

**FEDERAL
SPENDING
ON PRENATAL
TO THREE**

Developing a Public Response to Improving Developmental Trajectories and Preventing Inequities

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MARCH 2018



**Center for the
Study of
Social Policy**
Ideas into Action

Acknowledgments

CSSP is a national, non-profit policy organization that connects community action, system reform, and policy change to create a fair and just society in which all children and families thrive. We work to achieve a racially, economically, and socially just society in which all children and families thrive. To do this, we translate ideas into action, promote public policies grounded in equity, support strong and inclusive communities, and advocate with and for all children and families marginalized by public policies and institutional practices.

Published March 2018

Acknowledgments

The authors are grateful for the unique insights and recommendations supplied by the following colleagues in response to drafts of this brief:

Julia Isaacs, Senior Fellow, Labor, Human Services and Population Center, Urban Institute for her thoughtful review and substantive contributions to our thinking about how to describe the population and the data. In addition, we are grateful to the Urban Institute for permitting use of their methods for estimating federal investments in children.

From the Center on Budget and Policy Priorities, Arloc Sherman, Senior Fellow, and Chye-Ching Huang, Deputy Director, Federal Fiscal Policy Team for sharing their knowledge, data and perspectives regarding federal tax credits for families with children.

The staff of the First Focus Children's Budget team, for their willingness to respond to specific questions during our analysis.

Dan Hawkins, Senior Vice President for Public Policy and Research, and Michelle Proser, Director of Research at the National Association of Community Health Centers, Inc. for their contributions to our estimate of the proportion of federal health center spending used by pregnant women and young children.

Nicole Garro, Director, Public Policy Research, Office of Government Affairs, March of Dimes for input on methods for the estimation of Medicaid financing for maternity care.

Their contributions considerably enriched the final product.

This paper is made possible by the generous support of the Pritzker Children's Initiative, a project of the JB and MK Pritzker Family Foundation, and the JPB Foundation.

We also thank CSSP staff Frank Farrow, Donna Cohen Ross, Amy Fine, Shadi Houshyar, Patsy Hampton, Jessica Pika and Viet Tran for their assistance with the production and review of this publication.

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Executive Summary

America's youngest children are both the most diverse age group in society and those most likely to live in poverty. Further, the first years

in a child's life are critical to lifelong well-being, setting the trajectory for healthy development — physical, social, emotional and cognitive. From prenatal to the third birthday (prenatal to three), safety, stability and nurturing are foundational to child health and development.

Yet by the third birthday, at least three in 10 children can be identified — either by their own status or their home environment — to have developmental risks that jeopardize their likelihood for school readiness, on-grade advancement, educational completion, avoidance of justice system involvement and economic self-sufficiency as adults.

Public investments in these earliest years should be judged on whether or not they ensure children start life on a successful life trajectory. This analysis provides estimates of federal spending for pregnant women, infants and toddlers, birth to three. It also gives a sense of the reach and scale of the programs supported by these federal expenditures in relationship to meeting the needs of young children and their families.

Income Support, Nutrition and Housing Assistance

(\$35,933 million): With health, by far the largest federal investments in young children and their families are to help meet basic needs such as income, food/nutrition and housing. While current federal programs provide a safety net, these programs together provide a floor of economic support that still leaves most families struggling to meet basic needs, vulnerable to economic hardship from any unexpected events and with little to support their children's physical, social and educational development.

- An estimated 7.4 million children 0-3 live in households that receive an EITC/CTC refund, at a combined federal cost of \$16 billion.
- Nearly \$800 million in Temporary Assistance for Needy Families (TANF) cash assistance goes to families with children 0-3, reaching 4 percent of that age group. An additional \$849 million in cash assistance comes in the form of Supplemental Security Income (SSI) for children with major disabilities.
- Children receive an estimated 44 percent of Supplemental Nutrition Assistance Program (SNAP, formerly known as the Food Stamp Program) benefits. Approximately 8 million mothers, infants and young children participate in WIC. In FY2016, 24 percent of WIC participants were women, 24 percent were infants

and 52 percent were ages 1-4 years. Some infants and toddlers also receive subsidized meals in child care. Together, federal investment in food and nutrition for the prenatal to three population totals to more than \$13 billion.

- Federal housing assistance programs spend \$2 billion to serve 450,000 million families with a child under three, about 5 percent of all families with children under three.

Health (\$39,758 million): Expenditures on health care for pregnant women and children 0-3 have increased both to provide more children with coverage and to respond to rising health costs that have made private coverage less affordable. As a result of investments in Medicaid and CHIP, 95 percent of children had health coverage by 2015 and almost all mothers had access to prenatal care. Much of the other federal health spending for the population prenatal to three addresses the specific needs of underserved populations, including health centers and vaccines. A much smaller amount is for investments to reduce, prevent or treat developmental delays and disabilities.

- Medicaid provides coverage for more than half of all births and of all very young children (ages 0-3). Altogether, Medicaid expenditures for the prenatal to three population were \$34.0 billion, one-third of that for prenatal and maternity care and another substantial share for newborn hospital care. The Children's Health Insurance Program (CHIP) provides health coverage to additional low-income, uninsured children, with federal funding for the 0-3 population of \$2 billion.
- In FY2015, the Title V Maternal and Child Health program had the most extensive reach, within the prenatal to three periods of all federal programs, serving a reported 2.6 million pregnant women and 3.8 million infants, as well as an estimated 3.5 million toddlers ages one to three. For the population prenatal to three, federal Title V expenditures were \$108 million. That year, the combined federal, state and local expenditures for the prenatal to three population totaled \$779 million.
- The Vaccines for Children program provides vaccines at no cost to children who are on Medicaid, or who are uninsured or underinsured. Funding for the population 0-3 is estimated to be \$2.3 billion.
- The Individuals with Disabilities Education Act (IDEA) Part C Program for Infants and Toddlers with Disabilities (also known as "early intervention") assists states in serving infants and toddlers 0-3 with disabilities and their families. In 2016, at least 358,000 infants and toddlers participated in the program, about 3 percent of all young children. Federal appropriations for FY2016 were \$459 million.

- Community health centers provide comprehensive primary health care in underserved communities. The 25 million persons served included more than 552,000 prenatal patients and 1.5 million children 0-3, approximately 150,000 of whom were uninsured. An estimated \$562 million of federal grants for health centers benefited pregnant women, infants and toddlers in FY2016.

Family Support (\$2,573 million): In addition to the areas of income support, health care, child care and child welfare, the federal government provides funding to states to deliver other services and supports to families with young children, generally directed to more vulnerable children and their parents. Many of these are designed to be preventive and to strengthen the capacity of families to provide a safe, nurturing home environment and include “two generation” strategies to improve both child and family well-being. Most federally funded family support programs, however, are small in terms of the share of the population of at-risk families they serve. Even the two most prominent and extensive programs in this area, federal home visiting and Early Head Start, together serve 2 percent of all young children in the country.

- Some federal funds go directly to local program sites (e.g. Early Head Start), others are administered through state agencies (e.g. Maternal, Infant, and Early Childhood Home Visiting MIECHV), and still others are managed through state decisions with respect to federal block grants.
- In FY2016, for pregnant women and young children 0-3, the federal investment in home visiting through the MIECHV program was \$320 million and the Early Head Start program was \$2.0 billion.
- TANF, the Social Services Block Grant and the Community Services Block Grant provide states with flexibility to address child and family needs. This may include parenting education programs, family resource centers, resource and referral programs and family development workers who help families from a two-generation perspective. The combined federal funding from these three programs for family support prenatal to three was \$253 million.

Child Care (\$4,219 million): The pressures on parents to work mean that substitute care for the youngest children often is a necessity, while formal child care is out of economic reach for many families. In the last two decades, the assistance available to families to cover the cost of child care for young children has increased. Overall, however, a fundamental mismatch remains between what most families can afford to pay for formal child care arrangements for their young children and what that care costs. This is particularly true for families with very young children, who generally have lower incomes from work and where the costs of providing quality care in formal settings are greatest. Informal, family, friend and neighbor care is

the predominant means for providing such care for very young children and deserves attention in addressing the needs of their families.

- The Child Care and Development Block Grant (CCDBG) provides funding to states to subsidize child care for low-income families and allows states to use TANF and the Social Services Block Grant to finance child care. In 2015, an estimated 3.4 percent of all young children benefited from a child care subsidy. Total federal spending was approximately \$3 billion.
- The federal Child and Dependent Care Tax Credit provides assistance through the tax code to cover up to \$2,000 of the cost of child care, primarily to middle- and upper-income families, with credits for families with children 0-3 of \$1.2 billion.

Child Welfare (\$1,175 million): There is no single funding source for child protective services. Thus, states made use of a complex mix of dedicated program funds, allocations from block grants and other funds. Very young children, particularly children in their first year of life, are most likely to be subject to child maltreatment allegations (three-quarters of which are about neglect and not abuse). While a very small percentage of all children birth to three (less than 2 percent of the population), expenditures for child welfare services are substantial, averaging \$4,755 per child.

- Among children with confirmed cases of maltreatment (abuse and neglect), 197,000 were 0-3. Approximately 97,000 infants and toddlers were in foster care, and an estimated 17,000 children 0-3 had publicly supported adoptions. The combined spending on child welfare services for children 0-3 was approximately \$1 billion in FY2016, including programs such as Safe and Stable Families, Foster Care and Adoption Assistance.



Looking ahead

Core federal investments in basic income, housing, nutrition, health care, child care and child welfare provide basic living supports for young children and their families essential to immediate safety and support. Currently, however, each of these is offering support at only a minimal and subsistence maintenance level for the most vulnerable families with young children. Cutting any of these would imperil more young children and could significantly increase, rather than reduce, the proportion of young children on jeopardized developmental trajectories.



A broader and more comprehensive approach to ensure livable wages and adequate housing is needed to fully close disparities experienced by young children due to their family's economic circumstances.

Yet meeting the needs of children for safe, stable and nurturing home environments must extend beyond material needs and circumstances. Health care coverage and spending is essential to support not only clinical services to address injuries and illnesses, well-child checkups, vaccinations and treatment for chronic conditions and disabilities, but also to initiate developmental interventions that address risks before they become serious medical conditions. Programs to strengthen and support families are needed before children become involved in the child welfare system — and can serve a dual role of building community in neighborhoods where young children and their families face the greatest challenges to success.

No single policy or public investment is likely to support families in ensuring quality caregiving for their young

children when they are working and not at home. Paid family leave policies that support families at all income levels and types of employment are one part of an answer. Increasing subsidies for and the quality of formal child care arrangements also will fill gaps. More generous, refundable child and dependent care tax credits would assist both moderate income and middle-income families in bearing the cost of child care. Resources directed to family, friend and neighbor caregivers can improve their ability to provide nurturing environments and address stressors they may face, as well as to help build community in the process. Efforts are needed to make both child care and child welfare systems more appropriate and responsive for infants and toddlers.

In the earliest years, federal funding plays its greatest relative role in financing services, much more so than in either the preschool or school-aged years. Federal policies and expenditures govern most state and community investments that are made. Federal programs and funding also provide a starting point, a foundation upon which to build. Yet for the youngest children, and particularly for the three in 10 on trajectories that seriously compromise their future success, services to strengthen families and assure healthy development generally are not available, in sufficient supply or sufficiently comprehensive in their approach to address their needs. For this population, what is needed is much more than better coordination of existing services.

The biggest opportunities for gains in improving young children's health and developmental trajectories are through expanding efforts to improve safety, stability and nurturing in the home environment and expanding community resources and opportunities in poor neighborhoods. Giving particular attention to young children and their families with identified individual or community risks but no diagnosis or crisis will require a fundamental shift in thinking and commitment. Dedicating increased amounts of federal, state, local and private funding to finance such expansions of capacity and support will be required, but the long-term benefits and the rates-of-return from such investments are ones that society cannot afford to ignore.

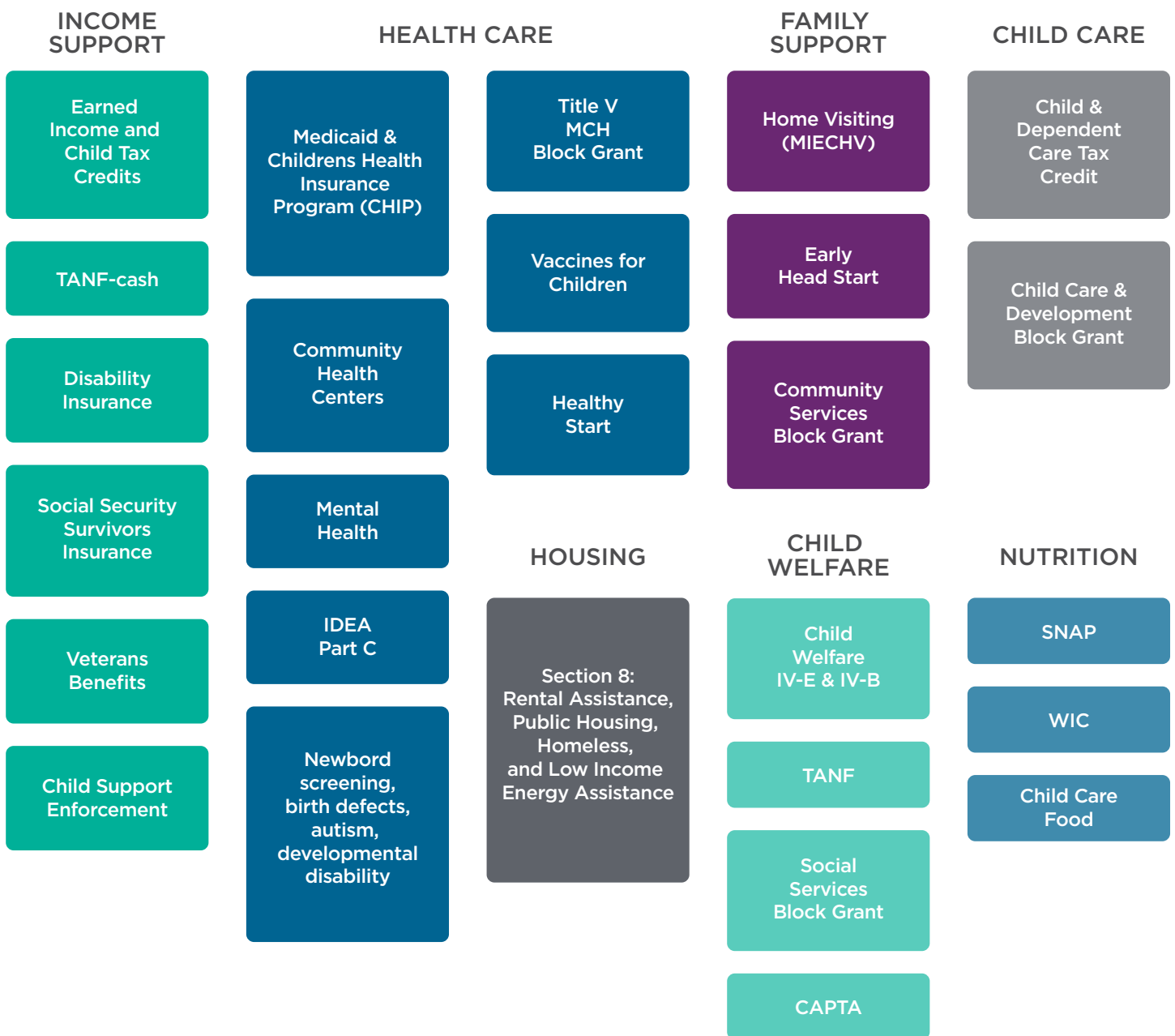
Table 1.

Federal Expenditures for Pregnant Women and Children 0-3

MILLIONS OF DOLLARS

TOTAL . . . . .	.\$83,652
Income Supports. \$20,456	
Earned Income Tax Credit (EITC outlays)	\$ 12,055
Child Tax Credit (outlays)	\$ 4,631
Temporary Assistance to Needy Families (TANF) Cash Assistance	\$ 798
Supplemental Security Income	\$ 849
Social Security Survivors Insurance	\$ 483
Disability Insurance Trust Fund	\$ 621
Veterans Combined	\$ 365
Child Support Enforcement	\$ 654
Nutrition \$ 13,345	
SNAP	\$ 7,470
WIC	\$ 5,207
Child Care Food Program	\$ 668
Housing \$ 2,132	
Tenant-Based Rental Assistance (Section 8)	\$ 919
Project-Based Rental Assistance Program	\$ 479
Public Housing	\$ 340
Homeless Assistance Grants	\$ 204
Rental Assistance	\$ 65
Low Income Home Energy Program	\$ 125
Health \$ 39,758	
Medicaid	\$34,000
Children's Health Insurance Program (CHIP)	\$ 2,016
Title V Maternal and Child Health Block Grant	\$ 108
Vaccines for Children	\$ 2,372
Community Health Centers	\$ 562
Children's Mental Health Services	\$ 12
IDEA Part C Early Intervention	\$ 459
Healthy Start	\$ 104
Universal Newborn Screening	\$ 18
Birth Defects and Developmental Disabilities	\$ 72
Autism Initiative	\$ 35
Family Support. \$ 2,573	
Home Visiting (MIECHV)	\$ 320
Early Head Start	\$ 2,000
TANF (for other family support)	\$ 139
Social Services Block Grant (for other family support)	\$ 68
Community Services Block Grant	\$ 46
Child Care. \$ 4,219	
Child Care Development Block Grant	\$ 1,987
TANF Transfers to CCDBG	\$ 900
Social Services Block Grant for Child Care	\$ 105
Child and Dependent Care Tax Credit	\$ 1,227
Child Welfare and Family Support \$ 1,175	
Foster Care IV-E	\$ 432
Adoption Assistance IV-E	\$ 80
Child Welfare Services IV-B	\$ 54
Safe and Stable Families IV-B	\$ 133
Child Abuse Prevention and Treatment Act	\$ 25
Adoption Legal Guardian	\$ 10
Adoption Opportunities	\$ 10
TANF (for child welfare)	\$ 256
Medicaid (for child welfare)	\$ 72
Social Services Block Grant (for child welfare)	\$ 104

Figure 1.
Key Federal Funding Streams Prenatal to 3



¹ TANF funding is shown in multiple categories
² MIECHV Home Visiting is authorized under Title V, MCH Block Grant
³ TANF funding is shown in multiple categories

Background and Introduction

This report examines federal funding sources for families with pregnant women and/or children to the third birthday (i.e., prenatal to three), which lay a foundation for most state investments and undergird the implementation of programs and services to support young children within their families and communities. (See Appendix A for general methodology used for expenditure estimates.) This includes a diverse array of programs for income support, food and nutrition, housing, health, early care and education, child welfare and family support. The number of different federal funding sources can give rise to an assumption that the needs of young children and their families are being sufficiently addressed and the primary need is to better integrate or coordinate them. While many in number, however, the overall reach of these investments is quite limited, particularly in the areas of prevention, early intervention and supports to strengthen families. This report first discusses the importance of the earliest years to life course development and describes the current status of the nation's youngest children and the need to do far better in advancing healthy development, both overall and in achieving fairness and equity, regardless of children's family backgrounds.

The report then describes current federal funding and how it supports child health, income support, food and nutrition, housing, early care and education, child welfare and safety and family and community support needs. It concludes with a discussion of how current federal funding can serve as a building block for state and community actions to improve healthy trajectories and reduce disparities — and where additional federal and other funding must occur to achieve these ends, with a particular emphasis upon the roles communities play in developing that overall system. (See Appendix B for more regarding state and local investments in young children.)

The Importance of Developing Effective Policies and Investments in Young Children

In 1990, President George H. Bush and the nation's Governors, led by then Governor Bill Clinton, established six national education goals, the first that "all children will start school ready to learn." The National Goals Panel further defined "school readiness" broadly and holistically, across the domains of health and physical development, social and emotional development, approaches to learning, early literacy and general cognition. The objectives set forth under the goal were similarly broad and encompassed strengthening families, improving health and nutrition and expanding preschool:

- Every parent in America will be a child's first teacher and devote time each day to helping his or her preschool child learn; parents will have access to the training and support they need.
- Children will receive the nutrition and health care needed to arrive at school with healthy minds and bodies, and the number of low birthweight babies will be significantly reduced through enhanced prenatal health systems.
- All disadvantaged and disabled children will have access to high quality and developmentally appropriate preschool programs that help prepare children for school.

Since that time, there have been many advances in neuroscience deepening the knowledge base on the critical and foundational role of the first three years of life, in particular, to brain development and life-long learning and health. There has been much greater recognition and knowledge of the profound effects that stress and adversity can have on the developing child across physical, social, emotional and cognitive health.

Since 1990, federal policies establishing the Child Health Insurance Program (CHIP) and expanding Medicaid have reduced the number of uninsured children, and young children in particular. Federal and state supports to subsidize child care for working families have expanded (in part with the increase of mothers of young children in the workforce) with greater recent attention to promote quality in those arrangements. Particularly at the state level, publicly financed preschool has expanded, in some states targeted to disadvantaged children but in other states on a more universal basis. Currently, the research on adverse childhood experiences has led to more efforts to respond preventively to at-risk children and their families and to expand trauma-informed care to children experiencing adversity.

A wealth of research from different fields has made clear that the safety, stability and nurturing in the home environment is foundational to healthy child development, particularly in the prenatal to three period. It is during these years that children acquire their sense of security, attachment with others, abilities to self-regulate and approaches to their learning and exploration and communication — through intimate, serve-and-return interactions with consistent and caring primary caregivers (usually parents). While the three to five years include more formal and group socialization and learning environments, many of the foundations for lifelong health and well-being are established in the first three years.

At the same time, we are far from achieving our national goals for early childhood and school readiness. Of the three objectives under the First Educational goal, as future sections of this report will show, the first is the one least reflected in public policy activities over this quarter century. Disparities remain in readiness and development not only at the time of school entry, but these are reflective of equivalent disparities at age three.

A Profile of Young Children and Their Families: The Context for Taking Action

No single source of information provides an overall profile on very young children and their families, particularly to estimate the size of the population of young children whose healthy trajectories are at risk by age three. At the same time, there are multiple sources of information that can provide a good estimate of the numbers and proportions of young children who, at age three, are at very high risk of not starting school equipped for success, with a large share already evidencing cognitive, physical, social, emotional or behavioral conditions requiring special attention and response.

Size of Young Child and Families of Young Children Populations

According to vital statistics records, there are nearly 4 million births each year in the United States, and 1.5 million of those births are to first-time mothers. U.S. Census data tell us there are 11.8 million children aged 0-3, with 8.6 million households where the youngest child is under the age of three. (Note there is a recognized 5 percent undercount of young children in the Census.) Strategies to respond during the prenatal to three age period therefore must consider the needs of nearly 16 million children and pregnant women.

Of the 8.6 million households where the youngest child is under three, 2.4 million are headed by a single parent and an additional half million are headed by a grandparent or someone other than a parent.

Economic Status of Young Children and their Families

One-quarter of all births and one-quarter of all young children are within households below the poverty level, and half live in low-income households (below 200 percent of the poverty level, a better representation of the income needed to make ends meet). Of all age groups, young children are the most likely to live in poor and economically insecure households. While a share of these families have sources of support from their own parents and others (e.g. a graduate student couple living in subsidized, married student housing) that ensure they are able to meet their young child's needs in a predictable way, others do not (e.g. a single mother working at a service job in a poor neighborhood whose own parents

are struggling economically). A great share of those in poverty, and even up to twice the poverty level, struggle to make ends meet, living just one unexpected expense from severe hardship and with constant pressures simply to pay for essentials such as housing, utilities and food, let alone to enrich their child's development. As the federal spending analysis shows, federal safety net programs (particularly the Earned Income Tax Credit, SNAP and Medicaid), provide a floor or safety net for most of these households, but not a floor where those households either can feel economically secure or have the ability to invest in their children's development.

Racial Composition and Location of Young Children and their Families

America is becoming more diverse, and young children are leading the way. While nearly 80 percent of all seniors are White and non-Hispanic, more than half of all births are children of color. Figures 2 and 3 show the distribution of infants and toddlers by race and ethnicity, both overall and by those living in poverty. While diversity can and should be a source of strength in society, this is only true if children have equivalent opportunities to grow and develop. In recent years, children of color represent 70 percent of births to households in poverty and 70 percent of all children living below 200 percent of the poverty line. Moreover, children of color also are much more likely to live in poor neighborhoods, which compound the challenges their parents face. While only 16 percent of all children live in Census tracts with child poverty rates of over 40 percent, these are home to 4 percent of all poor children. Not only do these neighborhoods have much less economic capital, they also have far less realized educational, recreational and other infrastructural and social capital that contribute to the safe, stable and nurturing environments young children need for their growth and development. Within these neighborhoods, community-building as well as individual service provision strategies are necessary.



Figure 2.
Distribution of US Children Ages 0-3, All Income Levels, by Race and Ethnicity, 2016

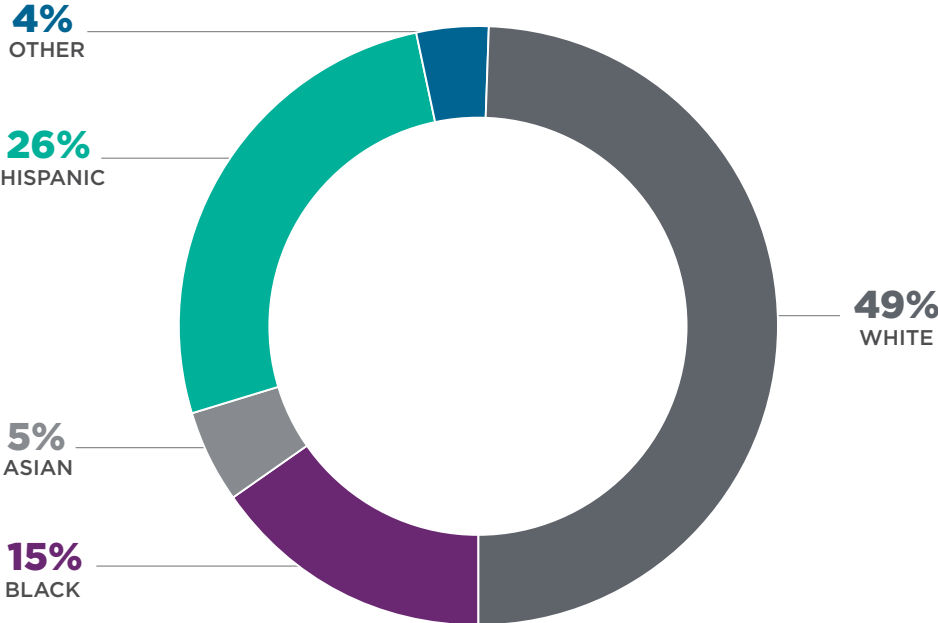
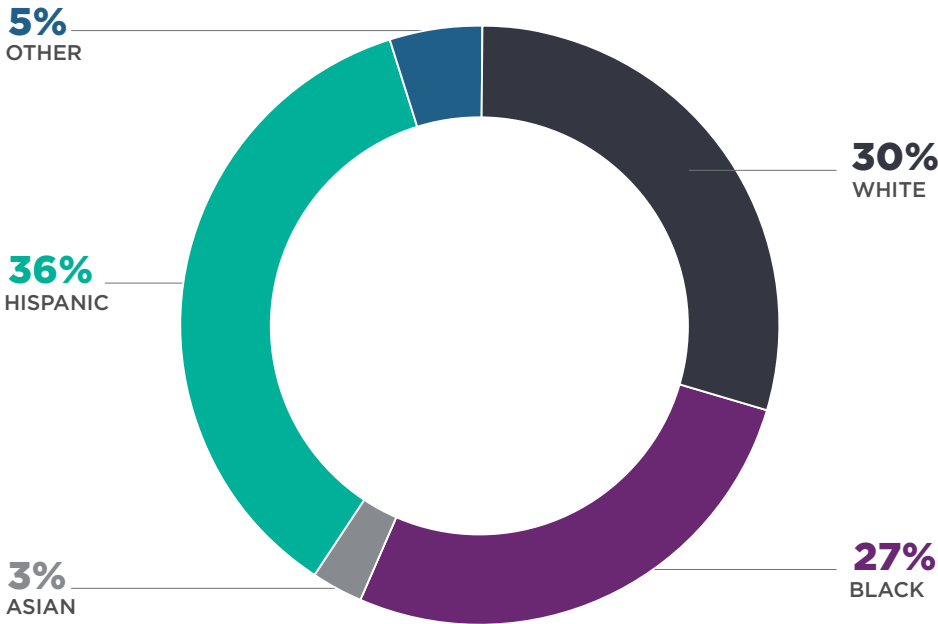


Figure 3.
Distribution of US Children Ages 0-3 with Income Below Poverty, by Race and Ethnicity, 2016



Developmental Status and Compromising Conditions by Age 3

The range of what is considered healthy development birth to age three is recognized to vary substantially by child and across physical, cognitive and social development. In particular, children often make big gains in one area for which their young minds and bodies focus attention, while lagging in another. At the same time, even by age three there can be large disparities in development that are directly linked, without significant remediation and response, to future healthy growth and educational, social and emotional success. The extent of this compromised development is reflected in part in diagnosed developmental or behavioral delays, but it also extends to additional young children, who do not manifest specific diagnosable conditions or have delays, but are not progressing on paths toward success in school and lifelong health and well-being.

At the highest level of need, some infants are born with congenital conditions (e.g. Down's syndrome, spina bifida, fetal alcohol syndrome, sickle cell anemia, extremely preterm birth) that require ongoing medical attention and often long-term, complex care. These conditions place additional stresses and demands upon even the best resourced and resilient families in providing the consistency and stability these infants and toddlers need, while their medical needs also must be addressed.

In some instances, infants and toddlers come to the attention of state child welfare systems due to abuse, neglect or exposure to drugs (e.g., neonatal abstinence syndrome from exposure to addictive opiate drugs while in the mother's womb). In extreme cases, their family life has been so chaotic and devoid of nurturing that they must be placed into substitute care, with serious concerns as to the impact of this earliest adversity on their bonding and attachment. In instances of complex medical needs and of family stresses and disruptions, if special attention is not given to provide as normalized and stable a life as possible with a caring adult providing consistent care and nurturing, even with medical attention and treatment the prognosis for the child is poor. Fortunately, these instances are quite rare, their identification is nearly unavoidable and there are protocols and professional responses to their special health or environmental needs. These also are the children who, because of the complexity and intensity of their needs, currently are the highest cost users of existing services. While at most 3 to 6 percent of the population of children birth to three, they are the most likely to receive medical and psychosocial interventions.

The group of infants and toddlers who develop some conditions that require specific attention — physical, developmental and emotional/behavioral — is larger than the group described above. The National Survey of Children with Special Health Care Needs estimates the prevalence among young children (birth to five) of

9.3 percent. The proportion of very young children with developmental delays is estimated to be in the range of 13 to 15 percent. Research related to early childhood mental health (including autism spectrum disorder) and behavioral concerns and disorders suggests that, even at age three, upward of 15 percent of all children can be identified with significantly compromised development. Overall, the proportion of three-year-olds with identifiable and diagnosable child-specific physical, developmental or behavior/mental concerns is much larger than those at the highest level of need — more like 12 to 20 percent of all children birth to three.

This still does not encompass all children who are not on a path or developmental trajectory for readiness for school, however. Another group of young children do not receive the safety, consistency, nurturing and educational stimulation they require for optimal development. Research on language development shows dramatic disparities by age three between children in families with lower versus higher socio-economic status. Including those in such households with those who could be diagnosed with specific delays or physical or mental health conditions, upwards of 30 percent of all young children are progressing on lower and problematic developmental trajectories due, in large measure, to the lack of sufficient support, nurturing and brain stimulation they receive in their homes and neighborhoods, as well as their high levels of exposure to adversity and stress.

While many other families could benefit from additional supports and access to information and resources to enhance their child's experiences in development, this report gives particular attention to the role of federal funding in ensuring healthy development for those three in 10 young children at highest risk. While there are needs across all socio-economic groups and geographies, the prevalence of need and risk is greatest within specific neighborhoods and communities.



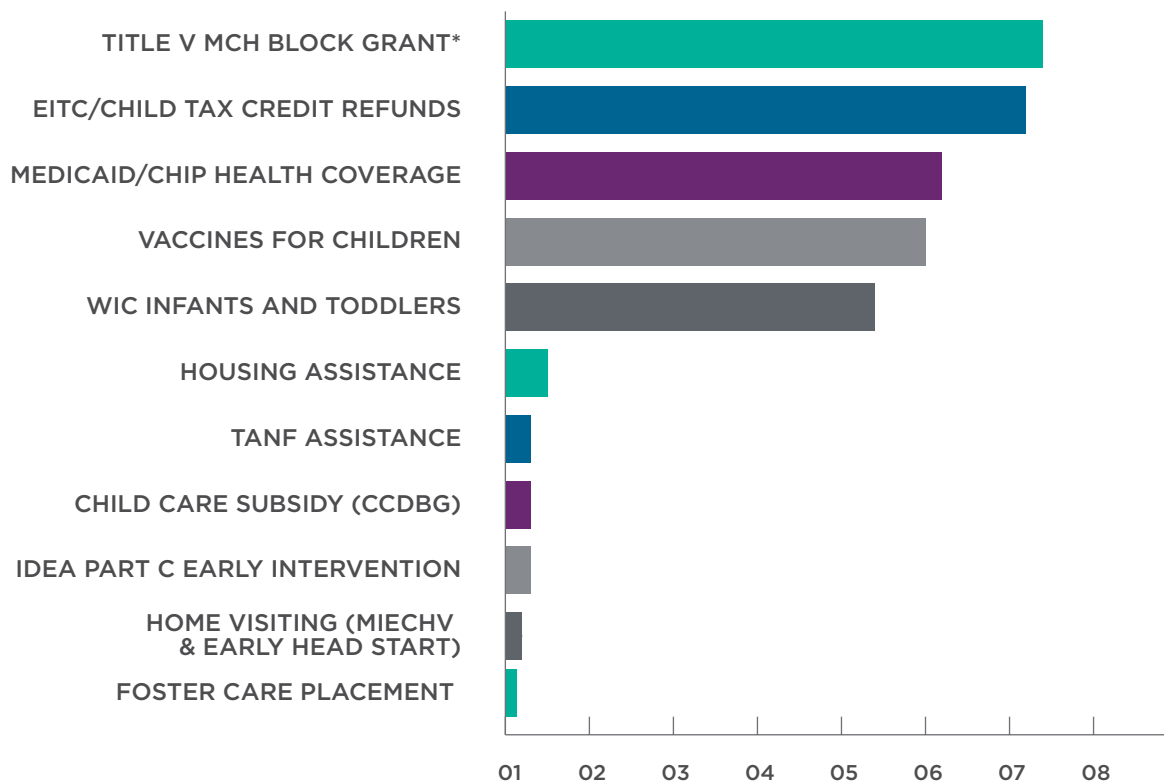
The Reach and Impact of Federal Funding Prenatal to 3

This report describes federal funding prenatal to three, building upon other reports regarding children in the federal budget. The Urban Institute (*Kids Share*) provides estimates and analysis of budget outlays in major federal funding streams for children and their families, including: income support, food and nutrition, housing, health, education (and early care and education), child welfare and family support. In 2013, the Urban Institute further broke down this spending to apportion it by age groups of children (0-2, 3-6, 6-12 and 12-18). This report relies primarily on the Urban Institute’s methods and estimates for infants and toddlers, referred to here as birth to three, or up to the third birthday. First Focus (*The Children’s Budget*) also offers details regarding federal funding (budget authority and appropriations) for children and

families, which have been used to further inform this report. These together with additional federal agency data give us a picture of the reach and impact of federal funding prenatal to three.

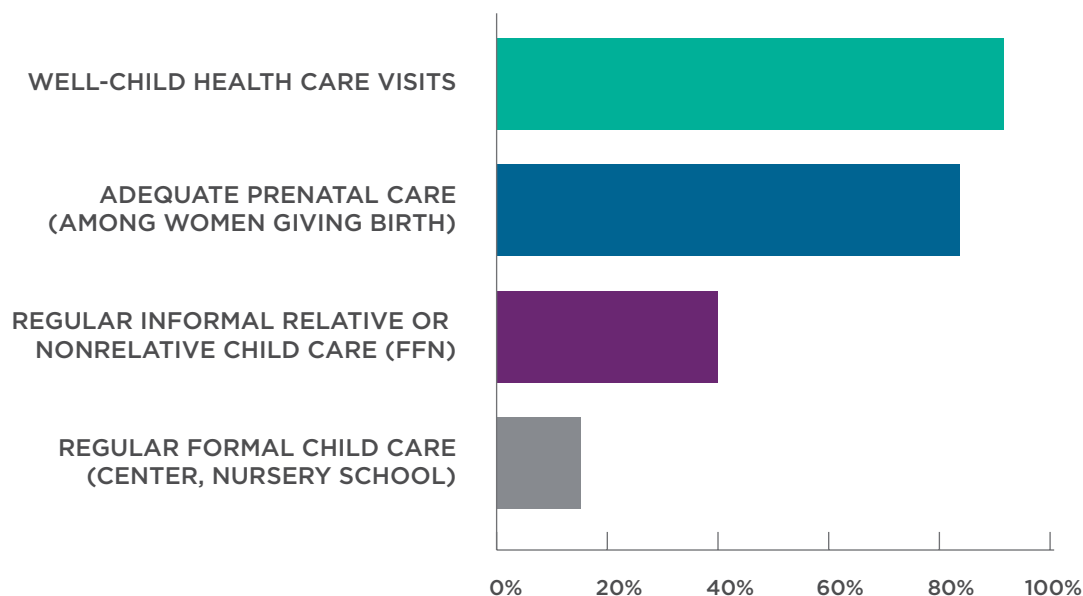
While most of the public investment made in school-aged children comes through the K-12 education system and is largely funded by state and local funds, most of the investments in young children are made at the federal level or through federal funding that goes to states and is matched with state funding. While there are additional sources of public funding for the population prenatal to three (e.g., states and local public dollars or sometimes as public-private partnerships with United Ways or community foundations), federal funding and levels of participation in federal programs offer a good estimate of both the reach and the degree of public investments currently made in young children and their families.

Figure 4.
Percent of 0-3 Population Served by Selected Programs and Services



*State reported Title MCH Block Grant contacts with pregnant women, infants, and young children under 3 may include case management or health education and may not be direct clinical services

Figure 5. Points of Contact with Families and Young Children 0-3



Before going into detail on federal funding and what it supports across each of these areas, it is important to recognize the actual reach of different federal resources in terms of the proportion of the prenatal to three population. There is substantial variation in use of federal services, related to the availability of funds, eligibility rules, location and capacity of services and other factors. (See Appendix E for more regarding estimates of program participations levels.) Figure 4 shows program participation information for select programs. These proportions often stand in contrast with the estimates of the proportion of very young children with complex needs (3 to 6 percent of the population), with diagnosable conditions requiring child-specific responses (12 to 20 percent of the population) and with conditions, experiences and development that compromise their development and usually require responses that strengthen the ability of their families to provide safe, stable and nurturing home environments (30 percent).

Figure 5 shows the participation rates for select services, both publicly and privately financed, among the population prenatal to three. Examples include the proportion receiving adequate prenatal care, well-child visits and formal and informal child care. These data tell us that the great majority of this population comes into contact with the health care system, often in preventive visits. Child care is important for families who need it, but a much smaller proportion of families use these services and the services they do use are much more likely to be through family, friends and neighbors.

Income Support, Nutrition and Housing

Income support \$20,660 Million (\$20.5 billion)
 Nutrition Assistance \$13,345 Million (\$13.3 billion)
 Housing Assistance \$2,134 Million (\$2.1 billion)

Income Support

Next to health, the largest federal investments in young children and their families are intended to meet basic needs such as income, food and nutrition and housing. Most of these are means-tested supports, either phasing out as household income increases or having a fixed income cutoff for eligibility. Even the few income support programs that are not means tested apply to families under particular circumstances, such as Social Security survivor benefits following death of a parent, Supplemental Security Income (SSI) for persons with disabilities and veteran's benefits for children in families with a deceased or disabled veteran.

Tax Credits

The Earned Income Tax Credit (EITC) and Child Tax Credit are refundable for low- and moderate-income working families, and mean that millions of families with young children who have earnings owe no federal income tax (although they do pay social security and Medicare taxes) and receive a refund. Thus, these tax credits provide income in addition to earnings, not just a tax deduction or offset. (Because the EITC is based on earned income, it does not benefit families with no reportable employment income.) The EITC has become one of the nation's most effective tools for increasing income and encouraging work among low-income families. The EITC also is associated with improvements in low birthweight and preterm births, as well as school success.

The Child Tax Credit helps both low- and middle-income families, because it phases out at a higher income level than EITC. While the Child Tax Credit (and the EITC in some instances) reduces but does not eliminate federal income tax liability, the figures reported here are those for when the EITC and Child Tax Credit provide a credit that is refunded and above any income tax obligation — therefore providing actual income that the family can use. Taken together, the EITC and Child Tax Credit together lifted more than 8 million children out of poverty, and lessened poverty for another 5 million children.

In 2014, 19.7 million tax filers with a child dependent received an EITC refund, representing 34.7 million

children. Drawing upon the Urban Institute's estimate that 21 percent of child beneficiaries of the EITC are young children (given that rates of poverty and low-income status are highest among young children), this means that 7.3 million of the 11.8 million children 0-3 live in families or households who received an EITC refund, or 62 percent of all infants and toddlers.

While both the EITC and Child Tax Credit have income eligibility limits and very few families are eligible for refunds if their incomes are above 200 percent of poverty, the reach of these programs is very broad. An estimated 90 percent of eligible poor and low-income households applied for and received a refund.

Means-tested Income Support

The Temporary Assistance to Needy Families (TANF) program is designed to provide assistance to families to strengthen family self-sufficiency. TANF provides block grants to states to provide "temporary" (generally time-limited) cash assistance to qualifying families as well as fund work-related activities, child care, home visiting and other family supports and prevention services. A few states use TANF to offer the equivalent of paid maternity leave for three to 12 months to low-income, single mothers of infants, without impacting time limits or requiring work-seeking activities. TANF has time limits on duration of eligibility (generally no longer than 60 months) and requirements for work or work-seeking requirements.

TANF was established in 1997 as a block grant from its predecessor program, Aid to Families with Dependent Children (AFDC), which operated as a matching state-federal funding program. Initially, federal funding in the TANF block grant provided some opportunities for expanding employment, child care and other services, but as a block grant TANF has not continued to increase in funding either to reflect inflation or overall population growth. In addition, most states have not increased TANF (or its predecessor, AFDC) cash assistance benefits over the last three decades to account for inflation. As a result of time limits and stagnant funding levels, participation in TANF has declined significantly and the actual value of the cash assistance portion of TANF has eroded substantially.

Most families with young children receiving TANF cash benefits have no or very little earned income, and only a small proportion of young children are in households receiving TANF benefits. An increasing share of TANF beneficiaries are to “one person” (e.g. child-only) families, where the child is living with a relative or friend and not his or her parent or parents. In these instances, the child is eligible regardless of household income and also receives Medicaid benefits. There is no time limit on the family’s receipt of cash assistance payments for the child in these instances, although the one-person payments are generally quite small and designed to cover basic necessities. One-person payments to such households also are usually well below those for children in family foster care, so there also has been movement in some states, through expanding legal guardianship or expanding foster parent participation, to cover children being cared for by a relative as foster children and not as TANF recipients.

Just over one-third of families served by TANF include a pregnant woman or child under age three. In 2015, there were nearly 2.4 million children receiving TANF assistance, and nearly 500,000 — about one in five — was aged 0-3, about 4.2 percent of all children that age. Most families served in TANF also qualify for additional supports that are means-tested and available to all who qualify, including 89 percent with Medicaid and 84 percent with SNAP nutrition benefits. At the same time, only a small share receives other supports to meet daily needs that are not provided as means-tested entitlements, with 12 percent in subsidized housing, and 8 percent with child care subsidies. While TANF was once the major source of income support to poor families with dependent children, the EITC/Child Tax credit and SNAP are now much larger programs with more overall financial support per family and with reach to many more families.

In addition to TANF, about 4.3 million children under age 18 receive Social Security Income (SSI) due to the child’s disability. In these instances, cash benefits are provided but parental income is considered in making these payments. Only a small proportion of those are infants and toddlers. For example, older children are more likely to qualify for SSI payments for persons with disabilities as disabilities and functional limitations emerge with age. Infants and toddlers with very low birthweight, failure to thrive, Down syndrome, blindness, deafness and HIV infection may qualify. The application process often takes substantial time, so even when applications are made when children are very young, most of the benefits they receive occur when they are older.

Non-means Tested Income Support

In addition to these means-tested programs, both the Social Security system and veterans’ benefits programs provide benefits to children of parents who are deceased, have disabilities or are retired. These represent, in some sense, insurance payments due to the loss of earning

potential in the household. They are not conditional on the other income or resources that a child or household currently has, although they may be adjusted for prior earnings. While important to compensating for the loss of earning capacity, a substantial share of benefits goes to children who are in households above 200 percent of the poverty level, and these are more likely to be received by older children. While children ages three to 18 are more likely to experience the death of a parent or disability, some infants and toddlers receive Social Security survivor benefits.

Finally, the federal government plays a role in enforcement of child support payments. Federal funding to states helps to ensure that noncustodial parents are both identified (through paternity determinations) and contribute in providing financial support to their children through establishment and enforcement of child support payments. This helps to ensure that children receive economic support from both their biological parents. Child support enforcement systems can apply to families of all income levels, but the beneficiaries of these efforts most often are children in low income families.

Table 2 provides information on income supports for families with children 0-3. The table separates means-tested, non-means tested and other income supports. Most represent direct income transfers (i.e., families receive cash income not dedicated vouchers), including the EITC and Child Tax Credit, TANF cash assistance, SSI child payments, veterans’ benefits and Social Security survivor benefits.



Table 2. Income Supports for Families with Children 0-3 MILLIONS OF DOLLARS

CATEGORY/PROGRAM	TOTAL FUNDING CHILDREN 0-17	PERCENT TO 0-3	FUNDING FOR CHILDREN 0-3
Tax Credit			
Earned Income Tax Credit (refunds)	\$ 57,405	21%	\$ 12,055
Child Tax Credit (refunds)	\$ 25,727	18%	\$ 4,631
Means-tested Income Support			
TANF Cash Assistance	\$ 3,629	22%	\$ 798
Supplemental Security Income (SSI)	\$ 12,125	7%	\$ 849
Non-means Tested Income Support			
Social Security/OASD Survivor Insurance	\$ 24,166	2%	\$ 483
Disability Insurance Trust Fund	\$ 8,870	7%	\$ 621
Veterans Income Supports Combined	\$ 5,289		\$ 365
Other Income Support			
Child Support Enforcement	\$ 4,088	16%	\$ 654
Total			\$ 20,456

Nutrition Assistance

An estimated one in six Americans lives with food insecurity. As defined by the National Academy of Sciences food insecurity exists whenever the availability of nutritionally adequate and safe foods or the ability to acquire acceptable foods in socially acceptable ways is limited or uncertain. It is when people do not have access to enough food for an active, healthy life. It is lack of food due to a socio-economic problem, lack of financial resources or other physical constraints (e.g., when people with disabilities cannot get out to purchase food). It is not voluntary fasting or dieting, or because of illness or for other reasons. For pregnant women and children 0-3, food insecurity and hunger can cause serious harm. These problems are associated with adverse birth outcomes, poor physical health and impaired learning.

The Supplemental Nutrition Assistance Program (SNAP)

The Supplemental Nutrition Assistance Program (SNAP, formerly known as the Food Stamp Program) offers nutrition assistance to millions of low income individuals. SNAP helps approximately 45 million low-income Americans per month to afford a nutritionally adequate diet. Approximately half of participants are children, and nearly 70 percent of those using the program are in families with children. The average SNAP recipient received about \$127 a month (or about \$4.23 a day) in nutrition assistance in FY2015.

Unlike many means-tested benefit programs, which are restricted to particular categories (e.g. children, pregnant women, persons with disabilities), almost all low income individuals are eligible for SNAP. For most households, gross income eligibility is set at 130 percent of the federal poverty level (states can raise this level, through categorical eligibility), but after adjustments for items such as child care and housing income the income must be at or below the federal poverty level, and household assets must meet certain limits (again, with flexibility to states to not impose asset limits).

As with tax credits, SNAP nutrition assistance can keep families out of poverty. SNAP lifted 2.1 million children above half of the poverty line in 2012.

The federal government pays the full cost of SNAP benefits and splits the cost of administering the program with the states for operations. In FY2016, the federal government spent about \$81 billion on SNAP. Of the total, nearly \$7.5 billion was for children 0-3.

Table 3. Nutrition Assistance for 0-3 MILLIONS OF DOLLARS

CATEGORY/PROGRAM	TOTAL FUNDING CHILDREN 0-17	PERCENT TO 0-3	FUNDING FOR CHILDREN 0-3
SNAP	\$ 35,574	21%	\$ 7,470
WIC (including pregnant women)	\$ 6,350 . . . . .	.82%	\$ 5,207
Child Care Food Program	\$ 3,340	20%	\$ 668
Total . . . . .			.\$13,345

WIC

Since 1972, the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) has provided nutrition-rich foods, nutrition education (including breastfeeding promotion and support) and referrals for health and social services to eligible low-income women, infants and children. WIC benefits are aimed at a critical period of health and development. Research shows the positive benefits of WIC participation, including healthier births, better nutrition, improved infant feeding practices, better health for children and subsequent school achievement.

WIC eligibility categories include: women during pregnancy and up to six weeks postpartum, breastfeeding women up to one year after a birth, infants through the first year of life and/or children less than

five years of age. Income eligibility is met if: 1) household income is at or below 185 percent of the federal poverty level or 2) applicants already receive benefits through certain means-tested programs such as TANF, SNAP or Medicaid. Eligibility also depends on having nutritional risk (e.g., poor diet, medical conditions).

Funding for WIC is provided through federal appropriations, with most program funds allocated via formula grants to state or tribal agencies. While a small number of states supplement their programs with their own funding, WIC law does not require state matching funds. Since WIC funding is discretionary, the number of participants served by the program is limited by the level appropriated by Congress.

Approximately 6.1 million pregnant women and children 0-3 are enrolled in WIC, or about 40 percent of all pregnant women and young children. In FY2016, 24 percent of WIC participants were women, 2 percent were infants and 52 percent were ages one to four years. Two-thirds of WIC participants have income below the federal poverty level.

A related WIC Farmers’ Market Nutrition Program was established in 1992 to provide fresh, locally grown fruits and vegetables to WIC participants and to expand the use of farmers’ markets. In FY2015, 1.7 million WIC participants received these special benefits.

Table 3 includes federal spending for major nutrition assistance programs. In total, \$13 billion is estimated in expenditures for children 0-3 and pregnant women.



Table 4.
Housing Assistance for Families with Children 0-3
 MILLIONS OF DOLLARS

CATEGORY/PROGRAM	TOTAL FUNDING CHILDREN 0-17	PERCENT TO 0-3	FUNDING FOR CHILDREN 0-3
Tenant-Based Rental Assistance (Section 8) . . .	\$ 5,103	18%	\$ 919
Project-Based Rental Assistance Program . . .	\$ 2,663	18%	\$ 479
Public Housing	\$ 1,790	19%	\$ 340
Homeless Assistance Grants	\$ 1,132	18%	\$ 204
Rental Assistance	\$ 361	18%	\$ 65
Low Income Home Energy Program (LIHEP) . .	\$ 780	16%	\$ 125
Total . . . . .			.\$2,132

Housing Assistance

The U.S. Department of Housing and Urban Development (HUD) administers a number of voucher and public housing programs providing assistance to pay a portion of the rent for low-income households (generally households below 80 percent of the median income in any state) who are considered “cost burdened” because of the cost of their housing. Families who pay more than 30 percent of their income for housing are considered cost burdened. The costs of housing for these families make it difficult for them to afford other necessities such as food, clothing, transportation and medical care. Together, these different HUD programs serve 1.74 million families with children, of 34.8 million families with children (8.4 million families have a child under 3), 5 percent of all families. The United States Department of Agriculture also has a housing assistance program for rural areas, but it primarily serves elderly and disabled households.

Families must apply for these programs and most have waiting lists. In some instances, it can take years for eligible families to receive housing assistance. Even with these programs, an estimated 2.7 million renter and homeowner households with children now pay more than 50 percent of their annual incomes for housing, and a much larger number pay more than 30 percent of their annual incomes for housing.

Of these programs, the HOME Investments Partnerships Program (HOME) provides grants to states and local governments to fund a wide range of activities including: 1) building, buying and/or rehabilitating housing for rent or homeownership or 2) providing direct rental assistance to low-income families. It is the largest federal block grant program for state and local governments designed exclusively to create affordable housing for low-income households. Project-based rental assistance provides for federally contracted and subsidized rent in designated buildings that are privately owned and operated. Tenant-based rental assistance is a distinct subcategory of HOME investments, which typically make up the difference between the amount a household can afford to pay for housing and the local rent standards. The Housing Choice Voucher Program (Section 8) is the federal government’s largest program assisting very low-income families, the elderly and the disabled to afford decent, safe and sanitary housing in the private market. Housing choice vouchers are administered locally by public housing agencies. Participants are free to choose any housing that meets the requirements of the program and are not limited to units located in subsidized housing projects. The challenge for participants is to find housing that accepts the vouchers. Public housing programs provide rental housing for eligible low-income families, the elderly and persons with disabilities, managed by 3,300 local housing authorities. Public housing comes in all sizes and types, from scattered single family homes to high rise apartments.



Illustration of the Impact of Income Supports to a Low-Income Family

The calculations below take into account both earned income and income supports that may be available to a family, with the example for a mother with a two-year-old and: no earned income, with a job earning at the poverty level (\$16,240 per year) and with a job earning at twice the poverty level (\$32,480 per year). It assumes her cost of rent and utilities (used to calculate SNAP benefits) is \$600 per month and the maximum TANF benefit she is eligible to receive is \$400 per month (slightly above the median payment among states). In terms of hourly pay, a \$16,240 income would represent full-time (40 hour per week and 2,080 hours per year) employment at \$7.80 per hour or three-quarter time (30 hours per week) at \$10.50 per hour. A \$32,480 income would be an hourly wage of \$15.60 full-time and \$21.00 at three-quarter time.

This illustration shows that there are significant gains for the family between not working and securing employment at a poverty-level wage, but even with a doubling of income from that point, the family’s available income is increased by a much smaller amount.

	NO EARNED INCOME	ANNUAL INCOME AT POVERTY LEVEL	ANNUAL INCOME AT TWICE POVERTY LEVEL
Gross Income	\$ 0	\$ 16,240	\$ 32,480
Payroll taxes (Social Security and Medicare Deductions)	\$ 0	\$ -1,242	\$ -2,484
EITC/Child Tax Credit	\$ 0	\$ 4,372	\$ 489
SNAP Benefits	\$ 4,284	\$ 1,453	not eligible
WIC Benefits	\$ 480	\$ 480	not eligible
TANF Cash Assistance	\$ 4,800	\$ 0	\$ 0
Available Annual Income	\$ 9,564	\$ 21,303	\$ 30,485
Other factors/adjustments			
Family Health Costs (parent+child)	Medicaid	Medicaid	\$ -3,000
Child Care Costs	CDBG subsidy	CDBG subsidy	\$ -3,000
If child has disability and SSI	\$ 1,200	\$ 1,200	Medicaid for child
Available Income	\$10,764	\$22,503	\$24,485

In addition to these programs, the Low-Income Energy Assistance Program (LIHEAP) is a block grant to states from the Office of Community Services in the U.S. Department of Health and Human Services to provide assistance to: 1) low-income households to pay a portion of home energy (primarily winter heating) costs; 2) provide emergency assistance to meet energy needs and 3) weatherize homes to reduce energy consumption and costs. The majority of LIHEAP funding goes for assistance in paying utility bills. LIHEAP support is based upon household income, with additional efforts to ensure vulnerable persons (the elderly, disabled and children under five) are served. Overall, 5.7 million households received heating assistance in 2014, 1.4 million of them households with children younger than five (of 12.7 million families with children younger than five), or 11 percent of those households.

Housing (including utility) costs represent one of the major costs that families with young children face. The various housing assistance programs provided through federal funding largely are administered through local governments and community agencies. While they help to make housing more affordable for the low-income families they serve, they only serve a small share of those with housing costs that represent a burden to meeting other daily family necessities.

Table 4 shows the primary programs that provide federal housing assistance to families with young children.



Combined Program Impact

To discuss how the benefits interact, and the extent to which they provide support, the insert box provides an illustration for benefits a single mother of a two-year-old would receive if she has: 1) no earned income; 2) earned income at the poverty level or 3) earned income at twice the poverty level. As shown in this example, the family at the poverty level has available income that is, at best, minimally sufficient to make ends meet. Since benefits phase out with increased earnings, however, doubling the mother's gross income only modestly increases her overall disposable income, particularly if she also must assume more of the cost of health care, child care and food. Even at twice the poverty level, the families' available income is at a level barely sufficient to make ends meet, according to most family self-sufficiency studies and analyses, with few resources to invest in family well-being or child development.

In short, while current federal programs provide a safety net in terms of income, food, access to medical care and sometimes child care or housing support, these programs, taken together, provide a floor of economic support that still leaves most families struggling to meet basic needs and with little to support their children's physical, social and educational development. The resources to secure truly safe, affordable housing, quality child care and a car for transportation may not be available, not to mention enriching books, toys, child activities and time away from work during a child's waking hours.

Health care expenditures for pregnant women and children 0-3 constitute, with income supports, the largest area for public investments for this group. This is for two main reasons. First, pregnant women and young children are less likely to have health coverage through other sources, such as employer-sponsored health care, and, particularly prior to enactment of the Affordable Care Act, are more likely to be in households without the means to independently secure such health coverage and care. Second, pregnancy and childbirth represent a significant health cost, and, for most children, is the time when their health care costs are greatest. Among adult women under age 65, maternity care (prenatal and birth services) often is the highest cost service they use. Infants have the highest spending among children by age. This is primarily related to inpatient costs for newborns, which accounted for 80 percent of the average cost of \$11,741 per infant in 2013. Much of the other federal health spending for the population prenatal to three addresses the needs of the underserved, including health centers and vaccines. A third main category of investment is to reduce or treat developmental delays and disabilities.

Health

Medicaid \$34,000 million (\$34.0 billion)
 Children's Health Insurance Program \$2,016 (\$2.0 billion)
 Vaccines for Children Program \$2,372 (\$2.3 billion)

Health Coverage

Medicaid

Medicaid is a federal-state entitlement program for medical assistance to low-income individuals, including children, persons with disabilities of all ages, the elderly and adults — with different eligibility and benefits for each. While children are approximately half of all persons receiving Medicaid, they account for less than one-quarter of the costs.

Today, Medicaid provides coverage for more than half of all births and for more than half of all very young children (ages 0-3). Medicaid finances a wide array of services and supports, including prenatal care, well-child visits, developmental services, newborn screenings and treatments for children with complex medical conditions and disabilities. Its Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) provision promotes preventive and developmental services for young children, as well as treatment for illness and interventions to reduce disabilities.

Through bipartisan actions at the federal and state levels, Medicaid coverage for pregnant women and children has expanded over the past 30 years. Prior to the enactment of the Affordable Care Act, the federal minimum required eligibility level was 133 percent of the federal poverty level for pregnant women and children age birth to five. Virtually all states have used their option to establish higher eligibility levels for pregnant women and young children. In 2016, the national median eligibility level for pregnant women was 200 percent of the federal poverty level, and for infants (less than one year of age) it was 210 percent of the federal poverty level. A majority of states also expanded eligibility for children over age one.

Table 5 shows estimated federal Medicaid FY2016 spending for pregnant women and young children, based on data from the Office of the Actuary, Centers for Medicare and Medicaid Services. Overall, Medicaid covers 28 million children ages zero to 18 and 1.6 million children eligible as a result of their disability. The federal government does not collect and report data on Medicaid expenditures specifically for maternity and infant care (and maternity care is generally covered under the mother's Medicaid number as an adult, while newborn care is provided under the child's Medicaid number as a child). In 2015, there were 3,977,745 births and 2,086,525

infants were enrolled in Medicaid. Medicaid financed a little more than half of all births in the United States — at least 2 million births. Given an estimated cost of \$10,000 per birth, Medicaid payments for maternity and newborn care in 2015 were in the \$20 billion range, with \$12.6 billion of that in federal expenditures for maternal birth costs. (See Appendix C for Medicaid calculations and estimates.) Altogether, Medicaid expenditures for the prenatal to three population were \$34.0 billion.

Children's Health Insurance Program (CHIP)

The Children's Health Insurance Program (CHIP) provides health coverage to children in families whose income is too high to qualify for Medicaid, and who are otherwise uninsured. Like Medicaid, CHIP is jointly funded through a federal-state partnership. Unlike Medicaid, CHIP is not an entitlement, but it helps states provide health insurance coverage to uninsured children. State CHIP plans may expand eligibility for children under Medicaid or create a separate children's health insurance program managed by the state and typically operated by private insurance companies, or establish a combination public-private approach. In 2016, the national median CHIP income eligibility level was 254 percent of the poverty level. In FY2014, 8.1 million children were enrolled in CHIP. CHIP federal funding for the 0-3 population was an estimated \$2 billion.



Table 5.
Federal Medicaid Expenditures 0-3
 BILLIONS OF DOLLARS

CATEGORY OF EXPENDITURE	TOTAL AGES 0-18	PERCENT 0-3	FUNDING 0-3
Children	\$ 62.5	29%	\$ 18.1
Children with Disability	\$ 20.1	16%	\$ 3.2
Maternity Care (billed to mother)	\$ 12.6	100%	\$ 12.6
Administrative	\$ 6.7	29%	\$ 1.9

Other Health Programs

Title V Maternal and Child Health (MCH) Block Grant

Created with the passage of the Social Security Act in 1935, the Title V Maternal and Child Health (MCH) Block Grant Program is the nation’s oldest federal-state partnership, providing grants to state public health agencies to improve the health and well-being of all mothers and children. The Title V MCH Block Grant funds distributed to states aim to: improve access to quality care for pregnant women and children; reduce infant mortality, preventable disease and disabilities among children; increase access to prevention, assessment, diagnostic and treatment services for children; and promote development of comprehensive, family-centered, community-based and coordinated systems of care for children with special

health care needs. The largest share of spending is for children with special health care needs. A small portion of Title V funds is retained at the federal level for special projects, research, demonstration and training. States must provide a \$3 match for every four federal dollars allocated; however, most states “overmatch” and other local and private funds also support Title V program activities. Title V provided health care services also may be reimbursed by Medicaid (included in program income). (See Figures 6 and 7.) As a result, in FY2015, while the federal expenditures were \$526 million, the combined federal, state and local expenditures totaled \$6.3 billion for the population of mothers and children of all ages. Federal block grant dollars to states represented only 10 percent of what was spent on pregnant women and 19 percent of what was spent on infants. For the population prenatal to three, federal Title V expenditures were \$108 million. The Title V program served a reported 2.6 million pregnant women and 3.8 million infants, as well as an estimated 3.5 million toddlers ages one to two, or 64 percent of all pregnant women and children 0-3 in the country.



Vaccines for Children

The Vaccines for Children program is one of the nation’s largest specialized investments in child health. The program uses federal funds to provide vaccines at no cost to children who might not otherwise be vaccinated because of inability to pay. Medicaid-eligible, uninsured, underinsured and American Indian or Alaska Native children may qualify. The federal government buys vaccines at a discount and distributes them to state health departments and certain local and territorial public health agencies, which in turn distribute vaccines to private physicians’ offices and public clinics. Infants and toddlers are a primary target for publicly funded immunization efforts. While more needs to be done to ensure all young children receive the full series of vaccines recommended before their third birthday, immunization rates for children 19 to 35 months are above 80 percent. The Vaccines for Children program funding for the population 0-3 is estimated to be \$2.3 billion for FY2016.

Figure 6.
Title V Maternal and Child Health Block Grant Expenditures by Source, FY2015

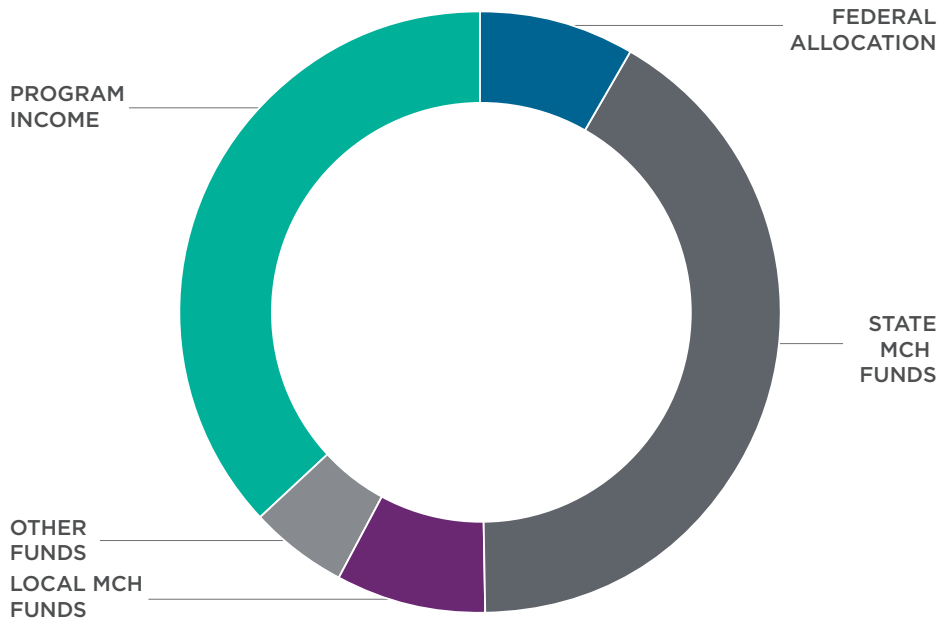
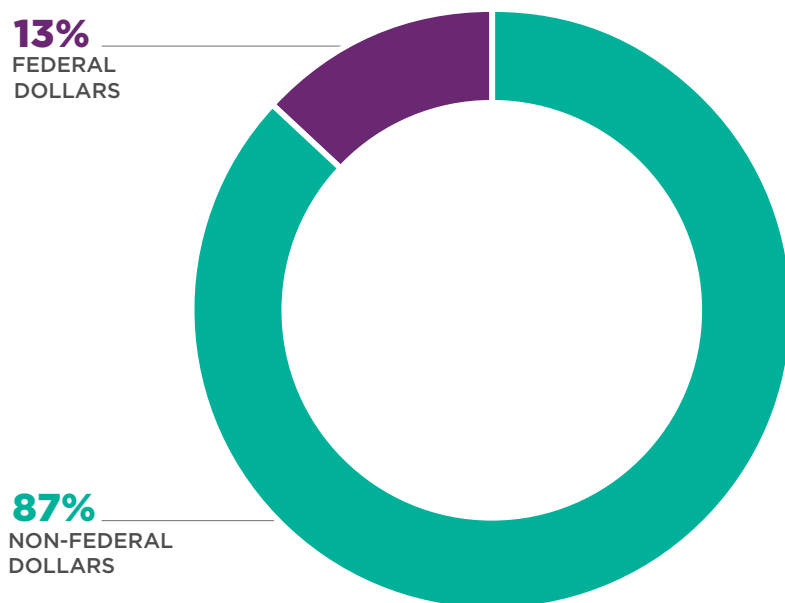


Figure 7.
Title V Share of Federal and Non-federal Expenditures for Pregnant Women and Infants, FY2015



Part C Early Intervention Program for Infants and Toddlers with Disabilities

The Individuals with Disabilities Education Act (IDEA) Part C Program for Infants and Toddlers with Disabilities (Part C), also known as “early intervention,” is a federal grant program that assists states in operating a comprehensive statewide program to identify and provide early intervention services for infants and toddlers 0-3 with disabilities and their families. Since the program was created 30 years ago, state systems for identifying and serving children and families have evolved. The program offers an entitlement to services for infants and toddlers identified as eligible, based on their qualifying under their state’s definition of a developmental delay or disability. Unlike open-ended Medicaid financing, however, Part C federal funds are limited to a specific federal appropriation. At a minimum, two types of children may be eligible: 1) those with a diagnosed physical or mental condition with a high likelihood of developmental delays or 2) a developmental delay in one or more of five areas of development (cognitive, motor, communication, social/emotional, adaptive). States determine specific eligibility criteria (i.e. what level and type of disability enables a child to qualify), and tend to be restrictive, which limits the reach and cost of the entitlement. Notably, both the IDEA and CAPTA laws require that state Part C and child welfare systems coordinate for the referral to Part C services of substantiated cases of abused, neglected, or drug-exposed infants and toddlers. States also have the option to serve those at risk for delay because of biological or environment risk factors in addition to those with diagnosed delays or disabilities, but only a small number of states choose to do so.



In 2016, at least 358,000 infants and toddlers participated in the program, about 3 percent of all young children. Given substantial variation in state eligibility definitions and outreach activities, Part C participation levels range from less than 2 percent in six states to more than 5 percent in four states. In addition, as a result of variations in eligibility, the children served differ with respect to their conditions and the age at which they enter the program. In general, children are most likely to be identified due to a speech-language-hearing problem, vision problem, motor delay, birth-related condition or developmental delay. National surveys indicate that children with developmental delays have lower odds of using the program due to state variations in eligibility, compared to those with medical conditions. The majority of services are delivered in home. Federal appropriations for FY2016 were \$459 million. State, local, Medicaid, private insurance and fees paid by families make up the balance (estimated to be 50 to 75 percent) of program expenditures, again with substantial variations from state to state.

Community Health Centers

For 50 years, the federal government has funded community health centers to ensure the availability of high-quality health care services for low-income children and adults. Health centers are consumer-driven and patient-centered organizations that serve as comprehensive and cost effective primary health care for America’s most underserved communities. Health centers receive direct federal grants (primarily for serving the uninsured), and Medicaid represents 44 percent of health center revenues. In 2015, among the 25 million persons served by community health centers, more than 552,000 prenatal patients and 1.5 million children 0-3 were served in nearly 10,000 health center sites across the country. Community health centers serve a large share of the nation’s population with no health care coverage, including an estimated 150,000 children birth to three, or one-quarter to one-third of all uninsured very young children. An estimated \$562 million of federal grants for health centers benefited pregnant women, infants and toddlers.

Children’s Mental Health Services

The Community Mental Health Services Block Grant Program assists states in providing mental health services to children and adults and in implementing a comprehensive, community-based mental health system. Funding goes to the states on a formula basis. The program is administered by the Substance Abuse and Mental Health Services Administration (SAMHSA). The Comprehensive Community Mental Health Services for Children program, known as the Children Mental Health Initiative, provides grants to states, territories, counties and tribes. While some states choose to use funding for early childhood mental health initiatives, little funding is spent on preventing significant mental health conditions and less than one-quarter of those served are under the age of five. An estimated \$12 million of the FY2016 funds in the Children’s Mental Health Initiative went to children 0-3.

Healthy Start Infant Mortality Reduction

In 1991, the federal Healthy Start program was established as a pilot program to reduce infant mortality and eliminate disparities in maternal and health by improving access to services and enhancing community health care systems. Since that time, Healthy Start funding has been increased and it now serves 100 communities with infant mortality rates at least 1.5 times the national average that have high rates of poverty and other socio-economic risk factors. The funds support health services, case management, health education and community supports. The FY2016 funding level was \$104 million.



Newborn Screening, Birth Defects and Developmental Disabilities

Most newborn screening is funded at the state level by fees; however, these resources were not generally used to screen for hearing problems. The Universal Newborn Hearing Screening and Intervention Program provides grants to states for the implementation of systems for universal newborn hearing screening, diagnostic evaluation and enrollment in a program of early intervention. Working with other child health programs (e.g. Title V MCH Block Grant, WIC, Part C early intervention), health professionals and families, the goal of the program is to support the development of statewide programs and systems of care that ensure that deaf or hard of hearing children are identified and receive interventions that optimize their language, literacy and social-emotional development. As a result of dedicated federal funding — \$18 million in FY2016 — newborn hearing screening programs have been implemented by all 50 states and more than 92 percent of newborns are screened. About one in 1,000 newborns

suffer from hearing loss. Challenges remain in assuring early intervention for those diagnosed.

The Centers for Disease Control and Prevention, National Center on Birth Defects, Developmental Disabilities, Disability and Health funds state birth-defects systems, studies patterns of birth defects and disabilities and supports activities that improve the lives of persons with disabilities. For example, FY2016 funds were dedicated to conditions such as autism spectrum disorders, congenital heart failure, fetal alcohol syndrome, hemophilia, muscular dystrophy, spina bifida and Zika. A majority of funding goes to child-related activities, including a substantial share that affects the lives of infants and toddlers. An estimated \$72 million benefited infants and toddlers age 0-3.

Since 1995, federal initiatives have aimed to increase understanding of and interventions for autism spectrum disorders. Congress specifically dedicated funds beginning in 2006. In 2014, Congress passed the bipartisan Autism Collaboration, Accountability, Research, Education and Support Act — Autism CARES Act — to continue federal investments in research, surveillance, early detection and intervention services for both children and adults on the autism spectrum. Grants to states from the Maternal and Child Health Bureau, Health Resources and Services Administration and funds for professional training and research are key elements of the program. Priority is given to early identification, effective treatment and access to services for underserved populations, including minority and rural communities. The program has helped to support diagnostic evaluations for 224,000 children. In FY2015, an estimated \$35 million in federal spending for the Autism Initiative benefited infants and toddlers.

Table 6 shows federal funding related to health, excluding Medicaid expenditures. The programs range from the large investments of more than \$2 billion each for the CHIP and Vaccines for Children programs to \$12 million for early childhood mental health services.

Health coverage through Medicaid and CHIP is critical for improving the health and development of children. As a result of the investments in Medicaid and CHIP, 95 percent of children had health coverage by 2015, with rates even higher for very young children (96 percent for the birth to five population). While rising health care costs have made it more difficult for employers to offer and employees to participate in the health care offered, particularly family coverage, the expansions to Medicaid and the establishment of the CHIP program reduced the number and percentage of children who are uninsured. This is particularly true in states that expanded Medicaid and CHIP eligibility levels about federally required minimums. Equally important is continuing coverage for pregnant women and other women of child-bearing age, so they enter any pregnancy in good health.

Table 6.
Other Federal Health Expenditures for 0-3
 MILLIONS OF DOLLARS

PROGRAM CATEGORY	TOTAL AGES 0-18	PERCENT 0-3	FUNDING 0-3
Children’s Health Insurance Program (CHIP)	\$ 14,400	14%	\$ 2,016
Title V MCH Block Grant (includes prenatal)	\$ 638	NA	\$ 108
Vaccines for Children	\$ 4,161	57%	\$ 2,372
Community Health Centers (includes prenatal)	\$ 1,847	NA	\$ 562
Children’s Mental Health	\$ 119	10%	\$ 12
IDEA Part C Early Intervention	\$ 459	100%	\$ 459
Healthy Start (includes prenatal)	\$ 104	100%	\$ 104
Universal Newborn Hearing Screening	\$ 18	100%	\$ 18
Birth Defects and Developmental Disabilities	\$ 96	75%	\$ 72
Autism Initiative	\$ 47	75%	\$ 35
Total without Medicaid			\$5,758

Although not a universal program, through enactment of the Vaccines for Children program the nation made a major commitment to affordable immunization services for underserved infants and toddlers. Expansion of community health centers provided quality care for millions more underserved families across the nation, with substantial benefit to pregnant women, infants and toddlers. Health coverage expansions helped to ensure that women of childbearing age would enter any pregnancy in optimal health and these expansions addressed maternity coverage in particular.

Other initiatives have increased attention and response to specific child health concerns and attention to both children’s special health care needs and their developmental trajectories, but much more is needed. While federal programs have provided an entry into primary health care for the majority of all very young children, too few young children actually receive preventive and developmental services, to promote healthy development. Infants and toddlers with developmental risks — particularly those risks driven more by social than by medical factors — remain seriously underserved. Better serving those children is key to improving health trajectories and reducing the incidence of preventable health conditions during adolescence and adulthood that currently are driving health care costs.

Family Support Services for Pregnant Women and Young Children

Home Visiting and Other Family Supports \$2,573 (\$2.6 billion)

Home Visiting, Early Head Start and Other Family Support Services

In addition to providing services to vulnerable children in child welfare and to households with children in the areas of income, nutrition, housing and health care, the federal government provides additional funding to states to deliver other services and supports to families with young children, generally directed to more vulnerable children and their parents. While these defy neat categorization, most involve some counseling, support or education to parents in helping to raise their children. Some federal funds are administered directly through program sites (e.g. Early Head Start), others through state agency administration for specific programs (e.g. MIECHV), and others through state decisions with respect to federal block grants (TANF, SSBG and CSBG).

Home visiting programs to support parenting skills, maternal and child health and family self-sufficiency have received increased attention and funding in recent years. Some are directly related to strengthening families and enhancing parenting skills, while others use two-generation approaches that couple parent education and employment with child health and development. The federal Maternal, Infant and Early Childhood Home Visiting (MIECHV) program was established in 2010, and is designed to give at-risk pregnant women and families with young children the support and skills to raise children who are physically, socially and emotionally healthy and ready to learn. While authorized in health legislation, the MIECHV program purposes are broader than health, including an array of family supports. In FY2016, MIECHV funds served approximately 160,000 parents and children (and a little over 80,000 children zero to three) in 893 of the 3,144 counties across all 50 states, DC and 5 territories. At current levels of participation, however, the program reaches a relatively small portion of families at risk who might benefit for home visiting programs (e.g. teen parents, very poor, at risk for abuse and neglect). The US Department of Health and Human Services has identified 17 evidence-based programs from which state can choose to use the bulk of their MIECHV funds.

While Head Start began in 1963 and has a long history of providing preschool experiences for three- to five-year-olds, the Early Head Start program was established in 1994 to extend the overall Head Start program to also have a focus upon children birth to three. The Early Head home-based option is a federally approved, evidence-based home visiting program, focused upon parents and two-generation strategies to improve family prospects and well-being. Even more than Head Start, Early Head Start is focused on family support. All center-based Head Start programs, including Early Head Start center-based sites, use family service workers that provide parenting education and often offer additional recreational programming and family-friendly activities (which can extend to infants and toddlers in the home as well as to the preschoolers in the Head Start program itself). In 2009, Early Head Start funding was doubled to approximately \$2 billion. This level of funding still represents a small share of the \$9 billion that funds the overall Head Start program, with most of the funding going to preschool programs for four-year-olds.

The MIECHV federal investment in home visiting was \$400 million in FY2016, with an estimated \$320 million for pregnant women and children 0-3. The remainder is predominantly used for home visiting services delivered to children ages 3-5. Approximately \$800 million in Early Head Start funding is used exclusively for the home visiting approach. While some center-based Early Head Start funding also might be considered under child care, the Early Head Start funding is all included here as family support because of its emphasis upon strengthening the skills and capacity of families to provide nurturing home environment.

Both Early Head Start and MIECHV represent relatively recent efforts by the federal government to finance services specifically for low-income and vulnerable young children and their parents to strengthen parenting in the earliest years of life. Importantly, both have been developed and continue to be based upon research evidence of their effectiveness in strengthening families and improving child developmental trajectories. Further,

Table 7. Federal Home Visiting, Parenting Education and Family Support Services for Pregnant and Young Children

MILLIONS OF DOLLARS

PROGRAM CATEGORY	TOTAL AGES 0-17	PERCENT 0-3	FUNDING 0-3
Home Visiting (MIECHV)	\$ 400	80%	\$ 320
Early Head Start	\$ 2,000	100%	\$ 2,000
TANF (other family support)	\$ 878	NA.	\$ 139
Social Services Block Grant (other family support)	\$ 286	16%	\$ 68
Community Services Block Grant	\$ 286	16%	\$ 46
Total Home Visiting and Family Support			\$ 2,573

both are relational and involve relatively long-term and frequent involvement with the families served — with equivalent per family costs. Taken together, MIECHV and Early Head Start serve approximately 240,000 children birth to three, or 2 percent of all very young children. Notably, additional home visiting programs and services are financed by states and communities, although often on a demonstration and small-scale basis.

In addition to these two efforts, different federal block grants provide states with flexibility to address child and family needs as states determine them, including investing in programs which offer counseling and support to families and with attention to those families’ dual roles as caregivers and economic providers for their children. These might include parenting education programs, family resource centers, resource and referral programs and family development workers who help families develop self-sufficiency plans from a two-generation perspective (where a good share of Community Services Block grant funded is directed). Clearly, this is not a firm and fixed category for spending — but these programs are likely to seek to strengthen and support families in raising their youngest children. The three specific federal sources most used for such services are TANF, the Social Services Block Grant and the Community Services Block Grant, which are shown in Table 9 with estimates of their actual funding for children 0-3.

In addition, other programs and services also offer some family support, usually around their specific areas of focus. For example, WIC programs offer nutritional counseling to parents during pregnancy and with young children which provides support for that aspect of parenting. The Expanded Food Nutrition and Education Program through the Cooperative Extension Service of the United States Department of Agriculture offers community-based, relationship-driven, hands-on assistance through peer educators to influence nutrition and physical behavior activities for low-income families. In health care settings, providers may screen for and make referrals to

programs that supporting parenting, as well as providing anticipatory guidance on child development. Typically for children with special needs, health providers also may use care coordination services that link families to sources of support, and a few even finance some aspects of home visiting under Medicaid. Some of the programs supported with funds under the Child Abuse Prevention and Treatment Act

(CAPTA) are truly preventive and community-based and not solely for those already involved in the protective services system. While listed under child welfare services because it largely is administrated at the state level under state child protective service system agencies, CAPTA supports community-based efforts across a spectrum of prevention and treatment services.

Table 7 shows funding for this diverse category of other federal program funds, including specific home visiting programs that are directed to providing services to families with young children, usually to improve parenting and nurturing. While federal investments in home visiting in particular have increased in recent years, these programs do not reach a substantial share of the population of families who could benefit from their support.

Even the two most prominent and extensive programs in this area, MIECHV and Early Head Start, serve only 2 percent of all young children in the country. The costs per family served generally range from \$4,000 to \$12,000, in keeping with the comprehensiveness and frequency of contact with the families. While these can appear as large per child investments for prevention programs, their long-term impact — in terms of improved child health and development trajectories — has been estimated in several studies as much larger in public benefits (in health, education, justice system involvement and adult employment), with such investments providing for the highest long-term returns-on-investment or rates-of-return of any social investments.

Child Care

Child Care Subsidies and Support \$4,219 Million (\$4.2 billion)
Dependent Care Tax Credit \$1,227 Million (\$1.2 billion)

Infants and toddlers need secure and nurturing, one-on-one relationships that help them develop and thrive, with continuous, 24/7 care and supervision. Most of this is provided by their parents, but some is usually also provided in substitute care arrangements, either informal or formal. (By comparison, preschoolers benefit from group activities and learning environments where they socialize and learn with and from many others.)

Over the last 40 years, the proportion of parents (particularly mothers) who are working outside the home, even when their children are very young, has increased dramatically. About two-thirds of women with children under age three are in the workforce, including 59 percent of those with infants under age one.

While some families are able to balance their schedules so one parent is always at home, nearly 6 million children under age three spend substantial time in substitute care. Census data reveal different patterns of care among young children, with parents of infants and toddlers relying upon themselves, grandparents and other relatives to provide most of that care, while parents of preschoolers make much greater use of formal child care. (See Figure 8.) Among infants and toddlers (ages 0-3), only 15 percent are served in a formal child care setting, compared to about 40 percent of preschool age children (ages 3-4). Informal care is used by more than one-third of all families with infants and toddlers. This is particularly true for Black and Hispanic young children. When care is provided by someone other than the parents, it is most likely to be a grandparent or relative. Parents across all educational backgrounds, incomes and races and ethnicities prefer that care provided to their infants, in particular, be intimate and in a setting where the infant is nurtured and cared for by a primary caregiver who knows the family.

This substitute care for infants and toddlers is both a basic support for working parents and an opportunity to promote and protect the development of young children. Research shows high quality care promotes healthy development, while low quality care does not and can do harm. Further, the strongest positive effects of high quality care are for children in families with low socio-economic backgrounds.

While securing quality, affordable and consistent child care arrangements often is a challenge for parents at all incomes and with children at all ages, it is most challenging for low-income parents with very young children —

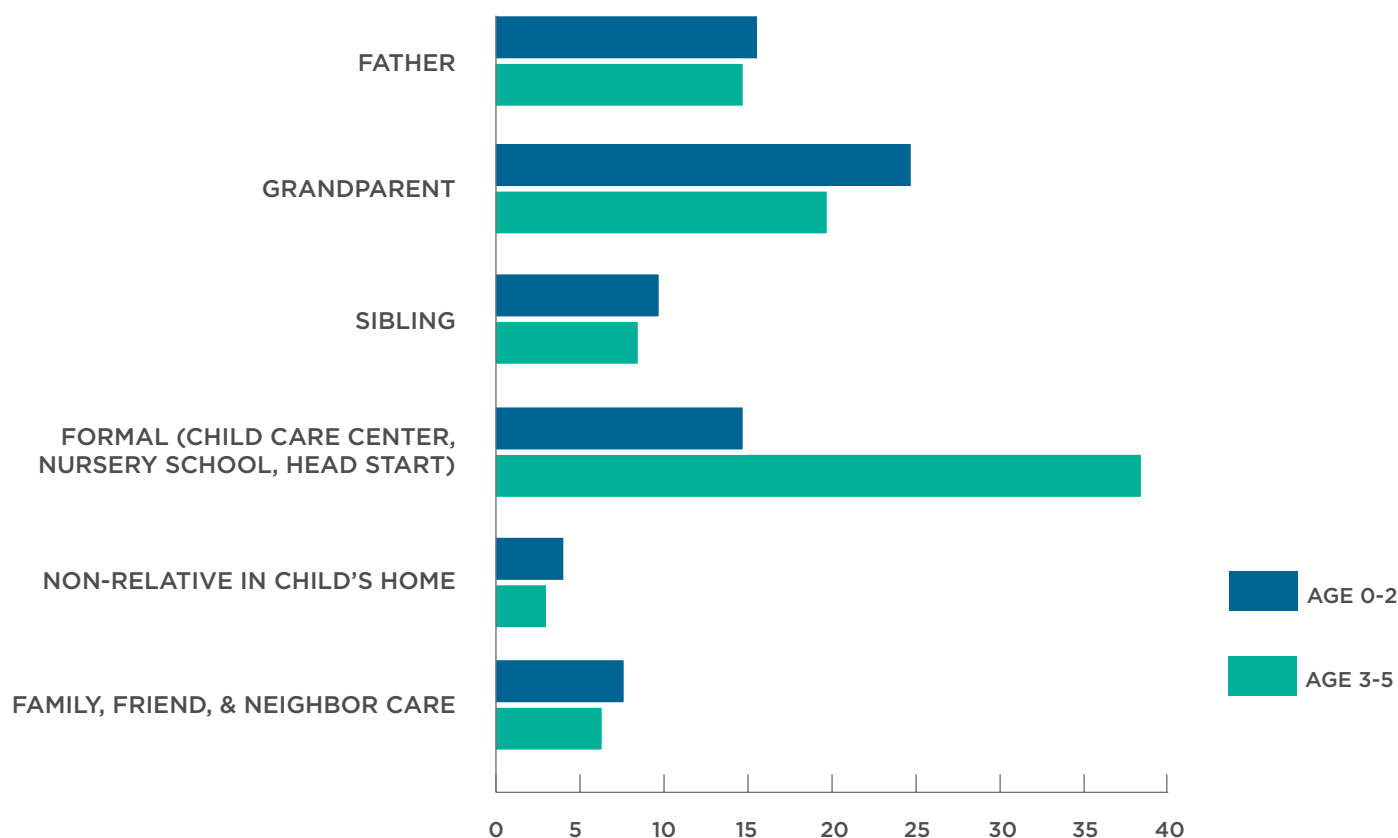
and has become a greater public policy issue with the enactment of welfare reform and its greater expectations on parents to be in the workforce, even when their children are very young. In 1997, federal welfare policy shifted from providing “Aid to Families with Dependent Children” (AFDC) to providing “Temporary Assistance to Needy Families” (TANF). This shift has resulted in dramatic reductions in the number of families receiving cash assistance payments and staying at home to care for their infants and toddlers.

Family Leave

While there are new efforts to provide some paid family leave to parents of infants, welfare reform actually moved in the opposite direction, with increased requirements for seeking work in order to qualify for benefits. Under the federal Family and Medical Leave Act (FMLA), unpaid leave is now available for up to 12 weeks in a 12 month period, but applies only for about half of workers, largely because the provisions do not apply to small employers or part-time workers. Only 13 percent of workers have access to paid family leave through their employers, and this is most likely to exist for large employers, permanent full-time employees and employees in more professional businesses. Women who are married, white and have a college education are most likely to have access to and use such leave. The TANF emphasis upon work for low-income parents is applied in most states even during infancy, and most states do not use the option to offer a type of paid maternity leave under TANF (i.e., TANF cash assistance following a birth without counting toward lifetime TANF eligibility) for the poorest families.



Figure 8.
**Child Care Arrangements for Young Children
 Birth to Age 5, by Type, US, 2011**



Child Care Subsidies

The pressures on parents to work mean that substitute care for the youngest children is a necessity, while formal child care (family-based or center-based child care) is out of economic reach on their own earnings, particularly for low-income families. In response, in the last two decades, the assistance available to families to cover the cost of child care for both TANF recipients and for working families with young children has increased. The Child and Development Block Grant (CCDBG) provides funding to states to subsidize child care for families up to 85 percent of the median family income in the state, although few states set eligibility near this level (i.e., in 2016, a family with an income above 150 percent of the poverty level, \$30,240 a year for a family of three, would not qualify for a subsidy in 17 states and would have to pay a substantial co-payment for that care in many others).

When TANF replaced AFDC, states also were allowed to transfer a share of the TANF block grant directly to CCDBG and to directly fund child care for TANF families through the TANF block grant. Some states also use funding from the Social Services Block Grant to finance child care.

States determine the eligibility levels and the provider payments for child care subsidies, and also must contribute to the funding through maintenance of effort provisions. As expenditures under TANF for cash assistance and the number of children and families on TANF have declined, the amount of funding for child care subsidies has increased. Overall, in 2015, 1,456,000 children received a child care subsidy, 407,000 of them 0-3, representing 3.4 percent of all young children.

Child and Dependent Care Tax Credit

In addition to providing child care subsidies, federal law also provides a non-refundable Child and Dependent Care Tax Credit to cover a portion of child care costs for those without a subsidy. Parents may claim the Child and Dependent Care Credit if they paid expenses for child care to enable them to work

or actively look for work. The amount of the credit depends on adjusted gross income and is a percentage of the amount paid. The total amount paid for which a credit can be claimed may not be more than \$3,000 for one qualifying child or \$6,000 for two or more qualifying individuals. The maximum Child and Dependent Care Credit is \$2,100 (based on two or more dependents and \$6,000 or more of qualifying expenses).

In 2015 (for tax year 2014), 6.5 million taxpayer households claimed the credit, with a value of \$3.5 billion. Of this amount, over half the claims and credits went to taxpayer households with adjusted gross incomes of \$75,000 or more. The estimated share of the Child and Dependent Care Credit going to families with children zero to three was \$1.2 billion.

Table 8 shows a summary of federal supports for child care subsidies and tax credits. The total was over \$4 billion, but many families have unmet needs for support in this area.

Many experts set a goal that child care expenses should not exceed 10 percent of a family’s income. For low-income families who receive a child care subsidy, depending upon the state, this goal is often met, but only a small share of families with young children currently receives a subsidy. For quite affluent families (generally those with incomes over \$100,000), this also may be met, with the federal child care tax credit contributing to a small degree. Overall, however, a fundamental mismatch remains between what most families can afford to pay for formal child care arrangements for their young children and what

that care costs. This is particularly true for families with very young children, who generally have lower incomes from work and where the costs of providing quality care are greatest. The amount estimated to provide full-day child care for children under age three, based upon market surveys, ranges from \$5,500 to \$17,000 across the country. When there is more than one child involved, the amount often approaches or exceeds the amount that the parent is earning.

No single policy or public investment is likely to support families with young children in ensuring a nurturing home environment for their youngest children throughout the day. Paid family leave policies that support families at all income levels and types of employment are one approach. Increasing subsidies for and the quality of formal child care arrangements also will fill gaps. More generous, refundable tax credits for child and dependent care would assist both moderate income and middle-income families in bearing the cost of child care.

Providing other forms of support for informal, family, friend and neighbor (FFN) care represents an equally important approach for the nation’s youngest children. FFN care, by its nature, not only is the most common form of substitute care for very young children, but also is one that is most likely to be culturally and linguistically reflective of the parents’ home and where one-on-one nurturing is most likely to occur. At the same time, for low-income families, particularly those in low-income communities, these FFN caregivers themselves are likely to be struggling economically, stressed and challenged in providing quality, nurturing care. Several states (e.g., Minnesota, Washington, and Arizona) have sought to support and strengthen such FFN care, largely through additional voluntary supports to those caregivers, but there is currently very limited policy or financial support for such care.

Table 8.
Federal Child Care Supports for Children 0-3
 MILLIONS OF DOLLARS

PROGRAM CATEGORY	TOTAL AGES 0-17	PERCENT 0-3	FUNDING 0-3
Child Care Development Block Grant	\$ 5,678 . . . . .	.35%	\$ 1,987
TANF (transfers to CCDBG and direct child care)	\$ 2,622 . . . . .	.35%	\$ 900
Social Services Block Grant (for child care)	\$ 300 . . . . .	.35%	\$ 105
Child and Dependent Care Tax Credit.	\$ 3,505 . . . . .	.35%	\$ 1,227
Total			\$ 4,219

Child Welfare Services for Young Children

Foster Care and Adoption Assistance Services (IV-E) \$512 Million
Other Child Welfare Services \$663 Million

Every state has a child protective service system to respond to allegations of child maltreatment (abuse or neglect) and to take actions to ensure the safety, permanency and well-being of children. In 2015, there were 2.2 million child abuse reports that were investigated, involving 3.4 million children. There were 680,000 confirmed cases of maltreatment and post-response services were provided for 400,000 children, including 150,000 foster placements. Post response services also were provided to 900,000 children where there was no confirmed instance of maltreatment, including 60,000 foster placements.

Of the 680,000 children with confirmed cases of maltreatment (480,000 first-time victims), 97,000 were under the age of one and 93,000 were ages one or two. Very young children, particularly children in their first year of life, are most likely to be subject to child maltreatment allegations (three-quarters of which are about neglect and not abuse).

There is no single funding source for child protective services, and states have made use of multiple sources of federal funding to provide services and placements for children who come to the attention of the child protective service system. There often is no clear demarcation between services offered to prevent child abuse or divert children from the protective service system through family support and those to respond to children who have been identified as victims of child abuse or neglect. The largest share of funding, however, is for placement services among children removed from their birth families.

In this respect, Title IV-E of the Social Security Act provides funding for children who are placed into foster care or adopted as special needs children. While a small share of the funding under Title IV-E can be used to prevent placement, it primarily is used by states for placement programs. Safe and Stable Families Act funding (under Title IV-B), and the Child Welfare Services grant program provide funding more frequently used to support families and avert placement. In addition, some states make use of Medicaid (Title XIX) to fund specialized treatment and foster care placement services. Block grant funding (particularly from TANF and from the Social Services Block Grant) also is used for child welfare services. (See Appendix C for more

about the various uses of TANF and Social Services Block Grant Funds.) The Child Abuse Prevention and Treatment Act (CAPTA) is a program specifically designed to be more preventive in orientation and has some provisions with specific focus on infants and toddlers.

Currently, approximately 420,000 children are in foster care at any point in time (97,000 of them children 0-3). Placements for young children may be short-term, while older children may have very extended stays in care. In addition, approximately 50,000 children are adopted annually (17,000 age 0-3) and most receive adoption assistance, many until they become adults. While many such termination of parenting rights and adoption proceedings begin when child are infants or toddlers, the process takes time and most children receiving adoption assistance services and support are older.

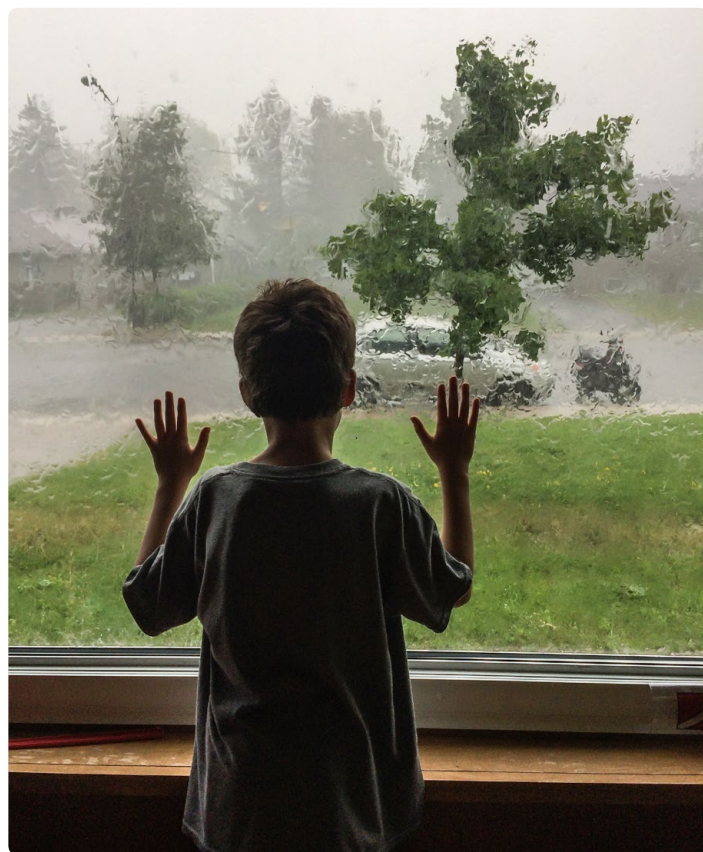


Table 9. Federal Expenditures for Child Welfare Services MILLIONS OF DOLLARS

PROGRAM CATEGORY	TOTAL AGES 0-17	PERCENT 0-3	FUNDING 0-3
Foster Care IV-E.	\$ 4,800	9%.	\$ 432
Adoption Assistance IV-E.	\$ 2,674	3%.	\$ 80
Child Welfare Services IV-B.	\$ 269	20%.	\$ 54
Safe and Stable Families IV-B.	\$ 532 . . . . .	.25%.	\$ 133
Child Abuse Prevention and Treatment Act (CAPTA)	\$ 98 . . . . .	.25%.	\$ 25
Adoption Legal Guardian	\$ 38 . . . . .	.25%.	\$ 10
Adoption Opportunities	\$ 39 . . . . .	.25%.	\$ 10
TANF (for child welfare)	\$ 990	9%.	\$ 256
Medicaid (for child welfare).	\$ 800	9%.	\$ 72
Social Services Block Grant (for child welfare) \$	286 . . . . .	.16%.	\$ 104
Total Child Welfare			\$1,175

While very young children are those most likely to be subject to investigation and response (including entry into foster care), most system resources go to older children, particularly as once a child enters placement, that child often remains in placement or is adopted as a special needs child. Further, older children in care are much more likely to be in residential treatment programs than in family foster care, with substantially higher costs.

The following provides federal financing information on children who become involved with the child protective service system through investigations. The Annie E. Casey Foundation, Casey Family Programs and Child Trends produced a report on child welfare spending, Child Welfare Financing SFY2014, A Survey of Federal, State and Local Expenditures, that represents the most comprehensive effort to assess overall federal and state child welfare spending. That report indicated total financing of \$29.1 billion, with the federal government contributing 44% of that funding (\$12.8 billion) and the state and local public funds contributing 56% (\$16.3 billion), the largest portion of state funding in the form of required matching funding for Title IV-E.

Table 9 shows FY2016 federal expenditures for child welfare programs and services for all children and for the population prenatal to three.

Conclusion

Core federal investments in basic income, housing, nutrition, health care, child care and child welfare provide basic living supports for children 0-3 and their families essential to immediate safety and support. Currently, however, each of these is offering support at only a minimal and subsistence level for the most vulnerable families with young children. Cutting any of these would imperil more young children and could significantly increase, rather than reduce, the proportion of young children on jeopardized developmental trajectories.

A broader and more comprehensive approach to ensure livable wages and adequate housing is needed to fully close disparities experienced by young children due to their family's economic circumstances. We know, for example, that improving family income through tax credits or wages is associated with improved family outcomes.

Yet meeting the needs of children for safe, stable and nurturing home environments must extend beyond material needs and circumstances. Health care coverage and spending is essential to support not only clinical services to address injuries and illnesses, well-child checkups, vaccinations and treatment for chronic conditions and disabilities, but also to finance developmental interventions that address risks before they become serious medical conditions. Programs to strengthen and support families are needed before children become involved in the child welfare system, and can serve a dual role of building community in neighborhoods where young children and their families face the greatest challenges to success.

No single policy or public investment is likely to support families with young children in ensuring quality caregiving when they are working and not at home. Paid family leave policies that support families at all income levels and types of employment are one part of an answer. Increasing subsidies for and the quality of formal child care arrangements also will fill gaps. More generous, refundable child and dependent care tax credits would assist both moderate income and middle-income families in bearing the cost of child care. Resources directed to family, friend and neighbor caregivers can improve their ability to provide nurturing environments and address stresses they may face in this important role (and help build community in the process). Efforts are needed to make both child care and child welfare systems more appropriate and responsive for infants and toddlers.

In the earliest years, federal funding plays its greatest relative role in financing services, much more so than in either the preschool or school-aged years. Federal policies and investments govern most state and community

investments that are made. Federal programs and funding also provide a starting point, a foundation upon which to build. Yet for the youngest children, and particularly for the three in 10 on trajectories that seriously compromise their future success, services to strengthen families and assure healthy development are generally not available or in sufficient supply or sufficiently comprehensive in their approach to address their needs. For this population, what is needed is much more than better coordination of existing services.

The biggest opportunities for gains in improving young children's health and developmental trajectories are through expanding efforts to improve safety, stability and nurturing in the home environment and expanding community resources and opportunities in poor neighborhoods. Giving particular attention to young children and their families with identified individual or community risks but no diagnosis or crisis will require a fundamental shift in thinking and commitment. Dedicating increased amounts of federal, state, local and private funding to finance such expansions of capacity and support will be required, but the long-term benefits and the rates-of-return from such investments are ones that society cannot afford to ignore.

Appendices

The following appendices provide more explanation of the methodologies used to develop the expenditure and participation figures in this report, describe how federal funding relates to state and community funding, and how the information can be used at the community and state levels to support action. There is a further list of resources that were drawn upon in the production of this report.

The following is a brief description of each Appendix.

A. General Methodology for Expenditure Estimates. This appendix shares the overall approach taken to calculate federal spending on the population prenatal to three (to third birthday).

B. Accounting for State and Local Investments in Young Children. This appendix describes the importance of federal expenditures for the population prenatal to three in terms of overall public investments.

C. Estimating Medicaid Enrollment and Expenditures for Very Young Children and for Maternity and Newborn Care. This appendix describes the particular data sources and analytic tools used to determine overall spending (and enrollment) for Medicaid for maternity care and for young child care.

D. Apportioning the TANF and Social Services Block Grants. This appendix describes how both TANF and SSBG expenditures were further disaggregated and apportioned to the different spending categories within the report.

E. Estimates of Program Participation Levels for the Prenatal to Three Population. This appendix describes the methodology and data sources used to determine the numbers of children 0-3 (and where relevant, pregnant women) served by these programs.

F. Cross-System Federal Initiatives to Innovate and Test New Approaches to Advance Healthy Young Child Development. This appendix describes specific federal efforts to develop comprehensive and cross-system responses to young child and their development, which generally are small in terms of funding but important in terms of providing opportunities for innovation.

G. Roles for Communities and Grassroots Advocacy. This appendix describes how communities and advocates can use this information and these resources in their work at the community level.

H. References. This appendix provides a list of key resources use in developing this report.

APPENDIX A.

General Methodology for Expenditure Estimates

In conducting this analysis, we sought to be as consistent as possible with two other recognized and valuable descriptions of federal funding for children's services, prepared by First Focus (Children's Budget) and the Urban Institute (Kids Share). The Urban Institute (Kids Share) provides estimates and analysis of budget outlays in major federal funding streams for children and their families, including: income support, food and nutrition, housing, health, education (and early care and education), child welfare and family support. In 2013, the Urban Institute further broke down this spending to apportion it by age groups of children (0-2, 3-6, 6-12, and 12-18). This report relies primarily on the Urban Institute methods and estimates for infants and toddlers referred to in their report as 0-2 and herein as birth to three, or up to the third birthday. First Focus (The Children's Budget) also offers details regarding federal funding (budget authority and appropriations) for children and families, which have been used to further inform this report.

Except where otherwise noted, the budget numbers in this report are for federal fiscal year 2016. Our baseline figures for federal expenditures were drawn from the First Focus *Children's Budget 2016* and its apportionment of funding to children for programs serving a broader population than children. First Focus, as this report, draws on the work of the estimates and allocations developed in analyses by the Urban Institute. This report also drew upon the Urban Institute's *Kids Share 2016* (which actually reported on the 2015 budget and not the 2016 budget), particularly for tax expenditure information, which is not included in the First Focus analysis.

Note that the Urban Institute focuses on federal outlays and the First Focus Children's Budget generally reports on budget authority. Thus the Urban Institute reports on what was actually dispersed from the U.S. Treasury for the federal fiscal year and the First Focus reports on the level at which Congress funds the program for the fiscal year.

We further drew upon the Urban Institute's apportionment for programs by child age (0 to 2, 3 to 5, 6 to 11, 12 to 17) in its analysis of the 2011 federal budget, *How Do Public Investments in Children Vary by Age?* and its appendix describing the methodology for making that apportionment. We note that some changes between 2011 and 2016 may not be captured here. Since the categories of expenditure did not always match (the Urban Institute reports combine some of the programs in the First Focus *Children's Budget*), we made efforts to reconcile the Urban Institute's calculations in apportioning the Children's Budget 2016 numbers. When a multiplier/apportionment was not available for a particular program from the Urban

Institute, we tried to use a similar program or category. For example, in estimating expenditures in the Disability Insurance SSA program, we used the 2 percent multiplier which the Urban Institute applied to Social Security Survivors Insurance.

To compare our estimates to past figures and recent trends, we prepared a table with the Urban Institute 2011 estimates for this age group, as well as trends for all children of all ages from Urban Institute report for federal fiscal year and First Focus children's budgets for the years 2015 and 2016 from First Focus. (See references in Appendix H). This comparison to trends enabled us to identify any major inconsistencies, in effect to ensure our estimate is in the right "ballpark."

While we used these reports as a base, we also reviewed other reports and, in particular, federal data on specific programs and block grants, in order to refine some of the analyses. This was needed to take into account federal expenditures on prenatal and maternity, as well as newborn care. We limited our overall analysis of expenditures on pregnant women, in this respect, to those programs with a specific focus upon supporting pregnant women toward giving birth — Medicaid, the Maternal and Child Health Block Grant and the Supplemental Nutrition Program for Women, Infants and Children (WIC). Appendices C through E provide additional information on how we derived certain federal expenditures and on how we determined program participation levels for them.



In some cases, we developed a new multiplier. This was most often when our category of expenditures was distinctly different from what was used by Urban Institute for this population or for the larger set of programs combined together in the Urban Institute report. For example:

- The Child Care Food Program is more likely to support nutrition assistance to young children than the full child nutrition category compiled by Urban Institute, which included a larger array of nutrition programs for school age children. So we have applied a 20 percent multiplier instead of the 4 percent multiplier used by Urban Institute for this age group.
- For the grouping of newborn hearing screening, birth defects prevention, autism and similar programs (HRSA and CDC), we estimate that 75 percent of expenditures accrue to the prenatal, infant and toddler population.
- We estimate that only 10 percent of SAMHSA funding (e.g., children's mental health grants to states, Project LAUNCH) for infant-toddler mental health.
- For a few programs, we worked directly with federal agency staff, organizational experts and/or federal databases to get a more precise estimate, not simply a multiplier. (Other organizations also work with federal agencies; however, not necessarily for these categories.)
- Administration on Children and Families (ACF) staff directed us to the appropriate source to obtain Early Head Start spending, which is not reported separately in the overall Head Start budget.
- Data from the Title V Information System (TVIS) are available on federal spending for pregnant women and infants. Using TVIS data on children ages 1-22 and Census data, we calculated an estimate of the number and expenditures for children ages one and two. MHCBHRSAs was invited to comment on these estimates.
- By using federal databases on utilization and expenditures, an estimate on spending for pregnant women and young children was created for community health centers. The estimates were reviewed by analysts at the National Association of Community Health Centers and George Washington University who routinely work with these databases

We found that there is not a single source of information on the federal budget on how much is spent upon children, and there often were small differences in what was reported by First Focus or the Urban Institute and what was found in federal expenditure reports. There also were some decisions that had to be made in who benefits from a particular program, especially when it is directed at a family or household and not a child or an adult. The apportioning of SNAP benefits, for instance, considers children receiving a share of the benefits from the overall SNAP benefit the household receives, as do

TANF cash benefits. The EITC and Child Tax benefits going to households with children, however, are directed entirely to children. This is consistent with the analysis done by First Focus and the Urban Institute. We excluded programs directed to the employment of adults (work and training, job search and vocation and higher education supports), although some of these are used by youth and adults who are parents and are designed to contribute to their children's income and security. This is most notable in our exclusion of such job-related activities within TANF as constituting benefits to children.

The minor differences we found across different reports regarding the size and character of federal expenditures on children prenatal to three showed the complexity and imperfect nature of doing a report like this, but also reinforced one another that the estimates we developed very closely approximate the federal funding levels directed to this population. Appendix B also places this federal funding in the context of overall public (federal, state and local) funding for very young children and the foundational role that federal funding plays in this period of life.

APPENDIX B.

Accounting for State and Local Investments in Young Children

The Urban Institute's Kids Share report, *How Do Public Investments in Children Vary with Age?*, showed that per capita overall investments by child age were largest for those in the six to 18 population (primarily for K-12 education), while investments were smallest in the 0-3 years (and predominantly for income supports, health and nutrition). The BUILD Initiative's analysis, *Early Learning Left Out*, showed even more pronounced differences in public investments in children's learning and development, even when including services designed to support families in their parenting. For every dollar invested in the education and development of a school-aged child, the report showed only 25 cents was invested per preschooler (three to five) and seven cents per infant and toddler (zero to three). Most investments made in very young children (0-3) come either through federal funding or through state matching of that funding. In the case of Medicaid and Title IV-E, a formula is set for states required match of federal funds, with the federal government averaging picking up 63 percent of overall service costs.

With respect to federal block grants, this generally involves either a prescribed state match or requirements related to state maintenance of effort and continuation of efforts made at the time of the block grant establishment. Many states "overmatch" or exceed prescribed state matching, however. For example, in the Title V MCH Block Grant, states and jurisdictions must match every four dollars of federal Title V funds by at least three dollars of state or local funds, but most states overmatch. In 2015, of the \$306 million in federal Title V expenditures for pregnant women, 80 percent was state dollars and 20 percent was federal dollars. Similarly, of the \$433 million expended for infants, 91 percent was state dollars. While state matching is not required, the IDEA Part C Early Intervention program funding assumes that states will pay a portion of the share of this entitlement. WIC does not require state matching, but as a federally funded discretionary program, participation may be limited by annual funding set by Congress and states' supplemental funding. For home visiting, states have been making investments since the 1990s, when there was not a designated source of federal funds. Despite grants starting in 2010 from the federal home visiting program (MIECHV), a substantial share of states continues to appropriate state general revenues for home visiting. Some use state funds for specific models and others fund a variety of programs and models. Examples include: Arkansas, Colorado, Hawaii, Iowa, Massachusetts, Michigan, Minnesota, Missouri, New Mexico, New York, Vermont, Virginia and Washington. A number of states have directed state funding to communities for communities to invest in early childhood generally. Using dedicated tax dollars or state general revenues and

focusing on children from birth, these initiatives include Arizona Families First, California First Five, Early Childhood Iowa, Michigan Great Start, North Carolina Smart Start and Vermont Children's Integrated Services.

Overall, however, the level of state and local investment in the birth to three years, particularly in approaches to strengthening families and parenting, has been in the form of small demonstration projects. Unlike services for young children, states and their school districts and communities assume the major role in financing the K-12 education system. Over the last decade, however, many states have developed or expanded state-funded preschool programs for four-, and sometimes, three-year-olds. These actions have more than doubled the number and proportion of children receiving preschool as four-year olds, to over 35 percent of all children and to \$7.4 billion in state investments annually. Many states have made other efforts to expand child care availability and quality, often through support for quality rating and improvement (QRIS) systems directed to formal (child care center and family child development home) care, again often with an emphasis upon children 3-5, who are much more likely to be in formal systems of care covered by QRIS. A small number of states (e.g., Washington Department of Early Learning and Oregon Early Learning Hubs) have initiatives that support integration of early care and education services. No parallel investments have been made in family supports and child development programs for children 0-3.

In terms of income support, 26 states and the District of Columbia have state-specific tax credits that operate similarly to the federal Earned Income Tax Credit or Child Tax Credit. Not all of these are refundable and the size of the credits varies considerably. The same holds for child and dependent care credits.

While updating either the Urban Institute or BUILD analyses is beyond the scope of this report, there is nothing to suggest that state investments in children 0-3 have increased dramatically since these reports were conducted. By way of context, while the federal home visiting program was not included in those two prior analyses, MIECHV's overall investment of \$400 million represents a per capita amount of \$33 (if all the funding is allocated to 0-3), and would not significantly change the overall investment. The expansion of Early Head Start (with about \$1 billion in additional funding), would account for another \$83 per young child.

APPENDIX C.

Estimating Medicaid Enrollment and Expenditures for Very Young Children and for Maternity and Newborn Care

Together, Medicaid and the Children’s Health Insurance Program (CHIP) cover a large share of the nation’s children, and young children in particular. According to national Medicaid data, in 2016 the unduplicated count of children (birth to 18) covered sometime within the year by Medicaid (37.08 million) or CHIP (8.9 million) was 45.98 million in that age group. On a monthly enrollment basis, for March 2017, there were 35.78 million children enrolled in Medicaid or CHIP. Further, both Centers for Medicare and Medicaid Services 416 forms and the National Child Health Survey show that numbers and rates of enrollment are highest in the earliest years. The Form 416 reports regarding children’s use of Medicaid services (as submitted by states for 2015) showed 42.15 million children covered overall, with 7.24 million young children birth to three to seven) representing 17.2 percent of all children covered (while representing 15.1 percent of all children 0 to 18).



In 2015, there were 78.18 million children in the United States, 11.84 of them under the age of three. On an annual basis, this means that the reach of the Medicaid and CHIP programs for the under 18 population is, on an annual basis 58.8 percent and on a monthly basis 45.8 percent — with commensurately higher percentages for children zero to three. In short, more than half of all young children in the country now covered by Medicaid or CHIP at any point in time, and the number covered at some time during a calendar year this level approaches 60 percent.

For several reasons, Medicaid enrollment of children is highest for very young children, particularly for the first year of life. First, families with very young children experience the highest levels of poverty, with one in five children under the age of three living in poverty. Second, federal and state Medicaid eligibility levels for younger children generally are set at a higher family income level. In 2010, the federally minimum required eligibility level for children age six to 18 was 100 percent of the federal poverty level, but for pregnant women, infants and children birth to five it was 133 percent. Most states have used the option to establish higher eligibility levels for pregnant women and young children and, in 2010, the national median eligibility level for infants (under one year old) was 200 percent of the federal poverty level. Third, federal law requires automatic newborn eligibility when a birth is financed by Medicaid, and continuous enrollment throughout the first year of life. In addition, actual expenditures for primary and preventive care and response to illness and injury are higher for young children, as very young children see their primary care practitioner more frequently, both for scheduled well-child visits and for responses to colds and other illnesses. On the other hand, older children are more likely to receive mental health services and substance abuse treatment services, as well as dental care (where those are covered under Medicaid). Finally, while most Medicaid financed maternity care (including labor and delivery) is billed under the mother’s Medicaid number, newborn care is generally billed under the child’s number — and specialized neonatal intensive care (NICU) to treat preterm, low birthweight or other infants with congenital abnormalities is expensive and one of the highest cost treatments and reasons for hospitalization of children throughout the birth to 18 years.

Medicaid reports break out spending by three categories — children, persons with disabilities (which includes children with disabilities) and the aged. Our estimates may not fully account for the number of children with disabilities; however, from 0-3 fewer children qualified for Medicaid coverage on the basis of disability status compared to older age groups.

While those in the category “children” are half of the Medicaid population, they account for somewhere around 20 percent of Medicaid costs. This report has drawn upon First Focus’ and the Urban Institute’s estimates of spending on children overall, and the Urban Institute’s calculation that 29 percent of that spending (because of newborn costs) goes to children 0-3.

Calculating Medicaid expenditures for the prenatal to three period also requires developing estimates of maternity care (prenatal, birth and postpartum) care. In most instances, maternity care is covered under the mother's Medicaid number, while postnatal newborn care is covered under the child's number. In most instances (when the birth is to a mother aged 19 or over), the mother also is an adult and not a child under Medicaid.

Federal and state agencies do not routinely report separately on maternal and newborn expenditures in Medicaid. A number of studies have used other national databases to estimate costs. The most recent study estimating Medicaid expenditures for maternal and infant care (using 2010 data) showed that the average payments under Medicaid for maternal and newborn care at the time of birth were about \$10,500, of which \$2,540 was prenatal care, \$4,140 was birth or postpartum care and \$3,790 was newborn care. It was not reported in that study how much of this amount is billed to the mother's Medicaid number (as most maternity care expenses are billed to the mother), and how much was billed to the child's Medicaid number. Other studies of spending on childbearing between 2000 and 2010, including a series that use Medical Expenditure Panel Survey (MEPS) data, show approximately \$7,000-\$8,000 in maternity care spending under Medicaid.

While we have been unable to find a more recent estimate of Medicaid expenditures for maternity and newborn care, we know that the cost of maternity care and payments under Medicaid both have increased since 2010. For 2015, we use an estimate of \$10,000 per Medicaid financed birth for maternity care (prenatal, birth and postpartum) expenditures.

We also know that the proportion of births covered under Medicaid has risen, in part because additional women of childbearing age were covered under Affordable Care Act expansions. In 2015, there were 3,977,745 births and 2,086,525 infants enrolled in Medicaid. We estimate that Medicaid financed a little more than half of all births in the United States — or 2 million births, somewhat higher than the number noted on birth certificates. (There is underreporting of Medicaid as source of payment on birth certificates in part because coverage has not always been determined at the time the birth certificate is completed).

Therefore, we estimate that current Medicaid payments for prenatal and maternity care billed to the mother's Medicaid number are 2 million births X \$10,000 or \$20 billion dollars. Since the federal government assumes an average of 63 percent of this amount, the expenditures for maternity care are estimated to be \$12.6 billion. Newborn costs are included in the table for 0-3 expenditures.

For other Medicaid expenditures, we took the Medicaid report on spending both on children and on persons with disabilities (apportioning a share of that amount

for children) and the amount spent on administration for children with Urban Institute recommendations on apportioning expenditures.

The figures in the report are imperfect estimates of total federal Medicaid spending on the prenatal to three period and should be considered as ballpark estimates. Given the importance to states and the nation in understanding both the extent of public (Medicaid and CHIP) coverage of children and of prenatal care through childbirth, we believe that reporting systems at the state and to the federal level should be enhanced to provide the information that we have estimated.

At the same time, these estimates are sufficient to show that Medicaid (particularly with CHIP) provide the majority of the health coverage for the birth and care of very young children in the United States, and particularly the health coverage for those most vulnerable to poor child health trajectories. Therefore, how they provide coverage and the content of the coverage they provide are critical to children's healthy development, particularly in the birth to three years. In addition, it is important to recognize that the overall expenditures on most children (with the exception of certain medically complex instances which often are within the disability coverage area), outside of childbirth, primarily involve primary care. Children definitely are not drivers of health costs or the high cost users of health services in Medicaid; but their healthy development can be impacted by the quality and availability of developmental health services and supports.

Note that CHIP provides additional supports to states to cover children at higher eligibility levels than those set for Medicaid. This can be through the Medicaid (Title XXI) program, which is then included in the Medicaid counts for children served. It also can be through a private coverage option. There is some movement between Medicaid and CHIP among children and Medicaid, because of its higher eligibility levels for young children and the higher rates of poverty and low income among children, generally has a larger proportion of young children than CHIP. CHIP is not discussed separately in this report, but its contribution to prenatal to three health care (\$2.016 billion) is included in the health expenditure section.

APPENDIX D.

Apportioning the TANF and Social Service Block Grants

States are given broad flexibility on what services to provide under both the Temporary Assistance to Needy Families (TANF) and Social Services Block Grant (SSBG). States vary widely in how they make use of TANF funding, but national reporting provides overall information on how each state uses its funding — for direct income support, for child care and for other services, which may be directed to either children or adults. This report separates funding under each of these programs in the general categories (income support, health, child care, child welfare and family support) used in this report.

Temporary Assistance to Needy Families (TANF)

While TANF and its predecessor, the Aid to Families with Dependent Children (AFDC) program, traditionally provided a major share of their support in the form of monthly cash assistance payments to families, that is no longer the case. TANF now provides a much smaller share

of its funding to cash assistance and also directs some of its funding to other block grants, both SSBG and the Child Care and Development Block grant. SSBG is the oldest of the federal block grants and states use it for a variety of purposes, serving both children and adults. There is wide variety in the use of both block grants, but the federal government requires reporting within general categories, which can be used to apportion the expenditures both by the amount directed to children (and to young children) and the type of services. The most recent breakout of TANF spending is for FY2015 and for SSBG spending for 2014. Spending in FY2015 and FY2014 was slightly less than that for 2016, so an additional general figure was added to reflect 2016 spending.

Table D1 shows the breakout of spending for TANF, with subtotals for categories shown in the report (e.g. income supports, child welfare, child care, family support services.

Table D1.
TANF Expenditures by Category
 MILLIONS OF DOLLARS

	TOTAL FUNDING	PERCENT FOR 0-17	FUNDING 0-17	PERCENT 0-3	FUNDING 0-3
TANF Cash Benefits	\$ 4,013	75%	\$ 3,010	22%	\$ 662
Other Cash Assistance	\$ 727				\$ 130
Emergency Assistance	\$ 264	.75%	\$ 198	.22%	\$ 44
Non-Recurrent Short-Term Benefits	\$ 167	.75%	\$ 125	.22%	\$ 27
Refundable EITC	\$ 296	100%	\$ 296	20%	\$ 59
Foster Care (FC) & Child Welfare	\$ 1,903				\$ 256
Foster Care and Adoption Payments	\$ 144	100%	\$ 144	7%	\$ 10
Child Welfare Prior Law FC Payments	\$ 380	100%	\$ 380	.16%	\$ 61
Child Welfare Prior Law FC Services	\$ 389	100%	\$ 389	7%	\$ 27
Child Welfare Services	\$ 990	100%	\$ 990	.16%	\$ 158
Child Care	\$ 2,622				\$ 900
Child Care Assistance	\$ 1,250	100%	\$ 1,250	35%	\$ 438
Transferred to CCDF	\$ 1,320	100%	\$ 1,320	35%	\$ 462
Preschool	\$ 52	100%	\$ 52	0%	\$ 0
Family Support Services	\$ 735				\$ 139
Fatherhood	\$ 88	100%	\$ 88	30%	\$ 26
Home Visiting	\$ 21	100%	\$ 21	80%	\$ 17
Supportive Services	\$ 221	.75%	\$ 165	20%	\$ 33
Services to Children and Youth	\$ 225	100%	\$ 225	.16%	\$ 36
Emergency Services under Prior Law	\$ 180	.75%	\$ 135	20%	\$ 27
Transfer to SSBG	\$ 1,165				

Social Services Block Grant (SSBG)

Table D2 shows the breakout of spending for SSBG, with the last column showing the category in which each item was placed in the report. States vary widely in their use of SSBG, with 44 percent of those served children and 56 percent adults, overall but states having very different configurations of amounts. Similarly, some states transfer no funding from TANF to SSBG, while others transfer the maximum allowed. The latest SSBG annual report provides

a breakout of spending by 30 different categories, some clearly for children and for adults, but others (case management, prevention and intervention) unspecified. Those which constitute programs where a significant share is directed to children are shown in the Table. The report (Table F3 provides the detail) is available at: https://www.acf.hhs.gov/sites/default/files/ocs/ssbg_2014_annual_report_final_508_compliant.pdf

Table D2.
SSBG Expenditures by Category
 MILLIONS OF DOLLARS

	TOTAL FUNDING	PERCENT FOR 0-17	FUNDING 0-17	PERCENT 0-3	FUNDING 0-3
SSBG	\$ 1,584				
SSBG transferred from TANF.	\$ 1,165				
Total	\$ 2,749				
Child Welfare Services	\$ 426	100%	\$ 426	9%	\$ 38
Child Protective Services	\$ 329	100%	\$ 329	20%	\$ 66
Child Care	\$ 300	100%	\$ 300	35%	\$ 105
Prevention, Case Management, Counseling	\$ 573	36%	\$ 206	20%	\$ 41
Disability Services.	\$ 272	30%	\$ 82	5%	\$ 4
Other	\$ 400	53%	\$ 212	11%	\$ 23
Other Adult and Senior Services.	\$ 449	0%	\$ 0	0%	\$ 0

APPENDIX E.

Estimates of Program Participation Data for the Prenatal to Three Population

11,840,000 Children 0-3

(Infants and toddlers younger than three, prior to third birthday)

4,000,000 Births



Earned Income Tax Credit

The Internal Revenue Service publishes a table of returns with the Earned Income Tax Credit. The latest available for the 2014 tax year (<https://www.irs.gov/uac/soi-tax-stats-individual-income-tax-returns-publication-1304-complete-report>). This includes information both on tax filers receiving a refund and those having their tax liability lowered.

In 2014, there were 28,537,908 claiming an EITC, with a total amount of tax credits equal to \$68,339,181,000, of which the refundable portion was \$58,888,895,000, with 24,644,199 returns getting a refund.

EITC Refunds:

7,300,000 children 0-3

TANF Enrollment:

498,000 children 0-3

SNAP Participation:

4,100,000 children 0-3

WIC Participation:

5,250,000 children 0-3
and 900,000 pregnant women

Housing Subsidy Recipient:

540,000 children 0-3

LIHEAP Participation:

830,000 children 0-3

Medicaid/CHIP enrollment:

6,000,000 0 to 3 + 2,000,000 pregnant women

Title V MCH Block Grant Program Contact – pregnant women and children 0-3

Community Health Center Patients:

150,000 children 0-3

IDEA Part C Early Intervention Participation:

360,000 children 0-3

MIECHV Participation: 90,000 children 0-3

Early Head Start Participation:

160,000 children 0-3

Child Care Subsidy Participation:

407,000 children 0-3

Foster Care Placement:

97,000 children 0-3

Confirmed Victims of Maltreatment:

190,000 children 0-3

Post-response Child Welfare Services Provided:

360,000 children 0-3

- There were 9,473,064 returns with one qualifying child receiving a refund, with an amount refunded of \$21,195,632.
- There were 6,855,947 returns with two qualifying children receiving a refund, with an amount refunded of \$23,792,338.
- There were 3,309,578 returns with three or more qualifying children receiving a refund, with an amount refunded of \$12,416,711.

Calculations: The number of children in households with EITC refunds is estimated to total 9.5 million plus 13.7 million (2 x 6.85 million) plus 11.5 million (3.5 x 3.3 million) or 34.7 million children. Taking the Urban Institute's estimate that 21 percent of the benefits go to children 0-3 (slightly above their proportion of all children), the number of children 0-3 in families receiving an EITC refund is calculated as 7.3 million children 0-3. There currently are 11.8 million children 0-3, so this works out to 62 percent of all young children in households receiving a refund.

TANF Recipient Data

The Office of Family Assistance produces reports on the Characteristics and Financial Circumstances of TANF Recipients, with the latest report for 2015 (<https://www.acf.hhs.gov/ofa/resource/characteristics-and-financial-circumstances-of-tanf-recipients-fiscal-year-2015>).

That report shows 1,333,707 families on public assistance, with an average household size of three, of which 648,669 were families with no adult recipients, 626,247 with one adult recipient and 58,888 with two or more adult recipients. Of those with no adult recipient, 22.9 percent were SSI recipients.

There were 2,370,198 children on assistance, 83 percent the child of the head of household, 11.6 percent the grandchild and 5 percent some other designation. Of these children, 14.3 percent were under the age of two and 26.6 percent were between two and five, or (author's estimate) 21 percent under the age of three. Of these children, 25,450 or 1.1 percent received disability benefits.

There were 744,257 adult recipients, 112,300 males and 631,957 females. Of these, 48.6 percent had less than a high school education, 53.9 percent had only a high school diploma and 7.5 percent had more than high school. 26.7 percent were employed and 0.7 percent received disability benefit.

Of the total recipients, 614,434 were teens, and of those 5.1 percent, or 31,432 were teen parents, 81.4 percent the head of household.

Among all families, the young child was unborn in 1.2 percent of families, 13.2 percent under age one, and 20 percent under age two, constituting 34.2 percent of all families (but a lesser percentage of actual children).

Of the families on TANF, 88.7 percent received medical assistance, 11.6 percent subsidized housing, 84.3 percent SNAP benefits and 8.2 percent subsidized child care. Of all families, 11.4 percent received child support.

Note: This report also provides racial breakouts for a number of categories, and provides state-level as well as national data.

Calculation: 2,370,198 children x 21 percent of children = 498,000 children 0-3 receiving TANF

Supplemental Nutrition Assistance Program (SNAP)

The United States Department of Agriculture produces an annual statistical report on the SNAP program, the most recent of which is for 2015 (<https://fns-prod.azureedge.net/sites/default/files/ops/Characteristics2015.pdf>).

In 2015, 45,184,000 participants were in households receiving SNAP, 19,891,000 million of those were children. Of those children, 2,371,000 were between the ages of 0-3, and 3,749,000 were between the ages of three and five. Based upon this, it is estimated that 4,100,000 were between the ages of 0-3. They received, in prorated benefits, (apportioning equally each individual's benefits from the household benefit), \$490,000,000 million in benefits (note: this is different from the calculation made based upon the Urban Institute and First Focus reports).

Overall, there were 22,293 households participating in SNAP, with 9,510 including children. Of the households with children, 54.9 percent had earned income, 24.5 percent had social security, 20.5 percent had SSI, 22.2 percent had zero income, 12.9 percent had TANF and 1.5 percent had general assistance.

Calculation: 4,100,000 children 0-3 receiving SNAP benefits

Special Supplemental States Department tics report, the most Nutrition Program for Women, Infants, and Children (WIC). The Unit of Agriculture produces an annual WIC Participant and Program Characteristics report for 2014 (<https://www.fns.usda.gov/sites/default/files/ops/WICPC2014.pdf>).

The report shows numbers for April 2014 of: 896,551 pregnant women, 1,30,900 breastfeeding or postpartum women, 2,141,988 infants under the age of one, 1,819,921 one- to two-year-olds and 1,286,485 two- to three-year-olds.

About 90 percent of recipients reported income and 7.5 percent indicated participation in TANF. Of those reporting income, 37.8 percent had income below 50 percent of poverty, 36.3 percent between 50 percent and 100 percent of poverty, 12.3 percent between 101 and 130 percent of poverty and 12.6 percent above 130 percent of poverty. Calculations: 0-3 participation is 5,248,394 and pregnant women is 896,551.

Housing Programs Providing Assistance

The Center on Budget and Policy Priorities has summarized the total number of rental subsidies available to families, indicating that 35 percent of those households have children. These subsidies include: 2,217,000 households with housing choice vouchers, 1,020,000 with public housing and 1,175,000 with Section 8 project-based housing, totaling to 5,150,000 people using housing assistance.

These different HUD programs serve 1.74 million families with children, of 34.8 million families with children (8.4 million families have a child under the age of three), or 5 percent of all families.

Calculations: With 29 percent of all families having a child under three (8.4 million/34.8 million), one estimate is that 29 percent of the 1.74 million families served have a child under three, or 505,000 families (with some having more than one child under two). Taking 35 percent of the 5,150,000 subsidies provided to families with children and considering zero- to three-year-olds as 15 percent of that total produces an estimate of 540,000 children 0-3.

LIHEAP Home Heating

LIHEAP data regarding its largest program, home heating, shows that, overall, 5.7 million households received heating assistance in 2014, 1.4 million of them households with children under five (of 12.7 million families with children under five, or 11 percent of those households). A somewhat smaller percentage of these households would have children under three (census data shows 8.4 million households with children under three, or 66 percent of those under five). Families with children under three receiving LIHEAP home heating assistance is approximately 7 percent of the 11.8 million young children, or 830,000 children 0-3.

Medicaid and CHIP

See Appendix C.

Community Health Centers

Community health centers routinely report data on utilization and expenditures to the federal Health Resources and Services Administration (HRSA). HRSA makes health center data available online, as reported by grantees, with the latest data being for FY2015 (<https://bphc.hrsa.gov/uds/datacenter.aspx>). That information shows 24,295,946, with 31.2 percent of those children and 13.1 percent of those uninsured children.

Calculations: A rough calculation of zero- to three-year-olds served in Health Centers not served by other insurance coverage is 15 percent of all uninsured children served or 150,000 among zero to three.

Title V Maternal and Child Health Block Grant

Under the Title V MCH Block Grant, states make annual reports on utilization and expenditures by population.

HRSA provides this data in aggregate for the nation as part of the Title V Information System (TVIS). For FY2015, states reported making contact with 2.6 million pregnant women, 3.9 million infants birth to one.

Based on Census Bureau population estimates and TVIS utilization among children ages one to 22, we estimated the number of toddlers one and two years old to be 3.5 million. Thus, Title V served an estimated 10.0 million pregnant women, infants and toddlers.

Part C of the Individuals with Disabilities Education Act. The U.S. Department of Education provides a number of reports on Part C, drawing from state 618 reports. The latest are from FY2015 (<https://ed.gov/programs/osepidea/618-data/static-tables/index.html#partc-cc>).

For 2015, 47,846 children under age one, 112,855 children age one to two and 197,012 children age two to three received Part C services, for a total of 357,715 children. The cumulative number is 690,174.

Calculation: The number of zero- to three-year-olds receiving services is 360,000.

Maternal, Infant, and Early Childhood Home Visiting

The Maternal and Child Health Bureau provides information on the Maternal, Infant and Early Childhood Home Visiting Program (MIECV), including an infographic with the following participation figures for 2015 (<https://mchb.hrsa.gov/sites/default/files/mchb/MaternalChildHealthInitiatives/HomeVisiting/fy2015homevisitinginfographic.pdf>).

MIECHV served 145,500 parents and children, providing 894,000 home visits, in 2015 and reports 160,000 parents and children served in 2016.

77 percent of families had incomes below the poverty level (46 percent below 50 percent of the poverty level), 31 percent of adults had less than a high school diploma (and 35 percent had only a high school diploma), 22 percent of newly enrolled households had a pregnant teen, 12 percent reported substance abuse and 15 percent reported a history of child maltreatment.

Calculation: Estimating that half of all parents and children served are children, in 2016 80,000 children 0-3 were served.

Early Head Start

The federal government provides detailed data on Head Start through its Performance Information Reporting (PIR) data (<https://eclkc.ohs.acf.hhs.gov/hslc/data/pir>), which is now available for FY2015.

Center for Law and Social Policy (CLASP) has a searchable database that provides both state and national information on a number of federal programs, including Head Start and

Early Head Start (<http://www.clasp.org/data>). The CLASP database has statistics from the FY2014 PIR data, showing that 145,308 children and 14,299 pregnant women participated in Early Head Start. This involved 132,896 families (some families had more than one child under three).

Of these, 58 percent were single-parent families, 17 percent participated in WIC, 12 percent received housing subsidies and 75 percent participated in WIC.

Half of the participants were receiving home-based/home visiting, while half were receiving center-based services.

Calculation: Early Head Start participation = 160,000 children and pregnant women, 80,000 in center-based and 80,000 in home-based services.

CCDBG — Child Care

The Administration on Children and Families of the U.S. Department of Health and Human Services reports data on the Child Care and Development block grant annually (<https://www.acf.hhs.gov/occ/resource/ccdf-statistics>).

For FY2015, the average monthly participation was 1,456,300 children from 852,000 families. By age, the percentage of children served was: 28 percent 0-3, 37 percent three to five, and 35 percent six to 11.

Overall, 65 percent families had co-payments, and 13 percent of families participated in TANF.

Calculation: CCDBG 0-3 participation = 1,456,300*.28 = 407,000.

Foster Care and Adoption Assistance Data

The Administration for Children and Families of the U.S. Department of Health and Human Services provides an annual Adoption and Foster Care Analysis and Reporting System (AFCARS) data report, the most recent for FY2015 (<https://www.acf.hhs.gov/cb/resource/afcars-report-23>).

That report shows the number of children entering, leaving and in care and awaiting and receiving adoptive placements, with breakdowns by child age.

On September 15, 2015, there were 427,910 children in care, 96,660 age 0-3 (22 percent of all children).

There were 269,500 entering care in FY2015, 85,089 age 0-3 (25 percent of all children), including 47,219 age 0-3.

There were 243,060 exiting care in FY2015, 49,937 0-3 (22 percent of all children).

There were 111,820 waiting to be adopted, 25,412 0-3 (23 percent of all children).

There were 53,549 adopted, 15,083 0-3 (28 percent of all children).

The data also include information by race and type of placement, and can be disaggregated in multiple ways, including information by state.

Calculation: 917,000 children 0-3 in foster care.

Child Maltreatment Data

The Children's Bureau of the Administration for Children and Families produces a detailed annual report, Child Maltreatment, based upon its National Child Abuse and Neglect Data System (NCANDS). The most recent report is for 2015 (<https://www.acf.hhs.gov/cb/research-data-technology/statistics-research/child-maltreatment>).

The report shows that, while there are 4 million reported cases of abuse to child protective service systems (involving 7.2 million children), only a portion (58 percent; 2.2 million cases and 3.4 million children) are subject to investigation and only a small share of these receive are confirmed cases that the child is a victim of maltreatment (683,487). Following either investigation or an alternative response (some states provide for a different response to more minor allegations), some children receive post-response services (402,300 victims and 887,131 non-victims) and 146,262 victims and 58,544 non-victims receive foster care services. In 433,489 of the confirmed cases (63.4 percent), neglect (or medical neglect) was the only reason for confirmation. In 481,925 (71 percent) of the cases, the confirmation was the first received for the child.

Young children are the most likely age group to be subject to investigation. They also are the most likely to receive a disposition as a victim of maltreatment. This includes 97,044 children zero to one, 47,310 children one to two and 45,302 children two to three of the entire population of 683,487 victims of maltreatment, 189,656 young children in all and 28 percent of the overall child victim population.

If post-response services were provided to young children at the same rate as for older children, this would mean, according to the state reporting, that 112,000 victims receive post-response services and 248,000 non-victims receive post-response services.

One of the Tables in the report also enumerates the number of children that states report as receiving preventive services, but the information is very incomplete. It does include most of the same funding sources as are enumerated in the Child Trends report.

Calculations: 190,000 0-3 child victims of maltreatment, 360,000 0-3 children receiving post-response services.

APPENDIX F.

Cross-system Federal Initiatives to Innovate and Test New Approaches to Advance Healthy Child Development

In addition to providing federal funding through the categorical funding efforts described earlier, the federal government also has provided funding to innovate and test more systemic responses that cross traditional funding areas, typically as pilot, demonstration or research programs. Several, like Healthy Start, the Early Childhood Comprehensive Services System (ECCS) grants from the Maternal and Child Health Bureau and Project LAUNCH from the Substance Abuse and Mental Health Services Administration, have become ongoing initiatives, although the selection of grantees and the specific foci of the work may change. Others, like the Race to the Top Early Learning Challenge grants (jointly developed by the Department of Education and the Department of Human Services), the Promise Neighborhoods grants (under the Department of Housing and Urban Development) and Strong Start (under the Center for Medicare and Medicaid Innovation Center), while they represent multiyear initiatives, are not funded as ongoing activities. The federal government also has provided opportunities, through Title IVe waivers in child welfare and home and community-based waivers and 1165 waivers in Medicaid, for states to develop more cross-system approaches to achieve the goals for their systems.

The lessons learned from these efforts can inform practice development in the field and even give rise to new overall federal funding approaches and efforts. The ones described below all have had some emphasis upon improving child health trajectories prenatal to three, across physical, social, emotional and educational development and through involving multiple service sectors to this end.

The **Early Childhood Comprehensive Services (ECCS) grants**, begun in 2003, have been directed to states to support cross-system planning to promote healthy early childhood development. Previously awarded to virtually all states, they were restructured in 2015 into a competitive grant program to focus specifically on improving developmental trajectories of children birth to three in select high need communities — with a collaborative innovation and improvement network (CoIIN) of participating states and the federal government working together to improve children’s developmental trajectories in up to five designated communities in each grantee site. Ten grantee states and two grantee organizations were selected and began a five-year grant cycle in July 2016, with overall funding to the grantees and the CoIIN Coordination Center of \$6 million, annually.

The **Promise Neighborhoods Initiative**, again under a competitive grant process, provides support to eight communities for “cradle to career” actions to dramatically improve children’s development and educational process in high poverty neighborhoods, based upon a comprehensive approach designed to improve results on a population level as well as with individual children. Inspired by the Harlem Children’s Zone (which included as a “Baby College” component that started the cradle to career efforts by engaging families with infants), the Promise Neighborhood sites all have some focus upon strengthening families of very young children, although most of the resources and funding (\$73.3 million in 2016) are directed to older children, including school transformation.

Through three phases beginning in 2012, the federal government invested nearly \$1 billion in **Race to the Top Early Learning Challenge grants**, providing funding of \$40 million to \$100 million to 20 states for four-year efforts to build early learning systems that both improve overall school readiness and reduce disparities in child development for children. The specific goal of the Race to the Top Early Learning Challenge grants is “to improve the quality of early learning and development and close the achievement gap for children with high needs.” Grantees focus on: (1) Increasing the number and percentage of low-income and disadvantaged children in each age group of infants, toddlers and preschoolers who are enrolled in high-quality early learning programs; (2) Designing and implementing an integrated system of high-quality early learning programs and services; and (3) Ensuring that any use of assessments conforms with the recommendations of the National Research Council’s reports on early childhood. While there is no new federal funding in 2016, the states in phases two and three are continuing their work and funding from the upfront funding they received. States also have been encouraged to integrate health into their strategic responses and to engage families and support family leadership.

In 2012, the Center for Medicare and Medicaid Innovation (CMMI) within CMS, launched the Strong Start for **Mothers and Newborns Initiative**, which directed \$100 million to a competitive grant program designed specifically to improve birth outcomes and reduce preterm births through more comprehensive approaches to prenatal care that, in particular, focus upon responding to social, emotional and fiscal supports as well as providing clinical prenatal services. Strong Start is supporting 182 separate sites that are completing the four-year demonstration.

Since its creation in the Affordable Care Act (where it received \$10 billion in funding), CMMI also has provided **State Innovation Models (SIMs) Initiative** grants to over 34 states, three territories and the District of Columbia, to develop new financing strategies that emphasize value over volume and seek to achieve the triple aim of improved health quality, improved population health and reduced per health care costs. Several of the states have some focus in their work on young children, and several have a particular focus upon addressing social as well as biomedical determinants of health. While the lion's share of the CMMI funding both in the SIMs grants and in its other initiatives has been directed to high cost patient populations (particularly seniors and disabled adults receiving care under Medicaid and Medicaid), CMMI, through a **Children's Alternative Payment Model Request for Information** is currently exploring the role it can play in promoting value-based care for children through alternative Medicaid financing strategies.

Since established in 1991, **Healthy Start** has grown from a demonstration project in 15 communities to a demonstration in 100 sites across 37 states. Healthy Start targets communities with infant mortality rates that are at least one and a half times the U.S. national average and works to reduce other negative birth outcomes as well as infant mortality. Healthy Start uses five strategic approaches to provide individual services and community support to women, infants and families: (1) Improve women's health before, during and after pregnancy; (2) Promote quality services; (3) Strengthen family resilience; (4) Achieve collective impact and (5) Increase accountability through quality improvement, performance monitoring and evaluation. The funding for Healthy Start in 2016 is shown in the health section and was \$100 million.

Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) promotes the wellness of young children ages birth to eight by addressing the physical, social, emotional, cognitive and behavioral aspects of their development. States, territories and tribes select a local pilot community within the larger jurisdiction to be a partner in Project LAUNCH. Local communities have a dual focus on improving collaboration across the child-serving system and improving access to and availability of evidence-based prevention and wellness promotion practices. Grantees implement five core prevention and promotion strategies: (1) screening and assessment in a variety of child-serving settings, (2) enhanced home visiting, (3) mental health consultation in early care and education programs, (4) family strengthening and parent skills training and (5) integration of behavioral health into primary care. Innovative and effective prevention/promotion practices at the local level serve as models to be sustained and replicated throughout the state, territory and tribe. Since 2008, Project LAUNCH generally has awarded five to eight grants annually (both to states and

to communities) for five-year demonstration efforts, with specific grant awards of \$3.4 million in 2015.

Enacted in 1994, Section 1130 of the federal Social Security Act gives the Secretary of Health and Human Services the authority to approve **Title IVE waivers** (for foster care and adoption assistance) to finance demonstrations that provide more flexible use of those funds to better achieve IVE goals to of safety, permanency and well-being of children. Congress reauthorized HHS to approve up to 10 waivers per year in federal fiscal years 2012 through 2014 and revised certain demonstration project goals and requirements. One of the goals of these waivers has been to enable states to respond more preventively to avoid the need for placement through preserving and strengthening families. While IVE funding now primarily goes for placement (or adoption) services to older children, initial entry into foster care is most likely to occur in the early years (birth to three), where opportunities for prevention efforts to preserve families and avert placements or long-term engagement with the child welfare system are greatest.

Medicaid has established three different **Medicaid waiver** programs that enable states flexibility in developing service systems that can extend beyond traditional medical services in order to achieve patient health goals. These waivers generally require that state waivers achieve equivalent or better health outcomes while maintaining federal cost neutrality, although in select cases (such as Oregon's waiver) this neutrality can be defined over a period of years, recognizing upfront investments in prevention do not have their major fiscal impacts over a single year or contractual period. The three different federal waiver types are: (1) Section 1115 Research and Demonstration Projects to test new or existing approaches to financing and delivering Medicaid and CHIP, (2) Section 1915(b) Managed Care Waivers to provide services through managed care delivery systems or otherwise limit people's choice of providers and (3) Section 1915(c) Home and Community-Based Services Waivers to provide long-term care services in home and community settings rather than institutional settings.

APPENDIX G.

Roles for Communities and Grassroots Advocacy

While many funding decisions are made at the state or federal level, ensuring service quality, promoting system integration and the blending of funds happen mainly at the community level. Further, city and county governments play core and often primary roles in financing and providing recreational programs, community center activities and public services such as libraries, as well as supporting housing programs and supporting neighborhood associations and groups. Local school districts provide educational services that can be initiated even before children enter school and have footprints and represent loci for parent engagement within most neighborhoods.

Communities also know their geography best and have the most on-the-ground opportunities to engage both those providing frontline services through public funding streams and those in the voluntary sphere representing social, spiritual, artistic and community capital. Moreover, it is at the neighborhood and community level that the voices of parents are most likely to be raised and the opportunity for dialogues across racial, language, cultural and class lines to occur. And, it is where the use of data, particularly when broken down by census tract and neighborhood, can inform action.

Much of the data that can be used to focus attention on young children, their families and their needs, already exist and are part of public systems and publicly available. Further, there are requirements on many institutions to conduct community assessments. Many grant programs require needs assessments to secure funding. Many of the nation's largest cities have nonprofit organizations, represented as members of the National Neighborhood Indicators Partnership, committed to “democratizing information” and making a broad range of data available, on a census tract, neighborhood or zip code level, for residents, nonprofit organizations and grassroots advocacy voices.

Importantly, as part of their nonprofit status, nonprofit hospitals are required to conduct community assessments at least every three years, and to employ the results from these assessments to provide “community benefits.”

While community leaders generally recognize that disparities exist in access to resources and supports across different neighborhoods, particularly in terms of physical and economic resources, there often has been much less developed with respect to young children and other resources that support them and their families. Both the process and the product in conducting assessments is important. The product can be specific, quantifiable data about these disparities instrumental in focusing greater attention and informing action. The process can offer

opportunities for engagement and leadership of parents and residents themselves.

Young children and their families need adequate resources to meet basic needs for food, shelter, clothing and transportation and to make investments in their future — which often must be addressed at the state and federal levels. But they also need social supports and opportunities for participation and engagement — one's that draw upon their own initiative and leadership and often primarily involve voluntary and community support. To be most effective, services which touch the lives of young children and their families must be responsive to and have ownership from those being served. In short, they need to be embedded within the community and not only responsive to, but in many instances representative of the culture, language and ethnicity of those they serve. It truly is at the community level that this needs to occur — and then needs to be used to advocate for the other necessary services, supports and investments needed at the state and federal levels.

Suggested Roles for Community in Monitoring Federal Funding and Availability

What may be best for communities to do is not to try to recreate a federal funding scan that covers such programs as Medicaid, EITC, SNAP, TANF and other programs, but instead to seek to identify the more preventive, developmental and family strengthening (protective factoring) sources of support in their communities, including how these are funded and making sure that MIECHV and Early Head Start are included and any preventive programs which may be funded under other federal sources (CAPTA, SAMSA, SSBG, etc.) are included.

In addition, communities can and should drill down below the community to the neighborhood (census tract) levels in identifying both the location of those services/sources of support and where the needs exist.

Communities are in the position to further strengthen and support programs and services offered by faith institutions, hospitals, schools, libraries, community centers and other local institutions and to leverage support from United Ways, Community Foundations and other civic, health and housing entities.

APPENDIX H.

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