Building Supply, Enhancing Quality, and Advancing Equity:

The Early Head Start-Child Care Partnership Series

POLICY RECOMMENDATIONS TO GROW EHS-CCP IN STATES

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INTRODUCTION

Children's healthy development occurs within the context of warm and secure relationships with their primary caregivers, with access to basic needs like nutritious food, quality healthcare, and stable housing, and with promotive experiences and opportunities to play and learn alongside other children. Unfortunately, millions of children in the United States do not have access to the full array of supports they need to thrive. The US child poverty rate is the highest among wealthy nations. Public systems are chronically underfunded, serving only a fraction of even the narrow group of eligible families, leaving children particularly vulnerable to food and housing insecurity, academic and mental health challenges, and intergenerational poverty. These challenges are both chronic and acute, and disproportionately affect children of color, including Black, Latine, American Indian and Alaska Native, and Asian American and Pacific Islander children. But as the pandemic revealed for many, the US is falling short of meeting the need for most children, not just some. And the trauma, grief, loss of routine and social engagement with peers and others, and extended periods of virtual connections, took their toll on millions of children and laid bare weaknesses in early care and education (ECE) and broader education systems.

Early learning experiences for young children require more than a narrow focus on care or academics. They require a holistic approach to development and wellness that includes quality care and learning, and that prioritizes children's health, mental health, and social-emotional wellness, and their families' health and wellness, including economic wellness. Any proposed solution to support our youngest learners and their families that neglects the holistic nature of development and the complex array of basic needs children and families need to flourish, will simply not result in the outcomes we hope to see from our early learning systems.

These investments are important for all children, but particularly critical for children from historically and contemporarily marginalized communities. The Children's Equity Project has published comprehensive policy agendas with actionable recommendations for Congress, federal agencies, states, and communities to address the unfairness our young learners and their families face in the ECE system. This includes policies to: address harsh discipline, which is disproportionately and unfairly applied to Black children; promote full inclusion of children with disabilities; establish equitable funding formulas; and expand access to dual language learning for emerging bilingual children, among many others. These factors must also explicitly be a part of the solution.

The US already has a holistic model to support young children that operates in nearly every zip code in the nation serving about a million children every year. The Head Start program, now has over a half century of research indicating positive outcomes across health, education, and economics, for the children and families served. Recent research has even found intergenerational effects associated with Head Start, with the children of Head Start graduates demonstrating improved outcomes, compared to their peers.

For too long, this approach to early education has been seen narrowly as a specific program targeted for children from low-income households, as opposed to as a model that can support all children, across the socioeconomic spectrum. Although

implementation varies and is not perfect, the Head Start model is a critical part of the solution to the challenges the ECE system, and by extension, young children and their families, face today. The model is worthy of replication and could be especially powerful in addressing three of the most significant challenges that face the ECE field today: **pandemic response and recovery for child care system stabilization, workforce retention, and expanded access to comprehensive services.**

One clear way that policymakers can expand access to the holistic Head Start model that supports children in the context of their families and their communities is through the Early Head Start-Child Care Partnerships (EHS-CCP). The EHS-CCP were first established in 2014 as an approach to increase access to high quality care for infants and toddlers. The model provides adequate resources to in-home and center-based licensed child care programs to establish partnerships with Head Start and boost quality by implementing the holistic Early Head Start model that includes low ratios and group sizes; credentialed, supported, and better-compensated early educators; research-based curriculum and assessment; safe and healthy physical environments, including clean water, good air quality, and safe and physically accessible structures; parent policy councils and strong parent support and engagement; and comprehensive health, nutrition, mental health services to meet the holistic needs of children and families.

Due to funding constraints, the model has yet to reach its **full potential in significantly influencing the quality of home- and center-based care. Based on actual enrollments in 2021, only approximately 32,000 infants and toddlers received high-quality services through EHS-CCPs.** This is a fraction of the more than 1.3 million children who benefited from a child care subsidy during the same period of time.

This brief discusses how EHS-CCPs can serve as a mechanism to increase access to holistic, high quality infant and toddler care for more children and families through greater state leadership. We provide concrete ways states can expand EHS-CCPs including by:

- Becoming EHS-CCP grantees
- Investing unused pandemic response funds on establishing EHS-CCPs
- Targeting CCDF quality funds to support sustained investment in quality improvement efforts aligned with the Head Start model through expansion of the EHS-CCPs
- Directing Preschool Development Birth to Five grant funding toward building and expanding EHS-CCPs

SUMMARY OF FUNDING

for EHS-CCP Grantees

In 2013, the Obama Administration's budget included a request for the creation of EHS-CCP to support states and communities in expanding the availability of early learning opportunities that meet the highest levels of quality for infants and toddlers.[1] The budget request called for $1.4 billion. Congress ultimately appropriated $500 million for the EHS expansion and this new initiative[2] and recent legislation passed by the U.S. House of Representatives Appropriations committee would keep it at that level for the next fiscal year.[3]

Over the past eight years, the U.S. Department of Health and Human Services (HHS) Administration for Children and Families (ACF) awarded 275 EHS-CCP and EHS Expansion grants in 2015: 75 new grants in 2017, 78 new grants in 2019, and 62 new awards in 2021.[4] Publicly available budget documents do not indicate how many of these grants have gone directly to foster partnerships, and how many have been used strictly for expansion.[5] The fourth round of grants awarded in March 2021 will provide Early Head Start services to 5,100 infants and toddlers and their families. HHS reports that actual enrollments in EHS-CCP in FY21 included 32,905 children in EHS-CCP slots, with an estimated slight reduction to 32,178 under the continuing resolution for FY22.

The Biden Administration has recommended a doubling of EHC-CCP with an increase of $650 million in FY23. This funding would support an additional 29,777 infants and toddlers to serve a total of 61,995 children through EHS-CCP.[6]

RESEARCH & EVALUATION

of EHS-CCPs

The research base for the Head Start model is strong and has been reinforced over nearly 60 years.[7] As summarized in the Children's Equity Project's recent brief arguing for the expansion of public preschool using the Head Start model, children and families who participate in Head Start demonstrate significant and positive academic, social, and health outcomes. Children who participate in Head Start demonstrate significant improvement in reading, math, and writing skills. Dual language learners who participate in Head Start show gains in school readiness. Families who participate in Head Start report stronger parental involvement. And compared to those children who are in non-Head Start program, the parents of children who participate in Head Start report that their children receive more dental care, have better overall health, and have greater health insurance coverage.

Whether the positive effects of Head Start can be carried into other family- and center-based settings through partnerships has been a more recent focus. Recent studies suggest that those involved in partnerships between Head Start and child care see the same positive outcomes that children and families experience who enroll in the Head Start program.

In the fall of 2013, the Office of Planning, Research and Evaluation (OPRE) in the ACF initiated a fourteen month study to review the state of the field of EHS-CCP.[8] The study included a review of the literature to summarize the knowledge base around EHS-CCP and the development of a theory-of-change model to articulate relationships between program features, characteristics, and expected outcomes of partnerships.

In all, the review included 78 studies of two or more entities working in partnership to plan and implement early care and education services. There were three categories of studies: (1) studies on partnerships between Head Start and Early Head Start grantees and child care providers; (2) studies on partnerships between school districts and early care and education providers (child care and Head Start); and (3) studies that examine other types of partnerships, such as those between home-based caregivers (licensed and legally license-exempt) to improve quality, and partnerships between early intervention and other ECE organizations to service children with disabilities and delays in inclusive environments.[9]

The review found that the primary motivation for forming partnerships was to expand services to more families or augment existing services (e.g., in the form of greater duration). Partnerships relied on a number of funding streams, but primarily relied on Head Start and Early Head Start grant funds, CCDF child care subsidies, and state/local preschool funding.

A third of studies reported on the potential or perceived benefits of forming and implementing partnerships, including improving the quality of ECE services; increasing staff credentials, knowledge, access to professional development, and increasing access to comprehensive services. Roughly half of the studies reported on barriers organizations faced in forming and sustaining partnerships, including: regulatory differences across funding streams, poor collaboration quality between organizations, discrepancies in program standards, insufficient and uncertain funding, discrepancies in teacher pay and teacher turnover, and communication issues.

A review of the literature uncovered these common barriers to creating partnerships, including poor collaboration quality among partners, regulatory differences across funding streams, discrepancies in standards (HSPSS, state preschool standards, child care licensing), insufficient or uncertain funding, or discrepancies in teacher pay and issues with teacher turnover across settings.

In recognition of the findings in the literature, HHS designed the partnerships and provided guidance to address the challenges inherent in forming partnerships between programs with varying standards, eligibility criteria, funding mechanisms, and compensation structures.[10]

The positive results are reflected in a recently released study on the EHS-CCP.[11]

Supporting Children & Families: A review of grantees found that more than 80% of child care partners offered developmental assessments and other screenings to children in partnership slots. Nearly 80% of partners offered referrals to children including medical, dental, mental health, and social service referrals. 67% offered mental health observations or assessments. Additionally, 70% of partners provided at least one service to children in non-partnership slots. Nearly all child care partners (98%) offered full–day, full-year care to children in partner slots, enabling families the stability they need to work.

Enhancing Family Engagement: 72% of child care partners developed individualized family partnership agreements with families in partnership slots to identify their parenting and self-sufficiency goals, and 86% conducted home visits with families in partnership slots. Child care partners also extended these services to some families in non-partnership slots.

Supporting the Workforce: Most child care partners participated in professional development opportunities from EHS grantees. 86% of child care partners said that grantees provided coaching or one-on-one training. Nearly all grantees offered quality monitoring activities to child care partners and used information from these activities to provide staff professional development — such as online training or workshops. 77% of child care partners reported that grantees offered their staff the opportunity to obtain a CDA credential. 37% of partner staff had the opportunity to work towards a state-awarded credential that met or exceeded CDA requirements, 26% had the opportunity to achieve an associate's degree, and 19% had the opportunity to pursue a bachelor's degree.

Providing Sufficient Funds to Advance Quality: The median amount EHS-CCP grant was $1.4 million with a median amount provided to child care partners of $7,875 per partnership slot. The most common source of funding to offset the cost of care for children in partnership slots other than EHS-CCP funds were federal or state child care subsidies and federal Child and Adult Care Food Program (CACFP) funds. Layering the funding from EHS-CCP for child care partners is significant, considering that the median rate of reimbursement for toddlers in licensed centers is $8,652.[12] This would allow child care partners receiving the median amount from EHS-CCP and CCDF to invest more than $16,000 per year for high-quality toddler care — nearly double what child care providers receive strictly through the subsidy.

THE STATE ROLE

in Advancing High-Quality Infant & Toddler Care & Services

While Head Start is a federal-to-local program, states can play a significant role in the expansion of EHS grantees and integrating the EHS model in center- and home-based child care programs. Given states' role in supporting the child care system, including administration of CCDF, states are well positioned to align policies and leverage funds to expand EHS-CCPs. States can do this by: applying to become an EHS-CCP grantee; leveraging current CCDF funding dedicated to quality improvement activities to align to the EHS model and establish or expand EHS-CCP; and obligating any remaining funds under the CCDF supplemental program from the American Rescue Plan Act for EHS-CCP.

States should apply to become EHS-CCP grantees.

States are eligible to serve as EHS and EHS-CCP grantees, in contrast to the Head Start program where states are precluded from serving as grantees. The ability for a statewide approach to improve the quality of early care and education opportunities for infants and toddlers has tremendous potential. By overseeing child care, pre-K, and EHS-CCP programs, states can create more seamless ECE systems, better align child care standards to the Head Start model, reduce red tape for families in enrollment and determination processes, and ensure that no matter what ECE door a child walks into, they will be safe, cared for, and learning in a healthy environment.

States can also use partnership slots to address access gaps in rural and underserved communities, where existing high-quality ECE supply is limited or non-existent. California, for example, is an EHS-CCP grantee and operates slots in rural communities across the state that previously lacked access to Head Start and other high quality infant and toddler care. States can also use Partnership slots to concentrate services in communities with the highest need, such as high poverty communities, that are not yet serving all eligible children through Head Start.

The opportunities for aligning policies across programs to benefit families is particularly ripe. For instance, during the past eight years, a number of providers relied on EHS-CCP funds to maintain continuity of services for children when they fell out of eligibility for federal child care assistance. However, a state would be well within its authority to ensure that continuity of services was maintained for all children involved in partnerships given their responsibility in setting policies relating to eligibility and redetermination.

In the case of Alabama, the state's Department of Human Resources operates the EHS-CCP. The agency is also responsible for monitoring and licensing child care centers and homes. Significantly, it serves as the state's CCDF administrator, responsible for the child care subsidy program and quality initiatives, including the state's Quality Rating & Improvement System. As stated in a prior report released by the Bipartisan Policy Center, having the CCDF state lead agency serve as the

EHS-CCP grantee has been critical in that state's success.[13] It has enabled seamless coordination across various state initiatives aimed at enhancing the quality of child care. It has also led to changes in CCDF subsidy policy to accommodate those families benefiting from the partnerships. For example, the state changed its policy of requiring families to apply for a subsidy in-person and shifted to taking applications over the phone. This minor change proved crucial in the recruiting families, quickly determining eligibility, selecting families, and quickly enrolling them.

Alabama's experience is worth noting and potential exists across state lead agencies. CCDF state lead agencies have the authority to set eligibility requirements for subsidy, including income thresholds, copayments, and the time periods for redetermination. Aligning subsidy policies with those in EHS would benefit the children in partnership slots as well as their families.

For example, EHS operates with "presumptive eligibility," meaning that once a child is determined eligible for services, they remain eligible for EHS until they reach preschool-age. Frequent changes in providers and starting and stopping care regularly, can interfere with the bond children form with their child care providers, disrupt their routines and sense of security, and interfere with healthy development. Beyond supporting children's healthy development through continuity of care, presumptive eligibility reduces the administrative burden placed on parents by avoiding having to resubmit materials to verify eligibility. It could also save states resources by cutting down on time intensive, burdensome, frequent redeterminations, while cutting red tape for families. A state could apply a similar presumptive eligibility for children involved in the partnerships.

While the law governing federal child care assistance sets a minimum period of time for eligibility of twelve months, nothing would preclude the state from extending the period of eligibility for those children involved in partnerships.[14] Such is the case in Pennsylvania, where its CCDF lead agency also administers an EHS-CCP grant. While the state's subsidy policy requires redetermination for eligibility in CCDF every six months (prior to the implementation of the 2014 reauthorization, which extended redetermination to twelve months), children who benefit from EHS-CCP partnerships do not receive redetermination until they age out of the program.[15]

States have already begun to extend longer periods of eligibility for providers with whom they contract for the provision of infant and toddler care. In Delaware, its Division of Social Services initiated a pilot project where the state will buy annual child care slots from some of its programs achieving the highest level of 4 and 5 stars in its QRIS so that those programs can provide stable care to eligible families through a contract between the state and provider. This pilot is designed to stabilize the provider workforce and incentivize providers to serve infants and toddlers. The pilot allows subsidy for eligibility for 24 months.[16]

States also have the ability to better align eligibility policies between EHS and CCDF where stark differences exist. For example, CCDF requires eligible families to participate in a qualifying workforce, education, or training activity to receive subsidy. However, EHS has no such requirement. Under CCDF, states set policies around what constitutes an acceptable work, education, or training activity for eligibility purposes and some states have modified their policies to facilitate parents' participation in EHS. In Georgia, to ensure continuity of high-quality care for participating families in EHS-CCP, the state changed its subsidy policy to allow for EHS family activity engagement time to count towards the 17.5 parental subsidy work hour requirements.[17] Another strength of the Partnership model is that states benefit from having a parent policy council that could provide important insights applicable across the broader early care and education landscape.

States should invest any remaining pandemic recovery ECE funds, including American Rescue Plan Act–CCDF Funding, on building EHS-CCPs

The American Rescue Plan Act (ARPA) provided states with an unprecedented amount of federal funding to stabilize the child care provider sector. ARPA included $24 billion in stabilization grants for states, territories, and tribes to address the financial burdens faced by providers during the worst parts of the pandemic so that they could remain open, or re-open in the event they had to close. ARPA also included $15 billion in supplemental CCDF discretionary grants to build a stronger child care system and help more families afford child care over the next three years. Both of these funding streams included an emphasis on supporting health, and in particular children's mental health, as well as workforce support.

The stabilization grant funding set forth specific criteria with respect to the distribution of funds to providers, and the types of expenses providers could put the funds toward in order to stabilize their operations.[18] It was also designed to be distributed and spent quickly in order to stave off imminent closures and to resuscitate the supply of providers in areas that had already experienced closures during the pandemic. To incentivize rapid use of funds, the statute

required states, territories, and tribes to obligate stabilization funds by September 30, 2022, and to liquidate stabilization funds by no later than September 30, 2023.[19] Based on the targeted and time-limited nature of the stabilization grants, their applicability toward the establishment or expansion of EHS-CCP is also limited, though states can encourage providers to use their funds in ways that support children's holistic development and families' wellness, or in ways that set a foundation for high quality care, including through critical infrastructure investments, as allowable by statute.

However, CCDF supplemental funding provided through ARPA included greater flexibility around the uses of funds, and a longer timeline to obligate and spend them down. The statute exempts states, territories, and tribes from the requirements under the law that require at least 70% of funds to be spent on direct services and 12% to be spent on quality improvement activities.[20] This means that lead agencies have full discretion to determine how much funds can be spent on quality activities and how much can be spent on direct services. Lead agencies also have a longer period of time to plan around the use of funds. The statute requires that states obligate funds by September 30, 2023, and that they liquidate funds by September 30, 2024. Significantly, lead agencies may spend funding on any activity allowable under the Child Care and Development Block Grant Act (CCDBG) and CCDF regulations.

ACF has encouraged states to use CCDF supplemental funds to increase reimbursement to providers, change underlying payment policies so they are more generous to providers and staff, generally increase wages and benefits for early educators, and build the supply of care for underserved populations.[21] All of these things can be accomplished by extending the EHS model to providers who care for subsidy-eligible infants and toddlers and is a strategy states should pursue while they are engaged in important work to improve their child care systems — including by raising income eligibility thresholds, improving provider payment policies, eliminating family copays, and improving compensation for providers.[22] They should strongly consider establishing or expanding EHS-CCP through their lead agencies. Even if the funding does not continue, based on the availability of funds, it could support at least a cohort of partners who could invest in sustained quality improvements through alignment to the EHS model that would greatly improve the experiences of infants, toddlers, and their families. This could include conducting environmental assessments and addressing any health and safety concerns in the classroom or home and outdoor play environments, including ensuring safe and clean drinking water. It could include purchasing training, coaching, and early childhood mental health consultation for teachers and providers to build their capacity to support children's complex needs, particularly their mental health needs during and post-pandemic. It may include boosting provider and teacher capacity to support the needs of children with disabilities to increase inclusive learning opportunities across the state. It may include decreasing ratios for children, even temporarily, so that instead of one provider caring for 10 toddlers, they can care for 5, ensuring a safer, more individualized, and more enriching experience for children during a critical period in brain development.

States should invest CCDF quality improvement funding on establishing and growing EHS-CCPs

In 2014, Congress reauthorized the CCDBG to include certain improvements relating to health and safety, licensing and monitoring, professional development for child care providers, and activities to improve the quality and availability of child care. As a part of the reauthorization, states are required to spend at least 12% of their funding for quality improvement activities, including 3% of their funding to improve the quality and supply of care for infants and toddlers.[23]

There are ten authorized uses for quality funds, set forth under the law, including activities to improve the quality of child care services supported by outcome measures that improve provider preparedness, child safety, child well-being, or kindergarten entry.[24]

Additionally, federal regulations clarify that states may carry out activities to "improve the quality of infant and toddler care provided, and for which there is evidence that the activities will lead to improved infant and toddler health and safety, infant and toddler cognitive and physical development, or infant and toddler well-being . . . "[25] These activities are determined by *the state*, and thus do not require approval from the federal government to carry out. The evidence-base for EHS is robust, and access to EHS services has demonstrated positive impacts on children's cognitive, social-emotional, and physical development, as well as positive impacts on children's parents and guardians.[26]

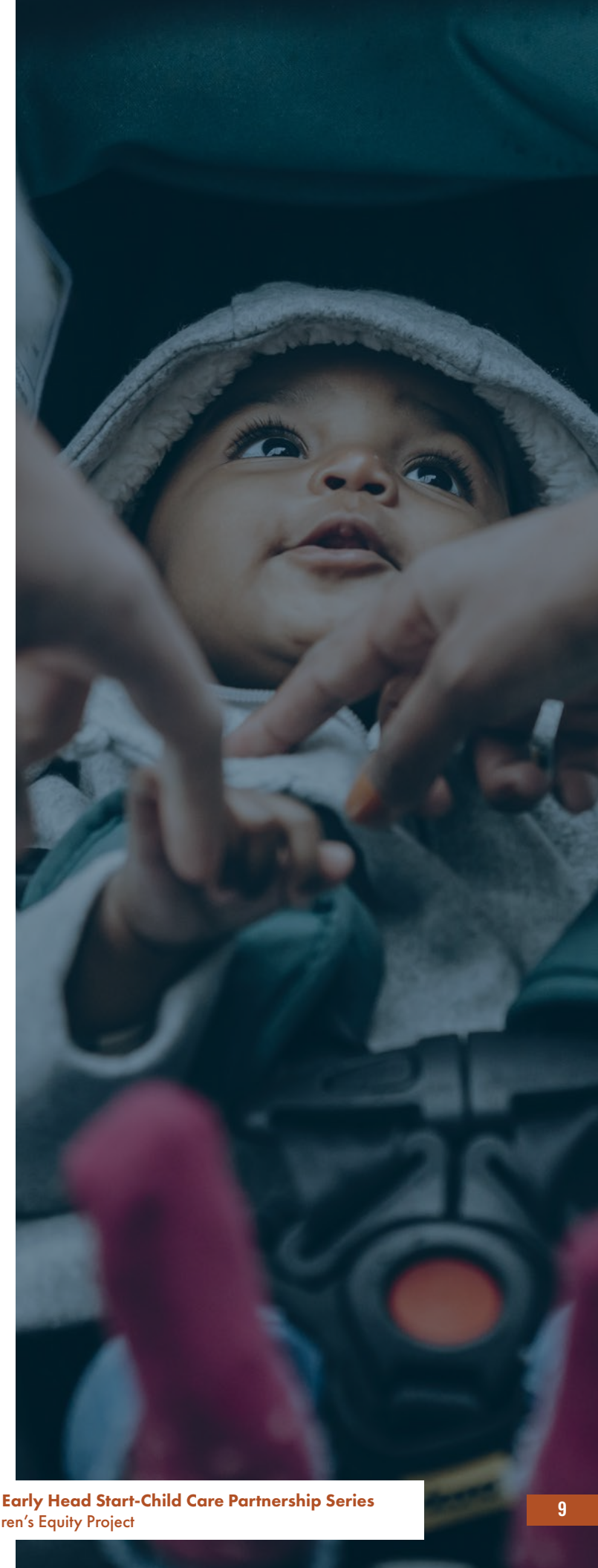
States should leverage, at the least, the robust amount of funding they are required to spend to improve infant and toddler services toward building EHS-CCPs. In FY22, states received in excess of $9.4 billion solely through CCDBG discretionary ($5.911 billion) and mandatory funding ($3.55 billion) — separate and apart from the $39 billion received through the American Rescue Plan Act. Relying solely on the 3% of funding statutorily required for infant and toddler quality improvement activities, states could dedicate more

than $250 million to EHS-CCP.[27] If they leveraged some of the funding from the overall quality set-aside, states could easily outspend the amount of funding provided by the federal government for EHS-CCPs. This would boost the quality of services children and families receive by appropriately and adequately resourcing providers to provide an array of supportive services and increase provider compensation to stabilize the workforce crisis.

States should use Preschool-Development Grant Birth-to-Five funds to build and grow EHS-CCPs.

The Preschool Development Grant program was initially created through the appropriations process in 2014 to build the capacity among states and localities to establish or expand high-quality preschool for four-year old children from low- and moderate-income families. It was administered by the U.S. Department of Education (ED). The Every Student Succeeds Act, passed in 2015, authorized the program but re-oriented the program to focus on the coordination of delivery models and funding streams existing in each state's mixed delivery system serving children from birth through age five. The program was moved to the HHS, and is now co-administered by ED & HHS. As the PDG program supports improved collaboration among existing programs as well as a mixed delivery system that includes child care and family child care providers, Head Start, and home visiting, states should strongly consider leveraging these resources to establish or expand the EHS-CCP model, which is an exemplar of the type of program and funding collaboration PDG B-5 is meant to support.

PDG B-5 funding could be used specifically to fund child care programs to forge partnerships with Head Start to facilitate implementation of the Head Start model and approach. It could also be used to build shared services hubs statewide as a mechanism to support child care and Head Start partners in, for example, a) ensuring access to comprehensive services to children and families (e.g. developmental screenings and dental healthcare for children, connections to health insurance, job support, or housing assistance for families), b) engaging in shared business services (e.g. support payroll, human resource systems, and cost allocation); and c) delivering quality professional development opportunities (e.g. training and coaching) and access to higher levels of education for the workforce (connections to and onsite learning for CDA, AA, and BA degree programs).



RECOMMENDATIONS

Federal and State

Though this brief is focused on the state role in building EHS-CCPs, the federal government, including Congress and the U.S. Department of Health and Human Services, can play a critical role in scaling and elevating EHS-CCPs. As such, we provide recommendations across the federal government, as well as state governments.

In 2019, the Bipartisan Policy Center released a comprehensive report spotlighting the successes of the EHS-CCP. The report included recommendations for Congress, HHS, the states, and to grantees. Here, the Children's Equity Project, together with the Bipartisan Policy Center and Start Early, build on those recommendations to leverage state funding to advance EHS-CCPs.

Recommendations to Congress

Congress should authorize the EHS-CCP in statute. Authorizing the EHS-CCP would not only signal Congress's commitment to the EHS-CCP model, it would allow Congress to set parameters and priorities within the program, including greater incentives for the participation of home-based providers, rural providers, and providers serving high need and historically marginalized communities as a part of the program. Congress should also focus on establishing partnerships with providers who are low-resourced. Congress could also establish a reservation in EHS-CCP for territories, tribes, and migrant and seasonal workers, as it has in the Head Start program.

Congress should expand funding for the program. The EHS-CCP have enjoyed bipartisan support. But they are only funded to serve a fraction of the need and are far from reaching their potential. Congress should greatly expand funding for the program to build greater cohesion between Head Start and child care, align standards, and raise quality to ensure children have access to safe and enriching experiences, regardless of whether they participate in a child care program or a Head Start program.

Recommendation to U.S. Department of Health and Human Services, Office of Head Start

HHS, including regional offices at the Administration for Children and Families, should conduct listening sessions with EHS-CCP state and local grantees regarding federal monitoring of EHS-CCPs. Informed by this feedback and existing data on the EHS-CCPs and Head Start monitoring more broadly, HHS should set monitoring conditions that prioritize and never compromise child health, safety, and development, while also acknowledging startup processes and reaching full implementation of the EHS model may require more time and resources. In addition, unique considerations should be made for states as grantees, leveraging their oversight of other ECE systems, recognizing the fundamental differences in

administrative structure, and adjusting rules and requirements where it makes sense, while maintaining fidelity to the EHS model.

HHS should prioritize grantees who propose to build capacity in historically disinvested in and high need communities that have an insufficient supply of high quality child care.

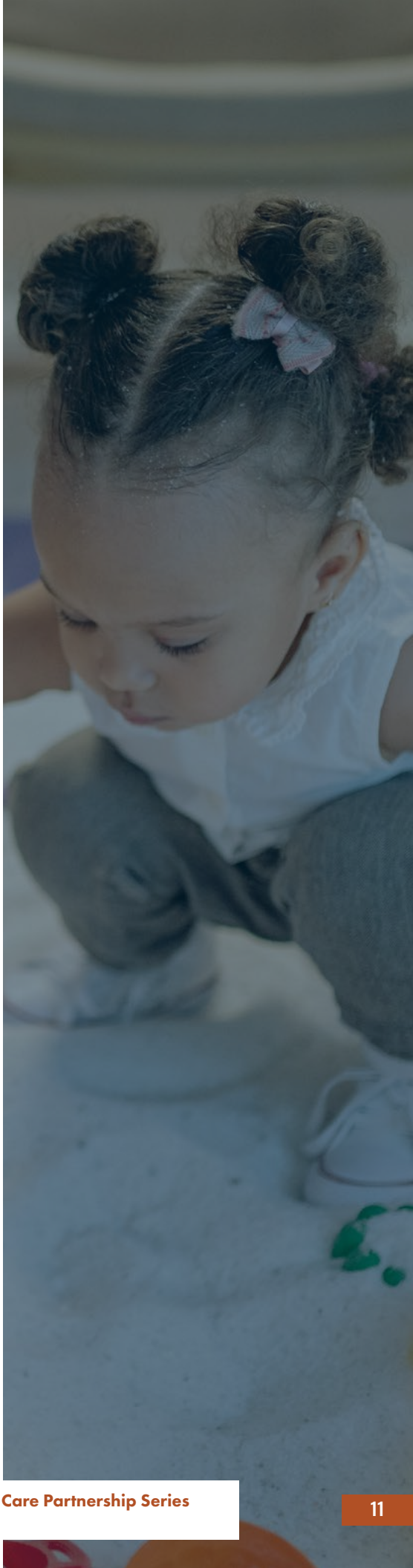
HHS should provide tailored technical assistance to support all EHS-CCPs, including states and the unique context, challenges, and opportunities associated with being state grantees. This may include facilitating communities of practice or peer to peer sessions to share lessons learned, providing guidance on aligning state policies across child care and Early Head Start, facilitating partnerships between community based Head Start grantees and state grantees, and facilitating cross-sector partnerships (health, behavioral health, human services, child welfare agencies) to support the success of EHS-CCPs.

Recommendations to States

As new rounds of EHS-CCP grants become available, **state lead child care agencies should apply to serve as grantees.** Successful state lead agency applicants will be able to create statewide strategies for increasing the supply and quality of infant and toddler services and are uniquely positioned to align policies between CCDF and EHS. They can also fill in access gaps in communities without Early Head Start or without enough community-based Early Head Start capacity.

States should leverage existing funding to expand EHS-CCPs. This begins with investing any available **ARPA funds** or other discretionary funds toward planning for and building the partnerships and infrastructure needed to get these models off the ground, and is followed by dedicated **CCDF quality improvement activity funds** to sustain and grow the model. States should also consider using funds provided to them through the **Preschool Development Grant Birth-to-Five program** to establish or enhance EHS-CCP. The central purpose of the PDG B-5 program is to coordinate and align early care and education programs within a state to expand the availability of high-quality services to young children. Directing these funds toward EHS-CCP serves that purpose. Additionally, lead agencies should work closely with their state education agencies (if they are not co-located), to determine whether any of the **formula programs governed by the Elementary and Secondary Education Act** of 1965 could be used to advance EHS-CCP. Non-regulatory guidance released during the Obama Administration clarified that these programs can be used to support early learning, including programs that support infants and toddlers.[28] States should identify any other state funds that can be used to build EHS-CCPs and ultimately increase access to high quality care for infants and toddlers. Similar approaches can be used to extend these partnerships up to preschool aged children through partnerships with Head Start.

States who have already served as EHS-CCP grantees should share lessons learned with other state lead agencies to facilitate broader adoption of the EHS-CCP model, whether or not additional funds become available at the federal level. Philanthropy could serve as a convenor of these states to establish a community of practice so they can learn from one another's successes and setbacks, provide resources to distill the essential components for successful EHS-CCP, and provide support to policy officials in states where EHS-CCP is not present to initiate the model.



CONCLUSION

The federal government has expressed a commitment to EHS-CCP through continued funding for the model over the past eight years. The amount of funding, however, has been insufficient to expand the program significantly, despite the benefits these partnerships extend to providers, families, and young children. States can begin expanding EHS-CCP without significant new funding by leveraging state funds, federal funding streams over which it has control, including flexible funding currently provided through the different relief packages passed by Congress as well as other major federal programs, including CCDF. HHS and other independent organizations have done extensive work to highlight how EHS-CCP has been successful across grantee types. States should review the examples of current grantees and begin discussions of how to implement EHS-CCP in their own contexts, establishing partnerships in communities that need them most.

ENDNOTES

1 Department of Health and Human Services. 2014 Budget in Brief. https://wayback.archive-it.org/3920/20150326110529/http://www.hhs.gov/budget/fy2014/fy-2014-budget-in-brief.pdf.

2 Department of Health and Human Services. Program Instruction. FY2014 Funding Increase. https://eclkc.ohs.acf.hhs.gov/policy/pi/acf-pi-hs-14-01.

3 House of Representatives. Committee on Appropriations. FY 2023 Departments of Labor, Health & Human Services, Education, and Related Agencies. https://docs.house.gov/meetings/AP/AP07/20220623/114920/BILLS-117--AP--LaborHHS.pdf.

4 Department of Health and Human Services. 2023 Budget. Congressional Budget Justification. https://www.acf.hhs.gov/sites/default/files/documents/olab/fy-2023-congressional-justification.pdf.

5 Information received anecdotally suggests that building partnerships between EHS providers and child care providers can be challenging. Thus, when new funding is available for either EHS expansion or EHS-CCP, the funding is tilted toward expansion due to a lack of willingness among EHS providers to partner with child care providers. While it is difficult to determine how many grants have gone toward EHS-CCP, specifically, funded enrollments presented in this brief for EHS-CCP are accurate and derived from budget documents.

6 Department of Health and Human Services. 2023 Budget. Congressional Budget Justification. https://www.acf.hhs.gov/sites/default/files/documents/olab/fy-2023-congressional-justification.pdf.

7 *See generally* the Children's Equity Project. Building a Universal Preschool System around Head Start. Available at: https://childandfamilysuccess.asu.edu/sites/default/files/2021-08/headstart-report-080221%20%281%29.pdf.

8 Mathematica Policy Research. Early Care and Education Partnerships: A Review of the Literature. 2014. https://www.acf.hhs.gov/sites/default/files/documents/opre/early_care_and_education_partnerships_a_review_of_the_literature.pdf.

9 Ibid.

10 *See, e.g.,* U.S. Department of Health and Human Services. Policy and Program Guidance for the Early Head Start-Child Care Partnerships. ACF-IM-HS-15-03. https://eclkc.ohs.acf.hhs.gov/policy/im/acf-im-hs-15-03-attachment

11 Department of Health and Human Services. Office of Planning, Research, and Evaluation. Findings from the National Descriptive Study of Early Head Start-Child Care Partnerships. 2020. https://www.researchconnections.org/sites/default/files/pdf/rc38216.pdf

12 U.S. Department of Health and Human Services. Child Care Subsidies Under the CCDF Program: Overview of Policy Differences Across States and Territories as of December 1, 2019. https://www.acf.hhs.gov/sites/default/files/documents/opre/state-2019-ccdf-policies-graphics-dec-2020.pdf.

13 Bipartisan Policy Center. Early Head Start-Child Care Partnerships: Spotlighting Early Successes Across America. https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2019/03/Early-Head-Start-Child-Care-Partnerships.pdf.

14 The law states that each child receiving federal child care assistance "will be considered to meet all eligibility requirements for such assistance and will receive such assistance, for *not less than* 12 months before the state or designated local entity determines eligibility . . . ." 42 U.S.C. 9585c(b)(N) (emphasis added).

15 U.S. Department of Health and Human Services. Early Head Start Child Care Partnership Grantee Profile: Pennsylvania. Available at: https://www.acf.hhs.gov/sites/default/files/documents/ecd/pa_ehsccp_grantee_profile_final.pdf.

16 U.S. Department of Health and Human Services. Early Head Start Child Care Partnership Grantee Profile: Delaware. Available at: https://www.acf.hhs.gov/sites/default/files/documents/ecd/de_ehsccp_grantee_profile_final.pdf.

17 U.S. Department of Health and Human Services. Early Head Start Child Care Partnership Grantee Profile: Georgia.. Available at: https://www.acf.hhs.gov/sites/default/files/documents/ecd/ga_ehsccp_grantee_profile_final.pdf.

18 U.S. Department of Health & Human Services. Information Memorandum: ARP Act Child Care Stabilization Funds. Available at: https://www.acf.hhs.gov/sites/default/files/documents/occ/CCDF-ACF-IM-2021-02.pdf.

19 Ibid.

20 There are also other exemptions, including an income eligibility exemption for workers deemed essential during the pandemic.

21 *Supra* note 18.

22 Child Care Aware of America. Federal Relief Funds: State Progress, Winter 2022. Available at: https://info.childcareaware.org/blog/federal-relief-funds-state-progress-fall-2021-0.

23 U.S. Department of Health and Human Services. Fundamentals of CCDF Administration. https://childcareta.acf.hhs.gov/ccdf-fundamentals/activities-improve-quality-child-care-services.

24 42 U.S.C. § 9585e.

25 45 CFR 98.53(a)(4)(vi).

26 U.S. Department of Health & Human Services. Making a Difference in the Lives of Infants and Toddlers and Their Families: The Impacts of Early Head Start. Volume I: Final Technical Report. https://www.acf.hhs.gov/sites/default/files/documents/opre/impacts_vol1.pdf.

27 This includes a downward adjustment in consideration of the set-asides that exist for tribes, territories, and administrative activities.

28 U.S. Department of Education. Non-Regulatory Guidance: Early Learning in the Every Student Succeeds Act. Available at: https://www2.ed.gov/policy/elsec/leg/essa/essaelguidance10202016.pdf.