



*Coalition Of Provider Associations*



The Coalition of Provider Associations, or COPA, which consists of five associations – 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 2019-2020 Executive Budget proposal.

## DEPARTMENT OF HEALTH

- Early Intervention Funding
- Insurance Coverage of Early Intervention
- The Consumer Directed Personal Assistance Program
- Financial Stability for Clinics Serving People with I/DD
- Prescriber Prevails
- Medicare Part B Cost Sharing

### ✓ **PROVIDE A 5% INCREASE TO ADDRESS 25 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 25 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%. 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and several re-calculations resulting in decreases in some rates since that time, the reimbursement is significantly out of date in terms of costs for salaries, benefits, and other fixed costs that have skyrocketed in the last 25 years.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 resulting in a state-wide shortage. In recognition of this fact, the Governor's budget proposal includes a 5% increase for Occupational, Physical

and Speech and Language Therapies. We are heartened by this recognition and welcome the proposed increase, but while these therapies constitute approximately 60% of Early Intervention services, there is a similar shortage of the other 40%, including educational services such as Applied Behavioral Analysis, which are not included.

*\*To make matters worse, although Minimum Wage funding was approved in previous budgets, none of these funds have been made available to providers who were already required to increase salaries. Minimum Wage funding should be made available to providers immediately!*

While all other comparable service systems have received continuing increases in trend factors and cost of living adjustments over these past 25 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. We believe that a 5% increase is justified based on the overall impact of rate adjustments, the increased cost of services over the past 25 years and the significant administrative and billing responsibilities associated with the State Fiscal Agent.

➤ **Recommendation:** Include a 5% across the board increase for EI program reimbursement rates.

**Cost: Approximately \$8 million**

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

Under Public Health Law, Early Intervention (EI) 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 EI 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, COPA supports 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 EI costs. For the first year, an amount of \$15 million would be paid into the pool. This amount is based on the approximate percentage commercial insurers currently pay of total EI program costs (utilizing data from the 2012-13 program year) increased by the estimated amount paid by commercial insurers related to mandated coverage for autism spectrum disorder. 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 health insurers.

➤ **Recommendation:** Shift current commercial insurance coverage from a claims-based model to a covered lives pool funded program.

**Cost: No additional cost**

✓ **OPPOSE CHANGES TO THE CONSUMER DIRECTED PERSONAL ASSISTANCE PROGRAM (CDPAP)**

New York's CDPAP program has been a national model enabling consumers with disabilities to direct their own care. CDPAP began in the 1990s with a number of COPA agency members as the original fiscal intermediaries (FIs) and CDPAP has provided Medicaid cost savings while providing independence. The CDPAP program allows people to hire and manage their own caregivers. 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 the costlier home care model and research proves that CDPAP works. The ability of the participant to hire the person of their choice and not be assigned staff by an agency, promotes a better quality of life, less stress than having a stranger in their home, and at a lower cost.

**Consumer Directed Personal Assistants can help with an array of home-care needs, including:**

- Dressing
- Bathing and toileting
- Medication administration & injections
- Meal prep
- Light housework
- Transportation to doctor's appointments

**The CDPAP program allows individuals to live in their own homes longer, be more independent and manage their own care leading to:**

- Higher consumer satisfaction
- Greater independence
- Improved physical and mental health
- Lower cost for New York State vs. home health care agency (NP duties)
- Stability in staffing

The Executive budget proposes changes to the CDPAP program that threaten access to consumer-directed services both by drastically reducing the number of CDPAP fiscal intermediaries (FI's), and by drastically reducing the payment to CDPAP FI's. Current FI payments are based on a percentage, reflecting the needs and complexity of each consumer, but the Executive proposes providing \$100 per consumer no matter how complex or simple the person's needs are. As a result, this proposal will penalize the FI's and the very consumers that this program was intended for and will provide an incentive for FI's to only serve individuals who need very few hours of personal care. If the FI payment is cut so dramatically, FI's will be forced to close – including those with extensive experience serving individuals with very complex needs and a track record of providing excellent services.

CDPAP FI's do much more than cut checks and manage paperwork. They:

- Provide weekly orientation for new hires to ensure they know what tasks can and can't be completed
- Conduct annual in-person visits with participants
- Provide referrals to other community-based programs
- Deliver needed medical equipment
- Provide tuberculosis testing of staff
- Assist in staff recruitment when requested by participant

- Promote best practices
- Protect tax payer funds by auditing timecards to limit errors and fraud attempts
- Provide Quality Assurance teams which conduct regular audits to ensure quality
- Hire staff who are local and build relationships with participants to learn their needs
- Train participants on employment law

The 2017 State Budget established a new authorization process for FI's which requires all FI's to apply to the Commissioner for an operating license. Nearly two years after enactment, applications have been filed and the first authorizations are *just* being issued. DOH should use this licensing process to eliminate the FI's that fail to meet standards, a far more rational process of selection than what is now proposed. The Governor's proposal is to first eliminate all who were not continuously operational prior to 1/1/12 unless the FI is an independent living center, and ultimately, to reduce the number of FI's to one or two statewide.

Upstate, where the home care worker shortage is most severe, CDPAP has played a critical role for MLTC organizations to staff authorized home care for their members. There is a well-known shortage of both licensed agencies and workers in rural areas and small towns. MLTC organizations even pressure their members to accept CDPAP when they would prefer traditional care, because the plans simply cannot provide the staff. Therefore, limiting the number of CDPAP FI's in these areas would lead to reduced access to any type of home care services.

If CDPAP ceased to exist, consumers would wind up in nursing homes, group homes, institutions, or left with no services. The Executive proposal would decimate the CDPAP program and would steal independence from individuals with disabilities while increasing Medicaid costs.

- **Recommendation:** Reject the Executive proposal to dismantle the CDPAP program and reduce the FI payment to \$100 per member per month and instead use the current licensing process to eliminate FI's that fail to meet DOH criteria and maintain the current FI reimbursement methodology.

**Cost: The Executive estimates a \$75 million savings, but we would argue that elimination of the CDPAP program will increase state Medicaid costs for those individuals forced into nursing homes, group homes and traditional home care.**

✓ **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 an array of Article 16, Article 28 and Article 31 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, 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), 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 concerns 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 recommend the State invest in these specialty clinics supporting patients with I/DD and recognize them as an essential part of the service delivery network.

Following are a few of the DOH/OPWDD *Clinic/APG Base Rates Workgroup* recommendations:

- **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.**
- **Recommendation:** Repeal MRT 26 rate penalties.  
**Cost: \$2.4 million and will produce savings from prevented/reduced ER visits and acute care utilization.**
- **Recommendation:** Require Managed Care plans to pay the revised Article 28 APG plus add-on rate for all services provided to patients with code 95 and code 81.  
**Cost: No additional cost to New York State.**

✓ **OPPOSE ELIMINATION OF PRESCRIBER PREVAILS**

COPA members provide medical care for well over 100,000 individuals with disabilities and their families. The Executive has proposed the elimination of a physician or prescriber's determination as to which medication is best for his or her patient, also known as prescriber prevails. This proposed elimination of the "Prescriber Prevails" medication management for all classes of medications, particularly seizure, epilepsy, and endocrine medications, in Medicaid fee-for-service, will result in costly, unintended consequences including delays in treatment (due to appeals), sub-optimal substitutions and increased acute care utilization by patients who had been previously stable on a medication regimen.

This proposal will directly impact one of the most vulnerable New York State populations, those with developmental disabilities who receive care in Diagnostic and Treatment Centers (Article 28) and Article 16 clinics. Individuals with developmental disabilities have a higher risk of seizure disorders and hospitalization if not controlled by the most appropriate seizure or epilepsy medication. Specialty providers who treat individuals with developmental disabilities are in short supply. The addition of a labor-intensive appeals process to this already scarce resource is not a judicious use of medical practitioners' time. Our practitioners have demonstrated significant Medicaid cost savings with reduced acute care utilization and minimal hospitalizations of people with the most medically and behaviorally complex developmental disabilities in New York. *We strongly urge that Prescriber Prevails be maintained for all nine classes of drugs in Medicaid fee-for-service and include the same nine classes in Medicaid managed care.*

- **Recommendation:** Maintain Prescriber Prevails for all classes of drugs, including seizure and epilepsy drugs, in Medicaid fee-for-service and include the same nine classes in Medicaid managed care. This proposal produces savings from reduced acute care utilization.

**Cost: Negligible due to savings from reduced acute care**

✓ **OPPOSE THE ELIMINATION OF MEDICARE PART B COST SHARING**

The Executive budget proposes to limit Medicaid payments for Medicare Part B deductibles and Medicare Part B coinsurance for ambulance and psychologist services for dual-eligible members so that the Medicaid payment does not exceed the amount Medicaid pays for a non-dual eligible member.

More than 50% of individuals with developmental disabilities are dual eligible. Under Medicare, low income elderly and individuals with disabilities are able to enroll in the Qualified Medicare Beneficiary (QMB) program or Medicaid in order to assure meaningful access to Medicare services by paying the Medicare deductibles and cost-sharing, as well as for Medicare Part B premiums. However, federal law allows states to limit their cost-sharing assistance by paying the "lesser of" Medicaid or Medicare rates, which New York has done for most services since 2015. At the same time, federal law also bars providers from "balance billing" QMB enrollees for any unpaid cost sharing; providers bear the loss from serving these dual eligible individuals. As a result, many providers refuse to serve Medicaid recipients, or QMBs, resulting in reduced access to routine and specialty health care among QMB and Medicaid enrollees.

The Executive proposals would limit primary and specialty physicians serving dual eligible individuals to the Medicaid approved rate of \$100, instead of the Medicare deductible of \$185. Federal studies have demonstrated that QMB and Medicaid recipients face a loss of

access to providers willing to treat them. The reduction in the payment of the Part B deductible will further limit access to care for individuals with I/DD.

In 2016, an exception to the "lesser of" Medicare cost sharing assistance was enacted ensuring Medicaid paid the 20% co-insurance at the full Medicare approved rate for two critical services – psychologists and ambulances. The Executive budget proposes to repeal these 2016 exceptions. Individuals with developmental disabilities already have great difficulty finding psychologists willing to accept Medicare; the Executive proposal exacerbates this challenge. Lower reimbursement for ambulance services will make it difficult for individuals with developmental disabilities, who frequently require regular ambulance transportation, and already face long waits and difficulty accessing transportation, to get to the health care services they so critically need.

- **Recommendation:** Reject the Executive proposal to limit the payment of the Part B Deductible and to limit the payment of coinsurance for psychologists and ambulance services.

**Cost: Restoration of the proposed Medicaid change will increase state Medicaid spending by \$17.5 million in 2020 and \$23.3 million in 2021 according to DOB.** DOB does not estimate the increased hospitalization costs resulting from reduced preventative care and how loss of access to needed ambulance and psychiatry services for individuals with disabilities will lead to cost increases due to the increased usage of nursing homes and group homes for individuals with developmental disabilities.

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