PHI QUALITY CARE THROUGH QUALITY JOBS

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ISSUE BRIEF

New York's Home Care Quality Incentive Pool: A State Framework

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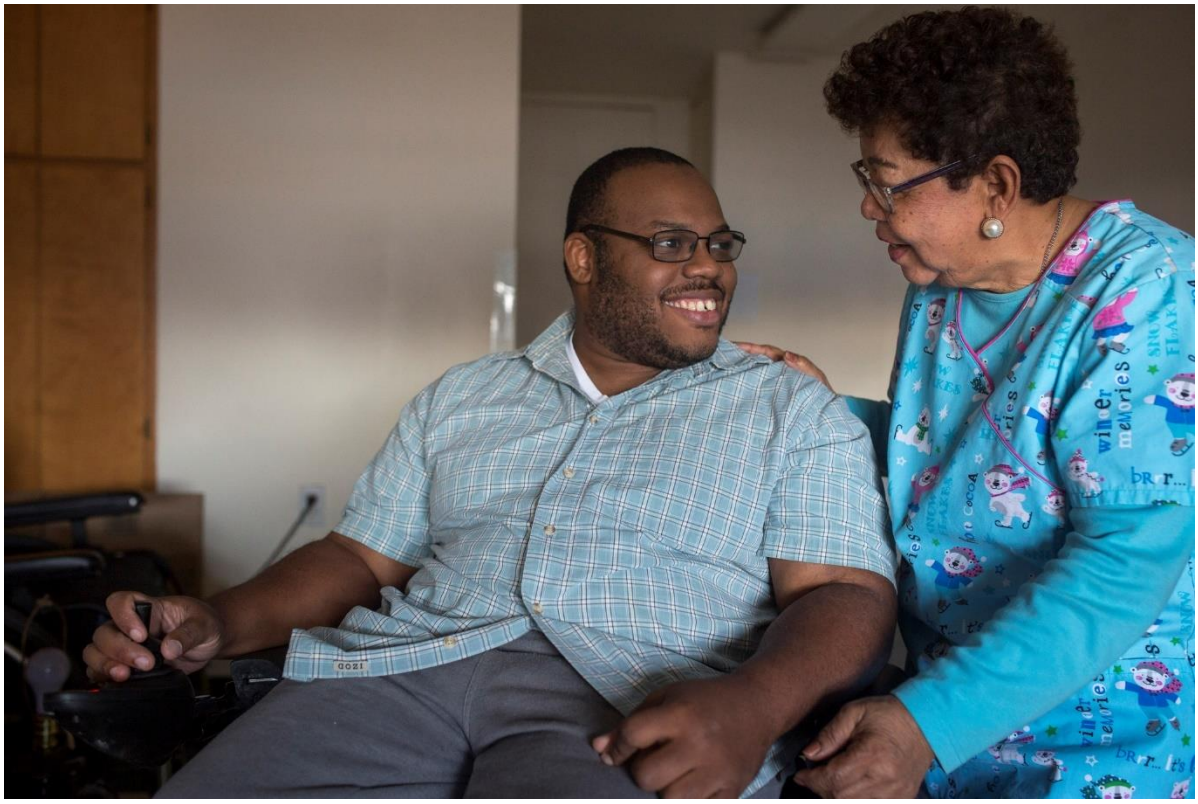
When New York State passed legislation to create a wage-and-benefit floor for home care aides in New York City, home care agencies struggled with the new costs. Agencies that had previously invested in additional training and other job-quality improvements were facing difficult choices. To help these "high-road" agencies cover new labor expenses, the state established the Quality Incentive Vital Access Provider Pool (QIVAPP). Agencies that invested in comprehensive health benefits and additional training for their home care aides — and met other specified criteria — could apply for these funds. Our analysis shows that QIVAPP outcomes were limited by insufficient and delayed payments. Nonetheless, learnings suggest that when properly implemented, a quality incentive pool can provide a model by which New York and other states can invest in quality home care employers and support quality care for home care clients.



In 2011, New York began transitioning Medicaid long-term care consumers from traditional fee-for-service programs to managed long-term care plans. The goal of this "Medicaid Redesign" was to reduce costs and improve the quality of care through care management and coordination. In the new system, the state pays a Medicaid managed long-term care plan a flat, risk-adjusted rate to coordinate services for each of the plan's clients. When the client needs personal care or home health aide services, the managed care plan contracts with a licensed home care services agency (licensed agency), which employs aides to deliver the service. PHI has published a series of papers[1] that tracks the impact of these changes on employers, home care aides, and consumers.

In this paper, we look at the Quality Incentive Vital Access Provider Pool (QIVAPP), which was created to provide additional funds to "high-road" licensed agencies that are investing in their home care aides through measures such as providing additional training and offering comprehensive health coverage. These employers believe strongly that they better serve their clients and their workers by investing in quality jobs. Higher labor costs, however, have put these investments and their businesses at risk in the competitive managed care market. QIVAPP has helped these employers manage these rising costs, and as such, provides an important model that states can use to improve the quality of jobs for home care workers.

DID YOU KNOW?

Home care aides fall under two official occupations — "personal care aides" (PCAs) and "home health aides" (HHAs). PCAs provide assistance with Activities of Daily Living (ADLs), such as bathing and dressing, as well as Instrumental Activities of Daily Living (IADLs), such as laundry and meal preparation. HHAs provide the same ADL and IADL assistance, as well as assistance with some health-related tasks, such as taking vital signs or changing dry dressings.

[1] See more at: http://phinational.org/policy/state-activities/phi-new-york/medicaid-redesign-watch

RISING LABOR EXPENSES

While licensed agencies have varied employment strategies for home care aides, Medicaid Redesign increased labor costs across the board. An historical wage inversion in the New York City metropolitan region,[2] in which home health aides earned an average starting wage of $8.00 per hour while personal care aides earned $10 per hour, was deemed a serious barrier to a smooth transition to managed long-term care.[3] To address this issue, the New York State legislature passed a "wage parity" budget provision, which gradually increased home health aide wages to match those of personal care aides.[4] In March 2014, with full implementation in New York City, licensed agencies were required to pay home care aides a base wage of $10 per hour and additional compensation of $4.09, either through benefits or supplemental wages. Home care aides in Westchester and Long Island reached the $10 wage floor in March 2015, with the additional benefit or supplemental wage amount of $3.22 fully implemented in March 2016.

Just as employers began to feel the full effect of wage parity, they were faced with another increase in labor costs related to the extension of federal wage-and-hour protections to home care aides under Fair Labor Standards Act (FLSA). Beginning in October 2015, licensed agencies were required to increase overtime pay from the standard New York practice of 1.5 times the minimum wage to 1.5 times base pay, and to compensate aides for travel time between clients.[5]
In addition to these two significant changes in home care aide compensation, employers have had to absorb several other cost increases, including: higher health care premium costs, an increase in workers' compensation rates, and an increase in state unemployment taxes.

Reasons for Labor Cost Increases:

- Wage parity
- Fair Labor Standards Act (FLSA)
- Higher health care premiums
- Higher worker compensation rates
- Increase in state unemployment taxes
- Increase in minimum wage

As costs rose, licensed agencies competing for contracts with the new managed care plans were not necessarily receiving hourly rates that fully covered their labor expenses. Many were forced to close or merge with other agencies.[6] Employers that had previously distinguished their businesses by investing in their workers were finding it difficult to sustain these investments in the new environment. In the coming years, costs will continue to rise as the minimum wage (and consequently the wage parity base wage) increases to $15.[7]

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[2] The New York City metropolitan region includes the boroughs of New York City and the counties of Westchester, Nassau and Suffolk.
[3] Home health aides receive a minimum of 75 hours of training, 35 hours more than personal care aides, yet they were earning a lower hourly wage. It was assumed that managed care plans would be unwilling to pay more for personal care services and that they would prefer to hire home health aides, who could provide care for both Medicare and Medicaid clients.
[4] PHI (2014). *Wage Parity for Home Care Aides*. Accessed at: http://phinational.org/sites/phinational.org/files/research-report/medicaid-redesign-watch-1.pdf
[5] Cook (November 20, 2015), "FLSA Implementation Begins in New York." *PHI Policy Blog*. Accessed at: http://phinational.org/blogs/flsa-implementation-begins-new-york
[6] The total number of licensed agencies is difficult to determine as the industry has been expanding and contracting through mergers, acquisitions, and closures. A single owner of multiple licensed agencies may do business under different business names. During this period, new licensed agencies were also entering the marketplace.
[7] The minimum wage reaches $15 in the NYC metropolitan area by 2021 and $12.50 in the rest of the state by 2020, with further increases determined each year until it reaches $15. New York State Department of Labor, "Minimum Wage." Accessed at: https://labor.ny.gov/workerprotection/laborstandards/workprot/minwage.shtm

QIVAPP: A PLAN TO ADDRESS RISING COSTS

In the face of new costs, particularly those related to wage parity, the state decided to assist employers who were willing to make investments in their workers. The state Department of Health (DOH) created a funding pool that would distribute Medicaid funds only to licensed agencies that met certain training and employment practice standards. The money would be given to managed long-term care plans, which would pass it along to the qualifying licensed agencies in their networks.

Before establishing the pool, the state surveyed the plans to estimate the total funding that would be needed based on actual and expected hours of home care aide services. The state proposed a pool of $70 million, which came half from state funds and half from federal funds, per the Medicaid formula for New York. This was intended to cover the $1 difference between the $18.50-per-hour-of-service rate agencies were receiving from plans and the $19.50 needed to cover required labor and operational costs.

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Working with 1199SEIU and other advocates, including PHI, to establish the criteria for accessing the QIVAPP funds, the state determined that to receive funds employers would have to meet the following standards:

- Compliance with wage parity;
- A negotiated minimum hourly rate between the managed care plan and the licensed agency of at least $18.50 an hour;
- Training of home health aides that exceeded the minimum requirements for either entry-level or in-service training;[8]
- A comprehensive health plan available to aides; and
- A written, implemented, and currently active quality assurance program.

While an agency did not need a collective-bargaining agreement to meet the criteria, those that were unionized were more likely to have already met the criteria through their agreement. The state's application process for the funds required attestations from the managed care plans and the licensed agencies that they met the criteria.

When a greater number of licensed agencies applied for funds than had originally been estimated, the state issued new guidance, adding greater specificity to the criteria. The state provided a definition of "comprehensive health coverage" for employers to clarify that the health insurance offered to aides

[8] Rodat (2010), "Preparing New York's Home Care Aides for the 21st Century." *PHI.*

had to be equivalent to union plan coverage.[9] In addition, the guidance clarified that 30 percent of all employees — including part-time and full-time — had to be enrolled in the employer-provided coverage.

In March 2015, the state paid its share of the pool — $35 million — while still waiting approval from the Centers for Medicare and Medicaid Services (CMS) to pay the federal share. Funds went to 136 licensed agencies for qualifying hours of care delivered between April 1, 2014, and March 31, 2015. However, subsequent audits of employer compliance led the number of qualified licensed agencies to decrease to a total of 61 and a reallocation of approximately $8 million. The adjustments and audits took time, which delayed full payment to agencies. CMS approved its participation in the initiative and the final $35 million was paid in August 2016, resulting in total payments (from state and federal funds) of approximately $0.68 on the hour, an amount significantly less than the original target of $1 per hour.

With many of the kinks in the process ironed out, QIVAPP funding for FY 2016 (April 1, 2015, through March 31, 2016) was allocated using the same qualifications as the previous year. Again, allocations did not meet the full $1 per hour cost of wage parity; providers received .58 per hour. Payments were also delayed, with licensed agencies receiving the funds in January 2017.

At this time, it is unclear if QIVAPP funding will be allocated for FY 2017 and FY 2018.

DISCUSSION

Wage parity was a mandate that was never fully funded. The state sought to fill the rate gaps for quality employers through QIVAPP, but delays and insufficient funding hindered this process. Despite the challenges, however, QIVAPP funding has been critical in allowing many agencies to keep their doors open. Over the course of the years, QIVAPP has helped to highlight some trends and lessons.

Delayed and Inadequate Payments Led to Industry Consolidation

The process of defining pool criteria, answering questions from plans and employers, and obtaining final approval from the federal government for its share took time, resulting in licensed agencies receiving the funds long after the costs were incurred. QIVAPP for FY 2016 was released in January 2017, leaving employers to absorb the new costs for nearly a year. These delays ultimately led to

[9] A DOH sample of the minimum required benefit can be found at: https://www.health.ny.gov/health_care/medicaid/redesign/docs/2014-06-13-_benefits_overview_qivapp_application_attach2.pdf

cash flow problems for licensed agencies, resulting in consolidation of agencies through sale, mergers, and closings.

Managed care plans have responded with differing approaches. Some have established "preferred provider networks," contracting with only a small number of trusted licensed agencies. Contracting with fewer agencies provides the plans with greater influence over quality and decreases the transaction costs associated with a larger supply chain. In some cases, this can allow more space in the budget to invest in workers.

Licensed Agencies Still Under Stress

Wage parity began a series of labor requirements, including application of the FLSA to home care aides and a state minimum wage increase, that were not fully funded. The QIVAPP payments provided some relief, but did not resolve the problem of increased cost pressures.

These unfunded labor costs could lead to reductions in aide services, as well as pressure providers to move clients to congregate settings such as adult day programs. Family and informal caregivers — when available — will likely be increasingly called on to provide supports and services. This continued financial stress could also increase the number of licensed agencies that close or merge in the coming years.

> The QIVAPP model would be a more useful tool if mandatory costs were included in base rates and the funds incentivized best practices.

Home Care Aides Not Necessarily Earning Higher Incomes

A lack of data prevents state actors from assessing the impact of wage increases on the overall earnings of home care aides. As a result of wage pressures, particularly the increase in overtime pay through FLSA, employers appear to have become particularly cautious in assigning cases and hours, limiting most aides to between 30 and 35 hours a week. Anecdotal evidence suggests that aides are responding by working for more than one employer, taking private pay jobs working directly for families, or leaving the industry altogether.

Gaps in Funding and Data Undermined the Model's Full Impact

Through setting standards, QIVAPP established a floor for sound employer practices. However, it did not proactively further job quality strategies such as offering quality training, full-time work, on-the-job support, and greater career opportunities. The funding was too limited — and came too late — to encourage employers to make new investments in their workers. Instead, QIVAPP funds filled

gaps in licensed agency budgets. The QIVAPP model would be a more useful tool if mandatory costs were included in base rates and the funds incentivized best practices.

QIVAPP also highlights continued gaps in data collection. Without better data, it remains difficult to determine how individual employer practices impact the quality of home care jobs and the health and well-being outcomes for the individuals receiving care. A better data system could help determine what future eligibility requirements should look like, as well as help high-road licensed agencies transition to a value-based payment system.

Despite its limitations, QIVAPP still provides a promising model for a state to invest in quality employers. The lessons learned so far in New York can be used to adjust the model to proactively encourage implementation of quality job measures and improve the quality of care for home care clients.

Allison Cook is PHI New York Policy Manager. She would like to thank Carol A. Rodat, whose contributions were essential in creating this policy brief.

PHI works to transform eldercare and disability services. We foster dignity, respect, and independence for all who receive care, and all who provide it. As the nation's leading authority on the direct care workforce, PHI promotes quality direct care jobs as the foundation for quality care. Drawing on 25 years of experience working side-by-side with direct care workers and their clients in cities, suburbs, and small towns across America, PHI offers all the tools necessary to create quality jobs and provide quality care. PHI's trainers, researchers, and policy experts work together to:

- Learn what works and what doesn't in meeting the needs of direct care workers and their clients, in a variety of long-term care settings;
- Implement best practices through hands-on coaching, training, and consulting, to help long-term care providers deliver high-quality care;
- Support policymakers and advocates in crafting evidence-based policies to advance quality care

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