4 Ensure Equal Access to Child Care for Low-Income Children

A core purpose of CCDF is to promote parental choice and to empower working parents to make their own decisions regarding the child care services that best suit their family's needs. Parents have the option to choose from center-based care, family child care, or care provided in the child's own home. In supporting parental choice, the Lead Agencies must ensure that families receiving CCDF funding have the opportunity to choose from the full range of eligible child care settings and must provide families with equal access to child care that is comparable to that of non-CCDF families. Lead Agencies must employ strategies to increase the supply and to improve the quality of child care services, especially in underserved areas. In addition to generally building the supply of child care for all families, this effort also supports equal access for CCDF eligible children to the priced child care market.

This section addresses strategies that the Lead Agency uses to promote parental choice, ensure equal access, and increase the supply of child care. Note: In responding to questions in this section, the Office of Child Care (OCC) recognizes that each state/territory identifies and defines its own categories and types of care. The OCC does not expect states/territories to change their definitions to fit the CCDF-defined categories and types of care. For these questions, provide responses that closely match the CCDF categories of care.

Note: When asked for citations, responses can include state statute, regulations, administrative rules, policy manuals or policy issuances. See the Introduction on page 4 for more detail.

4.1 Maximize Parental Choice and Implement Supply Building Mechanisms

The parent(s) of each eligible child who receive(s) or is offered financial assistance for child care services has the option of either receiving a child care certificate or, if available, enrolling their child with a provider that has a grant or contract for providing child care services (658E(c)(2)(A); 98.30(a)). Even if a parent chooses to enroll their child with a provider who has a grant or contract, the parent will select the provider, to the extent practicable. If a parent chooses to use a certificate, the Lead Agency shall provide information to the parent on the range of provider options, including care by sectarian providers and relatives. Lead Agencies must require providers chosen by families to meet health and safety standards and has the option to require higher standards of quality. Lead Agencies are reminded that any policies and procedures should not restrict parental access to any type of care or provider (e.g. center care, home care, in-home care, for-profit provider, non-profit provider, or faith-based provider, etc.) (98.15 (a)(5)).

4.1.1 Describe the child care certificate, including when it is issued to parents (before or after the parent has selected a provider) and what information is included on the certificate (98.16 (q)).

The parent receives the Child Development and Care Client Notice (DHS-198c), upon provider assignment. This serves as the child care certificate.

The following information is included on the notice: Information explaining reporting changes, provider ratings, how to file a complaints against licensed and license exempt providers, the overpayment process including repayment, where to find Child Development and Care (CDC) payment rules, where to find results of provider annual inspections and star ratings, the names of children approved for care, the number of biweekly need hours approved for attendance and billing, the family contribution amount, the assigned providers name, provider ID/license number (if licensed), and the 12-month eligibility period that is approved.

4.1.2 Identify how the parent is informed that the child care certificate allows the option to choose from a variety of child care categories, such as private, not-for-profit, faith-based providers; centers; FCC homes; or in-home providers (658E(c)(2)(A)(i); 658P(2); 658Q). Check all that apply.

- [x] a. Certificate provides information about the choice of providers
- [x] b. Certificate provides information about the quality of providers
- [x] c. Certificate is not linked to a specific provider, so parents can choose any provider
- [x] d. Consumer education materials on choosing child care
- [ ] e. Referrals provided to child care resource and referral agencies
- [ ] f. Co-located resource and referral staff in eligibility offices
- [x] g. Verbal communication at the time of the application
- [ ] h. Community outreach, workshops, or other in-person activities
- [x] i. Other. Describe:

The parent receives the Child Development and Care Client Notice (DHS-198c), upon provider assignment. This serves as the child care certificate.

The following information is included on the notice: Information explaining reporting changes, provider ratings, how to file a complaints against licensed and license exempt providers, the overpayment process including repayment, where to find Child Development and Care (CDC) payment rules, where to find results of provider annual inspections and star ratings, the names of children approved for care, the number of biweekly need hours approved for attendance and billing, the family contribution amount, the assigned providers name, provider ID/license number (if licensed), and the 12-month eligibility period that is approved.

4.1.3 A core principle of CCDF is that families receiving CCDF-funded child care should have equal access to child care that is comparable to that of non-CCDF families (658E(c)(4)(A) and 98.45(a)).

a. Describe how parents have access to the full range of providers eligible to receive CCDF:

When parents apply for child care, they are provided with information on how to select a child care provider through Great Start to Quality (GSQ) that meets their needs. Families receiving child care subsidy have the same access to eligible provider types as non-subsidy families.

b. Describe state data on the extent to which eligible child care providers participate in the CCDF system:

Overall, 89% of providers indicated that they are either currently caring for children receiving child care subsidies or are willing to care for subsidized children in the future (Market Rate Survey 2020-2021). Although centers were more likely than home-base providers to indicate that they are currently caring for children receiving subsidies, the proportion of providers who indicated that they will not accept any subsidized children in the future was low across all provider types.

c. Identify any barriers to provider participation, including barriers related to payment rates and practices - including for family child care and in-home providers - based on provider feedback and reports to the Lead Agency:

Rates, co-pay collection, and timing issues (receiving notices, length of the application process) were cited by providers as the most challenging aspects of accepting the child care subsidy. (Market Rate Survey 2020-2021)

4.1.4 Certify by describing the Lead Agency's procedures for ensuring that parents have unlimited access to their children whenever their children are in the care of a provider who receives CCDF funds (658E(c)(2)(B); 98.16(t)).

Michigan's child care licensing rules and regulations require providers to ensure parents have unlimited access to their child regardless of whether they receive CDC subsidy. In addition, our current license exempt-related and unrelated provider population is notified of this requirement at the time of application.

4.1.5 The Lead Agency must allow for in-home care (i.e., care provided in the child's own home) but may limit its use (98.16(i)(2)). Will the Lead Agency limit the use of in-home care in any way?

☐ No.

☑ Yes. If checked, what limits will the Lead Agency set on the use of in-home care? Check all that apply.

☐ a. Restricted based on the minimum number of children in the care of the provider to meet the Fair Labor Standards Act (minimum wage) requirements.

Describe:

☑ b. Restricted based on the provider meeting a minimum age requirement.
Describe:

18-year-old minimum.

☐ c. Restricted based on the hours of care (i.e., certain number of hours, non-traditional work hours).

Describe:

☐ d. Restricted to care by relatives. (A relative provider must be at least 18 years of age based on the definition of eligible child care provider (98.2)).

Describe:

☐ e. Restricted to care for children with special needs or a medical condition.
Describe:

☑ f. Restricted to in-home providers that meet additional health and safety requirements beyond those required by CCDF.

Describe:

Both related and unrelated license-exempt providers must complete a seven-hour GSQ Orientation prior to receiving a CDC subsidy payment. Payment may be issued retroactively for care that was provided up to 30 days prior to the orientation,

after the provider was enrolled and all criminal history background checks are completed.

☑ g. Other.

Describe:

License exempt-unrelated providers and all adult household members are subject to in-state criminal history checks, which includes: Central Registry, Michigan criminal history records (ICHAT), incarceration information (OTIS), and the Public Sex Offender Registry (PSOR). Daily matches are ongoing for Central Registry and ongoing monthly checks on other information are conducted. These checks are completed prior to enrollment.

License exempt-unrelated providers are subject to the same in-state criminal history checks as listed for license exempt-related providers. In addition, there is a required is a fingerprint submission which allows for the following additional checks: Michigan State Police (MSP) criminal history records, National Crime Information Center (NCIC), National Sex Offender Registry (NSOR), and inter-state clearances for criminal history, sex offender and child abuse. These checks are all completed prior to enrollment. License exempt-unrelated providers also must complete an annual monitoring visit.

4.1.6 Child care services available through grants or contracts.

a) In addition to offering certificates, does the Lead Agency provide child care services through grants or contracts for child care slots (658A(b)(1))? Note: Do not check 'yes' if every provider is simply required to sign an agreement to be paid in the certificate program.

☑ No. If no, skip to 4.1.7.

☐ Yes, in some jurisdictions but not statewide.

If yes, describe how many jurisdictions use grants or contracts for child care slots.

☐ Yes, statewide. If yes, describe

i. How the Lead Agency ensures that parents who enroll with a provider who has a grant or contract have choices when selecting a provider:

ii. The entities that receive contracts (e.g., shared services alliances, CCR&R agencies, FCC networks, community-based agencies, child care providers) and how grants or contracts are promoted by the Lead Agency:

iii. How rates for contracted slots are set through grants and contracts and if they are viewed by providers as a vehicle for stabilizing payments.

4.1.6 Child care services available through grants or contracts.

b) Will the Lead Agency use grants or contracts for child care services to increase the supply and/or quality of specific types of care?

- [x] No
- [ ] Yes. If yes, does the Lead Agency use grants or contracts to increase the supply and/or quality of child care programs serving the populations below? Check all that apply.

i. Grants or Contracts are used in Child Care Programs that serve Children with disabilities:

- [ ] To increase the supply of care
- [ ] To increase the quality of care

ii. Grants or Contracts are used in Child Care Programs that serve Infants and toddlers:

- [ ] To increase the supply of care
- [ ] To increase the quality of care

iii. Grants or Contracts are used in Child Care Programs that serve School-age children:

- [ ] To increase the supply of care
- [ ] To increase the quality of care

iv. Grants or Contracts are used in Child Care Programs that serve Children needing non-traditional hour care:

- ☐ To increase the supply of care
- ☐ To increase the quality of care

v. Grants or Contracts are used in Child Care Programs that serve Children experiencing homelessness:

- ☐ To increase the supply of care
- ☐ To increase the quality of care

vi. Grants or Contracts are used in Child Care Programs that serve Children with diverse linguistic or cultural backgrounds:

- ☐ To increase the supply of care
- ☐ To increase the quality of care

vii. Grants or Contracts are used in Child Care Programs that serve Children in underserved areas:

- ☐ To increase the supply of care
- ☐ To increase the quality of care

viii. Grants or Contracts are used in Child Care Programs that serve Children in urban areas:

- ☐ To increase the supply of care
- ☐ To increase the quality of care

ix. Grants or Contracts are used in Child Care Programs that serve Children in rural areas:

- ☐ To increase the supply of care
- ☐ To increase the quality of care

x. Grants or Contracts are used in Child Care Programs that serve Other populations, please specify:

- ☐ To increase the supply of care
- ☐ To increase the quality of care

Describe

4.1.7 Lead Agencies must identify shortages in the supply of high-quality child care providers that meet parents' needs and preferences. List the data sources used to identify any shortages and declines in the supply of care types that meet parents' needs. Also describe the method of tracking progress to support equal access and parental choice (98.16(x).

a. In child care centers.

Michigan tracks the number of providers monthly in the Bureau Information Tracking System (BITS) database located within Licensing and Regulatory Affairs (LARA). Each month, data reports are run that include the number of child care centers, including those that were closed during the month. A capacity report is also run monthly. In addition, licensing consultants work closely with the GSQ Resource Center to provide support to providers to become licensed.

b. In child care homes.

Michigan tracks the number of providers monthly in the BITS database. Each month, data reports are run that include the number of child care family homes and group homes (both included in family child care), including those that were closed during the month. A capacity report is also run monthly. Licensing consultants work closely with the GSQ Resource Center to provide support to providers interested in becoming a licensed child care home.

c. Other.

n/a

4.1.8 Lead Agencies are required to develop and implement strategies to increase the supply of and improve the quality of child care services (98.16 (x)). These strategies should address children in underserved areas; infants and toddlers; children with disabilities, as defined by the Lead Agency; and children who receive care during non-traditional hours. Identify what method(s) is (are) used to increase supply and/or to improve quality for the following populations and indicate in the description if a strategy

is focused more on building supply or on improving quality.

a) Children in underserved areas. Check and describe all that apply.

☐ i. Grants and contracts (as discussed in 4.1.6).

Describe:

☐ ii. Targeted Family Child Care Support such as Family Child Care Networks.

Describe:

☐ iii. Start-up funding.

Describe:

☑ iv. Technical assistance support.

Describe:

Michigan, through its GSQ Resource Centers offers an infant/toddler support network through Infant Toddler Specialists who lead peer to peer opportunities, provider technical assistance and offer specialized infant/toddler training.

☐ v. Recruitment of providers.

Describe:

☑ vi. Tiered payment rates (as in 4.3.3).

Describe:

All age-eligible children whose family has a need, and the child is in foster care, the family receives temporary assistance for needy families (TANF), the parent or child receive supplemental security income (SSI), the parent is a migrant farmworker, the child is experiencing homelessness, or the family has an active substantiated neglect/abuse case qualify for protective services category and shall be considered without an income test, determined on a case-by-case basis.

☐ vii. Support for improving business practices, such as management training, paid sick leave, and shared services.

Describe:

☐ viii. Accreditation supports.

Describe:

☐ ix. Child Care Health Consultation.

Describe:

☑ x. Mental Health Consultation.

Describe:

Through a partnership of Michigan Department of Education (MDE) and the Michigan Department of Health and Human Services (MDHHS), leveraging Preschool Development Grant (PDG) B-5 funding and Child Care Development Funds (CCDF), some communities in Michigan (18 out of 83 counties) have access to infant and early childhood mental health consultation. Additionally, when a family is eligible, these services can be supported through a MDHHS Prevention-Direct Service. This prevention direct service is part of the Behavioral Health and Intellectual/Development Disabilities chapter of the Michigan Medicaid Provider Manual. Michigan implements an evidence-based, state-driven Infant and Early Childhood Mental Health Consultation (IECMHC) model originally developed in the 1990's and refined based on science and practice. Master's prepared, IECMH consultants use this evaluated approach that includes partnering with early care and education providers to listen, observe, assess, plan and coach around the specific mental health needs of children and providers. This process enhances the overall quality of care and environmental climate. Training and peer supports are also available for providers.

☑ xi. Other.

Describe:

The Head Start State Collaboration Office and the CDC program developed, through a Memorandum of Understanding, a pilot program centered on Michigan's Early Head Start-Child Care Partnership grants. The pilot allows Early Head Start - Child Care Partnerships (EHS-CCP) childcare partners to bill for the full amount of subsidy a partnership-enrolled child is eligible for encouraging continuity of care for infants and toddlers in poverty; and, increasing the capacity of providers to provide quality care to low-income infants and toddlers. In Genesee county, partnerships

were created through Genesee Intermediate School District (GISD) to support a high-quality early learning opportunity for children in Flint.

4.1.9 Lead Agencies are required to develop and implement strategies to increase the supply of and improve the quality of child care services (98.16 (x)). These strategies should address children in underserved areas; infants and toddlers; children with disabilities, as defined by the Lead Agency; and children who receive care during non-traditional hours. Identify what method(s) is (are) used to increase supply and/or to improve quality for the following populations and indicate in the description if a strategy is focused more on building supply or on improving quality.

b. Infants and toddlers. Check and describe all that apply.

☐ i. Grants and contracts (as discussed in 4.1.6).

Describe:

☐ ii. Family Child Care Networks.

Describe:

☐ iii. Start-up funding.

Describe:

☑ iv. Technical assistance support.

Describe:

Michigan, through its GSQ Resource Centers offers an infant/toddler support network through Infant Toddler Specialists who lead peer to peer opportunities, provider technical assistance and offer specialized infant/toddler training.

☐ v. Recruitment of providers.

Describe:

☑ vi. Tiered payment rates (as in 4.3.3).

Describe:

Infants and toddlers receive a higher CDC reimbursement rate for all provider types, except license exempt - related and unrelated who do not take an additional 10 hours of health and safety training each year.

☐ vii. Support for improving business practices, such as management training, paid sick leave, and shared services.

Describe:

☐ viii. Accreditation supports.

Describe:

☐ ix. Child Care Health Consultation.

Describe:

☑ x. Mental Health Consultation.

Describe:

Through a partnership of Michigan Department of Education (MDE) and the Michigan Department of Health and Human Services (MDHHS), leveraging Professional Development Grant (PDG) B-5 funding and Child Care and Development Funds (CCDF), some communities in Michigan (18 out of 83 counties) have access to infant and early childhood mental health consultation. Additionally, when a family is eligible, these services can be supported through a MDHHS Prevention-Direct Service. This prevention direct service is part of the Behavioral Health and Intellectual/Development Disabilities chapter of the Michigan Medicaid Provider Manual. Michigan implements an evidence-based, state-driven Infant and Early Childhood Mental Health Consultation (IECMHC) model originally developed in the 1990's and refined based on science and practice. Master's prepared, IECMH consultants use this evaluated approach that includes partnering with early care and education providers to listen, observe, assess, plan and coach around the specific mental health needs of children and providers. This process enhances the overall quality of care and environmental climate. Training and peer supports are also available for providers.

☑ xi. Other.

Describe:

The Head Start State Collaboration Office and the CDC program developed, through a Memorandum of Understanding, a pilot program centered on Michigan's

Early Head Start-Child Care Partnership grants. The pilot allows Early Head Start - Child Care Partnerships (EHS-CCP) childcare partners to bill for the full amount of subsidy a partnership-enrolled child is eligible for encouraging continuity of care for infants and toddlers in poverty; and, increasing the capacity of providers to provide quality care to low-income infants and toddlers. In Genesee County, partnerships were created through Genesee Intermediate School District (GISD) to support a high-quality early learning opportunity for children in Flint.

4.1.10 Lead Agencies are required to develop and implement strategies to increase the supply of and improve the quality of child care services (98.16 (x)). These strategies should address children in underserved areas; infants and toddlers; children with disabilities, as defined by the Lead Agency; and children who receive care during non-traditional hours. Identify what method(s) is (are) used to increase supply and/or to improve quality for the following populations and indicate in the description if a strategy is focused more on building supply or on improving quality.

c. Children with disabilities. Check and describe all that apply.

☐ i. Grants and contracts (as discussed in 4.1.6).

Describe:

☐ ii. Family Child Care Networks.

Describe:

☐ iii. Start-up funding.

Describe:

☑ iv. Technical assistance support.

Describe:

Michigan offers technical assistance and training around supporting children with disabilities through our GSQ Resource Centers, and through a partner agency, Early on Training and Technical Assistance (EOTTA). We currently have a PDG B-5 project with EOTTA that is focused on professional development and coaching to support providers with inclusive practices and working with families with special needs.

☐ v. Recruitment of providers.

Describe:

☐ vi. Tiered payment rates (as in 4.3.3).

Describe:

☐ vii. Support for improving business practices, such as management training, paid sick leave, and shared services.

Describe:

☐ viii. Accreditation supports.

Describe:

☐ ix. Child Care Health Consultation.

Describe:

☐ x. Mental Health Consultation.

Describe:

☐ xi. Other.

Describe:

4.1.11 Lead Agencies are required to develop and implement strategies to increase the supply of and improve the quality of child care services (98.16 (x)). These strategies should address children in underserved areas; infants and toddlers; children with disabilities, as defined by the Lead Agency; and children who receive care during non-traditional hours. Identify what method(s) is (are) used to increase supply and/or to improve quality for the following populations and indicate in the description if a strategy is focused more on building supply or on improving quality.

d. Children who receive care during non-traditional hours. Check and describe all that apply.

☐ i. Grants and contracts (as discussed in 4.1.6).

Describe:

n/a

☐ ii. Family Child Care Networks.

Describe:

n/a

☐ iii. Start-up funding.

Describe:

n/a

☐ iv. Technical assistance support.

Describe:

n/a

☐ v. Recruitment of providers.

Describe:

n/a

☐ vi. Tiered payment rates (as in 4.3.3).

Describe:

n/a

☐ vii. Support for improving business practices, such as management training, paid sick leave, and shared services.

Describe:

n/a

☐ viii. Accreditation supports.

Describe:

n/a

☐ ix. Child Care Health Consultation.

Describe:

n/a

☐ x. Mental Health Consultation.

Describe:

n/a

☐ xi. Other.

Describe:

n/a

4.1.12 Lead Agencies are required to develop and implement strategies to increase the supply of and improve the quality of child care services (98.16 (x)). These strategies should address children in underserved areas; infants and toddlers; children with disabilities, as defined by the Lead Agency; and children who receive care during non-traditional hours. Identify what method(s) is (are) used to increase supply and/or to improve quality for the following populations and indicate in the description if a strategy is focused more on building supply or on improving quality.

e. Other. Check and describe all that apply.

☐ i. Grants and contracts (as discussed in 4.1.6).

Describe:

n/a

☐ ii. Family Child Care Networks.

Describe:

n/a

☐ iii. Start-up funding.

Describe:

n/a

☐ iv. Technical assistance support.

Describe:

n/a

☐ v. Recruitment of providers.

Describe:

n/a

☐ vi. Tiered payment rates (as in 4.3.3).

Describe:

n/a

☐ vii. Support for improving business practices, such as management training, paid sick leave, and shared services.

Describe:

n/a

☐ viii. Accreditation supports.

Describe:

n/a

☐ ix. Child Care Health Consultation.

Describe:

n/a

☐ x. Mental Health Consultation.

Describe:

n/a

☐ xi. Other.

Describe:

n/a

4.1.13 Lead Agencies must prioritize investments for increasing access to high-quality child care and development services for children of families in areas that have significant concentrations of poverty and unemployment and do not currently have sufficient numbers of such programs (658 E(c)(2)(M); 98.16 (x);98.46(b)).

a) How does the Lead Agency define areas with significant concentrations of poverty and unemployment?

Michigan has implemented policy around CDC protective services for a child in foster care, a family receiving TANF, a parent or child receiving SSI, a parent who is a migrant farm worker, a child experiencing homelessness, or a family with an active substantiated neglect/abuse case. Additionally, children experiencing homelessness and those placed in licensed foster care are determined under expedited processing and presumptive eligibility that waives most verification requirements temporarily.

Today, 1.4 million Michiganders (20% of children) fall below the poverty level, but more importantly, the United Way's ALICE Report shows that 43% or 4.3 million of working Michigan households struggle to afford the necessities like housing, childcare, food, technology, health care and transportation. https://www.michigan.gov/leo/0,5863,7-336-78421_97193---,00.html

b) Describe how the Lead Agency prioritizes increasing access to high-quality child care and development services for children of families in areas that have significant concentrations of poverty and unemployment and that do not have high-quality programs

Michigan has implemented CDC protective services for a child in foster care, a family receiving TANF, a parent or child receiving SSI, a parent who is a migrant farmworker, a child experiencing homelessness, or a family with an active substantiated neglect/abuse case. Additionally, children experiencing homelessness and those placed in licensed foster care are determined under expedited processing and presumptive eligibility that waives most verification requirements temporarily. In addition, if a family chooses a 3, 4, or 5 star rated program the family contribution is waived.

4.2 Assess Market Rates and Analyze the Cost of Child Care

4.2 Assess Market Rates and Analyze the Cost of Child Care

Key principles of the CCDF are to: (1) provide equal access to childcare for children receiving childcare assistance; and (2) ensure parental choice by offering a full range of childcare services. Payment rates that are too low to support equal access undermine these principles.

To establish subsidy payment rates that ensure equal access, Lead Agencies collect and analyze data through a number of tools. Lead Agencies have the option to conduct a statistically valid and reliable (1) market rate survey (MRS) reflecting variations in the price to parents of childcare services by geographic area, type of provider, and age of child or (2) an ACF pre-approved alternative methodology, such as a cost estimation model (CEM) (658E(c)(4)(B)). A cost estimation model estimates the cost of care by incorporating both data and assumptions to judge what expected costs would be incurred by childcare providers and parents under different scenarios. Another approach would be a cost study that collects cost data at the facility or program level to measure the costs (or inputs used) to deliver childcare services (CCDF-ACF-PI-2018-01).

Regardless of whether Lead Agencies conduct a MRS or an alternative methodology, they are required to analyze the cost of providing child services, known as the narrow cost analysis, that meet basic health/safety/quality and staffing requirements (base level care) (98.45(b)(3), (f)(1)(ii)(A), and (f)(2)(ii)), and higher-quality care at each level of quality, as defined by the Lead Agency (98.45(b)(4), (f)(1)(ii)(B), and (f)(2)(iii)). The analysis must identify the gaps between the cost of care and subsidy levels adopted by the state and then be considered as part of the rate setting process.

Note: Any Lead Agency considering using an alternative methodology, instead of a MRS rate survey, is required to submit a description of its proposed approach to its ACF Regional Child Care Program Office for pre-approval in advance of the Plan submittal (see https://www.acf.hhs.gov/occ/resource/ccdf-acf-pi-2016-08
). Advance approval is not required if the Lead Agency plans to implement both a MRS and an alternative methodology.

A MRS or an ACF pre-approved alternative methodology must be developed and conducted no earlier than 2 years before the date of submission of the Plan (658E(c)(4)(B)(i) (98.45 (c)). Due to the COVID-19 pandemic, Lead Agencies may request a waiver for up to one additional year (until July 1, 2022) to complete the required MRS or an ACF pre-approved alternative methodology. Lead Agencies may also request the required Narrow Cost Analysis be waived for one year (until July 1, 2022). These waiver requests must include a justification linked to the COVID-19 pandemic.

4.2.1 Completion of the MRS or ACF pre-approved alternative methodology.

Did the state/territory conduct a statistically valid and reliable MRS or ACF pre-approved

alternative methodology?

☑ Yes. If yes, please identify the methodology(ies) used below to assess child care prices and/or costs.

☑ a. MRS.

When was your data gathered (provide a date range, for instance, September - December, 2019)?

October 26, 2020 - January 8, 2021

☐ b. ACF pre-approved alternative methodology.

Identify the date of the ACF approval and describe the methodology:

☐ No, a waiver is being requested in Appendix A.

a. Please identify the Lead Agency's planned methodology(ies) to assess child care prices and/or costs.

☐ i. MRS.

If checked, describe the status of the Lead Agency's implementation of the MRS.

☐ ii. ACF pre-approved alternative methodology.

If checked, describe the status of the Lead Agency's implementation of the ACF pre-approved alternative methodology, including if applicable, the date of the ACF approval and a description of the methodology:

b. If a waiver is requested, Lead Agencies will need to respond to questions 4.2.2-4.5.2 based on data collected for the FY 2019-2021 CCDF Plan or any data collected since then. Identify the date of the Lead Agencies' most recent and complete Market Rate Survey or ACF pre-approved alternative methodology that will provide data to inform responses to questions 4.2.2 - 4.5.2.

4.2.2 Prior to developing and conducting the MRS, or conducting the ACF pre-approved alternative methodology, the Lead Agency is required to consult with (1) the State Advisory Council or similar coordinating body, local child care program administrators, local child care resource and referral agencies, and other appropriate entities, and (2) organizations representing caregivers, teachers, and directors (98.45 (e)). Local child care program administrators may also be good informants to Lead Agencies on narrow

cost analyses.

Describe how the Lead Agency consulted with the:

a) State Advisory Council or similar coordinating body:

n/a

b) Local child care program administrators:

The Department convened a group of child care administrators/providers, including a tribal partner to provide feedback on the development of the Market Rate Survey (MRS) questions. In addition, throughout the pandemic the Department had many listening sessions with providers that guided the development of the MRS.

c) Local child care resource and referral agencies:

Throughout the pandemic the Department had many listening sessions with the Great Start to Quality Resource Centers and other partners that guided the development of the MRS.

d) Organizations representing caregivers, teachers, and directors:

The Department convened a broad group of child care administrators/providers, including a tribal partner to provide feedback on the development of the MRS questions. In addition, throughout the pandemic the Department had many listening sessions with providers that guided the development of the MRS.

e) Other. Describe:

n/a

4.2.3 ACF has established a set of benchmarks, largely based on research, to identify the components of a valid and reliable market rate survey (81 FR, p. 67509). To be considered valid and reliable a Market Rate Survey or preapproved alternative methodology meets the following:

- represents the child care market
- provides complete and current data
- uses rigorous data collection procedures
- reflects geographic variations
- analyzes data in a manner that captures other relevant differences

An MRS can use administrative data, such as child care resource and referral data, if it is representative of the market.

a. Describe how each of the benchmarks are met in either the MRS or ACF pre-approved alternative methodology.

i. Represent the child care market: Click or tap here to enter text.

The survey included providers that charge a price established through an arm's length transaction, i.e., not relatives or friends (license exempt - related and license exempt - unrelated). Final analytic data included 3,008 unduplicated responses from open and active providers. This yielded a response rate of 44% for open and active providers. Response rates were above 40% for all three licensed provider types, although centers had a lower response rate (40%) than family homes (45%) or group homes (48%).

ii. Provide complete and current data:

The 2020 Michigan survey was based on a sampling frame of all open licensed child care providers in the priced market. The survey was conducted over a three-month period with results promptly reported. Because the pandemic resulted in short- and long- term fluctuations in the activity of child care providers, the estimation of the sample universe and response rates have higher levels of uncertainty than normal.

iii. Use rigorous data collection procedures:

Every effort was made to ensure quality data collection processes within the scope of time and resources available to the team. While the overall participation rate for the 2020 survey (44%) was below the target response rate, it represented a substantially increase relative to the 2017 survey. In addition, analysis comparing the sample of respondents to non-respondents showed the sample to be highly representative of the overall population of providers. To further strengthen the alignment between the sample of providers who responded to the 2020 survey and the overall population of child care providers in Michigan, data, including price estimates, were weighted by

geographic region based on aggregated PUMAs (Public Use Microdata Area) and provider type.

iv. Reflect geographic variations:

The 2020 Michigan survey included providers from every county, and price data were analyzed and reported by Great Start to Quality region.

v. Analyze data in a manner that captures other relevant differences:

To further strengthen the alignment between the sample of providers who responded to the 2020 survey and the overall population of child care providers in Michigan, data, including price estimates, were weighted by geographic region based on aggregated PUMAs and provider type. In addition, results were analyzed separately by star rating (where available), age group, and type of care. As in past years, calculating price per slot of was complicated by ambiguities in reported capacity. Licensing records have one data point for capacity-total permitted capacity at any single time. While survey questions asked providers to identify the number of slots for children in each of the four age groups, the study found that reported slots, in aggregate, were substantially greater than known capacity. For example, a provider might have a state-reported capacity of 100 and report 30 slots for infants, 45 slots for toddlers, 45 slots for preschool, and 30 slots for school-aged children, totaling 150. While we believe the discrepancies are a function of part-time attendance and specialty programs (100 half-time preschoolers is compatible with a capacity of 50), the data are inadequate to fully disentangle which children are being served full time and which are being served part time, which is the data needed to allocate total capacity to the varied age groups.
If we were to weight reported rates for infants, toddlers, preschoolers, and school-aged children alike by the single capacity in licensing records, we would have been assigning the full capacity of any facility to each age group-a real distortion if one considers the differences between three centers with capacity of 100, the first of which serves children across the age ranges, the second of which specializes in preschool, and the third of which specializes in part-time service and cannot accommodate families with parents working full time.

b. Given the impact of COVID-19 on the child care market, do you think that the data you gathered (as indicated in 4.2.1) on the prices or costs of child care adequately reflect the

child care market as you submit this plan?

☐ No

☑ Yes.

If yes, why do you think the data represents the child care market?

Since this research was conducted during the pandemic, the survey also addressed special cost considerations associated with COVID-19. In addition, extent data from a variety of sources and in-depth interviews conducted with 24 providers were analyzed to assess the cost to provide care using the Provider Cost of Quality Calculator from the U.S. Department of Health and Human Services, Office of Child Care.

4.2.4 Describe how the market rate survey or ACF pre-approved alternative methodology reflects variations in the price or cost of child care services by:

a) Geographic area (e.g., statewide or local markets). Describe:

The survey data were weighted on the basis of facility type (center, family home, or group home) and region of the state. Because of the prevalence of small-population counties with few child care providers (and sometimes zero providers of a particular type), the American Community Survey (ACS) Public Use Microdata Area (PUMA) areas were used to classify providers by geographic region. PUMAs are geographic units of at least 100,000 residents that observe political boundaries. For counties with small populations, adjacent counties are grouped based on similarity of demographic profiles until the total population reaches 100,000. High-population counties with much more than 100,000 residents are divided in the ACS into multiple PUMAs. For the purpose of this study, PUMAs within a county (e.g., Wayne and Kent) are aggregated to create a county-level identifier. This results in 26 specific geographic regions. Weights represented the percentage of cases in the sample frame in the given category divided by the percentage of cases in the sample in the given category. For example, if 4% of cases in the sample were group homes in Wayne County and 5% of cases in the sampling frame were group homes in Wayne County, the case weight would be 0.5/0.4, or 1.2. This would mean that when conducting analysis, each facility of this type in the geographic region would be counted as 1.2 providers, rather than simply 1, so that final estimates would reflect the balance of provider types and geography in the state as a whole.

b) Type of provider. Describe:

The 2020 Market Rate Survey was a census survey, meaning all licensed child care providers were invited to participate. Although not licensed by the State, tribal providers were also invited and responded to the survey. As of January 2021, the Child Care Licensing Bureau (CCLB) database of licensed child care providers included a total of 6,935 licensed and active providers; 3,008 of those providers responded to the market rate survey, for an overall response rate of 44%. Although the participation rates among group homes (48%) and family homes (45%) were higher than among centers (40%), analysis comparing the sample of respondents to non-respondents showed the sample to be highly representative of the overall population of providers.

c) Age of child. Describe:

Ages of children were broken into three categories for analysis. Infant/toddler, preschool, and school age. Ages were compared across all licensed provider types.

d. Describe any other key variations examined by the market rate survey or ACF pre-approved alternative methodology, such as quality level.

In addition to the above items, Michigan also included analysis across quality levels, whether the child care subsidy offered to families is enough to cover the cost of care, whether or not registration fees are charged, and what the most common frequency of payment is used by providers across the state. Michigan also looked at equitable access to quality care.

4.2.5 Has the Narrow Cost Analysis been completed for the FY 2022 - 2024 CCDF Plan?

☐ No, a waiver is being requested in Appendix A. If no, describe the status of the Lead Agency's upcoming narrow cost analysis.

☑ Yes, the narrow cost analysis information is included in the report as described in 4.2.6. If yes, describe how the State/Territory analyzed the cost of child care through a narrow cost analysis for the FY 2022 - 2024 CCDF Plan, including:

a. The methodology the Lead Agency used to conduct, obtain, and analyze data on the estimated cost of care (narrow cost analysis), including any relevant variation by geographic location, category of provider, or age of child (98.45 (f)(ii)).

To assess the cost of quality care to meet the health and safety standards in

Michigan, a pre-programmed model was used: The Provider Cost of Quality Calculator (PCQC) developed for the U.S. Administration for Children and Families' Office of Child Care. The PCQC is a dynamic web-based tool that calculates the estimated cost of the inputs used by providers to deliver services at various levels of quality. The PCQC model considers hypothetical expenditures and revenues for child care centers and home settings separately.

To determine what impact various factors thought to be cost drivers could have on the bottom line for operating costs, the model was used to create multiple scenarios by systematically altering several of these factors. This is a sensitivity analysis.

Cost drivers that were manipulated for assessment include:

- Level of star rating.
- Quality activities such as additional professional development time and conducting screenings.
- Child-to-teacher/caregiver ratios.
- Enrollment as a percentage of capacity.
- Percentage of families receiving the CDC subsidy.
- CACFP participation and mix of eligible children.

b. How the methodology addresses the cost of child care providers' implementation of health, safety, quality and staffing requirements (i.e. applicable licensing and regulatory requirements, health and safety standards, training and professional development standards, and appropriate child to staff ratio, groups size limits, and caregiver qualification requirements (98.45 (f)(ii)(A)).

As part of the MRS, Michigan used data that was available to the Department to help populate and inform Provider Cost of Quality Calculator (PCQC). Inputs were drawn from the market rate survey results, as well as multiple secondary sources, including:

•The Bureau of Labor Statistics (BLS)

•The Michigan Department of Education, Office of Great Start (OGS)

•The Center for Educational Performance and Information (CEPI)

•The Early Childhood Investment Corporation (ECIC).

In addition, interviews were conducted with 24 providers, representing a mix of centers and home-based programs who were selected using a stratified random sampling. Information provided by the interviewees helped to refine cost estimates and provided additional context related to the costs of providing care.

To assess the cost of quality care to meet the health and safety standards in Michigan, the assessment was conducted using a pre-programmed model: The Provider Cost of Quality Calculator (PCQC) developed for the U.S. Administration for Children and Families' Office of Child Care by Andrew Brodsky and Simon Workman at Augenblick, Palaich and Associates and Anne Mitchell at the Alliance for Early Childhood Finance. The PCQC is a dynamic web-based tool that calculates the estimated cost of the inputs used by providers to deliver services at various levels of quality. The PCQC model considers hypothetical expenditures and revenues for child care centers and home settings separately.

To determine what impact various factors thought to be cost drivers could have on the bottom line for operating costs, the model was used to create multiple scenarios by systematically altering several of these factors. This is a sensitivity analysis. Cost drivers that were manipulated for assessment include:

- Level of star rating.
- Quality activities such as additional professional development time and conducting screenings.
- Child-to-teacher/caregiver ratios.
- Enrollment as a percentage of capacity.
- Percentage of families receiving the CDC subsidy.
- CACFP participation and mix of eligible children.

c. How the methodology addresses the cost of higher-quality care, as defined by the Lead Agency using a quality rating and improvement system or other system of quality indicators, at each level of quality (98.45 (f)(ii)(B)).

To model the cost of higher-quality care, multiple PCQC cost models were developed to reflect costs among providers at various quality rating levels. Detailed quality rating score data for existing providers were used to generate accurate models at various levels of quality. Specifically, the range of scores for each of the quality rating categories for providers at particular rating levels were used to estimate how specific cost drivers (e.g., child-to-teacher ratios, use of student assessments, staff time spent on quality activities) vary as quality rating levels increase.

d. The gap between costs incurred by child care providers and the Lead Agency's payment rates based on findings from the narrow cost analysis.

Despite raising the base reimbursement rates in 2020, the differences between the base subsidy rates and market rates changed very little since the last market rate survey. Overall, subsidy rates are lower than the market rate for centers at all age levels; subsidy rates are closer to market rates for home-based providers across age levels; the closeness of subsidy and market rates varies by region; and about 62% of providers charge families the full different between the subsidy and tuition cost.

Cost analysis revealed:

- Biggest cost driver for providers is staffing.
- Many home-based providers are making less than minimum wage.
- The Child and Adult Care Food Program (CACFP) plays a critical role in the financial health of child care providers.
- Higher quality ratings increase provider costs.
- The CDC program strengthens provider finances and enhances access to child care.
- The pandemic has weakened providers' financial situations.

4.2.6 After conducting the market rate survey or ACF pre-approved alternative methodology, the Lead Agency must prepare a detailed report containing the results of the MRS or ACF pre-approved alternative methodology. The detailed report must also include the Narrow Cost Analysis, as described in 4.2.5, which estimates the cost of care (including any relevant variation by geographic location, category of provider, or age of child) necessary to support (1) child care providersâ implementation of the health, safety, quality, and staffing requirements, and (2) higher quality care, as defined by the Lead Agency using a quality rating and improvement system or other system of quality indicators, at each level of quality. For states without a QRIS or for a state with a QRIS system that is currently limited to only certain providers, those states may use other quality indicators (e.g. provider status related to accreditation, PreK standards, Head Start performance standards, school-age quality standards, or state defined quality measures.)

The Lead Agency must make the report with these results widely available no later than 30 days after completion of the report, including posting the results on the Lead Agency website. The Lead Agency must describe in the detailed report how the Lead Agency took into consideration the views and comments of the public or stakeholders.

Describe how the Lead Agency made the results of the market rate survey or ACF pre-approved alternative methodology report widely available to the public (98.45(f)(1)) by responding to the questions below.

a. Date the report containing results was made widely available - no later than 30 days after the completion of the report. 3/30/2021

b. Describe how the Lead Agency made the detailed report containing results widely available and provide the link where the report is posted.

MDE - PARTNERS (michigan.gov) . This report was shared electronically on our website and with partners by email. In addition, stakeholders were able to provide feedback and comments on the market rate survey during four public hearings or in writing.

c. Describe how the Lead Agency considered stakeholder views and comments in the detailed report.

Comments were evaluated to determine whether they changed or clarified the content of the report. Edits to the report were made, as necessary. Comments that were specific to future program improvements related to child care rates were reviewed by staff for the possibility of future implementation.

4.3 Establish Adequate Payment Rates

The Lead Agency must set CCDF subsidy payment rates, in accordance with the results of the current MRS or ACF pre-approved alternative methodology, as identified in 4.2.1, at a level to ensure equal access for eligible families to child care services that are comparable with those provided to families not receiving CCDF assistance. Lead Agencies must also consider the costs of base and higher quality care at each level as part of its rate setting. The Lead Agency must re-evaluate its payment rates at least every 3 years.

4.3.1 Provide the base payment rates and percentiles (based on the most recent MRS as identified in 4.2.1) for the following categories below.

4.3.1 Provide the base payment rates and percentiles (based on the most recent MRS as identified in 4.2.1) for the following categories below.

Lead Agencies are required to provide a summary of data and facts in their Plan to demonstrate how its payment rates ensure equal access. The preamble to the final rule (81 FR, p. 67512), indicates that a benchmark for adequate payment rates is the 75th percentile of the most recent MRS. The 75th percentile is the number separating the lowest 75 percent of rates from the highest 25 percent. Setting rates at the 75th percentile, while not a requirement, would ensure that eligible children have access to three out of four child care slots.

The 75th percentile benchmark applies to the base rates. Base rates are the lowest, foundational rates before any differentials are added (e.g., for higher quality or other purposes). Further, base rates must be sufficient to ensure that minimum health and safety and staffing requirements are covered.

Percentiles are not required if the Lead Agency conducted an ACF pre-approved alternative methodology, but must be reported if the Lead Agency conducted a MRS. For states that conduct an ACF pre-approved alternative methodology, report the base payment rates based on a full-time weekly rate.

The ages and types of care listed below are meant to provide a snapshot of the categories on which rates can be based and are not intended to be comprehensive of all categories that might exist or to reflect the terms used by the Lead Agency for particular ages. If rates are not statewide, please use the most populous geographic region (defined as the area serving highest number of CCDF children) to report base payment rates below.

a. Provide the base payment rates and percentiles based on either the statewide rates or the most populous area of the state (area serving highest number of children accessing CCDF). To facilitate compiling state by state payment rates, provide the full-time weekly base payment rates in the table below. If weekly payment rates are not published, then the Lead Agency will need to calculate its equivalent.

i. Age of child in what type of licensed child care setting (All rates are full-time) - Infant

(6 months) Center care:

Base payment rate:4.30

Full-time weekly base payment rate: 193.50

If the Lead Agency conducted an MRS, what is the percentile of the base payment rate? 66.4

If the Lead Agency used an alternative methodology what percent of the estimated cost of care is the base rate?

ii. Age of child in what type of licensed child care setting (All rates are full-time) - Toddler (18 months) Center care:

Base payment rate:4.30

Full-time weekly base payment rate: 139.50

If the Lead Agency conducted an MRS, what is the percentile of the base payment rate? 66.4

If the Lead Agency used an alternative methodology what percent of the estimated cost of care is the base rate?

iii. Age of child in what type of licensed child care setting (All rates are full-time) - Preschooler (4 years) Center care:

Base payment rate:3.05

Full-time weekly base payment rate: 137.25

If the Lead Agency conducted an MRS, what is the percentile of the base payment rate? 56

If the Lead Agency used an alternative methodology what percent of the estimated cost of care is the base rate?

iv. Age of child in what type of licensed child care setting (All rates are full-time) - School-age child (6 years) Center care (Based on full-day, full-year rates that would be paid during the summer):

Base payment rate:2.95

Full-time weekly base payment rate: 112.50

If the Lead Agency conducted an MRS, what is the percentile of the base payment rate? 68.9

If the Lead Agency used an alternative methodology what percent of the estimated cost of care is the base rate?

v. Age of child in what type of licensed child care setting (All rates are full-time) - Infant (6 months) Family Child Care:

Base payment rate:3.45

Full-time weekly base payment rate: 115.25

If the Lead Agency conducted an MRS, what is the percentile of the base payment rate? 81.8

If the Lead Agency used an alternative methodology what percent of the estimated cost of care is the base rate?

vi. Age of child in what type of licensed child care setting (All rates are full-time) - Toddler (18 months) Family Child Care:

Base payment rate:3.45

Full-time weekly base payment rate: 115.25

If the Lead Agency conducted an MRS, what is the percentile of the base payment rate? 81.8

If the Lead Agency used an alternative methodology what percent of the estimated cost of care is the base rate?

vii. Age of child in what type of licensed child care setting (All rates are full-time) - Preschooler (4 years) Family Child Care:

Base payment rate:2.95

Full-time weekly base payment rate: 112.50

If the Lead Agency conducted an MRS, what is the percentile of the base payment

rate? 73.8

If the Lead Agency used an alternative methodology what percent of the estimated cost of care is the base rate?

viii. Age of child in what type of licensed child care setting (All rates are full-time) - School-age child (6 years) Family Child Care (Based on full-day, full-year rates that would be paid during the summer):

Base payment rate:2.85

Full-time weekly base payment rate: 128.25

If the Lead Agency conducted an MRS, what is the percentile of the base payment rate? 73.3

If the Lead Agency used an alternative methodology what percent of the estimated cost of care is the base rate?

b. If the Lead Agency does not publish weekly rates then how were these rates calculated (e.g., were daily rates multiplied by 5 or monthly rates divided by 4.3)?

The cost analysis required weekly rates rather than hourly rates. These rates were calculated by multiplying the previously estimated full-time hourly rate by 45 (i.e., 5 9-hour days), weighted by geography and provider type.

c. Describe how the Lead Agency defines and calculates part-time and full-time care.

Part-time 1-30 hours /two weeks hours billed x hourly rate.

Part-time 31-60 Hours /two weeks 60 Hours x hourly rate.

Full-time 61-80 Hours /two weeks 80 hours x hourly rate.

Full-time+ 81+ hours /two weeks 90 hours x hourly rate.

d. Provide the date these current payment rates became effective (i.e., date of last update based on most recent MRS as reported in 4.2.1). January 2020

e. If applicable, identify the most populous area of the state (area serving highest number of children accessing CCDF) used to complete the responses above.

Rates are statewide.

f. Provide the citation, or link, if available, to the payment rates

https://www.michigan.gov/documents/mde/Payment_Rates_for_Website_469416_7.pdf

g. If the payment rates are not set by the Lead Agency for the entire state/territory, describe how many jurisdictions set their own payment rates (98.16(i)(3)).

n/a

4.3.2 Describe how and on what factors the Lead Agency differentiates payment rates. Check all that apply.

☐ a. Geographic area.

Describe:

☑ b. Type of provider.

Describe:

Child care centers, homes, and license exempt providers all receive different rates of pay.

☑ c. Age of child.

Describe:

Licensed providers, license exempt centers, and group/family homes, and license exempt related and unrelated providers who have taken additional training receive higher reimbursement rates for infant/toddlers (birth to age 2 ½ years), preschoolers (age 2 ½ to 5 years), and school age (over age 5).

☑ d. Quality level.

Describe:

Licensed providers with a star rating of 2, 3, 4, or 5 receive tiered rates and Level 2 license exempt providers are paid above the base rate.

☐ e. Other.

Describe:

4.3.3 Lead Agencies can choose to establish tiered rates, differential rates, or add-ons on top of their base rates as a way to increase payment rates for targeted needs (i.e., a higher rate for special needs children as both an incentive for providers to serve children with special needs and as a way to cover the higher costs to the provider to provide care for special needs children). Lead Agencies may pay providers more than their private pay rates as an incentive or to cover costs for higher quality care (81 FR, p. 67514).

Has the Lead Agency chosen to implement tiered reimbursement or differential rates?

- [ ] No.
- [x] Yes. If yes, identify below any tiered or differential rates, and at a minimum, indicate the process and basis used for determining the tiered rates, including if the rates were based on the MRS or an ACF pre-approved alternative methodology. Check and describe all that apply.
- [ ] a. This option should not be selected if the answer above is "Yes" -- Tiered or differential rates are not implemented.

Describe:

- [ ] b. Differential rate for non-traditional hours.

Describe:

- [ ] c. Differential rate for children with special needs, as defined by the state/territory.

Describe:

- [ ] d. Differential rate for infants and toddlers. Note: Do not check if the Lead Agency has a different base rate for infants/toddlers with no separate bonus or add-on.

Describe:

- [ ] e. Differential rate for school-age programs. Note: Do not check if the Lead Agency has a different base rate for school-age children with no separate bonus or add-on.

Describe:

☑ f. Differential rate for higher quality, as defined by the state/territory.
Describe:
Licensed providers with a star rating of 2, 3, 4, or 5, tribal, and military providers receive tiered rates and Level 2 license exempt-related and unrelated providers.

☐ g. Other differential rates or tiered rates.
Describe:

4.3.4 Establishment of adequate payment rates.

a. Describe how base payment rates are adequate and enable providers to meet health, safety, quality, and staffing requirements under CCDF, and how they were established based on the most recent MRS or ACF pre-approved alternative methodology and the Narrow Cost Analysis, as reported in 4.2.1 and 4.2.5.. In determining compliance with the Act for the equal access provisions in the FY2019-2021 CCDF Plan, the OCC reviewed all the states with payment rates below the 75th percentile benchmark. Of those states, the half with the lowest payment rates were considered non-compliant and placed on a corrective action plan (CAP). These states all had rates below the 25th percentile for either some or all categories of care. The 25th percentile is not to be viewed as a benchmark or a long-term solution to gauge equal access. It is also not to be viewed as sufficient for compliance in future plan cycles. OCC expects to continue to take action against states with the lowest rates in future plan cycles in an effort to keep payment rates moving upward toward ensuring equal access. Note: Per the preamble (81 FR p. 67512), in instances where an MRS or ACF pre-approved alternative methodology indicates that prices or costs have increased, Lead Agencies must raise their rates as a result.
For centers, the subsidy rates at all star levels are below the 75th percentile of the base market rates for all age groups. The gaps are largest among the preschool age group, where the base reimbursement rate is 44% below the base market rate. The gaps are smallest among the infant and toddler age group, where the base reimbursement rate is 33.9% below the base market rate.

Compared to centers, the reimbursement rates across all age groups and star ratings for home-based providers are closer to the base market rates. At higher star levels (4 and 5 stars), the reimbursement rates for home-based providers surpass base market rates. As noted above, though, only 3% of family homes and 5% of group homes are currently rated above the 3-star level.

As part of the MRS, Michigan used data that was available to the Department to help populate and inform Provider Cost of Quality Calculator (PCQC). Inputs were drawn from the market rate survey results, as well as multiple secondary sources, including: •The Bureau of Labor Statistics (BLS) •The Michigan Department of Licensing and Regulatory Affairs, Child Care Licensing Division •The Michigan Department of Education, Office of Great Start •The Center for Educational Performance and Information (CEPI) •The Early Childhood Investment Corporation (ECIC). In addition, interviews were conducted with 24 providers, representing a mix of centers and home-based programs. Information provided by the interviewees helped to refine cost estimates and provided additional context related to the costs of providing care. After utilizing the PCQC, additional data and provider interviews, it was determined that base payments rates are not enough to support the cost of meeting health, safety, quality and staffing requirements under CCDF. It was determined that staffing alone accounts for 75%-85% of operating costs in child care centers. When possible, Michigan continues to offer funding to help mitigate the cost of the criminal history check requirements for
providers and developed low cost health and safety training modules, and free ongoing health and safety training modules. Overall, programs are more concerned about ongoing health and safety costs. Food was also identified as a high cost for programs, as well as home insurance for those operating a program in their home. Costs for higher quality programs in the GSQ were also identified. A common factor seemed to be enrollment and being able to count on that enrollment to meet costs.

b) Describe how payment rates are adequate and have been established based on the **most recent MRS or alternative methodology** . Note: Per the preamble (81 FR 67512), in instances where a MRS or alternative methodology indicates that prices or costs have increased, Lead Agencies must raise their rates as a result.

For families that qualify for CDC assistance, the State reimburses approved providers for the hours that a child is in care, up to a maximum number of hours approved for each child. The hourly rate for reimbursements is determined based on the age of the child,

the type of provider, and the provider's Great Start to Quality (GSQ) star rating. The current reimbursement rates for centers and home-based providers, was set by the state legislature in January 2020. In addition to increased rates, the changes that took effect in January 2020 also included a new preschool age category, separating children over two and a half years old into two groups. Despite raising the base reimbursement rates in 2020, the differences between the base subsidy rates and market rates changed very little since the last market rate survey was conducted in 2017. The average difference between the current base subsidy rate and base market rate across all age groups is $2.26 among centers and $0.98 among home-based providers. In 2017, the average differences were $2.21 and $0.95, respectively. In 2020, the CDC program also implemented a new bi-weekly block reimbursement rate. This policy moved away from hourly billing and closer to the daily or weekly billing that is common among providers. Depending on the hours of care billed over a two-week period for a child receiving subsidies, the block reimbursement rate allows providers to round the actual hours to a pre-determined standard number of hours for part-time or full-time care before multiplying the rounded total by the hourly rates. COVID-19 appears to have increased costs to providers while their revenues were reduced by low enrollment. In interviews, providers noted the powerful effect of the pandemic. COVID-19 resulted in lower enrollments and higher costs required for cleaning (both in time and supplies), as well as additional personnel and direct costs to ensure safety protocols were adhered to (especially at centers). Most interviewees expected these increased costs to remain permanent. COVID-19 may also be responsible for the higher numbers of open slots in the 2020 Market Rate Survey. While the 2017 survey had an average of 88% enrollment efficiency (the proportion of open slots to capacity), centers and family home providers reported in February 2021 enrollment efficiency levels of 69%, and group homes had enrollment efficiency of 77%. Unfilled slots are lost revenue to providers, which affects the profitability of child care providers. The analysis presented thus far assumes that providers' daily enrollment is at the PCQC default rate of 85%. However, if this number is lower because of shorter hours or fewer students (and hence less tuition and subsidy revenue), it has a major effect on the net revenue of providers. If the lower enrollment efficiency indicated in the Market Rate Survey is indicative of long-term trends during the pandemic, it would result in serious financial losses to providers. However, several providers interviewed as part of this study indicated that state grants (including the Child Care Relief Fund grants) played a critical role in compensating for lost enrollment.

4.3.5 Describe how the Lead Agency took the cost of higher quality, as determined in 4.2.5, into account, including how payment rates for higher-quality care, as defined by the Lead Agency using a QRIS or other system of quality indicators, relate to the estimated cost of care at each level of quality. Note: For states without a QRIS, the states may use other quality indicators (e.g. provider status related to accreditation, PreK standards, Head Start performance standards, or state-defined quality measures).

The Great Start to Quality's quality rating and improvement system aims to help parents understand the quality of care available as they select a provider and to assist providers in continually improving the care they are able to offer through professional development, professional membership fees, educational supplies, vehicle expenses, licensing and permits, and utilities, thereby supporting quality care across the child care system in the state.

The QRIS calculates ratings, or "stars," for participating licensed child care providers based on a detailed point system to signal level of quality being provided. Points are earned based on provider characteristics and practices associated with high quality. These include staff credentials and professional development, family and community engagement, administrative capacity, health and physical safety, curriculum and assessment, and certain child-to-teacher ratios.

Providing higher quality care, as reflected by higher QRIS star ratings, is associated with higher operating costs for child care providers, and in particular higher personnel costs. The chief reason is that one of ways for providers to increase quality is to employ personnel who have more early child care-specific training and education. Even at lower-rated providers (including home-based providers), staff are expected to have at least a Child Development Associate (CDA) credential, which requires a fee and professional education. With more credentials, staff expect greater compensation, thus increasing staffing costs.
Improving quality by ensuring lower teacher-to-child ratios also necessarily increases personnel costs by increasing the number of staff required. Holding all other factors, such as enrollment and poverty level, fixed, child care centers with higher star ratings had higher total personnel costs than those with lower ratings. Two-star centers had total personnel costs that were nearly 40% lower than 5-star centers in the analysis. Differences in non-personnel costs were negligible.

Interviews with providers found that there was little appetite for making the quality improvements necessary to move to a higher star rating, largely due to the increased costs a provider would incur. This reluctance was largely due to the difficulties of finding adequately trained staff and the wages necessary to pay them. There was also frustration at delays in the certification of staff in the Michigan Registry (www.miregistry.org) system.

4.3.6 Identify and describe any additional facts that the Lead Agency considered in determining its payment rates ensure equal access. If applicable, provide a description of how any additional health and safety costs, because of the COVID-19 pandemic are included in rate setting.

A principal aim of the study was to examine the extent to which there is equal access to care across Michigan. Factors influencing access include geographic proximity to care, access to care that is responsive to the individual needs of children and families, and affordability. Since this research was conducted during the pandemic, the survey also addressed special cost considerations associated with preventing the spread of COVID-19. Six percent of providers increased their rates to cover the extra costs associated with covid-19. The primarily costs identified by providers were driven by fewer children in care, which was reported by 54% of family homes and 84% of centers, combined with the fact that very few providers reported changing the rates charged to families. Only 17% indicated a change in rates, and within that small percentage 64% reported that they decreased rates rather than increasing them.

4.4 Implement Generally Accepted Payment Practices and Ensure Timeliness of Payments

4.4 Implement Generally Accepted Payment Practices and Ensure Timeliness of Payments

Lead Agencies are required to demonstrate that they have established payment practices applicable to all CCDF child care providers that include ensuring the timeliness of payments by

either (1) paying prospectively prior to the delivery of services or (2) paying within no more than 21 calendar days of the receipt of a complete invoice for services. To the extent practicable, the Lead Agency must also support the fixed costs of providing child care services by delinking provider payments from a child's occasional absences by (1) paying based on a child's enrollment rather than attendance, (2) providing full payment if a child attends at least 85 percent of the authorized time, (3) providing full payment if a child is absent for 5 or fewer days in a month, or (4) using an alternative approach for which the Lead Agency provides a justification in its Plan (658E(c)(2)(S)(ii); 98.45(l)(2)).

Lead Agencies are required to use CCDF payment practices that reflect generally accepted payment practices of child care providers who serve children who do not receive CCDF-funded assistance. Unless a Lead Agency is able to demonstrate that the following policies are not generally accepted in its particular state, territory, or service area or among particular categories or types of providers, Lead Agencies must (1) pay providers based on established part-time or full-time rates rather than paying for hours of service or smaller increments of time and (2) pay for reasonable, mandatory registration fees that the provider charges to private-paying parents (658E(c)(2)(S); 98.45(l)(3)). Responses may also identify any additional health and safety fees providers are charging as a result of COVID-19.

In addition, there are certain other generally accepted payment practices that are required. Lead Agencies are required to ensure that child care providers receive payment for any services in accordance with a payment agreement or an authorization for services, ensure that child care providers receive prompt notice of changes to a family's eligibility status that could impact payment, and establish timely appeal and resolution processes for any payment inaccuracies and disputes (98.45(l)(4) through (6); 658E(c)(2)(S)(ii); 98.45(l)(4); 98.45(l)(5); 98.45(l)(6)).

4.4.1 Certify by identifying and describing the payment practices below that the Lead Agency has implemented for all CCDF child care providers.

a. Ensure the timeliness of payments by either (Lead Agency to implement at least one of the following):

☐ i. Paying prospectively prior to the delivery of services.

Describe the policy or procedure.

☑ ii. Paying within no more than 21 calendar days of the receipt of a complete invoice for services.

Describe the policy or procedure.

Child care providers bill electronically after care has been provided on a bi-weekly basis. There is a published billing deadline, which is a few days after the pay period ends. If the billing is done by the billing deadline, payment is generated within eight to ten days. If billing is done after the deadline, but before 90 days, payment is generated within eight to ten days of billing. Payroll is processed on a weekly basis to ensure providers are paid in a timely manner.

b. To the extent practicable, support the fixed costs of providing child care services by delinking provider payments from a child's occasional absences by: (Note: The Lead Agency is to choose at least one of the following):

☑ i. Paying based on a child's enrollment rather than attendance.

Describe the policy or procedure.

Due to COVID 19 and Executive Order 2020-21: During the time period of March 16, 2020 - June 20, 2020, (Pay Periods 007 through 013), providers were instructed to bill regular child care hours instead of absence hours when the child was in attendance, absent, or the facility was closed. Providers were not required to utilize annual absence hours during this time. During the time period of August 16, 2020 (Pay Period 018) - December 19, 2020, (Pay Period 026) child care providers may bill the child care subsidy for care provided during the school day for school-age children. To be eligible for billing the child must be enrolled in a virtual education program where virtual learning is the only available option, or the family has a health concern. If funding becomes available this policy could be extended.

☑ ii. Providing full payment if a child attends at least 85 percent of the authorized time.

Describe the policy or procedure.

All Michigan child care providers billing for CDC are allowed to bill for up to 360 absence hours per child per fiscal year for days when the child would normally be in care, regardless of the reason for the absence. For children in full time care who attend 85% or more of the time, the 15% absence is covered, resulting in full payment. The maximum payment issued per child is for 90 hours every two weeks (Michigan pays biweekly). There are 26 two-week pay periods per year. 90 hours multiplied by 26 pay periods is equal to 2,340 maximum available hours per child per year.

2,340hours multiplied by 15 percent (amount required to be covered) is equal to 351 hours per year. Michigan allows 360 hours per year, exceeding the requirement for full time enrollment. For part time enrollment, 360 hours is an even greater percentage of allowable absence hours (example: for a child approved 60 hours every two weeks, 360 hours covers up to 23 percent of absences). Additionally, to ensure the child has absence hours available through the year, billing of absence hours is limited to 10 consecutive days of billing for absences when no billing for care is submitted.

☐ iii. Providing full payment if a child is absent for five or fewer days in a month.

Describe the policy or procedure.

☐ iv. Use an alternative approach for which the Lead Agency provides a justification in its Plan.

If chosen, please describe the policy or procedure and the Lead Agency's justification for this approach.

c. The Lead Agency's payment practices reflect generally accepted payment practices of child care providers who serve children who do not receive CCDF subsidies. These payment practices must include the following two practices unless the Lead Agency provides evidence that such practices are not generally accepted in its state (658E(c)(2)(S); 98.45(l)(3)).

i. Paying on a part-time or full-time basis (rather than paying for hours of service or smaller increments of time).

Describe the policy or procedure and include a definition of the time increments (e.g., part time, full-time).

Child care centers, group homes, and family homes are eligible to receive part-time and full-time reimbursement rates, calculated using the time billed, and multiplied by the provider's hourly rate. Part time is 1-30 hours billed at an hourly rate/two weeks; 31-60 hours billed 60 hours/2 weeks; Full time is 61-80 hours multiplied by hourly rate/2 weeks and full-time 81+ hours multiplied by hourly rate/2 weeks. Providers were asked to indicate how they charge both their full-time and part-time rates for families that do not receive any state and/or federal tuition assistance. Providers who charge tuition using multiple rate structures were asked to indicate the two most common

ways they charge. Approximately 61% of providers indicated that they charge on a weekly basis, and 43% offer a daily rate. While weekly fee structures are most common for full-time tuition, part-time tuition is more often charged daily. In general, these patterns remain consistent across the provider types.

ii. Paying for reasonable mandatory registration fees that the provider charges to private-paying parents.

Describe the policy or procedure.

To fully assess the price of child care, it is important to look beyond tuition rates. Sixty-two percent of providers charge one or more fees in addition to tuition. Among these additional fees, registration fees are the most common, especially among center-based providers. Nearly 90% of centers charge some form of registration fee. The majority (58%) reported only charging an initial fee to register. The other 42% indicated that they collect an initial registration or application fee plus an annual, semi-annual, or other recurring registration fee.

Although not as prevalent as registration fees, other fees include charges for field trips, supplies, transportation, security deposits, and fundraisers. Additional fees for registration and/or supplies, multi-child discounts, and/or absence policies may have an impact on how much parents ultimately pay for child care. Child care centers, group homes, and family homes may bill the CDC program for child care fees. This is intended to help cover fees that are sometimes charged to families, such as registration fees, annual fees, or field trip fees. This is not intended to cover late payment fees, late pick-up fees, bounced check fees, etc. The total fees charged to the CDC program must not exceed what is charged to the general public. Payment for child care fees is limited to $65.00 for centers, and $40 for group and family homes, per child per fiscal year (10/1 - 9/30). Note: License exempt-related and license exempt-unrelated providers are not eligible for payment of child care fees.

d. The Lead Agency ensures that providers are paid in accordance with a written payment agreement or an authorization for services that includes, at a minimum, information regarding provider payment policies, including rates, schedules, any fees charged to providers, including fees related to COVID 19, and the dispute-resolution process. Describe:

Information related to all program requirements for billing and the dispute resolution

process are provided in the CDC Handbook. All child care providers certify that they have read the CDC Handbook, available at our website Michigan.gov/childcare, each time they submit a billing. Billing disputes can be resolved by calling the program office toll-free line at 866-990-3227.

e. The Lead Agency provides prompt notice to providers regarding any changes to the family's eligibility status that could impact payments, and such a notice is sent no later than the day that the Lead Agency becomes aware that such a change will occur.
Describe:
Bridges generates a DHS-198, CDC Provider Notice, to notify CDC providers when: an authorization is added; there is a change in the authorization period; the authorized hours change; closing the CDC eligibility determination groups (EDG); or the family contribution changes.

f. The Lead Agency has a timely appeal and resolution process for payment inaccuracies and disputes. Describe:
If there is a billing or payment issue, child care providers or parents may contact the CDC program during normal business hours at 866-990-3227. The situation is reviewed and resolved as soon as possible by a unit dedicated to ensuring accurate provider payments.

g. Other. Describe:
n/a

4.4.2 Do payment practices vary across regions, counties, and/or geographic areas?

☑ No, the practices do not vary across areas.
☐ Yes, the practices vary across areas.
Describe:

4.4.3 Describe how Lead Agencies' payment practices described in subsection 4.4 support equal access to a full range of providers.

Michigan uses a variety of strategies to ensure families have access to a provider who accept subsidy children by ensuring we provide reimbursement for an adequate number of absences, reimbursement for some registration fees, payments to providers within 21 days, allowing 90 days for back-billing and a part-time/full-time reimbursement structure. In addition, all licensed providers in Michigan are eligible to receive child care subsidy payments without an additional registration process, therefore CCDF children can be assigned to them without delay, allowing them to begin billing for the care of CCDF eligible children as soon as the parent identifies them. License exempt providers are enrolled through the lead agency and must be approved prior to being eligible to receive payments.

4.5 Establish Affordable Co-Payments

Family co-payments are addressed in Section 3 related to minimum 12-month eligibility and the graduated phase-out provision and also in this subsection, because they are an important element for determining equal access. If a Lead Agency allows providers to charge amounts more than the required family co-payments, the Lead Agency must provide a rationale for this practice, including how charging such additional amounts will not negatively impact a family's ability to receive care they might otherwise receive, taking into consideration a family's co-payment and the provider's payment rate.

4.5.1 How will the Lead Agency ensure that the family contribution/co-payment, based on a sliding-fee scale, is affordable and is not a barrier to families receiving CCDF services (98.16 (k))? Check all that apply

☑ a. Limit the maximum co-payment per family.

Describe: .

Co-payment per child, along with a family limit, is limited to no more than 7% of any income category.

☑ b. Limit the combined amount of co-payment for all children to a percentage of family income. List the percentage of the co-payment limit and

Co-payment per child, along with a family limit, is limited to no more than 7% of any income category.

☑ c. Minimize the abrupt termination of assistance before a family can afford the full cost of care ('the cliff effect') as part of the graduated phase-out of assistance discussed in 3.2.5.

Policy minimizes the abrupt termination of assistance before a family can afford the full cost of care (the cliff effect) as part of the graduated phase out of assistance. There are five additional income levels in the sliding co-payment scale to ease families more gradually from child care assistance as they increase their income level up to 85% SMI.

☐ d. Other.

Describe:

4.5.2. Does the Lead Agency choose the option to allow providers to charge families additional amounts above the required co-payment in instances where the provider's price exceeds the subsidy payment (98.45(b)(5))?

☐ No

☑ Yes. If yes:

i. Provide the rationale for the Lead Agency's policy to allow providers to charge families additional amounts above the required co-payment, including a demonstration of how the policy promotes affordability and access for families.

Michigan does not require providers to accept subsidy children. Due to Michigan's low reimbursement rates, it would be cost prohibitive for providers to not charge families and could significantly reduce the number of subsidy providers. By waiving co-payments for those choosing high quality care, we are minimizing parental cost. Additionally, while not completely sufficient, we expect the part-time/full-time reimbursement structure change to help close the gap between state subsidy reimbursement rates and the amounts providers charge.

ii. Provide data (including data on the size and frequency of such amounts) on the extent to which CCDF providers charge additional amounts to families.

When the CDC reimbursement rate does not cover the full price of a child's care, a provider may charge parents directly for the remaining balance or a portion of the balance. In addition to most providers charging families the differences between the actual price and the subsidy rate, 9% charge those families a portion of the difference, and 10% indicated that decisions about whether to charge a co-pay and/or the amount of the co-pay are made on a case-by-case basis. Only 19% of providers indicated that they do not charge families receiving subsidies anything beyond the amount covered by the subsidy.

iii. Describe the Lead Agency's analysis of the interaction between the additional amounts charged to families with the required family co-payment, and the ability of current subsidy payment rates to provide access to care without additional fees.

Rates, co-pay collection, and timing issues were cited by providers as the most challenging aspects of accepting the subsidy. Providers most frequently cited the length of time it takes a family and the provider to receive notices of changes to eligibility, current reimbursement rates, and challenges collecting co-pays from families. Many providers find that rates per hour paid by CDC are below their rates, that billable hours allowed by CDC are below actual hours of care provided, or both, many parents are left with a substantial financial liability after subsidies have been paid. While not completely sufficient, we expect to continue to work to change the part-time/full-time reimbursement structure change to help close the gap between state subsidy reimbursement rates and the amounts providers charge.