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HBCCSQ Policy Research Brief OPRE Report #2024-060

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

Quality Rating and Improvement Systems

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]

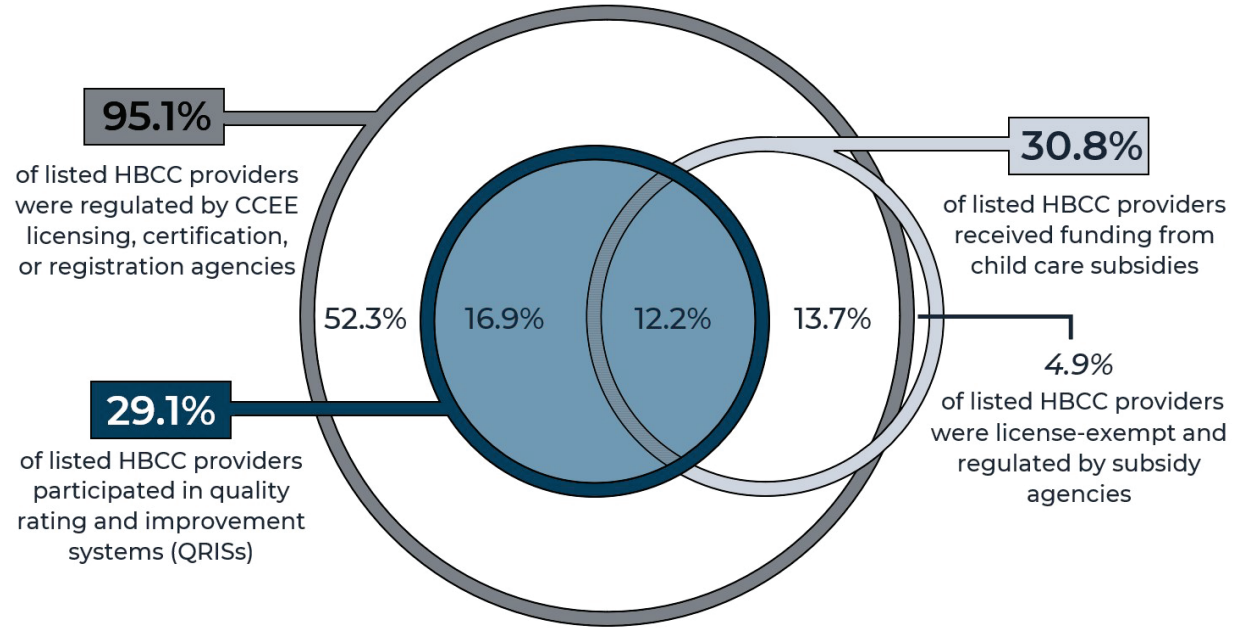
- **State-administered regulations** set and enforce minimum requirements related to health and safety in all CCEE settings.[3]
- The **Child Care and Development Fund (CCDF)** provides funding to states, in part, to subsidize CCEE costs for families with low incomes.
- **Quality rating and improvement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

This brief, focusing on state QRISs, is part of a series of research briefs presenting findings from the first nationally representative analysis of the patterns and predictors 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 state QRIS 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 participation and recent progress in QRISs

- ✓ Among listed HBCC providers in states in the analysis, about two in five reported participating in QRIS, on average, though this percentage was higher in states that required some or all providers to participate.
- ✓ A greater percentage of listed HBCC providers reported QRIS participation in states that offered QRIS-related coaching, mentoring, and professional development and progressively incremental tiered subsidy reimbursement policies.
- ✓ Many listed HBCC providers who participated in QRIS also reported participating in other publicly funded CCEE policies and were accredited or certified.
- ✓ About one in three listed HBCC providers reported that they improved their quality rating in the prior two years. This percentage was higher in states that offered alternative pathways to obtain QRIS ratings and in states that did not offer progressively incremental tiered subsidy reimbursement.
- ✓ Listed HBCC providers' reports of recent engagement in professional development activities – such as coaching, home visiting, and CCEE coursework – and greater knowledge of effective teacher-child interactions were positively associated with reports of increased QRIS ratings.

Figure 1. Listed HBCC providers reported interacting with one or more CCEE policies; about one third participated in QRISs nationwide



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

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.

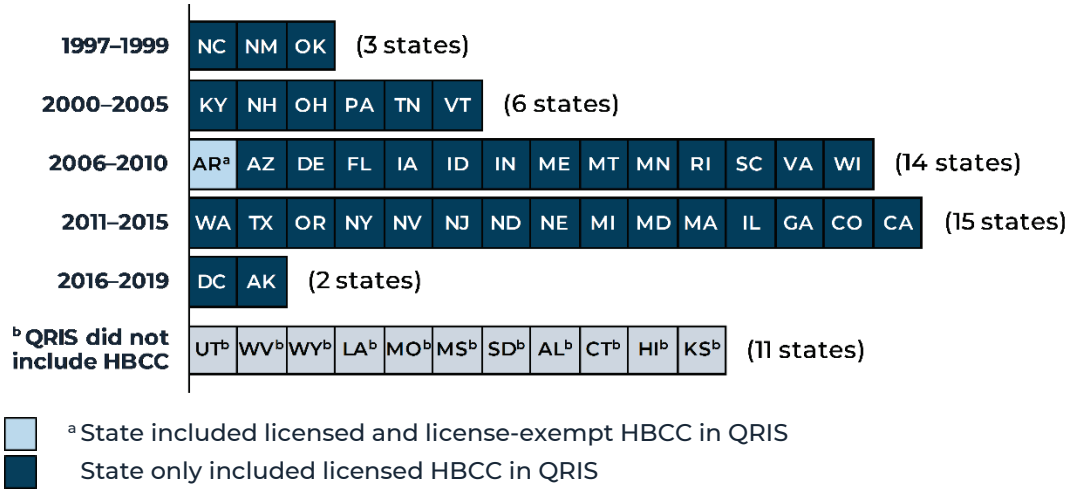
Prior research about HBCC provider participation in state QRISs is limited.

QRISs are implemented by states, territories, and Tribes to assess, improve, and communicate the level of quality in CCEE settings. Though each state, territory, or Tribe may design its own QRISs—for example, by requiring or not requiring CCEE settings to participate—all QRISs assign overall quality ratings according to a set of standards they have each established. Although these standards vary from system to system, some common types of standards include those related to staff qualifications and training; the quality of provider-child interactions; and adult-child ratios, group sizes, and health and safety regulations that build on minimum licensing standards (Schilder et al. 2015). QRISs use those standards to communicate the quality of participating CCEE settings to families to help them find quality care that meets their needs. QRISs offer providers opportunities to receive quality improvement technical assistance (such as coaching and professional development) and financial incentives (such as higher subsidy reimbursement rates) (Boller et al. 2015; Child Care Technical Assistance Network n.d.[b]; National Center on Early Childhood Quality Assurance [NCECQA] 2018).

QRISs began to be developed in the late 1990s as a way for states and localities to combine separate strategies for promoting quality—such as offering higher child care subsidy payments to accredited settings or professional development to meet licensing regulations—into coherent systems (Mitchell 2005; NCECQA 2018; Elicker and Ruprecht 2019). In the two decades since, research on the inputs to CCEE quality and on its importance for child development focused public policy on investing in and expanding QRISs through means such as the federal Race to the Top – Early Learning Challenge and the reauthorization of

the Child Care and Development Block Grant (McDonald 2013; Build Initiative 2019). During this time, many localities started including listed HBCC providers in their QRISs (Figure 2). As of 2019, 40 states (including the District of Columbia) operated statewide QRISs, and 38 of those states included listed HBCC providers. Two states (Florida and California) also operated QRISs that included both centers and listed HBCC providers, although they set QRIS-related policies at the county level. Most statewide QRISs only included licensed, certified, or registered providers; only one state (Arkansas) included license-exempt HBCC providers. Of the 11 states that did not include HBCC providers in their QRISs, seven did not operate QRISs for any CCEE setting, and four states (Alabama, Connecticut, Louisiana, and Utah) operated QRISs that included center-based settings only.

Figure 2. As of 2019, 40 states included licensed HBCC providers in their QRIS; one state also included license-exempt HBCC providers



Source: Data from the 2019 Quality Compendium Database.

Note: The figure presents counts of states (including the District of Columbia) that introduced QRISs for HBCC providers over time, as of 2019. Once introduced, QRISs continue to operate. Each bar represents the additional number of states introducing QRISs in that period. Florida dates are based on introduction in Duval County. Florida, and California operated QRISs at the county level. This figure does not include territories or Tribes with QRISs.

Until recently, most QRISs invested more in improving strategies used in center-based settings and less in adapting systems for HBCC providers (Tout et al. 2017; Tout et al. 2018; Lloyd et al. 2021). Although some QRIS-related policies (such as financial incentives) designed for center-based settings may apply to HBCC providers, others may need to be customized to address their distinctive strengths and challenges. For example, assessing quality in HBCC may require using standards different than those used in center-based settings. HBCC providers often serve smaller, mixed-age groups of children and thus may benefit from fluid learning activities that are simultaneously appropriate for different developmental levels (NSECE Project Team 2013; Bromer et al. 2021). Many HBCC providers also offer care during nontraditional hours like evenings and weekends, during which children's learning experiences may be more informal and individualized than curricula-based lesson plans (Bromer et al. 2021; Schochet et al. 2022). HBCC providers may also benefit from differentiated QRIS-related technical assistance. For example, outreach, trainings, or coaching may have to be tailored for HBCC providers who work long hours without other adults, balance work and family within the same physical environment, and manage multiple roles (Porter et al. 2010; Bromer et al. 2021).

When states do not tailor the relevant features of their QRISs to the specific needs of HBCC providers, they risk excluding them from participating in or progressing through these systems. Indeed, prior evidence from localities where HBCC providers were eligible but not required to participate in QRISs reveals that they

were less likely than center-based settings to participate (Hallam et al. 2017; Tout et al. 2011). Other studies suggest that HBCC providers who did participate were less likely than center-based settings to access supports for quality improvement (Smith et al. 2010), had lower quality ratings, and were often less likely to be in the highest rating levels (Tout et al. 2010).[5]

QRIS-related policies and standards for HBCC vary by locality.

States, territories, and Tribes design and implement their QRISs and have considerable discretion in choosing standards and determining how they incorporate standards and policies for eligible providers. This brief focuses on several statewide QRIS-related policies in 2019, drawn from the Quality Compendium Database (Build Initiative & Child Trends n.d.), and our scan of state QRIS-related documentation presented in Doran and colleagues (2022). Of the 40 states that included HBCC providers in their QRISs in 2019, 37 operated both statewide QRISs and reported data on QRIS-related policies. This brief analyzes data from these 37 states.[6]

Some QRIS-related policies are tailored for HBCC providers in these states (Figure 3). For example, tailored QRISs may have rating standards that are designed to measure the features of quality that may be specific to HBCC, specialized technical assistance for HBCC providers, and alternative pathways for HBCC providers to obtain QRIS ratings (distinct from alternative pathways for center-based settings). In other cases, some QRIS-related policies do apply to HBCC providers in these states but are not specifically tailored for them. For example, states may require participation in QRISs from at least some center-based settings and HBCC providers, and some states implement progressively incremental tiered subsidy reimbursement for these settings and providers. The next section provides an overview of each of these policies and their prevalence in the states included in the analysis.

Some state QRIS-related policies are tailored for HBCC providers.

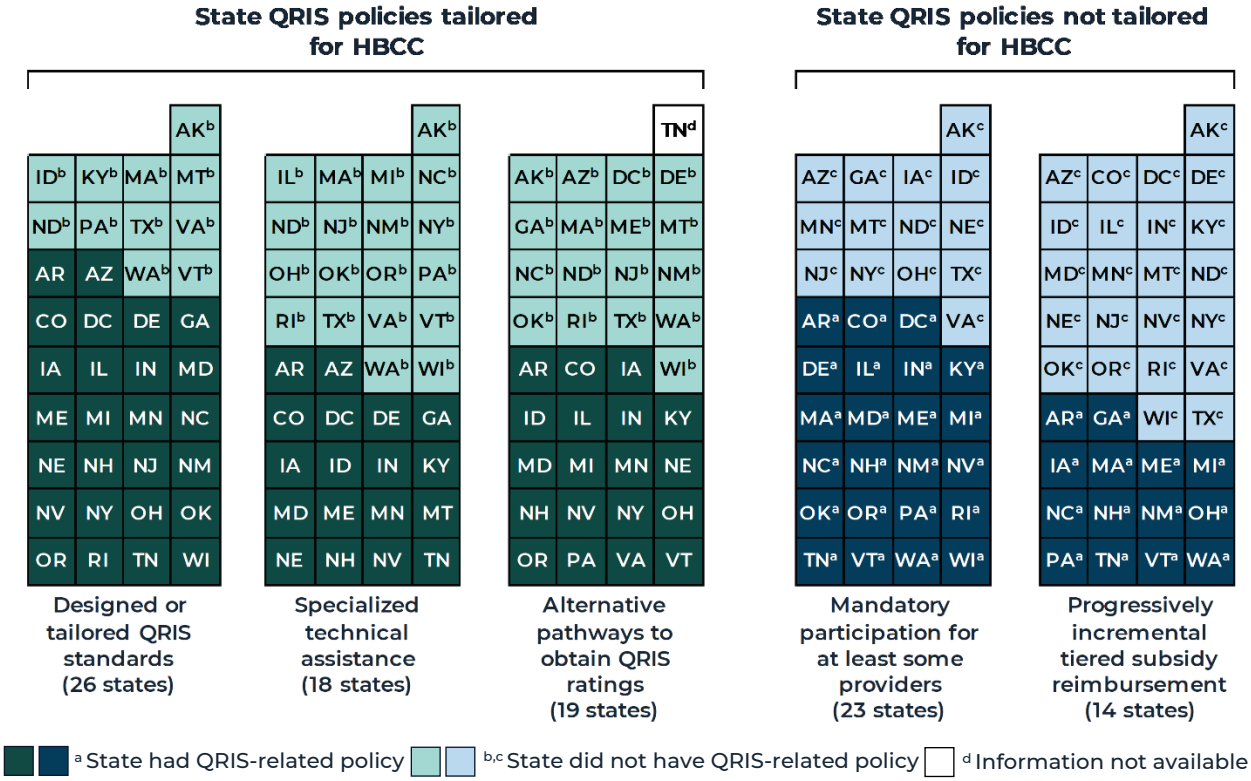
States that designed or tailored QRIS standards for HBCC. Of the 37 states in the analysis, 26 either created new (designed) or adapted existing (tailored) QRIS standards and indicators for HBCC providers. Eleven states did not design or tailor their standards for HBCC (that is, they used the same standards and indicators to measure quality in both HBCC and center-based settings). Among the 26 states that designed or tailored their standards for HBCC, five (Arizona, Colorado, Indiana, Maryland, and Michigan) provided evidence of positive associations with other measures of CCEE quality or child outcomes (Daily et al. 2017; Elicker et al. 2011; Elicker et al. 2018; Epstein et al. 2017; Iruka et al. 2018; Swanson et al. 2017).

States with specialized technical assistance. In 2019, all 37 states in the analysis offered technical assistance to support quality improvement. Examples included providing self-study materials (for example, workbooks and worksheets to help understand standards and conduct self-assessments), self-assessment trainings, or consultations with QRIS staff for general guidance, such as how to prepare and submit required documentation. Eighteen of these states also offered specialized technical assistance specifically for HBCC providers, such as relationship-based coaching or mentoring by QRIS specialists, other agency staff, or consultants; career advisors to help providers with qualifications and professional development requirements; and peer-to-peer support (Doran et al. 2022). These support services were often implemented via Child Care Resource and Referral networks (Build Initiative 2019).

Alternative pathways to obtain QRIS ratings. Some states allow providers to obtain QRIS ratings through alternative or streamlined pathways without going through the full, traditional rating process in some cases. Alternative pathways to obtain QRIS ratings for HBCC providers may include national accreditation (such as by the National Association for Family Child Care [NAFCC]) or meeting standards for other public policies (such as Head Start or Early Head Start; Doran et al. 2022). Some states also offer providers alternative pathways to meet the specific requirements of a particular rating level. For example, if a college degree is required to achieve a certain rating level, an alternative pathway might allow providers to achieve that rating level through having a set number of years of experience. Nineteen states in the analysis offered

alternative pathways to HBCC providers, and 17 did not.[7] Three of these 17 states (Delaware, New Jersey, and New Mexico) offered alternative pathways through accreditation, but only for center-based settings.

Figure 3. State QRIS-related policies for HBCC providers in 2019, among the 37 states in the analysis



Source: Data from the 2019 Quality Compendium Database and HBCCSQ Measures and Indicators Compendium, Appendix B (Doran et al. 2022).

Note: The figure presents counts of states with each policy characteristic or standard among the 37 states (including DC) that (1) operate a statewide QRIS that includes HBCC providers and (2) reported QRIS policies in 2019. Florida and California were excluded because their QRIS policies are made at the county level. South Carolina was excluded due to missing information about its QRIS policies in the 2019 QRIS Compendium Database and state documentation. We conducted our scan of information about state QRIS-related standards and policies using the QRIS Compendium Database and related state documentation available as of October 2020.

Some state QRIS-related policies include HBCC providers, but may not be tailored for them.

States with voluntary or mandatory participation in QRISs. In 2019, center-based settings and HBCC providers were subject to the same QRIS participation requirements in all states in the analysis. Ten states required all providers to participate by automatically enrolling them at an initial rating level (Doran et al. 2022; Maxwell & Starr 2019). Thirteen states made QRIS participation mandatory for providers who received public funding (such as through CCDF subsidies), but voluntary for those that did not. Fourteen states made QRIS participation voluntary for all providers.

States with progressively incremental tiered child care subsidy reimbursement rates. The federal government provides CCDF funding to states, territories, and Tribes so that qualifying families with low incomes can receive subsidies to help pay for child care. Tiered subsidy reimbursement refers to the practice of allocating subsidy payments to providers based on their quality rating levels, with higher payments corresponding to higher rating levels. Among providers receiving funding from subsidies, tiered reimbursement could both attract new providers to enroll in QRISs and incentivize participating providers

to improve their quality rating (Adams & Dwyer 2021; Isaacs et al. 2018; NCECQA 2018). In all cases, states applied the same tiered reimbursement structure for HBCC providers and center-based settings. Tiered reimbursement rate policies vary according to the size of the reimbursements at different QRIS levels and the levels at which higher reimbursement rates are introduced. For instance, one study quantified this variability according to the difference between each state's lowest and highest payment tier (Isaacs et al. 2018). Other categorizations might consider the consistency of rate increases across tiers, or the number of QRIS levels eligible for higher subsidy rates.

We categorized states based on the relationship between the number of payment tiers and the number of voluntary QRIS levels.[8] In 2019, 14 of the 37 states in the analysis had the same number of payment tiers and rating levels. These states implemented tiered payments in "progressive increments," such that providers were offered higher subsidy payments beginning at the lowest voluntary rating level, with larger increases at each successive level.[9] States without progressively incremental tiered reimbursement had fewer payment tiers than QRIS levels. In most cases, this was because states introduced higher subsidy payments at higher rating levels only (18 states). In other cases, this was because states did not use tiered reimbursement at all (5 states).[10]

The NSECE data provide an opportunity to deepen our understanding of listed HBCC providers in QRIS and associations with state QRIS-related policies.

Most research evidence on QRIS focuses on validation studies that assess standards and indicators against observed quality in center-based settings (Cannon et al. 2017). Other studies have examined causal impacts of state QRISs on the CCEE market—for example, as they relate to supply (such as provider turnover rates; Herbst 2018) and demand (such as enrollment rates; Bassok et al. 2019). Surprisingly, the least is known about providers' participation and engagement in QRISs despite their importance in implementing effective QRISs. Beyond evidence on provider participation rates such as that published in the QRIS Compendium, to our knowledge only one study has addressed questions of predictors of QRIS participation by center-based settings (Jenkins et al. 2021). Using the 2012 NSECE (which did not collect information on reported QRIS participation for HBCC providers), the study found few differences between QRIS participants and nonparticipants, though it did show that QRIS participants were more likely to receive revenue from multiple sources (such as private pay, Head Start, child care subsidies, state pre-K) and be accredited.

No prior research has examined the factors associated with HBCC providers' reported participation in QRISs or increased quality rating levels. These factors range from HBCC provider characteristics and features of their communities to state-specific QRIS-related policies and standards. In this brief, we explore the influence of these factors on self-reported HBCC provider participation in QRISs and whether participating providers reported improving their quality ratings during the prior two years. Using restricted-use data from the 2019 NSECE Home-Based Provider Survey—with providers matched on state location to the 2019 QRIS Compendium Database—and our scan of state QRIS-related documentation presented in Appendix B of the HBCCSQ Compendium of Measures and Indicators (Doran et al. 2022), we address the following research questions:

1. **What percentages of listed HBCC providers were aware of and reported participating in their state QRIS?**
2. **Did participation vary according to state-specific QRIS policies for HBCC providers? Which characteristics of listed HBCC providers and their communities were associated with participation in QRISs?**
3. **Among listed HBCC providers who participated in QRISs, to what extent were provider and community characteristics and state QRIS policies associated with reports of increased quality ratings?**

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 QRIS policies for HBCC drawn from the Quality Compendium Database, a catalog of information on state QRISs (Build Initiative & Child Trends n.d.), accompanied by our team's scan of state QRIS-related documentation presented as part of the HBCCSQ Compendium of Measures and Indicators, Appendix B (Doran et al. 2022). 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 were non-relationship based (served one or more children with whom they did not have a prior relationship) or who were relationship based and "family child care (FCC)-like" (served at least four children in their own home and provided at least 21 hours of care per week to one or more child[ren]) were asked whether they had a rating from their state QRIS (N=4,065). Approximately 2,700 of these providers operated in one of the 37 states in the analysis (those with a statewide QRIS that included HBCC providers and had valid information on state QRIS-related policies, as noted). Approximately 1,160 providers who reported participating in their state QRIS were then asked whether they had increased their rating in the prior two years. This included around 980 providers in the 37 states in the analysis.

Analytic strategy. We first examined differences between providers who reported each outcome measure (that is, whether providers participated in QRISs and whether participating providers increased their rating level in the prior two years) across background characteristics of providers and the communities in which they operated, and state-level indicators of QRIS-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 outcome from the selected provider-, community-, and state-level factors that were found to be statistically significant on their own. 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 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 participating in QRISs in subgroups of states with or without a given QRIS-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 that associate with QRIS-related outcomes.

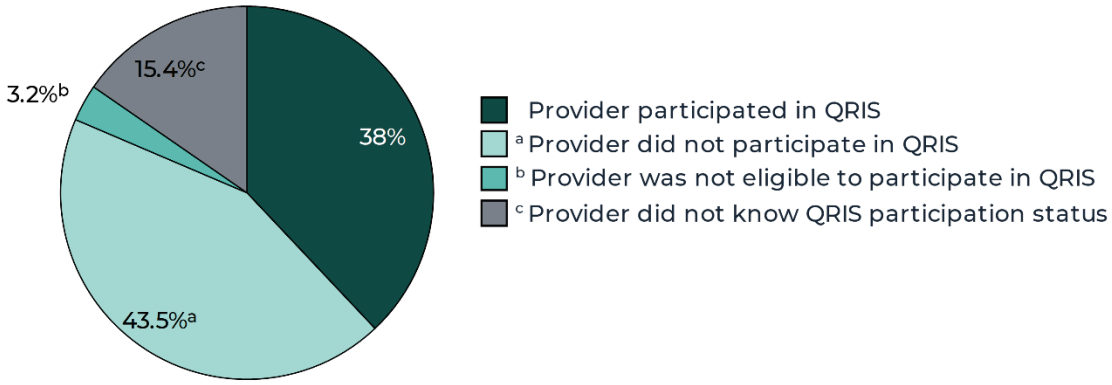
More information on the 2019 NSECE study methodology and measurement is available in the Data Collection and Sampling Methodology Report (NSECE Project Team 2022). See the technical report on the current analyses for more details about the variables used, the sample included in the analyses, treatment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

What were the patterns and predictors of listed HBCC provider participation in state QRISs?

Among listed HBCC providers in states in the analysis, about two in five reported participating in QRIS, on average, though this percentage was higher in states that required some or all providers to participate.

Among providers in the 37 states in the analysis, 38 percent reported participating in their state QRIS (Figure 4). Forty-four percent of providers in these states reported that they did not participate in their state QRIS, and 3 percent of providers reported that they were ineligible to participate in their state QRIS. Fifteen percent did not know their participation status. We exclude providers who did not know their QRIS participation status from the remainder of the analysis.

Figure 4. Almost 40 percent of listed HBCC providers operating in states in the analysis reported participating in QRISs



Source: Data from the 2019 NSECE Home-Based Provider Survey and 2019 Quality Compendium Database.

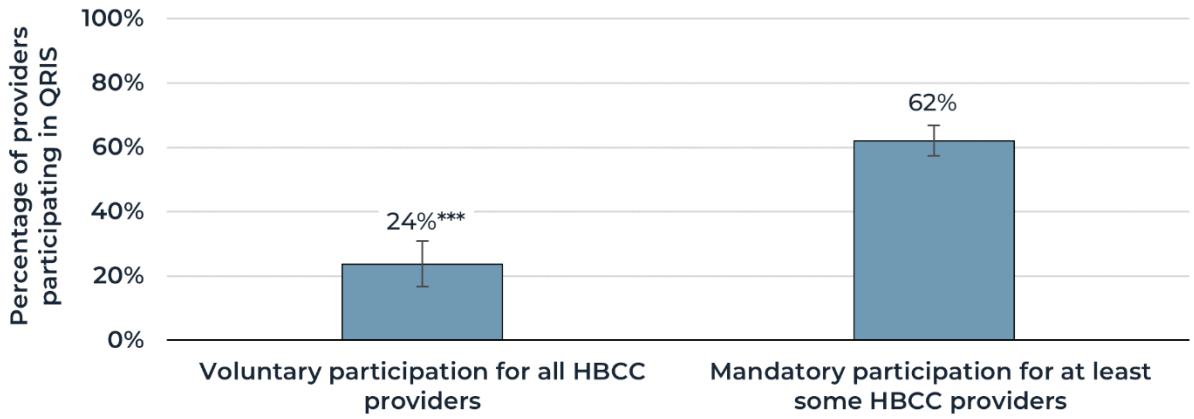
Note: The figure presents unadjusted percentages from approximately 2,700 providers in states that operated a QRIS and included HBCC providers, weighted to represent approximately 51,400 providers. Data were drawn from Table A.1 in the accompanying technical report. Probability of sampling weights were applied. All estimates are reported out to a maximum of three significant digits in accordance with RUF reporting requirements. Provider participation in QRIS asked of non-relationship–based or FCC-like providers. Providers in Florida and California were excluded because QRIS policies were made at the county level. Providers from South Carolina were excluded due to missing information about its QRIS. These analyses excluded providers in states that did not operate a QRIS or did not include HBCC providers.

State participation requirements were most predictive of QRIS participation among providers in states in the analysis (Figure 5). In states where QRIS participation was mandatory for some or all HBCC providers, providers were nearly three times more likely to report having a quality rating than these same kinds of providers were in states where QRIS participation was always voluntary (62 versus 24 percent).

A greater percentage of listed HBCC providers reported QRIS participation in states that offered QRIS-related coaching, mentoring, and professional development and progressively incremental tiered subsidy reimbursement.

The findings also suggest that state policies intended to support or incentivize QRIS participation are promising. Among the states in the analysis, providers were around 13 percentage points more likely to report participating in QRISs when states offered coaching, mentoring, or professional technical assistance for the rating process (52 percent) compared with providers in states that did not offer these specialized supports (39 percent; Figure 6).

Figure 5. Among states in the analysis, a greater percentage of listed HBCC providers reported participating in QRIS when states had mandatory enrollment policies

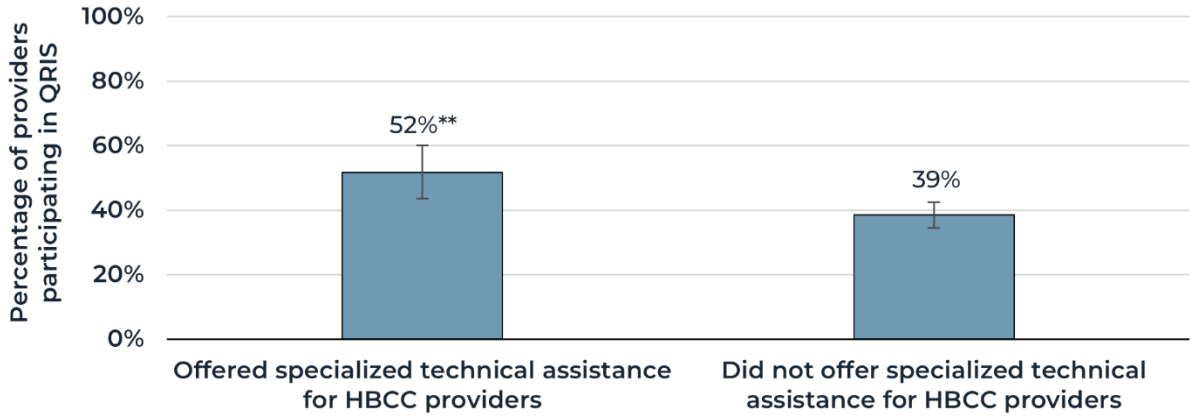


Source: Data from the 2019 NSECE Home-Based Provider Survey and 2019 Quality Compendium Database.

Note: The figure presents percentages and 95 percent confidence intervals adjusted using a multivariate logistic regression including approximately 2,060 providers weighted to represent approximately 46,800 providers. Data were drawn from Table A.4 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. In addition to the exclusions described below Figure 4, these analyses exclude providers who did not know their QRIS rating. Twelve percent of providers in states with mandatory participation policies did not know their rating status, compared with 24 percent of providers in states with voluntary enrollment.

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

Figure 6. Listed HBCC providers were more likely to report participating in their state's QRIS in states that offered QRIS-related coaching, mentoring, professional advising, or peer-to-peer technical assistance



Source: Data from the 2019 NSECE Home-Based Provider Survey, 2019 Quality Compendium Database, and HBCCSQ Measures and Indicators Compendium.

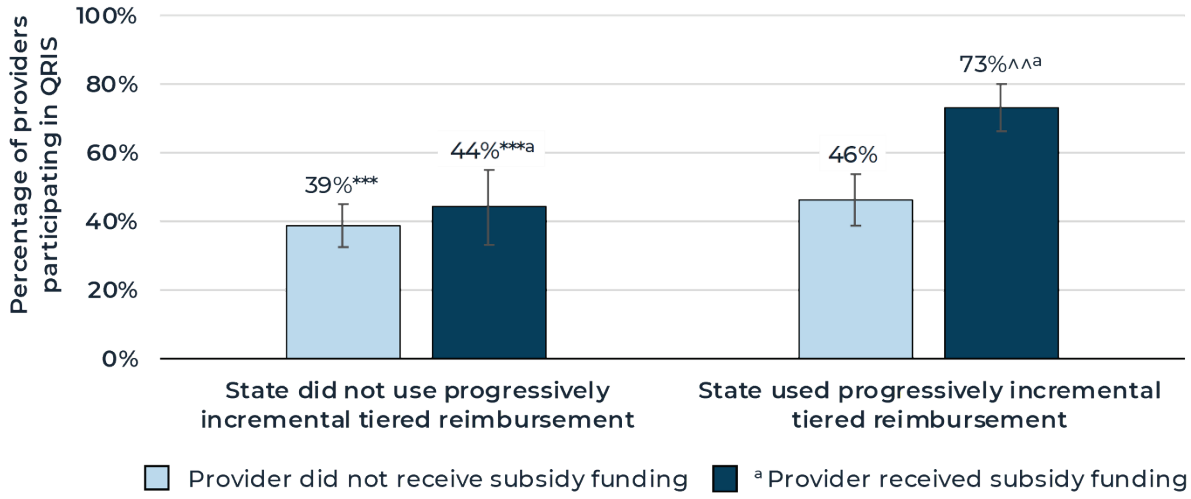
Note: The figure presents percentages and 95 percent confidence intervals adjusted using a multivariate logistic regression including the analysis sample detailed in the text below Figure 5. Data were drawn from Table A.4 in the accompanying technical report. Probability of sampling weights were applied. All estimates are reported out to a maximum of three significant digits in accordance with RUF reporting requirements.

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

In addition, reported QRIS participation rates, on average, were higher among HBCC providers who received funding from child care subsidies. Reported QRIS participation rates were also higher, on average, among providers who operated in a state that offered progressively incremental tiered subsidy reimbursement (Figure 7). In light of both of these findings, this analysis further explored the combination of these two distinct characteristics, estimating the association between QRIS participation rates and progressively incremental tiered reimbursement for both HBCC providers who did and did not report receiving funding from child care subsidies. This analysis suggests positive associations between this form of tiered subsidy reimbursement and QRIS participation among providers who reported receiving subsidy funding. Specifically, among providers who received subsidy funding, reported QRIS participation rates were about 29 percentage points higher in states that offered progressively incremental tiered reimbursement (73 versus 44 percent). QRIS participation rates were more similar among providers who did not receive subsidy funding in these states (46 versus 39 percent).

There was no difference in the percentage of providers who reported participating in QRISs in states that did and did not design or tailor their QRIS standards for HBCC providers (Figure 8). For this reason, we did not include this policy indicator in the multivariate analysis.

Figure 7. Among those who received funding from subsidies, listed HBCC providers in states with progressively incremental tiered reimbursement were more likely to report participating in their state's QRIS



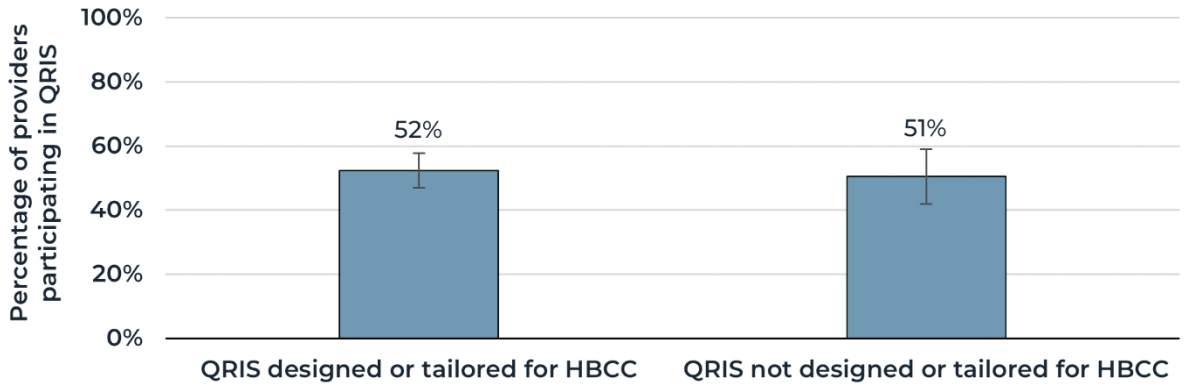
Source: Data from the 2019 NSECE Home-Based Provider Survey and 2019 Quality Compendium Database.

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 5. Data were drawn from Table A.4 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 bar indicate statistical significance between states that did and did not use progressively incremental tiered reimbursement, on average. Asterisks above the second bar indicate statistical significance between providers who did and did not receive subsidy funding, on average. Carets indicate statistical significance in the difference between states that did or did not use progressively incremental tiered reimbursement by whether providers received subsidy funding.

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

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

Figure 8. A similar percentage of listed HBCC providers reported participating in QRISs in states that did and did not design or tailor their QRIS for HBCC providers



Source: Data from the 2019 NSECE Home-Based Provider Survey, 2019 Quality Compendium Database, and HBCCSQ Measures and Indicators Compendium.

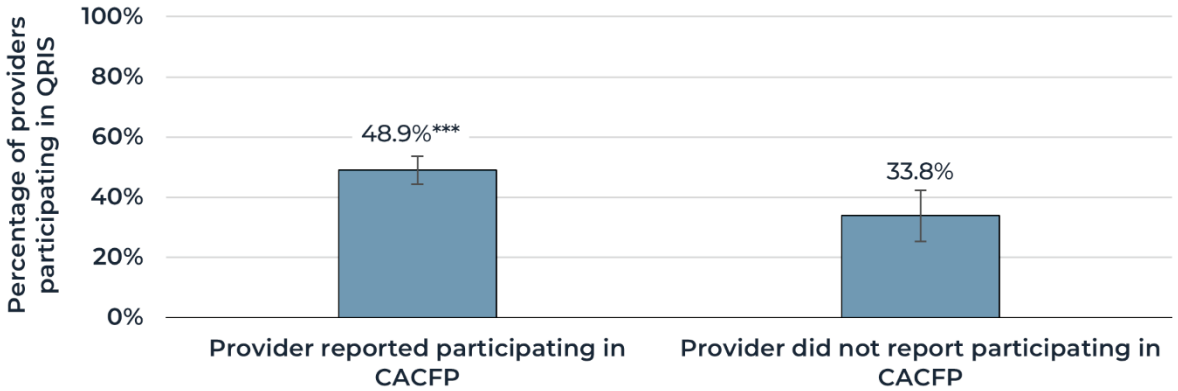
Note: The figure presents unadjusted percentages and 95 percent confidence intervals within the analysis samples detailed below Figure 5. Data were drawn from Table A.3 in the accompanying technical report. Probability of sampling weights were applied. All estimates are reported out to a maximum of three significant digits in accordance with RUF reporting requirements.

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

Many listed HBCC providers who participated in QRIS also reported participating in other public CCEE policies and were accredited or certified.

In addition to higher rates of reported QRIS participation among providers who received subsidy funding (though particularly within states that offered progressively incremental tiered reimbursement; Figure 7), providers who reported participating in the CACFP were 15 percentage points more likely to report participating in a QRIS (49 percent) than providers who did not report participating in the CACFP (34 percent; Figure 9).

Figure 9. Listed HBCC providers who reported participating in the Child and Adult Care Food Program (CACFP) were more likely to report participating in their state's QRIS



Source: Data from the 2019 NSECE Home-Based Provider Survey and 2019 Quality Compendium Database.

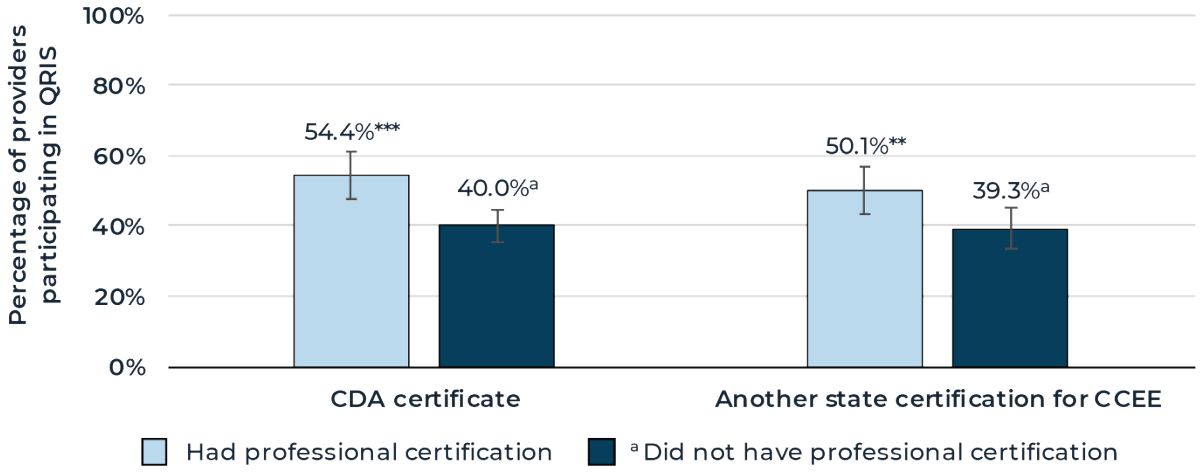
Note: The figure presents percentages and 95 percent confidence intervals adjusted using a multivariate logistic regression including the analysis sample detailed in the text below Figure 5. Data were drawn from Table A.4 in the accompanying technical report. Probability of sampling weights were applied. All estimates are reported out to a maximum of three significant digits in accordance with RUF reporting requirements.

CACFP = Child and Adult Care Food Program.

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

In addition, providers who reported having a CDA certificate were 14 percentage points more likely to report participating in their state's QRIS (54 percent) than providers without a CDA certificate (40 percent; Figure 10). Providers who reported having another state certification (other than a CDA) or endorsement for CCEE were approximately 11 percentage points more likely to report participating in their state's QRIS (50 percent) than providers who did not have another state certification or endorsement for CCEE (39 percent).

Figure 10. Listed HBCC providers who reported having a Child Development Associate (CDA) or another state certification for CCEE were more likely to report participating in their state's QRIS



Source: Data from the 2019 NSECE Home-Based Provider Survey and 2019 Quality Compendium 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 5. Data were drawn from Table A.4 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.

CDA = Child Development Associate.

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

Other characteristics of providers and their communities were not associated with providers' reported participation in their state's QRIS (Report Table A.2). Specifically, the percentage of HBCC providers who reported participating in a QRIS did not vary by provider race and ethnicity, household income, health status, age, education level, program size, ages of children served, whether the provider had a prior relationship with the children in care, operating schedules, and other characteristics of the communities providers operated in, such as poverty density and urban population density.

What state policies and provider characteristics predict reported increased QRIS ratings among listed HBCC providers who participated in QRIS?

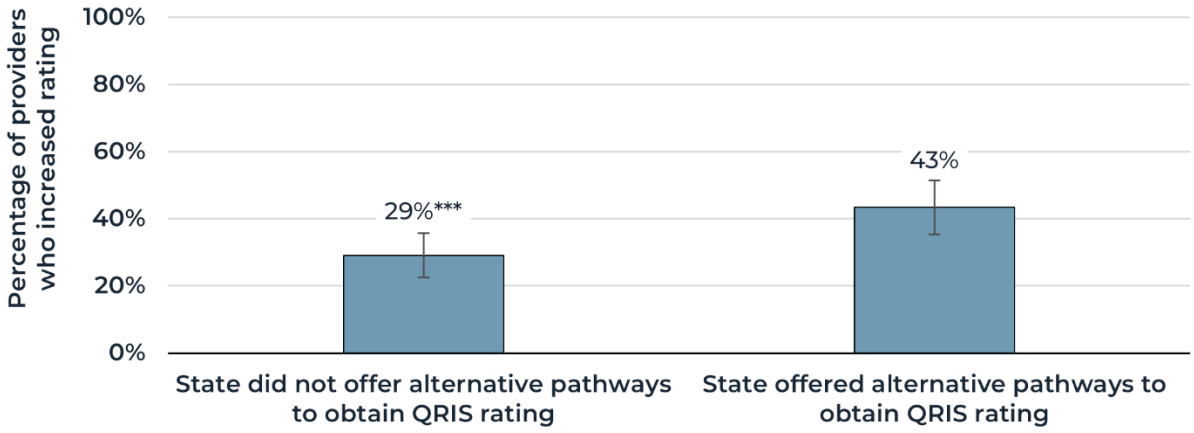
About one in three listed HBCC providers reported that they improved their quality rating in the prior two years. This percentage was higher in states that offered alternative pathways to obtain QRIS ratings and in states that did not offer progressively incremental tiered subsidy reimbursement.

What can we learn from providers' reports of increased quality ratings?

Just over one-third (36 percent) of listed HBCC providers who reported participating in their state QRIS reported increasing their quality rating in the prior two years. Those who reported moving from a lower rating to a higher rating indicated receiving a higher rating level from their state's QRIS during the two-year reference period. However, there are many reasons why other providers may not have reported increased quality ratings. Some could have moved from a higher rating to a lower rating. Others might not have changed their rating status, either because they did not have a re-rating in the prior two years or because they had a rating that resulted in the same score. In 2019, eight of the 37 states in the analysis required providers to be re-rated each year, six required providers to be re-rated every two years, 14 required providers to be re-rated every three years, and nine had different re-rating policies for providers at different rating levels (generally permitting providers with higher rating levels to be re-rated less frequently). In 17 states, providers were allowed to request a re-rating before their current quality rating had expired. Additionally, some providers may have already attained the highest possible rating level in their state.

Alternative pathways were positively associated with reports of increased quality ratings. Alternative pathways give providers an opportunity to demonstrate that they meet indicators of quality care based on criteria outside of a state's QRIS standards, such as through NAFCC accreditation. Participating providers in states that offered alternative pathways to obtain quality ratings were 14 percentage points more likely than those in states that did not offer alternative pathways to report moving to a higher rating level in the prior two years (43 versus 29 percent; Figure 11).

Figure 11. Among those who reported participating in their state QRIS, listed HBCC providers were more likely to report improved QRIS ratings in states that offered HBCC providers alternative pathways to obtain quality ratings

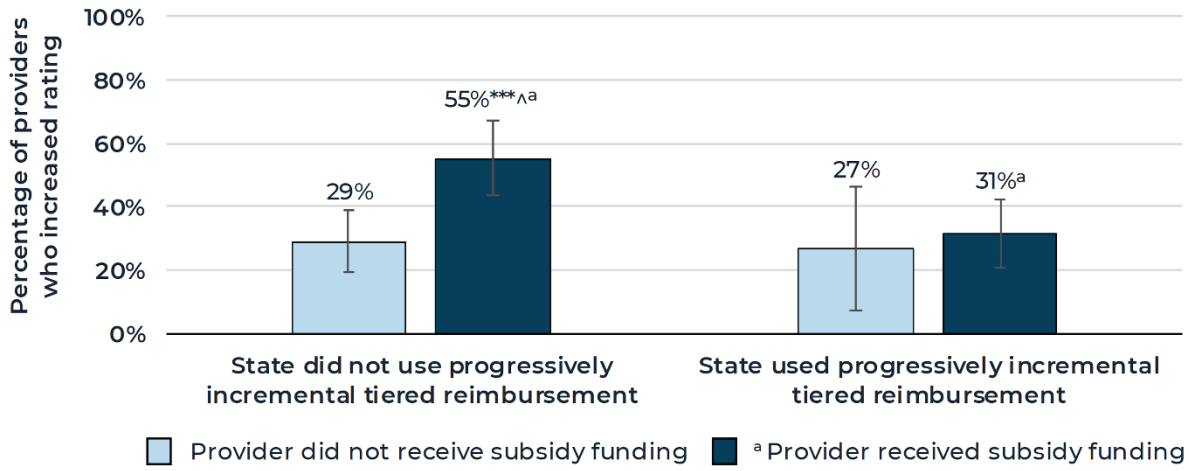


Source: Data from the 2019 NSECE Home-Based Provider Survey, 2019 Quality Compendium Database, and HBCCSQ Measures and Indicators Compendium.

Note: The figure presents percentages and 95 percent confidence intervals adjusted using a multivariate logistic regression including approximately 980 providers weighted to represent approximately 21,320 providers. Data were drawn from Table A.5 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. In addition to the exclusions described below Figures 4 and 5, these analyses exclude providers who did not report participating in QRIS. Providers in Tennessee are excluded from estimates of alternative pathways to obtain QRIS ratings due to missing information.

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

Figure 12. Listed HBCC providers who received funding from subsidies were less likely to report improved QRIS ratings in states that used progressively incremental tiered reimbursement



Source: Data from the 2019 NSECE Home-Based Provider Survey and 2019 Quality Compendium 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 A.5 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 second bar indicate statistical significance between providers who did and did not receive subsidy funding, on average. Carets indicate statistical significance in the difference between states that did or did not use progressively incremental tiered reimbursement by whether providers received subsidy funding.

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

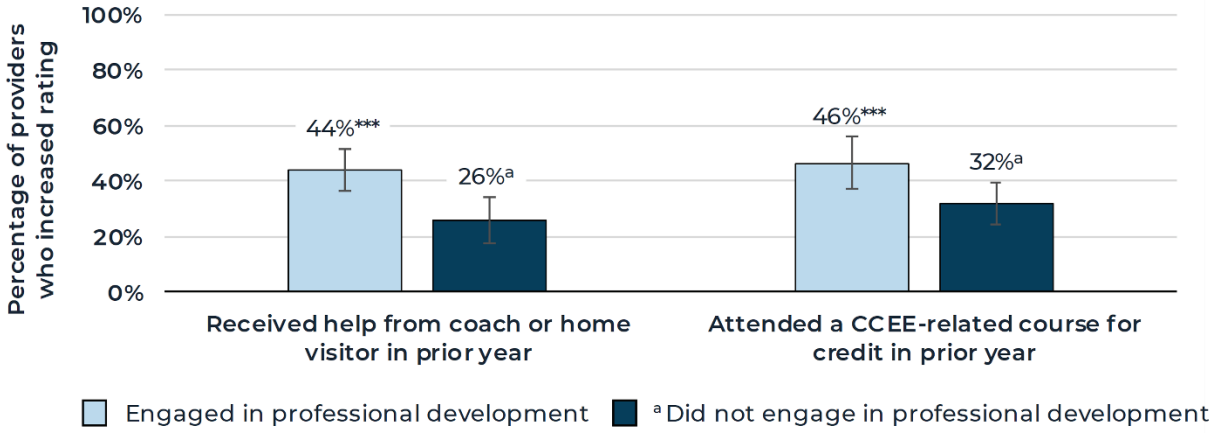
^^^/^^/^ Differences within state subgroups between provider subgroups are statistically significant at the .01/.05/.10 level, two-tailed t-test.

Listed HBCC providers' reports of recent engagement in professional development activities – such as coaching, home visiting, and CCEE coursework – and greater knowledge of effective teacher-child interactions were positively associated with reports of increased QRIS ratings.

The strongest predictors of whether providers reported increased QRIS ratings was recent engagement in professional development. This included receiving support from a coach or home visitor and attending a CCEE-related course for credit in the prior year (Figure 13). Providers who reported receiving support from a coach or home visitor were 18 percentage points more likely to report improving their quality rating than those who did not receive this type of support. Similarly, providers who reported attending a CCEE-related course for credit were 14 percentage points more likely to report improving their quality rating compared to providers who did not report attending a course.

Providers who scored higher on the Teachers' Knowledge of Effective Teacher-Child Interactions Abbreviated Scale (Hamre & Pianta 2007) were also more likely to report increased QRIS ratings, on average (Figure 14). Though statistically significant on average, this association was more positive at the 10 percent level for providers in states that did not tailor their QRISs for HBCC. This scale is aligned with the CLASS framework and was designed to measure teachers' knowledge of developmentally appropriate practice for young children in center-based settings.

Figure 13. Listed HBCC providers who engaged in professional development in the prior year were more likely to report increasing their QRIS rating

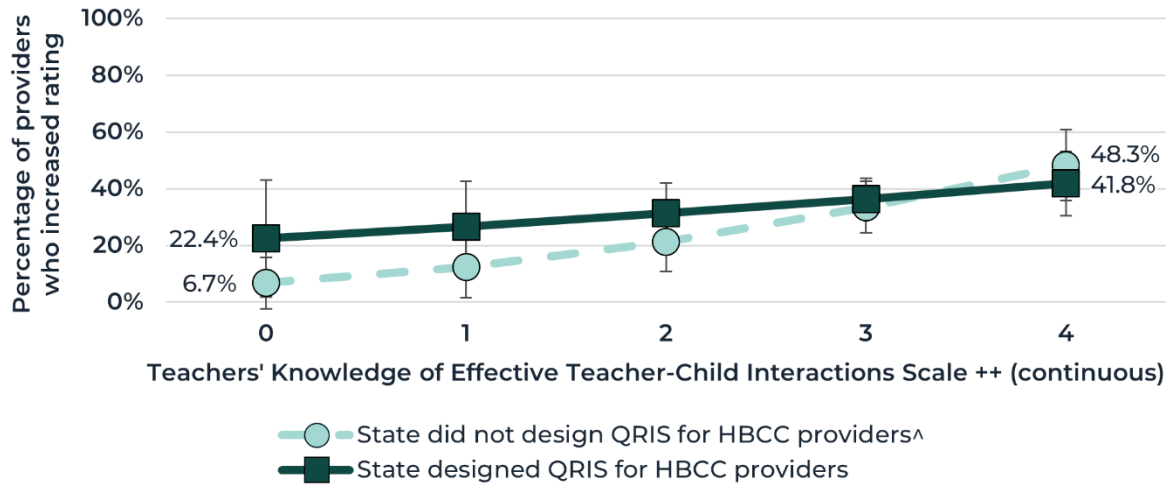


Source: Data from the 2019 NSECE Home-Based Provider Survey and 2019 Quality Compendium Database.

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 A.5 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.

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

Figure 14. Listed HBCC providers with higher scores on the Teachers' Knowledge of Effective Teacher-Child Interaction Scale were more likely to report increased QRIS ratings



Source: Data from the 2019 NSECE Home-Based Provider Survey, 2019 Quality Compendium Database, and HBCCSQ Measures and Indicators Compendium.

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 A.5 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 next to the horizontal axis label indicate a statistically significant, positive association between providers' scale scores and whether providers reported improved QRIS ratings, on average. The caret next to the first state subgroup label indicates a statistically significant difference at the 10 percent level in the association between providers' scale scores and improved QRIS ratings by whether states designed their QRIS for HBCC providers.

+++/++/+ Differences in the responses for each one-unit change in providers' scale scores are statistically significant at the .01/.05/.10 level, two-tailed t-test.

^^^/^^/^ Differences in associations with providers' scale scores between state subgroups are statistically significant at the .01/.05/.10 level, two-tailed t-test.

What are the implications of these findings for integrating listed HBCC providers into QRISs?

To improve, acknowledge, and communicate CCEE quality, QRISs have continued to expand and evolve to engage HBCC providers in recent years. However, research has not kept pace with these reforms to examine whether and how HBCC providers are experiencing the substantive variations in QRISs across the country and how different state policies and provider characteristics may predict QRIS participation and ratings. The 2019 NSECE included data that allowed us to explore these questions for the first time.

As of 2019, QRISs in 40 states included HBCC providers (37 of which were part of this analysis), and QRISs in 11 states did not. Among states in the analysis, about 40 percent of listed HBCC providers participated in QRISs. However, among states that included HBCC providers in QRISs on a voluntary basis, fewer than one in five participated, and about one in four were not aware of their state's QRIS. Low rates of participation suggest that when selecting CCEE, families in states with voluntary QRISs only have information on quality ratings for the smaller share of HBCC providers who volunteer to participate (Zellman & Perlman 2008). They might also suggest that QRIS-related incentives or technical assistance policies are not enough to support higher levels of participation in voluntary QRISs. HBCC providers' awareness of QRISs in these states could possibly benefit from public education campaigns—in 2019, only four of the 14 states with voluntary QRISs had dedicated funding to promote public awareness of QRIS (Build Initiative & Child Trends n.d.).

Contrary to our expectations, we found that among HBCC providers accepting subsidies, progressively incremental tiered reimbursement was positively related to QRIS participation but negatively related to the percentage of providers reporting increased quality ratings. Future research should explore these dynamics. A key area of inquiry is understanding which providers participate in voluntary QRISs with these policies when they otherwise would not have. For instance, because this policy rewards providers who enroll at lower rating levels with subsidy payments that are ensured to be larger than the payments received before enrolling, it may principally incentivize QRIS participation by providers who would expect to receive a low quality rating. Progressively incremental tiered reimbursement may have less influence on the QRIS participation decisions of providers anticipating higher rating levels who, in most states, could receive higher subsidy payments regardless of the tiered reimbursement policy.

Research is also needed to investigate why providers who enroll in QRISs with progressively incremental tiered reimbursement may then be less likely to report increasing their quality rating. For instance, what barriers do they face in participating in activities that support development of skills associated with higher-quality providers? For example, providers who enter QRISs at lower levels may find the incentive amounts from progressively incremental tiered reimbursement too small to finance quality improvement activities (Lee 2021). Among states in the analysis with this policy, just one (Georgia) offered providers at the lowest QRIS level a reimbursement rate increase above 5 percent. Overall, our findings suggest that progressively incremental tiered subsidy reimbursement may be an effective strategy to incentivize HBCC provider participation in QRISs, though questions remain about the types of providers who enroll and why providers in these states were less likely to report increased quality ratings.

We found no clear associations between QRIS indicators that were designed or tailored by states for HBCC and the percentages of providers who participated in QRISs or improved their ratings. It is possible that our method of categorizing states that tailored any indicators included states that did not tailor them enough to adequately capture quality features of HBCC. For example, states often tailor their center-based indicators by using different child assessments, observation tools, or curricula, but these adaptations might not address quality features that may be particularly pronounced in HBCC, such as offering families flexible child care schedules during nontraditional hours (Doran et al. 2022). Another possibility is that designing or tailoring rating standards for HBCCs has positive associations with QRIS-related outcomes, but only for some providers within certain state QRISs. For instance, research could explore whether designing or

tailoring QRIS standards for HBCC positively associates with QRIS participation among providers within a QRIS for whom participation is voluntary and not required. There may also be variability in associations between tailoring and providers' reports of increased quality ratings – for instance, with more positive associations for providers who are more likely to implement practices that are unique to or more common in HBCC.

Offering specialized technical assistance and connections with other government agencies (such as those administering CCDF, CACFP, or state certifications) or organizations (such as those offering CDA credentialling) were each positively associated with QRIS participation. Conversely, providers who did not report connections with government agencies or organizations had lower QRIS participation rates, on average. Although state QRISs may use partnerships with agencies or organizations that regularly communicate with HBCC providers to conduct outreach to expand QRIS participation (Build Initiative 2017), future research could seek to better understand how these approaches work for providers who are not yet connected to professional systems. Providers were also more likely to report improved QRIS ratings when they had recently engaged in professional development such as coaching, home visiting programs, or classes on child development. These findings suggest that a range of quality improvement activities that are often components of QRISs were positively associated with improved quality ratings. State policies offering providers alternative pathways to obtain ratings were also positively associated with reports of improved quality ratings. Although certain pathways benefit nationally accredited providers, others, such as allowing years of experience to substitute for a college degree or certification, could foster more equitable opportunities in QRISs among providers who are less connected to professional systems.

Some of our study findings require careful interpretation. First, we are limited by the fact that the data come from a single year. We are unable to understand how QRIS participation may change over time or what factors predict continuing participation. Indeed, if QRISs are intended to help identify and support the strengths and areas of growth for providers, then it could take time for quality improvement to be reflected in higher ratings. Second, the variables we used to operationalize QRIS participation and improved quality ratings were self-reported by providers. Providers could incorrectly report QRIS participation for many reasons, including because they were automatically enrolled because of licensing, or their state QRIS was relatively new or had a name or acronym they did not recognize.

Despite these limitations, our findings suggest that some state QRIS-related policies positively predicted HBCC provider participation in QRISs, but most were not associated with reported increases in ratings among participants in the prior two years. Independent of participation requirements, state policies such as offering specialized technical assistance and progressively incremental tiered reimbursement were linked with higher QRIS participation rates among HBCC providers. Research that collects data from the same providers over multiple time points is needed to understand whether these policies influence QRIS participation, encourage quality improvement, or both. Policymakers and QRIS administrators can use these findings that share insights into how HBCC providers may be experiencing state QRIS policies, as well as potential barriers to participation and quality improvement.

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: Toni Porter, Anna Beckham, 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. 2021; Del Grosso et al. 2021).

[5] State-level administrative data from the 2019 QRIS Compendium suggest that, on average, 18 percent of listed HBCC providers participated in QRISs in states where participation was always voluntary, compared with 33 percent of center-based programs. Nationally, these rates are 29 and 52 percent, respectively.

[6] Florida and California operate QRIS programs at the county level, as noted. We exclude providers in these states from analysis of state-level QRIS policies. In addition, we exclude providers in South Carolina because information about its QRIS was missing from the 2019 Quality Compendium Database. We exclude Tennessee from analysis of alternative pathways to higher ratings because we could not find information on this policy. We also exclude territories or Tribes with their own QRISs.

[7] We were not able to learn whether Tennessee offered alternative pathways that applied to HBCC providers.

[8] In states where participation was voluntary, this included all QRIS levels, beginning at the lowest level (relative to providers not participating in QRISs). In states where participation was required for providers receiving subsidy funding, this included the second rating level and higher.

[9] For instance, Ohio's voluntary, five-level QRIS offered a tiered subsidy payment rate of 5 percent at Level 1, 18 percent at Level 2, 21 percent at Level 3, 29 percent at Level 4, and 35 percent at Level 5.

[10] Five states (Alaska, Idaho, Kentucky, Montana, North Dakota, and Virginia) did not offer tiered reimbursement to providers at any rating level. These states provided the same subsidy reimbursement rate to providers regardless of QRIS participation status (if voluntary) or quality level.

References

Adams, G., and K. Dwyer. "Child Care Subsidies and Home-Based Child Care Providers." Urban Institute, 2021. Child Care Subsidies and Home-Based Child Care Providers (urban.org).

Bassok, D., T.S. Dee, and S. Latham. "The Effects of Accountability Incentives in Early Childhood Education." *Journal of Policy Analysis and Management*, vol. 38, 2019, pp. 838–866.

Boller, K., D. Paulsell, P. Del Grosso, R. Blair, E. Lundquist, D.Z. Kassow, R. Kim, and A. Raikes. "Impacts of a Child Care Quality Rating and Improvement System on Child Care Quality." *Early Childhood Research Quarterly*, vol. 30, part B, 2015, pp. 306–315.

Bromer, J., T. Porter, C. Jones, M. Ragonese-Barnes, and J. Orland. "Quality in Home-Based Child Care: A Review of Selected Literature." OPRE Report #2021-136. Office of Planning, Research, and Evaluation, Administration for Children and Families, Department of Health and Human Services, 2021.

Build Initiative. "Finance and QRIS." Build Initiative, 2017. https://buildinitiative.org/wp-content/uploads/2017/01/FinanceQRIS.pdf.

Build Initiative. "Engaging Family Child Care in QRIS." Build Initiative, 2019. https://buildinitiative.org/wp-content/uploads/2021/06/QRIS2019FamilyChildCareReportREV2-1.pdf.

Build Initiative and Child Trends. "A Catalog and Comparison of Quality Initiatives (Data System)." Build Initiative, n.d. https://qualitycompendium.org/.

Cannon, J.S., G.L. Zellman, L.A. Karoly, and H.L. Schwartz. "Quality Rating and Improvement Systems for Early Care and Education Programs: Making the Second Generation Better." RAND Corporation, 2017. Working Paper PE-235-RC.

Child Care Technical Assistance Network. "National Database of Child Care Licensing Regulations." Administration for Children and Families, U.S. Department of Health and Human Services, n.d.(a). https://licensingregulations.acf.hhs.gov/about.

Child Care Technical Assistance Network. "Quality Rating and Improvement System (QRIS)." Administration for Children and Families, U.S. Department of Health and Human Services, n.d.(b). https://childcareta.acf.hhs.gov/ccdf-fundamentals/quality-rating-and-improvement-system-qris.

Daily, S., M. Soli, V. Lin, V. Perkins, E. Bultinck, J. Cleveland, and K. Maxwell. "Colorado Shines Validation Study 2015–2017: Final Report." Report #2017-48. Child Trends, 2017.

Doran, E., A. Li, S. Atkins-Burnett, J. Forde, J. Orland, M. Ragonese-Barnes, N. Mix, N. Reid, and A. Kopack Klein. "Compendium of Measures and Indicators of Home-Based Child Care Quality." OPRE Report #2022-28. Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services, 2022.

Elicker, J., C. Clawson Langill, K.M. Ruprecht, J. Lewsader, and T. Anderson. "Evaluation of 'Paths to QUALITY,' Indiana's Child Care Quality Rating and Improvement System: Final Report." Department of Human Development and Family Studies, Center for Families, Purdue University, 2011. https://www.in.gov/fssa/pathstoquality/files/PTQFinalReportRev11012.pdf.

Elicker, J., S. Lane, Z.S. Gold, A. Mishra, and S. Christ. "Paths to QUALITY Evaluation—Phase 2." Department of Human Development and Family Studies, Purdue University, 2018. https://www.in.gov/fssa/pathstoquality/files/Final_PTQ_Evaluation_Progress_Report_4-18-18.pdf.

Elicker, J., and K. Ruprecht. "Child Care Quality Rating and Improvement Systems (QRIS): National Experiment for Improving Early Childhood Education Quality." In *The Wiley Handbook of Early Childhood Care and Education*, edited by Christopher P. Brown, Mary Benson McMullen, and Nancy File. John Wiley and Sons, Inc., 2019.

Epstein, D., D. Hegseth, S. Friese, B. Miranda, T. Gebhart, A. Partika, and K. Tout. "Quality First: Arizona's Early Learning Quality Improvement and Rating System Implementation and Validation Study." Child Trends, 2017.

Hallam, R.A., A. Hooper, K. Bargreen, M. Buell, and M. Han. "A Two-State Study of Family Child Care Engagement in Quality Rating and Improvement Systems: A Mixed Methods Analysis." *Early Education and Development*, vol. 28, no. 6, 2017, pp. 669–683.

Hamre, B.K., and R.C. Pianta. "Learning Opportunities in Preschool and Early Elementary Classrooms." In *School Readiness and the Transition to Kindergarten in the Era of Accountability*, edited by R. Pianta, M. Cox, and K. Snow. Brookes, 2007.

Herbst, C.M. "The Impact of Quality Rating and Improvement Systems on Families' Child Care Choices and the Supply of Child Care Labor." *Labour Economics*, vol. 54, 2018, pp. 172–190.

Isaacs, J.B., E. Greenberg, and T. Derrick-Mills. "Subsidy Policies and the Quality of Child Care Centers Serving Subsidized Children." Urban Institute, 2018.

Iruka, I.U., A.-M. Faria, J. Claxton, N. Tucker-Bradway, F. Andrade, J. Pan, C. Markley, B. Hardin, R. Bruner, E. Nyhof, and S. Khan. "Great Start to Quality Validation Study Final Report." HighScope Educational Research Foundation, 2018. https://www.michigan.gov/mde/-/media/Project/Websites/mde/ogs/pdgb5/GSQ_Validation_Final_Report.pdf.

Jenkins, J.M., J.K. Duer, and M. Connors. "Who Participates in Quality Rating and Improvement Systems?" *Early Childhood Research Quarterly*, vol. 54, 2021, pp. 219–227.

Lee, E. "A Mixed-Methods Study of Maryland's Monetary Incentives to Improve the Quality of Child Care Centers." *Early Childhood Research Quarterly*, vol. 55, 2021, pp. 349–362.

Lloyd, C.M., M.B. Salomone Testa, M. Kane, and P. Harris. "Promising Practices for Home-Based Child Care: A Review of State-Level Approaches." Child Trends, 2021.

Maxwell, K.L., and R. Starr. "The Role of Licensing in Supporting Quality Practices in Early Care and Education." OPRE Research Brief #2019-31. Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services, 2019.

McDonald, D. "Quality Rating and Improvement Systems in Race to the Top – Early Learning Challenge Program Annual Performance Reports." Office of Early Childhood Development, Administration for Children and Families, U.S. Department of Health and Human Services, 2013.

Mitchell, A. "Stair Steps to Quality: A Guide for States and Communities Developing Quality Rating Systems for Early Care and Education." United Way of America, Alexandria, VA, 2005.

NCECQA. "QRIS Resource Guide." Administration for Children and Families, U.S. Department of Health and Human Services, 2018. https://ecquality.acf.hhs.gov/resource-guide.

NSECE Project Team. "Number and Characteristics of Early Care and Education (ECE) Teachers and Caregivers: Initial Findings from the NSECE." OPRE Report #2013-38. Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services, 2013.

NSECE Project Team. "Home-Based Early Care and Education Providers in 2012 and 2019: Counts and Characteristics." OPRE Report #2021-85. Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services, 2021.

NSECE Project Team. "2019 National Survey of Early Care and Education Data Collection and Sampling Methodology Report." OPRE Report #2022-118. Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services, 2022.

Porter, T., D. Paulsell, P. Del Grosso, S. Avellar, R. Hass, and L. Vuong. "A Review of the Literature on Home-Based Child Care: Implications for Future Directions." Mathematica Policy Research, 2010.

Schilder, D., I. Iruka, H. Dichter, and D. Mathias. "Quality Rating and Improvement Systems: Stakeholder Theories of Change and Models of Practice." Build Initiative, 2015. https://buildinitiative.org/wp-content/uploads/2021/06/QRIS-3.0-Report-V11-2016.2.5-FINAL.pdf

Schochet, O., A. Li, P. Del Grosso, N. Aikens, S. Atkins-Burnett, T. Porter, and J. Bromer. "A National Portrait of Unlisted Home-Based Child Care Providers: Learning Activities, Caregiving Services, and Children Served." OPRE Brief #2022-292. Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services, 2022.

Schochet, O., P. Del Grosso, S. Atkins-Burnett, J. Bromer, T. Porter, A. Li, and N. Reid. "Listed Home-Based Child Care Providers and Child Care and Early Education Policies Series: Technical Report." OPRE Report #2023-330. Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services, 2024.

Smith, S., W. Schneider, and J.L. Kreader. "Features of Professional Development and On-site Assistance in Child Care Quality Rating Improvement Systems: A Survey of State-wide Systems." National Center for Children in Poverty, 2010.

Swanson, C., D. Carran, A. Guttman, T. Wright, M. Murray, C. Alexander, and J. Nunn. "Maryland EXCELS Validation Study." Johns Hopkins University, School of Education, Center for Technology in Education, 2017. http://marylandexcels.org/wp-content/uploads/2017/08/Maryland-EXCELS-Validation-Study-FINAL-June-29-2017.pdf.

Tout, K., R. Starr, M. Soli, S. Moodie, G. Kirby, and K. Boller. "Compendium of Quality Rating Systems and Evaluations." Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services, 2010.

Tout, K., R. Starr, T. Isner, J. Cleveland, L. Albertson-Junkans, M. Soli, and K. Quinn. "Evaluation of Parent Aware: Minnesota's Quality Rating and Improvement System Pilot Final Evaluation Report." Child Trends, 2011.

Tout, K., K. Magnuson, S. Lipscomb, L. Karoly, R. Starr, H. Quick, D. Early, D. Epstein, G. Joseph, K. Maxwell, J. Roberts, C. Swanson, and J. Wenner. "Validation of the Quality Ratings Used in Quality Rating and Improvement Systems (QRIS): A Synthesis of State Studies." OPRE Report #2017-92. Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services, 2017.

Tout, K., S. Friese, R. Starr, and A. Hirilall. "Understanding and Measuring Program Engagement in Quality Rating and Improvement Systems." OPRE Research Brief #2018-84. Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services, 2018.

Zellman, G.L., and M. Perlman. "Child-Care Quality Rating and Improvement Systems in Five Pioneer States: Implementation Issues and Lessons Learned." RAND Corporation, 2008. https://www.rand.org/content/dam/rand/pubs/monographs/2008/RAND_MG795.pdf.

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