

## TESTIMONY BEFORE THE MEDICAID COMMISSION

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January 25, 2006

Thank you for the opportunity to speak before you today. My name is Elizabeth Priaulx and I speak before you as a member of the board of the Virginia Office for Protection and Advocacy. VOPA is the federally funded and state designated protection and advocacy system for the rights of people with all disabilities in Virginia. A primary focus of VOPA advocacy is to assist individuals with mental, cognitive, sensory, or physical disabilities access the Medicaid supports that make it possible to participate in their community and workplace.

My main goal in coming to you today is to ask that you keep the requirements of the American with Disabilities Act integration mandate, as interpreted by the U.S. Supreme Court in the *Olmstead v L.C. and E.W.* decision, in mind as you make recommendations for long-term cost reductions in the Medicaid program.

On June 22, 1999, the United States Supreme Court held in *Olmstead* that the unnecessary segregation of individuals with disabilities in institutions constitutes discrimination based on disability. The court ruled that the Americans with Disabilities Act (ADA) may require states to provide community-based services rather than institutional placements for individuals with disabilities when a state's own medical

professionals reasonably conclude that an individual can reside in the community.

Medicaid is affected by the *Olmstead* decision because it is the major source of public financing for long term services for people with disabilities. People with disabilities rely on long term care for the most basic needs such as getting out of bed, toileting, and use of a wheelchair. Services that are rarely high cost but in fact make the difference between institutionalization in a nursing facility and self-sufficiency in their own homes and workplaces. *Olmstead* established that state Medicaid programs must operate in compliance with the integration mandate of the ADA.

States can increase Medicaid funding for community based services in at least three ways: 1) increase access to supports through the home health benefit; 2) add more optional state plan services; and 3) apply for or expand home and community based services waivers. The Medicaid commission can play an important role in supporting states' efforts to expand services in all three ways. At the same time, if *Olmstead* is not a routine consideration in all commission recommendations, these recommendations could result in unnecessary institutionalization of beneficiaries currently living and working in the community.

In particular, *Olmstead* and President's New Freedom Initiative requirements must be considered in conjunction with any Commission recommendations that allow states more flexibility to waive federal Medicaid requirements. While flexibility can enable states to serve more low income populations, provide more supports and services in the community, and reduce costs, flexibility, without proper safeguards, can result in unnecessary institutionalization of people with disabilities currently living in the

community, and fundamental changes in the Medicaid program – not anticipated or intended by this Commission.

One example of flexibility granted to states for the worthy purpose of increasing access to community based services and supports, but that has in fact for some people with disabilities meant a loss of community based supports, is the 2001 Centers for Medicare and Medicaid Services, Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative. HIFA encourages states to seek waivers of various provisions of the Medicaid Act and the State Children’s Health Insurance Program (SCHIP) to expand basic health insurance coverage to groups not currently eligible to receive benefits. In return, CMS promises the states fast-track consideration of their waiver requests.

However, CMS has also required that a state’s resulting waiver program, with the expansion in coverage contemplated by HIFA, must not cost the federal government any more money over the life of the waiver than it would have paid without the waiver. Thus HIFA provides states new discretion – and indeed incentives because of the cost-neutrality requirements – to cut benefits to and impose unrestrained cost-sharing on optional Medicaid groups currently receiving community based services, in order to serve new populations under Medicaid. Reductions in services to optional groups could mean people currently living in the community are no longer able to access the level of services needed to remain and are forced into institutional settings.

Another recommendation that the Commission will likely consider is to allow individuals the option of converting Medicaid benefits to personal accounts or vouchers. Many states have used these programs to increase consumer choice and control over

community supports and services. However, without proper safeguards, even this positive new flexibility can lead to loss of services for individuals with disabilities. For example, if a person's medical needs are much higher than anticipated in his or her capped voucher – and there is no safeguard in place to cover unanticipated health costs - people with disabilities are likely to cut back on needed services and medications in order to stretch the voucher. In many cases this would lead to health deterioration and a shift from low cost preventive care to high cost urgent care.

A most recent example of how good public policy can be distorted can be seen in the recent Budget Reconciliation Act, currently before the U.S. House of Representatives. Senate Bill 1602, The Improving Long-Term Care Choices Act of 2005, was introduced this past July to create an option for states to provide home-and community-based services as part of its state plan for individuals up to 300% of Social Security Income. The bill increases state flexibility to provide community based services to people with disabilities by decoupling the requirement of an institutional level of care in order to receive home and community-based services. The original bill provided long-term supports to individuals with disabilities based on need and without the caps currently available to states through Medicaid waivers.

By the time it got through conference, new language was inserted that will actually create a fundamental change in a beneficiary's right to state plan services, unintended by its original co-sponsors. The bill still creates a new state plan option to expand access to community services for Medicaid beneficiaries with income up to 150% of the poverty level without requiring individuals to need an institutional level of care. However, it now allows for enrollment caps and waiting lists that could actually limit

access to services individuals need to maintain their independence. The new flexibility could render obsolete Medicaid's existing protection that once a state agrees to provide an optional service, it must provide the service to all Medicaid beneficiaries who need them.

The Administration and Congress repeatedly have spoken to their desire to advance the civil rights of people with disabilities. The President has stated, "I am committed to tearing down the remaining barriers to equality that face Americans with disabilities today. My New Freedom Initiative will help Americans with disabilities by increasing access to assistive technologies, expanding educational opportunities, increasing the ability of Americans with disabilities to integrate into the workforce, and promoting increased access into daily community life." I urge the Commission to keep the President's commitment to community integration for people with disabilities in mind as it considers the impact of long-range restructuring of Medicaid.

Respectfully Submitted on January 25, 2006

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