PROGRAM EVALUATION

THE CRIPPLED CHILDREN'S SERVICES PROGRAM

Research Report No. 201

Legislative Research Commission

Frankfort, Kentucky

Program Review & Investigations Committee

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THE CRIPPLED CHILDREN'S SERVICES PROGRAM

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Research Report No. 201

Legislative Research Commission
Frankfort, Kentucky
October, 1983

This report was prepared by the Legislative Research Commission and paid for from state funds.

FOREWORD

At the March 1, 1983 meeting of the Program Review and Investigations Committee, the membership voted unanimously to conduct a preliminary review of the Kentucky Crippled Children's Services Program. The study request came from several legislators who were concerned that decentralization of the program, which began July, 1982, would have a negative effect on the 14,000 children who receive medical services through the statewide program.

Our appreciation is extended to staff from the Department for Health Services, the Louisville based Crippled Children's Services program and the district health departments for their cooperation in providing information for the study. Particular appreciation is extended to Lynne Flynn and Jim Yonts of the Pediatric Services Branch, Department for Health Services.

This study was conducted by Mary Yaeger and Judith Rozeman with assistance from Vinson Straub. The manuscript was prepared by Esther Robison and Jeanie Privett.

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The Capitol
Frankfort, Kentucky
October, 1983

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SUMMARY

Purpose

On March 1, 1983, the Program Review and Investigations Committee was requested to carry out a preliminary review of the Kentucky Crippled Children Services (CCS) Program. The primary purpose of the request was to see if the program was operating as effectively and efficiently as it did when it was operated by the state Louisville CCS office. Specifically, the Committee was asked to investigate changes in: (1) services to children; (2) funding of the decentralized program, especially administrative costs; (3) the role of the Medical Advisory Committee (MAC); and (4) the effect of program changes on state employees.

Overview of the Study

A detailed analysis of the cost-effectiveness of the decentralized program was not possible, but remains to be done when the Department has additional budgetary data.

While the program has undergone transitional problems, patient service seems, for the most part, to have been maintained at a level equal to that of the program before decentralization. However, our study has shown that there are still issues related to decentralization that may have an effect on the quality of care and efficient program operations. We recommend sound budgetary practices based on needs assessment data, using accurate client and accounting information. Since the program is administered by the Cabinet for Human Resources and the Secretary is responsible for the program, statewide policies concerning eligibility, funding formulas, and clinic distribution should be promulgated by Kentucky Administrative Regulation.

Finally, there is a concern about the way decentralization was implemented. There may have been possible violations of merit system policy as it relates to the state employee resignation process. Also, the method in which decentralization took place may have ignored statutory restrictions on reorganization, as discussed in KRS 12.025, the Governor's reorganization powers.

Major Findings

Reasons for Decentralizing

1. Motivations for decentralization appears to have orginiated in a desire to see public health services administered at the regional level.
2. Assessment of conditions within CCS which needed improvement appears to have been a lesser consideration.

3. The Governor's order to reduce state employees was a catalyst to the process.

Changes in Budgeting and Expenditures

4. Funds were allocated to individual District Health Departments based on the District's poverty and non-poverty populations under age 21, but adjusted for service need after the first six months of operations.
5. State budgeting priorities seem to have shifted slightly away from the Personnel category to Operating Contracts, but "real" staffing expenditures were not decreased.
6. The scope, time and information available for a preliminary study left most questions related to administrative costs and appropriateness of expenditures unanswered.

Changes in Service Delivery

7. Our study produced no evidence to indicate that services to children or the number receiving services have changed significantly.
8. More children will probably be served close to home because of decentralization.
9. Efficient "out-of-district" service delivery is sometimes hampered by the case manager role.
10. Follow-up and outreach activities are improving.
11. Loss of experienced CCS nurses may have a negative impact on the quality of care.

Accessibility

12. There has been no apparent change in the number of children diagnosed or made eligible.
13. CCS parents surveyed do think that they have been effected negatively by decentralization.
14. Accessibility under decentralization for the severely disabled and multi-handicapped child needing more sophisticated health care is yet to be determined.

The Medical Advisory Committee

15. The MAC was informed of decentralization after the decision was made.

CCS Employees

16. Those employees who resigned and were hired by District Health Departments did not receive a reduction in pay; however, they lost state merit status and may have suffered other losses in benefits.
17. Merit system practices may have been violated in the resignation process.

18. CCS employees played a passive role in the decision and plan to decentralize.

Recommendations

1. The Department for Health Services should provide the Interim Joint Committee on Appropriations and Revenue an analysis of the fiscal impact of the CCS program since decentralization. This analysis should compare the allocations and expenditures prior to decentralization with those since (for FY 1983). The analysis should clearly delineate how allocations and expenditures were derived and operational definitions of all categories, including administrative, indirect and direct medical costs.
2. Budgetary and expenditure data should be refined to assure that budgetary ceilings are not exceeded.
3. The Cabinet for Human Resources should adopt regulations requiring that all "new" case managers/nurses working with the program in local health districts be trained, or have their training arranged for, in crippled children's conditions, diseases, and treatment.
4. The Division of Maternal and Child Health should streamline case management procedures in order to reduce paperwork, particularly when out-of-district care is provided by another case manager.
5. Eligibility determination, whether it is initial or updated, should be standarized, taking into consideration all relevant medical, financial, and family information. Responsibility for determination should be placed with responsible authorized agents as close to the client application process as feasible.
6. Funding medical care of children by district risks making accessibility of services contingent on local management of funds, not statewide eligibility practices and availability of funds. Therefore,
   (a) funds for medical services should either be drawn from a central statewide resource pool; or
   (b) the funding formula should take into consideration not only population data, but also frequency of medical conditions within a district, costs of care for these types of medical conditions, existing service populations, and other relevant factors.
7. The General Assembly should amend KRS 12.025 to specify that any internal agency change in program approach which results in a major shift of policy, funding or administrative approach, as outlined to the General Assembly and implied in the Appropriations Act, in effect shall constitute a reorganization for the purposes of this chapter.
8. The Program Review and Investigations Committee should request that the Kentucky Personnel Board review the resignation process of CCS employees as it relates to KRS Chapter 18A and 101 KAR 1:030 through 101 KAR 1:200, regarding merit employee rights and responsibilities.

9. The Cabinet for Human Resources should adopt programmatic and oversight policies as Kentucky Administrative Regulations. These should include, but not be limited to:
   (a) the eligibility determination process.
   (b) district funding formula.
   (c) process for which new clinics are approved or existing ones eliminated.

CHAPTER I

INTRODUCTION

Purpose of and Mandate to Conduct a Study

At the February 1, 1983 meeting of the Program Review and Investigations Committee, Representative Pat Freibert spoke on behalf of a review request which she, Senator Jack Trevey, and Representatives Joe Clarke and Billy Ray Smith had submitted eariler. The Committee directed staff to prepare a proposal for the review.

At the March 1, 1983 meeting, after an additional request and statements concerning the need for a study by Representative Gerta Bendl, the Committee unanimously voted to have staff conduct a preliminary review.

Concerns centered on the fear that decentralization of the Crippled Children's Services program will result in a less effective and efficient means of service delivery. Based on these concerns, a workplan was developed which focused primarily on a comparison of the "new" system with what had existed prior to July 1, 1982. Issues addressed in the study which follows are:

- changes in budgetary allocations and expenditures since decentralization;
- changes in services and children served since decentralization;
- changes in accessibility of services to crippled children since reorganization;
- the role of the Crippled Children's Services Medical Advisory Committee in the Cabinet for Human Resources' decision to decentralize;
- changes in state employees' salaries and positions because of decentralization; and
- overall justification and reason for reorganization.

Methodology

In order to accurately assess whether the decentralization of the CCS program is and will be an effective and efficient means of service delivery, the following data collection methods were used:

(1) **Comprehensive Written Information Requests to**

(a) Dr. David Allen, Commissioner of Health Services, Cabinet for Human Resources (CHR).

- Information covering all aspects of CCS program before and after decentralization.

(b) Executive Directors, twelve district health departments.

- Information covering budget, personnel, services, and procedures.

(2) **Interviews with**

(a) Department for Health Services, Central Office Staff.
- Information on program operations.

(b) Nurse/Case Managers.
- Representatives of both new and old CCS staff and office locations.
- Information on program status and procedures.

(c) Task Force Chairman for "Review of Kentucky's District Health Department Program."
- Impact of decentralization on the CCS program.

(d) Director, Louisville CCS program.
- Descriptive information concerning the Louisville-based CCS program.

(e) Member, Medical Advisory Committee (MAC).
- Information concerning consultation of the committee by the Cabinet for Human Resources before CCS decentralization.

(3) **Survey**
- Random sample of parents of CCS recipients (excluding Louisville area) who have been affected by decentralization.
- Gathering of information on perceptions of program changes and general level of satisfaction.

Limitations of Preliminary Review

The long-term effects of decentralization on the CCS program cannot be adequately addressed by a preliminary review. Because the implementation of the decentralization philosophy will be a gradual process, future benefits or problems cannot be assessed immediately. The delivery of services closer to home will not be fully realized in the short term.

Further Study

If an analysis of the cost efficiency of decentralization is to be done in the future, changes in the accounting and service reporting methods used, as recommended later in this paper, should be implemented to provide more reliable and consistent data.

CHAPTER II

RATIONALE FOR PROGRAM CHANGES

Crippled Children's Services Program Purpose and Scope

The overall mission of the Crippled Children's Services (CCS) program is to prevent handicapping conditions and to maximize the capabilities of children with the following eleven disabling conditions: cerebral palsy, cystic fibrosis, neurological disorders, cranio-facial anomalies, neurosurgical disorders, orthopedic conditions, conditions calling for plastic surgery, heart defects, eye injuries and disease, and hearing problems.

The eligible population are residents of the Commonwealth under age 21. Except for the initial diagnostic examination, the parent or guardian's ability to pay for services is a factor.

Mechanisms are in place to serve approximately 13,569 children through the following services: case finding, medical services, surgery, hospitalization and convalescent care, medication, provision of prosthetic devices, and a variety of therapies (e.g., speech, audiological, psychological, physical, occupational, and social services.)

Total funding for this program in FY 1983 is $7,809,561. For the federal fiscal year beginning October 1, 1983, $2,095,000 came from the Maternal and Child Health Block Grant.

Organizational History

A formal organization to serve handicapped children began in 1924, with the creation of the Kentucky Crippled Children's Commission. In 1960 the Commission for Handicapped Children was established (KRS 200.400 through KRS 200.500); it operated independently from its Louisville headquarters until its abolishment by the 1974 State Reorganization Act, creating the "umbrella" agency, the Department for Human Resources. The program for crippled children was placed within the Bureau for Health Services, Department for Human Resources; primary responsibility for the program's operation was retained in a centralized Louisville office. Services were provided through Louisville, seven regional centers and itinerant clinics throughout the state.

Present Organization and Decentralization

On June 16, 1982, Executive Order 82-543 renamed the Department for Human Resources the Cabinet for Human Resources (CHR). The Bureau for Health Services was renamed the Department for Health Services. A subsequent Administrative Order, HR 82-

18, July 15, 1982, established the Crippled Children Statewide Services Section and the Louisville Crippled Children's Clinic Services Section, under the Pediatric Services Branch, within the Division of Maternal and Child Health.

The Cabinet's efforts to have a portion of the functions of the Crippled Children's Services program assumed by the District Health Departments most notably took place in July, 1982. Children in all areas of the state, except in Louisville and surrounding counties, began receiving services through the District Health Departments. (See Figure A.)

The major decentralization activities include:

- The Human Resources Cabinet's agreement with twelve District Health Departments, called District Coordinating Agencies, to plan, provide and arrange for services to eligible children within designated geographic areas.
- CHR's allocation of funds to District Health Departments for the provision of services to children within designated geographic areas.
- CHR's agreement with the District Health Departments to contract for services, pay for services and supplies, collect patient and third-party billing and account for all expenditures incurred.
- The elimination of the Louisville Statewide headquarters and the establishment of a regional approach to service delivery.
- The reduction of staff within the state Crippled Children's Services program and the addition of employees with the District Health Departments for service delivery.

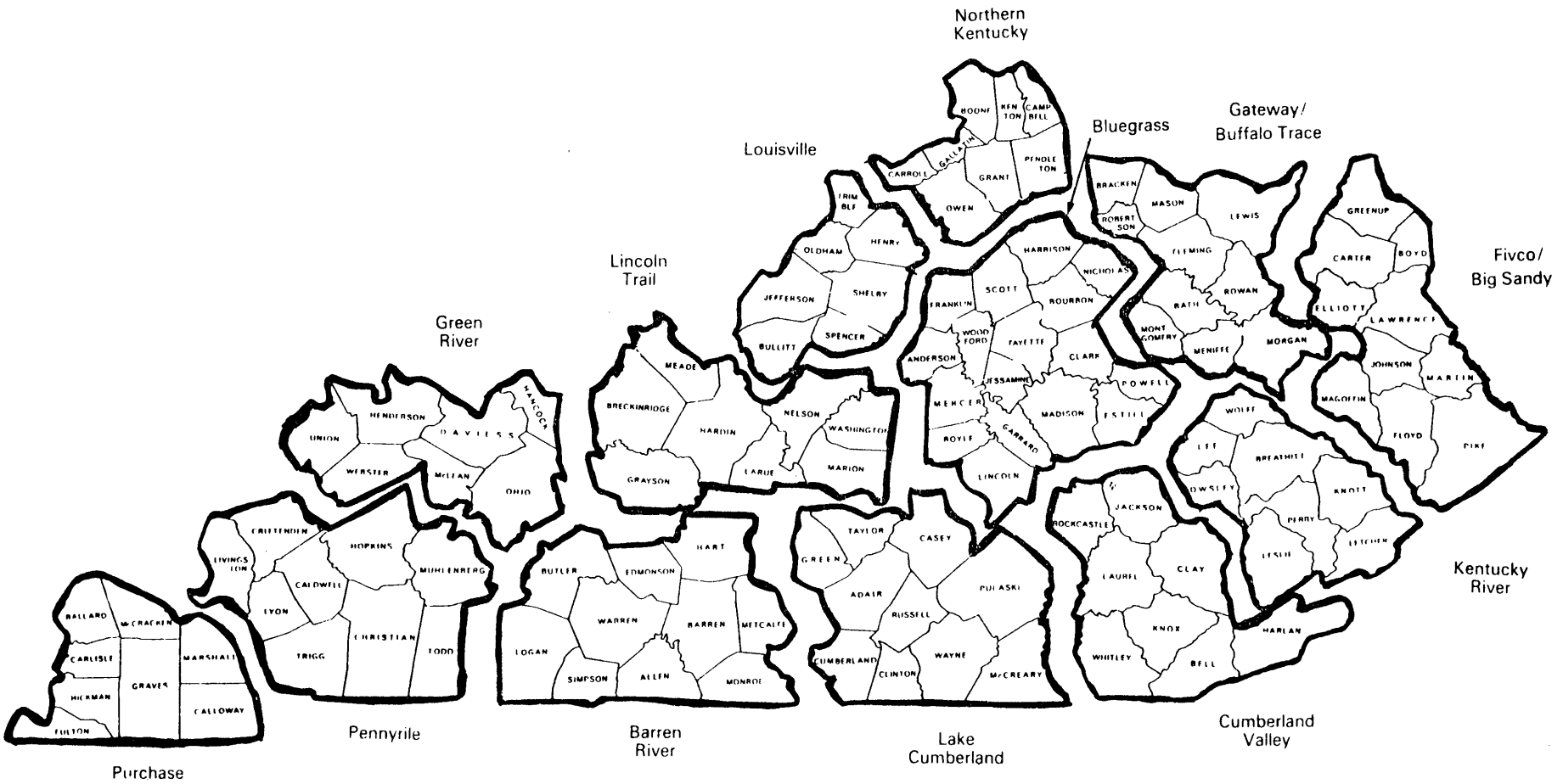
The responsibilities retained by the statewide Crippled Children's Section in Frankfort include: overall administration and policy development, provision of technical assistance, allocation of funding and making payments to districts, monitoring, compiling statewide reports, and establishing initial patient eligibility.

The Louisville Clinic Services Section for Crippled Children maintains a clinic program for children within the KIPDA District and provides, upon referral, clinic services to children throughout the state.

FIGURE A

KENTUCKY CRIPPLED CHILDREN'S SERVICES PROGRAM

District Coordinating Agencies



Departmental Rationale for Decentralization

Administrative changes in the Crippled Children's Services (CCS) Program did not arise from an assessment of needs within CCS. Rather, decentralization was initiated by the Secretary for Human Resources, without the benefit of a study of cost effectiveness or need for such a change. Nor were personnel within the CCS program part of the decision to decentralize. Decentralization of the CCS program appears to have been motivated by a general philosophy not directly associated with CCS. The basic premise of decentralization is to have public health services administered from regional centers. Also, a major catalyst to this process was the Governor's order to reduce the number of state employees by July 1, 1982.

The Cabinet for Human Resources (CHR) cited the following reasons and justification for decentralization of the CCS program:

(1) To continue the integration of services with the strengthening of District Health Departments (previously decentralized programs include "family planning," the "venereal disease program," and the "tuberculosis program");

(2) To align case management in the home district of patients served whenever possible; and

(3) To treat more patients in home districts (because more services are becoming available around the state).

Dr. David Allen, Commissioner of Health Services, also stated in press releases that "regional offices operated by non-state agencies would watch more carefully how state funds would be spent as they made decisions about providing services." He further stated that the people administering each case should be closer to the families and that using thirteen CCS sites rather than eight will make services more accessible to patients.

Dr. Pat Nicol, division director of Maternal and Child Health (MCH) in CHR, informed the Medical Advisory Committee (MAC) on January 14, 1982 about the changes in the CCS program as they would be effected by departmental policy. The meeting minutes read:

(1) **DHR policy on regional health departments.** We have been notified that the development of regional health departments as a statewide system of public health care is DHR policy and we have been instructed to work actively toward this end.

(2) **DHR policy on decentralization of services.** The DHR policy on decentralization of services is also the Governor's policy. The concept places the delivery of services at the local level through the allocation of funds to the various regions.

(3) **BHS (and MCH) personnel ceiling.** The Governor has mandated a 20% reduction in state personnel by July 1, 1982. We were advised in November of the number that MCH would have to cut. Last year we were at 225 and now we will have to be down to 110. The options were to close the central office in

Frankfort or decentralize the crippled children's program. This will mean a reduction of 40 positions.

Program Employees and MAC Perceptions of Need for Change

Several nurse/case managers from across the state were interviewed in May, 1983. They represented both recently hired health department employees and state employees who transferred to the health department from state CCS offices. Louisville staff were also interviewed. In response to the reasons and need for decentralization of CCS, there was a clear split of opinion between "old" and "new" employees. Of the four "new" case managers, all said there was a need to decentralize. The reasons given included:

(1) More children will be reached (outreach will improve);
(2) There will be better tracking and follow-up of patients;
(3) Clinic procedures (i.e. wait time) will be improved; and
(4) Family travel time will be cut down in most cases.

Of the three "old" case managers, all said there was no reason to decentralize. They maintained that:

(1) Decentralization of CCS was done only to cut staff;
(2) No short-term needs were met; however, clinics may eventually be closer to home; and
(3) In some cases, decentralization has made it harder to give care, due to increased paperwork and personnel shortages.

Dr. David Stevens of the MAC made the following statement on May 17, 1983:

> Reorganization (decentralization) won't solve any problems. Dividing up a specialized program is not a sound administrative move. I haven't seen any advantages. It all depends on how well the District Coordinating Agencies (DCA's) work. There is possibly better access to decisionmakers now. It may be too early to pass judgment on the system.

Federal Evaluation of the Centralized Approach

In 1981, the U.S. Department of Health and Human Services completed a federal review of the Kentucky Division of Maternal and Child Health. The CCS program was examined and recommendations made. The report discussed both positive and negative aspects of the program. On the positive side:

(1) "CCS has developed good relationships with the public, private, and voluntary sector;"
(2) The program is held in high esteem at all levels throughout the state;
(3) The administrative organization is fine-tuned; and
(4) The program has been able to increase its caseload on a yearly basis.

On the negative side the report stated:

> Specifically, CCS does not seem to be active in interpreting needs for legislation, policy and resources to affect the course of services to handicapped children in the state. Similarly, its role is passive regarding consumer and community awareness.

Its recommendations included:

(1) Extending program categories to serve more handicapped children; accepting more related conditions;
(2) Enlarging CCS's role by involving the voluntary sector and private health providers;
(3) Implementing the "districting" concept without unnecessary duplication of services while developing regionalization of care, establishing minimally acceptable standards for practitioners and providing technical assistance and consultation as well as clinical protocols;
(4) Utilizing computer services to enhance the scope and analysis of data; and
(5) Enhancing the CCS MAC by the addition of non-medical representatives.

The basic thrust of the report pertaining to decentralization was that without certain assurances (nonduplication of services, and maintaining of standards and protocol), problems with districting may occur. The negative impact could be increased costs, less than adequate services and unnecessary duplication of effort and activities at the local level.

State Task Force Evaluation of Decentralized Approach

In December, 1982, a report entitled "Review of Kentucky's District Health Department Program" was submitted to CHR. This study was conducted by a special task force headed by Robert Slaton, and its purpose in part was to investigate the status of decentralization procedures. The analysis of the CCS program resulted in a series of recommendations. These included:

(1) Case management across district lines appears to be inefficient and a better procedure should be developed.
(2) The distribution of financial resources should be retained in CHR for surgery and hospital care, while resources for district staff for local clinics should be decentralized.
(3) The MAC membership should reflect statewide representation.
(4) A single contract should be developed for statewide providers.
(5) Financial and case management information needs to be available at the district and state level (a review of the computer information system should be conducted to determine if this need can be met).
(6) Decentralization should be completed to include the Louisville office. This should not occur until a plan has been developed and adopted to minimize negative effects on personnel or service.

According to a May 25, 1983 memo from Dr. Allen, the status of the recommendations is as follows:

(1) Decentralization of the Louisville office will take place before September 1, 1983, and a plan has been developed to minimize negative effects.

(2) Incorporation of CCS data into the CHR information system is being investigated.

(3) "Umbrella" agreements for statewide providers have been approved and should be implemented by fiscal year 1984.

(4) Case management problems have been discussed in group problem solving meetings and some modifications made.

(5) The recommendation concerning money retained in CHR for surgeries is not being considered at the present time.

(6) The MAC membership has been changed to more adequately represent the state (Administrative Order HR 83-13).

Conclusions

- The initiators for decentralization appear to have been policymakers outside the Maternal and Child Health Division and outside the Crippled Children's Program.
- The motivation for decentralization appears to have **originated** in a desire to see public health services administered from regional centers, not assessment of conditions within the CCS program which needed improvement.
- The Governor's order to reduce the number of state employees appears to have been a deciding factor in activating the plan for decentralization **by** July 1, 1982.
- Interviewed staff and MAC members within the "old" CCS program see decentralization as a drastic and unnecessary change for a program that has historically been well respected.
- District Health Department (DHD) staff working in the CCS program view decentralization as a way to improve the program.
- Outside independent evaluators have not attempted to assess the wisdom of decentralization, but have suggested activities which may improve the effectiveness of the change.

CHAPTER III

BUDGETARY ALLOCATION AND PROGRAM EXPENDITURES

How has the methodology for allocating funds changed?

Prior to decentralization of CCS, the program operated under a statewide budget and followed normal Department of Finance procedures. Aside from indirect administrative costs, funding went for medical care for individual children, irrespective of the child's county of origin. The Louisville office pre-audited and processed all expenditures.

Since decentralization, the District Coordinating Agencies have been granted an allotment based on population. The funding formula took into consideration poverty and non-poverty population under age 21, giving double weight to poverty populations. A dollar amount was then attached to this sum. The Department was aware that this method did not take into account prior service patterns, types of handicapping conditions in a locality or existing caseloads. After the first six months of billing experience, district allotments have been revised.

How have budgetary allocations changed?

Table 1 shows the four-year history of funds allocated to CCS. These include all revenues received from general funds, all federal revenues, trust and agency receipts, including collections from Title XIX, medical insurance, and self-pay, plus all rebudgeted federal carry-over revenues.

TABLE 1

FUNDS ALLOCATED TO CCS
FY 1980—FY 1983

Fiscal Year	Budget	Percentage Change from Previous Year
1980	6,302,667	—
1981	7,010,045	11% up
1982	8,307,444	19% up
1983	7,809,561	6% down

In attempting to answer the question, "Did funding allocation change since decentralization?", staff reviewed the CHR Program Budget Management Reports. This computerized financial document indicated by category (minor and major object codes) how funds were allocated. Taking into consideration a decrease in overall funding by $997,883 from FY 1982 to FY 1983, Table 2* shows funds allocated by category, the percentage that amount is of the total, and the difference in allocated amounts from FY 1982 to FY 1983.

From this analysis, we see that in all categories, except Operating Contracts and Care and Support, actual allotments are less this year than last. Notably, the Personnel category for FY 1983 is 8.2 percent less than for FY 1982 and Operating Contracts are increased by 8.1 percent this year. There are several subcategories (minor object codes) that should also be noted: Professional Contracts, under Personnel, received $196,000 last year but only $30,000 this year. Supplies merited a $328,145 allocation last year but only $34,075 this year; and Care and Support was budgeted $2,015,633, which amounts to 5.8 percent more funds this year than last.

The limitations of time did not allow a full review of why there is such a large difference in the budgeted amount of some categories from one year to the next. We did, however, find one plausible explanation for the decrease in the personnel funding from 1982 to 1983. In 1982, all staff funded within the CCS program were state employees; therefore, these related costs fell into the state personnel subtotal. In 1983, through the decentralization process, many of the personnel in the program are employed by the District Health Departments (DHD), so their salaries could no longer be labeled personnel in a CHR Budget Management Report. The funding for these DHD personnel costs appears to be reflected in the Operating (Care and Support) or Operating Contracts code, thus explaining the increases in these categories.

* Table 2 from the CHR Program Budget Management Report shows a FY budget of $7,309,561. This report, prepared 12/31/83, did not show a $500,000 federal carryover from the previous year. The reintroduction and use of this $500,000 into the budget was not made available to us.

To gain an understanding of how much money was actually budgeted to personnel, since the CHR Budget Management Report was unclear, we reviewed the DHD budget plans, provided by the DHD executive directors. The DHD program plans indicate $1,128,727 for personnel. When this is combined with $1,467,061, the funding budgeted for CCS state employees, the total expenditure for the year is $2,595,788. As shown in Table 3, the FY 1983 figures show an increase in personnel allocations of $246,065 over the $2,349,723 allocated in FY 1982. Thus, we can conclude that while decentralization has caused the state personnel budget to decrease, it has caused the overall personnel allocations in CCS to increase by ten percent.

TABLE 2

CABINET FOR HUMAN RESOURCES
BUDGET FOR CRIPPLED CHILDREN'S SERVICES
FY 1982—FY 1983

Expenditure Item	Amount Budgeted FY 82	% of Total FY 82 Budget	Amount Budgeted FY 83	% of Total FY 83 Budget	Difference FY 83 Compared to FY 82 Budgeted		Difference in % of Total Budgeted	
					FY 83 $ Up (+)	FY 83 $ Down (—)	FY 83 % Up (+)	FY 83 % Down (—)
Total Budgeted:	$8,307,444	100%	$7,309,561	100%				
Salaries/Wages	$1,838,091	22.13%	$1,225,116	16.76%		—612,975		—5.37%
Fringe Benefits	315,632	3.80%	211,945	2.90%		—103,687		—0.90%
Other Personnel	0	0%	0	0%		0		0%
Professional CTS	196,000	2.36%	30,000	.41%		—166,000		—1.95%
Other	0	0%	0	0%		0		0%
Personnel Subtotal	$2,349,723	28.29%	$1,467,061	20.07%		—882,662		—8.22%
Util./Heat Fuel	$ 9,208	.11%	0	0%		— 9,208		— .11%
Rentals	149,888	1.80%	53,170	.73%		— 96,718		—1.08%
Maint/Repairs	14,553	.18%	11,920	.16%		— 2,633		— .01%
Postage/Related Ser.	31,355	.38%	14,200	.19%		— 17,155		— .18%
Misc. Services	9,329	.11%	6,850	.09%		— 2,479		— .02%
Telecommunications	46,588	.56%	6,600	.09%		—39,988		— .47%
Computer Services	7,972	.10%	7,000	.10%		— 972		0%
Resale Items	0	0%	0	0%		0		0%
Supplies	328,145	4.00%	34,075	.47%		—294,070		—3.50%
Commodities	3,947	.05%	2,200	.03%		— 1,747		— .02%
Travel Exp./Exp. Allow.	12,066	.15%	11,400	.16%		— 660		— .01%
Misc. Comm./Other Exp.	0	0%	0	0%		0		0%
Care and Support	1,812,382	21.82%	2,015,633	27.58%	+ 203,251			+ 5.76%
Debt Service & Fees	0	0%	0	0%		0		0%
Operating Subtotal	$2,425,433	29.20%	$2,163,046	29.59%		—262,387		— .40%
Operating Contracts	$3,490,353	42.02%	$3,659,827	50.07%	+ 169,474			+ 8.05%
Benefits Payments	0	0%	0	0%		0		0%
Capital Equip. Sub.	$ 5,875	.070%	0	0%		0		0%
Allocated Cost (This Bureau)	$ 36,060	.43%	$ 19,625	.29%		— 16,435		— .17%
Other Allocated Costs	0	0%	0	0%		0		0%
Total Expenditures & Obligations	$8,307,444	100%	$7,309,561	100%				

TABLE 3

PERSONNEL BUDGET
(FY 1982—FY 1983)

FY 1982 Budgeted Funds (CHR Prog. Budget Mgt. Report)	$2,349,723
FY 1983 State Budgeted Funds (CHR Prog. Budget Mgt. Report)	$1,467,061
FY 1983 DHD Budgeted Funds (DHD Program Plans)	$1,128,727
FY 1983 TOTALS:	**$2,595,788**

Has the revenue collected from third party payors changed?

The Department for Health Services (DHS) provided us a chart showing the amount collected from third parties, which indicates an improvement in the amount of dollars received through this source. (See Table 4.) Also, several case managers stated verbally that they are committed to collecting these funds.

TABLE 4

AMOUNT COLLECTED FROM THIRD PARTY PAYORS
FY 1980—FY 1983

Fiscal Year	Third Party Payments for Crippled Children's Services	Source of Payment
1980	$249,525	Medicaid
	62,381	Medical insurance and patient payments
	$311,906	
1981	$341,286	Medicaid
	65,007	Medical insurance and patient payments
	$406,293	
1982	$338,147	Medicaid
	29,404	Medical insurance and patient payments
	$367,551	
1983 (7/1/82-12/31/82)	$291,871	Medicaid
	82,323	Medical insurance and patient payments
	$374,194	

How has the method for calculating expenditures changed?

The CCS program adhered to accounting requirements similar to those of agencies, prior to its decentralization, except that all services and/or expenditures were preauthorized by CCS staff. Bills were audited by the Louisville office and paid by the Louisville office and/or by Frankfort, if the bill was of a type which could not be paid from the Imprest Cash Account.

Contracts for hospital and therapy services included a maximum dollar figure. Amendments were processed through channels if more funds were needed in certain contracts.

Monthly financial reports were prepared to determine financial status. If financial problems seemed likely, staff members were advised that only Category I (most urgent) patients could be admitted to the hospital. Category II and III patients were placed on a waiting list for subsequent considerations. Copies of these reports were forwarded to DHS monthly.

Since decentralization, accounting/fiscal management follows general Department for Health Services' guidelines, as set forth in the *Financial Management Manual.* Funds for the CCS program are granted and paid to District Health Departments in the same manner as funds for other Maternal and Child Health (MCH) Programs. All funds are restricted to use within the Crippled Children's Services Program. All funds that are collected from third parties (Title XIX, medical insurance, self-pay) are rebudgeted back into the CCS program and also restricted to the program for future use.

The District Health Departments authorize all patient services and receive the bills for services rendered. Bills are audited in accordance with Crippled Children's Services Standards and paid against the CCS allocation. All expenditures are recorded using an automated financial data system and guidelines established by the Division of Local Health.

The assignment of priority levels to hospital admissions described above is still utilized. Departmental policy states that any district health department which must reduce expenditures to ensure that adequate funds are available for the remainder of a fiscal year may place Category II and III patients on a waiting list. Hospital stays continue to be preauthorized, based on length-of-stay controls.

As described earlier, district allotments are based on a poverty population formula, adjusted this fiscal year to reflect actual service provision expenditures during the first six months. This is a departure from the prior method, since county of origin does not affect the funds available to each district. It is our understanding that if a district expends its allocation prior to the end of the fiscal year, a statewide pool is now used to pay program expenses for children from that district. So, until the statewide pool is exhausted, every eligible child should receive program services. In the event a district spends less than its annual allotment the Department may either redistribute the surplus to any other district which has used up its allotment or carry the balance forward to be utilized by the former district in the next fiscal year.

While these district budgets are being modified this year to adjust for real need

and expenditures not accurately reflected in the distribution formula, eventually DHD expenditures will be restricted by a funding ceiling. The issue of how accurately these ceilings reflect service need is discussed in more detail in the Accessibility of Services and Program Administration chapters.

Have expenditures changed?

Table 5 shows budgeted funds for FY 1983, and actual expenditures, as well as projected expenditures, for FY 1983. The actual expenditures for FY 1983 only reflect one-half of the year, July 1 through December 31, 1982. Because decentralization has existed for less than one year, it is impossible to show real shifts in dollars spent from the previous year. The table does, however, project expenditures by doubling what was spent the first half of the year. Caution must be used in concluding anything based on this, however, since spending patterns may not be consistent within a year (i.e., medical provider bills may be processed late in the year after third-party billing is received).

TABLE 5

ACTUAL EXPENDITURES BY CATEGORY
FY 1983

	FY 1983 Budgeted Funds	One-half of FY 1983 Actual Expenditures	FY 1983 Projected Expenditures
Personnel	$1,467,061.00	$ 816,635.50	$1,633,275.00
Operating	2,163,046.00	754,760.58	1,509,521.10
Operating Contracts (Medical, etc.)	3,659,827.00	1,857,840.04	3,715,580.00
Capital-Equipment	0	2,600.00	5,200.00
Indirect Costs	19,625.00	28,958.31	57,916.62
TOTAL	$7,309,561.00	$3,460,896.30	$6,921,792.00

SOURCE: CHR Program Budget Management Report

Analysis is difficult, primarily because spending data available is incomplete, as it only takes into consideration bills paid in the first half of FY 1983. Also, as discussed in the budgeting section, personnel costs for the DHD's staff are not reflected in the personnel category here, but contained in the Operating or Operating Contracts category.

The issue of how budgeted funds are expended is basic to a review of the efficiency of the CCS program. Unfortunately, this preliminary review has not been able to answer

this question. However, we can identify three areas in which funding data were not available and will have to be identified before this question can be addressed. They are: (1) a full year's expenditure information under the decentralization system; (2) an accurate description of minor and major codes—definitions and rationale for why funds are allocated to each; and (3) an explanation of what constitutes a direct medical cost, indirect cost and administrative cost.

Recommendations

1. The Department for Health Services should provide the Interim Joint Committee on Appropriations and Revenue an analysis of the fiscal impact of the CCS program since decentralization. This analysis should compare the allocations and expenditures prior to decentralization with those since (for FY 1983). The analysis should clearly delineate how allocations and expenditures were derived and operational definitions of all categories, including administrative, indirect and direct medical costs.
2. Budgetary and expenditure data should be refined to assure that budgetary ceilings are not exceeded.

CHAPTER IV

CHANGES IN SERVICE DELIVERY

How have service provision and program operations changed?

There have been changes in program operations since decentralization. Previously, once eligibility had been determined, parents could take their child directly to specialty clinics to arrange treatment. Authorization for services was given at the clinic. Presently, parents are required to contact the district office in which they reside. The case manager of each district then contacts and sets up the appointment at the clinic as well as making the authorization for treatment. Cases in which a child crosses district lines for care involve a "middle-man" case manager. In some cases parents must deal with a case manager with whom they have had no real contact, whereas before they dealt directly with the staff who treated their child. This practice could result in delay of care, primarily in those cases (twenty percent) in which the clinic is held out of the district of origin. It should also be noted that for the multi-handicapped child, before decentralization, there existed a "team" approach, according to Louisville staff. In a one-day/one-stop visit this child could receive a variety of services. It is possible in the new system that treatment may instead be fragmented. For example, a child may be scheduled for multiple treatments at a variety of locations (some closer to home). This approach may not represent the most convenient or sound system of care.

Before decentralization, responsibility for case management was taken by the individual clinic "charge nurses" and staff. These administrative duties are now performed by the local district case manager. This individual makes clinic appointments, contracts for other services and oversees follow-up treatment.

Interviews with case managers concerning these changes covered both positive and negative features. Case managers who were "old" CCS staff expressed concern that quality of care would suffer if "new" case managers were not present at the clinic site and did not possess the medical expertise required for complicated cases. Their opinion was that a health department nurse unfamiliar with CCS disorders could not adequately monitor the case and advise the parents. We were informed by "new" case managers that they were not given training involving medical conditions associated with the CCS program. Also, some interviewees expressed a fear that some case managers would be too involved in other health department functions than the CCS program.

"New" case managers uniformly cited a strengthening of follow-up activities under the new system. They were of the opinion that more children would be reached, fewer cases would go without follow-up, and that a district's own population of potential recipients would be better known.

They also mentioned that when they sent a child to a clinic out of the district they would typically pre-authorize the child for any screening or immediately needed treatment that the "charge nurse" felt was necessary.

In general, paperwork has increased. Case managers who worked with CCS prior to decentralization all stated that paperwork had "tripled." At least one case manager said that this increased load had hampered efforts to give care, especially in managing children who must go out of their own district for care. However, most offices were recruiting extra personnel. "New" case managers expressed little concern regarding the amount of paperwork. They also pointed out that some forms and procedures were already being streamlined as a result of statewide case manager/central office meetings.

Also, an increase in the number of clinics appears to be anticipated. All new district office case managers indicated they were attempting to put new clinics in place.

Other comments from these interviews touched on eligibility determinations. These determinations take from two to four weeks and are made in central office. Previously, these determinations were made weekly by Louisville staff. The present system did result in delay of treatment in at least one case, according to one case manager.

How have the number of children served, services delivered, and patient data collection changed?

All comparisons of patient services data before and after decentralization must be qualified by changes made in the method and focus of data collection. Previously, information was supplied to Louisville from the regional offices by manually tabulated reports. Presently, data are being collected from the automated "Patient Services Documents," health department forms designed to be analyzed in Frankfort for the purpose of financial monitoring and needs assessment. Manually collected data on numbers and types of clinics held each month is also sent to Frankfort.

Table 6 illustrates the actual number of children who received services for fiscal years 1980, 1981, 1982, and the first six months of fiscal year 1983.

This information was supplied by CHR and reflects the type of information collected on the "Patient Services Documents," part of a comuterized data system introduced July 1, 1982. Since the requirement to document each client contact was a new reporting requirement, the numbers may reflect higher, and hopefully more accurate, client information than reported before July, 1982.

Considering this limitation in interpretation, there does not appear to be a significant change in the number of new patients admitted to the program or a reduction in the number of services. However, if one examines the percentage of unduplicated patients hospitalized of the total unduplicated patients over the last three years, it appears that fewer children are being treated in the hospital. Also, the number of hospital days is decreasing. This data may indicate a trend away from more costly treatments for more severely handicapped children. If CCS is committed to serving a certain proportion of these

cases, a policy describing this intention and designating appropriate funds should be implemented.

TABLE 6

NUMBER OF CHILDREN RECEIVING SERVICES
FY 1980—FY 1983

	FY 1980	FY 1981	FY 1982*	July-Dec. 1982
Clinic Visits	33,542	32,359	27,696	12,527
New Patients	5,357	4,986	4,003	2,213
Unduplicated Patients (M. D. Services)	13,074	14,469	12,682	8,641
Unduplicated Patients (Hospitalized)	2,219	2,152	1,749	845
Hospital Days	15,214	12,878	10,323	4,858

* Data from one area development district (Barren River) not available for last four months.

What are the perceptions of crippled children's parents concerning program changes (since 7/1/82)?

A random sample of parents was sent questionnaires pertaining to the CCS program changes. Only those families involved in the program for over one year and currently receiving services were included. The Louisville area parents were omitted from the survey because this office has not yet been decentralized. Out of 319 surveys mailed, 178 were returned, for a response rate of approximately 56 percent. Parents were asked about changes in the quantity and quality of services, travel time, appointment waits, payment for services, case manager familiarity, and general satisfaction with the CCS program.

Over 90 percent of the respondents indicated they were either "satisfied" or "very satisfied" with the program. For all other questions, the vast majority of parents (83-92%) indicated there was either "no difference" in such categories as services, travel, and payment, or that these program aspects had improved.

Recommendations

3. The Cabinet for Human Resources should adopt regulations requiring that all "new" case managers/nurses working with the program in local health

districts be trained, or have their training arranged for, in crippled children's conditions, diseases, and treatment.

4. The Division of Maternal and Child Health should streamline case management procedures in order to reduce paperwork, particularly when out-of-district care is provided by another case manager.

CHAPTER V

CHANGES IN ACCESSIBILITY TO SERVICES

Has the referral and application process changed?

In the CCS program, referrals can be made by anyone for children under the age of 21. These referrals typically come from a variety of sources, including private physicians, health care facilities, social agencies, schools, and local health departments, as well as interested individuals. In the past, these referrals were received in Louisville and at the seven regional centers. The consensus of nurse case managers interviewed was that referral sources have not changed significantly, but that inquiries are now coming to the District Health Departments. However, some mentioned that they were more actively involved in outreach, typically through the county health departments. Most case managers said that referrals were increasing.

The application information is still basically the same as before decentralization. Eligibility is based on applications, which include medical and financial information. These applications were previously taken at the Louisville office, the regional offices or at clinics. Now they may be taken at any one of the twelve District Health Departments or the Louisville office. Case managers are also mailing these forms directly to parents to complete. Some have arranged for the county health department personnel to help complete applications or for knowledgeable social agency personnel to aid the client. Clinic nurses occasionally gather information not previously supplied by the patient or case manager, when the diagnostic screening is held.

Has the eligibility determination process changed?

One major change has taken place in the eligibility process. Determinations are now made by the Frankfort central office staff, rather than the Louisville staff. The current Eligibility Committee consists of staff representation from administration, nursing, and speech and hearing.

As before, eligibility is based on the child's medical information (from a diagnostic visit) and the family's financial situation. Decisions are based on medical compatibility with the program, degree of financial need and responsibility of the family.

In case manager interviews, nurses mentioned that it takes from two to four weeks to get a determination back from Frankfort, which they said could cause delay in medical scheduling. When asked, most said they would be capable of determining eligibility, if procedures were detailed, since they already do yearly updates.

Has there been a change in the number of children diagnosed and made eligible?

In response to our effort to determine if more or fewer children are being screened and made eligible for services since decentralization, the Department provided information about the number of children diagnosed and found eligible. The Department's figures show no decrease in this area of activity, as depicted in Table 7.

TABLE 7

NUMBER OF CHILDREN DIAGNOSED AND MADE ELIGIBLE

FY 1980-FY 1983

Year	Number Diagnosed	Number Not Eligible	Percent Eligible
FY 80	5,411	1,224	77.4%
FY 81	4,986	1,262	74.7%
FY 82*	4,291	1,006	76.6%
July-December, 1982	2,213	504	77.2%

* Data from one area development district (Barren River) not available for last four months.

Has the crippled children's access to service providers changed?

According to the parent and case manager interviews and district written inquiries, it appears that little change has occurred for the patient in terms of where services are presently provided. More district clinics are beginning to be developed. A definitive list of all providers before and after decentralization, however, has not been compiled. The issue is further complicated by the fact that CCS personnel once provided certain services which are beginning to be provided by contract. When asked, ten districts said they had 249 provider contracts, giving an average of 25 providers per district. Table 8 shows the number of actual CCS state employees as of January 1, 1982, before decentralization, and the number of CCS state employees plus "full-time equivalents" coding to the CCS program as of January 1, 1983.

There is no significant difference in total numbers, but nursing positions are slightly fewer. Most case managers interviewed said they were in the process of hiring nurses.

Also note that employees working for the Health Department are officially only recognizable by the fact that they code their time to the CCS program. A survey conservatively estimated that the work of the 45.96 full-time equivalents was performed by 137 individuals.

TABLE 8

NUMBER OF CCS EMPLOYEES BEFORE AND AFTER DECENTRALIZATION

Classification	Louisville CCS Actual Employees		DHD's Full-Time Equivalent	
	Number as of January 1, 1982 (A)	Number as of January 1, 1983 (B)	Number as of January 1, 1983 (C)	Totals (B + C)
Clerical/Clerical Supervisory	52	34	18.30	52.30
Nurse	34	16	13.00	29.00
Other Medical	18	9	6.56	15.56
Administrative/ Other	12	7	8.10	15.50
TOTAL	116	66*	45.96	111.96

* Excludes full-time staff involved in statewide administration in Frankfort.

Recommendations

5. Eligibility determination, whether is is initial or updated, should be standardized, taking into consideration all relevant medical, financial, and family information. Responsibility for determination should be placed with responsible authorized agents as close to the client application process as feasible.
6. Funding medical care of children by district risks making accessibility of services contingent on local management of funds, not statewide eligibility practices and availability of funds. Therefore,
   (a) funds for medical services should either be drawn from a central statewide resource pool; or
   (b) the funding formula should take into consideration not only population data, but also frequency of medical conditions within a district, costs of care for these types of medical conditions, existing service populations, and other relevant factors.

CHAPTER VI

ROLE OF THE MEDICAL ADVISORY COMMITTEE

Statutory Mandate and History

The Medical Advisory Committee (MAC) is a group of CCS physicians which functions as an advisory counsel to CHR within the Division of Maternal and Child Health (MCH). Before the 1974 State Reorganization Act, this committee acted as the independent Commission of Handicapped Children. The 1974 Act, in creating the Department for Human Resources, provided for the abolishment of such a commission (KRS 194.280). However, the Act also provided for the creation of special task forces by the Secretary (KRS 194.170). The MAC continued to advise for the CCS program from 1974 to 1983. It was, however, neither mandated by law nor created by Administrative Order. On March 1, 1983, the MAC was officially created by Administrative Order HR 83-13. The Secretary for Human Resources is required to make all the appointments for specific terms. It is, therefore, a legitimately appointed committee which may function in an advisory role. The committee enjoys statewide representation and is composed of physicians from various medical specialties and the Council for Health Services, as well as other children's services providers.

What are the functions of MAC?

In order to insure high standards of care, the MAC is charged with making recommendations to CCS concerning provider qualifications and medical standards of care. The committee also assists in carrying out quality control and peer review functions, as well as reporting to the Council for Health Services.

Was the MAC consulted about decentralizing CCS?

The MAC was not directly consulted about decentralizing the CCS program. It was informed of the decision to decentralize in MAC meetings with Dr. Pat Nicol, medical director of CCS. On October 28, 1981, Dr. Nicol introduced the policy of developing regional health departments to the committee. She described the proposal to transfer the regional CCS offices to the local level. During the January 14, 1982 MAC meeting, the decentralization process was discussed at length. Members of the committee expressed apprehension at that time concerning the decentralization.

CHAPTER VII

PROGRAM CHANGES' EFFECT ON STATE EMPLOYEES

Have the number of employees, their positions and salaries changed?

We requested the Department to list by position title and salary each state employee who worked in the CCS program on January 1, 1982, and give the same information for each individual one year later. In January, 1982, CCS employed 116 individuals (this figure does not seem to include Frankfort central office staff); by January 1, 1983, sixty-six remained. (See Table 9.)

From an analysis of the position titles, not specific job descriptions, it appears that 45% were involved with clerical, typist, or accounting functions or the supervision of employees performing these functions. Another 45% had medically-related positions, 29% of which were nursing. The remaining 10% were administrative, social work or maintenance positions.

TABLE 9

CHANGE IN STATE EMPLOYEE POSITIONS

		After Decentralization					
	Number as of January 1, 1982	Louisville CCS January 1, 1983	Other Terminations	DHD	Hired by Central Office	Resignations	Transfers Out
Clerical/Clerical Supervisor	52	34	2	8	—	2	6
Nurse	34	16	1	10	2	4	1
Other Medical	18	9	2	5	—	2	—
Administrative/ Other	12	7	—	4	—	1	—
Total Numbers	116	66	5	27	4	9	7
Total Percents	100%	57%	4%	23%	2%	8%	6%

A year later, and six months after the official change in the program, fifty-seven of the employees were still retained in the Louisville program and 82 percent were still involved in the Crippled Children's Services program; 23 percent were employed by the District Health Departments and 4 percent were working in Frankfort.

Of those twenty-seven employees who resigned from state employment and were employed by the District Health Departments, all had a monthly salary which was the same as, or higher than, their old one one year later. One employee took a slight reduction in pay

initially, but by the end of the year received an increment which raised his salary to a level at least equal to what it had been Janaury 1, 1982.

These figures, however, in no way reflect what the employees' salary would have been had they been retained in the state system. Nor do they reflect differences in fringe benefits, leave time policy, retirement, or merit system privileges.

Salary data were not available on those employees (14%) who transferred to other state positions or resigned state employment altogether.

What effect did the changes have on employee morale and program operations?

Interviews with "old" CCS state employees outside of Frankfort, involved in the decentralization, revealed a sense of frustration. The employees expressed pride in the competency of their work, belief that the majority of changes were unnecessary and fear that the changes would adversely affect handicapped children's care. Secondly, the staff expressed feelings of resignation or fear concerning their own loss of state merit employee status. Finally, there seemed to be a feeling that their hard work and dedication to the goals of the CCS program were not rewarded by the Department. A major grievance was that, although they were "experts" in the field, they were not consulted with (or were consulted only minimally) on the policy decisions made during the decentralization process.

An additional factor affecting the morale of the Louisville CCS staff is the fact that the program has been decentralized for almost one year but they have not been informed of how the decentralization plans will affect their jobs.

On the issue of the shifting of staff and workloads from a state program to a district program, "old" and "new" case managers agreed that the way the program was transferred caused a great deal of frustration and overwork. Comments generally suggested that a more gradual transition period would have alleviated problems with patient scheduling and staff paperwork. It should be noted, however, that all case managers expressed their dedication to the care of crippled children.

Were proper procedures followed in reorganizing the CCS?

No official executive order reorganizing the CCS was issued by the Governor. Nor was any official order transferring the program from the CHR to the local health departments issued by the Secretary of the Cabinet. An administrative order (HR 82-18) was issued by the Secretary of the Human Resources Cabinet, but this order simply created the Crippled Children's Statewide Services Section and the Louisville Crippled Children's Clinic Services Section under the Pediatric Services Branch of the Division of Maternal and Child Health. The Secretary does have authority under KRS 200.460 and 211.160 to provide crippled children's services by employing state employees or by contracting with outside providers. Operating under this authority, the Secretary maintained the program but changed the method of providing services. This change was treated as an internal departmental change falling under the authority of the Secretary, under KRS 12.040, which grants

agency heads the authority to exercise direction and control over their departments and is not subject to the Governor's reorganization powers in KRS 12.025.

The impact of this decentralization, however, changes the policy approach to crippled children's services, affects the way in which millions of dollars of public revenue will be spent, may cause as many as one hundred staff (including plans for Louisville staff) to lose their state employment status, alters service provision for approximately fourteen thousand children, and changes the health provider-client relationship throughout the state. Given the magnitude of these changes, it seems that an Executive Order by the Governor should have been used.

Recommendation

7. The General Assembly should amend KRS 12.025 to specify that any internal agency change in program approach which results in a major shift of policy, funding or administrative approach, as outlined to the General Assembly and implied in the Appropriations Act, in effect shall constitute a reorganization for the purposes of this chapter.

Another questionable procedure used in decentralizing this program is that used to eliminate the state employee positions of those affected by decentralization. As many as forty-five state employees were affected by the initial personnel action. These merit employees were shifted from state government positions into the District Health Departments by requesting their resignations and then having the districts employ them as health department staff. According to our interviews, this process occurred in a very short time, to meet a July 1st deadline, fifteen days prior to the administrative order reorganizing Crippled Children Services. Furthermore, staff said that they were asked for their resignations at a meeting with administrators from Frankfort and told to submit them that day as there was no time for them to be processed through the mail.

This use of "requested resignations" rather than layoff procedures had the effect of depriving these state employees of their rights of transfer and re-employment which would have been accorded them under a layoff. Since some sixty-five employees in the Louisville area will soon be affected by decentralization, issues pertaining to resignation procedures should be examined promptly.

Recommendation

8. The Program Review and Investigations Committee should request that the Kentucky Personnel Board review the resignation process of CCS employees as it relates to KRS Chapter 18A and 101 KAR 1:030 through 101 KAR 1:200 regarding merit employee rights and responsibilities.

CHAPTER VIII

CABINET FOR HUMAN RESOURCES ADMINISTRATIVE RESPONSIBILITY

Statutory Compliance and Legislative Intent

In Kentucky Acts 1974, Chapter 74, Article V, Sections 22, 23 and 107(27), authority for the CCS program was given to the Cabinet for Human Resources. The Secretary of the Cabinet then became responsible for administering the statewide program and was granted the authority (KRS 200.460 and KRS 211.160) to provide services "through contractual agreement, or otherwise" for the benefit of handicapped children. The Secretary also, through the federal Maternal and Child Health Block Grant, Title V of the Social Security Act, as authorized by the Governor, is responsible for the statewide administration of the Crippled Children's Services program and relevant federal funds.

The Secretary has by agreement funded District Health Departments to operate the program under the direction of the Maternal and Child Health Division. However, the ultimate responsibility still rests with the Secretary and within the Cabinet; therefore, policies which would affect the overall administration of the program and client benefits and services should be generated from within CHR and the Department, not District Health Departments.

Reviewing the concerns which have been generated about decentralization, as reflected throughout this report, we may conclude that two types of administrative responsibility are important: (1) policies affecting the actual service given the public through the CCS program; and (2) oversight functions regarding effective and efficient operating practices.

While these concerns have always been important in administering this program, they are particularly pertinent given that the impact of change will not be evident immediately. We have learned that the client flow and service provider system has not changed drastically in this first year, but we do not know how the program will change when thirteen DHD's are independently operating the program in the future.

Future Policy

Our understanding of the administrative responsibility leads us to believe that administrative planning is an important initial step in assuring continuity and quality of care. Planning, based on such input as needs assessment by district, cost of care by type of handicap and treatment, service provider availability by district and effective caseload size, has not been stressed throughout this decentralization process. It is important that such planning take place, and that administrative policies concerning the standardized delivery of

services be established, based on this planning.

These administrative policies, which affect the public throughout the Commonwealth, constitute a regulation as defined in KRS 13.080(3).

> "Regulation" means each statement of general applicability issued by an administrative body that implements, interprets, or prescribes law or policy, or describes the organization procedure, or practice requirements of any administrative body.

In order to avoid policy decisions which vary from district to district, and in an attempt to assure the possibility of public input, through the regulatory process, the following recommendation is set forth.

Recommendation

9. The Cabinet for Human Resources should adopt programmatic and oversight policies as Kentucky administrative regulations. These should include, but not be limited to:
   (a) the eligibility determination process.
   (b) district funding formula.
   (c) process by which new clinics are approved or existing ones eliminated.