A Comprehensive Fiscal Analysis of the Prenatal to Five System in Montana

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Jeanna Capito
Jessica Rodriguez Duggan
Karen Rhinehardt
Simon Workman

Prenatal to Five Fiscal Strategies

P▸5 Fiscal Strategies

About Prenatal to Five Fiscal Strategies

Prenatal to Five Fiscal Strategies is a national nonprofit founded by Jeanna Capito and Simon Workman that seeks to address the broken fiscal and governance structures within the prenatal to five system with a comprehensive, cross-agency, cross-service approach. The nonprofit is founded on a set of shared principles that centers on the needs of children, families, providers, and the workforce. This approach fundamentally rethinks the current system to better tackle issues of equity in funding and access.

For more information about Prenatal to Five Fiscal Strategies, please visit: www.prenatal5fiscal.org

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Table of Contents

A Comprehensive Fiscal Analysis of the Prenatal to Five System in Montana

Executive Summary

The early years of a child's life lay the foundation for lifelong health, learning, and well-being. Yet, the programs and systems that support young children and their families remain consistently underfunded and fragmented. Multiple funding sources, each with distinct rules and limitations, create a complex landscape that families and providers must navigate. These challenges fall most heavily on those with the fewest resources.

Montana's prenatal to five system reflects a deep commitment to young children and their families but faces persistent challenges. Services rely on multiple funding streams – federal, state, local, and private – each with its own requirements and limitations. This complexity creates inefficiencies, makes coordination difficult, and often prevents providers from covering the full cost of delivering care. Rural geography, workforce shortages, and the importance of honoring Tribal sovereignty further shape how services are delivered and financed.

The Montana Prenatal to Five Comprehensive Fiscal Analysis (CFA), conducted by Prenatal to Five Fiscal Strategies (P5FS) in collaboration with the Montana Department of Public Health and Human Services (DPHHS) and Zero to Five Montana, provides a data-driven foundation for strengthening the state's prenatal to five system. The CFA examines how prenatal to five services are financed, how funds are used, and what it truly costs to deliver high-quality services to children and families across the state. The analysis aims to highlight the financial realities of delivering prenatal to five programs and services, establishing the groundwork for strategic investments and system-wide improvements to achieve the vision established for young children and families in Montana.

To understand and address these challenges, the CFA integrates three components:

1. **Fiscal mapping** – to document and analyze existing funding that supports prenatal to five programs and system-building activities.
2. **Cost modeling** – to estimate the true cost of delivering high-quality services, including the workforce compensation needed to attract and retain qualified staff.
3. **System analysis** – to connect findings across early care and education, family

strengthening, and system supports and identify opportunities to strengthen efficiency, equity, and sustainability.

Leadership and Engagement

The CFA was guided by a cross-sector Work Group representing child care, early education, home visiting, early intervention, health, Tribal programs, and economic development. Engagement with providers, Tribal Nations, and community leaders was central to the process. Through statewide meetings, webinars, and interviews, constituents shared experiences that informed every stage of the analysis, from defining the fiscal vision and guiding principles to refining cost model assumptions and shaping recommendations.

Fiscal Vision and Guiding Principles

At the outset, partners established a fiscal vision and guiding principles to ground the CFA in shared values and long-term goals. The fiscal vision calls for:

> *A sustainable prenatal to five system that meets the needs of every child and family and is supported by sufficient and stable funding streams that provide maximum flexibility for families, efficient administration and infrastructure, and minimal burden for families and program providers.*

This vision is supported by guiding principles that emphasize equity, collaboration, community voice, data-informed decision-making, and financial sustainability. The principles commit to fair compensation for the workforce, culturally responsive care, reduced administrative burden, and continuous feedback loops to ensure the system remains adaptive and effective.

Fiscal Mapping

Fiscal mapping offers a comprehensive overview of the existing funding streams supporting Montana's prenatal to five system. Fiscal mapping activities identified funding sources, their administrators, and how resources flow across programs and support system-level infrastructure such as workforce development, program coordination, and data systems. Fiscal mapping and analysis prioritized fiscal year 2024 with data collected from budgets, contracts, reports, and interviews with approximately 30 program and system administrators. Findings from fiscal mapping show:

- Total investment in prenatal to five programs, services, and system-building supports is approximately **$135.8 million** annually.
- Direct service programs totaled approximately $115 million in 2024 of which early care and education made up 94% and family strengthening programs received 6%.
    - Early care and education programs received almost $108.6 million for Best Beginnings Child Care Scholarship, Montana Milestones Part C Early Intervention, and Head Start programs. Head Start programs, including Head Start and Early Head Start, make up 55% of total early care and education funding which flows directly to local grant recipients.
    - Family strengthening programs received approximately $6.5 million for Healthy Montana Families, Child Abuse Prevention Programs/Children's Trust Fund, and Early Head Start Home-Based Option. Early Head Start Home-Based programs make up 38% of total family strengthening funding.

- Most direct service funding comes from federal sources (88%) with 12% from state sources, highlighting the need for diversified revenue streams.

- System supports receive approximately 15% of total funding at $20.7 million with a mix of federal (86%), state (5%), and private (9%) sources.

Title I, Early Childhood Special Education, and Early Literacy Interventions administered by the Montana Office of Public Instruction were not included in fiscal mapping and analysis.

Cost Modeling and Analysis

Cost modeling estimates the true cost of high-quality prenatal to five services. The CFA includes the development of cost models for child care and home visiting direct service programs and models as well as a combined system cost model. These cost models estimate the true cost of services by integrating operational data, compensation benchmarks, and program quality standards as well how costs change based on program type, location, caseload or ratios, and service intensity.

The CFA prioritized cost modeling for child care and home visiting due to significant gaps between service costs and existing payment levels. Early intervention and other programs were not modeled where recent rate studies, established reimbursement methodologies, or data limitations made additional cost modeling duplicative or less informative.

Two Ad Hoc Work Groups, one for child care and one for home visiting, helped identify the cost drivers, workforce needs, and program variables that influence service delivery. Both models incorporate compensation based on the MIT Living Wage for Montana, reflecting the CFA guiding principle of ensuring financial stability for the workforce. Findings from the cost model show:

Child Care Cost Model

Using the state's 2023 cost calculator as a foundation, the updated model estimates costs for child care centers and family child care homes under different scenarios. Each scenario includes base requirements (ratios, training, and benefits) and enhancements such as family engagement, additional professional development, planning time, inclusion supports, transportation, and developmental screenings.

Findings show that current subsidy rates cover only **43 – 61%** of the true cost of care depending on the setting and age group. Gaps are largest for infants and toddlers, even when programs meet higher-quality standards. Raising compensation to a living wage increases stability, retention, and program quality but requires substantial investment ranging from approximately **$76 million** to almost **$744 million**.

Home Visiting Cost Model

The home visiting cost model estimates the true cost of delivering multiple program models across the state, accounting for differences in caseload size, service intensity, and staffing structure. Costs per child vary based on the intensity of the program model, with personnel expenses representing the largest share of total costs. The model also includes optional enhancements such as infant and early childhood mental health consultation, trauma-informed practices, and dual-language pay differentials.

Results demonstrate that existing contracts and funding levels fall below what is required to sustain

evidence-based models and compensate home visitors at a living wage by almost **$7 million**. Expanding home visiting to reach all Medicaid-eligible births, and eventually universal touch services for all families, will require coordinated investments ranging from over **$47 million** to almost **$57 million**.

Systemwide Cost Scenarios

To connect program-level data to statewide needs, system cost estimates were developed combining child care and home visiting data to estimate the total cost of a comprehensive prenatal to five system. Three incremental phases were developed, aligned with the CFA's fiscal vision and principles:

1. **Phase 1 – Stabilize the Workforce:** Increase payment rates to reflect the true cost of care and support living wage compensation or the current number of children and families served. **Estimated annual cost: $91 million**
2. **Phase 2 – Expand Access:** Extend access for families at or below the 185% of the federal poverty level and all Medicaid-eligible births, maintaining living wage salaries. **Estimated annual cost: $377.5 million to $646 million**
3. **Phase 3 – Achieve Universal Access:** Fund access to child care for all children birth through age five with all available parents in the workforce and provide home visiting for all Medicaid-eligible births plus 60% of all other births through a universal touch model. **Estimated annual cost: $743.7 million**

Each scenario includes infrastructure costs ranging between 8% and 10% to cover monitoring, quality supports, and administration, as well as family contributions for child care capped at 7% of income, consistent with federal affordability standards.

The cost modeling results demonstrate that achieving Montana's fiscal vision will require significant and strategic new investment. Current funding levels fall far short of the true cost of care and services, especially in infant and toddler child care and home visiting. By quantifying these costs and identifying funding gaps, the CFA provides Montana with a clear, transparent foundation for aligning future fiscal decisions with the real cost of delivering high-quality, equitable prenatal to five services.

Recommendations

Based on fiscal mapping, cost modeling, and extensive engagement, seven key themes emerged that reflect shared priorities across Montana's prenatal to five system: access, authentic engagement, investing in the true cost, workforce investment and support, comprehensive family supports, cultural and Tribal partnership, and system capacity. These themes informed three overarching recommendation areas – Access, Workforce, and System – that together provide a roadmap for a cohesive, sustainable, and equitable prenatal to five system.

1. **Access – Increase access to quality, responsive prenatal to five programs and services.** Montana families need affordable, available, and culturally responsive services regardless of geography or income. Recommended strategies include expanding program capacity, simplifying eligibility and enrollment processes, strengthening preschool to third grade alignment, and increasing investment in family engagement, navigation, and mental health supports.
2. **Workforce – Explore long-term strategies, including public investment, to attract and retain prenatal to five professionals.** The CFA identified compensation gaps and workforce shortages that threaten program

quality and sustainability. Recommendations include establishing wage and benefit benchmarks informed by cost model data, investing in professional development and mental health supports, expanding career pathways, and strengthening leadership capacity at all system levels.

3. **System – Invest in the efficiency, flexibility, and coordination of services and system.** Building an effective prenatal to five system requires strong infrastructure and collaboration across sectors. Strategies include increasing policy flexibility to reflect local and Tribal contexts, establishing continuous feedback loops, using true cost data to guide fiscal decisions, building trust-based relationships with communities and Tribal Nations, and coordinating funding across sectors to meet whole-child, whole-family needs.

Together, the CFA findings and recommendations create a path for a stronger, more coordinated prenatal to five system in Montana. By aligning fiscal decisions with true cost data, Montana can advance its vision of equitable access, a thriving workforce, and sustainable investment in young children and families.

I. Introduction

The first five years of a child's life are some of the most critical in their development.[i] However, the programs and systems that serve young children face persistent underinvestment and many pregnant women and families with young children struggle to access or afford the cost of services to meet their children's needs.

The complexity of multiple funding streams in the prenatal to five system, each with its own requirements, has created a system that is difficult for families to navigate and challenging for providers to sustain. These challenges fall hardest on children and families who are farthest from opportunity.

To better understand and address these financing challenges, the Montana Department of Public Health and Human Services (DPHHS) and Zero to Five Montana partnered with Prenatal to Five Fiscal Strategies (P5FS) to conduct a comprehensive fiscal analysis (CFA) of the prenatal to five system. The CFA set out to answer four central questions:

1. What funding currently supports prenatal to five services in Montana?
2. How are these funds being used?
3. What is the true cost of delivering services for children and families?
4. What opportunities exist to better coordinate, streamline, and maximize funding?

To answer these questions, the CFA includes a fiscal map of existing funding streams,

cost models for child care and home visiting services, and a system level analysis. The cost models estimate the true cost of services at varying levels of quality and intensity, including the workforce compensation necessary to recruit and retain qualified staff. Together these tools provide a clear picture of what it would take to build and sustain a high-quality prenatal to five system across Montana.

The Need for a Comprehensive Fiscal Analysis

Building and sustaining a prenatal to five system requires a clear understanding of how services are financed. Montana has made steady progress in building a prenatal to five system, supported by state and federal investments, community leadership, and partnerships with Tribal Nations.[ii] At the same time, the financing that underpins this system remains complex.

Montana's prenatal to five programs and services rely on a complex mix of federal, state, local, and private funding streams. Each source comes with its own requirements and limitations, which can create inefficiencies, duplication, and gaps in access.[iii] While these resources are essential, their fragmented nature can make it harder for providers to plan long-term and coordinate services, and for families to fully access what they need.[iv]

Montana is not alone in facing this challenge. The 2018 National Academies of Sciences, Engineering, and Medicine report *Transforming the Financing of Early Care and Education* highlighted how these fragmented financing mechanisms across the United States contribute to challenges in access, affordability, quality, and cultural responsiveness.[v]

These issues can be magnified in Montana by the state's rural geography and the importance of honoring Tribal Sovereignty. Communities are resourceful, but workforce shortages and reimbursement structures that do not always reflect the true cost of services create persistent pressures on providers.

A CFA offers an opportunity to understand these challenges better, providing a clearer picture of the financing system. By examining the funding streams that support prenatal to five programs and modeling the true cost of services, the CFA provides the information needed to strengthen the prenatal to five system and ensure children, families, and providers are supported in every community.

The Prenatal to Five Landscape in Montana

Montana has a long-standing commitment to understanding what it truly costs to provide quality prenatal to five services and to using that knowledge to shape more innovative and effective policies. In 2015, DPHHS developed a Cost of Care Calculator to help child care programs participating in the state's Quality Rating and Improvement System, formerly STARS to Quality, better understand the financial realities of delivering high-quality care. Building on that effort, Zero to Five Montana partnered with P5FS in 2023 to update and expand the tool into a statewide Cost of Care Modeling Tool that reflects today's workforce and program needs.

Montana by the Numbers	
1,137,233 people live in Montana[vi] 68,644 (6%) are children under age six[vii] 11,345 babies are born each year[viii] 7,000 (11%) of children birth to five live in poverty[1] [ix]	44,000 (69%) children under age six have all available parents working[x] 4,607 (41%) of births are covered by Medicaid funding[xi]

In 2023, Montana received a Preschool Development Grant Birth through Five (PDG B-5) Renewal Grant.[xii] Administered by DPHHS, the PDG B-5 funding focused on building a stronger, more connected early childhood system by strengthening coordination, reducing duplication, and investing in workforce recruitment, retention, and expansion. The initiative also emphasizes system-building activities that ensure families, especially those in rural and Tribal communities, can access high-quality prenatal to five services.

The enactment of House Bill 924 (HB 924) (2025) further advances Montana's commitment to sustainable funding for young children by establishing the Montana Early Childhood Special Revenue Account, the state's first dedicated fund for early childhood. The legislation creates the account within the state special revenue fund, managed by DPHHS, and directs a portion of interest earnings from the Montana Growth and Opportunity Trust ("GO Trust") fund into this account, up to $15 million annually, to support early childhood programs and grants.[xiii] The law also establishes an Early Childhood Account Board to oversee grantmaking and align investments with the state's early childhood priorities.[xiv]

While the statute authorizes deposits of up to $15 million per year, current fiscal projections estimate that approximately $2.3 million will be available for Early Childhood Account Board administration and grantmaking in state fiscal year 2026, with modest increases projected in subsequent years as GO Trust earnings grow.[xv]

HB 924 also signals a shift toward a more intentional state role in supporting Montana's mixed-delivery prenatal to five system. The account's flexible funding design enables investments not only in expanding access to early learning and family support services but also in workforce recruitment, retention, and compensation. By linking the account's revenue to ongoing trust earnings, Montana has positioned itself to build a more stable, adaptable, and high-quality prenatal to five system over time.

These efforts show Montana's commitment to improving the prenatal to five system. However, families continue to struggle with affordability and access, while providers grapple with low compensation, workforce shortages, and limited resources. At the same time, Montana's rural geography, Tribal sovereignty, and population dynamics create unique conditions that require tailored approaches.

[1] Poverty is defined at 100% of the Federal Poverty Guideline (FPG), income thresholds used by the federal government to determine eligibility for various programs and benefits. The guidelines are adjusted annually based on the Consumer Price Index and vary by family size. The FPG for 2024 was $31,182 for a family of four with two children.

Montana's prenatal to five system faces unique conditions:

- Rural geography and limited providers in many communities.
- Tribal sovereignty requires funding approaches that respect local priorities.
- Workforce shortages with difficulties in recruiting and retaining staff.

By embarking on this CFA, Montana recognizes that the state's prenatal to five system faces persistent challenges that cannot be solved by small adjustments alone. By integrating cost modeling, fiscal mapping, and system analysis, the CFA provides a clear picture of what it will take to sustain a high-quality prenatal to five system in Montana, one that reflects the state's values, meets the true cost of services, and ensures children and families across Montana can thrive.

Understanding the True Cost of Services

Discussions about the "cost" of prenatal to five services often focus on what families can afford to pay (the *price*) on what programs are reimbursed through contracts or grants (the *rate*). While important, these figures do not reflect the *true cost* of delivering services that meet the needs of children and families. The true cost not only includes staff time and materials, but also the resources needed to sustain programs, recruit and retain a qualified workforce, and ensure services meet the quality and intensity of services that families need and want.

Because funding typically falls short of actual costs, providers have adapted in creative but unsustainable ways by taking on extra duties, working unpaid hours, relying on donated materials, or keeping wages low to balance budgets. While these efforts demonstrate the deep commitment of Montana's prenatal to five workforce, they also highlight the need for a more accurate and sustainable approach to financing.

This underfunding shows up in several ways:

- Wages that fall below a living wage.
- Limited access to benefits for the prenatal to five workforce.
- Payment rates are tied to available funding rather than the actual cost of delivering services.

Defining Terms

PRICE: the tuition prices the market can bear, what families can afford to pay, or the value of available grants and contracts. These depend on competitive rates in programs' local markets, ensuring that programs can operate as close to full enrollment as possible, or on the available revenue for contracting out services.

COST: the actual expenses for operating programs. Program costs are typically higher than the price, rate or contract amount paid. Costs may be subsidized by other programs within the same organization, staff working more hours than they are compensated, or by in-kind support such as discounted or free rent or donated services from family or friends.

TRUE COST: the cost of operating a program with the staff and materials needed to meet regulatory and program standards and provide the program intensity and quality reflective of the needs of the children and families served. The true cost includes adequate compensation to recruit and retain a professional and stable workforce.

- A system that places heavy demands on women, particularly those already living with limited resources.
- Fragmentation across sectors and competition for limited funds make coordination more difficult.

Setting public funding rates based on cost provides a clearer and sustainable path forward. A cost-based approach that is informed by cost models can provide data on the true costs of delivering services, and any gaps between that cost and the available revenues, including how those gaps vary by program or community characteristics[xvi] By combining provider input, program data, and local context, cost models offer a transparent view of the true cost of delivering quality services. They also highlight how changes in compensation, quality enhancements, or service intensity affect costs, and where gaps exist between current revenue and actual expenses. Importantly, cost models shine a light on the financial realities programs face, demonstrating why the true cost of care in this labor-intensive sector is significantly higher than what current funding levels, or families, can cover.

Cost Model

A cost model is a customized functional and dynamic tool, such as an Excel workbook or online calculator, designed to determine the cost of implementing a prenatal to five system, program, or service. Cost modeling can estimate how costs vary based on program characteristics and policy changes and can integrate revenue data to demonstrate any gaps between costs and revenue.[xvii]

In most states, child care subsidy reimbursement rates a are set using market rate surveys, which reflect the tuition rates child care programs charge families. This market-based approach captures what families can afford to pay, rather than the true cost of providing care. In many communities, providers must keep tuition low to meet the financial constraints of families; as a result, market prices often fall short of what is needed to adequately compensate the child care workforce or cover the full cost of operating a program.

When setting child care assistance rates based on the market prices, the inadequacy of tuition rates is carried forward into the child care subsidy rate. The impact of the market-based approach to rate setting falls disproportionally on programs in regions with the lowest socioeconomic status, where the income levels translate into the lowest tuition rates and, therefore, the lowest subsidy reimbursement rate.

Since the 2014 reauthorization of the federal Child Care and Development Block Grant Act, the primary source of funding for Best Beginnings Child Care Scholarship Program, states have had the option to use cost to inform subsidy rates rather than market prices. This approach helps ensure public funding reflects the real cost of care and avoids reinforcing inequities in the private market.[xviii]

Similar challenges exist in home visiting, parenting education, and family support programs. Revenue is typically determined by contracts or fee-for-service models set based on available revenue for the service, not the cost of the service. Additionally, these contracts are limited in their total resources and cannot account for rising costs over time, so the payment amounts become increasingly inadequate to cover service costs over time. Program staff frequently stretch to meet family needs, taking on high-stress work without adequate compensation and working hours well beyond their compensated work week to deliver services to families and meet all the program requirements. Recruiting and retaining qualified staff is especially difficult when other jobs, even outside the field, offer higher pay

with less stress. The result is a persistent funding gap between what programs are paid and the actual cost of providing services.

Understanding the true cost of services is essential to closing these gaps. By making visible the real resources required, cost models provide Montana with the tools to design financing strategies that value the workforce, sustain programs, and ensure families have access to high-quality prenatal to five services across Montana.

Comprehensive Fiscal Analysis Approach

A comprehensive fiscal analysis, or CFA, is designed to look across the entire prenatal to five system, promoting systemwide thinking and uncovering how programs, services, and funding streams interact. Rather than focusing on isolated programs, the CFA examines the whole picture – where investments are working well, where gaps remain, and how resources can be better aligned to meet the true cost of services.

As a foundation for the work, a **fiscal vision and guiding principles** are developed to anchor the analysis. The fiscal vision describes what a well-financed prenatal to five system should achieve for children, families, providers, and communities. The guiding principles articulate the values that drive decision-making.

The CFA process developed by Prenatal to Five Fiscal Strategies (P5FS) combines three key components:

1. **Fiscal Mapping** to capture the scope of current investments, including federal, state, local, Tribal, and private funding, and to identify both limitations and opportunities to maximize existing dollars.
2. **Cost Modeling** to estimate the true cost of services at the program and system levels, using provider and constituent input to reflect real-world conditions, workforce needs, and program quality goals.
3. **System Analysis** to connect the findings, highlight cross-cutting challenges, and assess where financing strategies can better support access and quality across Montana.

Throughout these components, constituent engagement guides the process, ensuring the voices of providers, families, Tribal Nations, and community leaders shaped the analysis at every stage.[2] Engagement creates feedback loops that ground the CFA in lived experience and helps to define the fiscal vision, guiding principles, and recommendations. As illustrated in Figure 1, these elements together provide Montana with a clear, actionable understanding of its prenatal to five financing system, which is used to inform recommendations that advance the state's shared fiscal vision and guiding principles.

Grounded in this framework, Montana's CFA is designed to support the state's vision for early childhood: *Every Montana family has the opportunity to choose, use, and engage with early childhood services to meet their family's and children's needs and interests from pregnancy through age eight.*[xix] This vision guides strategies to maximize investments in early experiences for young children, support the adults who care for them, improve compensation for the prenatal to five workforce, remove barriers to access for families, and advance equity across the state.

[2]P5FS uses the term constituent instead of *stakeholder*, where possible, to describe those directly involved in the project and those most impacted by the system, programs, and services studied. See Section II: Montana Prenatal to Five Comprehensive Fiscal Analysis Leadership and Engagement for further explanation.

Figure 1: Components of Comprehensive Fiscal Analysis

Comprehensive Fiscal Analysis

Fiscal Mapping	Cost Modeling	System Analysis
• Review extant data on federal, state, Tribal, and local public funding streams • Conduct key informant interviews with fund administrators • Products include a fiscal map and summary analysis charts	• Collect data from providers, diverse delivery, across the state • Engage providers to obtain detailed understanding of revenue and expenses • Develop cost model frame to inform the models • Products include child care and home visiting direct service and system cost models	• Analyze existing strategic plans for intersection with fiscal and governance system change • Engage constituents in planning for response to CFA • Apply an equity frame to analyzing system approach and developing recommendations • Products include gap analysis of systemic approach, governance, and fiscal needs; others as need determines

Constituent Engagement

Overview of the Comprehensive Fiscal Analysis Report

This report details the results of the CFA, including recommendations for advancing the prenatal to five system in Montana. Section II describes the project's leadership and how Montanans were engaged at all stages. Section III presents the fiscal vision and principles that guided the analysis. Section IV presents a fiscal map of existing funding that supports direct service programs and system-building initiatives for children under five and their families in Montana, including narrative and table summaries. Section V presents a cost analysis for child care and home visiting programs, including cost estimates of the true cost of services from the child care and home visiting direct service and system cost models. Finally, Section VI presents findings and recommendations drawn from constituent input and analysis of the prenatal to five system.

II. Montana Prenatal to Five Comprehensive Fiscal Analysis Leadership and Engagement

Constituent engagement is a cornerstone of a comprehensive fiscal analysis, ensuring that funding decisions reflect the real needs and priorities of families, providers, and communities. Engaging parents, providers, advocates, and policymakers surfaces critical insights into funding gaps, service accessibility, and the impact of financial policies.

Constituent[3] engagement was an essential component of Montana's Prenatal to Five Comprehensive Fiscal Analysis (CFA).[xx] Because the prenatal to five system touches families, providers, Tribal Nations, community leaders, and state partners in different ways, it was essential to bring a wide range of voices into the process.

[3]P5FS intentionally uses the term *"constituent"* rather than *"stakeholder,"* where possible, to describe individuals and entities within the system who are directly involved in and most impacted by programs, services, and system decisions. While *"stakeholder"* is commonly used in policy and planning contexts, it can sometimes suggest a more indirect or transactional relationship. The term 'constituent' is used to emphasize the people and communities who experience and shape Montana's prenatal to five system – children, families, providers, Tribal Nations, and community leaders – as active participants. This language reflects a commitment to centering lived experience, shared responsibility, and collective agency in shaping the design, implementation, and future of the prenatal to five system.

Through work groups, community discussions, Tribal consultations, and interviews, Montanans helped shape the fiscal vision, guiding principles, fiscal mapping, cost modeling, and recommendations in this report. Their input provided critical insight into how funding flows affect programs on the ground, what families experience when navigating the system, and where opportunities exist to strengthen access, equity, and quality.

Montana Comprehensive Fiscal Analysis Engagement

The Montana CFA was launched in May 2024. The full day, in person, launch included an overview of the CFA process, key activities, anticipated outcomes, opportunities for input, and alignment with other statewide initiatives, such as the Preschool Development Grant Birth through Five (PDG B-5) activities.

Comprehensive Fiscal Analysis Work Group

To guide the Montana CFA, a Comprehensive Fiscal Analysis Work Group (CFA Work Group) was convened. Members represented diverse sectors of the prenatal to five system, including child care, early intervention, home visiting, maternal and child health, special health care needs, Tribal policy, advocacy, and economic development. A full roster of CFA Work Group members is provided in Appendix A.

The CFA Work Group launched in May 2024 and met regularly between August 2024 and September 2025. Its role was to guide and support decision-making throughout the CFA, ensuring the process reflected both technical expertise and community realities.

Constituent Updates

Broader input was gathered through open-invitation Constituent Update meetings. In addition to the in-person launch meeting in May 2024, virtual constituent update sessions were held in November 2024, March 2025, May 2025, and November 2025. These meetings allowed providers, state partners, legislators, and community members to hear updates, provide feedback on draft cost model elements, and weigh in on priorities and recommendations.

Technical Ad Hoc Groups

In addition to the CFA Work Group, two targeted groups provided technical expertise on cost modeling, priorities, and recommendations.

- **Child Care Ad Hoc:** Comprised of CFA Work Group members and child care providers, this group met four times between December 2024 and May 2025 to inform the assumptions and structure of the Montana Child Care Cost Model.
- **Home Visiting Ad Hoc:** Comprised of CFA Work Group members, home visiting program administrators, and providers, this group met four times between February and May 2025 to guide the development of the Montana Home Visiting Cost Model.

The P5FS team also met with the Home Visiting Coalition three times to ensure the perspectives of all home visiting models and programs implemented in Montana were reflected. Feedback from these groups directly shaped cost model inputs, assumptions, and recommendations.

A list of meeting dates for the CFA Work Group, Constituent Update meetings, and Technical Ad Hoc groups is in Appendix B.

Fiscal Mapping Interviews

To inform the fiscal mapping and analysis, the P5FS team conducted interviews with state and local fund and program administrators for each prenatal to five program and service in Montana. These interviews provided critical context on how funds are allocated, the challenges administrators face in managing them, and opportunities to better coordinate resources. A complete list of interviews conducted is in Appendix C.

Alignment with Preschool Development Grant Birth through Five

To ensure alignment across Montana's prenatal to five initiatives, the CFA also drew on data from the state's PDG B-5 grant. The Montana Department of Public Health and Human Services (DPHHS) shared data collected through the Needs Assessment Update process to ensure system and provider data were incorporated into the CFA. The P5FS team attended a webinar and met with the Rural Institute Research and Evaluation team at the University of Montana, the organization responsible for finalizing the Needs Assessment Update and Strategic Plan, to coordinate recommendations and avoid duplication.

This extensive engagement process helped ensure the CFA was grounded in lived experience. The input received informed every component of the CFA – from shaping the fiscal vision and guiding principles to refining assumptions in the cost models and identifying opportunities for systems change. By involving families, providers, Tribal Nations, community leaders, and policymakers throughout the process, Montana's CFA reflects the realities on the ground and builds a stronger foundation for equity, accountability, and long-term sustainability in the state's prenatal to five system.

III. Fiscal Vision and Guiding Principles for the Prenatal to Five System in Montana

Establishing a fiscal vision was a critical early step with aligning Montana's prenatal to five system with fiscal strategies work. By developing this vision and the guiding principles that accompany it, partners across programs and sectors created a common frame to guide fiscal decision making, promote collaboration, and ensure resources are used strategically to support the state's priorities.

To meet the complex needs of children and families within a prenatal to five system, communities must establish a clear fiscal vision to increase investments, optimize the use of existing resources, and create funding and governance structures that maximize efficiency while reducing administrative burdens.

A fiscal vision, paired with guiding principles, serves as a "north star" for future work, anchoring decisions in shared values and long-term goals. Prenatal to Five Fiscal

Strategies (P5FS) facilitated discussions among the members of the Montana Prenatal to Five Comprehensive Fiscal Analysis Work Group (CFA Work Group) to develop this fiscal vision and set of guiding principles within the context of existing statewide efforts to support young children across the health, education, and family strengthening fields. Additional feedback was gathered through Constituent Update webinars.

The fiscal vision and guiding principles developed through this CFA align closely with the state's broader vision[4] and mission[5] for Montana's early childhood system.[xxi] Both emphasize data-informed decision-making, the efficient and sustainable use of resources, and reducing administrative burden for families and providers. The fiscal vision complements this statewide approach by focusing specifically on how financing structures can make these goals achievable ensuring funding systems are stable, equitable, and designed to sustain high-quality programs over time.

Fiscal Vision for Montana's Prenatal to Five System

A sustainable prenatal to five system that **meets the needs of every child and family** and is supported by **sufficient and stable funding** streams that provide maximum **flexibility** for families, **efficient administration** and infrastructure, and **minimum burden** for families and program providers.

This fiscal vision is supported by guiding principles specifying what a system that meets this vision will do. The principles drive the important work of a cohesive, equitable, and effective prenatal to five system to best support families and young children. Participants in each of the engagement activities – the CFA Work Group, Constituent Update Webinars, and topical Ad Hoc groups – acknowledged that supporting the healthy development of young children requires collaborative partnerships across many entities that impact these critical years of a child's life to ensure access to the highest quality services for all young children and their families.

[4]Vision for the Early Childhood System – Every Montana family has the opportunity to choose, use, and engage with early childhood services to meet their family's and children's needs and interests from pregnancy through age eight.

[5]Mission for the Early Childhood System – Sustain and strengthen Montana's comprehensive early childhood system by engaging families and supporting the early childhood workforce to improve young children's health, well-being, and developmental outcomes.

Guiding Principles for Montana's Prenatal to Five Fiscal Vision

A system that...

- works for and **positively impacts** all children and families ensuring programming reaches children and families **when they need it** including prenatal and **parental supports** for expectant families.
- is fair, **equitable**, and **accommodating** to providers and supports their developing capacity, well-being, and expertise to meet the complex and diverse needs of all children and families through high-quality, individualized care and services.
- uses public resources wisely and efficiently, augmenting with private resources to build **universal access** to services.
- recognizes that **societal context** affects all Montana children, families, and communities and commits to implementing changes to remove systemic barriers to ensure access, experiences, and outcomes.
- compensates the workforce at a level that allows for financial stability and acknowledges their **expertise** and significant impact on child development.
- supports the entirety of a child's and family's experiences **before entering kindergarten**, during the **transition to kindergarten**, and **through grade three**.
- addresses and supports the **role of the local community** to inform and implement policies and practices.
- actively engages and supports all communities, with particular attention to **rural areas and Tribal Nations**, seeking to understand and provide **culturally responsive care** while addressing barriers to access.
- is **collaborative** and **driven by the voices** of those impacted by the system with families, providers, communities, and the private sector as equal partners ensuring all voices are heard and valued in the decision-making process.
- establishes **clear and open communication** channels among families, providers, educators, policymakers, and community members, implementing **regular feedback loops** to gather input, address concerns, and make adjustments so the system remains **responsive and adaptive** to the evolving needs of children and families.
- is informed by accurate, timely, and relevant **data** and designed for long-term **sustainability** ensuring programs are efficient, financially viable, scalable, and resilient, while streamlining processes to minimize administrative burden for families and providers.

The CFA fiscal vision and guiding principles were reviewed throughout the process. Routinely, these draft statements were returned to, as new information and data emerged in the CFA work, the accuracy and applicability of the vision and principles were reviewed and revisions were made as needed. In completing the analysis of the fiscal mapping and cost modeling, the information from these sources was considered in light of the 'goals' laid out in the fiscal vision and principles. This analysis in the context of the vision and principles guided the development of recommendations and sought to ensure the relevance of the vision, principles and recommendations from the CFA to the full Montana prenatal to five system.

IV. Fiscal Mapping and Analysis

A prenatal to five fiscal map presents the current funding streams supporting programs and systems serving pregnant women and children from birth to age five and their families, organized by direct service programs and system supports with funding source and amounts, administrator, and funded capacity.

Fiscal mapping provides Montana with a view what resources are allocated to support young children and families. By analyzing total funding data, the state gains a clearer understanding of how dollars flow, how they are used, and the total reach of services funded.

To create a fiscal map for Montana's Prenatal to Five Comprehensive Fiscal Analysis (CFA), the Prenatal to Five Fiscal Strategies (P5FS) team reviewed documents such as budgets, contracts, program requirements, grant reports, program evaluations, needs assessments, and publicly available state and local data for state and federal fiscal years 2023 – 2024 and 2024 – 2025 (FY24 and FY25). Data included in fiscal mapping were selected from a one year spanning two fiscal years using the most recently available data. In addition, P5FS conducted approximately 30 interviews with prenatal to five system and program administrators. Input and feedback from the CFA Work Group identified areas for further exploration and discussion to support the development of a fiscal map.

The fiscal mapping and analysis conducted for this CFA focused on direct service programs and system supports specifically designed for families and children from prenatal to age five. Programs and services included in fiscal mapping include early care and education programs; family strengthening programs providing home visiting, parenting education, and family support services; and system supports.[6] Document review and interviews explored the funding source and amount, financial and program requirements, and child or family service capacity for each included funding stream. Each program and service included in the fiscal map is listed in Table 1.

Table 1: Programs, services, and system supports included in fiscal mapping

Type	Program
Early Care and Education*	Best Beginnings Child Care Scholarship Program
	Montana Milestones Part C Early Intervention Program
	Head Start and Early Head Start Programs
	Head Start and Early Head Start Programs – American Indian Alaska Native
	Head Start State Collaboration Office
Family Strengthening	Healthy Montana Families
	Child Abuse Prevention/Children's Trust Fund
	Early Head Start Home-Based Option
	Early Head Start Home-Based Option – American Indian Alaska Native
System Building Initiatives	Infant and Early Childhood Mental Health Consultation
	Montana Budget and Policy Center/KidsCount
	Montana Advocates for Children
	Professional Development, Training, and Technical Assistance • Equity, Inclusion, and Justice • Trauma-Informed Care • Annual Perinatal Health Conference • Early Childhood Tribal Language Summit
	Montana Early Learning Alliance
	Montana Home Visiting Coalition
	Early Childhood Tribal Coalition
	Montana Early Childhood Coalitions
	Montana Early Childhood Network
	Montana Trauma-Informed Early Childhood Advisory Coalition
	Policy, Advocacy, and Research
	Montana Doula Collaborative
	Workforce Recruitment and Retention Project

[6]Family strengthening programs are evidence-based or evidence-informed programs, services, and initiatives aimed at enhancing the stability, health, and well-being of families with the goal to support families in overcoming challenges and building resilience so they can thrive. Family strengthening programs and services included in this CFA include Early Head Start Home-Based Option, Exchange Parent Aide, Family Spirit, Nurse-Family Partnership, Parents as Teachers, Safe Care, the Universally Offered Home Visiting Pilot, and Welcome Baby. Child abuse prevention efforts, including those supported by the Children's Trust Fund, are also part of Family Strengthening fiscal mapping.

*Data for Early Childhood Special Education, Title I, and Early Literacy Targeted Interventions[7] were not available from the Office of Public Instruction (OPI) and therefore were not included in the fiscal mapping. Coordination with OPI will be important in future analyses to ensure a more comprehensive understanding of early learning investments administered through the education system.

Preschool Development Grant Birth through Five Funding

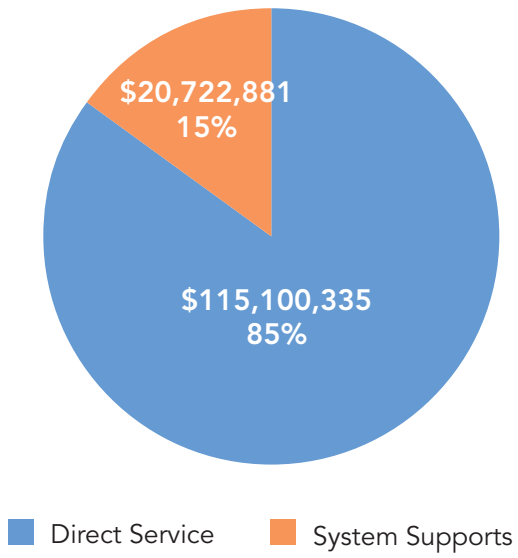
In addition to the programs, services, and system supports identified above, Montana received its Preschool Development Grant Birth through Five Renewal Grant (PDG B-5) on December 31, 2022, providing $24 million over three years, spanning 2023–2025. Initiatives funded through PDG B-5 supported increased quality and access to prenatal to five programs and services, family engagement, and system-building activities such as enhancing data systems, workforce development, and coordination. Most PDG B-5 funding is not included in the total fiscal map because it is nonrecurrent. Some programs and services may include PDG B-5 funding if the program or service will continue using other funds in future years and will be noted.

[7]In 2023, the Montana legislature passed an *Early Literacy Targeted Intervention Act*, to increase the number of students reading proficiently by third grade. In 2025, House Bill 338 expanded the program's scope to include numeracy, and the Office of Public Instruction subsequently adopted the broader title *Early Targeted Interventions*. Because the CFA focuses on FY 24 and 25, prior to the enactment of HB 228, the report maintains the original program name, E*arly Literacy Targeted Intervention*. Source: Montana Office of Public Instruction, Early Literacy Resources, https://opi.mt.gov/Educators/Teaching-Learning/Literacy/Early-Literacy-Resources.

Montana Prenatal to Five Funding

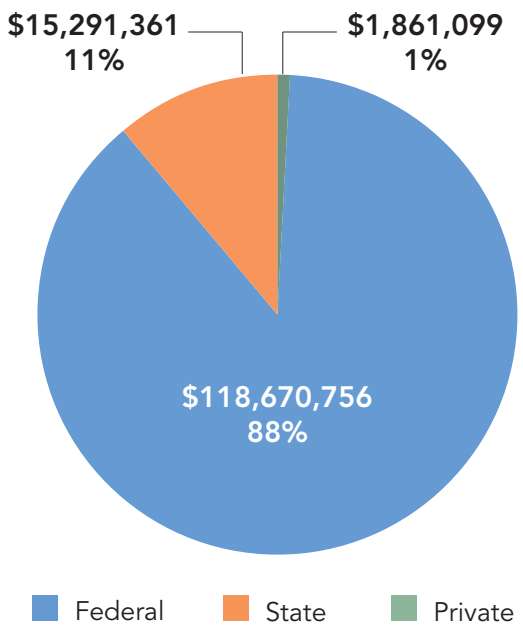
The fiscal analysis identifies total funding amounts by type and source, offering insight into the overall investment in Montana's prenatal to five system. Total funding for prenatal to five services in Montana was approximately $135.8 million annually in FY24. Figure 2 illustrates the percentage and amount, broken down by direct services, service activities delivered directly to children and families, and system supports, activities focused on building capacity, infrastructure, and coordination across agencies and programs. The overwhelming majority of funding, over $115 million, or 85%, is dedicated to direct service activities. This substantial allocation demonstrates a strong commitment to programs and services that have an immediate impact on families and children. Within direct services, early care and education accounts for approximately 94% of total direct service funding, while family strengthening programs represent about 6%. The system investment totals approximately $20.7 million, accounting for 15% of the total resources.

Figure 2: Total and percentage of funding by type, FY24



The total funding can also be broken down by funding source. Shown in Figure 3, federal contributions total approximately $118.7 million, or about 87% of total funding. This level of dependence on federal funding highlights the importance of federal programs and grants for the sustainability of prenatal to five initiatives in Montana. It is important to note that HS/EHS federal funds included in this total do not flow to the state but are awarded directly to local grant recipients. State funding totals approximately $15.3 million or about 11% of the overall amount, complementing federal dollars and shows an ongoing commitment at the state level. The final 1% is provided by private funding, totaling almost $1.9 million. This limited contribution from private and philanthropic sources suggests an area for potential growth and diversification, which could support program stability and increase access to services, even if public funds fluctuate. At the community level, some programs report success in using private dollars to support programs directly and often rely on these funds to maintain operations.

Figure 3: Total and percentage of funding by source, FY24



Direct Service Funding

Direct service prenatal to five programs provide support, resources, and interventions specifically tailored to pregnant women, infants, toddlers, and young children up to age five. These programs aim to promote healthy development, address child development, and support families during this critical period of growth. Direct service funding included in the fiscal mapping consists of the Best Beginnings Child Care Scholarship Program, the Montana Milestones Part C Early Intervention Program, and Healthy Montana Families administered by the Montana Department of Public Health and Human Services (DPHHS), as well as Head Start and Early Head Start programs within local communities. Title I, Early Childhood Special Education, and Early Literacy Interventions administered by the Montana Office of Public Instruction (OPI) are not included in fiscal mapping.

While financial data was not captured for the OPI early childhood funding, there is an opportunity to improve alignment across OPI and DPPHS. OPI administers the state's Title I funds that could support various early learning services, including programming for eligible children from birth to five. OPI implements the Early Literacy Targeted Intervention program through classroom-based, home-based, and Jumpstart early literacy interventions. These programs are essential to Montana's early care and education system, ensuring support for children who need assistance but may not qualify for programs with more stringent eligibility requirements. For this reason, collaboration and clear communication between OPI and DPHHS are critical. By building on their established partnership, both agencies can align efforts and identify strategic opportunities to expand access, strengthen supports, and ensure more equitable outcomes for Montana's children.

Early Care and Education Direct Service Funding

Fiscal mapping data was analyzed by funding source and funding type across early care and education programs. Early care and education programs receive approximately $108.6 million in funding which includes almost $60 million in federal funding for HS/EHS programs in local communities. This leaves nearly $35 million in federal funds for early care and education that are directly administered by the state, in addition to just over $14 million in state funding.

Early care and education programs account for more than half of total direct service investments representing 94% of funding allocated across major initiatives. As shown in Table 2, excluding Head Start and Early Head Start (HS/EHS), the Best Beginnings Child Care Scholarship Program receives the largest share of funding at over $41 million. Montana Milestones Part C Early Intervention program receives over $7.6 million through Medicaid billing, as well as federal Individual with Disabilities Education Act and state funding. HS/EHS programs receive almost $60 million in federal funding flowing directly to local grant recipients.

Table 2: Early care and education direct service funding by type and source, FY24

	Federal	State	Total
Best Beginnings Child Care Scholarship Program	$29,519,372	$11,732,329	$41,251,702
Montana Milestones Part C Early Intervention Program	$5,368,842	$2,271,071	$7,639,913
Early Care and Education Direct Service Subtotal (without HS/EHS)	**$34,888,215**	**$14,003,400**	**$48,891,615**
Head Start/Early Head Start Program	$40,426,718	$0	$40,426,718
Head Start/Early Head Start Programs AIAN	$19,283,295	$0	$19,283,295
Head Start/Early Head Start Subtotal	**$59,710,013**	**$0**	**$59,710,013**
ECE Direct Service Total	**$94,598,228**	**$14,003,400**	**$108,601,628**

Excluding HS/EHS funding, early care and education direct service investments total almost $49 million, of which 84% is for the Best Beginnings Child Care Scholarship Program, as shown in Figure 4. When federal HS/EHS funding for local community grant recipients is included, HS/EHS accounts for the largest share of funding at 55%, followed by the Best Beginnings Child Care Scholarship Program, shown in Figure 5.

Figure 4: Early care and education funding, excluding Head Start and Early Head Start, FY24

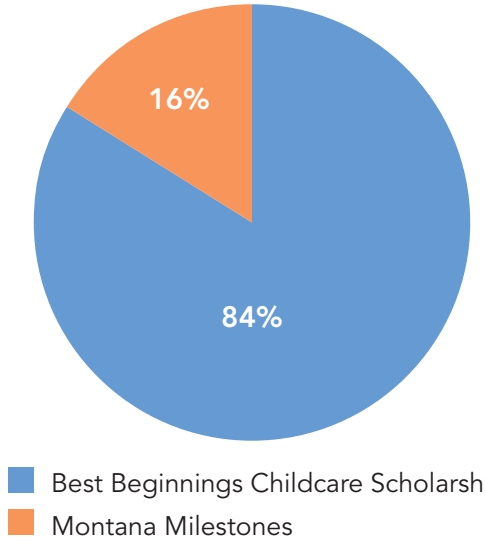
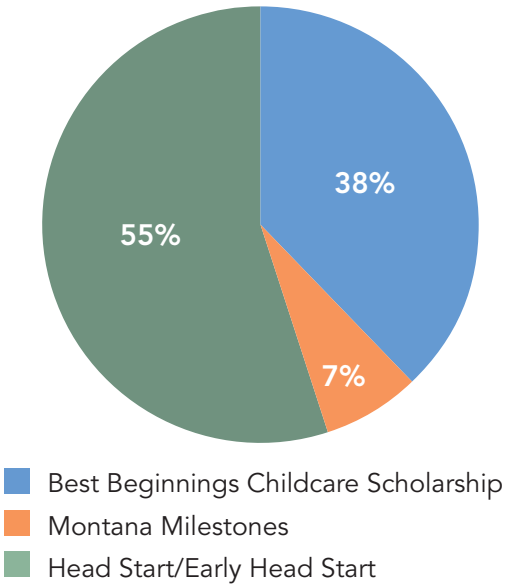


Figure 5: Early care and education funding, including Head Start and Early Head Start, FY24



The fiscal mapping activity conducted for this CFA also included analysis of the number of children and/or families served through each funding stream. This analysis finds that the $108.6 million annual investment supports access to prenatal to five services for approximately 10,350 children in Montana. Table 3 illustrates the distribution of these service numbers across program types, showing almost 50% of the children are served through the Best Beginnings Child Care Scholarship Program.

Table 3: Children served in early care and education direct service programs included in fiscal mapping, FY24

Program	Total Number Served	As Percent of Total
Best Beginnings Child Care Scholarship Program	5,130[xxii]	49.5%
Montana Milestones Part C Early Intervention Program	1,316[xxiii]	12.7%
Head Start/Early Head Start (Local grants, including AIAN)	3,904[xxiv]	37.8%
TOTAL	**10,350**	**-**

The 10,350 children served in early care and education represent approximately 15% of the total population of children under age six in Montana (68,644). Census data shows that around 44,000 children under age six are living in households where all available parents are in the workforce,[xxv] and therefore could reasonably be expected to need access to early care and education services. Current service numbers are reaching only 23.5% of that potential population, with Best Beginnings Child Care Scholarships reaching only about 12%.[xxvi]

Family Strengthening Direct Service Funding

Family Strengthening direct service programs account for around 6% of total direct service funding in Montana. The fiscal mapping data was analyzed by funding source and funding type across these family strengthening programs. Family strengthening programs and services receive approximately $6.5 million for Healthy Montana Families, the state's Maternal Infant Early Childhood Home Visiting program (MIECHV); Child Abuse Prevention/Children's Trust Fund programs; and EHS Home-Based. Of this $6.5 million, 95% are federal funds, including almost $2.5 million for EHS Home-Based. Table 4 shows the programs and associated funding included in this service area.

As shown, the largest funding stream for family strengthening programs in Montana is the federal MIECHV grant. This MIECHV supported initiative implements four national models and 18 programs in 16 counties across the state. In addition to MIECHV funding, local grant recipients receive over $2.4 million in federal funding for EHS Home-Based programming, which provides intensive home visiting services for families with higher risk factors. EHS Home-Based funding is also shown separately because the federal funds flow directly from the U.S. Department of Health and Human Services, Office of Head Start to local grant recipients and are not administered by the state. The Child Abuse Prevention/Children's Trust Fund, administered by DPHHS, provides $306,909 in direct service funding from a mix of federal and state dollars. These funds are awarded to local, community-based nonprofits to provide primary and secondary prevention programs, resources and education for families, and support/intervention for at-risk children.

Table 4: Family strengthening direct service funding by program and source, FY24

	Federal	State	Total
Healthy Montana Families	$3,426,804	$300,249	$3,727,053
Child Abuse Prevention/Children's Trust Fund	$282,000	$24,909	$306,909
Family Strengthening Direct Service Subtotal	**$3,708,804**	**$325,158**	**$4,033,962**
Early Head Start Home-Based Option	$2,289,779	$0	$2,289,779
Early Head Start Home-Based Option AIAN	$174,965	$0	$174,965
Early Head Start Home-Based Subtotal	**$2,464,744**	**$0**	**$2,464,744**
FS Direct Service Total	**$6,173,548**	**$325,158**	**$6,498,706**

As shown, of the almost $6.5 million invested in family strengthening direct services, Healthy Montana Families accounts for 57% of the funding. EHS Home-Based is 38% of the total funding, and Child Abuse Prevention/Children's Trust Fund receives 5% of the total amount. Figure 6 illustrates the percentage of total funds for each specific program, and Figure 7 shows the percentages without EHS Home-Based funding.

Figure 6: Family strengthening funding, including Early Head Start Home-Based Option, FY24

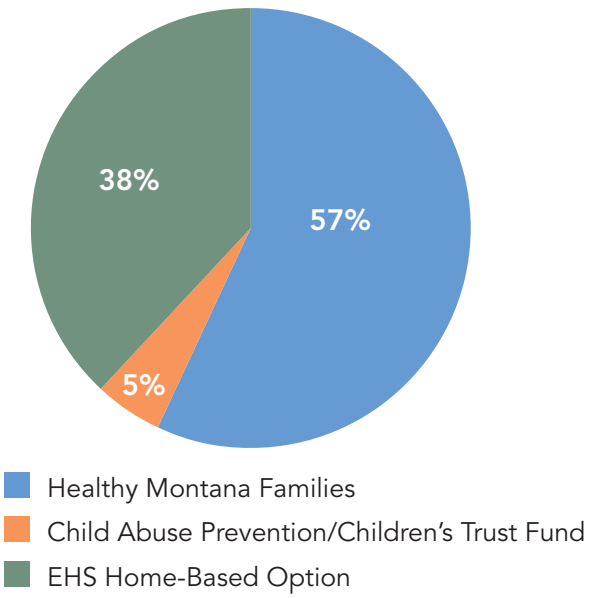
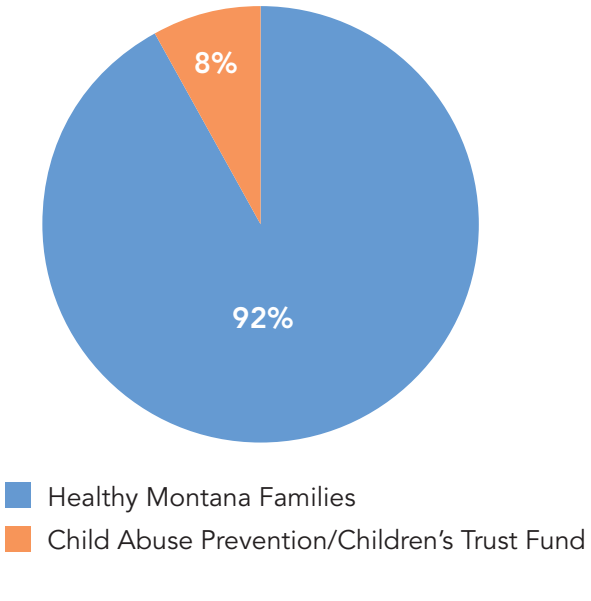


Figure 7: Family strengthening total funding, excluding Early Head Start, FY24



Through investments in family strengthening programs, a total of 1,071 children were served in FY24 through home visiting services, and a total of 1,233 caregivers and 1,385 children through the Children's Trust Fund and Child Abuse prevention programming, shown in Table 5.

Table 5: Children served in family strengthening direct service programs included in fiscal mapping, FY24

Program	Total Number Served
Early Head Start Home-Based Option	124[xxvii]
Healthy Montana Families	947[xxviii]
Children's Trust Fund (CTF)/Child Abuse Prevention Community Response	CTF: 1048 caregivers,1074 children Community Response: 185 caregivers, 311 children[xxix]

Montana has approximately 11,345 births[xxx] each year, with 41% of those births covered by Medicaid funding.[xxxi] The fiscal data illustrates a small percentage of the births are served by family strengthening programs currently (approximately 10% with home visiting and approximately 20% with CTF services), which points to a need for additional funding for various types of family strengthening services, from intensive home visiting models designed to serve those family with high needs, to universal touch home visiting models that benefit all families.

System Supports

Investing in system supports for Montana's prenatal to five system is a critical component to ensuring long-term quality, stability, and capacity across the state. Current investments in system supports total approximately $20.7 million annually, with funds coming from federal, state and private sources, shown in Table 6.

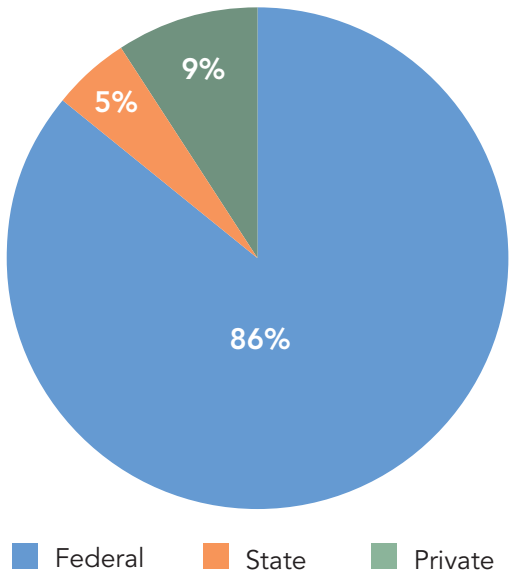
Table 6: System type funding by source

System Funding	Federal	State	Private	Total
Early Care and Education	$15,055,619	$732,069	-	$15,787,688
Family Strengthening	$2,843,361	$230,733	-	$3,074,094
System Building Initiatives	-	-	$1,861,099	$1,861,099
Total	**$17,898,980**	**$962,802**	**$1,861,099**	**$20,772,881**

Of the total system investments, 86% are from federal sources, 5% from state funds, and 9% from private sources. System supports funding helps create a strong foundation for professional development, community infrastructure, and robust data systems across the prenatal to five system. Beyond specific supports for early care and education and family strengthening, almost $1.9 million in private philanthropic dollars is dedicated to general infrastructure that supports the overall system funded by. By focusing resources on these key areas, Montana can support the workforce and ensure that the systems needed for high-quality prenatal to five services continue to develop and improve.

Funding to support direct service program infrastructure is the largest category of investment, accounting for over 91% of system funding for administration, capacity-building, and quality initiatives. System building initiatives funded by private dollars support coordination, policy and advocacy, professional development, Tribal policy, and workforce development, and account for approximately 8% of system support funding. This breakdown highlights the diverse financial strategies that support Montana's prenatal to five infrastructure and its commitment to ensuring quality, access, and accountability at every level.

Figure 8: System supports funding by source, FY24



Fiscal Mapping Summary

Direct service programs, system supports, and system-building initiatives summarized in this fiscal mapping analysis include approximately $135.8 million for FY24 in Montana's prenatal to five system. Montana's fiscal mapping and analysis highlights substantial investments from state and federal sources, with an opportunity to increase local and private funding for both direct services and system supports. Table 7 summarizes the funding described throughout this fiscal mapping analysis.

Table 7: Fiscal mapping summary

	Federal	State	Private	Total
Early Care and Education				
Best Beginnings Child Care Scholarship Program	$29,519,372	$11,732,329		$41,251,702
Montana Milestones Part C Early Intervention Program	$5,368,842	$2,271,071		$7,639,913
Head Start/Early Head Start Programs	$40,426,718			$40,426,718
Head Start/Early Head Start AIAN Programs	$19,283,295			$19,283,295
Total Early Care and Education	**$94,598,228**	**$14,003,400**		**$108,601,628**
Family Strengthening				
Health Montana Families	$3,426,804	$300,249		$3,727,053
Children's Trust Fund/Child Abuse Prevention	$282,000	$24,909		$306,909
Early Head Start Home-Based Option	$2,289,779			$2,289,779
Early Head Start Home-Based Option AIAN	$174,965			$174,965
Total Family Strengthening	**$6,173,548**	**$325,158**		**$6,498,706**
System Building Initiatives				
Professional Development			$159,592	
Workforce Recruitment and Retention			$50,000	
Policy and Advocacy			$683,500	
Coordination			$829,950	
Capacity Building			$138,057	
Total System Building Initiatives			**$1,861,099**	
Total	**$118,670,756**	**$15,291,361**	**$1,861,099**	**$135,823,216**

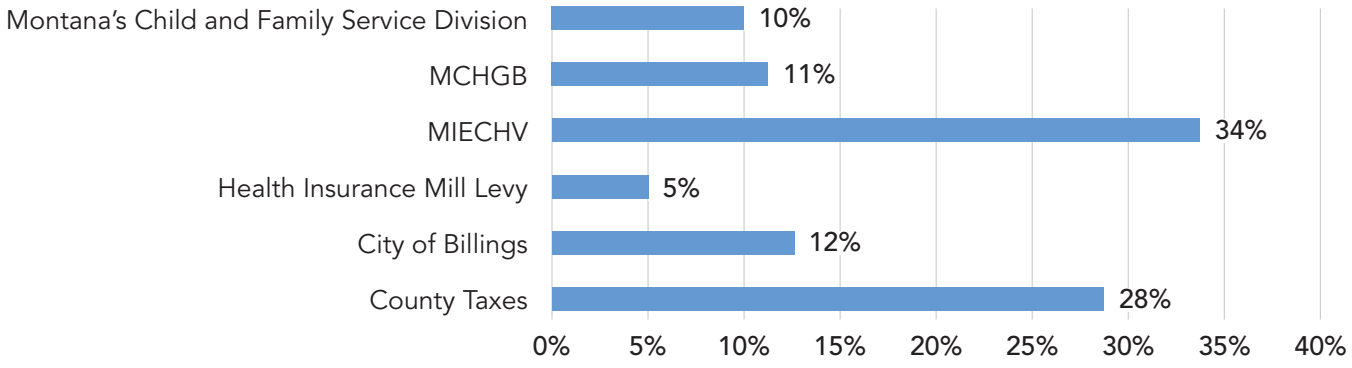
Despite Montana's substantial investments in the prenatal to five system, challenges in program accessibility, service quality, and provider capacity persist, especially in rural and Tribal areas statewide. Achieving impact and sustainability across Montana will require strategic partnerships and targeted resource allocation to address these disparities. Strengthening these areas is essential to ensuring equitable access, increasing child and family resilience, and improving health and developmental outcomes in Montana communities. Future planning should include the strategic allocation of funding and increased collaboration among state agencies, Tribal organizations, and philanthropic partners to build a sustainable, high-impact prenatal to five system for all children and families in the state.

Family Strengthening in Montana: Local Home Visiting Funding Innovations

As detailed in the previous section's fiscal mapping analysis, Montana's family strengthening programs rely heavily on federal and state funding sources. Some communities have secured other local funding for home visiting services. Two examples of these local funding sources are shared to demonstrate opportunities for local support.

RIVERSTONE HEALTH | Riverstone Health provides home visiting services across multiple counties, including Billings. Riverstone's home visiting programs are supported by federal funding streams such as Maternal, Infant, and Early Childhood Home Visiting (MIECHV) and the Maternal and Child Health Block Grant (MCHBG). Still, Riverstone Health leveraged additional local, non federal sources. Figure 9 illustrates this broader funding landscape, showing that local sources contribute a substantial 45% of total program funding, highlighting Riverstone's ability to diversify its funding base.

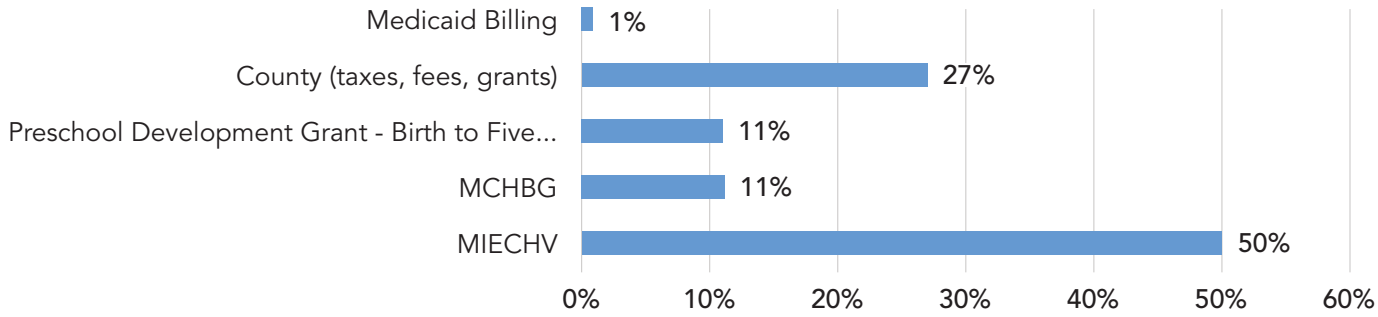
Figure 9: Percentage of funding by source, Riverstone Health programs



As illustrated in Figure 9, Riverstone Health's home visiting programs receive local funding from several key sources. Local contributions include 12% from the City of Billings and 28% from county taxes, while the Health Insurance Mill Levy accounts for an additional 5% of funding. Together, these local sources account for 45% of overall funding, demonstrating a promising practice of leveraging other dollars rather than relying heavily on federal and/or state funds.

GALLATIN COUNTY | Gallatin County has also leveraged multiple funding sources to strengthen its home visiting programs, reducing reliance on federal dollars. This diversified approach includes modest but growing billing to Medicaid and select private insurers, as well as county-specific funds that together provide a beneficial addition to federal support. Figure 10 shows the percentage of each funding source, which includes Medicaid billing and County funds.

Figure 10: Percentage of funding by source, Gallatin County



As shown above, Gallatin County has secured 28% of its total funding from sources other than federal and state sources. At least 27% of the funds come from county sources, and 1% comes from Medicaid billing. Although this currently represents a relatively small share of total funding, this diversified approach can help increase stability and extend the reach of local home visiting services, especially if Medicaid and private insurance billing grows over time.

V. Cost Modeling and Analysis

To fully understand the cost of providing services that align with the vision and guiding principles and meet the needs of children and families, the comprehensive fiscal analysis includes developing of cost estimation models.

Cost models estimate the true cost of delivering services by reflecting program standards, adequate workforce compensation, and the quality enhancements necessary to meet family needs. They move beyond what programs are reimbursed or what families can afford, capturing the resources required to sustain programs and the workforce that delivers them.

Two direct service cost models, for child care and home visiting, were developed for the Montana Prenatal to Five Comprehensive Fiscal Analysis (CFA) to estimate direct service delivery costs.[8] The models quantify day-to-day operational expenses such as salaries, benefits, staffing ratios or caseloads, materials and other program characteristics that influence cost. Each model includes a range of variables, from baseline requirements to enhancements that support workforce stability, strengthen service delivery, or address state- or community-identified needs. By allowing choices such as compensation, staffing patterns, capacity, family engagement

[8]The CFA prioritized cost modeling for child care and home visiting due to significant gaps between service costs and existing payment levels and potential for expanded reach. Early intervention and other programs were not modeled where recent rate studies, established reimbursement methodologies, limited eligibility criteria, or data limitations made additional cost modeling duplicative or less informative.

supports, or other program characteristics, the models show how changes in program design affect total cost and clarify the fiscal implications of different policy choices.

Building on these direct service models, system cost models were developed to estimate the statewide cost of a comprehensive prenatal to five system spanning both sectors. These models connect program-level data to system-level investments, including infrastructure, administration, data systems, and quality supports, allowing for statewide cost estimates that align with the fiscal vision and guiding principles established through the CFA.

Scenarios were then created for the direct service and system cost models. A cost model scenario is a hypothetical situation used to estimate the true cost of services under specific conditions. Direct service scenarios adjust variables such as staff-to-child ratios, caseloads, quality features, wages, and geographic location to show how different operational choices influence program-level costs and funding needs. Systemwide scenarios include services and supports for the whole system and test options such as increasing wages, expanding access, or introducing universal services to estimate statewide financial implications. Together, this approach illustrates how incremental steps build on one another, highlighting the relationships among workforce stability, program capacity, and the availability of high-quality services for families.

This section of the report details the methodology and assumptions embedded in the child care, home visiting, and system cost models. A sample of results are presented, along with associated analysis.

Constituent Engagement

To ensure the cost models are fully informed by those closest to the reality of operations, the CFA process convened two technical Ad Hoc groups, one for child care and one for home visiting. These groups brought together providers, administrators, and other experts to review program standards, identify cost drivers, and refine key variables and assumptions. Meeting regularly from December 2024 through May 2025, they examined data and operational practices and provided detailed feedback on compensation levels, cost assumptions, and other program variables. Additional input was received through Constituent Engagement Update meetings, fiscal mapping interviews, and cross-agency conversations. In addition, scenario development was informed through extensive engagement with the CFA Work Group and other constituent input activities, including provider discussions through technical Ad Hoc meetings, Constituent Update meetings, and cross-agency conversations. More information on engagement activities can be found in Section II: Montana Prenatal to Five Comprehensive Fiscal Analysis Leadership and Engagement.

Input from these activities ensured that the direct service and system cost models were grounded in lived experience and accurately reflected the workforce, infrastructure, and quality components required to deliver effective prenatal to five services. The P5FS team worked across both groups to ensure alignment in shared assumptions, such as wage scales, geographic considerations, and scenario design, so the models could produce consistent and comparable cost estimates across the child care and home visiting sectors. Together, these elements form the foundation for understanding the assumptions and calculations that underpin Montana's cost modeling analysis. Details of Ad Hoc membership are included in Appendices C and D.

Compensation

Workforce compensation is a primary cost driver in prenatal to five programs and services as wages and benefits typically account for most program

expenses. Compensation levels directly affect program quality and the ability to recruit and retain a qualified and stable workforce. When salaries are underfunded, programs face high turnover, staffing shortages, and difficulty sustaining consistent, high-quality services for children and families.[xxxii]

Compensation emerged as one of the most significant factors influencing the true cost of prenatal to five services in Montana. Constituent feedback consistently underscored that current wage levels are insufficient to recruit and retain qualified staff and to recognize the critical role this workforce plays in both child development and in supporting parents' ability to work or attend school.

Aligned with the CFA guiding principle to *"compensate the workforce at a level that allows for financial stability and acknowledges their expertise and significant impact on child development,"* the child care and home visiting cost models include multiple compensation options that extend beyond current market wages, using multiple salary data sources to understand the impact of different pay levels.

To establish these compensation assumptions, the Ad Hoc groups developed wage scales representing two approaches:

- **Current compensation** levels derived from the **U.S. Bureau of Labor Statistics (BLS)** (May 2025) data for relevant child care and home visiting occupations in Montana, serving as a proxy for typical or existing wage levels.[xxxiii] BLS includes state-specific salary data for over 800 different positions to most closely replicate current salaries in the field.
- **Living wage compensation** using the **Massachusetts Institute of Technology (MIT) Living Wage Calculator** (February 2025) reflecting a more sustainable and equitable standard for Montana's workforce.[xxxiv]

  The MIT Living Wage Calculator estimates the hourly wage needed for a full-time worker to meet basic needs, including food, housing, health care, transportation, and taxes, based on local costs of living. The **MIT Living Wage Calculator** is used to inform two options for understanding living wage in Montana in the cost models: **MIT Living Wage Single Person** and **Living Wage Family Composition** for an individual with dependents.

In building wage scales, the lowest-paid positions serve as the starting point, or the base of the scale, for each wage type in the cost model. The wage scale then adjusts proportionally to reflect increasing responsibilities associated with higher-level positions. Beyond base salary, both models include assumptions for benefits, including employer contributions to health insurance and paid vacation and sick leave. The models also allow users to layer in additional benefits, such as retirement contributions, when running alternative scenarios.

Recognizing the critical role of compensation in ensuring program sustainability and workforce stability, the CFA Work Group committed to using a living wage as the standard for all staff across the two cost models when determining the true cost of child care and home visiting services in Montana. This living wage baseline was determined using the MIT Living Wage Calculator. Because many members of the prenatal to five workforce support families and are not single earners, the CFA analysis used data on the average family composition of the early care and education workforce to calculate a weighted-average living wage. This approach provides a more accurate reflection of the income required to support a typical professional in the field and their family, rather than relying solely on a "single adult, no children" benchmark.

Regional Approach

Geographic variation in cost is another important consideration in cost modeling, as local economies influence wages, housing costs, travel demands, workforce availability, and the availability of services. Some states set regional payment rates for publicly funded programs, while others use statewide averages. Within any program, certain expenses will naturally vary by region, especially in states with both urban population centers and predominantly rural counties or Tribal communities.

In Montana, current geographic differences in service costs are driven primarily by variation in compensation, reflecting local economic conditions. Urban areas often have higher pay due to higher housing and living costs. Rural and frontier regions may also require higher salaries due to limited labor pools, long travel distances, and the need to attract and retain staff. When cost models incorporate higher compensation levels than are currently in place, those benchmarks can reveal meaningful regional differences. For example, compensation, travel time and mileage, supervision and administrative supports, and infrastructure needs all vary across regions.

In the child care system, the Best Beginnings Child Care Scholarship Program reimbursement rates are set at a statewide level. Six counties, however, are designated as 'high growth' and providers operating in those counties receive a 15% rate enhancement to account for higher costs of care.[xxxv] For home visiting, Healthy Montana Families (HMF) programs receive a statewide rate based on the service model, with no additional regional adjustments for rural, frontier, Tribal, or counties.[xxxvi]

For the CFA, the Child Care and Home Visiting Ad Hocs reviewed data related to geographic cost variation to determine the most appropriate approach for the cost models. County-level living wage data was the primary point of analysis:

- Living wages range from $19.63 per hour in Deer Lodge County to $24.95 in Broadwater County, with a statewide average of $22.06.
- Among the high-growth counties, the average living wage is $22.89 per hour, ranging from $21.67 in Missoula to $24.86 in Gallatin.

When examining population size, distribution across counties, and options for grouping counties by living wage, the overall variation in cost of living was relatively small, roughly a $2-per-hour difference. The CFA Work Group also considered which types of expenses are most likely to vary by region and the difficulty of capturing the tradeoffs such as higher housing costs in urban areas versus higher basic-necessity costs, like groceries and transportation, in rural areas.

Given these findings and the purpose of the CFA, a single statewide approach is used in the cost models. Because the CFA is intended to estimate the cost of achieving Montana's vision for the prenatal to five system rather than to set payment rates, this approach was deemed sufficient. If future work uses these models to directly inform public reimbursement rates for child care or home visiting, additional data collection would be recommended to determine whether regional rate adjustments are warranted.

Child Care Cost Model

High-quality child care supports children's early learning and development, enables families to work or attend school, and strengthens Montana's economy. Licensed child care programs, whether centers or family child care homes (FCC), provide safe, nurturing environments where children build foundational skills and relationships. These programs rely on a skilled workforce of educators

who create developmentally appropriate learning experiences and partner with families to support children's growth.

A child care cost model is a tool for understanding what it truly costs to operate child care in a state or community, including personnel and nonpersonnel expenses, and recognizes that costs vary across program types, ages served, staffing structures, facility needs, and service intensity. Cost models allow policymakers and communities to explore the fiscal implications of decisions such as improving compensation, adjusting ratios or group sizes, or expanding access for infants and toddlers.

The child care cost model used for the CFA is based on the cost calculator developed in 2023 in partnership between Zero to Five Montana, the Montana Department of Public Health and Human Services, and Prenatal to Five Fiscal Strategies. The calculator was initially designed to estimate the cost of meeting quality standards under Montana's *Bright Beginnings STARS to Quality* program. Its development was guided by a provider work group, pilot testing with several child care providers, and feedback gathered through provider presentations. The existing tool served as the foundation for estimating the true cost of child care in Montana.

This section describes how the Child Care Ad Hoc and other constituent input informed updates to the model, outlines the model's functionality, and presents results that supported the CFA's statewide cost estimates.

Engagement

Through the CFA engagement activities, participants identified key elements of quality, current challenges, and recommendations for improving sustainability and access.

- The top program quality characteristics identified include (a) developmentally appropriate learning experiences and environments, (b) low teacher-to-child ratios and small group sizes, (c) access to ongoing training and professional development, and (d) a whole child, whole family approach to care.
- Challenges currently faced by child care providers included (a) inability to offer competitive wages and benefits to recruit and retain staff, (b) difficulty finding qualified staff, and (c) insufficient resources to meet children and families' complex needs.
- Recommendations to address these challenges included (a) increasing pay and providing additional benefits, (b) expanding planning time, professional development, and family engagement opportunities, (c) adding staff to reduce workload and support program operations, and (d) providing resources to offset rising liability and insurance and property tax costs.

In addition, participants reviewed the 2023 child care cost model, evaluated initial outputs, and recommended additions to align with the CFA's vision. The following updates were incorporated into the revised cost model based on their feedback:

- Ability to include additional staffing positions (e.g., cook, janitor, or education coordinator)
- Options for expanded family engagement activities (e.g., home visits, family events, family engagement coordinator)
- Inclusion of transportation expenses (e.g., field trips)
- Built-in planning time within weekly staffing patterns
- Coaching, in addition to the required professional development
- Developmental screening expenses
- Costs related to inclusion and serving dual language learners

Child Care Direct Service Cost Model Functionality

The Child Care Cost Model includes child care centers and family and group child care home settings and is informed by financial and qualitative data collected from providers across the state, as well as other public sources. The child care cost model allows users to model a full day, full-year program serving children from birth to school age, with variations based on program size and characteristics. To estimate available revenue streams, the model also allows the user to modify the number of children receiving state child care subsidies relative to private-pay families.

The model accounts for all expenses related to a legally operating child care program, including meeting licensing requirements, as well as all federal and state requirements for running a business, such as employee and employer taxes and required breaks. Personnel expenses, which account for the largest cost in a provider's budget, are included in the model, along with required taxes, and users can modify salary levels and benefits.

Program Characteristics

Child care programs have varied characteristics reflected in their program design and operating structure. These characteristics, or variables, reflect the realities of operating child care programs across settings and age groups. Differences across program types, centers and family child care homes, as well as state and community context contribute to variation in operations and expense. Program characteristics include:

- Staffing patterns related to group size and ratios
- Workforce compensation and benefits
- Nonpersonnel expenses
- Additional variables such as family engagement activities, inclusion supports, and educational program costs

Staffing

The number of staff in the child care center scenario is driven by Montana's ratio and group size regulations, detailed in Table 8.[xxxvii]

Table 8: Montana ratio and group size regulations for child care centers

	Adult:Child Ratio	Maximun Group Size
Infants (0-11 months)	1:4	12
Toddlers (12-23 months)	1:6	12
2 to 3-year-olds	1:8	16
3 to 5-year-olds	1:10	20
School Agers	1:20	40

To ensure classrooms meet ratio requirements at all times, the model includes sufficient staffing to account for the program being open 50 hours per week, which is beyond the 40-hour work week of most employees. Beyond the classroom, the model includes one full time program director by default, and then additional staffing of an assistant director and an administrative assistant based on 0.5 full time equivalent (FTE)[9] for every 60 children enrolled. The model allows for users to add additional staffing if needed. For family and group child care homes, the model uses state licensing requirements to determine the maximum number of children that can be enrolled, shown in Table 9.[xxxviii]

[9] A full-time equivalent (FTE) is a unit of measurement that indicates the workload of an employed person. For the cost model, 2,080 hours would be equal to one FTE (40 hours x 52 weeks = 2,080 hours).

Table 9: Montana ratio and group size regulations for family and group child care homes

Family Child Care Homes	Three to eight children, 1:8 ratio, no more than three children under two-years-old.
Group Family Child Care Homes	Nine to 15 children, 1:8 ratio, no more than three children under two years old or six children under two-years-old with two staff members.

In the family child care home, the provider/owner is the only full time staff member, but an additional eight hours of assistant time are included to support the provider. In the group family child care home setting, the provider/owner is accompanied by a full time assistant to meet licensing requirements and an additional 16 hours of assistant time are included to ensure that an assistant is available during the hours the program is open and to further support to the provider/owner. As in the center model, additional staffing can be added.

Wages

The child care cost model includes three default salary scales that can be selected, along with a user entry field for users to override the defaults. The first default salary scale uses wage data from the BLS for child care-related roles in Montana, serving as a proxy for current salaries. The second and third default salary scales use wage data from the MIT Living Wage Calculator to inform a salary scale that ensures no employe earns less than a living wage. One option uses the single person living wage value, and the other is based on an estimate of the family composition of the workforce.

For family and group child care providers/owners, the model includes a salary, while acknowledging that most family and group child care home providers/owners do not pay themselves a salary, but rather, as small business owners, their income is whatever is left over after covering all business expenses. This typical approach to compensation drastically undervalues home based providers and often results in income well below the minimum wage when accounting for actual hours worked. The cost model includes a salary for the provider/owner position to recognize this required position under licensing, the need for the provider/owner to be compensated for their work, and to better compare costs across settings. Table 10 presents the default salary options in the model for each position included in the programming.

Table 10: Salary defaults included in child care cost model

	Bureau of Labor Statistics	MIT Living Wage Single Person	MIT Living Wage Family Composition
Director	$53,910	$89,094	$111,332
Assistant Director	$43,128	$73,631	$92,010
Admin Assistant	$46,150	$46,426	$58,014
Lead Teacher	$36,770	$60,353	$75,418
Assistant Teacher	$32,450	$46,426	$58,014
Floater/Substitute	$32,450	$46,426	$58,014
FCC Provider/Owner	$50,559	$82,986	$103,670

Mandatory and Discretionary Benefits

All mandatory employer expenses are built into the cost model, including required federal and state contributions such as Social Security, Medicare, unemployment insurance, and workers' compensation. The model applies standard rates for these costs: FICA-Social Security is included at 6.2%, Medicare at 1.45%, unemployment insurance at 1.0%, and workers' compensation at 2%.

The model also includes several discretionary benefit options. The cost to employers of providing health insurance to employees can be included. When this selection is made, either $6,627 per FTE or $10,000 per FTE is included in the model which could be used for health insurance or other benefits.[10] Ten days of paid sick leave and 10 days of paid vacation are also included by default and can be modified by the user. The model also allows users to include a retirement contribution, as a percentage of salary, and to include a value for other annual benefits.

Nonpersonnel

The model includes all nonpersonnel costs related to operating a program. Specifically, nonpersonnel costs are aggregated into the following categories:

- **Program Management and Administration:** Office supplies, telephone, internet, insurance, legal and professional fees, permits, fundraising, memberships, administration fees
- **Occupancy:** Rent/lease or mortgage, real estate taxes, maintenance, janitorial, repairs, and other occupancy-related costs
- **Education Program for Children and Staff,** including:
  - **Education/Program-Child:** Food/food-related, classroom/child supplies, medical supplies, postage, advertising, field trips, transportation, child assessment materials.
  - **Education/Program-Staff:** Professional consultants, training, professional development, conferences, staff travel

Default values for each of these nonpersonnel categories are based on nonpersonnel expense data in the federal Provider Cost of Quality Calculator tool.[11] The model allows for overriding these default values when other data is available or to provide a customized output.

Additional Program Variables

Beyond the cost of operating a program that meets licensing requirements, the model includes several variables to account for program costs beyond these minimum standards. These variables are informed by requirements under Montana's previous Quality Recognition System (formerly called STARS to Quality)[12] and can be included in whole or in part. Users can run a scenario at the licensing level or select each of the different points for each variable. Additional program options include family engagement, learning environment, inclusion, as well as transportation, field trips, and developmental screenings.

[10]The $6,627 selection is based on the average employee contribution to health insurance in Montana. Source: Kaiser Family Foundation, Average Annual Single Premium per Enrolled Employee For Employer-Based Health Insurance, 2024. Available at: https://www.kff.org/other/state-indicator/single-coverage/?currentTimeframe=1&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[11]The Provider Cost of Quality Calculator (PCQC) is an online tool provided by the U.S. Department of Health and Human Services (HHS), Administration for Children and Families (ACF), Office of Child Care (OCC) that allows users to estimate the annual costs and revenue of running a child care program. The tool is available at https://pcqc.acf.hhs.gov.

[12]Montana's Quality Recognition System (QRS), formerly known as STARS to Quality, is in a redesign phase with a projected launch date of October 1, 2026. The Montana Child Care Cost Model program variables were informed by the STARS to Quality framework prior to the redesign phase.

Family Engagement

- Family engagement conferences - the cost of providing substitute coverage for the teacher to attend the conference.
- Social events
- Home visits to enrolled families
- Family engagement coordinator

Learning Environment

- Paid planning time, either one hour per lead teacher per week or 2.5 hours per lead teacher and one hour for assistant teachers per week.
- Paid time for employees to participate in professional development activities, either to meet licensing standards (four hours for teachers and seven hours for directors annually), or additional professional development (36 hours for teachers and 21 hours for directors annually).

Inclusion

- Additional materials and inclusion aides for the children with special needs

Miscellaneous

- Transportation for children to/from the program, school, or home
- Field trips
- Developmental screenings
- Additional sanitation expenses beyond daily cleaning, such as a monthly deep cleaning and additional costs of sanitation supplies.
- Contribution to operating reserve, aligned with sound business practices

Child Care Direct Service Cost Model Outputs

Understanding the range of costs is essential to fully grasp the resources required to provide stable, high-quality child care. Total program costs vary significantly depending on program type, age group, staffing structure, and the level of quality and support services offered.

The cost model supports decision making by illustrating how program choices affect total investment needs. Model outputs highlight variation in cost across settings and show how regional or statewide investment is shaped by compensation, the types of child care programs selected, and the number of children served in each age group. Using these outputs, communities and state partners can align funding strategies with both impact and efficiency, ensuring that resources are responsive to local context and family needs.

Child Care Direct Service Model Scenarios

For the CFA, three direct service scenarios were generated from the Montana Child Care Cost Model, producing cost per child outputs for child care centers and family and group child care homes to estimate the true cost of child care in Montana. The first two scenarios detail the costs for a program meeting state licensing standards, with one using current salaries and the second using salaries at the MIT Living Wage Family Composition selection point. The third scenario uses the living wage selection but includes the cost of additional program options related to higher-quality standards such as additional staffing and benefits, family engagement staffing and activities, additional professional development, field trips, and offering developmental screening. This higher-quality scenario was informed by input from the Child

Care Ad Hoc, and other constituent input on the additional resources needed to meet the full needs of children and families. Details on the assumptions of the default scenarios for child care centers and family and group child care homes can be found in Appendix F.

The True Cost of Child Care in Montana

Figures 11, 12, and 13 illustrate the annual cost per child model outputs, for all three scenarios, showing the true cost of providing child care using the variable selections shown in Tables 19 and 20 in Appendix F.

Figure 11: True cost of care, child care center, annual cost per child outputs

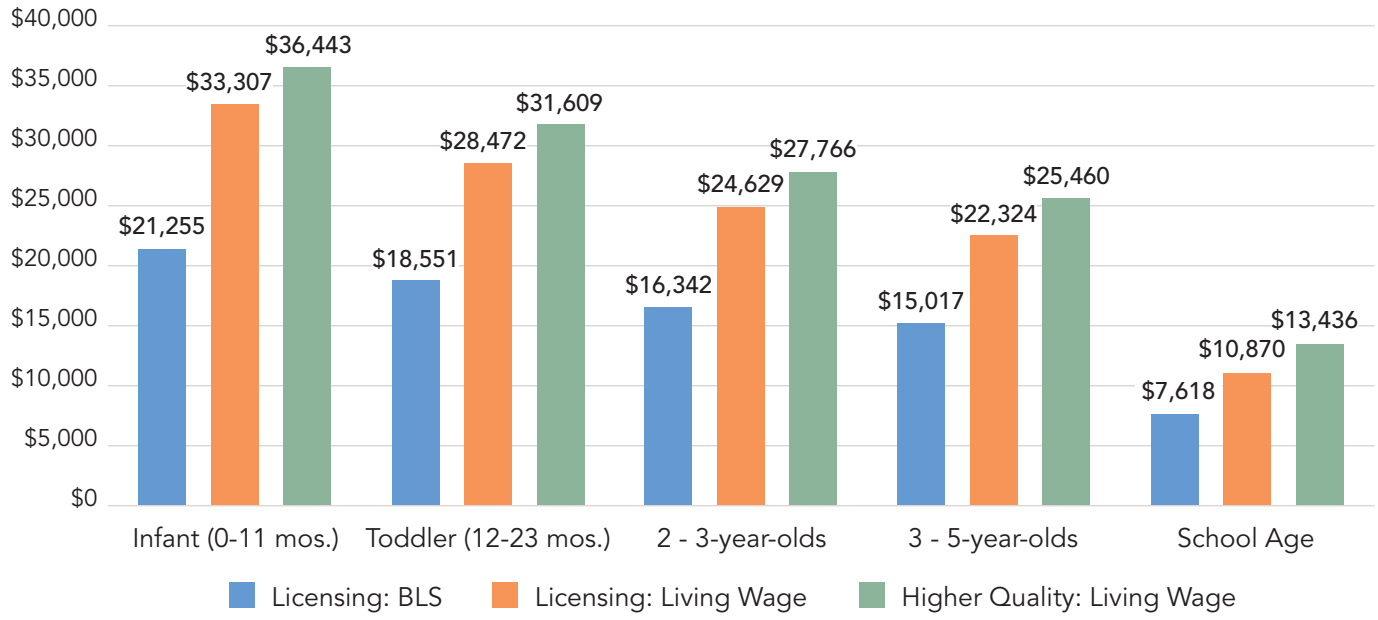


Figure 12: True cost of care, family child care home, annual cost per child outputs

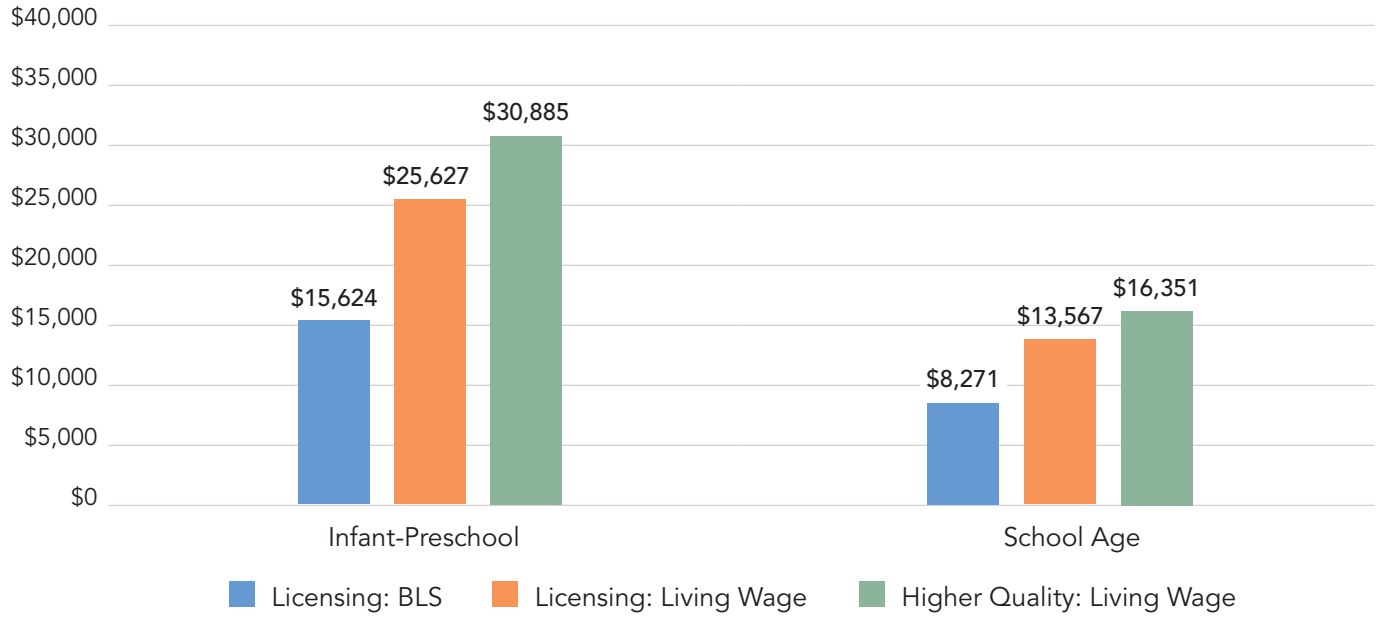
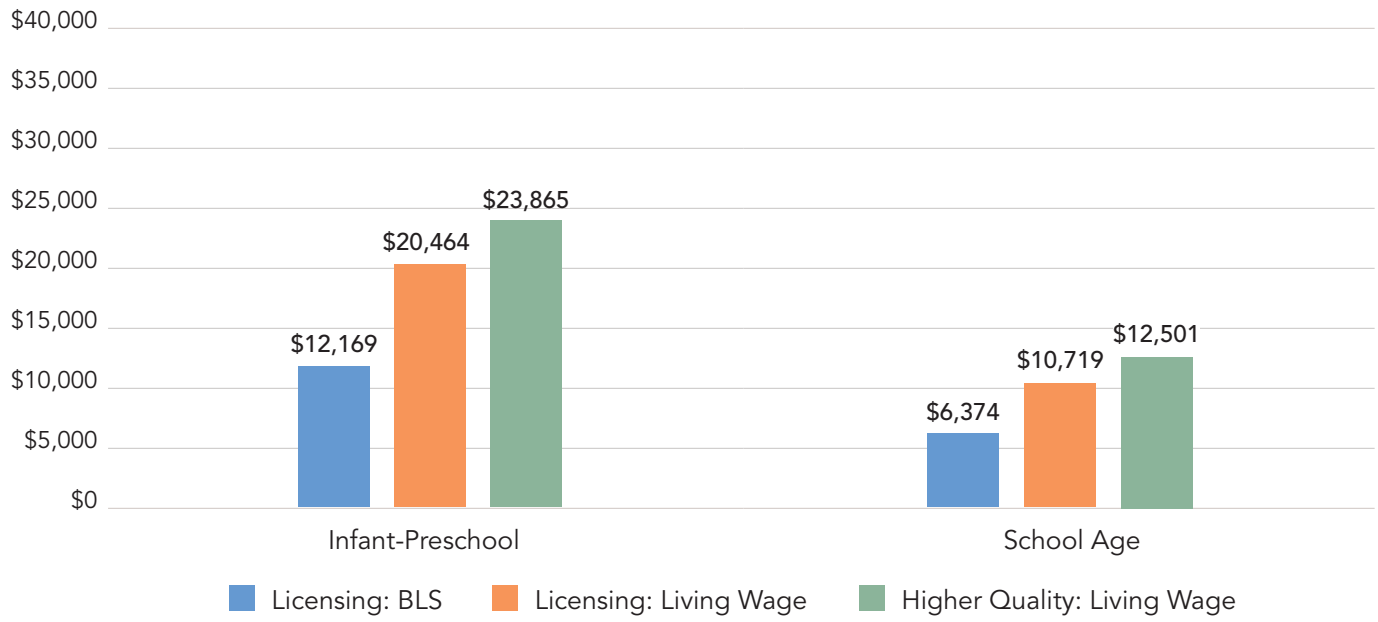


Figure 13: True cost of care, group family child care home, annual cost per child outputs



Gap Analysis

Integration of revenue data into the cost model allows for a calculation of any gaps between the estimated true cost of quality and current public subsidy rates and analysis of how these gaps vary by age and program type. Figures 14, 15, and 16 detail these gaps using direct service outputs. For cost data at the licensing level, the base subsidy level is used. For cost outputs at the higher quality level, the subsidy rate payable to programs rated STAR 5 in Montana's Quality Recognition System is used.

Figure 14: Gap between annual cost per child and subsidy rate, child care center

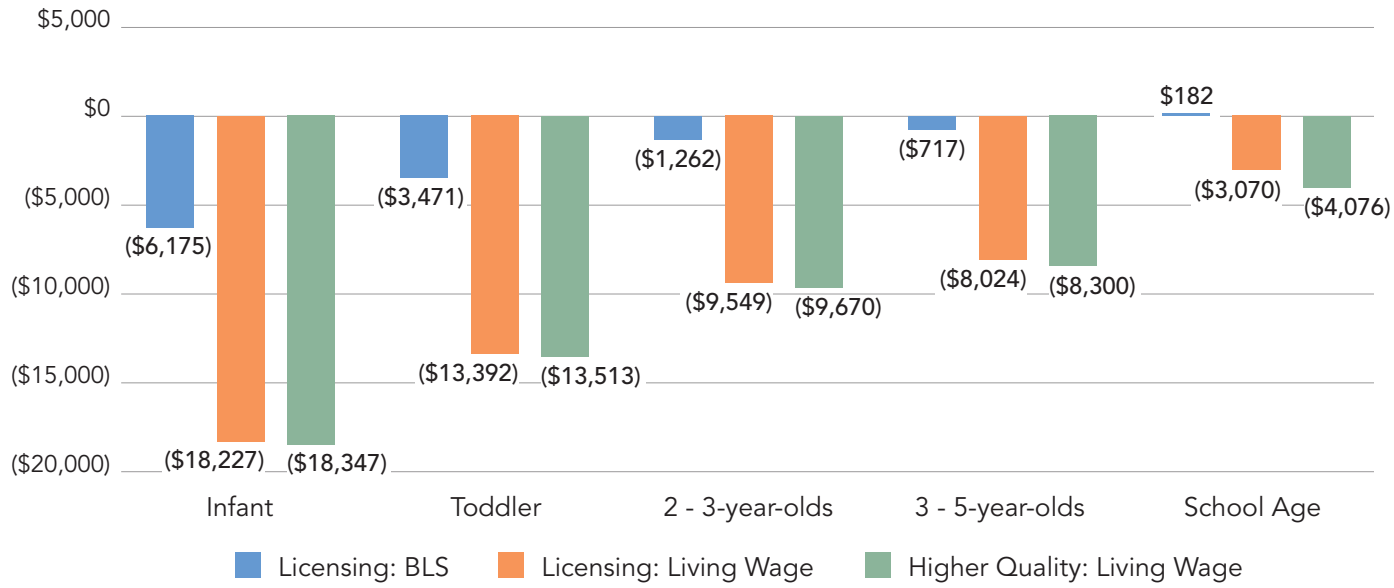


Figure 15: Gap between annual cost per child and subsidy rate, family child care home

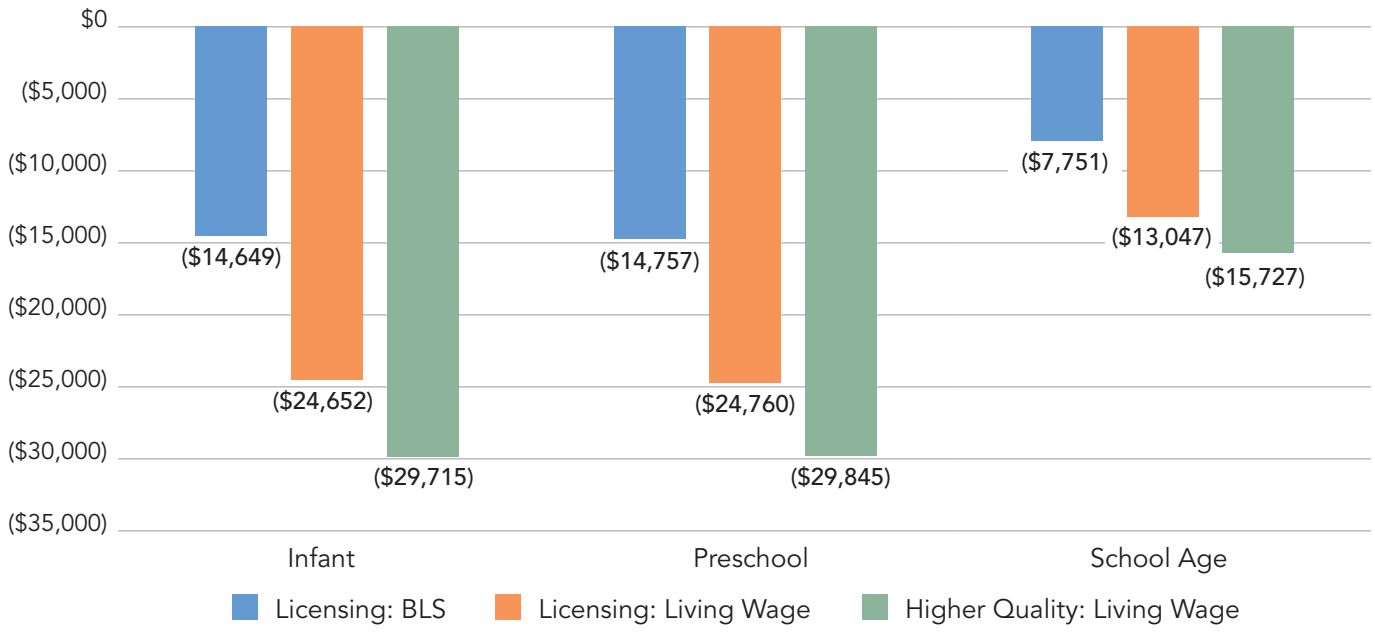
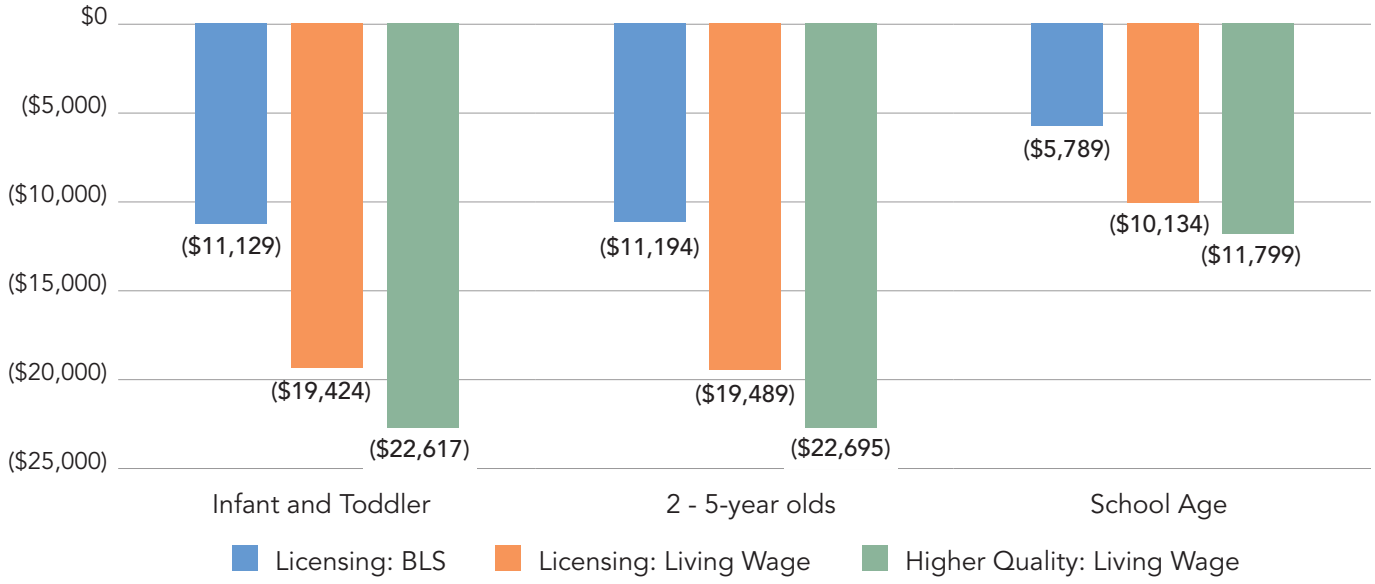


Figure 16: Gap between annual cost per child and subsidy rate, group family child care home



As shown, child care subsidy rates fail to cover the true cost of care in almost all settings across all ages and quality levels. However, the data show several disparities, with larger gaps in certain age groups and settings. For example, for infants in child care centers, the base subsidy rate covers around 45% of the estimated cost of care, whereas the rate for a preschooler covers about 64% of the true cost of care. While Montana pays a higher subsidy rate for those at STAR 5 on the Montana Quality Recognition System, this higher rate does not fully cover the higher cost of care. However, it does cover a higher percentage of the estimated cost than at the licensing level – 50% for infants and 67% for preschoolers.

Home Visiting Cost Model

Home visiting and parenting education programs provide critical support to parents and caregivers, promoting the healthy development and well-being of young children and their families.[xxxix] These programs connect expectant and parenting caregivers with trained professionals such as home visitors, parent educators, and nurses who typically deliver services in the family's home. Programs focus on strengthening parent-child relationships, promoting positive parenting and child development, and connecting families to community resources to help them thrive.

A home visiting cost model estimates the true cost of delivering different program models within a state or community. Because programs vary in design, staffing, and service intensity, their costs differ. The model captures both personnel and nonpersonnel expenses, with wages, benefits, caseloads, visit frequency, and supervision serving as primary cost drivers.

A comprehensive home visiting system requires a mix of programs with different intensity levels and areas of focus. The Montana Home Visiting Cost Model generates per child cost estimates that inform statewide planning and can be used by local communities to understand the true cost of delivering services in their region or program. Clarifying the full cost of home visiting across models and levels of intensity, the cost model helps shift the conversation from competition for limited funding toward coordinated investment in a continuum of supports. This shared understanding of cost enables state leaders, local programs, and community partners to align funding strategies, advocate for adequate resources, and make informed decisions to better meet the diverse needs of Montana families.

The following section describes the model's structure, data sources and assumptions, and presents findings from the analysis.

Engagement

Through the CFA Engagement activities, specific feedback that was incorporated into the cost model included:

- Program staff emphasized the need for the model to reflect variations in workforce compensation and to include a salary scale that accounts for regional differences, particularly in rural and frontier areas. Participants shared that current wages for home visitors are below the cost of living in many areas supporting the use of the BLS and MIT Living Wage data as reference points.
- Participants noted recruitment challenges and the impact of administrative cost caps on program operations and these full costs should be represented in the model.
- Participants emphasized the importance of modeling options for smaller caseloads, additional supports for high-need families, and community flexibility to choose or adapt models based on local needs.
- Participants identified enhancements critical to quality and workforce stability including reflective supervision, dual language wage supplements, trauma-informed practice, infant and early childhood mental health consultation, and professional development.
- Discussion also focused on nonpersonnel expenses, notably travel and mileage costs which vary by geography. Participants noted these costs often exceed available funding and should be accurately represented to show the true cost of service delivery.
- Participants highlighted infrastructure and startup costs, emphasizing the need to model resources for expansion, staff training, and data systems to support implementation.

The feedback and insights shared by Montana's home visiting program administrators and providers through the CFA Work Group, Home Visiting Ad Hoc, interviews, and Constituent Update meetings directly informed the assumptions and structure of the cost model. Drawing on their on-the-ground expertise, the model incorporates real-world conditions such as salary and benefit expectations, rural and frontier cost variations, service intensity, caseload differences, and quality supports required to sustain the workforce and achieve positive family outcomes. These inputs ensure the model reflects the full cost of delivering services across diverse communities.

The following section presents results from the Home Visiting Cost Model, illustrating the variation in cost across program models and scenarios and highlighting the fiscal implications for sustaining and expanding a comprehensive home visiting system statewide.

Home Visiting Direct Service Cost Model Functionality

The Home Visiting Cost Model is designed to support Montana in considering the multiple program models needed to serve their unique population of children and families. The cost model produces an output that incorporates all selected program models drawing on unique service model data and expense details to inform the output. The home visiting service models included in the Montana Home Visiting Cost Model are:

- Attachment and Behavioral Catch-Up (ABC)
- Early Head Start Home-Based Option (EHS Home-Based)
- Exchange Parent Aide
- Family Connects
- Family Spirit
- Healthy Families America (HFA)
- Nurse-Family Partnership (NFP)
- Parents as Teachers (PAT)
- Safe Care
- Universally Offered Home Visiting Pilot
- Welcome Baby

The cost model incorporates models that are not currently implemented in Montana (i.e., ABC and Family Connects). These models are included to determine the required investments for the expansion of services for children and families.

The cost model is designed to reflect the ongoing operational costs of the programs, not the costs associated with program startup. To use the cost model, users select the program models to be implemented and the number of children served by each program model. The selection of program models draws on program specifics related to each model's operations. These specifics of operating a given model, such as home visitor caseload, the ratio of home visitor to supervisor, and the number of group services, are driven by program standards from the model's national service office or local implementing agency, as applicable.

Home visiting program costs are largely driven by the intensity of the service and staff compensation. Some models, such as EHS Home-Based, are designed to provide more intensive services with more frequent visits and smaller caseloads per home visitor. Other models may be less intensive and provide fewer visits over a shorter period, allowing home visitors to serve more children and families over the course of a year. Understanding these cost drivers helps estimate the true cost of delivering services and identify adequate funding amounts to ensure the sustainability of high-quality home visiting programs in Montana. Cost drivers include both personnel and nonpersonnel expenses. Personnel expenses include salary and benefits, while nonpersonnel expenses include occupancy

and program costs such as materials, training, travel, and mileage.

Program Characteristics

Different home visiting programs have varied program characteristics, or what is referred to as their program model. These variances are established by the model, often at the model purveyor level, and may include variations related to:

- **Services to children and families:** caseload capacity of the home visitor, frequency of points of connection, duration of services, one-on-one activities, and/or group services.
- **Staffing:** caseload of staff to a program supervisor, reflective supervision approach and frequency, and supervisor to program manager/director ratio.
- **Quality supports and infrastructure:** ongoing training requirements, credentialing or national accreditation, affiliation roles, and responsibilities.

Model Requirements

The Montana Home Visiting Cost Model incorporates all model-specific requirements to operate each included home visiting service model. The home visiting model-specific requirements may include staff type, service and supervisory caseloads, service intensity, and program and supervision components, which vary by home visiting model.

Staffing

Caseload, or the number of children[13] a home visitor serves at one time, is one of the main factors influencing the cost of home visiting programs. Each home visiting model establishes recommended caseload standards based on the program's structure, service intensity, and fidelity requirements. These model standard caseloads serve as a consistent starting point for estimating staffing needs and costs in the Montana Home Visiting Cost Model.

Personnel costs are calculated based on staffing structures that align with caseload capacity for each program model. Because caseload size drives the number of home visitors and supervisors required, staffing levels vary across models and by the selected caseload option. In practice, however, contracted caseloads may differ from model recommendations based on local conditions, including geography, travel time, community needs, workforce availability, and negotiated agreements between implementing agencies and model developers.

Caseloads inform program staffing in the cost model of the home visitor and supervisor positions. The caseload is the number of children on the home visitor's caseload, or the funded caseload for one full-time home visitor. Programs with smaller caseloads or higher-intensity services require more staff to serve the same number of families. In comparison, programs with larger caseloads or lower-intensity services may operate with fewer personnel. Staffing is then further determined for the program supervisor, or nurse program supervisor, as a caseload of home visitors to one full-time supervisor. Using home visiting model standards, a base caseload for each service model was established as the Model Standard Caseloads, shown in Table 11, while recognizing that actual caseloads may vary locally.[14]

[13]The Montana Home Visiting Cost Model defines caseload by the number of children served, rather than families, because annual turnover results in programs serving more children than funded slots. This approach more accurately reflects true cost.

[14]Caseloads shown reflect model-recommended standards used for cost estimation. Actual contracted caseloads may vary by community based on geography, service intensity, workforce availability, and negotiated agreements between local implementing agencies and model developers.

Table 11: Home visitor and supervisor model standard caseloads used in the Home Visiting Cost Model

Home Visiting Models	Model Standard Caseloads	
	Children per Home Visitor/Parent Educator	Home Visitor/Parent Educator per Supervisor
Attachment and Biobehavioral Catch-Up	40	5
Early Head Start Home-Based	12	8
Exchange Parent Aide	10	6
Family Connects	325	12
Family Spirit	20	5
Healthy Families	20	6
Nurse-Family Partnership	22	8
Parents as Teachers	22	10
SafeCare	39	4
Universally Offered Home Visiting	250	6
Welcome Baby	250	6

Caseload Capacity

The cost model allows for three additional caseload selections to reflect different levels of service intensity and staffing needs. Two selections lower the caseloads from the model standard: Lower Caseload 1 (Medium Intensity) and Lower Caseload 2 (High Intensity). The last option, User Input, allows users to enter caseload values for the home visitor and supervisor. The additional caseload options are outlined in Appendix G.

Wages

Qualifications for home visitors also vary by model. Some models require licensed professionals such as nurses or social workers, while others allow paraprofessionals or peer home visitors who bring lived experience with participating families. The differences in qualifications, training, and supervision requirements drive variation in personnel costs. The cost model incorporates these distinctions to estimate the staffing needed to deliver services with fidelity.

Because home visiting is labor-intensive, staff salaries and benefits are among the largest cost drivers. The cost model includes three salary options, plus a customizable user-defined option. The first option uses BLS wage data for home visiting roles in Montana and represents current or typical wages. The second option applies the MIT Living Wage for a Single Person, establishing a compensation baseline of living wage for a single person with no dependents. The third option uses the MIT Living Wage Family Composition, reflecting a wage structure for the early care and education workforce that encompasses staff who are also raising children and face higher living costs.

These salary options enable users to compare the financial impact of continuing current wage levels versus investing in a more sustainable, living-wage workforce. Table 12 compares the three default salary options in the model for each position.

Table 12: Salary defaults included in home visiting cost model

	Bureau of Labor Statistics	MIT Living Wage Single Person	MIT Living Wage Family Composition
Program Manager	$62,413	$82,920	$111,489
Nurse Program Manager	$109,563	$145,110	$195,105
Program Supervisor	$51,158	$67,967	$91,384
Nurse Program Supervisor	$89,806	$118,942	$159,922
Home Visitor	$41,933	$55,711	$74,905
Nurse Home Visitor	$73,611	$97,494	$131,084
Clinical Home Visitor	$60,715	$74,095	$99,624
Community Health Worker	$56,514	$ 69,081	$92,882
Parent Educator	$41,933	$55,711	$74,905
Administrative Support	$34,944	$46,426	$62,421

Mandatory and Discretionary Benefits

The cost associated with personnel expenses such as mandatory taxes and discretionary benefits is included in the model using a percentage approach. There are two default percentage options to select from, 25% or 30%. The User Input option can be used to key in a different percentage. The percentage selected for Benefits is applied to all salary lines in Personnel expenses. This percentage approach is designed to cover all the mandatory costs, including Social Security, Medicare, unemployment insurance, and workers' compensation. In addition to these mandatory costs, the total percentage allows for coverage of discretionary benefits, such as health insurance, retirement contributions, and paid leave. The selected percentage is applied across all staff positions to estimate total benefit expenses, providing a realistic picture of overall personnel costs and workforce investment.

Nonpersonnel Expenses

The cost model also includes typical nonpersonnel expenses associated with operating home visiting programs. These include occupancy costs such as rent or mortgage, educational and family service supplies, mileage and travel, professional development, and national model affiliation fees. Default nonpersonnel expenses from the federal PCQC were referenced as a starting source of national values on basic nonpersonnel costs of home visiting programs.[15]

Each expense category is calculated using either a per-child or per-staff approach, depending on the type of cost. This structure reflects how expenses scale differently across programs, some based on the number of children served, while others are tied to the number of staff required to deliver services.

[15]While the PCQC is a child care cost modeling tool, it was used as a starting point for nonpersonnel expenses, due to it representing a valid and reliable source of data across several categories such as rent/mortgage, utilities, training, office supplies and administrative expenses that are similar across child care and home visiting.

Additional Program Variables

Beyond the core components required to operate a home visiting program according to model specifications, the cost model includes several additional variables that help users to understand the cost implications of supports that exceed minimum program expectations. These variables reflect components that strengthen workforce stability, enhance service delivery, or deepen family engagement, elements that emerged through constituent input and align with Montana's vision for a comprehensive prenatal to five system.

Users can choose to run a scenario using only the core model requirements or select additional variables to add to any of the service models to explore how changes in areas such as reflective supervision, training, travel expectations, or administrative capacity influence program cost. This approach allows the model to reflect differences in community context and program priorities while maintaining flexibility to test a range of policy and investment decisions.

Dual Language Salary Increase

The cost model includes an option to account for salary adjustments for bilingual home visitors. Programs may choose to provide additional compensation for staff who deliver services in more than one language, recognizing the added skills and cultural responsiveness they bring to families.

This option adds a salary percentage to positions that bring dual language capacity to their role. The salary percentage increase is added to all home visitor types and administrative support staff. If selected, the percentage will also be added to the case manager position when these are added to the scenario.

Rural Service Modification

Rural home visiting programs often incur higher costs due to greater travel distances, limited service infrastructure, and the additional time required to reach and serve families across large geographic areas. The cost model includes an option to account for the added costs of delivering services in rural and frontier areas.

This option adds an annual amount per child to cover the additional costs of rural service delivery with preset amounts of $1,200, $2,400, $3,600, or $6,000, or entering a custom value. The model also allows users to specify the percentage of children to whom the rural service modification applies, ensuring that only the portion of families served in rural or hard-to-reach areas is modeled.

Case Management Support

The cost model includes an option to account for dedicated case management support within home visiting programs. When selected, this enhancement adds a case manager position to the staffing structure to reflect programs that provide additional coordination and resource navigation for families. This position is calculated using the same caseload as the home visitor and at the administrative support salary point.

Parent Education Groups

The cost model includes an option to estimate the cost of parent education groups to selected home visiting models. This option is not available for models that require groups as part of model standards (i.e., EHS Home-Based and PAT), as parent education group expenses are already included in the calculations for those models. When selected, users enter the number of group sessions per year and the estimated number of attendees. The model then calculates related costs, such as staff time, materials, and supplies, based on these inputs.

This allows users to capture the additional resources needed to offer group-based parenting education as a complement to individualized home visiting services.

Reflective Supervision

Reflective supervision supports staff well-being, professional growth, and program quality by providing structured time for reflection, problem-solving, and relationship-based practice. The cost model includes an option to add additional reflective supervision hours beyond those required by each home visiting model.

Users can select the type and frequency of additional reflective supervision. Each monthly add-on is calculated at two hours per activity and may include one of the following options:

- None
- Group reflective supervision for managers
- Group reflective supervision for home visitors
- Group reflective supervision for all staff
- Individual reflective supervision for managers
- Individual reflective supervision for home visitors
- Individual reflective supervision for all staff
- Group and individual reflective supervision for all staff

Additional hours apply to both home visitor and supervisor positions and are costed at $150 per hour.

Enhanced Professional Development

The cost model includes an option to account for additional professional development beyond the standard training required by each home visiting model. When selected, this enhancement adds 16 hours of training per home visitor and supervisor. The additional hours are costed at $150 per hour.

Infant Early Childhood Mental Health Services

The cost model includes an option to add Infant and Early Childhood Mental Health Consultation as an enhancement. When selected, this option allocates eight hours per child per year for consultation and support by a mental health professional at $150 per hour.

Home Visiting Direct Service Cost Model Outputs

Understanding the range of costs is important to fully grasp the resources required for home visiting services. Total program costs shift depending on how many children are served by models with higher or lower per service costs.

In communities where families face greater or more complex challenges, investing in more intensive, evidence-based home visiting models may be appropriate. These models typically include smaller caseloads, more frequent visits, and deeper clinical or developmental support, and although they carry higher per-child costs, they have demonstrated strong, positive outcomes for children and families.[xl] At the same time, lower-intensity or universal home visiting models can also produce meaningful benefits, especially when the goal is to offer broad reach, early screening, or universal connection to community resources. Universal and low-intensity models have been shown to improve parent satisfaction, reduce infant emergency medical care, and strengthen family well-being across population groups.[xli] Communities may choose a more intensive model when addressing significant health, developmental, or social risk factors, while low-intensity or universal options can be effective for reaching all families, reducing stigma, promoting equity of access, and ensuring that families with emerging needs are identified and connected to

appropriate supports. Together, these approaches allow communities to provide the right level of service at the right time, based on local needs, capacity, and family support goals.

This strategic use of the cost model helps communities and state partners align investments with both impact and efficiency, ensuring that home visiting resources are responsive to each region's context and family needs. The cost model outputs highlight cost variation across programs and underscore how a region's total investment is driven by two primary factors: the model(s) selected and the number of children served.

Home Visiting Direct Service Cost Model Scenarios

The Montana Home Visiting Cost Model allows users to make different selections to estimate the true cost of home visiting services. For the CFA, two scenarios were run on each home visiting model currently implemented in Montana producing cost per child outputs to estimate the true cost of home visiting in Montana.

For each scenario, model caseloads were retained, and no other program selections (such as dual language increase, rural service modification, additional professional development or reflective supervision, mental health consultation, etc.) were added. The benefits selection was set at 25% to include all the mandatory taxes for operating a staffed program and to allow an average of 10% of the salary costs to cover discretionary benefits for staff.

The True Cost of Home Visiting Direct Services in Montana

Two direct service scenarios were calculated using these choices to generate cost-per-child outputs. The first uses the BLS salary scale option. The second scenario retains the same selections for home visiting model implementation but uses the MIT Living Wage Family Composition salary scale.

The sample outputs illustrate the range of per-child costs across different program models. The range reflects the difference between salaries at the BLS and living wage levels. In contrast, the variation in cost per home visiting service model reflects differences in their duration, intensity, and the program services provided. Outputs show costs for universal touch models (Welcome Baby and Universally Offered Home Visiting Pilot), low intensity models (SafeCare), medium intensity models (Family Spirit, HFA, NFP, and PAT), and high intensity models (EHS Home-Based and Exchange Parent Aide).

At BLS informed current salaries, models at the lightest touch, such as those designed as universal touch models, range in cost from $990 to $1,250 per child annually. Intensive ongoing home visiting models, designed to see families over the course of multiple years and, in some cases, multiple times a week, range from $5,060 to $10,300, under the same BLS salary scale selection, depending on program model services.

If salaries are set at living wage levels, the increase in the cost per child for low intensity models averages 36%, ranging from $1,300 to $1,700 per child annually. For high intensity models, the move from BLS to living wage salaries results in a 57% to 66% cost increase per slot. The range for intensive ongoing home visiting increases from $7,600 to $17,100 when using the living wage salary option.

Table 13: Home visiting annual cost per child outputs, by salary selection and service intensity

Salary Salary Point	Universal Touch Models	Low Intensity Models	Medium Intensity Models	High Intensity Models
Models by Intensity	**Welcome Baby, UOHV**	**SafeCare**	**Family Spirit, HFA, NFP, PAT**	**EHS Home-Based Exchange Parent Aide**
BLS	$1,122 ($990 – $1,250)	$3,904	$5,871 ($5,060 - $6,616)	$8,924 ($7,600 – $10,300)
MIT Living Wage Family Composition	$1,526 ($1,300 – $1,700)	$6,136	$9,332 ($7,978 – $10,664)	$14,855 ($12,500 – $17,100)

Gap Analysis

Current public funding for home visiting services under the federal Maternal Infant and Early Childhood Home Visiting (MIECHV) grant has not kept pace with the rising cost of delivering services, in large part due to limited increases in the federal award over time. As a result, state and local administrators must make difficult funding decisions within fixed funding levels to maximize the number of children and families served. For example, public contracts for medium intensity home visiting models fund an average of $5,000 per slot per year.

Cost modeling shows that this reimbursement level falls short of the cost of services under either current workforce wages and at living wage compensation levels. Under the current MIECHV funding thresholds, fully aligning workforce wages with BLS or MIT Living Wage recommendation s would significantly reduce the number of families that could be served due to higher personnel costs required to operate programs. As a result, programs often balance lower compensation, reduced capacity, or reliance on additional funding sources to maintain service reach.

Under BLS salary assumptions, the average cost to provide a medium intensity home visiting slot is $5,871 per year, leaving a gap of $871 per slot. This represents approximately 17% underfunding relative to the resources needed to operate a home visiting program, including all personnel and nonpersonnel expenses. Even at these wage levels, which providers consistently report are insufficient to recruit and retain qualified staff, programs must subsidize the gap through local fundraising, braided funding, or by reducing service capacity.

When salaries are adjusted to reflect the cost of services with salaries at the MIT Living Wage, the gap grows substantially. The average annual cost of a medium intensity home visiting slot increases to $9,332, more than $4,300 above current public payment levels. In this scenario, programs are approximately 86% underfunded, underscoring how current reimbursement structures constrain both workforce compensation and service reach.

Salary Selection	True Cost per Slot	Current Funding per Slot	Gap	Percent Underfunded
BLS / Current Wages	$5,871	$5,000	$871	17%
Living Wage	$9,332		$4,332	86%

A key contributor to this funding misalignment is that major federal sources, particularly MIECHV, have not kept pace with the actual cost of service delivery. While MIECHV remains a critical cornerstone of Montana's home visiting system, its per-slot funding levels contribute to program instability and workforce challenges. At the same time, Montana has taken meaningful steps to address these gaps through initiatives such as the PREP wage program, which has helped bolster compensation and mitigate turnover. These efforts demonstrate the state's commitment to strengthening its home visiting workforce within the constraints of available funding.

Together, these findings show that Montana's home visiting programs operate within a context of structural underfunding across workforce and operational cost categories. Without adjustments to reimbursement levels, programs will continue to face challenges in maintaining service capacity, stabilizing their workforce, and meeting the needs of families across the state.

System Cost Models

Modeling system level costs allows states and communities to understand what it takes to ensure child care and home visiting are high-quality, accessible, and financially sustainable. This approach supports long-term planning and shared accountability, helping build a coordinated system where families receive the right services at the right time, enabling the workforce to remain stable and effective.

Direct service cost models provide the per-child cost of delivering high-quality child care and home visiting services. These per-child outputs become the foundation for system modeling. When paired with demographic data, such as the number of children who need care, birth counts, eligibility criteria, or desired access levels, they allow the state to estimate the total statewide cost of different goals or policy choices. In this way, program decisions (such as compensation, caseloads, or quality enhancements) scale into real fiscal implications for the prenatal to five system. Building on this foundation, system cost models were developed to estimate the statewide costs of child care and home visiting under different assumptions related to compensation, access, and service intensity.

System Cost Model Scenarios

The system cost models were used to develop scenarios outlining an incremental phased approach for moving child care and home visiting forward together to achieve the CFA vision. Throughout CFA engagement activities, participants consistently emphasized the need for a coordinated, sequenced approach that first stabilizes the workforce, then expands access, and ultimately builds toward a fully aligned, sustainable prenatal to five system. This input shaped the structure, order, and assumptions of the system scenarios, ensuring they reflect both the lived realities of Montana communities and the shared vision for a more cohesive and equitable system.

Three system scenarios were developed using this phased approach:

Phase 1: Increased Workforce Investments

Reflecting the importance of the workforce and the impact of low salaries on programs' ability to recruit and retain qualified educators and home visitors, the first phase focuses on stabilizing the existing system through improved compensation.

- Child care subsidy rates and home visiting contract rates are increased to reflect the true cost of care under a living wage salary scale in the direct service cost models.
- Higher rates are applied to the current number of children and families served to estimate the cost of improving quality and workforce stability within existing capacity.

This phase sets the foundation for a stable and sustainable system.

Phase 2: Increased Access to Services

The second phase builds on the foundation of a stable workforce by providing incremental increases in access to services for children and families.

- **Child Care:** expanded access first to children in families with incomes at or below 185% of the federal poverty level, then to all children under age six with all available parents in the workforce at increased quality (68% the cost of quality).
- **Home Visiting:** Increased capacity to serve all Medicaid-eligible births, addressing gaps in access for families most in need of early supports.

This phase models the costs of expanding high-quality services to more children and families while maintaining true cost payment levels used in phase one.

Phase 3: Achieve CFA Vision

The third phase is aligns with the fiscal vision for the prenatal to five system providing access to all children and families who need services.

- **Child care:** Models the cost of providing high-quality care to all children under age six with all available parents in the workforce and moves the child care payment rates to 100% of the true cost of care.
- **Home visiting:** Includes the capacity to serve all Medicaid-eligible births plus a universal touch model reaching approximately 60% of total births, reflecting an integrated system of universal and targeted supports. Rates continue to pay the true cost of home visiting services.

This phase captures the full cost of achieving a cohesive, equitable, and high-quality system across service types.

Together, these phases outline a strategic progression from stabilization to expansion to the full realization of the vision for the prenatal to five system in Montana. They provide a framework for strategic planning, budget forecasting, and policy alignment. Specific details of the three phases and their selection points are included in Table 14.

Estimating the Cost of the Child Care System in Montana

The systemwide child care cost estimate includes the direct service cost of providing child care as well as the infrastructure necessary to support a robust child care system. This estimate includes children, infants through kindergarten entry. For the child care cost estimate, scenarios were developed in a phased approach, assuming not all those eligible will choose to take up services. Therefore, under phases 2a, 2b and 3, the cost estimate assumes that 60% of the eligible infant and toddler population

Table 14: Systemwide scenario details for child care and home visiting

	Phase 1: Increased Rates	Phase 2a: Increased Access	Phase 2b: Increased Access	Phase 3: Universal Access
Population	**Child care:** Children birth to five currently served by Best Beginnings Child Care Scholarship Program **Home Visiting:** Current estimated funded capacity	**Child care:** 60% of infants and toddlers, 80% of preschoolers with incomes at or below 185% FPG **Home Visiting:** Current estimated funded capacity	**Child care:** 60% of infants and toddlers, 80% of preschoolers with all available parents working **Home Visiting:** All Medicaid-eligible births	**Child care:** 60% of infants and toddlers, 80% of preschoolers with all available parents working **Home Visiting:** All Medicaid-eligible births and 60% of all other births
Rates	• Outputs using living wage salary • Child care rates at 68% of cost • Home visiting at 100% of cost	• Outputs using living wage salary • Child care rates at 68% of cost • Home visiting at 100% of cost	• Outputs using living wage salary • Child care rates at 68% of cost • Home visiting at 100% of cost	• Outputs using living wage salary • Child care rates at 100% cost of quality • Home visiting at 100% of cost
Total Slots	5,300	22,084	36,256	43,063

and 80% of the eligible preschool population is funded. This is aligned with data from other states where universal access has been offered. Phases 2a and 2b use rates at 68% of the cost of quality, and Phase 3 uses 100% the full cost of quality.

Infrastructure costs are estimated at 8% of the total direct service cost accounting for monitoring and compliance activities, income eligibility, administration, and quality supports such as professional development and coaching.

The total cost estimate also accounts for family contributions towards the cost of care. Family contributions are estimated based on a sliding fee scale, with no family paying more than 7% of their income on child care, with families at or below the federal poverty line paying nothing, and then contributions increasing gradually as income increases, up to a maximum of 7%.[16] Table 15 details total annual cost of each phase.

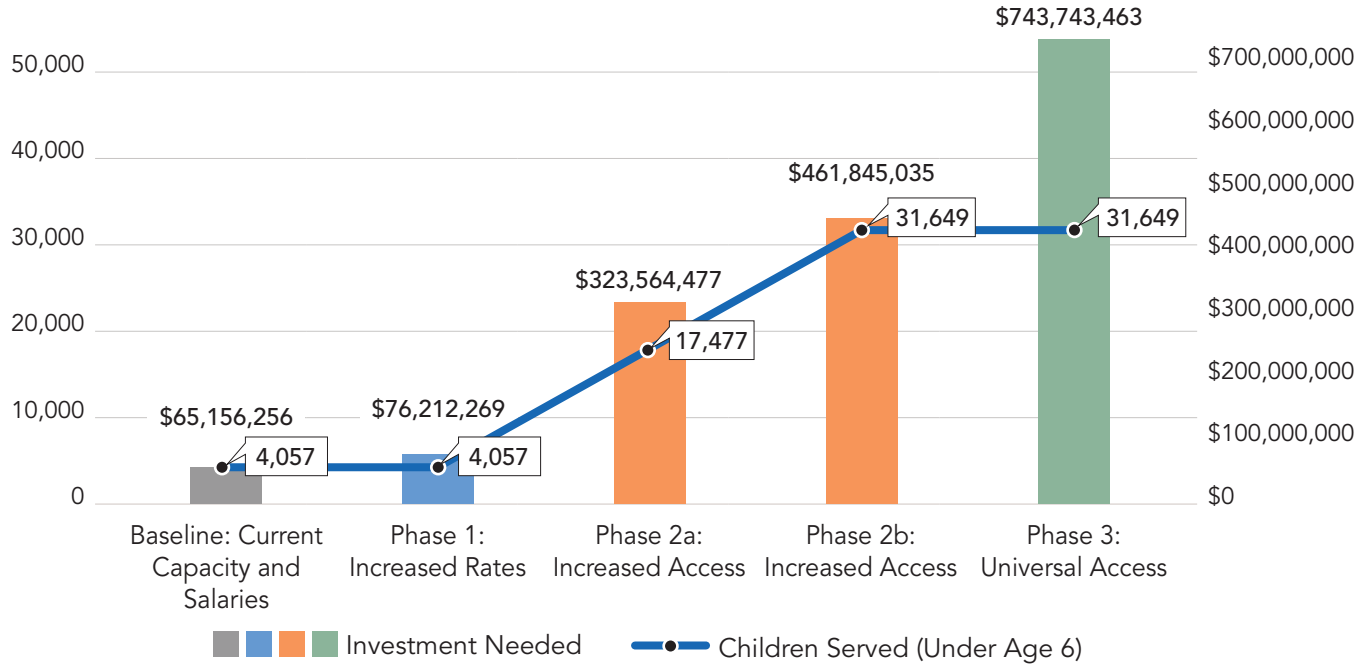
As shown, these estimates range from $76.2 million per year to increase funding rates for those currently served by the Best Beginnings Child Care Scholarship Program so that they cover a higher percentage of the cost of care, to $743.7 million per year to achieve the full vision for the child care system. The results are further illustrated in Figure 17.

[16]The 7% limit on family co-payments is aligned with how the federal definition of 'affordable' child care. See U.S. Department of Health and Human Services, 45 CFR Part 98, Final Rule, Improving Child Care Access, Affordability, and Stability in the Child Care and Development Fund (CCDF), available at: https://www.federalregister.gov/documents/2024/03/01/2024-04139/improving-child-care-access-affordability-and-stability-in-the-child-care-and-development-fund-ccdf - page-15368.

Table 15: Annual statewide child care cost scenarios

		Systemwide Scenarios			
	Baseline: Current Capacity and Salaries	**Phase 1: Increased Rates**	**Phase 2a: Increased Access**	**Phase 2b: Increased Access**	**Phase 3: Universal Access**
Children 0-5 years served	4,057[17]	4,057	17,447[18]	31,649[19]	31,649
Direct Services Cost	$61,763,172	$72,000,221	$305,760,511	$554,661,258	$815,678,321
Infrastructure Cost	$4,941,054	$5,760,018	$24,460,841	$44,372,901	$65,254,266
Family Copay Estimate	*(-$1,547,970)*	*(-$1,547,970)*	*(-$6,656,875)*	*(-$137,189,124)*	*(-$137,189,124)*
Annual Total	**$65,156,256**	**$76,212,269**	**$323,564,477**	**$461,845,035**	**$743,743,463**

Figure 17: Child care statewide cost summary



[17]Baseline and Phase 1 capacity includes children birth through five served by Montana Department of Public Health and Human Services, Early Childhood and Family Support Division, Best Beginnings Child Care Scholarship Program, 2024, https://dphhs.mt.gov/assets/Statistics/childcare/ManagerialReportSFY2024FINAL.pdf .

[18]Phase 2a capacity includes 60% of infants and toddlers and 80% of preschoolers eligible for Best Beginnings Scholarship (families earning 185% of Federal Poverty Guideline) determined using the American Community Survey, 2020, 5 year estimates, table B17024, Age by ratio of income to poverty level in the past 12 months, accessed via https://team3si.com/public/.

[19]Phase 2b capacity includes 60% of infants and toddlers and 80% of preschoolers eligible for eligible for Best Beginnings Scholarship Program and children under age six with all available parents working, accessed via https://datacenter.aecf.org/data/tables/5057-children-under-age-6-with-all-available-parents-in-the-labor-force?loc=28&loct=2#detailed/2/28/false/1096,2545,1095/any/11472,11473 .

Estimating the Cost of the Home Visiting System in Montana

The home visiting system cost estimate includes the direct service cost of providing home visiting as well as the infrastructure necessary to support a robust home visiting system. For the home visiting cost estimate, scenarios were developed using a phased approach to estimate the true cost of delivering home visiting programs and services across the state.

The first phase updates the estimated current funded capacity of all home visiting programs by adjusting the payment rates to include workforce compensation at MIT Living Wage.[20] The second phase builds on this by expanding capacity to serve all Medicaid-eligible births with home visiting payment rates informed by the MIT Living Wage salary point.[21] The third scenario further broadens services by maintaining full coverage for Medicaid-eligible births and adding capacity to reach 60% of all births through a universal touch model, also using payment rates for services with MIT Living Wage for compensation assumptions.[22] Infrastructure costs are estimated at 10% of the total direct service cost and cover program administration, professional development and training, and data collection and analysis. Table 16 presents these phased scenarios, all of which utilize the MIT Living Wage salary scale to inform the investments needed to raise wages and increase service capacity.

Table 16: Annual statewide home visiting cost scenarios

	Current Service Levels at BLS	Phase 1: Increased Rates	Phase 2: Increased Access	Phase 3: Universal Access
Funding Capacity	1,243	1,243	4,607	11,414
Direct Service Cost	$7,491,353	$12,071,871	$42,949,622	$51,738,586
Infrastructure Cost	$749,135	$1,207,187	$4,294,962	$5,173,859
Total Cost	**$8,240,488**	**$13,279,058**	**$47,244,584**	**$56,912,445**

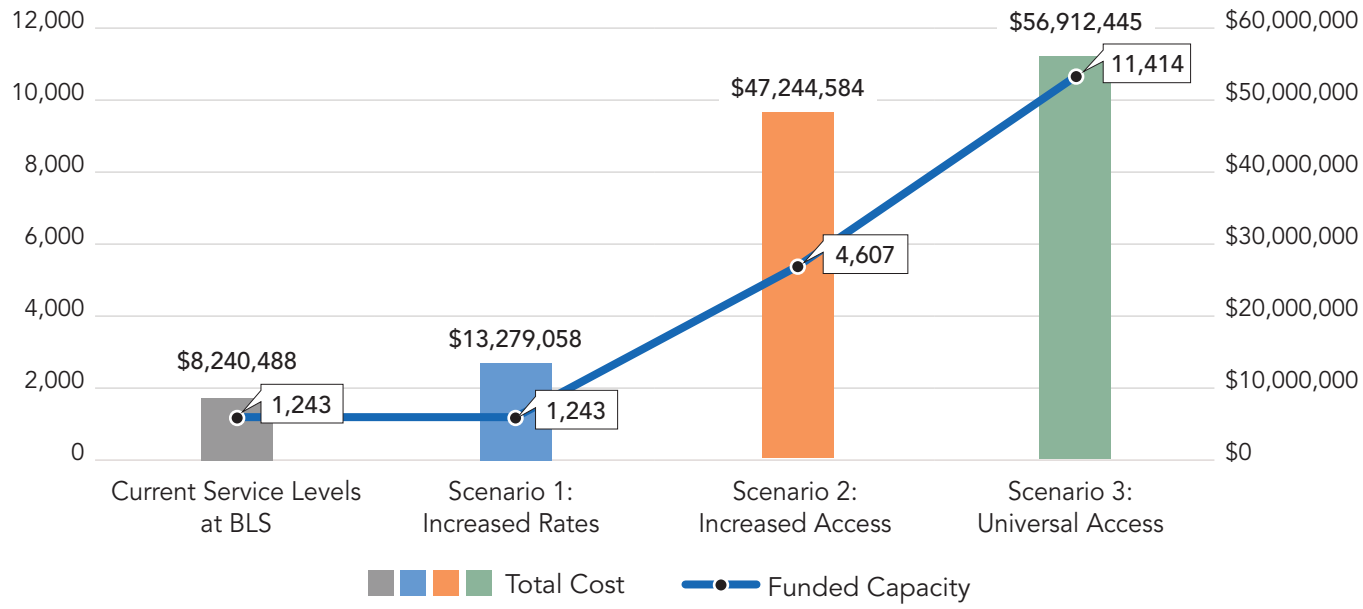
As shown, these estimates range from approximately $13.3 million per year to increase funding rates for those currently served by home visiting programs so that they cover a higher percentage of the cost of care, up to almost $57 million per year to achieve the full vision for the home visiting system. The results are further illustrated in Figure 18.

[20] Estimated funded capacity of home visiting programs in Montana including EHS Home-Based (124), Exchange Parent Aide (150), Family Spirit (30), Healthy Families America (100), Nurse-Family Partnership (125), Parents as Teachers (657), and SafeCare (57), data provided by the Montana Department of Public Health and Human Services.

[21] Scenario 2 adds 3,364 funded slots to include all Medicaid eligible births using 2023 data retrieved from https://dphhs.mt.gov/InteractiveDashboards/mtmedicaidbirthsdashboard.

[22] Scenario 3 adds 6,807 funded slots to include all Medicaid eligible births and 60% of all births using 2023 data retrieved from https://dphhs.mt.gov/InteractiveDashboards/mtmedicaidbirthsdashboard.

Figure 18: Home visiting statewide cost summary



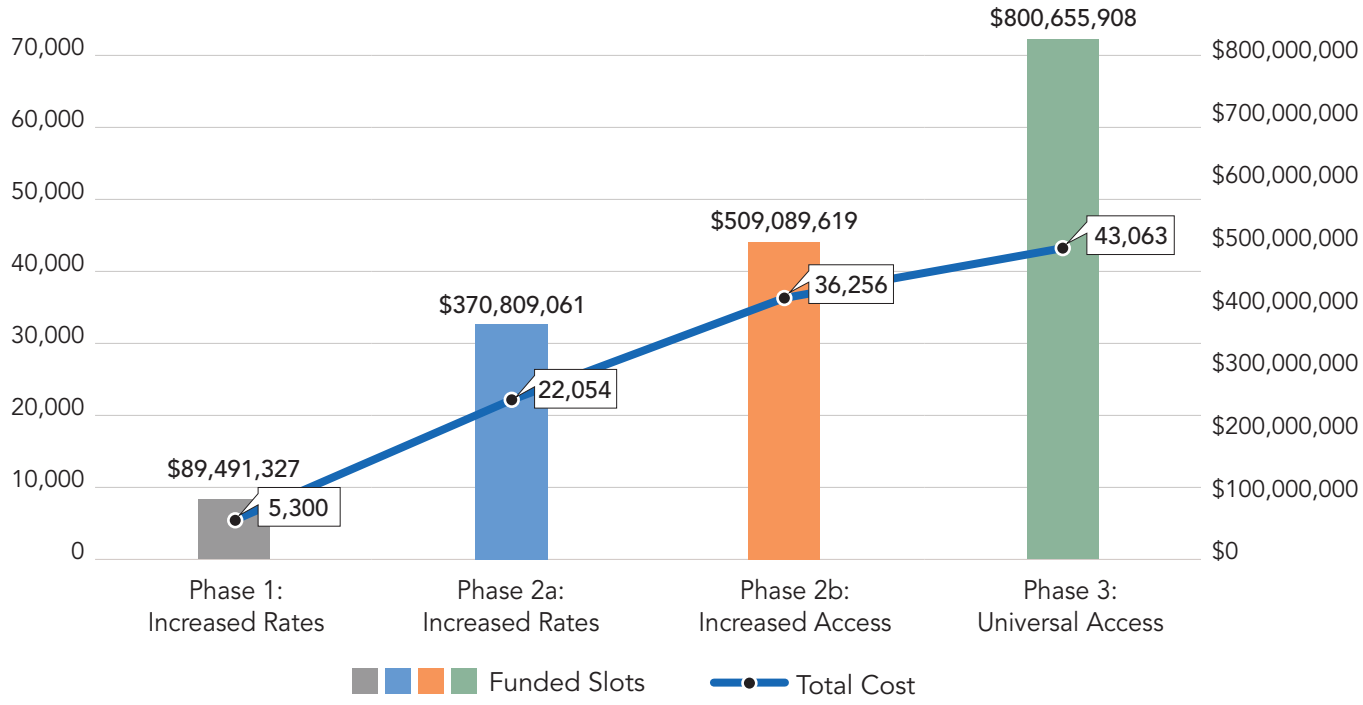
Overall Results

Combining the estimates from the child care and home visiting models, the total cost of achieving the vision for the prenatal to five system, as detailed in the CFA, is over $800 million, as shown in Table 17.

Table 17: Combined annual cost of child care and home visiting scenarios

	Systemwide Scenarios			
	Phase 1: Increased Rates	**Phase 2a: Increased Access**	**Phase 2b: Increased Access**	**Phase 3: Universal Access**
Capacity	5,300	18,690	36,256	43,063
Child Care	$76,212,269	$323,564,477	$461,845,035	$743,743,463
Home Visting	$13,279,058	$47,244,584	$47,244,584	$56,912,445
Total Estimated Cost	**$89,491,327**	**$370,809,061**	**$509,089,619**	**$800,655,908**

Figure 19: Combined annual cost of child care and home visiting scenarios



VI. Findings and Recommendations

Informed by the fiscal mapping and cost modeling analysis and with input from the Montana Prenatal to Five Comprehensive Fiscal Analysis Work Group, recommendations were developed to strengthen and support the prenatal to five system in Montana, aligned with the priorities that emerged throughout the engagement process.

The Montana Prenatal to Five Comprehensive Fiscal Analysis (CFA) process identified several themes that represent shared priorities for advancing Montana's prenatal to five system. These themes cut across programs, geography, and roles within the prenatal to five system:

1. **Increase access to prenatal to five programs and services**
   Participants emphasized the importance of building a system where every family can find and afford services, regardless of geography or income. rural community participants described barriers such as long travel distances, limited program options, and challenges with digital access. Participants also requested a unified, user-friendly approach to connecting families to resources and simplifying eligibility processes.
2. **Enhance authentic engagement**
   Families, providers, and community coalitions emphasized the importance of

being heard in decision-making processes. Participants supported structures such as the Early Childhood Network, Early Childhood Coalitions, and the Early Childhood Tribal Coalition which provide ongoing feedback loops among state and local partners.

3. **Invest in the true cost**
   Participants supported using accurate cost data to inform funding decisions and policy changes. Many noted that data collection should be efficient, transparent, and not burdensome for providers, while being used to demonstrate the value and sustainability of investments.
4. **Build and support the prenatal to five workforce**
   Providers and administrators described widespread workforce shortages, low pay, and high turnover that undermine service quality and consistency. Feedback highlighted the need for sustainable funding for wages and benefits, leadership development, career pathways, and professional supports such as coaching and mental health consultation.
5. **Fund comprehensive supports for children and families**
   The need for integrated services that address families' full range of needs, including health, mental health, education, housing, and economic stability, was emphasized. This need included calls to embed trauma informed approaches and strengthen family navigation supports statewide.
6. **Promote cultural competence and Tribal partnership**
   Across discussions, participants stressed the need to honor Tribal sovereignty, integrate culturally grounded practices, and ensure alignment between state regulations and local traditions. Strengthening trust-based relationships and co-developing frameworks with Tribal Nations were viewed as essential to effective system change.
7. **Build the capacity of the prenatal to five system**
   Participants consistently urged greater alignment across programs and agencies to reduce duplication and administrative burden. They called for flexible policies that recognize local and Tribal contexts, support cross-sector collaboration, and create efficiencies through coordinated funding and shared data systems.

These seven key priorities emerged as critical to strengthening Montana's prenatal to five system reflecting the interconnected nature of challenges and opportunities across programs and communities. The discussions reflected broad agreement that Montana's prenatal to five system is strongest when it is locally informed, culturally responsive, and fiscally aligned.

Recommendations

The seven themes became the foundation for three overarching recommendations: **Access, Workforce, and System**. Together, these overarching recommendations outline a strategic roadmap for building a cohesive, sustainable prenatal to five system that meets the needs of all Montana children and families. These recommendations are rooted in the experiences and insights of Montana providers, Tribal partners, community leaders, and program administrators, and reflect both the needs identified in the fiscal analysis and the values outlined in the state's fiscal vision for the prenatal to five system.

The following section details each recommendation and its related strategies, outlining both the rationale and the fiscal actions needed to advance the prenatal to five system in Montana.

1. **Access:** Increase access to quality, responsive prenatal to five programs and services.
2. **Workforce:** Explore long term strategies, including public investment, to attract and retain prenatal to five professionals.
3. **System:** Invest in the efficiency, flexibility, and coordination of services and the system.

Each recommendation includes strategies that operationalize the fiscal vision and guiding principles, align with Montana's Preschool Development Grant Birth through Five (PDG B-5) Needs Assessment Update[xlii] and Strategic Plan[xliii], and provide actionable steps for state and local partners to advance a more cohesive, equitable, and financially sustainable prenatal to five system.

Alignment with the Montana Preschool Development Grant Birth through Five

Montana's early childhood strategic plan, Sustaining and Strengthening Montana's Early Childhood System, highlights five focus areas around access, workforce, family engagement, coordination, and governance. These five focus areas align with the three recommendation themes in the CFA, demonstrating shared priorities for expanding access, building and supporting the workforce, and strengthening system efficiency and equity:

Strategic Plan Focus Areas	CFA Recommendation Themes
1. Access to High-Quality Services	1. Access
2. Workforce	2. Workforce
3. Family Engagement	3. System
4. Coordination	
5. Shared Early Childhood Governance	

The CFA findings and recommendations align closely with Montana's 2025 – 2030 Early Childhood Strategic Plan, developed under the PDG B-5 funding. Both emphasize equitable access, workforce sustainability, data-informed decision-making, and efficient system coordination. The CFA provides the fiscal analysis and cost modeling foundation to operationalize the Strategic Plan's goals, particularly through strategies that support sustainable financing, align with the Montana Early Childhood Special Revenue Account established through the Growth and Opportunity Trust passed by the legislature through House Bill 924, and promote continuous improvement across the prenatal to five system.

With these recommendations, the prenatal to five system can better meet the needs of every child and family in Montana. This section presents the significant findings of the analysis and the rationale supporting each recommendation, shown in Table 18.

Table 18: Montana Prenatal to Five Comprehensive Fiscal Analysis Recommendations and Strategies

Recommendations	
1. Increase **access** to quality, responsive prenatal to five services and programs.	a. Develop a comprehensive strategy to ensure all families can access prenatal to five services by identifying and securing sustainable funding sources, expanding program capacity, simplifying eligibility processes, and removing barriers to participation. b. Advance a statewide preschool to third grade alignment strategy through shared leadership and planning between early childhood programs and school districts, including joint transition planning and family engagement. c. Define shared, outcome-based quality standards that promote continuous improvement while allowing for local flexibility and responsiveness to community strengths. d. Increase investment in family engagement and navigation services, such as universal home visiting, parenting education, family navigation and warm handoff systems to connect families to essential supports, such as housing, food, and behavioral health services. e. Embed services, including mental health services for children, families, and the workforce across the prenatal to five system, with a focus on supporting professionals and families in rural and underserved areas.
2. Explore long term strategies, including public investment, to attract and retain the prenatal to five **workforce**.	a. Increase compensation, including wages and benefits, to support the recruitment and retention of prenatal to five professionals. b. Invest in ongoing professional development, reflective supervision, coaching, and mental health supports for early childhood professionals. c. Strengthen the capacity of the prenatal to five workforce's capacity to engage respectfully and effectively with children and families from varied backgrounds, including children with developmental delays and/or disabilities and special health care needs, through training and coaching. d. Expand and support accessible, sustainable career pathways into the prenatal to five field. e. Build leadership capacity at all system levels to foster inclusive, supportive workplace cultures that promote staff well-being and longevity.

Recommendations	
3. Invest in the efficiency, flexibility, and coordination of services and the **system**.	a. Develop flexible state policies that allow for responsive implementation across diverse local contexts, including Tribal Nations and rural areas. b. Establish consistent, meaningful engagement opportunities for families, providers, and communities to inform decision-making across the prenatal to five system, with clear feedback loops. c. Use data on the true cost of delivering quality services to inform state and local funding decisions. d. Invest in sustained, trust-based relationship building among state agencies, rural communities, and Tribal Nations using a framework, led by Tribal and rural community leaders, that guides policy, service delivery, and training. e. Empower local communities by providing dedicated resources and decision-making authority to develop and implement strategies that reflect local priorities while aligning with statewide goals. f. Ensure state standards reflect and respect community practices, particularly in Tribal Nations and rural areas, to promote alignment and continuity across systems. g. Support funding strategies that prioritize children and families' full range of needs, such as early learning and development, health, housing, and emotional well-being, by investing in coordinated services that work together to help families thrive.

Recommendation 1:
Increase access to quality, responsive prenatal to five services and programs.

Ensuring all families can find, afford, and benefit from high-quality prenatal to five programs is central to building a strong and equitable system. The CFA revealed that access challenges in Montana are shaped by geography, affordability, and limited program capacity, particularly in rural communities and Tribal Nations. Addressing these gaps requires coordinated fiscal and policy strategies that expand services, align eligibility and funding structures, and strengthen connections between families and supports. These recommendations and strategies aim to build a system where every family, regardless of income or location, can access the resources they need to thrive.

a. **Build a comprehensive access strategy:** Families across Montana experience inconsistent access to prenatal to five

programs and services due to limited capacity, fragmented eligibility systems, and funding constraints that vary by community. A coordinated statewide access strategy ensures that all children and families, regardless of income, geography, or background, can connect to the supports they need. A comprehensive plan should identify and secure sustainable funding sources, expand program capacity, simplify eligibility and enrollment processes, and remove administrative and logistical barriers to participation. This strategy should align state and local funding mechanisms and prioritize investments that reach underserved rural and Tribal communities.

Collaboration between the Department of Public Health and Human Services (DPHHS) and the Office of Public Instruction (OPI) is essential to building a cohesive preschool through third grade system. Fiscal mapping identified data gaps in early childhood special education, Title I, and early literacy funding, limiting a complete understanding of statewide early learning investments. Strengthening fiscal and program data sharing between agencies would improve transparency, provide a more complete picture of early childhood spending, and ensure funding decisions across departments are aligned to promote equitable access, smooth transitions, and continuity of learning from birth through grade three.

> **Strategy:** Develop a comprehensive strategy to ensure all families can access prenatal to five services by identifying and securing sustainable funding sources, expanding program capacity, simplifying eligibility processes, and removing barriers to participation.

b. **Strengthen preschool to third grade alignment:** Smooth transitions between early learning and elementary school are essential for children's long-term success. When early childhood programs and schools share leadership, expectations, and communication, children experience continuity in learning, and families remain engaged in their child's education. A statewide preschool to third grade alignment strategy encourages collaboration between school districts and early learning programs and includes joint professional development, data sharing, and transition planning. State leadership can support this alignment by providing coordinated guidance, offering incentives for local partnerships, and integrating alignment activities into strategic planning and accountability systems.

   > **Strategy:** Advance a statewide preschool to third grade alignment strategy through shared leadership and planning between early childhood programs and school districts, including joint transition planning and family engagement.

c. **Define shared, outcome-based quality standards:** Clear and consistent quality standards ensure that all children and families receive effective, developmentally appropriate care and services while allowing programs to meet local needs. Shared standards create transparency across funding streams and help the state target resources to where they will have the greatest impact. Outcome-based quality measures that support continuous improvement can be defined through collaboration with providers, families, Tribal partners, and community leaders, aligned these standards across program types and funding sources, and emphasizing results rather than compliance. Technical assistance, coaching, and data tools should be provided to help programs apply these standards to ongoing quality improvement efforts.

Strategy: Define shared, outcome-based quality standards that promote continuous improvement while allowing for local flexibility and responsiveness to community strengths.

d. **Expand family engagement and navigation services:** Families are more likely to access and sustain services when they have trusted guides to help them navigate complex systems. Family engagement and navigation supports, such as home visiting, parenting education, and warm handoff systems, connect families to essential resources that address their holistic needs. Increasing investment in family engagement and navigation infrastructure through coordinated funding and workforce development will build capacity for universal home visiting and other family support programs that offer consistent connection points for families. Integrating navigation roles within existing programs ensures families can easily access supports related to housing, food, health care, and behavioral health.

   Strategy: Increase investment in family engagement and navigation services, such as universal home visiting, parenting education, family navigation and warm handoff systems to connect families to essential supports, such as housing, food, and behavioral health services.

Both the CFA and the Strategic Plan emphasize centering families as partners in system design and implementation prioritizing investments in family navigation, home visiting, and engagement supports that make systems more responsive and accessible.

e. **Embed family and workforce mental health supports:** Children's healthy development depends on the well-being of the adults who care for them. Embedding mental health supports for children, families, and the workforce promotes resilience, reduces stress, and improves program quality, especially in communities with limited access to services. Investing in integrated infant and early childhood mental health consultation, staff wellness programs, and family support services across all prenatal to five programs and expanding in rural and underserved areas through shared service models, telehealth partnerships, and cross-agency funding will strengthen the entire system by supporting those who receive care and those who provide it.

   Strategy: Embed services, including mental health services for children, families, and the workforce across the prenatal to five system, with a focus on professionals and families in rural and underserved areas.

Recommendation 2:
Explore long term strategies, including public investment, to attract and retain the prenatal to five workforce.

Montana's prenatal to five workforce is the foundation of the state's prenatal to five system, yet it remains among the most underpaid and undervalued sectors in the economy. Compensation levels in Montana's prenatal to five sector fall far below the living wage and the true cost of sustaining a qualified workforce, leading to recruitment and retention challenges across program types.[xliv] Investing in the workforce is both an equity and fiscal strategy ensuring that programs can deliver high-quality services, that professionals earn a living wage, and that the system can attract and retain the talent needed to meet family demand.

These recommendations and strategies outline a roadmap for building a stable, supported, and respected prenatal to five workforce statewide.

> The Strategic Plan explicitly focuses on a "coordinated, supported, and sustainable early childhood workforce pipeline", including expanding apprenticeships and pre-apprenticeships, funding stipends and wellness supports, and integrating Tribal approaches. The CFA's workforce recommendations and strategies operationalize these objectives by identifying the true cost of fair compensation and by aligning wage scales and benefits across sectors.

a. **Address compensation:** Most of the workforce in Montana's prenatal to five sector earns wages well below the state's living wage, often without access to benefits such as health insurance or paid leave. Low compensation undermines recruitment, increases turnover, and weakens program quality and stability. Cost modeling data should be used to establish wage and benefit benchmarks that reflects the true cost of quality, which should be incorporated into rate-setting, grant programs, and contracts across funding streams. Compensation strategies, including wage supplements and salary scales, should be explored to help programs meet wage goals while maintaining affordability for families.

   Strategy: Increase compensation, including wages and benefits, to support the recruitment and retention of prenatal to five professionals.

b. **Build capacity:** Ongoing professional learning strengthens the quality of care and builds a more confident, skilled, and committed workforce. However, many Montana providers lack access to consistent coaching, reflective supervision, or mental health supports that help them manage the emotional demands of their work. Investment in professional development systems that integrate coaching, reflective supervision, and mental health supports into everyday practice should be expanded. Higher education and training partners should be leveraged to build consistent statewide frameworks and ensure equitable access to these supports across regions and program types.

   Strategy: Invest in ongoing professional development, reflective supervision, coaching, and mental health supports for early childhood professionals.

c. **Strengthen workforce capacity to support all children and families:** Montana's workforce serves children and families with diverse cultural backgrounds, languages, and developmental needs. Equipping professionals with the skills to deliver culturally and linguistically responsive care and to support children with disabilities or special health care needs is essential for both quality and equity. Targeted professional development and ongoing coaching focused on inclusion, cultural responsiveness, and trauma-informed care should be offered. Tribal Nations, higher education institutions, and family advocacy organizations should co-develop training curricula and credentialing opportunities that reflect Montana's unique cultural and community contexts.

   Strategy: Strengthen the capacity of the prenatal to five workforce to engage respectfully and effectively with children and families from varied backgrounds, including children with developmental delays and/or disabilities and special health care needs, through training and coaching.

d. **Expand career pathways:** Sustainable workforce development requires accessible, affordable, and aligned career pathways that lead to advancement and professional recognition. Without clear progression and leadership opportunities, Montana risks losing talented professionals to other sectors that offer higher pay and greater stability. Stackable credentials, articulation agreements, and paid apprenticeship models that make entry into and advancement within the prenatal to five field more attainable should be developed and expanded. State credentialing and licensing systems should be aligned to ensure that experience, coursework, and community-based training are recognized across program types. These strategies can help recruit new professionals, diversify the workforce, and strengthen retention across Montana's prenatal to five system.

   Strategy: Expand and support accessible, sustainable career pathways into the prenatal to five field.

e. **Strengthen leadership capacity at all levels:** Strong leadership is essential to creating positive workplace cultures, supporting staff well-being, and guiding continuous quality improvement, yet many administrators and supervisors lack access to leadership training, coaching, or resources to support staff in high-stress, low-wage environments. Leadership development initiatives at the local, regional, and state levels should include targeted training in inclusive management, reflective supervision, and organizational health to help leaders foster supportive, equitable workplaces. Mentorship networks and peer learning communities that elevate emerging leaders and promote collaboration across sectors should be encouraged. Strengthening leadership capacity improves staff retention, enhances quality, and contributes to a more resilient prenatal to five system.

   Strategy: Build leadership capacity at all system levels to foster inclusive, supportive workplace cultures that promote staff well-being and longevity.

The CFA builds on the Strategic Plan's workforce objectives by identifying the fiscal strategies needed to sustain competitive compensation, expand career pathways, and integrate professional development models that reflect Montana's Tribal and rural contexts.

Recommendation 3:
Invest in the efficiency, flexibility, and coordination of services and the system.

A well-functioning prenatal to five system depends on strong infrastructure, efficient financing, and authentic collaboration across sectors. The CFA identified opportunities to improve coordination among funding streams, streamline administrative processes, and ensure state standards reflect community and Tribal priorities. Strengthening system capacity through data integration, local flexibility, and sustained engagement creates the conditions for long-term sustainability and equity. These recommendations focus on building a responsive, fiscally sound, and community-informed system that can adapt to Montana's diverse needs and effectively support children and families.

a. **Strengthen policy flexibility:** Montana's communities are diverse spanning large rural areas, frontier regions, and sovereign Tribal Nations. Overly rigid state policies can create

unintended barriers to access and quality when local programs cannot adapt to community needs or realities. Flexible policy design ensures that local innovation can flourish while maintaining statewide consistency and accountability. State policies, funding requirements, and program standards should continue to be reviewed and revised to allow for local adaptation and implementation. Mechanisms such as waivers, pilot initiatives, or differentiated support models should be established to enable communities to tailor solutions while aligning with statewide goals should be established.

Strategy: Develop flexible state policies that allow for responsive implementation across diverse local contexts, including Tribal Nations and rural areas.

b. **Institutionalize continuous engagement and feedback loops:** Effective system improvement depends on consistent communication and shared learning between the state and the communities it serves. Without structured feedback mechanisms, policy and funding decisions can become disconnected from on-the-ground realities. Ongoing engagement strengthens trust, transparency, and accountability while ensuring fiscal decisions reflect family and provider experiences. Advisory councils, regional forums, and cross-sector networks, like the Early Childhood Network and Early Childhood Coalitions, should be leveraged to facilitate regular, meaningful engagement with families, providers, and local leaders. Expectations for feedback should be embedded in program contracts and strategic plans to inform funding priorities, simplify administrative processes, and continuously refine system design.

Strategy: Establish consistent, meaningful engagement opportunities for families, providers, and communities to inform decision-making across the prenatal to five system, with clear feedback loops.

Together, the CFA and Strategic Plan advance a shared vision for transparent, coordinated governance and continuous improvement, where data, community feedback, and fiscal accountability guide decisions.

c. **Use true cost data to drive fiscal decision-making:** Without accurate cost data, funding decisions risk perpetuating inequities and inefficiencies. Current rates and allocations often fall short of covering the true cost of delivering services, particularly in rural and underserved areas. Using cost modeling data provides a more transparent and equitable foundation for investment decisions. Cost model data should be used in rate-setting, grant award decisions, and budget development. Data should also be used by local communities, providers, and coalitions to inform local planning, build community partnerships, and advocate for diversified funding strategies that complement state and federal investments. Cost models should be updated regularly to reflect inflation, workforce compensation benchmarks, and regional cost variations. Training and tools to help state and local partners use these data to plan, evaluate funding gaps, and inform policy decisions should be offered.

Strategy: Use data on the true cost of delivering quality services to inform state and local funding decisions.

This recommendation supports the Strategic Plan's emphasis on data-informed decision-making and aligns directly with its call to establish a statewide Early Childhood Fund and conduct ongoing fiscal analysis to guide sustainable investments.

d. **Build trust-based relationships:** Trust and collaboration are essential to an effective prenatal to five system. Tribal Nations and rural communities bring deep expertise and cultural knowledge about what works for their children and families. Sustained, trust-based relationships ensure that policies and funding structures respect local sovereignty, traditions, and priorities. Investing in ongoing relationship-building through a shared framework co-developed and led by Tribal and rural community leaders will build trust. This framework should guide policy alignment, service delivery, and workforce training. Regular consultation, transparent communication, and joint planning processes that honor self-determination and local decision-making authority should be prioritized.

   Strategy: Invest in sustained, trust-based relationship building among state agencies, rural communities, and Tribal Nations using a framework, led by Tribal and rural community leaders, that guides policy, service delivery, and training.

e. **Empower communities:** Local communities are best positioned to understand their own needs and strengths. When they are empowered with resources and authority, they can design and implement strategies that improve coordination and responsiveness. Shifting decision-making closer to communities strengthens accountability and ensures fiscal resources are used efficiently and equitably. Dedicated funding to support local early childhood coalitions, including rural and Tribal partnerships, to lead planning and implementation efforts should be offered. Flexible grant mechanisms that allow communities to pilot innovative strategies aligned with statewide goals should be developed. Reporting and learning systems should be established to share best practices and track outcomes.

   Strategy: Empower local communities by providing dedicated resources and decision-making authority to develop and implement strategies that reflect local priorities while aligning with statewide goals.

f. **Align state standards with community and cultural practices:** Statewide standards and accountability systems help ensure consistency, but when they do not reflect community or Tribal practices, they can create tension or limit participation. Aligning standards with local context improves relevance, supports cultural responsiveness, and fosters shared ownership of quality and outcomes. Collaboration with Tribal Nations, community leaders, and local providers should occur to review and revise standards and program requirements, incorporating culturally grounded practices, local languages, and community-defined indicators of success. Flexibility within statewide frameworks to ensure alignment without compromising quality or accountability should be allowed.

   Strategy: Ensure state standards reflect and respect community practices, particularly in Tribal Nations and rural areas, to promote alignment and continuity across systems.

The CFA aligns with the Strategic Plan's emphasis on formalized Tribal consultation and culturally grounded service design, reinforcing the state's commitment to equity and honoring local sovereignty.

g. **Coordinate funding for comprehensive supports for children and families:** Families' needs are interconnected spanning early learning, health, housing, and economic stability. Fragmented funding streams make it difficult for programs to coordinate supports effectively, leading to service gaps and inefficiencies. Coordinating funding to address the full range of family needs ensures that public dollars are used strategically to achieve comprehensive outcomes. Financing strategies that braid and blend funds across early learning, health, and family support sectors should be explored and adopted. Interagency collaboration and shared outcome measurement to align investments should be encouraged. Funding models that support comprehensive family navigation, cross-sector service coordination, and equitable access to wraparound supports that help families thrive should be prioritized.

   Achieving a truly comprehensive, aligned system for children and families also requires coordinated funding and data sharing across state agencies. Collaboration between DPHHS and OPI is essential to ensure that fiscal and program data reflect the full scope of early learning investments, from early childhood special education and Title I to early literacy supports. Enhanced coordination would enable more complete fiscal mapping, guide cost modeling updates, and promote integrated planning that supports equitable access and the efficient use of resources statewide. Establishing shared fiscal data systems and consistent reporting mechanisms across agencies would strengthen transparency, accountability, and the state's capacity to make informed, data-driven investments that reflect the true cost of quality services.

   Strategy: Support funding strategies that prioritize children and families' full range of needs, such as early learning and development, health, housing, and emotional well-being, by investing in coordinated services that work together to help families thrive.

The three recommendation areas – **Access, Workforce, and System** – are deeply interconnected and mutually reinforcing:

- Expanding access ensures all families can benefit from high-quality prenatal to five programs and services.
- Strengthening the workforce guarantees programs are led by skilled, fairly compensated professionals who can provide consistent, responsive care.
- Investing in system coordination creates the infrastructure, policy environment, and fiscal alignment needed to sustain these efforts over time.

These strategies provide a roadmap for stabilizing and strengthening Montana's prenatal to five system – one that is efficient, equitable, and financially sustainable. By aligning fiscal decisions with the true cost of services and the lived experience of families and providers, Montana can build a cohesive system that supports every child, family, and community to thrive. Together, these recommendations establish a framework for implementation that connects fiscal policy, community leadership, and sustainable investment, ensuring Montana's prenatal to five system continues to grow stronger for generations to come.

VII. Conclusion

The findings of the Montana Prenatal to Five Comprehensive Fiscal Analysis make clear that Montana's current financing structure is not sufficient to meet the true cost of delivering high-quality prenatal to five services across the state. Despite deep commitment at the state, local, and Tribal levels, Montana's programs continue to operate within funding systems that fall short of what is required to sustain a skilled workforce, support consistent quality, and ensure that all families, regardless of geography, income, or background, can reliably access the services they need.

Cost modeling demonstrates significant gaps between existing reimbursement, grant, or contract levels and the resources required to deliver stable, high-quality prenatal to five services and programs. Fiscal mapping highlights the state's heavy reliance on federal funds. Together, these findings underscore the urgent need for long-term, coordinated financial reform to stabilize the workforce, expand access, and build a system capable of meeting Montana's vision for young children and families.

Addressing these challenges will require intentional, sustained investment;

strengthened coordination across state agencies, Tribal Nations, and community partners; and the use of true-cost data to guide policy and funding decisions. By adopting the recommendations outlined in this report, including increased workforce compensation, expanded access to high-quality prenatal to five services, and investments in system infrastructure, Montana has an opportunity to build a prenatal to five system that is equitable, resilient, and financially sustainable.

Moving forward, Montana's success will depend on shared ownership of this work: state and Tribal leadership, prenatal to five professionals, families, policymakers, advocates, and community partners all play essential roles in advancing a system that reflects Montana's values and meets the needs of every child and family. With strategic action and ongoing collaboration, Montana can transform its prenatal to five system to fully support children's healthy development, strengthens families, and contributes to the long-term vitality of communities across the state.

Appendix

A. Montana Prenatal to Five Comprehensive Fiscal Analysis Work Group Members

Amber Bell	Children's Special Health Services Section Supervisor	Montana Department of Public Health and Human Services
Taylor Boylan Forrester	Director	Montana Early Childhood Project
Hollin Buck	Program Manager	Healthy Mothers Healthy Babies
Jill Christensen	Bureau Chief, Early Childhood Services	Montana Department of Public Health and Human Services
Mary Collins	Project Director, Center for Children, Families and Workforce Development	University of Montana
Alex DuBois	Policy and Engagement Director	Zero to Five Montana
Karen Filipovich	Executive Director	Montana Head Start Association
Stephanie Iron Shooter	American Indian Health Director	Montana Department of Public Health and Human Services
Jacqueline Isaly	Family and Community Health Bureau Chief	Montana Department of Public Health and Human Services
Caitlin Jensen	Executive Director	Zero to Five Montana
Sheridan Johnson Hoyer	Government Relations Specialist	Montana Chamber of Commerce
Carrie Krepps	Executive Director	Florence Crittenton Family Services
Leslie Lee	Healthy Montana Families Supervisor	Montana Department of Public Health and Human Services
Jody Lehman	Child Care Bureau Chief	Montana Department of Public Health and Human Services
Stephanie Morton	Executive Director	Healthy Mothers Healthy Babies
Tracy Moseman	Administrator	Montana Department of Public Health and Human Services
Callie Parr	Early Childhood Tribal Coordinator	Zero to Five Montana
Ashley Peña-Larsen	Director / Chair	Rocky Head Start / Montana Head Start Association
Mandy Rambo	Deputy Director	Montana Department of Commerce
Kathy Rich	Bright Futures B-5 Grant Manager	Montana Department of Public Health and Human Services
Rhiannon Shook	Child Care Workforce Consultant	Montana Department of Labor & Industry

Tori Sproles	Director of Early Learning	Greater Gallatin United Way
Rhonda Schwenke	Program Director	Zero to Five Montana
Sara Urbanik	Executive Director	OP & WE Edwards Foundation
Rachel Wanderscheid	Director	The Montana Afterschool Alliance
Amy Watson	State Economist	Montana Department of Labor & Industry
Mandi Zanto	Maternal Child Health Coordination Section Supervisor	Montana Department of Public Health and Human Services

B. Montana Prenatal to Five Comprehensive Fiscal Analysis Engagement Activities and Dates

Engagement Activity	Date
Constituent Group and CFA Work Group Launch Meetings	May 29, 2024
Child Care Business Connect Summit Presentation and Feedback	August 8, 2024
CFA Work Group Launch	August 8, 2024
CFA Work Group Catch-Up Meeting	October 4, 2024
CFA Work Group	October 16, 2024
Constituent Group Quarterly Update Meeting	November 19, 2024
Child Care Ad Hoc	December 4, 2024
CFA Work Group	December 12, 2024
CFA Work Group	January 10, 2025
Child Care Ad Hoc	January 16, 2025
Home Visiting Ad Hoc	February 5, 2025
Child Care Ad Hoc	February 10, 2025
Constituent Group Quarterly Update Meeting	March 11, 2025
Home Visiting Ad Hoc	March 12, 2025
CFA Work Group	March 13, 2025
Home Visiting Ad Hoc	April 9, 2025
CFA Work Group	April 10, 2025
Home Visiting Ad Hoc	May 1, 2025
CFA Work Group	May 14, 2025

Engagement Activity	Date
Child Care Ad Hoc	May 21, 2025
Constituent Group Quarterly Update Meeting	May 27, 2025
CFA Work Group	July 22, 2025
CFA Work Group	September 12, 2025
Constituent Group and CFA Work Group Implementation Meeting	November 13, 2025

C. Child Care Ad Hoc Members

Participant	Organization
Michelle Bowser	Opportunities, Inc.
Collette Box	Discovery Developmental Center
Sarah Forney	St. Johns United
Sheryl Hutzenbiler	Montana Family Child Care Network
Callie Parr	Zero to Five Montana
Molly Rios	Butte 4-C's
Carrie Schwartz	Baker Childcare and Early Learning Center
Rhonda Schwenke	Zero to Five Montana
Karen Smith	Child Care Training/Child Care Resources
Tori Sproles	Greater United Way
Sara Urbanik	O.P. & W.E. Edwards Foundation
Kristi Wilson	Kristi's Kiddie Korner

D. Home Visiting Ad Hoc Members

Participant	Organization
Terri Amburg	Butte 4-C's
Hollin Buck	Healthy Mothers Healthy Babies
Karen Filipovich	Montana Head Start Association
Amie Gatterdam	Gallatin City-County Health Department
Shannon Hauck	RiverStone Health
Jacqueline Isaly	Montana Department of Public Health and Human Services
Jenn Kirscher	Missoula Public Health
April Quinlan	Mineral County Health Department
Sarah Sandau	Lewis and Clark Public Health
Rhonda Schwenke	Montana Zero to Five
Renee Steinbron	Dawson County Health Department
Austin Waldbillig	Montana Department of Public Health and Human Services

E. Montana Prenatal to Five Comprehensive Fiscal Analysis Fiscal Mapping Interviews

Program/Service/Initiative	Interviewee
Montana Milestones Early Intervention	Jill Christensen Josh Kendrick
Head Start Programs	Karen Filipovich Ashley Peña-Larson
Head Start State Collaboration Office	Mark Douglas
OPI Programs • Title 1 • Preschool Special Education • Early Literacy Targeted Interventions	Christy Mock Stultz
Best Beginnings Child Care Scholarship Program	Jody Lehman Nicole Quirino Sally Tillman
Funders for Montana's Children	Sara Urbanik
Medicaid	Tracy Moseman Gene Hermanson

Program/Service/Initiative	Interviewee
Children's Trust Fund	Josh Kendrick
Healthy Montana Families	Leslie Lee Jacqueline Isaly
Butte 4C's	Terri Amberg Kim Polich
Riverstone Health	Kristen Bonner
Title V Maternal and Child Health Block Grant	Mandi Zanto
Children's Health Services	Amber Bell
Healthy Mothers Healthy Babies	Hollin Buck Stephanie Morton
Early Childhood Coalitions	Alex DuBois
Early Childhood Tribal Coalition	Callie Parr
Raise Montana	Grey Bertsche
MTAEYC	Jennifer Sevier
University of Montana Center for Children, Families, and Workforce Development	Kate Chapin Mary Collins
University of Montana Institute for Early Childhood Education	Allison Wilson
Montana Family Child Care Network	Sheryl Hutzenbiler
Montana Budget and Policy Center	Xanna Burg
Montana Advocates for Children	Grace Decker
Zero to Five	Rhonda Schwenke Caitlin Jensen
Preschool Development Grant Activities	Kathy Rich
Prenatal to Five Systems	Alex DuBois Rhonda Schwenke Caitlin Jensen
School Administrators of Montana	Rob Watson

F. Child Care Direct Service Cost Model Outputs

Table 19 details the assumptions of the default scenarios for child care centers. Table 20 provides the same for the family child care home and group family child care home scenarios.

Table 19: Child Care Direct Service Cost Model selection points, child care centers

	Child Care Center – Licensing, Current Salaries	Child Care Center – Licensing, Living Wage	Child Care Center – Higher Quality, Living Wage
Classrooms	Infants: 1 Toddler: 1 2 to 3-year-olds: 1 3 to 5-year-olds: 1 School age: 1 Total: 5	Infants: 1 Toddler: 1 2 to 3-year-olds: 1 3 to 5-year-olds: 1 School age: 1 Total: 5	Infants: 1 Toddler: 1 2 to 3-year-olds: 1 3 to 5-year-olds: 1 School age: 1 Total: 5
Capacity	Toddler: 1	100	100
Staffing	Director: 1 Assistant Director: 2 Admin Assistant: 2 Lead Teacher: 1/classroom Assistant Teacher: 1/classroom Additional classroom coverage: 20%	Director: 1 Assistant Director: 2 Admin Assistant: 2 Lead Teacher: 1/classroom Assistant Teacher: 1/classroom Additional classroom coverage: 20%	Director: 1 Assistant Director: 2 Admin Assistant: 2 Additional FTE at Assistant Director Level: 2 Lead Teacher: 1/classroom Assistant Teacher: 1/classroom Additional classroom coverage: 20%
Salary	BLS	MIT Living Wage	MIT Living Wage
Benefits	Health Insurance - $6,627/FTE Paid Sick Days: 10 Paid Vacation: 10	Health Insurance - $6,627/FTE Paid Sick Days: 10 Paid Vacation: 10	Health Insurance - $6,627/FTE Paid Sick Days: 10 Paid Vacation: 10 Additional benefits: $1,000/FTE
Program Variables			
Family Engagement	None	None	Conferences: 2/year Social Events: 2/year Home Visit: 2/year Family Engagement Coordinator: 1 FTE

	Child Care Center – Licensing, Current Salaries	Child Care Center – Licensing, Living Wage	Child Care Center – Higher Quality, Living Wage
Learning Environment	Planning time – 1 hour/lead teacher/week Professional Development: 4 hours/teacher/year, 7 hours/director/year	Planning time – 1 hour/lead teacher/week Professional Development: 4 hours/teacher/year, 7 hours/director/year	Planning time – 1 hour/lead teacher/week Professional Development: 4 hours/teacher/year, 7 hours/director/year 36 hours/teacher/year, 21 hours/director/year
Inclusion	IEP/IFSP: 10% of enrollment	IEP/IFSP: 10% of enrollment	IEP/IFSP: 10% of enrollment
Miscellaneous	Contribution to Operating Reserve: 5%	Contribution to Operating Reserve: 5%	Contribution to Operating Reserve: 5% Transportation for School Age Children Field Trips: 2/year Developmental Screening

Table 20: Child Care Direct Service Cost Model selection points, small and group family child care homes

	FCC – Licensing, Current Salaries	FCC – Licensing, Living Wage	FCC – Higher Quality, Living Wage
Capacity	*Small FCC:* Infants: 2 Toddler to Preschool: 4 School Age: 2 Total: 8 *Group FCC:* Infants: 3 Toddler-Preschool: 8 School Age: 4 Total: 15	*Small FCC:* Infants: 2 Toddler to Preschool: 4 School Age: 2 Total: 8 *Group FCC:* Infants: 3 Toddler-Preschool: 8 School Age: 4 Total: 15	*Small FCC:* Infants: 2 Toddler to Preschool: 4 School Age: 2 Total: 8 *Group FCC:* Infants: 3 Toddler-Preschool: 8 School Age: 4 Total: 15
Staffing	*Small FCC:* Provider/Owner: 1 Full-Time Assistant: 0.2 FTE *Group FCC:* Provider/Owner: 1 Full-Time Assistant: 1.5 FTE	*Small FCC:* Provider/Owner: 1 Full-Time Assistant: 0.2 FTE *Group FCC:* Provider/Owner: 1 Full-Time Assistant: 1.5 FTE	*Small FCC:* Provider/Owner: 1 Full-Time Assistant: 0.2 FTE *Group FCC:* Provider/Owner: 1 Full-Time Assistant: 1.5 FTE

	FCC – Licensing, Current Salaries	FCC – Licensing, Living Wage	FCC – Higher Quality, Living Wage
Salary	BLS	MIT Living Wage	MIT Living Wage
Benefits	Health Insurance - $6,627/FTE Paid Sick Days: 10 Days Paid Vacation: 10 Days	Health Insurance - $6,627/FTE Paid Sick Days: 10 Days Paid Vacation: 10 Days	Health Insurance - $6,627/FTE Paid Sick Days: 10 Days Paid Vacation: 10 Days $ Additional Benefits: $1,000/FTE
Program Variables			
Family Engagement	None	None	Conferences: 2/year Social Events: 2/year Home Visit: 1/year Family Engagement Coordinator: .25 FTE
Learning Environment	Planning time – 1 hour/week provider/ owner Professional Development – 4 hours/year/assistant teachers, 7 hours/year provider/owner	Planning time – 1 hour/week provider/ owner Professional Development – 4 hours/year/assistant teachers, 7 hours/year provider/owner	Planning time – 2.5 hour provider/owner per week, 1 hour/asst teacher/week Professional Development – 36 hours/teachers/year, 21 hours provider/owner per year
Inclusion	IEP/IFSP: 10% of enrollment	IEP/IFSP: 10% of enrollment	IEP/IFSP: 10% of enrollment
Miscellaneous	Contribution to Operating Reserve: 5%	Contribution to Operating Reserve: 5%	Contribution to Operating Reserve: 5% Transportation for School Age Children Field Trips: 2/year Developmental Screening

G. Home Visiting Direct Service Cost Model Functionality

Caseload Capacity

The cost model includes four caseload options to reflect different levels of service intensity and staffing needs:

1. **Base: Maintain Model Standards** – Uses the standard caseload defined by the model purveyor.
2. **Lower Caseload Option 1: Medium Intensity** – Reflects smaller caseloads allowing more frequent or longer visits.
3. **Lower Caseload Option 2: High Intensity** – Represents the most intensive service delivery with fewer families per home visitor.
4. **User Input** – Allows users to enter their own caseload assumptions based on local context or program experience.

Each caseload option includes assumptions for both home visitor-to-child ratios and supervisor-to-home visitor ratios, recognizing that staffing structures must adjust when caseloads change. Supervisor ratios are essential to maintaining program quality, allowing supervisors to provide reflective supervision, coaching, and support that helps retain staff and sustain fidelity to the model.

Selecting the "Base" option keeps each program model's original caseload capacity, while the lower caseload options illustrate how increasing visit frequency or service intensity impacts staffing and cost. Table 21 shows the caseload and capacity assumptions applied in the cost model for each home visiting program and caseload option.

Table 21: Caseload capacity and intensity options

	Base: Maintain Model Standards		Lower Caseload Option 1: Medium Intensity		Lower Caseload Option 2: High Intensity	
Home Visiting Models	**Children per HV/ PE**	**HV/ PE per supervisor**	**Children per HV/ PE**	**HV/ PE per supervisor**	**Children per HV/ PE**	**HV/ PE per supervisor**
Attachment and Biobehavioral Catch-Up	40	5	36	5	30	4
Early Head Start Home-Based	12	8	10	7	8	6
Exchange Parent Aide	10	6	10	5	8	5
Family Connects	325	12	300	12	300	12
Family Spirit	32	5	20	5	18	4
Healthy Families	20	6	16	5	12	4
NurseFamily Partnership	22	8	20	7	18	6
Parents as Teachers	22	10	20	8	18	7
SafeCare	39	4	12	4	11	3.5
Universally Offered Home Visiting	250	6	225	6	200	6
Welcome Baby	250	6	225	6	200	6

Wages

The salary options enable users to compare the financial impact of continuing current wage levels versus investing in a more sustainable, living-wage workforce. Table 22 compares the three default salary options in the model for each position.

Table 22: Salary defaults included in home visiting cost model

	Bureau of Labor Statistics	MIT Living Wage Single Person	MIT Living Wage Family Composition
Program Manager	$62,413	$82,920	$111,489
Nurse Program Manager	$109,563	$145,110	$195,105
Program Supervisor	$51,158	$67,967	$91,384
Nurse Program Supervisor	$89,806	$118,942	$159,922
Home Visitor	$41,933	$55,711	$74,905
Nurse Home Visitor	$73,611	$97,494	$131,084
Clinical Home Visitor	$60,715	$74,095	$99,624
Community Health Worker	$56,514	$ 69,081	$92,882
Parent Educator	$41,933	$55,711	$74,905
Administrative Support	$34,944	$46,426	$62,421

H. Initial Implementation Considerations

This appendix summarizes implementation-related feedback gathered through the Montana Prenatal to Five Comprehensive Fiscal Analysis (CFA) engagement process. The information presented reflects early implementation signals, ideas, and examples shared by constituents and partners across the state. The level of detail varies by recommendation, reflecting differences in system readiness, existing infrastructure, active pilots, and funding conditions. This appendix is not intended to serve as an implementation plan, but rather as a reference to inform future action planning, sequencing, and decision-making.

Implementation feedback highlights where Montana has momentum, where additional planning or investment is needed, and where further education and alignment may be required before action. These insights are intended to support state and local partners as they determine next steps following the CFA.

1. Increase **access** to quality, responsive prenatal to five services and programs.

   Early implementation of Montana's prenatal to five recommendations and strategies centers on coordination, sustainability, and shared responsibility. Feedback emphasized that increasing access to prenatal to five services requires a coordinated, systemwide approach that goes beyond expanding individual programs or funded slots. Participants consistently noted that fragmented systems, duplicative services, stigma, and complex eligibility processes limit families' ability to access supports, even when services exist. Access was described as a function of coordination,

navigation, financing, quality alignment, and shared understanding of outcomes.

Feedback highlighted the importance of aligning child care, preschool, early intervention and special education, home visiting, family engagement, and mental health supports into a more navigable system for families while preserving local flexibility and respecting community strengths. Coalitions play a critical role in connecting partners, braiding funding, elevating best practices, and building shared language across sectors. Participants also emphasized the need to reframe access as a shared community investment, with benefits extending to children's development, family stability, workforce reliability across sectors, and long-term community well-being.

Implementation Themes

- Fragmentation, duplicative services, and competition across programs point to the need for stronger coordination.
- Coalition-based coordination and shared leadership, particularly at local and regional levels, to reduce duplication and align strategies across services and sectors
- Strong examples exist of blending federal, state, local, philanthropic, and private dollars (e.g., Florence Crittenton, Whitehall, Bozeman, Great Falls).
- Opportunities to better leverage Medicaid, IDEA, ESSA, child care subsidies, employer contributions, school district partnerships, and mill levies.
- Braided and diversified funding strategies, leveraging federal, state, local, philanthropic, and employer-based resources
- Simplified access and navigation for families, including single-point-of-entry approaches, universal applications, and warm handoff systems.
- Cross-system alignment, including preschool–third grade transitions, quality standards, and workforce pathways, while accounting for impacts on community-based providers
- Family engagement and navigation supports, including universal home visiting and culturally responsive models
- Integration of mental health supports for children, families, and the workforce, with particular attention to rural and Tribal communities
- Education and narrative change to build understanding of access as a community-wide benefit rather than an individual family responsibility

Action Steps

- Convene local or regional Early Childhood Coalitions to conduct joint reviews of access barriers, service duplication, and unmet needs, and to identify shared priorities across child care, preschool, home visiting, and family support services.
- Explore development or expansion of single-point-of-entry systems, including universal applications and strengthened family navigation supports that reduce stigma and administrative burden.

- Invest in training and technical assistance for providers and partners using eligibility, intake, or referral systems, with attention to confidentiality protections, internet access, and data-sharing practices.
- Identify opportunities to braid Medicaid, IDEA, ESSA, child care subsidies, state funds, local funds, and private dollars, particularly to sustain and expand home visiting, early intervention, child care, family engagement, and mental health supports.
- Document and share Montana-based partnership models, including school district collaborations, local levies, philanthropic pathways, and employer-supported strategies, as implementation examples for other communities.
- Support preschool to third grade alignment efforts through cross-system leadership groups, joint transition planning, and family engagement strategies that strengthen continuity while protecting the sustainability of community-based providers.
- Continue refinement and implementation of shared, outcome-based quality standards, emphasizing tiered, continuous improvement approaches aligned with Montana Early Learning Standards and national best practices.
- Assess lessons learned from recent and current family engagement, navigation, and mental health pilots to inform sustainability, redesign, or scale decisions, particularly as time-limited funding sunsets.
- Explore rural and Tribal service delivery models, including shared services, regional staffing, and culturally grounded approaches, to expand access in underserved communities.
- Develop and disseminate Montana-specific messaging and data that communicates the full range of outcomes associated with access to prenatal to five services supporting child development, family stability, community vitality, and long-term system sustainability.
- Integrate outcome-focused education into community forums, legislative briefings, coalition outreach, and cross-sector partnerships to shift narratives from individual responsibility to shared community investment.
- Strengthen mixed-delivery models that support family choice and equitable access, especially in rural and tribal communities.
- Expand early intervention eligibility by reviewing and revising state eligibility criteria to ensure more children with developmental delays can access early intervention services.

2. Explore long term strategies, including public investment, to attract and retain the prenatal to five **workforce**.

   Implementation feedback consistently emphasized that workforce challenges are among the most urgent and interconnected issues facing Montana's prenatal to five system. Participants described workforce compensation, recruitment, retention, professional development, and well-being as foundational to access, quality, and system sustainability. Many noted that the CFA data was a necessary precursor to action, providing shared evidence to support policy discussions and investment decisions.

Participants also highlighted implementation barriers such as wage compression, administrative constraints, and time-limited funding. At the same time, Montana has promising models to build from, including shared services, apprenticeships, scholarships, direct-to-worker compensation strategies, and cross-sector partnerships with K–12, higher education, and workforce agencies. There was broad agreement that workforce strategies must be coordinated across child care, home visiting, early intervention, and related systems, and that investments should support both immediate stabilization and long-term career sustainability.

Implementation Themes

- Compensation as a system sustainability strategy, including wages, benefits, bonuses, and direct-to-worker approaches, such as wage supplements or retention bonuses, that flow directly to the employee.
- Coordinated professional development and reflective supports, rather than fragmented, one-time training.
- Career pathways and pipelines, beginning in high school and extending through higher education and apprenticeship.
- Workforce well-being and mental health, particularly for rural, Tribal, and underserved communities.
- Inclusive practice and capacity-building, including support for children with disabilities and diverse needs.
- Leadership development at program, coalition, and system levels.
- Use of data to evaluate workforce investments and guide continuous improvement.

Action Steps

- Use CFA cost and compensation data to inform discussions of wage enhancements, bonuses, benefits, or direct-to-worker subsidy models, including short-term stabilization strategies and longer-term solutions.
- Assess potential implementation barriers, such as wage compression, prevailing wage constraints, and administrative feasibility, to inform design of compensation strategies.
- Use available workforce data to evaluate the impact of investments on recruitment, retention, and stability, and refine strategies over time.
- Explore incentives such as scholarships, stipends, or bonuses to support participation in ongoing professional development and credential attainment.
- Adjust incentive structures to support multiple pathways to competency, recognizing differences by role, setting, and community need.
- Align and coordinate workforce investments, including professional development, coaching, and reflective supervision initiatives, across child care, home visiting, early intervention, and preschool to reduce fragmentation and improve access statewide.

- Expand and refine career pathway models, including pre-apprenticeships, apprenticeships, and dual-credit opportunities beginning in high school, with clear links to wage progression and retention.
- Partner with higher education and workforce agencies to address workforce supply gaps, including specialized roles such as home visiting nurses and early childhood mental health professionals.
- Invest in training and coaching pathways that support inclusive, trauma-informed practice and go beyond one-time trainings, tailored to role and setting.
- Identify sustainable strategies to support workforce mental health and well-being, particularly as time-limited funding sunsets.
- Explore shared services or regional staffing models to support workforce capacity in rural and underserved communities.
- Strengthen leadership development for program directors, supervisors, coalition leaders, and system partners to foster inclusive, supportive workplace cultures.
- Identify priority training, professional development, and coaching activities currently supported by PDG B-5 and other expiring funds that should be sustained through alternative funding sources.
- Improve feedback loops between local providers, coalitions, and state agencies to ensure workforce policies reflect on-the-ground realities.

3. Invest in the efficiency, flexibility, and coordination of services and the **system**.

   Implementation feedback underscored that Montana's prenatal to five system operates within a complex landscape of federal, state, local, Tribal, and private funding, policies, and governance structures. Participants emphasized that improving system efficiency and effectiveness requires greater coordination, flexibility, and trust, rather than uniform solutions. Participants highlighted policy and administrative barriers that unintentionally limit family access to supports, underscoring the need for clearer education, alternative pathways, and more responsive program design.

   Local and Tribal Early Childhood Coalitions were identified as essential infrastructure for coordination, trust-building, and implementation, but many lack sustained funding. Participants also raised concerns about unintended consequences of system shifts, such as public school expansion displacing four-year-olds from community-based settings, highlighting the need for intentional local partnerships that preserve family choice and developmentally appropriate services.

   Feedback highlighted the importance of meaningful engagement and feedback loops, particularly with providers, families, rural communities, and Tribal Nations. Participants also stressed the need for data, including true cost information, to inform funding decisions, legislative education, and system design. Across recommendations, there was consensus that system strategies should empower local communities while aligning with shared statewide goals. Finally, constituents emphasized that achieving true system alignment will require looking beyond traditional early childhood funding sources to include employers, workforce systems, and other public-private investments.

Implementation Themes

- Policy flexibility to support diverse local, rural, and Tribal contexts.
- Use of true cost and needs data to inform funding and policy decisions.
- Consistent engagement and feedback loops with families, providers, and communities.
- Trust-based state, community, and Tribal relationships.
- Local empowerment, supported by sustained resources and decision-making authority.
- Elevate the role of coalitions as implementation and feedback hubs.
- Alignment and coordination of funding streams across sectors and agencies.
- Promote partnerships that protect mixed-delivery and community-based models.
- Legislative education and partnership, grounded in data and lived experience.

Action Steps

- Review state policies and administrative practices to identify opportunities for greater flexibility, including differentiated or tiered approaches that reflect varied service models and populations served.
- Use CFA findings, fiscal mapping, and cost model data to support transparent, data-informed funding decisions, including rate-setting, grant-making, and budget development.
- Provide training and tools to support state and local partners in using cost and fiscal data for planning, advocacy, and evaluation.
- Establish or strengthen formal feedback loops that ensure input from families, providers, coalitions, rural communities, and Tribal Nations informs decision-making and receives timely response.
- Support regional and local engagement structures, including Early Childhood Coalitions, with sustained resources to convene partners and coordinate implementation.
- Strengthen the role of the Early Childhood Tribal Coalition as a trusted connector, recognizing the time and relationship-building required for effective collaboration.
- Support coalitions in understanding the practical realities of policy implementation so they can meaningfully engage in system design and advocacy.
- Invest in trust-based relationship-building between state agencies and Tribal Nations, guided by frameworks co-developed with Tribal and rural leaders.
- Empower local communities with dedicated resources and authority to design strategies aligned with statewide goals while reflecting local priorities.
- Identify opportunities to align and braid funding across learning, health, housing, behavioral health, workforce, and other sectors to support families' full range of needs.
- Encourage local, collaborative planning between school districts and community-based providers to support family choice, age-appropriate services, and workforce stability.

- Provide guidance and technical assistance to communities navigating preschool expansion to avoid displacement of infant and toddler care.
- Strengthen legislative education and engagement by sharing qualitative and quantitative data, community examples, and implementation insights.
- Clarify governance roles and responsibilities to support coordination across agencies and reduce administrative burden on providers and communities.

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