

CLASP

CENTER FOR LAW AND SOCIAL POLICY

POLICY PAPER

Child Care and Early Education Series

July 2008
Paper No. 3

Ensuring Quality Care for Low-Income Babies Contracting Directly with Providers to Expand and Improve Infant and Toddler Care

by **Hannah Matthews and Rachel Schumacher**

Introduction

The earliest years, from birth to age 3, are critical for young children's healthy development. Experiences during the infant and toddler years shape the architecture of the brain—including cognitive, linguistic, social, and emotional capacities—at a phenomenal rate and lay the foundation for future growth and learning.¹ Nearly 5.8 million children under the age of 3 regularly spend some time in non-parental care.² The quality of those earliest child care experiences is important for young children's growth and

development. Babies and toddlers need access to warm, responsive, child care providers, and safe and stimulating child care environments that meet the full range of their developmental needs.³ Yet, the supply of high-quality infant and toddler care is limited—especially for low-income children. State policies, in particular child care subsidy policies, can help to build the supply and improve the quality of available care for this vulnerable population. One way states are doing this activity is by contracting directly with child care providers for high-quality infant and toddler care. Contracts guarantee a number of infant/toddler child care spaces with a particular provider and, importantly, may require and support higher quality standards beyond basic health and safety provisions of

ACKNOWLEDGEMENTS

The research and analysis reflected in this paper were made possible by grants from the Birth to Five Policy Alliance and the Irving Harris Foundation, as well as general support from the John D. and Catherine T. MacArthur Foundation, the Moriah Fund, and an anonymous donor.

Many individuals contributed to this report. We are indebted to the administrators who took time out of their busy schedules to speak with us. We are grateful to Danielle Ewen, director of Child Care and Early Education at CLASP, for her advice and input and to Cyra Master, publications and communications coordinator at CLASP, for her editing support. We also appreciate the insights of our reviewers, Helen Blank, National Women's Law Center; Mark Greenberg, Center for American Progress; and Eric Karolak and Mary Beth Salomone, Early Care and Education Consortium.

While CLASP is grateful for all assistance and funding related to this paper, the authors alone are responsible for its content.

About the Authors

Hannah Matthews is a Senior Policy Analyst and Rachel Schumacher is a Senior Fellow at CLASP.

state licensing regulations, thereby increasing the supply and quality of available care.

The supply of licensed child care is inadequate in general to meet the demand for affordable care, and is even rarer for babies and toddlers—particularly in low-income communities.⁴

DEFINITION OF TERMS

In this paper, a *contract* is defined as a payment that is made through a contractual agreement directly with a child care provider or network in order to assure that a given number of child care service slots will be made available to serve a given number of children qualifying for child care assistance. (This does *not* include contracts with providers that are intended to assure their willingness to receive children with vouchers, on a reimbursement basis.) Contracts are an allowable use of federal child care funds.

A *voucher* is defined as a certificate awarded to a parent determined eligible for child care assistance that may be used by that parent to select a child care provider of his or her choice in the child care market.

Babies and toddlers in lower-income and immigrant families are more likely to be in unlicensed care than those in higher-income or U.S.-born citizen families.⁵ One reason licensed infant and toddler care is difficult to find is because it is more expensive for providers to offer than care for older children.⁶ Babies and toddlers need additional care and services that are different from older children, for example, more adults, holding, and physical attention including feeding and diaper-

ing, and special equipment like cribs and changing areas. Licensed care for babies and toddlers is unaffordable for many parents. In 38 states, the average annual cost of center-based infant care exceeds 10 percent of the median household income for two-parent families and is a substantially larger portion of household income for single parents.⁷

Even when parents access licensed care, it is unlikely to have the characteristics of quality care that meet the needs of babies and toddlers. A landmark study conducted in the 1990s established that the center-based child care supply was mostly inadequate, unable to provide high-quality environments for young children, and that quality care for babies and toddlers was the least likely to exist compared to care for other age groups.⁸ Studies of family child care have found great variation in the quality of care in general. A 1995 study of family child care and relative care in three communities rated 56 percent of providers and caregivers as “adequate,” 9 percent as “good,” and 35 percent as “inadequate,” using the Family Day Care Rating Scale (FDCRS).⁹ More recently, reviews of state licensing rules have found that very few states hold centers or family child care homes to standards linked

to better quality care, such as provider-to-child ratios recommended for babies and toddlers, small group size, and teacher education and training specific to the age of the child prior to caring for children. Also, few states provide sufficient oversight and monitoring to ensure children are safe.¹⁰

In addition to these issues, all families do not have equal access to information on quality child care, and what information on quality child care that is available may not be specific to infants and toddlers. Parents may be unfamiliar with indicators of high-quality care, as well as with the various licensing and accreditation standards for child care. They may assume that state governments are doing more to ensure training and monitoring than is actually required in standards for child care programs.¹¹ Seventeen states have quality rating and improvement systems (QRIS) designed to evaluate and communicate levels of quality in child care settings to parents.¹² These systems often incorporate standards for learning, environment, parent and family involvement, professional development and staff training, and credential and compensation requirements. Yet even in these systems there is a gap in quality for very young children: only six states have QRIS that

include specific quality standards for infant and toddler care.¹³ For all parents, good information is hard to find. For some, it is especially difficult due to language or literacy barriers. For instance, 14 percent of children under age 3 have at least one limited English proficient parent; these parents are likely to face additional barriers accessing information about quality child care.¹⁴

Program standards such as provider-to-child ratios, group size, teacher education, and teacher experience are significantly related to the quality of child care settings.¹⁵ State child care and licensing policies that promote the quality and continuity of early childhood experiences can positively impact the healthy growth and development of babies and toddlers. The child care subsidy system is one means through which low-income families can access infant and toddler care, and it is also a vehicle for states to improve the overall supply and quality of infant and toddler care available.¹⁶

Across the country, administrators and policymakers are trying different approaches to improve the quality of infant and toddler child care, including expanding access to high-quality, comprehensive Early Head Start services, raising

standards through QRIS and tiered subsidy provider payments, and addressing infant/toddler development through early learning guidelines.¹⁷ While few states are funding high-quality, licensed infant and toddler care through direct contracts with child care providers, such an approach merits the attention of policymakers because of its potential to expand the supply and improve the quality of care for babies and toddlers. As this paper explains, contracts can be a tool to create or stabilize care in particular communities or for specific populations; to create child care slots meeting quality standards important for infants and toddlers; to extend the day for infants and toddlers served in Early Head Start; and to improve the quality of infant/toddler family child care.

About this paper

This paper explores the potential of contracts to address issues of supply and quality in the provision of infant and toddler child care. CLASP interviewed policymakers in five states to understand why and how they use contracts in their state child care subsidy programs for infant and toddler care.¹⁸ CLASP also interviewed representatives of contracted providers. We discussed their thoughts on whether and how contracts could be used to

increase quality or supply of infant and toddler child care, as well as implementation chal-

CONTRACTS ARE A TOOL TO:

- **Create or stabilize care in particular communities or for specific populations,**
- **Create child care slots meeting quality standards important for infants and toddlers,**
- **Extend the day for infants and toddlers in Early Head Start, or**
- **Improve the quality of family child care.**

lenges and their suggestions for policy changes that would improve the contracts approach. This paper presents the findings of these discussions and offers guidance for other states considering using contracts in this way.

State Delivery of Child Care Assistance

States Provide Assistance through a Combination of Contracts and Vouchers

The primary source of federal funding for child care subsidies for low-income working families and funds to improve child care quality is the Child Care and Development Block Grant (CCDBG). States provide CCDBG funded assistance to families through vouchers or certificates, contracts or grants,

or cash payments. Vouchers, or certificates, are given directly to parents, who then use them to purchase child care from a provider of their choice.¹⁹ Typically, the provider is then reimbursed by the state for the care provided. With contracts, states make a contractual agreement directly with a child care provider to serve a set number of children who are eligible for assistance. States may choose to pay contracted providers prospectively, schedule regular payments over the year, or reimburse them for care. Parents who receive assistance through contracted care enroll their child in a contracted program with an open space. According to federal regulations, states are *required* to provide child care assistance through vouchers but they may also *choose* to provide assistance through contracts. When contracts are used, parents must have a choice to enroll their child with a contracted provider or to receive a voucher for child care.²⁰

In 2006, the last year federal data are available, most children (83 percent) receiving CCDBG assistance did so through vouchers; 11 percent of children nationally received assistance through contracts, and 6 percent of children received assistance through cash payments. There was great varia-

tion in the extent to which children in individual states were served through contracts: 17 states used contracts for at least some portion of children served, ranging from 1-51 percent. Eight states—Arkansas, California, Connecticut, Florida, Hawaii, Maine, Massachusetts, and Nevada—served at least a fifth of children in CCDBG through contracts.²¹

States also fund child care through the Temporary Assistance for Needy Families (TANF) block grant. National data on the use of contracts or vouchers for children who receive assistance through TANF funds directly are not available. However, it is permissible for states to use TANF funds for contracts.²²

Infants and Toddlers in the Child Care Subsidy System

Over 5 million children under age 3 live in low-income families with incomes below 200 percent of federal poverty.²³ Approximately 500,000 infants and toddlers are served in CCDBG each month, comprising 28 percent of all children served in CCDBG from birth to age 13. The share of children receiving CCDBG that are infants and toddlers varies from state to state. For example, Arkansas serves the greatest share with over half (55 per-

cent) of children under the age of 3. Infants and toddlers make up the smallest share of children served in California (19 percent).²⁴ Information on the number of infants and toddlers who receive child care assistance directly from the TANF block grant is not available. While estimates from 2000 (the latest year data are available) put the share of eligible children receiving child care assistance through all federal funding sources at one in seven,²⁵ the share of eligible infants and toddlers receiving child care assistance is unknown. Infants and toddlers in low-income families that receive child care assistance are more likely than infants and toddlers in low-income families overall to be in center-based care: 52 percent of infants and 60 percent of toddlers receiving CCDBG are cared for in centers.²⁶ Thirty-five percent of infants and 29 percent of toddlers are cared for in family homes, which include licensed and license-exempt providers.²⁷

Less information is known about the share of infants and toddlers served through contracts in the subsidy system. States are not required to report the ages of children served through voucher or contract payments. Only six states mentioned serving infants and toddlers through contracts in

their fiscal year 2006-2007 CCDBG state plan.²⁸ Based on available information and conversations with state policymakers, it appears that contracts currently play a fairly small role in the provision of child care for infants and toddlers.

Vouchers Alone May Not Address Uneven Access to Child Care for Low-Income Families

Many states rely exclusively, or almost exclusively, on vouchers to provide child care assistance and some states consider the provision of vouchers to be the only method of meeting the federal requirement for parental choice in child care arrangements. (While some states have interpreted the federal regulations in this way, federal law clearly allows states to offer child care assistance in the form of contracts as long as vouchers are also made available.) In reality, persistent gaps in the availability of licensed child care—particularly in low-income communities or for hard to serve populations, including infants and toddlers—lessen the choices that parents receiving child care vouchers ultimately have in securing child care.²⁹ Low-income families, in particular, may be additionally constrained by factors such as uneven access to information, the proximity of child care arrangements to their

work, the need for full-day or extended-day care, the need for care during non-traditional hours including evening and weekend shifts, or the need to secure child care rapidly in order to begin a job. The choices of low-income parents who receive a voucher are further restricted to child care providers who will accept this form of payment.³⁰

Child Care Providers Need Regular, Stable, and Sufficient Funding

Regular, stable, and sufficient funding is necessary for any business to sustain itself and meet expenses. The payment rate that a child care provider receives is important as it determines the amount of resources available for quality improvements. As of 2007, only nine states had set provider payment rates at the 75th percentile of current market rates, the rate recommended by federal guidance. Thirteen states set their maximum payment rates for a 1-year-old in a child care center at 20 percent or more below the 75th percentile.³¹

A recent study of the experiences of child care providers who receive vouchers found that while vouchers provide an important source of income for providers, participation in the voucher system is also challenging for many providers.

Providers reported that voucher payment levels were too low and that subsidy policies, at times, caused delays in payments.³²

With a stable source of sufficient funding, child care providers in low-income communities may be able to make investments in better qualified teachers, supplies, materials, and other resources they may not otherwise be able to afford, as well as carry out more long-term planning and development.³³ This may be especially true in the case of infant and toddler care, since high-quality standards such as provider-to-child ratios are stricter for younger children. For example, a case study of initiatives to expand quality infant/toddler care in three communities found that providers were willing to serve additional babies or add additional services for babies and toddlers provided that they received stable and on-going funding and technical assistance and support in providing services for infants and toddlers.³⁴

Some research suggests that the burden required to get paid through the subsidy system is nearly as important as the amount of the payment in determining whether a provider will accept the subsidy.³⁵ Compared to contracts, vouch-

WISCONSIN MIGRANT CHILD CARE CONTRACTS

Since 1986, the Wisconsin Department of Workforce Development has contracted directly with United Migrant Opportunity Services, Inc. (UMOS) to offer Migrant Child Care to approximately 354 children from 6 weeks to 12 years of age. UMOS provides bilingual child care services that meet the needs of migrant and seasonal farmworkers, including transportation. UMOS has developed and operates a statewide system of licensed providers in centers and family child care homes to provide child care for migrant families. The program extends the day and the week for children in Migrant and Seasonal Head Start. The state also funds UMOS to provide technical assistance and training to providers on issues related to cultural competency in serving migrant families. UMOS monitors all contracted providers in order to ensure a quality environment that is appropriate for the children served.

ers are inherently unstable for providers, as parents have the option of leaving their child care arrangement at any time, consequently taking away a provider's payment without any guarantee that another child will fill the vacant space. Contracts guarantee payment for a specific number of children and may be paid prospectively, which provides even more stability for a child care provider.

How Contracts May Increase Supply and Improve Quality of Infant and Toddler Care

Both vouchers and contracts provide distinct benefits for low-income families in need of

child care. A mixed-approach of vouchers and contracts may help states achieve multiple goals.³⁶ The focus of this paper is on how contracts may expand and improve infant and toddler care.

Contracts can be a way to guarantee that families find the care they need—particularly in communities without an adequate supply of child care. Contracting directly may bring stability to child care providers in underserved communities and provide more stable child care for families. Research in New York City suggests that low-income children in center-based and family child care programs, primarily funded through contracts, remain two to three times longer in these programs than in informal care that is paid for with child care vouchers.³⁷ States may also tie certain standards to contracts in order to ensure the quality of the child care that is being purchased. These standards can be especially important for very young children for whom quality child care experiences can positively impact healthy growth and development across all developmental domains.³⁸

Based on conversations with policymakers and others, CLASP identified the following reasons that states may use con-

tracts for infant and toddler care:

- To create or stabilize care in particular communities or for specific populations;
- To create child care slots meeting quality standards important for infants and toddlers, including requiring the provision of comprehensive services and family supports;
- To extend the day for infants and toddlers in Early Head Start; and
- To improve the quality of family child care.

Some contract programs are intended to meet more than one of the above purposes. In this section, we describe how contracts meet the above purposes and may increase the supply or quality of infant and toddler child care. State examples are used for illustrative purposes and are not meant to be exhaustive of all states engaged in a particular activity, or to serve as in-depth case studies.

Create or Stabilize Care in Particular Communities or For Specific Populations

Contracts allow states to target specific areas or populations with insufficient child care capacity by paying for a set number of infant/toddler child care spaces with one provider

or one network. We found states using contracts to create or stabilize infant/toddler care in different ways.

Address special needs of certain populations. Some states use contracts to meet the needs of a range of target populations including teen parents, homeless families, parents who work non-traditional hours, children in protective care, children of migrant farmworkers, and infants and toddlers.³⁹ Wisconsin, for example, contracts directly with a non-profit organization to provide child care, beginning at 6 weeks, for children in migrant families.

Increase child care capacity in low-income neighborhoods by paying higher rates. New York City has prioritized increasing the availability of infant and toddler care as a major goal of its citywide strategic plan, and contracted child care programs are part of a planned effort to build supply.⁴⁰ Historically, New York City has used contracts to ensure child care capacity in low-income communities where the private market does not ensure an adequate supply.⁴¹ New York City primarily pays its contracted providers at a rate above the market rate as a means and incentive to increase supply and quality. Most contracted child care and Head Start programs

in New York City are located in neighborhoods with high rates of poverty. In general these communities have relatively little private, licensed child care. While contracts are generally helping to meet the need for supply in those neighborhoods, most of the city's publicly funded early childhood programs are targeted at 3- to 5-year-olds.

Design payment policies to attract providers. Policymakers acknowledged that when payment rates are not high enough, or do not increase regularly, it is difficult to make additional quality improvements and require more from providers. In order to help providers plan for and implement quality improvements and maintain basic fiscal health, a state may choose to pay a contracted provider prospectively, rather than as a reimbursement. Connecticut, for example, pays contracted providers 25 percent of their payment as an advance at the beginning of the contract. These advance payments can help stabilize providers who rely on subsidy payments. Vermont combines CCDBG funding and state general revenue to contract with providers to deliver high-quality, full-day, full-year programs, and has three-year agreements allowing providers to stabilize their resources over time. Due to

limited funds only one new agreement was added in the last five years.⁴²

In California, contracts have contributed to an increase in the supply of infant and toddler care in low-income communities.⁴³ California spends a significant share of dollars on contracts (\$762 million in 2006, compared to \$1 billion for vouchers). Thirty-seven percent of children served in California's child care assistance program are in contracted care. While all providers receive a higher payment rate for infant and toddler care,⁴⁴ voucher and contracted providers receive different payment rates. The payment rate for child care vouchers is based on a percentile of the child care market as determined by a market rate survey. According to California's FY 2006-2007 CCDBG state plan, the state sets rate ceilings at the 85th percentile of child care rates. The payment rate for contracted providers is set by the state legislature; the standard rate for fiscal year 2007-2008 is \$34.38 for a six-hour day. In a child care center, an infant caregiver would receive an adjusted rate of \$58.45, and a toddler caregiver would receive an adjusted rate of \$48.13. Family child care providers caring for infants and toddlers receive an adjusted rate of \$48.13.⁴⁵ In some

California communities, voucher care is paid at a higher rate than contracted care. In Alameda County, for example, the full-time maximum voucher payment rate for an infant in a child care center is \$71.66.⁴⁶

According to one report, quality contracted child care programs have closed in the last 10 years due to the state's low payment rate.⁴⁷ The state is examining this issue. A study by the California Department of Education, the agency that administers California's child care program, recommends applying a regular cost-of-living-adjustment to payment rates for contracted child care providers and preschool providers in order to help to retain these providers and continue to expand the supply of quality care for underserved populations like infants and toddlers.⁴⁸

Create Child Care Slots Meeting Quality Standards Important for Infants and Toddlers

Contracts can be used to improve the quality of child care programs through good program standards and/or to enhance the comprehensiveness of a program, through the provision of health, mental health, and family support services and referrals that are critical for low-income infants and tod-

dlers.⁴⁹ In order to ensure adherence to high-quality standards for infant and toddler care, states can provide strong monitoring and technical assistance for contracted providers.

Require quality program standards. Several states tie contracted child care to quality standards above minimum child care licensing standards, which focus primarily on ensuring basic health and safety conditions. States may link contracts to better provider-to-child ratios, higher staff education or training requirements, or performance standards. For example, Connecticut requires all contracted child care providers to be accredited by the National Association for the Education of Young Children (NAEYC) within a period of three years. The state supports providers in meeting accreditation by funding a career development system that includes a statewide Accreditation Facilitation Project.⁵⁰ Recognizing that high-quality care is expensive, Connecticut allows contracted providers to layer voucher payments and contracted payments to support the costs of high-quality care and meeting NAEYC standards.

California requires a number of higher standards and comprehensive services for contracted child care providers serving

infants and toddlers. Contracts include standards and guidelines related to staff education, parental involvement, family support, and referral services. Contracted programs serving babies require better provider-to-child ratios than other licensed providers. Both center-based child care and family child care home contracts require ratios of 1:3 for infants less than 18 months, exceeding state licensing requirements of 1:4 for infants and toddlers. One study found that teachers in contracted centers, including Head Start centers, had higher education levels compared to teachers in centers that received vouchers. The study also found that teachers in contracted centers were more likely to have received training or education in working with English Language Learners or children with special needs.⁵¹

In Vermont, all contracted programs are required to be nationally accredited, earn four or five stars on the state's QRIS (Vermont STARS), and follow Head Start Program Performance Standards (if they are Head Start grantees). In addition, providers must ensure the coordination of services with prevention and early intervention services. While child care providers may be funded for reserved spaces for three years, all families enrolled in

Vermont's child care subsidy program are approved for a one-year assistance eligibility period and re-determine eligibility annually.

Promote access to comprehensive services critical to early development. Low-income infants and toddlers typically have less access to critical comprehensive services, but child care settings can be the link to connect families to services.⁵² Early Head Start, a model that provides referrals and helps families access health, mental health, and family support services as well as early care and education, is also targeted to very low-income families and has proven positive results.⁵³ States may use contracts to support comprehensive family support services and referrals to child care settings for low-income children. Some state administrators reported that contracts make it easier to link children and families with comprehensive services compared to vouchers. Contracted providers may be required to provide additional services or link families to services. In Connecticut, several contracted child care programs voluntarily coordinate with community partners to provide support services or partner with Early Head Start.⁵⁴

Illinois requires contracted providers to report how they connect families to community services and what referrals they make for families. They are also required to make regular contact with Family and Community Resource Centers. There are no comparable requirements for providers who receive vouchers to demonstrate how they connect families to comprehensive services.

In Massachusetts, the supportive child care contracts for abused and neglected children require a needs assessment and provision or referral of additional services. Contracted providers receive an additional \$15 a day to cover the costs of case management services, transportation, or other services.

Provide technical assistance, monitoring, and evaluation to meet higher standards. As with other state efforts to improve the quality of care, in order for contracts to improve and expand the supply of quality infant and toddler care, it is important to ensure that providers have the resources and skills they need to meet high standards. It is equally important to monitor and evaluate contracts to determine whether the high standards they require are being adequately met. States can require, and fund, professional develop-

ment for contracted providers. They may also provide technical assistance to contracted

Contracted center-based care provides a higher level of accountability than voucher care by establishing and enforcing standards and providing leverage to influence the quality of care. Contracts are effective mechanisms for monitoring and supporting high-quality early education for children from low-income families.

—Chaudry et al., *Rethinking Child Care*.

providers directly in order to ensure continuous quality improvements over time. Connecticut, for example, provides guidance to child care centers on NAEYC accreditation through a statewide Accreditation Facilitation Project; in 2006, 44 of the 49 supported centers achieved NAEYC accreditation.⁵⁵

States can also require that contracted providers demonstrate their ability to provide high-quality infant and toddler care through monitoring and evaluation of contracts. New York City has an assessment system using an evaluation tool based on the NAEYC standards. Every contracted child care program site is assessed annually using this tool. The city is currently developing a new, more comprehensive, and city-wide unified performance measurement system for

contracted child care, Head Start grantee and delegate agencies, and Universal Pre-Kindergarten programs. A set

NEW YORK CITY'S EARLY CHILDHOOD FIELD CONSULTANTS

The Administration for Children and Families in New York City employs Early Childhood Field Consultants for monitoring and providing technical assistance to contracted programs. Field Consultants are independent of licensing monitors and focus on quality improvements based on NAEYC standards and best practices. Child care providers may receive technical assistance as often as once or twice a month.

of common program standards, using national assessment and rating instruments, is in the pilot stage. The new system will be implemented in July 2009. Currently, contracted providers receive technical assistance on quality indicators from Early Childhood Field Consultants. Similar technical assistance is not available for voucher recipients.

California requires contracted providers to do an annual self-assessment of quality, "Desired Results for Children and Families," which includes indicators related to children's social-emotional, cognitive, language, and physical development.⁵⁶ The assessment program includes teacher observation, parent survey, and evalua-

tion of the physical environment through the Infant/Toddler Environment Rating Scale (ITERS). Contracted care is also audited and monitored more frequently than other licensed providers. Licensed child care centers in California receive a monitoring visit once every five years.⁵⁷ Contracted providers are visited by the state once every three years. In these visits, programs are assessed based on program components, including parental involvement, governance and administration, staffing and professional development, and teaching and learning.⁵⁸

A clear advantage to contracted care is that it allows state agencies more contact with providers, which can be an opportunity to ensure the delivery of better quality care. Several policymakers told us that they have more opportunities for communication and interaction with contracted providers, which lends itself to greater oversight compared to providers who receive vouchers. Yet, in practice, states may monitor administrative requirements for contracts, such as verifying compliance with eligibility, attendance, and parent fee requirements, but engage in little to no monitoring of the quality of care.

Extend the Day for Infants and Toddlers in Early Head Start

Several states make funding available to expand access to extended day/year Early Head Start services for babies and toddlers.⁵⁹ The federal Early Head Start program provides early care and education and comprehensive services to infants and toddlers and supports pregnant women and families. Longitudinal research shows that children who participate in Early Head Start outperform their peers on measures of cognitive, language, and socio-emotional development.⁶⁰ Some states target their Early Head Start initiatives to specific populations, for example, TANF recipients or children who attend federally-funded Early Head Start programs.⁶¹ Maryland uses CCDBG quality funds to contract with four Early Head Start programs to extend the day/year.⁶²

Vermont contracts directly with 47 licensed center-based program sites to provide full-day, high-quality services to children birth to school-age. Three of these sites are Early Head Start programs and four sites partner with Early Head Start.⁶³ The initiative is intended to enhance the quality of subsidized care, assure the continuity and stability of subsidized care, stabilize funding for child care providers receiving subsidies, expand the

availability of full-day and full-year quality programs to children eligible for subsidies, meet the therapeutic needs of children with identified special needs, and provide Early Head Start services to subsidized children.

Improve the Quality of Family Child Care

Infants and toddlers are more likely to be in family child care compared to older children. Among low-income children under age 3 with employed mothers, 11 percent are in family child care as their primary child care arrangement.⁶⁴ Infants and toddlers receiving CCDBG-funded child care assistance are much more likely to be in a family child care home: 35 percent of infants and 29 percent of toddlers.⁶⁵ Therefore, quality improvement initiatives that focus on family child care are likely to improve the quality of care received by infants and toddlers in the subsidy system.

Some states contract with family child care providers, or more commonly, family child care networks or systems to provide infant and toddler child care. Family child care systems are community-based networks comprised of family child care providers. These networks are intended to support children and their families in accessing

quality family child care and to support family child care providers by lessening their isolation and providing peer support, resource sharing, and professionalization.⁶⁶ Family child care networks provide technical assistance to family child care providers in the form of curricula, professional development and training opportunities, and home visiting.

Massachusetts, Illinois, and New York City contract with family child care networks to serve infants and toddlers in the subsidy system; funds go directly to the network, and the network facilitates payments to individual providers caring for the children.⁶⁷ Typically, the network retains a portion of the state's payment as an administrative fee to cover their services and supports to their members. In Illinois, most family child care networks are managed by a child care center, but family child care networks may be independent agencies. In New York City, family child care networks are typically non-profit organizations, some of which are connected to child care centers or other social service agencies. The Massachusetts Department of Early Education and Care contracts directly with 50 agencies that have family child care systems, including Child Development and Education, Inc., a family

CALIFORNIA'S "DESIRED RESULTS"

Programs funded by the California Department of Education (CDE) are required to complete an annual assessment of results across developmental domains. The Desired Results initiative is intended to support program quality and positive outcomes for children and families. It also serves as a mechanism for collecting data about quality across child development programs. CDE uses information from Desired Results assessments to target technical assistance for providers.

The six basic desired results of the programs are:

- **Children are personally and socially competent.**
- **Children are effective learners.**
- **Children show physical and motor competence.**
- **Children are safe and healthy.**
- **Families support their children's learning and development.**
- **Families achieve their goals**

For more information on measurement tools and processes, see: <http://www.cde.ca.gov/sp/cd/ci/desiredresults.asp>

child care system that provides technical assistance, curriculum and training, and home visiting to family child care providers.

Possible Challenges of a Contracts Approach

Policymakers acknowledged that administering contracts can be challenging, but also offered ideas for solutions. CLASP believes many of the challenges identified can be addressed in

policy, particularly through strong monitoring processes. The challenges identified by administrators include the following:

- **Adequately funding contracts to meet high-quality standards and support infant and toddler care.** Without adequate funding, there may be less of an incentive for providers to care for infants and toddlers, who are costlier to care for than older children, as well as to meet higher standards that may be required through contracts. For many states, stagnant federal funding for child care assistance⁶⁸ has created a challenge to administering contracts. First, contracts create fixed costs that cannot be lowered or eliminated if funding runs out, as can be done with vouchers. Second, over time it is difficult to require quality improvements from providers without the investment of additional funds; without continued investment to support quality, the intent of the contracts may be undermined.
- **Effectively administering and monitoring contracts.** Compared with vouchers, some administrators reported that contracts may be more time-consuming to

administer. They may require additional paperwork and include additional auditing and oversight. Yet, this oversight may help ensure that contracts are meeting their goal of providing quality infant and toddler care.

- **Reassessing contracts.** In some states, the reprocurement process for contracts was reported to be politically difficult. Since providers depend upon a contract to stay in business, ending a contract may be challenging. Yet, some of those interviewed suggested that since the contracted provider does not have to attract consumers, or compete with other child care providers, the assurance of a continuing contract may cause him or her to turn attention away from continuous quality improvements. Without a regular monitoring or reprocurement process, the continual renewal of contracts may not guarantee that contracted slots are serving their intended purpose.
- **Responding to demographic changes.** As communities are impacted by economic conditions, low-income populations shift; as a result, contracted programs may be located in neighborhoods that are no longer low income. For contracts to be

effective, it is important for state and local administrators to have a clear understanding of supply and demand for licensed infant/toddler care in communities.

- **Filling slots.** If providers have unfilled slots, they risk not meeting their contractual agreement; states risk paying for contracted care that is not available to families most in need. A study of unspent child care funds in California found an incentive for providers to under-enroll their child care slots in order to avoid exceeding their subsidized enrollment limit. If providers over-enroll, they risk not being paid for that care and consequently place themselves at risk monetarily.⁶⁹ Several state administrators recommended the use of centralized waiting lists to expedite the filling of vacancies when they occur.
- **Ensuring sufficient infant/toddler facilities and capacity.** A few policymakers mentioned the limitations of facilities for infant/toddler care. New York City faces unique challenges in its contracted system because the city owns or leases many contracted facilities. This lessens the city's ability to shift contracts to new neighborhoods. Because most of these facilities are designed

to provide preschool-aged care, increasing the city's capacity to provide infant and toddler care through contracts is a challenge. As part of the city's strategic planning efforts, licensed child care providers serving preschool-aged children may choose to provide infant/toddler care instead, by lowering the age limit of their current license without a change in the funding they receive, or converting to infant/toddler care and requesting a change in their budget capacity. To do the latter, contracted providers will be required to demonstrate staff training in best practices for infant and toddler care.⁷⁰ In areas where contracted care exists and there is unmet need for quality infant/toddler care, states may want to consider assisting contracted providers with the resources and training they require to convert to providing high-quality care for babies and toddlers.

Planning for Successful Implementation of Contracts for Infant and Toddlers

States interested in using a direct contracts approach to expand and improve infant and toddler care through the child care subsidy system should con-

sider the following policies and strategies to implement contracts effectively.

Map the Need for Infant and Toddler Care and Availability of Licensed Care

For contracts to be effective, it is important for state and local administrators to have a clear understanding of supply and demand for licensed infant/toddler care in communities. To use contracts to expand infant and toddler care in underserved communities, policymakers should identify where the gaps in care exist. Mapping should include information on where low-income babies and toddlers live; where licensed infant and toddler care exists; where subsidized programs for infants and toddlers, including Early Head Start, exist; and unmet need as determined by waiting lists and data from child care resource and referral agencies. Data on supply and demand should be updated annually as communities change and the location of low-income populations may shift. Attention should be given to emerging populations of infants and toddlers, including in language minority and immigrant communities, which may have different experiences accessing child care. Contracts may be designed to reflect the needs of changing communities, for example, to ensure that

PLANNING FOR SUCCESSFUL IMPLEMENTATION OF CONTRACTS:

- **Map the need for infant and toddler care and availability of licensed care.**
- **Require and support higher program and content standards for contracted care.**
- **Make infant and toddler child care contracts tied to high-quality standards financially feasible for providers.**
- **Ensure continuous quality improvement through ongoing monitoring, technical assistance, and evaluation of contracts.**

contracted providers have multilingual capacity to communicate with parents and children whose home language is not English.

Require and Support Higher Program and Content Standards for Contracted Care

The great potential of contracts is to ensure that low-income families have access to infant and toddler care that is of better quality than what is currently available in many communities. Contracts may also guarantee the provision of additional comprehensive and family support services that can benefit vulnerable infants and toddlers. Strategies to achieve higher standards may include linking contracted care to accreditation standards, linking to higher levels of QRIS, or requiring comprehensive serv-

ices, including funding to increase access to Early Head Start services or programs that meet Early Head Start standards. It is important for states to ensure that standards require a focus on the particular needs of babies and toddlers for warm, responsive relationships and continuity of care with their providers. Support should include funding for the costs associated with higher quality care, as well as support for professional development and technical assistance for infant/toddler providers to meet higher standards.

Make Infant and Toddler Child Care Contracts Tied To High-Quality Standards Financially Feasible for Providers

Linking contracts to quality standards requires adequate funding and guaranteeing higher payment rates for providers. High-quality infant and toddler care, tied to quality standards, comes at a higher expense. States have the opportunity, in using the contracts approach, to work directly with providers to determine the level of funding necessary to buy the high-quality care they want for babies and toddlers. States should consider methods of determining necessary payment levels to sustain program standards that support the quality of care babies and toddlers need to thrive. States can also write contracts to

require and pay for additional services for children and families. In a contracted process, the state can use a request for proposals (RFP) to ask providers to lay out both their costs to meet the determined standards and other sources of revenue. With this information, administrators can decide the appropriate level of funding through the contract for each infant/toddler provider. States may also wish to develop other policy strategies and incentives, including paying at least some portion of a contract prospectively, guaranteeing regular monthly payments, adjusting for the costs of inflation, or reducing required paperwork, in order to encourage providers to apply for contracts and expand care for this age group. At a minimum, states should establish maximum payment rates for contracted care at no less than the 75th percentile of the current market rate, based on a market rate survey that is conducted at least annually; that is statistically valid and reliable; and that reflects cost variations by geography, age of children, and provider type.

Ensure Continuous Quality Improvement through Ongoing Monitoring, Technical Assistance, and Evaluation of Contracts

Ensuring that providers meet required standards specific to babies and toddlers, use

resources effectively, and make quality improvements depends upon effective technical assistance and monitoring and the evaluation of recurring contracts. Monitoring is important to ensure compliance with basic licensing and safety standards, as well as adherence to higher quality standards that may be required through contracts. Contracts can only increase the supply of high-quality infant and toddler care if providers are meeting the high standards established through a contract. Through monitoring, states can assess whether providers are successfully implementing standards, thereby both ensuring quality and identifying areas for improvement and increased technical assistance. Technical assistance should be informed by the current research base on what core knowledge and skills are necessary to care for babies and toddlers effectively. If a state does not have the capacity to monitor contracts, they may not ensure increased quality. States thinking about implementing contracts to achieve the goal of building the supply of high-quality child care will want to devote resources to help providers meet higher standards and to monitor compliance.

Frequent evaluations of contracts will provide quality assurance to states that public funds

are improving and expanding quality care for the most vulnerable infants and toddlers. Agencies should review contracts on a regular basis, at least every three years, and be authorized to remove contracts if there are recurrent, documented problems or make adjustments to the number of child care slots awarded in a contract as necessary.

Conclusion

In nearly every community across the country, high-quality child care for infants and toddlers is in short supply. Yet, research shows that very young children need access to consistent, stable, quality care that meets the full range of their developmental needs. It is clear that states can use contracts through their child care subsidy system to address both of these issues. While child care assistance is linked to parental works hours and may have differing standards and rules based on funding streams, the use of direct provider contracts tied to high standards, adequate funding, and ongoing technical assistance and monitoring can be an important tool for states seeking to improve opportunities for infants and toddlers.

Endnotes

- 1 Jack P. Shonkoff and Deborah A. Phillips, eds., *From Neurons to Neighborhoods: The Science of Early Childhood Development*, National Research Council and Institute of Medicine, 2000.
- 2 U.S. Department of Education, National Center for Education Statistics, *Initial Results from the 2005 NHES Early Childhood Program Participation Survey*, 2006, <http://nces.ed.gov/pubs2006/earlychild/index.asp>.
- 3 Shonkoff and Phillips, *From Neurons to Neighborhoods*; NICHD Early Child Care Research Network, "Characteristics of Infant Child Care: Factors Contributing to Positive Caregiving," *Early Childhood Research Quarterly*, 11 no. 3 (1996): 269-306; Richard Fiene, *13 Indicators of Quality Child Care: Research Update*, National Resource Center for Health and Safety in Child Care, University of Colorado, Presented to Office of the Assistant Secretary for Planning and Evaluation and Health Resources and Services Administration/Maternal and Child Health Bureau, U.S. Department of Health and Human Services, 2002, <http://aspe.hhs.gov/hsp/ccquality-ind02/>.
- 4 Jean Layzer and Ann Collins, *National Study of Low-Income Child Care – State and Community Substudy*, Abt Associates, 2000, <http://www.abtassoc.com/reports/ES-NSCCLIF.pdf>; P. Lindsay Chase-Lansdale and Rachel Gordon, "Availability of Child Care In The United States: A Description and Analysis of Data Sources," *Demography*, 38 no. 2 (2001): 306; U.S. Government Accountability Office, *Welfare Reform: Implications of Increased Work Participation for Child Care*, 1997, <http://www.gao.gov/archive/1997/he97075.pdf>; National Association of Child Care Resource and Referral Agencies, *Child Care in Thirteen Economically Disadvantaged Communities*, 2006, http://www.naccrra.org/randd/data/Casey_Report.pdf.
- 5 Jeffrey Capizzano and Gina Adams, *Children in Low-Income Families Are Less Likely to be in Center-Based Child Care*, Urban Institute, 2003, http://www.urban.org/UploadedPDF/310923_snapshots3_no16.pdf; Hannah Matthews and Danielle Ewen, *Reaching All Children: Understanding Early Care and Education Participation Among Immigrant Families*, Center for Law and Social Policy, 2006, http://www.clasp.org/publications/child_care_immigrant.pdf.
- 6 Diane Paulsell, Julie Cohen, Ali Stieglitz, Erica Lurie-Hurvitz, Emily Fenichel and Ellen Kisker, *Partnerships for Quality: Improving Infant-Toddler Child Care for Low-Income Families*, ZERO TO THREE and Mathematica Policy Research, 2002, <http://www.mathematica-mpr.com/pdfs/partnership.pdf>.
- 7 National Association of Child Care Resource and Referral Agencies, *Parents and the High Price of Child Care: 2007 Update*, 2007, http://www.naccrra.org/docs/press/price_report.pdf.
- 8 Suzanne W. Helburn, ed., *Cost, Quality, and Child Outcomes in Child Care Centers: Technical Report*, 1995.
- 9 Ellen Galinsky, Carollee Howes, Susan Kontos, and Marybeth Shinn, *The Study of Children in Family Child Care and Relative*

- Care, Families and Work Institute, 1995.
- 10 National Association of Child Care Resource and Referral Agencies, *We Can Do Better: NACCRRAs Ranking of State Child Care Center Standards and Oversight*, 2006, http://www.naccrra.org/policy/recent_reports/scorecard.php; National Association of Child Care Resource and Referral Agencies, *Leaving Children to Chance: NACCRRAs Ranking of State Standards and Oversight of Small Family Child Care Homes*, 2008, http://www.naccrra.org/policy/recent_reports/fcc_report.php.
 - 11 National Association of Child Care Resource and Referral Agencies, *Parents' Perceptions of Child Care in the United States*, 2006, <http://www.naccrra.org/policy/docs/PollReport.pdf>.
 - 12 More states (28) are in the process of developing a QRIS. Davida McDonald, *Quality Rating and Improvement Systems (QRIS) and National Association for the Education of Young Children (NAEYC) Accreditation*, National Association for the Education of Young Children, 2008, <http://www.naeyc.org/policy/state/pdf/FactSheetQRS.pdf>.
 - 13 National Infant and Toddler Child Care Initiative, *Designing Quality Rating Systems Inclusive of Babies and Toddlers*, 2008, <http://www.nccic.org/itcc/PDFdocs/qrsdesignelements.pdf>.
 - 14 Data on children with a limited English proficient parent was calculated from Census 2000 5% microdata (IPUMS) by Donald J. Hernandez, Nancy A. Denton, and Suzanne E. Macartney, Center for Social and Demographic Analysis, University at Albany, State University of New York, <http://mumford.albany.edu/children/>; Hannah Matthews and Deena Jang, *The Challenges of Change: Learning from the Child Care and Early Education Experiences of Immigrant Families*, Center for Law and Social Policy, 2007, http://www.clasp.org/publications/challenges_change.htm.
 - 15 Helburn, *Cost, Quality and Child Outcomes*; Nancy L. Marshall, Cindy L. Creps, Nancy R. Burstein, Joanne Roberts, Frederick B. Glantz, and Wendy W. Robeson, *The Cost and Quality of Full-Day Year-Round Early Care and Education in Massachusetts: Infant and Toddler Classrooms*, 2004, <http://www.eec.state.ma.us/docs/RECQInfantToddler.pdf>.
 - 16 To read more about how state subsidy, licensing, and quality policies can support the healthy development of infants and toddlers in child care, see Rachel Schumacher, Elizabeth Hoffmann, and Anne Goldstein, *Charting Progress for Babies in Child Care: Policy Framework Summary*, Center for Law and Social Policy, 2008, http://www.clasp.org/publications/cp_framework_sum.pdf.
 - 17 See Rachel Schumacher, Katie Hamm, Anne Goldstein, and Joan Lombardi, *Starting Off Right: Promoting Child Development from Birth in State Early Care and Education Initiatives*, Center for Law and Social Policy, 2006, <http://www.clasp.org/publications/startingoffright.htm>; Rachel Schumacher and Elizabeth DiLauro, *Building on the Promise: State Initiatives to Expand Access to Early Head Start for Young Children and their Families*, Center for Law and Social Policy and ZERO TO THREE, 2008, http://www.clasp.org/publications/building_on_the_promise_ehs.pdf.
 - 18 CLASP interviewed state-level policymakers in California, Connecticut, Illinois, and Massachusetts, and city-level policymakers in New York City. CLASP also interviewed a policymaker in West Virginia, a state that does not use contracts in their child care subsidy system. CLASP communicated with policymakers in additional states that may serve infants and toddlers through contracts, but do not explicitly use contracts to improve the quality or supply of that care.
 - 19 Child Care and Development Block Grant, Final Rule 45 C.F.R. Parts 98 and 99.
 - 20 *Ibid.*
 - 21 U.S. Department of Health and Human Services, Administration for Children and Families, Child Care Bureau, *FFY 2006 CCDF Data Tables (Preliminary Estimates)*, http://www.acf.hhs.gov/programs/ccb/data/ccdf_data/06acf800_preliminary/list.htm.
 - 22 TANF funds spent directly are not subject to CCDBG rules, including the parental choice requirement. Rachel Schumacher, Mark Greenberg, and Janellen Duffy, *The Impact of TANF Funding on State Child Care Subsidy Programs*, Center for Law and Social Policy, 2001, http://www.clasp.org/publications/the_impact_of_tanf.pdf.
 - 23 Ayana Douglas-Hall and Michelle Chau, *Basic Facts About Low-Income Children Birth to Age 3*, National Center for Children in Poverty, 2007, http://www.nccp.org/publications/pub_765.html.

- 24 U.S. Department of Health and Human Services, *FFY 2006 CCDF Data Tables (Preliminary Estimates)*.
- 25 Jennifer Mezey, Mark Greenberg, and Rachel Schumacher, *The Vast Majority of Federally-Eligible Children Did Not Receive Child Care Assistance in FY 2000*, Center for Law and Social Policy, 2002, www.clasp.org/publications/1in7full.pdf.
- 26 Jennifer Macomber, Gina Adams, and Kathryn Tout, *Who's Caring for Our Youngest Children? Child Care Patterns of Infants and Toddlers*, Urban Institute, 2001, <http://www.urban.org/url.cfm?ID=310029>. Among children under age 3 of employed mothers, 18 percent from poor households (under 100 percent of poverty) and 16 percent from low-income households (100-200 percent of poverty) are cared for in centers; U.S. Department of Health and Human Services, *FFY 2006 CCDF Data Tables (Preliminary Estimates)*.
- 27 U.S. Department of Health and Human Services, *FFY 2006 CCDF Data Tables (Preliminary Estimates)*.
- 28 States are required to submit a biennial plan reporting on their activities through CCDBG, including information on child care subsidy policies for families with children up to age 13 and descriptions of quality improvement initiatives funded through the block grant. States' plans represent activities the state intended to carry out at the beginning of the grant period; not all initiatives may have been implemented during the period of the plans.
- 29 Layzer and Collins, *National Study of Low-Income Child Care*; Chase-Lansdale and Gordon, "Availability of Child Care In The United States"; Susan Walker and Kathy Reschke, "Child Care Use by Low-Income Families in Rural Areas," *Journal of Children & Poverty*, 10 no. 2 (2004): 149-168; Kristin Smith, *Rural Families Choose Home-based Child Care for their Preschool Aged Children*, Carsey Institute, 2006, http://www.carseyinstitute.unh.edu/publications/PB_childcare_06.pdf; U.S. Government Accountability Office, *Welfare Reform*; Gretchen Kirby and Andrew Burwick, *Using Vouchers to Deliver Social Services: Considerations Based on the Child Care and Development Fund (CCDF) and Temporary Assistance for Needy Families (TANF) Program Experiences*, Mathematica Policy Research, Inc., 2007, <http://aspe.hhs.gov/hsp/07/vouchers/experiences/index.htm>.
- 30 For a discussion of the failures of the child care market in relation to the vouchers vs. contracts debate, see Rachel Schumacher, Kate Irish, and Mark Greenberg, *Untapped Potential: How States Contract Directly with Providers to Shore Up Child Care Choices*, Center for Law and Social Policy, 2003, http://www.clasp.org/publications/untapped_rpt.pdf.
- 31 Karen Schulman and Helen Blank, *State Child Care Assistance Policies 2007: Some Steps Forward, More Progress Needed*, National Women's Law Center, 2007, <http://www.nwlc.org/pdf/StateChildCareAssistancePoliciesReport07Web.pdf>.
- 32 Gina Adams, Monica Rohacek, and Kathleen Snyder, *Child Care Voucher Programs: Provider Experiences in Five Counties*, Urban Institute, 2008, http://www.urban.org/UploadedPDF/411667_provider_experiences.pdf.
- 33 Gina Adams, Kathleen Snyder, and Kathryn Tout, *Essential but Often Ignored: Child Care Providers in the Subsidy System*, Urban Institute, 2003, http://www.urban.org/uploadedpdf/310613_OP63.pdf.
- 34 Diane Paulsell, Renee Nogales, and Julie Cohen, *Quality Child Care for Infants and Toddlers: Case Studies of Three Community Strategies, Executive Summary, ZERO TO THREE*, 2003, <http://www.mathematica-mpr.com/PDFs/qualchildhlth.pdf>.
- 35 Adams et al, *Essential but Often Ignored*.
- 36 For a discussion of why a mixed-approach may work best see Schumacher et al., *Untapped Potential*.
- 37 Ajay Chaudry, Kate Tarrant, and Julie Asher, *Rethinking Child Care: An Integrated Plan for Early Childhood Development in New York City*, Administration for Children's Services, 2005, http://www.nyc.gov/html/acs/html/child_care/pub_rethinking_childcare.shtml, based on Ajay Chaudry, *Putting Children First: How Low-Wage Working Mothers Manage Child Care*, 2004, p. 104.
- 38 Deborah Lowe Vandell and Barbara Wolfe, *Child Care Quality: Does It Matter and Does it Need to be Improved?* 2000, <http://aspe.hhs.gov/hsp/ccquality00/index.htm>.
- 39 U.S. Department of Health and Human Services, Administration for Children and Families, *Child Care and Development Fund: Report of State and Territory Plans, FY 2006-FY 2007*, 2006, <http://nccic.acf.hhs.gov/pubs/stateplan2006-07/index.html>.
- 40 Chaudry et al., *Rethinking Child Care*.

- 41 *Ibid.* For more on the shortcomings of the child care market see Schumacher et al., *Untapped Potential*; Diane Paulsell, *The Economic Rationale for Investing in Children: A Focus on Child Care*, 2001, <http://www.mathematica-mpr.com/publications/PDFs/econrationale.pdf>.
- 42 Information on Vermont's contracting program was provided to CLASP by the Assistant Director of the Vermont Child Development Division for a study on state-funded Early Head Start programs. See Schumacher and DiLauro, *Building on the Promise*.
- 43 Interview with Michael Jett, California Department of Education, October 18, 2007.
- 44 Center-based providers receive a 70 percent higher rate for infant care and a 40 percent higher rate for toddlers. Family child care home providers serving infants or toddlers receive a 40 percent higher rate. California Department of Education, *Reimbursement Fact Sheet: Child Care and Development Programs, FY 2007-08 Budget Act, Center-based Direct Services*, 2008, <http://www.cde.ca.gov/sp/cd/op/factsheet07.asp>.
- 45 California Department of Education, *Child Care and Development Programs FY 2007-08 Budget Act Center-based Direct Services*.
- 46 *Ibid.* See also Kidango, *The State Paying More Money for Less Quality: State Contract Versus Voucher Funded Child Development*, 2007, <http://www.earlyeducation.org/moreforless.pdf>.
- 47 Kidango, *The State Paying More Money for Less Quality*.
- 48 Interview with Michael Jett, California Department of Education, October 18, 2007; California Department of Education, Child Development Division and Fiscal and Administrative Services Division, *Report on Unspent Child Care Funding*, 2007, <http://www.earlyeducation.org/unspentfunds.pdf>.
- 49 Helene Stebbins and Jane Knitzer, *Highlights from the Improving the Odds for Young Children Project: State Early Childhood Policies*, National Center for Children in Poverty, 2007, http://www.nccp.org/publications/pdf/text_725.pdf.
- 50 Connecticut Department of Social Services, *The Status of Child Care in Connecticut: SFY 05-06: Annual Report to the State General Assembly*, http://www.ct.gov/dss/lib/dss/pdfs/child_care_annual_report_for_sfy_2005-2006.pdf.
- 51 Marcy Whitebook, Fran Kipnis, and Dan Bellm, *Disparities in California's Child Care Subsidy System: A Look at Teacher Education, Stability and Diversity*, Center for the Study of Child Care Employment, 2007, http://www.iir.berkeley.edu/cscce/pdf/subsidy_system07.pdf.
- 52 See Elizabeth Hoffmann, *Comprehensive Services: Charting Progress for Babies in Child Care Research-Based Rationale*, Center for Law and Social Policy, forthcoming.
- 53 U.S. Department of Health and Human Services, *Making a Difference in the Lives of Infants and Toddlers and Their Families: The Impacts of Early Head Start*, 2002.
- 54 Email to authors from Peter Palermينو, Connecticut Department of Social Services, October 1, 2007.
- 55 Connecticut Department of Social Services, *The Status of Child Care in Connecticut*.
- 56 California Department of Education, Child Development Division, *Introduction to Desired Results*, <http://www.cde.ca.gov/sp/cd/ci/desiredresults.asp>.
- 57 National Association of Child Care Resource and Referral Agencies, *We Can Do Better*.
- 58 See California Department of Education, *Child Development (CD) Instrument for Categorical Program Monitoring (CPM) 2007-08*, <http://www.cde.ca.gov/ta/cr/cc/documents/childdevins07.doc>.
- 59 Schumacher and DiLauro, *Building on the Promise*.
- 60 U.S. Department of Health and Human Services, *Making a Difference*.
- 61 Idaho and New Mexico target funds for TANF families. Funding for Idaho's efforts to extend the capacity of existing Early Head Start programs and extend the day or year for Tribal Head Start Programs ends 6/30/08. Schumacher and DiLauro, *Building on the Promise*.
- 62 States are required to spend a minimum of 4 percent of CCDBG funds on initiatives to improve quality and expand access to child care programs.
- 63 Two Head Start delegate agencies in Vermont operate three licensed, center-based programs serving Early Head Start children.
- 64 Capizzano and Adams, *Children in Low-Income Families*. Low-income is defined as households with incomes under 200 percent of poverty.

- 65 U.S. Department of Health and Human Services, *FFY 2006 CCDF Data Tables (Preliminary Estimates)*.
- 66 Bruce Hershfield with Anita Moeller, Abby J. Cohen, and the Mills Consulting Group, *Family Child Care Networks/Systems: A Model for Expanding Community Resources*, Child Welfare League of America, 2005, http://www.cwla.org/programs/daycare/policyfamily_carereport.pdf.
- 67 In New York City, family child care networks are supported by state and city tax levy funds.
- 68 Hannah Matthews and Danielle Ewen, *President's Budget Disregards Sound Investments for Young Children*, Center for Law and Social Policy, 2008, [http://www.clasp.org/publications/cc_2009_budget.pdf](http://clasp.org/publications/cc_2009_budget.pdf).
- 69 California Department of Education, *Report on Unspent Child Care Funding*.
- 70 New York City Administration for Children's Services, *Procedure for Infant-Toddler Conversion*, received by email from Shari Gruber on September 19, 2007.

Child Care and Early Education Series

July 2008
Paper No. 3

ABOUT OUR WORK

The Center for Law and Social Policy (CLASP) is a national non-profit that works to improve the lives of low-income people. CLASP's mission is to improve the economic security, educational and workforce prospects, and family stability of low-income parents, children, and youth and to secure equal justice for all.

©2008 Center for Law and Social Policy

CLASP's child care and early education work is dedicated to promoting policies that support both child development and the needs of low-income working parents. CLASP conducts policy analysis, research, and technical assistance to expand access to and resources for high-quality, comprehensive child care and early education; build effective child care and early education systems,

including child care subsidies, Head Start, pre-kindergarten, and other early education initiatives; and ensure these systems can be responsive to the developmental needs of all children, in particular infants and toddlers and children in immigrant families. CLASP's child care and early education work highlights state-by-state data where available. For more information, see <http://childcareandearlyed.clasp.org>.



CENTER FOR LAW AND SOCIAL POLICY

1015 15th Street, NW, Suite 400
Washington, DC 20005

202.906.8000 main
202.842.2885 fax

www.clasp.org