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Center for Disability Rights, Inc.

Analysis of the 2012-2013 Executive Budget:
Proposals that Impact People with Disabilities

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The Center for Disability Rights, Inc. (CDR) is a non-profit independent living center providing services and advocacy to people of all ages and with all types of disabilities. CDR is headquartered in Rochester, New York, with satellite offices in Geneva and Corning, as well as a policy office in Albany. Each year, CDR closely reviews and responds to the Executive's proposed budget. CDR's response focuses on the proposed budget's impact on people with disabilities and, more specifically, how the budget affects the ability of people with disabilities to live independently in the community. The order of the following issues in no way indicates priority of importance.

HEALTH/MEDICAID

CDR opposes the elimination of spousal refusal, which includes parents of young children
This proposal prohibits a spouse or parent from refusing to contribute any available income or assets towards the costs of health care services being provided to a spouse or family member to reduce unnecessary Medicaid financing of long term care services. This proposal is incorrectly positioned as a fraud prevention mechanism to prevent wealthy couples from taking advantage of the system. The reality is that this proposal actually harms low income families. Low-income couples will be forced to divorce in order to qualify for assistance or be forced to institutionalize the spouse who requires long term care services. This proposal actually places more strain on the system as people will loose their natural supports. While CDR opposes the elimination of spousal refusal, the State could consider modifying the proposal to accomplish their goal. This would entail: capping spousal refusal so that it is only available where the refusing spouse's income and assets are within the spousal impoverishment limits for nursing home care; including a hardship exception for those applicants where the spouse truly refuses to contribute or even to document his/her assets, such as in cases of domestic violence; and including a provision so that parents may also exercise refusal up to the same thresholds used by a spouse of a nursing home resident, even though there is no exact analogous standard for parents of minor children.

CDR supports the reinvestment of Medicaid savings toward housing, but funds should support accessible, affordable, integrated housing
This proposal would allow for the re-investment of Medicaid savings achieved from hospital and nursing home closures or bed de-certifications to expand supportive housing and related services. Supportive housing is typically a model used by the Office for Mental Health (OMH) and the Office of Alcoholism and Substance Abuse Services (OASAS) to provide housing with services on the premises. Often, residents do not have a choice and must use the services

provided through the facility. While this is a model that works for certain populations, CDR is concerned that that tying up the limited resources in this system does not afford for the expansion of fully integrated, accessible, affordable housing - which is what people with disabilities prefer. CDR opposes targeting these funds for supportive housing models where the services are directly linked to the housing.

CDR supports the position of the New York Association on Independent Living (NYAIL), which participated in the Medicaid Redesign Team's Affordable Housing workgroup, that called for the broadening of the term "supportive housing." As previously mentioned, in New York, "supportive housing" has traditionally meant services linked to housing. First, if the intent of the State is to actually use these available funds to support people with disabilities out of institutions, then the funds should go toward mechanisms that provide for the most independence and integration, such as the Nursing Home Transition and Diversion (NHTD) Medicaid Waiver housing subsidy, instead of shifting funds from big institutions to smaller ones. Second, if the State is going to generate savings from nursing home closures or bed de-certifications, than those dollars should follow that population to support them in the community; as opposed to serving other populations in other models. Third, particularly in light of the reduced funding for the *Access to Home* program (see below), the State must invest in home modification options for people who find themselves facing institutional placement solely for housing reasons. Finally, the State must move forward cautiously to ensure that the result of the deinstitutionalization is not simply a shift toward other congregate settings that are diagnosis-specific; essentially creating "mini institutions."

CDR does not support policy where certain populations receive certain services in Medicaid
This proposal states that Medicaid would cover podiatry visits for adults with diabetes; lactation services to pregnant and postpartum women; harm reduction supports and counseling for people with substance abuse; and Enteral formulas (e.g. Boost and Ensure), which were cut in last year's budget, for people with HIV related illnesses. CDR supports the expansion of benefits, but proposals that prioritize one condition or disability over another are poor policy. The system should strive to be equitable and fair. For example, if Medicaid is going to cover Enteral formula for a certain population, then all people who require it *based on need* should be eligible.

CDR supports the proposal for increased education, outreach, and enrollment assistance for people with disabilities who receive Medicaid
CDR fully supports efforts to provide more education, outreach and enrollment assistance for people with disabilities. This proposal comes directly from the Medicaid Redesign Team's Streamlining and State/Local Responsibilities Workgroup. It extends the facilitated enrollment program to the disability community, which has not benefited from the enrollment assistance and counseling previously afforded to other Medicaid recipients. Eligibility determinations are particularly complex for this group, as they must navigate the various components of coverage. The law does not require that the contracts be awarded through a competitive bid process; rather it outlines several requirements of the Department of Health Commissioner, including the criteria for selection. There are no programmatic details in the proposal so CDR will monitor this as the State moves forward.

CDR supports the requirement that managed care plans and managed long term care plans offer the consumer directed personal care program to enrollees

This proposal requires mainstream managed care and managed long term care plans give people the option to receive consumer directed personal assistance program (CDPAP) services. The proposal includes no details other than setting forth the requirement for managed care organizations to offer CDPAP as part of the benefit package. Nothing in the law defines the roll out plan – timelines, geography, eligibility, etc. CDR certainly supports the requirement that managed care organizations offer CDPAP but the plans must be educated on consumer directed in order to prevent a sullied program, which raises concerns over liability. To that end, we believe that the state should require that plans receive education and training on CDPAP from the network of independent living centers that currently provide CDPAP services.

CDR is concerned about the Early Intervention cost shift proposal

Early Intervention (EI) provides critical support services and access to durable medical equipment to about 72,000 children under age three who have disabilities or developmental delays. This proposal will shift the counties' administrative costs of $99 million over five years to private insurers. The EI program is essential to supporting babies and infants in the community. CDR is concerned that this proposal will disrupt services, as well as disrupt longstanding relationships that exist in the community in order to support families with children with disabilities.

CDR supports providing additional funds for data collection relating to health disparities

The Medicaid Redesign Team's Health Disparities workgroup outlined necessary data collection measures in order to reduce health disparities among populations, in particular, the disability community. The Executive budget includes funds for collecting data relating to health disparities, which expand beyond the requirements of the Affordable Care Act, by including detailed reporting on race, ethnicity, gender, housing status, and six disability-related questions used in the U.S. Census' American Community Survey. CDR supports efforts by the State to reduce health disparities and is pleased that the Executive is committing funds to advance this policy.

CDR supports improvements in language access to address disparities

CDR supports efforts to improve language access in order to reduce disparities. The Executive budget provides funding for interpretation services for people with limited English proficiency and communication services for people who are Deaf and Hard of Hearing. While CDR commends the State for working to resolve health disparities, regardless of this funding, providers have to assure effective communication with individuals who are Deaf or Hard of Hearing as required by the Americans with Disabilities Act (ADA). Increased reimbursements will impact services provided at hospital inpatient and outpatient departments, hospital emergency departments, diagnostic and treatment centers, and federally-qualified health centers.

CDR supports the inclusion of the health insurance exchange in the budget

CDR is very pleased to see the language for the health insurance exchange ("Exchange") in the Executive Budget. An insurance Exchange is a statewide marketplace where consumers and small businesses can buy health insurance. According to federal law, the Exchange must be

certified operational by the federal government by next January. If not, the feds will set one up for New York, disregarding New York's policies. According to Health Care for All New York (HCFANY), an insurance exchange will:

- Make health insurance rates more affordable.
- Give consumers and small businesses help in choosing the program that is right for them.
- Let consumers and small businesses better navigate insurance paperwork and changes relating to things like new jobs or changing family circumstances.
- Bring greater accountability and transparency to health insurance plans.

For people with disabilities, the exchange is significant because it is predicated on a large pool. In other words, by putting people who have low needs into the same matrix as people with significant needs, it will drive down costs for everyone. Furthermore, New York is committed to including Medicaid in the Exchange, which is good policy. The Exchange will be most effective if it can provide comprehensive coverage options. For people with disabilities, the Exchange must be able to do a thorough evaluation of eligibility that takes into consideration disability-related Medicaid, such as Medicaid Buy-in and Medicaid spend-down. Under current law, the Medicaid enrollment entity must not deny or terminate Medicaid based on income without exploring all possible avenues of eligibility. The Exchange must be capable of recognizing the need for coverage that will adequately serve people with disabilities.

CDR supports the State taking over *parts* of Medicaid

According to the proposal, the State will assume the growth in the county share of Medicaid expenditures as well as the local government administration of the Medicaid program including processing Medicaid applications, making eligibility determinations, and authorizing benefits. The proposal authorizes the Department of Health to transition some county employees to the State to assist with these additional responsibilities, which probably means the same people will be administering the program but will receive a paycheck from the State instead of the county. CDR supports an even and fair Medicaid program and unfortunately, the current county-led administration of Medicaid has been anything but. There are too many disparities county to county in enrollment, eligibility, and authorization. CDR supports the proposal that the State assume parts of the Medicaid program because it is important to ensure that the system serves people consistently. However, while consistency is key, it is important that the State raises everyone to the highest standards, not the lowest common denominator.

CDR opposes the elimination of the cost of living adjustment for human services providers

Every year, reimbursement for cost of living adjustment (COLA) and trend factors are targeted for elimination. The impact of no COLA means that CDR will continue to operate on previous year's reimbursements and there will be no pass through of additional funds to the direct care workforce that is critical to supporting people with disabilities in the community. While it is not surprising that the human services COLA was targeted for elimination, it nonetheless makes an already difficult situation even worse. The elimination of the COLA will place an even greater hardship on providers due to the companionship exemption proposed to calculate over time; which will ultimately have a negative impact on people with the most significant disabilities. Direct care workers play a vital role in people with disabilities' independence. In order to support people with disabilities in the community, the State must provide enough funds to support direct care workers.

CDR strongly believes that consumer protections are needed as the State moves to implement mandatory managed long term care

Last year's budget mandated that all individuals who are over 21, require more than 120 days of community-based long term care assistance, and are dually eligible for Medicare and Medicaid, enroll in a managed long term care (MLTC) plan. When approved, over 100,000 seniors and people with disabilities currently receiving home care services will be required to enroll in a MLTC plan. Efforts to implement this proposal, which is a result of the Medicaid Redesign Team's MLTC workgroup, are currently moving forward. As the State moves forward, consumer protections are needed to ensure that individuals are supported at home and avoid unnecessary institutionalizations. We urge the Legislature to require systematic and transparent monitoring of the Managed Long Term Care program, and ensure that fair hearing rights are preserved.

NOTE ON COMMUNITY FIRST CHOICE OPTION

The Community First Choice (CFC) Option is a community-based Medicaid state plan service which includes hands on assistance, safety monitoring, and cueing for assistance with activities of daily living, instrumental activities of daily living and health related functions based on functional need, not diagnosis or age. Through the Affordable Care Act, CFC adds 1915(k) to the Social Security Act under Medicaid. It supports choice, independence, and integration in accordance with the *Olmstead* decision. Services must be provided in a home and community-based setting and cannot be provided in an institution. States that implement CFC will receive an additional 6% in federal matching funds, with no sunset. **For New York, it is estimated that implementing CFC will result in drawing down additional federal funding for a net increase to the State of $90 million a year.** Because CFC is the first long term care program that is not age or diagnosis-specific, all of the human services agencies will be required to coordinate.

CFC will revolutionize the long term care system for New York State. CDR applauds the Governor for his continued commitment to implementing CFC in New York State. As the State moves forward with Medicaid redesign and the shift toward managed care expansion, it is imperative that planning for CFC occur simultaneously. Although the State is awaiting final rules from the Centers for Medicare and Medicaid Services (CMS), the State should (and is permitted to by CMS) move forward with the creation of the *Development and Implementation Council*. In his State of the State, the Governor explicitly outlined his commitment to *Olmstead* and supporting people in the most integrated setting. CDR urges the Legislature to support an aggressive *Olmstead* plan, recognizing that CFC ought to be the centerpiece of this strategy. CDR played an integral role in the development and passage of the Community First Choice Option as part of the Affordable Care Act and CDR is available to work with the Legislature to ensure that CFC is implemented in a manner that supports all New Yorkers who require long term services and supports.

INDEPENDENT LIVING

CDR supports the maintenance of funding for state-funded Independent Living Centers

In this difficult economy, the independent living community commends the Governor for protecting funding for Independent Living Centers, which offer vital advocacy and direct

services to people with disabilities. CDR is affiliated with the Regional Center for Independent Living (RCIL) in Rochester, New York, which receives state funding for operations.

AGENCY INITIATIVES

CDR supports the directive to agencies (DOH, OPWDD, OMH, etc) to establish limits on reimbursements for the costs of executive compensation and administration

CDR supports this proposal, which specifically targets state-funded service providers. It is most likely a response to the *New York Times'* exposé that revealed excessive compensations for executives of certain agencies that provide services to people in the Office for People with Developmental Disabilities (OPWDD) system. The bill requires the executive pay for providers be capped at $199,000 and requires at least 75 percent of every dollar to be dedicated to direct care or services instead of administration. This will increase by 5 percent each year for the next two years. On January 18, 2012, the Governor signed this in Executive Order. Clearly, the Governor is committed to this proposal and wanted to codify it outside of the budget process. CDR supports sincere attempts to reign in excessive executive compensation structures for organizations that receive State funds. In fact, there are no executives at CDR who earn close to the cap. CDR also supports increasing the percentage of the dollar that must go to direct care services to at least 75 percent, with a 5 percent increase each of the next two fiscal years. In fact, CDR spends an average of 92 percent of every dollar on direct service. The concern is that it is unclear how this proposal will play out in practice. The real test will be whether it will impact entities like hospitals and insurance companies who have notoriously avoided such proposals and receive enormous executive compensations, only to provide poor care to people with disabilities. CDR is concerned that this proposal, which is now an Executive order, will have a disproportionate impact on the nonprofit service providers.

CDR is concerned by the proposal to streamline the organizational structure of OPWDD

This proposal would reorganize OPWDD to create "Developmental Disabilities Regional Offices" and "State Operations Offices" in order to oversee service delivery in designated areas around the State. The "Developmental Disabilities Regional Offices" would oversee the administration of supports and services to individuals being served in settings outside of State operated programs and the" State Operations Offices" would provide for the direct delivery of supports and services in State operated programs. As an agency that works directly with the current regional office for developmental disabilities services, it is unclear how this proposal will actually improve the system. Is this just another tool in the State's toolbox to become more responsive to problems with the developmental disabilities system, or will this not streamline the system and in fact just create another layer of bureaucratic oversight?

CDR supports the efforts to combine and streamline human services in DOH, OMH, OPWDD, and OASAS

In order to support the State's move toward health homes, this proposal attempts to integrate and coordinate physical and behavioral health services/programs across agencies. While this is created for care coordination models, this proposal could have a significant positive impact on the State moving forward with the Community First Choice (CFC) Option.

Establish pilot programs in accordance with the "People First 1115 Waiver" application
This proposal is brief and basically allows OPWDD to enter into contracts without the need for competitive bids or RFP in order to establish pilot programs in accordance with the People First 1115 Waiver application. CDR is noting this proposal merely to highlight the fact that the State is moving full steam ahead with the People First 1115 Waiver.

PUBLIC BENEFITS/SSI

CDR supports the State taking over the administration of the State Supplemental Program for Supplemental Security Income
New York offers a supplement to the federal Supplemental Security Income (SSI) program. The feds charge the State $10.94 per recipient each month to process the State supplemental checks and New York projects that it can do it for about $2 per recipient, resulting in significant savings to the State. According to the Executive, New York is now one of only five states that continue to contract with the feds (U.S. Social Security Administration) for this service. This was proposed a couple years ago and did not pass. CDR supports the State administering the program so long as the State puts in place assurances that SSI recipients do not experience any disruptions in their SSI deposits and/or reductions in benefits.

HOUSING

SAVE ACCESS TO HOME!
The *Access to Home* program gets a $1 million commitment from the Executive, but HCR commits no funds.
Due to decades of bad housing policy, which continues today, home modifications are still necessary for many seniors and people with disabilities in order to remain independent in their own homes. The *Access to Home* program is an essential program that provides grants for modifications, assisting many individuals to avoid nursing facility placement solely due to housing problems. CDR commends the Executive for allocating $1 million to *Access to Home*, yet the State's Division of Homes and Community Renewal will not be committing their usual annual allocation amount of $4 million. Even the usual commitment of $4 million is far below need and HCR typically receives applications for *five times* the amount of available funding. In other words, *Access to Home* always scrapes by, functioning far below the level of need. Yet this year may be the last year for this critical program if the Legislature does not provide for additional funding. CDR urges the Legislature to support *Access to Home* and increase the funding for this program!

CDR supports the proposal to provide additional credits of $8 million for the low-income housing tax credit for each of the next five fiscal years
CDR commends the Executive for his commitment to advancing affordable housing options in New York State. The State Low-Income Housing Tax Credit (LIHTC) is modeled after the federal program and subsidizes the development of affordable rental housing by offering dollar for dollar tax credits. This proposal allows the State's Division of Housing and Community Renewal to allocate $40 million (up from $32 million) in 2012 with an additional $8 million for each of the next four fiscal years. Units are for people who are below 90 percent area median income (AMI). (The federal program is for people below 60 percent AMI.) While CDR supports advances in affordable housing for all populations, it is still problematic that the State program

does not target people below 30 percent AMI, which is where most low income people with disabilities fall. In a real sense, this proposal will not provide the critical assistance to those people with disabilities who are extremely poor. CDR will continue to advocate for changes with the State's LIHTC program to ensure that people below 30 percent AMI are prioritized.

CDR supports the increase for the Rural Rental Assistance Program

The Rural Rental Assistance Program (RRAP) is a rental subsidy program for approximately 4,700 low income people and seniors in upstate New York who live in properties financed through the U.S. Department of Agriculture's 515 program. The Executive proposes an increase of $4.6 million to address the costs of federally approved rent increases in the program. Last year, RRAP did not experience a similar increase in state funding so this move will allow the program to be maintained, and ensure that tenants are able to stay in their housing.

CDR opposes the elimination of funding for the Neighborhood and Rural Preservation Programs

Last year, the Executive budget proposed an alarming 50 percent reduction in state funding for Neighborhood Preservation Program (NPP) and the Rural Preservation Program (RPP). CDR is concerned that in this year's Executive budget, the Executive proposes eliminating all state funding for NPP and RPP. Rural Preservation Companies (RPCs) and Neighborhood Preservation Companies (NPCs) serve communities that rely on affordable housing. Not only do RPCs and NPCs provide vital affordable housing assistance to low income individuals, but they are extremely successful at leveraging their limited state funds. According to the New York State Rural Housing Coalition, by the 2008 fiscal year, RPCs achieved a leverage ratio of $30 for every RPC dollar appropriated. Eliminating state funding will force these organizations to drastically reduce staff, further limiting their ability to provide resources to people who need affordable housing, and worse yet, many of these organizations will be forced close.

CDR supports the maintenance of funding for the Nursing Home Transition and Diversion Medicaid waiver housing subsidy

CDR is pleased that the Executive budget includes continued commitment from the Department of Health to fund the housing subsidy administered by HCR for the Nursing Home Transition and Diversion Medicaid waiver. For people with disabilities, the lack of accessible, affordable, integrated housing is a primary barrier to transferring to and remaining in the community. The NHTD housing subsidy is critical to the success of the waiver in supporting people's independence.

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