



RESEARCH REPORT

Increasing Access to Quality Child Care for Four Priority Populations

Challenges and Opportunities with CCDBG Reauthorization

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Executive Summary

In recent decades, policymakers have increasingly focused on the importance of high-quality child care and early education services in supporting the development of low-income children. Though high-quality early care and education (ECE) can exist in any setting—including child care centers, family child care programs, and other home-based care arrangements—the emphasis on high-quality ECE services has often translated into a singular focus on investing public funds in formal settings, especially center-based programs.

This report explores the implications of this trend in the context of the 2014 reauthorization of the Child Care and Development Block Grant (CCDBG), also known as the Child Care and Development Fund. It focuses on four priority populations: families with parents working nontraditional schedules, families with infants and toddlers, families living in rural areas, and families with children with disabilities and special needs. It concludes with a discussion of state policy strategies to better address the child care needs of these families.

Our goal in this report is twofold: First, to help policymakers and other policy stakeholders understand how current policy strategies and trends toward center-based care may be inadvertently challenging the ability of vulnerable groups of families to access subsidies and take advantage of public investments in child care quality. And second, to contribute to informed and strategic policy efforts to increase access to and the supply of high-quality care for all children across the spectrum of child care settings.

Key Insights

Trends in Subsidized Center Care in the Context of the CCDBG Reauthorization

- **The CCDBG is a two-generation program that supports the employment of low-income parents and the development of their children.** It historically has supported parental choice of care across a range of settings, including child care centers, licensed family child care homes, and legally license-exempt home-based settings.
- **Over the past two decades, the proportion of children receiving CCDBG subsidies who are cared for in center-based child care programs has risen significantly**—from 56 percent in 1998 to 73 percent in 2015—with the trend becoming more pronounced after 2006.

- » **All but four states have reported increases in the use of center-based care since 1998.** By 2015, center-based arrangements were used by the majority of children receiving child care subsidies in 43 states, and by more than 90 percent in 10 states.
- **The CCDBG reauthorization may accelerate the trend toward subsidized center-based care.** The reauthorization was designed to strengthen the child development aspects of CCDBG by adding several new provisions that prioritize the health and safety of children and the quality of child care settings. This may accelerate the trend toward center-based care for three reasons:
 - » **Although quality child care exists across sectors, the increased focus on quality may inadvertently advantage child care centers over home-based settings,** especially over homes legally exempt from licensing. This may be partially a result of the reliance on definitions of quality that do not reflect the unique strengths of home-based settings.
 - » **Stronger health and safety standards and monitoring requirements may deter (or perhaps exclude) home-based providers,** especially license-exempt family, friend, and neighbor care, from participation in the subsidy program unless states actively support their continued involvement.
 - » **Implementing new health and safety requirements can be costly,** and states' budget constraints may limit their ability to invest in supporting the new requirements, such as inspections and enforcement, for home-based programs. The recent increase in federal funding passed in the spring 2018 omnibus spending bill may alleviate the pressure, but states must balance competing priorities for these funds.

Implications for Subsidy Access for Priority Populations

- **An increasing focus on center-based care disadvantages families who find it harder to access centers because of their location, schedules, or limited availability of slots serving their particular needs.** It also is challenging for families who prefer home-based alternatives and thus undercuts the core CCDBG principle of parental choice.
- **Four groups of children are of special concern**—children who need care during nontraditional and variable hours, infants and toddlers, children in rural areas, and children with disabilities and special needs (which we abbreviate to “children with special needs”)—for three reasons:
 - » **The reauthorized CCDBG explicitly identifies these groups (among others) as being priority groups for service** and requiring the targeted attention of state efforts to improve access and quality.

- » **Some families in these groups do use center-based care; however, this form of care remains less accessible to many of these families** for different reasons.
- » **These children make up the majority of low-income children under age 6 with working parents.** Though data are not available on children with special needs, analysis of cumulative American Community Survey (ACS) data from 2011 to 2015 finds that 61 percent (2.95 million) children who live in families with income below 200 percent of the federal poverty level are infants or toddlers, live in nonmetropolitan areas, and/or have parents who work the majority of their hours outside traditional daytime hours. This share is more than 50 percent in all states and rises to 80 percent or higher in five states. (This is an underestimate, as we use a conservative estimate of nonstandard work—specifically, one that includes only children in families where parents work *most* hours outside traditional work schedules instead of *any* hours.)
- **These realities suggest that the trend toward subsidies in center-based care may inadvertently create barriers to subsidy access for a significant share of the low-income children who are a priority for the CCDBG,** barring a drastic change in their access to center care or greater availability of subsidized home-based care.

Understanding the Needs of Four Priority Populations

- **Children with parents who work at *least some hours* during early morning, evening, weekend, or overnight hours represent 58 percent of the 4.77 million low-income children under 6 with working parents; a smaller yet significant share have parents who work *the majority of their hours during these nonstandard times.*** Few centers are open during nonstandard hours or accept children who need care at variable times across the week. Parents with nontraditional work schedules disproportionately use home-based providers, especially family, friend, and neighbor caregivers, or rely on multiple arrangements to cover the combination of their daytime and nonstandard hour care needs. Centers often require families to enroll their children for a regular schedule and pay for full-time attendance, which can be challenging for parents with limited resources and variable schedules. Children whose parents work nontraditional and variable schedules may particularly benefit from a stable, high-quality child care arrangement, regardless of the type of setting.
- **Infants and toddlers make up almost half (46 percent) of low-income children under 6 with working parents.** Children younger than 3 with working parents, compared with their 3- and 4-

year old counterparts, are less often cared for in child care centers and more often cared for in home-based settings. Fewer centers serve young children, and some parents of young children prefer home-based settings. Access to high-quality care regardless of setting is particularly important for young children during this critical developmental stage.

- **Children living in nonmetropolitan areas make up about 16 percent (or 776,000 children) of all low-income children under 6 with working parents.** The definition of nonmetropolitan includes counties that are neither in nor around a highly populated urbanized area; these counties are referred to as “rural” throughout this report. The size of the rural population varies significantly across states. Children in these areas are less likely to be enrolled in child care centers. Further, children living in these areas may particularly benefit from access to high-quality care, in whatever setting they use, because of the more limited availability of formal early education opportunities and the relatively high rates of economic need.
- **Children with special needs also benefit from high-quality early education and child care.** The population of children with special needs is diverse. Although some children with special needs are enrolled in center-based care, they are disproportionately more likely to be served in home-based settings, especially by relatives. Regardless of setting, high-quality child care can be especially important for these families, who face the burdens of poverty and material hardship in addition to the developmental and health challenges associated with a child’s disability. But the families may require additional services and supports to take full advantage of the developmental benefits that high-quality settings can provide.

What Factors Affect the Availability of Center-Based Care?

- **Insufficient demand.** For a center to extend services to populations with specific needs, demand must be both sufficient in scope *and* sufficiently reliable over time to consistently operate classrooms at near capacity and support investment in needed staff and other resources. In brief, there must be enough families asking for (and able to pay for) such care to make it worth the effort to serve them. Demand for care among the four groups of interest in this report may not be sufficient—or sufficiently concentrated and reliable—to incentivize center providers to enter the market or to maintain a financially viable program. There may not be enough children in a particular location with that specific need, its high cost may be prohibitive even when the numbers are there, and/or parents may simply prefer home-based care.

- **Higher costs.** Providing high-quality child care requires significant investment in labor, training, and infrastructure. Parents pay for a large portion of these costs, as public financing is inadequate and fragmented and private and philanthropic funds are not sufficient to fill the gap. This cost burden is difficult for many parents, but especially lower-income parents. Limited parental resources also make it difficult for providers to charge prices that allow them to adequately invest in the physical and human capital necessary to provide high-quality care. All these challenges become greater when considering services for the populations of focus here, whose care can involve additional costs.
- **Provider readiness.** Limited provider interest, skill levels and training, and their comfort with traditional ways of operating may prevent them from expanding their service models to serve families needing care during nontraditional hours, infants and toddlers, families in rural areas, and/or children with special needs. Not all providers are interested in or prepared to take the steps necessary to serve these families, and those that are interested may require supplemental resources and targeted education and training.
- **These findings suggest that important steps should be taken to help expand the supply of center-based programs serving these families, and that a robust home-based sector is also key to meeting their needs.** State investments in supporting quality and supply are necessary across both center and home-based sectors. However, the combination of market and business realities, provider motivation, and—not to be overlooked—parental preferences suggest that subsidized access to home-based settings will be particularly essential to ensuring access to quality care for families in these focal groups.

What Should States Do to Increase Access and Quality for Priority Populations?

Employ CCDBG Policy Tools Strategically

- **Policy Tool 1: Offer financial incentives through higher payment rates, bonuses, or grants to providers that serve priority populations.** States have many financial incentive strategies at their disposal. They can raise the ceiling on the amount they reimburse providers, which allows more higher-cost providers to serve subsidized families and helps higher-cost providers recoup more of their costs if they already serve subsidized families; they can also give bonuses to providers for serving priority groups or disburse grants to address one-time costs. These

strategies can be used across all settings (centers and homes) and, when employed for home-based providers, may be an effective counterweight to the additional challenges and costs that home-based providers face with the new and more rigorous CCDBG standards and regulations. However, current payment levels are already significantly below the recommended levels, so they may need to be increased substantially to incentivize providers, and financial incentives alone may not be sufficient to address the structural budgetary challenges created by inadequate or unreliable demand, shift provider attitudes on serving families in these priority groups, or change parental preferences.

- **Policy Tool 2: Use a mix of vouchers and contracts to increase services for priority populations.** The use of vouchers as the sole payment mechanism can create risks for child care providers who cannot count on sufficient or reliable demand for their services. A contract-based payment mechanism—where states agree to pay for a specific number of children (or slots) for a specified period (e.g., a year)—can reduce this risk. Providers are typically required to meet contractual obligations regarding such things as quality standards, attendance minimums, and serving children with particular characteristics. Contracts can be used to increase the quality and supply of centers or family child care homes (and family child care networks) in a targeted way, especially for vulnerable populations and geographic areas, and to stabilize funding and ensure providers are paid in a timely manner. However, contracts may not be as effective in situations where demand is inadequate, unstable, or diffuse; where the cost is too high (unless the contract is coupled with higher rates); where providers are not willing or ready to accept the contract to serve a particular population; or where preference leads parents to make other choices.
- **Policy Tool 3: Target training, technical assistance, or other resources to support supply and access for priority populations.** Training and technical assistance activities could help address provider readiness barriers to serve special populations for both centers and home-based options, though they seem less likely to address demand or cost barriers. These activities could be especially helpful as part of a strategy to maintain the supply of licensed family child care homes and license-exempt providers who need to meet new health and safety standards or wish to engage in quality improvement efforts.
- **Policy Tool 4: Develop targeted consumer education efforts.** Consumer education strategies can be tailored toward increasing awareness and knowledge around child care availability, access, and quality across the diverse care settings for each population that is the focus of this study. Although a consumer education strategy on its own cannot solve inequities in access due

to supply shortages for particular populations, it could be a critical piece of a multipronged approach if designed with the needs of these four populations in mind.

More research is needed to understand how different providers and families respond to these four policy tools when they are strategically deployed to increase the supply and quality of care for priority populations.

Package Multiple Tools to Create Carefully Targeted Strategies

- **Use a multipronged approach.** No single policy tool is likely to address the complex set of factors limiting child care access for these target populations. States should consider a multipronged approach using a carefully targeted combination of the policy tools described above. States can expand the supply of care by thoughtfully combining strategies that use financial incentives to address cost barriers and incentivize supply, use contracts for providers where there is sufficient demand, use training and technical assistance to overcome knowledge gaps, and expand consumer education to support demand.

Ideally, these approaches are grounded in an understanding of market forces, community characteristics, family circumstances, preferences, and needs, as well as provider strengths and challenges. States that assess these factors as they develop their strategic plan may have greater success identifying a response that adequately reflects the needs and conditions of their local environments. States may need to partner with researchers to obtain these critical data.

- **Package tools to support the supply and quality of providers willing to serve target populations in *each type of setting*.** States can expand the supply of providers in each setting type (centers, family child care homes, and legally license-exempt home-based settings) by carefully combining the four policy tools described above, though the combination of strategies should be tailored to the barriers experienced by each setting type.

However, even in combination, these policy tools may not be able to overcome the basic challenges of inadequate or diffuse demand that center-based providers commonly face in serving these four groups. They also do not address underlying parental preferences for home-based settings, which may be in play for at least a subset of parents. As a result, states with a weaker supply of home-based settings should focus both on supporting the supply of quality home-based providers *and* increasing access to quality center-based alternatives.

- **Package tools to support the supply of care for *specific populations* across setting types.** States can target the supply of care for each focal population by thoughtfully combining strategies that address the particular constraints faced by each group. More information is needed about parental preferences, patterns of demand, and the constraints facing providers in different settings for each of these groups to better inform population-specific strategies.

Conclusions

- **Ultimately, a multipronged strategy is needed to increase access to affordable, quality child care for families needing care during nonstandard hours, for infants and toddlers, in rural areas, and for children with special needs.** The CCDBG reauthorization presents states with several policy tools that can be strategically combined to support providers across sectors and increase quality care options for these priority populations.
- **To effectively serve these four target groups, states must actively support quality and access for home-based care (including license-exempt settings) and help centers more effectively meet these families' needs.**
- **Despite the recent increase in CCDBG funding, states are likely to continue to face resource constraints as they work to address the issues highlighted in this report** while also reforming their programs to comply with the new access and quality objectives of the reauthorized law.
- **Researchers and policymakers should work together to continue to develop and expand the use of a multidimensional definition of quality that includes the diverse ways in which child care providers support children and families across settings** and throughout the 24-hour, 7-days-a-week schedule that constitutes the realities of nonparental care environments.
- **There is a clear need for better data to inform state decisions about how to increase access to high-quality child care for vulnerable populations,** especially regarding barriers to supply, patterns of demand, and parent and provider preferences that shape supply and access for these groups. Relatively little is known about the effectiveness of different policy strategies to shape provider behavior and supply decisions, information critical to influence future policy decisions.

Introduction

In recent decades, policymakers have emphasized the importance of high-quality child care and early education services in supporting the healthy development and school readiness of low-income children. This focus is increasingly visible within the Child Care and Development Block Grant (CCDBG), also known as the Child Care and Development Fund, the nation's leading child care assistance program serving low-income working families. The CCDBG, which helped pay for child care for about 1.37 million children in 2016,¹ is a two-generation program that supports the employment of low-income parents and the development of their children. Until recently, the work support goal has been the more salient of the two priorities (Adams and Rohacek 2002), but the 2014 reauthorization underscored a more child-focused shift by enacting several provisions to enhance low-income parents' access to quality early childhood settings for their children. (See appendix A for a summary of the CCDBG program.)

The quality of care that children receive is vital for all families, and many families across income levels face challenges finding high-quality care. This is especially true for low-income families, who have fewer resources to spend on early investments that can give their children a strong start. However, though high-quality early care and education (ECE) can exist in any setting, including child care centers, family child care programs, and other home-based care arrangements, much of the quality emphasis has been directed to public investments in formal settings, especially center-based programs. And the proportion of CCDBG child care subsidies going toward center-based programs has risen steadily for the past two decades. Centers now represent 73 percent of all CCDBG-funded arrangements and more than 90 percent in some states and territories.²

Our focus in this paper is twofold. First, we examine the trend toward increased use of subsidies for center care and explore its implications for child care access for four types of families: **families working nontraditional schedules, families with infants and toddlers, families living in rural areas, and families with children who have disabilities and special needs (hereafter, "children with special needs")**. We focus on these four populations because (1) they have known challenges accessing child care centers, (2) they are singled out as priority populations in the reauthorized law, and (3) they represent about three in five low-income children younger than 6 with working parents. We also examine some key reasons center-based care is less available for these populations. Our goal is to help policymakers and other policy stakeholders understand how current policy strategies may inadvertently challenge the ability of vulnerable groups of families to access subsidies and take advantage of public investments in child care quality.

Second, we consider the tools available to states within the CCDBG law to increase access to quality child care arrangements for these priority populations. We look at the four basic CCDBG policy tools and how policymakers may package and target these tools to address supply and access challenges. Our goal is to contribute to informed and strategic policy efforts to increase the supply of, and access to, high-quality care for all children.

What Is in This Report?

This report is set up in five sections:

- **Exploring the trend toward the use of subsidies for center-based care.** This section describes the patterns of subsidy use for child care centers nationally and for the 50 states and the District of Columbia. It also discusses some of reasons why the 2014 reauthorization of the CCDBG may accentuate the trend towards subsidizing center-based care.
- **Understanding the needs of our focal populations.** This section provides a brief introduction to the child care needs of each of the priority populations highlighted in this report and what is known about the barriers to serving them, especially through a center-based system.
- **Understanding factors that affect the accessibility and availability of center-based care for our focal groups.** This section provides an overview of the major factors shaping the supply of center-based care, with a particular focus on how these factors play out for the focal populations.
- **Examining what states can do to increase access to high-quality care for these priority groups.** We next lay out steps states can take through implementing CCDBG policy to address access challenges for these priority populations.
- **Conclusions.** We conclude with some final overarching reflections on ways policymakers and the child care field can help address the issues raised in the report.

The report includes three appendixes: appendix A, a summary of the CCDBG program; appendix B, a table with the share of subsidies used for center care over time by state; and appendix C, two tables with state-by-state statistics—one showing the proportions of low-income children younger than 6 who fall into at least one of three priority groups (parents with majority of work hours at nontraditional times, infants and toddlers, and/or people who live in nonmetropolitan areas), and one showing the separate proportions of children in each of these groups—and a section discussing how we define these categories.

Exploring the Trend toward Center-Based Care in the CCDBG

From its inception, the CCDBG has entrusted parents—rather than the state—to make their own decisions regarding the child care arrangements that best meet their needs, a principle commonly referred to as “parental choice.” As a result, and in recognition of the diverse circumstances and priorities that contribute to child care selection, the CCDBG has historically served families in both home- and center-based arrangements, both regulated and legally exempt from regulation. (Box 1 describes different child care and early education settings.)

BOX 1

Child Care and Early Education Settings

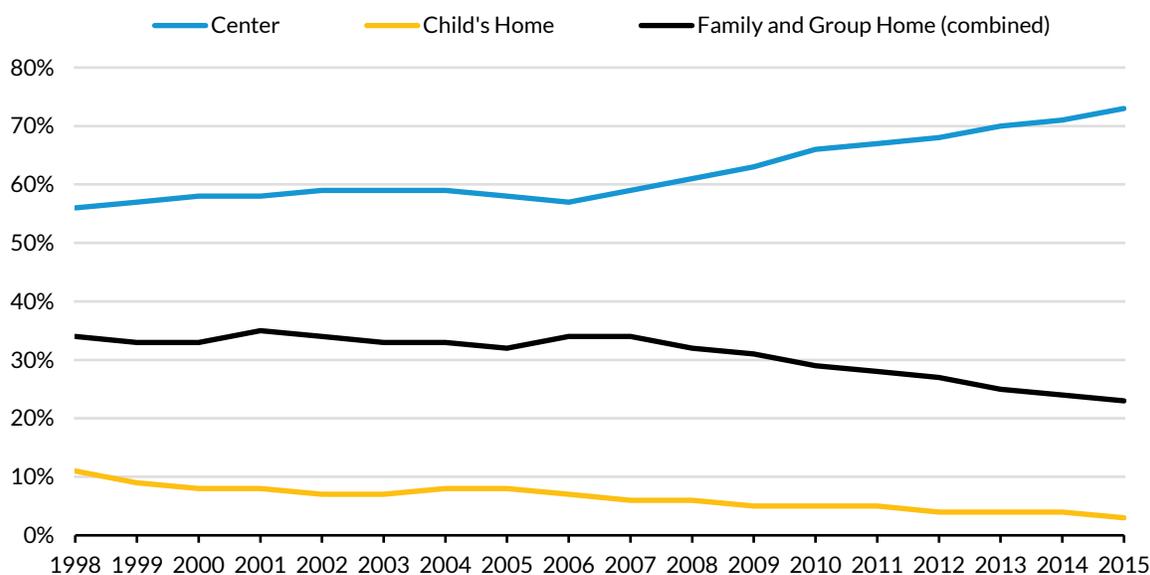
Child care and early education can take place in centers and preschools, in family child care homes, or in home-based care provided by family, friends, and neighbors. These settings may vary in their physical structure, the activities they offer to children, the supports they provide families, and their relationship with state early care and education systems (and related systems, such as those designed to support children with special needs). The center-based sector is itself diverse and includes nonprofit organizations, government-operated programs, and for-profit businesses. Centers operate in institutional spaces (e.g., schools), independent buildings, and religious institutions such as churches, mosques, and synagogues. The home-based child care sector is also diverse in the formality, regulatory status, and size of its programs, as well as in caregiver characteristics, experience and training, and reasons for providing care (Tonyan, Paulsell, and Shivers 2017). The home-based sector ranges from family child care homes, which typically care for several children in the home of an unrelated caregiver, to family, friend, and neighbor caregivers.

States vary in their regulatory standards governing child care and early education and in their requirements for determining which providers are legally exempt from regulation, further adding to the complexity of the child care market. While most center-based options are regulated, states can choose to exempt some center-based programs from licensing; some exemptions for center-based care may be programs operating part time, programs operated by faith-based communities, and programs operated by other agencies such as schools. States also vary in their approach to requiring licensing oversight for home-based settings and usually set a threshold for the number of children in care that triggers licensing. In some states, a home-based provider must be licensed if they care for any children who are unrelated to them, while in other states home-based providers may care for several children before having to be licensed (National Center on Early Childhood Quality Assurance 2015).

What Is the Trend in Using CCDBG Subsidies for Center Care?

In the past two decades, CCDBG program funds have been increasingly going to subsidize children in child care centers. Specifically, the share of subsidies going toward center care has been growing since the late 1990s and especially since 2006 (figure 1). In 1998, 56 percent of children receiving subsidies were cared for in centers, 34 percent in family child care or group homes, and 11 percent in the child's own home. By 2015, however, the share of subsidized children in centers had risen to 73 percent, while the share of children in family child care had fallen to 23 percent. Only 3 percent of subsidized children were cared for in their own homes (1 percent had invalid data or did not report any data).³ While not shown in this figure, the share of children cared for by license-exempt home-based providers decreased as well, from 14 percent to 6 percent for relatives and from 11 percent to 4 percent for nonrelatives. This represents a 70 percent decrease, or 312,861 fewer children served in license-exempt settings, including relative and nonrelative providers (Mohan 2017).

FIGURE 1
Share of Total Children Served by Care Types, 1998–2015



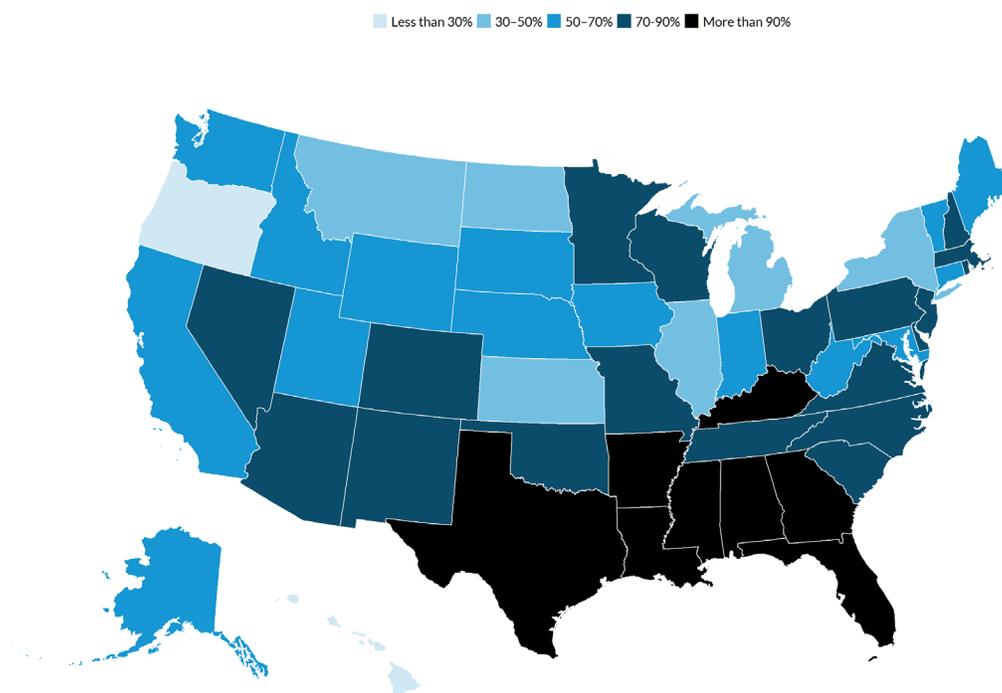
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Source: Based on data available from the Department of Health and Human Services, Administration for Children and Families, Office of Child Care website. These data are reported by states and territories to the ACF-800-Annual Aggregate Child Care Data Report and ACF-801—Monthly Child Care Data Report, <https://www.acf.hhs.gov/occ/resource/ccdf-statistics>.

The move toward greater use of center care is a pattern seen in many states. (Appendix B provides a state-by-state look at the change in the share of children receiving subsidies in center care from 1998 to 2015.) Specifically, the share of subsidized children attending centers increased during this period in all but four states (California, Hawaii, Nevada, and Utah, which actually saw decreases), though specific numbers and the magnitude of change varied significantly. Nineteen states saw increases of at least 20 percentage points, and another 17 states saw increases between 10 and 19 percentage points. The remaining states reported less than 10 percentage-point increases, and four, as noted, reported decreases.

By 2015, center care was the most common kind of care for CCDBG-subsidized families in most states (see appendix B). In 2015, the majority of states reported that over 50 percent of subsidized children were enrolled in center care, with nine states (mostly in the South) reporting shares of 90 percent or more (figure 2). In contrast, eight states reported that fewer than 50 percent of subsidized children were enrolled in center care in 2015, and only Hawaii and Oregon reported shares lower than 30 percent. These states have more robust home-based care sectors than the rest of the nation.⁴

FIGURE 2
Share of Children Receiving CCDBG Subsidies Cared for in Child Care Centers, 2015



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Source: “FY 2015 Final Data Table 3 - Average Monthly Percentages of Children Served by Types of Care,” Office of Child Care, March 8, 2018, <https://www.acf.hhs.gov/occ/resource/fy-2015-final-data-table-3>.

Nationally, the growth in the share of CCDBG funds used to subsidize center care occurred during a period when inflation-adjusted CCDBG funding levels were in decline, after more than doubling from 1997 to 2001 (Walker and Matthews 2017). Since 2001, federal CCDBG funding has declined each year except for a two-year infusion of new funds through the American Recovery and Reinvestment Act of 2009. In 2015, the program served fewer children than it had since 1998 (less than 1.4 million), with a substantial drop in CCDBG-funded providers as well (from 701,000 in 2006 to 339,000 in 2015; see Mohan 2017). The number of programs receiving CCDBG funds dropped among both centers and home-based settings during this period, with particularly steep declines of 60 percent among family child care providers (Mohan 2017). In March 2018, Congress passed a historic increase in funding for the CCDBG, boosting discretionary spending by \$2.4 billion. Experts suggest that these funds will help states meet the requirements set out in the 2014 reauthorization while serving an additional 151,000 children (CLASP 2018).

In light of the shrinking and increasingly center-based CCDBG-subsidized provider base, client caseload demographics may also be changing, although national data are lacking. Of particular concern to this report, the program might now be serving families whose needs align more closely with center practices and leaving behind families for whom center care is less accessible or desirable given their circumstances and care needs (Mohan 2017). It is critical that future research analyze caseload characteristics in the context of the shifting makeup of providers receiving CCDBG funds and the changing market overall to determine whether this shift toward centers has benefited some families at the expense of others.

The trends described in this section are probably a result of a combination of factors, including the broader national conversation highlighting the benefits of early childhood investments, the disproportionate use of centers and preschools by higher-income families (especially those with 3- and 4-year-olds), shifting policy priorities at the federal and state levels, changes in the child care market itself (including the decline in licensed family child care homes), and the circumstances, needs, and priorities of subsidized families. More research is needed to understand how these diverse factors explain these national trends and the wide variation among states demonstrated in figure 2 (and appendix B).

Understanding the Potential Impact of the 2014 CCDBG Reauthorization on Trends toward Center Care

The reauthorized CCDBG included several changes to the law. The program still maintains parental employment as a program goal but was redesigned to strengthen its child development focus. States are now encouraged to direct subsidies to programs that meet quality standards, and the reauthorized law includes several new provisions that prioritize the health and safety of children and the quality of child care settings:⁵

- adoption of training and professional development criteria that establish professional standards and competencies that providers must meet
- more CCDBG funds (9 percent of total funds by fiscal year 2020) directed at quality improvement activities (also known as the “quality set-aside”) and a requirement that, beginning in fiscal year 2017, 3 percent of CCDBG funds be directed toward infants and toddlers (the “infant-toddler set-aside”)
- mandatory background checks for all providers, except those related to all children in their care
- stronger health and safety standards and inspection requirements for providers, including license-exempt providers, who must participate in preservice, orientation, and ongoing training, as well as annual site monitoring
- consumer education to promote parental choice when selecting quality child care services and to promote parental knowledge about child development and caregiving
- payment rates and practices that ensure equal access to child care services comparable to those provided to non-CCDBG families

Experts predict that the new provisions guiding CCDBG state policies will accelerate the trends described above, with an even higher share of state CCDBG funds going to center-based care and away from regulated and unregulated home-based alternatives.⁶ The reauthorization seems likely to reinforce trends toward center care for at least three reasons:

- **Provisions that aim to increase access to high-quality care may advantage centers over homes, especially license-exempt homes, unless states directly involve home-based providers in their quality efforts.** Although quality child care exists across all settings, much of the national conversation on improving access to quality programs has focused on centers. As box 2 indicates, until recently, most research on quality care has been conducted in centers,

with less attention to the development of quality definitions, measures, and standards that capture the unique strengths of home-based providers. Quality rating and improvement systems (QRIS) have become an important mechanism states use to identify, assess, and support quality child care and early education programs, and the majority of states include only centers and licensed homes in their QRIS. Eligible center-based programs have higher rates of participation in QRIS than eligible home-based programs (Tout et al. 2017), and states vary in the range of child care programs they allow to participate in QRIS. In 2017, only eight states allowed license-exempt providers to participate in their QRIS.⁷ Because QRIS participation rates and approaches (to both center- and home-based care) vary significantly across states, tying CCDBG eligibility to QRIS involvement, which states are permitted to do, will likely have differential consequences for providers in different states.

More broadly, the continued acceleration of trends toward subsidized center care may depend on how states apply the CCDBG policy levers designed to promote quality. For example, some states may narrowly target financial incentives, training, and other tools to center providers, whereas others will use them as an opportunity to expand quality across all sectors (see the “Understanding Four Key CCDBG Policy Tools” section, page 30).

- **New regulatory standards, health and safety requirements, and inspection and monitoring requirements may deter (and in some cases, exclude) home-based providers, especially license-exempt family, friends, and neighbors, from participation in the subsidy program.** Some license-exempt home-based providers may not wish to participate in a more highly regulated child care system and may choose not to comply with the new standards and requirements. Others might be interested in participating but remain unaware of what they need to do to attain or maintain their eligibility without a successful public information campaign. Finally, even providers fully knowledgeable about the new standards may lack the resources and supports to comply with the new standards and requirements. Without significant guidance and support, these providers may not have the resource capacity to remain in the system.

Thus, as states implement new regulatory standards, there may be a drop in subsidized home-based providers, especially those who are license exempt, unless states proactively support their continued participation.

- **Without considerable new resource investment, states may not be prepared to provide the newly required preservice and ongoing trainings or to carry out annual inspections at a pace that can retain their current numbers of home-based providers, especially license-exempt providers.** License-exempt providers have generally not been subject to state inspection.

Experts are concerned that some states, especially those in difficult fiscal circumstances, may not devote the resources necessary to comply with these new monitoring and inspection requirements and instead will discourage or outright eliminate legally unlicensed family, friend, and neighbor providers from participating in the subsidy system. In a recent Center for Law and Social Policy report, Matthews and colleagues (2017, 2) address this concern by noting, “Some states, in an effort to control implementation costs, have taken steps to restrict the types of providers that can receive CCDBG dollars, effectively limiting the choices of care.” For example, Pennsylvania has moved to limit subsidies to licensed providers. The recent funding increase for the CCDBG may alleviate some of this pressure, though it is unclear how states will choose to spend these funds given competing priorities. The new funds, along with the new requirements, may give some states incentive to find innovative ways to support providers across all sectors.

These three interacting forces may accelerate existing trends toward center-based care. Some states may pursue strategies that intentionally direct subsidies toward centers, even though the quality standards in the new law can be met by home-based and center-based arrangements. Other states may work to improve quality within the context of parental choice and support access to high-quality regulated and license-exempt home-based settings as a strong part of their subsidy system. However, states that aim to maintain home-based options may struggle given the costs associated with meeting the new health and safety requirements in these settings and the possibility that some license-exempt providers will prefer to discontinue participation rather than comply with increased state oversight. And while new funds provide states with greater flexibility, there are competing demands for those resources.

BOX 2

Exploring Child Care Quality across Child Care Sectors

Experts and consumers agree that high-quality child care arrangements offer a safe and nurturing environment where caregivers are responsive and warm, and where opportunities are provided for cognitive and socioemotional growth in early childhood (Forry et al. 2013; Votruba-Drzal, Coley, and Chase-Lansdale 2004).

The research on child care and early education quality mostly focuses on child care centers, as do most quality-focused policy discussions, which largely emphasize the capacity of formal programs, especially centers, to prepare children for school (Layzer and Goodson 2006). However, the majority of children, especially low-income children and the specific populations of focus in this report, are cared for in diverse, home-based settings, mostly by family, friend, and neighbor caregivers. The National Survey of Early Care and Education, for example, estimates that more than 7 million children under age 6 are cared for in home-based settings, compared with about 3.8 million children in centers (Tonyan, Paulsell, and Shivers 2017).

Responding to this reality, there has been considerable national attention to (and progress toward) the development of multidimensional definitions and measures of quality that capture unique aspects of quality across and within sectors (Guzman et al. 2009; Martinez-Beck 2011; Porter et al. 2010). In particular, research funded by the Administration for Children and Families and expert working groups sponsored by the Office of Planning, Research, and Evaluation’s Child Care and Early Education Policy Research Consortium are generating considerable new knowledge about quality in home-based care.^a

Bromer and colleagues (2011) propose an expanded definition of quality that includes aspects of care that are sensitive to families’ needs alongside the child-focused dimensions targeted by conventional quality definitions. They argue that a family-sensitive model of care that aligns with the needs of parents and children recognizes the potential for child care and early education settings, whether home-based or center-based, to directly and indirectly (through their effects on parents) support children’s development. The field has also seen the development of new indicators that tap dimensions of quality that may differ, or in some cases even be distinct, in homes and centers (National Survey of Early Care and Education Project Team 2015a) and that specifically relate to family-provider relationships and family engagement (e.g., the development of the Family and Provider/Teacher Relationship Quality measure). Moreover, some QRIS include standards related to provider-family partnerships (Porter, Bromer, and Forry 2015).

Some features of home-based care may be especially important to parents, particularly those poorly served by the center care market:

- The more informal, “family-like” setting of home-based arrangements creates unique opportunities for developing sensitive and engaging relationships among providers, children, and families (Paulsell et al. 2010; Porter et al. 2010). Some research indicates that the quality of caregiver interactions with children in home-based settings is generally high (Forry et al. 2012; Porter et al. 2010).
- Home-based providers, especially license-exempt caregivers, are likely to have prior relationships with the families they serve, possibly reducing the anxiety and stress for both parents and children when a child is in unfamiliar surroundings. This familiarity may be particularly valuable to families with young children or children with special needs, as well as families who need care during evening, overnight, and weekend hours, when the more intimate activities of family life occur (Paulsell et al. 2010; Porter et al. 2010).
- Home-based providers often take care of children of varied ages in the same setting, which may be a logistical support for families with multiple children (Paulsell et al. 2010; Porter et al. 2010). Interacting in a mixed-age setting can also present unique developmental opportunities.
- Home-based settings tend to be more flexible in their scheduling and hours, and these providers may offer supports to families in addition to child care (e.g., running errands, providing transportation), making them more supportive of family schedules and reducing logistical challenges and family stress (Bromer and Henly 2009; Henly and Lyons 2000).

^a See also a recent special issue of *Early Education and Development* on home-based child care (Tonyan, Paulsell, and Shivers 2017).

Understanding the Needs of Our Focal Populations

For many families, CCDBG subsidies provide access to center-based care that they desire and could otherwise not afford. However, not all families prefer centers for all their care needs, and many families who desire center care face barriers to accessing it. In this section, we consider the needs of four populations with known challenges accessing center care:

- families with parents working nontraditional and variable-hour schedules
- families with infants and toddlers
- families living in rural areas
- families with children with disabilities and special needs

We focus on these four populations for three reasons. First, there is evidence that center care does not adequately meet the needs of these children. Some children in these groups are cared for in centers, but center-based care is generally less accessible to their families, and they disproportionately use home-based settings. As a result, the trend of CCDBG subsidies going increasingly to families using centers could present an additional challenge for these families. To keep these families in the subsidy system, it will be important for states to consider the barriers they face to accessing centers and support their efforts to find quality care in both centers and home-based settings.

Second, the reauthorized CCDBG explicitly identifies several groups of families, including these four populations, that require the targeted attention of state efforts to improve access to and quality of care. (Other populations highlighted in the law include children who are homeless, in foster care, or who live in economically disadvantaged areas.)

Finally, these children make up the majority of all low-income children under age 6 with working parents. While data are not available on children with special needs, analysis of cumulative American Community Survey (ACS) data from 2011 to 2015 finds that 61 percent of children younger than 6 with working parents in families with incomes below 200 percent of the federal poverty level—almost 3 million children—are infants or toddlers, live in a rural area, or have parents who work the majority of their hours outside traditional daytime hours. This share is more than 50 percent in all states and rises above 80 percent in four states (see appendix table C.1). Further, these cumulative numbers are based on a conservative estimate of nonstandard-hour work patterns, as we only count children whose

parents work *a majority* of their hours outside a traditional daytime schedule. These numbers would be substantially higher if we included all children whose parents work *any* hours on nontraditional schedules. (See appendix table C.2. Appendix C also includes information on how these categories were defined.)

These realities underscore the importance of paying particular attention to how focusing public funds on child care centers may inadvertently create barriers to access for a significant share of low-income children.

Why Focus on Families Working Nonstandard Schedules?

Nonstandard, variable, and unpredictable work hours are common in today's labor market, especially in low-wage jobs. Parents working these nontraditional schedules face unique child care challenges, as most formal child care programs are only open during standard weekday hours and require regular attendance on a set schedule. Our analysis of 2011–15 ACS data suggests that 58 percent of the 4.77 million low-income children under age 6 with working parents (2.76 million children) are in households where all principal caretakers work at *least some hours* before 8:00 a.m. or after 6:00 p.m., and for about a quarter of those children (715,900 children), *the majority of those hours* are during nonstandard work times (see appendix table C.2 and the subsequent discussion on methods). The ACS data indicate that working during nonstandard times is prevalent in all states and the District of Columbia. But in 20 states, at least 60 percent of children have a parent who works at least some nonstandard times. This share is as high as 71 percent in Mississippi and as low as 45 percent in New York. Other data sources provide estimates on work hour unpredictability and variability, finding that 38 percent of workers receive one week or less of advance notice of their work schedule, and 74 percent report that the number of hours they work varies from week to week (Lambert, Fugiel, and Henly 2014).

To meet their child care needs, parents with nontraditional working hours disproportionately use home-based providers, especially family, friend, and neighbor caregivers, or rely on multiple arrangements to meet caregiving needs (Laughlin 2013). There are simply too few centers open outside regular business hours (Dobbins et al. 2016). According to the National Survey of Early Childhood Education (NSECE), in 2012, only 8 percent of centers offered care during evenings, weekends, or overnight (NSECE Project Team 2015b). Additionally, centers often require families to enroll on a regular schedule and pay for full-time attendance, thus reducing its appeal to parents with unpredictable work schedules or variable scheduling needs. The NSECE study found, for example, that only 45 percent of centers allowed any kind of flexible scheduling, and only 40 percent allowed flexible payments.

Nationally, the NSECE finds that home-based settings are more likely to offer nontraditional hour options. For example, in contrast to the 8 percent of child care centers offering any care during evenings, weekends, or overnight, the survey found that about one-third of “listed” home-based settings and almost two-thirds of “unlisted” home-based child care settings that were paid offered such care, with that figure rising to over 80 percent of those unlisted home-based settings that were unpaid (NSECE Project Team 2015b).⁸ Although systematic data by state on the availability of nonstandard hour care are not readily available, patterns seem to vary across communities. For example, a 2014 study in Massachusetts surveyed centers and family child care homes and found that effectively no programs were open after 6:15 or 6:30 p.m. during the week or during any hours on weekends (Brodsky and Mills 2014).

Thus, family, friend, and neighbor caregivers appear to be providing most of the care to accommodate nontraditional work hours and maintaining flexible schedules to accommodate fluctuating and unpredictable work schedules. Because state programs have permitted families to use subsidized providers across a range of settings, low-income parents with nonstandard work schedules have used subsidies to pay for license-exempt and licensed family child care. One study of child care assistance recipients in Cook County, Illinois, found that 64 percent of subsidized families working during nontraditional hours used license-exempt home-based providers compared with only 22 percent of subsidized families with daytime work hours (IAFC 2016).

Research suggests that children of low-income parents working nontraditional schedules may particularly benefit from stable child care experiences, given that they typically experience forms of instability that put them at developmental risk (Adams, Derrick-Mills, and Heller 2016; Adams and Rohacek 2010; Sandstrom and Huerta 2013). Specifically, instability for a parent at work can translate into instability in family routines, contribute to housing instability, and disrupt children’s participation in developmentally enriching activities (Clawson and Gerstel 2014; Henly and Lambert 2005; Henly, Shaefer, and Waxman 2006). Ensuring that subsidies are available to help children access high-quality settings during regular daytime hours in addition to other forms of high-quality care for any nonstandard hours can offer stability and consistency to children and may mitigate the negative effects of their parents’ erratic work schedules on their development (Sandstrom and Huerta 2013).

The reauthorized CCDBG recognizes the challenges facing families needing care during nontraditional hours and aims to increase state investments in the supply and quality of care for this population. For example, the state child care subsidy agency (also known as the “lead agency”) is required to describe in its state plan how it will increase the supply and improve the quality of child care services for these children and provide consumer education about the availability of providers offering

nontraditional hour care. Lead agencies are also encouraged to assess the availability of nontraditional hour care across child care sectors when developing their quality improvement systems.

Why Focus on Families with Infants and Toddlers?

Almost half of low-income children under age 6 with working parents are infants and toddlers (46 percent, or 2.2 million children; see appendix table C.2). Not only are children under 3 a significant portion of the population of children needing care, they are in a critical developmental stage characterized by rapid brain development. Learning is cumulative, and development that occurs early on is a foundation for later growth and development (National Research Council and Institute of Medicine 2000; National Scientific Council on the Developing Child 2007). Infants and toddlers make dramatic cognitive, language, and socioemotional gains in these early years that can be nourished by high-quality, stimulating home and out-of-home environments. Further, high-quality arrangements can mitigate the negative effects of poverty and disadvantage (National Research Council and Institute of Medicine 2000; National Scientific Council on the Developing Child 2007).

National survey data show that children younger than 3 are less often enrolled in child care centers than 3- and 4-year-olds. For example, among children with employed mothers, organized care facilities (e.g., centers, Head Start, and nursery or preschool programs) provide care for 16 percent of children younger than 1, 30 percent of 1- and 2-year-olds, and 51 percent of 3- and 4-year-olds (Laughlin 2013). Overall, infants and toddlers are disproportionately enrolled in home-based settings, especially with family, friend, and neighbor providers (Halle et al. 2009; Iruka and Carver 2006; NSECE Project Team 2015c; Susman-Stillman and Banghart 2008). This corresponds with a lower supply of centers for this age group: data from the National Survey of Early Care and Education indicate that only 36 percent of centers serve children younger than 1, 43 percent serve 1-year-olds, and 52 percent serve 2-year-olds, whereas over 80 percent serve 3- and 4-year-olds (NSECE Project Team 2015c). As a result, parents with infants and toddlers seeking center-based care have fewer options from which to choose. Households in impoverished communities are especially less likely to have access to centers that serve children under 3 (NSECE Project Team 2015c).

Over a quarter of children receiving CCDBG are younger than 3 years old. Most of these subsidized families use centers despite the limited overall supply of center care slots for infants and toddlers. In 2015, among children receiving subsidies, 70 percent of infants (younger than 12 months) and 73 percent of toddlers (1 to 2 years old) were cared for in a subsidized center, compared with 78 percent of preschoolers (3 to 5 years old) (HHS 2015). Given the low rates of infants and toddlers in center care in

the general population, and especially the general low-income population, these numbers suggest that subsidies disproportionately help the small segment of those families with infants and toddlers who can find a center who will serve the youngest children.

The reauthorized CCDBG recognizes the critical need for expanding access to quality arrangements for this age group. As such, not only does the law require states to direct 9 percent of CCDBG funds toward quality improvement activities, it also requires that (as of fiscal year 2017) states direct at least 3 percent of CCDBG funds to support the supply and quality of care for infants and toddlers. The law also encourages states to collaborate across programs and combine funding streams to expand and improve services for infants and toddlers and to consider establishing eligibility periods longer than the required 12 months for children enrolled in programs such as Early Head Start-Child Care Partnerships. The law also requires that lead agencies describe, in their state plans, how they will increase supply and improve quality of child care services for infants and toddlers and assess the availability of infant and toddler care across child care sectors when developing their quality improvement systems.

Why Focus on Rural Families?

Definitions and approaches to measuring the rurality of a geographic area vary across studies. In this report, we use ACS 2011–15 data to identify *nonmetropolitan areas*, a classification that includes counties that are neither in nor around a highly populated urbanized area (i.e., at least 50,000 people). Using this definition, which we refer to as rural in this report, we estimate that about 16 percent of low-income children younger than 6 with working parents (776,300 children) live in nonmetropolitan areas (see appendix table C.2).⁹

This varies significantly from state to state. As shown in appendix table C.2, six states (Mississippi, Montana, North and South Dakota, Wyoming, and Vermont) have more than half their low-income children living in these areas. In contrast, some states have less than one-tenth of these children residing in nonmetropolitan areas: Arizona, California, Connecticut, Delaware, Florida, Maryland, Massachusetts, Nevada, New Jersey, New York, Rhode Island, and Washington, DC.

Notwithstanding the important heterogeneous characteristics of the rural population (Glauber and Schaefer 2017) and the extreme pockets of poverty found in urban and suburban neighborhoods, household incomes are lower and poverty more extreme and of longer duration in rural areas compared with urban and suburban areas (O’Hare 2009; Thiede, Kim, and Valasik 2017). This is despite a growth in female rural employment over the past several decades, which has been comparable to or greater

than the growth in female employment rates in urban areas (Cochi Ficano 2006). However, economic insecurity in rural areas is relatively high because of economic transformations that have disproportionately affected the former agricultural economic base of rural America (De Marco et al. 2015).

Although studies vary, most research finds that rural families' use of child care centers trails that of families in metropolitan areas. An analysis of 2005 National Household Education Survey data shows that although rural children were as likely as urban children to be in nonparental care arrangements, they were more likely to be cared for by relatives and had lower rates of center care participation (55 percent of urban children ages 5 and younger attended Head Start, prekindergarten, day care centers, or other organized early education programs compared with 44 percent of rural children; see Swenson 2008). Other studies also show higher rates of rural children being cared for by relatives and nonrelative unregulated providers, likely at least partly a result of less availability of centers in rural areas (De Marco et al. 2015).

The disproportionately lower rates of center care usage in rural areas is also true among families receiving child care subsidies. That is, although rural families with subsidies are more likely to use centers than rural families without subsidies, *subsidized* rural families are less likely to use centers than their nonrural subsidized counterparts (De Marco et al. 2015). Moreover, child care providers in rural areas have less education and training, and professional development opportunities may be harder to access in these communities (Magnuson and Waldfogel 2005; Maher, Frestedt, and Grace 2008).

The reauthorized CCDBG directs states to increase the supply of quality child care and early education programs in underserved areas, including rural areas. The final rule highlights rural areas as particularly important because of existing shortages in child care programs. The law also identifies families in areas of high poverty and unemployment as a priority population, which would include many rural communities. As with the other priority areas in the law, it directs lead agencies to assess the availability of care in underserved areas across different types of care when developing their quality improvement systems.

Why Focus on Families of Children with Disabilities and Special Needs?

Children with disabilities and special needs are an underserved group in need of high-quality early education and child care while their parents work or participate in education and training programs (Sullivan, Farnsworth, and Susman-Stillman 2018a, 2018b; Weglarz-Ward and Santos 2018). There is

no universally agreed-upon definition of disability in children (National Academies of Sciences, Engineering, and Medicine 2018a). Children with special needs are diverse, and their special needs may or may not be visible. The types and severity of conditions recognized as special needs by state systems and programs, as well as in the definition used across federal programs, also vary considerably (Spiker, Hebbeler, and Barton 2011). The CCDBG considers a child to have a disability if he or she meets at least one of the following criteria: (1) meets the definition in Section 602 of the Individuals with Disabilities Education Act (IDEA); (2) is eligible for early intervention services under Part C of IDEA; (3) is under 13 years old and eligible for services under Section 504 of the Rehabilitation Act of 1973; or (4) is a child with a disability, as defined by the state.¹⁰ Children with special needs may experience mild to severe mental or physical disabilities that require occasional or daily specialized attention, including administration of medication, use of specialized equipment and structural accommodation, and personal caregiver attention (National Academies 2018a).

Some children with special needs qualify and receive specialized services funded through IDEA (Spiker, Hebbeler, and Barton 2011). Data limitations preclude a precise figure, but it is estimated that approximately 13–15 percent of all children under age 6 have needs that may require special services, although fewer than 6 percent (about 350,000 infants and more than 750,000 toddlers and preschool-age children) actually receive special education and related services under the federal IDEA program (Boyle et al. 2011; Grant and Isakson 2013; Hebbeler, Spiker, and Kahn 2012; Rosenberg, Zhang, and Robinson 2008; US Department of Education 2015).¹¹ Low-income families are estimated to be 50 percent more likely to have children with special needs than higher-income families (Lee, Sills, and Oh 2002; see also Simon et al. 2013).

Children with special needs reap real benefits from high-quality care, but they may require additional services and supports matched to their particular needs to realize the full developmental benefits that such settings can provide (Spiker, Hebbeler, and Barton 2011). Such supports can be even more important for low-income families, who face the cumulative burdens of poverty and material hardship in addition to the developmental and health challenges associated with a child's disability (Parish et al. 2005). Not only are low-income families more exposed to environmental conditions that may lead to disabilities, but families with children who have special needs experience an increased risk of poverty because of the economic and social costs of raising a child with special needs. Research also demonstrates that in addition to their compromised economic circumstances, families with children with special needs have greater family expenses (e.g., health care, transportation, specialized equipment) and are more often caring for a child as a single parent (DeVore and Bowers 2006; Knoche et al. 2006).

Depending on the type and magnitude of their disabilities and their families' access to financial and other supportive resources, children with special needs may be particularly vulnerable to poor outcomes if they do not receive high-quality, safe, and affordable early care and education services. Quality care and caregivers trained to meet the particular needs of children with special needs can allow low-income parents to respond to their own employment challenges and provide the foundational support necessary for their children to develop to their full potential (Lukemeyer, Meyers, and Smeeding 2000; Ward et al. 2006). But these families often have limited child care options (Grisham-Brown et al. 2010; Knoche et al. 2006; Sullivan, Farnsworth, and Susman-Stillman 2018a, 2018b; Weglarz-Ward and Santos 2018). Their compromised economic status makes access to financial assistance more important; yet these families are less likely to use child care subsidies than families who do not have children with special needs. Moreover, for subsidized families with toddlers and preschoolers, children with special needs use subsidized center-based care at lower rates than children without special needs (Sullivan, Farnsworth, and Susman-Stillman 2018a). Generally, whether or not receiving a subsidy, children with special needs disproportionately use informal care arrangements, use care for fewer hours a week than other children, and experience more child care instability (Booth-LaForce and Kelly 2004; Knoche et al. 2006). These discrepancies in service coverage exist even though child care programs that receive federal funding are required to comply with the Americans with Disabilities Amendments Act of 2008 and Section 504 of the Rehabilitation Act of 1973 (Sullivan, Farnsworth, and Susman-Stillman 2018a). Further, although the majority of states with QRIS recognize that children with special needs require high-quality care (National Center on Early Childhood Quality Assurance 2017b), research suggests that there can be conflicts between QRIS standards and standards that are appropriate for children with special needs (Schulman et al. 2012).

Families caring for children with special needs are a priority population in the 2014 CCDBG reauthorization. As such, the law directs states to provide consumer and provider education about developmental screenings for children at risk of cognitive or developmental delays, to increase access to quality early care and education programs for families with children with special needs, and to improve coordination across CCDBG and other programs that serve these families, including IDEA and Head Start. The law also requires lead agencies to report in their state plans how they will prioritize services to children with special needs and enhance the supply and quality of services. The final rule also encourages states to add caring for children with special needs to its provider trainings as an optional health and safety topic.

What Factors Affect the Availability of Center-Based Care?

A number of factors shape provider decisions whether to serve these populations. To begin with, providers must be fundamentally concerned with the business viability of their programs. Can a provider bring in enough revenue to cover the cost of serving particular families or providing programming in a particular manner? This depends on whether there is **sufficient demand for the service to ensure a consistent and adequate level of enrollment** and on whether the center is able to collect **sufficient funds per child to cover the cost of providing service**, either directly from parents or from third-party sources, such as public subsidies or private scholarship funds (Stoney 2010). The **provider's interest in and readiness to provide services of a particular type or to diverse populations** also shapes the decisions it makes around its program. If providers have limited knowledge or have concerns about perceived or real challenges involved with serving families with particular care needs, they are less likely to extend services to these families. (Factors shaping providers' *willingness to accept subsidies*, while important, are not addressed in this report, as they are not issues unique to these populations.)¹²

These three factors can affect subsidized and unsubsidized providers across all sectors—centers, licensed family child care providers, and license-exempt informal providers. And they affect the type and scope of care provided overall, not just for the four priority populations. However, our interest here is on the factors that may discourage *centers* from serving these populations.

The four populations of interest in this report disproportionately use home-based providers, especially unregulated family, friend, and neighbor providers. Although there has been little research on the sector-specific drivers of care for these populations, it seems possible that it may be somewhat easier for home-based providers to enter this market because their business model is different (they are smaller and serve mixed-age groups, so they do not need the same level of demand as a center), they face different regulatory requirements, and their staffing demands are very different (i.e., a single provider may be the main staff person and does not need to worry about finding staff trained to serve special populations or experiencing turnover in staff with specialized training). That said, home-based licensed and license-exempt providers subject to more rigorous state standards under the 2014 CCDBG reauthorization may now face greater barriers to serving children receiving subsidies (Matthews et al. 2017). We return to this point in a later discussion of state policy implications.

There are significant gaps in our understanding of the forces shaping supply and demand for child care among the four priority populations. As a result, some discussion in this section comes from conjecture rather than from research findings, and we have noted this where relevant.

Adequate and Reliable Demand

For a center to extend services to populations with specific needs, demand must be both sufficient in scope *and* sufficiently reliable over time to consistently operate classrooms at near capacity and support investment in needed staff and other resources. In brief, there must be enough families asking for (and able to pay for) such care to make it worth the effort to serve them. Demand for care among the four groups of interest in this report may be inadequate or insufficiently concentrated or reliable enough to incentivize center providers to enter the market, as in the following examples:

- Providers may choose not to extend hours beyond a regular weekday schedule, as would be needed to offer services to **families with nontraditional work schedules**, because the work schedules of these families may be too variable to guarantee regular enrollment or because it is unclear that enough of these families want and can afford center-based care to justify the additional labor costs. Moreover, centers may not extend services to **families needing care on irregular schedules** because demand may not be high enough to justify the necessary additional costs that come with staffing for variable-hour care. Slots may go partially unused in a program that keeps availability open for families with “just-in-time” work schedules. While there is relatively little research on this issue, it also seems likely that some parents may prefer the more familial settings of family, friend, and neighbor care for times such as evenings, overnight, or weekends.
- Some providers may not offer care for **infants and toddlers** because of the perception or reality that not enough families with young children prefer center care *and* can afford the higher cost of such care. While some parents prefer home-based settings for their young children, more families have begun using center care for infants and toddlers in recent years (Chaudry et al. 2017), suggesting that attitudes have shifted or that providers are slowly increasing the number of slots available for infants and toddlers.
- Running and operating a center in a **rural area** may not be economically viable if there are not enough working families with young children in the area to consistently fill center enrollment needs (Gordon and Chase-Landsdale 2001; Maher, Frestedt, and Grace 2008). There may not be enough families to enroll because of the general population size and density, transportation

challenges, or the inconvenience of lengthy commutes (Colker and Dewees 2000; Walker and Reschke 2007).

- Providers face similar challenges in serving **children with special needs**, as there may not be enough of these families who prefer center care *and* can afford the higher cost. Some research finds that parents of children with special needs perceive home-based child care as more aligned with their needs (Booth-LaForce and Kelly 2004). Some parents who prefer home-based care may be responding to a recognized lack of qualified center staff who can meet their families' unique and often varied needs. For example, parents of children with special needs seek providers who have relevant experience and training, who can alleviate safety concerns, and who will take a collaborative stance with families and specialists (see Weglarz-Ward and Santos 2018).

The above examples highlight how parental preferences and constraints can interact with provider perceptions about demand and their need to maintain a financially viable program to limit the availability of quality center care for these populations.

Cost of Staffing, Training, and Infrastructure Investments

High-quality centers provide a costly service that requires significant investment in labor, training, and infrastructure (National Academies of Sciences, Engineering, and Medicine 2018b). Unfortunately, the current financing system does not provide sufficient resources to cover the cost of providing high-quality care. Funding comes from three sources: direct consumer tuition, government subsidies, and philanthropic support. Though parents bear a significant portion of overall child care costs through tuition, most parents (particularly low-income parents) cannot fully cover the costs of high-quality care. Likewise, government funding for early care and education is inadequate, fragmented, and does not fully reimburse providers for per child costs associated with providing quality care. Finally, private and philanthropic revenue streams seldom make up for the difference between what providers are paid (by parents and the public sector) and the true cost of delivering care (Stoney 2010).

These realities make it difficult for providers to invest in the physical and human capital necessary to provide high-quality care. To stay in business, providers and child care staff subsidize the cost of care by accepting low wages and minimal benefits, which may then undercut the quality of care they can provide (Stoney 2015).

Thus, covering the cost of providing high-quality care is a challenge (Caronongan et al. 2016; Stoney 2010) even before considering the additional costs associated with serving the four priority populations. It is unrealistic to expect providers to charge tuition rates that are sufficient to cover the higher costs of providing care for these families. Costs include the following:

- Center-based child care for **families with nontraditional and variable schedules** can be more expensive to provide and to purchase (Brodsky and Mills 2014). One study of nontraditional-hour care recommends a provider payment rate 130 percent higher than that of standard care (Kochanek 2003). Extra costs can be related to additional regulations regarding staffing and facility requirements (e.g., having a bed for each child, enhanced security systems, additional staff training) (Brodsky and Mills 2014). Center care can also be costlier for parents, as centers often require them to pay for a full-time slot even if they can only use it irregularly or part time.
- Center-based child care for **infants and toddlers** is significantly more expensive to provide and to purchase than care for older children (Sandstrom, Moodie, and Halle 2011) because providers must maintain lower child-staff ratios, smaller group sizes, and, in several states, higher staff qualifications. Providers must also meet building specifications addressing health and safety requirements for infants and toddlers. Providers face difficult trade-offs in meeting these extra demands, as they may not be able to recoup the additional investments through higher tuition rates alone given affordability concerns among low- and middle-income families (Stoney 2015). Further, the additional costs of providing care for infants and toddlers may not be sufficiently covered by subsidies.
- Although real estate costs in **rural areas** are lower on average than in cities and suburbs, rural centers may incur other costs, such as the cost of transportation supports necessary to facilitate program access in sparsely populated areas. Research suggests that centers may be less economically feasible in rural areas in part because of the significant fixed costs involved in running a center (Maher, Frestedt, and Grace 2008). Centers in more densely populated areas are larger and can benefit from economies of scale (Hotz and Ziao 2011). The small size of rural programs may make it difficult for providers to afford the costs of opening and staffing a center and complying with regulations and licensing requirements (Maher, Frestedt, and Grace 2008).
- Serving **children with special needs** also creates additional costs due to specialized staff training and equipment necessities. These costs vary depending on the precise accommodations needed, but they can represent a significant financial investment for providers, especially small centers, and they may be perceived by providers as a risky business decision given high turnover rates and uncertain or unreliable demand (Essa et al. 2008;

Matthews et al. 2017; Weglarz-Ward and Santos 2018). Evidence suggests that providers spread the additional costs of meeting the accessibility requirements of the Americans with Disabilities Act across all families in a program (US Department of Justice 2017). The incentives for providers to make additional investments beyond what is legally mandated are unclear given that there may not be a steady stream of children needing particular services. Moreover, staff turnover in centers is relatively high, making investments in staff members with specialized knowledge to serve children with special needs especially risky.

Center directors may lack the financial resources to make these important but costly investments, and without significant subsidization, families are unlikely to be able to afford the higher cost of care. Given the limited options available to providers to address cost barriers, absorbing these costs can threaten their financial viability and the quality of care they provide (Rohacek and Adams 2017).

Readiness and/or Willingness of Providers

Provider interest, skill levels and training, and discomfort with nontraditional ways of operating may prevent them from expanding their services to a more diverse client base, including the four priority groups examined here. Center directors may lack the knowledge or interest needed to develop new programs or adapt existing programs to meet the needs of these populations. Some may be deterred by real or perceived risks associated with accommodating a more diverse clientele. In addition to the specialized training and equipment needed to provide high-quality care to some of these groups, providers may need to become familiar with different policies, regulations, and supports to meet legal standards of care and access resources that can help offset additional costs. Not all providers are interested in or prepared to take the steps necessary to serve these families, and those that are interested may require supplemental resources and targeted education and training.

While there is relatively little research on provider interest in and capacity to serve these priority groups, it is possible to conjecture some challenges providers may face, as in the following examples:

- The absence of center-based options for **families with nontraditional work schedules** may not only be the result of a lack of perceived demand but also of a disinterest in or unwillingness to provide care to this population. One study found that most center providers were willing to provide care (even if they did not currently do so) in the early morning (between 6:00 a.m. and 7:00 a.m.) and early evening (between 5:00 p.m. and 7:00 p.m.) but were not willing to offer care later in the evening, overnight, or on the weekend (Brodsky and Mills 2014). It is possible that

some center directors may understand their professional role in terms of early education and child development more than parent/family support and custodial care, which may not conform with evening, overnight, weekend, or variable schedule models of practice. There may be developmental or pedagogical reasons that these centers choose not to extend hours or allow variable attendance. Even for providers who conceptualize their mission more explicitly as a work support for families, it may be logistically challenging to adapt their service delivery design to the needs of nonstandard- and variable-hour workers. It may also be difficult to recruit teachers interested in and able to accept employment that requires nonstandard and variable work hours with the wages and benefits that centers can afford.

- There is some evidence that some providers are discouraged from serving **infants and toddlers** because it is considered difficult and involves additional investments. For example, a 2015 survey of CCDBG program administrators on the barriers to providing infant and toddler care found that 83 percent considered the greatest barrier to be the cost of maintaining ratios. In addition, 41 percent reported concerns with a lack of providers with infant and toddler training, 22 percent cited a lack of interest among providers, 22 percent noted the burden of compliance with regulations and paperwork, and 20 percent pointed to a simple lack of space (Resnick et al. 2015). It would also be interesting to see whether the focus on early education for preschoolers has resulted in some providers self-defining as preschool educators; if so, serving infants and toddlers may seem less consistent with the service model or approach.
- Little research is available as to whether providers have concerns about providing care in **rural areas** other than the issues of unreliable demand and costs described above.
- The broader research base concerning barriers to serving **children with special needs** suggests that many providers are hampered by a lack of confidence in their ability to care for these children. Although most providers believe that programs should be inclusive of children with special needs, they face unfamiliarity, uncertainty, and fear about their ability to serve these children well, especially if they have limited education and experience with this population (Essa et al. 2008; Weglarz-Ward and Santos 2018). These findings are corroborated by parent reports that suggest parents encounter an unwillingness and a lack of provider training related to delivering appropriate services for children with special needs (Forry, Daneri, and Howarth 2013; Grisham-Brown et al. 2010). Interestingly, centers are more likely than licensed family homes to serve children with special needs, especially large centers with the financial capacity to invest in necessary staff training and equipment (Weglarz-Ward and Santos 2018).

What Should States Do to Increase Access and Quality for Priority Populations?

The reauthorized CCDBG directs states to develop strategies that support access to subsidies and high-quality and stable care, particularly for vulnerable populations such as our four focal groups. However, there are several challenges to meeting the needs of these populations, especially through a system that predominantly relies on center-based care. The combination of market and business realities, provider motivation, and—not to be overlooked—parental preferences suggest that both an expanded supply of appropriate services in center-based programs and increased access to quality home-based settings will be essential to meet CCDBG objectives for families in these focal groups. Moreover, child care subsidy administrators are being charged to meet these new quality goals amid longstanding, considerable funding obstacles that limit the scope of their work. Though the March 2018 CCDBG funding increase offers states an exciting opportunity to invest new resources toward achieving the objectives of the CCDBG reauthorization, states must balance many competing demands for these funds in an already underresourced system. Given that the program funds only 15 percent of all eligible families, on top of the particular challenges we've highlighted to serving the four populations in this report, considerable work is yet to be done.

Nonetheless, states will need to take intentional and focused action to support access to quality care *across all sectors*—with a particular focus on home-based settings—to move closer to achieving the access and quality goals of the CCDBG for the populations of focus in this report. This may be particularly important in states that predominantly rely on centers and therefore may have not traditionally served these families. Otherwise, there is a risk that the subsidy program may inadvertently leave behind many low-income children and families who are most vulnerable.

In this section, we first consider four policy tools that states can use in designing their subsidy policies to meet CCDBG goals around access and quality for priority populations. We highlight these tools because they are recommended and accessible to states in the reauthorized CCDBG. We then discuss how these tools can be combined to first expand the supply of care in each setting, including centers as well as licensed and license-exempt home-based arrangements, and then strategically affect supply for each of the four populations.

One theme we emphasize throughout is how much the field still needs to learn about whether and how these policy tools work, for which providers and families they work best, and in what contexts and circumstances. Our discussion underscores how important it will be for states to understand the factors that are most pressing in their home regions (on both the supply and demand sides of the equation) to fashion policy strategies that are evidence-based and that align with the needs of parents, providers, and communities.

Understanding Four Key CCDBG Policy Tools

Tool 1: Offer Financial Incentives to Help Providers Serve Priority Populations through Differential Payment Rates, Bonuses, or Grants

The new law recommends that states establish higher payment rates and/or provide bonuses to address the higher costs of providing quality care to priority populations. This is most directly stated for infants and toddlers, as states are explicitly encouraged to use their set-aside funds for infants and toddlers to establish rate differentials for providers who serve this age group (Matthews et al. 2017). The final rule also directs states to develop strategies to increase the supply and improve the quality of child care services for several other populations (including the ones discussed in this report), and the preamble to the rule encourages states to consider offering differential rates as one such strategy. Thus, states can use payment incentives to encourage providers to serve the populations highlighted in this report and can use these strategies across the full range of settings. In fact, a strategy focused on payment incentives for home-based providers serving priority populations may be an effective approach to encouraging compliance with the new and more rigorous CCDBG standards and regulations that may otherwise discourage some providers from participating in the subsidy system.

The use of payments or financial incentives to encourage providers to serve subsidized families generally, to extend service to specific groups, or to meet identified quality standards is not a new idea (Schulman 2017). Our conversations with experts highlighted a basic set of financial incentives states can work with, though it is important to be clear about definitions as several related terms are often used interchangeably¹³

- **Basic payment (or reimbursement) rates.** The most basic financial strategy affecting provider participation is how much states will pay them to care for children. The CCDBG is based on a principle of paying providers the same amount that they charge private-paying parents, as long as that amount falls at or below a rate ceiling, or cap, established by the state. Therefore, when

policymakers “raise the payment rate,” they may not be increasing the amount paid to all subsidized providers if those providers’ private-pay rates already fell below the previous cap. It does, however, allow providers who previously accepted a subsidized payment rate below their private-pay rate to receive a higher rate that is closer or potentially equal to their private-pay rate. It may also encourage providers who had chosen not to participate when the subsidized rate was below their private-pay rate to join the system.

Since the CCDBG’s inception, states have been encouraged to set rate ceilings at levels that allow parents to access 75 percent of the market (also known as the *75th percentile*), a strategy designed to ensure that their access to child care services is comparable to that of non-CCDBG families. However, the 75th percentile is not a requirement, and state rate ceilings vary widely. Few states actually set their rate ceiling at this level. In 2017, only 2 states set their rate ceilings at the 75th percentile of current market rates, and 23 states set their payment rate ceilings for center-based care for an infant at least 20 percent lower than the 75th percentile (Schulman 2018). Thus, families getting subsidies are only able to access smaller shares of the market unless (1) they can make up the difference between the provider’s rate and the state payment, which is allowed in some states, or (2) providers are willing to accept a lower payment for serving these families and absorb the income loss.

Little information is available about raising rate ceilings to improve the supply of care for special populations, particularly for populations where demand is diffuse. More information is needed, about both how states design and implement such strategies and their possible impact.

- **Tiered payments.** More recently, states have been encouraged to use a tiered payment approach (these are also described in the final rule as “alternative” or “differential” payments). Tiered approaches set payment rates at progressively higher levels, usually to create provider quality incentives or to encourage providers to serve a particular population or engage in specific desired but costly activities. (There are often multiple tiers tied to different levels of quality, though usually just a single higher level for providers serving special populations.)

Though relatively little information is available on this issue, it appears that tiered payments can take one of two forms:

- » **Tiered rates (used to set higher rate ceilings).** States can use tiered rate structures the same way they use rate ceilings—only paying the rate the provider charges or the state rate ceiling, whichever is lower—but could raise the ceiling selectively for priority groups. This may create an opportunity for providers who serve these children, and whose private-pay

rates are higher than the ceiling set for base payments, to participate in the subsidy program. It also may allow providers that already participate (but receive a subsidized payment below their private-pay rate) to receive higher payment for services they are already providing. The difference between the base rate and tiered rate would shape how many additional providers might be affected and by how much, either because new providers would be able to participate in the subsidy system under the higher rate ceiling or because current participants could get additional resources. The level of the incentive is also affected by the number of children the provider serves who fit into the special category. This approach would not affect providers whose rates are already below the ceiling. And it remains unknown whether it would effectively encourage providers to start serving families in priority populations if they are not already doing so.

- » **Tiered rates (as bonuses).** States could use tiered rates more as a bonus mechanism, allowing providers to get an additional amount per priority child served without having to charge this higher rate to their private-paying parents. This makes the incentive more broadly available to any provider participating in the subsidy system who is serving or wants to serve the priority group. The power of the incentive would likely depend on the size of the bonus, along with such factors as how many priority children the provider is serving and the costs involved in offering the specialized service. For example, a bonus might not induce a provider to hire a more highly trained teacher to serve only a few children, whereas it could make a difference for providers serving significant numbers of priority children.

These tiered payments are also affected by the low rate caps set by states. For example, in 2017, more than two-thirds of states using tiered payment rates still set their highest tier below the 75th percentile (Schulman and Blank 2017). In the case of infants and toddlers, states already set rates that are higher than the rates they set for older children (reflective of the difference in costs and private-pay rates for care for infants and toddlers versus care for older children), but the payment rate ceilings for infants and toddlers in most states still do not allow parents to access 75 percent of the market (Schulman 2018).

- **Bonuses.** States can also provide a straight bonus to providers who serve particular populations. States using bonuses calculate and pay them in various ways. States can pay bonuses monthly or quarterly, and they can be incorporated into the payment rate or paid separately. As described above, bonuses do not have to be linked to the rates the provider charges private-pay families, and they thus may be more evenly distributed across different

levels of providers. The effectiveness of this strategy likely relates to the size of the bonus and the ease or difficulty of accessing it.

- **Grants.** Finally, states can use grants or one-time financial investments to help providers overcome some of the one-time cost barriers needed to gear up a program to provide quality care to priority populations. New providers in particular may be hesitant to invest in the physical outlays and human capital investments necessary to effectively expand services to these populations without grants in addition to higher payment levels or bonuses.

Though it is not always clear which of the above strategies is being evaluated, research has found that the size of the financial incentive makes a difference (Gormley and Lucas 2000; Greenberg et al. 2018; Mitchell 2012; Schulman et al. 2012).

States' familiarity with using rates and grants to incentivize providers makes these strategies relatively straightforward for states to consider as they take steps to support quality and supply for priority populations. However, the current low rates mean that for many states, it will be a big lift to solve the access problem through increasing general payment rate ceilings or establishing targeted tiered reimbursement for priority populations. Also, any strategy that relies upon paying providers what they charge private-paying parents doesn't address the fundamental problem mentioned earlier, which is that many providers can't charge what it actually costs to provide services to these families. It is not clear whether or how these strategies can affect the behavior of providers whose rates are constrained by the incomes of the families they serve, or whether they can induce providers to *start* serving these populations. Finally, unlike using rates to support higher-quality programs—where the higher rate may be paid for all children in the program—rate-based strategies focusing on building supply for underserved populations may only be effective when providers serve enough children in the category to help them cover the associated higher costs of services.

It is too early to know whether the law will prompt states to implement any of the above financial incentives to a level that will ultimately increase the supply of care, especially high-quality care, to the four groups of interest in this report. Only a few states adopted new or expanded existing tiered rates for higher-quality care between 2016 and 2017 (Schulman and Blank 2017), and even fewer states adopted new or expanded existing differential rates for other specialized types of care, such as care for children with special needs or care during nontraditional hours (Schulman 2017). Furthermore, those states that had such policies appeared to vary widely in how they approached designing and implementing these strategies. (Schulman, 2017), Without new funding, the choice to use scarce funding to improve payment levels was likely to force states to make a trade off between raising rates

and reducing the total families served by the CCDBG. However, the new funding recently passed by Congress could reduce the starkness of these tradeoffs and allow states to make progress in this area.

STRATEGIES TO CONSIDER

- **Target incentives across settings.** States could implement targeted financial incentives high enough to increase the supply of quality care for these priority populations across both centers and family child care homes. Within the home-based sector, states could offer financial incentives to both licensed and license-exempt providers serving priority populations. Such incentives may stem the loss of family child care homes from the subsidy system.
- **Focus on providers facing cost barriers.** Raising the payment ceilings and providing bonuses may be effective for programs, especially centers, that face inadequate demand owing to the current cost of providing the service (as may be a good part of the barrier for serving infants and toddlers).
- **Explore effectiveness of strategies.** States could work with providers and researchers to explore the relative effectiveness of the different financial incentive strategies to support this kind of targeted supply-building strategy. Of particular interest is the responsiveness of providers across sectors to distinct incentive types and amounts.
- **Use one-time grants to overcome start-up costs.** States could maintain a targeted supply of funds to use for grants to address barriers for center-based and family child care providers that might be interested in starting to serve these families—such as the cost of special equipment, fixing physical space, and building costs. These funds could be provided when it is reasonable to assume that sufficient and stable demand warrants the investment. As mentioned earlier, states should be encouraged to analyze potential demand as a way to determine such awards.
- **Target grants to home-based settings to comply with new requirements.** States could provide small grants to help license-exempt home-based providers bring their homes into compliance with new standards and to encourage quality improvements for family, friend, and neighbor providers in the subsidy system who are serving vulnerable children, especially those in the four priority populations discussed in this report. Resource constraints may impede setting up homes to meet important safety regulations and to complete health and safety trainings, especially for economically disadvantaged providers. Small grants, especially when paired with technical assistance and free trainings (see below), may stem the loss of license-exempt providers from the subsidy system and may encourage some license-exempt providers to become licensed and participate in quality initiatives (IAFC 2015; Porter 2007).

RESEARCH QUESTIONS TO EXPLORE

Limited information is available on why states design the payment policies they do or how different financial incentives affect provider and consumer behavior. Thus, more research is needed on the payment approaches states offer, their implication for increasing care quality and access to diverse populations, and how they may affect different providers differently. Such research questions include the following:

- **Do low payment rate ceilings differentially constrain access for special populations?** It would be interesting to examine whether low rate ceilings particularly constrain access to care for subsidized families in these priority populations. If this is the case, a core strategy to support access to them may be to encourage states to raise their rate ceiling to the 75th percentile; this would allow more providers with higher rates, including those who charge more because of serving special populations, to serve children in the subsidy system.
- **Under what circumstances are payment incentives likely to be more effective?** Though little information is available about this question, it seems likely that payment incentives might be more effective for two types of providers:
 - » *Center and home-based providers who are already serving priority populations.* These providers may be more amenable to payment incentives as they have demonstrated their commitment, know what serving these families entails, and have already invested in the necessary additional infrastructure and staff development for at least some portion of their clients. If providers are confident that demand is high enough and that their costs would be reimbursed, expanding services may seem both reasonable and desirable. Further, raising the ceiling is likely to make it much easier for providers who are serving target populations but not currently accepting subsidized families to consider doing so.
 - » *Providers for whom cost has been the primary barrier to serving priority populations.* For these providers, the financial incentives would need to be large enough to cover any additional start-up and ongoing costs necessary to serve new populations, such as higher staff costs, the addition of transportation supports for rural families, and new investments in facility accommodations for children needing care outside daytime hours, infants and toddlers, and children with special needs (Schulman 2017).
- **Under what circumstances might payment incentives be less effective?** While there is relatively little information on this issue, payment incentives could have little effect on the following constraints:

- » Provider attitudes, or their lack of desire or feelings of unpreparedness to meet the needs of families in these priority groups.
 - » Inadequate or unreliable demand for services. Rate strategies may have little impact on providers who cannot expect to reliably serve a significant number of subsidized children from a particular target population.
- **Do financial incentives targeted toward serving priority populations shape provider behavior in the same way as financial incentives aimed at improving overall quality?** For example, centers serving larger numbers of children receiving subsidies may be more likely to respond to tiered rate incentives around quality (Schulman and Blank 2016) because the additional per child funds will apply to the whole center, and thus seem more likely to allow a provider to pay more qualified staff and so on. Is this likely to also be true for special populations where providers may be serving smaller numbers of children that allow them to receive a higher rate?

Tool 2: Strategically Use Contract-Based Financing to Support the Supply of Care for Priority Populations

Almost 9 in 10 children in subsidized care are paid for with certificates or vouchers.¹⁴ In a voucher system, a parent applies for a subsidy and seeks care from within the private child care market; the state reimburses the provider per child, typically with the addition of a parental co-payment. Parents can change providers at will and take their voucher with them to their next provider if they are still eligible, meaning providers are not sure how many subsidized families they will be serving from one week to the next. While this approach can maximize flexibility and choice from a parent perspective, reliance on vouchers can create more risk for child care providers who cannot count on sufficient or reliable demand for ongoing service. Thus, even with financial incentives for specific populations, providers in a voucher system can still find it challenging to invest in serving a particular population if demand for care by parents with vouchers is unsteady and/or insufficient.¹⁵

Partly out of recognition of these challenges, contract-based payment mechanisms are getting greater attention as a strategy to increase quality and supply in a targeted way (especially for vulnerable populations and geographic areas), and to stabilize funding and ensure providers are paid in a timely manner. States can contract with providers (most commonly with centers but also with family child care homes and networks of family child care homes) for a block of slots rather than reimbursing per child, and states may commit to the payment for a specified period (e.g., a year) contingent on certain performance measures being met. Thus, providers who have a contract are paid based on

enrollment rather than attendance and have the security, at least for the specified period of the contract, that payments will be reliable. Contracted providers may receive higher payment rates in return for meeting higher quality standards or offering additional services, such as parent support services or developmental screenings. The law encourages states to use contracts to increase the supply of child care for priority populations, such as children with special needs, infants and toddlers, and targeted geographic areas.

Overall, although the empirical base is limited, contracts appear to have the potential to increase the supply and consistency of care by stabilizing enrollment—and hence revenue—over a defined period, thus reducing provider uncertainty and improving the program’s financial viability (NCCCSIA 2016; Weber and Grobe 2015). In these ways, contracts may expand parental choice for some families, especially those poorly served by vouchers. However, contracts involve trade-offs, including the potential for limiting parental choice for some families or making it more difficult for families to change providers to accommodate changing needs (Adams and Katz 2015).¹⁶

STRATEGIES TO CONSIDER

Although contracts are not a CCDBG requirement, states are encouraged to use them to improve the supply of quality child care, generally and for priority populations. Ideas include these two:

- **Base contracting decisions on good demand data.** Best practices suggest that states base contracting decisions on sound data about demand for services to maximize likelihood of sufficient enrollment. States should also provide ongoing technical assistance, supports, and monitoring to contracted providers, and adopt clear goals and accountability mechanisms (NCCCSIA 2016).
- **Set up family child care networks and use contracts to support them.** Some research suggests that using contracts to support networks of family child care providers can increase the quality of such care, reduce the administrative burden on subsidy offices by facilitating the placement of subsidized children with particular needs into appropriate family child care homes, and stabilize revenue for providers (Bromer and Porter 2017). Family child care networks provide services and supports to family child care providers, including home visits, technical assistance and coaching, training and peer networking, support for business and administrative tasks, and materials and equipment (Bromer et al. 2009). The Office of Child Care reports that at least 12 states indicated that they intend to develop or expand family child care networks in their 2016–18 CCDBG plans (Bromer and Porter 2017). However, more information is needed about how to build strong networks to maximize the likelihood that they will function effectively and stay in operation.

RESEARCH QUESTIONS TO EXPLORE

States differ significantly in how they design and implement contracts, and there is limited research about the pros and cons of different approaches (Adams and Katz 2015; Schumacher, Irish, and Greenberg 2003; Weber and Grobe 2015). Research questions that are important to understand include these three:

- **Under what circumstances can contracts effectively support supply for special populations?** There is little information on this issue, but contracts may work most effectively when demand for care in a particular center or program is sufficient to guarantee full or close-to-full enrollment, and where without the contract, either cost or provider willingness to invest in such services is a primary barrier.
- **Can contracts be used to support small numbers of slots for priority populations?** Contracts are often discussed as strategies to support a program, or a classroom of children. Can they be used to support services in centers or home-based settings where demand is smaller but steady—for example, a few children with special needs, or a few families with nontraditional-hour needs?
- **What circumstances are not auspicious for contracts?** Contracts may not be effective in situations where demand is inadequate, unstable, or diffuse; where the cost is too high (unless the contract is coupled with financial incentives); where providers are not willing or ready; or where parental preferences lead them to make other choices.

Tool 3: Target Training, Technical Assistance, or Other Resources to Support Supply and Access for Priority Populations

The new law recognizes that it may be challenging for providers to extend services to the identified priority populations without training, technical assistance, or other resources. States have diverse opportunities to support providers as a way of expanding access for the populations discussed in this report, and to encourage investment in quality, improve business practices, and promote compliance with new standards.

STRATEGIES TO CONSIDER

Training and technical assistance, as well as small grants to pay for training and program improvements, can help overcome some barriers around provider readiness, as well as proactively support home-based

providers affected by the new CCDBG requirements. For example, states could use training and technical assistance resources and activities in the following ways:

- **Support licensed family child care homes and license-exempt providers' efforts to meet new health and safety standards and improve quality.** States could help license-exempt providers meet the new health and safety requirements and raise program quality by adopting unique approaches geared toward this setting, including cohort or peer group training models, individualized mentoring; tuition assistance or free training; and training monitors and staff with expertise in home-based child care. License-exempt providers might also respond more positively toward training approaches that use a community organizing approach rather than a traditional early childhood education/professional development approach (Bromer and Weaver 2016; Douglass et al. 2017).

Recent research indicates untapped demand for training and support to improve quality overall in home-based settings, yet the evidence base remains limited regarding the most effective ways to engage and support the diverse home-based sector (Bromer and Korfmacher 2017; Tonyan, Paulsell, and Shivers 2017). States should explore varied delivery models, including self-paced online courses, as well as supports to ensure providers have the necessary time and funding to fully participate.

- **Address provider concerns around serving specific populations—such as children with disabilities and special needs—or provide the additional knowledge and skills necessary to meet quality standards for effectively serving children in priority groups.** The CCDBG final rule encourages states to develop optional health and safety topics to help educate providers about caring for children with special needs and infants and toddlers; it also encourages states to use the infant-toddler quality set-aside to improve provider capacity for high-quality, age-appropriate infant-toddler care. Suggested ways to use the quality set-aside include the establishment of resource centers and staffed family child care networks that can support providers through mentoring, coaching, and other supports.

RESEARCH QUESTIONS TO EXPLORE

More information is needed about the specific concerns and needs of different providers when it comes to serving children in these priority groups. Such information is critical in designing training and technical assistance activities that are effective and targeted. Research questions to consider include the following three:

- **How can states assess providers' key concerns around serving populations with whom they are unfamiliar or have limited experience providing care?** It would be useful for communities to survey providers across sectors about their concerns and the challenges they would expect to encounter if they extended services to these priority populations. Providers could also be asked about the services they would find useful for expanding the reach of their programs.
- **What can we learn from child care providers and others serving these populations?** It would be helpful to learn from professionals and paraprofessionals already providing care to these populations about best practices, and to model quality enhancements and provider trainings accordingly.
- **Are there creative ways to deliver health and safety trainings and other quality enhancements to license-exempt home-based providers?** How can we best help license-exempt providers comply with new quality standards, given they may have fewer resources and be less familiar with and less connected to professional development opportunities?

Tool 4: Develop Targeted Consumer Education Efforts

The emphasis on consumer education in the new CCDBG law provides an exciting opportunity to tailor strategies that increase the awareness and knowledge about child care availability, access, and quality across various care settings for each priority population. The law requires states to improve consumer education overall so all parents are more knowledgeable and better able to make informed child care choices. Although a consumer education strategy on its own cannot solve access inequities stemming from supply shortages for particular populations, it is still a critical piece of a multipronged approach to expanding knowledge and use of high-quality programs. New CCDBG requirements stress greater transparency about subsidy program eligibility and application procedures, identification of providers who accept subsidies, and provider quality and compliance histories with health and safety standards. States are also required to increase consumer education around what quality child care and early education looks like (Matthews et al. 2017).

STRATEGIES TO CONSIDER

As states design or revise consumer education strategies to address these new requirements, it will be important to keep the needs of the four priority populations in mind.

- Given the principle of parental choice in CCDBG and the importance of home-based settings for these populations, **consumer education efforts should reflect information about best**

practices and list both center-based and home-based providers as feasible options for families.

- **Strategies will likely be most effective if they offer search support and education that aligns with how parents approach the child care decision process** (National Center on Early Childhood Quality Assurance 2017a). Here are a few examples:
 - » Web-based consumer education sites, including those that are part of state QRIS systems, could include filters for what quality characteristics parents should look for when seeking care for infants and toddlers, for children with special needs, or at nontraditional times. These filters could also allow parents to restrict searches to providers that serve these populations and to providers who offer transportation services, individualized intervention services, providers trained to administer medicine, or other family supports.
 - » Consumer education efforts could capitalize on the fact that many parents learn from one another about child care alternatives (see Forry et al. 2013). Thus, the tailored messaging that states provide via consumer education websites will broaden its reach if it is designed to be easily shared by parents through their personal contacts and social media outlets (National Center on Early Childhood Quality Assurance 2017a).
 - » Some targeted messaging might also be placed in sites frequented by families in these priority populations. For example, flyers placed strategically in work sites that employ workers outside weekday hours, or distributed in health care settings and through parent support groups for children with special needs, may be effective ways to reach these populations (Matthews et al. 2017).

RESEARCH QUESTIONS TO EXPLORE

Consumer education strategies are likely to be most effective when they are based on an understanding of parent's interests, concerns, and priorities. Yet knowledge gaps remain about what influences care decisions for parents in these priority groups or how distinct consumer education strategies might affect decisions.

- **What can we learn from parents in each priority population about their interests, concerns, and priorities when using the CCDBG program to access high-quality child care that meets their families' needs?** Much more needs to be understood about how families in these four groups learn about the child care subsidy program (and what keeps them from knowing about it and using it) and how they make decisions about using the kinds of child care available to them.

- **Which of the strategies above, or other strategies, can most effectively inform parents about child care alternatives to meet particular needs?** Systematic research on the effectiveness of different consumer education strategies for distinct population groups is necessary to improve the targeting of strategies.

Packaging Multiple Tools to Create Carefully Targeted Strategies

The complexity of challenges described in the preceding pages makes it clear that it is unlikely that any single policy approach will adequately address the specific circumstances and needs of families and those of the providers who wish to serve them. None of the four policy levers will work to increase quality or supply to all populations all the time, and the levers are less likely to work in isolation. Thus, to effectively expand access to the populations of focus in this report, it is important that states develop a multipronged approach, using a carefully targeted combination of the different strategies described above. To be most effective, the specific combination of strategies should be based, whenever possible, on an understanding of the unique market forces, community characteristics, family circumstances and needs, and provider strengths and challenges.

Supporting the Supply and Quality of Particular Child Care Settings

To improve the ability of these target groups to access care that meets their needs, states will need to assertively support the supply of the full range of child care settings. It is also important to consider which tools will affect which barriers and whether they are sufficient to overcome concerns about insufficient and unreliable demand, additional costs, or lack of provider preparedness. The tools also may not address underlying personal preferences for home-based settings, which may factor into decision making for some parents. This underscores the importance of developing strategies that focus on the home-based sector as well as centers.¹⁷

Some suggested policy packages that states could put together to support access within each type of care are described below.

CENTER-BASED CARE

Given the reality that the majority of subsidies are being spent in child care centers across the country, it will be important for states to develop targeted efforts to increase how many centers are available to priority populations. Ideally, states would take the following steps:

- **Work with center-based providers to better understand their barriers to serving priority populations**, in order to identify appropriate policy strategies. Moreover, states can work with researchers to better estimate demand for center-based care among priority populations and their barriers to using center alternatives.
- **Develop packages of strategies designed to affect the specific barriers identified above**, using targeted combination of adequate financial incentives, contracts, training and technical assistance, and consumer education.

LICENSED HOME-BASED CARE

Not only have licensed family child care homes declined as a proportion of all subsidized arrangements (Mohan 2017), but the total number of licensed family child care homes has declined nationwide.¹⁸ Yet licensed family child care homes may be a particularly promising sector on which to target quality improvement efforts. These providers are already part of a state's licensing and regulatory system and many already serve children with special needs and infants and toddlers; many also provide care outside traditional hours and in rural areas. Though we could not find research on this topic, licensed family child care homes may face lower cost barriers to expanding their services to some priority populations. For example, they can provide services without the same level of concentrated demand as a center requires; they do not have to staff an entire classroom because they serve only a small number of children, usually of mixed ages. Similarly, it may not be as big a hurdle for licensed family child care homes to care for children in the evening or overnight, as their homes are equipped with kitchens and may already include a bedroom that could be set up for a child to spend the night. Moreover, family child care meets the needs of parents who prefer the intimacy of a home-based setting. On the other hand, family child care programs do not benefit from the economies of scale that larger child care centers experience (Weglarz-Ward and Santos 2018).

Thus, it is important for states with weaker supply of home-based settings to consider building their supply of licensed family child care and to ensure that families receiving subsidies can access these homes. With a multipronged, targeted strategy of supports and incentives, licensed family child care providers may find it more appealing to provide care to special populations and may welcome the

opportunity to engage more with the subsidy system, participate in quality initiatives, and further professionalize and develop their child care and early education programs.

In addition to using a combination of the four policy tools identified above strategically to support licensed family child care settings, states might want to take the following steps:

- **Assess whether the number of licensed family child care homes has declined, statewide as well as specifically in the subsidy program. If yes, understand the reasons for the decline to design appropriate strategies for increasing supply.** Different reasons have been hypothesized for the decline in family child care homes nationwide, though little has been proven at this point.¹⁹ To help support the supply of family child care, states need to identify the factors at work and develop strategies to counteract them.
- **Examine whether the state QRIS system is designed to reflect the special strengths of licensed family child care settings.** Assessing QRIS in this way could ensure that incentives created by the QRIS system, and any subsidy-related strategies to guide parents to QRIS-rated programs, don't inadvertently advantage centers or disadvantage home-based settings.
- **Develop packages of strategies designed to affect the specific barriers identified above,** using targeted combinations of adequate financial incentives, contracts, training and technical assistance, and consumer education.

LICENSE-EXEMPT HOME-BASED CAREGIVERS

License-exempt caregivers play a critical role in supporting the child care needs of many of these priority populations. Yet the current CCDBG law creates disincentives for their participation in the subsidy program, and they are only a small fraction of the providers in the system. States recognizing a need for this child care sector will benefit from identifying targeted ways to support the participation of license-exempt home-based caregivers in the subsidy system and to help them invest in quality enhancements. Given the diversity in which home-based settings can be legally exempt in different states, it is important to provide varied strategies.

Because there has been less focus on license-exempt providers in the quality literature, we suggest several strategies below, in addition to the four policy tools discussed earlier:

- **Work with license-exempt providers to understand their needs, motivations, and incentives.** States should ensure that they have talked with their license-exempt subsidized providers, so states understand what they need, what barriers they face, and how to best design trainings to

meet their needs. States should also try to learn from license-exempt unsubsidized caregivers about potential barriers that keep them outside the subsidy system.

- **Resist narrowly tying child care subsidies to QRIS.** A tight link between QRIS and acceptable providers for subsidy payments can make it more challenging for parents who rely on license-exempt settings to enroll in the subsidy program. State QRIS programs seldom include license-exempt home-based providers in the rated system, which can limit their participation in the subsidy program.
- **Minimize barriers to compliance with the new law for relative caregivers.** CCDBG does not require states to impose new health and safety standards on relatives caring for related children. States could help sustain the willingness and ability of relative providers to care for their family members who prefer this arrangement, or who lack access to formal child care and early education arrangements, by not imposing new standards on relative caregivers and by working closely with them (supportively rather than punitively) to encourage quality.
- **Fund organizations that can support license-exempt caregivers.** Intermediary organizations can provide important supports to license-exempt caregivers, such as technical assistance, training, and other resources. These organizations can also function as a liaison between the subsidy agency and license-exempt caregivers to ensure clear communication and to help the subsidy agency understand the needs of this sector.
- **Encourage local collaboration between license-exempt home-based providers and formal early care and education programs and other child-serving community organizations.** Recognizing that different providers and programs have unique strengths and resources, states can launch collaborations between child care, early education, and other programs working with children and families. These collaborations might include relationships between license-exempt providers and Child Care Resource and Referral agencies that sometimes have trained specialists to work with license-exempt providers (Bromer and Weaver 2016). Collaborations can also be set up between license-exempt home-based providers and Early Head Start to address the educational and socioemotional needs of infants and toddlers, or with early intervention services that support children with special needs. Partnerships with other community programs such as mobile libraries, recreational sports programs, and other supports that encourage social-emotional and cognitive development can supplement home-based programs (Paulsell et al. 2010). These types of collaborations would be particularly useful for providers who may be unable to offer such services on their own because of limited resources or training, distance from activities, or smaller size. For effective collaborations, it is important

to provide transportation assistance between programs, work closely to align programs, and offer financial incentives for participation (IAFC 2015).

Supporting the Supply of Quality Care for Particular Populations

In addition to strategically targeting specific child care sectors, states should develop packages of carefully selected policies that address the challenges facing each vulnerable population examined in this report. Again, each of these would benefit from a better understanding of demand and supply barriers for each type of care, overall and within states. Brief examples are provided below.

NONSTANDARD AND VARIABLE-HOUR CARE

A strategy that effectively increases access and quality of care to families needing child care during nontraditional or variable hours would benefit from (1) the establishment of financial incentives for providers across settings serving children outside standard daytime/weekday hours, including home-based settings and legally unlicensed caregivers; (2) the strategic use of contracts and capacity grants, based on careful analysis of demand, to support targeted supply-building efforts in areas with sufficient, steady demand for nonstandard-hour care; (3) targeted training and technical assistance to help providers understand how to best meet the needs of these families; (4) use of consumer education strategies to increase information about the location of child care services that are offered outside traditional daytime, weekday hours and that allow for variable-hour care needs; (5) the implementation of practices that allow a more flexible link between parental work hours and authorized child care hours (it is possible, for example, for states to allow a family to use a high-quality center although the child care hours do not align with all of a parent's work hours); and (6) use of expanded definitions of quality care to include the particular characteristics and activities of greatest importance to children being cared for outside daytime, weekday hours. States would also benefit from additional study regarding the care that families who need care outside standard daytime/weekday hours prefer and the constraints they face in accessing services.

INFANT AND TODDLER CARE

An effective strategy to serve more infants and toddlers could simultaneously offer (1) increased financial incentives for various providers, including home-based settings and legally unlicensed caregivers; (2) contracts to both centers and family child care homes and networks to serve this age group; (3) targeted training and grants to help providers with start-up costs and help providers overcome concerns about serving this population; and (4) consumer education about the importance of

quality care for infants and toddler’s healthy development. This approach is particularly plausible for infants and toddlers because the reauthorized law requires states to earmark at least 3 percent of CCDBG funds for quality improvement efforts targeted at infants and toddlers, and cost of care is a primary barrier.

RURAL FAMILIES

A strategy that effectively increases access and quality of care to rural families might include (1) establishing financial incentives for rural providers, set at adequate levels to support supply and quality providers across settings serving rural children, including home-based settings and license-exempt caregivers; (2) awarding grants to providers for transportation and collaboration with community programs and other services to reduce isolation and connect home-based rural providers to formal programming; (3) strategically using contracts and capacity grants, based on careful analysis of demand, to support the establishment of centers and/or family child care networks in areas with sufficient, steady demand; and (4) using consumer education strategies to increase information about the location of child care services and the availability of transportation to these services. States could also look closely at their approaches to setting rates for rural areas; market-rate strategies often assign rural providers the lowest rates, which can be a disincentive.

CHILDREN WITH SPECIAL NEEDS

A strategy to address the challenges of families with children with special needs might include (1) carefully assessing the kinds of barriers faced by these families in states and communities, including an examination of demand, preferences, and supply opportunities and constraints; (2) establishing financial incentives to providers across settings (including home-based settings and legally unlicensed caregivers) to serve children with special needs; (3) issuing grants and contracts to providers to support investments in facility infrastructure and equipment that make programs more accessible; (4) developing training and technical assistance strategies to help providers gain skills for serving children with special needs; and (5) developing consumer education strategies about the availability of developmental screenings, early intervention services, and the benefits of high-quality interventions.

Conclusions

Strengthening the child care subsidy program's ability to effectively support children's developmental outcomes is an important and laudable goal, one that was urged in earlier writings by these authors (Adams and Rohacek 2002). As policymakers have increasingly pursued a child developmental focus with CCDBG policy, center-based care has increased its share of the subsidized child care market. In this report, we raise concerns that such a shift could inadvertently reduce the accessibility of subsidized child care for the millions of American families for whom center-based care is unavailable, unviable, or undesirable. Specifically, we highlight four populations we believe may face barriers to accessing subsidies and quality care given the subsidy system's move toward conventional center care alternatives over other child care settings. Children in these four populations make up a substantial proportion of all children who could be eligible for child care assistance; they also need high-quality child care alternatives while their parents work or participate in education and training.

To effectively ensure that the full range of eligible families can access subsidized quality care, we argue that it is essential to ensure that families can use their subsidies in a range of programs that meet their needs. We consider four policy tools for state efforts to increase supply and quality across sectors to the four populations of focus: financial incentives; contract-based financing; training, technical assistance and supports; and consumer education. We argue that when considered in combination, and with particular attention to population needs and a diverse array of child care settings, these tools could increase access to quality child care for families who need care during nonstandard hours, families with infants and toddlers, families living in rural areas, and families who have children with special needs. It is important for states to review the new CCDBG provisions systematically, paying attention to how each could either increase or reduce barriers and costs to providers and make it easier or more difficult for families to participate in the program. States can then consider these policy tools in developing methods that make sense for the particular barriers to participation and cost considerations that their state faces in a targeted fashion.

Overall, we suggest that policymakers, stakeholders, and advocates consider a few overarching issues as they try to meet the needs of families in these priority groups:

- **Ultimately a multifaceted strategy is needed to increase access to affordable, quality child care for families needing care during nonstandard hours, for infants and toddlers, in rural areas, and for children with special needs.** The CCDBG reauthorization presents states with

several policy tools can be strategically combined to support providers across different setting types, and to increase quality care options for these priority populations.

- **States can effectively meet the goals of the CCDBG to support parental employment and child development for all low-income families *only if* they use these tools to actively support quality and access for home-based settings as well as center-based settings.** Our findings suggest that it is particularly important that these efforts include both licensed and license-exempt home-based care. Efforts should also focus on ways to help centers more effectively meet the needs of groups for whom centers are currently less accessible.
- **States will require considerable resources to address the issues raised in this report while reforming their CCDBG programs to comply with both reauthorization and access and quality objectives for all families, including the populations targeted here.** Since the inception of CCDBG, inadequate funding has fundamentally undercut efforts to increase supply and improve access to high-quality child care programs. Funding constraints have also limited the ability of states to meet the dual-generation goals of the program. The new funds should help this challenge, though states still face competing priorities. Thus, states would benefit from developing and expanding existing creative partnerships with Head Start and similar programs, public health departments, schools, libraries, and other community agencies to support the health, safety, and quality objectives of CCDBG.
- **It is important to develop and use a multidimensional definition of quality that includes the diverse ways in which child care providers support children and families across settings and throughout the 24-hour, 7-days-a-week schedule that constitutes the realities of nonparental care environments.** To increase access to high-quality arrangements for low-income children in these four populations, states need to develop quality standards and policy approaches to increasing the supply of child care alternatives that consider the different aims and functions of child care. This includes, for example, the purpose and function of care offered at different times of day, offered in different settings, and serving different family needs. There is important work to be done to satisfactorily build diverse concepts of quality into training and TA supports, and to adopt provider approval and payment processes that reward quality in its many forms.
- **States clearly need more and better information to inform their decisions about how to best increase access to high-quality child care across sectors for vulnerable populations.** This information includes increased knowledge about how to best define quality for these families, the particular barriers to child care supply, the scope and concentration of demand, the

preferences that shape supply and access for diverse populations, and the effectiveness of different policy levers. A major challenge facing states wishing to design policy strategies to address barriers to supply and quality care is that the research base that can inform their efforts is relatively small. We have highlighted evidence gaps about the complex needs of the priority populations of focus in this report and the factors that shape provider decisions to serve them. We have identified some key research questions in this report, although our list is not exhaustive. The answers to these questions are likely to be shaped by unique state and local policies, labor markets, demographics, culture, and so forth. States need better information about these issues to use resources wisely and strategically. Thus, we urge researchers to continue working with states to fill these important knowledge gaps, leading to the design of better policies that improve access and quality of care for all families.

It is critical that as the country considers strategies to support work for low-income parents while supporting the development of their children, we ensure that the policies put in place meet the needs of the full range of low-income parents. To do so, we must fully understand the parent's point of view and understand the provider's perspectives and constraints in serving families and children with different needs and in different contexts. It is only by recognizing the unique challenges faced by families and providers, and by implementing strategies to support high-quality care in the full range of settings, that we will be able to finally meet the dual goals of CCDBG to support both parental employment and child development for our vulnerable children and families.

Appendix A. The Child Care and Development Fund and Its Reauthorization: An Overview

The CCDBG is the nation's child care assistance program, helping to pay for child care for 1.4 million children in the United States each month.²⁰ Over \$11 billion in federal and state funds were spent on child care assistance for low-income families in 2014 (Matthews and Walker 2016). Yet, the program's funding levels are sufficient to serve only a fraction of eligible families: most recent estimates are that 16 percent of those eligible under federal guidelines were served in 2012 (Chien 2015). The program is funded as a federal block grant to states. Several states supplement the grant with funds from the Temporary Assistance for Needy Families program, state general revenue, and in some cases federal Title XX dollars. The federal CCDBG law governs the CCDBG program and includes key parameters and guidance for states on who can receive services, how much providers can be paid, and how funds can be used, while allowing states considerable discretion in how they design and implement the program within these parameters. The CCDBG program was reauthorized in 2014 with significant changes to the law designed to increase families' access to high-quality child care.²¹

Since its inception, the program's two overarching goals have been to "promote both the healthy development of children and parents' pathways to economic stability."²² To accomplish these goals, most of the funds are used to provide child care assistance to low-income parents who need help paying for child care so they can work or receive education and training. The program also requires states to use a percentage of CCDBG funds to support the quality of care in their state both overall and specifically for children receiving subsidies.

In addition, a central purpose of the law is "to promote parental choice to empower working parents to make their own decisions regarding the child care services that best suits their family's needs" (Child Care and Development Fund, 45 CFR § 98.1 (a) (2) (2016)). Parental choice of provider has been a core principle of the program since its inception. As a result, provider participation across child care sectors has been a critical feature of the program to broaden access to families with diverse care preferences and needs. For example, families use subsidies to enroll children in centers, licensed family child care homes, and license-exempt homes (e.g., family, friend, and neighbor providers).

The CCDBG reauthorization reaffirmed many of the principles and basic program structure described above, but it also tightened federal guidelines for state compliance with goal of simplifying access and reducing program instability for families, and increasing safety and quality of subsidized care. The requirements concerning quality are the most relevant to the issues raised in this paper. For example, the new law includes requirements around consumer education that aim to increase parental knowledge and access to safe and quality child care settings. The new law also strengthens requirements regarding provider qualifications including the implementation of mandatory background checks, health and safety standards, and ongoing monitoring and inspection of child care settings for compliance with health, safety, and fire standards. Moreover, the law instructs states to invest resources in quality improvement activities and adopt training and professional development criteria for providers to meet. To encourage providers to participate in CCDBG and to incentivize providers to improve the quality of their services, the law requires that states establish payment rates and practices that ensure equal access to child care services comparable to those provided to non-CCDBG families and encourages the establishment of payment rates that reward investments in quality and that expand the reach of their services.

States vary in the approaches they are taking to meet the law's dual objectives of increased access to high-quality and stable care for vulnerable families and improved work outcomes for parents. States are currently at different phases of implementation of the reauthorized law. Several states already have policies in place that are consistent with many aspects of the new law, others have begun to implement some new policies in accordance to certain provisions but not others, and still others are planning for implementation but have either received waivers or are otherwise not yet in compliance with the new law (Schulman 2017).

Appendix B. National and State Data on CCDBG-Subsidized Children Served in Child Care Centers, 1998–2015

TABLE B.1

Average Monthly Shares of Subsidized Children Served in Child Care Centers, by State

State	1998	2006	2015	Percentage-point change, 1998–2015
Alabama	74%	88%	94%	20
Alaska	35%	46%	61%	26
Arizona	73%	74%	85%	12
Arkansas	82%	82%	94%	12
California	70%	46%	54%	-16
Colorado	57%	62%	76%	19
Connecticut	37%	40%	54%	17
Delaware	55%	58%	79%	24
District of Columbia	94%	81%	95%	1
Florida	85%	88%	94%	9
Georgia	76%	85%	92%	16
Hawaii	28%	33%	22%	-8
Idaho	44%	49%	70%	26
Illinois	31%	33%	43%	12
Indiana	36%	55%	61%	25
Iowa	33%	37%	52%	19
Kansas	36%	35%	44%	8
Kentucky	61%	79%	94%	33
Louisiana	49%	74%	92%	43
Maine	29%	52%	66%	37
Maryland	35%	40%	60%	25
Massachusetts	56%	67%	73%	17
Michigan	19%	15%	47%	28
Minnesota	27%	36%	74%	47
Mississippi	69%	73%	91%	22
Missouri	40%	54%	74%	34
Montana	30%	38%	48%	18
Nebraska	58%	53%	70%	12
Nevada	82%	86%	77%	-5
New Hampshire	-	61%	88%	-
New Jersey	74%	76%	90%	16
New Mexico	43%	53%	80%	37
New York	41%	28%	42%	1
North Carolina	81%	81%	88%	7
North Dakota	26%	26%	39%	13
Ohio	65%	59%	81%	16

State	1998	2006	2015	Percentage-point change, 1998-2015
Oklahoma	81%	72%	87%	6
Oregon	21%	19%	27%	6
Pennsylvania	59%	48%	78%	19
Rhode Island	65%	67%	75%	10
South Carolina	76%	78%	86%	10
South Dakota	27%	51%	56%	29
Tennessee	73%	79%	84%	11
Texas	79%	79%	96%	17
Utah	65%	38%	67%	-2
Vermont	44%	46%	65%	21
Virginia	54%	61%	80%	26
Washington	41%	43%	57%	16
West Virginia	40%	59%	65%	25
Wisconsin	60%	60%	84%	24
Wyoming	31%	15%	58%	27
National total	56%	57%	73%	17

Sources: Data for all years extracted from Data Fact Sheets available from the US Department of Health and Human Services, Administration for Children and Families, Office of Child Care website. Per the website, “Child Care and Development Fund statistics are compiled through data reported by States and Territories on the ACF-800--Annual Aggregate Child Care Data Report and ACF-801--Monthly Child Care Data Report,” <https://www.acf.hhs.gov/occ/resource/ccdf-statistics>

Note: No data available for New Hampshire in 1998.

Appendix C. American Community Survey 2011–15 Tables and Data Definitions

TABLE C.1

Estimated Number and Share of Low-Income Children Younger Than Age 6 with Working Parents Who Are In at Least One of Three Priority Groups, by State

Children who have parents working mostly nonstandard hours, are infants or toddlers, or live in nonmetropolitan areas

State	All low-income children < 6 with working parents	Of this total, children in at least one priority group	
		#	%
Alabama	80,800	52,500	65%
Alaska	9,700	7,000	71%
Arizona	109,200	62,300	57%
Arkansas	58,200	40,700	70%
California	517,000	279,600	54%
Colorado	68,900	40,400	59%
Connecticut	37,500	19,900	53%
Delaware	13,600	7,700	57%
District of Columbia	8,300	4,900	58%
Florida	305,100	168,200	55%
Georgia	183,600	116,200	63%
Hawaii	13,300	9,000	67%
Idaho	31,900	21,700	68%
Illinois	178,900	105,300	59%
Indiana	115,700	75,500	65%
Iowa	52,400	39,100	75%
Kansas	52,800	37,400	71%
Kentucky	66,600	47,500	71%
Louisiana	94,900	57,200	60%
Maine	15,400	10,700	70%
Maryland	69,100	37,900	55%
Massachusetts	63,000	34,400	55%
Michigan	145,000	97,800	67%
Minnesota	76,500	52,300	68%
Mississippi	65,800	52,700	80%
Missouri	99,900	69,100	69%
Montana	16,200	12,900	80%
Nebraska	35,900	25,400	71%
Nevada	47,500	28,900	61%
New Hampshire	12,500	8,800	71%
New Jersey	94,500	51,000	54%
New Mexico	38,500	27,000	70%
New York	248,400	139,500	56%
North Carolina	165,200	106,900	65%
North Dakota	11,200	9,100	81%

State	All low-income children < 6 with working parents	Of this total, children in at least one priority group	
		#	%
Ohio	183,400	117,900	64%
Oklahoma	73,200	50,800	69%
Oregon	57,700	36,400	63%
Pennsylvania	158,300	95,400	60%
Rhode Island	12,300	6,700	54%
South Carolina	84,100	52,900	63%
South Dakota	17,200	13,300	77%
Tennessee	111,500	70,900	64%
Texas	497,100	287,700	58%
Utah	49,900	29,700	60%
Vermont	7,300	6,600	90%
Virginia	102,600	61,700	60%
Washington	91,900	55,000	60%
West Virginia	23,800	17,500	74%
Wisconsin	89,600	59,800	67%
Wyoming	8,600	7,400	86%
50 state and DC total	4,771,600	2,925,800	61%

Source: 2011–15 American Community Survey five-year estimates.

Note: See pages 55–56 for definitions of low income, priority groups, and other terms.

TABLE C.2

Estimated Number and Share of Low-Income Children Younger Than Age 6 with Working Parents, Who Have Parents Working Some and Majority Nonstandard Hours, Are Infants and Toddlers, or Live in Nonmetropolitan Areas

State	All low-income children < 6 with working parents	Of this total, children whose parents work <i>some</i> nonstandard hours		Of this total, children whose parents work <i>majority</i> nonstandard hours		Of this total, children who are infants and toddlers		Of this total, children who live in nonmetropolitan areas	
	#	#	%	#	%	#	%	#	%
Alabama	80,800	54,400	67%	12,000	15%	36,500	45%	20,400	25%
Alaska	9,700	4,600	47%	1,400	14%	4,200	43%	3,600	37%
Arizona	109,200	69,800	64%	16,600	15%	49,600	45%	7,400	7%
Arkansas	58,200	38,100	66%	9,400	16%	25,700	44%	22,700	39%
California	517,000	278,600	54%	67,900	13%	237,600	46%	11,800	2%
Colorado	68,900	39,300	57%	10,300	15%	31,000	45%	8,000	12%
Connecticut	37,500	20,600	55%	5,300	14%	16,600	44%	1,100	3%
Delaware	13,600	7,600	56%	2,300	17%	6,400	47%	0	0%
District of Columbia	8,300	4,800	58%	1,700	20%	3,900	47%	0	0%
Florida	305,100	165,800	54%	40,900	13%	141,100	46%	12,900	4%
Georgia	183,600	112,200	61%	31,100	17%	85,200	46%	33,800	18%
Hawaii	13,300	8,300	62%	2,600	20%	5,700	43%	3,300	25%
Idaho	31,900	16,300	51%	3,900	12%	14,400	45%	11,100	35%
Illinois	178,900	108,600	61%	29,000	16%	79,200	44%	23,200	13%
Indiana	115,700	72,000	62%	20,100	17%	53,700	46%	25,000	22%
Iowa	52,400	32,800	63%	9,200	18%	23,100	44%	22,500	43%
Kansas	52,800	31,300	59%	9,000	17%	24,900	47%	18,800	36%
Kentucky	66,600	41,500	62%	10,500	16%	30,300	45%	25,200	38%
Louisiana	94,900	59,100	62%	14,500	15%	43,300	46%	16,000	17%
Maine	15,400	7,900	52%	1,400	9%	6,500	42%	6,800	44%
Maryland	69,100	40,000	58%	9,500	14%	31,200	45%	2,100	3%
Massachusetts	63,000	35,200	56%	10,300	16%	28,500	45%	600	1%
Michigan	145,000	84,600	58%	28,200	19%	70,300	48%	29,000	20%
Minnesota	76,500	46,600	61%	13,300	17%	35,900	47%	19,800	26%
Mississippi	65,800	46,600	71%	11,800	18%	28,900	44%	37,100	56%
Missouri	99,900	63,000	63%	13,700	14%	46,700	47%	32,100	32%
Montana	16,200	8,300	51%	1,800	11%	7,400	46%	9,400	58%
Nebraska	35,900	21,900	61%	4,900	14%	17,300	48%	12,600	35%
Nevada	47,500	28,600	60%	9,900	21%	21,500	45%	4,000	9%
New Hampshire	12,500	6,600	53%	1,900	15%	5,200	42%	6,000	48%

State	All low-income children < 6 with working parents	Of this total, children whose parents work <i>some</i> nonstandard hours		Of this total, children whose parents work <i>majority</i> nonstandard hours		Of this total, children who are infants and toddlers		Of this total, children who live in nonmetropolitan areas	
		#	%	#	%	#	%	#	%
New Jersey	94,500	48,100	51%	12,800	14%	44,600	47%	0	0%
New Mexico	38,500	21,800	57%	5,500	14%	16,700	43%	15,500	40%
New York	248,400	111,300	45%	29,600	12%	114,700	46%	18,800	8%
North Carolina	165,200	100,800	61%	25,400	15%	74,400	45%	37,800	23%
North Dakota	11,200	5,900	52%	1,300	11%	5,800	52%	6,100	54%
Ohio	183,400	107,900	59%	35,200	19%	83,800	46%	35,200	19%
Oklahoma	73,200	44,400	61%	11,200	15%	33,500	46%	25,500	35%
Oregon	57,700	32,000	55%	8,200	14%	26,900	47%	11,000	19%
Pennsylvania	158,300	90,700	57%	27,100	17%	72,600	46%	17,900	11%
Rhode Island	12,300	7,000	57%	1,600	13%	5,900	48%	0	0%
South Carolina	84,100	51,100	61%	14,100	17%	37,900	45%	16,000	19%
South Dakota	17,200	9,300	54%	1,700	10%	8,000	46%	9,200	54%
Tennessee	111,500	72,200	65%	19,000	17%	50,000	45%	24,100	22%
Texas	497,100	296,200	60%	63,200	13%	227,400	46%	58,600	12%
Utah	49,900	24,400	49%	7,000	14%	24,000	48%	5,200	10%
Vermont	7,300	3,400	46%	900	12%	3,400	47%	5,100	70%
Virginia	102,600	60,600	59%	15,000	15%	46,700	46%	14,500	14%
Washington	91,900	49,700	54%	12,400	13%	42,700	46%	12,100	13%
West Virginia	23,800	13,900	59%	3,800	16%	11,100	47%	9,700	41%
Wisconsin	89,600	55,000	61%	15,400	17%	41,500	46%	21,700	24%
Wyoming	8,600	4,500	53%	900	10%	4,000	46%	5,900	68%
50 state and DC total	4,771,600	2,765,300	58%	715,900	15%	2,187,400	46%	776,300	16%

Source: 2011–15 American Community Survey five-year estimates.

Note: See pages 55–56 for definitions of low income, some and majority nonstandard hours, and other terms.

Data Definitions

The estimates of population size that we use in this report come from the United States Census Bureau's 2011–15 American Community Survey. The data were collected between January 1, 2011, and December 31, 2015. We use the five-year data instead of relying on data for a single year because it allows for more precise estimates and is preferable for analyzing very small populations and for examining smaller geographies.²³

For our base sample on which all analyses are based, we restrict the sample to

- low-income children, defined as those whose family income in the previous 12 months was 200 percent of the federal poverty threshold or below;
- younger than age 6;
- living in US states and Washington, DC; and
- for whom all principal caregivers are working. For children with a single parent in the household, this parent must be working to be included; for those with two parents in the household, both must be working; for those with no parents in the household, the head of household must be working. Children in group quarters where no parents or head of household were present were dropped.

Below are definitions for the three population groups on which statistics are calculated and displayed in tables C.1 and C.2.

- **Children whose parents work nonstandard hours (any time before 8:00 a.m. or after 6:00 p.m.).** Because the ACS indicates when someone typically arrived at work, but not when they typically leave, we constructed an estimated proxy measure for when children's caretakers departed work by taking their hours usually worked each week, dividing it by five (assuming they worked the standard five days a week), and added the result to the time they typically arrived at work.
 - » *Some nonstandard hours* includes children for whom *all* principal caretakers are working *any* nonstandard hours.
 - » *Majority nonstandard hours* includes children whose principal caretakers primarily work nonstandard hours. More specifically, of all hours worked by a child's principal caretaker(s), we estimated that over half those hours were nonstandard. This does not capture whether

each principal caretaker in two-parent households has majority nonstandard hours, just that, combined, the majority of their work hours are nonstandard.

- **Infants and toddlers.** Children younger than age 3.
- **Metropolitan status.** Because the metropolitan status of all households is not reported or determinable in the ACS's public use microdata sample (PUMS), we estimated the share of children in each state living in nonmetropolitan areas, by cross-walking observations' public-use microdata area (PUMA), the smallest unit of geography available in the PUMS, to the metropolitan areas to which it belonged.

In general, the Census Bureau attempts to define PUMAs to follow the borders of counties or county groups, which are also the building blocks of metropolitan areas. In some cases PUMAs cut across the borders of metropolitan areas or vice versa. In these cases, we allocated each observation in a PUMA to all the areas in which the PUMA overlapped and reweighted them by the proportion of the PUMA's population in each area in the 2010 Census using allocation factors from the Missouri Census Data Center's Geocorr14 website: <http://mcdc.missouri.edu/websas/geocorr14.html>. For example, if 20 percent of a PUMA's population was in a nonmetropolitan area and 80 percent was in a metropolitan area in the 2010 Census, each observation in that PUMA would be counted as 20 percent in nonmetropolitan regions and 80 percent in metropolitan regions.

Notes

- ¹ “FY 2016 Preliminary Data Table 1 - Average Monthly Adjusted Number of Families and Children Served,” Office of Child Care, March 12, 2018, <https://www.acf.hhs.gov/occ/resource/fy-2016-preliminary-data-table-1>.
- ² For simplicity’s sake, we use “states” instead of “states and territories” for the remainder of this report.
- ³ Based on data available from the Department of Health and Human Services, Administration for Children and Families, Office of Child Care website. These data are reported by states and territories to the ACF-800-Annual Aggregate Child Care Data Report and ACF-801—Monthly Child Care Data Report, <https://www.acf.hhs.gov/occ/resource/ccdf-statistics>.
- ⁴ For trends in the variation in use of license-exempt care across states, see Mohan (2017).
- ⁵ For more information on key provisions of the 2014 reauthorization of the CCDBG, see Matthews and colleagues (2017) and resources on the Office of Child Care’s website, <https://www.acf.hhs.gov/occ/ccdf-reauthorization>.
- ⁶ Based on authors’ conversations with Helen Blank (National Women’s Law Center) and Hannah Matthews (Center for Law and Social Policy), spring 2018.
- ⁷ For more information, see the state profiles on the Quality Compendium website, <https://qualitycompendium.org>.
- ⁸ “Listed” settings are those that are listed with, for example, state licensing or subsidy agencies, while “unlisted” settings are those that are not listed by any public agency and therefore are unlikely to be regulated.
- ⁹ The nonmetropolitan classification used in this report excludes counties that are part of metropolitan statistical areas and includes both counties that make up micropolitan statistical areas and those that are part of neither metropolitan or micropolitan areas. Metropolitan statistical areas are delineated by the Census Bureau and are made up of central counties that contain at least one urbanized area that has a population of at least 50,000 and the surrounding counties with a high degree of economic and social interaction with the core counties as measured by commuting patterns. Micropolitan statistical areas consist of central counties with at least one urbanized cluster with a population of at least 10,000 but less than 50,000 and the surrounding counties with a high degree of economic and social integration. Other counties that make up neither metropolitan nor micropolitan areas comprise the remainder of the US. The nonmetro definition that we use is a frequent proxy for rurality that is correlated with the Census Bureau’s rural area definition; however, we use the metropolitan and nonmetropolitan population density definition rather than the Census Bureau’s definition of rural and urban areas as the former is available at the county level while the latter is not. The county-level definition allows for more straightforward and accurate population estimates of the groups in interest in this study using publicly available Census ACS microdata, the data source with the largest nationally representative sample.
- ¹⁰ See Section 10 Definitions of the Child Care Development Block Grant Reauthorization, which describes the amendment to the CCDBG Grant Act of 1990, Section 658P. <https://www.gpo.gov/fdsys/pkg/BILLS-113s1086eah/pdf/BILLS-113s1086eah.pdf>
- ¹¹ Many children receiving IDEA-funded services also attend general programs; and the IDEA supports may be integrated into programs or offered as discrete services (Spiker, Hebbeler, and Barton 2011). However, many children who qualify for IDEA services, do not receive them at all and may still attend general child care and early education programs outside their homes (Booth-LaForce and Kelly 2004). Not all these programs are designed to be inclusive; indeed, many children with special needs attend general programs without accommodations or specialized services or supports. Still, at least one-third of children with special needs are estimated to go without services at all (Booth-LaForce and Kelly 2004; Peterson et al. 2013).

- ¹² Families using subsidies may face additional barriers to accessing centers if providers choose to not participate in the subsidy program or to accept subsidy vouchers. For more information on provider willingness to participate in the subsidy system, see Rohacek and Adams (2017), Adams and Rohacek (2008), and Schneider and colleagues (2017).
- ¹³ Karen Schulman of the National Women’s Law Center provided very helpful insights into these various mechanisms, with additional input provided by Hannah Matthews of the Center for Law and Social Policy.
- ¹⁴ “FY 2016 Preliminary Data Table 2 - Percent of Children Served by Payment Method,” Office of Child Care, March 12, 2018, <https://www.acf.hhs.gov/occ/resource/fy-2016-preliminary-data-table-2>.
- ¹⁵ This problem is compounded by high levels of subsidy instability (Ha and Meyer 2010; Henly et al. 2017; Pilarz, Claessens, and Gelatt 2016; Weber, Grobe, and Davis 2014). Historically many parents experienced very short spells of subsidy use which contributes to discontinuity of child care (Henly et al. 2015; Krafft, Davis, and Tout 2017). The new law works to address this instability by requiring states to provide a minimum of a 12-month eligibility period, with the intention that this will result in longer subsidy spells, more stability for providers, and more continuity of care for children.
- ¹⁶ See the joint report by the National Center on Child Care Subsidy Innovation and Accountability and the State Capacity Building Center for a useful state-by-state summary and discussion of the use of contracts and grants (NCCCSIA 2016).
- ¹⁷ For more information about incorporating home-based settings into child care and early education systems, see a recent special issue of *Early Education and Development* (Tonyan, Paulsell, and Shivers 2017) and recently released resources on supporting family child care and family child care networks collected on the Office of Child Care’s website at <https://childcareta.acf.hhs.gov/national-resources-family-child-care>.
- ¹⁸ The National Center on Early Childhood Quality Assurance is developing a brief that explores the reasons for the decline in family child care providers and potential responses that states and localities can take to reverse the trend. Its release is anticipated in the fall of 2018.
- ¹⁹ The National Center on Early Childhood Quality Assurance is developing a brief that explores the reasons for the decline in family child care providers and the potential responses states and localities can take to reverse the trend. Its release is anticipated in fall 2018.
- ²⁰ “FY 2016 Preliminary Data Table 1 - Average Monthly Adjusted Number of Families and Children Served,” Office of Child Care, March 12, 2018, <https://www.acf.hhs.gov/occ/resource/fy-2016-preliminary-data-table-1>.
- ²¹ For more information about the CCDBG reauthorization and its major provisions, see resources on the Office of Child Care’s website at <https://www.acf.hhs.gov/occ/ccdf-reauthorization> and the Center for Law and Social Policy/National Women’s Law Center/s reauthorization guide at <https://www.clasp.org/implementing-ccdbg-reauthorization>.
- ²² Final Rule for the Child Care and Development Fund (CCDF) Program, 81 Fed. Reg., 67438 (September 30, 2016).
- ²³ “American Community Survey: When to Use 1-Year, 3-Year, or 5-Year Estimates,” US Census Bureau, last revised June 17, 2018, <https://www.census.gov/programs-surveys/acs/guidance/estimates.html>.

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