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Family Day Care Home (FDCH) Participation Study

Written Summary

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Executive Summary

The Child and Adult Care Food Program (CACFP) is designed to support the health and wellness of children and adults in care settings. The program is administered by the U.S. Department of Agriculture's (USDA) Food and Nutrition Service (FNS) through State Child Nutrition Agencies. CACFP reimburses child care providers, including centers, family day care homes (FDCHs), before- and afterschool programs, and emergency shelters, for meals served to eligible children in their care. These reimbursements help providers serve populations with low incomes. They also enable providers with lower household income to provide child care at a lower cost.

This study focuses specifically on FDCHs participating in CACFP. These providers serve a critical need within the child care system, often offering longer hours of care (often at a lower cost) than other types of providers to children in their own communities and neighborhoods (Johnson, 2005; Porter et al., 2010). Over the past two decades, the number of FDCHs enrolled in CACFP has decreased by almost half (USDA ERS, 2019). The reasons for this decline are unclear. However, the reduction in CACFP participation among FDCHs occurred at the same time the overall number of FDCHs declined, and it is possible the decline in CACFP-enrolled FDCHs is primarily the result of the decline in FDCHs (National Center on Early Childhood Quality Assurance, 2019). It is also possible that providers face obstacles in participating in CACFP or that retention of FDCHs in CACFP could be increased through additional support for participating providers. Understanding the reasons for the decline in FDCHs in CACFP could help expand vulnerable children's access to affordable care with healthy, nutritious meals.

Through a nationally representative[1] survey of current and former CACFP FDCH providers,[2] this study examines their characteristics, patterns of CACFP enrollment, perceptions of CACFP, challenges to participating in CACFP, and recommendations for improving the program. Several findings are noteworthy:

- The study examines the exit rate and timing among providers participating in CACFP before the COVID-19 public health emergency. It confirms the continued decline in CACFP FDCH providers during the COVID-19 public health emergency, despite COVID-19 changes to CACFP that effectively increased the meal and snack reimbursement rate for many providers and increased flexibilities (including fewer in-person monitoring visits and other changes) for all providers between 2021 and 2023 (USDA FNS, 2021b).
    - Of those FDCH providers who had left CACFP since 2019, most were no longer operating FDCHs. Less than a third of former CACFP FDCH providers were still operating FDCHs.
    - Many former providers said they left CACFP because they closed their business due to personal circumstances or the challenges of operating during the COVID-19 public health emergency.

[1] Five States did not submit data to FNS and were not included in the study: Alaska, Connecticut, Hawaii, Maryland, and Nevada. The survey produced results that are representative of the Nation except for these five States.

[2] Current providers are those who reported being enrolled in CACFP as FDCHs at the time of survey completion. Former providers are those who were enrolled in CACFP as FDCHs as of 2019 but were not enrolled in CACFP as FDCHs at the time of survey completion.

- Current and former providers largely perceived CACFP positively, finding the program easy to enroll in and praising it for helping provide food to more children.
    - While over half of current and half of former providers said that parents seemed to know little about CACFP before enrolling their children, a majority of current and former providers said that after enrollment, parents thought CACFP reduced their stress and helped them feed their children healthy foods.
    - Over a quarter of current providers and a quarter of former providers said they had not experienced any issues while participating in CACFP.
- Current and former providers also reported few issues with their sponsors. In many cases the providers' main contact in CACFP is through their relationship with their sponsor, which may greatly impact providers' experience in CACFP.
    - Less than 5 percent of former providers reported leaving CACFP because their sponsor no longer participated in CACFP or because their sponsor did not provide enough guidance and support or because their sponsor did not have staff who spoke their primary language.
    - Under 3 percent of current providers reported not getting enough support from their sponsor or having difficulty finding sponsor staff who spoke their primary language.

These findings suggest that declines in CACFP participation may primarily be the result of declines in FDCH providers overall, and these closures were commonly attributable to circumstances outside the program's control.

Providers did mention areas they felt the program could be improved, including both issues that would require statutory approval to change and issues that could be addressed through education or policy.

- Over half of current and half of former providers who experienced challenges said that meal and snack reimbursements did not cover their food costs. It should be noted that reimbursements are not designed to completely cover food costs, and providers also cited the fact of CACFP reimbursements as a benefit of the program. However, many providers indicated that they felt that current reimbursements were insufficient. This response aligns with the findings of the Study of Nutrition and Activity in Childcare Settings I, which focused on child care centers and HeadStart programs in 2016 and 2017 (Logan et al., 2021).
- Over one-third of providers who experienced issues said that unannounced monitoring visits were disruptive to child care.
- Over one-quarter of providers who experienced issues reported difficulty attending in-person trainings.

Providers' recommendations for policy changes and program supports closely track these issues:

- Over 80 percent of current and former FDCH providers recommended increasing the meal and snack reimbursement rate (this would require an act of Congress).
- About a third of current and former providers recommended replacing some in-person monitoring visits with remote monitoring visits.
- Over a third of current and former providers endorsed the program offering remote trainings.

Providers also requested tools to make it easier to meet nutritional requirements, including checklists to meet requirements and apps to help shop for foods that meet the requirements. They also sought help with accessing healthy foods at a lower cost. Some of the programmatic supports sought by both current and former providers have already been implemented, many prior to the fielding of the survey. For instance, many trainings are now offered remotely, and FNS provides many recipes and menus with foods from different cultures on the CACFP website. This indicates that FNS could aid providers by making existing supports more accessible and more widely understood. Sixty-seven percent of current providers and former providers said they preferred to learn about CACFP from other providers, suggesting a role for peer-to-peer education on the program and its resources.

Overall, the study suggests that policy and programmatic challenges may not be the primary reason FDCHs leave CACFP. However, changes in these areas may make it easier for FDCH operators to serve children in their local communities and enhance the nutrition safety net.

Chapter 1. Study Introduction and Background

Study Purpose

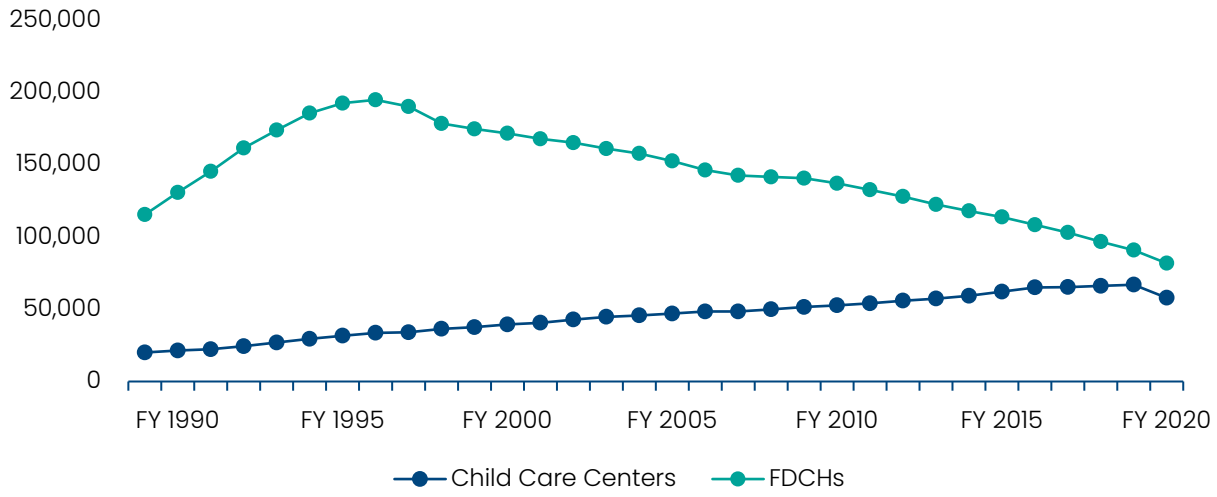
The Child and Adult Care Food Program (CACFP), administered by the Food and Nutrition Service (FNS) through State Child Nutrition Agencies, plays a critical role in supporting the health and wellness of children and adults by reimbursing providers for nutritious meals served to eligible children and adults in their care. Child care centers (including Head Start Programs), family day care homes (FDCHs), before- and afterschool programs, adult care centers, and emergency shelters serving children can participate in CACFP.

FDCHs, the focus of this study, are required to have a sponsor organization to participate in CACFP (7 C.F.R. § 226.18(b)). Sponsors ensure the home's compliance with Federal and State regulations, provide CACFP training, monitor the home's meal service, and process the claims for meal reimbursement. Sponsor organizations also determine the appropriate meal reimbursement tier for each of their FDCHs: Tier I or Tier II. Tier I FDCHs must be (1) in a low-income area where at least 50 percent of children qualify for free and reduced-price school meals, as determined by school records or Census data, or (2) operated by a provider whose household income is at or below 185 percent of poverty (USDA FNS, 2007). Tier II homes do not meet the location or provider income criteria for a Tier I home and therefore receive lower reimbursements than Tier I homes (USDA FNS, 2021a). Between 2021 and 2023, FNS waived the location and provider income criteria to ensure all providers could receive Tier I reimbursement rates as part of the nationwide COVID-19 Child Nutrition Response waivers (USDA FNS, 2021b).

In the last 25 years, the number of FDCHs in CACFP has decreased by 46 percent, while the number of centers in CACFP has almost doubled (see figure 1). Although only about 5 percent of FDCH sponsors reported asking FDCH providers why they left CACFP (Glantz & Germuth, 2018), among those that asked, most sponsors (57 percent) cited FDCHs closing as the reason for leaving CACFP. Indeed, the number of licensed small FDCHs (those with a sole caregiver or a caregiver and a partner/helper) fell by 48 percent between 2005 and 2017 (National Center on Early Childhood Quality Assurance, 2019). More recently, a survey of Child Care Resource and Referral agencies by Child Care Aware of America found a decrease of 10 percent in all licensed FDCHs between December 2019 and March 2021 (Child Care Aware of America, 2022). Although the exact reasons for this general decline are unknown, State licensure groups attribute it to economic downturn and increased regulation (National Association for Regulatory Administration, 2014).

This decline is concerning because FDCHs have a distinct role in the demanding child care market. They serve smaller numbers of children and are typically located in the same neighborhood as the families they serve. FDCH providers also have diverse ethnic backgrounds and offer longer hours of care (Johnson, 2005; Porter et al., 2010).

Figure 1. Number of FDCHs and Child Care Centers in CACFP, FY 1989–2020



CACFP = Child and Adult Care Food Program; FDCH = family day care home; FY = fiscal year
Source: USDA ERS National Data Bank, 2019

Research Objectives and Questions

The FDCH Participation Study is the first national study to ask FDCH providers why they participate in CACFP and why those who left the program made the decision to leave. The study fills this knowledge gap by 1) identifying the challenges and barriers FDCH providers participating in CACFP face; and 2) gathering and summarizing recommendations from current and former FDCH providers to address these issues. In addition to differences by CACFP enrollment status (former/current), the study also examines differences by urbanicity (urban/rural) and program size (large/small) among the former and current participants. The objectives and questions for the study are the following:

1. Identify and describe the reasons FDCH providers discontinue their participation in CACFP.
   - What are the main reasons FDCH providers no longer participate in CACFP?
   - How do those reasons vary by location and number of children? Which factors are most closely associated with the different reasons for leaving?
   - How frequently do FDCHs outgrow their status as homes and reclassify as centers? How frequently do FDCHs cease to operate as licensed homes?
2. Determine and describe CACFP program statutory and regulatory requirements and operational and financial considerations frequently cited as burdensome by involved parties.
3. Gather and summarize recommendations from FDCH providers on how to reduce barriers or challenges to CACFP participation.
   - What improvements could be made to policies and procedures to reduce barriers or challenges to participation? What feasible policy and program flexibilities and supports would help retain FDCHs in CACFP?

- What are the reported benefits of participation in CACFP? What are the reasons providers continue to participate?
- How much does public perception of CACFP affect the decision of FDCHs to continue participation in the program? How can FNS and States expand the understanding of CACFP among providers?

Organization of the Report

This report is organized into nine chapters. Chapter 2 describes the study methods, including the sampling design and analyses conducted. Chapter 3 highlights providers' characteristics. Chapter 4 presents current FDCH operating status and CACFP enrollment status of providers and the timing of ceasing FDCH operation and/or leaving CACFP for those who have left. Chapter 5 examines the reasons former FDCH providers closed their FDCHs and left CACFP. Chapter 6 looks at the benefits of CACFP participation as perceived by providers and parents. Chapter 7 presents the challenges of CACFP participation. Chapter 8 highlights providers' recommendations for program improvement. Finally, chapter 9 summarizes and concludes the report.

The report includes three appendices: Appendix A presents the study methods in greater detail; Appendix B includes the survey instrument (in English and Spanish); and Appendix C includes full tables of results.

Chapter 2. Study Methods

This chapter summarizes the methods the study team employed to create the sample frame, survey FDCH providers, and analyze the survey data. Appendix A includes additional details about the survey methodology, including the nonresponse analysis.

Sample Design

The study included currently enrolled and previously enrolled CACFP FDCH providers. The study team defined *current providers* as those FDCH providers who were enrolled in CACFP at the time of sampling (March 2022), while *former providers* were those who were participating in CACFP as FDCH providers in 2019 but were not enrolled in CACFP as FDCH providers in 2022. Former providers could still be operating as an FDCH but were no longer enrolled in CACFP, have re-enrolled in CACFP as a child care center, or have closed their FDCH completely. The study initially called for examining providers by reimbursement tier and CACFP enrollment status. However, the COVID-19 waivers suspending tiering made this analysis infeasible.

The study team created two sampling frames: one for current providers (the list of 2022 providers) and one for former providers (those on the list of 2019 providers but not on the list of 2022 providers). FNS provided data from 46 State agencies on FDCH providers enrolled in CACFP as of March 2022. FNS also provided a list of CACFP FDCH providers from 2019 from 49 States. To match the 2019 data to the 2022 data, providers from the five States that did not provide data in both 2019 and 2022 were excluded.[3] The study team then cleaned the data and matched providers across the 2019 and 2022 files. Providers were first matched by State, sponsor, and provider's first and last name. Providers were considered to be matched if State, sponsor, and first and last name were exactly the same in the 2019 and 2022 files. For the unmatched cases, the study team were then able to match cases using only the State and first and last name of the provider (again, providers were only considered to be a match when the State and first and last name matched exactly). Finally, the study team matched remaining cases by manual examination. In this step, the study team matched providers where, as an example, the State and first and last name were the same in the 2019 and 2022 files but the spelling of the sponsor name was different in the two files. Providers present in the 2019 list but not present in the 2022 list were categorized as former providers. The current providers sample frame included 72,034 providers, while the former providers sample frame included 45,140 providers.

The study team drew two systematic samples of providers from the two sampling frames (current and former) sorted by State, sponsor, and provider size category (based on the number of children cared for).[4] The systematic order ensured that all States who provided data were included in the sample as well as both large and small providers. The use of the sponsor variable in sampling ensured sponsors were not overrepresented by chance.

[3] The following States did not provide data to FNS: Alaska, Connecticut, Hawaii, Maryland, and Nevada.
[4] The study defines small providers as those caring for fewer than seven children; large providers are those caring for seven or more children.

Tables for the distribution of the samples by urbanicity,[5] FNS Regional Office, and provider size category were produced and compared with the frames to confirm each selected sample was balanced. Because the study team assumed former providers would be more difficult to reach than current providers, they oversampled former providers. To produce national-level estimates of current and former providers at the ± .04 level of precision, with a .95 level of confidence for each group, assuming response rate of 35 percent for current providers and 20 percent for former providers, the team sampled 5,264 providers, including 2,393 current providers and 2,871 former providers.

Survey

The study team designed the survey to maximize the collection of data responsive to the research questions while minimizing burden on the providers. The survey included 33 substantive questions, divided into the following sections:

1. "About your family child care home"
2. "Your experience with the Food Program"
3. "Recommendations for helping family child care providers participate in the Food Program"

The survey also asked providers to answer demographic questions (e.g., race and ethnicity of the provider). Appendix B provides the full survey instruments in English and Spanish.

The study team designed the survey in consultation with FNS and individuals with expertise in CACFP and FDCH providers. The survey instrument was pretested with a total of nine current and former providers in California and Virginia. Former providers included those who left CACFP and those who no longer operated FDCH. The team revised the survey based on feedback from pretesting. The survey was translated into Spanish by bilingual translators, and the web version was pretested and cognitively tested in English and Spanish. During cognitive testing, respondents took an average of 25 minutes to answer the survey.

Data Collection

The study team collected data between January 6 and April 17, 2023. All sampled providers received an email invitation to complete the Family Child Care Home (FDCH) Provider Experience Survey via the web and a hardcopy invitation by mail with a $5 pre-incentive, study brochure, and endorsement letters from the USDA, the CACFP Roundtable, National CACFP Sponsors Association, and the National CACFP Forum. All information was sent to providers in both English and Spanish, and providers could choose to complete the survey in English or Spanish.[6]

The study team offered a $40 post-incentive to all providers who completed the survey. The study team mailed reminder postcards to nonresponding providers in February and again in March; a

[5] Urbanicity is defined using National Center for Education Statistics locale categories for the census block of the provider. Providers labeled as urban include those in large, midsize, and small cities and large, midsize, and small suburban areas. Providers labeled as rural include those in fringe, distant, and remote towns and fringe, distant, and remote areas.

[6] At survey close, 5.6 percent of surveys were completed in Spanish, and 94.4 percent were completed in English.

hardcopy survey was also mailed to nonresponding former providers.[7] Data collection closed on April 17, 2023.

Table 1 presents survey completes by CACFP enrollment status at sampling.

Table 1. Survey Completes by CACFP Enrollment Status at Sampling

Provider Status at Sampling[a]	Number of Cases Released	Number of Completes	Percentage of Completes[b]	Response Rate[c]
Current	2,393	1,064	49.0	45.5
Former	2,871	1,106	51.0	39.5
Total	5,264	2,170	100.0	42.2

CACFP = Child and Adult Care Food Program

[a] Based on the sample frame (comparison of the 2019 and 2022 CACFP provider lists). Current providers were defined as providers on the 2022 CACFP list. Former providers were defined as providers on the 2019 list but not the 2022 list.

[b] Percent of completes is the number of completes in the subgroup divided by the total number of completes.

[c] Response rate is the number of completes divided by the total sample, excluding ineligible respondents and duplicates.

Upon processing completed surveys, the study team identified over 400 providers who were sampled as former providers but had re-enrolled in CACFP and were, in fact, current providers. There are two interpretations for this misclassification. First, this number could indicate significant churn in the program if these providers had left the program sometime between 2019 and 2022 but had returned to CACFP by early 2023; the report addresses churn more directly in chapter 4. Second, it is also possible that these providers were incorrectly identified in the 2022 sampling files provided by States as former providers when in fact they had never left at all. It is likely that some of these 400 providers are providers who have churned, while others were misclassified by the State. The study team recategorized these providers as current providers for analytic purposes.

Table 2 presents the number of completes by provider enrollment status at sampling and provider status at survey completion.

Table 2. Number of Completes by Provider Status at Sampling and Provider Status at Survey Completion

Provider Status at Survey Completion[b]	Provider Status at Sampling[a]		Total
	Current	Former	
Current	965	420	1,385
Former	99	686	785
Total	1,064	1,106	2,170

CACFP = Child and Adult Care Food Program; FDCH = family day care home

[a] Based on the sample frame (comparison of the 2019 and 2022 CACFP provider lists). Current providers were defined as providers on the 2022 CACFP list. Former providers were defined as providers on the 2019 list but not the 2022 list.

[b] Based on responses to question 19 of the FDCH Provider Experience Survey

Throughout the rest of the report, the terms “current” and “former” provider refer to provider status at survey completion.

[7] Given higher than expected response rates for current providers, the decision was made not to mail hardcopy surveys to nonresponding current providers.

Weighting

The survey team created weights to (1) reflect the differential probabilities of selection and (2) compensate for survey nonresponse. They designed these weights to produce nationally representative estimates of the current CACFP FDCH provider population and the former CACFP FDCH provider population (excluding the States without provider data), based on the sample frames.[8] The base weight was computed as the inverse of the probability of selection of the main sample; this was adjusted to account for providers with unknown eligibility (providers without any information on whether they qualified for the study). The study team created 100 jackknife replicate weights to estimate variance for analysis purposes. Replicate weights provide consistent variance estimates for population totals, means, percentiles, and ratios. The study team also created stratification variables and other necessary information to be used in analyses, including urbanicity based on the location of the provider.

Findings in the rest of the report are presented using weighted estimates and percentages unless otherwise stated.

Analyses

The study team produced descriptions of all survey items, including the sample size for each item, weighted estimate and standard error, and weighted percentage and standard error. The team also analyzed survey items by CACFP enrollment status at survey completion, urbanicity (rural versus urban), and provider size (small versus large). Appendix C includes full tables of results for analyses discussed in this report.

The study team used Satterthwaite t-tests assuming unequal variances to determine whether responses by different subgroups of interest were statistically significant.

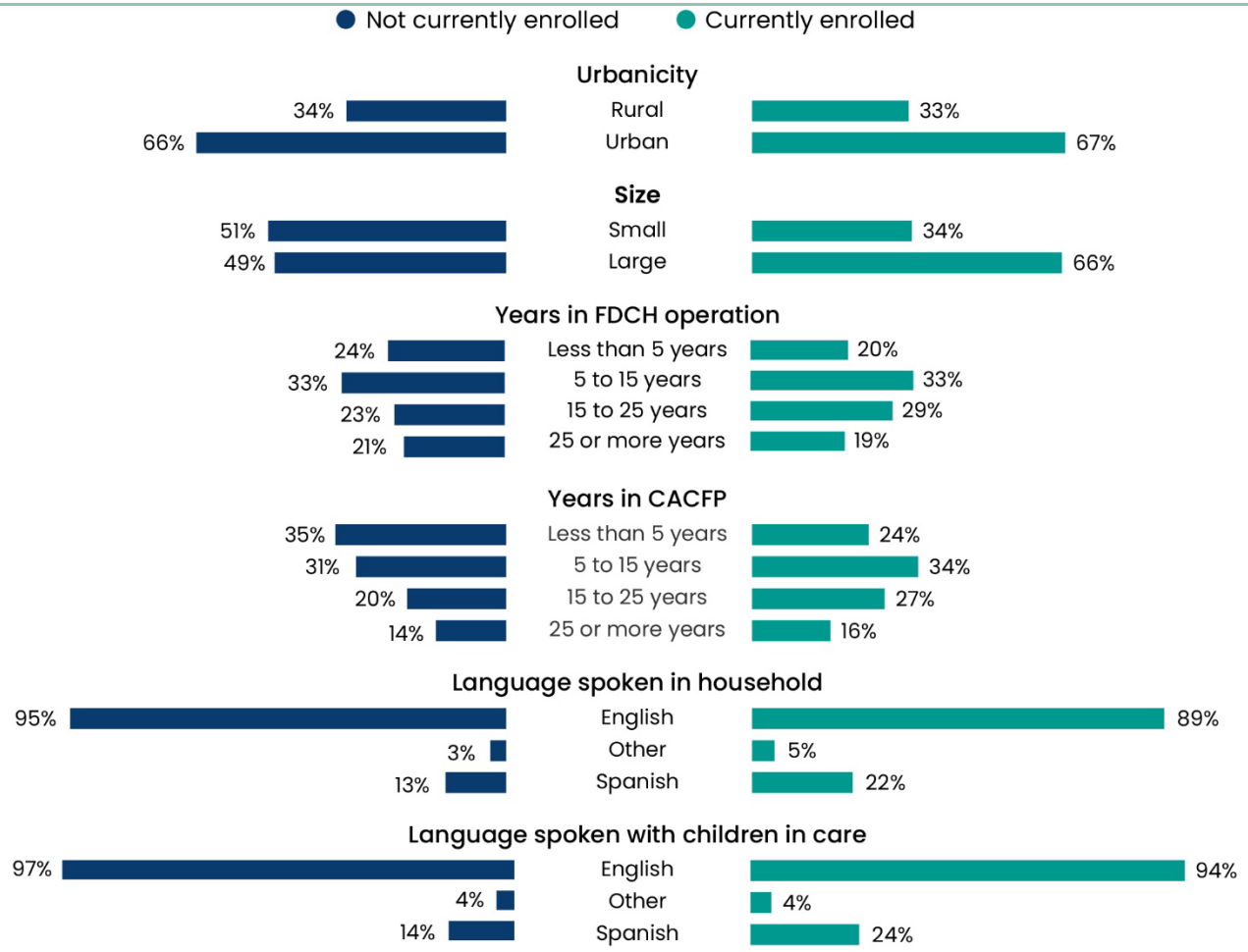
[8] The study team assumed a design effect of 1.25 to account for misclassification of current and former providers and increased the sample size accordingly. Therefore, the misclassification of providers does not affect the representativeness of the sample.

Chapter 3. Provider Characteristics

This chapter presents descriptive analyses of provider characteristics for the provider population; full data appear in Appendix C as tables 1-13. The current provider population is a cohort of providers enrolled in CACFP in 2022 and as of survey completion in 2023. The former provider population is a cohort of those enrolled in CACFP in 2019 and not enrolled as of survey completion. It does not include providers who left before 2019 or those who entered and exited between 2019 and survey completion. Survey provider status (current and former) is defined by survey responses.

Figure 2 presents providers' urbanicity, size, years in FDCH operation, years in CACFP, and primary language spoken, by CACFP enrollment status.

Figure 2. Provider Characteristics



Note: Estimates and percentages were weighted to be nationally representative. The study excluded Alaska, Connecticut, Hawaii, Maryland, and Nevada because they did not submit data to FNS; 39 providers were excluded because of missing data.
Sample size varies by item. Total *n* ranges from 2,147 to 2,170; *n* current providers ranges from 1,353 and 1,381; *n* former providers ranges from 630 and 785.
CACFP = Child and Adult Care Food Program; FDCH = family day care home
Source: FDCH Provider Experience Survey (2023) questions 1, 4, 6, 18, 19, 32, and 33

Current and former providers were largely located in urban areas. More current providers were large providers, while more former providers were small providers. Thirty-three percent of current providers and 33 percent of former providers were in operation as an FDCH for 5 to 15 years. Thirty-four percent of current providers were enrolled in CACFP for 5 to 15 years while 35 percent of former providers was enrolled for less than 5 years.

Providers could select multiple languages spoken; current and former FDCH providers most commonly spoke English, both within their household and with the children they cared for. However, Spanish was also commonly spoken, with 22 percent of current providers and 13 percent of former providers using Spanish with members of their household and 24 percent of current providers and 14 percent of former providers using Spanish with the children under their care.

The study also collected details on several other characteristics:

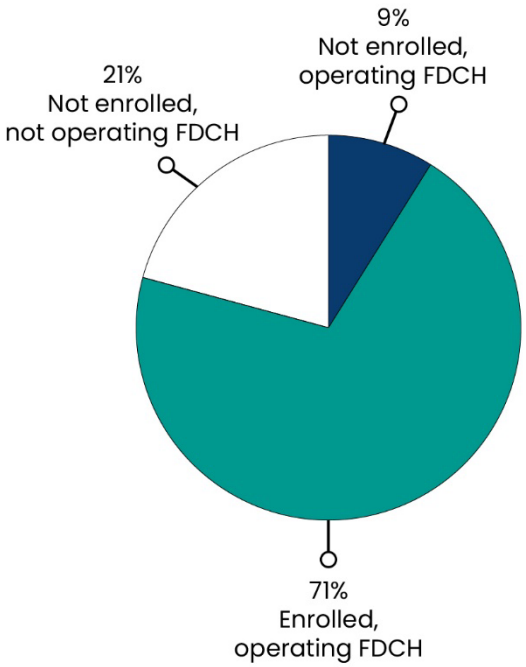
- Providers could report multiple racial identities; over half of former providers and current providers identified as White, over a fifth of former providers and current providers identified as Black or African American, and less than five percent of current providers and former providers identified as Asian, American Indian or Alaska Native, or Native Hawaiian or other Pacific Islander. Slightly over ten percent of current providers and former providers chose "other" or "prefer not to answer" (see Appendix C Table 13 for more detail).
- Sixteen percent of former and 24 percent of current providers identified as Hispanic or Latino/Latina/Latinx.
- The average number of children cared for during a usual week was eight for former providers and nine for current providers.
- The smallest percentage of providers cared for school-aged children on schooldays (59 percent of former providers and 61 percent of current providers). The largest percentage of providers cared for children aged 3–5 years (86 percent of former providers and 90 percent of current providers).
- FDCH providers typically had few staff. Over half of surveyed current and former providers reported having no staff or volunteers, meaning that they operated their FDCH by themselves. Among providers reporting any full or part-time staff, current providers indicated they had a mean of 1.5 full-time paid or volunteer staff and 1.1 part-time paid or volunteer staff while former providers indicated they had a mean of 1.2 full-time paid or volunteer staff and 0.9 part-time paid or volunteer staff.
- Providers were most commonly open 5 days a week. Almost all providers were open either 5 days a week (84 percent) or 6–7 days a week (13 percent), with only small numbers open 2, 3, or 4 days a week or with variable schedules.
- Providers served multiple meals to the children in their care. Lunch (97 percent), afternoon snack (97 percent), and breakfast (90 percent) were the most commonly served meals.

Chapter 4. CACFP Enrollment Status and FDCH Operating Status

This chapter details providers' FDCH operation status, CACFP enrollment status, and the timing of FDCH closures and CACFP disenrollment.

Figure 3 shows the universe of providers from which the sample was selected.

Figure 3. Percentage of Providers, by Whether They Currently Operate FDCH and CACFP Enrollment Status

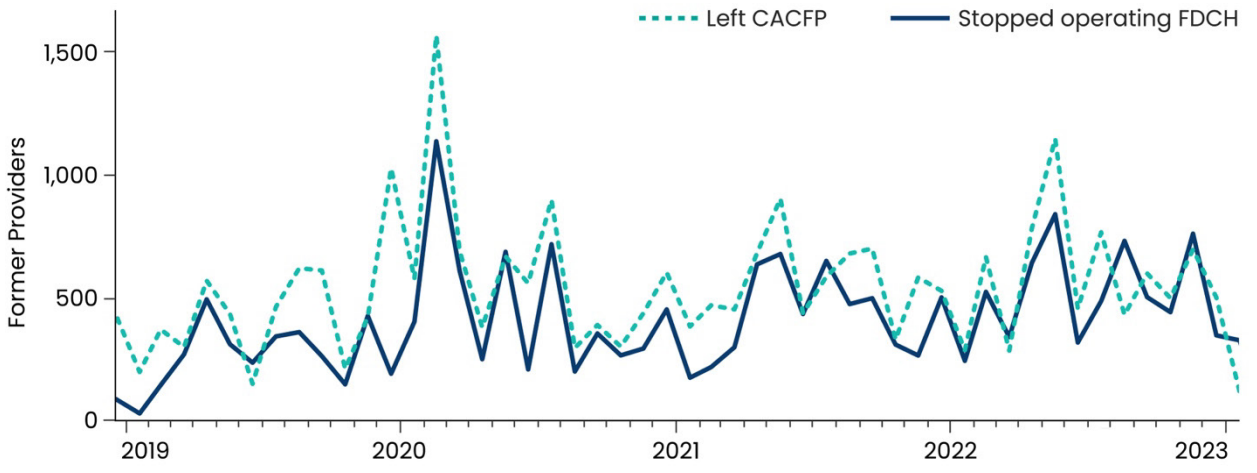


Note: Estimates and percentages were weighted to be nationally representative. The study excluded Alaska, Connecticut, Hawaii, Maryland, and Nevada because they did not submit data to FNS; 39 providers were excluded because of missing data.
Total *n* = 2,165; *n* current providers =1,385; *n* former providers = 780.
CACFP = Child and Adult Care Food Program; FDCH = family day care home
Source: FDCH Provider Experience Survey (2023) questions 1, 19, 20, and 21

Seventy-one percent of providers were current CACFP FDCH providers. Twenty-one percent of providers were former CACFP FDCHs who had closed their FDCH. Only nine percent of providers were former CACFP FDCHs who were still operating FDCH. Most former providers had closed their FDCHs, suggesting a correlation between the decision to leave CACFP and to close the FDCH.

Understanding the timing of CACFP disenrollment and FDCH closures can help determine trends over time and suggest the reasons providers disenroll and/or close their FDCHs. Figure 4 presents the number of former providers by the month and year they left CACFP and, for those who closed their FDCHs, the year they closed. The line labeled "stopped operating FDCH" is a subset of "left CACFP"—these are former CACFP FDCHs who closed their FDCHs.

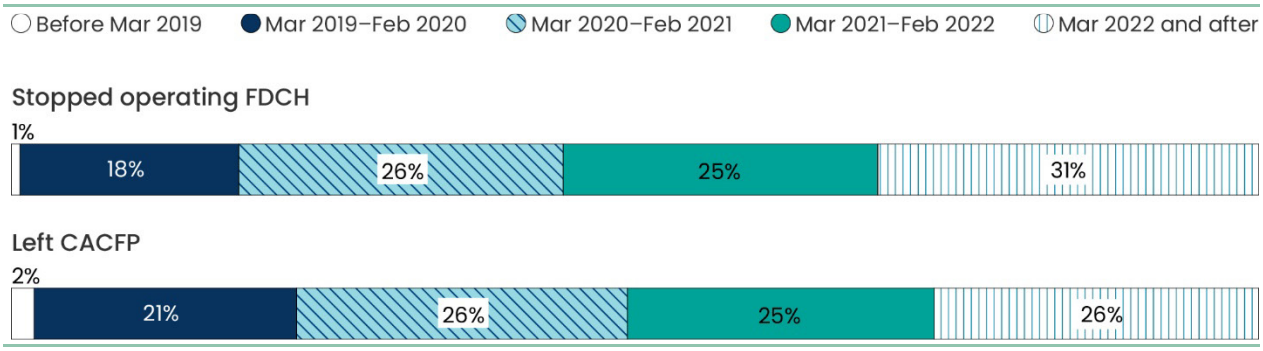
Figure 4. Number of Former CACFP FDCHs, by the Month and Year They Left CACFP, and Number of Former CACFP FDCHs Who Closed Their FDCH, by the Month and Year They Closed Their FDCH



Note: Estimates and percentages were weighted to be nationally representative. The study excluded Alaska, Connecticut, Hawaii, Maryland, and Nevada because they did not submit data to FNS; 136 providers were excluded because of missing or invalid data.
N = 649 former CACFP FDCH providers
n = 515 former CACFP FDCH providers who no longer operate a FDCH
CACFP = Child and Adult Care Food Program; FDCH = family day care home
Source: FDCH Provider Experience Survey (2023) questions 1, 19, 20, and 21

Figure 5 presents the percentage of former providers that closed their FDCHs and the percentage of former providers that left CACFP in each time period, aggregating data from figure 4.

Figure 5. Percentage of Former CACFP FDCHs by the Year They Left CACFP, and Percentage of Former CACFP FDCHs Who Closed Their FDCH, by the Year They Closed Their FDCH



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CACFP = Child and Adult Care Food Program; FDCH = family day care home
Source: FDCH Provider Experience Survey (2023) questions 1, 19, 20, and 21

These findings show an increase in CACFP disenrollment and FDCH closures early in 2020, coinciding with the beginning of the COVID-19 public health emergency. Twenty-six percent of

former CACFP FDCHs who closed their FDCH ceased operating between March 2020 and February 2021; 26 percent of former CACFP FDCHs, including those who closed their FDCHs and those who did not, left CACFP in the same year. But while this spike is notable, the overall level of disenrollments and closures is relatively constant over the 2019 to 2023 period, with between 6,200 and 7,200 providers leaving CACFP each year. These data suggest that although the public health emergency contributed to declines in CACFP FDCHs, it is by no means the whole story.

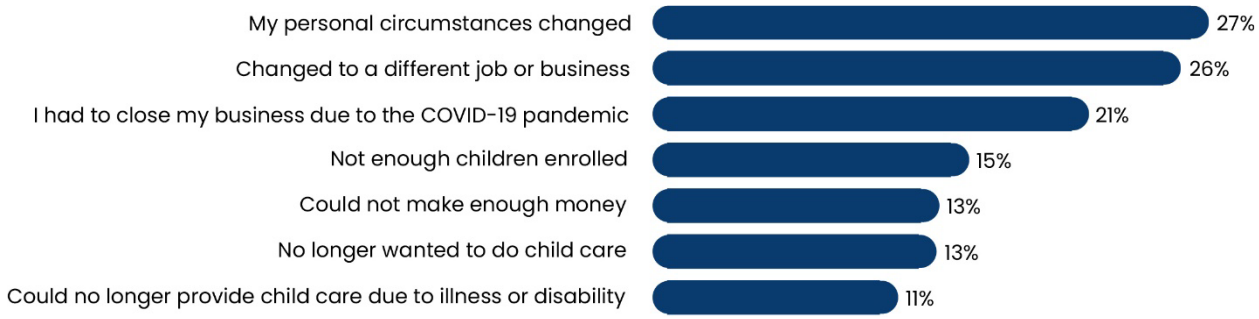
Many of those providers who leave CACFP may return. Chapter 2 discussed one possible indication of churn: providers sampled as former providers who indicated they were currently enrolled in CACFP. However, this measure is inexact because it only captures misclassification of sampled providers. The survey asked about churn directly. About eight percent of current CACFP FDCH providers reported they had left the program in the past (Appendix C table 17). When asked how long they spent not participating in CACFP, the most common response was 3 or more years (29 percent), followed by 7 to 12 months (23 percent) (Appendix C table 18).

Chapter 5. Reasons FDCH Providers Close Their FDCHs and Reasons They Leave CACFP

The prior results show that closing FDCHs and leaving CACFP are overlapping decisions, with most former CACFP FDCHs closing their FDCHs. To investigate these decisions more closely, the study team asked former CACFP FDCHs why they closed their FDCHs. The study also asked former CACFP FDCHs, including those who did and those who did not close their FDCHs, why they left CACFP.

Figure 6 shows the top reasons (those selected by five percent or more of providers) former CACFP FDCHs closed their FDCHs; providers could select multiple answers.

Figure 6. Top Reasons for Leaving the FDCH Business Among Providers No Longer Operating FDCH

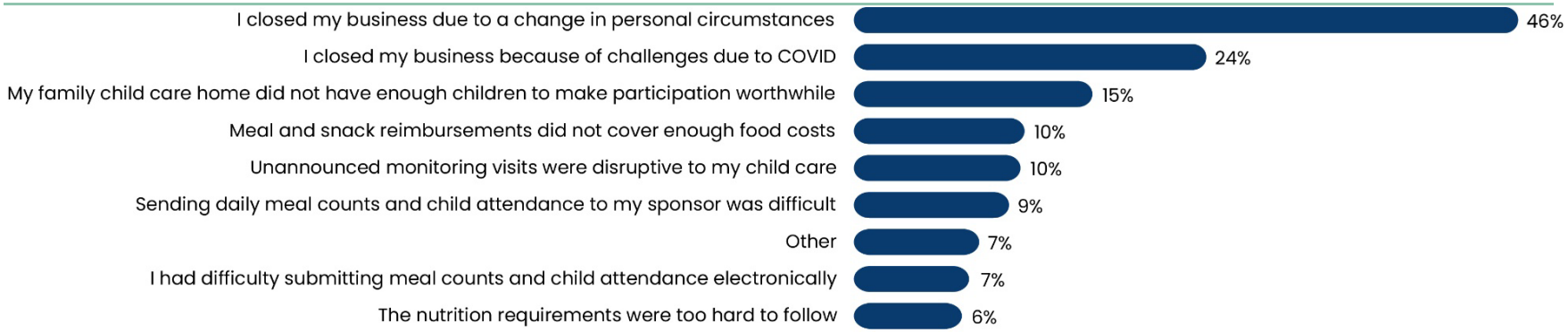


Note: Estimates and percentages were weighted to be nationally representative. The study excluded Alaska, Connecticut, Hawaii, Maryland, and Nevada because they did not submit data to FNS; 1,602 providers were skipped out or ineligible for this question; additional 4 providers were excluded because of missing data. The following responses were selected by less than 5 percent of providers and are not shown: "disqualified from CACFP," "I now operate a child care center," "issues with sponsoring organization," "my home is no longer a suitable space for child care," and "I had difficulty complying with child care regulations and requirements." Providers could choose all applicable options; percentages sum to more than 100.
n = 564 former CACFP FDCH providers who no longer operate a FDCH
CACFP = Child and Adult Care Food Program; FDCH = family day care home
Source: FDCH Provider Experience Survey (2023) question 3

The most common reasons why providers left the FDCH business were "my personal circumstances changed" (27 percent), "[I] changed to a different job or business" (26 percent), and "I had to close my business due to the COVID-19 pandemic" (21 percent). Additional reasons former FDCH providers closed their FDCH appear in Appendix C table 19. Less than four percent closed their business because they had difficulty complying with child care regulations and requirements, less than two percent said they closed because they were disqualified from CACFP, and only three percent of former providers said that they closed their FDCH to open as a child care center.

These data suggest that factors related to CACFP did not significantly contribute to the decision to close a FDCH. How do such factors contribute to the decision to leave CACFP? Figure 7 presents the top reasons former CACFP FDCHs left CACFP; the respondents include former CACFP FDCHs who closed their FDCH and former CACFP FDCHs who continued to operate their FDCH. Providers could select more than one answer.

Figure 7. Top Reasons Providers Left CACFP



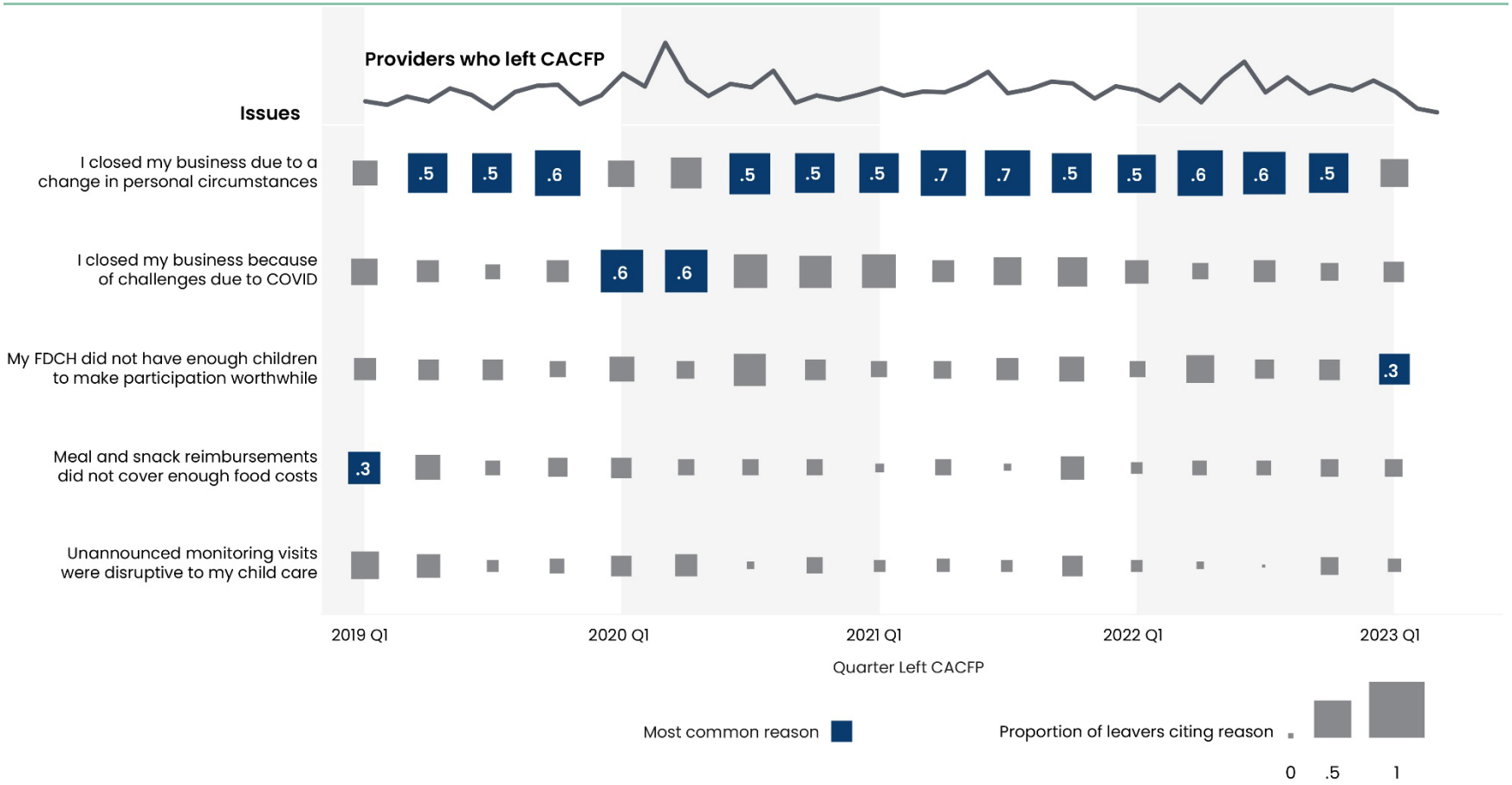
Note: Estimates and percentages were weighted to be nationally representative. The study excluded Alaska, Connecticut, Hawaii, Maryland, and Nevada because they did not submit data to FNS. Providers could choose all applicable options; percentages sum to more than 100. The following responses were selected by less than 5 percent of providers and are not shown: "lost license or registration to provide child care," "disqualified from the CACFP," "sponsor no longer participated in the CACFP," "no longer serve meals and snacks," "collecting income eligibility forms from parents was difficult," "the CACFP nutrition requirements were too hard to follow," "getting meal reimbursements was often delayed," "parents have negative views about the CACFP," "sponsor did not provide enough guidance and support," "unannounced monitoring visits were disruptive to child care," "had difficulty attending in-person trainings," "sponsor did not have staff who spoke my primary language," "did not qualify for the higher reimbursement rate," and "the criteria for what counts as a Serious Deficiency was too harsh."
n = 774 former CACFP FDCH providers
CACFP = Child and Adult Care Food Program; FDCH = family day care home

Reasons for leaving CACFP were similar to reasons for closing FDCHs. The most common reason selected for leaving CACFP was providers closing their business because of personal circumstances (including moving, illness, and career change) (46 percent). The next most common reason for leaving was closing their business due to challenges from COVID-19 (24 percent). In write-in responses (shown as "other" in figure 6), many former providers expanded on these answers, speaking of the stress of having additional people in their homes during COVID-19 (including the children themselves) and the stress of managing a child care business when life circumstances changed (such as difficulty caring for children when a spouse also needed care).

Fifteen percent of providers continued operating as FDCHs but left CACFP because their family child care home did not have enough children to make participation worthwhile. Few providers indicated they left CACFP because of disqualification from CACFP or specific burdens of CACFP regulations. Ten percent or less of former providers selected responses indicating they left because of disqualification; because sending daily meal counts and child attendance was difficult; because collecting annual re-enrollment forms was difficult; because they had difficulty submitting meal counts and child attendance electronically; because collecting income eligibility forms from parents was difficult; or because nutrition requirements were too hard to follow.

An analysis of these reasons by the timing of when the provider left CACFP (Figure 8) highlights how personal circumstances dominate the reasons for leaving CACFP. The figure looks at the top five reasons for leaving CACFP from Figure 7 by the quarter in which the former providers reported leaving CACFP. This analysis illustrates whether different reasons are given at different times to disentangle large-scale disruptions (e.g., COVID-19) from personal reasons.

Figure 8. Top Reasons for Leaving CACFP Among Former CACFP FDCH Providers, by Quarter and Year of Leaving CACFP



Note: Estimates and percentages were weighted to be nationally representative. The study excluded Alaska, Connecticut, Hawaii, Maryland, and Nevada because they did not submit data to FNS. Figure shows top five response categories. Providers could choose all applicable options; percentages sum to more than 100.
n = 649 former CACFP FDCH providers
CACFP = Child and Adult Care Food Program; FDCH = family day care home; Q = quarter
Source: FDCH Provider Experience Survey (2023) questions 1, 3, 19, and 25

Personal circumstances are among the most commonly chosen reasons in each quarter. Meanwhile, the figure shows that those who left because of COVID-19 did so largely at the beginning of the public health emergency (and before some COVID-19 waivers had been implemented).[9]

The study team examined how the reasons for leaving CACFP varied by urbanicity of the provider and provider size; these results appear in Appendix C tables 20b and 20c. The analysis showed few significant differences by these provider characteristics. Rural providers were more likely to say they closed their business because of a change in personal circumstances compared with urban providers, although "closed business due to a change in personal circumstances" was the choice of a plurality of urban and rural providers. Small providers were more likely than large providers to say they left CACFP because their FDCH did not have enough children to make participation worthwhile. Large providers were more likely than small providers to say they left because program materials were not available in their primary language.

Finally, the study team examined the correlation between provider characteristics, including urbanicity, provider size, years in FDCH operation, and years in CACFP, and the reasons for leaving CACFP among former providers; these results appear in Appendix C table 20d. No provider characteristic was closely correlated with the reason for leaving. That is, while several characteristics were associated with a reason for leaving, no characteristic was strongly correlated with a reason for leaving. For example, while small providers were more likely than large providers to say they left CACFP because their FDCH did not have enough children to make participation worthwhile, provider size on its own did not predict whether an individual former provider said they left because their FDCH did not have enough children to make participation worthwhile. Overall, the reasons for leaving CACFP appear complex and nuanced.

[9] Note that some former providers gave COVID-19 as a reason why they left CACFP, but gave a date when they left the program that is before the COVID-19 pandemic began. This may be due to providers misremembering the date they left CACFP, or they may have left and returned to the program multiple times and their given reason for leaving does not correspond to the date they gave.

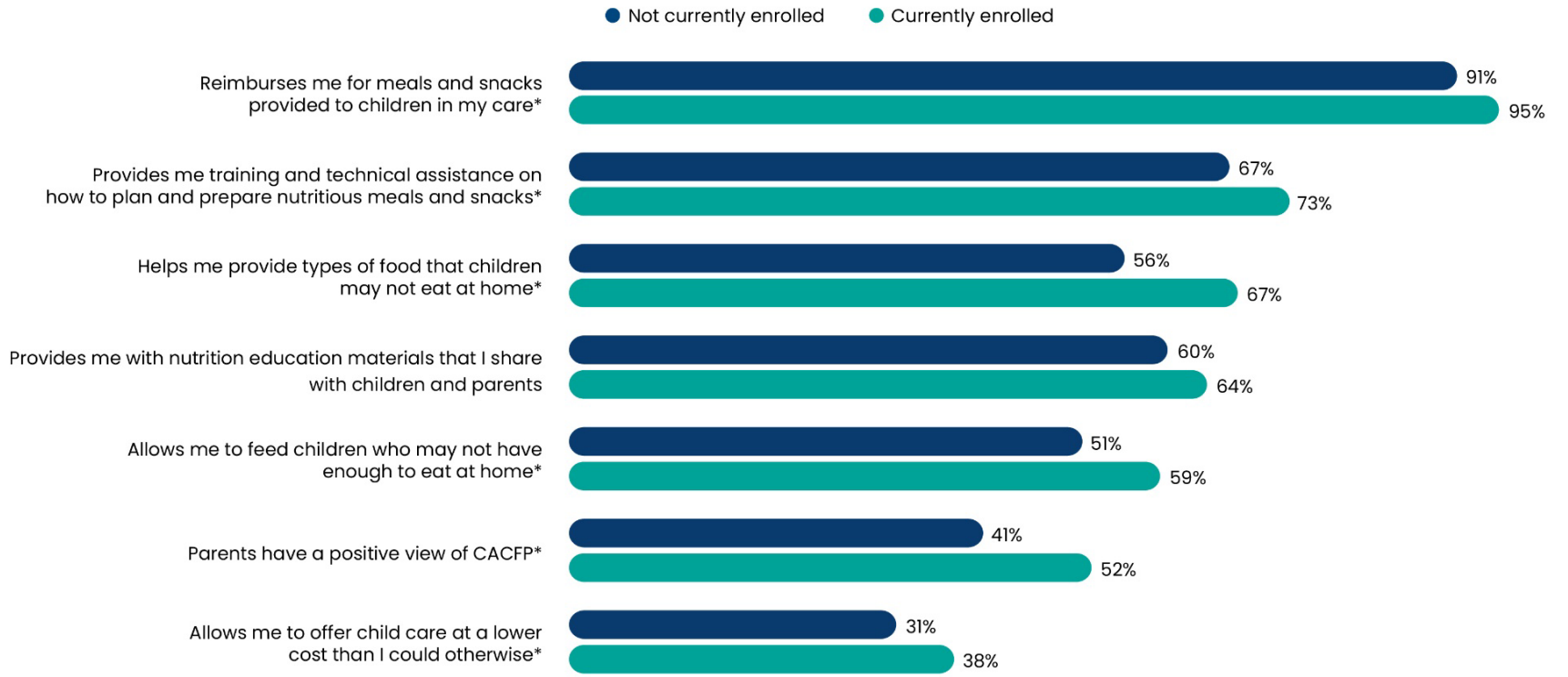
Chapter 6. Benefits of CACFP Participation

Former providers appear to leave CACFP for largely individual reasons related to their circumstances. How, then, do they and current providers view CACFP? The survey asked current and former providers about their experience in CACFP, from enrollment to ongoing participation.

First, the survey asked providers about the ease of enrolling in CACFP (see Appendix C table 21). Overwhelmingly, current and former providers said it was “easy” or “very easy” to enroll, with almost 97 percent of current CACFP FDCHs and 90 percent of former CACFP FDCHs saying enrollment was easy or very easy.

Current and former providers also identified a number of benefits of CACFP participation. Figure 9 presents the top benefits (identified by at least five percent of providers) by CACFP enrollment status. Differences by CACFP enrollment status that are statistically significant at the .05 level are marked with an asterisk. Providers could select multiple benefits.

Figure 9. Top Reported Benefits of CACFP Participation, by CACFP Enrollment Status



Note: Estimates and percentages were weighted to be nationally representative. The study excluded Alaska, Connecticut, Hawaii, Maryland, and Nevada because they did not submit data to FNS; one respondent was excluded because of missing data. Providers could choose all applicable options; percentages sum to more than 100. The following responses were selected by less than 5 percent of providers and are not shown: "other benefits" and "there are no benefits."
Total *n* = 2,169 providers; *n* current providers = 1,384; *n* former providers = 785
CACFP = Child and Adult Care Food Program; FDCH = family day care home
*Difference is statistically significant at the .05 level.
Source: FDCH Provider Experience Survey (2023) questions 13 and 19

The top identified benefits were meal and snack reimbursement (95 percent of current CACFP FDCHs and 91 percent of former CACFP FDCHs) and training and technical assistance on planning and preparing meals (73 percent of current providers and 67 percent of former providers). A majority of current and former providers also identified helping provide a variety of foods to children, nutrition education materials, and feeding children who may not have enough to eat at home as program benefits. Many providers also identified positive views of CACFP by parents (52 percent of current providers and 41 percent of former providers) and the ability to offer child care at a lower cost (38 percent of current providers and 31 percent of former providers) as program benefits. Less than two percent of providers said there were no benefits (see Appendix C table 22a). Overall, former CACFP FDCH providers still viewed the program quite positively.

While both current and former providers endorsed many benefits, current providers were more likely than former providers to choose all benefits except for providing nutrition education materials, where there was no significant difference. The largest difference is for those reporting parents having a positive view of CACFP: 52 percent of current providers identified this as a benefit, while only 41 percent of former providers did.

The study team also examined how reported benefits of CACFP participation varied by provider urbanicity and provider size; Appendix C tables 22c and 22d present the results. Overall, few statistically significant differences emerged by urbanicity and provider size, but where these exist, rural providers were less likely to select benefits than urban providers, and small providers were less likely to select benefits than large providers.

The survey asked providers whether they used participation in CACFP as a selling point to parents; Appendix C table 23 shows the results. A majority of providers did not use participation as a selling point; 47 percent of current providers used it as a selling point, and 41 percent of former providers had done so. This finding suggests that providers did not think parents knew much about the program before they enrolled, or at least that parents did not directly ask about CACFP enrollment before placing their children in care. Providers confirmed this when asked directly (Appendix C table 24): 58 percent of current providers and 64 percent of former providers said parents did not know about CACFP before enrolling or providers were unsure if parents knew about CACFP before enrolling.

Once enrolled, however, providers did believe that parents saw the benefits of CACFP participation. Providers were asked about parental perception of CACFP; Appendix C table 25 shows the results. A majority of current and former providers thought CACFP reduced parents' stress because they knew their children were being fed well, liked not having to pack meals and snacks, and thought providers in CACFP offered healthier food. Only ten percent of current providers and nine percent of former providers said parents thought CACFP meals and snacks were not well liked by children.

Chapter 7. Challenges of CACFP Participation

As discussed in chapter 6, a majority of providers noted many benefits of CACFP participation. The previous chapter also noted that fewer former providers identified multiple benefits to program participants than did current providers (although a majority of both current and former providers endorsed program benefits). To the extent that former providers experienced more problems with program participation (even if their decision to leave CACFP was not driven by these problems), it makes sense that they would be less likely to acknowledge program benefits. This chapter investigates the challenges providers identified.

When asked directly about the issues they had experienced while participating in CACFP, 38 percent of current providers and 30 percent of former providers reported experiencing no issues (Appendix C table 26a). The remaining respondents did report experiencing issues. Figure 10 shows the top issues reported by these current and former providers, by CACFP enrollment status. Providers could select more than one issue; the figure does not show issues selected by less than five percent of providers. Differences by CACFP enrollment status that are statistically significant at the .05 level are marked with an asterisk.

Figure 10. Top Reported Issues FDCH Providers Experienced While Participating in CACFP Among Those Who Reported Experiencing at Least One Issue, by CACFP Enrollment Status

Note: Estimates and percentages were weighted to be nationally representative. The study excluded Alaska, Connecticut, Hawaii, Maryland, and Nevada because they did not submit data to FNS. The table excludes 727 providers who reported not experiencing any issues while participating in CACFP. The following responses were selected by less than 5 percent of providers and are not shown: "my sponsor does not provide enough guidance and support," "parents have negative views about the CACFP," "program materials are not available in my primary language," "my sponsor does not have staff who speak my primary language," and "other." Providers could choose all applicable options; percentages sum to more than 100.
Total *n* = 1,443; *n* current providers = 889; *n* former providers = 554
CACFP = Child and Adult Care Food Program; FDCH = family day care home
*Difference is statistically significant at the .05 level.
Source: FDCH Provider Experience Survey (2023) questions 17 and 19

Meal and snack reimbursements not covering food costs was the most common challenge cited, with 65 percent of current providers and 49 percent of former providers reporting experiencing this issue. By design, reimbursements are not meant to cover the entirety of food costs but rather to offset them, but it may be that these providers do not think the reimbursements offset costs enough. Other common challenges included "unannounced monitoring visits are disruptive to my child care," "difficulty attending in-person trainings," and "nutrition requirements are hard to follow." Some providers made additional comments on issues related to nutrition requirements in the "other" category, criticizing the inability to choose milk alternatives (such as oat and almond milk) and high levels of food waste because of portion size requirements. Many wrote in comments about the general burden of CACFP and reported difficulty with technology, including problems with the program app and website.

Current providers were significantly more likely than former providers to say that meal and snack reimbursements did not cover food costs. This suggests that maximum reimbursements for all providers from COVID-19 waivers between 2021 and 2023 did not mitigate high food costs. Current providers were also more likely than former providers to say that meal reimbursements were often delayed. The impact of high food costs and delayed meal reimbursements may have been perceived as cumulative by providers; current providers have been experiencing these issues for longer than former providers and therefore saw it as more salient.

The study team also examined how issues providers experienced varied by urbanicity and provider size; Appendix C tables 26c and 26d show the results. Much like the reasons for leaving, the analysis showed few statistically significant differences by these provider characteristics, and the magnitudes of the existing differences were small. Rural providers were more likely than urban providers to report difficulty attending in-person trainings, while large providers were more likely than small providers to report that meal and snack reimbursements did not cover their food costs.

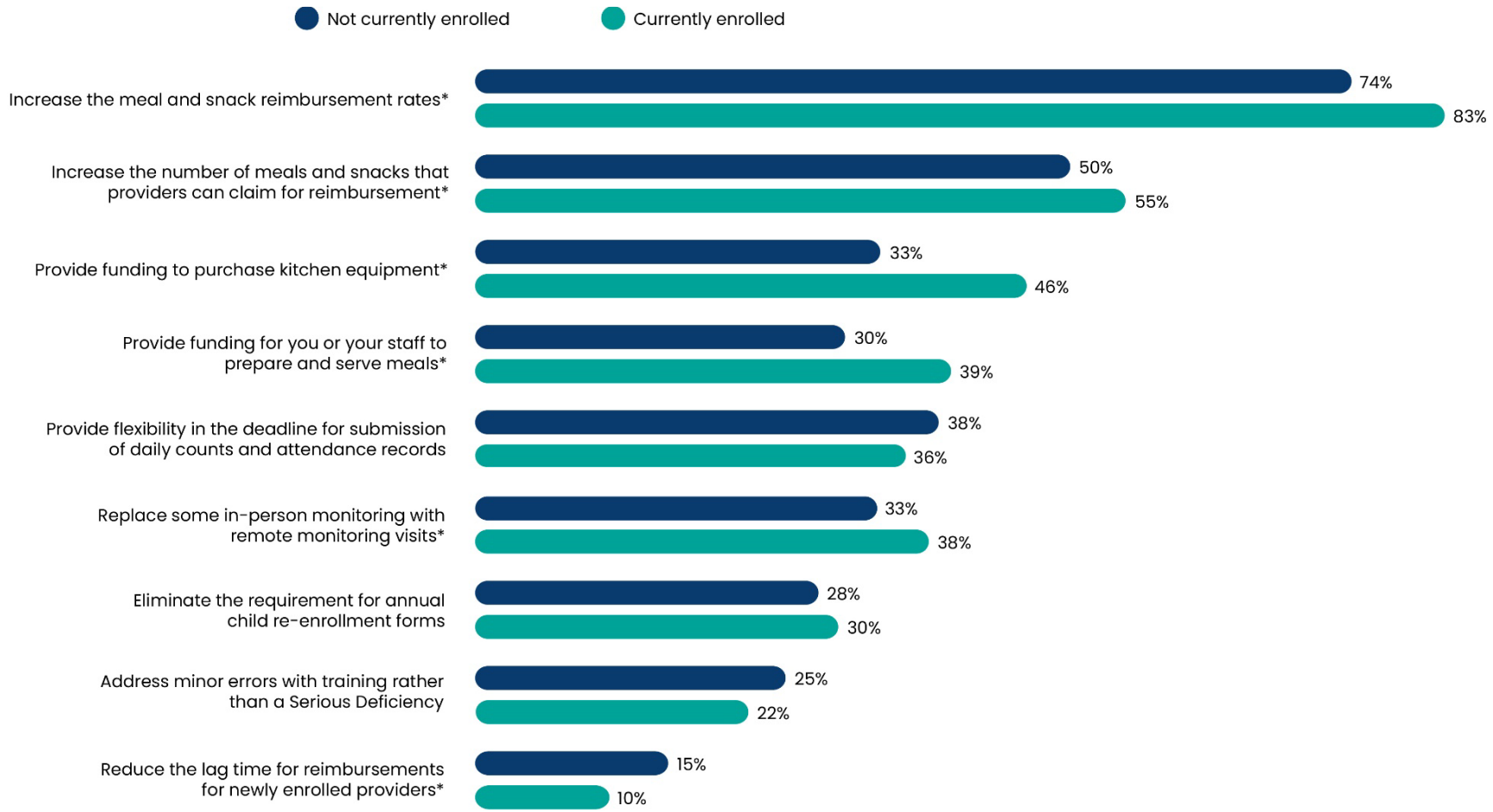
Overall, these findings show that although a large percentage of current and former providers reported experiencing no issues while participating in CACFP, a majority of current and former providers did experience some issues. Among these providers, the most pressing issues were food reimbursements and unannounced visits. The next chapter investigates the providers' recommendations for policy changes and increased supports to address these and other issues.

Chapter 8. Provider Recommendations to Improve FDCH Participation in CACFP

The survey asked providers to assess which policy changes and program supports would help improve CACFP participation. Policy changes are those changes that would require statutory approval, including reimbursement rates, additional funding, and reporting requirements. Program supports are changes that would not require statutory approval and most commonly include types of education and guidance to providers.

Figure 11 shows policy changes (many of which would require an act of Congress) endorsed by at least five percent of providers, by CACFP enrollment status. Providers could select more than one policy change. Differences by CACFP enrollment status that are statistically significant are marked with an asterisk.

Figure 11. Top Policy Changes Recommended by FDCH Providers, by CACFP Enrollment Status



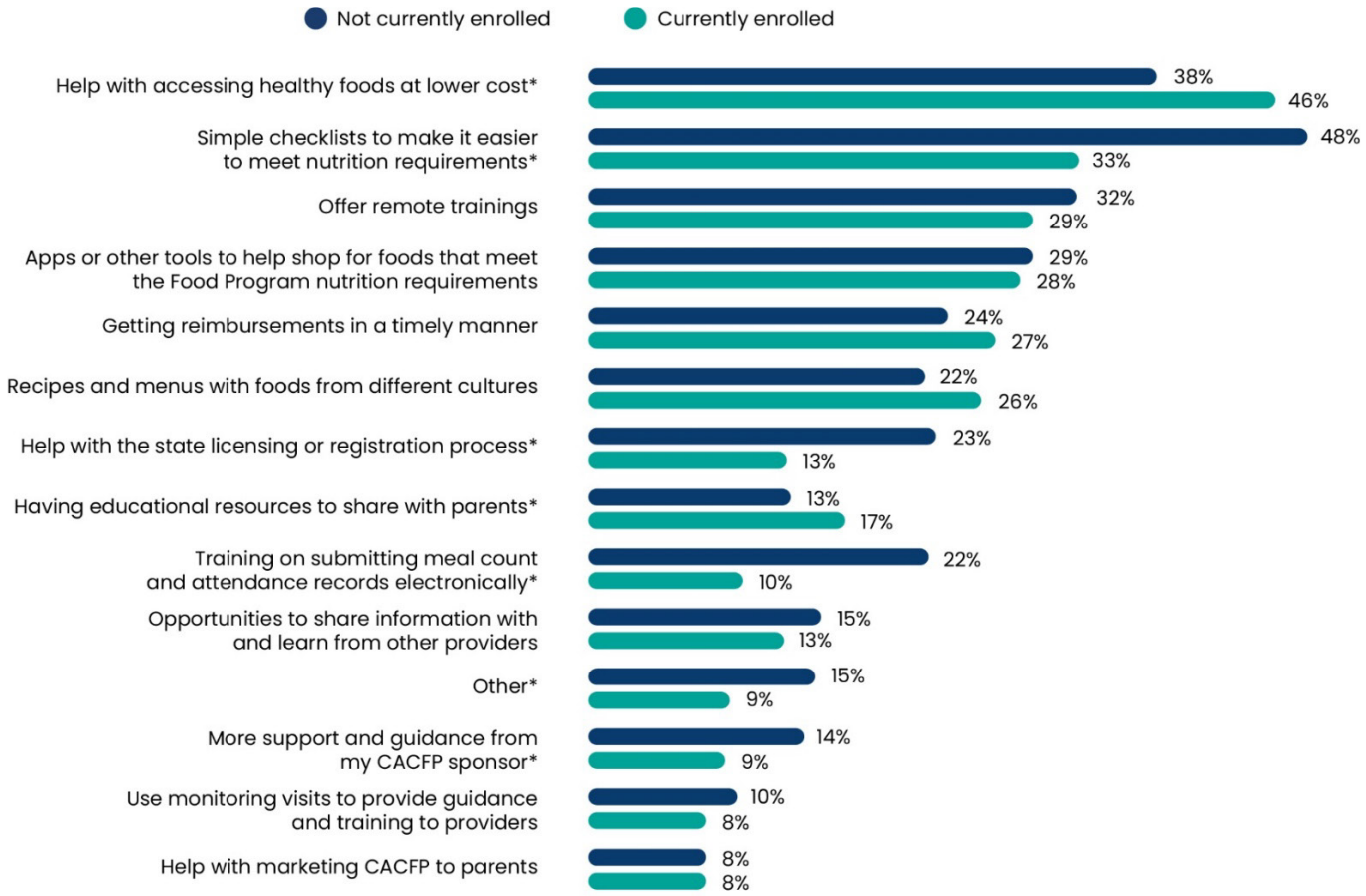
Note: Estimates and percentages were weighted to be nationally representative. The study excluded Alaska, Connecticut, Hawaii, Maryland, and Nevada because they did not submit data to FNS; 53 providers were excluded because of missing data. Providers could choose all applicable options; percentages sum to more than 100. The following response was selected by less than 5 percent of providers and is not shown: "other."
Total *n* = 2,115 providers; *n* current providers = 1,351; *n* former providers = 764
CACFP = Child and Adult Care Food Program; FDCH = family day care home
*Difference is statistically significant at the .05 level.
Source: FDCH Provider Experience Survey (2023) questions 19 and 27

The majority of providers indicated that increasing the meal and snack reimbursement rates (83 percent of current providers and 74 percent of former providers) and increasing the number of meals and snacks that providers can claim for reimbursements (55 percent of current providers and 50 percent of former providers) could improve CACFP participation. Other commonly chosen policy change recommendations included providing funding to purchase kitchen equipment, providing funding for staff to prepare and serve meals, replacing some in-person monitoring with remote monitoring visits, and providing flexibility in the deadline for submission of daily meal counts and attendance records. Current providers were more likely to select almost all policy improvements than former providers. Former providers may be less invested in recommending changes now that they are no longer enrolled.

The study team also examined differences in policy recommendations by urbanicity and provider size; these results are shown in Appendix C tables 27c and 27d. There are few statistically significant differences by urbanicity. However, large providers were more likely to choose almost all policy improvements than smaller providers.

Figure 12 shows the top supports providers said would make it easier for them to participate in CACFP, by CACFP enrollment status. Providers could select more than one support. Differences by CACFP enrollment status that are statistically significant at the .05 level are marked with an asterisk.

Figure 12. Top Reported Supports That Would Make It Easier for FDCH Providers to Participate in CACFP, by CACFP Enrollment Status



Note: Estimates and percentages were weighted to be nationally representative. The study excluded Alaska, Connecticut, Hawaii, Maryland, and Nevada because they did not submit data to FNS; 24 providers were excluded because of missing data. Providers could choose all applicable options; percentages sum to more than 100. The following responses were selected by less than 5 percent of providers and are not shown: "program materials in languages other than English and Spanish" and "sponsor staff who speak languages other than English."
Total *n* =2,146 providers; *n* current providers 1,374; *n* former providers = 772
CACFP = Child and Adult Care Food Program; FDCH = family day care home
*Difference is statistically significant at the .05 level.
Source: FDCH Provider Experience Survey (2023) questions 19 and 26

The top recommended support was help with accessing healthy foods at a lower cost (46 percent of current providers and 38 percent of former providers), followed by simple checklists to make it easier to meet nutrition requirements (33 percent of current providers and 48 percent of former providers) and remote trainings (29 percent of current providers and 32 percent of former providers). Other supports endorsed by at least 20 percent of providers included apps or other tools to help shop for foods that meet nutrition requirements, getting reimbursements in a timely manner, and recipes and menus with foods from different cultures.

Former providers were more likely to endorse help with State licensing or registration processes, more support and guidance from sponsors, simple checklists to make it easier to meet nutrition requirements, and training on submitting meal count and attendance records electronically. Former providers were less likely to endorse help with accessing healthy foods at a lower cost and educational resources to share with parents. These findings could suggest supports that would help increase retention of FDCH providers in CACFP.

Appendix C tables 28c and 28d show results by urbanicity and program size. Urban providers generally endorsed more program supports, while there were few differences by program size.

Notably, some of the programmatic supports sought by both current and former providers have already been implemented, many prior to the fielding of the survey. For instance, many trainings are now offered remotely, and FNS provides many recipes and menus with foods from different cultures on the CACFP website. This indicates that FNS could aid providers by making existing supports more accessible and more widely understood. Sixty-seven percent of current providers and former providers said they preferred to learn about CACFP from other providers, suggesting a role for peer-to-peer education on the program and its resources.

Chapter 9. Summary and Conclusions

This study aims to reveal the reasons FDCH providers leave CACFP, identify issues that providers face in participating in CACFP, and summarize provider recommendations for policy changes and program supports that could improve CACFP participation. Through this study, FNS seeks to better understand the circumstances under which FDCH providers discontinue participation and examine whether changes to CACFP might alter the trajectory of decline in CACFP participation in the last two decades.

The study team surveyed over 2,000 current and former CACFP FDCH providers in the spring of 2023. The survey asked respondents about their businesses, whether they had ever left CACFP, their reasons for leaving CACFP if they had, the issues they had faced, their views about the benefits of CACFP participation and parents' perceptions of CACFP, and how they would change CACFP if given the opportunity.

Several important findings emerged. The previously documented decline in CACFP FDCHs continued throughout the COVID-19 public health emergency despite waivers that reduced paperwork requirements, enhanced operational flexibilities, and effectively increased meal and snack reimbursements for many providers. Most of those who left CACFP also closed their FDCHs, with less than a third of those who left CACFP still operating a FDCH. The most common reason for leaving CACFP was closing their business because of a change in personal circumstance, with 46 percent of this sample citing it as the reason they left. The next most common reason, with 23 percent of the sample, was closing their business because of challenges related to the COVID-19 public health emergency.

Most current and former providers viewed CACFP participation positively. Almost all said that the enrollment process was easy or very easy, and they also identified numerous benefits of participation. Over half of current and former providers said that CACFP helped with meal and snack reimbursement, provided training and technical assistance on planning and preparing meals, helped provide a variety of foods to children, provided nutrition education materials, and enabled providers to feed children who may not have enough to eat at home.

A majority of current providers also said that parents had a positive view of CACFP. While providers did not think that many parents were aware of CACFP before enrolling their children in the FDCH (and therefore providers did not typically use CACFP participation as a selling point to parents), they thought that once enrolled, parents believed CACFP providers offered healthier food, CACFP reduced parents' stress because they knew their children were being well fed, and parents liked not having to pack meals and snacks for their children.

While 38 percent of current providers and 30 percent of former providers reported experiencing no issues while participating in CACFP, the majority of current and former providers did identify some challenges with CACFP participation. Among providers who experienced one or more issues, the majority reported that meal and snack reimbursements did not cover their cost, while over a third said that unannounced monitoring visits were disruptive to their child care.

Providers' recommendations for CACFP policy changes and supports closely tracked the problems they highlighted. Many of the recommended policy changes would require an act of Congress. Among the policy changes noted, a majority of current and former providers recommended

increasing meal and snack reimbursement rates and increasing the number of meals and snacks providers could claim. Over a third of current and former providers also recommended replacing some in-person monitoring with remote monitoring visits. The most common support endorsed was help accessing healthy foods at a lower cost (46 percent of current providers and 38 percent of former providers). This suggests that food cost is a great concern for providers, although concerns about in-person monitoring and meeting CACFP requirements are also common.

This study has certain limitations. Five States did not provide data to FNS and therefore could not be included. Given the timing of the study, the study team could not examine the long-term effects of the COVID-19 public health emergency on rates of FDCH closures and program disenrollment. The team also could not determine whether providers in different reimbursement tiers viewed program challenges and benefits differently because the suspension of the tiers during the public health emergency meant the study team could not sample providers based on tiers.

This study does provide important information on how providers view CACFP and particularly about the factors that lead providers to leave CACFP. The findings suggest that reasons for leaving CACFP are highly individual and may often be outside the program's control. Despite many providers leaving the program, CACFP is viewed quite positively. However, the concerns of former providers offer clues for potential policy enhancements. While such changes may or may not reduce the closures of FDCHs, they could make it easier for FDCH operators to serve children in their local communities and enhance the nutrition safety net.

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