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Evaluation of Michigan's Performance-Based Funding Model

Final Report
Executive Summary

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Table of Contents

Executive Summary 1

E1. Introduction 1
E2. Methodology 1
E3. Cost, Outcome, and Process Results 3
Cost Study 3
Outcome Study 13
Process Study 16
E4. Summary and Conclusions 20

Tables

ES-1 Kent County – Expenditures in thousands of dollars, by Fiscal Year, service domain, and URM/YAVFC/JJ/OTI status, adjusted for inflation 4
ES-2 Kent County care days by state Fiscal Year and living arrangement (excluding URM, YAVFC, JJ, and OTI) 5
ES-3 Exited or still in care 13
ES-4 Cumulative exits to permanency 14
ES-5 Permanency categories by study group 15
ES-6 Time to exit by permanency type 15

Figures

ES-1 WMPC-related – Revenue totals by overall funding source and Fiscal Year, adjusted for inflation" 5
ES-2 Kent County care-day utilization by state Fiscal Year and placement setting as a percentage of total care days 7
ES-3 Kent County child entries, exits, and caseload count at the end of the Fiscal Year 7
ES-4 Median duration in months by state Fiscal Year of child entry in Kent County and the rest of the state 8
ES-5 WMPC-related average daily unit cost for out-of-home placements by Fiscal Year, adjusted for inflation 9
ES-6 Kent County and the rest of the state – Total child welfare expenditure trends by Fiscal Year, adjusted for inflation 10
ES-7 WMPC-related and the rest of the state – Average daily unit cost for out-of-home placements by Fiscal Year, adjusted for inflation 11

ES-8 Average cost per out-of-home placement spell for children entering care after 10/01/2017 and discharged from care as of 10/01/2022 12
ES-9 Permanency survival rate for study groups 14

Exhibit

ES-1 Words used to describe the Kent Model 22

Executive Summary

E1. Introduction

The Michigan Legislature, through Public Act 59 of 2013, Section 503, convened a task force that recommended a pilot project to plan, implement, and evaluate a performance-based funding model (referred to in this report as the Kent Model). The Kent Model is being implemented by the West Michigan Partnership for Children (WMPC), an organization that partners with five private Kent County-based service agencies.

The evaluation contract was awarded to Westat and its partners in 2016 and includes cost (Chapin Hall), outcome (University of Michigan School of Social Work), and process (Westat) components. The rigorous 5-year evaluation of the pilot was designed to test the effectiveness of the Kent Model on child and family outcomes in Kent County, results from which are summarized in this report. The cost study addresses cost effectiveness in service delivery, the outcome study documents changes in child and family outcomes (i.e., safety, permanency, and well-being), and the process study provides the context for foster care service implementation. While the comparison group for the cost and outcomes studies are all counties in Michigan other than Kent County, Ingham and Oakland counties served as the comparison counties for the process study.

E2. Methodology

The **cost study** is designed to understand the fiscal effects of the transition to the Kent Model using primarily system-level and child-level fiscal and placement data from Kent County. The cost study addresses the following research questions:

- What effect has the transition to the Kent Model had on expenditure and revenue patterns in the county?
- How does the cost of out-of-home care in Kent County compare to the cost of out-of-home care in prior periods and to the rest of the state?
- To what extent does the WMPC case rate (and subsequent capitated rate) fully cover the cost of services required under the contract?
- What are the cost implications of the outcomes observed under the transition to the Kent Model?

To address the first two research questions, the cost study team examined system-level expenditure and revenue trends in Kent County and the rest of the state, focusing on the 3-year baseline period (FY 2015 – FY 2017) and the first 5 years post-implementation (FY 2018 – FY 2022). These expenditure patterns and revenue sources were also compared with those across the state, to address the second research question. The cost study compares total expenditures, care day utilization by placement type, and per diem costs of care in Kent County and the rest of the state.

For the third research question, to understand whether the case rate funding model used for the first 3 years of the pilot covered the cost of services, the cost study team analyzed expenditures and fiscal policy changes initiated by WMPC. The pilot switched to a capitated allocation model beginning in FY 2021, and the cost study team used care day utilization and the average daily cost of care to project spending on a quarterly basis. To answer the fourth question about the cost implications of child outcomes, the cost study team used child-level fiscal data linked to child placement spells (a period during which a child is continuously in out-of-home care) to compare the cost per outcome of children in Kent County to a matched comparison group. The study team examined the type, amounts, and costs of services received by children in out-of-home placements and compared them with those provided to a matched cohort of children receiving out-of-home services delivered by private providers across the state; the outcome study team developed the comparison group using propensity score matching (PSM).

The **outcome study** team used PSM to generate a comparison group, for children who entered care prior to the 10/01/2017 pilot implementation date and matches for children entering care after 10/01/2017, separately for each entry year. The comparison group is comprised of children who were in foster care at least 80 percent of the time and had statistically similar covariate representation (e.g., age, sex, removal year, allegation type, race, and ethnicity). The outcome study addresses the following research questions:

- Does the Kent Model improve the safety of children?
- Does the Kent Model improve permanency for children?
- Does the Kent Model improve the well-being (placement stability) of children and families?

Outcome results are reported for children in Kent County and the comparison group before and after pilot implementation. Differences between children in Kent County and the comparison group by entry year are reported when substantial differences were found among entry year results.

Over the course of the evaluation, the **process study** team conducted interviews and focus groups with public and private child welfare agency leadership and samples of supervisors and caseworkers; and representatives from the Michigan Department of Health & Human Services (MDHHS), county court systems, and mental health agencies; and WMPC to answer the following research questions:

- Do the counties adhere to the state's guiding principles in performing child welfare practice?
- Do child placing agencies adhere to the MiTEAM practice model when providing child welfare services?
  - What resources (strategies, infrastructure) are necessary to support the successful delivery of child welfare services?
  - What factors facilitate and inhibit effective implementation of child welfare practice, in general, and, importantly, in the Kent Model (in Kent County)?
  - What resources are necessary to support the successful implementation of the Kent Model (in Kent County)?

The number of respondents each year ranged from 46 to 196 (n=124 in Year 1, n=196 in Year 2, n=98 in Year 3, n=156 in Year 4, n=153 in Year 5, and n=46 in Year 6). In Years 1, 2, 4, and 5 of the evaluation, the study team conducted interviews and focus groups with stakeholders in Kent, Ingham, and Oakland counties (and with MDHHS leaders in Years 1, 2, and 5). In evaluation Years 3 and 6, the study team collected data in Kent County only (and with MDHHS leaders in Year 6) to conduct an in-depth examination of changes resulting from Kent Model implementation. In evaluation years 1-6, focus groups and interviews included questions about Kent Model implementation, case planning and practice, services to families, monitoring and accountability, interagency collaboration, and challenges and facilitators. Data collection in the final year of the evaluation focused on implementation successes, limitations, and lessons learned.

E3. Cost, Outcome, and Process Results

Cost Study

Fiscal Trends Before and During the Pilot

Research Question: What effect has the transition to the Kent Model had on expenditure and revenue patterns in the county?

Overall, total out-of-home private agency expenditures increased in Kent County from FY 2016 through FY 2019 and decreased in FYs 2020 through 2022 (Table ES-1). In the baseline period prior to the pilot, from FY 2015 to FY 2017, total private agency expenditures (excluding URM, YAVFC, JJ, and OTI) increased by 12 percent, with the largest annual increase during the baseline period occurring from FY 2016 to FY 2017 when total expenditures increased by $3 million in the year immediately preceding implementation of the Kent Model (a 12% increase). Another large growth in private agency expenditures (20%) occurred from FY 2017 to FY 2018—the first year of the post-implementation period. However, in FY 2019 there was a slight expenditure increase, with a 5 percent escalation of private agency expenditures from FY 2018 to FY 2019. There was an annual decrease of 18 percent in total child welfare expenditures in FY 2020, followed by a 24 percent decrease in FY 2021 and a 17 percent decrease in FY 2022.

Table ES-1. Kent County[1] – Expenditures in thousands of dollars, by Fiscal Year, service domain, and URM/YAVFC/JJ/OTI status, adjusted for inflation

Service domain	Pre-implementation			Post-implementation				
	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
Total Kent County expenditures	$35,655	$38,187	$44,202	$51,219	$51,626	$45,572	$36,201	$29,015
Total private agency expenditures (excluding URM, YAVFC, JJ, & OTI)	$27,267	$27,104	$30,481	$36,515	$38,196	$31,219	$23,642	$19,528
Placement – Maintenance[2]	$12,832	$13,867	$16,498	$17,632	$17,691	$16,511	$12,107	$9,148
Placement – Administrative[3]	$13,214	$12,198	$13,481	$17,969	$19,843	$13,819	$11,059	$9,604
FC Placement Service	$934	$837	$216	$213	$245	$258	$273	$182
Residential Services	$112	$47	$134	$545	$259	$533	$99	$48
Mental Health	$139	$138	$122	$139	$124	$44	$31	$25
Physical Health	$8	$15	$20	$9	$15	$9	$6	$7
Independent Living	$0	$1	$1	$4	$13	$34	$65	$46
Education	$13	$1	$10	$4	$7	$12	$1	$2
Adult FC Service	$15	$0	$0	$0	$0	$0	$0	$466[4]
URM, YAVFC, JJ, or OTI expenditures	$8,388	$11,082	$13,721	$14,704	$13,430	$14,352	$12,559	$9,487

Note: FC = foster care.

The two largest funding sources for out-of-home placement services in Kent County are the Federal Title IV-E funds and the County Child Care Fund (Figure ES-1). Total Title IV-E revenue used each year remained fairly constant until an increase in FY 2018. The proportion of revenue attributable to this funding category declined in the baseline period—from 43 percent in FY 2015 to 36 percent in FY 2017. In FY 2018, Title IV-E revenue increased to make up 39 percent of total revenue, but between FY 2019 and FY 2022, this revenue source decreased in amount and proportion. During this same period, the amounts of all other funding sources fluctuated, but they each increased as a *proportion* of Kent County revenue.

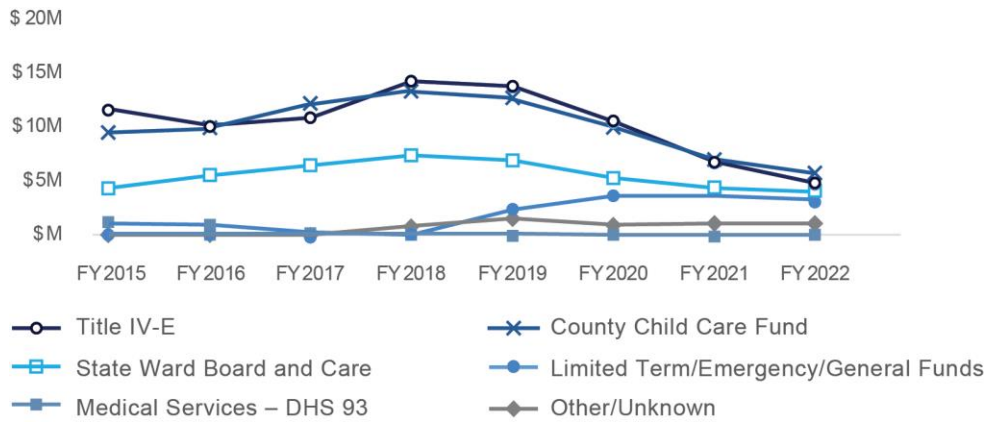
1 Kent County expenditures here represent all expenditures for which Kent County is listed as the responsible county.

2 Maintenance expenditures reflect the payments for the daily care and supervision of children in out-of-home care. For CCI placements, maintenance costs also include the provision of social services and clinical treatment. Administration expenditures represent the costs to manage child placement services and administrative costs related to foster care for children.

3 Administrative expenses reported are related to private agency payments, and do not include WMPC's $2 million administrative allocation.

4 During FY 2022, adult foster care services were added in Kent County.

Figure ES-1. WMPC-related – Revenue totals by overall funding source and Fiscal Year, adjusted for inflation[5,6,7]



Care Day Utilization

Expenditures are based on the number of care days provided, and the daily unit costs of care. As shown in Table ES-2, care-day utilization increased slightly in FY 2018 and again in FY 2019, compared to the 3 years prior to WMPC implementation. Care days decreased between FY 2019 and FY 2020 and continued to decline substantially in FYs 2021 and 2022. In FY 2022, care days declined 19 percent from 2021 levels, from 224,513 total days to 182,698 days.

Table ES-2. Kent County care days by state Fiscal Year and living arrangement (excluding URM, YAVFC, JJ, and OTI)

Placement setting	Pre-implementation			Post-implementation				
	2015	2016	2017	2018	2019	2020	2021	2022
Total Care Days	332,699	297,810	296,297	305,400	312,068	278,276	224,513	182,698
Foster Care	178,408	146,958	139,131	140,803	135,854	118,816	83,725	63,814
Kinship	71,401	78,331	82,039	88,166	98,987	83,569	75,396	70,475
Parental Home	38,986	29,667	28,989	26,649	27,967	28,586	26,237	15,163
Congregate	22,169	26,949	31,208	32,741	26,775	24,879	15,784	9,856
Independent Living	6,271	5,041	3,386	4,359	5,260	5,457	5,274	5,063
Emergency Shelter	1,688	1,861	3,311	3,109	2,829	1,957	635	300
Runaway	2,390	3,114	3,605	2,808	2,449	2,117	1,597	1,052
Enhanced FC				2,366	9,192	11,127	12,289	13,705

5 All pre-implementation revenue is determined by the OVERALL_FUND_SOURCE in MiSACWIS.

6 Most revenue in the post-implementation period is determined by the OVERALL_FUND_SOURCE in MiSACWIS or the revenue detail on the Residential Services tab in the WMPC Cost Report for the CCI placement expenditures. However, revenue associated with the aggregate EFC Admin costs was not available and was instead estimated by assigning revenue types to the EFC Admin expense based on the revenue type split in the pre-implementation period.

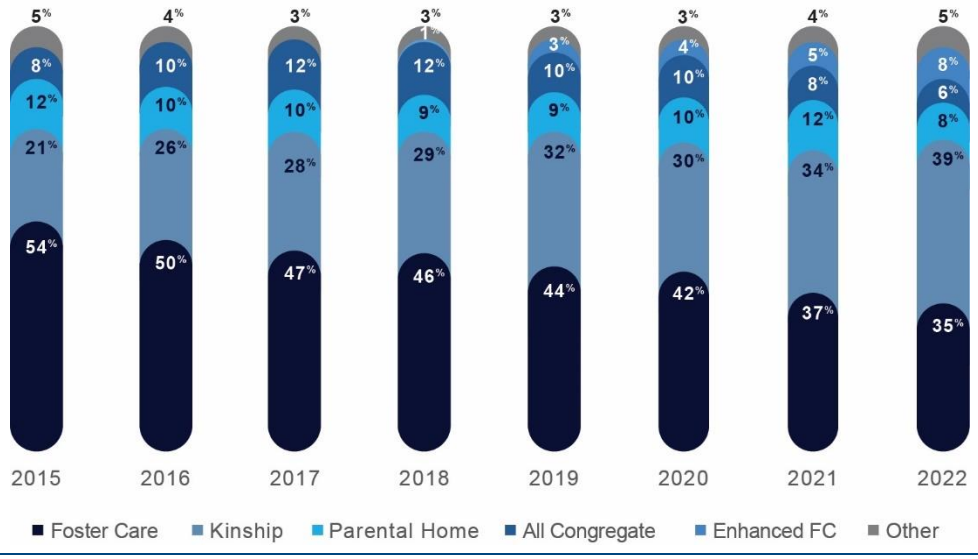
7 Other/Unknown revenue includes Temporary Assistance for Needy Families and Youth in Transition revenue and the revenue associated with Kids First expenditures.

Table ES-2. Kent County care days by state Fiscal Year and living arrangement (excluding URM, YAVFC, JJ, and OTI) (continued)

Placement setting	Pre-implementation			Post-implementation				
	2015	2016	2017	2018	2019	2020	2021	2022
Adoptive Home	6,738	2,578	936	1,547	1,058	50	279	395
Detention	1,812	1,246	642	1,156	595	682	1,334	836
Treatment FC	2,142	1,524	1,677	923			46	
Hospital	694	541	1,373	773	1,102	1,036	1,917	2,039
Total Year-Over-Year Change		-10%	-1%	3%	2%	-11%	-19%	-19%
Foster Care		-18%	-5%	1%	-4%	-13%	-30%	-24%
Kinship		10%	5%	7%	12%	-16%	-10%	-7%
Parental Home		-24%	-2%	-8%	5%	2%	-8%	-42%
Congregate		22%	16%	5%	-18%	-7%	-37%	-38%
Independent Living		-20%	-33%	29%	21%	4%	-3%	-4%
Emergency Shelter		10%	78%	-6%	-9%	-31%	-68%	-53%
Runaway		30%	16%	-22%	-13%	-14%	-25%	-34%
Enhanced FC					289%	21%	10%	12%
Adoptive Home		-62%	-64%	65%	-32%	-95%	458%	42%
Detention		-31%	-48%	80%	-49%	15%	96%	-37%
Treatment FC		-29%	10%	-45%				
Hospital		-22%	154%	-44%	43%	-6%	85%	6%

Care day utilization by placement type has also shifted during the pilot. In the pre-pilot period (FYs 2015-2017), approximately half of care days were spent in foster care, 10 percent in congregate care, and one quarter in kinship care (see Figure ES-2). Since the pilot began in 2018, the proportion of care days spent in kinship care has gradually been increasing while foster care has decreased. This change may be attributable to WMPC's policy decision to implement paid kinship care. The proportion of days spent in congregate care remained at pre-pilot levels the first 3 years under WMPC (FYs 2018-2020), but has declined in the most recent 2 years (FYs 2021-2022). In FY 2018, 12 percent of care days were spent in congregate settings compared to 6 percent in FY 2022. At the same time, the proportion of days spent in WMPC's enhanced foster care (EFC) program, which is intended to reduce reliance on congregate care, has increased steadily from 1 percent of care days in FY 2018 to 8 percent in FY 2022.

Figure ES-2. Kent County care-day utilization by state Fiscal Year and placement setting as a percentage of total care days

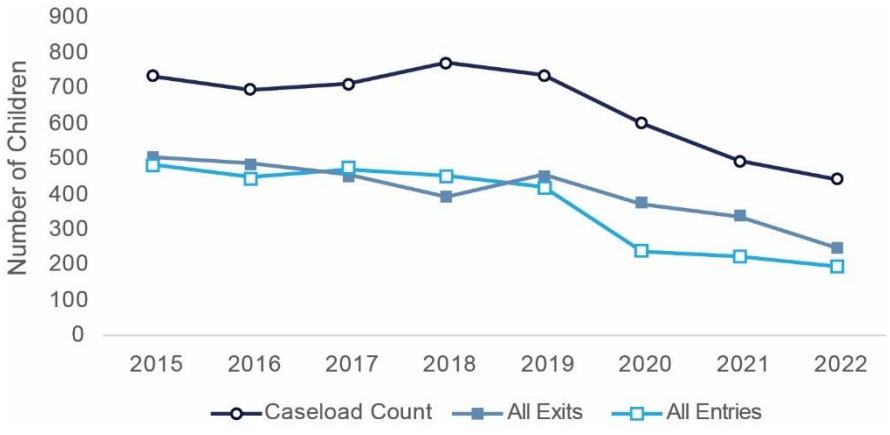


"All Congregate" includes congregate care, emergency shelter, and detention. "Other" placement settings include hospital, out-of-state placement, and runaway service facility.

Child Placement and Length of Stay Trends

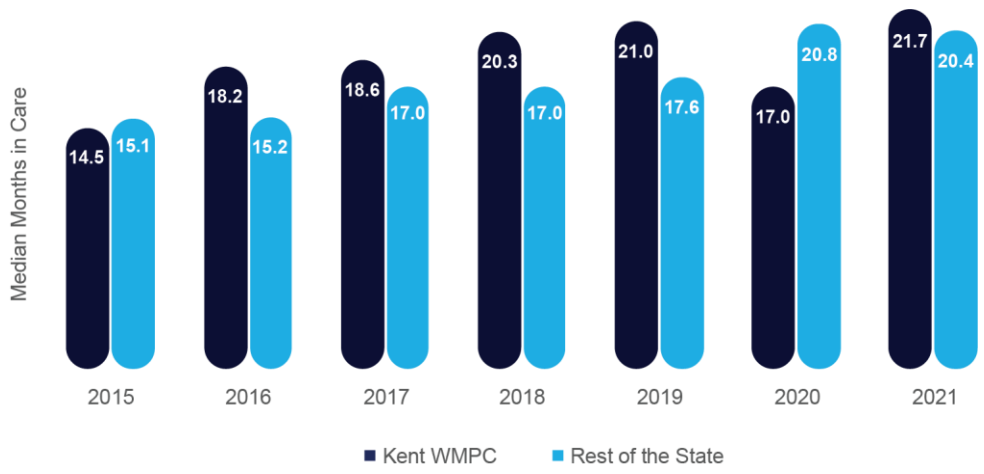
The decline in care day utilization from FY 2020 through FY 2022 is due in large part to a decline in admissions to care that began in FY 2019 and escalated during the COVID-19 pandemic (see Figure ES-3). Similar to the change in total care days, the number of child entries was fairly stable during the baseline period and into FY 2018, declined slightly in FY 2019, then declined more dramatically in FY 2020, and continued to drop in FY 2021 and FY 2022. In FY 2020, there was a 43 percent drop in the number of children entering care compared to FY 2019, and child entries continued to decline in 2021 and dropped 13 percent in FY 2022 compared to FY 2021. Child exits and the caseload count also declined in FY 2020 through FY 2022 compared to previous years. In FY 2022, the caseload count declined by 10 percent, relative to FY 2021, and exits dropped by 27 percent.

Figure ES-3. Kent County child entries, exits, and caseload count at the end of the Fiscal Year



Length of stay also impacts care day utilization. Figure ES-4 compares median duration in Kent County to the rest of the state. Median duration was somewhat higher than the rest of the state in the 2 years leading up to the pilot (FYs 2016-2017) and remained higher for the first 2 years of the pilot (FYs 2018-2019). For children entering care in FY 2018 and FY 2019, it took about 3 months longer for the first half of the cohort to exit care in Kent County than the rest of the state. Kent County's median duration dropped to 17 months for children entering care in FY 2020, nearly 4 months shorter than the rest of the state. This drop in duration corresponds to a statewide Rapid Permanency initiative implemented in April 2020.[8] For the FY 2021 entry cohort, median duration in Kent County increased to 21.7 months, which is slightly higher than the rest of the state (20.4 months).

Figure ES-4. Median duration in months by state Fiscal Year of child entry in Kent County and the rest of the state

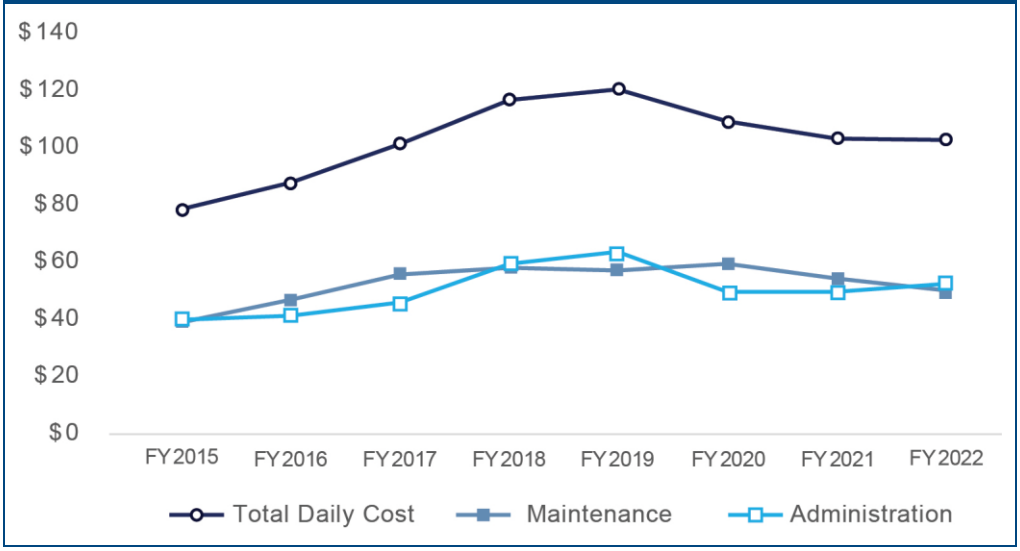


The Average Daily Unit Cost of Care

"Average unit costs" are calculated by dividing the total annual placement expenditures by total placement days for each Fiscal Year. In Kent County, for out-of-home placements the overall average daily cost per care day increased each observable year from FY 2015 through FY 2019 (Figure ES-5). The largest increase in average daily unit cost occurred during the baseline period (FYs 2015-2017), when the average daily unit cost increased by 29 percent. The average daily unit cost rose during the first 2 years of implementation (FYs 2018-2019) and decreased between FY 2020 through FY 2022. From the 2019 high, the average daily unit cost decreased 17 percent by FY 2022. In the last 2 years, the average daily unit costs of care have returned to pre-pilot levels in Kent County. In FY 2022, the average daily cost of care was 1 percent higher than it was in FY 2017 after adjusting for inflation.

[8] https://www.michigan.gov/mdhhs/inside-mdhhs/newsroom/2020/04/28/mdhhs-and-courts-partner-to-return-children-home-from-foster-care-safely-during-covid-19-pandemic

Figure ES-5. WMPC-related average daily unit cost for out-of-home placements by Fiscal Year, adjusted for inflation



The average daily administrative cost increased by 15 percent during the baseline period (FYs 2015-2017) and continued to rise during the first 2 years of the pilot. By FY 2019, the average daily administrative cost of a placement increased by 40 percent above FY 2017 levels. This increase was fueled by increases in the administrative daily rate paid to providers at both the state- and WMPC-levels. FY 2020 saw a decrease in the average daily administrative rate, as WMPC adjusted the daily rate being paid to providers from $48 to $46.20, leading to a small reduction of the average daily (administrative) unit cost (1%) between FY 2020 and FY 2021. Administrative daily unit costs started to increase again in FY 2022 when the Private Agency Foster Care (PAFC) admin rate was raised to $55.20 across the state. Average daily maintenance costs fluctuated during the pilot. The average daily maintenance cost of foster care stayed fairly steady from the pre-implementation period to the pilot period. However, the average daily maintenance cost of CCI placements increased 44 percent during the pilot. The average daily maintenance cost of CCI placements was approximately $350 during the pre-implementation period up to FY 2020, and then increased to over $430 per day in FY 2021 and reached nearly $500 per day in FY 2022. The increased cost is a combination of higher level CCI placements (e.g., mental and behavioral health stabilization) and statewide increased per diem rates for qualified residential treatment programs (QRTP) in April 2021. As a result, while WMPC decreased utilization of congregate care while increasing days spent in less costly EFC, the increased cost per day for CCI placements counteracted some of the savings reflected in the overall average daily unit cost of care.

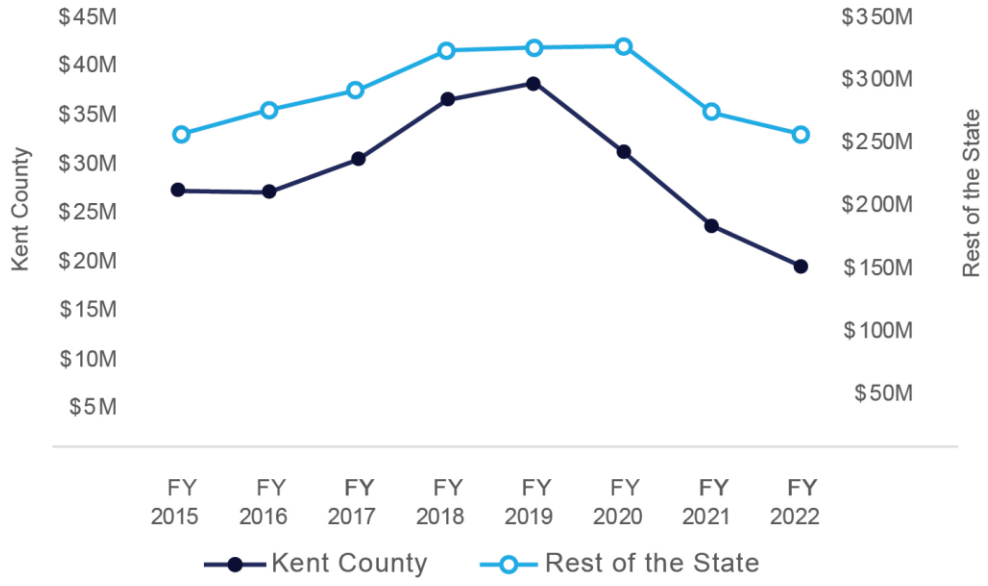
Comparing Kent County to the Rest of the State

Research Question: How does the cost of out-of-home care in Kent County compare to the cost of out-of-home care in prior periods and to the rest of the state?

Figure ES-6 lays the costs trajectory in Kent County atop that in the rest of the state to enable comparison of the trend lines despite the differences in volume of total costs. During the baseline period, the rest of the state saw a 14 percent increase while Kent County saw theirs increase by 12 percent. However, during the pilot period, the rest of the state saw total child welfare expenditures plateau between FY 2018 and FY 2020, while Kent County's expenditures increased

slightly in FY 2019 and then dropped in FY 2020. In FY 2021 and FY 2022, expenditures declined in Kent County and across the rest of the state, but the decline was more rapid in Kent County.

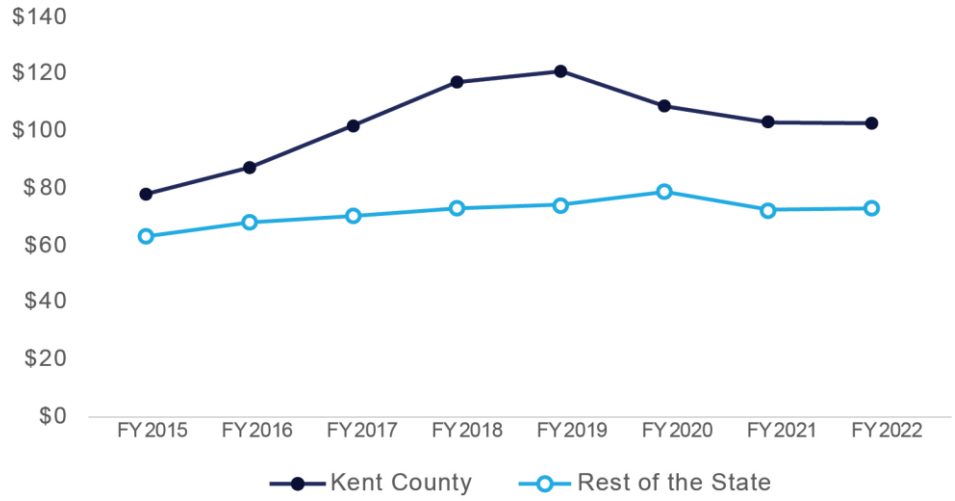
Figure ES-6. Kent County and the rest of the state – Total child welfare expenditure trends by Fiscal Year, adjusted for inflation



Another way to compare costs between Kent County and the rest of the state is the average daily unit cost of care. Figure ES-7 compares the total average daily unit cost of care in Kent County to the rest of the state. In FY 2015, Kent County's average daily unit cost was 23 percent higher than the rest of the state. This difference grew to 43 percent higher in FY 2017. The average daily unit cost in care grew slowly and steadily in the rest of the state until dipping in FY 2021 and remaining steady in FY 2022, while Kent County saw greater variability. In FY 2022, the average daily unit cost in Kent County was 40 percent higher than the rest of the state. Average daily unit costs fluctuated more in Kent County than they did in the rest of the state, but ended closer to pre-pilot levels—compared to FY 2017 levels (the last pre-pilot year), average daily unit costs in Kent County were 1 percent higher by FY 2022, and in the rest of the state, they were 4 percent higher.

As discussed previously, Kent's higher daily unit costs are related to placement agency administrative costs and utilization of more costly care types. From FY 2017 to FY 2022, the average daily cost of CCI maintenance increased 44 percent in Kent County and by only 3 percent in the rest of the state. There was a statewide rate increase for qualified residential treatment programs in April 2021, but this does not fully explain the rise in costs. The increased costs in Kent County are associated with placements in congregate settings with higher per diem rates (e.g., lower staffing ratios), which may be a result of increased acuity and/or an indirect result of a change to the approval process for residential placements during the pilot.

Figure ES-7. WMPC-related and the rest of the state – Average daily unit cost for out-of-home placements by Fiscal Year, adjusted for inflation



Funding Model Sufficiency

Research Question: To what extent does the WMPC case rate (and subsequent capitated rate) fully cover the cost of services required under the contract?

For the first 3 years of the pilot (FYs 2018-2020), WMPC paid for services via a semi-annual case rate payment. However, at the end of FY 2019, case rate revenue was found to be $5.5 million short of covering expenditures. The cost study team conducted a review of the factors contributing to this shortfall in 2020 and found that WMPC fiscal policy changes explained most of the deficit. The policies that had the largest impact were 1) implementing paid kinship care before the rest of the state, 2) increasing the PAFC administrative rate, 3) increasing CCI maintenance costs associated with changing the approval process for residential care placements, and 4) paying for shelter bed capacity instead of occupancy.

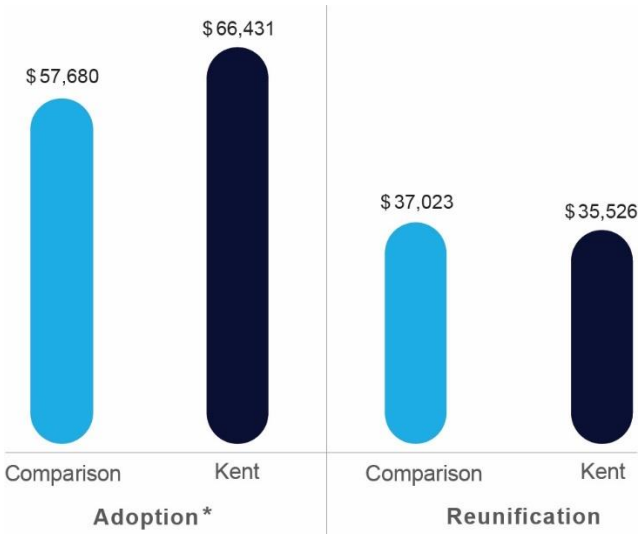
Beginning in FY 2021, the pilot shifted to a capitated allocation model. The allocation amount was developed by Public Consulting Group (PCG) based on historic spending and the average number of children served in Kent County—$36,975,656 for FY 2021, which was lowered to $34,467,356 for FY 2022. The WMPC administration rate increased in FY 2023 from $2,000,000 to $2,194,000 to include the raised Detroit Consumer Price Index. The cost study team has monitored spending under the capped allocation on a quarterly basis, using care day projections to estimate spending against the capped allocation before the end of the year. Each cost monitoring memo between FY 2021 and FY 2022 has shown that WMPC is spending substantially less than the capped allocation. Based on the $23.6 million for FY 2021 and $19.5 million for FY 2022 in private agency expenditures (excludes WMPC administration) shown in Table ES-1, WMPC spent approximately 60 percent of the capped allocation over the past 2 years, leaving a surplus of more than $28 million for FYs 2021 and 2022 combined. As discussed earlier, the large surplus is driven by reduced admissions and care day utilization in FYs 2020 through 2022 compared to the earlier years on which the capped allocation amount was based. In addition, several of the WMPC policies (e.g., higher PAFC administrative rates) that contributed to higher costs than the case rate could support, were discontinued. Reduced utilization of CCI care days and shorter length of stay for the FY 2020 entry cohort also contributed to lower costs.

Cost Effectiveness Analyses

Research Question: What are the cost implications of the outcomes observed under the transition to the Kent Model?

The child-level costs by the two most common discharge reasons (adoption and reunification, see Table ES-5 in the outcome section) are summarized in Figure ES-8. These are the total maintenance and administrative costs accumulated during an out-of-home placement spell. For children entering care after the pilot began, the average cost of achieving reunification was 4 percent lower in Kent County ($35,526) than in the comparison group ($37,023), which may correspond with a shorter time to reunification observed by the outcome study (see Table ES-6). However, this difference was not statistically significant in terms of costs. The average cost of completing an adoption for children who entered care after the pilot began was significantly higher in Kent County than in the comparison group—$66,431 compared to $57,680 (p=0.003). The outcome study did not find a significant difference in the time to adoption, but Kent County tends to have a higher average daily cost of care, which could explain why adoptions cost slightly more.

Figure ES-8. Average cost per out-of-home placement spell for children entering care after 10/01/2017 and discharged from care as of 10/01/2022



* Indicates p<0.05

Outcome Study

The propensity score matching (PSM) method for creating the comparison group resulted in equivalent groups (e.g., no statistically significant differences across race, ethnicity, gender, and age). These groups include:

1. Children in care in Kent County prior to 10/1/2017.
2. A matched group of children associated with counties other than Kent County prior to 10/1/2017.
3. Children in care in Kent County after 10/1/2017.
4. A matched group of children associated with counties other than Kent County after 10/1/2017.

Unless otherwise specified, comparisons are made between total populations in Kent County and the comparison group (i.e., groups 1 and 3 above, versus groups 2 and 4 above), and children in care after 10/1/2017 in Kent County and the comparison group (i.e., groups 3 and 4 above).

Research Question: Does the Kent Model improve the safety of children? Analysis of data on maltreatment recurrence and maltreatment in care indicated that there were no statistically significant differences between children served in Kent County and children in the matched comparison group in regard to safety.

Research Question: Does the Kent Model improve permanency for children? As shown in Table ES-3 children in Kent County who entered care after 10/1/2017 and exited, tended to stay fewer days in care, on average, than children in the comparison group (563 days versus 643 days); this difference is statistically significant (*p*-value <0.05).

Table ES-3. Exited or still in care

Group	Exit status	% (N)	Length of stay		
			Mean	Standard deviation	Median
Comparison, entered care after 10/01/2017	In care	34.4% (444)	688.6	475	548.5
	Exited	**65.6% (848)**	**642.5**	358.3	596.5
Comparison, in care prior to 10/01/2017 (legacy)	In care	4.4% (34)	2,280.3	356.1	2,157.5
	Exited	95.6% (736)	987.9	523.7	872.5
Kent, entered care after 10/01/2017	In care	30.2% (397)	623.7	447.2	533
	Exited	**69.8% (917)**[+]	**563.2**[*]	361.8	545
Kent, in care prior to 10/01/2017 (legacy)	In care	3.0% (23)	2,852.9	853.6	2,563.0
	Exited	97.0% (740)	955.7	521.4	839

[*] Indicates $p<0.05$, [+] indicates $p<0.001$.

Table ES-4 shows cumulative exits to permanency at 6, 12, and 18 months for all children who exited with each increase in time frame. A higher percentage of children in Kent County who entered care after 10/1/2017 achieved permanency within 6 months of entering care at a statistically higher rate than children in the comparison counties (15.4% vs. 8.8%, p-value <0.0001). This difference is maintained by the 12th month (28.4% vs. 23.2%, p-value <0.001) but is not observed by the 18th month.

Table ES-4. Cumulative exits to permanency

Group	Permanency within 6 months	Permanency within 12 months	Permanency within 18 months	Ever achieved permanency	Total exits (N = 3,241)
Comparison, entered care after 10/01/2017	**8.8% (75)**	**23.2% (197)**	39.9% (380)	87.85% (745)	848
Comparison, in care prior to 10/01/2017	2.2% (16)	7.5% (55)	16.6% (122)	84.38% (621)	736
Kent, entered care after 10/01/2017	**15.4% (141)⁺⁺**	**28.4% (260)⁺**	41.4% (380)	87.68% (804)	917
Kent, in care prior to 10/01/2017	1.4% (10)	4.9% (36)	15.8% (117)	86.76% (642)	740

⁺ Indicates $p<0.001$, ⁺⁺ indicates $p<0.0001$.

The study team used the survival analysis method to measure the rate of exits to permanency over time for the first 24 months in care. They found that among children who entered care after 10/1/2017, children in Kent County exit to permanency at a significantly faster rate than children in the comparison group (p-value <0.001) (Figure ES-9).

Figure ES-9. Permanency survival rate for study groups

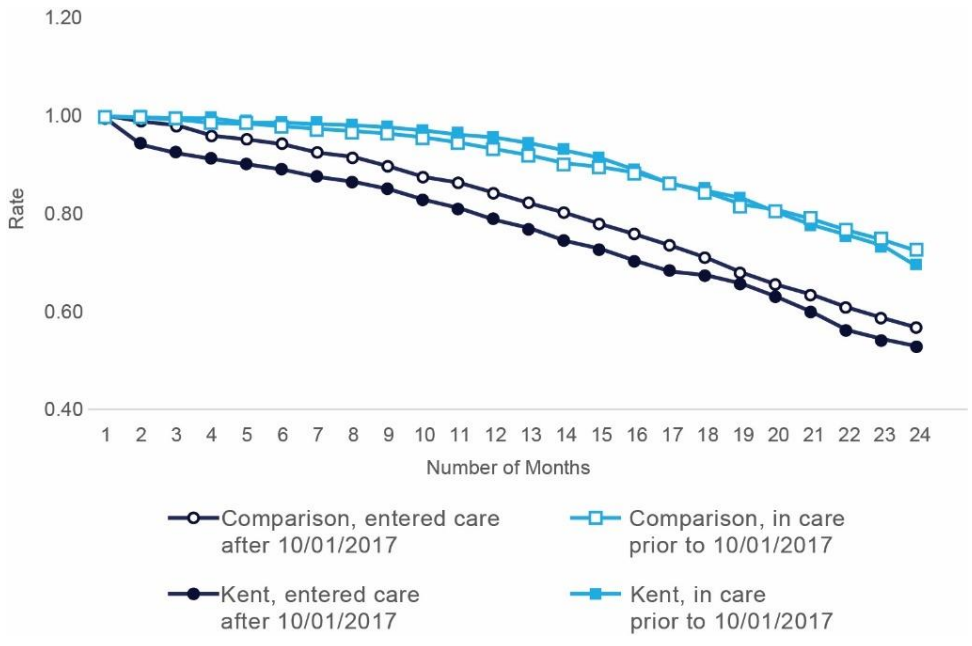


Table ES-5 shows that for children who entered care after 10/1/2017, those in Kent County exited to adoption at a *lower* rate than children in the comparison group (*p*-value <0.05).

Table ES-5. Permanency categories by study group

Group	Adoption	Guardianship	Living with other relatives	Reunification with parents or primary caretakers
Comparison, entered care after 10/01/2017	**39.2% (292)**	7.7% (57)	0.8% (6)	52.3% (390)
Comparison, in care prior to 10/01/2017	62.8% (390)	6.4% (40)	0.0% (0)	30.8% (191)
Kent, entered care after 10/01/2017	**33.2% (267)***	10.2% (82)	1.1% (9)	55.5% (446)
Kent, in care prior to 10/01/2017	56.9% (365)	10.0% (64)	0.9% (6)	32.2% (207)

* Indicates *p*<0.05; bolded figures indicate the comparison yielding the significant results.

As shown in Table ES-6, children served through the Kent Model who entered care after 10/1/2017 exited to reunification faster than those in the comparison group (359.5 versus 409.0 days); this difference is statistically significant (*p*-value <0.001).

Table ES-6. Time to exit by permanency type

Group	Exit type	N	Time to exit		
			Mean	Median	Standard deviation
Comparison, entered care after 10/01/2017	Adoption	292	836.0	841.8	321.2
	Guardianship	57	716.0	718.1	358.8
	Living With Other Relatives	6	524.0	431.7	303.6
	Reunification With Parents or Primary Caretakers	390	**409.0**	503.3	374.5
Comparison, in care prior to 10/01/2017	Adoption	390	958.5	1,051.7	441.1
	Guardianship	40	908.5	1,041.0	707.2
	Reunification With Parents or Primary Caretakers	191	571.0	745.6	513.7
Kent, entered care after 10/01/2017	Adoption	267	834.0	852.1	263.0
	Guardianship	82	734.5	688.2	328.5
	Living With Other Relatives	9	13.0	54.6	58.7
	Reunification With Parents or Primary Caretakers	446	**359.5+**	416.6	333.7
Kent, in care prior to 10/01/2017	Adoption	365	959.0	1,027.6	420.7
	Guardianship	64	799.0	824.2	314.7
	Living With Other Relatives	6	1,265.0	1,457.2	673.9
	Reunification With Parents or Primary Caretakers	207	599.0	759.7	512.0

+ Indicates p<0.001; bolded figures indicate the comparison yielding significant results.

Research Question: Does the Kent Model improve children's placement stability? Children in Kent County experienced two or more placement changes at a rate similar to children outside Kent County.

Process Study

Kent Model Implementation

Research Question: Do the counties adhere to the state's guiding principles in performing child welfare practice?

A key element of the Kent Model has been the Care Coordination structure, which assigns a designated Care Coordinator to each private agency. The Care Coordinator serves as a facilitator for service approvals, a liaison with WMPC, an intermediary between private agencies and Kent County DHHS, and a source of information, assistance, and support to foster care caseworkers. The success of care coordination depends on having the right person in the coordinator role, along with strong management of the overall program. In the final year of data collection, respondents at each of the private agencies said that they feel supported by their current Care Coordinator.

Since the start of implementation, EFC has been described as the most positively received component of the Kent Model. Through EFC, caregivers receive a higher foster care rate and intensive in-home services for children with higher needs. In the third year of implementation, WMPC instituted a per-agency cap on EFC cases and a process for regular case review. The cap and review process were intended to control EFC expenditures and ensure that EFC was being used as intended. In the most recent focus groups, private agency staff agreed that they were managing under the caps, but also perceived that there was an increased demand for EFC services due to statewide reductions in the availability of residential care and a higher proportion of children with high needs entering foster care.

Research Questions: What resources (strategies, infrastructure) are necessary to support the successful delivery of child welfare services? What resources are necessary to support the successful implementation of the Kent Model?

Increased flexibility. An important aspect of the Kent Model is greater financial flexibility for private agency staff to develop and implement innovative solutions to better meet the needs of children and families in the foster care system in Kent County. Early in the pilot, WMPC paid private agencies a staffing rate of $48, higher than the statewide rate of $46.20. In focus groups, private agency leadership and staff reported that private agencies used funding from the higher staffing rate to fund additional positions such as family finders, case aides, buffer workers (to help fill staffing gaps), and supervisors. In Year 4, WMPC lowered the rate to the statewide rate, prompting some agency leaders to identify alternate funding sources to retain these positions. However, MDHHS received additional 2022 Fiscal Year appropriations, enabling the agency to raise the staffing rate to $55.20 statewide. Additionally, most private agency respondents agreed that miscellaneous funding requests allow for greater creativity in case planning (e.g., medical or behavioral health services that could not be paid for through Medicaid). At a system level, WMPC also sought to facilitate innovation by bringing the private agencies together to share innovative processes and practices with each other.

Interagency collaboration. After the first year of pilot implementation, respondents described the relationship between Kent County DHHS and the five private child-serving agencies in Kent County as highly collaborative on the administrative level but tense on the line-staff level due to changes in roles and previous collaborative difficulties. In the second year, respondents at all levels described significant improvements in the collaborative relationships through the efforts of DHHS and WMPC leadership to work out previous points of tension, such as the case transfer process and funding approvals. In the final 2 years of the evaluation, respondents at Kent County DHHS, WMPC, and the private agencies described collaboration across the public/private divide as going smoothly.

Local partners played an integral role in supporting families served through the pilot. Over the years, judges and court staff interviewed have given positive feedback regarding the changes the Kent Model has brought to the child welfare system (e.g., faster service referrals). In terms of the partnership with the local mental health system, during early implementation of the Kent Model, private agency staff expressed frustration in connecting families with mental health services through Network 180. WMPC and Network 180 created a Clinical Liaison position based at WMPC to help assess children's mental health needs and to recommend appropriate services. By the end of the evaluation, most private agency staff agreed that the Clinical Liaison helped them identify services they might not know about, but they still had difficulty obtaining some services for families (e.g., they may not quality if they do not meet Medicaid eligibility criteria).

Service referrals. Efficiency and consistency in processing service requests was a major pre-implementation issue for private agency staff who expressed increased satisfaction with the process each year since implementation began. Consistent in the final 2 years of the evaluation, private agency staff reported that service referrals now run mostly smooth and have a reasonable turnaround time with both WMPC and Kent County DHHS.

Performance and quality improvement (PQI). WMPC's PQI team encountered a number of challenges throughout the evaluation period, including frequent turnover and restructuring, creating continuous quality improvement processes while building the infrastructure, and experiencing a delay of MindShare (data reporting system) implementation by nearly 2 years. Despite these challenges, the PQI team has continued to streamline processes and now produce reports and data analytics as originally envisioned. In Year 4 of the pilot, WMPC used predictive analytics to allocate services and resources more effectively, and the majority of private agency respondents reported support for WMPC PQI efforts. Nearly all the private agencies created specific staff positions that focus on PQI, data, and utilization management.

Utilization management. One substantial shift in Year 2 of implementation was the move to a fully integrated utilization management program focused on achieving permanency within 12 months by managing residential utilization and EFC services. At the end of the evaluation period, WMPC was in the early stages of implementing a new Clinical Utilization Manager position, developed as a result of an agency-wide analysis that identified utilization management as the *"center point"* between PQI and care coordination.

Facilitators and Barriers

Research Question: What factors facilitate and inhibit effective implementation of child welfare practice, in general, and, importantly, in the Kent Model (in Kent County)?

Facilitators to implementation. During the final data collection period, representatives from Kent County DHHS, all five private agencies, and WMPC identified EFC as the most important initiative that was introduced during the pilot that helps agency staff meet the needs of the families they serve. Another aspect of the Kent Model that respondents from all agencies and WMPC identified as being most important in helping agency staff meet clients' needs is the funding flexibility and the ability of agency staff to apply creativity to case planning. Respondents identified other important features of the pilot, which include WMPC's structure and operation (e.g., care coordination), increased collaboration and coordination among private agencies and WMPC, a higher case rate to support foster care providers and augment agency staff, the ability to obtain service approvals internally from agency leadership, expedited responses to requests for funding, and increased use of data to drive decisions.

> ***"Enhanced foster care is such a unique approach in this pilot and is probably the absolute best thing that has come out of it."***
>
> –Agency leader

Barriers to implementation. Respondents from several agencies discussed the challenges that staff turnover presents. As one supervisor explained, *"You start to get used to the style of a specific person in a role or they start to become familiar with your processes or your cases, and then they're gone."* Respondents from multiple agencies also identified limited availability of services for their clients; misalignment between their expectations for collaboration with WMPC and among agencies, and the extent to which agency/organizational staff actually work collaboratively; inadequate communication; and dissatisfaction with the extent to which and how data is used and interpreted as challenges. Other factors that respondents from multiple agencies identified as barriers to service provision through the pilot include WMPC adding *"another layer"* to collaborative structures that existed prior to the pilot, and a lack of clarity about specific aspects of the pilot, such as requirements, processes, and roles.

> ***"We had someone [from WMPC] in the office once a week and now they can't really come to us because they don't even live near us."***
>
> –Agency supervisor

Recommendations and Lessons Learned

Interagency collaboration following the pilot. Respondents from two different private agencies would appreciate having more opportunities to engage in shared decisionmaking with Kent County DHHS staff. Respondents also mentioned the value of having face-to-face contact with Kent County DHHS staff to build and maintain rapport. Relatedly, some respondents from private agencies appreciate having one WMPC Care Coordinator assigned to their agency, as opposed to multiple Kent County DHHS monitors assigned to one agency prior to the pilot. While interview and focus group respondents from nearly all the private agencies reported that they appreciate WMPC's flexibility around funding

> ***"I think it's important [for organization and agency representatives] to have connections and build rapport, just like we would do with clients."***
>
> –Agency supervisor

for services and exchanging ideas with Care Coordinators to identify creative solutions to case challenges, some respondents also discussed the need for more support from WMPC.

Recommendations performance-based model implementation. Respondents recommended that an entity like WMPC that will implement a similar funding model should establish and maintain effective collaborative relationships; ensure all organization staff is based in the community where the model is implemented; recruit appropriate staff, consultants, and leaders; and maintain active engagement with agency staff. Respondents also provided recommendations for state DHHS agency leaders, who will fund and oversee a performance-based model, and local provider agency directors. The former should outline and communicate expectations for the model, support and advocate for model implementation, and enable county agencies to have decision-making authority. Respondents recommended that private agency directors clarify and define roles and expectations, support and communicate to staff about model implementation, and build and maintain collaborative relationships with decisionmakers and staff at other private agencies.

Ingham and Oakland Counties

Agency staff in Ingham and Oakland counties, the comparison counties for the process study, described experiences that were similar to those described by staff in Kent County, relative to topics such as the barriers related to frequent staff turnover (e.g., increased workloads) and strengths and challenges to partnering with mental health agencies and the court system (e.g., waiting lists for mental health services). The experiences diverged relative to service approval processes, service availability, and collaboration with the county DHHS agency.

Service approval process. Private agency staff and leaders in comparison counties reported that the service approval process can take a considerable amount of time, due to communication issues, type and cost of service requested, incomplete information provided to the county DHHS agency, and a multi-layered approval process. While lengthy service approval processes were a persistent theme among respondents from comparison counties for most of the evaluation, the opposite was true among agency staff in Kent County. For the most part, WMPC expedited these processes.

Service availability. Agency staff from all three counties expressed frustration with the limited availability of some services for clients (e.g., mental health services, substance use screening). There are often waiting lists for certain services, there is an inadequate number of providers offering some needed services, and agency staff often have difficulty locating services that are necessary to meet a family's needs. Some services are available to families in Kent County as a result of the pilot (e.g., EFC). The implication is that although service availability is a common challenge in all three counties, families in Kent County have benefited from having access to support services they may not have received if it were not for the Kent Model.

Collaboration with DHHS. Private and public agency staff in Kent County have limited interactions given that the WMPC serves as the *"middle man."* In Ingham and Oakland counties, private agency staff must engage frequently with staff from the county DHHS agency as part of case practice (e.g., to seek approval for service requests). Overall, respondents from private and public agencies in the comparison counties described their relationships as collaborative and collegial, which they attributed to open lines of communication, responsiveness, positive rapport and trust, regular inter-agency leadership interactions, inter-agency trainings, and long tenure of staff at the county DHHS agency. Private agency staff in Ingham and Oakland counties also described challenges to collaborating with DHHS staff, which included communication issues, a perception that there was a lack of support from DHHS staff (e.g., *"Sometimes it very much feels like us against them or them*

against us"), and disagreement on family goals. DHHS agency staff reported having difficulty navigating multiple agencies with different policies and procedures, and expressed frustration with case assignment (e.g., DHHS staff must manage cases that private agency staff decline), and frequent turnover in private agencies that in turn require additional DHHS oversight.

E4. Summary and Conclusions

The 6-year Kent Model evaluation enabled the study team to examine changes in **costs** associated with the Kent Model, **outcomes** for children in care (safety, permanency, and stability), and agency and staff **processes** for supporting and engaging in effective case practice.

Total private agency expenditures in Kent County increased from the pre-implementation period (FYs 2015-2017) through the first 2 years of the pilot (FYs 2018-2019) before decreasing from FY 2020 through the end of the evaluation (FY 2022). Private agency expenditure trends in the county are driven by placement costs, as nearly all expenditures are related to placement maintenance and administration. In Kent County and across the state, CCIs composed the largest proportion of placement expenditures. Expenditure decreases were largely due to a decline in the number of children entering care and decreased care day utilization, particularly between FYs 2019 and 2020, with continued decreases through FY 2022.

Overall care day utilization shifted slightly to less restrictive, less costly settings during the pilot. Placement days spent in kinship care increased after WMPC implemented paid kinship care, although the rest of the state continues to use more kinship care than Kent County. Utilization of EFC increased during the pilot while days spent in congregate settings decreased. EFC is intended to provide a less restrictive, lower cost alternative to CCI. However, some of the potential savings from EFC were offset by high-level CCI placements; the average daily maintenance unit cost of CCI placements increased by 44 percent during the pilot while the rest of the state maintained relatively stable costs. Consequently, expanding EFC and placing children in the lowest level of congregate care possible could reduce costs.

Cost effectiveness analyses revealed that there was not a significant difference in the cost of achieving reunification, and a slightly higher cost of achieving adoption for children in Kent County compared to the matched group. The slightly higher cost of adoption can be linked to Kent County's higher average daily unit costs of care, and longer lengths of stay for children entering care during the first 2 years of the pilot. WMPC lowered costs in FY 2020 in part by decreasing the PAFC rate to state levels. Simultaneously, length of stay decreased for the FY 2020 entry cohort. However, median duration increased again for the FY 2021 entry cohort and these savings may not be sustained. WMPC could make strategic investments to reduce length of stay. For example, the statewide Rapid Permanency initiative implemented in April 2020[9] may have contributed to the shorter durations observed for the FY 2020 entry cohort. Additionally, prospective payment models inherently incentivize reduced length of stay—compared to traditional fee-for-service models that may promote overutilization—because providers retain excess revenue when children reach permanency more quickly (see Appendix E).

However, neither of the prospective funding models used during the pilot provided WMPC with an appropriate level of revenue. The case rate model used for the first 3 years of the pilot fell short of

[9] https://www.michigan.gov/mdhhs/inside-mdhhs/newsroom/2020/04/28/mdhhs-and-courts-partner-to-return-children-home-from-foster-care-safely-during-covid-19-pandemic

actual expenditures, largely due to WMPC policies (e.g., higher PAFC administrative rates and paid kinship care). Beginning in FY 2021, the pilot switched to a capitated allocation model that greatly overfunded the pilot, in part due to a large decline in the number of children entering care. Moving forward, the cost study team recommends shifting to a prospective payment model that uses care day utilization and child placement trends to project the allocation amount (see Appendix E). The revised fiscal model could also create an incentive structure for providers to make investments in the quality and process of care with the goal of improving outcomes.

Outcomes for children in Kent County were similar to the comparison group in the areas of safety (maltreatment in care and recurrence) and placement stability. For permanency outcomes, the study team found that children in Kent County exited to permanency at a higher rate at 6 and 12 months. These results imply that policy or practice changes made through the Kent Model increased the rate of children achieving permanency without compromising their safety. Because differences were not significant among children who exited to permanency within 18 months, to innovate the project further, more investigation could be done to determine why the difference disappears and for which children.

Throughout the course of Kent Model implementation, representatives from WMPC, Kent County DHHS, and private agencies described beneficial changes associated with the Kent Model, which could be implied as successful aspects of the pilot. These elements are **EFC;** having a **single point of contact** for service approvals, case monitoring, guidance, and support; having opportunities for staff to engage in inter-agency **collaboration** to share best practices and innovations; having **flexibility** in how agency staff use funding and apply **creativity** to case planning; and WMPC's application of a **utilization management approach.** There were also factors that impeded implementation. These elements are **staff turnover,** particularly among Care Coordinators whom private agency staff rely on for support and guidance; WMPC's **fiscal crisis,** which prompted adjustments in pilot management and administration; Care Coordinators being **located outside the community,** limiting their awareness of the local context for service provision and their accessibility to agency staff they support; and aspects of **data reporting and extraction** processes that made it difficult to accurately interpret and use data.

As with any new initiative, hurdles are to be expected, as are new processes that may lead to positive outcomes. This report described barriers to Kent Model implementation that were balanced with the introduction of valuable new initiatives and processes. Relatedly, during the final round of data collection for the process study (with participation from Kent County agency staff who had been with the agency since the pilot began as well as MDHHS leadership), the study team asked interview and focus group respondents for one word they would use to describe the Kent Model (Exhibit ES-1). The responses were mixed—some words were positive and others gave the impression that respondents would do things differently if given the opportunity. The most commonly used Kent Model descriptors were *"creative"* and *"collaborative"* followed by words such as *"disappointing"* and *"underwhelming."*

Overall, results for continuation of the initiative as a whole were inconclusive. The evaluation team recommends continuation of some components, while revising other components of the Kent Model. The Kent Model, like other programs and initiatives, has many different components that were implemented with varying levels of success. Additionally, the COVID-19 pandemic was an unprecedented event that occurred during Kent Model implementation. The pandemic led to unplanned disruptions and prompted immediate adjustments

Exhibit ES-1. Words used to describe the Kent Model

to how services were delivered. For these reasons, it is difficult to make an overall statement regarding Kent Model effectiveness. However, although evaluation results were mixed, some of the results uncovered promising policies and practices, which offers evidence of Kent Model strengths as well as areas for improvement.

Outcomes for children in Kent County were similar to or better than outcomes for children in the comparison group. Additionally, WMPC faced fiscal challenges but pivoted to identify strategies for supporting private agency staff needs and managing financial obligations. WMPC implemented policies and procedures that were intended to help agency staff serve children in care more effectively. Some were strongly supported while others were described as impeding service delivery. Taken together, evaluation results imply that it is appropriate to maintain ***components*** of the Kent Model that were described in positive terms in Section E3 and earlier in Section E4. For example, EFC helped agency staff serve families with children in care more effectively and reduced time in more costly placement settings (e.g., CCI). Neither the case rate funding model nor capitated allocation funding model provided WMPC with an appropriate level of revenue, leading the cost study team to recommend a prospective payment model that uses care day utilization and child placement trends to project the allocation amount. The revised fiscal model could also create an incentive structure for providers to make investments in the quality and process of care with the goal of improving outcomes. The evaluation team suggests modifying or eliminating Kent Model components that were barriers to service delivery (e.g., policies regarding data use and its interpretation to improve the quality and accuracy of data used to improve case practice). In a subsequent evaluation, MDHHS may benefit from further exploration of factors that contribute to outcomes (e.g., the rate at which children exit care to permanency and the permanency type to which they exit, such as adoption or reunification).