NATIONAL HEAD START ASSOCIATION

Attn: Mr. Andrew Williams,
Office of Child Care Policy Division
Office of Child Care,
Administration for Children and Families,
330 C Street SW,
Washington, DC 20201,

February 22, 2016

VIA ELECTRONIC SUBMISSION: http://www.regulations.gov
Re: 80 FR 80465- Child Care and Development Fund (CCDF) Program; Proposed Rule

Dear Mr. Williams,

The National Head Start Association (NHSA) respectfully submits the following comments on the US Department of Health and Human Services' Notice of Proposed Rule Making (NPRM) to amend the Child Care and Development (CCDF) regulations published on December 24th, 2015 (80 FR 80465).

The National Head Start Association (NHSA) is the national voice for more than a million children in Head Start and Early Head Start programs in the United States. Recognizing the devastating impact poverty can have on the future success of young children and their families, Head Start and Early Head Start represent a longstanding national commitment to provide early learning opportunities for vulnerable children and comprehensive supports to help their families achieve long-term stability and success. In communities across the country, Head Start and Early Head Start programs partner with and support child care agencies helping children get ready for school and life while supporting parents' ability to work and go to school. A number of Head Start programs provide child care themselves or in partnership agreements with third-party child care providers to provide services. In addition, Early Head Start/Child Care partnerships are growing quickly and state CCDF policies directly impact the success of these partnerships. To date, 275 grants have been made to Early Head Start programs nearly all have multiple child care partners – with more expected later this year. NHSA believes that every child, regardless of circumstances at birth, has the ability to succeed in life if given the opportunity that Head Start offers to children and their families.

Since the release of the proposed CCDF standards, NHSA has been in close communication with our members and through them, their partners, as to the challenges and opportunities of receiving CCDF funds. We are impressed with and commend the new direction the Department is taking to focus on children by increasing the quality of care, providing stability to families, and educating consumers. While we are cognizant of the CCDBG Act's importance in enabling low income parents to work and gain skills and credentials to foster their path out of poverty, NHSA is very pleased that the two generation significance of the law shines through with these regulations.

On behalf of Head Start parents, staff, and programs across the nation, NHSA and the undersigned state/regional Head Start associations offer the following specific comments and recommendations to the NPRM regarding eligibility, program quality, parent involvement and consumer education, and payments. Our comments begin with a discussion of our overarching themes and then go into a more detailed analysis of specific sections we strongly support, specific sections we support, and conclude with the sections we recommend changes are made.

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Overarching Themes

1. **The NPRM takes an overwhelmingly positive and vital step in the right direction by focusing on the quality of care and on the children served.**

Overall, NHSA and the Head Start community are very impressed with both the directions emphasized in law, under the Child Care and Development Block Grant Act of 2014, and these proposed regulations that bring that law into reality. While the legislation took years to accomplish, the 113th Congress took decisive action in 2014, dramatically supplementing the previous CCDBG Act, passed 18 years earlier in 1996, and providing positive new direction to this critically important program. As indicated in the Federal Register on page 80466, both represent sweeping changes in the direction of this important effort by the federal government. We are very pleased with this effort on behalf of children and low income families and commend the Administration as we agree that these proposed regulations for CCDF-funded children will have a significant effect upon all children enrolled in child care across the nation.

We are particularly impressed that the law and the regulation have dramatically shifted emphasis toward the need to assure that children from low income families gain access to the same quality of child care services that are available to those families who are not low income. The regulations clearly move forward the notion that the child development and the learning made possible through high quality care is important to the enrolled child and his or her family, and to our country. Finally, the CCDBG Act of 2014 and these proposed regulations emphasize that parents are important to making decisions and supporting the learning of their young child. The law and proposed regulations seek to strengthen these realities.

2. **Stability must be a driver in these regulations and in the actions of lead agencies in order to ensuring program quality and success of both children and families.**

As both research and best practice suggest, stability is a vital component of child care – for child development, family achievement, and program quality/sustainability. After decades of ignoring this simple fact, the CCDBG Act of 2014 took a significant step forward by including a requirement for 12-month eligibility. The NPRM further strengthens this critical requirement and NHSA strongly commends both Congress and the Administration for it. The Head Start community, particularly the new Early Head Start – Child Care Partner grantees, is thrilled with this provision as it will allow for closer alignment of eligibility systems; something that has often been a barrier to Head Start grantees.

In the past, children's enrollment in child care would suddenly be ended due to a change in their parent's employment or schooling which would cause them to lose child care. At the very time the family finds itself in deep stress, the child was sent home. This ran against both best practices in child development and simple logic. Further, it caused uncertainty and insecure funding for providers – often who are small businesses operating at the smallest of margins. The new 12 month eligibility, if properly implemented and enforced, should drive stability; drastically improving the child care system and, most importantly, its impact on children and their families.

3. **Parents and children must remain a focus throughout all parts of the CCDF system – no matter in which state, tribe or jurisdiction they live.**

When it comes to social policy creation and implementation, too often the role of parents and their children are ignored and/or forgotten. Instead, public administrators focus on systems or providers of services. While these groups are also important stakeholders, of course, there is nobody more important in child care than the child and their parents. As a whole, these standards and their corresponding law strike an appropriate balance between seeking to what is in the best interests of children and their families and what is in the best interests of the system or the provider. However, we must reiterate that parents and children must remain a focus throughout this system and it is the job of the Administration, in partnership with the States, territories, and tribes to ensure that focus.

4. **State, Territory, and Tribal Lead Agencies must be seen as partners and be encouraged to support, strengthen, and grow quality.**

While the CCDBG Act of 2014 did include several new basic health and safety requirements, it largely left the flexible administration of Child Care up to the Lead Agencies in states, territories, and tribes. Through this balance of flexibility and requirement, Congress sought to allow Lead agencies to set up their own programs based on the needs of their populations, their ability to innovate, and the capacity of their infrastructure while ensuring a basic baseline of quality. This balance is important and should be preserved in the Administration's implementation of the law if the CCDBG is to accomplish Congress' intent. The Administration has a unique opportunity to drastically improve the quality of child care across the nation by encouraging Lead Agencies to drive quality within their communities. Failing to accomplish this, not only disrespects states, territories, and tribes, but it risks failing children and families across the nation.

5. **The Federal Government needs to assure that State and other Lead Agencies will be held accountable for the provision of child care services - as child care providers are to be held accountable by their lead agencies.**

While the Federal Government must treat state, territory, and tribal lead agencies as partners, it should also not shirk on its responsibilities to ensure the appropriate implementation of the new CCDBG. The unfortunate reality is that states have varied dramatically in their commitment to how best to use federal CCDF dollars- often using them in order to meet the goals of state leaders rather than the best interests of children or their families. Some states have long seen the value in investing in quality child care services due to the return on investment that comes when a child from a low income family is given high quality developmental experiences. Other states have framed child care expenditures as "expenses to be reduced or avoided" as opposed to being "investments". For these states, the law and the proposed regulations will be seen as a threat and not an opportunity for the children of their state. It is these states that cause concern for NHSA and our grantee members.

NHSA believes that the content of these proposed regulations is in alignment with best practices in early child development. We hope that states will be encouraged and monitored to require compliance with the 2014 law and the proposed regulations. Where states have been longing to do things like stabilizing enrollment for children, or being able to allow a family to enroll their child in alignment with a provider's service delivery pattern, the law and regulations will now support these possibilities. In other states,

however, the new law and regulations may not be met with such anticipation. Therefore, NHSA Strongly Recommends the federal government retain the authority and tools in place to assure that states and other Lead Agencies meet the regulations included in this NPRM. This nation's children deserve the best learning experiences that we can provide.

Provisions NHSA Strongly Supports

On page 80568, second column, §98.21(a) - 12-Month Eligibility

NHSA strongly supports the new 12-month eligibility period which provides the continuity of care and learning so necessary to high quality child development. NHSA feels strongly that the longer eligibility period encourages continuity in planning child development services for an enrolled child, keeps children in a relationship building pattern with their peers and teachers, and contributes to better learning outcomes. In addition, stabilizing child care also reduces the stress felt within low income families, which in turn provides for a better home environment for children. The emphasis on longer periods of stable enrollment greatly facilitates the ability to partner with others such as Head Start and Early Head Start and increases the quality of those partnerships.

On page 80563, first column, §98.2 - Definitions of Homeless and Disabled Children

NHSA supports the definitions for a child experiencing homelessness and a child with a disability. We are pleased that this NPRM links these definitions to familiar frames of reference in current practice such as the McKinney-Vento Act. This is very useful in that it provides a frame of reference as critical decisions regarding eligibility for services are made. It does allow for the Lead Agency to expand the definition to include more children with disabilities should they so desire.

On page 80569, second column, §98.21(f) - Continuity of Care

NHSA supports the language that promotes the continuity of care since this is part of best practices in high quality early childhood development. It is also an important message for Lead Agencies who are working through the major changes in direction put into action with the CCDBG Act of 2014.

Section 98.43- On page 80572, second column, §98.43(a) - Criminal Background Checks

NHSA is highly supportive of the professional use of criminal background records checks. Head Start standards in this area are intense and grantees have lost their funding due to failure to manage the background records checks according to federal standards. In addition, the Head Start Act of 2007 and Head Start regulations require that these background records checks be completed before an individual can even be on the payroll. NHSA would urge that background checks under these regulations should be completely aligned with the background checks being performed by Head Start and Early Head Start grantees. Since there is a constantly increasing desirability of partnering between Head Start/Early Head Start and child care providers, complete alignment will assure a higher degree of efficiency and a lack of redundancy, saving both time and money.

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On page 80569, second and third columns, §98.30(f) - Support for Health and Safety Standards

NHSA supports this section which enforces Lead Agencies to ensure that health and safety standards are not compromised by limiting parent choice or otherwise. NHSA supports this section in its intent to strengthen the Health and Safety Standards for all children in care. NHSA agrees that Public funds should not be invested in young children where health and safety are not the priority; and ACF should be empowered to use its authority to withhold funds if Lead Agencies decide not to meet the standards of the new law. NHSA understands the fiscal pressures of some Lead Agencies but wishes to encourage prioritizing investing in healthy, safe, and quality child development.

On page 80570, second column, §98.33(c) - Developmental Screenings

NHSA supports providing information to families and providers as to existing resources and services that the Lead Agency can provide regarding developmental screenings. NHSA also supports the language that requires Lead Agencies to inform providers as to how to utilize the resources.

On page 80565, second and third column, §98.15(11) and §98.15(12) - Equal Access

NHSA strongly supports these two key inclusions in the proposed regulations as supportive of the deep strengthening of the investments being made in the availability of high quality child care to CCDF eligible families. NHSA feels strongly that rates should be set at levels to ensure that eligible children have equal access to comparable child care services in the state to children whose parents are not eligible for assistance

On page 80576, first column, §98.5(b)(1) and §98.5(c)(3) - Expanding High Quality Care

NHSA is enthusiastic about the commitment being made to expanding the stock of top quality child care available to families. NHSA fully supports language stating that no less than 7% in 2016 and 2017; 8% in 2018 and 2019; and 9% in 2020 must be used to improve quality of child care services, and increase parental options. We are supportive of the statement that Lead Agencies who are equally committed to increasing the quality as is the Congress, the White House and ACF might propose in their planning to move to the higher percentages of 8 and 9% earlier in order to increase quality of services to young children and their families earlier. Additionally, we support the limit of 5% on administrative activities and the commitment to having no less than 70% of CCDF funds allocated to direct service."

NHSA strongly supports the provision of special grants or contracts to increase the pool of child care providers offering services to infants, toddlers, children with special needs and homeless families. We believe that rate differentials are not sufficient to increase the supply and quality of child care services targeting these hard to serve groups. There are a number of ways grants and contracts could provide incentives and quality supports for providers motivated to take on the challenges of serving special populations. Here are ways grants and contracts could support increasing the supply and quality of inclusive child care:

- Grants for purchase adaptive equipment or make facility enhancements,
- Training grants could also support ongoing professional development for a targeted group of providers committed to providing inclusive child care services, and

- Contract with professionals to establish a network of specialists who can support providers serving infants/toddlers, children with special needs and homeless children.

On page 80576, second column, §98.51- Prioritizing Homeless Children

NHSA is supportive of regulations that allow Lead Agencies to expend funds on activities that improve access to quality child care services for children experiencing homelessness. Homelessness in America is far too prevalent and we are very supportive of the efforts to reach homeless children by encouraging swift enrollment and data gathering to follow. Releasing the Lead Agencies from having these expenditures deemed as an error or an improper payment is very important.

Provisions NHSA Supports

On page 80568, second and third columns §98.21(a)(1)- Temporary Changes

NHSA supports language clarifying that changes in income will not affect eligibility for child care unless the new income exceeds the 85% of SMI established in law and that temporary changes in a family's eligibility status do not disqualify a child from receiving assistance. This addresses some of the very real issues parents face: sick leave, reduction in work for seasonal employees, student holidays, and reduction in work or education hours, all of which are examples of the realities of families working their way out of poverty. The NPRM creates clarity with the wording addressing interruptions that do not exceed three months (or a longer period if established by the Lead Agency). This section reinforces that the investment in child care/child development is important not only to support the parent's education or employment but the learning and development of their child enrolled in care.

On page 80568, third column, §98.21(a)(2) - Discontinuation of Services

NHSA supports the language that once a parent does experience a change in employment or education that does not meet the definition of temporary, the Lead Agency can choose, but is not required to, discontinue child care assistance. We support the notion that the continued investment into the child by keeping them enrolled in high quality child care is being encouraged by ACF, understanding that this is up to the Lead Agency to decide. In addition, we are also pleased that ACF articulates that these investments will not be later interpreted as an error or improper, helping to codify both the acceptability and desirability of making these investments and relieve any indecision at the Lead Agency level. NHSA also supports the notion that if the Lead Agency does choose to discontinue, they must continue assistance at the same level for no less than three months in order to allow the parent to enter into a job search and resume work, or resume attendance at a job training or educational activity.

On page 80568, third column, §98.21(b) - Gradual Phase-Out

NHSA supports the language establishing a gradual phase-out for families that are no longer eligible for assistance. This focus on carefully moving the family from dependence upon CCDF funding is admirable in that it creates the opportunity for more stability for children and their families. In the past where cessation of services was much more instant, children and families suffered. Often losing child care support meant losing child care altogether. In some cases, this loss of child care resulted in job loss of the

parent making the family once again eligible for CCDF child care funding. NHSA is very supportive of phasing out gradually so as to mitigate this disruptive cycle.

On page 80569, third column, §98.30(e)- Variety of Choice

NHSA supports the regulations that help ensure that parents of eligible children should have the broadest choice of types of service in their community. The parent should be able to decide whether center-based, family child care, or in some instances in-home care is best for their child.

On page 80569, first column, §98.21(e)- Improved Reporting

NHSA is supportive of the new language that requires families to only report changes in status if they significantly impact their eligibility such as income exceeding 85% of SMI or the family has experienced a non-temporary cessation of work, training or education. We are supportive of the declaration that there should be efforts in place to ensure that these requirements do not impact the continuity for eligible families between determinations. The necessary redetermination must be able to be done without traveling to an office, by phone, mail, online forms or the use of extended submission hours. This is well done and meets both the needs to assure redetermination occurs and does not disrupt parents and their children.

On page 80569, second column, §98.21(g) Enrollment Flexibility

NHSA strongly supports the statement that Lead Agencies are not required to limit authorized child care services strictly based upon the work, training or educational schedule of the parents. This allows the Lead Agency to better support the effort to ensure high quality of care by potentially enabling the parent to enroll in the patterns made available by the provider. If those children from families above the 85% of SMI traditionally enroll in patterns of attendance such as full day or full week, the CCDF funded children would possibly be able to enroll in the same pattern as their peers. This is better not only for the child and their family, but it is also for the teacher and others working with the child. Stable predictable patterns like those of the other enrolled children enables better planning and delivers better learning results.

On page 80572, second column, §98.42(b)(a)(iv)(A)Differential Monitoring

NHSA supports differential monitoring procedures that can result in a safe and healthy environment for children being served. We encourage this regulation that would allow differential monitoring as a tool to enable Lead Agencies to assure the health and safety of every child and adult within a child care setting when there are reasons to have less trust such as patterns of complaints and lapses in key areas.

On page 80573, third column, §98.43(h) Disqualification from Employment

NHSA supports the regulation that enables states, territories and tribes to disqualify an individual from being employed in a CCDF funded child care program for crimes other than those specified in these regulations. If there is a strong reason to be concerned for child safety and wellbeing, we favor protecting young children wherever possible.

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On page 80569, third column, §98.31 Parent Access

NHSA strongly supports the regulation that allows parents to have access to their children at all times. This is both best practice and another way to ensure quality control. We know that informed parents and staff are a major factor in avoiding lax or inappropriate behavior.

On page 80569, third column, §98.32 Parental Complaints

NHSA supports requiring Lead Agencies to compile and make available parental complaints. We know that not all complaints, once investigated, have a basis in fact. While a hotline or a website might be an easy repository of parental complaints, Lead Agencies need to ensure that only substantiated complaints are made available to the public.

On page 80575, second column, §98.45(m) - Timeliness of Payments

NHSA strongly supports regulations that articulate the Department's expectation that Lead Agencies establish payment practices that ensure timeliness of payments. NHSA is pleased that Lead Agencies now have the option of paying prior to the delivery of services; paying for enrollment and not attendance; and providing full payment if the child is there at least 85% of the time or is absent less than five days in a month.

On page 80565, first column, §98.15(b)(8)- Delinking Payments from Occasional Absences

NHSA supports delinking provider payments from an eligible child's occasional absences. This is highly likely to encourage more high quality child care providers to want to serve children funded through CCDF funds. Given our experience in providing child care services, there are fixed costs which cannot be reduced by "flexing" with attempting to match the comings and goings of young children. Delinking provider payment rates from a child's occasional absences is exactly the manner in which non-CCDF funded families are billed and treated. This is a very important step forward in our vision of all CCDF-funding eligible children having access to the top quality child care available to those not eligible for CCDF support.

Recommended Changes

On page 80575, third column, §98.46-Priority for Children with Special Needs and Children Experiencing Homelessness

NHSA strongly recommends that children with special needs be given a high priority in receiving high quality services that will address children's medical, social-emotional and/or physical needs that may designate them for special needs or disability services. Building the supply of inclusive child care means fostering partnerships with providers that support them to: 1) enhance their physical learning environments, 2) reduce child/teacher ratios, 3) ensure qualified and well-trained staff, and 4) maintain a child development focus while engaging parents as partners. Some additional suggestions include:

- Raising the reimbursement rate for serving children with special needs
- Offer special grants for adaptive equipment and facility development or improvements.

- Recruit a cohort of providers interested in serving children with special needs. Align training and coaching offerings to enhance their professional development.
- Offer incentives like transportation reimbursement or paid substitutes for providers to attend professional development toward an inclusive child care certification.
- Use grants or contracts to establish a specialist network that can support providers serving children with special needs.

NHSA supports an expedited process to provide families experiencing homelessness with CCDF assistance. Waiving or delaying requirements around necessary documentation will also eliminate one of the key participation barriers for homeless families. Homeless families receiving expedited child care assistance will need time to stabilize their lives and secure housing for their families. Eligible homeless families will not be served if strictly held to current allowable activities for child care assistance. We recommend adding "active housing search" to the current allowable activities (i.e. work, job search, training and education) for child care assistance. This activity can include crisis counseling, participating in shelter or transitional housing services, applying for Section 8 housing and other services determined to support homeless families.

Child care providers serving homeless children will need training in trauma-informed care as well as have access to mental health consultation services and support. Homeless children and their families will need comprehensive early childhood supports that may not be available in traditional child care settings. Special considerations for services to children with special needs must also apply to those providers serving homeless children.

On page 80568, first column, §98.20(a)(2)(ii)Family Assets

NHSA has concerns regarding language which references the dimension of eligibility of family assets "do not exceed $1,000,000 (as certified by a member of such family)". The very high maximum asset level draws attention to the notion that CCDF funding could be given to families that are quite a distance from poverty. Additionally, if there is any basis for the importance of a $1 million ceiling, self-certification by a family member seems to negate the accuracy of tracking this.

On page 80565, first column, §98.16(b)(9)- Developmentally Appropriate Services

This section is very important to the expectation of the CCDBG Act of 2014 that children enrolled in CCDF funded child care receive high quality child development services. This paragraph holds Lead Agencies responsible to "maintain or implement early learning and developmental guidelines that are developmentally appropriate for all children from birth through kindergarten entry." It goes on to articulate what a full service, developmentally appropriate set of learning experiences should consist of. NHSA agrees with the learning experiences identified and believes strongly in requiring states to assure these conditions in order to achieve the vision of equal access to high quality child care. However, **NHSA makes the following two recommendations:**

1. **This section should make reference to expecting providers to work closely with parents as their child's "first and foremost teacher**." Further, this section could be strengthened through a statement holding states responsible for assuring that providers involve parents in planning the

learning for their child, and that parents be treated as partners and with respect. These are precepts that have been successful for Head Start grantees for over 50 years, working with low income preschool children and their parents. NHSA knows that this is critically important to successful work with families in poverty. In each section where this NPRM addresses the dimensions of best practice in early childhood, there should be a reference to working in partnership with the child's parent on behalf of the child's successful learning.

2. **This section should mandate that services to young children with CCDF funds be developmentally appropriate must not end at the age of kindergarten entry**. Given the recent Proposed Joint Policy Statement of the Secretaries of HHS and DOE, these regulations should be in alignment with department leaders who identified that the age range should be birth through age 8. We support the notion that any child care services funded with public dollars should be required to be developmentally appropriate and learning rich. Given that this should be the case, the stated age span should be changed to birth to age 13 years.

On page 80572, second column, §98.42(b)(2)(iv)(B)- Alternative Monitoring for Family Home Providers

NHSA supports regulations that allow for alternative monitoring requirements for child care provided in the child's own home. However, the fact that there are public dollars being invested does indicate that the Lead Agency should be empowered do what is necessary to ensure that the child care experience that is being funded is developmentally appropriate, safe, clean and is equal to what a family not eligible for CCDF funding might expect. **While there may need to be adjustments away from standards and expectations for center based care, NHSA maintains that since we are talking about very young children living in poverty, we must fault to doing what is best for children, even if this may cause some stress to the adults involved in providing care.**

On page 80572, third column, §98.43(a)(2)- Criminal Background Checks

NHSA does have concern with the regulation that would allow someone for whom a background check has been initiated to work with children while under the supervision of someone who has received a qualifying result on their own background check. We understand the pressure that providers find themselves under when a staff position becomes vacant. However, NHSA is concerned about the risk of having an individual who has not completed a background check being with children. In the case of an individual who has a criminal background, in almost every instance the individual does know that this exists in their past. Since they have this knowledge, indicating on their employment application that they have none of the specified criminal situations, followed by a signature likely constitutes fraud. They should agree to the fact that if the background check comes back with any of the disallowed items, that they would be immediately unemployed and that their situation would be reviewed with the proper authorities regarding potential prosecution for fraud. We have child care providers who have used this approach and have had individuals refuse to sign. They obviously were not given access to young children even temporarily. The hope would be that those who are harboring any of the adverse background items that would bar them from being offered a position once a background check is completed would be dissuaded from accepting a position that would have adverse impacts as soon as the background check is completed. Our suggestion comes from our lengthy experience in working in settings where children need to be protected from potentially dangerous adults.

Individuals working in and around a family child care home present an interesting challenge. Since we approach the protection of children very seriously, we would include all adults who have access to young children in care using CCDF funding (and all others present). This would include the director, any paid staff, any regular volunteers and any others who live in or regularly are present while children are present.

While we know that those under age 18 have a different set of rights of privacy, a good deal of physical, sexual and emotional abuse comes from persons under the age of 18, there should be something that could be addressed in regulations. We would recommend that the director sign an agreement stating that they have no knowledge of anything in the background of those present when children are receiving care that would cause a risk to these young children. This would serve to put the director on notice that should something adverse occur that they might be held responsible.

On page 80574, first column, §98.44- Training and Professional Development

NHSA would like to commend Congress, the White House and ACF in recognizing a major challenge facing CCDBG, which is the lack of high quality child care available to parents whether they be eligible for CCDF funding under this act or not. The basis for providing a high quality learning environment is a trained work force prepared to deliver a research-based curriculum and well-designed learning experiences.

While NHSA is fully supportive of much of the language included in this section, we recommend a change to the language referencing wanting where practicable, to have professional development include awards of continuing education or college credit. A great deal of professional development has been credit bearing, with the requisite additional cost for credit being paid to a credit-granting college or university only to have these credits have no use in any degree program. This wastes precious resources. **We suggest that this section be worded "(v) to the extent practicable, awards continuing education units or is credit bearing where these credits readily transfer to a degree or certificate program."**

On page 80563, third column, §98.2- Definition of Teacher

NHSA is opposed to the NPRM's identification of all workers in a classroom under the single title of "Teacher". We disagree in that in child care settings, lead teacher, teacher, teacher assistant or teacher aide mean distinctively different jobs and duties. Since these terms when used in the NPRM identify who should be trained, etc., this will lead to misunderstanding and an interpretation that might be interpreted by a Lead Agency, their subcontractor or a provider as meaning that only "teachers" need training in such things as health, safety or the many dimensions of child development. Since defining who is to be trained has an economic dimension to it, we are concerned that some might use the constricting term "teacher" to justify that only a few of those working with young children need continued professional development opportunities as outlined in the NPRM.

On page 80576, first column, §98.52- Resource and Referral Networks

NHSA supports having Lead Agencies use structures such as resource and referral networks to help families identify, understand and select the best possible child care for their child. This will also have the effect of providing neutral third party consumer education. In addition, this language mentions the potential for partnerships with Head Start and Early Head Start, identifying that, "grantees

may blend several funding streams so that seamless services are provided. Lead Agencies can layer Early Head Start and CCDF funds for the same child as long as there is no duplication in payments for the exact same part of the service." **NHSA would urge the Department to make this language a part of actual regulations as well.** Head Start programs are experts at working with others in communities to best serve young children growing up in low income family environments.

NHSA also embraces the additional reference to the notion that the "Lead Agency could make sure that there is an automatic referral of eligible children to Early Head Start or Head Start" and would urge its inclusion in the regulations. It is a great opportunity to improve the child development experience of these low income children. We work in tens of thousands of highly effective partnerships between Head Start, Early Head Start and child care across the nation.

On page 80569, third column, §98.33- Consumer Education
A major emphasis of both the 2014 CCDBG Act and the subsequent proposed regulations is on consumer education and helping families make the best possible choices about where to enroll their children. NHSA is pleased with the completeness of section S 98.33 and the details are extensive and illustrative. While, NHSA supports increased consumer education, we have some concerns:

1. Quality consumer education should be balanced, identifying any weaknesses or lapses in quality, but also examples of the provider doing the right things. Monitoring organizations gather comparatively far less good data than data regarding shortfalls or infractions. The regulations should encourage Local Agents to report both strengths and weaknesses as a provider is visited and a report created. States might approach to this through the creation checklist of quality items that would be expected for quality child care. This would limit the licensing or other monitoring personnel to present a balanced picture while not creating new work for these often very busy professionals. While QRIS systems will help with achieving the balanced information, QRIS systems vary widely and are stalled and even declining in involvement and importance in some states. As they evolve over time, QRIS may become a more and more useful indicator of quality, supporting parental decision making.

2. If consumer and provider education is to be useful, it often requires that assistance must be provided for families to understand and interpret information. An information-rich website that parents may not be able to access, may not be in their language or their reading ability and may not address their particular needs will need to be supplemented with written materials, audio and video information sharing. Family educators available via a hotline in the variety of native languages would be very supportive of parental decision making regarding identifying and choosing high quality child care. This could be a contracted service established by the Lead Agency, possibly using the Resource and Referral Network.

On page 80574, third column, §98.45(b)(3) and §98.45(b)(5) Rates Reflective of Quality

NHSA strongly supports making sure that Lead Agencies identify how base payments support health, safety, and quality and how they took the cost of higher quality into account. As the CCDBG Act of 2014 and these proposed regulations dramatically address the vision of having children eligible for child care able to be enrolled in high quality, developmentally appropriate child development programs with well-educated and trained staff members, it is clear that quality costs money. The Department's

acknowledgement that quality costs money is important for Lead Agencies to be aware of and address. **NHSA recommends that there needs to be a clause included that states that calculations of what it costs to meet the newly defined expectations of quality should not be used as a means of dropping below the payment levels that would enable the Lead Agency to pay rates which are below the targeted 75th percentile of programs in the market place, thus disallowing CCDF funded families from achieving the equal access to the top quality providers available to those families who do not qualify for CCDF funding.**

On page 80574, third column, §98.45- Competitive Rates

If eligible children are to gain access to the same high quality child care that those families who are not eligible can access, compensation to providers must be competitive. CCDF eligible children will not gain access to high quality care settings if providers are disinterested in serving them because of expectations of under-funding, payment challenges and children appearing on sporadic schedules. **NHSA asks that the Office of Child Care and ACF monitor the process of completing the required market rate survey and the subsequent establishing of rates of payment to providers. We strongly encourage OCC and ACF to hold states responsible for doing this openly and fairly.** A state should be held to the proposed standard of setting rates so that a parent of an CCDF eligible child carries with them payment rates that reflect the norm of at least the 75 percentile of rates charged in their community.

Even at the 75th percentile, we must assume that up to a quarter of providers may not be available to parents eligible for CCDF funding. States can let this slip over time, including the example shared earlier where the state had recently dropped down to only paying at a level that allowed access for families being funded with CCDF funds to 27% of child care providers. This does not enable eligible families to receive the quality of services that Congress has demanded in the CCDBG Act of 2014. NHSA would ask that ACF strengthen the regulations to emphasize the expectations for state performance. The desirability of using the 75th percentile as the target is clearly and powerfully articulated through ACF's expectation "to deny plans or take penalties under the equal access provision of the law". Please work strongly to require this in the regulations that you are creating. Make the regulation as clear and concise as the discussion of the regulations.

On page 80574, third column, §98.45(c) - Market Rate Survey and Alternative Methodologies

NHSA believes that while at the moment, in market areas where there are sufficient numbers of providers, the market survey will likely continue to be the best approach**.** In some lower populace areas where there are few or no comparable providers, the market survey approach is a challenge. Given that some Lead Agencies are not driven to enable CCDF eligible families to gain access to top quality, allowing Lead Agencies to perform the market survey can lead to questionable results. **NHSA would suggest that these regulations require that these surveys be prepared by a neutral third party.**

On page 80575, second column, §98.45(l) - Prohibiting Charges Above Copay

NHSA is opposed to requiring that Lead Agencies have a policy for prohibiting child care providers from charging above the copay amount. This is a challenging section of the proposed regulations. While it may appear to be logical that providers should be restricted in charging CCDF funded families additional

amounts, what must be factored into this restriction is that it could easily result in having eligible families not able to enroll in the top quality child care settings.

From a provider's standpoint, fees are set in order to be able to pay the bills. Child care fees are very frequently paid in advance and paid whether or not the child gets ill or the family takes a day or two off. Most providers factor in an allowable week or two of vacation time where the child may be absent and a fee is not required. All families pay the same amount for the same amount of service, which is seen as fair by most providers. In the past, if a CCDF funded family sought to enroll their child, the factors above were potential negatives for the provider to manage. Not paying in advance, not paying when the child is ill or the parents aren't able to use child care all created less revenues for the provider, causing them to decide not to serve the CCDF funded family. The CCDBG Act of 2014 is making great progress through the Department's leadership in canceling out these negatives by allowing and encouraging Lead Agencies to make timely payments; keep funding stable over a full year; disengage payments with occasional uneven attendance and potentially pay in advance and in a timely fashion.

In the past, providers found it possible to serve families if the family covered the difference between what the Lead Agency would reimburse the provider and the rate charged everyone else. This has the effect of having all families paying the same fees for service. It avoided providers either losing money in order to serve CCDF eligible families or having to charge non-CCDF eligible families additional fees to offset the shortfall in payments made by CCDF eligible families. If this is made impossible, an increasing number of providers will quit serving CCDF eligible families. These fees are often not particularly high and are very well accepted by parents. Part of whatever gap this involves is taken into consideration as co-pay. In providers that have sought these payments, parents have been readily able to make these payments and do so because they are committed to having their child in the best possible learning and care environment. We would ask that you consider the tradeoff of protecting the parent from being taken advantage of versus the chance that their child will miss out on top quality care. Allow that this should be parental choice.

Conclusion

NHSA appreciates the Department's efforts to listen to the Head Start and Early Head Start community and commends Congress, the White House and all those who advocated over the years for a reauthorization that truly improves conditions for young children in our country. NHSA is pleased with the work the Office of Child Care and the Administration for Children and Families has done to rapidly take the law and shape it into these proposed regulations. NHSA also thanks Dr. Tim Nolan and our affiliate members for their important contributions into helping us draft our comments.

Head Start is proudly moving into our 51st year of serving nearly one million young children and their families living in poverty. We have spent every one of those years working with child care providers in our communities, and in some cases providing these services ourselves in alignment with the others investing in young children and our nation's future. We will continue to be enthusiastic partners in moving the CCDBG vision forward into reality. Thank you for considering our recommendations and we look forward to working with you in the future.

Sincerely,

NATIONAL HEAD START ASSOCIATION

Yasmina Vinci
Executive Director
National Head Start Association