The New York City Developmental Disabilities Councils Support the Following Positions

SFY 2024 Budget Priorities

DEPARTMENT OF HEALTH

ADEQUATELY FUND THE EARLY INTERVENTION PROGRAM FOR INFANTS AND TODDLERS WITH DEVELOPMENTAL DELAYS

70,000 families depend on these services

1,834 rendering providers have left the field since 2019

65 EI agencies have closed

The Early Intervention (EI) program, which is 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 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.

The financial needs of the Early Intervention service system have been neglected over the past three decades, leading to a capacity crisis that threatens the viability and availability of EI services. Community-based EI provider reimbursement rates are similar to when the program began in 1994. This pattern of inadequate compensation has led to a critical shortage of EI providers, which has resulted in delays in service delivery across the state.

New York State is failing to meet its legal obligation to ensure access to timely evaluations and services for infants and toddlers with developmental delays.

NYS DOH and its Early Intervention Coordinating Council (EICC) have recognized the dire need to increase reimbursement rates. **The NYS EICC passed a resolution calling for an 11% rate increase in the Executive Budget Proposal- $0 was included.**

PROVIDE AN 11% RATE INCREASE FOR THE EARLY INTERVENTION PROGRAM

Additional Points:

- During the pandemic, almost 6000 fewer children received EI services.
    - These children now need more supports as they enter preschool than they would have had they received EI services.
    - The state saved thousands of dollars that were not reinvested into the program or into preschool special education services.

- The Covered Lives Legislation that was signed into law in 2021, saved the state $28 million by requiring insurance companies to cover their fair share of EI costs – this savings was not reinvested into the EI program.

- Center-based EI programs provide critical services to families and children living in traditionally underserved communities across New York State. Center-based EI programs have been decimated from years of disinvestment and many have already closed.
    - During the pandemic center-based EI programs were the hardest hit and suffered significant fiscal losses. They did not receive any Federal or State assistance. The rate increase of 11% is vital to ensuring that that these services continue to be available as part of the continuum of EI services. This is a matter of equity and justice for the families and children who depend on these services.

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DEPARTMENT OF HEALTH

SAVE CLINICS THAT SERVE PEOPLE WITH DEVELOPMENTAL DISABILITIES- PROMOTE HEALTH EQUITY

For more than forty years, New York State has counted on specialty Article 28, FQHC and Article 16 clinics, supporting patients with significant disabilities, to fill an essential gap in the service delivery system and prevent expensive and unnecessary services delivered in emergency room and acute care settings.

These clinics accommodate the unique needs of people with I/DD by providing:

- extra time for patients to feel comfortable
- techniques to minimize behaviors
- extra time to share information
- customized communication techniques
- desensitizing techniques
- other accommodations

Current rates do not cover actual costs associated with this specialty care and these accommodations are not available outside of our clinics.

Our 2022 survey of clinic operations shows a 20-35% loss
on operations for clinics across the State.

Clinic closures result in operatory procedures for issues that could easily have been avoided with more timely primary care and ER visits for untreated conditions often generate MRI and other expensive diagnostic tests since the patient is unable to communicate and has no previous relationship with ER physicians.

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 operating shortfalls. The workgroup recommended increasing the APG add-on for patients assigned Code 95 (I/DD) or Code 81 (TBI) by 10%. Since 2018, costs have risen and losses have compounded, so a 10% increase is no longer sufficient to preserve these services.

INCREASE ARTICLE 28 CLINIC APG ADD-ONS FOR CODE 95 (I/DD) OR CODE 81 (TBI) PATIENTS BY 30% TO COVER THE TRUE COST OF PROVIDING SERVICES

SFY 2024 Budget Priorities

DEPARTMENT OF HEALTH

PROVIDE PERMANENT TELEHEALTH FLEXIBILITIES FOR CLINICS THAT SERVE PEOPLE WITH I/DD

The telehealth flexibilities allowed by Medicare and Medicaid during the PHE enabled clinics to use telehealth technology in the most efficient and effective manner for people with I/DD.

With the end of the PHE in the near future, many of the telehealth flexibilities will be continued, but some will not. Current law stipulates that when the PHE ends, when services are provided via telehealth and both the clinician and patient are located outside the Article 28 clinic, the facility fee will be deducted from the APG payment rate.

Clinic buildings cannot close, so even when both the clinician and patient are offsite, the facility costs are still incurred:

rent or mortgage
gas and electric
salaries
all other overhead

No costs are eliminated simply because a service is provided via telehealth. In fact, telehealth creates additional expenses for software, hardware and internet services.

There's also an access issue, particularly for people with I/DD: it is very difficult for our Article 28 clinics to hire clinicians – particularly specialists, and remote work has made it possible to recruit specialists to meet our patients' needs. If specialists are required to come to the clinic site, people with I/DD will have reduced access to specialists. If patients with I/DD are required to come into the clinic for a telehealth visit with a clinician, the benefit of telehealth would be negated.

Telehealth provides better access and quality of care for people with I/DD.

Provide telehealth parity reimbursement for all telehealth services in the Article 28 clinic regardless of the location of the clinician and patient with I/DD (Code 95 and Code 81).