RESEARCH REPORT

Using Child Care Subsidy Payment Rates and Practices to Incentivize Expansions in Supply

Challenges and Policy Implications

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Executive Summary

Numerous studies have found that the supply of quality affordable child care in the United States is insufficient to meet families' needs, with particular gaps in good quality care as well as care for specific populations such as infants and toddlers, children with special needs, and children whose parents work nontraditional hours (Chaudry and Sandstrom 2020; Malik et al. 2018; Paschall, Davis, and Tout 2021). Concerns about these supply gaps have grown in recent years because of the significant number of child care providers who have had to close or reduce services in the pandemic, creating even greater supply gaps and shortages of care (Carson and Mattingly 2020; Lee and Parolin 2021). The pandemic appears to have particularly affected the supply of care in communities of color, who have more barriers to employment because of systemic inequities and where we see slower recovery of maternal employment rates (Landivar and deWolf 2022; Lee and Parolin 2021).[1]

Because of these realities, federal and state policymakers have increasingly focused on trying to expand the supply of child care options in recent decades. Building the supply of quality care and care for special populations is a goal of the Child Care and Development Fund (CCDF)[2]—the federal state child care program that subsidizes child care for families with lower incomes—and the federal pandemic relief funds were in part designed to stabilize and support the supply of child care.[3]

This report explores the use of CCDF child care subsidy payment rates and practices to try to expand the supply of specific types of child care that are in shorter supply and focuses in particular on one of the most common policy levers—increasing the per child subsidy payment (also known as "differential" or "tiered" rates) paid to providers for children receiving these types of care.[4] Although differential rates are used to support a variety of goals, this report specifically examines the following question: *What is known about using subsidy rate policies and practices to expand the overall supply of priority child care options, either by incentivizing providers to start delivering the priority service or by incentivizing providers who already deliver these services to expand their efforts?*

We are interested in this question because even though raising subsidy rates is a strategy commonly used to address gaps in the supply of targeted forms of care, we actually know very little about whether or how these higher rates work to expand the supply of care and under what circumstances. And we know little about whether their impact varies across providers, different child care settings, different types of priority care options, or providers in different communities.[5] Our goal is to provide state policymakers with actionable insights to support their efforts to expand the supply of priority child care options, and to understand the role of subsidy payments in that process.

To examine this larger question, we first reviewed the relatively scant research literature; then we interviewed policy experts, state administrators, and child care providers to begin exploring these questions. This work is, therefore, exploratory and based on the expertise and lived experience of these stakeholders, sharing their insights and knowledge. Our work raises a number of key questions that would benefit from rigorous research in the future.

Key Findings

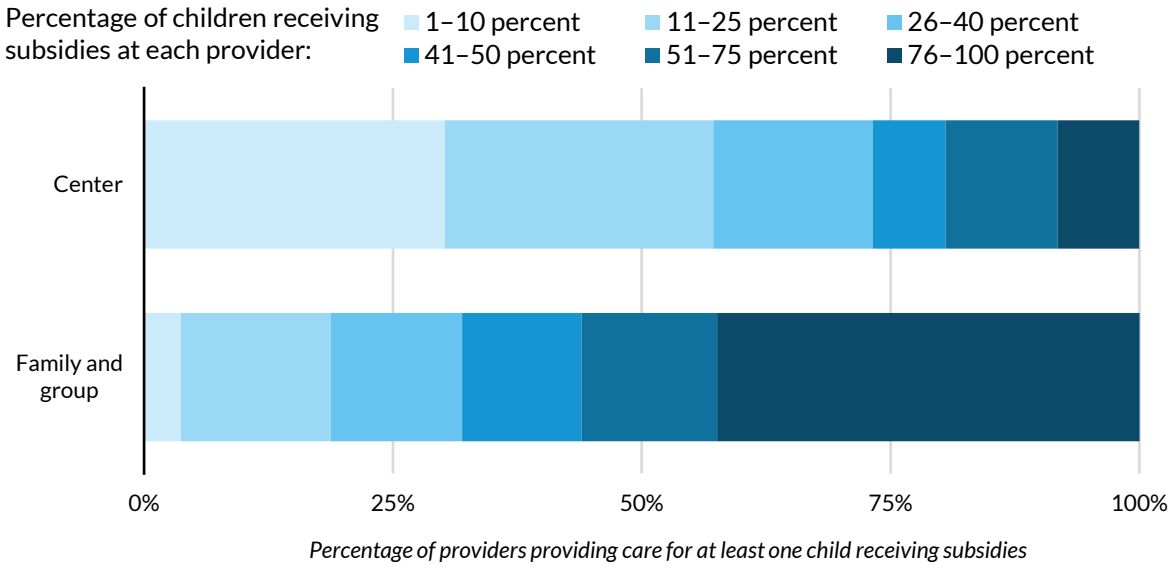
Our findings are organized in three sections: (1) sharing insights on the factors providers are likely to consider in making decisions about whether to expand supply; (2) exploring what is known about subsidy rate policies and practices and their potential role in affecting the key factors that providers consider; and (3) briefly discussing how these issues play out differently across providers and types of incentivized care (such as improving the supply of quality care or expanding the supply care for infants and toddlers, children with special needs, and children needing care during nontraditional hours). Thereafter, we provide implications for policy and future research.

In examining these questions, however, it is important to contextualize the challenges facing efforts to use subsidy policy to affect the larger child care market. Specifically, despite the central role that child care subsidy funds play in helping families afford child care, the funding that providers receive through the subsidy system is a fraction of the overall financing for providers in the child care market, which is dominated by parent payments and strongly affected by market forces. Further, providers who serve children in the subsidy system are likely to vary widely in the share of their enrollment that is subsidized versus the share paid for by private-paying parents. For example, subsidy data from Pennsylvania from July 2022 show that an estimated 71 percent of all licensed providers were serving at least one child who was receiving subsidies.[6] However, as shown in figure E.1, the share of these providers' enrollment that was made up of children receiving subsidies varied significantly. Further, significant shares—81 percent of centers and 43 percent of licensed family child care and group homes—reported that less than 50 percent of their enrollment was paid for by the subsidy program. This suggests that the impact of subsidy policies and payments on provider behavior and budgets are likely to vary significantly across providers. As a result, while CCDF funds are important, their ability to shift the larger child care market will likely be constrained.

FIGURE E.1

Percentage of Enrolled Children Receiving Subsidies among Providers Serving Children in the Subsidy System in Pennsylvania

Providers with at least one child receiving subsidies, July 2022



Source: Based on data available in Pennsylvania's Enterprise to Link Information for Children Across Networks (PELICAN), provided by the Office of Child Development and Early Learning.
Note: This represents licensed providers who provided care for not only school-age children and had at least one child receiving subsidies.

Key Provider Considerations and Contexts That Can Shape How They View Efforts to Build Supply

One of the key insights from our conversations with providers, experts, and state administrators is the importance of considering the perspectives, contexts, and realities of providers when designing supply-building strategies. These considerations can fall into three buckets, which work together to shape the provider's assessment of whether to begin providing the incentivized priority type of service or expand their existing services in response to the incentives:

- Personal and professional goals and beliefs, which raise, for example, these questions:
  - » Does the prioritized type of care policymakers are trying to expand fit with the provider's identity, their reason or motivation for providing care, and/or their goals?
  - » Does the provider feel comfortable or competent delivering the prioritized care?
  - » What implications would the provider expanding services for prioritized groups have for the families they currently serve?

- What would the proposed expansion mean for the provider and, if relevant, their staff in terms of their workload or demands on their time?

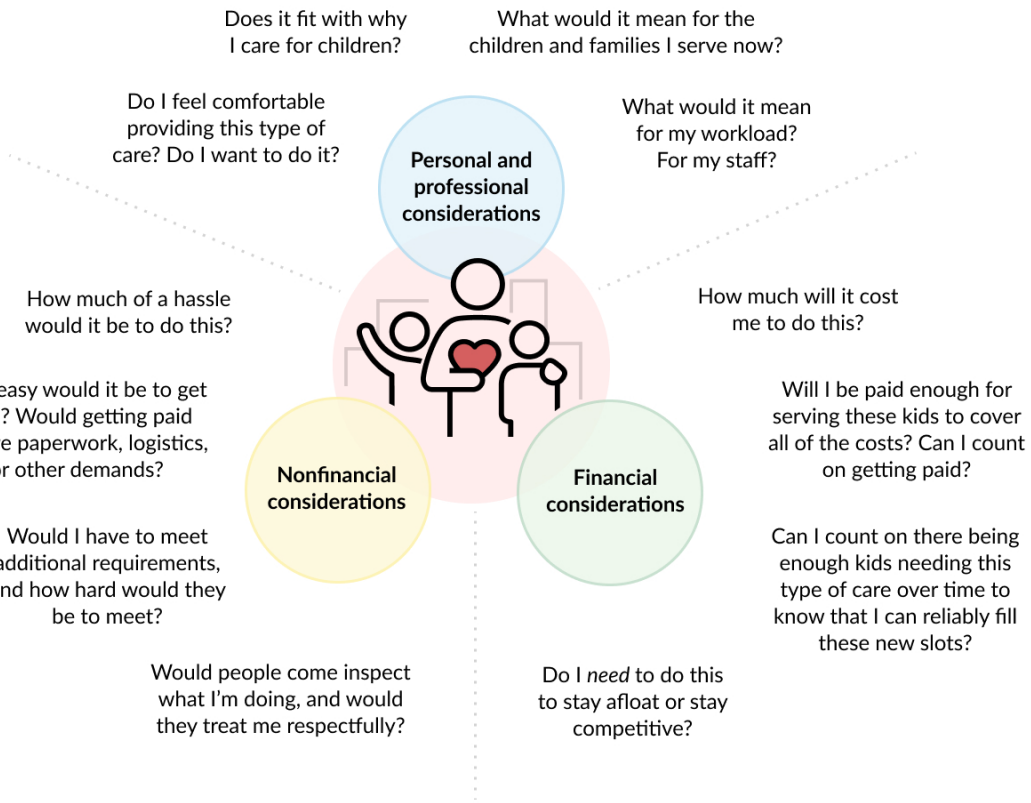
- Financial considerations, including, for example, these issues:
  - What will it cost the provider to make the desired change, both in the short term and over time? These costs include basic operational costs, short-term start-up costs, and ongoing costs associated with changing their business model.
  - Can the provider count on the additional resources being reliably available over time, which requires both a reliable and sustained *demand* for the services, as well as reliable and sustained *funding* to meet the costs of providing them?
  - If providers can get higher payments for the children they serve who are in the targeted priority group, how many children would receive the targeted service and get paid at the higher rate? Will it result in enough revenue to cover the costs?
  - Does the provider "need" to move toward expanding the targeted services for financial reasons or because they feel it is the right thing to do? Or are they doing well with their current approach and so do not need or want (or have the capacity) to make the incentivized changes?

- Nonfinancial considerations including, for example, these issues:
  - What would the change entail in terms of paperwork or administrative burden?
  - Would the expansion require the provider to meet additional requirements or undergo additional oversight or monitoring, and how easy or challenging would those be?
  - If the change requires interacting with a public agency in terms of funding or compliance oversight, what is the provider's experience or understanding about the relative ease or difficulty of working with that agency, and how they will be treated?

As shown in figure E.2, these factors and considerations are interrelated and can occur simultaneously. Further, they are likely to play out differently for providers depending on their characteristics, the markets they serve, and the services they provide, as well as for different forms of incentivized care. The cumulative informal cost-benefit analysis can then be compared with the resources the provider can access to address any of these issues whether they be personal or professional, financial, or nonfinancial.

FIGURE E.2

What Do Child Care Providers Ask Themselves When Considering Whether to Start Serving or to Expand Services for a Priority Group?



Source: The authors created this image based on interviews with child care providers and individuals working closely with providers.

Subsidy Rates and Other Policy Strategies to that Affect Provider Constraints to Expand the Supply

Our respondents suggest that a variety of policies and practices can affect the financial and nonfinancial considerations and barriers that providers can face in expanding supply.

- Policies and practices that can affect nonfinancial and personal barriers include whether states have strategies to address
  - » whether providers understand what providing the targeted service entails;
  - » nonfinancial start-up needs;

- logistical barriers, administrative burden, and paperwork associated with accessing the incentive payment;
- potential complexities and misalignment of any additional requirements and oversight associated with expanding supply or getting the incentive payment;
- the need for supportive services such as training or access to experts; and
- whether providers are seen as partners.

- Policies and practices that can shape financial considerations include
  - where states set their subsidy reimbursement caps, whether they are set at levels sufficient to cover the cost of care, and whether efforts to assess the "cost of quality care" recognize the unique costs of types of care that may be less well understood, such as care during nontraditional hours and care for children with disabilities;
  - whether states recognize the limitations of relying solely on subsidy payment rates to address financial costs of expanding services, and invest in additional financial incentive approaches;
  - the wide range of subsidy payment policies and subsidy payment practices that can reduce the actual amount that the provider can receive below the expected rate, thus reducing the incentive and financial benefit of expanding services; and
  - whether the funds are available in a reliable and sustainable way, such as by using grants or contracts, to provide more stability than provided through vouchers alone.

Understanding How Considerations, Policies, and Practices Play Out for Different Types of Providers and Types of Incentivized Care

Our review suggests that provider considerations, and the policies and practices to address them, play out differently across different types of providers and types of incentivized care.

- Some key provider characteristics that seem to shape how these issues play out across different types of providers include the following:
  - **Setting type.** Home-based child care settings may experience these issues differently than center-based settings, given differences in size, staffing, provider characteristics, and experiences.
  - **Provider size.** Larger providers who have more staff and resources and flexibility are likely to experience these issues differently than smaller providers without those supports.

- **Local markets.** The markets providers operate in can shape the level of demand they have for the priority service, the amount they can charge (which can affect the rate they get from the state), the resources they can access, and other factors.
- **Providers facing systemic inequities.** Providers who have faced systemic inequities may experience a number of these factors differently for a variety of reasons, including that they may be in communities with fewer resources because of barriers to opportunity created by structural racism; may be more likely to experience barriers due to technology, language, or literacy because of systemic barriers to resources and education experienced by Black and Latinx people, and people with immigrant status (Adams and Pratt 2021); and may have less trust in government and public institutions due to experiences of bias and discrimination.

- **These issues also seem likely to play out differently** depending on the types of supply a state is trying to incentivize, as each form of prioritized care presents different challenges and opportunities for providers:
  - **Incentivizing quality.** Our conversations highlighted concerns around issues such as paying at levels sufficient to cover the cost of quality, whether quality standards are inclusive and respectful of the full range of providers, and challenges programs face in accessing resources to support quality program-wide.
  - **Incentivizing care for infants and toddlers.** Some of the challenges for this population include appropriately establishing and paying for the true cost of care (Workman 2021; Workman and Jessman-Howard 2018), recognizing the costs of changing the business model, and navigating challenges around finding, training, and paying for staff.
  - **Incentivizing care during nontraditional hours.** Some issues that need to be considered for expanding this form of care include challenges around estimating the cost of quality care when there is no common agreement for what "quality" care is during nontraditional hours; supporting supply when the forms of care most often used are relatives, friends, and neighbors where there often is no market price to consider and many states do not pay for this form of care (Adams et al. 2022); often unstable demand patterns; potentially significant changes to business models, physical space, and staffing demands; and the reality that this care may not fit their goal and vision.
  - **Incentivizing care for children with special needs.** Some of the issues that need to be addressed for this population include establishing a better understanding of the actual costs of providing care to children with special needs; recognizing possible impacts on the

provider's overall budget and/or business model; considering the overall implications for staffing and resources and start-up costs;[7] recognizing that providers may feel less confident in their ability to serve this population and need extra supports and coaching;[8] and exploring partnering with other systems—such as early intervention services—to better support providers.

Policy Implications

Examining the findings described above reveals some key insights and policy action steps that policymakers could consider when designing policies to support supply. These are described below.

Overarching Insights

- **Although a valuable tool, CCDF's impact is diluted because it is only a small part of a much larger child care market that shapes provider behavior.** So while CCDF funds are important, their ability to shift the larger child care market will likely be constrained unless significant new investments become available.
- **Raising subsidy payment rates is necessary but not sufficient to address supply gaps.** Our review suggests that setting higher rates to incentivize expansions of the supply of particular types of care that are in short supply is an important first step but seems unlikely to be sufficient to have the desired outcomes. A broader package of policy reforms and provider supports addressing both the broader financial considerations providers face and their personal and nonfinancial considerations would be needed in addition.
- **Providers face a range of constraints in trying to expand to address supply gaps, only some of which are financial.** To effectively address the barriers facing providers in expanding supply for priority populations, it is essential to first understand the set of constraints they face given their different contexts and characteristics, as well as the unique challenges they face in expanding their services for any of the priority populations. This knowledge can be used to craft targeted and tailored incentive packages of supports to accompany rate strategies.

Key Action Steps

- **Engage with providers and stakeholders** to identify the full range of potential constraints, challenges, and costs associated with expanding the supply of targeted forms of child care. Ensure that this engagement reaches out to the full range of providers, and that supply-building strategies are designed to address the constraints they face and to support equity in access to supply-building resources.
- **Ensure that payment rates recognize the cost of providing the care.** Establish appropriate payment rates based on a *base* rate that reflects the cost of providing quality care rather than market rates and a *differential* rate that incorporates an assessment of the actual additional costs of delivering the incentivized forms of care. Explore the actual costs of the different types of care being incentivized—such as care during nontraditional hours and care for children with disabilities.
- **Recognize that payment rates are not sufficient to address the financial costs.** Establishing rates based on the actual financial costs of providing services is a necessary foundation but is unlikely to be sufficient to address the expenses associated with expanding services for priority groups. Additional steps include the following:
  - » **Assess and address often overlooked subsidy payment policies and practices that can significantly reduce the provider's actual payment to levels below the rate cap or their agreed-upon rate.** States need to assess what providers actually receive in payment. Policies and practices that can undercut payments include paying providers only what they charge private-paying parents if below the rate cap, limiting payments for absent days and not paying standard provider fees, failing to communicate in a timely way with providers about the child's eligibility status, and not paying accurately or having easy ways for providers to fix inaccurate payments. Further, these can affect some providers more than others, resulting in inequities in the subsidy resources they receive. Taking steps to address these often overlooked policies and practices is essential to ensure that providers get the financial supports they are intended to get.
  - » **Provide additional financial incentives to address costs that are not covered through per child subsidy payments.** Paying higher rates on a per child basis does not address start-up expenses, the actual costs of expanding services if relatively few children in the program get the higher rate, or overall programmatic costs related to changing the provider's business model and services. States should identify ways to address these financial costs as well.

- **Explore contracts to allow providers to know they can count on resources being available over time to meet the higher costs associated with the targeted services.** While voucher-based payments are critical for supporting parental choice, they can be financially unstable for providers, making it harder for them to commit to new service models that may be more costly and/or where demand patterns are less stable. Contract-based funding has the potential to stabilize resources, whether using contracts based on subsidy payments (which seem likely to be more effective when the provider serves enough children receiving the incentive rate to cover the program-wide costs of providing the service), program-based contracts—not linked to subsidies—that support overall costs associated with expansion (Adams et al. 2021), or both in combination.

- **Recognize and address the nonfinancial costs associated with expanding supply.** Agencies should assess and address nonfinancial costs associated with working with the agency by
  - simplifying and reducing paperwork and administrative burden,
  - aligning and simplifying oversight and compliance requirements across programs to maintain protections and accountability while reducing burden,
  - ensuring that they are responsive and supportive of providers in their interactions with them, and
  - ensuring that agency staff interacting with providers take a strengths-based approach across provider types.

  Additionally, agencies should consider investing in outreach and training for providers, addressing nonfinancial start-up costs such as materials and training, and providing supportive services directly or by partnering with other organizations or agencies.

- **Tailor incentive packages to address the specific constraints faced by different types of providers and associated with different types of incentivized care.** Create incentive packages of additional funds and supports that address the range of costs *and* nonfinancial barriers that providers face in expanding or taking on new services, including the strategies described above. However, agencies should tailor these packages to address the specific needs of different types of providers—given that the constraints they face are likely to differ depending on provider type, size, and other characteristics—and the unique challenges associated with different types of incentivized care.

- **Conduct and strengthen research around supply-building efforts**, including working to understand the constraints, costs, and benefits providers face in considering whether to

expand supply for targeted populations and areas, recognizing differences between subsidy payment policies and the reality of what providers actually receive in funding, and exploring how all of these issues may play out across different types of providers and types of care.

Conclusion

Understanding how to support and expand the supply of child care in targeted ways—to support more quality care or expand the supply of care for certain underserved populations—has been a question of concern for many years and has risen in urgency and priority given the pandemic's impact on the already-fragile child care system. This report's findings suggest that the most common strategy used to expand the supply of particular types of care—paying higher rates through the subsidy system—is a necessary first step in trying to accomplish this goal but not likely sufficient. Instead, a multifaceted approach—one that takes a more holistic view of the financial and nonfinancial costs providers face as they consider whether to change or expand their services, understands the full range of policies and practices that can affect these costs and what providers actually receive, and recognizes how these may play out differently for different providers *and* for different types of services—is essential for policymakers to successfully address these challenges.

Using Child Care Subsidy Payment Rates and Practices to Incentivize Expansions in Supply

Overview

Numerous studies have found that the supply of quality affordable child care in the United States is insufficient to meet families' needs, with particular gaps in good quality care as well as care for specific populations such as infants and toddlers, children with special needs, and children whose parents work nontraditional hours (Chaudry and Sandstrom 2020; Malik et al. 2018; Paschall, Davis, and Tout 2021). These concerns have grown in recent years because of the significant number of child care providers who have had to close or reduce services because of the pandemic, creating even greater supply gaps and care shortages (Carson and Mattingly 2020; Lee and Parolin 2021). This reality not only affects the development and well-being of millions of American children, but also the ability of their parents to work and support their families. Further, evidence shows that the reductions in supply because of the pandemic have been disproportionately greater in communities of color (Lee and Parolin 2021), including Black and Latinx communities who have traditionally faced more barriers to employment because of systemic inequities and where we see slower recovery of maternal employment rates (Landivar and deWolf 2022).[9]

Because of these realities, in recent decades policymakers and those concerned about families' child care needs have tried to expand the supply of child care available to families, and their interest and focus has been heightened because of the pandemic. This is illustrated by the focus on supporting and expanding the supply of child care both in the Child Care and Development Fund (CCDF)[10]—the federal state child care program that subsidizes child care for families with lower incomes—and the federal pandemic relief funds designed to stabilize and support the child care sector.[11] Correspondingly, state child care agencies across the country are working to implement strategies to expand the supply of child care.[12]

Our Focus and Research Questions

This report explores the use of CCDF child care subsidy payment rates and practices to try to expand the supply of child care, and focuses in particular on one of the most common policy levers—increasing the per child subsidy payment (also known as "differential" or "tiered" rates) paid to providers for specific types of care in shorter supply.[13] For example, in 2021, 43 states set higher child care subsidy rates for child care centers that met higher quality standards (Schulman 2022); and analyses of state CCDF plans for 2022–24 show that 41 states or territories reported planning to have higher rates for children with special needs,[14] and 19 states reported planning to use such rates to incentivize nontraditional-hour child care.[15] (The latter two analyses did not report whether these rate strategies were for both child care centers and family child care homes, so they may only apply to a subset of providers.)

Differential rates are used to support a variety of goals, including trying to ensure that providers delivering priority services are compensated more appropriately for the care they provide and are willing to serve children whose care is paid for by the subsidy system. *This report, however, specifically examines what is known about using subsidy payment rate strategies to expand the overall supply of priority care options, either by incentivizing providers to start delivering the priority service or by incentivizing providers who already deliver these services to expand their efforts.*

We are interested in this because even though raising subsidy rates is a strategy commonly used to address gaps in the supply of targeted forms of care, we actually know very little about whether or how these higher rates work to expand the supply of care and under what circumstances. And we know little about whether their impact varies across providers, different child care settings, different types of priority care options, or providers in different communities.[16] Our goal is to provide state policymakers with actionable insights to support their efforts to expand the supply of priority child care options, and to understand the role of subsidy payments in that process.

To better understand the role of this policy strategy in expanding supply, we examine the following research questions:

1. What factors are likely to shape providers' decisions about whether to begin delivering a priority service or to expand the extent to which they are already delivering this service? How might these differ across different types of providers or types of priority care options?
2. What do we know about whether and how subsidy payment *policies*, particularly policies around paying higher rates to try to expand the supply of particular types of care, might result

in expanding the supply of priority care options? What payment *practices* might support or undercut this goal? What other factors need to be considered in trying to reach this goal?

3. How might these play out across different types of providers or types of prioritized care?
4. What are the implications for policy and practice? What more do we need to know to better support policymakers in their efforts to use public funds to expand the supply of priority child care options?

Understanding the Role of Subsidies within the Market Context

In examining these questions, it is important to contextualize the challenges facing efforts to use subsidy policy to affect the larger child care market. Specifically, despite the central role that child care subsidy funds play in helping families afford child care, the funding providers receive through the subsidy system is a fraction of the overall financing for providers in the child care market, which is dominated by parent payments and strongly affected by market forces.[17] Here are some examples:

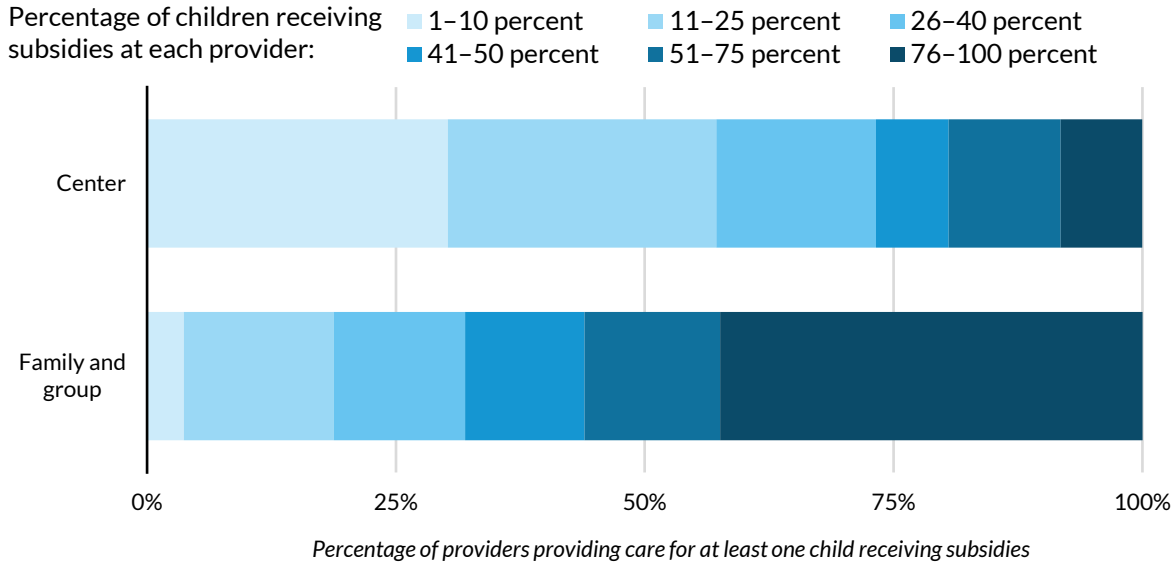
- Because funding levels only meet a fraction of the need, estimates show that in 2018 only 15 percent of children (from birth to age 12) who were eligible for subsidies under federal law were able to receive subsidies. Specifically, 1.9 million children received subsidies in an average month, 12.8 million were eligible under federal law in an average month, and there were an estimated 52.9 million children from birth to age 12.[18]
- Although we could not find recent estimates on the extent to which the child care market is touched by the subsidy system, an analysis of data from 2012 found that a third of center-based providers and a fifth of home-based providers received any revenue from the subsidy system (Greenberg et al. 2018). It seems likely that these numbers would have risen since 2012; however, it is unclear what impact the pandemic may have had.
- Further, this measure is of *any* revenue, meaning it includes a range of providers from those serving only one child receiving subsidies to those whose enrollment is entirely or mostly made up of children receiving subsidies. Understanding this particular question—the share of any individual provider's enrollment that is comprised of children being paid by subsidies—is often overlooked, but is important because it is likely to have a significant impact on the extent to which any adjustments to subsidy payments will result in the provider getting sufficient funds to incentivize or allow them to change their services.

For example, to look at these patterns in a single state, subsidy data from Pennsylvania found as of July 2022 that an estimated 71 percent of all licensed providers were serving at least one child who was receiving subsidies.[19] However the share of these providers' enrollment that was made up of children receiving subsidies varied significantly: with almost a third (30 percent) of centers who served at least one child in the subsidy system having only between 1 and 10 percent of their enrollment receiving subsidies, and another 27 percent having between 11 and 25 percent of their enrollment receiving subsidies (figure 1). Only 19 percent of licensed centers had more than 50 percent of their enrollment paid for by the subsidy program. These numbers looked somewhat different for licensed family child care and group home providers, where 57 percent had more than half of their enrollment receiving subsidies; however even for these providers, significant shares had less than 50 percent of their enrollment paid for by the subsidy system.

FIGURE 1

Percentage of Enrolled Children Receiving Subsidies among Providers Serving Children in the Subsidy System in Pennsylvania

Providers with at least one child receiving subsidies, July 2022



Source: Based on data available in Pennsylvania's Enterprise to Link Information for Children Across Networks (PELICAN), provided by the Office of Child Development and Early Learning.
Note: This represents licensed providers who provided care for not only school-age children and had at least one child receiving subsidies.

These findings suggest that although CCDF funds are important, their ability to shift the larger child care market will likely be constrained. They also suggest that even providers serving children receiving

subsidies vary in the share of their budget that comes from the subsidy program, and thus that the financial impact of subsidy policies on their services is likely to vary as well.

How We Approached This Project

To explore these questions, we took the following steps:

- **Reviewed the literature.** We began by conducting a review of the research literature to assess what we could learn from previous research. However, while research exists showing the association between payment rates and the existing supply (Greenberg et al. 2018), the research literature on payment rate policies and their role (or lack thereof) in *changing* or *expanding* the overall supply of care is minimal, further highlighting the importance of additional research on this topic.[20] We were able, however, to build on our team's extensive work on the experiences of child care providers with the subsidy system (Adams, Rohacek, and Snyder 2008; Adams et al. 2022; Adams and Pratt 2021; Adams and Snyder 2003; Henly and Adams 2017; Rohacek and Adams 2017; Sandstrom et al. 2019; Schilder et al. 2022) to understand some aspects of these issues.
- **Conducted expert interviews.** We interviewed national experts on the child care subsidy system, provider costs, subsidy payment approaches, the realities facing different child care providers, and/or market forces.[21]
- **Developed and sought feedback on draft findings.** We used the information from the preceding steps to develop preliminary findings, which we shared with small groups of key stakeholders for their input. Specifically, we shared these preliminary findings
  - » with our project advisors;[22]
  - » through small group interviews with three separate groups of child care providers or provider organizations (one each for center-based providers, licensed family child care homes, and legally license-exempt home-based providers); and
  - » through small group interviews with seven state child care administrators and lead staff from four states.

  We also shared preliminary findings with various other policy audiences to get feedback.

- **Summarized key findings and developed final products.** In the final stage of the project, we revised the project findings to reflect the input from the stakeholders described above, again

sought feedback from project advisors, and finalized the report and developed related products.

The ideas discussed in this report are based on the firsthand knowledge and lived experiences of a variety of experts and stakeholders with a range of perspectives and experiences, and thus provide important insights for policymakers to consider. However, at this point in time, there is not a strong established empirical research base for many of the questions presented here. It is our hope that the information in this report provides a framework for researchers to explore these issues further, and to provide a stronger body of research-based evidence to better inform policy action.

Findings

We present our findings in three sections:

- **Key Provider Considerations and Contexts That Can Shape How They View Efforts to Build Supply.** This section presents the contexts and considerations likely to shape the willingness and ability of providers to begin delivering the desired form of care or to expand their services, including how these factors may vary across different types of providers and types of prioritized care.
- **Subsidy Rates and Other Policy Strategies to Address Provider Constraints to Expand Supply.** This section presents the range of state policies and practices, beyond simply establishing a higher subsidy payment rate, that are likely needed to create an effective incentive package to address these provider realities.
- **Understanding How Considerations, Policies and Practices Play Out for Different Types of Providers and Types of Care.** A brief discussion of how these issues may play out across different providers and types of incentivized child care.

We then conclude with a summary of key takeaways, discussion of the implications of these insights for policy and practice, and suggestions for future research on these issues.

Key Provider Considerations and Contexts That Can Shape How They View Efforts to Build Supply

One of the most significant insights from our conversations with providers, experts, and state administrators is the importance of considering the perspective, context, and realities of providers when designing supply-building strategies. These considerations can fall into three buckets:

- personal and professional goals and beliefs
- financial considerations
- nonfinancial considerations

These can be in play simultaneously and can interact in how a provider approaches the question of whether to make the needed changes to either begin delivering the incentivized priority type of care or expand their existing services in response to the incentives. They also are likely to play out differently for different child care providers (i.e., centers and family child care homes, programs of different sizes, or programs in different market contexts) as well as for different types of incentivized services (such as improving quality or serving more infants and toddlers, children with disabilities, or children whose parents work nontraditional hours).

PERSONAL AND PROFESSIONAL GOALS AND BELIEFS

The first set of issues to consider has to do with the provider's personal and professional goals and beliefs, including their own motivations, comfort level with the incentivized service, and relationships with the families they serve. These issues are presented as questions to consider below:

- Does the prioritized type of care that policymakers are trying to expand fit with the provider's identity, their reason or motivation for providing care, and/or their goals?
- Do they feel comfortable or competent in providing the prioritized care?
- What implications would expanding services for prioritized groups have for the families providers currently serve?
- What would the expansion mean for them and, if relevant, their staff in terms of workload or demands on their time?

Does the prioritized type of care that policymakers are trying to expand fit with the provider's identity, their reason or motivation for providing care, and/or their goals? Specifically, is it a service that the provider wants to deliver? Is it one that their families want or need? Do they share the state's

belief that this is or should be a priority? Do they see it as a service that fits their identity? These issues can play out differently depending on the provider and the type of service incentivized. Here are some examples:

- Nontraditional-hour child care services that involve helping a child get a good dinner, have warm and nurturing bedtime routine, and feel safe in going to sleep may not appeal to a child care provider who is trained to focus on group activities, an educational curriculum, and how to support children's learning in a daytime environment.
- Providers focused on preparing children for school through preschool services for 3- and 4-year-old children may not see infants and toddlers as a population they want to serve.
- Providers with different perspectives on what quality care is may not see quality rating standards developed for state QRIS—which may not have been developed in ways that are inclusive of communities of color, communities with different cultural backgrounds, or the realities of home-based settings—as relevant to them or the families they serve.

Do they feel comfortable or competent in providing the prioritized care? Providers may not feel like they know how to provide the incentivized service. For example, research on care for children with special needs suggests that lack of confidence and misperceptions about what is needed to meet the needs of children with disabilities can shape whether providers are willing to provide these services (Weglarz-Ward, Santos, and Trimmer 2019).[23] Similarly, providers may feel uncomfortable or unfamiliar with providing care during nontraditional hours.

What implications would expanding services for prioritized groups have for the families providers currently serve? Specifically, providers may weigh the implications of changing their services for the families they currently serve, whether it be that they will have to reduce services for some families, change the program's identity, change the amount they charge, or make other changes that could affect the families and children they serve. They consider these questions both because of the relationship they have with the families and children and concerns about losing enrollment.

What would the expansion mean for them and. If relevant, their staff in terms of workload or demands on their time? Providers also must consider the implications of the change for their own workloads and those of their staff. For example, starting to provide care during nontraditional schedules can result in challenging workloads or changes in their schedules for staff. Family child care providers, for example, described the challenges of adding these hours onto their already long days or having to bring in assistants. Similarly, expanding services for children with special needs may entail

different responsibilities for staff, and improving quality can require staff to undergo additional training or change the way they care for children.

FINANCIAL CONSIDERATIONS

Providers' perspectives on the costs and benefits of expanding their services to address supply gaps are also affected by considerations of the costs and possible benefits of doing this. Questions they may consider include the following:

- What will it cost to make the desired change, both in the short term and over time?
- Can they count on the additional resources being sufficient and reliably available over time?
- If children in the targeted group are paid for at higher levels, how many children would get the higher payment level?
- Does the provider "need" to move to delivering the targeted services, either for financial reasons or because they feel it is the right thing to do?

Although it is not clear whether providers actually assess all of these issues, they are likely to consider some set of them as they contemplate the financial implications of expanding services to priority groups.

What will it cost the provider to make the desired change, both in the short term and over time? Our conversations with experts and providers suggested that providers may consider three types of costs:

- **The basic cost of the new service.** Providers are likely to consider how much it will cost them to provide the service in terms of paying additional staff, the costs of any additional services or materials, and so forth.
- **Short-term start-up financial costs.** Providers may face immediate start-up costs if they choose to change the services they provide. These costs could include ensuring staff have the training needed to provide the targeted service, making changes to the infrastructure such as the physical layout, or investing in new equipment or materials.
- **Ongoing or longer-term costs associated with changing their business model.** Respondents also discussed the reality that providers who start or expand services to meet particular goals may have to reduce services in another aspect of their programs unless the goal is program-wide affecting all of the children (such as raising the program's quality). This is a likely reality given constraints in physical space that can force providers to make trade-offs if they want to expand services to a particular group of children. As a result, there can be ongoing program-

wide costs associated with taking on new services that may not be accounted for in simply considering the cost of providing the new service for the children in the targeted group. For example, providers discussed the following:

- Starting or expanding services to serve infants and toddlers means that they are likely to serve fewer 3- and 4-year-old children. Given that it costs less to serve three- and four-year old children than it costs to serve infants and toddlers, this change can reduce the overall revenue for the program on an ongoing basis.
- Serving more children with disabilities can mean that the provider is not able to serve as many children overall to allow for the more individualized attention needed.
- Serving children during nontraditional hours can cause the provider to limit the services they provide during the day—for example, setting up a room for children to sleep in for nontraditional hours could cause the provider to lose the revenue associated with serving children in that space during the day.

Each of these examples can result in the provider losing money from their overall budget, beyond the specific costs associated with providing the new service, unless they are able to compensate for these lost resources by providing the new service or in some other way.

Can the provider count on the additional resources being reliably available over time? Providers need to be fairly confident that they will be able to access the resources they need to maintain their new service model or their newly expanded services over time. To support this confidence, they are likely to think about two elements:

- **Is demand for the service steady and sustainable over time?** Providers need to have confidence that there is a stable and reliable demand for the service so they will be able to enroll enough children to fill any new spaces they create. In some cases, this may be straightforward because they are already serving a particular population and know that there are more families they could serve—for example, they already serve infants and toddlers and have a waiting list. But in other cases, particularly if they are expanding into serving a new population, they may be much less confident in the demand. And in still other cases, the demand may fluctuate, as might (for example) be the case for parents working nontraditional and irregular schedules. It is important to understand that estimating demand is particularly challenging at the moment given the turmoil in the field from the pandemic, which is compounded by the lack of good data on vacancies (Stoney 2022).

Having confidence in demand can be a particular challenge for providers who may have only one or two children in the priority group—such as having a disability or having a parent working nontraditional hours—or where the population may have particularly unstable demand patterns, as can be the case with parents working nontraditional and irregular schedules. Without reliable demand, providers run the risk of investing in staff and expansion without knowing there will be children enrolled for the service.

- **Can the provider count on getting the resources needed over time to sustain the service?** In addition, given providers are likely to face ongoing costs that they have committed to—such as paying staff—they need to know that the funds they need to cover their costs would also be reliably available to them over time, whether from parents or from public funds such as the subsidy system.

If providers can get higher payments for the children they serve in the targeted priority group, how many children would receive the targeted service and get paid at the higher rate? An often-overlooked factor that can shape the value of financial incentives for providers to serve more children in priority populations is the number of children the provider serves who would qualify for the higher rate or financial incentive, and whether they can get this higher amount from private-paying parents. Two aspects of this issue can affect the provider's bottom line:

- **How many children will receive the higher rate?** If, for example, the provider is offered a higher rate to serve children needing care during nontraditional hours but only has a few children in their program who need such care and would qualify for that higher payment, the higher rate they get for those one or two children seems unlikely to supply the provider with sufficient resources to cover the costs of the target service unless they are able to access the needed funds from another source. Similarly, if the provider has more children needing this care who do not qualify for the incentive payments but the private-pay parents cannot cover the additional costs, the provider will not be able to cover the costs of providing the new service.
- **Does the per child amount paid assume the provider serves multiple children?** The per child amount the provider is paid is often based on an assumption that the provider is being paid to serve multiple children at the same time—so the combination of the payments across the children would result in the total provider payment. However, some targeted forms of care may involve serving only one or two children, resulting in the total payment the provider receives not being sufficient (Schilder et al. 2022).

These issues seem particularly likely to affect the effectiveness of financial incentives in situations where the provider does not have a critical mass of children who both need the targeted type of care (which may be the case for children with disabilities or children needing care during nontraditional hours) *and* whose care will be paid for using the higher financial incentive level, whether it be by private-paying parents or public funds.

Does the provider need to move toward delivering the targeted services because of financial reasons or because they feel it is the right thing to do? This question brings together some of the personal issues noted above with financial considerations. In other words, is the provider motivated to make the change, whether because their families want it, they think it is part of their mission, or they need to change their approach to stay afloat or expand in ways they want to? Is this a change of policy at the community or state level that means they will not be competitive with the other providers in their local markets if they do not expand their services? Or alternatively are they at full capacity? Are they struggling to even meet the needs of families they are serving or to get staff for their existing program model—a common challenge facing providers related to the pandemic—and therefore have no need or capacity to take on more challenges to try something different?

NONFINANCIAL CONSIDERATIONS

Finally, our conversations with stakeholders (i.e., providers, administrators, and experts) highlighted that it is critical to be aware of the nonfinancial realities providers are likely to consider when deciding whether to expand services for any particular priority population. Such costs and benefits include the following:

- paperwork and administrative burdens associated with expanding services
- meeting extra requirements or undergoing additional oversight
- how providers are treated by agencies overseeing compliance with any funding requirements

Paperwork and administrative burden. To the extent that expanding services for priority populations requires providers to undertake any additional administrative tasks or paperwork, this is likely to be factored in by providers assessing the "cost" of transitioning to provide the priority service. The greater the burden, the more it counteracts the value of the incentive.

Meeting any extra requirements or having to undergo additional oversight. Providers, administrators and experts also mentioned the importance of considering the "costs" of having to meet additional requirements and oversight to engage in the desired service. For example, working to meet higher QRIS standards in response to incentives to improve quality can involve additional reviews, inspections,

documentation of activities, and so forth (Workman 2021). Further, conditioning funds on meeting requirements, while a valid policy strategy, also can introduce additional instability into provider funding, as they can potentially lose resources if their funds are linked to meeting these requirements and they experience a challenge that makes them unable to comply. Their confidence in being able to continue to meet these requirements and in the fairness of the oversight process is, therefore, also an issue.

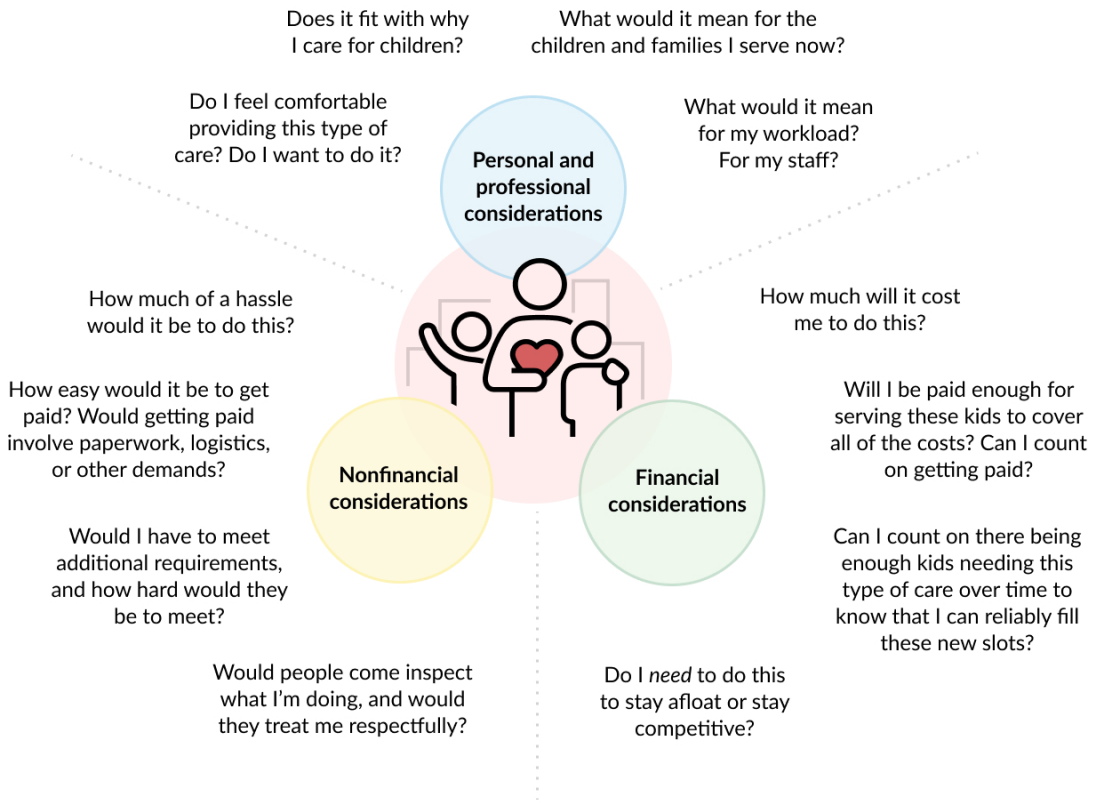
How providers are treated by the agency or agencies overseeing compliance with any funding requirements. Stakeholders we interviewed also discussed how the attitude of the subsidy or oversight agency toward the provider, and how the provider is treated, can play a significant role in shaping the costs that providers perceive in taking on the desired activities—whether it be a provider who might be interested in starting to deliver the targeted service and become involved with the subsidy system or oversight agency or existing providers who may face additional interactions with these agencies. Our respondents suggested that these issues can be particularly problematic for home-based providers for whom inspections and judgments can be personal because they are opening their home for review, and these issues can also shape the experiences of providers of color who may face systemic bias or barriers.

WEIGHING THESE FACTORS IN THE CONTEXT OF AVAILABLE RESOURCES

These factors and considerations are interrelated and can occur simultaneously, as depicted in figure 2. Further, they are likely to play out differently for providers depending on their characteristics, the markets they serve, and the services they provide, as well as for different forms of incentivized care. The cumulative informal cost-benefit analysis can then be compared with the resources the provider can access to address any of these issues whether they are motivation or knowledge, financial, or nonfinancial.

FIGURE 2

What Do Child Care Providers Ask Themselves When Considering Whether to Start Serving or Expand Services for a Priority Group?



Source: The authors created this image based on interviews with child care providers and individuals working closely with providers.

Subsidy Rates and Other Policy Strategies to Address Provider Constraints to Expand Supply

Our conversations with experts, state administrators, and providers revealed that while differential rates are often a focus of efforts to incentivize supply expansions, this policy is only one of several policies and practices needed to address the financial and nonfinancial barriers providers can face in taking on additional services. This section describes a number of state policies and practices, including subsidy payment rates, that can seem likely to shape these considerations:

- policies and practices that affect the previously discussed *nonfinancial and personal and/or professional considerations* of expanding supply, including subsidy policies and other child care strategies
- policies and practices that affect the previously discussed *financial considerations* of expanding supply, including subsidy policies and differential rates as well as other child care strategies

Before examining each of these in more detail, it is useful to recognize that several of the issues discussed below, which were raised by both experts and providers (across different provider types), involved their challenges with the subsidy system overall. These challenges also are likely to hinder the effectiveness of subsidy incentives in convincing existing providers in the subsidy system to expand their reliance on subsidies, and hinder efforts to bring new providers into the subsidy system who might be interested in expanding priority services. These issues were common among the providers we spoke with for this project and echoed feedback we received on the subsidy system in previous work on providers and subsidies (Adams, Rohacek, and Snyder 2008; Adams and Snyder 2003; Sandstrom et al. 2018).

POLICIES AND PRACTICES TO ADDRESS NONFINANCIAL AND PERSONAL CONSIDERATIONS

As described earlier, in addition to the financial costs that providers face in trying to expand their supply of targeted care, nonfinancial costs and personal considerations can factor into their assessments of the overall "costs" of undertaking this change in their services. State policies and practices that could help address some of these considerations include the following:

- helping providers understand what delivering the targeted service entails
- addressing nonfinancial start-up needs
- reducing logistical barriers, administrative burden, and paperwork
- simplifying and aligning any additional requirements and oversight
- providing supportive services
- working with providers as partners

Helping providers understand what delivering the targeted service entails. As discussed earlier, providers may have misperceptions about what delivering the incentivized type of care involves. States can provide materials, outreach, and trainings to providers to help them understand what is needed, how to assess potential demand among their families and communities, and what resources are available to support them.

Addressing nonfinancial start-up needs. Depending on the type of care incentivized, providers can face a number of additional demands such as ensuring that they can hire appropriate staff, that they or their staff can get and afford relevant training, and so forth. Ensuring providers can access resources they need to meet these demands can reduce the challenges they face.

Reducing logistical barriers, administrative burden, and paperwork. Providers described the challenges of meeting paperwork requirements and dealing with the administrative burden around enrolling in the subsidy system, dealing with payment paperwork, and other system requirements—again, concerns and challenges that have been voiced by child care providers for 20 years (Adams, Rohacek, and Snyder 2008; Adams and Snyder 2003; Sandstrom et al. 2018). To reduce these barriers, states could assess their systems, work with providers to identify what elements are burdensome or challenging, take steps to address particularly difficult aspects, and provide supports such as shared services.

Simplifying and aligning any additional requirements and oversight. As described earlier, our respondents also mentioned the importance of considering the cost of having to meet additional requirements and oversight to engage in the desired service. Further, they suggested that the requirements of different systems can be contradictory, making it particularly challenging for providers. States could consider the range of systems and requirements providers must address and identify elements that can be simplified or aligned (including oversight and monitoring) while maintaining agency goals around quality protections and accountability.

Providing or helping providers access supportive services and community partners. In some cases, providers could benefit from having access to supportive services and/or partnerships with other organizations. For example, helping providers access and work with the services offered by early intervention systems could help reduce barriers and concerns they have about serving children with special needs.

Working with providers as partners. As noted earlier, the way providers are treated in dealing with the agency can create incentives or disincentives as well and may be particularly challenging for home-based providers, providers facing language or literacy barriers, and providers facing systemic bias in their interactions with public agencies. Working directly with providers to understand their experiences, improving the agency focus on provider service and support across all provider types, working to treat and see providers as partners, and reducing strategies and attitudes focused on punitive enforcement could reduce barriers.

SUBSIDY POLICIES AND PRACTICES SHAPING FINANCIAL CONSIDERATIONS

Our interviews identified a number of policies and practices—primarily but not solely—in the subsidy system that can affect the financial incentives providers may have to expand supply:

- establish payment rates that support supply
- recognize the limitations of relying solely on subsidy payment rates to address financial considerations and invest in other strategies as well
- recognize and address subsidy policies and practices that reduce the actual amount that the provider can receive to levels below their expected rate
- help make funds reliable and stable

Establishing payment rates that support supply. The first and most fundamental question that shapes what providers will get financially if they serve a child in the subsidy system is where states set their payment rates—which is actually a rate cap or the maximum rate they will pay for a particular type of care and is not (as is discussed more later) necessarily what providers actually receive. Below we describe three aspects of setting these rate caps that are relevant to providers' concerns about whether the state rates will cover their costs: the level of the base rate, whether the state will pay more (and how much more) for particular types of incentivized care, and using cost modeling to identify rates based on the cost of providing the service rather than market prices.

Establishing the base rate. Historically, states have been directed to survey providers to identify how much they charge for care and then to establish their rate caps at a level that would allow parents to access 75 percent of the market—also known as paying "the market rate" or "the 75th percentile."[24] However, very few states actually set their rates at the 75th percentile level. In 2021, for example, 49 states set their rates below the 75th percentile of the market prices (Schulman 2022). As a result, significant numbers of providers across the country are likely to have to choose between the following options: (a) refuse to serve children in the subsidy system because the payment does not meet their costs; (b) serve them and have to accept payments below those they charge to private-paying parents, which can reduce the resources they have for their program and can—in some cases—reduce the number of children in the subsidy system they are willing to serve (Adams, Rohacek, and Snyder 2008); or (c) in states that allow this, try to collect—from parents—the difference between the state rate and the amount that they charge private-paying parents in addition to whatever copayments the parents were responsible for paying. This latter policy can present difficulties for those parents who already pay state-established copayments that can represent a significant amount of their income (Schulman 2022).

These realities underscore the importance of ensuring that base rates, at a minimum, meet the federal standard of covering 75 percent of the prices charged in the private market. However, this goal is still inadequate as basing rates on market prices, even if at the 75th percentile, fails to recognize that market prices are driven by parents' ability to pay the price charged by providers. As a result, providers in communities where families have lower incomes are likely to set their prices lower if they are to meet the needs and financial capacity of the families they serve. As a result, basing rates on the market rates effectively codifies market inequities that result in providers in lower-income areas receiving less (Adams and Pratt 2021; Stoney 2020) and constrains the subsidy system's ability to adequately pay providers. These concerns have contributed to the interest in establishing alternative mechanisms based on the cost of care for establishing rates, discussed more below.

Establishing higher differential or tiered rates for specific types of care. As described earlier, a common approach to incentivize increases in the supply of particular types of care is to create a higher rate for priority care types—such as for higher quality care or care for targeted populations such as infants and toddlers, children experiencing homelessness, children with special needs, and care during nontraditional hours. The federal Office of Child Care (OCC) has encouraged states to set these higher rates.[25]

However, research has found that these differential rates are not necessarily set at levels that meet the actual costs that providers incur to provide these services, even if only considering ongoing costs and ignoring start-up costs.[26] For example, one study found in 2019 that Arizona's infant and toddler rates were insufficient across all settings and all quality levels (Capito, Rodriguez-Duggan, and Workman 2021);[27] another study found that rates for higher quality levels were unsustainable in terms of revenue for urban settings in Ohio (GroundWork 2016);[28] and an Oregon-based study found that the amount a provider was supposed to receive—from the combination of the state payment and parent copayments—was insufficient to cover the cost of care at any quality level, with higher losses at higher quality levels (Stoney 2020).[29] In fact, in 2021, half of states that had tiered rates for quality set their payment levels for the highest quality care at levels below 75th percentile of current market rates for providers at all levels of quality (Schulman 2022).

Basing rates on the cost of care. In the 2014 reauthorization of CCDF, states were encouraged to set rates using alternative approaches, including basing rates on the cost of quality care rather than the price.[30] This approach is gaining increased interest and traction in recent years as the pandemic has raised awareness of the fragility of the child care system and the inequities built into paying for care based on prices constrained by market forces (BPC 2020; Capito, Rodriguez-Duggan, and Workman 2021; Capito, Rodriguez Duggan, and Workman 2021; OSSE 2021).[31]

This approach holds great promise for understanding the true costs associated with providing quality child care. When considering how to use this approach to support expansions in supply for specific types of care—such as infants and toddlers, nontraditional-hour care, or care for children with disabilities—it will be particularly important to consider whether and how to build in costs and assumptions that are uniquely appropriate to the form of care supported. This is already occurring for infant and toddler care in some places (Capito, Rodriguez-Duggan, and Workman 2021). However, identifying an average cost of quality care that is appropriate for the actual costs associated with serving specific underserved populations, rather than an arbitrary amount added to the base rate, may need additional exploration and thought. For example, determining the cost of quality care

- for a child with disabilities will depend significantly on the level and type of disability the child has and what services, supports, and equipment are needed, all of which need to be considered in determining an appropriate rate (or set of rates) that captures the cost of providing this care;
- for care during nontraditional hours is hampered by a lack of consensus on what quality care is during these hours (Schilder et al. 2022), is likely to vary significantly depending on whether it is for extending an existing program's hours slightly or involves providing care for children during dinnertime, overnight, or early mornings, and is complicated because it often involves care by relatives and legally unlicensed home-based caregivers who are often not supported by state subsidy systems and where states already find it challenging to set rates given the lack of market prices (Adams and Dwyer 2021; Schilder et al. 2022);
- for care for children experiencing homelessness or whose families are experiencing other major challenges can depend on questions such as whether transportation needs to be provided, what extra supports or services will be provided to the family, whether providers are supposed to pay for extra services out of their own funds or can partner with existing service providers, and so forth.

Recognize the limitations of relying solely on subsidy payment rates to address financial considerations and invest in additional funding strategies as well. In talking with experts, it became clear that subsidy payment rates based on paying providers on a per child basis are unable to address some financial issues around incentivizing expansions of supply. For example, subsidy rate strategies

- are problematic when the provider has small numbers of children in the priority group or getting the higher rate;
- do not address start-up costs; and
- do not address overall programmatic costs.

Because of these issues, states could consider developing separate financial approaches—such as grants or other financial supports—to package with rate strategies to address these financial considerations.

Rate strategies are problematic when serving small numbers of children. Creating a per child rate for types of care in short supply can be particularly problematic in situations where relatively few children are likely to receive this rate in a program, yet the financial implications for the provider may be program-wide. This creates challenges on multiple fronts:

- It seems likely harder for a provider to make the necessary changes in their service model, staffing, and so forth unless they are serving enough children receiving the higher rate to provide enough revenue to cover the costs.
- Rates are often set based on assumptions that providers are serving multiple children simultaneously and that the payments for one child will be added to payments for other children to cover the necessary costs. However, for some prioritized types of care where the demand may be less concentrated, such as nontraditional-hour child care, providers only serving a few children may be paid only a fraction of the amount that they would need to receive to cover the cost of their time (Schilder et al. 2022). This issue is of particular concern at the moment given the growing policy focus on compensation of the child care workforce and interest in setting rates at levels that support adequate compensation. Yet paying a provider the same amount regardless of the number of children cared for has the potential to create other challenges and inequities.

Another way to describe these challenges is that to the extent rate-setting strategies identify the cost (or in the case of market rate approaches, the price) of care by looking across the program or classroom to identify an average per child cost, it needs to be clear that that this amount must be covered for all children in the classroom or program (either through subsidy, private pay, or other funding) to assure that the revenue will be adequate to accomplish the goals. Or the per child cost or payment estimates need to reflect that the higher costs must be borne by a smaller number of children to ensure adequate revenue.

Rate strategies do not address program start-up costs. As described earlier, making the changes necessary to expand services can be costly for providers yet are not likely covered by subsidy payment rates. Assessing these costs and providing grants to providers to cover these costs can reduce barriers to expansion.

Rate-setting approaches may not consider the implications of the expansion on the provider's overall programmatic budget and business model. As discussed previously, the costs of changing to a new business model can result in program-wide costs for providers, which may not be sufficiently addressed by differential per child subsidy rates for the subset of children who qualify for them. Identifying these costs, and providing resources to cover them, could help reduce barriers to expansion.

Recognize and address subsidy policies and practices that reduce the actual amount the provider can receive below the expected rate. The rate policies we described earlier reflect the maximum amount a provider can receive. However, some often overlooked but important state subsidy policies and practices lead to providers getting less in payment for each child paid for by the subsidy system:

- limiting payments to what providers charge private-paying parents
- subsidy agency payment *policies* that undercut the actual payment
- subsidy agency payment *practices* that undercut the actual payment

Research on provider participation in the subsidy system overall suggests that these payment policies and practices can reduce providers' willingness to participate and reduce the funds given to providers who do participate (Adams, Rohacek, and Snyder 2008; Adams and Snyder 2003). They also seem likely to reduce the value of the incentives of increased subsidy rates for providers considering whether to expand their services to meet subsidy system supply incentives.

Limiting payments to what providers charge private-paying parents. Respondents suggested that some states will only pay providers the lesser of (a) the amount the provider charges private-paying parents or (b) the state payment rate, which means that providers with rates below the state cap will not be paid the state rate. Our interviews suggested that some states believe this is a federal requirement, but this is not the case. In fact, the preamble to the Child Care and Development Block Grant (CCDBG) Act of 2014 states,

> Payments may exceed private pay rates if they are designed to pay providers for additional costs associated with offering higher-quality care or types of care that are not produced in sufficient amounts by the market (e.g., non-standard hour care, care for children with disabilities or special health care needs, etc.). [And] Lead Agencies must set base payment rates at a level sufficient to support implementation of health, safety, and quality requirements even if such rates are higher than private-pay rates.[32]

In addition, it is not clear whether states who only pay private-pay rates with their base subsidy rates employ a similar policy with their differential or tiered rates—in other words, will they only pay the higher rate if the provider is charging that higher level to private-paying parents as well (Adams and

Snyder 2003; Henly and Adams 2018)? Alternatively, states could pay it effectively as a bonus that goes to any provider regardless of what they charge private-paying parents (Henly and Adams 2018).

This policy is likely to have different levels of impact depending on the specific provider, the community they live in, how much the parents they serve can pay for care (which affects what they can charge), and the extent to which they rely on private-paying parents or subsidies. Further, this approach can codify even further the market inequities described earlier, as providers in communities where parents cannot afford higher prices are even more limited in what they can charge, which in turn limits what they can get from public sources to cover the additional costs associated with providing the incentivized care (Adams and Pratt 2021; Stoney 2020). This seems likely to create inequities in which providers are able to respond to and benefit from supply-building strategies.

Subsidy agency payment policies that undercut actual payment. Respondents also highlighted that subsidy system policies can undercut whether providers are able to get the full amount they are supposed to get for children in the subsidy system. These include policies such as

- limiting the number of absent days states will pay for;
- whether the state will pay for other common fees that providers must charge (i.e., registration fees, diapers, field trips, and so forth);
- whether the state ties the authorized hours strictly to the hours the parent is working or in their work activity; and
- whether the ways that states authorize hours of care match the types of schedules that providers face (Adams, Rohacek, and Snyder 2008; Adams and Snyder 2003). For example, the ways states authorize hours may not accommodate parents who need child care to cover three 12-hour shifts (Schilder et al. 2022).

Although the federal government has encouraged states to pay providers in ways that are similar to private-paying parents[33]—including paying for absent days,[34] paying based on enrollment rather than attendance, paying for extra fees, authorizing hours in ways that are best for the child and their care and not tied strictly to parent work schedules, and so forth[35]—our interviews and the available data suggest that states vary significantly in their policies in this area.[36] In addition, respondents raised the issue of parent copayment policies and the challenges providers face in collecting copayments given the financial burden they can impose on parents, challenges that also can reduce the amount of money that providers actually receive.

Subsidy agency payment practices that undercut actual payment. In addition to explicit policies, some subsidy payment practices can also reduce what providers receive in payment. These were laid out in research that we conducted in the early 2000s (Adams, Rohacek, and Snyder 2008; Adams and Snyder 2003) and were corroborated in our conversations with experts and providers for the current project. Some common payment challenges mentioned by providers include, for example,

- **delays in authorization and lack of communication about when children are authorized or terminated from subsidies**, which can result in providers caring for children for significant periods of time without any form of reimbursement from the state;
- **payment inaccuracies and delays, and challenges working with the state to resolve payment problems**, can contribute to additional losses of payment as well—one expert suggested that few states had mechanisms whereby providers could reconcile what they were paid with what they were supposed to receive; and
- **challenges with the technology such as the Electronic Benefits Transfer (EBT) systems** that require parents to swipe their EBT cards, which can be challenging for providers to monitor, or Child Care Management Systems (CCMS), which can result in providers losing income if parents make mistakes in swiping their cards to prove their child's attendance.

These issues are problematic overall but may be particularly challenging for some providers, such as those who serve families whose lives are unstable and who therefore are likely to cycle in and out of the program; home-based providers or smaller providers without administrative staff who can find it challenging to spend time on the phone dealing with payment problems while they are caring for children; providers who do not have the resources to invest in administrative or accounting systems; and providers who face literacy or language challenges (Adams et al. 2003; Adams and Pratt 2021; Adams, Rohacek, and Snyder 2008).

Address the stability and reliability of the funds. As noted earlier, providers considering whether to expand services in response to incentives by the state may also consider whether they will be able to count on getting the incentive payments over time, which is linked to both the reliability of the demand and the payment. State policies to help support reliable and stable demand and funding include

- working with providers to understand and assess demand;
- considering a blend of voucher and contract funding to support more stable funding; and
- considering contract funding that is delinked from subsidies to give providers operational support to sustain services.

Support providers in assessing possible demand and tailoring services appropriately. While the state may not be able to affect demand directly, they can work with providers to help assess whether a demand for such services exists in the community and to support providers in developing and tailoring their services to meet the identified need.

Consider contract-based funding strategies. States' ability to help providers feel confident that they will be able to get the funding needed to pay for the services if they expand will likely be challenged by the reality that a reason for the inadequate supply is that child care market forces are not—on their own—supporting a sufficient supply of such care. Which means that resources other than those available from private-paying parents—such as public or philanthropic funds—are likely essential to start and sustain such services.

However, the child care subsidy system primarily relies on vouchers as the payment mechanism, which is where the parent can choose any approved provider to care for their child and change providers when needed.[37] While providing important flexibilities for parents, this approach can result in financial instability and uncertainty for providers. Specifically, the provider's enrollment of children receiving subsidies can change quickly, as parents can change providers at any time and it may not be possible to fill the slot with another child in the subsidy system depending on available funding and caseload turnover. This instability may be particularly challenging for providers receiving differential rates to serve populations where the demand is less consistent and reliable. If the higher rate is linked to a child with a disability, for example, and the family leaves, the provider may not easily find another child who would qualify for that higher rate—yet they must still continue to pay the staff and for other investments they made. As a result, relying on vouchers to pay providers higher rates may not function as a stable and reliable funding source overall.

Using subsidy-based contracts as an alternative financing approach to provide more reliability for provider payments is considered a valuable strategy that is thought to stabilize payment levels and allow providers more confidence that they will receive stable funding over the course of the contract as long as they meet their contractual obligations (Adams, Ewen, and Luetmer 2021). Contracts seem likely to be more useful when they are put in place either for an entire program or a classroom or group of children, when the amount paid per child is sufficient to cover the overall costs and where providers are confident in a steady level of demand that allows them to know that they can meet the contract's conditions of enrollment. It can, therefore, be useful to sustain and support existing supply that may be vulnerable because of unstable resources. However, little research exists on the role that contracts can play in *expanding* the supply of care, and the nature of a contract suggests that providers may need a reliable and stable demand to feel safe in committing to the contractual terms to expand care options.

This may mean that the state needs to reconsider the contractual expectations they put in place around attendance and enrollment for forms of care that are riskier for providers.

Consider delinking contracts from per child subsidy funding to provide core programmatic support. Subsidy-based contracts may be challenging when the contracted service only involves a few children, or a subset of the children in the program, which can be the case for the types of care that states are trying to expand. As a result, one option increasingly being discussed is to establish a program contract to support a baseline of services for all of the children in the program—perhaps paid for by the CCDF funds dedicated to quality and supply—and rely on subsidy system and private-paying parents to pay for the care of individual children (Adams, Ewen, and Luetmer 2021). This core contract could address the previously discussed overall programmatic costs of expanding supply and could be used in combination with other subsidy-based contracts or vouchers.

Understanding How Considerations, Policies and Practices Play Out for Different Types of Providers and Types of Care

Looking across the findings described thus far, it becomes apparent that provider considerations and the policies and practices to address them play out differently across different types of providers and incentivized care.

HOW THESE ISSUES MAY PLAY OUT ACROSS DIFFERENT TYPES OF PROVIDERS

Our conversations with experts, administrators, and providers helped reveal that the issues described in the previous sections seem likely to vary depending on the type of provider and their characteristics. Here are some examples of the provider characteristics that emerged as important to consider:

- **Setting type (i.e., child care centers and home-based settings).** Many issues described in the previous pages may look quite different for home-based settings rather than center-based settings. These include
  - » where and how states set rates;
  - » whether the unique strengths of home-based settings are appropriately measured in determining the "cost of quality care";
  - » the amount of additional funds the provider is likely to receive if they only are able to serve one or two children receiving the higher rate;

- the ease or difficulty providers have dealing with the state around payments and payment inaccuracies if they are the sole caregiver with the children during the day and have no administrative support;
- the costs associated with changing a business model when few children are served who get the higher rate; and
- experiences with licensing and monitoring agencies, and so forth (see Adams and Dwyer 2021 for more information about home-based settings and the subsidy system).

- **Provider size and staffing.** A number of respondents discussed how these issues play out differently across larger providers and may have administrative staff, more flexibility in terms of staff or physical infrastructure, be able to enroll enough children within the priority category to make the higher rates result in enough revenue to make it worthwhile, and so forth, when compared with smaller providers without those supports (Lee 2021).
- **Local markets and demand.** The markets providers operate in can shape the level of demand they have for the priority service and for their core services, the amount they can charge their private-paying parents (which can affect the rate they get from the state), the resources they can access, and numerous other factors.
- **Providers facing barriers because of systemic racism and inequities.** Providers who have faced systemic inequities may experience these factors differently for a variety of reasons, including that
  - they may be in communities with fewer resources because of the barriers to opportunity and resources created by structural racism;
  - the families they serve may be more likely to have experienced barriers to stable employment and thus may be less stably attached to the subsidy system;
  - they may be more likely to experience barriers to technology, language, or literacy because of systemic barriers to resources and education; and
  - they may experience bias and discrimination in their dealings with government and public institutions, creating inequities in treatment and supports and leading to less trust and willingness to engage with public supports.

HOW THESE ISSUES MAY PLAY OUT FOR DIFFERENT PRIORITY SERVICES

These issues also appear likely to play out differently depending on the specific types of supply a state is trying to incentivize, as each form of prioritized care presents different challenges and opportunities for providers. Although providers face common issues regardless of the form of care incentivized—such as

payment levels that fail to address the real costs of providing the care and are undercut by subsidy payment policies and practices that reduce actual payment levels, unreliable and unstable payments, lack of resources to deal with start-up costs, and nonfinancial barriers associated with expanding supply for incentivized types of care—some issues seem to play out differently for the following:

- **Incentivizing quality.** Though working to incentivize quality is a common goal, our conversations highlighted particular concerns around the amount paid, whether the standards and goals of licensing and QRIS are inclusive and respectful of the full range of providers[38] including home-based providers (Adams and Dwyer 2021), and whether resources are available to support the overall program's quality beyond the subset of children who receive public funds.
- **Incentivizing care for infants and toddlers.** Expanding the supply of care for infants and toddlers is another common priority for states and paying higher rates for these children is also a common policy approach. Some challenges for this population include appropriately establishing the true cost of care (Workman 2021; Workman and Jessman-Howard 2018), recognizing the costs of changing the business model which is likely to rely on serving older preschoolers to defray the higher costs of serving very young children (Stoney 2020), and challenges around finding, training, and paying for staff.
- **Incentivizing care during nontraditional hours.** Although expanding the supply of care for parents working nontraditional hours has become a priority at the national level and in many states, less attention has been paid to how to best accomplish this. Issues that need to be considered in working to expand care for this population include
  - » establishing estimates for the cost of quality care, which need to address the realities that
    - there is no common agreement for what "quality" care is during nontraditional hours, and this may differ depending on the period (evening, overnight, early morning, or weekends);
    - parents seem to rely on and may prefer using relatives, friends, and neighbors to care for their children during these hours, yet these caregivers are often not paid by subsidy systems and not part of a market, which makes it more challenging to determine an appropriate payment level (Schilder et al. 2022);
    - providers may only care for one or two children;
  - » addressing the instability of the demand;
  - » expanding existing programs to provide this form of care can require significant changes in business models, physical space, work schedules, and staffing demands; and

- providing this form of care may not fit with the goals and vision of some providers who do not see caring for children during activities such as dinner, bedtime routines, and sleeping as part of their professional goals.

- **Incentivizing care for children with special needs.** Addressing gaps in the supply of care for children with special needs is another priority under the CCDF. Issues that need to be addressed for this population include

  - working to establish a better understanding of the actual costs of providing care to children with special needs, including building in an understanding of how these needs can vary;
  - building in financial support to address possible impacts on the provider's overall budget/business model (e.g., do they have to serve less children if they accept children with special needs);
  - considering the overall implications for staffing and resources and start-up costs;[39]
  - considering how to stabilize funding and better understand demand patterns to ensure that payments recognize the complexities of demand for this population;
  - recognizing that providers may feel less confident in their ability to serve this population and need extra supports and coaching;[40] and
  - finally, recognizing that partnering with other systems, such as early intervention services, may be essential in supporting providers to meet the needs of children with special needs.

Policy Implications

Our findings provide important insights into understanding the constraints and opportunities policymakers face in using CCDF funds to expand the supply of child care in targeted ways. Below we highlight some key insights that emerge from looking across the findings and suggest policy action steps that policymakers could consider when designing policies to support supply.

Overarching Insights

When examining our discussion and findings, a few key insights emerge:

1. **Although a valuable tool, CCDF's impact is diluted because it is only a small part of a much larger child care market shaping provider behavior.** As a result, though CCDF funds are important, their ability to shift the larger child care market will likely be constrained unless significant new investments become available.

2. **Raising subsidy payment rates is necessary but not sufficient to address supply gaps.** Raising rates is an important tool in shaping the share of the *existing* child care market that parents in the subsidy system can access, and in increasing the funding that subsidy-participating providers receive for their core services. However, our review suggests that setting higher rates to incentivize *expansions* of the supply of particular types of care may not be sufficient to achieve the desired outcomes. To do so, a package of policy reforms and provider supports would be needed that addresses both the broader financial considerations providers face as well as their personal and nonfinancial considerations.
3. **Providers face a range of constraints in trying to expand to address supply gaps, only some of which are financial.** To effectively address the barriers facing providers in expanding supply for priority populations, it is essential to understand the unique set of constraints they face given their different contexts and characteristics, as well as the unique challenges they face in expanding their services for any of the priority populations. This knowledge could be used to craft targeted and tailored incentive packages of supports to accompany rate strategies.

Key Action Steps

Despite the challenges and overall market constraints, our report lays out a variety of steps states can take to more effectively expand the supply of targeted forms of care, though these will clearly be shaped by their resources and priorities:

- **Engage with providers and stakeholders to identify the full range of potential constraints, challenges, and costs associated with expanding the supply of targeted forms of care.** Our review makes it clear that the per child subsidy rate a provider is paid is only one of many factors that need to be addressed to incentivize providers to expand services for priority groups. To inform their policy efforts, states could talk with providers, subsidy agency staff, experts, and stakeholders to understand the true constraints providers face as they consider expanding to provide targeted services. They should make particular effort to engage a full range of providers to understand the constraints and considerations—including across setting types, program size, levels of community resources, and experiences with structural racism and inequities—and to explore the constraints specific to different types of incentivized care.
- **Ensure that the payment rates recognize the cost of providing the care**: Establish appropriate payment rates based on a *base* rate that reflects the cost of providing quality care rather than market rates and a *differential* rate that incorporates an assessment of the actual additional

costs of delivering the incentivized forms of care. Using cost modeling strategies, currently being considered or implemented in a number of states, is an important step forward. In addition, further exploration of the actual costs of the different types of care being incentivized—such as care during nontraditional hours and care for children with disabilities—would be helpful.

- **Recognize that payment rates are not sufficient to address the financial costs providers may face in expanding supply.** Establishing rates based on the actual financial costs of providing services is a necessary foundation but is unlikely to be sufficient to address the expenses associated with expanding services for priority groups. Additional steps include the following:
  - **Assess and address often-overlooked underlying subsidy payment policies and practices that can significantly reduce the provider's actual payment to levels below the rate cap or their agreed-upon rate**: Subsidy policies and practices can limit the value of the financial incentives and subsidy payments. They include paying providers only what they charge private-paying parents if below the rate cap, limiting payments for absent days and not paying standard provider fees such as registration fees or diaper fees, failing to communicate effectively and in a timely way with providers about the child's eligibility status, and not paying accurately or having easy ways for providers to fix inaccurate payments.

    As a result, one of the first steps states could take is to examine this issue in their systems to assess what providers *actually* receive in payment, what policies or practices are undercutting payment levels, and if there are particular disincentives to serving priority populations. Further, states could look to see whether these patterns vary across providers, with some types of providers being more likely to experience discrepancies than others and resulting in inequitable access to supports.

    Once the state identifies the discrepancies and their cause, they can take steps to address the core problems. This can include improving communication processes, making payment systems more accurate and timely, making it easier for providers to identify and resolve payment inaccuracies, investing in technological supports such as Child Care Management Systems, and ensuring that the systems and policies work for the full range of providers. A benefit of this approach is that the system will likely work better for all providers in the subsidy system and help strengthen their financial well-being and stability.

- **Provide additional financial incentives to address start-up costs, the needs of providers who may only serve a small number of children in the priority group, and those for whom expanding targeted supply has larger program budget implications**. Paying higher rates on a per child basis does not address start-up expenses. It is also unlikely to address the actual costs of expanding services if relatively few children in the program get the higher rate—a situation that may be fairly common as providers vary in the extent to which their enrollment is subsidized or would qualify for the higher rate. Also higher per child rates do not address overall programmatic costs related to changing the provider's business model and services. States could identify ways to support providers in meeting these additional costs.
- **Explore contracts to allow providers to know they can count on resources being available over time to meet the higher costs associated with the targeted services**. Although voucher-based payments are critical for supporting parental choice, they can be financially unstable for providers. This can make it harder for them to commit to new service models that may be more costly and/or where demand patterns are less stable. Contract-based funding is thought to stabilize resources, whether using contracts based on subsidy payments (which are likely more effective when the provider serves enough children receiving the incentive rate to cover the program-wide costs of providing the service), program-based contracts—not linked to subsidies—that support overall costs associated with expansion (Adams et al. 2021), or a combination of the two.

- **Recognize and address the nonfinancial costs associated with expanding supply.** Agencies should assess and address nonfinancial costs associated with working with the agency by
  - simplifying and reducing excessive paperwork and administrative burden,
  - aligning and simplifying oversight and compliance requirements,
  - ensuring that their interactions with providers are not punitive or negative, and
  - ensuring that agency staff interacting with providers take a strengths-based approach across provider types.

  Additionally, agencies should consider investing in outreach and training for providers and addressing nonfinancial start-up costs such as materials and providing supportive services. As part of this, states should explore working closely with key agency or community partners—for example, trusted community intermediaries to help support the home-based providers who are most likely to provide nontraditional-hour care; provider-serving organizations who can work with the state to support providers by offering training and technical assistance; and

community organizations involved in early intervention services, who can collaborate in ensuring that providers have access to the resources they need to serve children with disabilities.

- **Tailor incentive packages to address the specific constraints faced by different types of providers and associated with different types of incentivized care.** Create incentive packages of additional funds and supports that address the range of costs and nonfinancial barriers that providers face in expanding or taking on new services, including the strategies described above. However, agencies should tailor these packages to address the specific needs of different types of providers, given that the constraints they face are likely to differ depending on provider type, size, and other characteristics. Incentive packages also should address the unique challenges associated with different types of incentivized care. The constraints providers face differ, for example, if they are expanding services for infants and toddlers, children with disabilities, or during nontraditional hours, or if they are considering improving overall quality.
- **Conduct and strengthen research around supply-building efforts.** The lack of strong research in this area is of great concern given the central importance of these issues in meeting the CCDF's goals, though recent investments in research on subsidy rates and copayment levels could help in beginning to fill some of these gaps in the coming years.[41] Some steps that can be taken to fill knowledge gaps include the following:
  - » Explore which policies and practices actually *change* the overall supply of care and which make the *existing* supply more available to parents in the subsidy system, both of which are important goals but have different implications.
  - » Work with the full range of provider types to understand and explore the challenges they face in considering expanding services of different types and what incentives or supports might help.
  - » Explore what providers actually receive in payment, rather than relying on established rate caps, when examining the implications of payment rates for providers; recognize that the difference between rate caps and actual payments is likely to be greater for some providers than others, resulting in inequities; and assess the impact of policies that support providers in getting the resources they are intended to receive.
  - » Examine the strengths and limitations of contract-based funding strategies in sustaining supply and whether they can function to *expand* supply, explore different types of contract strategies (subsidy-based and program-based), and assess whether and how they work for

providers with different characteristics, for different types of care, and in situations where only a few children need the prioritized service at a particular provider.

- Look beyond per child rates or costs to explore the financial implications of expanding services for program-wide budgets and business models, provider financial constraints and incentives, challenges around serving small numbers of children within the priority group, and the unique costs associated with particular types of care.
- Ensure that assessments of the effects of supply-building policies recognize and explore differences across provider types and types of incentivized care.
- Assess policies from the perspective of the provider and their realities and constraints, and explore whether and how policies and incentives support providers equitably or are more likely to function and support some providers over others.

Conclusion

Understanding how to support and expand the supply of child care in targeted ways—to support more quality care or expand the supply of care for certain underserved populations—has been a question of concern for many years and has risen in urgency and priority given the impact of the pandemic on the already fragile child care system. Our findings suggest that one of the most common strategies used to expand the supply of particular types of care—paying higher rates through the subsidy system—is a necessary first step in trying to accomplish this goal but not likely sufficient. Instead, an approach that takes a more holistic view of the financial and nonfinancial costs providers face as they consider whether to change or expand their services—that understands the full range of policies and practices that can affect these costs and what providers receive in payment, and how these may play out differently for providers with different characteristics and for various types of services—is essential for policymakers to successfully address these challenges.

Notes

[1] Marokey Sawo, "An Economic Recovery for Whom? Black Women's Employment Gaps Show Important Differences in Recovery Rates," *Working Economics Blog*, Economic Policy Institute, December 21, 2021, https://www.epi.org/blog/an-economic-recovery-for-whom-black-womens-employment-gaps-show-important-differences-in-recovery-rates/.

[2] "The Act increases the share of CCDF funds directed towards quality improvement activities, authorizes a new set-aside for infant toddler care, and drives investments towards increasing the supply of high quality care for infants and toddlers, children with special needs, children experiencing homelessness, and other vulnerable populations including children in need of nontraditional hour care and children in poor communities" from the 2014 Reauthorization of the Child Care and Development Fund: Child Care Development Fund (CCDF) Program, 45 CFR 98, 81 Fed. Reg. 190 (Sept. 30, 2016), https://www.govinfo.gov/content/pkg/FR-2016-09-30/pdf/2016-22986.pdf.

[3] Child care funds were included in three pandemic relief packages: (1) $2.5 billion for CCDF in the Coronavirus Aid, Relief, and Economic Security Act from March 2020—see "Information Memorandum: CCDF-ACF-IM2020-01," April 29, 2020, https://www.acf.hhs.gov/sites/default/files/documents/occ/ccdf_acf_im_2020_01.pdf; (2) $10 billion for CCDF in the Coronavirus Response and Relief Supplemental Appropriations Act of 2021—see "Program Instruction: CCDF-ACF-PI-2021-01," February 12, 2021, https://www.acf.hhs.gov/sites/default/files/documents/occ/CCDF-ACF-PI-2021-01.pdf; and (3) the American Rescue Plan allocated $15 billion for CCDF and another $24 billion in stabilization funds for providers in and out of the subsidy system to support supply building (see "ARP Act Child Care Stabilization Grants," US Department of Health and Human Services (HHS), Administration for Children and Families (ACF), Office of Child Care (OCC), May 10, 2021, https://www.acf.hhs.gov/occ/policy-guidance/ccdf-acf-im-2021-02, and "ARP Act CCDF Discretionary Supplementary Funds," HHS, ACF, OCC, June 10, 2021, https://www.acf.hhs.gov/occ/policy-guidance/ccdf-acf-im-2021-03).

[4] "Setting Payment Rates," HHS, ACF, OCC, Early Childhood Training and Technical Assistance System (CCTAN), accessed July 1, 2022, https://childcareta.acf.hhs.gov/ccdf-fundamentals/setting-payment-rates.

[5] For more information on what is and is not known about this issue, see the proceedings from a virtual workshop designed and facilitated by Gina Adams for the 2020 Child Care and Early Education Policy Research Consortium at this link: https://www.researchconnections.org/sites/default/files/2021-04/SEPT2-1.pdf.

[6] The state reported that 90 percent of all licensed providers had a subsidy program agreement, and of this 90 percent, 79 percent had at least one child receiving subsidies enrolled in their program.

[7] Lawrence Wilson, "Washington Offers $4.5M in Grants for Special Needs Child Care," *The Center Square*, May 12, 2022, https://www.thecentersquare.com/washington/washington-offers-4-5m-in-grants-for-special-needs-child-care/article_c5639b30-d240-11ec-82a4-ab8c40575233.html.

[8] "Child Care Services September 2021 Newsletter," Tennessee Department of Human Services, November 17, 2021, https://www.tn.gov/content/dam/tn/human-services/documents/Child%20Care%20Services%20September%202021%20Newsletter.pdf.

[9] Sawo, "An Economic Recovery for Whom? Black Women's Employment Gaps Show Important Differences in Recovery Rates."

[10] "The Act increases the share of CCDF funds directed towards quality improvement activities, authorizes a new set-aside for infant toddler care, and drives investments towards increasing the supply of high quality care for infants and toddlers, children with special needs, children experiencing homelessness, and other vulnerable populations including children in need of nontraditional hour care and children in poor communities" from the 2014 Reauthorization of the Child Care and Development Fund: Child Care Development Fund (CCDF)

Program, 45 CFR 98, 81 Fed. Reg. 190 (Sept. 30, 2016), https://www.govinfo.gov/content/pkg/FR-2016-09-30/pdf/2016-22986.pdf.

[11] Child care funds were included in three pandemic relief packages: (1) $2.5 billion for CCDF in the Coronavirus Aid, Relief, and Economic Security Act from March 2020—see "Information Memorandum: CCDF-ACF-IM2020-01"; (2) $10 billion for CCDF in the Coronavirus Response and Relief Supplemental Appropriations Act of 2021—see "Program Instruction: CCDF-ACF-PI-2021-01"; and (3) the American Rescue Plan allocated $15 billion for CCDF and another $24 billion in stabilization funds for providers in and out of the subsidy system to support supply building (see "ARP Act Child Care Stabilization Grants," HHS, ACF, OCC, and "ARP Act CCDF Discretionary Supplementary Funds," HHS, ACF, OCC).

[12] "COVID-19: State Child Care Actions," Hunt Institute, August 19, 2021, https://hunt-institute.org/covid-19-resources/state-child-care-actions-covid-19/.

[13] "Setting Payment Rates," HHS, ACF, OCC, CCTAN.

[14] "State/Territory Plan 2022 – 2024, 4.3.3 Yes - c: Differential Rate for Children with Special Needs, as Defined by the State/Territory," ACF, HHS, July 20, 2021, https://www.acf.hhs.gov/sites/default/files/documents/occ/4.3.3-Yes-c-FFY2022.pdf.

[15] "State/Territory Plan 2022 – 2024, 4.3.3 Yes - b: Differential Rate for Non-Traditional Hours," ACF, HHS, August 27, 2021, https://www.acf.hhs.gov/sites/default/files/documents/occ/4.3.3-Yes-b-FFY2022.pdf.

[16] For more information on what is and is not known about this issue, see the proceedings from a virtual workshop designed and facilitated by Gina Adams for the 2020 Child Care and Early Education Policy Research Consortium at this link https://www.researchconnections.org/sites/default/files/2021-04/SEPT2-1.pdf.

[17] Note that the pandemic-relief funds provided states to support child care were not limited to programs receiving subsidies, so for that period of time a broader swath of the child care market is likely to have been receiving some public funds, though not necessarily through subsidies associated with particular children. Instead these funds were often distributed through grants.

[18] Nina Chien, "Factsheet: Estimates of Child Care Eligibility and Receipt for Fiscal Year 2018," HHS, Office of the Assistant Secretary for Planning and Evaluation, August 2021, https://aspe.hhs.gov/sites/default/files/2021-08/cy-2018-child-care-subsidy-eligibility.pdf.

[19] The state reported that 90 percent of all licensed providers had a subsidy program agreement, and of this 90 percent, 79 percent had at least one child receiving subsidies enrolled in their program.

[20] One exception is a study examining the impact of higher rates paid for care meeting higher quality rating standards in Maryland, which found "Results from the quantitative research showed that a greater subsidy density was associated with a greater likelihood of a center being rated 3 and receiving an incentive payment. However, results from the qualitative research showed that few center directors reported that tiered payments factored into their decision on what QRIS rating to reach and no directors were singularly motivated by the incentives. Rather, directors reported being intrinsically motivated to improve QRIS ratings or motivated by technical assistance providers. Additionally, directors who did not attain a rating of 3 experienced capacity challenges" (Lee, Erica S. 2021).

[21] The initial interviews were conducted with Harriet Dichter, Chad Dunkley, Louise Stoney, Mary Beth Salomone Testa, and Simon Workman.

[22] Our project advisors were Harriet Dichter, Louise Stoney, Mary Beth Salomone Testa, and Simon Workman.

[23] "Policy Statement: Inclusion of Children with Disabilities in Early Childhood Programs," HHS and US Department of Education, September 18, 2015, https://sites.ed.gov/idea/idea-files/policy-statement-inclusion-of-children-with-disabilities-in-early-childhood-

programs/#:~:text=This%20policy%20statement%2C%20released%20jointly,support%20in%20meeting%20high%20expectations.

[24] The 2014 Reauthorization of the Child Care and Development Fund: Child Care Development Fund (CCDF) Program, 45 CFR 98, 81 Fed. Reg. 190 (Sept. 30, 2016), https://www.govinfo.gov/content/pkg/FR2016-09-30/pdf/2016-22986.pdf); "Setting Payment Rates," HHS, ACF, OCC, CCTAN.

[25] "Lead Agencies can choose to establish tiered rates, differential rates, or add-ons on top of their base rates as a way to increase payment rates for targeted needs (e.g., a higher rate for children with special needs as both an incentive for providers to serve children with special needs and as a way to cover the higher costs to the provider to provide care for children with special needs). Lead agencies may pay providers more than their private pay rates as an incentive or to cover costs for higher quality care. Lead Agencies may also give higher rates as a way to improve quality or increase the supply of certain types of care" (see "Setting Payment Rates," HHS, ACF, OCC, CCTAN).

[26] For example, "In half of the 42 states with tiered rates for center care for a 4-year-old in 2021, the payment rate for this type of care at the highest quality level was below the 75th percentile of current market rates (which includes providers at all levels of quality) for this type of care" (Schulman 2022).

[27] As of 2019, Arizona's infant and toddler rates were insufficient across all settings and all quality levels. The gap between the monthly infant reimbursement rate to the cost of care increased from $207 for 2+ or 3 star licensed center-based care to $334 for 5 star care. Toddlers, 3-year-olds, and 4-year-olds saw a slightly smaller gap increasing from $94, $132, and $132 to $126, $198, and $153, respectively. However, the school-age subsidy provided a net gain for 2 or 3 star care of $51, which dropped to negative $14 for the highest quality level. In family child care settings, the gaps were relatively consistent across the quality levels, as between 2 and 3+ stars to 5 stars, the gap hovered around $320 for infant care, $425 for toddlers, $475 for 3-year-olds and 4-year-olds (Capito, Rodriguez-Duggan, and Workman 2021).

[28] In urban settings in Ohio, the 100 percent subsidy center will receive a net revenue in the 5 percent range at lower quality levels (below 3-Star), just break even at 3-Star (0 percent net revenue) and become unsustainable at higher quality levels (4-Star and 5-Star) (GroundWork 2016).

[29] An Oregon-based study showed that the state share and the family copayment for a rural child care center at any quality level, with a more substantial loss at the higher quality level, was insufficient to cover the price of child care. The cost gap is exacerbated for infant or toddler care in comparison with the 3- and 4-year-olds by a greater net loss of $4,000 at the lowest licensing level and $9,500 at the highest (Stoney 2020).

[30] 2014 Reauthorization of the Child Care and Development Fund: Child Care Development Fund (CCDF) Program, 45 CFR 98, 81 Fed. Reg. 190 (Sept. 30, 2016), https://www.govinfo.gov/content/pkg/FR-2016-09-30/pdf/2016-22986.pdf.

[31] See "Fiscal Modeling Studies," P>5 Fiscal Strategies, accessed September 7, 2022, https://www.prenatal5fiscal.org/fiscal-modeling, for resources and a compendium of state studies.

[32] The preamble to the CCDBG regulations provides information on the circumstances under which states may pay above the provider's private-pay rate—see 2014 Reauthorization of the Child Care and Development Fund: Child Care Development Fund (CCDF) Program, 45 CFR 98, 81 Fed. Reg. 190 (Sept. 30, 2016), https://www.govinfo.gov/content/pkg/FR-2016-09-30/pdf/2016-22986.pdf.

[33] 2014 Reauthorization of the Child Care and Development Fund: Child Care Development Fund (CCDF) Program, 45 CFR 98, 81 Fed. Reg. 190 (Sept. 30, 2016), https://www.govinfo.gov/content/pkg/FR-2016-09-30/pdf/2016-22986.pdf.

[34] Under CCDBG reauthorization, states or territories are required to provide assurance that they will, "to the extent practicable, implement enrollment and eligibility policies that support the fixed costs of providing child care services by delinking provider reimbursement rates from an eligible child's occasional absences due to

holidays or unforeseen circumstances such as illness." (see Child Care and Development Block Grant Act of 2014, Pub. L. 113-186, 128 Stat. 1971 (Nov. 19, 2014), https://www.congress.gov/113/plaws/publ186/PLAW-113publ186.pdf; "Does the Law Require States to Pay for Absence Days," HHS, ACF, OCC, March 24, 2015, https://www.acf.hhs.gov/occ/faq/does-law-require-states-pay-absence-days.

[35] "Attendance Policies and Systems," OCC, National Center on Child Care Subsidy Innovation and Accountability, updated April 3, 2015, https://childcareta.acf.hhs.gov/sites/default/files/public/attendance_policies_systems_0.pdf.

[36] See, for example, state policies around paying for absent days in 2019 in table 35 of Dwyer et al. (2020). Also, note that during the pandemic, about two-thirds of the states began paying providers based on enrollment rather than attendance to stabilize their payments, though most states have since rolled back these policies (Schulman 2021).

[37] "FY 2019 Final Data Table 2 - Percent of Children Served by Payment Method." ACF, OCC, May 23, 2022, https://www.acf.hhs.gov/occ/data/fy-2019-final-data-table-2.

[38] Maia Connors, "New Study Highlights Inequitable Participation in Quality Rating & Improvement Systems," *Start Early: Champions for Early Learning* (blog), February 12, 2021, https://www.startearly.org/post/new-study-highlights-inequitable-participation-in-quality-rating-improvement-systems/; Child Care and Development Block Grant Act of 2014, Pub. L. 113-186, 128 Stat. 1971 (Nov. 19, 2014), https://www.congress.gov/113/plaws/publ186/PLAW-113publ186.pdf.

[39] Lawrence Wilson, "Washington Offers $4.5M in Grants for Special Needs Child Care."

[40] Lawrence Wilson, "Washington Offers $4.5M in Grants for Special Needs Child Care."

[41] See, for example, current grants provided by the Office of Planning, Research, and Evaluation (OPRE) of the Administration for Children and Families at the US Department of Health and Human Services: "Coordinated Evaluations of Child Care Development Fund (CCDF) Policies and Initiatives: Phase I (Planning Grants)," accessed September 7, 2022, https://www.acf.hhs.gov/opre/project/coordinated-evaluations-child-care-and-development-fund-ccdf-policies-and-initiatives.

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