

JULY 2025

An Evaluation of Arizona's Federal Pandemic Recovery Investments in Child Care

LANDSCAPE, FINDINGS, AND IMPLICATIONS FOR THE EARLY CARE AND LEARNING SYSTEM

CHILDREN'S EQUITY PROJECT

AUTHORS

Brittany L. Alexander, Ph.D.
Shantel Meek, Ph.D.
Cinthia Palomino, Ph.D.
Darielle Blevins, Ph.D.
Eric Z. Bucher, Ed.D.
Afua Ameley-Quaye, M.Arch.
Xigrid Soto-Boykin, Ph.D.
Evandra Catherine, Ph.D.
Pranshu Mihirbhai Jayswal

RECOMMENDED CITATION

Alexander, B. L., Meek, S., Palomino, C., Blevins, D., Bucher, E.Z., Ameley-Quaye, A., Soto-Boykin, X., Catherine, E., & Mihirbhai Jayswal, P. (July 2025). *An Evaluation of Arizona's Federal Pandemic Recovery Investments in Child Care: Landscape, findings, and implications for the early care and learning system.* The Children's Equity Project at Arizona State University.

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About This Report

In this report, we share the findings of an evaluation of COVID-19 pandemic-era federal relief dollars and their use in the child care system in Arizona.

In December of 2020, Congress passed the Coronavirus Response and Relief Supplemental Appropriations Act (CRRSA) which included $10 billion in funding for child care for states. In March of 2021, the American Rescue Plan Act (ARPA) was passed by Congress which included $39 billion in new child care funding. These funds were allocated to state Child Care and Development Fund (CCDF) Lead Agencies to be distributed. In Arizona as the CCDF Lead Agency, the Arizona Department of Economic Security (DES) Division of Child Care (DCC) was tasked with this role. Between 2022 and 2024, the Children's Equity Project (CEP) at Arizona State University (ASU) examined DES activities funded by these additional child care funds and the implications of these investments in the Arizona child care system including access to child care, supports for the early childhood workforce, and the improvement of health, safety, and quality of child care. In this report, we lay out the background and context, data sources and analyses, key findings, and recommendations.

Introduction

INTRODUCTION

Decades of neuroscience and research show that quality, nurturing early childhood education experiences set children's trajectories for lifelong learning and success.[1]

Responsive and nurturing relationships with parents and caregivers and a healthy and safe environment set the foundation for positive development. The U.S. child care system, comprising programs such as home-based child care, Head Start and Early Head Start, and preschool or Pre-Kindergarten programs, was largely designed to serve children while their parents work or attend school. In fact, nationally 68% of children under age six have all parents in the workforce, making child care a necessity.[2] These settings—and, importantly, the caregivers who are tasked with caring for and teaching young children in these settings—greatly influence children's growth and overall health and well-being.[3]

The United States, unlike many other nations around the world, does not offer universal early care and education (ECE), creating a fragmented system that results in inequitable access to, experiences in, and outcomes for children.[4] In Arizona, decades of underinvestment have left a gap of 76,740 child care slots for families who need and rely on care to participate in the workforce, leading to a staggering economic loss of an estimated $4.7 billion annually due to insufficient child care access and lack of resources for ECE providers.[5] Stemming from inadequate federal and state funding and a flawed market-based system, many child care providers across states have long relied on parent-pay tuition to operate, often experiencing razor-thin margins that inadvertently result in low educator wages, which subsidize the true cost of providing quality child care. What's more, the quality of care—underpinned by funding and policy decisions—has historically been uneven across and within states, compromising the experiences children have in care and outcomes associated with those experiences.

The federally funded Head Start and CCDF programs do not fully serve all of the eligible children in Arizona, leaving a gap for families in low-income households to access ECE. For example, Arizona's Head Start programs only reach about 20% of eligible children ages five and under in low-income households while CCDF only reaches 30% of eligible children up to age 13.[6] For working parents who do not qualify for these child care subsidies, child care in Arizona remains largely unaffordable, with average infant care ranging from $8,840 per year in family child care to $14,040 in center-based child care.[7] As such, for some families, their child care costs are higher than average in-state tuition and fees at Arizona's public universities—ASU ($13,161), University of Arizona ($13,900), and Northern Arizona University ($13,010).[8] Toddler care is only slightly less, on average costing families $12,662 per year for center-based care and $7,800 for family child care. Still, this represents 12.8% of a median Arizona married couple's household income and 36.2% of median Arizona single-parent household income.[9]

This unstable and often inequitable system was ill-prepared for the onset of the COVID-19 pandemic when the disease forced children, families, and the workforce home. Children had disruptions in their access to child care, programs were at risk of closure, and there were health and safety issues for providers that remained open to serve essential workers. It is estimated that about 166,000 jobs in the child care industry were lost during the first eight months of the COVID-19 pandemic, and child care employment had only recently in 2023 surpassed pre-pandemic rates, though wages consistently remained stagnant.[10] A national survey of early childhood educators showed that one in four center-based child care providers and one in three family child care providers reported a risk of closing, while nearly half of all respondents reported that they knew of multiple child care programs in their community that closed permanently and indefinitely in 2020.[11] Further, home-based programs were more likely to permanently or temporarily close during the pandemic compared to center-based programs.[12] While many ECE programs have opened or reopened since due in large part to pandemic-era child care stabilization funding from the federal government, there is still a workforce shortage and turnover challenges mostly caused by low wages, meaning fewer slots available for families who need and rely upon consistent child care.[13]

Unfortunately, the pandemic also catalyzed a backslide on quality standards, with some states attempting to address workforce shortages by lowering standards, such as decreasing ratios, increasing group sizes, or lowering workforce credentials. In addition, quality supports, such as in-person early childhood mental health consultation, were also paused for periods of time during the pandemic, resorting to virtual supports, which was uncharted territory. Early intervention and special education evaluations and services were delayed and, in many instances, moved to virtual spaces, impacting relationship and service quality.

In sum, the COVID-19 pandemic impacted the entirety of the child care system, causing significant turmoil in child care access for families, safety, recruitment and retention of the workforce, and quality of care for children. To mitigate the challenges of the pandemic on the child care system, Congress allocated additional emergency child care funds to states between 2020 and 2021. Arizona received a total of more than $1.3 billion in federal child care pandemic relief funding from three federal spending packages.[14]

- $88 million in supplemental Child Care and Development Block Grant (CCDBG) funding from the Coronavirus Aid, Relief, and Economic Security (CARES) Act signed into law in March 2020
- $248.6 million in supplemental CCDBG funding from the Coronavirus Response and Relief Supplemental Appropriations (CRRSA) Act of 2021
- $969.3 million in CCDF funding through ARPA signed into law in March of 2021

In 2022, these temporary federal COVID-19 relief dollars represented nearly 70% of Arizona's ECE funding sources while the other majority was made up of other federal funding sources like Head Start, Individuals with Disabilities Education Act (IDEA) Part C funding for early intervention and Part B 619 funding for early childhood special education, and CCDBG and mandatory funds.[15]

As of 2023, the state had not invested any general funding for child care in the state budget for more than a decade.[16] However, in 2024, the state legislature allocated and Governor Katie Hobbs signed a fiscal year (FY) 2025 budget that included a one-time investment of $12 million in state general funds to DES to support the child care network,[17] but the specific usage and impact of those dollars is yet to be seen. Pandemic recovery funding from Congress was intended to stabilize the system, but the shaky foundation that existed before the pandemic will likely stunt long-term impacts without continued public investments.

Quality of care has historically been uneven across and within states, compromising the experiences children have in care and outcomes associated with those experiences.

This report looks specifically at Arizona's implementation of child care funding from the CRRSA and ARPA. Nationally, CRRSA earmarked $10 billion in flexible funding for child care which states could use to provide direct services or subsidies, support mitigation efforts in early learning settings, and provide grants to stabilize providers.[18] ARPA earmarked $39 billion in new temporary child care funding for states, including $24 billion for child care stabilization grants (CCSG) and $15 billion in supplemental discretionary CCDF.[19] The purpose was to stabilize child care systems across states and address challenges in ECE settings during the COVID-19 pandemic, such as increased operational costs, lower attendance, and enhanced cleaning and sanitation materials. Throughout the report, we refer to CRRSA and ARPA investments collectively as pandemic relief/recovery funds.

To distribute this large influx of federal funding, DES DCC developed Arizona's Child Care Recovery Plan for the implementation of the CCSG and other priority activities funded by additional CCDF monies for FY 2022-2024. Several major priorities and 20 strategies were selected to be implemented between July 1, 2021 and September 30, 2024. The priorities included: 1) expanding access to child care; 2) investing in quality; 3) stabilizing the child care network; and 4) accelerating educational support and early childhood literacy. A total of $1.3 billion was invested across 20 strategies and three key investments were selected as a key focus of this study—stabilizing the child care network, expanding access to child care, and investing in quality.

ARIZONA'S CHILD CARE LANDSCAPE

The pandemic relief child care funding was released to DES as Arizona's CCDF Lead Agency between July 1, 2021 and September 30, 2024.[20] These investments shaped the child care context in Arizona at the systems, program, and workforce levels, with intended indirect impacts on children's access to and quality of programming. Prior to reviewing the findings of the impacts of pandemic relief investments, we provide a summary of the Arizona child care landscape for context.

As of July 2023, the child care system in Arizona was made up of 3,720 child care providers serving children from birth to thirteen, the vast majority of whom are under the age of 5, which includes regulated providers (licensed child care centers, certified group homes, certified family child care providers), unregulated non-certified relative providers (NCRPs), and providers regulated by tribal agencies.[21] These providers operate in a variety of diverse settings including center-based, school-based, Head Start and Early Head Start, faith-based, home-based group care, and family child care. Approximately 19,220 professionals worked in the early childhood workforce as of 2019.[22]

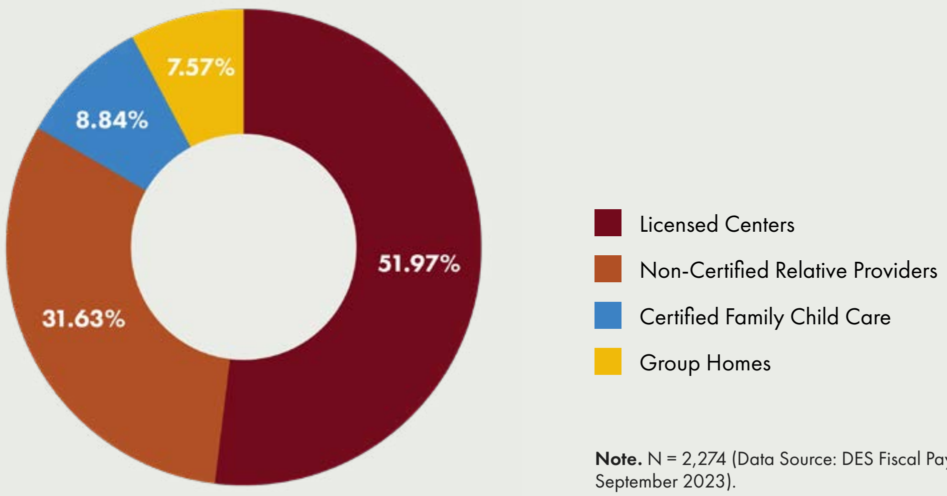
As the state's CCDF Lead Agency, DES DCC contracts with licensed child care centers, certified group homes, and certified family child care homes, across Arizona to serve children and families who are receiving child care assistance funded by federal CCDF dollars. NCRPs are also eligible to receive CCDF subsidies to care for eligible children in their home or the child's home, but they are ineligible for most other ECE programs since they are license-exempt (unregulated) providers. To be income eligible to receive child care assistance through DES, children must live in low-income households up to 165% of the federal poverty level (FPL) at the initial application then 85% of state median income at reapplication. Between January and September 2023, 2,274 child care providers in total were contracted with DES and served children who utilized child care subsidies.

Many eligible regulated child care providers in Arizona participate in one or more quality programs in the state's ECE system in addition to being licensed or certified to operate. NCRPs are not eligible for the programs listed below. These other programs include:

- The early childhood quality improvement and rating system (QIRS) First Things First (FTF) Quality First (QF) funded by state tobacco tax, which rates the quality of providers and provides supports to improve quality. QF scholarships offer support for children and families up to 300% of the federal poverty level along with coaching and training resources for providers.
- Federally funded Head Start (including Head Start preschool, Early Head Start for infants and toddlers, Early Head Start-Child Care Partnerships, Migrant and Seasonal Head Start, and Tribal Head Start) which provides competitive grants to ECE programs to implement comprehensive early learning, health, and family engagement services aligned with national performance standards for children up to 100% of FPL.
- Accreditation by a national early childhood accrediting body which generally requires providers to demonstrate that they meet comprehensive, quality standards that build upon the minimum regulations set by licensing agencies.[23]

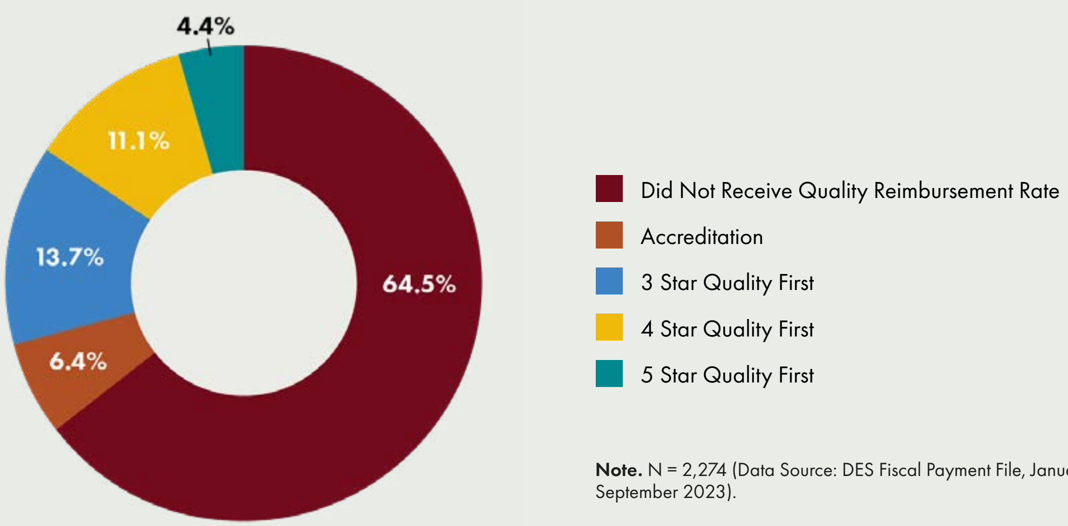
Next, we examined the data regarding contracted providers who were reimbursed to serve children and the children they served. Based on the most recent annual data for 2023 (January through September), the population of the 2,274 DES contracted providers who served children birth to thirteen (most children under the age of 5) that utilized subsidies was primarily made up of DHS licensed center-based child care providers (51.97%) then 31.63% NCRPs, 8.84% certified family child care providers, and 7.57% group homes (see **Figure 1**). DES-contracted providers that provided care to a child receiving subsidy and met quality standards by receiving a 3-5 star QF rating, were Head Start programs, and/or were accredited by a national early childhood accrediting body received an enhanced quality reimbursement rate starting in April 2018. The majority of DES contracted providers (64.47%) did not receive quality reimbursement rates in 2023. It is important to note that this number includes NCRPs who do not participate in the quality system, but is intended to provide an overall sense of the scope of quality system participants within the universe of DES providers. This may be due to the program not being nationally early childhood accredited, participating in Quality First (QF) but not receiving a 3 to 5 star rating, or not participating in QF (see **Figure 2**). Of the providers receiving the quality reimbursement rate, 13.7% were QF 3 star, 11.1% were QF 4 star, 6.4% were accredited, and 4.4% were QF 5 star (see **Figure 2**).

Figure 1: DES Contracted Child Care Providers by Type that Served Children Utilizing DES Child Care Assistance in 2023



Note. N = 2,274 (Data Source: DES Fiscal Payment File, January–September 2023).

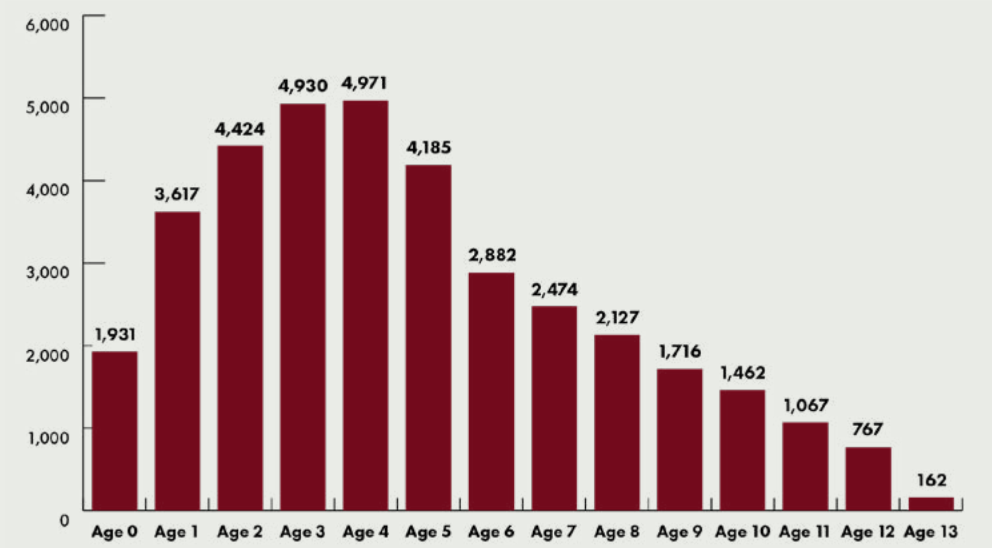
Figure 2: DES Contracted Providers that Served Children and Received Quality Reimbursement Rates in 2023



Note. N = 2,274 (Data Source: DES Fiscal Payment File, January–September 2023).

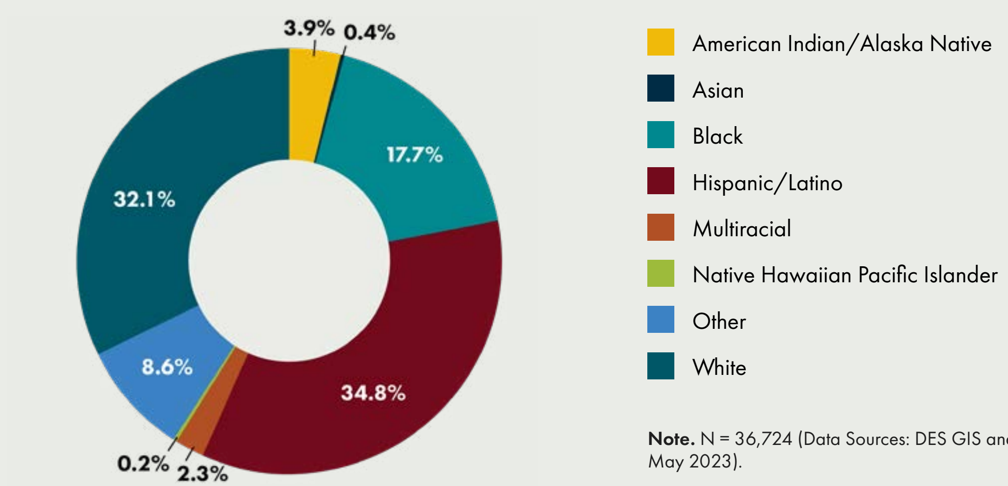
DES contracted providers primarily served children under the age of six (see **Figure 3**). Additionally, similar to the demographics in the state, the two largest racial/ethnic groups, Hispanic/Latino (34%) and White (32%), made up the majority of the children who utilized child care subsidies (see **Figure 4**).

Figure 3: Number of Children who Utilized DES Child Care Subsidies by Age in May 2023



Note. N = 36,723 (Data Sources: DES GIS and Fiscal Payment Files, May 2023).

Figure 4: Number of Children who Utilized DES Child Care Subsidies by Race/Ethnicity in May 2023



Note. N = 36,724 (Data Sources: DES GIS and Fiscal Payment Files, May 2023).

SECTION I

Evaluation of Arizona's Pandemic Recovery Investments in Child Care

INTRODUCTION

EVALUATION OF ARIZONA'S PANDEMIC RECOVERY INVESTMENTS IN CHILD CARE

Between 2022-2024, the CEP at ASU conducted an evaluation of DES activities funded by these additional federal child care funds and the influence on the Arizona child care system.

In Section I, we detail the research questions, theory of change, and data sources used in this evaluation. The CEP examined the allocation and use of funds, whether strategies met their intended goals, and the implications on the child care system when funds expired in 2023. The CEP worked with DES to develop a theory of change for this core part of the evaluation (see **Figure 5**) and key research questions across investment categories and all outcomes of interest. In the Fall of 2023, additional dimensions of the evaluation were established. This addition included examination of two key areas: 1) the child care landscape for children involved with the child welfare system; and 2) the patterns of contracted providers over time and the enablers and barriers to contracting with DES to serve children who utilized child care subsidies. These two key areas are discussed in supplementary reports.

We explored three major areas of investment:

- **Child Care Stabilization Grants (CCSG):** federal investments put into the hands of providers to spend on supporting personnel; rent, mortgage, or utilities; facilities; goods and services; mental health; and personal protective equipment or other equipment.
- **Reimbursement rate increases:** a series of changes in the amount that providers were reimbursed for providing care to a child with a child care subsidy, four rounds of increases were made to the base rates, and three to the quality and "special needs" rates.
- **Arizona Child Care Infrastructure Grants:** a grant program allowing providers to improve their facilities.

Overarching, Guiding Research Questions

- How were Arizona's pandemic relief investments spent at the state and program/provider levels, across region, size, and type of providers?
- What were the impacts of COVID-19 relief investments—including through CCSG, Arizona Child Care Infrastructure Grants, and reimbursement rate increases—for the child care workforce, on access to child care, and on health, safety, and quality in child care?
- What were the impacts for the child care system when funding expired?

We also examined the impacts of accessing multiple, combined supports, including CCSG, reimbursement rate increases, infrastructure grants, and other quality investments, such as access to Early Childhood Mental Health Consultation (ECMHC) and Quality First.

The evaluation plan and methodology for this project was co-created by the CEP and the DES DCC. The evaluation included a key focus on understanding Arizona's investment of the additional federal child care funds for the child care system across all 15 Arizona counties.

We used a pre-experimental methodology due to the nature of the intervention (a large, temporary influx of federal funds) and the inability to ethically or logistically include a control group. This design allows for the potential explanation of results but does not allow for causal inferences to be drawn. Additionally, we used a mixed-methods approach using state administrative data, collecting quantitative survey data on child care provider experiences, and qualitative focus groups with child care providers.

Across these three major investment categories we examined more than 80 research questions, using various data sources (described below) to understand four overarching areas:

- **CCSG spending patterns:** CCSG spending by category and provider type, impacts of the relief funding expiring as reported by providers, and provider needs post-ARPA funding.
- **Access to child care:** Open/closed status; waitlists; licensed capacity; child enrollment; authorization and utilization.
- **A stable, supported workforce:** Investments in the workforce, recruitment, retention, and other perceived impacts of grant funds on the workforce (e.g. staff morale).
- **Health, safety, and quality in child care:** Child care facility improvements, licensing violation remediations, QF providers contracted with DES, and mental health expenditures.

DATA SOURCES

We used a variety of data sources to address the questions in Part I of the evaluation, including administrative data from DES, DHS, FTF, and Local Initiative Support Corporation (LISC) Phoenix; survey data; and focus group data. We describe each data source at a high level below.

Administrative Data

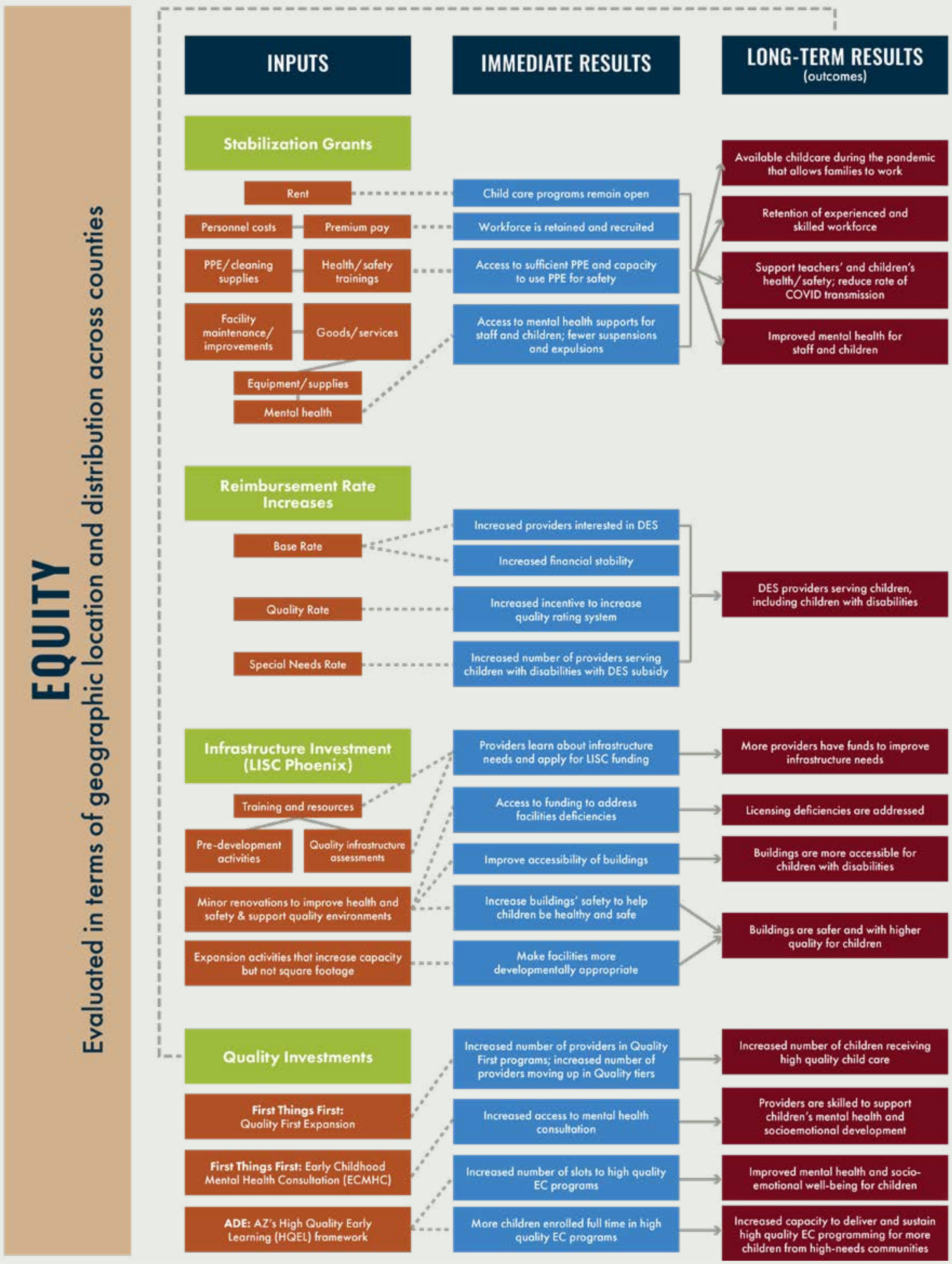
DES Geographic Information System (GIS) File. The GIS data file consisted of provider and client data in monthly files from August 2019 to July 2023. The provider files included a record of each provider contracted with DES including demographic data on the provider (i.e., provider service address, language spoken), descriptive information on the program (i.e., service type, address), and demographic data on the children served (i.e., race/ethnicity, age). The client files included child and family personal and program specific demographic data (i.e., child's city, state, zip code, and county; race/ethnicity of children served). Children's names were not included in the data for confidentiality.

DES Fiscal Payment File. The fiscal payment files consisted of yearly files from 2019 through 2023. The files contained a record of each payment made to child care providers for care delivered. It included the provider ID, child ID, family ID, the payment amount, eligibility category, length of child care day service, etc. In each dataset, binary variables were created for "quality" status, "subsidy" status, DCS status, and length of day service. Service codes, which included descriptive program information such as licensing type and national accreditation, were condensed from 56 categories to 14 categories.

DES CCSG Monthly Reports. CCSG monthly reports, including the final report submitted by providers, and administrative data on CCSG grantees were used for descriptive analysis. The monthly and final reports were submitted some time between August of 2021 and January of 2024, which includes final reports that were resubmitted for correction. The administrative data included the total and monthly payment amounts for all CCSG grantees throughout the grant period. First, duplicates were removed from the monthly and final report data before creating a new dataset that included the first report submitted by a provider along with the final report submitted by the same provider (N = 2,633). The first and final reports that were submitted within the same month and year were removed from analysis. Next, this dataset was merged with the CCSG administrative data (N = 3,001) in order to identify funding outliers (underreporting and overreporting of funding received). Outliers that reported unusually high numbers of staff employed and staff left from their programs were also identified at this stage and coded as missing data. The final sample consisted of 2,608 providers.

DHS Administrative Data. DHS, the child care licensing body in the state, requires licensed child care providers to comply with minimum health and safety regulations. Regular inspections are conducted to ensure that providers are meeting these criteria. Individuals may also submit complaints if they believe that a provider is not complying with licensing, requiring a process of substantiating the claim. If a child care provider is found to not be in compliance either from a regular inspection or complaint process they must resolve the issue in order to be in good standing. If a program does not resolve the issue they move into the enforcement stage and may be required to

Figure 5: Theory of Change for This Evaluation Project



pay a civil penalty, have their license suspended, or have their license revoked, among other consequences. For the purposes of this project we analyzed a subset of 780 child care providers who were in the enforcement stage, 75% of whom were required to pay a civil penalty. The data file included incidents from October 2020 to October 2023, a description of the violation, the penalty required to be paid, and the date of the enforcement action.

First Things First Administrative Data. For the current study, FTF reported data on the expansion of Quality First and ECMHC. The data used from these reports included counts of newly enrolled QF programs funded by federal pandemic relief dollars. Reports on the ECMHC program included the number of participants receiving ECMHC by center and home status funded by pandemic relief dollars, the number of additional mental health consultants newly hired, and the total number of additional sites receiving ECMHC. Additionally, these reports included priority population information particularly regarding providers serving DCS children, Spanish speaking providers with limited English proficiency, and providers serving infants and toddlers.

Arizona Department of Education High Quality Early Learning Data. ADE's High Quality Early Learning (HQEL) program was funded through the pandemic relief funds. This reporting included information about the participating programs, the requested slots, and the amount of funds received.

DES and DHS Provider Universe File. This file was created by DES staff by combining DHS and DES administrative data to create a file with both sets of providers, receipt of CCSG, program type, program name, license capacity group, DES contracted status, and open/closure status of these programs. The file was created in July 2023.

LISC Data

LISC Phoenix administered the Child Care Infrastructure Grant project and shared an application file and a close out survey for use in this evaluation. Grant funds were required to be expended in less than one year and the application file was collected in November-December 2022 and the close out survey was conducted in late summer 2023.

LISC Application File. The application file (N = 968 applicants) included a description of the program (i.e., name, ID number, address, program type) and a description about the applicant (i.e., race/ethnicity, language, veteran status, gender, role, etc.). Other program information included years in operation and participation in various state programs, including QF participation, QF rating, child care health consultation, and Child and Adult Care Food Program. Applicants also completed information about the children they served, including enrollment, license capacity, child care waitlist, percentage of children receiving DES subsidy, children with disabilities, dual language learners, infants and toddlers, children in the welfare system, and racial/ethnic group composition (percentage of children served belonging to each group). Additionally, applicants detailed their needs for an assessment of the building before improvement, the proposed facility project, and requested amount. Further, data on how the project will help increase capacity, enrollment, or quality and calculated if the program was in a child care desert or a low or middle income area.

LISC Closeout Survey. After selected grantees (N = 478) completed the grant they were asked to complete a final survey reporting on their experiences with and perceived outcome of the grant. This data file including the number of added slots and the age group of this added capacity, impact on the waitlist, any ways the program increased quality and how, and improving health and safety, if a program addressed a licensing and certification issue and how.

Child Care Provider Pandemic Relief Experiences Survey

In partnership with DES, the CEP designed and launched the Child Care Provider Pandemic Relief Experiences Survey (referred to moving forward as the "provider survey") to Arizona-based child care providers regarding their program's receipt of COVID-19 relief funding including CCSG and other programs funded by ARPA/CRRSA dollars including the expansion of QF and ECMHC, High Quality Early Learning (HQEL) program, and child care infrastructure grant. Providers were asked about their receipt of supports, experiences with and perceptions of CCSG, and interactions with DES. The sampling frame was all DES and DHS child care providers (N = 3,687 as of July 2023). The listed program point of contact email address was used to reach out to providers. The survey was available for two weeks between September 25 and October 13, 2023. Reminders were sent every three days to those who had not completed the survey. Providers were offered an incentive of a $10 gift card to compensate for their time. A total of 898 providers completed the survey, which was a response rate of 25%..

The survey included a total of 64 questions with sections regarding the characteristics of the program, stabilization grant experiences and outcomes, areas of need pre-pandemic and current (September/October 2023), workforce retention, experiences contracting with DES, and information regarding child care subsidy reimbursement rates. The sample included 51% Licensed Centers, 20% non-certified relative providers (NCRPs), 13% Group Homes, and 16% Certified Family Providers. The sample was 85% DES contracted, 64% DHS Licensed, and 53% both DES and DHS. The racial/ethnic and language make up of the survey included 3.12% American Indian/Alaska Native or Indigenous, 3.7% Asian, 11.5% Black or African American, 38.5% Hispanic/Latino(e/a), <1% Native Hawaiian/Pacific Islander, 40% White Non-Hispanic/Latino, 2.44% Other. Roughly half (51%) of participants spoke a language other than English, the most common of which was Spanish (81%).

Focus Groups

CCSG Focus Groups. Two rounds of focus groups were held with ECE providers (N = 36). Sampling for the focus group came from a cohort of child care directors participating in the Southwest Human Development Early Childhood Business Solutions program. The first focus group was conducted in October 2022 (N = 20), and the second focus group in June 2023 (N = 16). Most participants were female (N = 34), worked in center-based programs (N = 25) compared to home-based programs (N = 11), and held director and/or owner roles. Other roles included administrative assistant, preschool program coordinator, and lead teacher. Participants had varied years of work experience, from 4 months to 30-plus years. Providers were offered an incentive of a $10 gift card to compensate for their time.

Providers were asked about their receipt of supports, experiences with and perceptions of CCSG, and interactions with DES.

DES Contracted Providers Focus Groups. Sampling for this set of focus groups came from email addresses of Arizona child care providers reported through the provider survey, which included respondents from centers, group homes, family child care providers, and NCRPs. For survey respondents who completed the survey and answered whether or not they were currently contracted with DES or if they had been historically, we generated and sent an email (N = 480) in April 2024 inviting them to consent to participate in one of three focus groups: currently contracted (N = 378), never contracted (N = 72), used to be contracted (N = 30). For those that completed the consent form (N = 90), we invited the first six respondents for each of the six provider setting types (home-based, faith-based, school-based, center-based, Head Start, and Montessori) to join the virtual focus group through Zoom. Nineteen currently contracted providers, 12 never contracted providers, and 4 providers that used to be contracted attended the focus groups. We also conducted outreach through email to a subset of providers with the word "Montessori" in their email addresses (N = 17) in June 2024. However, none of the child care providers consented (N = 0). Of the focus group participants, providers lived or worked in ten of the state's 15 counties (Coconino, Gila, Maricopa, Mohave, Pima, Pinal, Santa Cruz, Yavapai, Yuma), and 31% were center-based, 25% were faith-based, 20% were school-based or Montessori, 20% were home-based, and 4% were non-certified relative providers. First, to establish a baseline and to identify any misinformation that may influence providers' desire and ability to contract with DES, we asked "In your own words, describe DES child care subsidies." Finally, the next set of questions directly related to the reason they were or were not contracted with DES, barriers, enablers, and challenges with DES contracting. Participants were offered an incentive of a $20 gift card to compensate for their time.

Evaluation of Arizona's Pandemic Recovery Investments in Child Care

PART I: CCSG SPENDING PATTERNS

This part shares findings on CCSG spending by category and provider type, impacts of the relief funding expiring as reported by providers, and provider needs post-ARPA funding.

PART II: EXPANDING ACCESS TO CHILD CARE

This part shares findings on program open and close status, percentages of providers with waitlists, levels of child enrollment across CCSG granted programs, and CCDF authorization and utilization.

PART III: SUPPORTING THE WORKFORCE

This part shares findings on workforce spending patterns and recruitment and retention.

PART IV: ENHANCING HEALTH, SAFETY, AND QUALITY

This part shares findings on reimbursement rate increases, the child care infrastructure grant, and other quality investments including Quality First and ECMHC expansions.

PART I

CCSG SPENDING PATTERNS

BACKGROUND

The CCSG was a major part of ARPA pandemic relief funds in the state and across the country. The main purpose of these stabilization funds was to support the stability of the child care sector to remain open or to reopen to serve young children and families during the pandemic emergency.[24] The stress of the pandemic compounded with decades of chronic underinvestment in ECE systems created difficult conditions for child care providers at the onset of the pandemic. They faced higher costs to ensure healthy and safe child care environments aligned with public health measures and experienced significant issues retaining qualified educators due in large part to lack of resources to support fair compensation and benefits, as well as the health risks of COVID-19 exposure as frontline workers.[25]

To help address these challenges, CCSG funds were subgranted to child care providers through the CCDF Lead Agency and were flexible in nature. Allowable expenses included operational costs associated with providing child care services during the pandemic, such as staff wages and benefits, rent, utilities, materials and supplies, personal protective equipment (PPE), and cleaning and sanitation. States were allowed to use their APRA supplemental CCDF discretionary funds outside of the specific CCSG allocations to more broadly address systemic issues, enhance policy, and pursue programmatic approaches to increase the supply and quality of child care. While the time-limited ARPA funds including CCSG did boost improvements in available child care resources across states, they were never intended to serve as a long-term solution.

Nationally, the $24 billion in ARPA CCSG reached more than 225,000 child care providers across the nation, which represents approximately 80% of all licensed providers, and ultimately impacted as many as 10 million children and their families.[26] The average child care center was awarded $177,000, most commonly allocating it to personnel costs.[27] Family child care providers on average received $27,000, most commonly using it for rent/mortgage and utility payments.[28]

In Part I, we describe 1) spending patterns for ARPA CCSG investment at the provider level using administrative data, by provider type, provider size, by region, and at two different time points (beginning and end of the grant period for each provider); and 2) provider-reported consequences and plans to mitigate negative impacts of funds expiring, via survey respondents and focus group participants. In subsequent Parts II, III, and IV, we examine the impacts of this grant **on child care access** (informed by open/close status, waitlists, and children served), **on the workforce** (informed by recruitment and retention trends, and by other provider reported impacts from the survey and focus groups), and **on health, safety, and quality** (reimbursement rates, child care infrastructure grants, other quality investments).

FINDINGS

In Arizona, the CCSG grant period was 22 months and reached a total of 3,001 providers between August 2021 and June 2023. Providers needed to be licensed or certified by March 11, 2021 to qualify for CCSG grants. Providers licensed after March 11, 2021 needed to be contracted with DES in order to qualify for grant funding. On average, providers received CCSG fundings for a period of 20 months, with the exception of DES Non-Certified Relative providers (NCRPs) who received funds for an average of 14 months (see **Figure 6**). 71%

of providers submitted their first report in Fall of 2021, meaning that around this time about 71% of providers in our sample started receiving CCSG funds in the Fall of 2021. Around 82% of providers submitted their final report between August and October of 2023; however, around 96% of providers in our sample received their last CCSG monthly payment between May and June of 2023. Therefore, when talking about "the beginning and end of the grant period", we are mainly referring to Fall 2021 (beginning of grant period) and May-June 2023 (end of grant period), while keeping in mind that a smaller group of providers started receiving CCSG funds at a later time point (after Fall 2021) or stopped receiving CCSG funds at an earlier time point (before May-June 2023).

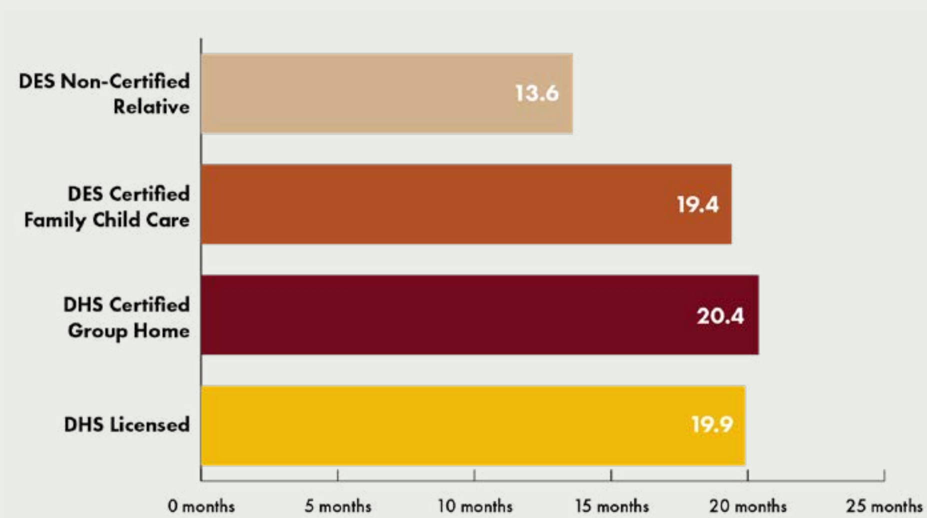
CCSG Spending Patterns

A total of $572,954,000 in CCSG funds were disbursed to Arizona child care providers, but on average DHS licensed providers received a total of $287,209, DHS group home providers received $55,686, family child care providers received $27,673, and NCRPs received $10,499 over the course of the grant period (see **Figure 7**). These average fund amounts varied due to DES funding award ceiling guidelines. That is, award funding ceilings were different for each type of provider, with DHS licensed providers having a higher ceiling due to serving more children in their programs. The caps ranged from $500 per month between August 2021-September 2022 and $900 per month after October 2022 for NCRPs to $10,000 per month and $14,600 per month for DHS licensed providers with a licensed capacity of more than 101 children plus potential receipt of additional workforce amounts.[29]

Personnel costs were the most common expense reported by providers, representing 77% of funds spent (see **Figure 8**). Next, rent, mortgage and utilities were the second most common expense representing 11% of funds spent, followed by goods and services (7%), and facility maintenance (5%). This is echos the trend nationally, showing child care centers most commonly spent funds on personnel and family child care providers most commonly spent funds on rent, utilities, and mortgage.[30]

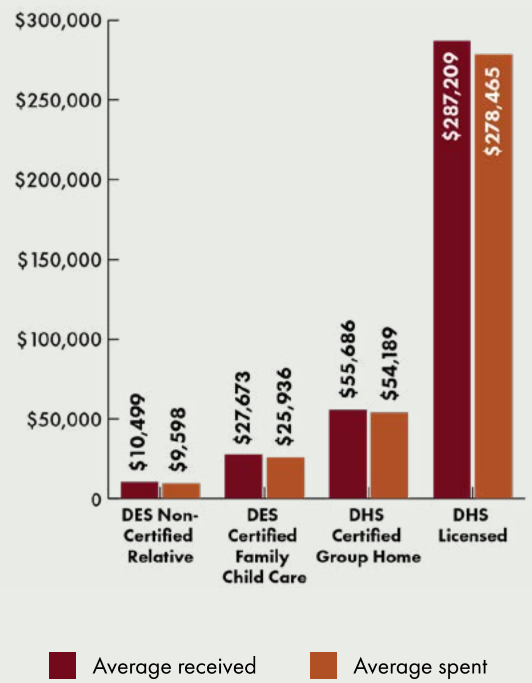
Additionally, at the beginning of the reporting period until the summer of 2022, providers were required to provide more detailed information regarding the allocation of funds within these larger categories (**Figure 9**). During this time, the majority of personnel costs were spent on payroll (96%) with smaller percentages spent on retirement benefits. Rent costs were broken down into mostly rent or mortgage payments (75%) followed by utilities and liability insurance. An additional category called

Figure 6: Average Number of Months of CCSG Funds Received by Provider Type



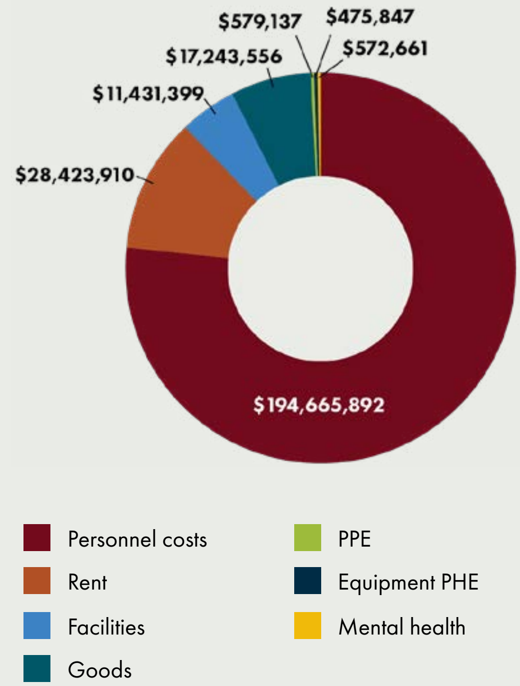
Note. N = 2,608 (Data Sources: Final DES CCSG Monthly Reports, November 2022 to January 2024, and internal DES CCSG total grant awards data).[39]

Figure 7: Average CCSG Funds Spent and Received by Provider Type



Note. N = 2,608 (Data Sources: Final DES CCSG Monthly Reports, November 2022 to January 2024, and internal DES CCSG total grant awards data).

Figure 8: Total CCSG Funds Spent by Category



Note. N = 2,608 (Data Sources: Final DES CCSG Monthly Reports, November 2022 to January 2024, and internal DES CCSG total grant awards data).

"premium pay" was created for analysis and included bonuses, insurance, education, tuition support, and others. Facilities costs were split between indoor and outdoor improvements and maintenance to serve children with disabilities.

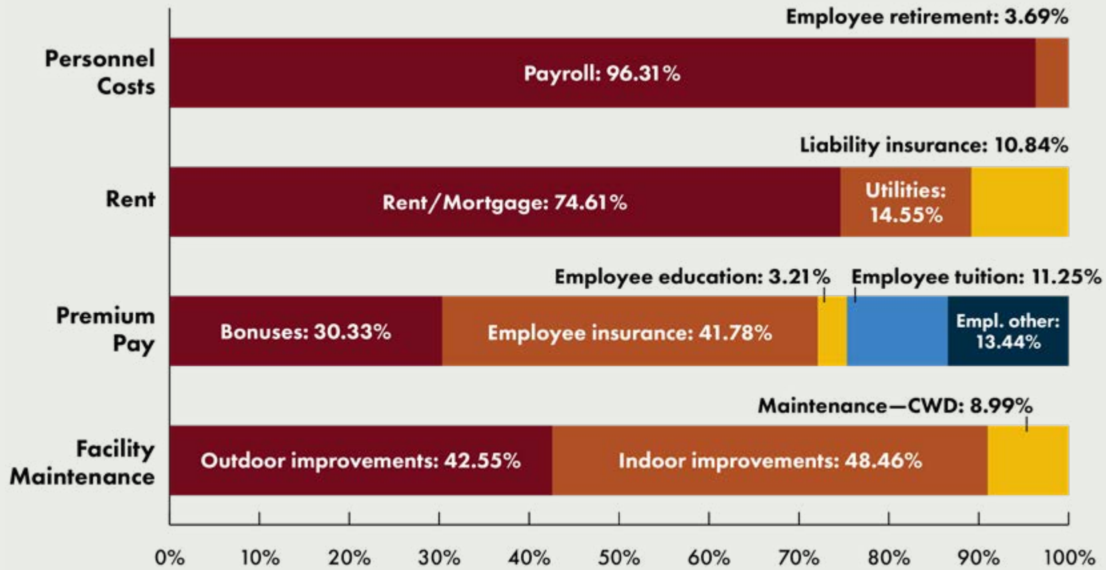
PERSONNEL

Personnel costs made up 77% of overall spending (**Figure 8**), though there was variation by program size and type, with DHS licensed providers spending the majority of their funds on personnel, DHS certified group homes spending roughly half, and certified family child care and NCRPs spending very little on personnel, given that these programs usually do not have outside staff. 71% of providers submitted their first report in Fall of 2021, meaning that around this time about 71% of providers in our sample started receiving CCSG funds in the Fall of 2021. Around 82% of providers submitted their final report between August and October of 2023; however, around 96% of providers in our sample received their last CCSG monthly payment between May and June of 2023. Therefore, when talking about "the beginning and end of the grant period", we are mainly referring to Fall 2021 (beginning of grant period) and May-June 2023 (end of grant period), while keeping in mind that a smaller group of providers started receiving CCSG funds at a later time point (after Fall 2021) or stopped receiving CCSG funds at an earlier time point (before May-June 2023).

RENT/MORTGAGE/UTILITIES

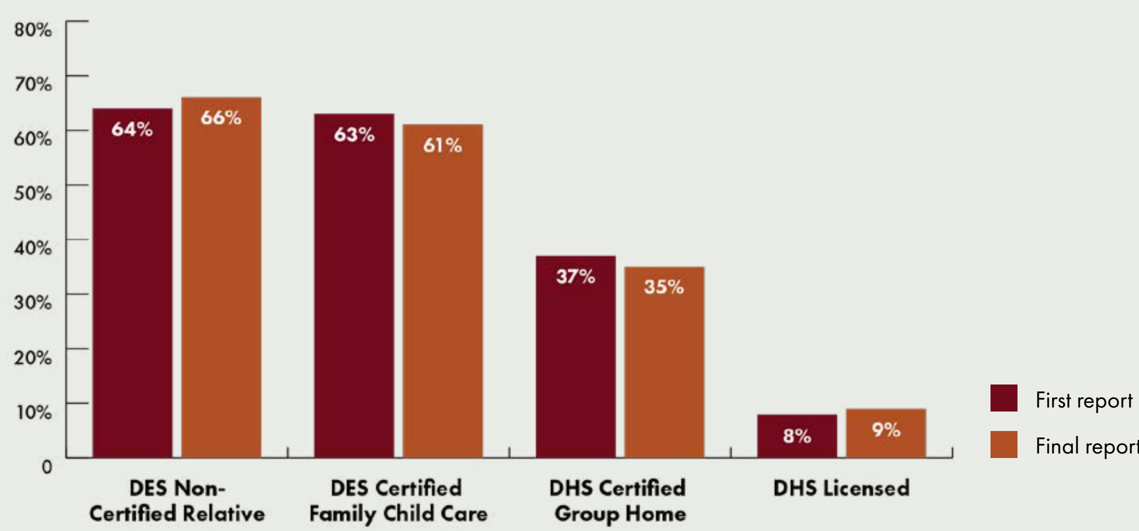
Rent, mortgage, and utilities cost were the second most common expenses reported by providers who received CCSG funds. To analyze spending throughout the CCSG grant period, we looked at provider's first report when they started the grant and final report the last month

Figure 9: June 2022 CCSG Spending Reporting



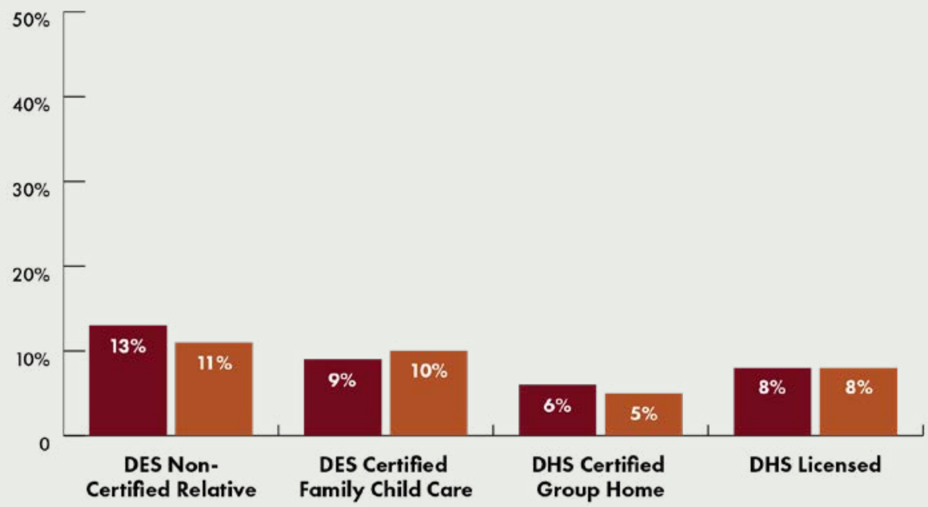
Note. N = 1,900 CCSG. (Data Source: DES CCSG Monthly Reports, June 2022).

Figure 10: Percentage of CCSG Funds Spent on Rent, Mortgage, and/or Utilities by Provider



Note. N = 1,310. (Data Source: First and Final DES CCSG Monthly Reports, August 2021 to January 2024). Data excludes grantees with missing data on category expenses.

Figure 11: Percentage of CCSG Funds Spent on Goods and Services by Provider Type



Note. N = 1,310 CCSG grantees. (Data Source: First and Final DES CCSG Monthly Reports, August 2021 to January 2024). Data excludes grantees with missing data on category expenses.

they participated in the grant. When looking into the percentage of funds spent on this specific category by provider type, we found that NCRPs and family child care (FCC) providers on average spent at least 60% of their funds on rent/mortgage/utilities (see **Figure 10**). On average, Group Home providers spent 35% of their funds in this category, too, whereas DHS licensed providers were the least likely to spend their funds in this area (between 8% and 9%). These findings are consistent with national level data, which found that home-based providers were more likely to spend on rent, mortgage, and utilities compared to center-based providers.[31] When breaking this category spending down by program size, the same trend was observed with providers serving less than 10 children being more likely to spend at least half of their CCSG funds in this category compared to providers who serve more than 10 children. The percentage of CCSG funds spent on this category at the beginning and at the end of the grant period stayed relatively consistent across all providers.

GOODS AND SERVICES

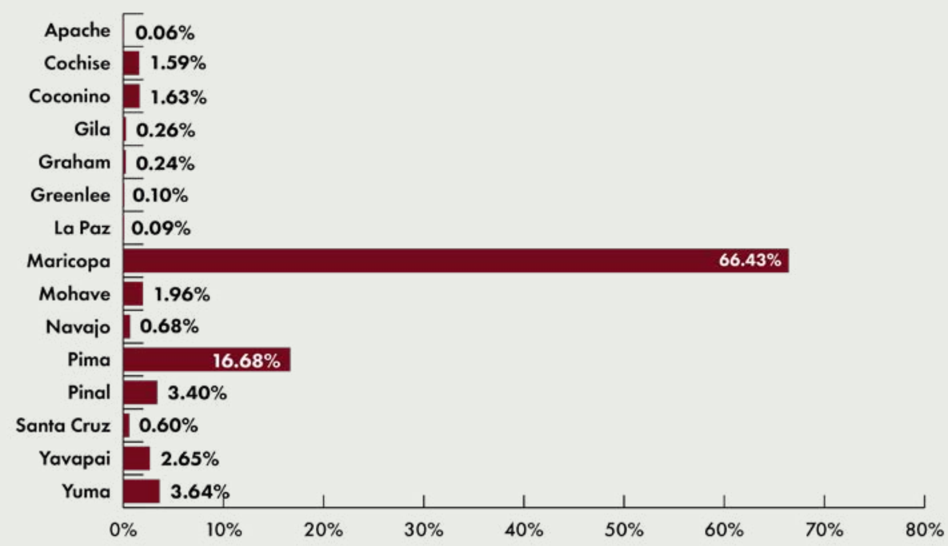
Goods and services represented the third most common expense reported by providers (7% of funds spent on this category; see **Figure 11**). Goods and services could include, for example, food, play, learning, diapering, or safe sleep materials. On average, DHS Certified Group Home providers were the least likely to report spending funds on this category (from 5% to 6%) compared to NCRPs, Family Child Care providers and licensed center providers. The percentage of CCSG funds spent on average on this category at the beginning and at the end of the grant period stayed nearly consistent across all providers (see **Figure 11**). When broken down by program size, those serving fewer than 60 children were more likely to report spending funds on goods and services compared to providers serving more than 60 children.

CCSG INVESTMENTS BY COUNTY

When examining how funds were distributed by county, funding allocations reflect population densities in Arizona, with the bigger counties receiving a higher amount of funds due to having a higher number of providers compared to smaller counties (see **Figures 12 and 13**). Maricopa county received the largest amount of funds compared to other counties: $367 million dollars. This represented 66% of total stabilization funds. Pima county received the second largest amount of funds, with more than $92 million dollars or 17% of total stabilization funds.

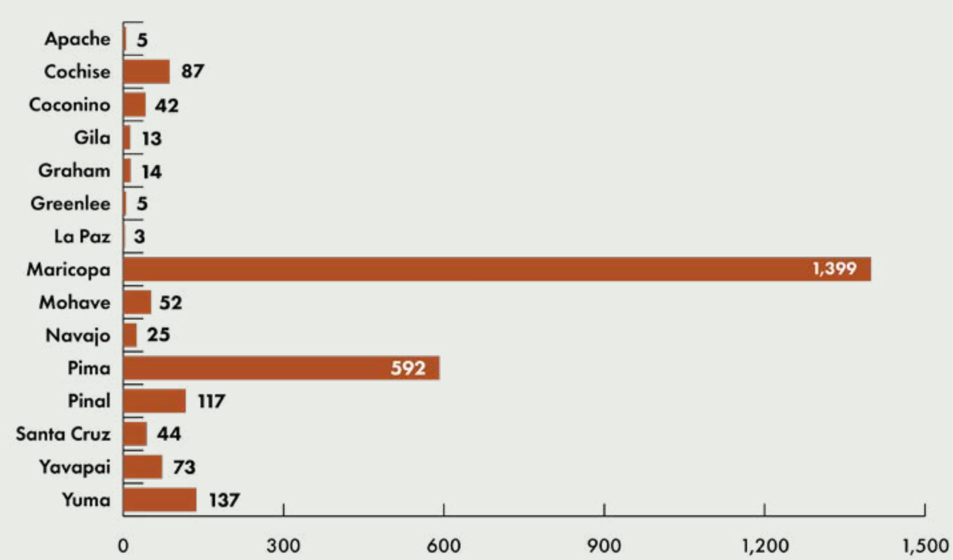
When examining the percentage of providers who received CCSG funds in relation to the provider universe as of July 2023, we observed that 10 out of 15 counties

Figure 12: Percentage of CSSG Funds Distributed by County



Note. N = 2,608. (Data Source: Final DES CCSG Monthly Reports, November 2022 to January 2024).

Figure 13: Total Number of CCSG Providers by County



Note. N = 2,608. (Data Source: Final DES CCSG Reports, November 2022 to January 2024).

had at least 50% of their providers receiving CCSG funds (see **Figure 14**). However, this was not the case for Apache, Coconino, Gila, Graham, and Greenlee, with Apache having the lowest rates of providers receiving CCSG funds (29% of providers). However, it is important to note that these results are based on data from a specific time point and not for the whole grant period. Therefore, they should be interpreted with caution.

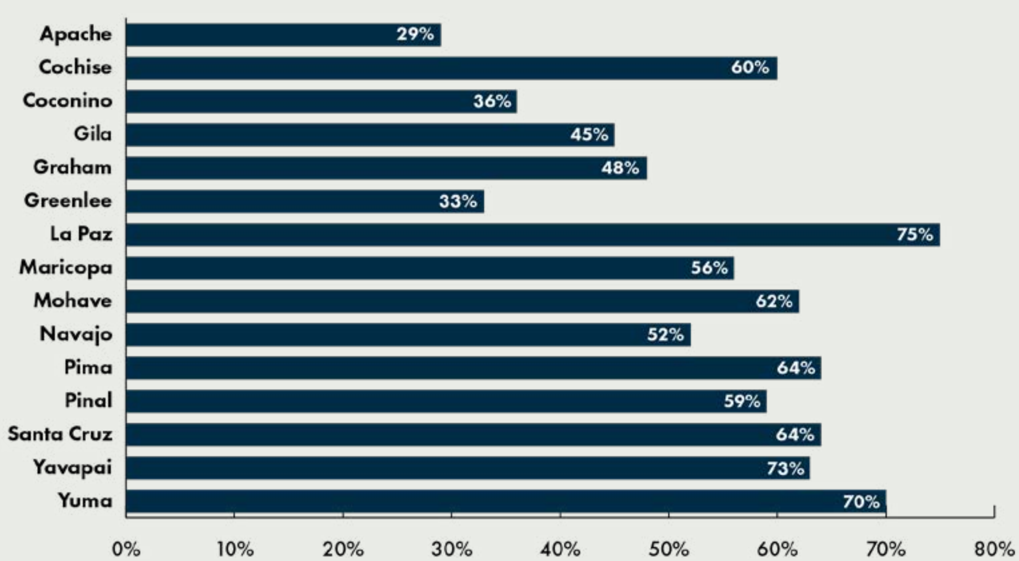
Provider Reported Impacts of Relief Funding Expiring

The influx of COVID-19 relief funding from ARPA stabilization grants (CCSG) ended in September 2023, creating a funding cliff for the child care sector across the country.[32] A 2023 analysis found that, without ongoing federal investments, this child care fiscal cliff would result in children losing access to care, parents experiencing work disruptions or having to leave the workforce altogether, educators losing jobs in the ECE workforce, and the state economy losing tax revenue.[33] Indeed, the post pandemic period has been characterized by negative profit margins, even with additional federal support.[34]

Additionally, it is important to note that Arizona was able to provide some relief from the funding cliff through the Arizona Child Care Assistance Provider (AZCAP) grant funded through ARPA from October 1, 2023 through June 30, 2024.[35] This was a one time funding award to extend the CCSG payments programs had been receiving in many cases for multiple years. It was intended to support DES contracted child care programs and DES certified family child care providers' personnel costs and rent/mortgage and utilities costs for programs that do not employ staff (family child care or group homes). Award caps ranged from $3,000 for DES certified family child care (serving 1-4 children) to $80,000 for centers with a capacity of 101+ children. However, due to the timing of program announcement and the evaluation period, AZCAP was not included in this analysis.

Throughout the CCSG time period, child care providers used funds to give pay raises and bonuses to their staff, many for the first time in years, pay for the space that their child care program operated in (rent/mortgage and utilities), or provide staff with benefits like health insurance and retirement. Using CCSG funding to increase

Figure 14: Percentage of Total Providers that Received CCSG by County



Note. Provider Universe N = 3,434. CCSG Provider N = 2,012. (Data Sources: Provider Universe, July 2023 and DES CCSG Monthly Reports, June 2023). Provider universe excludes 286 providers with missing county information.

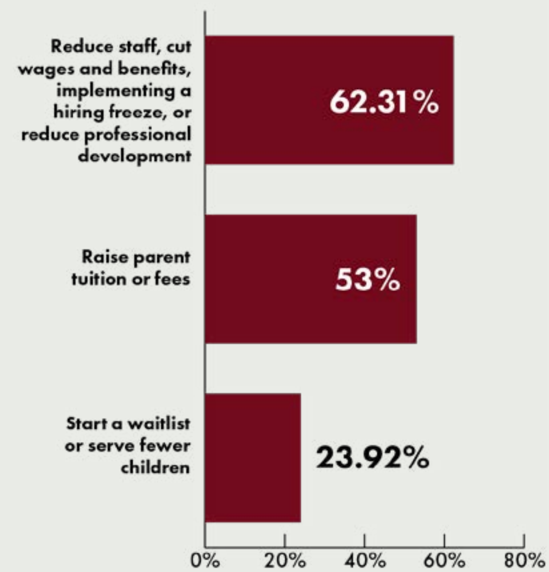
wages and provide access to benefits was particularly salient given that the ECE field is one of the lowest paid professions despite their expertise and essential role in the state's economy.[36] In fact, child care workers in Arizona earn a median wage of $14.54 per hour which is nearly two times less per hour than the average Arizona worker, placing many early childhood educators just below the poverty line for a family of four.[37] However, providers knew that this funding was not permanent and were required to spend the funds they received, making it difficult to plan for the future of their programs. Next, we highlight providers' own reporting on what actions they planned to take when funding ended and the outstanding needs of their programs.

Provider Actions and Planning Post-ARPA Funding

Child care providers were asked to report on what challenges they expected and what actions they planned to take at the end of the stabilization funds. Providers indicated that they would have difficulty maintaining raises that they had previously given to existing staff, and paying for their rent or mortgage. In order to support the financial stability of their program, of providers who responded to the question, 62.31% reported that they would have to take action that impacted staffing (cutting staff wages or benefits, letting teaching staff go, implementing a hiring freeze, and reducing professional development opportunities), 53.18% reported they would raise parent tuition, and about a quarter (23.92%) reported that they would have to serve fewer children or implement a waitlist (see **Figure 15**). Almost a third of providers (32.35%) reported they would seek additional public funding sources while 20.31% reported they would seek additional private dollars (see **Figure 16**). Almost 5% of respondents said they would need to close their program once CCSG ended.

Additionally, CCSG grantees were asked about their plans after funds end during focus groups (one held in Fall 2022 and one in the Summer of 2023). Participants in the latter focus group were more likely to have clearer plans after funds end compared to providers who were in the first round of focus groups. Specifically, providers reported planning to engage in a few strategies for sustaining

Figure 15: Provider Actions Planned for After CCSG Funding Ended



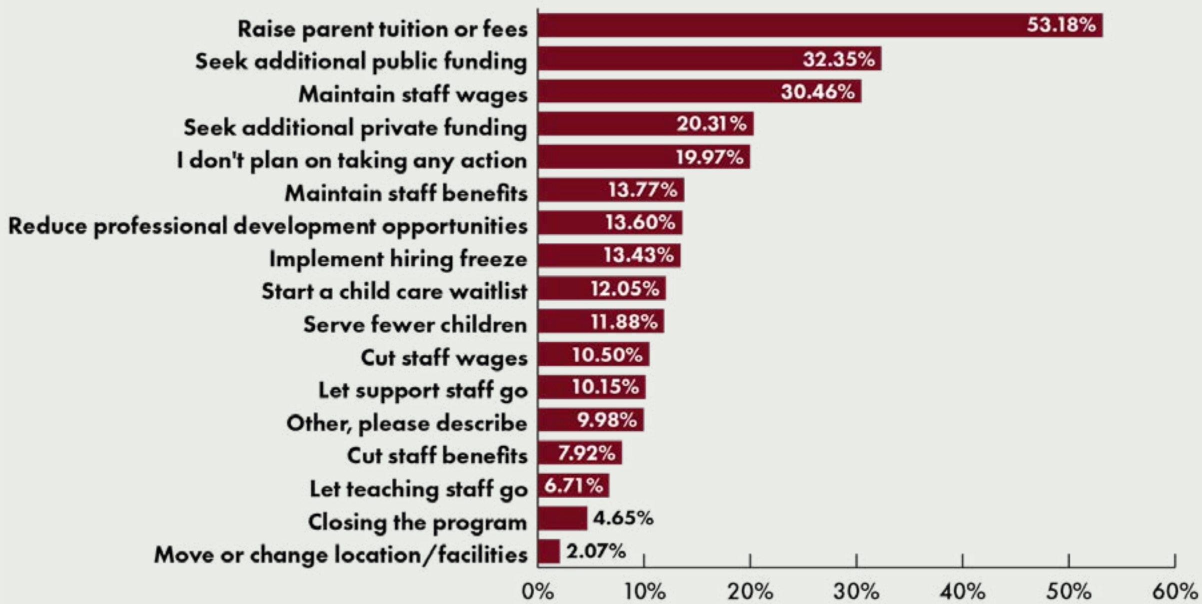
Note. N = 581 (Data Source: Provider Survey).

changes made during the CCSG funds period, such as applying or relying on other existing grants, increasing child enrollment, increasing child tuition, and effective budgeting like cutting down on expenses.

As this female, center-based provider conveyed:

> **"Obviously, this is the last month for June that we receive funding. And so...we know that going forward...we got to get enrollment going...we probably will need to increase our tuition, which we haven't done for some time because we haven't had to. Not that we want to put the burden on the parents, but realistically, we'll have to increase that a little bit. And so moving forward...we gotta kind of gotta get back in, gear up..."**

Figure 16: Provider Actions Planned for After CCSG Funding Ended (Expanded)



Note. N = 581 (Data Source: Provider Survey).

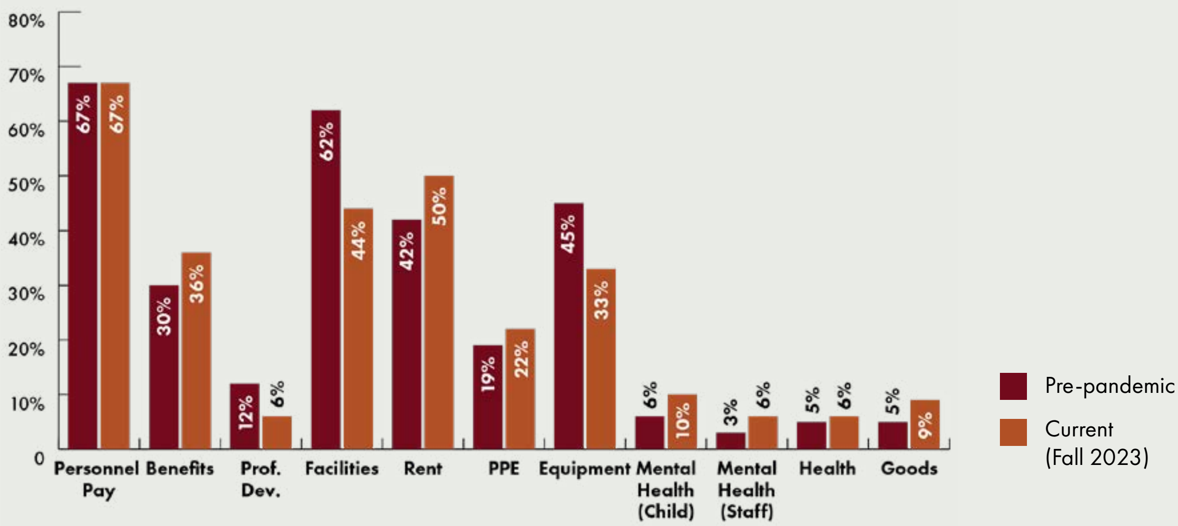
Almost half of providers anticipated that maintaining staff wage increases (48.64%) and paying the rent/mortgage (48.3%) would be a challenge.

Outstanding Needs After the End of ARPA Funding

Additionally, child care providers reported shifts in their needs between pre-pandemic experiences and the period after which federal relief funding ended. Providers were asked to respond to two questions "What were your program's TOP THREE GREATEST areas of need before the start of the COVID-19 pandemic (i.e. before January 2020)?" and "What are your programs' TOP THREE GREATEST areas of need currently?" in the provider survey. Providers could select up to three options, but did not rank these three choices.

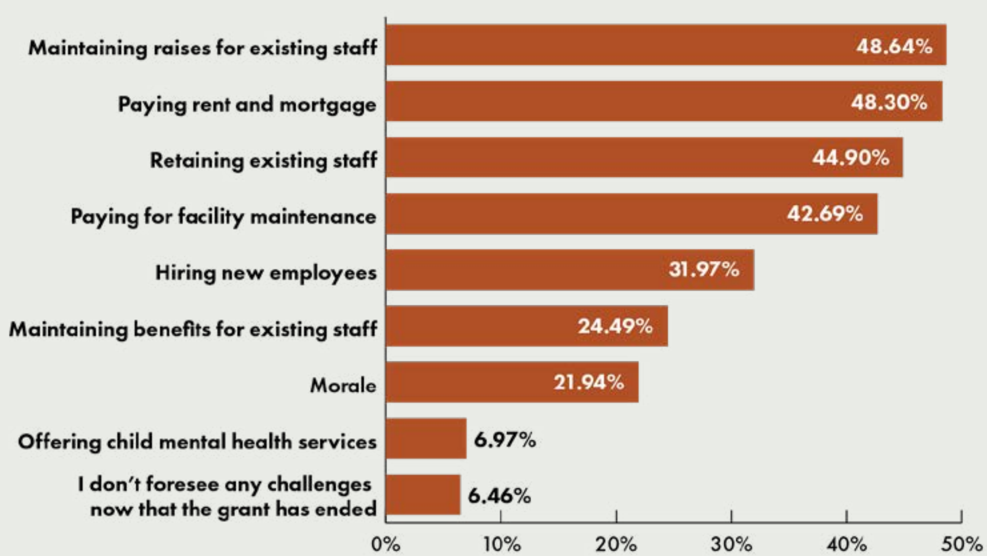
Personnel issues remained a pressing need for the majority of providers (67%) both pre-pandemic and in fall of 2023 when CCSG funds ended (see **Figure 17**). An increased number of providers reported benefits as an issue in Fall 2023 (30% pre-pandemic to 35% in fall of 2023). Rent needs also increased between pre-pandemic and fall of 2023. Two key areas of improvement were facilities and equipment where fewer providers reported these areas as a pressing need in fall of 2023 compared to pre-pandemic, though large percentages of providers (44% and 33%, respectively), still noted these as current needs. Additionally, almost half of providers anticipated that maintaining staff wage increases (48.64%) and paying the rent/mortgage (48.3%) would be a challenge (**Figure 18**). This is higher than the rate from a 2023 national RAPID survey which showed that 28% of providers across the nation reported cutting wages or not being able to sustain wage increases as a result of CCSG ending.[38]

Figure 17: Provider-Reported Needs Pre-Pandemic and Fall 2023



Note. Pre-Pandemic N = 484, Current Needs N = 631 (Data Source: Provider Survey)

Figure 18: Providers' Expected Challenges When CCSG Funds Ended



Note. N = 588 (Data Source: Provider Survey)

PART II

EXPANDING ACCESS TO CHILD CARE

BACKGROUND

One of the key aims of the CCSG and ARPA funds more broadly was to maintain and expand access to child care by keeping programs open and reducing child care program waiting lists. In Part II, we explored investments that impact access to child care and trends in the use of DES subsidies.[40] First, we utilized CCSG reports to analyze descriptive statistics on program openings and closures, waitlists, and child enrollments. Then, we examined GIS and fiscal administrative data to study changes in programs based on size. Finally, we examined DES subsidy authorization versus utilization rates over time.

FINDINGS

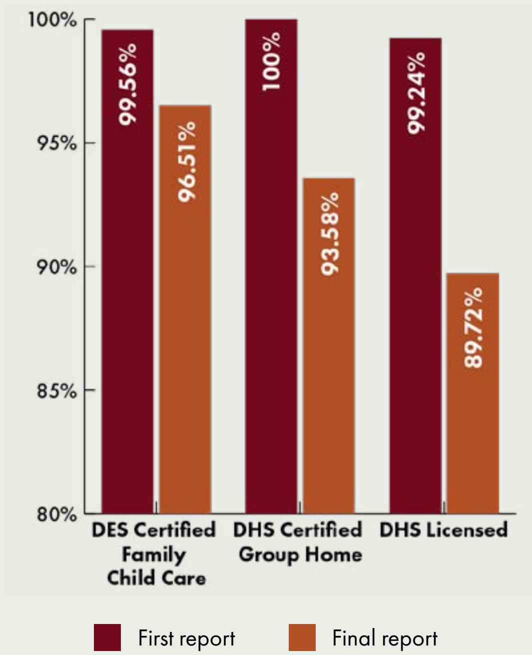
In our analysis of access to child care, we found that the vast majority of CCSG providers who submitted their final reports remained open (91%). Providers in small-sized programs (serving less than 60 children) were more likely to report closing their programs for more than 14 days (temporary or permanent) at the end of the grant period compared to providers in programs that served more than 60 children. Reasons for closures were varied. The amount of providers that reported having a waitlist on average, as well as those reporting a waitlist due to a staff shortage, decreased during CCSG, but when broken down by program type and child age served, figures differed. The number of providers with waitlists decreased for licensed-centers, for providers serving preschool and school-age children, but increased for those serving infants and toddlers. About half of providers who reported having waitlists, also reported to have waitlists due to staff leaving. Average child enrollment for providers receiving CCSG remained largely stable between timepoints for NCRPs, FCCs, and group homes. For licensed center-based providers, enrollment at the final time point was slightly higher than the first report, but still lower than provider reported enrollment in January of 2020.

Program Open/Close Status

A total of 3,001 providers received funds during the grant period, and 2,608 providers (87%) of the programs completed a report at both the first grant period and the final grant period. To determine rates of program closures within this sample, we removed NCRPs from this analysis given that they do not normally "close" like other providers. This resulted in a total of 2,295 providers. Within these 2,295 providers, 91% of them reported being open at the end of the grant period, which only varied slightly across provider type (see **Figure 19**). However, since not all providers submitted a final report (N = 368), it is unclear whether this was due to providers being closed or choosing not to submit a final report. This suggests that the rate of program closures are likely higher. Further, because of the nature of CCSG—including its intended impact to *prevent closures*—the wide array and proportion of providers who received support, and the lack of a control group, it is not possible to know how many programs would have closed without CCSG.

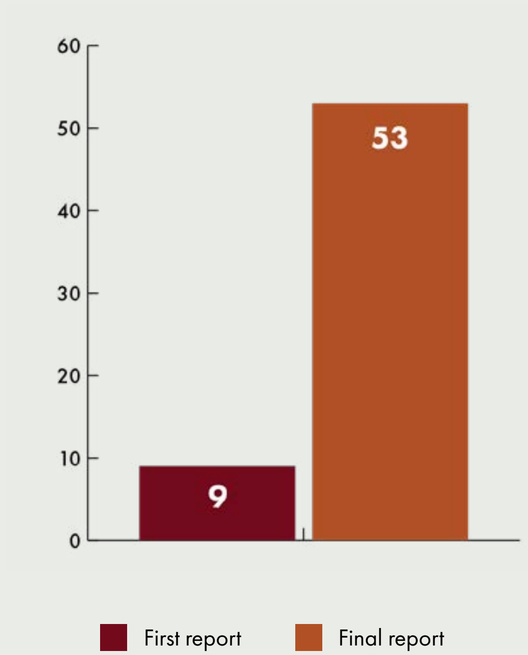
At the end of the grant period, there was a slight increase in the number of providers who reported being closed for more than 14 days, due to reasons other than summer closures, compared to the beginning of the grant period (from 9 to 53 providers, or from 0.35 to 2%, specifically; see **Figure 20**). Providers who were more likely to report being closed due to reasons other than summer closures were more likely to be group home providers or DHS

Figure 19: Percentage of CCSG Providers Open by Provider Type



Note. N = 2,295. (Data Source: First and Final DES CCSG Reports, August 2021 to January 2024). Data excludes NCRPs.

Figure 20: Total CCSG Programs Closed for More than 14 Days



Note. N = 212. (Data Source: Final DES CCSG Reports, November 2022 to January 2024). Data excludes NCRPs.

licensed providers who served less than 60 children. There are a variety of factors that contributed to this trend, though we did not follow up with these providers directly which could have provided clarification and further insight. Data from the CCSG final reports indicate that providers' reasons for closing their programs for more than 14 days other than summer closures varied, such as personal problems, selling their business, going through major renovations, and lack of funding (see **Figure 21**).

During focus groups held with providers back in the Fall of 2022 and Summer of 2023, providers shared that CCSG funds explicitly helped them keep their programs open mainly by using funds to increase the number of children served, and hiring and retaining staff. As this female, center-based owner and provider conveyed:

> **"What I can say is, I wouldn't have survived without the funds... We remained open the full time and without those funds, I don't know that the businesses would be here today and that's the honest to God truth... We had a lot of, I'm located near a few hospitals, so we had staff from the hospitals as well. So we were busy..."**

Waitlists

On average, the number of providers operating child care waitlists, where there are not enough open slots for families who want them, for their program decreased at the end of the grant period compared to the beginning of the grant period, from 1103 (42.3%) providers to 999 (35%) providers, respectively. This suggests a decrease

Figure 21: Reasons for Closure

Note. N = 53. (Data Source: Final CCSG Reports, November 2022 to January 2024).

in waitlists during this time of CCSG funding support. However, patterns varied by child age and program type (see Figures 23 and 25). Still, the vast majority of those serving preschool-aged children had waitlists, as well as those serving toddlers.

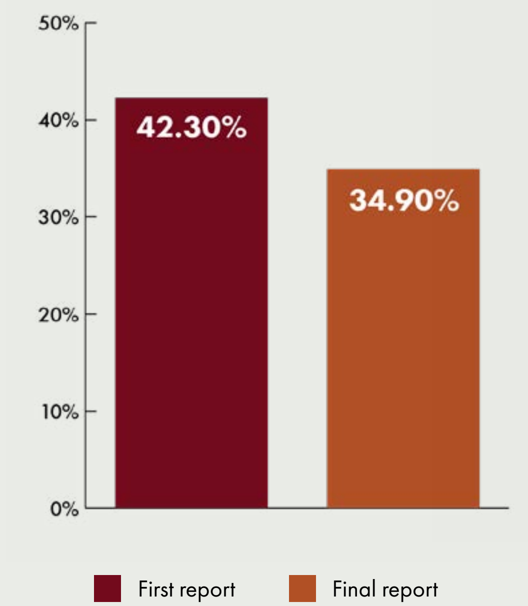
A larger percentage of licensed center-based providers reported having a waitlist compared to other provider types (see **Figure 23**). Fewer licensed center-based providers reported having a waitlist at the final report compared to the first report. Providers that served more than 10 children in their programs were more likely to report having waitlists, especially those serving more than 60 children. When broken down by county, five of 15 counties (Apache, Mohave, Navajo, Santa Cruz, and Yuma) had an increase between the beginning and end of the grant period, in the percentage of providers reporting to have waitlists (see **Figure 24**). Coconino had the largest reported waitlist at the beginning of the grant period (74%). Coconino, Greenlee, La Paz, and Gila had unchanged waitlist rates between the first and final reports.

For those with waitlists, providers were more likely to report having waitlists for toddlers (73%) and preschoolers (70%), than for infants or school-aged children at the end of the grant period (see **Figure 25**). In addition, we found that the percentage of providers with waitlists for preschool-age and school-age children decreased by 10% and 7% respectively between the first and final reports. However, the percentage of providers with waitlists for infants and toddlers increased by 6% and 1% respectively. This points to the need for both additional research on the number of slots available and the need for potential investments to expand slots for children under age 3. This is especially salient given that the recently revised 2024 CCDF rule requires states to build supply for infants and toddlers, children in under-served geographic regions, and children with disabilities through at least some portion of their grants and contracts.[41]

Next, we examined the number of providers who attributed their waitlist to staff shortages, meaning they could not serve more children because they did not have enough staff to do so. Only about half of providers who reported having waitlists, also reported to have waitlists due to staff leaving, suggesting that factors other than or in addition to staff turnover might be contributing to waitlists.

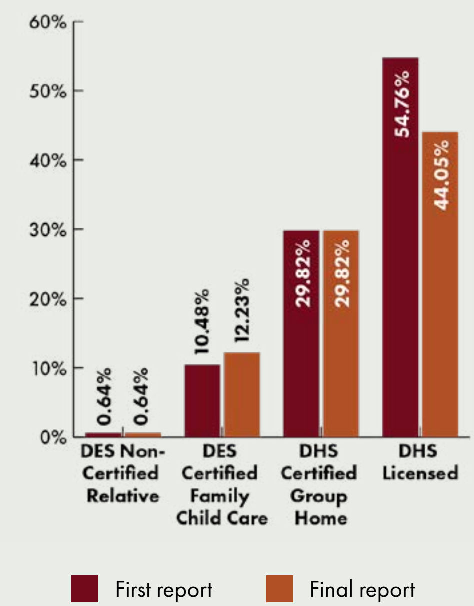
When looking at waitlists due to staff leaving, we observed a decrease in the percentage of providers reporting having waitlists due to staff leaving (see **Figure 26**). Again, licensed center-based providers, particularly those serving more than 60 children, represented the

Figure 22: Percentage of CCSG Providers Reporting Having Waitlists



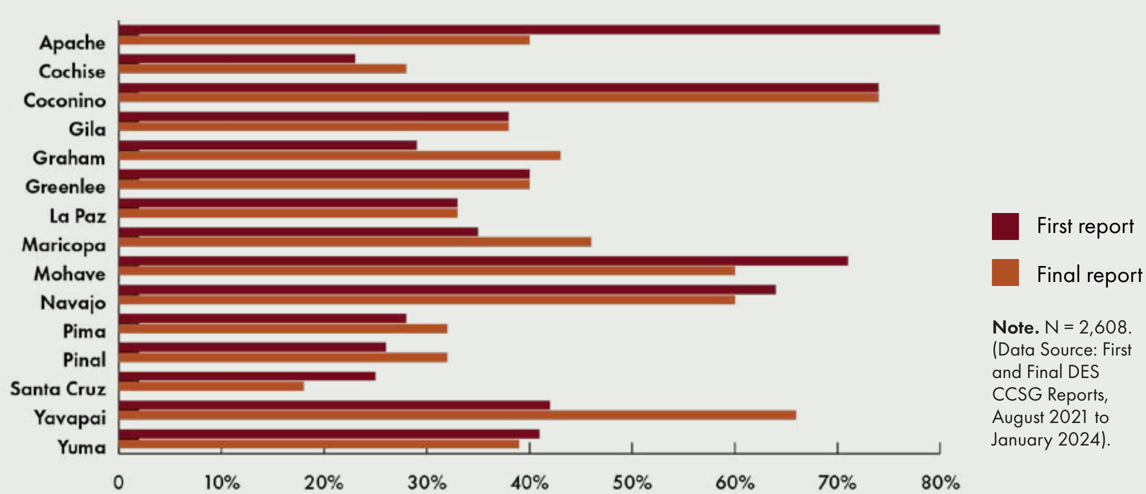
Note. N = 2,608 (Data Source: First and Final DES CCSG Reports, November 2022 to January 2024).

Figure 23: Percentage of CCSG Providers with a Waitlist by Program Type



Note. N = 2,608 (Data Source: First and Final DES CCSG Report data, August 2021 to January 2024).

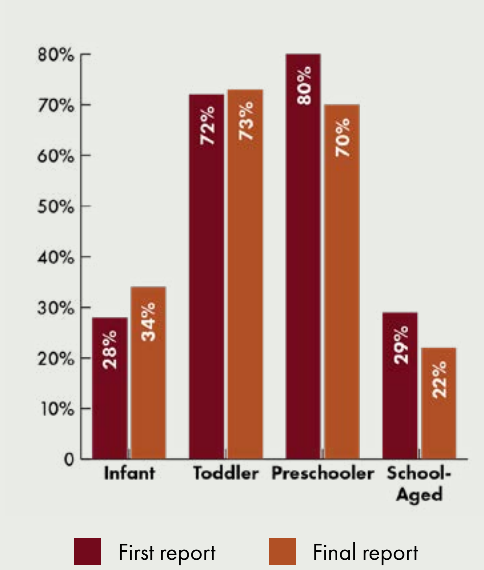
Figure 24: Percentage of CCSG Providers with Waitlists by County



Note. N = 2,608. (Data Source: First and Final DES CCSG Reports, August 2021 to January 2024).

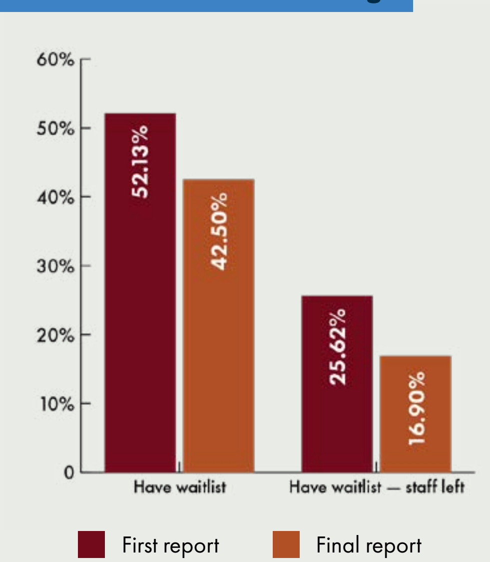
	Apache	Cochise	Coconino	Gila	Graham	Greenee	La Paz	Maricopa	Mohave	Navajo	Pima	Pinal	Santa Cruz	Yavapai	Yuma
1st Report	2	24	31	5	6	2	1	650	31	15	189	38	8	48	53
2nd Report	4	20	31	5	4	2	1	496	37	16	165	30	11	31	56

Figure 25: Percentage of CCSG Providers with Waitlists by Child Age



Note. N = 2,608. (Data Source: First and Final DES CCSG Reports, August 2021 to January 2024).

Figure 26: Percentage of CCSG Providers Reporting Having Waitlists and Waitlists Due to Staff Leaving



Note. N = 2,060. (Data Source: First and Final DES CCSG Reports, August 2021 to January 2024). Analysis excludes NCRPs and family child care providers.

highest drop in the percentage of providers reporting having waitlists due to staff leaving (from 15% at the beginning of the grant period to 10% at the end of the grant period).

Child Enrollment of CCSG Grantees

Child enrollment levels increased slightly for licensed center-based providers and stayed about the same for non-center based providers at the end of the grant period compared to the beginning of the grant period, Child enrollment did not return to pre-pandemic levels for any type of provider. This is consistent with providers' testimonies that speak to continuing challenges with child enrollment.

Average child enrollment for providers receiving CCSG remained largely stable between timepoints for NCRPs, family child care, and group homes, but this pattern was different for licensed centers (see **Figure 27**). Licensed center-based providers were the only ones that reported an increase in the average number of children enrolled, from 69 children at the beginning of the grant period to 71 children at the end of the grant period. When comparing these child enrollment averages to the average number of children providers reported to have in January of 2020, providers, particularly licensed center-based providers, are still serving fewer children compared to pre-pandemic times. This may be due to many reasons, including the increased availability of remote work during and after the pandemic potentially allowing for some families that may have previously sent their child to child care to keep their child at home to offset child care costs.

Research suggests that lower child enrollment was a pressing issue during the COVID-19 pandemic.[42] During our focus groups, providers (N = 8) also elevated this issue. As one female, center-based provider and program owner conveyed:

> **"...during COVID, I went from having [140 children] to 18 children with ten teachers on staff. And if you can imagine my feelings like, 'Oh my goodness, what am I gonna do? Am I gonna have to let these teachers go?' I had almost one-to-one ratio. 'What am I going to do?'...I'm not at 100% back where I was, I probably have about 75 to 80 children now. But that backup is work, has been work."**

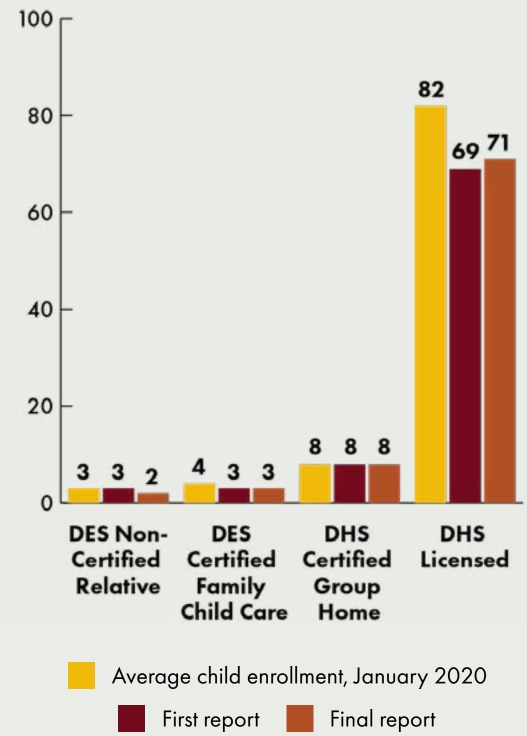
CCDF Child Authorizations and Utilizations

Child care subsidies, through the CCDF, aim to increase access for eligible children. In Arizona, DES serves as the CCDF lead agency and manages this process. Eligible children are initially authorized to receive care. Then, families locate and enroll in care with providers contracted with DES, and utilize child care services, which providers are then reimbursed for through payments. To understand the impact of subsidy use throughout the pandemic, child authorization was compared to utilization based on the count of subsidy payments providers receive per month. On average in 2019, DES authorized 46,597 children per month with 31,900 subsidy reimbursement payments made to providers. Data suggests a persistent disparity between the authorization of children and their actual access to care (utilization) from 2019 to 2023.

Figure 28 illustrates trends in months of children authorized to receive the DES subsidy compared to the number of children who utilized the subsidy between June 2019 and April 2023. Utilization here means that an authorized child used at least one day of child care assistance in a payment month and was based on payments made to the provider. Consistently, authorization numbers are higher than rates of utilization (see Figure 28). In June 2019, 46,451 children were authorized to receive subsidized child care through DES, decreasing to 38,903 by March 2023. In July 2019, the highest number of children were authorized with 48,206 being determined as eligible for care subsidy.

In early 2020, providers saw a significant decrease in attendance due to the global COVID-19 pandemic. In response, between March 2020 and December 2020, DES used CARES Act funding to maintain child care reimbursement payments for providers contracted with DES at a level that was no less than the reimbursements provided in January 2020 regardless of child attendance.[43] During this same time, providers were also reimbursed at a full-day rate for children who were previously part-time as of January 2020 but required full-time care such as was the case for school age children whose elementary schools had closures. This policy change may explain the peak in authorization and utilization in 2020, specifically peaks of 92% in November 2020 and declines to 62% in December 2020.

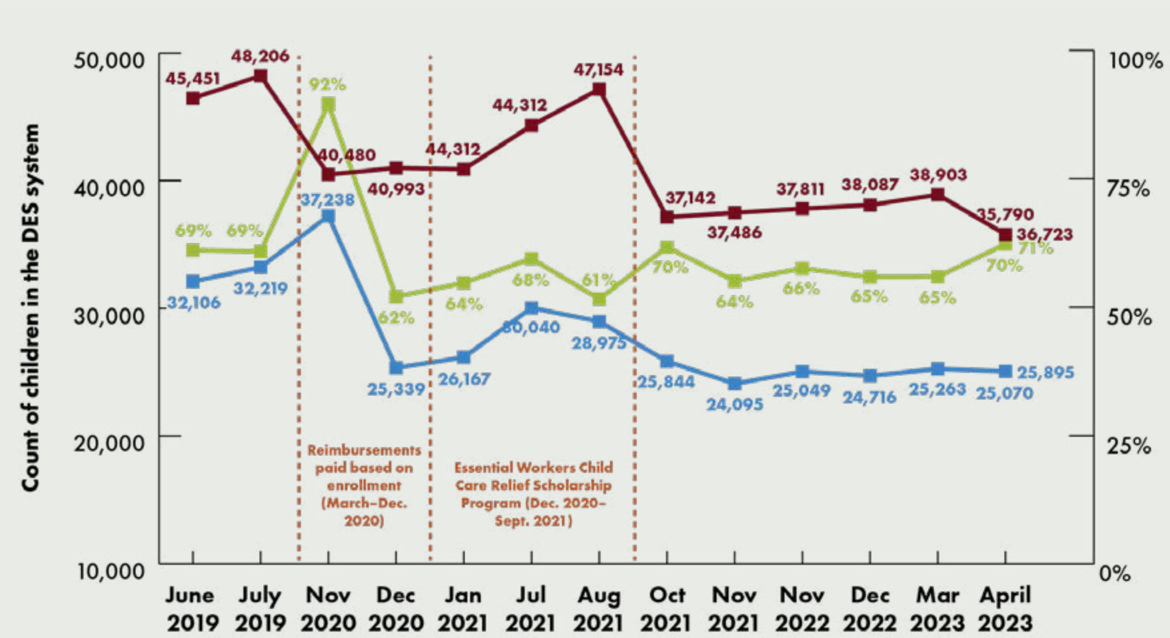
Figure 27: Child Enrollment Averages by CCSG Provider Type



Note. N = 1,812. (Data Source: First and Final DES CCSG Reports, August 2021 to January 2024). Analysis excludes providers with missing child enrollment data.

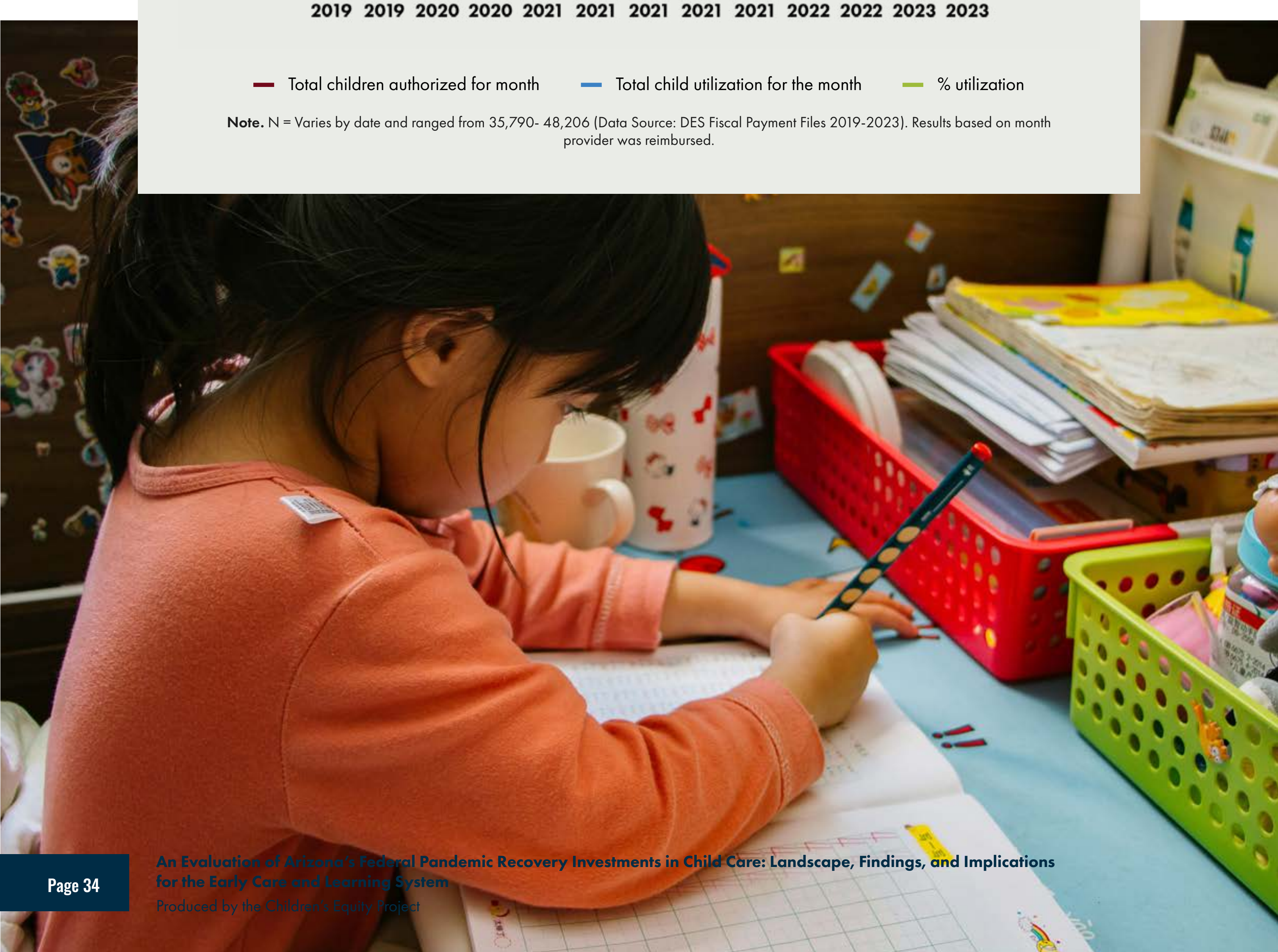
Additionally, we noted a steady increase between January and August 2021 from 40,893 to 47,154 children authorized, a rate that was higher than June 2019 authorization. Yet, utilization only slightly increased from 64% to 68% between January and July 2021 but hit its lowest point of 61% by August 2021. In October 2021, utilization was at 70%, a level that was not reached again until April 2023. Between December 2020 and September 2021, DES implemented the Essential Workers Child Care Relief Scholarship Program which provided child care scholarships to health care workers, first responders, essential government operations, grocery store and food bank workers, and licensed or certified child care workers.[44] These policy actions may have impacted the fluctuation in authorization and utilization rates.

Figure 28: Number of Children Authorized to Receive Subsidies vs. Utilized Subsidies



Total children authorized for month — Total child utilization for the month — % utilization

Note. N = Varies by date and ranged from 35,790- 48,206 (Data Source: DES Fiscal Payment Files 2019-2023). Results based on month provider was reimbursed.



PART III

SUPPORTING THE WORKFORCE

BACKGROUND

The Arizona ECE workforce experienced many challenges during COVID-19, and many providers were at risk of closure throughout the pandemic. Nationally, child care providers are underpaid when compared to K-12 educators, even with comparable education levels and despite the skill and knowledge of child development necessary to provide responsive early care and education for young children. For example, nearly 53% of the early childhood workforce nationally use public benefits as a result of their low wages.[45] In Arizona, child care providers are paid low wages as a result of a lack of federal and state funding, in line with national trends, but Arizona early childhood educators also reported higher rates of depression (47%, slightly higher than the national ECE sample of 45.8%), compared to the general population.[46] These problems existed before the pandemic but were exacerbated by the accompanying economic uncertainty and health and safety issues.

These issues do not fall equally, but rather most directly impact early childhood educators of color, a field that significantly comprises women, especially Black, Latina, Asian, and Indigenous women. For example, data show that the ECE workforce makes near-poverty wages despite the skills and experience necessary to teach young children. Additionally, the ECE workforce is consistently ranked as one of the lowest paid professions when compared to almost every other labor market in the U.S.[47] On top of this overall inadequate pay, it has been documented that an unfair racial pay gap exists within the field. For example, Black early childhood educators are paid an average of 78 cents less per hour than their White peers and up to $1.71 less per hour in preschool settings, resulting in a loss of more than $1,600 in salary per year for a full-time employee.[48] Even when teachers from marginalized groups access and complete advanced degrees, they experience pay gaps compared to White educators.

The CCSG portion of the COVID-19 Relief Funds were targeted specifically at the issues faced by child care programs and the child care workforce. CCSG provided a monthly grant to programs with the primary aim of covering workforce costs in order to retain existing staff, recruit new staff, and reduce child waitlists due to staff shortages, among other key areas of personnel and program spending. Over the course of almost two years (August 2021 through June 2023), over $550 million dollars were distributed to roughly 3000 child care programs across all 15 Arizona counties. Also, funds disbursed varied by provider type. Specifically, NCRPs had an award ceiling of $16,300, family child care providers had an award ceiling of $32,600, group home providers had an award ceiling of $63,400, and DHS licensed providers could receive up to $457,400 depending on their program capacity. As such, understanding provider's CCSG spending was central to the broader context of COVID-19 relief funding in the state, particularly as it relates to key workforce outcomes (i.e., retention, recruitment, waitlists due to staff shortage). In Part III, we examine spending patterns related to the workforce, and the impact of ARPA CCSG funds on recruitment, retention, and other outcomes as reported by providers.

FINDINGS

Spending Patterns on Workforce

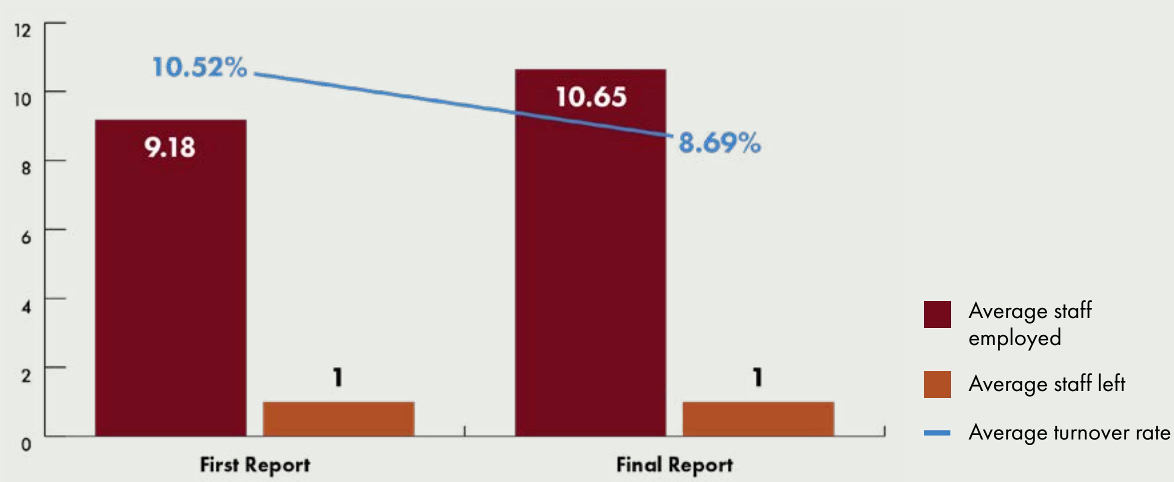
As described in the funding summary, the vast majority (77%) of CCSG spending was spent on personnel costs related to the ECE workforce. Until June 2022, additional details were collected on how personnel funds were spent, suggesting that much of this was spent on payroll (96%). Other expenses included bonuses, insurance, education, tuition support, and others (referred as "premium pay" in our analysis).

Retention and Recruitment

Staff retention has been a chronic issue in the early childhood education field.[49] Before CCSG funds were distributed in the summer of 2021, about 86% of providers in Arizona reported experiencing a staffing shortage and 45% of providers said it was more difficult to recruit and retain qualified educators compared to before the pandemic.[50] Our findings suggest that while CCSG funds did not fully eliminate turnover in ECE programs, particularly of programs serving more than 60 children, it did help with overall staff retention. Specifically we found evidence of lower turnover rates at the end of the grant period compared to the beginning of the grant period, a lower percentage of providers reporting having waitlists due to staff leaving at the end of the grant period compared to the beginning of the grant period, a substantial percentage of providers (73%) reporting retention as a benefit of CCSG funds based on survey data, and in providers' testimonies in focus groups. Further, our results suggest that providers who reported spending on personnel costs were significantly more likely to report improved recruitment and retention compared to providers who reported spending funds in other categories.

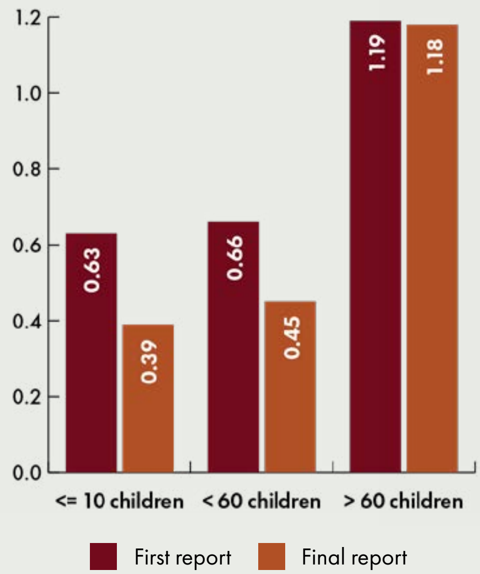
Using the first and the last CCSG monthly reports providers submitted, we examined the average number of staff employed and staff left at the beginning and the end of the grant period, as reported by providers who were DHS licensed and group-home providers (N = 2,060), in order to calculate staff turnover rates (see **Figure 29**). We chose to analyze these specific groups of providers given that they usually have more than one staff employed in their programs compared to NCRPs and family child care providers. Results suggest that providers reported having an average of nine staff employed and an average of one

Figure 29: Average Staff Employed, Staff Left, and Turnover Rates



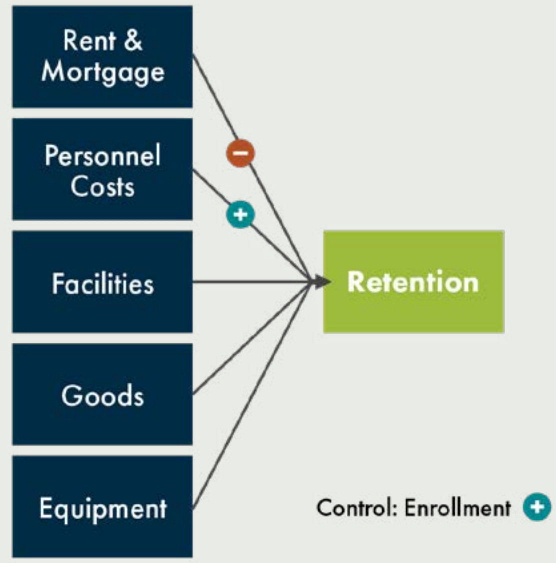
Note. N = 2,060 (Data Source: First and Final DES CCSG Reports, August 2021 to January 2024). Analysis excludes NCRPs and family child care providers.

Figure 30: Average Staff Left Per Month by Program Size



Note. N = 2,060 (Data Source: First and Final DES CCSG Reports, August 2021 to January 2024). Analysis excludes NCRPs and family child care providers.

Figure 31: CCSG Spending and Retention



Note. N = 814 (Data Source: Provider Survey).
⊖ p < .05 significant negative relation
⊕ p < .05 significant positive relation

staff leaving at the beginning of the grant period, which represents a turnover rate of 10.52%. At the end of the grant period, providers reported having an average of 11 staff employed and an average of one staff leaving, which represents a turnover rate of 8.69%. Therefore, turnover rates seemed to have decreased at the end of the grant period compared to the beginning of the grant period. Of note, these turnover rates are much lower than the national turnover rates in the 2019 National Survey of Early Care and Education (NSECE), which found that one third of centers had turnover rates of 20% or higher, likely due to representing annual turnover rates rather than monthly turnover rates.[51]

Based on the provider survey results (N = 898), about 73% of providers reported staff retention as a benefit of CCSG grants (the most commonly selected benefit, followed by increased wages). In addition, during focus groups conducted in the Fall of 2022 and Spring of 2023, providers (N = 9) reported staff retention as one of the major benefits of CCSG funds, especially of employees already working in their programs before the CCSG grant period started. As this female, center-based provider shared:

> **"...it helped with retention of my staff. And during such a hard time in the stress that everybody was under... it was able to provide and meet all of their needs... I wasn't even able to do this before the grant before COVID even came, but to be able to say to my staff, what is it that you need in your classroom? What is it that, you know, we can improve here and our preschool, what being able to give them...bonuses and funding more than I've ever been able to give them before, at such a hard time when I know their lives were stressful, definitely help[s] with retention."**

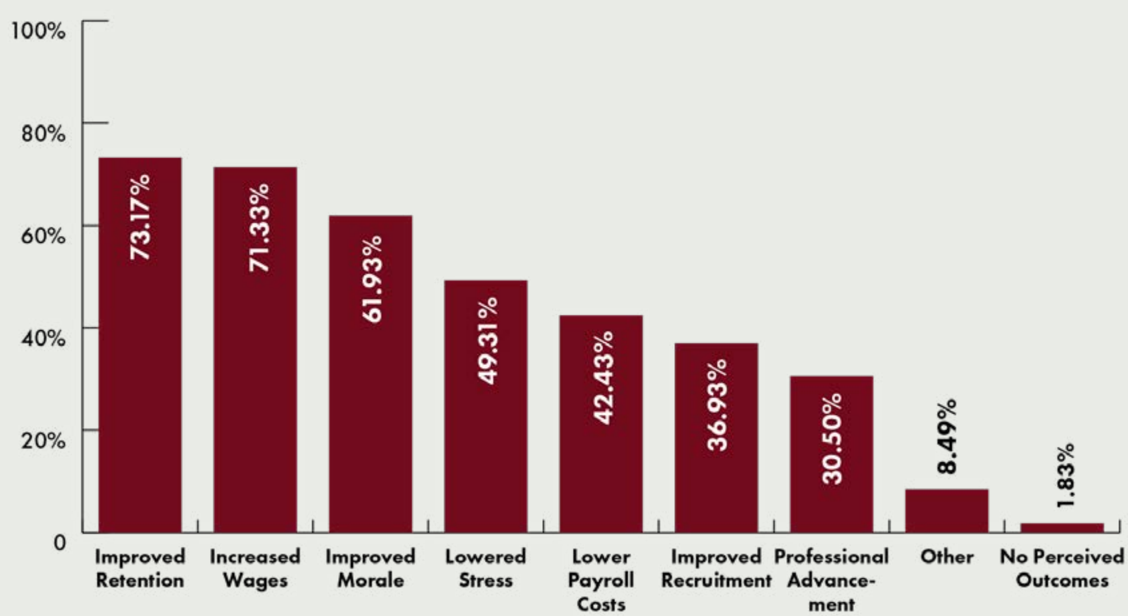
When breaking down results by provider and program characteristics, we found that programs did not report many staff leaving, though licensed center-based providers were more likely to report losing staff, reporting an average of one employee at the end of the grant period (see **Figure 30**). Similarly, when looking at program size, licensed providers who served more than 60 children reported losing about one staff on average at the end of the grant period.

Next, we examined workforce spending patterns in relation to retention. We found that providers who spent CCSG grant money on rent and mortgage were *less likely* to report improved retention and those that spent on personnel were significantly *more likely* to report improved retention as a result of CCSG (see **Figure 31**). It is important to note that we were unable to conduct this analysis by program type (i.e.,centers compared to homes) due to lack of variability within program type subgroups, however, in practice, this relation is likely varies by program types. For example, in the national data home-based programs, that generally have fewer or no additional staff, spent the majority of their funds on rent and mortgage and center-based programs, who employ more staff that they need to retain, spent the majority of funds on personnel costs..

To understand the provider's perspectives on the benefits of CCSG for the workforce, we used data from the provider survey. Providers were asked, "If applicable, how have the CCSG funds helped with personnel? Please select all that apply." We then examined the percentage of providers that indicated various outcomes as a result of CCSG (see **Figure 32**). The most commonly reported outcome categories were improved retention (73.17%) and increased wages (71.33%) followed by improved morale (61.93%), lowered stress (49.31%), lower payroll costs (42.43%), improved recruitment (36.93%), and professional advancement (30.50%) (see **Figure 32**). Only 1.83% of respondents reported that there were no perceived outcomes of CCSG personnel spending.

Overall, these findings are consistent with what was found in focus groups. Specifically, providers reported proper compensation, staff retention (especially of staff that was already employed before the beginning of CCSG grants or for a long period of time), improved morale, and lower stress or "peace of mind" as the main benefits of CCSG

Figure 32: Providers' Perceived Outcomes of CCSG Personnel Spending



Note. Note. N = 436 (Data Source: Provider Survey).

funds. Very few providers mentioned lower payroll costs, improved recruitment, or professional advancement as a benefit, which might explain the lower survey ratings in these areas. In fact, when it came to recruitment, providers (N = 13) were more likely to share this as a current challenge, particularly recruitment of qualified applicants. As this female, center-based provider shared:

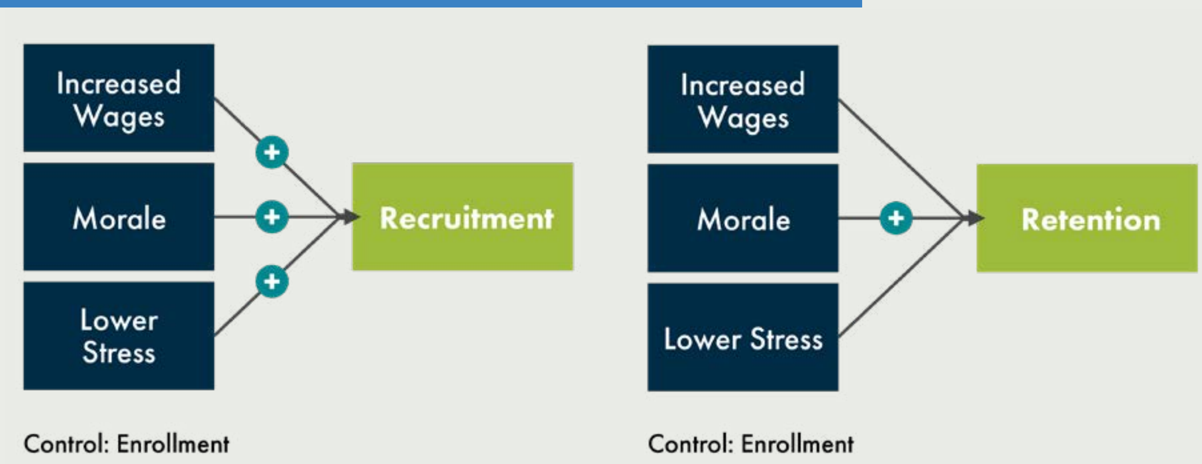
> **"...the 'no shows' are ridiculous... they send you the emails back and forth, and you're corresponding with them. You try to be convenient, and give them the time, and then nobody shows up. You're like, 'okay, what happened?,' and then they just disappear off the face [of the earth]. And then, you know, the quality... when they send in resumes, they've never worked with kids. And they feel that they can work with kids...pre-COVID...you just need one and you've just put out an ad and it's like, 20, you know, things come in, and now it's just like, you know, my ad's been sitting out there. I feel like it's already lost in the internet world because there's just no response."**

Next, we examined the associations between these benefits using multiple logistic regression and multiple imputation to account for missing data. Those who reported increased wages, improved morale, and lower stress were more likely to report improved recruitment of new staff into their programs (**Figure 33**). Yet, only those who reported improved morale were more likely to report improved retention.

To shed additional insight into the role of CCSG and workforce benefits we also examined provider's perceptions in the CCSG focus groups. A total of ten out of 36 providers shared experiences of improved morale and increased staff work satisfaction. For example, one female, center-based provider shared,

> **"What went well about that was that we finally were able to bring our staff up to...a decent pay rate. It was kind of disheartening, realizing that I was losing staff to fast food restaurants, because they were making more. So that was great, because then we had...happier staff, the morale of our team was much improved."**

Figure 33: Personnel Spending Outcomes, Recruitment, & Retention



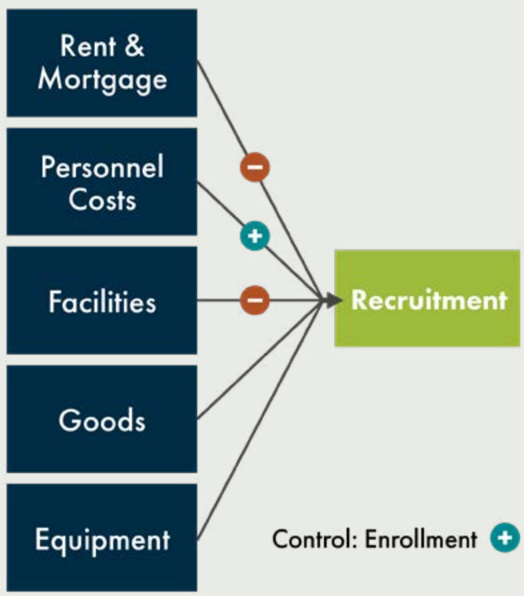
Note. N = 521 (Data Source: Provider Survey).
p < .05 significant positive relation

Additionally, nine out of 36 providers also reported experiences of lower stress as a perceived benefit or positive effect of the CCSG grants. For example, another female, center-based provider shared,

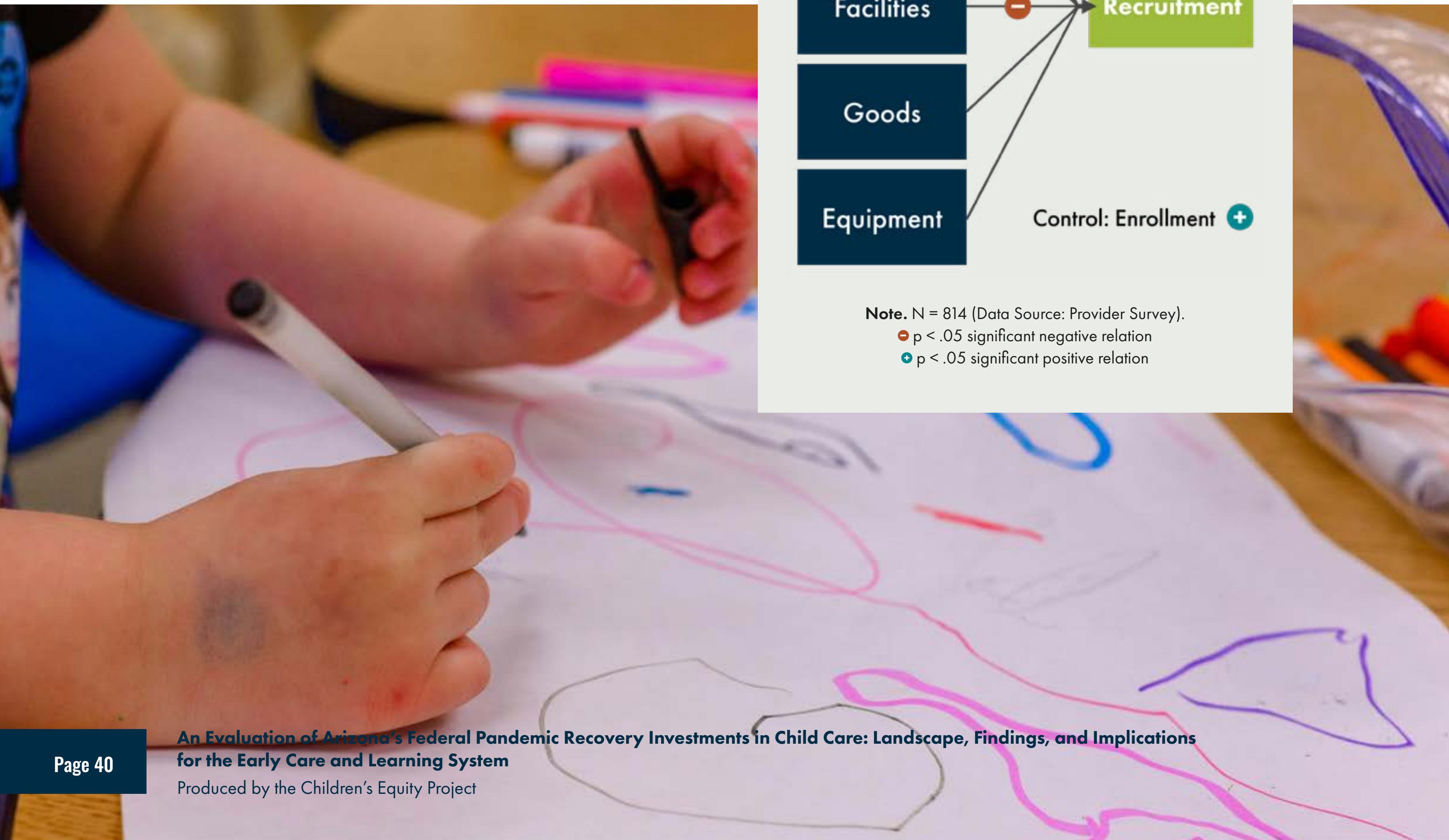
> **"It sounds like all of us have been in this industry for some time. So there is a lot of stress that comes [with]... running and managing the care for children and staffing and the kids that you're enrolling. And so you do take that on personally. And so knowing that there... has been almost like a cushion or something to help us so that we could even focus more on staff and our facilities and the kids. And we, it did definitely relieve some of those stressors... we need to get this many kids in here to get this amount of staff in here to be able to maintain, which is something that you're always thinking about. So that you can stay open. So I definitely am thankful because I feel like it has been a reprieve a little bit in the stress that can come along with the financial side of running... any type of home or center."**

Next, utilizing data from the provider survey, we examined the relation between the ways that CCSG grant money was spent by providers and their reports of improved staff recruitment as an outcome of the CCSG. We utilized multiple logistic regression (N = 814) and multiple imputation for missing data. We found that providers who reported spending on rent and mortgage costs or facilities were less likely to report improved recruitment (see **Figure 34**). Whereas, providers who reported spending on personnel costs were more likely to report improved recruitment. Again, It is important to note that we were unable to conduct this analysis by program type (i.e.,centers compared to homes) due to lack of variability within program type subgroups, however, in practice, this relation is likely varies by program types.

Figure 34: CCSG Spending and Retention



Note. N = 814 (Data Source: Provider Survey).
− p < .05 significant negative relation
+ p < .05 significant positive relation



PART IV

ENHANCING HEALTH, SAFETY, & QUALITY

BACKGROUND

The healthy, safe, and high quality environments children experience in child care programs is of utmost importance. Indeed, health and safety in particular are consistently cited as parents' highest priorities. Although decades of research find that access to high quality ECE experiences are associated with an array of long term outcomes across education, health, employment, and more, these outcomes are only possible when the level of quality in care is high. The CCDBG recognizes the critical nature of quality in child care and sets aside funding for solely this purpose. Through Arizona's recovery plan, DCC invested in an array of efforts to shore up health and safety in child care settings and improve quality. In Part IV, we reviewed findings for those efforts including 1) reimbursement rate increases, including base, "special needs", and quality rate increases; 2) Arizona child care infrastructure grants; 3) CCSG investments related to health, safety, and quality; and 4) other quality investments (e.g. QF, ECMHC, HQEL).

FINDINGS

Reimbursement Rates Changes and Improvements

Reimbursement rates are one critical dimension of a functioning child care system in Arizona because they serve as a funding source for child care providers contracted with DES to serve eligible children and families. Research has found that rate increases that are in line with the cost of quality and cost of living have long-standing associations with a number of other complex factors, like the number of providers contracted to serve DES-eligible children, children served, diversity of settings serving children, and more. During this evaluation, federal guidance suggests CCDF Lead Agencies set reimbursement rates at the 75th percentile of the current market rate, but this guidance has since been updated to suggest that payment rates at the 50th percentile and below are too low. This rate is calculated based on the price charged by the lowest 50% (or 75%) of child care providers as reported in the market rate survey. This baseline guidance often does not account for the true cost of providing quality care and education. Yet, for nearly two decades Arizona rates did not keep up-to-date with recommended guidelines. Trailing rates often leads to a significant gap between the amount providers are reimbursed and the actual costs providers incur to provider quality care.[52] This is not an issue isolated to Arizona. As of 2020, only one state had set rates at the federally recommended 75th percentile levels.

In recent years, DES has made several notable changes to the reimbursement rate system including rate increases, a move from District-based regional rates to statewide rates, daily rates, and enhanced rates for quality providers. The table that follows summarizes the rate increases for reimbursements from April 2019 to April 2023. It outlines the categories, such as age, that determine a provider's rate and the corresponding market rate survey (MRS) the rate was based on. Specifically, DES implemented six baseline reimbursement rate increases from June 2019 to April 2023. These represented the first reimbursement rate increases since 2007 (see **Table 1**). Additionally, there were three tiered quality rate changes for providers with 3 to 5 Star quality ratings from QF, nationally accredited centers, or family child care providers that hold a Child Development Associate (CDA) credential (see Table 1). As of June 2019, DES changed its enhanced rate policy from paying providers with 4 and 5 Star ratings to 3, 4, and 5 Star ratings receiving 35% beginning in October 2021 and 50% beginning in November 2022. Although there were six baseline rate increases, each increase did not impact all providers. This is because some increases were targeted toward providers serving infants and toddlers while other increases sought to increase parity among the six regional DES Districts. By April 2023, only providers serving infants were reimbursed at the 75th percentile of the most recent market rate.

CCDF Lead Agencies are required to set payment rates using a MRS or cost-based alternative methodology that reflects variations by provider type, geographic location, and age of child served. This must be conducted no more than two years before a CCDF Lead Agency submits its CCDF State Plan. Historically, DES captures pricing based on geographic variations by regionally defined Districts and analyzes provider rates by these Districts.[53] In April 2023, DES moved to statewide rates, although the market rates are still analyzed by District in the 2024 Market Rate Survey (MRS). **Table 2** shows changes in reimbursement rates for center-based providers serving preschool children ages 3, 4, and 5 years old. Rate increases varied from 71% for providers in District I (Maricopa) to 126% for providers in District IV (the western Counties of La Paz, Mohave, and Yuma). DES also aimed to eliminate waitlists and incentivize non-contracted providers to accept DES subsidies, in an effort to address the historical decline in DES-contracted providers.

Table 1: Summary of Provider Reimbursement Rate Changes April 2018 to April 2023

DES Rate	April 2018	June 2019	December 2020	July 2021	October 2021	November 2022	April 2023
Under age 1	75th[1]	50th[2], 25th[3]	50th[2], 25th[3]	50th[2], 25th[3]	75th[3]	75th[3]	75th[4]
Ages 1–2	75th[1]	50th[2], 25th[3]	50th[2], 25th[3]	50th[2], 25th[3]	75th[3]	75th[3]	75th[3]
Ages 3–12	75th[1]	50th[2], 25th[3]	50th[2], 25th[3]	50th[2], 25th[3]	50th[3]	75th[3]	75th[3]
Non-Certified Relative Providers	$10.50	$10.50	$10.50	$15.00	$15.00	$15.00	$15.00
"Special Needs"	$47.00	$47.00	$47.00	$47.00	$67.77	$73.50	$96.23

Note. [1]2000 Market Rate Survey (MRS), [2]2010 MRS, [3]2018 MRS, [4]2022 MRS. Adapted from DES Internal Reimbursement Rate Table.

Table 2: Child Care Reimbursement Daily Rates Preschool (3-to 5-year-olds) Center-Based Care

District	County	Daily Rate 2018	Daily Rate 2023	Percentage Increase
District I	Maricopa	$23.80	$40.80	71.42%
District II	Pima	$22.09	$40.80	84.7%
District III	Apache, Coconino, Navajo, Yavapai	$20	$40.80	104%
District IV	La Paz, Mohave, Yuma	$18	$40.80	126%
District V	Gila, Pinal	$20	$40.80	104%
District VI	Cochise, Graham, Greenlee, Santa Cruz	$19	$40.80	114.7%

Note. [1]2000 Market Rate Survey (MRS), [2]2010 MRS, [3]2018 MRS, [4]2022 MRS. Adapted from DES Internal Reimbursement Rate Table.

Figure 35: Maricopa County (District I) Center-Based Child Care Subsidy Reimbursement Daily Rates and Market Rate Preschool (3- to 5-year-olds) 2018–2023

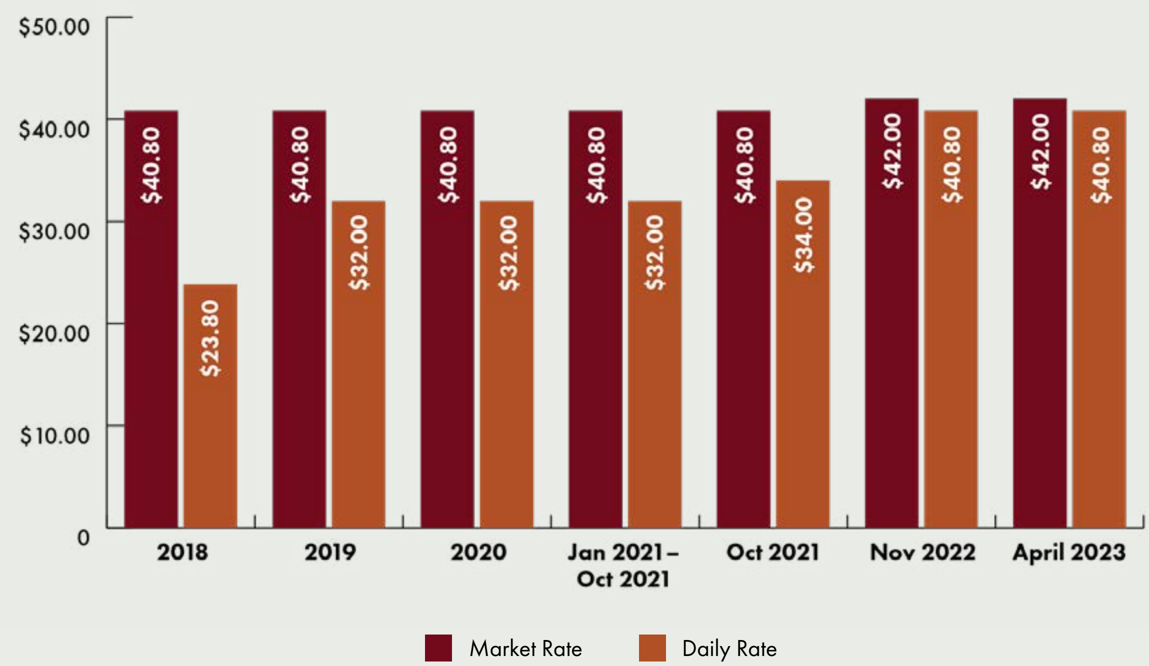


Figure 35 provides preliminary analysis of the impact of these rate changes. As described above, changes in reimbursement rates varied by District. Figure 35 compares the daily reimbursement rate and the market rate for DES District I in Maricopa County. From 2018-2021 the daily costs for operating a child care center exceeded the reimbursement rates. In 2018, the daily rate was 58% of the market rate rising to 97% of market rate by 2023.

CONTRACTED PROVIDERS AND REIMBURSEMENT RATES

The following analysis was based on the DES GIS administrative data, comparing pre-pandemic data to data at and after each reimbursement rate increase into Fall 2023. This analysis allowed us to see if there were increases in access to care due to increases in provider's financial resources through reimbursement rates.

Based on GIS administrative data from August 2019 to August 2023, the overall number of contracted providers increased, yet did not fully recover to numbers achieved in 2018 (see **Figure 36**). In August 2019, about 1,600 DHS licensed and DES certified providers were contracted with DES to accept subsidies for eligible children, not including slightly more than 900 NCRPs. By January 2021, one month after the third reimbursement rate increase, the number of DES contracted providers decreased by 1.02%. This decline persisted despite the requirement that providers licensed after March 2021 become contracted to receive CCDF subsides before they were eligible to receive CCSG and reimbursement rate increases in July 2021 and October 2021, reflecting 6.3% decrease from August 2019. Notably, these were the peak months of the pandemic, which deeply impacted the entirety of the child care system.

Following the fifth increase in November 2022, overall contracted providers increased by 6%. The November 2022 rate increase brought Arizona into alignment with federal recommendations, and therefore providers across age groups and districts were paid at the 75th percentile of the 2018 or 2022 market rate. **Taken together, from August 2019 to August 2023, there was an overall increase of 1.68% of providers contracted to serve children using child care subsidies.**

When analyzed by service type, data suggests the number of DHS licensed centers contracted with DES increased by 7.7%, and group homes increased by 5.17% from April 2019 to August 2023. Unfortunately, among DES certified family child care providers,[54] there has been a 25% decrease.

QUALITY PROVIDERS AND REIMBURSEMENT RATES

An aim of pandemic relief funding in combination with federal funding was to increase the number of high-quality contracted providers. Providing high quality care requires significant financial resources. Here, we use the state's definition of quality which is defined by participation in quality initiatives (i.e. 3 to 5-star rating in Quality First, national accreditation, or CDA for family child care providers). However, we note these initiatives often lack dimensions of quality that have been shown to shape children's experience in care including harsh discipline, inclusion of children with disabilities, access to dual language education and culturally responsive instruction.[55] To support the cost of high-quality care, DES implemented enhanced reimbursement rates for providers who achieve a 3 to 5-star rating on the scale of 1 to 5, with one being the lowest and five being the highest (see **Table 3**).

Contracted provider participation in Quality First increased from August 2019 to August 2023. The proportion of quality providers with 1 and 2-star ratings decreased, and high-quality providers with 5 Star ratings increased. **Figure 37** depicts the trends in the distribution of quality ratings among DES contracted providers before and after each baseline reimbursement rate increases, specifically examining data from August 2019 through August 2023. In August 2019, 653 DES providers participated in Quality First. By August 2023, the number

Figure 36: Trends in DES Contracted Providers by Type Between August 2019-August 2023

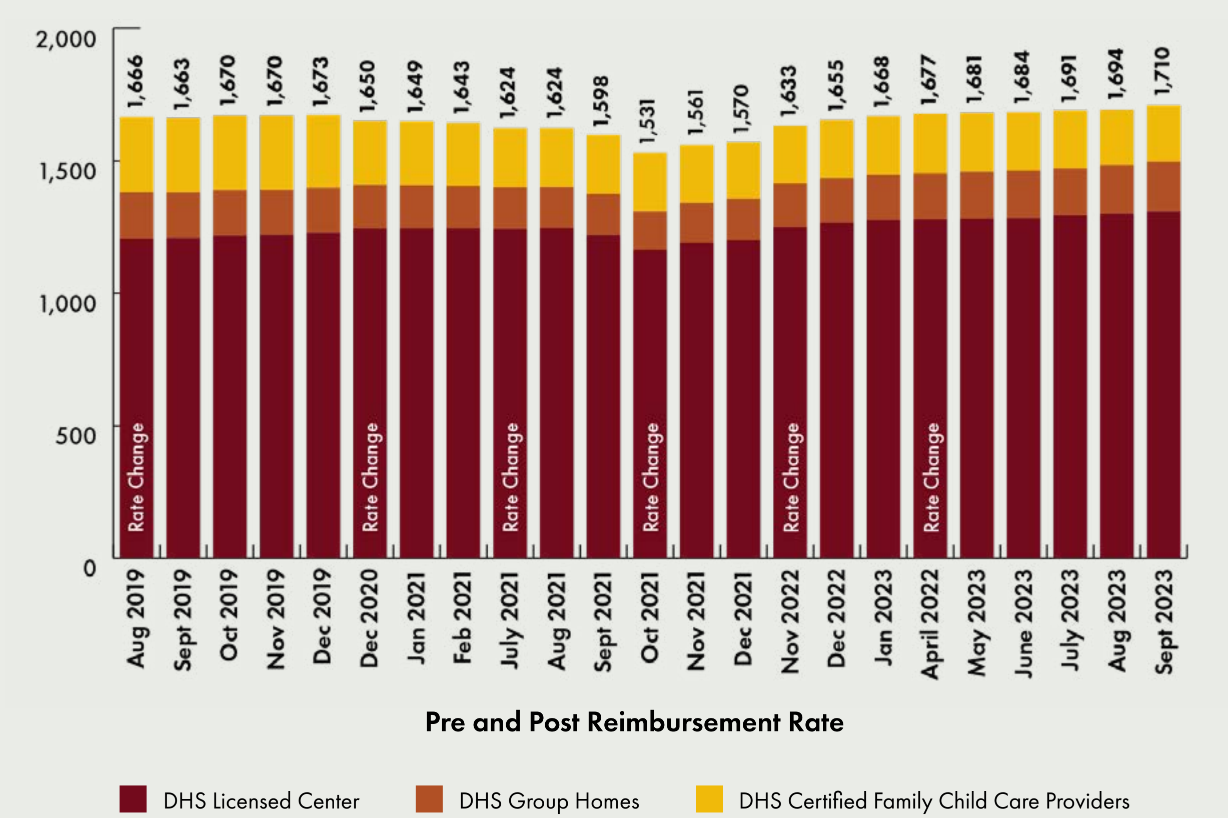


Table 3: Summary of Enhanced Rates Increases, District 1 (3- to 5-year-olds)

Enhanced Rate Increase	April 2018	% Increase	June 2019	% Increase	Oct 2021	% Increase	Nov 2022	% Increase
Base Rate	$23.80		$32.00		$34.00		$40.80	
QF3 Rate	$23.80	No increase	$33.60	5%	$45.90	35%	61.20	50%
QF4 Rate	$25.30	10%	$35.20	10%	$45.90	35%	$61.20	50%
QF5 Rate	$27.60	20%	$38.40	20%	$45.90	35%	$61.20	50%
Nationally Accredited	$27.60	20%	$38.40	20%	$45.90	35%	$61.20	50%
CDA Rate	$23.80	No increase	$35.20	10%	$40.80	20%	$55.08	35%

Note. Based on the DES CCA-1227A FORNA (3-18) Maximum Reimbursement Rates For Child Care 2018-2023.

increased to 871, growing from nearly 39% to almost 51% participation. At the same time, in FY2023 and FY2024, DES used pandemic relief dollars to expand access to the QF system, which eliminated the program waitlist with the goal of addressing gaps in access to quality care.[56] This coincides with the increase in the number of QF-participating providers.

Data suggests an overall decrease in 1 or 2-star rated providers, a slight reduction of 3-star rated providers, and increases of 4.2% and a nearly 11% in 4 and 5-star rated providers. In August 2019, 24% of providers were rated 1 or 2-stars, 41.8% rated 3, 28.6% 4, and 6.1% rated 5-stars. By April 2023, 14% of providers were rated 1 or 2, 37% rated 3, 33% rated 4, and 17% of providers were rated 5.

Next, we examined the overall number of DES-contracted providers in Quality First and the number of DES contracted providers in QF serving DES-eligible children from 2019 to 2023 (see **Figure 38**). We differentiate this by comparing the count of contracted providers with a star rating of 1 to 5 to the count of providers with a 1 to 5 Star rating who received payment. The number of DES contracted providers in the QF system increased by 29.6%. By April 2023, 78% of quality first providers were receiving a payment for serving a child utilizing DES child care assistance.

Next, we completed an analysis to understand the impact of the enhanced reimbursement rate given to QF providers with star ratings above 3. **There was an increase in both QF providers contracted with DES and those contracted who served DES-eligible children through the DES subsidy over time. The number of DES contracted providers with a star rating of 3 or above increased by 33% between 2018 and 2023. Providers in QF with a 3-5 rating that served children receiving CCDF increased by 65%.** In April 2020, 72% of QF providers were contracted to serve DES-eligible children and received payment that increased to 83% in April 2023. In April 2022, the number of contacted providers in QF with a 3 to 5 Star rating was in line with the number of providers receiving a payment. This shift could be due to a number of changes to the Quality First system including the change in assessment structure in which the point system was removed as well as influx of federal dollars that cleared the waiting list and allowed all interested providers to participate in Quality First. The increase in contracted providers in QF (n = 100) from April 2022 to April 2023 was not proportionate to the number of contracted providers in QF reimbursed for serving DES children (n = 38). Notably, there remains a gap between the number of QF providers contracted to care for DES-eligible children and those that are serving DES children and being reimbursed for it.

Figure 37: Trends in Quality Rating Over the Course of Reimbursement Rate Increases

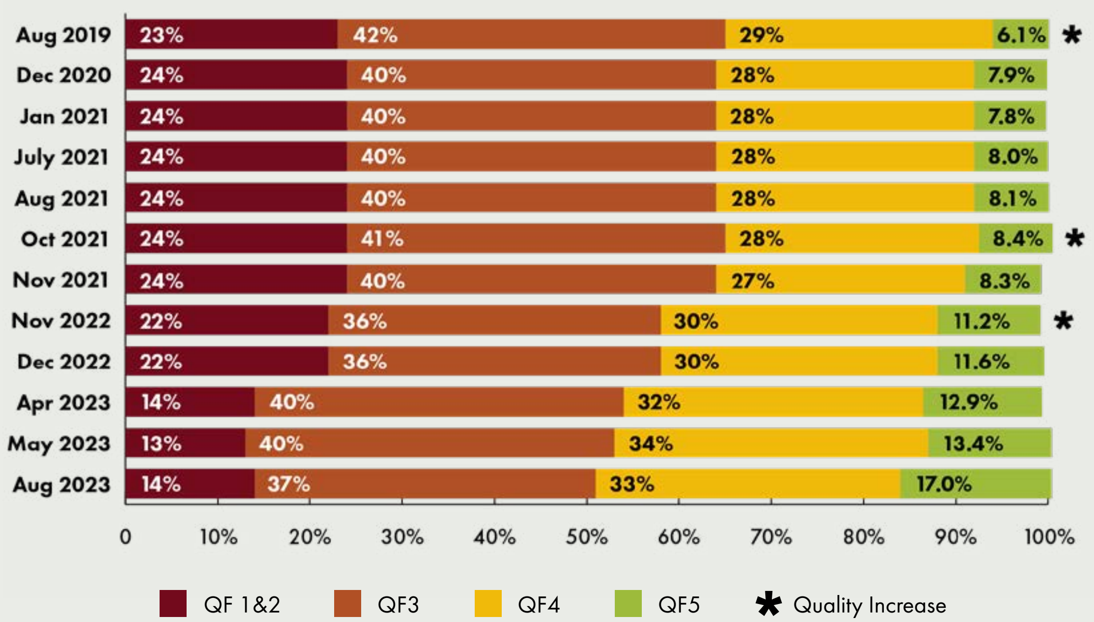
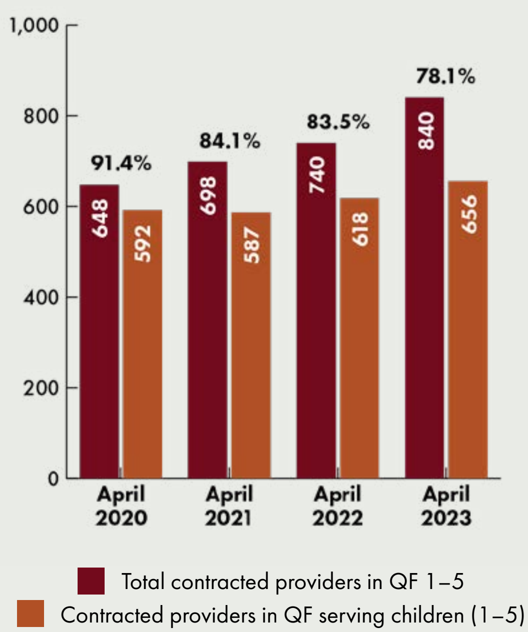
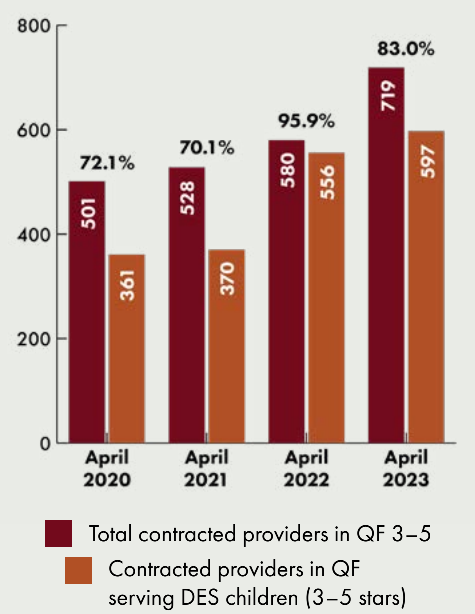


Figure 38: DES Contracted QF Providers



Note. N =648-840 Total Contracted Providers in QF; 587-656 Contracted Providers in QF Serving. (Data Source: GIS and Fiscal).

Figure 39: DES Contracted QF Providers Receiving Enhanced Rate



Note. N = 501-719 and 361-597. (Data Source: DES GIS and Fiscal Payment Files, April 2020-2023).

Consistently, a higher proportion of 3 to 5 Star providers were reimbursed to serve DES children than when comparing providers with a 1 to 5 Star rating overall (See **Figure 39**). The enhanced rate may provide incentive for providers with a 3 to 5 Star rating to ensure there are available slots for children using DES subsidy. Likewise, 3 to 5 Star providers have more support in place through QF to serve children as compared to the support offered to providers rated under 3 Stars.

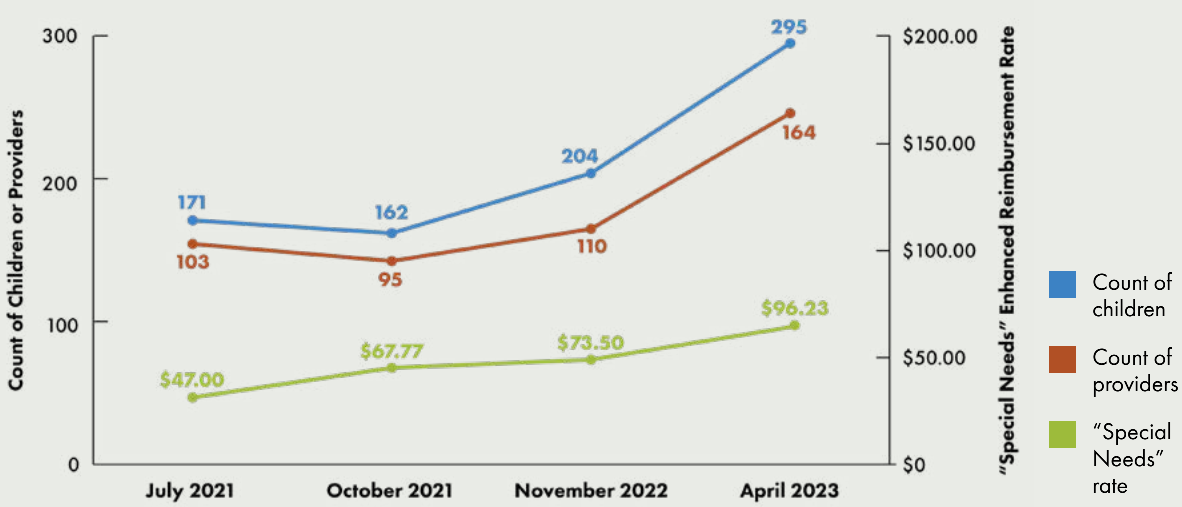
QUALITY AND "SPECIAL NEEDS" REIMBURSEMENT RATE ENHANCEMENTS

As a part of quality rate increases, DES increased an enhanced reimbursement rate that reimburses providers with 3, 4, and 5-star ratings from Quality First who serve children with disabilities. This policy also assumes that 3 to 5-star programs would be able to adequately serve children with disabilities, which may not always be the case. **Figure 40** shows trends in the number of DES contracted providers serving children with disabilities compared to enhanced rate amounts. Data suggest a slight overall increase in providers receiving the enhanced special needs rate. Overall, the number of providers fluctuated overtime. In July 2021, 171 providers were reimbursed the special needs rate to serve 103 children at a rate of $47 per day. By April 2023, 143 providers were paid the special needs rate to serve 142 children with disabilities. Further investigation is needed to understand these trends, access to child care for children with disabilities, the true cost of serving children with disabilities, and how these factors impact the special needs rate.

Provider Reported Impacts of Increased Reimbursement Rates

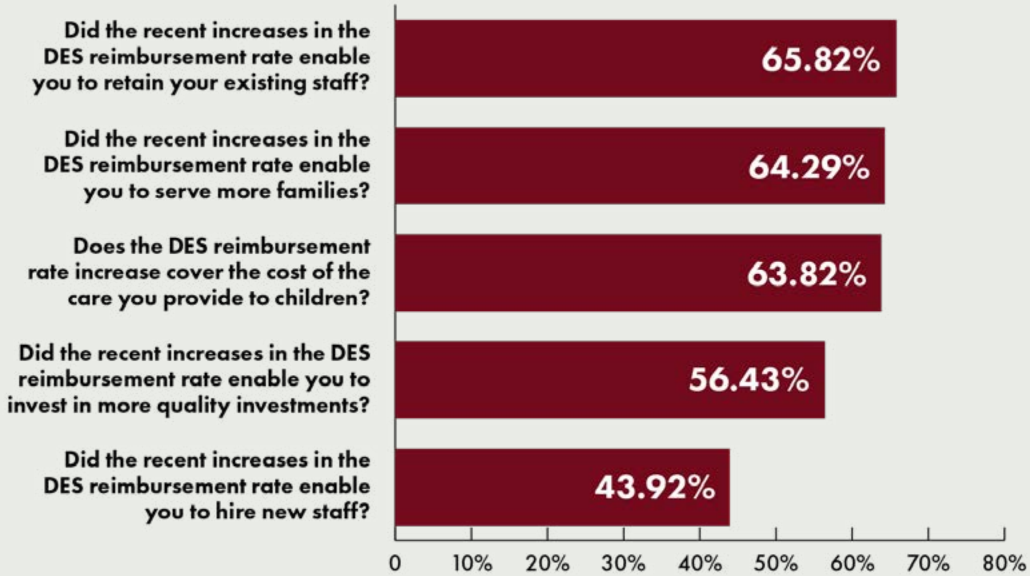
We examined provider's perspectives on the outcomes of increased reimbursement rates through the providers survey. This survey was conducted in September of 2023, meaning all of the reimbursement rate increases from June 2019 through April 2023 had been completed at the time of response. About a third of the overall sample responded to this survey question. The most commonly cited benefit of reimbursement rates was that it allowed providers to retain existing staff, serve more families, and cover the basic cost of providing care to children (see **Figure 41**). Next, we specifically asked providers about the ways in which reimbursement rates affected quality, if at all (see **Figure 42**). The most commonly cited quality benefit was being able to increase staff wages or benefits (29.19%).

Figure 40: Providers Receiving "Special Needs" Rate



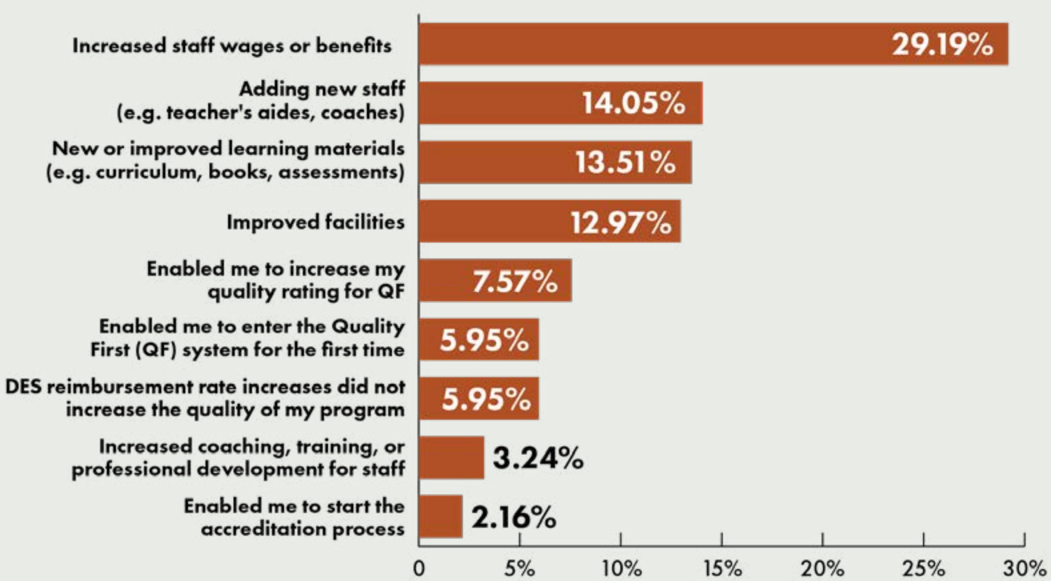
Note. N = 211-298 (Data Source: DES Fiscal Payment File, July 2021, October 2021, November 2022, April 2023).

Figure 41: Reimbursement Rate Outcomes



Note. N = 316-340 (Data Source: Provider Survey).

Figure 42: Reimbursement Rate Outcomes on Quality



Note. N = 185 (Data Source: Provider Survey).

Child Care Infrastructure Grants

In the fall of 2022, a total of $65 million in ARPA stabilization funds was allocated to child care infrastructure grants, including an initial $30 million from DES and an additional $35 million in unused ARPA funds from DES and FTF.[57] Funds were distributed through a grant program facilitated by LISC Phoenix to support providers through limited capital and technology infrastructure grants. Additionally, FTF partnered with DES in mobilizing applications and supporting program processes. Technical assistance partners in the state including Candelen, Child & Family Resources, Easterseals Blake Foundation, Southwest Human Development, and United Way of Tucson and Southern Arizona, supported providers in how to best use grant funds. Applications opened in December 2022 and projects had to be fully completed by September 30, 2023. Four hundred and seventy-eight providers were awarded—83% were women-owned programs and 60% Asian, Black, Indigenous or Hispanic/Latine providers—out of 968 total applications received for funding. Providers could invest these funds on a range of facility improvement efforts, including improvements to existing facilities, expanding facilities to serve more children or move to a new space, or a new entrant looking to open a child care program.

In this part, we discuss findings from the internal evaluation conducted by LISC and address additional research questions created by DES and CEP in an attempt to understand potential outstanding needs. Our analyses focused on research questions that could not be answered by the internal evaluation conducted by LISC. These included questions to understand the providers that did not apply to the infrastructure grant, specifically 1) those with multiple licensing enforcements and 2) those from communities with large child care gaps.

LISC EVALUATION FINDINGS

The Arizona child care infrastructure grant had a positive influence on the child care system including improving financial skills and knowledge of implementing facility improvement projects, better connectivity to resources, and improved morale, especially among Spanish-speaking providers and those in rural communities.[58] According to the LISC final report, this grant provided crucial support to child care providers, facilitating professional development and capacity building. Through financial assistance and expert guidance from nonprofits, providers effectively managed their projects and navigated the grant process. The key benefits included skill development and enhanced morale. Providers gained expertise in project management, technology use, and financial management, with many reporting improved understanding and comfort in these areas. For example, 60% of grantees reported a better understanding of renovation project management, 30% felt more comfortable with technology, and 30% improved their financial management skills. Additionally, 44% of grantees used funds to resolve licensing violations or certification concerns. Over half of the grantees felt more connected to resources, indicating lasting benefits beyond the grant program. The grant brought joy and pride to providers, particularly those in rural areas, Spanish-speaking providers, and those serving infants and toddlers, making them feel valued and recognized as essential workers.[59]

Key outcomes included quality improvements, health and safety improvements, and addressing licensing violations. Nearly every grantee reported enhancing the quality of care provided to children. The most common use of grant funds was for outdoor play areas, with 87% of grantees upgrading these spaces. Improvements included purchasing new playground equipment, installing shade canopies, and replacing sand or pavement with artificial turf and other soft surfaces for safe play (see **Table 4**). A total of 75% grantees reported improving the quality of the indoor learning settings, 59% grantees reported improving the quality of the program support spaces, 264 grantees reported improving their facility/home security and 212 reported improving technical design features.[60]

PROVIDERS WITH MULTIPLE LICENSING ENFORCEMENTS THAT DID NOT APPLY

Funding from the infrastructure grants was intended to support child care providers' facility needs, including addressing and remedying licensing violations. Child care providers that are licensed are required to maintain licensing standards, and those with multiple enforcement violations may represent those in the most need of supports. Indeed, with limited funds and an overwhelming amount of need in the field, it is important to understand the extent to which these limited funds were used to address the most pressing needs that impact child health and safety. LISC's internal evaluation found that 51% of

Table 4: Facility Improvements Reported from LISC Infrastructure Grants

Indoor Improvements	
75%	improved the quality of the indoor learning settings
59%	improved the quality of the program support space
59%	improved program support spaces by purchasing appliances, renovating kitchens to provide hot meals, and creating welcoming break rooms for staff
55%	improved their facility/home security
44%	improved technical design features
24%	purchased or installed security systems and/or locks
20%	improved building ventilation through HVAC or air purification systems
20%	maintained their indoor activity space and removed hazards
17%	maintained their furnishes and removed hazards
16%	set up and maintained diaper changing areas and also maintained age appropriateness
13%	added hand sanitation stations
12%	installed touchless features such as faucets and soap dispensers
Outdoor Improvements	
87%	improved the quality of outdoor play spaces
31%	maintained their outdoor activity space and removed hazards
21%	installed resilient surfaces under swings and climbing equipment
17%	improved sidewalks to provide a safer pathway

Note. N = 478 (Data Source: LISC "Arizona Child Care Infrastructure Grant: An Analysis of Grant Process and Impacts" report, March 2024).

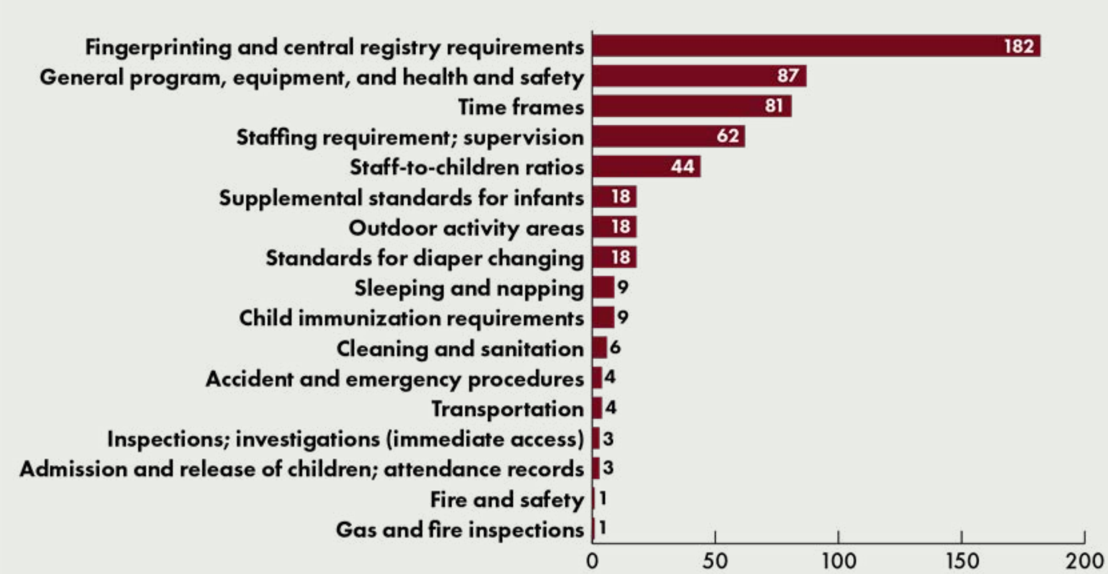
grantees reported addressing health and safety concerns and 44% reported addressing licensing/certification concerns through the infrastructure grants. However, it was unknown how many child care providers with multiple enforcement violations did not apply to the infrastructure grants in an effort to address their violations.

Building on the LISC analyses, we further explored the extent to which providers with multiple licensing enforcements applied (or failed to apply) for the grant, to better understand how these infrastructure grants addressed pressing needs identified by licensing.

To address this question first, we analyzed the DHS enforcement data to understand the nature of enforcements and to determine which of these were relevant to child care infrastructure. The most common citations for enforcement between 2019-2022 were 1) fingerprinting and central registry requirement violations, 2) general child care program, equipment, health and safety, and 3) time frames (see **Figure 43**). While infrastructure grants could not be used for direct fingerprinting and central registry fees to address some of these violations, fees and costs associated with meeting licensing requirements were an allowable expense under CCSG.[61]

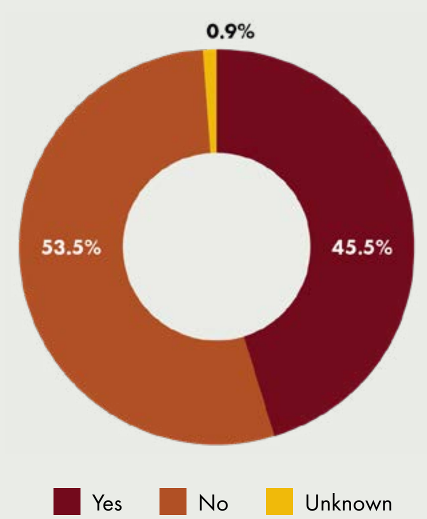
Next, we examined providers with multiple enforcements and cross referenced these to the LISC application file to determine who did or did not apply for infrastructure grants. **Out of 213 total providers that received multiple enforcements, 114 (53.52%) did not apply for the infrastructure grants, while 97 (45.54%) did apply** (see **Figure 44**).

Figure 43: Number of Arizona Child Care Providers with Multiple Licensing Enforcement Violations in 2019-2022



Note. N = 213 (Data Source: DHS Licensing Violations 2019-2022). The figure includes providers with multiple enforcement violations in one or more categories.

Figure 44: LISC Application Status for Providers with Multiple Enforcements



Note. N = 213 (Data Sources: LISC Application File and DHS Licensing Violations, 2019-2022).

PROVIDERS IN COMMUNITIES WITH 50% CHILD CARE GAPS THAT DID NOT APPLY

Next, we aimed to understand the extent to which child care providers from low resource communities did not apply to this grant. We built on work done by LISC finding that 37% of applicants, and 53% of selected grantees, were in low- or moderate-income communities and that 51% were located in a child care desert.[62] We utilized data from an analysis conducted by the Bipartisan Policy Center, to examine the communities with large child care gaps who did not apply.[63] A child care gap was calculating using the number of children with a potential need for child care who cannot reasonably drive to a formal child care facility (i.e., 3.5 miles in urban areas and 10 miles in rural areas). We examined cities/municipalities in Arizona and found that there were 16 cities/ municipalities across 11 counties with higher than 50% child gaps and at least 1 DES contracted or certified or DHS licensed child care provider. In those areas, 31% did not have a single provider that submitted an application to the child care infrastructure grant (see **Table 5**).

Table 5: Child Care Gap and LISC Applications

County	City / Municipality	Potential Need	Facility Capacity	Child Care Gap	% Gap	DHS Licensed Providers	DES Contracted or Certified Providers	Providers Applied to LISC
Apache	Springerville	177	79	150	85%	2	0	0
Coconino	Tuba City	329	65	288	69%	1	0	0
Coconino	Williams	140	10	90	64%	2	0	0
Gila	Globe	331	156	204	62%	1	2	1
Graham	Safford	352	351	178	51%	6	11	2
La Paz	Parker	206	81	152	74%	1	1	1
Mohave	Colorado City	97	129	51	53%	1	2	1
Mohave	Lake Havasu City	1,283	711	687	54%	17	9	4
Navajo	Pinetop-Lakeside	103	59	84	82%	4	2	0
Navajo	Show Low	582	272	410	70%	6	4	5
Navajo	Snowflake	103	25	96	93%	1	1	1
Pima	Sahuarita	1,699	549	911	54%	10	9	0
Pinal	Arizona City	415	65	349	84%	1	1	1
Santa Cruz	Nogales	713	630	405	57%	12	33	18
Santa Cruz	Rio Rico	1,002	206	588	59%	4	15	9
Yuma	Somerton	679	211	416	61%	5	9	3

Note. (Data Sources: LISC Application File, MAPLit, and DES-DHS Provider Universe, July 2023).

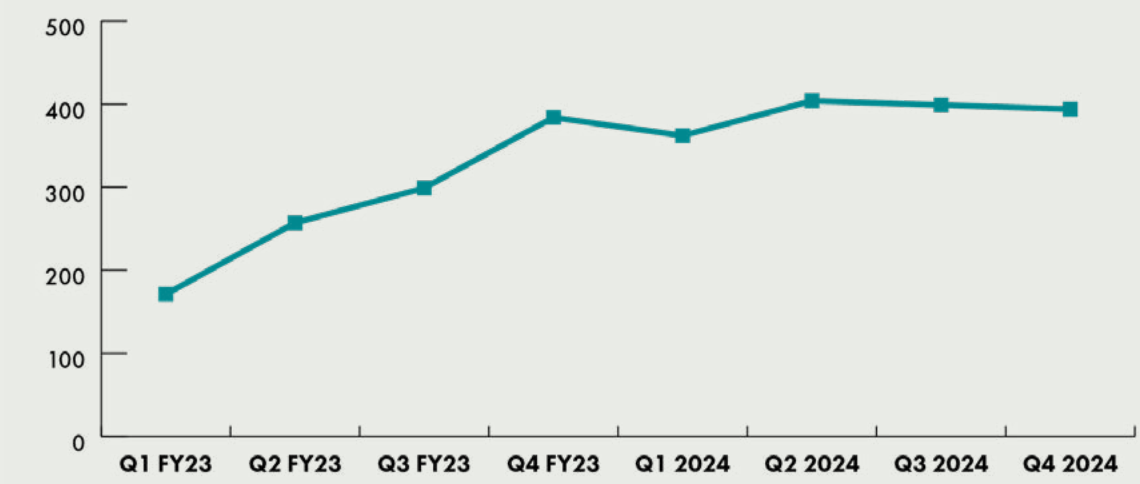
Other Quality Investments

There were four other areas of quality investment with federal child care recovery dollars: QF expansion, additional funding of FTF Early Childhood Mental Health Consultation, HQEL grants through the Arizona Department of Education, and CCSG funds that were used for mental health supports. We did not conduct evaluations on each of these programs individually. As such, in this part, we share high level descriptive information on these programs.

QUALITY FIRST EXPANSION

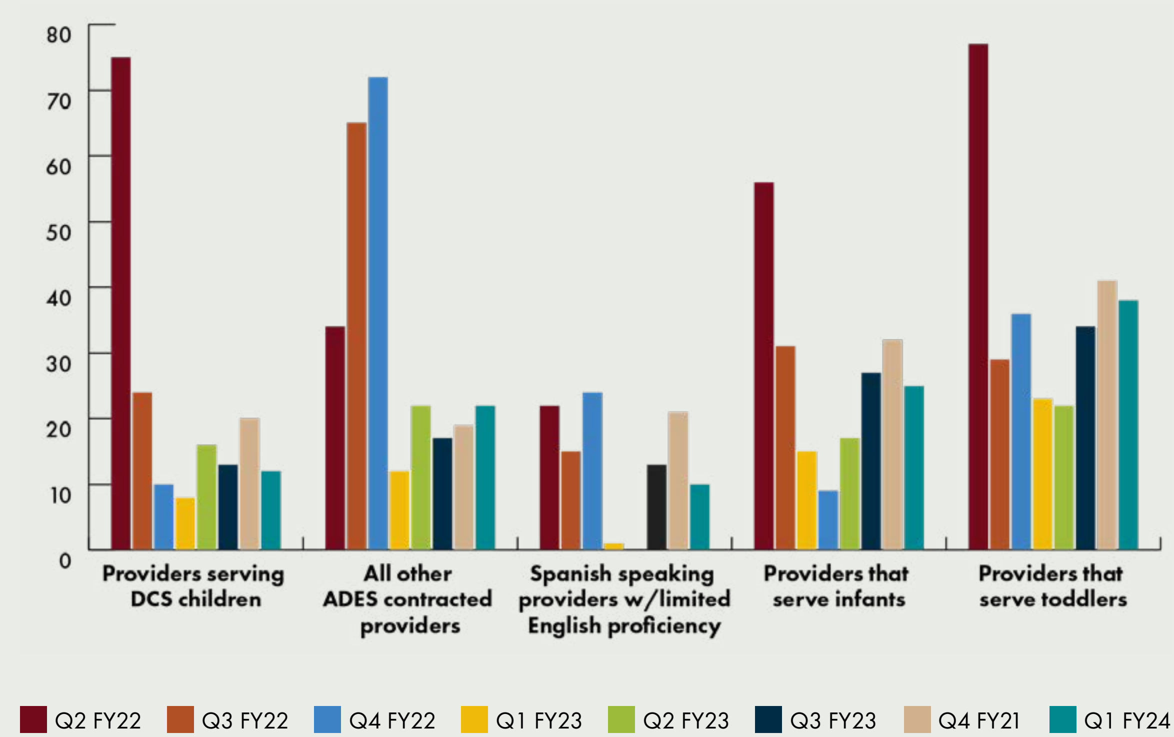
Funds were allocated for the expansion of the QF program administered by FTF. At its highest level, the program funded 404 providers' participation in QF in Fiscal Year 2024 Quarter 2 (see **Figure 45**). Additionally, FTF tracked the enrollment of providers from priority populations, as defined by the Office of Child Care (see **Figure 46**). Relatively few Spanish-speaking providers with limited English proficiency accessed this program compared to other groups (see Figure 46). Additionally the number of providers on Tribal lands (Tribally regulated or not) hovered between 0-1 between for the duration of the grant period.

Figure 45: Number of Providers Enrolled in Quality First Expansion, FY2023-FY2024



Note. N = 171-404 (Data Source: FTF QF Expansion Aggregate Reporting).

Figure 46: QF Expansion Priority Populations



Note. N = 0-77 (Data Source: FTF QF Expansion Aggregate Reporting).

FTF EARLY CHILDHOOD MENTAL HEALTH CONSULTATION

Another key area of quality investment was the expansion of FTF ECMHC between FY2022 and FY2024. ECMHC pairs early childhood mental health consultants with early childhood educators, administrators, and families to support children's social and emotional development. ECMHC consultants focus on fostering a healthy social-emotional climate for all children indirectly by working with providers and administrators to improve practices, processes, relationships, and policies.[64] In Arizona, DES partnered with First Things First to expand ECMHC through contracted service providers to partner early childhood mental health consultants with child care providers with the goal of promoting the social and emotional development of children and helping staff address behavioral concerns.[65]

Center-based participants made up the vast majority of those enrolled in ECMHC services compared to home-based participants (see **Figure 47**). Additionally, **Figure 48** shows the quarterly number of additional newly hired mental health consultants. There were a total of 173.27 from Q2 FY2022 through Q4 2024, with approximately 15 hired per quarter on average.

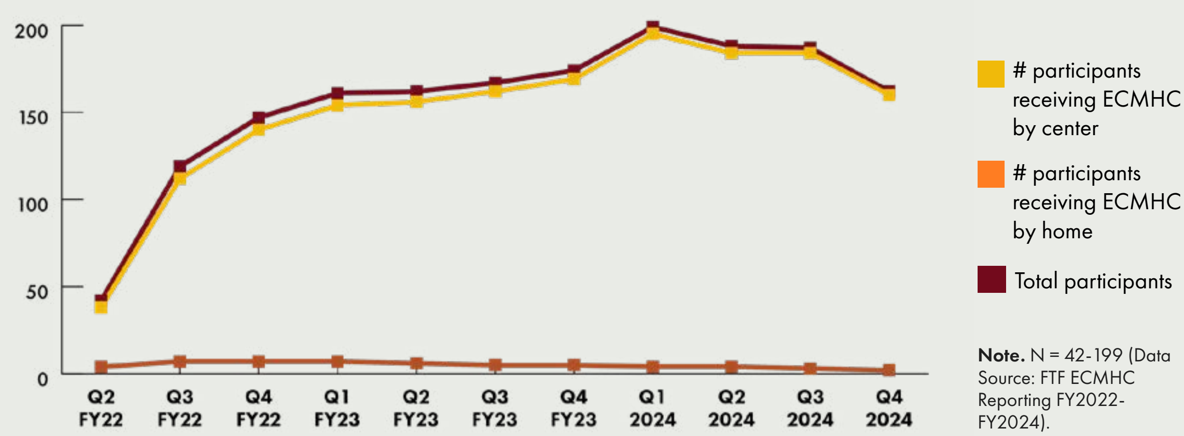
FTF also reported on the number of providers who served (child welfare, infants and toddlers, on Tribal lands) or were members of (limited English proficiency) priority populations. The vast majority of participants served children in the child welfare system (DCS children) and large numbers served infants and toddlers as well. However, fewer than 20 providers reported that they spoke Spanish with limited English proficiency (see **Figure 49**). Additionally the number of providers on Tribal lands (Tribally regulated or not) hovered between 0-1 between for the duration of the grant period.

ADE HIGH QUALITY EARLY LEARNING

DES also invested quality funds to support the HQEL program implemented by ADE. This program was not included as part of the CEP's evaluation. The goal of HQEL was to expand access to high-quality ECE in high needs areas throughout the state as well as systems-building efforts like improving data integration, creating a statewide family engagement center, establishing regional hubs, and supporting the pipeline for the ECE workforce through activities like college scholarships and Career and Technical Education (CTE) programs.[66] The slots were required to be filled with children from families at or below 300% of FPL.

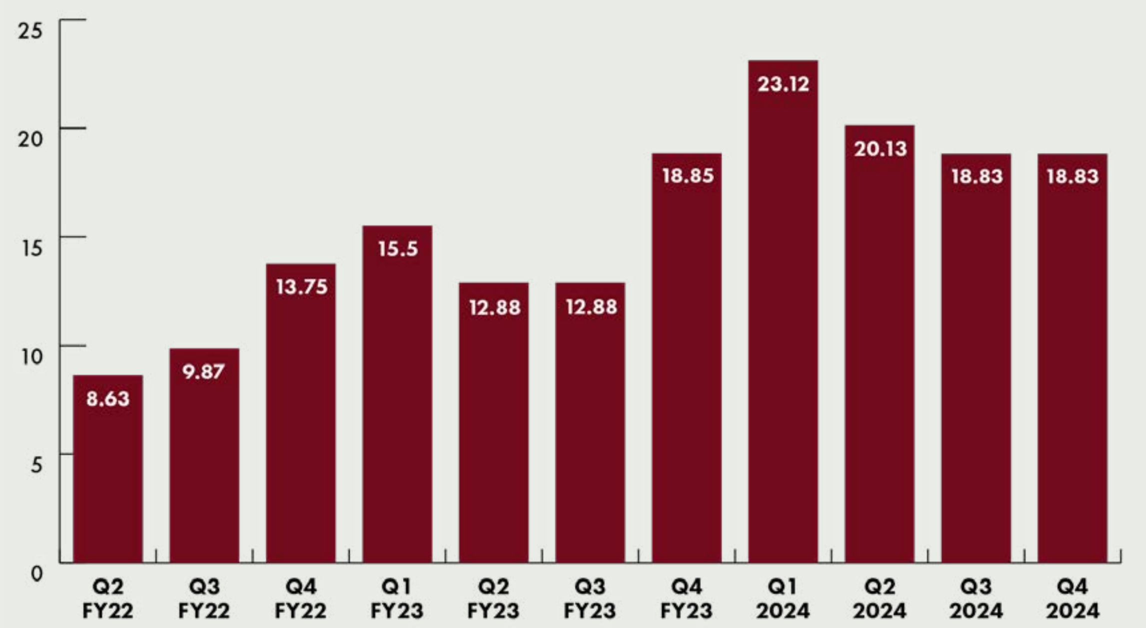
Between May and November 2022 (the full grant period ended in June 2024) across 68 participating programs,1,669 slots were requested and 1,584 children were enrolled full time. There was no variability in the reported slots requested and full time enrolled children at the April, September, November, and December 2022 time points. Additionally, 6 programs left HQEL by the end of the grant period.

Figure 47: Number of Participants Receiving Expanded ECMHC



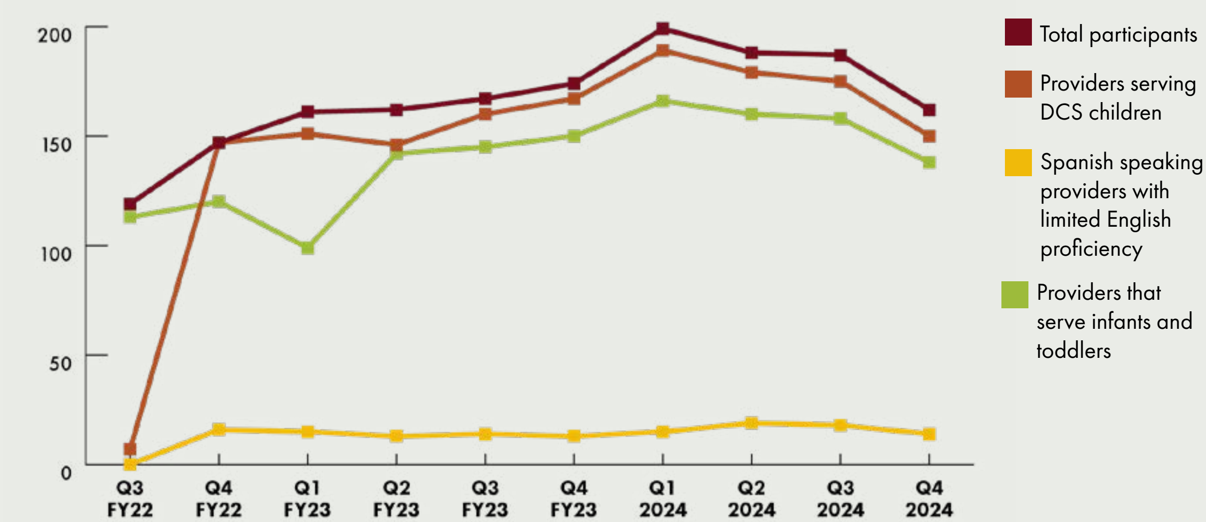
Note. N = 42-199 (Data Source: FTF ECMHC Reporting FY2022-FY2024).

Figure 48: Newly Hired Mental Health Consultants from Expanded ECMHC



Note. (Data Source: FTF ECMHC Reporting FY2022-FY2024).

Figure 49: ECMHC Participants per Quarter by Priority Populations



Note. N = Varies (Data Source: FTF ECMHC Reporting).

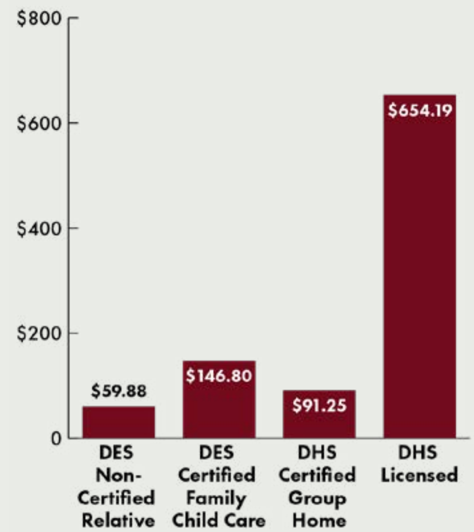
CCSG Mental Health and Quality Investments

ARPA legislation specified allowable expenses for CCSG. One of those expenses most directly related to quality was spending on mental health supports for children and providers. When examining how funds were spent on mental health, a very small amount of funds were spent in this category, with average fund amounts ranging from $60 to $653 dollars at the end of the grant period and by provider type (see **Figure 50**). These averages amount to less than 1% of the total funds spent by providers. When looking at providers who reported spending on mental health, about 53 providers reported spending funds to support the mental health of children at the end of the grant period compared to 20 providers at the beginning of the grant period, which still represented a very low percentage of providers. When providers were asked how CCSG funds have been helpful for their programs, 8% and 9% of providers indicated that it had been helpful for providing mental health support for children and families, and the workforce, respectively (see **Figure 51**). In comparison, 61.1% of respondents reported that CCSG funds were helpful to improve facilities while 42.24% reported that they were helpful to access personal protective equipment (PPE). It is important to note that ARPA funds were also being used to support ECMHC, separately from CCSG, which may have reduced the need the need for providers to spend CCSG funds on mental health expenses.

During focus groups, a few providers (N = 5) reported not spending funds on mental health for children because there were supports already in place, such as existing resources in the community, providing wrap-around services in their programs, or already having mental health support in their programs through other agencies, such as ECMHC. As one female, center-based provider shared:

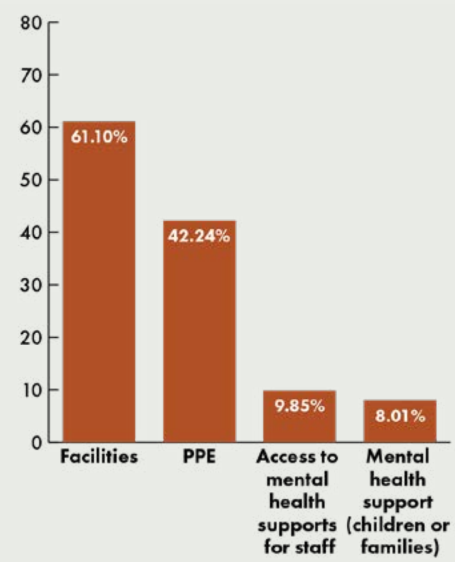
> **"We are under Quality First, so it's covered by them already. In our case, we have a mental health consultant, we have a nurse consultant, [and] inclusion coach, so they cover all those topics. We used our mental health consultant... during the first year of COVID to do like, parent nights, where we just talk about self-care and all that kind of stuff."**

Figure 50: Average Funds Spent on Mental Health by Provider Type



Note. N = 1,310. (Data Source: Final DES CCSG Reports, November 2022 to January 2024). Analysis excludes providers with missing mental health data.

Figure 51: How CCSG Funds Were Helpful to Program Health and Safety



Note. N = 599 (Data Source: Provider Survey)

Table 6: Percentage of Providers Receiving Supports by Provider Type

Provider type	CCSG	QF Expansion	ECMHC	HQEL	LISC
DES Certified Family Provider	99.21%	3.54%	0.00%	0.00%	22.05%
DHS Group Home	83.16%	3.16%	0.35%	2.11%	29.12%
DHS Licensed Center	82.29%	11.49%	5.40%	2.35%	12.07%
Non-Certified Relative Provider	74.50%	0.00%	0.00%	0.00%	0.00%
Total %	81.94%	7.98%	3.55%	1.69%	11.61%
Total N	3,048	297	132	63	432

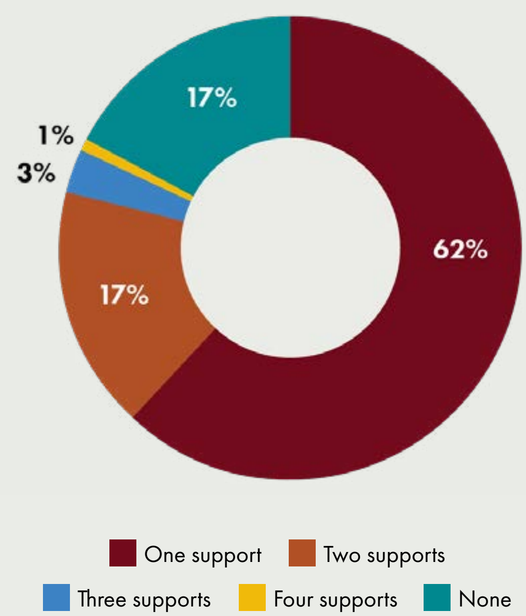
Note. N = 3,720 (Data Source: Provider Universe, July 2023).

Patterns and Impacts of Receiving Multiple ARPA and CRRSA Funded Supports

During the influx of COVID-19 relief funds, Arizona made investments across nearly 20 strategies and providers had the potential opportunity to participate in more than one strategy. CCSG and four other key quality investments (QF Expansion, ECMHC, HQEL, and LISC) were focused towards contracted providers intentionally by DES and were more concentrated among certain types of providers. In this part, we aimed to understand if there were patterns to the combinations of supports providers accessed and if this varied by provider type.

The vast majority (81.94%) of child care providers in the child care universe (DES & DHS providers) received CCSG, whereas smaller percentages of the universe benefited from QF expansion, DES-funded new ECMHC supports, HQEL, or LISC (see **Table 6**). It is important to note that many providers were already participating in QF or other accreditation systems before APRA investments and therefore, would not have been eligible to participate in QF expansion. These percentages also varied by program type. Nearly all DES certified family providers received CCSG. DHS Licensed centers had the highest percentage of QF expansion and EMCHC receipt, and very few DHS Group Homes or Licensed Centers received HQEL. Additionally, NCRPs could not receive QF expansion, EMCHC, HQEL, LISC.

Figure 52: Percent of Providers Receiving Multiple Pandemic Relief Supports



Note. N = 599 (Data Source: DES-CEP Survey)

SECTION II

Recommendations

RECOMMENDATIONS

1. ADDRESS UNDERUTILIZATION.

DES should conduct focus groups and survey families who are authorized for services but are not utilizing services to better understand and address systemic barriers preventing use of child care subsidies.

Pandemic relief funding provided support to increase access to child care through child care scholarships for the education workforce and essential workers, investments in infrastructure and renovations through LISC to improve child care facilities, and CCSG which helped providers stay open and retain a qualified ECE workforce to care for children. Even so, utilization rates have not meaningfully improved over time. The utilization rate has fluctuated, but has remained at or around 66% between January 2019 and March 2023. These child care utilization rates are happening against the backdrop of under-enrollment across the early childhood and K-12 continuum, that ramped up during the course of the pandemic and has yet to return to pre-pandemic levels. Data from the Arizona Department of Education show a steady drop in enrollment from the start of the pandemic persisting for the last four years, driven, primarily, by drops in younger students across the early grade and elementary school continuum. This is a trend seen nationwide with younger students.[67]

As this issue continues to challenge policy makers across sectors, DES should use data at its disposal and their direct contact with families to further explore barriers in the child care system, specifically. This will enable the agency to better understand factors standing in the way of authorized families utilizing care, and make appropriate policy or investment modifications to increase access to child care.

2. IDENTIFY THE TRUE COST OF QUALITY AND ALIGN REIMBURSEMENT RATES.

DES should fund an updated cost of quality study with an expanded and inclusive framework of quality that aligns with research and national standards for best practice. This data should build on findings from the 2024 Market Rate survey and directly inform DES reimbursement rate tiers to ensure maximum alignment and incentive for quality growth and maintenance.

DES invested $150.6 million to enhance quality systems through a Quality First expansion, expansions in ECMHC, and by increasing reimbursement rates for providers, including differentiated rates for QF providers rated 3 or above.[68] Some of these efforts appear to have made an impact on the quality landscape, as there has been a 43.5% increase in 3-5 star providers and a 21.5% decrease in 1 and 2-star providers. Still, analyses of contracted providers found little impact of reimbursement rate hikes on the number of contracted providers coming into the system. One of the contributors to this could be that reimbursement rates do not align with the true cost of providing quality child care services and would thus not be sufficient to help a provider reach and/or maintain a 3-5 star rating.

What's more, the 2023 **Start with Equity Arizona report** highlighted several shortfalls in the state's quality framework, including misalignment with best practices and research, and leaving out critical indicators for marginalized groups, including dual language learners and children with disabilities. For example, Arizona's staff-to-children ratios do not align with best practice or with research on optimal outcomes for young children, so calculations related to cost of quality should consider lower ratios and group sizes among other important facets of quality environments. This fundamental cost assumption, in itself, skews the estimates produced in previous cost of quality studies, as staff (which are required to improve ratios), are the most important and expensive dimension of quality. What's more, Start with Equity Arizona also identified several areas that are critical to the quality experiences of children from marginalized groups, that are not currently part of Arizona's quality framework, and as such, were not factored into the previous cost of quality study. For example, including children with disabilities in general early childhood settings, with appropriate accommodations and high quality supports is an important cost that high quality programs must invest in; however, the current quality framework overlooks children with disabilities, specifically, altogether, which also impacts cost estimates. If DES aims to continue implementing tiered quality reimbursement rates and building on investments from ARPA, the rates should be based on an accurate and inclusive cost of quality as it pertains to all children, including those with unique needs.

3. CALCULATE THE TRUE COST OF SERVING CHILDREN WITH DISABILITIES, ADJUST THE "SPECIAL NEEDS" RATE, AND ALIGN POLICIES TO BETTER SERVE CHILDREN WITH DISABILITIES.

Our analysis of reimbursement rate increases over time, including the "special needs" rate, indicated that despite many years of having a "special needs" rate in place, the number of providers receiving this rate has not meaningfully increased. The misalignment between what should be a policy that increases child care access for children with disabilities (i.e. "special needs" reimbursement rate), and the actual numbers of children with disabilities and providers who are receiving the state's special needs rate, should be explored.

If DES plans to continue investing in tiered reimbursement rates, building on pandemic relief investments, including the "special needs rate", the agency should align rates to the actual cost of care. This cost of care may differ for children with disabilities. As part of an updated cost of quality study, DES should examine the cost of serving children with disabilities (e.g. educators with special education certification and degrees, inclusion coaches, provider training, equipment and materials, facility accessibility modifications, family engagement specialists to support families in navigating ECE and IDEA systems, etc.) in inclusive, high quality child care settings. DES should then use this information to update and align the reimbursement rate to serve children with disabilities.

Currently, there is an assumption that 3-5 star quality programs should have the ability to care for children with disabilities. However, considering that the quality framework used to assign ratings to programs does not at all include children with disabilities specifically, the assumption may be flawed. This assumption should not be one that state policy relies on, unless and until there are specific policy and practice indicators built into the state's quality rating system for inclusively serving children with disabilities in child care settings.

Of note, part of the challenge in understanding the landscape of child care for children with disabilities is the lack of precise, usable data. We discuss this issue in the data recommendations that follow. Finally, DES should also consider renaming the "special needs" rate to the "rate for serving children with disabilities" or "disability rate", considering the term "special needs" is outdated and stigmatizing to many people with disabilities.

4. CONTINUE A GRANTS/CONTRACTS PROGRAM FOR PROVIDERS.

DES should continue a grants and contracts approach modeled after the CCSG to increase the supply of child care providers serving DES children and help address the gaps in service for children with disabilities, children in the child welfare system, and other underserved groups. The aforementioned cost of quality study, including the cost of serving children with disabilities, can directly inform the assumptions that go into developing funding amounts for grants and contracts. These grants and contracts can also address the workforce crisis, but assuming appropriate compensation for early educators, and factoring this into the grant or contract.

The stabilization grant program offered by DES during the pandemic provided a predictable, consistent level of funding to child care providers. In turn, our evaluation found that nearly all grantees remained open by the end of the grant period and spending on personnel costs was associated with improved recruitment and retention. This provided evidence that the CCSG largely met its goal of stabilizing the field and ensuring access by retaining early childhood educators that could continue to care for and teach young children.

This proposed shift to a grants and contracts model may also support improvements in the child care system for children with disabilities. Part of the reason why the "special needs" rate may not have had its intended impact over the years, is that the increase is simply not enough, particularly when delivered via subsidy for few, individual children. Serving children with disabilities may require greater investments, especially up front, in materials, equipment, training and coaching. All of these costs could be built into a new disability grant/contract program. This shift toward grants and contracts could start with establishing startup grants for quality providers agreeing to serve at least 10% of enrollment of children with disabilities in inclusive settings, or new quality providers agreeing to serve DCS children with trauma-informed and ECMHC supports.

The new 2024 CCDF rule from the U.S. Department of Health and Human Services, Administration for Children and Families requires Lead Agencies to use some funding on contracts and grants directly to providers, particularly to serve historically underserved groups like children with disabilities and children in rural areas.[69] Although they requested a waiver to begin this process, DES should start planning for implementation and implement as soon as possible.

5. COLLECT BETTER DATA ON PROVIDERS AND CHILDREN, CREATE MORE USABLE DATA FILES, AND ESTABLISH CODEBOOKS TO ENABLE REAL-TIME DATA ANALYSIS TO IMPROVE SERVICES.

Data challenges placed limitations on how much we could learn about the impact of pandemic relief funds on the child care system. Data shared with the CEP included dozens of files, each with differing information and differing timelines, from multiple organizations including DES, FTF, DHS, ADE, and LISC, which each had their own data structure and variables organization, and lack of codebooks. The only DES file connecting the child (client ID) with the provider ID was the fiscal payment file where each unique case represented a payment to a provider and which contains hundreds of thousands of rows leading to difficulty creating usable merged files due to file size. The existing formatting of data files with monthly provider and client files requires merging across months and years of these files, and in some cases, data fields and indicators changed over time, making it difficult to compare data multiple years old to current years. The existing data landscape is unwieldy and difficult to analyze on an ongoing basis.

Critically, DES and other agency partners should develop a codebook describing the contents of the file and definitions of variables and codes to aid in the sharing of data and accurate analysis. **DES should create annual child and provider comprehensive files.** The creation and maintenance of comprehensive annual files at the provider and child level could help address the overwhelming nature of the data, facilitate in ongoing data analysis, and aid in the sharing of datasets with external or other government partners. The ***annual comprehensive provider file*** should include: provider demographics (owners/directors, teachers, assistants), license capacity, the number of slots a child care provider has, the ages served, the total number of children enrolled, the number of children receiving DES subsidy. and their demographics, and the types of specialized services they may provide, such as dual language education, inclusive services for children with disabilities, or trauma-informed or mental health focused care. It would also include the months providers were contracted, months they were reimbursed for providing care to children receiving subsidies (and how many), the number of staff and turnover, quality, and program closures details. The ***comprehensive annual child/client file*** would include the ID(s) of their care provider, the hours of care utilized, child demographics, program quality, and any unique needs they have (e.g. identified disability, multilingual household, DCS involvement).

Of note, other social service programs, such as the supplemental nutrition assistance program (SNAP) longitudinal grant-funded data project, which Arizona participates in, have engaged in this type of coordinated data process, showing that it is doable and an important goal that can increase our understanding - in real time and over the long term - of the state's child care system.[70] Improved data linking of the provider and child landscape will help DES understand child care access for families in the state, and use these data to inform resource allocation, supply building efforts- including through grants and contracts, and more targeted quality spending.

These data can also inform more intentional pairing of DES families with providers according to families' goals. Children and families come to child care programs with varying experiences, needs, and strengths. A one-size-fits-all approach to child care and the child care subsidy process is inadequate. Understanding the provider landscape, as referenced above, across indicators that are meaningful for children and families can be a critical tool for intentional pairing. For example, many children involved in the child welfare system have been through traumatic experiences and may need greater levels of support and stability in their care settings. In these cases, DES case workers should pair families of children involved in the child welfare system with providers who provide trauma informed care and have access to ECMHC. A plethora of research indicates that children who are dual language learners greatly benefit from instruction and care in their home language, alongside English. DES should collect language of instruction information from providers and work to intentionally pair bilingual families with providers who offer services and at least have staff who speak families' home languages, to the extent possible. Additionally, children with disabilities may need care settings that are physically accessible or employ special educators on staff. Currently, families are largely on their own navigating the system and finding care that matches their needs; the process is even more difficult for families that may have unique strengths and needs.

6. IMPROVE THE CAPACITY TO EVALUATE POLICY INTERVENTIONS.

DES should embed evaluation principles to the extent possible in policy initiatives, particularly those with large funding streams, to better allow for the assessment of the true impact of investments. This should include collecting baseline information from providers to assess the state of relevant factors "pre" or before the intervention and reassessing these same factors at a midpoint (depending on the length of intervention) and "post" assessment and a follow-up (3 to 6 months) after the program ends. A more rigorous but not always practically feasible approach would be to include a control group or waitlist control group to assess impact and isolate an investment's true effect. Another option would be to form partnerships with other states to compare the implementation and reach of policies between states with similar populations. Without these measures, it is nearly impossible to isolate the true impact of investments.

7. IMPROVE STATE DATA SHARING ACROSS AGENCIES.

DES, with other state agencies, should establish a cross-agency data working group that would align data fields and create a standard data sharing agreement that would enable more efficient, timely data sharing and analysis to improve services for families, especially those who receive services funded or administered by multiple state and/or local agencies. Current efforts through organizations such as ReadOn Arizona, have not yet achieved these aims.

Data within the same state agency are often difficult to cross and share. This is especially complicated across different agencies. In our analysis, we primarily used DES data, but required data from FTF and DHS to answer a number of identified research questions. The process to attain that data took months and was burdensome for all involved—partner agencies, DES, and CEP. This process, both within and outside DES, could support greater collaboration and move us toward a unified early childhood data system, as described in the Start with Equity Arizona report.

8. EXAMINE SLOTS PER COMMUNITY TO DETERMINE WHERE TO PRIORITIZE PROGRAM CONTINUATION AND EXPANSION.

DES should closely examine the geographic distribution of contracted providers overlaid with where eligible DES families live to understand slots per child in communities. This will provide critical information to help DES (1) prioritize where grants and contracts may be targeted to support, improve, and expand access for children from priority populations; and (2) identify communities where DES can prioritize program expansion of ECMHC, Quality First, HQEL, and other quality improvement activities.

For example, our analysis found that five of 15 of Arizona's counties (Apache, Mohave, Navajo, Santa Cruz, and Yuma) had an increase in the percentage of providers reporting waitlists between the beginning and end of the grant period. There was no change in the reported percentage of providers with waitlists in Coconino, Gila, and Greenlee counties. While there was a limitation with some providers not submitting a final report, DES should consider examining slot capacity and child care needs across these eight specific counties to determine if they may be priority regions for grants and contracts or expansion of other programming to support access to quality child care for children and families.

The pandemic relief funds were invested across multiple programs that reached limited numbers of providers, with the exception of widespread investments in CCSG and reimbursement rates.. Efforts were made to collect data regarding the equity implications of the reach of some of these programs. For example, ECMHC data was collected on the number of providers serving DCS children and the number of Spanish speaking providers. LISC even used this criteria in the selection of grantees. We recommend expanding on these efforts in the future to proactively understand where need may be greatest, center the child and family, talking with communities about what they need, and then creating or directing existing programs to these areas.

Child care deserts or child care shortages are not just issues in rural parts of the state. MapLIT shows clear patterns in higher income communities having greater options for care than lower income communities. DES can target these differences, even within large population centers (e.g. Maricopa County) and target resources to build supply in areas that have fewer slots per community, giving families more choice. In addition, it is important to understand this overlay by race, ethnicity, and disability to address other possible disparities in access to care.

9. RECRUIT AND ALLOCATE RESOURCES TO ENSURE A DIVERSE PROVIDER UNIVERSE, WITH A FOCUS ON HOME-BASED SETTINGS.

DES should develop recruitment strategies and allocate resources to build supply and ensure a robust, diverse set of options for families, that include home-based settings like family child care and non-certified relative providers. DES should also continue to track data on and investigate the changing landscape of these home-based settings, including those who were contracted and no longer are; those who are not contracted and never have been; and those who are currently contracted. Better understanding these patterns in contracted providers would enable DES to track whether shifts across provider types are due to retiring or turning over from the field, children aging out, or providers shifting from one care type to another.

Our evaluation of the ARPA and CRRSA investments found that there was a slight overall increase in the number of DES contracted providers after reimbursement rates increased, with the largest increase seen in providers with a licensed capacity of more than 60. Concurrently, our supplemental analysis found an 84% decrease in the number of family homes contracted with DES over the last decade, between FY2002 and FY2023 and a 70% decline in providers serving a child in the child's home. In contrast, at the same time, there was a relatively constant pattern for center-based and group home providers contracted to receive child care subsidies, rising steadily for centers between FY2017 and FY2023.

The decline in license-exempt NCRPs and regulated family child care options is of particular concern given that a 2023 national survey from the Bipartisan Policy Center found that, increasingly, families prefer relative care or small group home-based settings because of convenience, affordability, and sense of safety, trust and security. Indeed, more than half of parents surveyed nationally would continue to use these informal care options even if licensed child care slots were available to them. While the racial/ethnic makeup of home-based child care educators and center-based educators nationally did not differ significantly as of 2020, unregulated license-exempt providers like NCRPs tended to be Black, Latine, or other women of color; they were more likely to speak a language other than English and to be born outside of the U.S.[71] Additionally, these providers disproportionately serve Latine children as well as children from immigrant families, making this group a key equity focus to support priority populations.[72]

SECTION III

Conclusion

CONCLUSION

The child care system lacked stability before the pandemic. Chronic underinvestment at the state and federal levels and uneven policies that were often not aligned with research and effective practice burdened the system and impacted access to care for families and high quality, enriching experiences for children. Child care supply was inadequate in many communities, families could not afford to pay for the child care they needed to work, especially for infants and toddlers, and child care providers were making minimum wage or close to minimum wage and most lacked access to job benefits. The quality of care was inconsistent, bound by low standards in licensing requirements and narrow quality frameworks that too often overlooked children from historically marginalized groups. Then, the COVID-19 pandemic surfaced and wreaked havoc on an already unstable child care system.

Undoubtedly, the $1.3 billion in federal child care pandemic relief funds provided much needed infusion of resources into Arizona's child care system aiming to stabilize the field; maintain child access; support the workforce; and enhance health, safety, and quality. Additional investments in quality took an expansive approach, from child care infrastructure grants to mental health supports. These investments impacted programs, the workforce, and children and families. While in many regards, pandemic relief funding did indeed stabilize and prevent further deterioration of the system, significant room for growth continues to be an urgent need across access, quality, affordability, and the workforce.

Highlights and Achievements

- CCSG reached 82% (3,048) of Arizona child care providers who were involved with DHS, DES, or both.
- Child care providers used CCSG to cover personnel costs, raise pay, and give bonuses to staff, many for the first time in years. As a result of CCSG, providers who spent on personnel were significantly more likely to report improved retention and recruitment.
- CCSG allowed 91% of grantees to keep their doors open and supported the sustainability of their operations to continue to serve children and families during the pandemic.
- Providers receiving CCSG saw child enrollment rates increase slightly over the course of the grant period.
- Reimbursement rates were increased, which helped narrow the gap between the true cost of care and the amount covered by child care subsidies. In fact, after reimbursement rate increases, there was a slight overall increase in the number of DES contracted providers, with the largest increase seen in providers with a licensed capacity of more than 60.
- The number of DES contracted providers in the QF system increased by 33.3% between April 2020-2023.
- 478 child care providers received the child care infrastructure grants; 87% of providers improved their outdoor spaces while 75% made improvements to indoor learning environments. Forty-four percent of grantees used funds to resolve licensing violations or certification concerns.

Shortfalls and Continued Need for Growth

- Child enrollment for licensed centers had still not recovered to pre-pandemic levels as of 2023.
- Current reimbursement rates likely do not cover the full cost of providing high quality care; this may be especially true for children from historically marginalized groups and children who have unique needs, such as children with disabilities.
- Providers were concerned about maintaining wage increases after CCSG ended, and more than half of survey respondents reported needing to raise parent tuition as a result of CCSG ending.
- The vast majority of providers had waitlists for toddlers and preschool-aged children at the end of CCSG.
- Providers experienced a variety of barriers in contracting with DES, leaving a potential gap in the number of providers available at which parents can utilize their child care subsidy. These challenges with contracting with DES existed pre-pandemic, and addressing them proactively now will help prepare for sustainability, especially if future unforeseen circumstances arise like another pandemic.

COVID-19 child care recovery dollars have fully come to an end as of September 30, 2024. The FY2025 state budget includes $12 million of general state funding for the child care assistance program, but this investment is temporary for just one year[73] and is woefully below the significant amount the state received in additional federal funds over the past four years. Moreover, inadequate levels of Congressional funding for CCDF limits the ability of states to maintain all the improvements they made during the pandemic. For example, a 2024 survey of state child care administrators showed that most respondents were worried they would need to make "trade-offs" as a result of insufficient resources to meet child care needs (p. 2).[74] A lack of predictable, ongoing funds makes it difficult for DES to be able to maintain, grow, and expand all of the successful activities funded with pandemic recovery dollars. It also makes it a challenge for providers to have access to the resources they need to stabilize and sustain their child care services.

The impacts of ARPA and CRRSA dollars can be sustained and even enhanced with continued public investments, especially through the state budget, and collaboration among agencies and communities tasked with ensuring all young children have access to safe, nurturing, quality ECE.[75] The findings and recommendations from this evaluation—along with the ECE policy agenda from the 2023 CEP report "**Start with Equity Arizona: Increasing Access, Improving Quality, and Advancing Equity for Arizona's Early Care and Learning Systems"**—provide a clear roadmap for the state to build upon the progress made with federal recovery dollars and advance equitable access, experiences, and outcomes.

Moving forward, the effects of the changes to the child care system after recovery funding has ended remains to be seen. But, the positive impact of these investments will likely have lingering effects for early childhood providers and ultimately children and families across Arizona.

SECTION IV

Abbreviations and Endnotes

ABBREVIATIONS

ADE	Arizona Department of Education
ARPA	American Rescue Plan Act of 2021
ASU	Arizona State University
AZCAP	Arizona Child Care Assistance Provider
AZ STEPS	Arizona Statewide Training and Technical Assistance for Expulsion Prevention
CARES	Coronavirus Aid, Relief, and Economic Security Act
CCDBG	Child Care and Development Block Grant
CCDF	Child Care and Development Fund
CCSG	Child care stabilization grant
CDA	Child Development Associate
CEP	Children's Equity Project
CRRSA	Coronavirus Response and Relief Supplemental Appropriations Act of 2021
DCC	Division of Child Care
DCS	Arizona Department of Child Safety
DES	Arizona Department of Economic Security
DHS	Arizona Department of Health Services
ECE	Early care and education
ECHMC	Early Childhood Mental Health Consultation
FTF	First Things First
FY	Fiscal year
GIS	Geographic Information System
HQEL	High Quality Early Learning
IDEA	Individuals with Disabilities Education Act
LISC	Local Initiatives Support Corporation
N =	Population or sample size number equals
NCRP	Non-Certified Relative Provider
NSECE	National Survey of Early Care and Education
OH/IH	Out-of-home/In-home
PRA	Provider Registration Agreement
QIRS	Quality improvement and rating system
QF	Quality First
SNAP	Supplemental Nutrition Assistance Program
T/TA	Training and technical assistance

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