Public Policy Associates

Effects of an Eligibility-Threshold Increase and Providing Stabilization Grants

MICHIGAN CHILD CARE SUBSIDY IMPROVEMENT THROUGH RESEARCH: CHILD CARE POLICY RESEARCH PARTNERSHIP

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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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Contents

EXECUTIVE SUMMARY **1**

2022 Policy Change Effects 1

Study Approach 1

Key Findings 2

Implications and Recommendations 3

INTRODUCTION **6**

Policy Focus 6

Study Overview 8

RESULTS **12**

Increase of Eligibility Threshold 12

Stabilization Grants 27

RECOMMENDATIONS **39**

REFERENCES **41**

APPENDIX A: METHODOLOGY **43**

Secondary Data 43

Primary Data 46

Executive Summary

2022 POLICY CHANGE EFFECTS

Public Policy Associates (PPA) studied two major shifts in the policies around child care affecting the Child Development and Care (CDC) program: (1) an increase in the program's eligibility threshold from 185% of the federal poverty level (FPL) to 200% of the FPL and (2) the introduction of temporary stabilization grants for child care providers. These changes occurred as part of a larger effort to respond to the economic consequences of the COVID-19 pandemic.

The eligibility-threshold change allowed two-parent families with two young children earning $49,000 per year and a single-parent family with one infant earning $32,200 per year to become eligible for child care assistance. The change sought to increase access to quality care for families.

The stabilization grants from November 2021 through October 2022 provided millions of dollars in support to the 6,400 providers who qualified. Providers could use the funds to cover personnel costs; to pay for facilities including rent, maintenance, and insurance; to buy equipment and supplies; to provide mental health services to employees; and to pay off past expenses. The intent of these grants was to provide financial support to keep providers open and serving families and children. The flexibility of the funds allowed providers to pay off sudden expenses caused by the COVID-19 pandemic without interrupting their ability to provide affordable child care.

STUDY APPROACH

The study has examined the effects of policy changes for the CDC program's outcomes since fall 2019. Each year the policies studied differed, but the study used a similar set of methods and maintained a continuous focus on understanding if racial/ethnic and geographic equity was present in the results. In this last year of the study, PPA sought out program actors' voices and experiences through:

- Parent and provider telephone interviews
- An eligibility specialist survey
- State agency policy coordination self-assessment
- Analysis of program case records

KEY FINDINGS

The major results of the analyses conducted in 2023 included:

Policy Implementation

- The Michigan Department of Education and the Michigan Department of Health and Human Services reported implementing the eligibility-threshold change with a high level of cooperation.
- The ongoing rapidity of policy changes in 2022 stretched State staff capacity for implementation.

Policy-Change Awareness

- Awareness of the threshold change was high among the providers but not the parents interviewed.
- Providers were well informed about the stabilization grants.

CDC Program Enrollment

- Enrollment in the CDC program rebounded to pre-pandemic numbers in 2022. More Black families enrolled in the CDC program after the threshold moved to 200% of the FPL than other racial/ethnic groups.

Access to Quality Care

- The eligibility-threshold change did not alter the level of quality of child care CDC-participating families received in 2022. However, the racial gap in access to quality care through the CDC program closed since the threshold change.
- Families did not change in their patterns of subsidy usage before and after the introduction of the eligibility-threshold change.
- The eligibility-threshold change did not have a significant effect on family persistence in the program or continuity of care with the same provider.
- CDC-participating providers were equally likely to receive a stabilization grant as non-participating providers. The stabilization grants balanced provider type, geographic distribution, and slot-capacity factors.
- Providers who received a stabilization grant were less likely to close, and providers with stabilization grants served more children with CDC assistance.
- Administrative data analysis did not show conclusive evidence of better continuity of care with the stabilization grants.
- Providers reported investing primarily in their staff and facilities with the grant funds. Providers reported passing along the benefits of the stabilization grants to families in the form of tuition relief, new equipment and supplies, and other offerings.

IMPLICATIONS AND RECOMMENDATIONS

Both the eligibility-threshold increase and stabilization grants were major undertakings for Michigan. The eligibility-threshold change required coordination across two state agencies, consideration of funding sustainability, staff capacity for increased enrollment, and the implications for another key program feature—the graduated exit of families from assistance as their incomes rose. Alerting potentially eligible families to the eligibility-threshold change was a tall order, and awareness was low despite a marketing campaign. The fact that Michigan has retained this threshold demonstrates a commitment to child care access.

The stabilization grants showed the impact supplemental funding could have for provider supply, particularly among home-based providers, and promotion of quality care, reaching thousands of children. However, the grants also demonstrated the short-term nature of such impacts when funding is time limited. Many providers continue to need business support and additional resources to stay operational without financial losses given the current market conditions, leaving plenty of room for ongoing investment and initiatives.

Recommendations to leverage the results of the eligibility-threshold increase and stabilization grants in the future include:

- Maintain the CDC-eligibility threshold at no less than 200% of the FPL.
- Examine how the graduated exit levels correspond with the 200% of the FPL and the effects for CDC-participating families.
- Build communication strategies to more effectively reach families who might be eligible for the CDC program across the state.
- Devise sustainable funding to support child care business viability, including situating the state's mix of licensed providers to deliver on Pre-K for All expansion and filling the financial gap left when four-year-olds move out of the care of provider programs to Great Start Readiness Program slots.
- Continue to invest in expanding the number of licensed Michigan child care providers needed to meet demand, including home-based providers.

Introduction

Introduction

POLICY FOCUS

The Child Development and Care (CDC) program is a State-administered subsidy funded by the Child Care and Development Fund (CCDF), a federal fund that seeks to provide needy families with child care. The CDC program provides payment to eligible providers on behalf of families enrolled within the program. Children under 13 are eligible to be part of the CDC program based on household income and an approved need reason, such as parental employment, family preservation, and approved parental activities. This provides needed child care for low-income parents so that they may go to work, school, or tend to other important matters such as urgent medical care. In December 2022, over 32,000 children received care in part thanks to the CDC program.

In the fourth year of the study, the research team focused on two changes to the program: an eligibility-threshold increase and the implementation of stabilization grants to providers.

Eligibility-Threshold Increase

The CDC eligibility threshold changed from 185% of the federal poverty level (FPL) to 200% of the FPL. The change went into effect in July 2022 and was funded initially by the pandemic-era federal funding increase. For that reason, at the time it was implemented, the State believed that the increase might be temporary, and the study proceeded to examine the change from that premise. However, so far Michigan has maintained this eligibility threshold for the program. For the past fiscal year, it has been funded using carryover funds from the state's block grant.

Increasing the eligibility threshold was intended to give more families access to the program benefits, and thereby, improve their ability to access quality child care.

Stabilization Grants

The State issued stabilization grants to licensed home-based and center-based providers over three rounds, in January, March, and November 2022. These grants ranged widely, depending on provider size, from $5,315 to $630,313. Michigan funded the grants with $700 million from its American Rescue Plan funding. A previous effort in Michigan (April – December 2020) called the Child Care Relief Fund also provided grants to providers; Public Policy Associates (PPA) studied those grants in the context of other pandemic-driven interventions in 2021 (Year 2 of the study period).

Like other states, Michigan remained concerned about the financial conditions in the child care market that threatened the ability of providers to secure adequate staffing, deliver quality care, and meet community child care needs. The grants offered providers resources to support the costs of personnel, supplies and equipment, facilities, and the mental health of employees, as well as previous costs. With the end of the federal funds, Michigan discontinued the stabilization grants, with the last grant spending required by July 2023.

Stabilization grants showed the impact supplemental funding could have for provider supply.

Most licensed providers qualified for a stabilization grant; eligibility requirements included being an active licensed child care provider (or only temporarily closed due to the pandemic), including Head Start and Great Start Readiness Program[1] providers of tuition-based child care. The State allotted grants to providers based on a first-come, first-served basis. The base funding provided was determined based on licensed capacity and provider type. Bonus funding was added based on whether a provider had a Great Start to Quality rating, served children utilizing the child care subsidy, provided care for infants and toddlers, offered nontraditional hours, and provided care for children with special needs. The Early Childhood Investment Corporation (ECIC) helped with the grant application (in WLS), but MDE reviewed, approved and paid grants.

Through these two activities—increasing program eligibility and supporting providers—Michigan used available funding in pursuit of improved access to child care. Families,

1 The Great Start Readiness Program is Michigan's public pre-K program.

providers, and the eligibility specialists (caseworkers) weighed in during the study about how well the changes worked for them. PPA supplemented their voices with program data to understand the impact of the eligibility threshold and stabilization grants on enrollment in the CDC program and utilization of the subsidy, retention of families in the program, continuity of care, and equitable access to quality care.

STUDY OVERVIEW

Research Questions

The research questions discussed in this report are:

1. What is the impact of changes to child care subsidy policy by State agencies related to clients and providers on client outcomes?
2. What is the differential impact of policy changes on highly disadvantaged subgroups (i.e., racial/ethnic minorities and families in deep poverty)?
3. What opportunities do families, providers, and eligibility specialists see for improvements in the application, award, renewal, and utilization processes?
4. How have the Michigan Department of Education (MDE)[2] and the Michigan Department of Health and Human Services (MDHHS) collaborated to improve the access of families in child care subsidies?

Data Sources and Methods Used

To address the research questions, PPA used a variety of qualitative and quantitative sources. Through the mixture of methods, the research team explored the effects of the stabilization grants and eligibility-threshold increase from multiple perspectives. Each method used is briefly described below; for additional detail, please refer to the Methodology appendix.

Policy Coordination Self-Assessments

MDE and MDHHS both had roles in the implementation of the child care assistance program. Eligibility specialists at MDHHS county offices review applications and make approvals or denials of benefits. MDHHS also communicates approved hours and family

2 Effective December 1, 2023, the CDC program moved along with other units to the new Michigan Department of Lifelong Education, Achievement, and Potential (MiLEAP). We refer to MDE as a state partner for this study throughout this report.

contribution (co-payment) requirements to families. The CDC program staff were housed in MDE and administered the program, had policy-making responsibilities, and oversaw payments to providers.

To understand the two agencies' degree of coordination around policy implementation, the research team developed a Policy Coordination Self-Assessment tool that State-partner teams completed annually. The tool's content and scoring structure remained the same year to year except for the policies of focus. MDHHS was not involved in implementing the stabilization grants.

Administrative Data

The research team utilized administrative data for both secondary and primary data analysis. Provider analysis and sampling utilized data from Great Start to Quality (GSQ), while parent- and child-level data were extracted from Michigan's Bridges benefits data system.

Eligibility Specialist Survey

Each year of the study, PPA conducted a survey designed for eligibility specialists who handle CDC-eligibility cases. The survey built upon the design of the first year in order to keep consistency as well as to measure changes in perspectives. It asked about eligibility specialists' perspectives of the CDC policies and changes, as well as their caseloads, work dissemination, clients, processes, and additional concerns and feelings pertaining to the CDC program. Here, the research team reports on the 869 responses to the survey.[3]

Provider Interviews

PPA conducted 36 interviews by telephone in March and April 2023 with child care providers who had received CDC payments in 2022. The interviews focused on providers' perceptions of the eligibility-limit policy change and the stabilization grants, as well as the implications of those for providers and the families they serve. The group of interviewees included a mix of home-based and center-based providers from across the state.
For more information about provider demographics, please refer to the Methodology appendix section.

3 PPA could not calculate a response rate since the total number of eligibility specialists in State employment is unknown to the research team.

Parent Interviews

Parent interviews occurred with two groups of parents/guardians: subsidy-utilizing families (consisted of parents whose providers received CDC payments in 2022) and non-subsidy-utilizing families (parents who were approved for CDC assistance in 2022 but for whom there were no recorded provider payments that year). PPA conducted 48 telephone interviews with subsidy-utilizing families and 48 telephone interviews with non-subsidy-utilizing families in June and July 2023.[4] For more information about parent demographics, please refer to the Methodology appendix.

Both interview instruments included questions about demographics, families' general child care and CDC-program experience in 2022, opinions about the increased eligibility threshold, overall satisfaction with the CDC program, and suggested improvements. Non-subsidy-utilizing families were also asked a series of questions designed to learn why parents did not use the assistance after being approved.

4 A separate, forthcoming report details parental reasons for non-utilization of the CDC assistance.

Results

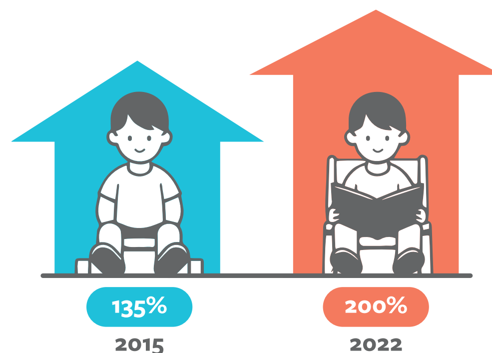
Results

INCREASE OF ELIGIBILITY THRESHOLD

The tools for data collection regarding the eligibility-threshold increase were designed with the assumption that the increase would be temporary, as it was not known whether it would continue. However, the threshold of 200% of the federal poverty level (FPL) continued as of early 2024. The results, therefore, should be understood with that in mind.

Hypotheses

For the eligibility-threshold increase, the research team explored the following hypotheses:



- The increase in income eligibility in November 2021 will be associated with higher rates of participation in the Child Development and Care (CDC) program than in prior periods.
- Clients who are approved for the subsidy program after policy changes will be more likely to participate in the program, and to do so after a shorter period of time than clients prior to policy changes.
- Policy changes will be associated with equitable outcomes among key demographic subgroups and across geographic regions.

Data Sources

To test the hypotheses, the research team utilized five data sources and methods designed to capture different insights, with the goal of generating a complete and accurate picture of the impacts of the eligibility-threshold increase (see Table 1).

Table 1. Eligibility-Threshold Data Sources and Uses

DATA SOURCES AND METHODS	USE IN THE STUDY
State Agency Partners – Policy Coordination Self-Assessment (2023)	Information on policy origin and aims
Administrative Data (2022) – Bridges case database, I-Billing provider payment system, GSQ provider Quality Recognition and Improvement System	Impact on provider uptake; change in enrollment and scores; impact on families' subsidy application, approval, and use, as well as continuity of care
Eligibility Specialist Survey (2023)	Observed impact on families; impact on specialists' own work
Provider Interviews (2023)	Awareness of policy; impact on providers; observed impact on families
Parent Interviews (2023) – active and non-active families	Awareness of policy; impact on behavior

State-Level Policy Coordination

State-agency coordination around the CDC program and, by extension, State goals to support the child care supply is crucial to the end-user experience, whether that user is a family receiving a subsidy looking for child care or a provider receiving a payment or grant through the State. In addition, how the Michigan Department of Education (MDE) and the Michigan Department of Health and Human Services (MDHHS) worked together to plan for and conduct all the small steps necessary to implement the eligibility-threshold change is related to achieving the intentions of the change (i.e., to increase access for families). Those steps included making updates to the Bridges data system, producing memos, preparing the eligibility specialists, creating a flyer for families, making website updates, conducting webinars with business owners (so they could tell their employees), adding an eligibility calculator to the State's Quality Recognition and Improvement System (QRIS), and updating the CDC Handbook.

The State agencies reported implementing the eligibility-threshold change with a high level of cooperation.

In their assessment of their policy coordination, MDE and MDHHS rated this change highly. On a scale of 1.0 to 4.0, the average scores ranged from 2.0 to 4.0. The State teams gave the highest ratings to interagency cooperation (4.0) and alignment of the policy change with their respective missions (3.5). Satisfaction with these was attributed to a lack of system errors connected with the change and a timely Handbook update.

The ongoing rapidity of policy changes in 2022 stretched State capacity for implementation.

The State teams gave the lowest rating (2.0) for the quality of the communication about the change. When asked to explain this score, the State leads pointed to how overwhelming the volume of CDC-program changes (and other benefit programs) were during the pandemic for eligibility specialists. In addition, the State teams had some concern about whether families heard about the change, so more could apply. Mining the data system for previously rejected applicants who might have qualified with the threshold increase was not practical.

Table 2. State Agency Policy Coordination Averaged Scores, Eligibility-Threshold Increase, 2023

ALIGNMENT WITH MISSION	COMMUNICATION QUALITY	INTERAGENCY COOPERATION	ACHIEVEMENT OF PURPOSE	POTENTIAL FOR POLICY IMPROVEMENT
3.5	2.0	4.0	3.0	3.0

Achievement of purpose and potential for policy improvement received scores of 3.0 each. In the eyes of the State teams, altering the way the graduated exit from the program worked or factoring families' annual work pattern into eligibility determinations (e.g., all income earned in one part of the year) were seen as potential improvements to consider, but they were not sure about how to improve on the threshold. They gave their 3.0 rating to achievement of purpose because of worries about being able to maintain the threshold at this level and those families who did not qualify but still had difficulty affording child care.

One unintended consequence of the policy change was the workload that came with the increase in CDC case numbers; new staff were not added. The gap between the eligibility threshold and the incomes allowed for graduated exit also closed with this change, causing a need to reevaluate that schedule.

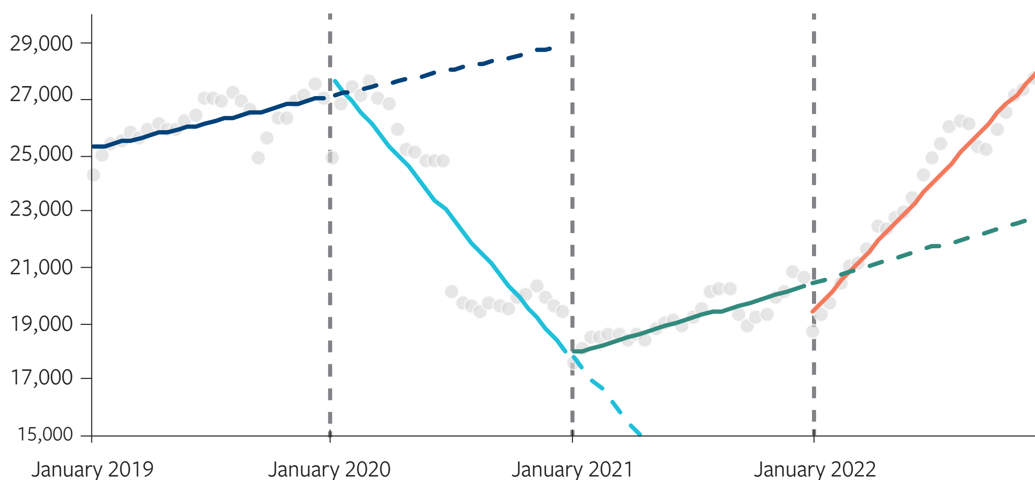
Impact on Providers

To combat the sudden and drastic shift of the economy in 2020, the State instituted many policy changes around child care to help stabilize the child care market. This was important not only for parents who suddenly needed child care due to the circumstances caused by the COVID-19 pandemic, but for the providers who were already facing financial

difficulties. As the economy started to recover, the State established new policies not only to help keep the markets stabilized for providers, but to have CDC enrollment rebound to 2019 rates. This was done by incentivizing new or returning parents to utilize the child care subsidy.

To determine whether this occurred, the research team utilized an interrupted time series design, which measures trends in enrollment and similar metrics over time from before the pandemic to after and the time after each major policy change, including the increased eligibility threshold from 185% to 200% of the FPL. This allows for a comparison of trends between time periods. Trends reflect an average change per two-week provider pay period based on aggregate data.

Figure 1: CDC Program Enrollment Trends by Year



Enrollment in the CDC program rebounded to pre-pandemic numbers in 2022.

On average CDC enrollment grew by 350 cases for each CDC payment period (two-week interval) during 2022. This is a significant increase, and it shows a rebound in enrollment to pre-pandemic levels. In Figure 1, the solid lines show the trend line for the given year, while the dashed lines show the predicted trend line based on the previous period's trend. The solid red line shows the trend following the eligibility expansion. As

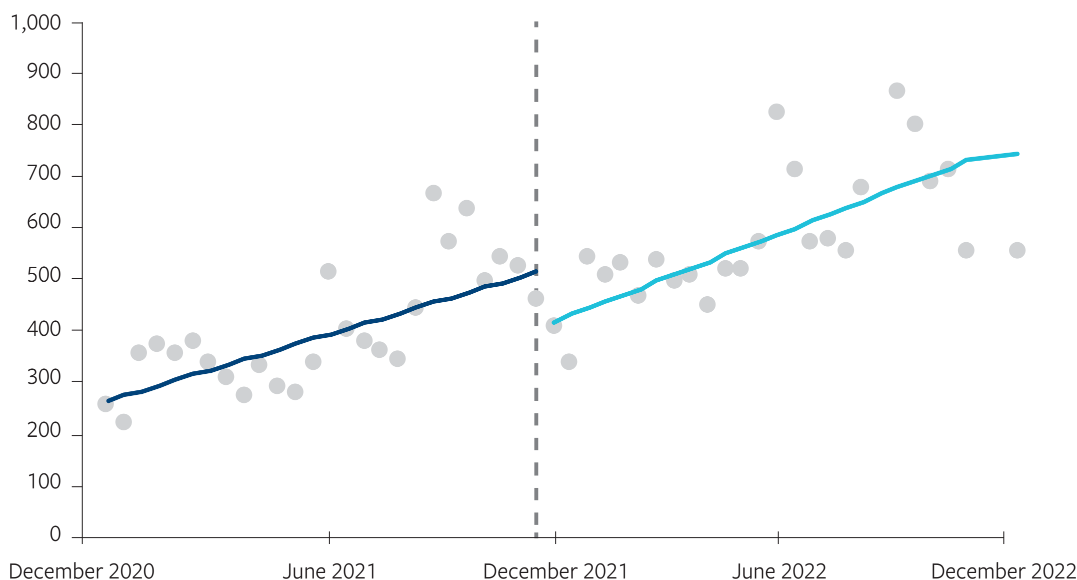
In 2022, the CDC program averaged 600 new families every two weeks, compared to 400 in 2021.

observed, these two lines differ drastically for 2022, indicating a severe shift in enrollment rates.

Not only was the increase in enrollment significant, but it brought the CDC-program enrollment back to pre-pandemic levels. The increase following the change to 200% of the FPL and the decrease during 2020 reflect each other. Equivalence testing validates this, as the absolute value of both were found to be equivalent.

On a county level, this rebound resulted in an average of four new cases per county per CDC pay period in 2022. Twenty-one counties had a significant growth in number of recipients, while 14 counties' enrollment declined. Saginaw County was by far the most productive county, as it gained as many as 11 recipients per month, while on the other extreme, St. Clair and Bay Counties lost about two cases each per month.

Figure 2: Bi-Weekly New CDC Enrollment for 2020 and 2021



In 2022, the CDC program as a whole averaged 600 new families every 2 weeks. This is an improvement over 2021, which had averaged 400 new clients every 2 weeks. In addition, the rate of growth increased by 13 families on average every payment period in 2022, compared to 2021 when the increase came as 10 new families every 2 weeks.

Income and family-size information is limited; therefore, it is hard to tell how many of the families that enrolled following the increase have income between 185% and 200% of the

FPL; however, the rate of increased growth is a good indicator that at least some families were newly eligible.

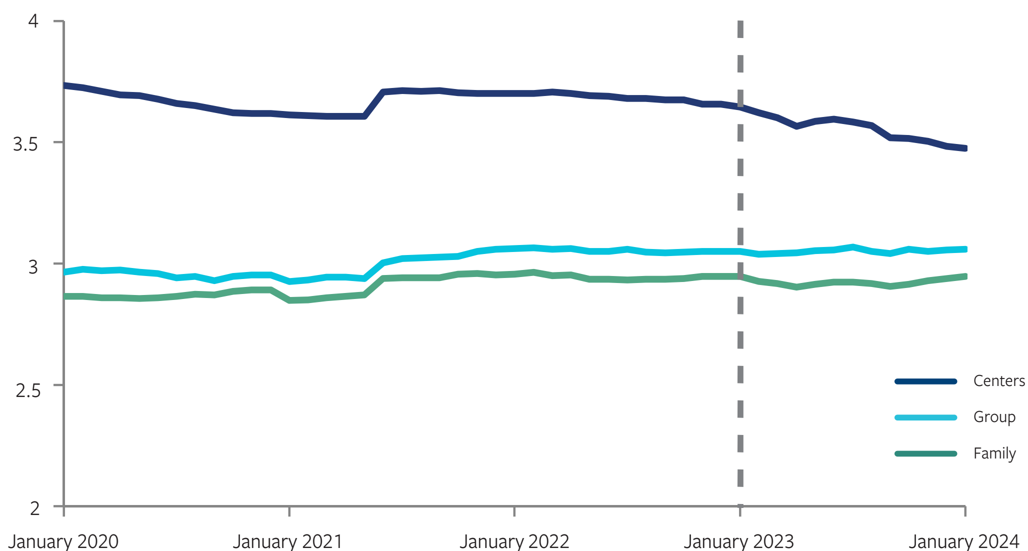
More Black families enrolled in the CDC program after the threshold moved to 200% of the FPL than other racial/ethnic groups.

Black families benefited far more than any other racial category, resulting in a net enrollment of over 200 Black families each month. For reference, white families were the next largest at 95 families, which appears to be a proportional rebound, given the difference on impact following the pandemic. From January through December 2020, enrollment of Black families dropped 31% from over 13,500 children to just under 9,400, while white enrollment decreased by 22% from 9,500 to just above 7,300. This is a statistically significant difference. This result is positive, as Black families were hit the hardest by the shutdowns of businesses and services in 2020.

Awareness of the threshold change among providers was high.

Most providers interviewed (81% of the 48) learned about the threshold increase prior to the interview via letters, emails, meetings, or direct contacts with staff from GSQ. Less commonly, they learned about it from provider-oriented social media, the Michigan Department of Licensing and Regulatory Affairs, and local public agencies. When asked their opinion about the information they received, most providers found the information satisfactory, informative, and easy to understand.

Figure 3: Average Great Start to Quality Level by Provider Type



The threshold change did not affect provider quality accessible to families.

The quality levels of the provider programs, as assessed by the GSQ system, were mostly consistent pre- and post-policy change. Home-based providers' (family and group licenses) quality levels were stable.

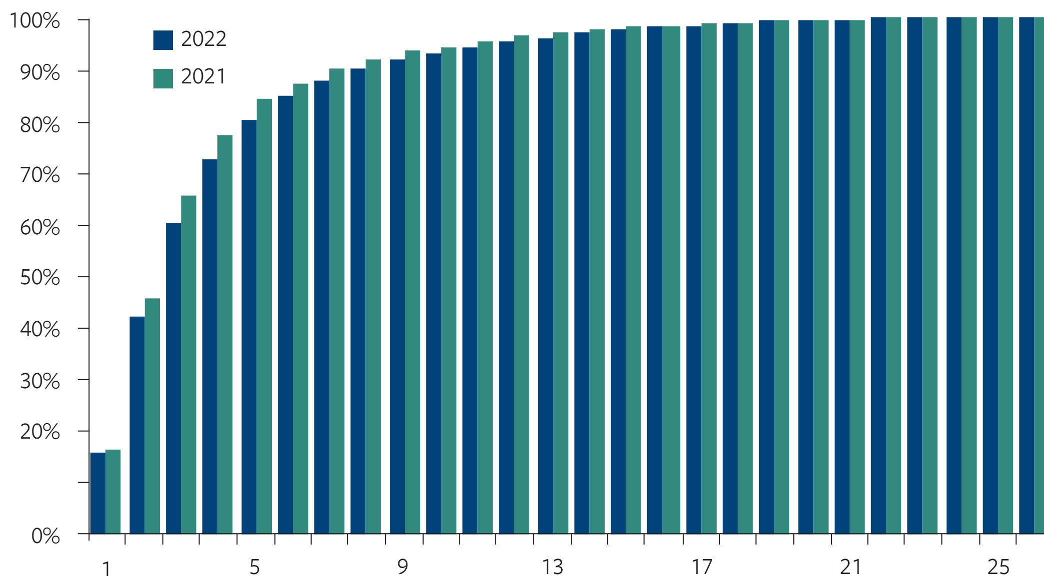
Impact on Families

Families did not change in their patterns of subsidy usage before and after the introduction of the eligibility-threshold change.

Two payment periods (or four weeks) was the median amount of time it took a family to start using their subsidy in 2022. This is the same as it was for 2021, and each year since 2017. In 2022, it took three payment periods for 70% of users (who eventually would use their subsidy), while in 2021 it took four payment periods. These differences are minimal and might be a result of a time bias caused by the data. For this analysis, the administrative data ended in December 2022, which means that those who started with the program in 2021 had more opportunity to have a recorded use further in time than those who were first authorized in 2022. These cases are outliers, so in terms of median they do not have much impact.

Limiting analysis on usage within the same calendar year to control this bias showed very similar results. No meaningful difference exists in the time a family would first use their subsidy between threshold changes. This appears to be true for geography and race/ethnicity as well. There is not much measurable improvement that can be made since 50% of participants that use the subsidy did so within the first month. Any signs of improvement would likely have to come in reducing the outliers or helping those who never use the subsidy to do so in a reasonable amount of time.

Figure 4: Number of Biweekly Payment Periods Families Took to Use the Subsidy Within the Calendar Year



The eligibility-threshold change did not have a significant effect on program persistence or continuity of care.

Families were slightly less likely to leave the CDC program in 2022 than they were the previous year. This effect, however, is minimal; families were only 10% more likely to continue enrollment in the program following the new threshold than they were in the preceding months. This slight change might have more to do with more job stability than with anything about the program itself as Michigan saw labor turnover rates fall from 8% in 2021 to 6% in 2022. However, Black families were 10% less likely to drop out after the eligibility change than white families. Black families had a larger drop-off in CDC enrollment during the pandemic, so the increase in program persistence helped bring them back to 2019 levels. No significant differences existed for Asian, American Indian/Native American, multi-racial, or Hispanic families.

In addition, families utilizing the CDC subsidy for the first time were not any more likely to take a break from or change providers following the threshold increase than they were before the increase while controlling for race, income status, and child age. This impact did not differ for families of different races, nor did it appear to differ for families based on need reasons.

The racial gap in access to quality care through the CDC program is closing since the threshold change.

CDC-participating Black families were more likely to have children at higher-rated programs following the policy change than before. Black families were still significantly more likely to have providers with lower ratings than white families, but the averages have started to converge, closing a quality-care access gap. No other racial group saw any significant differences in quality of the provider due to the eligibility-threshold change.

About two-fifths of the providers interviewed reported new families receiving CDC assistance after the eligibility-threshold change.

Slightly under half of the providers (44%) reported that families had joined the CDC program as a direct result of the threshold increase. By contrast, only about one in six providers (17%) saw no apparent effect.

"[The threshold increase] helped me [as a provider] … because the stabilization grant was great, but that's not forever. [With more families coming to me with assistance] then I can … make sure that my workers can keep their raises and keep them happy … it helps me to buy more things for the daycare and put towards my business and takes the pressure off of everyone, pretty much." – Participating Provider

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Providers thought that families benefited from the threshold increase.

Providers were asked how the threshold change was impacting families in their care. The most prevalent observed impact on families, noted above, was that more parents qualified for CDC as a result of the threshold change. Five providers (14%) reported that families were able to use more hours of care because of the change.

On the other hand, one in six providers (17%) stated that the higher threshold was still too low to meet the level of need. Smaller numbers of providers reported that more families might qualify for their care, that more families had applied for CDC assistance, or

that families they worked with had incomes that were below the previous threshold and were therefore not affected by the increase.

“I had a single parent that had three children, and for some reason she didn’t qualify for daycare help for many years, and I talked her into applying again after I heard about [the threshold increase], and she qualified, so that was a big blessing to her.”
– Participating Provider

“I actually passed that information [about the threshold change] on to one of my families in particular because she’s a single mom … and she still was not eligible. I know she makes a half-way decent [wage], but … in today’s society with the cost of rent being so high, to afford rent and a car payment … she’s really struggling financially.”
– Participating Provider

The eligibility-threshold change did not alter the level of quality of provider CDC-participating families received in 2022.

This policy-change goal was to increase enrollment. However, with any change comes the risk of unintended consequences, so it is important to measure other aspects of the child care market, to make sure there were no negative impacts. One such aspect is provider quality level, which is an important metric to ensure that new and existing enrolled children have access to high-quality providers. To measure this, the research team examined the GSQ levels of the CDC-participating providers. The GSQ reports the progress of licensed providers’ quality improvement over five levels, from Maintaining Health and Safety to Demonstrating Quality.

Awareness of the eligibility-threshold change was low among the parents interviewed.

About a quarter of the parents in subsidy-utilizing family interviews (23% of 48) had heard of the eligibility increase prior to the interview. Most of these parents had learned of the increase through correspondence from a State agency or directly from their eligibility specialists. Emails or other correspondence were parents' primary way of hearing about the policy change, followed by providers, eligibility specialists, television news, or when they applied for the program. Only 7 (14%) of the 48 non-subsidy-utilizing family interviewees knew about the eligibility-threshold increase prior to the interview.

"Previously, I did not qualify because they said that I made too much money, and so I didn't qualify for any assistance, but when they did raise it, I was able to get the assistance." – Non-Subsidy-Utilizing Parent

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Parents who had used the subsidy were more likely to say the eligibility threshold would affect their career or education decisions than parents who had not used the subsidy.

Almost half of the parents from the subsidy-utilizing family interviews (48%) said they had considered or would consider changing their career or education decisions so they could earn more, based on their knowledge of the threshold increase. Of the 40% who would not consider making a change, typical reasons included being satisfied with their current job or education, already having career plans laid out, or still being below the original income threshold.

"[The threshold increase] works for me because … since I'm a single parent and I'm the only provider [head] of the household, it gives me an opportunity to be able to do more, do better, and try to excel within the company and make more money, but not have to fear losing the child care [assistance] because [child care is] super expensive."
– Subsidy-Utilizing Parent

"They told me that I made too much money [to qualify for CDC] in the past. But this year, [I found out] that it was raised, and I'm like, "Okay, I'm going to try this again, see if I can get [approved] this time."
– Subsidy-Utilizing Parent

The non-subsidy-utilizing parents were also asked if their decisions regarding jobs or education might change now that they knew about the higher eligibility threshold. However, 95% said nothing would change about their plans because of the eligibility-threshold increase. For example, one parent explained that: “At that time, I was just starting school back up again, so I knew my income wasn’t going to be a huge issue. … I knew I’d hopefully get help just from not being able to work, being a full-time student.”

Eligibility Specialist Perspectives

Many eligibility specialists could not speak to the effect of the eligibility-threshold change on their clients.

A large proportion of eligibility specialists each year of the study reported “don’t know” when asked questions that pertain to their clients’ experiences with the CDC program, and 2023 results followed that pattern. In 2023, 44% of specialists reported they did not know if policies were well communicated to clients. When asked how clients would react to changes, they generally chose not to speculate. That said, specialists overall believed that the policy change did make it easier for clients to achieve financial stability (84%), remain with their provider of choice (84%), and access child care (70%).

Eligibility specialists doubted a temporary threshold change would impact child care accessibility or retention in the CDC program.

For the most part specialists believed that the temporary nature of the threshold change (as it was understood at the time) would have no significant impact on availability and accessibility of child care, nor retention in the CDC program. Eligibility specialists felt that they could say more about why a client might not use the subsidy after approval, but they were split as to the main causes. The specialists reported that finding child care was the biggest challenge.

Conclusions

Based on the outcomes from the data collection and analyses conducted, the increase in eligibility threshold to 200% of the FPL had some positive effects on program enrollment and family access to quality child care.

The first hypothesis was supported. The increase in income eligibility in November 2021 was associated with higher rates of participation in the CDC program than in

prior periods. Administrative data showed an increase of enrollment rates following the eligibility change. While talking to providers, 44% indicated that the increase directly caused new families to join, and only 16% saw no effect. While less than a quarter of the parents interviewed had heard of the threshold change, not all of those were new to the program so could not be expected to represent new enrollee motivations.

The second hypothesis was not supported by the evidence. Clients who are approved for the subsidy program after policy changes were not more likely to participate in the program, or to do so after a shorter period of time than clients prior to policy changes. There was no relationship between how long it took a family to start using the subsidy and when they were approved for it. Likewise, there is very little association with the time a family receives subsidy approval and whether they ever use the subsidy.

The third hypothesis about the eligibility-threshold change was supported for one racial/ethnic group: Black families. Policy changes were associated with more equitable outcomes for this group, but not for other groups or across geographic regions. Enrollment rates of Black families increased more than white families following the threshold increase, and so did their ability to stay with their provider of choice. This points towards more equitable outcomes, as Black families were more impacted by 2020 pandemic-induced economic hardships, leading to program enrollment and persistence declines.

In addition, while many parents were not aware of the change, providers were well-informed and able to help connect families they worked with to consider the program, as appropriate. For parents who were aware of the increased threshold, some saw it as an opportunity to accept a raise and/or seek further career opportunities.

Policy Implications of Increasing the Eligibility Threshold to 200% of the FPL

Based on the provider and parent interviews, eligibility specialists survey, State agency policy coordination self-assessment, and the administrative data results, the research team found that the impact of the eligibility-threshold increase was small but significant.

Increasing the threshold had obvious cost implications for the State. However, although enrollment increased as a result of the change, the numbers were not higher than pre-pandemic, avoiding an overstretching of program resources. Nonetheless, the change

was intended to help many more families afford child care and there remains a risk that more families will qualify than budget allows. Having a waitlist, as some states do, is not an attractive option in Michigan, according to State partners, since it creates added administrative work and leaves some families wanting.

The eligibility specialists on the whole believed that the CDC program and threshold increase helped families, but they also worried about increased workloads due to more families being eligible. The specialists pointed to CDC specialization in each MDHHS office as helpful for the general workflow as the utilization of CDC increased.

In addition, an increase in the eligibility threshold raised concerns at the state level about how it affected the graduated exit policy, since now the distance between the final eligibility level after enrollment and the point where a family could no longer receive assistance closed. The graduated exit policy helps to prevent a "benefit cliff" when families increase their earnings. There are ongoing discussions within the program about if and how to adjust the number of steps from income eligibility to exit to minimize financial shocks for families.

The study results also suggest that reaching potentially eligible families, even when the State ran an outreach campaign, is difficult and more may be needed over a sustained period to bring more families to the program. Additional education of parents about the graduated exit policy and how income changes affect their eligibility and family co-payment may also help support families as they try to balance career or wage advancement with affording the child care necessary for them to work.

This particular policy change capped (at least for now) a series of four threshold increases over five years in Michigan. Although federal recovery funding spurred this and other policy changes, the move to 200% of the FPL demonstrated a strong commitment within the State to increase access to quality child care, which came with some resource demands. This commitment is also strong in comparison to other states; according to the Office of Child Care at the Administration for Children and Families (2022), only 11 states had a CCDF eligibility threshold above 100% of the FPL at the end of fiscal year 2021. The eligibility threshold remains an important gauge of child care policy direction.

STABILIZATION GRANTS

The stabilization grants served as a major financial boost to licensed child care providers over 2022 and into 2023. Through the study analysis, the research team examined how these grants affected provider supply, equitable access to quality care, and the continuity of care for CDC-participating families.

Hypotheses

The research team explored the following hypotheses about the stabilization grants:

- Providers receiving child care stabilization grants will be more likely to have families with CDC assistance and greater continuity of care than in prior periods.
- Policy changes will be associated with equitable outcomes among key demographic subgroups and across geographic regions.

Data Sources

To examine the effect of the stabilization grants on child care access for CDC-participating families and on the program overall, the researchers looked again to the policy coordination self-assessments, provider interviews, and administrative data (see Table 3 below). Parents were not asked about the effects of the grants because it was expected that they would only be likely to hear about the grants second-hand through the providers, if at all. The MDHHS did not have involvement with the grants. Therefore, the eligibility specialists survey did not ask about the grants.

The grants were issued by the State in three rounds, with different applications for each round. Here, analysis is limited to just the spring and summer grants of 2022 since the first wave occurred in fall 2021, outside the scope of our analysis period. Also note that due to the timing of the summer grant, all analysis that includes CDC participation data is limited to the spring grants. For more details about the statistical analyses performed, see the Methodology appendix.

Table 3. Stabilization Grant Data Sources and Uses

METHODS AND DATA SOURCES	USE IN THE STUDY
Administrative Data (2022) – Bridges, GSQ, stabilization grant records	Grants awarded by county, type, and season; demographic characteristics of families of the awarded versus the non-awarded; enrollment for providers with and without the grants; provider characteristics
Provider Interviews (2023)	Awareness of policy; impact on providers; observed impact on families

Over 5,800 providers received at least one of the summer or spring stabilization grants

$530 million was distributed to licensed providers

Figure 5: Percentage of Grants Awarded by Type of Provider

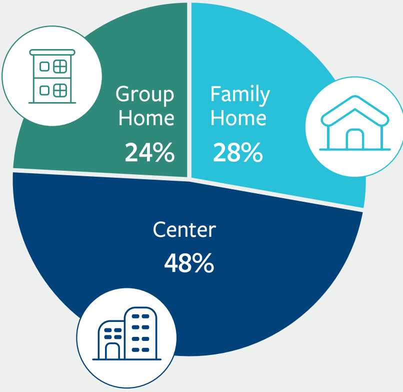


Figure 6: Percentage of Each Type of Provider Funded

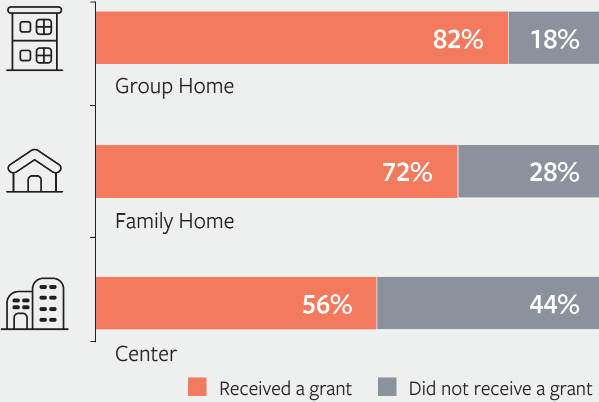


Figure 7: Percentage of Grant Dollars Issued by Provider Type

Figure 8: Average Grant Amount by Licensed Slot for Each Provider Type

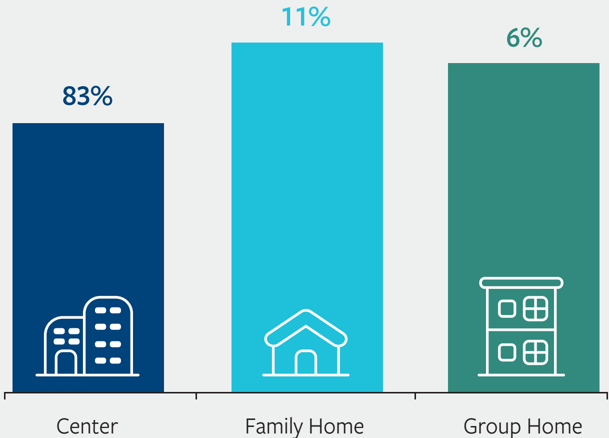
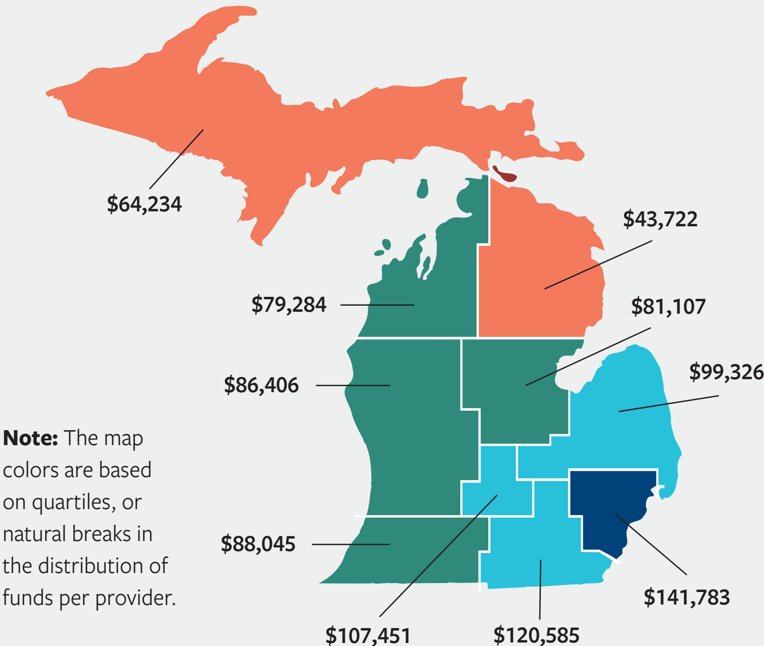


Figure 9: Combined Spring and Summer Stabilization Grant Funding Per Provider by Prosperity Region



Note: The map colors are based on quartiles, or natural breaks in the distribution of funds per provider.

Impacts on Providers

CDC-participating providers were equally likely to receive a stabilization grant as non-participating providers.

The stabilization grants reached many of Michigan's licensed child care providers. Most grant recipients received funding in both the 2022 spring and summer rounds (71%). Providers who received grants and those who did not were proportionally equivalent in terms of geography, provider type, and CDC–participating family demographics. Providers with grants served an average of 2.1 children with CDC assistance per month in 2022 and had 10 times more children with CDC assistance per month than those who did not receive a grant.

Centers received most of the stabilization grant funding, but more of the state's home-based providers received the grants.

Centers received an overwhelming majority of the dollars given out by the stabilization grants (Figure 7). On the surface this first appears to be an unfair distribution, as centers only constituted 57% of all licensed providers in Michigan during 2022. Centers, however, care for far more of Michigan's children than home-based providers. Exact enrollment numbers are unknown, but it appears that the number of dollars were distributed fairly on a per-pupil basis. While accounting for child care capacity (the largest number of children they may legally take care of at once), center-based child care providers received fewer funds by capacity than home-based providers (Figure 8).

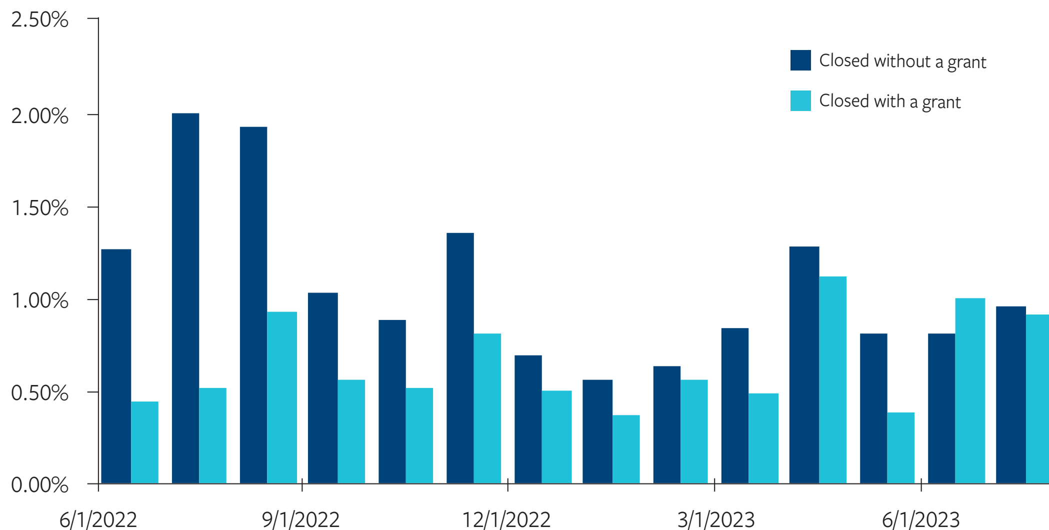
Forty-eight percent of the number of grants given out went to centers. This is the largest of the three types of licensed providers, but it means most of the grants went to home-based providers (family- and group-home providers combined) (Figure 5). On top of that, much larger proportions of home-based providers were funded than centers. A little over half of the state's child care centers were awarded a grant in either the spring or summer round, but just under three-fourths of group home providers and just over four-fifths of family home providers were awarded funding (Figure 6). This means that even though centers received more grants than either family or group providers, any given home-based provider was more likely to be awarded a stabilization grant than any given center.

The number of grants given to each region aligns with the number of providers in each Prosperity Region.[5] The metro Detroit area received 30% of the number of grants, as they had the most licensed providers and children in the state. Approximately 60%-70% of each of the Prosperity Regions' licensed providers receive stabilization grants, ranging from the Upper Peninsula (61%) to South Central and East Central (72% each).

Providers who received a stabilization grant were less likely to close, although regional effects varied.

When controlling for region, time in operation, and provider type, licensed providers who did not receive the funding were around three times more likely to close between the months of June and December 2022, than those who did receive funding. However, as time went on, this impact lessened. After just a few months, the impacts quickly decreased, and by a year out, the closure rates of those who received funds and did not were practically the same. This follows the economic theory of a lump sum or one-time payment. With a lump-sum payment, it is expected that the boost seen will also be one time and the effect will not hold; it will just give a temporary reprieve. Creating a change in a long-term trend would either need a structural change or continuous subsidization.

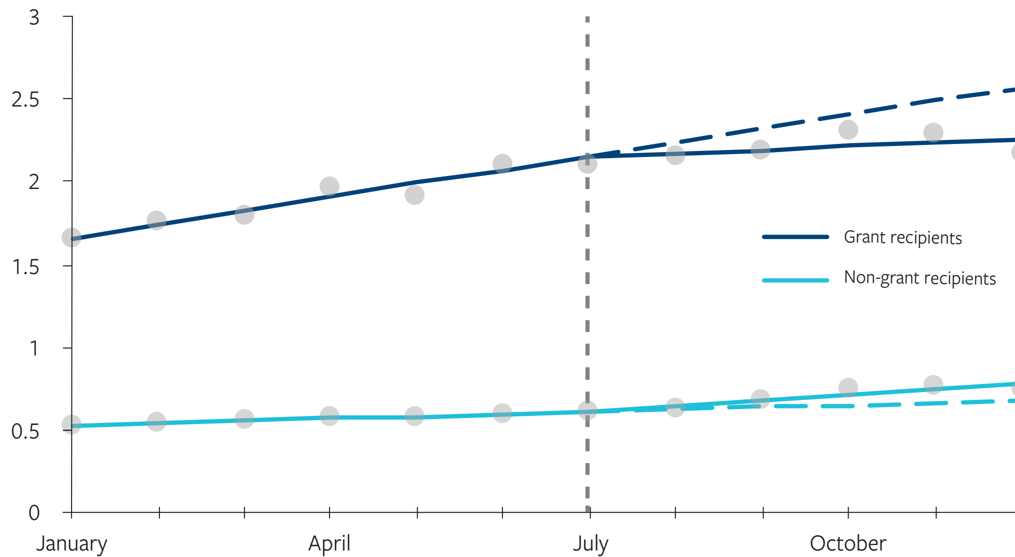
Figure 10: Monthly Grantee and Non-Grantee Provider Closure Rates



5 The Prosperity Regions are State of Michigan-designated areas with shared economic development interests. Michigan has 10 Prosperity Regions.

The impact of the grants appears to have been strongest in the Metro Detroit and Western Prosperity Regions, as providers there were about three times more likely to stay open if they received a stabilization grant. Meanwhile, providers who received the grants in the Upper Peninsula, Southwest, and Southeast regions did not fare any better than those who did not receive a grant.

Figure 11: CDC Clients Per Licensed Provider Per Month, 2022



Providers with stabilization grants served more children with CDC assistance on average.

In 2022, providers who received grants, on average, cared for over 11,000 CDC-participating families each month compared to just 460 by those who did not get a grant. This large difference continues to be true while controlling for number of providers (averaging 2 CDC-participating families per provider each month in 2022 versus 0.2 for other providers) in each of the two categories and licensed capacity, or the largest number of children a provider can care for at a time (.04 children with CDC assistance per licensed slot each month versus .004). Those who did not receive grants did not serve many families that had a subsidy. This might explain why many did not receive the grants to begin with, since caring for children with the CDC subsidy was one of the main ways a provider could be eligible for grants.

However, inexplicably, those providers who received a grant in the spring round leveled off in their enrollment of CDC-participating families, while those who did not receive a grant

had a slight uptick in the number of families with a subsidy. Grant recipients collectively gained 550 additional CDC families each month from February through June, but only 50 each month from July through December. Meanwhile those who did not receive grants went from collectively losing 18 CDC-participating families a month to gaining 50. Those who did not receive the grants still served far fewer families who used the CDC subsidy compared to the grant recipients by the end of the year.

Family-home providers saw a slight decline in Black families with assistance during the second half of 2022.

The number of CDC-participating Black families using family-home providers decreased by about 20 families from June to December 2022. This itself is a small number, but this is in contrast with a monthly increase among these families of about 30 each month from January to July 2022. The cause of this shift is unknown.

Few Prosperity Regions saw significant gains in CDC-participating family enrollment following the stabilization grants.

Some regions had modest gains of up to 100 more CDC-participating families enrolled with grant-receiving providers, despite a statewide leveling off in CDC enrollment, but most regions remained stagnant from June to December 2022. Providers with grants in the Upper Peninsula and the Northwest Prosperity Region gained about 50 more CDC-participating families each, while those in the South Central region gained about 100 families. No other Prosperity Region had a statistically significant growth in families with assistance among grant recipients.

Providers were well-informed about the stabilization grants.

Not surprisingly given the large-scale participation in the grants by Michigan's licensed providers, nearly all providers interviewed (92% of 36) expressed awareness of the grants in the interviews. As with the eligibility-threshold increase, the key source of information about the grants was the regular communication they receive from GSQ, including emails, letters, meetings or conference calls, and individual staff communications. Provider-oriented social media outlets were also a prevalent information source. Most providers (67%) considered the communications informative, easy to understand, and satisfactory. However, slightly less than half of the providers (44%) felt the communications came in a timely manner, indicating room for improvement in the timeliness of communications.

Providers reported investing primarily in their staff and facilities with the grant funds.

The grants had significant short-term impacts for providers, their staff, and their businesses. Over half (53%) invested in their staff via wage increases, bonuses, or new hirings, with corresponding impacts on retention and morale. Slightly fewer than half (44%) invested in facility renovations or equipment upgrades. Smaller numbers of providers invested in sanitation equipment or supplies (19%) or reported that the grants provided financial security to help them stay in business (17%).

"[The grants were] incredible because I was having so much trouble hiring people. And I wasn't able to take kids on because I didn't have the staffing. So, we were able to give $500 incentives or if they were full-time, $1,000 incentives." – Provider

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"I would say that [the grants] greatly helped my business because I was able to do a lot of things with the grant that I wouldn't have been able to do without it. A lot of improvements of new items for the daycare, new areas for the daycare, and that kind of thing." – Provider

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"[The grants had] a very big impact and it really kind of took some weight off your shoulders being newly open to thinking are we going to be okay? And then, those grants came around and they were very helpful, very helpful." – Provider

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Providers had few negative comments about the grants.

A few providers expressed complaints about the grants. Five (14%) noted that the grants were taxed as income, diluting their impact. Smaller numbers of providers stated that the covered uses of the grants were too restrictive, too much paperwork was required, their

staff thought the grants were permanent, and that some staff took their grant-funded bonuses and immediately left.

"The stabilization grant was—that's what saved our business, let's be honest." – Provider

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Impacts on Families

Administrative data analysis did not show conclusive evidence of better continuity of care with the stabilization grants.

Given that providers that did not receive the grant did not serve many CDC families, it is hard to tease out the effect of the grants on retention. Inference testing did not show any meaningful change in families' ability to stay with their providers, but that lack of difference could very well be the result of not having sufficient statistical power (i.e., not enough families using the subsidy at providers who did not receive grants). Providers without grants were more likely to close overall.

Providers reported passing along the benefits of the stabilization grants to families in the form of tuition relief, new equipment and supplies, and other offerings.

The providers observed numerous positive impacts of the grants on families. More than half (58%) used the additional resources to give families tuition relief or other coverage of child care costs. Close to one-third (31%) used the funding to buy supplies, food, or toys for the children. Others (22%) purchased programming, educational curricula, or books, and a similar proportion reported that the grants gave parents peace of mind about the stability and quality of the care they were receiving. Smaller numbers of providers reported that they were able to undertake renovations, offer smaller staff ratios, provide transportation, or not bill for absences.

"If we didn't receive those stabilization grants, obviously, we would have had to raise tuition in an already hurtful situation." – Provider

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"After receiving these stabilization grants, we've been able to go above and beyond making sure each classroom has the materials that it needs, and we were lacking a lot of things just because the funding wasn't there." – Provider

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Conclusions

The results from the administrative data and provider interviews showed that the stabilization grants had positive effects for providers' financial viability and overall access for families with assistance.

The first hypothesis stating that "Providers receiving child care stabilization grants will be more likely to have families with CDC assistance and greater continuity of care than in prior periods" was supported for the prevalence of families with assistance but not supported for greater continuity of care. Providers who had received stabilization grants had about three times more CDC-participating families than providers without grant funding. No definitive conclusion was drawn about whether families in subsidized facilities were more or less likely to stay with their provider. Although, these providers were about three times less likely to close, so it is safe to assume that it prevented a fair number of families from searching for a new provider.

The second hypothesis, "Policy changes will be associated with equitable outcomes among key demographic subgroups and across geographic regions," was supported. Overall, the grants were proportionally distributed among the Prosperity Regions and by the demographics of families with assistance. Likewise, the effects of the stabilization grants were mostly consistent by geography and race/ethnicity.

In addition, the study found that providers with grants were significantly more likely to remain open, and providers reported that families benefited from the grant funding directly (e.g., tuition rates) or indirectly (e.g., staffing).

Policy Implications of the Stabilization Grants

Nationally, the stabilization grants helped child care providers to stay open and continue to serve families and children (Office of Child Care, 2023). For families in Michigan, the

ability of providers to use the grant funds for a range of purposes, including materials and staffing, supported efforts to deliver quality programs. This reinforced the state's focus on continuous quality improvement, alongside significant changes to its GSQ system.

The grants also provided immediate and significant benefits for both providers and families, helping both groups cope with the rising costs of living in general and of child care in particular. At a time when providers struggled to retain staff and keep their doors open, the grants improved their financial stability. Given the continuing upward pressure of wages and inflation, together with the ongoing need for equitable early care and education for Michigan children, the boost prevented dramatic loss of child care supply. However, as the grants were time-limited and lump-sum, again the State faces a substantial shortfall in funding to support quality care on par with what it costs to deliver high-quality care.

Some other states issued monthly payments rather than a lump-sum approach for the stabilization grants. It could be that some states paid out the stabilization grants monthly rather than in lump sums like Michigan. The way the grants were issued may have had different effects, or possibly longer-term impacts (e.g., sustained staff wage increases), than those seen in Michigan.

Although centers received more dollars of funding than home-based providers in total, a much larger proportion of the state's home-based providers were funded than centers. Home-based providers remain important to a mixed-delivery system. Michigan has pursued business development and support strategies for these providers, such as Caring for MI Future and Family Child Care Networks. These types of strategies are critical to building and maintaining supply. At the same time, federal and state investment in strategies to address pervasive issues like low wages and benefits for child care workers is uncertain. As noted in the President's Council of Economic Advisors' (2023) analysis of the federal stabilization funds' economic impacts, the benefits of the investment outweighed the cost by 2 to 1. This report estimated that the grants led to a 7% increase in workers, a 16% increase in child care workers' wages, and a 5% increase in labor force participation among mothers of young children. Furthermore, the report found initial indications of a reversal of the increase in labor force participation after the grant funding expired.

Recommendations

Recommendations

Based on the results described in this report, the research team suggests these policy steps to continue to facilitate equitable access to quality child care in Michigan, particularly through the Child Development and Care (CDC) program.

- Maintain the CDC eligibility threshold at no less than 200% of the federal poverty level. Increased eligibility is responsive to the ongoing child care affordability issue.
- Examine how the graduated-exit levels correspond with the increased eligibility threshold and the effects for CDC-participating families in the context of federal regulations and State goals to avoid a benefit cliff and promote family economic stability.
- Build communication strategies to more effectively reach families who might be eligible for the CDC program across the state.
- Devise sustainable funding to support child care business viability, including situating the state's mix of licensed providers to deliver on PreK for All expansion and filling the financial gap left when four-year-olds move out of the care of provider programs to Great Start Readiness Program slots. Providers overall remain in precarious financial positions.
- Continue to invest in expanding the number of licensed Michigan child care providers needed to meet demand, including home-based providers. The number of providers increased in 2023 for the first time since before the pandemic; however, the gains were modest. Child care is a critical precursor to parental employment.

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APPENDIX A

Methodology

Appendix A: Methodology

SECONDARY DATA

Case-Level Analysis

The research team from Public Policy Associates (PPA) drew case-level Child Development and Care (CDC) program participation data from 2013-2021 administrative data held by the Michigan Department of Health and Human Services (MDHHS). The research team measured participation by payments to providers by two-week interval payment period and used unique parent, child, and provider IDs to indicate whether payments were made at any point in each calendar year. The research team excluded from the dataset children who attended multiple providers in the same pay period. The team grouped all license-exempt providers (including tribal providers) into the license-exempt category.

Trend Analysis

A trend analysis was run in the aggregate for families, children, and providers, as well as by provider type and by race/ethnicity. The team identified participants as “new” if they were not associated with any payments in prior years (back to 2013), and as “exited” if there were no additional payments in future calendar years (through 2022). Provider quality ratings were standardized to a pre-2022 Great Start to Quality (GSQ) star-rating measure. In cases where ratings were compared between years, providers with a rating of one star were dropped, due to the way the new system rated previously unrated providers. Provider-level data including location, quality rating, child capacity, and provider type was provided by the Early Childhood Investment Corporation (ECIC). Data on who received the stabilization grants was provided by the Michigan Department of Education, Office of Great Start (MDE/OGS).

Survival Analysis

The research team analyzed CDC program retention and families’ ability to remain with their providers using survival analysis. In both the family-based and child-based analyses, a randomly selected focal child represented each family to avoid biasing the results in favor of large families. The team employed a first-spell cohort design, with breaks requiring two consecutive pay periods (or four weeks) without a payment to providers.

Regression Analysis

Quality-of-care analysis used child-level data (again restricting the sample to focal children). Logistic regression analysis measured whether the child was in a child care program with at least one star at any point in the calendar year. These models included county fixed-effects, provider type, whether the parent reported any income (the modal category for the entire year), Hispanic, and non-Hispanic Black as controls. The calendar year served as the main independent variable, comparing all first-time spells in 2022 to those in 2021. The research team evaluated substantive significance using equivalence testing, with a TOST procedure. A .20 effect-size threshold was employed, which is equivalent to a 1.42 odds ratio and a 1.29 hazard ratio. Average star ratings of providers attended utilized Poisson and Ordinal regression techniques as well as standard regression methods to determine the differences of star-rating attendance between years.

Interrupted Time Series Analysis

On the aggregate level, interrupted time series analyses were conducted to determine the annual differences of enrollment rates and provider rating levels. Breaks were set on the first pay period of the year, and significance tests of slopes were compared across years to determine meaningful differences. Enrollment rates were broken down by race and county. Quality rating was disaggregated by provider type as well as prosperity region. The statewide program enrollment models were tested with standard deviations clustered at the county level. A TOST procedure was conducted to determine whether absolute values of enrollment rates of the 2020 and 2022 slopes were equivalent.

Data Limitations

The results should be interpreted with some caution. First, the findings may not be generalizable to all families because (a) each analysis primarily focuses on specific times between 2021 and 2023, 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.

Baseline equivalence between those who did and those who did not receive stabilization grants was conducted to ensure that comparison would be apt. Excluding the number of CDC clients served, the two groups are equivalent in geography, CDC client demographics, and provider type. Due to extreme overlap of the two grant rounds that

were processed in 2022, those who received at least one were combined into one group for analysis. Logistic and Cox regressions were utilized to determine likelihood of provider closure by type. A closure was defined as a provider either identified as closed in Michigan Department of Licensing and Regulatory Affairs databases, or no longer appearing in monthly datasets provided by ECIC. Logistic regressions measured whether a provider closed at any point from July 2022 to October 2023 and Cox regressions measured time to closure during the same period. These analyses used provider type, region, and duration of business operations as covariates.

Analysis in which a comparison of children's ability to remain with their provider between those who received stabilization grants and those who did not was run using Cox regression and a TOST procedure to determine equivalence as well as traditional statistical inference testing. CDC enrollment for those at grant-receiving providers utilized an interrupted time series design. In both cases, July was identified as the intervention date, with receiving a grant identified as the treatment. Due to the limitations of data, analysis only spanned until the end of 2022, which set a limited time to see effects. Child continuity used provider type, parent county, and race as covariates. The enrollment models were broken down by prosperity region, race, and provider type.

Moreover, demographic information of children and families at child care providers is limited to that of authorized subsidy users (as defined by provider billing), and limited to 2022 in this report unless explicitly compared to previous years. Providers serve a wide demographic of children, so it is possible that the general clientele of providers who were provided grants (or not) differ from CDC users. Not all families served by the providers who received stabilization grants received CDC assistance, and not all providers who received a grant participated in the CDC program in 2022.

Provider selection for the stabilization grants was based on need, so an experimental design was not possible. Analysis is, therefore, limited to observational analysis instead of causal since the grants were distributed to all who qualified; causal conclusions cannot be drawn. In addition, there are inherent selection and survivorship biases to who would choose to apply for the stabilization grants, which might have further influenced the outcomes. Due to the overlap between the summer and spring grants, as well as the close timing of these rounds, most analysis and inference testing conducted combines the effects of both grants, meaning receiving either grant is identified as the treatment,

and making parsing out the impact of each individually impossible. Finally, it is possible further impact of the grants on CDC outcomes exist for 2023; however, due to data limitations, they are unknown at this time.

Also, readers should be aware that tribal providers are excluded from analysis due to inconsistent linkage from license numbers. Licensed Out-of-School-Time providers are included in the large totals and ITS analysis, as some did receive funding, but are not in the logistic and individual-level analyses due to incomplete data records of sites. Analysis is limited to licensed providers. The research team excluded the approximately 2,000 license-exempt providers working with CDC-participating families in 2022.

PRIMARY DATA

Policy Coordination Self-Assessments

Two state agencies coordinated to implement the CDC program in Michigan—the Department of Education/Office of Great Start (now the program is housed in the Michigan Department of Lifelong Education, Achievement, and Potential) and the Michigan Department of Health and Human Services. 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 used 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 was also present, allowing for the possibility that a policy change was still underway and the outcome unknown.

The research team populated the tool with this year's focus policy information and verified implementation dates with the CDC program director. The tool included 15 items for each policy, 6 of which used rated scales and the others were memo fields. Items included 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.

The research team 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.

It is important to note that MDHHS is not involved in the stabilization grants, so the degree of coordination necessary for that is vastly different from the eligibility threshold.

Eligibility Specialist (Caseworker) Survey

This survey was developed in collaboration with the state agency 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. Items were based on the previous year's survey instrument, with constructs modified to address the specific policies implemented in 2023. In previous years the instruments had been piloted with a small group of eligibility specialists and revised based on their feedback. PPA piloted any questions that had been added, edited, or revised from the previous year's survey with a new group of eligibility specialists.

The final survey was disseminated to approximately 3,100 MDHHS eligibility specialists in March 2023 and the survey remained open until the end of April. The specialists were emailed an electronic link to the survey (with accompanying explanation) by the 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. The survey received 869 responses, for a response rate of approximately 29%.

Table 4. Number and Percentage of Eligibility Specialists Who Worked with CDC Clients Within the Last Year

RESPONSE	NUMBER (N)	PERCENTAGE (%)
Yes	719	83%
No	150	17%

Table 5. Disposition of Eligibility Specialist Surveys

PARTICIPANTS	NUMBER (N)	PERCENTAGE (%)
Used for analysis	633	73%
Removed because did not serve CDC children	150	17%
Removed for duplication, incompleteness, irrelevance	86	10%

Table 6. Business Service Centers of the Eligibility Specialists

BSC	NUMBER (N)	PERCENTAGE (%)
BSC 1	51	8%
BSC 2	152	24%
BSC 3	182	29%
BSC 4	247	39%

The research team ran descriptive statistics and conducted 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. It is possible that the specialists who did not respond to the survey had different views than those who did, potentially introducing selection bias.

Provider Interviews

The CDC provider interviews focused on perceptions of the two policy changes (eligibility limit and stabilization grants) and their implications for providers and the families they serve. Specifically, they were designed to gather data on how new policies are being perceived as well as current effects on provider behaviors and perceived effects for families.

The interview questionnaire contained both closed and open-ended questions. The topics in the questionnaire included participant background information, overall child care experience in 2022, CDC assistance program experience in 2022, awareness and opinions of the two policy changes, and overall perspectives on the CDC assistance program.

Before conducting the interviews, the questionnaire was pilot tested with a small subset of home-based and center-based providers to test for accuracy, respondent interpretation

and comprehension, and time to completion. Pursuant to the pilot test, the questionnaire was revised to improve the flow of the interviews and providers' understanding of the questions.

To select providers for the interviews, using the GSQ dataset, the research team conducted a random sample of provider contacts within 12 strata, with one stratum per provider type (licensed center, family home, group home) and MDHHS Business Service Center (BSC) region. To ensure an even geographic distribution, the research team selected 144 CDC-participating providers from each of the four BSC regions, for a total of 576 invitations.

Invitations were sent to providers via email, with a Microsoft Bookings link directing them to select an interview time. The research team monitored interview scheduling to ensure that the interviews reflected a range of provider types (centers, family homes, and group homes) across the BSC regions.

Out of the 78 participants who registered for an interview, 36 providers completed interviews by telephone in the months of July and August 2023. The 36 interviewees represented an even mix of providers by type and region, with 3 center-based providers, 3 group home care providers, and 3 family home care providers for each of the four regions.

Each interview lasted approximately 20-60 minutes. The interviews were recorded and transcribed using a third-party transcription service. Participants received a $50 gift card after completing the interview. The research team analyzed the interviews using NVivo software. A codebook was generated consisting of deductive and inductive codes. Due to the limited overall number of interviews conducted, as well as the potential for non-respondent bias, the results may not fully reflect the views of all providers in the state. In addition, nearly all providers (n=33, 92%) had over two years of experience working with the CDC program, so the results may not fully reflect the experiences of providers newer to the program.

The tables below provide additional information about provider interviewee demographics.

Table 7. Length of Time Providing Child Care Services

TIME	NUMBER (N)	PERCENTAGE (%)
Under two years	1	3%
2-9 years	9	25%
10-19 years	11	31%
20 years or longer	15	42%

Table 8. Length of Time Participating in the CDC Program as a Provider

TIME	NUMBER (N)	PERCENTAGE (%)
Under two years	3	8%
2-9 years	16	44%
10-19 years	8	22%
20 years or longer	9	25%

Table 9. Number and Percentage of Providers Per Business Service Center

SERVICE CENTER	NUMBER (N)	PERCENTAGE (%)
BSC 1	9	25%
BSC 2	9	25%
BSC 3	9	25%
BSC 4	9	25%

Table 10. Number and Percentage of Providers by Type

PROVIDER TYPE	NUMBER (N)	PERCENTAGE (%)
Licensed Child Care Centers	12	33%
Licensed Family Child Care Homes	12	33%
Licensed Group Child Care Homes	12	33%

Table 11. Number and Percentage of Children Providers Cared for with CDC Subsidy

QUANTITY OF CHILDREN	NUMBER (N)	PERCENTAGE (%)
1-5 children	12	33%
6-9 children	5	14%
10-19 children	11	31%
20 or more children	6	17%
No current CDC children at time of interview	2	6%

Parent Interviews

The parent interviews were conducted in two groups. The subsidy-utilizing family batch consisted of parents whose providers received CDC payments during 2022. The non-subsidy-utilizing family batch consisted of parents who were approved for CDC assistance but whose cases had no record of provider payments during 2022.

The interview questionnaire was similar for the two groups. Both questionnaires included closed and open-ended questions about demographics, general child care experience in 2022, CDC program experience in 2022, opinions about the increased eligibility threshold, overall satisfaction with the CDC program, and suggestions for program improvements. The non-subsidy-utilizing families were also asked a series of questions designed to learn why they had not used the subsidy in 2022.

The two interview questionnaires were reviewed by the state partners and then tested with a small number of parents from each of the two groups to ensure question clarity, check respondent comprehension, and verify the interview length. After the pilot test, the questionnaires were revised.

To select parents for the interviews, the research team conducted a stratified random sample of case ID numbers from the 2022 pool of participants matching the desired characteristics for the two groups, as described above. The sampled IDs were sent

to MDHHS, who emailed invitations to the parents. The invitation emails included a Microsoft Bookings link that parents used to schedule an interview at a time that worked best for them (within the bounds set by the research team).

Subsidy-Utilizing Families

The research team conducted 48 telephone interviews in June 2023 with subsidy-utilizing families. Completions were challenging to achieve; 78 parents had registered for interviews by the time the research team reached the target of 48 completes. These interviews focused on parent experiences with child care and the CDC program in 2022, as well as their knowledge and opinions of the increased eligibility threshold. These interviews lasted approximately 20-60 minutes.

Table 12. Ages of Children with CDC Subsidy That Was Used

CHILD AGE	NUMBER (N)	PERCENTAGE (%)
2 years and younger	19	21%
3-8 years	49	55%
9 years or older	21	24%

Table 13. Number and Percentage of Subsidy-Utilizing Families Per Business Service Center

SERVICE CENTER	NUMBER (N)	PERCENTAGE (%)
BSC 1	6	13%
BSC 2	12	25%
BSC 3	11	23%
BSC 4	17	35%
Unclear*	2	4%

*The BSC for two subsidy-utilizing parents could not be determined based on the information available.

Non-Subsidy-Utilizing Families

The research team conducted 48 telephone interviews in June and July 2023 with parents who were approved for the assistance but whose cases had no provider billings. Recruitment was more challenging with this group; the completed interviews followed 108 registrations for an interview. These interviews focused on parent experiences with child care and the CDC program in 2022, their knowledge and opinions of the increased eligibility threshold, and their reasons for not using the subsidy. Each of these interviews lasted approximately 20-40 minutes.

All parent interview participants received a $50 incentive from Public Policy Associates. The research team recorded all of the interviews and recordings were transcribed by a third-party service. The interviewers reviewed transcripts for accuracy and added clarifications as needed. The research team analyzed the interviews using NVivo software, and identified prevalent themes and categories within and across the groups. A codebook was generated consisting of deductive and inductive codes.

Table 14. Ages of Children with CDC Subsidy That Was Not Used

CHILD AGE	NUMBER (N)	PERCENTAGE (%)
2 years and younger	35	38%
3-8 years	44	48%
9 years or older	13	14%

Table 15. Number and Percentage of Non-Subsidy-Utilizing Families Per Business Service Center

SERVICE CENTER	NUMBER (N)	PERCENTAGE (%)
BSC 1	13	27%
BSC 2	12	25%
BSC 3	8	17%
BSC 4	15	31%