

Additional Notes

Puerto Rico Exclusion

Puerto Rico's resident population of 3.2 million people¹ in 2019 is larger than that of 20 states and the District of Columbia. The Commonwealth faces a number of challenges that the Prenatal-to-3 Policy Impact Center has identified as impediments to the health and well-being of young children and their families. These include high levels of poverty, unemployment, employment instability, and childhood food insecurity as well as low levels of labor force participation when compared to the rest of the United States.² Even so, due to systematic differences in policy implementation in Puerto Rico and data limitations, Puerto Rico data are excluded from the Prenatal-to-3 State Policy Roadmap.

Policy Implementation

Federal laws and programs apply equally to DC and the 50 states. The same is not true for the citizens of Puerto Rico. Public programs operate differently in Puerto Rico compared to the states. Puerto Rico's Medicaid program has lower income eligibility levels, lower reimbursement rates, and covers fewer health services than the Medicaid programs in the rest of the United States.³ The income eligibility for specific populations, including children and pregnant women, is lower in Puerto Rico than the federal minimum income eligibility threshold, as Puerto Rico is exempt from this federal eligibility requirement. Puerto Rico currently provides coverage to individuals with modified adjusted gross incomes up to 133 percent of the Puerto Rico Poverty Level, which was \$10,200 annually for a family of four in 2019, or approximately 40 percent of the federal poverty level.⁴

Additionally, federal Medicaid spending in Puerto Rico and other US territories is provided as a block grant, with a fixed matching rate and capped at a specific dollar value. In comparison, the federal match for Medicaid spending in states uncapped and adjusted annually based on a state's relative per capita income.⁵ Prior to the Affordable Care Act, this meant that the federal government covered 15 to 20 percent of Puerto Rico's annual Medicaid costs compared to the 50 percent minimum reimbursement rate provided to the states.⁶ Since 2011, the Affordable Care Act and other temporary Medicaid relief funds been available to territories to fund their Medicaid programs beyond the federal cap; however these funds expired at the end of 2019. The ability of states to expand Medicaid eligibility and/or require Medicaid coverage for specific services is central to successful implementation of three policies the Prenatal-to3 Policy Impact Center has found to have a strong evidence base for improving the health and well-being of young children and their families.

¹ <https://www.census.gov/data/tables/time-series/demo/popest/2010s-state-total.html>

² <https://datacenter.kidscount.org/data#PR/4/0/char/0> and <https://www.cbpp.org/puerto-rico-has-higher-poverty-unemployment-lower-labor-force-participation>

³ <https://www.cbpp.org/research/health/puerto-ricos-medicaid-program-needs-an-ongoing-commitment-of-federal-funds>

⁴ <https://www.macpac.gov/wp-content/uploads/2019/03/Medicaid-and-CHIP-in-Puerto-Rico.pdf>

⁵ <https://www.kff.org/report-section/medicaid-in-the-territories-program-features-challenges-and-changes-issue-brief/>

⁶ <https://ccf.georgetown.edu/2018/03/16/ensuring-robust-and-resilient-medicaid-programs-in-puerto-rico-and-the-u-s-virgin-islands-during-post-hurricane-recovery-and-over-the-long-run/>

Similarly, federal funding for food assistance is provided in Puerto Rico through the Nutrition Assistance Program (NAP), rather than the Supplemental Nutrition Assistance Program which operates in the 50 states and the District of Columbia. NAP is a block grant, while SNAP is an uncapped entitlement program. As such, NAP is unable to provide the same level of benefits and restricts eligibility to a lower level than SNAP. The USDA found that if Puerto Rico participated in SNAP using the same criteria as states, it would require a 23 percent increase in current spending through NAP.⁷ The participation in SNAP by eligible recipients was found to be strongly associated with improved health and well-being for young children and their families.

Due to the differences in program administration, funding, and eligibility Medicaid and SNAP/NAP are fundamentally different programs in Puerto Rico than the 50 states and the District of Columbia and will have a more limited ability to improve the health and well-being of young children and their families in the territory.

Data Availability

There are a number of limitations when comparing specific indicators across Puerto Rico and the rest of the United States. Specifically, Puerto Rico is not included in some of the datasets which are used for examining variation among states in terms of their demographic, health, socioeconomic, or other characteristics. In some cases, there are comparable Puerto Rico-specific datasets, but not all.

Puerto Rico is included in the Census Bureau's total annual resident population counts. It is not included in the American Community Survey, but is included in a customized version called the Puerto Rico Community Survey, that differs in survey terminology and methodology.⁸

Puerto Rico is not included in the National Survey of Children's Health or the Current Population Survey (including the Annual Social and Economic and Food Security Supplements)—datasets we rely on to calculate several outcome metrics of child and family wellbeing.

Other datasets including the Office of Special Education's SPP/APRs, the Quality Compendium's state QRIS profiles, the Office of Child Care's CCDF plans, the Centers for Disease Control's Vital Statistics datasets, the Bureau of Labor Statistics' Occupational Employment Statistics and Local Area Unemployment Statistics datasets, and the Early Childhood Learning and Knowledge Center's EHS PIRs do include data for Puerto Rico, though these data are not always the same as those provided for states.

Finally, there are ways in which the data for Puerto Rico are significantly different from that of the rest of the United States. In terms of poverty, income, and unemployment Puerto Rico is a considerable outlier from the national distribution. This makes a direct comparison with states less meaningful for the purposes of assessing the success of policy development and implementation.

⁷ <https://www.cbpp.org/research/food-assistance/how-is-food-assistance-different-in-puerto-rico-than-in-the-rest-of-the>

⁸ <https://www.census.gov/programs-surveys/acs/about/puerto-rico-community-survey.html>

Additional Measures – Other Solutions States Are Pursuing to Impact Policy Goals

Beyond the policies and strategies proven effective by the current research, states are also pursuing other approaches that hold promise for making progress toward policy goals. These approaches have not yet accumulated enough rigorous research to enable drawing conclusions on their effectiveness, or the Prenatal-to-3 Policy Impact Center has not yet conducted a comprehensive evidence review for the approach.

GOAL: Parents' Ability to Work

Fair Work Scheduling

Erratic, unpredictable work schedules create unique problems for workers and their families, making it difficult to secure reliable, quality child care. In response to a growing understanding of how scheduling issues affect hourly employees with low incomes, states have begun to develop practices, known as fair work scheduling policies, that improve schedule predictability and address related issues, such as adequacy of hours, compensation, and opportunities for employee input.

Measure: State has fair work scheduling policies

Definition: State has a policy that includes at least one of the fair work schedule requirements (see note 1)

Source: National Women's Law Center. (October 2019). *State and local laws advancing fair work schedules* [Fact Sheet]. Retrieved October 21, 2019 from <https://nwlc.org/resources/state-and-local-laws-advancing-fair-work-schedules/>

Notes:

1. Fair work schedule policies include one or more of the following requirements: (a) an employee can provide input into work schedule without retaliation; (b) employers provide advance notice of schedules; (c) employees are compensated for last minute schedule changes, split shifts, and/or shift scheduled close together; (d) part-time employees are compensated equitably; and (e) current employees receive priority access to additional hours.
2. Some of the fair work schedule policies apply to all employees while others are only applicable to employees/employers meeting specific requirements (e.g., non-exempt employee, industry or role, size of employer).
3. While Illinois currently has no fair work schedule policies, Chicago's Fair Workweek ordinance passed in July 2019 and took effect July 1, 2020.
4. While Pennsylvania currently has no fair work schedule policies, Philadelphia's Fair Workweek Employment Standards Ordinance passed in December 2018 and took effect January 1, 2020.
5. While Washington state currently has no fair work schedule policies, Sea-Tac adopted a fair work schedule policy in 2014 and Seattle's Secure Scheduling Ordinance was adopted in 2016.
6. Some states with state-level fair work schedule policies also have additional local-level policies.

GOAL: Sufficient Household Resources

Child Tax Credits

The federal child tax credit (CTC) aims to increase household resources by providing families with a credit worth \$2,000 per citizen child under age 17 to help offset tax liability or, if the value of the credit exceeds the tax liability, to provide a refund of up to \$1,400 per child. Some states have chosen to implement their own CTC, the value of which can be, but is not always, a percentage of the federal credit.

Measure: State has a Child Tax Credit

Definition: Status of state child tax credits (including refundable or nonrefundable)

Source: Tax Credits for Workers and Their Families. (n.d.). *State tax credits*. Retrieved June 1, 2020 from <http://www.taxcreditsforworkersandfamilies.org/state-tax-credits/#1468434105770-44f9c6c5-52e0>

Notes:

1. In California, the Dependent Exemption Credit is reduced for individual filers with income at or above \$172,615 and for married filers with income at or above \$342,235.
2. In Colorado, filers are eligible for the Child Tax Credit if they have a child aged 5 and under.
3. In New York, filers are eligible for the Empire State Child Credit if they have a child over 4 years of age.
4. In North Carolina, to qualify for the Credit for Children, filers must have an income below \$100,000 for married filing jointly, \$80,000 for head of household, \$60,000 for single, or \$50,000 for married filing separately.
5. In Oklahoma, filers are ineligible for the Child Tax Credit with an income of over \$100,000.

Child Care Tax Credits

The federal Child and Dependent Care Tax Credit (CDCTC) helps to subsidize child care expenses by providing a nonrefundable credit for 20% to 35% of \$3,000 in child care expenses per child to offset tax liability among families in which the adults are working or attending school. States can choose to implement their own CDCTC, the value of which is often a percentage of the federal credit, and can determine their own eligibility requirements.

Measure: State has a Child Care Tax Credit

Definition: Status of state child and dependent care tax credits (including refundable or nonrefundable)

Source: Tax Credits for Workers and Their Families. (n.d.). *State tax credits*. Retrieved June 1, 2020 from <http://www.taxcreditsforworkersandfamilies.org/state-tax-credits/#1468434107561-be99920d-11c4>

Notes:

1. In Arkansas, the tax credit is only available for children under 6 in an approved child care facility.
2. In Louisiana, the tax credit is refundable only for filers earning \$25,000 or less. It is nonrefundable for tax filers making more than \$25,000.

3. In Maine, the tax credit is refundable for up to \$500, though the nonrefundable credit can be up to 50 percent of the federal credit, if expenses are from a care center with a state-issued "Quality Certificate."
4. In Minnesota, filers with income above \$39,000 are ineligible. The credit is capped by the amount the tax filer would have received under federal law prior to 2003.
5. In New Jersey, the credit is phased out for filers with income above \$60,000.
6. In New Mexico, the credit is phased out for filers with income above \$30,160.
7. In Ohio, the credit is phased out for filers with income above \$40,000.
8. In Oklahoma, the credit is phased out for filers with income above \$100,000.
9. In Oregon, the credit is phased out for filers with income above \$45,000. Additionally, the Oregon credit is not limited by the federal credit and any unused credit may be carried forward for up to five years.
10. In Vermont, the credit is phased out for filers income above \$30,000 (\$40,000 if married filing jointly or civil partners).

GOAL: Healthy and Equitable Births

Approximately 700 women die in childbirth each year in the US. Most of these new mothers' deaths – an estimated 60% - are considered preventable. Black families experience this tragedy in disproportionate numbers. Although maternal mortality has fallen globally, the maternal mortality rate in the US increased between 50% and 70% over the past 20 years, and the rate of severe maternal morbidity has doubled. Among developed countries, the US stands alone in these troubling upward trajectories. Despite the urgency of this issue, lack of adequate state-level data on maternal mortality and morbidity has frustrated efforts to meaningfully parse the varied causes of the problem and to evaluate states' strategies to combat it. Observational studies point to some success among states' varied strategies, which include support of perinatal quality collaboratives, toolkits and bundles to guide medical practice, funding of doulas, and implicit-bias training.

Perinatal Quality Collaboratives (PQC) and Maternal Mortality Review Committees (MMRC)

These statewide, multidisciplinary networks promote evidence-based clinical practices by bringing key stakeholders together, producing issue briefs and strategic plans, and holding symposia and other events. Together PQCs and MMRCs are thought to improve birth outcomes through systemwide changes across a state.

Measure: State does not have an active perinatal quality collaborative (PQC)

Definition: Status of the state's perinatal quality collaborative (available, in development, or information is not available)

Source: Centers for Disease Control and Prevention. (n.d.) *State perinatal quality collaboratives*. As of January 2020. Retrieved May 5, 2020 from

<https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pqc-states.html>

Notes:

1. The CDC does not provide data for the District of Columbia, but it has not yet established an active PQC.

2. Information for Idaho and Rhode Island is not available.

Measure: State does not have a maternal mortality review committee (MMRC)

Definition: Status of the state’s maternal mortality review committee (active and reviewing cases)

Source: Centers for Disease Control and Prevention, Julie Zaharatos (personal communication, June 1, 2020) State Maternal Mortality Review Committee. As of May 2020.

Notes: Information was received in direct correspondence with Julie Zaharatos of the CDC on June 1, 2020.

Alliance for Innovation on Maternal Health (AIM)

States that wish to support efforts to reduce maternal mortality and morbidity can enroll and participate in the national Alliance for Innovation on Maternal Health (AIM), which works to bring maternal health improvement efforts at the national, state, and hospital level into alignment.

Measure: State does not participate in the Alliance for Innovation on Maternal Health

Definition: Status of state participation in the Alliance for Innovation on Maternal Health (AIM) program

Source: Council on Patient Safety in Women’s Health Care. (n.d.) AIM States. As of May 2020. Retrieved May 6, 2020 from <https://safehealthcareforeverywoman.org/aim-states-systems-2/>

GOAL: Parental Health and Emotional Wellbeing

Beyond the policies and strategies proven effective by the current research, states are also pursuing other approaches that hold promise for improving parental health and wellbeing. Both comprehensive and targeted health screenings promote optimal long-term child development and family wellbeing by allowing medical professionals to assess a patient’s health risks before problems develop. In contrast to comprehensive screenings – which allow a practitioner to identify a wide range of potential risks and health needs that a patient may have – targeted screenings allow for assessment of a patient’s risk for a specific issue that can impact health and wellbeing. For example, challenges during the perinatal and postpartum periods that can be identified in targeted screenings, such as maternal depression and developmental delays among children, affect a substantial number of families.

Measure 1: Medicaid treatment of maternal depression screenings during well-child visits

Definition: State Medicaid policy for maternal depression screenings during well-child visits

Source: National Academy for State Health Policy (n.d.) *Medicaid policies for maternal depression screening during well-child visits, by state*. As of February 2020. Retrieved May 5, 2020 from <https://healthychild.nashp.org/wp-content/uploads/2020/03/Mat-Depression-Screen-chart-3.20.20.pdf>

Notes:

1. Arizona, Florida, and Nebraska confirmed with NASHP that the Medicaid agency does not have a policy in place regarding maternal depression screening during well-child visits.

2. Alaska, Arkansas, Kansas, New Hampshire, and New Jersey did not confirm the status of their policy with NASHP.
3. States with Medicaid policies in place regarding screening for maternal depression during well child visits either allow, recommend, or require these screenings.

Measure 2: Medicaid requires and reimburses child development screenings

Definition: State Medicaid program requires developmental screenings during well child visits and reimburses for them using Current Procedural Terminology code 96110 as a part of the EPSDT benefit

Source: National Academy for State Health Policy. (n.d.) *Medicaid developmental screening policies by state*. As of July 23, 2019. Retrieved December 10, 2019 from <https://healthychild.nashp.org/wp-content/uploads/2019/07/Developmental-Screening-Reimbursement-Table-7.23.19.pdf>

Notes:

1. NASHP compiled data from state Medicaid websites and direct communication with state Medicaid or CHIP officials.
2. New York requires developmental screenings but does not reimburse for them.
3. Information for Florida was not confirmed by the state Medicaid agency.

GOAL: Nurturing and Responsive Child Care in Safe Settings

States use a number of different mechanisms to strengthen the quality of their child care systems. States may employ these mechanisms through licensing requirements or QRIS (or both).

Child Care Coaching

Coaching (also referred to as mentoring or consultation) is a means of professional development that connects caregivers with child care experts who help them improve their skills through an ongoing, collaborative process. States can promote coaching, as a means of improving classroom quality, through child care resource and referral (CCR&R) agencies, state licensing requirements, or QRIS standards.

[Specific Measure Details forthcoming]

Child Care Ratios

States may use ratio requirements – which govern the number of children allowed per caregiver in a room – as a mechanism for promoting child care quality and safety. A ratio of fewer children per teacher is expected not only to facilitate better classroom supervision, thereby improving safety, but also to allow sufficient opportunity for the enriching, one-on-one interactions on which young children’s developing brains rely.

[Specific Measure Details forthcoming]

Child Care Workforce Qualifications

Many states promote child care workforce quality through licensing requirements and QRIS standards for the education or training of child care staff. In determining the level of education to promote, states can follow the lead of national organizations such as Early Head Start, NAEYC, and the Institute of Medicine and National Research Council.

[Specific Measure Details forthcoming]

Child Care Workforce Compensation and Assistance

Teachers and caregivers in the child care field, particularly those serving infants and toddlers, commonly earn low wages. Recognizing the importance of fair compensation, states have begun to include workforce compensation guidelines in licensing requirements and QRIS standards. Many states also provide direct financial relief to child care workers through tax credits, bonuses, and stipends. Improving workforce compensation is thought to be important in recruiting and retaining a highly skilled workforce, ultimately improving classroom quality and outcomes for children.

[Specific Measure Details forthcoming]