HOUSE BILL REPORT
ESSB 6199

As Reported by House Committee On:
Health Care & Wellness
Appropriations

Title: An act relating to the consumer directed employer program.

Brief Description: Concerning the consumer directed employer program.

Sponsors: Senate Committee on Health & Long Term Care (originally sponsored by Senators Cleveland, Conway, Miloscia, Keiser and Fortunato; by request of Department of Social and Health Services).

Brief History:
Committee Activity:
Health Care & Wellness: 2/20/18, 2/23/18 [DP];
Appropriations: 2/24/18, 2/26/18 [DP].

Brief Summary of Engrossed Substitute Bill

- Authorizes the Department of Social and Health Services to contract with a consumer directed employer (CDE) to be the legal employer of individual providers and perform administrative functions related to providing personal care, respite care, and other services to individuals with functional disabilities.
- Retains the role of the person receiving the services of an individual provider as the managing employer with the authority to select, hire, schedule, supervise, and dismiss an individual provider.
- Establishes a rate-setting board and a process to set labor rates for payments to individual providers and an administrative rate to be paid to the CDE.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: Do pass. Signed by 9 members: Representatives Cody, Chair; Macri, Vice Chair; Clibborn, Jinkins, Riccelli, Robinson, Slatter, Stonier and Tharinger.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

Minority Report: Do not pass. Signed by 8 members: Representatives Schmick, Ranking Minority Member; Graves, Assistant Ranking Minority Member; Caldier, DeBolt, Harris, MacEwen, Maycumber and Rodne.

Staff: Chris Blake (786-7392).

Background:

Personal Care Services.
The Department of Social and Health Services (Department) provides publicly funded personal care services to eligible clients who live in their own home and are elderly or have developmental disabilities. The Department assesses these clients (consumers) to determine the level of their in-home care needs. Personal care services include assistance with various tasks such as toileting, bathing, dressing, ambulating, meal preparation, and household chores. There are two ways in which personal care services may be provided in the client's home: (1) by an individual provider; or (2) by an employee of a home care agency.

Individual Providers.
An individual provider is a person who has contracted with the Department to provide personal care or respite care to functionally disabled persons under a state program. There are currently over 38,000 individual providers in Washington serving almost 38,000 Department clients. Consumers have the right to select, hire, supervise the work of, and terminate any individual provider providing services to them. Individual providers are paid through a direct contract with the Department. Individual providers are considered public employees solely for the purpose of collective bargaining which determines their wages, hours, and working conditions. Individual providers, however, are not otherwise considered employees of the state or area agencies on aging (AAAs).

In 2014 the United States Supreme Court (Court) invalidated provisions of a state law very similar to Washington's permitting individual provider collective bargaining agreements. The Court held that the "state employees for only purposes of coverage under Illinois state labor law" did not work to extend a legal exception permitting the state to deduct mandatory "fair share" representation fees from "full-fledged" public employees to the individual providers without individual consent. As individual providers are mainly private employees of the recipients of home care services, not the state, the Court determined that the state could not compel individual providers funding of union representational activities under the First Amendment. Neither the ruling on collecting representation fees from Illinois individual providers, nor the related prior ruling on public employees, impact the ability of private sector labor agreements to contain representation fee or other union security provisions.

Area Agencies on Aging.
The Department contracts with AAAs to provide case management services to consumers receiving home and community services in their own home. Case management responsibilities are set in statute and include the following: verification that individual providers have met training requirements, are performing their duties, and have passed background checks; monitoring a plan of care to verify that it meets the needs of the consumer; and verifying worker time sheets.

Summary of Bill:

The Department of Social and Health Services (Department) is authorized to establish a consumer directed employer (CDE) program. A CDE is a private entity that contracts with the Department to be the legal employer of individual providers for the purpose of administrative functions related to providing personal care, respite care, and similar services to individuals with functional impairments under Medicaid programs. A CDE is patterned after the "agency with choice" model recognized by the federal Centers for Medicare and Medicaid Services for financial management in consumer directed programs. The consumer receiving services is considered to be the managing employer of the individual provider. Individual providers are not to be deemed state employees or vested in the state public employer retirement system. The Department is directed to begin the transition of individual providers to the CDE no later than July 1, 2021.

Authority and Responsibilities of a Consumer Directed Employer.
A CDE's responsibilities generally include coordination with the consumer, establishment of wages and benefits on behalf of individual providers, tax activities on behalf of individual providers, verification of individual provider qualifications, and other administrative and employment-related supports. As the legal employer of individual providers, a CDE must specifically:

- verify that individual providers meet necessary training requirements;
- conduct background checks on individual providers or verify that previously conducted background checks are still valid;
- implement an electronic visit verification system or monitor a statistically valid sample of individual provider claims to the receipt of services by the consumer;
- monitor individual provider compliance with employment requirements;
- provide a copy of the consumer's plan of care to the individual provider;
- verify that the individual provider is able and willing to carry out his or her responsibilities under the plan of care;
- consider information provided by the consumer, or the consumer's case manager, about the consumer's specific needs;
- discontinue the individual provider's assignment to a consumer if the CDE has reason to believe, or the Department or area agencies on aging (AAAs) has reported, that the health, safety, or well-being of a consumer is in imminent jeopardy due to the performance of the individual provider;
- reject requests by consumers to assign a particular individual provider if the CDE has reason to believe that the individual provider will not be able to meet the care needs of the consumer; and
- establish a dispute resolution process for consumers who would like to dispute a CDE decision not to allow a particular individual provider to be assigned to the consumer.

A CDE that holds a contract with the Department to provide Medicaid services through the employment of individual providers is deemed to be a Medicaid provider.

The CDE assumes the responsibility from the Department for maintaining a referral registry to assist consumers in finding individual providers.

Authority and Responsibilities of the Department.
The Department is authorized to establish a CDE program by selecting a single CDE to be a Medicaid provider and to coemploy individual providers. The Department must attempt to select a single CDE, but may select up to two CDEs, if necessary.

The Department must seek to contract with a vendor that demonstrates: (1) a strong commitment to consumer choice, self-direction, and maximizing consumer autonomy and control over daily decisions; and (2) a commitment to recruiting and retaining a high quality and diverse workforce and working with a broad coalition of stakeholders. The Department may also consider the vendor's:

- ability to provide maximum support to consumers to direct their own services;
- commitment to engage and work closely with consumers in designing and implementing operations through an advisory board;
- focus on workforce retention and developing qualified and trained providers;
- ability to prevent or mitigate disruptions to consumer services;
- ability to deliver high-quality training, health care, and retirement;
- ability to comply with the terms and conditions of the employment of individual providers at the time of transition;
- commitment to involving its home care workforce in decision making;
- vision for including home care workers as valued members of the consumer's care team; and
- ability to build and adapt technology tools that can enhance efficiency and provide better quality of services.

The Department may take enforcement action against the contract of a CDE that knowingly employs a long-term care worker who is not certified as a home care aide or, if exempt from certification, who has not met training requirements.

The Department shall continue to contract with individual providers until the transition to a CDE is complete, at which time the Department may not contract with individual providers except in situations in which there is no CDE available. The Department must perform background checks for these individual providers. The individual providers who contract with the Department continue to be considered public employees solely for the purpose of collective bargaining.

It is expressly stated that the bill does not modify the Department's authority to establish a plan of care for each consumer, including establishing the number of hours per week that a consumer may assign to a single independent provider. In addition, the Department retains the core responsibility to manage long-term in-home care services, including determining the level of care that each consumer is eligible to receive.

Authority of Area Agencies on Aging.
The general case management responsibilities of AAAs are maintained. The AAAs, however, must conduct the following activities with respect to individual providers who are contracted with the Department, rather than those who are employed by the CDE:

- verification of individual provider training requirements;
- attachment of the consumer's plan of care to the contract with the individual provider;

- performance of criminal background checks;
- termination of the contract if the individual provider's inadequate performance or inability to deliver quality care is jeopardizing the consumer;
- summary suspensions of individual providers who place a consumer in imminent jeopardy;
- monitor that the individual provider is providing services;
- verify that the individual provider is willing to carry out the responsibilities under the plan of care; and
- reject requests by consumers to assign a particular individual provider if there is reason to believe that the individual provider will not be able to meet the care needs of the consumer.

Regardless of whether the individual provider is employed by the CDE or contracted with the Department, the AAAs maintain their general responsibilities related to developing plans of care for consumers, monitoring the implementation of plans of care, reassessing and reauthorizing services, and explaining to consumers that they have the right to waive case management services.

The Department and the AAAs are given the general responsibility to notify the CDE if there is reason to believe an individual provider is not delivering or will not be able to deliver services identified in the consumer's plan of care, or the individual provider's performance is jeopardizing the health, safety, or well-being of a consumer.

The list of specific requirements that must be in a consumer's plan of care is eliminated.

Individual Providers.
Qualified and willing individual providers may apply to become employees of the CDE and may work as individual providers when selected by consumers. Whether an individual provider is employed by a CDE or contracted with the Department, the consumer has the right to select, schedule, supervise the work of, and dismiss any individual provider. The CDE and the Department, however, may refuse to employ an individual provider who may not be able to meet a consumer's needs, assign individual providers to different consumers, provide information to a consumer about an individual provider's work history, or terminate the employment of an individual provider who is not meeting the consumer's needs.

The Department must adopt rules describing criteria to be applied in determining whether a single Department-contracted individual provider may work more than 40 hours per week. The criteria relate to: (1) limiting the state's exposure to exceeding expenditure limits; (2) requiring consumers to use good faith efforts to locate other individual providers; (3) addressing travel time between worksites; (4) addressing the emergency needs of consumers; and (5) addressing conditions that could increase a consumer's risk of institutionalization.

Background check screening is not required for a CDE employee if the employee has an individual provider contract with the Department, the last background check is still valid, CDE employment is the only reason a new background check would be required, and the Department's background check results have been shared with the CDE.

Payment Rates and Overtime for Individual Providers.

Initial labor rates for individual providers employed through a CDE are established as the rates paid under the most recent collective bargaining agreement between the Governor and the Service Employees International Union 775, as well as any other legally required benefits or labor costs.

After the initial labor rates are set, subsequent labor rates, including an amount for health benefits, are to be established by a rate-setting board. The rate-setting board must consider current factors used in public employee collective bargaining related to individual providers, such as a comparison of wages; the financial ability of the state to pay for the compensation and fringe benefits; the state's interest in a stable long-term care workforce; the state's interest in assuring access to affordable, quality health care; and the state's fiscal interest in reducing reliance upon public benefit programs. The rate-setting board must also determine the administrative rate for the CDE.

The rate-setting board is comprised of 14 members. The four voting members are: (1) a representative of the Governor's office; (2) a representative of the Department; (3) a representative of the CDE; and (4) a representative of the exclusive bargaining representative of individual providers, or if none exists, a designee from the CDE's workforce. Nine of the nonvoting members include four legislators, a representative of the State Council on Aging, a representative of an organization representing people with intellectual disabilities, a representative of an organization representing persons with physical disabilities, a representative of the licensed home care agency industry, and a home care worker. The fourteenth member must be selected by the four voting members and will chair the rate-setting board and be the fifth voting member in the event of a tie. A process is established for selecting the fourteenth member in the event that the four voting members cannot agree.

Once the rates have been determined, the rate-setting board shall submit them to the Office of Financial Management for certification as financially feasible. If they are found to be financially feasible, the Governor must include them in his or her budget request. The Legislature may approve or reject the request in whole. If the rates are rejected, then the matter returns to the rate-setting board and the existing labor rates remain in effect.

The labor rates are an hourly rate to be paid to the CDE for paying wages, taxes, and benefits to individual providers. The CDE, however, has discretion to establish benefits and wages for individual providers, except as needed to pay for health benefits, as specific legislation requires, and according to a collective bargaining agreement. Funding for the training of individual providers must be included in the labor rate component.

In addition, overtime and travel time compensation considerations are factored into the reimbursement to the CDE. The CDE must permit an individual provider to work more than 40 hours per week if allowed under the Department's rules for Department-contracted individual providers. The CDE may permit an individual provider to work additional hours if required for training or if the individual provider had been working between 40 and 65 hours per week in January 2016. Otherwise, the CDE may allow the individual provider to work more than 40 hours per week.

Expenditures for hours worked beyond 40 hours per week may not exceed 8.25 percent of the total actual authorized personal care hours as projected by the Caseload Forecast Council.

The Department must prepare expenditure reports related to its monitoring of authorizations and costs over 40 hours each work week. The report must be submitted to the legislative fiscal committees and the Joint Legislative-Executive Overtime Oversight Task Force.

Funding Reductions.
Once the Department enters into a contract with a CDE and the transition to the CDE is complete, biennial funding for the subsequent biennium must be reduced by no more than:

- $2.908 million for AAAs;
- $1.361 million for home and community services; and
- $1.289 million for developmental disabilities.

Findings.
Legislative findings are made regarding in-home care services allowing people to choose to stay in their homes and being less costly than institutional care. Additional findings state that a CDE program will support consumers in directing their care, allow the state to focus on case management services, enhance the efficiency in the delivery of services, eliminate the possible classification of the state as a joint employer of individual providers, prevent the use of hospitals and institutions, and support the enhancement of home care worker skills.

Appropriation: None.

Fiscal Note: Available. New fiscal note requested on February 13, 2018.

Effective Date: The bill takes effect 90 days after adjournment of the session in which the bill is passed.

Staff Summary of Public Testimony:

(In support) According to a national scorecard, Washington has the best long-term services and supports system in the nation. Between 1999 and 2016 Washington has saved over $4.5 billion by serving people in the setting of their choice as opposed to more restrictive settings. The complexity of managing the individual provider workforce has increased significantly due to additional regulations, training requirements, and benefit coordination. The ability of case managers to spend time doing case management with the clients has been eroded by all of the additional obligations to assure that administrative requirements are met for the individual provider workforce. This bill is about giving case managers more time to spend with consumers. As people are living longer, the medical complexity of people in home care increases, and there needs to be adequate case management time to do service planning and assessment. The area agencies on aging (AAAs) provide the case management which is the quality assurance that keeps clients safe in their homes. The AAAs have nurses and social workers who visit clients at home, assess their need for long-term care, and design plans of care. The AAAs have an unfunded mandate to do all of the employment paper work for individual providers which is not central to the AAA's central mission to keep clients safe at home. The AAAs would like to get rid of the administrative functions and relieve this paperwork burden on case managers and they are the core to keeping the system sound.

The intent of this bill is to assure that after the transition to a consumer directed employer, consumers will keep the same rights that they have today, such as selecting a provider, supervising the hours, and directing care. The "difficulty of care" tax emption will continue and will not be changed by the bill. Moving payroll and administration to a private entity that has greater expertise in managing such activities will help improve what has been a challenging payroll system. This bill will help alleviate several of the challenges that caregivers have faced with overtime. The current administrative system needs to change because of workload issues and problems with Individual ProviderOne.

(Opposed) Families support the idea of case managers having less paperwork and more time to do case management; however, families provide the bulk of care for their children and do not want to see money spent on something that has no accountability when so many families are struggling with minimal or no services. It is already difficult to hire individual providers and this bill adds more barriers. This bill will allow individual providers to strike, even though many clients need continuity of care. The rate-setting board should include a consumer or somebody representing individuals with developmental disabilities.

The bill does not address the issues that parents have with using Individual ProviderOne, particularly around the issue of overtime. Parents want assurance that the bill will not change the tax status of parent providers who receive "difficulty of care" payments, which are currently tax-free. Parents are concerned about having to join a union and some want to continue to have the ability to opt-out.

Parent providers are concerned about the electronic verification system and how they will check-in and check-out of their own home. Because electronic visit verification systems are GPS-driven, parent providers are concerned about the privacy of their children, and they want to be sure that their civil rights are protected.

(Other) The language in the bill harms the consumer's potential to direct their care and minimizes the position of a person with a disability. The bill should not call the consumer directed employer (CDE) the primary employer and should keep it in an administrator role only so that the consumer is not undermined. The Department of Social and Health Services addressed concerns about the CDE becoming an entity that would get in the way of consumers directing their own care, as opposed to being an entity that would assist consumers. As long as the CDE is just an administrative body, this bill makes sense. A better name for the CDE would be a "consumer directed administrator." It would make sense to have consumers more involved in the process, particularly on the rate-setting board.

Going from 8.75 percent overtime use to 8.25 percent, plus flexibility, is fine if consumers have the right to assign 65 hours to the individual provider of their choice. Consumers should be given access to Individual ProviderOne. High users of services should be able to assign overtime as they see fit. Personal information that is in the individual care plan should only be given to an individual provider when authorized by the consumer or his or her representative.

Persons Testifying: (In support) Bill Moss, Aging and Long-Term Support Administration; Kate White Tudor, Washington Association of Agencies on Aging; Adam Glickman, Service Employee International Union 775; and Rhonda Parker.

(Opposed) Betsy McAlister; and Cathy Murahashi.

(Other) Nathan Loose; and David Lord, Disability Rights Washington.

Persons Signed In To Testify But Not Testifying: Emerick Leslie; Loren Freeman; Diana Stadden, The Arc of Washington; Becky Bisbee; John Ficker, Adult Family Home Council; Maxford Nelsen, Freedom Foundation; and Tammy Shipler.

HOUSE COMMITTEE ON APPROPRIATIONS

Majority Report: Do pass. Signed by 18 members: Representatives Ormsby, Chair; Robinson, Vice Chair; Bergquist, Cody, Fitzgibbon, Hansen, Hudgins, Jinkins, Kagi, Lytton, Pettigrew, Pollet, Sawyer, Senn, Springer, Stanford, Sullivan and Tharinger.

Minority Report: Do not pass. Signed by 15 members: Representatives Chandler, Ranking Minority Member; MacEwen, Assistant Ranking Minority Member; Stokesbary, Assistant Ranking Minority Member; Buys, Caldier, Condotta, Graves, Haler, Harris, Manweller, Schmick, Taylor, Vick, Volz and Wilcox.

Staff: Mary Mulholland (786-7391).

Summary of Recommendation of Committee On Appropriations Compared to Recommendation of Committee On Health Care & Wellness:

No new changes were recommended.

Appropriation: None.

Fiscal Note: Available.

Effective Date: The bill takes effect 90 days after adjournment of the session in which the bill is passed.

Staff Summary of Public Testimony:

(In support) Consumers can expect more time with their case managers on person-centered care plans, and consumers will retain the right to select employers. There will be better health outcomes and costly hospitalizations will be avoided.

The state can expect continued savings by supporting in-home services. The cost for a consumer-directed employer (CDE) program includes the cost of implementing an electronic visit verification program for individual providers, which is a new federal requirement for which the state is responsible.

It is important to get case managers back to case management. Area agencies on aging (AAAs) hire case managers who provide risk mitigation and quality assurance for in-home care clients. Increasingly, clients have dementia or other behavioral health challenges in their lives. Case managers are the front line protection against client abuse and neglect. They need to be able to pay attention so that risks can be identified, and not be distracted by paperwork. The case manager needs to be available to help developmentally disabled clients navigate the world. The state has the option of increasing case management capacity or getting a contracted vendor to perform administrative work. There is a structural solution that will give AAAs approximately $10 million in relief. Case management ratios for AAA case managers are often in the eighties or higher.

There are some folks who are concerned about losing the current opt-out provision for union membership. When individual providers transition to a CDE, the National Labor Relations Act will apply. Individual providers may choose to join the union or may elect to pay a representative fee.

One individual received a late payment last year and lost her healthcare for a month due to issues with the Individual Provider One (IP1) payment system. As a result, she had to pay significant out-of-pocket costs for medication. In contrast, the same provider today was able to recover from a stroke with adequate health care because she has consistent access to health insurance. The story conveys the urgency of the issues.

(Opposed) There would be a significant overhaul of the in-home caregiver system, but there is a lot of vagueness and unknowns over how the transition would take place. Another entity would be added into the mix at a cost to taxpayers. The transition to CDE would significantly disrupt the lives of caregivers and their families. It took about two years to get the bugs worked out of the IP1 system, and many caregivers had difficulty getting paid on time as a result of the rollout. The proposed transition would be longer and more disruptive than IP1, and there are no compelling reasons to make the change. A significant motivation is to increase union membership by making individual providers into private sector employees. Financial support to the union could become a condition of employment. A proposed amendment would carry over individual providers' existing right to opt out of union membership and dues if they choose.

Persons Testifying: (In support) Bill Moss, Aging and Long-Term Support Administration, Department of Social and Health Services; Kate White Tudor, Washington Association Agencies on Aging; Lani Todd, Service Employees International Union 775; and Ed Solseng.

(Opposed) Maxford Nelson, Freedom Foundation.

Persons Signed In To Testify But Not Testifying: None.