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 care. **HB 64 does not eliminate independent providers, but does clarify that the employer of record for a direct care worker must be either an individual who self-directs care or an agency, not the State of Ohio.**

HB 64 represents a significant opportunity to expand self-direction in Ohio and provide individuals more control over how care is provided. However, it requires making some changes to the program as it exists today. This document provides additional detail about the Administration’s goals, and proposes a process and timeline for dialogue to identify concerns, align common objectives, and fill in the detail required to implement expanded self-direction in Ohio.

The Administration is open to considering additional clarifying language that holds all participants accountable to our shared objectives, and reassures individuals who rely on these services that the goal is to expand choice and provide them with greater control over how care is provided.

**GOALS**

**Increase access to home and community based services.**

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 care 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. Use of Agency and Non-Agency Providers in Ohio Medicaid HCBS Waiver Programs](image)

77,561 Ohioans receive in-home services provided by direct care workers.
- 65,254 (84%) rely on home care agencies only
- 8,346 (11%) rely on independent non-agency providers only
- 3,961 (5%) rely on both

Source: Ohio Department of Medicaid (SFY 2014).

**Make self-direction an option in every HCBS waiver program.**

In recent years, self-direction has emerged as a game-changing strategy in organizing and delivering Medicaid-funded services. Self-direction refers to an approach to delivering HCBS that allows eligible individuals to directly control a range of services and supports – with the assistance of representatives of their choice – based on their own preferences and needs.

In a self-directed care model, individuals have the right and ability to assess their own needs, determine how and by whom those needs should be met, and evaluate the quality of the services they receive. Participants can choose who will work for them and schedule services according to their preferences. The goal of
self-direction is to maximize the participant’s opportunities to live independently in the most integrated community-based setting of his or her choice. Evidence indicates that individuals who self-direct their own care have fewer unmet needs and experience positive health outcomes and improved quality of life.\textsuperscript{3}

In Ohio, some individuals informally “self-direct” their care by hiring independent direct care workers to provide in-home care. 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, depending on the program design, 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 care gain access to services and 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 (\textit{SELF}, \textit{PASSPORT}, and \textit{MyCare Ohio}). The option for individuals to exercise both employer and budget authority has only been available statewide through the \textit{SELF} waiver since July 2013 and through \textit{PASSPORT} and \textit{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 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 care 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.)

To enforce the FLSA, there must be an employer of record. The majority of states and the federal Medicare program consider home care agencies and individual self-direction the only allowable employers of record. A few states (e.g., New York) regard direct care workers as state employees if they are not otherwise employed by an agency or an individual who self-directs care. Ohio may be the only state that has not adopted one of these models. However, the precedent is clear: Ohio does not serve as the employer of record for other health care providers, and the Administration would not choose to abandon that precedent.

The Executive Budget clarifies that the employer of record for a direct care worker must be either an individual who self-directs care or an agency, not the State of Ohio. It also establishes a timeline to transition independent direct care workers into employment by either an individual who self-directs care or an agency over the next four years, to be completed by July 1, 2019.
**Improve in-home direct care quality.**

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 care 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 care 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.

Based on the recommendation of the Advisory Workgroup, the Administration agreed to consider a rate increase for direct care 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 update the membership and reconvene the Direct Care Advisory Workgroup to (1) assist in the detailed design of self-directed options in each waiver, (2) revisit the recommendations for a direct care worker certification program and update if needed, (3) provide input on rate and other considerations related to compliance with the FLSA, and (4) assist to ensure meaningful consumer engagement and participation in all of these activities.

All of the goals described above – giving individuals more control, clarifying the employer of record, and certifying direct care workers – are intended to keep individuals safe and healthy while reducing opportunities for fraud and abuse. 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.

<table>
<thead>
<tr>
<th>Waiver</th>
<th>Enrollment 1</th>
<th>Self-Directed Users</th>
<th>Non-Agency and Agency Provider Users 2</th>
<th>Users of only Non-Agency providers</th>
<th>Users of only Agency providers</th>
<th>Users of both Non-Agency and Agency providers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>% of total enrollment</td>
<td>Number</td>
<td>% of total users</td>
<td>Number</td>
<td>% of total users</td>
</tr>
<tr>
<td>SELF</td>
<td>300</td>
<td>0.33%</td>
<td>176</td>
<td>0.06%</td>
<td>104</td>
<td>0.13%</td>
</tr>
<tr>
<td>Individual Options</td>
<td>18,183</td>
<td>0.28%</td>
<td>17,573</td>
<td>2.88%</td>
<td>14,233</td>
<td>18.35%</td>
</tr>
<tr>
<td>Level 1</td>
<td>14,180</td>
<td>0.27%</td>
<td>7,746</td>
<td>3.32%</td>
<td>4,678</td>
<td>18.35%</td>
</tr>
<tr>
<td>Ohio Home Care</td>
<td>10,046</td>
<td>0.50%</td>
<td>8,728</td>
<td>2.01%</td>
<td>5,920</td>
<td>7.63%</td>
</tr>
<tr>
<td>PASSPORT³</td>
<td>42,604</td>
<td>0.63%</td>
<td>37,478</td>
<td>0.70%</td>
<td>36,806</td>
<td>47.45%</td>
</tr>
<tr>
<td>Transitions Carve-Out</td>
<td>2,792</td>
<td></td>
<td>2,575</td>
<td>0.61%</td>
<td>1,746</td>
<td>2.25%</td>
</tr>
<tr>
<td>Transitions DD</td>
<td>3,085</td>
<td></td>
<td>2,811</td>
<td>1.09%</td>
<td>1,415</td>
<td>1.82%</td>
</tr>
<tr>
<td>Non-waiver PDN</td>
<td>478</td>
<td></td>
<td>474</td>
<td>0.09%</td>
<td>352</td>
<td>0.45%</td>
</tr>
<tr>
<td><strong>Statewide Total</strong></td>
<td><strong>90,824</strong></td>
<td><strong>0.95%</strong></td>
<td><strong>77,561</strong></td>
<td><strong>10.76%</strong></td>
<td><strong>65,254</strong></td>
<td><strong>84.13%</strong></td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Types of Authority</th>
<th>Financial Management Services Responsibility&lt;sup&gt;1&lt;/sup&gt;</th>
<th>Participant Decision Making Authority&lt;sup&gt;2&lt;/sup&gt;</th>
</tr>
</thead>
</table>
| **Co-Employment:** | - 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. |
| **FMS/Agency is common law employer of workers recruited by participant. Participant directs workers and is co-employer. (Agency with Choice Model)** | - 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. | |
| **Common Law Employer:** | | 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. |
| Participant is legally responsible employer of workers he/she hires, supervises and discharges directly. Participant is responsible for employment-related tasks. | |

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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.

<table>
<thead>
<tr>
<th>Types of Authority</th>
<th>Financial Management Services Responsibility¹</th>
<th>Participant Decision Making Authority²</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>Acts as fiscal/employer agency. &lt;br&gt; Serves as neutral bank, receiving and disbursing public funds, tracking and reporting on participant’s budget. &lt;br&gt; Processes/pays invoices for goods/services in the participant’s approved service plan. &lt;br&gt; Prepares and distributes budget/expenditure reports to participants and other entities specified in the waiver.</td>
<td>Employment-related functions the participant may perform under budget authority include, but are not limited to: &lt;br&gt; - Reallocating funds among services in budget. &lt;br&gt; - Determining wages for services within State’s established limits. &lt;br&gt; - Substitute providers. &lt;br&gt; - Scheduling. &lt;br&gt; - Specifying additional provider qualifications consistent w/waiver service qualifications. &lt;br&gt; - Specifying how services are provided consistent w/service specifications. &lt;br&gt; - Identifying providers/referring for provider enrollment. &lt;br&gt; - Authorizing payment for goods/services. &lt;br&gt; - Reviewing/approving provider invoices for services rendered.</td>
</tr>
</tbody>
</table>

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.


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.” 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.