RESEARCH REPORT

# Untapped Potential

## License-Exempt Home-Based Child Care Providers and the Child and Adult Care Food Program

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# Executive Summary

Food insecurity among children and their families is a persistent national public health problem, which is associated with a host of problems that affect children's short- and long-term development. In 2021, food insecurity affected an estimated 9.3 million children—or one out of eight children nationwide—who lived in households that were food insecure, meaning they did not have access to enough food for an active, healthy life (Coleman-Jensen et al. 2022; Hake, Engelhard, and Dewey 2023).[1] One of the key federal child nutrition programs designed to support children's healthy nutrition and development is the Child and Adult Care Food Program (CACFP), which was created to help children in child care programs get nutritious meals. In 2022, CACFP helped pay for almost 1.8 billion meals for children in child care programs across the country. Participating in CACFP has been associated with a reduction in household food insecurity (Heflin et al. 2015) and other benefits (Korenman et al. 2013).

This executive summary presents the key findings from a larger report. The full report examines a major gap in the CACFP's ability to reach children in nonparental child care settings. Specifically, although it is allowed under CACFP law, most states do *not* extend CACFP eligibility to the estimated 11.5 million children cared for by small home-based child care providers and friends and relatives who are legally exempt from their state's child care licensing requirements (NSECE 2021b)[2]—providers that we refer to as license-exempt home-based (LEHBCC) providers in this project. In fact, more children are cared for in these LEHBCC settings than are cared for in the child care centers and family child care homes listed with state licensing agencies and other agencies—settings that *are* allowed to participate in CACFP (NSECE 2021a, 2021b).

LEHBCC providers disproportionately care for many vulnerable children including infants and toddlers, children with disabilities, children from immigrant families, families who face challenges affording child care, and families working nontraditional hours (NCECQA 2022; Schilder, Lou, and Wagner 2022). As a result, failure to allow these providers to access the nutritional benefits of CACFP for the children in their care means that the program is not reaching a large share of children in nonparental child care, including many children who are likely vulnerable to food insecurity.

To better understand the potential opportunities and challenges states may face in extending CACFP to the many children cared for by LEHBCC providers, this study explores the following research questions:

- **What can we learn from select states who allow LEHBCC providers to participate in CACFP about what is and is not working?**

- **What can be done to expand these providers' participation?**

To explore this question, we first spoke with people in a few states that did not allow LEHBCC providers to participate in CACFP to better understand the questions and concerns they might have about this topic. We then identified three states that allow LEHBCC providers to participate in CACFP—Illinois, Louisiana, and Oregon. In each state, we talked with people in the state agency administering CACFP as well as other state-level agencies responsible for approving providers for CACFP, selected people responsible for administering the program at the local level (referred to as sponsor agencies, or "sponsors" hereafter), and other key experts. We also were able to gather some limited perspectives from LEHBCC providers, although more insights would be valuable. Given we only spoke with people in a few states, and with only one or two sponsor agencies within the states, our findings should be seen as providing insights into the research questions rather than conclusive or definitive statements about the experiences of CACFP agencies across states who support LEHBCC providers. We concluded our data gathering by sharing our preliminary insights with national experts to get their feedback on the information as well as on promising policy options.

Our findings provide important insights for policymakers, key stakeholders, advocates, and others interested in supporting the healthy development of children, helping vulnerable children at risk of food insecurity access nutritional supports, and addressing inequities in access to nutritional assistance.

# Understanding the Basics

To clarify the report's findings, we begin by briefly laying out some key contextual issues:

- **Why do we care about child food insecurity?** As noted above, an estimated one in eight children nationwide lived in food-insecure households in 2021. Food insecurity disproportionately affects families with lower incomes, as well as Black, Latinx, and Native American people who have faced historical barriers to opportunity because of structural racism and other challenges (Coleman-Jensen et al. 2022).[3] It has been associated with a host of problems for children, including increased health problems, behavioral and mental health problems, and worse academic performance and social outcomes—all of which can affect children's positive development and their ability to reach their full potential (Gallegos et al. 2021; Gundersen and Ziliak 2014; Meisenheimer 2016; Thomas, Miller, and Morrissey 2019).
- **What is CACFP?** CACFP is an entitlement program that reimburses eligible child care providers for some or all of the costs of providing nutritious meals to children in their care. The program is

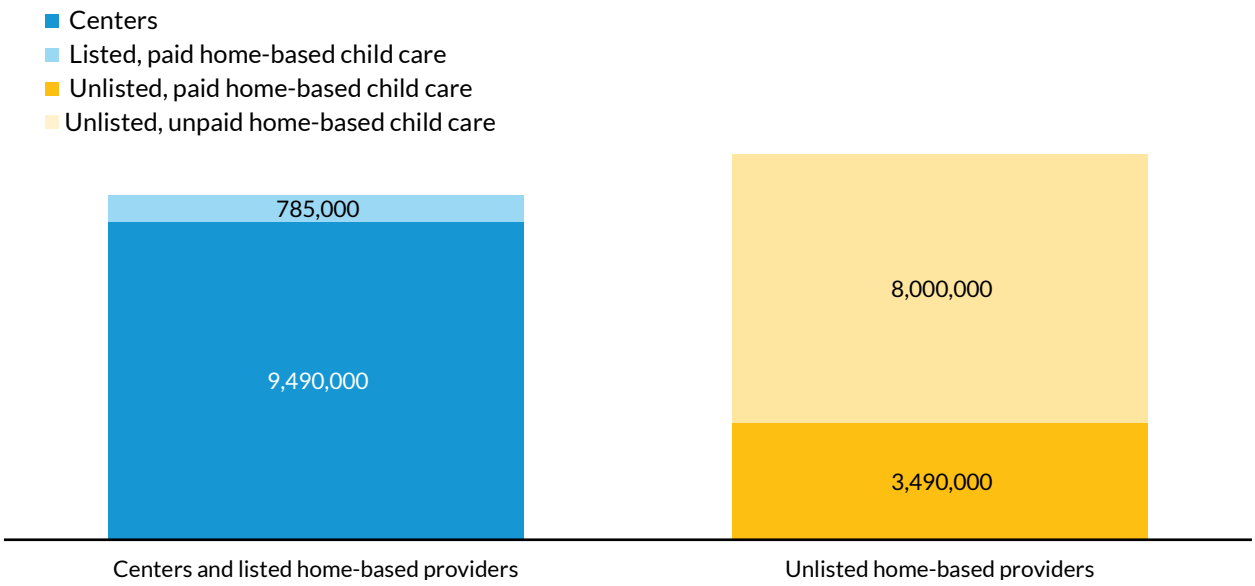
usually administered by state education or human service agencies. CACFP requires that participating child care providers meet applicable licensing standards, CACFP standards, or alternative standards established by the state if providers are not otherwise required to be licensed. Home-based child care providers work with sponsors who interface between the agency and provider and offer training, support, and monitoring, as well as collect information on meals provided so providers can be paid. Providers must serve meals that meet CACFP nutritional guidelines. Providers cannot participate in CACFP if they only care for children who live with them or only care for children in the children's home—though they can participate if they care for any children who do not live with them. In the latter situation, they can be reimbursed for all of the children in their care if they meet income requirements.

- **Who are LEHBCC providers?** The composition of LEHBCC providers varies across states—while states usually exempt relative caregivers from licensing if they are only caring for children related to them, states vary in the extent to which they also exempt unrelated caregivers who care for multiple children, often as a small business (also known as a family child care program). In 2020, for example, 10 states exempted home-based providers serving four or fewer children in their homes from having to be licensed (NCECQA 2022), and some states exempt homes serving even larger numbers of children. As a result, a provider caring for a few unrelated children in her home could be required to be licensed in one state and could be legally exempt from licensing in another. This also means there is significant variation from one state to another as to how much of the home-based child care sector would be legally exempt from licensing—with some states exempting large shares of their home-based child care providers and others exempting relatively few. As a result, whether a state chooses to make LEHBCC providers eligible for CACFP has very different implications from one state to another.
- **How many children do LEHBCC providers care for?** LEHBCC providers play a critical role in providing child care for an estimated 11.5 million children in the United States, including 3.5 million children cared for by paid home-based child care providers who are not listed on state or other government lists such as licensing lists, and 8 million cared for by unpaid home-based providers who are not on licensing or other government lists (NSECE 2021b). In comparison, in 2019, an estimated 10.5 million children were cared for in child care centers or home-based settings listed with federal, state, or local agencies such as licensing agencies (NSECE 2021a; see figure E.1). **In other words, more children are in LEHBCC settings that are often not allowed to participate in CACFP than in settings that usually can participate.** (Note that the 8 million children cared for by unpaid home-based providers could be cared for by family and friends who may or may not live in the same household as the children, meaning that some of

these providers would only be potentially eligible for CACFP if they also cared for some children from outside of the household.)

FIGURE E.1

**Number of Children Younger Than Age 13 Served in 2019 by Type of Child Care Provider**




**Source:** Based on data from the 2019 National Survey of Early Care and Education (NSECE 2021a; 2021b).
**Notes:** Listed providers refers to home-based providers who appear in national or state lists of early care and education services, which can include licensed or regulated providers as well as license-exempt providers that may be part of a public system. Unlisted paid providers refers to providers who did not appear on state or national lists but were reported to care for children other than their own for at least 5 hours a week in a home-based setting and received payment for at least one child in their care. Unlisted unpaid providers are similar to unlisted paid providers, except they do not receive payment for children in their care and include caregivers who are family and friends who may live in the same household as the children they regularly look after (NSECE 2021b).

- **What do we know about whether and how LEHBCC providers can participate in CACFP?** While little formal data are available, it appears that most states only allow licensed providers to participate in CACFP, with only about eight states allowing LEHBCC providers to participate—specifically, conversations with experts suggest that they include California, Colorado, Illinois, Louisiana, New Mexico, New York, Oregon, and Washington. To be eligible for CACFP, it appears that most of these states rely on the same approval process for LEHBCC providers that they use to approve these providers for the child care subsidy program—the Child Care and Development Fund (CCDF). Only two that we have identified so far—Louisiana and California—use an alternative process. In Louisiana, the approval process is handled by the CACFP agency working with the fire marshal's office that inspects LEHBCC providers; in California, the process is approving providers through the state Trustline system that performs background checks, as well as a self-certification process.[4]

Interestingly, under federal CACFP requirements, states have wide discretion in what they establish as "approval" requirements for LEHBCC providers. The US Department of Agriculture (USDA) has clarified that in cases where the state does not have licensing standards in place, as is the situation for LEHBCC providers, they can set standards that "define what is an acceptable care environment." USDA further elaborates that evaluating the setting against these standards can "range from onsite reviews of facilities by licensing/approval officials to a review of a self-certification checklist."[5]

- **Which states did we examine?** Our research focused on three states—Illinois, Louisiana, and Oregon. We chose these states because of their history of supporting LEHBCC providers more generally and because they included these providers in CACFP. Generally, Illinois's and Oregon's approaches are more similar, as both exempt home-based providers that serve three or fewer children from licensing, though they differ as to whether the provider's own children are counted. Both states also rely on the CCDF approval process to determine which LEHBCC providers are eligible to participate in CACFP. In contrast, Louisiana exempts home-based settings serving six or fewer children from licensing and requires homes serving seven or more children to be licensed as a center. Louisiana, as noted above, requires that LEHBCC providers pass a health and safety inspection conducted by the fire marshal to be eligible for CACFP.
- **How did the LEHBCC populations eligible for CACFP differ across our states?** The policy differences in exemptions and CACFP approval processes resulted in significantly different LEHBCC populations being eligible for CACFP across these states.
  - » Because providers serving up to six children are exempt from licensing in Louisiana, a much larger share of Louisiana's home-based child care sector is exempt from licensing than in Illinois and Oregon and thus is potentially eligible for their effort to extend CACFP to LEHBCC providers. Further, any LEHBCC provider—both paid and unpaid—can be eligible if they pass the fire marshal inspection.
  - » In contrast, significantly smaller shares of home-based providers are eligible for CACFP in Illinois and Oregon. This is for several reasons. First, as noted above, only providers serving three or fewer children are exempt from licensing in these states, creating a smaller pool of potential providers. Second, because only LEHBCC providers who are approved for the child care subsidy program—CCDF—can qualify for CACFP, it only is available to the subset of LEHBCC providers who are
    - paid providers (because CCDF is a program that helps parents pay for care, so parents will not apply unless they are using or want to use a paid provider);

- providers serving at least one child whose parents (a) meet CCDF work and income requirements, (b) knew about and applied for the subsidy, and (c) were able to get a subsidy, which can be challenging as nationwide the CCDF only has sufficient funds to serve one in six children eligible under federal rules;[6] and
- providers who meet CCDF standards such as training, home inspection, and comprehensive criminal background check for all adults in the household that might come into contact with the children.

As a result, the share of LEHBCC providers approved for CCDF subsidies in Illinois and Oregon—and that therefore could potentially be eligible for CACFP—is likely to be a relatively smaller subset of all home-based providers and LEHBCC providers in these states than in Louisiana.

# What We Learned

Our research revealed a number of useful insights in our effort to explore what we could learn from states that allowed LEHBCC providers to participate in CACFP, with a focus on understanding what could be done to address barriers and expand participation. Each is described in more depth in the full report but discussed briefly below.

- **Supporting LEHBCC providers' participation in CACFP is valued in our three states but not consistently prioritized.** Across our interviews with CACFP agencies, sponsors, and key stakeholders in the three states, LEHBCC providers were clearly seen as a critical part of the child care ecosystem, and many respondents highlighted the important role they played in caring for, feeding, and supporting children. These providers have been part of the CACFP in each state for decades. Respondents described the benefits of supporting LEHBCC provider participation as including
  - » supporting children's access to healthy food;
  - » building providers' knowledge about good nutrition, which had a ripple effect on the providers' families and the families they worked with;
  - » reducing the financial burden on providers by helping cover some or all of the costs of food;
  - » improving the health and safety of the care environment; and
  - » reaching children who otherwise would not get support.

However, as described below, respondents in two states—Illinois and Oregon—also discussed that despite these benefits, not all CACFP sponsor agencies in the state placed a priority on recruiting LEHBCC providers because of various challenges and insufficient administrative funding to address them.

- **LEHBCC providers face barriers to CACFP enrollment, and reliance on CCDF approval processes adds hurdles.** A close examination of the process LEHBCC providers went through to be able to enroll in CACFP revealed that it was significantly different in Illinois and Oregon, both of which relied on CCDF approval as a prerequisite for LEHBCC CACFP eligibility, versus Lousiana. As a result, the barriers and challenges differed as well, with the CCDF approval process involving many more steps that potentially reduce the pool of LEHBCC providers who could be eligible for CACFP than is found in Louisiana. Some of these barriers and challenges exist because of federal law, and others are related to state decisions or policies.
  - **The CACFP entry process for LEHBCC providers in Oregon and Illinois involved numerous steps** (figure E.2). Because both of these states have chosen to use the CCDF approval process to determine which LEHBCC providers can participate, the first stage in the process involves the LEHBCC provider being eligible and approved for CCDF, which requires numerous conditions to be fulfilled.
    - Some CCDF steps were specific to the *parents* the provider was serving or hoping to serve. Specifically, the provider would have to be caring for a child whose parents needed help paying for care, knew about CCDF, believed they could get CCDF assistance if they applied, saw the benefit of applying as outweighing the challenges, met the various work activity and income requirements to qualify for a subsidy, and were able to get a subsidy. Research on CCDF more broadly suggests that each of these elements can present challenges to parents (Adams and Matthews 2013; Adams, Snyder, and Banghart 2008; Lee et al. 2022),[7] with a related key challenge being the previously mentioned constraints in CCDF funding.
    - There were also CCDF steps related to the provider, established under federal law for CCDF subsidy payments (Adams and Dwyer 2021).[8] Specifically the provider had to be willing to apply for CCDF and go through the approval process, which required them to attend training, undergo comprehensive criminal background checks for all adults in the household who might come into contact with children, consent to home inspections, and comply with other steps that states could put in place. Research suggests that each of these can create barriers for parents and providers (Adams and Dwyer 2021).

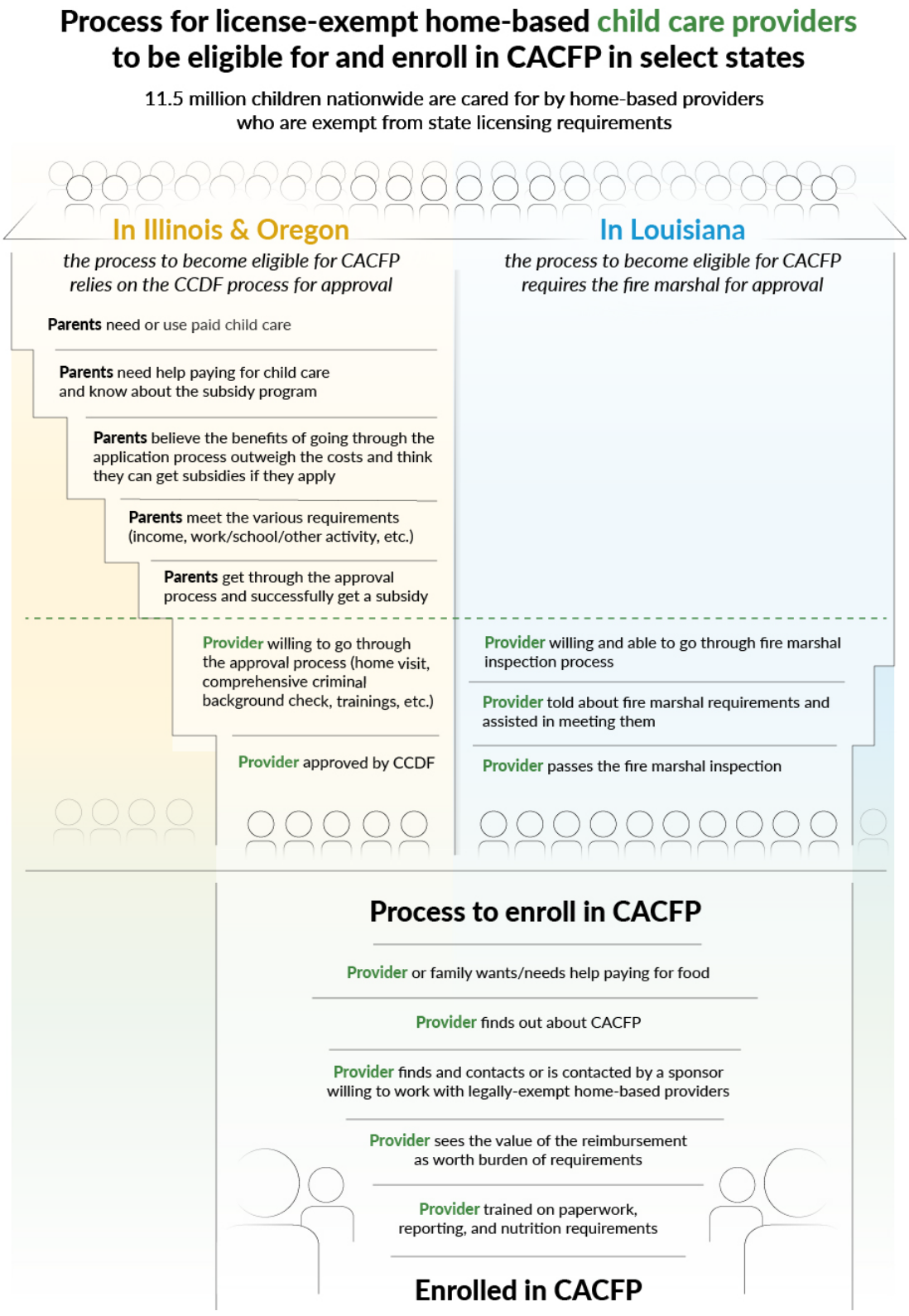
- Finally, the provider must learn about CACFP. In both Illinois and Oregon, this step in the process involved the CCDF agency sharing a list of approved providers with CACFP sponsor agencies, and the sponsors would then reach out to providers to see if they wanted to enroll. In both of these states, respondents felt that the cross-agency communication process seemed to function fairly smoothly, though we were not able to assess this. We did not hear much in these states about word of mouth or about providers reaching out to sponsor agencies; while this is likely to have occurred, it would likely be constrained by the reality that the steps above limit the size of the eligible provider population.

» **The CACFP entry process for LEHBCC providers in Louisiana was significantly less complex** (figure E.2). Providers generally learned about the program either through active sponsor agency outreach or word of mouth. Once a provider expressed interest, they would work with a sponsor to understand the program and help them come into compliance with the requirements for the fire marshal inspection, which were established by the state. When the provider was ready, the sponsor would submit the materials to the fire marshal's office to request an inspection. When the provider successfully passed the inspection and submitted to an interview, they could be enrolled in CACFP.

» **Finally, the actual enrollment process for CACFP is handled in all states by the sponsor agency and involves getting providers up to speed on the rules, paperwork requirements, and reporting systems**. These requirements are established at the federal level, with sponsor agencies having some discretion in the types of supports they provide to help providers enroll. Respondents noted that in some cases providers would decide that the burden of these requirements was not worth the trouble given the low reimbursement levels of the CACFP and would decide not to apply.

FIGURE E.2

**Process for LEHBCC Providers to Be Eligible for and Enroll in CACFP in Select States**



- **LEHBCC providers face barriers to stable participation.** In addition to facing challenges getting into CACFP, respondents described challenges LEHBCC providers faced in staying in the program. Some of these had to do with federal CACFP rules and requirements, and some were specific to the link to CCDF found in Illinois and Oregon.
  - » **Barriers to retention because of CACFP requirements.** Respondents described several issues with CACFP related to federal rules and policies that made it harder for LEHBCC providers to stay in the program, including low meal reimbursements,[9] administrative burden related to paperwork and reporting requirements, and unannounced visits, all of which could make providers unwilling to enroll or leave the program early on. Unannounced visits were challenging both because LEHBCC providers found them invasive and because they were supposed to notify the agency every time they left their homes during meal times so the agency would know not to visit—a step that caregivers such as grandparents may not remember to do (Adams and Hernandez 2021). One respondent said that failure to be home during unannounced visits was a key reason for LEHBCC providers being terminated from CACFP.
  - » **Barriers to retention because of the link to CCDF.** In addition, respondents in Illinois and Oregon said that providers often were terminated from CACFP because of CCDF-related changes—such as no longer serving a child receiving CCDF, either because the child went elsewhere or because the parent lost their eligibility for CCDF because of job loss, which could occur frequently. The policy of terminating CACFP eligibility because of changes in the provider's CCDF participation is a state policy decision and not one required by CACFP. (As noted earlier, CACFP does not require that providers be approved by or participate in other programs as a condition of eligibility.)
  - » **Turnover challenges.** Respondents in Illinois and Oregon described experiencing higher turnover with LEHBCC providers, citing the various factors described above as the cause.
- **LEHBCC barriers to enrollment and retention in CACFP have implications for equitable access to nutrition supports for children at risk of food insecurity.** Respondents described how the various barriers to getting into CACFP and staying in the program were higher for some groups of providers, including many who may face structural barriers to opportunity and resources. Some groups facing higher barriers to accessing and retaining CACFP included
  - » providers who spoke a language other than English;
  - » providers with low literacy levels;
  - » providers living in rural areas;

» providers who were inexperienced with technology; and
» providers who were immigrants, from immigrant communities, or were providers of color.

While data are not available as to the extent to which LEHBCC providers have characteristics similar to the children they care for, research on home-based providers who are listed with state licensing agencies suggests that they are likely to share the racial and ethnic identity of the children they care for (Hill, Arteaga, and Gable 2021), a finding which is likely to be even more true for LEHBCC providers—particularly those who are unpaid, many of whom likely caring for the children of relatives and friends (NSECE 2021b). As a result, it appears that some providers facing the greatest barriers to CACFP participation may be the most likely to serve children at greatest risk of food insecurity.

- **Delinking CACFP eligibility from CCDF could broaden and stabilize LEHBCC provider participation.** As noted above, states have the freedom to establish various approval mechanisms for LEHBCC providers. However, our review finds that linking CACFP eligibility for LEHBCC providers to their approval for CCDF child care subsidies—the most common strategy used by the states who allow these providers to get CACFP—restricts the eligible pool of providers significantly and may contribute to turnover. Respondents suggested two strategies that could help states that rely on CCDF to approve LEHBCC providers for CACFP:

  1. **Use a different approval mechanism that does not limit CACFP payments to LEHBCC providers in the subsidy system.** When asked whether using the CCDF approval process was the best way to meet CACFP's goals, respondents (including in states relying on this approach) suggested that eliminating the link to CCDF's approval process altogether would allow the state to more effectively get food to children in nonparental care, as tying access to food to whether the parent was working and on CCDF did not seem to meet the CACFP goals. However, some respondents noted that they wanted whatever alternative process was put in place to include a health and safety focus.

  2. **If continuing to use CCDF as an approval mechanism, states could allow LEHBCC providers to retain their approval status for a minimum of a year (or two)**, with the option to renew, even if they no longer served a child receiving subsidies. This strategy could stabilize their ability to stay in CACFP as long as they continued to meet CACFP requirements. Although this would not increase the share of providers who could become eligible, it would allow them to stay in the program longer.

- **Sponsors can face challenges serving LEHBCC providers.** Sponsor agencies also described how LEHBCC providers could be somewhat more challenging to work with, though this was more commonly reported in Illinois and Oregon than in Louisiana. Some challenges they described include the following:
  - » Working with LEHBCC providers can be more labor intensive (and therefore more costly) because of their lower levels of familiarity with working with an agency and sometimes higher likelihood of challenges with technology, literacy, and other barriers.
  - » Higher turnover rates among LEHBCC providers, reported as a challenge in Illinois and Oregon, can exacerbate the cost and reduce the benefits of working with them. Again, this seems at least partially related to the link to CCDF eligibility and participation.
  - » Communication between the approval agencies (i.e., the CCDF agencies in Illinois and Oregon and the fire marshal in Louisiana) needs to be open and clear to avoid complications of changing eligibility status.
- **CACFP's financing and rate structure does not adequately support working with LEHBCC providers.** The CACFP financing and rate structure does not recognize the higher costs of working with LEHBCC providers, creating a financial disincentive for sponsors to work with them in general and making it harder for sponsors to engage in the extra activities needed to meet the needs of providers who face greater barriers to participation.

# Policy Implications

The findings above, and our conversations with key stakeholders at the national level and in our target states, suggest that a number of policy steps could help improve and expand LEHBCC providers' participation in the CACFP and potentially help get nutritional supports to many children:

- **Raise awareness about the potential value of LEHBCC providers in supporting better nutrition and development for significant numbers of children through CACFP.** In our conversations with experts, it appeared that the potential of CACFP to support the well-being of the many children cared for in LEHBCC settings was often overlooked by the child nutrition and child care communities and by policymakers. Helping the stakeholders who are concerned about child nutrition, child well-being, and child care providers understand the value of expanding LEHBCC provider participation in CACFP could support progress in this area.

- **Prioritize child nutrition goals in designing strategies to approve and enroll LEHBCC providers.** Respondents clarified the importance of CACFP as a child nutrition support. Yet linking CACFP provider eligibility to CCDF goals inadvertently creates a situation where child care goals (such as supporting parental employment or implementing child care standards) and the child care system's funding constraints limits the CACFP's ability to reach the full range of nonparental child care providers the program can serve. This suggests that any effort to reach LEHBCC providers in CACFP needs to reprioritize getting nutritional supports to a broad range of children in nonparental care settings.
- **Identify and implement strategies to approve LEHBCC providers for CACFP that do not rely on CCDF approval processes.** Respondents suggested developing alternative strategies for approving LEHBCC providers for CACFP, using both Louisiana's strategy of fire marshal approval and California's approach of using their state Trustline background check system and self-certification as two examples of some approaches states are taking. Other strategies could be considered—for example, building on home-visiting models that may be working with LEHBCC providers or identifying other organizations who are trusted partners with LEHBCC providers.

  Another option for states that allow LEHBCC providers to participate in CCDF is to consider extending some aspects of the CCDF approval process to LEHBCC providers who are not serving a child in the subsidy system but who may be interested in participating in CACFP. For example, if the state has a statewide criminal background check (CBC) system used for CCDF LEHBCC approvals, it could consider making the CBC system more broadly available beyond providers involved with the subsidy system as a mechanism to check child care providers' credentials, as is done in California. However, while CBCs can be an important protection, CBC requirements can have a chilling effect on communities that have experienced unjust policing, as well as on immigrant communities who may have concerns about government involvement in their families.
- **Stabilize CACFP participation by allowing LEHBCC providers to maintain their approval status for a minimum of a year, with opportunities for renewal.** Nothing in the CACFP requirements stipulates that providers be actively participating in another program. In states that use CCDF approval processes for CACFP, respondents suggested stabilizing the provider's eligibility by making the provider eligible for a set period (i.e., one or two years) once they are approved, rather than having the provider lose eligibility if they no longer serve a child receiving a subsidy. This builds on the approach used by licensing systems and recognizes that the approval should be tied to the provider and not to whether they are serving a child in the

subsidy system. They would, of course, only be paid by CACFP if they continued to serve children who were eligible for CACFP.

- **Incentivize and facilitate outreach, recruitment, and retention of LEHBCC providers.** Several strategies to improve enrollment and retention emerged, including having the FNS, state agencies, and philanthropic organizations take steps to
  - » pay sponsors an "add-on" amount to address the higher costs of reaching, enrolling, and supporting LEHBCC providers, and particularly to support their efforts to reach underserved communities;
  - » develop and disseminate resource materials to help sponsors more effectively recruit and support LEHBCC providers.
  - » support a hybrid approach to monitoring that allows sponsors to do some monitoring virtually, making the program more accessible; and
  - » address barriers to participation in the program such as the low payment rates, paperwork demands, and elements that do not reflect the realities of LEHBCC providers.

  Such efforts could help bring needed federal resources to support healthy nutrition for children in underserved communities.

- **Develop an intentional plan to tackle barriers to CACFP participation for underserved LEHBCC populations.** Some LEHBCC provider populations appear to face greater barriers to CACFP participation than others, including those with language or literacy barriers, those living in rural communities, those who may have immigrant status or family members who are immigrants, and so forth. States, community organizations, or other stakeholders could partner with underserved communities to better understand the barriers they face, develop partnerships with trusted organizations, and assess current approaches and policies to identify and address potential barriers. States and philanthropists could provide resources to support such efforts through targeted outreach grants or other supports.

- **Collect better data on LEHBCC providers' in CACFP.** It was remarkably challenging to collect information on LEHBCC providers' participation in CACFP, whether it be which states allowed this to occur or the number or characteristics of LEHBCC providers participating in the states that do allow it. Improving data collection on these questions would be helpful to inform policy and practice.

Box E.1 provides a summary of steps that each sector—federal, state, and philanthropic—can take to support LEHBCC providers' participation in CACFP.

BOX E.1

**Key Actions at the Federal, State, and Philanthropic Levels to Expand LEHBCC Provider Participation in CACFP**

***Federal level***

- Prioritize expanding LEHBCC providers' participation in CACFP through guidance, technical assistance, and other supports.
- Provide leadership and guidance to states, encouraging them to design strategies to expand LEHBCC providers' participation in CACFP and to use approval approaches that are more inclusive than CCDF.
- Support better data collection on LEHBCC provider participation in CACFP.
- Provide an "add-on" for administrative costs associated with recruiting, enrolling, and retaining LEHBC providers to reduce the financial disincentive for sponsors.
- Develop and release materials and resources to support outreach, recruitment, and retention of LEHBCC providers in general, as well as targeted resources to support greater participation among underserved populations.
- Address major barriers to LEHBCC providers' participation including low payments, paperwork, and policies that do not reflect their caregiving realities.
- Conduct a systematic review of CACFP policies and rules to determine elements that do not reflect the realities of LEHBCC providers and thus create barriers to participation.
- Collect information on best practices and develop model processes, including new technologies, that minimize burden on providers and sponsor agencies and facilitate LEHBCC providers' enrollment.
- Allow sponsor agencies flexibility by providing a hybrid approach to monitoring, with some virtual and some in person, to support broader access to LEHBCC providers.

***State level****

For states that limit CACFP eligibility to LEHBCC providers who are approved by CCDF:

- Delink CACFP approval from CCDF and broaden the pool of eligible providers by using an alternative approach.
- Allow approved providers to retain their CACFP eligibility for a minimum of a year or two regardless of whether they continue to serve children enrolled in CCDF, with options for renewal.

For all states:

- Prioritize expanding LEHBCC providers' participation in CACFP.

- Explore and implement strategies that allow a broad range of LEHBCC providers to participate as allowed by CACFP; do not rely on CCDF approval processes to determine LEHBCC provider eligibility.
- Support better data collection on LEHBCC providers' participation in CACFP.
- Provide an "add-on" for administrative costs associated with recruiting, enrolling, and retaining LEHBC providers to reduce the financial disincentive for sponsors.
- Develop and release materials and resources to support outreach, recruitment, and retention of LEHBCC providers in general, as well as targeted resources to support greater participation among underserved populations.
- Conduct a systematic review of CACFP policies and rules to determine elements that do not reflect LEHBCC providers' realities and thus create barriers to participation, and identify those that states can help sponsor agencies address.
- Identify barriers that differentially affect the ability of LEHBCC providers in underserved communities to participate, and in collaboration with providers from these communities, design and implement an intentional plan to address these barriers.
- Provide funding for sponsor agencies to hire navigators to support LEHBCC providers and providers in underserved communities.

**The effect of most of these strategies and actions will be constrained for states that limit CACFP to LEHBCC providers who are approved by CCDF.*

***Philanthropy and other stakeholders***

- Prioritize expanding LEHBCC providers' participation in CACFP.
- Invest in communication strategies that highlight the importance of supporting access to CACFP nutritional supports for LEHBCC providers.
- Support state and federal efforts to expand LEHBCC providers' participation in CACFP.
- Fund and test pilot initiatives to support LEHBCC providers' participation in CACFP; identify and disseminate best practices and lessons learned.
- Provide sponsors with "add-on" funds for administrative costs associated with recruiting, enrolling, and retaining LEHBCC providers to reduce the financial disincentive for sponsors.
- Support the development, translation, and dissemination of materials and resources to support outreach, recruitment, and retention of LEHBCC providers in general, as well as targeted resources to support greater participation among underserved populations.
- Support efforts to conduct a systematic review of CACFP policies and rules to determine elements that do not reflect LEHBCC providers' realities and thus create barriers to participation.

- Identify barriers that differentially affect the ability of LEHBCC providers in underserved communities to participate and design and implement an intentional plan to address these barriers.
- Provide funding for sponsor agencies to hire navigators to support LEHBCC providers and those in underserved communities.

**Source:** Authors' Analysis.

In conclusion, our review of state efforts to support LEHBCC providers' participation in CACFP suggests we are missing a remarkable opportunity to reduce food insecurity and support the healthy development of many children cared for by LEHBCC providers who might be able to benefit from CACFP if states took steps to make them eligible. While the relatively few states that allow LEHBCC providers to access CACFP most commonly rely on the child care subsidy system as an approval mechanism, the CACFP allows states to set up alternative approaches that would make the program much more broadly available to providers and potentially stabilize enrollment. Encouraging states to develop such approaches, investing in the additional resources sponsors need to recruit and support the full range of LEHBCC providers caring for children, and making changes in federal policy and leadership to better support these providers could result in nutritional supports becoming available to many more children. Such steps could help support the healthy development, nutrition, and safety of children across the country who would benefit from such investments.

# Introduction

Food insecurity among children and their families is a persistent national public health problem that poses significant risks for development and well-being. In 2021, an estimated 9.3 million children—or one out of every eight children nationwide—lived in households that were food insecure, meaning they did not have access to enough food for an active, healthy life (Coleman-Jensen et al. 2022; Hake, Engelhard, and Dewey 2023).[10] And while food insecurity declined between 2020 and 2021 because of pandemic aid, evidence exists that it is rising again (Martinchek et al. 2023). Food insecurity disproportionately affects families with lower incomes, as well as Black, Latinx, and Native American people who have faced historical barriers to opportunity because of structural racism and other challenges (Coleman-Jensen et al. 2022).[11] It has been associated with a host of problems for children, including increased health problems, behavioral and mental health problems, and worse academic performance and social outcomes—all of which can affect children's positive development and their ability to reach their full potential (Gallegos et al. 2021; Gundersen and Ziliak 2014; Meisenheimer 2016; Thomas, Miller, and Morrissey 2019).

A major focus of public efforts to address this problem is to help children access nutritional meals in the nonparental settings they are cared for each day. This includes in child care settings through the Child and Adult Care Food Program (CACFP) as well as in schools through the National School Lunch Program and the School Breakfast Program. In this report, we focus on the former—CACFP—which reimburses child care programs for food costs for children. In 2022, CACFP helped pay for almost 1.8 billion meals for children in child care programs across the country.[12] CACFP is an entitlement program, meaning that children and providers who are deemed eligible will get supports. Participating in CACFP has been associated with a reduction in household food insecurity (Heflin et al. 2015), as well as increased consumption of milk and vegetables, and may reduce the likelihood that a child is overweight (Korenman et al. 2013).

This report focuses on a major gap in the CACFP's ability to reach children in nonparental care settings. Specifically, although it is allowed under CACFP law, most states choose to *not* extend CACFP eligibility to children cared for by small home-based child care providers and relatives who are legally exempt from their state's child care licensing requirements—providers we refer to as license-exempt home-based (LEHBCC) providers in this report. LEHBCC settings disproportionately care for many vulnerable children, including infants and toddlers, children with disabilities, children from immigrant families, families facing challenges affording child care, and families working nontraditional hours (NCECQA 2022; Schilder, Lou, and Wagner 2022).

However, even though states can choose to include these settings in their CACFP program under certain circumstances, it appears that relatively few do so and instead limit their CACFP supports to child care centers and licensed family child care homes. Although there is no official list of states that allow LEHBCC providers to participate in CACFP, conversations with experts suggest that they include California, Colorado, Illinois, Louisiana, New Mexico, New York, Oregon, and Washington.

To better understand the potential opportunities and challenges of extending CACFP to more of the millions of children cared for by LEHBCC providers, this report explores the following research questions:

- **What can we learn from select states who allow LEHBCC providers to participate in CACFP about what is and is not working?**
- **What can be done to expand these providers' participation?**

Our goal was to gain insights that may help other states who might consider expanding their CACFP program to support the nutritional needs of potentially millions of children in these child care settings.

To explore this question, we first spoke with people in a few states that did not allow LEHBCC providers to participate in CACFP to better understand the questions and concerns they might have about this topic, and we spoke with some national experts. We then identified three states that allow LEHBCC providers to participate in CACFP—Illinois, Louisiana, and Oregon.[13] In each state, we talked with people in the state agency administering CACFP as well as other state-level agencies responsible for approving CACFP providers, select people responsible for administering the program at the local level (sponsor agencies–referred to as "sponsors" hereafter), and other key experts. We also were able to gather some limited perspectives from LEHBCC providers, although more insights would be valuable. Given we only spoke with people in a few states, and with only one or two sponsor agencies within the states, our findings should be seen as providing insights into the research questions rather than conclusive or definitive statements about the CACFP agencies' experiences across states who support LEHBCC providers. We concluded our data gathering by sharing our preliminary insights with national experts to get their feedback on our findings as well as on promising policy options. For more information on our research methods, see the appendix.

The findings in this report provide some important insights into our research questions. However, many questions remain. We were not, for example, able to speak with many providers participating in these systems so do not have their full perspective. We also only spoke with one or two sponsors in each of our three states. As a result, our findings reflect the insights of the people we spoke with about

their perspectives on their states' efforts and should not be necessarily seen as reflective of other sponsors in our focal states or of all states who allowed LEHBCC providers to participate in CACFP. Our findings also focus on issues around policy and systems, and less specifically on providers' experiences. However, the latter is an important area of inquiry for future work in this area.

## What's in This Report

In this report, we first provide contextual information describing CACFP, license-exempt home-based child care providers, and CACFP rules about eligibility for these providers, and we describe LEHBCC providers and CACFP in our focal states. We then describe our key findings from what we learned from our three focal states about the challenges and opportunities involved in including LEHBCC providers in CACFP. We then discuss the policy implications of our findings and provide a few concluding remarks.

# Understanding the Basics

To contextualize this report's findings, we first briefly describe the CACFP program as well as some basic information about LEHBCC providers. We also describe what CACFP requires for LEHBCC providers to participate and provide a brief overview of how our three focal states handle LEHBCC providers in their CACFP programs.

## What Is CACFP?

CACFP is a federal nutrition program that reimburses child care providers (and other care settings) for some of the costs of providing nutritious meals to children in their care. As mentioned earlier, in 2022, CACFP helped pay for nearly 1.8 billion meals—breakfasts, lunches, dinners, and/or snacks—served to children in child care centers and family child care settings.[14] It is an entitlement program, which means that providers who are found eligible for benefits (because they meet the requirements and serve eligible children) have the right to receive them. The program is administered by the Food and Nutrition Service (FNS) at the US Department of Agriculture (USDA). States typically house CACFP administration in their state education department or state department of health and human services.[15]

To participate in CACFP, child care settings must either be licensed to provide child care or be "approved" through another mechanism that addresses basic health and safety standards.[16] As is described later in this report, states vary in whether they rely solely on state child care licensing rules—thereby limiting CACFP to licensed settings—or if they allow providers who are exempt from licensing to meet alternative approval standards that meet CACFP requirements for minimum health and safety.

Under federal law, any home-based child care program in CACFP must work with sponsors, which function as the interface between the state CACFP agency and provider. Sponsors for home-based child care programs and providers can be public or nonprofit organizations such as community organizations, school districts, county offices, or child care resource and referral agencies. Their responsibilities include

- identifying and recruiting providers;
- enrolling and training providers, and providing technical assistance to help providers become compliant with program standards (to the extent resources are available);
- conducting oversight and compliance monitoring, including announced and unannounced visits; and

- collecting information on meals provided to report to the CACFP state agency, as well as managing payments to providers.

Sponsors receive a set amount of reimbursement from CACFP to cover their administrative costs for these activities, with the amount per provider going down as the number of providers increases. Providers have to meet nutritional guidelines for their meals and report what they are feeding the children in their care. If their meals comply with the standards, they are reimbursed for meals at a rate set at the federal level. (More information on provider reimbursements is provided later.) Providers cannot participate in CACFP if they only care for children who live with them or only care for children in the children's home—though they can participate if they care for any children who do not live with them and can be reimbursed for all the children in their care.

## Who Are License-Exempt Home-Based Providers, and How Many Children Do They Care for?

As noted above, CACFP allows child care providers who are legally exempt from licensing rules to meet other "approval" standards to be eligible to participate in the program. Note that while we refer to these providers as license-exempt home-based (LEHBCC) child care, researchers and policymakers use various terms for this population, including family, friend, and neighbor (FFN) care and informal care. In this report, we are distinguishing LEHBCC providers from licensed family child care providers, or home-based providers that must be licensed under their state's laws or have chosen to be licensed.

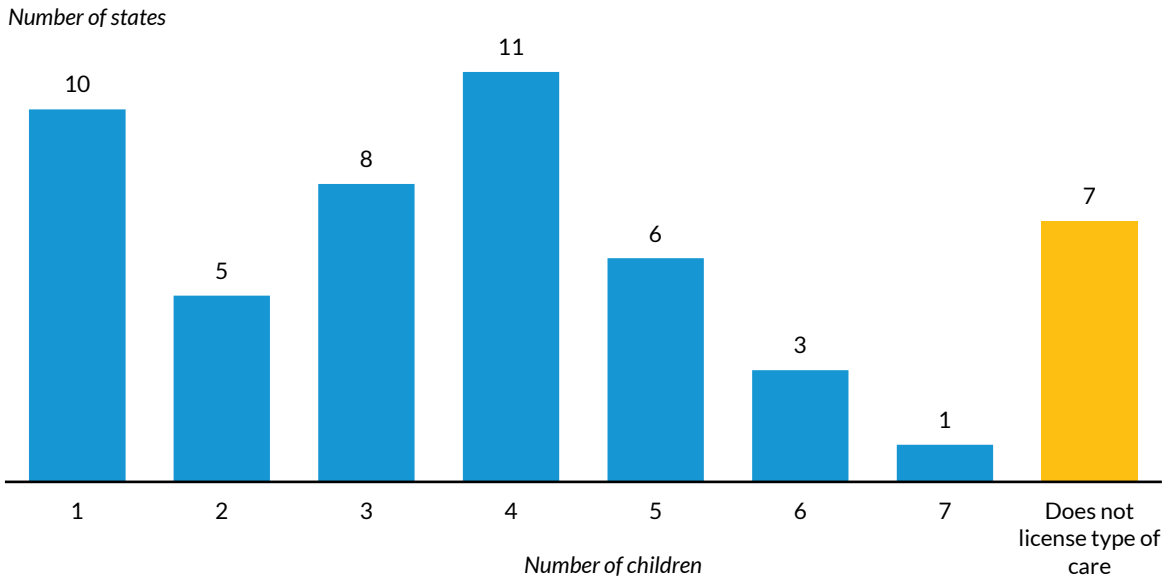
While often overlooked and excluded from policy discussions, LEHBCC providers play a critical role in caring for children in the US. To provide context for this report, there are a few key facts to understand about LEHBCC providers.

- **States vary in which home-based providers are exempt from licensing, so the size and composition of the LEHBCC sector varies widely across states.** While it is common for states to exempt care by relative caregivers who only care for children they are related to, they vary in the extent to which they also exempt providers caring for unrelated children in the provider's home (figure 1). For example, the following was true in 2020:
    - » Specifically, in the 10 states that require home-based providers to be licensed when serving even one unrelated child in the provider's home, LEHBCC providers would refer primarily to relative care.

» On the other hand, the majority of states set their licensing thresholds at three or four children, and a few set them at even higher levels. In these states, LEHBCC providers refer to a much larger swath of the home-based child care sector. For example, in 10 states, providers caring for as many as four children would qualify as LEHBCC providers (NCECQA 2022). This is likely to be a significant portion of the home-based child care sector in those states, though precise data are not available to examine this question. This reality means a home-based provider that is exempt from licensing in one state may well have to be licensed in another, and that the share of home-based providers who are excluded from CACFP because they are legally-exempt from licensing varies widely across states.

FIGURE 1

**Licensing Thresholds for Family Child Care Homes, 2020**




**Source:** NCECQA (National Center on Early Childhood Quality Assurance), "Trends in Family Child Care Home Licensing Requirements for 2020: Brief #2" (Washington, DC: Office of Child Care, 2015), https://childcareta.acf.hhs.gov/sites/default/files/new-occ/resource/files/fcch_licensing_trends_brief_2020_final.pdf.
**Notes:** Seven states—Arizona, Idaho, Indiana, Louisiana, New Jersey, Ohio, and South Dakota—do not license family child care homes. According to the source document, most of these states license home-based providers that meet the definition of a group child care home, while Louisiana, New Jersey, and South Dakota do not have mandatory licensing requirements for any home-based providers, whether defined as a family child care home or a group child care home.

- As a result, policies directed toward LEHBCC providers need to recognize the potential variation in their motivations and incentives and not treat them as a homogeneous group. For example, strategies focused on incentivizing providers to become licensed may be more effective for providers serving four-to-five children in their home (if the incentives are strong

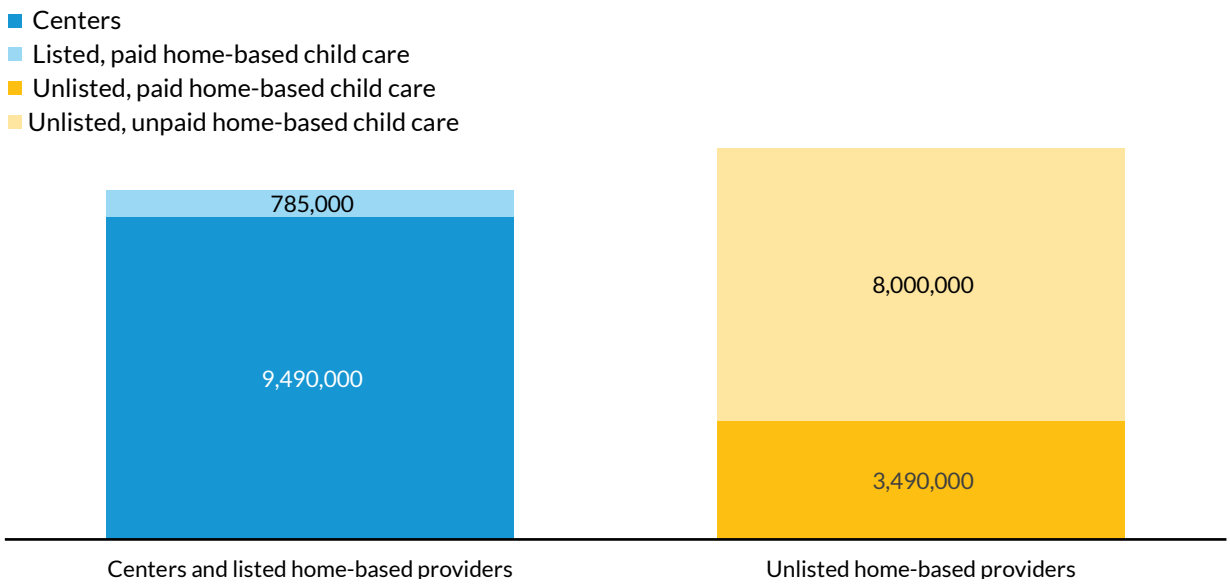
enough and barriers to becoming licensed are reduced) and who may see caring for children as a potential career, than it would be for relatives who are primarily caring for children to help out family members (NSECE 2021b; Schochet et al. 2023). On the other hand, while relatives may not be interested in professional development or becoming licensed, as they do not see themselves as professionals or running a business, they may be quite interested in learning how to better support the children's healthy development and nutrition (Bruner and Chase 2012; Le et al. 2018).

- The National Survey of Early Care and Education found that in 2019 11.5 million children were cared for in home-based settings that were *not* on state licensing or other lists (NSECE 2021b), which is roughly a million more children than the 10.5 million children cared for by child care centers and listed or licensed home-based providers (NSECE 2021a). While not being on state licensing or other lists is not exactly the same as being exempt from licensing, it is a fairly good approximation. Of these 11.5 million children, 3.5 million were with unlisted home-based caregivers who were paid, and 8 million were with unlisted home-based caregivers who were unpaid (most of whom have a prior relationship with the family) (NSECE 2021b; see figure 2).

  The precise number of children who could be made eligible for CACFP within the 11.5 million children in LEHBCC settings is unclear. We know that most of the 3.5 million children in paid unlisted or unlicensed home-based settings would likely be eligible. However, the 8 million children cared for by unpaid home-based providers can include children cared for by family and friends who may or may not live with them. Those who do live in the same household as the children they care for would only potentially be eligible for CACFP if they also cared for some children outside of the household. However, even if we only count those in paid LEHBCC settings, there potentially would be several million children who could be eligible.

FIGURE 2

**Number of Children Younger Than Age 13 Served in 2019 by Type of Child Care Provider**




**Source:** Based on data from the 2019 National Survey of Early Care and Education (NSECE 2021a; 2021b).
**Notes:** Listed providers refers to home-based providers who appear in national or state lists of early care and education services, which can include licensed or regulated providers as well as license-exempt providers that may be part of a public system. Unlisted paid providers refers to providers who did not appear on state or national lists but were reported to care for children other than their own for at least 5 hours a week in a home-based setting and received payment for at least one child in their care. Unlisted unpaid providers are similar to unlisted paid providers, except they do not receive payment for children in their care and include caregivers who are family and friends who may live in the same household as the children they regularly look after (NSECE 2021b).

- LEHBCC or unlisted home-based providers are disproportionately used by families who may face other challenges accessing care that meets their needs and/or who may find this form of care is the best for their child. LEHBCC providers are used by many families but seem to be used at even higher rates by several vulnerable populations. These include families with infants and toddlers, families with children with disabilities, immigrant families, families facing challenges affording child care, and families working nontraditional hours (NCECQA 2022; Schilder, Lou, and Wagner 2022). This suggests that identifying ways to support these providers in accessing CACFP could be an effective way to get nutrition resources to children and families that may particularly benefit from nutritional supports.

# CACFP and License-Exempt Home-Based Providers

Understanding what CACFP requires for LEHBCC providers to participate and how states that allow these providers to participate fulfill these requirements is also important context for the findings in this report. Each is addressed below.

- **What does CACFP require in terms of approving LEHBCC providers to participate?** CACFP rules require that for child care programs to participate, they must meet federal, state, or local child care licensing or approval standards, CACFP standards, or alternate standards that can be established by the sponsor under certain conditions as allowed by the state agency.[17] Interestingly, under federal CACFP requirements, states have wide discretion in what they establish as "approval" requirements for LEHBCC providers. The USDA has clarified that in cases where the state does not have licensing standards in place, as is the situation for LEHBCC providers, they can set standards that "define what is an acceptable care environment," and that evaluating the setting against these standards can "range from onsite reviews of facilities by licensing/approval officials to a review of a self-certification checklist."[18] States are not, however, allowed to use CACFP funds to implement or monitor compliance with licensing or other standards, though sponsor agencies can provide some assistance to providers on a one-time basis to help them address deficiencies in licensing.[19]
- **What do we know about the extent to which states allow LEHBCC providers to participate in CACFP?** Although we were unable to find any formal compilation of data on this, conversations with experts suggest that there may be as few as eight states who allow LEHBCC providers to participate in the program despite being permitted to do so under federal law. These states include California, Colorado, Illinois, Louisiana, New Mexico, New York, Oregon, and Washington. Generally, it appears that the most common approach in these states is to leverage the approval process used by the CCDF to approve LEHBCC providers for subsidy payments as their approval mechanism for CACFP. However, as of summer 2023, we had identified two states that use an alternative approach—Louisiana, which relies on the fire marshal to conduct inspections for CACFP standards (described in more detail below), and California, which allows LEHBCC providers to participate in CACFP by undergoing criminal background checks with the state registry system called Trustline, submitting a self-certification health and safety checklist and signing up with a CACFP sponsor.[20]

  It is also difficult to find data on the number of LEHBCC providers who participate in CACFP in these states. However, in 2019, only an estimated 17.8 percent of all of the paid unlisted home-based providers reported receiving any reimbursement from *any* government program,

including CACFP (NSECE 2021b).[21] These were all among paid unlisted providers, suggesting there is a sizeable share of paid unlisted providers who could potentially benefit, as well as an unknown share of unpaid, unlisted providers.

## Understanding Our States

In this study, we focus on three states: Illinois, Louisiana, and Oregon. While each state is unique, generally we found more commonalities between Illinois and Oregon than with Louisiana. Some key characteristics of our states are described below and summarized in table 1.

- **What is the incidence of child food insecurity in our three states?** Both Illinois and Oregon had child food insecurity levels similar to the national average, with roughly one in eight or nine children (11.3 percent or 315,330 children in Illinois and 12.4 percent or 106,000 children in Oregon) living in households with food insecurity, respectively. In contrast, child food insecurity levels were significantly higher in Louisiana, where more than one in five children (21.6 percent or 234,120 children) were living in households with food insecurity.[22]
- **Which home-based providers are exempt from licensing in our three states?** The states varied somewhat in which home-based providers were exempt from licensing:
  - » Illinois exempts providers serving three or fewer children, including the provider's own children, with at least one child being from a different family.[23]
  - » Oregon exempts providers serving three or fewer children, *not* including the provider's own children.[24]
  - » In contrast, Louisiana exempts home-based settings serving six or fewer children, including the provider's own children. Further, unlike Illinois and Oregon, home-based providers serving seven or more children are licensed as centers.[25]

  As a result, LEHBCC providers make up a larger portion of the home-based child care sector in Louisiana than in the other two states.
- **Who manages CACFP in the state?** In all three states, CACFP was managed by the agency that managed education for the state—specifically the Illinois State Board of Education, the Louisiana Department of Education, and the Oregon Department of Education. At the time of our interviews, they varied in the number of sponsors in the state—specifically, there were 10 in Illinois, 26 in Louisiana, and 3 in Oregon. (Home-based providers are not allowed—under federal rules—to participate in CACFP without a sponsor.)

Our interviews suggested that our states varied in the likelihood that providers would have access to sponsors. For example, in Louisiana, providers in every parish had access to at least two sponsors, whereas in Oregon respondents told us that there were gaps, particularly in the eastern part of the state, which is more rural. As a respondent in Oregon noted, "There are plenty of providers that aren't being served because our sponsors just aren't big enough, we don't have enough capacity to go to other counties."

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*There are plenty of providers that aren't being served because our sponsors just aren't big enough, we don't have enough capacity to go to other counties.*
*—respondent in Oregon*

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- **What approach does each state use to approve LEHBCC providers to participate in CACFP?** Our states differed significantly in how they chose to approach "approving" LEHBCC providers to comply with CACFP approval requirements:
  - » **CCDF approval.** Illinois and Oregon both relied on CCDF approval processes to determine which LEHBCC providers were eligible for CACFP. As is described in more detail later in this report, these federal requirements include trainings, annual home inspections, and comprehensive criminal background checks for all adults in the household who may come into contact with children, though states may waive some or all of these requirements for relative caregivers.[26] In both Illinois and Oregon, the CCDF approval process was managed by the state department of human services that manages the CCDF subsidy program, which in Illinois is the Child Care Assistance Program and in Oregon is the Employment Related Day Care Program. Thus, in these states, CACFP is only available to the subset of LEHBCC providers serving families who need help paying for care and are able to get a CCDF subsidy, meet CCDF provider health and safety requirements and are approved to be paid by the subsidy program, and meet CACFP eligibility and enrollment requirements.
  - » **Fire marshal approval.** In contrast, Louisiana relies on a fire marshal inspection to approve providers for CACFP. Specifically, any LEHBCC provider who is interested in participating in CACFP has to meet a set of child care standards that the state CACFP agency established with the fire marshal's office, which includes basic health and safety measures. This approach means that any home-based provider in the state who is caring for children

in her home, whether paid or unpaid, can access CACFP if they pass the fire marshal inspection and meet CACFP eligibility and enrollment requirements.

Once a provider is approved to operate as an LEHBCC provider in each state, they can begin the process of onboarding onto CACFP, which includes signing an agreement between the sponsor and the provider, completing training sessions, and the sponsor conducting an inspection. Once approved for the program, a provider can begin reporting meals served, documenting menus, and submitting requests for meal reimbursements through the sponsor.

TABLE 1

**Key Characteristics of Illinois, Oregon, and Louisiana: Incidence of Child Food Insecurity and CACFP Policies toward LEHBCC Providers**

| | Illinois | Oregon | Louisiana |
|---|---|---|---|
| **What share and how many children are living in food insecure households in 2021?** | 11.3%<br>315,330 children | 12.4%<br>106,470 children | 21.6%<br>234,120 children |
| **Which HBCC providers are exempt from licensing?** | Exempts providers serving three or fewer children, including the provider's own children, with at least one child being from a different family | Exempts providers serving three or fewer children, not including the provider's own children | Exempts home-based settings serving six or fewer children, including the provider's own children; home-based providers serving seven or more children are licensed as centers |
| **Who manages CACFP in the state?** | Illinois State Board of Education | Oregon Department of Education | Louisiana Department of Education |
| **What approach is used to approve LEHBCC providers to participate in CACFP?** | Approval process for the child care subsidy system (CCDF) | Approval process for the child care subsidy system (CCDF) | CACFP approval process involving fire marshal inspection |

**Sources:** Data on child food insecurity are from "Food Insecurity among Child (<18 years) Population in the United States," Feeding America, accessed August 31, 2023, https://map.feedingamerica.org/county/2021/child, using state level estimates of child food insecurity rates. Data on thresholds for licensing were collected from the Illinois Department of Children and Family Services, the Oregon Department of Human Services, and the Louisiana Department of Education. Information on who manages CACFP in each state and what the approval process is for license-exempt providers was collected from the Illinois State Board of Education, the Oregon Department of Education, and the Louisiana Department of Education.

- **What do we know about the LEHBCC providers served in CACFP in each state?** Data on LEHBCC provider participation in CACFP are not available from the USDA because the program data does not differentiate between licensed and unlicensed providers; instead, all home-based providers (licensed and unlicensed) are counted as "family child care homes." It was also challenging to get state-level data. However, our analysis suggests some important

differences between the population of LEHBCC providers who are eligible for CACFP in Illinois and Oregon on the one hand and Louisiana on the other.

The differences in licensing exemptions and the CACFP approval mechanisms described above result in significantly different LEHBCC populations being eligible for CACFP across these states:

» A much larger share of Louisiana's home-based child care sector is exempt from licensing than in Illinois and Oregon, and thus is potentially eligible. Further, eligibility is not limited to providers who are paid, as any home-based provider serving fewer than seven children in Louisiana can be eligible if they pass the fire marshal inspection. As described earlier, nationally there are more than twice as many LEHBCC providers who are unpaid than are paid, suggesting that this aspect of Louisiana's approach results in a significant expansion in the LEHBCC population eligible for CACFP.

» In contrast, significantly smaller shares of home-based providers are eligible for CACFP in Illinois and Oregon. Part of the reason for this is that a smaller share of the overall home-based provider sector is exempt from licensing in these states, because they both only exempt providers serving three or fewer children from being licensed. Another part is because CCDF is a program that helps parents pay for child care (so is only relevant for paid providers); conditions eligibility on the provider serving a child whose parent meets work or education and income requirements as well as the provider meeting a set of CCDF standards; and only has funds sufficient to serve a fraction of eligible families. As a result, the share of LEHBCC providers that are approved for CCDF subsidies in Illinois and Oregon—and therefore could potentially be eligible for CACFP—is a relatively smaller subset of all LEHBCC providers in the state.

In addition, information from our respondents suggests that CACFP LEHBCC caseload trends are quite different across the three states. For example, sponsors in both Oregon and Illinois suggested declines over the past decade, with one respondent suggesting that this was at least in part because of the more stringent health and safety requirements for LEHBCC providers established by the 2014 Reauthorization of CCDF,[27] which then reduced the eligible pool for CACFP. In contrast, in Louisiana the number of participating LEHBCC providers has stayed steady and increased slightly in recent decades.[28] Note that while the number of licensed family child care providers has declined significantly nationwide, the number of unlisted home-based providers has remained relatively consistent (NSECE 2021b), so these patterns seem unlikely to be related to a change in the overall LEHBCC population.

# What Did We Learn?

Our conversations with key stakeholders in the three states—including people involved in administering CACFP at the state level, sponsors, those involved in other aspects of the program, and other experts—provided the following insights:

- Supporting LEHBCC providers' participation in CACFP is valued in our states but not consistently prioritized.
- LEHBCC providers face barriers to CACFP enrollment, with reliance on CCDF approval adding complexity.
- LEHBCC providers face barriers to stable participation.
- LEHBCC barriers to enrollment and retention in CACFP have implications for equitable access to nutrition supports for children at risk of food insecurity.
- Delinking CACFP eligibility from CCDF could broaden and stabilize LEHBCC provider participation.
- Sponsors can face challenges serving LEHBCC providers.
- CACFP's financing and rate structure does not adequately support working with LEHBCC providers.

Each of these insights are explored more below.

## Supporting LEHBCC Providers' Participation in CACFP Is Valued in Our States but Not Consistently Prioritized

In our interviews, all respondents described the importance of LEHBCC providers in caring for children in their state, and many—particularly those in CACFP—reflected on the importance of enrolling these providers in CACFP. Below we describe their insights on the role of LEHBCC providers in the child care ecosystem, the history of their involvement with CACFP, and the impact of their engagement in the program. Overall, respondents felt that LEHBCC providers are an important way to reach more families and support child nutrition using CACFP funds.

## LEHBCC Providers Are Seen as an Important Part of the Child Care Ecosystem in These States Though Not Uniformly a High Priority for CACFP

Most respondents in our states viewed LEHBCC providers as critical parts of the child care ecosystem who support families and children, and many saw these providers as a critical way to provide food and nutrition services to children in need. Note that these perspectives are not surprising given these states have chosen to support these providers in their CACFP program and because we chose states that our project advisors suggested had a history of supporting LEHBCC providers. As such, LEHBCC providers may be more of a priority in these states compared with others.

Across all three states, respondents shared that LEHBCC providers are especially critical for children in families who struggle to afford child care. In Louisiana, one respondent referred to these providers as a "hidden gem," noting that "in some instances they take kids that are harder to care for, kids who cannot pay for child care." A respondent in Oregon told us, "I see [Department of Human Services (CCDF-approved LEHBCC)] providers in Oregon become a safe place for those kids and an opportunity to have some form of normalcy."

Despite these positive perspectives, some variation was apparent in the extent to which LEHBCC provider participation in CACFP was uniformly a statewide priority across the three states. For example, respondents in Illinois and Oregon suggested that LEHBCC providers were not necessarily a priority for all sponsors across the state because of various challenges, in part related to the system's reliance on CCDF for determining provider eligibility and on CACFP's funding approach (described more in later sections). This is in contrast to the perspectives of respondents in Louisiana, where any LEHBCC provider is eligible for the program if they meet the fire marshal inspection, which means there is a much larger potential pool of providers to recruit and there are fewer barriers to enrollment and retention. Key informants reported that all sponsors in the state actively recruit LEHBCC providers as they are their main clients for CACFP. It appears that actively supporting LEHBCC provider participation in CACFP was more uniformly a priority across the state in Louisiana compared with Illinois and Oregon.

## LEHBCC Providers Have Been Part of CACFP for Decades in These States

Across the three states, LEHBCC providers have been a part of the system for decades, with most respondents noting that LEHBCC providers started participating in CACFP before their time. The few that were present for these early discussions shared that LEHBCC provider participation in CACFP began as a conversation among a few people interested in nutrition, namely at the state agency, who

wanted to reach more HBCC providers with the program. Few respondents recalled any controversy around including these providers in the program, though in Illinois one participant noted some initial pushback to their participation, and in Oregon we heard from a sponsor that some providers did not think LEHBCC providers should be able to participate because they did not have to follow the same rules licensed providers did.

## LEHBCC Provider Participation in CACFP Is Seen as Having Many Benefits

Across the three states, respondents shared five main benefits of LEHBCC provider participation in CACFP:

- **Supporting children's access to healthy food.** Respondents shared that, for LEHBCC providers, participating in CACFP was critical to getting food and better nutrition to children who needed it. Generally, respondents across the states agreed that providers would feed children with or without the program but that having access to CACFP enhanced a provider's ability to feed children nutritious foods, particularly for providers with fewer resources who otherwise would not be able to afford it. As a respondent in Louisiana told us, "I've had providers tell me before this program I was never able to buy these children milk. They tell me before this program, I've never been able to buy a fresh fruit for these kids."

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*I've had providers tell me before this program I was never able to buy these children milk. They tell me before this program, I've never been able to buy a fresh fruit for these kids. —respondent in Louisiana*

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- **Building providers' knowledge about nutrition, with a ripple effect on the family and other families.** The nutrition education component was touted by respondents across all three states as a benefit for providers. Participating in CACFP requires training on "My Plate" (formerly the "food pyramid"), how to read nutrition labels, and information on foods that support children's healthy growth and development.[29] Respondents shared that by supplying providers with this information, they were more empowered to make decisions about healthy foods to serve children. One respondent from Illinois noted, "I'm constantly impressed by the [license-exempt]

providers I talk to that have learned so much about nutrition from the program….the relatives are so happy that their grandkids are getting a good meal."

Respondents also described how this can have broader benefits. A Louisiana respondent talked about seeing "the payout in the years to come for the children." Other respondents described the impact for other children the providers may care for in the future, and still others described the impact on other families. For example, a respondent in Illinois said there's "an impact on health and families. Both the families of providers and the kids in their care. The more the core family is learning, it gets passed off to other families."

*I'm constantly impressed by the [license-exempt] providers I talk to that have learned so much about nutrition from the program….the relatives are so happy that their grandkids are getting a good meal.*
*—respondent in Illinois*

- **Reducing financial burden on providers to cover the cost of food.** Respondents highlighted the program's ability to financially assist providers in paying for food who otherwise would likely have to pay out of pocket for the food they serve while providing care. One respondent underscored that CACFP is a reimbursement meal program so is simply reimbursing providers for some of their expenses and does not involve the provider making any profit. This was particularly an issue in Louisiana, where CACFP could help providers who were not paid by the parents. As one respondent said, "Some are getting no tuition, some do bartering….It's not a profit for them. A lot of times they aren't getting funds from the individuals they are caring for. It's a break even for some of them, or for some it's still at a loss."

*Some are getting no tuition, some do bartering….It's not a profit for them. A lot of times they aren't getting funds from the individuals they are caring for. It's a break even for some of them, or for some it's still at a loss.*
*—respondent in Louisiana*

- **Improving the health and safety of the home care environment.** Respondents noted that because CACFP eligibility is contingent on meeting basic health and safety requirements, the safety of the physical care environment is an important component of program participation. For example, a respondent from Louisiana emphasized the role of the fire marshal inspection for CACFP, which ensures that smoke detectors are in every room and noted that program participation helps providers pay for fire extinguishers, refrigerator thermometers, and other safety precautions if the provider cannot afford them. For these providers, participating in CACFP meant ensuring that their home care environments had basic safeguards for children, which was another benefit of the program. As one provider said, "When I go into a potential provider's home, I tell them, even if you don't decide to get into the program, you should still make your home safe. This is a food program but you have to make your home safe....our fire marshals want a fire alarm in every sleeping bedroom...they look for safety and electrical requirements....We take pride in that because we are...making it safe for children in the home."

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*When I go into a potential provider's home, I tell them, even if you don't decide to get into the program, you should still make your home safe. This is a food program, but you have to make your home safe….our fire marshals want a fire alarm in every sleeping bedroom….they look for safety and electrical requirements….We take pride in that because we are…making it safe for children in the home.*
*—respondent in Louisiana*

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- **Reaching children who otherwise would not get support**. The final benefit was noted by respondents in Louisiana, where CACFP was going to a much broader group of providers and children, including many who otherwise would be unlikely to get any public support—either to support better nutrition or make their homes safer. As one respondent put it, "They are going to raise their grandbabies with or without us...they are going to feed children no matter what....maybe they could only provide vegetables but now could do the fruit."

*They are going to raise their grandbabies with or without us…they are going to feed children no matter what….maybe they could only provide vegetables, but now could do the fruit. —respondent in Louisiana*

A Louisiana respondent reflected many of these points when they said, "[Without CACFP] what's going to happen to those other kids? They'll still be kept, but the providers will go underground, I mean, we're talking poor people. No fire extinguisher—which is $50—they won't have smoke detectors, but mainly they aren't going to have the food."

*[Without CACFP] what's going to happen to those other kids? They'll still be kept, but the providers will go underground, I mean, we're talking poor people. No fire extinguisher—which is $50—they won't have smoke detectors, but mainly they aren't going to have the food. —respondent in Louisiana*

## LEHBCC Providers Face Barriers to CACFP Enrollment, with Reliance on CCDF Approval Adding Complexity

The process for CACFP enrollment and participation for LEHBCC providers requires multiple steps and is different in Illinois and Oregon (because of their reliance on the CCDF approval process) than in Louisiana (which relies on the fire marshal inspection). The mechanism that states rely on to establish CACFP eligibility has significant implications for which providers are eligible, the sponsor's role in provider recruitment, and providers' ability to maintain their enrollment in the program over time. It also affects the number and complexity of barriers to CACFP enrollment and participation for LEHBCC providers. Generally, relying on CCDF approval processes appears to add a number of steps and barriers for providers in Illinois and Oregon that are not the case in Louisiana.

Below we describe the steps involved in being eligible for and becoming enrolled in CACFP—first in Illinois and Oregon and then in Louisiana. As shown below, there are many more conditions that narrow

down the potential pool of eligible providers in Illinois and Oregon than is seen in Louisiana. These steps are summarized in figure E.2.

## CACFP Entry Process for LEHBCC Providers in Oregon and Illinois

Both Oregon and Illinois use the CCDF approval process to satisfy federal CACFP requirements for LEHBCC providers to be "approved," which means several steps must occur before CACFP participation is a possibility. The first set of requirements is for CCDF qualification, and some of them have to do with the characteristics of parents the provider serves or seeks to serve. Although our study did not examine the CCDF processes in Illinois and Oregon in depth, we first summarize the general CCDF steps below. We then summarize the steps specific to CACFP.

### REQUIREMENTS FOR CCDF QUALIFICATION

- **Parents must need help paying for child care.** The first step is that parents must need help paying for child care, which would incentivize them to apply for child care assistance from CCDF. This step results in the first significant reduction in the population of LEHBCC providers who are likely to be eligible for CACFP in these states—specifically, as noted earlier, 8 million of the 11.5 million children cared for by LEHBCC providers are cared for by providers who are unpaid. The parents using these unpaid caregivers are less likely to have the incentive to jump through the hoops needed to apply for and access a subsidy.
- **Parents need to know about CCDF, believe that they can get help from it if they apply, and see the benefit of doing so as outweighing the cost.** While specific data are not available on this issue from Illinois and Oregon, research suggests that there are many reasons parents who need help paying for care may not apply for subsidies even they need help paying for child care. They may not know about the program, may not believe they could get help or would be eligible, or feel that the level of assistance they could get is not worth the cost of going through the application process (Adams and Dwyer 2021; Adams and Pratt 2021: Lee et al. 2022).
- **Parents must be able to qualify for and receive a CCDF subsidy.** If they do know about the program and apply, the next hurdle is that the parent must be able to get through the application process and prove their eligibility. Eligibility requirements include documenting that their income falls below state eligibility guidelines, that they are working or in school or meet other eligibility requirements, and that their children are younger than 13 (Adams and Matthews 2013). Although not specific to Illinois and Oregon, research suggests that state application processes and procedures can be difficult and burdensome for parents, making it sometimes difficult to prove

their eligibility even if they are eligible (Adams and Matthews 2013; Adams, Snyder, and Banghart 2008).[30] And even if they are found eligible, funds must be available to serve them. Of note, nationwide only one in six children whose families are eligible for CCDF subsidies under federal rules are actually served, because of funding limitations, which underscores the relatively small number of eligible parents who ultimately participate in the program.[31]

- **The provider must apply to be an approved provider for CCDF, be willing and able to meet CCDF approval requirements, and be approved.** If the parent gets a subsidy, the provider has to then apply and be approved by the state's CCDF agency. (While possible in Illinois and Oregon, many states do not report having any LEHBCC providers in their subsidy system who could potentially qualify for CACFP.)[32]

  To be approved for CCDF, LEHBCC providers have to meet health and safety requirements established under the 2014 CCDF reauthorization, which include preservice training, comprehensive criminal background checks for every adult in the household who might come into contact with the child, and annual in-person home inspections.[33] (States have some flexibility in how they implement these requirements and are allowed to waive some or all of these requirements for relatives.) Note that these requirements are designed to support CCDF's goals around child care; it is not clear that they are essential for a program focusing on supporting access to healthy meals for children. Our two states have the following requirements:

  - In Oregon, to qualify for CCDF payments, LEHBCC providers must become "DHS-listed" by being approved by the Department of Human Services (DHS). To become DHS-listed as a nonrelative provider, providers must complete the Child Care Provider Listing form, complete the DHS health and safety and child abuse trainings, undergo a background check, meet water-testing requirements, and have annual in-person inspections and trainings. Relative providers are waived for the water-testing requirements and must only complete the health and safety trainings. CCDF approval expires within 6 to 12 months if the provider stops submitting claims showing they have cared for a child in the CCDF program.
  - In Illinois, the process and requirements to receive approval are similar to those described above for Oregon, though nonrelative providers must also submit additional documentation, including a state ID card or driver's license and a copy of their Social Security card. CACFP approval expires within three months after the last CCDF claim is submitted.

  While provider experiences with meeting CCDF requirements were not this study's primary focus, previous research suggests that providers may not always be able or willing to fulfill these requirements (Adams and Dwyer 2021). For example, relative caregivers may not want or be able

to participate in training activities that may be designed for professional child care providers. These requirements may disproportionately affect access for populations who have experienced barriers to opportunity. For example, providers from communities with histories of unjust policing resulting in criminal justice system involvement or who may have family members who are undocumented immigrants may not want to deal with comprehensive criminal background checks or having government officials coming into their homes (Adams and Pratt 2021). Further, the relatively low subsidy payment rates that states pay for LEHBCC providers may not provide sufficient incentive (Adams and Dwyer 2021). Respondents in Illinois and Oregon noted these challenges, flagging issues such as the background check, home visits, and low subsidy payment rates as all contributing to providers not going through the process.

#### REQUIREMENTS FOR CACFP QUALIFICATION

- **Provider must learn about and enroll in CACFP.** Finally, once the previous conditions are met, the provider needs to learn about and—if interested—enroll in CACFP. In Illinois and Oregon, this takes place in the following steps:
  - » The CCDF agency shares a list of approved providers with the CACFP agency or sponsors. For example, in Illinois, every month the sponsors receive a list from the Illinois State Board of Education of the providers in their service area who have undergone the CCDF approval process and are therefore eligible for enrollment in CACFP. In Oregon, the process is similar.
  - » In both states, the sponsors can then reach out directly to the provider to explain CACFP, outline enrollment requirements, and gauge their interest in participating.
  - » If the provider is interested, the sponsor works with the provider—usually through an in-person visit—to review the application process, explain the program and reporting requirements, answer questions, and so forth.
  - » The sponsor then works with the provider to submit their application and paperwork.

When assessed cumulatively, the steps in the preceding pages make it clear that relying on the CCDF system to approve providers for CACFP is likely to result in a relatively small subset of all LEHBCC providers in the state being eligible and approved for CACFP.

## CACFP Entry Process for LEHBCC Providers in Louisiana

In Louisiana, the process is very different than in Illinois and Oregon, as the approval process is designed for and integrated in the CACFP eligibility and enrollment process and is *not* conditional on the parent

needing paid care and qualifying for a subsidy; and enrollment is open to a much broader range of the LEHBCC sector. **This results in a fundamental difference between the CCDF approval approach taken by Illinois and Oregon and that taken by Louisiana; in Louisiana, almost all LEHBCC providers, paid or unpaid, can be eligible for CACFP.** The only LEHBCC providers who would not be eligible in Louisiana are those caring for children in the children's home or only caring for their own children. This results in a larger potential pool of LEHBCC providers than in Illinois and Oregon. It is also notable that *unpaid* LEHBCC providers make up the largest group of LEHBCC providers nationally. If this approach were taken nationwide, CACFP would be available to some share of the 8 million children nationwide in unpaid unlisted settings, meaning they would potentially be eligible to receive nutritious meals and snacks from their child care provider who would now be supported with those grocery bills. Further, as noted earlier, Louisiana exempts many more home-based child care providers from being licensed, as the threshold for having to be licensed is set at seven or more children, so this potential pool is a large swath of the overall home-based child care sector in Louisiana.

- **Providers learn about CACFP through agency outreach and word of mouth.** Respondents reported that the majority of providers become aware of CACFP after seeing flyers or advertisements or hearing about the program from another provider and then reaching out to a sponsor directly. Some sponsors do outreach to raise awareness about the program, including advertising in newspapers and attending back-to-school events. These activities are paid out of administrative funds as an allowable cost. This broad sponsor outreach and word-of-mouth approach is likely to be particularly effective in Louisiana, given the large number of current participants and the large number of potentially eligible providers.
- **Once a provider expresses interest, the sponsor does an initial CACFP training and helps them apply and get their home into compliance and approved by the fire marshal.** In Louisiana, if a provider expresses interest in participating in CACFP, the following steps take place:
  - » If the provider contacts the state, the provider is given a list of sponsors that operate in their parish and they choose a sponsor to work with.
  - » The sponsor will make an appointment to visit the home to conduct a preliminary training and provide them with information about the program. This includes reviewing the application and introducing them to the software system they use for reporting meals. If the provider wishes to enroll, the sponsor will help them prepare the paperwork.
  - » The sponsor works with them to bring their home into compliance with the fire marshal safety requirements. The sponsor will inspect the home using the same sanitation and safety checklist used by the fire marshal and help the provider get the basic equipment necessary to

be in compliance (i.e., a refrigerator thermometer, safety plugs, fire extinguisher, smoke detector). If needed, they will help cover the costs—as one respondent reported, "We have provisions to help them get the materials. The materials cost about $120."

- Once the sponsor confirms the home meets the fire marshal safety requirements, the sponsor submits the paperwork to the fire marshal's office to schedule an inspection, which costs $30, paid by the provider.
- When the provider has passed the fire marshal inspection, the sponsor is notified via an online system whether or not the provider passed. Once approved, the sponsor submits the provider's paperwork to the Louisiana Department of Education, who has two weeks to call and conduct a phone interview to ensure their meal times, meal plans, and participation align with the paperwork. Providers must produce a driver's license and a Social Security card during the enrollment process. According to one sponsor, the process takes approximately 60 days from start to finish.
- To stay in the program, LEHBCC providers are required to receive an annual safety inspection, with the fire marshal inspecting every three years and the sponsor inspecting on the off years. (This is in addition to the CACFP related to ongoing monitoring that takes place throughout the year, described more below.)

## Enrolling in CACFP

Our respondents reported that the CACFP enrollment process primarily involved the sponsor helping the provider understand the rules, paperwork requirements, and processes for getting set up with the systems used for reporting meals and meeting other requirements. The sponsors we spoke with described taking time with providers to help them; as an Illinois respondent described it, this involved going through a "big binder of information; we sit them down and go through it page by page....we can work through it because we get the goal...you're going to get money and we'll make it easy for you."

While we had limited information directly from providers, sponsors and CACFP agency respondents described the process as being relatively straightforward, although they also discussed the administrative burden for providers as sometimes resulting in LEHBCC providers deciding it was not worth it. Earlier research we conducted on this topic found that some providers—particularly those who are less familiar with working with government agencies and those who face language or literacy barriers—may find this part of the process more challenging (Adams and Hernandez-Lepe 2021). Understanding more about provider experiences in this process is an important area of additional exploration.

# LEHBCC Providers Face Barriers to Stable Participation

Once providers are enrolled in the program, maintaining enrollment is key to consistently supporting child nutrition. Yet respondents reported provider retention challenges because of the demands of ongoing participation in CACFP, and respondents in Illinois and Oregon highlighted the additional retention challenges because of provider eligibility being tied to CCDF approval and participation. These issues resulted in LEHBCC providers being perceived as having higher turnover rates than licensed home-based providers in these two states; respondents in Louisiana did not serve licensed home-based programs and so did not have a comparison.

## Enrollment and Retention Challenges Related to CACFP Participation

Some challenges respondents highlighted that made it more difficult to enroll or retain providers in CACFP were specifically related to CACFP policies or requirements:

- **How much reimbursement providers receive.** CACFP reimbursement levels for meals can be a disincentive for providers to enroll or stay in the program. Providers are reimbursed for meals served to children in their care at a rate set at the federal level. There are two tiers of reimbursement for home-based child care:
  - » A provider can get a higher Tier I rate for all the children in her care if she lives in a geographical area with low incomes or if she has low income, or she can get the higher rate for individual children from families with low incomes. If she is Tier I, she can also get this rate to help cover meals for her own children as long as she has proven eligibility and is serving other children as well.
  - » Otherwise she would get the Tier II level, which is a significantly lower payment (about half), and her own child's meals and snacks cannot be claimed for reimbursement.
  - » In the 2023–24 school year, the rates for homes in the contiguous US were, for example, $1.65 for Tier I and $0.59 for Tier II for breakfast, and $3.12 for Tier 1 and $1.88 for Tier II for lunch and dinner.[34]

  Respondents and experts noted a number of challenges with current reimbursement rate levels and approaches:

  - » Reimbursement levels overall, and particularly for Tier II, are insufficient to cover what providers pay out of pocket to feed children in their care. In 2021, for example, the average

cost of a meal for a food-secure family was estimated $3.59 nationwide (Hake, Engelhard, and Dewey 2023) and is likely even higher now because of inflation.

- » Reimbursement rates do not reflect differences in the cost of living, with the result that providers living in higher-cost areas have even less of their costs covered. In 2021, for example, the average cost of a meal for a food-secure family ranged from $2.73 to $7.89 across the country (Hake, Engelhard, and Dewey 2023).
- » Because CACFP follows a reimbursement model, providers must first pay out of pocket and wait to be reimbursed, which can cause a cash flow problem.[35]

Nonetheless, the reimbursements are important for providers. An LEHBCC provider in Oregon commented, "It's been helpful to get some of the money back, especially these days. It may not cover all costs, but it helps."

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*It's been helpful to get some of the money back, especially these days. It may not cover all costs, but it helps.*
*—LEHBCC provider in Oregon*

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- **Paperwork, meal, and reporting requirements.** Respondents in this study, as well as our earlier work on home-based child care providers and CACFP, highlighted that the rules and regulations around menu planning, tracking and reporting attendance and food menus daily, and maintaining compliance with strict rules can result in a significant administrative burden for providers. These requirements can demand a fair amount of administrative skill, even with the advent of electronic reporting. Moreover, meal pattern requirements can be strict and difficult for providers to comply with. These can be even more challenging for LEHBCC providers who may be relatives who have little experience with this level of oversight and reporting, are used to feeding children as part of their family rather than as a business, and can face challenges with technology, literacy, and language.

  In addition, for providers in Illinois and Oregon, the paperwork demands of CACFP are on top of any requirements they must meet for CCDF. A respondent in Illinois reflected on hearing an LEHBCC provider say that the bureaucratic paperwork seemed too overwhelming given what they were doing and receiving, and they did not see the payoff.

- **Unannounced visits.** Additionally, providers must be prepared for unannounced visits by sponsors to observe meal times. This can be challenging on two fronts for LEHBCC providers:
  - » First, having unannounced visits can feel invasive—as an Illinois respondent said, providers sometimes just say, "You're coming into my home unannounced? Not interested."
  - » Second, to ensure the sponsor staff do not come for the unannounced monitoring visit when they are away, providers are required to call the sponsor in advance if they are going to be away during a meal time. Respondents across all three states noted that this was difficult for LEHBCC providers who do not think to call the sponsor every time they leave the house with the children in their care. As an Oregon respondent noted, "They don't want to text us and tell us that they aren't doing care or taking the kids out for a picnic, even though it's a rule...I love CACFP...but more and more there is no wiggle room...they have to serve meals and snacks in a certain time frame but have to tell us exactly when it is so when we make drop-in visits...we drop in at that time. Well I'm sorry, but that just doesn't work sometimes." Further, a respondent from Illinois noted that the provider not being home for an unannounced visit is a primary reason for termination from the program.

A cross-cutting theme across some of these areas of concern is that the rules and regulations for CACFP are not designed to reflect LEHBCC providers' realities and instead are more appropriate for child care providers that care for larger groups of children.

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*—respondent in Oregon*

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When taken together, these issues can result in providers being less willing to participate in the program. As an Illinois respondent noted, "There is paperwork that is daunting and now we had to move everything online and it's more daunting; this is a group that's been struggling with the internet since the pandemic. But we do it. Right off the bat you get people saying, 'I have one infant, too much paperwork, not worth it'....Of the [family, friend, and neighbor providers] that eventually join, still a quarter don't participate in the program and drop off, even after doing all the paperwork to get into the program."

*There is paperwork that is daunting and now we had to move everything online and it's more daunting; this is a group that's been struggling with the internet since the pandemic. But we do it. Right off the bat you get people saying, 'I have one infant, too much paperwork, not worth it," or "you're coming into my home unannounced, not interested.' Once we start to break down the program, a lot of people lose interest.*
*—respondent in Illinois*

## Additional Enrollment and Retention Challenges in Illinois and Oregon because of the Link to CCDF Participation

In Illinois and Oregon, LEHBCC providers' ability to stay on CACFP is further challenged because of the link to CCDF, as their ability to continue participating in CACFP also depends on whether they continue serving children eligible for CCDF subsidy funds. Specifically, if a provider in these states stops caring for a child whose care is paid for by CCDF subsidy funds, they can lose their eligibility to participate in CACFP after a certain grace period unless they enroll another child receiving CCDF subsidy.

Respondents in both Illinois and Oregon shared that LEHBCC providers in CACFP turn over frequently because of changes in their CCDF participation. That is, if the parent whose child the LEHBCC provider is caring for loses their job and can no longer receive CCDF subsidy funds to pay for child care, or if the child receiving a subsidy that the LEHBCC provider is caring for moves and is no longer in the provider's care, this affects the provider's CACFP eligibility—regardless of whether they are still serving other children and/or the fact that they were approved as meeting CACFP standards. As such, policies that make CACFP eligibility contingent on not only CCDF approval, but also on active CCDF participation, may result in providers being more likely to leave the program because of circumstances out of their control.

## LEHBCC Providers May Be More Likely to Experience Turnover, Particularly if Linked to CCDF

Respondents in both Illinois and Oregon discussed experiencing higher turnover with LEHBCC providers, though this was not reported to be as much of a problem by our respondents in Louisiana. Specifically, respondents in Louisiana noted that there was not a lot of turnover with their LEHBCC providers, as "once you are in, you stay in, as long as there isn't fraud." The turnover they did see was

from normal causes such as children aging out of child care arrangements and providers retiring. In contrast, respondents in both Illinois and Oregon described the turnover among LEHBCC providers as a significant challenge that created a disincentive for sponsors to want to work with them. Further, turnover also undercuts the core goal of CACFP, as it indicates that the children in the provider's care are losing access to the nutritional supports CACFP provides.

While some turnover was attributed to LEHBCC providers being less experienced at dealing with the administrative demands and burdens of CACFP described above (particularly in the early enrollment period while they were getting used to the program), respondents in Illinois and Oregon described a primary factor in shaping the turnover as being the likelihood that providers would lose CACFP eligibility because they were no longer serving a child who was receiving CCDF. For example, one respondent in Illinois said, "The provider will call the sponsor and say hey, I'm getting [the state subsidy program] payments for this person, and then 30 days later that person loses the job." Another noted, "A chunk of the [LEHBCC CACFP] turnover is driven by CCDF eligibility—the family, friend, and neighbor 'on and off' all depends on the CCDF. Once they get on CACFP and get used to the stuff, they are fine; they have no problem."

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*A chunk of the [LEHBCC CACFP] turnover is driven by CCDF eligibility—the family, friend, and neighbor "on and off" all depends on the CCDF. Once they get on CACFP and get used to the stuff, they are fine; they have no problem.*
*—respondent in Illinois*

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## LEHBCC Barriers to Enrollment and Retention in CACFP Have Implications for Equitable Access

Discussions with key respondents across the three states suggest that the barriers to access and retention are likely to disproportionately affect populations who already face structural barriers to resources and success. Respondents from all three states highlighted the barriers experienced by LEHBCC providers related to their English proficiency, literacy, rurality, and comfort with technology, in addition to particular concerns for populations such as communities of color and immigrants who face inequities because of

structural racism. Further, in states linking CACFP to CCDF participation, these barriers are likely to affect these populations' ability to participate in CCDF as well, thus having a double impact.

- **English proficiency.** Providers who speak a language other than English may be less likely to hear about CACFP from other providers or learn about it from flyers and materials developed by sponsors, as in many cases they are only available in English. Moreover, sponsors in the three states we spoke with had limited capacity to work in languages other than English and were aware of the need for more outreach and enrollment materials and staff who speak Spanish, Vietnamese, Chinese, Russian, and Korean, among other languages. These limitations were likely to affect the ability of LEHBCC providers who speak languages other than English to access CACFP. Further, respondents in Illinois and Oregon suggested that there are similar challenges facing LEHBCC providers seeking CCDF approval, thereby limiting their access at that stage as well. As an Illinois respondent noted, "Language barriers stop people from getting into CCDF, so that's a stop right there. If they are in the CCDF, generally it can be worked through to get into CACFP. The big language barrier is the CCDF."

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*Language barriers stop people from getting into CCDF, so that's a stop right there. If they are in the CCDF, generally it can be worked through to get into CACFP. The big language barrier is the CCDF.*
*—respondent in Illinois*

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- **Literacy.** Respondents also suggested that providers with low levels of literacy may have trouble learning about the program from text-based recruitment materials and may face difficulty with enrollment paperwork, training, and CACFP requirements for menu planning and submission. A Louisiana respondent noted, "Some providers do have challenges...when we go to sign them up...and we find that all they can do is sign their name, even though they can prepare meals and care for children." A sponsor in Illinois noted the difficulty of maintaining enrollment for providers with low literacy, especially with trainings offered with only Spanish subtitles, which required a great deal of reading for Spanish-speaking providers. This was especially challenging in cases where Spanish providers had low literacy. Again, these issues also seemed to present barriers for LEHBCC providers around the CCDF approval process.

- **Rurality.** Respondents suggested that providers who live in more rural areas may face barriers to participating in CACFP for multiple reasons. For example, they may be less likely to know about CACFP, either because of fewer connections to other providers and/or less exposure to sponsors and their outreach materials. Depending on how rural the area the provider lives in is, sponsors may be less likely or able to reach them for home visits, decreasing their chances of being reached out to by a sponsor. A sponsor in Illinois noted that providers who live in rural settings also have less access to mandatory in-person trainings, which tend to be centered in more populous, urban areas. Additionally, providers who live in rural areas may experience challenges with internet access, which may not be available or may be extremely limited. For these providers, completing paperwork associated with program enrollment and participation and mailing it in regularly may be especially cumbersome.
- **Technology.** In addition to having difficulty with internet access, some LEHBCC providers may not be comfortable using computers or smartphones to complete daily attendance logs and menu tracking. Respondents across the three states noted that many LEHBCC providers are often grandparents or older caregivers who are less comfortable with technology and in some cases do not have regular email accounts or access to computers. As noted by an Illinois respondent, "Now it gets wrapped up in IT literacy, and people saying they just can't do the IT piece. It's more the way the provider will see themselves. A 60-year-old provider said she was too old to learn the internet...all this bureaucratic paperwork that seems too overwhelming for what I'm doing right now and I don't see the payoff."
- **Immigrants and communities of color.** Respondents also described barriers facing immigrant communities and communities of color:

  Distrust of government agencies and unwillingness to have them conduct in-home monitoring was named as a concern for the following groups:

  - **immigrant communities** who may have family members who do not have legal documents and may be concerned about deportation risks. This was highlighted as a potential concern for immigrant communities in all of our states but particularly in Louisiana where an immigration expert described ongoing fear of being identified because of active enforcement by Immigration and Customs Enforcement agents.
  - **communities of color** who have had experiences with both unjust policing and state agency intervention in families. For example, unjust policing makes people more resistant to or concerned about steps such as comprehensive criminal background checks as required under federal law for CCDF approval and might discourage providers of color from participating

(Adams and Pratt 2021). Similarly, home inspections can be of concern to communities of color who have disproportionately experienced children of color being removed from their homes and placed in the child welfare system.[36] One respondent noted a potential additional challenge in Louisiana, where fire marshals are overwhelmingly white and male.

Requirements that providers supply their Social Security card—described as necessary for the fire marshal inspection in Louisiana and in Illinois to apply for CCDF approval—are of particular concern and present an access barrier. In states that require CCDF participation as a condition of getting CACFP, additional documentation requirements, including driver's licenses and other tax documents, may keep immigrants and other providers from participating. As one respondent in Oregon noted about the CCDF requirements, there is a general concern of "having your information in the system, especially if you are undocumented."

Respondents also noted the ongoing effects of the fears of immigrant communities related to accepting public funds because of the "public charge" proposal, which—although not implemented—was proposed in 2018 and would have made it harder for immigrants receiving certain public benefits to seek citizenship. The chilling effect of this proposal on immigrants seeking public benefits has been widely documented (Haley et al. 2021) and was noted as a concern by immigration experts in our target states.

Some immigrant communities have different cultural norms and experiences that can shape their perceptions of the program. For example, a sponsor in Louisiana noted that many Vietnamese families interpreted the fire marshal fee as a scam, and a sponsor in Illinois noted some immigrant groups felt extremely wary of government officials entering their home. Both of these reactions may relate to their experiences with government agencies in their countries of origin.

Given these barriers, it is perhaps unsurprising that that respondents noted there is an underrepresentation of the immigrant community in CACFP across the three states we interviewed.

Further, these barriers are likely to have implications for which children and families face barriers to accessing CACFP as well. Although data are not available on the extent to which LEHBCC providers have characteristics similar to the children they care for, research on home-based providers who are listed with state licensing agencies suggests that they are likely to share the racial and ethnic identity of the children they are care for (Hill, Arteaga, and Gable 2021). This finding is likely to be even more true for LEHBCC providers, many of whom likely care for the children of relatives and friends. As a result,

these findings suggest that children and families from communities that face these structural barriers may also find it more difficult to access CACFP.

# Delinking CACFP Eligibility from CCDF Could Broaden and Stabilize LEHBCC Provider Participation

The findings laid out in the preceding pages suggest that using CCDF's approval process and CCDF participation as the mechanism for establishing LEHBCC provider eligibility for CACFP constrains the eligible pool significantly and is thought to contribute to turnover rates. Through these interviews, two possible strategies emerged to address these challenges—one that reduces the link to CCDF and the other that eliminates it.

## Allowing LEHBCC Providers to Retain CACFP Eligibility, Even if No Longer Serving Children on CCDF, Can Stabilize Participation in States Relying on CCDF Approval

Interestingly, respondents in both Illinois and Oregon noted that they had seen improvements in turnover rates for LEHBCC providers because of two policy changes. First, a respondent in Illinois noted that the change from the 2014 CCDF Reauthorization, which required that parents be provided child care assistance for 12 months, had a significant impact on reducing turnover in CCDF for LEHBCC providers. Second, respondents in Illinois and Oregon described the impact of giving LEHBCC providers a grace period to retain their CCDF approval status if they were no longer serving a child receiving subsidy. For example, a respondent in Illinois noted that LEHBCC providers are given a three-month grace period for CACFP if they lose the subsidized child, saying, "It's not as bad as it used to be....Now DHS approves someone for three months, so now someone doesn't lose their job for a month and then everything goes away." Similarly, an Oregon respondent described how the grace period meant that "you could lose a child in the subsidy program but still gain a child a month later and still be DHS registered. [Otherwise it would] end CACFP here too with no grace period."

Conversations with respondents suggest that states who rely on CCDF to establish CACFP eligibility could go even further in loosening the ties between CCDF and CACFP by establishing that once the provider meets the approval standards or is approved, they would be eligible for CACFP for an established period (e.g., one-to-two years), regardless of the status of whether they continue to serve a child receiving CCDF. This is similar to the way licensing systems operate, which authorize the providers to operate or be eligible for established periods unless evidence of failure to meet standards

exists. Of course, the provider would only be paid by CACFP if they continued to serve children and comply with other CACFP requirements.

A respondent in Illinois described this approach: "I'd like to improve this, get it more consistent with what they do in licensing....Ideally what we would do is, once they are in, they go through the checks—a policy check, background checks, so those are the safety check....If they stay active in the program...if we could keep them up for a year or two as long as they have kids and the sponsor organizations do their unannounced reviews....We need a mechanism that notifies if something happens with the background check to shut them out of the system....And if not, leave them open for a two-year window because we still have the safety checks going on and sponsors are going into the homes."

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*—respondent in Illinois*

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## Respondents Saw Benefits in Delinking CACFP Approval from CCDF

When asked whether requiring LEHBCC providers and families to meet CCDF rules to access CACFP was the best approach to meeting CACFP's goals, respondents in these states suggested that eliminating the tie to CCDF would help fulfill CACFP's goals, though some noted the importance of ensuring that any alternative approach had health and safety provisions:

- **Several respondents said it would be good to be able to get CACFP to more families, rather than limit it to LEHBCC providers who are approved to serve families on CCDF.** For example, one Oregon respondent said, "I think it makes sense to offer those supports to all children and providers because ultimately if we're not providing those supports it's the children that are suffering because of it. The more that we tie supports for children to whether or not parents or providers deserve them, it's less beneficial to what the intent is. If our intent is to feed children, that should be central to our program." Another respondent from Oregon said, "The more we

can get food to the children, the better. Oregon is high in food insecurity." An Illinois respondent noted, "I don't see why there needs to be a connection, and I don't see the rationale. We may be missing a lot of people."

Further, several respondents noted that the children were going to be in these settings regardless of whether CACFP helped cover their nutritional needs. So limiting the program to a small number of providers simply means that fewer children are helped, and fewer children are in settings supported by external resources around nutrition and basic health and safety.

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*—respondent in Oregon*

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- **However, several respondents clearly felt there were some aspects of the CCDF approval process that had value and should be addressed in any alternative approach.** As respondents considered what elements of the CCDF approval and participation processes they felt were important and should be considered in any alternative approach, some of them noted the following:
  - » **Health and safety.** Some respondents identified the importance of a mechanism to ensure children are in environments that meet basic health and safety standards.
  - » **Criminal background checks.** A few respondents highlighted the CCDF requirements for criminal background checks as important. However, background checks are not required by CACFP, so this would be an additional requirement beyond what the federal CACFP rules require. Further, as noted earlier, while these can provide important protections, it is also clear that background checks can be particularly challenging for communities who have experienced unjust policing and for communities who may include immigrants without legal documents—thus potentially resulting in barriers that further contribute to inequities because of structural racism and barriers.

» **Monitoring visits.** Some respondents felt that the oversight by CCDF's annual visits was important. For example, one respondent noted, it is important "so we know for sure that they are receiving reimbursement for watching children." However, others suggested that the multiple visits (including unannounced visits) by CACFP sponsors over the course of each year serve a similar function and perhaps provide more assurance that providers are in operation than CCDF. For example, an Illinois respondent said the sponsors can "check it out—they aren't really approving it but they are looking and making sure...Sponsors go into the homes and do their entry visits; they do the safety assessment there. So sponsors handle the side that has to do with food safety and nutrition."

Another strategy that could stabilize LEHBCC CACFP participation *in states that rely on CCDF approval* is to allow providers to remain eligible for CACFP even if they are no longer serving a child in the subsidy system, as nothing in the CACFP rules or regulations requires that an approved provider has to be actively participating in another program. Specifically, conversations with respondents suggest that states who rely on CCDF to establish CACFP eligibility could loosen the tie between CCDF and CACFP by establishing that once the provider meets the approval standards or is approved, they would be eligible for CACFP for an established period (e.g., one-to-two years), regardless of the status of whether they continue to serve a child receiving CCDF. This is similar to the way licensing systems operate, which authorize providers to operate or be eligible for established periods unless evidence of failure to meet standards exists. Of course, the provider would only be paid by CACFP if they continued to serve children and comply with other CACFP requirements.

This could be done by simply clarifying in the state CACFP policy that providers could participate for a year or two after they meet their CCDF health and safety requirements, even if at some point during the year the provider no longer is serving a child in the subsidy system. These rules could also be rewritten to allow them to update their CACFP eligibility for another year after that by completing either the CCDF health and safety requirements or an alternative the state establishes (such as self-certification as allowed by the federal CACFP rules). This effectively breaks the tie to CCDF after the initial approval process.

CACFP's monitoring process and unannounced inspections can help sponsors ascertain whether providers continue to serve children. Implementing these strategies could potentially reduce turnover among LEHBCC providers in states relying on CCDF for approval and stabilize the nutritional supports for the children in their care.

# Sponsors Can Face Challenges Serving LEHBCC Providers, Particularly in States Relying on CCDF Approval

Respondents also described challenges they faced in working with LEHBCC providers. This was more commonly heard in Illinois and Oregon, both of whom tie CACFP eligibility to CCDF and where sponsors serve both license-exempt home-based providers and licensed home-based providers. In contrast, in Louisiana, LEHBCC providers are the only providers that sponsors work with—so they do not have similar groups of licensed family child care to compare with LEHBCC providers—and they do not tie eligibility to CCDF, so their experience is very different. On the other hand, we also heard sponsors describing the efforts they made to support LEHBCC providers across the three states, despite these challenges.

Respondents in both Illinois and Oregon, and conversations with experts, identified some important issues that sponsors can face in working with LEHBCC providers. Specifically, they suggested the following:

- **Working with LEHBCC providers was seen as more labor intensive in Illinois and Oregon.** Respondents in Illinois and Oregon reported that the cost of working with LEHBCC providers was often greater than for licensed providers, as these providers are typically harder to make initial contact with, can require more training and oversight to enroll, and can require more assistance to help maintain enrollment in the program. As a respondent in Illinois noted, "I would say they will need some patience...With a licensed provider, they are used to paperwork and filling things out. They have to fill out paper to do the [CCDF approval], but usually that's the parent, not the provider. So, the provider is many times an older individual, so it will take more work and time to acclimate them to the program."

  An expert also noted that sponsors have to monitor the food service itself—if a provider serves breakfast, lunch, and an afternoon snack, then at some point during the year the sponsor staff have to observe a breakfast service, a lunch service, and an afternoon snack service. This can be challenging for sponsors working with LEHBCC providers, who are more likely than other child care providers to care for children during nontraditional hours (Schilder, Lou, and Wagner 2023), as it might mean that they would have to visit during early morning, late evening, or weekends. These are outside the normal agency work hours so can be difficult for sponsor agencies to find staff to work these hours.

- **Higher turnover reported in Illinois and Oregon exacerbates costs.** The higher turnover among LEHBCC providers in the program further contributes to these costs. The current financing approach requires sponsors to invest time and money up front with a provider to onboard and enroll them in the program. Only after the first few months is a sponsor able to recoup the cost of enrolling a provider. But for the reasons discussed previously, in states that link CACFP eligibility to CCDF, LEHBCC providers appear to turn over at higher rates than other home-based providers, making it ultimately more costly for sponsors to work with these providers if they turn over soon after they enroll. As a sponsor in Illinois noted, "The up-front cost of getting them trained and up and running is huge, so if they don't stay, that's the biggest challenge. Our job is to get the program to the folks, but the turnover really kills us. And these people are probably in the greatest need of our program, and these providers are being trained what to do nutrition-wise, and they really need the program." This respondent also noted, "We still support license-exempt providers, but you have to think of the cost effectiveness of someone who is on and off of the program."

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- **Communication lines need to be clear between the CCDF agency and CACFP.** Finally, respondents in both Oregon and Illinois described the importance of having open lines of communication between the CCDF agency and CACFP agency and sponsors. While the basic process of communicating when providers became approved for CCDF or were no longer on the approved list seemed to function pretty easily for the sponsors we spoke with, there were more challenges if there were any complications. For example, an Illinois respondent noted, "Here's the problem—the list isn't totally accurate, so you think they qualify and they don't and you have to get something fixed and go back to the state agency," and noted that in some cases it is an "issue that takes forever to fix on our end." Similarly, in Oregon a respondent noted the importance of making "sure communication lines are open."

## CACFP's Financing Approach Does Not Recognize the Costs of Working with LEHBCC Providers

Respondents in Illinois and Oregon highlighted that the current CACFP rate structure and financing approach does not recognize the higher costs that can be associated with recruiting, onboarding, supporting, and retaining LEHBCC providers. In 2023, sponsors in the contiguous US states are paid a flat amount of $142 per provider for the first 50 providers they serve, $108 per provider for the next 150 providers, $85 per provider for the next 800 providers, and $75 per provider for any additional provider at that point.[37] These rates do not differ for LEHBCC providers and licensed providers. (These flat rates are higher for Alaska, Hawaii, and the territories.)

This rate structure creates challenges for sponsors and limits their ability to do the outreach, recruiting, onboarding, and training that is necessary to support better access. Specifically, many of the strategies needed to support more equitable access to CACFP require resources, and the program reimbursements do not take into account the additional investments that may be needed to reach these providers and the children they serve, which include—for example—the following:

- **Preparing accessible materials.** Translating materials into languages other than English and hiring bilingual staff can take resources that sponsors may not have. Similarly, developing materials that can work for providers with low levels of literacy, such as picture menus, and redesigning training and technical assistance materials, can require additional investments.
- **Accommodating technology barriers.** For providers who are less comfortable with technology, sponsors must invest more time and effort training them and must take more time on the back end to process paperwork if the provider opts to use paper instead of an online submission system. Respondents described ways that sponsors would help providers by offering alternatives. For example, a sponsor in Louisiana noted, "If providers prefer to do it on paper, we have forms for them to report their meal counts, daily attendance, and menus. We would never force anyone to do things by computer. We know in some areas the internet is not great." However, in Oregon, we were told that at least one sponsor reportedly only uses computer-based tracking, which may inadvertently keep those providers who are less comfortable with technology out of the program.

*If providers prefer to do it on paper, we have forms for them to report their meal counts, daily attendance, and menus. We would never force anyone to do things by computer. We know in some areas the internet is not great.*
*—respondent in Louisiana*

- **Building trust with communities that have reasons to mistrust public agencies.** For providers from different cultural backgrounds, or who are from communities with historical experiences of structural racism and difficulties with government agencies, sponsors may need to invest in different strategies and work with trusted intermediaries to bridge the gap and explain the reason for the requirements. Some sponsor agencies we interviewed noted the importance of working with community members to build trust. For example, the sponsor in Louisiana noted that they typically cover the fire marshal fee for all new Vietnamese providers as an allowable one-time use of their funds to build good will in the community.
- **Investing resources needed to support rural areas.** Recruiting and supporting providers in rural areas can be more challenging given the travel time and costs associated with reaching them. As a respondent in Oregon described, "If you don't have enough providers...in that area, it doesn't justify employing somebody or having someone drive out to have them in the program....USDA doesn't provide enough in reimbursement to make it worthwhile. So, there were 30 providers in eight counties and four hours between counties—doesn't make sense....Rural frontier counties struggle more to have access to CACFP."

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*—respondent in Oregon*

- **Recognizing costs of working in communities with higher costs of living.** For sponsors working in communities with higher costs of living, such as large cities, the flat rate does not recognize that more of the administrative funds are taken up by salaries and other costs. As an Illinois respondent noted, "The few times I've connected with sponsors in big cities...I don't know how they run a program....So, where we have higher rent and [staff] compensation is better, we have no money for outreach."

*The few times I've connected with sponsors in big cities…I don't know how they run a program….So, where we have higher rent and [staff] compensation is better, we have no money for outreach.*
*—respondent in Illinois*

- **Developing different ways of working with providers.** Working with LEHBCC providers can require different techniques and time investments. As an Illinois respondent noted, it is more "adult learning—you have to do a lot more engagement for them to get it and you have to use different adult learning principles instead of just telling them how it's done."

As a result, the current payment levels and approaches make it hard for sponsors to access the additional resources they need to work with LEHBCC providers who may be harder to reach and may need more supportive services. For example, an Illinois respondent noted working with these providers requires "administrative time without administrative dollars." And a respondent from Oregon noted, "If we had more money, we would be able to do more outreach....Caseloads are full so it is hard."

*A respondent in Illinois noted that working with LEHBCC providers requires "administrative time without administrative dollars."*

Respondents in Illinois and Oregon noted that these issues can create a disincentive for sponsors to work with LEHBCC providers, as they cannot afford the extra supports they need to help these

providers stay in the program. In the words of one Illinois sponsor, "When these providers come and go quickly, you can't rely on them as part of your revenue stream."

Although respondents in Louisiana did not describe this disincentive to serve LEHBCC providers, they also described the need to do fundraising to cover their program costs that were not covered by their administrative funds. For example, a sponsor in Louisiana said they use other funds to support providers in meeting the requirements: "I've never used our admin funds for that—I've always used our other funds…if one of our staff goes to a provider's home and you can tell they are struggling and they don't have the funds to get on the program—we will do that for anyone that needs our help."

Across our states, we heard from sponsors who clearly saw supporting these providers as part of their mission and worked to find other resources to cover these extra costs. Interviews with other respondents suggested that some other sponsors were similarly trying to find ways to fund the additional activities they needed to support these providers or had tapped into other resources because serving LEHBCC providers was a priority for them. However, it was clear that this was a struggle.

# Policy Strategies to Expand LEHBCC Provider Participation in CACFP

Discussions with national experts and key stakeholders in our states provided useful suggestions about possible policy strategies that could help expand LEHBCC providers' participation in CACFP, and thereby potentially extend nutritional supports to many children across the country. Some of the suggestions can be done by states or the federal government within current funding and policy contexts, while others are more challenging and would require either additional funding or supports or require congressional changes in the core program design and funding. These recommendations reflect opportunities for federal, state, and/or philanthropic actors can take to increase the number of children and providers served through CACFP.

The key policy areas that emerge as having the potential to support greater LEHBCC provider participation in CACFP include the following:

- Raise awareness about the potential value of LEHBCC providers in supporting better nutrition and development for many children through CACFP.
- Prioritize child nutrition goals in designing strategies to approve and enroll LEHBCC providers.
- Identify and implement strategies to approve LEHBCC providers for CACFP that do not rely on CCDF approval processes.
- Stabilize CACFP participation by allowing LEHBCC providers to retain their approval status.
- Incentivize and facilitate outreach, recruitment, and retention of LEHBCC providers.
- Develop and invest in an intentional plan to tackle barriers to CACFP participation for underserved LEHBCC populations.
- Collect better data on LEHBCC provider participation in CACFP.

Most of these have key actions that can be taken at the federal, state, local, and philanthropic levels. For a summary of these suggested policy actions organized by sector—federal, state, and local—see box E.1 in the executive summary.

## Raise Awareness about the Potential Value of LEHBCC Providers in Supporting Better Nutrition and Development for Many Children through CACFP

In our conversations with various stakeholders and national experts, it seemed that the untapped potential of LEHBCC providers in allowing CACFP to support the nutritional well-being of significant numbers of children in nonparental care was not on the radar of the broader child nutrition and child care fields, sometimes even within states that allow them to participate. LEHBCC providers seem to be often overlooked or lower priority for child care policymakers, and it is not clear that these providers are recognized as important within the CACFP world outside of the few states that allow them to participate.

Policymakers, advocates, and stakeholders in the child nutrition and child care fields, whether at the federal level, state, or local levels, could work to strengthen awareness of the importance of expanding LEHBCC provider participation in CACFP by the following means:

- Reaching out to others in both the child nutrition and child care fields, as well as to those working more broadly to support better outcomes for children, to help them understand the untapped potential of extending CACFP's nutritional supports to some of the millions of children cared for by LEHBCC providers.
- Strengthening partnerships between CACFP and a broader array of stakeholders who are interested in supporting children's well-being, including those who work with and for LEHBCC providers.

## Prioritize Child Nutrition Goals in Designing Strategies to Approve and Enroll LEHBCC Providers

Our respondents were clear about the importance of CACFP as a child nutrition program working to provide nutritious meals and education to children in nonparental child care settings, as well as its role in addressing food insecurity and supporting better nutrition. Yet one of the challenges they identified is that the most common approach to helping LEHBCC providers participate in CACFP (in the few states that allow these providers to participate) is by linking LEHBCC CACFP eligibility to CCDF approval. And they noted that this inadvertently results in the child care subsidy system's goals becoming higher priority and undercutting the CACFP's goal to help children in nonparental child care

settings get nutritious meals. Specifically, it significantly limits the pool of LEHBCC providers who can get CACFP by applying child care subsidy system rules, priorities, and funding constraints to determining which providers can get help to feed the children in their care. These include being available only to providers who care for children whose parents need a paid provider, meet CCDF's eligibility requirements, and are able to actually get a subsidy despite constrained funding levels, as well as requiring that the provider is willing and able to comply with CCDF's child care standards and rules. None of these requirements are under the CACFP rules.

These insights suggest that any effort to expand LEHBCC providers' participation in CACFP should ensure that the approval requirements prioritize child nutrition goals and focus on ensuring that CACFP resources reach children who are in nonparental care and need nutritional support.

## Identify and Implement Strategies to Approve LEHBCC Providers for CACFP That Do Not Rely on CCDF Approval Processes

Many states do not allow LEHBCC providers to participate in CACFP and thus are losing out on an important opportunity to address child food insecurity and support healthy child development. This report's findings suggest that there are various ways that states might consider approving LEHBCC providers to include them in their CACFP systems. However, despite the fact that it is currently the most common approach among the few states that do allow LEHBCC providers to participate in CACFP, the limitations described earlier in using the CCDF approval process suggest that states should consider *not* relying on the CCDF approval process and instead implement alternative approval strategies, such as those in place in Louisiana and California, or explore new strategies.

Our findings suggest the following actions:

- **Explore, develop, and implement alternative processes to approve LEHBCC providers for CACFP.** States could implement CACFP LEHBCC approval processes that do not rely on CCDF:
  - » Build on and learn from the approaches taken by Louisiana's fire marshal strategy or California's Trustline and self-certification strategy. These approaches provide two very different alternative approaches to approving LEHBCC providers for CACFP and provide interesting lessons for other states to learn from.

- » Build on home visiting models that may already work with LEHBCC providers, are in their homes, and are seen as trusted partners; see, for example, Colorado's pilot home-visiting effort for home-based providers including LEHBCC providers (Everson and Belcher 2021).
- » Collaborate with other organizations or initiatives that are working to support LEHBCC providers; partner to ensure that their knowledge, relationships, and connections are part of any strategies and that they reflect LEHBCC providers' realities (Miller and Schulman 2022; Prenatal-to-Three Capacity Building Hub 2023).[38]

These alternative approaches potentially could be supported by a variety of sources, including federal pilot project funding, state resources, or philanthropic efforts to pilot different strategies.

- **Provide guidance and leadership to help states identify alternative ways to approve LEHBCC providers.** The USDA and national stakeholders could provide leadership and guidance encouraging states to find ways to approve LEHBCC providers that meet federal CACFP requirements but also support greater participation. These efforts could include resources that highlight different approaches, provide technical assistance, and help states understand what is possible.
- **Explore building on some elements of existing CCDF approval processes to use them to approve a broader set of LEHBCC providers (beyond those who serve families in CCDF).** Another idea is to allow LEHBCC providers who are not serving families on CCDF to access some of the approval mechanisms set up for CCDF (i.e., a background check) if they seem relevant for CACFP, without having to meet all of the CCDF approval requirements or having to serve a child in the subsidy system. For example, California's Trustline system is used as part of the CCDF approval process but is also opened up to approve LEHBCC providers who are not part of the CCDF system for CACFP. This may be appealing for states as it can leverage and build on their existing investments in approval processes and systems to potentially broaden the number of providers who can be approved. These additional efforts may be an allowable activity for funds from the CCDF quality set-aside.

# Stabilize CACFP Participation by Allowing LEHBCC Providers to Retain Their Approval Status

Another strategy that could stabilize LEHBCC CACFP participation *in states that rely on CCDF approval* is to allow providers to remain eligible for CACFP even if they are no longer serving a child in the subsidy system, as nothing in the CACFP rules or regulations requires that an approved provider has to be actively participating in another program. As described earlier in the report, CACFP simply requires that providers be initially approved and assessed on an annual basis (which could be through a checklist or self-certification). This flexibility is demonstrated by CACFP in Louisiana, which makes the provider eligible for CACFP for a year based on the fire marshal's approval. In states that tie CACFP to CCDF approval and participation, this would reduce the likelihood that providers would have to leave CACFP because of, for example, the parent of the child in the provider's care losing their job and their subsidy.

Conversations with respondents suggest that states who rely on CCDF to establish CACFP eligibility could loosen the tie between CCDF and CACFP by establishing that once the provider meets the approval standards or is approved, they would be eligible for CACFP for an established period (e.g., one-to-two years), regardless of whether they continue to serve a child receiving CCDF. This is similar to the way licensing systems operate, which authorize the providers to operate or be eligible for established periods unless evidence exists of failure to meet standards. Of course, the provider would only be paid by CACFP if they continued to serve children and comply with other CACFP requirements.

This could be dealt with by simply clarifying in the CACFP policy that providers could participate for a year or two after they meet their CCDF health and safety requirements, even if at some point during the year the provider is no longer serving a child in the subsidy system. These rules could also be rewritten to allow them to update their CACFP eligibility for another year after that by completing either the CCDF health and safety requirements or an alternative the state establishes (such as self-certification, as allowed by the federal CACFP rules). This effectively breaks the tie to CCDF after the initial approval process.

The CACFP monitoring process and unannounced inspections can help sponsors ascertain whether providers continue to serve children. Implementing these strategies could potentially reduce turnover among LEHBCC providers in states relying on CCDF for approval and stabilize the nutritional supports for the children in their care.

# Incentivize and Facilitate Outreach, Recruitment, and Retention of LEHBCC Providers

Respondents noted a number of barriers and challenges to reaching, recruiting, and retaining LEHBCC providers that could be addressed through federal, state, or local efforts, or through philanthropic investments (on a smaller scale). Note, however, that many of the efforts below will be significantly more constrained in states that rely on CCDF approval processes given the relatively smaller number of providers who would be eligible and the role that the tie to CCDF appears to play in contributing to provider turnover.

- **Incentivize sponsor agencies to recruit and enroll LEHBCC providers by compensating them appropriately through CACFP sponsor payments or other financial incentives that reflect geography and capacity needed.** Our respondents were very clear that the CACFP's current funding structure makes it challenging to engage in the outreach, recruitment, and activities that can allow sponsors to better reach and support LEHBCC providers. These activities have the potential to not only support enrollment, but also could help providers stay in the program once enrolled.

  Specifically, the current resources available to sponsors through the per provider reimbursement are not differentiated by provider type (such as between LEHBCC and licensed home-based providers) and are available at the same level across the contiguous US, which does not recognize variation in costs.

  As a result, a clear message from respondents was the central importance of compensating sponsor agencies for their work to enroll and support LEHBCC providers by creating an "add-on" or some differentiated rate that paid sponsors more for LEHBCC providers to reduce the financial disincentives to enroll these providers. Although ideally this would occur as part of the federal CACFP core payment structure, in the meantime, states could choose to make additional payments to these providers, or philanthropic organizations could support such efforts on a pilot basis.

- **Develop and share materials that sponsor agencies can use to recruit, train, and support LEHBCC providers.** Sponsor agencies described challenges in developing outreach, recruitment, and training materials for providers who spoke languages other than English, faced literacy challenges, were new to technology or faced technology barriers, and so forth. The federal government, state agencies, and/or philanthropic entities could work with CACFP and LEHBCC

providers to help design and disseminate such materials to sponsor agencies to help reduce the cost and burden of developing new materials and identifying successful approaches.

- **Consider continuing some form of virtual monitoring to provide sponsors with more flexibility and support greater access.** During the pandemic, the USDA issued waivers allowing sponsor agencies to engage in virtual monitoring—a practice which sponsor agencies found to have many benefits around improving access and ability to support home-based providers, providers speaking languages that were not English, and providers in rural areas, as well as a more efficient use of resources (CACFP Roundtable 2023). These waivers have now lapsed, and sponsor associations have suggested the USDA consider a hybrid approach that ensures some in-person monitoring to support relationships and oversight, while allowing flexibility for different community and program needs.[39]
- **Improve outreach by both the CACFP agency and the agency that approves LEHBCC providers, as well as potentially by outside partners such as Child Care Resource and Referral agencies and others, to inform providers and parents about the program and its benefits for children.** The scope and potential impact of outreach efforts will vary depending on the state's approach to eligibility. For example, in states that limit CACFP to providers who are eligible for CCDF, agency staff interacting with providers and parents in the CCDF approval process could more proactively reach out to inform providers in that process that they potentially are eligible for CACFP. In these states, as well as in states that broaden CACFP eligibility, community organizations such as child care resource and referral agencies, child nutrition organizations, and organizations working with LEHBCC providers can work to ensure that providers and parents who may be eligible for the program know about it.
- **Incentivize LEHBCC providers to participate by raising meal payment rates, reducing administrative burden, and reviewing CACFP policies and practices to assess their relevance and appropriateness for LEHBCC providers.** Respondents also described how low reimbursement rates, significant paperwork and administrative burden, and policies that were not designed with LEHBCC providers' realities in mind (such as having to call the agency any time they were taking the children out of the house during meal time) created disincentives for LEHBCC enrollment and participation. These challenges are under the CACFP's purview at the federal level and need to be addressed there.
- **Invest in helping sponsor agencies provide ongoing support and technical assistance to providers to help them navigate and comply with program requirements.** Respondents described that, in some cases, LEHBCC providers had trouble navigating the program once

enrolled, whether because of unfamiliarity in dealing with a public benefit program, trouble complying with program requirements, internet challenges, and so on. One respondent suggested that the first months can be particularly challenging. The USDA, state governments, and/or philanthropists could work to help sponsors have the resources and staff to provide extra supports to LEHBCC providers to help them adjust to the program could help support retention.

## Develop and Invest in an Intentional Plan to Tackle Barriers to CACFP Participation for Underserved LEHBCC Populations

As noted in our findings, some groups appeared less likely to be reached by sponsors and/or to face extra barriers to enrollment and participation in the program. These include providers who were immigrants and/or whose primary language was not English, providers in rural areas, and so forth. To develop appropriate strategies to support their enrollment, it is important to first understand the sources of the barriers and ensure that the outreach, recruitment, and supportive activities are designed to address them.

The first set of barriers are those described above, in that sponsors do not have the resources to invest in additional outreach and material development for underserved communities. So the steps described above to compensate sponsors for additional outreach and supports, and developing materials to support their work, are both foundational for supporting underserved communities as well.

However, additional issues need to be addressed for these communities. For example, our conversations with respondents who were experts on barriers facing immigrant communities named issues such as the importance of trusted intermediaries; recognizing fears that immigrant providers may have about anyone from the government coming into their home; and literacy, technology, and language barriers. The issues raised by respondents about rural providers had more to do with difficulties in reaching them and internet access. In addition to these issues raised around CACFP, other research suggests that the CCDF approval requirements for LEHBCC providers may create particular barriers for Black and Latinx providers' participation, as well as for providers with immigrant status (Adams and Pratt 2021).

Some suggestions that emerged from our review include the following:

- **Collaborate with underserved communities to better understand the barriers to participation they face**, as understanding their realities is the first step toward building more equitable access. Further, engaging directly with providers to codesign a better approach will increase the likelihood of trust and success.
- **Do a systematic assessment of agency requirements and the steps needed to enroll in CACFP to identify possible barriers that providers in underserved communities may face**, including language, literacy, internet access, trust issues, and so forth. Work with trusted intermediaries and members of these communities to address or reduce any barriers identified.
- **Develop partnerships with trusted organizations in underserved communities to support more effective outreach and supports** and ensure that the information is designed to effectively communicate with target populations and can reach them. As seen in Louisiana, informal networks of providers and community members can be an important mechanism for spreading word about the program.

## Collect Better Data on LEHBCC Providers' Participation in CACFP

It was remarkably challenging to collect information on LEHBCC providers' participation in CACFP, whether it be on which states allowed this to occur or the number or characteristics of LEHBCC providers that participate in CACFP in the states that do allow it. The FNS and states could take steps to improve data collection on these questions, thus allowing for more informed policy development.

# Conclusion

In conclusion, our review of state efforts to support LEHBCC providers participating in CACFP suggests we are missing a remarkable opportunity to reduce food insecurity and support the healthy development of several million children cared for by LEHBCC providers who might be able to benefit from CACFP if states took steps to make them eligible. Although the relatively few states that allow LEHBCC providers to access CACFP most commonly rely on CCDF as an approval mechanism, CACFP allows states to set up alternative approaches that would make the program much more broadly available to providers and potentially stabilize enrollment. Encouraging states to develop such approaches, and investing in the additional resources that sponsors need to recruit and support the full range of LEHBCC providers caring for children, could result in nutritional supports being made available to significant numbers of children, including many children experiencing food insecurity. Such steps could help support the healthy development, nutrition, and safety of children across the country who would benefit from such investments.

# Appendix. Our Approach

This project had several phases.

First, we began by speaking to national CACFP experts, advocates, and state administrators in states that did not allow LEHBCC providers to participate in CACFP to better understand their questions and issues that we should explore. These interviews helped us explore some of the key questions these people had about LEHBCC providers and CACFP and to develop a deeper understanding of why some states may be reticent to include LEHBCC providers in CACFP.

Second, we worked with our project advisor to identify three states that did support LEHBCC providers in CACFP, choosing Louisiana because of its unique approach and Illinois and Oregon because of their history of supporting LEHBCC providers. In each of these states, we conducted virtual interviews with people at the state CACFP agency and one or two sponsor agencies, as well as key experts in the state. And in Illinois and Oregon, we also spoke with people at the state CCDF agency. We also spoke to immigration experts in each state to better understand the possible reasons for immigrant LEHBCC providers' low participation. Finally, we spoke to a small number of providers, though we were unable to recruit the number and types of providers we felt were necessary to reflect providers' perspectives.

Once interviews concluded, we coded interviews and developed key themes across all interviews in all states. We also collected programmatic information on state-specific CACFP requirements to inform the findings. Finally, we analyzed the data and shared our initial findings with a group of national experts who were knowledgeable about CACFP and/or LEHBCC providers, with the goal of getting their feedback on our findings and their policy implications.

# Notes

[1] "Food Insecurity among Child (<18 years) Population in the United States," Feeding America, accessed August 31, 2023, https://map.feedingamerica.org/county/2021/child.

The 2019 National Survey of Early Care and Education (NSECE) collected data on home-based providers and identified those who were listed on state licensing lists or other state lists—calling them "listed" home-based providers. Those who are not on licensing or other lists are referred to as "unlisted" home-based providers. While the "listed/unlisted" distinction is not exactly the same as licensed or legally exempt from licensing, those who are unlisted do not appear on licensing lists.

[2] The 2019 National Survey of Early Care and Education (NSECE) collected data on home-based providers and identified those who were listed on state licensing lists or other state lists—calling them "listed" home-based providers. Those who are not on licensing or other lists are referred to as "unlisted" home-based providers. While the "listed/unlisted" distinction is not exactly the same as licensed or legally exempt from licensing, those who are unlisted do not appear on licensing lists and therefore are unlicensed. It is possible that some of the providers who are listed are also legally exempt from licensing. Hence the estimates of LEHBCC providers may be slightly underestimating the actual number.

The 11.5 million is made up of 3.49 million children cared for by LEHBCC providers who are paid and 8 million cared for by LEHBCC providers who are unpaid. Only 17.8 percent of the paid providers reported receiving any government reimbursements, including from subsidies, prekindergarten, CACFP, and other programs (see NSECE 2021b).

[3] "Food Insecurity," Office of Disease Prevention and Health Promotion, accessed August 31, 2023, https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/food-insecurity; "Food Insecurity among Child (<18 years) Population in the United States," Feeding America.

[4] "How to Sign up for CACFP – FFN," Service Employees International Union; CACFP Roundtable, accessed August 31, 2023, https://e6e67899-49d6-428c-ae61-2f9822b39398.usrfiles.com/ugd/e6e678_dec453cce9d44778906009beddf9f04b.pdf; "Trustline," California Department of Social Services (CDSS), accessed August 31, 2023, https://www.cdss.ca.gov/inforesources/community-care/caregiver-background-check/trustline; "License Exempt (Trustline) Providers," CDSS, January 2005, https://www.cdss.ca.gov/cacfp/resources/license-exempt-trustline-providers.

[5] Samuel P. Bauer, director, US Department of Agriculture, Food and Nutrition Services, Child Nutrition Division, "Evaluation of State or Local Licensing and Approval," policy memorandum to regional directors, child nutrition programs, all regions, May 7, 1991, https://www.fns.usda.gov/cacfp/evaluation-state-or-local-licensing-and-approval.

This policy memorandum helps clarify state responsibilities in situations where the state does not license certain settings. It specifies, "Essentially, licensing and approval is a process under which criteria are established and compliance with those criteria evaluated. We have consistently held that the number and suitability of these criteria are determined by state and/or local officials, as is the appropriate method monitoring compliance with them. State or local licensing or approval requirements define what is an acceptable care environment pursuant to contemporary state or local standards. Licensing/approval requirements will entail submission of only such basic information as name and address would be acceptable. With regard to compliance with local or state standards, provided for in Section 226.6(d)(3), licensing or approval procedures must provide for evaluation of a facility against established standards. This evaluation may range from onsite reviews of facilities by licensing/approval officials to a review of a self-certification checklist submitted by a facility operator as to compliance with specific standards as established state and local licensing/approval officials."

[6] Nina Chien, "Factsheet: Estimates of Child Care Eligibility & Receipt for Fiscal Year 2019," Department of Health and Human Services, September 12, 2022, https://aspe.hhs.gov/reports/child-care-eligibility-fy2019.

[7] "Creating a Family-Friendly Child Care Assistance Application," Child Care Technical Assistance Network, last updated September 23, 2023, https://childcareta.acf.hhs.gov/creating-family-friendly-child-care-assistance-application.

[8] "Child Care and Development Fund Final Rule Frequently Asked Questions," Office of Child Care (OCC), June 12, 2023, https://www.acf.hhs.gov/occ/faq/child-care-and-development-fund-final-rule-frequently-asked-questions#HEALTH_AND_SAFETY_REQUIREMENTS.

[9] Providers are reimbursed for meals served to children in their care at a rate set at the federal level. There are two tiers of reimbursement for home-based child care. Tier I: A provider can get a higher Tier I rate for all the children in her care if she lives in a geographical area with low incomes or if she has low income, or she can get the higher rate for individual children from families with low incomes. If she is Tier I, she can also get this rate to help cover meals for her own children as long as she has proven eligibility and is serving other children as well. Tier II: The Tier II level has a significantly lower payment (about half), and the provider's own child's meals and snacks cannot be claimed for reimbursement. In the 2023–24 l school year, the rates for homes in the contiguous US were, for example, $1.65 for Tier I and $0.59 for Tier II for breakfast, and $3.12 for Tier 1 and $1.88 for Tier II for lunch and dinner. See Rates, and Administrative Reimbursement Rates for Sponsoring Organizations of Day Care Homes for the Period July 1, 2023 Through June 30, 2024, 88 Fed. Reg. 129 (July 7, 2023), https://www.govinfo.gov/content/pkg/FR-2023-07-07/pdf/2023-14317.pdf

[10] "Food Insecurity among Child (<18 years) Population in the United States," Feeding America.

[11] "Food Insecurity," Office of Disease Prevention and Health Promotion; "Food Insecurity among Child (<18 years) Population in the United States," Feeding America.

[12] "Child Nutrition Tables: National Level Monthly Data: Child and Adult Care Food Program," USDA, FNS.

[13] Although we often discuss these states' policies and their implications in present tense and the policies are all likely still in effect, we acknowledge that we collected these data in 2022 and it is possible that some policy changes have been made since then. The insights we provide reflect what was true in 2022.

[14] "Child Nutrition Tables: National Level Monthly Data: Child and Adult Care Food Program," USDA, FNS.

[15] Authors' calculation based on CACFP contacts' information: "Child & Adult Care Food Program Contacts," United States Department of Agriculture, Food and Nutrition Service, accessed July 14, 2023, https://www.fns.usda.gov/cacfp/program-contacts.

[16] Part 226—Child and Adult Care Food Program, Subpart C—State Agency Provisions, 7 CFR 226 (Aug. 20, 1982), https://www.ecfr.gov/current/title-7/subtitle-B/chapter-II/subchapter-A/part-226.

[17] See Part 226—Child and Adult Care Food Program, Subpart C—State Agency Provisions, 7 CFR 226 (Aug. 20, 1982), https://www.ecfr.gov/current/title-7/subtitle-B/chapter-II/subchapter-A/part-226.
Specifically, the regulations say: "(4) ***Alternate approval procedure:*** Each State agency shall establish procedures to review information submitted by institutions for centers or homes for which licensing or approval is not available in order to establish eligibility for the Program. Licensing or approval is not available when:

- No Federal, State, or local licensing/approval standards have been established for child care centers of day care homes; or
- No mechanism exists to determine compliance with licensing/approval standards. In these situations, independent centers and sponsors on behalf of their facilities, may choose to demonstrate compliance with either CACFP child care standards, applicable State child care standards, or applicable local child care standards. State agencies shall provide information about applicable State child care standards and CACFP child care standards to institutions, but may require institutions electing to demonstrate compliance with applicable local child care standards to identify and submit these standards. The State agency may permit certification forms, and may grant approval without first conducting a compliance

review at the center or facility. But the State agency shall require submission of health/sanitation and fire/safety permits or certificates for all independent centers and facilities seeking alternative child care standards approval."

[18] Samuel P. Bauer, director, US Department of Agriculture, Food and Nutrition Services, Child Nutrition Division, "Evaluation of State or Local Licensing and Approval," policy memorandum to regional directors, child nutrition programs, all regions, May 7, 1991, https://www.fns.usda.gov/cacfp/evaluation-state-or-local-licensing-and-approval.

This policy memorandum helps clarify state responsibilities in situations where the state does not license certain settings. It specifies, "Essentially, licensing and approval is a process under which criteria are established and compliance with those criteria evaluated. We have consistently held that the number and suitability of these criteria are determined by state and/or local officials, as is the appropriate method monitoring compliance with them. State or local licensing or approval requirements define what is an acceptable care environment pursuant to contemporary state or local standards. Licensing/approval requirements will entail submission of only such basic information as name and address would be acceptable. With regard to compliance with local or state standards, provided for in Section 226.6(d)(3), licensing or approval procedures must provide for evaluation of a facility against established standards. This evaluation may range from onsite reviews of facilities by licensing/approval officials to a review of a self-certification checklist submitted by a facility operator as to compliance with specific standards as established state and local licensing/approval officials."

[19] Cynthia Long, director, US Department of Agriculture, Food and Nutrition Services, Child Nutrition Division, "Monitoring of Licensing Requirements in the Child and Adult Care Food Program," policy memorandum to regional directors, special nutrition programs, all regions and state directors, child nutrition programs, all states, July 26, 2013, https://www.fns.usda.gov/cacfp/monitoring-licensing-requirements-cacfp.

[20] "How to Sign up for CACFP – FFN," Service Employees International Union; CACFP Roundtable; "Trustline," California Department of Social Services (CDSS); "License Exempt (Trustline) Providers," CDSS.

[21] The 11.5 million is made up of 3.49 million children cared for by LEHBCC providers who are paid and 8 million cared for by LEHBCC providers who are unpaid. Only 17.8 percent of the paid providers reported receiving any government reimbursements, including from subsidies, prekindergarten, CACFP, and other programs. See NSECE (2021b).

[22] "Food Insecurity among Child (<18 years) Population in the United States," Feeding America.

[23] "Child Care," Illinois Department of Human Services, accessed August 31, 2023, https://www.dhs.state.il.us/page.aspx?item=29720.

[24] "Becoming a Child Care Provider," ODELC (Oregon Department of Early Learning and Care), accessed August 31, 2023, https://www.oregon.gov/delc/providers/pages/become-a-provider.aspx#LicensedExemptChildCareOverview.

[25] "Home-Based Child Care Centers," Louisiana Department of Education, Louisiana Believes, accessed August 31, 2023, https://www.louisianabelieves.com/early-childhood/home-based-child-care-centers.

[26] "Child Care and Development Fund Final Rule Frequently Asked Questions," OCC.

[27] "Child Care and Development Fund Reauthorization," OCC, June 12, 2023, https://www.acf.hhs.gov/occ/ccdf-reauthorization.

[28] "Home-Based Child Care Centers," Louisiana Department of Education, Louisiana Believes.

[29] MyPlate, US Department of Agriculture, accessed August 31, 2023, https://www.myplate.gov/.

[30] "Creating a Family-Friendly Child Care Assistance Application," Child Care Technical Assistance Network.

[31] Chien, "Factsheet: Estimates of Child Care Eligibility & Receipt for Fiscal Year 2019."

[32] In 2020, for example, 24 states did not report any LEHBCC providers in their CCDF caseload that could potentially qualify for CACFP (i.e., they were LEHBCC providers caring for children outside of the child's home), and another 10 states reported less than 5 percent of their caseload in these settings (authors' calculations from table 6 in "FY 2020 Preliminary Data Table 6 - Average Monthly Percentages of Children Served in All Types of Care," Administration for Children and Families (ACF), May 24, 2022, https://www.acf.hhs.gov/occ/data/fy-2020-preliminary-data-table-6.

[33] "Child Care and Development Fund Final Rule Frequently Asked Questions," OCC.

[34] Child and Adult Care Food Program: National Average Payment Rates, Day Care Home Food Service Payment Rates, and Administrative Reimbursement Rates for Sponsoring Organizations of Day Care Homes for the Period July 1, 2023 Through June 30, 2024, 88 Fed. Reg. 129 (July 7, 2023), https://www.govinfo.gov/content/pkg/FR-2023-07-07/pdf/2023-14317.pdf.

[35] Additional challenges for home-based child care providers with CACFP reimbursement are discussed in Adams and Hernandez-Lepe (2021).

[36] "Working with Black Families," Children's Bureau, Child Welfare Information Gateway, accessed August 31, 2023, https://www.childwelfare.gov/topics/systemwide/diverse-populations/black/.

[37] Child and Adult Care Food Program: National Average Payment Rates, Day Care Home Food Service Payment Rates, and Administrative Reimbursement Rates for Sponsoring Organizations of Day Care Homes for the Period July 1, 2023 Through June 30, 2024, 88 Fed. Reg. 129 (July 7, 2023), https://www.govinfo.gov/content/pkg/FR-2023-07-07/pdf/2023-14317.pdf.

[38] "Family, Friend and Neighbor Child Care: Supporting Diverse Families and Thriving Economies," Home Grown Child Care, accessed August 31, 2023, https://homegrownchildcare.org/wp-content/uploads/2022/06/HomeGrown-Supporting-Diverse-Families-Thriving-Economies-final-6.2.22.pdf.

[39] Samantha Marshall, "CACFP Virtual Monitoring: Community Experiences," CACFP Roundtable, June 5, 2023, https://www.ccfproundtable.org/post/cacfp-virtual-monitoring-community-experiences; Samantha Marshall, "CACFP Virtual Monitoring: Different Needs = Needed Flexibility," CACFP Roundtable, May 18, 2023, https://www.ccfproundtable.org/post/cacfp-virtual-monitoring-different-needs-needed-flexibility.

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