

## Conclusion

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The principal objective of the PRWORA mandate for tiered reimbursements in the CACFP was to focus the program's benefits more narrowly on low-income children. A second objective may have been to contain cost, although this is not explicit in the legislation. The choice of the tiering mechanism rested on the premise that these objectives could be achieved by an indirect method—i.e., categorization based on the provider's location or income—without imposing an individual means test in most cases.

The new policy entailed some risk, which was recognized in the legislated requirement for an evaluation of the effects of tiering. A principal concern was that tiering might undermine the CACFP's fundamental objective of promoting the provision of healthy meals and snacks to children in family child care settings. This could occur if participating providers reduced the number or quality of meals offered, or if providers left the program (or declined to enroll) and offered fewer or lower-quality meals than those offered by providers operating under CACFP requirements. Additional concerns were that tiering might prove too burdensome for sponsors to continue playing their critical role in the program, or that it might change the economics of the family child care business sufficiently to reduce the nationwide supply of care.

The general message of the study findings is that substantial movement occurred in the direction of tiering's desired objectives with little evidence of negative consequences. The proportion of meal reimbursements going to low-income children doubled from 1995 to 1999, and the number of low-income children in the program grew by 80 percent. Expenditures for meal reimbursements declined while attendance held steady. The tiering mechanism was very effective in having low-income children's meals subsidized at the high rate, though less effective in applying the lower subsidy to higher income children. The number and nutritional characteristics of meals and snacks that Tier 2 providers offered were essentially the same as the offerings by similar providers before tiering. The national numbers of licensed providers grew, even though the number of CACFP homes declined.

If there is an area for concern in this generally positive picture, it relates to the providers and children who are not in the CACFP, but who might have participated if tiering had not been adopted. If tiering had not been adopted, the analysis indicates that the number of providers would have grown slightly rather than declining sharply. One would like to know what happened to the children who would have been served by those "missing" providers, but the study provides only fragmentary evidence on this point.

Some children were served by providers who dropped out of the CACFP when tiering was instituted but continued providing child care. The limited information available about these providers suggests that they did not account for most of the observed decline in participating homes. It also suggests that they tended to serve fewer children for fewer hours per week than was the average for active CACFP providers and, perhaps because of these operating patterns, they tended to offer fewer meals and snacks. The meals and snacks that these former CACFP providers offered were nutritionally similar to those offered by active CACFP providers, however.

The more important question is what happens to children in the care of providers who would otherwise enroll in the CACFP but choose not to do so because of the lower Tier 2 reimbursement rates. Such providers seem likely to have accounted for most of the decline in CACFP homes in 1998 and 1999. And if tiering continues to depress the number of CACFP providers in the future, it is logical that the effect would occur mainly through non-enrollments rather than early departures. The study affords no information on whether these non-enrollees will offer meals and snacks of a quality similar to those offered by CACFP providers—or by former CACFP providers, who have received CACFP training and been required to follow CACFP meal patterns in the past. Research on this question would be important in understanding whether the absence of these providers from the CACFP is an important impediment to the program goal of ensuring that children in family child care receive healthful meals and snacks.

An issue not addressed by the present study concerns the CACFP sponsors, whose role in recruiting, training, monitoring, and reimbursing providers is critical to the operation of the program as currently designed. Tiering clearly added new sponsor responsibilities and probably increased sponsors' per-home operating costs. This raises the question of whether administrative reimbursements are adequate to cover costs, and thus to ensure long-term viability of the sponsor role. Although this study provides no information on the question, USDA has undertaken a separate study to examine it.

Finally, beyond the impact of tiering, some of the study findings raise interesting questions about how CACFP family child care providers make decisions about the food they offer to children in their care. One might expect these decisions to reflect the provider's pre-existing knowledge and motivation about children's nutritional needs, the expectations of the provider's customers (i.e., the children's parents), the economic resource represented by the CACFP subsidy, and the information and motivation provided by the CACFP requirements. The complexity of these relationships is highlighted by the study finding that the lower subsidy for Tier 2 providers did not lead them to offer fewer or less nutritious meals and snacks. Numerous speculations might be offered about the role of the subsidy, but the present body of knowledge is insufficient to advance beyond speculation. Further research in this area could inform future efforts to enhance the efficiency and effectiveness of the CACFP.