Executive Summary

The first five years of a child's life are some of the most critical in their development, but the programs and systems that serve young children face persistent under-investment. The complexity of multiple funding streams with separate requirements results in an uncoordinated system that is difficult for families and programs to navigate. These challenges are felt most acutely by the children and families farthest from opportunity, perpetuating existing inequities. To better understand and address the broken finances of the prenatal to five system, Think Babies Michigan engaged in a comprehensive fiscal analysis (CFA) focusing on multiple services and elements of financing the prenatal to five system, including available service capacity, current funding, modeling the true cost of services and infrastructure, and projecting revenue needed to achieve the vision established for Michigan's young children and their families.

Fiscal Mapping

To understand Michigan's current investments, the CFA team conducted interviews and reviewed budget, grant, and contractual documents to create a "fiscal map." A number of state programs serve the health, educational, and social-emotional needs of young children in Michigan, including home visiting, early intervention, subsidized child care, public pre-K and Head Start, and health insurance programs such as the Healthy Kids Medicaid program and MIChild. Medicaid and the children's health insurance programs make up the largest state investments in children birth to five, although a large portion of these programs are also dedicated to serving older children. This fiscal analysis focused on programs specifically designed for children from birth to five, including early learning, early intervention, and family support/home visiting programs.

More than $1 billion in public funding is invested annually in early learning, early intervention and family support/home visiting programs and services for Michigan's young children and their families. The largest early learning programs are the Great Start Readiness Program (GSRP) pre-K program for four-year-olds, which receives approximately $338 million of mostly state funds; Head Start, which receives $260 million in federal funds; and Child Development and Care (CDC) child care subsidies, which receive about $199 million in combined federal and state funds. Michigan serves approximately 42,000 four-year-olds in GSRP and Head Start pre-K programs, 36,000 children with CDC subsidies, 18,000 children with home visiting services, and 18,000 children with Early On early intervention services.

Nonetheless, significant gaps remain. Approximately one-third of eligible four-year-olds are not served by state-funded pre-K (GSRP) or Head Start.[1] Currently, there are nearly twice as many children who have been found eligible and approved for CDC subsidies (about 62,000) as children who are using CDC subsidies for care (36,000). Meanwhile, Michigan child care providers earned an average salary of just $23,020 in 2019 or about $11 per hour, which is barely above Michigan's minimum wage, despite many providers' experience and qualifications in the field.[2] Currently, home visiting services reach about 18,000 Michigan children[3] out of more than 660,000 children who could benefit from home visiting services.[4] In input sessions held with child care providers and home visiting programs across the state, both types of programs consistently identified challenges hiring and retaining qualified staff and paying competitive salaries and benefits as their most pressing barrier to providing high-quality care.

Cost Modeling

An integral component of the Michigan Comprehensive Fiscal Analysis included developing cost estimation models for center-based child care, family child care, home visiting direct services, and the home visiting system. The CFA team developed child care and home visiting cost models to help constituents understand:

- The cost to provide prenatal to five services across Michigan, and how this varies by program type, location, and type of service.
- The extent to which current revenues are sufficient to cover the estimated costs of providing services.

Cost models are dynamic tools that estimate the true cost of services on a per-program and per-child basis, accounting for different quality or intensity levels of programs and decisions about compensation. The need for cost models stems from the broken market for child care and other early childhood services. High-quality early care and education costs more than most families can afford, which depresses the market demand for quality services. Providers must compete on price and set tuition prices at levels families can afford, which disincentivizes investment in more expensive, higher-quality programming.[5] Many providers rely on in-kind support, unpaid overtime, or artificially low wages for themselves and their staff to effectively subsidize the difference between what families can pay and the true cost of care. Similarly, home visiting and early intervention programs are funded by grants, contracts or fee-for-service models that do not consider the true costs borne by programs to pay competitive wages and meet all of the program requirements. Home visiting and early intervention programs often rely on cross-subsidization from other parts of their organizations, unsustainable workloads, and underpaid staff to close the gap. Cost models demonstrate the true cost of care in this labor-intensive sector, highlighting the interrelated nature of workforce compensation and the cost of the service.

The CFA included cost models for child care and home visiting services. (An additional analysis of Early On early intervention services is occurring in 2023, concurrent with the first publication of this report.) Both models can be run at current wages, estimated by the Bureau of Labor Statistics (BLS), or at a living wage, estimated by the MIT Living Wage calculator.

Current child care subsidy rates in Michigan are insufficient to cover providers' costs for a licensed program, even at current (BLS) wages. The annual cost of center-based care for an infant under this scenario is $20,152, which is $5,592 more than the annual subsidy rate for full-time care. The gap is slightly smaller for older children, but there is still a gap of $3,491 for four-year-olds between the current cost of care and the subsidy rate. In a family child care home, the cost of providing licensed care for a child under five with current salaries is estimated to be $14,579, which is $2,879 more than the subsidy rate for an infant or toddler and $4,569 more than the subsidy rate for a three- or four-year-old.

These gaps are much larger when the cost of care is estimated to include a living wage. The true cost of care—including a living wage for the early childhood education (ECE) workforce—in a child care center that meets minimum state licensing standards is over $26,000 for an infant, which is $11,500 more than current subsidy rates. For a four-year-old, center-based care is estimated to cost $16,805 annually, which is $6,405 more than the subsidy. In a family child care home, including a living wage for the provider/owner and any staff increases the cost of care to $18,613 per child, which is nearly $7,000 more than the subsidy rate for an infant or

toddler and $8,603 more than the subsidy for a three- or four-year-old. These disparities illustrate the difficulty providers face when trying to increase employee compensation. The gaps grow even larger when quality enhancements, such as smaller ratios and group sizes and release time for planning and professional development, are included.

Similarly, current public funding for home visiting is insufficient to cover program costs at the standard caseload and current salary levels. The home visiting cost model estimates an average cost per slot of $2,118. On average, this is roughly 13% higher than the current funding of $1,881 per family. Incorporating a living wage increases the cost per slot to $2,436, or 30% higher than current funding levels.

Cost modeling also includes the infrastructure and system costs to support child care and home visiting programs in the state. The models include these costs as a percentage of direct service costs; therefore infrastructure and system costs increase with an increase in the direct service cost. This relationship between direct services and the infrastructure and system of program supports is important for maintaining and growing the capacity and quality of services for families of young children.

Recommendations

The CFA generated three overarching recommendations:

1. **Maximize existing funding sources:** In some cases, there are opportunities to leverage existing funding streams more fully. Eligibility requirements for CDC subsidies should be reviewed to better align to families' needs and eliminate burdensome requirements that discourage enrollment. There may be further opportunities to draw on Medicaid funding to support home visiting services. School districts will be better positioned to expand GSRP pre-K slots if they receive more information about their potential funding earlier in the budgeting cycle.
2. **Use the true cost of services to inform future investments:** The most important initial step in expanding quality services for young children is to address the longstanding gap between the importance of early care and education providers' work and their low compensation. Public funding rates should be set with consideration for the true cost of services, including moving to a standard of living wages with benefits across the early childhood field. Michigan should use the flexibility offered by the federal Child Care Development Fund to set child care subsidy rates based on the true cost of care rather than the flawed market rate. Michigan should significantly increase public investment in child care and home visiting to close the gap between current investments and the overall investment needed to serve more families who need support and raise salaries to a living wage.
3. **Invest in coordination of services and systems:** Services for young children are spread across many agencies and programs, leading to challenges with coordination and navigation. Home visiting leaders should consider strategic priorities for the growth of the home visiting system with a shared leadership approach. At the community level, across the prenatal to five system, funding local systems coordination organizations equitably and sufficiently across the state and investing in systems such as coordinated enrollment and community information hubs will help ensure that families can benefit from other services, including child care, home visiting, and pre-K.