



Hearing to Consider the Graham-Cassidy-Heller-Johnson Proposal
Monday, September 25, 2017
United State Senate Committee on Finance
215 Dirksen Senate Office Building

FROM: Child Welfare League of America, 727 15th St NW, 12th Floor, Washington DC, 20005

The Child Welfare League of America (CWLA) urges the Senate Finance Committee and the Senate to reject the Graham-Cassidy-Heller-Johnson proposal.

In short, this legislation will be devastating to the nation's child welfare system.

This legislation will undercut the past work of the Senate Finance Committee to reduce the number of children in foster care, to strengthen families that adopt, to support young people that exit foster care, and to reduce and prevent child abuse.

CWLA urges senators to think of the young men and young women with foster care experience that you have sponsored as interns, fellows, and temporary staff. They have told you their stories about the trauma they have experienced, about their multiple placements and the missed opportunities in their care and support.

Too often these young people have told you stories of parents or guardians who could not access the needed drug treatment, mental health, or health services that might have kept their families intact and all of their siblings together.

These young men and women represent the 10–20% who, for reasons we cannot fully explain, were resilient enough to make it all the way to college. These young adults were even more extraordinary in that they also made it to Capitol Hill. Not as visible to you are countless others, and their brothers and sisters (figuratively and literally), who did not make it to college or to Capitol Hill. Too many of them face a future of incarceration, trafficking, or a life of struggle.

This legislation will undercut the critical role that Medicaid plays in addressing child abuse, reducing foster care, and supporting kinship families and families that adopt.

This comes at a moment when the child welfare system is facing another drug crisis: opioid addiction. This crisis has the potential to add to the number of children who are at risk of harm, in foster care, or awaiting adoption.

As a country, we have taken significant strides in reducing the nation's foster care numbers in this century. Foster care caseloads stood at 568,000 in 1999. (House Ways and Means Committee, 2000, The Greenbook). By 2012, the number of children and youth in foster care had

decreased to 397,000 (Department of Health and Human Services, Administration for Children and Families, 2016, AFCARS Report Number 23).

Last fall, the Department of Health and Human Services released their latest official child welfare data. That data showed that in 2015, 427,910 children were in foster care, an 8% increase since 2012. New data suggests that drug abuse by the parent was the primary reason for the child's removal in 32% of cases, and a parent's inability to cope was a factor in a child's removal in 14% of cases (Ibid.).

To better understand this data, officials at the Administration on Children, Youth and Families (ACYF) interviewed child welfare directors in states experiencing the highest increase in foster care numbers. State officials informed ACYF on what the data suggest: "A rise in parental substance use is likely a major factor driving up the number of children in foster homes. Citing opioid and methamphetamine use as the most debilitating and prevalent substances used, some state officials expressed concern that the problem of substance use is straining their child welfare agencies."

At this critical time when the caseloads are increasing, decreasing access to health care generally and Medicaid specifically will add to the number of children in foster care.

The expanded access to health care through Medicaid and private health insurance resulting from the Affordable Care Act (ACA) has provided more than \$5.5 billion in substance use and mental health services, according to research by Dr. Richard Frank and Dr. Sherry Glied of Harvard Medical School and the Wagner School of Public Service at New York University (Frank, R.G., & Glied, S.A., *The Hill*, January 11, 2017). According to Dr. Frank and Dr. Glied, a full repeal of the ACA would result in a loss of coverage for 2.8 million people with a substance use disorder, including 220,000 people who have an opioid addiction. Additionally, it would eliminate mental health coverage to 1.2 million people with a serious mental health disorder (Ibid.).

Early in 2017, *USA Today* highlighted mental health programs developed by the Montefiore Health System in the Bronx. They quoted psychiatrist Henry Chung, chief medical officer of Montefiore's care management organization, as saying the success of these programs is contingent upon patients getting early treatment in primary care. He went on to say the new mental health provisions in the recently enacted 21st Century Cures Act that improve access to treatment need "...to be combined with strong, affordable insurance. You can't have one without the other or some of that progress will be taken away" (O'Donnell, J., & DeMio, T. Obamacare repeal jeopardizes mental health, addiction coverage. *USA Today*, January 9, 2017).

This conclusion is further supported by *Facing Addiction in America*, a 2016 comprehensive report by the U.S. Surgeon General. One of that reports recommendations states that "Full integration of the continuum of services for substance use disorders with the rest of health care could significantly improve the quality, effectiveness, and safety of all of health care."

Many Finance Committee members know firsthand the impact the recent opioid epidemic is having on families in your states. This legislation will add to the pressure already increasing on your states because of opioids and other substances. It will not help that some states will get a

temporary increase in funding by cutting funding to the rest of the states not benefiting from the Graham-Cassidy-Heller-Johnson proposal.

CWLA supports the recent recommendations of the President's Commission on Combatting Drug Addiction and the Opioid Crisis when it called for efforts to enhance access to Medication Assisted Treatment (MAT).

According to the National Center on Behavioral Health, many states with the highest opioid overdose death rates have used Medicaid to expand access to Medication-Assisted Treatment (MATs). This includes 49.5% of medication-assisted treatment in Ohio, 44.7% in West Virginia, 44% in Kentucky, 34.2% in Alaska, and 29% in Pennsylvania (Blue, S.C, & Rosenberg, L. (2017). *Americans with Mental Health and Substance Abuse Disorders: The Single Largest Beneficiaries of the Medicaid Expansion*, the National Counsel of Behavioral Health).

Imagine the impact on foster care caseloads, child maltreatment, and other areas of child welfare if the expanded behavioral health and substance use treatment is repealed, cut back due to state options, or cut out due to a state hitting their annual Medicaid per capita cap.

According to our colleagues at First Focus, the State Policy Advocacy Reform Center (SPARC) and the American Academy of Pediatrics, due to their experiences of abuse, neglect, loss, and trauma, youth who are in foster care face a range of health issues that make it vitally important for them to have access to health care:

- 35-60% experience a chronic medical condition
- 50-75% exhibit behavioral or social competency issues that may require mental health treatment
- nearly 50% suffer from chronic conditions such as asthma, cognitive abnormalities, visual, and auditory problems, dental decay and malnutrition

In 2013, the Center for Health Care Strategies 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% of the overall Medicaid child population, but an estimated 38% 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% 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.

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.

CWLA believes that this legislation will also have an adverse impact on some families that adopt from foster care. Medicaid is a vital source of support. We know that adoption, as cited by past HHS publications, is a *“lifelong experience for a child and a family. It is normal to face challenges; some challenges may even appear long after the adoption has been finalized.”*

Post-adoption services are an increasing need as we have increased the number of adoptions from foster care over these past two decades. Much of this progress in increasing adoptions to more than 57,000 per year is because of past efforts of this Committee. These efforts include the de-linking of eligibility from the 1996 AFDC standard and the passage of the Adoption and Safe Families Act.

Medicaid and the behavioral health services it provides are a vital part of post-adoption services that may not be needed by these families until years later when this legislation will result in its biggest reductions.

Some will argue that the increased flexibility in funding that will be created by this legislation, will allow states to better address these new and ongoing demands. They will argue that flexibility in funding is all that is needed. That is wrong.

CWLA reminds you just how difficult it is for children and families involved with state child welfare systems and families that adopt from foster care to get to the top of the list of budget priorities.

Flexibility in Medicaid funding, along with future caps and reductions, will mean that these families, children and youth will be competing with future costs including the potential growth in demand for long term care and nursing home services. States will budget and choose according to top priorities and youth in foster care may not meet that priority.

Many of the members of the Finance Committee were present and vital to the enactment of 2008 Fostering Connections to Success Act. That historic law gave states the option to extend foster care to 21 and to expand federal funding to kin families. Nearly ten years later approximately 25 states have not extended care to age 21, and approximately 15 have not taken the subsidized guardianship option.

As health care and Medicaid funding becomes tighter, addressing the reduction of foster care placements, to support the adoption of children from foster care, to support those families with post-adoption services, and to provide the ongoing support to kinship families will inevitably slip down the list of budget and political priorities.

CWLA believes that the flexibility and the options this legislation will create will leave children and youth behind.

Senator Mary Landrieu and Senator Charles Grassley provided the inspiring leadership to create the Senate Caucus on Foster Youth. Senator Landrieu, during the original debate over the ACA, worked with some members of this Committee and other Senators to assure that every young person who aged out of foster care had access to Medicaid up to age 26. This was an attempt to assure that these young adults have the same protection all other young adults have to be on their parents' health insurance to age 26.

Unfortunately, because of the technical problem with the way that provision was written and interpreted, if that young person aged out in one state and moved to another state—if they, for example, move to go to college, have an internship, or move to a neighborhood just across state lines—they will not be covered unless the state takes the option to extend Medicaid.

According to our colleagues at First Focus, approximately 14 states have taken the option to extend Medicaid to youth formerly in foster care.

CWLA gives these examples to highlight that optional coverage does not always work to the benefit of families that encounter child welfare systems. These families, children, and youth often lose out due to competing pressures.

We join many of our colleague organizations in highlighting the fact that Medicaid is a critical children's health coverage program. A key, vulnerable population that Medicaid serves are children involved with the child welfare system. Children in or at risk for entering foster care experience disproportionate exposure to trauma, and often have complex medical needs. Medicaid covers all of children in foster care and is vital to meeting their health needs.

Changes to the Medicaid program that undermine its structure, including per capita caps and block grants, would harm vulnerable children and families in the child welfare system.

History has demonstrated the negative effects of converting funds into a flexible state block grant may not be felt next year but it will be felt in the very near future. That is not a comfort and it is not a solution.

Please vote to reject this Graham-Cassidy-Heller-Johnson Proposal and work instead toward bipartisan solutions both in health care and in child welfare.