

New York Legal Assistance Group

**Testimony to the New York State Legislature
Joint Hearing of the Senate Finance and Assembly
Ways and Means Committees**

THE 2022-2023 EXECUTIVE BUDGET

TOPIC: HEALTH/MEDICAID

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New York Legal Assistance Group (NYLAG) uses the power of the law to help New Yorkers experiencing poverty or in crisis combat economic, racial, and social injustice. We address emerging and urgent needs with comprehensive, free civil legal services, financial empowerment, impact litigation, policy advocacy, and community partnerships. We aim to disrupt systemic racism by serving clients, whose legal and financial crises are often rooted in racial inequality.

SUMMARY

NYLAG enthusiastically supports:	page
1. The increase in the Medicaid income limits and repeal of the asset test for age 65+, disabled or blind (Part N) but also requests aligned increase in income limits for the Medicare Savings Program, at no cost to the state	2
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NYLAG SUPPORTS THE GOVERNOR'S INITIATIVES THAT NARROW THE RACIAL GAP AND EXPAND ACCESS TO HEALTH AND COMMUNITY-BASED LONG TERM CARE FOR SENIORS AND PEOPLE WITH DISABILITIES

- **Part N – Support Medicaid Expansion for Aged, Blind & Disabled** - NYLAG strongly supports the Governor's bill that will equalize Medicaid eligibility for all New Yorkers, by increasing the income limit for seniors and people with disabilities to the same limit used for younger people under the Affordable Care Act (138% of the Federal Poverty Level (FPL) and by eliminating the asset test.. This increase ensures that when younger recipients age into Medicare; they will no longer fall off the "Medicaid cliff," as they do now when the monthly income limit drops:
 - From \$1563 to \$934 for a single person
 - From \$2105 to \$1367 for a couple

Repeal of the asset limit is essential to eliminate racial disparities in health care access. The current rules are biased against people of color, who statistics show are less likely to own homes¹ or retirement funds,² assets that have special exemption from the current asset limit, while cash assets count. People whose savings are in cash rather than a home or IRA will be able to save money for emergencies, rather than be forced to spend it down to a level that causes instability when the next urgent expense arises.³ Also, most retirees with income at even the increased level need to depend on savings just to make ends meet. We note that for those seeking nursing home or long term care, the limit on home equity (now \$955,000) remains intact, as required by CMS, retaining the existing exceptions when a spouse or certain other relatives live in the home.⁴

Increase in the income limit is essential. Now, individuals must "spend down" their so-called "excess" income to \$934/mo. – about 85% FPL -- on medical expenses before they can qualify for Medicaid. Navigating the spend-down program is so difficult that many needy New Yorkers either refrain from getting care they need or pay a spend-down they can ill afford. Increasing the income limits will ensure access to vital care.

¹ Stefanos Chen, *The Resiliency of New York's Black Homeowners*, New York Times, Aug. 17, 2021, available at <https://www.nytimes.com/2021/08/17/realestate/new-york-black-homeowners.html?referringSource=articleShare>. "From 2002 to 2008, the number of Black homeowners in the city dropped 10 percent... and there is evidence that the share dropped another 3 percent by 2017."

² Kelly Anne Smith, *America's Racial Wealth Gap In Retirement Savings*, Forbes, 9/1/2020, available at <https://www.forbes.com/advisor/retirement/retirement-racial-wealth-gap/>.

³ New York's asset poverty rate, including the equity in a home, is 26.9 % higher than the national average of 24.1%, based on 2016 data. Prosperity Now Scorecard, available at <https://scorecard.prosperitynow.org/data-by-issue#finance/outcome/asset-poverty-rate>.

⁴ See *Recoveries, Transfer-of-Asset Rules and Post-Eligibility Income Rules to MAGI Individuals*, <https://www.medicaid.gov/federal-policy-guidance/downloads/smd-14-001.pdf>.

NYLAG Calls on the Governor and Legislature to Increase the Medicare Savings Programs (MSP) Limits and Enact S8228

- **Enact S8228 to increase the Medicare Savings Program (MSP) income limits in sync with the Medicaid expansion.** The three MSP programs pay the cost of the monthly Part B premium. The 2022 premium rose to \$170.10 -- *ten percent* of a Social Security check of \$1701/mo. **S8228** would increase the top tier MSP limit from 135% to 156% FPL -- \$1766.70/mo. (\$2,285 couple). It would help 100,000 seniors and people with disabilities at NO COST TO THE STATE. This would ensure that no Medicare beneficiary must pay more than 10% of their income for this premium.

There is no added cost to the state for three reasons. First, for those with incomes under 138% FPL, the cost is already included in the Medicaid expansion. All people covered under the Medicaid expansion are entitled to reimbursement by the State of their Part B premium, and to payment of Medicare deductibles and coinsurance, which is the sole other benefit for Qualified Medicare Beneficiaries (QMB). Under S8228, those covered by the Medicaid expansion would be divided between two of the MSP programs:

- Those with incomes up to 120% FPL would be Qualified Medicare Beneficiaries (QMB), a 20% increase in the current income limit for that program of 100% FPL. QMB provides an added protection for beneficiaries at no cost to the state – prohibiting providers from “balance billing,” which is billing them for Medicare coinsurance and deductibles that Medicaid does not pay.
- Those with incomes from 120% - 138% FPL would be SLIMB’s, an 18% increase in the income limit for that program.

Second, the proposed increase for the third MSP program, called QI-1, has **100% federal funding**, requiring the State to contribute nothing. This would cover those with incomes from 138% - 156% FPL.

Third, not only is the QI-1 program free for New York State, it will save approximately **\$25 million** by *reducing* costs of the state-funded EPIC prescription drug program for seniors. EPIC’s costs are reduced because any one in an MSP program automatically qualifies for the federal Extra Help Part D drug subsidy. For anyone with “Extra Help,” EPIC costs drop to negligible amounts.

If the MSP limits are not expanded, the State must still reimburse Medicaid recipients with incomes between 120% - 138% FPL for the Part B premium, but with a cumbersome process of literally sending them a reimbursement check. This is a hardship to the beneficiary because the Part B premium is withheld from their Social Security check, reducing their already low income and making it difficult to pay basic expenses while awaiting the State’s reimbursement check. Those with incomes up to 156% FPL will lose

up to 10% of their checks just on the Part B premium, without even counting Medicare deductibles and coinsurance.

- **Part Q -- Expand Access to the Essential Plan and Post-Partum Care to Include Immigrants**– NYLAG supports the Governor’s proposal to expand eligibility for the Essential Plan from 200% to 250% of the FPL, though we urge a further expansion to 300% FPL. We also urge that this program be expanded to cover all immigrants, as proposed under **A880/S1572**. We also support the expansion of Medicaid coverage from just 60 days to one year after giving birth, which would allow for continuity of care and protect new parents from unaffordable medical bills
- **Part U – Reduce Costs for Children and Expand Services in Child Health Plus.** NYLAG supports removal of the \$9 monthly premium for children covered by Child Health Plus at 200% FPL eligibility level, and expansion of the benefit package for Child Health Plus to include services covered by Medicaid but that have not been covered by CHP, such as medical transportation and services for children who have chronic conditions or behavioral impairments.

NYLAG SUPPORTS INCREASING PAYMENT RATES FOR PRIVATE DUTY NURSING FOR MEDICALLY FRAGILE ADULTS AND URGES THAT THIS SERVICE BE CARVED OUT OF MANAGED CARE AND MLTC (Part O – HMH)

- We commend the Governor for giving **medically fragile adults the same access to private duty nursing** that medically fragile children were given in FY 20-21, by increasing the payment rates. This increase is much needed in light of the severe nursing shortage exacerbated by COVID-19. However, the proposed rate increases and those previously enacted for children only apply to those who receive these nursing services Fee for Service, not to those in managed care. The vast majority of adults and children who need these services are enrolled in Medicaid managed care plans, including Managed Long Term Care plans, which include Private Duty Nursing services in the MLTC benefit package. These rate increases will not help these members. NYLAG has clients authorized by both mainstream plans and MLTC plans to receive private duty nursing, but for whom there are frequently unstaffed shifts each week on a regular basis, at least in part because the rates paid by the plans for these services are low.
- **CARVE PRIVATE DUTY NURSING OUT OF MANAGED CARE & MLTC.** Many appeals are required to compel a mainstream or MLTC plan to authorize private duty services or to increase the number of hours. This is because of the inherent disincentive created by the managed care capitation model, which leads plans to deny authorizations for high-cost care such as private duty nursing. NYLAG strongly urges that this service be carved out of MLTC and mainstream managed care and authorized through the prior approval process administered by the Commissioner for Fee for Service recipients.

- We also note that the template for the MMCOR reports, discussed above, lacks any reporting by plans about this service. Unlike personal care and CDPAP, plans do not report their expenditures on this service, the number of months in which members were authorized for this service, or the number of members receiving various ranges of hourly allotments of these services. This should be added to the MMCOR reports.

NYLAG REQUESTS REPEAL OF PAST HARMFUL BUDGET CHANGES

REPEAL THE GLOBAL CAP

- We appreciate that the Governor’s budget proposal (Part H of HMH bill) would improve the formula for setting the cap and support this change if the global cap is retained. However, we urge that the global cap be repealed, and the Medicaid budget determined by the normal, public, transparent budget process. We support **A226/S04120** (*Gottfried, Braunstein*) that would repeal the “Global Cap” which, in the ten years since originally enacted in 2011, has become destructive, impeding flexibility needed to respond to urgent needs that increase Medicaid enrollment and spending, such as the COVID-19 pandemic.

REPEAL MRT II CUTS ON MEDICAID and HOME CARE ENACTED IN SFY 20-21

- **A5367/S5028** (*Gottfried, Rivera*): **NYLAG supports repeal of the Minimum Needs restrictions on eligibility for Medicaid personal care and consumer-directed services from MRT II**, which blatantly discriminate against people with developmental disabilities, visual and many other impairments, by requiring *physical* assistance with a minimum number of Activities of Daily Living for eligibility. Only people with dementia, and no other impairment, may still qualify if they need *verbal* cueing assistance with two ADLs. These new thresholds also eliminate the longstanding “Housekeeping” program, which by providing just 8 hours/week of help with household chores, prevents a person with a disability from a fall or other injury that would lead to higher cost care.
- **We urge repeal of other parts of MRT II including the “Independent Assessor,”** which burdens the task of assessing the need for Medicaid home care with a new massive bureaucracy operated by Maximus, adding two new assessments that will cause huge delays in services. Given the dire nursing shortage there is no capacity to start this program (See attached chart). It denies the consumer’s own trusted physician a voice in prescribing services that meets the consumer’s complex needs. Many concerns about implementation of this program can be found in a joint letter from NYLAG and Medicaid Matters NY dated Dec. 15, 2021, posted at <http://www.wnyc.com/health/download/801/>.
- We also urge **repeal of the lookback and transfer penalty for home care**, which make no sense in light of the Governor’s proposed repeal of the asset limits, and which will cause further delays and hardship.

NYLAG OPPOSES ROLLBACK OF CURRENT PROTECTIONS

Retain “Prescriber Prevails” for Prescriptions (Part BB of HMH bill)

The Executive Budget proposes to eliminate the longstanding principle that the “prescriber prevails” in determining the medical necessity of medications in fee-for-service (FFS) Medicaid and Medicaid managed care (Part BB, Section 1). This proposal would have a detrimental impact on people with disabilities and chronic conditions, as well as on those who rely on specific drugs and drug combinations. For these individuals, medical providers are best suited to determine which drug would treat their patients most effectively. Denials of necessary drugs, even if appealed and ultimately resolved in a patient’s favor, can endanger Medicaid beneficiaries when they face sudden disruptions in treatment. Providers are best equipped to ensure that their patients have access to the safest and most effective treatments for their conditions.

Retain the SFY 21-22 Advances in Protections for Nursing Home Residents (Part M)

We join the Center for Elder Law and Justice in opposing the dilution of critical protections enacted in SFT 21-22 to improve staffing levels in nursing homes and limit profits. Please see their testimony.

NYLAG GIVES QUALIFIED SUPPORT FOR MANAGED CARE REFORMS Parts O and P of HMH Article VII Bill

We give qualified support to the proposed procurement of managed care plans for the first time in NYS (Part P of HMH Article VII bill). This proposal, if done thoughtfully and with an infusion of State resources needed to review, select and then monitor plans fairly, may hold plans more accountable by quantifying and evaluating plan performance on meaningful metrics, and addressing quality of care issues. The factors identified in the budget proposal for selecting plans are a start. However, these criteria need to be further developed by convening a **stakeholder workgroup that includes consumers** from various populations and their advocates - seniors, people with disabilities, children and their families. Additionally, the managed care contracts need to be overhauled and updated to better protect consumer rights (see testimony of Medicaid Matters NY) and protections are needed to ensure continuity of care for members of plans that close.

More factors that should be considered in procurement include, but are not limited to --

- We support a preference for not-for-profit plans but urge the bill to go further and set a preference for locally based insurers over the national for-profit insurers that have increasingly taken hold in this state.

- Metrics that demonstrate the plans’ track record and commitment to providing care in the community as opposed to nursing homes, as required by the *Olmstead* decision of the U.S. Supreme Court and the Americans with Disabilities Act. This is especially true for Managed Long Term Care plans. This would include examining the extent to which MLTC members are admitted to nursing homes on a temporary basis and never discharged home, and the number of new members who enrolled in the plan upon being discharged from a nursing home, which could show a commitment by the plan to promote community-based care.
- Outcomes of members’ appeals challenging plans’ denial of services must be considered. If a high percentage of a plan’s denial of services are reversed or settled on appeal favorably for the member, this may demonstrate a high error rate and a pattern of violating state and federal standards for authorizing services. The State must examine this data to assess the extent to which the capitation model is driving the plan’s denial of services, especially for those with higher needs.
- The Commissioner collects a huge amount of relevant data from plans every quarter through *Managed Medicaid Cost and Operating Reports* (MMCOR), filed by plans for each geographic region in which they operate. See 10 NYCRR § 98-1.16(f - g). The data is not made public except through a Freedom of Information request, and then not in a format useful for the public to compare plans. The MMCOR reports are used by the State for rate-setting, but the data would be critically important for this procurement process. MMCOR data show, for example, the percentage of an MLTC plan’s members that received personal care or consumer directed personal assistance program services (CDPAP) in the highest amount available (over 700 hours/month) or in the lowest amount available (under 80 hours/month) and in between. This data can be correlated with the percentage of a plan’s members who received only nursing home care for all or part of the previous year. A plan authorizing fewer members with high hours of care but more members with nursing home stays should be strongly disfavored in the competitive bidding.
- Medical Loss Ratio must be considered, with “care management” costs defined as part of administrative costs.

The bill should also be further amended to require strong Transition Rights to ensure continuity of care for any members of plans that close or merge with other plans as a result of procurement. The Department recently promulgated a regulation that watered down Transition rights in exactly this situation, where a plan closes. 18 NYCRR §§ 505.14(b)(4)(viii)(c)(3)(vii), 505.28(i)(4)(iii)(h) as amended eff. 11/8/21. The statute should restore the longstanding principle that barred plans from arbitrarily reducing hours for a member to less than the number duly authorized previously – whether by the same Medicaid plan or a different plan or local district. Once a plan authorizes a certain type and amount of services for a member, if that member is required to move to a different plan because their

former plan closed, the new plan must be required to continue the same type and amount of services authorized by the former plan, and be prohibited from reducing those services unless it can prove a change in medical condition or circumstances that results in the member needing less care.⁵

Part O - The Article VII bill scraps the FY 2020-21 budget's required procurement of a uniform "task based assessment tool" by which home care needs would be assessed by managed care plans, and instead directs the Commissioner to develop guidelines and standards for plans and local districts to use their own tasking tools. We have the same concerns about these guidelines that we had about procurement of a uniform tasking tool.

- First, the **law should require convening a stakeholder workgroup** that includes consumers and their representatives to develop these guidelines and standards.
- Second, the lack of a uniform tool allows plans to continue using proprietary and often secret tasking tools that rely on algorithms that arbitrarily deny medically necessary care. Algorithm-driven decision-making tools have been found to raise serious concerns nationally, violating due process with the lack of transparency of the embedded criteria, the lack of ascertainable standards, and the failure to consider individual circumstances. People with disabilities experience disproportionate and particular harm because of unjust algorithm-driven decision-making, leading to extensive litigation in various domains, including Medicaid home care assessment. See, e.g., *Arkansas Department of Human Services v. Bradley Ledgerwood*, 530 S.W.3d 336 (Ark. 2017); Order, *Jacobs v. Gillespie*, No. 3:16-CV-119-DPM, (E.D. Ark. November 1, 2016). Use of **such algorithms must be prohibited.**
- Third, the development of a plan of care with or without a task tool depends on a comprehensive assessment of need. Yet the Commissioner has acknowledged serious shortcomings in the standard "Community Health Assessment" (CHA) also known as UAS-NY used by a nurse to do the primary assessment of need. Specifically, in promulgating amendments to state regulations to implement the MRT II budget changes, responding to a comment requesting that the new assessments specifically assess night-time needs, the Commissioner acknowledged that the CHA tool "does not ask these questions [about the frequency of needs] and the Department does not have another evidence-based validated assessment tool that can be used for this purpose..."⁶ Until that assessment tool is improved to elicit this information, no standard, guideline, or tasking tool can be fairly applied.

⁵ These rights are guaranteed by the Due Process clause, as held in *Mayer v. Wing*, 922 F. Supp. 902 (S.D.N.Y. 1996) and long incorporated in State Medicaid policy. 18 NYCRR § 505.14(b)(4)(viii)(c)(3)(i) – (vi); NYS Dept. of Health MLTC Policy 16.06, available at https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policy/16-06.htm.

⁶ NYS Dept. of Health, Revised Summary of Express Terms, available at https://health.ny.gov/health_care/medicaid/redesign/mrt2/express_terms_summary.htm;

ENACT FAIR PAY FOR HOME CARE ACT

The one-time bonuses proposed in the Governor's Budget for direct care health workers are insufficient to improve recruitment and retention of direct care workers. This is especially true for home care workers, for which the shortage has been exacerbated by COVID-19, and for which demand is increasing with the baby boom now aging and with growing longevity. We support **S5374A/ A6329** (*Gottfried, May*) **Fair Pay for Home Care Act** that would increase home care worker wages to 150% of the regional minimum wage.

Thank you for the opportunity to submit this testimony. Please feel free to contact me with any questions.

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https://health.ny.gov/health_care/medicaid/redesign/mrt2/docs/express_terms_summary.pdf at page 185. (Proposed Amendments to 18 NYCRR 505.14 and 505.28).

ESTIMATED NURSE CAPACITY NEEDED TO DO INDEPENDENT ASSESSOR		
Estimated Nurse Assessments per Mo	Purpose of Assessment	Notes
MANAGED LONG TERM CARE & MEDICAID ADVANTAGE PLUS (MAP)		
10,300	Conflict-Free assessment for initial eligibility to enroll in MLTC	This is the only assessment that is already being conducted – the rest in this chart will be new with NYIA. The CFEEC started Oct. 2014, when MLTC enrollment was only 125,040. It has more than doubled to 275,827. As of June 2018 Maximus had conducted 278,452 evaluations. ¹
23,000	Annual reassessments	Total 275,827 members end of Dec. 2021 ² (monthly est. is rounded)
2,300	Interim requests for increases, post-hospital or rehab discharge	Estimating 10% of all members request or need one of these assessments 1x/year. May be higher or lower.
MAINSTREAM MEDICAID MANAGED CARE		
12,800	Annual reassessments for members receiving PCS or CDPAP, Plus Estimated new requests and mid-year requests for increases.	About 95,000 of the 5.2 million mainstream members reportedly receive CDPAP services (no known public data). Low estimate of half that number receiving personal care services (PCS) or 42,000. Total 137,000 = 11,400/month. (These include elderly immigrants who are not eligible for Medicare, and disabled persons under 65 not yet on Medicare). Adds another 10% for new requests for service and mid-year requests for increases/ hospital discharges = 1400 +11,400=12,800/month
FEE FOR SERVICE ADMINISTERED by LOCAL DSS (Immediate Need, OPWDD/ TBI/NHTDW Waivers, Hospice)		
3,400	Annual reassessments, estimated new requests, mid-year increase requests. Note some will not have reassessments because they are Immediate Need cases transitioned to MLTC, but others are exempt/excluded from MLTC so will have reassessments.	The only public data we are aware of are monthly fact sheets posted by HRA, showing 2404 cases in Nov. 2021. ³ Assuming that, like MLTC, there are 4 times as many recipients in NYC as there are in the rest of state, there are an estimated 700 recipients in ROS for a total of 3100 . Adding 10% for mid-year increases, new requests.
51,800	TOTAL ASSESSMENTS PER MONTH	This is 6 times the number conducted in June 2018 with 217 nurses. ¹ The same number is also needed for the new IPP or CA – the medical practitioner’s assessment.
1,041– 1,302 nurses	Nursing Capacity needed Compare last figure available was 217 nurses in June 2018.	June 2018 DOH stats say 217 nurses were conducting conflict-free assessments, estimated as averaging 8,375/mo. ¹ Higher figure assumes SIX TIMES as many nurses would be needed to do 51,800 assessments/month. Lower figure calculates fewer nurses needed, as some will be done by Telehealth, which takes less time because no travel required. Consumer has right to request in-person assessment.

¹ Last available CFEEC statistics are from June 2018 as reported by DOH in MLTC Status Update 7/12/2018 presented to Plans at monthly meeting (copy attached). DOH shared slide deck with Medicaid Matters NY. The estimate of 10,300 assessments currently needed for initial MLTC enrollment is based on calculating the number of assessments conducted in the 4 months starting March 2018 through June 2018. From DOH MLTC Status Update dated Mar. 8, 2018, which said 244,951 estimates had been done through Feb. 2018. This means Maximus complete 33,501 assessments in the four months from March through June 2018, averaging 8,375/month. Since June 2018, MLTC enrollment has increased by 23%. Therefore, conservative estimate is that 23% more CFEEC assessments are needed now, which is 10,300. (Slides attached). New enrollment is likely higher than that estimate because over 20,000 MLTC members have been disenrolled for Long Term Nursing Home stays since 10/2020. So the 23% growth in enrollment does not reflect that more NEW MLTC members have enrolled to replace the nearly 10% of all members who were disenrolled.

² DOH [Monthly Medicaid Managed Care Enrollment Report](https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/), available at https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/ (Report for December 2021)

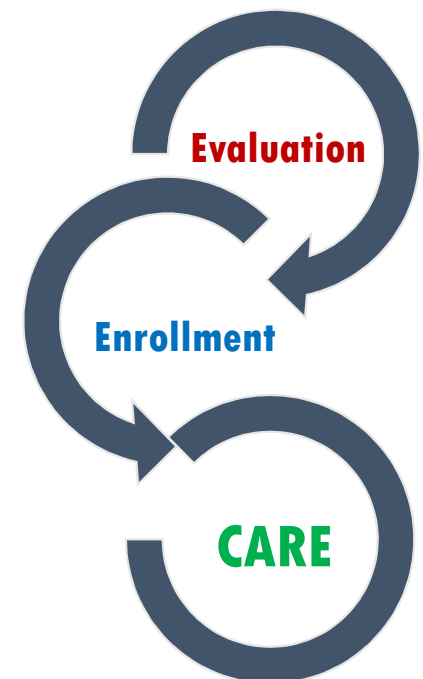
³ HRA Facts, available at <https://www1.nyc.gov/site/hra/about/facts.page>; data from December 2021 Fact Sheet available at https://www1.nyc.gov/assets/hra/downloads/pdf/facts/hra_facts/2021/hra_facts_2021_12.pdf.

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Conflict-Free Evaluation and Enrollment Center (CFEEC) Activity*

- **Requests for Appointments: 7,283**
 - Consumers living in home setting: 6,784
 - Consumers remaining in nursing facility/home: 499
- **Cumulative Activities: Since Program Inception**
 - 183 Nurses on Staff (*as of February 28th*)
 - 889,588 Incoming calls
 - 244,951 Notices mailed
 - 265,723 Total evaluation requests
- **Highest Demand for Evaluations: Top Three Counties**

1 st : NYC	197,088	74%
2 nd Nassau	12,079	5%
3 rd Suffolk	10,008	4%

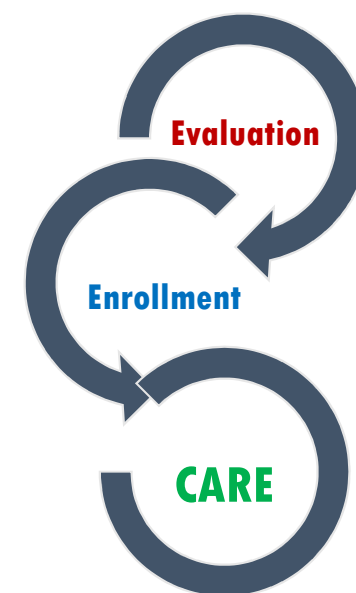


*Based on February 2018 activity report

Conflict-Free Evaluation and Enrollment Center (CFEEC) Activity*

- **Requests for Appointments: 9,506**
 - Consumers living in home setting: 8,811
 - Consumers remaining in nursing facility/home: 695
- **Cumulative Activities: Since Program Inception**
 - 217 Nurses on Staff (*as of June 31*)
 - 1,014,431 Incoming calls
 - 278,452 Notices mailed
 - 304,516 Total evaluation requests
- **Highest Demand for Evaluations: Top Three Counties**

1 st	NYC	225,859	74%
2 nd	Nassau	13,847	5%
3 rd	Suffolk	11,322	4%



*Based on June 2018 activity report