
Improving Wages for New York's Home Care Aides

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Options for Payment and Contract Reform

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About this Report

This report is one of three papers that provide an in-depth study of the home care workforce in New York State. The initiative is supported by a grant from the United Hospital Fund, a health services research and philanthropic organization whose mission is to shape positive change in health care for the people of New York. The United Hospital Fund has a long history of support for analysis in the field of long-term care, with several studies of home care in New York City.

This paper is the third in this series. The first paper, *New York's Home Care Aide Workforce—A Framing Paper* (see www.PHInational.org/policy), provides a context for understanding the major issues that shape these jobs: wages, benefits, training, and opportunities for advancement. The second paper in the series, *Preparing New York Home Care Aides for the 21st Century*, addresses the training of home care aides. This paper outlines factors that have suppressed wages for home health aides and a series of actions designed to improve both wages and the quality of the care by changing employer and payer practices. All three reports are available at: www.PHInational.org/policy

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About PHI

PHI (www.PHInational.org) works to improve the lives of people who need home and residential care—and the lives of the workers who provide that care. Using our workplace and policy expertise, we help consumers, workers, employers and policymakers improve long-term care by creating quality direct-care jobs. Our goal is to ensure caring, stable relationships between consumers and workers, so that both may live with dignity, respect and independence. Visit PHI PolicyWorks (www.PHInational.org/policy) for a comprehensive look at the nation's direct-care workforce.

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Introduction

New York State has one of the largest systems of home and community-based care in the country. To provide these services, the state's long-term care agencies and programs employ 213,000 home care aides, with over 60 percent of these aides providing services in New York City. In fact, home

This fast-growing workforce is expected to add more than 100,000 jobs between 2006 and 2016.

care aides—divided among two primary occupations, home health aides and personal care aides—comprise the *largest single occupational* grouping in New York City, with over 130,000 workers. Moreover, across the state, this fast-growing workforce is expected to add more than 100,000 jobs between 2006 and 2016.¹

The size and growth of this workforce is fueled by several forces: the aging of the population, the desire of seniors and people with disabilities to remain in their homes and communities, and public policy and court decisions that emphasize home and community-based care over institutions. Home care aides, with family caregivers, are the primary caregivers, with paid aide services accounting for at least 70 percent of the hands-on care in New York.²

Despite the importance of the home care aide workforce, their compensation—wages and benefits—does not reflect their value to the consumers and families who depend on them. These workers are among the state's lowest paid, with many relying on public benefits such as Medicaid, Family Health Plus, public housing subsidies, and food stamps. Since this work is paid for with public dollars—primarily Medicare and Medicaid—the state must take responsibility for the impact of these wages on the workers and their families, the quality of home and community-based services, and on public resources overall. *What are the costs and benefits to our communities when over 200,000 workers earn such low wages?*

In New York City, low wages are compounded by a second issue—better trained home health aides earn around \$8.50 per hour, while personal care aides (called “home attendants” in the City) earn \$10 per hour. PCAs also have more comprehensive health coverage, for themselves and their children, than home health aides.³

This paper explores the purchasing of home health and personal care aide services in the metropolitan New York City area⁴ and how this process affects aide compensation. It also examines the payment and contracting policies, or lack thereof, and provides a framework for changing these policies. Finally, it offers several steps that should be considered in order to stabilize and improve the workforce.

There are several reasons we chose to focus this analysis on New York City. First, it is primarily in the New York City area where subcontracting and market forces have pushed home health aide wages below those of lesser-trained personal care aides. Second, there is little data available on subcontracting rates and entry-level wages upstate. Finally, New York City employs half the state's home care workforce, and the ready supply of immigrant women workers makes the labor market quite different from upstate. Despite this geographical focus, many of the findings and recommendations—particularly those related to data collection, establishing workforce goals and subcontracting standards, and holding contractors accountable—are applicable across the entire state.

Home Care Delivery System

Two Types of Home Care Aides

New York’s home care aide workforce actually encompasses two occupations defined by the federal government: personal care aides (PCAs) and home health aides (HHAs). Despite their different titles, these workers provide very similar services: assisting consumers with Activities of Daily Living (ADLs: bathing, toileting, dressing, transferring, walking, eating) and Instrumental Activities of Daily Living (IADLs: shopping, preparing meals, light housework, managing money, laundry). The fundamental difference between the two occupations relates to training requirements and regulations that concern a few designated “health-related” tasks, which, outside of consumer-directed programs, can be performed only by home health aides.

The federal government requires home health aides to receive 75 hours of training and to work under the supervision of a registered professional nurse (RN). These aides generally provide short-term, post-acute support to Medicare and Medicaid beneficiaries, although an increasing number of Medicaid home health clients are receiving services for a year or more.

There are no federal training standards or supervision requirements for personal care aides.

By contrast, there are no federal training standards or supervision requirements for personal care aides who provide personal care and other support services to elders and people with disabilities who need ongoing assistance. New York requires personal care aides to have 40 hours of pre-employment training. Personal care services are most often paid for by Medicaid.

The Licensed Home Care Services Agency

The employer of home health aides and personal care aides in New York is the Licensed Home Care Services Agency (LHCSA). Understanding these agencies is essential to understanding how the payment, contracting, and delivery of home health aide services works. LHCSAs are primarily for-profit business entities that act as “staffing agencies,” employing, training, and supervising aides. They also employ nurses (who train and supervise the aides), coordinators who manage the scheduling of aides to meet client needs, supervisors, and administrative staff.

The existence of LHCSAs allows for the “outsourcing” of aide services by the payers and home care programs that are accountable for the delivery of skilled care. There are 742 LHCSAs in New York State, with a concentration of 497 companies in New York City.⁵ Some LHCSAs compete for, and are awarded, a contract with the City or one of the surrounding counties to provide Medicaid personal care services. Other LHCSAs—as well as those providing personal care services—sub-contract with CHHAs and other long-term care programs to provide home health aide services.

LHCSAs are licensed by the New York State Department of Health (DOH) and many, although not all, operate DOH-licensed home care aide training programs for personal care aides and/or home health aides. There is no state formula that determines the “need” for LHCSAs as there is for the other licensed home care programs, and for many years, operating a LHCSA was viewed

as a business opportunity that was encouraged by the DOH. Beginning in 2007, the New York State Attorney General focused attention on home health aide training and service delivery, identifying several instances of Medicaid fraud and abuse. This resulted in the DOH establishing a moratorium on the opening of new LHCSAs.

The business models for these agencies vary—though all focus exclusively on paraprofessional services. Some provide training, others do not; some focus on particular geographic areas or serve particular ethnic communities that need aides who speak particular languages. Regardless, revenues are dependent on contracts with providers who receive payments from Medicare or Medicaid to provide home health care services. Competition for contracts is high, driving down the price paid for services and reducing the funds available for wages and benefits for the aides.

Wages: Home Health Aides vs. Personal Care Aides

The New York City Wage Inversion

In New York City, unlike the rest of the state, home health aides are paid a starting wage of between \$8.00 and \$8.50 per hour,⁶ \$2.00 to \$1.50 less per hour than home attendants. This “wage inversion” is a consequence of the early unionization of home attendants and the City’s contract with the agencies that provide personal care services. This contract is subject to the City’s Living Wage law, which sets the hourly wage (now \$10 per hour). The Home Attendant program also “builds” the rate for service reimbursement by starting with the wage to be paid and the cost of health insurance, adding the costs of training and overhead for the employer as well as profit.

The counties of Westchester, Nassau and Suffolk, the remaining parts of the “metropolitan New York City” area, also enacted Living Wage laws that affect the wages of personal care aides. These counties have base wages as shown in Table 1.

Table 1: Living Wages for Personal Care Aides in NYC, Long Island and Westchester

County/City	Base Wage	Supplement in Lieu of Health Benefits
Nassau	\$12.50	\$1.66
Westchester	\$11.50	\$1.50
Suffolk	\$10.83	\$1.50
New York City	\$10.00	\$1.50

Source: 1199/SEIU and county laws and ordinances.

Home health aides, however, have only recently unionized⁷ and have not yet seen the same benefits from collective bargaining as New York City’s and the surrounding counties’ personal care aides. In addition, neither New York City nor the counties contract directly for home health aide services, leaving home health aides outside of the wage and benefit requirements of the living wage ordinances. As a result there is no “wage floor” for home health aides other than the state’s minimum wage of \$7.25/hour, or in the case of a unionized provider, the terms of the

collective-bargaining agreement.

The Effects of the Wage Inversion

Having different rates of payment for two types of home care aides—with those with more training and responsibility earning less—creates numerous barriers to providing quality services. First, it creates an incentive for workers to want only personal care aide work since that work pays a higher wage.

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More importantly, if workers choose to become personal care aides rather than home health aides, the system faces problems with continuity of care. If a client moves to another program, in which home health aide services are required, the current aide may not have the training required to provide the care. For this reason, many providers require that aides be trained at the home health aide level.

However, there is an additional problem. If the aide follows the client—providing continuity of care—she or he is forced to take a lower wage when the client needs more complex home health aide services. Equalizing the pay of these two occupations becomes not only a mechanism for improving the financial status of the home health aide workforce, but allows for smoother transitions of clients from one program to another.

The effect of this pay disparity on the individual home health aide should not be minimized. Paying the home health aides less sends a message that they are of less value in the home care field, and creates a constant challenge for employers and other providers accountable for the care. Being an aide is physically, emotionally and intellectually challenging. Today's home care clients require a degree of skill, patience and compassion that should not be minimized. Home health aides often have more training and appropriate experience than PCAs to meet these needs; yet their wages suggest that they are not valued for the care and support they provide.

As a result, turnover among home health aides is significantly higher than that of personal care attendants. The turnover rate in New York's home attendant program, where aides earn at least \$10.00 per hour, is 12 percent, compared to 25 percent or more for home health aides.⁸ This means that the system is losing home health aides at a rapid rate, reducing opportunities for learning and skill development.

Turnover among home health aides is significantly higher than that of personal care attendants.

The longer an aide remains in the field, the greater her experience and competence. Required in-service training also improves skills over time. The individuals needing and receiving long-term care often suffer from a variety of chronic diseases as well as forms of dementia. The better trained

the aide, the greater the opportunity that she can assist in minimizing the negative effects of these diseases and conditions. Moreover, having consistency in the aide workforce allows for better communication between the aide and the other members of the care team.

Rate Setting and the Impact on Wages

When a New York resident covered by Medicare or Medicaid needs home care services, these services must be provided by a Certified Home Health Agency (CHHA), Long Term Home Health Care Program (LTHHCP), Managed Long Term Care Plan (Medicaid only), Program of All Inclusive Care for the Elderly (PACE), hospice, or a Medicare or Medicaid Advantage managed-care plan. Medicare or Medicaid will pay one of these programs to provide the services, which can include nursing, various therapies, and/or home health aide supports. The certified agency or long-term care program provides most of the services directly, but subcontracts with a Licensed Home Care Services Agency (LHCSA) to provide the home health aide services. LHCSAs are not allowed to bill Medicare or Medicaid directly, though they are the employers of the home health aides. To explain how the rate for home health aide services is determined, we will use as an example a Certified Home Health Agency (CHHA) providing Medicaid-financed services.

Rate Setting

A CHHA provides nursing services as well as physical, occupational, and speech therapy, and home health aide services. For each of these services, the CHHA receives a Medicaid rate that is derived from its costs from two years past. CHHAs are classified into five groups (Upstate, Downstate, Public, Private and New York City) for which there is an overall group ceiling that

A trend factor is applied to the costs based on the Consumer Price Index rather than actual costs.

is the “centered average” of the group rate plus 10 percent. A trend factor is applied to the costs based on the Consumer Price Index rather than actual costs. Finally, the component of the CHHA’s billing rate that is attributable to administrative and general (A&G) costs—i.e., those costs other than salary and benefits of nurses and home health

aides—is capped. The CHHA A&G cap for 2009 was 23.95 percent. A CHHA’s costs may be over the cap; however, they will only be reimbursed up to the cap. Moreover, the trend factor has been subject to freezes, suspensions, or cuts in response to state budget realities.

Ensuring an adequate wage for the home health aide starts with the Medicaid rate for an hour of home health aide services. The rate must be reasonable and must cover the costs needed to

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deliver the service. The Medicaid rate to a CHHA for an hour of home health aide service in New York, from appearances, would allow a higher wage to be paid than \$8.50 per hour. For example, Table 2 shows the rates that are paid to a number of CHHAs throughout New York City and the surrounding counties. The rate is at least two or three times the hourly wage for the home care aide.

Table 2: Comparison of Sample CHHA Medicaid Rates for an Hour of Home Health Aide Service

CHHA	CHHA Rate for Hour of Home Health Aide Service	Type of CHHA and Location
A	\$25.44	Downstate, private
B	\$18.30	New York City
C	\$18.68	New York City
D	\$25.97	Downstate, private
E	\$20.37	New York City

Impact of Subcontracting on Wages

The next step in evaluating the reasonableness of payment is to examine the price paid by the contractor (the CHHA) to its subcontractor (the LHCSA), and finally, the wage paid to the aide as seen in Table 3.

Table 3: Comparison of Medicaid Rate Paid to CHHA for HHA Service, Rate Paid to LHCSA, and HHA Hourly Wage, 2007

CHHA	Subcontractor (LHSCA)	CHHA Medicaid HHA Rate	Contract Hourly Rate to LHCSA	Wage Rate to HHA	Differential b/t Contract and Wage Rates
A	1	\$23.89	\$15.00	\$8.06	\$6.94
A	2	\$23.89	\$14.20	\$8.50	\$5.70
B	1	\$19.59	\$12.75	\$8.75	\$4.00
B	2	\$19.59	\$13.00	\$8.00	\$5.00
B	3	\$19.59	\$12.50	\$8.00	\$4.50
B	4	\$19.59	\$12.50	\$9.50	\$3.00
C	1	\$15.64	\$13.00	\$8.00	\$5.00
C	2	\$15.64	\$13.00	\$8.00	\$5.00
C	3	\$15.64	\$13.00	\$8.00	\$5.00
C	4	\$15.64	\$13.00	\$7.50	\$5.50
D	1	\$20.19	\$12.80	\$8.75	\$4.05
D	2	\$20.19	\$12.50	\$7.15	\$4.45
D	3	\$20.19	\$12.50	\$8.00	\$3.50
D	4	\$20.19	\$12.90	\$7.15	\$5.75
D	5	\$20.19	\$12.00	\$7.30	\$4.70

Source: Data prepared for the Home Health Care Reimbursement Workgroup meeting, July 7, 2009, presented as Appendix D in the Interim Report of the Home Health Care Reimbursement Workgroup, December 2009. The 2007 CHHA rates include the additional dollars from the pools that fund workforce recruitment, training, retention and quality. Wage rates are starting rates and do not include differentials, fringe or other benefits.

Lack of Transparency. One of the primary challenges in assessing the adequacy of the rates and their relationship to home health aide wages is the lack of transparency with respect to the price negotiated by the CHHAs for an hour of service and the very limited data from LHCSAs

One of the primary challenges in assessing the adequacy of the rates and their relationship to home health aide wages is the lack of transparency.

concerning what they are paid or what they pay to the aides. The data in Table 3 was provided by the DOH as LHCSAs do not have to report the prices that they accept for an hour of home health aide service, and there is little discussion of these rates within the industry due to fears that these conversations would constitute a restraint of trade. This lack of transparency is additionally complicated by the fact that since a LHCSA is likely to subcontract with more than one CHHA, they will

have varying rates of payment for an hour of service as well as differing volume related to those payments. LHCSAs blend or average these rates along with the anticipated volume in order to compute the “blended rate,” which is the average that the LHCSA uses to determine home health aide compensation—wages and benefits.

Where the dollars go. These rates demonstrate that Medicaid pays a rate for an hour of home health aide service that should be sufficient to pay a wage equal to that paid to personal care aides, \$10.00 per hour. However, both the CHHAs and the LHCSAs retain a portion of the Medicaid rate. For example, Table 3, Row D5, shows that the CHHA receives \$20.19 for an hour of home health aide service. It keeps \$8.19 of this reimbursement, paying the LHCSA \$12.00. The LHSCA is paying the home health aide \$7.30 an hour, reserving \$4.70 as overhead. Whether or not these retained amounts are justified by the costs of each entity can only be determined by examining their actual administrative and general costs as well as their profits (or surplus in the case of a not-for-profit provider).

Wages equal one-third of rate. A simpler way of evaluating the sufficiency of the Medicaid rate than analyzing all CHHA and LHCSA administrative costs is to examine the percentage of the rate that is actually being used for aide compensation. In the same example, the CHHA is using 59.4 percent of the rate for aide compensation when contracting with the LHCSA, and the LHCSA is using 60.8 percent of the rate for aide compensation. Looked at from the perspective of the full rate, the home health aide is receiving only 36 percent of the reimbursement rate.⁹ A split of 75/25 with 75 percent of the rate being used for aide compensation is a far more reasonable allocation.

Cost Shifting. CHHAs do have costs related to home health aide services, even though they are not the employer; thus, retaining some portion of the rate makes sense. CHHAs negotiate with LHCSAs for contracts and coverage, assign cases, and are accountable for those cases. These responsibilities necessitate oversight activities as well as contract management, audit, and quality assessment activities.

For many CHHAs, however, it is important not only to cover their costs but to make a profit

The amount the CHHA retains can be used to subsidize other costs, which may not be fully reimbursed.

on home health aide services. Thus, the agencies want to pay the lowest price possible. Home health aides thereby become a “profit center” in the CHHA, and the amount the CHHA retains can be used to subsidize other costs, which may not be fully or adequately reimbursed.

For example, a Medicaid CHHA case requires a registered nurse in order to open the case. CHHAs compete with each other as well as hospitals and nursing homes for high-quality nursing staff. And while a hospital may be able to hire a nurse directly out of nursing school and place her on a floor immediately, a CHHA has the extra expense of training her in the specifics of home care practice and assessment before she can be placed in the field. The competition for speech therapists has also been fierce given the shortage of these practitioners. A truly adequate examination of the reimbursement structure of the CHHA would likely expose the fact that the reimbursement rate does not adequately cover the cost of licensed personnel or regulatory mandates, requiring the CHHA to offset those costs by keeping a large portion (often as much as one-third) of the home health aide rate for itself. This is one step to the final result of impoverishing the aides.

Impact of Subcontracting on Quality of Services

Because CHHAs subcontract for home health aide services, there is a lack of clarity regarding their responsibility for the quality of the service provided. In fact, it seems that the quality of aide services rarely enters into the subcontracting equation.

In most CHHAs, contract administration is focused on ensuring aide coverage of geographically remote areas or hard-to-serve cases, and performance is measured on the basis of the number of aide “call-outs” or “no-shows” as well as patient complaints. Although a CHHA can penalize poor performance by cancelling a contract or rewarding a high-performance subcontractor with greater volume, there is little indication that this is the practice.

Contractors have been reluctant to require more detailed reporting from their subcontractors.

Contractors have been reluctant to require more detailed reporting from their subcontractors for fear that they would be accused of engaging in anti-competitive practices—i.e., there might be an assumption that the information shared was being used to “set the market rate” and interfere with competition. Recent audit activity by the Attorney General’s Medicaid Fraud Control Unit

(MFCU) and the Office of the Medicaid Inspector General (OMIG) has only intensified these concerns. Auditors have scrutinized not only the billings and duty sheets of the aides, but asked for an explanation of the differences in contracting rates, suggesting that contractors who pay one subcontractor more than another for an hour of aide service are violating the “prudent purchaser” principle.¹⁰ However, Medicaid fraud and abuse investigations need not result in penalties when contractors can demonstrate—through the LHCSA’s rates of retention of home health aides, the amount of training given to aides, or other specialty services the LHCSA provides to the contractor—that the product being purchased is qualitatively distinct.

A small number of CHHAs use a scorecard to rank the LHCSAs with whom they subcontract, collecting data on aide replacements, percentage of cases accepted on a timely basis, and billing practices. Recently, one CHHA added clinical outcome measures to the mix, measuring functional

improvement or stabilization for bathing, transfers and ambulation, the incidence of falls, and the percentage of cases re-hospitalized within a certain time frame. These additions demonstrate a desire for more qualitative information, as well as important information that can benefit patient outcomes and, ultimately, reduce costs to the system.

Although these are positive developments, there is little indication that most contractors seek out this information. Nor do they ask about the training and experience of aides, even though cases are becoming more complex, with increased numbers of patients suffering from chronic diseases, Alzheimer’s and other forms of dementia. For the most part, contractors accept high rates of turnover among aides and ask few questions about how LHCSAs train and support the aides. This is despite the fact that specific workforce measures such as turnover and retention rates, compensation levels, and availability of full-time work as measured by hours worked per week have been shown to be important indicators regarding the stability of the workforce and subsequently, the quality of care delivered.¹¹

Both the contractors and subcontractors will need to recognize the importance of stabilizing the workforce.

Regardless of the measures chosen to determine the adequacy and stability of the workforce—and the quality of services provided—the subcontracting relationship requires that two parties participate in measuring outcomes. Both the contractors and subcontractors will need to recognize the importance of stabilizing the workforce, with better compensation, training,

and support, to meet the future needs of New York’s home care clients. However, unless the contractors or the state require these data, they will not likely be collected.

Keeping Workers Poor

This paper has focused on home health aides and their wages in comparison to those of personal care aides (home attendants) in New York City. However, both types of aides earn \$10 or less per hour, leaving most of New York’s home care aides—both personal care aides and home health

Low wages leave most of New York’s home care aides on the edge of poverty.

aides—on the edge of poverty. Most earn wages and benefits far below the 2010 Self-Sufficiency Standard for New York State and are reliant on public programs (e.g., Supplemental Nutrition Assistance Program, housing subsidies, Earned Income Tax Credits) to support their families (see Table 4 and Figure 1).

Table 4: Home Health Aide and Personal Care Aide Wages as Compared with Self-Sufficiency Standards for Family of One Adult and One Preschooler

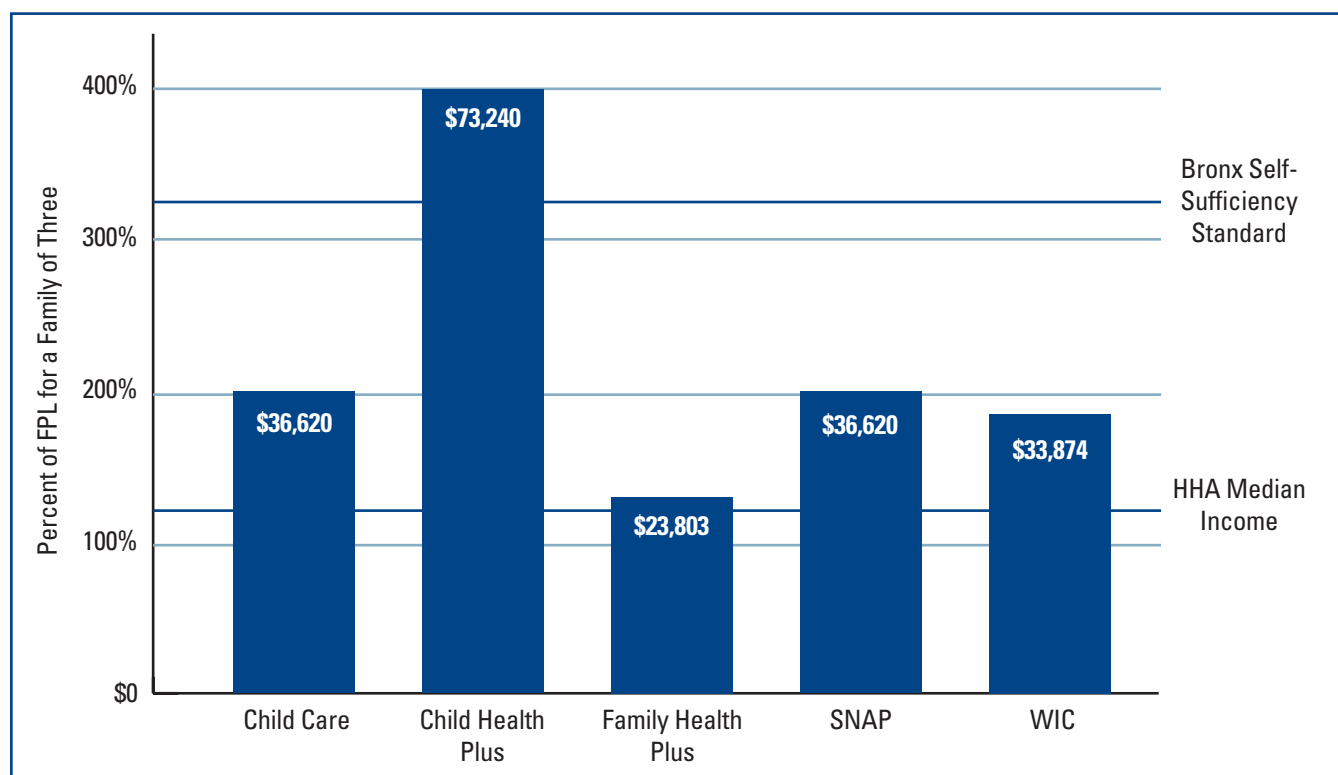
County	Bronx Self-Sufficiency Wage	Suffolk Self-Sufficiency Wage	Statewide HHA Median Wage	Statewide PCA Median Wage
Hourly Wage	\$23.39	\$31.20	\$10.66	\$10.71

Source: Home health aide and personal care aide median wages from NYS Department of Labor, Occupational Wages for New York State collected in 2006, 2007, 2008, 2009, and updated in first quarter of 2010. Self-Sufficiency Wage for the two counties are from "The Self-Sufficiency Standard for New York State 2010," by Diana M. Pearce, Ph.D., Director, Center for Women's Welfare, University of Washington School of Social Work, prepared for the NYS Self-Sufficiency Standard Steering Committee.

The state makes public benefits available to families on the basis of the size of the family and its earnings—and what percentage of the federal poverty level (FPL)¹² the family's income represents.

Figure 1 shows the maximum income for a family of three to qualify for child care subsidies, Child Health Plus, Family Health Plus, Supplemental Nutrition Assistance Program (SNAP), and Women, Infants and Children (WIC), all of which provide additional supports to low-income workers. This information is compared to the Self-Sufficiency Standard for a family of three living in the Bronx, and the median wages for New York's home health aides.

Figure 1: Home Health Aide Median Annual Income and Bronx Self-Sufficiency Standard for a Family of Three Compared to Eligibility for Public Programs



Source: "The Self-Sufficiency Standard for New York State 2010," by Diana M. Pearce, Ph.D., Director, Center for Women's Welfare, University of Washington School of Social Work, prepared for the NYS Self-Sufficiency Standard Steering Committee.

As can be seen in Figure 1, the home health aide median income is far below the threshold for all the public benefit programs (see Appendix A for information on additional public programs). Notably, the state negotiated with SEIU/1199 to provide health coverage for personal care aides by placing them in the Family Health Plus program. Home health aides, unless they are income-eligible for Family Health Plus, remain dependent on private employer insurance.¹³

Since eligibility for these public programs is dependent upon income, family size and resources, aides often attempt to manage their income to retain eligibility. This means that qualified, trained workers are sometimes limiting their work hours in order to ensure their families do not lose critical benefits. In an era in which there is rapidly expanding need for home care services, this dynamic is especially detrimental to potential consumers.

New York City's home care aides are one in seven of the City's low-wage workers. When the state looks at the impact of low wages paid to home care aides, it must also examine the use of public benefits. How much does it cost to subsidize these families in order to provide home and community-based services? Is this the most efficient use of public dollars? And would increased

wages, which would support families at a higher level and lead to greater spending in low-income communities, actually be a better use of public dollars? These questions are critical to building a more rational, cost-efficient, and effective system of home and community-based services.

How much does it cost to subsidize these families in order to provide home and community-based services?

Recommendations

1. Value Purchasing: CHHAs and other home care programs should hold LHCSAs accountable for workforce outcomes and contract with those with the best performance.

There have been several attempts to address subcontracting and improve the amount of the Medicaid rate available for aide wages both by the legislature and the governor. For example, bills were introduced in past state legislative sessions to minimize profits by requiring CHHAs and LHCSAs to share a single overhead percentage of the rate. Most recently, the governor proposed the elimination of subcontracting between CHHAs and LHCSAs. This proposal was rejected, largely due to the legitimate argument that the costs of recruiting, hiring, training and retaining aides would simply move into the CHHAs, without any additional benefit to the system in either cost or quality.

While these efforts failed, there is an opportunity for CHHAs and other home care programs to concentrate the contracts in those LHCSAs with better performance, by measuring workforce

LHCSAs are well-positioned to improve training and retention and to provide opportunities for advancement.

outcomes and holding LHCSAs accountable for the quality of the workforce. With their exclusive focus on home care aides, LHCSAs are well-positioned to improve training and retention and to provide opportunities for advancement, and contracting entities should reward LHCSAs with proven success in these areas.

If New York wants a high-quality aide workforce, and plans to continue the practice of subcontracting, the state needs to hold the CHHAs and other home care programs accountable for contracting on the basis of quality.¹⁴

2. Transparency: The New York State Department of Health must require more data on the price paid for aide services and on aide compensation.

Since neither the state nor the locality contracts directly with the LHCSA for home health aide services, in order to improve the aide wages, the DOH will need to know what the contractor is paying, what the LHCSA is receiving, and how the home health aides are compensated. DOH now requires the CHHAs and the Long Term Home Health Care Programs to report subcontracting rates for each subcontractor in an addendum to their Medicaid cost report. The next step is to collect information from the LHCSAs on entry-level wages, differentials¹⁵ and benefits through

their statistical report. These same reporting requirements must also be extended to other home care programs that subcontract.¹⁶ These steps will enable the state to determine whether or not the aide procurement process has been modified to reward those employers who compensate the aides at a higher level.

The adequacy of the rates for licensed personnel working in home care must be reviewed and revised as needed.

In addition, the adequacy of the rates for licensed personnel working in home care (RNs, physical, occupational, speech/language therapists) must be reviewed and revised as needed.

3. Wage Parity: There must be a plan to increase home health aide wages to the level of personal care attendants in New York City.

The steps enumerated above are insufficient unless New York reaches the primary goal of wage parity between the personal care aides (home attendants) and home health aides in New York City. Without parity, there is a lack of continuity of aide services for clients who move between home care programs, unless the aide is willing to lose both wages and benefits. Moreover, any policy changes in home care that would shift clients into models that use home health aides will create disruption in the home attendant workforce and their economic status, particularly if there are reductions in hours.

While parity is essential to rationalizing and stabilizing New York's home care delivery system, parity alone is not enough. Wages for *all* home care aides must be improved if we are to

build a long-term care workforce that can achieve the goal of quality home and community-based care that is readily available to meet the needs of New York's growing population of elders and people with disabilities.

Wages for all home care aides must be improved.

Conclusion

The home care system of today has moved beyond custodial care. Patients who are newly discharged from the hospital or rehab center as well as those with multiple chronic diseases, mental health issues, and dependence on remote monitoring equipment comprise the case loads that home health aides serve. Managing the care for these individuals calls for better training as well as specialization, and with these demands, improvements in wages.

While these recommendations were crafted within the context of political and budgetary realities, a home care system that is both cost effective and stable will pay its home care aides better and will make better use of their skills and abilities. Paying for parity involves recognizing that New York is getting neither the best value nor the best quality from its Medicaid expenditures for home health aide services. While some may argue that the market sets the price for home health aides, the reality is that low wages, dependence of aides and their families on public programs, high turnover, and limited opportunity function as barriers to an improved and more cost-effective long-term care system.

New York created one of the most robust systems of home care in the country, yet hundreds of thousands of women and their families have been relegated to poverty because of the way we purchase those services.

New York created one of the most robust systems of home care in the country and the majority of the services and the payments are for home care aide services. Yet hundreds of thousands of women and their families have been relegated to poverty because of the way we purchase those services. It fails any reasonable test of what a “prudent purchaser” would do in an attempt to get good value for the substantial funds spent for the care of New York’s elderly and disabled Medicaid beneficiaries.

Appendix A

Public Benefits and Eligibility Criteria Using Federal Poverty Level Calculation

Public Benefit Program	Eligibility	Federal Poverty Level (FPL) Calculation
Medicaid	For women with dependent children, 150% of the FPL; for infants up to age 1 and pregnant women, 200% of the FPL; for children 1-5, 133% of FPL; children 6-18, 100% of FPL	A single individual cannot earn more than \$8,479 a year; family of 2, \$10,584; family of 3, \$12,593; family of 4, \$14,622.
Family Health Plus (FHP)	Applicants must be between 19 and 64 and must be uninsured. Household income must be above Medicaid eligibility levels and up to 100% of FPL for single adult without children; up to 150% FPL for parent in a household of three. Must be a U.S. citizen	100% of FPL for single adult is \$10,830. 150% of FPL for family of 3 is \$27,465.
Supplemental Nutrition Assistance Program	Based on gross income up to 130% of FPL	Family of 3 may not earn more than \$23,808 a year.
Subsidized Child Care	Eligibility based on reason for needing subsidized child care and family income.	Family of 3 must have annual income less than \$46,692
Public Housing	Need-based depending on circumstances. Access to apartments based on family income with eligibility tied to 80% of area median income. Due to limited funding, most new program participants must have income below 30% of area median income. Section 8 eligibility criteria must be met (e.g., victim of domestic violence), as well as income limits.	Public Housing available to family of 3 earning less than \$55,300. Section 8 may not earn more than \$34,550 for a family of 3.
Earned Income Tax Credit	Federal EITC income limits: 1 parent family with one child: up to \$35,536; 1 parent with 2 children, up to \$40,363; 1 parent with 3+children, up to \$43,352. NYS EITC is 30% of the Federal EITC. NYC EITC is 5% of the Federal EITC.	

Appendix B

Workforce Reporting Requirements and Standards for Homecare Procurement Solicitations

Recommended Evaluation Criteria

- Starting hourly wage for a home health aide
- Median and mean wage paid to home health aides
- Rate paid for overtime hours beyond 40 hours in a week (or 44 hours in the case of live-in workers (e.g., 150% of the base wage, 150% of the New York State minimum wage of \$7.25)
- Differentials paid for weekends, language, or sleep-in cases
- Percentage of aides working full-time (defined as over 30 hours per week)
- Median work hours per week per aide
- Employer record of wage and hour violations
- Turnover rates (calculated by dividing the total number of separations for home health aides over a 12-month period by the average number of aides employed over that same 12-month period)
- Percent of Licensed Home Care Services Agency (LHCSA) revenue paid out in aide compensation
- Benefits
 - Health insurance: describe type of coverage (family or individual), eligibility criteria (e.g., length of employment required and number of hours that must be worked to qualify, cost sharing requirements and take-up rates)
 - Dental insurance
 - 401k Plan
 - Paid vacation and sick leave
 - Uniform allowance
 - Travel allowance

Alternatively, benefits could be reported as total “benefits per hour” cost calculation. Those LHCSAs that provide health insurance are likely to have a much higher benefit cost.

We recommend that the information that bidders provide regarding the recommended criteria should then be factored into the selection process, using a scoring system that gives greater weight to proposals from agencies that pay higher wages, provide more generous benefits, require less overtime work, experience lower turnover rates, etc. This scoring system should be disclosed along with the request for proposals.

Note: This criterion is taken from a memo developed by the National Employment Law Project (NELP) and the Paraprofessional Healthcare Institute (PHI) for Health and Hospitals Corporation Home Care. A copy of the full document is available from Paul Sonn, psonn@nelp.org or Carol Rodat, crodat@phinational.org.

Endnotes

- 1 New York has many titles for home care workers. This paper specifically addresses the two primary occupations regulated by the Department of Health, home health aides and personal care aides. For more information about the varied home care occupational titles see "New York's Home Care Workforce—A Framing Paper."
- 2 DOH data presented to Home Health Reimbursement Workgroup.
- 3 Home attendants may also have coverage for a spouse, although the eligibility requirements for this coverage are more stringent. For a complete discussion of health insurance coverage of the aide workforce, see PHI, *Is New York Prepared to Care? A Comprehensive Coverage Solution for Home Care Workers*, May 2009, at: <http://www.directcareclearinghouse.org/download/NY-HCAcoverage2009.pdf>
- 4 For purposes of this paper's discussion, the metropolitan New York City area encompasses the 5 boroughs of New York City and the counties of Nassau, Suffolk and Westchester.
- 5 There are 497 LHCSA companies operating in NYC out of 605 sites, some of which also operate in the surrounding counties of Westchester, Nassau, and Suffolk. There are 539 LHCSA companies operating out of 717 sites in the metropolitan NYC (Nassau, Suffolk, Westchester and NYC).
- 6 Personal communication with 1199/SEIU.
- 7 Home health aides began to be unionized in 2004 when Partners in Care, the Licensed Home Care Services Agency of the VNS of New York signed a labor agreement with 1199/SEIU. The remainder of the industry in New York City was not unionized until 2009.
- 8 According to 1199/SEIU, home health aides turnover at LHCSA's paying the highest wages and benefits is 25 percent.
- 9 These percentages for compensation may be slightly higher, if the LHCSA contributes to health coverage or provides other benefits in the aides' compensation package.
- 10 This is a principle that was originally established to protect Medicare from reimbursing inflated charges or billing schemes. More recently, however, Medicare has taken steps to become a prudent buyer of services, basing payment on better outcomes for patients.
- 11 National Direct Service Workforce Resource Center. *The Need for Monitoring the Long-Term Care Direct Service Workforce and Recommendations for Data Collection*, (February, 2009), at: <http://www.dswresourcecenter.org/tiki-index.php?page=Data+Collection>
- 12 Federal Poverty Levels are based on the cost of food and are "frozen" in that the FPL is updated annually using the consumer price index rather than the changes in the relative costs of food, non-food items or new costs that a family incurs. For example, the costs of health care, housing, food, energy, child care and taxes have risen faster than the costs of food.
- 13 For a full discussion of health insurance coverage, see PHI's publication, *Is New York Prepared to Care? A Comprehensive Coverage Solution for Home Care Workers*, at: <http://www.directcareclearinghouse.org/download/NY-HCAcoverage2009.pdf>
- 14 A recent example of contracting reform on the part of a CHHA can be found in the Request for Application that the Health and Hospitals Corporation (HHC) CHHA issued for aide services. The National Employment Law Project (NELP) and PHI assisted HHC in developing reporting requirements and new standards for procurement (see Appendix B), in recognition of the fact that low wages and high turnover rates compromise the quality of services. A scoring system was proposed that would give greater weight to those LHCSAs paying higher wages, providing more generous benefits, and having lower turnover rates.
- 15 Differentials are paid for nights, week-ends, difficult to serve clients, language needs and certain geographic areas.
- 16 Medicaid Managed Long Term Care Plans, Long Term Home Health Care Programs, Program of All-Inclusive Care for the Elderly (PACE), TBI, Nursing Home Transition and Diversion.

