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Listed Home-Based Child Care Providers and Child Care and Early Education Policies Series

Child Care and Development Fund Subsidies

In 2019, approximately 91,000 child care and early education (CCEE) providers cared for one or more young children in a home-based child care (HBCC) setting and were "listed" by state or local CCEE agencies (National Survey of Early Care and Education [NSECE] Project Team 2021).[1] Listed HBCC providers experience three predominant CCEE policies (Figure 1):[2]

- **State-administered regulations** set and enforce minimum requirements related to health and safety in all CCEE settings.[3]
- The **Child Care and Development Fund (CCDF)** provides funding to states, in part, to subsidize CCEE costs for families with low incomes.
- **Quality rating and improvement systems (QRISs)** assess the quality of and support quality improvement in CCEE settings.

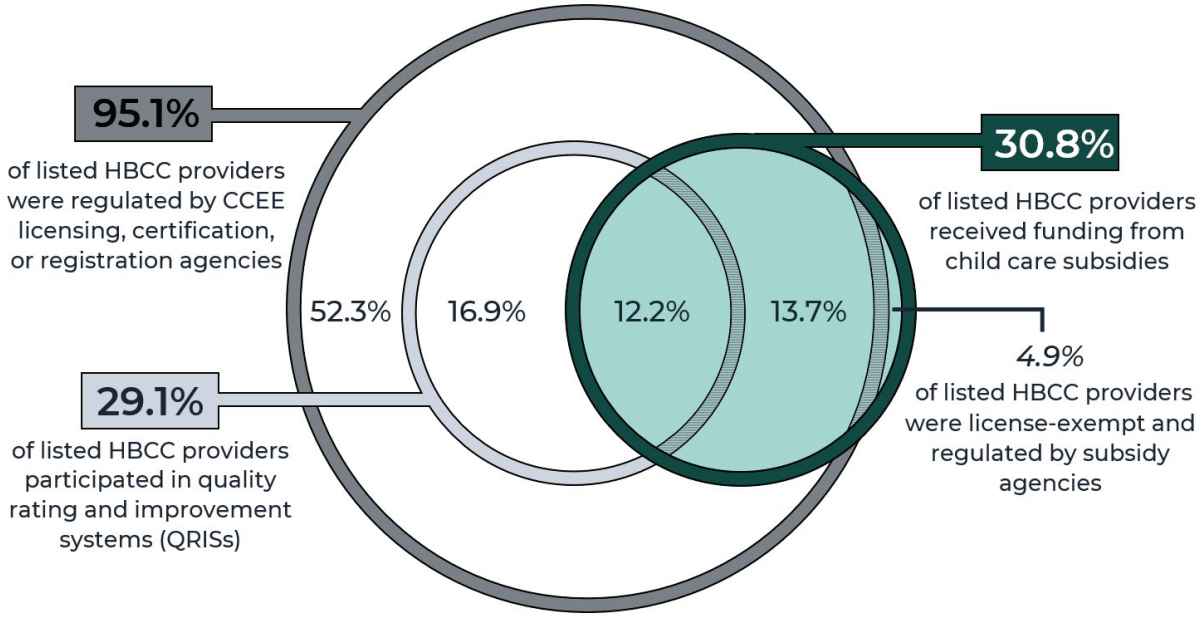
This brief, focusing on CCDF subsidies, is part of a series of research briefs presenting findings from the first nationally representative analysis of listed HBCC providers' reported interactions with these CCEE policies, as represented in the 2019 NSECE Home-Based Provider Survey.[4] It provides background on CCDF subsidy policies for HBCC providers, details study research questions and methods, presents results, and discusses key findings and their implications.

Summary of findings on listed HBCC providers' reported subsidy funding receipt, preferences, and payment arrangements

- ✓ Approximately one third of all listed HBCC providers received subsidy funding, though this rate was higher among providers in higher poverty communities, Hispanic and Black providers, and providers who offered flexible care schedules.
- ✓ Many listed HBCC providers were not aware of subsidies. Those who were aware did not generally prefer subsidies to private pay in terms of payment amount or administrative requirements, and were neutral in respect to payment reliability and ease of filling vacancies. Providers with higher subsidy densities and who did not serve infants or toddlers reported more favorable subsidy preferences.

- ✓ Listed HBCC providers in states with the most generous subsidy rate policies—those that paid providers most while asking families to contribute least—were less likely to receive subsidy funding compared to providers in other states.
- ✓ Among listed HBCC providers who received subsidy funding, state subsidy rate and provider payment policies predicted providers' subsidy payment arrangements related to family co-payments, additional fees, and the coverage of private rates.
- ✓ Compared to listed HBCC providers in other states, those in states with provider-friendly subsidy payment policies sometimes had more favorable preferences for subsidies compared to private pay in terms of the amount and reliability of payment.

Figure 1. Listed HBCC providers reported interacting with one or more CCEE policies; about one third received funding from subsidies



Source: Data from the 2019 NSECE Home-Based Provider Survey and 2017 Child Care Licensing Study Database (Child Care Technical Assistance Network n.d.).

Note: The figure presents percentages from approximately 3,700 providers who provided information on CCDF and QRIS and who provided information necessary to simulate licensing status (group size and prior relationship to children served). Probability of sampling weights were applied. All estimates are reported out to a maximum of three significant digits in accordance with restricted-use file (RUF) reporting requirements. Providers in Louisiana, New Jersey, and South Dakota were excluded because these states do not report licensing requirements for HBCC providers.

CCDF helps families afford CCEE and can be a revenue source for HBCC providers.

The Child Care and Development Fund (CCDF) is a federal program that provides subsidies to families with low incomes to help pay CCEE costs. It is administered as a block grant, providing funding to states, territories, and tribes that administer subsidies through lead agencies. CCDF requires states to ensure that families have access to a variety of available CCEE options, including center-based settings and home-based providers. States must also take steps to ensure that services are available during non-traditional hours and for children with special needs. Families who receive subsidies select providers, whereas providers choose whether or not to accept subsidies. In 2019, CCDF was funded at approximately $10.3 billion and served approximately 1.4 million children under age 13 per month (U.S. DHHS OCC 2021a, 2022).

CCDF was enacted by the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), the 1996 welfare reform law which replaced Aid to Families and Dependent Children (AFDC) that had provided child care subsidies to families for decades. Under AFDC, caregivers with children under five were exempted from work, job training, or educational requirements to receive public assistance. Under PRWORA, only caregivers with children under one remained exempt. Today, in most cases, families who meet income guidelines must also be engaged in work, education, or training activities to receive subsidies (Kwon et al. 2023). Several studies find that subsidies lead to increased use of CCEE (Berger & Black 1992; Crosby et al. 2005; Tekin 2005) and support parental employment and educational attainment (Blau & Tekin 2007; Forry 2009; Herbst 2010; Schochet & Johnson 2019). The 2014 reauthorization of the Child Care and Development Block Grant (CCDBG), which funds CCDF, included provisions to expand its scope to address quality

improvement in settings that accept subsidies (Greenberg et al. 2018), including health and safety standards and professional supports for providers (Matthews et al. 2015).

CCDF requires states to aim to provide families access to different types of CCEE that best suit their priorities and preferences, including both center-based settings and licensed and license-exempt HBCC providers. In 2019, approximately 20 percent of families who received subsidies chose to use them in a listed HBCC setting (though this share ranged from 2 percent to 55 percent across states [U.S. DHHS OCC 2021b]). Eligible families may choose to use subsidies to pay for HBCC for the many reasons families choose HBCC more generally—familiarity and comfort with a provider; flexible scheduling options for families with non-traditional work schedules or who need care on a part-time or occasional basis; personalized attention and individualized care for children; and cultural or linguistic preferences, such as the match between the family and provider (Bromer et al 2021a; Henly & Adams 2018).

In 2019, approximately 29 percent of providers receiving subsidies were listed HBCC providers (U.S. DHHS OCC 2022b). Listed HBCC providers who are licensed or certified—or who are license-exempt but meet necessary health and safety requirements for CCDF—apply to accept subsidies. Once approved, they are required to adhere to specific subsidy rules, such as those related to billing and payment. HBCC providers may decide to accept subsidies for many reasons, such as to fill vacant slots, expand their services to remain competitive in local markets, because the families they serve ask them to, or as a commitment to support families who are experiencing poverty in their communities (Sandstrom et al. 2018; Adams et al. 2022).

States have considerable latitude in how they design subsidy policies.

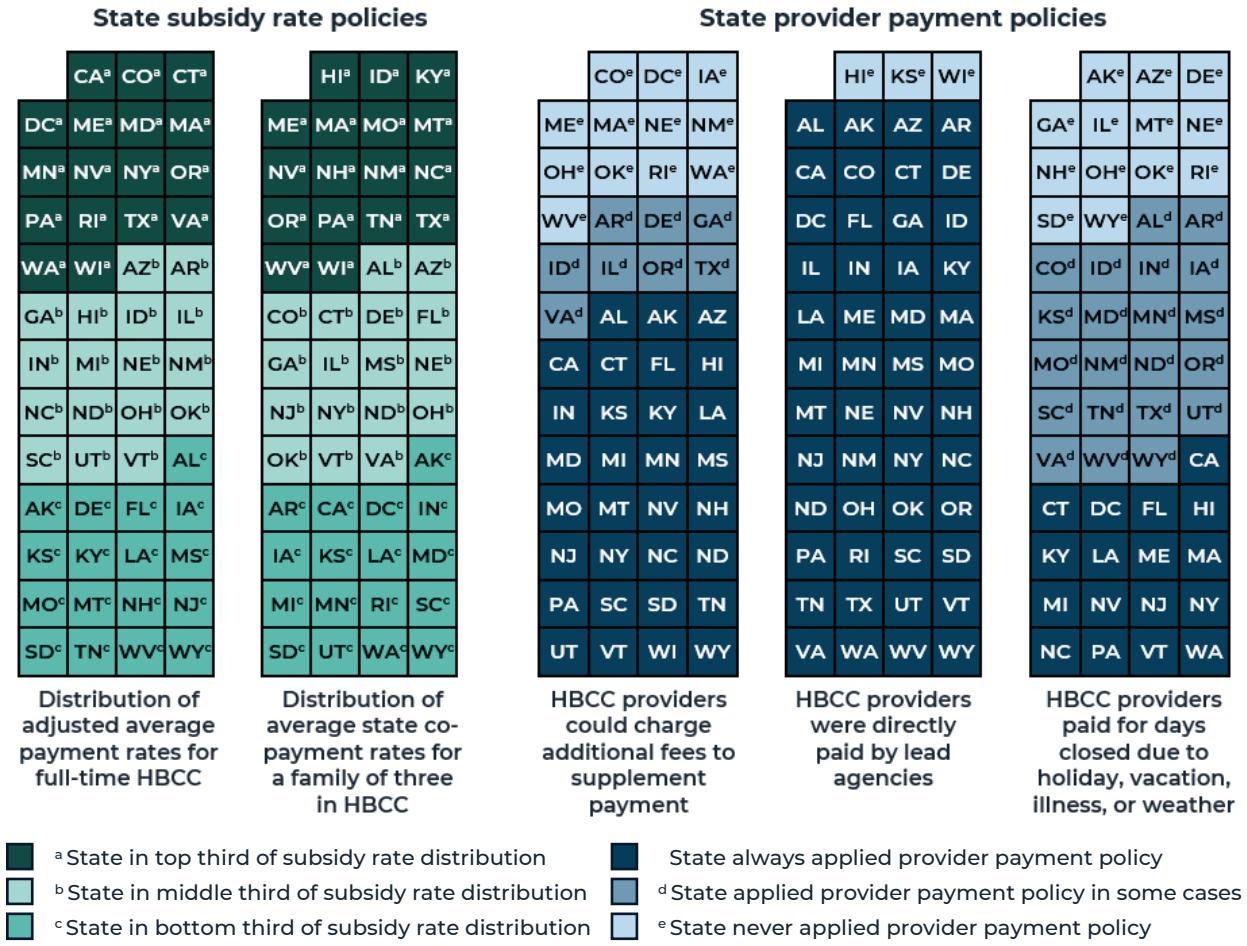
The 2014 CCDBG reauthorization gave states, territories, and tribes considerable discretion to design and operate their subsidy programs (Adams & Dwyer 2021). Each state can set its own subsidy payment rates and family co-payments. States can also set provider payment policies, such as additional family fee policies, how providers are paid, and under what conditions. This section provides an overview and definitions of subsidy rate and provider payment policies analyzed in this study (see Figure 2).

State subsidy rate policies determine the generosity and composition of subsidy payments.

Base payment rates for HBCC providers. States set the maximum amounts they pay providers who receive subsidy funding (Minton et al. 2020). States typically determine their payment rates by conducting market rate surveys of HBCC or center prices.[5] Federal guidelines recommend that states use this information to set payment rates at the 75th percentile of the distribution of prices for specific types and durations of CCEE (Schulman 2019). For this analysis, we ranked states according to the adjusted average payment rate for full-time care in HBCC across age groups (infants, toddlers, preschoolers, and school-aged children) in 2019. Consistent with prior studies (Greenberg et al. 2018; Madill et al. 2018), we adjusted these rates to capture cross-state differences in cost of living using Regional Price Parities developed by the U.S. Bureau of Economic Analysis (US BEA, n.d.). Adjusted average payment rates ranged from $337 to $1,031 per month, with a mean of $668 and a standard deviation of $169.

Size of family co-payments for HBCC. Within federal guidelines, states set family co-payments, or the out-of-pocket amount that families who receive subsidies contribute to provider payments. The family co-payment plus the state contribution sum to the total amount providers are paid from subsidies. Family co-payments are based on family income, family size, the number of children in care, and the type of care being provided (Dwyer et al. 2020). Some states also consider other factors such as cost of living, the number of hours of care needed, and the number of working parents in the household. For the analysis presented in this brief, we ranked states according to the average monthly co-payment amounts for HBCC for a family of three earning each of $15,000, $20,000, $25,000, and $30,000 per year in 2019. State average co-payment amounts for HBCC ranged from $0 to $1,004 per month, with a mean of $127 and a standard deviation = $141.

Figure 2. State CCDF policy variables included in this study



Source: Data from the 2019 CCDF Policies Database, Tables 29, 33, 35, and 37 (Dwyer et al. 2020).

Note: The figure presents counts of states with each policy characteristic as of October 1, 2019. The legend indicates either whether states were in the top, middle, or bottom third of each state subsidy rate policy distribution (left panel), or whether states always, sometimes, or never applied each provider subsidy payment policy (right panel).

State subsidy payment policies determine how and under what conditions HBCC providers are paid.

Whether providers can charge families additional fees. Because most state payment rates are set at a given percentile of the distribution of prices providers charge based on each state's market-rate survey (and, in 2019, just four states set their payment rates at or above the federally recommended level [Schulman 2019]), for many providers, the subsidy payment is less than what they charge to private-paying parents. In some states, providers may charge families receiving subsidies fees to supplement the funding received from subsidies. These fees are in addition to the co-payment most families are required to contribute to their subsidy payment. In 2019, 31 states permitted providers to charge all families these additional fees if they chose to do so. Eight states sometimes allowed providers to charge additional fees,[6] while 12 states did not allow providers to charge families additional fees under any circumstances. In these states, providers may be required to absorb the amount they might otherwise collect by charging families these additional fees. In states that do allow providers to charge families additional fees, providers are responsible for collecting payment.

Whether a state agency pays HBCC providers directly. In 2019, CCDF lead agencies in 48 states both processed and issued subsidy payments directly to listed HBCC providers (although two of these states issued payments through other entities, such as local R&Rs [Illinois] or workforce development boards [Texas]). Only three states – Kansas, Hawaii, and Wisconsin – did not pay listed HBCC providers directly. Rather, lead agencies in these states first issued payments to parents (for instance, through direct deposit to a checking account or electronic benefit transfer [EBT] card), who then paid their providers.

Whether HBCC providers are paid for days they are closed. In 2019, providers in 17 states were paid for days they were closed, including holidays, vacations, inclement weather, or illnesses. Twenty-one states "sometimes" paid providers for days closed—for instance, requiring providers to pre-establish paid days off (enabling providers to cover sick days, for example), only paying providers for certain types of closures (for instance, only state-approved holidays), and/or setting contingencies for payment according to provider payment structure (for instance, requiring providers to serve and bill private-pay parents for days closed in order to receive subsidy payment for participating families). Thirteen states do not pay HBCC providers for days they are closed.[7]

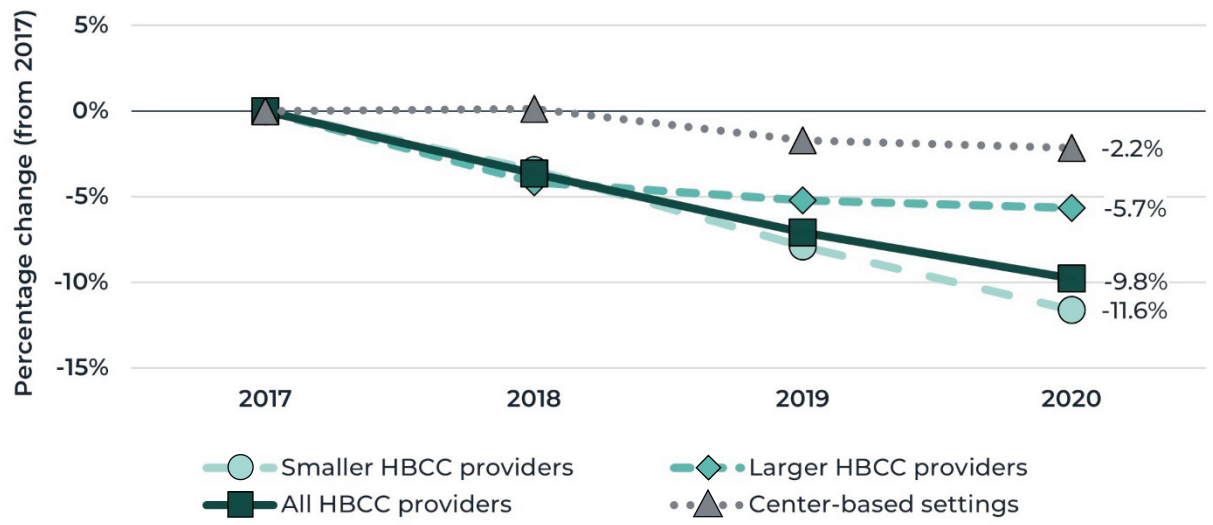
The NSECE data provide an opportunity to build knowledge about HBCC providers' decisions to accept subsidies and how state-specific CCDF policies might relate to these decisions.

Because these subsidy policies simultaneously affect access to HBCC for families with low incomes and HBCC providers' decisions to receive subsidy funding, each may be a lever for expanding the supply of HBCC. Though research is limited, one recent study found positive relationships between the generosity of state subsidy payment rates for centers and center-based providers' reports of receiving subsidy funding (Slicker 2022). Other studies found that increasing subsidy policy generosity positively associates with families' use of subsidies in centers (Ha et al. 2017; Weber et al. 2014). More generous subsidy policies may attract new HBCC providers into the subsidy system, or increase subsidy density (defined as the percentage of children served whose care is subsidized [Greenberg et al. 2018]). At the same time, provider-friendly subsidy payment policies may positively influence providers' preferences for subsidies and subsidy payment arrangements.

On the other hand, if many HBCC providers primarily decide to receive subsidy funding because the families they serve (or aim to serve) receive subsidies (Adams et al.2022), the generosity of state subsidy rate policies could also be linked with lower levels of subsidy funding receipt among HBCC providers. This is because states with more generous subsidy rate policies may be unable to accommodate a greater number of families with subsidies as they allocate a higher subsidy amount to each child (OIG 2019). Similarly, provider-friendly subsidy payment policies intended to increase providers' revenue could also result in fewer providers receiving subsidy funding. For example, policies that allow additional family fees may raise out-of-pocket expenses for families, leading fewer to opt for subsidies (Greenberg et al. 2018).

Understanding how subsidy rate and provider payment policies may shape the supply of HBCC providers who receive subsidy funding is a pressing issue for policymakers, given recent declines in the number of providers who do so (NCECQA 2020; NSECE Project Team 2021). Between 2017 (the first year that federal data distinguished between licensed or regulated HBCC providers) and 2020 (the most recent year available), levels of subsidy funding receipt among HBCC providers declined by nearly 10 percent (Figure 3), including nearly 12 percent for smaller HBCC providers. Levels of subsidy funding receipt among center-based settings changed less over this period.

Figure 3. The number of licensed or regulated HBCC providers who receive funding from CCDF subsidies is declining



Source: Data from FYs 2017 to 2020 CCDF Data Table 7 – Number of Child Care Providers Receiving CCDF Funds (U.S. DHHS OCC 2019a, 2020, 2022a, 2022b).

Note: The figure presents the percentage change in unduplicated counts of licensed or regulated HBCC providers between 2017 and each subsequent year. According to these data, in 2017, 77,191 licensed or regulated HBCC providers received funds from the CCDF; 53,283 of these providers were smaller HBCC providers. CCDF data from FY 2020 are preliminary and reflect the impact of the COVID-19 pandemic. Within federal guidelines, each state classifies licensed or regulated HBCC providers as smaller family child care (FCC) or larger group child care homes according to their own rules for minimum and maximum group sizes.

Public policy challenges to sustaining the supply of HBCC providers who accept subsidies include limited funding, and recruiting and retaining providers who are willing to participate. As noted, subsidy payments may be lower than what providers would charge for care without subsidies, which can make it difficult to generate the income providers anticipate from their business (Schulman 2019). HBCC providers may also be less confident that they would be able to rely on a steady and sustainable demand of families receiving subsidies given the smaller number of families they serve and the types of care they require (that is, on non-traditional or irregular schedules [Schochet et al. 2022a]). In addition, some HBCC providers may not be aware that subsidies exist or may not know how to apply, whereas others may be hesitant to participate because they fear losing autonomy over their business or being subject to increased regulations (Adams et al. 2022). Applying to or receiving subsidy funding also requires paperwork and other administrative tasks that may be particularly challenging for HBCC providers who do not have staff to support them.

In this brief, we explore the intersection between listed HBCC providers, CCDF subsidies, and subsidy policies across the nation. As noted, these policies vary across states and can include, for example, provider payment rates, additional family fee policies, and whether providers are paid for closures. Using restricted-use data from the 2019 National Survey of Early Care and Education (NSECE) Home-Based Provider Survey matched on location with indicators of state subsidy policies from the 2019 CCDF Policies Database (Dwyer et al. 2020), we address the following research questions:

1. **What percentages of listed HBCC providers were aware of and received funding from subsidies, and for what percentage of families? What were providers' preferences for subsidies compared to private pay? Among providers who received subsidy funding, what were their subsidy payment arrangements?**
2. **Did listed HBCC providers' subsidy funding receipt, preferences, and payment arrangements vary by characteristics of providers, their communities, or the subsidy policies in their state?**

Study methodology

Data sources. The NSECE is a nationally representative, cross-sectional study of the CCEE workforce in all 50 states and the District of Columbia (NSECE Project Team 2022). The NSECE Home-Based Provider Survey provides information at a national level about HBCC provider enrollment and rates, provider interaction with public CCEE policies, caregiving activities, characteristics of providers and their households, and provider operations.

Using state identifiers from a restricted-use data file, we linked the NSECE with state CCDF policies for HBCC providers from the CCDF Policies Database, a comprehensive database of CCDF policies (Dwyer et al. 2020). The analysis focused on policies pertinent to HBCC providers that were in place as of the NSECE data collection period (in 2019).

Sample. A total of 4,231 listed HBCC providers responded to the 2019 NSECE Home-Based Provider Survey. We further restricted the analysis sample to respondents who provided information about the study outcome measures.

All listed providers who confirmed they received payment for regular care (N=4,091) were asked whether they received public funding for the CCEE they provided, and if so, from what sources and the number of children served with those funds. These providers were also asked to provide information about their standard non-subsidy rate by age group served. Listed providers who confirmed they received payment for providing regular care and served at least four children were asked about their preferences for subsidies (N≈3,820). The providers who also indicated that they served one or more children whose care was funded by subsidies were asked whether the families they served paid co-pays or additional fees for child care subsidies (N≈1,340).

Analytic strategy. We first examined differences between providers who reported receiving subsidy funding and those who did not across their background characteristics and the characteristics of the communities in which they operated, and state-level indicators of CCDF-related policies. We used two-tailed t-tests to examine differences and identify those that were statistically significant at the .05 level or lower.

We then conducted a series of multivariate logistic regression models predicting each CCDF-related outcome from the selected provider-, community-, and state-level factors found to be statistically significant. We then added possible interactions between predictors in a stepwise fashion, with each subsequent model including only the statistically significant variables from prior models. We weighted all estimates from these models to be nationally representative of listed HBCC providers across the nation. For the multivariate analyses, we considered estimates as statistically significant at the .05 level, but also noted whether there was a trend at the .10 level.

Results. In this brief, we graphically present results from multivariate regression models using marginal means or percentages and 95 percent confidence intervals and differences. These values are statistics calculated from predictions of the multivariate model at fixed values for some predictors (for example, whether providers reported accepting subsidies in subgroups of states with or without a given CCDF-related policy) that average over the remaining predictors. This approach allows for graphical presentations of findings for predictors of interest that simultaneously adjust for other important factors associated with CCDF outcomes.

More information on the 2019 NSECE study methodology and measurement is available in the Data Collection and Sampling Methodology Report (NSECE Project Team 2022). See the technical report on the current analyses for more details about the variables used, the sample included in the analyses, treatment of missing data, and the analytic models (Schochet et al. 2024).

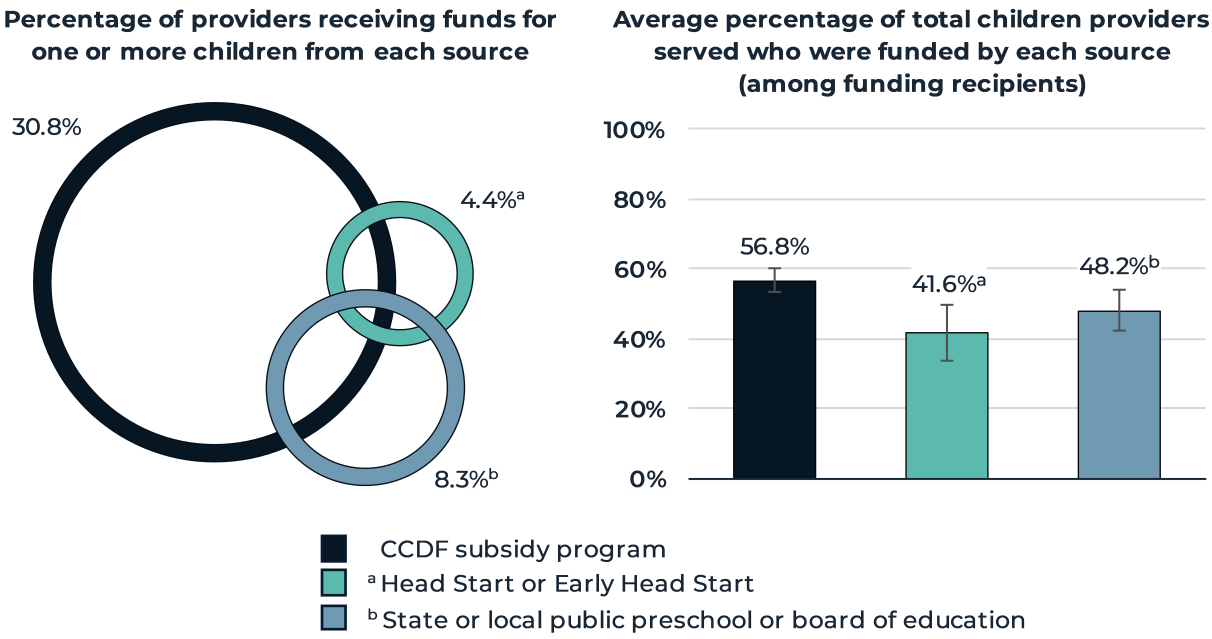
What were the patterns and predictors of listed HBCC provider subsidy funding receipt, preferences, and payment arrangements?

Approximately one third of all listed HBCC providers received subsidy funding, though this rate was higher among providers in higher poverty communities, Hispanic and Black providers, and providers who offered flexible care schedules to meet the needs of families.

Generally, small percentages of listed HBCC providers reported serving children who received subsidies, though these rates were much higher for subsidies than for other federal (Head Start or Early Head Start) or state or local (for example, public preschool) CCEE public funding sources (Figure 4). Thirty-one percent reported receiving funding for at least one child from subsidies, followed by eight percent from a state or local department of education, and four percent from Head Start or Early Head Start.

Among providers who received funding from subsidies, 57 percent of the children they served received subsidies. This percentage, or "subsidy density," was also higher than that for providers who received funding from other public sources (48 percent of children for public preschool, and 42 percent of children for Head Start or Early Head Start). Providers who received funding from subsidies served approximately five children whose care was subsidized, on average.

Figure 4. Although fewer than one in three reported receiving any subsidy funding, CCDF subsidies were the most common public CCEE funding source among listed HBCC providers



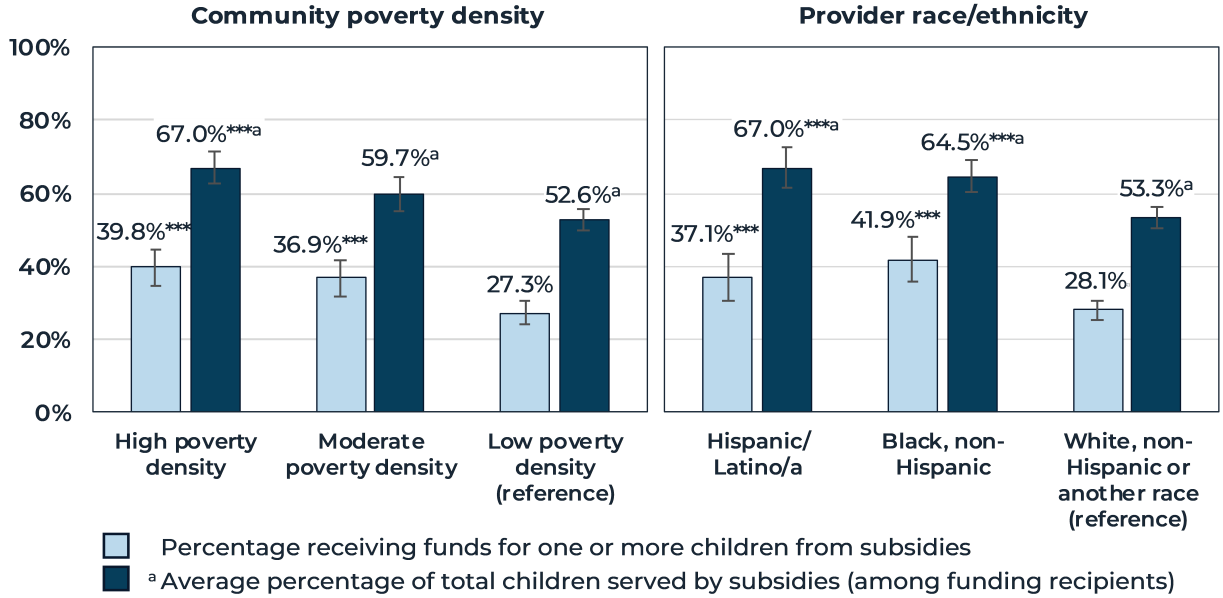
Source: Data from the 2019 NSECE Home-Based Provider Survey.

Note: The figure presents unadjusted percentages and 95 percent confidence intervals from approximately 3,820 providers, weighted to represent 83,400 providers across the nation. Data were drawn from Table B.1 in the accompanying technical report. Probability of sampling weights were applied. All estimates are reported out to a maximum of three significant digits in accordance with RUF reporting requirements. All listed, paid providers were asked whether they received public funding for the CCEE they provided from each source, and if so, the percentage of children served whose care was funded by that source.

Historically marginalized groups – listed HBCC providers who operated in communities with higher levels of poverty and who identified as Hispanic/Latino/a and Black, non-Hispanic – were more likely to receive funding from subsidies (Figure 5). Forty percent of providers in high poverty communities (those in which at least 20 percent of the population lived in poverty) reported receiving subsidy funding compared to 27 percent of providers in low poverty communities (those in which less than 14 percent of the population lived in poverty). Forty-two percent of Black providers and 37 percent of Hispanic providers received subsidy funding compared to 28 percent of providers who identified as White or another race or ethnicity.

Among these providers, those in higher poverty communities (67 percent) and who identified as Hispanic (67 percent) or Black (65 percent) also reported greater subsidy densities compared to providers in low poverty communities (53 percent) and those who identified as non-Hispanic and non-Black (53 percent), respectively (Figure 5).

Figure 5. Listed HBCC providers who operated in high poverty communities and identified as Hispanic/Latino/a or Black were more likely to receive funding from subsidies and had greater subsidy density



Source: Data from the 2019 NSECE Home-Based Provider Survey.

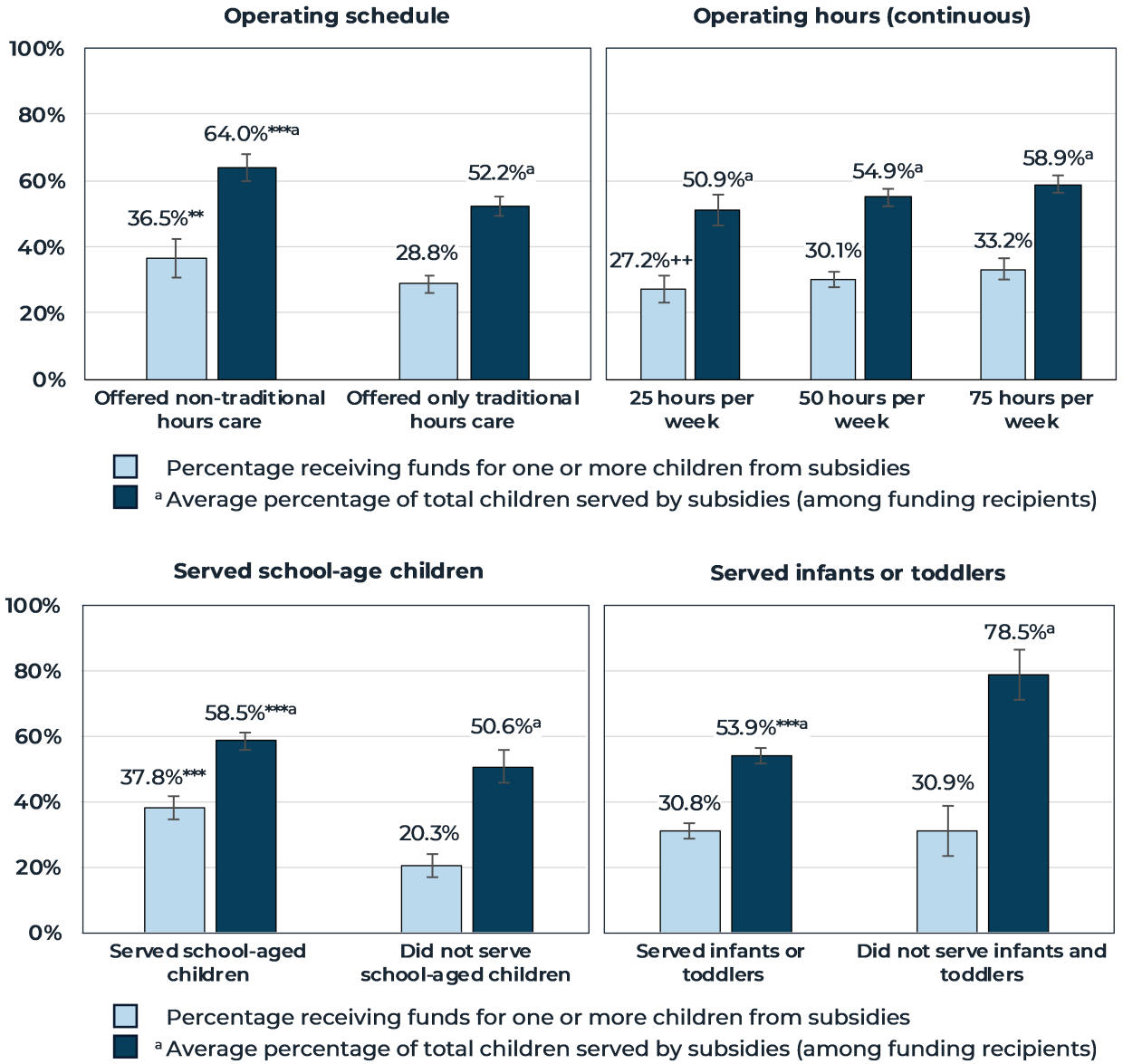
Note: The figure presents percentages and 95 percent confidence intervals adjusted using a multivariate logistic regression including the analysis sample detailed in the text below Figure 4. Data were drawn from Table B.6 in the accompanying technical report. Probability of sampling weights were applied. All estimates are reported out to a maximum of three significant digits in accordance with RUF reporting requirements. All listed, paid providers were asked whether they received public funding from child care subsidies and if so, the percentage of children served whose care was funded. The NSECE defines high-poverty communities as those where at least 20 percent of households lived at or below the federal poverty level and low-poverty communities as those where less than 14 percent of households lived in poverty.

***/**/* Differences between community or provider subgroups are statistically significant at the .01/.05/.10 level, two-tailed t-test compared to the reference group.

Rates of subsidy funding receipt and subsidy densities were also higher among providers who offered care during non-traditional hours (weekends, evenings, or overnight; Figure 6, top panel). These providers were 8 percentage points more likely to report receiving subsidy funding compared to providers who did not offer care during non-traditional hours (37 versus 29 percent). Providers who operated for more hours per week were also more likely to receive subsidy funding. Specifically, providers were about one percentage point more likely to report receiving subsidy funding with every eight additional weekly operating hours. Based on this underlying association, a provider who operated for 75 hours per week would be about 6 percentage

points more likely to receive subsidy funding compared to a provider who operated for 25 hours per week (33 versus 27 percent).

Figure 6. Rates of subsidy funding receipt and subsidy density were also higher among listed HBCC providers who offered care during non-traditional hours and operated for a greater number of hours (top panel) and who served older children (bottom panel)



Source: Data from the 2019 NSECE Home-Based Provider Survey.

Note: The figure presents percentages and 95 percent confidence intervals adjusted using a multivariate logistic regression including the analysis sample detailed in the text below Figure 4. Data were drawn from Table B.6 in the accompanying technical report. Probability of sampling weights were applied. All estimates are reported out to a maximum of 3 significant digits in accordance with RUF reporting requirements. All listed, paid providers were asked whether they received public funding from child care subsidies and if so, the percentage of children served whose care was funded.

***/**/* Differences between provider subgroups are statistically significant at the .01/.05/.10 level, two-tailed t-test.

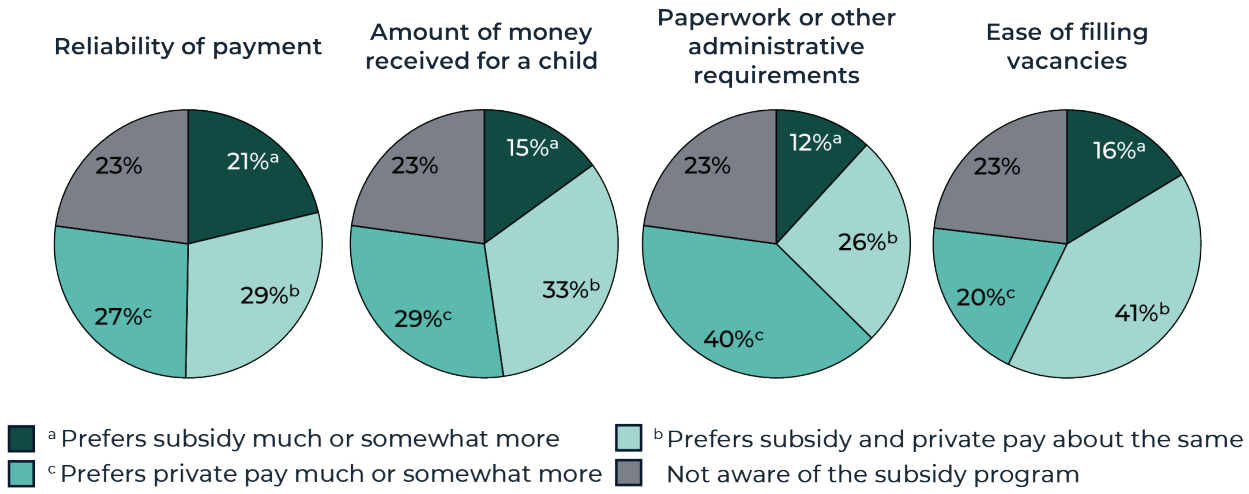
+++/++/+ Differences in the responses for each one-unit change in the underlying continuous characteristic (number of hours provider reported operating per week) are statistically significant at the .01/.05/.10 level, two-tailed t-test.

The ages of children served also associated with whether providers received subsidy funding (Figure 6, bottom panel). Providers who reported regularly serving school-aged children were nearly 18 percentage points more likely to report receiving subsidy funding compared to providers who did not serve school-aged children (38 versus 20 percent). Although similar percentages of providers who did and did not serve infants or toddlers reported receiving subsidy payments, among providers who received them, those who cared for infants and toddlers reported lower subsidy densities than those who did not (54 versus 79 percent).

Many listed HBCC providers were not aware of subsidies. Those who were aware did not generally prefer subsidies to private pay in terms of the amount of payment or administrative requirements, and were neutral in respect to the reliability of payment and ease of filling vacancies. Providers with higher subsidy densities and who did not serve infants or toddlers reported more favorable subsidy preferences.

Twenty-three percent of listed HBCC providers who were asked (those who served at least four children) reported that they were not aware of the subsidy system (Figure 7). Those who were aware of subsidies tended to prefer private pay to child care subsidies, or preferred subsidy and private pay equally. Providers who were asked generally had less favorable preferences for subsidies in terms of the amount of paperwork and administrative requirements (just 12 percent preferred subsidies at least somewhat more than private pay in this area, compared to 40 percent of providers who preferred private pay to subsidies) and the amount of money they were reimbursed (15 versus 29 percent, though 33 percent preferred subsidy and private pay equally). These rates were more similar as they related to reliability of payment (21 versus 27 percent, with 29 percent as neutral) and ease of filling vacancies (16 versus 20 percent, with 41 percent as neutral).

Figure 7. A majority of listed HBCC providers did not prefer subsidies to private pay in terms of payment amount and administrative requirements, and nearly one quarter were not aware of subsidies



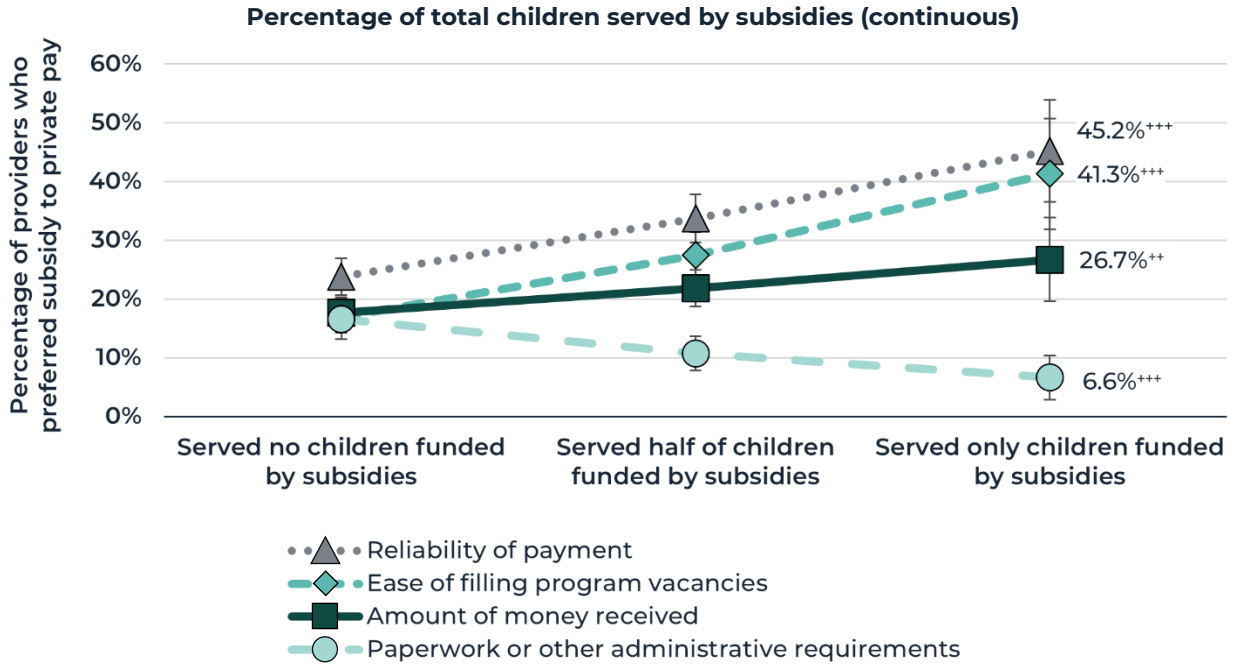
Source: Data from the 2019 NSECE Home-Based Provider Survey.

Note: The figure presents unadjusted percentages from approximately 3,400 providers, weighted to represent approximately 74,000 providers across the nation. Data were drawn from Table B.1 in the accompanying technical report. Probability of sampling weights were applied. All estimates are reported out to a maximum of three significant digits in accordance with RUF reporting requirements. Listed, paid providers who served at least four children were asked their preferences for subsidies.

Among providers who were aware of subsidies, those with greater subsidy densities were more likely to prefer subsidies to private pay in relation to reliability of payment, amount of money received per child, and ease of filling vacancies, but less likely to prefer subsidies to private pay in terms of paperwork or other

administrative requirements (Figure 8). For instance, based on predictions from the underlying associations between subsidy density and whether providers preferred subsidy to private pay in each area, providers who exclusively served children funded by subsidies were predicted to be more than 20 percentage points more likely to prefer subsidies to private pay in terms of filling program vacancies and reliability of payment – but 10 percentage points less likely to prefer subsidy with regard to administrative requirements – compared to providers who served no children funded by subsidies.

Figure 8. Listed HBCC providers with higher subsidy densities had more favorable preferences for subsidies in most areas, but less favorable preferences for subsidies in terms of paperwork or other administrative requirements



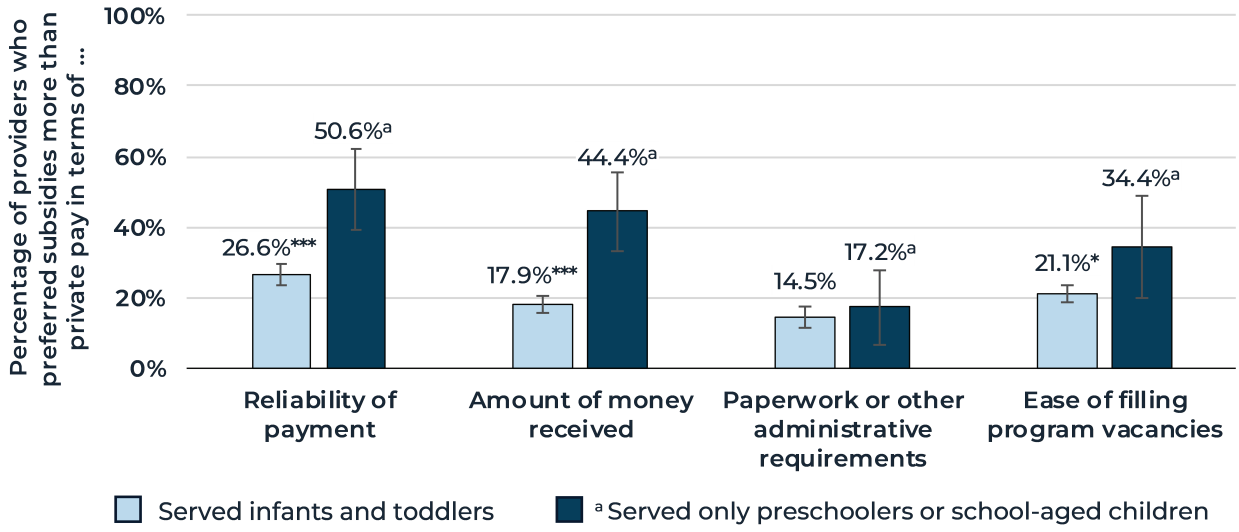
Source: Data from the 2019 NSECE Home-Based Provider Survey.

Note: The figure presents percentages and 95 percent confidence intervals adjusted using a multivariate logistic regression including the analysis sample detailed in the text below Figure 7. Data were drawn from Table B.8 in the accompanying technical report. Probability of sampling weights were applied. All estimates are reported out to a maximum of three significant digits in accordance with RUF reporting requirements. Listed, paid providers who served at least four children were asked their preferences for subsidies. These estimates excluded providers who reported they were not aware of subsidies.

+++/++/+ Differences in the responses for each one-unit change in the percentage of children served whose care is funded by subsidies are statistically significant at the .01/.05/.10 level, two-tailed t-test.

HBCC providers who served infants and toddlers had less favorable preferences for subsidies compared to private pay relative to providers who did not (Figure 9). This finding was particularly true in terms of the reliability of subsidy payment and amount of money received from subsidies. Providers who served infants and toddlers were 24 percentage points less likely to prefer subsidies much or somewhat more than private pay in terms of reliability of payment (27 versus 51 percent) and were 26 percentage points less likely to prefer subsidies in terms of amount of payment received per child (18 versus 44 percent). They were also less likely to prefer subsidies in terms of ease of filling program vacancies at the 10 percent level of statistical significance (21 versus 34 percent). Approximately equal percentages of providers who did and did not serve infants or toddlers favored subsidies over private pay in terms of paperwork or other administrative requirements (15 versus 17 percent).

Figure 9. Listed HBCC providers who served infants and toddlers were far less likely to prefer child care subsidies to private pay in terms of reliability of payment and amount of money received, and somewhat less likely to prefer subsidies in terms of ease of filling vacancies



Source: Data from the 2019 NSECE Home-Based Provider Survey.

Note: The figure presents percentages and 95 percent confidence intervals adjusted using a multivariate logistic regression including the analysis sample detailed in the text below Figure 7. Data were drawn from Table B.8 in the accompanying technical report. Probability of sampling weights were applied. All estimates are reported out to a maximum of three significant digits in accordance with RUF reporting requirements. Listed, paid providers who served at least four children were asked their preferences for subsidies. These estimates excluded providers who reported they were not aware of subsidies.

***/**/* Differences between provider subgroups are statistically significant at the .01/.05/.10 level, two-tailed t-test.

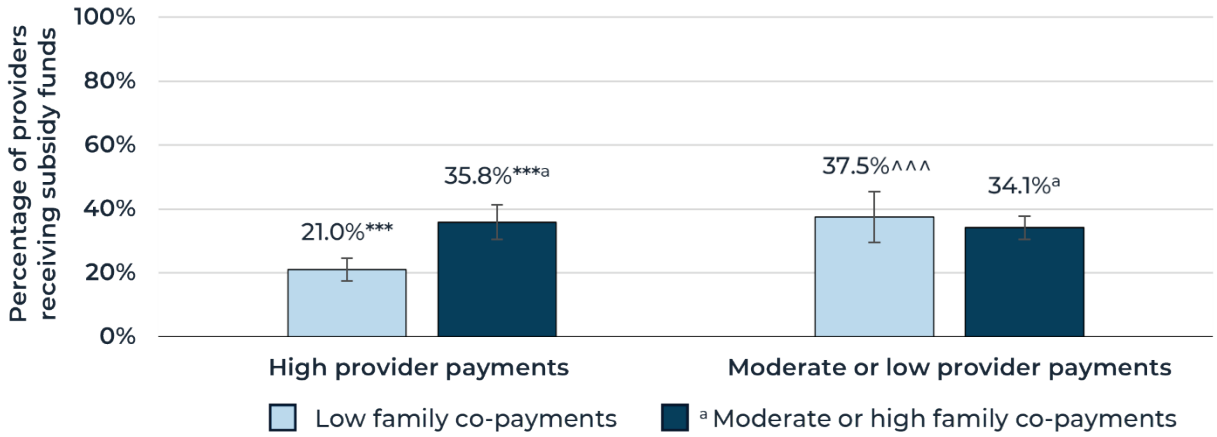
What were the relationships between state CCDF policies and practices and whether listed HBCC providers received subsidy funding, their subsidy payment arrangements, and their preferences for subsidies?

Listed HBCC providers in states with the most generous subsidy rate policies—those that paid providers most while asking participating families to contribute least—were less likely to report receiving funding from subsidies compared to providers in other states.

The subsidy payment amount a provider receives is determined by combining the family co-payment and the state's direct contribution from its subsidy fund. To explore the interplay between these state policies, we allowed relationships between provider subsidy outcomes and how generously states paid them through subsidies to further vary according to how much of that state subsidy payment was coming from family co-payments (as opposed to direct contributions from state subsidy funds), and vice versa. For instance, states that both had generous provider subsidy payments and generous family co-payments contributed the most money directly from their state subsidy funds per child served. As shown in Figure 10, a smaller percentage of HBCC providers in these states reported receiving subsidy funding (21 percent) compared to providers in other states (between approximately 34 and 38 percent).

Among providers who reported receiving subsidy funding, however, we do not generally find statistically significant differences in subsidy density by state subsidy rate policy subgroups after controlling for other characteristics of providers and the communities in which they operate (Report Table B.2).

Figure 10. A smaller percentage of listed HBCC providers reported serving one or more children funded by subsidies in states that had the most generous subsidy rate policies



Source: Data from the 2019 NSECE Home-Based Provider Survey and 2019 CCDF Policies Database.

Note: The figure presents percentages and 95 percent confidence intervals adjusted using a multivariate logistic regression including the analysis sample detailed in the text below Figure 4. Data were drawn from Table B.6 in the accompanying technical report. Probability of sampling weights were applied. All estimates are reported out to a maximum of three significant digits in accordance with RUF reporting requirements. Asterisks above the first and second bars indicate statistical significance within state subgroups, on average. All listed, paid providers were asked whether they received public funding from child care subsidies and if so, for how many children.

***/**/* Differences within state subgroups are statistically significant at the .01/.05/.10 level, two-tailed t-test.

^^^/^^/^ Differences between state payment rate and family co-payment subgroups are statistically significant at the .01/.05/.10 level, two-tailed t-test.

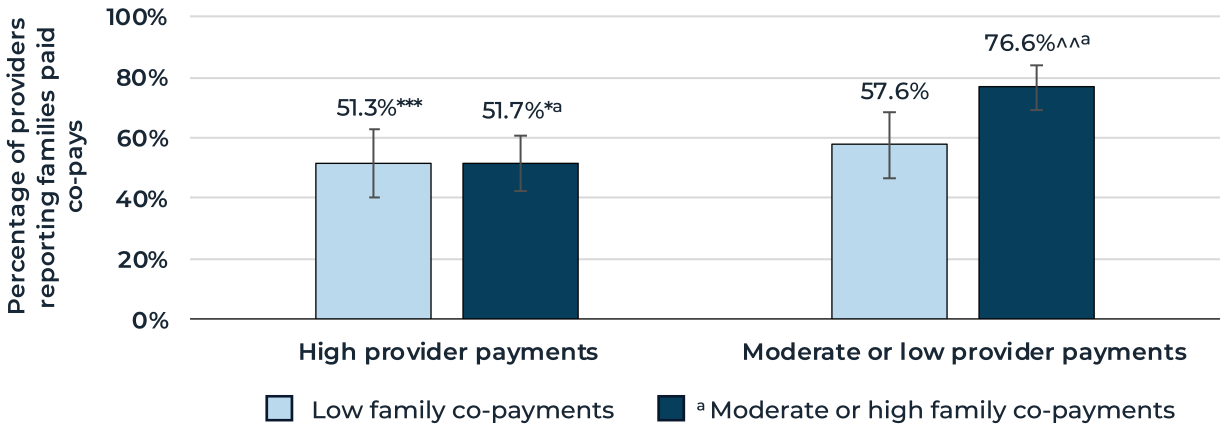
Among listed HBCC providers who received funding from subsidies, state subsidy rate and payment policies were strong predictors of providers' subsidy payment arrangements.

States that had the least generous subsidy rate policies were those that asked families to contribute more through co-payments and offered lower subsidy payments for providers. These states also contributed the least per child directly through state subsidy funds. In these states with both lower provider payments and higher family co-payments, approximately 77 percent of providers who received subsidy funding reported that the families they served whose care was subsidized paid co-pays, compared to between 51 and 58 percent of providers in other states (Figure 11).

Though only a small proportion of listed HBCC providers who received subsidy funding reported that families receiving subsidies paid additional fees to supplement subsidy payment rates below the levels providers required to operate their businesses (14 percent), providers were more likely to report that families paid additional fees when they operated in states that allowed them to charge some or all families additional fees (approximately 18 percent) compared to states that did not (5 percent [Figure 12]).

Providers were asked to report on their non-subsidy rate(s) charged to families who paid for care privately, which we averaged across age groups served. Using state average family co-payments and average adjusted provider payment rates, we simulated the percentage of providers' non-subsidy rate accounted for by each of these components and overall. Among states with high provider payment rates, subsidies reimbursed 90 percent of the non-subsidy rate compared to 85 percent in states with moderate or low payment rates, on average (Figure 13). In states that also had lower family co-payments, proportionally more of this total reimbursement came directly from state subsidy funds. Overall, just 24 percent of providers who received subsidy funding were reimbursed their full private rate (Report Table B.1).

Figure 11. A larger percentage of listed HBCC providers who received subsidy funding reported serving families who paid subsidy co-pays in states that had the least generous subsidy rate policies



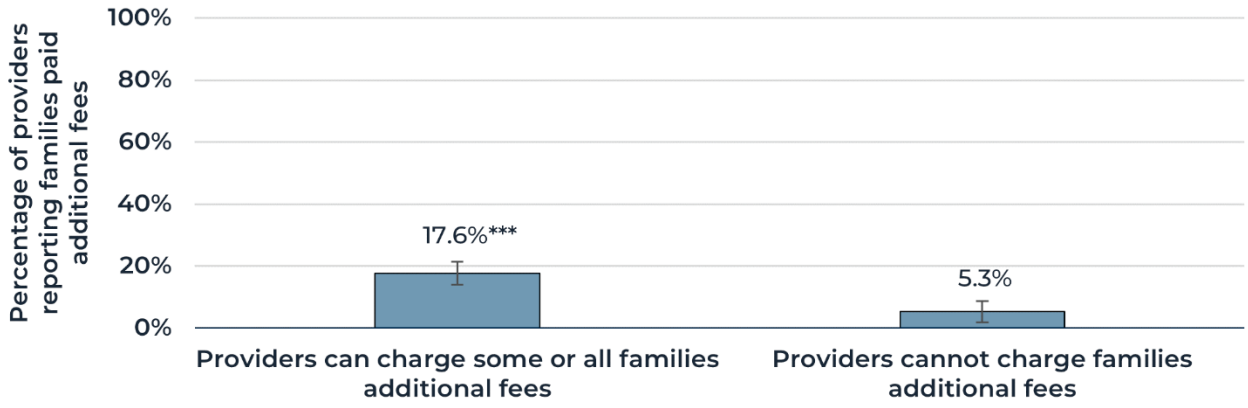
Source: Data from the 2019 NSECE Home-Based Provider Survey and the 2019 CCDF Policies Database.

Note: The figure presents percentages and 95 percent confidence intervals adjusted using a multivariate logistic regression including approximately 1,180 providers weighted to represent approximately 23,900 providers across the nation. Data were drawn from Table B.7 in the accompanying technical report. Probability of sampling weights were applied. All estimates are reported out to a maximum of three significant digits in accordance with RUF reporting requirements. Asterisks above the first and second bars indicate statistical significance within state subgroups, on average. Providers who reported serving one or more children whose care was funded by subsidies were asked whether participating families paid co-pays or additional fees.

***/**/* Differences within state subgroups are statistically significant at the .01/.05/.10 level, two-tailed t-test.

^^^/^^/^ Differences between state provider payment rate and family co-payment subgroups are statistically significant at the .01/.05/.10 level, two-tailed t-test.

Figure 12. A larger percentage of listed HBCC providers who received subsidy funding reported serving families who paid additional fees in states that allowed providers to charge additional fees to some or all families receiving subsidies

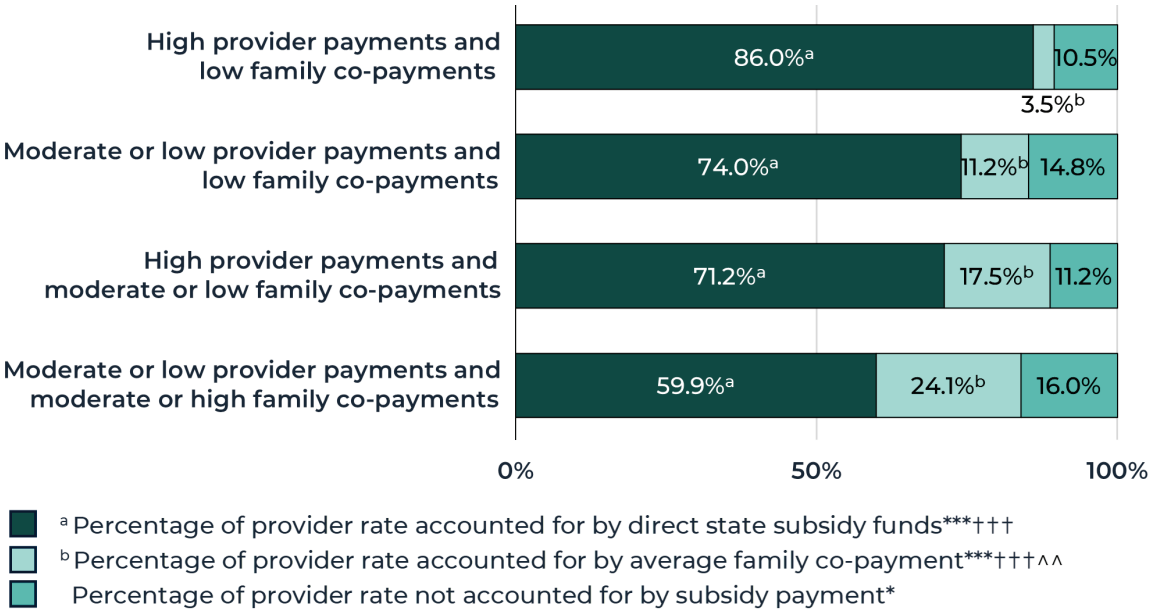


Source: Data from the 2019 NSECE Home-Based Provider Survey and 2019 CCDF Policies Database.

Note: The figure presents percentages and 95 percent confidence intervals adjusted using a multivariate logistic regression including the analysis sample detailed in the text below Figure 11. Data were drawn from Table B.7 in the accompanying technical report. Probability of sampling weights were applied. All estimates are reported out to a maximum of three significant digits in accordance with RUF reporting requirements. Asterisks above the first and second bars indicate statistical significance within state subgroups, on average. Providers who reported serving one or more children whose care was funded by subsidies were asked whether participating families paid co-pays or additional fees.

***/**/* Differences within state subgroups are statistically significant at the .01/.05/.10 level, two-tailed t-test.

Figure 13. Listed HBCC providers who operated in states with more generous subsidy rate policies received a larger proportion of their private rate from subsidies, and in states with lower family co-payments, a greater share of this payment came directly from state subsidy funds



Source: Data from the 2019 NSECE Home-Based Provider Survey and 2019 CCDF Policies Database.

Note: The figure presents percentages adjusted using a multivariate logistic regression including approximately 1,260 providers weighted to represent approximately 24,500 providers across the nation. Data were drawn from Table B.7 in the accompanying technical report. Probability of sampling weights were applied. All estimates are reported out to a maximum of three significant digits in accordance with RUF reporting requirements. These estimates included providers who reported serving one or more children whose care was funded by subsidies.

***/**/* Differences within state provider payment policy subgroup is statistically significant at the .01/.05/.10 level, two-tailed t-test.

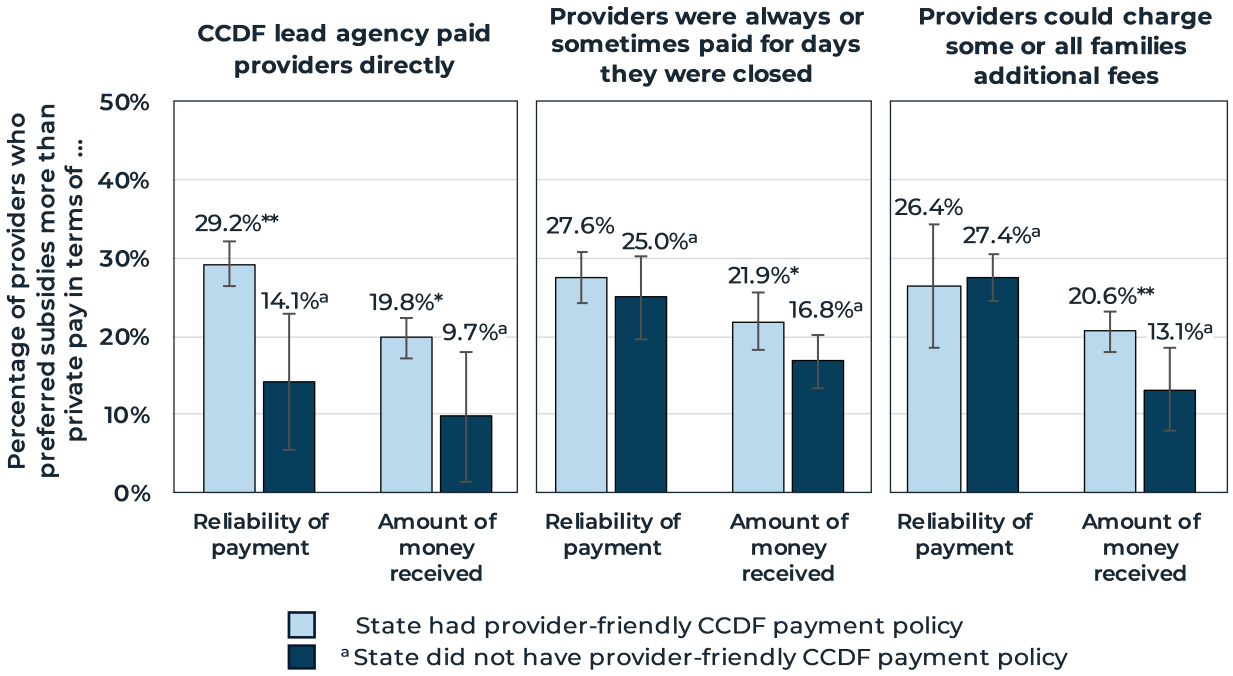
†††/††/† Differences within state family co-payment policy subgroup is statistically significant at the .01/.05/.10 level, two-tailed t-test.

^^^/^^/^ Differences between state provider payment and family co-payment policy subgroups are statistically significant at the .01/.05/.10 level, two-tailed t-test.

Compared to listed HBCC providers in other states, those in states with provider-friendly subsidy payment policies sometimes had more favorable preferences for subsidies compared to private pay in terms of the amount and reliability of payment.

Among those asked, listed HBCC providers in states with various provider-friendly subsidy payment policies were sometimes more likely to prefer subsidies much or somewhat more than private pay in terms of the reliability of payment and the amount of money received, compared to providers in states that did not have these policies (Figure 14). A greater percentage of providers preferred subsidies to private pay in terms of the reliability of payment received (29 versus 14 percent) in states that paid providers directly (rather than routing subsidy payments through families). Providers were also more likely to prefer subsidies to private pay in terms of the amount of money received in states that allowed providers to charge some or all families additional fees to supplement provider subsidy payments (21 versus 13 percent). At the 10 percent level of statistical significance, providers reported preferences for subsidies in terms of the amount of payment in states that paid providers directly (20 versus 10 percent) and in states that sometimes or always paid providers for days they were closed due to vacations, holidays, or bad weather (22 versus 17 percent).

Figure 14. Though most listed HBCC providers did not prefer child care subsidies to private pay in terms of payment reliability and amount, those in states that had more provider-friendly payment policies sometimes had more favorable preferences for subsidies in these areas



Source: Data from the 2019 NSECE Home-Based Provider Survey and 2019 CCDF Policies Database.

Note: The figure presents percentages and 95 percent confidence intervals adjusted using a multivariate logistic regression including the analysis sample detailed in the text below Figure 7. Data were drawn from Table B.8 in the accompanying technical report. Probability of sampling weights were applied. All estimates are reported out to a maximum of three significant digits in accordance with RUF reporting requirements. Listed, paid providers who served at least four children were asked their preferences for the subsidy program. These estimates excluded providers who reported they were not aware of subsidies.

***/**/* Differences within state subgroups are statistically significant at the .01/.05/.10 level, two-tailed t-test.

What did we learn about HBCC providers' subsidy funding receipt, preferences, and arrangements, and how they related to state subsidy rate and provider payment policies?

Fewer than one in three listed HBCC providers reported receiving funding from child care subsidies. This finding might indicate constrained opportunities for some families to use subsidies in HBCC settings, and for some HBCC providers to secure CCEE funding from public sources. Our findings suggest that lack of awareness is one key factor potentially contributing to relatively low rates of subsidy funding receipt—approximately one in four listed HBCC providers who were asked were not aware of subsidies. Even among those who are licensed or regulated, many HBCC providers may be disconnected from professional organizations or networks who share information about subsidies. For instance, in 2019, just 45 percent of listed providers reported a relationship with a program providing professional development resources, whereas approximately half reported meeting with other providers (Schochet et al. 2022b). These resources may be particularly important for increasing awareness of subsidies among HBCC providers.

However, factors other than awareness are also likely to shape HBCC providers' willingness and interest in accepting subsidies. The findings presented in this brief on providers' preferences for subsidies echo issues reported in the literature, such as the burden of paperwork and administrative requirements, communication between subsidy agencies and providers, and late or incorrect payment rates (Adams & Dwyer 2021; Bromer et al. 2021a; Rohacek & Adams 2017, Sandstrom et al. 2018). Perhaps more important,

providers may be accepting a loss in revenue by receiving subsidy funding because most states offer payment rates that are below the market value of CCEE (Schulman 2019). Among providers who received subsidy funding, just one in five preferred them to private pay in terms of amount of payment, while just one in four were simulated to receive a subsidy payment as large as their private rate. These figures are even lower among providers who served infants and toddlers, who are especially likely to charge more than state subsidy payment rates for these age groups (OIG 2019).

Though providers sometimes tended to prefer the amount and reliability of subsidy payments in states with provider-friendly family fee and direct reimbursement payment policies, providers were *less* likely to report receiving subsidy funding in states that reimbursed them most generously and contributed a larger proportion of this payment directly from state funds. This finding runs counter to suggestions that more generous subsidy payment might encourage providers to accept subsidies (Schulman 2019), which were supported by one study of center-based settings (Slicker 2022). Why might this be so? One possible explanation relates to the potential differences in how HBCC providers and center-based settings choose to accept subsidy funding in response to the *demand* for subsidies within their community. Demand is influenced by the number of families using subsidies and is likely to be inversely related to the generosity of state subsidy payments to providers, especially when a relatively larger portion comes directly from state funds and not family co-payments. In other words, states that are most generous to both providers and to families may be limited in their capacity to support the same number of families through subsidies (OIG 2019).

HBCC providers in these most generous states may be less likely to receive subsidy funding for several reasons. First, they may have less awareness of the subsidy program which could be in part a result of fewer families using subsidies in those states. Lack of access to information may disproportionally affect HBCC providers, who often work independently without the same level of regular interaction with professional networks and support systems available to center-based staff (Bromer et al. 2021b). Second, some HBCC providers may require sufficient demand for subsidies to counterbalance the administrative burdens associated with becoming approved to participate and the processes and logistics associated with receiving payment (Adams & Dwyer 2021). Factors such as challenges obtaining timely and accurate payments and communicating with lead agencies to resolve disputes may outweigh high payment rates if providers are able to serve only a small proportion of children through the program. Indeed, we find that although providers in states with higher payment rates were less likely to report receiving subsidy funds, among providers who did so, subsidy densities were similar. Providers with higher subsidy densities had less favorable views of the paperwork and administrative requirements of the program.

From the other perspective, HBCC providers in states that have greater demand for subsidies but offer lower subsidy payments may be more likely to receive subsidy funding because of their willingness to help families, even if it presents a challenge to the sustainability of their business. Indeed, HBCC providers often make tradeoffs between their business income and supporting families (Adams et al. 2022; Nelson 1991; Shdaimah et al. 2018; Tuominen 2003). For example, one qualitative study of HBCC providers in Chicago found that some set their fees below the market rate to offer affordable care to families, whereas others waived subsidy co-payments even though it meant sacrificing their own income (Bromer & Henly 2009; Bromer et al. 2021b). Close relationships with the families they serve (nearly half of listed providers cared for at least one family with whom they had a prior relationship [Schochet et al. 2022c]) potentially coupled with limited, if any, business training (Porter & Bromer 2020), may lead HBCC providers to experience tensions between their roles as caregivers and business owners. This situation may be especially true among providers who operate in higher poverty communities and offer care to meet the needs of families working low-wage jobs with non-traditional hours. We found that these providers were more likely to report receiving subsidy funding and served a greater proportion of children whose care was subsidized.

When setting subsidy rate and payment policies, states factor in numerous competing priorities to maximize available subsidy funds. They include trade-offs, such as between serving as many families as

possible and the generosity of subsidy rate policies, or between payment policies that are either provider friendly or family friendly, but not both. Against this backdrop are key contextual factors related to access to HBCC through subsidies—such as the features of providers and their communities—that influence which providers are most likely to receive subsidy funding or accept a loss of revenue with subsidies. This brief provides states with insights into navigating these complexities and challenges of subsidy policymaking.

The Office of Planning, Research, and Evaluation in the Administration for Children and Families contracted with Mathematica; the Erikson Institute; and Toni Porter, Early Care and Education Consulting, to conduct the Home-Based Child Care Supply and Quality (HBCCSQ) project. For more information about the project, visit https://www.acf.hhs.gov/opre/project/ home-based-child-care-supply-and-quality-2019-2024.

This brief is part of a series of research briefs presenting findings from the HBCCSQ analysis of listed HBCC providers' reported interactions with CCEE policies in the 2019 NSECE. The following individuals also provided key contributions to this analysis: Annie Li, Natalie Reid, Liza Malone, Louisa Tarullo, Gabriela Rosales, Yuri Feliciano, Judy Cannon, Cathy Lu, Yvonne Marki, Gwyneth Olson, Effie Metropoulos, Molly and Jim Cameron, and Allison Pinckney. We are grateful to Gina Adams, Rena Hallam, Alison Hooper, and Iheoma Iruka for their contributions to the development of this product, and to the NSECE Project Team for their ongoing collaboration.

Endnotes

[1] Many terms are used to categorize different types of HBCC. The NSECE groups HBCC providers into two categories: "listed" and "unlisted." Unlisted HBCC providers, sometimes referred to as "informal care" or "family friend and neighbor care," are providers who do not appear on any state or national list and work outside of the formal systems supporting CCEE programs.

[2] This series concentrates on the regulatory, subsidy, and quality improvement policies that define the broader CCEE landscape for listed HBCC providers. Nonetheless, in 2019, a minority also partnered with Head Start/Early Head Start (4 percent) or state or local public preschool (8 percent) programs. Additionally, 62 percent of listed HBCC providers served children whose meals were reimbursed by the Child and Adult Care Food Program.

[3] Most listed HBCC providers are regulated through licensing, certification, or registration processes. In some states, however, listed providers that serve a small number of children and/or are related to those children may receive a legal exemption from licensing in order to accept child care subsidies. These providers are also subject to health and safety regulations. In 2019, about 5 percent of listed HBCC providers were license exempt (Figure 1).

[4] This brief and the others in this series help fill knowledge gaps about HBCC as described in the HBCC Supply and Quality project's Research Agenda and Review of Selected Literature (Bromer et al. 2021a; Del Grosso et al. 2021).

[5] The CCDF Database also tracks whether providers are paid for days when children receiving subsidies are absent, which was a provider-friendly payment policy included in earlier studies (see Isaacs et al. 2018). By 2019, all but one state (Nebraska) paid providers based on a child's enrollment, regardless of their actual attendance.

[6] In some states (for example, Arkansas and Georgia), only providers who have received a state accreditation above a certain level can choose to ask families to pay additional fees, whereas in others, providers cannot charge certain types of families additional fees, such as those who have a child with a disability (Illinois), or those with the lowest incomes who are exempted from co-payments (Texas).

[7] The CCDF Database also tracks whether providers are paid for days when children receiving subsidies are absent, which was a provider-friendly payment policy included in earlier studies (see Isaacs et al. 2018). By 2019, all but one state (Nebraska) paid providers based on a child's enrollment, regardless of their actual attendance.

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