The Alliance of Long Island Agencies, Inc. (ALIA), Cerebral Palsy Associations of New York State, Inc. (CP of NYS), the Developmental Disabilities Alliance of Western New York (DDAWNY), the InterAgency Council of Developmental Disabilities Agencies, Inc. (IAC), and the New York Association of Emerging and Multicultural Providers (NYAEMP) have joined together to offer comments and recommendations on the Health section of the 2020-2021 Executive Budget proposal.

DEPARTMENT OF HEALTH

- **Early Intervention Program** – 3for5 & Covered Lives
- **Consumer Directed Personal Assistance Program –** Support and Sustain
- **Clinics Serving People with I/DD –** Provide Financial Stability

Individuals with developmental disabilities are, by definition, medically underserved throughout the health professional continuum. From Early Intervention through adult services, funding has been cut, remained flat or at best has had minimal increases over the past 26 years, so that providers are increasingly in scarce supply. Individuals often do not have access to physicians and medical professionals due to lack of training, experience and exposure. When individuals with disabilities do not have access to medical professionals with experience, they end up in Emergency Rooms (ER) for what may have been a routine or untreated condition. This usually results in expensive procedures (MRI, CT Scan, etc.) and hospital stays because the ER physicians and staff have no experience with these individuals, who may be nonverbal and/or medically complex. This situation is not only extremely costly to the New York State Medicaid program, but also traumatic for individuals and can all be easily avoided. Voluntary agencies supporting people with disabilities have stepped up to ensure their access to health services across the State through Article 28 and Article 16 clinics serving patients with the highest needs but often at a financial loss.

In order to address this scarcity of medical professionals, we strongly support the budget items below as well as legislation, which incurs no additional cost, which would require all medical schools to incorporate at least 16 hours of curriculum, during the 4 years of medical school training, pertinent to the care of children and adults with intellectual and developmental disabilities (I/DD), including but not limited to autism.

EARLY INTERVENTION

- ✓ **PROVIDE A 3% INCREASE FOR 5 YEARS (3for5) TO ADDRESS YEARS OF STAGNANT RATES**

  The Early Intervention (EI) program, authorized under Part C of the federal Individuals with Disabilities Education Act (IDEA), provides critical services for children with disabilities and developmental delays from birth to three years of age, and their families. Research has shown that EI services, which are provided in a comprehensive, coordinated

and collaborative manner as intended by law, are cost-effective and successful in improving long-term prognoses and minimizing the need for life-long services. *An investment in EI is clearly both fiscally and socially prudent.*

Over the past 26 years, the New York State Department of Health (DOH) has made EI rate adjustments that have resulted in millions in savings for the program and community-based providers are being paid less today than when the program began in 1994. The rate for home and community based individual visits, by far the most frequently delivered EI service, actually decreased in all areas of the state by an average of 6-8%. Even with the 5% increase for Occupational, Physical and Speech and Language Therapies in last year's budget, which recognized the EI provider shortage, these professionals still lag 1% to 3% behind what they made in 1994.

Therefore, with rates based on pre-1993 cost data, minimal across the board increases, and several re-calculations resulting in decreases in some rates since that time, the reimbursement is significantly out of date in terms of costs for salaries, benefits, and other fixed costs that have skyrocketed in the last 26 years. Many providers have discontinued EI services despite the promise of real and lasting improvements for the infants and toddlers with disabilities who utilize the service. All of which has resulted in an increasing state-wide shortage.

While all other comparable service systems (hospitals, nursing homes, etc.) have received continuing increases in trend factors and cost of living adjustments over these past 26 years, the financial needs of the Early Intervention service system have been neglected, discouraging providers and compromising the quality and availability of services for children and families.

Because the EI program has been neglected over the past 26 years, like the other programs and services included in the health and human services COLA that has been deferred every year, except for one 0.2% increase for the past ten years, we believe that a 3% increase for the next 5 years is more than justified. We need the 3for5 increase because of the statewide shortage of EI providers, the overall impact of rate adjustments, the increased cost of services over the past 26 years and the significant administrative and billing responsibilities associated with the State Fiscal Agent.

- **Recommendation: Provide a 3% increase (3for5) for all EI** program reimbursement rates.
  Cost: Approximately $5M (of the $170M for all human services 3for5 request)

- ✓ **SUPPORT AN EARLY INTERVENTION "COVERED LIVES" ASSESSMENT**

Under Public Health Law, Early Intervention (El) services must be provided to eligible children at no cost to their families. The EI program is financed through a combination of state and county funds, Medicaid and commercial insurance. Although Public Health Law and the IDEA mandate that public and private commercial insurance be maximized in financing El services, reimbursement from third party payers other than Medicaid has been minimal, leaving the cost of this entitlement to be paid by state and municipal tax dollars. Recognizing that the current structure of financing EI costs is inadequate (although approximately 45% of EI children have commercial insurance, only 2% of EI claims are paid by commercial insurance), we support a different approach to funding, utilizing a statewide Early Intervention services pool funded through a covered lives assessment from which municipalities and the State would be allocated funds to pay El costs. Allowing for

the direct allocation of funds to municipalities from the statewide pool will eliminate the unwieldy and inefficient step of requiring EI providers and municipalities (in the case where the insured is not eligible for Medicaid) to seek reimbursement from third party insurers, including time consuming appeals of insurance claim denials, and then, only upon a final determination of denial or other disposition of the claim, from the State. In cases where the insured is eligible for Medicaid, municipalities will remain obligated to seek reimbursement from Medicaid first. Making funds readily available and streamlining the process by which the funds are distributed to municipalities and the State will provide vital relief to EI providers, New York State and municipalities while improving our ability to more effectively provide EI to infants and toddlers who need the services. This proposal will also result in administrative savings for commercial health insurers.

- **Recommendation:** Shift current commercial insurance coverage from a claims-based model to a covered lives pool funded program.
  Cost: No additional cost

CONSUMER DIRECTED PERSONAL ASSISTANCE PROGRAM (CDPA)

- ✓ **PRESERVE CDPA FOR THOSE IT WAS DESIGNED TO SUPPORT**

Consumer Directed Personal Assistance (CDPA) is a statewide Medicaid benefit that allows consumers with stable medical conditions and/or disabilities to direct their own personal care services. New York's CDPA program began in New York City in 1980 and has expanded to meet the needs of consumers in every county. The program has served as a national model, enabling consumers with disabilities to direct their own care at a reduced cost to the Medicaid program. They choose who to interview and hire and make decisions about scheduling and even termination. The program's flexibility accommodates people who do not fit within costlier home care models or nursing homes. Research has proven that CDPA is cost efficient and works. The ability of the participant to hire the person of their choice (rather than being assigned staff by an agency) promotes a better quality of life, is less stressful than having a stranger in their home, and at a lower cost. In fact, the CDPA program was so successful and cost efficient that the first MRT promoted expansion of the program to everyone eligible for home care and allowed anyone to become a fiscal intermediary. It was because of this promotion that the CDPA program and budget has expanded so dramatically.

The program is also a valuable and cost-effective tool to address worker shortages and cultural and linguistic issues. Because consumers hire their own workers, the supply is only limited by the quantity of people willing to do the work and the consumer's criteria. Consumers who would otherwise have difficulty finding workers who understand their traditions – or their language – can hire those from their community, alleviating the concern entirely. For consumers upstate, where the home care worker shortage is most severe, CDPA has played a critical role and is often the only homecare available. There is a well-known shortage of both licensed agencies and workers in rural areas and small towns. If CDPA was curtailed or ceased to exist, consumers would be forced into nursing homes, group homes, institutions, or left with no services at all.

Because personal assistants are hired by and work for consumers, the choice of a Fiscal Intermediary (FI) is often governed by the amount of reimbursement that the FI can offer. Therefore, FIs are able to spend about $0.90 of every Medicaid dollar on direct care related expenses, maximizing wages and taxpayer dollars by minimizing administrative expenses.

The proposal previously advanced by the Executive would decimate the CDPA program and would steal independence from individuals with disabilities while increasing Medicaid costs. While there is no CDPA proposal in the Executive's budget, we are quite concerned that the MRT II will attempt to find savings that will severely limit the availability of services.

- **Recommendation:** Grandfather in all CDPA Fiscal Intermediaries (FIs) that have been operating prior to the 2012 expansion of CDPA FIs.
  Cost: No additional cost

- **Recommendation:** Halt efforts to restructure Administrative reimbursements for FIs until all relevant data is available and a sound analysis can be made. This will create savings by lowering the currently allowed administrative rate and extending it to FIs in managed care.
  Cost: No additional cost

✓ PROVIDE FINANCIAL STABILITY FOR CLINICS THAT SERVE PEOPLE WITH DEVELOPMENTAL DISABILITIES

For almost forty years, New York State has counted on clinics supporting patients with significant disabilities to fill an essential gap in the service delivery system, one which otherwise would lead to expensive and unnecessary services delivered in emergency room and acute care settings. Over time, voluntary agencies supporting people with disabilities have stepped up to ensure their access to health services across the State through Article 28 and Article 16 clinics. These clinics have evolved to become true specialty service providers, serving patients with the highest needs and often at a financial loss. With rate rationalization removing any surpluses to help providers to subsidize these clinics, the insufficient funding of clinical disability services has been glaringly exposed. The annual 20% loss on operations of our clinics no longer can be sustained and Boards statewide are facing tough decisions about the future of a variety of disability services.

To date, when Boards choose to close disability clinics, patients, in most instances, have no good option. In the absence of primary care, patients show up in the ER and operatory procedures are required for issues that easily could have been avoided with more timely primary care. Clinic visits are replaced with ER visits for untreated conditions that may not require, but almost always generate, MRI and other expensive diagnostic tests because the patient is unable to communicate and has no previous relationship with the ER physicians. This scenario would lead us in exactly the opposite direction from the one New York State has been moving toward.

Even though OPWDD supports and services were excluded from the 2011 Medicaid Redesign Team (MRT I), DOH added MRT# 26 which cut Article 16 clinics that had higher visits per patient (regardless of diagnosis or acuity) in comparison to their peers in any patient care area. Therefore, the more significant the physical disability of the patients served, the deeper the cut to the Article 16 rate. Meanwhile, the MRT cut to Article 28 clinics hospitals and other health providers was a flat 2% cut. The State fiscal plan savings for all the MRT cuts, including #26, expired as of 4-1-15. The 2014-2015 Budget restored all the MRT 2% across the board cuts one year early, but included language to continue the MRT #26 Article 16 cut, with the provision that the Commissioner of Health, in consultation with the Director of the Division of the Budget, has the authority to terminate

it "upon a finding that they are no longer necessary to maintain essential cost savings." The cut was not terminated and MRT #26 continues today to penalize Article 16 clinics that serve individuals with more complex needs.

Our Article 28 clinics accommodate the unique needs of people with I/DD allowing extra time for patients to feel comfortable, including techniques to minimize behaviors, extra time to share information, desensitizing techniques and other accommodations. While we currently receive an enhanced rate to accommodate for a portion of the extra time it takes for even a routine exam, the addition does not cover the actual cost of providing services.

In March of 2018, NYS DOH and OPWDD jointly established the *Clinic/APG Base Rates Workgroup* to address the concern that Article 16 and 28 clinics operated by OPWDD nonprofit agencies would cease to exist due to fiscal difficulties and operating shortfalls.

Following are two clinic recommendations of the DOH/OPWDD *Clinic/APG Base Rates Workgroup*:

- **Recommendation:** Repeal MRT #26 rate penalties on Article 16 clinics.
  Cost: $2.4M and will produce savings from prevented/reduced ER visits and acute care utilization

- **Recommendation:** Increase the Article 28 APG add-on for patients assigned code 95 (I/DD) or code 81 (TBI) from 20% to 30% in order to cover the true cost of providing services.
  Cost: DOH does not have data to calculate the fiscal; however, the overall cost would be significantly reduced and even negligible due to savings from prevented/reduced ER visits and acute care utilization.

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STATE EDUCATION DEPARTMENT – SPECIAL EDUCATION

- Provide an additional $8M State share, **$4M** for special education teacher salaries and a separate **$4M** for teacher assistant salaries to narrow the compensation gap
- Support the Regents' proposal to address Teacher Shortages in 4410 and 853 schools by providing **$2M** State share to incentivize staff to obtain appropriate certifications and **$2M** State share for student loan forgiveness
- Provide a tuition increase for 853 and 4410 special education schools comparable to the support for school districts in the finalized State budget – **no additional cost in this budget**

Our members operate schools providing special education services to preschool children ages 3-5 (known as 4410 schools) and school-age students, ages 5-21 years, (known as 853 schools) for their local school districts. 4410 and 853 schools are State Education Department approved, non-public, special education schools that serve students whose local school districts and BOCES are unable to educate because of the severity of their disabilities. Our associations represent more than 100 preschool special education and 853 state approved non-public schools. Our schools serve more than 15,000 children each day at hundreds of sites across New York State. The children who attend our members' preschool and school-age programs are public school children, many of whom have been diagnosed with autism spectrum disorder, cerebral palsy or other developmental disabilities and are placed in our education programs only after a determination has been made by a local Committee on Special Education or Committee on Preschool Special Education that there is no other appropriate educational setting available in a local public school. Therefore, *there is no other educational option for these students.* New York State has a legal responsibility under the federal IDEA to provide a "free and appropriate public education" (FAPE) to all children regardless of disability. Our programs help the state meet this federal mandate. Our 4410 and 853 schools serve New York State's most vulnerable children but have not been provided with the funding necessary to meet this challenge.

Our schools suffered for many years without any increase in tuition and only in the last few years have they received very small increases. Since 2012, state aid to school districts has gone up by 46%, but during the same time period 853 programs have received just 26% and our preschool special education providers have received only a 10% increase in tuition! This inequity in funding has had a significant negative impact on our preschool and school-age providers' ability to hire and retain certified teachers

and certified teacher assistants. Staff recruitment and retention is at crisis level for 853 and 4410 schools to the great detriment of the children they serve.

As has already been noted, while our 853 schools have been afforded modest growth over the past five years, our 4410s have received only five 2% increases. One of the reasons that DOB would not approve SED's requests to provide 4% (or higher) increases is the funding methodology itself. Counties pay 40.5% of the cost of preschool special education, with the State picking up the balance of the cost. With the counties' tax cap equivalent to the lesser of 2% or the CPI%, approving 4% increases on 4410 tuition rates would have constituted nearly the entire allowable spending growth for many counties. For this reason, and the fact that education costs should be the responsibility of the State rather than the counties in the first place, we request that counties' responsibility for 4410 preschool costs be capped at the current spending level. We support the Regents' goal to design a new tuition rate methodology and SED's initiative to eliminate rate reconciliation for the 2020-21 school year, establishing a more predictable and timely tuition methodology for 4410 and 853 providers.

- ✓ **NEW YORK STATE MUST ENSURE THAT EVERY STUDENT IN 4410 AND 853 SCHOOLS HAS A CERTIFIED SPECIAL EDUCATION TEACHER BY INCREASING EXCESSIVE TEACHER TURNOVER PREVENTION FUNDING**

  Our 853s and 4410s are unable to pay our teachers, who must meet the same certification requirements as public school teachers, anywhere near what a local school district pays. This has caused our staff recruitment and retention crisis. The average teacher turnover rate in our 853 schools last year was 25% with some schools significantly higher. For our 4410 schools, the average teacher turnover rate was 21%. As concerned as we are about the turnover rates, the alarming vacancy rates for certified special education teacher and certified teacher assistant positions threatens the future viability of these programs. The average vacancy rates for certified special education teachers in both our 4410 and 853 schools is 28%. More than one in four teaching positions remains vacant. The majority of our schools report that they no longer receive any resumes or applications for available positions despite significant recruitment efforts.

  Many of our programs are currently operating classrooms utilizing program administrators and supervising teachers who have teaching certifications but should be performing administrative roles at the schools (like training and supervising new teachers). Education Directors have told us that the majority of teaching staff who have left their schools have gone to work for local school districts, many of which have been aggressively recruiting our staff. The teaching staff aren't leaving because they are unhappy but because economically, the increased salary and benefits provide a better life for their families. They are often required to leave abruptly to fill school district teaching positions or be passed over for the job. It is extremely difficult for any young child, when their teacher leaves in the middle of the school year, but for children with developmental disabilities, frequent turnover with a lack of appropriate transition can be heartbreaking and detrimental to their social and emotional well-being.

  We are not asking for salary parity between 4410 and 853 schools and school districts but, prior to 2009, the salary differential was much smaller, and the vacancy and turnover rates were at least manageable. *Now, based on salary data that we received from the New York State Education Department, we have confirmed that school districts across New York State pay their teachers, on average, $36,000 more than our approved preschool and school-age providers can, for the same certification and qualifications. Their school year is 10 months, versus our 12, with a far superior benefits and pension package.*

Our schools are required by New York State Education Regulations to have a certified special education teacher in every class and to have certified teacher assistants to maintain New York State and IEP mandated classroom ratios. The children who attend 4410 and 853 programs are entitled to have a certified special education teacher in front of their classrooms every day. Ironically, due to the funding methodology, which reconciles income with expenses, surpluses caused by teacher and teacher assistant vacancies are recouped, leading to tuition reductions. So even if a school was able to hire teachers to fill all their vacant positions, their reduced tuition wouldn't cover the cost. *Schools must be held harmless in this downward spiraling fiasco.*

We are pleased that the Division of the Budget (DOB) and SED have previously agreed to include $8M intended to assist approved special education schools with recruitment and retention of teachers. While this funding has been helpful, the per-teacher distribution is minimal in comparison to the need. Therefore, we ask that an additional $4M (for a total of $12M) be added as a small, incremental step toward correcting our teacher compensation gap. As stated above, while this influx of funds will assist in the recruitment and retention of teachers, it will not address the certified teacher assistant shortage. Therefore, we also ask for a new ETTP fund for Teacher Assistants, also in the amount of $4 million, to begin to fairly compensate the Teacher Assistants we rely on to provide quality educational services and maintain required classroom ratios. These funds still won't help with paraprofessional and therapy staff shortages, but we believe it is a reasonable first step in assuring that students placed in these schools by school districts will have qualified teachers and teacher assistants available to provide the instruction mandated by the students' IEP's.

- **Recommendation:** Provide $8M in new funding, $4M to allow 853 and 4410 providers to narrow the increasing gap between their teachers' compensation and that of the public schools, and a separate $4M for certified teacher assistants, so that they can continue to provide FAPE for New York's students with the most severe disabilities.
  Cost: $8M

✓ **PROVIDE FUNDING TO CREATE A NEW TEACHER PIPELINE FOR 4410 PRESCHOOLS AND 853 SCHOOL AGE PROGRAMS**

While increased funding for teacher salaries is sorely needed, there is an overall shortage of special education teachers, making it impossible for our schools to compete given their inability to pay salaries or benefits even close to those paid to teachers in other settings. In response, the New York State Board of Regents has advanced a proposal to create a new teacher pipeline by providing funding to encourage recruitment of a diverse pool of potential teachers from the community, and provide funding for training, professional development and tuition and related teacher preparation expenses (like certifications). This proposal would be complemented by an additional allocation to support a tuition loan forgiveness program for these new teachers.

- **Recommendation:** Include the Regents' proposal to create a new teacher pipeline and tuition loan forgiveness program ($2M for each) to enable our schools to recruit and train new potential teachers
  Cost: $4M

✓ **PROVIDE 4410 AND 853 SCHOOLS WITH A TUITION INCREASE COMPARABLE WITH SUPPORT FOR SCHOOL DISTRICTS**

<u>4410 Preschools</u>

As mentioned above, in 2009 the State Education Department imposed a freeze on tuition increases for preschool special education programs. This freeze had remained in effect for six years and has pushed many preschool providers to the brink of extinction. For the past five

years, SED requested 4% (or higher) increases for these schools but only 2% was approved. SED's Rate Setting Unit has acknowledged that it does not reimburse these programs for all their approved costs and has expressed serious concerns about the resulting funding gap. In the past five years, 61 preschool special education programs have closed across New York State. 31 of them were located in New York City.

853 Schools

School-age 853 providers have faced a similar financial crisis due to the impact of a four-year tuition freeze. The financial losses reported by 853 providers are also considerable. Although the fiscal impact on 853 providers has been softened somewhat in the past six years by annual financial adjustments, significant challenges remain. Similar to 4410s, 853 schools struggle to recruit and retain teachers, clinicians, teacher's aides and other staff who are hired by their local districts where their pay and benefits are significantly higher, the school year is 10 months rather than 12 and the children have fewer needs and behavioral issues. As a result, when they leave 853 schools for jobs in public schools, they receive $30,000 to $40,000 salary increases, better benefits including a pension and summers off. New York State must invest in 853 schools in order to continue to fulfill the federal requirement of a free and appropriate public education for children with the most significant disabilities until they are 21 years old.

- **Recommendation:** Provide 4410 preschools and 853 school-age programs, which educate children that school districts and charter schools can't or won't serve, with a comparable increase because *all children in New York State deserve an appropriately funded, quality education*.
  Cost: No additional cost

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OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

- **3For5**
  Provide an annual 3% investment in OPWDD nonprofit programs for 5 years **to provide financial stability and ensure nonprofits' sustainability**

- **Article 16 Clinics**
  Remove the MRT I Article 16 clinic cut (MRT #26) as a step towards equity and providing the necessary financial support to preserve Article 16 clinics for people with I/DD, which prevent unnecessary, higher cost services

The Office for People With Developmental Disabilities (OPWDD) funds services and supports for people with intellectual and developmental disabilities (I/DD) and their families throughout their lifespans. Residential, day, employment, clinical and other supports enable New Yorkers with I/DD and their families to live lives that others take for granted. Currently, however, our nationally recognized service system is in trouble. Years of deferred annual rate increases have prevented nonprofit providers from keeping up with the rising cost of providing services and cuts and rate changes penalize providers serving the highest need individuals. A growing population whose needs are intensifying, with aging parents and caregivers who need more help just to maintain status quo, combined with a staff recruitment and retention crisis, threatens the very existence of services. These factors, coupled with our ongoing system transformation to managed care, has resulted in financially stressed providers, increasingly unable to sustain operations.

Nonprofit providers deliver approximately 85% of the day-to-day services for the more than 140,000 New Yorkers with developmental disabilities. Over the last decade, provider organizations have received only one cost-of-living funding increase of just 0.02 percent and have experienced $2.6 billion in cuts and more than $5 billion in deferred increases, pushing many provider agencies to the brink of insolvency. In a statewide survey conducted by New York Disability Advocates, nearly half of providers have less than 40 days of cash on hand. A third of them reported having to reduce services or cut programs completely in the last three years due to funding constraints, affecting almost 50,000 New Yorkers with I/DD and more than 30,000 employees who support these individuals. All over New York, providers are operating with minimal or outdated technology and deteriorating infrastructure.

This year, we join our colleagues from every corner of Human Services to ask for **3for5** as an alternative to a trend or COLA. As the name implies, we seek a 3% annual increase for 5 years beginning in the next finalized budget. Prior to 2011, Medicaid funded OPWDD supports and services received yearly increases

to cover the rising costs of providing services, called "Medicaid trends," similar to a COLA for non-Medicaid expenses. In 2010, a COLA/Medicaid Trend of 2.08% was given to both state and nonprofit operated programs. Since that time (with the exception of 0.2% given in 2017) nonprofit OPWDD providers have been denied any COLA/Trend to support agency operations; however, state operated services have received an average 3% trend factor, every year, since 2014. Federal and State laws require that all payments to providers be based upon the reasonable cost of services. Reasonable costs take into account both direct and indirect costs, including personnel, administrative, employee pension plans, rising health and liability insurance costs, workers comp and normal standby costs (related to unoccupied beds). While we appreciate the salary increases for certain staff, nonprofit providers haven't received funding to cover rising costs or increases for other staff positions.

In addition, the OPWDD Commissioner stated publicly that effective July 1, 2020, there will be a 2% reimbursement cut to all OPWDD nonprofit provider rates. Because approximately 80% of nonprofit provider costs are for staff salaries and benefits, the July 1, 2020 2% across the board reduction will inevitably reduce the ability of providers to maintain the targeted increases we have received for certain staff salaries. We depend on our direct support workforce and continually strive to provide reasonable compensation and opportunities for career advancement within our field for our dedicated staff. Cutting their long overdue (meager) increases would be a demoralizing blow we will need the Legislature's help to avoid by enacting 3for5.

We also request support for **S.6106 (Carlucci)/A.8388 (Gunther)** which will establish a Direct Support Professional (DSP) Credit and Career Ladder Tuition Assistance Grant Program. This program would permit community colleges to establish credentialing and career ladder programs with the tuition for each student funded by OPWDD and the nonprofit OPWDD agency employer. It would provide the opportunity for DSPs to attend college, improve their knowledge and skills as a DSP and allow individuals, who never thought they could attend college due to financial or other reasons, to work toward a degree.

Government funding is the lifeblood of care for people with intellectual and developmental disabilities. Nonprofit provider organizations rely on Medicaid for over 90 percent of their funding. New York has a mandate to provide services to these populations, and voluntary organizations are well-positioned to deliver cost effective care – eighty-five to ninety percent of every dollar goes directly to critical services.

The communities we serve deserve the same access to quality care as every other New Yorker. They deserve opportunities to lead independent, fulfilling lives and participate in their communities. The time is now to commit to "3for5" for our nonprofit providers that are a critical part of our communities.

- **Recommendation:** As part of the human services 3for5 initiative, provide an annual 3% investment in Human Services for 5 years – **$78M** State share, fully annualized **for OPWDD funded programs (**as part of the ~ $170M overall request for all human services programs)

- ✓ **PROVIDE FINANCIAL STABILITY FOR CLINICS THAT SERVE PEOPLE WITH DEVELOPMENTAL DISABILITIES**

  For almost forty years, New York State has counted on clinics supporting patients with significant disabilities to fill an essential gap in the service delivery system, one which otherwise would lead to expensive and unnecessary services delivered in emergency room and acute care settings. Over time, voluntary agencies supporting people with disabilities have stepped up to ensure their access to health services across the State through Article 16 clinics. These clinics have evolved to become true specialty service providers, serving patients with the highest needs and often at a financial loss. With rate rationalization removing any surpluses to help providers to subsidize these clinics, the

insufficient funding of clinical disability services has been glaringly exposed. The annual 20% loss on operations of our clinics no longer can be sustained and Boards statewide are facing tough decisions about the future of these services.

To date, when Boards choose to close disability clinics, patients, in most instances, have no good option. In the absence of primary care, dental patients show up in the ER and operatory procedures are required for issues that easily could have been avoided with more timely primary care. Clinic visits are replaced with ER visits for untreated conditions that may not require, but almost always generate, MRI and other expensive diagnostic tests because the patient is unable to communicate and has no previous relationship with the ER physicians. This would lead us in exactly the opposite direction from the one New York State has been moving toward.

Additionally, even though OPWDD supports and services were excluded from the 2011 Medicaid Redesign Team (MRT I), DOH added MRT# 26 which cut Article 16 clinics that had higher visits per patient (regardless of diagnosis or acuity) in comparison to their peers in any patient care area. Therefore, the more significant the physical disability of the patients served, the deeper the cut to the Article 16 rate. Meanwhile, the MRT cut to Article 28 clinics hospitals and other health providers was a flat 2% cut. The State fiscal plan savings for all of the MRT cuts, including #26, expired as of 4-1-15. The 2014-2015 Budget restored all the MRT 2% across the board cuts one year early, but included language to continue this MRT #26 Article 16 cut, with the provision that the Commissioner of Health, in consultation with the Director of the Division of the Budget, has the authority to terminate it "upon a finding that they are no longer necessary to maintain essential cost savings." The cut was not terminated and MRT #26 continues today to penalize Article 16 clinics that serve individuals with more complex needs.

In March of 2018, NYS DOH and OPWDD jointly established the *Clinic/APG Base Rates Workgroup* to address the concern that Article 16 and 28 clinics operated by OPWDD nonprofit agencies would cease to exist due to fiscal difficulties and operating shortfalls. In order to prevent New York State from incurring unnecessary Medicaid costs, we urge the MRT II and New York State to repeal MRT #26 imposed in 2011.

- **Recommendation:** Repeal MRT #26 rate penalties on Article 16 clinics.
  Cost: $2.4 million and will produce savings from prevented/reduced ER visits and acute care utilization

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