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The Interplay of Workforce Challenges and Infant/Toddler Slot Expansion in Michigan

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Introduction

Nationally, early childhood systems have high turnover and a shortage of qualified workers, which negatively affects the availability of child care for infants and toddlers. In Michigan, 58% of children aged birth to two years live where there is inadequate child care to meet needs (Michigan State University, 2025). Providers are limited in how many infants and toddlers they can care for due to adult-to-child ratio rules,[1] so opening more slots for these ages requires more staff. Additional space is also necessary to serve infants and toddlers, and costs for food and supplies are often higher. Altogether, this means that the cost of delivering high-quality infant/toddler care is more expensive than for other age groups.

Michigan has a tiered payment structure for subsidized child care that factors in the higher costs of care for infants and toddlers. It has also invested heavily over the past several years in different strategies to increase the supply of child care for infants and toddlers. For example, Caring for MI Future provided business supports, workforce development, and facility improvements (MiLEAP, 2024).[2] In another major initiative, the state piloted grant-funded slot expansion through the Child Development and

[1] In Michigan, family home providers are limited to two children under age three. In centers, the ratio is one adult to four infants or toddlers.

[2] Caring for MI Future and the Infant Toddler Pilot were funded by the American Recovery Plan Act.

Care (CDC) Scholarship program.[3] This Infant Toddler Pilot funded staff hiring and retention strategies like bonuses and wage increases, as well as facility improvements, materials that market openings to families, and equipment/supplies purchases. Providers chose how to use their grants to best meet their needs. However, providers received these additional funds for only a relatively brief 10-month period (December 2023 – September 2024).

$9,044 – $12,677

Average annual cost of child care for an infant in Michigan, depending on setting (First Five Years Fund, 2024)

The Infant Toddler Pilot was an important first step in planning a longer-term solution. The Child Care and Development Fund (CCDF, U.S. Department of Health and Human Services, 2024) requires states to offer granted or contracted slots to increase care access for children with certain characteristics, including infants and toddlers. Michigan must implement granted or contracted slots statewide by August 2026. This brief explores what happened to slot availability and staffing situations after the pilot ended and will help the state plan for the coming expansion of granted or contracted slots.

PILOT PARTICIPATION

The Michigan Department of Lifelong Education, Advancement, and Potential (MiLEAP) is Michigan's CCDF Lead Agency. On behalf of MiLEAP, the Early Childhood Investment Corporation (ECIC) began the Infant Toddler Pilot in November 2023. ECIC received 1,700 applications and prioritized 198 providers who served marginalized communities, were located in areas of high need,[4] and who already served scholarship families (see Figure 1). In total, 196 providers enrolled in the pilot. Since it was assumed that centers would be best positioned to increase their infant/toddler enrollment, most pilot participants (80%) were centers. However, group homes (13%) and family homes (7%) also participated, and some providers changed their license type to expand their capacity. Of the original providers, 193 stayed through the end of the pilot in September 2024.

Figure 1. Common Characteristics of Providers Prioritized for the Pilot

ECIC required providers to report each month how they spent pilot funds (staff bonuses, professional development, etc.) as well as whether infant/toddler enrollment or staff wages changed. To minimize burden on providers, ECIC used a text-message-based system for the monthly reporting and followed up

[3] The CDC Scholarship program is Michigan's child care assistance program for eligible families and children, funded largely by the CCDF. For information about the CDC Scholarship funding sources, see Michigan League for Public Policy, 2024.

[4] "High need" areas were those with large populations of children and low supply of child care slots. For a map of the provider locations, please refer to the appendix.

individually with non-responding providers. In April 2024, ECIC developed technical assistance tools and resources to help providers market, staff, and run their businesses, which included monthly newsletters, webinars, a job board, and a wage calculator.

INITIAL EVALUATION OF THE PILOT

Public Policy Associates (PPA) conducted a separate evaluation of how well the Infant Toddler Pilot met its goals of increasing worker compensation and access to infant/toddler slots (Farooqui & Reichel, 2024). The evaluation included surveys with staff employed at participating providers, analyses of the providers' monthly reports, and analyses of how providers reported using the grant funds. The team also conducted an analysis to determine how many newly created slots were utilized by children with special needs, children living in child care deserts (i.e., anywhere with more than three children competing for each child care slot; Malik, et al., 2018), and children from minoritized groups. Additionally, when the pilot was wrapping up, PPA conducted site visits to eight pilot providers to interview key staff and collect parent surveys about their experiences.

Figure 2. Infant Toddler Pilot and Evaluation Timeline

The initial evaluation found that most providers used pilot funds for staff bonuses and wage increases, improving retention rates, and influencing staff members' decisions to stay. Many staff engaged in supported professional development and had plans to pursue a Child Development Associate (CDA) certificate. However, many providers expressed concerns with their ability to continue wage increases, bonuses, and support for professional development after pilot funding ended. Additionally, infant/toddler enrollment and filling expansion slots remained a challenge, primarily due to ongoing difficulties in filling positions and meeting facility improvement/space needs. As a result, providers reported enrolling new infants and toddlers at similar rates as before.

Study Overview

Public Policy Associates (PPA) and the Michigan Department of Lifelong Education, Advancement, and Potential (MiLEAP) are partnering for a four-year study of the Child Development and Care Scholarship program's payment rates and structures. The mixed-methods study includes administrative data and review of program documentation, as well as insights from providers, families, and eligibility specialists. An advisory group provides additional perspectives to the research team. The analyses aim to understand any disparities in outcomes and how administrative burden affects program participation and families' access to child care.

Methods

For the follow-up study of the Infant Toddler Pilot, PPA conducted three surveys with a subset of 100 providers and examined administrative data. The two sources cover different time periods; surveys took place in November 2024, January 2025, and March 2025, while administrative data was only available through June 2024 (the mid-point of the pilot period). This brief is a first look at the pilot's longer-term impacts, but more administrative data are needed to draw final conclusions.

The follow-up surveys asked providers to report their infant/toddler enrollment, source of payment for enrolled infants/toddlers, staffing, classrooms, and staff wages. Response rates varied by month, from 53% to 75%. (See the technical appendix for additional details about the survey process.) CDC Scholarship records were analyzed to evaluate infant/toddler enrollment, demographic characteristics of the children and families served, and whether providers closed. The 196 participating providers were compared with a comparison group of providers in the CDC Scholarship program who applied for but did not receive pilot funds. Comparing the outcomes of pilot providers to similar providers helps determine whether changes in infant/toddler enrollment are likely due to the pilot, though the possibility always remains that enrollment for both pilot and comparison providers might be influenced by other external factors.

Results

INFANT/TODDLER ENROLLMENT

Infant/toddler slots slightly increased over a one-year span, with center-based providers seeing a bigger jump compared to home-based providers.

Comparing infant/toddler enrollment using administrative records from two timepoints, before the pilot began (June 2023) and midway through the pilot (June 2024), the research team found that providers in the pilot increased their infant/toddler slots paid (at least in part) by the CDC Scholarship program by a total of 209 slots, an overall increase of 15% (Figure 3). Centers were responsible for more of the increases (197 slots) than home-based providers (12 slots), as expected.

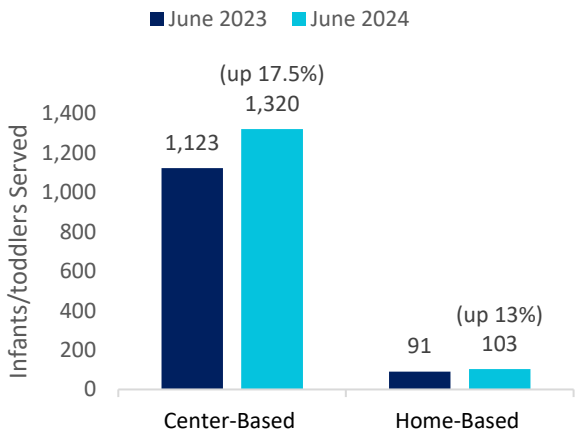

Figure 3. Total Number of Infants and Toddlers Served by Providers in the Pilot, June 2023 and June 2024

Infants and toddlers with CDC Scholarships accounted for half or more of filled slots, with a higher portion at home-based providers.

In November 2024, providers in the pilot reported that almost 6 in 10 of their infant/toddler slots were filled by CDC Scholarship children, which had declined by March 2025 to 5 in 10 (Figure 4). Home-based providers consistently had higher percentages of infants/toddlers with CDC Scholarships (59%–67%) than centers (43%–53%, Figure 5). However, both centers and home-based providers saw declines in the relative percentage of infant/toddler slots filled by children with scholarships over this period. It is not clear why the portion of CDC-supported slots declined.

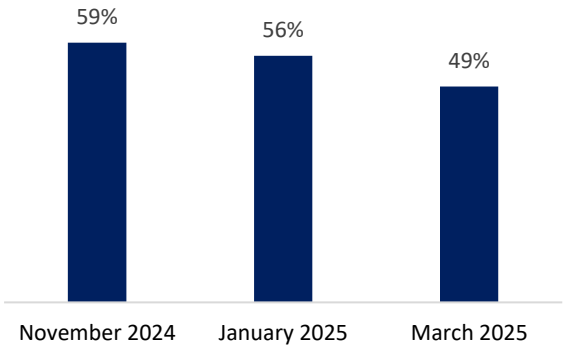

Figure 4. Percentage of CDC Scholarship Infant/Toddler Slots Among Providers in the Pilot

Midway through the pilot, enrollment of infants/toddlers with CDC Scholarships was slightly higher among providers in the pilot than the comparison group.

According to pre-pilot infant/toddler enrollment program data from June 2023, providers who went on to participate in the pilot and those in the comparison group tended to serve about the same number of infants/toddlers per pay period, with a gap slightly favoring pilot providers. By midway through the pilot in June 2024, the number of infants/toddlers served had increased for both the pilot and comparison groups (Figure 6), with larger gains for the providers in the pilot (1.1 children per provider) compared to providers in the comparison group (0.7 children per provider). While practically significant, these differences were not statistically significant. Once administrative records are available through the entire pilot and after the pilot, significant differences might be detected.

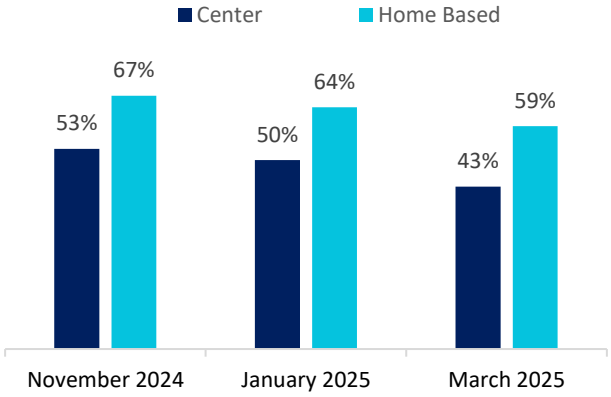

Figure 6. Percentage of CDC Scholarship Infant/Toddler Slots Among Pilot-Participating Providers by Provider Type

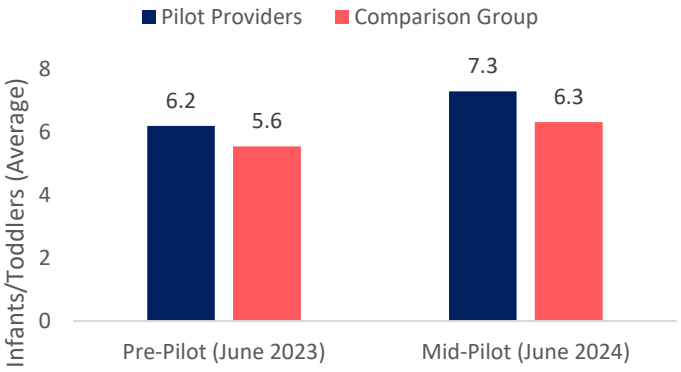

Figure 5. Average Number of Infants and Toddlers Served in June 2023 and June 2024

Providers in the pilot increased enrollment of infants/toddlers across multiple racial/ethnic groups.

Using CDC Scholarship records, the research team examined how infant/toddler enrollment patterns for pilot providers may have varied by children's racial and ethnic background. As shown in Figure 7, there were increases in the number of Black infants/toddlers enrolled in June 2024 compared to June 2023 among pilot providers. This held true for both centers and home-based providers. Centers in the pilot also saw increased enrollment of white infants and toddlers. Hispanic infant/toddler enrollment, on the other hand, remained stable across time and provider types for providers in the pilot. Given this general trend, the pilot did not appear to lead to differences in child enrollment for any racial/ethnic group.

Center-based providers reported notable reductions in infants and toddlers with CDC Scholarships after the pilot's end.

Based on provider-reported data, the average number of CDC infants and toddlers enrolled with providers slightly declined following the pilot's end, from 16 on average per provider in November 2024 to 12 on average in March 2025. Home-based providers reported relatively stable infant/toddler enrollment during the three months they were surveyed (7-8 infants/toddlers with CDC Scholarships per provider on average). Centers reported more instability, with a slight increase from 22 infants/toddlers with CDC Scholarships on average in November 2024 to 27 on average in January 2025, before falling to 14 on average in March 2025.

Providers reported both increases and decreases in the number of infant/toddler classrooms following the pilot, with an overall gain in classrooms.

Following the end of the pilot, providers reported opening 13 infant/toddler classrooms and closing 8 classrooms overall, for a net gain of 5 classrooms. Urban centers and home-based providers saw classroom openings (10 in centers, 3 in homes) and closings (4 in centers, 4 in homes). However, no opening or closing of classrooms were reported by the providers in rural counties.

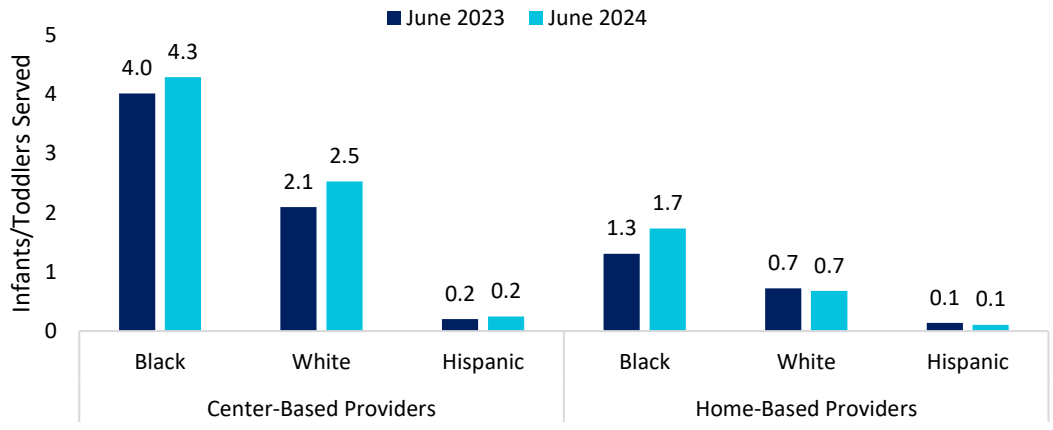

Figure 7. Number of Infant and Toddlers Served by Pilot-Participating Providers by Child Race/Ethnicity

PROVIDER CLOSURE RATES

Providers who participated in the pilot were three times less likely to close than their peers.

Providers in the pilot were over three times less likely to close than the comparison group. Following the introduction of the pilot, six of the pilot providers closed operations. This represents 3% of the pilot group. By contrast, an estimated 10% (826) of the licensed providers in the comparison group that opened prior to 2024 have had to cease operations.

INFANT/TODDLER STAFFING

Staff turnover was high at pilot providers during the follow-up period, with no differences by provider type or region, although some centers increased their staffing overall.

In follow-up surveys, providers from the pilot reported the number of staff who worked with infants/toddlers. Numbers ranged from 0 (sole proprietor) to 41 employees. Centers employed more staff, averaging between 9.4 and 10.9 individuals per month. Home-based providers averaged 2.2 to 2.7 staff per month. Over the follow-up period, there were no notable differences in average staff size across region.

When examined more closely, however, churn in staffing was evident. Between the end of the pilot and March 2025, providers reported that 140 staff were hired and 152 staff left, which represents a net loss of 12 infant/toddler staff overall (Figure 8). Across each month's survey, 41%–62% of providers reported at least one change in staffing level (i.e., either a new hire or a staff departure). During this period, center providers saw a net growth of 17 staff while home-based providers experienced a net loss of 29 staff. Staff departures mostly occurred in November, while hirings occurred in January and March.

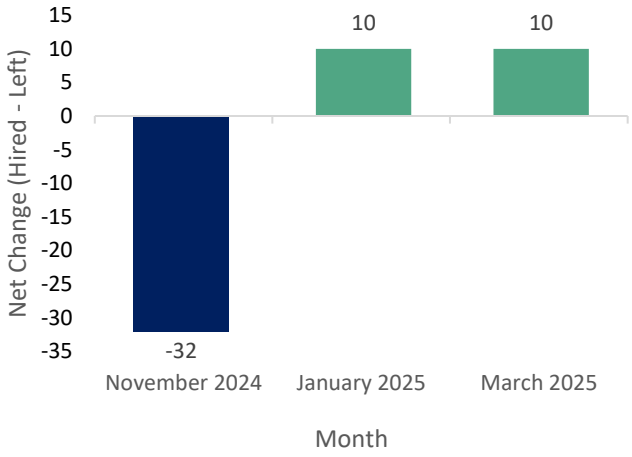

Figure 8. Net Staff Change at Pilot-Participating Providers by Month of Survey

Infant/toddler staff wages remained relatively stable and similar across provider types and regions following the pilot.

Providers' self-reported staff wages showed little fluctuation over time following the pilot. Wages ranged from $5.10 to $34 per hour, indicating high variability in individual compensation. However, the average wage of $15 per hour was similar for centers and home-based providers, as well as for providers in rural and urban counties.

Discussion

Based on the available data and limited comparison analysis, it appears that the pilot had a slight effect on infant/toddler slots, with pilot providers gaining more slots than the comparison group as of June 2024. Centers and home-based providers both gained infant/toddler slots, and there was an overall gain in infant/toddler classrooms reported by providers who participated in the pilot. However, it remains to be seen whether additional administrative data bears out the trend in gains. Based on self-reported data, the pilot seems not to have resulted in increased access for children with CDC Scholarships as both centers and home-based providers reported decreased numbers of slots funded with the scholarships. The new classrooms reported, particularly among centers, suggests that additional slots began to be filled by children without CDC Scholarships, but again further research is needed to test that supposition.

Clearer throughout the pilot and during follow-up was that the workforce challenges in the field influenced the outcomes, as also noted by the initial evaluation of the pilot. Increasing infant/toddler slots requires stabilization and expansion of the workforce to meet the low adult-to-child licensing ratios for this age group, among other prerequisites for increasing capacity.

Centers had an easier time adding infant/toddler slots, and they may have had an advantage in staff hiring too, which is supported by their ability to gain staff over the follow-up period despite experiencing high turnover. While it was not possible to establish a comparison group to examine staff turnover, other results from the study indicate that the financial incentives in the pilot alone were not enough to attract and retain staff (e.g., through bonuses), particularly for home-based providers. The stability in wages seen following the pilot reinforces the initial evaluation finding that providers were reluctant to increase staff compensation in the short term, knowing that they could not sustain those increases absent the grant funding.

The pilot did seem to help with provider financial stability, as closure rates were far less among the pilot providers than the comparison group. However, as seen with the Stabilization Grants provided during the pandemic and recovery period (2021–2023), this outcome may not be long-lasting. (Graber, Van Vliet, & Winans, 2024). The Stabilization Grants introduced additional funding and substantially improved provider viability, but closure rates climbed again after those grants ended.

The research team will continue to follow the pilot effects as more administrative data becomes available. Any difference between the pilot and comparison groups' trends could offer insights into future efforts to increase infant/toddler care availability within a challenging labor market.

Conclusion

Michigan is making some progress overall towards increasing infant/toddler slots, but it is a slow and arduous climb to improve access. Ensuring adequate staffing is a crucial component of establishing granted or contracted infant/toddler slots to meet demand (Figure 9). To make headway, funding to support staffing and the other prerequisites of additional slots must be adequate and consistent. Without assurance of greater financial stability, providers will not be able to offer the compensation and benefits necessary to attract and retain qualified staff, particularly given that infant/toddler teachers tend to be paid lower than those working with older children in centers (Sandstrom, Casas, and Lou, 2023). The infant/toddler care access issue must also be understood as part of a wider systems challenge; Michigan needs more early childhood professionals, and greater recognition of their importance in the lives of young children's development and well-being, as well as the economic health of the state.

Figure 9. Core Components of Infant/ Toddler Slot Expansion

RECOMMENDATIONS

The research team offers the following recommendations for MiLEAP:

- Work with the state legislature to establish a dedicated fund to supplement compensation for infant/toddler staff (and others working in the early childhood system), so they receive adequate wages and benefits, and experience amenable working conditions.
- Encourage providers to take advantage of shared services where available, including human resources support and substitute pools. Look for opportunities to ensure the availability of such supports statewide.
- Estimate the startup and maintenance costs for each new infant/toddler slot. This estimate should reflect costs for providers to hire, train, and retain staff, along with other expenses like facility renovations, equipment, marketing to families, and administrative reporting. Build this amount into provider payments as a supplementary amount to each newly enrolled infant or toddler, or increase the tiered rates paid by the CDC Scholarship program for these age groups by provider type.
- To capture better data on the early childhood workforce in real time (e.g., turnover, retention), require providers receiving contracted or granted slots to provide staffing data. This could be achieved using the existing MiRegistry system, where worker profiles with unique identifiers are tied to specific workplaces.
- Evaluate the implementation and outcomes of the state's future CDC Scholarship granted or contracted slots initiative.

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Technical Appendix

PROVIDERS IN THE PILOT

The providers who participated in the Infant Toddler Pilot were located across Michigan. Their distribution was concentrated in the state's population centers, but extended into the rural areas, as shown in Figure 10.

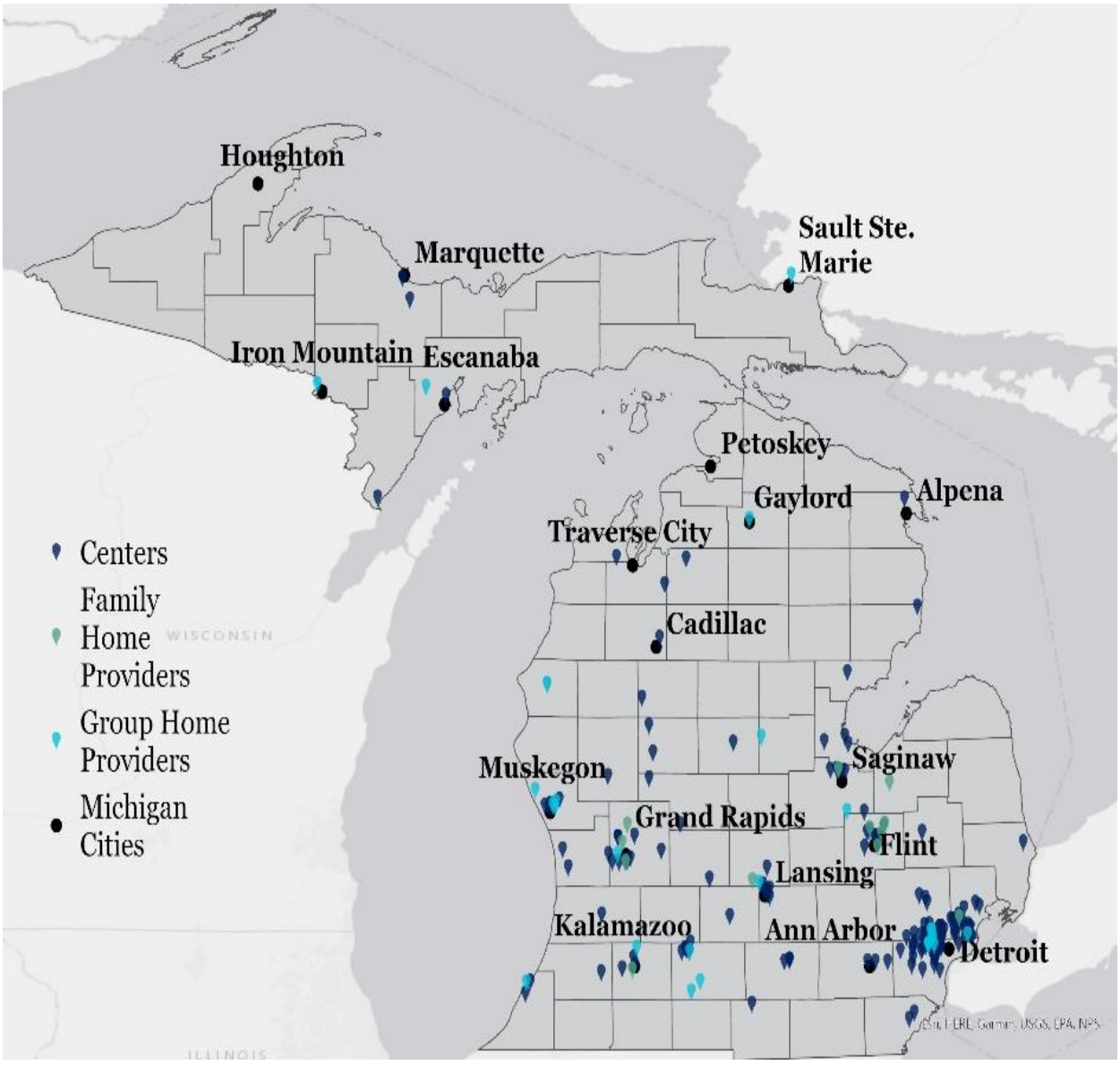

Figure 10. Locations of Participating Providers

PRIMARY DATA

Survey Design

The follow-up survey questions were designed collaboratively by PPA researchers and staff from ECIC and MiLEAP. During the pilot, providers completed monthly reports by responding via text message to a small number of straightforward questions. A post-pilot text-only survey was not feasible given the number and specificity of measures to be gathered with the follow-up surveys (see box at right).

Provider Survey Topics

- Infant/toddler enrollment by source (private pay, CDC, other)
- Number of infant/toddler staff (assistant teachers, lead teachers)
- Number of infant/toddler staff who left or were hired in the last month
- Number of infant/toddler classrooms
- Number of infant/toddler classrooms closed or opened in the last month
- Average hourly wage for infant/toddler staff

ECIC instead texted a link to providers directing them to a survey hosted by PPA using SurveyMonkey, where providers entered the requested information along with their business name and license number. Questions were the same for the November, January, and March surveys. Based on feedback from child care providers, an item asking for the number of infants/toddlers enrolled through other programs (e.g., Early Head Start) was added midway through November data collection (so only 21 of 53 survey respondents that month saw that question).

Survey Sampling and Outreach

From the 196 providers enrolled in the pilot, 100 were selected to complete the follow-up surveys. The 100 providers were purposively sampled to include all 8 case-study participants (Zuschlag & Worthington, 2024), all those who increased their number of infant/toddler slots during the pilot (16 providers), and all of the home-based providers (40). The remainder were randomly selected based on their geographic region.

ECIC sent providers an initial email in early November asking them to confirm their contact information. Text messages with the embedded survey link were sent on November 21, January 15, and March 14. ECIC followed up with non-respondents via text message two business days after the initial outreach and reminded any remaining non-respondents via phone call or email four business days after the initial outreach. There were 53 responses in November, 75 in January, and 70 in March. Sixteen providers did not respond to any surveys, and 43 responded to all 3 surveys (see Table 1 for more details). Respondents received $50 per survey completed from PPA (total of $150 possible).

TABLE 1. DEMOGRAPHICS BY PROVIDER SURVEY COMPLETION

	PROVIDER TYPE			PROVIDER COUNTY		
	Center Based	Home Based	TOTAL	Rural	Urban	TOTAL
No surveys	9	7	16	2	14	16
One survey	9	4	13	1	12	13[1]
Two surveys	18	10	28	2	26	28[2]
Three surveys	24	19	43	10	33	43
TOTAL	**60**	**40**	**100**	**15**	**85**	**100**

[1] Of the 13 providers who only completed one survey, 6 completed the January survey and 7 completed the March survey.
[2] Of the 28 providers who completed 2 surveys, most (18) completed the January and March surveys. An additional 8 completed the November and January surveys, and 2 completed the November and March surveys.

Survey Analysis

Descriptive statistics (sum, average, and range) were calculated for each survey question for each of the three surveys. As not every provider in the sample completed all three surveys, the research team compared the available completed surveys. Among the 71 providers who completed two or more surveys, their earliest and latest survey responses were compared. For 45 providers, the November and March responses were compared; for 18 providers, the January and March responses were compared; and for 8 providers, the November and January responses were compared. Comparing the earliest and latest surveys in this manner introduces non-uniform time intervals, making it more challenging to draw coherent conclusions about trends over time. However, the desire to compare change over time for more providers outweighed these concerns.

To identify simple main effects, the research team conducted within-subjects *t*-tests for each metric for the sample overall, as well as for each level of provider type (center-based and home-based providers) and each level of geography (urban counties and rural counties). By conducting many tests, the likelihood of a Type I error increased (that is, concluding that there is a significant change when there is none in reality). Additionally, comparing smaller sub-groups of providers increases the likelihood of a Type II error (failing to detect a significant change). Only one statistically significant difference was identified.

SECONDARY DATA

CDC Records

Administrative records of biweekly CDC Scholarship payments to providers were analyzed to evaluate the number of infants/toddlers served, the characteristics of the children and their families, and whether providers remained open or had closed.

Some analyses used point-in-time estimates of children and families served by comparing records from a two-week pay period in June 2023 (prior to the pilot's implementation in November 2023) and an equivalent two-week pay period in June 2024 (mid-way through the pilot). Time-series and mixed-effects model analyses used all records from June 2023 through June 2024, with November 2023 designated as the point of "interruption."

Comparison Group Formation

Propensity score matching was done to create a comparison group for the pilot providers. The providers who applied for, but did not receive, pilot funds were the pool for comparison to remove self-selection bias. Information from the applications informed the propensity scores, though the research team also used administrative records to confirm that the providers included cared for similar numbers of infants and toddlers prior to the pilot's implementation.

Both a *k* nearest neighbor of a *k* of four and a kernel matching algorithm were used to form the comparison group. For some variables, the nearest neighbor was a better fit, while for others, the kernel matching was a better fit, but ultimately each matching method fell below a reasonable collective bias threshold. Each analysis used both matching methods and led to similar conclusions.

Analyses

The research team calculated descriptive statistics (sum, average, range) of the administrative data to examine the number of infants/toddlers served, disaggregated by pilot participation and provider type (home based, center based), for each pay period from June 2023 to June 2024 (26 pay periods). Enrollment was further broken down by child race/ethnicity for the June 2023 and June 2024 analyses.

To assess the impact of the pilot, the research team conducted an interrupted time series analysis comparing enrollment trends in June 2023 and June 2024, for both participating and non-participating providers. A two-way fixed-effects method utilizing multilevel mixed models was also conducted to analyze trends over time, controlling for monthly variation and provider-level characteristics such as license type, quality level, and region. In these models, providers were cross-nested within region and provider license type. Finally, a survivorship model was employed to estimate the likelihood of provider closure during the analysis period, comparing participating and non-participating providers.

A limitation of the comparison analysis is that it only included data through June 2024 (no records beyond that date were available to the research team). The research team would prefer to have a longer timeframe to observe longer-term impacts on infant/toddler enrollment and provider stability after the pilot ends. Additionally, other unobserved factors apart from the pilot could have influenced trends in infant/toddler slots and provider closures, though the research team has tried to mediate this concern by comparing providers in the pilot to providers who applied for but did not participate in the pilot.

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