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New York State Assembly
Committee on Health
Committee on Aging
Committee on Labor
Task Force on People with Disabilities

Hearing to examine the growing need for home care and personal care, and to examine the obstacles to recruiting, employing, and retaining an adequate home care workforce.

February 27, 2017
Albany, NY

Testimony Presented by
Amy E. Lowenstein, Senior Attorney
Elizabeth P. Siegel, Staff Attorney

Empire Justice Center is grateful to the Assembly for holding these important hearings and investigating what we have experienced as a widespread home care workforce shortage that is leaving individuals in need of home care stuck in nursing homes, unnecessarily hospitalized, or putting their health and safety at risk at home without sufficient aide services. We are hopeful that these hearings will lead to concrete steps to reverse the home care workforce shortage so that New York's seniors and people with disabilities receive the support they need to live their lives with dignity in the community, and the workers who assist them are given wages and benefits that demonstrate respect and appreciation for the critical work they do.

Empire Justice Center is a statewide legal services organization with offices in Albany, Rochester, Westchester and Central Islip (Long Island). Empire Justice provides support and training to legal services and other community based organizations, undertakes policy research and analysis, and engages in legislative and administrative advocacy. We also represent low income individuals, as well as classes of New Yorkers, in a wide range of poverty law areas including health, workers' rights, public assistance, domestic violence, and SSI/SSD benefits.

Empire Justice has worked extensively on Medicaid home care issues from both the consumer and worker perspectives. Our efforts have taken many forms. Through informal advocacy, fair hearing representation, and state and federal litigation, we represent Medicaid recipients attempting to overcome barriers to accessing home care. We provide training and technical assistance to other advocates working with home care recipients and applicants. We provide feedback to and advocate directly with the State on issues affecting home care recipients through our roles on the Managed Long-Term Care Quality Incentives and Nursing Home Managed Care Transition workgroups; through monthly Medicaid Matters New York (MMNY) meetings with Department of Health (DOH) managed care staff; as co-chair of MMNY and Health Care for All New York's Public Programs Group, which meets regularly with Marketplace Medicaid staff; and through our positions on the steering committees of MMNY and the Coalition to Protect the Rights of New York's Dually Eligible. Last year we co-authored a report put out by MMNY and the National Academy of Elder Law Attorneys, New York Chapter, entitled "Mis-Managed Care," which documented widespread illegal reductions in Medicaid personal care hours by several Managed Long Term Care plans.[1] These experiences have helped shape the perspectives we provide today.

While our home care policy and federal litigation work is statewide, our individual advocacy for home care consumers and workers, as well as technical assistance work has been primarily outside of New York City and Long Island. For Medicaid consumers and their advocates in the regions in which we have worked, the existence of a Medicaid home care workforce shortage is undeniable. Although our clients encounter numerous barriers to accessing the home care to which they are entitled, the shortage of aides has been the biggest obstacle to care by far. The home care workforce shortage is not new, but it is reaching crisis proportions attributable to a constellation of factors including an aging

[1] Medicaid Matters New York & National Academy of Elder Law Attorneys, NY Chapter, "Mis-Managed Care," Jul. 2016, available at http://medicaidmattersny.org/cms/wp-content/uploads/2016/08/Managed-Long-Term-Care-Fair-Hearing-Monitoring-Project-2016-07-14-Final.pdf.

population; stagnation of already low home care wages; limited public transportation; and the relatively recent, and long overdue, application of Fair Labor Standards Act (FLSA) travel and overtime requirements to home care workers. Some agencies are capping aide hours to avoid FLSA requirements, resulting in further reduction of the available workforce. (See CAPCO Letter dated July 30, 2015, attached as Appendix A.)

New York Medicaid recipients are entitled to home care if they are found eligible for it. It's that simple. And yet time and again we are contacted by and about Medicaid recipients who everyone agrees should be getting home care – their doctor, their Medicaid plan, their family, an Adult Services worker who was called in. But they are not getting any services, or they are getting less care than they need, or they are getting intermittent care. As a result, the recipients are left to fend for themselves, risking institutionalization, and putting their lives and health in danger. The detrimental impact the aide shortage is having on our clients is illustrated in the attached Client Stories. (See Client Stories, attached as Appendix B.)

The home care workforce shortage persists across Medicaid programs.[2] We have seen it in fee-for-service Medicaid at the Local Departments of Social Service (LDSS), Managed Long Term Care, Mainstream Managed Care, and through the TBI and Nursing Home Transition and Diversion Waivers.

LDSSs are still responsible for authorizing and providing home care to individuals in fee-for-service Medicaid, dual eligibles not eligible for MLTC, people with an immediate need for personal care services or consumer directed personal assistance, and a number of waiver recipients. Many LDSSs readily acknowledge their inability to meet the need for home care. For example:

- In December 2015, Cortland County reported to DOH a shortage of nurses available to even assess people for personal care services and noted challenges in finding agencies willing to contract with the county to provide services. (See Letter from Cortland County Department of Social Services Commissioner Kristin Monroe to

[2] There are several avenues through which Medicaid recipients in New York State receive home care services:

- Mainstream Managed Care (MMC): MMCs are responsible for assessing and approving their members for home care services.
- Managed Long Term Care (MLTC): MLTC provides home care services to people dually eligible for Medicaid and Medicare who need more than 120 days of community based long term care services other than level one personal care services. Medicaid-only individuals may also receive home care through MLTC, but must, in addition to other eligibility requirements, meet a nursing home level of care and need at least one of three services that are available in MLTC, but not MMC: environmental or social supports, home delivered meals, or social adult day care.
- Local Department of Social Services/NYC Human Resources Administration: LDSS/HRA is responsible for ensuring the provision of home care for people on fee-for-service Medicaid (e.g., someone with third party health insurance other than Medicare); dual eligibles only eligible for level 1 personal care services or who need higher level services for less than 120 days, people with an immediate need for personal care services or consumer directed personal assistance, and TBI and NHTD waiver participants who do not receive Home and Community Support Services, or who additionally need home health services or private duty nursing.
- The TBI and NHTD waiver programs: Waiver program recipients who need Home and Community Support Services (oversight and/or supervision as a discrete service) receive any necessary personal care services through the waiver.

Jason Helgerson, Medicaid Director, NYS DOH dated Dec. 10, 2015, attached hereto as Appendix C.)

- In March 2016, Albany County stated on the record at a fair hearing that it had "79 people approved for personal care services who are not receiving these services because of the unavailability of aides."[3] It is our understanding that the number waiting for personal care services in Albany County has since increased.
- Rensselaer County had been requiring Medicaid recipients approved for home care to sign a form acknowledging the aide and nursing shortages and assuming the risk of accepting services in light of the shortages. (See Rensselaer County Department of Social Services form, attached hereto as Appendix D.)

Some counties attribute the aide and nursing shortages to home care agencies being able to obtain higher rates from Managed Long Term Care plans and to the less onerous procedures involved in becoming an MLTC provider as opposed to a fee-for-service Medicaid provider.

This is no doubt part of the problem, but managed care is not immune to the home care workforce shortage. Eager to avoid authorizing hours they are unable to fill, managed care organizations, some of which readily acknowledge the shortage, have responded to the workforce shortage with a variety of tactics including:

- rationing care by authorizing only the number of hours they believe they can fill, not the number of hours that a member needs;
- pressuring clients to use the Consumer Directed Personal Assistance Program, sometimes offering to authorize more hours under CDPA than for personal care, thereby shifting the onus of finding aides on to the member; and
- discouraging people with high needs from enrolling in the plan by claiming the plan cannot safely serve the person in the community or does not provide the 24 hour care the applicant needs.

The 1999 Supreme Court decision in Olmstead v. L.C., 527 U.S. 581, found that people with disabilities have a right to live in the most integrated setting appropriate to their needs. For years before Olmstead and the Americans with Disabilities Act, the assumption that a nursing home or other institution was an appropriate setting for people with disabilities and seniors to live out their lives was barely challenged. Olmstead changed the conversation. The language of community integration transformed expectations for people with disabilities and our growing aging population – living in the community and avoiding a nursing home is now considered a real option. While this puts pressure on the home care system, we should not be quashing the expectations and dreams of people who wish to live their lives in the comfort and familiarity of their homes and communities, instead of the dehumanizing and depressing environment of an institution.

But movement from an aspirational conversation about community integration to a society and State where community integration is realized has been slow going, even with the legal requirement to move people with disabilities to the community. By allowing the home care

[3] Fair Hearing #7249729K (Mar. 31, 2016), available at http://otda.ny.gov/fair%20hearing%20images/2016-3/Redacted_7249729K.pdf.

workforce shortage to continue unchecked, New York is shirking its legal obligations under Olmstead, and its moral obligations to New Yorkers.

Shifting the focus away from institutions towards the community requires more than lip service. We must invest in community integration. That is the only way to show we truly value the lives of the people with disabilities and seniors who want to live in the community, and the lives of the people - the home care workforce - who help make that happen.

We understand the challenge in finding solutions to the home care workforce shortage. But morally and legally, the crisis cannot be allowed to continue and must be reversed. With that in mind, we urge the following immediate steps to begin addressing the workforce shortage:

1. **Ensure adequate competitive wages and benefits for home health aides, personal care aides and consumer directed personal assistants.** Immediately, this means:
    - Matching the minimum wage for home health, personal care and consumer directed workers with the minimum wage for fast food workers.
    - Requiring reimbursement for aide travel costs.
    - Providing the necessary funds to pay competitive wages and benefits to aides as well as to pay for FLSA overtime and travel requirements. This includes providing managed care capitation rates that are sufficient to account for increased costs and requiring that any increased capitation rate be used to increase the availability of aide services. Managed care plans must be able to provide sufficient rates to Licensed Home Care Service Agencies, CDPA Fiscal Intermediaries and Certified Home Health Agencies that account not just for wages and benefits, but also administrative costs associated with increased wages. And these agencies must in turn be required to use the increased funds to meet minimum wage and overtime requirements and to increase wages above the minimum wage in order to attract and retain aides. Providing necessary funding also means ensuring that the LDSSs are able to offer competitive reimbursement rates to home care agencies that they pass on to workers. Currently counties cannot compete with the rates offered by managed care, even as the managed care rates are inadequate to attract sufficient numbers of aides.
    - Incentivizing managed care plans to enroll and serve individuals with high needs by creating a high needs community rate cell for managed long term care.
2. **Convene a stakeholder workgroup to investigate and make recommendations on ways of recruiting and retaining people in the home care workforce.** The workgroup should be charged with exploring and making recommendations on recruiting and retaining an adequate and adequately compensated home care workforce that will permit all seniors and people with disabilities who wish to live in the community to do so. The workgroup must have the authority to make policy recommendations as well as recommendations for changes to state law and

regulations. The workgroup must contain substantial representation from home care recipients, home care workers and organizations that represent their interests.

In 2013 New York State developed and released its Olmstead plan with the worthy goal of "Community Integration for Every New Yorker."[4] This goal will never come close to being achieved if the home care workforce shortage in New York State is not checked and reversed.

Thank you for the opportunity to present our perspective on this issue. Empire Justice Center looks forward to working with the Assembly, Senate, Governor Cuomo and the state agencies to move forward in addressing this crisis.

For more information:
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[4] https://www.ny.gov/programs/olmstead-community-integration-every-new-yorker.

APPENDIX A

Cortland County Community Action Program, Inc. (CAPCO)

32 North Main Street ❖ Cortland, NY 13045

Phone: (607) 753-6781 ❖ Fax: (607) 758-3620 ❖ www.capco.org

Head Start ❖ Early Head Start ❖ Energy Services ❖ WIC ❖ Consumer Directed Personal Assistance ❖ Family Development

To: Participants in the Consumer Directed Personal Assistance Program (CDPAP)

Date: July 30, 2015

RE: Reduction in CDPAP Funding→ Accrual Status Change→Maximum Hours Worked→New Entry Level Rate

The Cortland County Community Action Program recently received news that our Consumer Directed Personal Assistance Program (CDPAP) funding, particularly our Medicaid reimbursement rate, has significantly decreased for the 2015 billing cycle and beyond. This change comes as part of Medicaid's initiative to reduce costs across all Medicaid-funded programs. It is with great regret that this reduction in our Medicaid reimbursement rate will significantly impact our CDPAP program, and we have diligently worked to mitigate this impact and keep the program running while persistently trying to minimize the effect on our valued employees. As a result of this decrease, CAPCO has been forced to make difficult decisions to ensure the continuation of the program. The following change has been made in response to the reduction of CDPAP funding:

- **Change in Accrued Leave Status**: Effective **August 1, 2015**, employees in the CDPAP program will be ineligible to accrue leave. This includes annual/vacation, sick, and personal leave. If you were eligible to accrue annual/vacation leave and currently carry an unused balance, your annual/vacation accrued leave will be paid out to you, up to a designated amount, in your August 14, 2015 paycheck. This is a one time occurrence as CAPCO does not normally pay out annual leave for current employees. If you were eligible to accrue sick leave, you will be able to retain your accruals up to a designated amount. Any balance of accrued personal leave will be eliminated and not available to you after 8/1/2015. The designation is as follows:

    - **Annual/Vacation Leave**: balance to be paid out up to the amount of 40 hours.
    - **Sick Leave**: balance may be carried up to a maximum of 15 hours through 12/31/2015, at which point any unused balance will be eliminated.
    - **Personal Leave**: balance will be eliminated without access as of 8/1/2015

  Going forward, effective August 1, 2015, employees of the CDPAP program will not be eligible to accrue leave. Any leave taken, other than the current balance of your sick leave up to 15 hours, will be unpaid and must continue to have prior approval from your supervisor. If you have been ineligible to accrue leave and you do not carry a current balance of accrued leave, this change will not affect you and the provisions of this change do not apply to you.

- **Change in Maximum Hours Worked:** Effective immediately, when hiring a new aide the maximum hours they can be scheduled to work is 25 hours per week. Please keep this in mind if you are replacing an aide who currently works full-time.

- **<u>New Entry Level Rates</u>:** Effective immediately, Tier 1 (Aide) will start at $8.75 per hour; Tier II (Personal Care Aide), will start at $9.15 per hour; and Tier III (Skilled Care Aide) will start at $10.15per hour.

CAPCO has arrived at the aforementioned changes with much deliberation and evaluation. We put much effort into minimizing the impact our reduction in funding will have such as pay rate decreases for current employees. Please note that while CAPCO has worked diligently to curtail the impact of our CDPAP funding reduction, we cannot guarantee that we will not be forced to make further changes. Our commitment continues to be to provide support for the CDPAP participants and stability for the CDPAP employees. We do not take these decisions lightly and we hold our valued employees as a top organizational value. It is with significant regret that we have to make these changes, and we will continue to reevaluate our resources to be as equitable as possible.

Sincerely,

Lindy Glennon	Eden Harrington-Hall	Greg Richards
Executive Director	Assistant Director	Human Resource Director

APPENDIX B

Client Stories

Below are examples of the effect of the home care workforce shortage on our clients. To protect identity, the names have been changed and other identifying information has not been disclosed.

Jane

Jane is a young woman who lives in a rural part of New York. She became disabled unexpectedly at a young age. Due to her disability, she is not able to carry objects from one place to another, which makes moving around her home difficult. She also needs help with virtually every activity of daily living: showering, toileting, dressing and grooming. Despite her disabilities, Jane is a bubbly, perpetual optimist.

Jane enrolled in a Medicaid waiver program about 11 years ago after becoming disabled. The waiver recommended 24/7 care in the community as part of her care plan, which she received for a decade. Then, unexpectedly, her aides stopped coming. Her service coordinator in the waiver program told Jane that they were unable to replace her aides because there is an aide shortage and because Jane lives in a rural area. According to the service coordinator, the pool of aides is small, and when travelling to rural areas it becomes even smaller. Jane was told that many aides do not have cars, and even the ones who do have a way to get to her home do not want to go because she required 24/7 care. Her service coordinator said it would be hard, but she would continue to look for aides for Jane.

Being an optimist, Jane believed that her service coordinator could find her 24/7 care soon. But without aides, this meant that Jane was all alone in her home. Getting dressed, toileting and grooming were nearly impossible. Jane's frail, elderly mother who also has a disability came over daily to assist her. Showering was the most difficult because it required balance without assistance. Jane's mother was unable to assist her showering because of her own physical condition. This meant that Jane had to wait until the weekends when her sister would drive two hours to visit Jane and help her shower. Her sister did more than help her shower. She took Jane grocery shopping, to the pharmacy, and on any other errands Jane needed to run. She would also assist Jane by preparing pre-cooked meals for her to eat during the week.

This situation quickly became untenable for Jane and her family. Jane continued to reach out to her service coordinator to see if there was any headway on securing her an aide. Unfortunately, Jane's service coordinator told her that she had contacted every agency that serviced her area and there was not a single aide available to assist her because she required 24/7 care and lived in a rural area. The service coordinator recommended that Jane reduce her care from 24/7 to 12 hours, which she hoped would make it easier to find an aide. After considering this request, and with three months without care, Jane reluctantly agreed. Jane reduced her care from 24 to 12 hours. She used a life alert for the remaining 12 hours when she was alone.

Unfortunately, Jane's reduction in hours made no difference in her service coordinator's ability to find aides. Jane still went without aides. After six months with no aides, Jane's service coordinator suggested that Jane change her care again. This time she suggested that she use CDPAP aides for 8 hours, and the service coordinator would try to find an aide for the remaining 4 hours of care. Again, desperate for an aide, Jane reluctantly agreed.

Searching for an aide was difficult for Jane. She did not know anyone who could provide the CDPAP care for 8 hours a day. One woman she found through a friend was willing to assist, but turned the job down because of the low pay and lack of benefits. Jane explained that although the woman wanted to work, the position only paid $10.00 per hour and did not have any benefits. She said she would not be making enough to support her family. In the meantime, Jane's service coordinator also could not find an aide to work with her.

Jane continued without care for a full year until she found someone willing to work with her in the CDPAP program. However, this is the only aide Jane currently has, and she works 5 days a week, taking the weekends off. It has now been 14 months since Jane's services stopped and Jane is currently receiving 8 hours of care, 5 days a week, instead of the 24/7 care she really needs. Her service coordinator is still trying to fill the remainder of the hours. Jane believes the biggest factor preventing her from finding an aide is the poor wages and lack of benefits.

Martha

Martha is an elderly woman who lives by herself in a small apartment complex. She is bright, witty and loves to talk about the career she had in science. Martha was diagnosed with a degenerative neuromuscular disease, chronic blood clots in her legs and an eye condition. She wanted to remain as independent as possible for as long as possible, which she says she has done her whole life. Unfortunately, her condition deteriorated. Her lungs are weak. Simple chores, like making her bed, vacuuming or mopping, leave her totally out of breath. She requires an oxygen tank almost all the time. The blood clots in her legs coupled with her deteriorating vision make it difficult for her to walk around her apartment.

As a former nurse, she recognized she needed help bathing, dressing and getting around. So, despite her wish to remain independent, Martha enrolled in an MLTC plan for 6 hours a week of personal care services. At first the MLTC provided an aide three days a week for two hours a day. When the aide was there, they assisted Martha with bathing, grooming, preparing meals and straightening up the apartment. However, that aide stopped coming, and the MLTC told Martha they were going to switch her schedule for the new aide to two days a week of care for three hours each day. An aide never came.

Martha begged the MLTC to send an aide to her home, but they were never able to find someone. Martha even said that she would be willing to reduce the level of care she

needed. She suggested eliminating assistance with showering and grooming so long as someone could help with groceries and cooking. She started crying as she described how she would forego personal hygiene so that she wouldn't starve to death. She also cried as she described how humiliating the entire experience was for her. She was independent her entire life, and now she feels her body is betraying her and she is left to beg for help she just can't get.

Sara

Sara is a middle-aged woman who lives in a small city. She suffers from a severe degenerative lung disease that has made every activity of daily living a struggle. She cannot walk, dress, bathe, stand from a sitting position, or prepare meals without becoming out of breath and exhausted. She needs assistance with every aspect of her daily life.

The County authorized 49 hours of personal care a week for Sara, but the County was unable to provide her with an aide to cover the hours. They told her that there was an aide shortage in the entire region, and that they understood she needed the care but they could not find anyone to assist her for more than an hour per week.

Without the help of an aide, Sara's health declined. One afternoon she fainted. Fortunately, it was during the one hour a week that an aide was with her. The aide rushed her to the hospital, where she required medical attention for several days. While she was in the hospital a prior application she had made to an MLTC was accepted and her enrollment in the plan effectuated. When Sara was ready to be discharged from the hospital, the MLTC had not located aides to care for Sara. Without an aide, the hospital refused to discharge Sara to her home. Instead, they sent her to a nursing home where she remained for several weeks.

During her time in the nursing home, Sara won a fair hearing against the MLTC and the County for failing to provide her with aides. The fair hearing decision directed the MLTC to provide her with 49 hours of aides per week. Despite this fair hearing decision, Sara still only had sporadic aide services when she left the nursing home.

Without regular aides, her health continued to decline and she was hospitalized a second time. Her second hospitalization could have been prevented had an aide been with her. One day while home alone, Sara dropped a fork on the floor. Without anyone to help her pick it up, Sara tried to pick up the fork herself. She fell and seriously injured herself. She managed to call an ambulance and was hospitalized again. When she was ready to be discharged, the MLTC did not have an aide to assist Sara at home so she was sent to a nursing home - again. She remained in a nursing home for several more weeks.

Doctor's planning her release from the nursing home recommended significantly increasing Sara's home care hours. In an acknowledgment that she needed additional hours, the MLTC said they would approve more hours, but only if Sara enrolled in

CDPAP. Fearful for her health without the additional care, Sara agreed to enroll in CDPAP even though she did not have an aide lined up to assist her. Finally, after months of trying to secure aides through the County and MLTC, Sara was able to hire an aide. Sara went approximately nine months without any, or only sporadic, aide services until she was able to find the care herself.

Cortland County
Department of Social Services

APPENDIX C

Kristen Monroe
Commissioner

December 10, 2015

Jason Helgerson, Deputy Commissioner and Medicaid Director
New York State Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Mr. Helgerson:

There is an urgent critical situation occurring in Cortland County and a handful of other counties that I need to ensure you know about. I am writing to express concern over recent experiences trying to resolve a Personal Care Aide (PCA) service dilemma and to ask for your immediate assistance. State Department of Health (SDOH) policies are compromising our ability to serve vulnerable people in our community. Specifically, the delayed and incremental approach to moving all PCA cases to Managed Long Term Care (MLTC) has resulted in a situation whereby we have no trained authorized entity willing to provide PCA nursing assessment services to the remaining fee-for-service population.

The SDOH left responsibility with counties for the assessment and authorization of certain personal care cases, the Level I PCA cases and those waiver cases that require PCA services of any level. As the rest of the PCA cases have moved to the MLTC arena, this has created a delivery problem for several local districts. Not only have problems been created by these SDOH policies, but there has been a lack of effective response from SDOH to assist us. Our provider of PCA nursing assessments, Home Care of Rochester, notified us that they will no longer provide this service as of January 1, 2016. We have been trying to understand SDOH rules and policies in order to secure and prepare another provider in accordance with 18 NYCRR Part 505.14 for the cases we remain responsible for since we were notified of this situation at the end of October. To date, there has been no productive support provided to us. Please understand we are a small county, as are the others affected. In small counties, there are only one or two licensed agencies with very limited nursing resources and we have run into multiple challenges in trying to find an alternate provider. Our number of cases affected may be small, but whether we have one person or one thousand people, the authorization process required is the same. Each individual who needs and is eligible for the service is a real person in our community for whom we need to ensure there is a framework to serve.

My main SDOH contact on this issue, Margaret Willard, has been gracious and has attempted to assist with providing limited information. It is my inference that she is unable to gather the responses she needs from other SDOH decision makers. I offer the following description of the situation with a caveat that I have received many discrepant pieces of information from various divisions of SDOH so I remain uncertain of some policy and process details.

Managed Long Term Care plans have negotiated rates with PCA providers that are higher and more easily established, consistent and negotiable. As the majority of PCA cases have transitioned to MLTC, there is a smaller pool of cases that need to be served in the fee-for-service arena. The fee-for-service arena has a rate setting structure that provides a lower rate and burdens current providers with the need to develop and file costly reports if they are to have any chance of receiving a rate adjustment. In order for any new providers to enter the fee for

service arena, they must be willing to: pay hefty application fees to become a PCA provider and to be set up to bill in eMedNY, create expensive cost reports, provide employees days to be trained on the Universal Assessment System, and be willing to wait months for this approval process. In fact, I was told it would likely take up to a year for a licensed agency to complete the certification process to become a PCA provider and to have a rate established. For these reasons, current providers and potential licensed providers in our community are unwilling to perform PCA assessments for us. There are too few fee-for-service cases with rates too low for these agencies to afford to comply with burdensome and costly SDOH requirements and procedures in an attempt to have their rates increased or to become an authorized provider.

Although it is not related to the urgent nursing assessment crisis we are facing, it is worth noting that our Consumer Directed provider agency has also been challenged to continue service to our fee-for-service recipients because their rates are so low and the method for trying to raise them through cost reporting is expensive, lengthy and volatile in that their rate actually decreased this year. They have had to limit individual aide hours to 25 hours in order to avoid paying health insurance because they cannot afford to offer that benefit under the current rate structure. This has resulted in a system whereby our most vulnerable waiver consumers need to find and hire multiple aides to cover their needs on a part time basis.

The things that SDOH can do that would help are as follows:

- The process whereby potential PCA providers are approved as providers and subsequently obtain service rates needs to be clarified in writing for local districts. We need to know the exact steps that should be taken and the manner in which each of these steps must be taken. This would include points of contact, required paperwork, sequence of steps, and anticipated timeline for each step.
- Review and update the current process whereby fee-for-service rates are established for PCA providers. As the pool of fee-for-service clients has shrunk, providers no longer have a critical mass to operate with such low rates. This problem will only be exacerbated when the waiver cases go to MLTC and we are left to contract for Level I only PCA services.
- Provide local districts with comprehensive guidance regarding our ability to pay for PCA costs in the first instance and to seek full reimbursement through our claiming process. We have unanswered questions regarding local district discretion in setting rates, allowable entities to contract with, and how we can do this as a program claim without doing case specific authorizations much like we used to do with non-emergency transportation. If they have to be claimed administratively, then we need guidance on how our administrative cap will be impacted.

I urge you to resolve these coordination challenges within the various bureaus of SDOH in order to provide local districts with the necessary guidance and flexibility to fulfill the responsibilities left with us. Additionally, if the PCA system is going to be viable for the cases left with local districts, there must be some immediate changes made to the approval and rate setting processes. I would be happy to talk with you or your designee more about this situation if it would be helpful. I appreciate your time and attention in this matter.

Sincerely,
/S/

Kristen Monroe
Commissioner

CC Sheila Harrigan, Executive Director, NYPWA
Margaret Willard, SDOH

RENSSELAER COUNTY
DEPARTMENT OF SOCIAL SERVICES
127 BLOOMINGROVE DRIVE, TROY, NEW YORK 12180

Kathleen M. Jimino
County Executive

Randy Hall
Commissioner

Jennifer Girzone
Deputy Commissioner, Administrative Service

Theresa A. Beaudoin, Esq.
Deputy Commissioner of Services

Date:

Re: [redacted]

Address: [redacted]

MEDICAID (CIN NUM) [redacted]

I have been advised and understand that there is as aide/nursing shortage. I have been advised and understand that because of this shortage, aides/nurses may not be available to provide the care I have been authorized t receive. I understand that my caseworker will make diligent effort to secure the services authorized but that there still may be times when no aides/nurses are available. I also understand that services may not be available on the specific days or at the specific times requested.

☒ With full understanding of the above, I choose to participate /continue to participate in the personal care aide program/private duty nursing program/care at home program/long term home health care program accepting the risks associated with the aide/nurse shortage

☐ I do not choose to participate or continue to participate in any of the aboves programs.

☒ I have been given information regarding the Consumer Directed Personal Assistant Program.

lient ,Client representative) Signature/Date

Rensselaer County Department of Social Services representative/Date