MICHIGAN CHILD CARE SUBSIDY POLICY CHANGES 2021

Awareness Gaps, Support for Increased Access, and the Implications of Temporary Policies

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Public Policy Associates

Public Policy Associates is a public policy research, development, and evaluation firm headquartered in Lansing, Michigan. We serve clients in the public, private, and nonprofit sectors at the national, state, and local levels by conducting research, analysis, and evaluation that supports informed strategic decision-making.

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INTRODUCTION

Policy Focus

In this year of the Michigan Child Care Policy Research Partnership, Public Policy Associates (PPA) worked with the Michigan Department of Education/Office of Great Start (MDE/OGS) and the Michigan Department of Health and Human Services (MDHHS) to study several temporary policy changes for the Child Development and Care (CDC) program (Michigan's child care assistance program) that were put into place in 2021. All of these changes came about in response to the ongoing COVID-19 pandemic and continuing challenges in access to quality child care within the state. These program policy changes were financed through an influx of federal funding.

The first of these was an increase in the income eligibility threshold to 150% federal poverty level (FPL), up from 130%, in January 2021, which lasted until the State instituted a new threshold of 185% FPL as of November 2021.[1] This new temporary level remains in effect through September 2023.[2] There has been ongoing interest in increasing eligibility for child care assistance, given the rising costs and affordability issues for families in the state. These changes in eligibility threshold over a relatively short period of time were responsive to advocates and opened the program to more families. In 2020, Michigan was among the six states with the lowest eligibility levels in the nation.[3] In addition, Michigan implemented a 30% permanent increase in payment rates for child care providers in October 2021, with *additional* temporary increases to the new base rates, as amended by the fiscal year 2023 state budget bill, PA-166 of 2022.[4] These rate changes apply to all licensed and licensed-exempt child care providers and child ages.[5] Michigan has known that its provider payment rates lag behind the market rates charged for different age ranges by home-based and center providers in most areas of the state. Michigan has a single rate schedule for the entire state, meaning that the relative value of the payments varies by location.[6] Increasing the rates while possible to do so was intended to help

[1] As of July 3, 2022, Michigan instituted a 200% FPL income limit for the CDC program. The end date of this increase is indeterminate, although it will also be temporary. Certain caseload targets and spending limits apply. See: Michigan Department of Education, "State of Michigan Child Development and Care (CDC) Handbook," October 1, 2022, https://www.michigan.gov/mde/-/media/Project/Websites/mde/ogs/cdc-2/provider_docs/cdc_handbook.pdf?rev=ca94b918cd0540af85ac36a175d982c1&hash=D2489C23BA5D23E5FBD9309DD8D6B119.

[2] Michigan Department of Education, "Expanding Access to Quality, Affordable Child Care for Families," updated March 2022, 1.

[3] Ron French, "Michigan offers little help for child care. That may change in 2020," *Bridge Michigan*, January 27, 2020, https://www.bridgemi.com/talent-education/michigan-offers-little-help-child-care-may-change-2020.

[4] Michigan Department of Health and Human Services, "CDC Income Eligibility Scale and Provider Rates," RFB 2022-03, January 1, 2022. The temporary increases are added to the base increase of October 2021 over four phases, declining over time. The first add-on was a 50% increase, the second rate change is a 40% increase, and the third is the base rate multiplied by 30%, and the final rate change is a 10% increase over the October 2021 base rates.

[5] Ibid.

[6] *Michigan Child Care Market Rate Study – 2020* (Lansing, MI: Public Policy Associates, May 2020).

stabilize child care businesses, better compensate providers, and prevent further decline in child care supply. Still, the funding behind most of these rate changes is one-time federal resources, and at this time, the duration of the new rates is limited, beyond the original 30% increase.

To further alleviate financial challenges for families during this period, Michigan waived the co-payment requirement (called "family contribution" in the state) for families who would otherwise have been expected to contribute toward the amount covered by the subsidy. For instance, a family may have been required to pay $20 per week toward child care based on their income, lessening the subsidy by that amount.[7] This waiver went into effect in November 2021 and continues through September 2023.[8] Michigan had previously waived the family contribution for all families using a licensed provider rated 3 to 5 stars in the Great Start to Quality rating system and those whose low income did not allow for a family contribution. The State intends to revert to this policy when the waiver ends.

As a group these policies represent a robust effort to increase provider wages and ease the financial burden on families by expanding access to child care assistance and removing the required family contribution. Michigan enacted these policies in conjunction with additional policies that reached child care providers beyond the CDC program. Grants to help all providers with operating costs, bonuses and college scholarships for child care professionals, business startup grants, and mental health supports were implemented as well in 2021-2022, with the same set of stimulus resources from the federal government.

[7] A provider may still charge families additional fees to cover the cost of child care beyond the subsidized amount.

[8] Michigan Department of Education, Office of Great Start, Child Development and Care Program, letter addressed to Parents and Providers Participating in the Child Development and Care Program, September 26, 2022, 1.

Study Overview

The nature of these policies poses interesting questions for the State, and more broadly other states and the ACF OPRE, that also have interest in the effects of national and state efforts to support child care access through additional investments. In order to study the effects of the eligibility threshold increase and get various groups' perspectives on the policy changes implemented, the research team used mixed methods to answer the following questions.

Research Questions

1. What is the impact of changes to child care subsidy policy by state agencies related to clients and providers on client outcomes?
2. To what extent do local child care market conditions mediate the impacts of changes to subsidy policy?
3. What opportunities do families, providers, and caseworkers see for improvements in the application, award, renewal, and utilization processes?
4. How have the MDE and the MDHHS collaborated to improve the access of families to child care subsidies since passage of the CCDBG Act of 2014, retrospectively and through the course of the Michigan Child Care Policy Research Partnership (CCPRP) grant period?

Other reports produced or planned by PPA will convey additional results for these and other research questions within the scope of the study.

Data Sources and Methods Used

For Year 3 of the study, the research team continued to use interviews with families and providers, as well as secondary data and a survey of MDHHS eligibility specialists (i.e., caseworkers) to address the research questions. The families included those who had child care assistance payments throughout 2021, who had stopped using the subsidy for a period of time during the year and restarted or did not restart, or who used the subsidy significantly more or less in one half of the year as compared to the other half. These distinctions were made to understand patterns in subsidy use. The provider research participants had received subsidy payments from the State at some point during the previous year. The primary data were collected during spring 2022. The 2021 secondary data used to sample parents are from Michigan's Bridges database, and the analysis of the eligibility threshold change from 130% FPL to 150% FPL compared 2021 CDC participants to those in 2020 and 2019. The state partners took policy coordination self-assessments, designed by PPA, to reflect on their joint implementation efforts. For more detail about the study methodology, refer to the Appendix of this report.

RESULTS

Increasing the Eligibility Threshold

The eligibility threshold increases, the first bump in January 2021 and the other later in November 2021, were significant opportunities to open the CDC program to more families. As discussed in this section, the potential of these increases did not live up to expectations, mainly due to the societal conditions during which they were implemented. Ironically, the increases were supported in part by those same conditions.

The pandemic may have muted the impact of higher income limits on enrollment

When it adopted a higher income eligibility level, the CDC program staff expected that total enrollment in the program would increase. However, the move to a threshold of 150% FPL took place in the midst of the COVID-19 pandemic, which was still causing considerable economic disruption in early 2021 when the policy went into effect.[9] Consequently, the effect of higher income limits could be masked or muted if parents were working from home with children present or withheld their children from child care due to health concerns, or if providers were forced to close due to staffing shortages or illness outbreaks.

In comparing the total number of families participating in the CDC program, there were on average 4% fewer CDC families in the 16 weeks after the adoption of the policy compared with the last 16 weeks of 2020 (roughly the fall and spring school semesters). If the entire March – December periods in 2020 and 2021 are compared to one another—effectively comparing enrollment during the "pandemic year" of 2020 with the same months of 2021—7% fewer families were enrolled per pay period in 2021 than in 2020. However, the policy may have contributed to an increase in the number of new CDC families in 2021. In 2020 the March – December period saw an average of 131 new families receiving CDC subsidies per two-week pay period, but this number increased to 233 new families per pay period in 2021—a 78% increase. While an improvement, new families per pay period in 2021 were still fewer than in pre-pandemic years.

[9] Analysis of the impact of the 185% FPL threshold has not yet been conducted by PPA.

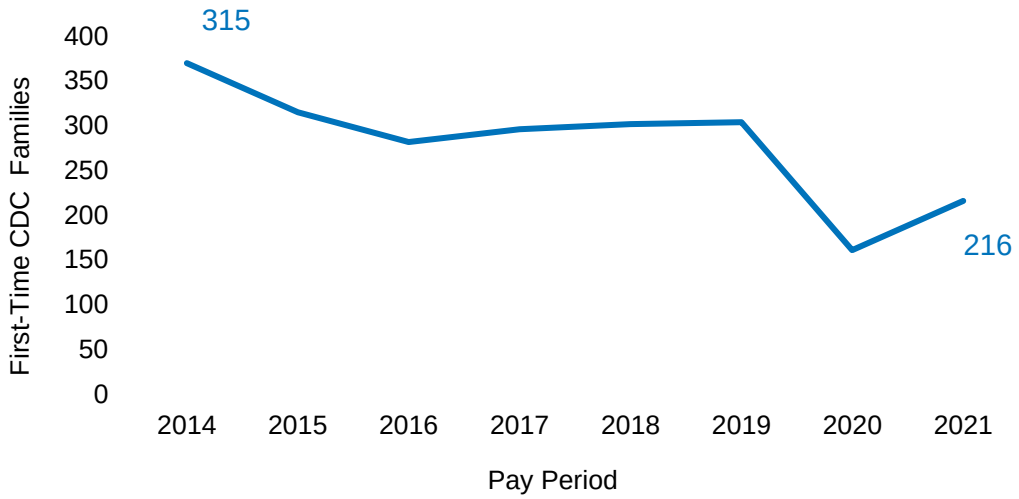

Figure 1. Average Number of First-Time CDC Families per Pay Period

Another analysis found that families new to the CDC program experienced some improvements in staying with the program and continuity of care during 2021, which may have resulted from the policy change. Families in the first 16 weeks of 2021 were statistically significantly less likely to exit the program, and children were also statistically significantly more likely to remain enrolled with their first provider. Statistical analysis did not identify any significant differences across racial and ethnic groups on either of these effects.

These positive trends should be treated with caution, since the improvements between the end of 2020 and the beginning of 2021 are not necessarily caused by the increased eligibility limits. Other economic and policy changes, and the ebbing of the pandemic, could also have played a role.

Few parents were aware of the threshold increase, and eligibility specialists said better information was needed

Parent knowledge is another potential influence on subsidy utilization in light of the eligibility threshold increase. Only seven parents (20%) interviewed had heard of the threshold change prior to being interviewed, and there was little parental clarity about information or communications concerning the change in income eligibility. For the five of the seven who could recall, the source of information about the policy varied; they heard about it through a letter from the state, their provider, and a TV news segment.

The quantity or quality of information from the state may be a factor in the lack of parent knowledge. Over half of the responding eligibility specialists indicated a need for better informational material on income and other eligibility requirements. Additionally, when it came to what areas of the program needed the most improvement, eligibility was in the top three for about half (257) of those specialists. Suggestions for changes on that included adding income limits to the application, removing the 12-month eligibility period, avoiding confusion and frustration for clients by not changing eligibility unless income changes, and not lowering the income eligibility threshold later.

The communication to them about the eligibility threshold policy change received mixed reviews from specialists. Slightly more caseworkers agreed that it was communicated well to them (46%) than did not (43%). Those specialists with 6-10 years on the job had more positive feelings about the communication about this change, compared to half of those in other experience categories; this was true of the other policy-change communications as well.

Parents were split on whether the threshold increase would influence their job decisions

Parents were asked whether they did not seek to increase their work hours or earnings because they feared losing their child care assistance. Ten parents (28%) responded in the affirmative. Most said their decisions concerning work hours or wage increases were unrelated to the CDC program, although three specifically identified the disincentive to work or earn more because of the program's income limits.

The interviewers also asked parents if they had known of the increase in the income eligibility limit they would look for a higher-paying job or increase their work hours (or consider using the subsidy again if they had stopped). Half of the parents (19) said this would matter to their employment decisions, while 40% (14) said it would not be a factor and the rest were unsure.

The interpretation of parental responses to this policy change warrants caution due to the hypothetical nature of the data, which is underscored by the fact (discussed above) that relatively few parents were aware of the increase in the income eligibility limit before the interviews.

"When you start to make more money when they're doing reviews and they start looking at your checks and see how much money that you bringing [sic] in, they start cutting your benefits or saying that you don't qualify for child care. So, you get kind of stuck [when] trying to do better because when you try to do better, … they'll start cutting your benefits." – Parent

"[I]f I knew that I could … work more, get paid more, and still qualify for daycare, and not have them either unqualify me for the other programs as well, I will definitely work more." – Parent

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Providers praised the threshold increase, but most did not have direct experience with it

Only three providers knew of families in their care who had qualified for CDC as a direct result of the raised eligibility threshold. However, a majority of CDC providers (18) had heard of the increase prior to the interview, and many (12) suggested that more families might qualify for their services as a result of this change.

Most of the providers interviewed who were not serving families with assistance (i.e., non-CDC providers) also supported the eligibility threshold increase. They felt it would likely result in financial relief for families (5), increase income for providers (5), and otherwise benefit families (2).

"I think it just benefits more families … so they can get the quality care that the child deserves that they might not get [otherwise] … whether it be healthy food or healthy activities, or learning…" – Child Care Provider

"I have one family that now is eligible that have not before … that [policy change] made a big difference. It made them able to afford my higher rate, no question about that, making it possible for them." – Child Care Provider

The new eligibility threshold was a positive change per state partners but did not fully satisfy aims

MDE/OGS and MDHHS gave this policy strong average scores of 3.5-4.0 out of 4.0 on alignment, communication, and cooperation around implementation. However, the partners expressed some concerns about the temporary nature of the 185% FPL threshold and rated it a 3.0 on achievement of intention due to the lower-than-anticipated increase in enrollment, which as noted above, was impacted by the pandemic.

Table 1. Average Assessment Scores for the 185% FPL Eligibility Threshold Policy Coordination, 2022

3.5	4.0	3.5	3.0	3.0
Alignment w/Mission	Communication Quality	Interagency Cooperation	Achievement of Intended Purpose	Potential for Policy Improvement

Few specialists believed that raising then lowering the threshold would have a positive impact, highlighting concerns about confusion

Very few specialists believed the temporary threshold increase will have a positive impact on clients or providers. Most are somewhere in between a minor negative and no impact for each category. About a third of responding specialists reported that raising then lowering the threshold will have a negative impact on retention of families in the assistance program. Overall, the more often a caseworker interacts with clients, the more likely they are to answer they do not know or are unsure what kind of impact raising then lowering the threshold would have.

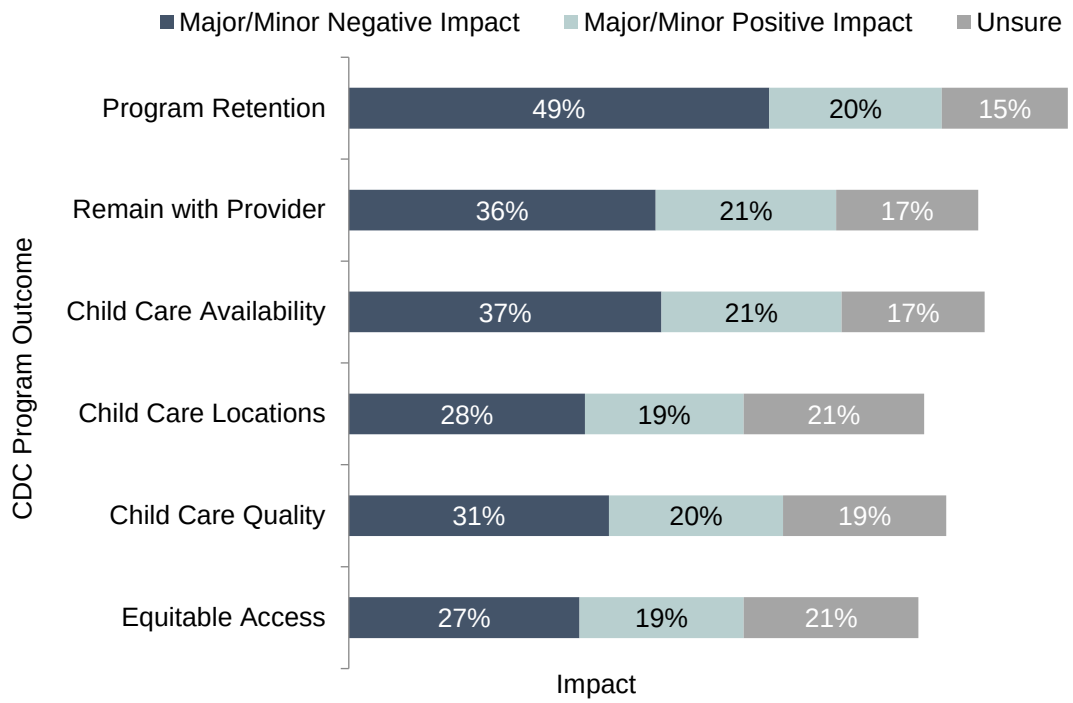

Figure 2. Impact of Raising then Lowering the Income Eligibility Threshold on Various Outcomes for the CDC Program, Caseworker Responses

A large minority of specialists also expected that the raising then lowering of the threshold would make their workload harder than before. Forty-three percent said they expected it to be "much harder" to explain to clients why they no longer qualify for the subsidy. Specialists said it would incur about the same amount of work in terms of processing eligibility determinations/redeterminations (40%) and implementing graduated exits (37%).

Policy Implications

The data suggest that the eligibility threshold increase has not led to a significant increase in enrollment. However, there is no indication that this is due to the policy itself. Rather, various mitigating factors such as the influence of the pandemic and communication issues appear to be influencing uptake of the program. Given these complications and the short time the change has been in effect, it may be unrealistic to expect clear signs of impact. As observed by MDHHS staff, parents, and providers, the increased eligibility threshold may include benefits for families and providers. These groups noted the high cost of child care, the cost of living in general, and/or the pace of inflation as reasons why the increase in eligibility could be beneficial.

The impact of eligibility changes (from 130% FPL to 150% to 185% and then to another level) and the temporary nature of more generous policy warrants further study. In the interim, those working with families can focus on improving communications and preparing in particular for how to explain any reduction in eligibility.

Payment Rate Increases

The increase in payment rates for providers is similarly complicated, with multiple staged increases planned for 2021 through 2023. Only the increase of 30% over the prior rates in October 2021 is to be permanent. The results from discussions with providers, the state partners, and the opinions of eligibility specialists[10] together reflect an interest in aiding families and providers through more generous rates while also recognizing the substantial resources it takes to deliver on that obligation.

Providers strongly supported the rate increases

The provider pay increase created an array of benefits for both providers and families. Forty-four percent (11) of providers interviewed passed the pay increase directly on to families by reducing or eliminating copays. One-quarter (6) increased their staffing or raised the wages of existing staff, resulting in reported increased morale. Several noted that the new reimbursement rate now reflected the quality of care they offered (5) or that the increase allowed them to purchase more (5) or higher-quality (3) equipment and supplies. Four providers said the increase helped prevent them from working at a financial loss.

"Well, the effects are, I would say, all positive. Believe in being is I have more income coming in. So, I pay my staff more money. I am allowing them to work more hours, like all of my staff, as well as myself, are full time, which is more the better care for each child, there are more adults per children. So, it's more one-on-one." – Child Care Provider

"It's basically cut the co-payments of the parents completely off.... So, it helps with their pocket level and income and their bills ... and stress levels, not to be worried about paying for child care." – Child Care Provider

Non-CDC providers supported the pay increase as well, despite the fact that they did not benefit from it personally. When asked what impacts the increase might have, most non-CDC providers felt it would confer financial relief to families (5) or providers (4), help providers buy more supplies or improve their services (3), or allow providers to raise their rates without passing the added cost on to families (2). Two felt the increase might make them more willing to accept CDC clients. Finally, two non-CDC providers thought the increase might cause CDC providers to be more in demand or more competitive in serving families.

[10] Parents were not asked about this policy; the focus of their interviews was subsidy usage and access to child care during 2021.

Most CDC provider responses during interviews indicated that the sunset of the rate increase will directly impact the affordability and quality of child care. These impacts could include raised rates or co-pays (8); reduced staff personnel counts, hours, or wages (6); or cutbacks in expenses or services (5). Four providers were saving money to prepare, but three others said they would return to a state of financial struggle once the rate increase was eliminated. Some providers had no current plans to make changes (5), would not change their staffing (3), or were seeking other funding sources (2).

"I'm going to say that, for the first time ever, it seems that the State of Michigan is reimbursing at a rate that programs are charging for child care. Now, this rate is temporary. I don't know what's going to happen when this rate then goes back to whatever levels of subsidy it's going to go to." – Child Care Provider

Most eligibility specialists felt the rate increase was not communicated well to them or to clients

The MDHHS specialists do not engage in payments to providers but were asked about their impressions of the quality of communication about the rate increase. Over 50% of those responding to the survey believed it was not well communicated to them, with 37% thinking that it was . In addition, they had concerns about the communication received by clients; two times more specialists believed it was not well communicated to clients than those who did think it was communicated well. This view may be connected to concerns among 57% of the responding specialists that the billing requirements information should be improved.

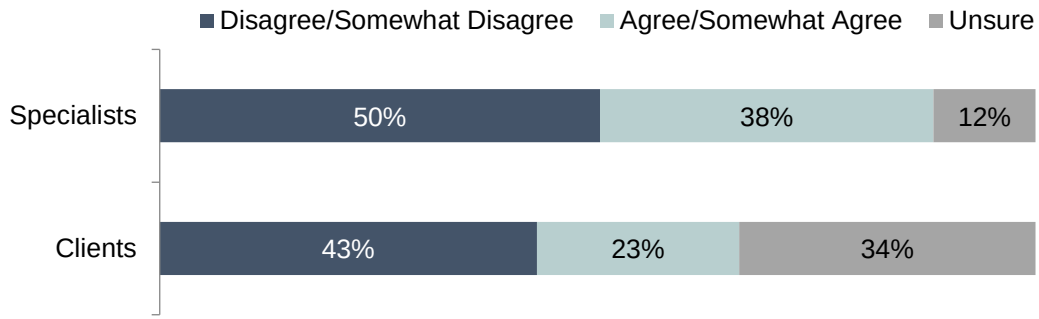

Figure 3. Ratings of the Communication of the Rate Increase, as Perceived by Eligibility Specialists

State agencies highly rated the coordination around the payment rate change

When rating the policy coordination around this policy, the scores were in the 3.0-4.0 range, with mutual communication, mission alignment, and cooperation all rated at the highest level. Potential for policy improvement and achievement of intended purpose were tempered by partner concerns about policy generosity, from two different angles. For the MDHHS team, the

fact that the subsidy does not always cover the full cost of child care for a family meant that payments could be more generous. However, the MDE/OGS team pointed to financial and time horizons that constrain what can be offered.

Table 2. Average Assessment Scores for the Payment Rate Change Policy Coordination, 2022

4.0	4.0	4.0	3.0	3.0
Alignment w/Mission	Communication Quality	Interagency Cooperation	Achievement of Intended Purpose	Potential for Policy Improvement

With the payment rate increases, the policy is not going to be fully implemented as originally planned, so that elicited a lower rating. With the latest budget bill (July 2022), the rates were increased 10% through the first full payment period of fiscal year 2023.[11]

Policy Implications

Providers who take the subsidy indicated a need to retain higher provider rates. The increases implemented up to that point had reportedly helped to alleviate environmental factors such as inflation and worker shortages by increasing wages. Providers warned that added costs resulting from a lower reimbursement rate will be passed on to low-income families or managed through staffing cuts. To maintain access to quality child care at an affordable level, the state will need to give serious consideration to increasing its investment in child care assistance in closer alignment to the market rate.

Although provider reimbursement rates are more directly relevant to providers than to parents or caseworkers, concerns about the amount of information given to eligibility specialists is important to note, as the specialists are often a key, initial informant about the program for clients. Program administrators can look to improve communication about rate changes by considering the various ways providers, specialists, and families learn about payment rates. As observed by the state partners, their respective roles with the CDC program (i.e., administrator or caseworker) give useful perspective on how policy responds to diverse needs.

Family Contribution Waiver

The waiver of a required family contribution or co-payment toward the cost of child care in connection with the subsidy meant that some families in the CDC program had a change in their costs. For others, either for income reasons or other exemptions, never had to make this contribution and were unaffected by the waiver. Like the other policies discussed in this report, it was nonetheless a significant policy change that involved parents, providers, MDHHS, and the program staff at MDE/OGS. This policy is also temporary, so these parties had concerns about how to smoothly transition between changes.

[11] Michigan PA 166 of 2022 (July 20, 2022), Sec. 1002 (1)-(2), 46.

Providers had positive opinions of the waiver despite having little experience with it

Provider perspectives on the family contribution waiver should be interpreted carefully because few providers had direct experience of the waiver, although most (18) knew of it before the interview. In addition, some providers may have confused or conflated family contributions (determined by MDHHS) with additional costs owed to them by families above and beyond what the subsidy covered (determined by the provider).

Roughly one-third of the CDC providers interviewed (13) felt that the family contribution waiver would offer much-needed financial relief to families, although most had not observed any effect of the waiver on their businesses (7), did not handle a family contribution (6), or had a star rating of three stars or higher, meaning that their families did not have to provide a contribution (6). Lesser numbers of providers felt the change would help more families afford the provider (1), leave their children longer with the provider (1), or require less time of them to keeping track of family contributions (1).

Likewise, non-CDC providers were broadly supportive of the family contribution waiver. They too felt it would provide financial relief to families (8) and providers (2).

"Well, it doesn't really affect me, since I don't already have a family contribution fee. [But] it's good for everyone else. And, I mean, it would be good for me too if I was below three stars."
– Child Care Provider

"I don't have any families that have shared with me that they have to [pay a family contribution] … but I would imagine that again, that's a huge impact for families that are struggling with lower-paying jobs and just trying to provide for their families."
– Child Care Provider

Parents did not perceive the waiver as a significant influence on their child care use

Over 60% of parents interviewed (22) did not have a family contribution. Only about one-third of all interviewed parents (11) were aware of the family contribution waiver policy before their interviews. Four parents made payments but were uncertain as to whether these were family contributions or added costs charged by the provider to cover full tuition, and one parent responded that they did not know or were unsure. It is unclear how many of these interviewees did not have a family contribution due to the quality star rating of their providers. One half (11) of parents with no family contribution were confident that their providers had at least a three-star quality rating.

When the one-quarter of the interviewees (9) who indicated that they had any family contribution were asked if the lack of a family contribution would cause them to find a more highly rated or more expensive provider, none of them said it would have that effect. An additional five parents who had stopped program participation altogether were asked if having that amount covered by the State would cause them to start using the subsidy again, and again, none of these said yes.

"I'd have to look at the cost and then weigh that out with what I make per hour. I'm a number cruncher kind of person.... I would have to weigh that out and then see what the benefits are [of switching to a more expensive or higher rated provider]." - Parent

"... I can't say that I'm going to look for a more expensive [provider]. Because I just went based off what I was looking for as a parent. I didn't go off what the state will cover for me." - Parent

Parents aware of the family contribution waiver learned about it from different sources

Of those parents aware of the waiver prior to the interviews, seven recalled receiving a state agency letter about the policy change, while three heard about it from their providers, two from television news reports, and one via a non-agency smart phone application. Those parents who received an agency letter about the family contribution waiver were nearly evenly split on its communicative quality: four expressed a positive opinion, and three found it unclear and confusing.

Eligibility specialists thought the waiver was not communicated well to them or to clients

Most of the specialists responding to the survey (52%) thought that the waiver was not communicated well to them, as compared to the 35% who thought it was communicated effectively. Over two times more caseworkers believe it was not well communicated to clients (48%) than those who did (19%). This reaffirms the lack of knowledge of the waiver among parents (or at least lack of recall about the waiver news) expressed by the parents interviewed.

Eligibility specialists thought it will be difficult to explain the end of the waiver to clients

A majority of specialists (64%) also reported difficulty explaining the family contribution to clients, so the waiver may have added to that challenge. Most reported that the reversion to the old policy after the temporary waiver expired would not have an effect on their work in terms of processing eligibility determinations and redeterminations (44%) and implementing graduated

exits (41%).[12] However, about one-third of specialists also noted that it would be "much harder" to explain to clients why they no longer qualified for the subsidy levels previously available (35%). This would be a compounding burden as caseworkers already reported having issues explaining the loss of eligibility and reported that the wavier was not well communicated to them (only 22% think it was well communicated) or clients (only 20% think it was communicated to clients).

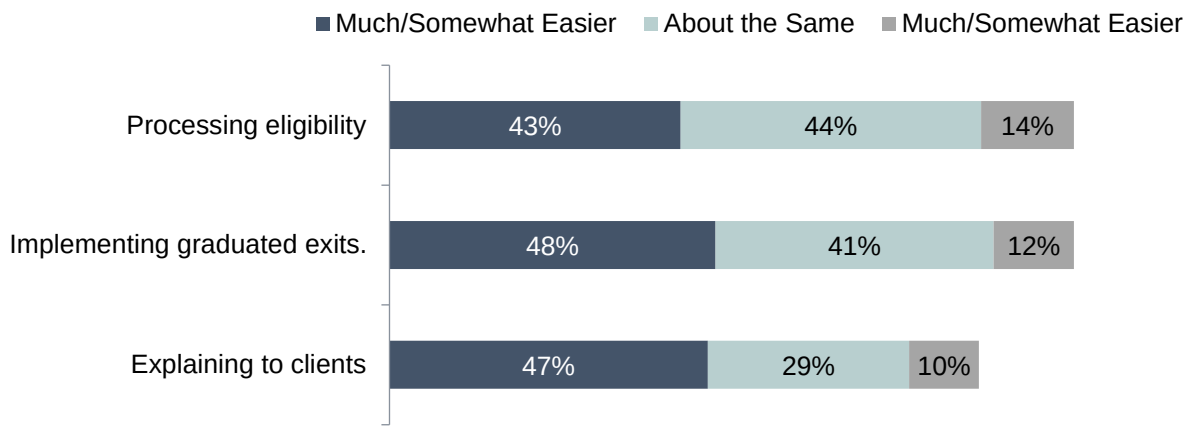

Figure 4. Effect of Waiver's End on Specialists' Work, as Reported by Specialists

Specialists were divided on the impact of ending the co-payment waiver

For all the topics asked about (processing eligibility determinations/redeterminations, implementing graduated exits, explaining to clients why they no longer qualify for the subsidy), specialists were far more likely to think that ending the co-payment waiver would make a major impact—either positive or negative—than a minor impact.

When broken down by community type, urban specialists had a bigger gap between minor and major impacts than specialists that serve suburban or rural areas. The Business Service Center (BSC) 1 area specialists (in the northern section of the state) responded "not sure" more frequently than those from the other BSCs. This might be due to a lack of variability associated with a smaller sample, or this might indicate a lack of understanding of the potential impacts of the

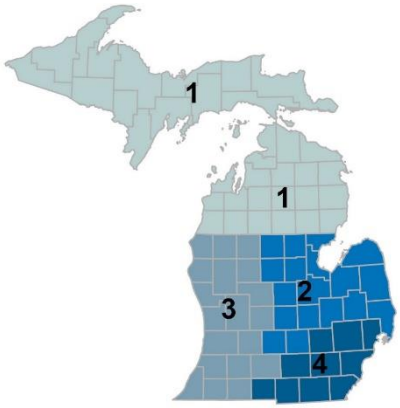

Figure 5. MDHHS Business Service Center Regions

[12] Michigan has a policy that allows families to earn more after initial eligibility and still maintain some level of child care assistance through a graduated program exit to avoid a "benefits cliff."

policy. For the most part, specialists who work more frequently with clients are more likely to believe there would be an impact from ending the waiver; however, they are divided on whether that impact would be positive or negative.

All that being said, the most common answer for all questions was that the policy change will have no significant difference.

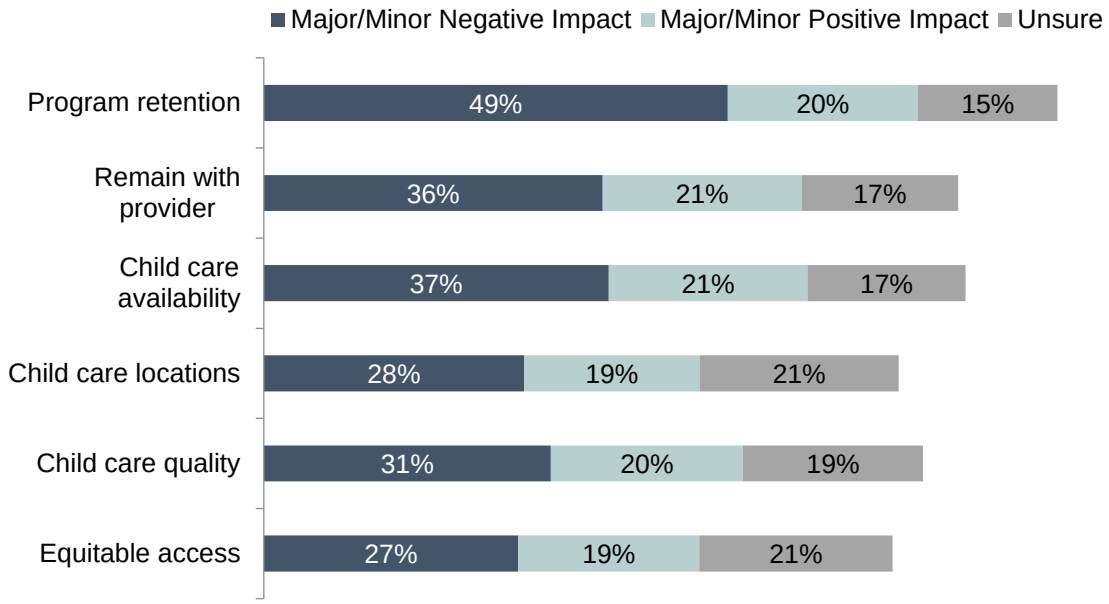

Figure 6. Effect of Waiver's End on Families, as Perceived by Specialists

State partners reported strong agency communication and cooperation around the waiver, but were wary of this policy's longer-term implications

Achievement of the intended purpose of the family contribution policy change was rated a positive 3.5 on average between MDHHS and MDE/OGS. During their self-assessments, the state teams noted some potential case errors and concerns about whether all providers followed through on the policy. If a provider did charge a parent for the contribution during the waiver period, there is no way either state agency would know that. The lack of parent awareness of the waiver policy also raises a concern around this possibility, however unlikely.

In addition, the MDE/OGS team worried about a financial cliff being created when there is no co-payment required, which would counteract the intent of the State's graduated exit policy. For instance, without any contribution required, a family with increased income would more rapidly reach the limits of the subsidy and not have a required contribution to ease them into taking on more child care costs.

Table 3. Average Assessment Scores for the Waiver of Family Contributions Policy Coordination, 2022

3.5	4.0	4.0	3.5	2.5
Alignment w/Mission	Communication Quality	Interagency Cooperation	Achievement of Intended Purpose	Potential for Policy Improvement

Policy Implications

For all groups, the family contribution waiver held great potential as a way to alleviate financial challenges for families and reduce their overall cost of child care. However, as Michigan already had a policy that waived the contribution requirement for many, it had limited application.[13] The policy also raised questions—as the other temporary changes did—about communicating the transition to the new policy and then back again, overall awareness, and its effect on specialists' already heavy workloads. The family contribution is traditionally confusing to explain in combination with the subsidy and any additional provider charges. This policy change was indicative of the need to consider carefully outreach, administrative controls, and interactions with other policies, to the extent circumstances allow.

[13] In 2018 and 2019, at any given point in the year, 16% of cases had a family contribution.

RECOMMENDATIONS

Across the three policies discussed, all can be classified as transitory, responsive to challenging times for families and providers, and somewhat difficult to address from an administrative standpoint. The eligibility threshold increase, family contribution waiver, and stepped increases in payment rates were supported in part by larger, ongoing needs in the state to improve child care affordability and access, but also acting in the context of the pandemic to quickly apply new federal resources through program policy levers. Although the pandemic has slowed substantially as of now, the recovery is still in progress. The combination of primary and secondary data collected and analyzed over the past year point to some recommendations for the CDC program and broader child care assistance policy.

- In times of downturns in the economy—whether driven by a catastrophic event or not—policy has a role in combating negative consequences for workers who need child care and those who provide that care. Policymakers should be ever mindful of the vulnerabilities in this market and seek to add stability.
- Program administrators and the Michigan Legislature should consider state-funded opportunities to make the current, more generous CDC policies longer lasting or permanent as the state continues to address child care affordability and supply challenges.
- MDE/OGS and MDHHS should continue to communicate policy changes and implementation steps to the eligibility specialists, providers, and families, with increased emphasis on the clarity and frequency of communication. Investigate ways to explain the often-confusing co-payment policy more readily.
- State partners in the CDC program could increase awareness and understanding of policy changes by engaging in robust outreach to non-participating providers and families in an effort to expand case numbers, particularly while the increased eligibility threshold, payment rates, and waiver of family contribution are in effect.
- Through state partner discussion and coordination, carefully prepare for the end to the temporary policies to reduce negative impacts for families, providers, and specialists.

APPENDIX A: METHODOLOGY

Secondary Data

Data on family Child Development and Care (CDC) program participation was drawn from state administrative data, with payments to providers on behalf of unique family case identifiers used to ascertain CDC utilization. The total number of parents recording a subsidy was aggregated by pay period. New parents were identified based on whether that ID was associated with any payments prior to the time point in question for the entire data set (2013-2021).

Family persistence and child continuity of care were analyzed via survival analysis using Cox regressions. The analysis compared families/children who first received the subsidy in the first 16 weeks of 2021 during their first spell, compared with the cohort that joined the program in the last 16 weeks of 2020. Focal children to represent each family were selected randomly to avoid biasing the results in favor of families with multiple children in the program (n=3,471). Missing values for race/ethnicity and geographic location were imputed from other periods in the year, while income was measured via the modal category. Cox regressions included controls for parent race and ethnicity (non-Hispanic Black and Hispanic), whether they reported any income, child age, and provider type, with county-level fixed effects. Moderator analysis was conducted to test for differences by race and ethnicity.

The results should be interpreted with some caution. First, the findings may not be generalizable to all families because (a) families enrolled prior to the study period were excluded, and (b) randomly selected "focal" children were used to represent each family. Second, the impact of increases in income eligibility are estimated by comparing periods of time during and before the new policy. As such, any other environmental or policy changes could account for or mitigate the results of the analysis.

Primary Data

Policy Coordination Self-Assessments

Two state agencies coordinate to implement the CDC program in Michigan—the Department of Education/Office of Great Start (MDE/OGS) and the Department of Health and Human Services (MDHHS). Agency teams consisted of 4-6 staff. Each team arrived at a consensus score for each item. They could enter notes to contextualize their responses and provide suggestions/comments on the policies and their implementation. The tool uses a four-point scale, from 1-4, with 4 signifying the highest rating. For one question, that about achieving its intended purpose, a "0" option is also present, allowing for the possibility that a policy change is still underway and the outcome unknown.

Public Policy Associates (PPA) populated the tool with this year's policy information and verified implementation dates with the CDC program director. The tool includes 15 items for each policy, 6 of which use rated scales and the others are memo fields. Items include policy description,

mission alignment, implementation date and status, implementation supports, quality of communication, quality of interagency cooperation, achievement of intended purpose, external factors, and potential for improvement. Ratings are on a 1.0-4.0 scale, with 4.0 being the highest rating and indicating strong coordination. The state partners also have the option to provide comments or notes for each rated item.

PPA entered the data from each assessment into a spreadsheet for analysis, then met separately with the leads of each team to discuss individual responses and scoring rationale where that was unclear. At a meeting with those same leads, the research team reviewed the results of the assessments and gathered further feedback. Before the joint meeting, the research analyst averaged the agencies' scores of each item, looking for divergence in perceptions of coordination as indicated by lower scores (<3.0), in addition to examining the scoring in the context of the agencies' notes to determine potential reasons for any disparities in scores.

To assess whether policy coordination improved year-to-year, PPA took the composite scores from five of the six ratings per policy and calculated the average across all of a year's policies to arrive at an annual average score. The scale remained 1.0-4.0.

It is important to note that MDHHS is not involved in payments to providers, so the degree of coordination necessary for that is vastly different than the eligibility threshold and waiver of co-payment policy changes.

Eligibility Specialist (Caseworker) Survey

This survey was developed in collaboration with MDE/OGS and MDHHS partners in order to assess the impacts of recent policy changes on clients with regard to need for child care services and subsidies, financial hardship, and access to and availability of child care services. It also assessed the impacts of policy changes made in 2021 in response to the pandemic from the caseworker perspective. Items were based on the previous year's survey instrument, with constructs modified to address the specific policies implemented in response to COVID-19. In previous years the instruments had been piloted on a small group of eligibility specialists and revised in light of their feedback. PPA piloted any questions that had been added, edited, or revised from the previous year's survey on a new group of eligibility specialists.

The final survey was disseminated to approximately 3,100 MDHHS specialists in January 2022 and the survey remained open for 2 months. The caseworkers were emailed an electronic link to the survey (with accompanying explanation) by MDHHS central office. Survey responses were confidential and without identifying information. The survey led with a question asking specialists how often they handle CDC cases. In instances where the participant indicated that they do not handle those cases, they were disqualified from the survey and given a message indicating as such as well as thanking them for their time.

The survey received 884 responses, for a response rate of 29%. Of the respondents, 688 (78%) worked with clients about the CDC program, and 32% of those 688 worked with clients in the program daily or weekly.

PPA analyzed the survey data using descriptive statistics and significance testing of differences among specialists (by experience, frequency of working with the program, community type, and region). In cases when a respondent reported "NA/not sure," they were coded as missing for statistical testing. However, in some cases "NA/not sure" counts were high enough to be significant (approximately 20% or greater), and so were included so as to not obscure the results. Additionally, it is possible that for other reasons than previously mentioned, the specialists who did not respond have different feelings than those who did, potentially introducing selection bias. Being that the attempt was a census, and the response rate was less than half, it is possible that this does not accurately reflect the population.

Table A-1. Demographic Breakdown of Eligibility Specialist Survey Respondents

CDC Client Frequency	Number	Percentage (%)
Less often that once a month	131	19
Monthly	224	33
Weekly	142	21
Daily	191	28
Total	**688**	

Experience	Number	Percentage (%)
< 1 year	51	10
1-5 years	98	19
6-10 years	75	14
10 or more years	296	57
Total	**520**	

Caseload	Number	Percentage (%)
1-250	50	10
251-500	68	13
501-750	89	17
751-1,000	137	27
1,000+	39	7
Works in a Universal Caseload (UCL) county	122	23
N/A	17	3
Total	**522**	

Business Service Center Region	Number	Percentage (%)
BSC 1	39	8
BSC 2	146	28
BSC 3	112	22
BSC 4	223	43
Total	**520**	

Community Type of Clients	Number	Percentage (%)
Urban	193	37
Suburban	120	23
Rural	152	29
Unsure	55	11
Total	**520**	

Provider Interviews

The provider interviews were conducted using an interview tool developed by PPA and vetted by MDHHS. Prior to the interviews, the draft tool was tested on one home-based provider and one center-based provider who were identified with the assistance of MDE/OGS. The purpose of the pilot was to test providers' understanding of and ability to respond to the questions. Pursuant to the pilot, the interview tool was revised to make the language simpler and easier for interviewees to understand.

PPA randomly selected 48 CDC providers and 24 non-CDC providers per MDHHS BSC region from the Great Start to Quality dataset, for a total of 288 providers. Of these, a total of 183 providers received invitations. PPA's goal was to complete 6 interviews (2 per type of setting) per BSC, for a total of 24 who were actively working with the subsidy program and 12 who were not currently with the program but had been within the last 3 years.

For providers with known emails, PPA sent up to two email invitations via SurveyMonkey to schedule phone interviews, with MDE as the sender. The email invitation directed providers to a short SurveyMonkey registration form. Non-respondents, providers without emails, and providers whose emails bounced received up to two phone calls from PPA using a call script. In the registration form and recruitment calls, PPA asked providers whether they were currently working with CDC subsidy clients or had done so in the past three years, gathered their current contact information, and requested their preference of an interview time. Confirmation emails were sent upon recruitment, and reminder phone calls were made one business day before each scheduled interview.

In February, March, and April 2022, PPA conducted interviews with 34 licensed child care providers in Michigan, including 25 current CDC providers and 9 non-CDC providers. PPA initially sought to conduct interviews with non-CDC providers who had participated in the CDC program in the past three years. However, the research team had great difficulty reaching providers who met this criterion. To reach the goal of 10 non-CDC providers, PPA opened recruitment to providers who had participated in the program more than three years ago or who had never participated at all. As a result of this change, PPA was able to complete interviews with nine non-CDC providers. Six of the nine providers had never participated in the program.

All interviews were conducted by telephone. A PPA researcher conducted each interview and took an audio recording. Interview duration varied from roughly 20 minutes to an hour, depending on how much the interviewee had to say. Upon completion of interviews, PPA distributed $50 incentive checks to providers via mail.

Most CDC interview participants were experienced child care providers with many years of experience participating in the CDC subsidy program. On the other hand, most non-CDC providers had little or no experience with the program.

Table A-2. Demographic Breakdown of Provider Interviewees

Years in Child Care Business CDC Providers	Number	Percentage (%)
< 2 years	1	4
2-9 years	8	32
10-19 years	8	32
20 years or more	8	32
Total	**25**	

Years in Child Care Business Non-CDC Providers	Number	Percentage (%)
< 2 years	3	33
2-9 years	2	22
10-19 years	2	22
20 or more years	2	22
Total	**9**	

Years Participating in CDC Program – CDC Providers*	Number	Percentage (%)
< 2 years	2	8
2-9 years	8	33
10-19 years	7	29
20 or more years	7	29
Total	**24**	

Years Since Last Participation in CDC Program – Non-CDC Providers	Number	Percentage (%)
Never	6	66
10 or more years	3	33
Total	**9**	

Number of Subsidized Children in Care – CDC Providers*	Number	Percentage (%)
1-5	12	48
6-20	9	36
20 or more	3	12
Total	**24**	

*One CDC provider was not asked this question.

In keeping with the research design, the CDC providers were equally distributed between the four BSC regions. For non-CDC providers, the research team was only able to conduct 9 of the 12 interviews desired due to the difficulty in finding non-CDC providers who would respond.

Interview recordings were sent to an external vendor for transcription. PPA staff then coded the interview responses by topic using NVivo© software, with a focus on identifying prevalent themes across the interviews as well as outlying viewpoints.

Parent Interviews

In April and May 2022, PPA conducted individual telephone interviews with 36 parents/guardians of children who received subsidized child care from licensed providers during 2021 through CDC program. PPA developed, piloted, and implemented the final interview instrument and protocol in collaboration with the MDE/OGS and the MDHHS.

The generation of the parent interview sample began with the stratification of the secondary data by (a) state region and (b) the four 2021 child care case or subsidy use patterns that an analysis of those data had identified. The four use pattern categories were:

1. Stopped using the CDC and did not start using it again
2. Used the CDC significantly more or less in the second half than in the first half of the year
3. Stopped using child care assistance for a while but started using it again
4. Used the CDC and had little or no change in use.

Prospective parent interviewees were then randomly selected from each stratum. Email invitations to register online for a pilot of the interview instrument were sent to a group of prospective interviewees; three invite respondents participated in cognitive interviews. The piloting process resulted in only minor modification to the interview instrument. Following this, PPA next made no more than two attempts to contact the rest of the prospective interviewees; as they responded, they were scheduled for interviews on a modified first-come, first-served basis such that nine interviews were arranged for each of the four *a priori* use patterns.

The interviews were scheduled to last up to 60 minutes each, but a large majority took substantially less time. All interviews were recorded. The 36 parents completed an interview, and each received an incentive of $50 for participating. The interview recordings were transcribed, with PPA staff coding the responses by topic using NVivo© software. Parent codes were determined *a priori* from the interview instrument, with child codes developed and revised iteratively through an open coding process.

Due to the emergent mismatch between use patterns applied for sampling and parents' reported use experience, the limited number of interviews conducted overall, and the potential for interview invitee non-response bias, the results may not fully reflect the views of all parents using subsidies for child care in 2021 in the state.

Table A-3. Demographic Breakdown of Parent Interviewees

CDC Enrollment	Number	Percentage (%)
6 months or less	0	0
6 months-1 year	2	7
1-2 years	6	17
2-5 years	16	44
5-10 years	8	22
> 10 years	4	11
Total	**36**	

Children's Ages	Number	Percentage (%)
Up to 1 year	1	2
1-3 years	9	18
3-5 years	17	30
5-7 years	11	25
7-10 years	10	19
> 10 years	4	9
Total	**52**	

Fostering Children	Number	Percentage (%)
Foster Parents	3	8
Non-Foster Parents	29	81
Indeterminant	4	11
Total	**36**	

Provider Type	Number	Percentage (%)
Center	26	69
Family	6	16
Home	4	11
License Exempt	0	0
Indeterminant	2	5
Total	**38**	

Employment Status	Number	Percentage (%)
Employed Full Time	16	44
Employed Part Time	12	33
Unemployed – Looking	7	19
Unemployed – Not Looking	1	3
Total	**36**	

Race/Ethnicity	Number	Percentage (%)
Black or African American	12	33
White	15	42
Latino/a/x or Hispanic	2	6
Multiracial or Biracial	3	8
Prefer not to say	4	11
Total	**36**	

Gender	Number	Percentage (%)
Female	34	94.5
Prefer not to say	2	4.5
Total	**36**	

Age (Years)	Number	Percentage (%)
Under 25	1	3
25-34	15	42
35-44	12	33
45-54	3	8
55-64	3	8
Prefer not to say	2	6
Total	**36**	

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