FEEDING HUNGRY MOUTHS: GETTING HEALTHY FOOD TO THE KIDS WHO NEED IT MOST

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Abstract

Child nutrition is one of the most legislated areas in Congress and in the states. Out of this plethora of legislation came the Child and Adult Care Food Program (CACFP), a program designed to provide food assistance to young children in out-of-home care. Although very well intentioned and important for children who benefit from it, there is a fundamental disconnect between the structure of the CACFP and its intended beneficiaries, as evidenced by the shockingly low participation rate of infants and children. Part of this stems from its history of modeling the National School Lunch Program (NSLP). The benefits the CACFP gained by its association with the NSLP also sentenced it to marginal effectiveness, not because it does not improve child nutrition, which it does, but because it does not reach the children in greatest need of food assistance. As a result, regardless of how excellent the forthcoming meal patterns proposed by United States Department of Agriculture (USDA) Food and Nutrition Services are or how much money Congress gives the program to enable providers to feed children healthy and balanced meals, young children must continue waiting until they are old enough to attend school to benefit from healthy meals and complete nutrition. Without radical structural changes and/or expansion, the CACFP will fail to make a dent in the nutritional well-being of most low-income children.

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I. INTRODUCTION

The United States government has a long and complex relationship with food. Regulation of food by the federal government began early in the nation's history. The ubiquitous regulation of tea was among the first items subject to government oversight through the Tea Importation Act enacted in 1897.[1] Beginning with the Food and Drugs Act of 1906, federal food regulation evolved to address almost all food through major agency authority from the Federal Food, Drug and Cosmetic Act enacted in 1938.[2] Food regulation continues to develop, as seen in the more recent and targeted Food Allergen Labeling and Consumer Protection Act of 2004.[3] Parallel to the growing interest in and authorization of food regulation was a growing interest in child welfare, including an examination of whether children had enough food and healthy food. As early as 1919, the federal Children's Bureau held a conference on child-welfare standards that touched on children's dietary needs.[4] In the first half of the twentieth century, the field of health and nutrition focused primarily on ensuring that children had enough food; this focus expanded to healthy food resulting in the development of school cooking classes to teach children and future parents how to make healthy food and in direct food provision and financial reimbursement to people deemed "in need."[5]

Although the science in this area is relatively new, the American Bar Association (hereinafter "ABA") issued a report on hunger in the United States as early as the 1970s, finding that hunger caused "[a]rrested child development, both mental and physical. Arrested ability to learn, to work productively and to participate in society."[6] Today, a similar reasoning supports the government's provision of a myriad of child care subsidies for children as young as infants, and even for pregnant mothers in the interest of prenatal health. Recognizing that the earliest years in life are some of the most important for healthy development, the executive summary of a recently proposed Child Care and Development Fund

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[1] Tea Importation Act, 29 Stat. 604 (March 2, 1897).

[2] Federal Food, Drug, and Cosmetic Act, 52 Stat. 1040 (June 25, 1938).

[3] Food Allergen Labeling and Consumer Protection Act of 2004, 118 Stat. 905 (August 2, 2004).

[4] *See, e.g.*, *Women in Industry, and Child Labor: Children's Bureau Conference on Child-Welfare Standards*, 8 MONTHLY LAB. REV. 1766 (1919).

[5] *See, e.g.*, Chase Going Woodhouse, *A Tentative Plan for A School for the Social Economy of the Home*, 4 Soc. F. 543 (1925-1926); *see also Special supplemental nutrition program for women, infants, and children*, 42 U.S.C.S. § 1786 (2014).

[6] *Report No. 2 of the Section of Individual Rights and Responsibilities: Recommendation*, 95 ANN. REP. A.B.A. 1076, 1115 (1970) [hereinafter *ABA Report No. 2*].

(CCDF) rule acknowledges that "compliance with health and safety standards is not enough to ensure that children are getting the quality care they need to support their healthy development and school success."[7] One additional area in which children require affirmative assistance is in promoting and providing good nutrition. The rule proposal underlines the importance of "nutrition and age-appropriate feeding" for healthy development, noting: "[t]his is of particular importance when working with families [who]…may be facing nutritional challenges in the home as well."[8] In a comment on the proposed rule, the Academy of Nutrition and Dietetics reiterated the necessity of providing healthy and nutritious foods as early as possible, writing, "[c]hild care programs are the ideal setting for the promotion of healthful eating and the prevention of obesity."[9]

As the proposed CCDF rule shows, the government has been responsive to concerns about child nutrition, and has provided increasing food assistance and focus on nutrition through government programs over the past fifty years. Currently, food provision to children includes not only adequate and safe food, but also healthy and nutritious food corresponding with federal nutrition guidance and developmentally appropriate nutrition levels.[10] In fact, "[c]hild nutrition is one of the most actively legislated areas in Congress" and has a wide variety of interested stakeholders that

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[7] Child Care and Development Fund Program, 78 Fed. Reg. 29442 (proposed May 20, 2013) (to be codified at 45 C.F.R. pt. 98). The CCDF Program is run by the Administration for Children and Families (through the Office of Child Care) under the Department of Health and Human Services. CCDF is a grant-making program that provides funding and financial assistance for child-care related needs of families and works to improve the quality of child care.

[8] *Id.*

[9] Letter from Jeanne Blankenship, Vice President, Policy Initiatives and Advocacy, Academy of Nutrition and Dietetics and Pepin Andrew Tuma, Director, Regulatory Affairs, Academy of Nutrition and Dietetics, to Cheryl Vincent, Office of Child Care, Administration for Children and Families, Department of Health and Human Services (August 5, 2013) (on file with the Federal Register under Docket ID ACF-2013-0001). According to its website, "The Academy of Nutrition and Dietetics (formerly the American Dietetic Association), founded in 1917, and is the world's largest organization of food and nutrition professionals. The Academy is committed to improving the nation's health and advancing the profession of dietetics through research, education and advocacy." Academy of Nutrition and Dietetics, *Who We Are*, http://www.eatrightpro.org/resources/about-us/academy-vision-and-mission/who-we-are (accessed February 21, 2015).

[10] *See, e.g.*, Comm. on Agric., Nutrition & Forestry, *Healthy, Hunger-Free Kids Act of 2010*, S. Rep. No. 111-178, at 9 (2010); *see also Child Nutrition and Wic Reauthorization Act of 2004*, 150 Cong Rec H 4930, 150 Cong Rec H 4930; 110 H.R. 1363, 2007 H.R. 1363, 110 H.R. 1363; 111 H.R. 1324, 2009 H.R. 1324, 111 H.R. 1324; 111 S. 934, 2009 S. 934, 111 S. 934; 113 H.R. 2562, 2013 H.R. 2562, 113 H.R. 2562.

include farmers, health professionals, food manufacturers, wholesalers, parents and children.[11] In light of a growing obesity epidemic, increasing awareness of children's nutrition needs, and glaring income inequality and its accompanying nutrition disparities, food provision by the government has become a mainstay for many Americans.[12] The USDA's Food and Nutrition Services (FNS) directs 15 nutrition assistance programs, and the government's investment in the nation's nutrition increased by 76%, totaling $60 billion, from 2001 and 2008.[13]

Despite these efforts, there are still issues of both access and quality to nutritious and healthy diets for many young children in the United States. Much of this stems from the fact that most young children are not actually enrolled in state-supported child care, but spend a significant amount of time in non-parental care.[14] According to the National Center on Education Statistics, "[i]n states with state supported pre-school programs…approximately 5 percent of 3-year olds and 30 percent of 4-year olds were enrolled in the programs."[15]

This article reviews the history of government food provision to young children leading up to the Child and Adult Care Food Program (CACFP), and highlights gaps in government supported nutrition

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[11] Jean Yavis Jones, Cong. Research Serv., CRS-1994-ENR-0107, *Child Nutrition Programs: A Narrative Legislative History and Program Analysis* 1 (1994).

[12] *See, e.g.*, Center for Disease Control, *Healthy Youth*, http://www.cdc.gov/healthyyouth/obesity/facts.htm (last visited February 21, 2015); Let's Move, *Learn the Facts*, http://www.letsmove.gov/learn-facts/epidemic-childhood-obesity (last visited February 21, 2015); *see also* Cynthia L. Ogden et al., *Prevalence of childhood and adult obesity in the United States, 2011-2012*, J. OF THE AMERICAN MEDICAL ASSOC. 806 (2014); U.S. Dep't. of Health and Human Services, National Center for Health Statistics, *Health, United States, 2011: With Special Features on Socioeconomic Status and Health* (2012); Office of the Surgeon General, U.S. Department of Health and Human Services, *The Surgeon General's Vision for a Healthy and Fit Nation*, (2010), *available at* http://www.surgeongeneral.gov/initiatives/walking/index.html; K. Pickett et al, *Wider income gaps, wider waistbands? An ecological study of obesity and income inequality*, 59 J. OF EPIDEMIOLOGY & COMMUNITY HEALTH 670 (2005), *available at* www.ncbi.nlm.nih.gov/pmc/articles/PMC1733121/pdf/v059p00670.pdf.

[13] Leah Loeb, *Childhood Obesity: The Law's Response to the Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity*, 12 J. HEALTH CARE L. & POL'Y 295, 305 (2009).

[14] W. Steven Barnett, Megan E. Carolan, James H. Squires & Kristy Clarke Brown, U.S. Dep't of Educ. National Center for Education Statistics, NCES 2013-078, *State of Preschool 2013: First Look* 3 (2014), *available at* http://nces.ed.gov/pubsearch.

[15] *Id.* The National Center for Education Statistics is a federal organization that collects and analyzes education-related data. It is seated in the Institute of Education Sciences, within the Department of Education.

assistance that may run counter to the government's stated goals of improving American children's diets for their healthy development. Part II outlines the historical evolution of food provision for children in the United States. Part III provides an overview of the CACFP and how it fits in with the overall goals of food provision for American children. Part IV addresses the challenges in analyzing the CACFP's effectiveness and the access and quality of food resulting from the current structure of the CACFP. Part V concludes that the current formulation of the CACFP does not serve to improve the nutrition needs of all or enough of our country's youngest children.

II. HISTORY OF FEDERAL NUTRITION ASSISTANCE IN AMERICA

A. General History of Food Programs in the United States

In the first half of the twentieth century, government concern over child and maternal nutrition primarily occurred in the labor context. Whether due to concern for children with working mothers who could no longer cook for them, providing child care for young children of working parents, or addressing the needs of underserved and disadvantaged populations, the discussion of food and health occurred in the context of labor and of parents acquiring labor skills. The Smith-Lever Extension Act of 1914,[16] administered through the USDA's Office of Cooperative Extension Work, attempted to address family food problems among other things by providing "nineteen million dollars…annually…for cooperative extension work in Agriculture and in home economics."[17] In 1919, the Children's Bureau paid special attention to this issue in its four-day conference on child-welfare standards. The first day of the conference was "devoted to the means of protecting the health of mothers and children and the standardization of laws concerning children in need of special care."[18] The study of food provision fell under the category of "home economics," and took on a women's labor perspective.[19]

In recognition of an invigorated women's movement and women increasingly vocalizing their desire to work in the 1920s, efforts were

[16] 7 U.S.C. § 341 et seq. (1914).

[17] Woodhouse, *supra* note 5, at 552-53. The Office of Cooperative Extension Work was an agency within the USDA that worked to advance agriculture through grant-making to universities and other organizations. Today it has been subsumed under the National Institute of Food and Agriculture.

[18] *Women in Industry, and Child Labor: Children's Bureau Conference on Child-Welfare Standards*, 8 MONTHLY LAB. REV. 1766 (1919).

[19] *Id.*

undertaken to make homemaking, including family food preparation, more professional.[20] In an article about enhancing the professionalism and academics of fields that were previously considered solely family concerns, Chase Going Woodhouse invoked the need for increased services, education, and research in these areas. Cooked food service was among his list of "more than fanciful ideas" to address the needs of children with working mothers, an insightful observation. Woodhouse even asserted that "most of the work now being done deals with the food problems of the home."[21] Private "home" problems evolved into the field of "home economics," requiring "well-equipped teachers who [were] not merely specialists in food or in clothing, for example, but who [understood] the whole problem of family, who [had] a philosophy of the home."[22] In addition to training women to be home professionals, the early 1900s marked an increased focus on nutrition and addressing broader, related societal problems associated with industrialization. In advocating for "a malnutrition clinic in cooperation with perhaps the [Home Economics] college, perhaps the public schools…to combine knowledge of principles with actual practice" and "a practice house where both adults and children would be fed," Woodhouse makes a prescient suggestion that schools provide a fertile ground for both nutrition study and intervention.[23]

Nutritional needs came to the forefront of national policy during the Great Depression when the prices of agricultural commodities plummeted and left farmers across the country desperate to increase their incomes from crop yields. The USDA played a crucial role in both supporting farmers and meeting basic caloric needs of the population. The Agriculture Act of 1935 (hereinafter "1935 Act") granted USDA funds and authority to stabilize the agricultural market, buy surplus food from farmers, and distribute it to those in need.[24] According to the USDA, the legislation was designed to "remove price-depressing surplus foods from the market through government purchase and dispose of them through exports and domestic donations to consumers in such a way as to not interfere with normal sales."[25] The 1935 Act identified groups and individuals in need that would not otherwise purchase or be able to

[20] *See, e.g.*, Woodhouse *supra* note 5.
[21] *Id.* at 544, 553.
[22] *Id.*
[23] *Id.*
[24] 32 Pub. L. No. 74-320 § 32 (1935).
[25] U.S. DEP'T OF AGRIC., FOOD & NUTRITION SERV., FOOD DISTRIBUTION: FDD – HISTORY AND BACKGROUND, http://www.fns.usda.gov/fdd/fdd-history-and-background (last visited November 3, 2014) [hereinafter FNS HISTORY].

purchase enough food. These initial federal nutrition assistance acts highlight the tension between economic concerns and nutrition and welfare concerns present in much of today's food-related legislation. They also indicate the government's earliest entry into nutrition assistance through the public school system.

Among those eligible for food under the 1935 Act were children at schools and summer camps.[26] The Monthly Labor Review, a journal published by the U.S. Bureau of Labor Statistics since 1915, published details of the New Deal's Works Progress Administration (WPA) programs that provided pre-school care and food costs for nursery schools as "essentially…[initiating] the school lunch and other child feeding programs."[27] The WPA, an agency formed to employ millions of unemployed Americans during the Great Depression, was enacted in the same year as the 1935 Act as part of President Franklin D. Roosevelt's New Deal, consisting of sweeping progressive legislation.[28] Because segregation was still in full effect, there were separate programs to provide these services for African American children through the Division of Negro Affairs, a unit of the National Youth Administration, another New Deal agency focused on education and jobs for young people, established in 1935.[29] The nutrition assistance programs that we have today grew out of these early interventions for children suffering from malnutrition as a result of the Great Depression.[30]

As the Great Depression led into World War II, greater attention was paid to the needs of children in ally countries, primarily in Europe. The United Nations International Children's Emergency Fund (UNICEF) was created at this time to meet the needs of those children, and focused primarily on nutrition and calorie provision.[31] UNICEF reports documented both stunting in middle-aged children generally, and the widespread school meal provision programs that existed for pre-school children and older children.[32] During this period, nutrition assistance

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[26] *Id.*

[27] *Workers' Education: Education Program of Works Progress Administration*, 45 MONTHLY LAB. REV. 140, 140-41 (1937).

[28] Appropriations, Emergency Relief., 49 Stat. 115, 49 Stat. 115, 74 Pub. Res. 11, 74 Cong. Ch. 48 (1935).

[29] *Education and Training: NYA Aid to Negroes, 1935-40*, 52 MONTHLY LAB. REV. 1442, 1442 (1941).

[30] *See* FNS HISTORY, *supra* note 25.

[31] Katherine F. Lenroot, *International Children's Emergency Fund*, Soc. Sec. Bull. (Soc. Sec. Admin., D.C.) Apr. 1947, at 7.

[32] *See Id.*

through schools and similar institutions became a globally accepted practice.

During World War II, food shortages in the United States coupled with limited transportation led Congress to allow the USDA to provide financial assistance to schools and child care centers rather than donating actual food to support children's lunches, as it had done during the Great Depression.[33] This was an important and lasting shift in nutrition assistance policy in the U.S.[34] By 1943, state agencies, rather than the federal government, had become distributing agencies and were responsible for the donated food program.[35] Food provision continued to grow, and in 1946 the National School Lunch Act (hereinafter "NSLA") paved the way for food and cash support to schools across the nation.[36] This proved to be a popular development. Congressional and popular appreciation for government food programs had grown in light of the dual goals of supporting the agricultural market and improving "the health and well-being of the nation's youth," and the balance between these goals began to shift from farm subsidies toward child nutrition.[37]

By the 1960s, the U.S. had entered the era of President Lyndon B. Johnson's "War on Poverty," and the country had gained a growing awareness of hunger and food shortage domestically and internationally.[38] The "War on Poverty" stimulated the creation of various government programs to support children and families that form the foundation of today's nutrition assistance programs.[39] In the 1960s, there was a vast expansion of food programs, beginning with an Executive Order in 1961 that required the USDA to increase the quantity and variety of food donated to those in need.[40] In President Johnson's 1964 State of the Union Address, he pushed the nation and Congress to help those in need by passing widespread reform.[41] Johnson urged the passage of a broad array

[33] FNS HISTORY, *supra* note 25.
[34] Notably, today, almost all nutrition assistance to children is through financial assistance. *See* Randy Alison Aussenberg, Cong. Research Serv., CRS-2014-DSP-0527, *School Meals Programs and Other USDA Child Nutrition Programs: A Primer*, 19 (November 10, 2014).
[35] FNS HISTORY, *supra* note 25.
[36] *Id.*
[37] *Id.*; *see also* Direct Expenditures for Agric. Commodities and Other Foods, 42 U.S.C. § 1755 (West 2015).
[38] *See* S. DOC. NO. 88-86, at 5493 (1964).
[39] *See id.*
[40] FNS HISTORY, *supra* note 25.
[41] President Lyndon B. Johnson, State of the Union Address (January 8, 1964), *available at* http://www.americanrhetoric.com/speeches/lbj1964stateoftheunion.htm.

of legislation that would "distribute more food to the needy through a broader food stamp program," suggesting that food security and hunger were among the primary concerns of the administration and the country.[42] Congress responded in the following years with a range of government food programs, including food stamps through the Food Stamp Act of 1964, the School Breakfast Program, the Summer Food Service Program, the Special Food Service Program for Children (the predecessor to the CACFP) and the Commodity Supplemental Food Program (the predecessor to WIC).[43] In 1969, Food, Nutrition and Consumer Services was established and consolidated many of the government's recently enacted programs under the new agency.[44] Through these programs, the current array of government nutrition assistance and its delivery structure was born.[45]

As these programs show, by the 1960s the official rationale for food assistance programs had squarely shifted from stabilizing the agricultural industry and caloric intake to public health, food security and child nutrition. In fact, in its annual 1970 report, the ABA asserted that "efforts to alleviate hunger proceed on two basic premises…a. It is desirable for our society to attempt to eliminate hunger. b. Government efforts are essential if [t]hat attempt is to have a chance to succeed."[46] The ABA appended a 1969 report on "The Evidence and Effects of Malnutrition," which provided data on hunger and malnutrition in pre-school aged children across the country, and described initial findings from a pilot-study showing that low-income children were more likely to have "'low' caloric and other nutrient intake" than higher income children.[47] The ABA and Congress was becoming more attuned to the complex nutrition needs of children, and from the 1970s to the present, the government has generally supported food programs to those in need, and more specifically, to children.

B. History of the Child and Adult Care Food Program

The program that eventually became the Child and Adult Care Food Program (CACFP) was created in 1968 as a pilot program under the

[42] *Id.*
[43] *Id.*
[44] FNS HISTORY, *supra* note 25.
[45] *Id*.
[46] *ABA Report No. 2*, *supra* note 6.
[47] *Id.* at 1134-35.

NSLA.[48] It was authorized under Section 13 of the NSLA Amendments of 1968[49] as the Special Food Service Program for Children (hereinafter "SFSPC").[50] Representative Charles A. Vanik of Ohio introduced the SFSPC through a bill on October 3, 1967.[51] He hoped to build on the recently passed Social Security Act, which provided "training opportunities for employable parents currently on welfare rolls" whose children would be "provided day care in a network of day care centers."[52] In light of these new services and mirroring the successful expansion of the school lunch legislation, Representative Vanik introduced the expansion of child feeding to child care facilities.[53]

In addition to bolstering the nutrition of the nation's children, Congress reasoned that providing food to children in day care would "free the poverty organizations of the burden of buying food goods on the regular market—thus it will free far more than $32 million [the cost of the program] for use on personnel and materials with which to help the disadvantaged children of America."[54] The goal of relinquishing resources for anti-poverty organizations as such eventually disappeared from Congressional reasoning for supporting the program. However, in the CACFP's goal of making child care more affordable for individual low-income families that might otherwise be assisted by poverty alleviation organizations, we see remnants of the original broader, organizational-level anti-poverty goals of the 1960s.[55]

Nutrition concerns were seriously considered and addressed in the SFSPC bill, as they had been in the NSLA. A representative from the USDA testified that having done extensive research in child nutrition and having set minimum standards for government-provided school meals, USDA meal requirements "are designed to meet between a third and one

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[48] Harv. Food L. & Pol'y Clinic, *The Child and Adult Care Food Program in Massachusetts* 4 (January 2013), http://blogs.law.harvard.edu/foodpolicyinitiative/files/2013/01/FINAL-Massachusetts-CACFP-Analysisv2.pdf.

[49] Pub. L. No. 90-302, 82 Stat. 117.

[50] Jones, *supra* note 11, at 67.

[51] *See Hearings Before the Gen. Subcomm. on Educ. of the Comm. on Educ. and Labor, House of Representatives, Ninetieth Congress, Second Session on H.R. 13293: A Bill to Amend the Nat'l Sch. Lunch Act to Strengthen and Expand Food Serv. Programs for Children, and Other Purposes*, 90th Cong. 5 (1968) [hereinafter *1968 Hearings*] (statement of Hon. Charles A. Vanik, Rep. in Cong. From the State of Ohio).

[52] *Id.* at 6.

[53] *Id.*

[54] *Id.* at 7.

[55] *See, e.g.*, Aussenberg *supra* note 34, at 1442.

half of a child's daily requirements for all the essential nutrients."[56] A representative from the Citizen's Board of Inquiry into Hunger and Malnutrition in the United States, a group of experts from the fields of medicine, law, philanthropy, social activism, labor, and religion convening to research the issue of hunger and malnutrition, underscored a focus on nutrition, testifying that "the most damage that occurs from malnutrition occurs between conception and the age of 4."[57] Thus, to address this critical early period in child development, Congress proposed to supplement young children's nutrition through pre-schools.

The SFSPC bill was introduced at a time when the workforce was rapidly changing and women were entering the workforce at fast-growing rates. In the SFSPC bill, Congress responded to the feminization of the workforce by voicing growing concern for the "unsupervised" children of these women, while acknowledging working women's necessity to the national economy.[58] Child care, child feeding programs, and women entering the workforce were inextricably linked, as evidenced in the reasoning presented in Congressmen's testimony during 1968 Congressional hearings (hereinafter "Congressional hearings") on the proposed bill,

> "By 1970-71, when this Nation hopefully reaches a higher economic level, we anticipate that we will need 50 percent of the mothers to be working mothers just to fill the needs of industry. One of the great needs in our country today is the tremendously large number of children who are totally unsupervised or receive no adult supervision during the day…because the mother either has to be the breadwinner of the family or she has to supplement the family income…You can't say to a woman, "You have to go to work," when you make no provisions for the youngsters. Many of these women have gone to work and their youngsters are left totally unsupervised which creates a great social problem…This is one reason we are holding these hearings: to extend a very successful School Lunch Act to provide lunches in these day care centers so that we can release these people into gainful employment."[59]

[56] *1968 Hearings*, *supra* note 51, at 11 (statement of Howard P. Davis).
[57] *Id.* at 75 (statement of Robert B. Choate).
[58] *Id.* at 8 (statement of Hon. Charles A. Vanik).
[59] *Id.*

As evidenced by this statement, there was a consistent tension throughout the hearing between acknowledging the need for women to join the workforce and resenting mothers for leaving their children and "their stoves" to look for work.[60] This "flood of welfare mothers" looking for work had apparently failed to make provisions for their very young children or to answer the question, "[w]ho is to prepare the food for the children thus left in institutional mothers' care?"[61] Thus, Congress, notably mostly white men, took on some of this burden through the proposed child nutrition legislation, in reaction to women's perceived poor planning, irresponsibility, and admittedly difficult situation.

Even among the various stated reasons for proposing and supporting the bill, the primary and often repeated reason for extending food provision to child care settings was improving child nutrition. As such, the USDA, the agency ultimately responsible for implementing the program, enthusiastically supported the SFSPC bill because it enabled the USDA to "fill the final gap in [its] capabilities to improve nutrition among children in group situations away from home."[62] Rodney E. Leonard, the Administrator of the USDA Consumer and Marketing Service, testified at Congressional hearings on the SFSPC bill: "[w]e are saying, in effect, that we know the importance of good nutrition for children—we know that in early childhood poor nutrition can have lasting effects, physical and mental—but the children will just have to wait until they are old enough for school" unless the SFSPC bill was passed.[63] Unfortunately, despite these initial efforts, most young children still must wait until they enter public school to receive the benefits some members of Congress argued for so passionately.

A telling indication of why the SFSPC developed to operate through the infrastructure of institutional pre-school was that the SFSPC purported to extend the "level of nutritional service and benefits similar to those enjoyed by Head Start children," who represented a large proportion of children in government recognized child care,[64] to children in other forms of institutional child care.[65] In fact, part of the impetus for supplying food to children in day care was in response to Head Start's exposure of nutritional inadequacy among the children it served.[66]

[60] *Id.* at 75 (statement of Robert B. Choate).
[61] *Id.*
[62] *Id.* at 9 (statement of Rodney E. Leonard).
[63] *Id.* at 10 (statement of Rodney E. Leonard).
[64] *See, e.g.*, *id.* at 7 (statement of Hon. Charles A. Vanik).
[65] *Id.* at 101 (statement of Jule Sugarman).
[66] *Id.* at 11.

Proponents who introduced the SFSPC bill said it was "the vehicle that can most economically and efficiently provide the food goods required by the Nation's antipoverty organizations" and was proposed in conjunction with the "increased demands placed on day care centers by the social security legislation," which included Head Start.[67] The Senators and the USDA, however, apparently did not consider care beyond institutional pre-school into the homes of relatives and neighbors, many of whom continue to receive no nutrition assistance for their young wards nor any relief for the costs of providing care. This disconnect at the inauguration of the program continues to burden the efficacy of attempting to support very young children's nutrition through licensed child care providers.

Perhaps not realizing the complexity of reaching young children in out-of-home care, those who testified at the 1968 Congressional hearings implied that the goals of the SFSPC were simple and achievable. According to USDA Administrator Rodney E. Leonard, "Secretary Freeman stated it well in outlining what we have in mind: 'The Administration goal for child nutrition is quite simple. It is to provide every child, regardless of the family's income—with access to a complete meal during the day when he or she is away from home.'"[68] The lawmakers asserted the logistical feasibility of the program by turning to the School Lunch Program, saying that the SFSPC would be based on the "21 years of hard-learned expertise in providing a food service for children."[69] The expertise in school nutrition services would be leveraged to expand nutrition assistance and food provision to child care programs, placing the administration of the program in "the same State educational agency that administers the lunch and child nutrition programs."[70] In some respects, this made perfect sense. K-12 school administrators had experience with a large, government-run nutrition assistance program. In other ways, it may have looked to the wrong expertise when it saddled people working within the well-defined infrastructure of compulsory education and the public school system with the task of providing food to children in a completely voluntary, mostly private collection of unconnected child care providers. As the program evolved, different lawmakers would attempt to address this fundamental flaw by expanding program eligibility; the program remains tied, however, to the idea of

[67] *Id.*
[68] *Id.* at 10 (statement of Rodney E. Leonard). Secretary Orville L. Freeman was the Secretary of Agriculture in 1968, originally appointed in 1961 by President Kennedy.
[69] *Id.*
[70] *Id.*

operating through some kind of formal, licensed and out-of-home child care.

Despite these early gaps in service, the SFSPC was well-received and successfully reached children in child care centers. As a result, Congress extended the SFSPC[71] beyond its initial three-year duration as a pilot program in 1972.[72] The SFSPC provided meals to children outside of school – those in child care and to school-aged students in the summer months - through grants to states.[73] In 1975, Congress split the SFSPC into the Child Care Food Program (CCFP), to serve young children in day care, and the Summer Food Service Program (SFSP), to serve school-aged children during months when school was not in session.[74] By that time, approximately 457,100 children participated in the former and 1.8 million children participated in the latter.[75] In addition to splitting the SFSPC into the CCFP and the SFSP, Congress recognized that a greater variety of child care was being used than originally anticipated, and amended the law to expand eligible institutions to include "any nonresidential public or private non-profit organization providing care in low-income areas," including "family day care programs, Headstart programs, and comparable Homestart programs for children under 3."[76] However, the amendments also required institutions to be approved or licensed by the state or federal government to ensure that standards were equally as comprehensive as "those required under the Federal interagency day care requirements."[77]

In 1977, less than ten years after its creation, the CCFP served 580,000 children at an estimated cost of 120 million dollars.[78] By 1978, the CCFP had become a permanent federal program, authorized at Section 17 of the NSLA.[79] During the period when Congress expanded program eligibility to the CCFP to programs providing "day care outside of school hours and public or private nonprofit organizations sponsoring family or

[71] Special Food Service Program for Children, Pub.L. 90-302 (1972).
[72] *See* DONNA LEUCHTEN, AN ASSESMENT OF THE CACFP SUPPER PROGRAM IN MILWAUKEE PUBLIC SCHOOLS 5 (2010) http://hungercenter.wpengine.netdna-cdn.com/wp-content/uploads/2011/06/As-Assessment-of-the-CACFP-Supper-Program-in-Milwaukee-Public-Schools-Leuchten.pdf.
[73] *Id.*
[74] *Id*.
[75] Jones, *supra* note 11, at 68.
[76] *Id.* at 69.
[77] *Id.*
[78] Mary Jo Bane, Laura Lein, Lydia O'Donnell, C. Ann Stueve & Barbara Wells, *Child-care arrangements of working parents*, 102 MONTHLY LAB. REV. 50, 50 (1979).
[79] National School Lunch Act, 42 U.S.C. 1766 (1978). *See also* Harv. Food L. & Pol'y Clinic, *supra* note 48.

group day care homes,"[80] it also made changes to simplify the process for child care providers claiming benefits. Congress developed a three-tier system[81] to reimburse sponsors at three different financial levels for meals served, categorizing centers by the proportion of children whose family income made them eligible for reduced-price school lunches and distinguishing the reimbursement system by institutional or home-based care. In doing so, Congress specified that in sponsored family or group homes, "federal payments were not related to the family income of the children."[82] These changes simplifying reimbursement for providers by expanding eligibility and using proportions and averages of family income, rather than directly linking individual children's family incomes to reimbursement, were an attempt to incentivize greater participation in the CCFP by family day care homes.[83] These improvements reflect an attempt by Congress to adapt the CCFP to a highly varied, heterogeneous field of child care providers serving children who increasingly spent some or most of their time in non-parental care.

Unfortunately, this expanded tiered system was short-lived. After President Ronald W. Reagan's election, Congress significantly cut down the CCFP in the Omnibus Budget Reconciliation Act of 1981 (hereinafter "1981 Act"), including eliminating the three-tier reimbursement system for children in child care centers and opting for an individual family income measure.[84] Home-based day care providers continued to be eligible to participate in the program without an income requirement, but these providers were prohibited from getting reimbursed for food served to their own children in the day care unless their own family income was less than 185% of the poverty level.[85] The 1981 Act also limited eligibility to children aged 12 and under and reduced the levels of reimbursement and

[80] Jones, *supra* note 11, at 70.

[81] *Id.* First, centers were divided into institutional or home-based care. One tier covered all institutional care. Within home-based care there were Tier 1 (higher reimbursement levels) and Tier 2 (lower reimbursement levels) providers.

[82] *Id.*

[83] *Id.*

[84] *Id.* at 70-71. *See also Child Nutrition Programs: Issues for the 103d Congress. Prepared for the Subcommittee on Elementary, Secondary, and Vocational Education of the Committee on Education and Labor. House of Representatives, One Hundred Third Congress, Second Session* (1994), *available at* http://files.eric.ed.gov/fulltext/ED371827.pdf.

[85] *Id.*

the numbers of meals and snacks that could be reimbursed in family day care homes.[86]

Despite the drastic cuts of the early 1980s, the number of children served by the CCFP continued to grow, reaching 1.5 million children by 1997 as more parents joined the workforce and families placed their children in day care centers.[87] Congress allocated more funding to increase meal reimbursements in 1986 and 1988.[88] The program also underwent additional structural changes to arrive at what we have today. In 1996, under President William J. Clinton, the two-tier system of reimbursement used for home day care settings that we continue to use today was implemented as part of The Personal Responsibility and Work Opportunity Reconciliation Act.[89] In addition, from 2000-2004, a period during which the CCFP was expanded to include more children, discussed further below, the government introduced integrity regulations to the program.[90]

In 1989, two years after "adult day cares" were added to the CCFP mandate, the CCFP officially became the Child and Adult Care Food Program (CACFP).[91] The CACFP slowly began reincorporating older children into its services again, allowing schools to serve after-school snacks in 1989, allowing schools to serve children 13 to 18 years of age in high-risk neighborhoods in 1994,[92] extending the school snack program to "at-risk" areas in 1998,[93] and establishing a state-based pilot program in 2000[94] to serve suppers to students under 18 years of age in at-risk afterschool programs.[95] By 2009, the District of Columbia and 13 states provided CACFP reimbursement for meals for children under 18 years of age in at-risk areas. The states included Connecticut, Delaware, Illinois,

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[86] *See* KELLY MEREDITH, A STATEWIDE ANALYSIS OF THE CHILD AND ADULT CARE FOOD PROGRAM AND FAMILY CHILD CARE PROVIDERS IN OREGON 4 (2009), http://hungercenter.wpengine.netdna-cdn.com/wp-content/uploads/2011/07/Statewide-Analysis-of-CACFP-Family-Child-Care-in-OR-Meredith.pdf.

[87] *Id.*

[88] Jones, *supra* note 11, at 72.

[89] MEREDITH, *supra* note 86, at 4. The two-tier system is discussed in the next section.

[90] *Id. See also* LEUCHTEN, *supra* note 72 (discussing the expansion of the program in the early 2000s).

[91] LEUCHTEN, *supra* note 72, at 5.

[92] The Healthy Meals for Healthy Americans Act of 1994, P.L. 103-448, 108 Stat 4699 (1994).

[93] The Child Nutrition Reauthorization Act of 1998, P.L. 105-336, 112 Stat 3143 (1998).

[94] Agricultural Risk Protection Act, P.L. 106-224, 114 Stat 358 (2000).

[95] LEUCHTEN, *supra* note 72, at 5.

Maryland, Michigan, Missouri, Nevada, New York, Oregon, Pennsylvania, Vermont, West Virginia, and Wisconsin.[96]

The evolution of young child nutrition assistance from the SFSPC into the CACFP that we have today reflects the United States' strong commitment to child health and to public support for needy families, even through conservative periods of government. Embedded in this evolution are several tensions that reflect and contribute to the challenges still facing the program today. These include tensions between individual markets, providers, and government accountability; between the need to assist low-income children, families, and providers and a lack of trust in child care providers' compliance with benefits requirements (seen through increased accountability and anti-fraud measures since the 1980s); between different stakeholders, many of whom are not the children, families, and providers the program directly impacts; and perhaps most importantly, between the goal of reaching young children from low-income families through institutional infrastructures and the fact that such "infrastructure" does not actually exist as it does with public schools. Despite these tensions and challenges, the CACFP serves as an important program supporting the nutritional well-being of millions of American children today, and is based on the sound scientific rationale that nutrition and health is essential in a child's earliest years. As such, the CACFP provides an excellent opportunity to improve nutrition for America's young children and to support families and providers in ensuring their healthy development.

III. OVERVIEW OF THE CACFP TODAY

The Federal Nutrition Service (FNS) administers the CACFP and other nutrition assistance programs pursuant to its mission "to provide children and needy families better access to food and a more healthful diet."[97] In the House and Senate Reports on the Healthy, Hunger-Free Kids Act of 2010 (HHFKA), Congress notes that "child care facilities are a natural setting in which to lay the foundation for good nutrition and wellness in children," and that "at the federal level, one opportunity to promote better health in child care settings is USDA's Child and Adult Care Food Program."[98] In the fiscal year 2013 (hereinafter "FY2013"), "approximately 57,000 child care centers with an average daily attendance

[96] *Id.*

[97] U.S. DEP'T OF AGRIC., FOOD & NUTRITION SERV., FAMILY SERVICES: ABOUT USDA FOOD AND NUTRITION SERVICES (FNS), http://www.outreach.usda.gov/familyservices.htm (last visited March 28, 2015).

[98] S. REP. No. 111-178, *supra* note 10, at 9 (2010).

of 2.7 million children participated in CACFP."[99] Administration of the CACFP falls to states, which are required to assign duties to one or more state-level agencies.[100]

A. Provider Eligibility and Administrative Requirements

Unlike many child food assistance programs where eligibility is determined by the child's household income, eligibility for the CACFP ultimately depends on the child care provider.[101] As noted previously, one effect of this structure is that many low-income children are not served by the CACFP because they are not in eligible child care settings.[102] Notably, stringent criteria is not the primary reason centers are unlicensed or do not participate; "any child and most providers are eligible to participate in the program" with reimbursement rates varying depending on eligibility criteria.[103] To be eligible, a child care provider, both center-based or home-based, must be licensed or approved by a federal, state, or local licensing authority; licensing processes and requirements differ by state, indicating one area where states can have an important impact on incorporating more providers and care givers into the program.[104] Once a provider is licensed, the provider may opt in to participating in the CACFP. The "central criteria" that determine eligibility and reimbursement rates are "type of care (center vs. home, for-profit vs. non-profit, licensed vs. unlicensed), neighborhood income, provider income, and/or family income of children."[105] Non-profit child care centers are eligible for CACFP reimbursements. For-profit child care centers are only eligible for CACFP reimbursements if 25% of the children they serve have family incomes that make them eligible for free or reduced-price lunch, or if the center receives federal child care subsidies or Title XX funds[106] for at least 25% of the children they serve.[107]

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[99] Aussenberg, *supra* note 34, at 20.
[100] *See* Harv. Food L. & Pol'y Clinic, *supra* note 48, at 5.
[101] *See* RACHEL A. GORDON, ROBERT KAESTNER, SANDERS KORENMAN & KRISTIN ABNER, THE CHILD AND ADULT CARE FOOD PROGRAM: WHO IS SERVED AND WHAT ARE THEIR NUTRITIONAL OUTCOMES? 6 (Nat'l Bureau of Econ. Research, Working Paper No. 16148, 2010), *available at* http://www.nber.org/papers/w16148.
[102] *Id.* at 6.
[103] *Id.* at 3.
[104] 42 U.S.C. 1766(a)(1)(b)(5) (West 2012).
[105] Gordon et al., *supra* note 101, at 3.
[106] The Social Security Act provides Title XX funds to States to support child care (and other social services). Jones, *supra* note 11, at 62.
[107] *See* Harv. Food L. & Pol'y Clinic, *supra* note 48, at 11.

Home-based child care providers face an additional hurdle to participating in the CACFP. In fact, the Harvard Law and Food Policy Clinic notes that "gaps in CACFP participation are not usually the consequence of a facility's lack of interest in government assistance, but rather a result of the onerous program requirements and oftentimes confusing hurdles associated with enrollment."[108] Home-based providers must participate through a sponsoring organization to which they submit meal plans and other related paperwork.[109] Sponsoring organizations are frequently child care centers and can be public or private organizations or institutions.[110] They act as intermediaries, dealing with the state "on behalf of…providers, submitting reimbursement claims, distributing Program funds, and monitoring provider compliance with Program requirements."[111] In FY 2013, more than 850 sponsors worked with over 122,000 home-based day care providers to serve approximately 22% of the children benefiting from the CACFP, enabling providers to receive meal reimbursement and support.[112]

Congress and some states have made some efforts to alleviate these hurdles and facilitate participation of home-based providers in the CACFP. To ease entry into the CACFP and the reimbursement process, Congress enacted several amendments to "streamline application processes [and]…eliminate some paperwork," and to increase sponsor and provider "flexibility over administrative funds."[113] Some states have gone even farther to encourage entry into the program. In Massachusetts, for example, the Department of Elementary and Secondary Education "classified certain neighborhoods as automatically qualifying as Tier I," which "may encourage family day care home providers to join the program."[114] Although this relates to the tiered reimbursement system, discussed below, rather than to enrollment eligibility, it does reduce some of the administrative burden on both home-based providers and sponsoring organizations and thus reduces the initial costs of enrollment to these providers and increases the potential returns to getting licensed and enrolling in the CACFP. This is a particularly important step towards increasing enrollment of child care providers that operate in less formal care environments.

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[108] Harv. Food L. & Pol'y Clinic, *supra* note 48, at 2.
[109] *See id.* at 30. *See also* Healthy and Hunger-Free Kids Act of 2010, 42 USC 1751 §111 (West 2012).
[110] *See* Harv. Food L. & Pol'y Clinic, *supra* note 48, at 13.
[111] Harv. Food L. & Pol'y Clinic, *supra* note 48, at 13.
[112] Aussenberg, *supra* note 34, at 21.
[113] *Id*.
[114] Harv. Food L. & Pol'y Clinic, *supra* note 48, at 25.

B. Tiered Provider Reimbursement

In its current iteration, the CACFP serves children in child care centers, child care homes, and after-school care, and although not discussed in this paper, adults in adult day care centers and homes.[115] The CACFP can apply to "(1) public or private nonprofit centers, (2) Head Start centers, (3) for-profit proprietary centers that meet certain requirements as to the proportion of low-income children they enroll, and (4) shelters for homeless families."[116] Although pre-school aged children are the most common recipients of CACFP assistance, the CACFP also reimburses meals and snacks for children twelve years old or younger, migrant children age 15 years old or younger, and children with disabilities regardless of age.[117] Only 1% of CACFP assistance is through USDA food provision; the vast majority of assistance is through cash reimbursements.[118]

Home-based child care providers may get CACFP reimbursements based on a two-tiered system and must apply for these reimbursements through sponsor organizations, often child care centers.[119] Tier I reimbursements provide higher reimbursement rates to home-based providers and apply to home-based providers that satisfy the school area test (at least 50% of children enrolled in the area elementary school are eligible for free or reduced-price meals), the census test (at least 50% of children residing in a geographic area designated by the FNS in which the home is located live in households eligible for free or reduced-price meals), or the provider income test (the provider's household income qualifies the household for free or reduced-price meals).[120] If home-based providers do not qualify for Tier I reimbursements, they may apply for Tier II reimbursements and separately apply for Tier I reimbursements for individual meals served to children who meet Tier I requirements.[121] All other meals not qualifying for Tier I reimbursements are reimbursed under Tier II rates.[122]

The most recent changes to the CACFP through the HHFKA slightly expanded home-based providers that qualify for Tier I reimbursements by allowing them to qualify based on any school in their

[115] 42 U.S.C. § 1766 (2010).
[116] Aussenberg, *supra* note 34, at 20.
[117] 42 U.S.C. § 1766(a)(3) (2010)
[118] Aussenberg, *supra* note 34, at 19.
[119] Harv. Food Law & Pol'y Clinic, *supra* note 49, at 11.
[120] *Id.* at 12.
[121] *Id.* .
[122] *See* S. Rep. No. 111-178, *supra* note 10, at 20.

district, not just elementary schools.[123] Congressional reports predicted that as a result, 2,250 Tier II homes would become Tier I homes and that 225 new homes would join the CACFP.[124] The Act made other adjustments to streamline enrollment, eligibility and reimbursement for home-based providers, such as direct certification of students based on eligibility for other benefits, like the Supplemental Nutrition Assistance Program (hereinafter "SNAP") and Medicaid, and expansion of reimbursement for after school programs serving children at risk.[125] Taking their own initiative, some states have reduced the administrative costs providers must bear to enroll in the CACFP program. For example, Illinois allows child care providers to identify children who qualify for meal reimbursement through an online system that accesses SNAP and Temporary Assistance to Needy Families databases, reducing child eligibility paperwork for providers and for sponsors.[126]

C. Reimbursable Meal Patterns and Nutrition Requirements

Currently, the CACFP reimburses participating centers for two meals and one snack or one meal and two snacks per child.[127] These meals and snacks must satisfy federal nutrition standards.[128] The nutrition requirements are based on the Dietary Guidelines for Americans (hereinafter "Guidelines"),[129] guidelines jointly published by the USDA and the United States Department of Health and Human Services about health and nutrition, reviewed "not less frequently than once every 10 years."[130] Although the Guidelines were reviewed and updated at the time of the proposed rulemaking regarding the CCDF in 2010, the CACFP meal patterns have not been updated to align with the new guidelines in over 20 years.[131] In fact, there is ample opportunity to improve the

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[123] *Id.* at 20.
[124] *Id.*
[125] *Id.* at 19-20.
[126] Harv. Food L. & Pol'y Clinic, *supra* note 48, at 25.
[127] *See* Aussenberg, *supra* note 34, at 20.
[128] *Id.*.
[129] National Nutrition Monitoring and Related Research Act, 7 U.S.C. 5341 § 301 (1990).
[130] 42 U.S.C. 1766(g)(1)(B)(i) (2010)
[131] *See* ROBERT WOOD JOHNSON FOUND. CTR. TO PREVENT CHILDHOOD OBESITY, CHILD NUTRITION PROGRAMS: FEDERAL OPTIONS AND OPPORTUNITIES 6 (2010); *see also* Food Research and Action Ctr. (FRAC), *New IOM Report Outlines Nutrition Recommendations to Update CACFP Meal Requirements*, http://frac.org/new-iom-report-outlines-nutrition-recommendations-to-update-cacfp-meal-requirements/ (last visited Nov. 27, 2014); Julie Mikkelson, Keynote address at the National CACFP Sponsors Association Conference (September 16, 2013), *available at*

effectiveness of CACFP reimbursements on child health and nutrition through continued revision of the program meal patterns alone. Notably, and discussed later in Part IV, the Institute of Medicine (IOM), a non-governmental organization founded under the National Academy of Sciences that provides expert guidance on health and science, issued a report in 2010 outlining extensive recommendations for improving CACFP meal patterns.[132]

It appears that the CACFP improves the nutrition of children who receive benefits. Children who attend full-time day care eat half to two-thirds of their daily food intake while in the child care setting, highlighting the importance of high nutrition standards for the food served through day care providers.[133] A study done by the National Bureau of Economic Research found that children in CACFP-assisted centers drank more milk, ate more vegetables and slightly more fruits, and had a lower likelihood of being underweight than children in home care or non-CACFP-assisted centers.[134] In proposing a new rule for the CCDF, the CACFP is cited as an example of the White House Task Force on Obesity finding that "public programs can improve the nutritional quality of food, as children who receive food through government regulated programs…eat healthier than those bringing food from home."[135]

The USDA issues meal patterns outlining meals and snacks that are reimbursable for providers under the CACFP.[136] Current USDA-issued meal patterns appropriately provide separate guidance for infants and for children. Infant meal plans are divided by meal (breakfast, lunch or supper, and snack) and age (birth through 3 months, 4 through 7 months, and 8 through 11 months), adjusting the quantities of formula or breast

http://www.cacfp.org/files/5013/7943/3219/Julie_Mikkelson_NCA_2013_Welcome-091613.pdf.

[132] Comm. to Review Child and Adult Care Food Program Meal Req's, Inst. of Med., *Child and Adult Care Food Program: Aligning Dietary Guidance for All* 11, 183 (Suzanne P. Murphy, Ann L. Yaktine, Carol West Suitor & Sheila Moats, eds., The National Academies Press, 2011), *available at* http://www.nap.edu/catalog.php?record_id=12959 [hereinafter *2010 IOM Report*].

[133] Gordon et al., *supra* note 101, at 10. This is very notably more than the one-third to one-half of nutrition intake initially contemplated by the SFSPC. *1968 Hearings*, *supra* note 51, at 75.

[134] *Id.* at 22.

[135] Child Care and Development Fund Program, 78 Fed. Reg. 29442 (proposed May 20, 2013) (to be codified at 45 C.F.R. pt. 98) at 28.

[136] The nutrition quality of required meal patterns is discussed in Part IV. The following overview of current meal patterns serves as a background for understanding IOM recommended changes to improve child nutrition.

milk required for each meal or snack.[137] Solid foods are introduced in the oldest age group, 8 months through 11 months, if the child is developmentally ready, and in addition to formula or breast milk, it requires and/or allows, depending on children's developmental ability to consume solid foods, 2-4 tablespoons of infant cereal and 1-4 tablespoons of fruit or vegetable or both for breakfast; 2-4 tablespoons of infant cereal and/or 1-4 tablespoons of meat, fish, poultry, egg yolk, cooked dry beans or peas, or 1/2-2 ounces of cheese or 1-4 ounces of cheese product, and 1-4 tablespoons of fruit or vegetable or both for lunch or supper; and 2-4 fluid ounces of fruit juice (which may be substituted for formula or breast milk) and 0-1/2 bread slices or 0-2 crackers for snack.[138] These meal patterns require that formula and cereal be iron fortified, fruit juice be full-strength, and grains or breads be whole-grain or made from enriched meal or flour, and encourage serving breast milk over formula.[139]

Similarly, child meal patterns provide requirements for breakfast, lunch or supper, and snack, and divide children by age (1-2 years, 3-5 years, 6-12 years). The meal pattern advises that for full reimbursement, the provider must select all three components of a breakfast meal (1 milk, 1 fruit/vegetable, 1 grains/bread) and all four components of a lunch or supper (1 milk, 2 fruits/vegetables, 1 grains/bread, 1 meat/meat alternate).[140] Breakfast for a child aged 3-5 years must include ¾ cup of milk, ½ cup of a fruit or vegetable or juice, and ½ slice of bread (or varying amounts of other grains).[141] For lunch or supper, children aged 3-5 years must receive ¾ cup of milk, ½ cup of fruits or vegetables or juice, ½ slice of bread (or other amount of other grain), and 1½ ounces of meat or poultry or fish (or alternate protein, including cheese, egg, beans or peas, peanut butter, nuts, seeds, or yogurt).[142] Like for infants, milk must be low-fat or non-fat for children over 2 years old, juice must be full-strength, and breads and grains must be made from whole-grain or enriched meal or flour.[143] Notably, yogurt may be flavored and/or sweetened.[144]

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[137] U.S. DEP'T OF AGRIC., INFANT MEAL PATTERNS (2014), *available at* http://www.fns.usda.gov/sites/default/files/Infant_Meals.pdf.
[138] *Id.*
[139] *Id.*
[140] U.S. DEP'T OF AGRIC., CHILD MEAL PATTERNS (2014), *available at* http://www.fns.usda.gov/sites/default/files/Child_Meals.pdf.
[141] *Id.*
[142] *Id.*
[143] *Id.*
[144] *Id.*

While meal patterns and reimbursable food provided to children through the CACFP must meet federal dietary guidelines, states are empowered to issue stricter nutrition requirements. Some states have added requirements increasing whole grains and decreasing the amount of sugar permitted in reimbursable foods (West Virginia), prohibiting flavored milk on a daily basis (Texas), prohibiting sweetened beverages and limiting the number of reimbursable fruit juice servings (California), or providing guidance on technically creditable but discouraged foods that have high salt, fat, or sugar content and low nutrition value (New York).[145] Between 2007 and 2008, many states enacted nutrition and child health-related legislation, including 13 states that issued school nutrition standards, three states that enacted nutrition education requirements, and 17 states that amended requirements for physical activity.[146] While the CACFP and federal policy seek to establish an acceptable floor for child nutrition outside of the home, states can and should go beyond these minimum requirements to address other nutrition issues, like sugar and fat content.

III: GETTING HEALTHY FOOD TO HUNGRY KIDS

A. More and Broader Research Needed

It is widely acknowledged that the CACFP is one of the least studied government food programs in operation today. In the 2010 IOM report on aligning CACFP meal plans with dietary guidelines, the authors noted a dearth of information on the operation and reach of the program and "a need to improve data-gathering in all aspects of the program."[147] The authors also recommended "a plan of ongoing evaluation, targeted research, and periodic reassessment to determine the magnitude of impact and identification of the need for future revision in the Meal Requirements."[148] Similarly, the FNS is concerned that the "CACFP has been an under-researched component" of its nutrition programs, and in response, it has funded additional research on the program.[149]

Researchers, too, have noted a lack of information and data on the CACFP. In one of the few studies on the program, researchers wrote, "the CACFP is clearly understudied compared to other federal nutrition programs" despite it being "one of the most important of the smaller food

[145] Harv. Food L. & Pol'y Clinic, *supra* note 48, at 9, 22.
[146] Loeb, *supra* note 13, at 325.
[147] *2010 IOM Report*, *supra* note 136, at 11, 183.
[148] *Id*.
[149] Mikkelson, *supra* note 135, at 2.

programs."[150] In another study done by many of the same researchers, they wrote, "[d]espite the size and potential importance of the program, few studies have examined the effects of CACFP on children, and…only one study of two centers…has compared children in CACFP-participating settings to similar children in non-participating settings."[151] Studies of childhood hunger and its policy implications are currently underway, including CACFP impacts on childhood hunger and nutrition, CACFP day care provider characteristics, "nutritional quality of foods provided in child care settings," "facilitators and barriers to providing healthy food and physical activity and participation in CACFP," the dietary intake of children in day care, and costs of "producing a reimbursable meal under CACFP," among others.[152]

In addition to the studies in progress, the government should invest in research examining how to reach children who are not in participating center-based or home-based day care. This would include children cared for by friends or relatives, and children cared for in either unlicensed settings or through licensed but non-participating providers. Information about who provides child care for these children, the nutrition level of the food served to non-participating children, where non-participating providers shop and how they purchase and prepare food would be invaluable to improving access and quality of nutrition assistance for millions of more children.

B. Improve Overall Nutrition Quality

Although Congress instructed the USDA to update its CACFP nutrition guidelines in conjunction with the current U.S. Dietary Guidelines for Americans in 2010,[153] at the time of this writing, no proposed rule aligning CACFP meal patterns to the new USDA nutrition guidelines had been published. Instead, the USDA has focused on improving nutrition programs and revising meal plans for school aged children[154] and the technical operation and implementation of the CACFP.[155] The USDA intends to publish a final rule in 2015, with changes based on the IOM report published in November 2010 in response

[150] Gordon et al., *supra* note 101, at 2, 11.
[151] Sanders Korenman, Kristin S. Abner, Robert Kaestner & Rachel A Gordon, *The Child and Adult Care Food Program and the nutrition of preschoolers*, 28 EARLY CHILDHOOD RESEARCH Q. 325 (2013).
[152] Mikkelson, *supra* note 135, at 3.
[153] *See* S. Rep. No. 111-178, *supra* note 10, at 39.
[154] *See* 7 C.F.R. §§ 210 & 220 (2014).
[155] *See* 7 C.F.R. § 226 (2014).

to Congressional instruction.[156] Notably, "in the past, CACFP meals and snacks did not need to conform to the U.S. Dietary Guidelines for Americans" and only needed to be "'consistent with the *goals* of the most recent…Guidelines' and 'promote the health' of the children served."[157] Provided that the USDA's final rule follows recommendations provided by the IOM, it should conform to or exceed the requirements in the Guidelines in its forthcoming iteration.

The IOM report recommended significant changes to the CACFP. It suggested adjusting age group categories, increasing the variety of fruits and vegetables and the amounts of vegetables required, distinguishing between starchy and non-starchy vegetables, providing detailed food specifications limiting sugar, fats, and oils, and increasing the proportion of whole grains, among other things.[158] The IOM report also suggests taking a new approach to flexibility in meal planning. Rather than requiring daily serving options for snacks, it recommends requiring that snacks include two servings per week of fruit, vegetables, grains/breads, lean meat/meat alternates, and milk, and that each snack be composed of at least two food groups.[159] It also suggests giving providers the option of providing two regular snacks or one enhanced afternoon snack for older children and adults.[160] Notably, child care standards suggest that multiple small meals and snacks throughout the day are preferable for children,[161] though the report does not specifically address this.

Comprehensive health and nutrition remain at the forefront of proposing any rule. Despite the delay in updating CACFP nutrition guidelines, Julie Mikkelson, Special Nutrition Programs Director of the Midwest Regional Office of the FNS, affirmed that "[o]ur concern for the children and families we serve isn't just THAT they are able to eat; we also care about WHAT they eat."[162] Even so, she noted that the magnitude and expected cost of changes recommended by the IOM in 2010 required careful balancing of nutrition needs and the "practical abilities of traditional and nontraditional centers and day care providers."[163] Underscoring that the CACFP is ill-suited to be the awkward little sister of

[156] Mikkelson, *supra* note 135, at 2.
[157] Harv. Food L. & Pol'y Clinic, *supra* note 48, at 8.
[158] *2010 IOM Report*, *supra* note 123, at 4. The report suggests the following age groups for infants: 0-5 months, 6-11 months; for children: 1 year, 2-4 years, 5-13 years, 14-18 years. *Id*.
[159] *Id.* at 117-24.
[160] *Id.* at 122-24.
[161] *See* Harv. Food L. & Pol'y Clinic, *supra* note 48, at 17.
[162] Mikkelson, *supra* note 135, at 2.
[163] *Id.*

school lunch programs, Mikkelson also explained the delay in updating CACFP nutrition guidelines by noting that the USDA was "keenly aware that CACFP homes and centers were not given a reimbursement increase, as schools were" to make the nutrition improvements required under the HHFKA.[164]

While waiting for the FNS to propose improved meal patterns, however, individual providers are free to provide meals and snacks that exceed the nutrition requirements, just as some local and state agencies have improved nutrition requirements in several states. In fact, in Massachusetts, "providers often serve more than three meals or snacks per day…especially if the children come for before and afterschool care."[165] State guidance is helpful both to providers and as models for the eventual revision of USDA meal pattern materials.

In addition to changing requirements, the USDA and several states are putting out materials and guidance for providers that are not required to go through the rulemaking process as resources offering nutrition guidance, not rules.[166] The USDA has established "Team Nutrition", an initiative that will facilitate collaboration with other agencies and develop resources to help improve the nutrition quality of CACFP meals served and "help day care homes and centers create healthier environments for the children in their care, with advice and best practices on nutrition, active play, and screen time."[167] Team Nutrition projects include "a curriculum of creative ways to change the way children think and feel about fruits and vegetables."[168] Other projects are "Farm to Child Care" and "Know Your Farmer Know Your Food," which increase children's access to fresh produce while supporting local farmers and agricultural producers, a multi-stakeholder investment that harkens back to the original food provision programs in the 1930s.[169]

C. Increase Access to CACFP Benefits

As stated in the Congressional Reports on the HHFKA, food assistance remains a significant need in the United States. These reports cite statistics indicating the highest levels of food insecurity recorded since the first national food security survey in 1995, with 14.6% of U.S.

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[164] *Id.*
[165] Harv, Food L. & Pol'y Clinic, *supra* note 49, at 17.
[166] Mikkelson, *supra* note 135, at 2.
[167] *Id.*
[168] *Id.*
[169] *Id.*

households facing food insecurity at some time during 2009 and 6.7 million of these households facing very low food security, indicating insufficient resources for food such that children's eating patterns were disrupted throughout the year.[170] These numbers represent the national average, but rates were much higher for low-income households, single-parent households, and black and Hispanic households.[171]

Despite having the greatest need, Early Childhood Longitudinal Survey-Birth Cohort (hereinafter "ECLS-B") data, taken from a sample of children born in 2001 and followed through kindergarten entry,[172] suggests that there is a low level of participation in the CACFP, even among low-income children.[173] As expected, among the few low-income children that receive CACFP benefits, more four year olds (37%) than two year olds (8%) benefit from the program.[174] A major barrier to low-income young children receiving CACFP benefits is that they are not cared for in licensed day care settings, whether home-based or center-based, which includes Head Start where almost every center and enrolled child participates in the CACFP.[175] According to the ECLS-B data, 61% of two-year-olds are cared for in exclusive maternal care and a large portion of the remaining two-year-olds are cared for in non-eligible, non-participating, or low-reimbursement rate child care centers.[176] Although eligible providers that care for four-year-olds are much more likely to participate in the CACFP (66% of home-based providers participate), again, few children are actually enrolled in eligible and participating child care.[177] There is, therefore, a significant disconnect between the stated goals of the program and the children it is actually reaching. In fact, one of the few studies of the effectiveness of the CACFP found,

> "CACFP … misses many poor children, and a sizable fraction of non-poor children participate in the program. Coverage of poor children is particularly limited at age two because over 80% of two-year olds are cared for by parents

[170] S. REP. No. 111-178, *supra* note 10, at 3.
[171] *Id.*
[172] National Center for Education Statistics, *Early Childhood Longitudinal Program Overview*, http://nces.ed.gov/ecls/ (last accessed February 21, 2015).
[173] Gordon et al., *supra* note 101, at 16.
[174] *Id.*
[175] *Id.* at 18. This is in large part because these children automatically qualify for CACFP reimbursable meals and Head Start centers are automatically eligible for participation in the program. *See* 42 U.S.C. § 1766(a)(2)(c)(5); *see also* Aussenberg, *supra* note 34, at 20.
[176] Gordon et al., *supra* note 101, at 16-17.
[177] *Id.* at 18.

> at home or in an unlicensed child care home, and family poverty rates are relatively high for two-year old children who are cared for in these settings. The program reaches a higher fraction of poor four-year olds because many poor children spend time in Head Start centers, where CACFP participation rates are nearly 100%, or in other participating centers…[but] even at four years, nearly 40% of children are cared for by parents at home or in an unlicensed child care home, and a relatively high proportion of children in these settings are poor."[178]

While the two-tiered system attempts to divert funds given to providers to low-income children, it cannot reach children who are not in eligible care. Thus, there is a clear trade-off between requiring licensing and extensive oversight and reaching the target population for nutrition benefits.[179]

In addition, it is likely that there are misaligned incentives embedded in the program structure. Center-based and home-based providers look very different: FY2013 CACFP data shows that child care centers serve an average of 48 children each day, while child care homes serve an average of 6 children per day.[180] Notably, the reimbursement structure of the CACFP favors large center-based providers. Researchers note,

> "Because the costs of participation are relatively fixed (e.g., a menu must be planned for three or three hundred children), but reimbursement increases linearly with the number of children, especially poor children, participation should become more attractive when the provider cares for more children, particularly low-income children…If one assumes that centers and home-based care providers would serve meals and snacks in the absence of the program, then it is clear that homes and centers that serve large numbers of poor children (Tier I or full reimbursement) have very substantial monetary incentives to participate. For many mid-size to large centers, benefits as high as $9,000 to $14,000 per month would likely far exceed administrative

[178] *Id*. at 24-25.

[179] *See id*. at 27. Contrast the CACFP structure, which excludes "license-exempt homes" and other ineligible care settings, with that of the Child Care and Development Fund (CCDF), "which provides general child care subsidies…[moving] increasingly toward reimbursing whatever type of care parents choose, including license-exempt care." *Id*.

[180] Aussenberg, *supra* note 34, at 19.

> costs of CACFP. Likewise, a large home would receive nearly $1,000 per month at the Tier I rate."[181]

Therefore it may not be worth participating or even getting licensed if a family member or friend is providing care for only one or two children. In fact, "reimbursement rates are not tied to the actual cost of food served," further reducing the program's ability to align nutrition incentives with program operation.[182] Instead, rates are set sums dictated by children's family income and provider type, and dispensed based on meal pattern compliance and child eligibility.[183]

Other barriers may deter or prevent home-based providers from participating in the program, including language barriers (which likely affect awareness of the program, ability to interact with sponsors or government agencies, etc.), lack of knowledge or information about the program, difficulty finding or working with a sponsor organization, and onerous paperwork requirements.[184] Paperwork requirements include requiring that the provider transmit documented proof of child eligibility based on family income to either their sponsoring organization or the state agency administering the program.[185] Center-based providers can now enter into permanent operation agreements with state agencies, but no such provision is created for home-based providers.[186]

In Massachusetts, for example, attendance-based reimbursement policies provide another challenge to providers from fully benefiting from the program. Although providers plan meals well in advance, they are reimbursed based on how many children attend care each day.[187] This means that they must be very good at predicting when a child will be absent during the period for which they are submitting meal plans or forgo reimbursement for meals and food already purchased in anticipation of children attending care. Based on the average number of children served, the impact of an absent child may be minimal at a day care center where food is bought in bulk and many children are served, but for small home-based providers, an absent child may constitute 20% to 100% of reimbursements for a given day, assuming a provider cares for between one and six children at a given time. Further, home-based providers have

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[181] Gordon et al., *supra* note 101, at 7.
[182] *See* Harv. Food L. & Pol'y Clinic, *supra* note 48, at 5.
[183] *Id.*
[184] *See* Gordon et al., *supra* note 101, at 8; *see also* Harv. Food L. & Pol'y Clinic, *supra* note 48, at 32.
[185] *See* Harv. Food L. & Pol'y Clinic, *supra* note 48, at 11.
[186] *See* P.L. 111-296 Title III, Subtitle C (HHFKA) (2010).
[187] *See* Harv. Food L. & Pol'y Clinic, *supra* note 48, at 3.

difficulty recording meals and requesting reimbursement for meals when they provide care to children in different shifts (e.g. they care for some children in the morning and others after school).[188] In addition to CACFP participation requiring more detailed record-keeping, providers worry that CACFP administrators will misunderstand their reimbursement claims because they include childcare shifts that may make it appear they are exceeding the number of children permitted to be in care at a given time, which could cause them to lose their child care licenses.[189]

Massachusetts offers an example of the impacts of these barriers. From 1996 to 2011 in Massachusetts "the number of family day care homes participating in CACFP…dropped by 30%" while "the number of child care centers participating in CACFP…increased by about 4%."[190] A number of factors may contribute to this trend. According to the Harvard Food Law and Policy Clinic, in Massachusetts,

> "Family day care homes are more likely to struggle with [food] costs, due to their small scale operations and dearth of additional financial resources. This is especially the case for providers focused on increasing the nutritional quality of the meals they serve, since fresh produce, whole grains, lower-fat dairy products, and healthy meats can be more expensive to purchase, store, and prepare than other grocery items…[S]ome providers react to the low reimbursement rates by choosing to forgo fresh produce, opting instead to purchase canned or frozen items in bulk or to select lower-quality foods. Others request that parents send lunches with their children, opting to provide only snacks and/or breakfast, neither of which requires providers to serve meat or a meat alternative."[191]

Based on this data, it is possible that even more stringent meal patterns would not necessarily even reach children in home-based care, let alone children in non-participating care settings.

V. CONCLUSION

The CACFP is a promising program that serves children who greatly benefit from it. When the FNS incorporates IOM recommendations concerning the nutrition quality of meal patterns provided to children in

[188] *Id.* at 32.
[189] *Id.*
[190] *Id.* at 13.
[191] *Id.* at 16.

out-of-home care, it will hopefully vastly improve the nutrition and health of the children it serves. Although a smaller food program, there is no doubt that it is an important piece of the array of government nutrition assistance programs in effect today.

Despite this, and although very well intentioned, there is a fundamental disconnect between the structure of the CACFP and the majority of the people it aims to help. Part of this stems from its close association with the NSLP, which is based on a wide existing infrastructure of public schools, a situation that is not paralleled in the child care setting. Unlike school-aged children, pre-school aged children are not required to attend school, nor are there structures for all of them to receive licensed child care. While public schools are an excellent avenue to improve nutrition for children aged five through 18, pre-schools do not even begin to approach the kind of infrastructure necessary to reach low-income children in need of nutrition assistance, as evidenced by their shockingly low participation rate in the CACFP. Much more research is needed to understand how to reach a greater proportion of low-income young children through the CACFP.

The benefits that the CACFP gained by its association with and modeling on the NSLP also sentenced it to marginal effectiveness, not because it does not improve child nutrition, which it does, but because it does not reach the children in greatest need of food assistance. As a result, no matter how excellent the forthcoming meal patterns proposed by the FNS are, or how much money Congress gives the program to enable providers to feed children healthy and balanced meals, it will fail to make a significant impact in the overall nutritional well-being of most low-income children. Unfortunately, they must continue waiting until they are old enough to attend school to benefit from school-provided healthy meals. To be effective, the CACFP will have to be radically restructured and/or expanded. It may need to attach CACFP benefits directly to children regardless of who is providing child care, or find other creative ways to reach low-income children who spend a significant portion of each day in non-parental care. Congress and states should take advantage of the program's permanent authorization to get healthy food to the nation's hungriest mouths.