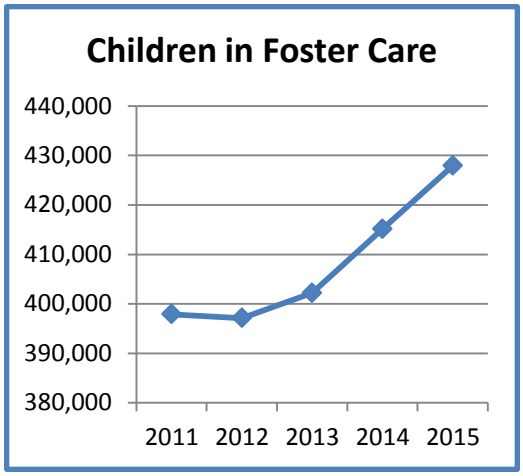
Children of the Opioid Crisis

By Jennifer Lav

As the opioid crisis ravages the country, children are entering the foster care system in record number.[1] After reaching a low point in 2012, the number of children in foster care has grown steadily, increasing by almost 8% between 2012 and 2015.[2] These children enter care with an array of challenges: infants exposed to opioids in utero may have neonatal abstinence syndrome (NAS) while older children are, at a minimum, coping with the separation or loss of a parent. Children are the hidden victims of the opioid crisis.

Medicaid plays an essential role in these children's lives. It provides mental and physical health care for children removed from their families, and provides treatment for their parents. For most youth in foster care, Medicaid coverage is mandatory, either because the child receives federal foster care payments ("Title IV-E" eligibility), has a disability, or was removed from a family with a very low income.[3] For other youth in foster care, Medicaid coverage is optional, but most states have exercised these options.[4] Medicaid covers almost all children in foster care.[5]



Kids Count Data Center, Annie E. Casey Foundation

The Senate has proposed gutting Medicaid, most recently in the form of Better Care Reconciliation Act (BCRA), by forcing monetary caps on state Medicaid programs that drastically cut funding to states and effectively eliminates Medicaid expansion.[6] The Senate's proposed cuts and caps threaten foster children's access to timely and comprehensive medical services and their parents' ability to obtain substance use disorder (SUD) treatment necessary for family reunification. Current discussions to provide additional Medicaid funding as a "wrap-around" once expansion ends will do little to solve BCRA's long term decimation of Medicaid funding.[7]

Under Medicaid's current structure, states get significant and predictable help providing for the high needs of children in foster care; the federal government contributes, on average, 63% of

every Medicaid dollar a state spends on behalf of children.[8] If state Medicaid expenditures rise due to an influx of children in the child welfare system with enhanced needs, federal Medical expenditure rise proportionately.

Per Capita Caps & Foster Care Are a Dangerous Combination

BCRA (along with similar proposals currently being considered by Congress) dismantle Medicaid's federal-state partnership by imposing per capita caps. Per capita caps divorce funding from states' actual expenditures, replacing a predictable federal match for state expenditures with an artificial cap, and forcing states to massively cut health care expenditures or dramatically raise revenues. All children, except children who are blind or have significant disabilities, will have the same "cap" amount allotted to the state for their expenditures.[9] Per capita caps create increasingly larger cuts to Medicaid over time because BCRA applies a growth index that is significantly lower than expected Medicaid costs.[10]

If a children's cap is imposed, all children in foster care would be lumped together with all other children under the "children's cap." On average, children's health services cost the least compared to other categories of enrollees. In the vast majority of states, the children's cap would likely be the lowest of the five categories of enrollees that will be subject to a cap.[11] However, children in foster care have higher Medicaid expenses than other children enrolled in Medicaid—they account for 9% of the all spending for non-disabled children, while only making up 2% of nondisabled child enrollees.[12] While the average Medicaid benefit spending per nondisabled child was approximately $2,000 per child for fiscal year 2010, spending per child enrolled in Medicaid due to foster care status (through Title IV-E eligibility) in that same time period was $5,767.[13]

Furthermore, children entering foster care due to parental SUD have specific physical and mental health challenges, which may cause their care to cost even more. Newborns may suffer from Neonatal Abstinence Syndrome (NAS), which is caused by prenatal exposure to opioids. NAS can cause significant health problems in newborns, including excessive weight loss, fever and seizures; the average length of stay in a hospital for a child born with NAS is 17 days.[14] Older children entering foster care due to parental SUD may have an increased need for mental health services; children experiencing both exposure to family members with SUD and parental separation may be at increased risk of suicide attempts, depression, the early initiation of alcohol use, and other adverse outcomes.[15]

Because Medicaid expenditures are approximately twice as high for children who are enrolled due to foster care status, and children of parents with SUD may have even more special needs, any significant influx of children in foster care cause by the opioid epidemic means that funds allotted based on the average past expenditures for all children will be insufficient to pay for future expenditures of higher cost children.

BCRA Threatens Access to Services and Coverage

BCRA will cut federal expenditures for Medicaid by over $750 billion, or 26%, over 10 years.[16] These cuts will accelerate starting in 2025, when an even lower annual growth rate is imposed, and result in a cut of 35% by 2036.[17] Cuts to Medicaid shift costs to states and place extraordinary pressures on state budget.

Many state child welfare budgets depend on Medicaid to fund nurses and other health care professionals within child welfare agencies.[18] In FY 2014, Medicaid constituted approximately 3% of total spending for child welfare services. In some states, it is much more: in West Virginia, Medicaid constitutes 11% of spending by their child welfare agency and in Vermont, it is 31% of all funds.[19] Large cuts to federal Medicaid funding may cause significant funding gaps in state child welfare budgets.

A state experiencing a budget crisis due to caps will have an incentive to reduce enrollment or service utilization for expensive populations including children in foster care. A state may, for example, try to find savings by delaying medical screenings upon entering care, or reducing the scope and comprehensiveness of follow up exams and treatment. These screenings and exams are important to monitor signs and symptoms of abuse and neglect, assess adjustment to foster care, and evaluate mental health needs. Although the American Association of Pediatrics and the Child Welfare League of America have jointly published standards for the frequency of medical exams and screening for children in foster care, states have flexibility to allow a less comprehensive schedule; BCRA provides perverse incentives to do so. [20]

An unexpected influx of children gaining access to Medicaid through Title IV-E eligibility could exacerbate these anticipated reductions by causing a state to spend more than its cap, and force the state to absorb 100% of the health costs that are above the cap or cut services to all children or other Medicaid enrollees. For example, because the cap is ultimately finalized in the aggregate, states could respond to significant expenses by cutting any optional benefit, such as home and community based services for people with disabilities, hospice care, or even prescription drugs. States could also respond by restricting eligibility; by eliminating entire groups of optional categorically needy individuals, such as women with breast or cervical cancer, limiting eligibility to a lower income level; or by erecting more stringent eligibility or redetermination requirements.

BCRA Reduces Opportunities for Family Reunification

Family reunification is both the most common goal and outcome of foster care placements. Put simply, most children return home.[21] If a child is removed due to parental SUD, and reunification is likely, parents must have access to SUD treatment.

BCRA and other recent proposals, such as the Obamacare Repeal and Reconciliation Act of 2017, will markedly limit access to SUD treatment by effectively eliminating coverage for the Medicaid adult expansion population. [22] Approximately 1.2 million individuals with SUD are now eligible for health care through the Medicaid expansion.[23] Child welfare agencies cannot easily facilitate access to treatment necessary to reunify families if parents do not have access to health care. Prior to expansion, pathways to Medicaid eligibility for adults without disabilities were limited -- often the only way a parent was covered was based on his or her status as a "caretaker" of a dependent child, but only if the parents is also at a very low income.[24] When a child was removed from the home, the parent lost eligibility. These parents, due to their very low incomes, often are not able to afford marketplace coverage. If BCRA is enacted and the Medicaid expansion is effectively repealed, the driving reason a parent needs SUD treatment – e.g. to successfully reunify their family – might be the very thing preventing access to treatment.

Conclusion

If a state removes a child from her parents, the state has an obligation to take care of her. Medicaid helps states meet that obligation. With the opioid crisis devastating families and overwhelming child welfare agencies, Medicaid's promise of federal help could not be more important. Protecting Medicaid means access to all-important physical and mental health care to children of the opioid crisis, more SUD treatment for their parents, and increased opportunities for family reunification. Drastic Medicaid cuts would significantly reduce if not eliminate the help needed by these families, children and child welfare agencies.

ENDNOTES

[1] While NHeLP is not aware of any national statistics on how many children enter foster care due to parental or guardian substance use, experts have noted two trends. First, there is an increasing number of infants entering foster care, which some have hypothesized is related to federal law requiring hospitals to notify of child protective services of any child prenatally exposed to substances. Second, young adults are dying at higher rates from substance use, which may leave more children without parents. See Examining the Impact of the Opioid Epidemic: Hearing before the S. Comm. on Homeland Security and Governmental Affairs, 114th Cong. (April 22, 2016) (written Testimony of Nancy K. Young, Director, Children and Family Futures, Inc.); See also Perry Stein and Lindsay Bever, "The Opioid Crisis is Straining the Nation's Foster Care System," Washington Post, July 1, 2017; Julia Lurie, "Children of the Opioid Epidemic Are Flooding Foster Homes. America Is Turning a Blind Eye," Mother Jones, July/August 2017; Ronald Brownstein, "How Medicaid Cuts Could Exacerbate the Opioid Epidemic," The Atlantic, July 13, 2017.

[2] Kids Count Data Center, Annie E. Casey Foundation (2015 is the most recent year national data available).

[3] 42 U.S.C. § 1396a(a)(10)(A)(i)(I); 42 C.F.R. § 435.145 (Title IV-E eligibility); 42 C.F.R. § 435.120 (SSI eligibility); 42 C.F.R. § 435.118 (eligible due to low income of family from which child is removed).
[4]42 C.F.R. § 435.222; Medicaid and CHIP Payment Access Comm'n. (MACPAC), June 2015 Report to Congress on Medicaid and Chip, Chapter 3: The Intersection of Medicaid and Child Welfare, at 76 (many states use what is called the "Ribicoff option," which allows states, at their option, to cover other "reasonable classifications" of children who are not eligible for Title IV-E).
[5] Center for the Study of Social Policy, Promoting Healthy Outcomes for Young Children and Their Families: Implications of Proposals to Restrict Medicaid, Children's Health Insurance Program (CHIP) and the Affordable Care Act (ACA), March 2017.
[6] Matt Broaddus and Edwin Park, Center on Budget and Policy Priorities, Senate Bill Would Effectively Eliminate Medicaid Expansion by Shifting Hundreds of Billions in Expansion Costs to States, July 13, 2017.
[7] Judith Solomon, Center for Budget and Policy Priorities, $200 Billion More Won't Fix Unfixable Senate Health Bill (last visited July 21, 2017).
[8] Kaiser Family Found., Federal and State Share of Medicaid Spending for FY 2016 (last visited July 21, 2017).
[9] Per capita caps are calculated by first finding the average amount spent per enrollee for a specific year (or set of years) in each of five different categories of enrollees: older adults; people with disabilities; children; the adult Medicaid expansion population, and other adult enrollees. These separate caps (one per enrollee category) are then multiplied by the number enrolled within the category to determine the state's total expenditure amount. See Mara Youdelman, NHeLP, Per Capita Caps in Medicaid Under the House Republicans' ACA Repeal Bill, March 22, 2017.
[10] Loren Adler, *et al*., Brookings, Effects of the Medicaid Per Capita Cap Included in the House-Passed American Health Care Act at 8, May 2017.
[11] In FY 2014, states spent the least on children as an enrollee category in all but three states. Kaiser Family Found., Data Note: Variation in Per Enrollee Medicaid Spending, June 2017.
[12] Kristin Turney, Christopher Wildeman, Mental and Physical Health of Children in Foster Care, 138 Pediatrics 5, 2016.
[13] MACPAC, June 2015 Report to Congress on Medicaid and Chip, Chapter 3: The Intersection of Medicaid and Child Welfare, at 66, 72, June 2015 (analysis is for fiscal year 2010). The current version of BCRA excludes from the "cap" children who become eligible for Medicaid because they are blind or have a disability. Many children in foster care who may have disabilities or special health care needs would likely be overlooked from inclusion in this "carve out" because they are not eligible for Medicaid through one of the more traditional "disability" categories. Children in foster care become eligible for Medicaid through a myriad of pathways, such as Title IV-E, optional state categories, and based on parental income. Therefore, the current carve out likely would fail to identify foster care children who should be carved out but any additional carve-out for foster care children would not be administratively feasible.
[14] Karen McQueen and Jodie Murphy-Oikonen, "Neonatal Abstinence Syndrome." New Eng. J Med., December 22, 2016.
[15] See generally the Centers for Disease Control and Prevention website on Adverse Childhood Experiences; Marian Wright Edelman, "Tell Congress To Stop Picking On Our Most Vulnerable Children!" Huffington Post, July 7, 2017.
[16] Congressional Budget Office, H.R. 1628, the Better Care Reconciliation Act of 2017: An Amendment in the Nature of a Substitute, July 20, 2017.
[17] Congressional Budget Office, Longer-Term Effects of the Better Care Reconciliation Act of 2017 on Medicaid Spending, June 29, 2017.
[18] Marian Wright Edelman, "Tell Congress To Stop Picking On Our Most Vulnerable Children!" Huffington Post, July 7, 2017.
[19] Child Trends, Child Welfare Financing SFY 2014: State-Level Data Table, October 3, 2016.
[20] The American Academy of Pediatrics recommends the following schedule of screenings upon entering foster care: a health screening within 72 hours of placement, comprehensive evaluation within 30 days, and a follow up within 60 to 90 days. Many states have adopted these recommendations, in some form, as state law. These screenings are different from the periodic screenings that are required under Medicaid for all children. While states must submit a "Health Care Oversight and Coordination Plan" that describes a schedule for initial and

follow-up health screenings that meet reasonable standards of medical practice," states still have discretion in setting this schedule. See 42 U.S.C. § 622 (requirements for Health Care Oversight and Coordination Plans).

[21] U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, AFCARS Report, Preliminary Estimates for FY 2015 as of June 2016.

[22] Héctor Hernández-Delgado, National Health Law Program, "Medicaid Caps and the Opioid Epidemic," June 1, 2017; Kim Lewis and Mara Youdelman, National Health Law Program, Top 10 Changes to Medicaid Under the Senate's ACA Bill, June 26, 2017.

[23] Héctor Hernández-Delgado, National Health Law Program, Congressional Effort to Repeal ACA & Cut Medicaid Would Worsen the Opioid Epidemic, June 15, 2017.

[24] See e.g. 42 C.F.R. § 435.110.