Overview of Governor's Executive Budget

This document includes two overviews of the Governor's Executive Budget. They include:

1. A chart developed by the Early Care and Learning Council showing funding for various early childhood funding programs in the 2012 State Budget and 2013-14 Executive Budget.
2. Selections of Kate Bresilin's testimony on the relevant programs in the Health Budet.

Child Care	2012-2013 State Budget	2013-2014 State Budget
Child Care		
Child Care Subsidies Total	**$532,329,700**	**$532,329,700**
TANF - Subsidies	$324,276,000	$394,967,000
State general funds-subsidies	$208,053,700	$137,362,700
Migrant worker	$1,754,000	$1,754,000
CCR&R*	$22,034,000	$22,034,000
Legally exempt enrollment agencies - NYC	$6,125,000	$6,125,000
Infant Toddler Centers	$1,100,000	$1,100,000
Child Care Provider Training	$6,434,000	$6,434,000
Automated licensing systems	$2,000,000	$2,000,000
Scholarships Education Ongoing Professional Development	$10,240,000	$10,240,000
Health and Safety Start up	$586,000	$586,000
Child Care in State Courts	$300,000	$300,000
SUNY CC	$2,020,000	$2,020,000
CUNY CC	$2,020,000	$2,020,000
Migrant Child Care	$750,000	$750,000
Market Rate Survey	$50,000	$50,000
Additional spending authority if funds received	$38,332,000	$38,332,000
Quality Child Care and Protection Act**		$343,000
Other Areas		
UPK***	$384,000,000	$385,034,734
Early Intervention	$163,942,000	$163,121,000
Healthy Families NY	$23,288,200	$23,288,200
Nurse-Family Partnership	$2,500,000	$2,500,000
Advantage After School	$17,755,300	$17,255,300
Extended School Day (ESD)/School Violence Prevention (SVP)	$24,344,000	$24,344,000
Youth Development/Delinquency Prevention (YDDP)/Special Delinquency Prevention Program (SDDP)****	YDDP-$10,622,675 SDPP-$3,499,025	$14,121,700

*Up to $22,340,000 may be available…the overall contract was cut by nearly $850,000 in SFY 2012-2013.

**State Operating Funds for Licensing Enforcement/Training/Admin.

***The Executive budget also provided $25 million for full-day pre-kindergarten targeted toward higher need students in lower wealth school districts via a competitive process.

****Last year the legislature added $1,285,544 which was distributed separately from the normal YDDP/SDPP allocation and is not reflected in the Executive proposal. Additional changes include the consolidation of these two funding streams into a single Youth Development Program.

Selections from Kate Breslin's Testimony before the Joint Fiscal Committees on the SFY 2013–14 Executive Budget Health/Medicaid Budget Hearing Financing and Administration

Hospital Indigent Care Pool

The Executive Budget proposes improvements the Hospital Indigent Care Pool distribution methodology with the intent of improving transparency and equity; complying with federal rules; ensuring access to care; improving compliance with the HFAL. Assembly Bill 2844 (Gottfried) would add requirements for annual reports on the impact of the new distribution on safety net providers and access to care and would speed up the transition to the new distribution methodology.

The Hospital Indigent Care Pool was designed to help hospitals cover the costs of providing care to uninsured and underinsured people. The methodology that evolved for distributing the more than $1 billion has been notoriously opaque and lacking in accountability. In 2007, a Technical Advisory Committee that included legislators, the Commissioner of Health, and hospital representatives found, among other things, that there was no clear link between the Indigent Care Pool dollars received by a hospital and the services provided to individual patients. And, because of changes to federal rules, New York is at risk of losing federal funds for this purpose if it does not improve the distribution methodology.

New York's existing Hospital Financial Assistance Law (HFAL, also known as Manny's Law) requires that hospitals establish financial assistance programs for services to uninsured and low-income patients, but compliance with and enforcement of the law has been lax.

SCAA supports the Executive Budget's proposed distribution methodology changes and urges the addition of language that would require additional transparency. SCAA supports legislation proposed by Assemblyman Gottfried (A.2844) that would add requirements for annual reports on the impact of the new distribution on safety net providers and access to care and would speed up the transition to the new distribution methodology.

Consolidation of Medicaid Administration in the Department of Health

The Executive Budget moves to consolidate Medicaid administration within the Department of Health (DOH) with the stated intent of increasing efficiency and responsiveness. This would move certain functions—rate setting, negotiation of managed care contracts, claims processing— from the Office of Mental Health, Office for People with Development Disabilities (OPWDD) and Office of Alcohol and Substance Abuse Services to the Department of Health.

Consolidation could improve coordination of care and achieve efficiencies, including helping to reduce/eliminate problems faced by safety net providers trying to get integrated, comprehensive care to patients with multiple needs.

However, these types of transfers from agency to agency can be fraught with problems from the logistical to the philosophical. The OPWDD, for example, has a robust family and consumer engagement program. It will be extremely important to ensure that the needs of individuals who are involved with/served by these disparate agencies are reflected in the rates and policies put forth by the Department of Health.

The transfer of Medicaid functions to the Department of Health requires care and attention so that the needs of individuals with special needs are met.

Access and Workforce

Medicaid Managed Care Ombudsman Program

There are at least 1.3 million New Yorkers with disabilities or chronic illnesses who are covered by Medicaid. As New York moves forward with Medicaid managed care for all enrollees, it has become clear that many individuals will require expert assistance and navigation as they adjust to the shift to managed care. For people with disabilities and chronic illnesses, including seniors, this policy presents significant changes in how they access health and mental health care services because many have previously been exempt or excluded from mandatory enrollment.

The new Medicaid Managed Care Ombudsman Program contained in the Executive Budget would provide individual and systemic advocacy assistance for seniors and people with disabilities in managed care. This program will help managed care enrollees resolve disputes with managed care entities; monitor, document, and investigate systemic problems such as inadequate accommodations for people with mobility impairments; offer information, guidance, and support; and provide direct representation in grievances, fair hearings, and appeals. With the roll out of the mandatory Managed Long-Term Care Program (MLTCP) already underway, we support implementation of this program as soon as possible. $3 million is provided as part of the appropriations for non-institutional managed long-term care (state and federal Medicaid match at $1.5 million each). The initial focus will be the MLTC population, with other populations added as further resources are provided. The Department of Health anticipates moving quickly to get these services in place and will be designing and developing the program in the coming weeks and months.

SCAA urges the Legislature to approve the $3 million for the "managed long-term care ombuds program" in the Aid to Localities budget as a down payment on the creation of a more expanded ombuds program.

Primary Care Workforce

The Medicaid Redesign Team recommended a number of changes to workforce regulations and laws in order to expand access to primary care. Some of these proposals are included in the Executive Budget. SCAA is most familiar with the tremendous disparities across the state in access to dental services. Increasing access to primary and preventive dental care through the expanded use of dental hygienists is one approach to reducing these disparities. The collaborative model, in general, is a team model in which providers collaborate to provide safe, high-quality care. The basis of collaboration is the belief that quality patient care is achieved by the contribution of all care providers. The collaborative practice provision included in the Executive Budget would make it easier for clinics, nursing homes and other health facilities serving low-income populations to access the important preventive services provided by dental hygienists. Another section would authorize dental hygienists to sign dental health certificates. This could increase the number of children who are evaluated each year for dental problems as part of their school health checks and referred for care.

SCAA supports the Executive Budget's proposed changes that will improve access to dental care.

Coverage
Implementation of the Affordable Care Act (ACA) in New York was always going to be a daunting task. The complexity of the federal law and the multitude of regulations have required the state agencies involved to be creative, dedicated and innovative. The Executive Budget includes a range of proposals to bring State laws into compliance with the ACA and move toward an integrated continuum of affordable health insurance.

The Executive Budget restructures Medicaid eligibility to conform to new federal law creating groupings based on the Modified Adjusted Gross Income (MAGI)—the budgeting process that will be used to determine their eligibility for public benefits for pregnant women, children, caretakers and childless adults. There are also provisions that would enable the State to create online applications for benefits and allow for electronic verification of provided information. All these changes should simplify the application and determination process and result in savings.
Other proposed changes to eligibility include:

- Providing 12 month continuous coverage for adults.
- Extending the Medicaid spend down to childless adults.
- Expanding the Medicaid eligibility level for pregnant women to 200% of the FPL.

These changes will simplify administration of Medicaid and extend important coverage to these populations.

Support changes to Medicaid that implements eligibility requirements under the ACA and simplify enrollment.

Elimination of Family Health Plus
Among the provisions in the Executive Budget that are designed to implement the Affordable Care Act, is a problematic move to eliminate Family Health Plus (FHP). Justification for this move is that the current enrollees will be absorbed into either Medicaid or the Health Benefit Exchange. Based on the ACA rules, Medicaid will cover all adults up to 138% of the federal poverty level (FPL). Our concern is for very low-income parents between 138% FPL and 150% FPL who are currently eligible for FHP, but after 2014 will not be eligible for Medicaid. Their option for health insurance will be the Exchange where even the federal subsidies will not be high enough to make coverage affordable.

While the State has proposed some assistance for parents who apply for FHP before the end of 2013 in the form of assistance with cost-sharing and premiums, families who miss that deadline will receive no assistance. The ideal of the ACA is affordable health coverage for all. It is not enough for the State to indicate that this population has a place in the system if that place is unaffordable.

New York should consider creating a Basic Health Plan to provide coverage for low-income individuals below 200% of the FPL. The Basic Health Plan could offer free or very low-cost coverage and could achieve state savings. The State should take the necessary steps to create a Basic Health Plan as it awaits federal guidance on the Basic Health Plan.

A portion of the savings derived from the implementation of the ACA should be set aside to assist these parents and the State should establish a placeholder in the budget for the creation of a Basic Health Plan as provided for in the ACA.

Medicaid for Children and Youth in Foster Care
New York is implementing Medicaid Managed Care for children and youth in foster care. This is an issue that is not addressed in the Executive Budget but is happening administratively. These are the more than 20,000 children who are among the most vulnerable in our society. Children and youth in foster care experience higher rates of physical, mental and dental health problems than the general population as well as higher rates of developmental disability. The transition of these children and youth to Medicaid Managed Care needs to be done with extreme care with the ultimate goal of making sure that they receive better care and better outcomes.

In addition, the ACA requires that states provide Medicaid coverage for youth who age out of foster care until they reach age 26.

The implementation of both of these policies should be done with extreme care and attention to outcomes with the ultimate objective of significant improvement in access and care for these children and young people.

Early Intervention
Early Intervention (EI) provides comprehensive, coordinated services to meet the needs of infants and toddlers with disabilities and their families. To be eligible for services, children must be less than three years of age and have a confirmed disability or established developmental delay in one or more of the following areas of development: physical, cognitive, communication, social-emotional and/or adaptive. EI aims to identify and evaluate infants and toddlers whose development is compromised as early as possible and provide appropriate intervention to improve development.

The Executive Budget proposes significant changes to the EI program especially around health insurance reviews, service determinations and network participation. The proposal would require insurers to include EI service providers in their networks and require consumers to use providers in their insurance networks with limited provisions for exemptions. There are also changes to provider billing and contracting that may be an administrative challenge to some providers.

It is important that children and families who need EI's developmental services are able to get appropriate services in a timely way. In the few short years that a child is an infant or toddler with a disability, every day matters. As the Legislature considers the Governor's proposals, we urge consideration of the following:

- The EI system should be child and family-centric. The Department of Health should consider creating an ombudsman to help address families' concerns in a timely manner.
- EI providers may find it difficult to navigate the process of negotiating contracts and rates with health insurance companies.
- Cash flow may become a concern for EI providers if payments are not timely or when there are administrative obstacles, such as claim denials.

*E**arly Intervention provides services for some of the State's most vulnerable children. While moving in the direction of better care coordination, fiscal stability and health plan accountability, New York must ensure that children and families that need EI services can get them in a timely manner.***

Public Health, Outreach and Advocacy

Strengthen and expand evidence-based maternal, infant and early childhood home visiting. Maternal, infant and early childhood home visiting has emerged across the nation as a promising way to engage new and expecting parents and their children with services that support the family and lead to positive health and other outcomes—and public cost savings—in the short, medium and long term. The federal Affordable Care Act (ACA) provides funding for states to develop their home visiting infrastructure to improve outcomes for families who reside in at-risk communities and New York State has invested ACA funds in home visiting. The Medicaid Redesign Team and Department of Health are moving forward with an initiative to include evidence-based home visiting in the Medicaid program.

SCAA urges the Legislature to support home visiting programs and infrastructure. The Legislature included a dedicated $2.5 million last year in the DOH budget to help support the sustainability of Nurse-Family Partnership maternal, infant and early childhood home visiting program; the Executive Budget did not continue this funding. We request that the Legislature restore funding.

Outcome-Based Health Planning

The Executive Budget proposes to consolidate a number of public health programs into six programmatic areas: Chronic Disease Prevention and Treatment, Environmental Health and Infectious Disease, Maternal and Child Health Outcomes, HIV, AIDS, Hepatitis C and STDs, Health Quality and Outcomes and Workforce Development. Current funding for a number of individual programs will be collapsed into these categories, with a reduction of over $40 million, and would be awarded through grants and contracting on a competitive basis.

We applaud the Governor's articulation of a willingness to examine and reorganize programs and find new and better ways of improving population health. We are concerned though, that in the case of health program funding, the Executive Budget provides little explanation or rationale for the proposed consolidation and reductions at a time when families and communities are vulnerable and may not be ready to absorb the impacts. We are also concerned about the stability of safety-net providers during a time of tremendous change already in the health care system. The uncertainty of how the money will be allocated within each category and the uncertainty of how existing contracts will be handled create big budgeting problems for many providers.

Making our system more effective will entail moving our focus significantly from institutions to communities and from intervention to prevention. It will also entail supporting programs that work—those that help ensure that children and families are physically and mentally healthy and well-cared for, that support parents' ability to work and that keep students in school and on a path to success. While we support the move of the Department of Health toward evidence-based programs and outcomes measures in the implementation of programs, we have questions about how decisions will be made to determine funding for programs and how outcomes for populations served in these broad categories will be monitored.

Ensure that funding in the Outcome-Based Health Planning program does not jeopardize important public health initiatives or infrastructure while reshaping public health priorities.

General Public Health Work

The Executive Budget includes substantial changes to the General Public Health Work (GPHW) section of the Public Health Law (Article 6), that provides funding to local county departments of health. This is an important section of Public Health Law because county health departments are often the first line of defense for communicable disease and emergency preparedness and support activities that promote the health of communities and populations.

The proposal increases the base funding for counties and also adds $1 million for incentive performance standards through increases to state aid. At the same time, the proposal streamlines reporting requirements and redefines core public health services. We believe these changes will better support the efforts of county health departments but we are still assessing the impact all these changes will have on populations. It has been many years since the importance of public health has been recognized with increased funding.

Support both the funding increases for the GPHW program and the proposals to modernize reporting, services and administration.