CONNECTICUT VOICES FOR CHILDREN

Careening Toward Crisis: State and Federal Funding of Child Welfare Services in Connecticut

Executive Summary

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The State of Connecticut has a legal and moral responsibility to ensure the health, safety, education, and sound development of all children and youth placed into its care and custody because of parental abuse or neglect. When the Department of Children and Families (DCF) fails in this duty, it compounds the harm already done to these children.

This report, the first in a two-part series, examines how state and federal funding is used *now* in DCF's budget to meet that responsibility, and how that funding has changed over time. The report finds that perverse federal funding incentives, coupled with some imprudent past state budget choices, is causing DCF and the children and families it is to serve to careen toward crisis in two significant ways:

- Connecticut's budget now invests far too little in the home and community-based services that can prevent child abuse and neglect in the first instance, and then avert out-of-home placements if a child is referred to DCF. Instead, families are helped primarily after crises erupt, children are harmed, and the problems have become more difficult and costly to address.

- Once children are in DCF's care, Connecticut's spending remains skewed, with a diminishing share of all funding allocated for the programs and services that could maintain children in family-like settings, and an increasing share of funds being spent on more costly and restrictive institutional out-of-home care.

This report concludes that past state budget choices, coupled with illogical restrictions placed on the use of federal child welfare funding under Title IV-E of the Social Security Act, actually have undermined the development of a system of child welfare services that meets all requirements of federal and state law and serves the best interests of children.

While there have been some recent, and very important, efforts to reverse some of these funding patterns (e.g., the development of KidCare, increased funding for Nurturing Families), concurrent state budget choices have actually accelerated the trends (e.g., increased reliance on TANF funds in DCF's budget). As a result, there remains a very serious mismatch between the goals of a well-functioning child welfare system (as specified in state and federal law) and current state and federal financing of that system. It will take a fundamental re-structuring of how state and federal child welfare-related funds are used to prevent continuing increases in DCF's caseload and budget.

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Key Findings

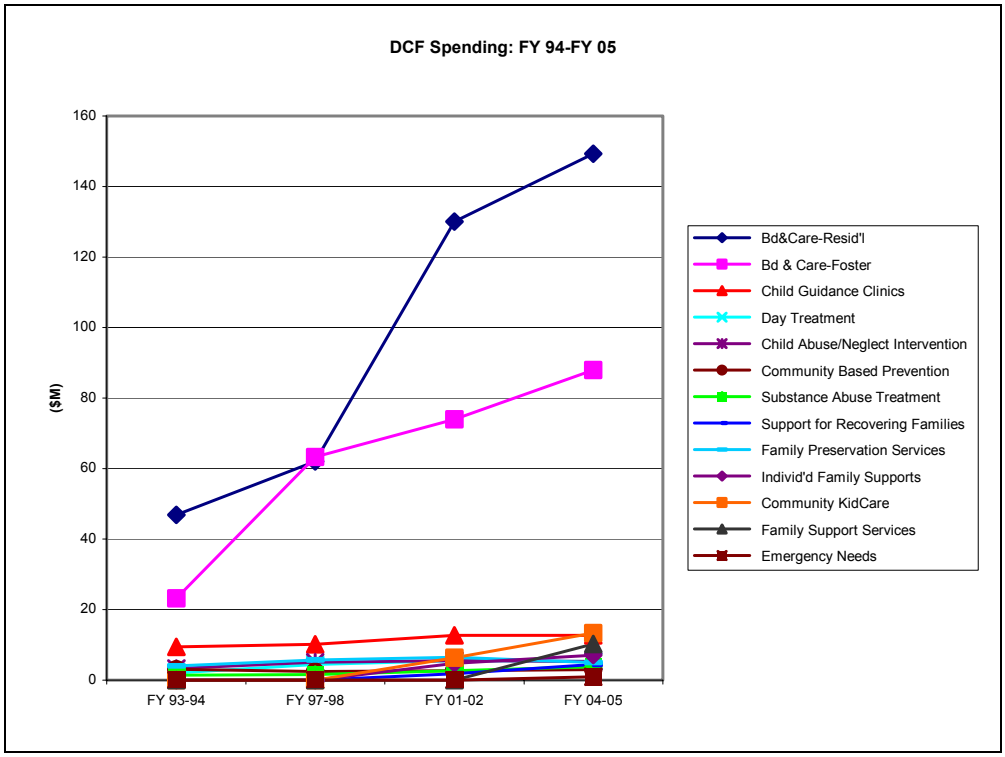
1. Growth in DCF's Budget Has Far Exceeded Growth in DCF's Caseload

In the last decade, the number of children served by DCF increased from 7,500 children at the end of FY 94 to 12,247 children at the end of FY 04 (a 63% increase). DCF's General Fund budget grew faster -- from $227.6 million in FY 94 to $604.1 million in FY 04 (a 165% increase). With DCF's revised SFY 05 General Fund budget at $642.6 million, there has been a 182% nominal increase since FY 94. While some of this growth can be attributed to the more complex clinical needs of children now in care and to long overdue investments to improve the quality of DCF's care for these children, much growth also is due to skewed spending choices that skimp on funding for services that could reduce child welfare involvement while, at the same time, increasing spending for expensive "back end" placements and services.

2. DCF's Spending on Out-of-Home Placements Has Far Exceeded Growth in Its Spending on the Programs and Services That Could Help Avert Such Placements

Out-of-home care. As Chart 1, below, chart illustrates, over the past decade DCF's investments in the home and community-based services that could help prevent child abuse and neglect and avert out-of-home placements have been anemic, while spending on expensive out-of-home care has soared.

Residential treatment. In addition, as Chart 1 further illustrates, DCF's growth in spending on expensive residential treatment has far outstripped growth in spending for less expensive and more family-like foster care and therapeutic foster care placements. Moreover, the growth in DCF's spending for residential treatment (a 218% increase between FY 94 and FY 04) is nine times greater than the growth in the number of children and youth placed in residential treatment (a 24% increase over this period).



In-patient psychiatric hospitalizations. Spending growth also has been rapid for in-patient psychiatric hospitalizations. A significant portion of this growth can be attributed to "gridlock" in Connecticut's children's mental health system. Connecticut's failure to invest adequately in a robust continuum of home and community-based services has resulted in children in DCF care and custody languishing in costly psychiatric hospital settings past the time for discharge. Connecticut's "reinsurance" program is the cause of much of this acceleration in spending.

Specifically, soon after children in the care of DCF were enrolled in the Medicaid managed care program, issues arose concerning discharge of children from psychiatric hospitals. The Medicaid managed care organizations often determined that a child was no longer in need of inpatient treatment, but DCF had no appropriate placement to which the child could be moved. Since September 1998, this discharge issue has been addressed through reinsurance. The Connecticut Department of Social Services (DSS) reimburses the managed care plans for in-patient psychiatric hospital care after a certain length of stay. Under the current contract between the health plans and DSS, the health plans are fully responsible for the first fifteen days of care at both the acute and sub-acute levels. However, from day 16 to day 45, the state assumes 75% of the cost of care; from day 46 to day 60, the state pays 90%; and after 60 days, the state is fully responsible for paying for the care that is provided to the child.

This reinsurance program has become extremely costly. In 2002, DSS made over $23 million in reinsurance payments to the managed care organizations (*nearly half* – 46% -- of the health plans' total behavioral health spending). Importantly, these payments were *in addition to* the monthly capitation payments DSS already had paid the health plans to provide *all* needed behavioral health care to enrolled children. During just the first six months of 2003, reinsurance payments to the health plans totaled over $12 million (the same amount that had been projected for *all* of 2000).

3. Multiple State Factors Contribute to Increased "Back End" Funding at DCF

A number of factors -- *other than* the clinical needs of the children and youth in DCF care –contribute to Connecticut's increased spending at the "back end" – for in-patient psychiatric care, residential treatment, and foster care. They include:

- *Lack of a comprehensive continuum of home and community-based services, resulting in DCF relying more than may be clinically-necessary on more restrictive out-of-home placements that also are far more costly.* As illustrated in the following chart, the annual cost for a child to stay in an in-patient facility or a residential treatment program far exceeds the annual cost of the comprehensive home and community-based services that can prevent child abuse or neglect or, if such maltreatment occurs, might allow a child either to remain at home or be placed in a less restrictive, more family-like placement. For example, for the average cost of maintaining a child at DCF's Riverview Hospital for a year ($492,000/child), DCF could provide in-home therapy services to 65 children for a year ($7,500/child).

A Sampling of Costs of State-Funded Programs and Services	
	Cost Per Year, Per Bed/Child
DCF-Riverview Hospital	$492,020
DCF-High Meadows	$456,615
DCF-CT Children's Place	$339,450

DCF-CT Juvenile Training School	$325,215
DCF-Funded Private Residential Treatment	
High: Wellspring	$123,560
Stonington Institute	$112,610
Low: APT Foundation/Alpha House	$40,898
New Hope Manor	$38,504
After-School Extended Day Treatment	$32,000
Special Needs Day Care	$31,200
Head Start with Parent Partnering	$10,630
Intensive Case Management	$9,600
Intensive In-Home Child & Family Therapy	$7,500
Multi-Systemic Therapy	$6,800
Home Visiting for At-Risk Children (by nurses)	$6,200
Medication and Monitoring	$6,000
Home Visiting for At-Risk Children (by trained paraprofessionals)	$3,200
Supportive Case Management	$3,200
Average Cash Assistance Grant under Temporary Family Assistance	$6,500/yr for a family of 3 (2004)
Sources: *Letter from Office of the State Comptroller to Commissioner of Department of Administrative Services* (July 17, 2003)[DCF facility per capita costs, as of July, 2003]; Office of the Child Advocate & Attorney General of Connecticut, *The Cost of Failure* (2003), pp. 18-21 [other cost data].	

Importantly, Connecticut squandered an important opportunity in the late 1990s to build a comprehensive continuum of home and community-based services using General Fund surplus funds.[1] Had Connecticut built "front-end" capacity in these years, it would now be far easier to keep children and youth with their families, and out of more restrictive and expensive settings.

- *Differences in state funding formulas.* State law guarantees Connecticut's private residential treatment facilities a cost-based rate of reimbursement; DCF's rate of reimbursement to the facilities increases as their costs of operation increase. By comparison, there is no cost-based reimbursement for home- and community-based services (such as child guidance clinics, family preservation services, and family support programs). Indeed, these programs have not consistently received cost of living increases.

- *Connecticut's costly reinsurance program undermines efforts to provide appropriate community-based services to children and reduces access to in-patient hospitalization for DCF children in psychiatric crisis.* The fact that Connecticut is now spending tens of millions of dollars on reinsurance – i.e., essentially paying managed care plans *twice* for behavioral health care – means there is less funding available for the home

[1] Like the time when the polio vaccine was developed and governments found themselves briefly paying both for the costs of the vaccine to prevent future cases and also the costs of care for those who had polio, some period of "double" funding is necessary to build capacity among providers of home and community-based services before Connecticut children can be moved out of residential and in-patient care into less restrictive placements. Connecticut elected *not* to make this "double" investment when the state had large budget surpluses, preferring to reduce taxes. A notable exception was the Community Mental Health Strategic Investment Fund that used state surplus funds to seed innovative pilot initiatives to reduce gridlock and improve services in Connecticut's adult and children's mental health systems.

and community-based services that would address the underlying problem of gridlock in the system. With substantial state funding going toward this clinically-unnecessary care, funding to develop more appropriate placements and services is lacking.

In addition, while the current reinsurance system absolves the managed care organizations and the mental health care providers of having to pay for care at a level of acuity that is no longer needed, it also removes any incentives that the health plans and hospitals previously had to find community-based placements for children no longer in need of in-patient hospitalization. Instead, children linger in the hospital longer than is clinically necessary, occupying beds that then are not available to other children who urgently need in-patient psychiatric hospitalization.

4. Connecticut's Current Use of Federal Funds Contributes to DCF's Increasing Caseload and Soaring Budget. Over the past 70 years, the federal government's involvement in child welfare has expanded primarily through enactment of various funding initiatives. Congress would appropriate funds for specific child welfare-related purposes and condition states' receipt of these funds on compliance with the specified requirements set out in the federal enabling legislation.

As discussed in detail in this report, DCF's projected $658 million budget for FFY 05 includes federal funds[2] from a variety of sources: a) Title IV-B of the Social Security Act ($5.1 million); b) the Child Abuse Prevention and Treatment Act ($0.3 million); c) the Chafee Foster Care Independence Program ($2 million); and d) various other smaller federal grant programs ($3 million). It also includes $118 million in funds from the TANF block grant, as well as $174.4 million in funds appropriated and claimed under Title IV-E of the Social Security Act and $21.9 million appropriated and claimed under Medicaid. In addition to these child welfare-related federal funds, Connecticut receives significant reimbursements under Medicaid for health care spending on the vast majority of children in DCF care; in March, 2004, 72% of the children in DCF care were Medicaid-eligible.

There are two primary ways in which Connecticut's current use of federal funds contributes to DCF's increasing caseload and its soaring budget:

- *"Mis-allocations"* -- by diverting significant amounts of federal funds intended to stabilize families and divert children from foster care to uses that are not wholly consistent with these purposes, resulting in families having to be in crisis before Connecticut provides help.
- *"Missed opportunities"* -- by failing to be more creative and aggressive in claiming federal reimbursements to which Connecticut has a right (or option) under Medicaid and Title IV-E.

By addressing both issues, Connecticut could re-structure its child welfare financing to better control caseload and budget growth, and also serve children and families more effectively.

[2] The manner in which Connecticut presents its budget fails to reflect, on its face, this full federal contribution. Connecticut *gross* budgets, i.e., it appropriates both state and also anticipated federal reimbursements through its General Fund budget. It then counts federal reimbursements when received (e.g., under Medicaid, Title IV-E) as General Fund revenues. For example, a significant portion of the $149.3 million General Fund appropriation for residential board and care in DCF's budget includes anticipated federal reimbursements under Title IV-E of the Social Security Act (50% reimbursement for the costs for IV-E eligible children in residential treatment). In March 2004, nearly 53% of the children in DCF out-of-home care were determined to be Title IV-E eligible.

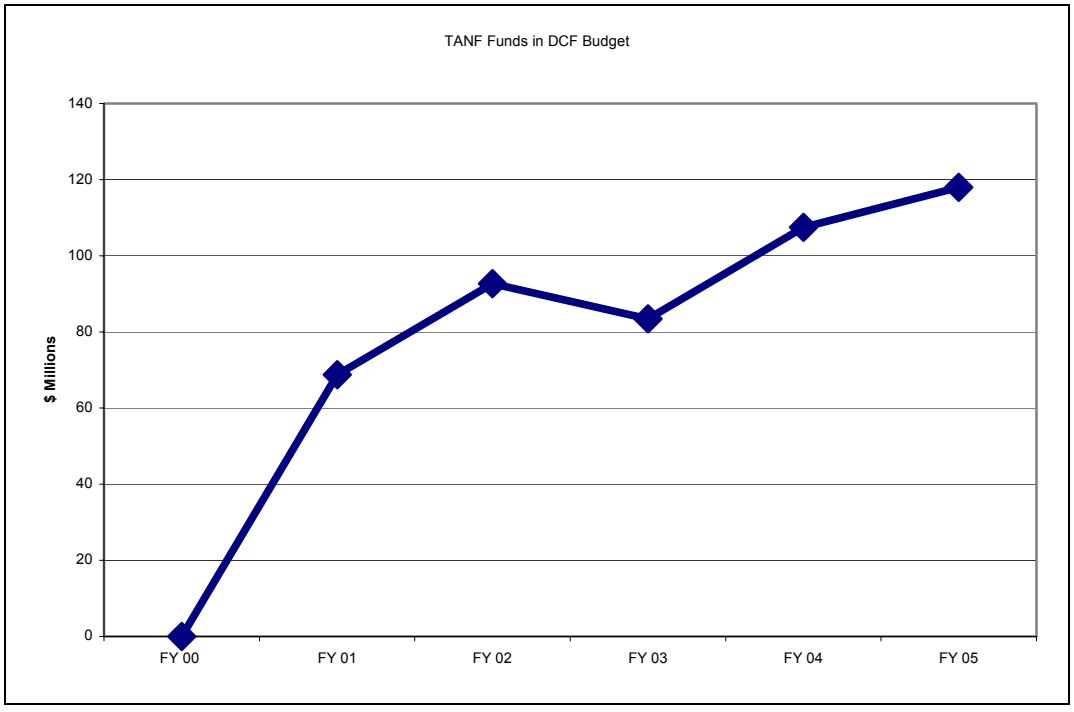
Diversion of federal "front-end" funds. As this report discusses in more detail, DCF's budget increasingly relies on federal funds that primarily are intended to *avert* families' involvement with child protective services. The following two examples illustrate this point:

- *Diversion of Title IV-B Funds to Fund DCF Staff.* By federal law, Title IV-B, subpart 1 funds are to be used for services to prevent child abuse and neglect, reduce foster care placements, reunite families, arrange adoption, and ensure adequate foster care. To assure that states focus *most* of these funds on services to *prevent* out-of-home placements, federal law limits the amount of these funds that can be used for other purposes. Despite the fact that Title IV-B, subpart 1 funds are already a small amount (and declining) source of very limited amounts of flexible federal funding that is targeted to preventive services, DCF uses these funds primarily for salaries for DCF staff at the Connecticut Children's Place (formerly the State Receiving Home) and also for three staff positions located in area offices, *not* to prevent children's DCF involvement and out-of-home placement.

- *Diversion of TANF Block Grant Funds to Fund DCF staff.* Like Title IV-B, federal funds in the Temporary Assistance for Needy Families (TANF) block grant are intended to fund "front end" services: a) to provide assistance to needy families so that children may be cared for in their own homes or in the homes of relatives; b) to end the dependence of needy parents on government benefits by promoting job preparation, work and marriage; c) to prevent and reduce the incidence of out-of-wedlock pregnancies and establish annual numerical goals for preventing and reducing the incidence of these pregnancies; and d) to encourage the formation and maintenance of two-parent families.

Prior to FFY 1999, no more than $16 million of TANF funds were included in DCF's budget in any year (and in some years, *no* such funds were used). However, since 2001 this has markedly changed, as illustrated in the chart below.

In FFY 05, $118 million of DCF's budget -- one in five of all dollars – is to come from TANF. Further, more than four in ten of all TANF dollars (41%) will be spent on DCF programs and services.



The relationship between the current uses of the majority of these TANF funds in DCF's budget and the federally-authorized uses of TANF funds is fairly attenuated. In FFY 03 (when $113.7 million of TANF funds were in DCF's budget), three-quarters of the TANF funds were spent either for DCF case management services ($61 million) or DCF investigations ($27 million in FFY 03). By comparison, far smaller amounts of TANF funds were used for services to prevent child abuse and neglect and support families so children would not need to come into DCF care, e.g., $4.1 million for treatment and prevention of child abuse, $2.5 million for early childhood development, $4.6 million for family preservation, and $3.7 million for intensive in-home services.

The clear – and troubling -- trend is for an increasing proportion of TANF funds to be diverted to DCF to pay its staffing costs rather than being used to fund programs and services that help families on welfare and in low-wage jobs achieve economic self-sufficiency. A likely consequence of this shift is that children living in families unable to meet their basic needs are referred to DCF for services. That is, it is increasingly likely that families will receive help only when they reach crisis and reports of child neglect or abuse are made. In addition, core functions of our child welfare system will become increasingly vulnerable to cuts in federal TANF funding, since an increasing share of DCF budget is being funded with TANF funds.

Missed Opportunities to Claim Federal Reimbursement. Connecticut has failed to maximize federal reimbursements for a variety of services provided to DCF-involved children and youth. As a result, there is less total funding to meet current needs and – importantly – also less funding to make the initial investments necessary to develop the robust continuum of home and community-based services that can avert, or reduce the duration of, many out-of-home placements.

As this report identifies, and as the second part of this two-part report will discuss in much greater detail, these missed opportunities include:

- *Failing to Make More DCF Children Eligible for Medicaid.* To meet the DCF's obligation to provide necessary health care services to all children in its care, children are enrolled in HUSKY A, Connecticut's Medicaid managed care program. For nearly three-quarters of the children in DCF's care and custody, these health benefits are federally-subsidized through Medicaid (Connecticut receives 50% reimbursement). In March 2004, for example, 72% of the children in DCF care were eligible for federally-funded Medicaid (8,464 DCF-related children out of 11,760). For children not eligible for federally-funded Medicaid, Connecticut provides *state-funded* HUSKY A coverage and DSS does *not* receive federal reimbursement for the cost of the services these children receive. As of March 2004, 3,296 DCF children were in state-funded HUSKY (about 28% of all DCF children).

Importantly, most of the DCF children in state-funded HUSKY are *not* disqualified from federally-funded benefits because of their immigration status[3] or their placement in certain state institutions (such as detention centers), but because DCF fails to make application on their behalf in a timely fashion to determine their eligibility for federally funded benefits,[4] or because they had turned 18 years

[3] In general, federally funded Medicaid benefits are not available for most legal immigrants who have been in the country less than five years and for any undocumented immigrants.

[4] While Medicaid allows retroactive reimbursement (for up to three months from date of application) for care provided to a child determined to be Medicaid-eligible, delays in filing applications for Medicaid (or failure to file applications at all) can result in reduced reimbursements.

of age. Almost all these children *could be* provided with federally funded Medicaid benefits through fairly simple changes in policy and procedures.

For example, when a child first comes into the care of DCF, the child receives state-funded benefits while eligibility for federally funded Medicaid coverage is being determined.[5] Because the vast majority of children in DCF care are eligible for Medicaid, policies and procedures that assure timely application and speedy eligibility determinations would increase federal reimbursement to the state. Two ways to accomplish this are: a) to station a DSS worker at DCF to determine accept applications and eligibility; and b) to designate DCF a "qualified entity" able to provide immediate, temporary Medicaid eligibility to children entering DCF care.

In addition, currently *state*-funded HUSKY benefits are provided to the young adults who remain in DCF care past their 18th birthday under its Independent Living program who have income or resources that exceed the very low eligibility levels that would make them otherwise eligible for Medicaid. However, these youth *could* be eligible for federally funded Medicaid under the Foster Care Independence Act of 1999. This Act established a Medicaid option that would allow Connecticut to provide Medicaid coverage to *all* children in foster care on their 18th birthday until they reach the age of 21. By taking advantage of this federal option, Connecticut could receive federal reimbursement for the currently state-funded HUSKY A benefits provided to almost all of the young adults between 18 and 21 who are currently in DCF care and custody. In addition, young adults who leave foster care at age 18 *or any time before they turn 21* could also receive federally-subsidized HUSKY A coverage through this pathway to eligibility.

- *Failing to Fully Claim Medicaid Reimbursement for Covered and Optional Services.* Since at least 1989, consultants have advised Connecticut regarding ways in which federal reimbursements through Medicaid and Title IV-E for child welfare-related services could be enhanced.[6] Recommended "re-financing" ideas have included:

    a) Medicaid targeted case management reimbursement for DCF's direct service and administrative costs;
    b) The Medicaid rehabilitative services option to cover community services for children and youth not currently reimbursed by Medicaid;
    c) The Medicaid private non-medical institution (PNMI) coverage for treatment components of residential care programs;
    d) Title IV-E reimbursement for training not only of DCF case managers, but also for case assessment, case planning, case management, and consumer family training associated with the development of local systems of care, and for broad training initiatives that include *all* public agencies concerned with high-risk children and families.

[5] DCF caseworkers provide information to a special unit at DCF that completes HUSKY applications for the children and mails them to the regional DSS offices. Once at DSS, the application can take up to 45 days and sometimes longer to be acted on.

[6] E.g., Connecticut Department of Children and Youth Services, *Refinancing and Expanding Services to Children Through a Controlled Use of Medicaid (Title XIX): A Proposal for the Consideration of the Department of Income Maintenance* (July 21, 1989); Maximus, *Children and Family Services Federal Reimbursement Options* (October 4, 1999); Connecticut Department of Social Services, *Delivering and Financing Children's Behavioral Health Services in Connecticut: A Report to the Connecticut General Assembly Pursuant to Public Act 99-279, Section 36* (February 2000).

While Connecticut now claims some federal reimbursement under PNMI for residential treatment, it has not taken full advantage of these ways to maximize federal revenues.

5. Current Federal Funding Rules Under Title IV-E of the Social Security Act Contribute to DCF's Problems in Funding Child Welfare Services in a Manner That is Cost-Effective and Serves Children's Best Interests.

Current restrictions placed on the use of federal funds for child welfare services also are impeding states' efforts to provide competent care. Not only is there a need for *increased* federal funding support, but also for increased *flexibility* in the use of child welfare funds.

As discussed more fully in the report, federal "front-end" funding for services targeted at preventing child abuse and neglect and averting out-of-home placements when maltreatment has occurred has grown slowly, if at all, over the last decade. The federal government contributes relatively little to states' efforts to keep children in their homes, or move them to permanency through such federal funding streams as Title IV-B and CAPTA. There is a need for *increased* federal funding for such services.

By comparison, federal funding under Title IV-E has grown far more significantly over the last decade. Here, there is a need for greater *flexibility* in the use of federal funds. Connecticut receives 50% reimbursement for the costs of a foster child's out-of-home care if the child is eligible for Title IV-E, but does *not* receive such reimbursement for the service costs associated with keeping a Title IV-E eligible child in his home (or returning the child to his home). As a result, the Title IV-E financing rules "reward" DCF for making out-of-home placements by providing matching federal funds. However, if DCF successfully averts a placement, or moves a child back home, it not only fails to receive federal matching funds for the services the child may then need in her home, but also *loses* the federal matching funds it had been provided when the child was in foster care.

In short, current federal funding requirements create a perverse incentive, making it more financially advantageous for states to place children out of home than to provide services to keep families together. As two child welfare experts note:

> The federal foster care program provides open-ended funding for the room and board of certain eligible children in foster care, but only very limited funding for the development of alternative services for abused and neglected children and their families, both before a child must be placed in foster care or after a child returns home following placement. As a result, out-of-home care is often the easiest option for workers besieged with large caseloads and few other resources. Moreover, because funding under the federal foster care program is generally restricted to room and board, it is often difficult to give even those children placed in foster care the services and treatment they need.[7]

As will be discussed more fully in the second report in this two-part series, there are a variety of alternatives being considered to address the problems created by the current federal funding "straitjacket." These include – most significantly – the recommendations of the Pew Commission on

[7] M. Allen & M. Bissell, "Safety and Stability for Foster Children: The Policy Context" in *Children, Families, and Foster Care* (The David and Lucile Packard Foundation, The Future of Children, 14(1), 2004), p. 63.

Foster Care.[8] This Commission (a national, nonpartisan panel funded by The Pew Charitable Trusts and composed of leading experts in child welfare) recommended, inter alia:

- Preserving Title IV-E federal foster care maintenance and adoption assistance as an entitlement and expanding it to *all* children, regardless of their birth families' income and including Indian children and children in the U.S. territories;

- Providing federal guardianship assistance through Title IV-E to all children who leave foster care to live with a permanent legal guardian when a court has explicitly determined that neither reunification nor adoption are feasible permanence options;

- Helping states build a range of services from prevention, to treatment, to post-permanence by: (1) creating a flexible, indexed Safe Children, Strong Families Grant from funds currently included in Title IV-B and the administration and training components of Title IV-E; and (2) allowing states to "reinvest" federal and state foster care dollars into other child welfare services if they safely reduce their use of foster care;

- Encouraging innovation by expanding and simplifying the federal waiver process and providing incentives to states that: (1) make and maintain improvements in their child welfare workforce; and (2) increase all forms of safe permanence; and

- Strengthening the current Child and Family Services Review process to increase states' accountability for improving outcomes for children.

VI. In Sum: Careening Toward Crisis

State and federal spending on child welfare services *should* support the development of a system of services that furthers best practices in child welfare, meets all requirements of federal and state law, and serves the best interests of children and families. This includes working to ensure that children are maintained with family whenever possible, and are placed in the least restrictive, most family-like setting when this is not possible. Currently, that is not the case.

Federal funding constraints and state budget choices have resulted in a DCF budget that, in many respects, has been allocating its resources at cross-purposes to what is known to be best practice in child welfare. The second policy brief on this subject, to be released by Connecticut Voices for Children early in 2005, will examine ways to change this course -- through changes in state policy and different state budget choices, by taking advantage of existing options in and possible waivers to current federal law, and through changes to federal law.

[8] http://pewfostercare.org/