

Promoting Sustainability of Child Care Programs during the COVID-19 Pandemic: Considerations for States in Allocating Financial Resources

Special Topics Paper | November 2020

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Introduction

The global COVID-19 pandemic has caused dramatic changes in the landscape for child care and early education programs in the United States. Already operating on fragile margins, child care programs have experienced financial upheaval as a result of mandated closures in some states, fluctuating and unpredictable demand for child care, increased health and safety regulations (including decreased ratios and stringent cleaning procedures), and shifts in school district plans for full or partial virtual learning for K–12 education. A June 2020 survey conducted by the National Association for the Education of Young Children of more than 5,000 individuals working in centers and family child care in the United States (not a nationally representative sample) estimated that without assistance two in five programs will close permanently. The survey also found that enrollment in child care programs decreased by two-thirds on average while costs for providers increased.¹

As policymakers consider responses to the child care financial crisis, they must ensure that their decisions reflect the unique financial needs and structures of child care programs. Guidance and technical assistance are needed to support state policymakers in allocating financial resources to promote short- and long-term sustainability of child care programs.

Goals of the Paper

The goals of this paper are twofold. First, the paper provides **basic background information** about the structure of child care costs and revenues and clearly shows how the pandemic and associated changes in regulations and demand have affected them. This section of the paper describes the different types of costs in child care programs (e.g., overhead costs and those that vary with enrollment) and the differential effects of the pandemic on these costs. This section also discusses typical revenue structures of programs and the link between enrollment changes and revenues. It outlines different cost and revenue scenarios to demonstrate how shifts related to COVID-19 (e.g., changes in required ratios or square footage guidelines) and how resources such as grants and loans impact the bottom line for programs. The paper provides basic information to describe how different levels of demand affect program costs and revenues.

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Second, the paper describes **implementation issues for allocating financial resources to child care programs** and offers considerations related to implementation² (e.g., considerations related to determining program eligibility for grants, selection criteria for grants, and calculation of award amounts). The document also addresses using available administrative data, program self-report data, and family survey data to document how changes in the supply of child care impact families' access.

While the paper focuses on child care centers (because existing research primarily addresses centers), the unique structures and needs of family child care programs (and families' perceptions of these programs) and school-age care programs are acknowledged when possible. While further research is needed to shed light on the unique financial needs of family child care and school-age care programs, many of the principles, strategies, and recommendations discussed apply across settings.

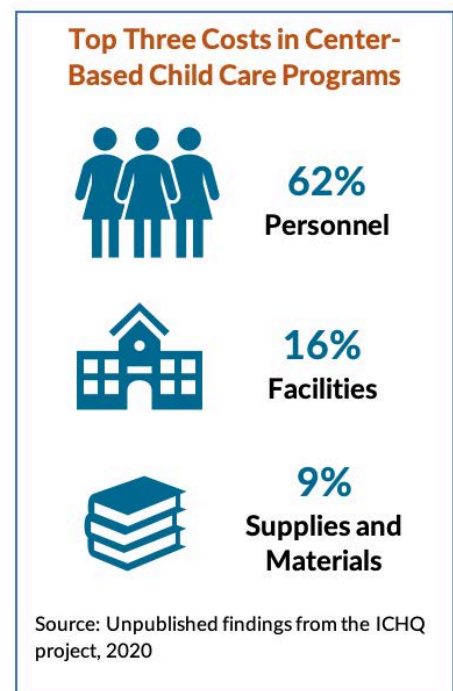
Understanding the Child Care Market and Costs and Revenues Post COVID-19

Understanding the typical cost structure of center-based child care programs may help policymakers anticipate the types and amount of support programs need to continue operating under changed conditions due to the pandemic. This section describes typical cost and revenue structures for child care centers and how COVID-19 may affect programs' expenditures and revenue streams.

Costs

To describe typical cost structure and possible variation across center-based providers, this paper draws on information from a recent survey of child care providers that serve children ages 0 to 5, conducted as part of the [Assessing the Implementation and Cost of High-Quality Early Care and Education \(ICHQ\) project](#), funded by OPRE.³

The main costs that child care programs incur include personnel (e.g., salaries and benefits); payments for facilities; supplies and materials (e.g., classroom supplies, food, and contracted services); and other miscellaneous and administrative costs. Personnel costs generally account for the largest proportion of a provider's total costs. Among the 26 programs included in the ICHQ cost analysis, personnel costs accounted for more than three-fifths (62%) of annual costs, on average. Other major cost categories in annual expenditures included facilities (16%, on average) and



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supplies and materials (9%, on average).⁴ Other studies of child care costs have found similar distributions of cost across categories.^{5,6}

On a per-child basis, costs are generally higher for programs with features associated with quality care, such as lower child-teacher ratios and more teachers with more educational qualifications (who may receive higher salaries than teachers with fewer qualifications). Among programs in the ICHQ sample, the average cost of providing one hour of child care was substantially higher in programs with higher ratings from a quality rating and improvement system (QRIS) than in programs with lower QRIS ratings. Programs that serve younger children, especially infants and toddlers, are also expected to have higher costs per child than those serving older children, because more adults are needed per child to address the needs of young children (e.g., diapering, feeding).

Regulations in response to COVID may affect the per-child cost of providing child care in several ways. First, regulations may reduce class or group sizes, thereby reducing the number of children for whom each teacher can provide care. This effectively increases the labor cost of providing an hour of care to each child. It also means that fixed costs of the center—such as rent or mortgage payments for facilities, which tend not to change with short-term fluctuations in the number of children a center serves, are spread over fewer children. As a result, the fixed cost of serving each child also increases. In response to COVID, several states reduced the maximum group size for all age groups while other states set separate maximums for infants and toddlers and for preschool-age children.⁷ For example, Arizona and Arkansas set a group size maximum of 10 children for all age groups (compared with a pre-COVID maximum of 12 to 30 children depending on the state and age group). Connecticut maintained a maximum group size of eight children for infants and toddlers but lowered the maximum from 18 children to 16 children for preschoolers.

Second, centers' personnel costs might rise because centers opt to increase compensation for staff by providing hazard pay, or because they need additional staff to manage increased health and safety requirements (e.g., temperature checks for children and adults and regular cleaning of classrooms and materials) or to fill in for caregivers who are out. Third, guidelines for cleaning and sanitizing facilities may require centers to purchase additional cleaning supplies and possibly to contract for services for periodic deep cleaning. (It is also possible that new requirements related to cleaning result in longer hours for existing staff or shorter operating hours for centers to facilitate cleaning, both of which would increase the cost per hour of care the center provides.) Finally, a center may be required to modify its space (e.g., by installing plexiglass partitions), which may involve one-time investments in additional equipment and miscellaneous costs for installation. Table 1 summarizes the potential effects on centers' total and per-child costs.

Table 1. Potential effects of COVID-19 on child care centers' costs⁸

Type of cost	Potential changes in costs related to typical operation	Effects on total costs	Effects on per-child costs
Personnel	<ul style="list-style-type: none"> Increased staff or longer staff hours to meet new requirements; higher compensation to include hazard pay 	Increase (assuming center retains all existing staff)	Increase (due to higher compensation and reduced child-teacher ratios)
Facilities	No change	No change	Increase (due to reduced enrollment)
Supplies and materials	<ul style="list-style-type: none"> Higher costs for cleaning supplies New costs for personal protective equipment Lower costs for classroom supplies and food if enrollment declines 	Increase or decrease	Increase or decrease (but likely the former due to reduced enrollment)
Other costs (e.g., equipment and miscellaneous costs)	<ul style="list-style-type: none"> New costs for equipment and/or modifications to space 	Increase	Increase

Given that teacher-child ratios are an important cost driver, Table 2 illustrates the effects on per-child cost by age group of full-time, year-round care when a maximum group size is imposed that falls below what is typically required by state licensing. For the baseline, the authors of this paper assume a center with five classrooms in total: one classroom each serving the five age groups shown.⁹ The paper's authors also assume the teacher-child ratios by age group shown in the first row, based on the most common ratios by age group across the states, and the resulting group size shown in the next row is based on assuming a lead teacher and one assistant teacher per classroom.¹⁰ The model-based estimate of per-child annual cost is shown for the baseline in the third row, ranging from about \$15,100 per year for infants (0- to 11-months) to about \$8,200 for a 4-year-old.

The next scenario (S1 in Table 2) assumes a maximum group size of 14 children which reduces the allowable class size for children 19-months and older (the three older age groups) relative to the baseline. This increases the annual per-child cost by 14 percent for the older toddlers (19- to 36-months) and by about 30 percent for the 3- and 4-year-olds. The cost increase is larger for the preschoolers because the decline in the maximum group size is the largest (from 20 to 14 children for the two older age groups compared with 16 to 14 children for the older toddlers). Note that there is also a 4 to 5 percent increase in cost for infants and younger toddlers even though their maximum group size stays the same. This increase occurs because of the center's reduced enrollment overall which increases the per-child fixed cost for the center operations.

Another scenario, S2, is also shown with a maximum group size of 10. Except for the infants, this scenario now reduces the size of all classrooms relative to the baseline. In this scenario, per-child costs increase about 25 percent for children 12- to 18-months and reach about 70 percent for the 3- and 4-year-old children. Again, there is a smaller increase in per-child cost for the infants because of the decline in overall enrollment. A similar pattern of per-child cost increases would be expected for school-age care, with the magnitude of the effect tied to the size of the reduction in the allowable maximum group size.

These estimates, even without accounting for the effects of increases in per-child cost associated with additional COVID-related materials and supplies and site retrofitting, illustrate that the increases in per-child costs can be substantial when lower group sizes are required, especially for the older children where the reduction in group size is proportionately the largest. Such reductions in group size may also occur if programs do not reach full enrollment because of decisions families make about using child care. Families may no longer need care if one or both parents are no longer working; they may have made arrangements for another type of care while their previous arrangement was closed, or they may be concerned about the risk of contracting or transmitting the virus if their child is enrolled in care. Thus, even without changes in state policies regarding group sizes, providers may face an increase in per-child costs because of reduced demand on the part of families with young children (see Section 2).

Table 2: Illustrative effects on annual per-child costs for center-based care of reducing the maximum group size: By age group¹¹

	Birth- to 11-months	12- to 18-months	19- to 36-months	3-years	4-years
Baseline: Typical ratios and group sizes					
Baseline: Teacher-child ratio	1:4	1:6	1:8	1:10	1:10
Baseline: Group size	8	12	16	20	20
Baseline; Per-child annual cost	\$15,117	\$11,210	\$9,314	\$8,176	\$8,176
S1: Maximum group size of 14					
S1: Teacher-child ratio	1:4	1:6	1:7	1:7	1:7
S1: Group size	8	12	14	14	14
S1: Per-child annual cost	\$15,645	\$11,713	\$10,629	\$10,629	\$10,629
S1: Percentage change from baseline	3.5%	4.5%	14.1%	30.0%	30.0%

	Birth- to 11- months	12- to 18- months	19- to 36- months	3-years	4-years
S2: Maximum group size of 10					
S2: Teacher-child ratio	1:4	1:5	1:5	1:5	1:5
S2: Group size	8	10	10	10	10
S2: Per-child annual cost	\$16,481	\$14,025	\$14,025	\$14,025	\$14,025
S2: Percentage change from baseline	9.0%	25.1%	50.6%	71.5%	71.5%

Revenues

Child care programs receive funding from a variety of public and private sources, and the majority of centers receive funding from multiple sources according to data from the National Survey of Early Care and Education.¹² In that survey, more than two-thirds of centers reported that they rely in part on fees paid by families, and about one-third reported that their largest sources of revenue include government and non-government funding.

The effects of COVID-19 on centers’ revenue are likely to vary based on the funding sources a center receives. Surveys indicate that closures or reductions in enrollment capacity have resulted in dramatic declines in revenue for centers (as well as family child care programs and afterschool programs) due to reductions in tuition and fees paid by families and per-child subsidies funded by federal and state governments.^{13,14,15} Many states have disbursed funding from the Coronavirus Aid, Relief, and Economic Security (CARES) Act to help child care providers sustain operations or prevent closures in the short term. Over the longer term, however, other sources of funding for child care providers may be affected by declines in state and local funding as a result of shrinking government budgets due to worsening economic conditions. Table 3 summarizes possible changes in center revenues.

Table 3. Sources of revenue for child care programs and possible effects of COVID-19

Revenue source	Possible changes in center revenues due to COVID-19
Private tuition and family co-pays	May decrease if enrollment declines due to reduced child-teacher ratios and group sizes, or if demand for care falls
Federal and state child care subsidies	May increase or decrease, depending on disbursement of Coronavirus Aid, Relief, and Economic Security (CARES) Act funding or other funding sources. Revenues from subsidies disbursed on a per-child basis may decrease if center enrollment declines.
Head Start/Early Head Start	May increase temporarily due to additional federal funding for Head Start in the CARES Act.

Revenue source	Possible changes in center revenues due to COVID-19
State pre-kindergarten funding	May decrease if reductions in state budgets result in cuts to pre-kindergarten programs
Other state and local funding	May decrease if reductions in state and local budgets result in cuts to other early childhood or school-age care subsidy programs
Private/philanthropic grants	May increase or decrease depending on trends in state and local philanthropic spending

Determining Financial Needs of Providers

As states consider options for assisting child care programs with the added cost of delivering care during the COVID-19 pandemic, decision makers would ideally have information at the provider level about program structure (e.g., number of classrooms, hours of care, staffing levels), enrollment by child age, revenue and expenditures over a typical fiscal year, and estimates of how provider enrollment, staffing, revenue, and expenditures are expected to change during the pandemic. Such data could help policymakers understand the implications of the pandemic for provider services, enrollments, and per-child cost and inform how financial assistance to providers could be prioritized and distributed (a topic discussed in the next section). Unfortunately, this information is not likely to exist in most states because it is costly to collect and maintain and because providers may consider some information proprietary. The remainder of this section reviews options for determining the financial needs of child care programs related to COVID-19.

Information on providers (the supply side)

Most states do not routinely collect information at the provider level about child care programs' services, enrollment levels by child age group, annual revenues, and annual expenditures. Limited information may be available from the state child care licensing agency on each licensed provider. That database may include information such as the provider licensed capacity and possibly the ages of children served. Some states can merge their database of licensed providers with their database of children and families receiving subsidies to identify which providers serve children with child care subsidies. If the database of licensed providers includes current contact information for each provider (e.g., an email address or phone number for the director), the database may be used to survey all providers or a random sample of providers to obtain additional information that could be used to determine the need for financial assistance. Several states have conducted such surveys after state shutdown orders and other policy changes were issued in response to the COVID-19 pandemic. (See the Appendix for a list of state surveys.)

Another potential source of information on providers, especially related to program costs, are specialized studies focused on financial data for child care providers more generally or for state-funded preschool programs more specifically. With the reauthorization of the Child Care and

Development Fund (CCDF) as part of the Child Care and Development Block Grant Act of 2014, states are required to take the cost of providing care into account when setting CCDF provider reimbursement rates.¹⁶ This has led some states to invest in cost studies to gather information about provider expenditures or to develop cost models to support estimation of per-child cost under alternative scenarios. States that contract with CCDF subsidy providers or with state-funded preschool providers also typically have some financial information as part of determining provider reimbursement payments. State-funded preschool programs delivered through private community-based providers also have a similar need to understand provider cost structures when setting reimbursement rates and have therefore invested in collecting data about costs. National data collection efforts may also be informative (including the ICHQ project described in Section 1). Some provider-level information (not including expenditure data) was also collected in the 2012 National Survey of Early Care and Education (NSECE), which was recently fielded again in 2019.

In addition to drawing on provider-level financial information, another approach to understanding the financial needs of providers during the pandemic is the use of cost modeling, an approach noted as relevant for informing CCDF reimbursement rate structures. Tools such as the Provider Cost of Quality Calculator (PCQC)¹⁷ and those already developed by states to match their circumstances can be employed to estimate the per-child cost of providing care under the “old normal” and the “new normal” as illustrated in Table 2 (i.e., baseline vs. S1 or S2). The advantage of a cost model is the ability to consider differences in the financial effects of the pandemic across providers based on features such as the type of setting (centers versus family child care), the provider size measured by enrollment, the age groups of children served, and the geographic area.

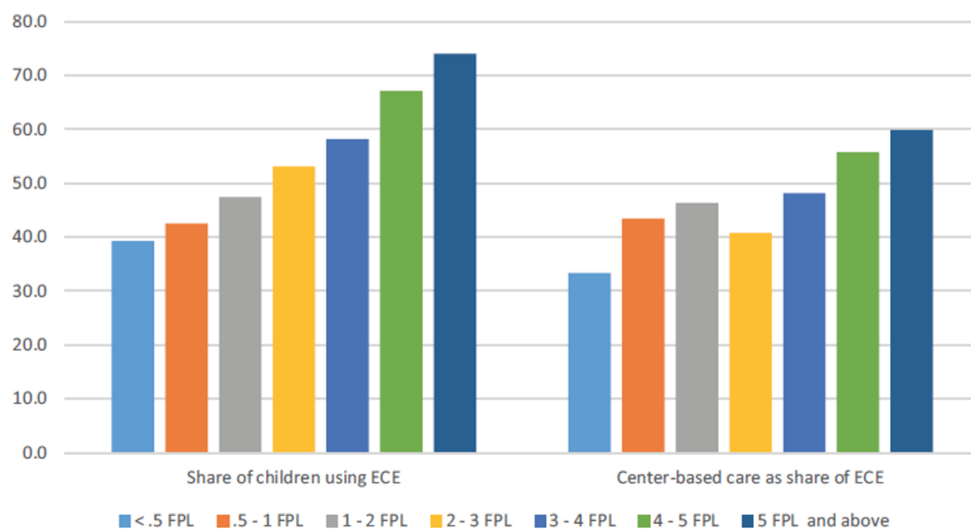
Finally, states can consider collecting information directly from providers as part of determining the need for financial assistance and the amount of need. For example, a grant application process could require providers to present a basic budget that reflects their program operations, expected enrollment by child age, staffing levels, salaries and benefits (including allowable hazard pay), and other financial costs, including added expenditures required to ensure a healthy and safe environment in their care setting during the pandemic. Expected revenues could be estimated as well and the size of the gap between income and expenditures documented. Although many providers have well-organized financial systems with accompanying staff support (e.g., a bookkeeper or accountant) and could readily provide such information, doing so will be challenging for providers without those skills or access to professional resources. Family child care providers may be more likely to need support documenting their financial circumstances than center-based programs, so it will be important to address any needs for support with the application process, data collection, and reporting requirements. Technical assistance could be made available for providers with more limited financial capacity. Accountability for the self-reported financial information could be ensured through random audits or other processes to verify how providers use assistance funds.

Information on family use of care (the demand side)

Anticipating the needs of families for child care services during the pandemic is arguably more challenging than obtaining information on the provider side. Much of researchers' understanding of how families make choices about child care use – whether to use care, the desired hours of care, the type of setting, and quality level – is based on data collected and analyzed in the pre-pandemic period. As a result of COVID-19, the need for care has been affected by multiple factors, independent of the changes on the supply side:

- **Employment status.** Families that used child care services prior to the pandemic may face different needs for care based on the employment status of the parent(s) and other possible caregivers. A parent who is now unemployed and not looking for work may elect to become the at-home caregiver. A grandparent or other relative who is no longer working may now become the caregiver, although that choice may depend on the potential vulnerability of grandparents or other relatives with health concerns if they were exposed to the virus. The loss of income when family members become unemployed may also mean that families can no longer afford their prior care arrangement or a new arrangement if fees increase because of the effect of the pandemic on provider costs. Some families may become newly eligible for child care subsidies which could affect their care choice. Family income (and affordability) of child care were key predictors of regular use of child care before the pandemic and are likely to be even stronger predictors in the wake of COVID 19.¹⁸ Figure 1 shows the correlation between income (denoted as a proportion of the federal poverty level – FPL) and child care use (depicted as the share of children using Early Care and Education (ECE) and center-based care as a share of ECE settings).¹⁹ The dip in use of center-based child care among families with incomes at 2-3 times the federal poverty level (yellow bar on the right) indicates the income range at which families are no longer eligible for subsidies and Head Start but are not yet able to afford unsubsidized care.

Figure 1. Patterns of ECE utilization by income category, all children ages 0–5 years (not in kindergarten).



Source: Figure originally appeared as Figure 4.1 in National Academies of Sciences, Engineering, and Medicine. (2018). Transforming the Financing of Early Care and Education. Washington, DC: The National Academies Press. doi: <https://doi.org/10.17226/24984>. Figure is based on analyses of the 2012 NSECE conducted by Latham, 2017.

- Essential worker status. Depending on the state, workers designated as “essential workers” may be granted priority in accessing child care services, especially if the overall demand exceeds the supply in the community. Depending on the jobs those workers hold and how their work hours, transportation needs, and other circumstances change, those workers may desire to continue their prior care arrangements or make changes. Again, the employment and health status of other family members may also factor into their preferred care options.
- Schooling status of older siblings. Families balancing care for children under five and school-age children may make different care choices depending on whether school is fully or partially virtual. Families may prefer options that keep their children together in the same setting, either at home or in another setting that can accommodate both younger children and their school-age siblings for the required hours.
- Family concerns with health and safety. Families may vary in their comfort level with having their children in a nonparental care environment during the pandemic, either generally or specific to the provider type or even specific providers based on their known health and safety practices. These concerns may be especially salient for families with children with special health care needs or where other family members are at risk for serious illness if infected with the virus.

These and other factors may alter the choices that families will make regarding child care in ways that may not be reflected in prior data and estimates of the demand for care. In the absence of updated state-level data on care choices, states at a minimum can compile information on the share of families with young children or school-age children in various circumstances, such as (1) families with some or all available parents unemployed or out of the labor force, (2) families with one or more essential workers, (3) families with only young children, only school-age children, or both young children and school-age children, where the latter two groups are affected by public schools adopting online learning, and (4) families with vulnerable children or adults. Some of this information can be obtained from population-based surveys in the pre-pandemic period (e.g., the American Community Survey²⁰ to measure the size of the state workforce in “essential occupations” or the National Survey of Children’s Health to estimate the prevalence of young children in the state with special health care needs) or through surveys that have been conducted in the post-pandemic period such as the Census Bureau’s Household Pulse Survey conducted weekly since April 2020.²¹ Such information can then be used to consider assumptions about how care choices would be affected by the pandemic and the potential aggregate effect on child care demand overall and by setting type. States can also consider collecting data directly from families with young children through interviews, focus groups, or surveys to better understand their care needs and preferences. Data collection through a survey could be less costly if added to an existing household survey such as a periodic state poll.

In addition to the potential for reductions in the overall demand for care, there is also the possibility that parents will shift their demand for different types of child care based on health and safety concerns. Some parents may now feel that a home-based family child care provider that serves a small number of children would be a safer environment for limiting the spread of coronavirus than a center. Families may also decide to use nannies or other caregivers, including

family members or friends, in their own homes. Changes in family finances may also impact families' decisions to use care or the type of care, as they seek more affordable options in response to lower incomes. If providers raise tuition due to higher costs related to the pandemic, parents may find care less affordable and therefore reduce demand.

There is no simple way to estimate or simulate changes in demand for child care due to the pandemic. Starting with an estimate of the number of children who potentially need care gives an upper limit on potential demand.

Monitoring changes in local employment rates and local school districts' decisions about distance learning can provide information on how to adjust this number to reflect the amount of care actually needed. Through child care resource and referral agencies (CCR&Rs), states can track trends in the number of requests by families for help in finding child care (by location, type of care, age of child). States can also use analytics from consumer education websites to track changes in search dynamics. This information, along with data on providers with open slots (by location, type of care, age of child) can be used to estimate gaps in care needed.

Changes in applications for and use of child care subsidies from state child care assistance programs may also provide important information about families' demand for care. More families may apply for assistance if their incomes have declined, and more families may be eligible if states raise income eligibility limits. As the economy re-opens and more parents return to work, an increase in use of child care subsidies may indicate rising demand for child care. See adjacent text box for findings from an August 2020 survey of families.²²

Key Findings from an August 2020 Survey of Families

(Source: Bipartisan Policy Center, August 2020)

- One quarter of parents indicated they are employed and salaried and working in-person; 21 percent are employed and paid hourly and working in person; and 18 percent are employed and salaried and working remotely.
- 70 percent of parents reported their child care provider is closed or operating with limited hours or space.
- One third of parents who had a child care provider before the pandemic now have a family member or relative caring for their child(ren); similarly, 37 percent of parents who were not paying for care but in a formal child care program before the pandemic say a family member or relative is caring for their child in August 2020.
- One third of parents have sought child care during the COVID-19 pandemic; 72 percent of parents with an income below \$50,000 said they had difficulty finding affordable care.
- More than half (59%) of parents do not plan to send their child to a child care program; more than half (53%) of families said they were not comfortable sending their child to a child care center. Most (77%) parents are concerned their child and family may be exposed to COVID-19 if their child returns to a child care program.
- Two thirds of parents with school-age care say schools will require some type of online learning this fall; 38 percent of parents with school-age children say they will look for a child care provider if their school doesn't open this fall; however, 75 percent of the parents said they are unable to afford or unwilling to pay for this care.

Limitations of the survey: The survey did not ask parents who have secured a new child care arrangement during the pandemic which type of care they selected and whether this differed from the type of care they previously had. Additionally, parents of school-age children were not asked who they plan to help assist with online learning, the hours of care needed for school-age children, and whether they have searched for school-age care for the fall.

*N=1,000 parents with children under the age of 5 at home and a parent who was employed in January 2020. One third of families had incomes below \$50,000. Thirty-seven percent of parents said they are considered an essential worker by their state.

Tracking changes in enrollment numbers may provide the timeliest information on changing trends in child care demand and utilization. Unfilled spaces for children may be a sign that there is more supply than needed to meet the current level of demand. Demand for child care decreased early in the pandemic because of mandated closures and stay-at-home orders. As the economy and schools re-open, the need for child care is expected to rebound, although some parents may continue to choose not to use non-parental care arrangements. Enrollment does not perfectly reflect families' preferences, however, because only parents who find a slot that is open, affordable, and meets their needs will enroll. Surveying families with young children may be necessary to determine if they are not using child care because of lack of available openings, lack of affordability, or other reasons such as health and safety concerns.

In June 2020²³, average enrollment was reported to be down by 67 percent, suggesting that overall there may be sufficient supply to meet current demand (although this may not be true in particular locations and does not address issues of affordability). Falling enrollment may be due to decreased demand, decreased (or lack of available) supply, or a combination of both. As noted above, some families may shift their preferences to home-based care or smaller settings so the decline in demand is likely to vary across provider types and location. Estimates of the number of providers who have closed, or who have reduced capacity due to group size or ratio restrictions, are relatively easy to collect. Estimates of changes in demand are harder to assess. Being able to monitor the level of enrollment relative to the available supply by location (and age of child) may help states assess where families are having difficulty accessing care.

Collecting accurate and timely information on enrollment in child care can be challenging. However, the need for timely data has driven many states to quickly adopt new technologies and forced innovation to gather information about available child care slots, enrollment, and attendance. Electronic attendance systems used by some providers may be a source of data in some states.²⁴ Accurate enrollment numbers combined with family surveys and CCR&R reports could shed light on trends in parents' demand for child care.

Key Considerations for Distributing Funds

Goals, objectives, and priorities

The goals each state aims to achieve by distributing funds to support child care sustainability will reflect differences in how the COVID-19 pandemic has impacted the state's child care sector and broader economy. Some states have experienced widespread closures of child care facilities while others have seen fewer closures as well as new providers entering the field. Articulating a set of goals or objectives can help state policymakers determine criteria and a process for distributing funds. States must also be prepared to respond and adapt to new federal legislation, funding, and requirements.²⁵ As part of this process, identifying priorities also provides a framework to address trade-offs. It may be necessary to articulate short- and longer- term goals. There may be different needs over a relatively short time as providers, families, and schools adjust to changing

circumstances. Having a clear set of goals and priorities is also a prerequisite for determining if the funding achieved its purpose.

This section discusses key considerations for states around the following questions:

- What goals are to be prioritized for distributing child care sustainability funds (e.g., keeping programs open, helping programs reopen, supporting families' ability to pay, covering COVID-related increased costs, etc.)?
- Which populations are to be prioritized (e.g., children in a particular geographic area, children of a particular age group, or children of essential workers or type of service)?

While each state will identify its own goals, two critical questions revolve around *what goals to prioritize* and *which populations to prioritize* recognizing that the answers will overlap. A state can prioritize funding for areas with low access or for populations with the greatest need. This section discusses considerations regarding different mechanisms for distributing funds, in particular whether funds are distributed directly to providers (e.g., through one-time payments, grants, or contracts) or to families (e.g., through vouchers or reductions in copayments). If a state chooses to prioritize funding to areas with low levels of supply, grants or contracts to providers could provide a direct means of supporting access in those areas. Alternatively, prioritizing families with certain characteristics can provide a means to support access for subgroups (e.g., families with infants and toddlers, school-age children, children with special needs, or children of essential workers).

Another example of a priority group is providers who are closed but able to re-open or those who are open but are most likely to close. Depending on whether the goal is to prioritize access in particular areas or for particular families/children, there may be a need to support providers in re-opening and providers who are open but in financial difficulty. Prioritizing funding for families with most need requires knowledge of families' plans to use child care and their financial circumstances. If the unemployment rate remains high, the demand for child care may be lower than pre-pandemic, in which case it is likely that the child care sector will shrink (fewer providers and less capacity). Targeting funds to families who need care for their children is a means of targeting funds where there is demand (if the market can respond and provide the supply that is needed). Targeting funds to providers can help ensure that supply is available for families who need it.

Principles to guide state decision making

In setting the goals and priorities for using child care sustainability funds, it may be helpful to develop guiding principles. Articulating a set of principles can help state policymakers determine the objectives, criteria, and process for distributing funds. Identifying and using a core set of principles can help policymakers identify and approach trade-offs and difficult choices in a consistent manner. Table 4 identifies principles to consider along with key questions or considerations.

Ideally, a state will direct funds where the funds will have the biggest impact. But states are unlikely to have sufficient information on a timely basis to know how and where funds will have

the biggest impact. Careful consideration of available data about costs, revenues, and use of child care may help inform these decisions. States may prioritize the most vulnerable children and families or may focus on providers who are most likely to close permanently without financial supports. States may consider whether distributing smaller amounts of funds to more providers or families has a greater impact than providing larger sums to fewer recipients. The sorts of cost information described in Section 1 may provide some insight into the question of the size of the grant needed to keep the provider open.

States will also need to work within the guidelines or restrictions imposed with new or increased federal funding. These restrictions may affect the process and implementation of distributing funds by identifying or limiting who is eligible and award amounts. Some types of federal funding have been flexible, leaving decisions about implementation largely up to the states. Federal rules or guidelines on eligibility and distribution mechanisms will nonetheless impact states' decisions.

Table 4: Principles or criteria to consider in setting goals and priorities

Principle or criteria	Specific considerations
Impact or effectiveness	Will distribution of smaller amounts of funds to more providers or families have a greater impact than providing larger sums to fewer recipients?
Burden on applicants and recipients	Do providers or families have to apply for these funds or is distribution part of the existing system (through subsidies, contracts, or other mechanisms)? Do providers or families need to provide information or evidence on financial need or other qualifications in order to get funds? What's the minimum information required?
Equity	Will funds be distributed so that inequities are not exacerbated? Will areas with low access or subgroups with less access have priority?
Timeliness	Will funds be distributed rapidly to increase their impact for many families and providers?
Transparency	How is the information about the availability and distribution of funds provided to stakeholders?
Cost	How will the planned distribution of funds impact administrative costs for the state (county or local agency)?
Data-based decisions	Will data be collected and used to inform decision making in order to direct funds in an effective and impactful manner?
Fairness	Will the distribution of funds be perceived as fair by those who do not receive funds?
Flexibility	Given the uncertainty around COVID-19 trends and economic circumstances, how can states be flexible in responding to changing needs and priorities?

Implementation issues

When developing plans to disburse funds, states will need to consider several implementation issues that include focusing on the following two questions:

- What are some of the mechanisms states can use and have used for distributing funds to child care programs, and how might these lead to different impacts?
- What options do states have to incentivize quality when allocating funding to child care programs or families?

Mechanisms or options for disbursing funds

States have received guidance from the Office of Child Care on existing flexibilities and waivers to allow changes to CCDF policies during the pandemic.²⁶ A variety of options states have adopted are shown in Table 5 along with key considerations for different options. Certain approaches will directly benefit providers and others directly benefit families, but most options will help support families and providers regardless of the distribution method. Which families and which providers are supported will depend on the details of the distribution method and are important considerations in light of the principles described in the previous section.

Some states have created grant funds to support providers who are not (necessarily) tied to the CCDF subsidy program. Funding for programs that serve the children of essential workers or funding for “hazard pay” or bonuses to child care workers are examples of programs that can support the broader child care sector. A stable and financially secure child care sector is needed to support reopening the economy, yet funding the sector broadly may exacerbate inequities in the system. To the extent that distribution of funds is tied to the subsidy system and done through raising payment rates or bonuses for providers serving children receiving CCDF assistance, it is likely that only providers who serve mostly subsidized children will receive enough funding to cover their increased costs. If funds are distributed to support children whose families do not meet the usual income eligibility requirements or their providers, disparities in access may grow. Tracking how distribution of funds impacts access is needed to assess this potential unintended consequence.

There may be advantages to using several mechanisms to stabilize and rebuild the child care sector. For example, stabilization grants to providers can help to cover a provider’s fixed costs or overhead, while policies such as higher subsidy payment rates could help cover the variable or per child costs. Subsidy payments based on enrollment rather than attendance help cover the costs that the provider incurs whether or not the child attends, as well as helping to stabilize the income of the provider (thus reducing the chance of business closure). Using financial mechanisms aimed at providers and families can help stabilize the sector by helping to ensure that providers remain open and have sufficient enrollment to be sustainable. For family child care providers, financing programs generally stabilizes both the business and the provider’s income. For centers, financing mechanisms directed at the workforce may be needed in addition to financing for programs. Hazard pay, tax credits, or access to free or reduced health insurance could be designed to help support staff in child care centers and family child care providers. In general, funds can be directed

toward providers (e.g., grants and contracts), to families (e.g., waiving copays, increasing family income eligibility limits), or to the workforce (e.g., tax credits, hazard pay). Using a combination of these types of financing mechanisms may provide widespread support for the child care sector and families who need it.

Table 5a and b: Mechanisms to distribute child care sustainability funds

a. Change to CCDF policy or practice	Likely impact
Pay based on enrollment, not attendance or relaxing policies re: child absences; payments based on capacity/enrollment/attendance	Directly helps providers cover fixed costs when children are not in attendance; indirectly helps families if it “holds a spot” for the child
Increased subsidy rates for emergency/open child care providers; pay a differential in excess of the state reimbursed rate	Directly helps providers cover increased costs due to COVID-19 related health and safety requirements; indirectly helps families if supply is more available as a result
Expand use of contracts	Can help providers by providing more stable funding; can be tied to quality or access priorities
Waive family copayment or cover family copayment	Directly helps families to afford care; indirectly helps providers if more families are able to continue to use care
Extend length of family redetermination period	May help families maintain stability of care arrangements
Pay enrollment fees	Directly helps families to afford care; indirectly helps providers if more families are able to enroll
Increase income eligibility or eliminate income restriction for children of essential workers	Directly helps families to afford care; indirectly helps providers if more families can enroll or continue to use care; consider impact on equity if there is no income eligibility restriction

b. Mechanisms not directly linked to CCDF program	Likely Impact
Cover private pay tuition ^a	Directly helps families to afford care; indirectly helps providers if more families can enroll or continue to use care; consider impact on equity if there is no income eligibility restriction
Grant programs for providers	Directly helps providers cover fixed costs or increased costs due to COVID-19 related health and safety requirements; indirectly helps families if supply is more available as a result; consider impact on equity
Grant programs to support re-opening	Directly helps providers to cover the costs of reopening; indirectly helps families by increasing available supply
Loans or forgivable loan programs	Helps providers address current financial shortfalls and improve facilities; many providers will be challenged by loan repayment if loans are not forgivable
Training and technical assistance	Helps providers manage financial challenges but unlikely to be sufficient without financial support for providers
Contracts ^b	Can help providers by providing more stable funding; can be tied to quality or access priorities
Child care worker pay increases; bonuses; hazard pay; tax credits; access to free or reduced cost health insurance ^c	Directly helps workforce; helps programs retain staff and stay open; indirectly helps families if more supply is available as a result
Community organization grants	Indirectly benefits providers and families; may be able to target to areas/programs with greatest need

^a: Some states (e.g., New Mexico) extended child care assistance to essential workers. While these extensions may be part of the existing CCDF program, it seems possible that states could use other sources of funding to cover tuition for some families. It is possible that child care could be included as an allowable expenditure in federal and state emergency relief funds and used to address child care needs of parents as they return to work.

^b: This could include, for example, Head Start and state prekindergarten programs.

^c: See for example: <https://nmpoliticalreport.com/2020/03/18/childcare-workers-with-covid-19-can-get-state-funded-insurance/>

State example: How Wisconsin spent CARES funding

Wisconsin has supported child care access through an Emergency Payment Program (\$51 million in funds to 2,712 providers statewide between May and July 2020) and a Supplementary Payment Program starting in September 2020. These programs provide examples of different targeting criteria and financing mechanisms to meet multiple state objectives.

The Wisconsin Child Care Counts: COVID-19 Emergency Payment Program included three components:

Payment Program 1: Funding to Care for Essential Workforce Families

This program supported the costs of providing care for essential workforce families. Funds were used for paying staff, reimbursing families, or other allowable expenses as outlined in the Terms and Conditions.

Payment Program 2: Incentive Pay

This program supported the costs for providing incentive pay for child care providers and individual educators. Funds were required to be used to increase pay during the State of Emergency for current employees, providers, and individual educators as outlined in the Terms and Conditions.

Payment Program 3: Support for Temporarily Closed Child Care Programs

This program supported the costs of retaining staff and reopening child care programs as Wisconsin's workforce returns to work. Funds were required to be used for reopening within 30 days of receiving funding. Funds were required to be used for paying staff, reimbursing families, or other allowable expenses as outlined in the Terms and Conditions.

An additional round of funding was launched in September 2020 through the Child Care Counts: COVID-19 Supplementary Payment Program, which had two components.

Payment Program A: Providing Safe, Healthy, and High-Quality Child Care Opportunities

This program supports the costs of maintaining or enhancing compliance status, maintaining quality level (YoungStar rating), and increasing health and safety practices. Funds will help ensure high-quality care is available across the state, specifically at younger ages where reasonable alternatives to child care do not exist.

Payment Program B: Funding Staff Recruitment and Retention Efforts

This program supports the costs associated with recruiting and retaining high-quality staff.

Sources (Accessed November 6, 2020):

<https://dcf.wisconsin.gov/covid-19/childcare/payments-closed>;

<https://dcf.wisconsin.gov/covid-19/childcare/payments>

Options to Support Quality

The Child Care and Development Block Grant Act of 2014 emphasized the role of CCDF in improving the overall quality of child care services and programs and in increasing the number and percentage of children from families with low incomes who are served in high-quality child care settings. Protecting the health and safety of children in care and ensuring the well-being of teachers and caregivers is the foundation of high-quality care. The pandemic introduced challenges to manage new, rigorous guidelines and regulations for health and safety, including the appropriate use of personal protective equipment (which was in short supply in the early months of the pandemic). At the same time, monitoring of licensing and health and safety rules was suspended in some states or conducted virtually in others; consequently, the extent to which programs are fully complying with new rules is unknown. When states distribute child care sustainability funds, it will be important to request attestation of compliance with health and safety rules, guidelines, and basic quality provisions.

It is also important to consider the access that workforce members have to training and other professional development opportunities such as coaching, mentoring, and professional learning communities. These opportunities will be necessary to support adopting new practices, especially those that promote health and safety and engagement with families. While some teachers and family child care providers may have greater access initially to virtual learning opportunities while their programs are temporarily closed (as reported by some states early in the pandemic), others may experience barriers in accessing these essential supports because of spotty Internet access, family responsibilities, or working at another job. Workforce members are also likely to experience increased stress and isolation. States can consider options like repurposing the work of coaches and trainers who typically work on-site with programs to implement virtual coaching and training opportunities. Professional development content that acknowledges provider well-being and stress (e.g., training on mindfulness and stress reduction) will be important for supporting teachers and caregivers, especially those who may feel isolated or disconnected. Content should also focus on children's experience of trauma, social-emotional development, and practices that promote race equity.

For states that choose to suspend the quality rating process during the pandemic, creative solutions can be implemented to support programs in meaningful self-assessment and continuous quality improvement. Professional learning communities that connect teachers and caregivers can be conducted virtually and can serve as a forum for sharing lessons learned and spreading effective practices. Providers who spend more time on cleaning and disinfecting, monitoring children's health, and other pandemic-related operational changes may have less time for child assessments or their own training. On the other hand, low enrollment and pandemic restrictions may result in smaller group sizes and fewer children for each teacher, which could increase the quantity and quality of teacher-child interactions.

As families navigate child care during the pandemic, their preferences for care may shift toward smaller, home-based settings with relatives or licensed family child care providers. Families'

assessment of the quality of a provider may be more tightly linked to health and safety and family engagement with less emphasis on other aspects of quality during this time. Family surveys can illuminate the factors that families prefer and their rationale. States can use their consumer education resources to support families in their child care searches by providing current information about health and safety guidelines and supporting conversations between families and providers. For example, families may need help asking questions about safety practices that feel awkward but are critical to open communication.

States should ensure that providing high-quality care is viewed as a complement (not a conflict) with enhanced health, safety, and business practices. States that choose to prioritize support of high-quality providers may target grants, contracts, or higher payment rates to providers who meet certain qualifications, such as high QRIS ratings. Alternatively, states could prioritize providers with lower ratings who commit to quality improvement and participation in available professional and organizational development. Taking these considerations into account in conjunction with data on the distribution of supply within local areas may help states build or support the supply of high-quality care.

States may also incentivize families to choose highly rated providers by waiving copays for these settings. Ensuring that families have access to an adequate supply of highly rated providers may be a longer term goal. Supports to rebuild the supply will be needed if providers go out of business in the short run.

Summary and Next Steps

Taking steps to stabilize child care in response to COVID-19 requires consideration of many dynamic factors. This paper offers background information about typical costs and revenues in center-based child care programs and shows how COVID-19 has affected them. The paper also proposes questions and key issues to consider when implementing activities to support child care programs in meaningful and equitable ways.

As states make decisions about financial interventions for child care programs, it will be important to simultaneously review and strengthen existing data on child care programs that can be used to inform later decisions. Critical data include “real-time” information about:

- Available child care slots by program type, child age, and geography
- Cost (to the provider) of child care slots by program type, child age, and geography
- Price of child care slots by program type, child age, and geography
- Enrollment in child care by child age, race/ethnicity, and income
- Current workforce by program type, child age, and geography
- Program closures by program type and geography
- New licenses issued by program type and geography
- Participation in virtual quality improvement activities

Surveys and focus groups have been a valuable source of information about how providers and families are experiencing child care during the pandemic. These data collection efforts will be essential for learning more about how providers use grants and loans, which child care programs remain open, and how families navigate the next phases of the pandemic.

Appendix

Links to Select Resources on Child Care and COVID-19:

[List of state COVID-19 child care reports](#) (Research Connections)

[List of COVID-19 child care surveys](#) (Urban Institute)

[Child care state actions](#) (Hunt Institute)

[State impacts and responses](#) (National Women's Law Center)

[Child Care is Key to Our Economic Recovery: What it will take to stabilize the system during this crisis \(Technical Appendix\)](#) (CLASP and National Women's Law Center)

[An Anti-Racist Approach to Supporting Child Care Through COVID-19 and Beyond](#) (CLASP)

[Using the Access Framework to Guide Child Care Policy during the COVID-19 Crisis](#)

(Child Trends)

[Supporting Families and Child Care Providers during the Pandemic with a Focus on Equity](#)

(Child Trends)

[Supporting the Child Care Market Through the COVID-19 Pandemic](#)

(Bipartisan Policy Center)

[Tip Sheet for States and Territories: Using CCDF Amendments and Waiver Flexibilities to](#)

[Meet the Child Care Needs as a Result of COVID-19](#) (U.S. Department of Health and Human Services, Administration for Children and Families, Office of Child Care)

[Want to Support Your Community's Equitable Recovery from COVID-19? Invest in Child Care](#)

(The Bridgespan Group)

[States are Using the CARES Act to Improve Child Care Access during COVID-19](#)

(Child Trends)

[How States Can Use Early Care and Education Provider Surveys to Develop COVID-19](#)

[Response Strategies](#) (Child Trends)

[Financial assistance for child care providers: Key considerations during COVID-19](#)

(Federal Reserve Bank of Minneapolis)

Examples of Emergency Funds for Child Care:

[Philadelphia Emergency Fund for Stabilization of Early Education](#) (Reinvestment Fund)

[Requirements and Priorities for the PA Coronavirus Small Business Assistance Program](#)

(Reinvestment Fund)

[Minnesota Peacetime Emergency Child Care Grants](#) (Child Care Aware of Minnesota)

[Minnesota COVID-19 Public Health Support Funds for Child Care](#) (Child Care Aware of Minnesota)

Endnotes

¹ Hogan, L., Kim, M., Merchen, A., Peyton, J., Recio, L., & Siblesz, H. (2020). *Holding On Until Help Comes A Survey Reveals Child Care's Fight to Survive*. Washington, DC: National Association for the Education of Young Children. https://www.naeyc.org/sites/default/files/globally-shared/downloads/PDFs/our-work/public-policy-advocacy/holding_on_until_help_comes_survey_analysis_july_2020.pdf

² A key assumption of this paper is that states will have access to funds through pending federal legislation.

³ Findings from the ICHQ project are not yet publicly available. Details about the ICHQ project are available at: <https://www.acf.hhs.gov/opre/research/project/assessing-the-implementation-and-cost-of-high-quality-early-care-and-education-project-ece-ichq#:~:text=The%20goal%20of%20the%20Assessing.children%20birth%20to%20age%205>

⁴ The sample for the ICHQ survey included centers from three states (Arizona, Arkansas, and Pennsylvania). The centers varied in size, age groups served, and other characteristics. However, the sample is not representative of centers nationwide.

⁵ Karoly, L., & Walsh, S. (2020). *Estimating the Cost of Quality Early Childhood Care and Education in Oklahoma*. RAND Corporation. https://www.rand.org/pubs/research_reports/RRA280-1.html

⁶ Workman, S., & Jessen-Howard, S. (2018). *Understanding the True Cost of Child Care for Infants and Toddlers*. Center for American Progress.

⁷ *COVID-19 State Child Care Resources list by State*. (2020, September 14). The Hunt Institute. Retrieved from <https://hunt-institute.org/covid-19-resources/state-child-care-actions-covid-19/>

⁸ The table is similar to a table that appears in this resource: <https://nwlc.org/resources/technical-appendix-child-care-is-key-to-our-economic-recovery-what-it-will-take-to-stabilize-the-system-during-this-crisis/>

⁹ Details about the assumptions to produce the cost estimates are available from Lynn Karoly.

¹⁰ National Center on Early Childhood Quality Assurance,. (2020). *Trends in Child Care Center Licensing Requirements and Policies for 2017, Research Brief #1*. U.S. Department of Health and Human Services, Administration for Children and Families, Office of Head Start, Office of Child Care, Health Resources and Services Administration. <https://childcareta.acf.hhs.gov/resource/trends-child-care-licensing-requirements-and-policies-2017>

¹¹ While this model does not cover school-age care, the same principle will apply (i.e., higher per-child cost if group size maximums are reduced below the pre-COVID level).

¹² National Survey of Early Care and Education Project Team (2014). *Fact Sheet: Characteristics of Center-based Early Care and Education Programs*. OPRE Report No. 2014-73b. Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

<http://www.acf.hhs.gov/programs/opre/research/project/national-survey-of-early-care-and-education-nsece-2010-2014>.

¹³ Child Care Aware of America. (2020). *Picking up the pieces: Building a better child care system post COVID-19*. Arlington, VA. <https://www.childcareaware.org/picking-up-the-pieces/>

¹⁴ Daro, A., & Gallagher, K. (2020). *The Nebraska COVID-19 early care and education provider survey II: Experiences, economic impact, and ongoing needs*. Buffet Early Childhood Institute at the University of Nebraska.

¹⁵ Quick, H., White, L., Brodziak de los Reyes, I., Bergey, R., & Carbuccia-Abbott, M. (2020). *A system in jeopardy: California's early learning system and its dual language learners during the COVID-19 pandemic*. American Institutes for Research.

¹⁶ For more information about subsidy payment rates, see:

<https://www.acf.hhs.gov/occ/resource/ccdf-acf-pi-2018-01>

¹⁷ Office of Child Care. (n.d.). *Provider Cost of Quality Calculator*. Administration for Children and Families, U.S. Department of Health and Human Services. <https://www.ecequalitycalculator.com/>

¹⁸ National Academies of Sciences, Engineering, and Medicine. (2018). *Transforming the Financing of Early Care and Education*. Washington, DC: The National Academies Press. DOI: <https://doi.org/10.17226/24984>.

¹⁹ Ibid.

²⁰ *American Community Survey Data*. (n.d.). U.S. Census Bureau. <https://www.census.gov/programs-surveys/acs/data.html> <https://www.census.gov/programs-surveys/acs/data.html>

²¹ *New Household Pulse Survey Shows Concern Over Food Security, Loss of Income*. (2020, May 20). U.S. Census Bureau. <https://www.census.gov/library/stories/2020/05/new-household-pulse-survey-shows-concern-over-food-security-loss-of-income.html>

²² Morning Consult (2020). *Child care during COVID-19*. Washington DC: Bipartisan Policy Center. https://bipartisanpolicy.org/wp-content/uploads/2020/08/BPC-Child-Care-Survey-Analysis_8.21.2020-1.pdf

²³ Hogan, L., Kim, M., Merchen, A., Peyton, J., Recio, L., & Siblesz, H. (2020). *Holding On Until Help Comes A Survey Reveals Child Care's Fight to Survive*. Washington, DC: National Association for the Education of Young Children. <https://www.naeyc.org/sites/default/files/globally->

[shared/downloads/PDFs/our-work/public-policy-advocacy/holding_on_until_help_comes.survey_analysis_july_2020.pdf](#)

²⁴ The Child Care Aware of America report “Picking up the Pieces” describes trends in attendance based on data from several technology platforms. <https://www.childcareaware.org/picking-up-the-pieces/>

²⁵ Several legislative proposals to create and fund child care stabilization funds are under consideration by the U.S. House of Representatives and the U.S. Senate, including [H.R. 8406 The Heroes Act, amended](#), which passed the House on October 1, 2020, and [S.4322 Safely Back to School and Back to Work Act](#), introduced in the Senate on July 27, 2020

²⁶ Office of Child Care. (2020, November 2). *Office of Child Care COVID-19 Resources*. U.S. Department of Health and Human Services, Administration for Children and Families. <https://www.acf.hhs.gov/occ/resource/occ-covid-19-resources>

Suggested Citation

Burwick, A., Davis, E., Karoly, L., Schulte, T., & Tout, K.* (2020). *Promoting Sustainability of Child Care Programs during the COVID-19 Pandemic: Considerations for States in Allocating Financial Resources*. OPRE report #2020-175, Washington, DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, U. S. Department of Health and Human Services.

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Acknowledgements

This Special Topics Paper was funded through the Office of Planning, Research, and Evaluation (OPRE) in the Administration for Children and Families (ACF) with research set aside funds from the CCDBG Act of 2014 and managed through a contract with Child Trends (contract number HHSP233201500034I). The authors thank Ivelisse Martinez-Beck, Ellen Litkowski, Tracy Carter Clopet and Meryl Barofsky at OPRE for their guidance and reviews of this paper. We also appreciate reviews from staff at the Office of Child Care including Megan Campbell, Francesca Longo, and Ellen Wheatley.

