Block Grant Head Start? Devolution’s Potential Negative Impact on Children and Families

Christopher A. Mallett, Ph.D., J.D., LISW
Assistant Professor
School of Social Work
Cleveland State University

Benjamin L. Allen, Ph.D.¹
Research and Evaluation Director
National Head Start Association

ABSTRACT
The “new federalism” paradigm offers an explanation why the federal government has devolved much of its administration of the Temporary Assistance for Needy Families (TANF, formerly AFDC) and Medicaid (through managed care) programs. A review of child and family outcomes data resulting from these devolutionary changes in TANF and Medicaid indicates that these devolutionary changes generally appear to have decreased access to medical coverage, decreased well-being outcomes, decreased cognitive development, increased behavioral and emotional difficulties, and increased the incidence of poor health for children and families. If the “new federalism” paradigm is extended to the Head Start program by block granting it to the states, children and their families served by Head Start are in potential jeopardy of suffering similar fates. This strong possibility should make policy makers very cautious about devolving or block granting the Head Start program to the states.

¹ The views, perspective, and content presented here do not represent the policy positions of the National Head Start Association. All views expressed are solely Dr. Benjamin Allen’s and must not be construed to represent the National Head Start Association’s positions.
BLOCK GRANT HEAD START? THE POTENTIAL DISPROPORTIONATE IMPACT ON CHILDREN WITH DISABILITIES

Introduction
During the past two decades the federal government has devolved much of its administration over social service programs to the states. Explaining this devolution, the “new federalism” paradigm holds that the federal government should devolve its administration of social service programs by block granting them to the states so that the states will have the flexibility to make these programs “…more responsive to both the people they are meant to help and the people who pay for them” (Reagan, 1982; OMB, 1991). Critics of this paradigm contend that devolution is a step backwards in social welfare policy because the federal government had originally created its social service programs due to the states’ prior inability to meet their citizens’ needs (DiNitto, 2005; Karger & Stoesz, 2002). These critics point out that state and local policymakers have often not been as supportive of these social service programs as the federal policymakers have been (DiNitto, 2005).

The “new federalism” paradigm has been applied to the Temporary Assistance for Needy Families (TANF), formerly the Aid to Families with Dependent Children (AFDC), and Medicaid programs, but recently, the Bush administration and its congressional allies have sought to extend this paradigm to the Head Start program by proposing to block grant it to the states. This paper seeks to gauge the potential consequences of block granting the Head Start program to the states by reviewing the possible relationships between the devolutionary changes in the TANF and Medicaid programs and the outcomes for children and their families. To pursue this line of inquiry, this paper first briefly describes the Head Start program and the population it serves. Second, the debate over block granting Head Start to the states is explored. Third, the devolutionary changes in the TANF and Medicaid programs, along with their outcomes for children and their families within these programs, are reviewed. Finally, public policy implications for the Head Start program are discussed in light of this review.

Head Start and its Demographic Characteristics
Established in 1965, the Head Start program provides comprehensive education, health, nutrition, family support, and parent involvement services to primarily low-income children and their families. It is administered as a federal-to-local program in which the Head Start Bureau in the U.S. Department of Health and Human Services (DHHS) funds Head Start providers through grants. During the 2003-2004 program year, there were 1,442 grantees. Each grantee can decide to delegate its administrative responsibilities to another organization, a delegate agency. There were 540 delegate agencies in the 2003-2004 program year. During that program year,

Compared to the general childhood population, Head Start serves a disproportionate number of poor children, minority children and families, and children with disabilities. Seventy-four percent of families enrolled in Head Start programs, representing 729,270 children, lived at or below the federal poverty guideline during the 2003-2004 program year (U.S. DHHS, 2005). In comparison, 17 percent of the nationwide childhood population lived at or below the federal poverty guideline in 2003 (U.S. Census, 2003). Children of color are significantly more likely to live in families with low income (NCCP, 2004). Families in Head Start programs are disproportionately families of color as 32 percent were African American, 31 percent Hispanic or Latino, 28 percent were Caucasian, three percent were American Indian or Alaskan Native, two percent were Asian, and one percent were Hawaiian during the 2003-2004 program year (U.S. DHHS, 2005).

Families served by Head Start programs have significantly higher prevalence rates of children with disabilities (13 percent of enrollees) compared to the general population of children. Although prevalence estimates of childhood chronic illness and disability vary depending on the data source and population, a majority of findings indicate the nationwide prevalence rates to be between one and nine percent of the childhood population (Aday, 1992; McNeil, 1993; U.S. DHHS, 2005). Disabilities identified in Head Start include severe asthma, hearing and visual impairments, speech disorders, learning disabilities, mental retardation, and mental/emotional disorders (U.S. DHHS, 2003-2004). Almost all identified children with disabilities received special services through Head Start, and nine out of ten children were enrolled in a publicly funded health insurance program (Medicaid; Early and Periodic Screening, Diagnosis, and Treatment; or the State Children’s Health Insurance Program) (Hart & Schumacher, 2004).

In addition, Head Start children receive or have access to medical services. During the 2002-2003 program year, 87 percent of children enrolled in Head Start received medical screenings, and 89 percent received follow-up medical treatment (Hart & Schumacher, 2004). Poor children in Head Start programs are significantly more likely to have health insurance (89 percent) when compared to the general

---

3 “Economic Opportunity Amendment,” PL 92-424, Section 640(d) (1972); Section 504 (1973); PL 94-142 (1975) mandate that at least 10% of Head Start enrollees be children with disabilities. “Head Start” refers to all Head Start programs including programs for preschool-age children and programs serving infants, toddlers, and pregnant women.

4 The most common disability identified in the Head Start population in recent years is speech and language impairments, accounting for 64 percent of the disability population (Mezey, 2003). However, Head Start serves children with many disability types including developmental delays/mental retardation/non-categorical (20 percent in 2003), multiple disabilities (four percent in 2003), health/visual impairments (three percent in 2003), emotional/behavioral disabilities (three percent in 2003), autism, traumatic brain injury, learning delays, hearing impairments, and orthopedic disabilities (Hart & Schumacher, 2004; U.S. DHHS, 1972-2003).

5 Of those children in Head Start who received treatment in the 2003-2004 program year, 28 percent were treated for asthma, 25 percent for obesity, 16 percent for anemia, 15 percent for vision problems, and 10 percent for hearing problems (U.S. DHHS 2005).
childhood poverty population (79 percent) (Hart & Schumacher, 2004; U.S. Census, 2003). With the growing attention to health disparities and disproportionate impacts on populations of color, particularly those with low incomes (Smedley, Stith, & Nelson, 2003), Head Start programs may be providing a vital link in addressing this inequity.

**Proposed State Control of Head Start**

Recently, the Bush administration and its congressional allies have sought to change Head Start’s administrative structure by seeking to block grant Head Start to the states. By block granting Head Start to the states, the federal government would administer Head Start as a federal-to-state-to-local program with the states assuming much of the federal government’s current oversight of and responsibilities for Head Start.

Proponents claim that permitting some states to administer Head Start would strengthen it by increasing the coordination of numerous federal and state early childhood or related programs and providing more efficient administration and access to early childhood programs (Horn, 2004, p. 8-10). Proponents cited the Family and Child Experiences Survey (FACES) showing that Head Start children by the end of their Head Start year do not perform as well as children in non-Head Start preschool programs in early math and vocabulary (Horn, 2004, p. 4-5). Many proponents also support this legislation ideologically as they believe that states, not the federal government, should administer early childhood programs.

Opponents have been against devolving Head Start to the states for several reasons. First, Head Start currently does not prevent its coordination with state and other early childhood programs. In fact, the Head Start Program Performance Standards encourage this kind of collaboration. The Head Start Bureau (2002) extensively documented the collaboration between Head Start programs and other early childhood or related programs in their communities.

Second, research shows that Head Start is effective as a federal-to-local program. Recent FACES data identified that Head Start graduates, by the spring of their kindergarten year, were essentially at national norms in early reading and early writing and were close to meeting national norms in early math and vocabulary knowledge (Greene, 2004; Zill & Sorongon, 2004). The U.S. Department of Health and Human Services funded study found that Head Start children performed better on cognitive, language, and health measures than their peers in a comparison group (Abbott-Shim, M., Lambert, R., & F. McCarty, 2003). Additionally, a longitudinal study of more than 600 Head Start graduates in San Bernardino County, California,  

---

6 In the face of strong opposition from the Head Start community across the country, and after much arm-twisting by the House Republican leadership and the Bush administration, the House of Representatives on July 25, 2003, narrowly approved H.R. 2210, the School Readiness Act, by a vote of 217 to 216. This legislation would have block granted Head Start programs in as many as eight states. This legislation was not enacted into law because the U.S. Senate did not vote on it before the 108th Congress ended. At the beginning of the 109th Congress (current Congress), the Bush administration proposed block granting Head Start in as many as nine states, and the House and Senate will consider legislation to block grant Head Start.
found that every tax dollar invested in Head Start, society saves nearly nine dollars (Meier, 2003).

Third, it is unlikely that states can administer Head Start as effectively and rigorously as the federal government. State-funded pre-kindergarten programs, in general, are of lower quality, less effective, and provide a narrower range of services than Head Start programs (Gilliam & Ripple, 2004; Gilliam & Zigler, 2004; Zigler & Styfco, 2004). Over the past 16 years, only 18 states have conducted formal evaluations of their pre-kindergarten programs’ effects on children (Gilliam & Ripple, 2004; Gilliam & Zigler, 2001). Block granting Head Start to the states would likely increase the administrative costs of the program by inserting a state bureaucracy between the federal government and the local grantees. The U.S. General Accountability Office (formerly the General Accounting Office) found that state educational agencies use six percent of the federal funding received for administrative purposes and that federal funding is eight times more likely than state funding to target poor students (U.S. GAO, 1994, p. 4; 1998, p. 8).

Federal Policy Changes and the Impact on Children with Disabilities

The devolution of the AFDC/TANF and Medicaid programs over the past two decades has shifted much control and decision-making to the states. Although research outcomes to date are limited in scope, these devolutionary changes generally appear to have decreased access to medical coverage, decreased well-being outcomes, decreased cognitive development, increased behavioral and emotional difficulties, and increased the incidence of poor health for children and families.

Temporary Assistance for Needy Families Program

The 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) made unprecedented changes to the welfare system eliminating the 60-year-old Aid to Families with Dependent Children (AFDC) program and replacing it with a block grant to states to create the Temporary Assistance for Needy Families (TANF) program. Under AFDC the federal government reimbursed states for at least half the cost of providing this assistance with no cap on expenditures. AFDC benefits also assured ready access to other benefits such as Medicaid and food stamps. The new TANF law set funding levels on states’ historical expenditures under AFDC and gave states increased flexibility to design their own welfare programs and support services for low-income families.7 States gained extraordinary authority to determine the nature and scope of their welfare programs including welfare benefit receipt time frames, training, and child-care services availability (Zaslow & Emig, 1997). To date, a majority of states (28) require all families with a child over the age of 1 year to participate in work activities; four states require all families to participate; and 13 states require families with children over the age of 4 months to participate (Pavette, 2003).

Noncompliance with TANF guidelines caused a range of sanctions to be applied

7 U.S.C. 42 et seq.
to individuals and families. Sanction rates for families have differed depending on the tracking methodology used, but these rates ranged from 5 to 60 percent for all TANF families (Born, Caudill, & Cordero, 1999; Edilhock, Liu, & Martin, 1999; Fein & Lee, 1999; Holcomb & Ratcliff, 2000; Koralek, 2000; Ovwigho, Born, Ruck, Srivastava, & Owens, 2002; U.S. GAO, 2000; Westra & Routley, 2000). Sanctioned families experience hardships at a higher rate than non-sanctioned families (Pavette, 2003).

This change from AFDC to TANF under PRWORA has led to a dramatic 50 percent decrease in the participation and enrollment rates of families since this Act’s implementation (Acs & Lopres, 2001; U.S. DHHS, 2000). Seven million recipients have left TANF since 1996, and 70 percent of these former TANF recipients are children (Brown, 1999; Cook, et al., 2002; Meyers, Lukemeyer, & Smeeding, 1996; Morris, Knox, & Gennetian, 2002; U.S. DHHS, 2003; U.S. DHHS, 1999; U.S. DAFNS, 1997). Forty-one percent of these former recipient children were less than 3 years of age, while another 25 percent were between 3 and 6 years of age (Loprest, 2002).

--

8 States are authorized through the PRWORA to determine when non-compliance by family members leads to temporary or permanent discontinuation of cash assistance. These cash assistance withholdings are entitled “sanctions,” and “sanction rates” are the percentage of TANF-eligible families “sanctioned” during a particular time period.

9 Reasons for this decrease arguably include the following: the changes in welfare policy itself; the most robust economic expansion in this nation’s history; the increase in the Earned Income Tax Credit for low-income citizens; expanded health care coverage (State Children’s Health Insurance Program); departures due to sanctions and time-limits; diversion programs; and stronger enforcement of child-support laws (Blum & Francis, 2002; Jacobson, 2001; Johnson, 2000). There is significant concern with the states’ abilities to effectively manage these most at-risk TANF families, those of children with disabilities. Blame has been placed on states’ failure to develop effective administrative systems to deliver the family assistance (Zedlewski, 2002). State and local offices seldom communicate effectively the message of benefit eligibility to those who are eligible, and the drop in Medicaid coverage may be due to administrative complexities. Eligibility for the 12 months of Medicaid benefits post-TANF requires reports on earnings and child-care costs at the 4th, 7th, and 20th months, a burden many low-income families with at-risk children may find very difficult (Greenstein & Guyer, 2001).

10 However, it is well documented that children with special needs are overrepresented in poverty samples (Meyers, Brady, & Seto, 2000). Former TANF families have younger children compared to the general population. Former TANF families’ median number of children is two, although 14 percent of families have more than three children. Over 66 percent of former TANF families have a child less than 6 years of age (Loprest, 2002).

11 Twenty-four percent of families in Head Start programs during the 2002-2003 program year received TANF cash assistance or benefits. This proportion represents a significant decrease from the 45 percent of families in Head Start programs who received TANF in 1997, the inaugural year of full TANF program implementation. Since 1997, one-fourth of Head Start families have experienced the changing TANF requirements. (Hart & Schumacher, 2004; U.S. DHHS, 2003).
TANF Outcomes

To date, 10 studies have examined the effects of replacing AFDC with a devolved TANF program on child outcomes (see Table 1). This research reviewed the following TANF outcomes: mother and child physical health; children’s behavior/emotional adjustment, cognitive development, and health/safety concerns; children’s hospitalization rates; food and family welfare insecurities; and health insurance access.

The first study, a longitudinal review of four large urban areas (Cleveland, Los Angeles, Miami, and Philadelphia), examined health and well-being outcomes for mothers and their children. Twenty percent of all families had a child with a chronic illness/disability that limited mother’s work or school participation. Disturbingly, families who had experienced TANF sanctions were disproportionately families with children with disabilities (Polit, London, & Martinez, 2001). Reported children’s disabilities included asthma, developmental disabilities, autism, brain damage, seizure disorders, emotional/behavioral disorders (attention deficit hyperactivity disorder, bipolar, depression), and other physical disorders (Polit, et al., 2001). Children of mothers who did not receive TANF were substantially more likely to have forgone both routine health care and dental care, and their children received less preventive health care (Polit, et al., 2001, chaps. 3, 4, 5, & 7).

The second study, a longitudinal analysis of three urban areas (Boston, Chicago, and San Antonio), collected high-quality measures of test scores, behavior, and mental health for children aged 3 to 5 years of age (Chase-Lansdale, Coley, Pittman, & Lohman, 2003). Children in current and former TANF families that had been sanc-

<table>
<thead>
<tr>
<th>Lead Author</th>
<th>TANF Subject Reviewed</th>
<th>Location</th>
<th>n</th>
<th>Ages</th>
<th>Disability Area Reviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Polit (2001)</td>
<td>Health status, insurance, and utilization</td>
<td>4 urban areas</td>
<td>3,741</td>
<td>0 to 6</td>
<td>Physical, learning, mental or health</td>
</tr>
<tr>
<td>Chase (2003)</td>
<td>Employment and welfare transitions</td>
<td>3 urban areas</td>
<td>564</td>
<td>3 to 5</td>
<td>Cognitive, behavioral, and mental</td>
</tr>
<tr>
<td>Ovwigho (2003)</td>
<td>Demographics and employment</td>
<td>Maryland</td>
<td>8,567</td>
<td>0 to 17</td>
<td>Medical and welfare needs</td>
</tr>
<tr>
<td>Acs (2001)</td>
<td>Health and insurance coverage</td>
<td>15 states or counties</td>
<td>n/a</td>
<td>0-17</td>
<td>Child health, well-being, &amp; welfare</td>
</tr>
<tr>
<td>Zaslow (2002)</td>
<td>Childhood development outcomes</td>
<td>10 states</td>
<td>n/a</td>
<td>3 to 10</td>
<td>Cognitive, behavioral, and health</td>
</tr>
<tr>
<td>Frame (2001)</td>
<td>Urban poverty and parenting</td>
<td>1 California city</td>
<td>10</td>
<td>0 to 4</td>
<td>Welfare and well-being</td>
</tr>
<tr>
<td>Cook (2002)</td>
<td>Childhood hospitalization rates</td>
<td>5 states &amp; D.C.</td>
<td>2,718</td>
<td>0 to 3</td>
<td>n/a</td>
</tr>
<tr>
<td>Shields (2002)</td>
<td>Economic progress</td>
<td>Large data review</td>
<td>meta</td>
<td>0 to 5</td>
<td>n/a</td>
</tr>
<tr>
<td>Duncan (1997)</td>
<td>Single-parent families</td>
<td>Large data review</td>
<td>meta</td>
<td>0-17</td>
<td>Child development and well-being</td>
</tr>
<tr>
<td>Loprest (2002)</td>
<td>Reviewed TANF-leaving children</td>
<td>10 states</td>
<td>n/a</td>
<td>0 to 6</td>
<td>n/a</td>
</tr>
</tbody>
</table>
tioned had higher rates of serious behavioral and emotional problems and lower cognitive achievements than children in other TANF families. In particular, 56 percent of preschoolers whose mothers were sanctioned and left TANF scored in the “range of concern” for serious behavioral and emotional problems compared to only 28 percent of non-sanctioned leavers. This rate of problem behavior is three times the national norm (Chase-Lansdale et al., 2003; Fremstad, 2004). It is unknown whether these increased rates were caused by sanctions or if mothers left TANF to meet their child’s disability needs (for example, the inability to find appropriate child care).

In the third study, a randomly assigned longitudinal review of all welfare leavers in Maryland, most families exiting TANF had a child under 6 and two in five had a child under the age of 3 (Ovwigho, Born, Ruck, & Kirk, 2003). Leaving TANF did not discontinue the need for children to have governmental supports. Medical Assistance (Maryland Children’s Health Insurance Program) access rates for children leaving TANF during the first year averaged 63 percent; five years later, this rate was 55 percent. The study concluded that while not a cost-shifting issue to date, the children within Maryland’s TANF families have significant medical insurance needs met by the MCHIP/Medicaid program (Ovwigho, Born, Ruck, & Kirk, 2003).

The fourth study was a congressionally mandated DHHS review of TANF reform outcomes through 15 large grant-funded state/county analyses. Administrative and survey data was utilized, including a review, albeit limited, of child well-being. Reports of children in “poor” or “fair” health were generally low, ranging from 5 to 10 percent. However, one-tenth to one-quarter of these families with children in “poor” or “fair” health had children without health insurance. TANF sanctions disproportionately impacted this sub-group of children and their families’ access to health care (Acs, Loprest, & Roberts, 2001).

The fifth study reviewed TANF effects on children’s cognitive development, behavioral and emotional adjustment, and health and safety concerns with significantly mixed results (Zaslow, Moore, Brooks, Morris, Tout, Redd, & Emig, 2002). While numerous effects were neutral, positive impact on young mothers receiving TANF was difficult to find based on the children’s developmental measure. Unfavorable outcomes for children’s health status and well-being were found within two of the programs studied. Favorable impacts on income facilitate, but did not assure, favorable child outcomes (Zaslow, et al., 2002).

The sixth study, a qualitative review of 10 families’ experiences in California, found that low-income and TANF parents of children with disabilities faced significant challenges. These challenges included: a sense of difficulty providing the necessities of life for one’s children with disabilities; an awareness of providing limited opportunities for children with disabilities; an experience of having limited time,

---

12 Studies reviewed included the New Chance Demonstration Project, Teenage Parent Demonstration Project, Job Opportunities and Basic Skills Training (JOBS – one predecessor program, along with AFDC, to TANF), Minnesota Family Investment Program, New Hope Project, Canada’s Self-Sufficiency Project, Florida Family Transition Program, Connecticut’s Jobs First Program, Indiana Welfare Reform Evaluation, and Iowa’s Family Investment Program. This research also utilized some of the findings from Acs, Loprest, & Roberts (2001).
physical energy, or emotional availability due to competing demands; impediments to protecting one’s children with disabilities from harm in the environment; and effects on the parents’ sense of their child’s future, including a foreshortened sense of that future (Frame, 2001).

Four additional studies found negative results for this at-risk TANF population. Young children in families whose welfare benefits had been terminated or reduced by TANF sanctions had a 130 percent greater chance of being in the hospital compared to those families whose benefits had not been reduced (Cook, et al., 2002). When state TANF programs resulted in families making no economic progress or experiencing a setback, the effects on children tended to be negative across all types of outcome measures (Shields & Behrman, 2003). Children in single-parent families receiving TANF services, especially those with no male present, were more likely to suffer adverse effects on their development and well-being (Duncan & Brooks-Gunn, 1997). Families with children who left TANF reported decreasing their meal size and intake, with 40 percent reporting an inability to pay the mortgage, rent, or utilities (Loprest, 2002).

Although further research is needed in this area, these 10 studies generally found negative or inconclusive effects on child and family outcomes from replacing AFDC with a devolved TANF program. These findings indicate that policy makers should be very cautious about devolving or block granting the Head Start program to the states.

**Medicaid**

During the past two decades, the Medicaid program has also followed a devolutionary pattern from federal to state control through the use of managed care technologies and federal waivers. These changes have led to decreased access to needed medical specialists, decreased participation rates, increased medical necessity limitations, and poorer health outcomes for children.

Medicaid provides health insurance for the nation’s poorest citizens through financing health and long-term care services for more than 52 million individuals. Enacted in 1965 as an amendment to the Social Security Act of 1935, Medicaid is a medical assistance program jointly financed by state and federal governments for

---

13 “Managed care” refers to a variety of financing and delivery arrangements, with a unifying characteristic being the requirement/encouragement of the enrollee to obtain care through a network of participating providers. This approach contrasts with the older “fee for service” model where patients seek care from any professional, and these professionals are reimbursed for what they judge is professionally needed.

14 The Social Security Act provides for two types of Medicaid waivers. Program waivers include Freedom of Choice waivers authorized under section 1915(b), primarily for the development of managed care models. They also include Home and Community-Based Services waivers authorized under section 1915(c) that allow alternatives to institutional care for the elderly and disabled. Research and demonstration waivers (1115) provide exemption from a wider set of Medicaid regulations – state-wideness; eligibility expansion; benefit design, and service delivery (Health Policy Institute, 2005).

low-income individuals. Enacted in 1997, the State Children’s Health Insurance Program (SCHIP) expanded Medicaid coverage through provision of a capped amount of federal matching funds to states for health insurance coverage of children (and some parents) with incomes too high to qualify for Medicaid but for whom private insurance was unavailable or unaffordable. SCHIP currently covers approximately five million children.

Public sector health and human services have gone through a period of significant and rapid change over the past 15 years. States, and increasingly local governments, have applied managed care practices to the delivery of Medicaid to improve the management of health care costs (Jensen, Morrisey, Gaffney, & Liston, 1997; Roland & Hanson, 1996). Most states have implemented managed care programs for a majority of Medicaid beneficiaries, principally those enrolled through the TANF program. Most state Medicaid programs no longer permit consumers to choose between managed care and fee-for-service arrangements, instead requiring enrollment in a managed-care Medicaid program (Hughes & Luft, 1998). By 1996 more than 13 million Medicaid recipients had managed care requirements with over 20 million just three years later (Deal & Shiono, 1998; Hughes, 1998). Many states have continued to increase managed care enrollment of children with special needs, while others have tried to protect this at-risk population by not capitating mental health, health-related special education, dental care, early intervention, and personal care (Fox, McManus, & Almeida, 1997).

Eighty-nine percent of Head Start children are enrolled in health insurance programs. Medicaid and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) cover 56 percent of these enrolled children; private insurance, 14 percent; SCHIP, 8 percent; or a combined Medicaid/SCHIP program, 8 percent (Hart &

---

16 The Balanced Budget Act of 1997 (P.L. 105-33). States may design their SCHIP program as a stand-alone program that is separate from Medicaid, use SCHIP funds to expand existing Medicaid eligibility, or combine both approaches.

17 The 1997 Balanced Budget Act allowed states to “require” Medicaid recipients to enroll in managed care initiatives changing the “voluntary” choice option. Children with special needs are exempted from this requirement but the states have continued to pursue federal 1115 and 1915(b) waivers (exceptions).

18 Medicaid has experienced significant funding decreases, leading to a projected 490,000 to 650,000 low-income and at-risk children losing their health insurance over the past year. State policies have restricted eligibility or enrollment, reduced the scope of benefits, increased cost-sharing by beneficiaries, and reduced or frozen health care provider payments. The state with the deepest cuts is Texas, followed by Alabama, Alaska, Arizona, Colorado, Connecticut, Florida, Indiana, Kentucky, Maryland, Minnesota, Nebraska, Oklahoma, Rhode Island, Utah, Vermont, and Washington (Ku & Nimelandran, 2003).

19 EPSDT program is designed to ensure preventive health care services for low-income children under age 21 and is a major funding source for children with special needs who often require more extensive services.
Research on Medicaid outcomes reviewed here includes: utilization and participation rates; behavioral and emotional disabilities; chronic health; general health; and diagnoses. This research covers outcomes and data reviewed over the past 15 years.

<table>
<thead>
<tr>
<th>Lead Author</th>
<th>Medicaid Subject Reviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hart (2004); DHHS (2003); Freund (1999)</td>
<td>Enrollment – Specialists for children with disabilities</td>
</tr>
<tr>
<td>Ross (2003)</td>
<td>Decreased participation rates, dental care, anemia</td>
</tr>
<tr>
<td>Stroul (2000)</td>
<td>Access, medical necessity limitations, no system to support children with SED</td>
</tr>
<tr>
<td>CDC (2003b); Ku (2004)</td>
<td>Private v. public health care insurance outcomes</td>
</tr>
<tr>
<td>Bennett (2004); O’Brien (2003)</td>
<td>Access and children’s health</td>
</tr>
</tbody>
</table>

A review of the Medicaid managed care outcomes suggests that Medicaid managed care is likely to achieve some of its intended objectives, containing costs and improving access for some, but it also has an unintended consequence, reducing access to needed care for certain high-risk populations. Enrollment in Medicaid managed care decreased utilization of specialists by children with disabilities and special needs (Freund & Lewit, 1999; Hart & Schumacher, 2004; Maulden & Leibowitz, 1994; U.S. DHHS, 2003). These children have chronic and disabling conditions.

Many states have increased cost-sharing for Medicaid and SCHIP beneficiaries as a way to reduce state expenditures. While federal law generally protects low-income Medicaid beneficiaries, states are securing federal waivers to allow this change. Premiums and co-payments have decreased enrollment, specifically for low-income individuals and children. These low-income children were more likely to be anemic and to have more untreated dental needs (Ross & Cox, 2003).

A study of state managed care Medicaid/SCHIP program initiatives have been reviewed for children with behavioral and emotional disabilities with discouraging outcomes (Stroul, Pires, & Armstrong, 1998; 2000). In seven states, Medicaid managed care reforms aggravated the problem in determining which system was responsible for delivering and paying for services to the children with disabilities. Access to care within the systems was difficult because of rigid application of medical necessity criteria. Fifty-one percent of reforms did not incorporate a dedicated planning process, special management mechanisms, or differential benefits for children with serious disorders (Stroul, Pires, & Armstrong, 1998; 2000). Medical necessity criteria were used to limit the duration of care and provide incentives for cost-shift-

---

20 To date this project has completed two all-state surveys (1995 and 1997-98) and two impact analyses (2000) in the following states: Arizona, California, Connecticut, Colorado, Delaware, Florida, Iowa, Massachusetts, Michigan, Missouri, New Mexico, North Carolina, Oregon, Pennsylvania, Rhode Island, Texas, Utah, and Washington. A 1915(b) waiver from the DHHS has been the most widely implemented managed care tool.

21 Limits on hospitalization had shifted responsibility for youth with very serious behavioral disabilities to child welfare and juvenile justice systems that may have been ill-equipped to serve them.
Seventy percent of states reported that provider payment rates had been cut over a four-year period. Medicaid coverage was restricted for children with serious emotional disorders because they were not linked to managed care initiatives (Stroul, Pires, & Armstrong, 1998, 2000).

Children served by Medicaid/SCHIP, compared to both privately insured and uninsured children, were four times more likely to be in only “fair” or “poor” health, to suffer from severe asthma, and had three times more chronic health or other health conditions that required regular prescription drug treatment. Children covered by public insurance were more likely to have been diagnosed with learning disabilities or Attention Deficit Hyperactivity Disorder (ADHD) (Center for Disease Control, 2003b; Ku & Nimelandran, 2004). However, access to Medicaid and SCHIP can improve children’s health (Bennett & Kenney, 2004; O’Brien & Mann, 2003).

Overall, these changes in Medicaid services for children are linked to decreased access to needed medical specialists (Freund & Lewit, 1999; Hart & Schumacher, 2004; Maulden & Leibowitz, 1994; U.S. DHHS, 2003), decreased participation rates with corresponding increased difficulty accessing coverage (Ross & Cox, 2003; Stroul, Pires, & Armstrong, 1998; 2000), and increased medical necessity limitations (Stroul, Pires, & Armstrong, 1998; 2000). Most disturbingly, these children were significantly more likely to be in much poorer health compared to their non-Medicaid peers (Center for Disease Control, 2003b; Ku & Nimelandran, 2004).

Discussion
At the beginning of the current (109th) Congress, the Bush administration sought to extend the “new federalism” paradigm to Head Start by proposing to block grant it in as many as nine states. The House of Representatives and the Senate are considering legislation to block grant Head Start. The devolution of the AFDC/TANF and Medicaid programs and outcomes for children have been reviewed in this paper with generally discouraging and distressing results for policy makers, advocates, and practitioners. Children and families served by Head Start programs are in potential jeopardy if Head Start follows a similar devolutionary path.\footnote{It should be noted that a possible mitigating factor to a similar change to state-controlled Head Start programs is that all states currently have in place an early childhood and preschool special education system for children with disabilities. It is not known how many children are currently receiving services through both systems or how this may protect these children and families.}

This review of the TANF program found inconclusive or negative effects on child and family outcomes from replacing AFDC with a devolved TANF program, and the Medicaid program review found generally negative and harmful effects on children and family outcomes from the managed care and waiver devolvement. These discouraging outcomes include the children’s and families’ decreased access to medical coverage, decreased well-being outcomes, decreased cognitive development, increased poor health outcomes, and increased behavioral and emotional difficulties. Additional research on TANF and Medicaid outcomes for children and fami-
lies is needed before a block-granting decision is made for Head Start, a program that currently requires outreach and comprehensive, inclusive services for children and families.

REFERENCES


23 The Head Start Act and the federal Head Start Program Performance Standards require grantees to seek out children with disabilities or who are at risk of developing disabilities in order to provide them with Head Start services (Mezey, 2003). The Head Start Act and federal Head Start Program Performance Standards require grantees to collaborate with other social service and health agencies in delivery of services and to assess and address the needs of children with disabilities and their families (Mezey, 2003).
Science, 299 (March 7), 1548-52.


Duncan, G. J., & Brooks-Gunn, J. (Eds.). (1997). Consequences of growing up poor: New York: Russell Sage Foundation. (Sixty-one percent of former recipients are single and without a partner compared to only 32 percent of low-income mothers).


Health Policy Institute (February 2005). *Ohio Medicaid Basics.* Health Policy Institute of Ohio, Columbus, Ohio.


Policy Institute of California (found through interviews with California welfare recipients in 1992 and 1996 almost 20 percent of the families had at least one child with a disability or severe illness).


