Center for Disability Rights, Inc.

The Center for Disability Rights' Testimony to the Joint Senate Finance and Assembly Ways and Means Committees Hearing on Health/Medicaid

March 3, 2011

Thank you for the opportunity to testify today. My name is Leah Farrell and I am the Policy Analyst for the Center for Disability Rights, Inc. CDR is a non-profit service and advocacy organization devoted to the full integration, independence and civil rights of people of all ages with all types of disabilities. With services in 10 counties in New York State and offices in Rochester, Corning, Geneva, and Albany, CDR represents the concerns of thousands of people with disabilities.

The disability rights community has been calling for redesign of Medicaid in New York for more than a decade. No one understands the impact of this system better because we see it first hand. It not only wastes taxpayer money, but steals our freedom by needlessly forcing some seniors and people with disabilities into nursing facilities and institutions. In fact, according to the latest report from Thomson Reuters, based on CMS figures, New York spends more per capita on nursing facility placement than any other state.

When the Governor announced the Medicaid Redesign Team (MRT), although others criticized it, we supported the approach. Many of us around the state participated in the MRT public forums. We repeatedly explained how Medicaid's system for providing long term services and supports could be redesigned to promote independence and integration, foster compliance with the Supreme Court's *Olmstead*[1] decision, and control costs. We provided the research and fiscal analysis to back up our suggestions which would save New York $1 billion over five years by shifting people from institutional to community based settings, maximizing the use of consumer directed services, and taking advantage of federal initiatives that promote rebalancing of the long term care system[2].

Part of our proposed savings can be achieved by implementing the Community First Choice Option[3] (CFC), one of the new federal initiatives. Because of the hard work of disability rights advocates and the strong support of Senator Schumer, the *Affordable Care Act* included a provision that would allow states to provide community-based attendant services as an alternative to expensive institutional placement while giving the states an extra six percent in federal funding. I'll say it again, an additional six percent federal match with no sunset. Conservatively, we estimate that implementation of CFC would save New York at least $90 million a year.

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[1] *Olmstead v. L.C.* 527 U.S. 581 (1999)

[2] *Proposals to reduce New York State spending and promote the independence and integration of seniors and people with disabilities*. Prepared by the New York Association on Independent Living (NYAIL) and the Center For Disability Rights (CDR). January 7, 2011. Available at: http://cdrnys.org/files/BudgetProposals.pdf

[3] Pub. L. No. 111-148 §2401

Another proposal involves taking advantage of the Nursing Home Transition and Diversion (NHTD) Medicaid waiver. This is an existing program and does not require any additional resources or infrastructure from the State. If the State transitioned only 10% of the Medicaid-eligible individuals living in nursing facilities who have expressed a desire to return to community-based living, according to CMS figures, even factoring in a 1% disenrollment rate, New York State would save $6.3M in the first year and $127.15M in the non-federal share over five years. Too often, people are placed in a nursing facility immediately following a hospital stay and struggle to leave this costly setting later to return to the community. By implementing an expedited enrollment process in the NHTD waiver and diverting just 10% of the Medicaid-funded nursing facility admissions, New York State would save $6.2M in the non-federal share during the first year and $125.25M in the non-federal share over five years. We gave the Administration specific recommendations for improving the NHTD waiver and reducing unnecessary red tape in order to take full advantage of the model's potential savings, yet we still have not seen any movement[4].

These are only a few of the recommendations that we submitted to the MRT. A copy of our report is attached to this testimony and an accompanying fiscal analysis is available upon request.

Although we had been told that every idea would be compiled, none of our proposals were included in the materials presented to the MRT. Perhaps the administration did not expect ideas to come from regular New Yorkers, particularly those with disabilities. Even so, $90 million in savings should have caught someone's attention.

In the world of public relations, often times, the nuances of a proposal get lost. I want you to really understand what was voted through:

- An elderly middle-class woman will be forced to divorce her husband in order to receive care in the community – or be pulled from her home to receive institutional care in a nursing home. (#18: Eliminate Spousal and Parental Refusal)

- A man with Multiple Sclerosis who may finally be on an effective medication regimen will have to "fail first" on different medication, resulting in potentially serious health risks and increased hospitalizations. His physician will no longer be able to insist his specialized medication is covered. (#15: Limit Access to Prescription Drugs)

- A newly disabled person with a Traumatic Brain Injury will only be able to get the therapies necessary to relearn walking, speaking, and self-care at a maximum of 20 sessions a year—that is less than one session every other week. This proposal could create a hindrance to people maximizing their independence by using therapies to reach a higher level of functioning. (#34: Establish Utilization Limits for PT, OT, and Speech Therapy/Pathology)

- A woman with a spinal cord injury will suddenly find out, because of a decision made by the health Commissioner, that she will not get the services and supports she needs to stay in the community. (#4652: Personal Care Utilization Limits)

[4] *Recommendations for Improving New York's Nursing Home Transition and Diversion (NHTD) Medicaid Waiver*. Prepared by the New York Association on Independent Living (NYAIL) and the Center For Disability Rights (CDR), January 26, 2011. Report is available on request from NYAIL.

- By increasing co-pays, a person living on SSI will put off health care that they feel they can "get away with" until their health deteriorates to a point that they require more costly care. This is well documented. People with disabilities on fixed, low incomes, cannot incur additional co-pay expenses and instead would forgo necessary care, such as skipping a doctor's visit or cutting pills in half. (#104: Increase Enrollee Copayment Amounts for MA FFS and FHP; Require Copayments for CHP)

- A blind man will not get adequate assistance doing simple tasks like laundry or vacuuming to ensure his home is clean and safe. Or an elderly woman with diabetes may skip a meal because she cannot get assistance with preparation of adequate nutritional meals in order to prevent health complications. (#4652: Limit Personal Care Level I to 8 hours a week)

- Most alarming, there is a mandate that nearly 20,000 seniors and people with disabilities who need long term care must enroll in Managed Long Term Care (MLTC) plans; a system with a built-in financial incentive to serve those people that do *not* have significant disabilities. (#5 and #90: Mandatory enrollments in Managed Long Term Care) Currently, one in three Managed Long Term Care plan members file complaints, while fewer than half of the complaints (41.5%) are resolved satisfactorily from the consumer's point of view[5]. In addition, there are few younger people with significant disabilities served in the existing MLTC programs[6]. Finally, the vast majority of all current enrollees live in New York City (92%)[7]. Why, then, is managed long term care the State's solution to redesigning Medicaid, given this as the starting point? There is a concern that MLTC will not result in promised savings, but will only pull money out of direct services.

It's not at all clear that these proposals are "penny wise," but they are most certainly pound foolish. It is understandable that the State hopes that managed care will provide cost savings. It offers the budgetary convenience of a per enrollee "capitation" payment (i.e. insurance premium) and transfers certain financial risks to managed care organizations (MCOs) which act like HMO insurance companies. Unfortunately, in the absence of carefully crafted health care quality standards and meaningful enforcement of those standards by the State, the profit-making priorities of the MCO threaten to overwhelm their health care function to the detriment of New Yorkers.

One of the more concerning components to the MRT package is the across the board cut because, in the end, it appears it is not across all sectors. The draft bill language states, "…be subject to a uniform two percent reduction and such reduction shall be applied, to the extent practicable, in equal amounts during the fiscal year, provided, however, that an alternative method may be considered at the discretion of commissioner of health and the director of budget based upon consultation with the health care industry." Health care industry, i.e. not consumers. Imposing a cap at a time of economic downturn and a rise in the senior demographic is very concerning. On top of that, there are still over $500 million in unspecified cuts necessary to reach this stated target with no publically disclosed details. Crain's reported that the Administration has given control over services to providers and included a "gain-sharing arrangement" if actual spending is lower

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[5] *Managed Long Term Care (MLTC) Plan Member Satisfaction Survey Report*. Prepared on behalf of the New York State Department of Health. IPRO, October 22, 2007

[6] ***An Overview of Medicaid Log-Term Care Programs in New York: Medicaid Managed Long-Term Care.*** United Hospital Fund Medicaid Institute. Prepared by Alene Hokenstad and Meghan Shineman of the United Hospital Fund and Roger Auerbach of Auerbach Consulting, Inc. April 2009.

[7] Ibid

than his global target[8]. This creates a system where provider networks and managed care entities will be financially rewarded for restricting access to services.

There is a clear institutional bias at play here. While we may not always agree with the New York State Association of Health Care Providers, they rightfully noted that approximately 33% of the Medicaid cuts target home care, despite the fact that community-based long term care is the most cost-effective model. And community-based care accounts for just 12% percent of Medicaid long term care spending on seniors and people with physical disabilities.

In just the few hours we have had to review the actual language in the legislation, it is clear that all of the identified stakeholders on the MRT got something out of the process. Because we need to achieve savings in a closed system, the offset for these "gives" will be cuts to services for people with disabilities, with the brunt of the cuts hitting people who have the most significant disabilities.

According to the draft Article VII language, regarding changes to the personal care program, "the commissioner is authorized to adopt standards for the provision and management of services available under this paragraph for individuals whose need for such services exceeds a specified level to be determined by the commissioner." This gives the Administration complete authority to cut services in the personal care program without public comment or discourse and it clearly targets people with the most significant disabilities. Reducing access to services for seniors and people with disabilities is NOT the only way to reform the Medicaid system and save the state money. The ideas presented by the disability rights community – including implementation of the Community First Choice Option – provide opportunities for the State to bring needed reform to Medicaid long term care and generate long term savings. Research shows that states are containing Medicaid costs using the approaches we are proposing

Finally, it is important to recognize that the right to live and receive services in the most integrated setting has been affirmed by the Supreme Court in the *Olmstead* decision. An increase in home care is a step in the right direction; a fact to be applauded, not deplored. New York State has already been found non-compliant with this important civil rights decision. Disturbingly, the issue of supporting people in the most integrated setting has not been publicly acknowledged in this process. The disability rights community has worked to show the state that we can achieve both goals: contain costs and comply with *Olmstead*. We ask you to support our civil rights and do what is right for the state.

Again, I have attached our proposals that reduce New York State spending and promote the independence and integration of seniors and people with disabilities and I strongly urge this Legislature to review them. Thank you.

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[8] *NY Medicaid panel makes surprise move*. Crain's New York Business. Barbara Benson. February 24, 2011