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

Health and Safety Regulations

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]

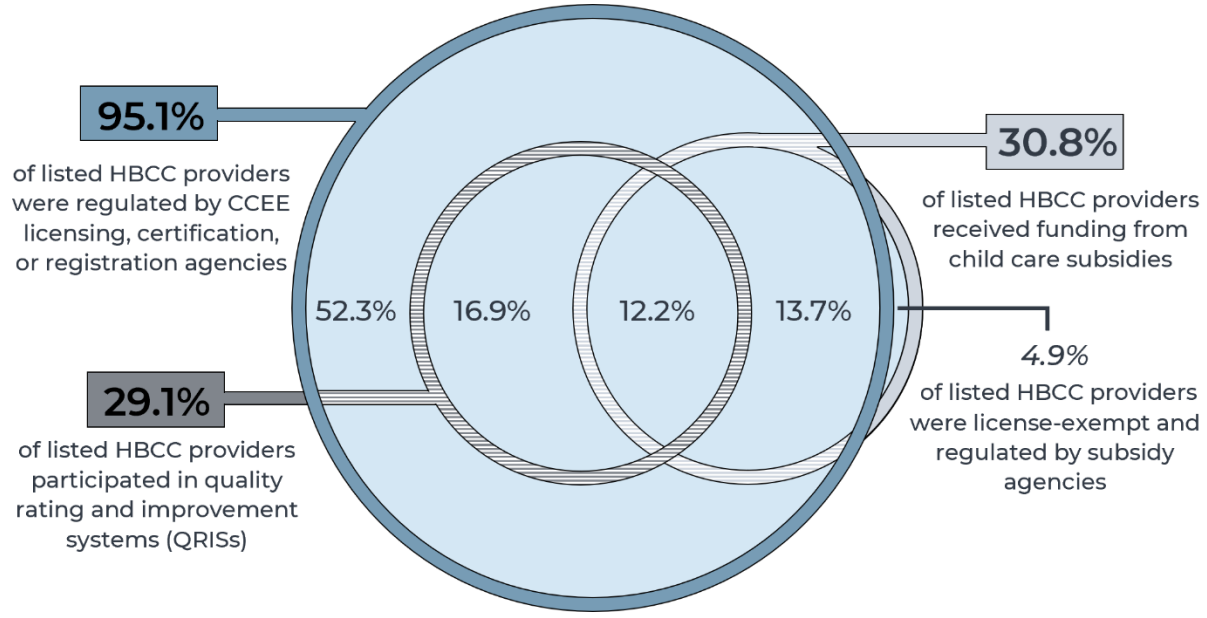
- **State-administered regulations** set and enforce minimum requirements related to health and safety in all CCEE settings.[3]
- The **Child Care and Development Fund (CCDF)** provides funding to states, in part, to subsidize CCEE costs for families with low incomes.
- **Quality rating and improvement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

This brief, focusing on health and safety regulations, 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] This brief also includes data from the 2012 NSECE. It provides background on regulatory 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 interactions with, perceptions of, and responses to CCEE regulations

- ✓ Approximately nine in ten providers reported receiving an inspection or attending a health and safety training in the prior year, and these rates were even higher among providers who reported interacting with other CCEE policies.
- ✓ Virtually all listed HBCC providers agreed that background checks are important for children's health and well-being, although some perceived discomfort about them or reported that they created hardships in their businesses.
- ✓ In communities with higher concentrations of Hispanic/Latino/a and Black, non-Hispanic residents, and communities with higher rates of poverty, listed HBCC providers were less likely to report health and safety trainings and inspections, and were more likely to perceive that some providers experience discomfort and associate burdens with background checks.
- ✓ For some listed HBCC providers, difficulties complying with regulations and requirements contributed to their decisions to leave the CCEE workforce, although financial reasons such as low wages were reported most often.
- ✓ Increases in state CCEE health and safety regulations between 2012 and 2019, and the addition of mandatory background checks in particular, was associated with a decrease on the percentage of listed HBCC providers who received subsidy funding.

Figure 1. Listed HBCC providers reported interacting with one or more CCEE policies; all were subject to health and safety regulations



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.

Public CCEE policies impose regulations and requirements on listed HBCC providers to keep children safe and healthy.

Health and safety regulations are a key element of public CCEE policy (Maxwell & Starr 2019). For instance, states require most center-based settings and listed HBCC providers to be licensed (sometimes referred to as being certified or registered).[5] To ensure children are safe and healthy, most states require HBCC providers to become licensed if they serve more than a certain number of children, and many also consider HBCC providers' prior relationships with families (such as whether they care for relatives), whether providers choose to receive public funding for the children they serve, and how many hours they spend caring for children (Child Care Technical Assistance Network n.d.). For example, in 2020, 10 states and the District of Columbia required HBCC providers caring for any unrelated child to be licensed, and most others (33) required providers serving more than three or four children, regardless of whether they were relatives, to be licensed (National Center on Early Childhood Quality Assurance [NCECQA] 2022a).

As part of the licensing process, states and localities inspect settings to ensure compliance with regulations, conduct comprehensive background checks on providers and other adults in the home, and require training on health and safety topics. Licensing inspections—which first occur pre-licensing and continue on an unannounced, routine basis—regulate structural features of care such as the maximum number of children and adult-child ratios for specific age groups; environmental features such as square footage per child, and fences for the outdoor area; and equipment such as fire extinguishers and first aid kits. States also require licensed HBCC providers, staff, and other adults residing in providers' homes to pass comprehensive background checks to promote child safety within child care settings, and require providers to complete pre-

licensing and ongoing trainings on health and safety topics, such as first aid and CPR.[6] Although all states require inspections, background checks, and health and safety trainings for licensed HBCC providers, specific regulatory policies vary within states, such as how often regulatory agencies conduct inspections, the number of years between background checks, and the number of required health and safety training topics. For example, in 2019, 44 states and the District of Columbia required routine inspection visits once a year or more, whereas four states required these visits once every two or three years (Child Care Technical Assistance Network n.d.).

State and local governments enact regulations and requirements for health and safety against the backdrop of guidelines set by the federal government. Particularly influential are federal regulatory requirements for HBCC providers who receive funding from the Child Care and Development Fund (CCDF). CCDF includes requirements for health and safety not only for licensed HBCC providers, but also for providers who are legally exempt from licensing. For instance, federal regulations through the CCDF require state regulatory agencies to ensure that providers, staff, and adults living in the home undergo background checks at least once every 5 years. However, many states (18 in 2020) conducted CCDF background check components more often (Child Care Technical Assistance Network n.d.; Matthews et al. 2015). As covered in the next section, the 2014 reauthorization of the Child Care and Development Block Grant (CCDBG), which funds the CCDF, had the effect of making health and safety requirements more stringent for licensed HBCC providers, including those who did not receive subsidy funding, and for license-exempt HBCC providers who received funding from subsidies (Matthews et al. 2015).

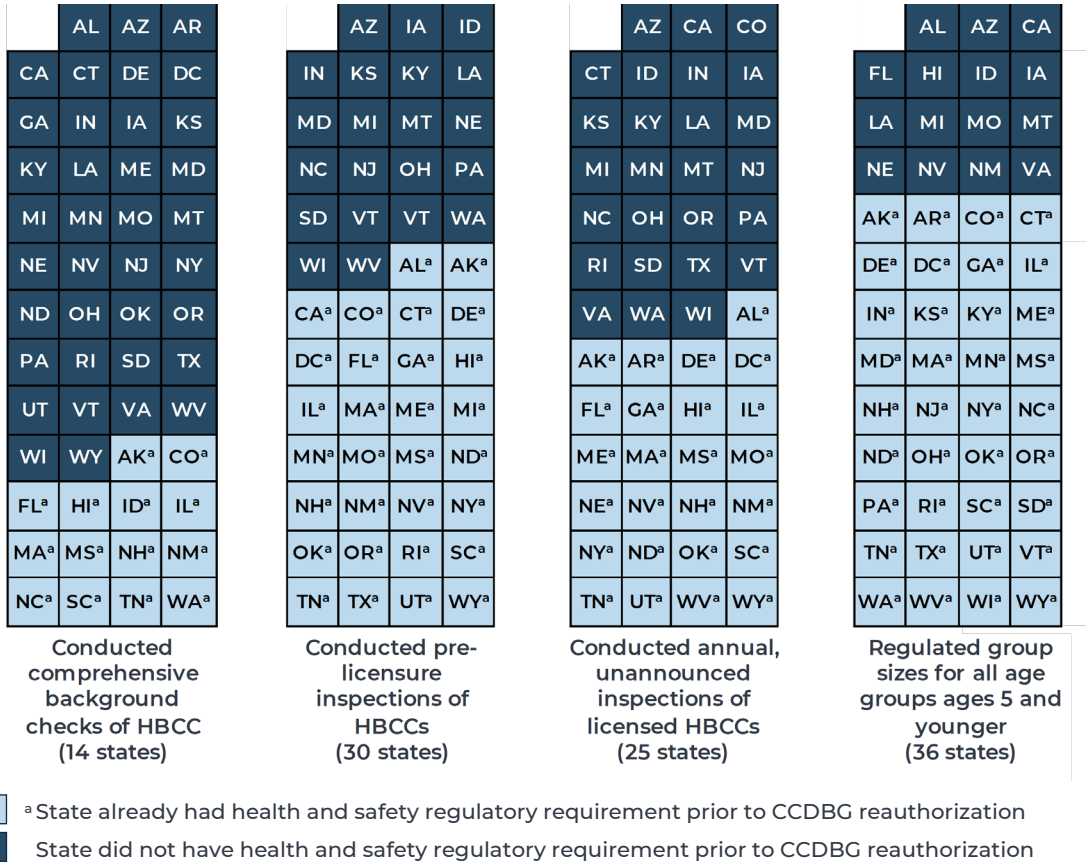
Although listed HBCC providers most commonly interact with health and safety regulations through state licensing and subsidy agencies, other federal, state, and local CCEE policies may have their own health and safety requirements. For example, the federally-funded Child and Adult Care Food Program (CACFP) provides state agencies with additional inspection funds to carry out health inspections and monitor the quality of meals at least three times a year (USDA FNS 2014). State regulations for QRISs may have additional requirements, such as inspections to assess and monitor the quality of CCEE services including, but not limited to, health and safety (Build Initiative & Child Trends n.d.).

The 2014 reauthorization of the federal Child Care Development Block Grant increased CCEE regulatory requirements for HBCC in many states.

The prevalence of CCEE regulations and requirements is in large part due to federal efforts over the past decade to promote consistency in health and safety standards across state licensing systems. In 2014, the Child Care Development Block Grant (CCDBG), which supports the federal CCDF subsidy program, was reauthorized for the first time since the 1996 federal Personal Responsibility and Work Opportunity Reconciliation Act, which reformed the welfare system. Among the key goals of the 2014 legislation was to help protect the health and safety of children receiving subsidies in CCEE. All states were required to certify and enforce their licensing requirements for HBCC providers and to enhance consumer education around licensing.[7] States were also required to extend health and safety regulations to license-exempt providers who wanted to receive subsidy funding (Matthews et al. 2015; Adams & Dwyer 2021). Other goals of the reauthorization were to improve child care quality and to update policies determining provider subsidy rate and payment, family eligibility, and subsidy re-determination periods (Matthews et al. 2015).

New federal requirements for HBCC providers who received funding from subsidies included home inspections, comprehensive background checks, health and safety training, and group size limits.[8] Many states had not enacted these health and safety requirements for HBCC providers prior to the reauthorization. As a result, they were required to revise existing requirements or add new ones (Figure 2). Recent data suggest that 40 of the 48 states that license HBCC providers enacted new or increased requirements between 2017 and 2020 (NCECQA 2022a, 2022b). The rest of this section provides an overview of the specific regulatory changes that related to HBCC providers.

Figure 2. State CCEE health and safety regulatory requirements for HBCC providers prior to the CCDBG reauthorization



Source: Data from Implementing the Child Care and Development Block Grant Reauthorization: A Guide for States, Appendix III (Matthews et al. 2015).

Note: The figure presents counts of states with each regulatory requirement in 2013 based on the most recent data available to the authors. The CCDBG reauthorization required states to implement the key provisions of the law beginning in FY 2016.

State changes in required background checks. Before the CCDF was reauthorized (as of November 2013), only 14 states required comprehensive background checks comparable to the CCDF requirements for HBCC providers (including both licensed and license-exempt providers; Matthews et al. 2015).[10] By 2019, all 48 states that licensed HBCC providers required comprehensive background checks for HBCC providers, 42 states required providers to complete state and federal criminal history checks with fingerprinting, and 41 conducted state and federal sex offender checks (Dwyer et al. 2020; authors' calculations from the 2017 Child Care Licensing Study Database). All states also required background checks for HBCC program staff (such as assistants and substitutes), and other individuals such as family members in the provider's home. Most states also required program staff and other household members to undergo state child abuse and neglect registry checks (38), presence on a sex offender registry (41), and fingerprinting (41).

State changes in required inspections. According to the National Association for Regulatory Administration's (NARA) 50-State Child Care Licensing Study, in 2013, 30 states conducted pre-licensure inspections of HBCC providers, and 25 states also conducted unannounced inspections once a year (Melusky et al. 2013). Another estimate suggests that in 2014, just 21 states conducted unannounced inspections for HBCCs (NCECQA 2020a). By 2017, all 48 states that license HBCC providers conducted both pre-licensure and ongoing, routine licensing inspections. Forty-four states conducted these routine unannounced

inspections at least once a year or more (authors' calculations from 2017 Child Care Licensing Study Database).[9] Thirty-seven states also required HBCC providers to be inspected again when their license was up for renewal, and 15 states required annual license renewal that included an inspection.

State changes in regulated group sizes. Prior to the CCDBG reauthorization, 36 states regulated minimum and maximum group sizes for HBCC providers for every age group of children ages 5 and younger (Matthews et al. 2015). (State data were not available for school-age care). By 2017, all 48 states that license HBCC providers identified (1) a maximum number of children who could be served before licensing was required and (2) a maximum number of children licensed HBCC providers could serve. In 2020, 10 states required all providers serving any children unrelated to them to be licensed. Most states (33) required providers serving greater than three or four children to be licensed and exempted providers serving one or two children. In some states with higher minimum group sizes, HBCC providers are still required to be licensed to receive subsidy funding (Dwyer et al. 2020).

State changes in required health and safety training. In 2013, all 48 states that required some or all HBCC providers to be licensed required training on one or more health and safety topic(s) for licensing (for example, first aid, CPR, preventing child abuse and neglect, and/or preventing the spread of communicable disease [Melusky et al. 2013]). Consequently, we do not examine cross-state variation in this policy indicator. However, CCDF reauthorization required 10 training topics, which lead many states to increase the number of training topics. For instance, between 2017 and 2020, 16 states imposed new requirements for pre-service or orientation training that included new training topics, and 19 states required HBCC providers to complete training on all health and safety training topics (NCECQA 2022).

The NSECE data provide an opportunity to increase our understanding of HBCC providers' reported interactions with, perceptions of, and responses to state CCEE health and safety regulations.

Most families indicate that a "clean and safe" environment is extremely important to them in a CCEE setting (Bassok et al. 2018). Through the CCDBG reauthorization, policymakers have introduced more stringent health and safety-related regulations for HBCC providers—including those who were previously license-exempt—on behalf of families. Yet, the increase in these regulations has coincided with a decline in the number of regulated HBCC providers over the past decade. Estimates suggest the number of listed HBCC providers declined by approximately 25 percent between 2012 and 2019 (NSECE Project Team 2021), whereas the total number of licensed family child care homes declined by approximately 35 percent between 2011 and 2017 (NCECQA 2020b). There has been a parallel decrease in the number of HBCC providers who report receiving funding from subsidies—particularly among license-exempt providers who saw more than a 60 percent decrease in levels of subsidy funding receipt between 2011 and 2017 (NCECQA 2020b).

Researchers have named several factors that may contribute to declines in the number of regulated HBCC providers, including workforce conditions; challenges to business sustainability, such as from low wages; and CCEE policy factors, including the burdens of interacting with health and safety regulations (Bromer et al. 2021b). Yet research on the reasons for these changes is limited, and just one study has considered health and safety regulations specifically (Alexander et al. 2022). The introduction of health and safety requirements could influence the supply of HBCC providers regulated by licensing or subsidy agencies for several reasons, both intended and unintended. It is possible that some providers have been compelled to close or were denied subsidy funding as a result of violating health and safety requirements. Before the CCDBG reauthorization, fatalities and serious injuries (though rare) and less serious violations (such as missing first aid kits or unsecured electrical outlets) were more likely to occur in HBCC setting than in center-based settings (Bassok et al. 2016; Wrigley & Dreby 2005). Compelling HBCC providers who do not meet minimum regulatory requirements to exit the regulated workforce would have the effect of decreasing HBCC supply but increasing the level of basic health and safety.

Unintended consequences of new or more stringent health and safety regulations might result from difficulty navigating multiple and evolving requirements, inconsistencies in how regulations are interpreted by different regulatory agencies (such as among local licensors enforcing state regulations or between licensing and subsidy staff), costs of compliance (such as fees for background checks or travel expenses to attend trainings), and inequitable implementation (such as disproportionate effects of background checks on household members in communities that have frequent contact with the criminal justice system [Adams & Dwyer 2021; Bromer et al. 2021b; Henly & Adams 2018; NCECQA 2020b, 2022b]). An unintended effect of health and safety regulations could be to decrease the number of regulated HBCC providers without influencing the health and safety of care.

This brief is the first national analysis of listed HBCC providers' reported interactions with inspections and health and safety trainings, as well as their perceptions of background checks. We also consider the potential for variation in these data by the characteristics of providers and the communities in which they operate. Finally, we examine HBCC providers' responses to CCEE regulations by analyzing data from providers who recently stopped providing care, and report the results of a difference-in-differences analysis of the effect of increased health and safety regulations on HBCC providers' receipt of subsidy funding before and after the CCDBG reauthorization.

Using restricted-use data from the 2012 and 2019 National Survey of Early Care and Education (NSECE) Home-Based Provider Surveys matched on location with indicators of state health and safety regulatory policies before and after CCDBG reauthorization from the 2013 NARA 50-State Child Care Licensing Study (Melusky et al. 2013), the Center for Law and Social Policy and National Women's Law Center (Matthews et al. 2015), and the Child Care Licensing Study Database (Child Care Technical Assistance Network n.d.), we address the following research questions:

1. **How did listed HBCC providers interact with selected health and safety regulations? What percentage were inspected or attended a health and safety training in the prior year? What were their perceptions of background checks?**
2. **How, if at all, do these patterns vary by the characteristics of providers, their communities, and state CCEE health and safety regulatory policies?**
3. **How might listed HBCC providers have responded to CCEE health and safety regulations? What percentage of former providers cited difficulties complying with regulations as a reason for exiting the CCEE workforce? Did increasing health and safety regulations through the CCDBG reauthorization influence the percentage of providers who received funding from subsidies?**

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 2012 and 2019 NSECE with state CCEE health and safety regulatory policies for HBCC providers from the 2013 NARA 50-State Child Care Licensing Study (Melusky et al. 2013), the Center for Law and Social Policy and National Women's Law Center (Matthews et al. 2015), and the Child Care Licensing Study Database (NCECQA 2017). The analysis focused on policies pertinent to HBCC providers that were implemented between the two NSECE survey waves.

Sample. A total of 3,934 listed HBCC providers responded to the 2012 Home-Based Provider Survey and 4,231 listed HBCC providers responded to the 2019 Home-Based Provider Survey. About 600

listed HBCC providers who were identified as ineligible to participate in the 2019 Home-Based Provider Survey because they reported having recently left the CCEE workforce responded to the 2019 Home-Based Provider Survey Screener. Analyses describing "providers who recently left the CCEE workforce" were based on this subsample.

In 2019, all listed providers were asked whether they had recently attended a health and safety training. Listed providers whose services were not relationship-based (that is, they served one or more children with whom they did not have a prior relationship) or whose services were relationship-based but (1) served at least four children and (2) served at least one child with public funds were asked whether they had recently been inspected (N=4,010). All listed providers were asked about their perceptions of conducting background checks on family members and to protect children. Listed providers who regularly served more than six children were asked their perceptions of background checks causing hiring delays (N=2,570). In 2012 and 2019, all listed providers who confirmed they received payment for providing regular care (N=3,725 and 4,091, respectively) were asked whether they received public funding from child care subsidies.

Analytic strategy. We first examined differences between providers who reported each outcome measure (for example, whether providers reported receiving an inspection for health and safety, or whether they felt uncomfortable doing background checks on family members) across background characteristics of providers and the communities in which they operated, and state-level indicators of CCEE regulatory 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 discuss our difference-in-difference analysis of state health and safety regulatory policies later in the brief. 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 attending a health and safety training in subgroups of providers of different races or ethnicities) 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 outcomes related to health and safety regulations.

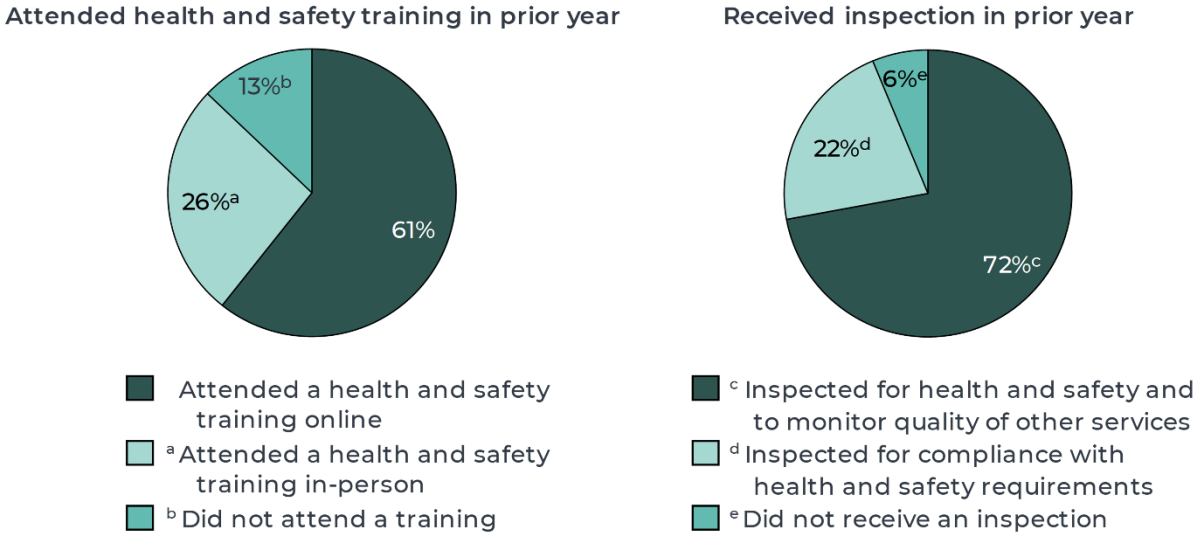
More information on the 2019 NSECE study methodology and measurement is available in the Data Collection and Sampling Methodology Report (NSECE Project Team 2022). See the technical report for the current analyses for more details about the variables used, the sample included in the analyses, treatment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

What were the patterns and predictors of reported interactions with and preferences for selected CCEE health and safety regulations?

Complying with health and safety regulations is a key part of being a listed HBCC provider and interacting with CCEE policies. Approximately nine in ten providers reported receiving an inspection or attending a health and safety training in the prior year, and these rates were even higher among providers who reported interacting with other CCEE policies.

Eighty-eight percent of listed HBCC providers reported having attended a health or safety training during the prior year, either online or in-person, and 94 percent reported having received an inspection to monitor compliance with health and safety requirements and the quality of other services (Figure 3).[11]

Figure 3. Approximately nine in ten listed HBCC providers reported interacting with CCEE health and safety regulations in the prior year



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

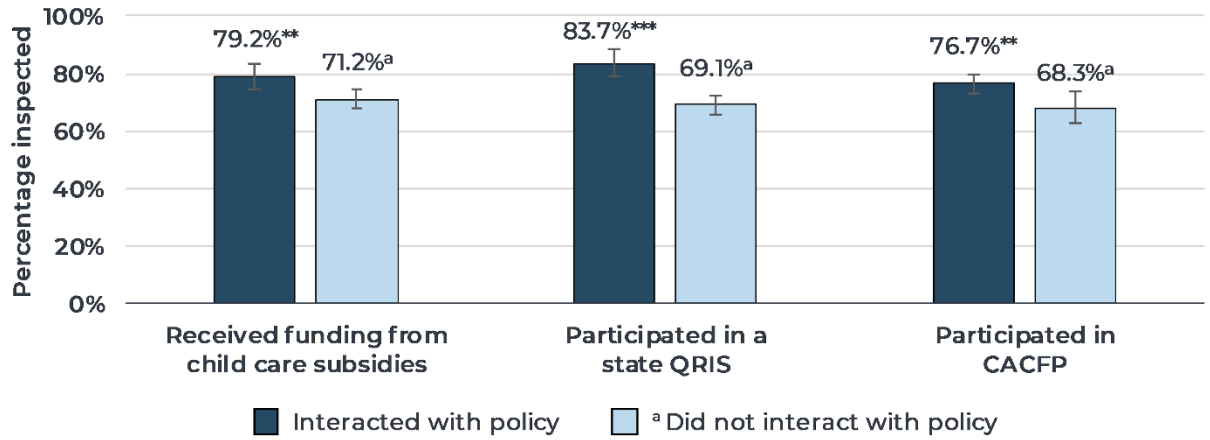
Note: The figure presents unadjusted percentages and 95 percent confidence intervals from between approximately 3,940 (received inspection in prior year) and 4,100 (attended health and safety training in prior year) providers weighted to represent between approximately 87,100 and 89,200 providers across the nation. Data were drawn from Table C.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 inspections asked of non-relationship-based and large, relationship-based providers who served at least one child with public funds.

In addition to licensing requirements, listed HBCC providers may be subject to other health and safety regulations as part of interacting with other CCEE policies. For instance, state CCDF lead agencies ensure that license-exempt providers are also inspected to meet health and safety requirements, CACFP sponsoring organizations conduct unannounced visits to monitor provider operations (CACFP 2022), and state QRISs conduct additional inspections to monitor QRIS compliance (NCECQA 2018). Listed HBCC providers who reported receiving funding from subsidies, participating in QRISs, or participating in CACFP were between 8 and 15 percentage points more likely to report a recent inspection—including inspections to monitor caregiving quality over and above basic health and safety—than listed providers who did not report interacting with each policy (Figure 4). HBCC providers were also more likely to report participating in a health and safety training when they participated in QRISs and CACFP (Report Table C.4).

Virtually all listed HBCC providers agreed that background checks were important for children's health and well-being, although some perceived discomfort about them or reported that they created hardships in their businesses.

Nearly all HBCC providers (98 percent) agreed or strongly agreed that background checks protected children (Figure 5). Yet, a large proportion of providers—41 percent—reported that they agreed or strongly agreed that "some providers" were uncomfortable doing background checks on family members. Among providers serving more than six children, a similar percentage (40 percent) agreed or strongly agreed background checks caused delays in their ability to hire new staff.

Figure 4. Listed HBCC providers were more likely to have been inspected for health and safety and to monitor the quality of other services when they also interacted with other CCEE policies

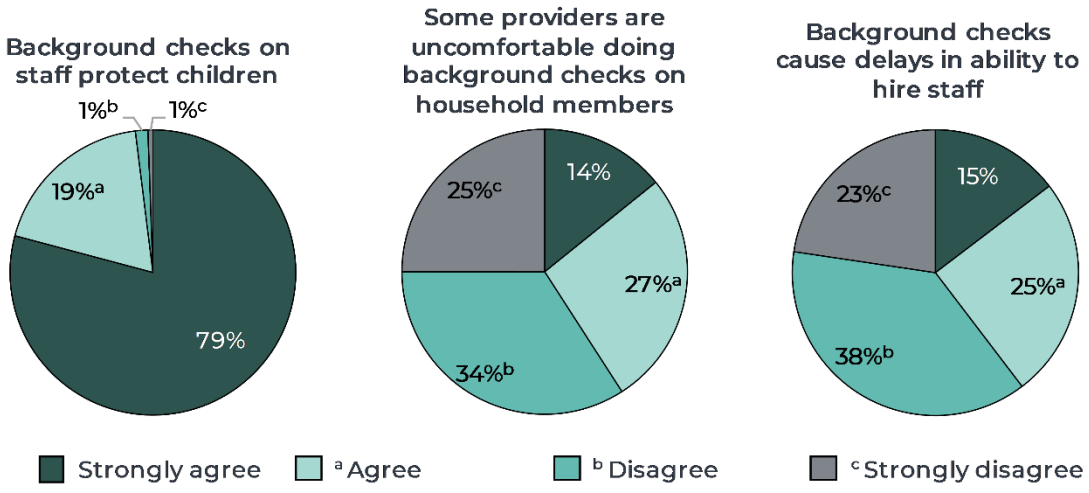


Source: Data from the 2019 NSECE Home-Based Provider Survey and the 2017 Child Care Licensing Study Database.

Note: The figure presents percentages and 95 percent confidence intervals adjusted using a multivariate logistic regression including approximately 3,840 providers weighted to represent approximately 83,800 providers across the nation. Data were drawn from Table C.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. Provider participation in inspections asked of non-relationship-based and large, relationship-based providers who served at least one child with public funds. Providers in Louisiana, New Jersey, and South Dakota are excluded from estimates of receiving inspections because they did not report licensing requirements for HBCC providers.

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

Figure 5. Listed HBCC providers all agreed background checks on staff protect children, but many reported that providers were uncomfortable doing background checks on household members



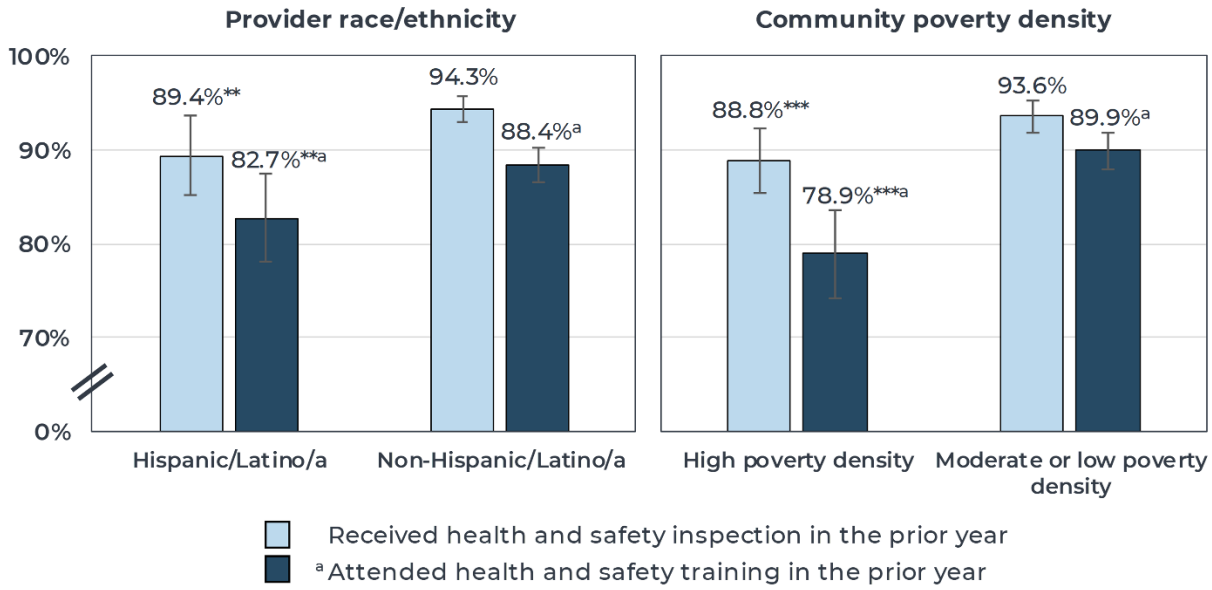
Source: Data from the 2019 NSECE Home-Based Provider Survey.

Note: The figure presents unadjusted percentages from between 2,360 (background checks cause delays in ability to hire staff) and 4,100 (background checks on staff protect children) listed providers weighted to represent between approximately 52,500 and 88,100 providers. Data were drawn from Table C.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. Perceptions of background checks on causing delays in ability to hire staff only asked of providers who regularly served more than six children.

In communities with higher concentrations of Hispanic/Latino/a and Black, non-Hispanic residents, and communities with higher rates of poverty, listed HBCC providers were less likely to report health and safety trainings and inspections, and were more likely to perceive that some providers experience discomfort and associate burdens with background checks.

Hispanic/Latino/a listed HBCC providers and those who operated in communities with higher rates of poverty were less likely to interact with health and safety trainings and inspections (Figure 6). Hispanic providers were about 5 percentage points less likely to have received a health and safety inspection and to have attended a health and safety training in the prior year compared to providers of other races and ethnicities. Providers who operated in high poverty communities (those in which at least 20 percent of the population lived at or below poverty) were also 5 percentage points less likely to have been inspected, and 11 percentage points less likely to have attended a health and safety training than providers who operated in communities with lower levels of poverty.

Figure 6. Hispanic/Latino/a providers and those who operated in high-poverty communities were less likely to report recent health and safety inspections and health and safety trainings



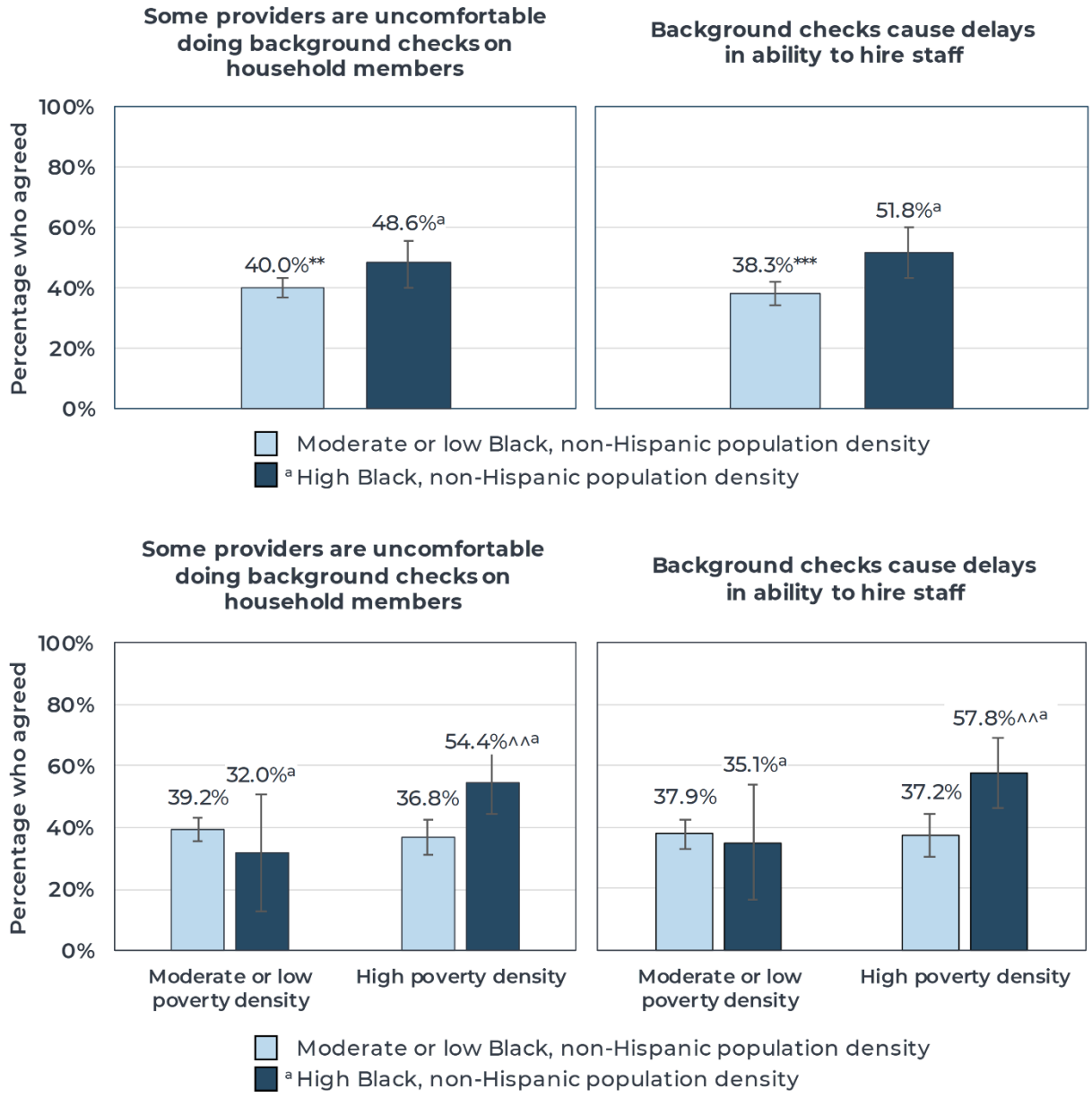
Source: Data from the 2019 NSECE Home-Based Provider Survey and the 2017 Child Care Licensing Study Database.

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 C.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. Provider participation in inspections asked of non-relationship-based and large, relationship-based providers who served at least one child with public funds. Providers in Louisiana, New Jersey, and South Dakota are excluded from estimates of receiving inspections because they did not report licensing rules for HBCC providers. The NSECE defines high-poverty communities as those where at least 20 percent of households lived at or below the federal poverty level.

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

Listed HBCC providers in high-density Hispanic and Black communities with high poverty levels were more likely than those in other communities to agree that (some) providers were uncomfortable with background checks on household members and that background checks delayed their staff hiring process (Figure 7).

Figure 7. Listed HBCC providers' perceptions of background checks varied by the racial and ethnic composition and poverty density of the communities in which they operated



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 5. Data were drawn from Table C.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. Perceptions of background checks on hiring staff only asked of providers who regularly served more than six children. The NSECE defines high-poverty communities as those where at least 20 percent of households lived at or below the federal poverty level, communities with high Hispanic/Latino/a population densities as those where at least 50 percent the population identified as Hispanic, and communities with high Black, non-Hispanic population densities as those where at least 40 percent of the population identified as Black.

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

^^^/^^/^ Differences between community race/ethnicity subgroups by poverty density subgroups are statistically significant at the .01/.05/.10 level, two-tailed t-test.

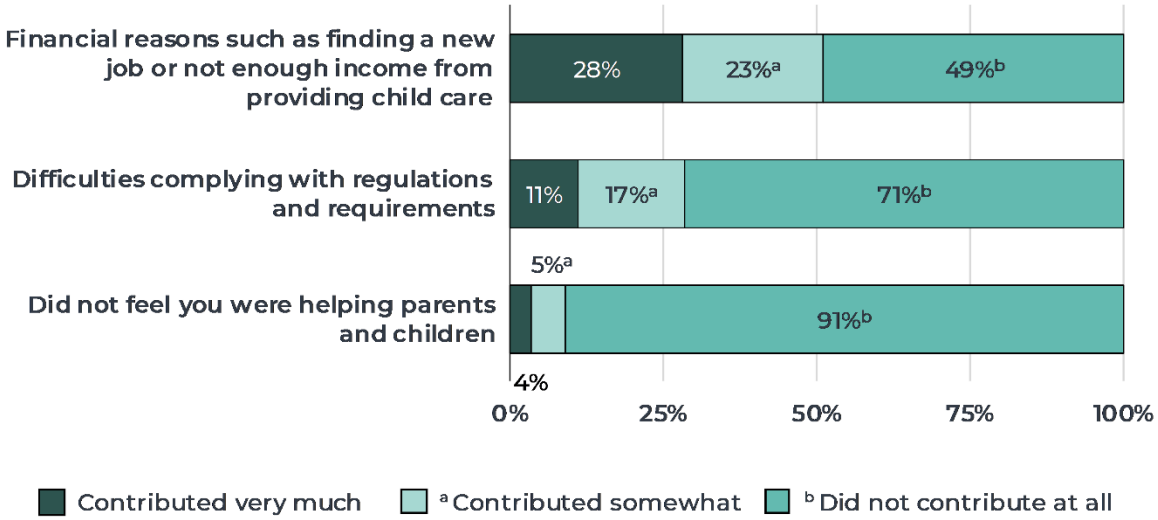
Providers in communities with higher concentrations of Hispanic residents were 9 percentage points more likely than providers in communities with lower concentrations of Hispanic residents to perceive discomfort with background checks on household members, and 12 percentage points more likely to report that background checks delayed their ability to hire new staff. Providers in high-poverty communities with high proportions of Black residents were approximately 20 percentage points more likely to report these perceptions than providers in communities with lower concentrations of poverty and Black residents.

What were listed HBCC providers' responses to CCEE health and safety regulations and their potential implications for continued interaction with CCEE policies?

For some listed HBCC providers, difficulties complying with regulations and requirements contributed to their decisions to leave the CCEE workforce, although financial reasons such as low wages were reported most often.

The NSECE Project Team asked approximately 600 listed HBCC providers who recently stopped providing paid care to children (in any CCEE setting) to report how much three reasons contributed to their decision to leave the CCEE workforce (Figure 8). More than half (51 percent) reported that financial reasons such as not enough income or finding a new job contributed either somewhat or very much; this was the most commonly reported reason. Yet approximately three in ten providers reported that difficulties complying with regulations and requirements were among the reasons they stopped providing regular care, although just 11 percent indicated that this contributed "very much" to their decision. Just 9 percent of listed HBCC providers reported that they stopped providing care because they did not feel they were helping parents and children.

Figure 8. Financial reasons were cited most often by listed HBCC providers who recently left the CCEE workforce, followed by difficulties complying with CCEE regulations and requirements



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

Note: The figure presents unadjusted percentages from approximately 600 listed providers who recently stopped providing regular, paid care to one or more children under the age of 13 who were not their own. Data were drawn from Table C.1 in the accompanying technical report. All estimates are reported out to a maximum of three significant digits in accordance with RUF reporting requirements. Percentages are unweighted because probability of sampling weights were not generated for these listed HBCC providers who were ineligible for the survey.

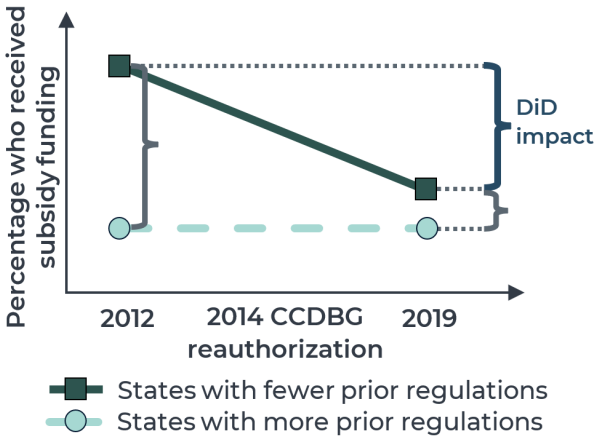
The 2014 CCDBG reauthorization, which increased health and safety regulatory requirements for HBCC providers, offers an opportunity to better understand the relationship between increased regulation and providers' interactions with CCEE policies over time.

The 2014 reauthorization of the CCDBG—the first reauthorization since 1996—included provisions to ensure the health and safety of children served by HBCC providers who were receiving funding from child care subsidies. These legislative changes offer an opportunity to assess the policy impacts of imposing more or expanded regulatory requirements on a national scale. These requirements included comprehensive background checks for providers and staff; pre-licensure inspections and routine, unannounced inspections thereafter; regulated group sizes for all age groups; and health and safety trainings for providers (Adams & Dwyer 2021; Matthews et al. 2015).

The standardization of these regulatory policies required states to implement them if they were not already in place. States that had already conformed to the requirements of the new legislation for HBCC providers, however, did not need to implement them (see Figure 2). In these states, HBCC providers had already been subject to the types of regulatory requirements that providers in other states would be subject to for the first time following the reauthorization. We use this variation to estimate difference-in-differences models, with the goal of assessing the influence of the CCDBG reauthorization on rates of subsidy funding receipt among listed HBCC providers before 2012 and after 2019 in states that had different numbers and types of health and safety requirements in place before the new rules.

What is a difference-in-differences analysis?

Difference-in-differences (DiD) analysis (see Card & Krueger 1994) is one way to estimate the effects of a policy change (such as the health and safety regulatory requirements introduced by the CCDBG reauthorization) on outcomes of those affected by that policy (such as the percentage of listed HBCC providers receiving funding from child care subsidies). The technical report for the current analyses provides details on how we applied DiD methods (Schochet et al. 2024a).



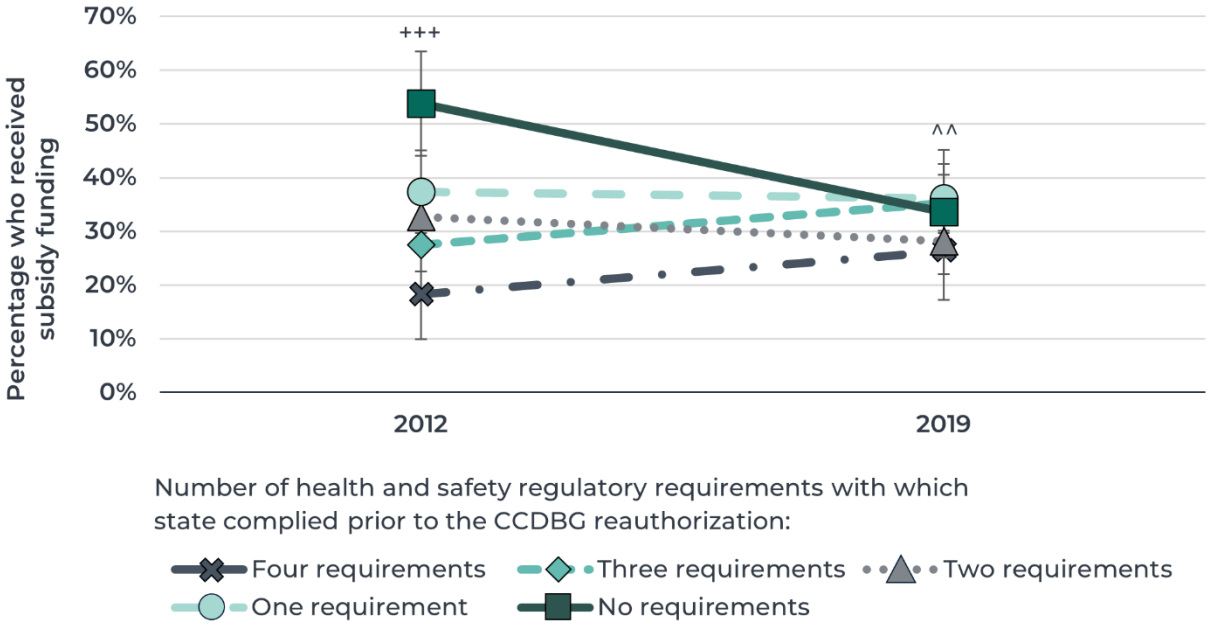
DiD analysis requires outcomes for people who were (such as providers in states that had fewer requirements in place prior to the reauthorization) and were not (such as providers in states that had more prior requirements) affected by the policy change, both before and after that change occurred. In this study, the impact is measured as the difference in the change in the percentage of providers who received subsidy funding between 2012 and 2019, comparing providers in states with more versus fewer prior regulatory requirements.

Increases in state CCEE health and safety regulatory requirements between 2012 and 2019, and the addition of mandatory background checks in particular, had a negative impact on the percentage of listed HBCC providers who received subsidy funding.

Efforts to standardize in health and safety requirements led to more uniform rates of subsidy funding receipt among HBCC providers across the nation, primarily because these rates decreased in states that implemented more requirements to comply with the new regulations (Figure 9). In 2012, prior to the CCDBG reauthorization, states with fewer requirements had higher rates of subsidy funding receipt than states with more requirements such that, for each additional requirement, the odds of subsidy funding receipt decreased by 35 percent (or about 7 percentage points). In 2019, after the CCDBG reauthorization, there was

no association between rates of subsidy funding receipt and the number of requirements with which states initially complied, with each additional requirement decreasing odds of subsidy funding receipt by just 4 percent (or less than 1 percentage point). The significant difference between these effects suggests that each new requirement led to a 6-percentage point decrease in rates of subsidy funding receipt.[12]

Figure 9. Listed HBCC provider rates of subsidy funding receipt declined in states that added regulatory requirements to comply with the CCDBG reauthorization, but stayed about the same in states that were already compliant



Source: Data from the 2012 and 2019 NSECE Home-Based Provider Surveys, Implementing the Child Care and Development Block Grant Reauthorization: A Guide for States (Appendix III), and 2013 NARA 50-State Child Care Licensing Study.

Note: The figure presents percentages and 95 percent confidence intervals adjusted using a multivariate logistic regression on approximately 3,100 listed providers in 2012 weighted to represent 96,500 providers across the nation, and 3,820 listed providers in 2019 weighted to represent 84,800 providers across the nation. Data were drawn from Table C.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. All listed, paid providers were asked whether they received public funding from child care subsidies at both timepoints. Regression-adjusted estimates for states with different numbers of requirements prior to CCDBG reauthorization came from a single composite which sums whether states (1) required pre-licensure inspections; (2) conducted annual, unannounced inspections of licensed providers; (3) conducted comprehensive background checks; and (4) regulated group size for all age groups for children ages 5 and younger.

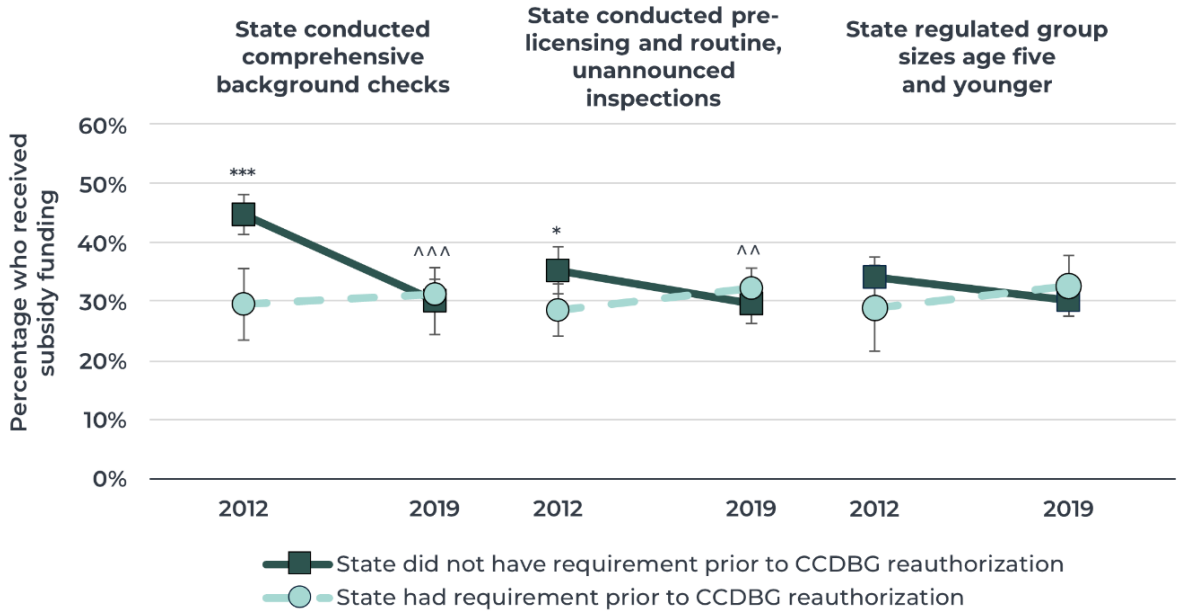
+++/++/+ Differences for each one-unit change in the number of initial health and safety requirements within survey cohort are statistically significant at the .01/.05/.10 level, two-tailed t-test.

^^^/^^/^ Differences in associations with the number of initial health and safety requirements between survey cohorts are statistically significant at the .01/.05/.10 level, two-tailed t-test.

An important question is whether all or only some of the new requirements accounted for this decline in subsidy funding receipt among HBCC providers. To examine this question, we ran a second DiD model that simultaneously estimated the impacts of each requirement on the percentage of providers who reported receiving subsidy funding. This analysis suggests that the introduction of mandatory background checks, in particular, had negative impacts on subsidy funding receipt (Figure 10). In 2012, 45 percent of providers in states that did not conduct comprehensive background checks reported receiving subsidy funding, compared with 30 percent of providers in states that did conduct them. In 2019, about 30 percent of providers in both groups of states received subsidy funding. These findings suggest that introducing

background checks led to a significant, 14-percentage point decrease in subsidy funding receipt. The introduction of inspections and group size limits accounted for less of the overall decline.

Figure 10. The introduction of background checks accounted for much of the decline in subsidy funding rates for listed HBCC providers after the CCDBG reauthorization increased health and safety regulatory requirements



Source: Data from the 2012 and 2019 NSECE Home-Based Provider Surveys, Implementing the Child Care and Development Block Grant Reauthorization: A Guide for States (Appendix III), and 2013 NARA 50-State Child Care Licensing Study.

Note: The figure presents percentages and 95 percent confidence intervals adjusted using a multivariate logistic regression on the analysis sample detailed in the text below Figure 9. Data were drawn from Table C.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. All listed, paid providers were asked whether they received public funding from child care subsidies at both timepoints. We combined indicators of whether states required pre-licensure inspections and whether states conducted annual, unannounced inspections because they overlapped.

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

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

What did we learn about CCEE health and safety regulations and their implications for listed HBCC providers' interactions with CCEE policies?

Regulations have increased in the past decade with the goal of ensuring the health and safety of children in CCEE settings. States have enacted new or more complex licensing requirements, largely in response to the 2014 reauthorization of the CCDBG, which required states to certify and enforce licensing requirements for HBCC providers. The reauthorization also established new requirements for health and safety inspections, training topics, and background checks for providers who received subsidy funding, including those who were license-exempt. Home inspections ensure that providers comply with health and safety regulations that apply to the environment and provider practices; they also help monitor the quality of care. Health and safety training helps providers understand how to meet these regulations. Background checks are designed to protect children from harm that might be inflicted by individuals—providers, staff, or household members—in the care setting.

In the 2019 NSECE, listed HBCC providers reported on their recent interactions with health and safety inspections and trainings and shared their perceptions of background checks. Nine in ten listed HBCC providers reported having received an inspection in the prior year, and approximately the same percentage reported having attended a health and safety training. Providers who interacted with policies that may impose additional regulations and requirements to licensing—subsidy, QRIS, and CACFP—were even more likely to report interacting with inspections and trainings. Second, we found that providers recognized background checks as important for children's safety, though some had negative perceptions of specific background check processes or requirements. About 40 percent agreed that some providers were uncomfortable conducting background checks on household members, and the same percentage agreed that conducting background checks on staff led to hiring delays. The total processing time for comprehensive background checks—which can include federal and state criminal history checks with fingerprints, national and state sex offender registry checks, state child abuse and neglect registry checks, and interstate checks—may be several weeks or longer (Cunningham & Ravishankar 2021). According to a 2022 report from the Interagency Task Force for Child Safety, no states complied with the requirement that background checks be completed within 45 days (Lynch 2022).

There were differences by provider and community characteristics in listed HBCC providers' reported interactions with and perceptions of health and safety regulations.

We also found variation in listed HBCC providers' recent interactions with inspections and trainings and perceptions of background checks by their race and ethnicity and their community's poverty status. Listed HBCC providers who identified as Hispanic/Latino/a and those who operated in high-poverty communities were less likely to report interacting with inspections and trainings, and Hispanic/Latino/a providers and Black providers who operated in high poverty communities were more likely to perceive that some providers experience discomfort with background checks on household members and to acknowledge that background checks may cause hiring delays. Costs of complying with licensing requirements for the home environment, background checks, and training may be obstacles for providers who have low incomes and live in under-resourced communities (Adams & Dwyer 2021; Bromer et al. 2021b; Henly & Adams 2018). Implementing inspections and background checks for providers living in marginalized communities of color and in immigrant communities could be seen as invasive and discriminatory rather than supportive of their work to offer safe and healthy environments for children and families (Bromer et al. 2021b).

Former listed HBCC providers reported that low wages and difficulties complying with regulations contributed to their decision to leave the CCEE workforce.

Little is known about how listed HBCC providers respond to health and safety regulations. Our analysis of 2019 NSECE data collected from approximately 600 listed HBCC providers who recently stopped providing care indicated that low wages—named by half—were the most commonly selected reason for leaving the field. The second most common was difficulty complying with regulations and requirements, which was named by one in three former providers. Three in four providers who cited challenges complying with regulations also identified financial challenges. These findings are consistent with extant research focused on the factors contributing to exit from HBCC. One qualitative study featuring interviews with 30 formerly licensed HBCC providers revealed that a majority cited challenges with CCEE policies, which included increasing regulations; poor alignment of regulations across policies; regulations that did not fit the realities of HBCC settings; licensing staff that were disrespectful and distrusting; and challenges financing regulatory activities (Bromer et al. 2021b).

The implementation of additional CCEE health and safety regulatory requirements affected the supply of listed HBCC providers receiving subsidy funding.

The findings from our DiD analysis suggest that the introduction of new or expanded health and safety requirements, particularly background checks, after the CCDBG reauthorization negatively impacted the percentage of listed HBCC providers who received subsidy funding. Post-reauthorization declines in states that introduced new or expanded regulations for listed HBCC providers might have been the result of both direct changes to health and safety requirements for license-exempt HBCC providers and a combination of perceived burdens and changing characteristics of licensed HBCC providers. First, license-exempt providers in states that did not previously regulate them (such as those that did not require background checks) could receive subsidy funding without regulation before, but not after, the reauthorization. License-exempt providers in these states would have been subject to new or expanded regulatory requirements for subsidies as a result of the policy change. This interpretation is consistent with findings suggesting larger proportional declines in the number of license-exempt HBCC providers receiving subsidy funding after the reauthorization (NCECQA 2020b), as well as at least one correlational study reporting negative effects of new state health and safety requirements for license-exempt providers on receipt of subsidy funding (Alexander et al. 2022). The consequences of new or expanded requirements for the supply of license-exempt HBCC providers accepting subsidies may be intended (that is, providers denied the ability to accept subsidies because they failed to meet the new requirements) and unintended (costs and burdens related to new or expanded regulations and requirements lead to declines in subsidy funding receipt among providers who would otherwise have complied).

The mechanisms by which new or expanded regulations and requirements decreased subsidy funding receipt among licensed HBCC providers likely relate to changes in the heightened regulatory environment for licensing, rather than for subsidies specifically. One possibility is that these changes discouraged some licensed HBCC providers from assuming additional responsibilities—such as anticipating the need to comply with even more requirements—associated with receiving funding from subsidies. Another possibility is that increased licensing regulations changed the landscape of licensed HBCC providers, such that licensed providers became less likely to accept subsidies, on average. Although associations between subsidy funding receipt and most characteristics did not change over time, those that did may help to illustrate how this landscape changed. For instance, we found that the number of children served was positively associated with subsidy funding receipt before, but not after, the reauthorization. After the reauthorization, listed HBCC providers also served fewer children on average and became more uniformly sized. To the extent increased regulations contributed to standardization of group sizes and reductions in the number of children served, patterns such as this could explain lower rates of subsidy funding receipt among licensed HBCC providers.

What are the implications of findings on listed HBCC providers' interactions with, perceptions of, and responses to CCEE health and safety regulations? What directions should future research pursue?

Findings on listed HBCC providers' reported interactions with, perceptions of, and responses to health and safety regulations provide insights into the relationships between CCEE regulations, the minimum quality and supply of regulated HBCC, and families' access to these settings. When functioning as intended, regulations reduce the risk of harm to young children, primarily by forcing noncompliant providers to improve or exit the market. However, the costs and burdens of meeting the requirements of new or expanded regulations might unintentionally contribute to decisions to stop providing care among HBCC providers who would have otherwise complied. Decreases in the supply of safe and healthy HBCC may reduce the availability of this care for families, including those with infants and toddlers, school-age children, children with disabilities, and children requiring care during non-traditional hours, who account for a significant share of the children served by HBCC providers (Datta et al. 2021; Lou et al. 2021).

The findings presented in this brief point to several areas for future research. Further research is needed to explore how new or expanded health and safety regulations and requirements may have had a negative impact on the percentage of listed HBCC providers receiving funding from subsidies, such as by influencing

subsidy eligibility processes for license-exempt HBCC providers or altering the broader regulatory environment for licensing. In addition, research, including studies using data collected since the onset of the COVID-19 pandemic, is needed to better understand the full range of regulatory requirements across CCEE policies that represent obstacles or barriers for HBCC providers. Such research could also examine requirements across CCEE policies to identify strategies for improved coordination, which could minimize potential inconsistencies and related burdens on HBCC providers. Future research is needed to identify promising strategies and supports to ensure that necessarily stringent regulations do not reduce the supply of HBCC providers who have the capacity to meet or exceed basic health and safety requirements.

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, 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. 2021a; Del Grosso et al. 2021).

[5] Three states—Louisiana, New Jersey, and South Dakota—do not have mandatory licensing for HBCC providers (NCECQA 2022a), though still require providers to be regulated in order to receive subsidy funds or CACFP reimbursement (Dwyer et al. 2020).

[6] States often set additional requirements focused on supporting child development beyond basic health and safety. These requirements relate to staff qualifications, such as minimum work experience and education, credentials such as the Child Development Associate or state certifications, and other professional development and training requirements. These regulations vary substantially across states (Herbst 2022).

[7] In 2013, prior to the reauthorization, 29 states posted inspection reports or summaries online (Matthews et al. 2015). States were required to maintain a 5-percent set-aside to support local or regional consumer education systems.

[8] For health and safety requirements in the CCDBG reauthorization, see: eCFR :: 45 CFR 98.41 -- Health and safety requirements. For background check requirements, see: eCFR :: 45 CFR 98.43 -- Criminal background checks. For training requirements, see: eCFR :: 45 CFR 98.44 -- Training and professional development.

[9] States enacted changes in required inspections for license-exempt providers of care to either non-relatives or relatives who participate in the subsidy program: in 2019, 39 states required an inspection at least once a year for providers of care to non-relatives after initial compliance; 33 states required an inspection for providers of care to relatives (Dwyer et al. 2019).

[10] Twelve states and territories imposed background check requirements on license-exempt HBCC providers who received funding from child care subsidies (Matthews et al. 2015).

[11] All states that license HBCC providers conduct routine, unannounced inspections, but the frequency of these inspections ranges from multiple times a year to once every three years, as noted. Forty-four states conduct routine licensing inspections once per year or more, while four (California, Idaho, Kentucky, and Vermont) do so every two or three years (Child Care Technical Assistance Network n.d.). Among listed HBCC providers in states that conduct licensing inspections at least once a year (N=3,200), about 96 percent reported having received an inspection in the prior year (Report Table C.3).

[12] Relationships between provider and community characteristics and subsidy funding receipt were generally similar over time, with few exceptions (Report Table C.7). The number of children served positively predicted subsidy funding receipt in 2012, but not in 2019. Whether providers paid other staff and whether providers served school-aged children were each positively associated with subsidy funding receipt in 2019, but not in 2012. Whether providers offered care during non-traditional hours positively associated with subsidy funding receipt at both time points, but had a larger association in 2012 than in 2019. A companion brief in this series presents additional findings on predictors of subsidy funding receipt in 2019 (Schochet et al. 2024b).

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