The Early Childhood DATA Collaborative

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State Policies for Assessing Access:

Analysis of 2016-2018 Child Care Development Plans

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Table of Contents

Introduction

A large body of research has established that high-quality early care and education (ECE) has benefits for young children's cognitive and social-emotional development that can lead to improved outcomes later in life,[1] especially for children who are economically disadvantaged.[2] Research also shows that disadvantaged children have unequal access to high-quality ECE programs in the United States, compared to their peers in higher-income families.[3] To address these disparities, there has been a growing effort to develop policies that increase access to ECE. To assess the effectiveness of these policies, decision makers need accurate and comprehensive data on which children have access to services, the quality of these services, and how such factors are changing over time.

This research report examines how states and territories are addressing, or plan to address, new requirements and goals of the Child Care and Development Fund (CCDF) reauthorization law related to access to early care and education (ECE) services described in their 2016–2018 FY state/territory CCDF plans. We summarize state and

The **Early Childhood Data Collaborative** (ECDC) is committed to promoting policies and practices that support the development and use of state coordinated early childhood data systems to improve the quality of early learning programs and the workforce, increase access to high-quality care, and, ultimately, improve child outcomes. These data systems are a critical tool for policymakers to know who is receiving services and where there are service gaps. Having comprehensive data helps policymakers and state decision-makers support full access to high-quality early care and education to all children.

[1] U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation (2014). The Early Achievement and Development Gap. Assistant Secretary for Planning and Evaluation Research Brief. Washington, DC. https://aspe.hhs.gov/system/files/pdf/180276/rb_AchievementGap.pdf.

[2] Yoshikawa, H., Weiland, C., Brooks-Gunn, J., Burchinal, M., Espinosa, L., et al. (2013). Investing in Our Future: The Evidence Base on Preschool. Washington, DC: Society for Research in Child Development. https://www.fcd-us.org/the-evidence-base-on-preschool/

[3] Nores, M. & Barnett, W.S. (2014). Access to High Quality Early Care and Education: Readiness and Opportunity Gaps in America (CEELO Policy Report). New Brunswick, NJ: Center on Enhancing Early Learning Outcomes. http://ceelo.org/wp-content/uploads/2014/05/ceelo_policy_report_access_quality_ece.pdf

territory policies related to increasing access to ECE for specific populations defined by the state, determining payment rates for care, and building the supply of high-quality care. We highlight innovative state/territorial policies and practices, and provide recommendations for how states might further address access through more comprehensive data collection and analysis to inform future child care development plans.

Following this introduction, we present key findings across states and territories, then present more detail on each dimension of access measured. We conclude with recommendations to help states strengthen their use of data to assess access for vulnerable populations and their efforts to increase the supply of high-quality care as they look ahead to their 2019–2021 FY CCDF plans.

What Does Access to ECE Mean?

Historically, the term *access* in ECE has had numerous meanings and has sometimes been used interchangeably with indicators of supply and demand for ECE. The ECE Access project—a project supported by the Office of Research, Planning, and Evaluation in the U.S. Department of Health and Human Services and managed by Child Trends—found that access to ECE has been conceptualized in the literature by several indicators, including "the availability and utilization of care, the cost of ECE to families, and the quality of ECE." This review provided examples of how access to ECE varies across different sectors (e.g., Head Start, school-based pre-k) and groups of children (e.g., low-income, English language learners). It also identifies common metrics that can be used to measure indicators of ECE access, such as the number of children enrolled in ECE by age groups, the number of ECE programs accepting subsidies, and the number of children enrolled in high-quality ECE programs.[4]

Given the variation in how the literature defines ECE access, the ECE Access project suggests a working definition of four dimensions of access that includes many of the commonly used indicators, in addition to new or less commonly used indicators:

> *"Access to early care and education means that parents, with reasonable effort and affordability, can enroll their child in an arrangement that supports the child's development and meets the parents' needs."*[5]

The four dimensions of access in this definition groups the indicators of ECE access as follows:

1. **Reasonable effort**—includes indicators about the interaction between the supply of ECE programs (including available slots), the use of ECE programs by families, and the extent to which information about ECE programs is readily available to parents
2. **Affordable**—includes indicators related to the cost to parents (i.e., out-of-pocket ECE expenses), their use of public programs that subsidize child care/ECE costs (e.g., child care subsidies, Head Start, public pre-kindergarten, and scholarships/donations/grants), and the cost to ECE programs of providing early care and education services (i.e., the advertised price of an ECE program and fundraising to cover per child costs)
3. **Supports the child's development**—indicators about the ECE program's designation of quality (e.g., a QRIS rating), coordination of services, practices that support children's stability in ECE arrangements, and program practices that meet children's unique needs (i.e., for children with developmental or physical disabilities, vulnerable children, and children who speak a language other than English)

[4] Friese, S., Lin, V., Forry, N. & Tout, K. (2017). Defining and Measuring Access to High Quality Early Care and Education: A Guidebook for Policymakers and Researchers. OPRE Report #2017-08. Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. P4 https://www.acf.hhs.gov/sites/default/files/opre/cceepra_access_guidebook_final_213_b508.pdf

[5] Friese, et al., 2017. P. 5.

4. **Meets the parents' needs**— indicators like the program type, the availability of transportation, and program hours of operation (i.e., ECE features that align with a family's needs)"[6]

ECE Access and Child Care Development Fund Reauthorization

Child care assistance, administered by states through the federal Child Care Development Fund (CCDF)[7] (along with other federal and state funding sources), provides financial support to help low-income, working families afford the cost of child care. Access to child care financial assistance in the form of subsidies is impacted by state policy decisions that determine which families, and under what circumstances, children are eligible to receive child care, how much parents are required to contribute toward the cost of care, and how much the state reimburses providers for care.[8] Administrative practices—what a parent needs to do to obtain and keep their subsidy—have also been identified as important to understanding procedural barriers preventing access.[9] For example, a parent may lose their subsidy if they fail to submit the correct paperwork in a timely manner.

As part of the requirement to receive and administer CCDF, states and territories must describe their child care assistance policies in their CCDF state plans. These plans outline activities and goals aimed at promoting access to high-quality ECE for low-income families and describe how the state will implement and achieve CCDF requirements related to family engagement, health and safety, financial assistance, workforce development, and quality improvement activities.[10]

The Child Care Development Fund was reauthorized in 2014 for the first time in 20 years. In addition to providing funding, the law required states to take a broader look at which child care assistance policies can help determine whether states are promoting access. It also added a new purpose to CCDF: *to increase the number and percentage of low-income children in high-quality child care settings*.[11] The law includes several requirements related to building the supply of high-quality care. States must:

> "Develop and implement strategies to increase the supply and improve the quality of child care services for children in underserved areas, infants and toddlers, children with disabilities, homeless children, and children who receive care during nontraditional hours. (Section 658E(c)(2)(M)); and
>
> Prioritize investments that increase access to high-quality child care services for children in areas that have significant concentrations of poverty and unemployment and that lack high-quality child care services (Section 658E(c)(2)(Q))."[12]

CCDF reauthorization also requires that parents have *equal access* to child care programs. Under this requirement, states must conduct a market rate survey or use an alternative methodology, such as a cost estimation model, and describe how payment rates will be established based on results of the survey or alternative methodology, accounting for the cost of providing higher-quality services.[13]

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[6] Friese, et al., 2017 Pp. 6-8.
[7] CCDF is also commonly referred to as the Child Care and Development Block Grant (CCDBG) and the two terms may be used interchangeably.
[8] Schulman, K. & Blank, H. (2017) Persistent Gaps: State Child Care Assistance Policies. 2017. Washington, DC: the National Women's Law Center. https://nwlc.org/resources/persistent-gaps-state-child-care-assistance-policies-2017/
[9] Snyder, K; Banghart, P.; & Adams, G. (2006) Supporting Child Care Subsidy Access and Retention: Strategies from Seven Midwestern States. Washington, DC: the Urban Institute. https://www.urban.org/sites/default/files/publication/50671/311388-Supporting-Child-Care-Subsidy-Access-and-Retention.PDF
[10] See Schulman & Blank, 2017 for a summary of these child care assistance policies across states.
[11] OCC plain language summary https://www.acf.hhs.gov/occ/resource/ccdbg-of-2014-plain-language-summary-of-statutory-changes
[12] United States. Office of Child Care. (2015). Building the supply of high-quality child care. (Log No: CCDFACF-IM-2015-02). Washington, DC: U.S. Office of Child Care. http://www.researchconnections.org/childcare/resources/31231/pdf
[13] U.S. Department of Health and Human Services, Administration for Children and Families, Office of Child Care. (2014). "Child Care Development and Block Grant Act (CCDBG) of 2014: Plain Language Summary of Statutory Changes. Available at https://www.acf.hhs.gov/occ/resource/ccdbg-of-2014-plain-language-summary-of-statutory-changes.

Methodology

Information for this report was collected from all 56 state and territory CCDF plans for FY 2016–2018. We selected seven sections of the CCDF plans related to this goal. Table 1 below outlines the plan section title and number, specific questions analyzed, and how the section questions correspond to the dimensions of access defined by the ECE Access Project described above.

To analyze responses, responses to each question in Table 1 from all state/territory CCDF plans were entered in a spreadsheet. Next, we developed tables summarizing policy information described in each section. Additionally, information from open-ended questions in the sections of interest was reviewed for common themes and then categorized in tables. We emailed CCDF administrators to request their review of our summary of their state/territory data and provide corrections or updates as needed. We received responses from 33 of the 56 states/territories contacted. Sixteen administrators shared updated information regarding their CCDF plans, and 17 confirmed that the information provided was accurate.

Table 1. Components of CCDF Plans Related to Access Analyzed

CCDF Child Care Plan Section	CCDF State Plan Questions Analyzed	Dimensions of Access
Section 3.2: Increasing Access for Vulnerable Children and Families	3.2.1 State definitions of children with special needs and low-income families 3.2.2 Improving Access for Homeless Children and Families—the status of procedures to enroll and provide outreach to homeless families and establish a grace period for children in foster care for meeting immunization requirements	Reasonable effort and Supports a child's development
Section 4.4: Summary of facts used to determine that payment rates are sufficient to ensure equal access	4.4.1 What data and facts did the state use to determine that payment rates ensure equal access? 4.4.2 Does the state certify that payment rates are sufficient to ensure equal access either based on the current MRS or alternative methodology?	Affordable
Section 4.6: Supply building strategies to meet the needs of certain populations	4.6.1 Has the state/territory conducted data analysis of existing and growing supply needs? 4.6.2 Describe what method(s) is used to increase supply and improve quality for infants and toddlers, children with disabilities, children who receive care during non-traditional hours, and homeless children. 4.6.3 Procedures and processes to increase access to programs providing high-quality child care and development services, to give priority for children in families in areas with significant concentrations of poverty and unemployment that don't have subsidies	Reasonable effort, Supports a child's development, and Meets parents' needs

Table 1, cont. Components of CCDF Plans Related to Access Analyzed

CCDF Child Care Plan Section	CCDF State Plan Questions Analyzed		Dimensions of Access
Section 7.1: Activities to improve the quality of child care services	7.1.1	What are your overarching goals for quality improvement?	Supports a child's development
	7.1.2	Check and describe which of the following specified quality improvement activities the state/territory is investing in.	
Section 7.2: Quality rating and improvement systems	7.2.1	Does your state/territory have a quality rating and improvement system?	Supports a child's development
	7.2.2	Describe the measures relevant to this activity that the state/territory will use to evaluate its progress in improving the quality of child care programs?	
Section 7.3: Improving the supply and quality of child care programs and services for infants and toddlers	7.3.1	What activities are being implemented by the state/territory to improve the supply (see also section 4) and quality of child care programs and services for infants and toddlers?	Reasonable effort, Supports a child's development, Meets a parent's needs
	7.3.2	Describe the measures relevant to this activity that the state/territory will use to evaluate its progress in improving the quality of child care programs and services	
Section 7.6: Evaluating and assessing the quality and effectiveness of child care programs and services	7.6.1	Describe how the state/territory measures the quality and effectiveness of child care programs and services offered in the state/territory, including any tools used to measure child, family, teacher, classroom, or provider improvements, and how the state/territory evaluates that such programs positively impact children	Supports a child's development
	7.6.2	Describe the measures relevant to this activity that the state will use to evaluate progress in improving the quality of child care programs and services	

Limitations

Our analysis of states' and territories' policies to increase access to ECE was limited to information provided in the CCDF plans. While states/territories were asked to review the policy information in the tables related to their state, we did not interview state CCDF administrators to collect further details about their policies. We also did not assess whether their proposed strategies resulted in increased access.[14] The information included in this report reflects information reported in the plans only. Additional research is needed to determine the outcome and/or effectiveness of any strategies proposed.

[14] The Access Guidebook identifies a number of data sources that states can use to assess access.

Key Findings

Finding 1: Focus on prioritizing services for high-poverty communities

Of the groups of vulnerable and underserved children for which states and territories must prioritize CCDF funds—children living in low-income households, infants and toddlers, children with special needs, children who are homeless, and children in foster care—states and territories most commonly reported having implemented policies to prioritize services for children in high-poverty areas (75%), relative to policies aimed at outreach for children who are homeless or in foster care (55%).

Finding 2: Inconsistent methods for measuring child care supply

Most states/territories (71%) conduct analyses to determine their child care supply needs, but the remaining states/territories reported that they do not track supply. Additionally, data sources used to track supply across states/territories were not consistent.

Finding 3: Tiered/differential payment rates commonly determine whether reimbursement rates provide equal access

Using tiered/differential payment rates to increase access for targeted needs (i.e., for a specific vulnerable or underserved population) was the most frequently reported (71%) metric to determine that payment rates ensure equal access. Only 22 states/territories report using a market rate survey or alternative method to ensure that payment rates provide equal access.

Finding 4: QRIS ratings are a primary measure for tracking quality improvement efforts

States and territories are implementing a number of strategies to help meet the goal of improving the supply of *high-quality* child care. Most states/territories (82%) operate a QRIS, and more than half evaluate quality improvement efforts by tracking changes to quality indicators or QRIS ratings. Moreover, technical assistance was the most common strategy used to improve quality across all groups of vulnerable and underserved children.

Analysis of CCDF Plans

State Policies to Increase Access for Vulnerable Children and Families (sections 3.2, 4.6, and 7.3)

State and territory child care plans describe how certain groups of vulnerable children will be given priority for CCDF funds. These groups include (but are not limited to) children living in low-income households, children who have been determined to have a special need, and homeless children.[15] Definitions of each group of children are provided as part of the plans. Plans also include descriptions of strategies that states/territories will implement to increase the supply and improve the quality of care for vulnerable populations, and remove barriers to accessing care. For example, some children face barriers due to insufficient supply of specific types of care, such as infant care or care available during non-traditional hours.

Prioritizing child care assistance for populations who have the most difficulty accessing care is a key focus of this part of state/territory child care plans. Care for infants and toddlers and children with special needs is often in short supply[16] because of the high costs of meeting adult-child ratios, completing specialized training, or the cost of equipment.

States can use their CCDF plans to advance access to high-quality care for vulnerable groups of children in the following five sections:

- Prioritization for vulnerable children and families (Section 3.2.1)
- Improving access for homeless children and families (Section 3.2.2)
- Analyzing supply needs (Section 4.6.1)
- Increasing supply and improving quality for vulnerable children (Section 4.6.2 a,b,c,d)
- Prioritizing families in areas with significant concentrations of poverty and employment (Section 4.6.3)

State goals related to each of these areas are summarized below.

Prioritizing vulnerable children and families (Section 3.2.1): In this section, states reported how they define and prioritize child care services for target groups of children. Seventy-five percent include physical health needs and mental, emotional, and behavioral health needs in their definitions of *special needs*. Additionally, many states (63%) specify that the *special needs* category includes children with developmental delays. Over half of states (55%) further operationalize this definition by specifying that the child must receive specialized care for their condition, or that their needs are documented by a physician, court order, or other official document (52%). A few states (14%) include children who are in the child welfare system or who have a disadvantaged background in some other way.

[15] Matthews,H., Schulman,K., Vogtman,J., Johnson-Staub,C., & Blank, H. (2017) Implementing the Child Care and Development Block Grant Reauthorization: A Guide for States. Washington, DC: the Center for Law and Social Policy. https://www.clasp.org/sites/default/files/publications/2017/08/CCDBG-Reauth-Guide-Updated.pdf

[16] National Association of Child Care Resource & Referral Agencies. (2006), Child care in thirteen economically disadvantaged communities. Arlington, VA: National Association of Child Care Resource and Referral Agencies; Ackerman, D. J., & Barnett, W. S. (2009). *Does preschool education policy impact infant/toddler care?* (Preschool Policy Brief). New Brunswick, NJ: National Institute for Early Education Research

Just over half of states and territories define *families with very low incomes* as those at a certain percentage of the federal poverty level (FPL). Other states (25%) define it based on percentage of state median income (SMI) or Temporary Assistance for Needy Families (TANF) eligibility (21%). A few (14%) had other definitions of families with very low incomes (e.g., homeless families), while two states did not provide a definition (see Table 2). Appendix A includes definitions by state/territory.

Table 2. Definitions of Families with Very Low Incomes

Definition	Number of states/ territories	Percentage of states/ territories
Percent of FPL	29	52%
Percent of SMI	14	25%
Eligible for TANF	11	21%
Other	8	14%
Not defined	2	4%

State Policy Highlight

Florida's Definition of Families with Very Low Income

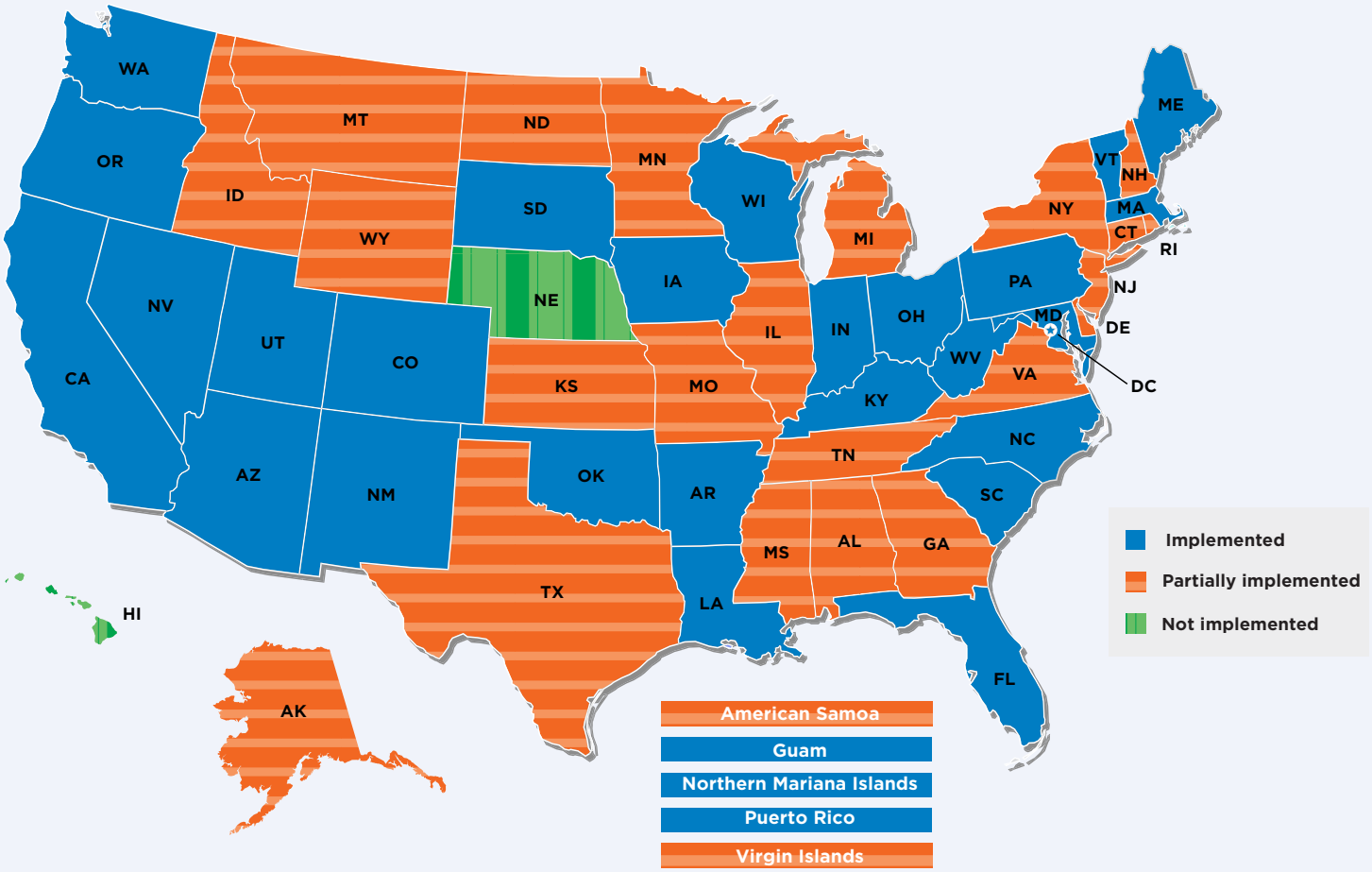
Florida's definition of families with very low income is specific to the needs of families in the state. In addition to defining families with very low income as having a family income less than a certain percentage of the Federal Poverty Level like many other states, Florida included being a child of a working migratory family as part of their definition to accommodate families whose income varies according to weather conditions and market stability. This adaptation was relevant for Florida, which has more migratory workers than most other states.

Improving access for homeless children and families (Section 3.2.2): Families experiencing homelessness are less likely than poor families with housing to receive child care assistance, most likely due to the many barriers they face in accessing assistance (such as being required to produce birth certificates, immunization records, and proof of residency).[17] In this section, states/territories report how they will increase access to CCDF subsidies for homeless children and families by describing policies such as giving priority, granting grace periods for documentation requirements, waiving copayments, etc. States/territories also describe how they will conduct outreach to homeless families.

Over half of states and territories have implemented procedures to enroll and provide outreach to homeless families and establish a grace period for children in foster care for meeting immunization requirements (55%). Examples of procedures to enroll and provide outreach to homeless families include outreach to shelters or interagency collaborations. However, most of the remaining states have partially implemented[18] these procedures. Two states did not have procedures implemented at the time their plan was submitted (see Figure 1). Appendix B includes implementation status by state/territory.

[17] The McKinney-Vento Act in the late 1980s removed these barriers so that children experiencing homelessness had the same access to educational opportunities. Early care and education programs such as Head Start and programs under IDEA are now following the same requirements for public education systems under the McKinney-Vento Act.
[18] Partially implemented means that the state/territory has met some but not all of the federal requirements for a particular directive.

Figure 1. Status of Procedures to Enroll and Provide Outreach to Homeless Families and Establish a Grace Period for Children in Foster Care for Meeting Immunization Requirements



Definition	Number of states/territories	Percentage of states/territories
Implemented	30	55%
Partially implemented	24	41%
Not implemented	2	4%

Of the 31 states with procedures implemented, most (65%) have a grace period for homeless children and families to comply with immunization requirements. In addition to the grace period, some states (26%) prioritize homeless families for CCDF subsidies or conduct extra outreach to homeless families (23%). Other states waive documentation requirements, automatically accept all homeless children, or provide 100 percent subsidized cost of child care (see Table 3).

Table 3. Procedures to Increase Access to CCDF Subsidies for Homeless Children and Families

Procedure	Number of states/ territories	Percentage of states/territories
Grace period for immunizations	20	65%
Prioritize homeless families	8	26%
Extra outreach to homeless families	7	23%
Eligibility/documentation requirement waivers	5	16%
Accepts all homeless children	5	16%
Subsidy pays 100% of child care costs	2	6%
Potential to qualify for care to stabilize living arrangements	1	3%
Expedited payments	1	3%
None	1	3%

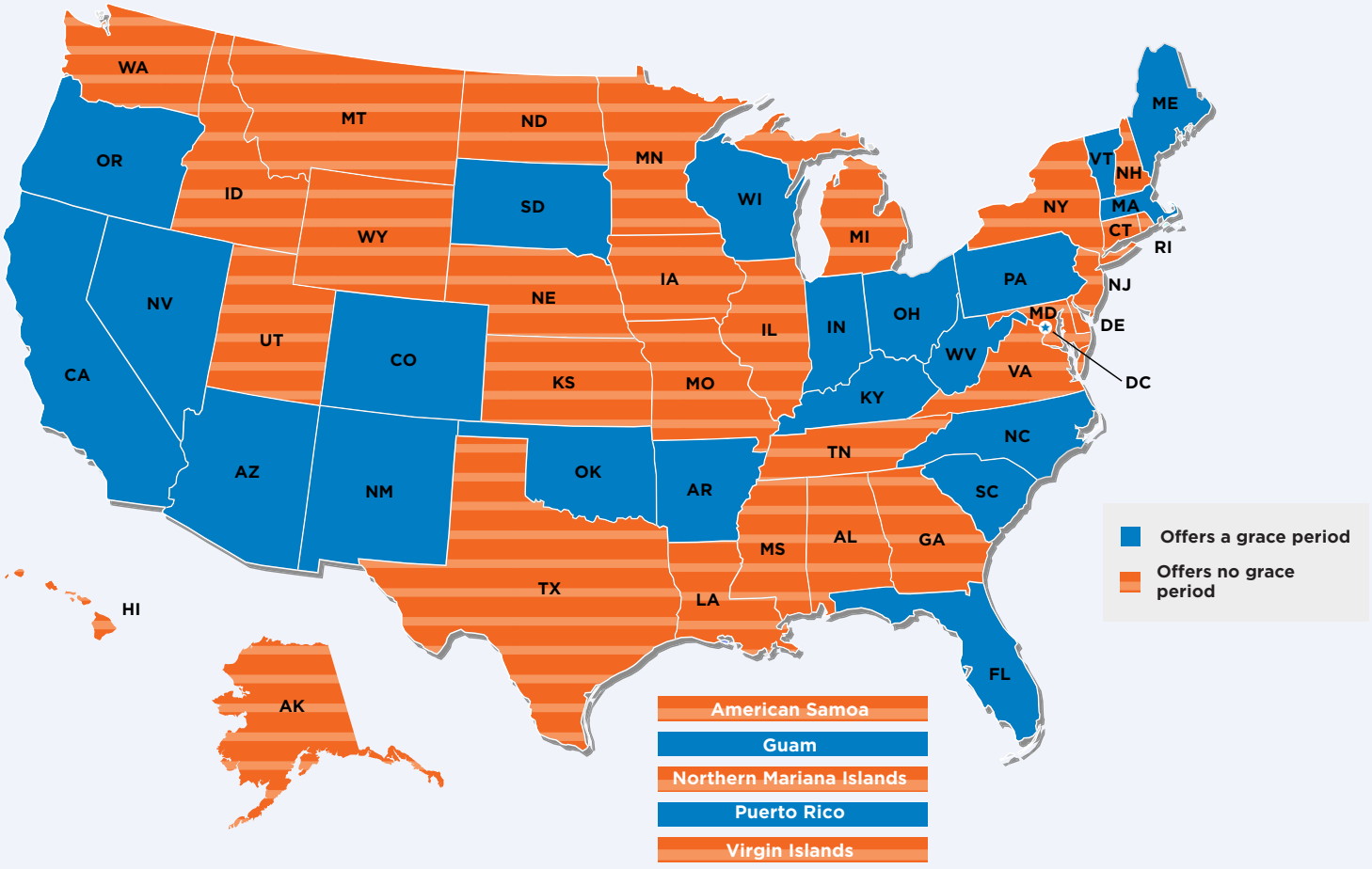
Additionally, many of these states/territories conduct outreach to homeless families to improve their access to child care services through direct service agencies (e.g., shelters; 61%) or interagency collaborations (48%), including working with local educational agencies (LEAs, 23%) or child care resource and referral agencies (CCR&R) (26%). Nine states (29%) cited the McKinney-Vento Homeless Assistance Act, which outlines guidelines for ensuring that homeless youth have equal access to education services. These provisions were recently updated through the Every Child Succeeds Act as of October 1, 2016. Three states noted that they share information about child care financial assistance or homeless rights with homeless families.

Table 4. Policies to Conduct Outreach to Homeless Families to Improve Access to Child Care Services

Procedure	Number of states/territories	Percentage of states/territories
Community outreach to direct service agencies (e.g. shelters)	19	61%
Interagency collaborations	15	48%
Cited McKinney-Vento Homeless Assistance Act	9	29%
Child Care Resource & Referral outreach	8	26%
Work with local education agencies	7	23%
Share information about child care financial assistance	6	19%
Share information on homeless rights	3	10%
n/a	1	4%

Finally, many of these states offer a grace period to comply with immunizations for children in foster care (see Figure 2). The largest portion of states allow for 30 days or six weeks (32%), although the range extends from no time to six months (see Table 5). Three states noted that they provide additional support for this population. See Appendix C for information about grace period policies by state/territory.

Figure 2. States and Territories that Provide a Grace Period to Comply with Immunization and Other Health and Safety Requirements for Children in Foster Care



Offers a grace period	Number of states/territories	Percentage of states/territories
Yes	24	43%
No	32	57%

Table 5. Policies to Provide a Grace Period to Comply with Immunization and Other Health and Safety Requirements to Expedite Enrollment for Children who Are in Foster Care

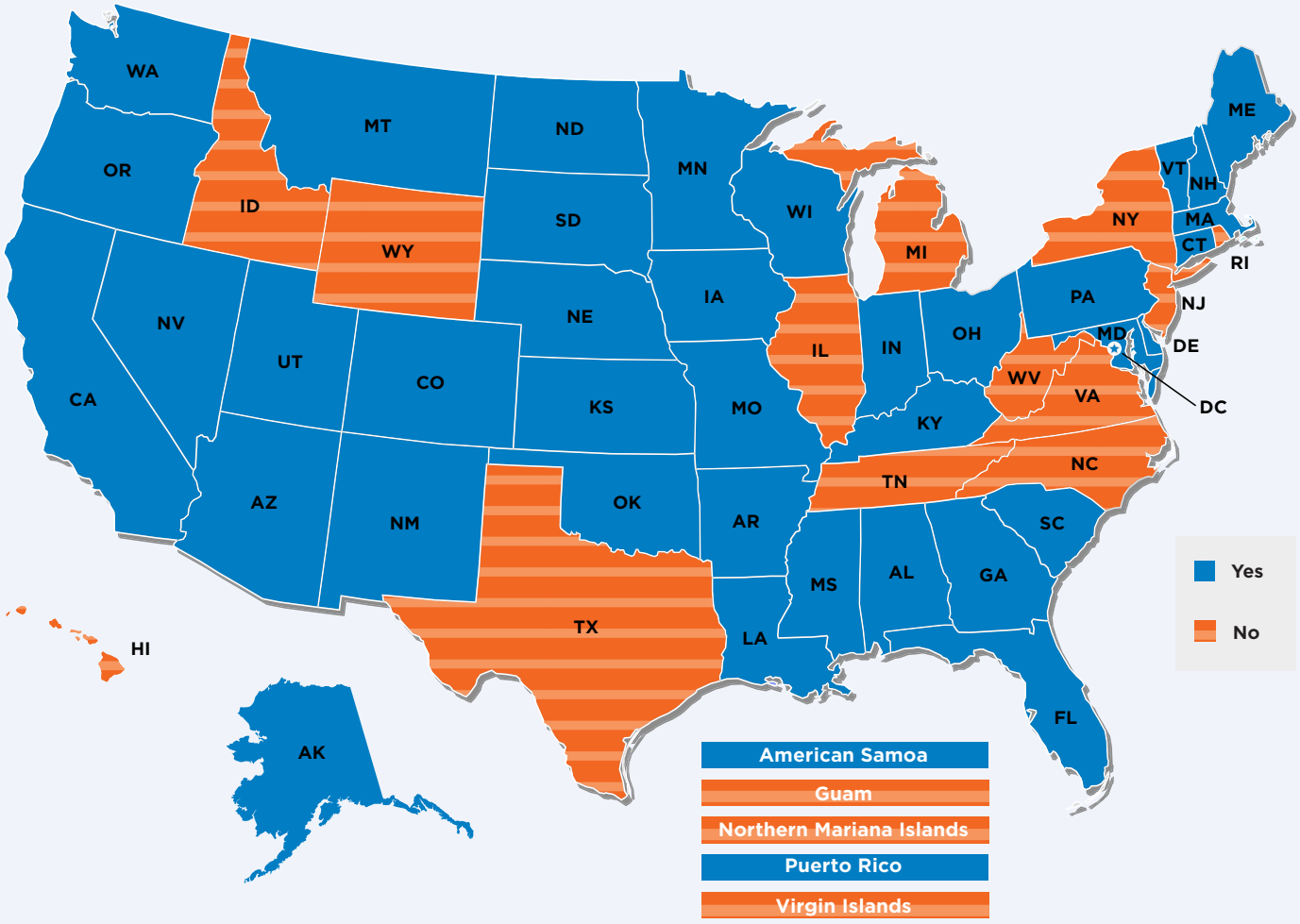
Policy	Number of states/territories	Percentage of states/territories
Additional time	24	43%
Unspecified time	5	16%
<30 days	1	3%
30 days/6 weeks	10	32%
60 days/2 months	1	3%
90 days/3 months	6	19%
6 months	1	3%

State Policy Highlight

Massachusetts's grace periods for homeless children to comply with immunization requirements and other health and safety requirements

Of the 24 states that offer grace periods, Massachusetts has the most generous. In recognition of the fact that homeless children may have difficulty obtaining medical records at the time of their admission into a child care program—because of the stresses caused by issues that affect this priority population—Massachusetts offers a six-month grace period from the date of the child's admission into a child care program to obtain the child's medical records.

Figure 3. States and Territories that Conduct Data Analysis of Child Care Supply Needs



Conducts analysis of needs	Number of states/territories	Percentage of states/territories
Yes	40	71%
No	16	29%

Analyzing supply needs (Section 4.6.1): States are asked whether they have conducted data analyses of existing and growing supply needs. Most states/territories (71%) have conducted some type of relevant data analysis (see Figure3). States/territories used a variety of data sources to analyze supply needs (Table 9). The most frequently used source of data was state data (35%), such as a statewide study of unmet needs, state welfare data, and Race to the Top Early Learning Challenge (RTT-ELC) evaluation results. States/territories also reported using national datasets (18%) such as census data. Further, states/territories also commonly used program data (13%) and provider surveys (13%) to analyze their supply needs. See Appendix D for information analysis of child care supply needs by state/territory.

Increasing supply and improving quality for vulnerable children (Section 4.6.2 a,b,c,d): States are asked specifically to describe what method(s) are used to increase supply and improve quality for the following populations: infants and toddlers, children with disabilities, children who receive care during non-traditional hours, and homeless children.

States/territories reported using a variety of methods to increase supply and improve quality for different populations of children (Table 6). Technical assistance support was the most commonly used method across populations of children, with most states reporting using this method to increase access and improve quality for infants and toddlers (71%) and children with disabilities (61%); many states also reported using technical assistance to increase supply and the quality of care for homeless children (41%) and children who receive care during nontraditional hours (39%). Offering tiered payment rates was the second-most common method to increase access for infants and toddlers and children with disabilities, and recruiting providers was the second-most common for children who receive care during nontraditional hours and for homeless children. Appendix E includes methods to increase supply and improve quality by state/territory.

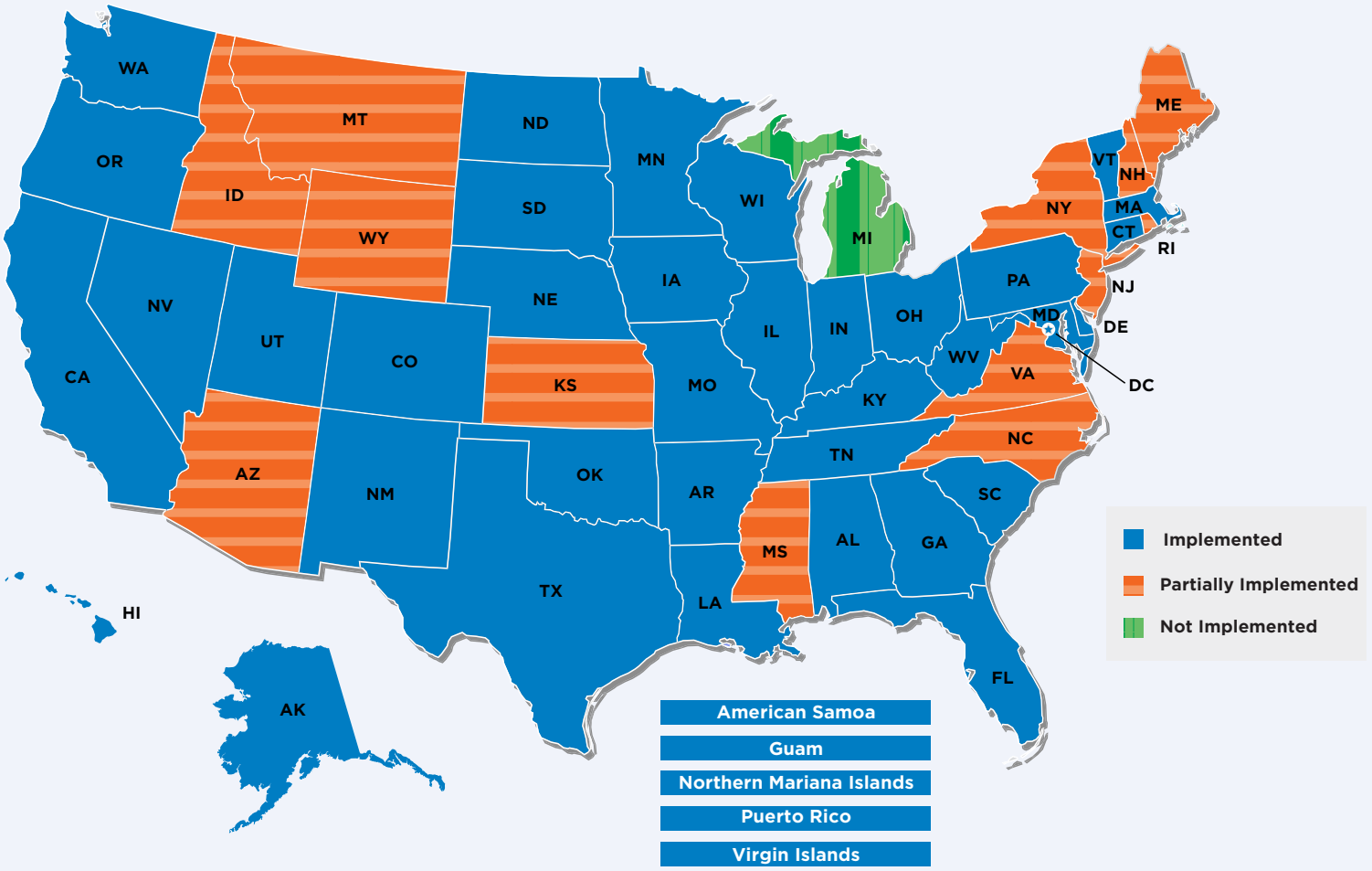
Table 6. Methods to Increase Supply and Improve Quality for Vulnerable Populations (percentage of states/territories)

Method	Infants and toddlers	Children with disabilities	Children who receive care during non-traditional hours	Homeless children
Grants and contracts	46%	23%	16%	21%
Family child care networks	20%	11%	13%	7%
Start-up funding	16%	13%	9%	4%
Technical assistance support	71%	61%	39%	43%
Recruitment of providers	39%	30%	30%	29%
Tiered payment rates	57%	50%	23%	13%
Other	48%	34%	30%	30%

Prioritizing families in areas with significant concentrations of poverty and employment (Section 4.6.3): States are asked what procedures and processes they will implement to increase access to programs providing high-quality child care services, to give priority to children whose families are in areas with significant concentrations of poverty and unemployment.

The majority (75%) of states and territories said they have fully implemented a process to increase access for children in families living in poverty and/or experiencing unemployment (see Figure 4). Of those that have fully implemented procedures, there was a range of strategies implemented, including: offers of technical assistance and professional development or other quality improvement activities for providers serving these communities (38%); contracting with, giving priority to, or offering higher rates for providers serving these communities (36%); offering family-friendly policies for families living in communities with high rates of poverty and unemployment, including prioritizing eligibility for these families, reducing or waiving copayments, exempting families from waitlists, etc. (28%); and collaborating with other ECE programs to help serve these communities, such as Early Head Start Child Care Partnerships (see Table 7). See Appendix F for policies to increase access for children in poverty or experiencing unemployment by state/territory.

Figure 4. States and Territories that Prioritize Children in Families in Poverty or Experiencing Unemployment



Implementation status	Number of states/territories	Percentage of states/territories
Fully implemented	42	75%
Partially implemented	13	23%
Not implemented	1	2%

Table 7. Implemented Policies to Increase Access and Prioritize Children in Families in Poverty or Experiencing Unemployment

Policies	Number of states/ territories	Percentage of states/territories
States reporting that policies have been fully implemented	42	75%
Collaboration with other ECE programs (i.e., EHS-CCP, Head Start, pre-K, etc.)	9	21%
Family-friendly policies (e.g., prioritize eligibility, reduce/waive parent copayments, exempt from waitlists, application offices are conveniently located)	11	26%
Contracts with, offers higher rates, or gives priority to providers in low-income communities	14	33%
Grants for providers serving children with subsidies in low-income communities	10	24%
Technical assistance and professional development, or other quality improvement activity (e.g., participate in QRIS) for providers serving in these communities	15	36%
Other	5	12%

Early Head Start Child Care Partnerships: A strategy for prioritizing families in areas with significant concentrations of poverty

Seven states (AL, AR, DC, FL, MI, OK, and WA) all identified Early Head Start Child Care Partnerships as a strategy for prioritizing infants and toddlers in areas with significant concentrations of poverty. Early Head Start Child Care Partnerships provide layering of funding (from CCDF and EHS) to provide comprehensive and full-day, full-year services' to low-income infants, toddlers, and their families.

State Approaches to Ensure that Child Care Payment Rates Ensure Equal Access (Section 4.4)

Parental choice of a child care provider is a key component of the child care assistance program. Parents receiving child care assistance should have the same access to the range of child care options in their community as other parents. A key determinant of whether families who receive child care assistance have access to the providers in their community is the rate that providers are paid for serving children receiving child care assistance. If payment rates for serving children with subsidies are lower than market prices, providers will either choose not to participate in the child care subsidy program or will charge parents the difference between the rate and cost of care (if allowed)—making child care less affordable for parents receiving a subsidy. States are therefore encouraged to set payment rates close to market rate prices (the 75th percentile of the market rate is the recommended benchmark) to help ensure access to child care providers in the community. In 2017, only two states set payment rates at the 75th percentile.[19] States struggle with the tension of setting payment rates that encourage provider participation in the subsidy system and being able to serve as many eligible children as possible.

The CCDF reauthorization law now requires states and territories to demonstrate that providers who care for children receiving child care subsidies have payment rates that ensure "equal access" to child care services in the market. States must develop and conduct a "statistically valid and reliable" market rate survey (MRS) or alternative methodology (i.e., a cost estimation model) and base their subsidy payment rate on the results. Any payment rates established using an alternative methodology or market rate survey must be approved by the Administration for Children and Families. States/territories must prepare a public report containing the results of the MRS and/or alternative methodology. When setting payment rates, the cost of providing higher-quality child care services needs to be considered without reducing the number of families receiving CCDF.[20]

States have the opportunity to advance access to care by setting payment rates that ensure equal access in their child care plans. States are asked to describe the methods they will use to ensure equal access in the following sections:

- Data used to determine equal access (Section 4.4.1)
- Certifying payment rates ensure equal access (Section 4.4.2)

Data used to determine equal access (Section 4.4.1): States were asked to select what data and facts they use from a list of options to determine equal access (i.e., what is your metric or benchmark of equal access, such as percentile that rates cover or proportion of costs covered?).

States and territories use a variety of data and facts to determine that payment rates ensure equal access (see Table 8). Most states/territories (71%) said that they use tiered/differential payment rates for targeted needs to help ensure access. Additionally, just under half of states/territories indicated using data on where children are being served (48%) and on the proportion of children receiving subsidies being served by high-quality providers (45%).

[19] Schulman & Blank, 2017.
[20] Matthews, H. et. al., 2017.

Table 8: Facts that States/Territories Reported Using to Determine that Payment Rates Ensure Equal Access

Facts	Number of states/territories	Percent of states/territories
Payment rates are set at the 75th percentile or higher of the most recent survey	11	20%
Using tiered rates/differential rates to increase access for targeted needs	40	71%
Rates based on data on the cost to the provider of providing care meeting certain standards	9	16%
Data on the size of the difference (in terms of dollars) between payment rates and the 75th percentile in the most recent survey, if rates are below the 75th percentile	13	23%
Data on the proportion of children receiving subsidies being served by high-quality providers	25	45%
Data on where children are being served showing access to the full range of providers	27	48%
Data on how rates set below the 75th percentile allow CCDF families access to the same quality of care as families not receiving CCDF	15	27%
Feedback from parents, including parent survey or parent complaints	8	14%
Other	17	30%

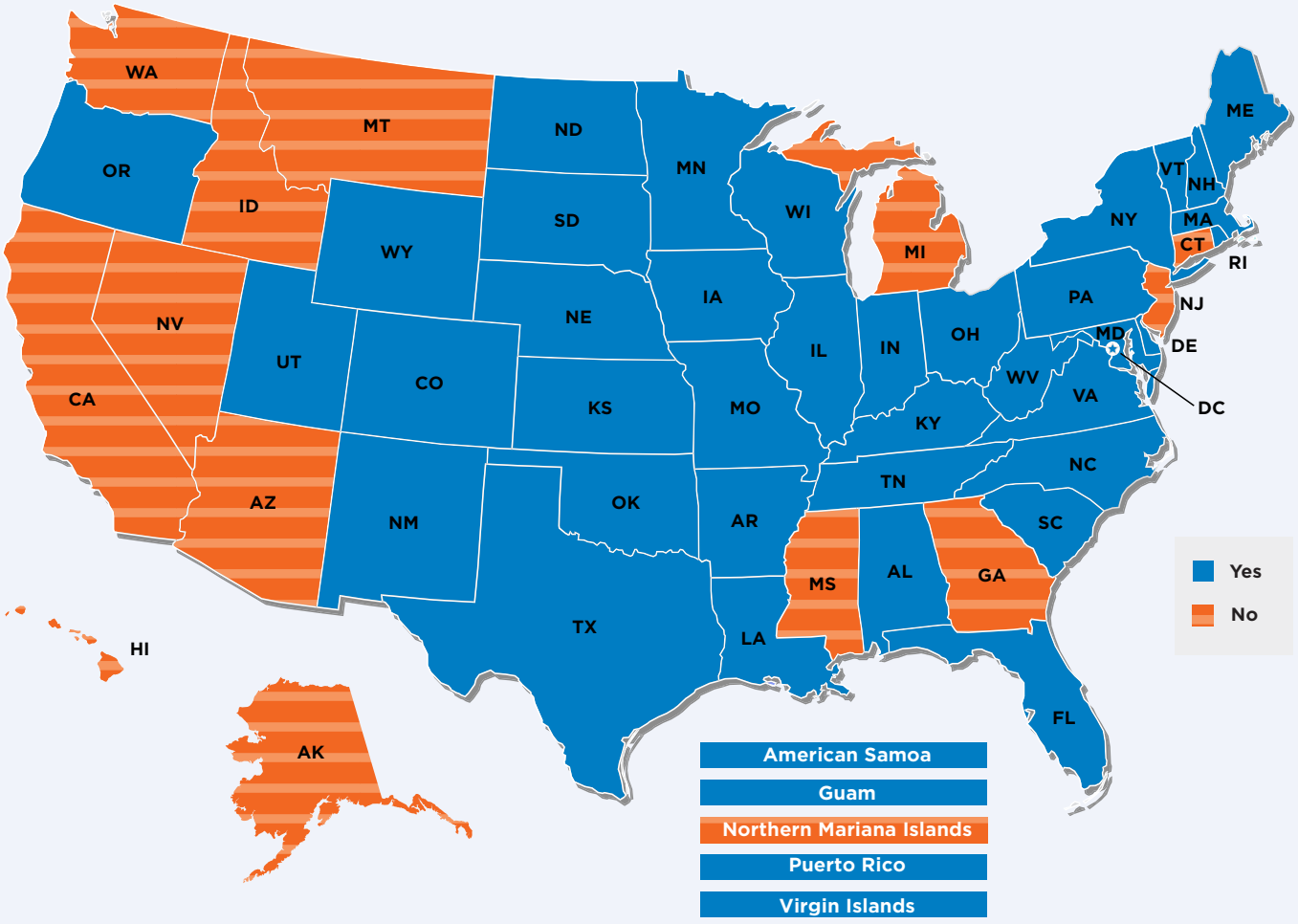
**Note: states/territories could list more than one data source, so percentages will not sum to 100 percent.*

Certifying that payment rates ensure equal access (Section 4.4.2): States/territories were asked whether they certify that payment rates are sufficient to ensure equal access, either based on the current[21] MRS or alternative methodology, and to describe the method they use to certify payment rates.

The majority (75%) of states and territories said that they do certify that payment rates are sufficient to ensure equal access (see Figure 5). Only about half of these states and territories use a market rate survey to certify payment rates, and only one territory mentioned using cost information. The remaining states and territories described using another method to certify that payment rates ensured equal access, including the percent of licensed or regulated providers that participate in the subsidy system (27%); the percent of children receiving subsidies in licensed or quality-rated care (29%); whether the state/territory offered tiered reimbursement for providers caring for children with subsidies (27%); or some other method (17%), such as requesting funds from legislators for provider payment rates (see Table 9). The fact that only half of states and territories said that they certify payment rates with a market rate survey or an alternative method highlights that they may need further clarification of the requirement or further assistance with conducting these methods. Appendix G includes methods used to certify payment rates by state/territory.

[21] The market rate survey or alternative methodology must be developed and conducted no earlier than two years before the date of State Plan submission, or between July 1, 2013 and March 1, 2016.

Figure 5. States and Territories that Certify that Payment Rates Are Sufficient to Ensure Equal Access



Certifies that payment rates are sufficient to ensure equal access	Number of state/territories	Percent of states/territories
Yes	42	75%
No	14	25%

State Policy Highlight

Colorado uses a market rate survey and cost information to determine that payment rates ensure equal access

Colorado has utilized a statistically valid market rate study (MRS) and the Provider Cost of Quality Calculator (PCQC) to determine state-recommended reimbursement rates that ensured that payment rates were commensurate with private pay market rates, and incentivized quality improvement. The results of the market rate study conducted in the state were used to develop county or community tiered reimbursement rates based on the provider's quality rating

Table 9. Methods to Certify Payment Rates Are Sufficient to Ensure Equal Access

Method	Number of state/ territories	Percent of states/ territories
Market rate survey (conducted between July 1, 2013 and March 1, 2016)	22	52%
Alternative method/cost information	1	2%
Percent of licensed or regulated providers participating in the subsidy system	11	27%
Offers tiered reimbursement/differential rates	11	27%
Percent of children receiving subsidies in licensed or quality-rated care	12	29%
Other	7	17%

State Approaches to Measure Quality and Evaluate Quality Rating and Improvement Systems (Sections 7.1, 7.2, 7.6)

The degree to which a program supports a child's development is a dimension of access. An ECE program's designation of quality (e.g., a QRIS rating) is one of the indicators of this dimension of access that acknowledges the association between high-quality ECE and children's development.[22]

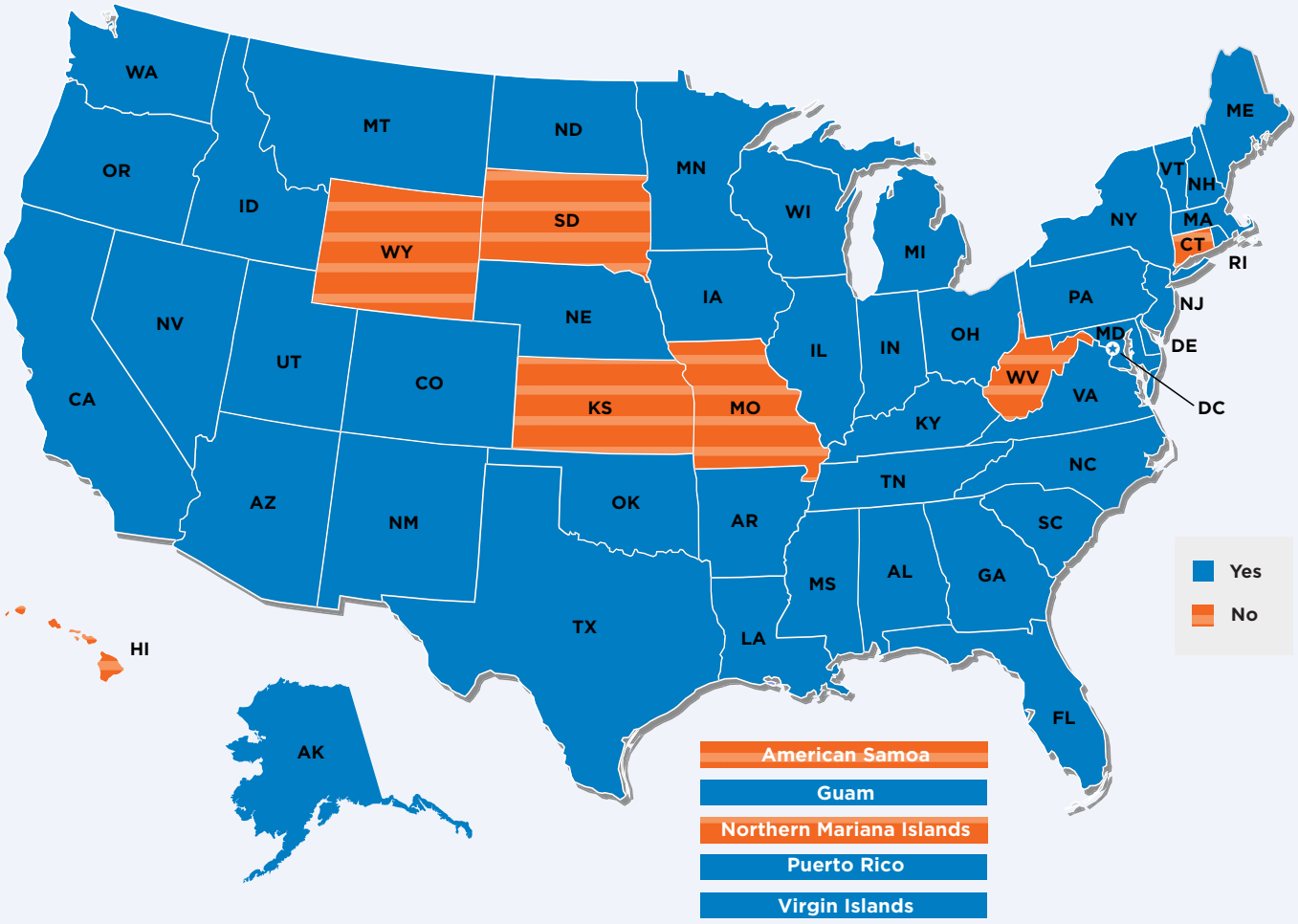
CCDF reauthorization emphasizes the importance of high-quality care. To meet the goal of improving the quality of care and improving the number and percent of low-income children in high-quality care, the CCDF reauthorization law increased the proportion of funding that states are required to spend for quality improvement initiatives (the "quality-set-aside" amount). States must use quality set-aside funds on at least one activity specified in the reauthorization law and based on an assessment of need. Developing, implementing, or enhancing a tiered quality rating system is included in the list of options. States are also required to measure outcomes and evaluate their quality improvement activities.[23]

States have the opportunity to advance access—specifically the degree to which a program supports a child's development—by using quality improvement funds for quality improvement strategies, including QRIS. States are asked about the methods they will use to do so in the following sections:

- Quality Rating and Improvement System (Section 7.2.1)
- Evaluating quality improvement (Section 7.2.2)
- Evaluating and assessing the quality and effectiveness of child care programs and services (7.6.2)

[22] Friese, et al., 2017.
[23] Matthews, et al., 2017

Figure 6. States and Territories with a Quality Rating and Improvement System (QRIS)



State has QRIS	Number of states/territories	Percent of states/ territories
Yes	47	84%
The state/territory has a QRIS operating state-/territory-wide	40	71%
The state/territory has a QRIS operating as a pilot, in a few localities, or only a few levels	7	13%
No	9	16%
The state/territory is in the development phase	7	13%
The state/territory has no plans for development	2	4%

Quality Rating and Improvement System (QRIS) (Section 7.2.1): States are asked whether they have a quality rating and improvement system.

Most states/territories (82%) said that they have an operating QRIS (see Table 14). Of those states/territories that do have a QRIS, most (85%) said that the QRIS is operating state-/territory-wide, while only a few (11%) have a QRIS operating as a pilot or in only a few localities. Of those states/territories that do not currently have a QRIS, most (80%) said that a QRIS is currently in development, and two states/territories have no plans to develop a QRIS. Appendix H includes QRIS implementation status by state/territory.

Evaluating quality rating and improvement systems (QRIS) and activities to increase the number of children in high-quality child care (7.2.2 and 7.6.2): States/territories were asked to describe the measures they will use to evaluate their progress in improving the quality of child care programs and services.

More than half of states/territories measure changes to quality indicators or QRIS ratings to evaluate their progress in improving the quality of child care programs (see Table 10)—for example, by calculating the number of programs at different levels of quality and how those numbers change over time. Over one-third use QRIS participation rates to assess progress toward improving quality based on their CCDF plans. About one-quarter of states shared that they were conducting a validation study to evaluate their efforts to improve access to high-quality care. States/territories were more likely to report using measures related to professional development activities to improve the workforce when asked about increasing access, compared to implementation for QRIS systems.

Table 10: Methods Used to Evaluate Progress Improving the Quality and Effectiveness of Programs and Services

Methods	Progress Related to Quality Rating and Improvement System		Progress Increasing the Number of Low-income Children in High-quality Child Care Settings	
	Number of states/ territories	Percentage of states/territories	Number of states/ territories	Percentage of states/ territories
Measure changes to quality indicators/QRIS ratings	33	59%	26	46%
Measure QRIS/QI participation rates	21	38%	20	36%
Conduct evaluation/ validation study of QRIS/QI	15	27%	12	21%
Assess technical assistance related to QRIS ratings/ quality indicators (i.e., coaching, training, improvement plans)	8	14%		
Assess professional development activities to improve workforce quality (i.e., scholarships, wage stipends)	7	13%	18	32%

Table 10, cont. Methods Used to Evaluate Progress Improving the Quality and Effectiveness of Programs and Services

Methods	Progress Related to Quality Rating and Improvement System		Progress Increasing the Number of Low-income Children in High-quality Child Care Settings	
	Number of states/ territories	Percentage of states/territories	Number of states/ territories	Percentage of states/ territories
Measure changes to program accreditation status	3	5%	4	7%
Assess number of children receiving subsidy in quality care	8	14%	8	14%
Measure changes to kindergarten readiness	1	2%	2	4%
Not specified	4	7%	4	7%
Other	7	13%	13	23%

*Note: states/territories could list more than one data source, so percentages will not sum to 100 percent.

State Policy Highlight

Pennsylvania method to track and evaluate progress improving program quality

Pennsylvania utilizes data from the Pennsylvania Enterprise to Link Information for Children Across Networks (PELICAN)—an integrated data system with information about children, teachers, and programs—to evaluate its early childhood quality initiatives. Reports generated by PELICAN include:

- Number of programs increasing or decreasing their Keystone STARS rating
- Supply and demand for professional development offerings
- Analysis of staff core knowledge and competencies
- Geographic disparities to prioritize resources
- Trends analysis to identify barriers to programs increasing quality

State Policies to Improve the Supply and Quality of Child Care for Infants and Toddlers (Section 7.3)

As mentioned above, the new CCDF law emphasizes increasing the supply and quality of care for infants and toddlers given the barriers that their parents might face in finding care (i.e., the high cost of providing infant care can result in a lower supply of available infant and toddler care). The extent to which a parent can find care for their child's age group is related to the "meeting parent's needs" dimension of access.

The CCBDG law requires that 3 percent of quality improvement funds be used for improving the quality of infant and toddler care. Examples of activities for which the infant and toddler quality funds can be used include establishing or expanding a community family child care network, offering coaching or technical assistance to teachers from infant-toddler specialists, and coordinating with early intervention specialists.

States were asked to describe the activities they will implement to improve the supply and quality of care for infants and toddlers, and how they will measure their progress in improving the quality of programs in the following sections:

Improving the supply and quality of infant and toddler care (Section 7.3.1)

Measuring the quality of programs (Section 7.3.2)

Improving the supply and quality of infant and toddler care (Section 7.3.1): States were asked what activities are being implemented to improve the supply and quality of child care programs and services for infants and toddlers (see Table 11).

Nearly all states provide training and professional development to promote and expand child care providers' abilities to provide developmentally appropriate services for infants and toddlers (96%). Most states also developed infant and toddler components for their early learning and development guidelines (82%) and provided coaching and/or technical assistance on infants and toddlers' unique needs (79%). On the other hand, strategies to increase the supply of infant and toddler care were less common. Just over half of states offer financial incentives to care for infants and toddlers. Additionally, only about one-third are implementing activities related to establishing/expanding high-quality community- or neighborhood-based family and child development centers (34%) or family child care networks (32%) to improve the supply of infant and toddler care. For more information on activities that states are implementing to improve the supply and quality of care for infants and toddlers, see Table 11.

State Policy Highlight

Massachusetts' Statewide Family Child Care Network: Comprehensive strategy for improving the quality in family child care homes serving infants and toddlers

Massachusetts has contracts with 42 family child care systems statewide, which provide resources and supports to family child care providers. These include training, technical assistance and consultation, monitoring, and referrals to health and social services for FCC providers and the children in their care.

Table 11: Activities to Improve the Supply and Quality of Child Care Programs and Services for Infants and Toddlers

Activities	Number of state/ territories	Percent of states/ territories
Providing training and professional development to promote and expand child care providers' ability to provide developmentally appropriate services for infants and toddlers	54	96%
Developing infant and toddler components within the early learning and development guidelines	46	82%
Providing coaching and/or technical assistance on this age group's unique needs from statewide networks of qualified infant-toddler specialists	44	79%
Improving the ability of parents to access transparent and easy to understand consumer information about high-quality infant and toddler care	37	66%
Coordinating with early intervention specialists who provide services for infants and toddlers with disabilities under part C of the Individuals with Disabilities Education Act (20 U.S.C. 1431 et seq.)	33	59%
Developing infant and toddler components within the state's/ territory's child care licensing regulations	33	59%
Providing financial incentives (including the use of grants and contracts as discussed in section 4) to increase the supply and quality of infant-toddler care	32	57%
Developing infant and toddler components within the state's/ territory's QRIS	32	57%
Carrying out other activities determined by the state/territory to improve the quality of infant and toddler care provided in the state/ territory, and for which there is evidence that the activities will lead to improved infant and toddler health and safety, infant and toddler cognitive and physical development, or infant and toddler well-being	26	46%
Establishing or expanding high-quality community- or neighborhood-based family and child development centers, which may serve as resources to child care providers in order to improve the quality of early childhood services provided to infants and toddlers from low-income families, and to help eligible child care providers improve their capacity to offer high-quality, age-appropriate care to infants and toddlers from low-income families	19	34%
Establishing or expanding the operation of community- or neighborhood-based family child care networks	18	32%
Other	3	5%

Measuring the quality of programs (Section 7.3.2): States were asked to describe the measures relevant to evaluate their progress in improving the quality of child care programs and services for infants and toddlers (see Table 12).

Most states reported using measures of program quality, including changes in the levels of quality, to evaluate their progress in improving the quality of child care programs and services (54%). Some states were more specific in their responses and mentioned using the Infant/Toddler Environmental Rating Scale (ITERS) to assess progress in improving quality (29%). Many states also mentioned that they used workforce-related measures to evaluate their progress, including tracking teacher training or professional development (25%), technical assistance (21%), or teacher credentialing (14%). States also use reports to evaluate their progress in this activity, including Child Care Resource & Referral (CCR&R)/referral reports (16%), validation or evaluation studies (13%), and other status reports (9%). Other methods include creating surveys for both families and providers and monitoring and tracking the number of programs accepting subsidies and/or participating in QRIS or other programs.

Table 12. Methods to Evaluate Efforts to Improve the Supply and Quality of Child Care Programs and Services for Infants and Toddlers

Method	Number of state/ territories	Percent of states/ territories
Measures of program quality (and changes in the levels of quality)	30	54%
Infant/Toddler Environmental Rating Scale	16	29%
Tracking teacher training and professional development	14	25%
Tracking technical assistance	12	21%
CCR&R/referral reports	9	16%
Tracking teacher credentialing	8	14%
Number of infant/toddler slots available in accredited or licensed programs, or programs that have completed particular trainings	7	13%
Validation/evaluation study	7	13%
Monitoring (licensing, health and safety, safe sleep, etc.)	7	13%
Provider or family surveys	6	11%
Number of programs participating in QRIS	6	11%
Status reports	5	9%
Monitoring how programs use quality incentives	4	7%
Number of programs that serve subsidy children	3	5%
Family surveys	2	4%
Number of providers receiving rate differential	2	4%
Other	2	4%

Conclusions

More states/territories report implementing plans to prioritize services in high-poverty areas (75%), relative to policies aimed at outreach for children who are homeless or in foster care (55%).

Child care plans identify and define multiple vulnerable populations to prioritize for child care assistance. These groups include, but are not limited to, children with disabilities, those in foster care, those living in poverty, those experiencing homelessness, and infants. Strategies to increase access for these children include policies to provide higher payment rates for providers serving children with disabilities, granting additional time to meet immunization requirements for enrollment of children in foster care, providing outreach to homeless shelters, and using technical assistance to increase the supply of high-quality care for infants and toddlers. Developing metrics for the percentage of children served in each of these populations and changes over time will help policymakers understand how well policies are working to reach and serve vulnerable populations, and identify where there are gaps.

Most states/territories (71%) conduct analyses to determine their child care supply needs. Data sources used to track supply needs vary from state to state.

States/territories reported a wide range of data sources to analyze child care supply needs. State administrative data (i.e., statewide needs assessments, RTT-ELC data, and state welfare data) were the most common sources used, but there was not a consistent data source used across states. Even with a majority of states/territories conducting some type of analysis, 16 reported that they did not track the supply of care. This suggests that states may need more guidance on how to track the supply of care for vulnerable and underserved populations, and on recommended data sources.

Most states/territories (71%) report using tiered/differential payment rates to help ensure access by offering different rates for higher-rated quality of care or care for specific populations (e.g., children with special needs). Only 22 states/territories report using a market rate survey or alternative method to ensure that rates provide equal access.

States may need support to implement market rate surveys and alternative method studies for setting payment rates to ensure equal access. Twenty-two states/territories reported using a market rate survey, and one territory uses an alternative method/cost information to certify that payment rates ensure equal access. The remaining 21 states/territories use another type of data source to certify that payment rates ensure access, such as the percentage of licensed or regulated providers participating in the subsidy system or the percentage of children who receive a subsidy in licensed or quality-rated care. It was unclear from the state and territory CCDF plans exactly how these sources are used to ensure equal access for families. This suggests that further guidance may be helpful on how to assess whether state/territory payment policies result in equal access for families.

Most states/territories operate a QRIS and more than half evaluate quality improvement efforts by tracking changes to quality indicators or QRIS ratings.

States/territories are progressing in their implementation of quality improvement activities for the care of vulnerable and underserved children. Most (82%) states/territories have implemented a QRIS, and a majority of these are implemented statewide (40 of 46). To evaluate their progress in improving the quality of child care programs, states/territories track changes in the number of programs meeting state-designated quality indicators or QRIS ratings at different levels of quality. In future child care plans, states may want to expand how they measure improvements in quality to include specific metrics related to technical assistance and professional development. Technical assistance was the most common strategy used to improve quality across all groups of vulnerable and underserved children.

Recommendations for Assessing Access to ECE

States' and territories' 2016–2018 FY CCDF plans provide an overview of policies that they identified to increase access to high-quality care for the most vulnerable children. Based on our review of these plans, there are opportunities to clarify and strengthen states' use of data to assess access for vulnerable populations and their efforts to increase the supply of high-quality care. The following recommendations are intended to provide guidance and resources to ECE leaders as they begin developing their 2019–2021 FY CCDF plans.

1. **Assess policies based on multiple dimensions of access:** How states define access can have a strong effect on the methods used to assess and track progress related to access. *Defining and Measuring Access to High Quality Early Care and Education: A Guidebook for Policymakers and Researchers* highlights policy questions and data sources that policymakers and researchers can use to measure access. For example, the guidebook highlights different approaches for measuring access based on how easy it is for families to find care, the affordability of care, and how well available programs meet the needs of young children and their families. The access guidebook describes methods for analyzing trends, access for subpopulations, and geographic variations in access. A multi-pronged approach for measuring access will help inform policies to support equal access for children.

2. **Disaggregate data to examine barriers to economic and racial equity:** Policymakers can use ECE data to identify patterns of inequity and inform policies to address disparities in access, service, and quality of early childhood programs for children. It is important to separate out data by characteristics of families such as race/ethnicity, income, and high-needs populations, as these characteristics are critical components of access assessments. The access guidebook identifies several data sources for identifying race/ethnicity and economic characteristics: the American Community Survey (ACS), state child care subsidy administrative data and/or ACF 801, the Current Population Survey (CPS), the National Survey of Early Care and Education (NSECE), the Head Start Program Information Report (PIR), Survey of Households with Young Children, Survey of Income and Program Participation(SIPP), and U.S. Census data. It also identifies sources for household income (ACF-801, ACS, CPS, NSECE) and for high-needs populations, including homeless children (Homeless Management Information Systems (HMIS) data and ACF-801) and child welfare involvement (Head Start PIR).

3. **Identify a comprehensive list of data sources (including integrated data) to measure access to early childhood programs:** States use a wide variety of data sources to analyze child care supply needs. They most-commonly listed state administrative data (e.g., statewide needs assessments, RTT-ELC data, and state welfare data) as their sources. Still, 16 states/territories did not track child care supply needs at all. The ECE access guidebook includes recommendations for data sources for measuring access. Child care licensing data, child care resource and referral data, Head Start PIR data, and Pre-K program data are examples of data sources that can be used depending on the research question. Some states, however, may be challenged to utilize all of these data sources if the data is collected across separate state departments. Additionally, capturing the supply of care for special populations such as homeless children poses a challenge for many states[24] and may require data from other state departments that serve special populations. One strategy that states are using to address the challenge is to develop an integrated early childhood data system. Integrated data systems allow for data collected on young children across state departments and programs to be securely connected, allowing policymakers and administrators to have critical data to make informed decisions. (For more information on strategies for building ECE integrated data systems, see the Early Childhood Data Collaborative at http://www.ecedata.org/).

[24] Bires,C., Kenefick,E., & Gunderson, A. (2018). Strategies for Expanding Access to Child Care Subsidy for Children Experiencing Homelessness. Chigaco, IL: Ounce of Prevention Fund. Accessed January 29, 2018 at http://www.ywcapgh.org/uploads/media/PDFs/Report_HomelessnessChildCareSubsidy.pdf

4. **Expand data collection methods to assess how subsidy policies support affordability:** As noted above, the ECE access guidebook explains that the affordability dimension of access includes costs to parents and the costs that ECE programs pay to provide high-quality care. When determining subsidy payment rates for providers that *ensure equal access* for families receiving child care assistance, states should consider data collection methods that capture both the cost of care for parents and the costs that ECE providers pay. Market rate surveys help measure the cost of care to parents in a community, but do not capture the costs to ECE programs to provide child care. Cost studies (i.e., ECE provider surveys of program costs), however, can inform the cost of providing care in communities. In their CCDF plans, few states reported analyzing the costs of providing high-quality care (in addition to the results of market rate surveys) when setting payment rates. The ECE access guidebook provides examples for measuring the price of high-quality care in low-income areas, which could be used by states. For instance, payment rates can be compared to prices for care by geographic locations and quality level to assess the affordability of care for families receiving a subsidy. These types of analyses can help states and territories understand how payment polices support access to high-quality care for families.

5. **Develop measures to evaluate technical assistance and professional development activities:** Nearly all states/territories reported providing training and professional development to promote and expand the abilities of staff working with children. Technical assistance was also the most common strategy to support the quality of care for vulnerable populations such as infants and toddlers**.** However, less than one-quarter of states/territories reported assessing progress toward improving the quality of care based on measures of workforce supports. Understanding how state-funded technical assistance supports a strong and stable early childhood workforce is important for assessing access to high-quality care. To accomplish this, some states are developing workforce registries to capture comprehensive data about the workforce, including demographics, education, certification, training, and technical assistance information. These data can be used to address research questions related to the early childhood workforce and its impact on access. For more information on state workforce data policies, see the Center for the Study of Child Care Employment at UC Berkeley's Early Childhood Workforce Index (http://cscce.berkeley.edu/early-childhood-workforce-index/). For more information on state workforce registries visit the National Registry Alliance (TNRA) at https://www.registryalliance.org/index.php).

Appendices

Data Tables by State and Territory

Appendix A: Definition of Families with Very Low Income, by State/Territory

State/ Territory	Percent of Federal Poverty Level	Percent of State Median Income	TANF eligible	Other	N/A
Alabama	x				
Alaska		x			
American Samoa		x			
Arizona	x				
Arkansas	x				
California					x
Colorado			x		
Connecticut		x			
Delaware	x				
District of Columbia				Family of a specific size with an income under a specific limit	
Florida	x			Working migratory family	
Georgia					x
Guam	x				
Hawaii	x				
Idaho			x		
Illinois		x			
Indiana	x				
Iowa	x				
Kansas	x				
Kentucky	x				
Louisiana	x	x			
Maine	x				
Maryland		x			
Massachusetts		x			
Michigan	x				
Minnesota		x			
Mississippi		x			
Missouri		x			
Montana	x		x		
Nebraska	x				
Nevada	x				

Appendix A, cont.: Definition of Families with Very Low Income, by State/Territory

State/ Territory	Percent of Federal Poverty Level	Percent of State Median Income	TANF eligible	Other	N/A
New Hampshire	x				
New Jersey	x				
New Mexico	x				
New York		x			
North Carolina		x			
North Dakota			x	Eligibility for other assistance programs	
Northern Mariana Islands	x				
Ohio	x				
Oklahoma				Income less than a certain amount	
Oregon	x				
Pennsylvania			x		
Puerto Rico		x			
Rhode Island	x				
South Carolina	x				
South Dakota	x				
Tennessee			x		
Texas			x	Eligibility for other assistance programs	
Utah			x	Homeless families	
Vermont			x	CCFAP Sliding Fee Scale - 100% eligible	
Virgin Islands		x			
Virginia			x	Head Start participants	
Washington			x		
West Virginia	x				
Wisconsin	x				
Wyoming	x				

Appendix B: Status of Procedures to Enroll and Provide Outreach to Homeless Families and Establish a Grace Period for Children in Foster Care for Meeting Immunization Requirements, by State/Territory

State/Territory	Implemented	Partially Implemented	Not Implemented
Alabama		x	
Alaska		x	
American Samoa		x	
Arizona	x		
Arkansas	x		
California	x		
Colorado	x		
Connecticut		x	
Delaware		x	
DC	x		
Florida	x		
Georgia		x	
Guam	x		
Hawaii			x
Idaho		x	
Illinois		x	
Indiana	x		
Iowa	x		
Kansas		x	
Kentucky	x		
Louisiana	x		
Maine	x		
Maryland	x		
Massachusetts	x		
Michigan		x	
Minnesota		x	
Mississippi		x	
Missouri		x	
Montana		x	
Nebraska			x
Nevada	x		
New Hampshire		x	
New Jersey		x	
New Mexico	x		
New York		x	
North Carolina	x		

Appendix B, cont.: Status of Procedures to Enroll and Provide Outreach to Homeless Families and Establish a Grace Period for Children in Foster Care for Meeting Immunization Requirements, by State/Territory

State/Territory	Implemented	Partially Implemented	Not Implemented
North Dakota		x	
Northern Mariana Islands	x		
Ohio	x		
Oklahoma	x		
Oregon	x		
Pennsylvania	x		
Puerto Rico	x		
Rhode Island		x	
South Carolina	x		
South Dakota	x		
Tennessee		x	
Texas		x	
Utah	x		
Vermont	x		
Virgin Islands		x	
Virginia		x	
Washington	x		
West Virginia	x		
Wisconsin	x		
Wyoming		x	

Appendix C: Policies to Provide a Grace Period to Comply with Immunization and Other Health and Safety Requirements for Children in Foster Care, by State/Territory

State/Territory	Offers a grace period	Offers no grace period	Additional time provided	Unspecified time	<30 days	30 days/6 weeks	60 days/2 months	90 days/3 months	6 months	Additional support provided
Alabama		X								
Alaska		X								
American Samoa		X								
Arizona	X		x	x						
Arkansas	X		x		x					x
California	X		x			x				
Colorado	X		x				x			
Connecticut		X								
Delaware		X								
DC	X		x					x		
Florida	X		x			x				
Georgia		X								
Guam	X		x	x						
Hawaii		X								
Idaho		X								
Illinois		X								
Indiana	X		x					x		
Iowa		X								
Kansas		X								
Kentucky	X		x					x		
Louisiana		X								
Maine	X		x					x		
Maryland		X								
Massachusetts	X		x						x	
Michigan		X								
Minnesota		X								
Mississippi		X								
Missouri		X								
Montana		X								

Appendix C, cont.: Policies to Provide a Grace Period to Comply with Immunization and Other Health and Safety Requirements for Children in Foster Care, by State/Territory

State/Territory	Offers a grace period	Offers no grace period	Additional time provided	Unspecified time	<30 days	30 days/6 weeks	60 days/2 months	90 days/3 months	6 months	Additional support provided
Nebraska		X								
Nevada	X		x					x		
New Hampshire		X								
New Jersey		X								
New Mexico	X		x			x				
New York		X								
North Carolina	X		x			x				
North Dakota		X								
Northern Mariana Islands		X								
Ohio	X		x			x				
Oklahoma	X		x			x				
Oregon	X		x			x				
Pennsylvania	X		x	x						
Puerto Rico	X		x			x				
Rhode Island		X								
South Carolina	X		x	x						
South Dakota	X		x	x						
Tennessee		X								
Texas		X								
Utah		X								
Vermont	X		x			x				x
Virgin Islands		X								
Virginia		X								
Washington		X								
West Virginia	X		x					x		
Wisconsin	X		x			x				
Wyoming		X								

Appendix D: State/Territory Conducts Data Analysis of Child Care Supply Needs

State/Territory	Yes	No
Alabama	x	
Alaska	x	
American Samoa	x	
Arizona	x	
Arkansas	x	
California	x	
Colorado	x	
Connecticut	x	
Delaware	x	
DC	x	
Florida	x	
Georgia	x	
Guam		x
Hawaii		x
Idaho		x
Illinois		x
Indiana	x	
Iowa	x	
Kansas	x	
Kentucky	x	
Louisiana	x	
Maine	x	
Maryland	x	
Massachusetts	x	
Michigan		x
Minnesota	x	
Mississippi	x	
Missouri	x	
Montana	x	
Nebraska	x	
Nevada	x	
New Hampshire	x	
New Jersey		x
New Mexico	x	
New York		x
North Carolina		x
North Dakota	x	

Appendix D, cont.: State/Territory Conducts Data Analysis of Child Care Supply Needs

State/Territory	Yes	No
Northern Mariana Islands		x
Ohio	x	
Oklahoma	x	
Oregon	x	
Pennsylvania	x	
Puerto Rico	x	
Rhode Island		x
South Carolina	x	
South Dakota	x	
Tennessee		x
Texas		x
Utah	x	
Vermont	x	
Virgin Islands		x
Virginia		x
Washington	x	
West Virginia		x
Wisconsin	x	
Wyoming		x

Appendix E: Methods to Increase Supply and Improve Quality for Infants and Toddlers

State/Territory	Infants and toddlers						
	Grants and contracts	Family child care networks	Start-up funding	Technical assistance support	Recruitment of providers	Tiered payment rates (as discussed in 4.4.1)	Other
Alabama							x
Alaska				x	x		x
American Samoa					x		x
Arizona	x			x	x	x	
Arkansas				x	x	x	
California	x						
Colorado	x						x
Connecticut		x		x		x	
Delaware	x			x	x	x	
DC		x	x		x	x	x
Florida	x	x		x			
Georgia	x	x		x	x		x
Guam				x			
Hawaii	x			x	x	x	x
Idaho			x	x	x		x
Illinois	x	x		x			
Indiana	x		x	x	x	x	x
Iowa	x					x	x
Kansas	x					x	
Kentucky				x		x	
Louisiana				x		x	x
Maine				x		x	
Maryland	x			x		x	
Massachusetts	x	x		x	x	x	
Michigan	x				x		x
Minnesota			x			x	x
Mississippi	x			x			
Missouri							x
Montana						x	x
Nebraska			x	x		x	
Nevada	x				x		
New Hampshire				x			x

Appendix E, cont.: Methods to Increase Supply and Improve Quality for Infants and Toddlers

State/Territory	Infants and toddlers						
	Grants and contracts	Family child care networks	Start-up funding	Technical assistance support	Recruitment of providers	Tiered payment rates (as discussed in 4.4.1)	Other
New Jersey	x	x		x	x	x	
New Mexico				x		x	
New York							x
North Carolina				x		x	x
North Dakota			x	x	x		
Northern Mariana Islands				x	x		x
Ohio				x		x	x
Oklahoma				x			x
Oregon	x	x		x		x	
Pennsylvania		x	x	x	x	x	
Puerto Rico	x	x		x	x		
Rhode Island				x		x	
South Carolina	x	x		x	x	x	x
South Dakota			x	x	x	x	
Tennessee	x					x	
Texas				x		x	x
Utah	x		x	x	x	x	
Vermont	x						
Virgin Islands	x			x	x		x
Virginia				x			x
Washington	x			x		x	x
West Virginia				x		x	x
Wisconsin	x					x	
Wyoming				x	x		

Appendix E: Methods to Increase Supply and Improve Quality for Children with Disabilities

State/ Territory	Children with disabilities						
	Grants and contracts	Family child care networks	Start-up funding	Technical assistance support	Recruitment of providers	Tiered payment rates (as discussed in 4.4.1)	Other
Alabama							x
Alaska				x	x		x
American Samoa					x		x
Arizona	x			x	x	x	
Arkansas				x		x	
California	x						
Colorado							
Connecticut				x		x	
Delaware	x			x	x	x	
DC		x	x			x	
Florida		x		x		x	
Georgia				x	x	x	
Guam				x			
Hawaii							
Idaho			x	x	x		x
Illinois	x	x		x		x	
Indiana	x		x	x	x		
Iowa						x	
Kansas	x						x
Kentucky				x		x	
Louisiana						x	x
Maine				x			
Maryland							x
Massachusetts		x		x	x		x
Michigan							
Minnesota						x	x
Mississippi						x	
Missouri						x	
Montana						x	
Nebraska			x	x		x	
Nevada	x				x		

Appendix E, cont.: Methods to Increase Supply and Improve Quality for Children with Disabilities

State/ Territory	Children with disabilities						
	Grants and contracts	Family child care networks	Start-up funding	Technical assistance support	Recruitment of providers	Tiered payment rates (as discussed in 4.4.1)	Other
New Hampshire				x		x	
New Jersey					x	x	
New Mexico				x			
New York							x
North Carolina				x			x
North Dakota			x	x	x		
Northern Mariana Islands				x			
Ohio				x			x
Oklahoma				x		x	x
Oregon				x	x	x	
Pennsylvania			x	x			
Puerto Rico	x	x		x	x		
Rhode Island				x		x	
South Carolina	x	x		x		x	
South Dakota			x	x	x	x	
Tennessee	x						
Texas				x			x
Utah						x	x
Vermont	x			x	x	x	
Virgin Islands	x			x	x		x
Virginia						x	x
Washington				x			x
West Virginia				x		x	
Wisconsin	x					x	
Wyoming				x	x		x

Appendix E: Methods to Increase Supply and Improve Quality for Children Who Receive Care during Nontraditional Hours

State/ Territory	Children who receive care during nontraditional hours						
	Grants and contracts	Family child care networks	Start-up funding	Technical assistance support	Recruitment of providers	Tiered payment rates (as discussed in 4.4.1)	Other
Alabama				x			
Alaska				x	x		
American Samoa				x	x		x
Arizona	x				x		
Arkansas						x	
California	x						
Colorado							
Connecticut							
Delaware	x			x	x	x	
DC		x	x			x	
Florida		x		x			
Georgia		x			x	x	
Guam				x			
Hawaii				x			
Idaho			x	x	x		x
Illinois	x	x					
Indiana				x	x		
Iowa							x
Kansas	x						x
Kentucky						x	x
Louisiana							x
Maine				x		x	
Maryland							x
Massachusetts		x		x	x		
Michigan							
Minnesota			x			x	
Mississippi	x						
Missouri						x	
Montana							
Nebraska		x	x				x
Nevada							

Appendix E, cont.: Methods to Increase Supply and Improve Quality for Children Who Receive Care during Nontraditional Hours

State/ Territory	Children who receive care during nontraditional hours						
	Grants and contracts	Family child care networks	Start-up funding	Technical assistance support	Recruitment of providers	Tiered payment rates (as discussed in 4.4.1)	Other
New Hampshire				x			
New Jersey							
New Mexico						x	
New York							x
North Carolina							
North Dakota			x	x	x		
Northern Mariana Islands					x		
Ohio				x		x	x
Oklahoma							
Oregon				x	x		
Pennsylvania				x	x		
Puerto Rico	x	x		x	x		
Rhode Island				x	x	x	
South Carolina	x	x		x	x	x	x
South Dakota							
Tennessee							x
Texas							x
Utah							
Vermont							
Virgin Islands	x			x	x		x
Virginia							x
Washington							x
West Virginia						x	
Wisconsin							x
Wyoming				x	x		

Appendix E: Methods to Increase Supply and Improve Quality for Homeless Children

State/ Territory	Homeless children						
	Grants and contracts	Family child care networks	Start-up funding	Technical assistance support	Recruitment of providers	Tiered payment rates (as discussed in 4.4.1)	Other
Alabama							
Alaska				x	x		
American Samoa				x	x		x
Arizona	x		x	x	x		
Arkansas							x
California	x						
Colorado							
Connecticut		x		x			
Delaware							
DC							x
Florida				x			x
Georgia	x				x	x	x
Guam				x			x
Hawaii							
Idaho							
Illinois							
Indiana				x	x		
Iowa							x
Kansas	x						
Kentucky						x	x
Louisiana						x	x
Maine				x			
Maryland							x
Massachusetts	x	x		x	x	x	
Michigan							
Minnesota						x	
Mississippi	x						
Missouri							
Montana							
Nebraska							
Nevada					x		
New Hampshire							

Appendix E, cont.: Methods to Increase Supply and Improve Quality for Homeless Children

State/ Territory	Homeless children						
	Grants and contracts	Family child care networks	Start-up funding	Technical assistance support	Recruitment of providers	Tiered payment rates (as discussed in 4.4.1)	Other
New Jersey				x			x
New Mexico							x
New York							x
North Carolina				x			
North Dakota			x	x	x		
Northern Mariana Islands					x		
Ohio				x			x
Oklahoma				x		x	
Oregon							
Pennsylvania				x	x		
Puerto Rico	x	x			x		
Rhode Island				x	x		
South Carolina	x	x		x	x	x	
South Dakota				x	x		
Tennessee	x						
Texas				x			
Utah				x			
Vermont	x			x			
Virgin Islands	x			x	x		x
Virginia							x
Washington							x
West Virginia				x			
Wisconsin	x						
Wyoming				x	x		

Appendix F: Implementation Status and Policies to Prioritize Children in Poverty or Experiencing Unemployment

Implementation of plans to prioritize children in families in poverty or experiencing unemployment				Policies to increase access for children in families in poverty or experiencing unemployment					
State/Territory	Implemented	Partially implemented	Not implemented	Collaboration with other ECE program (i.e., EHS-CCP, Head Start, pre-K, etc.	Family friendly policies: Prioritizes eligibility, reduce/waive copayments, exempt from waitlists, application offices are conveniently located	Contracts with, offers higher rates, or gives priority to providers in low-income communities	Grants for providers serving children with subsidies in these communities	TA and professional development, or other quality improvement activity (e.g., participate in QRIS) for providers serving in these communities	Other
Alabama	x			x		x			
Alaska	x				x				
American Samoa	x				x				x
Arizona		x							
Arkansas	x			x					
California	x			x					x
Colorado	x						x		
Connecticut	x					x	x		
Delaware	x						x	x	
DC	x			x				x	
Florida	x			x		x			
Georgia	x			x	x		x	x	
Guam	x				x				
Hawaii	x				x				
Idaho		x							

Appendix F, cont.: Implementation Status and Policies to Prioritize Children in Poverty or Experiencing Unemployment

Implementation of plans to prioritize children in families in poverty or experiencing unemployment				Policies to increase access for children in families in poverty or experiencing unemployment					
State/Territory	Implemented	Partially implemented	Not implemented	Collaboration with other ECE program (i.e., EHS-CCP, Head Start, pre-K, etc.	Family friendly policies: Prioritizes eligibility, reduce/waive copayments, exempt from waitlists, application offices are conveniently located	Contracts with, offers higher rates, or gives priority to providers in low-income communities	Grants for providers serving children with subsidies in these communities	TA and professional development, or other quality improvement activity (e.g., participate in QRIS) for providers serving in these communities	Other
Illinois	x								
Indiana	x						x	x	
Iowa	x								
Kansas		x							
Kentucky	x							x	
Louisiana	x			x	x	x			
Maine		x							
Maryland	x							x	
Massachusetts	x							x	
Michigan			x						
Minnesota	x				x	x			
Mississippi		x							
Missouri	x					x			
Montana		x							
Nebraska	x							x	
Nevada	x								

Appendix F, cont.: Implementation Status and Policies to Prioritize Children in Poverty or Experiencing Unemployment

Implementation of plans to prioritize children in families in poverty or experiencing unemployment				Policies to increase access for children in families in poverty or experiencing unemployment					
State/Territory	Implemented	Partially implemented	Not implemented	Collaboration with other ECE program (i.e., EHS-CCP, Head Start, pre-K, etc.	Family friendly policies: Prioritizes eligibility, reduce/waive copayments, exempt from waitlists, application offices are conveniently located	Contracts with, offers higher rates, or gives priority to providers in low-income communities	Grants for providers serving children with subsidies in these communities	TA and professional development, or other quality improvement activity (e.g., participate in QRIS) for providers serving in these communities	Other
New Hampshire		x							
New Jersey		x							
New Mexico	x			x				x	
New York		x							
North Carolina		x							
North Dakota	x							x	
Northern Mariana Islands	x							x	
Ohio	x								x
Oklahoma	x			x	x			x	
Oregon	x				x				
Pennsylvania	x					x			
Puerto Rico	x					x			
Rhode Island		x							

Appendix F, cont.: Implementation Status and Policies to Prioritize Children in Poverty or Experiencing Unemployment

Implementation of plans to prioritize children in families in poverty or experiencing unemployment				Policies to increase access for children in families in poverty or experiencing unemployment					
State/Territory	Implemented	Partially implemented	Not implemented	Collaboration with other ECE program (i.e., EHS-CCP, Head Start, pre-K, etc.	Family friendly policies: Prioritizes eligibility, reduce/waive copayments, exempt from waitlists, application offices are conveniently located	Contracts with, offers higher rates, or gives priority to providers in low-income communities	Grants for providers serving children with subsidies in these communities	TA and professional development, or other quality improvement activity (e.g., participate in QRIS) for providers serving in these communities	Other
South Carolina	x					x			x
South Dakota	x					x	x		
Tennessee	x				x	x			
Texas	x					x			
Utah	x					x	x		
Vermont	x						x		
Virgin Islands	x					x	x	x	
Virginia		x							
Washington	x				x			x	
West Virginia	x								x
Wisconsin	x						x	x	
Wyoming		x							

Appendix G: Methods to Ensure that Payment Rates Are Sufficient to Ensure Equal Access

State/Territory certifies that payment rates are sufficient to ensure equal access			Methods to certify payment rates are sufficient to ensure equal access					
State/Territory	Yes	No	Market rate survey	Alternative method/cost information	Percent of licensed or regulated providers participating in the subsidy system	Tiered reimbursement/ differential rates	Percent of children receiving subsidies in licensed or quality-rated care	Other
Alabama	x		x					
Alaska		x						
American Samoa	x							x
Arizona		x						
Arkansas	x					x		
California		x						
Colorado	x		x					
Connecticut		x						
Delaware	x		x			x		
DC	x				x			
Florida	x				x			
Georgia		x						
Guam	x		x	x				
Hawaii		x						
Idaho		x						
Illinois	x				x			
Indiana	x		x					
Iowa	x		x					
Kansas	x		x			x		
Kentucky	x		x					

Appendix G, cont.: Methods to Ensure that Payment Rates Are Sufficient to Ensure Equal Access

State/Territory certifies that payment rates are sufficient to ensure equal access			Methods to certify payment rates are sufficient to ensure equal access					
State/Territory	Yes	No	Market rate survey	Alternative method/cost information	Percent of licensed or regulated providers participating in the subsidy system	Tiered reimbursement/ differential rates	Percent of children receiving subsidies in licensed or quality-rated care	Other
Louisiana	x							x
Maine	x		x			x	x	
Maryland	x				x			x
Massachusetts	x				x			x
Michigan		x						
Minnesota	x							x
Mississippi		x						
Missouri	x					x		
Montana		x						
Nebraska	x		x					
Nevada		x						
New Hampshire	x		x				x	
New Jersey		x						
New Mexico	x				x		x	
New York	x							
North Carolina	x		x		x	x	x	
North Dakota	x						x	
Northern Mariana Islands		x						
Ohio	x		x			x		

Appendix G, cont.: Methods to Ensure that Payment Rates Are Sufficient to Ensure Equal Access

State/Territory certifies that payment rates are sufficient to ensure equal access			Methods to certify payment rates are sufficient to ensure equal access					
State/Territory	Yes	No	Market rate survey	Alternative method/cost information	Percent of licensed or regulated providers participating in the subsidy system	Tiered reimbursement/ differential rates	Percent of children receiving subsidies in licensed or quality-rated care	Other
Oklahoma	x		x				x	x
Oregon	x		x					
Pennsylvania	x				x		x	
Puerto Rico	x		x					
Rhode Island	x						x	
South Carolina	x		x			x	x	
South Dakota	x		x					
Tennessee	x				x		x	
Texas	x				x			
Utah	x		x					
Vermont	x				x	x	x	x
Virgin Islands	x		x					
Virginia	x					x	x	
Washington		x						
West Virginia	x					x		
Wisconsin	x		x					
Wyoming	x		x					

Appendix H: State/Territory Has a Quality Rating and Improvement System (QRIS)

State/Territory	Yes	Operating state-/ territory-wide	Operating as a pilot, in a few localities, or only a few levels	No	In the development phase	No plans for development
Alabama	x	x				
Alaska	x		x			
American Samoa				x	x	
Arizona	x	x				
Arkansas	x	x				
California	x		x			
Colorado	x	x				
Connecticut				x	x	
Delaware	x	x				
DC	x	x				
Florida	x		x			
Georgia	x	x				
Guam	x	x				
Hawaii				x		x
Idaho	x	x				
Illinois	x	x				
Indiana	x	x				
Iowa	x	x				
Kansas				x	x	
Kentucky	x	x				
Louisiana	x	x				
Maine	x	x				
Maryland	x	x				
Massachusetts	x	x				
Michigan	x	x				
Minnesota	x	x				
Mississippi	x	x				
Missouri				x		x
Montana	x	x				
Nebraska	x	x				
Nevada	x	x				
New Hampshire	x	x				
New Jersey	x	x				

Appendix H, cont.: State/Territory Has a Quality Rating and Improvement System (QRIS)

State/Territory	Yes	Operating state-/ territory-wide	Operating as a pilot, in a few localities, or only a few levels	No	In the development phase	No plans for development
New Mexico	x	x				
New York	x	x				
North Carolina	x	x				
North Dakota	x		x			
Northern Mariana Islands				x	x	
Ohio	x	x				
Oklahoma	x	x				
Oregon	x	x				
Pennsylvania	x	x				
Puerto Rico	x		x			
Rhode Island	x	x				
South Carolina	x	x				
South Dakota				x	x	
Tennessee	x	x				
Texas	x	x				
Utah	x		x			
Vermont	x	x				
Virgin Islands	x		x			
Virginia	x	x				
Washington	x	x				
West Virginia				x	x	
Wisconsin	x	x				
Wyoming				x	x	