Economic Impact Analysis
Virginia Department of Planning and Budget

22 VAC 42-11 –Standards for Interdepartmental Regulation of Children's Residential Facilities
Boards of Education; Juvenile Justice; Mental Health, Mental Retardation and Substance Abuse Services; and Social Services
October 21, 2004

The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with Section 2.2-4007.G of the Administrative Process Act and Executive Order Number 21 (02). Section 2.2-4007.G requires that such economic impact analyses include, but need not be limited to, the projected number of businesses or other entities to whom the regulation would apply, the identity of any localities and types of businesses or other entities particularly affected, the projected number of persons and employment positions to be affected, the projected costs to affected businesses or entities to implement or comply with the regulation, and the impact on the use and value of private property. The analysis presented below represents DPB's best estimate of these economic impacts.

Summary of the Proposed Regulation

Due to the extensive nature of the changes, the boards of education, juvenile justice, mental health, mental retardation and substance abuse services, and social services propose to replace existing standards for interdepartmental regulation of children's residential facilities (22 VAC 42-10) with new regulations (22 VAC 42-11). The major changes are 1) increasing administrative/supervisory personnel qualifications, increasing staff training requirements, and modifying staffing ratios, 2) establishing several new administrative requirements, and 3) allowing downgrading of triennial licenses to annual or provisional licenses and of annual licenses to provisional licenses if systemic deficiencies are found.

Estimated Economic Impact

The proposed regulations contain minimum standards for children's residential facilities. These facilities include child caring institutions, independent living programs, schools for

children with disabilities, temporary care facilities, emergency shelters, wilderness programs, facilities for mentally/emotionally disturbed and retarded children, facilities for children with substance abuse problems, respite care facilities, post-dispositional/pre-dispositional group homes, juvenile correction facilities, and detention homes. Approximately 275 such facilities with the capacity to serve 7,201 children fall under these regulations. However, the actual number of children in these facilities is not tracked by the state.

Four different agencies, the Department of Social Services (DSS), the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS), the Department of Juvenile Justice (DJJ), and the Department of Education (DOE) participate in the interdepartmental regulation program and jointly promulgate the Standards for Interdepartmental Regulation of Children's Residential Facilities. After reviewing the program description, one of these agencies is assigned to each facility as the lead licensing agency. In some cases, a facility may be regulated by more than one agency. In addition to complying with these regulations, that are common to all facilities, some may be subject to additional regulations promulgated by the lead regulatory agency to cover issues that are agency specific. For example, juvenile correctional centers run by DJJ are subject to some additional security rules that are established in a separate regulation. Similarly, mental health facilities regulated by DMHMRSAS are subject to additional mental health regulations.

There is no comprehensive industry-wide economic data available on children's residential facilities. These facilities serve children placed by public agencies as well as children placed privately by parents. Federal funding is available for some of the children placed in these facilities. Services are provided continuously 24 hours a day and 365 days a year. It appears that the industry largely operates under free market conditions. However, facilities that accept Medicaid must agree to accept the Medicaid approved rate and meet Medicaid requirements. Prices charged by the facilities are not regulated, with each facility setting its own price. Public agencies and private parents make their placement decisions knowing the prices charged for these services by various facilities. However, there is little information available on the daily rates charged as well as the gross revenues earned by these facilities. According to the agency[1], the daily rates may be as high as $300 per child per day in some cases. Average length of stay is

believed to be between one and two years. The DSS reported that in fiscal year 2003 these facilities received $4,700 per child or $7.9 million (state and federal) for the room and board of 1,696 children placed with them under the Comprehensive Services Act. However, this is only a fraction of the total number of children housed at these facilities, making it impossible to reliably estimate industry revenues.

The driving force behind the proposed changes is to update the standards with current child welfare practices. According to the agency, the children's residential facility business in Virginia also has changed in the last few years. Previously, children's residential facilities were operated by child welfare agencies, religious groups, or hospitals and many were operated as nonprofit agencies. Today private citizens are applying to operate children's residential facilities as for profit facilities. The agency believes that lucrative prospects attract many new entrants who may or may not be qualified despite meeting the current minimal qualification standards, raising significant concerns about the quality of care provided. The agency received 244 inquiries from potential applicants about starting a facility in FY 2001 and 435 in FY 2004, representing a 78% increase. The number of applications received by DSS increased from 20 in FY 2003 to 37 in FY 2004, an 85% increase. The total number of operating facilities increased from 221 in July 2000 to 268 in July 2004 and to 275 in September 2004, representing a 21% increase over a four-year period and a 3% increase for the most recent three-month period. These statistics support the agency's observation that there are many more facilities entering this industry than before. However, the fact that more facilities are entering this industry does not necessarily imply a lower quality of care.

Available statistics on quality-of-care indicators are imperfect proxies for actual quality of care and are not sufficient to support the perception that there are quality-of-care problems. For example, the number of provisional licenses issued increased from four in FY 2001 to 12 in FY 2003 and to 17 in FY 2004. While one might be tempted to interpret this as evidence of increasing non-compliance, the observed increase may well be the result of more facilities applying for licensure, or a more stringent enforcement policy. Similarly, estimates on systemic deficiencies do not present a convincing picture of increasing non-compliance. DSS estimates that it found roughly 23 systemic deficiencies in FY 2003 and roughly 17 in FY 2004. DOE

[1] For convenience "the agency" is used to denote the office of interdepartmental regulation of children's residential

estimates that it found only one systemic deficiency in FY 2003 and two in FY 2004. DMHMRSAS does not currently track the number of systemic deficiencies issued by the Department but also has issued systemic deficiencies.

However, the agency indicated that the standards proposed are not based solely on documented problems, but rather on an analysis of current accepted practices in the child welfare industry, the experience of regulators during initial, complaint, and follow-up visits, programs doing well, the experience of other states, Child Welfare League of America recommendations, and federal guidelines. Furthermore, available research literature appears to support the proposed changes.

The proposed changes will most notably strengthen the personnel qualification and training requirements and the staffing ratios, which may improve the health, safety, and welfare of the children placed in residential facilities. On the other hand, the stricter standards are likely to introduce non-negligible compliance costs for providers, which could increase the price of residential care and lead to a decrease in the number of children cared for in these facilities. This, in turn, could increase the risk to children who are then placed in unregulated forms of childcare due to the higher price of regulated care. The net effect of more stringent personnel qualification and training requirements and staffing ratios is uncertain.

Qualifications, Training, and Staffing Ratios: One set of changes increase the required administrative/supervisory staff qualifications. Staff qualifications are established in terms of a required degree and experience. Currently, a chief administrative officer is required to have a baccalaureate degree in a human services field (social work, psychology, or counseling), or to have a baccalaureate degree in a related field (institutional management, education, or other allied disciplines) and two years of work experience working with children. The proposed changes require that a chief administrative officer have a master's degree in a human services field with five years of experience (three years in a children's residential facility and two years in an administrative or supervisory position), or have a baccalaureate degree with seven years of experience (five years working with children, with three years in a residential facility and two years in an administrative or supervisory position). A degree in education may be accepted for a

facilities that represents DSS, DMHMRSAS, DJJ, and DOE.

chief administrative officer for a facility regulated by DOE. The lead regulatory agency also has the discretion to approve other degrees and experience as deemed appropriate.

Similarly, program director qualifications have been increased. A program director is currently required to have a baccalaureate degree in a human services-related field, a graduate degree in a profession related to child-care and development, or be licensed as a drug or alcoholism counselor/worker. The proposed changes require that a program director have a master's degree in a human services field with three years of experience working with children (one year of which is in a children's residential facility), or have a baccalaureate degree in social work or psychology with five years of experience working with children (two years of which are in a children's residential facility). The lead regulatory agency also has the discretion to approve other degrees and experience as deemed appropriate.

The proposed regulations also establish qualification requirements for case managers. A case manager will be required to have a master's degree in human services, or a baccalaureate degree in social work or psychology with documented fieldwork experience. The lead regulatory agency also has the discretion to approve other degrees and experience as deemed appropriate.

The proposed changes will no longer allow a person with a high school diploma and five years of experience in a human services field (one year of which in a children's residential facility) to be appointed as a child care supervisor unless approved by the regulatory authority.

According to available research [2] on out-of-home childcare, directors with more experience and education are found to be more likely to appropriately monitor staff, and staff are more likely to exhibit behaviors that protects children's health and safety when they are being monitored. These findings may be interpreted to imply that a supervisor should obtain at least as much or maybe even more, education/experience as a caregiver. Additionally, a significant body of literature indicates that caregivers with baccalaureate degrees and specialized training or experience are more likely to produce the best behavioral, social, health, safety, and welfare outcomes. To the extent that a supervisor must possess more education or experience than a caregiver with a baccalaureate education or equivalent experience, the proposed master's-level

[2] Any reference to research literature in this analysis is obtained from the literature overview by Dr. Richard Fiene, "13 Indicators of Quality Child Care: Research Update," Submitted to Office of the Assistant Secretary for Planning and Evaluation and Health Resources and Services Administration/Maternal and Child Health Bureau, U.S. Department of Health and Human Resources.

education, or equivalent specialized experience for the supervisory positions should improve health, safety, and welfare of children.

However, master's level education or more experience requirements for administrative/supervisory positions will increase compliance costs. As the qualifications of the personnel (in terms of diploma or experience) increases, the wages paid to these personnel would increase. Thus, residential care providers will likely incur some additional costs in order to maintain personnel with graduate degrees or equivalent experience. However, the proposed regulation allows current staff to be "grandfathered." Residential facilities that have staff that do not currently meet these proposed qualification standards would incur no additional costs until a position is vacated and a new staff person is hired. It is also unknown how many chief administrative officers, program directors, case managers, and child care supervisors already meet the proposed qualification standards. The standards also allow one person to perform multiple job duties as long as they are qualified for all positions. For, example the CAO could also serve as the program director.

Another set of proposed changes increase staff training requirements. The regulations will require that staff administering medication take annual refresher training offered by the board of nursing. Also, the proposed changes require that all staff be trained in First Aid and Cardiopulmonary Resuscitation (CPR) within one month of hire. Existing regulations require that one staff member per 16 residents be trained in first aid and CPR. The agency indicated that it is difficult for facilities to track the 1:16 ratio all the time and many facilities train all direct care staff to insure compliance with the current ratio. Training all direct care staff reduces the likelihood that children experiencing emergency situations will be with untrained staff. The current standard only addresses situations on the facility grounds and does not take into consideration when staff take residents off grounds.

The proposed additional training in medication administration, first aid, and CPR are expected to reduce medication mistakes and help staff appropriately respond to an emergency involving first aid and CPR. Given the fact that it is difficult to ensure compliance with the current 1:16 ratio at all times and the unpredictable nature of emergencies, the proposed training requirements are expected to improve protection afforded to children under the care of a residential facility.

On the other hand, the proposed training requirements will likely increase compliance costs. A majority of the additional costs are in terms of the time required to attend the training, as time so spent would be valued at the ongoing wage rate. In addition, there are fees and other costs associated with obtaining first aid and CPR training. It is unknown how many facilities currently train all direct care staff.

The final set of proposed changes increase staff supervision of children. This is to be done by increasing the staff-to-resident ratio from 1:10 to 1:6 while residents are awake and from 1:16 to 1:12 while the residents are asleep. Following this change, facilities will have to maintain 67% more staff when children are awake and 33% more staff when children are asleep. However, according to the agency, 67 DJJ facilities are not subject to these ratios and will not be affected and all 106 mental health facilities are already meeting this requirement. One DOE facility would need two additional staff to meet the proposed non-awake hours ratio. The remaining 33 DOE facilities already meet the proposed staffing ratios. Seventeen of the DSS facilities already meet the proposed staffing ratios as their capacity is 6 or less. This leaves only 51 DSS facilities that may be affected, but DSS believes that many of these facilities are currently meeting the proposed ratio. Thus, this change is most likely to affect 51 DSS facilities with a capacity to serve about 806 children and only one DOE facility. If the capacity utilization were at 100%, the increase in the number of staff at DSS facilities would be 54 new positions during the day and 17 new positions during the night in addition to the two night shift personnel needed for one DOE facility. However, of the 51 DSS facilities, some may not be operating at full capacity and some are believed to be already meeting the proposed ratios. Thus, the actual impact on DSS facilities will be smaller than the estimated 54 day shift positions and 17 night shift positions.

The staff-to-resident ratio is one of the most important factors affecting the quality of care. According to available research, more staff supervision gives caregivers a better chance to monitor and promote healthy practices and behaviors. More supervision is associated with fewer situations involving potential danger and child abuse. Caregivers are found to exhibit more positive, nurturing interactions with children and provide individualized attention when the number of children they care for is lower. Children show less distress, less apathy, and greater social competence when they receive more attention. More supervision is associated with more verbal communication and educational activities, which in turn foster academic development.

The costs of increased staff ratios depend on the way facilities respond to this change. They may choose to hire new personnel, reduce the number of children served to meet the proposed ratios, or do both. So, the compliance costs may be in terms of increased labor costs for the new staff or reduced revenues. However, there is no existing data to accurately estimate the size of the potential compliance costs associated with this change.

Administrative Changes: Another category of changes introduces several administrative requirements. One of these changes requires facilities to develop a plan to ensure health and safety of the children during recreational trips away from the facility. According to the agency, three fatalities occurred recently during inadequately planned recreational activities. Such a plan is to include a supervision plan for the duration of the trip, an emergency plan, a plan for the safekeeping and distribution of medication, an evaluation of each resident's health status and capabilities in relation to the trip activity, etc. This will force facilities to pay more attention to averting potential problems. While the cost of preparing such a plan is not expected to be significant, this requirement may help prevent the occurrence of low probability, high cost catastrophic events.

Another significant change under this category will require facilities to develop policies and procedures for medication administration, review, and distribution, for general recordkeeping procedures, and for independent living and mother/baby programs. The cost of these requirements are expected to be primarily in terms of staff time required to develop the plans and procedures. The main benefits on the other hand include the reduced likelihood of medication errors, up-to-date information on children necessary for the provision of appropriate treatment, and established guidelines for the smooth operation of independent living and mother/baby programs.

Other proposed changes under this category will require facilities to conduct an internal financial audit every year and an external audit every three years. The main purpose of this requirement is to make sure that the facilities have the financial capacity to provide services in a manner that does not put their residents at risk. While this requirement will likely introduce additional compliance costs, the agency does not know the size of these audit costs. The agency also believes that some of the facilities are already conducting financial audits and does not expect them to face additional costs by the proposed change.

Change in Licensing Practices: The proposed changes will allow DOE, DMHMRSAS, and DSS to change an existing license to an annual or provisional license if one or more systemic deficiencies are found. Currently, facilities hold a triennial or an annual license, which cannot be downgraded to an annual or provisional license during the licensure period. According to the agency, systemic deficiencies are issued when repeated violations or significant violations are found. This change is expected to strengthen compliance as facilities try to maintain their triennial or annual licenses. Because this change will likely reduce the chances of a systemic deficiency that must be addressed with or without this new requirement, a net economic benefit is expected. However, the agency does not know how many licenses may be reduced to an annual or provisional license as a result of this change.

Businesses and Entities Affected

The proposed regulations apply to 67 DJJ facilities with capacity to serve 3,014 children, 106 DMHMRSAS facilities with capacity to serve 2,163 children, 34 DOE facilities with capacity to serve 946 children, and 68 DSS facilities with capacity to serve 1,078 children.

Localities Particularly Affected

The proposed regulations apply throughout the Commonwealth.

Projected Impact on Employment

The proposed staff qualifications are expected to increase the demand for services of individuals with master's level education or equivalent experience and decrease the demand for services of individuals with baccalaureate level education or equivalent experience. Increased staff-to-child ratios on the other hand are likely to increase the demand for caregivers with baccalaureate level education or equivalent experience. Furthermore, new administrative requirements may increase demand for administrative personnel by a small margin. However, there is a good chance that the facilities may respond to higher compliance costs by reducing their capacity and consequently maintaining or reducing their demand for labor. Thus, the likely net impact on employment is not known.

Effects on the Use and Value of Private Property

No change in the use and value of real private property is expected. However, the proposed regulations will increase compliance costs of the facilities affected. Higher compliance

costs will likely reduce the profit stream of children's residential care businesses and reduce their asset values. Some of the additional costs could be passed on to the consumer through higher prices.