State Notes

TOPICS OF LEGISLATIVE INTEREST

Fall 2024

Child Caring Institutions: Impact of COVID-19 and Transition to New Funding Model

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Executive Summary

- Child caring institutions (CCIs) are funded through a mix of Federal, State, and local funds.
- The reimbursement-based funding model was not equipped to handle the growing needs of youth and the impact of the pandemic.
- Michigan is implementing a capacity-based funding model to alleviate the pressures on the system.

Introduction to Child Caring Institutions

A child caring institution is defined in the child care licensing Act as "a child care facility that is organized for the purpose of receiving minor children for care, maintenance, and supervision, usually on a 24-hour basis, in buildings maintained by the child caring institution for that purpose, and operates throughout the year".[1] Child caring institutions are congregate care providers (i.e., residential group facilities) that serve youth in foster care and juvenile justice-involved youth. These facilities provide specialized treatment to youth and a range of mental and behavioral health services. Child caring institutions are approved by the Department of Health and Human Services (DHHS) to provide services based on the service type. Examples of service types include general residential, mental and behavioral health stabilization, youth with problematic sexual behavior, autism, and developmentally disabled/cognitively impaired.

The oldest CCIs in Michigan have operated for over a century and were known as orphanages or children's homes before the modern child welfare system. In Grand Rapids, D.A. Blodgett Home for Children formed in 1887, while St. John's Orphan Asylum formed in 1889. In 2010, these organizations merged and now they operate as one of the CCIs contracted by the State as D.A. Blodgett St. John's.[2] Methodist Child Care was founded in 1917 in Detroit as a children's home.[3] In 1926, the name was changed to Methodist Children's Home Society, and now it operates as MCHS Family of Services, a State-contracted CCI. These are just two examples of the long-standing history of these residential care facilities in Michigan that are now known as CCIs.

Child Welfare Funding

Child welfare in Michigan is funded through Federal funding, State funding, and local government funding. There is some complexity in the funding of child welfare in Michigan because of the various fund sources and the elements of decentralization in the system. Federal funding is sourced through Title IV-E of the Social Security Act, 42 USC 470-479B, which is the main Federal funding source for child welfare and the largest portion of child welfare funding in the State.[4] Title IV-E eligibility requires that the child is a United States citizen in an out-of-home placement, the child was removed by a court order, the child comes from a family that is considered needy based on the Aid to Families with Dependent Children (AFDC) standard, and the child is in an eligible placement.[5] Federal funding directed for services is based on the Federal Medical Assistance Percentage (FMAP), which accounts for the share of Federal and state dollars; in fiscal year (FY) 2023-24, the FMAP matching rate for Michigan is approximately 65% Federal and 35% State.[6] Federal Title IV-E funding is distributed as a reimbursement: state funds are spent, and eligible uses are reimbursed by the Federal

government. Delinquent court or state wards generally are not eligible for Federal Title IV-E funding. Delinquent court wards are children who come into the jurisdiction of the court from a violation of the delinquency section of the Juvenile Code (MCL 712A.1, *et seq*.) or committed to the State as a result of a violation of delinquency through the Youth Rehabilitation Services Act (MCL 803.301-309).[7]

For youth who are not eligible for Title IV-E reimbursement because they do not meet the needs threshold or because of delinquency, the State and counties share costs of youth in child welfare. The mechanics of the funding depend on if the child is a ward of the State and under the supervision of the DHHS, or a ward of the court. If the child is a ward of the court, the cost of services is paid out of the Child Care Fund (CCF). Under this mechanism, the county pays the bill, and the State reimburses 50% of the costs. However, if the child is a court ward and the DHHS supervises the child, then the State pays first, and the county reimburses the State for 50% of the costs. State-ward costs are paid out of the State Ward Board and Care. There are instances in which the State pays more than 50% of the costs. These include rate increases that are approved by the Legislature through which the counties are held "harmless" and continue to pay the same rate while the State pays the difference. This arrangement ensures that counties are not unduly burdened by costs. This is the case with CCIs; counties are held harmless to legislative rate increases. When a new CCI program starts, the program starts out at as a 50/50 cost share. This can be seen below in Table 1, which shows a portion of a CCI rate spreadsheet.

Table 1

Gender Identity	Age Accepted	Service Description	County	State	Age Accepted
Female	11-17	Mental Health Behavior Stabilization	$907.64	$968.90	8/1/2023
Female	11-17	Human Trafficking Reintegration	$651.93	$654.67	8/1/2023
Female	11-17	Human Trafficking Stabilization	$656.59	$659.33	8/1/2023
Female	11-17	Mental Health Behavior Stabilization	$734.57	$775.40	8/1/2023
Female	11-17	Human Trafficking Stabilization	$668.15	$670.89	8/1/2023
Female	11-17	Human Trafficking Reintegration	$663.05	$665.77	8/1/2023
Male	10-17	DD/CI (Developmentally Disabled/Cognitively Impaired)	$983.43	$983.43	8/1/2023
Both	0-17	Shelter Residential Care	$853.72	$857.83	10/1/2023
Male	10-17	Shelter Residential Care	$675.68	$857.83	12/1/2023
Female	12-17	Shelter Residential Care	$579.65	$579.65	10/1/2023
Female	12-17	Shelter Residential Care	$857.83	$857.83	10/1/2023
Note: Each row represents a separate contract and facility.					

Source: DHHS.

Funding Model of Child Caring Institutions

The DHHS contracts with CCIs to provide mental and behavioral health services to juvenile justice-involved youth and youth in foster care. The Department contracts a specified number of beds for a designated service type, age range, and gender, and agrees on a standard monthly rate for that

service type. For example, the DHHS contracts with CCI A for a yearlong contract for 25 mental and behavioral health stabilization beds for females 13-17 years old to be paid at a rate of $700 per month. Child care institution A could have multiple contracts with DHHS through which it provides a specified number of beds for different services or different age ranges or genders in different parts of their facility. The contract model works as a reimbursement model; the State or court refers the child to a facility and, if the CCI accepts the child, it offers services for the child, and the State or county pays the agreed per diem rate for the child. The State then reconciles the payments based on if the child is Title IV-E eligible for Federal reimbursement and, if not, the initial payor reconciles the cost-sharing with the State or county.

Under this funding model, CCIs are reimbursed only for youth in their facilities who receive services; they are not reimbursed for the total number of beds under contract. So, if CCI A has 25 contracted beds but there are 20 youth in its facility, it is paid only for those 20 beds. The contracted number of beds represents the maximum number of children a CCI has the bed space, and staffing, for whom it can provide care. The median bed utilization in FY 2021-22 and FY 2022-23 was under 50%.[8] The required staff-to-youth ratio are agreed to during the licensing process for CCIs and vary depending on the needs and acuity of the child and the services they are receiving. There is a designated staff-to-youth ratio for each service type for daytime and for nighttime. A mental and behavioral stabilization service may allow for one staff to six youths in the daytime and a 1:10 ratio in the nighttime, while an intensive stabilization may require one staff to two youth in the day and a 1:4 ratio in the nighttime. A portion of the CCI rate spreadsheet illustrates this in Table 2 below.

Table 2

Service Description	Licensed Beds	Contracted Beds	Day Ratio (1:x)	Night Ratio (1:x)
DD/CI (Developmentally Disabled/Cognitively Impaired)	6	6	2	6
DD/CI (Developmentally Disabled/Cognitively Impaired) - High Intensity	6	6	2	6
Mental Health Behavior Stabilization	12	12	2	6
Mental Health Behavior Stabilization	6	6	3	6
General Residential	31	22	3	10
Mental Health Behavior Stabilization	31	22	3	10
DD/CI (Developmentally Disabled/Cognitively Impaired)	66	6	2	6
Mental Health Behavior Stabilization	66	6	3	6
Mental Health Behavior Stabilization-High Intensity	20	16	3	6

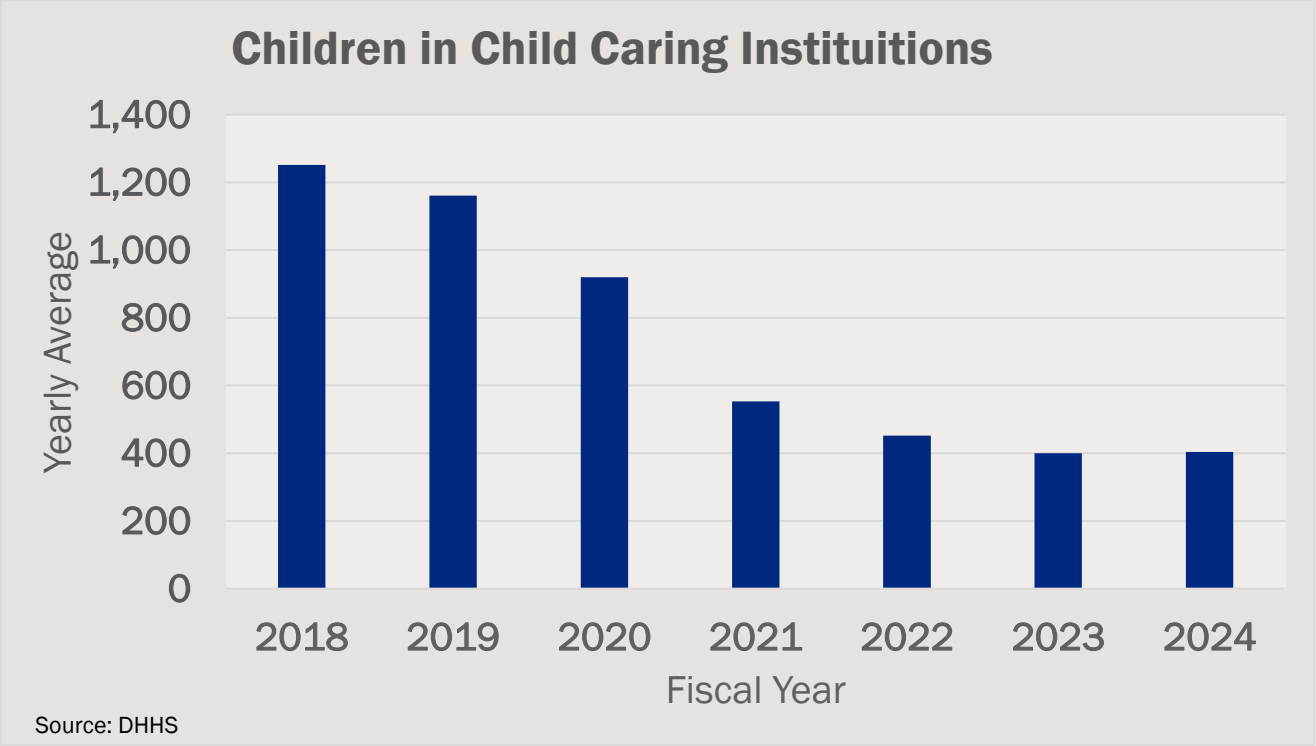
Source: DHHS

Funding Complications and COVID-19

The uncertainty of any reimbursement model stems from the fact that stability in funding for providers depends on consistent volume. Child caring institution providers are paid not based on contracted bed spaces, but for the number of children in those beds. A given facility could have 20 beds filled one month and 15 the next. Reimbursement-based providers often have reserves to cover the normal volatility in volume; however, any major shocks can leave lasting impacts. The COVID-19 pandemic represented such a shock to the child welfare system and CCIs. The pandemic forced the court system to stall, slowing the entry of children into the child welfare system and into

CCIs. It also caused a significant exodus of children from CCIs. The number of children in CCIs decreased slightly in the period leading up to the pandemic. The 2019 average of 1,161 children represented a 7% drop from the 2018 average of 1,252, as seen in Figure 1. The number of children in these facilities fell significantly beginning in spring 2020. There were 1,087 children in CCIs in March 2020, but by August that number dropped to 840. This represents a 22% decrease in five months. The numbers continued to fall sharply over the course of 2020 and through 2021. There were, on average, 682 children in CCIs in December 2020, but this number fell to 498 by December 2021. Even as pandemic restrictions eased, the court system returned to regular proceedings, and the child welfare system adjusted to a new normal, the volume of children in CCIs did not return to pre-pandemic levels or even approach them. The largest month-to-month increase in volume since March 2020 is a positive 4%, with the median month-to-month change at a negative 2%.

Figure 1



Source: DHHS

This downturn in the number of youths in CCIs forced the facilities to significantly reduce staffing, as reimbursement revenue sharply fell. Reduced staffing results in reduced capacity and fewer services offered. The most intensive needs require the lowest staff-to-youth ratios, making these services the most at risk for reduced staffing. Also complicating the situation is the rising acuity , the complexity and severity of mental and behavioral health needs, of youth in the child welfare system. A greater proportion of youth in the child welfare system have mental, behavioral, and physical health needs, which require a higher level of care and treatment. This trend was heightened by the pandemic, because while many youth exited residential facilities or the foster care system, the youth who remained were disproportionately higher acuity.[9] Reduced bed capacity and increased needs of youth created a shortfall in bed spaces for both juvenile justice-involved youth and foster care youth. Child care institutions were able to staff a fraction of the bed capacity that they were serving pre-pandemic, and the State was left without adequate placements for youth. Despite attempts to address the problem through rate increases to the providers, the increases

could not keep up with inflationary costs and the rising needs of youth to expand capacity enough to meet the demand.

Public Act 166 of 2022, the omnibus budget appropriation bill for FY 2022-23, introduced a monthly boilerplate report listing the number of foster youth and juvenile justice-involved youth awaiting placement in a CCI.[10] The historic average weekly waitlist volume is 154 youth, according to DHHS data. In addition to the number of children who are awaiting bed availability, higher acuity youth often face the most difficulty in finding placement because of the extra resources needed to care for them. Providers can reject youth from being placed at their facilities if they feel they are unable to care for them. The reasons for rejection can vary; for example, the youth may not fit with the current milieu of youth at the facility, the youth may be significantly older or younger than the youth at the facility, or the youth may have needs that would make them a poor fit at the facility. The most frequent reasons for placement delays or denials are a lack of staffing and the high needs of the youth. Staffing shortages disproportionately affect youth who have high needs because more staff are needed for their care, and high-needs youth are most likely to be rejected by CCIs.

Capacity Based Funding Model

The FY 2024-25 budget includes funds to transition from the reimbursement-based funding model to a capacity-based funding model.[11] The Legislature and Executive sought to address the issues that exist in the current reimbursement-based environment. These include a shortage of staffed beds available for youth, eliminating the waitlist, placing the high acuity cases, and providing funding predictability and stability for providers. The State contracted with Public Consulting Group to explore capacity funding options and recommend a model that would increase the likelihood that high-need youth will be placed and ensure that revenue for providers would allow them to operate at full capacity, even if all beds were not full. The final report analyzed utilization of contracted beds, including the number of youth on the waitlist, examined refusal and waitlist data, Title IV-E funding capacity payments, and examined other states that used a capacity-based funding model.[12] The key findings of the report include the following:

- The utilization rate of contracted beds was under 50% during FY 2021-22 and FY 2022-23.
- The majority of provider refusals were because of the youths' extensive needs or behavior.
- Given the capacity and the waitlist data, a rightsized bed capacity estimate would lower the estimated need for contracted beds from 793 to 600.
- Title IV-E payments could not fund empty beds; however, states could build-in the costs of operating at less-than-full capacity in a rate-setting methodology.
- There is precedent in other states (including MA, ND, and PA) for funding a predetermined number of beds regardless of usage.

In designing a capacity model, the State had to weigh how many beds to fund, at what rate empty beds were funded, whether there would be tiered funding for empty versus filled beds, and if the rate would include an incentive or penalty to ensure compliance in accepting youth and filling contracted bed spaces. The numbers of contracted beds had to closely fit demand in a capacity model for it to be fiscally prudent if unfilled beds are being reimbursed, so the State's CCI reimbursement plan follows the recommendation of a need for 600 beds. The next part of the model to be decided was, if there was a rate at which unfilled beds were paid, should that rate be at 50%, 90%, or 100% of the rate paid for filled beds? Ultimately, the proposed model uses blended rates for different services with close staff-to-youth ratios, rather than having 15 different rates for various service types, and pays rates for unfilled beds equal to 100% of the rate paid for filled beds. The plan also needed a compliance mechanism to ensure providers were attempting to fill beds and

to minimize the number of youth denials. The State included an incentive payment for facilities operating at full capacity. This seeks to reward providers that operate at full capacity and, in doing so, reduce the waitlist and the number of denials. To fund this, the FY 2024-25 budget included new funding of $38.0 million Gross and $30.3 million General Fund/General Purpose to transition to a capacity model. State General Fund dollars make up most of the investment because the funding of empty beds is not Federally reimbursable.

Future of Child Caring Institutions in Michigan

The growing needs of youth in the child welfare system and the pandemic created a capacity crisis for Child Caring Institutions in the State. The number of available CCI beds in Michigan has not accommodated the demand for those bed and the current funding model has made it difficult to address those issues. Shifting from a reimbursement-based funding model to a capacity-based model is a step that the Department hopes will alleviate some of the issues, by funding beds commensurate with the level of needs and by allowing a stable stream of funding for providers to rely on and utilize to appropriately staff the beds. This, however, does not guarantee an immediate resolution. The most frequent reasons for denial of youth in CCIs per the providers were "needs too extensive" and "aggressive/assaultive behaviors", with capacity ranking third. Increasing the funding to facilities via payment of empty beds should help; however, it does not ensure that facilities will accept the youth in need of placement. The DHHS will use current and historical data to match the beds under contract to the population of youth. The array of beds of each service type ideally should match the treatment needs of the youth. Providers must be willing and able to accept youth, including higher-need youth, for this transition to be effective. Additional boilerplate reporting that was added to list the number of incentive payments awarded, number of incentive payments denied, and reason for denial of incentive payments will give data that indicate the number of providers operating at capacity, those denying youth, and the reasons for their denial. This will give a picture of the effectiveness of the funding model and will help decisionmakers in Michigan understand any necessary adjustments going forward.

[1] MCL 722.111(1)(c).
[2] D.A. Blodgett St. John's, "Who We Are". Retrieved 8-12-2024.
[3] MCHS Family of Services, "Our History". Retrieved 8-12-2024.
[4] Maxwell, John, "Michigan's Child Care Fund: History and Details of a Decentralized Juvenile Justice and Child Welfare System", Senate Fiscal Agency, *State Notes*, Summer 2020.
[5] Office of the Administration for Children & Families, FFY 2023 and FFY 2024 CCDF State Matching Rates.
[6] Note 4.
[7] Public Consulting Group LLC (PCG), "Michigan Department of Health and Human Services Final Report", February 16, 2024.
[8] Akujobi, Humphrey, "Trends in Child Welfare: A Look at Caseloads, Expenditures, and Changing Needs of Youth", Senate Fiscal Agency, *State Notes*, Fall 2023.
[9] Michigan Department of Health and Human Services, Legislative Reports, Section 510.
[10] Public Act 166 of 2022.
[11] Public Act 121 of 2024.
[12] Note 7.