State CCDF Policies and Child Care Access for Families of Children With Disabilities

Ying-Chun Lin and Emily Maxfield

Introduction

In school year 2022-2023, the U.S. public school system served 7.5 million children ages 3 to 21 with an identified disability; nationally, 20 percent of children under age 18 (14.5 million children) have a special health care need (The Annie E. Casey Foundation, 2023). While a complex policy landscape supports the families of children with disabilities, the role of policy in improving child care[1] access for these families is not well understood. The lived reality of many families of children with disabilities is that accessing high-quality child care can be challenging (U.S. Government Accountability Office, 2024), despite the legal protections guaranteed by the Americans with Disabilities Act (Department of Justice, 2020; National Academies, 2018; Americans With Disabilities Act, 1990). These challenges can negatively impact the developmental trajectories for children with disabilities (U.S. Department of Health and Human Services & U.S. Department of Education, 2023), as well as their family's economic well-being (Glader et al., 2021).

Definition of disability

Per the National Academies of Sciences, Engineering, and Medicine, childhood disability does not have a universally accepted definition (2019). In these analyses, disability status is defined in alignment with the National Survey of Early Care and Education (NSECE), which relies on a self-report measure of whether the child has "a physical, emotional, developmental, or behavioral condition that affects their care."

The primary goal of the Child Care and Development Fund (CCDF) is to make child care subsidies available to eligible families, thereby supporting child care access, child development, and parents'[2] ability to work (Office of Child Care, 2025). Strengthening policymakers' understanding of how CCDF can achieve this goal for families of children with disabilities stands to not only support this group, but to strengthen the subsidy and child care system as a whole. Furthermore, because of limited funding, states must often make tradeoffs when designing policy. Examining the degree to which state CCDF policies are effective in increasing access to child care for families with children who have disabilities not only informs states' ongoing efforts to support children and families, but also provides insights into which policy levers could be prioritized to maximize the use of limited funds.

The 2016 CCDF Final Rule introduced a set of optional policies that states could adopt to support child care access for families of

Child Care and Development Fund

Authorized under the Child Care and Development Block Grant (CCDBG), the CCDF program provides federal funding to assist eligible families in affording child care. While the federal government sets national CCDF guidelines, administering agencies—states, territories, or Tribal governments—retain flexibility in implementing CCDF to best address the needs of their respective populations. As a result, CCDF policies, practices, and implementation vary, allowing for comparative analysis.

[1] For the purposes of these analyses, the term child care refers to all forms of paid nonparental child care and early education, including centers, home-based, and individual caregiving arrangements.

[2] Family structures vary; the term "parents" is intended to be inclusive of all primary caregivers.

children with disabilities. This study examines two of those policy options: 1) prioritizing or guaranteeing a subsidy to these children (i.e., priority status) and 2) offering higher reimbursement rates to providers enrolling children with disabilities (i.e., differential reimbursement rates). We examine how these policies are associated with the use of paid child care, use of full-time child care, and weekly cost of care for families of children with disabilities with household incomes less than 200 percent of the federal poverty level (FPL). First, we employ a pre-post design that examines states that did not have these policies in 2012, comparing changes in outcomes in 2019 between states that implemented the policy following the 2016 Final Rule and those that did not. To provide additional context to the causal analyses, we also examine overall relationships between these two policies and outcomes among all states in 2012 and 2019.

This brief provides an overview of the disability policy landscape and child care, then reviews the methods used in the current study. We conclude with a discussion of the study findings and future research possibilities for the field.

Key findings

- This study did not find a causal relationship between either optional policy type—subsidy prioritization or differential reimbursement rates—and use of paid care or full-time paid care for children with disabilities in households with low incomes.
- Descriptive analyses did, however, identify the following:
    - Children with disabilities were more likely to use paid care than children without disabilities, particularly among children under age 5.
    - Differential reimbursement rates were associated with an increased likelihood of using paid care for children with and without disabilities. The increase was statistically significant for children ages 5 to 13, but not for children younger than age 5.
    - The weekly cost of care was higher for children with disabilities ages 5 to 13 than for children without disabilities. The differential reimbursement rate policy was associated with lower costs for care for this group of children, reducing the cost gap between children with and without disabilities.

Context: Disability Policy and Child Care

Disability rights policies such as the American with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act guarantee legal protections related to child care for children by prohibiting discrimination based on disability and requiring that child care be offered in an integrated and accessible environment (U.S. Department of Justice, 2020; U.S. Department of Health and Human Services, 2006). Parts of the Individuals with Disabilities Act (IDEA) may impact child care needs for families of children with disabilities—specifically, IDEA Parts B and C. IDEA Part B addresses special education for children with disabilities from ages 3 to 21 and provides state grants for public pre-K for children ages 3 to 5 (Dragoo, 2024). IDEA Part C authorizes a grant program for early intervention services for eligible infants and toddlers, which encompasses services such as speech or physical therapy but does not address child care needs (Centers for Disease Control and Prevention, 2023). If a child with a disability is receiving Medicaid, some states allow a family member, friend, or health care provider to become a paid caregiver (USA.gov, 2025); however, this benefit is designed to support children's medical needs rather than provide child care (Agrawal, 2023). Head Start and Early Head start, federal child care programs for children not yet enrolled in school, directly address child care access for children with disabilities by requiring that at least 10 percent of enrollment in Head Start and Early Head Start programs be made available to children with disabilities (Head Start Act, 2007). Head Start also requires that all educators participate in ongoing training and plan

lessons tailored to the development of children with disabilities (Meek et al., 2025). While these policies and programs offer legal and programmatic support to children with disabilities, they may not fully address the barriers to child care access faced by families of children with disabilities.

Child Trends' child care access framework identifies four domains of child care access that apply to all children, including children with disabilities (Paschall & Maxwell, 2022):

1. Affordability— care that costs a reasonable proportion of household income
2. Meets parents' needs—care that aligns with parents' preferred care type and the hours of care needed so parents can work or attend school or training
3. Reasonable effort—ease of finding, enrolling, and traveling to the care arrangement
4. Supports child's development—addresses the quality of care provided

Disability rights statutes

While ADA and Section 504 guarantee that child care providers do not discriminate against children with disabilities, in practice, providers make individualized assessments of whether or not they can make reasonable modifications to meet the needs of children with disabilities. As a result, some providers may feel they have not had adequate training and professional development in providing child care to children with disabilities (Henly & Adams, 2018). ADA and Section 504 do not directly address the increased costs or trainings required for providers to adequately provide care to these families, so families may not be able to locate a provider that adequately addresses the domains of the access framework.

Individuals with Disabilities Education Act

IDEA Part B (Section 619) provides grants to states for public pre-K for children ages 3 to 5 and stipulates that school systems can work with community-based early childhood settings to provide these services. In practice, however, pre-K services may be provided within public schools for a limited number of hours (Friedman-Krauss et al., 2025). As a result, the children of parents working full time may need to transition between multiple care arrangements, which can negatively impact children's learning (U.S. Department of Health and Human Services & U.S. Department of Education, 2023) and may challenge parents' work schedules. As a result, these programs may not fully address the reasonable effort and meets parents' needs domains of the access framework. Wraparound care may be expensive, which could impact the affordability domain. While IDEA Part C does not address child care directly, these programs may not reach the entire population of children with disabilities, and there are disparities in access to Part C services by a child's state of residence, gender, race, and ethnicity (Friedman-Krauss & Barnett, 2023).

Head Start and Early Head Start

Many Head Start and Early Head Start programs meet the 10 percent enrollment threshold of children with disabilities (Office of Head Start, 2025). However, slots in Head Start/Early Head Start programs are limited and many eligible children are never enrolled (National Head Start Association, 2022). Furthermore, many of these programs do not offer full-day, full-year, or nontraditional[3] hour care (National Head Start Association, 2022), so families with children with disabilities may still need to find other sources of care. In this way, Head Start may not meet the reasonable effort or meets parents' needs domains of the access framework. While there is no cost for families associated with Head Start, wraparound care may be

[3] Nontraditional hour care includes care provided in the early morning before 7 a.m., in the evening or overnight after 6 p.m., or on weekends.

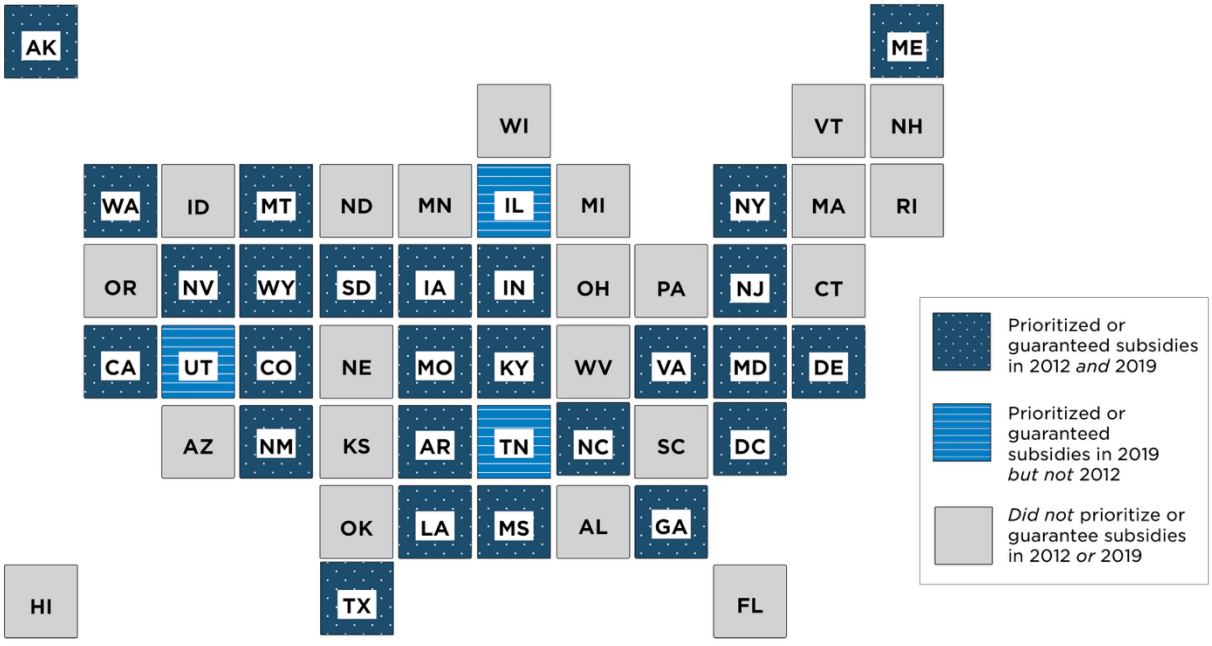
expensive and, depending on the household's income, could challenge the affordability domain of the access framework.

Child Care and Development Fund

While not specific to children with disabilities, CCDF can potentially help families of children with disabilities access child care and meet the domains of the access framework that are not addressed though existing disability policy. CCDF subsidies are designed to support families with lower incomes (Office of Child Care, n.d.), and research has shown that structural and access barriers associated with disabilities can lead these families to experience lower incomes (American Psychological Association, n.d.). Receipt of a CCDF subsidy increased the use of child care—particularly center-based care—among families with a young child with a disability, relative to families of a child without a disability and of children with a disability not receiving a subsidy (Sullivan et al., 2018a). Home-based care providers accepting child care subsidies were more likely to report serving a child with a disability than were providers not accepting subsidies (Hooper & Hallam, 2021). Close to half (44%) of children receiving CCDF are enrolled in school (National Center on Afterschool and Summer Enrichment, 2024).

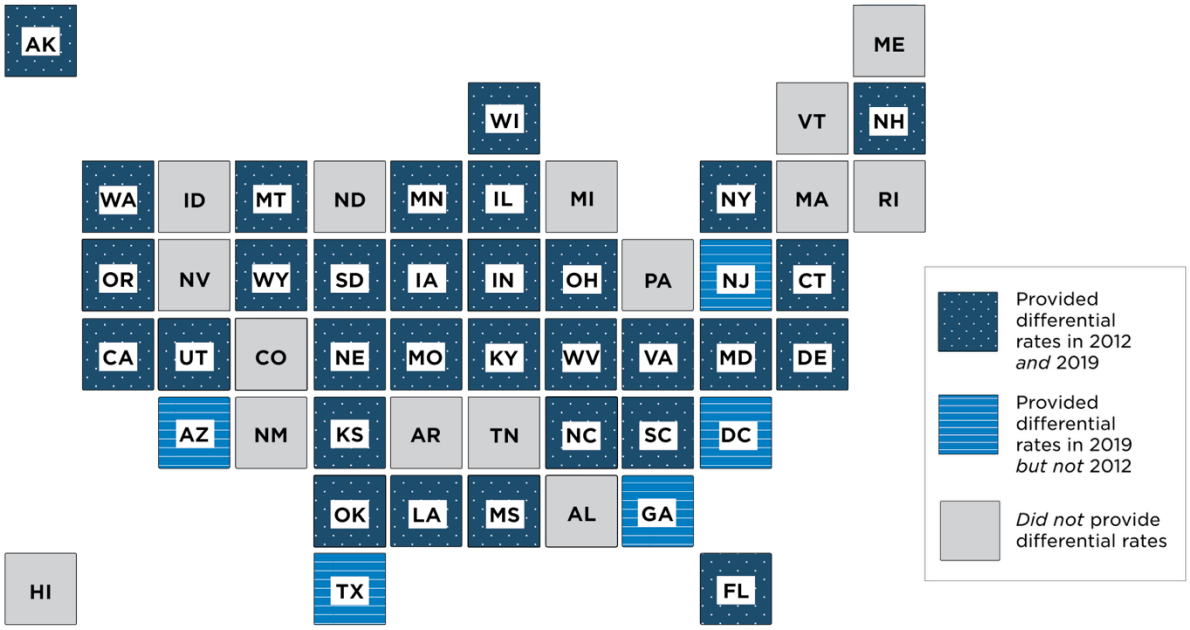
CCDF guidelines from the 2016 Final Rule outline several policy options that states may take to support child care access for children with disabilities; as a result, some states changed their CCDF policies. Figure 1 shows which states prioritized or guaranteed subsidies for children with disabilities in 2012 and 2019. Twenty-two states did not have this policy in either year, three states had this policy in 2019 but not in 2012, and 26 states had this policy in both 2012 and 2019. Figure 2 shows which states provided differential reimbursement rates to providers caring for children with disabilities in 2012 and 2019. Fifteen states did not have this policy in either year, five states had implemented this policy in 2019 but not in 2012, and 31 states had this policy in both 2012 and 2019.

Figure 1. States that prioritized or guaranteed subsidies for children with disabilities



Source: CCDF Policies Database, Urban Institute

Figure 2. States that provided differential reimbursement rates to providers caring for children with disabilities



Source: CCDF Policies Database, Urban Institute

The Present Study

The current study asks whether adoption of policies that prioritize children with disabilities and those that increase provider reimbursement rates are associated with child care outcomes. Priority policies for children with disabilities are intended to make it easier for these families to receive child care subsidies by allowing families to move to the front of waitlists, increasing the proportion of these families enrolled in paid care or paid full-time care. The cost of care would also be expected to decline as additional families begin receiving subsidies.

States can set different base reimbursement rates, tiered rates, or add-ons for children with disabilities, which could help offset the higher cost of care and allow providers to invest in higher-quality care for children with disabilities, such as trainings, equipment, and physical accommodations (Todd et al., 2025). The increased reimbursement rates also serve as incentives for providers to serve children with disabilities (Bires et al., 2017). The expectation is that this policy would increase the supply of child care providers serving children with disabilities, resulting in increased use of paid child care and full-time paid care among families of children with disabilities. The increased reimbursement rates could also lower cost of care for families of children with disabilities.

Research questions

The current study aims to answer the following questions:

1. Does a state's CCDF priority policy or differential reimbursement rate policy increase the use of paid care among children with disabilities from families with low incomes?
2. Does a state's CCDF priority policy or differential reimbursement rate policy increase the use of full-time paid care among children with disabilities from families with low incomes?

3. Does a state's CCDF priority policy or differential reimbursement rate policy reduce out-of-pocket care costs for children with disabilities from families with low incomes?

Methodology and Data

Data sources

We used data from the 2012 and 2019 National Survey of Early Care and Education (NSECE; NSECE Project Team, 2022) and the Child Care Development Fund (CCDF) Policies Database (Minton et al., 2025). The NSECE is a nationally representative survey consisting of four related surveys: 1) households of children under age 13; 2) home-based providers; 3) center-based providers; and 4) members of the center-based workforce. We focused on the household survey that includes detailed information about families' use of child care, costs of care, parents' preferences and searches for care, parental employment and child care schedules, and demographic information. Using these two repeated cross-sectional surveys in 2012 and 2019 allowed us to examine changes in child care usage (including type of care and out-of-pocket costs) for children with disabilities. Although the measure of children's disabilities in the NSECE is broader and less specific than other national surveys,[4] the NSECE includes more recent and detailed data on child care arrangements. Information on child care in the NSECE reflects more of the significant changes in the CCEE landscape in the past couple of decades than other national datasets, making it the best option for the current study.

The CCDF Policies Database, maintained by the Urban Institute, collects information annually about state CCDF policies from all 50 states, the District of Columbia, and U.S. territories based on these jurisdictions' policy manuals and updates (Dwyer et al., 2023). The Database currently includes detailed policy information from 2009 to 2022 on eligibility, family copayments, provider reimbursement rates, policies for which groups of eligible applicants are prioritized for subsidy, and other policies for families and providers. To match the timeframe and geographic areas of the NSECE household data, we focused on state CCDF policies that were in place in 2012 and 2019[5] and included data from 50 states and DC (hereafter referred as a "state"). The two datasets were linked using the state identifiers.

Sample

Our analysis sample focused on children under age 13 from households with low incomes (defined as those with household income below 200 percent of the federal poverty level [FPL]), as CCDF is designed to support low-income working families and applicants must meet state income requirements. We used the cutoff of 200 percent FPL because it approximates income eligibility for child care subsidies in many states.[6] We included all children in households with incomes under 200 percent FPL regardless of whether they actually received subsidies. The full sample pools data from the 2012 and 2019 NSECE and consists of 23,060[7] (unweighted) children under age 13 from low-income families; 10.5 percent of children in the sample have a disability (see Table A1 in Appendix). For research question 3, we limited our sample to children who used paid care to examine out-of-pocket costs.

[4] National Household Education Survey-Early Childhood Program Participation (NHES-ECPP) and Early Childhood Longitudinal Study-Birth Cohort (ECLS-B) have more details on children's disabilities, including several types of disabilities and whether the child has an individualized education plan (IEP). However, they either have smaller samples or the data are quite outdated compared to the NSECE. We also considered the National Survey of Children's Health, but information is limited on child care arrangements.
[5] Information in the CCDF Policies Database is based on fiscal year. We used policies that were in place in calendar years 2012 and 2019 (i.e., from January to December of 2012 and 2019).
[6] Many states changed their income eligibility thresholds (either higher or lower) from 2012 to 2019.
[7] The number was rounded to the nearest 20 based on NSECE level-2 data reporting guidelines.

Variables

Disability status

This is an indicator of whether the child has a physical, emotional, developmental, or behavioral condition that affects the way the child is cared for, as reported by respondents (i.e., mostly parents) in the NSECE. The child who has a condition that affects how their care is provided may or may not have a diagnosis from a health care or education professional. This broad definition of disability status would include children with a wide range of health- or development-related conditions such as developmental delay and speech and language impairment, and some children may not qualify or receive early intervention (under IDEA Part C) or special education services (IDEA Part B) due to different definitions used. It is also possible that, under this broad definition, children with asthma or children who require vision correction with glasses[8] are perceived by their parents to have a condition affecting their care.

State CCDF policies

We focused on two state CCDF policies that could affect child care access for families of children with disabilities[9]: priority policies for children with disabilities and different provider reimbursement rates for caring for children with disabilities. Other state CCDF policies may directly or indirectly influence child care access for families of children with disabilities. For example, states could provide grants and contracts to providers rather than certificates or vouchers to families to increase the supply and quality of care for children with disabilities; however, information about this policy from 2012 to 2019 is not available in the CCDF Policies Database.

Comparing 2012 and 2019, three states changed their policies for prioritizing or guaranteeing subsidies for children with disabilities, and five states implemented different reimbursement rates for providers caring for children with disabilities. Some states had already implemented one or both of these policies before 2012 and the policies remained in 2019; thus, there were no changes within these states between these two years. In addition, several states had policies that vary across different geographic areas within the state; we selected the policy that applies to the majority of the areas in the state. Below, we provide an overview of each of these policies.

Priority policies for children with disabilities. When the number of eligible applicants exceeds the number of families the state program can serve due to limited funds, states may choose to prioritize certain groups of eligible applicants to receive benefits. Further, states may guarantee subsidies for children with disabilities who meet eligibility requirements. Children with disabilities in states that have these policies will certainly receive subsidies or receive benefits sooner, which increases the affordability of care for these families. Because very few states guarantee subsidies for children with disabilities, we created an indicator of states that either prioritized or guaranteed subsidies for children with disabilities in 2012 and 2019. We also created an indicator of states that changed their priority policy.

Different provider reimbursement rates for caring for children with disabilities. State CCDF policies determine provider reimbursement rates (i.e., the amounts paid to CCEE providers) based on several factors such as child age, care setting (e.g., centers vs. family child care homes), geographic region, and hours in care. States may also establish different payment rates for providers caring for children with disabilities by paying additional amounts in addition to the base reimbursement rates or specifying different rates. Because caring for children with disabilities often requires additional resources (Mitra et al., 2017; Stabile & Allin, 2012),

[8] Other commonly used national data sets that have information about disabilities use various definitions of disability status. For example, ECLS-B includes asthma and vision correction with glasses as part of the definition.
[9] State CCDF policies use the term special needs when referring to children with disabilities. We used the term disability to refer to CCDF policies related to this population.

higher provider reimbursement rates could help offset some of the additional costs, providing an incentive to encourage CCEE providers to provide care for children with disabilities. We created an indicator of states that had different reimbursement rates for children with disabilities in 2012 and 2019 if they provided add-on to a base rate, specified different rates, or determined rates on a case-by-case basis. We also created an indicator of states that changed their differential reimbursement rate policy.

Use of paid child care

In the NSECE household survey, respondents reported CCEE arrangements and schedules for all children under age 13 in the household during the prior week[10] of data collection. The public-use dataset includes information about the number and type of regular care providers (i.e., those providing care for at least 5 hours a week) used by each child. The types of providers include: 1) individual, no prior relationship, paid (e.g., a licensed or registered family child care home or a nanny); 2) individual, prior relationship, paid (e.g., a family member, friend, or neighbor who is paid); 3) individual, unpaid (e.g., a family member who is not paid for providing care); 4) center-based CCEE; 5) other organizational CCEE (e.g., after-school care, drop-in or single activity care or lessons); 6) K-8 schooling; 7) irregular CCEE (i.e., care fewer than 5 hours a week); 8) all other, setting unknown; and 9) parental care. A child was considered to be using any regular paid care if the respondent reported the child was in paid individual care, center-based CCEE, or other organizational CCEE. Note that some respondents reported a center-based CCEE or other organizational CCEE with $0 direct charge paid to the provider. Arrangements with $0 cost may include care provided free of charge to families (e.g., Head Start, free public pre-K programs) and subsidized care with $0 copay. However, we were unable to distinguish children with free care (e.g., Head Start) from those in subsidized care with $0 copay in the data.

Use of full-time paid care

We calculated the total number of hours a child was in paid care by summing the hours a child spent in paid care as described above. We then created an indicator of full-time paid care if the child spent 30 or more hours a week in paid care.

Weekly out-of-pocket costs for CCEE

The NSECE household survey respondents reported the amount they and other household members paid and the amount of financial assistance they received directly[11] for each regular care arrangement (i.e., 5 hours or more a week). The NSECE project team constructed the weekly out-of-pocket cost for each child-provider arrangement that reflects the difference between direct charges of care a household paid and the amount of financial assistance paid directly to the household. The cost of care was $0 for unpaid regular care (e.g., individual, unpaid), regular care that was free of charge (e.g., Head Start and free public pre-K), or subsidized care with $0 copay. If a child had more than one care arrangement, we summed the costs across regular care arrangements. We did not adjust the 2012 costs to reflect costs in 2019 dollars (due to inflation).

[10] In the 2019 NSECE, some households were interviewed during the summer when school and child care provider schedules change significantly. For these households, respondents were asked about child care arrangements and schedules during a typical week in May instead of the prior week of data collection.

[11] The financial assistance respondents reported is likely not from the CCDF as CCDF subsidies are not paid directly to parents; instead, CCDF subsides are paid to providers.

Covariates

We included a set of child, household, and community characteristics in the models that may be associated with child care arrangements. Child characteristics include child age, race, and ethnicity. Household characteristics include mother's highest level of education, the number of nonparental adults in the household, the number of children in the household, family structure (i.e., whether it is a single-parent household), and parents' employment status. Community characteristics include community urban density and community poverty level based on information from the 2010 census (for the 2012 NSECE) and 2013-2017 ACS (for the 2019 NSECE), included in the NSECE data. We also controlled for state-level factors, including female employment rates (from ACS) and spending on CCDF, Head Start, and state public pre-K programs per child (including federal dollars; information publicly available from the National Institute for Early Education Research; Barnett et al., 2012, Friedman-Krauss et al., 2020).

Analytic strategy

Descriptive and bivariate analysis. We first conducted descriptive analyses to describe children's use of paid care, full-time paid care, and weekly care costs for children under age 13 and examined whether the rates of paid care, full-time paid care, and weekly costs differed by children's disability status, using pooled 2012 and 2019 data.

DDD models. Next, to examine how key CCDF policy changes affect child care access for families of children with disabilities, we used a series of difference-in-difference-in-differences (DDD, or triple difference) modeling to estimate changes in families' use of paid care, full-time paid care, and weekly costs before and after the 2014 CCDBG reauthorization, for each policy. The DDD is an extension of the difference-in-differences framework that includes an additional comparison group (Olden, & Møen, 2022). The DDD design compares the treatment group (for whom the event or intervention happened) to a comparison group (for whom the event did not happen) by comparing the outcome before and after the specific event. The assumption behind this method is that the difference in outcome between treatment and comparison groups would have remained the same over time if the event did not happen. In our analyses, the event is the implementation of selected CCDF policies. Our treatment group is low-income children with disabilities and the comparison group is low-income children without disabilities. States that implemented these CCDF policies at some point from 2012 to 2019 are the treatment states and other states that did not implement these policies in this timeframe are the comparison states. Note that states with the supportive CCDF policies in both 2012 and 2019 were excluded from the DDD models as they could not be compared because there were no policy changes.

Specifically, the DDD model compares changes in child care outcomes between 2012 and 2019 (comparison one) across treated and untreated states (comparison two) and between children with and without disabilities (comparison three). The DDD design addresses concerns of 1) potential spillovers of supportive CCDF policies to nondisabled children; and 2) different economic conditions across states, based on the assumption that the general economic differences will not affect the relative outcomes of children with disabilities (treatment group) and children without disabilities (comparison group).

Regression models. To leverage the full sample that includes all states, including those with supportive CCDF policies in both 2012 and 2019, we also used logistic and linear regression models to estimate the associations between the supportive CCDF policies and child care outcomes, using data from both the 2012 and 2019 NSECE. The models included the same variables as DDD models. Because we expected these policies would affect children with and without disabilities differently, we added an interaction term between disability status and the priority policy (or reimbursement policy) to the models. Unlike the DDD models, these regression models examine the associations between the key variables instead of causal relationships. Additionally, we conducted subgroup analysis by child age to examine whether results differ between age groups.

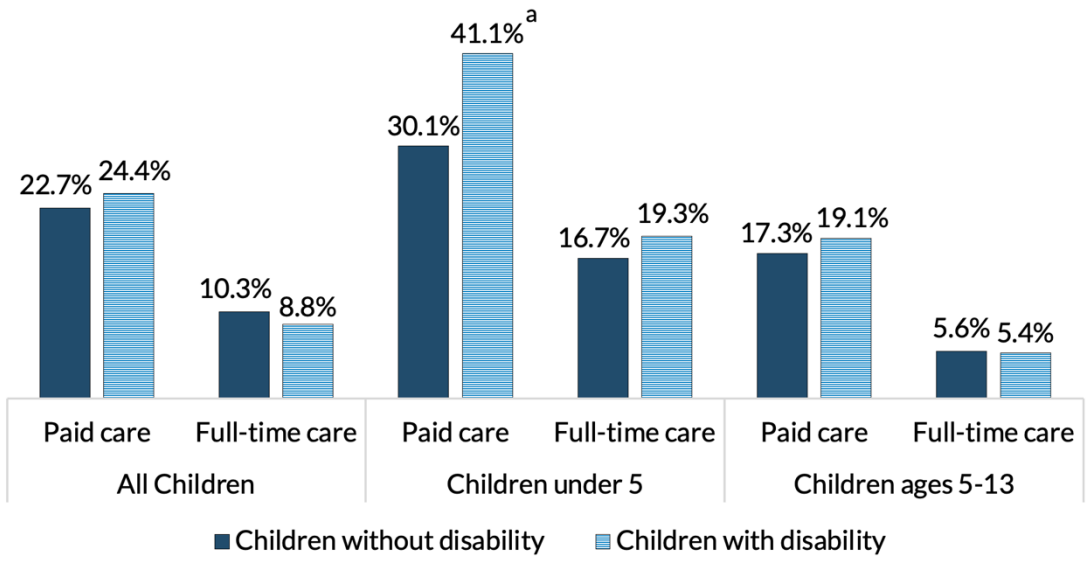
For all analyses, we accounted for the complex sample design and followed the NSECE restricted-use data reporting guidelines to ensure proper interpretation of the results and prevent disclosure risk.

Findings

Use of child care and weekly costs

As shown in Figure 3, 23 percent of children without disabilities and 24 percent of children with disabilities used paid child care, and 10 percent and 9 percent were enrolled in full-time paid care, respectively. For young children under age 5, a higher percentage of children with disabilities were in paid care than children without disabilities (30% vs. 41%); for children ages 5 to 13, the percentages of children who used paid care were similar between children with and without disabilities (17% vs. 19%). The percentages of children in full-time care were similar between children with and without disabilities (6% vs. 5%). The percentages of young children in full-time care (17-19%) were at least three times higher than those of school-aged children (5%-6%), but the rates were similar between children with and without disabilities.

Figure 3. Percentages of children in paid care and full-time paid care by child disability status and age

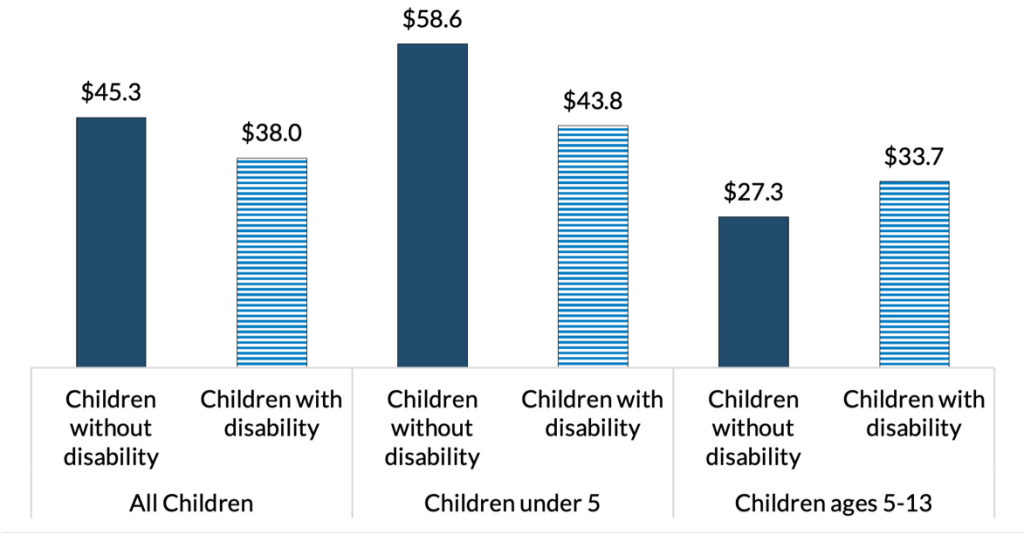


Source. Data from 2012 and 2019 NSECE Household Survey were pooled together.
Note. [a] indicates significant difference between children with and without a disability ($p < 0.05$).

The average weekly care costs were $45 for children without disabilities and $38 for children with disabilities (Figure 4).[12] Among children under age 5, the weekly costs were lower for children with disabilities ($44) than for children without disabilities ($59), but the difference was not statistically significant. By contrast, among school-aged children, the weekly costs for children with disabilities were higher ($34) than their peers without disabilities ($27), although the difference was not statistically significant.

[12] The average weekly costs of care include care with $0. There is a wide variation in weekly care costs.

Figure 4. Mean weekly care costs by child disability status and age



Source. Data from 2012 and 2019 NSECE Household Survey were pooled together.
Note. Weekly costs included care with $0 cost. We conducted significance tests and there were no significant differences between children with and without disabilities.

Associations between disability status and child care outcomes

In this section and the sections that follow, we report findings from a series of DDD and multiple regression models to examine the associations between disability status, supportive CCDF policies, and child care outcomes. Each model included disability status and one of the supportive CCDF policies. The models also controlled for child, family, community, and state characteristics and year. We report results for disability status in this section and the results for each policy in the following two sections.

DDD models. Results from the DDD models indicated that children with disabilities were more likely to be enrolled in paid care than children without disabilities. The estimates vary across models due to differences in policies included and sample sizes; differences range from 10.6 to 14.4 percentage points (Tables A2 and A3 in Appendix).

Regression models. Results from the regression models also showed a positive association between disability status and use of paid care. Children with disabilities were more likely to be in paid care than children without disabilities, by 5.5 to 5.7 percentage points (Tables A4 and A5). Results from subgroup analysis by child age suggested that the difference in using paid care by disability status was more prominent for children younger than age 5 (12.2 to 12.4 percentage points; Tables A4 and A5).

There were no associations between child disability status and use of full-time paid care or weekly care costs.

Associations between priority policies and child care outcomes

DDD models. Results from DDD models estimating causal relationships did not provide evidence that state priority policies increased the likelihood of using paid care or full-time care for children, regardless of their disability status (Table A2). In other words, there was no causal relationship between this type of policy and any child care outcomes. We were not able to report how priority policies affected weekly care costs due to small cell sizes and the need to prevent disclosure.

Regression models. We also conducted regression models to examine whether there were different associations between priority policies and use of paid care, by disability status. The likelihood of using paid care was virtually identical for children with and without disabilities (Table A4). Similarly, states' priority policies were not associated with use of full-time care or weekly costs for children with and without disabilities (Tables A6 and A8 in Appendix).

Associations between differential reimbursement rate policies and child care outcomes

DDD models. Results from DDD models estimating causal relationships did not provide evidence that differential reimbursement rate policies increased the likelihood of using paid care or full-time paid care or reduced weekly care costs for children with disabilities. In other words, there was no causal relationship between this type of policy and any child care outcomes (Table A3 in Appendix). We were not able to report how differential reimbursement rate policies affected weekly care costs due to small cell sizes and the need to prevent disclosure.

Regression models. Regression models that examined whether there were different associations between these policies and use of paid care, by disability status, indicated a positive relationship between differential reimbursement rates and use of paid care, with an increased likelihood of using paid care by 6.7 percentage points for children (regardless of their disability status) living in states with such a policy. Separate analyses by child age showed that this positive association existed among school-aged children (9.2 percentage points) but not among children under age 5 (Table A5 in Appendix). There were no relationships between these policies and use of full-time care (Table A7).

Additionally, regression models that examined whether there were different associations between these policies and weekly costs, by disability status—using the full sample of children from families with low incomes—showed no association between differential reimbursement rate policies and weekly costs (Table A9). However, subgroup analysis by age indicated that, among school-aged children, disability status was associated with higher weekly care costs by an average of $33.70. Differential reimbursement rate policies were associated with lower weekly costs for children with disabilities by $30.20 but not for children without disabilities (Table A9). In other words, in states that implemented differential reimbursement rate policies, weekly costs of care would be similar between children with and without disabilities.

Discussion

This study contributes to the overall body of research on how child care policies can impact access to care for families of children with disabilities. Specifically, these analyses have examined whether state CCDF policies—specifically, those that prioritize/guarantee subsidies and those that provide differential

reimbursement rates—were related to use of paid child care, use of paid full-time child care, and weekly cost of care for families of children with disabilities. Overall, we did not find causal relationships between the key CCDF policies and child care outcomes using the DDD models. Additionally, multiple regression analyses did not identify relationships between priority policies and any child care outcomes specific to children with disabilities. However, multiple regression analyses did demonstrate that differential reimbursement rates were associated with increased use of paid care among all children (with and without disabilities) and a lower weekly cost of care for children with disabilities, particularly for school-aged children. These findings could be related to differences between the two types of policies, interactions with other CCDF or disability policies, limited CCDF uptake, differences by child care and identified disability, and/or limited data on children with disabilities. Future research could consider how to additionally account for these factors.

Differences between priority status and differential reimbursement rates

Although priority policies and differential reimbursement rates are both hypothesized to impact child care access, they operate via distinct pathways and might potentially impact children with disabilities differently due to their age or type of disability. Priority policies help families enroll in the subsidy program by moving to the head of a waiting list when there are more eligible families than state subsidies can serve. We hypothesized that this type of policy would help make child care more affordable, which, in turn, would increase families' likelihood of using paid care and full-time paid care. However, prioritizing children with disabilities does not mean that their subsidies are guaranteed.

One important caveat in interpreting these findings is that, to obtain an adequate sample size, we grouped together states that prioritized subsidies and states that guaranteed subsidies for children with disabilities. The impacts could differ for children who are guaranteed a subsidy and those who are prioritized, who may still be on waiting lists as states also prioritize other groups of children. Some states provide subsidies for all eligible children, essentially granting them priority status—including children with disabilities. Further, the limited number of child care slots for children with disabilities is a common barrier faced by families of children with disabilities (U.S. Government Accountability Office, 2024). Additionally, priority policies may not address child care supply issues, such as reasonable access to appropriate facilities and qualified staff, which affect families' access to paid care and full-time care. Parental awareness of this type of policy may also play a role, and lack of awareness of subsidy programs and eligibility is cited as a reason for non-use of subsidies (Heinz et al., 2025).

Differential reimbursement rates, on the other hand, may function to increase both the supply of providers enrolling children using subsidies and the supply serving children with disabilities. Providers may face additional costs related to the infrastructure, staff, and training needed to provide care for children with disabilities. Many states' provider reimbursement rates from the CCDF are below the actual cost of providing high-quality care (Prenatal-to-3 Policy Impact Center, 2022), and increasing these rates incentivizes child care providers to enroll children with disabilities who have child care subsidies (Bires et al., 2017; Rafa & Kresse, 2023). The findings on the relationship between differential reimbursement rates and cost of care show that these policies may play a role in defraying additional costs, which in turn increases child care access for all children regardless of disability status—particularly for school-aged children. States with differential rates might have higher reimbursement rates for providers overall or may offer tiered reimbursement rates based on quality rating.

Additionally, we found that differential reimbursement rates were associated with lower weekly care costs for children with disabilities, and that the relationship between differential reimbursement rates and weekly cost of care was more pronounced for school-aged children. The findings suggest that providing differential (i.e., higher) reimbursements to providers caring for children with disabilities is associated with lower child care costs for these families. One possible explanation for the lack of association between differential

reimbursement rate policies and use of paid care for children under age 5 is that there may be more resources available for young children (e.g., Head Start and public pre-K); another is that CCDF subsidies for young children may play a less critical role in lowering costs than for school-aged children. However, differential reimbursement rates may not be sufficient for providers to make large or long-term investments in staffing or infrastructure. Furthermore, providers may view subsidies as an unstable source of revenue because of ties to employment and family income (Adams & Rohacek, 2010), further challenging providers' ability to make large or long-term investments.

CCDF, IDEA, and Head Start policies may jointly impact child care access

In addition to priority status and differential reimbursement rate policies, CCDF also allows states to implement other policies meant to support child care access for families of children with disabilities—e.g., increased flexibility in determining eligibility for specific groups of children; the use of quality set-aside funds to offer disability-related professional development opportunities; and the use of grants or contracts to keep slots available to children with disabilities. The current analyses suggest that supporting the supply of child care may be particularly important for child care access for children with disabilities; an examination of the use of grants or contracts could help flesh this out. Similarly, grants and contracts stabilize payments to providers enrolling children using subsidies; subsidy rates are typically below the actual cost of care (Prenatal-to-3 Policy Impact Center, 2022), so future research could explore how stabilizing reimbursement rates selectively may strengthen child care supply. Using quality set-aside funds to offer disability-related professional development may also increase the supply of child care by building providers' capacity to serve children with disabilities. Additionally, more than one of these policies may be implemented at the same time, so future research could consider examining packages of or interactions between policies.

CCDF policies are part of a complex and fragmented policy landscape that aims to support children with disabilities. The findings from this study suggest that programs like Head Start and public pre-K may play a role in supporting child care access for children younger than age 5; additional analyses could consider the interplay between IDEA, Head Start, and CCDF. In the 2012 and 2019 NSECE data used for these analyses, it was difficult to determine receipt of each of these funding sources due to parents' difficulty understanding the source of funding for their children's programs. Given the complex nature of the policy landscape, future research could consider how to include families' experiences with medical care systems and the role of additional systems like the K-12 and foster care systems in access to high-quality child care.

CCDF uptake is limited, particularly among children with disabilities

Nationally, CCDF-funded child care subsidies are used by just 15 percent of families eligible under federal rules of eligibility (Chien, 2024). Within this limited reach, CCDF uptake is even lower among families of children with disabilities (Sullivant et al., 2018b), potentially limiting any policy impacts on children and families. We see three opportunities for future research related to CCDF uptake among families of children with disabilities. First, additional analyses could describe how families of children with disabilities and providers enrolling children with disabilities interact with the subsidy system and how state CCDF policy implementation translates into improved access for these families. Second, researchers could consider how the subsidy system might better meet the needs of families of children with disabilities across such barriers as challenging application processes, insufficient awareness of subsidy programs, or ability to locate high-quality care (Madill, 2017). Third, future analyses could examine how CCDF could expand in ways that are specific to serving families of children with disabilities. For example, CCDF focuses specifically on providing

child care support while parents are working. However, an additional child care need specific to families of children of disabilities is respite care—or short-term care while the caregiver is *not* at work—to support family well-being and decrease stress (Strunk, 2010). Cross-system coordination (e.g., between CCDF and Medicaid) could open many doors for families of children with disabilities and bolster long-term outcomes.

Child care needs vary by child age and identified disability

Children with disabilities younger than age 5, regardless of their state's CCDF policy status, were more likely to be enrolled in paid care than their counterparts without disabilities; however, this association was less prominent for school-aged children, implying that child care services available and care needs may be distinct between the two groups of children. Additionally, programs like Early Head Start and Head Start are only available to children before enrolling in kindergarten. Information on care supports for school-aged children with disabilities is limited, but research has shown that school-aged children with disabilities engage in out-of-school-time activities at lower rates than their counterparts without disabilities (Redd et al., 2025), possibly indicating barriers in locating care specific to that age group.

Beyond differences in access to child care resources, IDEA data suggest that the identified disabilities between older and younger children may differ (U.S. Department of Education, 2025). The priorities, supports, and experiences of families with children who have disabilities identified in early childhood and those of children identified after entering the K-12 system likely differ, implying they would also require different things from a child care provider. Further, because disability refers to a broad spectrum of experiences, the experiences of families using subsidies to access child care for a child with a disability likely vary. The definition of disability used in the NSECE is very broad: Children with medical complexity,[13] for example, may only find adequate care in medical child care[14] centers that may be challenging to access.[15] To better understand how CCDF policies can influence child care access for children with disabilities, future research could also consider for whom CCDF policies work best, based on identified disability and level of required support. The breadth of experiences of families who have children with disabilities also illustrates the necessity of considering the interaction with the health care system when accessing child care.

Data on child care for children with disabilities is limited

The most critical need for future research on child care access for children with disabilities is responsibly collected and managed data. In the case of our analyses here, causal findings were limited by our inability to examine findings by age or identified disability. Detailed information on identified disabilities and child care can be difficult to obtain. The NSECE data used in this study, for example, contain rich information on child care usage, but only broad or more general information on disabilities (NSECE, 2019). IDEA data contain a wealth of information on children with disabilities but do not discuss wraparound or out-of-school-time care on which parents may rely (U.S. Department of Education, 2025). The National Survey of Children's Health contains detailed information on children's health, as well as learning and intellectual disabilities, but does not ask about child care (U.S. Census Bureau, n.d.). CCDF could potentially allow for regular and detailed state data collection on the experiences of children with disabilities and the subsidy system to support more

[13] Children with medical complexity have chronic health conditions associated with the need for extensive care coordination (Cohen, 2011).
[14] Medical child care or Prescribed Pediatric Extended Care offers care for children who require skilled nursing support, typically requiring a doctor's prescription or certification (Spark Pediatrics, ND). Note that research on the role of medical child care as part of the child care landscape is limited.
[15] For example, there is one medical child care center in the state of Maryland (Kennedy-Krieger, 2025).

effective policy implementation. Additional data would also allow for examination of the intersecting social identities of children with disabilities, as research has shown that systemic disparities related to social identities can influence factors like the decision to recommend children for special education (U.S. Government Accountability Office, 2019).

Study Limitations

The findings presented in this study should be interpreted with caution due to several data limitations. First, the broad definition of disability in the NSECE limits our ability to clearly describe the children with disabilities (such as the type of disability and accommodations needed) included in these analyses and to distinguish whether and how their child care arrangements vary. Second, the NSECE does not provide information to differentiate between children who are enrolled in free child care because they receive child care subsidies and those who are enrolled in a program free of charge to parents (e.g., Head Start or public pre-K), which could potentially explain some of the differences in findings related to cost of care by child age. Because Head Start and public pre-K are available only to children under age 5, being unable to separate free care from subsidized care with $0 copay limits our ability to more precisely examine the effects of the CCDF policies on care cost for young children.

Small sample sizes limited our ability to conduct subgroup analyses by child age and care type, particularly in our DDD models. Because child care arrangements tend to be different between young children and school-age children, grouping them together in our analyses limited our ability to examine potentially different policy impacts on children with disabilities by age. Finally, coding states into dichotomous policy categories does not capture all variation in policy design (e.g., prioritizing as opposed to guaranteeing subsidies) that might have different impacts on children and families.

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Appendix

Table A1. Sample characteristics by disability status

	All children (N=23,060)	Children without disability (N=20,860)	Children with disability (N=2,220)	Diff.
	%/Mean (SD)	%/Mean (SD)	%/Mean (SD)	
Full Sample	100.0%	89.5%	10.5%	
Use of paid care	22.8%	22.7%	24.4%	
Use of full-time paid care (>= 30 hours a week)	10.1%	10.3%	8.80%	
Total weekly cost of care	$44.5 ($81.2)	$45.3 ($78.8)	$38.0 ($87.1)	
Child race and ethnicity				
White, non-Hispanic	38.1%	37.3%	44.9%	***
Black, non-Hispanic	19.5%	19.9%	16.4%	*
All other race, non-Hispanic	4.4%	4.5%	3.3%	
Multiple races	4.7%	4.3%	7.9%	***
Hispanic	33.3%	34.0%	27.5%	***
Child age				
Under 5	40.2%	42.1%	24.2%	***
5-13	59.8%	57.9%	75.8%	***
Mother's highest level of education				
Less than high school	21.7%	21.9%	20.2%	
High school or GED	31.7%	32.1%	27.8%	*
Some college or associate degree	34.1%	33.4%	40.8%	***
Bachelor's degree or higher	12.5%	12.6%	11.2%	
Number of parents (by child)	1.41 (0.64)	1.42 (0.64)	1.33 (0.62)	***
Number of non-parental adults in HH (by child)	0.93 (1.27)	0.92 (1.29)	0.96 (1.16)	
Number of children <13 in HH	2.50 (1.40)	2.50 (1.41)	2.54 (1.34)	
All parents working	44.8%	44.9%	44.0%	
Having relative nearby to provide care	57.6%	58.1%	53.0%	*
Community poverty density				
Low poverty density	39.4%	39.4%	39.4%	
Moderate poverty density	26.5%	26.5%	26.3%	
High poverty density	34.1%	34.1%	34.3%	
Urban density				
High density of urban population	72.3%	72.9%	66.8%	**
Moderate density of urban population	16.3%	15.8%	20.3%	*
Rural population	11.4%	11.3%	12.9%	

Note. Estimates were based on pooled data from 2012 and 2019 and weighted. Diff. = Statistical difference by disability status.
*** p<0.001, ** p<0.01, * p<0.05, + p<0.1

Table A2. DDD models estimating impacts of states implementing priority policies on child care outcomes

	Use of Paid Care	Full-time Paid Care	Cost of Care
	Coef.	Coef.	Coef.
Treated state	-0.000	-0.060	-32.7
	(0.089)	(0.066)	(23.9)
Children with disabilities	0.106***	0.028	7.35
	(0.030)	(0.028)	(8.28)
DDD (Treated state X Disability X Post)	0.242+	0.053	†
	(0.137)	(0.109)	†
Observations	8,000	8,000	1,840

Note. Standard errors in parentheses. "Post" refers to data from 2019. † estimates were suppressed to prevent disclosure due to small cell sizes. The sample size for the cost model is smaller because only children in paid care were included.

*** p<0.001, ** p<0.01, * p<0.05, + p<0.1

Table A3. DDD models estimating impacts of states implementing differential reimbursement rate policies on child care outcomes

	Use of Paid Care	Full-time Paid Care	Cost of Care
	Coef.	Coef.	Coef.
Treated state	0.015	0.040	-18.1
	(0.060)	(0.043)	(16.0)
Children with disabilities	0.144**	0.015	10.2
	(0.049)	(0.029)	(11.4)
DDD (Treated state X Disability X Post)	0.131	-0.000	†
	(0.092)	(0.065)	†
Observations	7,280	7,280	1,540

Note. Standard errors in parentheses. "Post" refers to data from 2019. † estimates were suppressed to prevent disclosure due to small cell sizes. The sample size for the cost model is smaller because only children in paid care were included.

*** p<0.001, ** p<0.01, * p<0.05, + p<0.1

Table A4. Marginal effects from logistic regression models predicting use of paid care by presence of priority policy

	All Children	Under 5 year olds	5-13 year olds
VARIABLES	Margins	Margins	Margins
Child with disability	0.055***	0.122***	0.028+
	(0.015)	(0.029)	(0.016)
Prioritize or guarantee subsidy	0.053	0.070	0.036
	(0.037)	(0.059)	(0.041)
Child with disability x prioritize or guarantee subsidy	0.055	0.072	0.041
	(0.051)	(0.088)	(0.055)
Observations	20,100	8,180	11,920

Note. Standard errors in parentheses

*** p<0.001, ** p<0.01, * p<0.05, + p<0.1

Table A5. Marginal effects from logistic regression models predicting use of paid care by presence of differential reimbursement rate policy

	All Children	Under 5 year olds	5-13 year olds
VARIABLES	Margins	Margins	Margins
Child with disability	0.057***	0.124***	0.028+
	(0.015)	(0.029)	(0.016)
Differential reimbursement rate	0.067**	0.035	0.092***
	(0.025)	(0.041)	(0.025)
Child with disability x differential reimbursement rate	0.09	0.028	0.112
	(0.040)	(0.073)	(0.039)
Observations	20,105	8,200	11,920

Note. Standard errors in parentheses

*** p<0.001, ** p<0.01, * p<0.05, + p<0.1

Table A6. Marginal effects from logistic regression models predicting use of full-time paid care by presence of priority policy

	All Children	Under 5 year olds	5-13 year olds
VARIABLES	Margins	Margins	Margins
Child with disability	0.015	0.036	0.007
	(0.012)	(0.024)	(0.012)
Prioritize or guarantee subsidy	0.035	0.044	0.031
	(0.030)	(0.048)	(0.030)
Child with disability x prioritize or guarantee subsidy	0.048	0.003	0.06
	(0.043)	(0.072)	(0.044)
Observations	20,100	8,180	11,700

Note. Standard errors in parentheses

*** p<0.001, ** p<0.01, * p<0.05, + p<0.1

Table A7. Marginal effects from logistic regression models predicting use of full-time paid care by presence of differential reimbursement rate policy

	All Children	Under 5 year olds	5-13 year olds
VARIABLES	Margins	Margins	Margins
Child with disability	0.015	0.039	0.005
	(0.012)	(0.024)	(0.012)
Differential reimbursement rate	0.019	0.019	0.020
	(0.018)	(0.031)	(0.017)
Child with disability x differential reimbursement rate	0.024	0.04	0.02
	(0.030)	(0.052)	(0.031)
Observations	20,100	8,180	11,700

Note. Standard errors in parentheses

*** p<0.001, ** p<0.01, * p<0.05, + p<0.1

Table A8. Regression models predicting cost of care by presence of priority policy

	All Children	Under 5 year olds	5-13 year olds
VARIABLES	Coef.	Coef.	Coef.
Child with disability	-2.07	-8.60	9.22
	(5.71)	(9.91)	(5.87)
Prioritize or guarantee subsidy	11.6	13.3	7.06
	(9.77)	(11.5)	(9.39)
Child with disability x prioritize or guarantee subsidy	7.07	2.54	4.96
	(8.09)	(13.8)	(9.15)
Observations	4,440	2,380	2,060

Note. Standard errors in parentheses

*** p<0.001, ** p<0.01, * p<0.05, + p<0.1

Table A9. Regression models predicting cost of care by presence of differential reimbursement rate policy

	All Children	Under 5 year olds	5-13 year olds
VARIABLES	Coef.	Coef.	Coef.
Child with disability	8.85	-11.5	33.7**
	(8.31)	(9.10)	(11.1)
Differential reimbursement rate	-3.89	3.12	-9.75
	(8.96)	(12.3)	(9.17)
Child with disability x differential reimbursement rate	-9.91	7.12	-30.2*
	(9.72)	(13.1)	(12.1)
Observations	4,440	2,380	2,060

Note. Standard errors in parentheses

*** p<0.001, ** p<0.01, * p<0.05, + p<0.1