PHI Medicaid Redesign

Shaping the Future of New York's Home Care Workforce

The Impending Threat to the NYC Home Care System

May 2013

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).

The New York City (NYC) publicly funded home care industry is entering into the most turbulent period of its 40-year history. Profound changes in public policy and industry practice are now creating foundational shifts not only in the underlying cost of home care delivery, but also in how home care is paid for, and by whom.

The sheer multiplicity of these policy changes and the rapidity of their implementation are creating a swirl of confusion, obscuring how these changes might impact providers, home care workers, and consumers—all within the next 12 months.

Foundational Shifts

New York State (NYS) is shifting completely away from a Medicaid fee-for-service system, toward a managed-care system: It will no longer reimburse the home care system directly, based on the number of hours of service delivered, but rather will prepay insurance plans within a fixed rate, for a bundle of subcontracted services that includes—among a very wide range of other services—home care provision.

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Such a fundamental financial change toward Medicaid managed long-term care within such a large system is causing substantial restructuring and eventual consolidation within the provider delivery system. Already, private and community-based home care provider agencies are beginning to fold, merge, or be purchased.

Convergence of Four Increasing Labor Costs

As the reimbursement system fundamentally shifts beneath them with alarming speed, New York City's Licensed Home Care Service Agencies (LHCSAs, the nonprofit and for-profit agencies that now employ the vast majority of NYC home care aides) are confronting a brace of four financial pressures converging in 2014 that will increase—significantly—their home health aide labor costs:

- **Wage Parity.** In the same 2011 NYS budget that heralded the rapid shift toward Medicaid managed care, New York State passed legislation that mandated a minimum wage and benefits package for all Medicaid-funded NYC home care aides. Due to this "Wage Parity" law[1], approximately half of the city's 150,000 home care workers are enjoying significant per-hour wage increases: From a base in 2011 when home health aide wages averaged $8.00/hour with few or no benefits, home health aide wages have now risen to $9.50/hour, plus $1.43 in mandated benefits.[2]

  The Home Care Aide Wage Parity Law states that in March 2014, home care aide compensation will rise to the "prevailing rate of total compensation" paid to all home care aides covered by the collectively bargained agreement in place as of January 2011 for the greatest number of aides, which in New York City likely will be deemed the 1199SEIU Home Attendant contract covering services that were reimbursed by New York City's Human Resources Administration. The wages in these contracts are $10.00/hour, and benefits include health insurance, pension, paid time off, and several other benefits. According to 1199SEIU, the total value of that compensation package is $14.10—with wages at $10.00/hour and benefits, including health insurance, totaling an additional $4.10/hour. This would be a significant increase over the 2013 Wage Parity Law compensation requirements, totaling at least $2.00/hour or more for employers.[3]

- **Health Insurance and the Affordable Care Act.** Although the Wage Parity law requires a minimum benefits package for home care aides, the federal Affordable Care Act (ACA) places additional responsibilities on home care agencies (and all U.S. employers with more than 50 employees) to either insure their workers, or pay a penalty, starting in 2014. The financial implications for LHCSAs of the new ACA requirements are impossible to predict, since many guidelines have not yet been issued by the U.S. Department of Health and Human Services.[4]

  However, it is quite clear that: 1) the cost for health insurance (and/or the federal penalty for *not* providing health insurance) in 2014 will threaten to increase the overall labor bill substantially for most LHCSAs employing full-time home care aides—and therefore 2) LHCSAs will be tempted to move their employees to part-time status (beneath 30 hours/week), to limit or avoid paying the new federally mandated insurance premiums or penalties.

- **NYS Minimum Wage Increase.** Overtime above 40 hours/week for NYS home care workers must be paid at a minimum of *150 percent of the state's minimum wage* (significantly below the norm for other New York occupations, which is 150 percent of the worker's ***base*** hourly wage). Currently, with the state's minimum wage set at $7.25/hour, most all LHCSAs pay their workers $10.87/hour (150 percent of $7.25) for overtime hours.

  However, the very recently passed 2013–14 New York State budget included a stepped increase in the state minimum wage for most occupations, raising the floor to $8/hour in January 2014; $8.75 in 2015; and $9.00 in 2016. Therefore, when calculating overtime, LHCSAs must start paying their home care workers overtime pay of $12/hour in January 2014; $13.13/hour in 2015; and $13.50 in 2016.[5]

- **Workers Compensation Costs.** Worker compensation costs have been increasing well beyond inflation for every occupational sector involving physical work. This overall trend is compounded for home care aides since the bankruptcy in 2010 of one of the largest self-insurance trusts for home care workers, which increased costs for all employers. Over the last three years worker compensation costs have risen by approximately 50 percent.

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Combined, these four factors converging in 2014 could add an annual increase of approximately 15 percent to the cost of home care aide services. However, Medicaid managed-care rates are based on costs that the plans experienced two years earlier, in this case 2011–2012, trended forward for two years. If these new cost pressures are not fully taken into account,

the 2014–2015 Medicaid managed-care rates will significantly underestimate the cost of home care aide services, which represent approximately 70 percent of the medical expenses for Medicaid Managed Long-Term Care plans.

These emerging financial pressures may soon become so intense that "high-road" employers may well be squeezed out of the industry entirely.

Challenges to a Level Playing Field

The public policy intent of the Wage Parity legislation was to help build a level playing field across all New York City home care employers, by creating a new minimum wage and benefit *floor*—removing wages, and at least a portion of benefits, out of competition between employers. In fact, if this step had not been taken in 2011, the financial pressures now converging on the industry would surely have kept wages suppressed at historic lows.

However, these emerging financial pressures may soon become so intense that "high-road" employers (those that employ a full-time, well-trained, low-turnover workforce of home care aides) may well be squeezed out of the industry entirely—or at least be forced to start behaving like low-road employers.

For *home care aides*, the result of a primarily low-road industry will be a return to jobs offering mostly part-time work (and thus a far smaller paycheck, despite recent per-hour wage hikes), poor-quality training, and poor-quality supervision. This will mean a return to very high turnover—just at a time when turnover was beginning to decrease. The result for *home care consumers* will be that their vital and intimate care will be delivered primarily by poorly trained, low-paid workers who, because of high turnover, will be constantly revolving through their homes.

LHCSAs have direct control over three critical cost areas. These are the areas where LHCSAs will look to save, and thus could easily disrupt the state's attempt to create a level playing field:

1. **Training.** Currently, many of the larger home care agencies sponsor their own "in-house" employer-based programs, providing entry-level certification training for some or all of their new home care aide employees. This model of entry-level training provides the greatest control by the employer over the quality of aide recruitment, selection and training—and has been consistently documented to result in improved aide retention.

   The costs of these programs are currently paid by the employers, through a portion of their home care fee-for-service rate.[6] However, many smaller LHCSAs do not operate training programs and place the responsibility, and the cost, of obtaining entry-level training solely on the prospective employee.

   Therefore, high-road employers who train their aides and thus have higher costs will be viewed by their new managed-care contractors as too expensive compared to agencies that do not conduct training—making training one of the first "discretionary" investments in quality home care jobs that agencies will jettison in order to compete.

The combined result of these cost-based decisions… will result in poor-quality training of aides who will increasingly be employed part-time with limited supervision and support.

2. **Supervision and other employer supports.** PHI has documented the positive impact on job satisfaction and retention among home care aides, of high-quality frontline supervision; supportive management practices such as peer mentoring programs; and facilitation of access to public benefits such as the Earned Income Tax Credit (EITC), housing supports, food stamps and transportation benefits.

   These investments in supervision and employee support programs require additional management expenses—and are worthwhile from a business model perspective *only* if purchasers (in this case the managed-care plans) value the quality of service provided. However, if the managed-care plans are forced to make contracting decisions

solely on the basis of lowest-cost provision, these "best practices" will be deemed unaffordable by even high-road LHCSAs.

3. **Managing for part-time aides.** Most destabilizing of all is the unintended consequence of the ACA, which in 2014 may inadvertently encourage employment of a predominantly part-time (under 30-hour) workforce.[7]

We do not believe a low-road industry is the home care system envisioned or desired by the Cuomo Administration, the New York Legislature, nor New York City public officials.

Therefore, LHCSAs may well determine that their safest financial course will be to structure the majority of their aide employees under 30 hours/week. The federal ACA regulations include a three- to twelve-month "look back" period in the determination of part-time employment status. If the LHCSAs want to take advantage of the "shelter" of a primarily part-time workforce in 2014, they must begin re-structuring their workforce hours in 2013.

If implemented, the combined result of these cost-based decisions on the part of LHCSAs and their managed-care contractors will result in poor-quality training of aides who will increasingly be employed part-time, with limited supervision and support. We do not believe a low-road industry is the home care system envisioned or desired by the Cuomo Administration, the New York Legislature, nor New York City public officials. However, without immediate response, a low-road system is precisely what we will witness emerging within the next year.

Recommendations

PHI recommends the following three measures to address these issues:

1. **Managed Care Rate Assumptions:** That the Department of Health (DOH) *assess the impact of the four labor escalators* described in this issue brief to determine whether the Department's current home care aide cost assumptions for 2014 will provide sufficient payment rates to managed-care plans, in order to cover fully the additive impact of the four labor escalators on LHCSAs.

2. **Dedicated Training System Funding:** That DOH create a *dedicated funding **stream** for home care aide training*—to ensure that essential entry-level and specialized training investments are not squeezed out of the cost structure of even high-road LHCSA employers. There is now a considerable body of knowledge and experience for "best practice" standards for funding of high-quality training programs.[8]

   Funding for training expenses could be derived in part from the Medicaid source that funded the recently closed NYC Home Care Services training program, and from dedicated Medicaid pools for worker recruitment, training and retention. This DOH-based funding could be augmented by Department of Labor federal, state and city monies—in particular, Small Business Services program funds.

3. **Dedicated Health Insurance Financing:** That DOH immediately convene a group of high-level stakeholders—perhaps within the framework of the New York State Health Benefit Exchange Regional Advisory Committee structure—to consider crafting a *health care financing mechanism wholly outside the managed-care reimbursement rate* for home care aides.

   This home care aide workforce—250,000 workers statewide, most all of whom are low-income women, the majority of whom are paid with state-originated Medicaid dollars—constitutes a large and distinct cohort, deserving of a dedicated insurance solution. This solution must also take into account the role that the health care union benefit funds have played in meeting the health care needs of this workforce. Creating a dedicated solution, built *outside* of the managed-care reimbursement rate, would remove health coverage from labor competition between LHCSAs, and just as importantly, would remove the temptation of LHCSAs to rush toward a primarily part-time aide workforce.

PHI stands ready to assist DOH, and all key stakeholders within the New York City home care industry, to design incentives for a truly high-road system—resulting in a 150,000-strong workforce of well-trained, well-supported, full-time home care aides, caring for NYC's frail elders and people with disabilities.

Endnotes

1 NY Public Health Law, Chapter 45 of the Consolidated Laws, Article 36, Section 3614-c.

2 Benefits are required by the Wage Parity Law, unless the aides are offered health insurance. An agreement with organized labor, known as a Collective Bargaining Agreement (CBA), that includes health insurance is deemed to meet the law's required benefits.

3 By November 1, 2013, the New York State Department of Health, in consultation with the New York State Department of Labor, is expected to provide final guidance on what the Wage Parity Law will require of employers for the March 2014 home care aide total compensation package.

4 In addition, many LHCSAs currently participate in one of two TAFT Hartley health insurance plans, jointly governed by 1199SEIU and home care employers. Those two funds could soon be consolidated into a single plan, with the union initially projecting costs to rise for many participating agencies by as much as $1.50/hour—to $2.87/hour—by 2014.

5 In addition, one other minimum wage-related change may occur in 2014: The U.S. Department of Labor has announced its intention to narrow the "Companionship Exemption" for minimum wage and overtime protection for all home care aides nationwide. Should that exemption be narrowed, most all Medicaid-funded home care aides in New York City would be entitled to overtime pay at 150 percent of their base wage (compared to the current 150 percent of minimum wage). This federal change would supersede the impact of the state's newly announced increase in the minimum wage described above, with overtime pay in 2014 required by the new federal regulation pegged at $15.00/hour (150% of the new $10.00/hour home care base wage as of March 2014).

6 In addition, the New York City Home Care Services Program fielded a distinct entry-level training system, separately funded with city and state Medicaid dollars. That training program, and the dedicated funding stream of training dollars that supported it, ended in 2012.

7 These part-time employees will soon have access to subsidized health insurance through the forthcoming Exchange, and thus they will likely enjoy health coverage no matter whether full- or part-time. However, a part-time paycheck—even with the new $10/hour wage floor—still results in a poverty-level income.

8 In New York City, the Homecare Aide Workforce Initiative of the UJA–Federation, funded by the Harold and Jeannette Weinberg Foundation and several major local foundations, will be an excellent source for guidance.

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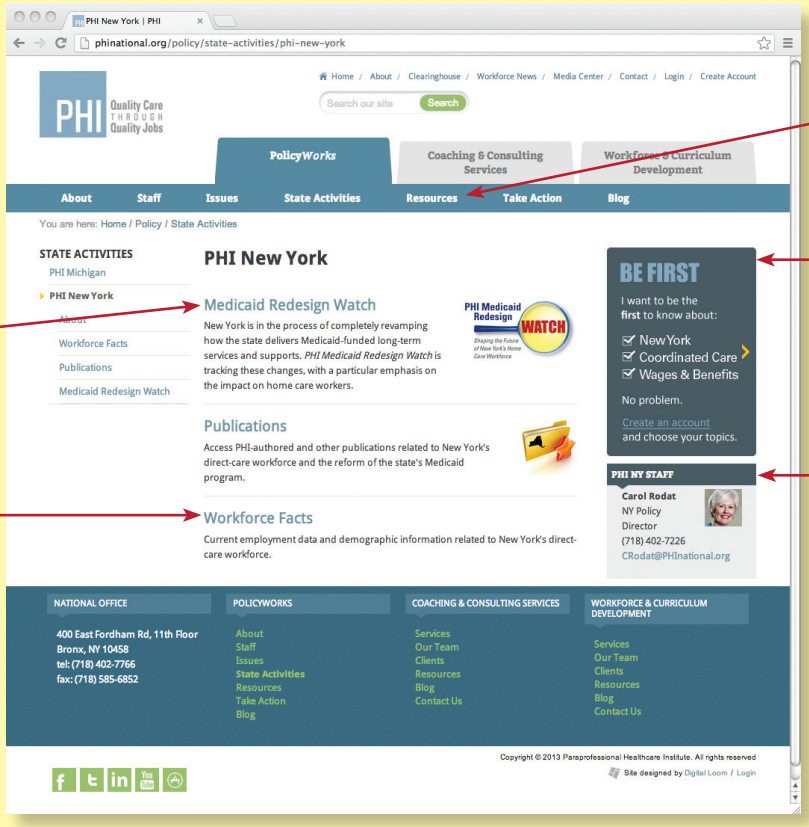

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