



The Future of Medicaid and Child Welfare

Background

Medicaid is a vital part of the safety net for the children and youth in the child welfare system. Under federal statute children receiving Title IV-E foster care and adoption assistance are categorically eligible for Medicaid. Additionally, all states currently extend Medicaid benefits to non-IV-E eligible children in foster care. Children in foster care are at higher risk for physical and mental health issues, stemming from the maltreatment that led to their placement or from preexisting health conditions and unmet long-term health care needs. Medicaid covers their basic health care needs and serves as the major source of coverage for special services. These include rehabilitative services, targeted case management, and in-patient psychiatric services. Federal law and regulations require states to provide Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services to Medicaid eligible children under the age of 21. The EPSDT program is an essential element of providing health care to children in foster care and screens children to uncover physical challenges, mental health problems, developmental delays, and dental needs.

High Share of Medicaid Expenditures

Children in foster care account for a disproportionately high share of Medicaid expenditures when compared to other children in the Medicaid program. For example, although children in foster care represent only 3.7% of the nondisabled children enrolled in Medicaid, they account for 12.3% of total expenditures and 25 to 41% of Medicaid mental health expenditures.¹ In California, for example, Medicaid-eligible children in foster care accounted for 53% of all psychological visits, 47% of psychiatry visits, 43% of the public hospital inpatient hospitalizations, and 27% of all psychiatric inpatient hospitalizations among the program's entire child population. A Pennsylvania study found that Medicaid mental health-related expenditures for children in foster care are nearly 12 times greater than costs for non-foster children.²

Disruptions in Coverage

Aside from their unique and often unmet needs, placement instability is too often a fact of life for children in child welfare, further limiting their access to stable health care services. Children in child welfare systems may churn in and out of Medicaid depending on the practices in a given state or county program. Some children who are reunified with their families lose their Medicaid coverage through no fault of their own and unfortunately, once children leave foster care they have no guarantee of continued Medicaid eligibility.

Child welfare case workers and caregivers play a critical role in helping children access necessary services and supports. Frequent case worker turnover, coupled with changes in placements, undermines the ability to coordinate consistent care. Thankfully, federal Medicaid regulations require that children who have been categorically eligible for Medicaid cannot be cut off until a determination is made that they are not eligible for Medicaid under other eligibility guidelines.



The transition in and out of the child welfare system makes it particularly difficult to ensure continuous coverage for the most at-risk children and families, many of whom have disproportionate health needs. Currently, 33 states have 12-month continuous eligibility for one or both of their Medicaid and/or separate CHIP programs, which ensures continuity of care for children who may come into contact with the child welfare system for intermittent periods of time. Recently the Ensuring Continuous Medicaid Coverage for Children Act of 2011 (HR 669) was reintroduced in Congress. This legislation requires state Medicaid plans to provide for 12-month continuous coverage of children, which is similar to the requirement in private insurance plans. This, together with additional protections available under the Affordable Care Act, offers coverage stability not only for children who come in and out of care, but also the youth who age out of the foster care system each year. Educating caregivers and training the child welfare workforce on the health needs of this unique population is critical to improving health related outcomes and ensuring that children and families who come into contact with the child welfare system have access to continuous coverage.

Chairman Ryan's FY 2012 Budget Proposal

The budget plan for FY2012 approved by the House of Representatives (H.CON.RES.34) includes the repeal of the Affordable Care Act and drastic cuts to the Medicaid program. The total cuts amount to just over \$1 trillion, with more than \$770 billion of the cuts coming from the proposal to block grant Medicaid, and the remaining estimated from the repeal of the ACA. While limited flexibility, such as anticipated through the block grant plan, may benefit states that are facing budget crises, flexibility that allows states to bypass the federal minimum standards on eligibility and benefits pose significant risks to the health and economic security of families who rely on the program to meet their basic health needs, especially in times of recession or other economic difficulty.

Under the Ryan plan states would receive a fixed amount of funding from the federal government, beginning in 2013, which would be indexed for inflation and population growth, but would not guarantee equity across states. States would be allowed to adopt their own program standards and rules for coverage, benefits, and enrollment. Block granting Medicaid would not only jeopardize coverage for millions of children, it would also result in cost-shifting that would place an even greater burden on state and local governments to ensure access for children and families already in underserved communities.

Another provision in the House Budget Plan would repeal the ACA, which includes extension of the Children's Health Insurance Program (CHIP) and the expansion of Medicaid eligibility up to 133% of the federal poverty level. The plan would also eliminate the expansion of Medicaid eligibility to former foster youth up to age 26. Until these provisions become fully enacted states have the option to extend Medicaid to former foster youth between the ages of 18-21, under the Foster Care Independence Act (P.L. 106-169). The Fostering Connections to Success and Increasing Adoptions Act (P.L. 110-351) allows states the option to extend foster care support up to age 21, and while the majority of states report they are offering some level of care beyond age 18, a significant number of older youth remain without health coverage.



Implications of a Medicaid Block Grant

Under the current Medicaid structure, the federal government sets minimum eligibility standards, and states may expand beyond these minimum levels. Eligible individuals are entitled to have payment made on their behalf for a defined set of benefits, and states are entitled to federal matching payments for the costs of this coverage. States cannot cap or close enrollment for individuals who meet eligibility standards for the program, which helps to ensure that coverage is available when unemployment rises and incomes fall during an economic downturn, or in the event of a natural disaster.³

Block grants however, do not guarantee coverage for eligible populations. Under a Medicaid block grant it is likely that mandatory services like EPSDT would no longer be guaranteed. States will likely have broader flexibility to cut or eliminate benefits in addition to reducing eligibility or freezing enrollment once they reach their capped allotment. The issue of entitlement based on eligibility is uniquely tied to the capped financing structure. If states are not assured that the federal government will fully share all related costs, it is not likely that Congress could or would require states to serve all eligible people. As a result, programs funded through capped federal grants typically limit the number of people served through priority lists, waiting periods, and by simply closing down enrollment.⁴

Implications of MOE Repeal

The Maintenance of Effort (MOE) provision in the Affordable Care Act requires states to maintain their current Medicaid and Children's Health Insurance Program eligibility standards and application and renewal procedures for children until 2019. Any state found violating any of these requirements risk losing federal matching funding for its entire Medicaid program until the violation is corrected. The National Governor's Association sent a letter to Congress asking them not to impose maintenance-of-effort (MOE) requirements as a condition of receiving federal funding. As a result, legislation was introduced that would attempt to provide some relief and flexibility to states that are facing financial difficulty under the MOE. The State Flexibility Act, introduced in the Senate by Senator Orrin Hatch (R-UT) and in the House by Representatives Phil Gingrey (R-GA) and Cathy McMorris Rodgers (R-WA), would repeal MOE requirements under the ACA. The House Energy and Commerce Subcommittee on Health recently passed the bill, which currently awaits action before the full committee.

Eliminating this important requirement will allow states to forgo many of the obligations that are in place in current law and under the ACA to protect Medicaid and CHIP beneficiaries, without losing matching funds from the federal government. The absence of maintenance of effort protections would allow states to cap enrollment, establish waiting lists, and implement stricter application and renewal applications, all of which serve as barriers to coverage for eligible children and families. The Congressional Budget Office estimates that the repeal of the stability protections, while saving over \$2 billion, could cause half of states to eliminate their CHIP



programs completely by 2016. As a result, in the next few years, up to 400,000 people a year will lose Medicaid or CHIP coverage, two-thirds of who will be kids.

Representative Frank Pallone (D-NJ) offered an amendment that would prevent any state from altering eligibility standards, methodologies, or procedures that apply to individuals under 19 years of age under Medicaid or CHIP to make them more restrictive than the ones in place currently. His amendment, along with two others that would protect pregnant women and those in need of long term services, was defeated. The bill must now go before the full Energy and Commerce Committee.

Looking Ahead—CWLA, Congress and Beyond

Over the last decade, the investments and expansions in the CHIP and Medicaid programs have driven the uninsured rate of children down to the lowest level on record. Unfortunately the most recent attempts to cut, cap, and/or block grant funding streams could drastically alter the landscape of children's coverage. For example, repealing the ACA not only jeopardizes the health care of the 30 million of children currently covered, but also the 8 million who remain uninsured. Furthermore, a Medicaid block grant would end the entitlement to Medicaid coverage that is currently available to hundreds of thousands of children in the child welfare system.

While so much focus has been placed on cuts and caps to valuable entitlement programs like Medicaid, the need to invest in and protect these programs has been grossly neglected. Despite the claim from some states that Medicaid is not flexible in its current form, states are already granted flexibility under current law to adapt their programs in times of budget deficits. Protecting the entitlement to Medicaid and continuing to strengthen the program is vital to its success as a safety net for children in child welfare.

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¹ Rubin, D., Alessandrini, E.A., Feudtner, C., Mandell, D.S., Localio, A.R., & Hadley, T. (2004). Placement stability and mental health costs for children in foster care. *Pediatrics*, 113(5), 1336-1341. Retrieved October 5, 2010, from <http://pediatrics.aapublications.org/cgi/content/full/113/5/1336#R40>.

² K. Allen. *Medicaid Managed Care for Children in Child Welfare*. Center for Health Care Strategies, Inc, Issue Brief, April 2008. Available at: http://www.chcs.org/usr_doc/CW_MC_Brief.pdf

³ *Implications of a Federal Block Grant for Medicaid*. Kaiser Commission on Medicaid and the Uninsured, April 2011. <http://www.kff.org/medicaid/upload/8173.pdf>.

⁴ *Medicaid and Block Granting Financing Compared*. Kaiser Commission on Medicaid and the Uninsured, January 2004. <http://www.kff.org/medicaid/upload/Medicaid-and-Block-Grant-Financing-Compared.pdf>