

**THE PAYMENT OF DIFFERENTIAL REIMBURSEMENT RATES
AS A STRATEGY TO IMPROVE CHILD CARE QUALITY**

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Twenty-five states currently have a differential reimbursement rate structure that ties quality levels to reimbursement rates as a strategy to improve and maintain child care quality. Higher scoring programs receive higher reimbursement rates than lower scoring programs. The differential rate structure is thought to be an incentive for programs to improve and maintain quality. The effectiveness of this strategy, however, has not been documented by research or evaluation studies. A review of the literature combined with the examination of programs in several states will provide some guidelines.

Accreditation as an Indicator of Quality

Most states have a simple two-tiered system, usually that state's regulatory standards and accreditation by NAEYC. As of July 2000, 18 states had accreditation-linked differential reimbursement policies in place. Most states use the standards of the National Association for the Education of Young Children (NAEYC), which requires child care centers to meet certain standards of good practice before they can achieve accreditation. Such standards include child/staff ratios, training requirements, adherence to health and safety precautions, and others. All states with differential reimbursement policies accept accreditation by NAEYC, but some states accept other credentials as well. These include the National Early Childhood Program Accreditation (NECPA), The National School-Age Alliance (NSACA), the Council on Accreditation of Services for Children and Families, and the National Accreditation Commission for Early Care and Education Programs (NACECPPP).

The State of Florida accepts more accrediting systems than any other state. These include all those cited above plus the Association of Christian Schools International (ACSI), the Accredited Professional Preschool Learning Environment (APPLE), and the National Accreditation Council for Early Childhood Professional Personnel and Programs (NAECECEP). Gormley and Lucas (2000) feel "there is much to be said for allowing more than one accrediting organization to participate in the differential reimbursement process." However, they caution that each state must decide how far they are willing to go in ceding to the private sector the right to define child care quality. An accrediting body whose standards fail to push the envelope beyond existing state licensing standards is unlikely to yield any quality improvement. They conclude, "our rule of thumb is this: an accrediting organization should be eligible to participate only if its standards offer the likelihood of substantial quality improvement as measured by the variables of greatest importance in the relevant research. These variables include education and training requirements for staff, child/staff ratios, and health and safety precautions." However, research often does not identify unacceptable levels of quality below which children's development may be compromised, or the thresholds of quality that must be exceeded before programs can expect to have a meaningful impact. Each state or community must establish these.

NAEYC is the only accrediting system that has been studied in depth by independent investigators. The National Child Care Staffing Study, for example, found that NAEYC accredited centers provided higher than average quality services to children. Harms and Clifford (1980) found overall quality as measured by the Environmental Rating Scales to be higher in accredited than in nonaccredited centers, and Phillipsen, Burchinal, Howes, & Cryer (1997) also found higher Environmental Rating Scales scores in classrooms of programs accredited by NAEYC. Based on such research, accreditation of centers by NAEYC has topped the list of strategies to upgrade quality.

The Cost, Quality, and Child Outcomes in Child Care Centers (1995) confirmed the higher than average quality in NAEYC-accredited centers, but raised questions about the level of quality and staff instability in many of these centers. As a group, NAEYC-accredited centers did **not** provide the best care in their communities, and on average, fell slightly short of a good overall quality rating, although they did provide better care than other centers not in the high-quality group. It appears that NAEYC accreditation status indicates moderate to good care rather than a firm criterion of excellence.

This finding was confirmed by an extensive longitudinal study of the relationship between NAEYC accreditation and child care quality which found that despite improvements made by centers achieving NAEYC accreditation, nearly 40% continued to be rated as mediocre in quality (Whitebrook, Sakia, & Howes, 1997). These researchers concluded, “NAEYC accreditation clearly falls short as a consistent standard of excellence.” (p.47). Findings such as these have led various states to add other indicators of quality to their tiered reimbursement system.

Only one structural indicator directly predicts quality of care: wages paid to teachers and directors (Scarr, Eisenberg, & Deater-Deckard, 1994; Whitebrook, Sakia, & Howes, 1997); CQO, 1999). Wages are related to the retention of well-trained staff, which in turn, is related to program quality. NAEYC accreditation does not produce reductions in staff turnover. Higher wages do. Whitebrook, Sakia, & Howes (1997) recommend that NAEYC accreditation criteria require centers seeking accreditation to develop a concrete wage plan, with an implementation timetable, for improving staff compensation. One could extend this reasoning to the tiered reimbursement system. In addition, they suggest that NAEYC consider including information about the tenure of employed staff and their educational backgrounds in validating and revalidating accredited centers. They suggest a clear cut-off point, in terms of staff turnover rates, be established at which point centers would need to be re-validated.

In conclusion, it appears that accreditation alone is not sufficient to produce changes in quality of child care. Tiered reimbursement systems that include accreditation should also measure staff turnover, and include provisions to tie increased reimbursement rates to increased wages and training for teachers and administrators. Finally, states/communities must carefully evaluate accreditation systems to determine the degrees to which quality is supported.

Licensing Compliance as an Indicator of Quality

The foundation for a tiered reimbursement system in most states is its licensing system. The tiered reimbursement system is designed to build on mandatory state licensing standards, not replace them. States with low standards or inadequate monitoring systems will have more difficulty implementing a tiered reimbursement system than states with higher standards.

Licensing relates to the structural features of quality, such as such as group size, caregiver to child ratios, caregiver training and education, and administrator training and experience. Licensing regulations can control some structural indicators, but not others. For instance, licensing may control education and training of staff, but not wages and teacher turnover, all variables related to program quality.

Studies have examined the impact of improving staff/child ratios, group size, and training and education of teaching staff in state licensing regulations. (Sibley, Abbot-Shim, and Galinsky, 1994; The Florida Child Care Quality Improvement Study, 1998)). In general, these studies found that increased staff education and more rigorous ratio requirements had a positive impact on children without a marked negative impact on the affordability and accessibility of the child care marketplace. This is positive news for the development of tiered reimbursement systems.

Learning Environments as Indicators of Quality

Identification of structural aspects of center child care that are predictive of child care quality and child outcomes has been a goal of policy makers and child development mentalists for many years. Regulatable variables can set the stage for higher quality care, but they do not adequately capture what actually happens in classrooms of small children and one or two caregivers. Process quality appears to be a better predictor of child outcomes than regulatable indicators (Whitebrook, Howes, & Phillips, 1995).

The Early Childhood Environmental Rating Scales (ECERS) is the most widely used process assessment of classroom quality. North Carolina's five-star tiered-reimbursement system measures quality directly using the ECERS. State licensors assign one to five stars to every regulated child care facility in the state. The most compelling advantage of the five-star system is that it has the capacity to affect all licensed child care facilities and not just a small subset of those facilities. A system like this is time-consuming and demanding. It requires an increase in the number of licensing personnel, and pressure may build on licensors to award more stars to facilities than they actually deserve.

Considerations in Design of Tiered Reimbursement Systems

Little information is available on whether or not a tiered reimbursement system does improve quality. Oklahoma found trends in that direction, but these are not yet significant. Keep in mind, however, that use of tiered reimbursement systems is new, and not enough time may have lapsed to show quality improvement. One of the most significant outcomes in Oklahoma has been the number of people who have become involved in training and the rise in wages as centers sought to recruit and retain "master teachers" to meet quality criteria.

A tiered reimbursement system is beneficial only if providers participate in it and only if these participants are successful. Focus groups of providers in Oklahoma indicated that almost one-third of the respondents did not intend to apply for the second tier within the next 12 months. Reasons included difficulty in finding and retaining staff that met the quality criteria, rates did not make it worth the time and effort, cost of meeting the training criteria was unaffordable, training was not available, training was not of good quality, business is good as is, and they already have a quality program. New Mexico had a three-tiered reimbursement system that was withdrawn for some of these reasons.

States with differential reimbursement policies differ sharply in how much they are willing to pay for improved quality. Ohio and New Jersey pay only 5% more for accredited care. Other states, including Florida, pay 20% more for accredited care. Gormley and Lucas (2000) after a review of states using NAEYC accreditation in tiered reimbursement systems concluded that "a state that wants to maximize its chances of having a positive impact should set its rates for accredited centers at least 15% higher than its regular rates." Otherwise, providers do not participate. In Oklahoma, the difference between the reimbursement rate at the bottom level and that at the top level was \$7.00 per day per child. Oklahoma developed worksheets to help providers calculate how much more they would make in the upper tiers. This was a very effective marketing strategy.

In addition to feeling that the rate differential is worth the extra effort, providers must be convinced that the tiers are obtainable. A successful tiered reimbursement system must provide a balance between the criteria thought to advance quality care and those that would keep providers from advancing in the system. Providers will not participate if the criteria appear unattainable. Oklahoma originally started with three steps or tiers. A fourth tier was added between steps one and two to make movement up the ladder obtainable.

Demographics in the community must be studied before designing a tiered reimbursement system. Washington, D.C. did this, and established the base level of their tiered reimbursement system according to licensing stands and training opportunities. Washington, D.C. began with criteria lower than Oklahoma's because the demographics of the area were lower. In areas with good professional development systems and strong regulations, centers are better able to meet the high professional standards required in a tiered reimbursement system. For example, if few providers have the CDA credential, this training system must be established before a tiered reimbursement system that includes a CDA in its training criteria is put into effect.

States must include marketing strategies in their tiered reimbursement system. Marketing to providers has been addressed above. Marketing to parents must also be a part of the system. Parents should know which child care facilities have well-educated teachers and which do not, which facilities have five stars and which have one. If such information is routinely released, parents will be able to take quality into account and put pressure on child care providers to do a better job. The degree of system success is related to demand of parents for centers that have achieved the higher levels of quality.

Financial incentives, obtainable steps, marketing systems, and availability of professional training opportunities may still not be enough. Providers also need support. The study by Whitebrook, Sakia, & Howes (1999) found that centers seeking NAEYC accreditation that received intensive support, including onsite technical assistance from an early childhood professional, custom designed training for staff and directors, and an ongoing facilitated support group for directors, achieved accreditation at more than twice the rate of centers receiving moderate support or seeking accreditation independently, and at nearly ten times the rate of centers in a limited support group. Only these centers were more likely to achieve good (or better) classroom quality ratings. NAEYC found that a lot of support went a long way, but a little support was not money well spent. The same could most likely be said of centers seeking to advance in tiered reimbursement system. Several states with tiered reimbursement systems have established early childhood professional development centers, which include free consultation and training opportunities to all licensed child care centers.

Conclusions

1. The tiered reimbursement system is designed to build on mandatory state licensing standards, not replace them. States with low standards or inadequate monitoring systems will have more difficulty implementing a tiered reimbursement system than states with higher standards.
2. If existing accreditation systems are used, these systems must be carefully evaluated to ensure that the standards are based on research findings about the effects of program practices on the quality of services and outcomes for children and families. The accrediting standards should extend beyond existing state standards to yield quality improvements.
3. Accreditation alone is not sufficient to produce changes in quality of child care. Tiered reimbursement systems that include accreditation should also measure staff turnover and establish clear cut-off points, in terms of staff turnover rates, at which point centers would need to be reevaluated.
4. Increased reimbursement rates should be tied to increased wages and training for teachers and administrators.
5. A tiered reimbursement system is not likely to appeal to a bad or mediocre center that has trouble satisfying state licensing requirements. To encourage provider participation there must be a balance between criteria that advance quality care and those that would keep providers from participating in the program.
6. Rate differentials must be attractive to providers. A decision must be made about whether to allow subsidized rates to exceed private pay rates under any circumstances.
7. Resources must be available to provide intensive support to providers. A lot of support goes a long way, but little support is not money well spent.
8. Marketing is needed to help the public understand the link between children's healthy development and learning and good early childhood programs. The more parents demand quality programs the greater the incentive for providers to increase quality.
9. Adequate funding is needed to cover the ongoing costs of maintaining high quality services, including providing staff with equitable salaries.
10. Adequate funding should be available to help all interested programs make the quality improvements necessary to meet the higher standards.
11. An overall plan for supporting the creation of a highly qualified, stable professional workforce is needed. Current teacher preparation and ongoing professional development programs may need to be strengthened. TEACH scholarships must be available to support individuals' efforts to earn the CDA and college degrees. Career ladders may need to be created, as well as a system to track individuals' professional achievement.
12. Differential reimbursement systems will affect a fairly small percentage of child care centers. However, the centers it does affect are those serving low income, high risk children—the children that stand to benefit the most from quality improvements.
13. An evaluation plan should be established from the start.

In conclusion, a tiered reimbursement system has the potential to be a very powerful program-improvement tool. Development of a tiered reimbursement system, however, must be preceded by a careful study of the community and careful selection of the indicators of quality. The establishment of such a system also requires adequate funding for a supporting infrastructure that includes professional development and supply-building activities; financial assistance to help centers with program costs; marketing to providers to encourage participation and to parents to demand quality; and research and development. A tiered reimbursement system to increase quality appears deceptively simple to establish. It should not be undertaken, however, without adequate study, preparation, and resources.

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