July 3, 2003

TO: Cathy Grace
FROM: HSPC Team
RE: Center and FCC Staffing Specifications

The MS team specified a large number of family support staff (11 FTE) per 100 children for both center-type and FCC settings. Thus, in addition to 11 teaching/directing staff in the minimum adequate scenario, an average size center with 60 children would have 6-7 full time staff for family support, health/mental health and speech therapy. Since they cover a wide range of specialties, we will refer to them as 'ancillary staff' in the remainder of this memo. We have run some preliminary, ballpark estimates of hourly costs to see the impact of this staffing pattern. In round numbers, the hourly costs of high quality center care would be as follows:

	Without Ancillary Staff	**With Ancillary Staff**
Infants	5.60	8.00
Toddlers	3.60	6.00
PreSchooler	2.75	6.00

As you can see, the specified level of ancillary services would add 2.50-3.25 per hour to high quality center costs, more than doubling the cost for children age 3-5. This staffing pattern would yield hourly center costs that are as high or higher than those generated by the higher-income states that we have worked with. Making such hourly costs affordable would require substantial subsidies for most of the MS population at a substantial budgetary cost.

You have specified that the same ancillary staffing should apply to FCC. On a practical basis, such staff probably cannot be directly attached to most FCC settings. You may want to consider something like the Head Start collaboration model, where FCC providers are linked to centers for ancillary services. Appropriate organizational costs for linkages and administration would have to be added.

We would therefore suggest that your team review these issues, consider whether this is the balance among different types of staff that you really want (i.e., approximately 40% ancillary service staff for centers and 33% for FCC) and consider several potential staffing options solely or in combination.

1. Keep the current staffing specifications, and recognize that the financing policy will require large subsidies for most of the population. We would probably have to add to administrative and non-personnel costs to accommodate such a large ancillary service component.

- *Pro*: provides high level of comprehensive social and health services for all children regardless of income.
- *Con*: high hourly and high state budget cost. Regardless of cost, it may not be feasible to implement such staffing recommendations in the real world of private market ECE. Middle income parents are not likely to be willing to pay high fees for services they do not think their children need (e.g., why should a parent whose insurance covers health and mental health services choose to pay a higher fee for ECE at a center that provides such services, when another center offering lower fees and no health/MH service is available?). Even if rates are set high to encompass ancillary service costs, centers are not likely to hire such staff unless required by regulation, parents desire the services and the costs are highly subsidized. It is probably not feasible to build ancillary staff directly into FCC operations.

2. Reduce the number of ancillary staff per 100 children substantially. Note that the staffing pattern you are specifying here is the *average* to obtain across all providers serving all children in the state, not the maximum level to apply for at-risk populations.
   - *Pro*: reduces cost, affordability and market feasibility problems.
   - *Con*: may leave insufficient services for vulnerable children and excess services for middle-upper income children.

3. Only provide ancillary staff for high risk populations, defined by demographic characteristics (e.g., low income, single parent, teen parent …); create a differential rate covering enriched services for children from families with these characteristics. This assumes that there are identifiable high risk populations for needing and affording these services.
   - *Pro*: targets resources to most vulnerable children; since ECE for these children will be highly subsidized -- with sufficiently low co-payments, high costs may still be affordable.
   - *Con*: concept works well for centers serving all or mostly vulnerable children; would be a challenge for centers serving mixed populations – if they get the higher rate for only some of the children, may not be able to hire staff; and staff would have to only be available to some of the children/families. If the percentage of children eligible for the higher rate fluctuates through the year, or year to year, it would be difficult to maintain a stable ancillary staff.

4. Provide ancillary services in entities that are separate from centers and FCC's; estimate the percent of population likely to need/utilize such services and HSPC would help produce rough estimates of the cost of such external provision. You would have to consider whether such separately offered services would be subject to their own co-payment requirements for parents of various income groups or if they would be provided free; we are not in a position to analyze a separate set of co-payments, though we could reduce the overall cost of such services by a fraction to reflect the overall effect of a co-pay requirement..

- *Pro*: deals with the organizational problems of services for children in FCC or centers that serve economically diverse populations; flexibility to provide services across a community at lower overall cost.
- *Con*: funds would appear separately, not be amortized within basic ECE costs. Experience with comprehensive service networks indicates that many children/families referred to an external entity do not actually follow through and receive services. If services are in community organizations separate from ECE providers, it might be hard to limit the service to children enrolled in ECE unless the staff travel and deliver the services at the ECE facility. Unless the co-payment rate is extremely low, the high differential rate including the current level of ancillary staff may be too high for low income families to afford.

Please note for all options: our cost modeling is set up to estimate costs of ECE service in ECE settings. If a substantial number of ancillary staff are available they are likely to generate a large number of referrals for health, mental health and family services, adding to the state budget costs for those services, particularly those funded as on open-ended entitlement like Medicaid. We are not in a position to estimate those costs, which would have a state budget impact above and beyond what we are estimating for expansion of ECE.