Child Care Quality in Illinois

As Illinois begins a new assessment program, what can be learned from other states?

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By Rachel A. Gordon

Barack Obama's *Blueprint for Change* included a promise to "provide affordable and high-quality child care to ease the burden on working families."[1] John McCain's campaign website promised he would "focus federal resources on ensuring that the neediest children have access to a range of high quality programs."[2] Widespread agreement about the importance of quality child care rests on two widely-disseminated research findings: (1) stimulating early environments are critical to young children's brain development and (2) several high quality and intensive early educational interventions showed large impacts on at-risk children's school readiness.[3]

What is less known is the range of quality in existing child care settings, how to help those settings achieve higher quality, and whether such initiatives ultimately lead to better child well-being. Nationally, several prominent studies estimated that the quality of most child care settings was mediocre or poor, suggesting that initiatives were needed to stimulate quality.[4] But it is costly to replicate such intensive research studies locally, and thus it is hard for policymakers to assess the quality of care available to their constituents at state or district levels. Also, there is increasing recognition that findings from intensive and very high-quality interventions may not extrapolate to the varied settings where child care takes place in most communities and that, unlike these interventions, variation in the quality of these community child care settings may be only modestly related to children's early learning outcomes.[5]

Illinois recently launched a Quality Rating System (QRS) aimed at boosting the quality of child care used by families who receive child care subsidies. Similar to movie or restaurant ratings, QRSs use stars or numbers to distinguish child care settings of varying levels of quality. As discussed below, QRSs aim to improve quality as parents demand higher levels, providers seek higher ratings, and policymakers hold settings accountable for increasing quality. Typically, supports or incentives are integrated into the system to help achieve these goals (such as higher subsidy reimbursement rates in the subsidy program for settings with higher quality ratings).[6]

This chapter compares Illinois' new system to systems developed over the past decade in other states, highlighting some lessons Illinois can draw from their experiences

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[1] Barack Obama. *The Blueprint for Change.* Downloaded September 9, 2008, from http://origin. barackobama.com/pdf/ObamaBlueprintForChange.pdf.

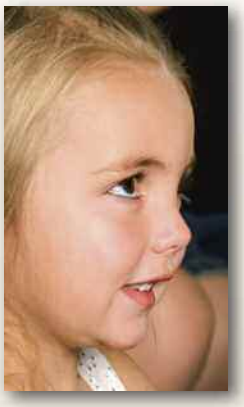
[2] John McCain. *Early Childhood Education.* Downloaded September 9, 2008, from http://www. johnmccain.com/ Informing/Issues/ read.aspx?guid=3883232c-bdeb-44e5-9387-22d1316e 75ed.

[3] Jack P. Shonkoff and Deborah A. Phillips. *From Neurons to Neighborhoods: The Science of Early Childhood Development* (Washington, DC: National Academy Press, 2000).

[4] Suzanne W. Helbum and Carollee Howes. *Child Care Cost and Quality. Future of Children* 6(2): 62-82 (1996); Ellen S. Peisner-Feinberg and Margaret R. Burchinal. "Relations between Preschool Children's Child-Care Experiences and Concurrent Development: The Cost, Quality, and Outcomes Study," *Merrill-Palmer Quarterly, 43(3),* 451–477 (1997).

[5] William T. Gormley, Deborah Phillips, and Ted Gayer. "Preschool Programs Can Boost School Readiness," *Science, 320,* 1723-1724 (2008).

[6] Anne W. Mitchell. *Stair Steps to Quality: A Guide for States and Communities Developing Quality Rating Systems for Early Care and Education*. United Way, Success by 6 (2005).



(and the broader child care research literature) as its QRS matures. I begin by defining child care quality and examining how Illinois compares to other states on some of the easiest to measure aspects of quality. I then briefly highlight how and why QRSs began in other states, compare Illinois' new system to those in other states, and draw from the handful of evaluations to consider some challenges Illinois may face as the rollout of the QRS continues.

What is child care quality?

We might know it when we see it but child care quality is difficult to define and measure.[7] Experts point to aspects of care that have been labeled *process* quality: the quality of the actual experiences children have in child care especially the warmth, responsiveness, and consistency of their relationships and the level of learning stimulation in their interactions. Developmental theory and research suggest that children should thrive in settings that demonstrate these aspects of care, and wither in settings that do not. But this type of quality is particularly difficult to measure. A central debate in research and policy circles surrounds the measure of process quality most often used in Quality Rating Systems, including whether it truly signals the type of quality that QRSs are trying to boost.

Developmental theory and research suggest that children should thrive in settings that demonstrate high process quality of care, and wither in settings that do not. But this type of quality is particularly difficult to measure.

What has been termed the *structural* quality of child care settings is easier to define and measure (e.g., caregiver education, adult-to-child ratios). Because process quality is believed to be higher when structural quality is higher, Quality Rating Systems often require structural characteristics that increasingly exceed minimal licensing standards as ratings get higher.

What is the quality of child care in Illinois, and how does that compare to child care quality in other states?

Most datasets that assess details about quality – structural or process – are limited in their geographical coverage, and national datasets typically do not assess quality, making it difficult to make cross-state comparisons. However, we can infer something about state-to-state variation in quality by examining variation in licensing standards and how these compare to recommendations made by accrediting organizations. We also know more about children using care that is subsidized with state and federal dollars than about all children in child care, because of these programs' administrative systems and reporting requirements. Looking at variation across state subsidy programs provides another window into possible quality variation. Examining the subsidy program is also relevant because in Illinois, as in some other states, the QRS is directed only at providers who care for children whose fees are paid by subsidies. Finally, recent studies of state preschool programs provide additional insight into states' abilities to expand high-quality early care opportunities. And, ideally, quality initiatives across child care and early education, such as QRSs and universal preschool, should complement and reinforce one another.

Licensing standards. Licensing standards differ for child care centers and private homes. In Illinois, most centers must be licensed (exceptions include care of 3-year-olds in public and private schools) and homes must be licensed when the care group includes more than three children, including the caregiver's own.[8]

Licensing standards are generally seen as assuring only a minimal level of quality. Comparing them to the recommendations of professional accrediting associations helps us identify the relative strengths of states' licensing standards and helps us understand the steps above minimal standards often built into QRSs. The most prominent accrediting body for centers is the National Association for the Education of Young Children (NAEYC). Its guidelines require that all child care teachers have a minimum of an associate's degree or equiv-

[7] Ibid.

[8] Illinois Department of Children and Family Services. *Day Care and Early Childhood Licensing* (2008). Available at http://www.state.il.us/dcfs/daycare/index.shtml.

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alent and that at least 75 percent of a center's teachers have a bachelor's degree in early childhood education, or equivalent. Teaching assistants should have at least a high school diploma or GED, and 50 percent should have a Child Development Associate Credential (CDA; or equivalent).[i] The center director should have at least a bachelors' degree with some credit hours in management and early childhood education or related fields. Group sizes should be no larger than eight with a 1:4 adult-to-child ratio for infants, no larger than 12 with a 1:6 ratio for toddlers, and no larger than 20 with a 1:10 ratio for preschoolers.

The National Association of Child Care Resource and Referral Agencies[ii] recently reviewed state licensing standards and oversight procedures for centers using NAEYC standards as part of their benchmarks.[iii] Illinois ranked well relative to other states, particularly in its standards, although in absolute terms the standards leave room for improvement. In particular, Illinois tied with New York for the top spot among states, but both states had only 90 points out of a possible 150. Illinois fully met the NACCRA recommendations for background checks, health and safety standards, parental involvement, and programmatic coverage. But it failed to meet, or partially met, the recommendations for staff training and education, group sizes, and adult-to-child ratios. Tables 1 and 2 (pg. 80) place Illinois' requirements next to NAEYC requirements, and show where Illinois falls short.[iv]

Illinois ranked 22nd among states in terms of oversight, meaning centers may not be monitored well enough to assure they meet state standards. The state met only the requirement that licensing staff have a bachelor's degree in a related field. It fell short on the remaining four requirements:

- NACCRRA recommended quarterly monitoring visits, whereas Illinois conducts them once a year.
- NACCRRA recommended a program-to-licensing staff ratio of 50:1, whereas Illinois allows 80:1.
- NACCRRA recommended that inspection and complaint reports be made available to parents, which Illinois does not do.
- NACCRRA recommended that all providers be licensed, whereas Illinois exempts small homes.

Table 1
Education and Training: Illinois vs. NAEYC

	Education/Training	
	Illinois	**NAEYC**
Director	* At least two years of college or equivalent experience/credentials	* At least a Bachelor's Degree with some hours in management and ECE
Teacher	* At least two years of college or equivalent experience/credentials	* At least an Associate's Degree * At least 75% with a Bachelor's Degree in ECE
Teaching Assistant	* At least a high school diploma or equivalent	* At least a high school diploma or GED * At least 50% with a CDA

Notes: ECE = early childhood education or related field. CDA = Child Development Associate
Red font indicates Illinois does not meet NAEYC standards.

Source: National Association for the Education of Young Children, Accreditation Criteria for Teachers Standard, available at http://www.naeyc.org/academy/standards/standard6/standard6A.asp

NACCRRA did not compare states' licensing standards for homes. Home standards can be more complicated than centers because they allow mixed-age groupings. It is instructive, though, to compare Illinois standards to a recent "research-based rationale" for family child care ratios and group sizes for infants, released by the Center for Law and Social Policy.[9] CLASP recommends that when a child-care home includes infants and toddlers (under age 2) that the group does not exceed six children and not include more than two infants and toddlers (including the provider's own children). Illinois' licensing standards include a variety of configurations, but the most similar configuration allows a total group size up to eight with up to three infants and toddlers.[10] CLASP's report also recommends more stringent standards for infants and toddlers in centers than the NAEYC guidelines shown in Table 2, with no more than six infants in a group and adult-to-child ratios of 1:3 and no more than eight toddlers in a group with ratios of 1:4,[11] distancing them further from Illinois' standards.

Table 2
Ratios and Group Sizes: Illinois vs NAEYC

	Adult:Child Ratio		Group Size	
	IL	NAEYC	IL	NAEYC
Infants	1:4	1:4	12	8
Toddlers	1:5	1:4	15	12
Two years	1:8	1:6	16	12
Three years	1:10	1:9	20	18
Four years	1:10	1:10	20	20
Five years	1:20	1:10	20	20

Note: Toddlers are defined as ages 15 to 23 months in Illinois. The maximum ratio and group size for the NAEYC 12-28 age range is presented for this group. Red font indicates Illinois does not meet NAEYC standards.

Sources: State of Illinois Summary of Licensing Standards for Day Care Centers, Department of Children and Family Services. Available at: http://www.state.il.us/dcfs/docs/CFS105052.pdf; and National Association for the Education of Young Children, Teacher-Child Ratios Within Group Size, available at http://www.naeyc.org/academy/criteria/teacher_child_ratios.html.

So Illinois' standards are strong relative to other states, but don't measure up to the highest quality benchmarks. To the extent that these structural process indicators relate to process quality and both relate to child outcomes, many children may not be getting high quality care. Yet simply increasing the standards may drive some providers out of the market because of higher labor costs and leave parents with few options that they can afford.[12] This is one reason why implementing more gradual increases in standards through a Quality Rating System, with appropriate supports, is attractive.

Subsidy program. As part of the 1996 welfare reform legislation, the federal government consolidated child care funding into the Child Care Development Fund (CCDF). This subsidy program targets employed, low-income families. In most states, only a small fraction of participating families (less than 6 percent in Illinois) also receive cash assistance through the Temporary Assistance for Needy Families program. One of the notable features of Illinois' program is that a relatively small number of children receive care in centers. Whereas nationally the majority of chil-

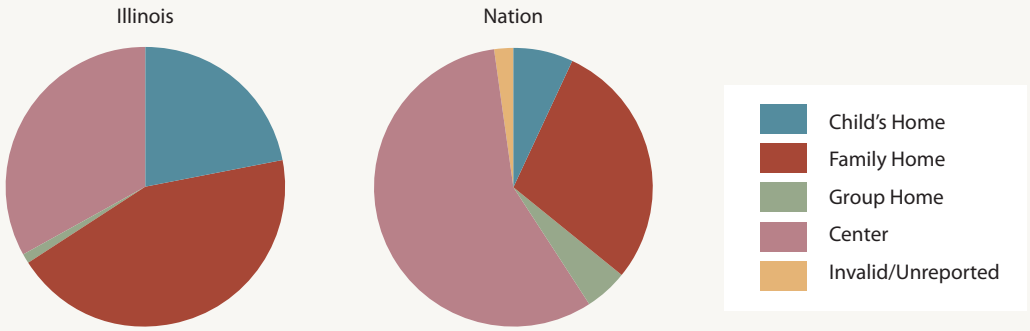
[9] Rachel Schumacher and Elizabeth Hoffman. *Family Child Care Ratios and Group Sizes: Charting Progress for Babies in Child Care Research-Based Rationale* (Washington, DC: Center for Law and Social Policy, 2008): 1.

[10] Illinois Department of Children and Family Services. *Day Care and Early Childhood Licensing* (2008). Available at http://www.state.il.us/dcfs/daycare/index.shtml.

[11] Rachel Schumacher, Rachel. *Center Ratios and Group Sizes: Charting Progress for Babies in Child Care Research-Based Rationale* (Washington, DC: Center for Law and Social Policy, 2008).

[12] V. Joseph Hotz and Mo Xiao. "The Impact of Minimum Quality Standards on Firm Entry, Exit, and Product Quality: The Case of the Child Care Market," *NBER Working Paper 11873* (New York: National Bureau of Economic Research, 2005); Elizabeth Rigby, Rebecca M. Ryan, and Jeanne Brooks-Gunn. "Child Care Quality in Different State Policy Contexts," *Journal of Policy Analysis and Management, 26(4)* (2007): 887-907.

Figure 1
Type of Care: Illinois vs. Nation



Source: U.S. Department of Health and Human Services, Administration for Children & Families, Child Care Bureau: FFY 2006 CCDF Data available at Tableshttp://www.acf.hhs.gov/programs/ccb/data/ccdf_data/06acf800/table3.htm

dren whose fees are paid by subsidies are cared for in centers, the majority in Illinois are cared for in homes (see Figure 1). In fact, Illinois is one of seven states in which one-third or fewer of children are cared for in centers. Among Midwestern states, Michigan, Minnesota and Iowa have similarly low rates of children in centers, while Indiana and Wisconsin exceed the national average.

Given these differences, it is not surprising that Illinois is also near the bottom in terms of the percentage of children with subsidies who are cared for in licensed facilities, nationally and in the Midwest.

Fifty-one percent of these children in Illinois are cared for in license-exempt settings, compared to one-quarter of children nationally (Figure 2). Only one Midwestern state (Michigan) has more children in license-exempt care than Illinois. Such license-exempt care could be provided by relatives. But in Illinois, two-thirds of children in license-exempt settings are cared for by non-relatives, higher than the national average of 42 percent.

It is possible that these differences simply reflect different preferences of families in Illinois than in other states. Parents are especially likely to say in research studies

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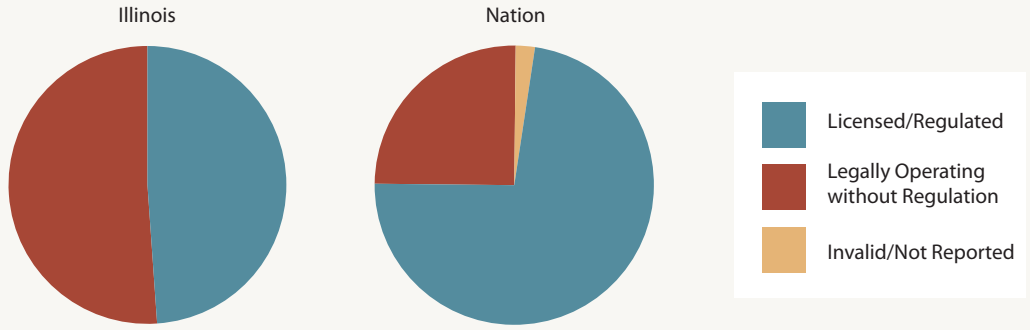
Figure 2
Licensed Care: Illinois vs. Nation



Source: U.S. Department of Health and Human Services, Administration for Children & Families, Child Care Bureau: FFY 2006 CCDF Data available at http://www.acf.hhs.gov/programs/ccb/data/ccdf_data/06acf800/table4.htm

that they prefer to use smaller, home-based settings for infants and toddlers.[13] Some parents may also find certain formalized care settings differ from their personal or cultural values more than does care in their neighbors' homes.[14] But from the standpoint of assuring that children are in settings that meet at least minimal safety standards, the high percentage of children in license-exempt care in Illinois is troubling. For example, Illinois does not require license-exempt providers to have training in CPR or first aid.[15] Furthermore, research finds that parents often choose home-based care, including license-exempt care, because it best meets their needs, but that these settings score lower when process quality is measured with intensive observations by researchers.[16]

Another reason for a high rate of home-based, license-exempt care may be the constraints of parents' limited budgets and the state's limited coffers. The CCDF requires states to conduct regular market rate surveys to help them set reimbursement rates (with a recommendation that reimbursement rates be no lower than the 75th percentile of market rates). The most recent Illinois market rate survey found that the cost of center-based care exceeded home-based care across age groups and geographic regions of the state.[17] The differential was especially high for infants in Chicago and the collar counties, where the median cost of center-based care was $48 per day, in contrast to $26 per day in licensed home-based care.[v]

Illinois' reimbursement rates have historically been well below the recommended 75th percentile of market rates, although the state has been taking incremental steps toward raising them. The most recent survey indicates reimbursement rates for centers in Cook County were at the 27th percentile for infants and toddlers, the 38th percentile for 2-year-olds and the 34th percentile for preschoolers. Licensed home-based providers in Cook County were at the 37th, 47th, and 50th percentile for the respective age groups. Although no other Chicago metro-area counties met or exceeded the 75th percentile for centers or homes, many downstate counties did. Illinois' rates also are low in relation to some of its neighbors. As of the federal fiscal year (FFY) 2008-2009 plans, Illinois fell in the middle of Midwestern states in terms of reimbursement rates.[18] Its rates were higher than those set by Iowa and Michigan, but lower than Indiana, Minnesota, and Wisconsin (see Table 3).

In its FFY 2008-2009 plan, the state reported a goal of achieving the 50th per-

Table 3
Weekly Reimbursement Rates in Midwestern States by Type of Care and Age Group

	Center-Based			Family		
	Infant	Toddler	Preschool	Infant	Toddler	Preschool
Iowa	77.50	77.50	62.50	60.00	60.00	56.25
Michigan	142.50	142.50	112.50	100.00	100.00	100.00
Illinois	196.35	165.85	138.30	129.15	124.30	116.50
Indiana	218.00	188.00	160.00	130.00	125.00	100.00
Wisconsin	232.00	200.00	180.00	190.00	175.00	165.00
Minnesota	266.04	218.94	198.45	167.17	160.17	145.60

Note: Illinois and Iowa, daily rates multiplied by 5. Michigan, hourly rates multiplied by 50.

Source: U.S. Dept. of Health and Human Services, Administration for Children and Families, Child Care and Development Fund Report of State and Territory Plans FY 2008-2009, available at http://nccic.acf.hhs.gov/pubs/stateplan2008-09.

[13] Diane M. Early and Margaret R. Burchinal. 2001. "Early Childhood Care: Relations with Family Characteristics and Preferred Care Characteristics," *Early Childhood Research Quarterly, 16* (2001): 475-497.

[14] Bruce Fuller et al. "Rich Culture, Poor Markets: Why do Latino Parents Forgo Preschooling?" *Teachers College Record, 97(3)* (1996): 400-418.

[15] United States Department of Health and Human Services. *Child Care and Development Fund Reports of State and Territory Plans FY 2008-2009* (2008). Available at http://nccic.acf.hhs.gov/pubs/stateplan2008-09/part6.pdf, 156.

[16] C.P. Li-Gining and R.L. Coley. "Child Care Experiences in Low-income Communities: Developmental Quality and Maternal Views," *Early Childhood Research Quarterly, 21* (2006): 125-141.

[17] Illinois Department of Human Services. Market Rate Survey of Child Care Programs in Illinois FY 2006 (2006). Available at http://www.dhs.state.il.us/page.aspx?item=35884.

[18] United States Department of Health and Human Services. *Child Care and Development Fund Reports of State and Territory Plans FY 2008-2009* (2008). Available at http://www.nccic.org/pubs/stateplan2008percent2D09/, 156.

centile in the Chicago metro area, the 60th percentile in other large urban areas of the state, and the 75th percentile in all rural counties of the state. Recent unionization of family child care homes has also led to rate increases for child care homes.

The still relatively low reimbursement rates in Illinois are expected to associate with lower quality of care because providers charging higher market rates presumably cannot recover all of their costs if they accept lower rates and because lower-paid providers are not likely to afford to offer the highest quality care.[19] Setting rates below the market also means that low-income children whose care is paid by subsidies cannot access the highest cost (and thus likely highest quality) care. In its FFY 2008-2009 plan, Illinois reported that nearly one-third of providers in the statewide Child Care Resource and Referral database indicated they would not accept children whose care was paid by subsidies. Yet it is these low-income children that some research shows benefit the most from higher quality care.[20] The Quality Rating System offers a strategy to raise the rates for some providers and give some lower-income children access to higher quality care, while not taking on the full cost of suddenly making up the difference between current reimbursement rates and market rates.

Universal preschool. State-funded prekindergarten ("pre-k") programs expanded at the end of the 20th century,[21] and Illinois has a strong record among the states in this arena. Illinois began offering a Prekindergarten Program for At-Risk Children in 1985. The program was later made part of the state's Early Childhood Block Grant (89 percent of which goes toward 3- and 4-year-olds; the remainder funds programs for at-risk infants and toddlers) and is being expanded through the *Preschool for All* initiative which aims to make state-funded preschool available by 2011 for all 3- and 4-year-olds whose parents want it. Programs serving at-risk children receive priority, with at-risk defined locally.[22] The program is part-day/part-year, operating 2 1/2 hours per day up to five days a week during the school year.

Illinois stands out especially in its inclusion of 3-year-olds in its state-funded program. According to the 2007 *State of Preschool* report by the National Institute for Early Education Research, Illinois is one of just 26 states with state-funded programs for 3-year-olds and ranked first in the percentage of children of this age enrolled, at 19 percent.

However, whereas the percentage of 3-year-olds enrolled in Illinois state pre-k increased from 8 percent to 19 percent between 2002 and 2007, the percentage of 4-year-olds enrolled increased by less than one-fourth, from 22 percent to 27 percent placing Illinois 22nd among the 38 states with programs for 4-year-olds. Still, in the Midwest, only Wisconsin had a higher fraction of 4-year-olds enrolled in state-funded pre-k in 2007 (36 percent).

States may face a tradeoff between serving more children and spending more per child. In Illinois, while the percentage of children enrolled has been increasing, the state spending per child has been decreasing (from $3,902 in 2002 to $3,322 in 2007, in constant 2007 dollars). In 2007, Illinois ranked 22nd in terms of state spending out of 38 states with programs.

NIEER estimated that Illinois would need to spend $4,520 per child on a half-day program to achieve high quality.[vi] Although its state funds fell short of that target by $1,198 per child, the state did not report about local or federal funds that might make up some of that difference. Still, Illinois' standards met nine of 10 structural quality benchmarks that NIEER reviewed, including requiring teachers to have a BA degree and assistant teachers to have an associate's degree and having class sizes of 20 with an adult-to-child ratio of 1:10.

[19] Suzanne W. Helburn and Carollee Howes. "Child Care Cost and Quality," *Future of Children, 6(2)* (1996): 62-82.

[20] Katherine A. Magnuson et al. "Inequality in Preschool Education and School Readiness," *American Educational Research Journal, 41(1)* (2004): 115-157.

[21] W. S. Barnett, K. Brown, and R. Shore. (2004, April). "The Universal vs. Targeted Debate: Should the United States Have Preschool for All?" *Preschool Policy Matters(6)* (New Brunswick, NJ: National Institute for Early Education Research, Rutgers, 2004).

[22] Ibid.

Do these rapidly expanding state pre-k programs in Illinois and other states meet their goal of providing "high-quality" preschool when process quality is measured, consistent with their generally solid structural standards? A recent study of state-funded pre-k programs in 11 states, including Illinois, suggests they may not.[23] On the measure of process quality also used in many Quality Rating Systems, the observed state pre-k programs averaged a 3.80, or minimal quality. Minute-by-minute snapshots of what children were doing throughout the day also revealed that they spent substantial time in routine activities, like snacks, meals and hand washing, and in transition between activities. Relatively little time was spent on learning activities. This minimal quality was found despite observed structural quality being consistent with the generally strong recommended standards, with an average class size of about 17, about eight children per adult, and nearly three-quarters of teachers having at least a bachelor's degree.

But a separate study of the state pre-k program in Oklahoma suggests it is possible to achieve high process quality on a large scale. That state began funding pre-k in 1980, and was the second state to aim to expand to "universal preschool" for all 4-year-olds in 1998. Like Illinois, Oklahoma meets nine of NIEER's 10 benchmarks, including teacher education, group size, and adult-to-child ratios. Several additional structural features may further support process quality in Oklahoma. All of its programs are run by or in collaboration with schools, and teachers receive similar pay as teachers in the public schools. Teachers must be certified in early childhood education, and the majority of them receive required training in early childhood reading and math instruction.[24] Most importantly, 97 percent of school districts participate, and Oklahoma has the highest participation rate for 4-year-olds of all states, at 68 percent, in contrast to one-third or fewer children served in most other states.[25]

When researchers compared Oklahoma classrooms to those from the 11-state study, they found that a measure of the quality of teacher's instruction was significantly higher in Oklahoma than the other states.[26] Based on researchers' moment-by-moment observations, the Oklahoma teachers also spent double to triple the time reading to children, practicing letters and sounds, and engaged in math and science. The Oklahoma teachers spent about 10 percent to 20 percent of their time on each of these activities, whereas teachers in other states generally spent less than 10 percent. In a related rigorous study of Oklahoma's program, children showed gains in reading that were somewhat larger than evaluations of other state pre-k programs and on par with the intensive early interventions that motivated these universal preschool policies.[27]

The authors of both the multi-state and Oklahoma studies acknowledge many potential reasons for these findings. For example, many states, like Illinois, have a goal of making pre-k available "universally," to all parents who want it, but prioritize at-risk children as the programs begin to expand.[28] Oklahoma comes much closer to universality than any other state. Of the 11 states in the multi-state study, all but one prioritized low-income or otherwise at-risk children, and the study found that 55 percent of children in the observed programs came from families whose incomes fell below 150 percent of the federal poverty threshold. These at-risk classrooms may require even greater structural quality. The model early childhood interventions – which showed substantial benefits to low-income, primarily African-American children – had adult-to-child ratios of about 1:6, smaller than the standard of 1:10 used by most state pre-k programs.[vi],[29] States may also need to go beyond structural quality. The authors of the multi-state study conclude:

> States cannot rely solely on professional standards and structural indicators of

[23] Diane M. Early et al. 2005. "Pre-Kindergarten in Eleven States: NCEDL's Multi-state Study of Pre-Kindergarten and Study of State-Wide Early Education Programs (SWEEP)" (2005). Available at http://www.fpg.unc.edu/~NCEDL/pdfs/SWEEP_MS_summary_final.pdf.

[24] Deborah Phillips, William T. Gormley, and Amy Lowenstein. "Classroom Quality and Time Allocation in Tulsa's Early Childhood Programs," Paper presented at the biennial meetings of the Society for Research in Child Development, Boston, MA, March 30, 2007.

[25] NIEER, 2007.

[26] Ibid.

[27] William T. Gormley. 2007. "Early Childhood Care and Education: Lessons and Puzzles," *Journal of Policy Analysis and Management, 26(3)* (2007): 633-671.

[28] Illinois Early Learning Council. *Preschool for All: Reaching At-Risk Children First* (2007). Available at http://www.illinois.gov/gov/elc/reports/ELC_White_paper_on_capacity_building_FINALpercent202-22-07. pdf.

[29] Barbara Gault, Anne W. Mitchell and Erica Williams. *Meaningful Investments in Pre-K: Estimating the Per-Child Costs of Quality Programs* (Washington, DC: Institute for Women's Policy Research, 2008).

quality (e.g., ratios, teacher education) to ensure that their programs are fulfilling their potential. To improve classroom quality and interactions, states may consider providing teachers with additional supports to further their knowledge and use of appropriate instruction for young children. These supports might come in the form of mentoring relationships, technical assistance, or increased supervision. Likewise, state systems of teacher preparation and professional development may require supports in order to increase their capacity and quality.[30]

Historically, Illinois has had a strong record of professional development and system coordination to support such efforts. A "Type 04" early childhood state certificate is available for teaching children from birth through grade 3, and is required for teaching in state pre-k. However, a study by the Illinois Education Research Council found that attracting qualified teachers may be difficult as *Preschool for All* expands. Offering preschool in community centers, rather than only in schools, was deemed essential to serving the targeted 10,000 additional preschoolers per year during expansion.[viii] But certified teachers reported that they required higher salaries and benefits in order to teach preschool in child care centers. Supply of certified teachers was particularly low in Chicago, and those in Chicago reported needing even higher salaries to attract them to work in centers.[31]

Taxpayer dollars can be used most efficiently, and the highest levels of quality can be achieved, if initiatives in child care – like Quality Rating Systems and universal preschool – inform and support one another. The lack of uniformly high quality in state universal preschool programs suggests that additional quality incentives may be needed, like those in child care. Two states fund state pre-k programs at higher levels when they meet quality indicators. Louisiana pays higher rates for advanced teacher and assistant credentials. Missouri pays higher rates for accredited programs. Furthermore, innovative models are emerging for combining part-day preschool with child care. These new models encourage parents, practitioners and policymakers to think in new ways about which aspects of quality are essential in each part of the child's day.

Quality Rating Systems

The history of Quality Rating Systems. The first Quality Rating System – *Reaching for the Stars* – was offered in Oklahoma in 1998. Since then, 13 more states and the District of Columbia have begun similar programs.[32]

The Oklahoma program was proposed through a welfare-reform task force in 1996 at a time when reimbursement rates were well below market rates. The committee concluded that linking higher rates to higher quality would provide better care settings for children as their parents moved from welfare to employment, and would encourage quality improvements in existing programs.[33]

Oklahoma's QRS and those that followed in other states typically have five components:

- *Program standards* with two or more levels beyond state licensing regulations.
- *Accountability measures* used to ensure that programs are meeting the standards associated with each level.
- Program and practitioner *outreach and support*, such as training, mentoring, and technical assistance, to encourage participation and facilitate progress.
- *Financial incentives,* which are linked to quality levels such as tiered reimbursement.
- *Parent education* to help parents understand the features of quality in general and the QRS ratings in particular.[34]

[30] Diane M. Early et al. *Pre-Kindergarten in Eleven States: NCEDL's Multi-state Study of Pre-Kindergarten and Study of State-Wide Early Education Programs (SWEEP)* (2005). Available at http://www.fpg.unc.edu/~NCEDL/pdfs/SWEEP_MS_summary_final.pdf, p. 33.

[31] Jennifer B. Presley, Brenda K. Klostermann, and Bradford R. White. *Pipelines and Pools: Meeting the Demand for Early Childhood Teachers in Illinois*, (Edwardsville, IL: Illinois Education Research Council, 2006).

[32] Child Care Bureau. "Systemic Approaches to Improving Quality of Care: Quality Rating System Gain Ground Across the Nation," *Child Care Bulletin*, *32* (2007).

[33] Child Care Bureau. "Systemic Approaches to Improving Quality of Care: Quality Rating System Gain Ground Across the Nation," *Child Care Bulletin*, *32* (2007); Gail L. Zellman and Michael Perlman. *Child-care Quality Rating and Improvement Systems in Five Pioneer States*, (Santa Monica, CA: RAND, 2008).

[34] Child Care Bureau. "Systemic Approaches to Improving Quality of Care: Quality Rating System Gain Ground Across the Nation," *Child Care Bulletin*, *32* (2007).

Quality Rating System standards are based on "consensual ideas" about what aspects of quality are most important, rather than solid research evidence, although descriptive and impact evaluations of QRSs are beginning to accumulate.[35] Most states include in their standards provider qualifications/training, parent involvement, and the learning environment. Other areas covered by several states include regulatory compliance, administration, staff compensation, program evaluation, ratios/group size, and personnel/staffing.[36]

The Environment Rating Scales (ERSs) are used by 11 states to assess the program's learning environment, including process quality. Separate versions of these scales are available for infants and toddlers and for preschoolers in child care centers and for children in family day care.[37] Each form includes about 40 items that are scored from *1 = Inadequate* to *3 = Minimal* to *5 = Good* to *7 = Excellent*. Subscales on each form cover similar content. For example, the form for preschoolers in centers covers Space and Furnishings, Personal Care Routines, Language-Reasoning, Activities, Interaction, Program Structure, and Parents and Staff. Usually, programs must achieve a particular average score across items to reach a higher rating level.

Illinois' new Quality Rating System. Illinois launched its Quality Rating System - *Quality Counts* – in July 2007.[38] To "assist with the higher costs of quality care," Illinois offers higher reimbursement rates to higher-quality licensed and license-exempt providers who care for children receiving state subsidies.[39]

For licensed providers, there are four star levels which associate with a 5 percent to 20 percent increment to the standard reimbursement rate. Table 4 provides an example of the amount of the increment, taking the rates from Table 3 as a base. The absolute dollar increment is largest for center-based care of infants; centers gain about $10 per week more per infant with each additional star level. To be eligible, licensed centers must be filling at least one-quarter of their licensed capacity with children who receive subsidies. For a large center serving mostly children receiving subsidies, the total quality increment could be more than $1,000 per week. For family child care of preschoolers, the increment is closer to $5 per week per child. Licensed home-based providers must care for at least three children who receive subsidies, so the increment would be at least $15 per week.

Table 4
Illinois Weekly Reimbursement Rates by Type of Care and Age Group, with Tiered Add Ons

	Center-Based			Family		
	Infant	Toddler	Preschool	Infant	Toddler	Preschool
Standard rate	196.35	165.85	138.30	129.15	124.30	116.50
Tiered Levels						
*	206.17	174.14	145.22	135.61	130.52	122.33
**	215.99	182.44	152.13	142.07	136.73	128.15
***	225.80	190.73	159.05	148.52	142.95	133.98
****	235.62	199.02	165.96	154.98	149.16	139.80

Note: Illinois daily rates multiplied by 5.

Sources: U.S. Dept. of Health and Human Services, Administration for Children and Families, Child Care and Development Fund Report of State and Territory Plans FY 2008-2009, available at http://nccic.acf.hhs.gov/pubs/stateplan2008-09, Illinois Network of Child Care Resource & Referral Agencies (INCCRA) web site at http://www.inccrra.org/qrs.aspx?id=3821.

[35] Gail L. Zellman and Michael Perlman. *Child-care Quality Rating and Improvement Systems in Five Pioneer States*, (Santa Monica, CA: RAND, 2008).

[36] Child Care Bureau. "Systemic Approaches to Improving Quality of Care: Quality Rating System Gain Ground Across the Nation," *Child Care Bulletin*, *32* (2007).

[37] Thelma Harms, Richard M.Clifford, and Debby Cryer. *Early Childhood Environment Rating Scale, Revised Edition*, (New York, NY: Teachers College Press, 1998).

[38] Linda Butkovich and Teri Talan. "Illinois Launches New Quality Rating System for Early Care and Education," *The Director's Link, Fall*, (2007)1-3; Illinois Network of Child Care Resource and Referral Agencies. *Quality Counts: Quality Rating System* (2008). Available at www.inccrra.org.

[39] Illinois Network of Child Care Resource and Referral Agencies. *Quality Counts: Quality Rating System* (2008). Available at www.inccrra.org.

Like many states, Illinois uses the Environment Rating Scales to measure process quality at each star level for licensed providers. Providers can also achieve the highest levels through accreditation by one of several approved organizations, including NAEYC. A variety of resources are available to help providers achieve higher quality. For example, Illinois has long offered scholarships and wage supplements to support and reward providers' higher education.

License-exempt family child care providers can also progress through three training tiers and receive a 10 percent to 20 percent rate increment. To qualify, license-exempt providers must care for at least one child who receives child care subsidies. License-exempt providers receive $63.75 per child for five full days of care at the standard reimbursement rate, so the quality increments amount to from $6 to $13 per child per week, depending on the level.

Lessons learned from other states' experiences. What do other states' experiences suggest about the challenges Illinois may face as the rollout of the QRS continues and how these challenges might be addressed?

General lessons learned. Most QRSs required refinements as they were implemented. After interviewing key informants in five "pioneer" states which were among the first to offer a QRS, Zellman and Perlman concluded, "The lack of piloting in most of these states and the relatively fast implementation of their [QRSs] led to early reassessments and numerous revisions."[40]

For example, participation was low in the first year of Oklahoma's *Reaching for the Stars*. The state added a level of "One Star Plus" because it found that the large gap between the first and second star discouraged participation. Oklahoma also found that annually assessing programs' process quality was too expensive. The state switched to program self-assessment in the first tier and reduced the number of independent assessments at the higher tiers.[41] Other states similarly adjusted their systems once confronted with the cost of rating process quality, especially with independent assessors.[42] In addition to cost, the Environment Rating Scale is problematic from a high-stakes accountability perspective because providers may focus on increasing their ratings on the specific items in the scale, rather than thinking more broadly about improving quality, and may focus on the items that are easiest to address. Many of the informants interviewed by Zellman and Perlman "argued that ERSs placed too much emphasis on physical attributes of the setting and on hygiene issues, such as hand-washing, and not enough on processes, such as adult-child interactions."[43] Other states reported that providers found the observers disruptive, the ratings inconsistent, and the feedback about the reason for their rating insufficient.

Another finding from prior QRSs is the need to assure that the levels are of sufficient number and spacing in order for providers to make progress.[44] It is especially important that the lowest level is not above what most providers can achieve. At the same time, it is important that the top level is high enough so providers continue to strive for it and so that the rules of the system aren't changed midway to add levels if many providers achieve the top too quickly. Unfortunately, decisions about specific requirements and cut-points at each level are often "best guesses" by QRS developers, rather than being based on sound evidence.[45] Piloting in a few communities first is one recommended strategy, so states can refine the system before unrolling it statewide.

Scholars and practitioners also debate the fact that the standard total score calculation for the Environment Rating Scale gives equal weight to each of the subscales

[40] Zellman, Gail L. and Michael Perlman. 2008. *Child-care Quality Rating and Improvement Systems in Five Pioneer States*. Santa Monica, CA: RAND, p. xiii.

[41] Child Care Bureau. "Systemic Approaches to Improving Quality of Care: Quality Rating System Gain Ground Across the Nation," *Child Care Bulletin*, *32* (2007).

[42] Zellman, Gail L. and Michael Perlman. 2008. *Child-care Quality Rating and Improvement Systems in Five Pioneer States.* Santa Monica, CA: RAND.

[43] Ibid, p 20.

[44] Ibid.

[45] Ibid.

and a program can achieve a higher score by raising any one of these subscales.[46] A similar mid-range total score could reflect a setting rich in positive caregiver-child activities and interactions, but lacking in the presence and accessibility of materials in the classroom and resources for staff and parents. Alternatively, a similarly scored setting might have considerable materials and resources, but few activities and poor interactions among caregivers and children. Thus, QRS designers need to think carefully about what types of quality they want to promote, and whether selected assessments measure these aspects of quality. The Early Learning Standards developed by Illinois and many other states could help ensure that quality measures line up with goals for early learning.

In addition to geographically-restricted piloting, states can also incrementally roll out the program in various communities. Such incremental roll-outs can help the state gain the support of various stakeholders. In reviewing some of the earliest programs, researcher Anne Mitchell noted:

> Programs that provide early care and education can be both allies and opponents. Those who want to be recognized for the quality of the services that they offer welcome QRS. Programs that believe they will not benefit financially, and that increased requirements will come without sufficient support to achieve or maintain them, have opposed QRS.[47]

Geographically staggered roll outs also can concentrate state dollars in smaller areas to ensure sufficient resources to encourage provider participation and progress in each community. This is important for parents as well. Early adopting states found that consumer education was most effective at the point where a modest proportion of early care and education programs were participating in the QRS.[ix,48] Otherwise, there were too few rated programs from which parents could choose. Once provider participation started to take off, however, it was critical for the state to stimulate parent demand with consumer education because parents' increasing preference for higher quality programs helped encourage more programs to participate.

Licensing standards. States signal to providers and parents what is important about child care with the standards they set for ratings.[49] Illinois covers three areas: (1) learning environment, (2) program administration, and (3) provider/staff qualifications and training.[50] Two of these (learning environment and provider/staff qualifications and training) are covered in most or all other QRSs,[51] but program administration is covered by only about half of the other state QRSs. Other areas covered by multiple states include parent involvement, staff compensation, program evaluation, ratios/group sizes, and personnel.

Illinois did not explicitly include staff-to-child ratios and group size in its star levels, although they are implicit in the highest levels where providers can use accreditation as an alternative to the Environment Rating Scale. Some other states have similarly omitted adult-to-child ratios and group size from their explicit QRS requirements because they are seen as costly to achieve without appropriate state support or incentives.[52] But to the extent that they are costly for providers that attempt to achieve Illinois' accreditation option, the state needs to assure that appropriate supports and incentives are in place so that programs can pursue accreditation. Other states have found accreditation difficult for programs to achieve and maintain, and Zellman and Perlman in their 2008 review recommend being sure that an appropriate number and spacing of levels is available. The state might, for example, add another higher level with stricter adult-to-child and group-size options and/or accreditation requirements, with additional incre-

[46] J.I. Layzer and B.D. Goodson. 2006. "The Quality of Early Care and Education Settings: Definitional and Measurement Issues," *Evaluation Review, 30*(5) (2006): 556-576.

[47] Mitchell, Anne W. 2005. *Stair Steps to Quality: A Guide for States and Communities Developing Quality Rating Systems for Early Care and Education*. United Way, Success by 6, p 15.

[48] Zellman, Gail L. and Michael Perlman. 2008. *Child-care Quality Rating and Improvement Systems in Five Pioneer States.* Santa Monica, CA: RAND.

[49] Ibid.

[50] Butkovich, Linda and Teri Talan. "Illinois Launches New Quality Rating System for Early Care and Education." *The Director's Link, Fall 2007*, 1-3.

[51] Child Care Bureau. "Systemic Approaches to Improving Quality of Care: Quality Rating System Gain Ground Across the Nation," *Child Care Bulletin*, *32* (2007).

[52] Zellman, Gail L. and Michael Perlman. 2008. *Child-care Quality Rating and Improvement Systems in Five Pioneer States.* Santa Monica, CA: RAND.

ments to reimbursement and supports for hiring additional staff.

Subsidy program. Most Quality Rating System systems, like Illinois, are voluntary and target providers with children who receive subsidies in their care. Unlike Illinois, most do not include license-exempt providers.

The license-exempt component is particularly important in Illinois, given the large fraction of children in the subsidy program who are cared for in license-exempt settings. But providers who often care for friends' and relatives' children short-term may see the needed training as not worth the modest subsidy increment of up to $13 per child per week. Again, piloting the program would help inform the state about whether these rate increments will attract license-exempt providers.

Time frames built into the system may also provide a disincentive to providers. Centers and family day care providers must have been licensed for two years before applying. As written, this would be true for a license-exempt provider who decided to become licensed after completing the required training to achieve the highest license-exempt tier. Similarly, a home or center just entering the market with a new high quality program would have to wait two years before receiving the higher rate of a higher star rating. To the extent that higher quality care costs more, these providers face a choice of either (1) offering lower quality care for two years or (2) providing higher quality care, but excluding children who receive subsidies, or (3) accepting children at the lower standard rate but possibly going out of business due to costs exceeding the rate for this extended period.

Because Illinois' Quality Rating System targets providers who serve children in the subsidy program, it misses a large number of families who earn just over the threshold for the subsidy. As of the state's FFY 2008-2009 plan, income eligibility was set just above 50 percent of state median income ($2,647 per month for a family of three). Families below the threshold have a small co-pay and those above it pay the full market rate. A recent publication by Illinois Action for Children reports that as a family's income moves just above the cutoff, they can go from paying about 12 percent to nearly 30 percent of their income on the most expensive (center) care. Because co-payments are set independently of the provider's rate, this change will be most dramatic for parents using providers that charge the highest market rates (and thus presumably are highest quality). These parents may have to change to a lower quality provider once they move above the subsidy level.[x] Tax incentives are one strategy the state might explore to assist families who fall modestly above the cutoff for subsidies in purchasing quality care. Arkansas, Maine, and Vermont have such dependent-care tax credits that provide higher credits when families use higher quality care settings.[53]

A final question within the subsidy program is whether all programs should be required to participate. Several states have moved to mandatory systems, often automatically assigning the lowest star level to programs when they become licensed.[54] Participation of centers in Oklahoma is at 97 percent in contrast to other early adopting states with voluntary systems, where participation is much lower (e.g., 10 percent in Colorado). In states with low levels of participation, parents may lack real choices and providers may lack meaningful incentives to invest in quality.

Universal preschool. Like many other states, Illinois has separate initiatives aimed at universal preschool and child care quality. Ideally, these efforts will be increasingly aligned. For example, a recent National Early Childhood Accountability Task Force report recommended that:

[53] Child Care Bureau. "Systemic Approaches to Improving Quality of Care: Quality Rating System Gain Ground Across the Nation," *Child Care Bulletin*, *32* (2007).

[54] Anne W. Mitchell. *Stair Steps to Quality: A Guide for States and Communities Developing Quality Rating Systems for Early Care and Education*, (United Way, Success by 6, 2005); Gail L. Zellman and Michael Perlman. *Child-care Quality Rating and Improvement Systems in Five Pioneer States*, (Santa Monica, CA: RAND, 2008).

Considering the landscape of care that parents and providers currently use, researchers and practitioners are also beginning to think in new ways about whether children can get different aspects of quality at different times of the day, possibly from different providers.

- States should develop a unified system of early childhood education that includes a single, coherent system of standards, assessments, data, and professional development efforts across all categorical programs and funding systems.
- States should align high-quality and comprehensive standards, curriculum, and assessment as a continuum from prekindergarten through grade 3.[55]

Although the task force focused on preschool, other groups have similarly called for alignment and integration among child care and preschool[56] which could be extended from birth to grade 3. This is increasingly important as state-funded preschool is offered in centers, and as providers draw on multiple funding sources to serve children full-day and full-year.[57] Currently, with regard to QRSs, most states include Head Start centers, but only Colorado, North Carolina, and Vermont include state pre-k.[58]

Considering the landscape of care that parents and providers currently use, researchers and practitioners are also beginning to think in new ways about whether children can get different aspects of quality at different times of the day, possibly from different providers. Toni Porter and her colleagues have conceptualized a continuum of care,[59] and it is possible that home-based care is best-suited to offer a certain type of quality (intimate, stable) and center-based care is best-suited to offer other types of quality (formal learning). The Community Connections Model[60] offers this kind of approach, advocating for transporting children from family day care to part-day/part-week preschool. Under this model, preschool teachers visit the family day-care home one day a week, fostering connections and continuity between the two settings. This is an exciting new approach for the state to explore, including whether funding rules might require modification and additional incentives might be needed to encourage participation (e.g., should family day care providers who participate in these programs receive their full-day reimbursement rate, as a "bonus" for participation, rather than having their rate reduced by the hours the child is away at preschool?). Parents are most likely to use family day care for infants and toddlers, and center-based care for preschoolers. Yet continuity of care benefits children, and spending extensive time in large-group setting has been associated with spread of illness[61] and elevated problem behaviors.[62] An approach like the Community Connections Model might allow preschool children to stay with a family day-care provider they have used since infancy and

[55] National Early Childhood Accountability Task Force. 2008. *Taking Stock: Assessing and Improving Early Childhood Learning and Program Quality.* Available at http://www.fcd-us.org/usr_doc/Accountability_Task_Force_Final_Report1.pdf , p. 5).

[56] Illinois Action for Children. *State-funded Preschool and Home-Based Child Care: The Community Connections Model,* (Chicago: Author, 2008).

[57] Karen Schulman and Helen Blank. *A Center Piece of the PreK Puzzle: Providing State Prekindergarten in Child Care Centers*, (Washington, DC: National Women's Law Center, 2007).

[58] Anne W. Mitchell. *Stair Steps to Quality: A Guide for States and Communities Developing Quality Rating Systems for Early Care and Education*, (United Way, Success by 6, 2005).

[59] Toni Porter and Rena Rice. *Lessons Learned: Strategies for Working with Kith and Kin Caregivers,* (New York, NY: Bank Street College, 2000).

[60] Illinois Action for Children. *Child Care in Cook County: Elements of Child Care Supply and Demand,* (Chicago: Author, 2008).

[61] R.A. Gordon, R. Kaestner and S. Korenman. "Child Care and Work Absences: Trade-offs by Type of Care," *Journal of Marriage and the Family, 70* (2008): 239-254.

[62] S. Loeb et al. "How Much Is Too Much? The Influence of Preschool Centers on Children's Social and Cognitive Development," *Economics of Education Review, 26(1)* (2007), 52-66; K.A. Magnuson, C. Ruhm and J. Waldfogel. "Does Prekindergarten Improve School Preparation and Performance?" *Economics of Education Review, 26(1)* (2007), 33-51; NICHD Early Child Care Research Network. "Are There Long-term Effects of Early Child Care?" *Child Development, 78(2)* (2007), 681-701.

spend only a portion of the day in a center-based setting. This approach presents continuity with their family day-care provider while at the same time giving children access to learning at formalized centers without spending too much time in potentially stressful large-groups.

Summary and Conclusions

Illinois continues to sit at the top of many state rankings for its investments in child care and early childhood education. However, this good performance relative to other states cannot overshadow the need for Illinois to continue to work on raising its absolute performance to meet the quality standards set by the professional community and research evidence. Structural quality indicators in the licensing systems are below these standards for teacher education, adult-to-child ratios, and group sizes for many age groups. The subsidy system gives many children access to care, but the state's below-market rates and extensive use of license-exempt care raise concerns about whether these children are getting the quality of care needed to best support all aspects of their development. The state has set an ambitious goal for making state-funded preschool available to all parents who want it, although whether it can meet that goal without shortchanging program quality remains an open question.

The recently launched Quality Rating System has the potential to address some of these concerns. The QRS could move providers toward higher structural quality, bring higher quality providers into the subsidy system through closer-to-market reimbursement rates, and encourage alignment between quality efforts in preschool and child care. However, QRSs are challenging. Most states have found that their systems required revision over time, and that slow roll-outs with piloting identified areas needing improvement. As providers, parents, and a wider set of stakeholders learn about Illinois' new *Quality Counts* program, the state should retain flexibility to make such adjustments. This is also an opportune time for the state to look across funding streams, age groups, and types of settings, and ensure that incentives and standards are aligned. Rather than requiring all systems and settings to achieve the same levels of structural and process quality, innovative models suggest new ways to think about how systems and settings in child care and preschool can complement one another to support the broad range of physical, cognitive, and emotional development in early childhood.

The state has set an ambitious goal for making state-funded preschool available to all parents who want it, although whether it can meet that goal without shortchanging program quality remains an open question.

Endnotes

[i] The CDA was developed in the 1970s to recognize the expertise of experienced caregivers and train those entering the field. Applicants complete 120 hours of training and a final assessment, including a verification visit. (Council for Professional Recognition. 2008. *CDA Credential.* Available at http://www.cdacouncil.org/cda.htm.)

[ii] NACCRRA is a national organization whose members include state and local child care resource and referral agencies (CCR&Rs). They provide training and technical assistance, collect and analyze data about child care supply and demand, and advocate for national policies that "facilitate universal access to high quality child care." (National Association of Child Care Resource and Referral Agencies. 2008. *We Can Do Better: NACCRRA's Ranking of State Child Care Center Standards and Oversight.* Available at http://www.naccrra.org/policy/recent_reports/scorecard.php.)

Taxpayer dollars can be used most efficiently, and the highest levels of quality can be achieved, if initiatives in child care – like Quality Rating Systems and universal preschool – inform and support one another.

[iii] In some cases, NACCRRA's scoring system allowed lower levels than NAEYC.

[iv] Most states with licensing requirements, in contrast, have more stringent requirements for group sizes and ratios. For example, Illinois is one of just eight states that allow group sizes of 12 or more for infants. Twenty-nine states require smaller groups, including 20 states that require the recommended eight or fewer (Wisconsin and Minnesota are among the latter group). Similarly, Illinois is one of only 12 states with ratios for 5-year-olds at 1:20 or higher. Thirty-eight states require lower ratios. Seven states, including Minnesota, meet NAEYC's recommended 1:10 ratio for 5-year-olds.

[v] Care in license-exempt settings is presumably less expensive (sometimes provided by relatives at no charge to parents), although the state's market rate survey is based on those license-exempt providers who voluntarily sign up with resource and referral agencies and their calculations are based on too small numbers of providers to be meaningful.

[vi] NIEER started with the Institute for Women's Policy Research's recent estimates of the full cost of providing quality pre-k (Gault et al., 2008. *Meaningful Investments in Pre-K: Estimating the Per-Child Costs of Quality Programs.* Washington, DC: Institute for Women's Policy Research). For Illinois, NIEER used their estimate for a half-day program with a group size of 20 and a teacher with a bachelor's degree who was paid a kindergarten-level wage. NIEER then adjusted the IWPR national value using a geographic cost adjustment developed by the National Center for Education Statistics and a yearly inflation adjuster to convert to 2007 dollars (Barnett, 2008. "The universal vs. targeted debate: should the united states have preschool for all?" *Preschool Policy Matters(6).* New Brunswick, NJ: National Institute for Early Education Research, Rutgers; personal communication; Taylor et al., 2006. *A Comparable Wage Approach to Geographic Cost Adjustment* (NCES 2006-321). Washington DC: U.S. Department of Education, National Center for Education Statistics).

[vii] The lowest required ratio in state pre-k is 2:15 in the New Jersey Abbott preschool program; five states, including Iowa and Michigan, require ratios of 1:8 (NIEER 2007). The Chicago Child-Parent Centers, which have also shown sizable benefit:cost ratios have a class size of 17, with two adults (Barnard 2007).

[viii] Indeed, nationally, although three-fifth of state pre-k programs operate in public schools, over one-quarter occur in child care settings (Schulman, Karen and Helen Blank. 2007. *A Center Piece of the Pre-K Puzzle: Providing State Prekindergarten in Child Care Centers.* Washington, DC: National Women's Law Center).

[ix] For example, parents may believe that licensing ensures high, rather than minimal, quality (Zellman and Perlman *Child-care Quality Rating and Improvement Systems in Five Pioneer States*. Santa Monica, CA: RAND, 2008). Many parents do not "shop around" to multiple settings before they select care, especially if they use license-exempt providers and parents overwhelmingly report being satisfied with their care arrangements

(Gordon and Högnäs 2006. "The Best Laid Plans: Expectations, Preferences, and Stability of Child-Care Arrangements." *Journal of Marriage and Family, 68*, 373-393). Parents also report that the quality items in the Environment Rating System are important to them, especially those dealing with caregiver-child interactions, health and safety. But parents rate their current provider higher on quality than do independent observers, especially when aspects of care are difficult to monitor (Cryer and Burchinal 1997).

[x] The broader child care literature similarly finds that the poorest and the wealthiest families have access to the highest quality care, on average; in the middle, families often cannot obtain this care because their incomes are too low to pay the market rate but too high to qualify for subsidies (Fuller and Strath 2001. "The Child-Care and Preschool Workforce: Demographics, Earnings, and Unequal Distribution." *Educational Evaluation and Policy Analysis, 23(1)*, 37-55).

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