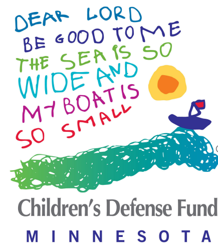


# *Health and Well-Being of Minnesota Children Jeopardized in Health and Human Services Budget*

## *May 13, 2011**

**Subject to change. This overview is based on the final agreement reached by the Health and Human Services Conference Committee on May 12, 2011.*

*The Senate and House are in the process of finalizing budgets for the coming biennium (July 1, 2011- June 30, 2013) to send to the Governor. To balance the budget and close the more than $5 billion deficit, both legislative bodies passed budget bills with massive cuts. Governor Dayton's proposed budget contains a mix of large cuts and $3.2 billion in additional revenue, mostly through tax increases on the wealthiest Minnesotans (e.g., a new 4th income tax tier at 10.95% for joint filers over $150,000 and head of household filers over $500,000; a temporary income surtax of 3% for all filers over $500,000; and a statewide property tax on home values over $1 million).*

Last night, the Health and Human Services (HHS) Conference Committee released a budget agreement containing $1.8 billion in cuts to health care and supportive services. The new budget contains fewer program cuts and eliminations affecting children and their families than the HHS Finance bills initially passed by the House (House File 1362) and Senate (Senate File 760). Several grant programs that were originally eliminated in the Senate's bill are held harmless in the current budget, including: American Indian Child Welfare Program grants which annually provide core child welfare services to 3,000 American Indian children and families; Children's Mental Health Capacity School Based Services grants which provide mental health services to more than 6,000 uninsured and under-insured children during the school year; Developmental Disability Family Support grants which provide financial assistance to more than 1,600 families raising a child with a disability; and grants to Community Action Agencies to offer local support annually to more than 300,000 Minnesota families in need. A bright spot in the budget is the inclusion of the House's proposal to increase funding for both Adoption Assistance and Relative Custody Assistance – two programs that provide financial assistance to adoptive families and relative caregivers who are caring for and providing permanent homes for children with special needs (the Senate eliminated grant funding for these programs in their initial budget). While we are relieved that the Senate and House agreed to remove the inclusion of children from one of their major health care reform proposals (i.e., the Healthy Minnesota Contribution Program), Children's Defense Fund-Minnesota (CDF-MN) does not support moving low-income parents and adults from MinnesotaCare into the private health insurance market.

Moreover, CDF-MN is still concerned with several of the proposals contained in the HHS Conference Committee Agreement. These cuts will jeopardize the well-being of Minnesota's children. Many of the cuts may save money in the short-term; but will result in greater long-term costs to our children and our state.

Not only is the HHS Conference Committee Agreement void of critical investments in child well-being, it cuts and, in a few cases, eliminates existing critical programs and services. By failing to ensure the success of Minnesota's children, all Minnesotans will ultimately pay the price.

CDF–MN identified three overarching areas of concern with the HHS Conference Committee Agreement:

1. The HHS Conference Committee Agreement cuts funding for supportive services, including prevention and intervention, placing thousands of vulnerable and at-risk children in even greater peril. Several proposals affect services for children who are neglected and abused; and many proposals affect children's mental health services.

2. The HHS Conference Committee Agreement reduces needed work supports for low-income children and their families, and will make it more difficult for families to provide their children with basic needs and stability, thereby making it substantially more difficult for families to move out of poverty. As a result, more children and their families will be pushed deeper into poverty.

3. The HHS Conference Committee Agreement restructures the delivery of Minnesota's public health care programs by shifting low-income Minnesotans into the private market, which will ultimately affect access to affordable and quality healthcare for Minnesota families.

CDF–MN opposes the following proposals in the HHS Conference Committee Agreement:

**1. CUTTING AND ELIMINATING FUNDING FOR SUPPORTIVE SERVICES WILL HARM THOUSANDS OF CHILDREN AND FAMILIES WHO NEED ADDITIONAL HELP.**

**Neglected and Abused Children**

In 2009, Minnesota county and tribal child welfare services assessed 25,000 reports of child neglect and abuse. Children who experience maltreatment are at high risk for delays in cognitive capacity, language development and academic achievement. If systems and other supports do not adequately respond to the needs of these children, they will likely suffer lifelong obstacles in terms of mental health, chronic health conditions and reduced earning capacity – all of which have personal consequences and public implications for Minnesota's future prosperity.

**Children and Community Services Act (CCSA) grants** are provided to all Minnesota counties to provide supportive services for children, adolescents and other individuals who are experiencing abuse, neglect, poverty, disability, dependency, or chronic health conditions. CCSA grants contribute to costs for services for more than 435,000 Minnesotans each year. Over 70% of CCSA grant funds are utilized to protect children and provide mental health services for uninsured and underinsured children.

- Proposal **reduces** CCSA grants by $22 million in Fiscal Years (FY) 12-13 and $24 million in FY 14-15. The CCSA grants are the only state dollars in Minnesota's child welfare system.

**Child Welfare Reform Prevention and Early Intervention grants** are provided to counties for child protection services designed to support families and keep children safely at home. These grants support services for 3,500 – 4,000 Minnesota families each year.

- Proposal **reduces** grants by $786,000 in FY 12-13.

Minnesota's child welfare system has one of the largest racial disparities in child welfare involvement in the country. In Minnesota, American Indian children are 6 times more likely to be subjects of child protection assessments and investigations; 8 times more likely to be subjects of a neglect report; and 12 times more likely to spend time in out-of-home placement. Additionally, 39% of American Indian children are living in poverty. Children in low-income families are seven times more likely to experience neglect than children from higher income families.

**Indian Child Welfare Act Transfer to R21 grants** are provided to tribes and American Indian social service agencies to offer services that preserve and strengthen American Indian families and reunify children in out-of-home placements with their families. These grants fund 18 programs and serve more than 2,800 Minnesota children.

- Proposal **reduces** grants by $1.5 million in FY 12-13.

## Children's and Families' Mental Health

Positive mental health is essential to a child's development. Mental health problems can develop at any age, and can seriously impact children's lives. In Minnesota, 9% of school age children and 5% of preschool children have a serious emotional disturbance, which is defined as a mental health problem that has become longer lasting and interferes significantly with the child's functioning at home and in school. Diagnosis and treatment are crucial to improving the mental health of children.

**Children's Mental Health Screening Grants** are provided to county child welfare and juvenile justice agencies to pay for mental health screenings and follow-up diagnostic assessment and treatment. These grants cover children who are already deeply involved in systems serving children. In 2009, 4,279 children involved in the child protection system received services through these grants, and 4,698 children involved in the juvenile justice system received services through these grants.

- Proposal **reduces** grants by $3.8 million in FY 12-13.

**Children's Mental Health Capacity Evidence Based Practices Grants** are provided for training individual mental health clinicians. For example, these grants provided training to 29 clinicians in the area of Parent-Child Interaction Therapy.

- Proposal **reduces** grants by $750,000 in FY 12-13.

**Children's Mental Health Cultural Competence Provider Capacity Grants** increase access to mental health services for children from cultural minority families. Last year, 355 children received direct mental health services through these grants.

- Proposal **reduces** grants by $300,000 in FY 12-13.

## Family Assistance

**Adoption Assistance Program** provides payments to adoptive families to offset the cost of assuming custody of and caring for children with special needs. These funds are critical to securing permanent homes for children with special needs. Adoptive parents of more than 7,000 children receive adoption assistance annually. **Relative Custody Assistance Program** provides payments to relatives to offset the cost of assuming permanent physical and legal custody of, and caring for, children with special needs. These funds are critical to securing permanent homes for children with special needs. Relatives and caregivers of more than 2,000 children receive relative custody assistance annually.

- Proposal **increases** appropriations by $3.3 million in FY 12-13 and $3.3 million in FY 14-15.

**Home Visiting Grants** are provided to Community Health Boards and Tribal Governments to deliver voluntary family home visiting programs designed to foster healthy beginnings, improve pregnancy outcomes, promote school readiness, prevent child abuse and neglect, reduce juvenile delinquency, promote positive parenting and resiliency in children, and promote family health and economic self-sufficiency for children and families. In 2009, nearly 81,000 home visits were completed. Nearly half of all home-visiting participants were infants and children.

- Proposal **reduces** TANF funding for home visiting grants by $7 million in FY 12-13 and $7 million in FY 14-15.

**Adult Mental Health grants** provide critical services (community supports, medication services and treatment) to adults with mental illness. A parent's mental illness can have a significant impact on a child's well-being. Children who have a parent with a mental illness are at-risk of developing social, emotional and behavioral problems.

- Proposal **reduces** mental health grants by $14 million in FY 12-13 and $14 million in FY 14-15. This 10% cut will affect Community Support Programs, supportive housing and community mental health centers that provide treatment for the uninsured and underinsured. The Senate also eliminates mental health crisis grants.

**2. REDUCING CRITICAL WORK SUPPORTS WILL MAKE IT MORE DIFFICULT FOR FAMILIES TO MOVE OUT OF POVERTY, AND WILL PUSH MORE CHILDREN AND FAMLIES INTO POVERTY.**

**Minnesota Family Investment Program (MFIP)**

Strong families are critical to creating a nurturing environment for children and contributing to their healthy development. All parents need information and support to be successful, and some must count on state-supported services to help them through challenging times. The **Minnesota Family Investment Program (MFIP)** is our state's primary program for assisting low-income families with children move out of poverty through work. A family of three, which includes two children and one adult, receives $532 in MFIP cash support and $473 in MFIP food support monthly. That amount does not even bring this family of three to the federal poverty line. In fact, this amount of assistance represents 66% of the federal poverty level. A family can receive MFIP assistance until its gross earned income is 115% of the federal poverty level ($1,754 per month). In December 2009, 57 percent of MFIP families with eligible adults had been receiving assistance for fewer than 25 months against the program's 60-month lifetime limit.

- **Proposal cuts MFIP assistance by $50 a month for each disabled parent in a family receiving MFIP assistance.** This proposal would affect 6,400 Minnesota families with a disabled parent. The federal government has determined that these parents are too disabled to hold a job. Because the parents are receiving federal disability assistance, they are not receiving any state assistance through MFIP. It is the children's assistance that will be cut by $50 a month. For example, a disabled mother with two children is treated as a family of two, not three, when calculating the family's assistance amount. Nearly 1,800 Minnesota families receiving MFIP assistance have more than one disabled family member. If the other disabled family member is the other parent, that family would lose $100 per month in critical assistance. One-third of children in SSI-parent households are struggling with a serious health condition, such as cystic fibrosis, cancer, epilepsy, or ADHD (projected short-term savings of $4.1 million in FY 12-13 and $6.8 million in FY 14-15).

**MFIP Consolidated Fund** is the source of funding counties use to pay employment services and work supports for parents receiving MFIP assistance, emergency assistance grants to families facing homelessness, the state's share of financial worker salaries, and the staff and administrative costs for the Diversionary Work Program (a four-month assistance program).

- Proposal **reduces** the MFIP Consolidated Fund by $20 million in FY 12-13 and $20 million in FY 14-15.

**MFIP Training and Education** opportunities are critical to a parent's ability to move themselves and their families out of poverty.

- **Proposal requires parents who are pursuing training and education to also be working at least 10 hours per week**. Forty-eight percent of MFIP caregivers have not completed their high school degree. Requiring work in addition to training and education activities fails to recognize that parents who receive MFIP assistance often have very young children. This proposal also fails to acknowledge that most of the jobs available to parents receiving MFIP assistance are jobs with unpredictable and inconsistent hours, thereby making it difficult to both arrange child care and build the consistent schedule necessary to succeed in training and school (projected short-term savings of $954,000 in FY 12-13 and $1.2 million in FY 14-15).

## <u>Child Care</u>

**Child care** can have a tremendous impact on a child's development. The quality of care children receive during the early years of life has a long-lasting impact on their ability to learn and, thus, their future well-being. Three out of four Minnesota families use child care for their children under the age of 13. Over 230,000 Minnesota children under the age of 6 spend time in licensed child care settings.

**Minnesota's Child Care Assistance Program** (CCAP) helps to make quality child care affordable for income-eligible families. Child Care Assistance is available to families participating in MFIP, families that had an MFIP case close within the last 12 months, and low-income families who may be eligible for the Basic Sliding Fee (BSF) program. The CCAP can help families pay child care costs for children up to age 12, and for children with special needs up to age 14. Child care costs may be paid for qualifying families while they go to work, look for work or attend school. This program has already experienced major funding cuts in past sessions.

- Proposal **reduces** reimbursement rates by 5% for all types of child care providers. This proposal would affect nearly 18,000 working families and impact the financial health of many child care providers (projected short-term savings of $13.7 million in FY 12-13 and $17.2 million in FY 14-15).
- Proposal **reduces** reimbursement rates by 16% for legally non-licensed child care providers (Family, Friend and Neighbor – FFN). This proposal would affect more than 4,000 low-income families (projected short-term savings of $6.7 million in FY 12-13 and $7.4 million in FY 14-15).
    - Cutting child care rates means that the providers that care for our children will be underpaid. Rate cuts will likely make it harder for working Minnesotans to find quality child care for their children. Centers may close, and family, friend and neighbor (FFN) providers may have to sacrifice quality in order to make ends meet for themselves and the children in their care.
- **Proposal makes various changes to CCAP to simplify the program, address program integrity and improve the quality of child care in unregulated child care settings**. *We will provide more information on specific policy changes after the bill is released* (projected short-term savings of $6.2 million in FY 12-13 and $14.8 million in FY 14-15).

**Child Care Service Development Grants** are provided to child care and resource referral agencies to build and improve the capacity of the child care system for centers and family child care providers. Each year, 2,300 grants are awarded to providers to improve the quality and availability of child care.

- Proposal **eliminates** grants in FY 12-13 (projected savings of $500,000 in FY 12-13).

**Child Care Resource and Referral Grants** are provided to child care resource and referral agencies to support the child care infrastructure through information for parents, supports and training resources for providers, coordination of local services and data collection to inform community planning. These grants provide 27,000 child care referrals annually, and support high quality training opportunities through classes offered to 35,000 participants.

- Proposal **eliminates** grants in FY 12-13 (projected savings of $1.5 million in FY 12-13).

**Migrant Child Care Grants** are given to community based programs for comprehensive child care services for migrant children throughout Minnesota. Annually, 850 migrant children under the age of 14 are served.

- Proposal **reduces** grants by $170,000 in FY 12-13.

**Child Care Facility Grants** are given to child care providers and centers in communities to improve child care or early education sites or to plan, design and construct, or expand sites to increase availability of child care and early education.

- Proposal **reduces** grants by $326,000 in FY 12-13.

**Basic Sliding Fee Child Care Assistance** provides financial subsidies to help low-income families pay for child care. Parents can pursue employment, or education that will lead to employment, while their children receive care. Each month, Basic Sliding Fee Child Care purchases child care for 15,900 children in 9,100 families.

- Proposal **takes** $5 million in unused funds from the Basic Sliding Fee Child Care program to help solve the budget deficit. Under current law, unspent funds are to be redistributed to counties with families on child care waiting lists. These funds could have been used to serve 1,000 additional families in the future. Currently, 4,000 Minnesota families remain on the waiting list for child care.

**3. SHIFTING LOW-INCOME MINNESOTANS INTO THE PRIVATE INSURANCE MARKET WILL RESULT IN THE LOSS OF HEALTH CARE COVERAGE FOR THOUSANDS OF MINNESOTA FAMILIES.**

**The Healthy Minnesota Contribution Program (HMCP)** would reduce the number of Minnesotans able to access affordable health care. The proposal would move low-income adults off of MinnesotaCare and push them into the private market. MinnesotaCare serves more than 100,000 Minnesotans each month, and plays a critical role in helping families move out of poverty. MinnesotaCare currently provides coverage to adults without children with incomes up to 250% FPG and to families and children with incomes up to 275% FPG. Under the HMCP, adults with incomes above 125% FPG, and parents above 133% FPG would be moved out of MinnesotaCare and would receive a set amount of money each month (a sliding fee subsidy based on income) to purchase health insurance through the private market. These Minnesotans would likely have to purchase insurance policies with higher premiums, deductibles and copayments, and with lesser benefit sets than they currently receive under MinnesotaCare.

The HMCP is somewhat similar in design to the Affordable Care Act (ACA, federal health care reform). Both the HMCP and the ACA establish a subsidy program to assist lower-income families and individuals in purchasing health insurance through the private market. However, the HMCP does not include the

necessary consumer protections and market reforms (e.g., prohibition of preexisting conditions, prohibition of lifetime limit on benefits, individual mandate, and cost-sharing affordability provisions) that make health care truly affordable and accessible. In order for the HMCP to be enacted for parents, Minnesota would have to alter its waiver and have it approved by the federal government. However, adults without children are not included in the federal waiver so the HMCP could be enacted for this population, if passed, without federal approval. In its fiscal analysis, the Minnesota Department of Human Services (DHS) assumes that only 90% of adults without children eligible under MinnesotaCare would be able to navigate the private market to be successful in purchasing an insurance policy. DHS also assumes that one-third of the current MinnesotaCare population of adults without children would be denied eligibility through the private market due to preexisting conditions. The HMCP calls for these individuals to be enrolled in high-deductible plans through the Minnesota Comprehensive Health Association (MCHA), Minnesota's high-risk insurance pool. These individuals would receive a subsidy to help with MCHA premium costs, which are higher than the market average.

While CDF-MN supports the general idea behind both health care reform and the HMCP, we believe that there needs to be more discussion and analysis around HMCP before it is enacted. Because the HMCP does not capture any General Fund savings (MinnesotaCare is funded through the Health Care Access Fund, a designated fund), it does not bring the state any closer to balancing the $5 billion budget deficit. CDF-MN believes that more time should be allowed for further discussion on the HMCP, and sees the potential that the HMCP may have as a demonstration project to lay the groundwork for the ACA. We further suggest aiming any future demonstration project at a limited segment of the MinnesotaCare population, such as those with incomes at 200% FPG or above.

**Other Health Care Proposals**

- Proposal **repeals** the MA Bridge Program, which would help children by authorizing two months of extended MA eligibility followed by automatic MinnesotaCare eligibility until renewal for children ages 2-18 whose income exceeds 150% FPG. The MA Bridge Program has not yet been implemented. Minnesota is awaiting federal approval to the State's Prepaid Medical Assistance Project Plus (PMAP+) Demonstration waiver (projected short-term savings of $23 million in FY 12-13 and $82 million in FY 14-15).

- Proposal **repeals** the MinnesotaCare premium grace month and the renewal rolling month. Currently, MinnesotaCare enrollees are required to pay their monthly premiums in the month prior to the coverage month to continue coverage. The premium grace month permits MinnesotaCare enrollees to pay their premiums up to the last day of the coverage month, thereby giving enrollees an extra month to pay their premiums before they are disenrolled. This is important for families working to make ends meet in a struggling economy. The renewal rolling month allows enrollees who fail to submit their renewal forms in a timely manner to remain eligible for an additional month before being disenrolled. The MinnesotaCare premium grace month and the renewal rolling month have not yet been implemented. Minnesota is awaiting federal approval to the State's PMAP+ Demonstration Waiver (projected short-term savings of $6.4 million in FY 12-13 and $10.5 million in FY 14-15).

- Proposal **repeals** the MinnesotaCare provision eliminating the income limit for children. Under this provision, any child whose household income exceeds 275% FPG would be eligible for MInnesotaCare while paying the maximum premium ($480 per month). This provision has not yet been implemented. Minnesota is awaiting federal approval to the State's PMAP+ Demonstration Waiver (projected short-term savings of $6.3 million in FY 12-13 and $55 million in FY 14-15).

- Proposal **repeals** the MinnesotaCare provision that exempts children with household income equal to or below 275% FPG from disenrollment for failure to renew coverage annually. This provision has not yet been implemented. Minnesota is awaiting federal approval to the State's PMAP+ Demonstration Waiver (projected short-term savings of $2.4 million in FY 12-13 and $21 million in FY 14-15).

- Proposal **repeals** automatic MinnesotaCare eligibility for children who are exiting foster care. This policy makes children residing in foster care on their 18th birthday automatically eligible for MinnesotaCare upon termination of foster care until their 21st birthday. If children are receiving Title IV-E foster care services, they automatically receive MA until the age of 21. This provision has not yet been implemented. Minnesota is awaiting federal approval to the State's PMAP+ Demonstration Waiver (projected short-term savings of $347,000 in FY 12-13 and $3.4 million in FY 14-15).

- Proposal **shortens** MinnesotaCare eligibility reviews from 12 months to 6 months which would make the program more complex and reduce enrollment (projected savings of $8.3 million in FY 14-15).

- Proposal **eliminates** grant funds (U Special Kid Care Management) for disease management programs for MA and GAMC recipients who are not enrolled in PMAP or prepaid GAMC and are receiving services on a fee-for-service basis (projected short-term savings of $410,000 in FY 12-13 and $410,000 in FY 14-15).

- Proposal **eliminates** grant funds for outreach activities, such as providing information, application and assistance in obtaining coverage through Minnesota health care programs (projected short-term savings of $180,000 in FY 12-13 and $180,000 in FY 14-15).