Increasing Access to Quality Child Care for Four Priority Populations

Executive Summary

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October 2018

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

The report from which this summary is taken explores the implications of this trend in the context of the 2014 reauthorization of the Child Care and Development Block Grant (CCDBG), also known as the Child Care and Development Fund.[1] It focuses on four priority populations: families with parents working nontraditional schedules, families with infants and toddlers, families living in rural areas, and families with children with disabilities and special needs. It concludes with a discussion of state and territory policy strategies to better address the child care needs of these families.[2]

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

Key Insights

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

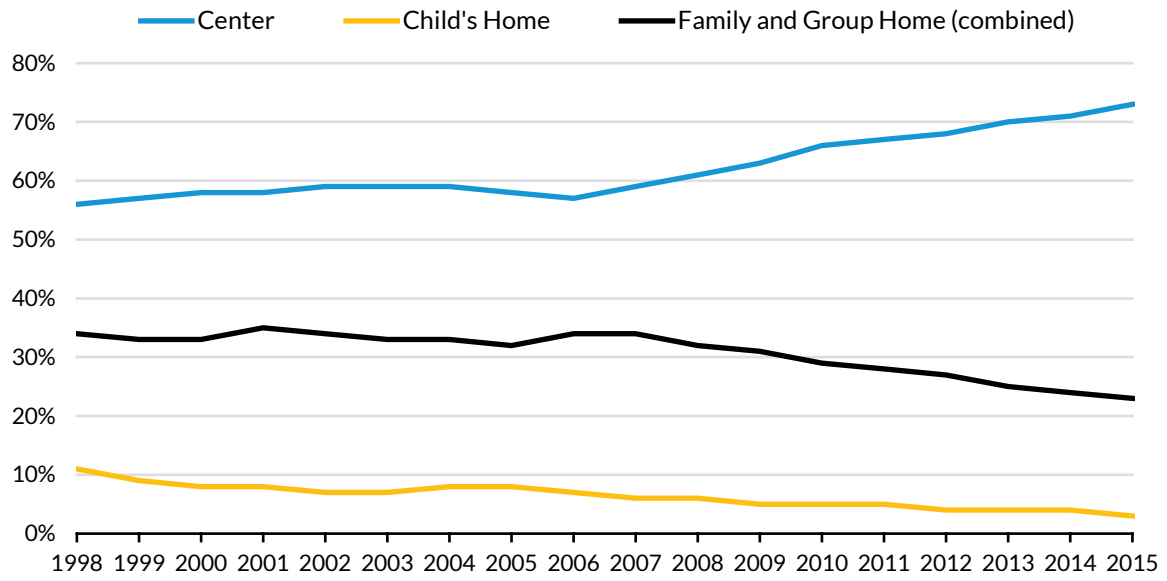
The CCDBG is a two-generation program that supports the employment of low-income parents and the development of their children. It historically has supported parental choice of care across a range of settings, including child care centers, licensed family child care homes, and legally license-exempt home-based settings.

Over the past two decades, the proportion of children receiving CCDBG subsidies who are cared for in center-based child care programs has risen significantly—from 56 percent in 1998 to 73 percent in 2015—with the trend becoming more pronounced after 2006 (figure 1).

- **All but four states have reported increases in the use of center-based care since 1998.** By 2015, center-based arrangements were used by the majority of children receiving child care subsidies in 43 states, and by more than 90 percent in 10 states (figure 2).

FIGURE 1

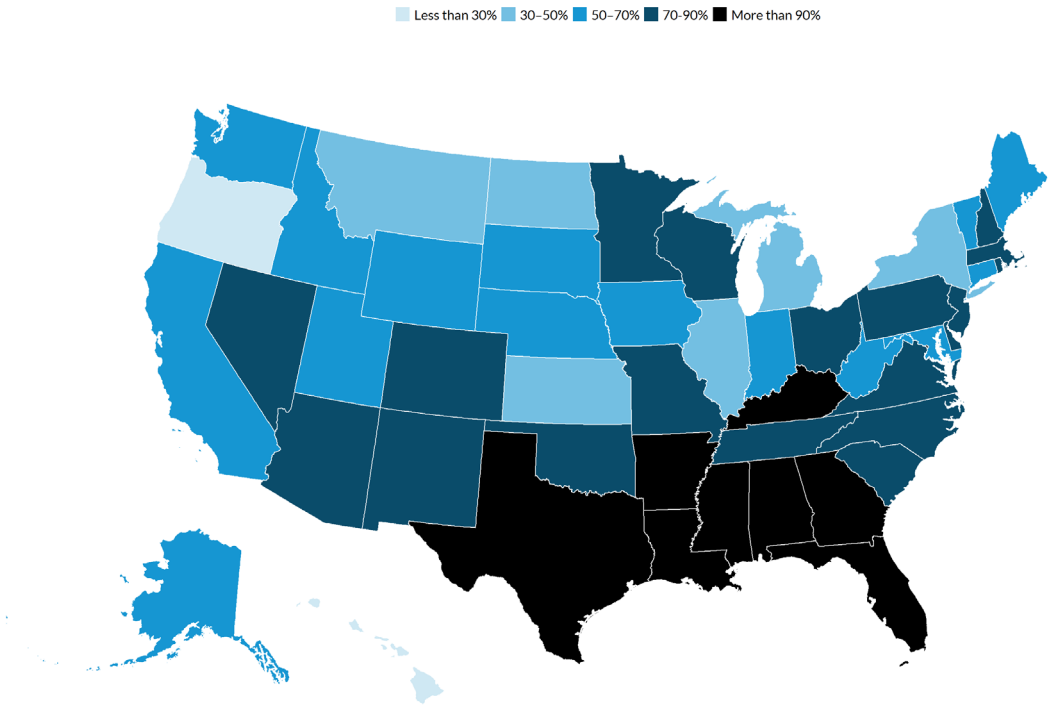
Share of Total Children Served by Care Types, 1998–2015



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

FIGURE 2

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



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

The CCDBG reauthorization may accelerate the trend toward subsidized center-based care. The reauthorization was designed to strengthen the child development aspects of CCDBG by adding several new provisions that prioritize the health and safety of children and the quality of child care settings. This may accelerate the trend toward center-based care for three reasons:

- **Although quality child care exists across sectors, the increased focus on quality may inadvertently advantage child care centers over home-based settings,** especially over homes legally exempt from licensing. This may be partially a result of the reliance on definitions of quality that do not reflect the unique strengths of home-based settings.
- **Stronger health and safety standards and monitoring requirements may deter (or perhaps exclude) home-based providers,** especially license-exempt family, friend, and neighbor care, from participation in the subsidy program unless states actively support their continued involvement.
- **Implementing new health and safety requirements can be costly,** and states' budget constraints may limit their ability to invest in supporting the new requirements, such as inspections and enforcement, for home-based programs. The recent increase in federal funding passed in the spring 2018 omnibus spending bill may alleviate the pressure, but states must balance competing priorities for these funds.

Implications for Subsidy Access for Priority Populations

An increasing focus on center-based care disadvantages families who find it harder to access centers because of their location, schedules, or limited availability of slots serving their particular needs. It also is challenging for families who prefer home-based alternatives and thus undercuts the core CCDBG principle of parental choice.

Four groups of children are of special concern—children who need care during nontraditional and variable hours, infants and toddlers, children in rural areas, and children with disabilities and special needs (which we abbreviate to "children with special needs")—for three reasons:

- The reauthorized CCDBG explicitly identifies these groups (among others) as being priority groups for service and requiring the targeted attention of state efforts to improve access and quality.
- Some families in these groups do use center-based care; however, this form of care remains less accessible to many of these families for different reasons.
- These children make up the majority of low-income children under age 6 with working parents (table 1). Though data are not available on children with special needs, analysis of cumulative American Community Survey data from 2011 to 2015 finds that 61 percent (2.95 million) children who live in families with income below 200 percent of the federal poverty level are infants or toddlers, live in nonmetropolitan areas, and/or have parents who work the majority of their hours outside traditional daytime hours. This share is more than 50 percent in all states and rises to 80 percent or higher in five states. (This is an underestimate, as we use a conservative estimate of nonstandard work—specifically, one that includes only children in families where parents work *most* hours outside traditional work schedules instead of *any* hours.)

These realities suggest that the trend toward subsidies in center-based care may inadvertently create barriers to subsidy access for a significant share of the low-income children who are a priority for the CCDBG, barring a drastic change in their access to center care or greater availability of subsidized home-based care.

TABLE 1

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

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

State	All low-income children < 6 with working parents	Of this total, children in at least one priority group	
		#	%
Alabama	80,800	52,500	65%
Alaska	9,700	7,000	71%
Arizona	109,200	62,300	57%
Arkansas	58,200	40,700	70%
California	517,000	279,600	54%
Colorado	68,900	40,400	59%
Connecticut	37,500	19,900	53%
Delaware	13,600	7,700	57%
District of Columbia	8,300	4,900	58%
Florida	305,100	168,200	55%
Georgia	183,600	116,200	63%
Hawaii	13,300	9,000	67%
Idaho	31,900	21,700	68%
Illinois	178,900	105,300	59%
Indiana	115,700	75,500	65%
Iowa	52,400	39,100	75%
Kansas	52,800	37,400	71%
Kentucky	66,600	47,500	71%
Louisiana	94,900	57,200	60%
Maine	15,400	10,700	70%
Maryland	69,100	37,900	55%
Massachusetts	63,000	34,400	55%
Michigan	145,000	97,800	67%
Minnesota	76,500	52,300	68%
Mississippi	65,800	52,700	80%
Missouri	99,900	69,100	69%
Montana	16,200	12,900	80%
Nebraska	35,900	25,400	71%
Nevada	47,500	28,900	61%
New Hampshire	12,500	8,800	71%
New Jersey	94,500	51,000	54%
New Mexico	38,500	27,000	70%
New York	248,400	139,500	56%
North Carolina	165,200	106,900	65%
North Dakota	11,200	9,100	81%
Ohio	183,400	117,900	64%
Oklahoma	73,200	50,800	69%
Oregon	57,700	36,400	63%
Pennsylvania	158,300	95,400	60%
Rhode Island	12,300	6,700	54%
South Carolina	84,100	52,900	63%
South Dakota	17,200	13,300	77%
Tennessee	111,500	70,900	64%
Texas	497,100	287,700	58%
Utah	49,900	29,700	60%
Vermont	7,300	6,600	90%
Virginia	102,600	61,700	60%

State	All low-income children < 6 with working parents	Of this total, children in at least one priority group #	%
Washington	91,900	55,000	60%
West Virginia	23,800	17,500	74%
Wisconsin	89,600	59,800	67%
Wyoming	8,600	7,400	86%
50 state and DC total	**4,771,600**	**2,925,800**	**61%**

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

Notes: Nonstandard hours are any time before 8:00 a.m. or after 6:00 p.m. Because the ACS indicates when someone typically arrived at work, but not when they typically leave, we constructed an estimated proxy measure for when children's caretakers departed work by taking their hours usually worked each week, dividing it by five (assuming they worked the standard five days a week), and added the result to the time they typically arrived at work. *Majority* (or *mostly) nonstandard hours* includes children whose principal caretakers primarily work nonstandard hours. More specifically, of all hours worked by a child's principal caretaker(s), we estimated that over half those hours were nonstandard. This does not capture whether each principal caretaker in two-parent households has majority nonstandard hours, just that, combined, the majority of their work hours are nonstandard. **Infants and toddlers** are children younger than age 3.

Because the **metropolitan status** of all households is not reported or determinable in the ACS's public use microdata sample (PUMS), we estimated the share of children in each state living in nonmetropolitan areas, by cross-walking observations' public-use microdata area (PUMA), the smallest unit of geography available in the PUMS, to the metropolitan areas to which it belonged. In general, the Census Bureau attempts to define PUMAs to follow the borders of counties or county groups, which are also the building blocks of metropolitan areas. In some cases PUMAs cut across the borders of metropolitan areas or vice versa. In these cases, we allocated each observation in a PUMA to all the areas in which the PUMA overlapped and reweighted them by the proportion of the PUMA's population in each area in the 2010 Census using allocation factors from the Missouri Census Data Center's Geocorr14 website: http://mcdc.missouri.edu/websas/geocorr14.html. For example, if 20 percent of a PUMA's population was in a nonmetropolitan area and 80 percent was in a metropolitan area in the 2010 Census, each observation in that PUMA would be counted as 20 percent in nonmetropolitan regions and 80 percent in metropolitan regions.

Data Definitions

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

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

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

[a] "American Community Survey: When to Use 1-Year, 3-Year, or 5-Year Estimates," US Census Bureau, last revised June 17, 2018, https://www.census.gov/programs-surveys/acs/guidance/estimates.html.

Understanding the Needs of Four Priority Populations

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

Infants and toddlers make up almost half (46 percent) of low-income children under 6 with working parents. Children younger than 3 with working parents, compared with their 3- and 4-year old counterparts, are less often cared for in child care centers and more often cared for in home-based settings. Fewer centers serve young children, and some parents of young children prefer home-based settings. Access to high-quality care regardless of setting is particularly important for young children during this critical developmental stage.

Children living in nonmetropolitan areas make up about 16 percent (or 776,000 children) of all low-income children under 6 with working parents. The definition of nonmetropolitan includes counties that are neither in nor around a highly populated urbanized area; these counties are referred to as "rural" throughout our related report. The size of the rural population varies significantly across states. Children in these areas are less likely to be enrolled in child care centers. Further, children living in these areas may particularly benefit from access to high-quality care, in whatever setting they use, because of the more limited availability of formal early education opportunities and the relatively high rates of economic need.

Children with special needs also benefit from high-quality early education and child care. The population of children with special needs is diverse. Although some children with special needs are enrolled in center-based care, they are disproportionately more likely to be served in home-based settings, especially by relatives. Regardless of setting, high-quality child care can be especially important for these families, who face the burdens of poverty and material hardship in addition to the developmental and health challenges associated with a child's disability. But the families may require additional services and supports to take full advantage of the developmental benefits that high-quality settings can provide.

What Factors Affect the Availability of Center-Based Care?

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

Higher costs. Providing high-quality child care requires significant investment in labor, training, and infrastructure. Parents pay for a large portion of these costs, as public financing is inadequate and fragmented and private and philanthropic funds are not sufficient to fill the gap. This cost burden is difficult for many parents, but especially lower-income parents. Limited parental resources also make it difficult for providers to charge prices that allow them to adequately invest in the physical and human capital necessary to provide high-quality care. All these challenges become greater when considering services for the populations of focus here, whose care can involve additional costs.

Provider readiness. Limited provider interest, skill levels and training, and their comfort with traditional ways of operating may prevent them from expanding their service models to serve families needing care during nontraditional hours, infants and toddlers, families in rural areas, and/or children with special needs. Not all providers are interested in or prepared to take the steps necessary to serve these families, and those that are interested may require supplemental resources and targeted education and training.

Findings across all three factors suggest that **important steps should be taken to help expand the supply of center-based programs serving these families, *and* that a robust home-based sector is also key to meeting their needs.** State investments in supporting quality and supply are necessary across both center and home-based sectors. However, the combination of market and business realities, provider motivation, and—not to be overlooked—parental preferences suggest that subsidized access to home-based settings will be particularly essential to ensuring access to quality care for families in these focal groups.

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

Employ CCDBG Policy Tools Strategically

Policy Tool 1: Offer financial incentives through higher payment rates, bonuses, or grants to providers that serve priority populations. States have many financial incentive strategies at their disposal. They can raise the ceiling on the amount they reimburse providers, which allows more higher-

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

Policy Tool 2: Use a mix of vouchers and contracts to increase services for priority populations. The use of vouchers as the sole payment mechanism can create risks for child care providers who cannot count on sufficient or reliable demand for their services. A contract-based payment mechanism—where states agree to pay for a specific number of children (or slots) for a specified period (e.g., a year)—can reduce this risk. Providers are typically required to meet contractual obligations regarding such things as quality standards, attendance minimums, and serving children with particular characteristics. Contracts can be used to increase the quality and supply of centers or family child care homes (and family child care networks) in a targeted way, especially for vulnerable populations and geographic areas, and to stabilize funding and ensure providers are paid in a timely manner. However, contracts may not be as effective in situations where demand is inadequate, unstable, or diffuse; where the cost is too high (unless the contract is coupled with higher rates); where providers are not willing or ready to accept the contract to serve a particular population; or where preference leads parents to make other choices.

Policy Tool 3: Target training, technical assistance, or other resources to support supply and access for priority populations. Training and technical assistance activities could help address provider readiness barriers to serve special populations for both centers and home-based options, though they seem less likely to address demand or cost barriers. These activities could be especially helpful as part of a strategy to maintain the supply of licensed family child care homes and license-exempt providers who need to meet new health and safety standards or wish to engage in quality improvement efforts.

Policy Tool 4: Develop targeted consumer education efforts. Consumer education strategies can be tailored toward increasing awareness and knowledge around child care availability, access, and quality across the diverse care settings for each population that is the focus of this study. Although a consumer education strategy on its own cannot solve inequities in access due to supply shortages for particular populations, it could be a critical piece of a multipronged approach if designed with the needs of these four populations in mind.

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

Package Multiple Tools to Create Carefully Targeted Strategies

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

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

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

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

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

Conclusions

Ultimately, **a multipronged strategy is needed to increase access to affordable, quality child care for families needing care during nonstandard hours, for infants and toddlers, in rural areas, and for children with special needs.** The CCDBG reauthorization presents states with several policy tools that can be strategically combined to support providers across sectors and increase quality care options for these priority populations.

To effectively serve these four target groups, **states must actively support quality and access for home-based care (including license-exempt settings) *and* help centers more effectively meet these families' needs.**

Despite the recent increase in CCDBG funding, states are likely to continue to face resource constraints as they work to address the issues highlighted in this study while also reforming their programs to comply with the new access and quality objectives of the reauthorized law.

Researchers and policymakers should work together to continue to develop and expand the use of a multidimensional definition of quality that includes the diverse ways in which child care providers support children and families across settings and throughout the 24-hour, 7-days-a-week schedule that constitutes the realities of nonparental care environments.

There is a clear need for better data to inform state decisions about how to increase access to high-quality child care for vulnerable populations, especially regarding barriers to supply, patterns of demand, and parent and provider preferences that shape supply and access for these groups. Relatively little is known about the effectiveness of different policy strategies to shape provider behavior and supply decisions, information critical to influence future policy decisions.

Notes

1 See Julia R. Henly and Gina Adams, *Increasing Access to Quality Child Care for Four Priority Populations: Challenges and Opportunities with CCDBG Reauthorization* (Washington, DC: Urban Institute, 2018).

2 For simplicity's sake, we use "states" instead of "states and territories" for the remainder of this brief.

3 *Some nonstandard hours* includes children for whom all principal caretakers are working any nonstandard hours. *Majority nonstandard hours* includes children whose principal caretakers primarily work nonstandard hours.

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Acknowledgments

This brief was funded by the Annie E. Casey Foundation through the Urban Institute's Low-Income Working Families initiative, a multiyear effort that focuses on the private- and public-sector contexts for families' well-being. We are grateful to them and to all our funders, who make it possible for Urban to advance its mission.

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