Medicaid Redesign & the Home Care Workforce (*updated March, 2012)*

Background

On February 1st, 2011, Governor Cuomo released his Executive Budget, including State Medicaid cuts of approximately $2.85 billion, which totaled over $5 billion once the federal share was included.

However, rather than identifying the specific ways to contain costs, the Governor created a Medicaid Redesign Team (MRT) to identify ways to meet the reduction target for FY 2011-12. This Team consists of 32 members — leaders in health care delivery and insurance, health care workforce, business, consumer advocates, and state legislators.

The MRT's charge was to find ways to reduce costs and increase quality and efficiency in the Medicaid program. The MRT received over 274 proposals, from which a consolidated package of 79 proposals was voted on, and accepted by the Governor for inclusion in his 2011-2012 State Budget. Following the passage of the budget, the MRT established workgroups to guide the implementation of specific proposals.

The following changes have the greatest impact on the home care workforce:

Home Care Worker Wage Parity

The New York State Budget (2011-2012), established a minimum wage for home care aides who perform Medicaid reimbursed work for certified home health agencies (CHHAs), Long Term Home Health Care Programs (LTHHCPs) and managed care organizations (MCOs) within New York City and within the counties of Nassau, Suffolk and Westchester. MCOs include mainstream plans, as well as all forms of managed long term care plans (MLTCs)[1]. This requirement also affects licensed home care services agencies (LHCSAs) to the extent that they contract with a CHHA, LTHHCP or MCO to provide Medicaid services to clients of those entities in the same counties.

The parity provision is tied to the Living Wage laws in the individual counties, and will be phased-in as follows:

March 1, 2012 – 90 percent of the total compensation[2] of the Living Wage Law of NYC
March 1, 2013 – 95 percent of the total compensation of the Living Wage Law of NYC

[1] This includes the partially capitated Managed Long Term Care Plan, the Program of All-Inclusive Care for the Elderly (PACE) program, and the Medicaid Advantage Plus (MAP) plans; however, Medicaid beneficiaries have to qualify for PACE and MAP. PACE enrollees must be 55 or older and nursing home eligible; MAP enrollees must be nursing home eligible.

[2] The NYC living wage law currently provides for wage + benefit supplement ($10.00 + $1.50) totaling $11.50 and 90% of that is $10.35. Section 3614-c(3)(a)(i) provides that for the period 3/1/12 to 2/28/13 NYC providers are required to pay at least 90% of the local living wage standard. Therefore, 90% of the total compensation required by the Living Wage law includes an hourly wage of $9.00 plus health benefits or a benefit supplement rate of $1.35.

March 1, 2014 – 100 percent of the total compensation of the Living Wage Law of NYC

Wage requirements for entities that employ home care aides providing services in Nassau, Suffolk and Westchester counties will begin transitioning to parity one year after New York City, effective March 1, 2013, and will pay different amounts that relate to the specific Living Wage of those individual counties.

Additionally, employers will be required to provide health benefits or, in lieu of health benefits, pay a health benefit supplement rate of $1.35 hour in 2012, $1.43 in 2013, and $1.50 in 2014. Employers with a collective bargaining agreement in place on January 1, 2011 that provides for the provision of health benefits through payments to a jointly-administered labor management fund will have met the health insurance/health supplement requirements of the wage parity law. The wage supplement requirements of the law may be satisfied in either cash or benefits. The employer who provides benefits can credit their costs to reduce the amount that they would otherwise have to pay in wages provided the total benefit supplement equals $1.35 in benefit value to the aide.

The interpretation of the wage parity law is complicated and PHI recommends that the reader consult the Frequently Asked Questions released in January and February of 2012.

Net Impact: Home health aides will ultimately earn the same wage as personal care aides (also known as home attendants in NYC). By 2014, minimum wages of home care workers must meet the Living Wage Requirement (of $10 an hour in NYC and $1.50 for health benefits).

Managed Care Plans (including MLTC plans) will now become the primary payors for home care aide services and a vehicle for implementing the transition to this new wage. Plans, as well as the other organizations covered by the law, are responsible for compliance and must monitor employer compliance with the new law on at least a quarterly basis, and must provide the Commissioner of the Department of Health with written certification. No payment will be made to providers unless they have filed the required certification. In addition, DOH released a policy statement and guidance for MLTCs to contract with Home Attendant providers that are currently servicing the case to help ensure continuity of care; however vendors must meet the plan's quality or credentialing standards and be willing to accept the same rate they are receiving under their current personal care arrangement with New York City.

Medicaid Managed Care

Since 1999, New York's Medicaid recipients have been enrolling in mainstream managed care plans for their medical services for their medical services. However, those individuals needing long-term care have largely remained in either the Medicaid Personal Care Program, or one of the waiver programs for special populations (e.g., the Long Term Home Health Care Program, the Traumatic Brain Injury waiver).

As part of the MRT redesign of the Medicaid system, personal care services became part of the Medicaid Managed Care benefit package as of August 2011. Individuals who received no long-term care services other than personal care, and received these services through the traditional (fee-for-service) Medicaid personal care, now have their personal care services paid for directly by their Medicaid Managed Care Plan. In order to ensure continuity of care, clients with existing relationships with aides and a personal care agency that are non-participating (i.e., do not have a signed contract) with their managed care plan were permitted to continue receiving personal care services for up to 60 days, with extensions by the plan as appropriate. Plans have generally kept the aide with the client and executed a contract with the home attendant agency that employed the aide.

Over the next year, the State will enroll a number of additional populations into Medicaid Managed Care, pending approval by the federal government. For example, Medicaid recipients residing in a nursing home will enroll in Medicaid Managed Care in October of 2012, and current recipients of the Long Term Home Health Care Program will have to enroll in either mainstream managed care or an MLTC plan in January of 2013.

Mandatory Managed Long-Term Care Enrollment

The FY11-12 state budget also included a mandatory enrollment in MLTC plans for individuals 21 years old and over with Medicare and Medicaid coverage who need 120 days or more of community-based long-term care. (People who are dually eligible for Medicare and Medicaid between the ages of 18 and 21, and people who are Medicaid only, may also voluntarily enroll into MLTC as well.) This proposal still requires the approval of the federal government.

New persons first requiring community-based long-term care will be referred to an enrollment broker for assistance and will receive an information guide that outlines who must join, plan features, how to choose a plan, and a list of plans. The booklet will tell the consumer what happens after you join a plan, how to change plans, how to file a grievance, what to do if there's a problem and how to request a fair hearing. Consumers will be encouraged to call the enrollment broker for multi-lingual assistance. Those who do not enroll within 60 days from the time they receive the letter and information guide will be auto-enrolled in a plan. Most enrollments will occur over the phone and the broker will have a network of information for each of the plans. Once a MLTC plan has been selected, it will conduct an assessment to determine eligibility and transmit enrollment information to the enrollment broker.

Mandatory enrollment will also be phased-in by service type, borough and zip code for those persons already receiving long-term care services. People will be given 60 days to choose a plan according to the following Phase I schedule:

- **July 1, 2012 –** Enrollment of Personal Care recipients in New York County begins
- **August 1, 2012 –** Continue enrollment of Personal Care recipients in New York County

- **September 1, 2012 –** Enrollment of Personal Care recipients in Bronx County begins and enrollment of consumer-directed personal assistance program (CDPAP) cases begins in New York and Bronx counties
- **October 1, 2012** – Enrollment of Personal Care recipients in Kings County begins; Continue enrollment of personal care and CDPAP cases in New York and Bronx counties
- **November 1, 2012** – Continue Personal Care and CDPAP enrollment in New York, Bronx and Kings counties
- **December 1, 2012 –** Enrollment of Personal Care recipients in Queens and Richmond counties and continue personal care and CDPAP enrollment in New York, Bronx and Kings counties
- **January 2013 –** Begin enrollment citywide of Long Term Home Health Care Program (LTHHCP), Certified Home Health Agency (CHHA) clients needing home health services for more than 120 days, and Adult Day Health Care recipients. People receiving personal care from a Medicaid Advantage plan will begin enrollment in a MLTC at this time.
- **February 2013 --** Personal care, CDPAP, LTHHCP, home health clients over 120 days on service, adult day health care program and private duty nursing cases in New York, Bronx, Kings, Queens and Richmond counties are enrolled until all people in service are enrolled.

Once MLTC plan capacity is established, Phase II enrollment is anticipated to continue beyond New York City, starting in January 2013 with Nassau, Suffolk and Westchester Counties. Phase III is anticipated to begin in June 2013 with enrollment in Rockland and Orange Counties. Phase IV is anticipated in December 2013 with enrollment in Albany, Erie, Onondaga and Monroe Counties. Phase V is anticipated to begin in June 2014 with all other counties with capacity.

Excluded Populations: Those individuals who are currently enrolled in the Nursing Home Transition and Diversion or Traumatic Brain Injury waivers, nursing home residents who are dually eligible, and Assisted Living Program participants are excluded from the mandatory enrollment at this time; these populations may be enrolled during the last phase of roll-out of MLTC.

Net Impact: About 70,000 beneficiaries are expected to be transitioned out of the Personal Care Program, CHHAs, and LTHHCPs. In total, a new market of 100,000 beneficiaries and as many as 75 total MLTC plans may be available.

Workforce Flexibility / Scope of Practice Workgroup

Final Recommendations – Home Care Workforce

The Medicaid Redesign Team established additional workgroups to expand on implementation of the initial work. The Workforce Flexibility and Change of Scope of Practice Workgroup was charged with developing a multi-year strategy to redefine and develop the workforce, including redefining the roles of certain types of providers and aligning training and certification requirements with workforce development goals. The workgroup released their final recommendations to the MRT on November 21, 2011, and the following are the most relevant to home care workers.

Summary Listing of Final Recommendations			
Rank (Priority)	**Short or Long Term**	**Original Proposal Number(s)**	**Proposal Description**
1	Short	27,40,66	Permit Advanced Aides, with supervision and training by a registered nurse, to assist self-directing and non-self-directing consumers with routine pre-poured medications.
2	Short	1,64,12,28,67	Creating an advanced home care aide certification and expanding the ability of registered nurses to assign tasks to such aides.
6	Short	2	Stackable certification and credentials for direct care workers
13	Long		Create an Advisory Committee to the Office of the Professions of the State Education Department (SED) to assist with future scope of practice issues and data collection.

1) Permit advanced aides, under the supervision and training by a RN, to assist in self-directing and non-self-directing patients with pre-poured medication in various settings (i.e. MLTC, hospice, private pay). Permit home care providers, including LHCSAs, CHHAs, LTHHCPs, MLTCPs, and home hospices to identify specific non-self-directing consumers who can be safely assisted by an Advanced Aide to assist their clients with "routine" pre-poured medications, including routine pre-filled injections of insulin, as is currently permitted for self-directing individuals under "special circumstances". The Advanced Aide would be permitted to provide this assistance only in cases where the registered nurse has determined the case to be appropriate, the Aide receives specific training from a registered nurse on the individual consumer's medications and circumstances, demonstrates ongoing competency following this training, and then the registered nurse provides ongoing supervision. The training, supervision, and Advanced Aide competency evaluation requirements must follow protocols to be approved by the Department of Health. New Jersey and Washington State have implemented similar pilot programs with successful higher quality outcomes.

2) Create advanced home care aide certification. This proposal would direct the Department of Health to create an advanced home care aide certification and outline the minimum training and qualifications required. The training would focus on accurate reporting, communication skills and problem solving. The proposal would then permit Registered Nurses, based on their assessment of the advanced home care aide, the self-directing resident and the home care environment, to assign an expanded range of tasks to Advanced Aides, under the same requirements and restrictions currently outlined for tasks which can be assigned to home health aides in "special circumstances." This proposal is **not** intended to alter nursing scopes of practice (RN or LPN), but rather, to facilitate the development of a home healthcare team which includes paraprofessionals. The tasks would be outlined in regulation by the DOH, and could move forward without a change in statute.

3) Stackable certification and credentials for direct care workers. Articulate training for certification for aides working in various patient care settings--from Personal Care Aide (PCA) to Home Health Aide

(HHA) to Certified Nursing Assistant (CNA)--in order to avoid repeating training already received and demonstrated. Direct care workers (PCAs, HHAs, CNAs), are often forced to take the entire training for an additional certificate or credential despite the fact that they could simply add on the additional skills and hours needed to achieve an additional level. For example, there are 35 additional hours to move from PCA to HHA. These workers should be able to add the necessary hours through a standardized process to facilitate ease of transition to other jobs and work environments to allow for stackable credentialing.