AN ANALYSIS OF THE HANDICAPPED CHILDREN' PROGRAM WITHIN THE DIVISION OF FAMILY HEALTH SERVICES

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I. Potential Losses Within the Handicapped Children's Program

The Handicapped Children's Program of the Division of Family Health Services is vulnerable to losses in government resources in several major areas. First, the aggregate level of services provided to handicapped children from all sources throughout Massachusetts may be large compared to the size of the problem. Second, the specific services provided to individual clients in the Handicapped Children's program may be "excessive" (i.e., the treatment offered may be so comprehensive or so lavish that serious issues of equity arise when compared with services provided to other populations). Third, the Division may fail to produce the maximum level of services possible within the resources provided to the Handicapped Children's Program. Fourth, the Division may be failing to collect reimbursements from "third parties" who are both liable and able to pay for the services. Fifth, the Division may be vulnerable to different types of fraud. Evidence suggesting that losses are, in fact, accruing in these areas, and descriptions of the vulnerability of the Division to these charges are offered below.

A. Aggregate Levels of Services Compared to the Problem

The size of the population to be treated by the Handicapped Children's Program is probably the most difficult issue to be resolved. It is difficult to estimate the population afflicted by one or more crippling conditions; difficult to develop a sense for the relative seriousness of the disability within and across diagnostic categories; difficult to know which cases are acute cases to be treated ad dismissed and which are chronic requiring regular management over the long term; and difficult to know how much of the problem can be effectively handled by the private sector alone.

Lacking solid data on either the size of the population to be treated or the level of services provided by other institutions in both private and public sectors, the Division of Family Health Services is vulnerable to the unholy suspicion that there is more than enough treatment capacity for handicapped children. Several observations kindle this skepticism. First, the Division appears to underspend its budget each year.[1] Second, in every region we visited, there appeared to be excess capacity in one or more service programs.[2] Third, since we know: (a) that the population of seriously handicapped children is small; (2) that serious handicaps are often associated with other problems such as mental retardation; (3) that there are other very large institutions committed to the care of handicapped children (e.g., the Department of Mental Health; the Special Education Programs established by Section 766; the Massachusetts Rehabilitation Commission; the Massachusetts Commission for the Blind; and a huge medical establishment); and (4) that the most serious handicaps will be relatively easy to diagnose and will stimulate aggressive parental efforts to find treatment; it seems a safe bet that a large portion of the population will be treated.

These observations fail to provide compelling proof that the system is too large. However, the fact that this weak evidence makes some claims on our credibility points to several vulnerable areas in the Handicapped Children's Program. First, the organization lacks any serious estimate of the size and character of the problem. Second, the program is not currently coordinated with competing (or

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[1]The Federal Crippled Children's budget had a carryover of approximately $50,000 in Fiscal Years 1974, 1975, and 1976. Expenditures in the 03 category of the State Crippled Children funds are significantly below the $678,000 budgeted for Fiscal Year 1976.

[2]The Canton School had an excess capacity of ___ beds. The Kennedy Centers have never been filled to capacity.

complementing) providers of services to handicapped children. Third, the Division lacks a system for monitoring the utilization of its capacity.

B. Excessive Services to Individual Clients

The issue of "gold plated" services is also difficult to resolve Part of the problem is the lack of widely accepted standards for treating handicapped children. However, a more serious part of the problem is that it appears that a major objective of the Handicapped Children's program is to establish a new, higher standard for service to this population. Given this situation, it is difficult to document a charge of excessive service.

Still, two observations raise the issue. First, the unit costs of services contracted in the Multiple Handicapped Program are sufficiently high compared with services to other populations that the issue cannot be avoided. Table 1 presents some data on costs of service units. Second, since national studies reveal significant levels of excess surgery; since the largest clinics in the program are orthopedic and cardiac clinics; and since physicians in the clinics routinely refer patients to themselves for surgery [see Sussman data]; the issue of a particularly dangerous type of excess service appears.

Again, even if untrue, the Division is currently defenseless against the charge of "gold plating" because it lacks established standards for treatment and a system of medical audits. Indeed, in a few programs (e.g., Cystic Fibrosis; Eplipsey), the decision to provide medical services is made directly by providers without review by FHS personnel. Approximately $800,000 is involved in these programs. [$643,000 for Cystic Fibrosis; $136,000 for Epilepsy].

Table 1

Unit Costs of Services Provided
by Division of Family Health Services

Service	Unit Cost
I. In-Patient Evaluation Center (Canton)	$690/Child-Week
II. Developmental Day-Care Programs	
1. Kennedy Center (Duxbury)	$138/Child-Week
2. University Hospital	$124/Child-Week
3. Kennedy Center (New Bedford)	$120/Child-Week
4. Early Beginning Center	$111/Child-Week

C. Inefficient Production of Services

There is much less uncertainty about the issue of efficient production of services: there is substantial evidence of inefficiency in the clinic program; and a strong presumption of inefficiency in the multiple handicapped program.

Table 2 presents [Tom Glynne] estimates of the costs of clinic visits in the crippled children program. The estimates of [$100] per visit does not compare well with other out-patient clinics. In addition, in calculating proposed billing rates for the Northeast Region, the Division proposed that 3 days of a nurse's time; 3 days of a physical therapist's time; and 2 days of a secretary's time be allocated to each 1/2 day clinic session--in addition to the costs of the Medical Consultant!

The major problem in the Multiple Handicapped Program is loosely written contracts. Table 3 presents a listing of $1.64 million in contracts made under the 03 account of the State Multiple Handicapped Program. As one can see, 60% of the contracts representing 33% of the funds are "line item" contracts which fail to specify required levels of service or reports on levels of service delivered. With such contracts, there is virtually no incentive for efficient production. Within the other contracts, incentives for performance are attenuated because there is no headquarters capacity to audit the reports.

The Division is defenseless against this charge because it lacks a system for monitoring levels of services provided directly or under contract. They do not know how many service units are provided, nor how many clients receive these services. In addition, their budget and accounting systems are not currently set up to monitor costs in directly provided services.

Table 3

List of Expenditures
Multiple Handicapped 03 Account

	OUTPUTS		INPUTS		Type of Contract
	Clients	Service Units	Total Cost	Staff	
II. Multiple Handicaps Program (03)			1,647		
A. Early Identification and Development			250		
1. Thom Clinic: Intervention Team	?	?	30	3	Line Item
2. Hampden County ARC	?	?	74	9	Line Item
3. Human Services Corp.	?	?	96	7	Line Item
4. N.E. Medical Center (Kearsky)	25-35	?	50	3.5	Line Item
B. Evaluation Centers			121		
1. AOE (Canton Nursery)	?	175 Child-Weeks	121	8.5	Line Item
C. Developmental Day-Care Centers			966		
1. AOE (Early Beginning Center)	15	600 Child-Weeks	67	9	Per Diem
2. Christ Church	11	?	16	5	Per Diem
3. Thom Clinic: Anne Sullivan	?	?	44	4	Line Item
4. Thom Clinic: East Mountain	6	?	39	3	Line Item
5. Kennedy Center: New Bedford	33		114	16.2	Per Diem
6. Kennedy Center: Dunbury	26		152	16.2	Per Diem
7. Kennedy Center: Foxboro	36		180	14	Per Diem
8. University Hospital	60		321	26.5	Per Diem
9. Boston Center for Blind	?	?	33	3	Line Item
D. Miscellaneous			61		
1. Education Collaborative			53		Line Item
2. Project Accept			7		Line Item
3. Northern Berkshire			1		Per Diem
E. Blanket (Consultants & Services)			249		

D. Reimbursements from "Third Parties"

It is important to keep in mind that the expenditures of the Handicapped Childrens' Program represents only a fraction (probably a small fraction) of the total amount of government and private expenditures on handicapped children. Some portion of the total expendtures and services are provided without any participation from Family Health Services (e.g., privately diagnosed and purchased; privately diagnosed and publicly funded through Medicaid; publicly diagnosed and funded wholly through other agencies). However, even for cases known to FHS, the FHS expenditures represent only a fraction of the amount expended on the client population. The remainder of the services recommended by FHS to their client population are paid by "third parties." To the extent that FHS can shift the burden of paying for services to these third parties, they can provide services to a larger population within a constant budget.

It is useful to analyze FHS reimbursement efforts in terms of different "third parties" to be pursued within different programs. Basically, there are four important categories of "third parties": government insurance programs for the poor (Medicaid); other government programs obligated to provide services to handicapped children (DMH; Local School Systems; SSI); private insurance companies (regardless of how the client became insured); and the individual clients themselves. Similarly, there are three important classes of services within the Handicapped Children's Program: services provided directly to clients by FHS personnel (e.g., Crippled Children Clinics); services provided to FHS clients by private providers, but recommended and authorized by FHS personnel; and services provided by institutions under contract to FHS.

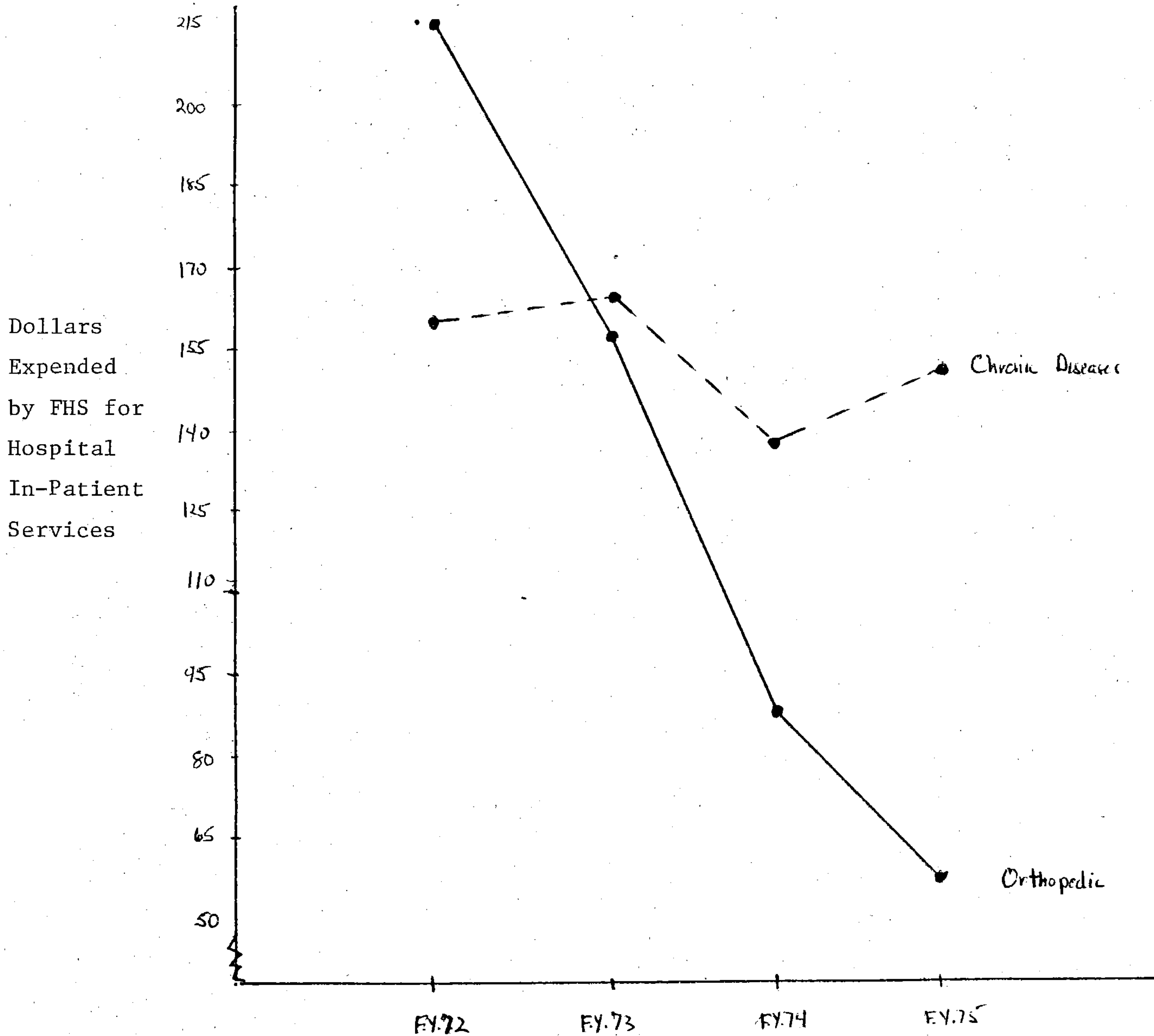
Efforts and accomplishments in securing reimbursements varies significantly across these programs and possible third parties. FHS' greatest success has been in the important area of seeking third party reimbursement from Medicaid and private insurers for services provided by the private sector under authorization from FHS clinics. For example, the total amount paid by FHS to private hospitals for services authorized in orthopedic clinics decreased from $215,000 in Fiscal Year 1972 to $60.000 in Fiscal Year 1975, while total hospital days authorized only declined from 9,000 in Fiscal Year 1972 to 6,000 in Fiscal Year 1974. [Some of this effect due to more extensive use of State Hospitals: remained at 3,000 days from Fiscal Year 1972 to Fiscal Year 1975 while total days were declining].

It interesting to note that while third party reimbursemnt seems to have become more effective in the orthopedic clinics which are effectively controlled by FHS, similar improvements have not developed in clinics that are less effectively controlled by FHS. Figure 1 compares dollars billed to FHS from hospitals over time in the orthopedic clinics (over which FHS has good control) with dollars billed for in-patient services in the Chronic disease program (over which FHS has much less control). To some extent, the difference reflects differences in the zeal with which third-party reimbursement is sought in the different kinds of clinics.

Recently, FHS has begun an experiment to secure reimbursements for services which they provide directly. They have made calculations to establish a billing rate for clinics in the Northeast Region, and have begun the design of record-keeping and billing systems. While this holds some promise, the experiment has not yet started. Moreover, once

Figure 1

Comparison of Dollars Billed to FHS for In-Patient Services
in Effecitively Controlled Clinics (Orthopedic) Compared
With Less Effectively Controlled Clinics (Chronic Disease Program)



Source: "Hospital Costs and Days" FHS Statistician's Office
Fiscal Year 1972 - Fiscal Year 1975

begun, it will be limited to the Northeast. In the meantime, over 1 million dollars in direct services are provided by the State Department of Public Health without reimbursement from private citizens who may be able to pay, [There is lip service paid to financial eligibility and clients sharing in the cost of drugs and outpatient services in the Program Director's Manual, but the system has no teeth] or who may have private insurance that covers them for these services.

The only effort made in securing reimbursements for contracted services has been to collect SSI payments from eligible clients in Pediatric Nursing Homes. It is not clear how much has been collected. Nor is the disposition of this money clear. In other contracted programs (representing 1.6 million in the 03 account of the Multiple Handicapped, and 0.6 million in the 03 account of the Pre-School Account), no effort is made to attract or monitor third-party reimbursements despite the fact that at least some of the programs have established billing rates. [e.g., Thom Clinic]

Table 4 summarizes the areas of potential reimbursement efforts, notes the areas in which efforts have been made, and indicates priority areas for future efforts. Note that theoretically, nearly all services provided by FHS could be billed to some "third-party." In this case, the budget of the program would have only two purposes: (1) "front end" money to develop a clinic infrastructure to attract cases; and (2) to cover large or small costs of otherwise uninsured people. The actual cost of treating handicapped children would have been transferred to other state and private budgets. While one cannot be sure what the right level of such money should be, it seems that 6 million devoted

Table 4

Potential Targets and Current Efforts of Reimbursement Policy

"Third Parties" / Programs Within FHS	Private Insurers	Medicaid	Other Government Programs (SSI;DMH)	Clients Themselves
I. Direct Services (Crippled Childrens' Clinics) (1 - 1.5 million)	Initial Stages of Experiment in Northeast Region. Should be Moved Quickly and Expanded.			Stricter Eligibility Determinants
II. Private Services	High Priority Success in Clinics Controlled by FHS	High Priority Success in Clinics Controlled by FHS		
Authorized by Clinics (600 Thousand)				
III. Contract Services (2.0 - 2.5 million)	No Action Yet: Very High Priority			

to this purpose would attract many people from the private sector; would stimulate a demand for services among marginal cases; and would insure many people who are "uninsured" only because they are rich enough to be "self-insured."

E. Fraud

[Major loopholes in chronic disease and cardiac surgery program amounting to perhaps $600,000. Problem noted above concerning contracted services billign third-parties without notification. Problems in verifying vouchers.]

II. Reasons for These Vulnerabilities

The Handicapped program is vulnerable to those potential losses because of chronic management problems involving the structure, personnel, and information systems in the Division of Family Health Services. We will discuss problems in three areas: clinic operations; contract operations; and overall integration of the program.

A. Crippled Children Clinics: (Combination Direct Services and Payments for Services)

- Some expenditures (Chronic Disease; Epilepsy; Hard of Hearing) are made without prior authorization by FHS personnel. The Gap should be closed.
- A major portion of the personnel providing services and administration support to the clinics lie outside the authority of FHS--even outside the authority of Bluestone.
- Management of clinics is currently split between geographic and functional units; and within functional units between professional groups (e.g., PT. S.W., Nurses) and specific

disease conditions. No overall head. Cass as chairman does not work. Pappas not around. Morse lacks professional stature. (Pappas has done good job have getting around civil services).

- Treatment protocols are fragmentary. No medical audit of cases.
- Reporting on services to clients within clinics is too infrequent and aggregative.
- No data on characteristics of clients (e.g., seriousness of disability; income of parents).
- Vouchers paid to private medical providers not keyed to clinics in which authorization was made (true for out-patient treatments--no in-patient or drugs where information is available).

B. Multiple Handicapped Programs (Contract Services)

- Loosely Drawn Contracts: (1/3 are Line Item; Services are spelled out too generally)
- No Validation of Reports on Levels of Services
- No controls over Third Part reimbursement
- No data on Client Characteristics
- Poor Coordination with Crippled Children Clinics
- Poor Coordination with DHH and Local Schools (Section 766)

C. Overall Management and Integration Within Handicapped Children

- No Regular Manager. (Pappas has done well in building up high class services; recruiting good staff).
- Budgets badly organized to track allocation of resources or expenditures.
- No organizational structure or staffing plan.
- No planning or evaluation capability.

III. Recommendations (See Atkins; Chase)

IV. Appendices

Appendix 1: Overview of to the Program

Appendix 2: Recent History of the Organization

Appendix 3: Estimates of the Size of the Problem in Mass.

Table 4

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