

The Better Care Act and Child Welfare



The Better Care Act is the name of the latest version of the House health care legislation. When Congress broke for the July 4th recess, there were several concerns with the legislation. One of the most significant relates to how these bills will change Medicaid. This paper examines just some of the ways in which the current bill will affect child welfare through the imposition of a per capita cap and new requirements on work and eligibility.

- Per capita caps will encourage state Medicaid systems to suppress and reduce access to care for high-needs child populations, including children in foster care who are in need of behavioral health services.
- Other reforms such as work requirements, and more frequent eligibility re-determination, will likely reduce access to health care for youth in care and youth formerly in foster care.
- Growing state budget pressure, over time, will push child welfare funding and services down the list of political priorities.

Some child welfare advocates have focused their advocacy efforts on maintaining the current ACA requirement that former foster youth have Medicaid coverage to the age of 26¹ but the current Senate and House bills threaten not just this provision but adequate access for all children and youth in child welfare.

Both the House bill and the Senate bill have at least three provisions that will change Medicaid as it has existed for half a century, and both bills will have an impact on child welfare. These bills create a per capita cap with an optional state block grant, both allow work requirements, and both allow more frequent eligibility re-determination.

Work Requirements

If the Better Care Act is signed into law, states would have the option to require work. Some will argue the benefits and the “fairness” of work requirements. These same proponents also tend to see Medicaid not as a national health insurance program but as a “safety net” program, not unlike cash assistance or food stamps/SNAP. But Medicaid was enacted along with Medicare as a partial national health insurance program in 1965. Medicare would cover the elderly while Medicaid would cover the poor.²

¹ This is an attempt to mirror the current Affordable Care Act provision that allow parents to cover their adult children up to age 26.

² Since that point, Medicaid has also taken on the role of being the primary funder of long-term care (nursing home) services, as Medicare is limited to skilled nursing care and not the in-higher-demand basic/custodial long-term care.

From a child welfare perspective, the work requirement could directly hit youth formerly in foster care. Under the Senate and House bill language, although this potential work requirement only applies to the non-disabled, non-elderly, and non-pregnant, there are four categories of people who are specifically defined as exempt. Work can't be required as a condition of Medicaid eligibility for: expectant mothers through 60 days after their pregnancy; children and youth age 18 or younger; a parent or caretaker who is the sole caretaker of a child under 6; and someone under 20 who is married or head of the household attending school or vocational education. That would mean a state could require work for young people, including former foster youth who are attending a university and not working.

Why would a state create such hurdles? They will be under a Medicaid cap, meaning that if they exceed their annual cap funding total, all remaining Medicaid costs will be taken from the state budget. This will provide continual and increasing budget pressure on states to shave costs in any way possible.

Eligibility Re-determination

Both bills allow for more frequent eligibility re-determinations rather than annually. The House requires this at least every six months, people will be required to re-determine if they are still eligible for Medicaid. The Senate bill makes this a state option, with states allowed to conduct eligibility re-determination at least every six months.

Some proponents will argue that more frequent re-determinations to prove you are still eligible for Medicaid coverage is an anti-fraud measure. It can also have the effect of pushing some eligible individuals off coverage (which in turn creates a budget savings). Some people covered by Medicaid may not always be able to arrange work hours to meet more frequent re-determinations. Others, especially young people, may not be aware of the requirement. As a result, eligible people could be pushed off Medicaid.

One example of this issue is the reauthorization of the 2014 Child Care and Development Block Grant (CCDBG). This revised law now requires minimum eligibility (and redetermination) every 12 months. Under the previous CCDBG, states set their own re-determination rules; in some instances, these re-determinations could be as frequent as several times a year, tied to changes in jobs, work hours, schedules, and other conditions. A working parent (working being a requirement under CCDBG) with a low-wage job might not have the job schedule flexibility, transportation, or child care options to frequently re-determine eligibility. This has had the effect of stretching a state's child care funding by pushing some eligible parents off.

Such frequent re-determinations could raise further barriers to certain populations, including youth transitioning out of foster care or former foster youth in a state that provides Medicaid eligibility/coverage.

Per Capita Caps (Medicaid Block Grants) and Children in Child Welfare

The House and Senate bills establish a complex formula of caps that will ultimately incentivize states to reduce their coverage of the more expensive sub-populations covered under their Medicaid program. Children in child welfare fit this category; they are generally a more expensive subpart of the children's population.

In 2013 the [Center for Health Care Strategies](#), in *IDENTIFYING OPPORTUNITIES TO IMPROVE CHILDREN'S BEHAVIORAL HEALTH CARE: An Analysis of Medicaid Utilization and Expenditures*, analyzed behavioral health care use and expenses for children in Medicaid in all 50 states. They found common themes other researchers have documented:

- Children using behavioral health care represented under 10 percent of the overall Medicaid child population, but an estimated 38 percent of total spending for children in Medicaid.
- Children in foster care and those on SSI/disability together represented one-third of the Medicaid child population using behavioral health care, but 56 percent of total behavioral health service costs.

The research showed that for ***all children accessing behavioral health care services*** through Medicaid, the mean annual behavioral health services totaled \$4,868, while physical health services totaled \$3,652 – a total ***combined Medicaid health cost of \$8,520***.

Now compare that to the subcategory of ***children and youth in foster care***:

Annual behavioral health expenses of \$8,094 and physical health services cost of \$4,036, ***for a total of \$12,130 for children and youth in foster care*** with at least one behavioral health cost.

These numbers are significant because of the per capita cap.

The cap breaks Medicaid into five subcategories: children, the elderly, blind/disabled, people accessing Medicaid because of the expanded enrollment through the Affordable Care Act,³ and all the remaining adults not in the other categories.

Based on the Senate bill (which is very close to the House bill expect for the inflation formula), states would select a two-year sample period ranging from federal fiscal year 2014 through 2017. Based on this two-year period (8 fiscal quarters), the average cost per patient would be determined.

So, in simple math: If you had 100 elderly patents and the cost was \$1 million the average cost would be \$10,000. These same calculations would be made for children, the disabled, adults, and those covered through the ACA expansion.

That base figure in each of the five categories would then serve as the basis for future state grants. In this simple math example, that \$10,000 per elderly person would be adjusted by the urban consumer price index (plus 1 percent through 2024) and that CPI-U adjusted amount would be multiplied by the number of elderly. The same calculation would be made for all groups, and that would result in a state's annual cap.

If a state is eligible for \$100 million in a year, that state would draw down the \$100 million (through the current Federal Medical Assistance Percentage (FMAP) rate of 50 percent match up to 75 percent match depending on the state). If and when a state drew down that \$100 million in federal funds and still had

³ This group will decrease over time. Under the legislation, people who cycle off Medicaid due to job changes and other insurance coverage will not be able to return as this ACA expansion is eliminated.

more of the year to go, any costs beyond the cap would be the responsibility of the state: no federal Medicaid assistance.

The urban consumer price index that the Senate bill uses is lower than the medical consumer price index in the House bill. Either CPI inflation adjustment has been criticized because they would not allow for medical emergencies such as a pandemic, unique regional needs (a drug treatment that may be costlier), and other health care factors that could emerge within a year.

The Senate formula also penalizes states if their annual increase is more than 25 percent above the median increases. It also adjusts states upward if they are 25 percent below the median. If a state's per capita Medicaid spending is above the national mean by 25 percent or more, its cap funding will be decreased the following year. In a move to assure some Senate votes for the overall bill, some states are exempt from this provision. States with a population density of less than 15 individuals per square mile (Alaska, Montana, North Dakota, South Dakota and Wyoming) would be exempt. This adjustment applies to a state's overall cap payment until 2022, when the adjustment is made to each subcategory—including children.

According to an analysis by [Manatt on Medicaid, The Senate's New Per Capita Cap Redistribution Policy](#):

"20 states would be hit by a tighter cap either because their average per capita spending is high (which is the metric used in FY 2020 and FY 2021) or their per capita spending in one or more individual eligibility groups is high (which applies in FY 2022 and beyond). In comparison, only 12 states would experience some relief from the per capita cap cuts because they have expected spending that is low on average for their overall populations or for any of the individual eligibility groups. Under the test applied in FY 2022 and beyond, five states—Alabama, Colorado, Iowa, Kentucky and Wisconsin—meet the threshold for both "high" and "low" spending state, making it difficult to say whether they would be harmed or helped by the policy."

Children and the Cap and Block Grant

We know that the cost of within certain populations varies dramatically. Analysis by [Health Voter Blog: The Downstream Consequences Of Per Capita Spending Caps In Medicaid](#) cited research by the Kaiser Family Foundation. This research offers an example of spending on children in the state of Oklahoma: Average health care spending is \$2,724 per child but varies from \$131 in the first quartile of that state's child population to \$24,571 in the top 5 percent of the spending on children's health care costs. Similarly, the cost of health care for adults can vary dramatically. Again, using the same sources:

"average annual spending per adult in Ohio is \$4,498, spending for adults varies widely with per-person average costs of \$530 for those in the first quartile to \$20,143 for those in the top 5 percent of the spending distribution."

If children in child welfare are a more expensive part of the population, the incentive is to reduce that coverage, reduce reimbursements to providers, or restrict the range of services provided. That same calculation may be made between groups: adults, children, the disabled, and the elderly.

A recent *Washington Post*⁴ article highlighted just how the Medicaid cap will impact on another group with potential great voting and political power, the aging baby-boomer population. According to that article the cuts in Medicaid will have a tremendous impact on nursing homes with severe cuts (an accompanying lay-offs). Referencing Census Bureau data, the number of people age 65 and older will rise from 40 million people in 2010 to 72 million by 2030. Nearly two-thirds of the nation's 1.4 million nursing home residents rely on Medicaid.

States can replace their per capita cap with a block grant, but this will look a lot like the same funding levels with greater state flexibility and less accountability on how the spend the money.

Conclusion

As state budget struggles continue due to the dynamics of shifting tax policies and revenues, a changing workforce and aging population, these dramatic Medicaid cuts ("reductions in the rate of growth") create increased pressure on governors and state legislatures to reduce health care coverage, payments and services.

A *Washington Post* article, [It's not just New Jersey and Illinois — many states are facing budget trouble](#) points out the fact that thirty-three states had revenue shortfalls in 2017. The article stated:

"An analysis by Connecticut's Office of Policy and Management estimates that, by 2026, the Senate bill would shift up to \$2.9 billion in annual costs to the state, potentially forcing up to 230,000 people off its Medicaid rolls...Arizona, California and Minnesota have issued similar analyses. Late last month, the National Association of Medicaid Directors issued a statement saying that the Medicaid changes contemplated by the Senate "would be a transfer of risk, responsibility, and cost to the states of historic proportions."

Child welfare services: prevention and intervention services, foster care, reunification, adoption, and kinship care, to youth transitioning services are low on the state spending priority list just as they are in the U.S. Congress. These Medicaid reductions will create increased state budget pressure.

Just as important, **Medicaid is vital to children and families touched by child welfare**. We see this through the increased demand for substance use services due to the opioid epidemic and the resulting increases in the foster care caseload.

"Primum non nocere"—Latin for "first do no harm"—is associated with the Hippocratic Oath. For Members of Congress and the Senate seeking to strengthen the child welfare system and wanting to reduce the number of children and families in child welfare:

First, do no harm—and this includes harm to Medicaid.

Child Welfare League of America 757 15th St, NW, 12th Floor, Washington, DC 20005, 202-688-4154, www.cwla.org

⁴ "Health-care bill could devastate nursing homes." Paquette, D., *Washington Post*, June 29, 2017.