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November 9, 2021

Hon. Richard N. Gottfried  
Chair, Committee on Health  
New York State Assembly  
The Capitol  
Albany, NY 12224

***Re: Testimony on the New York State Medicaid Program Efficacy and Sustainability***

Dear Assembly Member Gottfried:

Thank you for the opportunity to address the efficacy and sustainability of the Medicaid program, including managed care and the actions of the 2011 Medicaid Redesign Team (MRT I) and the 2020 changes from the second iteration of the Medicaid Redesign Team (MRT II). Our comments focus on the perverse incentives toward unnecessary institutionalization that these state policies have created, particularly in relation to the Assisted Living Program (ALP).

Mobilization for Justice’s mission is to achieve social justice, prioritizing the needs of people who are low-income, disenfranchised or have disabilities. We do this by providing direct civil legal assistance, conducting community education, engaging in policy advocacy, and bringing impact litigation. For 30 years, Mobilization for Justice (formerly MFY Legal Services) has advocated for residents in New York’s long-term care facilities. We advise and represent residents of nursing homes and adult care facilities (adult homes and enriched housing programs) in individual matters and impact litigation. We also provide know-your-rights trainings to residents at New York City’s adult homes, particularly “transitional” adult homes that historically have warehoused people with mental health disabilities in scandalously poor conditions.<sup>1</sup> These are institutional settings, in which residents follow regimented schedules for

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<sup>1</sup> See, e.g., Ava Kofman, “*We Don’t Even Know Who Is Dead Or Alive*”: *Trapped Inside an Assisted Living Facility During the Pandemic*, PROPUBLICA, Nov. 30, 2020, <https://www.propublica.org/article/we-dont-even-know-who-is-dead-or-alive-trapped-inside-an-assisted-living-facility-during-the-pandemic>; Joaquin Sapien, *After Failing Mentally Ill New Yorkers, Adult Homes Get Second Chance*, PROPUBLICA, July 30, 2019, <https://www.propublica.org/article/after-failing-mentally-ill-new-yorkers-adult-homes-get-second-chance>; Liena Zagare, *Disabled People Lived in Squalor for Years in a Dickensian Adult Home in Ditmas Park, Bklyner*, Jul. 26, 2018, <https://bklyner.com/disabled-people-lived-in-squalor-for-years-in-a-dickensian-adult-home-in-ditmas-park/>; Jennifer Gonnerman and Erica McDonald, *A Place for Us: For Decades, New York’s Adult Homes Have Profited by Keeping the Mentally Ill in Squalor*, MOTHER JONES, March/April 2010, <http://www.motherjones.com/politics/2010/02/surf-manor-coney-island>, New York State Comm’n on Quality of Care and Advocacy for Persons with Mental Disabilities (CQC), *A Review of Assisted Living Programs in “Impacted” Adult Homes* (2007), CQC, *Health Care in Impacted Adult Homes: A Survey*, 2006; CQC, *Adult Homes Serving Residents with Mental Illness: A Study on Layering of Services* (2002); Clifford J. Levy, *Broken Homes*, N.Y. TIMES, Apr. 28-30, 2002, [http://www.nytimes.com/ref/nyregion/BROKEN\\_HOMES.html](http://www.nytimes.com/ref/nyregion/BROKEN_HOMES.html).

eating, taking medication, and other aspects of daily life; are assigned roommates and lack privacy in their rooms; and have meals, medication, phone calls, and mail deliveries announced over a public address system. These facilities—many run for profit—are also major centers of Medicaid spending, where payments for ALP services are layered with on-site doctors, near-constant emergency and non-emergency medical transportation, and a revolving door for residents between ACFs, hospitals, and nursing homes in place of coordinated care.

**Conflicts of interest in the ALP program create Medicaid waste.** Most transitional adult homes operate or plan to operate Assisted Living Programs (ALP) in their facilities. ALPs are adult care facilities that are certified to provide additional services, including assistance with activities of daily living and physical, speech, and occupational therapy. In addition to the adult home room and board fee, these facilities charge Medicaid a daily rate per resident. That daily rate, which varies roughly between \$75 and \$150 per day, is determined by the RUG category corresponding to the resident's UAS score. The UAS is completed by an employee or contractor of the adult home operator, creating a conflict of interest to overestimate a resident's need for assistance to increase the daily Medicaid rate. Despite the increased Medicaid spending on their care, many residents who lived in facilities before they became ALPs did not notice a difference in the level of services provided after conversion to ALP. Although enrollment in ALP services is supposed to be a resident's choice, residents MFJ has spoken to feel pressured to enroll, or are unaware they have been enrolled by their adult home, underscoring the disconnect between Medicaid payments and services provided. MFJ's 2017 testimony before this committee detailed how facilities siphon funding from resident services into operators' pockets. MRT II did not address the staggering waste in the ALP program.

**Carve-outs to managed care for long-term care facilities increase the unnecessary institutionalization of seniors and people with disabilities.** The carve-out incentivizes managed care plans to recommend nursing home placement or delay discharge from short-term rehabilitation in nursing homes for high-need enrollees. This increases unnecessary institutionalization and increases the cost to the state. But the effect of the carve-out goes beyond managed care plans cherry-picking lower-need participants. Many decisions about long-term care happen at stressful moments when individuals are facing an imminent hospital discharge or an urgent need for personal care services. Families face immense pressure from hospital and nursing home discharge planners to agree to a discharge quickly, whether it is the best discharge option for the Medicaid beneficiary, or simply the most expedient. Admission to an ALP can be accomplished by completion of a simple two-page form and a brief interview. Admission to a nursing home does not even require that. By contrast, arranging home care services through managed care requires multiple in-person assessments of the individual and the individual's proposed discharge location, first by Maximus's conflict-free evaluation to qualify for MLTC and then by as many managed care plans as are necessary to secure the appropriate home care services. Someone could apply, be admitted, and move into a long-term care institution in less time than it takes to simply arrange an assessment by a managed care plan. Arranging home care should be easier, and certainly not more burdensome than arranging institutional care.

**MRT II incentivizes institutional care over community-based services.** The MRT II recommendations codified in the SFY2020-21 budget eliminate Medicaid housekeeping services and restrict the availability of home care services to Medicaid participants who need physical assistance with three or more activities of daily living (ADL) or, for people with dementia, supervision with two or more ADLs. Nonsensically, this is a higher threshold than is required for ALP or long-term nursing home placement. MRT II thus creates a system that forces seniors and people with disabilities who could live in the community with minimal assistance into much more costly institutions because their need for assistance is too low. MRT II's changes to independent assessment of needs by a state-selected doctor also increases the burden on people trying to access community-based services but does not create any similar independent assessment for institutional care. MRT II's restrictions on home and community-based services—but not on institutional care—force seniors and people with disabilities into institutions with limited oversight, higher costs, less dignity and privacy, and worse health outcomes.


MFJ suggests recommends seven measures to rebalance New York's Medicaid services toward home and community-based services to promote the goals of independence, dignity, and aging in place, while realizing state savings by divesting from institutional settings.

- 1. Remove the carve-out for costly institutional care.** Providing coverage for home and community-based services and institutional care through the same mechanism will remove the perverse incentives toward unnecessary institutionalization. If New York continues to rely on managed care, ALP and nursing home coverage should be included in that system. The risk of institutionalization must be borne by the payor, not by the individual needing care.
- 2. Reverse the MRT II's changes in the SFY 2020-21 budget.** Seniors and people with disabilities who are largely independent but need some assistance will be forced into institutional settings to receive assistance that is easily provided at home under these changes. Because institutionalization leads to worse health outcomes, MRT II's cost-reduction goals will be offset by spending on more serious medical interventions and lower quality of life. The lookback will not have the intended effect of preventing enrollment by wealthy seniors, but will prevent low-income seniors and people with disabilities—disproportionately people of color—from accessing needed care.
- 3. Require independent assessment of ALP residents' needs.** Before the state created the Conflict-Free Enrollment and Evaluation Center (CFEEC) to determine if Medicaid recipients qualified for enrollment in MLTCs, plans acted much like ALPs do now: enrolling as many participants as possible, even if the resident did not qualify under the eligibility guidelines. The state enacted a new check on the plans, which was successful in limiting the problem. Similar steps must be taken to ensure appropriate assisted living enrollment.

- 4. Collect data to track and reduce racial health disparities in long-term care.** New York does not collect data about the race of ALP residents, and therefore has no way to determine if quality Medicaid services are available to everyone in the setting of their choice. New York must collect race data from ALPs.
- 5. Ensure that Medicaid expenditures on institutional care benefit residents.** ALPs should be subject to medical loss ratios to ensure residents benefit from Medicaid spending. Managed care plans and nursing homes are now subject to some form of a medical loss ratio, but ALPs are not. While some expenses in nursing homes and managed care plans should be reallocated in medical loss ratio calculations, the existing rules are an important baseline to ensure minimum service delivery.
- 6. Develop supportive housing and rental subsidies for residents throughout the state to reduce the need for institutional living and spending.** Rather than pouring more money into institutions, New York must invest in programs and services that will enable adults with disabilities to live in the most integrated setting appropriate to their needs. Supported housing programs, home care services, and case management can allow many residents who are institutionalized or are at risk of institutionalization in ALPs and nursing homes to live independently in their communities. MRT I developed and invested in housing and rental subsidies to improve health outcomes and reduce the cost of care. The state must commit to building on that success.
- 7. Lift the Medicaid Global Cap to ensure quality services are provided to those who need them.** The cap artificially limits the state's health care spending irrespective of the changing needs and enrollment of the Medicaid program. The Global Cap jeopardizes the health of low-income New Yorkers and reduces the availability of needed services.

Mobilization for Justice thanks the Committee on Health for holding this hearing. We are committed to helping the State develop and implement a financially sound system that ensures that Medicaid supports seniors and people with disabilities in living with dignity in their communities, with the necessary support services to maximize their potential.

Sincerely,



Daniel A. Ross  
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