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Client Alert

March 19, 2024

Proposed NYC Legislation: Hour Limits Home Care Aides Can Work

Councilmember Christopher Marte has introduced a bill (City Council Bill No. 615) which, if adopted, would amend the New York City administrative code by setting the maximum hours NYC employers can assign to home care aides.

Specifically, the bill would prohibit NYC employers from assigning a home care aid to work any single shift exceeding 12 hours; consecutive 12-hour shifts; or shifts totaling more than 12 hours in any 24-hour period. The bill appears to be an attempt to end 24-hour "live-in" cases which would not only disrupt patient access to care but would also require an increase in home care aides needed to fill cases.

In emergency circumstances, home care aides could be assigned additional hours, but not more than 2 hours per day or 10 hours per week. Employers would be permitted to assign a home care aide to more than 56 hours of work in a single week if they provide the aide with 2 weeks advance notice and obtain written consent from the aide.

If adopted, the bill would take effect in NYC on October 1, 2024.

Addendum #1 Released for Statewide Health Care Facility Transformation Program IV (RFA #20244)

The New York State Department of Health has released an Addendum to the Application for the Statewide Health Care Facility Transformation Program IV (SHCFTP IV) (RFA #20244). Notably, the submission deadline has been extended to Wednesday, April 10, 2024, at 4:00 PM ET and the information requested has been clarified to no longer require disclosure of non-clinical employees whose salaries are $250,000 or more.

A funding pool of up to $250,000,000 is available through SHCFTP IV to health care providers in support of capital projects, debt retirement, working capital, or other non-capital projects that facilitate furthering transformational goals, including, but not limited to, transforming, redesigning, and strengthening quality health care services in alignment with statewide and

regional health care needs and in the ongoing pandemic response, or other activities intended to build innovative, patient-centered models of care, to increase access to care, to improve the quality of care and to ensure financial sustainability of health care providers. Grants shall not be made to support general, day-to-day operating costs.

Eligible Applicants include hospitals, residential health care facilities, adult care facilities, assisted living programs, children's residential treatment facilities, and residential facilities. Eligible Applicants also include community-based health care providers, defined as diagnostic and treatment centers, home care providers, hospices, primary care providers, and independent practice associations or organizations; and community-based behavioral health care providers, defined as mental health clinics, alcohol and substance use disorder treatment clinics, day program facilities and clinics licensed under article 16 of the MHL, and Community-Based Programs funded under the Office of Mental Health, the Office of Addiction Services and Supports, the Office for People with Developmental Disabilities, or through local governmental units.

If you need help with your application, contact our office.

Response to Hochul's proposal to eliminate CDPAP Wage Parity

The Senate and Assembly have both rejected the Governor's proposed budget cuts to the Consumer Directed Personal Assistance Program. The Senate and Assembly's answer to the proposed budget, known as the one-house budgets, rejected each proposed cut to the program.

As a reminder, the original release of the 2025 Executive Budget and 30-day Amendments incorporated into the proposed budget a number of changes to long-term care in New York State, including the potential discontinuance of wage parity for CDPAP personal assistants, prohibiting entities from engaging in multiple types of healthcare services, eliminating the FI RFO, and establishment of the maximum daily and weekly hours that any individual aide can provide personal care services.

We are awaiting the final budget which current deadline is April 1, 2024. However, as we have seen in previous years, that deadline is often extended several weeks as a result of extensive negotiations. We will follow the process and provide updates as they occur.

Reminder: NHTD and TBI Conflict of Interest Rules went into effect on March 1, 2024

The Centers for Medicare and Medicaid Services (CMS) Conflict of Interest (COI) requirements went into effect on March 1, 2024 for all clients who provide waiver services in the Nursing Home Transition and Diversion (NHTD) and Traumatic Brain Injury (TBI) programs.

Any service plan approved before March 1, 2024 will be allowed to complete the natural cycle of its current plan year. Any service plan, including amended service plans, approved after March 1, 2024 must be fully compliant. The Regional Resource Development Centers (RRDC) will be conducting desk audits to ensure compliance.

The CMS COI rule prohibits providers of home and community-based services

(HCBS) for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual to provide case management or develop the person–centered service plan for the same individual, unless authorization is obtained by the state. In other words, service coordination cannot be provided by the same provider that provides the HCBS services, unless there is no other willing and qualified entity in a geographic area available to the individual.

Service Coordination must be conflict free and may only be provided by agencies and individuals employed by providers who are not:

- Related by blood or marriage to the participant or to any paid service provider of the participant
- Financially or legally responsible for the participant
- Empowered to make financial or health-related decisions on behalf of the participant
- Sharing any financial or controlling interest in any entity that is paid to provide care for or conduct other activities on behalf of the participant
- Individuals employed by agencies paid to render direct services (as defined by the Department) to the participant

Agencies that are approved to provide service coordination and waiver services may still provide both, just not to the same individual. A COI occurs not just if the entity is a provider but if the entity has an interest in a provider or if they are employed by a provider.

Waiver services which are non-direct, such as Assistive Technology, Community Transitional Services, Congregate and Home Delivered Meals, Environmental Modifications, and Moving Assistance, may be offered by the same provider.

Registration of Temporary Health Care Services Agencies

The requirement for temporary health care services agencies and health care technology platforms to register with the Department of Health, as set forth in Article 29-K of the PHL, went into effect on August 1, 2023.
Temporary Health Care Service Agencies are defined as “a person, firm, corporation, partnership, association, or other entity in the business of providing or procuring temporary employment of health care personnel for health care entities.” This includes:

- A nurses’ registry licensed under Article Eleven of the General Business Law; and
- Entities that use technology-based solutions, such as apps, to provide or procure temporary employment of health care personnel to health care entities

The definition does not include home care agencies, or individuals that on a temporary basis provide their own services to health care entities.
To register, agencies must pay an annual registration fee of $1,000 and complete a form that includes the following information:

- The names and addresses of the controlling person(s)
- The names and addresses of any health care entities where the controlling person or persons or their family members: (i) have an ownership relationship; or (ii) direct the management or policies of such health care

entities
- A demonstration that the applicant is of good moral character and able to comply with all applicable state laws and regulations relating to the activities in which it intends to engage
- The state of incorporation of the agency
- Any additional information necessary, as determined by the Commissioner

In addition to registration, agencies must also comply with reporting requirements that include submission of quarterly financial related reports, and contracts between the agency and the health care entities to which the agency intends to provide personnel.

DISCLAIMER

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