Building a Better Child Care System

What Michigan Can Do to Help More Parents and Children Access Quality Care

Prepared for the Michigan Department of Education Office of Great Start

Prepared by Public Sector Consultants

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Call to Action

Every day parents across Michigan make difficult decisions about who will care for their children when they go to school and to work. Some choose center-based programs. Others select providers who care for children in the provider's home. Yet others choose to have family, friends, or neighbors care for their children. Regardless of the provider and setting, parents want stable, affordable child care where their child is safe, happy, healthy, and learning. Too often, however, parents experience challenges when trying to access quality care, which in turn makes it difficult to maintain employment or enroll in college or training. High costs price some parents out of the market. Finding a provider on short notice is challenging for some parents—particularly for parents of infants, toddlers, and children with special needs. Finding a provider that is open when they work can be especially difficult for parents who work second or third shift. These challenges cannot be overcome by parents and providers alone. Child care must be part of Michigan's broader effort to improve early learning and development in our state.

Improving the state's child care system has not been a high enough priority for state policymakers. This mistake may have serious consequences for Michigan's children, and policymakers should turn their attention to child care for three important reasons:

1. Access to high-quality child care can change children's lives.
2. Access to high-quality child care can help families escape poverty.
3. Access to high-quality child care is important to economic development.

CHANGING CHILDREN'S LIVES

Research has firmly established the importance of the first thousand days of life to the intellectual and emotional development of children. What happens in this period can have a lifelong impact. Early investments can increase children's future education success, make them less likely to rely on social welfare programs, and make them more likely to succeed in the labor force.

The majority of children under four years of age are being raised in households where all parents are working, and many of these young children spend the majority of their waking hours in child care. If investments are going to reach children in their first thousand days, these investments are going to need to be delivered, at least in part, through the child care system.

HELPING FAMILIES ESCAPE POVERTY

Access to high-quality, reliable child care can be a difference-maker for low-income parents seeking access to the labor market. Unreliable child care can cause parents to miss work and potentially lose their jobs, and for low-income families, this job loss can start a cascade of negative consequences, including the loss of a vehicle or home, which can make it difficult to again access the labor market. These negative consequences can push a family deep into poverty.

By contrast, access to high-quality child care makes it easier for parents to work. It reduces their absenteeism and turnover. It allows them to stay in the labor market for longer continuous periods, increasing their productivity and wages. It can help them move from poverty to the middle class.

IMPROVING ECONOMIC DEVELOPMENT

Michigan is facing a talent shortage. The state's unemployment rate has fallen below 5 percent, and while this seems like a positive, this is a level at which firms struggle to fill open positions. The lack of readily available workers means that firms may become reluctant to increase investments in the state. This low unemployment rate, however, masks the fact that the state has many people across the skills spectrum who would work if they could access high-quality, affordable child care. If high-quality child care were easier to access, more parents could enter the workforce, helping to alleviate the talent shortage. In addition, the increased availability of high-quality child care would reduce absenteeism, and thereby increase overall worker productivity.

FALLING INVESTMENT

In recent years, Michigan's investment in child care has fallen sharply. As recently as 2003, Michigan was a relatively high-spending state. Michigan's spending on its child care program was equal to about $1,556 per low-income child in a working household—11th highest among states, and well above the national average of $933. By 2013, however, Michigan's per-child spending dropped to $336, which was 11th lowest in the country, and significantly below the year's national average of $679. The number of children served by Michigan's child care program has fallen by more than half, and state spending on child care subsidies has fallen by more than $280 million.

In 2016, Michigan had the unfortunate distinction of returning some child care dollars to the federal government due to an inability to allocate this funding. Currently, Michigan allocates funding for the child care subsidy through a case consensus process. This process allocates funding for the program based on the previous year's spending— and declining enrollment has led to fewer resources for the program. Technical changes in this budget process could allow Michigan to access federal dollars to improve services to children and families as well as implement some of the recommendations in this report.

WE CAN DO BETTER

How can we improve? In late 2015 and early 2016, the Office of Great Start partnered with Public Sector Consultants to gather input on the state of child care in Michigan. More than 1,000 individuals across the state participated in this engagement effort:

- 943 participated in an online survey between December 2015 and January 2016.[1]
- 78 people attended community forums in Detroit, Kalamazoo, and Traverse City.
- 29 attended focus groups in Dearborn, Escanaba, Lansing, and Muskegon.

This report summarizes their feedback and identifies a number of ways to improve Michigan's child care system, particularly focusing on methods related to the state's child care subsidy. These recommendations include practical ways to improve the ability of low-income families to access the subsidy, including simplifying the application process, changing eligibility thresholds, and rationalizing the way providers are reimbursed. Addressing access issues would allow many more low-income families a chance to access a high-quality child care system.

[1] The online survey was shared with a broad array of stakeholders. The biggest share of participants were child care center administrators (18.2 percent), center- or school-based child care providers (17.1 percent), parents or guardians (14.3 percent), and home-based child care providers (13.8 percent). Additionally, a large number of participants (over a quarter) classified themselves as "other." These individuals commonly included respondents who identified as belonging in more than one category.

The inadequacy of some current policies serves a hidden purpose, however. An application process that is difficult for families to navigate keeps them out of the system and helps keep down the cost of the program, while cumbersome reimbursement policies that make many centers reluctant to participate in the program does the same. Policies that make it hard for potentially eligible families to access the system are a back-door way of rationing care.

Michigan can make changes that will improve low-income families' access to care. Improving the process for determining eligibility, streamlining the application process, and rationalizing reimbursement policies are all ways to make the system fairer and more efficient. A system like this will allow more families access, but will cost more money.

Michigan has to have the political will to say that we can do better. We have to be willing to say we are not going to save money by creating a system that prevents children and families from accessing quality care as well as the system's reimbursement rates. Michigan is one of the lowest-ranking states on both of these measures. Given the importance of high-quality child care to child development, helping families escape poverty, and increasing economic development, it is worth closely examining the whole system to see how it can work best for Michigan, as well as what types of investments are needed to put a high-quality system in place that serves Michigan well.

In many regards, Michigan is building on a strong foundation. Interest in early learning and development is high, cross-agency collaboration is improving, and partners across the state are committed to supporting our youngest children. Throughout the report, we intentionally build on this foundation and identified recommendations for the state *and its partners*. Michigan benefits from a robust early childhood network that must be leveraged to successfully elevate quality across the child care system. We call on all partners to support this effort to improve access to quality child care for each and every child in our state, including *state partners* across the Michigan Department of Education (MDE), the Michigan Department of Health and Human Services (MDHHS), the Michigan Department of Licensing and Regulatory Affairs (LARA), and the Early Childhood Investment Corporation (ECIC); *regional partners* including Great Start to Quality Resource Centers and Community Action Agencies, Michigan Works! offices, and United Way organizations; and *local partners* including child care providers, Great Start Collaboratives and Parent Coalitions, local school districts, and *philanthropic partners*.

What's Working

Michigan is making progress on improving its child care system. Throughout this effort participants noted that there are components of Michigan's current system that are working well for children and families.

Participants said that the system overall is increasing its focus on quality. They explained that programs like the Great Start to Quality rating system and licensing standards are bringing more awareness of the importance of quality.

> A business owner explained, "I am the owner of a child care center, working toward 4 Stars and having opened a [Great Start Readiness Program (GSRP)] class within our center. Both GSRP and the stars program have given us incentive to work for higher quality in our program."

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> A program administrator said, "I have noticed that there has been a shift in the last few years in recognizing the importance of the early years in a child's life. There have been attempts made to ensure the quality of the programs that Michigan is supporting."

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> One parent said, "I think it's helpful that some centers are being held accountable to the Great Start to Quality Star Rating System. This is helpful for parents to feel confident in choosing a center."

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For some families, this system-wide focus on quality is translating to access to quality care. Some participants indicated that they can find quality care in their local community, and they praised the number of choices available to families. A parent said, "There are many choices for families to ensure various needs can be met ([such as] schedules, location, services, ages, etc.)."

Other participants pointed to the expansion of the Great Start Readiness Program (GSRP) as an important tool in expanding access to quality care. Others also noted that Head Start and Early Head Start provide high-quality education and care for low-income children from birth through age five.

Participants also praised the quality of child care providers. An administrator said it well: "The dedication of professionals who see a need in early education and the passion to see it available to all children is one of the things that is working in Michigan child care."

Providers also have access to professional development that helps them continually improve care. A home-based provider said, "I'm enjoying having the opportunity to better the quality of child care in my home. The support of my consultant from Great Start to Quality has been very helpful!"

In addition, participants noted there is increased communication and collaboration among those working in the child care system in local communities and regions of the state.

Beyond these specific examples of what is working, participants overwhelmingly expressed optimism that the system can improve.

An advocate said, “I think the greatest improvement is a greater awareness of the need for quality child care.”

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A center-based provider agreed: “I feel that Michigan is starting to realize the importance of early childhood to set a foundation for K–12 experiences.”

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An administrator said, “What happens in child care for children under five years old is being recognized as important! Child care is no longer seen as babysitting but the start of education.”

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“I look for a combination of things [when selecting a provider]. Price, unfortunately, has always been first and foremost for me, but I also look for a safe, nurturing environment where my child can learn and grow.”

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What Parents Want

Throughout this engagement effort, parents reported that they want quality, affordable child care where their child is safe, happy, healthy, and learning.

Parents regularly said they want to trust their providers. One parent said, "[The child care provider] has to be trusted. I need to know they are going to care about my kids and make sure they are safe." Another said, "I pay attention to what they are feeding the kids. I want to know my kids are getting veggies, fruit, and meat, and that they like the food. If [the provider] cares about my kids' health, I can trust them."

Parents wanted their children to be happy. Even, as one parent explained, when it seems that their child likes the child care provider more than mom or dad. "My husband and I felt like chopped liver when our four-year-old wanted to be with [her provider] the whole time at a daycare party. But I want my kids to love their providers; they are with [the provider] for eight to ten hours a day."

Parents want providers that support their child's health and development. One parent explained, "At first, I picked the center because of its reputation that I heard through word-of-mouth, but in time, it was more about the outcome I was seeing in my child. That was a big indicator. They were working with her and educating her along with caring for her." Another added, "The projects [my child] brings home and the songs that she learned in daycare are concrete evidence that they are doing something good while she is there."

These goals, however, all needed to be balanced with cost. As one parent explained, "I look for a combination of things [when selecting a provider]. Price, unfortunately, has always been first and foremost for me, but I also look for a safe, nurturing environment where my child can learn and grow." Parent after parent reported that the cost of child care limits their options. As one person succinctly put it, "You have to go with what's in your budget."

Parents also reported that finding care at all is challenging, regardless of cost. They want to be able to find care when they need it. One parent explained, "The hardest thing I've dealt with is knowing where to go to look for child care. Our friends have older kids so we didn't have word-of-mouth for the area where we live. I ended up at home after [my baby's] birth and in a panic."

Finding care can be particularly difficult for parents of infants and toddlers and those working second and third shifts. Parents believe that the extra regulations for care of infants, along with the higher staffing ratio required, discourage child care providers from accepting infants. One parent said, "Even if you do find [a provider who takes infants], you might end up on a waiting list." Another explained, "I work at a factory going from third, second, and weekend crew 12-hour shifts. I've run across young parents and grandparents who have no daycare options. I know a young couple who couldn't find daycare, so the wife quit her job. In other families, grandparents are raising grandkids because there is no other option. It's the same story in every single plant."

Michigan's Child Care Subsidy

Michigan currently helps working families access child care through the state's Child Development and Care (CDC) program. In FY 2015, the program invested $155,849,400 million[2] in state and federal dollars and provided subsidies to 29,624 Michigan children.[3] State subsidies are available to eligible low-income households in which parents or guardians are engaged in (a) employment or another work-related activity (such as job training), (b) family preservation activities aimed at preventing the out-of-home placement of children who are currently in the home, (c) high school completion, or (d) an approved activity, such as postsecondary education or training.[4] Participating families receive an hourly reimbursement for care based on family income, age of the child, provider type, and quality of the program.

OVERVIEW OF THE CDC PROGRAM

The CDC program is Michigan's implementation of the federal Child Care and Development Block Grant. The block grant was created in 1996 as a public assistance program with the goal of providing affordable care to children while their parents went to work and attended school.

Federal law provides broad guidelines under which states must operate their individual Child Care and Development Fund (CCDF) programs. Eligible children must reside with a family whose income does not exceed 85 percent of the state median income of a same-sized family. Federal law also requires states to conduct a local market-rate survey of child care providers every two years in order to determine prevailing market rates for child care in different areas of the state. Regulations suggest—but do not require—that states set maximum reimbursement rates at levels equivalent to the 75th percentile of relevant market rates; in other words, rates that equal or exceed the charged market rate of 75 percent of the providers in the related market area.

Still, within these guidelines, states have a wide degree of latitude, and programs vary significantly from state to state. States have flexibility in determining income eligibility limits for families, and many, including Michigan, set limits that fall well below the 85 percent state median income maximum guideline. (Michigan's specific requirements are discussed on page 14.) Reimbursement rates to child care providers within the program are also established at the state level. States establish maximum reimbursement rates with family copayments based on a sliding-fee scale linked to income and family size, so that the state picks up a greater share and families pick up a lesser share of the costs at lower levels of income.

REAUTHORIZATION

In 2014, the federal Child Care and Development Block Grant (CCDBG) program was reauthorized with three significant new mandates for states. First, the law introduced new requirements related to health and safety including minimum standards, mandatory criminal background checks, and increased training for licensing inspectors. Second, the law authorizes additional opportunities for states to focus on quality. The law promotes increasing the supply of high-quality providers in underserved communities, requires states to implement early learning and development guidelines, and requires additional professional development

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[2] Funding for the CDC program in FY 2015 was appropriated through PA 252 of 2014, updated by Executive Order 2015-05, and supplemented by PA 6 of 2015.

[3] Michigan Department of Health and Human Services. 2015. "Annual Table: 41–Child Development and Care (CDC) Annual Information." *Annual Report of Key Program Statistics: Fiscal Year 2015.* Available: http://www.michigan.gov/documents/mdhhs/2015_Annual_State_Summary_513885_7.pdf.

[4] For a full discussion of eligibility requirements, see the Bridges Eligibility Manual CDC Program Requirements, April 2016. Available online: http://www.mfia.state.mi.us/OLMWEB/EX/BP/Public/BEM/703.pdf#pagemode=bookmarks.

for providers. To support this focus on quality, states are required to invest at least 7 percent of their federal award on quality improvement in FY 2016. This will increase to 8 percent in FY 2018 and 9 percent in FY 2020. Finally, the law focuses on helping families easily access stable, quality care. This includes providing expanded consumer information and changing eligibility processes.[5] In March 2016, Michigan submitted its plan to meet these requirements, and implementation is underway now.

UNMET NEED

Throughout the recommendations that follow, this report explores several of the challenges associated with the CDC program, including low reimbursement rates, strict income guidelines for initial eligibility, and implementation hurdles. In addition to addressing specific challenges, the recommendations aim to increase overall participation and address unmet need across the state. Since 2007, investment in child care subsidies has plummeted. In FY 2007, total payments were slightly below $416 million and an average of 106,062 children were served each month. By FY 2013, spending had fallen by 67 percent to $135 million, and the number of children served dropped to 43,246.

This drop is attributed to a number of factors, including a performance audit from the Michigan Office of the Auditor General in 2008, new training requirements for unlicensed providers that likely reduced provider participation, increased monitoring of attendance, limits on the number of hours that could be reimbursed (down to 90 every two weeks from 100), and an economic recession that likely decreased employment and the need for child care. Regardless of the cause, Michigan is now spending $280 million less annually on child care subsidies.

Data suggest, however, that need for child care assistance is growing. For example, analysis in *Policy Options to Support Children from Birth to Age Three* (written by the Citizens Research Council and Public Sector Consultants in 2014), explored the unmet need among children in the earliest years of life (birth through age three). This analysis found that a quarter of Michigan's children ages birth through age three—108,000—live at or below 100 percent of the federal poverty level and have all available parents engaged in employment. This suggests that there are many more families eligible for the CDC program than are currently served.

DECLINING INVESTMENT

While there is an unmet need, Michigan's investment in the CDC program has declined since 2003. Michigan was a relatively high-spending state in FY 2003 with expenditures equal to about $1,556 per low-income child in a working household—11th highest among the states and the District of Columbia and well above the national average of $933. By FY 2013, however, Michigan's per-child spending dropped to $336, which was 11th lowest and significantly below the year's national average of $679. Clearly, tight budgets caused by an ailing economy had a significant impact on state child care spending nationally, but Michigan's decline was the sharpest of any state.

[5] Matthews, H. et al. (2015). Implementing the Child Care and Development Block Grant Reauthorization: A Guide for States. National Women's Law Center and CLASP. Available online: http://www.clasp.org/resources-and-publications/publication-1/ccdbg-guide-for-states-final.pdf.

How to Improve Access to Quality Care

How can the state and its partners help families access quality care at an affordable price? Participants suggested five areas of focus:

1. **Increase financial assistance to families**
2. **Increase access to quality providers**
3. **Make it easier for providers to improve their programs**
4. **Increase access to quality information**
5. **Support the early childhood workforce**

While the state is a critical leader in this work, it cannot implement these strategies alone. Michigan benefits from a robust early childhood system, and support from all partners will be necessary to build a child care system that effectively supports each and every child in the state.

These recommendations are based on the survey, focus groups, and community forums conducted as part of this work and on research about other state's approaches to child care. Recommendations are categorized as efforts to improve the CDC program or the state's full child care system. Additionally, timelines are included for each of the recommendations.

- Short term: Implement in the next 18 months
- Medium term: Implement in the next 18–36 months
- Long term: Implement in the next 36 months and beyond

These timelines are intended to help prioritize the recommendations, not limit focus. If capacity, opportunity, or political will would make a different order of events more palatable, this report would encourage reprioritizing.

All of the recommendations outlined below have some cost associated with implementing them. Most of the recommendations have a relatively low cost and require an investment under $10 million. For example, the recommendations call for implementing an advisory team or creating blueprints to implement policy. These are potentially time consuming efforts, but relatively inexpensive ones. Other recommendations start as low-cost efforts, but they could result in increased expenditures. For example, improving the CDC application process is not a significant investment; however, if it is easier to apply to the program, it may result in increased participation, which could significantly increase cost.

1. INCREASE FINANCIAL ASSISTANCE TO FAMILIES

		Recommendations	Short Term	Medium Term	Long Term
CDC program	1.1	Improve the application process			
	1.2	Help families access the subsidy faster	■		
	1.3	Raise reimbursement rates	■		
	1.4	Raise the threshold for initial eligibility		■	■

Over and over again participants—from families and providers to administrators and advocates—reported that families are struggling to pay for child care, particularly quality child care.

One parent said, "I spend almost $10,000 on child care expenses in a year, and I am at the cheapest center that I could find in [my area]."

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Parent after parent agreed. One said, "Quality programs are expensive. While there are scholarships available for low-income people, there is nothing for middle-income families."

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Another parent said, "[My community] does not have very many options that are reasonably priced. A lot of nice centers have closed. The few that are here are good but very expensive."

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As one person succinctly put it, "You have to go with what's in your budget."

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An administrator said, "Most of our parents make too much to qualify [for state assistance] yet day care cost is a real struggle for them."

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Data show that the cost of child care is rising at a rate that outpaces the incomes of typical American families. For example, a recent study conducted by the Economic Policy Institute found that the average

cost for infant care in Michigan is $824 a month—or nearly $10,000 annually. That is 6 percent more than the average price for rent in the state and only 12.5 percent less than families pay for in-state tuition at a four-year public university. The price drops for older children. Average cost of care for a four-year-old is $564 per month—or nearly $7,000 a year. The Economic Policy Institute explains that these costs are particularly unattainable for low-income workers. "A minimum-wage worker in Michigan would need to work full time for 29 weeks, or from January to July**,** just to pay for child care for one infant."[6]

Michigan is not alone. The high cost of child care is a challenge nationally. The recommendations here focus on how Michigan can make child care a manageable expense for our state's neediest families.

1.1 Improve the application process

Details

Over 60,000 families applied for the subsidy and were denied in FY 2015. Participants indicate that many of these families meet the eligibility requirements, but did not correctly complete the application. The state should:

- Analyze data regarding denials to better understand why families are denied
- Clarify current application requirements
- Reassess the application process
- Increase customer service during application and after eligibility determination
- Gather input regarding application process improvements from applicants

Rationale

In FY 2015, 82,377 applications were submitted for the CDC program, and 60,318 were denied—73 percent.[7] Applications were denied for several reasons including being over the income requirements, failing to submit documents, and having incomplete applications. Based on these reasons, it is reasonable to assume that at least some of those applicants would be considered eligible if they received additional support during the application process.

Participants indicated that families commonly experience road blocks during the current application and redetermination process that prevent them from receiving the subsidy—even if they are income eligible

> A parent said, "The application is too hard and time consuming for parents who already have challenges. There has to be a shorter application process and one that someone with a third grade reading and comprehension level can fill out!"

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> Another parent agreed. "[The CDC program] is not worth it for the process you have to go through to get the child care. The CDC program wants you to give them all of your information. They make you keep reapplying."

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[6] Economic Policy Institute. (2016). The Cost of Child Care in Michigan. http://www.epi.org/child-care-costs-in-the-united-states/#/MI.

[7] Data provided by the Michigan Department of Education, Office of Great Start for FY 2015.

To address these needs the state should first clarify the application requirements. Participants said the information about the requirements is inconsistent, and that caseworkers and Internet resources are sometimes contradictory. Families and providers are not sure where to turn for assistance.

Participants also said that the application process itself needs to be revamped. Specifically, they said the process is confusing and that it can be particularly difficult to submit documents.

> A community forum participant said, "The application process can be challenging for those of us who understand the bureaucratic language. People can be rejected very easily for something seemingly minor. It is discouraging for parents to go through this. They will just use a neighbor or a friend to care for their children instead."

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> Another forum participant agreed. "I cannot refer families to the website, because it is impossible. Families are just told there is a website and it is hard to fill out [the online application]. There are a lot of rural areas without access to computers. Decisions [about how to structure application systems] are made for 'middle class and up' parents. There is a lack of awareness that parents don't have access to a computer. We need to think outside the box. The language needs to be readable for lower levels. It can take a lot for professionals to know what they are actually asking for."

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Participants further indicated that they would like to have more customer service available during the application process. Participants said that they were not sure who to call when they had questions, and they suggested assigning caseworkers specifically to the CDC program so families and providers can ask questions and receive consistent, accurate information.

1.2 Help families access the subsidy faster

Details

A long approval window makes it difficult for families to quickly access subsidy assistance when they need it. The state should consider policies to help families access the subsidy faster, including:

- Shortening the approval period
- Granting temporary eligibility to all families
- Granting temporary eligibility for siblings or categorically eligible children

Rationale

After an application is submitted, MDHHS has 45 days to determine if a child is eligible to receive the child care subsidy. Participants said the timeline for approval is challenging from two perspectives. First, families are applying for the subsidy because they are working and cannot afford care. Participants indicated that waiting 45 days to be approved puts additional financial stress on families and/or requires that they find alternate care while they wait for approval.

Second, providers are in a difficult position. Providers reported an interest in helping families secure care while the CDC program application is pending. However, participants indicated that if a provider cares for a child who is found ineligible, the state does not pay for that care. This leaves providers (often small businesses with limited cash on hand) to either absorb the cost or pursue payment from families who often

cannot afford to pay. A provider explained, "We take the kid thinking it is a done deal, but then the parent loses the job and we are out the total cost of caring for that child."

These challenges can be addressed by shortening the approval process for all applicants. Additionally, the state could grant temporary eligibility to all applicants. Once a family submits an application, the state could offer the subsidy for a limited time while the application is under review. This would allow families to start care immediately, and ensure that providers are paid for providing care. Another option is to grant temporary eligibility to siblings or children who are eligible for the subsidy regardless of family income (such as foster children or children who are homeless). This concept of presumptive eligibility is not new to Michigan; it is currently used in Medicaid.[8]

While shortening the application approval period may create an administrative challenge that requires additional staffing, participants indicate that this investment would be worthwhile in terms of increasing access to the CDC program.

1.3 Raise reimbursement rates

Details

Low reimbursement rates make it difficult for families to access child care—even when they qualify for the child care subsidy. Michigan should consider:

- Raising reimbursement rates
- Raising reimbursement rates for specific types of care
- Raising reimbursement rates in the tiered reimbursement structure
- Setting reimbursement rates regionally

Rationale

The CDC program pays for care hourly based on how old the child is and the type of program (this is called standard, or base, reimbursement) and the quality of the program (called tiered reimbursement).

Overall, Michigan's standard reimbursement rates are among the lowest in the country. For a four-year-old in center-based care, Michigan pays center-based providers $2.50 per hour or roughly $487 per month—about 59 percent of the 75th percentile market rate for center-based care, which was $823 per month in the 2013 market rate survey.[9] For infants, Michigan's standard hourly rate is $3.75 per hour per child, equivalent to $731 per month or 60 percent of the 75th percentile market rate of $1,219 for that age group. Only three states—Arizona, Missouri and Ohio—had established lower reimbursement rates as a percentage of the 75th percentile benchmark for one-year-olds in center care. By the same measure, only Arizona and Missouri had lower rates for four-year-olds.[10]

Low reimbursement rates can make it more difficult for families to access care. In general, families are responsible for child care costs that exceed the hourly rate.[11] For example, picture a four-year-old in center-

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[8] State of Michigan. (2016). Bridges Eligibility Manual 136: Presumptive Eligibility. Available online: http://dhhs.michgan.gov/OLMWEB/EX/BP/Public/BEM/136.pdf#pagemode=bookmarks.

[9] Michigan published an updated market rate survey in May 2015. The 2013 data is used to allow for comparisons with other states based on research conducted by the National Women's Law Center. The 2015 MRS can be found here: https://www.michigan.gov/documents/mde/MI_2015_MRS_Final_Report_493236_7.pdf.

[10] Schulman and Blank, Building Blocks: State Child Care Assistance Policies 2015, National Women's Law Center, Table 4A. Available online: https://nwlc.org/wp-content/uploads/2015/11/CC_RP_Building_Blocks_Assistance_Policies_2015.pdf.

[11] Providers can choose not to charge families the balance of the cost of care.

based care. The CDC program pays $2.50 per hour for care for that child. If market rate for care is $4.50 per hour, then the family is responsible for paying the difference: $2.00 an hour. If the family cannot afford to pay, they must seek out a lower-cost—and possibly lower-quality—option.

Standard Reimbursement (Type of Care + Age)

Currently, Michigan offers different reimbursement rates depending on the type of care and the child's age. There are different rates for children in centers, in family and group care, and in unlicensed care (generally family, friend, and neighbor care). Additionally, Michigan offers a higher reimbursement rate for infants and toddlers (under two and a half years of age) to offset the higher costs of care. Despite this higher rate, participants still reported difficulty accessing infant and toddler care. Parents said:

> "Daycare for infants and toddlers costs more. There are more regulations, like labeling bottles. Babies need more changing and cleaning."

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> "Even if you do find [a provider who takes infants], you might end up on a waiting list. When I was pregnant, I did my search early on. [My daughter] was on a waiting list for quite a while before [a spot] opened up."

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EXHIBIT 1. Michigan's standard reimbursement varies, based on type of care and the child's age.

	Center-based Care		Family and Group Child Care		Unlicensed Providers	
	Birth–2.5 years old	Over 2.5 years old	Birth–2.5 years old	Over 2.5 years old	Birth–2.5 years old	Over 2.5 years old
Base Rate	$3.75	$2.50	$2.90	$2.40	$1.35	$1.35

Source: Michigan Department of Education. (N.D.) Child Development and Care (CDC) Reimbursement Rates. Available online: http://www.michigan.gov/documents/mde/Payment_Rates_for_Website_469416_7.pdf.

Some participants also pointed out that families who use child care during nontraditional hours (such as in the evenings or overnight) have even more trouble finding and affording care because providers charge more for care during those hours. They suggested that the subsidy be higher for care provided during non-traditional hours, saying that may lead more providers to offer care during that time, too.

> An administrator said, "There is a big need for late-night care, transportation, special education support, flexibility, but all of these things are costly. I wish I knew [the solution]."

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> An advocate said, "[There are] not many night or weekend centers for child care. I have clients who work third shift but cannot find care. Not sure how it can be improved. 24-hour centers?"

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Another parent agreed. "It is very difficult to find anything for an off-shift like a third shift, call-in shift, or someone going to multiple part-time jobs. The majority of licensed day-cares aren't open past 6 PM."

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Tiered Reimbursement

In 2014 Michigan introduced tiered reimbursement, which pays providers more per hour if they meet certain quality metrics (as defined by the state's quality rating and improvement system—Great Start to Quality). This structure pays high-quality (5 Star) providers up to $1 more per hour of care.

EXHIBIT 2. Michigan's tiered reimbursement varies, based on type of care, the child's age, and provider quality.

	Center-based Care		Family and Group Child Care		Unlicensed Providers	
	Birth–2.5 years old	Over 2.5 years old	Birth–2.5 years old	Over 2.5 years old	Birth–2.5 years old	Over 2.5 years old
Base Rate	$3.75	$2.50	$2.90	$2.40	$1.35[1]	$1.35[1]
2 Star[2]	$4.00	$2.75	$3.15	$2.65	$2.20[2]	$1.85[2]
3 Star	$4.25	$3.00	$3.40	$2.90	N/A	N/A
4 Star	$4.50	$3.25	$3.65	$3.15	N/A	N/A
5 Star	$4.75	$3.50	$3.90	$3.40	N/A	N/A

Source: Michigan Department of Education. (N.D.) Child Development and Care (CDC) Reimbursement Rates. Available online: http://www.michigan.gov/documents/mde/Payment_Rates_for_Website_469416_7.pdf.
[1] Unlicensed providers must complete 7 hours of training per year to be eligible for the subsidy. Their base rate is called "Level 1."
[2] Unlicensed providers may complete 10 additional hours of training per year to be eligible for a higher rate called "Level 2."

Tiered reimbursement can be an effective tool to promote quality, both in encouraging families to select higher-quality providers and encouraging providers to improve quality.

To incentivize providers to pursue quality improvements, tiered reimbursement policies need to consider the one-time and ongoing cost implications of increasing quality and how they impact enrollment, fee collection, and revenues meeting per-child costs.[12] Research suggests that investing in quality is an expensive venture, even with tiered reimbursement. The federal Office of Child Care within the U.S. Department of Health and Human Services now hosts a "Provider Cost of Quality Calculator"—a web-based tool for use by states in evaluating the cost of care at different quality levels based on site-level provider data.[13] Several states have utilized the tool to estimate the costs of operating child care programs at quality levels consistent with state quality rating and improvement system (QRIS) rating levels. Studies conducted in Rhode Island, Washington, and Ohio all suggest that net revenue per child declined significantly as quality levels rose

[12] Alliance for Early Childhood Finance. (2010). The Iron Triangle: A Simple Formula for Financial Policy in ECE Programs. Available online: http://www.earlychildhoodfinance.org/downloads/2010/IronTriangle_10.2010.pdf.
[13] Available online at https://www.ecequalitycalculator.com.

given their current tiered reimbursement policies and employing reasonable assumptions regarding enrollment and fee collection rates.[14] Thus, from a financial standpoint, child care providers still had a disincentive to move to a higher-quality level despite the more favorable reimbursement rates.

Feedback from participants suggests this holds for Michigan as well; the increased reimbursement does not offset the increased cost of quality. As one administrator said, "The current QRIS undoubtedly raises quality of care but at enormous cost to the provider. The QRIS needs to be realistic when setting the standards. The increase in labor hours [for training] is substantial. The cost involved will really hurt the smaller operations."

Setting Reimbursement Rates Regionally

Michigan is among a minority of states that have established a single set of reimbursement rates that apply on a statewide basis. Most states have regional structures that pay different rates in different areas of the state based on the region's—rather than statewide—market rates. The single statewide rate structure creates considerable variance across the state in the adequacy of the state's reimbursement rate when compared to local market rates.

This variability is illustrated in the data analysis found within the most recently updated market rate survey of child care providers released by Michigan in May 2015. As an example, the state's reimbursement rate for infants and toddlers in center-based care met or exceeded the local 75th percentile market rate in 15 counties but was less than 75 percent of the local 75th percentile market rate in four others.[15]

1.4 Raise the threshold for initial eligibility

Details

After Michigan has implemented strategies aimed at maximizing the number of families served by the CDC program under existing income thresholds, the state should raise the threshold for initial eligibility to a higher percentage of the federal poverty level.

Rationale

Many forum participants said that the income level required for someone to be eligible to enter the CDC program is too low. They reported that parents making just a little bit more than current guidelines are also struggling to make ends meet and need assistance paying for child care. Participants further noted that since the program now allows families to maintain their eligibility as their income grows to 250 percent of the federal poverty level, families should be able to enter the program if their income is anywhere below that income level.[16] For example:

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[14] Mitchell, Anne. (2013). The Cost of Quality Early Learning in Rhode Island: Interim Report. Available online: http://qrisnetwork.org/state_resource/2014/cost-quality-early-learning-rhode-island-interim-report. Mitchell, Anne. (2013). Modeling the Cost of Quality in Early Achievers: Centers and Family Child Care. Build Initiative. Available online: http://www.del.wa.gov/publications/elac-qris/docs/Cost_of_Quality_Mitchell_2013.pdf. Johnson, Nina, et al. (2015). Quality Costs How Much?! 2015 QRIS National Meeting. http://qrisnetwork.org/sites/all/files/conference-session/resources/Session194PPTasPDF.pdf.

[15] State of Michigan, Office of Great Start. (2015). Child Care Market Rate Study. Available online: https://www.michigan.gov/documents/mde/MI_2015_MRS_Final_Report_493236_7.pdf.

[16] In July 2015, Michigan established different entry and exit criteria to allow families to continue receiving the child care subsidy until their income reaches 250 percent of the federal poverty level. This policy change now gives Michigan one of the highest exit income limits in the country according to the National Women's Law Center.

A parent said, "They say you make too much [to be on the program], but you can barely feed your kids. I'm paying $900 per month for daycare."

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An administrator said, "Most of our parents make too much to qualify [for state assistance] yet day care cost is a real struggle for them."

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Both currently and historically, Michigan's income eligibility limits have been among the strictest in the country, meaning that families in Michigan have needed a lower monthly income to qualify for any kind of child care subsidy. A 2015 report published by the National Women's Law Center (NWLC) shows that Michigan's income limit for initial eligibility for child care subsidy support is the lowest in the nation in dollar terms and exceeds the threshold of only one other state (Maryland) as a percentage of state median income.[17]

As of February 2015, a family of three in Michigan could become income-eligible for child care assistance when their family income was at or below $1,990 per month, which equates to $23,880 per year. That is equivalent to 38 percent of state median income and 121 percent of the federal poverty level for a same-sized family. Thirty-three states along with the District of Columbia have income limits for initial eligibility equal to at least 50 percent of state median income.

In addition to raising the eligibility threshold, the state should consider *how* the threshold is set. Currently, Michigan's threshold is set indirectly through the annual budget process. The annual allocation for the CDC program is heavily influenced by the number of cases in the previous fiscal year and the average cost per case. This spending data is then used to project and set the next year's budget. Unless a lawmaker specifically changes the eligibility threshold in statute (as was done in the FY 2017 budget when the eligibility threshold was increased to 125 percent of FPL), the eligibility threshold stays the same.

Michigan should consider intentionally setting income eligibility on a metric that is automatically adjusted each year, such as the federal poverty level or state median income. Michigan's eligibility criteria, for example, could require that a family's income be less than 180 percent of the federal poverty level, or the criteria could require income below 60 percent of the state median income. Maintaining such a criteria would require an increase in the CDC program's budget when the FPL or median income increases. The benefit of this approach is that it allows for annual income adjustments that recognize inflation rather than leaving the allocation stagnant. The National Women's Law Center report shows that 28 states have some form of target to aid in regularly adjusting their income limits. Twenty-two of the states use the federal poverty level as a target, while the other six use state median income.

States without any kind of target for income eligibility limits, including Michigan, generally maintain a fixed income limit until such time that the body overseeing the rates (e.g., state agency through rules, or state legislature through budget process) determines that an adjustment is warranted. This can lead to long periods during which the eligibility limits are not adjusted, effectively making eligibility more difficult to achieve as family incomes rise more quickly than the fixed eligibility limits.

[17] National Women's Law Center. (2015). Building Blocks: State Child Care Assistance Policies 2015. Available online: http://nwlc.org/resources/building-blocks-state-child-care-assistance-policies-2015/.

2. INCREASE ACCESS TO QUALITY PROVIDERS

		Recommendations	Short Term	Medium Term	Long Term
CDC Program	2.1	Continue to reassess payment policies	■	■	
	2.2	Contract with quality providers		■	
	2.3	Explore community-based eligibility		■	
State System	2.4	Better understand need	■	■	
	2.5	Help quality providers increase capacity		■	■

In order for families to have access to quality child care, they must not only be able to afford care, but there must also be quality providers in their community. Participants reported that there are limited options for families in their area.

An administrator said, "There is a shortage in our area of spots for all ages of children, and a large shortage in quality programs."

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A parent said, "Distance is a barrier; good child care is too far away . . . Quality child care should be in all areas so everyone has access."

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Another parent agreed. "There is not enough [quality child care], either in home or day care centers. There is not enough or [they're] too far for a parent to drive. Not being open long enough and something [else], overnight day cares don't exist for single parents who work midnights."

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The data agree. Across the state, there are over 9,000 centers, group homes, and family homes.[18] Only 163, or 1.8 percent, of these providers have earned the state's top quality rating, a 5 Star. More providers—28 percent—have earned a 3, 4, or 5 Star rating, indicating that they have demonstrated quality across several

[18] The Early Childhood Investment Corporation tracks data on the number of providers and their star rating monthly. The most current data can be found online: http://greatstarttoquality.org/great-start-quality-data.

categories of program quality indicators in the state's quality rating and improvement system: staff qualifications and professional development; family and community partnerships; administration and management; environment; and curriculum and instruction. Most providers, however, meet only licensing guidelines and do not participate in the quality rating system.[19]

EXHIBIT 3. There are not enough quality providers to serve Michigan's children.

Program Type	Total Programs[1]	Empty Star[2]	1 Star	2 Star	3 Star	4 Star	5 Star
Child Care and Preschool Centers	3,929	2,002	3	39	603	1,167	115
Group Child Care Homes	1,724	1,283	27	94	269	33	18
Family Child Care Homes	3,484	2,890	59	162	331	12	30
Total Programs	**9,137**	**6,175**	**89**	**295**	**1,203**	**1,212**	**163**

[1] Includes programs and providers that are eligible to participate in the Great Start to Quality rating system. Total does not include programs and providers that serve school-age children only or programs and providers that are not in good standing with licensing.
[2] Indicates that a program or provider has met the guidelines to be licensed and registered.
Source: Great Start to Quality. (2016). Dashboard Report: 3-4-16. Available online: http://greatstarttoquality.org/great-start-quality-data.

In addition to centers, group homes, and family homes, Michigan children are also cared for by family, friends, and neighbors—all of which are called unlicensed providers. Twenty-six percent of children receiving the subsidy are cared for by unlicensed providers.[20] These providers must participate in at least seven hours of training to be eligible for subsidy dollars, but are not required to participate in additional quality improvement activities.

To increase access to quality care statewide, Michigan must implement a two-pronged strategy. As outlined in recommendation 2, the state should work to increase the number of children served by high-quality providers. This includes implementing strategies such as making it easier for providers to participate in the CDC program and removing barriers for quality providers that want to increase capacity (by adding classrooms or additional locations). At the same time, the state and its partners should work to improve the quality of programs that children are currently attending. Recommendation 3 includes strategies such as providing more support during the licensing process and increasing participation in Great Start to Quality.

2.1 Continue to reassess payment policies

Details

Michigan has recently implemented policies to update payment processes such as assisting providers with calculations and increasing access to training. These changes aim to make it easier for providers to participate in the CDC; however, additional review of payment policies is needed. The state should consider policies such as:

- Paying for care by the half or full day, rather than hourly
- Paying for care prior to delivery of service

[19] We discuss increasing overall participation in recommendation 3.7.
[20] Data provided by the Michigan Department of Education, Office of Great Start.

- Notifying providers about approval and termination of service more quickly (via online systems, e-mail, text message, etc.)
- Improving communication regarding eligibility

Rationale

Participants indicated that payment processing is a barrier to provider participation in the CDC program—potentially limiting access to quality providers. Participants said that providers are frustrated with payment procedures that do not align well with their general billing and attendance policies. For example, under the CDC program, participants reported that providers:

- Are paid for care hourly, although they charge families by the half-day or full day
- Are paid only for hours the child attends, although they charge families whether a child is present or not[21]
- Are paid after care is provided, although they charge families in advance
- Provide care for children in real time; changes in benefits may then affect payment for care that was already provided

Providers cited several specific examples in which payment policies place an undue burden on providers. First, providers noted that when payments are considered improper, the state expects providers to repay any improper subsidy payments. An improper payment may occur, participants said, when a family is deemed ineligible for the subsidy but the provider is not notified promptly. The provider cares for the child and bills the state, but the bill is rejected. The provider's only option is to attempt to recoup payment from the family directly—a difficult proposition. Most commonly, providers said they simply absorb the cost, which is difficult for these small businesses. Participants explained:

> "Every provider site and every family has a unique number. They should use these to send out communications when there are changes."

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> "It would be amazing for providers to have a portal to get the most up-to-date info on DHS subsidies. We don't know if parents are dropped. It makes us hesitant to take on these families. Sometimes the letter never comes. The communication is poor."

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Second, providers said that payment glitches can delay payment from MDE, sometimes for weeks at a time. These delays again cause financial pressure on providers. They also create frustration and confusion. Providers explained that when payment glitches occur there is often no explanation as to why it happened.

Third, providers reported that eligible families are sometimes unauthorized "randomly." In some instances, the child is no longer eligible, and the provider reports that they were not notified in a timely manner. In other cases, the child is still eligible, and eventually the problem is cleared up, and the family is again eligible for care. In the meantime, providers care for the child but are not able to bill the state for that time.

[21] The CDC program does allow providers to bill for up to 208 absence hours per year per child.

Finally, providers explained that if parents drop off their children at child care and do not go to work, the care provided is not eligible to be billed to the state. Providers expressed frustration with this and equated it to expecting providers to "babysit" parents.[22]

The Office of Great Start has begun efforts to update payment policies. Most importantly, in July 2015, the state introduced 12-month continuous eligibility. This policy confirms eligibility when the parent applies and allows the child to continue receiving the subsidy for a full 12 months before the state will confirm eligibility again. This allows for a continuity of care for the child and helps providers plan more effectively. Additionally, in the state's most recent CCDF state plan, OGS explains that child care providers submit bills electronically every two weeks after care is provided. If bills are submitted on time, providers are paid within eight to ten days. The state monitors the payment process to limit delays and notifies providers in the event of a delay. In addition to these processes, the state has updated its payment policy to allow providers to bill for up to 208 absence hours for days when a child is absent, but would generally be attending care. This policy recognizes the fixed costs associated with providing child care.

[22] Note: While MDE implemented 12-month eligibility in July 2015 to address this concern, participants continued to cite it as a concern.

2.2 Contract with quality providers

Details

The state should award CDC program "slots" to quality providers to encourage those providers to expand service to low-income children. In addition, the state should remove application and redetermination barriers that families face.

Rationale

The federal CCDF program allows states to provide child care subsidies through a voucher-style system or through direct contracts with child care providers. Most states, including Michigan, have systems based on vouchers, whereby the state agrees to subsidize a specific child within an eligible household. The child's family then selects a participating provider, who is reimbursed by the state for the costs of that child's care.

Direct contracts are an alternative to this voucher-based system. With contracts, the state forms an agreement with a specific provider for a care "slot." The provider then seeks to fill the contracted slots with eligible children. The contract offers a degree of financial stability for the child care provider by reducing payment fluctuations.

Contracting also gives states flexibility to customize reimbursement rates and contract requirements. The National Center on Child Care Subsidy Innovation and Accountability has found that contracts can help states to serve previously underserved regional areas as well as hard-to-serve populations and to improve the quality of care through contract requirements. The Center also notes that states have used contracts as a tool to extend Early Head Start, Head Start, and pre-kindergarten programs and help those programs offer more comprehensive services.[23]

Various states have employed the use of contracts with their CCDF programs. Kansas uses CCDF dollars to contract with Kansas Early Head Start grantees who then partner with community-based child care providers to ensure that wrap-around child care is available for participating families; Kansas estimates that 25 percent of CCDF funding will be used through these contractual arrangements. Massachusetts utilizes contracts for children whose families have an ongoing protective services case, who are teen parents, or who are homeless. Oregon has used contracts to promote quality of care. Contracts are available to Head Start providers who are able to provide full-year, full-day care and to providers that have achieved "Oregon Program of Quality" designation. As of 2016, the program will be limited to providers that achieve at least a 3-star rating within Oregon's QRIS.[24]

Michigan piloted a contract system with Early Head Start, Head Start, and GSRP providers through the Early Learning Enhancement Grants in 2013. This pilot was structured as a two-year grant and ended in 2015.

2.3 Explore community-based eligibility

Details

The state should consider designating all children in qualifying communities eligible for the child care subsidy.

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[23] National Center on Child Care Subsidy Innovation and Accountability. (2013). Contracting for Child Care Services for Families Eligible for Subsidy. Available online: https://childcareta.acf.hhs.gov/resource/contracting-child-care-services-families-eligible-subsidy.

[24] State of Oregon. (2015). Child Care Assistance: Contracted Child Care. http://apps.state.or.us/caf/fsm/07cc-m.htm

Rationale

Contracts (as described in recommendation 2.2) provide more financial stability for providers, but they still require families to complete the CDC program application to be eligible. A potential alternative to qualifying individuals is to make entire communities eligible for the program. Communities could be designated as eligible based on criteria such as the number of children living under the federal poverty level, average family income, or participation rates in other means-tested state programs. If a community were eligible, providers could offer the subsidy to any child who lives at an address in that community, without the family having to complete the application process. If considering communities is too broad, census tracts could also be used to identify areas likely to have high need.

There are many details that would need to be considered; however, this would not be the first federally funded effort to consider such an approach. In 2010, the National School Lunch Act was amended to allow districts and schools in high poverty areas to apply for the Community Eligibility Provision (CEP). This provision allows all students in the district or building to receive free breakfast and lunch—without submitting an application. CEP uses data from other means-tested programs such as the Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families to determine whether the school or district meets program qualifications. Prior to implementing the provision, eligible children were missing out on meals due to barriers such as lack of awareness of the program, complex forms, limited English proficiency, and failure to successfully complete the application process.[25]

A similar approach in child care would be innovative. It would eliminate all application barriers for families in the approved communities, and would create an incentive for providers to expand access for low-income families in those areas. CEP was successful in improving participation. When the CEP provision was implemented by the National School Lunch Program, three pilot states (Illinois, Michigan, and Kentucky) saw a 13 percent increase in lunch participation and a 25 percent increase in breakfast participation.[26]

2.4 Better understand need

Details

The state should conduct an analysis of the state's child care market to assess the alignment between the areas where children live and the location of child care providers (at all QRIS levels). This will help identify needs and inform decisions about where to focus supply building efforts.

Rationale

In order to wisely invest resources in supply building, the state must have a comprehensive understanding of needs in the child care market. An analysis of supply and demand can help the state answer questions such as:

- Where are providers located? How many children could they serve in comparison to the number of children in the community?
- Where are high-quality providers located? How many children could they serve in comparison to the number of children in the community?
- Are there any child care "deserts" where there are no licensed providers?

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[25] Frentz, Nate, and Zoë Neuberger. (2012). Key Steps to Improve Access to Free and Reduced-Price School Meals. Center on Budget and Policy Priorities. Available online: http://www.cbpp.org/research/key-steps-to-improve-access-to-free-and-reduced-price-school-meals?fa=view&id=3826

[26] Levin, Madeleine, and Zoë Neuberger. (2013). Community Eligibility: Making High-Poverty Schools Hunger Free. Center on Budget and Policy Priorities. Available online: http://www.cbpp.org/research/community-eligibility-making-high-poverty-schools-hunger-free?fa=view&id=4026

- Are there areas that have a surplus of quality slots?
- How is the current alignment between need and supply likely to change?

This analysis can leverage existing data from sources such as the Census, Great Start to Quality, and state licensing.

In early 2016, the Kresge Foundation funded a report studying need in Detroit neighborhoods titled *The System We Need: A Neighborhood Snapshot of Early Childhood Education in Detroit*. This report compared supply to demand and identified ten high-need neighborhoods.[27] The Kresge Foundation is using this information to inform a five-year, $20 million investment in improving access to high-quality early childhood development programs in the city.[28]

2.5 Help quality providers increase capacity

Details

To help quality providers increase capacity, the state should consider:

- Forming partnerships to fund startup grants
- Forming partnerships to help providers find and fund facilities
- Offering contracts to guarantee CDC slots
- Promoting shared services

Rationale

There are significant costs associated with opening a new child care program—whether it is located in a center or the provider's home. These costs can be mitigated by the state to promote access in high-need communities.

One opportunity is to help providers access start-up funding. Before a provider can accept children and start collecting revenue, providers have a litany of tasks to complete—many of which cost money. Start-up grants or loans would provide much-needed funding to help programs get off the ground. The state of Washington offers such support through the Child Care Facility Fund. Providers apply for loans of $25,000–$100,000 to support operations while the provider completes the licensing process. Funds can be used to start or expand a child care program, make capital improvements to an existing facility, buy classroom materials, and pay for operational expenses for the first three months. Providers repay the loan with 5 percent interest over ten years.[29] While the state of Washington supports this program directly, the Office of Great Start could collaborate with the business and philanthropic community to offer loans or grants.

Another way to support providers as they expand is to help them find and fund facilities. Participants, especially during the community forum in Detroit, explained:

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[27] IFF. (2016). The System We Need: A Neighborhood Snapshot of Early Childhood Education in Detroit. Available online: http://kresge.org/sites/default/files/library/iff-detroit-report-final.pdf.

[28] Kresge Foundation. (2016). Kresge Foundation introduces $20 million initiative to improve early childhood outcomes. Available online: http://kresge.org/news/kresge-foundation-introduces-20-million-initiative-improve-early-childhood-outcomes.

[29] State of Washington, Department of Commerce. (2012). Child Care Facility Fund. Available online: http://www.commerce.wa.gov/Programs/services/CapitalFacilities/Pages/Child-Care-Facility-Fund.aspx.

"There are not enough licensable buildings. The inspector comes in and can't license the building. It reduces the number of spaces for our kids."

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"The facilities are an issue. There should be support dollars to help make the facilities be more licensing-ready. It takes a lot of money and time. You can't do new construction, and we have very old buildings."

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Depending on their situation, providers may need assistance in order to renovate an existing facility or build a new one. In both instances, the state can help either by creating a loan fund with state dollars or through partnerships with nonprofit and philanthropic partners. For example, First Children's Finance offers loans to child care providers in Michigan. The Kresge Foundation is also investing in facilities. The foundation recently partnered with IFF to create the Detroit Quality Fund—a low-interest loan program that will invest in facilities in Detroit and Southeast Michigan. The state should consider how this effort might be bolstered by a partnership with the OGS.

Participants also suggested exploring how elementary schools could be used by child care providers. As the state's K–12 enrollment declines, there may be opportunities to explore how existing infrastructure can be repurposed.

Offering contracts for CDC slots is another tool to assist expansion efforts. Currently, if a high-quality program expands, its new site must complete the quality rating process. This makes sense. The state would want to confirm that the level of quality that existed in the previous location has been maintained. However, while this process is underway, the provider is ineligible to receive the higher subsidy payments available under tiered reimbursement. The Office of Great Start could work with high-quality providers that wish to expand to areas of need by offering contracts that guarantee the provider a certain number of slots at a specific reimbursement rate. The OGS could include terms that require the provider to meet recruitment benchmarks and to achieve a 4 or 5 Star rating over a certain number of years.OGS could also help facilitate shared services initiatives. These initiatives can be as simple as providing materials that streamline common business functions and help providers navigate state regulations. As an example, SharedSource Pennsylvania provides access to tools related to marketing (e.g., customizable templates, e-mail services), administrative forms (e.g., creation of a Family Handbook), and human resources tools (e.g., interview guides), as well as access to online training and professional development aids and guidance in many other administrative areas. The SharedSource website also offers purchasing savings by allowing providers to access negotiated discounts on products and services offered by select vendors.

A more intensive example of sharing services is the formation of a local or regional shared services alliance. A shared services alliance is a community-based partnership comprised of various child care centers and family child care homes working together to share costs and deliver services more efficiently. The child care providers that make up the alliance draw on services provided through a centralized administrative hub made up of shared staff who specialize in different areas of need (e.g. human resources, payroll and billing, assessment and QRIS support, etc.). In some cases, a large child care development center manages the initiative and employs the shared staff, receiving a management fee to support the added cost. In other areas, an intermediary agency such as a child care resource and referral agency or a nonprofit statewide association has taken the lead.

3. MAKE IT EASIER FOR PROVIDERS TO IMPROVE THEIR PROGRAMS

		Recommendations	Short Term	Medium Term	Long Term
CDC Program	3.1	Create a provider advisory team	■		
	3.2	Continue to explore how to best support unlicensed providers	■		
	3.3	Provide funding to support quality improvements		■	
State System	3.4	Align expectations across programs and funding streams	■		
	3.5	Create blueprints outlining how to implement multiple programs and funding streams		■	
	3.6	Increase support during the licensing process	■	■	■
	3.7	Increase participation in Great Start to Quality	■	■	■

Participants reported that one of Michigan's current strengths is an increased focus on quality throughout the child care system. They indicated that efforts like Great Start to Quality and revised licensing standards are raising expectations and encouraging more providers to focus on quality.

One parent said, "I think it's helpful that some centers are being held accountable to the Great Start to Quality Star Rating System. This is helpful for parents to feel confident in choose a center."

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Another parent said, "I think [it's a good thing that] the standards for child care have been set higher so children are getting better quality care. Great Start to Quality has helped a lot of child care providers get to this point."

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This increased focus on quality is a strong foundation, but more needs to be done. Participants reported that statewide, there are simply not enough quality choices for families. A center-based provider explained that when it comes to the quality of child care, "location should not be a factor. Children are children regardless of where they live. I know it is easier said than done, but if the government does not step up and help, I don't see how any parents will be able to afford child care. If they can't afford child care, then they can't work."

In addition to helping quality providers expand (as discussed in recommendation 2.5), the state can also support existing providers in their pursuit of quality.

3.1 Create a provider advisory team

Details

The state and its partners should identify a group of providers (including unlicensed, licensed, and registered providers) to serve as an informal advisory team to offer feedback on areas such as potential policy changes and effective communication methods with the field.

Rationale

As the state continues to expand its focus on improving the quality of the child care system, it is helpful to have a direct line to a group of providers that can quickly provide candid feedback about providers' current thinking and response to draft documents. These quick feedback loops can help state staff hone ideas and ensure that when policies are introduced they do not have unintended consequences. As one administrator explained, "Even the smallest change at the state level has huge implications across the state. When there is a change, not everyone learns about the change or takes on the requirements of the change, and then there is just a lot of confusion."

For the past year, the state has convened the Office of Great Start Advisory Council. This recommendation is not intended to replace that body or update its membership. This is envisioned as a more informal structure in which feedback is solicited via e-mail, webinar, and conference call.

3.2 Continue to explore how to best support unlicensed providers

Details

The state and its partners should:

- Gather lessons learned about working with unlicensed providers
- Ask unlicensed providers what type of support they want
- Explore how other states support unlicensed providers— family, friends, and neighbors

Rationale

For the state to improve quality across the child care system, there must be an intentional effort to support unlicensed providers. Twenty-six percent of children receiving the subsidy are served by unlicensed providers; commonly, these providers are family, friends, and neighbors. This group of providers is unique. They are likely providing care for a limited number of children for a limited amount of time. They are not career child care workers. So how can the state and its partners help grandparents, aunts, and neighbors best support the children in their care? Unfortunately, the answer is not clear, and those providers' voices were not captured fully in this engagement effort. (For example, only four survey participants—0.5 percent—identified as an unlicensed provider receiving the subsidy.)

Currently, unlicensed, subsidized providers are not included in the Great Start to Quality rating system; however, they can achieve a level one through three that represents the amount of training they have completed. Level one training, including seven hours of training related to health, safety, and child development, is required to receive the subsidy, and providers are eligible for a higher subsidy reimbursement rate if they achieve a level two or level three. Through the Race to the Top—Early Learning Challenge Grant, quality

improvement consultants are working with cohorts of unlicensed providers to help them achieve a level two rating.

Unlicensed providers are also about to experience a significant change in requirements to receive the child care subsidy. Child care reauthorization requires states to hold unlicensed providers (called "license exempt" in federal law) to the same health and safety standards as other providers. For example, they must be monitored annually, meet FBI fingerprint requirements, and participate in health and safety training. While relatives are allowed to be exempt, any unrelated caregivers providing care in the child's home will be required to comply with the new regulations.

More work is needed, however, to understand how the state can improve support for these providers. The state and its partners should start by gathering lessons learned from current efforts supporting unlicensed providers such as the required orientation training and the expanded role of quality improvement consultants.

Another source of information is unlicensed providers themselves. The state could add a question asking about the kind of support these providers need, as well as how to provide that support during the application interview. (To be approved to receive the child care subsidy, unlicensed providers must complete an application, phone interview, and criminal background checks on the applicant and all adults in the household.)

Finally, Michigan can explore how other states are supporting family, friend, and neighbor care. Not all states allow unlicensed providers to participate in the subsidy. In 25 states, no children receiving the subsidy are cared for in their own home. To identify best practices, Michigan might consider policies in states that have similar rates of family, friend, and neighbor care such as Hawaii (54 percent of children receiving the subsidy are cared for in their own home), Utah (20 percent), Connecticut (16 percent), Oregon (15 percent), and Illinois (14 percent).[30,31]

"Twenty-six percent of children receiving the subsidy are served by unlicensed providers; commonly, these providers are family, friends, and neighbors."

♦♦♦

[30] In this data set, 15 percent of children receiving the subsidy in Michigan are cared for in their own home. For the purposes of identifying peer states, this is used as a proxy for unlicensed care. It is an imperfect proxy, however, as unlicensed providers can also provide care in the provider's home.

[31] Office of the Administration for Children & Families, Office of Child Care. (2015). FY 2014 Preliminary Data Table 3—Average Monthly Percentages of Children Served by Types of Care. Available online: http://www.acf.hhs.gov/programs/occ/resource/fy-2014-preliminary-data-table-3.

3.3 Provide funding to support quality improvements

Details

The state and its partners should gather lessons learned about using financial support to incentivize providers to pursue quality improvements from existing efforts.

Rationale

Participants recognized that quality matters, and they expressed interest in serving all of their children well. However, participants also explained that pursuing quality improvements is expensive.[32] One way to mitigate this barrier is to offer financial support for providers to buy materials, attend professional development, upgrade facilities, and so on.

Efforts in other states suggest that this is difficult work. Which providers should be eligible? How large does the grant award need to be to help the provider raise the level of quality? How does the application process work? How does the state know that quality has increased? How does the state ensure that funds are used appropriately? Broadly, we believe that providers serving subsidy-eligible children should be the focus of such an effort. Beyond that, however, many answers are unclear.

Michigan is already starting to explore how to effectively leverage investments in quality. With funds from the Race to the Top—Early Learning Challenge grant, the Early Childhood Investment Corporation will be launching Quality Improvement Grants in 2016. This effort will help identify ways in which to implement an efficient program that results in quality improvements. Michigan also provides funding for professional development under the Teacher Education and Compensation Helps (T.E.A.C.H.) program. This effort too will offer valuable lessons learned about how to structure support for quality improvement.

3.4 Align expectations across programs and funding streams

Details

The state and its partners should:

- Identify programs and funding streams commonly used by child care providers
- Identify opportunities to streamline reporting requirements and eliminate competing or redundant expectations

Rationale

Participants reported that child care providers must respond to fragmented offices with different program expectations, resulting in duplicated reporting and requirements. As one participant explained, "[There are] a lot of entities that rule or govern licensed centers. I think centers should know who is over them. We take rules from…a lot of people. There should be one main rule book that incorporates all of the different offices."

Participants recommended revising rules and regulations with the goal of reducing administrative burden while maintaining quality. Two areas to consider are licensing and Great Start to Quality. Participants reported that it is not clear how the two programs complement each other. As one administrator stated, "I'm

[32] In recommendation 3.7, we discuss the need to increase participation in Michigan's quality rating and improvement system – Great Start to Quality. This recommendation is included here because it encourages focusing investments with providers that care for children who receive the child care subsidy.

not sure why we have both licensing and Great Start to Quality. If we participate in Great Start, which [carries] higher standards than licensing, why do we need to go through both? Eliminate or combine them."

Michigan is currently exploring how to increase efficiency and effectiveness of the state licensing system and the Great Start to Quality rating system by aligning metrics and improving data sharing. With support from the Race to the Top—Early Learning Challenge Grant, Michigan is developing a set of key indicators. These indicators will help licensing consultants assess compliance more quickly, allowing for more time to provide technical assistance related to improving quality. These changes are expected to be implemented in 2017.

3.5 Create blueprints outlining how to implement multiple programs

Details

The state and its partners should create blueprints that explain how providers can implement multiple programs and funding streams simultaneously.

Rationale

After aligning expectations, as discussed in recommendation 3.4, the next step is to help providers implement programs more efficiently. Currently, over 9,000 licensed and registered providers statewide are sifting through program requirements and determining how best to meet them. They are putting systems in place to meet multiple reporting requirements that are creating administrative burdens locally.

As a home-based provider explained, "The paperwork alone is paralyzing. We have to keep attendance in three different places. Food program, our regular daily attendance, and for kids on state assistance. That's three times the work right there. It needs to be consolidated so we can focus more on care, not paperwork."[33]

The state and its partners can help providers by creating blueprints for how to implement and comply with more than one program at a time. For example, the state and its partners can create a joint handbook for the CDC program and the Child and Adult Care Food Program (CACFP). Admittedly, this is not easy work. The CDC program and CACFP are administered by different offices and require compliance with two different federal laws. However, the alternative to providing explicit state guidelines is to have providers across the state struggle to keep up with two sets of eligibility requirements, reporting requirements, and rule changes. Implementing this change would lower administrative burdens and potentially increase participation in both programs.

3.6 Increase support during the licensing process

Details

The state and its partners should:

- Increase one-on-one support for providers during licensing
- Increase training for licensing consultants

[33] Note: Current rules do not specifically require providers to take attendance in this way. This quote, however, highlights the fact that providers are not clear on how to be both compliant and efficient when trying to meet multiple rules and regulations.

- Ensure consistency across licensing consultants

Rationale

The goal of child care licensing is to ensure that child care providers meet a minimum set of health and safety standards. PA 116 of 1973 defines three types of child care providers that must be registered or licensed: family child care homes (one to six children in care in the provider's home), group child care homes (seven to 12 children in care in the provider's home), and child care centers (a facility other than a private residence serving one or more children). All of these providers must maintain compliance with requirements related to staffing, staff-to-child ratios, food preparation, facilities, record maintenance, and more.

As has been mentioned previously in this report, participants noted that the state's focus on quality is a strength of the child care system. Participants said that licensing standards are a critical part of the continuum of quality—ensuring that all programs meet basic health and safety requirements.

Participants discussed several problems with child care licensing. They said rules are considered unclear and often interpreted differently by different licensing consultants.

A participant explained, "The relationship with the consultants is huge. We had a consultant forever. The new person comes in and says something is not okay, but it is interpreted differently. It is all about little issues, and we can't build relationships. Those things keep us from doing things we need to do. The interpretation is difficult."

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Another agreed. "Consistency is an issue. One will say yes to something; another will say no to something. It is a cumbersome process and it takes a lot of resources."

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Some participants also expressed frustration with what they perceive to be consultants' insufficient understanding of licensing rules. They said that providers are often more familiar with the rules than are the consultants—or are expected to be.

"Sometimes you have to tell them what the rules are and you have to really know the rules yourself."

♦♦♦

"We are expected to know every detail, but the inspector is not."

♦♦♦

"Between fire and environmental inspections, it is infuriating. They can't point out the rules in the policy, but they still want it enforced."

♦♦♦

Participants also said there are not enough licensing consultants to cover the number of providers in the state. One pointed out that the ratio of providers to consultants had recently been as high as 180 to one, and said that the state recently hired more consultants to bring the ratio down to 100 to one. In 2016, LARA is

in the process of hiring and training 17 new licensing consultants. With this change in progress, some participants pointed to the issues caused by limited consultant capacity.

An administrator said, “The licensing consultants are overloaded with too many sites. They do not have time to do anything but the bare minimum. It would be helpful to have staff that may not be responsible for the actual licensing, but could assist with questions and concerns on a regular basis.”

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A participant said, “The caseload for consultants is too high. And the turnover is high for those who conduct inspections.”

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Another participant agreed. “There are not enough licensing folks. They tell us when we start the process that it can take up to six months, but that is most of the school year. And we can’t put the kids in an unlicensed program. There are just not enough licensing people to do the work needed.”

While participants recognized the need for compliance, they wanted more one-on-one support that would help them improve.

An administrator expressed dissatisfaction with “Licensing consultants that take a punitive approach to keeping centers in line with licensing rules rather than helping a center achieve their optimal potential with ideas or suggestions on how to improve. We should all be working to provide the best care for children, not punish the providers for something they may have misunderstood.”

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A participant said, “The licensing consultants are about complaints, not about building partnerships. They don’t seem willing to work with providers.”

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Another participant said, “The licensing consultant we used to have—we had a great partnership and she would see what was working in the center and see how it fit into the rules. The next one saw things as more black and white and didn’t see how the center was working within the rules. I think it helps if the inspectors have experience or education in early childhood [programs and development].”

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3.7 Increase participation in Great Start to Quality

Details

The state and its partners should:

- Continually improve the structure of the rating system
- Address barriers to participation
- Continue to implement recruitment strategies in the Race to the Top—Early Learning Challenge Grant

Rationale

Participants recognized Great Start to Quality as Michigan's benchmark of program quality. They explained that the rating system demonstrates the state's focus on quality and articulates the characteristics of effective providers. Participants identified two key challenges related to the quality rating and improvement system: the rating criteria and overall participation.

Rating Criteria

Great Start to Quality has a set of five program quality indicators that are used to assess providers: staff qualifications and professional development; family and community partnerships; administration and management; environment; and curriculum and instruction. Providers complete a Self-Assessment Survey and submit evidence of their performance against these criteria. They then complete a quality improvement planning process. In some circumstances the self-reported performance is validated, and then the provider's rating is published.

There was disagreement among participants regarding whether the criteria and process identified or improved program quality. Many participants were clear that the process raised quality.

> An administrator said, "Great Start to Quality has given a public notice to our communities of what quality care looks like and how we can all work to improve all aspects of programming."

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> A home-based provider said, "[It's] good to see the Great Start to Quality in operation. There are still many areas that can be improved upon, many bugs to work out, but it is a step in the right direction."

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> A parent said, "The star rating system works well for programs that participate."

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Others were not yet convinced, and recommended that the program's approach be validated. This was particularly true for some home-based providers who indicated that the program quality indicators are more aligned with how centers operate.

One home-based provider explained, “Not everyone wants to run their daycare like a center. There is very little consideration for individuality. I do not participate in the Great Start star system, and will avoid it as long as possible. There is too much emphasis on getting ’program’ people in the home to ‘help’ providers, when in reality, most of the time, it’s just plain invasive and unproductive. It takes away from the quality care provided to families.”

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Another home-based provider said, “Home child care providers shouldn’t be held to the same standards as corporate owned child care centers and preschools. The bar does need to be raised and there needs to be a standard set, but if I am using a curriculum that is affordable, and still evidence based, but not on the state’s ‘approved’ list, does that really mean I don’t have a quality curriculum?”

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Participation

Participants said more providers need to participate in the system. Increased participation increases the number of providers actively working on program quality, and provides families with a more accurate view of performance for a greater number of providers. Participants, however, noted several barriers to participating in the rating system, including cost, meeting staff qualification requirements, and risk associated with participating and receiving a low rating.

Cost and time were common concerns. Participants reported that pursuing quality improvements is a significant investment and that the revenue is not always there to support those investments.

An administrator said, “The current QRIS undoubtedly raises quality of care but at enormous cost to the provider. The QRIS needs to be realistic when setting the standards. The increase in labor hours is substantial. The cost involved will really hurt the smaller operations.”

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A home-based provider said, “Not all child care homes can give more time than the 12 hours we already work each day.”

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Participants also reported that in some cases participation does not help their bottom line—especially if the provider earns a low rating (1 or 2 Star). Providers understood that these ratings recognize a focus on quality above and beyond licensing requirements but added that too often, parents view providers with 1 or 2 Star ratings as low-quality options.

Together, these concerns turn some providers off from participating.

> An administrator summarized a common perception: "The [rating process] is extremely time consuming and expensive for small private centers to achieve the highest star. This is not fair, as the smaller centers do not have access to the same funding as the Head Start and GSRP programs. I think the incentives are great to get the quality higher, but at what cost? Awesome providers will be pushed out because the money to achieve the 5 Star is very difficult to achieve."

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> A provider agreed. "We, as providers, understand that one star is better than basic licensing, but parents don't fully understand the rating system. No one wants to stay at a one-star hotel. So we have providers that will not participate in the system unless they are ready to enter at three stars or higher."

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> One center-based provider said, "Star rating system causes low-rating centers or families not to participate; they feel ashamed."

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This feedback is likely familiar to those close to the Great Start to Quality system. Many of these challenges have been previously identified, and strategies for improvement were included in the state's Race to the Top—Early Learning Challenge Grant. Some of this work is currently underway, and more plans are in the works. For example, the Early Childhood Investment Corporation recently administered a round of Participation Bonuses (funded through the Race to the Top—Early Learning Challenge grant) that offered a financial incentive for providers to join Great Start to Quality, and is currently providing intensive training to unlicensed providers and home-based providers entering the system.

According to participants, in addition to current efforts, the state and its partners should consider offering or expanding the following to improve participation:

- Offer one-on-one technical assistance to complete the process
- Provide financial assistance to help programs meet standards
- Offer different ways for programs to demonstrate quality (for example, expand the definition of approved curriculum; offer a path designed for home-based providers)
- Reconsider staff qualifications (for example, recognize years of experience in addition to credit hours and degrees in non-education fields)
- Focus on technical assistance, not just ratings
- Require participation to receive the subsidy
- Require participation to apply for other state funding support (such as grants or food programs)

4. INCREASE ACCESS TO QUALITY INFORMATION

		Recommendations	Short Term	Medium Term	Long Term
CDC Program	4.1	Support and promote a hotline to answer questions from parents, providers, and caseworkers	■		
	4.2	Expand training for MDHHS caseworkers	■		
State System	4.3	Provide consistent information across all sources	■		
	4.4	Launch a statewide public awareness campaign about quality child care		■	
	4.5	Continually improve the Great Start to Quality website	■	■	■
	4.6	Create an ombudsman position		■	

Clear, consistent, coordinated information is essential for stakeholders to effectively navigate the child care system—both from the perspective of a parent and that of a provider. One participant explained, "We have a dream in our region—we are trying to set our sights on having a one-stop-shop center for this type of information, for families, for providers. To navigate the system for parents is frustrating. Many get lost in this. [The Michigan Department of Education] could provide us a grant for the region to help seed that and make it happen—a one-stop-shop, like 2-1-1, when there are needs for child care and they could come into a place to get the information. It would help them with all of this stuff. Parents get frustrated and give up."

Other participants shared that dream. Participants, particularly parents in the focus groups, said it is very hard to know where to find information about child care options. They rely predominantly on word-of-mouth information from friends, family, and coworkers. Some participants said schools and churches are sources of useful information. A few participants in each group mentioned resources on the State of Michigan's official website, but some said the information on the state-sponsored website is not accurate or up to date. Several participants said they do not trust reviews or information they find online about child care anyway. As one participant put it, "That is just the business advertising itself." More parents explained:

> "The hardest thing I've dealt with is knowing where to go to look for child care. Our friends have older kids so we didn't have word of mouth for the area where we live. I ended up at home after [my baby's] birth and in a panic."

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"I started my search with Google and then put it on Facebook and reached out through social media to get some ideas. One of my coworkers ended up giving me a recommendation. I knew that if it was good enough for her kids, it was good enough for mine."

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"We scrambled a little when my daughter was an infant. The school provided us with a list, and the secretary provided some recommendations. That's how we found the provider we went with."

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Participants also indicated that it is difficult to find consistent, clear information about the child care subsidy. They expressed a high level of frustration with MDHHS caseworkers and said that more needed to be done to help families navigate the program requirements.

The state and its partners can make significant progress in this area because so much work is currently underway. Sites across state government share information about child care. Great Start to Quality offers comprehensive resources for all stakeholders—with a specific focus on parents and providers. Early childhood programs have a presence on social media. The recommendations in this section identify opportunities to build on these efforts and improve access to quality information across the child care system.

4.1 Support and promote a hotline to answer questions from parents, providers, and caseworkers

Details

The state and its partners should support a hotline that serves parents, providers, and caseworkers and provides detailed, consistent information about CDC program requirements.

Rationale

Participants reported that throughout the process—from the time families first apply to the time when providers request payments—it is difficult to find consistent information about the CDC program requirements. For example, participants said that communication intended for parents, like award letters, were often unclear.

An administrator said, "Parents will come in with a letter saying 95 percent of daycare is covered. Then I have to break it to them that it isn't 95 percent of the entire bill, it's 95 percent of the highest rate the state will pay, which usually is more like 70 percent of the total cost. The new Family Contribution listing is even more confusing."

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Another administrator agreed, "Families [do] not fully understand what it means when they are subsidized 100 percent; they think they will owe nothing."

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Providers agreed too; they said the program is complex and rules are often interpreted differently by different caseworkers. They wanted more information so they could better support families and proactively address problems.

One way to improve communication about CDC program requirements is to support a hotline. This hotline would be available to all parents, providers, and caseworkers and would ensure that all parties can easily ask questions and receive clear, consistent answers. Online resources and training are essential (and will be discussed later in this section); however, it is often helpful to process complex requirements or unique circumstances with an expert rather than trying to find an answer online. This is not a new approach. The Office of Great Start already supports a hotline for CDC program billing questions. They also have an e-mail address for MDHHS supervisors and staff to ask broader questions about the CDC program.

4.2 Expand training for MDHHS caseworkers

Details

The state and its partners should assess current training and support for MDHHS caseworkers and determine how to provide additional support to ensure consistent application of CDC requirements.

Rationale

On average, MDHHS caseworkers have a caseload of 563. In other counties, however, caseloads exceed 1,000, as is the case in Macomb (1,010) and Wayne (1,137).[34] These large caseloads show up in the caseworkers' ability to support families.

Participants reported challenges working with DHHS caseworkers. They said caseworkers are difficult to contact and are not always fully aware of program requirements. Some participants reported that caseworkers are overloaded and sometimes unwilling to go above and beyond to support families.

> A parent explained, "Caseworkers don't help you. They are supposed to help you with the paperwork, but mine sees me coming and turns and walks the other way. I think it is frustration with the system. The system is broken."

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> Another parent said this is particularly evident during the CDC program application process. "Caseworkers are so overloaded they will push [reviewing the application] off to the very last minute. If you bug them enough, they are going to do it, but my caseworker didn't rush it. She would say, "I have 60 days to do it."

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[34] Michigan Department of Health and Human Services. FY 2017 Budget Presentation. Data as of 01/01/2016.

Another participant agreed, "I knew a parent who applied for the subsidy so her child could receive child care while the parent was receiving substance abuse treatment. Her application was denied because she wasn't working, but was in rehab. [Rehab] is an allowable activity for receiving the subsidy. They are not even aware of their own resources and rules. We have to advocate for parents."

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While frustration ran high, participants recognized that there are great caseworkers in the system too. As one parent explained, "Sometimes you have a good case manager who goes out of their way. I know some who have helped people."

How can the state and its partners help current caseworkers to more effectively serve families that are receiving the subsidy? The hotline outlined in recommendation 4.1 is the first step. The next step is to ensure that caseworkers have strong foundational knowledge about the program. This will help ensure that caseworkers can identify families that follow common application and determination protocols, and also identify situations that require additional investigation to determine if a family is eligible. Training should serve to build foundation knowledge, while the hotline can help caseworkers sort through less common scenarios.

4.3 Provide consistent information across all sources

Details

The state and its partners should create a focused, coordinated, consistent communication effort to ensure that all stakeholders have access to the right information regardless of how they seek it.

- Review the materials available on all state-funded websites and ensure that they are consistent and appropriate for the intended audience
- Focus on consumer education and connecting stakeholders with the information they need when they need it

Rationale

A hotline cannot be launched and training cannot be improved unless there is consistent information to inform that work. Michigan needs a focused, coordinated, consistent communication effort to share information about the CDC program and other child care resources.

It is understandably difficult to coordinate materials across multiple agencies—especially when three different state agencies play important roles in implementing this program. It is helpful to first conduct a review of all materials available via state-funded sites to ensure that stakeholders are referred to the same documents, regardless of where they access the information.

This consistency is important across Great Start to Quality (where families can find child care providers in their area) and the Michigan Department of Licensing and Regulatory Affairs (LARA) child care licensing site as well. Both sites provide parents with information about the quality of providers.[35] LARA's site includes licensing and inspection reports that may identify problems. The site, however, does not provide follow-up information to indicate whether the problem was resolved. This makes it difficult for parents to determine if the basic health and safety requirements are in place at the program they are researching.

[35] The Great Start to Quality site includes a link that directs users to the LARA site to view licensing reports, however, it does not host the reports.

After focusing on consistency, work to ensure that information is appropriate for the audience. While a caseworker may find it helpful to be referred to the Bridges Eligibility Manual for details about eligibility, a dad will likely find it difficult to decipher the document to determine whether his family is eligible to participate.

Finally, focus broadly on consumer education. Under the 2014 reauthorization of CCDF, the state must publicly post information such as the process for licensing and monitoring providers, the process for conducting criminal background checks, and aggregate information on the number of deaths, serious injuries, and child abuse in child care settings. This information is necessary, but insufficient to propel Michigan's system to offer a quality setting for each and every child.

Work on consumer education must be broader. Participants indicated that many sites are helpful.

> An administrator said, "There is a site that we can easily refer families to when they need child care services. Great Start [to Quality] is a resource I often use when helping families find options."

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> A home-based provider explained, "As an in-home child care provider, [I find that] the website created to inform parents of licensed and registered providers and the services they provide is a huge positive impact for both parents and providers."

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> A policy maker said, "The development of Great Start to Quality has allowed a one-stop place for families and interested others to go to find information on child care, as well as a place where providers can access information about improving their knowledge and skills."

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These sites, however, are underutilized. Participants said the system must do a better job of helping parents find the resources they need to select a provider and pay for care, They also said there should be more advertising about the importance of early childhood, the availability of Great Start to Quality, and the programs and services available to parents. Additionally, participants expressed some interest in helping those parents who need access to more education and resources about parenting.

One place to start may be in optimizing search results. Parents indicated that sites like Great Start to Quality do not always show up in the results of common child care searches.

4.4 Launch a statewide public awareness campaign about quality child care

Details

Michigan invests in resources to help parents find and evaluate child care providers; however, these resources are underutilized. A statewide awareness campaign could help the resources become mainstream.

Rationale

Participants emphasized that parents use an array of sources to help them make decisions about child care. Trusted sources, such as friends and family, health care providers, community organizations, and faith-based communities are critical partners in educating families about child care options and the need for quality. Participants indicated that repeated exposure to resources helps ensure that parents—or their trusted sources—know how to find the information parents need when they need it. For example, participants said:

> "The state could develop infomercials that would play in the lobbies at the hospital and in doctors' offices. When you see it over and over again, you will remember it and look into it."

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> "TV, radio, text messages, Facebook, Twitter—parents use these things. There are easy ways to get this information out there. You can put it on the popular radio stations and the electronic billboards."

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One example of a current public awareness campaign is the *Don't Worry, but Don't Wait* campaign that encourages families to access *Early On*® services. This effort was launched in the early 2000s as part of an effort to expand knowledge of the early intervention system. With the help of marketing specialists and experts in public health awareness, the campaign was launched and continues to operate today. Currently, Clinton County RESA *Early On* Training and Technical Assistance maintains the effort. They create and print materials, maintain a social media presence (through platforms like Facebook and Twitter), buy billboards and radio ads, staff a hotline for questions and referrals, and provide technical assistance to partners. The effort targets families directly as well as through stakeholders that work with families, such as doctors and community centers. The campaign is successfully connecting families to services. Since 2005, referrals are up nearly 600 percent (from 1,900 referrals in 2005 to more than 13,000 in 2014).

4.5 Continually improve the Great Start to Quality website

Details

Great Start to Quality is a helpful resource to parents, but more needs to be done to build awareness of the site, increase the number of participating provides, and expand provider profiles.

Rationale

The Great Start to Quality online rating system is designed to allow parents to compare the level of quality offered by different child care providers in their area. Participating providers are rated from 1 to 5 Stars, with 5 Stars denoting the highest level of quality. Providers who choose not to participate in the rating system, but are registered or licensed, are represented by an "empty" star. There are two aspects of the system: the web-based portal that allows parents to access information about providers in their area, and the rating system. This recommendation addressees the informational website, while the rating system and its components are discussed in recommendation 3.

In general, participants highlighted the need for parents to have more information about child care providers and the need for quality child care. Participants said online resources, like Great Start to Quality, are important in helping families find child care, gather information about financial support, learn how to identify quality care, and determine which local providers have openings. As a center-based provider said, "The

community needs to be educated as to what high-quality child care looks like and where these opportunities exist."

While participants overall agreed that an online resource for parents is critical, there were mixed reviews as to whether existing resources (such as Great Start to Quality) fit the bill. In aggregate, these reviews identify areas for improvement on the site and opportunities to improve communication about what the site offers. In some cases, participants called for functionality or information that is currently available. There are also improvements (such as search engine optimization) that are currently underway.

A parent said, "The development of the Great Start to Quality has allowed a one-stop place for families and interested others to go to find information on child care, as well as a place where providers can access information about improving their knowledge and skills."

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An educator said, "Great Start [to Quality] is a great resource. [We] just need to make sure parents are aware of it."

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A parent said, "The Great Start to Quality website was helpful, but you still have to do the legwork and drive around to visit places. Instead of driving around aimlessly though, I had some options to be able to broaden or limit my search."

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Participants reported some challenges using the site. Some said Great Start to Quality did not provide a full list of providers in their area.

A parent said, "I did not find it helpful. I used my coworkers and friends to give me names, then I got on the website and almost none of the names they gave me were there. We have wonderful providers who don't want to go through the licensing process. My great provider only had one or two stars. There was one [provider] with four stars and my coworkers said they would quit working and take care of [my daughter] before they would let me take her there."

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Another participant said, "They don't keep the State of Michigan licensed daycare web-site updated. There are a ton of licensed daycares listed and the majority weren't operating anymore."[36]

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Other participants were frustrated that the site did not indicate whether a provider was accepting children. One parent said, "It was not helpful. Most of the provider names I saw on there were already full."

Others were confused about whether they needed a username and password to access the site. One participant said, "You have to log in to get to it. That's the problem with it. When you go in through mobile, you

[36] Note: LARA updates their site (http://www.dleg.state.mi.us/brs_cdc/sr_lfl.asp) daily based on reports from providers. If a provider does not report that the location has closed, the site will not be updated until the license is up for renewal.

have to create an account and it doesn't give you an option to log in as a guest. It doesn't make sense to have to sign in to a public website. And when I did log in, it didn't let me export or print the information." (Note: The site does allow visitors to register, but visitors can also access the site without registering via guest access.)

Participants offered a number of suggestions for site improvement. Focus group participants indicated that the most important thing is for the site to be accurate. They would also like to see it include location, hours of operation, curriculum, any citations or complaints against the facility, reviews from families, pictures of the site, and information about openings or waiting lists. In addition:

An administrator suggested making the site mobile friendly. "I think you need an 'app' for that. More parents use their phones as their Internet and information source than any other. If the online systems don't have a free app, they are cumbersome and harder to use."

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Parents called for more information to be available on the site. For example, one said, "Parent comments would be helpful on the website, and details about each facility. The hours they are open, location, rate, the age range they accept, and whether they have openings. That kind of stuff would help us narrow things down right off the bat."

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A parent suggested including more details about curriculum. "If they advertise a pre-school curriculum, I want to know what kind of curriculum they are doing. What are they actually working on? What qualifies them to be a teacher?"

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Another parent called for more detailed licensing reports. "I would like access to more information. If [the provider] is licensed, I want to know where to look to see inspection reports. We had a short list to start with, and violations cut it down even more."

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Participants said low-tech solutions work too. A center-based provider suggested "keeping brochures, pamphlets, and other information readily available in areas highly trafficked, such as hospitals, doctor/dentist offices, schools, Internet, churches, libraries, and other related establishments and of course advertising via radio."

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4.6 Create an ombudsman position

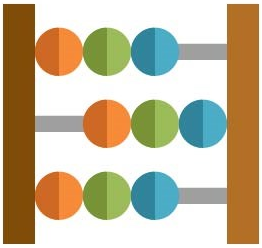
Details

Identify an individual (employed by either the state or one of its partners) to serve as an ombudsman for stakeholders in the child care community.

Rationale

Since its inception, the Office of Great Start has been committed to gathering input from stakeholders and using that feedback to guide its decisions and policies. An ombudsman would formalize that process and provide a visible point person to whom stakeholders could provide feedback, raise concerns, ask questions about unclear policies or procedures, or report that they have been treated unfairly. The ombudsman would work to address questions or concerns early, before they escalate.

When questions or concerns are identified, the ombudsman would work with the Office of Great Start and its partners to address them. If the complaint is related to health or safety concerns, the ombudsman could immediately refer the stakeholder to existing reporting structures, like the LARA process for reporting licensing violations. Other feedback could be routed to state staff, reviewed, and addressed. To show stakeholders that their voices are being heard, there could be a follow-up system that details how the input was shared and explains any next steps.



5. SUPPORT THE EARLY CHILDHOOD WORKFORCE

		Recommendations	Short Term	Medium Term	Long Term
State System	5.1	Assess professional development opportunities for licensed providers	■	■	
	5.2	Explore how to improve benefits and wages			■

It is simple. Our state will never have a quality child care system if we do not adequately train and support our early childhood workforce. The state and its partners can support a range of policies in the pursuit of quality, but without a focus on the providers themselves, efforts will ultimately fall short. [37]

Participants agreed, noting that the best providers are the ones who have a passion for their work and a clear interest in helping children. Passion alone, however, cannot move the needle on quality. Participants frequently expressed a need for increased training and the challenges associated with low wages.

> One center-based provider said, "I want to pay my providers more, and they are getting training, but I can't afford to pay them more. I want the care to be affordable [for parents], so I can't pay [my employees] more."

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> Another center-based provider said, "It is hard to find qualified and quality staff willing to work for little pay. They need to truly love their jobs and the children to be willing to work for much less than they deserve."

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[37] Throughout this report, we have used the term "provider" to include centers and individuals providing care. In this section, however, "provider" refers specifically to those who comprise the early childhood workforce. It refers to the individuals who work directly with children as well as directors who operate local programs.

An advocate agreed. “The fact that those working in child care are not well compensated and the work is very challenging is a problem. Access to quality care starts with quality professionals that want to provide quality care. Families demanding quality care is also a driver. Professionalizing the workforce and attracting new professionals into the field must be prioritized—this can only be done if early childhood is seen as a viable career choice.”

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There are no clear answers to the question of how to improve training and wages. Michigan already offers a wide range of training and support opportunities for providers, and while participants had clear recommendations for how to improve access, they did not speak to how to build a comprehensive, coordinated professional learning system. The question of how to improve wages is even more difficult—particularly given the high cost of subsidizing compensation. These recommendations aim to help the state and its partners take the next step in workforce development.

5.1 Assess professional development opportunities for licensed

Details

The state and its partners should:

- Address barriers to accessing current professional development
- Partner with providers to identify topics that are relevant to current challenges
- Catalog and sequence current professional development requirements and opportunities

Rationale

Michigan currently offers a variety of resources for child care providers and workers. These professional development opportunities are hosted and promoted by a range of partners, including state agencies, Great Start to Quality Resource Centers, and colleges and universities. Still, participants noted the need for improved training and support for child care workers. For example:

A university faculty member said, “Best practices are not always in place because of a lack of education in some centers.”

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A parent explained, “Professional development opportunities are limited if existent at all. Staff need to be receiving continuing education to stay up on best practice and research-based techniques in our field. This goes back to providing high-quality care and would ensure [that] staff meet the needs of all students.”

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Participants offered solutions to common barriers to accessing current professional development. They recommended creating training opportunities that are:

- Low or no cost
- Available at convenient times (for example, in the evenings or on weekends)
- Offered in multiple locations throughout the state

- Available online and on-demand (through webinars, for example)
- Relevant and focused on early learning and development, classroom management, social-emotional intelligence, and quality standards (in other words, that go beyond basic health and safety requirements)
- Participants emphasized the need to make training low or no cost.

A center-based provider said, "[There needs to be] additional funding. [There are] requirements for employees to continue education without a requirement for funding said education."

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An administrator said, "Provide all caregivers with ample opportunity to be trained at low cost since the pay scale in child care remains low. Most caregivers cannot afford quality training and eventually quit due to low pay."

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Relevance was also a common topic. Participants recognized the need for basic health and safety training; however, they expressed interest in meatier topics such as child development, social-emotional health, alternatives to suspensions and expulsions, and how to better support children with special needs. As the needs of the field evolve, the state needs a mechanism to collect feedback about which topics providers would like covered in future professional development events and resources.

Beyond these short-term changes, there is value in exploring this issue more extensively. Michigan has identified what child care workers need to know in a document titled *Core Knowledge and Core Competencies for the Early Care and Education Workforce*.[38] This comprehensive document identifies the skills, knowledge, and attributes an educator should develop to work effectively with children and families. While materials related to the Core Competencies encourage educators to use the competencies to plan professional development and map out a career path, there is not sufficient support for educators to translate the 122-page document into action. Educators need more help to assess their skills and identify professional development that can improve their practice.

In addition, it can be challenging to identify relevant professional development. Right now, the system relies heavily on savvy providers and word-of-mouth to connect providers with the best training for them. This "spray and pray" strategy creates pockets of well-supported providers, but will not support a systemic focus on quality. All of the training programs, regardless of who offers them, need to be cataloged and sequenced to help providers find professional development opportunities that align with their needs and interests and to ensure identification of gaps that need to be addressed.

Currently, Michigan relies heavily on ten Great Start to Quality Resource Centers (and their partners) to support providers as they improve the quality of their programs. Resource Centers offer coaching to aid in the development of quality improvement plans, as well as information about professional development, lending libraries, learning kits, and financial assistance to improve the child care or preschool setting. There was limited discussion about the Resource Centers; however, a handful of participants highlighted the Resource Centers as helpful supports, and others called for improvements. For example, participants said that only providers in the rating system are eligible for support, and that training provided by the Resource Centers is directed at improving in the star system; it is not necessarily personalized to the provider's need. If the Resource Centers are to be an effective way to provide and access professional development, more

[38] Available online: http://www.michigan.gov//documents/mde/MI_CKCC_10-13-14R_471355_7.pdf.

will need to be done to determine if their services are meeting the needs of the field and to raise their profile among early educators.

5.2 Explore how to improve benefits and wages

Details

The state and its partners should explore ways in which they can improve benefits and wages for child care workers to attract and retain talented providers to the workforce.

Rationale

Low wages and the lack of benefits make it difficult to achieve quality, participants said. They indicated that an increase in wages would help recruit more staff and reduce turnover—which would likely increase quality.

> An administrator said, "High-quality care begins with high-quality people who want to care for children. The staff has to have the knowledge and skills to care for children. They have to have the resources available to them to provide what the children need. And they have to have the respect that they deserve. This includes compensation equal to any profession where the workers are required to put in a certain number of years of college work and internships. Where the staff are required to continue their education every year, they are practicing their profession."

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> An advocate agreed. "Low pay results in high turnover. The push is for more highly educated providers, but those persons do not make a living wage."

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> A parent said, "Offer financial incentives for programs to increase quality that offset the expense. Offer state-funded bonuses to early childhood professionals that have attained credentials that research has demonstrated correlates to higher quality environments for children."

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> A participant said, "If you told someone in the business field, 'Go get your MBA, and you can come back and do the same job, but we aren't paying for it, and you don't get paid more for it,' no one would do this."

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Low pay is particularly challenging when child care providers are competing for talent that is also qualified to work in K–12 districts. An administrator explained, "Many times teachers and workers have the same degrees as K–12 teachers, but make less than half the salary and most times without health insurance benefits because jobs are designed to be part time to avoid benefits. This causes constant staff changes and very little continuity of service to families."

The data support this frustration. The average child care worker in Michigan makes $8.36 an hour, slightly less than the national average for child care workers. Child care workers in Muskegon County earn the least, with a median hourly wage of $6.92 an hour; workers in Houghton County earn the most, with a

median hourly wage of $10.01 an hour.[39] Research also finds that child care workers rarely receive benefits like health insurance or a pension plan.[40]

There are tools that states can use to increase compensation packages. One current example in Michigan is the T.E.A.C.H. program. Through T.E.A.C.H., child care providers can apply for scholarships to take college courses and earn a credential or degree. Providers are eligible if they work at least 20 hours per week in a licensed or registered facility and earn no more than $17.00 an hour. T.E.A.C.H. is supported by CCDF funds.

Participants supported scholarship opportunities. For example, one said, "We need to incentivize going into early childhood [careers]. The state should offer student loan forgiveness for people who go into early childhood. Working in the field is actually doing good things for the world; make it appealing. That will help increase the quality."

In addition to scholarships, states have implemented efforts to augment compensation. For example, Nebraska recently passed the School Readiness Tax Credit Act. This income tax credit is available to providers that enroll in a database of early childhood professionals and work at a child care program that participates in the state's quality rating system. Eligible staff can earn $500 to $1,500 a year.[41]

A study from the Institute for Women's Policy Research found that compensation initiatives can be effective in improving retention among child care workers. Successful programs included strategies such as:

- Increasing starting salaries
- Establishing minimum education and training requirements
- Linking professional development activities to bonuses or pay increases
- Providing access to credits toward a college degree
- Leveraging multiple funding streams to sustain the effort[42]

[39] Estimated using Standard Occupational Classification (SOC)-level data from EMSI Economic Modeling, 2016, available at http://economicmodeling.com/.

[40] Gould, Elise. (2015). Child care workers aren't paid enough to make ends meet. Economic Policy Institute. Available online: http://www.epi.org/publication/child-care-workers-arent-paid-enough-to-make-ends-meet/.

[41] Nebraska Legislature. (2016). School Readiness Tax Credit Act. Available online: http://nebraskalegislature.gov/bills/view_bill.php?DocumentID=28185.

[42] Park-Jadotte, Jennifer, Stacie Carolyn Golin, and Barbara Gault. (2002). Building a Stronger Child Care Workforce. Institute for Women's Policy Research. Available online: http://www.iwpr.org/publications/pubs/building-a-stronger-child-care-workforce-a-review-of-studies-of-the-effectiveness-of-public-compensation-initiatives.

Conclusion

Every day parents across Michigan make difficult decisions about who will care for their children when they go to school and to work. As a state, we can do much more to help each and every family across Michigan access quality care at an affordable price. This report outlined five key recommendations:

1. Increase financial assistance to families
2. Increase access to quality providers
3. Make it easier for providers to improve their programs
4. Increase access to quality information
5. Support the early childhood workforce

Together these recommendations identify what the state and its partners can do differently to improve access to high-quality, affordable child care in our state. These recommendations are the culmination of a broad engagement effort and represent the perspectives of over a thousand stakeholders. We are grateful for this robust participation; however, stakeholders must continue to raise their voices to highlight the critical need to invest in our child care system. Parents, families, providers, and community leaders must continue to call for change and engage in a conversation about how to most effectively serve our state's youngest residents. Together with critical partners at the state, region, and community levels, as well as in in philanthropy, we can all build a brighter future for Michigan children.

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