# The Child and Adult Care Food Program and Home-Based Child Care Providers

## Expanding Participation

*Gina Adams and Fernando Hernandez*

*April 2021*

**Home-based child care (HBCC) providers play a central role in supporting children's development and helping parents work in the United States. In 2012, slightly more than 1 million paid HBCC providers cared for more than 3 million children from birth to age 5; another 2.7 million unpaid HBCC providers cared for an additional 4 million children in this age group. These numbers are even greater if school-age children are counted. Yet despite the important role these providers play, many of them and the children they serve do not participate in and/or benefit from public child care investments (OPRE 2016). Key among these public investments is the Child and Adult Care Food Program (CACFP), which reimburses child care providers for some costs of providing nutritious meals. CACFP gives key financial supports to providers and important nutritional supports to children, yet many HBCC providers do not participate in the program.**

This brief provides an overview of some key opportunities, challenges, and needed action steps to expand participation of HBCC providers in the Child and Adult Care Food Program. Based on expert interviews[1] and a literature review, it first provides background on HBCC and CACFP to set the context and then summarizes findings on the key barriers these providers face to participating in CACFP. It concludes with a discussion of recommended action steps, possible impacts of improving participation, and a discussion of areas where more information is needed. Box 1 summarizes the findings and action steps. A companion brief, "Child Care Subsidies and Home-Based Child Care Providers: Expanding Participation," covers participation barriers for HBCC providers in the child care subsidy system funded by the Child Care and Development Fund.

BOX 1

**Key Takeaways and Action Steps**

HBCC provider participation in CACFP is shaped by the cumulative result of several factors, including

- **the role, availability, and resources of CACFP sponsor agencies,** who are the gatekeepers to the program for HBCC providers;
- **factors that shape whether HBCC providers can or will enroll in CACFP,** including if they are eligible, if they know about the program, and if the enrollment process is seen or perceived as easy or difficult; and
- **factors that shape whether providers stay in the program**, including how much they are reimbursed, whether they have nonfinancial incentives to participate, and how easy or difficult it is to comply with the program requirements.

These issues are, in turn, shaped by two overarching issues. First, there is a widespread misconception that home-based settings are of lesser quality than center-based programs, a belief that is partly related to an often-unconscious center-centric bias inherent to many of the metrics used to assess quality. Second, CACFP is not consistently connected to other key elements of the child care system at the federal, state, and/or local levels, making it more challenging for the program to leverage partnerships and cross-sector coordination efforts.

**Federal action steps**

- **Establish requirements, incentives, and supports to help sponsor agencies expand participation by hard-to-serve HBCC providers,** including those that are legally exempt from licensing, face language or literacy challenges, live in rural areas, or do not have access to the internet.
- **Study the gaps in coverage of sponsor agencies, and work to ensure full coverage** by providing incentives and start-up costs for sponsors to begin operations in areas with inadequate coverage.
- **Ensure that providers are fairly compensated** by examining the equity and adequacy of reimbursement levels for home-based child care and taking steps to address inequities and inadequacies.
- **Simplify targeting of CACFP to children with low incomes** by coordinating with eligibility for other means-tested federal programs and considering community eligibility strategies.[a]
- **Reduce administrative burden** by assessing and addressing paperwork and administrative requirements for HBCC providers, particularly those facing language, literacy, or internet barriers.
- **Build on lessons learned during the COVID-19 pandemic and explore doing at least some compliance and support visits virtually,** which can support coverage and access to providers, particularly in rural areas.
- **Encourage more active collaboration between other federal programs, such as the Child Care and Development Fund (CCDF), and CACFP**, including using CCDF and child care pandemic relief funds to support CACFP participation as a provider stabilization strategy.
- **Provide resources and incentives to sponsor agencies to partner with intermediary organizations supporting HBCC providers** (such as family child care networks or shared service models) to expand participation in CACFP.

- **Ensure regulations, materials, and resources reflect the realities of different types of HBCC providers** so they are relevant and reasonable, not based on requirements that are more relevant for child care centers.
- **Ensure penalties for noncompliance are commensurate with the transgression** by reviewing current penalties and regulations, identifying where penalties do not correspond to the error, and revising and simplifying regulations and penalties so the most serious penalties only apply to fraud and abuse.

**State action steps**

- **Identify alternative approval strategies—other than licensing—for providers that are legally exempt from licensing requirements** so that HBCC providers who are unlikely to be interested in becoming licensed can access CACFP.
- **Encourage other state agencies and state-funded entities to coordinate with CACFP to support outreach and enrollment to HBCC providers**, including licensing agencies, child care subsidy agencies, and child care resource and referral agencies.
- **Use child care pandemic relief funds to support more active collaboration between CCDF and CACFP to expand HBCC enrollment and participation,** given that CACFP can help stabilize providers and support healthy child development.
- **Include supporting CACFP enrollment and participation in the activities and responsibilities of any funds going to intermediary organizations supporting HBCC providers,** such as family child care networks or shared service models.
- **Use related funding sources to help HBCC providers access CACFP**, including CCDF and resources focused on system reform and coordination.
- **Ensure that CACFP agencies are represented in child care/early education coordinating entities,** such as state advisory councils or other cross-system planning entities.

[a] For more information about community eligibility strategies, see https://frac.org/community-eligibility.

Identifying policy strategies to support expanded participation among home-based child care providers is particularly timely given that the federal legislation authorizing child nutrition programs (including CACFP) has been due for reauthorization since 2015 and could be reauthorized in the near future. The insights from this brief, therefore, can inform policymakers and stakeholders interested in revising the law to better support HBCC providers. And, because CACFP is an entitlement program, funding is automatically available if providers meet and comply with requirements, thus reducing concerns about competing with other child care sectors for scarce resources.

# Setting the Context

## Understanding HBCC Providers

In 2012, the most recent year for which data from the National Survey of Early Care and Education are available, more than 1 million paid HBCC providers cared for more than three million children from birth to age 5; these numbers underestimate the reach of home-based child care because they do not

include school-age children (OPRE 2016).[2] The more than 1 million paid providers include 118,000 that are listed with a public agency and are assumed to be licensed (which we will refer to as "licensed HBCC providers" in this brief) and another 919,000 that are not listed with any agency including licensing (which we will refer to as "unlicensed HBCC providers" in this brief; see box 2). Another 2.7 million unpaid HBCC providers that were not listed with any public agency cared for another 4 million children in this age group. Data from the 2019 survey, which will be released shortly, will provide more current estimates.

HBCC providers play a critical role in caring for America's children and are particularly likely to care for infants and toddlers, children in rural areas, and children whose families work nontraditional hours, among others (Henly and Adams 2018). Yet HBCC providers, like child care providers overall, tend to earn very little: for example, the 2012 National Survey of Early Care and Education found that half of unlicensed HBCC providers had household incomes of $25,000 or less, and half of licensed providers had incomes of $45,000 or less (OPRE 2016). However, despite the important role HBCC providers play and their need for financial resources, they are less likely than child care centers to participate in and benefit from public child care investments (OPRE 2014, 2016).[3]

BOX 2

**Understanding Our Terminology**

The child care field uses many, often poorly defined, terms to refer to HBCC caregivers. These include "informal care," "family, friend, and neighbor (FFN) care," "family child care," "license-exempt care," and "relative care."[a]

For the analysis presented here, we predominantly use

- "licensed HBCC" to refer to any home-based provider that meets their state or local licensing requirements and
- "unlicensed HBCC" to refer to home-based child care settings that are legally exempt from state or local licensing, including care by individuals who are related or not related to the child.

We differentiate between licensed and unlicensed because licensing status helps shape whether providers can access public resources. However, states vary widely in which HBCC providers they require to be licensed; some states require HBCC providers to be licensed as soon as they care for even one unrelated child, and others do not require HBCC providers to be licensed until they are serving many children.[b] As a result, the size of the license-exempt HBCC sector likely varies significantly from state to state.

As noted earlier, the CACFP requires that programs be licensed or "approved" to participate, though many states choose to not create an "approved" designation, thus precluding license-exempt providers. However, eligibility for accessing CACFP funds is not affected by whether the caregiver is related to the child. Instead, federal rules require that to be eligible for CACFP, the caregiver must be caring for at least one child who does not live in the caregiver's home.

[a] Sarah Haight, "Family Prosperity: 10 Minutes with a Leading Early Childhood Researcher on Home-Based Care and Opportunities Ahead," Ascend at the Aspen Institute, November 9, 2020, https://ascend.aspeninstitute.org/family-prosperity-10-minutes-with-a-leading-early-childhood-researcher-on-home-based-care-and-opportunities-ahead/.

[b] See "Threshold of Licensed Family Child Care in 2014," National Center on Early Childhood Quality Assurance, 2015, https://childcareta.acf.hhs.gov/sites/default/files/public/threshold_fcch_2014.pdf.

### Understanding CACFP

The Child and Adult Care Food Program is a federally funded entitlement program administered by the Food and Nutrition Service of the US Department of Agriculture. It provides reimbursements for meals and snacks for eligible children and adults enrolled in child care centers, home-based child care settings, and adult day care centers. In fiscal year 2019, CACFP provided 2 billion meals with expenditures totaling $3.7 billion (Tiehlan 2020); about 75 percent of these meals were served in centers while 21 percent were served in HBCC settings.[4] In fiscal year 2018, almost 97,000 HBCC providers participated in CACFP, a nearly 82 percent drop since 1998, while child care centers increased their participation by 82 percent in the same period (Rosso and Henchy 2019).[5]

### Understanding Current Levels of HBCC Provider Participation in CACFP

Although few data are available on how many HBCC providers participate in CACFP, the most recent national survey of HBCC providers found that only three-fifths of licensed paid providers and one-eighth of unlicensed paid providers received government funds from any source, including CACFP (OPRE 2016). These data are imperfect for many reasons, including that they are from 2012 and are not specifically about CACFP, but they suggest that easily more than 700,000 paid HBCC providers—licensed and unlicensed—could participate in the Child and Adult Care Food Program and gain significant financial resources by doing so. Again, forthcoming data from the 2019 National Survey of Early Care and Education will give a more current estimate.

These data corroborate the widespread agreement among experts that the gaps in CACFP participation among HBCC providers are significant, particularly among those legally exempt from licensing. This is because even though CACFP allows "licensed or approved" HBCC providers to participate in the program, the definition of "approved" varies by state, and many states limit CACFP resources to licensed HBCC providers. Despite data not existing on the number of CACFP-participating HBCC providers in the "approved" category (i.e., those not licensed), the experts we spoke with agreed that the number was likely very small even in states that allow unlicensed providers to participate. However, some exceptions, such as Louisiana, show it is possible to expand participation among this population (OPRE 2016).

## Factors Shaping HBCC Participation in CACFP

Our assessment suggests that an HBCC provider's participation in CACFP depends on several issues, each of which appears to present a barrier for home-based providers. These issues collectively shape whether different HBCC providers can participate in the program and their experiences with it, in turn affecting their willingness and interest in participating. These policy areas include

- the role of sponsors,
- getting providers enrolled, and
- retaining providers.

## The Role of Sponsors

Sponsor agencies are the administrative entities responsible for enrolling, paying, and monitoring providers in CACFP. As established by federal legislation and regulation, HBCC providers can only participate in CACFP through a sponsor agency—unlike child care centers, which can work directly with the state agency. Sponsor agencies are, therefore, effectively the gatekeepers to CACFP for HBCC providers. Sponsor agencies can be standalone or embedded in another organization, and they range from food banks to child care resource and referral programs to other community organizations.

Experts identified numerous aspects of the sponsor's role that can affect participation, including the following:

- **The relationship between the sponsor agency and providers is critical** because the sponsor provides outreach as well as technical assistance and support with enrollment and rule compliance. Our respondents suggested that sponsors able to provide a "high touch" relationship can support CACFP participation very effectively. But sponsors are also responsible for compliance and monitoring for CACFP, and that role can be difficult to balance with the technical assistance role. One respondent noted that the people working with HBCC providers have to combine the roles of police officer, psychiatrist, and friend. This balancing act can be even more challenging for sponsor agencies that are also responsible for child care licensing. Further, the cost of extra technical assistance supports and visits associated with more supportive practices are not necessarily covered through the administrative funding provided to sponsors.
- **The availability of sponsor agencies can vary widely**; some geographical areas have very few (or no) sponsor agencies, and other areas have multiple sponsor agencies competing for providers. "Sponsor deserts" inhibit participation in CACFP, affecting child nutrition in rural areas already hard hit by food insufficiency, among other areas. One respondent noted that the lack of sponsor agencies in some communities, and/or the loss of sponsors that close down operations in a community, can weaken the area's HBCC sector. However, no centralized data source compiles both the numbers of sponsors and HBCC providers and their geography to assess where gaps in coverage exist. Further, experts noted that no resources are allocated to help sponsor agencies set up services in low-coverage service areas. In addition to clear gaps in coverage, experts noted that there can be underserved communities even within geographical areas covered by sponsors because of the challenges sponsors may face going into some communities.

- **Other challenges in the supports and incentives provided to sponsor agencies limit their ability to conduct outreach and engage in extra supports needed to support participation**, including
  - » inadequate administrative funds for sponsors in areas with high costs of living;
  - » inadequate incentives for sponsor agencies to enroll providers that take more resources to support, such as license-exempt providers or providers that face extra challenges;
  - » lack of incentives and resources to address barriers to participation around language, literacy, and cultural practices;
  - » challenges facing sponsors working in rural areas that may face many hours traveling to visit HBCC providers;
  - » lack of incentives and resources to provide culturally appropriate technical assistance on the Meal Pattern, which can support participation of less-well served and more diverse caregivers and communities; and
  - » lack of sufficient funding to use CACFP visits as "high-touch" supports with appropriate follow-up and supports or to allow sponsors to engage in additional visits if needed.

## Getting Providers Enrolled in CACFP

Three elements affect whether HBCC providers enroll in CACFP: whether they are eligible (and under what conditions), whether they know about the program, and whether the enrollment process is easy or difficult.

### ELIGIBILITY

Under CACFP rules, HBCC providers are required to either be licensed or be approved to participate in CACFP. Given the significant variation in the size and characteristics of the legally license-exempt HBCC sector across states, with some exempting family child care homes serving several unrelated children and some only exempting relatives, state decisions about the conditions under which legally exempt providers can participate sometimes affect a wide swath of the HBCC sector.[6]

**Licensing:** As a result, the first hurdle that unlicensed HBCC providers must overcome to participate in CACFP in many states is the licensing system. Although licensing standards help ensure the basic health and safety of child care settings, our interviews for this brief as well as the CCDF subsidy participation brief highlighted many ways that licensing requirements can present inequitable challenges for HBCC providers:

- Licensing standards may not reflect the realities, strengths, and cultural practices of different communities of HBCC providers and instead rely on center-based definitions of quality and safety.
- These standards do not always reflect the heterogeneity of the HBCC sector and may be particularly inappropriate for some providers, such as relatives and individuals caring for children because of personal connections rather than professional goals.

- Agency communication about requirements and misalignment between requirements for different systems, such as licensing and Quality Rating and Improvement Systems, can be problematic and may create extra barriers and burden for HBCC providers.
- HBCC caregivers can face extra challenges in meeting requirements because of inadequate resources to improve their home, access the needed materials or training, or pay for criminal background checks.
- Supports to help HBCC providers meet standards may not be appropriate; for example, trainings may be only offered in English or require high literacy levels, require the provider to have internet access, or be costly.

These issues suggest many ways that a requirement to be licensed to receive CACFP funds can create barriers to access, particularly for smaller HBCC providers.

**Approval for license-exempt providers:** At this point, no systemic information is available on whether states allow HBCC providers who are legally exempt from licensing to participate in CACFP, or how the states that allow these providers to participate define "approved." However, the experts we interviewed were under the impression that relatively few states allowed legally exempt providers to participate. Further, it appears that what "approved" entails varies; at least one state simply requires providers to pass a fire marshal inspection,[7] and another state allows any legally exempt provider that was approved to receive CCDF subsidies to participate. (Our companion brief on CCDF subsidy participation for HBCC has more information about CCDF health and safety standards for license-exempt providers.)

Given the lack of information about what states may require license-exempt providers to be "approved" if they allow these providers to participate, it is difficult to assess whether these requirements are challenging. However, if states require license-exempt providers to meet CCDF standards, experts we interviewed about participation in the CCDF subsidy system suggest that these standards may present similar challenges as those described above for licensing. On the other hand, the recent study of Louisiana's approach requiring that providers pass a fire marshal's inspection suggests that this strategy may support broad participation, offering a promising model for other states.

**Debate about incentives to become licensed:** One area of significant debate is whether the CACFP system should be designed to ensure that children can access nutritious meals or if it should also be designed to incentivize child care providers to become licensed—which is one motivation behind requiring programs to be licensed so they can participate. The challenge with the latter view is that some HBCC providers, such as those caring for children because of personal relationships, likely have little interest in becoming licensed. As a result, this requirement simply makes the program inaccessible to them. Further, no evidence exists that being licensed is necessary to feed children nutritious meals, raising the question of whether these goals should be conflated. Having a serious conversation about this assumption, and about the fundamental goals and priorities of CACFP, may be important for the field as it considers strategies to better meet the nutritional needs of all children in child care.

### OUTREACH

The experts we interviewed suggested wide variation in how much HBCC providers know about CACFP and whether or how to enroll in it. Factors behind this variation include the following:

- **Whether the child care agencies in contact with the providers let them know about CACFP and how to sign up**. In addition to the sponsor agencies that are responsible for conducting outreach and facing the challenges identified above, other state agencies and organizations could help reach out to providers to let them know about CACFP. This includes the licensing agency, CCDF subsidy agency, or the child care resource and referral agency. One respondent suggested that licensing agencies were good about notifying providers about CACFP, but others suggested there was little connection or interest—indicating that the reality may vary across states. Resources and incentives to support this outreach could be useful, particularly given the inadequate resources available to many child care entities.
- **Whether the HBCC provider is licensed or license-exempt.** Experts suggested that licensed programs are more likely to hear about the availability of CACFP and are much easier to reach because they are listed with state agencies. Experts felt that providers that were not licensed are much harder to contact and enroll; providers participating in the subsidy system are a possible exception, though they are a very small share of subsidized providers in most states. Alternative and potentially more time-intensive outreach strategies may be necessary to reach unlicensed providers.
- **Whether the sponsor agency has the incentive, resources, or capacity for significant outreach and recruitment** and/or whether a local sponsor agency is even accessible, as discussed in the section on sponsor agencies.

### ENROLLMENT

No clear information is available on the enrollment process, but our interviews suggest that it is managed by the sponsor agency and mostly involves instructing the provider on the rules and paperwork requirements involved with the program. Respondents suggested that this step can have challenges as well as opportunities.

The challenges involve the reality that enrollment involves significant amounts of forms and paperwork, as well as details about how to comply with program requirements, all of which can be challenging in general and particularly for providers facing language and literacy barriers. These issues are likely even more complex for smaller, unlicensed HBCC providers that are likely less familiar with working with government agencies and processes. On the other hand, respondents also noted that this step in the process could support the development of a strong supportive relationship with the sponsor agency if that is the approach the agency takes.

Identifying ways to facilitate and simplify the enrollment process, to ensure that it is accessible to the full range of HBCC providers and creates a supportive partnership between the sponsor and the provider, could be an area worth further investigation, as it seems likely to vary across agencies and sets the foundation for the provider's willingness and ability to participate.

## Retaining Providers

Informing and enrolling providers is only the first step. To support participation, it is also essential to *retain* the providers that enroll. Our assessment suggests that several elements of the program shape the interest and willingness of providers to participate, including how much they are paid, whether there are nonfinancial rewards or incentives, and the administrative ease/complexity of participating.

### REIMBURSEMENT

The CACFP reimbursement levels for meals served in home-based child care, set at the federal level, are complex. A provider can get a higher Tier 1 rate for all the children in her care if she lives in a geographical area with low incomes. She can also get the higher rate for all children in her care if she has low income, or she can get the higher rate for individual children from families with low incomes. In the latter situation, she must gather information to prove either her income eligibility or income eligibility of the children she serves (also known as the means test). Providers or children who don't meet these conditions get a significantly lower Tier 2 rate.

Our assessment identified the following issues with the reimbursement levels:

- **The level of reimbursement overall, and especially for Tier 2, is insufficient**. Providers leaving the system (or considering leaving the system) report that the reimbursement level was a factor in their decision (Meredith 2009). Further, one expert suggested that the reimbursement levels are designed to offset some food costs, not cover them completely.
- **The fact that providers must pay out of pocket for the food and then wait to be reimbursed can present a cash flow problem**, particularly for providers with fewer resources. Further, if a provider mistakenly provides food that is not "creditable" (i.e., approved for reimbursement by CACFP), she will not be reimbursed for those expenses.
- **The cost index CACFP uses to determine reimbursement levels differs for home-based child care and child care centers, resulting in lower levels of reimbursement**. Reimbursements for home-based child care rely on the Consumer Price Index (CPI) Urban index for meals at home, but reimbursements for center-based care rely on the CPI Urban index for meals away from home—even though children in home-based child care are eating meals away from *their* homes. This has resulted in significant differences and inequities in reimbursements for home-based versus center-based care. Our respondents strongly urged a deep look at the actual costs and challenges facing HBCC providers, which are unable to buy food in bulk, may face much more limited purchasing options, and must do their own food prep and service.
- **The individual means testing required for providers that do not live in communities with low incomes, and for the children they serve, means these providers face a significantly higher hurdle to access the resources they need,** even if they are serving similarly poor children as providers living in communities with lower incomes (Binder et al. 2015; Kirlin et al. 2008). Experts suggested this requirement may have a particular impact on rural communities.

- **Providers do not get to keep all the reimbursements they receive** because they are considered taxable income. This further reduces the value of participating for providers and creates an additional challenge for them.

### NONFINANCIAL INCENTIVES

Our assessment suggests two concrete nonfinancial benefits can give HBCC providers additional incentives for participation:

- access to training and resources about healthy eating and supporting children's nutrition and physical activity and
- helping HBCC providers access peer support and relationships with other providers and sponsor staff.

Experts agreed on the important roles of these incentives but also noted that the previously mentioned financial and administrative cost constraints facing sponsor agencies can seriously undercut their ability to support such efforts. They recommended actively encouraging or requiring these activities for sponsor agencies and supporting their ability to provide these supports through sufficient funding, technical assistance, and resource supports and oversight (Bernstein and Hamilton 2002; Gormley 1992; Kharofa et al. 2016; Pettigrew, Kuchak, and Ghelfi 2006; Yee et al. 2017).

Experts also, however, cautioned that these efforts must recognize the constraints and realities facing HBCC providers and that the training must be high quality, relevant to the realities that providers face (including limited time), and accessible in language and literacy levels. Getting input from providers on what they need and what would be useful is important to ensure the relevance of the resources and supports. It is also essential to pay particular attention to the challenges facing providers in rural areas or other areas with less access to sponsor support.

### STAYING ENROLLED

Our assessment suggests that many aspects of what providers must do to stay enrolled in the program can create challenges, including filling out paperwork, complying with meal requirements, having at least three visits a year (at least two unannounced),[8] and avoiding penalties from very strict compliance rules.

- **Paperwork:** Providers in CACFP must track and report attendance and food menus daily, to prove both attendance and compliance with nutrition requirements. If they do not, they may not be paid for the meals. Fulfilling this requirement requires providers to do careful meal planning and shopping, keep receipts, monitor meal ingredients, and track which children were present at each meal. Experts believe this process is likely easier now because of electronic reporting systems, though providers still must document meals daily. However, experts continue to be concerned about providers that have limited access to the internet, less access to sponsor support, or less experience with bureaucratic requirements, as well as providers with language or literacy barriers. Some of these issues are likely to be even more challenging for smaller HBCC providers, including license-exempt providers. In addition, our experts noted

that providers also have to submit new enrollments for children each year, even when there are no changes to child participation. Some providers also serve both Tier 1 and Tier 2 children, and this eligibility must be reset annually as well.

- **Meal pattern requirements:** CACFP participants are required to follow menu guidelines, and meals will only be reimbursed if they comply. Complying with these requirements has been found to increase the burden of shopping, meal planning, and preparation, and to demand more time (Richards et al. 2015). Providers also find it challenging to comply with the requirements while ensuring that children will eat what is prepared (Speirs et al. 2019). These challenges can be even greater for providers that live in food deserts or have limited access to shopping options, including providers who live in rural areas, have cultural food customs and preferences that do not match the requirements, or serve children and families with nutritional demands that do not match the meal requirements (Speirs et al. 2019).
- **Unannounced visits:** Our experts suggested that the requirement of at least two unannounced visits a year can be challenging for some providers for various reasons. These include general concerns about privacy, concerns about contact with government agencies for providers that may have family members without legal documentation, and the difficulty of remembering to notify the sponsor agency every time the providers take the children out of the house during a meal or a snack time. The latter issue seems particularly problematic for smaller home-based providers who are likely to spontaneously take the kids for a picnic in the park or on an errand and to forget to notify the agency.
- **Compliance rules:** The CACFP system was described as having "tighter regulations...than there are in military contracts. Providers that violate one rule can get kicked off the program for seven years." Our experts recommended carefully assessing the rules and regulations for burden and compliance challenges and revising the penalties for mistakes to distinguish between a mistake and outright fraud, which they suggest is quite rare. They also suggested providing sponsor agencies more support and flexibility to focus on helping providers come into compliance if they are violating a rule, with harsh penalties being reserved for fraud. They believed that these changes would make it much easier for sponsor agencies to develop more supportive relationships with providers and make participating in the program more appealing.

These issues are even more important for smaller HBCC providers, including those exempt from licensing, that are less likely to have formal programming, less likely to be accustomed to following bureaucratic rules, more likely to have one or two children whose schedules may not be fixed, and more likely to do more daily spontaneous activities than group programs that have more fixed schedules. One expert suggested that it would be helpful to think differently about how these rules work for HBCC providers and ensure that they fit within their realities.

# Overarching Challenges

In addition to these specific challenges, our experts identified some overarching challenges that can limit HBCC participation in CACFP. In addition to the size and heterogeneity of the HBCC sector, two issues were highlighted in our interviews:

- **Public misconception about HBCC quality:** A widespread misconception exists in the child care policy field, and among policymakers, about the quality of home-based child care; this misconception can affect all HBCC providers but is particularly prevalent for unlicensed providers. Many experts do not believe that home-based settings can be as good as center-based care, an unsurprising belief given that many of the quality evaluation metrics are based on center-based research. As a result, states and policymakers may have little incentive to implement policies to support HBCC provider participation in CACFP, particularly unlicensed providers, or to invest scarce resources in home-based care. They also may want to continue to focus on requiring programs to be licensed as a condition of participation in CACFP.

  This issue is complex and worth further discussion. Examining how we define quality and ensuring that no unconscious center bias affects the standards we apply in CACFP, is an important area of exploration. It is also important to openly discuss whether the primary goal of CACFP is to support children's access to food or to support licensed child care. This is particularly challenging given that a significant share of the HBCC sector may not see themselves as child care providers or have any interest in becoming licensed; as a result, the focus on licensing simply makes nutritional supports unavailable to the children they serve.

- **Limited connections with other child care systems and organizations:** One issue that undercuts the efficacy of the CACFP is that it involves the intersection of various systems that do not know much about each other and may not know much about the realities facing HBCC. At the state level, the program is usually run out of whichever agency runs the larger child nutrition programs focused on schools—usually state departments of agriculture or education—which may not be particularly knowledgeable about the child care market, particularly home-based settings. According to one respondent, the federal government mostly focuses on the state agencies and sponsors and less on the HBCC providers, leaving more of the HBCC participation issues in the hands of the state agency. As a result, CACFP at the state level may not be connected with key elements of the child care infrastructure, such as the licensing agency, the agency administering the Child Care and Development Fund, and state and local child care resource and referral programs, all of which could support participation for HBCC providers. Identifying ways to improve communication across these agencies and to incorporate the voices of HBCC providers and experts in establishing and implementing policies that make sense for the unique aspects of home-based child care could be critical to make the program work better for this population.

# Policy Action Steps, Potential Impact, and Areas for Further Investigation

This assessment suggests numerous policy actions that states and advocates could undertake to expand HBCC participation in CACFP. Although it is challenging to quantify the possible impact of these efforts, given the uncertainties and lack of data, we also provide some ideas about the possible impact of expanding participation. We also provide some ideas of areas where further research, information collection, or collaborative processes could inform efforts to improve HBCC participation in CACFP.

## Suggested Policy Actions

This assessment suggests that efforts to support higher levels of HBCC participation in CACFP require a multifaceted approach that addresses both barriers to entry and making participation worthwhile through payment policies and access to resources. Addressing one without the other will be less effective. The policy suggestions that emerge from this scan are laid out below. Note, however, that all the suggestions laid out below will function more effectively if the overarching challenges described above are addressed. States need to have the motivation to expand HBCC participation in CACFP, and the program needs to allocate resources to sponsors so they can take on the additional expenses and workload to support greater participation among the full range of HBCC providers.

### FEDERAL ACTION STEPS

- **Establish requirements, incentives, and supports to help sponsor agencies expand participation by hard-to-serve HBCC providers** by expanding outreach, technical assistance, and supports. Hard-to-serve HBCC providers include those that are legally exempt from licensing, face language or literacy challenges, live in rural areas, or do not have access to the internet. Provide resources and supports to sponsor agencies and establish accountability measures ensuring that sponsor agencies expand their enrollment and retention of providers in these categories.
- **Study the gaps in coverage of sponsor agencies, and work to ensure full coverage** by providing incentives and start-up costs for sponsors to begin or target operations in areas with inadequate coverage—including underresourced communities within areas that have sponsor coverage but face gaps because of challenges reaching providers.
- **Ensure that providers are fairly compensated** by examining the equity and adequacy of current reimbursement levels for home-based child care and taking steps to address inequities and inadequacies. Steps to accomplish this can include assessing the validity, equity, and administrative burden of the tiered reimbursement approach and payment levels; recognizing the unique constraints and costs incurred by HBCC providers; paying home-based care centers using the same CPI indices as used by child care centers; and exempting CACFP payments from being taxed.

- **Simplify targeting of CACFP to children with low incomes** by coordinating with eligibility for other programs (the Supplemental Nutrition Assistance Program, the Child Care Development Fund, the Supplemental Nutrition Program for Women, Infants, and Children, etc.) and considering community eligibility strategies.[9]
- **Reduce administrative burden** by assessing the levels of paperwork and administrative burden and how they affect different kinds of providers, including smaller providers facing language and literacy barriers; reduce or adjust requirements to only essential elements, and support providers facing difficulties complying with requirements.
- **Building on lessons learned during the COVID-19 pandemic, explore doing at least some compliance and support visits virtually,** which can support coverage and access to providers, particularly in rural areas.
- **Explore using pandemic relief funds to support more active collaboration between CCDF and CACFP to expand HBCC enrollment and participation.** Given the important role that CACFP can play in supporting providers financially and supporting children's development, the flexible funds available to states under the various pandemic relief packages for child care stabilization and expansion of CCDF can be used to support CACFP participation.
- **Provide resources and incentives to sponsor agencies that partner with intermediary organizations supporting HBCC providers** (such as family child care networks or shared service models) to expand participation in CACFP. Partnership activities could include technical assistance, outreach, help navigating system challenges, and targeted training and peer supports.
- **Ensure regulations, materials, and resources reflect different HBCC providers' realities** so they are relevant and reasonable for everything from large licensed family child care homes to smaller license-exempt providers, not based on requirements that are more relevant for child care centers. Seek input from HBCC providers in review and revisions.

**Ensure penalties for noncompliance are commensurate with the transgression** by reviewing current penalties and regulations; identifying where the penalty does not correspond to the error; and revising and simplifying regulations and penalties so the most serious penalties are only imposed for fraud and abuse and other serious transgressions. Create supportive mechanisms through which sponsor agencies can help providers come into compliance before imposing penalties.

### STATE POLICY ACTION STEPS

- **Identify alternative approval strategies—other than licensing—for providers that are legally exempt from licensing requirements** so that HBCC providers who are unlikely to be interested in becoming licensed can access CACFP.
- **Encourage other state agencies and state-funded entities to coordinate with CACFP to support outreach and enrollment to HBCC providers**, including licensing agencies, child care subsidy agencies, and child care resource and referral agencies.

- **Use child care pandemic relief funds to support outreach and enrollment for CACFP,** given that CACFP can help stabilize providers and support healthy child development.
- **Include supporting CACFP enrollment and participation in the activities and responsibilities of any funds going to intermediary organizations supporting HBCC,** such as family child care networks or shared service models, by helping them link to sponsor agencies, coordinate technical assistance, provide support for navigating system challenges, provide targeted training and peer supports, and so forth.
- **Use related funding sources to help HBCC access CACFP.** These could include quality funds from the CCDF, reaching out to providers receiving subsidies through CCDF, and funds dedicated to system reform and coordination.
- **Ensure that CACFP agencies are represented in child care/early education coordinating entities,** such as state advisory councils or other planning entities, planning and coordination efforts funded by the Preschool Development Grants, and other cross-sector efforts.

## Potential Impact of Expanding HBCC Participation in CACFP

The steps outlined above could help significantly increase HBCC provider participation in CACFP. Although it is challenging to quantify the impact of expanding participation given the gaps in our knowledge about the program, likely outcomes could include the following:

- **Increased income and reduced hardship for participating providers.** One expert estimates that the after-tax income benefits of participating in the CACFP is $393 to $945 a child (depending on whether the provider or children are Tier 1 or Tier 2, and the provider's tax bracket).[10] This means that a caregiver with low income (qualifying for Tier 1 and at a low tax bracket) serving five children could get an additional $4,500 to $5,000 a year after taxes, an amount that could significantly increase their well-being. (Data from 2012 suggest that the average licensed HBCC provider served about eight children, and the average unlicensed paid HBCC provider served three-to-four children; see OPRE 2016.) Although estimates of the annual income of home-based child care providers vary widely,[11] these increased funds are likely to create positive outcomes for providers, including reduced material hardship, more economic stability, and less stress.
- **Improved nutrition for the children in the provider's care:** Although studies are not available on the impact of CACFP participation specifically for HBCC providers and the children they care for, some research exists on the impacts of CACFP participation for centers and children in centers. For example, a study of center directors found that those participating in CACFP report fewer barriers to serving healthy food (Zalt et al. 2020); another study found that CACFP participation was associated with moderate increases in milk and vegetable consumption and may also reduce the prevalence of weight problems (both overweight and underweight; Korenman et al. 2018); and yet another study found that CACFP participation resulted in better health outcomes for children (Gayman et al. 2010).

## Areas Where Further Work Is Needed

Our review clarified that major gaps exist in our knowledge about CACFP and HBCC providers. In fact, little information is available to inform many of the policy actions identified above, indicating that many suggestions would benefit from a deeper assessment of the issue and of promising policy strategies to address them. Below we highlight just some of the issues that would be useful to explore further.

- What are promising practices for supporting HBCC providers in the CACFP program? What are promising practices for supporting CACFP participation for legally exempt HBCC?
- What do we know about the role of sponsors and promising practices to have them support HBCC provider enrollment and participation? What supports and incentives do they need to better support HBCC providers in ways that help meet program goals of providing good nutrition to children in child care settings?
- What are the gaps in service coverage from sponsors and the reasons for these gaps? What incentives and supports can be provided to sponsor agencies to set up in areas with no coverage or do more intensive outreach in underserved communities within their current area?
- What roles can other child care agencies play in supporting CACFP enrollment, such as licensing agencies, subsidy agencies, and child care resource and referral agencies?
- Are there equity issues in the extent to which CACFP is easily accessible to and appropriate for providers from different racial and ethnic backgrounds, and with different cultural beliefs?
- To what extent are states allowing legally exempt HBCC providers to participate, and what health and safety requirements must they meet? What is the relationship between state policies and participation levels? What policies can states put in place to ensure accountability without creating undue barriers to nutrition assistance? Do states only support caregivers that are paid to care for children, or do unpaid relative caregivers also qualify?
- What is the value and cost of requiring licensing as a condition of participation, and should the concept of using CACFP resources as an incentive for legally exempt providers to become licensed (given that many such providers do not see themselves as child care providers and will not pursue licensing) be examined further?
- How well does the current approach to reimbursing providers work, and how could it be revised to better support providers' ability to meet the food requirements and provide them with an incentive to participate?
- To what extent are the current reimbursement Tier 1 and Tier 2 strategies creating barriers or inadequate compensation for providers and children who may live in rural areas or suburban areas with scattered areas of poverty?
- What can we learn about positive coaching models and strategies to develop stronger supportive relationships with providers as a way to support compliance and good nutrition practices?

- What are the benefits of revising the current strict and punitive compliance strategies to better disentangle errors from fraud?

# Conclusion

The federal Child and Adult Care Food Program is designed to provide nutritional supports to children in child care programs. However, the program as currently designed has significant barriers to participation by HBCC providers, who are caring for millions of children in the United States each day including many infants and toddlers, children in rural areas, children whose parents work nontraditional hours, and children with special needs. Supporting the participation of these providers in the CACFP could significantly improve the material well-being of HBCC providers, many of whom have low incomes themselves, and improve the health and well-being of the many children they serve.

# Notes

[1] David Alexander, Juliet Bromer, Tom Browning, Tom Copeland, Toni Porter, Karen Schulman, and Mary Beth Testa Salomone were interviewed for this brief.

[2] Published data provide information on the number of HBCC providers overall when also considering school-age children, but data on the total number of children served including this age group are not as readily available.

[3] Data from the National Survey of Early Care and Education show that in 2012, 7 in 10 child care centers reported getting some public revenue (OPRE 2014) compared with 6 in 10 listed home-based child care providers and slightly more than 1 in 10 unlisted paid home-based child care providers.

[4] Authors' calculations using "Annual Survey of Food and Nutrition Service Programs (Data as of December 11, 2020)," Child Nutrition Tables, US Department of Agriculture, https://fns-prod.azureedge.net/sites/default/files/resource-files/annual-1a.pdf.

[5] Although there has not been definitive research on the causes for this decline, it is likely because of a combination of the overall decline in the number of operating family child care providers and the imposition of a means test on family child care home reimbursements as part of 1996's welfare reforms, which effectively halved the federal reimbursement for meals and snacks to providers serving moderate-income children. See Rosso and Henchy (2019), page 3.

[6] See "Threshold of Licensed Family Child Care in 2014," National Center on Early Childhood Quality Assurance, November 2015, https://childcareta.acf.hhs.gov/sites/default/files/public/threshold_fcch_2014.pdf.

[7] Mary Beth Testa Salomone, interview by author, April, 15, 2021.

[8] In normal times (i.e., before the COVID-19 pandemic), CACFP-sponsoring organizations must review each facility three times a year and (1) at least two of the three reviews must be unannounced; (2) at least one unannounced review must include observation of meal service; (3) at least one review must be made during each new facility's first four weeks of program operations; and (4) not more than six months may elapse between reviews. The pandemic waivers for this requirement can be found at Sarah Smith-Holmes (director, program monitoring and operational support division, USDA), "Nationwide Waiver of Onsite Monitoring Requirements for Sponsors in the Child and Adult Care Food Program," August 4, 2020, https://fns-prod.azureedge.net/sites/default/files/resource-files/COVID19%20Onsite%20Monitoring%20Nationwide%20Waiver%20CACFP%20Sponsors.pdf.

[9] For more information about community eligibility strategies, see https://frac.org/community-eligibility.

[10] Tom Copeland, "After Tax Impact of Food Program Participation," *Tom Copeland's Taking Care of Business* (blog), accessed February 1, 2021, https://www.dropbox.com/s/tehul20e1h8w08e/After%20Tax%20Impact%20of%20Food%20Program%20Participation.pdf?dl=0.

[11] One source suggests average income levels of $21,000 to $31,500 a year. See "Home Child Care Provider Salary," ZipRecruiter, accessed February 1, 2021, https://www.ziprecruiter.com/Salaries/Home-Child-Care-Provider-Salary. Another source suggests that half of HBCC providers earn less than $59,000 a year (LaRocca 2020, figure 6).

# References


Bernstein, Lawrence S., and William L. Hamilton. 2002. *Sponsoring Organizations in the CACFP—Administrative Effects of Reimbursement Tiering. A Report to Congress on the Family Child Care Homes Legislative Changes Study*. Washington, DC: US Department of Agriculture, Economic Research Service.

Binder, Christine, Joel Berg, Maryam Adamu, and Katie Hamm. 2015. *How the Child and Adult Care Food Program Improves Early Childhood Education*. Washington, DC: Center for American Progress.

Gayman, Annie, Stephanie Ettinger, Elizabeth March, John T. Cook, Sharon Coleman, and Deborah A. Frank. 2010. "Child Care Feeding Programs Support Young Children's Healthy Development." Boston: Children's HealthWatch.

Gormley, William T. 1992. "Food Fights: Regulatory Enforcement in a Federal System." *Public Administration Review* 52 (3): 271–80. https://doi.org/10.2.307/976925.

Henly, Julia R., and Gina Adams. 2018. *Increasing Access to Quality Child Care for Four Priority Populations. Challenges and Opportunities with CCDBG Reauthorization*. Washington DC: Urban Institute.,

Kirlin, John A., Joseph f Kirchner, Nancy Teed, Mitch Wang, and Barbara Milton King. 2008. *Report to Congress: The Nebraska Rural Area Eligibility Determination Pilot for the CACFP*. Report CN-08-ND. Alexandria, VA: US Department of Agriculture, Food and Nutrition Service.

Korenman, Sanders, Kristen S. Abner, Robert Kaestner, and Rachel A. Gordon. 2013. "The Child and Adult Care Food Program and the Nutrition of Preschoolers." *Early Childhood Research Quarterly* 28 (2): 1–27. https://doi.org/10.1016/j.ecresq.2012.07.007.

LaRocca, Alison. 2020. *Home Grown Technical Assistance Program for the Paycheck Protection Program: Project Outcomes Report*. Pittsfield, MA: Luminary Evaluation Group.

Meredith, Kelly. 2009. *A Statewide Analysis of the Child and Adult Care Food Program and Family Child Care Providers in Oregon*. Wilsonville: Oregon Child Development Coalition.

OPRE (Office of Planning, Research, and Evaluation). 2014. *Characteristics of Center-Based Early Care and Education Programs: Initial Findings from the National Survey of Early Care and Education (NSECE)*. Report 2014-73a. Washington, DC: US Department of Health and Human Services, Administration for Children and Families, OPRE.

———. 2016. *Characteristics of Home-Based Early Care and Education Providers: Initial Findings from the National Survey of Early Care and Education*. Report 2016-13. Washington, DC: US Department of Health and Human Services, Administration for Children and Families, OPRE.

Pettigrew, Iris, JoAnn Kuchak, and Linda Ghelfi. 2006. *Administrative Costs in the Child and Adult Care Food Program. Results of an Exploratory Study of the Reimbursement System for Sponsors of Family Child Care Homes*. Washington, DC: US Department of Agriculture.

Richards, Mark, Anita Sharma, Mara Hollander, John Almond, and Beth Eagleton. 2015. *Formative Research on Nutrition, Physical Activity, and Electronic Media Use in Child and Adult Care Food Program*. Alexandria, VA: US Department of Agriculture, Food and Nutrition Service.

Rosso, Randy, and Geri Henchy. 2019. *Child and Adult Care Food Program: Participation Trends 2018*. Washington, DC: Food and Research Action Center (FRAC).

Speirs, Katherine E., Rachel A. Gordon, Elizabeth T. Powers, Brenda D. Koester, and Barbara H. Fiese. 2019. "Licensed Family Child Care Providers' Participation in the Child and Adult Care Food Program (CACFP): Greater Benefits and Fewer Burdens in Highly Urban Areas?" *Early Education and Development* 32 (2): 153–76. https://doi.org/10.1080/10409289.2019.1648087.

Tiehlan, Laura. 2020. *The Food Assistance Landscape: Fiscal Year 2019 Annual Report*. EIB-218. Washington, DC: US Department of Agriculture, Economic Research Service.

Yee, Andrew, Z., May O. Lwin, and Shirley S. Ho. 2017. "The Influence of Parental Practices on Child Promotive and Preventive Food Consumption Behaviors." *International Journal of Behavioral Nutrition and Physical Activity* 14 (1): 47–61. https://doi.org/10.1186/s12966-017-0501-3.

Zaltz, Daniel A., Amelie A. Hecht, Russell R. Pate, Brian Neelon, Jennifer R. O'Neil, and Sara E. Benjamin-Neelon. 2020. "Participation in the Child and Adult Care Food Program Is Associated with Fewer Barriers to Serving Healthier Foods in Early Care and Education." *BMC Public Health* 856 (20): 1–9. https://doi.org/10.1186/s12889-020-08712-7.

# About the Authors

**Gina Adams** is a senior fellow in the Center on Labor, Human Services, and Population and directs the Low-Income Working Families and the Kids in Context initiatives. She is a national expert on factors that shape the affordability, quality, and supply of child care and early education services and the ability of families with low incomes to benefit from them.

**Fernando Hernandez** is a research analyst in the Center for Labor, Human Services, and Population, where his work focuses on child care and early education, and food and nutrition policy. He is experienced in quantitative and qualitative methods, including program and impact evaluations, survey design, and focus groups and interviews.

# Acknowledgments

This brief was funded by Home Grown Child Care funders collaborative members: Buffett Early Childhood Fund, Imaginable Futures, Klingenstein Philanthropies, and the Pritzker Children's Initiative. We are grateful to them, and to all our funders, who make it possible for Urban to advance its mission.

The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, or its funders. Funders do not determine research findings or the insights and recommendations of Urban experts. Further information on the Urban Institute's funding principles is available at urban.org/fundingprinciples.

We thank David Alexander, Juliet Bromer, Tom Browning, Tom Copeland, Toni Porter, Karen Schulman, and Mary Beth Testa Salomone, who were willing to share their insights and expertise with us for this brief, as well as Danielle Ewen, Geri Henchy, Natalie Renew, Mary Beth Testa Salomone, and Karen Tylek, who reviewed earlier drafts. Finally, our thanks to Heather Sandstrom and Kelly Dwyer, our partners and members of our overall project team, who have been helpful at each step.


500 L'Enfant Plaza SW
Washington, DC 20024

www.urban.org

## ABOUT THE URBAN INSTITUTE

The nonprofit Urban Institute is a leading research organization dedicated to developing evidence-based insights that improve people's lives and strengthen communities. For 50 years, Urban has been the trusted source for rigorous analysis of complex social and economic issues; strategic advice to policymakers, philanthropists, and practitioners; and new, promising ideas that expand opportunities for all. Our work inspires effective decisions that advance fairness and enhance the well-being of people and places.