PHI Medicaid Redesign

Shaping the Future of New York's Home Care Workforce

Wage Parity for Home Care Aides

February 2014

New York's Medicaid Redesign is intended to reshape the state's entire health delivery system, including home- and community-based services for elders and people with disabilities. The state's new model will move dramatically away from fee-for-service reimbursement, toward a more efficient and effective "capitated" payment system—one in which a managed care insurance plan receives a monthly pre-payment to pay for all of an individual's covered health and social services.

This fundamental restructuring is intended to place nearly all Medicaid-eligible recipients into managed care plans to coordinate their care needs, and thus better manage their disabilities and chronic diseases—while at the same time, achieving cost efficiencies.

PHI Medicaid Redesign WATCH is a three-year project to record, analyze, report—and intervene to mitigate dislocation of consumers and workers—as New York fundamentally transforms its Medicaid-funded long-term services and supports. Funding for this initiative is provided by the Ira W. DeCamp Foundation, the Ford Foundation, the Altman Foundation, and the Bernard F. and Alva B. Gimbel Foundation. Additional partners in this project include Wider Opportunities for Women (WOW) and the National Employment Law Project (NELP).

One crucial element of New York's Medicaid Redesign is the Legislature's decision to provide "wage parity" for home health aides in New York City (where two thirds of the state's home care workers are employed) and the surrounding metropolitan counties. This issue brief describes the wage disparity that led to the need to create a new "minimum wage floor" for all home care workers in the greater New York City area. It goes on to explain why wage parity is essential to successful Medicaid reform, describe some of its early implications and unintended consequences, and make recommendations regarding further implementation.

Background—Home Attendants and Home Health Aides

New York City's home care workforce is divided into two primary occupations: home attendants (known as "personal care aides" in Medicaid regulations) and home health aides.

Home attendants, who have traditionally served New York's Medicaid clients in need of long-term personal care services, are required by state law to have 40 hours of entry-level training and 6 hours of in-service training annually. Most of these home attendants are employed within the Medicaid-funded Personal Care Services Program.

Home health aides, who serve both short-term Medicare clients and Medicaid clients in need of skilled care, are required by both state and federal law to have 75 hours of entry-level training and 12 hours of in-service training annually. Home health aides can perform some medical assistance tasks such as checking blood pressure or changing dry dressings. Most of these aides are employed within home care agencies called Licensed Home Care Service Agencies (LHCSAs), which receive their funding indirectly from New York State.

In New York City, taken together, the two occupations employed a little over 150,000 workers in 2012—making this one of the city's largest occupational groups employing low-income workers. Notably, *one out of every seven* low-wage workers in New York City is employed as a home care aide.

Though they perform similar personal care and support tasks for their clients, the workers in these two occupations have historically received substantially different rates of pay, with home attendants—the workers with fewer mandated hours of training—receiving a minimum of $10 per hour, while the more clinically trained home health aides received an average starting wage of only $8 per hour. This disparity in pay is referred to as a "wage inversion," because the more highly trained home health aides are earning less per hour than the less skilled home attendants.

This wage inversion, which the wage parity law is now addressing, resulted from two factors: 1) home attendants have been unionized longer, and more completely, than their counterparts in the home health care sector, and 2) home attendants, as employees of agencies that contract directly with the city, are subject to New York City's Living Wage Law,[1] which currently mandates a minimum $10 per hour wage floor. These disparities created an imbalanced labor market and contributed to instability in the workforce, particularly among home health aides who have unusually high rates of annual turnover (see Table 1).[2]

Why Wage Parity Is Essential For Successful Reform

Under the Medicaid Redesign plan, the first group of service recipients targeted to transition to managed care were those being served by the city's fee-for-service Personal Care Services Program—specifically those who had no long-term care needs other than personal care and whose medical care was covered by a Medicaid managed care plan. The second group to move from the Personal Care Services Program to managed care includes those Medicaid clients[4] who live with disabilities, chronic illnesses or conditions severe enough to require at least 120 days of home and community-based care. Both of these beneficiary groups depend on their home attendants for many intimate activities of daily living, *e.g.*, toileting, bathing, and dressing.

As the state began to contemplate converting Personal Care clients into managed care plans, it did not want to disrupt the continuity of relationships those clients had with their home attendants. In particular, policymakers feared that without wage parity, the more highly paid home attendants might be quickly displaced by less costly home health aides—resulting in disruption in care as well as a loss of work for thousands of home attendants.

Attracting workers to become home health aides would be difficult if those home health aide positions were to continue to earn lower wages than home attendants.

Furthermore, in the next stage of Medicaid Redesign, New York State's health policy goal is to integrate acute, primary, and long-term care for those who are "dually eligible," meaning those clients who receive both Medicare and Medicaid benefits. For the dually eligible, Medicare-funded aide services must by law be provided by a home health aide, regardless of the level of service needed. Also, since home health aides are allowed to perform certain medical-related

Table 1: New York City Home Care Occupations (Prior to Wage Parity Law)

Occupation	Compensation, pre-Medicaid Redesign	Training Requirements	Number of Workers	Annual Turnover Rates
Home Attendant	$10.00/hour plus benefits[3]	40 hours personal care 6 hours of in-service annually	NYC: 76,890 Rest of state (ROS): 39,030	11-15%
Home Health Aide	$8.00	75 hours (federal mandate); 12 hours in-service annually	NYC: 77,640 ROS: 56,340	25-50%

Source: Number of workers is based on Occupational Employment Statistics (OES) survey, available at New York State Department of Labor: **http://www.labor.state.ny.us/stats/lswage2.asp**

tasks—while home attendants are not—home health aides offer the managed care plans greater flexibility in meeting client needs. For both of these reasons, the home health aide worker will be increasingly preferred over the personal care aide by managed care plans.

Yet, attracting workers to become home health aides would be difficult if those home health aide positions were to continue to earn lower wages than home attendants. Therefore, policymakers understood that raising home health aide wages would make the occupation more attractive, contribute to better retention, improve the quality of care, and remove the disparity of pay for two relatively similar occupations. Moreover, increased wages would create greater income self-sufficiency for nearly 80,000 New York City workers: a $2/hour raise in wages equates to more than $240,000,000, annually, in additional income for these workers and their families.

With New York State intending to move tens of thousands of recipients with a high need for aide services into managed long-term care plans, it made no sense to drive home attendants out of the workforce, and in turn, disrupt the relationship between the consumer and aide. Policymakers thus committed to wage parity as essential to Medicaid Redesign, understanding that most of the home attendants would, over time, need to be "trained up" to become home health aides.

The Home Care Worker Wage Parity Law

Governor Andrew Cuomo proposed the Home Care Aide Worker Parity law (or "Wage Parity Law") in the thirty-day amendments to the state budget for 2011–2012. Jason Helgerson, Medicaid Director for the State of New York, testified in support of the proposal, stating that a stable workforce, paid sufficient wages to combat turnover, was key to implementing managed long-term care. The proposal, which originally would have applied to the entire state, was limited in the final legislative language to the downstate metropolitan counties of New York City, Nassau, Suffolk and Westchester.[5]

The Wage Parity Law requires three incremental wage increases, which began with a minimum wage of $9.00 per hour on March 1, 2012 and culminates with an increase to $10 per hour on March 1, 2014 (see Table 2). It applies to any home health aide service that is paid for, in any part, by Medicaid.[6] In addition to paying the specific wage identified in the law, employers must either offer benefits, or pay an additional supplemental wage specified by the law.[7]

Table 2: Achieving Parity for Home Health Aides in NYC

Effective Date	Wage Requirement	Benefits
March 1, 2012	90% of the Living Wage: $9.00/hr.	Either: health benefits as specified by collective bargaining agreement (CBA) current as of 1/1/2011, or if benefits equal to $1.35 are not provided, an additional $1.35/hour paid directly to the worker (calculated as 90 percent of $1.50/hour, which is the amount required in lieu of coverage provided by the Living Wage Law).
March 1, 2013	95% of the Living Wage: $9.50/hr.	Either: benefits equal to $1.43/hour, or an additional $1.43/hour in wages and/or wages and benefits.
March 1, 2014	100% of the Living Wage: $10.00/hr.	Employers must meet the prevailing rate of compensation, which is defined as the compensation in the Home Attendant contract as of 1/1/2011, which includes $10 wage, additional wages up to $1.69/hour, and supplemental compensation in wages and/or benefits up to $2.40/hour. Overtime is not included in these rates and must be paid as required by state and federal law.
March 1, 2015	The greater of the Living Wage or the wage required by the collective bargaining agreement in place on March 1, 2015	As stated for 2014, although the Health Exchange could affect the structure and cost of the health benefit as well as the process for accessing benefits.

For unionized employers, the terms of the supplemental benefit are spelled out in their collective bargaining agreement (CBA).[8] However, the rising cost of health insurance premiums has forced the reopening of many CBAs, sometimes resulting in reductions in other benefits in order to retain health insurance coverage and meet the terms of the law.

To ensure compliance, the law now requires that managed care plans and all other contractors for aide services provide the Commissioner of Health written certification that home care providers (LHCSAs) are complying with the law. To do this, the contractors must obtain quarterly data from the providers attesting to their compliance. The contractor then submits its certification to the Commissioner.

If a program is found to be out of compliance with the Wage Parity Law, the penalty is a withholding of Medicaid payment. However, an insurance plan or provider that is operating in good faith that its sub-contracted agencies were in compliance would not be penalized. Instead, the non-compliant sub-contracted LHCSA employing the aides would bear the burden of the penalty. In all likelihood, losing access to Medicaid payments would put the noncompliant agency out of business.

Consequences—Intended and Unintended

Medicaid Redesign has generated a wide range of consequences, most of which were fully intended. Yet unintended consequences are also now unfolding, since even small design changes can generate large implementation challenges within such an exceptionally complex system.

- **Closures of home care employers.** One of the primary *intended* goals of Medicaid Redesign was to slow the rise in home care costs through program efficiencies. In fact, when Governor Cuomo first took office in 2012, the Citizen's Budget Commission warned that Medicaid-funded home care was one of the largest causes of the state's widening budget crisis.

  Creating "efficiencies" in such a large program is often a euphemism for consolidation. Yet consolidation, by definition, cannot be achieved without encouraging the creation of relatively large provider agencies—which in turn cannot be achieved without closing or merging smaller agencies.

Therefore, while never explicitly stated, an expected consequence of Medicaid Redesign was the closure of smaller home care agencies—and that has indeed begun to occur: Smaller *home attendant agencies* are finding it harder to survive, as their costs are not always reimbursed fully by the managed care plans. Notably, these agencies' single "customer," the city's Human Resources Administration (HRA), has been replaced by a myriad of managed long-term care plans—making contracting a far more complex and expensive process. In addition, the home attendant programs are now responsible for finding, and paying for, workers compensation and general liability coverage, costs that earlier had been borne by HRA.

Smaller *LHCSAs* are also finding it harder to exist, because their home health aide wage costs are rising (due to the wage parity law) without a comparable increase in reimbursements. As just one example: a LHCSA in Spanish Harlem employing 350 home health aides closed this fall, unable to pay a $500,000 annual increase in wages—and knowing that it faced a similarly sized wage increase between now and March 2014.

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The result is the beginning of a significant consolidation in the home care employer base across all five boroughs of New York City—with the unintended consequence that some home attendants may lose their jobs entirely as employers close and cases shift from one program to another. In addition, the same cost containment pressures may, over time, result in clients within the managed long-term care plans receiving, on average, fewer hours of care—and thus even those home health aides fortunate enough to have jobs may experience fewer hours of employment and, thus, smaller pay checks.

By 2016, it is possible that only a fraction of the home attendant programs will survive, and many smaller LHCSAs will have either closed or merged. What will remain standing will be several relatively

large LHCSAs. At that time, the labor market for home care aides will stabilize—with home health aides far outnumbering personal care aides—but in the meantime, a great deal of uncertainty will prevail for employers, clients and aides.

- **Loss of wages; loss of jobs.** While the consolidation described above was intended, other consequences of Medicaid Redesign were not. For example, the new Medicaid Redesign law includes a provision that requires the Managed Long-Term Care (MLTC) plans to continue to contract with the home care agencies that were providing services at the time of the transition to MLTC.[9] This requirement is known as the "continuity of care" provision, with the stated intention of maintaining as much stability for clients and workers as possible.[10]

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However, while the MLTC plans appear to be complying with this continuity requirement for clients who have consistent care needs, not all clients remain stable over time. For example, if a client is hospitalized and returns home with a need for Medicare home health services, or has a change in condition that requires skilled care, the home attendant must, by state law, be replaced by a home health aide.

In these cases, the home attendant loses wages—and could lose health insurance as well if she is unable to maintain enough hours to retain eligibility for health insurance (see below).[11] And although technically the home attendant could be returned to the case once the Medicare home health episode has ended, some clients are reluctant to make yet another change in caregivers, and therefore the client may request that the new home health aide stay on, permanently replacing the original home attendant.

Also, job loss can occur when the home attendant's employer fails to contract with a particular plan, or when the client chooses a plan whose provider network does not include the aide's employer. These instances will happen with increasing frequency, for as noted above, changes in the home care system are already forcing some home attendant programs to close or merge.

- **Loss of health insurance coverage.** As home health aides and home attendants follow their clients, many will be forced to change employers. When this happens, the aide may experience a diminution or even loss of health coverage. This can occur if the new employer has different rules of coverage in terms of seniority or minimum hours of employment to determine eligibility.
- **Inability to access training for a HHA certificate.** As the number of home attendant cases shrinks over time, with a concomitant rise in home health care cases, home attendants will face fewer and fewer employment opportunities if they hold only a home attendant certification. Therefore, many home attendants who wish to stay in the field will look to acquire the necessary training for home health aide certification.[12]

Many home attendants, however, work for employers that do not operate their own employer-based Home Health Aide Training programs.[13] Therefore, the home attendants' options are limited as to where and how they can access the additional training needed to qualify as home health aides. While the aide could go to a proprietary training program—and some unionized workers have accessed these private schools with initial funding from 1199SEIU—going forward, a likely scenario is that the aide will have to pay out of pocket for the training.

Unfortunately, although plans for additional training that would support the upgrade of home attendants to home health aides are included in a New York State Medicaid waiver request to the federal government, that request has yet to be granted.

As an interim measure, the 1199 Training and Employment Fund is working with the City of New York's Small Business Services program to pilot-test upgrade training within the CUNY system. However, this will begin as a relatively small initiative—approximately 2000 home attendants—compared to the tens of thousands may wish to have higher certification.

Recommendations

Based upon PHI's 25 years of experience within New York City's home care delivery system, we believe that achieving wage parity with the least amount of disruption for consumers and workers can be facilitated by the following steps:

1. **Managed care payment rates to providers must be sufficient to cover the costs of parity, and must be paid *prospectively*.** The state must pay managed care plans—particularly managed long-term care plans—reimbursement rates that are timely and sufficient to cover the wages and benefits for the wage parity requirements that the state itself mandated.

   This recommendation will require the state to pay a rate for aide service that allows the employer (the LHCSA) to meet the wage parity requirements *and* cover the other indirect and direct costs of the aides' employment. Each provider's overhead costs vary, depending upon the size of the organization, the volume of cases, and the sophistication of the organization's operations. For example, an employer that operates a Home Health Aide Training Program has higher costs than those that do not, and an employer with a highly developed information system has made a capital investment that others have not.

   Of equal importance, current rate-setting practices are inadequate for making a smooth transition to wage parity. Rate setting for the plans is currently "retrospective," meaning the rates are set for services long past the point when the plan begins paying for those services. For example, the proposed rate currently includes an additional payment for Workforce Recruitment, Training and Retention[14] (see Recommendation #2). This additional payment is usually paid out retrospectively, in the latter part of the fiscal year—well after those services have been delivered and the plans have paid for aide services. This structural delay in payments creates fiscal uncertainty for the plans and encourages many to contract for aide services at the lowest rate possible, or to seek to use lower-cost home health aides.

2. **The state and city require a coordinated effort to upgrade home attendants.** The need for upgrading at least 30,000 home attendants in NYC was easily identifiable long before wage parity began to take effect, and in response, 1199SEIU, the union representing the majority of these workers, allocated funding to upgrade those most in danger of losing their jobs. However, those initial funds were limited, and only a fraction of home attendants have been able to secure upgrading training.

   When wage parity was just beginning to take effect in 2012, the union requested additional funding from the state to upgrade these workers. However, those multiple requests for funding still remain unanswered, leaving these aides at risk of substantial dislocation. Their current employers, the home attendant agencies, have neither training funds nor official approval from the state to start up new employer-based Home Health Aide Training Programs. Understandably, providers with already-approved training programs are unwilling to train workers whom they do not employ, and thus that training infrastructure is not readily available to other home attendants—unless the state decides to encourage those programs with targeted funding.

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   Still, the employer-based training programs—which now number over 300 approved Home Health Aide Training sites in the five boroughs—comprise the largest training system for home health aides in New York City.[15] These employers have historically funded their training through state reimbursement rates that were cost-based and included training expenses—yet those training reimbursements have now ended upon transition to managed care. While the managed care plans have been directed to ensure that both parity and Living Wage requirements are met, there is now no explicit inclusion of training or upgrading in the plans' employer reimbursement rates.

In prior times of workforce shortages, New York State created grant funding for workforce retraining. For more than a decade, the state has funded a Workforce Recruitment, Training and Retention initiative[16] that has allocated hundreds of millions of dollars in funding, proportional to each payer's Medicaid expenditures. Unfortunately, those special funds are slated to end in 2013. Even if they are reinstated by the incoming Legislature, the state now has an overall cap on Medicaid expenditures—and thus these funds may be limited, since any pay-out must not exceed the cap.

In the event home attendants lose their jobs, the cost of inaction could be substantial. Public dollars—to cover health insurance (Medicaid) and unemployment insurance—would be needed to support these workers as they attempt to transition to other employment. These are entitlements that the state cannot choose to ignore.

3. **New York State must incorporate training expenses into the managed care rate.** The state's Department of Health has had a variety of mechanisms to pay for home care aide training—entry-level, in-service, and upgrading. The methods include grants, add-ons to the rates, and lump sum payments at the end of the year. Yet there has been very little oversight for the majority of this funding as to how the funds were spent and whether the funds resulted in good training and better retention.

   The managed long-term care plans use significant amounts of aide service. These aides not only have annual training requirements in order to retain certification, but will need additional skills if they are to play a role in care management. The managed care plans must have an operational and financial stake in the preparation of this workforce—otherwise, high turnover and minimal training will continue to weaken the entire home care delivery system.

4. **The state and city require a robust and up-to-date workforce information system.** For many years, the home care aide workforce was treated as a contingent workforce, "accepting" high rates of turnover and "backfilling" by continually training new home health aide replacements. While a New York State Home Care Registry—in which all aides must be entered in order to work on a case paid for with public dollars—does exist, the registry provides only an imprecise picture of this critical workforce.

With thoughtful strengthening of the existing home care registry, New York could better position itself to plan for a more stable home care delivery system.

For example, currently the state cannot answer critical labor market questions, such as: How large is the workforce? Where do regional gaps exist? How will the redesign of the health delivery system affect this workforce's size? Will there be sufficient capacity to care for the clients across the state? How many home attendants are in need of a home health care certificate? Judging current capacity and future need is important to making policy decisions in areas such as training, financing and quality.

With thoughtful strengthening of the existing home care registry, New York could answer these critical questions, and thus better position itself to plan for a more stable home care delivery system.

Conclusion

PHI is confident that, over time, Medicaid Redesign can result in a system that will prove more cost effective for the state, provide greater care coordination for consumers, and build a more stable and fair labor market for home care aides. However, we also acknowledge that the speed with which these changes are occurring, within an exceptionally large and complex system, is causing unprecedented disruption for key stakeholders.

Therefore, the intent of the ***PHI Medicaid Redesign Watch*** series is to assist the state, and all key stakeholders, in minimizing these inevitable disruptions—by monitoring the system redesign, providing accurate analyses, and making real-time recommendations for mid-course corrections in the implementation of these new state policies. We welcome reactions and additional suggestions at: www.PHInational.org/newyork. Or contact Carol Rodat, PHI director of New York policy, at crodat@PHInational.org

Endnotes

1 The counties of Suffolk and Westchester enacted similar legislation in the same time period, and several counties in upstate New York either enacted or considered living wage ordinances.

2 A description of the variation in wages and the causes can be found in "Improving Wages for New York's Home Care Aides," at: http://phinational.org/sites/phinational.org/files/clearinghouse/New%20York%20UHF%20Contracting%20Paper%209%2030%2010.pdf

3 These wages and benefits are required for Home Attendants employed in the NYC Personal Care Program.

4 This targeted group also includes clients currently being served by other programs, such as those in a Certified Home Health Agency, Adult Day Health Program, or in receipt of Private Duty Nursing.

5 NY Public Health Law, Chapter 45 of the Consolidated Laws, Article 36, Section 3614-c. The home care industry opposed the proposal, which was championed by 1199SEIU, ultimately leading to the law being scaled back to those counties with a substantial unionized aide workforce.

6 The law does not apply to home health aides whose service is wholly paid for by Medicare or to personal assistants employed directly by consumers using the state's Consumer Directed Personal Assistant Services program.

7 The Wage Parity Law originally included a requirement that employers offer health insurance and that employers who had a Collective Bargaining Agreement in place, would be presumed to have met the requirement. That provision was declared invalid by the U.S. District Court for the Northern District on September 25, 2013. All remaining provisions of the Wage Parity Law were left in place.

8 The most common change was the loss of days off, either by combining vacation and sick days into paid time off and then reducing the number of days, or by revising the number of days available in those categories.

9 Plans must contract with a sufficient number of providers at the posted HRA rate.

10 The "continuity of care" requirement as applied to MLTC will end on 3/31/2013.

11 The majority of the home attendants receive their health insurance through the 1199SEIU National Benefit Fund, which requires aides to work a minimum of 80 hours a month for two consecutive months in order to retain their health insurance.

12 To become certified as a home health aide, the home attendant worker must receive an additional 35 hours of training, including eight hours of Supervised Practical Training at an approved site (e.g., Adult Day Health Program), allowing an RN to review the aide's skills with patients. Also, the aide must pass written and practical skills competency tests.

13 There are only 10 home care agencies out of the 50 agencies that have City contracts for the Personal Care Services Program that operate approved Home Health Aide Training Programs.

14 There is an add-on of $2.55 for home attendants and a $1.26 add-on for home health aides. The variation is the result of differing policies agreed to in 2000 and 2002.

15 There are 150 approved Home Health Aide Training programs licensed by the New York State Department of Health, 56 of which are operated by employers with sites in New York City. In many instances, the organizations approved to train provides training in multiple sites throughout the city.

16 This initiative is authorized through State Fiscal Year 2013, and will need to be renewed in the 2013-2014 State Budget if it is to continue.

National Headquarters: 400 East Fordham Rd, 11th floor • Bronx, New York 10458 • Phone: 718.402.7766 • E-mail: info@PHInational.org