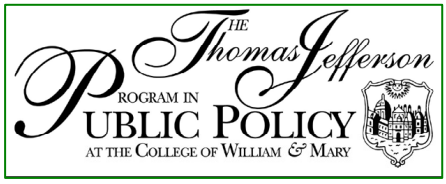
POLICY AND BUDGET ANALYSIS OF VIRGINIA'S CHILD CARE SUBSIDY PROGRAM (CCDF)



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Executive Summary

The Child Care Development Fund (CCDF) is the primary Federal program for providing quality child care subsidies to low-income families. The major goals of the CCDF funds and child care subsidies are to enhance early childhood development, enable parents to participate in welfare to work programs, and promote the overall self-sufficiency of families receiving public assistance. Three of the main issues that affect child care subsidy programs are: quality, access, and cost. This report will explore national trends in these three areas by examining the child care programs in Virginia and a variety of other states to identify best practices. Our analysis of Virginia in comparison to other states has allowed us to determine meaningful policy options to improve the quality, cost, and access of child care subsidies in Virginia.

Quality

Quality child care for children receiving subsidies plays an important role in achieving the CCDF funding goals, by improving the standards of child care available to low-income individuals and families. Research shows that quality child care can directly influence children's development, especially for newborns and toddlers. For the purposes of this report, quality will be analyzed in three broad areas: standards and oversight, professional development, and Quality Rating Systems (QRS). Standards and oversight aid in the understanding of how a program is run, what nationally recommended benchmarks a child care subsidy program meets, and the degree to which child care providers meet health and safety standards. Professional development and the use of state Professional Development Plans serve as an important tool in training and educating child care providers, which can improve provider retention and greatly influence the overall quality of child care. The last aspect of quality is the use of a QRS, which serves to increase parental awareness about quality indicators, improve resources to sustain and improve quality, and create system-wide improvements for all ages of children served in child care programs. Best practices in these quality areas include setting achievable goals and outcomes in a Professional Development Plan, creating public and private partnerships to improve standards, oversight and professional development opportunities, and coordinating child care activities through a QRS.

Costs

The economic value of child care subsidies and associated costs to low-income working families also plays a pivotal role in achieving the CCDF funding goals. Cost will be evaluated in two areas, reimbursement rates and parent co-payments, both of which are ideally set at a rate that makes high quality child care affordable for low-income working parents. The federal recommendation for maximum reimbursement rates, which is the amount that a state reimburses providers to care for subsidized children, suggests that provider reimbursement rates be set at the 75^{th} percentile of current market rates. At this level, subsidized families would have access to 75 percent of area child care providers. Federal regulations require that families above certain income levels that are participating in child care subsidy programs must assist in paying the costs of child care through parent co-payments. Federal guidelines suggest, but do not mandate, that

parent co-payments not be greater than 10 percent of income, regardless of the size of the family. Best practices in the area of cost include tiered reimbursement rate schedules that offer larger payments for high quality child care providers, and sliding fee co-payment scales that use family income and family size to determine the amount of the family's co-payment without exceeding 10 percent of family income.

Access

Ensuring that families in need of subsidies are able to access them also plays an important role in achieving the CCDF funding goals. States are required to prioritize subsidies to low-income families and families with special needs children; however other characteristics such as being a TANF, Head Start or Food Stamp and Employment Training (FSET) participant can be used to grant subsidies as well. Access to child care subsidies will be evaluated in two areas, income eligibility rates and waiting lists. Income eligibility rates are guidelines used to qualify families up to a certain income level for subsidy use, and are usually adjusted to correct for inflation and changes in the federal poverty level or state median income level. When the demand for subsidies exceeds the available funding, most states use waiting lists to keep track of eligible families until subsidies can be made available. Both income eligibility and waiting lists pose a significant barrier to access for some families who may not receive priority for subsidies but are still in need of child care assistance. Best practices for these two areas include establishing exit eligibility rates so that families can maintain subsidies despite increases in income or inflation, and the formation of public and private partnerships to provide additional care options for families on waiting lists.

Virginia's Child Care Subsidy Program

Virginia's child care subsidy program is the 22nd largest program in the country, serving approximately 29,000 children a month, for an annual total of 55,107 children throughout FY 2008. Of the approximately 189,000 children receiving child care services in either a center-based or family provider situation throughout FY 2007-FY 2008, approximately 12.5 percent are receiving subsidies. According to VDSS, total funding for Virginia's child care subsidy program in FY 2008, excluding staff allowances, was $124,007,139. While this amount is an increase from the total funding amount of $98,999,869 in FY 1999, it was a decrease in funding from levels of $141,721,412 and $151,361,361 in FY 2005 and FY 2006. Other pertinent aspects of Virginia's child care program include

- Virginia is currently in the process of developing a QRS, and is in the planning phases of a instituting a Professional Development Plan.
- Of the states that offer subsidies to families at the 150 percent FPL, Virginia has the 10th highest co-payment rate in the country for a family of three.
- Virginia has the 40th lowest maximum provider reimbursement rates in the country.
- When Virginia's four income eligibility rates are averaged they equal 195 percent of the federal poverty level, and are the 14th highest rate in the country.
- Virginia is one of 17 states with waiting lists, but was able to decrease its waiting list by over 2,000 children this year due to additional TANF funding.

Virginia's child care subsidy program has been successful at helping thousands of low-income working families by improving early development and education opportunities for children, promoting positive employment outcomes, and encouraging self-sufficiency. However, in light of some of the practices being developed and implemented in other states, there is clearly potential to improve Virginia's child care program. Our analysis of Virginia's child care program, and best practices used by other states in the areas of quality, cost, and access has warranted the following policy options.

Policy Options to Improve Virginia's Child Care Subsidy Program

Access Policy Option: Establish partnerships with other entities to help serve families on the waiting list, and devote additional funding to provide subsidies to serve unmet need.
Quality Recommendation: Create public and private partnerships to address training and certification needs for child care providers.
Quality Policy Option: Address the unmet needs of professional development across the state, including carefully constructing and implementing a Professional Development Plan.
Quality Policy Option: Implement a statewide Quality Rating System.
Cost Policy Option: Standardize maximum reimbursement rates for licensed providers across the state to the federally recommended 75th percentile, with at least two higher quality tiers set above this level with specific criteria in place for high quality providers, such as NAEYC accreditation, to incentivize high quality child care facilities.
Access Policy Option: Establish an exit eligibility rate to allow families to maintain subsidies despite income increases and inflation.
Cost Policy Option: Implement a sliding fee scale for co-payments whereby as income increases, the percentage of gross monthly income (GMI) required as co-payment increases.

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Chapter One: Introduction and Overview

The Child Care Development Fund (CCDF) is the primary Federal program for providing quality child care subsidies to low-income families. Child care subsidies play an important role in enhancing early childhood development, enabling parents to participate in welfare to work programs, and promoting the overall self-sufficiency of families receiving public assistance. Due to decreases in overall CCDF and Temporary Assistance for Needy Families (TANF) funding, the Bush Administration estimated that 200,000 children were expected to lose child care subsidies through FY 2007.[1] In addition to dwindling Federal funding, many states including Virginia are facing their own budgetary problems, which could have negative impacts on the quality and costs of child care, as well as the number of families eligible to receive child care subsidies. With nearly one quarter of America's families with young children earning less than $25,000 a year[2], and the average cost of child care ranging from $3,400 to $14,600 a year, it is important that funding levels for child care do not decrease.[3]

Also problematic are shifts in the economy that have increased the number of people holding low wage jobs to between 35 and 46 million workers. This increase in low-wage jobs negatively affects employees in terms of benefits, health insurance, leave time, and retirement. At the same time, costs of supporting families including housing, medical expenses, transportation, and child care are increasing and consuming larger portions of families' budgets. Many of these families face daily financial struggles, as they are forced to decide which basic necessities they can afford. Government "work support" benefits for low-wage workers such as the Earned Income Tax Credit (EITC), health insurance (Medicaid and SCHIP), housing assistance, and child care subsidies help workers to fill the income gap of low-wages and everyday basic expenses. Specifically, research shows that work support programs have positive impacts on family employment and household incomes, which is beneficial to children and can help families achieve self-sufficiency. To understand the role that child care subsidies play in providing low-income families with access to quality and affordable child care, it is necessary to better understand the origin and purposes of the CCDF and its implementation throughout the states.[4]

Due to the important role that subsidies can play in supporting low-income working families, and given the current budgetary issues facing Virginia, an evaluation of Virginia's child care subsidy program is warranted to determine what improvements can be made. This report will provide information on the current child care subsidy program at both the federal and state

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[1] Jennifer Mezey and Sharon Parrott, "Bush Administration Projects That the Number of Children Receiving Child Care Subsidies Will Fall By 200,000 During the Next Five Years," Center on Budget and Policy Priorities, (February 2003), 1, http://www.cbpp.org/2-5-03tanf.pdf.

[2] Children's Defense Fund, "The State of America's Children 2005," (2005), 59, http://www.childrensdefense.org/site/DocServer/Greenbook_2005.pdf?docID=1741.

[3] Helen Blank and Karen Schulman, "State Child Care Assistance Policies 2008: Too Little Progress for Children and Families," National Women's Law Center, (September, 2008), 1, http://www.nwlc.org/pdf/StateChildCareAssistancePoliciesReport08.pdf.

[4] Nancy K Cauthen , "Improving Work Supports: Closing the Financial Gap for Low-wage workers and their Families," Agenda for Shared Prosperity, (October 2007), http://www.sharedprosperity.org/bp198.html.

level, with a focus on the issues of quality, access, and cost. We will evaluate Virginia and other states that spend similar amounts on child care subsidies as Virginia, within these three issue areas to ascertain what improvements Virginia can make while maintaining or slightly increasing its current spending levels per child per month.

The first chapter will provide a general overview of the basis, purpose and funding of the CCDF and highlight some of the reasons why child care subsidies are important supports for low-income working families. In the second chapter, we will focus on and describe the national trends of child care subsidies in terms of quality, economic costs, and access. The third chapter will detail the scope of this report, the methodology used to compare Virginia to other states, and the limitations we encountered. The fourth chapter will include statistics and a description of the current child care subsidy program in Virginia in the areas of quality, economic cost, and access, to better understand where improvements can be made. In the fifth chapter, we will evaluate a range of positive and negative practices used in other states as the basis for potential improvements and warnings for Virginia's program, and finally the sixth chapter will focus on our policy options for Virginia's child care subsidy program and their implications. The policy options for the subsidy program will include cost efficient policy options that will allow improvements with limited to no additional spending, as well as the costs of program policy options that would require additional funding to be implemented.

I. Legal Basis

The Federal legal basis for child care subsidies originates in the Child Care and Development Block Grant Act of 1990 (42 USC 9801 et seq.), and Hunger Prevention Act of 1988. Title VI entitlements of the Social Security Act offered three child care aid programs: Aid to Families with Dependent Children (AFDC) Child Care Program, which provided funds to families who were in educational or training programs; the Transitional Child Care Program, which was available for those in transition from AFDC to work; and the At-Risk Child Care, which provided child care assistance to families at-risk for AFDC eligibility. The Personal Responsibility and Work Opportunity Act of 1996 (PRWOA) (Public Law 104-193), was merged with Title VI of the Social Security Act and the Child Care Development Block Grant (CCDBG), and is now commonly referred to as the Child Care and Development Fund (CCDF). This act established work requirements associated with TANF support and therefore increased the need for child care subsidies to allow parents to participate in the workforce. It also eliminated all federal child care entitlements to provide states with more flexibility to determine family needs and state funding levels, created discretionary funding for child care subsidy programs, and allowed states to transfer TANF funds for CCDF purposes.[5]

CCDF was further amended in the Balanced Budget Act of 1997. The Code of Federal Regulations Parts 98 and 99 set the specifications and responsibilities for the state Lead Agencies administering CCDF child care subsidies. Virginia's legal basis is codified in *The Code of*

[5] Sandra J. Clark and Sharon K. Long, "The New Child Care Block Grant: State Funding Choices and Their Implications," Urban Institute, (October 1997), 1, http://www.urban.org/publications/307043.html.

Virginia 63.2-620, which allows local social services departments to grant child care subsidies to TANF families and at-risk non-TANF families whose incomes are at or below 185 Federal Poverty Level (FPL).[6]

II. CCDF Funds

The CCDF is a Federal program run out of the Administration of Children and Families in the Child Care Bureau Division within the Department of Health and Human Services. The Federal government, through the CCDF block grant legislation, has made available five billion dollars to all 50 States, Territories, and Tribes in fiscal year 2008 for child care subsidy provisions. Federal child care subsidy funding peaked in FY 2002 at $4.817 billion, declined by 17 million in FY 2005, and rose slightly in FY 2006. However, FY 2008 funding fell below FY 2002 levels after adjusting for inflation. In addition to Federal funding, states have the ability to transfer up to 30 percent of Federal TANF block grants funds to CCDF funds for child care subsidy programs. Federal TANF funds were at a high of $3.97 billion in FY 2000, but have declined substantially to $3.12 billion in FY 2006.[7]

States must submit a biennial CCDF State Plan to the Federal government in order to apply for funds. The State Plan outlines the use of child care monies for each state. States use a variety of funding sources to provide child care subsidies, including: Mandatory funds, Discretionary funds, Matching funds, and Maintenance of Effort (MOE) funds. Mandatory funds accounted for $1.2 billion of the Federal CCDF funds and can be described as a state's share of the Federal funds based upon the former AFDC-linked child care programs that the CCDF replaced. In FY 2006, nearly two billion dollars in Discretionary funds were allocated to the states based on a proportional formula weighting the ratios of children under five-years-old and those receiving free or reduced school lunches, to a three year per capita income average formula.

Discretionary funds are used to enhance school age child activities, fund the Child Care Aware Hotline, improve quality for infant and toddler child care, and perform child care research. In addition, states are obligated to use some of the CCDF funds for enhancing child care quality and access. Matching funds provide the remainder of Federal funds, excluding Mandatory funds, and those reserved for technical assistance. Matching funds are allocated to states based on the number of children in the state less than 13 years of age compared to the national average. States receive nearly all of the remaining 98 percent of both Matching and Mandatory funds. In order to receive Federal Matching funds, a state must contribute at the current Medicaid match rate for that state.[8]

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[6] The Code of Virginia, "Chapter 6 - Temporary Assistance for Needy Families Program," http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+TOC63020000006000000000000.
[7] Blank and Schulman, 4.
[8] United States Department of Health and Human Services, "Overview of the Child Care Development Fund, FY 2006-2007," Administration for Children and Families (November 2006), http://www.acf.hhs.gov/programs/ccb/ccdf/ccdf06_07desc.htm.

States must also contribute in the form of MOE. These funds are state funds that are required to continue at the level a state was matching the former AFDC-linked child care programs in FY 1994 or FY 1995, whichever was greater. States are also required to use no less than four percent of CCDF funds for quality enhancing activities such as professional development.[9] In the Commonwealth of Virginia, the Lead Agency for CCDF is the Virginia Department of Social Services (VDSS). Virginia is one of 13 states that operate as a state supervised and locally administered program; meaning that VDSS receives funding then allocates it to the localities to provide services. The Commonwealth of Virginia receives Federal CCDF allocations amounting to a total of $101,473,446 for FY 2008. Virginia's CCDF funding includes Mandatory, Discretionary, MOE, Matching Federal Share, and Matching State Share. Federal regulation allows each state the option of transferring TANF funds to CCDF. Virginia does not always utilize the TANF transfer option, but in July of 2008, $12,000,000 was transferred into CCDF funds from TANF funds. Virginia receives an additional two million dollars of Federal funds, which is contributed though direct TANF funds specifically allocated for child care and is different then direct TANF transfers. The General Assembly of Virginia allocates CCDF and MOE, which totaled $21,328,762 for FY 2008.[10]

III. Purpose

The purpose of the CCDF to assist low-income families, families receiving TANF, and those transitioning from public assistance in obtaining child care subsidies to enable them to participate in welfare to work programs, attend training or enroll in education programs, with the ultimate goal of becoming self-sufficient. CCDF funding plays an essential role in the implementation of child care subsidies, providing early care and education services to over 1.7 million children a month throughout FY 2006-2007.[11] The long-term goals of the CCDF include:

- improving the quality of child care available to low income families and families receiving or transitioning from TANF;
- decreasing the number of families who are incapable of working due to a lack of child care;[12]
- providing services and supports to encourage stable, self-sufficient families who do not rely on public or private assistance and;
- promoting the development of social and educational skills to help children succeed in a school environment.

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[9] Ibid.
[10] Virginia Department of Social Services, "Child Care and Development Fund Plan for Virginia: FY 2008-2009," (2007), 6, http://www.dss.virginia.gov/files/about/reports/children/child_care/2008/ccd_plan2008-2009.pdf.
[11] United States Department of Health and Human Services, "Child Care and Development Fund: Report of State and Territory Plans FY 2006-2007," Administration for Children's and Families, (2007), 1, http://nccic.acf.hhs.gov/pubs/stateplan2006-07/stateplan.pdf.
[12] United States Department of Health and Human Services, "Child Care Development Fund Performance Measures," Administration for Children and Families, (June 2008), http://www.acf.hhs.gov/programs/ccb/ccdf/gpra/measures.htm.

To achieve these goals CCDF funds are distributed to states to operate child care subsidy programs for eligible families. Funding in this format provides states with set standards for the provision of child care including health, safety, and education requirements; while also allowing flexibility to states to design their own programs to meet state specific needs.[13]

The need for child care funding is a result of multiple factors, most importantly being the welfare reforms instituted in the PRWOA and the introduction of TANF. These reforms tied welfare benefits to employment and effectively increased the number of low-income parents in the workforce. After the implementation of these welfare reforms, employment among mothers, particularly single and never married mothers continued to rise, increasing the need for accessible child care.[14] Currently, three out of four mothers with children are participating in the workforce, yet for mothers with low-incomes child care has become increasingly unaffordable. Increases in the number of children and families living in poverty are another factor contributing to the need for child care. From 2000 to 2004, the number of families with children under the age of 18 living below the poverty line increased from 4,866,000 families to 5,847,000 families.[15] Providing quality child care to these low-income families is essential to improving the early education and developmental capabilities of children in poverty, as well as a necessary support for parents to maintain steady employment and eventually become self-sufficient.

IV. Child Care Subsidies and Early Education and Development

Child care and early education improve the health of young children and aid in the promotion of development and learning. Research indicates that children's daily experiences have a dramatic impact on the structural and functional development of their brain at an early age. Daily experiences obtained in quality child care have long-term positive effects for low-income children, which is beneficial for families and society. Thorough research indicates that children enjoy short and long-term well-being through exposure to early education and quality child care, resulting in higher graduation rates and lower receipt of welfare. Thus, it is imperative for working families to receive child care subsidies to provide children with stable quality care, and help families break their cycle of poverty.[16]

Researchers have also linked quality child care to an increase in school readiness. Early intervention for low-income children such as Head Start and quality child care have been connected to increased educational attainment, decreased criminal activity, and positive effects on younger siblings. Furthermore, research finds that children who are enrolled in higher quality child care perform better in cognitive (math and language) and social skills (positive interaction

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[13] United States Department of Health and Human Services, "Overview of the Child Care Development Fund."
[14] Ann Collins et al., "The Dynamics of Child Care Subsidy Use: A Collaborative Study of Five States," National Center for Children In Poverty, (June 2002), 5, http://www.nccp.org/publications/pdf/text_484.pdf.
[15] Children's Defense Fund, 69.
[16] Policy Statement, "Quality Early Education and Child Care From Birth to Kindergarten Committee on Early Childhood, Adoption, and Dependent Care," Pediatrics 115, no. 1 (January 2005), 187-191, http://pediatrics.aappublications.org/cgi/content/abstract/115/1/187.

with peers and behavior management). Parents working full-time jobs place their children in child care for up to 30 or 50 hours a week. Since these children spend vast amounts of time in child care it is particularly important to expose low-income children, who otherwise might not receive early education, to high quality care to ensure that their well-being and development is being fostered.[17]

V. Child Care Subsidies and Public Assistance Programs

Work support programs increased in the 1990's as welfare reform moved away from handouts and towards promoting self-sufficiency by offering short-term subsidies and additional supports to enable recipients to maintain employment and get back on their feet. The welfare reforms of 1996, specifically the implementation of welfare to work initiatives like TANF, increased the need for supports like child care subsidies for families receiving public assistance. Similar to CCDF funding, TANF provides block grants to states in order to meet any of four purposes:

- provide assistance to needy families so that children may be cared for in their own homes or in the homes of relatives;
- end the dependence of needy parents on government benefits by promoting job preparation, work, and marriage;
- prevent and reduce the incidence of out-of-wedlock pregnancies and;
- encourage the formation and maintenance of two-parent families.[18]

States are able to decide eligibility criteria for their TANF funds within the Federal guidelines that funding be used to help families with children. Other Federal guidelines for TANF eligibility include work requirements of 30 hours a week and a general guideline that families receive no more then five years of overall assistance.[19]

While TANF and child care subsidies through CCDF funding represent two very distinct public assistance programs, the success of both programs is intertwined. Research indicates that the availability of child care subsidies increases employment rates and improves the quality of employment for low-income families.[20] Specifically, studies have shown that affordable child care increases job retention among TANF users, which can increase the number of hours low-

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[17] Colleen Henry, Misha Werschkul, and Manita C. Rao, "Child Care Subsidies Promote Mother's Employment and Children's Development," Institute for Women's Policy Research (October 2003), 3-5, http://www.iwpr.org/pdf/G714.pdf.
[18] Martha Coven, "An Introduction To TANF," Center for Budget and Policy Priorities, (March 2005), 1, http://www.cbpp.org/1-22-02tanf2.pdf.
[19] Ibid. 2.
[20] Sharmila Lawrence and J. Lee Kreader, "Parent Employment and the Use of Child Care Subsidies," Child Care and Early Education Research Connections, (June 2006), 2, http://www.childcareresearch.org/SendPdf?resourceId=9511.

income parents can work, and potentially increasing their earnings.[21] These positive employment outcomes are even more pronounced in TANF recipients, with studies indicating that TANF mothers receiving child care subsidies are more likely to work standard daytime schedules then non-TANF mothers.[22] Subsidy receipt can also improve productivity by allowing parents to worry less about the quality of their child's care. Accordingly, majorities of states prioritize eligibility for child care subsidies to TANF families, and 23 states waive parental fees for subsidies to TANF families to ensure access to affordable care.[23] By prioritizing CCDF funding to TANF families, child care subsidies allow welfare recipients to maintain employment while receiving and transitioning from public assistance, and provides recipients with the potential to earn higher and more stable incomes to end their reliance on public assistance programs.

VI. Child Care Subsidies and Self-sufficiency

While the overall goal of public assistance programs and child care subsidies is to provide assistance to those in need, the ultimate goal is to encourage self-sufficiency. Self-sufficiency lies within the legislative intent of child care subsidies, which is to allow parents to work or obtain education. Virginia defines "self-sufficiency" as having a stable income without any individual or family dependence on public or private assistance. However, Virginia's diverse economic environment makes it difficult to create statewide self-sufficiency levels. To calculate this, Virginia uses the Self-Sufficiency Standard, which measures "how much income is needed for a family of a certain composition in a given place to adequately meet their basic needs—without public or private assistance."[24] Each locality is evaluated as to their standard of self-sufficiency. It is significant to understand that the Self-Sufficiency Standard differs from the FPL in five important ways. The Standard:

- independently calculates the cost of each basic need (not just food) and does not assume that any one cost will account for a fixed percentage of the budget;
- assumes that all adults—married or single—work full-time and includes all major costs (child care, taxes, and so forth) associated with employment;
- varies costs by family size, as does the FPL, but the Standard also varies costs by family composition and the ages of children.
- differentiates costs geographically (by state, region, county, and in some cases, by city or

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[21] Bong Joo Lee, et al, "Child Care Subsidy Use and Employment Outcomes of TANF Mothers During the Early Years of Welfare Reform: A Three State Study," University of Chicago, Chapin Hall Center for Children (2004), 26-28, http://www.chapinhall.org/article_abstract.aspx?ar=1370.

[22] Erdal Tekin, "Single Mothers Working at Night: Standard Work, Child Care Subsidies and Implications for Welfare Reform," Upjohn Institute Working Paper no. 05-113 (February 2004), 25, http://www.upjohninst.org/publications/wp/05-113.pdf.

[23] United States Department of Health and Human Services, "Child Care and Development Fund: Report of State and Territory Plans FY 2006-2007," 141.

[24] Virginia Department of Socials Services, "Methodological Appendix, Virginia 2006: Appendix and Sources," (2006), http://www.dss.virginia.gov/files/about/reports/agency_wide/self_sufficiency_standards/2006/appendix_a.pdf.

locality) whenever possible and appropriate;

- includes Federal, state, and local taxes (e.g., income, payroll, and sales taxes) and tax credits" [25]

The Standard helps to provide a realistic and achievable level for families to aim for so that they can enjoy life without relying on public assistance.

Child care subsidies aid greatly in improving the self-sufficiency of working mothers. Receiving subsidies helps to guarantee parents that their children are taken care of, and being provided with a secure source of child care funding enables parents to work more hours at potentially higher wages. Child care subsidies are particularly importance considering a survey in 2005 showed that every region in the U.S. faced higher child care costs for center-based care than food expenditures, and in 49 states center-based care for two children exceeds the median rent. Thus, families receiving child care subsidies are impacted greatly by having more financial freedom due to decreased out of pocket expenditures. Although child care subsidies are a temporary support they can often be enough to help create stable employment for families and ultimately result in self-sufficient families.[26]

[25] Ibid.
[26] Cauthen.

Chapter Two: Literature Review

The three most important aspects of effectively administering child care subsidies are: improving quality of care, decreasing costs to low-income families, and increasing access and eligibility to subsidies. This chapter will examine child care policies by exploring national trends in the implementation of child care subsidies throughout these three areas and provide an overview of child care subsidy practices.

I. Quality

The quality of child care subsidies plays an important role in achieving the CCDF funding goals by improving the standards of child care available to low-income individuals and families. Quality is one of the most defining aspects of child care. The key to successful child care programs in any state is to ensure that families have access to quality child care. When referring to child care, quality can encompass many different elements including the provider regulations, child to staff ratio, environment, safety standards, cleanliness, services, child development, and child relationships both with staff and other children. Research shows that these elements of quality child care directly influence children's development, especially for newborns and children who are not of school age.[27]

The Federal government suggests that states adhere to certain practices surrounding quality. These suggestions are minimum standards, thus many states go above Federal requirements to ensure quality care. Federal statutory requirements mandate that states spend at least four percent of CCDF funds on activities that improve quality through various activities; this could include activities that provide consumer education to parents and the community, encourage parental choice, and/or design improvement in quality.[28] Provider care is the largest measure of quality and it is important that states have nationally accredited providers who follow quality benchmarks. While providing access to child care is important in the sense that parents are able to work, if child care is sub-par then children are at-risk for being placed with unsafe providers who do not aid in their well-being or mental and physical development.

Providing child care not only has a positive impact on labor participation but also on child development. Lempke et al. found that high quality child care for children of working mothers had larger effects on their participation in the workforce than the cost of child care alone.[29] Research also shows that the early years of a child's life are especially critical in long-run social, emotional, and cognitive development. Additionally, children raised in poverty are

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[27] Marlys Ann Boschee and Geralyn Jacobs, "Ingredients for Quality Child Care," National Network for Child Care, (April 1998), http://www.nncc.org/Choose.Quality.Care/ingredients.html.
[28] United States Department of Health and Human Services, "Overview of Child Care and Development Fund: FY 2006-2007."
[29] Lempke, Robert J., Ann Dryden Witte, Magaly Queralt, and Robert Witt 2000, "Child Care and the Welfare to Work Transition," National Bureau of Economic Research (NBER) Working Paper Series: Working Paper 7583. Massachusetts: NBER.

often exposed to numerous social and educational obstacles, thus it is important to maximize exposure of quality child care by enrolling them at an early age.[30]

Child Care Standards and Oversight

The National Association of Child Care Resource and Referral Agencies (NACCRRA) is the nation's main information source for families seeking child care. This organization works with over 800 state and local Child Care Resource and Referral agencies to give families access to quality and affordable child care. In 2006, the National Association for Regulatory Administration (NARA) and the National Child Care Information and Technical Assistance Center (NCCIC) released findings for all 50 states, the Department of Defense (DOD) child care system, and the District of Columbia based on their research of child care center regulations. NACCRRA took the findings and compiled a comprehensive ranking of state child care center standards and oversight (See Appendix A, Table 1A).[31]

The study evaluated centers based on standards and oversight, with a total possible score of 150 points. Standards included health and safely regulations, teacher training, center director training, developmental domains, and meeting National Association for the Education of Young Children (NAEYC) standards (See Appendix 2B). Theoretically, states that scored well should be meeting certain benchmarks in health and safety, child development, and professional development. The report card was based on 15 basic standards relating safety, protection, and school readiness. The average score was 70.2 with the highest score (117) granted to the DoD and the lowest score (15) granted to Idaho. Below are several trends highlighted in the study:

- Illinois and Nevada are the only states that require a full background check of staff,
- Eight states plus the DoD address all 10 basic health and safety benchmarks[32],
- Four states allow or do not prohibit corporal punishment,
- Three states plus the DoD require quarterly inspections of child care providers and eleven do not conduct annual inspections,
- Twenty-one states do not minimum education requirements for child care teachers,
- Virginia scored 79/150 and ranked number 15 in the country.[33]

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[30] Henry, Werschkul, and Rao, "Child Care Subsidies Promote Mother's Employment and Children's Development," 5.

[31] National Association of Child Care Resource & Referral Agencies, "We Can Do Better: NACCRRA's Ranking of State Child Care and Center Standards and Oversight," (2007), http://www.naccrra.org/policy/recent_reports/scorecard.php.

[32] The list includes fire drills, administration of medication, prevention of Sudden Infant Death Syndrome, diapering and hand-washing, and safe playground surfaces (Illinois, Wisconsin, New Jersey, Texas, Oregon, Oklahoma, Mississippi, and Ohio.

[33] National Association of Child Care Resource & Referral Agencies, "New State Report Card on Child Care: States Fall Short in Protecting Children's Safety & In Promoting Learning in Child Care," (March 2007), http://www.naccrra.org/news/press_releases/full.php?id=31.

Professional Development

The Federal Child Care Bureau finds that quality can be improved by providing additional training and education to child care providers. Research shows that states that invest in professional development and/or increase employee compensation aid in reducing turnover and improving retention. States have developed incentives to encourage professional development such as scholarships for educators, state sponsored trainings, and bonuses. Requirements vary from state to state for professional development standards. Some states mandate that all center directors and teachers must have a minimum education such as a GED, a high school diploma, or Associate's Degree, and most states require teachers to undergo training throughout the year. Professional development training can be offered through a State's Lead Agency, institutions of higher education, or non-profit and advocacy groups. Traditionally, the U.S. Department of Education received appropriations for Early Childhood Educator Professional Development; however, this program did not receive any funding for FY 2008. To compensate for this loss in funding, many states use CCDF funding allocated for quality improvements to provide professional development opportunities.[34]

Professional development of child caregivers through training and education not only aids in staff retention but also greatly influences the quality of care for children. Research increasingly shows that high quality care has a positive impact on the development of young children. As a result, many states have turned to establishing training and/or educational requirements for licensed providers and have launched training initiatives for both regulated and unregulated providers. Research shows that increasing provider training increases the quality of child care received. For example, Delaware has improved its training programs by creating a 100-hour of prior training requirement for caregivers of infants and toddlers, which has increased the quality of family and center-based care providers across the state. A study in Pennsylvania found that personalized mentoring of center-based caregivers resulted in significant quality improvements in establishing routines, learning, sensitivity, and appropriate discipline for children. Furthermore, studies show that professional development has a positive impact on early child development and learning, especially for infants and toddlers.[35]

Statewide Quality Rating System (QRS)

NAEYC is at the forefront of creating and advocating a quality rating and improvement system (QRS). Through their research and advocacy, NAEYC bases their system on indicators of program quality. QRSs are important because they are used to increase consumer awareness about quality indicators, improve resources to sustain and improve quality, and create system-wide improvements for all ages of children served in child care programs. NAEYC collaborates

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[34] United States Department of Health and Human Services, "Quality Expansion Activities," Administration for Children and Families-Child Care Bureau (November 2006), http://www.acf.hhs.gov/programs/ccb/law/guidance/current/pi9905/pi9905.htm.

[35] J. Lee Kreader, Daniel Ferguson, Sharmila Lawrence, "Impact of Training and Education for Caregivers of Infants and Toddlers," National Center for Children in Poverty, (August 2005), 4, http://www.childcareresearch.org/SendPdf?resourceId=6874.

with the National Association for Family Child Care to recognize accreditation systems that are designed specifically for family child care.[36]

Over the past seven years, 17 states including the District of Columbia implemented statewide QRSs and an additional 30 states are in the process of developing a QRS. There are also several counties and cities, including some in Virginia, who are embarking on QRS pilots with hopes of expanding their systems statewide. Some states like Maryland mandate that child care programs must be nationally accredited in order to participate in Maryland's QRS, indicating the important role that a QRS can play in providing standardization in the quality of care available. To enable child care programs to join the QRS, Maryland provides funding to programs to assist with costs associated with accreditation. Accreditation can be costly, thus some states use improvement funds or mini-grants to help child care programs become accredited.[37]

The Rand Corporation recently completed a study of five states (Oklahoma, Colorado, North Carolina, Pennsylvania, and Ohio) with statewide Quality Rating and Improvement Systems (QRIS). These states were chosen because they were pioneers in QRIS and demonstrate a wide range of QRIS designs, implementations, and approaches. The study found that all of the states' QRISs contained the important measures of: staff training and education and classroom or learning environment; and that the states differed on including parent involvement, child-staff ratios, and national accreditation status. Through the interviews conducted during the study, Rand found an increase in provider and parent interest in QRIS, specifically that more providers were volunteering to be rated and parents were more active in inquiring about program ratings. Additionally, most people interviewed found that the QRIS helped in raising awareness of quality standards and the positive outcomes that these standards can have on children.[38]

II. Economic Costs

The economic value of child care subsidies and associated costs to low-income families depend upon provider reimbursement rates and parent co-payments. Reimbursement rates and co-payments are set to achieve the CCDF funding goals of providing high quality child care to low-income working parents and encouraging self-sufficient families who do not rely on public assistance. The reimbursement rate schedule most specifically determines affordability of child care and whether or not low-income parents can access stable quality child care. If reimbursement rates are too low, providers have little incentive to serve low-income families, or can require parents to pay additional fees beyond the parent co-payment, thereby greatly reducing the impact of the subsidy. Low reimbursement rates can also lead to low-income

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[36] National Association for the Education of Young Children, "Statement from the NAEYC Public Policy Program," (November 2007), http://www.naeyc.org/policy/state/pdf/public_policy_program.pdf.

[37] National Association of Child Care Resource & Referral Agencies, "We Can do Better."

[38] Gail L. Zellman and Michal Perlman "Child-Care Quality Rating and Improvement Systems in Five Pioneer States: Implementation Issues and Lessons Learned," Rand Corporation, (2008), xii-xiii, http://www.rand.org/pubs/monographs/2008/RAND_MG795.sum.pdf.

families' dependence on poorer quality child care, as high quality child care services may cost much more than the subsidy amount. Similarly, parent co-payments must be set at a level to ensure that payments are meeting the Federal requirement for parental contribution, while also ensuring that they are not paying more than they can afford. There are several different ways states set reimbursement rates and co-payments to ensure affordability and access to quality care. Tiered reimbursement rates can be set so that the greater the quality of a child care facility, the greater the amount of the subsidy that facility receives per child. Successful tiering systems incentivize quality care, increasing early childhood development and school readiness, while also increasing funds to promote continuing education and professional development at high quality facilities.

A NACCRRA study found that more than two thirds of parents rated child care costs as one of their top three concerns when choosing child care for their children.[39] Lower costs to low-income parents have been positively linked to workforce participation and the ability to earn higher income, which can lead to a stronger likelihood of self-sufficiency. Research indicates that parents who receive adequate child care assistance are more likely to enter and remain in the workforce, work additional hours, and that child care subsidies may be more effective than a government work subsidy alone, generating more additional hours worked per subsidy dollar.[40] Other studies have estimated that lower costs of child care lead to positive impacts on single mothers' employment decisions. Child care costs are estimated at 30 percent of the annual income for those earning less than $18,000 a year in 38 states; therefore the greater the subsidy amount, the more net income a parent has to put towards basic needs that will enable self-sufficiency.[41] Reimbursement rates and co-payments together can be set to provide quality and stability for subsidized children in their early childhood developmental stages, while increasing low-income parents' workforce participation, their ability to provide for their families, and obtain self-sufficiency.

Reimbursement Rates

Maximum reimbursement rate schedules are set individually for each state. These schedules quantify the subsidy amount given to providers based on age of child and type of child care setting, such as regulated or unregulated. The goal of reimbursement rates is to provide those who receive child care subsidies equal access, as providers can only charge private-paying parents rates equal to or above the rates subsidized families pay. Some providers accept subsidized children even if the reimbursement rate is somewhat low, due to the stability offered by this type of payment. However, low reimbursement rates can negatively affect the quality providers are able to give by making it difficult for providers to hire adequate and well-trained staff, which can lead to higher child-staff ratios and result in poor quality.

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[39] The Nation's Network of Child Care Resource and Referral, "Breaking the Piggy Bank: Parents and the High Price of Child Care," (February 2006), http://www.naccrra.org/docs/policy/price_report_summary.pdf.
[40] Hanna Matthews, "Child Care Assistance Helps Families Work: A Review of the Effects of Subsidy Receipt on Employment," Center for Law and Social Policy, (2006), 2-4, http://www.clasp.org/publications/ccassistance_employment.pdf.
[41] The Nation's Network of Child Care Resource and Referral, "Breaking the Piggy Bank."

Federal child care subsidy statutes require states to conduct a Market Rate Survey (MRS) of local child care provider market rates every two years and to consider these results when establishing rate ceilings. States are given the ability to define the geographic scope of the MRS, with approximately one-quarter using a statewide survey, one-quarter using a regionally-based survey, and the rest using rural/urban based surveys. Despite these surveys, the states are not required to set the maximum rate at any specific level and the established rate schedules often predate the MRS. A Government Accountability Office study in 2002 found that states consider budget allocations and policy goals in addition to market rates when updating rate schedules, giving states even more variation in their reimbursement rates.[42] Since 2006, forty-one states have updated their reimbursement rate schedules, and two states, Connecticut and Idaho, have not updated their reimbursement rates since 2001.[43]

The federally recommended level suggests that maximum reimbursement rates be set at the 75th percentile of current market rates. At this rate, the subsidy amount for providers would equal the amount charged at 75 percent of possible child care providers for subsidized families, granting them equal access to affordable and high quality care. In 2001, 22 states set reimbursement rates at the 75th percentile of current market rates, yet only 10 met this recommended standard in 2008.[44] On the other hand, some states have made drastic improvements. For example, in 2007, Oregon significantly increased provider payments rate from the 26th percentile to the 75th percentile of current market rates to meet the federally recommended level (See Appendix A, Table 2A).[45]

Low reimbursement rates and reimbursement rates that do not keep up with inflation make access to high quality child care less affordable for low-income families. This can lead to sacrifices in quality or significant financial burdens for these families. High quality child care facilities that do accept subsidized children at lower reimbursement rates have less funding available to maintain their quality level and enhance early childhood development.

Thirty states use tiered rate schedules, which grant higher reimbursement ceilings for child care providers that meet higher quality standards or are licensed by a state board. Other states have tiers set for services that are more expensive to provide, such as services for children with special needs or care during non-traditional business hours. The difference between the tiers ranges from two percent to 61 percent. However, a majority of states with tiered rates still fall below the 75th percentile, which is the federally recommended level to provide adequate access to high quality care. A majority also set their highest tier no more than 20 percent above the basic tier, thus providing little incentive for providers to increase expenses to provide higher quality care. Only 10 states offered rate tiers above the 75th percentile, which provide stronger monetary incentives for high quality child care providers to accept subsidized children.[46]

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[42] United States Government Accountability Office, "Child Care: States Exercise Flexibility in Setting Reimbursement Rates and Providing Access for Low-Income Children," (September 2002), 2-3, http://www.eric.ed.gov/ERICDocs/data/ericdocs2sql/content_storage_01/0000019b/80/1a/9d/87.pdf.
[43] Blank and Schulman, 21-23.
[44] Ibid. 21-23.
[45] Blank and Schulman, 2.
[46] Ibid. 21-23.

Parent Co-payments

PRWOA and associated Federal regulations require that families above certain income levels that are participating in child care subsidy programs must assist in paying the costs of child care. The parent co-payments are typically calculated based on a sliding fee scale, where the income a family makes and the size of the family determine to the size of the family's co-payment. Federal guidelines suggest, but do not mandate, that parent co-payments not be greater than 10 percent of income, regardless of the size of the family. Forty-three states use the sliding fee system based on a percentage of income, while nine states use percentage of price of care or the provider reimbursement rate to set co-payments. Additionally, in 2004-2005, half of all states also used factors other than family size and income to determine co-payments. For example, 18 states required additional co-payments for every child while others set lower rates for part-time care.[47]

The scale used to set co-payments must be set so that those below FPL can still afford child care. In 2004-2005, 11 states waived co-payments for families receiving child care subsidies that had incomes at or below the FPL, including Virginia.[48] However, in one-third of the states a family at 100 percent of the FPL was required to pay 6.4 percent of income ($94 a month) in co-payments, a percentage greater than the national unsubsidized average spent on child care. From 2001 to 2008, twenty-eight states increased co-payments as a percentage of income, while co-payment amounts remained the same during that time period in seventeen states (See Appendix A, Table 3A). However, many states offer specific discounts in the co-payment amount for additional children or for length of care. For example, Alabama, Maine, and West Virginia all offer different discounted co-payments for additional children. Illinois and Iowa both offer reduced co-payment amounts for half-day child care, as opposed to full-time care.[49] In 2008, a family of three at 150 percent of the FPL was not eligible for child care subsidies in six states. In 19 states that allowed child care subsidy assistance for families at this income level, co-payments increased between 2001 and 2008. Of those that provide subsidies for families at this level, fifteen states require co-payments equivalent to at least 10 percent of income (See Appendix A, Table 4A).[50] Furthermore, families below the 150 percent FPL are most subject to losing a child care subsidy due to small increases in income, making self-sufficiency difficult if a family is not expecting to lose the subsidy. In some cases, the cost of losing the subsidy greatly outweighs the benefits of wage increase.

It is also important to note that high co-payments alone cannot be considered a proxy for measuring high economic costs of child care. Many states with low co-payment requirements also allow providers to charge additional fees to cover the difference between private and subsidized rates. This practice is allowed in approximately three-quarters of states, including

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[47] National Child Care Information and Technical Assistance Center, "State Child Care Subsidies: Trends in Rate Ceilings and Family Fees," (May 2005), http://www.nccic.acf.hhs.gov/pubs/issuebriefs/rateceilings.html.
[48] Ibid.
[49] United States Department of Health and Human Services, "Child Care and Development Fund: Report of State and Territory Plans FY 2006-2007," Administration for Children's and Families, (2007), 154, http://nccic.acf.hhs.gov/pubs/stateplan2006-07/stateplan.pdf.
[50] Blank and Schulman, 18.

those with maximum rate ceilings set at the current federally recommended level.[51] While this payment provides child care providers with greater funds to make quality and training improvements, it dampens the effect of the subsidy and places an increased financial burden on low-income families.

III. Access

Whether or not low-income families have access to child care subsidies is an issue that links the two dimensions of cost and quality. On the cost side, if parent co-payments are too high, then low-income families will be unable to contribute to, let alone afford child care; and if reimbursement rates are too low then child care providers will be unable to care for low-income children. If parents cannot afford to access child care, and providers can not afford to give care to subsidized children, then access to child care decreases.

On the quality side, if states impose too many regulations on providers fewer will be able to enter the market. However, if quality goes unregulated families will have no other option then to enroll their children in sub-par child care programs. When providers do not have the incentive to enter into the market and parents do not have quality child care options, access to child care decreases. Furthermore, established quality standards improve access to high quality care for families using child care subsidies. These standards effectively alter the market for child care providers by dedicating portions of funding to improve quality for subsidized child care providers, allowing them to remain competitive with other providers and improving overall quality of care. Both cost and quality measures affect the number of families with access to child care, as well as the overall market for child care.

Access to child care subsidies also plays an important role in achieving the CCDF funding goals of increasing the number of low-income parents in the work force, improving the developmental skills of children, and giving families the opportunity to be self-sufficient. Ensuring that families receiving public assistance are able to access affordable child care enables them to retain and improve the quality of their job, increase their potential earnings, and increase the chances they will be able to support their families independent of public assistance programs. Specifically, research shows that the availability of subsidies increases the likelihood of maternal employment, particularly in lower income groups.[52] Additionally, access to quality child care increases the likelihood of families using formal care providers, which can help advance development and early education opportunities for children and better prepare them for school.[53]

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[51] Ibid. 8.
[52] Sandra Hofferth and Nancy Collins, "Child Care and Employment Turnover," Population Research and Policy Review (August 2000), 388-389, http://www.springerlink.com.proxy.wm.edu/content/r2hrtu4182236882/fulltext.pdf.
[53] Henry, Werschkul and Rao, 3-5.

Income Eligibility Requirements

One way states determine access to child care subsidies is through income eligibility requirements. Many states give priority to families receiving TANF or families with special needs. Beyond these priorities, states utilize income eligibility guidelines to determine which other families qualify for the limited amounts of CCDF funding. Federal guidelines stipulate that CCDF funding is limited to families with incomes at or below 85 percent of the state median income, although states are able to determine their own eligibility rates up to 85 percent. A majority of states determine eligibility by examining the total gross income in a household, excluding non-parent minors. A majority of states also deduct most forms of public assistance from overall income calculations, including Social Security Income, food stamps, and TANF.[54]

State income eligibility rates play an important role in determining which families are able to access child care subsidies. While all states have income eligibility requirements that are above the poverty level, many other low-income families in the 150 percent to 200 percent FPL are not eligible for subsidies but are unable to afford quality child care without public assistance. In FY 2007-2008, the average state median income level was 58 percent for a family of three. Twenty-two states met or exceeded the average state median income level, while 29 fell below it. Additionally, 34 states increased their income eligibility rates to keep up with or exceed inflation rates, ensuring that families who previously received subsidies remain eligible.[55] States that increased their income eligibility rates include Missouri, Oklahoma, Kentucky, and Wyoming. On the other hand, Hawaii, Maine, Georgia, and Rhode Island decreased their income eligibility, resulting in decreased access to child care subsidies (See Appendix A, Table 5A).[56]

If states choose income standards that correspond to a low percentage of their state median income or FPL, fewer families will qualify for subsidies. Likewise, if income eligibility requirements do not account for adjustments in inflation, low-income families could find their incomes increase above the eligibility requirements. Maintaining an appropriate income eligibility level is essential to providing access to low-income families. Studies have shown that providing access to subsidies increases the stability of employment outcomes in low-income working families, and reduces the likelihood of subsidized families returning to welfare.[57]

Waiting Lists

Federal requirements for CCDF funds only stipulate that access to funds should be prioritized for families with very low-incomes or special needs. However many states must further narrow their eligibility criteria due to excess demand and inadequate funding levels. While some states choose to narrow eligibility criteria enough to decrease the number of families

[54] United States Department of Health and Human Services, "Child Care Development Fund: Report of State and Territory Plans FY 2006-2007," 133.
[55] Blank and Schulman, 12.
[56] Ibid. 12.
[57] Center for the Study of Social Policy, "Policy Matters: 2008 Update," (March 2008), 20, http://www.cssp.org/policymatters/pdfs/FULL%202008%20REPORT.pdf.

qualifying for subsidies, other states maintain their eligibility standards and form waiting lists for eligible subsidy recipients. In some states, families experience small waiting times to receive benefits, while in other states families can end up waiting for long periods of time, if they receive benefits at all. Families that are unable to receive benefits due to waiting lists or high eligibility standards face poor quality child care options and an inability to pay financial obligations due to the cost of child care, which can result in possible job loss.

From FY 2007-2008, 17 states maintained waiting lists or stopped accepting families for child care subsidies. Of these states, nine experienced increases in the number of children on their waiting lists, while five were able to shorten their waiting lists.[58] The five states that were able to decrease the number of children or families on their waiting lists were Georgia, California, Maine, Massachusetts, and Virginia.[59] States that experienced increases in the number of children on the waiting list include Alabama, Florida, Mississippi, and Texas (See Appendix A, Table 6A). It is important to note however, that waiting lists do not serve as a proxy for unmet need. Some states decrease their waiting lists by increasing eligibility standards or subsidy requirements to avoid waiting lists, essentially denying subsidy access to previously qualified families. Conversely, other states may decrease the subsidy amount per child in order to provide eligibility to all in needy families. While waiting lists may not be a good indicator of unmet need, studies have shown that mothers receiving subsidies were more likely to be employed then mothers on the waiting list for child care subsidies.[60] The important role that access to child care subsidies can play in helping low-income families maintain employment and spend less money on child care cannot be underestimated.

[58] Blank and Schulman, 16.
[59] Ibid. 16.
[60] Matthews, 4.

Chapter Three: Scope and Methodology

The focus of this report is on the funding, utilization, and implementation of child care subsidies in Virginia. Specifically, we will focus on three key areas of child care subsidy administration: quality, economic cost, and access. Using VDSS data on child care subsidy expenditures, utilization statistics, and program characteristics, we hope to describe and explain the current administration of child care subsidies in Virginia in terms of quality, economic cost and access. However, in order to gain a better understanding of trends and practices across the country, we will choose a variety of other states to compare and contrast with Virginia. By examining other state practices, and national trends in the child care subsidy field, we hope to illustrate the strengths and weaknesses in Virginia's current child care subsidy program and offer recommendations for the future to improve the use of subsidy funding and administration.

I. Comparison States

To make accurate comparisons between Virginia's child care subsidy program and other state programs, we chose states with similar average spending per child per month. To determine each state's average per capita spending we utilized estimated funding for child care services data from the Department of Health and Human Services (DHHS)' "Child Care and Development Fund: Report of State and Territory Plans 2006-2007." The expenditures reported by the DHHS represent estimates of Federal, CCDF, TANF, and state monies. Each state's total funding estimate was divided by 12 in order to provide us with a monthly estimate of child care subsidy expenditures by state. To determine the number of children served by child care subsidies in each state we utilized data from the Administration for Children and Families data tables for FY 2006. The number of children reported represents the average monthly number of children served by state. By dividing the average monthly child care subsidy expenditure by the average number of children served, we were able to estimate each state's average spending per child per month. To choose a pool of states to use as comparison states, we picked states that spent within 25 percent of Virginia's average spending per child per month. Virginia spent $480.12 per child per month, and multiplying that expenditure amount by .25 provided us with a range of states that spend within 25 percent of Virginia, from $360.09 per child per month to $600.15 per child per month. All comparison states are within this expenditure range (See Appendix A, Table 7A).

Comparison States-Economic Cost and Access

To choose comparison states for the issues of economic cost and access we ranked states in the areas of parent co-payment rates, reimbursement rates, income eligibility rates, and waiting lists (See Appendix A, Tables 2A-6A). We used 2008 data from the National Women's Law Center Issue Brief, "State Child Care Assistance Policies 2008: Too Little Progress for Children and Families." Parent co-payment rates are ranked from lowest rate to highest rate; reimbursement rates were ranked from lowest percentile rate to highest percentile rate; income

eligibility rates are ranked from highest rate to lowest rate; and waiting lists are ranked from smallest waiting list to largest waiting list. To provide an accurate view of all practices, states were chosen that are ranked higher and lower when compared to Virginia in all of the above categories, and consideration was also given to states that have state supervised and locally administrated child care programs similar to the program design in Virginia.

Comparison States-Quality

It is necessary to choose comparison states for the issue of quality using another method than was used for economic cost and access, due to the different nature of quality issues. Since every state varies in their programs and quality initiatives, comparison states were chosen depending on quality issues, however consideration was given to states that have state supervised and locally administered child care programs, states within 25 percent of Virginia's spending per child per month, and states with demographics similar to Virginia. States were chosen for the issue of quality standards based on states in the top ten and bottom ten states ranked in the NACCRRA report, to give a general idea of where Virginia falls compared to other states (See Appendix A, Table 1A). The comparison states for professional development were chosen from research based on literature reviews and research that highlighted best practice states found at the Child Care and Early Education Research Connects database. States were chosen similarly for the QRS section based on best practices, innovative ideas, and overall success of QRSs. However, QRSs for child care facilities have yet to achieve national consistency and support over the past ten years. Therefore, data regarding these measures is not typical for prior to 2003, making multi-year changes in the quality of state child care subsidies difficult to track.

Limitations

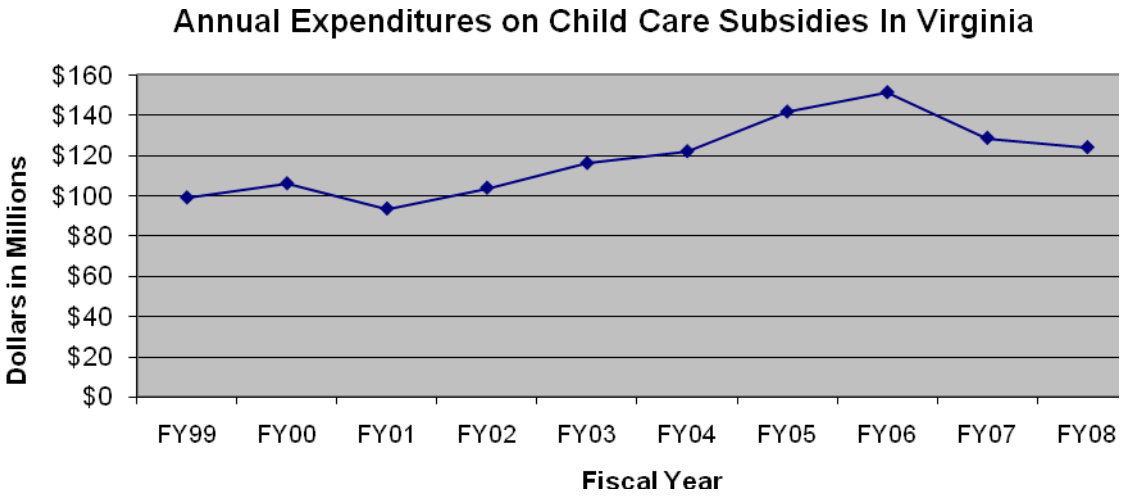
The methodology utilized to choose comparison states in terms of cost and access provides a consistent and accurate measurement of state spending. However, there are several limitations of this methodology to address. First, spending per child per month does not take into consideration the differences in state demographics, size of the program, Federal Matching funds, or Direct TANF transfer funds that have significant impacts in the total funding amounts in some states. Furthermore, while the states chosen spent within 25 percent of Virginia's per child per month expenditures, choices within that range were somewhat subjective. Other factors such as political environment and overall child care program stability were informally considered when determining states. In addition, the average spending per child per month was calculated based upon annual expenditures on the child care subsidy program, which does not take into account the seasonality of child care. For example, before-and-after school care decreases substantially in the summer months. Another factor to consider is that the spending per child per month figures are based on number of children served by child care subsidies and annual expenditures from FY 2006 data, while the parent co-payment rates, reimbursement rates, income eligibility rates, and waiting lists were compiled from FY 2008 data.

An issue specific to the data used for reimbursement rates is that it was collected for the most urbanized areas of some states and statewide for others. In states that have a range of rates or tiered rates, the rates for urbanized areas are likely to be higher to compensate for higher costs

of living. Thus, these rates may be overestimating the reimbursement rate for a majority of the state. Also, without a Federal requirement for reimbursement rate levels, there are a wide variety of rate schedules, which are difficult to capture through only one measurement of urbanized areas. Finally, there is also a strong correlation between all measures of quality, cost, and access. Decreases in the units of one variable, such as reimbursement rates, may lead to positive impacts in the funding levels of another variable, such as lowered waiting lists or state funded professional development initiatives. These issues are irreversibly intertwined and no method can truly capture the strength of these links appropriately.

Chapter Four: Virginia's Child Care Subsidy Program

Virginia's child care subsidy program is the 22nd largest program in the country, serving approximately 29,000 children a month, for an annual total of 55,107 children throughout FY 2008. Of the approximately 189,000 children receiving child care services in either a center-based or family provider situation throughout FY 2007-FY 2008, approximately 12.5 percent are receiving subsidies. According to our spending per child per month data from FFFY 2006, Virginia's overall funding amount was 19th in the country, and the $480 the state spends per child per month was 20th in the country. According to VDSS total funding for Virginia's child care subsidy program in FY 2008, excluding staff allowances, was $124,007,139. While this amount is an increase from the total funding amount of $98,999,869 in FY 1999, as the graph below indicates it was a decrease in funding from levels of $141,721,412 and $151,361,361 in FY 2005 and FY 2006. As a result more children were served in those years then in FY 2008, which draws attention to the need for increased funding across the state to address the unmet needs of low-income working families (See Appendix C, Tables 1C and 2C).[61]



Source: VDSS Annual Data From FY 1999-FY 2008.

I. Funding Stream and Process

The Commonwealth of Virginia's child care subsidy program received approximately $124,000,000 in total state and Federal funds in FY 2008. Federal funds are distributed based on two authorizations; the Federal authorization of the CCDBG and the Deficit Reduction Act, which provides specification for funding formulas and distribution of Federal and State matching funds. There are specific requirements that Virginia must adhere to when using Federal funds. For example, up to 20 percent, or $4,265,752, of Virginia's State MOE funds and 30 percent of

[61] Virginia Department of Social Services, "Annual Data From FY 1999 –FY 2008: Total Dollars (excludes staff allowances)," (October 2008).

their State Matching Funds, or $2,140,724, must be used specifically for pre-kindergarten initiatives to ensure that the majority of funds go towards direct service. No more than five percent of Federal CCDF and State Matching Funds, or $7,135,749 for Virginia, can be used for administrative costs of the program. Additionally, 70 percent of Mandatory and Matching Funds must be used for TANF recipients, those transitioning out of TANF, or families at-risk of becoming dependent on TANF.[62] In FY 2008, Virginia's child care subsidy program served 55,107 children, with annual spending per child averaging $2,250 of total expenditures, excluding staff allowances.[63] Approximately 28,000 of the total number of children served were from TANF families and received fully subsidized care.[64]

Local Administration of Child Care Subsidies

Virginia is one of 13 state supervised and locally administered child care subsidy programs, which functions through a series of consultation and coordination efforts. VDSS is responsible for setting eligibility and regulatory requirements for both TANF and non-TANF child care subsidy recipients. Local departments function as sub-grantees of VDSS, and portions of the funds are distributed through the state to the localities. Localities are then responsible for aiding eligible families in finding child care, and providing reimbursement payments to the provider.

Child care subsidies are granted to working parents receiving public assistance based on need, to assist an approved activity. These activities include full time or part time employment, education or employment training, or families receiving child protective services. Additionally, in two-parent households there must also be good cause as to why one parent cannot provide this care. To receive subsidies, children must also be residents of the locality in which they receive child care subsidies, immunized, and must be U.S. citizens or qualified aliens, however no documented proof of citizenship is required beyond a parent-signed affidavit. Child care is also not available during school hours for school-age children who could be enrolled in school, unless there is a valid reason for them not to attend school. There are also several exceptions for each non-income eligibility requirement, such as religious exemptions for immunization requirements, and waived citizen requirements for TANF recipients.[65]

In Virginia, TANF recipients are guaranteed a child care subsidy if they apply, and VIEW recipients, Head Start participants, Food Stamp and Employment Training (FSET), and children with special needs are granted priority status but are not guaranteed subsidies. Families are made eligible for subsidies based on the gross income level of all household members and family size. Families above the poverty line are required to contribute co-payments based on a flat rate of 10 percent of gross family income, where the more a family earns, the more money

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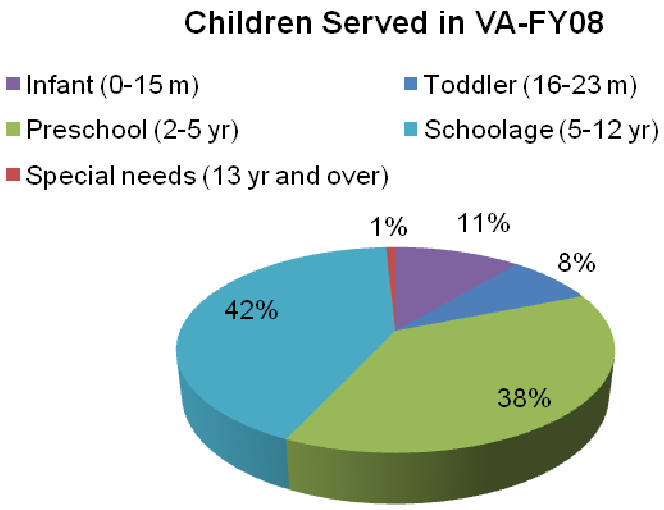
[62] Virginia Department of Social Services, "Child Care and Development Fund Plan for Virginia," 9-10.
[63] Virginia Department of Social Services, "Annual Data From FY 1999 –FY 2008: Unduplicated Number of Children Served," (October 2008).
[64] Virginia Department of Social Services, "Child Care and Development Fund Plan for Virginia," 36.
[65] Virginia Department of Social Services, "Child Care Policy Manual: Volume VII, Section II, Chapter D," (October 2008), 25, http://www.dss.virginia.gov/files/division/cc/policy_manual/manual_09_19_2008.pdf.

they pay toward child care services. However, families below the poverty line do not have to pay parent co-payments and are fully subsidized by the state.

Federal statute mandates that states use CCDF funding to serve children less than 13 years of age although some states, including Virginia, also serve children under age 19 who are incapable of self-care or are under court supervision. School age children ages five through 12, are the largest group of subsidy recipients, with over 23,000 children being served in FY 2008. Preschool children, ages two to five, were the second largest group of recipients, at almost 21,000 served in FY 2008 (See Appendix C, Table 3C).[66]



Source: VDSS Annual Data From FY 1999-FY 2008.

If a family is determined eligible and there is no waiting list in the locality, the parent can choose to accept services from any area provider that meets training requirements and passes employee background checks. If child care subsidy funds are insufficient, individual localities may maintain waiting lists for eligible applicants. Once a provider is chosen, the Local Department of Social Services (LDSS) sends a purchase order to the provider, which states the amount of the provider payment and the copayment amount. The provider then bills the LDSS monthly at the set maximum reimbursement rate, which is also determined by the locality. Any payments above the reimbursement rate are the responsibility of the parents, including co-payments and additional fees that providers are legally able to charge. Fee-based child care (non-TANF) recipients have a maximum five-year non-consecutive limit for receiving child care subsidies.[67]

II. Public Assistance Programs

Public assistance programs in Virginia play an important role in determining which families are eligible to receive child care subsidies, as well as helping families retain

[66] Virginia Department of Social Services, "FY 2008: Number of Children Served," (October, 2008).
[67] Virginia Department of Social Services, "Child Care and Development Fund Plan for Virginia," 22.

employment and move towards self-sufficiency. Virginia has been particularly innovative in the welfare to work arena, implementing the Virginia Independence Program (VIP) in 1995 prior to the TANF welfare reforms executed in the PRWOA of 1996. TANF, VIP and its counterpart the Virginia Initiative for Employment not Welfare Program (VIEW) are relevant to understanding the administration of public assistance programs and child care subsidies in Virginia.

VIP and VIEW

The passage of VIP in 1995 is a prime example of the changes that occurred to welfare programs throughout the 1990's. These changes included eligibility policies under the Aid to Families with Dependent Children (AFDC) to encourage parental responsibility, and the creation of welfare to work initiatives to encourage the employment of public assistance recipients.[68] When TANF replaced the AFDC in 1996, minimal changes to VIP and VIEW occurred to institute TANF requirements within the VIP program. In 1997, TANF was fully implemented throughout the state and the TANF block grant was and still is used to fund multiple public assistance programs throughout the Commonwealth, including child care subsidies, VIP, and VIEW.

VIP's main goal is to encourage parental responsibility for low-income families by requiring TANF participants to determine the paternity of their children, capping assistance for children born more then 10 months after the family begins public assistance, requiring school attendance, and mandating immunization for children.[69] These eligibility requirements are in place to encourage parental accountability, promote family reunification, and provide a disincentive for families to have more children to receive more public assistance. TANF participants who fail to meet these requirements within a certain time period are sanctioned from the VIP program.

VIEW is incorporated within VIP to promote the movement of TANF recipients into the work force by enabling participants to receive work experiences and skills to promote self-sufficiency and achieve economic independence.[70] VIEW requires that TANF recipients begin a work activity within 90 days of receiving assistance, limits TANF benefits to two years, and requires that VIEW participants must work 35 hours a week unless already employed full-time or attending school. Of these 35 hours, 20 hours must be "core work activities," which include job search and job preparation activities, subsidized and unsubsidized employment, unpaid community or non-profit work, on-the job training, and vocational education and training directly related to the participant's employment. "Non-core work activities," which may constitute the other 15 hours of the work requirement, include job skills training to prepare participants for employment and education below the post-secondary level.[71]

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[68] Susanne James-Burdumy and Anne Gordon, "Impacts of the Virginia Initiative for Employment Not Welfare," Mathematica Policy Research Inc, (January 2002), 1, http://www.mathematica-mpr.com/PDFs/imvafinal.pdf.
[69] Ibid. 5.
[70] Virginia Department of Social Services, "TANF Manual: Virginia Initiative for Employment Not Welfare," (October 2006), 7, http://www.dss.virginia.gov/files/division/bp/tanf/policy/manual/1000.pdf.
[71] Ibid. 7-9.

In some areas, VIP and VIEW have been effective in encouraging stable employment and financial independence. Specifically, since 1995 more then 83,000 of the 112,232 VIEW enrollees have found employment and successfully joined the work force. Other important outcome measures since the program's implementation include that 63 percent of VIEW participants maintained employment for at least six months after their TANF benefits ceased, and 85 percent of recipients that had employment at the end of their TANF benefits did not return to TANF within 12 months. In FY 2006 approximately 39 percent of VIEW recipients left TANF with unsubsidized employment, the average recipient pay increased to $7.35 an hour, and 42 percent of recipients or approximately 9,582 employed VIEW participants, received child care subsidies.[72]

The importance of TANF and VIEW to the implementation of child care subsidies in Virginia cannot be underestimated. Of greatest importance is the fact that TANF recipients are given priority for child care subsidies, increasing the likelihood that TANF and VIEW participants are utilizing child care subsidies in comparison to other low-income families. Additionally, child care subsidies play an important role in enabling participants to maintain steady employment, particularly considering VIEW participants are required to work after their child reaches 18 months, and the cost for infant care is significantly higher then other age groups. Without the availability of prioritized child care subsidies, TANF and VIEW recipients would face much greater obstacles in searching for and retaining employment.

Self-sufficiency

Public assistance programs like TANF, VIEW, and VIP are designed to provide appropriate supports including job-training, education, and parenting advice. These supports help low-income working families to find employment, maintain a job, and stabilize their families financially. Considering that a number of positive employment outcomes are linked to public assistance supports likes TANF, VIEW, and child care subsidies, it is possible for families receiving these supports to gain enough financial independence to achieve self-sufficiency when they leave welfare.

However, while the goal of many public assistance programs is the achievement of economic independence and self-sufficiency, those goals may not ultimately be achieved through programs like VIEW. Virginia's Joint Legislative Audit and Review Commission (JLARC) completed a report in 2006 to assess the effectiveness of Virginia's social services system by measuring changes in self-sufficiency. JLARC measured self-sufficiency by analyzing the "financial outcomes of 14,500 social services benefit recipients between 2002 and 2004, conducted site visits of human services and workforce development agencies in 15 localities, and held interviews with the State Department of Social Services and other State agency staff."[73] JLARC found that over the two years of the study, a majority of social services clients in

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[72] Anthony Conyers, "Annual Virginia Independence Report," Virginia Department of Socials Services (October 2007), 3-7, http://www.dss.virginia.gov/files/about/reports/financial_assistance/tanf/2006/vip_annualreport_sfy2006.pdf.

[73] Joint Legislative Audit and Review Commission, "Self-Sufficiency Among Social Services Clients in Virginia" House Document No. 33, (2006), Preface, http://jlarc.state.va.us/Reports/Rpt332.pdf.

Virginia decreased their reliance on government assistance but were seldom able to remove themselves from poverty. Although families were increasing their income and financial stability, it was not enough to enable them to achieve self-sufficiency because many continued to receive benefits to help meet basic needs by supplementing their income.

JLARC also took the time to evaluate VIEW's impact on self-sufficiency and found that while individuals were able to obtain jobs, they were not able to attain self-sufficiency. However, JLARC points to the fact that VIEW's primary goal is to act as a safety net and not as an instrument for the client to become fully self-sufficient.[74] In the final analysis and recommendations of the report, JLARC concluded that self-sufficiency is a necessary goal for families and that the report should serve as a "valuable tool in recognizing incremental steps that can be taken to bring more families to self-sufficiency."[75] While VIEW alone may not be an adequate support to achieve self-sufficiency, the JLARC report highlights the importance of utilizing multiple public assistance supports, including child care subsidies, to assist low-income families in becoming self-sufficient.

III. Quality

Virginia families that depend on subsidies rely on VDSS to ensure that children have access to high quality child care. One of VDSS's roles is to oversee the child care system, thus it mandates several requirements for child care providers to ensure state-wide quality for the participating providers in the subsidy program, including regulated and unregulated providers. These quality requirements range from professional development, training, resources, referral, and classroom standards. Quality is not only regulated at the state level but also at the Federal level, since the CCDF Federal law mandates that states use at least four percent of total funds for quality improvement. Virginia estimates that $5,487,205, or four percent of funding not including additional ear marked funds, was used in FY 2008 for quality activities.[76] Quality activities for the past fiscal year included consumer education, monitoring compliance, professional development, activities in early language, literacy, pre-reading, and early math, health programs, increasing parental choice, and activities that improve access to child care.[77] These activities are crucial in advancing the quality of child care in Virginia and fostering child development among subsidy recipients.

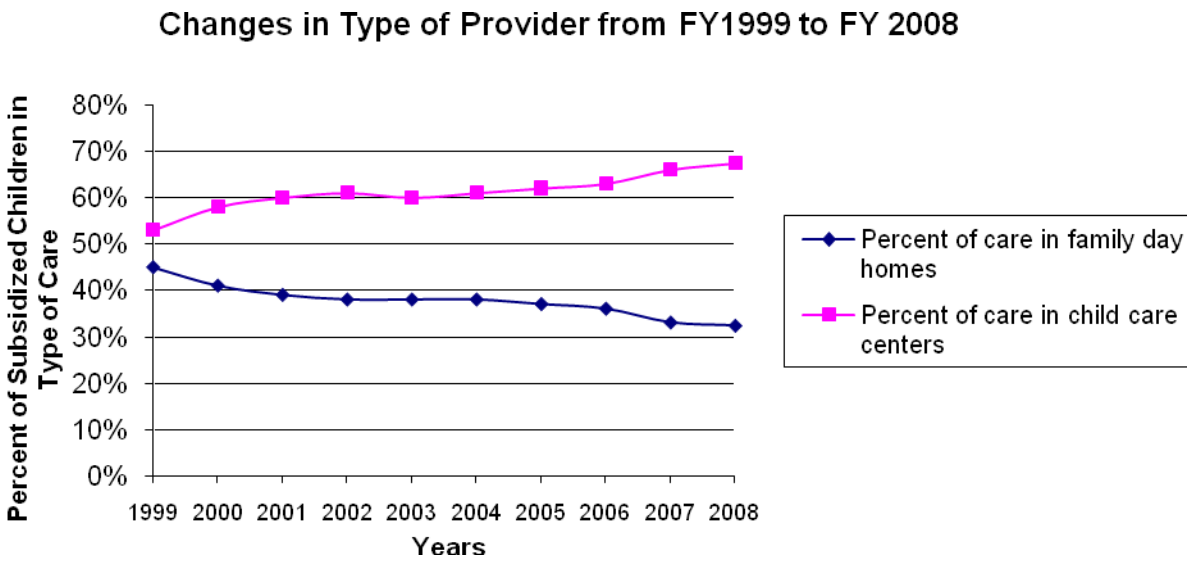
Child Care Providers in Virginia

Since FY 1999, there has been a slow change in the type of child care provider parents choose for their children. There are several types of child care providers that are prevalent in Virginia: in-home child care, child day centers, and family day homes. Child day centers are defined as facilities that serve children under the age of 13, offer care to more then 13 children,

[74] Ibid. 3.
[75] Ibid. 167.
[76] Virginia Department of Social Services, "Child Care and Development Fund Plan for Virginia," 46.
[77] Ibid. 47-49.

and are not the residence of the provider or the child in care. This type of provider is by far the largest care provider, serving over 18,000 subsidized children and over 169,000 children overall in 2007. Based on survey responses from the 2007 MRS, the median number of children in the care of child day centers was 66 in 2007 and six of those children were subsidized children. Since FY 1999, the number of subsidized children in child day centers has increased almost every year, from 53 percent in FY 1999 to 67.4 percent in FY 2008. According to the Virginia 2007 MRS, 10.8 percent of all children in child day centers are subsidized children (See Appendix C, Tables 1C and 2C).[78]

In-home child care has also decreased in Virginia, particularly in the past year. While in-home care was not responsible for large portions of subsidized care to begin with, it has decreased from two percent of all child care subsidies in FY 1999 to 0.3 percent of subsidies in FY 2008. Family day homes are defined as child care providers who offer care in their own home for a maximum of 12 children under the age of 13, excluding any children who reside in that home.[79] The 2007 MRS indicates that the median number of children receiving family day home care was five, and two of those children were subsidized. Over 5,300 children were cared for in family home care in 2007. Over the past ten years, the percentage of subsidized children in family day homes has decreased annually, from 45 percent in FY 1999 to 32.3 percent in FY 2008 (See Appendix C, Tables 1C and 2C).[80]



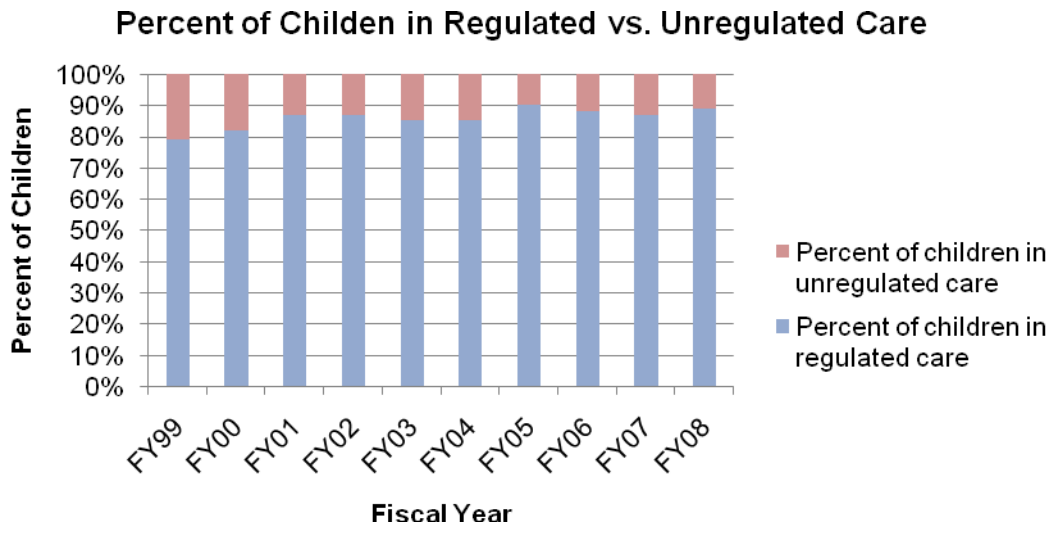
Source: VDSS Annual Data

[78] Virginia Department of Social Services, "Annual Data From FY 1999-FY 2008:Number of Children Receiving Subsidized Child Care (2007-2008 market rate survey)," (October 2008).
[79] Virginia Department of Social Services, "Child Care Policy Manual," 5.
[80] Virginia Department of Social Services, "Annual Data From FY 1999-FY 2008*:* Percent of Care In Family Day Homes," (October 2008).

Provider Regulations

VDSS oversees licensed providers and tracks which providers parents receiving subsidy payments choose. The Division of Licensing controls the listing of licensed and some unlicensed child care facilities on a public website to provide parents with access to providers in their areas. To increase quality and safety, the Division of Licensing also maintains a record of parental complaints, oversees the investigation of providers, and publishes the findings for the public. Licensing inspections are also available to the public and providers must post inspection outcomes and any information dealing with compliance in their facilities.[81]

Providers are also required to offer parents unlimited access to their children, and state staff have unlimited access to provider homes or centers as long as one or more children receives child care subsidies.[82] Ensuring that parents and state employees can have oversight over providers are two very important child care policies that help to ensure quality, and many child care advocacy groups encourage states to adopt similar policies. Virginia also has policies intended to safeguard children who go to regulated and unregulated providers. An unregulated provider is defined as any child care provider who is not: state licensed, Department of Education approved, licensed family day system approved, local ordinance approved, voluntarily registered, religiously exempt, or not listed as a certified pre-school facility.[83] The number of children in unregulated care has declined from 21 percent in FY 1999 to 11 percent in 2008, indicating improvements in the quality of care being received by both subsidized and unsubsidized children (See Appendix C, Table 1C).[84]



Source: VDSS Annual Data from FY 1999-FY 2008

[81] Virginia Department of Social Services, "Child Care Policy Manual," 40.
[82] Virginia Department of Social Services, "Child Care Policy Manual," 48.
[83] Ibid. 11.
[84] Virginia Department of Social Services, "Annual Data From FY 1999-FY 2008: Percent of Children in Unregulated Care," (October 2008).

Another provider regulation to help ensure quality is that providers, employees, volunteers, and agents working in or living in a family home of an unlicensed provider must undergo a background check including: State Criminal History Check or Sex Offender and Crimes Against Minor Registry (through VA State Police); Central Registry Child Protective Services Check; a sworn statement or affirmation as to if the adult has ever been the subject of a found complaint of child abuse or neglect, convicted of a crime, or is pending criminal charges within the Commonwealth or in another state.[85] To further ensure the health of children, providers must also pass a Tuberculosis screening and pass a checklist for health and safety standards, including the possession of a current first aid and CPR certification.[86] Additionally, VDSS promotes professional development and education of new health and safety topics by mandating that providers and any adult working with children must complete four hours of annual training related to child health, development, or safety.[87]

Child Development

To improve childhood development opportunities, VDSS and the Virginia Department of Education (VDOE) have been coordinating to create the Virginia's Foundation Blocks for Early Learning to provide standards and tools to help increase quality through child development. VDOE recently added physical motor and social emotional standards to help measure progress of four-year-old children in pre-K and childcare. VDSS is also providing a training session called "The Milestones of Child Development" for providers who serve children from birth to kindergarten to improve the quality of care in these younger age groups.[88] This program offers child care providers a comprehensive reference and guide for children to help meet their emotional, cognitive, and physical needs.

Professional Development Initiatives

Professional Development is one of the most important aspects of improving quality for children in child care. Virginia is in the process of strengthening their professional development program; however, Virginia falls behind nearly all states in the development of the state's Professional Development Plan. The CCDF State and Territory Plan report finds that Virginia is one of only seven states still in the planning process of their Professional Development Plan, including developing goals and outcomes for their professional development program. Virginia and ten other states fall behind standards when it comes to professional development, in that they do not offer incentives for additional training and do not have available opportunities for in-home providers to obtain training and education.[89] While the report does highlight Virginia as a

[85] Virginia Department of Social Services, "Child Care Policy Manual," 49.
[86] Ibid. 54.
[87] Ibid. 56.
[88] Virginia Department of Social Services, "Child Care and Development Fund Plan for Virginia," 14.
[89] United States Department of Health and Human Services, "Child Care Development Fund: Report of State and Territory Plans FY 2006-2007," 136-144.

state who assesses the professional development components of their program, Virginia still falls behind a majority of states by lacking a Professional Development Plan.

Not having formulated a Professional Development Plan does not mean that Virginia is not working towards strengthening their program. In fact, Virginia is currently working on promoting a number of professional development activities, which is especially important to improving the quality of child care since research, new teaching methods, and new health and safety information are released annually. For example, increasing the number of providers with degrees is an initiative that VDSS is undertaking by working to create standardized child care curriculum with the creators of the college curricula for early childhood certificate and degree programs, Virginia Early Childhood Comprehensive System (VECCS). The overall goal is to transfer the infant, preschool, and toddler-training series to the Community College Workforce Alliance to further standardize the level of care received.

Several other state initiatives in the professional development arena are worth noting. First, VDSS is working with the Department of Labor to create an apprenticeship program for early childhood degree seekers, with the ultimate goal of increasing their experience level and the overall number of trained professionals.[90] Another program is the Virginia Child Care Provider Scholarship Program, which helps child care teachers to earn degrees or certificates in early childhood education; this regulation is currently being changed to give priority to individuals working in the field.[91] Additionally, VACCRRN administers TEACH® Virginia, a program for professionals to earn associate's degrees through scholarships and wage incentives. VDSS has given VACCRRN approximately two hundred thousand to pay for tuition, transportation, technology, and books to scholarship recipients.[92]

Quality and Standards

Virginia is currently undertaking and supporting several programs to help increase quality and standards for the child care subsidy program. For example, VDSS allocates a Quality Initiative award to all 120 LDSS offices to improve child care with programs ranging from professional training and resources to referral activities.[93] VDSS is also working with existing resources to create a new structure for a "School-age Child Care Provider Credential" with the goal of providing content-specific credentials for individuals working with school-age children. This is important because care for school-age children is often overlooked for care for infants and toddlers. Furthermore, VDSS is working to expand programs that provide training, specifically for working with school-age children, and expects to have a new video/DVD series for child care teachers working with school-age children.[94] One strength of Virginia's program is that parents have full discretion to choose a child care provider, as long as they are legally operating child care providers and meet the state issued provider requirements. The ability to choose providers, along with Virginia's understanding of the need for consumer education, helps

[90] Virginia Department of Social Services, "Child Care and Development Fund Plan for Virginia," 14.
[91] Ibid. 18.
[92] Ibid. 52.
[93] Ibid. 45.
[94] Ibid. 46.

parents to select quality programs, which can in turn increase the incentives for providers to offer quality care.[95]

The NACCRRA report referenced in the literature review ranked Virginia's child care program 15th overall with a total score of 74/150, a 44/100 on standards, and a 35/50 on oversight. Two of Virginia's notable strengths are the parent communication and visitation rights, and that Virginia met nine of the 10 basic standards for health and safety requirements.[96] These are major strengths that helped to push Virginia to the top of the list for quality and standards. However, the report also pointed to weaknesses, including that Virginia did not comply with any of NAEYC's standards for all age groups, center directors are not required to hold Associate's degrees or CDAs, center teachers are only required to hold a high school diploma or GED before being allowed to work with children, and Virginia does not require a child abuse and neglect registry check.[97] NAEYC recommends certain standards; including minimum education levels for professional child care providers, to ensure that children are receiving qualified care and education (See Appendix 2B). Although Virginia does have weaknesses, there is room to grow and Virginia has taken strong steps to improve quality through various professional development and quality improvement initiatives.

Quality Ratings System Initiative

The Strategic Plan for Virginia's Early Childhood System describes the goals, strategies, and outcomes for implementing a QRS in Virginia. This is a very progressive step that many states are undertaking to work towards improving quality by creating QRSs. VDSS's Early Childhood Alignment Project is developing standards for a QRS to increase the consistency of quality and provide parents with access to a listing of quality child care programs.[98] The Governor's Working Group on Early Childhood Initiatives and the Virginia Early Childhood Foundation will work with the Early Education Committee and other partners to establish a statewide voluntary QRS. Over the next two years, the QRS will be finalized and a plan for implementing it in Virginia will be designed. Other initiatives tied to the QRS are the creation of a system for technical assistance for child care providers, bonuses for quality through tiered reimbursement schedules, early care and education training programs, and the development of incentives for unregulated providers to enter into the regulated system.[99] As the QRS is developed and put into place salaries and wages are expected to improve. The Milestones Training Program will be used in the creation of the QRS. In addition, Quality Ratings will be derived from Infant and Toddler Environment Rating Scale (ITERS), Early Childhood Environment Rating Scale, the Family Day Care Rating Scale (FDCERS), which measures the quality of environment, and the Classroom Assessment Scoring System (CLASS) instrument to

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[95] Ibid. 37.
[96] Immunization, guidance/discipline, fire drills, diapering and hand washing, medicine administration, placing baby on back to sleep, hazardous material, playground surfaces under outdoor equipment, and emergency preparedness
[97] National Association of Child Care Resource and Referral Agencies, "State of Child Care Centers in Virginia," (2007), http://www.naccrra.org/policy/docs/scorecard/states/VA.pdf.
[98] Virginia Department of Social Services, "Child Care and Development Fund Plan for Virginia" 55.
[99] Ibid. 103.

evaluate teacher child relationships.[100] Virginia is working hard to design and implement an appropriate QRS and improve child care provider quality standards for families receiving child care across the state.

IV. Economic Costs

The costs of child care to low-income families would be substantial without child care subsidies. Maximum Reimbursement Rates (MRRs) and parent co-payments are set to help low-income families afford high quality child care. In Virginia, there are two rate schedules of MRR, those for licensed providers and those for unlicensed providers and parent co-payments are set at a flat 10 percent rate of gross family income.

Maximum Reimbursement Rates

Average reimbursement rates for Level 2 state licensed child care providers in Virginia ranges from the 40th to 55th percentile of current market rates. Compared to the rest of the states and the District of Columbia, these rates fall into the lowest quartile of Maximum Reimbursement Rates (MRRs), with only 11 states falling below Virginia's reimbursement rate range. These rates have been in effect since September of 2004. The most recent Market Rate Survey was conducted in April of 2007 and it surveyed both licensed and unlicensed providers in 42 localities across the five regions of Virginia. In total, 606 licensed centers and 841 family providers were surveyed. The Federal recommendation is to set the MRR at the 75th percentile to grant subsidized families access to 75 percent of the child care providers in the market. In order for a child care facility to receive Level 2 reimbursement rates, the LDSS must certify that the facility meets or exceeds the minimum licensing standards. For Level 2 providers, MRRs average at the 50th percentile for center care and the 20th percentile for family care providers. For Level 1 unlicensed child care centers the MRR ranges from the 15th to 30th percentile. When considering the cost of infant care, which is typically the most expensive type of care, the Level 1 MRRs are particularly low, at the 15th percentile for center care and the 5th percentile for family providers. However, despite low Level 1 provider rates, VDSS estimates that 77 percent of licensed child care centers for infant, toddler, and pre-school child care had rates set to at least 80 percent of the 2007 market rates.[101] In the case of special needs children, reimbursement rates are typically negotiated between the LDSS, parents, and the provider to cover the entire cost of care regardless of the rate schedule.[102]

Since 1999, the average subsidy payment per child per month has increased slightly in most fiscal years until FY 2007, when average monthly subsidy contributions increased only one dollar from the year before. Although average subsidy payments have remained stable over the past 10 years, in FY 2008 payments decreased approximately 7.5 percent from FY 2007.

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[100] Ibid. 59.
[101] Virginia Department of Social Services, "Child Care and Development Fund Plan for Virginia," 177.
[102] Ibid. 25.

Average subsidy payment per family per month over the 10 year time period increased slightly more than payments per child per month. From FY 1999 to FY 2003, the average monthly subsidy contribution per family increased almost 65 percent. However, the average payment per family per month increased only minimally until FY 2008, when it decreased by approximately $70.00 from the prior year (See Appendix C, Table 1C).[103]

Overall, the differences in the MRRs for the two levels suggest that there are some monetary incentives for child care centers to meet the licensing requirements, as rates are highest for licensed child care centers in all age groups. However, neither of the MRR schedules meets the federally recommended levels, which are proposed to ensure that subsidized children can receive both affordable and high quality care. This would imply that MRRs that are not relatively close to the Federal level deny low-income families the same access to high quality care, unless they undertake additional financial obligations. Increased burdens on the finances of low-income families can force them to choose between quality child care and other necessities, and can create difficulties in obtaining self-sufficiency.

Parent Co-payments

VDSS found that low-income parents without subsidies pay approximately 18 percent of their income in child care co-payments, and un-subsidized parents with higher incomes pay approximately seven percent of their income for child care co-payments. VDSS considered these estimates when setting parent co-payments for subsidy recipients. Parents with one child pay a co-payment equal to 10 percent of income. Therefore, the greater a family's income is above FPL, the greater the co-payment in dollars. Virginia's co-payment amount is high compared to other states, with only nine of the 45 states (including the District of Columbia) that offer child care subsidies for families at 150 percent FPL requiring higher co-payments (See Appendix A, Table 4A). However, TANF recipients and those with incomes at or below 100 percent of FPL do not have parental co-payments requirements in Virginia. Additionally, parents with more than one child are not required to pay 10 percent of income in co-payments for each child, but rather pay a slightly decreased percentage of their income for each additional child.[104]

Four Virginia localities, Alexandria, Arlington, Fairfax, and Virginia Beach, have alternative sliding fee schedules, where the percentage of parental income paid in co-payments increases as family income increases. For example, in the City of Alexandria, families with incomes from zero to 70 percent FPL pay one percent of monthly income in child care co-payments, but families with incomes 151-185 percent FPL pay 10 percent of monthly income in child care co-payments.[105] It is also important to note that Virginia allows child care providers to charge low-income parents additional fees equal to the difference between non-subsidized care and subsidized. Thus, while parent co-payments rates have remained stable, these numbers are not necessarily representative of the actual amount low-income parents are paying for child care.

[103] Virginia Department of Social Services, "Annual Data From FY 1999-FY 2008." (October 2008).
[104] Virginia Department of Social Services, "Child Care Policy Manual," 35.
[105] Virginia Department of Social Services, "Child Care and Development Fund Plan for Virginia," 179.

Another issue many states face in the cost arena is improper payments based on mistakes in eligibility determination and inaccurate payment estimates for providers or clients. The main solution to mitigate improper payment problems and increase coordination among government programs is to implement statewide automation systems to gather information. Automation would allow for eligibility determinations and provider and parent payments to be calculated in a standardized manner, and would allow eligibility mistakes, overpayments, and underpayments to be easily identified and flagged in an electronic system. Additionally, automating the system would result in a greater coordination among similar government programs such as TANF and FSET, and a more efficient use of government resources, as only one agency would be responsible for collecting information on clients. Several of VDSS's programs are already automated and the result has been positive. Currently, 25 states use automation systems to identify eligibility mistakes, and improper payments, 11 states use automation to determine provider payments, and 10 states use automation to determine family eligibility for subsidies.[106] While Virginia's local waiting lists are already automated, the distribution of child care subsidies could be greatly improved if the entire subsidy program were automated. Especially considering Virginia is a state supervised, locally administered program with a small number of state staff, an automated system would be beneficial in accomplishing large tasks with minimal staff. By fully automating its child care subsidy system, Virginia would be better equipped to determine income eligibility, provide payments, and share resources across government agencies, making the provision of subsidies more efficient and cost-effective.

V. Access

To ensure that those low-income families most in need of subsidies are able to access them, Virginia, like most states has several eligibility requirements in place. TANF recipients receive the highest priority and are guaranteed subsidies, followed by families with special needs children, Head Start participants, and FSET participants. For other low-income families, subsidies are provided based on income eligibility criteria, and families are placed on a waiting list if CCDF funding is insufficient to serve all those eligible. In Virginia, income eligibility and waiting lists pose a significant barrier to access for some families who may not receive priority for subsidies but are still in need of child care assistance.

Income Eligibility

To provide subsidies for families that are not in prioritized groups, Virginia uses income eligibility rates to qualify families earning below a certain income level for child care subsidies. Virginia defines income as the gross countable income of all family members in a household, including unearned incomes such as social security and child support, but not including public assistance such as TANF benefits, food stamps, supplemental security income, and EITC.[107]

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[106] United States Department of Health and Human Services, "Child Care Development Fund: Report of State and Territory Plans FY 2006-2007,"
[107] Virginia Department of Social Services, "Child Care and Development Fund Plan for Virginia," 178.

While the Federal requirement is that states may only provide subsidies to families earning below 85 percent of the state median income (SMI) level, Virginia and many other states set income eligibility rates at well below that level. Virginia's income eligibility rates vary by region because of large disparities in average income levels across the state. The four regional income eligibility rates in 2008 are $26,400, $28,160, $32,560, and $44,000, and reflect the 150 percent, 160 percent, 185 percent, and 250 percent of the 2008 FPL respectively. In terms of SMI, Virginia's income eligibility rates range anywhere from 40 to 66 percent of Virginia's SMI.[108] If Virginia's income eligibility ranges are averaged, they are equivalent to 195 percent of the 2008 FPL, which ties them for 14th highest eligibility rate in the country.[109] With this average income eligibility rate, Virginia is above the median income eligibility rate of 180 percent FPL, but below the 75th percentile rate of 199 percent FPL (See Appendix A, Table 5A).

While raising the income eligibility rate in Virginia would qualify more families for subsidy use, it would also substantially increase the current waiting list numbers in Virginia. On the other hand, if income eligibility rates in Virginia were decreased a number of families would be disqualified from eligibility and removed from the waiting list. While decreasing rates could give the appearance that all families in need of child care subsidies were being served, unmet need for subsidies throughout the Commonwealth would actually increase, a number of parents may face an inability to afford child care, and as a result may be unable to maintain their jobs and public assistance benefits.

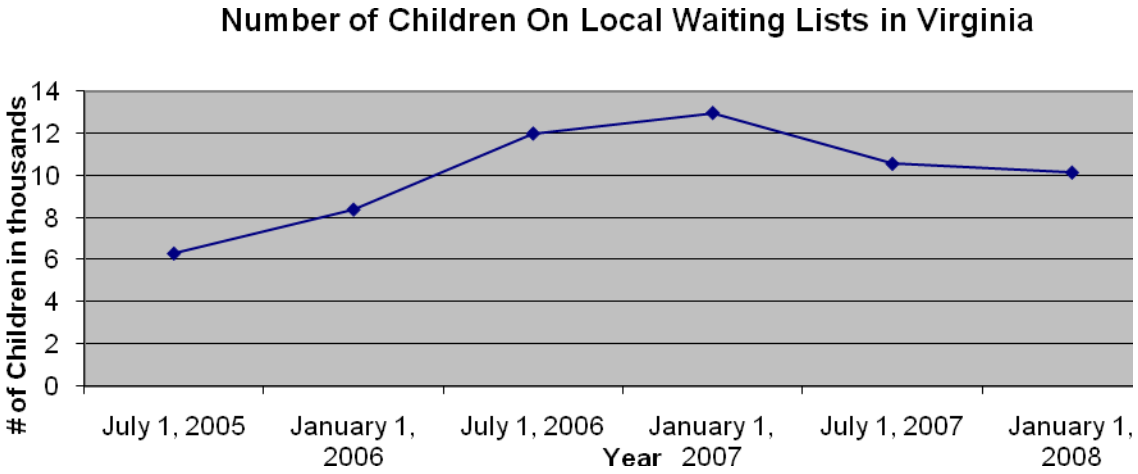
Waiting Lists

Waiting lists can serve as another barrier to access, and are generally utilized by states when there is more demand for child care subsidies then there is funding. In Virginia, low-income families that request child care subsidies are told through their LDSS at the time of request if there is not enough funding to receive them, and are given the choice to be placed on a waiting list pending the approval of their eligibility. Due to the priorities for subsidy distribution, no TANF recipients, Head Start participants, FSET recipients, or children with special needs were on the waiting list in FY 2008. Additionally, if there are local waiting lists, Head Start Wrap Around funds may be used to provide child care to eligible siblings of Head Start participants.[110] Localities have the discretion to manage their waiting list on a priority basis or serve family on a first come first serve basis, however any other method must be approved by VDSS.[111]

When funding is insufficient to serve all families in need of subsidies, the LDSS often recommends alternative resources such as community programs, or the YMCA to assist the family until a subsidy is available. However, the availability of these resources varies by locality, leaving some families with few options for affordable care if child care subsidies are unavailable.[112] Virginia is currently one of 17 states with waiting lists, experiencing an increase

[108] Blank and Schulman, 15.
[109] Ibid. 15.
[110] Virginia Department of Social Services "Child Care Policy Manual," 19.
[111] Ibid. 34.
[112] Virginia Department of Social Services, "Child Care and Development Fund Plan for Virginia," 34.

from 6,291 children in July 2005 to a high of 12,960 children in January 2007. The waiting list has fallen since then to a recorded total of 10,135 children in January (See Appendix C, Table 4C).[113] Additionally, Virginia has experienced a decrease in its waiting list in July as a result of the $12 million TANF transfer being utilized to serve families waiting for subsidies. While the National Women's Law Center Brief estimates the Virginia waiting list at 7,184 children in September of 2008, official DSS data on those figures has yet to be released. According to the National Women's Law Center estimates, of those states with waiting lists, Virginia has the sixth largest waiting list (See Appendix A, Table 6A).[114]



Source: VDSS Annual Data From FY 1999-FY 2008

When waiting lists are considered by reimbursement rate region, the areas facing the greatest demand for subsidies become apparent. The waiting list in the Warrenton region contains 6,638 children, the Virginia Beach area contains 1,673 children, and the Henrico area contains 1,157 children. These areas alone account for 9,468 of the children on the state waiting list in January 2008, and should be target areas for improvements in child care subsidy distribution.[115] Providing subsidies for children on the waiting list is just one option for states when faced with additional funding, as funding could be devoted to additional quality or cost improvement measures. However, decreasing the overall unmet need throughout the state significantly helps additional families in need of subsidies to gain financial independence and move towards self-sufficiency.

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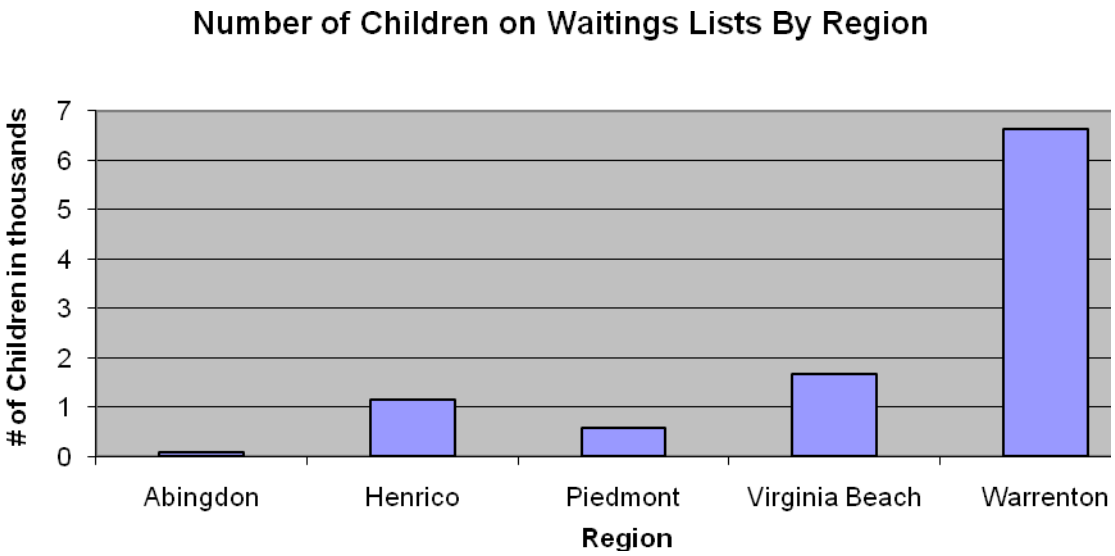
[113] Virginia Department of Social Services, "Annual Data From FY 1999-FY 2008: Waiting List by Children," (October 2008).
[114] Blank and Schulman, 16.
[115] Virginia Department of Social Services, "Annual Data From FY 1999-FY 2008: Waiting List by Children," (October 2008).



Source: VDSS Annual Data From FY 1999-FY 2008.

Chapter Five: Comparison States and Best Practices

We have chosen comparison states using the methodology discussed in chapter three, and have ranked states based on the National Women's Law Center data on child care subsidy costs and access, and chosen states based on certain quality indicators (See Appendix 1A, Tables 2A-7A). To highlight a variety of state practices we have generally chosen one state with similar per child per month spending that performs better then Virginia, and one state that performs worse then Virginia in the areas of quality, economic cost, and access. The quality section is structured somewhat differently in that there are some cases where both comparison states have performed better then Virginia due to the nature of some of the quality indicators. By highlighting a variety of practices across other states, we hope to better ascertain where improvements can be made in Virginia's child care subsidy program.

I. Quality

States implement a variety of methods to improve the quality of their child care program; however some states lag behind in implementing national standards of quality. States' quality measures can be evaluated in the three quality areas of standards and oversight, professional development, and the implementation of a statewide QRS. Standards and oversight will be evaluated based on the NACCRA study, which serves as a benchmark for states to meet nationally recommended practices and achieve high quality child care programs. Professional development practices are evaluated based on Federal recommendations for state "Professional Development Plans." Also relevant are the goals and outcomes of state professional development programs, which enhance the competency and training of child care professionals by providing developmental opportunities, early learning, and safety measures, all of which can improve the quality of care received by subsidized children. Finally, the development and implementation of QRSs will be explored in order to see the effective outcomes states have experienced by utilizing statewide QRSs.

Standards and Oversight

Maryland

Maryland is a state that ranks high on standards and oversight by the NACCRA study, particularly for their center-based care providers. In 2007, Maryland served 22,900 children per month, as of 2008 had a total CCDF funding level of $145.6 million (Federal CCDF, TANF transfer, MOE, and State Matching), and does not have children on their waiting list.[116] Maryland uses the State Department of Education as the Lead Agency to implement and

[116] Maryland State Department of Education, "Child Care and Development Fund Plan for Maryland: FFY 2008-2009," (2007), 5, http://www.marylandpublicschools.org/NR/rdonlyres/38C2D261-0C1C-45B6-BD7C-F4C1C3347F0E/14925/0809CCDFStatePlan_121107.doc.

administer most of the quality programs but also utilizes other entities such as the Department of Human Resources for "Memorandum of Understandings," Maryland Committee for Children, Maryland Child Care Network, and The State Comptroller's Office. Out of the total state and Federal funds, Maryland uses the Federal minimum for quality activities by setting aside exactly four percent of CCDF funds, which amounts to $4.2 million each fiscal year.[117] Furthermore, quality activities are earmarked for infant and toddler development to fund the Maryland Child Care Resource Network, Resource and Referral Network, and school-age children initiatives.[118] Although Maryland uses the Federal minimum set aside, their quality funding is not limited to that four percent in the sense that they have been able to utilize partnerships to help achieve high standards of professional development and quality child care programs.

According to the NACCRA study, Maryland ranked fourth and scored an 89/150 with a 63/100 on standards and a 26/50 on oversight. Maryland's overall strengths included that it met NAEYC's requirements for five of the seven age groups.[119] Similar to Virginia, Maryland's center staffs are also required to hold certification or trainings in first aid, CPR, and other health and safety topics. Maryland also has institutionalized standards in child development activities. Currently, they have activities that address social, physical, language/literacy, cognitive/intellectual, and emotional developmental areas, which account for five of six of NACCRRA's recommendations. Additionally, Maryland has standards in place that address nine of the 10 NACCRRA recommendations. In terms of professional development, Maryland requires all licensed provider staff to hold a minimum of a bachelor's degree in child care related care, and requires all centers and family child care homes to be licensed. Both of these requirements help to improve child care oversight by ensuring that all providers meet certain requirements and are held responsible through sanctions.[120]

Louisiana

Unlike Maryland, Louisiana has struggled to maintain high ratings in standards and oversight. In 2007, Louisiana served 39,100 children per month, with total 2008 CCDF funding levels of $153.3 million (Federal CCDF, TANF Transfer, Direct Federal TANF, MOE, and State Matching) and does not have children on its waiting list.[121] Louisiana uses the Lead Agency to implement and administer most of the quality programs but also utilizes State Colleges and Universities, Child Care Resource and Referral (CCRR), individuals, the Department of Health, hospitals, and the Office of Citizens with Developmental Disabilities. Out of the total funds, Louisiana uses the Federal minimum for quality activities by setting aside exactly four percent or $5.3 million each fiscal year.[122] Furthermore, quality activities are earmarked for CCRR and

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[117] Ibid. 40.
[118] Ibid. 39-40.
[119] Including: six weeks old, nine months old, 18 months old, 27 months old, and four years old.
[120] National Association of Child Care Resource and Referral Agencies, "State of Child Care Centers in Maryland," (2007), http://www.naccrra.org/policy/docs/scorecard/states/MD.pdf.
[121] Louisiana Department of Social Services, "Child Care and Development Fund Plan for the State of Louisiana: FFY 2008-2009," (2007), 8, http://www.dss.state.la.us/Documents/OFS/CCDFPlanAmend_Novemb.pdf.
[122] Ibid. 48.

professional development, with a particular focus on infant and toddler development.[123] The use of minimal quality funding and the lack of extensive partnerships has limited the quality of Louisiana's child care programs.

In contrast to Maryland, Louisiana was ranked 51st in NACCRRA study for standards and oversight for child care centers with a total score of 37/150, a 13/100 in standards and a 24/50 in oversight. NACCRRA was only able to highlight one strength in Louisiana's program, that center staff are required to have training or a certification in CPR or other health and safety topics. The weaknesses in quality were attributed to the lack of standards across the state, especially in the area of professional development.[124]

Among the weaknesses is that Louisiana's child care subsidy program does not meet staff/child ratios for any size age group based on NAEYC standards. Specifically, there are no standards for teachers or staff working in center-based providers and they are not even required to hold a high school diploma or GED before working with children. Furthermore, provider staff members are not required to have first aid training and are only required to have three hours of annual training. Of additional concern is that Louisiana still allows corporal punishment and only meets five of the 10 health and safety standards. This raises numerous concerns surrounding quality and child development, particularly considering children receiving subsidies depend upon educated staff to help foster early development.[125]

Additional Practices-Standards and Oversight

Several other highly ranked states outside of the scope of this report can be pointed to as best practice states. Both Illinois and New York ranked highest on the report card, both receiving a total score of 90/150. Illinois received a 66/100 for standards and a 24/50 for oversight. Some of the reason for Illinois' high ranking is that the state requires center teachers to undergo a minimum of 30 semester hours of college credits in early childhood education or a related field in order to work with children. Additionally, they require a criminal history record check, child abuse and neglect registry checks, Federal and state fingerprint checks, and sex offender registry checks. Another significant strength is that Illinois requires all program activities to address NACCRRA's six developmental domains and meet all 10 health and safety basic standards. Centers have protocols established for parent involvement and communication as well as allowing parental visits.[126] These states, while not achieving perfect scores can still be used as examples of states that have achieved high standards and oversight in the quality arena.

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[123] Ibid. 46-47.
[124] National Association of Child Care Resource and Referral Agencies, "State of Child Care Centers in Louisiana," (2007), http://www.naccrra.org/policy/docs/scorecard/states/LA.pdf.
[125] Ibid.
[126] National Association of Child Care Resource and Referral Agencies, "We Can do Better."

Professional Development

North Carolina

North Carolina is a state that has been successful at achieving the Federal recommendations for professional development. In 2007, North Carolina served 95,800 children per month, as of 2008 had a total CCDF funding level of $380.5 million (Federal CCDF, Federal TANF Transfer, Direct Federal TANF, MOE, and State Matching) and has 27,153 children on its waiting list.[127] North Carolina uses the Department of Health and Human Services as theLead Agency to implement and administer most of the quality programs but also utilizes other entities such as County TANF agencies, State Colleges and Universities and CCRR. Out of the total funds, North Carolina goes slightly over the Federal minimum for quality activities by setting aside 4.03 percent, which amounts to $11.9 million each fiscal year.[128] Earmarked quality activities include the CCRR, promoting healthy behavior activities, pre-licensing training, Infant/Toddler Environment Rating Scale, preventing abuse and neglect, and many different T.E.A.C.H elements.[129] Although North Carolina uses about the same as the Federal minimum set aside, their quality is not limited to that funding because they have been able to utilize partnerships to help achieve high standards of professional development and quality child care programs.

According to the Child Care and Development Fund Report, all states are required to have a professional development plan and within this plan the Federal government makes suggestions and sets goals for each state to meet. North Carolina meets all of components of the Federal recommended "Elements of Professional Development Plans: Qualifications, Pathways, and Credentials and Quality Assurance.[130] [131] Additionally, North Carolina is the only state to require providers to have credentials documenting or certifying that they have passed requirements related to skills and knowledge with a general early childhood focus.[132] [133] North Carolina also offers statewide professional development opportunities for center-based child care providers, family providers, and in-home providers. To provide accountability, the state assesses the effectiveness of its professional development initiatives to ensure that they are achieving quality development programs.[134] North Carolina has been successful in making sure that professional development needs for child care providers are being met in many different areas.

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[127] North Carolina Department of Health and Human Services, "Child Care and Development Fund Plan for the State of North Carolina: FFY 2008-2009," (2007), 7, http://ncchildcare.dhhs.state.nc.us/pdf_forms/nc_ccdf_2008_2009.pdf.
[128] Ibid. 59.
[129] Ibid. 48-59.
[130] United States Department of Health and Human Services, "Child Care Development Fund: Report of State and Territory Plans FY 2006-2007," 139.
[131] a) Continuum of training and education, b) Articulation, c) State credentials, d) System to track providers' training, e)Assessment or evaluation of training effectiveness, f) Trainer approval process, g) Training approval process
[132] Ibid. 140.
[133] Professional development plan includes State/Territory credentials, director/administrator, infant and toddler, general early childhood/preschool education, school-age, and family provider or group home child care.
[134] Ibid. 146.

One way has been that North Carolina placed professional development standards into its QRS, which has successfully made child care professionals accountable for training and education. Overall, its inclusion of both home and center-based care providers, its detailed and expansive Professional Development Plan, and its integration into a QRS make North Carolina a state to look to for guidance and best practices.

North Carolina has also provided innovative professional development programs by contracting Health and Human Services with the North Carolina Institute for Early Childhood Professional Development. They serve as an advisory group that advocates for implementing comprehensive childhood professional development. Similar to Virginia, North Carolina utilizes the T.E.A.C.H fund. T.E.A.C.H. is a scholarship program provided to the early childcare workforce to access educational opportunities,[135] and North Carolina uses these funds to supplement health care costs for providers.[136] In addition to T.E.A.C.H, North Carolina has started a pilot program in 100 counties using state and Federal dollars (including the CCDF quality improvement funding) to help cover the cost of tuition for center employees to obtain additional education.

Arizona

Unlike North Carolina, Arizona is only in the beginning stages of implementing an effective Professional Development Plan. Arizona served 30,900 children per month as of 2007, with a total CCDF funding of $201.1 million (including Federal CCDF, TANF Transfer, Direct Federal TANF, MOE, State Matching, State Monies, and SSBG Funds) in 2008 and does not have children on its waiting list.[137] Arizona uses the Department of Economic Security as the Lead Agency to implement and administer most of the quality programs, but also utilizes other entities such as private for profit organizations, CCRR, Community Based Organizations, Community Colleges, and non-TANF State agencies. Out of the total CCDF funds, Arizona adheres to the Federal minimum for quality activities by setting aside exactly four percent, which amounts to $4.6 million each fiscal year. Arizona utilizes these funds for quality activities such as CCRR, Infant and Toddler Development, and a special program targeted at "tweens" and school age children.[138] The use of a minimal amount of set aside along with the lack of extensive partnerships has limited the growth in quality for Arizona's child care programs.

States around the country are all at different stages with their Professional Development Plans. On the high end are states like North Carolina, who have been implementing a plan since 1993, and at the beginning stages of the planning process are seven states, including Virginia and Arizona. Virginia happens to be one of the bottom states for implementing the Federal recommendations in a Professional Development Plan. Arizona ranks similar to Virginia in professional development because it is at the planning stage of its Professional Development

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[135] United States Department of Health and Human Services, Quality Expansion Activities.
[136] Center for Law and Social Policy, "North Carolina T.E.A.C.H. Early Childhood® & Child Care WAGE$®," (March 2007), http://www.clasp.org/ChildCareAndEarlyEducation/map030707nc2.htm.
[137] Arizona Department of Economic Securities, "Child Care and Development Fund Plan for Arizona FFY 2008-2009," (2007), 6, https://www.azdes.gov/childcare/fund.asp.
[138] Ibid. 50.

Plan and has not specified any goals or outcomes. Additionally, Arizona has not established credentials for the professional development training programs and does not have available opportunities for professional development on a statewide level for center-based, in-home, or family providers.[139] While, Arizona does offer incentives for professionals to seek additional training education, they do not utilize scholarships, QRS systems, T.E.A.C.H, Early Childhood Project, or monetary bonuses to help child care providers complete trainings. Furthermore, while Arizona does have professional development components in their statewide program and assesses those initiatives, both Virginia and Arizona lag behind other states in the completion of their federally recommended Professional Development Plans.

Additional Practices-Professional Development

While professional development and training is in need across all areas of child care, it is important for states to focus special programs on infants and toddlers, especially in the areas of brain development and early learning. Indiana has been engaged in developing training programs focused specifically on infant and toddler care. Indiana's Infant/Toddler Professional Development Network created a dialogue and partnership between Indiana's infant and toddler care providers including Head Start, First Steps, and other child care organizations to talk about infant/toddler needs and training plans. Included in this dialogue were ways to utilize higher education to promote Infant/Toddler Credentialing.[140] Another state initiative is the Illinois Network of Child Care Resource and Referral Agencies (CCRRA), which administers Gateways to Opportunity Early Care & Professional Development Network. This system brings together State government and non-government agencies, CCRRAs, child care providers, and two and four year colleges. The collaboration created a website that offers Illinois professional development information for early care providers, contacts for career advising, makes available training and college courses, job postings, and other resources and referral service information.[141]

Quality Rating Systems

Oklahoma

Oklahoma is on the forefront of quality initiatives, as one of the first states to implement a QRS and also for its commitment to devoting additional funds to quality. Oklahoma served an average of 25,000 children per month in 2006, with total FY 2008 CCDF funding of $184.1 million (Federal CCDF, TANF Transfer, Direct Federal TANF, MOE, State Matching and 25

[139] United States Department of Health and Human Services, "Child Care Development Fund: Report of State and Territory Plans FY 2006-2007," 138-140.
[140] Ibid. 185.
[141] Ibid. 202.

million in State Appropriated Funds), and does not have any children on its waiting list.[142] Out of the total funds, Oklahoma goes above and beyond the Federal minimum of four percent for quality activities by setting aside 10.4 percent of funds for quality activities, which amounts to 12.1 million dollars each fiscal year.[143] Quality activities are performed by the Oklahoma Department of Human Services, The Oklahoma CCRRA, University of Oklahoma Center for Early Childhood Professional Development, Oklahoma Department of Mental Health & Substance Abuse, University of Oklahoma, Oklahoma State Regents and the Oklahoma University Health Sciences Center.[144] The large amount of set aside funds and collaborative efforts among a variety of entities have had a significant impact on Oklahoma and the quality of child care.

Oklahoma was the first state to pioneer a statewide QRS system, "Reaching for the Stars." Since its inception in 1998, Oklahoma has served as model for other states that are or have developed a QRS system. In 1996, a child care committee formed from a State task force on welfare reform decided to look at state wide concerns in child care. To address the concerns found by the task force, Oklahoma decided to develop their QRS system with three main goals: raising reimbursement rates, improving the competency level of child care providers, and giving parents the opportunity to evaluate the quality of child care programs. It is built on a block system as opposed to a point system, whereby each quality level consists of certain standards and all standards must be met before moving to a higher rating level.

A particular strength of the Reaching for the Stars program is that Oklahoma took the time to evaluate the program after its first year and made it a priority to address some of the early challenges in the program. This assessment has not only improved Oklahoma's QRS, but has provided other states with constructive lessons for the implementation of their own QRSs.[145] While there are very few studies completed on the impact of QRS systems, Oklahoma's early implementation of a QRS has given the child care community evidence that QRS systems can improve quality. Reaching for the Stars has increased the number of child care programs that exceed licensing requirements from 26 percent to 50 percent; the number of accredited three-star programs across the state have increased; and over the past seven years staff turnover rates have dropped from 60 percent to 35 percent. The Oklahoma QRS system has demonstrated effective results and thus has contributed greatly to the quality of child care and increased the opportunity for provider parent relationships.[146]

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[142] Oklahoma Department of Human Services, "Child Care Development Fund Plan For Oklahoma: FFY 2008-2009," (2007), 6, http://www.okdhs.org/NR/rdonlyres/BCB30FED-BA3E-4006-BC27-391BA2B6A733/0/ChildCareAndDevelopmentFundPlan_occs_08312007.pdf.
[143] Ibid. 42.
[144] Ibid. 43.
[145] United States Department of Health and Human Services, "Child Care Bulletin: Oklahoma's Pioneering QRS: Reaching for the Stars" Administration for Children and Families, Child Care Bureau (Winter/Spring 2007), 14, http://www.nccic.acf.hhs.gov/ccb/issue32.pdf.
[146] Ibid.15.

Pennsylvania

Pennsylvania is another state that devotes additional funding to quality and has its own innovative QRS. In 2007, Pennsylvania served 86,700 children per month, with total CCDF funding of $472.8 million (Federal CCDF, Federal TANF Transfer, Direct Federal TANF, MOE, and State Matching funds) dollars in 2008 and currently has about 8,500 children on its waiting list.[147] Pennsylvania uses the Department of Public Welfare as the Lead Agency to implement and administer most of the quality programs; however, they also use County Assistance Offices, Child Care Information Services, and the Pennsylvania Early Learning Keys to Quality Sites. Out of the total funds, Pennsylvania goes above and beyond the Federal minimum of four percent for quality activities by setting aside 17.5 percent, which amounts to $31.5 million dollars each fiscal year.[148] A portion of the funds are earmarked for the Keystone STARS program, infant and toddler development programs, professional development, infant mental health, resource and referral services, and for the Office of Child Development and Early Learning.[149] The significant amount of set aside funds and collaborative efforts have had a major impact on Pennsylvania and its ability to increase the number of quality child care programs.

Pennsylvania and Oklahoma are two of five states that were on the forefront of implementing statewide QRS systems (See Appendix D, Table 1D). Their goal was to support current child care programs and providers, and to improve the development of children by increasing and promoting higher-quality care. In 2002, Pennsylvania instituted its QRS system: Standards, Training/Professional Development, Assistance, Resources, and Support (STARS). The Keystone STARS program focuses on four components: director and staff qualifications including professional development, the early learning program, partnering with families to communities, and promoting leadership and management. They rate each provider on five levels and Pennsylvania followed Oklahoma by using a block system with mandatory expectations for each rating level. Also similar to Oklahoma, STARS went through a review process and has made changes based on research to ensure a high quality and effective QRS.[150]

Pennsylvania has created several innovative ways to connect different aspects of their child care program within their QRS system. As an example, Pennsylvania has decided to align standards across child care providers by using some Head Start standards within their quality levels. Pennsylvania also contracts with T.E.A.C.H., and gives staff employed in child care programs that participate in Keystone STARS priority for new scholarships. As of 2007, 87 percent of staff in the T.E.A.C.H. scholarship program worked with a provider who participates in the STARS program.[151] As an incentive to participate in the Keystone STARS program, Pennsylvania offers quality mini grants or awards to child care programs that enroll in Keystone STARS, maintain rating standings, or improve rating standings.[152] These innovative strategies,

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[147] Department of Public Welfare, "Child Care and Development Fund Plan for the Commonwealth of Pennsylvania: FFY 2008-2009," (2007), 6, http://www.dpw.state.pa.us/Resources/Documents/Pdf/AnnualReports/FY0809/OCDEL/PACCDFPlan.
[148] Ibid. 48.
[149] Ibid. 46-47.
[150] Zellman and Perlman, 25-26.
[151] United States Department of Health and Human Services, "Child Care Bulletin," 10.
[152] Ibid. 12.

incentives, and partnerships have successfully increased quality in several areas across the entire state.

Additional Practices-QRS

Although Oklahoma and Pennsylvania have the model QRSs in the country, it is also pertinent to draw attention to states are who are in the initial stages of development. Maine, as one of the three states that began a QRS in 2008, has recently unveiled its QRS, "Quality for ME" for center-based providers, Head Start providers, family child care providers and school-age programs. Maine's Department of Health and Human Services administers the voluntary system. Beginning in 2009, providers receiving CCDF funds are required to participate in the new system, so that Maine can track public investment in quality child care. Additionally, Maine has switched to a two-year licensing process that requires annual visits whether announced or unannounced. Its strategy is proactive because Maine took two of its quality problems, the need for a QRS and the need for an increase in provider licensing, and created a solution by implementing a statewide QRS to meet both needs.

II. Economic Costs

Reimbursement Rates

States use a range of methods to set reimbursement rates to ensure that providers are being adequately compensated without sacrificing quality or compromising subsidy recipients' access to care. States have different geographic locations for which reimbursement rates are established, different definitions and rates for the ages of children that receive subsidies, varying rates for multiple provider types, and different payment structures to create incentives for certain provider behavior. An increasingly common child care subsidy program component is a tiered reimbursement rate system, though there is still much variation in the implementation and success of such systems. Parent co-payments are another aspect of the cost of child care subsidies, and are set to guarantee parental participation without overly burdening already low-income families. States also have a variety of techniques for achieving this goal. Some states do not require co-payments for TANF families, while others operate a sliding fee system whereby the co-payment as a percentage of monthly income increases as income rises.

Montana

In 2006, the state of Montana had an estimated $23,234,009 in total funds (Federal CCDF, Federal TANF Transfer, Direct Federal TANF, State MOE, and State Matching Funds),

and served 4,800 children in its Best Beginnings child care subsidy program.[153] While both of these numbers are significantly smaller than the relative numbers of Virginia, Montana's average spending per child per month is approximately $403.37, compared to Virginia's $480.12. The state of Montana has a state supervised and locally administered system similar to that of Virginia, whereby eligible families can apply for the program must contact their regional Child Care Resource and Referral Agency (CCR&RA) to apply. There are currently twelve of these districts across the state.[154]

Montana's Early Childcare Services Bureau has set district scholarship rates, or reimbursement rates, effective July 1, 2007 to correspond with the 75th percentile of the June 2007 Market Rate Survey (MRS) and the federally recommended level for state reimbursement rates. To ensure that reimbursement rates are adequate to cover child care expenses, Montana has also committed to an annual MRS, as opposed to the minimum federal requirement of performing an MRS every two years. Since state subsidies are considered the most reliable form of payment for a provider, annually adjusting the reimbursement rates for inflation can help to stabilize the child care provider market. In Montana, the local CCR&RA pays the provider either the district scholarship rate or the provider rate, whichever is lower. There are four types of providers that Best Beginnings will fund: day care centers, family-based care, group child care home, and legally unregistered providers.[155] Rates are set at the 75th percentile for infant care, and child care, where an infant is a child under two year old and a child is defined as a child at or above two year old.

Montana also has two additional tiers of scholarship rates for high quality child care facilities. Facilities that meet the standards for the one-star quality rating receive an additional 10 percent above the set scholarship rate, and two-star quality facilities receive an additional 15 percent scholarship payment above the district rate.[156] This system successfully incentivizes quality and access for two reasons. First, Montana strives to maintain the federally recommended 75th percentile by allocating adequate and stable funds to providers to cover facility costs, and thereby supporting access to subsidized low-income working families. Second, the quality tiering system has two steps to provide an intermediate step for providers to meet before receiving a quality accreditation from a nationally recognized authority such as NAEYC, which is necessary for a two-star rating.[157] This financially rewards higher quality facilities enough to make higher quality an incentive, but without a complicated system that can make achieving high quality and NAEYC accreditation an unobtainable goal. In short, the system makes high quality and financial support a state goal for providers, which in turn leads to better access, costs, and quality for child care subsidy recipients.

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[153] United States Department of Health and Human Services, "2006 CCDF Expenditure Data" and "2006 CCDF Data Tables-Average Monthly Adjusted Number of Families and Children Served," (October 2008) http://www.acf.hhs.gov/programs/ccb/data/index.htm.
[154] Montana Department of Public Health and Human Services, "Child Care and Development Fund Plan for Montana: FY 2008-2009, (2007), http://www.dphhs.mt.gov/hrd/childcare/documents/2008-2009stateplan.pdf. 8.
[155] Ibid. 34.
[156] Montana Department of Public Health and Human Services, "Child Care Policy Manual: Child Care Scholarship Rates," (July 2007), 8, http://www.dphhs.mt.gov/hcsd/ecsbmanual/cc1-4.pdf.
[157] Montana Department of Public Health and Human Services, "Child Care Development Fund State Plan," 39.

On the other hand, not all states within the same per child per month spending range as Virginia are as successful as Montana in making child care affordable to low-income working families. The state of Missouri is similar to Virginia in monthly spending per child at $361.57 in 2006, and in overall funding and number of children served. In FY 2008-2009, Missouri's total state and Federal CCDF Funds (Federal CCDF, Federal TANF Transfer, State MOE, and State Matching Funds), were estimated at $152.5 million, and served approximately 33,600 children. The most recent MRS was conducted in 2006 and was considered when Missouri recently increased its base reimbursement rates.[158]

In recent years, Missouri has made great efforts to increase the quality of its child care program by increasing funding. In FY 2007, the state legislature approved an additional $20 million for child care subsidies.[159] While most of these funds were used to increase income eligibility limits, provider reimbursement rates were increased by 5 percent in 2007. Additionally, FY 2009 funds will be used to increase the infant care provider rate to 65 percent of the current market rate and the preschool care reimbursement rate to 50 percent of the current market rate.[160]

Despite these improvements, the base reimbursement rate for licensed providers is set in metropolitan areas at an average of the 21st percentile and at the 13th percentile for family day homes. These rates would allow subsidy recipients access to 21 percent and 13 percent respectively of local child care providers, which is relatively low. However, Missouri does allow for increases in the provider rate based on select criteria. For example, an additional 30 percent is added to the licensed provider payment if at least 50 percent of the children it cares for are subsidized. Furthermore, accredited providers receive an additional 20 percent increase to the base rate, and providers that operate during non-business hours receive an additional 15 percent increase. More than one rate increase can be added to the base rates.[161]

Approximately 40 percent of Missouri's subsidized children are cared for in family day homes that care for four or less children at a time, and are subsidized at the 13th percentile of current market rates. These facilities are license-exempted, and not as likely to be accredited, therefore they are not likely to be eligible for at least half of the possible base increases.[162] That these facilities receive such a low reimbursement rate, and are not eligible to receive rate increases negatively affects the quality of care received for almost 40 percent of Missouri's children. While the Missouri reimbursement rate system does provide a quality tier and an even larger tier to encourage providing access to subsidy recipients, only some providers that meet both of these standards would be eligible to receive the federally recommended 75th percentile.

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[158] Missouri Department of Social Services, "Child Care and Development Fund Plan for Missouri: FFY 2008-2009," (2007), 5, www.dss.mo.gov/cd/childcare/pdf/08_09stateplan.pdf.
[159] Voices for America's Children, "Increasing State Investments in Early Care and Education: Lessons Learned from Advocates and Best Practices," (Spring 2008), 22, http://www.voices.org/uploads/VoicesECEStrategies(1).pdf.
[160] Citizen's for Missouri's Children, "2008 Legislative Session: Final Wrap- Up," (June 2008), 4, http://www.mokids.org/Portals/0/SessionSummary_000.pdf.
[161] Missouri Department of Social Services, "Child Care and Development Fund Plan for Missouri," 21-22.
[162] Ibid, 22-23.

Additional Practices-Reimbursement Rates

The reimbursement rate schedules of Montana and Missouri are two different examples of how states with similar monthly spending per child to that of Virginia attempt to make child care affordable for low-income working families. Other states with similar spending ratios as Virginia successfully implement different rate schedules. For example, North Carolina has a system composed of tiers based on five quality licensing ratings, with each tier providing the 75th percentile of current market rates in each county.[163] In other words, all providers receive the federally recommended level, but higher quality providers have higher payment structures to account for the higher costs of providing such care. This makes the transition from low-quality care to high quality care more affordable for providers, and further ingrains quality into the system by requiring a license change before an increase in the payment structure.

Outside of the spending methodology used, there are other provider payment practices that merit attention. For example, South Carolina's quality-based reimbursement tiers provide bonus incentives for high quality providers that accept subsidized children. These providers receive an average of five dollars per week for every subsidized child and one-time bonus awards ranging from $2,000 to $4,000 depending on licensure and scores on the Environmental Rating Scale. Additionally, all providers receive the federally recommended 75th percentile in South Carolina.[164] Arkansas sets rates for all providers at the federally recommended level as a minimum, adjusted rates for inflation twice in the past year, and ensures that the maximum rates for infant and toddler care in center care or family homes are equal to or greater than rates for preschool or school age children. This system essentially enhances rates for certain types of child care or providers to ensure equity based upon licensing requirements. Arkansas has also constructed a five-tiered QRS-based rate structure to be implemented by the end of the 2008 calendar year.[165]

Co-payments

The methodology of this report seeks to highlight other state's child care subsidy practices with per child per month spending within 25 percent of Virginia. When this methodology was applied to parent co-payments, interesting results were discovered. Of the 28 states that have parent co-payments set at five percent of monthly income or less, half spent less than 25 percent of what Virginia spends. Of the eight that had similar spending amounts as Virginia, two did not provide subsidies for families with income greater than 150 percent FPL. However, all of the seven states that had parent co-payment requirements at six percent of family income had spending within or above the 25 percent of Virginia range. This pattern of extremely low co-payments suggests one of two extremes: a state child care subsidy program that

[163]North Carolina Department of Health and Human Services, "Child Care and Development Fund Plan for the State of North Carolina," 32.
[164] South Carolina Department of Social Services, "ABC Voucher Program," Division of Child Care Services (2008), http://childcare.sc.gov/main/general/programs/abc/voucher.aspx#bonus08.
[165] Arkansas Department of Human Services, "Child Care and Development Fund Plan for Arkansas: FFY 2008-2009," (2007), 37, http://www.arkansas.gov/childcare/generalpdf/0809stateplan.pdf.

significantly lacks funding in areas of access or quality, or a state child care subsidy program that has achieved success in all other program components.

Arizona

Arizona is a state that does not require TANF families to pay co-payments, and has decreased its co-payment requirement since 2001. In 2006, the state of Arizona had an estimated $132.4 million in total funds (Federal CCDF, TANF Transfer, Direct Federal TANF, MOE, State Marching, State Monies, and SSBG Funds), and served an estimated 30,200 children in its Child Care Assistance Program (CCAP).[166] In FY 2008-2009, total funding was approximately $201.1 million, which reflects an additional $56.9 million in state funds and $239,000 from the Social Services Block Grant.[167] The program is primarily state supervised and administered, but utilizes community organizations, private companies, community colleges, and other state agencies for quality activities. Maximum reimbursement rates are set for six geographic regions. Though they are not set at the federally recommended 75th percentile of current market rates, Arizona DES estimates that they are within 83 percent of this standard. Additionally, nationally accredited providers receive reimbursement rates 10 percent higher than the maximum rate.[168]

Arizona's CCAP has a successful parent co-payment component that does not overly burden low-income working families, and is implemented as sliding fee co-payment system that is used across the entire state. Families receiving TANF or families at or below FPL have no co-payment requirement. Above 100 percent FPL, the sliding fee system begins, and parent co-payments are fixed based on family size, number of children, and as a percentage of gross annual income. Co-payment amounts decrease with each additional child, and transitional TANF families with more than three children have co-payment requirements only for the first three children. This component, not found in all states, aids larger low-income families that already have increased child expenses from paying substantially more in child care payments. In 2007, the parental co-payment was five percent of income, but decreased to four percent of monthly income for a family of three with one child just above 100 percent FPL in 2008.[169] A second child would require the parents to pay an additional half of the amount of the first co-payment for full-time care.[170] The co-payment for families of three with incomes at 150 percent FPL has also decreased, from 12 percent in 2001 to seven percent in 2008.[171] This system is structured to require no contribution for the poorest of subsidy recipients, a small parental contribution from those just above FPL, and increasing amounts as low-income families become closer to attaining self-sufficiency.

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[166] United States Department of Health and Human Services, "2006 CCDF Expenditure Data" and "2006 CCDF Data Tables-Average Monthly Adjusted Number of Families and Children Served."
[167] Arizona Department of Economic Security, "Child Care and Development Fund Plan for Arizona," 7.
[168] Ibid. 31.
[169] Blank and Schulman, 19.
[170] Arizona Department of Economic Security, "Child Care and Development Fund Plan for Arizona," 161.
[171] Blank and Schulman, 19.

Louisiana

Although Louisiana has some positive aspects to its child care subsidy program, families at both the 100 and 150 percent FPL pay high co-payments. In FY 2008-2009, total funding for Louisiana's Child Care Assistance Program (CCAP) was approximately $153.3 million (Federal CCDF, Federal TANF Transfer, State MOE, and State Matching Funds), reflecting a $37.7 million dollar increase from Federal TANF Transfers to CCDF.[172] In 2006, Louisiana CCAP served approximately 39,100 children, at a monthly spending level of $384 per child.[173] Unlike Virginia, Louisiana's CCAP is both state supervised and administered, but contracts certain quality activities out to Child Care Resource &Referral Agencies (CCR&A), colleges and universities, and other individuals.

Maximum reimbursement rates are set based on the current 2007 MRS for nine geographic regions. The majority of provider payment rates are not set at the federally recommended 75th percentile of current market rates. However, Louisiana DSS provides quarterly bonuses, which amount to 20 percent of all provider payments. These bonuses are given to providers caring for subsidized children, for Class A providers that are nationally accredited, and represent 10 percent of total payments from subsidized care for family child day home providers. Louisiana also provides bonuses for participation in its QRS, and has higher tiers for care of special needs children and high-priced infant/toddler care.[174]

Louisiana has a statewide sliding fee co-payment system that uses family size and family income to determine provider subsidy payments. Any amount that a provider charges that is above this subsidy amount is added to the co-payment, and is the parent's responsibility. In other words, the amount of the co-payment is not just based upon income and family size, but can vary by facility based upon the costs of child care and the value of the subsidy. For families ineligible for co-payment waivers, the estimated family contribution for monthly full-time care is a minimum of 35 percent of the cost of care, and a maximum of 75 percent of the cost of care.[175] If parents pay a minimum of one third of the costs, the impact of having a subsidy is greatly reduced, and can make progress towards self-sufficiency difficult by reducing access to affordable high quality care for low-income working families.

At both the 100 percent and 150 percent FPL, a family of three with one child in Louisiana has co-payment requirement of 11 percent of total income, which ranks high compared to other states at both levels. In fact, these numbers are a significant increase for Louisiana, as families of three at 100 percent FPL only had a co-payment requirement of four percent in 2000. Similarly, three person families at 150 percent FPL had co-payment requirements of six percent in 2000.[176] One exception is that children in protective services and recipients of Louisiana's Strategies to Empower People (STEP) program, a state-based program to enhance self-sufficiency through employment and job training initiatives similar to Virginia's VIEW program,

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[172] Louisiana Department of Social Services, "Child Care and Development Fund Plan for Louisiana," 8.
[173] United States Department of Health and Human Services, "2006 CCDF Expenditure Data" and "2006 CCDF Data Tables-Average Monthly Adjusted Number of Families and Children Served."
[174] Louisiana Department of Social Services, "Child Care and Development Fund Plan for Louisiana," 29.
[175] United States Department of Health and Human Services, "Child Care Development Fund: Report of State and Territory Plans FY 2006-2007," 148.
[176] Blank and Schulman, 18.

are eligible to have all of their child care costs covered, provided the costs are less than the amount of the child care subsidy. While the sliding fee system income levels were recently adjusted to capture the 2008 FPL and State Median Income level adjustments, Louisiana is certainly a state with room to improve its CCAP parent co-payment structure.

Additional Practices-Co-payments

States at all funding levels have difficulty balancing high subsidy values with low parental contributions. Oftentimes, a strength in one area implies weakness in the other. However, in addition to an adequate reimbursement system for providers, Montana has successfully followed a sliding fee system of co-payments. TANF families and families below 95 percent FPL pay approximately $10.00 a month as a co-payment, or one percent of non-TANF gross monthly income (GMI). Families above this level pay two to 14 percent of GMI in co-payments, under a system where the co-payment percentage of GMI increases one percent for every five-percentage point increase in the FPL range, up to 150 percent FPL.[177] Arkansas also has high reimbursement rates, yet has been successful in implementing a sliding fee scale with five different levels of parent co-payments for families who qualify for child care assistance, effective July 1, 2008. With this new schedule, parents do not have a co-payment if their monthly income is below 60 percent of the state median income, but parents who earn up to 85 percent of the state median income must pay 80 percent of the full co-payment rate.[178] Hawaii is another state with similar per child per month spending as Virginia, that requires zero co-payments for families at 100 percent FPL and co-payments of two percent of total income for families at 150 percent FPL. Hawaii has been able to solicit low co-payment amounts while maintaining high income eligibility limits and reimbursement rates that are close to federally recommended levels. Other states put heavy importance on non-monetary factors, such as number of children and length of daily care, when deriving co-payment fees.

III. Access

States use a variety of methods to control access to child care subsidies, including age requirements, minimum work requirements, income eligibility rates, the inclusion of certain types of income in eligibility determinations, and waiting lists. In terms of income eligibility rates, some states strive to make child care subsidies available to more families by increasing the income rate and allowing higher incomes for those transitioning from public assistance. In terms of waiting lists, some states mandate that all families in need of subsidies receive them, and work with other community or business resources to provide child care through alternative means to provide high percentages of eligible children with subsidies.

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[177] Montana Department of Public Health and Human Services, "Child Care Policy Manual: Child Care Sliding Fee System," (July 2007), 2, http://www.dphhs.mt.gov/hcsd/ecsbmanual/CC1-5.pdf.
[178] Arkansas Department of Human Services, "Voucher Client Fee Chart," Division of Child Care and Early Childhood Education, (July 2008), http://www.arkansas.gov/childcare/familysupport/feechart.html.

Income Eligibility

New Jersey

New Jersey is one state that has made efforts to improve access to child care subsidies by maintaining an appropriate income eligibility level. According to 2006 statistics from the Administration of Children and Families, New Jersey served an average of 37,900 children a month, with approximately $248.9 million in funding, for an average per child expenditure of $547.[179] In FY 2008, New Jersey's child care subsidy program operated with approximately $280 million in funding (Federal CCDF funds, direct TANF transfer, State CCDF MOE funds, and State Matching Funds),[180] and is a state supervised locally administered program like Virginia.

New Jersey is one state that has increased its income eligibility rate from FY 2007 to FY 2008 in terms of the FPL and SMI. In 2007, the income eligibility limit was $33,200, which coincided with 193 percent FPL and 44 percent of the SMI. Eligibility was increased to $34,340 in early 2008, and in October it increased eligibility further to $35,200, or 200 percent FPL, which is equivalent to approximately 46 percent of the SMI.[181] Of additional importance is that New Jersey is one of 11 states that utilize tiered income eligibility rates to ensure that families who are eligible for subsidies remain eligible despite inflation or slight raises in incomes. New Jersey's exit income eligibility rate, or the rate at which a family is no longer eligible for subsidies, is $44,000 or 250 percent FPL.[182] In addition to New Jersey's efforts to increase income eligibility as a means to serve more families, for the last eight years the state has also participated in outreach efforts by sending informational flyers to all families leaving TANF. These flyers are intended to inform families of benefits and services like child care subsidies that are available to them as they transition off of TANF.[183]

While New Jersey's income eligibility level still falls below the federally recommended level of 85 percent of the SMI, the use of a two-tiered eligibility system helps to ensure that those families that are eligible for assistance remain eligible. Furthermore, New Jersey has maintained a steady income eligibility rate while using additional funding sources to decrease the number of children on its waiting list, decrease the parent co-payments at both the 150 percent and 100 percent FPLs, and maintain a reimbursement rate of just below the 75th percentile of the 2006 market rates. Essentially, New Jersey has been able to increase its eligibility levels, while not sacrificing the cost or quality of care received.

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[179] United States Department of Health and Human Services, "2006 CCDF Expenditure Data" and "2006 CCDF Data Tables-Average Monthly Adjusted Number of Families and Children Served."
[180] New Jersey Department of Human Services, "Child Care and Development Fund Plan for the New Jersey Department of Human Services Division of Family Development: FFY 2008-2009," (2007), 6, http://www.state.nj.us/humanservices/dfd/CCDF_08-09_State_Plan_final.pdf.
[181] Blank and Schulman, 12 and 15.
[182] Ibid. 15.
[183] Michelle Ganow, "Child Care Subsidies: Strategies to Provide Outreach to Eligible Families," Welfare Information Network (2000), http://www.financeproject.org/Publications/childcaresubsidiesissuenote.htm.

Missouri

On the other hand, while Missouri has made significant improvements to its income eligibility rate from 2007 to 2008, it still has the fourth lowest income eligibility rate in the country. Missouri's State Plan does not specifically prioritize child care subsidies for TANF recipients. Instead, the Plan prioritizes subsidies to families of children with special needs and with low-incomes, which should inherently include TANF families. Those families participating in the proper TANF work activities may access subsidies, and in the case of a waiting list the state will give priority to TANF families.[184]

Missouri's income eligibility rate increased in early 2008 to $22,032, which coincides with 125 percent FPL and 41 percent of the SMI. In July of 2008, the rate was increased further to $22,356, or 127 percent FPL. While these rates are still relatively low, they are certainly improvements considering that in 2007 the income eligibility rate was the lowest in the country at $18,216, or 106 percent FPL and 34 percent of the SMI. In addition to increasing its income rate, Missouri recently implemented a two-tiered eligibility system in 2008, with an exit income established at $24,464, or 139 percent of poverty.[185] As mentioned earlier, the income eligibility increase was largely a result of legislation passed to increase the child care subsidy funding by $20 million in order to provide more low-income, working families access to subsidies.[186] Yet even with such a substantial increase in eligibility, Missouri is still one of only 14 states that does not provide subsidies to families at 150 percent FPL.

While Missouri's improvements have increased access to a number of families, there is likely significant unmet need for families above 127 percent FPL. While the state does not maintain a waiting list, a number of families between the 127 percent and 200 percent of FPL are unsubsidized and might be unable to afford quality child care. Even those families that are eligible for subsidies at 100 percent FPL are paying six percent of their monthly income, or $88 a month in co-payments, which could be unaffordable for some families and provide an additional obstacle towards achieving self-sufficiency.

Additional Practices-Income Eligibility

While New Jersey and Missouri are two states with different eligibility requirements for providing families with access to child care subsidies, there are other state practices that are outside of this report's methodology for choosing comparison states. For example, Rhode Island implements its child care subsidy program as an entitlement to all families in need of subsidies to maintain TANF work requirements, all families at income levels below 185 percent FPL, and has no time limits for subsidy use. The passage of additional legislation has further expanded eligibility to all working families with incomes at or below 225 percent FPL.[187] Alabama and Georgia have also expanded eligibility to TANF families. Georgia allows families who lose

[184] Missouri Department of Social Services, "Child Care and Development Fund Plan for Missouri," 29-30.
[185] Blank and Schulman, 12.
[186] Voices for America's Children, 23.
[187] United States Department of Health and Human Services, "Child Care Development Fund: Report of State and Territory Plans FY 2006-2007," 141.

TANF due to lack of employment to continue subsidy use for one year if they meet eligibility requirements, and if funding allows, provides subsidies for families at-risk of becoming TANF dependent. Alabama also provides child care to families who become ineligible for public assistance as a result of unemployment, and provides care to families at-risk of welfare dependency if funds are available.[188]

The variety of ways in which some states are working to increase eligibility to child care subsidies to low-income families indicates the importance that simply making a family eligible for subsidies can have on their ability to afford child care. While extending subsidies to higher incomes increases the cost of the subsidy program, the possibility of charging parents co-payments based on income can decrease the overall cost to the state, while significantly increasing the affordability of care for families.

Waiting Lists

Nevada

Nevada is a state that until July of 2008 has operated without a waiting list, while maintaining high-income eligibility rates. The average number of children served per month in FY 2006 was 6,000 with approximately $39.8 million in funding, with average monthly spending per child equaling about $553. In FY 2008, Nevada's overall state funding for child care subsidies was $44.5 million (Federal CCDF funds, State Matching funds, and State MOE funds).[189] Nevada may seem like an unlikely state to compare to Virginia due to their small-subsidized population. However, the number of children receiving subsidies per month in both states represents one percent of the total number of children in the state, so they are serving similar percentages of the population.[190]

Until recently, Nevada had no waiting list, despite the fact that it also has the sixth highest income eligibility rate in the country. In 2008, Nevada's income eligibility was $38,916, which represented 221 percent FPL and 75 percent of the SMI. In addition, Nevada has maintained a high rate since 2001, when the income eligibility was $33,420, which coincided with 228 percent FPL and 67 percent of the SMI. Despite the presence of a waiting list, the income eligibility rate was further increased in October to $41,640 to coincide with new estimates of the state's median income.[191] While maintaining such a high-income eligibility rate is a positive aspect of Nevada's child care subsidy program, it could also be the reason behind Nevada's recent use of a waiting list. In the case of a waiting list, Nevada prioritizes funding first to unemployed families pending or receiving TANF, second to families with special needs children at income levels below 130 percent FPL, third to families at-risk of becoming TANF dependent with incomes below 130 percent FPL, fourth to families with special needs children at

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[188] Ibid. 136 and 142.
[189] Nevada Department of Human Resources, "Child Care and Development Fund Plan for Nevada: FFY 2008-2009," Division of Welfare Services, (2007), 5-6, http://dwss.nv.gov/dmdocuments/CC_StatePlan-2008.pdf.
[190] Children's Defense Fund, "State Developments In Child Care, Early Education, and School Age Care 2003," (2003), 87 and 131, http://www.childrensdefense.org/site/DocServer/statedevelopments03.pdf?docID=915.
[191] Blank and Schulman, 14-16.

incomes between 130 percent FPL and 75 percent of the SMI, and fifth to all other families with incomes between 130 percent FPL and 75 percent of the SMI.[192]

Since Nevada allows subsidy use to a large income range, it is possible that the economy in its current condition is impacting the number of families that are currently in need of assistance and qualify for subsidies. Despite the presence of a waiting list, Nevada is likely one of the highest ranked states in terms of the number of children served versus the number of children that would be eligible if the state set eligibility at the federally recommended level of 85 percent. Furthermore, that Nevada continued to adjust its eligibility levels in October after the creation of a waiting list is indicative of their commitment to serve families in need of subsidized child care.

Minnesota

Minnesota is one of 17 states with a waiting list or frozen intake. In FY 2006, the average number of children served per month was 27,300, with approximately $154.5 million dollars in funding, equaling approximately $471 spent per child per month. In FY 2008, the total funding for Minnesota's child care subsidy program was $151.6 million (CCDF Federal funding, a Federal TANF transfer, State MOE funds, and State Matching funds).[193] Minnesota administers their child care program under the same state supervised locally administered format as Virginia.

Minnesota offers child care subsidies through three different programs; the Minnesota Family Investment Program for families receiving cash assistance; Transition Year assistance for families transitioning from public assistance; and Basic Sliding Fee Child Care for all other low-income families. Recipients in these three groups also receive priority in the above order when there are waiting lists at the county level.[194] Currently, Minnesota's waiting list is at 3,785 children for FY 2008, an increase from 3,077 families in 2007, and an overall decrease from the 2001 waiting list of 4,735 children.[195] On the surface, this decrease may seem to be a result of improvement or additional funding for child care subsidies in Minnesota, however this is not the case. In FY 2001, Minnesota operated its subsidy program with an income eligibility limit of $42,304, which was equivalent to 289 percent of 2001 FPL, and 76 percent of 2001 SMI.[196] As a result of budget deficits, the legislature reduced the income eligibility rates, increased parent co-payments, and stopped the use of a tiered reimbursement rate system, which was in place to provide additional payments to high quality providers.[197]

These actions have decreased access to child care subsidies for families in need of child care assistance. Reducing the income eligibility rate by such a large amount has likely disqualified numerous families from receiving subsidized care, and those numbers would not be

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[192] Nevada Department of Human Resources, "Child Care and Development Fund Plan for Nevada," 25-26.
[193] Minnesota Department of Human Services, "Child Care and Development Fund Plan for Minnesota: FFY 2008-2009," (2007), 5-6, http://www.dhs.state.mn.us/main/groups/children/documents/pub/dhs_id_050735.pdf.
[194] Ibid. 41.
[195] Blank and Schulman, 16.
[196] Ibid. 13.
[197] Karen Tout, Martha Zaslow, Child Trends, "Tiered Reimbursements in Minnesota Child Care Settings," Minnesota Child Care Research Partnership, (July 2004), 3 http://www.dhs.state.mn.us/main/groups/children/documents/pub/dhs_id_027967.pdf.

reflected in Minnesota's current waiting list numbers. Increasing parent co-payments can decrease low-income, working families' ability to pay for other essential items. Finally, a potential consequence of dispelling with the tiered reimbursement rate system is that in 2007, 121 child care programs, or approximately 1,625 facilities closed, leaving families receiving subsidies with fewer options for care.[198] All of these consequences decrease access for low-income working families, and illustrate how intertwined all of these subsidy issues are.

Additional Practices-Waiting Lists

Other states are making progress in either preventing the occurrence of a waiting list or attempting to decrease their waiting list with the use of outside resources. For example, Florida, which currently has a waiting list of 47,603 children, recently appointed a Child Care Executive Partnership Board. The Board is made up of business leaders with the goal of partnering businesses and their funding with child care programs to increase the availability of child care and subsequently decrease the number of children on the waiting list.[199] Similarly, Tennessee, which currently has frozen its child care subsidy intake, uses community resources and educational efforts to inform low-income working families of other child care and public assistance options like Head Start, non-profit care options, scholarships for child care, and the availability of the EITC.[200] Finally, while Vermont does not have a waiting list, its legislature prohibits the DSS from denying child care subsidies to eligible families. Instead the DSS is required to request additional funding for in need families or seek legislative approval to form a waiting list.[201]

The use of additional resources and supports for child care, whether through the community, local businesses, or state and Federal funding are all appropriate ways to expand access to child care subsidies. The provision of additional funds in some communities, or the development of community programs to serve as a supplement to the state child care program are both options that states can utilize to decrease or eliminate waiting lists. Other states have used additional federal funding sources like TANF or the SSBG to serve more families and decrease their waiting lists. Overall, to decrease the unmet need for child care across the country, states must start by working to eliminate the number of families on waiting lists.

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[198] Minnesota Child Care Resource and Referral Network, "Child Care Matters: Quality Care and Education for Every Child: 2006-2007 Annual Report," (2007), 7, http://www.mnchildcare.org/mktg_matls/2007_Annual.pdf.
[199] United States Department of Health and Human Services, "Child Care Development Fund: Report of State and Territory Plans FY 2006-2007," 144.
[200] Ibid. 145.
[201] Ibid. 144.

Chapter Six: Analysis and Policy Options

Virginia's child care subsidy program has been successful at helping thousands of low-income working families by improving early development and education opportunities for children, promoting positive employment outcomes, and encouraging self-sufficiency. However, in light of some of the practices being developed and implemented in other states, clearly there is potential to improve Virginia's child care program. Improvements in the funding, structure, and administration of child care subsidies will enhance the quality, cost, and access of child care in the Commonwealth.

Funding is particularly important to successfully improve the subsidy program. At a minimum, funding for child care needs to be maintained at its current levels since child care subsidies play such an integral role in enabling TANF and VIEW participants and other low-income working parents to maintain steady employment. Specifically, VDSS reported that the cumulative impact of programs that support employment is to decrease TANF participation, which increases Virginia's workforce and contributes to a net savings at the federal and state level of over $957 million. Particularly in a time of economic recession, child care subsidies and other work supports must remain strong to keep low-income families in the workforce and ensure that they can eventually attain self-sufficiency

I. Sensitivity Analysis- Estimated Costs to Improve Virginia's Child Care System

While additional funding would increase Virginia's ability to improve its child care subsidy program, in some areas it is possible to enhance the subsidy program while maintaining the same monthly cost per child. Our policy options focus both on improvements that require little to no additional funding as well as those that require additional funds. Some policy options can be enacted through forming public and private partnerships to maintain current monthly costs per child, and for these options no sensitivity analysis has been performed. However, to estimate the costs and implications of the policy options that will require additional funding, we performed a sensitivity analysis to determine the costs to make advancements in Virginia's child care subsidy program. While our sensitivity analysis is based on a number of assumptions, it does help to illustrate the potential costs of certain actions such as increasing parent co-payments, income eligibility rates, or reimbursement rates.

One possible policy for additional funding would be to increase per child per month spending to $551.66, or the 75th percentile of state spending (See Appendix D, Table 6D). This would require an additional $71.54 per child per month, for a total increase in monthly spending of $2,050,980.26 or $24,611,763.12 annually. While this might seem like a substantial increase, several of the best practice states that Virginia was compared to in chapter five had monthly spending per child closer to $550.00, indicating that additional spending per child could be devoted to implementing some of the practices utilized by these states. Although Virginia currently spends more than the median amount compared to the other 50 states, it is not within the top 25 percent of the nation. Therefore, it may be more beneficial to allocate funds to specific aspects of the program, and not just the overall program itself. Additional spending per child

could be allocated toward improving the quality of care, increasing reimbursement rates, and decreasing parent co-payments. Our policy options suggest potential areas where increased funding can be beneficial.

Another policy option that could be achieved through both cost efficient means and with a funding increase is to decrease Virginia's waiting list (i.e. reduce unmet needs by serving children currently unable to obtain a subsidy) If additional funding were utilized to serve all 7,184 children on the current 2008 waiting list, at a monthly cost of $480.12 per child, total costs would be approximately $3,499,182 a month, or $41,390,185 a year. Again, the impact of additional funds on waiting lists has already been demonstrated through the 2008 decrease of the waiting list accomplished by adding $12 million in subsidy funding.

Additional revenue to fund waiting list reductions could be generated by increasing the co-payment requirement for non-TANF subsidized families, which is currently set at a flat rate of 10 percent gross monthly income (GMI). In FY 2006, there were 12,378 VIEW and transitional TANF families receiving child care subsidies but not paying co-payments[202]. Subtracting this number from the current estimate of 17, 133 families receiving child care subsidies every month leaves approximately 4,755 families that pay co-payments. We calculated the additional revenue that could potentially be generated by various co-payment increases. A co-payment increase from the current 10 percent to 15 percent GMI, would generate an additional $523,050 in revenue per month, enough to remove approximately 3,268 children from the monthly waiting list. Doubling the co-payment to 20 percent of GMI would generate $1,046,100 and if the entire 20 percent co-payment were devoted to serving additional children it would remove only 4,358 children from the monthly waiting list. If the co-payment were doubled to 20 percent, it would be significantly higher than the co-payment requirement in all other states and would impose an unreasonable burden on low-income parents. Furthermore, the increase would not generate enough revenue to eliminate the waiting list, because 2,930 children would remain on the monthly waiting list.

Another way to utilize additional funding would be to expand Virginia's income eligibility in order to serve more low-income families (See Appendix D, Table 5D). When Virginia's four income eligibility criteria are averaged, they are at 195 percent FPL, or an annual income of $34,320. Virginia's average income eligibility approaches the 75th percentile of all states and would require an increase of $704 to reach the 75th percentile. According to the 2000 Census Bureau data, there are 207,152 families within the $25,000 to $34,999 income range.[203]Assuming that each $1,000 increase in income encompasses 10 percent of the 207,152 families, the $704 increase in income eligibility would make an additional 14,501 families eligible for child care subsidies. Assuming an average of 1.67 children per family, approximately 24,217 children would be added to the subsidy program, and at an average monthly cost of

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[202] Anthony Conyers, "Annual Virginia Independence Report," Virginia Department of Socials Services (October 2007), 3-7, http://www.dss.virginia.gov/files/about/reports/financial_assistance/tanf/2006/vip_annualreport_sfy2006.pdf.

[203] United States Census Bureau, "DP-3, Profile of Selected Economic Characteristics: Virginia 2000," (2000), http://factfinder.census.gov/servlet/QTTable?_bm=y&-geo_id=04000US51&-qr_name=DEC_2000_SF3_U_DP3&-ds_name=DEC_2000_SF3_U.

$480.12 the addition of these children would cost approximately $11,627,066 a month to subsidize.

An additional method of enhancing the child care subsidy program in Virginia would be to increase reimbursement rates to the median standard across all of the states (See Appendix D, Table 4D). Virginia's reimbursement rates for licensed facilities range from 40 to 55th percentile of 2007 rates, the average of this range, the 48th percentile, falls in the 25th quartile of all state reimbursement rate schedules. This low quartile captures state reimbursement rates up to the 49th percentile of current market rates. Therefore, a small increase in the average licensed facility reimbursement rates would increase Virginia's reimbursement rate ranking in comparison to other states. If Virginia increased the average reimbursement rate payment to licensed facilities from the 48th percentile to the 62nd percentile, Virginia would be at the median reimbursement rate of all the states. The average monthly reimbursement rate payment in Virginia is currently $360.61 per child, and $603.43 per family.[204] A 14 percent increase in reimbursement rates to the 62nd percentile would increase the average monthly payments $50.49 per child and $84.48 per family. This would cost an estimated $1,447,395.84 in additional funds per month. A substantially more costly increase would be to set the reimbursement rates to the federally recommended level of the 75th percentile of current market rates. This would increase the average monthly reimbursement rate per family by $162.93, with a total monthly increase of approximately $2,791,479.69 to achieve the 75th percentile for all families served.

Additional funding is also necessary for the implementation of a QRS. The amount of funding for this will vary depending on if the QRS is statewide or voluntary. There are several ways to implement and fund a QRS, including utilizing CCDF funds or general funds, or using state staff or contractors to perform the work. North Carolina operates its program by contracting out its QRS. To start-up the QRS, its contract was for $2.6 million and each additional year has been $3.5 million. North Carolina currently has a voluntary program, falling within 25 percent of Virginia's per capita spending range. Ohio, although outside of Virginia's per capita spending range, has also been operating a QRS for several years. The start up cost for Ohio's QRS was $7 million, and since then has cost $22 million annually to operate. While the upfront and operating costs for a QRS can be substantial, the potential savings that can be accrued through QRS coordination can contribute to the overall costs of its operation.

These two states will serve as examples for the sensitivity analysis. Currently, North Carolina utilizes less than one percent (0.0092) of their total CCDF funding on QRS. Ohio, on the other hand utilizes 3.6 percent of their total CCDF funding to pay for its QRS. While Ohio has a larger program and a large number of providers participating in their QRS, it provides a valuable example of a state spending a significant amount of CCDF funding on quality. If Virginia utilized the same proportion of funding as North Carolina (0.0092 percent of total CCDF funding of $164 million) then it would cost Virginia approximately $1.1 million in the start up year, and $1.5 million for each subsequent year. If Virginia spent a similar proportion of funding as Ohio (3.6 percent of total CCDF funding) then Virginia would spend $1.8 million in

[204] Virginia Department of Social Services, "Annual Data From FY 1999 –FY 2008: Average Payment Per Child and Per Family Per Month," (October 2008).

start up costs and $5.9 million for each subsequent year. Using theses estimates, the cost of operating a QRS for one year could be between $1.5 million and $5.9 million.

II. Program Policy Options

***<u>Access Policy Option</u>: Establish partnerships with other entities to help serve families on the waiting list, and devote additional funding to provide subsidies to serve unmet need.**

One of the most important issues facing Virginia's child care subsidy program is the lack of resources available to serve all eligible families in need of child care subsidies. If income eligibility levels and funding remain the same, our sensitivity analysis indicates that Virginia would require approximately $41.4 million dollars a year in additionally funding to serve the 7,184 children on the waiting list. While additional funding will be as successful as the recently passed $12 million was at decreasing the number of children on the waiting list, considering $41.4 million is approximately one quarter of the current child care subsidy funding, it is important to consider other cost efficient resources as well. Partnering with businesses, non-profits and community resources to implement or fund other affordable care options are some possibilities that could increase access to care while maintaining the same spending per child per month. States like Florida and Indiana have both been successful at collaborating with business leaders and child care resource and referral agencies to gain additional funding or inform parents of other affordable care options.[205] Additionally, promoting the availability of before and after school care options through the Virginia Department of Education and the Virginia School Age Child Care Association, particularly on the local level through various LDSSs, can create additional child care options for families on the waiting list.

***<u>Quality Recommendation:</u> Create public and private partnerships to address training and certification needs for child care providers.**

Partnering with other entities is a cost effective way to share resources, provide more resources to providers, and help combat unmet need across the state. VDSS needs to collaborate with public and private entities across the state to help provide professional development training by collaborating with existing training programs provided by Early Head Start, Head Start, Virginia Preschool Initiative (VPI), Department of Education, and institutions of higher education. The VDSS child care subsidy program, similar to VPI, should partner with local community colleges or universities to create incentives such as tuition discounts, or scholarships to encourage more providers to obtain certifications in early education.

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[205] U.S. Department of Health and Human Services, "Child Care Development Fund: Report of State and Territory Plans FY 2006-2007," 144.

* Indicates cost-efficient policy options

***Quality Policy Option: Address the unmet needs of professional development across the state, including carefully constructing and implementing a Professional Development Plan.**

Virginia currently falls behind most states with the design and implementation of the Federal recommended Professional Development Plan. VDSS needs to evaluate current deficiencies and create goals and measurable outcomes for professional development including: training, incentives for higher education, scholarships for providers, and ensuring that training programs are being assessed and evaluated on a regular basis. Virginia is currently in the planning stage of the Professional Development plan, and by allotting more time and research to the development of the plan Virginia can increase its standing among other states while at same time improving the program without raising costs.

Quality Policy Option: Implement a statewide Quality Rating System.

When designing and implementing a statewide QRS, VDSS must look towards best practice states such as Oklahoma and Pennsylvania. Additionally, a QRS should be based on a block system to ensure certain quality standards are being met before moving into the next rating level. These would include the following standards: professional development, staff salaries, health and safety ratings, licensing, and early learning and child development activities. If the QRS is voluntary VDSS must provide incentives similar to Pennsylvania to encourage participation. A QRS will require an increase in funds; however, states like North Carolina run a QRS on less than one percent of total CCDF funds. If Virginia dedicated $1.5 million in CCDF funds per year, then Virginia would be among the first 25 states to implement a QRS. Furthermore, a small increase in funds would also be cost efficient because a QRS acts as an umbrella under which multiple areas such as professional development, the number of regulated providers, and NAEYC standards are incorporated and have the potential of being improved through the same QRS funding stream. In addition, partnering with Head Start and VPI for the QRS will help disperse costs among programs, thus reducing the cost burden of one agency alone (See Appendix D, Figure 3D).

Cost Policy Option: Standardize maximum reimbursement rates for licensed providers across the state to the federally recommended 75th percentile, with at least two higher quality tiers set above this level with specific criteria in place for high quality providers, such as NAEYC accreditation, to incentivize high quality child care facilities.

Currently, Virginia only differentiates between registered and unregistered providers. VDSS should adopt a reimbursement rate structure similar to that of Montana, where all child care facilities receive the 75th percentile of current market rates, but higher quality facilities receive an additional 10-15 percent of this amount. Adopting this structure would allow Virginia to achieve the federally recommended rate, and low-income families would have equal access to 75 percent of the child care facilities in their specific area. Furthermore, tying provider rates to quality encourages child care facilities to maintain standards of quality in order to receive additional monetary benefits, thus legitimizing the importance of quality

child care. Additionally, a tiered system with several steps would allow child care facilities to achieve the highest level of quality incrementally, without being punished financially for a lack of accreditation. The implementation of this recommendation would have a substantial impact on the budget, as additional monthly funding of approximately $2,791,479.69 would be required just to achieve the 75th percentile for all families served. However, a possible short-term step to achieve this goal would be to increase reimbursement rates to the national median of the 62nd percentile of current market rates. This increase would require an estimated $1,447,395.84 in additional funds per month, and should be instituted with the incentive that higher quality child care providers receive an additional 10-15 percent above this level.

<u>Access Policy Option</u>: Establish an exit eligibility rate to allow families to maintain subsidies despite income increases and inflation.

Considering Virginia currently has unmet need with eligible children already on the waiting list, it is not recommended that Virginia increase its income eligibility rates. Furthermore, the estimated cost of approximately $11.6 million a month to serve an additional 24,217 families is unreasonable considering there is already unmet need. However, once Virginia is able to meet its current demand for child care subsidies, rather then simply raise the income eligibility rate, the state should implement an exit eligibility income rate. The implementation of a higher exit eligibility rate, similar to New Jersey, would be a positive step in helping families already receiving subsidies to maintain those supports. Without an exit eligibility rate, families that are successful at earning additional income or achieving greater financial independence can end up losing their subsidy. By allowing families to maintain their subsidy use despite increases in income, families can keep their children in stable care situations, earn more money, achieve economic independence, and eventually achieve self-sufficiency.

<u>Cost Policy Option:</u> Implement a sliding fee scale for co-payments whereby as income increases, the percentage of gross monthly income (GMI) required as co-payment increases.

The current co-payment structure in Virginia is such that all fee-based child care subsidy recipients are required to pay 10 percent of income, and all TANF recipients have no co-payment requirement. A more progressive system would implement a negligible co-payment requirement (up to 2 percent GMI) for TANF recipients, and increase co-payments slightly as the family income increases as a percentage of FPL. The higher the exit income eligibility, the higher the final co-payment requirement would be, potentially reaching 15 percent of GMI. This system, similar to those of Arizona and several specific localities in Virginia, would allow the lowest income families to pay a minimal amount, but require a higher contribution as families become closer to obtaining self-sufficiency. The budget impact of this policy option would depend upon the financial status of child care subsidy recipients in relation to the FPL and the specific sliding fee schedule set. For example, if TANF families that are subsidy recipients were required to pay one percent of monthly income, $14.67, an

additional $181,585.26 per month would be contributed to the cost of child care. However, if the majority of fee-based families hovers just above 100 percent FPL, the overall amount collected through co-payments would likely decrease substantially, as these fee-based recipients would contribute a much smaller portion of gross monthly income than the 10 percent currently required. Thus, a sliding fee scale that changes the percentage of income required based on relationship to FPL would need to be set carefully to ensure that equity and affordability are maintained.

<u>Funding Policy Option</u>: Commit to exploring additional funding options including: General State Funds, TANF funds, Social Security Block Grant (SSBG) Funds, and additional community resources.

While some of the above policy options are improvements that can be made without increasing funding, maintaining the viability of the child care subsidy program in some policy areas will require additional funding. For example, increasing provider reimbursement rates, implementing higher exit eligibility rates and a sliding co-payment system, and removing all of the children from the waiting list will all require sufficient funding. One potential funding source for achieving these policy options is increasing state funding, because financial allotments from general state funds provide more flexibility in how they can be utilized than Federal Funds, State MOE Funds, or State Matching Funds. As a result, Virginia could choose which policy options to focus on without having to follow federal stipulations.

Other funding sources include unused TANF or SSBG funds that can be transferred to the child care program. For example, the additional $12 million infused into the subsidy program in July was transferred from unused TANF funding, and its availability has provided access to child care for over 2,000 children. In FY 2006-2007, 14 states made use of both TANF transfers and Direct Federal TANF spending, and 41 states utilized their SSBG funding for day care purposes.[206] Considering there was a $19.1 million carry over in TANF funds in FY 2008, and that Virginia does not utilize any SSBG funding, there are significant improvements that can be made if this funding is put to use in the child care program.[207]

Finally, with limited funding and an increasing budget shortage it is essential to find other means to enhance the child care program aside from state and Federal funding. Many private, non-profit, and state run programs can be used as resources to improve quality and access while at the same time not increasing costs. It is important for VDSS to work with and discover new innovative partnerships to improve and strengthen Virginia's child care program.

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[206] Department of Health and Human Services, Child Care Development Fund: Report of State and Territory Plans FY2006-2007, 14-15, and U.S. Department of Health and Human Services, Administration of Children and Families, Office of Community Services, Social Services Block Grant Program Annual Report 2006, 21.
[207] Virginia House Appropriations Committee, FY 2008-2010 Summary of Budget Actions: Health and Human Services, http://hac.state.va.us/documents/2008/Post-Session/HB30/Health-Human_Resources.pdf, 18.

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APPENDICES

APPENDIX A- STATE STATISTICS FOR COST, ACCESS, AND PER CAPITA SPENDING

APPENDIX A- STATE STATISTICS FOR COST, ACCESS, AND PER CAPITA SPENDING

Table 1A—NACCARA State Rankings

State	Standards	Oversight	Total Score	Ranking
Alabama	38	29	67	31
Alaska	50	27	77	18
Arizona	48	14	62	37
Arkansas	31	28	59	42
California	38	16	54	47
Colorado	34	27	61	40
Connecticut	61	10	71	25
Delaware	50	21	71	25
Department of Defense	77	40	117	1
District of Columbia	48	23	71	25
Florida	33	37	70	28
Georgia	33	31	64	35
Hawaii	53	27	80	14
Idaho	8	7	15	52
Illinois	66	24	90	2
Indiana	60	17	77	18
Iowa	47	15	62	37
Kansas	36	18	54	47
Kentucky	27	24	51	49
Louisiana	13	24	37	51
Maine	48	9	57	44
Maryland	63	26	89	4
Massachusetts	57	20	77	18
Michigan	52	31	83	7
Minnesota	66	16	82	10
Mississippi	44	23	67	31
Missouri	39	30	69	29
Montana	44	23	67	31
Nebraska	29	20	49	50
Nevada	50	31	81	12
New Hampshire	43	15	58	43
New Jersey	62	13	75	22
New Mexico	43	12	55	45
New York	61	29	90	2
North Carolina	41	34	75	22
North Dakota	62	21	83	7
Ohio	40	26	66	34
Oklahoma	50	35	85	6

Oregon	55	9	64	35
Pennsylvania	64	15	79	15
Rhode Island	64	15	79	15
South Carolina	33	35	68	30
South Dakota	45	17	62	37
Tennessee	51	32	83	7
Texas	51	30	81	12
Utah	46	9	55	45
Vermont	63	19	82	10
Virginia	44	35	79	15
Washington	55	34	89	4
West Virginia	55	22	77	18
Wisconsin	62	11	73	24
Wyoming	40	20	60	41

*Source: NACCARA, "Overall Ranking of State Child Care Center Standards and Oversight, http://www.naccrra.org/policy/docs/scorecard/Scorecard.pdf

Table 2A –2008 State Reimbursement Rates-Center Care for a Four-Year Old

State	City/County Region	Year of Market Rate	Percentile
Missouri^	St. Louis (Metro Region)	2007	25
Texas	Gulf Coast Workforce Development Area	2007	25
Nevada^	Clark County	2006	27
District of Columbia	Citywide	2006	31
Delaware	New Castle County	2007	38
Kansas	Sedgwick County	2006	43
Michigan	Wayne County (Shelter Area IV)	2007	43
Illinois	Metropolitan Region (Group 1A)	2006	46
Washington^	Seattle/King County (Region 4)	2006	46
New Mexico	Metropolitan Areas	2007	47
New Jersey*^	**Statewide**	**2005**	**48**
Vermont	Statewide	2006	49
Arizona^	Maricopa County (Phoenix)	2006	50
Connecticut	North Central Region	2005	50
Georgia	Region 13 (Fulton County)	2007	51
Florida^	Miami-Dade	2007	52
Maryland*^	**Region W**	**2007**	**52**
Colorado*	**Denver County**	**2006**	**53**
Massachusetts	Greater Boston	2006	53
Alaska	Anchorage	2007	55
North Dakota*	**Statewide**	**2007**	**58**
North Carolina^	Mecklenburg County	2007	59
Alabama*	**Birmingham Region**	**2007**	**61**
Rhode Island	Statewide	2006	61
Hawaii^	Statewide	2007	62
New Hampshire	Statewide	2005	62
Oklahoma^	Enhanced Area (Metro) Counties	2007	62

Minnesota*^	**Hennepin County**	**2007**	**63**
Ohio*	**Cuyahoga County**	**2006**	**64**
Iowa	Statewide	2006	65
Idaho	Boise Metro Area (Region IV)	2007	66
Louisiana^	Statewide	2007	66
Mississippi	Statewide	2007	67
Wisconsin*	**Top 25% Urbanized Counties**	**2007**	**68**
California*	**Los Angeles**	**2007**	**69**
Nebraska^	Lancaster, Douglas, Sarpy, Dakota Counties	2007	70
Tennessee^	Top 21 Counties in Population/Income	2006	70
West Virginia^	Statewide	2006	70
Kentucky^	Central Region	2005	72
Pennsylvania^	Philadelphia	2007	72
Arkansas	Pulaski County	2006	75
Indiana	Marion County	2007	75
Maine^	Cumberland County	2006	75
Montana*^	**Billings Region**	**2007**	**75**
New York*	**New York City**	**2007**	**75**
Oregon*	**Group Area A**	**2006**	**75**
South Carolina	Statewide Urban Counties	2007	75
South Dakota	Minnehaha County	2007	75
Utah	Statewide	2007	75
Wyoming	Statewide	2006	75
Virginia*	**N/A**	**N/A**	**N/A**

* Source: Helen Blank and Karen Schulman, "State Child Care Assistance Policies 2008: Too Little Progress for Children and Families," National Women's Law Center, (September, 2008), www.nwlc.org/pdf/StateChildCareAssistancePoliciesReport08.pdf

States were asked to report state reimbursement rates and the 75th percentile of market rates for their state's most populous city, county, or region. Monthly rates were calculated from hourly, daily, and weekly rates assuming the child was in care 9 hours a day, 5 days a week, 4.33 weeks a month. Differences between state reimbursement rates and the 75th percentile were calculated using raw data, rather than the rounded numbers shown in the table.

Table 3A –2008 Parent Co-Payments for a Family of Three at 100% FPL

State	Monthly fee as a dollar amount	Monthly fee as a percent of income
Arkansas	$0	0%
California*	**$0**	**0%**
Hawaii^	$0	0%
New Hampshire	$1	0%
Iowa	$9	1%
South Dakota	$10	1%
Utah	$10	1%
Wyoming	$10	1%
New York*	**$13**	**1%**
Alaska	$15	1%
Michigan	$22	2%
Rhode Island	$29	2%
Minnesota*^	**$39**	**3%**

District of Columbia	$44	3%
Washington^	$50	3%
Nevada^	$51	3%
Nebraska^	$57	4%
Kansas	$58	4%
Connecticut	$59	4%
Montana*^	**$59**	**4%**
New Mexico	$61	4%
South Carolina	$61	4%
Alabama*	**$65**	**4%**
Arizona^	$65	4%
Mississippi	$72	5%
Indiana	$74	5%
Vermont	$74	5%
New Jersey*^	**$77**	**5%**
West Virginia^	$81	6%
Tennessee^	$82	6%
Illinois	$87	6%
Pennsylvania^	$87	6%
Missouri^	$88	6%
Florida^	$90	6%
Wisconsin*	**$95**	**6%**
Delaware	$100	7%
Ohio*	**$105**	**7%**
Oklahoma^	$105	7%
Oregon*	**$114**	**8%**
Maine^	$116	8%
Massachusetts	$119	8%
Kentucky^	$121	8%
Georgia	$130	9%
Texas	$132-$161	9%-11%
North Carolina^	$147	10%
Virginia*^	**$147**	**10%**
Colorado*	**$150**	**10%**
Louisiana^	$154	11%
Maryland*^	**$156**	**11%**
Idaho	$177	12%
North Dakota*	**$189**	**13%**

*Source: Helen Blank and Karen Schulman, "State Child Care Assistance Policies 2008: Too Little Progress for Children and Families," National Women's Law Center, (September, 2008), www.nwlc.org/pdf/StateChildCareAssistancePoliciesReport08.pdf

Table 4A-2008 Parent Co-Payments for a Family of Three at 150% FPL

State	**Monthly fee as a dollar amount**	**Monthly fee as a percent of income**
New Hampshire	$2	<1%
Hawaii^	$50	2%
Alaska	$61	3%
Wyoming	$68	3%
Minnesota*^	**$71**	**3%**

California*	**$76**	**3%**
South Carolina	$87	4%
Arkansas	$102	5%
New Jersey*	**$106**	**5%**
West Virginia^	$114	5%
District of Columbia	$118	5%
Florida^	$120	5%
Connecticut	$132	6%
New Mexico	$135	6%
Mississippi	$147	7%
Utah	$150	7%
Arizona^	$152	7%
Washington^	$152	7%
Illinois	$160	7%
Pennsylvania^	$173	8%
Rhode Island	$176	8%
Georgia	$178	8%
Oklahoma^	$179	8%
Alabama*	**$184**	**8%**
Tennessee^	$191	9%
Ohio*	**$194**	**9%**
Massachusetts	$196	9%
Indiana	$198	9%
Texas	$198-$242	9-11%
Nevada^	$202	9%
Kansas	$207	9%
Wisconsin*	**$212**	**10%**
Maine^	$218	10%
Delaware	$220	10%
North Carolina^	$220	10%
Virginia*^	**$220**	**10%**
Louisiana^	$231	11%
Colorado*	**$242**	**11%**
Kentucky^	$253	12%
New York*	**$269**	**12%**
Maryland*^	**$300**	**14%**
Oregon*	**$307**	**14%**
Vermont	$321	15%
South Dakota	$330	15%
North Dakota*	**$336**	**15%**
Idaho	Not eligible	Not eligible
Iowa	Not eligible	Not eligible
Michigan	Not eligible	Not eligible
Missouri^	Not eligible	Not eligible
Montana*^	**Not eligible**	**Not eligible**
Nebraska^	Not eligible	Not eligible

*Source: Helen Blank and Karen Schulman, "State Child Care Assistance Policies 2008: Too Little Progress for Children and Families," National Women's Law Center, (September, 2008), www.nwlc.org/pdf/StateChildCareAssistancePoliciesReport08.pdf

Table 5A-- 2008 Income Eligibility Limits for Family of Three

State	As annual dollar amount	As percent of poverty ($17,600 a year)	As percent of state median income
Hawaii^	$47,124	268%	71%
Alaska	$46,243	263%	72%
California*	**$45,228**	**257%**	**76%**
Maine^	$40,828	232%	75%
District of Columbia	$40,225	229%	95%
Nevada^	$38,916	221%	75%
Connecticut	$38,726	220%	50%
North Carolina^	$36,684	208%	73%
Massachusetts	$35,876	204%	50%
South Dakota	$35,775	203%	69%
Arkansas	$35,724	203%	81%
Oklahoma^	$35,100	199%	79%
Mississippi	$34,999	199%	87%
Delaware	$34,344	195%	54%
Washington^	$34,344	195%	57%
New Jersey*^	**$34,340**	**195%**	**45%**
New York*	**$34,340**	**195%**	**57%**
Pennsylvania^	$34,340	195%	60%
Wyoming	$34,176	194%	65%
New Hampshire	$32,628	185%	48%
Oregon*	**$32,568**	**185%**	**63%**
Louisiana^	$31,836	181%	68%
Illinois	$31,776	181%	52%
Wisconsin*	**$31,765**	**180%**	**53%**
Kansas	$31,764	180%	58%
Ohio*	**$31,764**	**180%**	**57%**
Vermont	$31,032	176%	52%
Utah	$30,948	176%	64%
Rhode Island	$30,906	176%	47%
Minnesota*^	**$30,048**	**171%**	**46%**
Maryland*^	**$29,990**	**170%**	**40%**
North Dakota*	**$29,556**	**168%**	**59%**
Tennessee^	$28,668	163%	60%
Arizona^	$28,331	161%	55%
New Mexico	$28,330	161%	70%
Georgia	$26,560	151%	49%
Florida^	$26,400	150%	50%
West Virginia^	$25,764	146%	59%
Virginia*^	**$25,755-$42,925**	**146-244%**	**40-66%**
Texas	$25,755-$41,063	146-233%	53-85%
South Carolina	$25,755	146%	53%
Montana*^	**$25,752**	**146%**	**55%**
Kentucky^	$25,746	146%	56%
Iowa	$24,900	141%	45%
Michigan	$23,880	136%	40%
Colorado*	**$22,320-$38,628**	**127%-219%**	**38%-65%**
Alabama*	**$22,320**	**127%**	**49%**

Missouri^	$22,032	125%	41%
Indiana	$21,804	124%	40%
Nebraska^	$20,604	117%	38%
Idaho	$20,472	116%	46%

*Source: Helen Blank and Karen Schulman, "State Child Care Assistance Policies 2008: Too Little Progress for Children and Families," National Women's Law Center, (September, 2008), www.nwlc.org/pdf/StateChildCareAssistancePoliciesReport08.pdf

Table 6A--2008 Waiting Lists for Child Care Assistance

State	Number on Waiting Lists	Type
Maine^	1,100	children
New Jersey*^	**3,094**	**children**
Minnesota*^	**3,785**	**families**
Indiana	4,788	children
Arkansas	4,983	families
Virginia*^	**7,184**	**children**
Mississippi	7,455	children
Pennsylvania^	8,424	children
Alabama*	**10,131**	**children**
Georgia	10,268	families
Massachusetts	17,840	children
Texas	22,369	children
North Carolina^	27,153	children
Florida^	47,603	children
California*	**204,063**	**children**
Alaska	No waiting list	
Arizona^	No waiting list	
Colorado*	**No waiting list**	
Connecticut	No waiting list	
Delaware	No waiting list	
District of Columbia	No waiting list	
Hawaii^	No waiting list	
Idaho	No waiting list	
Illinois	No waiting list	
Iowa	No waiting list	
Kansas	No waiting list	
Kentucky^	No waiting list	
Louisiana^	No waiting list	
Maryland*^	**No waiting list**	
Michigan	No waiting list	
Missouri^	No waiting list	
Montana*^	**No waiting list**	
Nebraska^	No waiting list	
Nevada^	No waiting list	
New Hampshire	No waiting list	
New Mexico	No waiting list	
New York*	**Waiting lists at county level**	
North Dakota*	**No waiting list**	
Ohio*	**No waiting list**	
Oklahoma^	No waiting list	

Oregon*	**No waiting list**	
Rhode Island	No waiting list	
South Carolina	No waiting list	
South Dakota	No waiting list	
Tennessee^	Frozen intake	
Utah	No waiting list	
Vermont	No waiting list	
Washington^	No waiting list	
West Virginia^	No waiting list	
Wisconsin*	**No waiting list**	
Wyoming	No waiting list	

*Source: Helen Blank and Karen Schulman, "State Child Care Assistance Policies 2008: Too Little Progress for Children and Families," National Women's Law Center, (September, 2008), www.nwlc.org/pdf/StateChildCareAssistancePoliciesReport08.pdf

Table 7A-- Average Monthly Spending Per Child

State	Total Funding	Average Funding Per Month	Average Number of Children Served Per Month	Average Per Capita Spending Per Month
Ohio*	**$635,849,227**	**$52,987,435.58**	**39,900**	**$1,328.01**
District of Columbia	$46,789,509	$3,899,125.75	3,700	$1,053.82
Wisconsin*	**$339,155,569**	**$28,262,964.08**	**29,500**	**$958.07**
Massachusetts	$363,570,170	$30,297,514.17	32,100	$943.85
Rhode Island	$77,000,000	$6,416,666.67	7,100	$903.76
Arkansas	$56,316,170	$4,693,014.17	5,600	$838.04
Alaska	$47,624,485	$3,968,707.08	4,900	$809.94
California*	**$1,525,069,700**	**$127,089,141.67**	**175,500**	**$724.15**
Connecticut	$85,328,928	$7,110,744.00	10,100	$704.03
Illinois	$688,000,000	$57,333,333.33	82,200	$697.49
Colorado*	**$121,100,000**	**$10,091,666.67**	**16,300**	**$619.12**
Nevada^	$39,840,806	$3,320,067.17	6,000	$553.34
Maine^	$35,747,471	$2,978,955.92	5,400	$551.66
New Jersey*^	**$248,900,000**	**$20,741,666.67**	**37,900**	**$547.27**
Oklahoma^	$161,300,000	$13,441,666.67	25,000	$537.67
Maryland*^	**140,481,331**	**$11,706,777.58**	**22,900**	**$511.21**
West Virginia^	$55,965,276	$4,663,773.00	9,300	$501.48
Washington^	$315,880,937	$26,323,411.42	53,200	$494.80
Pennsylvania^	$491,203,000	$40,933,583.33	82,800	$494.37
Virginia*^	**$160,743,023**	**$13,395,251.92**	**27,900**	**$480.12**
Minnesota*^	**$154,500,000**	**$12,875,000.00**	**27,300**	**$471.61**
Hawaii^	$48,269,443	$4,022,453.58	8,600	$467.73
Kentucky^	$158,605,455	$13,217,121.25	28,900	$457.34
Florida^	$557,337,839	$46,444,819.92	108,600	$427.67
Tennessee^	$211,536,100	$17,628,008.33	42,500	$414.78
Montana*^	**$23,234,009**	**$1,936,167.42**	**4,800**	**$403.37**
Louisiana^	$180,066,147	$15,005,512.25	39,100	$383.77
Nebraska^	$58,929,827	$4,910,818.92	13,100	$374.87
North Carolina^	$356,314,391	$29,692,865.92	79,900	$371.63

Arizona^	$132,419,060	$11,034,921.67	30,200	$365.39
Missouri^	$145,785,766	$12,148,813.83	33,600	$361.57
Michigan	$378,310,000	$31,525,833.33	87,800	$359.06
Indiana	$140,155,341	$11,679,611.75	32,800	$356.09
South Dakota	$20,760,709	$1,730,059.08	4,900	$353.07
Alabama*	**$117,277,652**	**$9,773,137.67**	**28,000**	**$349.04**
New York*	**518,000,000**	**$43,166,666.67**	**123,700**	**$348.96**
South Carolina	$81,098,693	$6,758,224.42	19,700	$343.06
Oregon	**$82,275,105**	**$6,856,258.75**	**20,200**	**$339.42**
New Hampshire	$29,197,664	$2,433,138.67	7,500	$324.42
Iowa	$75,042,790	$6,253,565.83	19,400	$322.35
Vermont	$26,143,647	$2,178,637.25	6,800	$320.39
Texas	$478,513,845	$39,876,153.75	126,200	$315.98
Georgia	$240,673,157	$20,056,096.42	64,600	$310.47
Kansas	$79,427,224	$6,618,935.33	22,400	$295.49
Idaho	$33,690,300	$2,807,525.00	9,900	$283.59
Utah	$43,274,486	$3,606,207.17	13,000	$277.40
New Mexico	$69,246,662	$5,770,555.17	21,600	$267.16
Wyoming	$14,999,642	$1,249,970.17	4,700	$265.95
North Dakota	**$12,644,232**	**$1,053,686.00**	**4,000**	**$263.42**
Delaware	$22,711,430	$1,892,619.17	7,500	$252.35
Mississippi	$78,452,156	$6,537,679.67	39,100	$167.20

Source: United States Department of Health and Human Services, "2006 CCDF Expenditure Data" and "2006 CCDF Data Tables-Average Monthly Adjusted Number of Families and Children Served," (October 2008) http://www.acf.hhs.gov/programs/ccb/data/index.htm.

*Indicates states with state supervised, locally administered child care programs.
^Indicates states with spending per child per month within 25 percent of Virginia's spending per child per month.

APPENDIX B- NAEYC STANDARDS

APPENDIX B- NAEYC STANDARDS

Standard 5: NAEYC Accreditation Criteria for Health Standard

The following chart presents the accreditation criteria for this topic area. Each criterion provides specific details to guide program plans, policies and practices. The criteria are numbered (01, 02, 03, etc.) within their topic area. Each criterion within each program standard is identified by its relevant age group (or groups). Many criteria are identified as "universal" (U), meaning that all classrooms and programs pursuing NAEYC Accreditation must address these criteria. These aspects of quality should be seen in any programs or classrooms serving birth through kindergarten, though they may look somewhat different in practice depending on the children's age.

Age Groups:
U = universal
I = infant
T = toddlers/twos
P = preschool
K = kindergarten

5.B.
Ensuring Children's Nutritional Well-being

5.B.01
U I T P K
If the program provides food for meals and snacks (whether catered or prepared on-site), the food is prepared, served, and stored in accordance with the U.S. Department of Agriculture (USDA) Child and Adult Care Food Program (CACFP) guidelines.

5.B.02
U I T P K
Staff take steps to ensure the safety of food brought from home:

- They work with families to ensure that foods brought from home meet the USDA's CACFP food guidelines.
- All foods and beverages brought from home are labeled with the child's name and the date.
- Staff make sure that food requiring refrigeration stays cold until served.
- Food is provided to supplement food brought from home if necessary.
- Food that comes from home for sharing among the children must be either whole fruits or commercially prepared packaged foods in factory-sealed containers. (This indicator only is an Emerging Practice.)

5.B.03
U I T P K
The program takes steps to ensure food safety in its provision of meals and snacks Staff discard foods with expired dates. The program documents compliance and any corrections that it has made according to the recommendations of the program's health consultant, nutrition consultant, or a sanitarian that reflect consideration of federal and other applicable food safety standards.

5.B.04
U I T P K
For all infants and for children with disabilities who have special feeding needs, program staff keep a daily record documenting the type and quantity of food a child consumes and provide families with that information.

5.B.05
U I T P K
For each child with special health care needs or food allergies or special nutrition needs, the child's health provider gives the program an individualized care plan that is prepared in consultation with family members and specialists involved in the child's care. The program protects children with food allergies from contact with the problem food. The program asks families of a child with food allergies to give consent for posting information about that child's food allergy and, if consent is given, then posts that information in the food preparation area and in the areas of the facility the child uses so it is a visual reminder to all those who interact with the child during the program day.

5.B.06
U I T P K
Clean sanitary drinking water is made available to children throughout the day. (Infants who are fed only human milk do not need to be offered water.)

5.B.07
U I T P K
Liquids and foods that are hotter than 110 degrees Fahrenheit are kept out of children's reach.

5.B.08
I
If the program provides food to infants, then the program staff work with families (who are informed by their child's health care provider) to ensure that the food is based on the infants' individual nutritional needs and developmental stage.

5.B.09
I
The program supports breastfeeding by

- accepting, storing, and serving expressed human milk for feedings;
- accepting human milk in ready-to-feed sanitary containers labeled with the infant's name and date and storing it in a refrigerator for no longer than 48 hours (or no more than 24 hours if the breast milk was previously frozen) or in a freezer at 0 degrees Fahrenheit or below for no longer than three months;
- ensuring that staff gently mix, not shake, the milk before feeding to preserve special infection-fighting and nutritional components in human milk; and
- providing a comfortable place for breastfeeding and coordinating feedings with the infant's mother.

5.B.10
I
Except for human milk, staff serve only formula and infant food that comes to the facility in factory-sealed containers (e.g., ready-to-feed powder or concentrate formulas and baby food jars)

prepared according to the manufacturer's instructions. (This indicator is an Emerging Practice.) Bottle feedings do not contain solid foods unless the child's health care provider supplies written instructions and a medical reason for this practice. Staff discard after one hour any formula or human milk that is served but not completely consumed or is not refrigerated. If staff warm formula or human milk, the milk is warmed in water at no more than 120 degrees Fahrenheit for no more than five minutes. No milk, including human milk, and no other infant foods are warmed in a microwave oven.

5.B.11
I
Teaching staff do not offer solid foods and fruit juices to infants younger than six months of age, unless that practice is recommended by the child's health care provider and approved by families. Sweetened beverages are avoided. If juice (only 100% fruit juice is recommended) is served, the amount is limited to no more than four ounces per child daily.

5.B.12
I
Teaching staff who are familiar with the infant feed him or her whenever the infant seems hungry. Feeding is not used in lieu of other forms of comfort.

5.B.13
I T
The program does not feed cow's milk to infants younger than 12 months, and it serves only whole milk to children of ages 12 months to 24 months.

5.B.14
I T P
Staff do not offer children younger than four years these foods: hot dogs, whole or sliced into rounds; whole grapes; nuts; popcorn; raw peas and hard pretzels; spoonfuls of peanut butter; or chunks of raw carrots or meat larger than can be swallowed whole.

Staff cut foods into pieces no larger than 1/4-inch square for infants and 1/2-inch square for toddlers/twos, according to each child's chewing and swallowing capability.

5.B.15
T P K
The program prepares written menus, posts them where families can see them, and has copies available for families. Menus are kept on file for review by the consultant described in criterion 5.A.02.

5.B.16
T P K
The program serves meals and snacks at regularly established times. Meals and snacks are at least two hours apart but not more than three hours apart.

5.C

The following chart presents the accreditation criteria for this topic area. Each criterion provides specific details to guide program plans, policies and practices. The criteria are numbered (01, 02, 03, etc.) within their topic area. Each criterion within each program standard is identified by its relevant age group (or groups). Many criteria are identified as "universal" (U), meaning that all classrooms and programs pursuing NAEYC Accreditation must address these criteria. These aspects of quality should be seen in any programs or classrooms serving birth through kindergarten, though they may look somewhat different in practice depending on the children's age.

Age Groups:
U = universal
I = infant
T = toddlers/twos
P = preschool
K = kindergarten

5.C.
Maintaining a Healthful Environment

5.C.01
U I T P K
The routine frequency of cleaning and sanitizing all surfaces in the facility is as indicated in the Cleaning and Sanitation Frequency Table. Ventilation and sanitation, rather than sprays, air freshening chemicals, or deodorizers, control odors in inhabited areas of the facility and in custodial closets.

5.C.02
U I T P K
Procedures for standard precautions are used and include the following:

- Surfaces that may come in contact with potentially infectious body fluids must be disposable or made of a material that can be sanitized.
- Staff use barriers and techniques that minimize contact of mucous membranes or of openings in skin with potentially infectious body fluids and that reduce the spread of infectious disease.
- When spills of body fluids occur, staff clean them up immediately with detergent followed by water rinsing.
- After cleaning, staff sanitize nonporous surfaces by using the procedure for sanitizing designated changing surfaces described in the Cleaning and Sanitation Frequency Table.
- Staff clean rugs and carpeting by blotting, spot cleaning with a detergent-disinfectant, and shampooing or steam cleaning.
- Staff dispose of contaminated materials and diapers in a plastic bag with a secure tie that is placed in a closed container.

5.C.03
U I T P K
A toy that a child has placed in his or her mouth or that is otherwise contaminated by body secretion or excretion is either to be (a) washed by hand using water and detergent, then rinsed, sanitized, and air dried or (b) washed and dried in a mechanical dishwasher before it can be used by another child.

5.C.04
U I T P K
Staff maintain areas used by staff or children who have allergies or any other special environmental health needs according to the recommendations of health professionals.

5.C.05
U I T P K
Classroom pets or visiting animals appear to be in good health. Pets or visiting animals have documentation from a veterinarian or an animal shelter to show that the animals are fully immunized (if the animal should be so protected) and that the animal is suitable for contact with children. Teaching staff supervise all interactions between children and animals and instruct children on safe behavior when in close proximity to animals. Program staff make sure that any child who is allergic to a type of animal is not exposed to that animal. Reptiles are not allowed as classroom pets because of the risk for salmonella infection.

5.C.06
I
Before walking on surfaces that infants use specifically for play, adults and children remove, replace, or cover with clean foot coverings any shoes they have worn outside that play area. If children or staff are barefoot in such areas, their feet are visibly clean.

10 Areas for Health and Safety:
Immunizations, Guidance/discipline regulations, diapering and handwashing, incident reporting, placing infants on backs to sleep, hazardous materials, playground surfaces under outdoor equipment and emergency preparedness.

Six Developmental Domains:
Physical, language/literacy, cognitive/intellectual, emotional, and cultural.

Table 1B--Teacher[1]-Child Ratios within Group Size

For further clarification, please also see notes below.	**GROUP SIZE**									
AGE GROUP	**6**	**8**	**10**	**12**	**14**	**16**	**18**	**20**	**22**	**24**
Infants (birth to 15 months)[2]	1:3	1:4								
Toddler/Twos (12 to 36 months)[2]										
12-28 months	1:3	1:4	1:4[3]	1:4						
21-36 months		1:4	1:5	1:6						
Preschool[2]										
2.5-year-olds to 3-year-olds (30 - 48 months)				1:6	1:7	1:8	1:9			
4-year-olds						1:8	1:9	1:10		
5-year-olds						1:8	1:9	1:10		
Kindergarten								1:10	1:11	1:12

Notes: In a mixed-age preschool class of 2.5-year-olds to 5-year-olds, no more than four children between the ages of 2.5 years and 3 years may be enrolled. The ratios within group size for the predominant age group apply. If infants or toddlers are in a mixed-age group, the ratio for the youngest child applies.

Ratios are to be lowered when one or more children in the group need additional adult assistance to fully participate in the program:

a. because of ability, language fluency, developmental age or stage, or other factors or
b. to meet other requirements of NAEYC Accreditation.

A *group* or *classroom* refers to the number of children who are assigned for most of the day to a teacher or a team of teaching staff and who occupy an individual classroom or well-defined space that prevents intermingling of children from different groups within a larger room or area.

Group sizes as stated are ceilings, regardless of the number of staff.

Ratios and group sizes are always assessed during on-site visits for NAEYC Accreditation. They are not a required criterion. However, experience suggests that programs that exceed the recommended number of children for each teaching staff member and total group sizes will find it more difficult to meet each standard and achieve NAEYC Accreditation. The more these numbers are exceeded, the more difficult it will be to meet each standard.

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[1]*Includes teachers, assistant teachers/teacher aides.*

[2]*These age ranges purposefully overlap. Programs may identify the age group to be used for on-site assessment purposes for groups of children whose ages are included in multiple age groups.*

[3]*Group sizes of 10 for this age group would require an additional adult.*

APPENDIX C- CHILD CARE SUBSIDY STATISTICS FOR VIRGINIA

APPENDIX C- CHILD CARE SUBSIDY STATISTICS FOR VIRGINIA*

Table 1C—General statistics on Virginia's Child Care Subsidy Program

Data Categories	FY 99	FY 00	FY 01	FY 02	FY 04	FY 05	FY 06	FY 07	FY 08
Unduplicated total # children served	55,107	53,169	49,599	52,328	58,235	61,073	61,099	56,075	55,107
Unduplicated total # families	31,071	29,191	27,470	28,887	33,214	35,044	35,087	31,846	31,217
Average # children served	35,668	29,424	25,451	28,803	28,695	31,915	32,228	28,332	28,669
Average # families served	22,2933	16,491	14,236	15,935	16,602	18,653	18,918	16,404	17,133
Average payment per	$231	$296	$307	$303	$354	$369	$391	$390	$360.61
Average payment per	$370	$474	$546	$543	$613	$632	$667	$673	$603.43
% of children in regulated care	79%	82%	87%	87%	85%	90%	88%	86%	86.6%
% of children in unregulated care	21%	18%	13%	13%	15%	10%	12%	13%	11%
% of care in child's home	2%	1%	1%	1%	1%	1%	1%	1%	0.3%
% of care in family day home	45%	41%	39%	38%	38%	37%	36%	33%	32.3%
% of care in child care center	53%	58%	60%	61%	61%	62%	63%	66%	67.4%
Total dollars*	$98,999,869	$106,055,703	$93,501,497	$103,851,083	$122,027,448	$141,721,412	$151,361,261	$128,651,819	$124,007,139

*All Tables in Appendix C are based on data provided by the Virginia Department of Social Services in October 2008.

Table 2C--Number of Children Receiving Subsidized Care (2007-2008 Market Rate Survey)

	Total Number of Children	Number of Children Receiving a Subsidy	Proportion of Children Receiving a Subsidy	Caring for Children Receving a Subsidy	Providers Responding to the Survey	Median Number of Children in Care	Median Number of Children Receiving a Subsidy	Average Number of Children in Care	Average Number of Children Receiving a Subsidy
Centers	169,240	18,237	10.8%	1,721	80.7%	66	6	78	11
Family Providers	20,304	5,380	26.5%	2,375	65.0%	5	2	6	2.5
Total	189,544	23,617	12.5%	4,096	71.6%				

Table 3C—Number of Children Served By Age

	Ages	# Served	
Infant (0-15 m)	<16	6,141	11.1%
Toddler (16-23 m)	>15 and <24	4,280	7.8%
Preschool (2-5 yr)	>23 and <60	20,944	38.0%
Schoolage (5-12 yr)	>59 and <156	23,270	42.2%
Special needs (13 yr and over)	>155	463	0.8%
TOTAL SERVED		**55,098**	**100%**

Table 4C—Number of Children on Waiting List By Locality

Agency Name	July 1, 2005	January 1, 2006	July 1, 2006	January 1, 2007	July 1, 2007	January 1, 2008
Accomack (001)	13	43	25	13		
Albemarle (003)			122	164	113	
Alexandria (510)			179	422	333	154
Alleghany (005)	13	11				
Amelia (007)	28	43	23	22	18	21
Amherst (009)		5	50	14	9	
Appomattox (011)	1					
Arlington (013)	320	405	441		497	549
Botetourt (023)	1	17	4	18		
Brunswick (025)	25	28	28	22	5	10
Buchanan (027)		12	18	15		8
Buena Vista (530)		8	4			
Campbell (031)	26	3	1	27	79	
Caroline (033)		17	58			
Carroll (035)	1	17	9		4	9
Charles City (036)	8	14	19	11	17	11
Charlotte (037)					3	

Charlottesville (540)	19	134	72	67	30	
Chesapeake (550)	552	811	658	404	485	461
Chesterfield (041)	466	467	466	533	189	134
Clarke (043)					8	9
Colonial Heights (570)	57	72	45	75	24	9
Covington (580)		3			6	
Craig (045)				1	8	8
Culpeper (047)				8	89	82
Cumberland (049)		2	3			
Danville (590)		129	258	203	51	148
Diniwiddie (053)		15	28			
Essex (057)	24	26	27	2	38	25
Fairfax County (059)	1	878	2614	3784	4366	3864
Fauquier (061)	62	58	35	61	102	42
Fluvanna (065)	4			2		10
Franklin City (620)	5			1	30	34
Franklin County (067)	34			42		
Frederick (069)		25	42	49		
Fredericksburg (630)	99	76	60	66	49	17
Galax (640)	1	15			16	
Gloucester (073)	32	17	29	17	31	31
Goochland (075)	1	5				
Grayson (077)	13	13	20	10		
Greene (079)		19	30	27	37	69
Greensville (081)	6					
Halifax (083)			10			
Hampton (650)			439	151	21	75
Hanover (085)		58	115	131		77
Harrisonburg (660)	100	107	105	85	94	89
Henrico (087)	388	337	482	442	482	567
Hopewell (670)	112	175	116	82	96	128
Isle of Wight (093)				22		5
James City (095)	54	114	130			122
King George (099)	65	31	32	34	27	20
King William (101)				1		
Lancaster (103)	21	23	7		2	20
Lexington (678)		2				
Loudoun (107)	929	587	418	505	369	456
Louisa (109)			5	10	10	10
Lunenburg (111)	26	42	16			7
Madison (113)						4
Manassas (683)	67	58	127	100	136	77
Manassas Park (685)	9	9	25	25	35	14
Mecklenburg (117)		10	33	46	46	14
Middlesex (119)		7				1
Montgomery (121)	120	75	22	75	139	12
Nelson (125)	7	14				
New Kent (127)	5				7	6
Newport News (700)			725	706		332
Norfolk (710)			371	1299		
Northampton (131)	131	109	68	88	111	126
Northumberland (133)	3	10	10	12	16	3

Nottoway (135)						5
Orange (137)		20				
Page (139)	13	20	21	21	25	24
Patrick (141)	24	32	91	58	15	44
Petersburg (730)	78	41	41	127	91	14
Portsmouth (740)	513	333	377	348	154	354
Powhatan (145)			9	13	18	
Prince George (149)	25	85	67	59	70	73
Prince William (153)	761	947	928	609	545	809
Pulaski (155)	19	29	68	71	47	2
Radford (750)		3	32	21	12	13
Rappahannock (157)		4				
Richmond County (159)	2	7	3	8	3	2
Roanoke City (770)	126	115	80	146	78	227
Roanoke County (161)	185	162			282	135
Rockbridge (163)		5				
Rockingham (165)		22				4
Shenandoah (171)	8			2		
Smyth (173)		12		34	15	
Southampton (175)	21	40	35	58	66	75
Spotsylvania (177)	208	196	190	155	302	155
Stafford (179)	144	138	131	109	172	173
Suffolk (800)	97	153	198	146	56	87
Sussex (183)		2	18	15	10	
Virginia Beach (810)	198	828	1006	982	320	
Warren (187)	19	29	64	79	32	
Williamsburg (830)	1			5	5	
Winchester (840)						27
Wythe (197)						40
York (199)					2	2
Total Number of Children	6291	8379	11983	12960	10548	10135

APPENDIX D-ADDITIONAL STATE INFORMATION AND SENSITIVITY ANALYSIS

APPENDIX D-ADDITIONAL STATE INFORMATION AND SENSITIVITY ANALYSIS

Table 1D-Additional State QRS Practices

State	Colorado	North Carolina	Oklahoma	Pennsylvania
Name	Qualistar	Star Rated License	Reaching for the Stars	Keystone S.T.A.R.S.
Date Launched	1999, went statewide 2001	1999	1998	2002
Number of Levels	Four	Five	Four	Four
Type of System	Tiered reimbursement (county option), QRS	Tiered reimbursement, rated license, QRS	Tiered reimbursement, QRS	QRS
Programs Include	Centers, family child care homes, Head Start, public pre-K	Centers, family child care homes, school-aged, Head Start, public pre-K	Centers, family child care homes, school-aged, Head Start	Centers, family child care homes, school-aged
Funding Sources	CCDF, state, private, other	CCDF, state, TANF, other	CCDF	CCDF state
Accreditation (NAEYCE and/or others)	Extra 2 points	No	Yes	Highest star level, but alternative paths available
Web site	www.qualistar.org	http://ncchildcare.dhhs.state.nc.us/parents/pr_sn2_ov_sr.asp	http://www.okdhs.org/programsandservices/cc/stars/	http://www.dpw.state.pa.us/child/childcare/KeystoneStarChildCare

Table 2D—Best Practice State Summary Table

State	Total CCDF Funding 2008 (in millions)	Number of children served (2007)	Spending per child per month (2006)	State or local administered	Best Practice area
Maryland	$145.6	22,900	$511.21	Local	Standards and Oversight
North Carolina	$380.4	95,800*	$371.63	State	Professional Development **and** Reimbursement Rate
Oklahoma	$184.1	25,000	$537.67	State	Quality Rating System
Arizona	$201.1	30,900	$365.39	State	Co-Payment
New Jersey	$248.9	37,900*	$547.27	Local	Income Eligibility
Nevada	$39.8	6,000**	$553.34	State	Waiting Lists

Figure 3D—Flow Chart Depicting Integration Under QRS

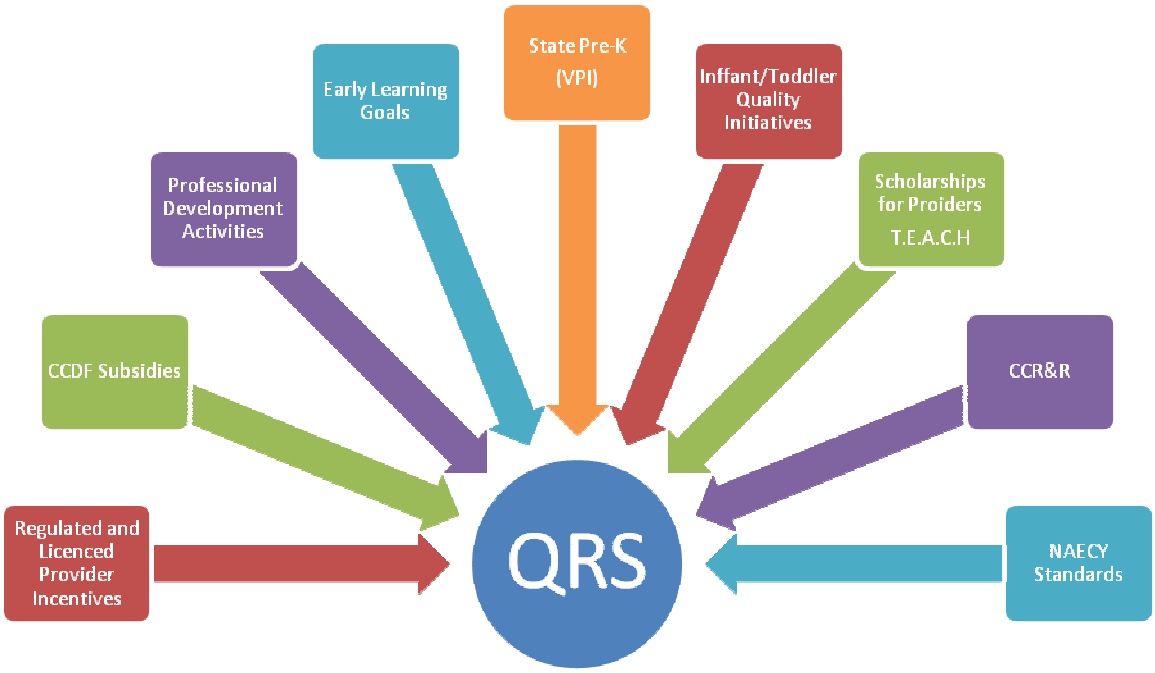

Table 4D—2008 State Reimbursement Rate Percentile Ranges

	Percentiles	**Smallest (MRR included in range)**
1%	25	25
5%	27	25
10%	40.5	27
25%	49	31
50% (median)	62	
		Largest (MRR included in range)
75%	70	75
90%	75	75
95%	75	75
99%	75	75

*Data Source: National Women's Law Center
*50 observations; Mean=58.55; Standard Deviation=14.30
*Virginia's average MRR for registered facilities is estimated to be the 48th percentile, falling in the 25th quartile range.

Table 5D—2008 Income Eligibility Limits as a Percentage of FPL Percentile Ranges

	Percentiles	**Smallest (eligibility limit included in range)**
1%	116	116
5%	124	117
10%	136	124
25%	151	125
50% (median)	180	
		Largest (eligibility limit included in range)
75%	199	232
90%	221	257
95%	257	263
99%	268	268

*Data Source: National Women's Law Center
*51 observations; Mean=180.34; Standard Deviation=35.23
*Virginia's average income eligibility limit is estimated to be at 195 percent FPL, falling just below the 75th percentile range.

Table 6D—2006 Average Spending per Child per Month State Percentile Ranges

	Percentiles	**Smallest (spending amount included in range)**
1%	167.2	167.2
5%	263.42	252.35
10%	277.4	263.42
25%	324.42	265.95
50% (median)	403.37	
		Largest (spending amount included in range)
75%	551.66	943.85
90%	838.04	958.07
95%	958.07	1053.82
99%	1328.01	1328.01

*Data Source: National Women's Law Center
*51 observations; Mean=487.58; Standard Deviation=237.73
*Virginia's average monthly spending per child is estimated at $480.12, above the 50th percentile of nationwide spending.