant may not be reported. In some cases, this can have a "chilling effect" on reporting. Because teachers are required by law to report child abuse and neglect, the State Office should analyze the effect that these reporting policies may have on teacher reporting. Written agreements between the school system and DSS could enhance cooperation and provide a clear explanation of their duties and legal responsibilities.

Public Awareness and Training of Individuals Legally Required to Report

All of the eight counties said that they do not have a formal plan for training of those required by law to report child abuse and neglect, or for public awareness. State law requires that DSS State and county offices inform and train, on a continuing basis, all persons with a legal obligation to report child abuse and neglect, of their duties and responsibilities. The law also requires DSS to educate the public of child abuse and neglect and of the services available to children and families.

DSS has not developed a statewide public information campaign or a training program for those required to report abuse. Effective public information and training activities are necessary so that all potential referral sources are informed about child abuse issues, State law requirements and the services provided by DSS.

Specialized Sexual Abuse Training

Four of the eight counties reviewed by the Council had sexual abuse units, staffed by workers who have received specialized sexual abuse training. One county stated that the sexual abuse training

program has enabled them to substantiate more sexual abuse cases. The State Office reports that this specialized training program has been successful. However, statewide, staff in 15 of the 46 counties have received the specialized sexual abuse training. The other 31 counties can benefit from receiving this training.

Legal Advice

Several of the counties noted some problems in getting adequate and timely legal advice in CPS cases. State law requires that the State and county CPS agencies be represented by the circuit solicitor or his representative in any judicial proceeding. One county said that their circuit solicitor's office places its priority on General Sessions, not on Family Court. In response to this problem, the State Office has conducted pilot projects to provide full-time legal representation by the Solicitor's Office in three counties. The State Office needs to ensure adequate legal representation in CPS cases for all counties. Therefore, it is important that DSS give careful consideration to Statewide implementation of this project.

Conclusion

The DSS State Office has not ensured that identified deficiencies are corrected by the counties. The State Office conducted CPS program reviews (from November 1981 to November 1983) of four of the counties reviewed by the Council. The State Office found problems in investigations, assessments, case planning and treatment, case documentation and other areas of the CPS process. Evidence of these problems was also found during the Council's review. To hold these counties accountable for

the quality of services they provide, DSS should use the program reviews as a monitoring tool to periodically assess all county CPS programs and to ensure that action is taken to correct problems that are identified. Without ensuring that actions are taken to identify and correct deficiencies, inadequate investigations and treatment of child abuse and neglect may continue.

## Child Support Enforcement Program

The Council reviewed DSS's efforts to administer the Child Support Enforcement Program and found the following problems.

### Implementation of Automated System

DSS has not automated its Child Support Enforcement Program, although it has had funding available since July 1982. Development costs have increased by $1,350,000 during this delay. Also, failure to automate has cost the program $1.9 million per year in increased collections, according to their Advanced Planning Document (APD).

The system now used by DSS was designed and implemented in 1978 and only partially automates the receipt and distribution of child support checks. This system was not designed to support other major program functions, such as case initiation, case management, enforcement and quality assurance. The proposed system provides for these functions.

On July 1, 1981, Federal Public Law 96-265 made available federal funds at a 90% match rate for developing and enhancing of automated Child Support Enforcement systems. Although the General Assembly appropriated the State matching funds in July 1982, DSS did not contract to develop the Advanced Planning Document (APD) required for the

federal funds, until July 1983. The APD, which was completed April 20, 1984, estimates the earliest the system will be fully operational is 2½ to 3 years.

According to federal officials, South Carolina is the least automated of the southeastern states. Florida's system was completely implemented in March 1982. Automated data processing increases both the effectiveness and efficiency of the Child Support Enforcement Program by streamlining work associated with major program functions, including case initiation, case management, security and reporting.

In July 1982, the General Assembly appropriated $65,000 as the State's 10% match to provide for a $650,000 automated system. However, two years after this appropriation, the APD estimates the cost to be approximately $2 million, an increase of 208%. Through the new automated system, the APD estimates that South Carolina will increase collections by $1.9 million annually. The cumulative net benefit of developing the new system is an increase in net revenue of approximately $6.5 million over the assumed five-year life of the system. The delay in implementing the fully automated system results in DSS's inability to collect these revenues. Additionally, DSS's delay will require additional funds of $1,350,000 to pay for the development of the system.

DSS management has not taken the initiative to pursue federal matching funds in a timely manner. The interim commissioner, in September 1982, placed a temporary hold on all automation projects, including Child Support Enforcement.

## Federal and State Tax Refund Intercept Programs

In 1981, the Federal Office of Child Support Enforcement and the Internal Revenue Service began a program for intercepting federal tax refunds due to child support obligors delinquent in their payments. The rationale of the program, which is limited to Aid to Families with Dependent Children (AFDC) cases, is to use the federal tax refunds due to delinquent parents to compensate for, or "offset," AFDC grant payments.

On June 10, 1983, Act 103, which provides for the offset of State tax refunds due to obligors who are past due in their child support payments, became law. Both AFDC and non-AFDC cases can be offset in the State program. Although DSS participates in both the IRS and the State Tax Intercept Programs, its performance has been below that of neighboring states.

### IRS Tax Refund Intercept Program

DSS has not effectively participated in the IRS Tax Refund Intercept Program. Although South Carolina has approximately the same AFDC population as Kentucky, Mississippi, and Tennessee, DSS's performance has been below the level of these states. In 1982 tax year, in the Southeast Region, South Carolina had the lowest percentage of submittals (3%) as related to the AFDC population, as shown in Table 3.

TABLE 3

PERCENTAGE OF CASES WITH CERTIFIED ARREARS TO IRS FOR OFFSET TO AFDC RECIPIENT FAMILY POPULATION

| Southeastern States | AFDC[1] Families | 1982 Tax Year Cases Submitted[2] | 1982 Tax Year % of AFDC Population |
|---|---|---|---|
| South Carolina | 53,400 | 1,519 | 3 |
| Alabama | 58,300 | 6,481 | 11 |
| Georgia | 84,600 | 5,551 | 7 |
| Florida | 94,000 | 8,565 | 9 |
| Kentucky | 55,900 | 4,307 | 8 |
| Mississippi | 54,700 | 3,383 | 6 |
| North Carolina | 69,200 | 19,388 | 28 |
| Tennessee | 56,000 | 3,402 | 6 |
| Regional Average | 65,763 | 6,575 | 10 |

[1]Source: 1981 Statistical Abstract of the United States.

[2]Source: Office of Child Support Enforcement, HHS, "Federal Income Tax Refund Offset Program, February 1, 1984 Statistical Worksheet."

In addition, neighboring states have shown marked improvements during the three-year life of the program. For instance, in 1981, North Carolina ranked 47th among the states in the number of cases submitted to the IRS and advanced to 15th in 1983; Georgia ranked 48th and moved to 26th; and, Florida progressed from 45th to 19th; while South Carolina was 39th in 1981 and 38th in 1983. DSS submitted 3,131 cases to the IRS for the tax year 1983, but if this State had performed at the level

of the region, South Carolina would have submitted 8,257 cases. Additionally, if South Carolina had performed as well as North Carolina, 17,296 cases would have been submitted.

As of December 1983, DSS reported that there was $32.8 million of arrearages in unpaid child support. South Carolina had the potential of offsetting $3.4 million in IRS refunds in 1983 for the 1982 tax year. This is based upon the number of cases on the CSE system with arrearages, and the anticipated collection rate and average offset. The Federal Office of Child Support Enforcement reports that only $369,313 will be intercepted. This has the effect of a potential loss of $3.1 million, with the State share being approximately $796,000.

State Tax Refund Intercept Program

The Division of Child Support Enforcement has not effectively implemented the State Tax Refund Offset Program. Although the State law authorizing the offset of tax refunds took effect June 10, 1983, DSS did not formally inform the counties of the program or provide them with an application form until November 22, 1983, with a December 15 deadline for submittals. As a result, counties reported that time did not permit their participation in the program in 1983. Further, only two non-AFDC applications were submitted by the counties for offset.

The Georgia Office of Child Support Recovery has implemented procedures which encompass the entire state tax offset process. Based on the performance of Georgia and North Carolina in the first year of their offset program, the State Auditor's Office estimated a net benefit to the State of $61,370 in the first year of South Carolina's program. However, based on the number of submittals to the Tax Commission, it

is estimated that there will be a net benefit of only $5,460. Georgia netted $350,000 in its 1981 State Tax Intercept Program and $674,012 from the 1982 Intercept Program. North Carolina netted $229,767, $434,279 and $633,173 in the 1980, 1981 and 1982 State Tax Intercept Programs.

DSS has not developed an internal plan with target dates, goals and objectives regarding the number of submittals for the Intercept Program. Nor has the Division developed internal operating procedures regarding the Federal Tax Offset Program. Additionally, federal officials have noted the Division's automated system is very weak. The inadequate system produces unreliable information, which, according to Division staff, limits the number of submittals to the IRS and State Tax Commission. For example, for the 1983 tax year only 19% of the active cases on the system with arrearages were submitted to the IRS for offset.

Distribution of Child Support Payments

The Department of Social Services has taken no action to allow all counties to provide direct distribution of non-AFDC Child Support payment checks. The present distribution system of non-AFDC checks results in an unnecessary cost to the State of $93,000 per year, is inefficient, and does not maximize benefits to the client.

Under the present system, all counties except Sumter collect support payments and send them to the Department of Social Services for distribution to the clients. In June 1983, after waiting 14 months for DSS approval, Sumter County began a pilot program which provides for direct county distribution of non-AFDC child support payments. DSS reports that the pilot program is working well in Sumter, and the federal office has encouraged expansion into other counties.

Division of Child Support Enforcement staff told the Council that as of December 15, 1983, the Division had not informed the other counties of the option of direct distribution of non-AFDC support payments.

The Federal Office of Child Support Enforcement supports the concept of direct distribution of non-AFDC checks and cites the following potential advantages of this system:

1) The recipient would receive their child support check from the county Clerk of Court's Office almost immediately;

2) The cost of cutting checks on the State level could be eliminated;

3) The need to balance accounts in the collection-distribution unit would be eliminated;

4) The process is not alien to the Clerk's office since most of this process is in use for non-IV-D cases, and there would be no extra expense to the counties; and,

5) State risk in terms of money handling responsibility would be shifted to the Clerk of Court while the risk of checks being lost in the mail would be minimized.

The county distribution of non-AFDC support payments could result in the State avoiding as much as $93,000 per year in unnecessary mailing and check processing expenses. Further, this process allows clients to receive their payments almost immediately rather than experiencing the 30-day wait due to the Department of Social Services monthly distribution procedure.

Child Support Funds

The Department of Social Services held approximately $1 million per month in child support funds from August 1983 to December 1983 instead of distributing the funds to the proper governmental entities and clients. When the distribution system cannot disburse receipts because of inadequate information, the collections are put into a "balances held" account and

are not distributed. According to the Federal Office of Child Support Enforcement, the Department of Social Services' excess backlog of undistributed funds far exceeds the normal percentage anticipated.

The problem of accumulating funds began in 1977 and grew due to several reasons. First, the Division has not reconciled the balances in the Absent Parent Clearing Account for several years. Secondly, management has not monitored cases to determine when information is available to allow distribution of held funds. In addition, as of August 1983, 11% of the Division's caseload was manual, and coordinating information from the automated and manual systems has contributed to this problem. Further, the Division's Advanced Planning Document states that the inability to share information between distribution and the AFDC system results in held money when a redetermination of eligibility must be made.

It is the agency's responsibility for following up to determine the disposition of held funds. The Department of Social Services Office of Audit and Control addressed this problem in an internal audit dated January 18, 1984. The audit found that internal controls and operational procedures could not adequately ensure the accurate accountability of funds received and disbursed. Federal regulations require that the IV-D Agency maintain fiscal accountability through its accounting system and supporting fiscal records.

Undistributed funds result in the client, State and federal governments not receiving their portion of the amount due. In addition, the Attorney General has warned the Department of Social Services that this area has the potential for creating a legal liability against the Department of Social Services. The Attorney General also noted that the undistributed

funds are a cause of complaints regularly received by his staff from custodians of children.

RECOMMENDATIONS

THE FULL AUTOMATION OF THE CHILD SUPPORT ENFORCEMENT PROGRAM SHOULD BE PLACED AS A PRIORITY OF DSS. THE DIVISION SHOULD DEVELOP INTERNAL OPERATING PROCEDURES, PLANS, TIME LINES, GOALS AND OBJECTIVES TO ASSIST IN THE DEVELOPMENT OF THE DIVISION'S AUTOMATED SYSTEM.

THE DIVISION OF CHILD SUPPORT ENFORCEMENT SHOULD DEVELOP AND IMPLEMENT INTERNAL PLANS, POLICIES AND PROCEDURES TO BE USED IN THE IRS AND STATE TAX REFUND OFFSET PROGRAMS.

THE DEPARTMENT OF SOCIAL SERVICES SHOULD TAKE STEPS TO ENCOURAGE COUNTIES TO ADOPT A DIRECT DISTRIBUTION SYSTEM FOR NON-AFDC CHILD SUPPORT PAYMENTS.

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During the course of the Council's review, the Department of Social Services took steps to decrease the amount of undistributed funds. In January 1984, DSS made a special distribution of Balances Held funds of approximately $900,000. DSS expects to disburse all excess funds, and the Division is attempting to automate all manual cases.

THE DIVISION SHOULD ESTABLISH WRITTEN PROCEDURES TO ENSURE THE RECONCILIATION OF THE ABSENT PARENT CLEARING ACCOUNT IS PERFORMED CORRECTLY WITH ALL NECESSARY INFORMATION IN A TIMELY MANNER.

CHILD SUPPORT ENFORCEMENT PERSONNEL SHOULD CLOSELY MONITOR ALL CASES WITH HELD MONEY TO DETERMINE WHEN NECESSARY INFORMATION IS AVAILABLE TO ALLOW DISTRIBUTION OF SUCH FUNDS.

EFFORTS MUST BE MADE TO AUTOMATE MANUAL CASES WHENEVER POSSIBLE. ANY CASE BEING MANUALLY RECORDED WHICH HAS ADEQUATE INFORMATION SHOULD BE PUT ON THE AUTOMATED SYSTEM.

Foster Parent Training Regulations

The Department of Social Services does not require foster parents to fulfill training requirements as required by regulation. The Council sampled 105 foster parent licensing files from ten counties and found that 64% (30 of 47) of the new foster parents were not receiving the required ten hours of preservice training prior to licensure. Further, in 50% (86 of 172) of the instances, the foster parents did not receive the required five hours of training prior to relicensure. Moreover, for

44% (30 of 68) of the foster parents, these deficiencies persisted for two or more years.

Through foster parent training, the agency expects to assure better-qualified foster parents, decrease turnover in foster parent population and reduce replacement of children. In addition, training provides the foster parents with a clear understanding of their role and the roles of natural parents and the placement agency in respect to the child in care.

Instead of mandating that training requirements are met prior to licensure, DSS is giving the foster parents temporary and "irregular" licenses when the training requirements are not met. However, DSS regulations do not provide for temporary and "irregular" licenses. The Council asked the DSS Director of Children's Services why foster parents are not meeting the training requirements. The Director stated that some of the smaller counties wait until there are several foster parents in need of training before sessions are held; parents for any number of reasons may refuse to attend training; and, the county may not place much emphasis on the importance of training. The Director said that DSS is not enforcing the regulations because the counties need the foster homes, and they will not remove a child if the foster parents do not meet the training requirements. However, the Director of Children's Services added that the Regulation is important and that DSS should not relax its requirements.

DSS Regulation 114-5-50(h) states "Foster parents must have a minimum of ten hours of appropriate foster care preservice training prior to licensure..." and "The foster parents will subsequently be required to complete a minimum of five hours training prior to the annual relicensure..."

By not enforcing R114-5-50, DSS cannot assure that foster parents are being adequately trained. This decreases the assurance that children in foster care are provided adequate care.

RECOMMENDATION

FOSTER PARENT LICENSES SHOULD NOT BE ISSUED UNTIL TRAINING REQUIREMENTS ARE FULFILLED.

Improvements Made in Child Development Program

DSS Division of Child Development (DCD) has acted on all the areas that the Audit Council recommended for improvement in its 1981 audit of the Division. The Council recommended that direct operation of child development facilities be discontinued and that services be provided through contractual agreements. As of December 1983, the total number of children in direct operation facilities decreased by 35%. By November 1983, entire programs in four counties were transferred to contractual providers.

The Council also recommended that the Division implement a system for logging information on reports of complaints that are received. DCD has implemented a logging system for child abuse and neglect and regulatory complaints. These complaints are summarized on an annual basis to identify problem areas, trends and habitual offenders.

Further, the Council recommended that standard fire safety regulations and a standard checklist be adopted and used by all authorities inspecting day care facilities. The State Fire Marshal had developed a training

program for inspectors and one fire safety code is beng applied statewide. In addition, a standard checklist is utilized during inspections and no other form is acceptable.

# CHAPTER III

# FRAUD, ABUSE AND DEBT COLLECTION

## Medicaid Fraud and Abuse

The Council reviewed State efforts for combatting fraud and abuse in the Medicaid Program and found problems which must be addressed before Medicaid fraud and abuse can be controlled.

### No State Medicaid Fraud Laws

South Carolina does not have a Medicaid fraud law. State laws do not adequately prohibit doctors, dentists, nursing home owners or other Medicaid providers from defrauding the Department of Social Services of Medicaid funds. Medicaid fraud must be prosecuted under existing statutes such as "obtaining signature or property by false pretense" (a misdemeanor). Additionally, it is only illegal if Medicaid funds are actually paid. It is not illegal to file a false claim if the Department of Social Services discovers it is false and does not pay the claim.

Furthermore, nursing home owners have received Medicaid funds for non-existent board meetings, travel to check on investments, and other non-related Medicaid business. These activities are considered "non-allowable" as opposed to fraudulent.

Also, State law does not adequately address the "misuse" of patients' personal funds. For example, one nursing home owner transferred approximately $17,000 from the patients' personal need funds to his nursing home account. This money was used in the purchase of another nursing home. According to officials from the Attorney General's Office, these funds were repaid after an investigation started. Because

it could not be proven that this individual intended to permanently deprive the patients of their money, no indictments were sought. This type of abuse of patient funds is not illegal under South Carolina law.

State law does not address Medicaid clients loaning their Medicaid cards to non-Medicaid clients. The Department of Social Services discovered seven instances of "card-loaning" in a seven month period. It is not illegal to loan cards unless DSS pays for medical services not entitled.

In its 1977 audit of the Department of Social Services, the Audit Council recommended that specific State Medicaid fraud laws be enacted. In other areas, penalties are prescribed for fraud and abuse. Section 38-9-310 of the South Carolina Code of Laws makes it illegal for doctors, dentists or other providers to file a false insurance claim. Additionally, the State passed specific legislation in 1976 making it a felony to defraud the Department of Social Services of more than $1,000 in food stamps.

The Governor's Office has recommended that State Medicaid fraud laws be enacted. Furthermore, the Federal Inspector General's Office has a Medicaid Fraud Model Law available for states to adopt. This law makes it a felony, with penalties up to five years imprisonment and $50,000 in fines, to submit a false claim, regardless of whether the claim is paid.

Without strict and adequate State fraud laws, there is little deterrence to Medicaid fraud. The Attorney General's Office, responsible for prosecuting fraud, cannot be effective without adequate statutes to indict and convict offenders.

In 1983 State Medicaid fraud legislation was introduced but did not pass. As of July 1984, no State Medicaid fraud laws existed.

Medicaid Abuse

There is little deterrence to prevent Medicaid providers from abusing the Medicaid program for financial gain. According to federal reports, fraud and abuse may be costing the State's Medicaid program $14 million annually. The strongest sanction imposed on providers by DSS when caught receiving overpayments or payment for services not rendered, is to repay the funds (except for one suspended from participation). No fine or interest can be assessed by law. The following is the manner in which some providers received Medicaid funds not due.

- At least 25 providers, such as doctors and dentists, filed and were paid duplicate claims.
- One doctor was discovered overbilling Medicaid $11,000 one year. The next year he was found overbilling Medicaid $4,240. He was warned to cease this practice.
- Providers billing for patients that did not attend their appointments.
- Billing for filling the same tooth on different days.
- Billing for service twice in a day when patient was seen once.
- Billing for services not documented in medical records.
- Overbilling for surgery.
- Billing for services which Medicare would pay.
- Billing for injections when drugs were given orally.
- Billing for services not medically necessary.
- Over-utilizing services to Medicaid patients.
- Billing for an emergency examination when regular office visit was provided.

These are examples of what the Department of Social Services considers "abuse" of the Medicaid program. Because they are considered "abuses" by the Department, they are not sent to the Attorney General for investigation for criminal violations.

Stronger administrative sanctions allowing the Department of Social Services to impose fines and interest payments on funds wrongfully received would provide more incentive to file correct claims. For example, the State of Georgia can fine Medicaid providers who obtain Medicaid funds not entitled, or obtain more funds than entitled. Section 99-4607.2 of the Georgia Code of Laws allows fines of "... three times the amount of any such excess benefit or payment. Additionally, interest on the penalty shall be paid at the rate of 12 percent per annum from the date of payment of any such excessive amount, or from the date of receipt of any claim for an excessive amount when no payment has been made, until the date of payment of such penalty to the department."

Also, the federal government can fine providers up to $2,000 and two times the amount wrongfully claimed for each false claim filed.

Without strong penalties for filing erroneous or improper claims, there is little assurance that Medicaid pays only proper and necessary medical claims. Federal officials have estimated that approximately 5% of Medicaid funds expended are consumed through fraud and abuse. This could have cost the South Carolina Medicaid program over $14 million in FY 82-83. (DSS identified and recouped approximately $450,000 in improper payments from July 1982 to December 1983, only 3% of possible Medicaid fraud and abuse in the State).

The Department of Social Services does not have the authority to fine providers or impose interest for improper claims. DSS does have authority to suspend or terminate providers from participating in the Medicaid program. However, since July 1982, only one provider, found to be practicing medicine without a license, has been suspended. Those not barred from participation in Medicaid include one losing his

license to practice medicine, one owing the State over $1 million, and others abusing the Medicaid program.

Use of Federal Funds to Combat Fraud

The Attorney General's Office has not taken advantage of all federal funding available to fund its Medicaid Fraud Unit. As a result, the State is paying more than necessary to investigate suspected Medicaid fraud cases.

Medicaid fraud units certified by the federal government are eligible to receive 90% of their operating costs from federal funds. These funds can be used for salaries, computers, automobiles, typewriters and other operating costs. After three years, the federal share drops to 75%. Because the Attorney General's unit is not a federally certified fraud unit, only 50% of its funding is federal. Title 42, Section 42:455.300 of the Code of Federal Regulations outlines the requirements the State must meet in order to be federally certified. The Attorney General's Office Medicaid Fraud Unit has the minimum number of staff positions outlined in these regulations.

North Carolina and Florida have had Medicaid Fraud Units certified to receive federal funding since 1979. Additionally, the establishment of a federally certified Medicaid Fraud Unit in South Carolina has been supported by the Governor's Office.

By not taking advantage of all resources available at the federal level, the State is paying more than necessary to investigate Medicaid fraud allegations. Not using 90% federal funding cost the State over $80,000 in FY 82-83 and FY 83-84. Furthermore, the State could have used State funds appropriated to match federal funds to employ more

attorneys and investigators to combat fraud at no additional cost to the State. That is, $30,000 in State funds could be used to bring in $270,000 in federal funds. North Carolina is federally certified and has a staff of 17 attorneys, investigators and auditors. Florida, also certified, employs a professional staff of 33. South Carolina only had one attorney and two investigators as of January 1984.

According to officials in the Attorney General's Office, they will conduct an evaluation concerning the certification of the unit for federal grant purposes.

RECOMMENDATIONS

IT IS NECESSARY THAT THE GENERAL ASSEMBLY ENACT LEGISLATION TO DEFINE AND PROHIBIT MEDICAID FRAUD. THE MEDICAID MODEL FRAUD LAW COULD SERVE AS AN EXAMPLE.

THE GENERAL ASSEMBLY SHOULD ENACT LEGISLATION TO ALLOW FOR CIVIL FINES AND PENALTIES TO BE LEVIED UPON PROVIDERS OBTAINING MEDICAID FUNDS AS A RESULT OF FILING ERRONEOUS CLAIMS.

THE ATTORNEY GENERAL'S OFFICE SHOULD TAKE STEPS TO BECOME FEDERALLY CERTIFIED TO RECEIVE 90% MATCHING FUNDS FOR THE MEDICAID FRAUD UNIT.

Division of Investigation, Projects FAIR and Integrity Reviews

The Audit Council reviewed the Division of Investigation and Project Integrity and found that each section fulfilled their responsibilities in an effective manner. The activities of both sections serve as examples of the types of efforts necessary to reduce waste, control error rates and improve follow-up on client claims in DSS programs.

Between July 1, 1982 and July 1, 1983, the Division of Investigation (DOI) received approximately 900 potential fraud cases for review. The Audit Council examined 298 of these cases. The sampled cases showed that, of the individuals referred to solicitors for prosecution by DOI, 97.9% were convicted of welfare fraud. The courts ordered restitution of the fraudulently obtained benefits in 87.2% of these cases. The total restitution ordered on the DOI referred cases sampled by the Audit Council was in excess of $110,000. Additionally, DOI was responsible for arranging for more than $81,000 in administrative repayments from the sampled cases.

Project Integrity (PI), located in the DSS Office of Audit and Control, performs management Evaluations and Eligibility Reviews of County Food Stamp operations. Project Integrity performs 15 county reviews yearly. The Eligibility Reviews conducted by PI are effective tools for targeting program problem areas. Project Integrity Eligibility Reviews have incorporated media participation to broaden the public knowledge of Food Stamp program reviews for fraud, waste and abuse. The sampling techniques used by Project Integrity, which include error prone case identification and computer matching, have been recommended by federal officials as effective new techniques for identifying program errors. Federal officials have praised the Project Integrity operation for its creativity and national leadership.

Project FAIR (Fighting Abuse through Investigation and Recoupment) was also reviewed. This Project has also been cited by federal officials for its contributions to the investigation of food stamp fraud. DSS documents indicate an average increase of nearly $190,000 per month in overpayments found for the period January 1983 through June 1983 over those established from July 1982 through December 1982.

Collection of Welfare Debts

The Audit Council examined records of funds owed DSS and found DSS is not attempting to recoup over $6.6 million in delinquent debts. An additional $498,000 in court-ordered restitution is deliquent. These debts are owed by doctors, dentists, hospitals, nursing homes and welfare recipients. The following problems were found in DSS's collection efforts.

Medicaid Debts

The Department of Social Services has not taken steps to recoup over $2.8 million in delinquent Medicaid debts owed the agency. These debts consist of funds obtained by fraud, overpayments to providers, duplicate payments to providers and other reasons for wrongful payment.

As of December 1983, approximately $2.8 million of the $5.6 million in Medicaid funds owed the agency was delinquent. The amount of delinquent Medicaid debts has increased from $1 million in April 1981 to $2.8 in December 1983. Regardless of whether DSS recoups the funds, the federal share of Medicaid debts must be repaid to the federal government. However, DSS has still not made efforts to recoup funds owed the agency. Table 4 lists examples of Medicaid debts not collected by DSS.

TABLE 4

EXAMPLES OF PROVIDERS OWING DSS MEDICAID FUNDS

| Provider | Date Debt Established | Amount[1] Owed | Amount[1] Collected by DSS |
|---|---|---|---|
| Doctor | 05/82 | $ 3,124 | 0 |
| Doctor | 08/79 | 27,083 | 0 |
| Nursing Home | 06/79 | 18,028 | 0 |
| Nursing Home | 08/81 | 15,832 | 0 |
| Pharmacy | 11/81 | 7,158 | 0 |
| Pharmacy | 11/81 | 1,498 | 0 |
| Hospital | 10/79 | 4,344 | 0 |
| Hospital | 07/79 | 3,409 | 0 |
| Hospital | 10/82 | 7,052 | 0 |

[1]As of December 1983

Source: DSS Records

Section 42 of the 1983-84 State Appropriation Act requires DSS to "...recoup all refunds and identified program overpayments and all such overpayments shall be recouped in accordance with established collection policy."

DSS policy pertaining to delinquent accounts requires the DSS legal department to collect delinquent accounts. North Carolina, Georgia and the federal government have recently enacted legislation to more efficiently collect debts. New efforts include tax refund intercepts and wage garnishments.

By not collecting money owed the State, DSS is expending more than necessary to provide medical services to the needy. In addition, when DSS allows doctors, pharmacists and other providers to keep public funds wrongfully obtained, there is little incentive for other Medicaid recipients to repay funds wrongfully obtained. Further,

additional State funds must be used to repay the federal government its share of Medicaid funds owed. As of December 1983, DSS had to repay the federal government approximately $2.3 million for debts not collected.

DSS has not attempted to recoup debts owed the agency for several reasons. First, the agency has no policies or procedures for the legal department to follow for collecting delinquent debts. The DSS legal department, responsible for collections, has not assigned an attorney to be in charge of collecting debts. Neither has the DSS legal section implemented civil action against providers owing money. Further, DSS does not send reminder notices when debts are not paid. There is no evidence the agency has reminded those owing money that their payments are due.

Additionally, the State has no policies or procedures for agencies to follow in collecting accounts. Neither does State law allow agencies to garnish wages or tax refunds for those owing agencies money.

Falsely Obtained Welfare Benefits

State and County Departments of Social Services collection efforts of falsely obtained welfare benefits are inadequate. As of January 1984, over $3.8 million was owed DSS on more than 6,700 accounts, and DSS was not attempting to collect these debts.

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During the course of this audit, DSS contracted with a private attorney for the collection of 20 delinquent Medicaid accounts of approximately $100,000. DSS officials stated if this was successful they would contract for the collection of more accounts.

The Department of Social Services' State and County Offices are responsible for the collection of debts. Approximately 40% (29 of 70) of the AFDC and Food Stamp debts in four counties sampled by the Audit Council were in arrears. Over 20% of these debts were 90 days or more delinquent. Additionally, internal audits prepared by DSS indicate that four additional counties they reviewed, from January 1983 to December 1983, did not appropriately follow-up on collections of overissued benefits.

Both the State and County offices are responsible for collecting debts. The DSS Finance Manual states that DSS's General Counsel has the primary responsibility and authority to collect debts. Also, claims are filed by counties against DSS clients who have erroneously received funds. DSS policy for the Food Stamp Program states that if a household fails to make a scheduled repayment, it is the county's responsibility to send a Notice of Payment Past Due. If a client fails to repay a claim that has been determined to be the result of fraud, the claim is to be referred to the County Review Board for review and possible prosecution in magistrate's court.

DSS policy in the AFDC Program requires that recovery of AFDC overissuances will be made automatically for current recipients. The county is required to send a request for payment to a former recipient. If the client fails to respond within ten days to a second notice, the case is referred to General Counsel for necessary action.

Department of Social Services documents indicate that only nine of the delinquencies noted in the sample had been sent late notices or referred to magistrate's court for legal action by counties. In one of the four counties, no one had been assigned responsibility for follow-up. DSS county officials also indicated that they have no policy for publicizing fraud convictions.

Officials in each of the sampled counties cited the time consuming nature of the follow-up process as a factor contributing to the low collection rate. The lack of an automated collection system dictates this manual follow-up. DSS internal audit documents also cite a failure to follow policy manual instructions, inadequate training and a lack of staff as causal factors.

Additionally, DSS's General Counsel has no written policy or procedures concerning the collection of debts. General Counsel does not send late notices to delinquent clients, and no attorney has been assigned responsibility for collections.

Further, the State does not have statutes permitting collection of Food Stamp or AFDC debt through a tax refund offset. In 1979, North Carolina enacted legislation which allows "claimant agencies" to submit delinquent clients' names for tax refund offsets. Georgia passed a similar law in 1980. In 1982, the federal government passed the Federal Debt Collection Act, which provides for private collection agency participation, federal tax refund offset, federal employee wage garnishment and the application of penalty and interest charges to delinquent accounts to collect federal debts. In 1983, South Carolina passed legislation to allow for a tax intercept to collect past due child support payments.

By not following up on collections, the deterrent effect of the collection of overissued funds is lost. Further, public confidence is eroded in social welfare programs when adequate measures to prevent fraud and abuse are not taken.

According to DSS records as of January 1984, there is $3.8 million in Food Stamp and AFDC delinquent accounts. Federal law permits states to retain 50% of all recovered fraud overissuances and 25% of all

non-fraud recoveries. By not collecting these overissued benefits, the State could be foregoing $1 million in potential revenue.

Court-Ordered Restitution of Welfare Fraud

Court-ordered restitution of more than $498,000 in fraudulently obtained welfare benefits has not been collected by the Department of Social Services. Between 1977 and 1982, the courts ordered 409 persons to repay welfare funds which were fraudulently obtained. Agency documents indicate that as of March 1983, 183 (45%) persons were delinquent in repayment. Of these, 72 were six months or more past due.

Restitution is often ordered by the courts as a part of the sentence given to those convicted of welfare fraud. In 20 counties, 50% or less of the individuals required to make restitution were current in their payments as of June 1983. There is no evidence that DSS or Probation officials are adequately addressing the problem of collecting the delinquent debts.

DSS, probation officials and the courts are all responsible for collecting funds ordered by the courts to be repaid. DSS Policy requires, in part, that if an individual does not make restitution as ordered by the court, the county will notify the court on a monthly basis until the court notifies the county of the disposition of the matter. There is no evidence that this is being done by each county.

Probation officials are responsible for notifying judges when individuals do not make restitution of funds as ordered. The courts have the responsibility to review individual cases and determine the appropriate action to be taken. There is evidence that coordination between DSS

county offices, probation officials and the courts in many counties has been inadequate to ensure repayment.

Some counties have been successful in collecting restitution. DSS records indicate that 15 counties have collection rates of 85% or greater in court-ordered restitution cases. The Audit Council contacted four of these counties. The counties' responses indicated that the keys to their high rate of collection were sending reminder notices, monitoring client repayment schedules, developing good relationships with court officials and maintaining an aggressive collection policy. None of the counties contacted indicated that they had taken extraordinary measures to ensure collections.

Federal law permits states to keep half of all recoveries of welfare fund related overissuances. As of March 1983, the State share of the total uncollected court-ordered restitution was $249,000. In one county alone, approximately $164,000 in outstanding balances remain in accounts of clients who were convicted of fraud in 1977 and 1978.

Adequate efforts to enforce court-ordered restitution are necessary to provide the proper deterrence to fraud in government benefit programs and to return lost tax dollars. Further, if funds are not collected after court-ordered restitution requirements are imposed, the deterrent to defrauding the government is diminished. Confidence in social programs is eroded when individuals are found defrauding the government, ordered to repay the funds, and do not do so.

Restitution is not collected because the agencies responsible for collections have not taken measures to ensure repayment of DSS funds. For example, one county's DSS officials, the Clerk of Court and

Parole and Community Corrections (DPCC) officials were aware of the arrearages, yet no action was taken concerning these debts, and restitution remained six or more months delinquent in 18 cases as of June 1983.

Additionally, reviews of all 72 cases which were six or more months in arrears were not conducted after DPCC was notified of the problem by the DSS Director of the Division of Investigation. At least six individuals, owing $11,269, have had their probation expire prior to making full restitution. Because their probation expired, these individuals are no longer required by law to repay the funds.

A DSS internal audit of one county revealed that the county was not actively pursuing the court-ordered restitution claims because the probation periods had expired on all those sentenced in 1977 or 1978. State law provides that the period of probation shall not exceed five years. However, the State Office had not sought civil remedy against these households once probation had expired to recoup the funds.

Medicaid Funds Improperly Paid Nursing Homes

The Department of Social Services is not recouping Medicaid funds paid nursing homes and other long term care facilities for patients not properly recertified to receive Medicaid. The State faces federal penalties, such as those imposed in North Carolina and Georgia, for not recouping these funds. Agency records indicate that approximately $71,000 was owed the Department by only 13 facilities in August 1983. DSS estimates that over $670,000 may be owed by all long-term care facilities.

Federal law requires Medicaid patients to be recertified by a physician every 60 days. Recertification in part means that a patient still is in

need of nursing home care and can continue to receive Medicaid funding. If the recertification is done on the 61st day, the recertification is one day late. The facility is not eligible for Medicaid for the patient that day. For example, one patient's recertification was due June 15, 1983. Not until September 28, 1983, 105 days later, was the recertification performed. This facility was paid Medicaid funds for the 105 days that the patient was not recertified.

The Department of Health and Environmental Control inspects nursing homes in part to ensure that recertifications are performed when required. These reports are forwarded to the Department of Social Services. DSS is responsible for recouping funds paid until the recertification is performed.

Federal Medicaid Regulations 42:456.260 and 360 require that physicians recertify that nursing home services are needed for each Medicaid patient every 60 days. The Department of Social Services officials have known since at least May 1983 that they are required to recoup funds paid for patients not recertified or face Federal fines. A letter from the Atlanta Regional Office of the Department of Health and Human Services dated May 17, 1983 reinforces federal regulations. This letter states in part:

> These regulations are exact and are not subject to liberalization. Please note, also, that the 1903 (g) (Social Security Act) penalty clause is administered using these regulations as guidelines.

In April 1983, DSS sent a letter to long-term care facilities warning them that payment may be recouped if recertifications were not performed in a timely manner. Additionally, another letter sent to all long-term care facilities by DSS dated July 20, 1983, regarding this, stated:

> Each nursing home administrator must make certain that this requirement is met each 60 days. Our only recourse, to avoid penalty, is to recoup all money paid to any home for each day in which recertifications are missed or in which the time period exceeds sixty days, by even one day.

In February 1984, nursing homes were again warned funds would be recouped for late recertifications. By not recouping funds paid for patients not recertified, the State faces federal penalties. Georgia, North Carolina and Florida were fined over $500,000 for not recouping funds paid for patients not recertified. Colorado was fined over $21,000 for one patient recertified one day late, and lost an appeal of this fine.

In addition, when the Department of Social Services fails to recoup funds identified as wrongfully paid, the integrity and public confidence of the Medicaid program is undermined. It is unfair to other providers that must repay funds wrongfully obtained. Some nursing homes are not having patients recertified every 60 days after being warned by DSS twice to do so. Based on DSS records, over $670,000 may have been overpaid.

When asked by the Council why the agency had not taken recoupment action, DSS issued a Medicaid bulletin stating that in the future, funds would be recouped for late recertifications. However, no provisions were made to recoup funds already identified as improperly obtained. DSS officials stated that DHEC records pertaining to recertifications may not be valid. Regardless of these reasons for not recouping funds paid improperly, DSS is liable to repay these funds or face federal fines for not doing so.

RECOMMENDATIONS

THE GENERAL ASSEMBLY SHOULD ENACT LEGISLATION ALLOWING STATE AGENCIES TO GARNISH WAGES AND STATE TAX REFUNDS FOR INDIVIDUALS, CORPORATIONS OR OTHER ENTITIES DELINQUENT IN REPAYMENT OF DEBTS OWED THE STATE. IF LEGISLATION IS NOT ENACTED, THE STATE BUDGET AND CONTROL BOARD SHOULD DEVELOP POLICIES AND PROCEDURES FOR STATE AGENCIES TO FOLLOW IN COLLECTING DEBTS.

THE DEPARTMENT OF SOCIAL SERVICES MUST TAKE STEPS TO IMPROVE ITS COLLECTION OF DEBTS. REMINDER NOTICES SHOULD BE SENT TO THOSE DELINQUENT IN PAYMENT. THE LEGAL SECTION SHOULD ASSIGN AN ATTORNEY TO BE IN CHARGE OF DEBT COLLECTIONS.

ANY AUTOMATED SYSTEM ADOPTED BY DSS FOR THE FOOD STAMP PROGRAM AND AFDC PROGRAMS SHOULD INCLUDE, AS A COMPONENT, A MECHANISM WHICH WOULD IDENTIFY DELINQUENT CLAIMS AND AUTOMATICALLY GENERATE LATE NOTICES. COUNTY PERSONNEL COULD THEN INITIATE APPROPRIATE ACTION.

DSS SHOULD SEEK CIVIL REMEDY IN CASES WHERE PROBATION HAS EXPIRED AND COURT-ORDERED RESTITUTION HAS NOT BEEN MADE.

DSS AND THE DEPARTMENT OF PAROLE AND COMMUNITY CORRECTIONS SHOULD REVIEW ALL DELINQUENT RESTITUTION CASES. DSS AND DPCC SHOULD FORM A TASK FORCE TO DETERMINE A SOLUTION TO COLLECTING FUNDS ORDERED TO BE PAID BY THE COURTS.

DSS SHOULD CONSIDER PUBLICIZING AFDC AND FOOD STAMP FRAUD CONVICTIONS ON A MORE FREQUENT BASIS.

THE DEPARTMENT SHOULD RECOUP MEDICAID FUNDS PAID LONG TERM CARE FACILITIES FOR PATIENTS FOR ALL DAYS PAST 60 UNTIL THE PATIENT WAS RECERTIFIED.

County Reviews of Potential Fraud

A review of four county DSS offices revealed the need for improvement of the fraud review process in three counties. The following are examples:

a. One county did not review all of the AFDC and Food Stamp cases to determine if a referral to the Division of Investigation was necessary. In this county, only those cases which were being considered for referral to Magistrate's Court were reviewed by the County Review Board.

b. A second county's Review Board did not meet on a timely basis. This county's Review Board met in only four months from February 1983 through January 1984.

c. A third county did not refer two cases of more than $1,000 to the Division of Investigation, as required. The county decided to handle the cases administratively rather than refer them for potential prosecution.

The County Review Board is the county's claims referral unit. The members determine if potential fraud or wrongdoing occurred and what course of action will be taken in cases presented by the county claims workers. The Review Board may refer cases to the Division of Investigation in the State Office, direct prosecution to magistrate's court or determine that administrative recovery at the county level is appropriate.

The DSS Policy and Procedures Manual for the AFDC and Food Stamp Programs states:

> The CRB (County Review Board) must meet at least one time each month. A written record of the action of the CRB will be maintained.

Additionally, the Manual states that the Review Board will review all cases involving intentional program violations by individuals participating in the AFDC, Food Stamp or Medicaid programs.

Further, the Programs Manual states that the following criteria are necessary for referral to the Division of Investigation:

a. Food Stamp claim of $1,000 or more;

b. The AFDC and Medicaid claim exceeds $500;

c. Any combination case of $1,000 or more;

d. The CRB determines that the case is serious or complicated enough to warrant prosecution.

It is not clear, however, what the CRB is required to determine to fulfill the criteria for (d) above. For example, one sentence in the Manual states that "the CRB will determine if fraud is suspected." In the following sentence it states that "the CRB will refer claims...when they have determined fraud exists." According to DSS officials, confusion over the interpretation of DSS policy regarding case referrals has resulted from this lack of clarity.

Additionally, the Office of Audit and Control in the State Office did not monitor county compliance with Review Board regulations prior to October 1, 1983. Although County Review Boards were established in September 1982, the maintenance of written records was not required prior to October 1983 and no responsibility for the monitoring of compliance by the counties had been assigned.

Action on a potential overissuance or fraudulent claim is delayed when a county claims worker does not properly present all cases to the County Review Board. By not meeting monthly, a board can stop the case referral process and leave discretion regarding the referral of cases to the claims worker. The lack of proper referrals of suspected fraud cases over $1,000 to the Division of Investigation circumvents the established process for the investigation of fraud. Therefore, there is no assurance that those who may be violating State laws will be properly investigated.

RECOMMENDATIONS

DSS SHOULD CLARIFY COUNTY REVIEW BOARD POLICY IN THE FOOD STAMP-AFDC PROGRAMS MANUAL TO AVOID CONFUSION REGARDING THE

REFERRAL PROCESS, AND NOTIFY COUNTIES OF THE CLARIFICATION.

DSS SHOULD TAKE STEPS TO BRING COUNTIES INTO COMPLIANCE WITH A CLARIFIED FRAUD REVIEW POLICY.

Sanctions for Error Rates

The Council reviewed error rates in the Food Stamp, AFDC and Medicaid programs and found the rates to be higher than the federal "tolerable" level. Payment for clients who are not eligible to receive the service or benefit is considered an error. A payment error rate is the percentage of funds paid in South Carolina for clients not eligible to receive the service or benefit. Because the amount of errors is considered excessive by the federal government, the State faces sanctions, or reductions in federal funding, in these programs. These problems are discussed below.

Sanctions in Food Stamp and AFDC Programs

The Department of Social Services faces sanctions of $1,549,035 in the AFDC Program, and $627,382 in the Food Stamp Program based on the October 1982-September 1983 Quality Control reporting period. DSS did not reduce their error rates to the levels required by the federal government for that period. Errors include overpayments to eligible clients, as well as payments to those who are ineligible under program regulations.

Federal guidelines for federal FY 82-83 indicate that the allowable error rate in the AFDC program was 4% and the allowable error rate in the Food Stamp Program was 9%. South Carolina's error rates were 6.919% and 9.9067% respectively.

Federal regulations provide that a sanction of 1% of the total program funds for each 1% above the target shall be imposed should a state fail to meet the established target error rate in the AFDC Program. This sanction amount will be deducted from the program funds provided to the State by the federal government. In the Food Stamp Program, a sanction of 5% of federally contributed administrative funds is required for each of the first three percentage points, or portions thereof, that a state misses its target.

DSS has not adequately reduced the error rates in the AFDC and Food Stamp Programs primarily due to a lack of sophisticated systems through which potential errors can be identified and avoided (see p. 109). The lack of adequate automated systems precludes the use of the most advanced techniques for identifying potential errors such as error-prone profiles and computer data matching.

For example, over 68% of the errors in the Food Stamp Program and 51% of the errors in the AFDC program are related to providing incorrect client information on family income or benefits. The United States' Department of Health and Human Services (HHS) encourages the use of computer systems to enhance program efficiency in the AFDC program. HHS provides a 90% match to states for the development of automated Family Assistance Programs. An HHS regional official stated that Georgia's management of the AFDC caseload has improved since the implementation of such a system.

The United States Department of Agriculture (USDA) strongly supports computer matching as a method of determining inaccurate reporting information. A USDA audit using computer matching techniques in Tennessee was successful in detecting misinformation in food stamp accounts. Additionally, the error rate in the Alabama Food Stamp Program during the 1983 reporting period was nearly 2% lower than the error rate in South Carolina. Alabama officials contacted by the Audit Council attribute their success, to a large degree, to their automated system and the matching options it provides.

Further, a USDA test project in North Carolina using error prone profiles to identify those accounts most likely to contain errors reduced the error rate in Mecklenburg County 10-15%, according to researchers at the Research Triangle Institute.

As a result of the sanctions imposed upon DSS program and administrative funds by the federal government, the State will be required to pay a larger percentage of the costs of the AFDC and Food Stamp Programs. Because of excessive error rates during the October 1982-September 1983 reporting period, sanctions imposed by USDA and HHS could total over $2.1 million in the AFDC and Food Stamp programs.

Medicaid Sanctions for Error Rate

The State's Medicaid Program faces reductions in federal funding for having a payment error rate of 5.68%, 2.68 percentage points higher than the federal "tolerance" level. This could cost the State approximately $5 million in reduced Medicaid funds in federal FY 84-85 if the error rate is not reduced to the federal "tolerance" level. An error is considered improper Medicaid payment for an individual or family ineligible to

receive a Medicaid service. The federal government allows states to have an error rate of up to 3% before imposing sanctions or reductions in federal funds.

In January 1984, the federal government notified DSS they would be sanctioned approximately $4.8 million in federal FY 83-84 for projected error rates above 3%. However, DSS won an appeal of this sanction until October 1984. If projected error rates are not reduced to acceptable federal levels by that time, the State could lose federal funds. DSS officials stated they are doubtful the error rate will be below 5.68% by October 1984.

Federal regulations effective January 1984 require reductions in Medicaid funds by the percentage over the 3% "tolerance level." The purpose of sanctions is to encourage states to reduce erroneous payment of Medicaid funds. North Carolina and Georgia had projected Medicaid error rates of only 1.4% and 2.41% in 1984 compared to South Carolina's rate of 5.68%.

The effect of federal sanctions on the State is more State funds will have to be used to make up the loss or the Medicaid program budget will have to be reduced. Also, high error rates mean a large amount of Medicaid funds are being spent on persons not eligible for the governmental program.

According to DSS staff and agency records, the primary cause of Medicaid errors is the agency not properly verifying institutional clients' property, bank accounts, trusts, inheritances and income. Also, the agency does not follow up on inconsistent client information or changes in status. Agency error accounts for 69% of the error rate. Client error, such as failure to report changes in income, accounts for 31% of the error rate.

DSS has instituted measures to reduce the error rate. The agency has required counties to perform a quality assurance review of all 9,000 institutional cases to determine any error. These cases will then be reviewed by State Office staff for accuracy.

Further, the Quality Control Division of DSS is conducting reviews of Medicaid files in certain counties. The Division shows county officials what is examined when reviewing cases for errors. Additional corrective actions have been initiated. However, the impact of these actions on the error rate could not be determined.

RECOMMENDATIONS

THE DEPARTMENT OF SOCIAL SERVICES SHOULD CONTINUE TO DEVELOP AUTOMATED SYSTEMS FOR THE FOOD STAMP AND AFDC PROGRAMS WHICH WILL ALLOW FOR THE IMPLEMENTATION OF MORE SOPHISTICATED TECHNIQUES OF VERIFYING CLIENT INFORMATION.

DSS MUST EMPHASIZE TO COUNTY OFFICE MEDICAID STAFF THE IMPORTANCE OF PROPERLY VERIFYING THE ELIGIBILITY OF MEDICAID CLIENTS. ANY QUESTIONS CONCERNING A CASE SHOULD BE REFERRED TO STATE OFFICE STAFF.

DSS STAFF SHOULD CONTINUE WORKING WITH COUNTY OFFICES IN AN EFFORT TO REDUCE THE MEDICAID ERROR RATE.

## Assignment of Support in AFDC Program

State law does not permit the automatic assignment of support rights to DSS by an AFDC client upon the completion and signing of an application for assistance. AFDC recipients are required by law to assign their rights to child support payments to DSS. According to agency records, DSS faces federal administrative fund reductions of approximately $119,000 in the AFDC Program because of errors made by incorrectly assigning support. DSS Quality Control Reports for the period April-September 1983 indicate that incorrect assignment of support is the fourth highest cause of error in the AFDC program.

While South Carolina has a separate form to be filled out on each child for an absent father, other states make the assignment of support payment rights an "operation of law." States such as Georgia, North Carolina, Tennessee and Kentucky all have legislation whereby assignment of support is made to the state by filling out an application and accepting public assistance. Assignment is automatic and does not require that a separate form be completed or that the agency determine the correct absent father at the time of application.

If the assignment of support form completed by the client is incorrect or absent from the case file, the case is deemed to be in error according to Quality Control criteria. For example, if an applicant has three children and the children have different fathers, DSS must establish the correct father for each child. If the information provided to DSS on the fathers proves incorrect, the case will be classified as in error. It would not be necessary for DSS to identify the correct father at the time of application if the assignment was made automatic by law.

Additionally, DSS has been slow to initiate action to get the legislation changed. DSS documents indicate that the issue has been discussed

internally for three years, but the Department had not formally requested legislative changes until February 1984.

The State cannot efficiently administer the AFDC Program without adequate statutes. The State's AFDC Program is facing $1,549,035 in federal sanctions as a result of excessive errors made during the October 1982-September 1983 reporting period (see p. 67). The elimination of the errors caused by inadequate assignment of support would have reduced the potential sanction amount during this reporting period by $119,000.

RECOMMENDATIONS

THE GENERAL ASSEMBLY SHOULD ADOPT LEGISLATION WHICH WOULD PROVIDE FOR MAKING ASSIGNMENT OF SUPPORT RIGHTS AUTOMATIC UPON MAKING APPLICATION FOR AFDC BENEFITS.

DSS SHOULD CONSOLIDATE ITS ASSIGNMENT OF SUPPORT FORMS TO THE APPLICATION FOR AFDC FORM.

County Implementation of Corrective Action Plans

County offices are not implementing procedures to correct Food Stamp program deficiencies found by agency officials. According to internal audit reports prepared by the Department of Social Services for the period January 1983 through December 1983, seven of 15 counties reviewed could not show evidence that corrective action had been taken

on deficiencies found and addressed in the DSS Corrective Action Plans.

A Corrective Action Plan is a means of identifying program deficiencies and ensuring that action is taken to eliminate those deficiencies. These deficiencies included providing clients with too many food stamps and a lack of county verification of client resources. For example, two counties could not demonstrate that they had taken measures to correct problems related to the improper completion of the forms used to determine the amount of monthly benefits a client receives. In another county, evidence that corrective action to address the county's lack of verification procedures for client income and benefits was not present. Overissuance is often the result of unreported income and benefits.

The DSS Policy and Procedures Manual for the AFDC and Food Stamp Programs states that each county office must maintain a Corrective Action Plan. Additionally, the county must submit a report to the State Office which outlines the success or failure of the corrective actions taken by the county in response to internal audit findings. Unsuccessful attempts at corrective action are subject to review and the county plan is revised appropriately.

If counties do not implement their Corrective Action Plans, program errors will continue. Federal legislation authorizes the Department of Agriculture to withhold federal funds if a state's error rate exceeds a federal target error rate. South Carolina's Food Stamp Program faces sanctions because of an excessive error rate (see p. 67). Further sanctions can be anticipated if corrective actions are not taken by the counties.

The counties cited for non-compliance with DSS policy regarding Corrective Action Plans, according to DSS internal audit documents, lacked training and adequate supervision by State and county DSS officials. Additionally, DSS State Office does not make annual reviews of each county operation. Management Evaluations are done by Project Integrity auditors on only 15 counties per year. Further, the State Office does not impose any administrative sanctions on county offices which do not comply with Corrective Action Plans.

RECOMMENDATIONS

STATE FOOD STAMP PROGRAM STAFF SHOULD CLOSELY MONITOR CORRECTIVE ACTION PLAN COMPLIANCE BY COUNTY OFFICES AND TRAIN COUNTY OFFICIALS IN THE METHODS OF SUPERVISION NECESSARY TO ENSURE COUNTY COMPLIANCE WITH THE CORRECTIVE ACTION PLANS.

DEPARTMENT OF SOCIAL SERVICES STATE OFFICE SHOULD CONSIDER DEVELOPING ADMINISTRATIVE SANCTIONS FOR COUNTIES WHICH CONSISTENTLY DO NOT COMPLY WITH CORRECTIVE ACTION PROCEDURES.

## Food Stamp Trafficking Statutes

The enforcement of statutes pertaining to Food Stamp trafficking requires too much staff time. To prosecute food stamp trafficking cases, the Division of Investigation must establish $1,000 worth of trafficking evidence to get a felony conviction. Lowering this amount to $500 would save staff time necessary to obtain a felony conviction.

On January 19, 1984, the Division of Investigation had 113 active food stamp trafficking cases on file. A review of active cases indicated that 72% (82) of those cases had been referred to the Division of Investigation more than six months prior to the sample date. Food stamp trafficking includes the acquisiton or transfer of food stamps except in exchange for food products for human consumption. For example, buying liquor, cigarettes or beer would be considered trafficking. The term trafficking is also used to describe a transaction in which food stamps are sold for cash.

A federal statute provides that any amount over $100 may be classified as a felony. The Director of the Division of Investigation has discussed the possibility of reducing the amount required for a felony conviction in South Carolina with the 16 Circuit Solicitors. According to the Director, they are in agreement that it would be in the best interest of the State to lower the amount required for a felony conviction from $1,000 to $500.

An effect of the current legal requirements for a felony conviction is that trafficking investigations frequently take more than six months to complete. To establish a trafficking case of $1,000, the investigators must sell food stamps to a proprietor or purchase illegal items with food stamps at his place of business. In most cases, the establishment is relatively small so the sale step must be completed many times.

Estimates based on information provided by DSS indicate that approximately $800 of staff time could be saved per case by reducing the amount necessary for a felony conviction from $1,000 to $500. Based on the number of active cases on file at DSS as of January 19, 1984, the increased efficiency of investigating these cases alone would be valued at more than $90,000.

Current State laws regarding felony conviction in food stamp trafficking cases are inadequate. This is because the law requires $1,000 in trafficking to get a felony conviction. Less than $1,000 in trafficking is a misdemeanor which does not serve as great a deterrent to the crime.

RECOMMENDATION

THE GENERAL ASSEMBLY SHOULD CONSIDER AMENDING SECTION 16-13-430 OF THE SOUTH CAROLINA CODE OF LAWS TO LOWER THE DOLLAR AMOUNT NECESSARY FOR A FOOD STAMP TRAFFICKING FELONY CONVICTION FROM $1,000 TO $500.

# CHAPTER IV

# MEDICAID

The Council examined management of the State's Medicaid program and found the following problems.

## Unresolved Prior Medicaid Problems

The following problems, which have been previously reviewed by the Audit Council, have not been resolved.

### Hospital Cost Containment Measures

The Department of Social Services has not implemented cost containment measures in the Hospital program. In its 1982 audit of the Medicaid program, the Audit Council examined various administrative cost containment measures which could be used to help control Medicaid expenditures to hospitals without reducing services. One measure, lowering hospital occupancy rates from 100% to 85%, could have saved $5 million for FY 77-78 and FY 78-79. Statewide hospital occupancy rates (the number of beds occupied) averaged 70%, and lowering the occupancy rate would mean Medicaid would pay less of a share for empty hospital beds.

Other options include disallowing unnecessary weekend admissions and lobbying expenses, and limiting laboratory and X-ray charges to those charged by efficient labs (see p. 87). However, none of these cost containment measures have been implemented.

In addition to administrative adjustments, the Council recommended that the Legislature consider implementing a prospective reimbursement system. This has not been done. Under a prospective reimbursement

method, the State could better control hospital reimbursements. Instead, Medicaid payments to hospitals are based on the old Medicare retrospective reimbursement system. Reimbursements are based on "reasonable costs" as reported to DSS. There are no specific limits on Medicaid reimbursements and, therefore, there is little incentive to contain costs under this type system.

On October 1, 1983, the federal government began phasing in a prospective payment system for Medicare patients. Payments for Medicare patients are based on diagnosis related groupings (DRG's). That is, a fixed rate is paid for a specific diagnosis, regardless of the patient's length of stay in the hospital. This is similar to the State's method for reimbursing physicians in that doctors receive a specified fee based on the service provided the Medicaid patient. Hospitals have incentives to reduce the cost of treating Medicare patients because they know they will only receive a specific payment for services rendered.

According to DSS officials, the agency is monitoring the federal DRG reimbursement system to determine if it can be used for Medicaid reimbursements in South Carolina. DSS is reviewing the DRG system to determine if the federal government will make any modifications.

Nursing Home Reimbursement Guidelines

The Department of Social Services has not revised its method of reimbursing nursing homes caring for Medicaid patients. In its 1982 review of Medicaid expenditures to nursing homes, the Audit Council found that DSS allowed nursing homes to be reimbursed Medicaid funds for unnecessary and questionable expenses. These expenses include items such as luxury automobiles, unnecessary travel, lobbying expenses,

and lease costs which do not contribute to patient care. The Council recommended that DSS develop guidelines specifying allowable costs in the nursing home program.

Nursing home rates paid for Medicaid patients have not been revised since the rates effective January 1981, except for an adjustment to the inflation factor in February 1982. These rates were based on nursing home cost reports for the October 1, 1979 to September 30, 1980 time period.

In February 1983, DSS required nursing homes to submit new cost information in order to update rates. These rates were to be effective July 1, 1983. In addition, the Department amended the Medicaid State Plan pertaining to nursing home reimbursements. This amendment, approved by the United States Department of Health and Human Services, outlined specific allowable costs for which nursing homes could claim Medicaid reimbursement. For example, management fees and salary guidelines, travel policies, and lobbying expense guidelines were established. Maximum profits, automobile costs, and limitations on lease expenses also were incorporated into the amended State Plan.

However, implementation of the amended State plan was challenged in a court suit by affected parties. On June 6, 1983, the case was heard in the federal courts. The Courts ruled that DSS did not comply with procedural requirements of The South Carolina Administrative Procedures Act as set forth in Section 1-23-10 of the South Carolina Code of Laws. The agency was prohibited from making any changes in the nursing home reimbursement methodology unless the Administrative Procedures Act is followed.

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During this review, a new contract for Medicaid payments to nursing homes was being negotiated.

## Intermediate Care Patients Paid at Skilled Rate

The Department of Social Services reimburses nursing homes caring for intermediate care patients at a more costly skilled care rate. In its 1977 and 1982 audits of the DSS Medicaid program, the Audit Council found that DSS reimbursed nursing homes for providing patients higher than necessary levels of care. In 1977, the Council identified 500 intermediate care patients occupying skilled care beds, costing approximately $1.1 million annually. In its 1982 audit, the Council found this number had grown to approximately 3,700 intermediate patients in skilled care beds, costing the State Medicaid program at least an additional $4.3 million annually. According to documents available during this audit, the problem has yet to be resolved.

This problem is caused by several factors. First, skilled dually certified nursing homes can accept intermediate patients. However, because they are licensed as skilled facilities, they have to provide more costly skilled care, although patients do not need such care. Additionally, there are more skilled than intermediate beds in the State, although there are more intermediate than skilled patients statewide.

The Council recommended, in part, that DSS reimburse nursing homes only costs necessary to provide the level of care appropriate to a patient's condition. This could be accomplished by partially relicensing skilled beds to intermediate beds or adjusting rates based on the assessment of patients' conditions or level of care. As of January 1984, the agency had not resolved the problem of paying skilled rates for Medicaid patients classified as needing only intermediate care. Although DSS staff examined several systems of adjusting rates paid skilled nursing facilities caring for intermediate patients, a system has not been implemented.

In November 1982, DSS staff proposed to the DSS Commissioner adjusting rates paid nursing homes based on a patient assessment conducted in June 1982. This assessment, conducted by the Community Long Term Care Program, examined the conditions of approximately 8,500 medicaid nursing home patients so that DSS would have reliable and current information on patient conditions. A system of reimbursing nursing facilities based on the patients' conditions would pay less to skilled facilities caring for intermediate patients.

The Board directed DSS staff, in November 1982, to continue their study of the patient assessment program and report back to the Board. As of January 1984, there is neither evidence that a report was made back to the Board nor that the Board has implemented a system of paying less for intermediate patients occupying skilled nursing home beds.

RECOMMENDATIONS

THE HEALTH AND HUMAN SERVICES FINANCE COMMISSION SHOULD IMPLEMENT A PROSPECTIVE HOSPITAL REIMBURSEMENT SYSTEM FOR MEDICAID REIMBURSEMENTS, SUCH AS THE SYSTEM USED BY THE FEDERAL GOVERNMENT.

IF A PROSPECTIVE REIMBURSEMENT SYSTEM IS NOT IMPLEMENTED, DSS SHOULD IMPLEMENT ADMINISTRATIVE COST CONTAINMENT OPTIONS WHICH DO NOT REDUCE SERVICES TO CLIENTS.

THE DEPARTMENT SHOULD TAKE THE NECESSARY STEPS TO ESTABLISH GUIDELINES OUTLINING ALLOWABLE COSTS IN THE NURSING HOME PROGRAM.

THE GENERAL ASSEMBLY SHOULD TAKE APPROPRIATE ACTION TO ENSURE THE DISCONTINUATION OF PAYING HIGHER THAN NECESSARY RATES FOR INTERMEDIATE PATIENTS OCCUPYING SKILLED NURSING BEDS.

## Medicaid Cost Containment Programs Needed

The Council reviewed Medicaid cost containment measures which could reduce Medicaid costs without reducing services. Some cost containment programs available are as follows.

### Mandatory Second Surgical Opinion Program

The South Carolina Medicaid program does not have a mandatory second surgical opinion program (SSOP). Although DSS will reimburse second surgical opinions patients seek voluntarily, the agency has not analyzed the voluntary program cost savings or analyzed the potential cost savings from a mandatory SSOP. Other states have realized significant cost savings in their mandatory second surgical opinion programs. For example:

- The Massachusetts SSOP was mandated by the legislature in 1976. A 1982 independent review of the Massachusetts SSOP showed estimated annual savings of $1 million.
- A 1981 evaluation of Wisconsin SSOP showed $1.8 million in total Medicaid savings. The program returned almost $22 in savings for

every dollar spent. A 1984 study showed that surgery rates had risen somewhat from the initial decline but still recommended that the SSOP be maintained as it has led to lower surgical utilization.

- Michigan SSOP was implemented in 1980. In 1981, annual savings were estimated at $3.7 million. According to Medicaid officials, 1984 estimated annual savings should be approximately $10 million. Michigan is planning to expand the SSOP to include almost all surgical procedures.

- Georgia plans to implement a mandatory second surgical opinion program for Georgia Medicaid recipients by Fall 1984. Estimated annual savings are $2.7 million.

- A March 1983 report by the Office of Inspector General, United States Department of Health and Human Services, estimated that a mandatory SSOP applied nationally could reduce elective surgery by as much as 29% in Medicaid and 18% in Medicare at an annual cost-savings of about $63 million and $94.7 million, respectively. The Inspector General wrote to the Health Care Financing Administration: "I am convinced that further delay in implementing a mandatory SSOP can only result in more unnecessary surgeries being performed and more health care funds wasted."

Voluntary second opinion programs, such as South Carolina's, encourage individuals to seek second opinions, but the patient can decide whether to participate. Voluntary second opinion programs have had low participation rates. According to a National Governor's Association (NGA) 1982 report on SSOPs, usually only 2% of the eligible population participates in voluntary programs. NGA concludes: "For state Medicaid programs, setting up a formal voluntary SSOP does not appear likely to result in significant cost-savings."

Under a mandatory program, the patient is required to get a second opinion before the cost of the surgery will be paid. Under both mandatory and voluntary programs, the patient ultimately decides whether to have the surgery. Typically, only a limited number of surgical procedures are included within a mandatory program. Savings from mandatory SSOPs are due not only to the direct effect (the change in the rate of surgery among program participants) but also to the "sentinel

effect" (the degree to which a program's existence prompts physicians to become more conservative in making initial recommendations for surgery).

In July 1983, the South Carolina Medical Care Advisory Committee reviewed the 1983 Inspector General's report and asked DSS to gather additional data from other states. According to a DSS briefing paper at the time, "DSS does not have data to substantiate or disprove the effect of second and third surgical opinions." As of April 1984, DSS had not collected any data on SSOPs as requested.

The Audit Council selected nine of the procedures commonly used by other state Medicaid SSOPs, such as tonsillectomy, adenoidectomy, hernia repair and hysterectomy, to evaluate South Carolina's potential savings. To estimate savings, the Audit Council used data from an eight-year study of the Cornell Medical Center-New York Hospital mandatory second opinion program. The New York Study showed that 18.7% of the participants obtaining a second opinion were told they did not need surgery. After one year, 61.4% of this group had not had surgery. Applying these figures to FY 82-83 South Carolina expenditures shows an estimated annual savings of over $381,000 on the nine selected procedures in the South Carolina Medicaid program. The addition of other surgical procedures to the mandatory list could result in substantial additional cost-savings.

Medicaid Drug Program

The Department of Social Services has not implemented a maximum allowable cost system (MAC) for drugs with generic equivalents. As a result, the Department is paying approximately $500,000 a year more than necessary for more expensive drugs for Medicaid recipients.

A MAC system would establish a maximum price DSS would pay for a drug with generic equivalents. For example, if five generic drugs are available, DSS could establish a maximum price at the midrange of the cost of the five drugs. DSS records indicate that 20% of the drugs on the Medicaid formulary have generic equivalents for which a maximum cost could be established. For example, Orinase (500 mg), a brand name drug, is on the formulary. This drug costs $16.20 per 100 tablets. Tolbutamide (500 mg) a generic equivalent, is not on the formulary. The generic equivalent costs $7.41 per 100 tablets, which is less than half the cost of the brand name. If a MAC system were established, DSS records indicate over $50,000 per year could be saved for this one drug. In addition, because the generic equivalent is not on the Medicaid formulary, physicians do not have the discretion of prescribing the less expensive drug.

In order to contain costs in the Medicaid program without reducing services, a prudent practice would be to pay only necessary drug costs. This could be accomplished by paying the lowest prices possible for quality drugs. For example, the federal government establishes price limits for drugs with generic equivalents, if the drugs are consistently available nationwide. In South Carolina, 52 drugs have a federally established price limit.

Additionally, a General Accounting Office report issued December 31, 1980 recommended that states implement their own state MAC program. This report stated that states can reduce Medicaid drug costs by establishing a MAC program.

Furthermore, in its September 23, 1982 meeting, the DSS Board requested "...That staff continue to evaluate the formulary for drugs

and cost containment." A state MAC system is a cost containment measure available for the Board's consideration.

Implementing a system requiring payment for less costly, generic drugs would decrease the cost of the drug program with no decrease in services or prescriptions. According to DSS budget requests, this approach would save approximately $500,000 in Medicaid funds annually. Funds saved could be reverted to the General fund or used for other Medicaid programs.

According to Department records, DSS staff attempted to implement a state MAC program in 1982. These records indicate that a committee of the Legislature "demanded" that this system be rescinded. The DSS Board has not taken up the issue of implementing a MAC system.

Additionally, officials stated that those opposed to a state MAC expressed concern that physicians would not be able to prescribe a "brand name" drug they felt was essential. However, DSS staff have stated that all a physician would be required to do to prescribe a "brand name" drug would be to write a note on the prescription explaining why the drug is necessary.

Competitive Bidding for Independent Laboratory Services

The Department of Social Services does not competitively bid independent laboratory services in the South Carolina Medicaid program. Competitive bidding among the 31 independent labs could be an efficient cost containment measure.

Lab tests may be performed by any of the 31 independent labs enrolled in the South Carolina Medicaid program. The labs are paid on a fee schedule basis. The federal government is encouraging states to

seek waivers from the "freedom of choice" requirement for Medicaid services such as independent laboratory tests so that states can realize greater economic benefit. Under a waiver, the State could bid out these services on annual contracts and require that lab tests be performed by the lab or labs awarded the contracts.

Title 42, Section 431.54 of the Code of Federal Regulations, exceptions to certain State plan requirements states:

> The Medicaid agency may enter into arrangements to purchase medical devices or laboratory and x-ray tests...through a competitive bidding process or otherwise... [Emphasis Added]

The February 1982 Audit Council review of the South Carolina Medicaid program noted that competitive bidding can be used as an administrative option for cost containment in the purchase of independent laboratory services. The legislation creating the State Health and Human Services Finance Commission requires specific attention to "achievement of optimum cost effectiveness in administration and delivery of services provided quality of care is assured." DSS considered competitive bidding for independent lab services in 1982, but the program was never implemented.

Quality of care would not be affected by a competitive bidding program, and the State could realize cost savings through maximizing the State's purchasing power. For example, bulk purchase agreements of eyeglasses have resulted in substantial savings in other states' Medicaid programs. Savings in the independent lab services program would make more funds available for other Medicaid services.

RECOMMENDATIONS

THE SOUTH CAROLINA MEDICAID PROGRAM SHOULD IMPLEMENT A MANDATORY SECOND SURGICAL

OPINION PROGRAM FOR SELECTED SURGICAL PROCEDURES. THE MEDICAID PROGRAM STAFF SHOULD DETERMINE WHICH SURGICAL PROCEDURES COULD BE THE MOST EFFECTIVE FOR COST-SAVINGS IN SOUTH CAROLINA.

A STATE MAXIMUM ALLOWABLE COST PRICING SYSTEM FOR FORMULARY DRUGS WITH GENERIC EQUIVALENTS SHOULD BE IMPLEMENTED.

THE INDEPENDENT LABORATORIES SERVICES SECTION OF THE MEDICAID PROGRAM SHOULD PREPARE AN ANALYSIS TO BE PRESENTED TO THE STATE BOARD SHOWING THE POTENTIAL COST SAVINGS FROM COMPETITIVE BIDDING IN THE INDEPENDENT LABORATORY SERVICES PROGRAM.

Third Party Liability Program

The Medicaid Third Party Liability (TPL) program is responsible for determining if a Medicaid client has other resources, such as insurance benefits, to pay his medical bills. Other resources must be exhausted before Medicaid can pay medical bills. The Council's review of the Third Party Liability program found deficiencies which are costing the Medicaid program at least $3 million annually. These problems follow.

## Inadequate Insurance Information Obtained from Medicaid Clients

The Department of Social Services and its county offices have not adequately determined if Medicaid clients have other insurance or medical benefits. Counties are not adequately determining if clients have insurance, the policy number, the name of the insurer, the dates of coverage and other necessary information. This information can be placed on the client's Medicaid card to alert providers to bill other third parties before billing Medicaid. Also, this information is needed for DSS's records to determine if a client has third party resources and the appropriate company responsible for a Medicaid bill.

Further, the Department does not reject Medicaid claims when records indicate the client has other insurance coverage, and require the provider to file a claim with the insurance company. This type of "cost avoidance" system, used by other states, could be used to avoid paying unnecessary Medicaid costs.

Alabama and North Carolina require county social workers to determine necessary insurance information from clients each time the client is seen. This information is immediately placed in the agencies' computer records. Both states also return Medicaid claims to providers without payment when agency records indicate other insurance coverage. Before Medicaid pays the charges, providers must provide documentation from the insurance companies indicating the company will not pay.

In a letter to DSS county offices dated September 9, 1982, the Interim Commissioner required social workers to obtain necessary Medicaid insurance information from Medicaid clients. According to agency officials, this is not being implemented.

Department of Social Services Medicaid officials, in December 1982, recommended insurance information "...should be printed out on the recipient's Medicaid I.D. card to alert providers to such coverage."

Because counties are not determining necessary information, and having this information on Medicaid cards, providers and DSS do not always know if a client has other resources to bill. The Department of Social Services cannot implement an adequate "cost avoidance" system without this information. In FY 82-83, Alabama and North Carolina avoided approximately $8.4 million and $5.1 million in Medicaid costs by rejecting claims for clients with other insurance coverage. In 1983, South Carolina did not reject any claims, potentially payable by insurance companies, to avoid costs.

According to DSS officials, county workers have not been trained to know what type information is needed from clients. Also, to implement a cost avoidance system, according to DSS officials, would require additional staff and attention of management. According to agency documents, management has not given the Third Party Liability program necessary attention to implement changes.

DSS Not Attempting Recoupment from Insurance Companies

The Department of Social Services does not seek recoupment from insurance companies which may be liable for Medicaid clients' bills. As a result, Medicaid is paying more than necessary for medical claims. DSS records indicate that between July 1983 and December 1983, over 3,400 claims totaling over $1.7 million were paid by Medicaid, although DSS records indicated other insurance companies may be responsible for the charges. The Department of Social Services did not follow up to determine if the insurance companies were financially liable.

For example, DSS records indicate that Medicaid was charged $95,000 for one client's medical bills. This claim was paid by Medicaid, although agency records indicated other insurance coverage was possibly available. The agency did not bill the insurance company.

In addition, over 9,000 "trauma" type Medicaid claims of less than $200 were not followed up to determine if a third party was responsible for the bills. Only "trauma" claims over $200 are investigated to determine the liability of other third parties. A "trauma" claim indicates a client was involved in an accident, and Medicaid may not be liable for the bill.

In an October 1983 assessment, the federal government criticized the Department of Social Services for not investigating records indicating other insurers may be liable. The assessment recommended the agency follow up on records indicating other third parties may pay.

The 1982-83 State Appropriation Act requires:

> That DSS shall collect the total amount identified as overpayments made to providers in accordance with Third Party Recovery guidelines.

Further, Title 42, Section 433.138 of the Code of Federal Regulations requires:

> The agency must take reasonable measures to determine the legal liability of third parties to pay for services ...

Section 44-6-70 of the South Carolina Code of Laws creating the Health and Human Services Finance Commission requires "Improvement of effectiveness of third party reimbursement efforts."

By not following up on records which indicate insurance companies may be liable for medical bills paid by Medicaid, the agency is paying more than necessary for the Medicaid program. This could cause the

agency to lose federal funding. DSS records indicate that at least $3 million more per year could be collected in third party recoveries with an adequate third party program. Alabama and North Carolina's third party programs saved approximately $14.2 million and $8.8 in FY 82-83. South Carolina's program only identified $2.5 million in savings.

According to DSS officials, records indicating other third party coverage are not investigated because of staffing limitations. All that are investigated are auto accident claims and trauma-type claims over $200. Also, agency officials stated the accuracy of the insurance information is not always reliable.

DSS Does Not Have Assignment Rights

DSS does not have authority to require Medicaid clients to assign their rights of medical benefits to DSS as a condition of participating in Medicaid. As a result, Medicaid clients have profited at the expense of the Medicaid program.

DSS cannot seek direct reimbursement from a Medicaid client's insurance company after paying the client's medical bills. For example, an insurance company paid one Medicaid client who was involved in a traffic accident $1,000 directly for injuries associated with the accident. Medicaid paid her medical bills of over $1,200. However, DSS was not reimbursed by the client, and the client kept the $1,000 insurance settlement. DSS, in this type situation, can only ask the client for reimbursement. If DSS had assignment rights, the insurance company could have paid the agency directly instead of paying the client.

Further, if Medicaid pays a client's bills and later finds that an insurance company was liable, the agency can only request that the

provider bill the insurance company and refund the money to DSS. DSS cannot bill the company directly.

North Carolina, Georgia and Alabama have statutes requiring Medicaid clients to assign medical insurance rights to the State before being allowed to receive Medicaid benefits. Federal law allows states authority to require clients to subrogate their benefits.

Without DSS having assignment of benefits, Medicaid recipients are able to profit at the expense of the Medicaid program. Public confidence is eroded and the integrity of the program becomes questionable. Without assignment laws, the Medicaid program costs more than necessary and fewer resources are available for the needy. The amount DSS could not recoup due to lack of assignment rights could not be determined. Allowing DSS assignment rights would streamline the efficiency of collecting from insurance companies and allow DSS to collect more TPL due the agency.

DSS does not have assignment of benefits authority because State subrogation laws are inadequate. Statutes do not adequately require recipients to assign their rights to DSS.

Unsolicited, Unidentified Medicaid Refunds Not Investigated

The Department of Social Services receives unsolicited, unidentified refunds from Medicaid providers but does not determine the reason for the refund. This information is needed for DSS's records to ensure the agency knows if clients have other resources to bill for future medical claims.

Unidentified medical refunds are returned to Medicaid accounts. The agency does not determine the client the refund is for or if a

client has other third party coverage initiating the refund. In 1983, DSS received over $1.4 million in unsolicited, unidentified Medicaid refunds.

Additionally, DSS sometimes receives documents indicating clients have third party coverage not indicated in DSS records. However, records are not updated to reflect the client has other coverage.

A DSS Internal Audit conducted of the Third Party Liability program dated June 1982 recommended:

> ...Providers be encouraged to include enough information with refunds in order to identify the receipt when received by the Department, and that more emphasis be placed on researching the sources of unidentified refunds to the extent feasible.

No action has been taken on this recommendation.

Further, a good practice would be to update agency records when it is learned a client has third party resources not listed on agency records. North Carolina, Georgia and Alabama immediately update their records when they determine a client has third party resources not identified on agency records.

By not following up on unidentified, unsolicited Medicaid refunds, the Department cannot determine if clients have insurance coverage not indicated on agency records. The agency cannot operate an adequate Third Party Liability program without determining the source of Medicaid refunds.

Unidentified refunds are not identified for several reasons. First, the agency has not requested providers to include identifying information on refunds. Further, DSS officials state they do not have the staff to investigate the quantity of unidentified refunds received. Neither does the Division have the staff to update its records when documents indicate other possible third party resources.

## Providers Not Audited to Ensure Third Party Refunds

The Department of Social Services has not audited hospitals, doctors or other Medicaid providers to determine if they have refunded all third party funds due the agency. Third party funds are funds paid by another source for the Medicaid client's medical bills. By not auditing providers, the agency cannot determine the amount of funds not returned to DSS.

Providers serving Medicaid clients are allowed to bill both Medicaid and the client's insurance company if the provider knows of other insurance. However, the provider cannot keep all funds. Third Party funds up to the amount of the Medicaid payment must be refunded to DSS.

An internal audit conducted of the Third Party Liability program dated June 1982 recommended DSS review providers to ensure third party refunds are made. For example, Georgia reviewed 10 providers in 1981 for unreported TPL and found over $500,000 unreported. Georgia then obtained an additional 10 positions to audit Medicaid providers for TPL owed the agency.

Additionally, the DSS Medicaid Director recommended to the DSS Audit Division in December 1982:

> Indepth audits of major providers looking specifically for unreported third party recoupment be performed.

There is no incentive for providers to refund money due DSS if they know they will not be audited. Consequently, the Medicaid program could be spending more than necessary to provide medical care to the needy.

RECOMMENDATIONS

THE DEPARTMENT OF SOCIAL SERVICES SHOULD ENSURE THAT CASE WORKERS OBTAIN ALL NEEDED THIRD PARTY LIABILITY INFORMATION FROM MEDICAID CLIENTS. THIS INFORMATION SHOULD BE PLACED ON THE CLIENT'S MEDICAID CARD AND IN THE AGENCY'S CLIENT INFORMATION SYSTEM.

IT IS NECESSARY THAT A SYSTEM BE IMPLEMENTED WHEREBY ALL MEDICAID CLAIMS FILED FOR CLIENTS WITH POSSIBLE THIRD PARTY RESOURCES ARE REJECTED WITHOUT PAYMENT. THESE CLAIMS SHOULD BE RETURNED TO THE MEDICAID PROVIDERS TO FILE A CLAIM WITH THE APPROPRIATE THIRD PARTY. IF A PROVIDER RESUBMITS A CLAIM FOR THAT CLIENT, THE PROVIDER SHOULD BE REQUIRED TO SHOW EVIDENCE AN INSURANCE COMPANY WOULD NOT COVER THAT CLAIM.

A SYSTEM TO FOLLOW UP ON ALL CLAIMS PAID BY MEDICAID WHERE RECORDS INDICATE ANOTHER PARTY MAY BE LIABLE FOR MEDICAL BILLS SHOULD BE IMPLEMENTED.

THE GENERAL ASSEMBLY SHOULD ENACT LEGISLATION TO REQUIRE MEDICAID CLIENTS TO SUBROGATE

ALL MEDICAL RIGHTS OF BENEFITS TO THE STATE AS A CONDITION OF PARTICIPATING IN THE MEDICAID PROGRAM.

A SYSTEM TO REQUIRE ALL PROVIDERS SUBMITTING MEDICAID REFUNDS TO IDENTIFY THE REASON FOR THE REFUND, THE CLIENT THE REFUND IS FOR, AND OTHER NECESSARY INFORMATION NEEDED BY THE THIRD PARTY LIABILITY PROGRAM SHOULD BE IMPLEMENTED. REFUNDS NOT PROPERLY IDENTIFIED SHOULD BE INVESTIGATED TO DETERMINE THE SOURCE.

AN AUDIT OF MAJOR MEDICAID PROVIDERS TO DETERMINE IF ALL THIRD PARTY FUNDS OWED THE DEPARTMENT HAVE BEEN REFUNDED SHOULD BE CONDUCTED .

MEDICAID OFFICIALS SHOULD PROPERLY ALLOCATE STAFF AND RESOURCES TO ENSURE THAT THE THIRD PARTY LIABILITY PROGRAM CAN FUNCTION ADEQUATELY.

Competitive Bidding for Medicaid Claims Processing

The Department of Social Services does not know if it is performing Medicaid claims processing in the most economical manner. South Carolina

is the only one of eight states in the Southeastern region that has Medicaid claims processing performed solely by a state agency. The other states, by competitive bidding, contract with a fiscal agent, that is, someone outside of government to process claims.

Competitive bidding is estimated by the United States Department of Health and Human Services to save six states in the Southeastern region up to $141 million over a three- to five-year period. Georgia's cost per claim in July 1984 was reduced from $1.24 to 35¢ through competitive bidding, saving $46 million over five years. Florida's cost per claim in 1982 was cut from 76¢ to 33¢, saving $40 million over five years. Mississippi's cost per claim dropped from 66¢ to 52¢, resulting in a savings of $2.7 million over the three-year contract period. Alabama's 1982 contract with a fiscal agent was renewed at the same cost of 52¢ per claim. However, enhancements were added as a part of the bid, eliminating future costs. A DSS internal memorandum in April 1983 presented other states' savings and DSS's cost per claim of 89¢ to the Interim Commissioner. The memo concluded, "However, it would appear that we could contract out for this service cheaper."

A good method to determine if the State is processing Medicaid claims efficiently is to issue a Request for Proposals (RFP) on the required work. This would result in bids from various fiscal agents that could be compared to the costs incurred by DSS for claims processing.

There has been no competitive bidding for Medicaid claims processing during the past eight years. This is because Section 59-119-150 of the South Carolina Code of Laws authorizes Clemson University to purchase computer equipment, and DSS to contract with the University for data processing services for seven years beginning July 1, 1976. Data

processing is an integral part of claims processing. The seven years ended in 1983; however, Act 83 which created the new Health and Human Services Finance Commission (HHSFC) was passed at the same time. The Act provides that during the first year of operation, beginning July 1, 1984, the new agency will contract with DSS for claims processing. Consequently, DSS extended its contract with Clemson in June 1983 and will renew it in June 1984. After July 1, 1985 the new agency could use competitive bidding in contracting for Medicaid claims processing.

RECOMMENDATION

THE STATE HEALTH AND HUMAN SERVICES FINANCE COMMISSION SHOULD INITIATE A REQUEST FOR PROPOSAL IN ORDER TO DETERMINE THE MOST EFFICIENT METHOD FOR PROCESSING MEDICAID CLAIMS.

State Does Not Have Lien Law

The Department of Social Services does not have the authority to place a lien against a Medicaid client's property to recover State funds expended in behalf of the client. Medicaid clients can own a certain amount of resources, including automobiles, homes, insurance policies, cash, and other resources, and be able to obtain Medicaid benefits. However, when they die or obtain sufficient resources to pay, DSS cannot file a lien to recover these assets to pay costs incurred by the State for medical care.

Code of Federal Regulation 42, Part 433.36 allows states to place a lien against Medicaid clients' property if the states so desire. In 1982, Alabama's Medicaid agency began placing liens against the property of Medicaid clients. Between January 1983 and May 1984, Alabama collected over $105,000 through lien collections and is in the process of collecting an additional $103,000.

The South Carolina Department of Mental Health can, by law, place a lien on the property of patients, discharged from a mental institution, owing money. Section 44-23-1120 of the South Carolina Code of Laws allows DMH to recover funds owed the agency from the estates of deceased mental patients.

Without legal authority to file claims against Medicaid clients' property, the State cannot recover funds paid for medical services from clients with sufficient resources to pay. Those who benefitted from taxpayer assistance should have their estates applied to help offset their medical expenses. DSS would then have more Medicaid funds available for the needy.

According to DSS, liens are not placed against Medicaid clients' property because State law does not allow for liens to be filed. State statutes do not allow for DSS to recover resources from clients.

RECOMMENDATION

THE GENERAL ASSEMBLY SHOULD CONSIDER ENACTING LEGISLATION ALLOWING THE PLACEMENT OF A LIEN AGAINST THE PROPERTY OF MEDICAID RECIPIENTS TO RECOVER STATE FUNDS PAID

FOR THAT CLIENT'S MEDICAL TREATMENT. EXCEPTIONS COULD BE MADE FOR HARDSHIP CASES.

Medical Screening Services

DSS is providing an inconsistent level of medical screening services for poor and disabled children across the State through its Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. Through this program, DSS refers Medicaid eligible children to receive medical screenings so that health problems may be treated and prevented.

Children in some counties, however, receive a lower percentage of recommended screenings than those in other counties. The ten counties with the highest screening rates in FY 82-83 conducted 93% of the screenings recommended by DSS for their clients, while the ten counties with the lowest screening rates conducted only 28% of the screenings recommended. Thus, children living in the top ten counties are three times more likely to receive medical screenings than children living in the bottom ten counties.

There are several reasons why some counties have lower screening rates than others. For example, State EPSDT officials note that there is an unequal allocation of staff, based on caseload, between the counties (see p. 114). In FY 82-83, Williamsburg County had no EPSDT workers and accomplished only 21% of 2,552 screenings recommended for its clients. Clarendon County, however, had one full-time worker and accomplished 86% of 1,175 screenings recommended for its clients. There is also no state-coordinated outreach effort to assist counties in educating clients of the benefits of medical screenings.

The effective management of a statewide program includes the consistent provision of services from county to county. This consistency can best be ensured by effective coordination at the State level.

Studies conducted by the states of North Carolina and Michigan indicate EPSDT screenings have the potential to be cost-effective by preventing illnesses which are treated at Medicaid expense. North Carolina estimates it may have been able to reduce Medicaid payments by $1.8 million if all eligible clients had participated in its medical screening program in 1981.

When medical screenings are provided inconsistently between counties, children receive inequitable health care treatment. When children do not receive proper preventive health care, medical problems are likely to be more expensive to treat later.

RECOMMENDATION

DSS SHOULD REVIEW THE PROBLEM OF INCONSISTENT MEDICAL SCREENINGS BETWEEN COUNTIES AND TAKE STEPS TO INCREASE THE SCREENING RATE IN THOSE COUNTIES WHERE IT IS SIGNIFICANTLY LOWER. THESE STEPS SHOULD INCLUDE THE EQUALIZATION OF STAFF ALLOCATION AND A STATE-COORDINATED EFFORT TO ASSIST COUNTIES IN EDUCATING CLIENTS OF THE BENEFITS OF MEDICAL SCREENINGS.

# CHAPTER V

# ADMINISTRATION

## DSS Board

The Council reviewed the DSS Board and found the following problems.

### Attendance At Board Meetings

Two Board members and one former member have a poor record of attendance at Board meetings. Minutes of Board meetings from March 1982 through February 1984 indicate that two current members had attendance rates of 50% and 54% while a former member had a rate of 49%. During that period, five other current members had attendance rates ranging from 88% to 98%.

Regular attendance at Board meetings enables members to keep informed about issues and problems affecting the agency. The Department of Social Services does not have a policy regarding member attendance at Board meetings. One state, concerned about the attendance of an agency's Board members, passed a law giving the Governor the authority to remove members who are absent from two consecutive meetings.

When Board members do not attend Board meetings, the public is not properly represented. The public experiences a reduction in oversight of agency activities when Board members are not present to discuss and vote on important issues affecting the Department.

Potential Conflict of Interest

An attorney who is chairman of one County DSS Board also acts as the legal representative of DSS clients in actions against the county department. This individual has represented clients against the agency of which he is the chairman. State and county DSS documents indicate that he has been involved as legal counsel against DSS in two of five cases referred to the State Office's Division of Investigation between July 1982 and January 1984. In addition to these two cases, he has also served as the attorney of individuals, accused of child abuse, who are suing DSS. Additionally, he has made inquiries on behalf of a client regarding a Food Stamp fraud case being handled administratively by the County DSS office.

This County DSS requested that the Division of Investigation close one of the cases being investigated. This request was made after the Division of Investigation had received a letter from the County DSS Board Chairman. He had requested a legal clarification of the facts of the case in his capacity as the attorney for the DSS client. The county then had the case closed.

In Advisory Opinion 84-030 issued on January 18, 1984, the State Ethics Commission addressed the issue of attorneys serving as counsel against boards they serve. The Ethics Commission summarized its opinion in a case where a law firm of a hospital trustee was representing clients in a legal action against the hospital as follows:

> It would appear that the law firm in which a member of the Board of Trustees of a public hospital serves would be prohibited from representing clients in actions against the hospital.

Furthermore, American Bar Association Opinion 192 states:

> ...an attorney holding public office should avoid all conduct which might lead the layman to conclude that the attorney is utilizing his public position to further his professional success or personal interests.

The relationship which this board member has with DSS and DSS clients involved in legal action against the county department raises the question of whether the best interests of the County DSS are being served. County employees, especially the fraud investigators, operate under the knowledge that a county board member may defend the clients that have been referred for prosecution. This can have a "chilling effect" on referrals. This County ranked 46th, or last, in the collection of overissued funds statewide for the period October 1, 1982 through October 1, 1983.

The Department of Social Services does not have adequate policies to safeguard against possible conflicts of interest. Additionally, DSS does not have procedures for notifying the Ethics Commission of potential ethics violations by Board members.

Voting Abstentions

One DSS Board member has elected to abstain from voting on certain Medicaid issues. Minutes of Board meetings indicate that from March 1982 through February 1984 the Board member abstained from voting on 32% of votes.

This member owns a nursing home which receives Medicaid funds. Due to a possible conflict of interest, he abstained from votes pertaining to certain Medicaid issues. Although the individual ceased to directly administer his nursing home upon joining the Board in 1981 (the nursing home is leased to another individual), he did retain ownership and, thus, an interest in the financial well-being of the business.

Being an effective member of a public board requires regular participation in discussions and votes on issues which come before the board. When a board member finds it necessary to abstain from one-third of all votes, however, the constituents of a district lose a significant portion of their representation.

Drugs Added to Formulary

The DSS Board has improperly approved the addition of over 200 drugs to the Medicaid drug formulary. This action cost the Medicaid program an additional $600,000 in FY 83-84. These drugs were approved for addition to the formulary without the review or input of the Department's Drug Formulary Advisory Committee, the DSS staff responsible for the drug program, or the Medical Care Advisory Committee (MCAC). The drug formulary is a schedule of drugs DSS will allow Medicaid clients to purchase with Medicaid funds.

The Department's policy for determining drugs placed on the formulary when the drugs were improperly added was to include only prescription drugs essential to saving or maintaining life, or those limiting the need for hospitalization. However, an analysis of the drugs added by the Board in February 1983 indicates this policy was not followed. Also, drugs previously denied by the Department as well as drugs not approved by the Food and Drug Administration were added. The following is a summary prepared by Department officials, of drugs added by the Board.

- 37 are "over-the-counter" drugs. Agency policy had been to exclude these drugs from the formulary.
- 31 drugs had not been approved by the Food and Drug Administration when added to the formulary.

- 59 drugs had been denied or removed previously by the Drug Formulary Advisory Committee.
- 27 drugs had been previously excluded because they are nonessential drugs.
- 22 drugs are presently on the formulary by another brand name.
- No information available for the remainder of the drugs.

Proper agency procedures for amending the formulary are for amendments to be presented to the Drug Formulary Advisory Committee. The Committee, in conjunction with DSS staff, evaluates the drugs to determine if they are needed on the formulary.

Additionally, adding drugs which constitute a change in agency policy, such as "over-the-counter" drugs, requires the review and input of the Medical Care Advisory Committee. Title 42, Section 431.12E of the Code of Federal Regulations requires that:

> The Committee must have opportunity for participation in policy development and program administration...

Furthermore, the 1982-83 Appropriation Act requires:

> That DSS shall adhere to federal regulations concerning the Medical Care Advisory Committee's participation in agency policy development and program administration.

In its 1982 report on Medicaid, the Audit Council recommended that "DSS should adhere to federal regulations concerning the Medical Care Advisory Committee's participation in agency policy development and program administration." The drug program will expend approximately $2 million more than budgeted in FY 83-84. Approximately $600,000 of this cost overrun is caused by improperly adding drugs to the formulary.

Also, by not consulting with the MCAC on decisions of this nature, the Department could face adverse legal action. In 1977, Hawaii's MCAC sued the state's Medicaid agency. The United States District Court directed the agency to "...consult the committee for advice and

suggest solutions before making decisions affecting policy development or program administration."

Adding these drugs without consulting the proper officials demonstrates the Board's disregard for State and federal laws. The public's confidence in the Board's ability to make equitable decisions is hampered when decisions are made without proper oversight, consultation, or regard to standard procedures.

These drugs were improperly added because the DSS Board did not adhere to standard agency procedures for adding drugs. According to DSS records, the Board's drug subcommittee, consisting of two Board members, recommended that the Board add these drugs. No evidence exists to indicate the Board consulted with the Medical Care Advisory Committee or Drug Formulary Committee concerning these additions. Also, there is no deterrent to Board members improperly spending funds because they are not required to repay misspent funds.

Implementing Automated Food Stamp System

The Department of Social Services delayed transferring the Alabama Automated Food Stamp System to South Carolina despite estimated annual savings of over $5 million. According to estimates based on agency documents, approximately $2.6 million in potential savings have been lost because of a six-month delay.

DSS did not take the initiative to pursue the transfer of the Alabama System after the potential savings had been identified for Agency management. The interim commissioner put a moratorium on the development of the proposal from September 1982 through June 1983. However, the cause of the foregone savings was the DSS Board's delay in approving the proposal from September 1983 to March 1984.

The Board had requested information on three items: 1) the county impact of automation and the compatability with existing systems; 2) the location of computer hardware; and 3) the training needs for DSS case workers. However, an analysis of each of these items had been included in the Advanced Planning Document and other analyses which were available to the Board. DSS staff again reviewed the areas of Board concern. A memo was written by two top agency officials to the Commissioner in response to the Board's questions stating:

> ...no new knowledge was gained and no plans are changed. Our estimates of equipment remain the same and our original training plans are unchanged.

The six-month delay has caused DSS to forego approximately $600,000 in estimated administrative cost savings. Additionally, approximately $2 million in estimated savings due to reductions in program error rates, fraud, waste, abuse, overissuance and administrative paperwork have been lost.

The Food Stamp System used by DSS is highly labor intensive. Application, recertification and issuance procedures in DSS county offices require manual processing of approximately 11 million pieces of paper a year at 46 county locations. Caseworkers spend approximately 45% of each work day processing paperwork. Additionally, the maintenance of eight different types of files are required by Food Stamp regulations. Data reports on daily, monthly, semi-annual and annual basis must be completed as well. The Alabama system, however, provides for automated application procedures, certification, monthly reporting, issuance, reconciliation, posting and reporting. Also the Alabama system will enhance the collection of overissued benefits and aid in verifying income and resources.

According to Alabama Food Stamp officials, their automated system has allowed them to control the error rate problem. Alabama's error rate is historically the lowest in the southeast region. At 8.2%, it is nearly two percentage points lower than South Carolina's for the April-September 1983 Quality Control review period. While South Carolina faces sanctions in the Food Stamp program, Alabama does not. Additionally, the federal government has recommended the Alabama system as a model system for the Food Stamp Program nationally.

RECOMMENDATIONS

THE DSS BOARD SHOULD ENACT A POLICY WHICH GIVES ITS MEMBERS INCENTIVE TO ATTEND BOARD MEETINGS.

DSS SHOULD DEVELOP A POLICY WHICH PROHIBITS DSS BOARD MEMBERS FROM REPRESENTING DSS CLIENTS IN LEGAL ACTIONS AGAINST THE COUNTY DEPARTMENTS.

DSS SHOULD DEVELOP PROCEDURES FOR REQUESTING OPINIONS FROM THE ETHICS COMMISSION IF POTENTIAL ETHICS VIOLATIONS ARE DETERMINED TO EXIST ON DSS BOARDS.

TO ENSURE EFFECTIVE PARTICIPATION BY PUBLIC BOARD MEMBERS, THE GENERAL ASSEMBLY SHOULD CONSIDER LEGISLATION PROHIBITING INDIVIDUALS

FROM SERVING ON BOARDS WHERE THERE MAY BE A CONFLICT OF INTEREST.

THE DSS BOARD MUST ADHERE TO FEDERAL AND STATE LAWS CONCERNING THE MEDICAL CARE ADVISORY COMMITTEE'S PARTICIPATION IN AGENCY POLICY DEVELOPMENT AND PROGRAM ADMINISTRATION.

THE GENERAL ASSEMBLY SHOULD CONSIDER ENACTING LEGISLATION REQUIRING AGENCY BOARD MEMBERS, STAFF OR OFFICIALS TO REPAY PUBLIC FUNDS EXPENDED IN VIOLATION OF STATE OR FEDERAL STATUTES, RULES OR REGULATIONS.

THE DSS BOARD SHOULD TAKE PROMPT ACTION TO CONSIDER AND ACT UPON COST-SAVINGS MEASURES PRESENTED BY THE STAFF WHICH HAVE THE SUPPORT OF STATE AND COUNTY ADMINISTRATIVE OFFICIALS.

Licensing of Adult Residential Care Facility

The Department of Social Services is considering issuing an Adult Residential Care Facility (ARCF) license to an individual who has demonstrated unethical business practices in this field. This individual, who once operated an ARCF, was found to have violated DSS regulations. She

moved seven residents from the facility to an unlicensed, inadequately heated home after being warned by DSS not to do so. The Department of Social Services informed this individual that if she moved the clients to an unlicensed facility, it would be a violation of State law and she could not obtain a license in the future. DSS could not locate the clients for four days, and the agency received a court order to obtain custody of the clients when they were found.

Further, this individual was an officer in a corporation going bankrupt, owing DSS over $1.2 million. DSS legal documents, pertaining to the facility of which this individual was an officer, state:

- The Nursing Home Ombudsman has received a substantial number of complaints concerning patient abuse and maltreatment.
- There is a serious question concerning the provision of proper dietary needs of the patients.
- Personal Needs Funds have continued to be misused by the operator for his personal use.

Regardless of this individual's background, DSS officials state they will issue her a license when Department of Health and Environmental Control and State Fire Marshal regulations are met.

Adult Residential Care facilities provide care for individuals who because of age, mental condition or other reasons, cannot adequately care for themselves. DSS is responsible for ensuring that facilities it licenses provide proper care to these people who cannot adequately care for themselves.

State Regulation 114-5-30 allows DSS to deny a license to individuals who do not "demonstrate mature judgment." Further, this regulation requires that operators "Be willing to cooperate with the supervising authorities in maintaining standards and necessary and required records."

By issuing a license to an individual with a background of providing improper patient care and dietary needs, there is little assurance patients will receive proper care and nutrition. The licensing process is suspect as a safeguard for patient care. The purpose of licensure is to ensure good services are provided.

When asked if they were aware of this individual's past history, DSS officials stated State regulations do not allow DSS authority to deny a license based on past history. Further, DSS officials stated it is possible for this individual to obtain a residential care facility license from another agency authorized to issue licenses, such as the Department of Mental Health or Department of Mental Retardation.

RECOMMENDATION

THE GENERAL ASSEMBLY SHOULD ENACT LEGISLATION CLEARLY ALLOWING RESIDENTIAL CARE LICENSING AGENCIES TO REFUSE LICENSES BASED ON PAST EXPERIENCES OF PROVIDING INADEQUATE CARE, VIOLATING STATE STATUTES, OR PERFORMING OTHER QUESTIONABLE PRACTICES.

Staffing Standards

The Department of Social Services does not have valid staffing standards for county Human and Economic Service caseworkers. The Department has not systematically identified the current staffing needs of the county departments. Further, the Council's survey of several county directors found that the counties are using different methods for

allocating caseloads. One county has noted that, although it has about a third of the statewide workload, counties with similar caseloads have at least 25% more staff.

On two occasions the Department has attempted to develop staffing standards. In 1978, DSS first tried to develop standards to be applied in allocating staff in the counties and announced in a circular letter to the counties. Again in 1981, revised caseload data in the DSS Personnel Summary FY 81-82 were agreed upon to distribute personnel allocations based upon the reduction in force policy. However, in a November 8, 1983 letter to the Legislative Audit Council, DSS stated that the adopted standards simply allocated the number of personnel positions based upon funds available and did not attempt to identify its actual and future needs for staff. Therefore, DSS concluded, neither the 1978 nor the FY 81-82 standards may be used to accurately assess the adequacy of DSS's staff size.

Other states have valid staffing standards. The Georgia Department of Human Resources has a staffing formula which is used to allocate funding and staff. The Virginia State Department of Welfare has caseload standards which have been designed to determine the number of workers needed to handle a certain number of cases. Also, the Child Welfare League of America states that the state social services agency should determine the optimum number of clients per caseworker for the most effective allocation of staff.

Valid staffing standards identify the work that can be performed effectively by a caseworker. They should be used to allocate staff so that each caseworker will have approximately the same caseload. When there is not enough staff to meet ideal staffing standards, caseloads

should still be equal. Staffing standards and caseloads should be reviewed frequently to ensure continuing equitable and efficient allocation of staff statewide.

DSS does not have optimum standards which identify the Department's needs for staff. A Department official told the Council that because of the changes in the management of the Department, DSS has never gotten around to formally adopting caseload standards. However, during the Audit Council's review, a DSS County Staffing Standards Committee was appointed to revise and update staffing needs in the various county programs. According to DSS, the revisions will indicate total staffing needs as well as show which county offices would receive new personnel allocations.

Without valid staffing standards, there can be no assurance that each caseworker is provided the time to effectively serve clients. Additionally, caseworkers in some counties can have heavier caseloads than caseworkers in other counties. Although DSS states that the standards they had established were invalid, when applied to county human services caseloads and workers, they point out discrepancies among the county offices. For example, one county had an average caseload of 88%, while another county had an average caseload of 214% of the standard.

RECOMMENDATIONS

DSS SHOULD REVISE STAFFING STANDARDS FOR HUMAN SERVICE AND ECONOMIC SERVICE WORKERS BASED ON THE NUMBER OF CASES WHICH CAN BE EFFECTIVELY CARRIED BY A CASEWORKER.

DSS SHOULD USE THE STANDARDS TO ALLOCATE AVAILABLE STAFF AND FUNDS SO THAT EACH CASEWORKER WILL HAVE APPROXIMATELY THE SAME CASELOAD.

STAFFING STANDARDS AND STAFFING ALLOCATIONS SHOULD BE REEVALUATED ANNUALLY.

Training and Certification Records

The Department's training and certification records for county Human Services workers are inadequate. Human Services workers take training and certification courses in areas including Adoption, Child Protective Services, Adult Services, and Adult Protective Services. The Department's central training records, however, do not contain the information needed to accurately determine:

- which training and certification courses individual workers are required to take
- individual training and certification deadlines
- whether continuing education requirements for recertification are met

The Audit Council examined State Office central training records for Charleston, Greenville, Richland, and Spartanburg Counties. In a sample of 56 (of 166) Children Services worker records, none indicated if the worker required training or certification, or if training or certification deadlines were met.

The 166 Children Services workers included 78 Child Protective Services (CPS) workers with "intake and assessment" responsibilities. In a sample of 27 of these records, 14 (52%) workers who had been initially certified, had not taken enough courses to maintain valid certification, while 3 (11%) workers had not been certified. A November 17, 1983 letter from the Department of Social Services to the Audit Council stated, however, "... This card file does not depict a complete training record for individuals employed by the Department of Social Services and all data should be verified by the individual employee..." Central training records are, therefore, unreliable for accurately determining training and certification taken.

During a review of county CPS programs, the Audit Council also found inadequate training and certification records in DSS county departments. Seven of eight counties reviewed did not maintain adequate records of training taken by CPS workers.

The Department encourages county Human Services workers to be certified in their areas of responsibility. Certification is required for Protective Services workers with "intake and assessment" responsibilities. Protective Services certification ensures that workers have the skills to properly investigate cases of abuse and neglect. To maintain valid certification, 30 hours of continuing education are required each year. Good management, however, includes establishing an accurate means of measuring its implementation.

The current training information system at the Department of Social Services was started in 1982. However, management has not taken the initiative to ensure that the system contains the information needed to accurately and effectively monitor training and certification of Human Services workers.

Inadequate training records can prevent an accurate assessment of training needed to maintain and improve the skills of Human Services workers. Inadequate certification records increase the probability that an uncertified worker who is required to be certified in the investigation of abuse and neglect will not be detected.

RECOMMENDATION

THE DEPARTMENT OF SOCIAL SERVICES SHOULD ENSURE THAT ITS TRAINING RECORDS ARE ADEQUATE FOR DETERMINING:

- WHICH TRAINING AND CERTIFICATION COURSES INDIVIDUAL HUMAN SERVICES WORKERS ARE REQUIRED TO TAKE;
- INDIVIDUAL TRAINING AND CERTIFICATION DEADLINES; AND
- WHETHER CONTINUING EDUCATION REQUIREMENTS FOR RECERTIFICATION ARE MET.

Assistance to Minority Businesses Act

The Department of Social Services has not complied with the South Carolina Consolidated Procurement Code requirements for assistance to minority businesses. Action plans and quarterly reports have not been submitted to the Governor's Office. Neither has the agency adequately solicited minority businesses or achieved the goals set for minority vendor participation.

The Small and Minority Business Assistance Office (SMBAO) of the Governor's Office was established to assist State agencies in carrying out the intent of Article 21 of the South Carolina Consolidated Procurement Code. The Department of Social Services did not submit the required Minority Business Enterprise Utilization Plan to the SMBAO for FY 83-84 and the FY 82-83 plan was never approved by the SMBAO. The Department did not solicit any minority businesses in FY 81-82 or FY 83-84 and only four in FY 82-83. Quarterly reports were not prepared and forwarded to the SMBAO for FY 83-84.

Goals were not achieved for the program's first three years of operation. DSS achieved none of the FY 81-82 goal of $61,726 and only $5,364 of the $52,104 goal set for FY 82-83. For FY 83-84, goals were not set as required.

Section 11-35-5240 of the South Carolina Code of Laws states:

> (1) In order to emphasize the use of minority small businesses, each agency director shall develop a Minority Business Enterprise (MBE) Utilization Plan. The MBE Utilization Plan shall include but not be limited to:
>
> (d) Goals that include a reasonable percentage of each governmental body's total procurements directed toward minority vendors.
>
> (2) MBE utilization plans shall be submitted to the SMBAO for approval not later than July thirtieth, annually. Progress reports shall be submitted to the SMBAO not later than ten days after the end of each fiscal quarter.
>
> (a) Number of minority firms solicited;
> (b) Number of minority bids received;
> (c) Dollar amount of minority bids awarded.

In addition to violating the procurement law, the Department's lack of action does not ensure that businesses owned and operated by minorities are afforded the opportunity to fully participate in the procurement

process of the State. This inaction prevents the General Assembly from meeting its goals of enhancing minority capital ownership and overall State economic development.

DSS management has not taken the initiative necessary to comply with the Assistance to Minority Businesses Act. DSS provided the Audit Council with a draft of the FY 83-84 utilization plan which was never finalized or forwarded to the Governor's Office. The procurement officer stated that the shortage of procurement personnel and the process of setting up of the new Health and Human Services Finance Commission has caused the agency to be behind in their program. The State Auditor's review of DSS in February 1983, found that the authorized number and types of staff positions were not sufficient to adequately manage and control the agency's procurement and property control activities. The Director of the Small and Minority Business Office stated that DSS's Coordinator for the program had not been placed at the appropriate level in the agency to provide for an effective program.

RECOMMENDATION

THE COMMISSIONER OF DSS SHOULD APPOINT A COORDINATOR RESPONSIBLE FOR MONITORING THE MINORITY BUSINESS PROGRAM WHO WOULD REPORT DIRECTLY TO THE COMMISSIONER. THE COMMISSIONER SHOULD STUDY THE PROCUREMENT OFFICE TO EXAMINE PRIORITIES AND ENSURE THAT PLANS AND QUARTERLY REPORTS ARE MADE AND MINORITY BUSINESSES ARE SOLICITED.

## Supervisory Skills

### Introduction

To determine employee opinions about Department supervision and to determine the amount of supervisory training taken by supervisors, the Audit Council administered a survey to all DSS State Office employees in January 1984 (see Appendix 2). Of 779 surveys mailed, 508 were returned for a response rate of 65%. The survey's 32 questions included 25 from a November 1981 survey administered by DSS. Two employee attitudes which were consistently positive were the percentage of employees who enjoyed their work, 84% in 1981 and 84% in 1984, and the percentage who stated their work gives them a chance to contribute to the success of the Department, 79% in 1981 and 82% in 1984. The survey, however, also revealed a need for improvement in supervisory skills.

### Supervisory Skills

The 1984 survey results demonstrate that DSS supervisors need improvement in the following supervisory skills:

1. Promotion and employee development.

   - 60% (304 employees) Definitely Agreed or were Inclined to Agree with the statement "The promotion policies of the department do not emphasize merit."

   - 42% (213 employees) Definitely Disagreed or were Inclined to Disagree with the statement, "My supervisor helps me make full use of my abilities and experience and has given me specific help in improving my present job."

2. Coordination of employee efforts:

   - 51% (261 employees) Definitely Agreed or were Inclined to Agree with the statement, "There is a need for considerable improvement in the teamwork of staff in this office."

   - 46% (236 employees) Definitely Disagreed or were Inclined to Disagree with the statement, "I can always depend on promptly getting from others the services and information I need to get my work done."

3. Communication with employees:

- 48% (244 employees) Definitely Agreed or were Inclined to Agree with the statement, "Too frequently I am kept in the dark about what goes on around here."

- 47% (240 employees) Definitely Disagreed or were Inclined to Disagree with the statement, "In this office employees always know where they stand in the eyes of their supervisors."

A University of South Carolina public administration professor, who specializes in personnel management, said about the survey:

> Although there is no proven level or percentage of employee dissatisfaction which indicates a significant problem in management, questions on this survey which indicate dissatisfaction of greater than 40% would clearly demonstrate to me that there is a management problem in those areas. Whether the survey responses indicate an actual or perceived dissatisfaction, there is still strong evidence of a management problem.

Good management includes the identification and resolution of supervisory problems. Supervisory skills can be improved through training.

DSS, however, does not have a systematic training program for supervisors. Analysis is not conducted to identify those who need supervisory training and the skills which need improvement. Nor are complete records maintained on those who have received training. The Audit Council's 1984 survey showed that less than one in five supervisors took training courses in supervisory skills in 1983.

When supervisors lack sufficient communication and employee coordination skills, policies are less likely to be efficiently or effectively implemented. When supervisors lack sufficient promotion and employee development skills, employee motivation can be reduced.

RECOMMENDATIONS

DSS SHOULD INSTITUTE A PROGRAM OF SUPERVISORY TRAINING TO INCLUDE:

- THE CONTINUING ANALYSIS OF TRAINING NEEDS.

- THE SYSTEMATIC PROVISION OF TRAINING BASED ON DETERMINED NEEDS.

- THE CONSISTENT RECORDING OF TRAINING TAKEN.

Budget Management Procedures

The Department does not have adequate procedures for managing its operating budget, which exceeded $98 million in FY 82-83. There is no policy requiring division managers to notify the Department's budget officer in writing when funds are transfered between cost centers within an object code. For example, 6 of 13 cost centers in the Department's Office of Support Services exceeded their budgets by a total of $433,200 in FY 82-83. Additionally, before exceeding an object code budget, there is no requirement that division managers receive written approval from the budget officer, with documentation that the budget has been adjusted.

DSS's operating budget is composed of cost centers and object codes. A cost center is a grouping of costs which is used to assign

accountability and to allocate costs. An object code is a cost category of a good or service such as travel, supplies and contractual services.

When managers are held formally accountable for the costs they control, there is an increased incentive to be efficient. Requiring written notification of cost center transfers and written approval before exceeding object code budgets permits upper-level management to effectively monitor cost overruns so their causes can be addressed.

In 1982, the Department established a review procedure to encourage efficient purchasing of equipment, but it has not established a system which encourages the efficient expenditure of all operating funds.

When managers are not required to obtain written approval before exceeding object code budgets, accountability and the incentive to minimize costs are reduced. Furthermore, when there is no requirement to give written notification of transfers between cost centers within an object code, central budget reports become inaccurate for assessing the performance of a cost center manager.

RECOMMENDATIONS

DSS SHOULD REQUIRE MANAGERS TO NOTIFY THE DEPARTMENT'S BUDGET OFFICER IN WRITING WHEN FUNDS ARE TRANSFERRED BETWEEN COST CENTERS WITHIN AN OBJECT CODE.

DSS SHOULD REQUIRE MANAGERS TO OBTAIN WRITTEN APPROVAL FROM THE DEPARTMENT'S BUDGET OFFICER BEFORE EXCEEDING MAJOR OBJECT CODE BUDGETS.

DSS SHOULD REQUIRE THAT ALL BUDGET TRANSFERS BE DOCUMENTED AND THAT THE RESULTING ADJUSTMENTS TO THE AGENCY'S BUDGET BE MADE IN A TIMELY MANNER.

Data Processing Requests

The Data Processing Division is not completing requests for computer services and resolving programming problems in a timely manner. As of April 1984, 298 requests for computer services and programming problem notifications had not been completed. Of those, 98 (33%) were over one year old. Eleven "top priority" items in September 1982 were also "top priority" in April 1984.

For example, in 1981, one staff member requested a computer program be written to specify the reason certain physician claims were being rejected without payment. The request stated that up to 20% of the workload in his area could be reduced by this program. The request has not been met. Another staff member, in 1981, requested a program be written to prevent payment for unnecessary dental services for babies. This request has not been filled.

In order to provide managers with accurate, relevant and timely information, it is important that requests be completed as soon as possible. A memorandum of understanding between the DSS Medicaid Division and Office of Administrative Services dated March 23, 1982 states:

> The Division of Information Systems will implement all on-line changes that are requested through the MMIS (Medicaid Management Information System) Liaison Committee in a timely manner. [Emphasis Added]

The MMIS Committee is responsible for determining priority orders for requests. When necessary data processing requests are not implemented in a timely manner, managers cannot efficiently and effectively administer their programs. Vital and timely information for decision making is not available.

According to DSS staff, there are several reasons requests have not been implemented. First, the Data Processing Division has lost 11 positions since 1980. The Division is discussing the possibility of "contracting out" to catch up on the backlog.

Also, top management has not reviewed the backlog to determine the most cost-efficient method of resolving this problem. Additionally, DSS does not periodically review old requests to determine if they still need to be completed.

RECOMMENDATIONS

DSS MANAGEMENT SHOULD REVIEW THE BACKLOG OF COMPUTER PROGRAMMING NEEDS OF THE AGENCY. THE MOST COST-EFFICIENT METHOD OF QUICKLY PROCESSING OUTSTANDING REQUESTS SHOULD BE IMPLEMENTED.

DSS SHOULD, ON A PERIODIC BASIS, EXAMINE REQUESTS WHICH HAVE NOT BEEN IMPLEMENTED IN A SPECIFIED TIME PERIOD. A DETERMINATION IF THE REQUEST SHOULD BE DELETED SHOULD BE MADE.

# APPENDICES

## APPENDIX 1

## LIST OF TABLES

APPENDIX 2

SURVEY OF DSS EMPLOYEES

# LEGISLATIVE AUDIT COUNCIL

## STATE OF SOUTH CAROLINA

620 BANKERS TRUST TOWER
COLUMBIA, SOUTH CAROLINA 29201

TELEPHONE:
803-758-5322

January 6, 1984



Dear DSS Employee:

At the request of the South Carolina General Assembly, the Legislative Audit Council is studying the South Carolina Department of Social Services. As part of this study, all employees at the DSS central office are being asked to participate in a survey.

We would greatly appreciate your honest and candid answers to the enclosed questionnaire. It is not necessary that you identify yourself since we are only interested in your response.

Please return the completed questionnaire to the Audit Council through the United States Mail, in the postage paid envelope provided, by January 16, 1984.

Thank you for your help, and if you have any questions do not hesitate to call Andy Young at 758-5322.

Sincerely,

George L. Schroeder

George L. Schroeder
Director

GLS:sp

The following statements express a range of opinions or feelings people might have about their job -- their work, their contacts, their opportunities, etc.

Please respond to each statement by showing how much you personally agree or disagree with it, using the following codes and circling only one for each statement:

1 - Definitely Agree
2 - Inclined to Agree
3 - Inclined to Disagree
4 - Definitely Disagree

| % Responding | | | | | |
|---|---|---|---|---|---|
| No Response | 1 | 2 | 3 | 4 | |
| 0.4 | 43.7 | 40.7 | 11.0 | 4.1 | 1. I like and enjoy my work here. |
| 0.6 | 28.0 | 38.2 | 19.9 | 13.4 | 2. My supervisor does all he/she should to insure getting good teamwork and follow up (e.g., checks on assigned work, reviews performance, measures accomplishments against established goals, etc.) |
| 0.2 | 33.1 | 34.8 | 20.1 | 11.8 | 3. My supervisor is always appreciative of my efforts to contribute suggestions and ideas and gives proper credit for those submitted to him/her. |
| 0.2 | 12.8 | 24.6 | 30.7 | 31.7 | 4. Sometimes I am left in the dark because there is no way to tell if my work is satisfactory to my supervisor. |
| 0.8 | 11.2 | 20.5 | 24.0 | 43.5 | 5. I am satisfied with my chances to be promoted to a better position (higher level) in the future. |
| 0.0 | 17.9 | 29.1 | 26.6 | 26.4 | 6. The work in this office provides me with ample opportunity to grow professionally. |
| 0.4 | 27.4 | 33.9 | 21.3 | 17.1 | 7. The policies and organizational structure of this office have been clearly set forth and explained. |
| 0.2 | 24.0 | 24.0 | 30.3 | 21.5 | 8. Too frequently I am kept in the dark about what goes on around here. |
| 0.6 | 20.3 | 44.1 | 22.4 | 12.6 | 9. The work I do receives adequate recognition and respect from my associates. |
| 0.2 | 35.8 | 43.7 | 11.4 | 8.9 | 10. My supervisor gives me the proper amount of responsibility and delegates sufficient authority for me to carry out my assignments. |
| 0.0 | 29.1 | 40.6 | 19.3 | 11.0 | 11. I get a great deal of satisfaction out of my work because it means being connected with a successful office which renders good services. |
| 0.4 | 19.5 | 38.2 | 24.8 | 17.1 | 12. My supervisor helps me make full use of my abilities and experience and has given me specific help in improving my present job. |
| 1.8 | 10.4 | 25.0 | 28.5 | 34.3 | 13. People get ahead as fast in my office as they do elsewhere in the Agency. |

| No Response | 1 | 2 | 3 | 4 | |
|---|---|---|---|---|---|
| 0.2 | 18.9 | 41.9 | 23.2 | 15.7 | 14. My supervisor always lets me know beforehand of changes that will affect my work. |
| 0.6 | 9.8 | 19.1 | 39.4 | 31.1 | 15. My supervisor does not give proper credit for new ideas submitted to him/her. |
| 1.4 | 18.9 | 43.1 | 22.8 | 13.8 | 16. There has been sufficient effort devoted to reviewing and evaluating my performance in terms of specific objectives established for my job. |
| 0.2 | 16.7 | 43.3 | 24.2 | 15.6 | 17. My supervisor takes effective and prompt action to make use of good ideas or recommendations submitted to him/her. |
| 0.0 | 13.8 | 39.8 | 32.3 | 14.2 | 18. I can always depend on promptly getting from others the services and information I need to get my work done. |
| 0.0 | 15.6 | 37.2 | 26.0 | 21.3 | 19. In this office employees always know where they stand in the eyes of their supervisors. |
| 0.6 | 36.4 | 45.3 | 11.0 | 6.7 | 20. My present work gives me a chance to make a significant contribution to the success of this office. |
| 1.4 | 23.8 | 37.6 | 25.2 | 12.0 | 21. A good job has been done in making known and interpreting the objectives of this office. |
| 0.4 | 22.4 | 42.5 | 24.0 | 10.6 | 22. I get a great deal of personal satisfaction because my job involves working with well-qualified associates. |
| 3.2 | 34.1 | 25.8 | 24.4 | 12.6 | 23. The promotion policies of the Department do not emphasize merit. |
| 0.8 | 16.9 | 24.6 | 34.8 | 22.8 | 24. My supervisor does very little to challenge me or increase my interest in the work of this office. |
| 1.2 | 29.7 | 21.7 | 28.9 | 18.5 | 25. There is a need for considerable improvement in the teamwork of staff in this office. |

2.0 Yes 0.8 No 97.2 — 26. Has anyone from your agency tried to influence your response to this survey?

27. What policies or practices at your agency have positively affected your ability to do your job?

_____

_____

_____

28. What policies or practices at your agency have negatively affected your ability to do your job.

_____

_____

_____

12.2 Yes 33.7 No 54.1 — 29. Do you supervise other people?

COMPLETE THE NEXT SECTION ONLY IF YOU SUPERVISE OTHER PEOPLE.

Have you taken any training courses or seminars in the skills and techniques of supervision (for example: management style, communication, employee motivation, human relations, leadership, etc.) during calendar year:

| No Response | | | | | |
|---|---|---|---|---|---|
| 7.0 | Yes 18.1 | No 74.9 | 30. | 1983? If yes, list the following: | |
| | | | | Course Title | Length (days) |
| 18.7 | Yes 12.9 | No 68.4 | 31. | 1982? If yes, list the following: | |
| | | | | Course Title | Length (days) |
| 20.5 | Yes 15.2 | No 64.3 | 32. | 1981? If yes, list the following: | |
| | | | | Course Title | Length (days) |

South Carolina
Department of Social Services

P. O. BOX 1520
Columbia, South Carolina 29202-9988

JAMES L. SOLOMON, JR.
COMMISSIONER

January 29, 1985

Mr. George L. Schroeder
Director
Legislative Audit Council
620 Bankers Trust Tower
Columbia, South Carolina 29201

Dear Mr. Schroeder:

I am writing to provide the Department's comments regarding the Legislative Audit Council Report on the South Carolina Department of Social Services.

We wish to state at the outset that we appreciate the professional and competent manner in which the members of your staff conducted the audit. We feel that the audit was thorough and we agree in principle with its findings and recommendations. However, we do have some comments.

The limitations placed upon the length of our response does not permit us to comment to any great extent on the narrative of the report. Consequently, we will limit such comments to several specifics regarding the approach of the narrative. First, in the chapter which discusses Child Protective Services, a number of examples are cited, ostensively to illustrate the quality, or lack of quality, of services in this program area. While the examples cited are from actual case files, the frequency of occurrence of the actions cited in the examples are not given. This could leave the impression that the examples reflect typical occurrences; while in fact, they reflect isolated occurrences. In our response to the draft audit report, we took the position that since this report is intended to be a report of facts, either the frequency of the occurrence of the actions cited by the examples given should be cited or the examples should be deleted. However, the Legislative Audit Council decided to leave the examples in without stating the frequency of their occurrence. Therefore, we wish to note for the record that the examples cited, represent isolated occurrences.

Also, with respect to the narrative, in a number of instances the report stipulates dollar loses or dollars that would have been saved if actions different from those that actually occurred had been used. It must be noted that these estimates have not been substantiated.

Finally, with respect to the report's narrative, it is stated that the creation of the Health and Human Services Finance Commission has resulted in the transfer of Medicaid, Social Services Block Grant and the Child Development (with the exception of its regulatory functions) programs to that agency. Further, you have stated that the Child Support Enforcement Legal Division is located in the Office of the

Attorney General. Accordingly, those agencies are the appropriate ones to comment on the sections of the report which reference their programs.

Our remaining comments will be limited to the major findings of the report and certain of its recommendations. Many of the recommendations reflect conditions identified by the agency prior to the issuance of the report. In such cases, steps have been taken or are being taken, to address these conditions. We wish also to note that the report contains several recommendations which fall within the province of the South Carolina General Assembly. We will not comment on such recommendations. Our comments on the major findings are as follows:

Major Finding: The Child Protective Services Program needs improvement. Child Abuse and Neglect Investigations are inadequate. Treatment plans are not being used and Family Court requirements are not being met. Casework has been inadequate in this area.

Response: In recent years, a great deal of attention has been focused on the problem of Child Neglect and Abuse. South Carolina, like many other states, is struggling with the problem of reconciling the expectations of the community, Legislature, Courts and special interest groups with the realities of decreasing resources for Human Service programs.

In April 1984, the State Board requested the development of recommendations and strategies for enhancing the effectiveness of the Child Protective Services program. These recommendations were approved by the Board on May 16, 1984 and are presently being implemented.

As a companion effort, during May 1984, a statewide evaluation of Child Protective Services Delivery System was conducted by the American Humane Association, Child Protection Division. The evaluation identified program strengths, as well as, areas which needed refinement. The recommendations of this report complemented the enhancement strategies that were initiated by the Board in May 1984.

Also, on September 24, 1984, the second phase of the Department's plan to enhance Child Protective Service was initiated. Forty-seven (47) public forums were scheduled throughout the state. The forums were designed to elicit public comment from citizens concerned for the quality of the Child Protective Services Delivery System. Finally, on October 22, 1984, the membership of the Children's Coordinating Cabinet gave final approval to recommendations of the Cabinet which are also designed to improve this service delivery function. An analysis of these recommendations has been developed and strategies and time lines set for the implementation of each recommendation in which DSS is identified as the "lead agency" or shares "lead agency"responsibilities.

These activities are cited to demonstrate the activities taken and those underway that are designed to improve the Child Protective Services program.

Major Findings: a) A delay in automation of the Child Support Enforcement program has cost approximately $1.9 million annually in the collection of Child Support Payments.

b) DSS management has been ineffective in collecting Child Support payments owed the agency through its tax intercept program. The agency could have collected over $3 million more with an adequate tax intercept program in 1983.

Response: In an effort to improve the effectiveness of the South Carolina Child Support Enforcement System, a task force, in this subject area, was established in August 1984. The task force completed its work in October 1984 and the State Board took the following actions:

- Adopted an organizational structure and design for the development and operation of a Comprehensive Child Support Enforcement System in South Carolina;

- Approved draft legislation required to implement the Comprehensive Child Support Enforcement System; and,

- Directed the identification and assessment of needs/ requirements, e.g., funding, staffing, automation, etc. to implement the Comprehensive System.

In addition, on November 16, 1984, Governor Riley signed an Executive Order No. 84-37, which established the State Commission on Child Support in compliance with Public Law 98-378, the Child Support Enforcement Amendments of 1984. The Governor appointed the Commissioner of the Department of Social Services as Chairman of the Commission. The purpose of the Commission is to examine, investigate and study the operation of the South Carolina's Child Support System to determine the extent to which the State's system has been successful in securing support and parental involvement for all children receiving Child Support. The work of the Commission and the actions taken by the DSS Board will address the deficiencies as noted in this finding.

Major Finding: DSS has not adequately collected funds owed the agency from providers and clients. Over $6.6 million in delinquent debts is outstanding from doctors, dentists, hospitals, nursing homes and clients.

Response: The agency has secured the services of a collection firm in an effort to improve the collection of funds owed from providers and clients.

Major Finding: The agency faces federal penalties in the Food Stamp, AFDC and Medicaid programs because of excessive errors. These penalties could cost the State over $6 million in program and administrative funds.

Response: In an effort to lower the error rates and prevent sanctions, a special Corrective Action Team has been formulated. This Team is charged with initiating and maintaining corrective action efforts in the thirteen (13) largest Counties in the State, for a test period of six to nine months. The Team will also develop and implement a performance accountability process (Quality Assurance System). This system will ensure that the quality of economic services delivered meets the regulations and guidelines set forth by the federal government. The Team will develop and implement the following:

1. A quality/quantity workload management system to measure worker/unit/county error rates;

2. An error prone profile system designed for front end detection of client errors; and,

3. Provide training resources to meet the particular training needs of each County, as requested.

The automated Food Stamp System is being implemented. It is now operational in sixteen Counties and will be operational in all 46 Counties by June 30, 1985.

Major Finding: DSS Management has not complied with the assistance to Minority Business Act. The agency has not insured that minorities are afforded the opportunity to fully participate in the State's procurement process.

Response: The DSS Minority Enterprise Utilization Plan was approved by the State Board in July 1984. The Plan incorporates a goal of 30 percent minority participation by DSS and a Joint Venture Policy Statement. The Joint Venture Policy of the agency requires that "all contractors (non-minority) form a joint venture partnership with minority owned business enterprises, where feasible." If a joint venture is not formed, the parties are required to complete a Joint Venture Disclosure Affidavit and submit it to the DSS Procurement Officer. "Joint Venture" is defined to be "a collaborative undertaking of two or more firms or individuals for which the participants are both jointly and individually responsible."

Medicaid Program: The report states that the failure of the agency to implement appropriate cost containment measures in the Medicaid program resulted in a loss of one-half million dollars annually in drug costs. The report further states that certain actions by the State Board in this area were inappropriate because of recommendations that did not come through the Drug Formulary Committee. We wish to call to your attention, that all recommendations were approved by the Pharmaceutical Advisory Committee. These recommendations were not considered by the Drug Formulary Committee because during the referenced period, that Committee was not functioning.

DSS Boards: The remainder of our comments relate to the portion of the report which addresses the DSS Boards. The report states that one Board member "has elected to abstain from voting because of a possible conflict of interest ..." We wish to call to your attention that this statement is no longer relevant (since the Medicaid function has been transferred to the State Health and Human Services Finance Commission).

With reference to the recommendations that the Board should enact a policy which gives its members an incentive to attend Board meetings, it is the agency's position that this is a Legislative matter. Accordingly, the Board does not have the authority to discipline its members.

Again, we wish to thank you for the professional manner in which your staff has conducted this audit and assure you that we are committed to take appropriate steps to implement recommendations that will enhance the effectiveness of the agency in meeting its responsibilities to its clients as prescribed by State and Federal law.

Sincerely yours,

James L. Solomon, Jr.

James L. Solomon, Jr.
Commissioner

JLSjr-h

# State of South Carolina

## State Health And Human Services Finance Commission



*P. O. Box 8206, Columbia, South Carolina 29202-8206*

January 10, 1985

Mr. George L. Schroeder, Director
Legislative Audit Council
620 Bankers Trust Tower
Columbia, South Carolina 29201

Dear Mr. Schroeder:

The State Health and Human Services Finance Commission has reviewed the changes made to the draft audit of the Department of Social Services and have no additional comments. We appreciate the opportunity to have input into the audit prior to it becoming final and look forward to working with you in the future.

Sincerely,

Thomas K. Barnes, Jr.
Deputy Director
Administrative Services

TKBjr/bl

cc: Mr. Dennis Caldwell

# State of South Carolina

## State Health And Human Services Finance Commission



*P. O. Box 8206, Columbia, South Carolina 29202-8206*

December 5, 1984

Mr. George L. Schroeder, Director
Legislative Audit Council
620 Bankers Trust Tower
Columbia, South Carolina 29201

Dear Mr. Schroeder:

The Health and Human Services Finance Commission has the following comments to make of the draft audit of the Department of Social Services:

Chapter II - Child Protective Services and Child Support Enforcement:

Improvements Made in Child Development Program - The last sentence of the first paragraph on page 48 has an error. That sentence reads: "An entire program in one county was transferred to a contractual provider in November, 1983." A more accurate statement would read as follows: "By November, 1983 entire programs in four counties were transferred to contractual providers." (Note: Entire programs were transferred to contractual providers in Richland, Darlington, Florence, and York counties).

Medicaid Debts - The discussion of debts would be much clearer if a chart were developed showing the following:

| TYPE DEBT | TOTAL ACCOUNT RECEIVABLES | DELINQUENT ACCOUNT RECEIVABLES |
|---|---|---|
| Welfare Fraud | _____ | _____ |
| Hospital | _____ | _____ |
| Nursing Home | _____ | _____ |
| Drug | _____ | _____ |
| Doctor | _____ | _____ |
| Etc. | _____ | _____ |
| Total | 7 Million | 2.8 Million |

This would denote where overpayments are occurring and which providers are delinquent in payment of their debts. Also, if there are exceptions noted in the delinquent accounts they could be footnoted and explained in detail.

Chapter II - Medicaid:

Hospital Cost Containment Measures - Laboratory Services

HHSFC is in the process of implementing a fee schedule for laboratory services performed by a hospital for all outpatients. The fees will be set at 62% of the Medicare areawide prevailing charge. This basically eliminates the difference in reimbursement for laboratory services for ambulatory patients furnished by a hospital and an independent laboratory. This action is expected to yield a substantial savings. HHSFC will monitor this initiative with the thought of extending it to other components of hospital services such as radiological services.

Hospital Cost Containment Measures - Prospective Payment

South Carolina Medicaid administrators have recognized for some time that the existing cost related inpatient hospital reimbursement methodology does not furnish incentives for efficient operation. An independent study has estimated that it will cost an additional $13 million dollars to fund a prospective payment system for inpatient hospital services because the limitations on the number of covered days will be eliminated. This short term increase in cost will result in long term savings. HHSFC is supportive of legislation seeking funding for a prospective payment system, is prepared to explore alternative systems and implement the most effective system when funding is available.

Nursing Home Reimbursement Guidelines

HHSFC has proposed a nursing home contract with a reimbursement methodology that specifically defines allowable costs. The proposed allowable costs address the issues set forth in the LAC report. The contract is in the final stages of negotiation now. Implementation has been delayed due to litigation.

Intermediate Care Patients Paid at Skilled Rate

The current negotiations with nursing homes include a proposal to provide incentives to serve patients requiring heavy nursing care. This may lead to a comprehensive patient assessment system. Once this initiative is in place, patient assessment and reimbursement will more accurately reflect the services furnished a patient.

Medicaid Cost Containment Programs Needed - Mandatory Second Surgical Opinion Program

HHSFC has proposed a pilot project to test the effectiveness of a mandatory second surgical opinion program in South Carolina. This project is in the planning stage at this time. The reason for testing this program on a pilot basis before instituting it statewide is that there are conflicting opnions regarding the effectiveness of mandatory surgical opinion programs.

Medicaid Drug Program

The current drug program has been enhanced to include the availability of all prescription drugs and certain over the counter items (with stated exceptions) which in effect removes all the formulary restrictions to the use of generic drugs.

The use of generics is controlled by No. 595 An Act to Enact the Drug Product Selection Act of 1978. This Act is a part of the Laws, Rules and Regulations governing the Practice of Pharmacy in South Carolina which is administered by the Board of Pharmacy. The consent of the physician and the patient is needed to substitute a generic product for a brand name. Under the present system there is no inducement for a Medicaid recipient to request a generic product. Changes in the legal restrictions would require action by the legislature.

Competitive Bidding for Independent Lab Services

Independent laboratories are reimbursed through a payment schedule. Management reports show that providers are reimbursed approximate 58% of their charges. Effective October 1, 1984 the fees paid under the payment schedule were capped at 60% of the Medicare areawide prevailing charge, further reducing reimbursement. The net effect of this reduction is not known at this time. HHSFC plans to conduct appropriate analysis to determine whether competitive bidding for independent laboratory services offers advantages.

Third Party Liability Program

With one exception, the LAC recommendations reflect HHSFC's long-range plans for Third Party Liability (TPL). The crucial recommendation is listed last on the report: that adequate staff and resources be allocated to the TPL activities. The first three recommendations form an interlocked set of activities that require substantial data processing support. Those recommendations are: 1) that health insurance data be collected by caseworkers, stored in the client information system, and reported on the Medicaid identification card, 2) that the health insurance data be used to cost-avoid Medicaid payment where possible, and 3) where not possible, that follow-up efforts be made to recoup benefits. A Request for Computer Services to develop a TPL subsystem within MMIS that would allow the performance of those three tasks has been submitted. This project qualifies for 90% FFP.

The LAC recommends that legislation be drafted to strengthen legal support for TPL activities. A committee of Legal Counsel, TPL and Medicaid program staff has just approved a final draft of new legislation for pre-filing.

At present, as the recommendations point out, no effort is made to identify what portion of unsolicited provider refunds are TPL refunds. Unsolicited refunds total about $1 million a year. The new adjustment process was originally intended to set a structure in place to not only identify the refunds but also reflect them in the paid claims history. Phase one of that project has been installed; the rest remains a high priority project. (This project extends far beyond the TPL area in Medicaid.)

The LAC recommends auditing major providers to identify third party payments the providers may have received which have not been refunded to Medicaid. Except in limited cases, TPL staff does not believe that auditing will be an effective means of TPL pursuit. The best estimate of total cost savings from TPL is 2% of total Medicaid benefits. That percentage includes some unknown number of claims that might have been submitted to an insurer but have not been submitted; auditing will not discover such potential claims. Unrefunded insurance payments are such a small percentage of claims paid that auditing would not discover a substantial part of the TPL potential.

Competitive Bidding for Claims Processing

The legislation which established HHSFC requires that HHSFC contract with DSS for claims processing during fiscal year 1984-85. HHSFC plans to explore all viable options for claims processing during future periods.

Families Not Required to Pay Nursing Home Costs

Idaho did pass a law which stated relatives (both children and parents) were responsible for some costs associated with institutional care. The state made collections for six (6) months. The Attorney General's Office ruled that this law was not one of general applicability and Idaho returned all collections and requested emergency repeal of the law. The State Legislative however wished to study the issue further with the possibility of pursuing a waiver. In summary, there is currently a law on Idaho's books, however, it is not being enforced. It should also be noted that the Federal Government did not participate in any of the monetary collections and did not support the law.

Chapter V - Administration:

Data Processing Requests

Requests for enhancements to the Medicaid Management Information System (MMIS) are considered by a coordinating committee comprised of the major users of the system. Data processing professionals act as advisers to the committee. The committee's functions are to consider the validity of each request, establish the priority in which requests will be handled and coordinate activites between the users and data processing. Semi-annually all requests that have not been acted on are reviewed to be certain they are still applicable. Those which are not applicable are omitted from future consideration.

Thank you for the opportunity to comment on this report.

Sincerely,

Thomas K. Barnes, Jr., Deputy Director
Administrative Services

TKBjr/mpkm

# The State of South Carolina

T. Travis Medlock
Attorney General

Attorney General

803-758-3970
Columbia 29211

January 18, 1985

Mr. George L. Schroeder
Executive Director
Legislative Audit Council
620 Bankers Trust Tower
Columbia, S.C. 29201

RE: DSS Comprehensive Audit Report - Medicaid Fraud

Dear Mr. Schroeder:

We appreciate the opportunity which the Legislative Audit Council has provided to the Attorney General to make written comments for inclusion in your published audit. Of course, our Office has reviewed only that portion of the draft audit which deals with medicaid fraud and abuse. This particular section addresses the area of concern relating to the Medicaid Fraud Unit operating in the Office of the Attorney General which reviews, investigates, and prosecutes certain suspected medicaid fraud cases. Since we have not been provided any other portions or parts of the draft report concerning the Department of Social Services, our comments are limited in this respect.

In response to the portion of the Legislative Audit Council Report, Chapter 3, entitled "No State Medicaid Fraud Laws", the Attorney General wholeheartedly agrees that existing State laws do not provide an adequate framework within which medicaid fraud cases can be adequately and effectively investigated and prosecuted. Last year, members of the Attorney General's staff assisted members of the State Senate in drafting adequate medicaid fraud statutes. Unfortunately, the legislation which was introduced did not obtain passage.

In an effort to remedy the problem which presently exists, the Attorney General has directed his staff to draft a proposed Medicaid Fraud Statute which addresses the present inadequacies of our State law. The Attorney General will discuss the proposed bill with members of the House and Senate in the next two weeks, and will recommend and urge prompt passage of a Medicaid Fraud Act during this legislative session.

In summary, the Attorney General concurs with the Legislative Audit Council's recommendation that additional legislation is necessary to adequately combat medicaid fraud. It is hoped that the General Assembly will act favorably on the Medicaid Fraud Statute which the Attorney General recommends.

An additional section under Chapter 3 of the published audit is entitled "Use of Federal Funds to Combat Fraud". The report correctly points out that there exists a procedure whereby the State of South Carolina may apply to the U.S. Department of Heath and Human Services for certification of our Medicaid Fraud Unit. In the event that certification is granted, the federal government would then fund the operation of the Medicaid Unit at the rate of 90% for the first three years and 75% thereafter. Presently, the Medicaid Unit receives 50% funding from the federal government.

When the Medicaid Fraud Unit was transferred to this Office in 1982, former Attorney General Daniel R. McLeod and his staff discussed with members of the General Assembly the advantages and disadvantages of certification. Concerns were expressed that utilization of the 90% federal grant would result in unnecessary personnel increases and inefficient utilization of existing staff. There were concerns that the withdrawal of such federal funding, which could occur at any time, would place an unexpected financial burden on the State and/or substantially disrupt the ongoing efforts of the Unit. Obviously the conclusion was reached that, on balance, the disadvantages of certification outweighed the funding advantages that certification provided.

The Attorney General has decided, however, to conduct a review of the certification issue with concerned members of the General Assembly. One consideration is the fact that federal certification will require legislative funding for an accountant position in the Medicaid Fraud Unit in the 1985/86 budget. However, if it now appears to be to the State's advantage to seek federal certification of the Medicaid Fraud Unit, the Attorney General will initiate that process as soon as possible.

Please note that, even without the funding provided through certification by the federal government, the Medicaid Fraud Unit has achieved a number of positive results during the last two years. Additionally, the Attorney General has placed the Medicaid Fraud and Consumer Fraud Sections of the Office under the Criminal Prosecution Section, a step which should provide better logistics for our Medicaid Fraud Unit.

We appreciate the opportunity to submit these written comments. Thanking you for your cooperation in this matter, I remain

Very truly yours,

Nathan Kaminski, Jr.
Executive Assistant for Administration

NKjr/drb