A Comprehensive Fiscal Analysis of the Prenatal to Five System in Michigan

A tool to promote understanding of essential services for young children and their true costs

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Prenatal to Five Fiscal Strategies

P▸5 Fiscal Strategies

About Prenatal to Five Fiscal Strategies

Prenatal to Five Fiscal Strategies is a national initiative, founded by Jeanna Capito and Simon Workman, that seeks to address the broken fiscal and governance structures within the prenatal to five system with a comprehensive, cross-agency, cross-service approach. The initiative is founded in a set of shared principles that centers on the needs of children, families, providers, and the workforce. This approach fundamentally rethinks the current system to better tackle issues of equity in funding and access.

For more information about P5 Fiscal Strategies, please visit:
www.prenatal5fiscal.org

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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.

I. Introduction

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.

Many families of young children struggle to afford the level of quality services their children need. 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 Prenatal to Five Fiscal Strategies (P5FS) to lead a comprehensive fiscal analysis (CFA) focusing on multiple services and elements of financing the prenatal to five system. This work included developing a fiscal map detailing the current funding streams supporting prenatal to five programs and systems and building cost estimation tools to estimate the true cost of programming for the prenatal to five period. The project sought to address the following questions:

- What funding currently supports prenatal to five services in Michigan?
- How are these funds being used, and can they be more fully leveraged?
- What opportunities exist to better coordinate, streamline, and maximize existing funds?

The comprehensive fiscal analysis also included development of cost models to estimate the true cost of quality services, including increased workforce compensation, for child care and home visiting. These cost models estimate a per-child or per-family cost of services at different levels of quality and intensity, as well as system-level supports. The information gathered through this comprehensive fiscal analysis informs recommendations and action steps for systems change.

The PF5S analysis was conducted by a team of early childhood system, program, and financing experts with experience working in multiple states and communities. The P5FS team partnered with a work group of Michigan stakeholders to articulate a vision, guiding principles, and key elements to be considered in the comprehensive fiscal analysis and cost models. The project followed a framework developed by P5FS which includes fiscal mapping, cost modeling, and systems analysis, informed by stakeholder engagement, all driving toward recommendations. Think Babies Michigan initiated and led this work, as part of the prenatal to three system-wide change effort funded by the Pritzker Children's Initiative. The work also advanced the Think Babies goals of maximizing investments in child care and home visiting, removing barriers to access for families, paying providers fairly, developing a cross-sector strategy to improve compensation for the early childhood workforce, and improving equity for children across the state.[6]

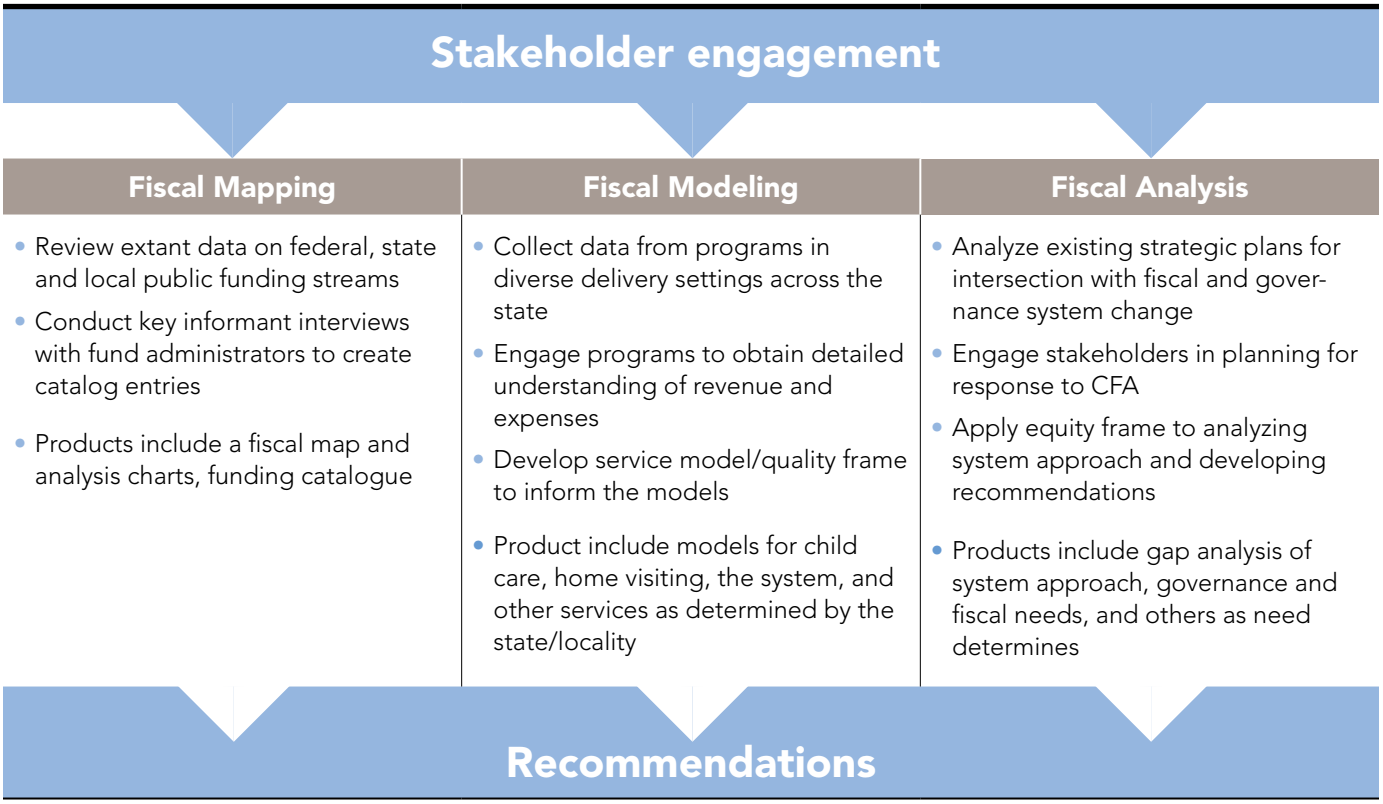
The need for a comprehensive fiscal analysis

To build an infrastructure that supports and sustains comprehensive and cross-sector prenatal to five systems work, an understanding of the fiscal context is imperative. One of the most complex challenges raised in the National Academies of Sciences, Engineering, and Medicine 2018 report *Transforming the Financing of Early Care and Education* is the patchwork of funding sources and financing mechanisms, which reinforces how issues of isolated impact and siloed approaches stem in large part from how programming and systems are funded.[7]

The National Academies report underscores the issues that result from an uncoordinated patchwork, or non-functioning system, including inequities in access, quality, affordability, cultural responsiveness, and accountability, critical issues that are felt most acutely by the children and families programs are designed to serve. Funding sources and mechanisms vary in their implementation requirements and contract approach, based on the funding entity, and have their own standards and reporting requirements. These variances and the lack of common understanding of them across the prenatal to five system puts stakeholders at a disadvantage when attempting to develop policies, develop funding mechanisms, and implement systemic changes that will result in efficiencies and economies to benefit family access and program quality.

A comprehensive fiscal analysis, or CFA, promotes system-wide thinking and cross-systems analysis to recognize common challenges and understand how programs and services across the prenatal to five sector interact. The process for funding the services and programs in the prenatal to five period represents a fragmented and broken model of funding that has never met the reality of the cost of the services. As shown in Figure 1, a CFA begins with fiscal mapping to understand the scope of current investments. The fiscal map also explores limitations on current funding and opportunities to leverage current funding sources more fully. The CFA then draws on provider and constituent input to create fiscal models that allow users to estimate the future costs of expanding programs and services, both on the basis of a cost per child and at the system level. This allows for a

Figure 1: Elements of a comprehensive fiscal analysis



complete systems analysis and development of recommendations that advance the shared vision and principles for the prenatal to five system.

Understanding the true cost of services

The current understanding of the cost of services for the prenatal to five period is typically more representative of the price of the service (what a family can afford to pay) or the amount reimbursed for the service (what a contract pays for the service). In both instances, these are not the cost of delivering the service but instead what a provider or program may be paid for the service by the consumer or public funding source. Staff in these programs have been forced into practices that will allow them to deliver services with revenues not covering cost. Programs and staff have made accommodations (e.g. use of personal funds for materials, working nights and weekends, management staff working in classrooms to maintain coverage, etc.) to maintain the work and attempt to meet family needs. Many of the programs across the prenatal to five system, including child care, home visiting, parent support, and early intervention rely on accommodations, making it extremely difficult to sustain the system, provide fair compensation for the workforce and the quality programming families and young children need. These accommodations include:

- low wages, poverty level in most communities, and limited benefits for staff
- reliance on women, particularly women of color, who are undervalued for their role in child rearing and domestic efforts
- funding mechanisms linked to available funding, not actual cost of service
- silos across state sectors that are seeking to serve and impact the prenatal to five period.

Identifying the true cost of providing programming for young children and families is critical

to addressing the underfunding of the system. Revenue and expense models, or cost models, are tools used to understand costs and the relationship between the expense of delivering services, or costs, and the available revenues. Models should be informed by program engagement and primary and secondary data collection, customized for the community in which they will be used. Cost models are dynamic tools that estimate the true cost of services on a per-program and per-child basis. Models can estimate the changes in cost for programs with different characteristics, such as varying compensation, or for services of different intensity. They can also show the gap between costs and revenue sources. Importantly, cost models provide transparency into the financial reality faced by programs offering prenatal to five services. 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, and why the true costs are so much higher than current funding levels or what families can afford.

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 to pay, which disincentivizes investment in more expensive, higher-quality programming.[8] 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 cost of care.

In child care, most states set subsidy rates based on a market rate survey, which reflects the existing gap between the price families can afford and the true cost of quality care. Providers in low-income areas face even greater pressure to lower prices, and they are then paid a lower subsidy rate because of the lower market price in their area. For states using a market price study to set subsidy rates, the U.S. Department of Health and Human Services recommends setting subsidies at the 75th percentile of the market rate.[9] As of 2021, only two states set their payment rates at this level.[10] In Michigan, the percentile varies based on child age and program type. For example, in 2021, the base subsidy level for

Defining terms

PRICE: the tuition prices the market can bear: what families can afford to pay, or the value of available grants and contracts. These depend on competitive rates in programs' local markets, ensuring that programs can operate as close to full enrollment as possible, and the available revenue for contracting out services.

COST: the actual expenses for operating programs. Program costs are typically higher than price or rate paid; costs may be subsidized by other programs within the same organization, staff working more hours than they are compensated for, or by in-kind support such as discounted or free rent or donated services from family or friends. The cost allocates expenses across children served based on the cost of providing the service and is not based the rate paid or on what parents can afford.

TRUE COST: the cost of operating a program with the staff and materials needed to meet regulatory and program standards and provide the program intensity and quality reflective of the needs of the children and families served. "Cost of quality" is another term often used to refer to the true cost of services. The true cost includes adequate compensation to recruit and retain a professional and stable workforce.

a four-year-old in center-based care was $838 per month, which was $201 less than the 75th percentile of the market rate.[11] (This reflects temporary increases to subsidy rates using federal COVID-19 relief funding.) Even setting rates at a higher percentile of the market rate still under-values child care services since the market for child care reflects what families can afford rather than the true cost of care. Two states, New Mexico and Virginia, along with the District of Columbia, now set subsidy rates on the basis of cost rather than a market rate survey.[12]

This disconnect between the cost of services and the available revenues exists for other prenatal to five programs. In programs such as home visiting, parent education and early intervention, a contract, grant or set fee-for-service approach dictates how much revenue is available to a program, irrespective of the cost of delivering the service. These programs rely on rates paid out by contracts. True costs of services are not driving these contract decisions. In addition, costs increase year after year often without an increase in the payment rate. Therefore, the payment rate does not cover the cost of the service. As noted above, program staff make accommodations to deliver their services to families. Home visitors are professionals who take on enormous stress as they work with many families with varying needs. However, they are not compensated anywhere near the level they should be for the amount and type of work they do for families of young children. Early intervention programs are faced with heavy caseloads and staffing shortages due to low compensation and high workload. In addition to high caseloads, in both of these programs, staff work far more than the hours they are reimbursed for each week, to meet the program requirements (both administrative and family service requirements). As in child care, the true cost of providing quality services does not dictate the price that providers are paid, leading to a structural funding gap.

This report details the results of the comprehensive fiscal analysis, including identification of recommendations for advancing the prenatal to five system in Michigan. Section II describes the leadership of the project and how Michigan stakeholders were engaged at all stages. Section III presents the fiscal vision and principles that guide this analysis. Section IV presents a fiscal map of existing funding that supports programs and systems for children under five and their families in Michigan, including narrative and table summaries. Section V presents cost modeling analysis for child care and home visiting, including estimates of the true cost of care and services. Finally, Section VI presents findings and recommendations drawn from constituent input and analysis of the prenatal to five system.

II. Michigan Leadership and Stakeholder Engagement

Think Babies Michigan initiated and led this comprehensive fiscal analysis, as part of a prenatal to three system-wide change effort. By providing detailed information about the true cost of services and the impact of varying levels of compensation on total cost, this fiscal analysis supports the Think Babies Michigan goals of maximizing investments in child care and home visiting, removing barriers to access for families, paying providers fairly, developing a cross-sector strategy to improve compensation for the early childhood work-force, and improving equity for children across the state.

To guide this project, Think Babies Michigan convened a Comprehensive Fiscal Analysis Work Group. Work Group members were drawn from across the state and represented different sectors of the prenatal to five system. A full roster of members is available in Appendix B. The Work Group met monthly from January to November 2022 and guided decision-making throughout the comprehensive fiscal analysis, cost models, and recommendations. P5FS also presented to the full Think Babies Michigan Steering Committee to gather additional input and inform the analysis and recommendations.

To support the technical development of the fiscal models, two targeted groups were utilized. A Child Care Ad Hoc group made up of Work Group members and other experts from the field met with the P5FS team three times to give input into the development of the child care cost model and to facilitate child care provider engagement. The Home Visiting Leadership group, comprising program administrators and advocacy partners for home visiting programs across the state, served as the technical assistance body for the development of the home visiting cost model. The P5FS team joined four meetings of this leadership body to seek input on home visiting technical and policy questions, and members of the leadership group helped to arrange provider input sessions for home visitors. The P5FS team also met with the Home Visiting Advisory Committee, which includes representatives from all funding streams and home visiting models in use in the state as well as multiple parents with home visiting experience, on several occasions to seek input and share findings from the fiscal analysis process.

In addition, as part of its Preschool Development Grant Birth through Five (PDG B-5) grant, the Michigan Department of Education (MDE) engaged the American Institutes for Research (AIR) to conduct a cost study to better understand the cost of providing high-quality child care in Michigan.[13] As part of the cost study, AIR collected data from 45 child care programs identified as high-quality. P5FS partnered with MDE and AIR to access the data collected from these 45 providers. These data were used to inform the comprehensive fiscal analysis without additional burden to these providers.

Think Babies Michigan is a collaborative of over 2,300 leaders, experts, families, organizations, and providers working together to improve the lives of babies prenatal to three years and therefore the well-being of the entire state. The initiative is co-chaired by Hope Starts Here, the Michigan Council for Maternal and Child Health, the Michigan League for Public Policy, Michigan's Children, and parent leaders. The Early Childhood Investment Corporation (ECIC) serves as the project lead for this statewide initiative and guided the work of the comprehensive fiscal analysis.

Engagement with the Prenatal to Five Field

The information in the fiscal map section of this report draws on direct engagement with stakeholders across the state, including managers of key programs and providers in the field. The P5FS team conducted interviews with 22 key informants across the state who administer programs as part of the system serving children under age five and

their families. The P5FS team also conducted a review of key documents, such as budgets, legislative reports, contracts, and grant reporting. A full list of those interviewed can be found in Appendix A.

Child care and home visiting programs in the field also had several opportunities to share cost data and give qualitative input on the challenges they are facing and the costs associated with those challenges. In partnership with Think Babies Michigan and the Home Visiting Leadership group, P5FS facilitated six virtual input sessions for child care providers, attended by 27 child care providers, and four virtual input sessions for home visiting program staff, attended by approximately 80 home visiting staff members. P5FS also partnered with several other organizations who were investigating the cost of services in 2022 to incorporate their findings into cost model development:

- The American Institutes for Research (AIR) conducted interviews with 45 high-quality child care programs. P5FS partnered with AIR to incorporate the findings from these interviews into the cost models and fiscal analysis.
- The Michigan Public Health Institute conducted a survey of 20 home visiting programs in summer 2022 that gathered detailed revenue and cost information, which P5FS used to inform the development of the home visiting cost model.
- The University of Michigan Child Health Evaluation and Research Center conducted a study on the cost of delivering home visiting in Michigan that collected data from 11 agencies funded by MIECHV, which was referenced as part of finalizing the home visiting cost model inputs.

These partnerships allowed for incorporation of data from more providers across the state while minimizing the burden on providers to gather and share cost information.

Across all of these opportunities for engagement, approximately 183 programs across the state participated in these interviews, surveys, or input sessions, representing at least 20 counties.[i]

Detroit Comprehensive Fiscal Analysis

While this report reflects costs and trends across the state of Michigan, communities with high rates of poverty and historic disinvestment have unique needs. In order to understand the specific context, needs, and desires of families and providers in these communities, the P5FS team partnered with Hope Starts Here, Detroit's early childhood partnership, to lead a simultaneous comprehensive fiscal analysis (CFA) of child care and home visiting services in Detroit. Detroit's CFA can be understood as an in-depth case study of the challenges and opportunities facing communities with greatest risk factors, including high poverty levels, across the state.

Many of the findings of the Michigan comprehensive fiscal analysis also apply to Detroit, especially the need for increased compensation for all those who serve young children, including child care and home visiting providers. Hope Starts Here recently partnered with the Corporation for a Skilled Workforce to develop an Early Childhood Education

[i] 80 home visiting providers and 27 child care providers participated in P5FS input sessions. 45 child care providers were interviewed by AIR, and 20 home visiting programs responded to the MPHI survey.

Career Pathway that lays out job profiles, career growth opportunities, training and development needs, and living wage scales for various roles within child care and early education. The wage scale takes a similar approach to the living wages used in the Michigan cost models: both use the MIT Living Wage Calculator and envision increases in pay as educators increase in skill, experience, and responsibility. There are slight differences between the two models in the specific salary amounts and the variation between roles. The Detroit child care cost models incorporate this Detroit-specific wage scale to ensure that cost estimates align with Detroit's ongoing workforce development efforts. While this wage scale is specific to child care, salaries in the home visiting cost model are also tied to the MIT Living Wage for consistency across the early childhood field.

Detroit stakeholders also identified additional needs that were factored into the child care and home visiting cost model. Providers and community leaders reported that the families they serve in Detroit often need more support with basic needs, such as accessing diapers and food and being connected to other services for assistance with transportation, health, and housing. Additionally, Detroit children and families are more likely to present with greater mental health and social-emotional needs, leading child care providers and home visitors to aim for smaller caseloads and lower adult-to-child ratios. These additional needs are reflected by running the child care cost model with more enhancements, which include funding for additional staff to support families' needs, smaller ratios of children to adults, and more funding for supplies and basic needs. The Detroit home visiting cost model uses the options for lower caseloads to allow for more individualized attention for each family.

These quality enhancements significantly increase the cost of care. For child care, using the "Point C" quality level and the Detroit living wage scale, the annual cost for an infant in center-based care is estimated to be $49,919 and serving a four-year-old in center-based care would cost $40,264. In a small family child care home, the estimated cost per child would be $54,525. These costs per child are more than double the cost of licensed care with no quality enhancements that was used as the baseline for statewide cost estimates. In home visiting, constituents recommend estimating costs using a reduced caseload to reflect the need for more individualized attention. These higher costs should be viewed through an equity lens as investments in meeting all families and communities where they are and reversing historic trends of under-investment.

Finally, Detroit stakeholders identified system-wide needs unique to the Detroit context. The Detroit comprehensive fiscal analysis included a system-level model for child care and early education costs that are citywide and not borne by individual providers. For example, many Detroit providers have trouble finding high-quality facilities that meet licensing and quality standards. Stakeholders also observed that many Detroit child care providers need support with business practices and navigating regulation to achieve economic viability, improve quality, and access public funds. The Detroit system model considers these and other citywide supports as part of the holistic system of child care and early education.

III. Fiscal Vision and Guiding Principles for Michigan's Prenatal to Five System

Among the CFA Work Group's first activities was the development of a fiscal vision and guiding principles for the prenatal to five system in Michigan.

To address the complexity of the needs of children and families and the non-system in which those needs exist, states must hold a vision for how to increase investments, better align current investments, and develop funding and governance structures that maximize efficiency and minimize burden. A fiscal vision, combined with guiding principles, establishes a "north star" for future work. P5FS facilitated discussion among the members to develop the fiscal vision and principles within the context of existing, broader visions for young children, across the health, education and family support fields. Building a shared agreement across this group for the future of prenatal to five services in Michigan was a key first step to ensure that decisions related to the fiscal analysis were grounded in this vision and aligned with these principles.

Michigan's Fiscal Vision and Guiding Principles for Prenatal to Five System

Fiscal Vision

A prenatal to five system that **meets the needs of every child and family,** and is supported by **sufficient and stable funding streams** reflective of true cost of programs; services and systems responsive to families; **efficient** administration that remediates inequities; and infrastructure with local flexibility and **minimum burden** for program providers.

The Work Group also identified a set of foundational principles. Operationalizing this fiscal vision is supported by these principles. The principles drive the important work of a cohesive, equitable, and effective prenatal to five system to best support families and young children. The principles specify what a system that meets this vision will do.

Guiding Principles: A system that...

- works for all children and families and ensures that programming reaches and positively impacts children farthest from opportunity
- is fair to programs and supports their developing capacity for quality implementation
- uses public resources wisely and efficiently, augmented with private resources from families who can afford services
- acknowledges embedded societal inequities and implements changes to remediate inequity
- compensates the workforce at a level that allows for financial stability and acknowledges their significant impact on child development
- supports the entirety of a child's experiences before entering kindergarten, including prenatal supports for expectant mothers
- is driven by constituent voices with parents, families, and communities as equal partners with public and private entities who work in the system.

The fiscal vision and principles were used to support the development of recommendations, informed by the fiscal mapping analysis and cost modeling results, ensuring that the recommendations were aligned with the shared goals for the state's prenatal to five system.

IV. Fiscal Mapping and Analysis

A fiscal map presents the current funding streams supporting programs and systems that serve children under five and their families, organized by funding source, administrator, and population served.

To create this fiscal map, the P5FS team began by reviewing key documents, such as budgets, legislative reports, contracts, and grant reports. In addition, the team conducted 22 interviews with key informants across the state who administer programs and systems serving children under age five and their families. Input and feedback from the Work Group identified further areas for exploration.

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 also serve older children. This fiscal analysis focused on programs specifically designed for children from birth to five years old, including early learning, early intervention, and family support/home visiting programs.

Michigan has a strong history of evidence-based services for young children:

- The Michigan model of infant mental health services, developed by Selma Fraiberg in the 1970s, pioneered a field in which interdisciplinary professionals work together to support the relational health of young children and their caregivers.[14]
- The state has a robust set of home visiting services, incorporating eight different models.
- The Michigan Great Start Readiness Program (GSRP) has funded pre-kindergarten for four-year-olds since 1985.[15]
- The Child Development and Care (CDC) program supports child care programs and provides subsidies to families using child care.

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 GSRP pre-K program for four-year-olds, which receives approximately $338 million of mostly state funds; Head Start, which receives $250 million in federal funds; and CDC child care subsidies, which receive about $199 million in combined federal and state funds. Michigan's current investments also include nearly $47 million in direct home visiting services, a combination of federal and state funding; $44 million in funding for young children with special needs; and about $80 million in system supports, including training, family engagement, and professional support for providers. Michigan serves approximately 42,000 four-year-olds in GSRP and Head Start pre-K programs, 36,000 children with Child Development and Care 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.[16]
- Home visiting services reach about 18,000 children in Michigan,[17] out of more than 660,000 children who could benefit from home visiting services.[18]
- Nearly twice as many children have been found eligible and approved for CDC subsidies (about 62,000) than are actually receiving child care services paid for by CDC subsidies (36,000).
- While the income eligibility threshold for child care subsidies was increased to 200% of FPL in 2022—up from 130%, which was one of the lowest eligibility rates in the country[19]—this increase was funded by COVID-19 relief dollars and is slated to expire in 2023.[20]
- 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 in the field and educational qualifications.[21]
- Home visiting programs report that current salaries are insufficient to attract and retain a qualified home visiting workforce. Low salaries and a lack of benefits mean that programs have trouble filling vacancies and face high turnover, which has practical costs as well as undermining trust and relationship-building with families.

Michigan's philanthropic sector provides funding to fill some of these gaps. While a full accounting of all philanthropic dollars spent on early childhood activities in Michigan was not included in this project, interviews with major foundations and outreach through the Council of Michigan Foundations revealed a few trends. Several foun-

dations reported funding preschool and child care scholarships for children who may not qualify for public programs for various reasons. Philanthropic funding also supports child care system activities, including connecting families to resources, building and renovating facilities, and supporting providers to improve the quality of their programs. For example:

- The W.K. Kellogg Foundation has supported data systems and technology platforms that help families in Wayne County learn about their child care options.
- The Max M. & Marjorie S. Fisher Foundation funds a quality improvement initiative in the Brightmoor neighborhood of Detroit.
- Both the W.K. Kellogg Foundation and the Max M. and Marjorie S. Fisher Foundations fund child care scholarships for families not covered by public subsidy programs.
- The Midland Area and Manistee County Community Foundations fund preschool scholarships.
- The W.K. Kellogg and Kresge Foundations in Detroit have invested in major facilities projects, including new construction and renovations.
- The Cadillac Area Community Foundation supports the Dolly Parton Imagination Library to provide books to children from birth to age five in the Cadillac Area Public Schools region.
- The Grand Traverse Regional Community Foundation's Cleo M. Purdy Endowment supports Central Lake Early Opportunities (CLEO), which connects families, partners, and resources to build a network of early childhood experiences in Central Lake.

In general, philanthropic capacity is uneven across the state, with many of the major foundations concentrated in Southeast Michigan. While philanthropy has an important role to play in filling gaps and supporting emerging approaches, it is not a substitute for equitable, consistent public funding.

The following tables summarize the results of the fiscal mapping analysis. Table 1 details the current direct service funding, with amounts by source, organized by Michigan department administering the funding. This table reflects FY2022 budgeted or expended amounts, except where otherwise noted. Table 2, following, summarizes eligibility information for each funding stream and the number of children/families served. Finally, Table 3 details the funding that supports the system by department and funding source. See Appendix C showing home visiting funding by model.

Table 1: Direct Services by Funding and Department, FY22

Program	Funding Sources	Federal Funding	State Funding	Private Funding	Total
Michigan Department of Health and Human Services					
Flint home visiting programs[22]	State General Fund		$760,000		$760,000
Healthy Moms, Healthy Babies home visiting slots (NFP, HFA, PAT, and Family Spirit)[23]	State General Fund		$2,245,442		$2,245,442
Healthy Moms, Healthy Babies — MIHP Pilot[24]	State General Fund		$4,597,561		$4,597,561
Medicaid Home Visiting Funds*— NFP, MIHP, IMH[25]	Medicaid	$17,684,677	$737,839		$18,422,516
Prenatal Care Outreach and Service Delivery Support — NFP[26]	Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV), Federal child abuse prevention funds, State General Fund	$2,207,200	$3,709,292		$5,916,492
Prenatal Care Outreach and Service Delivery Support — Rural home visiting programs[27]	State General Fund		$2,342,999		$2,342,999
Prenatal Care Outreach and Service Delivery Support — HFA, EHS, Family Spirit[28]	MIECHV, State General Fund	$5,849,264	$2,813,222		$8,662,486
Children Trust Michigan[29]		$182,883		$418,706	$601,589
				MDHHS subtotal	**$43,549,085**

Table 1: Direct Services by Funding and Department, FY22 / *continued*

Program	Funding Sources	Federal Funding	State Funding	Private Funding	Total
Michigan Department of Education					
Child Development and Care (child care subsidies)[30]	Child Care and Development Fund (CCDF)	$160,700,000	$38,400,000		$199,100,000
Child and Adult Care Food Program*[31]	Child and Adult Care Food Program	$56,596,265			$56,596,265
Early On (IDEA Part C Early Intervention)[32]	IDEA, State School Aid Act	$10,769,026	$21,250,000		$32,019,026
Great Start Collaboratives[33] **— Early Childhood Programming**[ii]	State School Aid Act		$2,180,000		$2,180,000
Great Start Readiness Program[34] **(Pre-K)**	State School Aid Act, Federal Title I and American Rescue Plan	$40,929,150	$296,739,695		$337,668,845
Homeless Task Force[35]	Preschool Development B-5 Grant	$300,000			$300,000
Section 32p Home Visiting Grants[36]	State School Aid Act		$2,500,000		$2,500,000
Section 619 Preschool Special Education Grants[37]	IDEA	$11,972,049			$11,972,049
Strong Beginnings Pilot (Pre-K for 3-year-olds)[38]	Preschool Development B-5 Grant	$1,250,000			$1,250,000
Title I Early Childhood Programs[39]	Title I	$2,352,373			$2,352,373
Universal Screening[40]	Preschool Development B-5 Grant	$140,000			$140,000
				MDE subtotal	**$646,078,558**

[ii]In FY22, Great Start Collaboratives (GSCs) were required to use 20% of their funding for direct early childhood services. Many GSCs choose to use this funding for home visiting services. In FY21, approximately $1.6 million statewide was used for home visiting. Specific local allocations for FY22 were not available at the time of publication.

Table 1: Direct Services by Funding and Department, FY22 / *continued*

Program	Funding Sources	Federal Funding	State Funding	Private Funding	Total
Early Head Start and Head Start[41]					
Head Start	Head Start	$260,517,806			$260,517,806
Early Head Start	Head Start, State School Aid Act	$99,194,673	$502,529		$99,697,202
Early Head Start — Child Care Partnership	Head Start	$20,908,480			$20,908,480
American Indian and Alaska Native Head Start & Early Head Start	Head Start	$8,373,764			$8,373,764
Migrant and Seasonal Head Start & Early Head Start	Head Start	$15,156,955			$15,156,955
				EHS/HS subtotal	**$404,654,207**
Michigan Women's Commission					
Tri-Share Pilot Program (employer partnerships)[42]	State General Fund		$2,500,000	$1,500,000	$4,000,000
				Michigan Women's Commission subtotal	**$4,000,000**
Inter-Tribal Council					
Family Spirit Home Visiting[43]	Tribal MIECHV	$798,240			$798,240
				Inter-Tribal Council subtotal	**$798,240**

*Medicaid and Child and Adult Care Food Program amounts are from FY2021; FY2022 expenditures were not yet available at the time of publication because of the lag in billing and reimbursement.

Figure 2: FY2022 Funding by Department

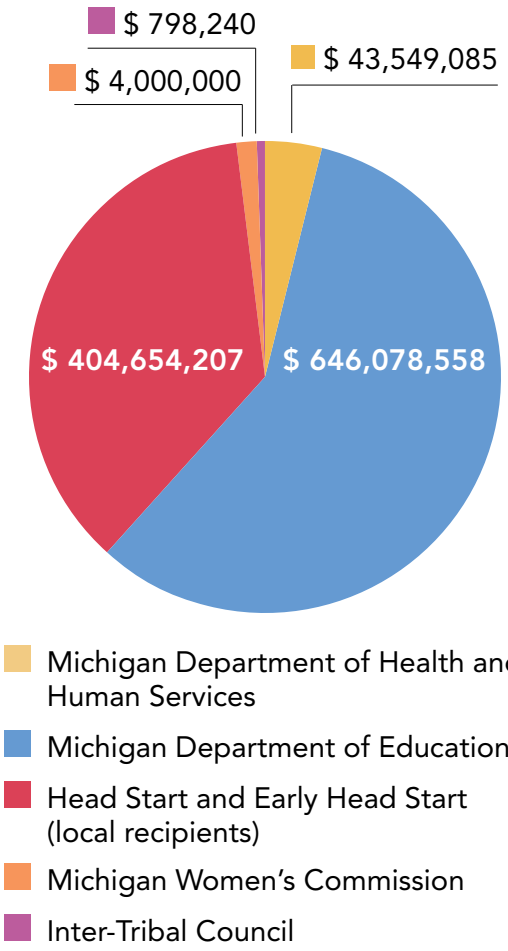
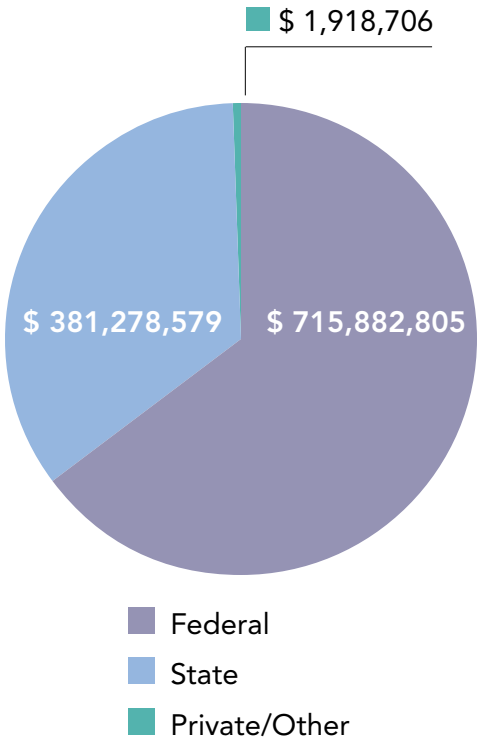


Figure 3: FY2022 Funding by Source



Design note: The smallest segments in Figures 2 and 3 have been enlarged for visibility

Table 2: Direct Services by Children/Families Served, FY22

Program	Eligible Population	Children/ Families Served
American Indian and Alaska Native Head Start & Early Head Start[44]	Head Start- and Early Head Start-eligible children in programs operated by federally recognized tribes	598
Child and Adult Care Food Program[45]	Children eligible for free- and reduced-price school meals or Head Start in participating programs	44,422[iii]
Child Development and Care subsidies[46]	Children under age 13 with family incomes below 200% FPL who need care while the parent is working or in school	36,306
Early Head Start[47]	Children under age 3 whose family income is below the FPL, foster children, children whose family is homeless/displaced, and certain other risk factors	6,038

[iii]CACFP participation number reflects average daily attendance across all programs, including school-age children and adults.

Table 2: Direct Services by Children/Families Served, FY22 / *continued*

Program	Eligible Population	Children/ Families Served
Early Head Start – Child Care Partnership[48]	Children enrolled in child care programs partnered with Early Head Start	1,034
Early On (Early Intervention)[49]	Children birth to three years with developmental delay(s) and/or disabilities	18,320
Great Start Readiness Program[50]	4-year-olds with family incomes below 250% FPL or with other identified risk factors	42,739[iv]
Head Start[51]	Children age 3–5 whose family income is below the FPL, foster children, children whose familiy is homeless/ displaced, and certain other risk factors	21,929
Home Visiting (all models)[52]	Varies by model and includes pregnant people	21,496[v]
Migrant and Seasonal Head Start & Early Head Start[53]	Children whose families are engaged in seasonal agricultural labor	929
Strong Beginnings Pilot[54]	3-year-olds with family incomes below 250% FPL or with other identified risk factors	168
Tri-Share Pilot[55]	Children in families between 200–325% FPL whose parents work for a participating employer	223

[iv] Includes four-year-olds served by GSRP and Head Start. Note that some children are enrolled in programs that offer both and braid funds to support the same classrooms.

[v] Families served across all models.

Table 3: System Supports Funding by Department and Source, FY22

System Support	Description	Funding Sources	Federal Funding	State Funding	Private Funding	Total Funding
Michigan Department of Health and Human Services						
CDC Subsidy Eligibility Determination[56]	Determine family eligibility for CDC subsidies	Child Care and Development Fund	$10,942,500			$10,942,500
Infant and Early Childhood Mental Health Consultation[57]	Prevention-based service that pairs a mental health consultant with families and adults who work with infants and young children to build adults' capacity to strengthen and support the healthy social and emotional development of children	Child Care and Development Fund and Healthy Moms, Healthy Babies	$926,021	$1,000,000		$1,926,021
Home Visiting state administration & Integrated Home Visiting System[58]	Oversees home visiting grants, provides consultation support to home visiting grantees across all models, supports centralized access for families	MIECHV, State General Fund	$532,095	$1,492,601		$2,024,696
Local Leadership Groups[59]	Supports counties to facilitate local leadership groups for home visiting programs	MIECHV	$327,000			$327,000
Michigan Public Health Institute Home Visiting Support[60]	Evaluation, training, and professional development for home visiting programs statewide	MIECHV, State General Fund, Children Trust Michigan	$1,079,393	$834,205	$35,000	$1,948,598
					MDHHS subtotal	**$17,168,815**

Table 3: System Supports Funding by Department and Source FY22 / *continued*

System Support	Description	Funding Sources	Federal Funding	State Funding	Private Funding	Total Funding
Michigan Department of Education						
Child care quality improvement activities (ECIC)[61]	Implementation of Great Start to Quality, health and safety visits, provider coaching	Child Care and Development Fund	$3,399,950			$3,399,950
Early Childhood Support Network[62]	Support implementation of quality rating and improvement system; provide technical assistance, training, and systems support to Great Start Collaboratives and Great Start to Quality Resource Centers	Child Care and Development Fund	$10,738,312			$10,738,312
Great Start Collaboratives & Parent Coalitions[63]	Local collaboratives to improve access, coordination, and quality of services for early childhood education	State School Aid Act		$8,720,000		$8,720,000
Mental health consultation to child care providers[64]	Prevention-based service that pairs a mental health consultant with families and adults who work with infants and young children to build adults' capacity to strengthen and support the healthy social and emotional development of children	Child Care and Development Fund	$1,500,000			$1,500,000

Table 3: System Supports Funding by Department and Source FY22 / *continued*

System Support	Description	Funding Sources	Federal Funding	State Funding	Private Funding	Total Funding
Michigan Department of Education						
Professional Development[65]	Includes home visiting quality improvement, infant mental health, early literacy training & support	Preschool Development B-5 Grant	$3,182,343			$3,182,343
Family Engagement[66]	Navigation & enrollment support, development of family-friendly communication, support for parent leadership	Preschool Development B-5 Grant	$9,105,081			$9,105,081
IDEA state supports[67]	Training, support to the field, supervisory positions, data collection, family engagement	IDEA	$2,522,888			$2,522,888
MiRegistry[68]	Online platform for child care providers' training and licensing	Child Care and Development Fund	$696,000			$696,000
					MDE subtotal	**$39,864,574**
Michigan Department of Licensing and Regulatory Affairs						
Child care licensing support[69]	Support child care providers with obtaining proper licenses	Child Care and Development Fund	$19,729,300			$19,729,300
					LARA subtotal	**$19,729,300**
Private Organizations						
Michigan Association for the Education of Young Chidren (MIAEYC)[70]	Provide TEACH scholarships to support child care providers with obtaining education and credentials	Child Care and Development Fund	$5,000,000			$5,000,000

Table 3: System Supports Funding by Department and Source FY22/continued

System Support	Description	Funding Sources	Federal Funding	State Funding	Private Funding	Total Funding
Private Organizations						
Michigan Association for Infant Mental Health[71]	Hosts biannual conference; supports professionals in obtaining IMH endorsement; support for reflective supervision	State General Fund, private grants and donations		$235,000	$605,000	$840,000
					Private Organizations subtotal	**$5,840,000**

Figure 4: FY2022 System Supports Funding by Department

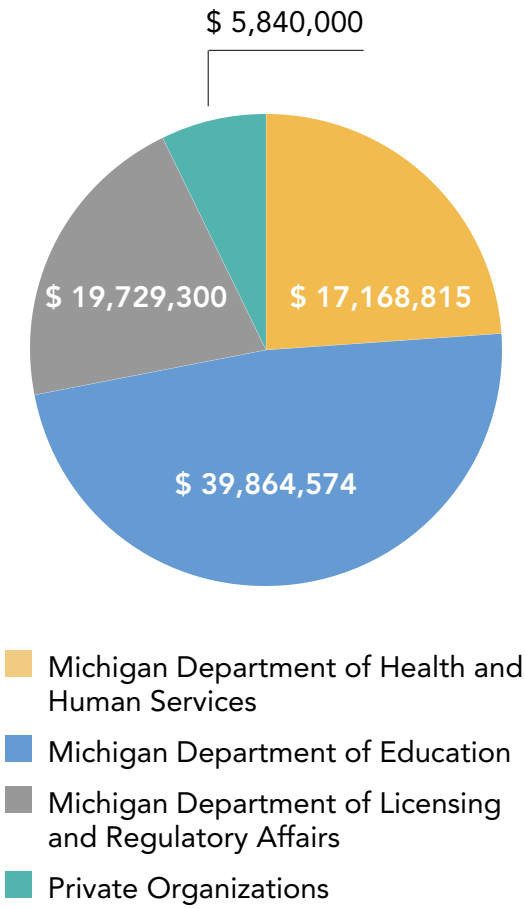
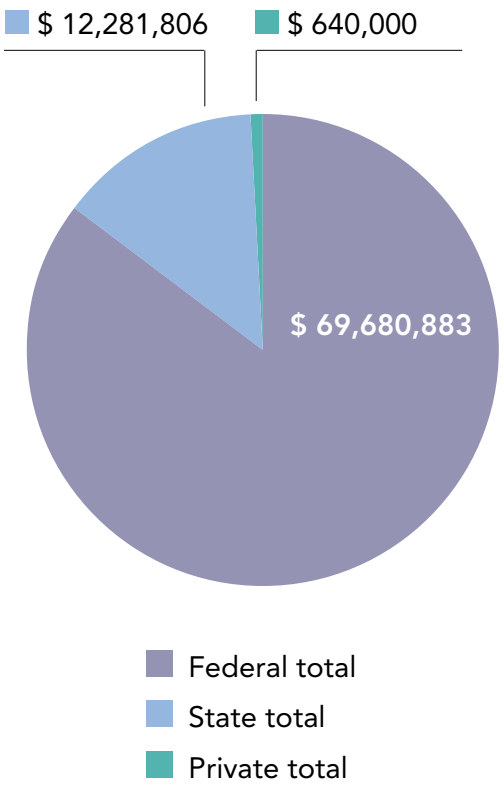


Figure 5: FY2022 System Supports by Funding Source



V. Cost Modeling and Analysis

To fully understand the cost of providing services that align with the vision and principles and meet the needs of children and families, the CFA includes the development of cost estimation models.

These models are informed by analysis of program standards, primary and secondary data collection, and input from key constituents, as detailed below. This section of the report details the methodology and assumptions embedded in the child care and home visiting cost models and presents a sample of results, along with an analysis of these results.

Child Care

Child care cost models can provide transparency into the fiscal realities of operating early education and care programs. Models can provide a full understanding of the true cost to meet program standards and the impact of different programmatic and policy decisions on the financial stability of child care providers.

Input from Child Care Providers

In partnership with Think Babies Michigan, P5FS facilitated six virtual input sessions for child care providers. Approximately 27 child care providers representing at least 19 Michigan cities and towns participated. During these sessions, providers had an oppor-

tunity to share the major challenges they are facing and how they relate to funding and costs. Providers were also asked to reflect on the types of support that would be helpful if funding were available. These input sessions provided valuable insights from practitioners to complement the input from organizations through the Work Group. Additionally, AIR conducted in-depth interviews with 45 high-quality child care providers for the MDE-commissioned child care cost study. P5FS partnered with AIR to incorporate data and findings from this cost study into the fiscal analysis.

By far the most common barriers faced by child care providers were challenges with **finding qualified staff, retaining them, and paying competitive salary and benefits.** Half of the providers identified finding qualified staff as a challenge; 46% said they were unable to pay competitive salaries and benefits; and 30% said they have trouble keeping qualified staff. The rising cost of supplies was also cited as a barrier by 30% of participants.

> "Increasing costs are affecting us like everyone else—we don't want to pass on the costs to parents. We're not able to pay more than $12.50 an hour for entry level, but we have been doing an additional $2 per hour retention bonuses using ARP and grant funds. New hires don't stay long enough to get through training—they find a higher paying job, often in the public schools, or they're leaving the field...."
>
> *—Child care center, Upper Peninsula*

> "Credentialed staff are hard to find. The credentials of a program director are hard to fill —we're remote in the UP, so we have standalone classrooms that need a program director. We don't have a local university producing staff with credentials."
>
> *—Child care center, Upper Peninsula*

> "I'm a small home-based provider. I could go to the group license and fill the spots, but I couldn't hire the staff… 50% of what I bring in goes back into my business to compete. I want to keep kids once they're 4, but I also need it to live on. I need curriculum and supplies to compete with the larger programs. Families struggle to see me as a professional."
>
> *—Family child care provider, Grand Rapids area*

When asked about what kind of support would help reduce the number of unpaid overtime hours they work, 30% of providers wanted **help with administrative tasks** and 22% wanted **help with daily preparation** such as cooking, cleaning, and shopping.

> "It's nonstop cleaning, planning and cooking, plus paperwork, shopping. I would like to do more with my own kids—I spend a lot of time on the weekends getting ready for the next week instead of spending time with them. I would like to be able to pay someone to clean the house and food prep so I can spend weekend time with my family instead."
>
> *—Family child care provider, Flint area*

Providers were also asked about serving **children with special needs, dual language learners, and children with mental and behavioral health challenges.** 56% of providers said that they wanted push-in support from special needs and behavioral health experts, such as mental health consultation. They also frequently expressed a need for more training and coaching for child care providers themselves, with 37% of providers requesting this support.

Modeling the Cost of Child Care

The child care cost models, a model for center-based care and one for family child care settings, are informed by financial and qualitative data collected from providers across the state, as well as other public data sources. Child care quality levels are informed by Michigan's Quality Rating and

Improvement System and national quality standards, including from the National Association for the Education of Young Children (NAEYC), Caring for Our Children, and Head Start. Staff qualifications are informed by the Michigan Career Pathway for Early Childhood and School Age Professionals.[72]

The child care cost models allow users to model a full-day, full-year program serving children birth to school age. It allows users to model different-sized programs as well as care during non-traditional hours. To estimate available revenue streams, the model also includes the ability to modify the number of children receiving state child care subsidy versus private-pay families.

The models account for all expenses related to a legally operating child care program, meeting either licensing or license-exempt requirements, as well as all federal and state requirements related to running a business, such as employee and employer taxes and required breaks. Personnel expenses, which account for the largest cost in a provider's budget, are included in the model along with required taxes, and users can modify salary levels and benefits within the model. In addition, the models include all nonpersonnel costs related to operating a program. Specifically, nonpersonnel costs are aggregated into the following categories:

Education Program for Children and Staff, which includes:

- **Education/Program—Child:** Food/food related, classroom/child supplies, medical supplies, postage, advertising, field trips, transportation, child assessment materials
- **Education/Program—Staff:** Professional consultants, training, professional development, conferences, staff travel

Occupancy: Rent/lease or mortgage, real estate taxes, maintenance, janitorial, repairs, and other occupancy-related costs

Program Management and Administration: Office supplies, telephone, internet, insurance, legal and professional fees, permits, fundraising, memberships, administration fees

Beyond the cost of operating a program that meets licensing or license-exempt requirements, the model includes several quality enhancements to understand the cost of a program that goes beyond these minimum standards. These variables can be included in whole or in part, and several have multiple levels that can be selected from, for inclusion in the cost estimate. Users can select to run a scenario at either licensing level or can select each of the different points for each variable. Table 4 details the quality enhancement options that may be included.

In addition to the quality enhancements, the models allow users to run scenarios at four different levels of ratio and group size. The Licensing level reflects the requirements for licensed center-based, family child care home, and group child care home providers in Michigan. The next level is ratio and group sizes that align to NAEYC accreditation standards for centers. The third level of ratio and group size aligns to the ratio and group size standards in Head Start and the Great Start Readiness Program, Michigan's state-funded pre-K program. The last selection point for ratios and group sizes aligns with the Caring for Our Children in Out of Home Care standards; this level is an aspirational level of quality that reflects the desired quality enhancements shared by Work Group members. Table 5 details these options.

The user can also choose to run the model at two salary levels: current salaries (estimated by Bureau of Labor Statistics data), and a living wage (estimated by the MIT Living Wage calculator).[73] For the living wage salary level, assistant teachers were assigned the living wage value, with other salaries increased

Table 4: Child care model enhancement selections

Enhancement	Description of cost driver activities
Family and Community Partnerships	Family conferences Family engagement specialist Translation for activities Basic needs supplies
Professional Development – Training	Additional hours for director/owner to participate in training Additional hours for teachers to participate in training
Professional Development – Coaching	Support from an instructional coach
Planning and Release Time	Additional planning time outside of classroom for lead teachers, and for all teaching staff
Additional Educational Materials	Increased resources to purchase additional materials for classroom
Health and Wellness	Health coordinator Mental health consultant
Inclusion Supports	Inclusion aides to support children on Individual Family Service Plans or Individual Education Plans
Dual Language Supports	Additional training for staff Bilingual materials Bilingual staff
Transportation	Transportation for preschool age children Transportation for children of all ages

from this floor.[vi] Lead teachers are assumed to make 30% more than assistant teachers, assistant directors receive a 22% increase over lead teachers, and directors receive a 21% increase overassistant directors.[vii]

As quality level increases, staff qualifications grow, following the Michigan Career Pathway for Early Childhood Professionals; salary levels in the model also increase to recognize these additional credentials. For each salary selection, salaries will increase with a higher quality enhancement level: 5% above the baseline at Point B, 10% above the baseline at Point C, and 25% above the baseline at Point D. Table 6 details the salary options included in the model.

The family child care cost model includes a salary for the provider/owner. Many family child

[vi] As living wage varies based on family composition, a weighted average was created for Michigan using data from a similar study conducted for another state. This weighted average uses workforce data to estimate the share of assistant teachers that fall into different family composition categories.

[vii] These pay scales are based on an average of data collected from providers in other states and localities.

Table 5: Ratio and group size options in cost model

Licensing	Point B	Point C	Point D
Centers			
Infants, 1:4 (12) Toddlers, 1:4 (12) 3-year-olds, 1:8 (30) 4-year-olds, 1:12 (36) School-agers, 1:18 (36)	Infants, 1:4 (8) Toddlers, 1:4 (12) 3-year-olds, 1:8 (24) 4-year-olds, 1:12 (24) School-agers, 1:18 (36)	Infants, 1:4 (8) Toddlers, 1:4 (8) 3-year-olds, 1:7 (14) 4-year-olds, 1:8 (18) School-agers, 1:15 (30)	Infants, 1:3 (6) Toddlers, 1:4 (8) 3-year-olds, 1:7 (14) 4-year-olds, 1:8 (16) School-agers, 1:12 (24)
Family Child Care Home			
6 children, including related children under 6 years old (7 with waiver) – No more than 4 children under 30 months – No more than 2 children under 18 months	No children under 2 yrs: 1:6 1 or 2 children under 30 months: 1:5	No children under 2 yrs: 1:6 1 or 2 children under 30 months: 1:4	No children under 2 yrs: 1:6, 6 total children One child under 2 yrs: 1:4, 5 total children Two children under 2 yrs: 1:2, no other children
Group Child Care Home			
1:6 ratio, maximum 12 children (14 with waiver) – No more than 8 children under 30 months (assuming 2 staff) – No more than 4 children under 18 months (assuming 2 staff)	No children under 2 yrs: 1:6 (12) 1 or 2 children under 30 months: 1:5 (10)	No children under 2 yrs: 1:6 (12) 1 or 2 children under 30 months: 1:4 (8)	Infants, 1:2 (6) Young toddlers (1–2 yrs), 1:2 (8) Older toddlers (2 yrs), 1:3 (12) 3-year-olds, 1:7 (12) 4-year-olds, 1:8 (12) School-agers, 1:12 (12)

care owners do not pay themselves a set salary, but rather their income is the net revenue after all expenses have been paid. This approach to family child care owner/provider salary drastically undervalues home-based providers, and often results in income equivalent to less than $5 per hour. To recognize family child care as a part of the early childhood system it is important that any cost estimate include compensation for the provider/owner, which is a required position in state child care licensing. As such, in the Michigan cost model a salary is included for the provider/owner position in the family child care home and they are assumed to earn 30% more than their assistant.

Table 6: Salary options in cost model

	Licensing	Point B	Point C	Point D
BLS				
Director	$47,210	$49,571	$51,931	$59,013
Assistant Director	$37,768	$39,656	$41,545	$47,210
Administrative Assistant	$39,720	$39,720	$39,720	$39,720
Lead Teacher	$35,950	$37,748	$39,545	$44,938
Assistant Teacher	$26,680	$28,014	$29,348	$33,350
FCC Provider/Owner	$34,684	$36,418	$38,152	$43,355
FCC Assistant Teacher	$26,680	$28,014	$29,348	$33,350
MIT Living Wage				
Director	$76,539	$80,366	$84,193	$95,674
Assistant Director	$63,255	$64,293	$67,354	$76,539
Administrative Assistant	$39,884	$39,884	$39,884	$39,884
Lead Teacher	$51,849	$54,441	$57,034	$64,811
Assistant Teacher	$39,884	$41,878	$43,872	$49,855
FCC Provider/Owner	$51,849	$54,442	$57,034	$64,812
FCC Assistant Teacher	$39,884	$41,878	$43,872	$49,855

Modeling the Cost Per Child in Center-Based Care

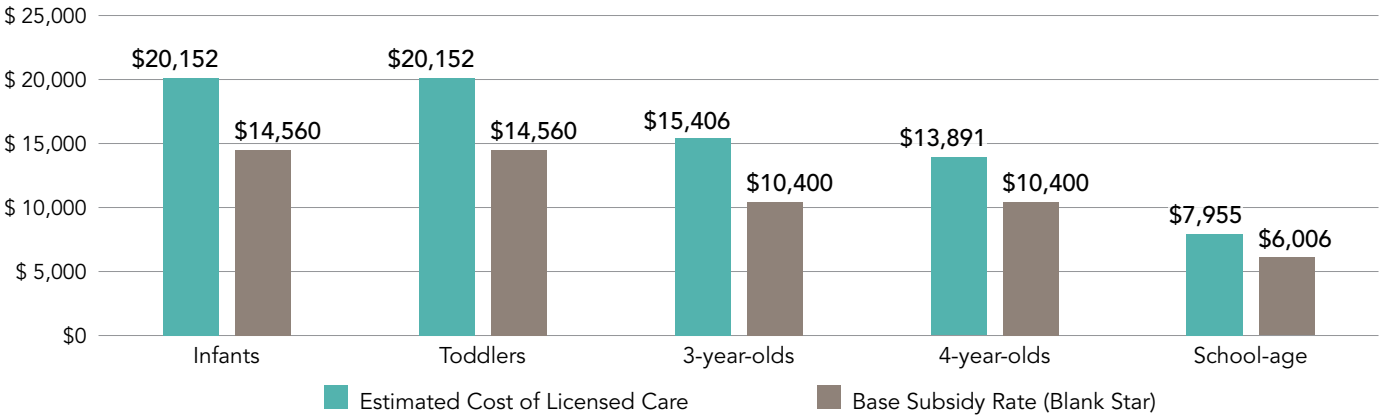
For the purposes of this report, the CFA team ran several models using a default program based on the most common sizes of center and compositions of children. The default center-based program includes one infant classroom, one toddler classroom, one three-year-old classroom, one four-year-old classroom and one school-age classroom. Total program capacity varies with quality level selected due to the lower staff-to-child ratios and group sizes at the higher levels of quality. Under this program profile, the default model includes a full-time program director, program supervisor, financial/business manager, and administrative assistant. Each classroom has a lead teacher and an assistant teacher.

The model includes time for "floaters" to maintain ratios during opening and closing and provide additional coverage throughout the day for activities.

Running the model using current wages (as reported by the Bureau of Labor Statistics) and at a level meeting licensing demonstrates that current subsidy rates in Michigan are insufficient to cover providers' costs even at these basic levels.[viii] For example, the annual cost of 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 $5,006 for three-year-olds and $3,491 for four-year-olds between the current cost of care and

[viii] The model includes the child care subsidy rates without the COVID-19 temporary increase in rates, which expires September 2023.

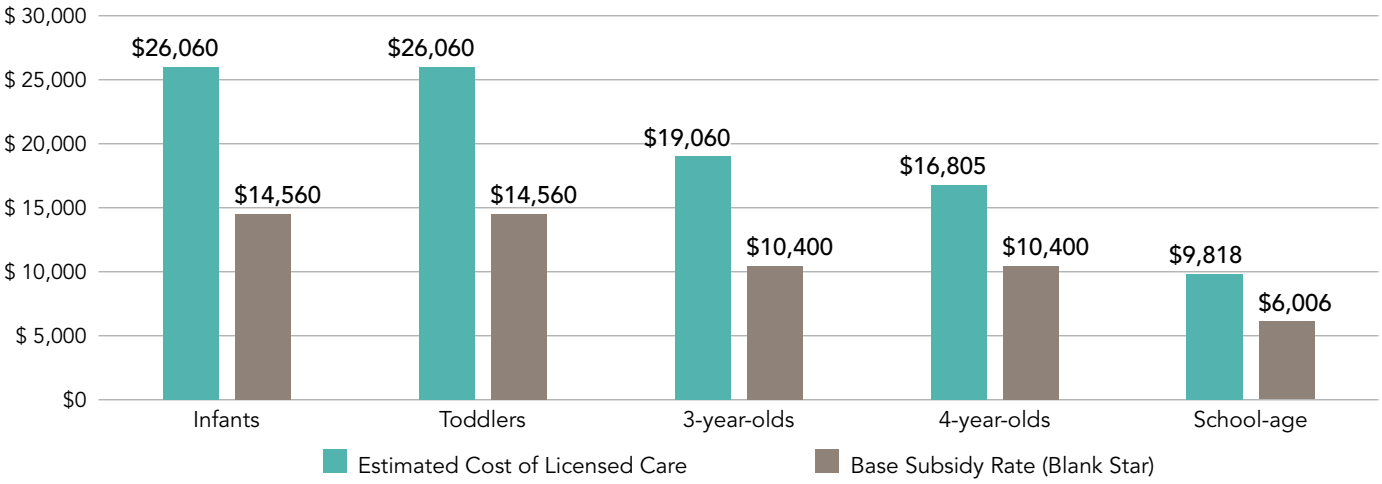
Figure 6: Comparison between estimated current cost of care and base subsidy rates, licensed level, BLS wages, child care center



the subsidy rate. Providers who rely on subsidies are losing money with every age child they serve.

These gaps are much larger when the cost of care is estimated to include a living wage. At the Licensing level, an infant's care with a living wage salary is estimated to cost $26,060, which is $11,500 more than current subsidy rates. For a four-year-old, care is estimated to cost $16,805 annually, which is $6,405 more than the subsidy. These disparities illustrate the difficulty providers face when trying to increase employee compensation.

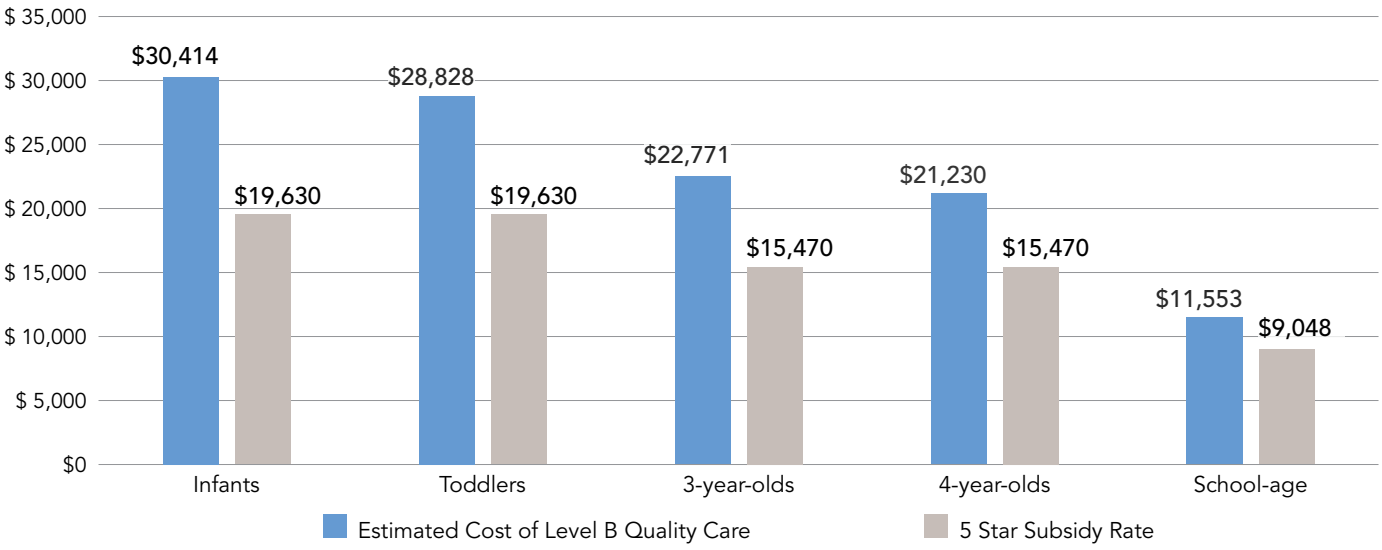
Figure 7: Comparison between estimated true cost of care and base subsidy rates, licensed level, MIT Living Wage salaries, child care center



Michigan provides a higher subsidy reimbursement for providers who have achieved higher quality, as defined by the state's quality rating and improvement system. Despite this, the increased costs faced by providers operating at higher quality are not covered by the increased revenue, resulting in even larger gaps between the true cost of care and the available revenues. For example, running the center-based care model with a scenario of "Point B" quality levels—one step up from Licensing, and with ratios and group sizes aligned to NAEYC standards—and a living wage for all staff

resulted in a cost of $30,414 per infant and $21,230 per four-year-old. These are nearly twice as much as the current subsidy payments. Point B in the cost model was used to compare to 5 Star subsidy rates in the current subsidy payment system, as it most closely aligns to the standards required of programs to achieve 5 Star. Figure 8 illustrates these gaps.

Figure 8: Comparison between estimated true cost of care at Level B and 5 Star subsidy rates, MIT Living Wage salaries, child care center



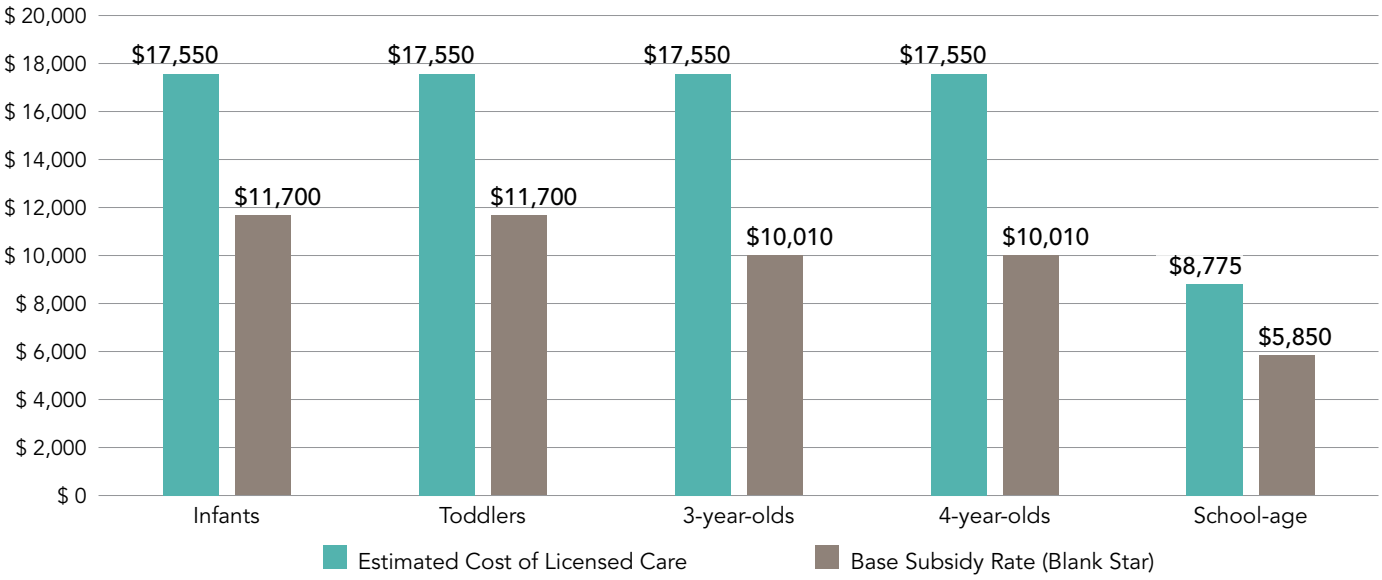
Modeling the Cost Per Child in Home-Based Care

Family child care homes in Michigan can serve up to six children (seven with a waiver), with no more than two under 18 months.[74] Group child care homes can serve up to 12 children (14 with a waiver) if they have at least one additional staff member. The family and group child care models include salaries and benefits for providers, including the business owner, and all non-personnel costs such as supplies, rent/occupancy, food and utilities.

Because family and group child care homes care for all children in a mixed-age setting, the cost model provides a single per-child cost estimate for children under five rather than different cost estimates for different ages of children. School-age children have a different cost because they do not require full-time care. For the purposes of this report, the CFA team estimated the per-child cost for family child care homes with six children enrolled (one infant, one toddler, one three-year-old, one four-year-old, and two school-age children) and group child care homes with 12 children enrolled (two infants, two toddlers, two three-year-olds, two four-year-olds, and four school-age children).

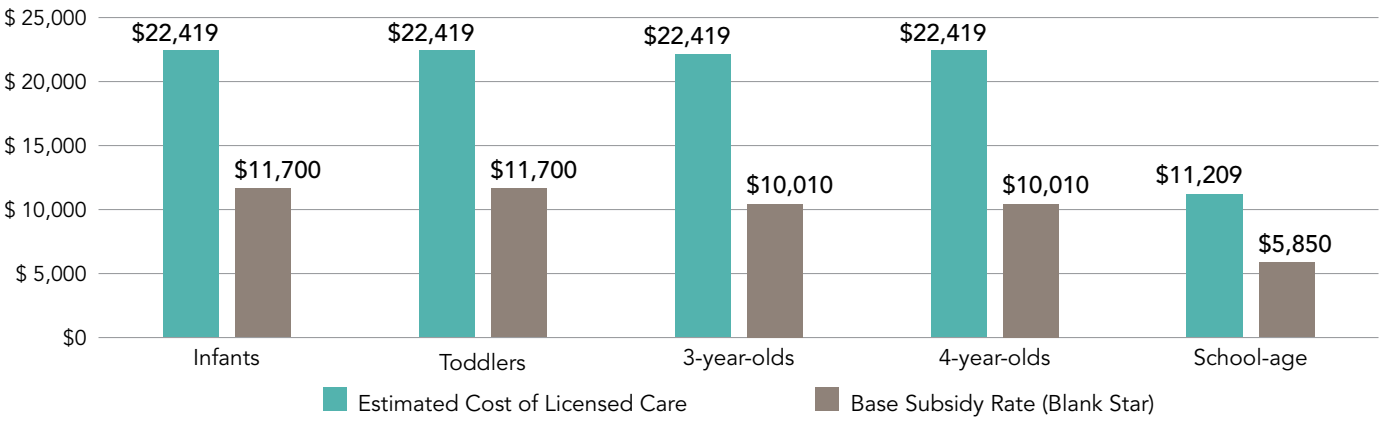
As with center-based care, current subsidy rates in Michigan are insufficient to cover the cost of care even at the most basic level of licensing with current (BLS) salaries. In a family child care home, the cost of providing full-time care for a child under five at the licensing level and with current salaries is estimated to be $17,550, which is $5,850 more than the subsidy rate for an infant or toddler and $7,540 more than the subsidy rate for a three- or four-year-old.

Figure 9: Comparison between estimated current cost of care and subsidy rate, BLS salaries, licensed level, small family child care home



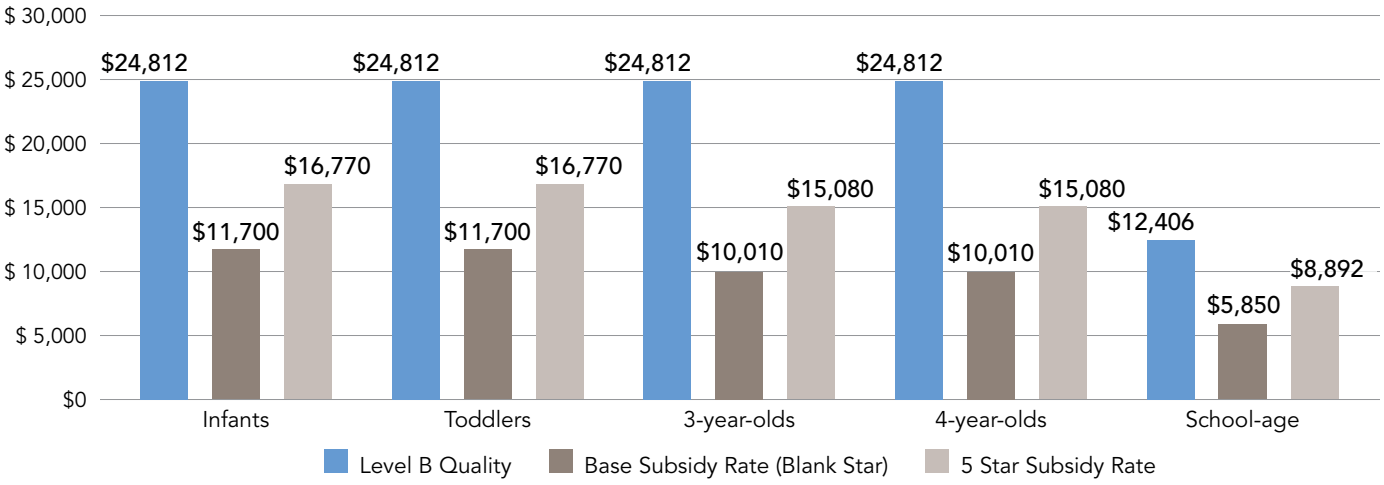
Increasing wages to the MIT Living Wage level increases the cost of care to $22,419 per child, which is $10,719 more than the subsidy rate for an infant or toddler and $12,139 more than the subsidy for a three- or four-year-old.

Figure 10: Comparison between cost of care and subsidy rate, MIT Living Wage salaries, licensed level, small family child care home



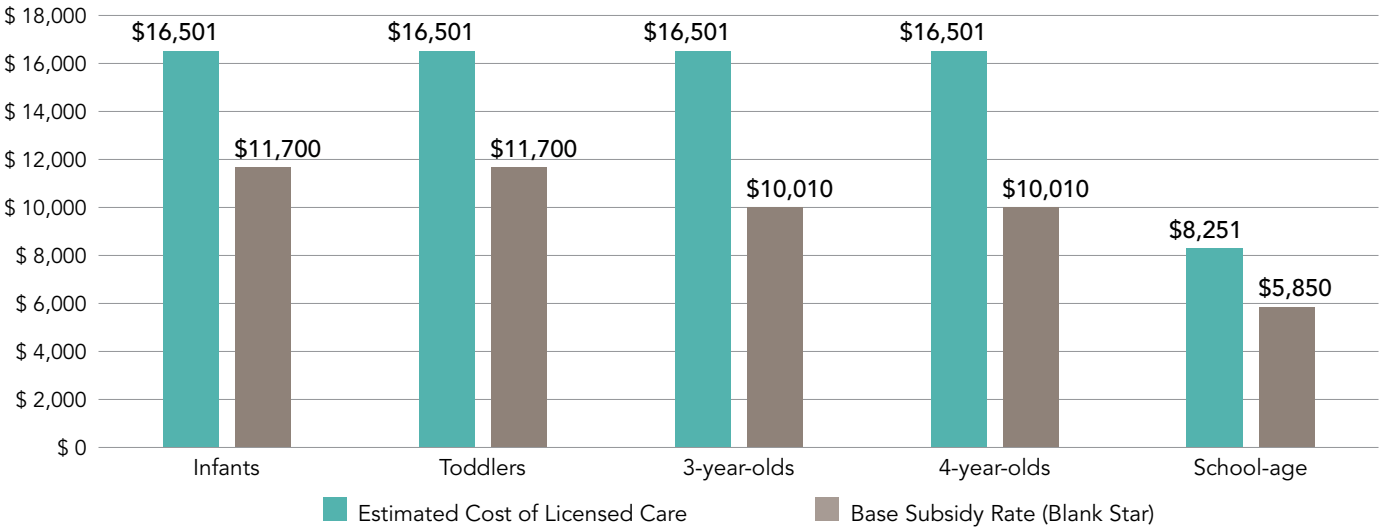
These gaps are even more pronounced at higher levels of quality. At the "Point B" quality level, one step above Licensing, which includes lower ratios (aligned with NAEYC standards for centers) and other enhancements such as planning time for staff, with an MIT Living Wage salary, care is estimated to cost $24,812 per child, $13,112 more than the base subsidy rate for an infant or toddler and $8,042 more than the highest level of subsidy reimbursement available to 5 Star programs.

Figure 11: Comparison between estimated true cost of care and subsidy rates, MIT Living Wage, Level B, small family child care home



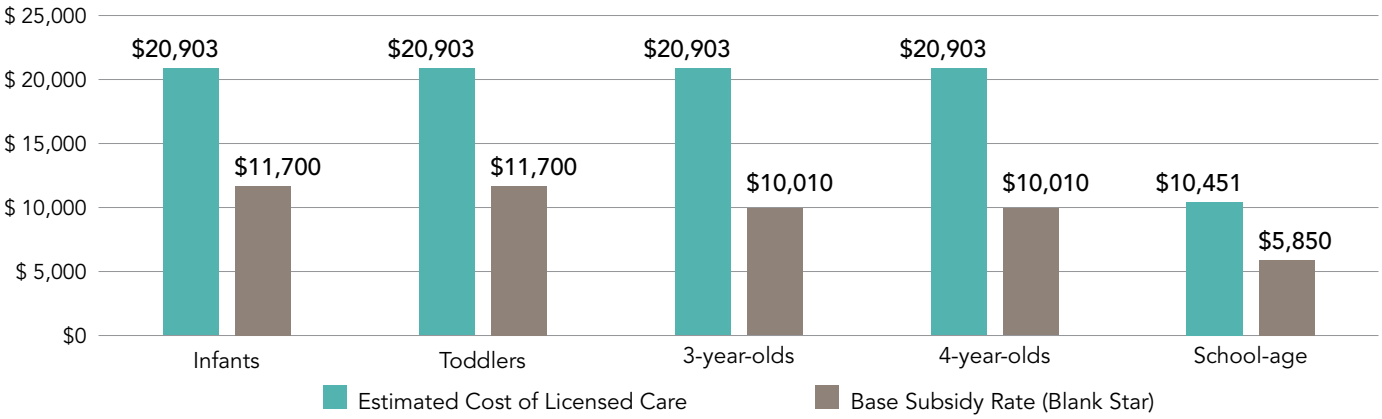
Similarly, in a group child care home, the cost of providing full-time care for a child under five at the licensing level and with current salaries is estimated to be $16,501, which is $4,801 per year more than the subsidy rate for an infant or toddlers, and $6,491 more than the rate for a three- or four-year-old.

Figure 12: Comparison between estimated current cost of care and subsidy rate, BLS salaries, licensed level, group child care home



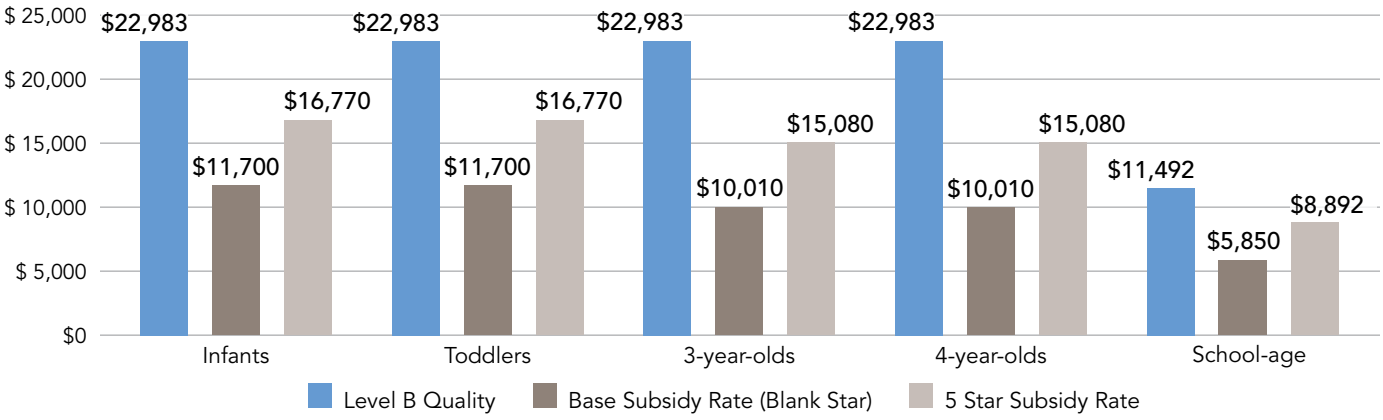
Increasing wages to the MIT Living Wage level increases the per-child cost of care to $20,903, more than $9,200 more than the annual subsidy rate for an infant and toddler, and $10,983 more than the rate for a three- or four-year-old.

Figure 13: Comparison between cost of care and subsidy rate, MIT Living Wage salaries, licensed level, group child care home



A group home at the "Point B" quality level, one step above Licensing, and the MIT Living Wage salary level is estimated to cost $22,983 per child, roughly twice as much as the base subsidy rate and more than $6,200 more than the highest level of subsidy reimbursement available to 5 Star programs for infants and toddlers.

Figure 14: Comparison between estimated true cost of care and subsidy rates, MIT Living Wage, Level B, group child care home



Modeling the Cost Per Child in License Exempt-Based Care

Michigan allows unlicensed providers to care for up to six children who are related to the provider or whose care is being provided in the child's home. License-exempt providers must be at least 18 years old and must complete a background check and certain health and safety trainings. License-exempt providers are eligible for family, friend, and neighbor child care subsidies and can receive a higher level of reimbursement if they complete an additional 10 hours of training.

P5FS modified the family child care model to estimate the cost of care for license-exempt providers at both the minimum level of operations and with the additional 10 hours of training to receive the higher subsidy rate. The model assumes three children are enrolled, reflecting that most providers do not serve the maximum of six allowed. License-exempt providers are not held to licensing standards and are not required to obtain specific education or credentials. The model therefore includes compensation for the provider aligned with BLS salary data and includes health insurance and paid time off.

With these assumptions, the estimated cost of care per child at the base level is $29,066 and at level 2 is $29,191, reflecting the cost of coverage for the provider to complete the additional training. The current subsidy rates are $5,980 at the base level funding and $10,140 at level 2 funding. As such, the model illustrates the significant impact the level 2 payment rate can have on providers, who see a gap of over $23,000 per child between cost and subsidy at the base level, or $19,000 at level 2.

Figure 15: Comparison between estimated cost of care and subsidy rate, license-exempt provider, base level

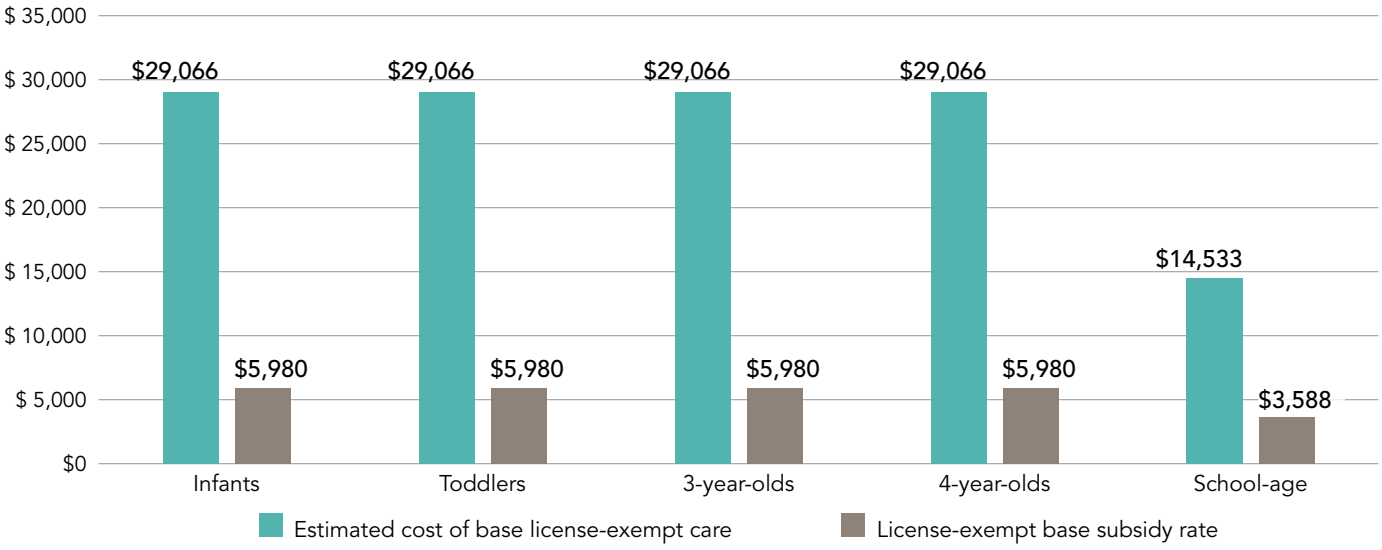
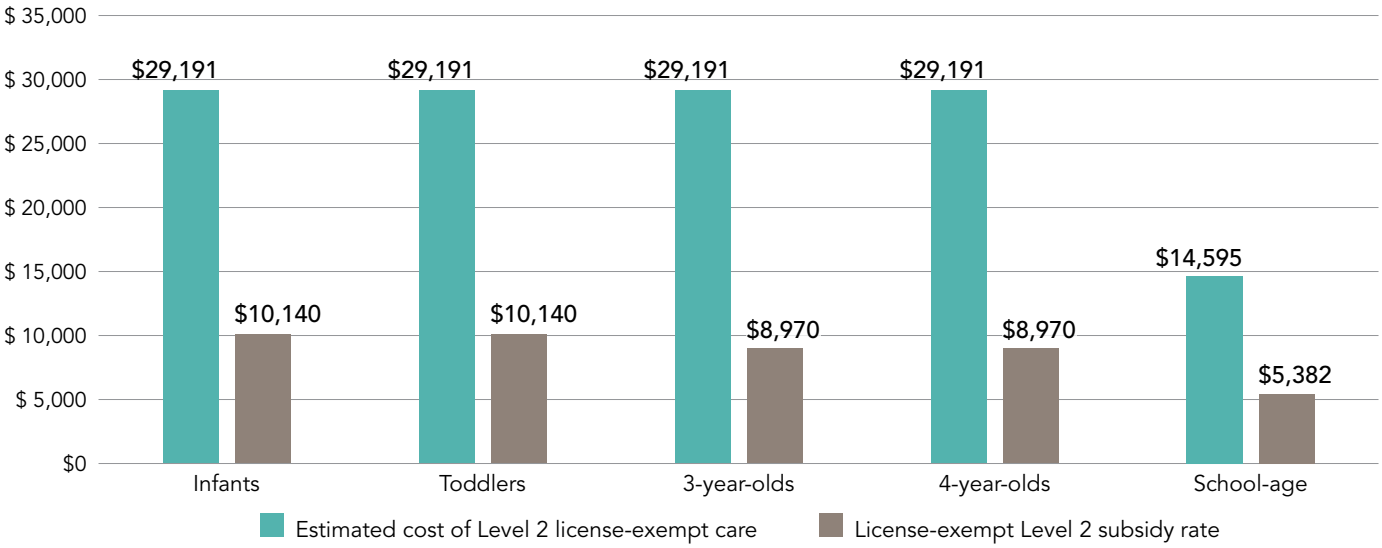


Figure 16: Comparison between estimated cost of care and subsidy rate, license-exempt provider, Level 2



Estimating the Statewide True Cost of Child Care

Through discussion with the Work Group, scenarios were developed in the cost models to determine the true cost of child care aligned with the fiscal principles, and further discussions focused on the population to be served and the level of need for different services. To promote an integrated prenatal to five system that is fair to all the providers within the system, the scenarios developed with the Work Group use the living wage salaries for both child care and home visiting cost model outputs. In this way, all direct service scenario results presented reflect both child care and home visiting staff receiving at least a living wage, along with full compensation of salary and discretionary benefits.

The child care scenario assumes a center-based program serving children from birth through school age, with a typical program size reflected in a capacity of between 78 and 126, depending on the ratios and group size selections. For family child care, the small home is assumed to serve between four and seven children, depending on the quality level selected, with the group home serving between eight and 14. Scenarios were run based on a program meeting licensing regulations and with additional quality enhancements at Point B and Point C. In all scenarios, the MIT Living Wage salary selection was used. Table 7 details the annual cost per child results under each of these scenarios, for the different settings.

Table 7: Cost per child results used in cost estimate

		Licensing	Point B	Point C
Child Care Center	**Infant**	$26,060	$30,414	$36,050
	Toddler	$26,060	$28,828	$36,050
	3–4-year-old	$19,060	$22,771	$29,133
	4–5-year-old	$16,805	$21,230	$29,520
Small Family Child Care		$22,419	$24,812	$30,548
Group Child Care		$20,903	$22,983	$28,200
License-Exempt		$29,066	$29,191	N/A

To estimate the cost to meet the child care needs of working families with young children in Michigan, a system-level analysis was completed. This model integrates the cost per child data shown in Table 7 and provides estimates based on the number of children to be served and the setting in which they will be served. For the purposes of this analysis, the cost estimate is based on providing access to child care for all children in working families at or below 200% of the federal poverty level. For a family of four this equates to an annual income of $55,500 in 2022. Based on data from Kids Count in Michigan, an estimated 139,599 children under six are in working families.[75]

This estimate assumes the current distribution of children by setting would remain in an expanded system, with just under 60% of this capacity in centers, 8% in small family child care homes, 16% in group child care homes, and the remaining 16% in license-exempt care.

As the quality levels in the cost model do not align directly with the current state quality rating and improvement system (QRIS), the study team compared the QRIS requirements to the enhancements include in the model and estimated the percentage of children who would be served in the programs meeting the different levels. Of note, the state QRIS was under active revision during the CFA project and roll-out of the new QRIS was pushed into 2023. For children in centers or licensed family child care programs, it is estimated that 75% would be in programs at the licensed level, 15% at Point B, and 10% at Point C. For children in license-exempt programs, 75% are at the base level and 25% at Point B. There are an additional 90,462 school aged children under 200% of the poverty level.

Based on these estimates, Table 8 provides the distribution of children to be served under this cost estimate by program setting, and quality level.

Table 8: Assumptions of children served, by child care setting, and quality level

	Center	Small FCC	Group	License-exempt	Total
Licensed	101,981	14,238	26,844	29,483	**172,546**
Point B	20,396	2,848	5,369	9,828	**38,441**
Point C	13,597	1,898	3,579	N/A	**19,074**
TOTAL	**135,975**	**18,984**	**35,792**	**39,311**	**230,061**

Beyond the cost of providing direct service, the systemwide analysis also includes the cost of infrastructure to support the delivery of this direct service. This is included at 10% of the direct service cost and is intended to cover costs of regulating and monitoring child care programs, providing professional development, and administering the subsidy program. Table 9 summarizes the statewide cost of child care under this scenario with assumptions detailed above.

Table 9: Estimated annual statewide true cost of child care in Michigan

	Annual Amount
Statewide annual cost	$2,920,885,957
System infrastructure	$292,088,596
TOTAL COST	**$3,212,974,553**

Home Visiting

Home visiting fiscal modeling has a unique role in understanding the costs of many types of home visiting, implemented together in a community or state. Modeling provides key information to shift away from competition for funding between programs and toward a system, or array, of care delivered through multiple programs, supported and available to meet diverse needs. A fiscal model of multiple programs reinforces the fundamental understanding that there is not one home visiting model that will meet the needs of every family, community or need profile—a complement of programs is necessary for every community. Fiscal modeling can support assessment and planning for the community or state, efforts to ensure adequate financing based on the actual cost of programs, and a shared advocacy strategy across programs. This section of the report details the methodology and assumptions embedded in the home visiting cost model and presents a sample of results, along with an analysis of these results.

Input from Home Visiting Providers

In partnership with the Home Visiting Leadership Team, P5FS facilitated four virtual input sessions for home visiting program staff, hosted by the statewide Home Visiting Advisory group, MDHHS's Local Implementing Agencies grantees, the Maternal Infant Health Program, and the Michigan Public Health Institute (MPHI). Approximately 80 home visiting staff participated. During these sessions, programs had an opportunity to share major challenges and how they relate to funding and costs. They were also asked to reflect on the types of support that would be helpful if funding were available. These input sessions provided valuable insights from practitioners to complement the input from organizations on the Work Group and those entities on the statewide Home Visiting Advisory.

Additional input on home visiting program operations and expenses were gathered through a survey distributed by MPHI for Early Head Start and Parents as Teachers programs that are not funded by MIECHV. P5FS partnered with MPHI in building the survey tool to cover cost and operations information to be collected without burden to programs, while ensuring all entities had the opportunity to provide information for the cost model. Twenty programs responded to the MPHI survey and provided their expense and operations details and sources of funding, uses of funds, and salary levels for staff. Eleven agencies funded by MIECHV also participated in a cost analysis conducted by the University of Michigan's Child Health Evaluation and Resource Center, from which data were referenced as part of finalizing the cost model inputs.

By far the biggest challenge facing home visiting programs across the state is **inadequate salaries for**

staff. This was identified as a top challenge by 26% of participants. Some programs (10%) also identified a lack of competitive benefits. This leads to difficulty recruiting qualified home visitors and high rates of turnover. Staff turnover was identified as a challenge by 18% of participants. They noted that high turnover imposes additional costs on programs as they constantly invest in training new staff members.

> "We primarily hire nurses and social workers, and we compete with large systems that are out-pricing us." —*Nurse Family Partnership program in Kent County*

> "As parent leaders who received home visiting services, competitive pay to retain great home visitors is so important. Families suffer when turnover rate for home visitors is high and they have to change home visitors frequently." —*Parent leader, Home Visiting Advisory*

> "We have a very small increase from a Bachelor's level to a Master's level of education, $1,000 to $2,000 a year, which [makes it] incredibly difficult to keep and attract staff." —*Healthy Families America program, Grand Rapids*

> "We contract with home visitors and offer pay per visit. It doesn't cover documentation or travel time. It's really hard to hire appropriately qualified staff when that's all we can offer. I would like to bring people on in a salaried role with benefits." —*Maternal Infant Health Program in the Upper Peninsula*

A smaller number of participants (11%) shared that they are part of larger health systems or local governments and are therefore able to pay **competitive wages and benefits**. However, they do so by supplementing their state funding with local or private dollars, and they worry about the sustainability of those supplemental funding sources.

> "We offer competitive wages and benefits, but HFA funding is flat every year so we have to put more and more local dollars in to keep the program going." —*Healthy Families America program, Health District 10*

> "We're part of a large health care system, which is the only way we're able to attract talent and provide competitive wages and benefits. [We take a] huge financial loss in our MIHP budget each year—the reimbursement rate is so low for the visits, there's added admin-type work that's not reimbursed. It's not financially possible to even break even." —*Maternal Infant Health Program that serves 6 counties including Wayne and Macomb*

> "I'm always worried we'll get cut. We have had support from our administration, but I don't know if that will change with a new board coming in." —*Maternal Infant Health Program, Ottawa County*

Sixteen percent of respondents said that they either use **administrative support staff** or they need it but cannot afford it. Some programs shared administrative support staff with other programs in their area, such as Early On, school districts, or health care systems. Support with documentation and insurance billing were highlighted as tasks needing administrative support. Some programs noted that the paperwork burden contributes to staff burnout and turnover.

> "I can't see how one can run a quality MIHP program unless you have people in office, which isn't covered. We have more than 200 clients. We need an assistant, data entry, and QA person. I sacrifice salary as coordinator and owner to make it happen." —*MIHP program, four counties including Wayne and Macomb*

"Paperwork is a reason we have lost people to private practice. One way to reduce some of the burden in some way [could be] case managers to manage resources or something. CMHs require so much paperwork for funders—Fed, State and local."

—Home Visiting Advisory member

Fifteen percent of respondents identified **translation, interpretation, and bilingual staff** as a key need for their programs. In some areas, there are several languages spoken, making it difficult to rely only on bilingual staff members. Translation and interpretation services that charge by the minute can be very costly.

"We have a huge line item in our budget for interpreters. 25% [of our families] are non English speaking, many refugees—we have to hire interpreters for harder to find languages."

—Home Visiting Advisory member, Kent County

"Home visits are typically longer for interpretation cases too… It's pretty much impossible to find staff that speak all the languages we serve. In FY22 we have served families who speak 16 different languages. We also have Spanish and Nepali speaking staff employed, so we are able to do 3 of 16 languages without interpreters."

—Healthy Families America program, Kent County

Programs in rural areas also reported specific challenges: **mileage and transportation reimbursement** are significant costs for their programs. Not only do home visitors have to travel long distances for visits, but they may also have to travel to drop off materials and to attend trainings or collaborative meetings with partners. Programs in rural areas often prefer to assign smaller caseloads to their home visitors because of the increased time required to travel between visits. In some cases, programs in all parts of the state also take into consideration the intensity of the family's need when assigning caseloads.

"[We spend] $100,000 per year just for traveling across our 10 rural counties. It eats into the cost of the visit." *—Maternal Infant Health program, District 10 (Northern Michigan)*

"Some regions are more spread out than others, we have to factor in the time to get there. It's not uncommon to travel 1–2 hours round trip, so we have smaller caseloads. FFPSA caseloads will be smaller because the families are complex. We could go as low as 5 families."

"Our caseload is smaller because we're rural. We have higher travel costs as well. We do a max of 16 with a weight of 24, which is lower than HFA national." *—Healthy Families America program, central Michigan*

Modeling the Cost of Home Visiting

The Michigan home visiting direct service cost model is designed to support communities and the state in considering the multiple program models needed to serve their unique population of children and families. From this holistic vantage point, the cost model will produce an output that incorporates all the program models selected, drawing unique service model data and expense details to inform that output. The program models included in the 2022 Michigan home visiting cost model are:

- Early Head Start Home-based
- Family Spirit
- Healthy Families America (HFA)
- Infant Mental Health
- Maternal-Infant Health Program (MIHP)
- Nurse Family Partnership (NFP)
- Parents as Teachers (PAT)
- Play and Learning Strategies (PALS)

The Michigan home visiting cost model is built to model ongoing operational costs of the programs, not the costs related to start up of a program. To use the model, one selects all the program models to be included in their desired scenario and the number of children or families served by each HV model. The selection of program models draws upon program specifics related to the operations of each model. These specifics of operating a given model, such as home visitor caseload, ratio of staff to supervisor, and number of group services, are driven by program standards from the national service office for each model, as applicable.

Program Characteristics

Different home visiting models have many variances in program characteristics, or what is referred to as their program model. These variances are established by the model, often at the model purveyor level:

- Services to children and families: caseload capacity of the home visitor or parent educator, frequency of points of connect, duration of services, one-on-one activities and/or group services
- Staffing and management: caseload of home visiting staff to a program supervisor, reflective supervision approach and frequency, supervisor to program manager/director ratio
- Quality supports and infrastructure: ongoing training requirements, credentialing or national accreditation, affiliation roles and responsibilities.

While many program characteristics found across the home visiting models are established at the model purveyor level, there may be some characteristics with flexibility in local implementation, such as caseload size. A model may allow for a range of families to be served and allow local programs to make a determination on their caseload within those parameters. The default data for these program characteristics are the model purveyor requirements. However, the Michigan home visiting cost model allows for the user to select a smaller caseload for a higher-intensity service, based on feedback that programs prefer to assign smaller caseloads because of travel distances in rural areas or higher needs for families with certain characteristics. These options within the model are demonstrated in Table 10, referred to as Reduced Caseload 1 and Reduced Caseload 2 options. (Note that caseloads reflect the number of families a home visitor can serve in one year, which may be more than one family in the same slot for programs with shorter durations.) The expenses related to delivering these program characteristics were informed by data collection with models funded by all the public and private sources supporting the delivery of home visiting in Michigan.

Home Visiting Costs Per Child/Family

Home visiting costs per child or family, depending on who is considered "enrolled" in the service, are largely driven by the intensity of the service and staff compensation. Some models, such as Infant Mental Health, are designed to provide more intensive services with more frequent visits and smaller caseloads per home visitors. Others, such as Play and Learning Strategies, are less intensive and provide fewer visits over a shorter duration, allowing home visitors to serve more families over a year.

Home visiting is a labor-intensive service, and the salaries and benefits provided to staff members are important drivers of cost. Current salaries for home visitors were modeled by the BLS category "Community and Social Service Specialists, All Other," which has an average salary of $43,080 in Michigan. Survey data collected by the Michigan Public Health Institute (MPHI) confirmed that

Table 10: Caseload values by home visiting program type, varying intensity

	Established Model Caseloads		Reduced Caseload 1		Reduced Caseload 2	
	Children/ families per HV	HV per Supervisor	Children/ families per HV	HV per Supervisor	Children/ families per HV	HV per Supervisor
Early Head Start Home Based	12	8	10	7	8	6
Family Spirit	25	5	20	5	18	4
Healthy Families	20	6	16	5	12	4
Infant Mental Health	22	6	12	6	10	5
Maternal Infant Health Program	75	6	69	6	60	5
Nurse Family Partnership	25	8	20	6	15	5
Parents As Teachers	25	12	20	10	18	8
Play and Learning Strategies (PALS) — Infant	75	12	60	10	28	4

this salary range was similar to current full-time equivalent salaries for Early Head Start home visitors and Parents as Teachers parent educators.[ix] Clinical home visitors were assigned the BLS value for a Licensed Practical Nurse (LPN) in Michigan, $54,090, while nurse home visitors were assigned a salary at the midpoint of LPN and Registered Nurse (RN) salaries, $65,010. Program supervisors were assigned a 22% salary increase from home visitors, which mirrors the salary increase for child care teachers to supervisors. Administrative support staff were assigned the BLS salary for office administrative support, $39,720, which mirrors the administrative support staff salaries in the child care model.

Stakeholders felt strongly that current salaries are insufficient to attract and retain a qualified home visiting workforce. Low salaries and a lack of benefits mean that programs have trouble filling vacancies and face high turnover, which has practical costs as well as undermining trust and relationship-building with families. Stakeholders also expressed a desire for shared compensation standards across the early childhood field. The home visiting cost model therefore also incorporates the MIT Living Wage scale. The entry-level position, administrative support, is assigned a baseline living wage of $39,884 and other positions are increased from there to reflect additional qualifications and responsibilities. Under this model, home visitors are assigned an annual salary of $51,849; clinical home visitors were assigned a salary of $65,330; and nurse home visitors are assigned an annual salary of $78,396. Table 11 delineates salary by position, for current (BLS) salaries and MIT Living Wage salaries.

[ix] According to survey data, Early Head Start home visitors earned an average full-time equivalent salary of $41,700 and Parents as Teachers parent educators earned an average full-time equivalent salary of $39,369. Michigan Public Health Institute survey data shared with Prenatal to Five Fiscal Strategies, 2022.

Table 11: Home Visiting Staff salaries, by salary type

	BLS Salaries	MIT Living Wage
Program Manager	$64,120	$77,172
Program Supervisor	$52,558	$63,256
Home Visitor	$43,080	$51,849
Nurse Home Visitor	$65,010	$78,396
Clinical Home Visitor	$54,090	$65,330
Administrative Support	$39,720	$39,884
Parent Educator	$43,080	$51,849

Modeling the Cost of Home Visiting Services

The current funding of the home visiting system is not sufficient to cover the program costs at these current estimated salary levels. Across all models, Michigan's home visiting programs served 21,496 families in FY 21 with $40.4 million in funding,[76] for an average payment of $1,881 per family. With BLS salaries, the home visiting cost model estimates an average cost per slot of $2,118. To find this average cost, the model was run with a mix of families that mirrors the number of families served by each model in Michigan in FY21.

The gap between the per-family served spending and the per-slot average cost demonstrates that home visiting services are underfunded at even minimum salaries. Programs cope with these low funding levels by paying their staff less than the BLS salary levels; staff working more hours per week than compensated for; subsidizing their home visiting programs through cost sharing across other parts of their organization; raising private funds from other sources; or some combination of these strategies.

Home visiting programs have variances in their cost per child/family served based on the program model. Variances in caseload size, term of the program services, and staff qualification requirements are key cost drivers. The cost per child/family values shared herein are averages across the models implemented in Michigan. Understanding the range of costs is important to fully understand the cost of home visiting services as the total cost of home visiting will change if more families are served by models that have a higher cost per service. In many instances, it is appropriate for states to focus on increasing service capacity with the more intense, and more expensive, home visiting models, as these models have a proven positive impact on at-risk family situations. (More on estimating the total cost of home visiting investment and the interplay with models selected based on family need is discussed in the section on the total true cost of home visiting.) Under BLS minimum salaries, the range of home visiting costs in Michigan is approximately $1,400 at the lowest intensity service model, $4,600 for intense services, and $5,900 annually for the most service intense model. This range of home visiting costs, compared to an average across the models, based on current service numbers, demonstrates how much the cost of home visiting models varies and how much the needed investment for a state is determined by how many families are served and by which model.

Running the model with MIT Living Wage pay scale and services matching the FY21 service numbers (21,496), increases the average cost per child/family to $2,436, or 30% higher than current funding levels. Again, the variance in actual cost per home visiting model is important in understanding overall cost. This variance is reinforced to be clear that the goal with a continuum of home visiting models is not to select the least expensive model but to understand which models will best meet the needs of

Table 12: Average cost per home visiting service, by model intensity

Salary Point	Low Intensity	Medium Intensity	High Intensity
BLS minimum	$1,428	$4,625	$5,942
MIT Living Wage	$1,626	$5,349	$6,966

the population of families they are designed to serve and the cost associated with this service delivery.

Running the model with smaller caseloads for higher-intensity services increases the cost further. Smaller caseloads may lead to higher-quality services for families with more intensive needs and may help to reduce home visitors' burnout and turnover. Smaller caseloads are particularly helpful in rural areas where the travel time between visits can be significant.

Table 13: Average cost per home visiting service, by model intensity, with improved caseload sizes and MIT living wage

	Low Intensity	Medium Intensity	High Intensity
Established Model Caseloads	$1,626	$5,349	$6,966
Reduced Caseload 1 (~20% smaller)	$1,879	$6,799	$9,860
Reduced Caseload 2 (~30% smaller)	$3,340	$8,394	$12,612

Home Visiting System

Home visiting services in Michigan are provided by a decentralized group of agencies, receiving funding from various sources. Currently, Michigan invests about $5.2 million in home visiting system supports, including consultation support and monitoring to home visiting grantees by state agencies and evaluation, training, and professional development provided by the Michigan Public Health Institute. This investment represents about 10% of the state's total home visiting funding.

Supporting a more robust home visiting system requires investing in the capacity of state agencies and their partners to fulfill various functions of a comprehensive system:

- Governance and administration
- Financing strategies and funding mechanisms
- Assessment and planning
- Continuous quality improvement, implementation, and evaluation
- Professional development, training, and technical assistance
- Monitoring and accountability

A more robust system investment could include activities such as more extensive data coordination and management; standardization of onboarding, training, and quality standards across models and funding sources; and state-level investment into family supports such as coordinated outreach and enrollment. Investment in system-wide education, awareness building and outreach could help to in-

crease the uptake of home visiting: some stakeholders shared that families are sometimes reluctant to invite visitors into their homes before building a relationship or because of perceived stigma associated with the programs. Funding system-wide and program level outreach activities could help grow awareness of the programs, support building trust in the programs by families and educate potential families on the benefits of home visiting before asking the family to commit to the program.

Other home visiting systems have created coordinating bodies to spearhead this system-level work. For example, the Los Angeles Best Babies Network convenes and coordinates the Los Angeles County Perinatal and Early Childhood Home Visiting Consortium, which provides training, technical assistance, data management, continuous quality improvement, communications management, and standardization within models and across all funding sources.[77] A model like this would require more dedicated staff and investment in technical tools.

In consultation with the Home Visiting Leadership team, made up of representatives from state agencies that administer home visiting grants, the CFA team decided to model this investment as a percentage of home visiting dollars being directed toward system investments. This builds on the work that Michigan has already done to support coordinated training and support and provides flexibility for stakeholders to identify the highest-impact uses of future system investments. As home visiting investments increase, this analysis estimates that keeping system investments at 10% of the total spending would allow these structural improvements to grow along with direct services.

Estimating the Statewide True Cost of Home Visiting

Research demonstrates that all families of young children may benefit from home visiting services, yet not all types of home visiting will meet the need of every family.[78] With home visiting, there is an array of types of programs and intensity in services, which have different costs per child served. To understand need for home visiting, the population of families of young children needs to be broken down according to strata driven by high need or at-risk characteristics, reflective of the populations in the state. As a rule, population-wide stratification of need seeks to sort the population into high, moderate and low risk, according to population characteristics.

Michigan has a high proportion of births at or below the federal poverty line, approximately 20%. An additional 28% of children under 5 years of age are in families who live just above the FPL, between 100 and 200% of federal poverty. Clearly family income is not the only driver of need, yet data demonstrate that income overlaps with other risk factors, including lack of access to prenatal and ongoing health care, lack of access to stable housing and basic needs, higher rates of substance abuse disorders and higher involvement with the child welfare system. When the rates of families of young children in poverty are high, these can serve as the first stratification for the highest need category, given the value encompasses such a large number of families with infants. Depending on the birth rate in a given year, these income percentages for families in Michigan reflect up to 20,000 families in poverty or deep poverty, and an additional 28,000 families of young children living between 100 and 200% of poverty. That is nearly 50,000 families in just one year who present farthest from opportunities, thus the population that home visiting seeks to partner with. This stratification data demonstrate that the greatest-need population is more than double the current home visiting services funded in the state. This data stratification informs estimating the total cost of home visiting in two ways:

- There is a need to increase the amount of home visiting services available in Michigan to reach more families with the service; and,
- There is a need to match the intensity of the home visiting model to the need of the families, therefore the additional home visiting services funded need to be at higher intensity, therefore higher cost per child/family.

An additional key consideration this data stratification points to is the need to retain the current home visiting services in the state. Therefore, addressing the current underfunding of the services is another element of understanding the total true cost of home visiting. The current home visiting services need to be invested in at a cost reflective of wages that will not only retain staff but also attract new and qualified staff to work in these programs. The staff-family relationship is the critical space in which all home visiting impact occurs for families of young children. While this report does not advocate for any particular funding stream, it is important to note that many home visiting programs rely on Medicaid as their primary funding source and would therefore need an increase in Medicaid reimbursement rates to be able to raise salaries.

With this information, two scenarios were developed and run in the home visiting system cost model to model the true cost of home visiting in Michigan. The home visiting system model tool allows for addressing the type of home visiting services offered, intensity of the home visiting model, and the population served. This system modeling tool uses cost per child values from the home visiting direct service cost model to inform the cost per child values for the services.

The first scenario includes all current home visiting models in place in the state, with staff moved to MIT Living Wage salaries, and current caseload intensity in line with the program model. Under this scenario, the cost of home visiting is $52.5 million, requiring an increase in the investment in home visiting services of $5.6 million. The purpose of this scenario is to demonstrate the investment needed to address the compensation issue within the home visiting field.

The second scenario includes the delivery of all current home visiting programs, with MIT Living Wage as the salary selection, and current caseload intensity in line with the program model, but also increases the service capacity. Thus this scenario demonstrates not only the cost to increase home visit staff compensation but also to increase the number of children/families served by home visiting. Additionally, this second scenario increases the number of home visiting services by models that are medium-intensity and high-intensity levels and costs. This scenario is designed to address the fact that nearly 50,000 families of young children in Michigan are in the highest-need strata, therefore more intensive services are needed. Each of these scenarios includes maintaining the home visiting system investment, at 10%, as is the current percentage of the home visiting direct service costs.

Table 14: Comparison of Home Visiting Cost Scenarios

	Scenario One	Scenario Two
Total Families Served/Slots	21,496 families served	40,713 slots 47,634 families
Home Visiting Direct Service Costs	$52,617,261	$273,626,194
Home Visiting System Costs	$5,261,726	$27,362,619
TOTAL HV Costs	**$57,878,987**	**$300,988,813**

The second scenario, with increased home visiting services, is based on number of slots, versus families served. Scenario one, which reflects only increased compensation, reflects the cost for most recent service numbers, 21,496. In scenario two, the number of slots would equate to about 47,634 families served in a year, as there are many instances where more than one family is served in a year by a given slot.

At this time more intense caseloads were not modeled. A comparison of the cost per child with current caseload requirements and smaller caseloads has already demonstrated a significant increase in the cost per child/family with smaller caseloads (25-30% increase in cost per slot).

Overall Cost Estimate

Table 15 details the estimated annual cost of providing the level of service detailed in the assumptions above. As shown, the total cost is estimated at just over $3.5 billion, with child care accounting for over 90% of this total. The fiscal mapping analysis found that current revenues supporting the prenatal to five system in Michigan total around $1.2 billion, leaving a significant shortfall to meet the goals set out in this comprehensive fiscal analysis.

Table 15: Total system-wide cost estimate

	Statewide Annual Cost
Child Care	$3,212,974,553
Home Visiting	$300,988,813
GRAND TOTAL	**$3,513,963,366**



VI. Findings and Recommendations

As a result of this analysis, and with input from the CFA Work Group, several recommendations have been developed for the Michigan prenatal to five system. These recommendations are intended to stabilize the system as it continues to navigate the impact of the COVID-19 pandemic as well as lay the long-term foundation for the future system envisioned in the vision and principles discussed in Section III.

The recommendations fall into three broad categories, focused on ensuring that the prenatal to five system (1) maximizes existing funding, (2) makes decisions informed by a full understanding of the true cost of care, and (3) invests in the necessary infrastructure to support a sustainable system. With these recommendations, the prenatal to five system can more fully meet the needs of every child and family. This section presents the major findings of the study and the rationale that supports each recommendation shown in Table 16.

Table 16: Summary of CFA Recommendations

Recommendations	
Maximize existing funding sources	Align eligibility requirements for CDC child care subsidies with family needs by revising the requirement that custodial parents obtain child support on behalf of the children for whom they receive assistance or seek an exception.
	Review Medicaid billing practices to identify eligible services provided by other home visiting models to better leverage federal funding. Review rates for preventative and early childhood wellness services to ensure that they reflect the true cost of quality services and all elements of the service model.
	Provide a range of possible GSRP allocations to school districts in the spring, based on proposed budgets, to allow them to plan for a range of scenarios. Consider shifting GSRP funding to a prior-year budget cycle so that GSRP slots can be allocated a year in advance to allow school districts to plan with greater confidence.
Use the true cost of services to inform future investments	Prioritize increased provider salaries and benefits when setting child care subsidy and home visiting contract rates. Move toward a standard of a living wage with benefits across the early childhood field. Update cost model scenarios on an ongoing basis to reflect changing costs and needs in Michigan.
	Seek federal approval to set CCDF subsidy rates based on an alternative methodology using a cost estimation model rather than a market rate survey. Engage child care providers and other stakeholders to ensure that they understand this change and have an opportunity to contribute information to the cost model.
	Significantly increase public investment in child care and home visiting to close the gap between current investments and the overall investment needed. Develop a multi-year plan for increased investments, prioritizing children and families most in need of support.
Invest in coordination of services and systems	Home visiting leaders across Michigan should consider strategic priorities for the growth of the home visiting system through the development of a shared leadership approach.
	Fund community-level systems coordination equitably and sufficiently across the state.

Recommendation 1:
Maximize existing funding sources

The comprehensive fiscal analysis considered current barriers to efficient use of funds, as well as future funding needs. The fiscal map analysis identified some areas where existing sources of funding can be utilized more fully. While these areas are not sufficient to address the major gaps between current funding and the true cost of quality services and infrastructure, they nonetheless affect families' and providers' experiences. Addressing

these barriers can increase the effectiveness of current funding sources and lay the foundation for future investments. These identified opportunities to ensure maximum use of funding include family uptake of child care subsidies, use of Medicaid funds for home visiting services, and school districts' ability to properly plan for and staff additional GSRP classrooms.

A. Child Development and Care subsidy eligibility requirements: Child care providers and advocates who work with families report that many families are reluctant to apply for CDC child care subsidies due to the requirement that single parents pursue child support from the non-custodial parent.[79] Families experience this requirement as punitive and are reluctant to put their current or former partner at risk of financial sanctions or criminal prosecution. This requirement is not federally driven, thus Michigan has the opportunity to adjust its approach to implementing child care subsidy funding to better meet family needs.

> **Recommendation:** Align eligibility requirements for CDC child care subsidies with family needs by revising the requirement that custodial parents either obtain child support on behalf of the children for whom they receive assistance or seek an exception to this family requirement.

B. Medicaid funding for home visiting: Medicaid supports some home visiting activities, such as Infant Mental Health Home Visiting and the Maternal Infant Health Program. However, other home visiting models may also provide services that are eligible for Medicaid funding. Additionally, Medicaid rates are currently not sufficient to support the full scope of work that goes along with quality home visiting services, which requires agencies that rely on Medicaid funding to subsidize their work with other sources of funding. This is particularly difficult for smaller and nonprofit agencies that have fewer alternative sources of funds.

> **Recommendation:** Review Medicaid billing practices to identify eligible services provided by other home visiting models to better leverage federal funding. Review rates for preventative and early childhood wellness services to ensure that they reflect the true cost of quality services and all elements of the service model.

C. Timing of GSRP funding: The annual state budgeting cycle makes it difficult for some school districts to plan for GSRP pre-K slots for the following school year, leading to funded slots being under-utilized. Currently, school districts often do not learn their GSRP allocations until after the state's budget is finalized in the summer, after staff hiring and student enrollment have already been underway for months. This makes it difficult to create and fill GSRP slots for the beginning of the school year, which sometimes results in school districts rejecting increased allocations or being unable to enroll eligible children, thus leaving funded slots unfilled.

> **Recommendation:** Provide a range of possible GSRP allocations to school districts in the spring, based on proposed budgets, to allow them to plan for a range of scenarios. Consider shifting GSRP funding to a prior-year budget cycle so that GSRP slots can be allocated a year in advance to allow school districts to plan with greater confidence.

Recommendation 2:
Use the true cost of services to inform future investments

The fiscal models developed as part of the comprehensive fiscal analysis provide Michigan with tools to understand the cost of a prenatal to five system

that aligns with the vision and principles detailed in Section III. Current child care subsidy rates are based on a market rate survey that does not accurately identify the true cost of providing quality child care, as described above. As a result, current child care subsidy rates are insufficient to support the cost of quality care, even before considering increased compensation. Home visiting contracts and grants do not fund programs at adequate levels to pay competitive living wages. Expanding these services and continuing to support and improve quality will require reevaluating payment rates to reflect the true cost of care. However, expanding services depends on being able to recruit and retain a qualified workforce.

A. Increased workforce compensation: The most important initial step to expand quality services for young children is to address the long-standing gap between the importance of early care and education providers' work and their low compensation. Through engagement with this study, many providers reported that they are unable to operate at full capacity—meaning they are not fully enrolled—because they are unable to offer competitive wages and benefits, making it difficult to find and retain qualified staff. Growing the supply of high-quality child care slots will require aligning payment rates to the true cost of care, with that cost being inclusive of a living wage and benefits for child care providers. Without this first step, providers will be unable to meet demand for expanded services, and the quality of care will suffer as experienced providers leave the field for higher paying jobs in other sectors.

Similarly, home visiting rates are currently insufficient to offer competitive wages and benefits to qualified staff, severely limiting the reach of home visiting services. Aligning contract and grant rates to the true cost of delivering the service, including a competitive living wage with benefits, is a necessary prerequisite to expanding services to more children and families. Stakeholders were clear that they are currently unable to serve more families because they cannot hire for the vacancies they currently have, let alone for new positions, at the current salary and benefit levels.

> **Recommendation:** Prioritize increased provider salaries and benefits when setting child care subsidy and home visiting contract rates. Move toward a standard of a living wage floor plus benefits across the early childhood field. Update cost model scenarios on an ongoing basis to reflect changing costs and needs in Michigan.

B. Set subsidy reimbursement rates based on a cost estimation model rather than a market rate survey: Two states, New Mexico and Virginia, along with the District of Columbia, now set child care subsidy rates using an alternative methodology that bases child care rates on the cost of care rather than a market rate survey. This approach overcomes the limitations of the broken market for child care services by considering the actual costs of providing quality care and early learning, rather than the rates that parents can afford to pay. Moving to this approach requires federal approval as part of the state's CCDF plan, and should be combined with additional stakeholder engagement and data collection to capture the nuances of the true cost of care in different regions of the state and at different quality levels under Michigan's newly revised QRIS system.

> **Recommendation:** Use alternative rate setting to base CDC subsidy rates on the true cost of care. Engage child care providers and other stakeholders to ensure that they understand this change and have an opportunity to give input on any variations needed in rates by region, setting, age of the child, and quality levels.

C. Serving all families who need support: The current child care and home visiting systems do not serve all eligible children or all families who need these services. Stakeholders observed that many families who struggle to afford child care have incomes that fall above the income eligibility threshold for CDC subsidies. This creates continued pressure to keep prices for families low, which forces providers to underpay themselves and their staff. Similarly, home visiting services currently do not reach all families who could benefit from them.

> **Recommendation:** Significantly increase public investment in child care and home visiting to close the gap between current investments and the overall investment needed as illustrated by this analysis in order to serve all families who need support. Develop a multi-year plan for increased investments, prioritizing children and families most in need of support. Increasing the number of families who benefit from subsidies will also reduce providers' reliance on private-pay tuition, allowing them to take advantage of public funding to raise wages without over-burdening working families with unaffordable tuition prices.

Recommendation 3:
Invest in coordination of services and systems

To build an early childhood system that uses public resources wisely and efficiently, funding for direct services is not enough; systems also need investments for coordination and administration to ensure that providers are well supported and statewide systems run effectively. This includes direct funding to organizations that support families in connecting to services, as well as building system-level infrastructure, such as coordinated enrollment and eligibility determination and community information exchanges. These system-level components are sometimes treated as an afterthought, but they are crucial to families' and frontline providers' success. As one interviewee put it, "[Funders] want to pay for wood, but we need nails and glue to hold the structure together."

A. Home visiting coordination: Home visiting administrators in MDHHS, MDE, and other relevant agencies have strong informal working relationships. These entities function within a siloed funding structure across the federal and state level, which at times keeps their focus internal to their individual operations. For example, State School Aid Act funding for home visiting must be allocated to intermediate school districts, with very little funding available to support system infrastructure at the state level. This may limit the opportunity for shared activities, change that positively impacts all of home visiting or growth in the system.

> **Recommendation:** A comprehensive system across all the home visiting programs, agencies and funding sources could support efforts to expand and strengthen home visiting services. A core feature of a comprehensive system is a shared leadership approach that supports joint oversight and coordination, as appropriate and beneficial, on elements of program implementation and advocacy to expand home visiting, both the overall capacity and specific elements of the system. Funding should flexibly support these system-wide activities across models and agencies. Home visiting leaders across Michigan should consider strategic priorities for the growth of the home visiting system in the development of this shared leadership approach.

B. Community level coordination: At the community level, several types of organizations support families with navigating a complex and decentralized system of services, including:

- ***Great Start Collaboratives*** provide system-level coordination to support early learning and school readiness and facilitate collaborative projects between organizations in the community. They are often, but not always, part of the Intermediate School Districts and are present across the state, with a range of funding.
- ***Early Childhood Support Networks*** support child care providers with professional development and quality improvement activities.
- ***Family Resource Centers*** meet families' basic needs (e.g. diapers and nutrition), while helping families navigate enrollment and access other services. They are primarily private non-profits and are not available in every county.

Together, these organizations provide the "glue" that holds local systems together. The organizations report that they are bare-bones operations that supplement their state funding with other sources. Funding levels are inconsistent across the state and from year to year and state funding does not consistently reflect the community's needs, leaving these critical entities struggling to provide the level of support needed. Because these organizations operate with limited resources, they often lack the capacity to invest in more ambitious projects such as coordinated enrollment and eligibility determination, but technical support from the state could make these projects more feasible at the local level.

Recommendation: Fund community-level systems coordination equitably and sufficiently across the state. Investing in family support helps ensure that families can benefit from other services, including child care, home visiting, and pre-K. Community-level collaboration also has a track record of leveraging other funding by creating partnerships that can win grants to support innovative community projects.

VII. Conclusion

There is increasing recognition of the importance of the early years in a child's life to cognitive, social, and physical development, and in turn, lifelong success. At the same time, the professionals who care for and support young children and their families during these crucial early years continue to be undervalued and underpaid.

Unlike in K-12 education, there has historically been limited societal commitment to investing in young children's development and learning.

One of the first steps to shifting this paradigm is to understand the true cost of quality care and services for young children, including a level of compensation for providers that recognizes the importance of their contributions. This comprehensive fiscal analysis summarizes the fiscal and structural requirements to build such a system in Michigan. The cost models developed as part of this analysis are dynamic tools that can be used on an ongoing basis to estimate the cost of changes to salaries, quality enhancements, and changing costs over time. When paired with structural and policy improvements, they can be powerful tools to build the comprehensive, high-quality systems that young children and their families deserve.

Appendices

A. List of interviews conducted to inform analysis

Name	Organization
Regina Bell	Council of Michigan Foundations
Iola Brubaker	Copper County Great Start Collaborative and Family Resource Center
Lisa Brewer-Walraven	Michigan Department of Education – Child Development and Care
Christy Callahan	Early Childhood Support Networks
Lynn Cavett	Child and Adult Care Food Program
Heidi Coggins	Children Trust Michigan
Sheryl Goldberg	Michigan Association for Infant Mental Health
Noel Kelty	Michigan Department of Education
Tiffany Kostelec	Michigan Department of Health and Human Services – Home Visiting
Richard Lower	Michigan Department of Education – Office of Great Start
Mary Ludtke	Michigan Department of Health and Human Services – Infant Mental Health
Tina Jones	Michigan Department of Health and Human Services – Infant Mental Health
Mary Manner	Traverse Bay Great Start Collaborative and Resource Center
Missy Smith	Traverse Bay Great Start Collaborative and Resource Center
Tami Mannes	Ottawa Intermediate School District
Joy Milano	Michigan Department of Education
Michael Powell	Michigan Department of Education
Dan Thompson	Michigan Department of Health and Human Services – Maternal Infant Health Program
Cherie Ross	Michigan Department of Health and Human Service – Maternal Infant Health Program
Lisa Wasacz	Michigan Department of Education – Preschool Special Education
Erica Willard	Michigan Association for the Education of Young Children
Amy Zaagman	Michigan Council for Maternal and Child Health

B. Comprehensive Fiscal Analysis Work Group Members

Name	Organization
Joan Blough	Early Childhood Investment Corporation
Nichole Blum	YMCA of Kalamazoo
Heather Boswell	First Steps Kent
Lisa Brewer-Walraven	Michigan Department of Education
Synthia Britton	Michigan Department of Health and Human Services
Ashanti Bryant	IFF

Christy Callahan	Early On Foundation
Jeffrey Capizzano	Policy Equity Group
Laurie Clark-Horton	LACC Child Care Academy
Cynthia Derby	Michigan Department of Education
Madeline Elliott	Michigan's Children
Dr. Nkechy Ekere Ezeh	Early Learning Neighborhood Collaborative
Nancy Garvin	Detroit Edison Public School Academy
Sheryl Goldberg	Michigan Association for Infant Mental Health
Kim Diamond-Berry	Michigan Association for Infant Mental Health
Alicia Guevara Warren	Early Childhood Investment Corporation
Loriel Grigsby	Parent Leader
Anne Gunderson	Southeast Michigan Early Childhood Funders Collaborative
Mina Hong	Start Early
Tina Jones	Michigan Department of Health and Human Services
Tiffany Kostelec	Michigan Department of Health and Human Services
Scott Koenigsknecht	Michigan Department of Education
Mary Ludtke	Michigan Department of Health and Human Services
Tami Mannes	Ottawa Intermediate School District
Joy Milano	Michigan Department of Education
Cari O'Connor	Montcalm Area Intermediate School District Great Start
Michelle Richard	Office of Governor Gretchen Whitmer
Rachel Richards	Michigan League for Public Policy
Monique Stanton	Michigan League for Public Policy
Denise Smith	Hope Starts Here Detroit
Cara Sutliffe	Parent Leader
Janet Timbs	Michigan Department of Education
Rich VanTol	Bay Arenac Intermediate School District
Erica Willard	Michigan Association for the Education of Young Children
Amy Zaagman	Michigan Council for Maternal and Child Health

Note: Organizational affiliations are correct as of the time of interview or participation in the workgroup.

C. Home Visiting Funding by Model

Home Visiting Model	Federal total	State total	Children Trust Michigan	Total
Healthy Families America Home Visiting	$2,295,366	$4,839,210	$70,706	$7,205,282
Nurse Family Partnership Home Visiting*	$3,564,014	$7,320,758		$10,884,772
Parents as Teachers Home Visiting	$152,000	$3,700,445	$348,000	$4,200,445
Maternal Infant Health Program*	$7,045,138	$4,597,561		$11,642,699
Family Spirit Home Visiting	$798,240	$300,000		$1,098,240
Infant Mental Health*	$9,282,725	$3,513,442		$12,796,167
Play and Learning Strategies (PALS)		$117,000		$117,000

*Includes Medicaid funding from FY21, since FY22 funding amounts were not yet available due to lags in billing and reimbursement.

Note: A portion of State School Aid Act section 32p funding is distributed by local Great Start Collaboratives based on determination of local needs. These totals reflect the use of 32p grant funding for FY21 because local grant determinations for FY22 were not available at the time of publication. Data on Early Head Start funding specific to home visiting service delivery was not available. Total EHS funding is reported in Table 1.

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