USING THE AFFORDABLE CARE ACT TO IMPROVE WELL-BEING OUTCOMES FOR CHILDREN & FAMILIES

The health, happiness and success – or well-being – of children and youth depends on multiple elements, including physical and mental health, educational progress, social and emotional functioning and healthy relationships. Child and youth well-being is also intertwined with and dependent on the well-being of caregivers, which is strongly tied to parental capacity, concrete supports and social connections.[1]

Untreated parent or caregiver mental health and substance abuse issues can be detrimental to a child or youth's well-being *and* an underlying cause of child maltreatment and neglect. One study found that 20 percent of parents involved with child welfare scored in the clinical range for major depression within the previous year compared to only seven percent of parents who were not involved with child welfare.[2] However, only 56 percent of parents involved with child welfare who need mental health services received treatment or medication, according to data from the second National Survey of Child and Adolescent Well-Being.[3] It is particularly important for policymakers and child welfare practitioners to recognize the importance of parental well-being on positive child and youth outcomes and consequently promote and implement programs and policies that support parental and family well-being.

The **Affordable Care Act (ACA)** provides states with a key opportunity to improve access to health care for parents involved with the child welfare system and consequently improve well-being outcomes for children, youth and their families. Beginning January 1, 2014, states will have the option to considerably expand the eligibility level for both working and non-working adults to 133[4] percent of the Federal Poverty Level (FPL) (currently 64 percent of the FPL for working parents and 38 percent of the FPL for non-working parents).[5] Should states elect to expand coverage; not only will this provide health and mental health care access to an additional group of parents never previously covered, but it will also provide continuity in health care coverage for parents who, without this expansion, would lose their health care coverage when their children were placed out of their home.[6] In states that elect to expand coverage to *all adults* who meet the income eligibility requirement, parents - regardless of whether or not their children are in their foster care or otherwise involved with the child welfare system - will have access to a broader array of supports and services.

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[1] Center for the Study of Social Policy & SPARC (2013). Raising the Bar: Child Welfares Shift Toward Well-Being. http://childwelfaresparc.files.wordpress.com/2013/07/raising-the-bar-child-welfares-shift-toward-well-being-7-22.pdf

[2] Dolan et al. 2011 as cited in Golden and Emam 2013.

[3] HHS, Office of Planning, Research, and Evaluation 2012.

[4] In addition to raising the eligibility level to 133 percent of the FPL, the ACA language also calls for a new methodology in calculating income which will make the effective minimum 138 percent of the FPL.

[5] Prior to the expansion of Medicaid under the ACA working parents were eligible at or above 64 percent of the FPL and non-working parents were eligible at or above 38 percent (American Public Health Association, *Medicaid Expansion*).

[6] American Public Health Association, *Medicaid Expansion*, http://www.apha.org/APHA/CMS_Templates/GeneralArticle.aspx?NRMODE=Published&NRNODEGUID=%7bD5E1C04A-0438-4FD4-A423-CEFDA0D9878D%7d&NRORIGINALURL=%2fadvocacy%2fHealth%2bReform%2fACAbasics%2fmedicaid%2ehtm&NRCACHEHINT=NoModifyGuest#Medi5.

States that elect to expand coverage also have the option to provide newly eligible adults with the full package of Medicaid coverage or an alternative benefit plan. Regardless of which Medicaid plan states elect to provide, both plans are required to include coverage for mental health and substance abuse treatment (behavioral health).[7]

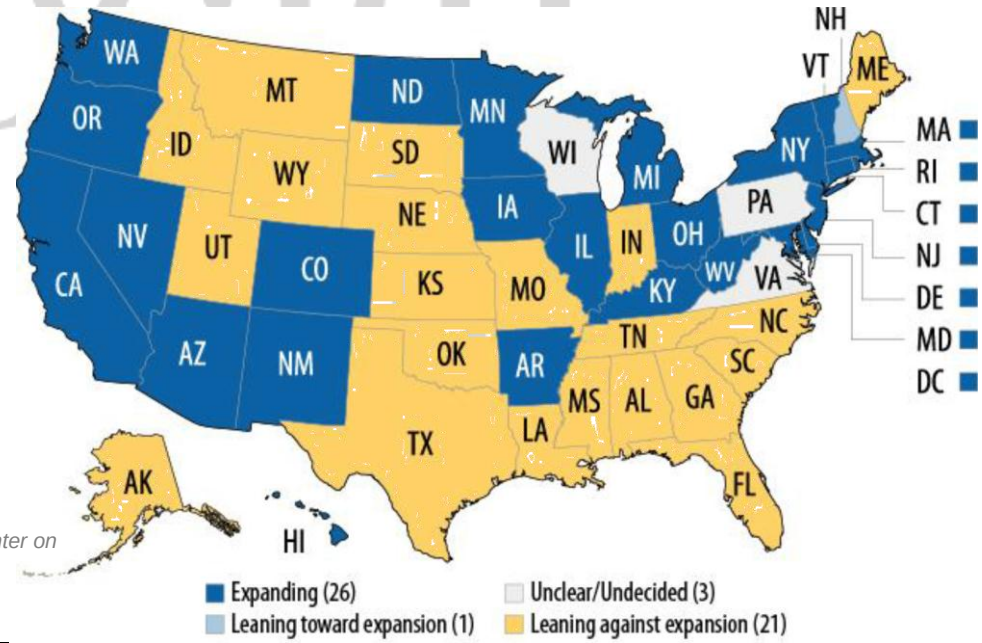
For families who are receiving in-home child welfare services, parental access to mental and behavioral supports and services can increase their capacity to provide a safe and stable home and decrease the risk of the child's removal. For parents whose children are in foster care, timely access to quality services and reducing the financial burden of treatment, can be critical to the family's ability to reunify successfully.

More importantly, increasing access to treatment can have positive impacts on child well-being by improving the caregiver's parental capacity to promote *their* children's health and well-being, potentially eliminating the trauma associated with maltreatment and separation from family due to foster care placement.

However, the expansion of Medicaid coverage to more parents is not guaranteed. A key finding from the 2012 Supreme Court ruling upholding the ACA is that the federal government cannot withhold federal Medicaid funds from states that do not elect to expand coverage to this population of adults; essentially making the expansion of coverage optional for states. But a critical point for states considering extending this coverage and for those advocating for it – is that under the ACA the federal government will cover the majority of the costs of providing coverage to those who are newly eligible.[8] Failing to elect this coverage is an important missed opportunity for parents and their children.

Recommendations for State Child Welfare Agencies:

As of November 26, 2013,[9] 26 states are expected to expand coverage, one state is leaning toward expansion, 21 states are not expected to expand coverage and three are undecided.[10] Efforts taken by child welfare and other stakeholders will likely vary based on the position their state has taken.



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[7] Golden and Emam 2013.
[8] Under the ACA, the federal government will cover 100% of the cost of coverage for those newly eligible for the first three years and phase down to 90 percent in 2020 and all subsequent years.
[9] As of September 4, 2013.
[10] Center on Budget and Policy Priorities. http://www.cbpp.org/files/status-of-the-ACA-medicaid-expansion-after-supreme-court-ruling.pdf

Strategic efforts should focus on:

1) The important relationship between child and family well-being and implementing supportive mental and behavioral health services for parents and caregivers.
2) Data that highlight the specific needs of families involved with child welfare systems.
3) The cost saving opportunities and long term fiscal benefits for states through innovative programming associated with the expansion of Medicaid coverage to a minimum level of 133 percent of the FPL.

Specifically, state policymakers, child welfare agencies and advocates should:

- *Elect the option to cover adults who have an income up to 133 percent of the FPL.* States should elect the option to expand Medicaid coverage under the ACA to adults up to 133 percent of the FPL to improve outcomes for children, youth and families. For states that elect to expand coverage, there is also the opportunity to continue expanding coverage to those with an income *above* the 133 percent of the FPL required minimum. In addition to the long-term benefits to children, expanding coverage can create opportunities to redirect funds that were previously used to cover services for those adults that are now covered through the expansion of Medicaid.

- *Understand the fiscal benefits for states if they elect to expand Medicaid coverage.* The Urban Institute has estimated that overall state savings in health care costs due to the expansion of coverage to previously uninsured individuals between 2014 and 2019 will be between $26 and $52 billion.[11] Strategic advocacy efforts should highlight the fiscal benefits of electing to expand coverage and the resulting opportunity that would arise to use federal funding for previously state funded services including state mental health treatment and parenting programs. By increasing the number of parents with access to behavioral health services there is the potential to prevent or shorten the length of stay in care for children, and reduce the associated costs. The long-term benefits of providing health care and behavioral treatment services will reduce future state expenditures for those who suffer from chronic health and mental health needs and often rely on emergency care rather than lower-cost preventive and continuous treatment.

- *Support the redirection of state and local funds, which were previously used to finance services now covered through Medicaid, to prevention and reunification services.* As states redirect resources to new programs, advocates should continue to highlight the benefits of prevention programs and supportive services to families involved in the child welfare system as means of reducing a child's length in foster care and a family's future involvement with child welfare. Child welfare agencies should use this opportunity to increase the implementation of innovative services to children, youth and families that may have had limited support before due to a lack of available funding.

[11] Center on Budget and Policy Priorities. http://www.cbpp.org/cms/?fa=view&id=3801

- *Utilize an automatic enrollment process and work with Medicaid agencies to coordinate enrollment and eligibility for parents as soon as they come into contact with the child welfare system.* Frontline workers may not be knowledgeable about the new eligibility criteria and process for enrollment. Now that an increased population of parents - regardless of whether or not their children are currently in their care, are eligible for Medicaid coverage - child welfare agencies should develop a streamlined process for ensuring all eligible parents that touch the system *are* enrolled. Additionally, as states choose which Medicaid benefit package to provide to those newly eligible, it is important that frontline workers can help parents select a health care package that best meets their needs.

- *Explore implementing integrated care models like Health Homes.*[12] Integrated care models will ensure the continuity of mental, behavioral and physical health care services and increase the quality of services for parents involved with the child welfare system. For states that have applied for Health Homes to target the needs of specific groups under the ACA, child welfare agencies and stakeholders should explore how these models can serve parents with complex mental health and substance abuse needs. In addition to Health Homes, other integrated models include primary care medical homes, demonstration projects for integration of mental health and primary care and accountable care organizations.[13]

- *Support child welfare and behavioral health agencies in collaborating to discuss the best way to spend ACA dollars in order to create a comprehensive system of care for families.* The ACA regulations now provide additional funds and opportunities for behavioral health services to be reimbursed through federal and Medicaid dollars. As a result, state funds that were previously allocated for these services can be redirected to create a comprehensive system of care. For example, Fresno County in California is working to improve their system of care through implementing a broader array of community-based services, particularly services that are trauma-informed, by redirecting funds that were previously allocated to the county Department of Behavioral Health to provide services to children, youth and families involved with the child welfare system.

[12] Medicaid Health Homes are designed to coordinate care, including primary, acute, behavioral health and long-term services, for people who fall into one of five categories: have two or more chronic conditions, have one chronic condition and are at risk for a second, have one serious and persistent mental health condition. States can also target health home services geographically.
[13] Hanlon 2010 and Howell et al. 2013 as cited in Golden and Emam 2013