Expanding Self Direction in Ohio's Medicaid HCBS Programs

The Executive Budget as introduced (HB 64) increases access to Medicaid home and community based services (HCBS), and creates new opportunities for HCBS recipients to self-direct their services. ***HB 64 does not eliminate independent providers, but does clarify that the employer for a direct support worker must be either the individual receiving services or an agency, not the State of Ohio.***

HB 64 represents a significant opportunity to expand self-direction in Ohio. Self-direction means that individuals – with the assistance of representatives of their choice – have the right to direct how their services are provided, choose who will work for them and schedule services according to their own preferences, and evaluate the quality of the services they receive. The goal of self-direction is to maximize the individual's opportunities to live independently in the most integrated community-based setting of his or her choice.

Expanding self-direction to all HCBS waivers in Ohio requires making some changes to the program. This document provides detail about the outcomes that will result from these changes, and proposes a process and timeline for discussion with stakeholders to identify concerns, align common objectives, and fill in the detail required to implement expanded self-direction in Ohio.

The Governor's Office of Health Transformation (OHT) is open to suggestions that hold all participants accountable to our shared objectives, and reassure individuals who rely on these services that the goal is to expand choice and provide them with greater control over how care is provided.

OUTCOMES:

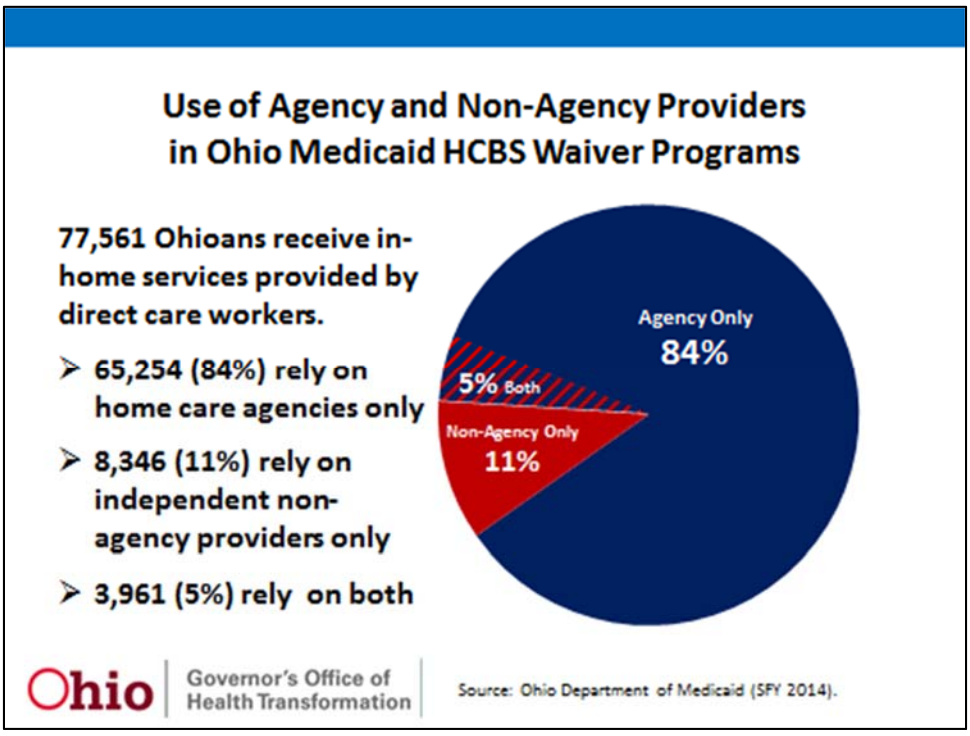
<u>Increase access to home and community based services.</u>

The Executive Budget will provide 10,000 more Ohioans a choice to live at home or in another community setting instead of receiving facility-based care. This represents a 34 percent increase in the number of individuals served in home and community based settings since 2011.[1] Last year, Ohio ranked first among states in transitioning persons with mental illness from long-term care facilities into

alternative settings, and second overall in the number of residents moved from institutions into home and community based settings.[2] Since 2011, more than 6,000 residents of institutions have moved into HCBS settings.

Currently, 90,000 Ohioans receive home and community based services through eight of Ohio's approved Medicaid waiver programs and *MyCare Ohio*. Most of these individuals (85 percent) receive in-home services provided by direct support workers (e.g., home health aides, personal care aides, and nurses). Among those receiving in-home care, 84 percent use only agency providers, 11 percent use only non-agency (independent) providers, and 5 percent use both (Figure 1, Table 1).

Figure 1.



<u>Make self-direction an option in every HCBS waiver program.</u>

In recent years, self-direction has emerged as a game-changing strategy in organizing and delivering Medicaid-funded services. Evidence indicates that individuals who self-direct their own care have fewer unmet needs and experience positive health outcomes and improved quality of life.[3]

In Ohio, some individuals informally "self-direct" their care by hiring independent direct support workers to provide in-home services. However, to comply with the federal definition of self-direction that is used for employment authority, an individual, guardian, or authorized representative who chooses self-direction must be recognized as the employer of record or enter into a co-employer arrangement with an agency that employs workers on the individual's behalf. Self-directed "employer authority" includes recruiting job candidates, deciding whom to hire, setting work schedules, supervising and evaluating job performance, and deciding when to dismiss a worker whose performance is unsatisfactory (Table 2). Also, participants may have "budget authority" to reallocate funds among services within a budget, determine wages for services within established limits, and authorize payment for services (Table 3).

Individuals, guardians, and authorized representatives who formally self-direct services gain access to supports that are not available through informal self-direction. For example, the State of Ohio contracts with Morningstar to provide financial management services (FMS) for individuals who choose self-direction. The FMS may serve as the fiscal agent and employer agency, collect and process timesheets, operate payroll services, and receive and disburse funds (Tables 2 and 3). In addition, any individual, guardian, or authorized representative who formally chooses self-direction also has access to all other Medicaid and approved HCBS waiver services, as needed, and will continue to receive case management.

Less than one percent of Ohioans receiving Medicaid home and community based services are formally enrolled in self-direction (Table 1). Currently, self-direction is available only in three HCBS waivers (*SELF, PASSPORT*, and *MyCare Ohio*). The option for individuals to exercise both employer and budget authority has only been available statewide through the *SELF* waiver since July 2012 and through *PASSPORT* and *MyCare* since March 2014, so it is new and not yet widely understood. However, advocates and the Administration agree that increasing awareness of self-direction and adding it to more HCBS waivers is a priority.

The Executive Budget clarifies that Ohio Medicaid has the authority to add the self-directed option to any waiver[4] and in February 2015 the Administration announced it will add self-direction to every HCBS waiver except assisted living, where direct care is provided by the facility, and the Transitions DD waiver, which is proposed to terminate in June 2017. The exact design of self-direction in each

waiver will be determined through a comprehensive public input process, as required by federal law. This process will determine who is eligible to self-direct and for what services. The public input process will be completed and self-direction will be made available in every HCBS waiver program except as noted above not later than January 1, 2017.

Comply with federal fair labor standards.

Congress amended the Fair Labor Standards Act (FLSA) in 1974 to provide minimum wage and overtime protections for most direct support workers, including home health aides, personal care aides, and nurses employed by home care agencies, managed care organizations, and state agencies. (In some cases related to self-directed care, exemptions to the FLSA may apply.[5])

The FLSA has a broader test to determine an employer than the IRS test for employer of record and, in the FLSA, there may be more than one employer (known as a "joint employer"). Depending on the design of the self-directed program, the individual consumer only, the individual and an agency, or the individual and the state can all be FLSA employers. Ohio does not serve as the employer of record or FLSA employer for any health care providers, and OHT would not choose to abandon that precedent.

The Executive Budget clarifies that the employer for a direct support worker must be either an individual who self-directs their support or an agency, not the State of Ohio.[6] It also establishes a timeline to transition independent direct support workers into employment by either an individual who self-directs care or an agency over not less than four years. (HB 64 as introduced would complete this transition by July 1, 2019.[7] However, based on feedback from stakeholders, OHT would consider extending the transition period to July 1, 2021).

Improve quality of in-home direct support.

As self-directed options become more available, it will be essential for individuals who choose self-direction to be able to identify quality, trained, and ready-to-work direct support providers. To support this goal, the Ohio General Assembly enacted legislation in 2013 that directed the Office of Health Transformation (OHT) to implement a certification program for direct support workers and

require certification as a condition of participating in Medicaid. OHT convened a Direct Care Worker Advisory Workgroup to design the program and delivered the Workgroup's recommendations to the legislature in December 2013.[8]

Based on the recommendation of the Advisory Workgroup, the Administration agreed to consider a rate increase for direct support workers certified under the new program. The rationale for an increased rate is based on covering the additional cost to the provider related to becoming certified, and the value to the state of greater confidence in direct care competencies through certification. However, before the certification program could be implemented, the DOL guidance described above raised questions about the certification approach, so the program and corresponding rate increase were put on hold.

The Executive Budget addresses concerns raised by the DOL guidance and would allow the Administration to restart implementation of a certification program. OHT proposes to convene a Self-Direction Advisory Workgroup to (1) assist in the design of a direct support worker certification program, (2) assist in the detailed design of self-directed options in each waiver, (3) provide input on rates and other considerations to comply with the FLSA, (4) identify implementation timelines that ensure individuals have choice and do not lose services as self-direction expands and independent direct support providers transition to self-directed or agency employment, and (5) ensure meaningful engagement and participation by individuals receiving these services in all of these activities.

All of the goals described above – giving individuals more control, clarifying the employer of record and FLSA employer, and certifying direct support workers – are intended to keep individuals safe and healthy while reducing opportunities for fraud and abuse.[9] The benefit of the Executive Budget proposals is that they simultaneously increase choice and control for individuals, while also providing better oversight of the taxpayer dollars that are used to pay for care.

Table 1. Use of Agency and Non-Agency Providers in Ohio Medicaid HCBS Waiver Programs.

Waiver	Enrollment[1]	Self-Directed Users		Non-Agency and Agency Provider Users[2]	Users of only Non-Agency providers		Users of only Agency providers		Users of both Non-Agency and Agency providers	
		Number	% of total enrollment		Number	% of total users	Number	% of total users	Number	% of total users
SELF	300	300	0.33%	176	48	0.06%	104	0.13%	24	0.03%
Individual Options	18,183			17,573	2,231	2.88%	14,233	18.35%	1,109	1.43%
Level 1	14,180			7,746	2,578	3.32%	4,678	6.03%	490	0.63%
Ohio Home Care	10,046			8,728	1,561	2.01%	5,920	7.63%	1,247	1.61%
PASSPORT[3]	42,604	573	0.63%	37,478	541	0.70%	36,806	47.45%	131	0.17%
Transitions Carve-Out	2,792			2,575	473	0.61%	1,746	2.25%	356	0.46%
Transitions DD	3,085			2,811	844	1.09%	1,415	1.82%	552	0.71%
Non-waiver PDN	478			474	70	0.09%	352	0.45%	52	0.07%
Statewide Total[4]	**90,824**	**861**	**0.95%**	**77,561**	**8,346**	**10.76%**	**65,254**	**84.13%**	**3,961**	**5.11%**

1. Individuals may be duplicated across waivers, and some individuals have subsequently enrolled in the *MyCare Ohio* Waiver. The categorization is waiver enrollment and then state plan (for example, if a person is enrolled in the IO Waiver and uses private duty nursing, then the person is categorized as IO Waiver in the chart).
2. Individuals are not duplicated across waivers (determined by the last paid waiver claim for SFY 2014). The actual number of individuals who use agency providers is understated because the chart only shows home health services provided through HCBS waivers, not state plan home health services, which are required to be provided only by Medicare-certified agencies.
3. Includes former Choices enrollees
4. All statewide totals are unduplicated counts.

Table 2. Employer Authority in Self-Directed Medicaid HCBS Waivers.

Types of Authority	Financial Management Services Responsibility[1]	Participant Decision Making Authority[2]
Co-Employment: FMS/Agency is common law employer of workers recruited by participant. Participant directs workers and is co-employer. (Agency with Choice Model)	- Verifies workers' citizenship/legal alien status. - Collects/processes worker's timesheets. - Operates payroll service (including withholding taxes, filing/paying Federal, state and local employment taxes and insurance premiums, and distributing payroll checks on the participant's behalf). - Brokers and pays worker's compensation or other types of insurance premiums. - May furnish orientation/skills training to participants about responsibilities associated with employer authority.	Employment-related functions the participant may perform under (co-employment) employer authority include, but are not limited to: - Recruiting staff. - Referring staff for hiring. - Selecting staff from worker registry. - Verifying qualifications. - Obtaining criminal records checks of staff. - Specifying additional staff qualifications based on participant needs/preferences and consistent w/service qualifications in waiver. - Determining staff duties consistent w/service specifications. - Determining wages. - Scheduling. - Orienting/instructing staff in duties. - Performance evaluations. - Verifying time worked/approving timesheets. - Discharging staff.
Common Law Employer: Participant is legally responsible employer of workers he/she hires, supervises and discharges directly. Participant is responsible for employment-related tasks.	- Assists participant in verifying workers' citizenship/legal alien status. - Collects/processes support worker's timesheets. - Operates payroll service, (including withholding taxes, filing/paying Federal, state and local employment taxes and insurance premiums, and distributing payroll checks on the participant's behalf). - Brokers and pays worker's compensation or other types of insurance premiums. - May furnish orientation/skills training to participants about responsibilities when they have employer authority of their workers.	Employment-related functions the participant may perform under (common law) employer authority include, but are not limited to: - Recruiting staff. - Selecting staff from worker registry. - Hiring. - Verifying staff qualifications. - Obtaining criminal records checks of staff. - Specifying additional staff qualifications based on participant needs/preferences consistent w/service qualifications in waiver. - Determining staff duties consistent w/service specifications. - Determining wages. - Scheduling. - Orienting/instructing staff in duties. - Performance evaluations. - Verifying time worked/approving timesheets. - Discharging staff.

1. 1915(c) waiver authority does not permit making payments for services directly to a waiver participant, either to reimburse for incurred expenses or so the participant can directly pay a service provider. Payments must be made through a fiscal intermediary organization (FMS) that performs financial transactions on behalf of the participant.
2. It would be up to the State to decide about certification/licensure – consistent with waiver service specifications.

Table 3. Budget Authority in Self-Directed Medicaid HCBS Waivers.

Types of Authority	Financial Management Services Responsibility[1]	Participant Decision Making Authority[2]
Participant has authority/responsibility for managing a participant-directed budget and making decisions about purchase of waiver goods and services that are authorized in the waiver service plan.	- Acts as fiscal/employer agency. - Serves as neutral bank, receiving and disbursing public funds, tracking and reporting on participant's budget. - Processes/pays invoices for goods/services in the participant's approved service plan. - Prepares and distributes budget/expenditure reports to participants and other entities specified in the waiver.	Employment-related functions the participant may perform under budget authority include, but are not limited to: - Reallocating funds among services in budget. - Determining wages for services within State's established limits. - Substitute providers. - Scheduling. - Specifying additional provider qualifications consistent w/waiver service qualifications. - Specifying how services are provided consistent w/service specifications. - Identifying providers/referring for provider enrollment. - Authorizing payment for goods/services. - Reviewing/approving provider invoices for services rendered.

1. 1915(c) waiver authority does not permit making payments for services directly to a waiver participant, either to reimburse for incurred expenses or so the participant can directly pay a service provider. Payments must be made through a fiscal intermediary organization (FMS) that performs financial transactions on behalf of the participant.
2. It would be up to the State to decide about certification/licensure – consistent with waiver service specifications.

Notes

[1] The number of Ohioans enrolled in Medicaid HCBS waiver programs increased from 72,000 in 2011 to an estimated 96,000 by 2017 if HB 64 (see: *Prioritize Home and Community Based Services*).

[2] *Ohio Recognized as National Leader in Transitioning Individuals into HCBS Settings*.

[3] Robert Wood Johnson Foundation, *Cash and Counseling Program Results* (2015).

[4] HB 64 as introduced clarifies in Section 5164.302(A) that "participant-directed Medicaid waiver component" means "A Medicaid waiver component in operation on the effective date of this section to which is added a participant-directed service delivery system" or "a Medicaid waiver component that begins operation on or after the effective date of this section and includes a participant-directed service delivery system."

[5] In October 2013, the U.S. Department of Labor issued a final rule that would have changed long-standing exemptions from the Fair Labor Standards Act related to "third party employers" and "companionship services" (*DOL Interpretation of the FLSA Rule*). As a result, DOL would have extended FSLA protections to direct care workers employed by individuals who self-direct care and designated state agencies as a "joint employer" for the purposes of self-directed care. However, both regulations were vacated in federal district court. The district court's decision means that neither the third party employer regulation or companionship services regulation will become effective, unless and until the district court's decisions are stayed pending appeal or reversed on appeal. DOL has filed an appeal asking the U.S. Court of Appeals in the District of Columbia to overturn the lower court orders.

[6] "An independent provider … shall not be considered to be either … an employee of the state or in the service of the state for the purpose of Chapter 124 of the Revised Code … [or] … a public employee for the purpose of Chapter 41117 of the Revised Code (HB 64 Section 5164.302(E)).

[7] HB 64 requires Ohio Medicaid to not enroll any new independent service providers after July 1, 2016; not renew independent providers whose certification is expiring after July 1, 2016; and no longer accept claims submitted by non-agency providers after July 1, 2019, except in cases of self-directed services.

[8] Direct Care Advisory Workgroup, *Report to the Ohio General Assembly* (December 2013).

[9] In-home care presents some of the greatest challenges in Medicaid related to preventing fraud and abuse. From 2010-2014, the Medicaid Fraud Control Unit of the Ohio Attorney General's Office (MFCU) received 1,473 referrals for home care-related Medicaid fraud. Of those, 634 (~43 percent) were tied to independent providers. During the same period, MFCU indicted 535 home care providers. Of those 535 fraud indictments, 335 (~63 percent) were for independent providers. From 2010-2014, 479 home care providers were criminally convicted, and independent providers accounted for 306 (~64 percent) of those convictions. During federal fiscal year 2014 (the most recent statistical data available), *in-home convictions accounted for 87 percent of all MFCU convictions.*