DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Liggett	12-31-13

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000207	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR _____ cc: Kost	[ ] Prepare reply for appropriate signature DATE DUE _____ [ ] FOIA DATE DUE _____ [X] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

Brenda James

From: Jan Polatty
Sent: Tuesday, December 31, 2013 10:27 AM
To: Peter Liggett
Cc: Annmarie McCanne; Brenda James; Bryan Kost; Joshelyn James
Subject: FW: NAMD Memo: Regulatory Update on HCBS Related Rules
Attachments: NAMD memo HCBS DOL update 131223.docx; ANCOR Companionship Exemption Rule Analysis oct13.pdf; NASDDDS oped FP 08-2013.pdf

Pete – TK may have sent this to you.... I will ask Brenda to log for documentation. Thanks, Jan.

Jan Polatty
Administrative Coordinator II
POLATTYJ@scdhhs.gov
803.898.2504
cell: 803-351-6126
1801 Main Street
Columbia, SC - 29201
www.scdhhs.gov

SOUTH CAROLINA Healthy Connections MEDICAID

From: Andrea Maresca [mailto:andrea.maresca@namd-us.org]
Sent: Monday, December 23, 2013 3:06 PM
Cc: Matt Salo; Andrea Maresca
Subject: NAMD Memo: Regulatory Update on HCBS Related Rules

To All State Medicaid Directors:

We know many of you are already enjoying some much needed vacation. However, before the year ends, we wanted to bring your attention to two notable federal-level activities related to long term services and supports and home and community-based services. The first is the forthcoming Center for Medicare & Medicaid Services (CMS) regulation concerning home and community based services. The other is a Department of Labor (DOL) rule issued earlier this Fall that will impact wages for home-based services in certain states.

The Administration has signaled that it will shortly release a rule to finalize the remaining provisions of CMS regulations for 1915(c) waivers, 1915(i) state plan amendments and the 1915(k) community first choice option. No specific date has been set, but it could be issued before the end of the year. The rule is intended to align and provide certainty around the federal definition for a home and community-based (HCB) setting. While state Medicaid agencies will need to review the entirety of the regulation once issued, we expect that the provisions around the characteristics of a HCB setting will be of particular interest and focus for states.

The attached memo provides Medicaid Directors and staff with context and insight that we hope will help you plan for and implement the rules. We will continue to notify you of major developments on these issues in the future. You may contact me with questions [andrea.maresca@namd-us.org].

Wishing you all the best this holiday season.

-Andrea
Andrea Maresca
Director of Federal Policy and Strategy
National Association of Medicaid Directors
444 North Capitol St, #524
Washington, DC 20001
202.403.8623
www.medicaiddirectors.org

Jan Polatty

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Bruce,

Please log to Pete for documentation

—

I sent electronically to: Pete, Annie Bryan, Joslelyn & TK.

Thx!

12/31

NAMD
National Association of Medicaid Directors

To: All Medicaid Directors
From: NAMD Staff
Re: Federal Regulatory Action on LTSS Issues
Date: December 23, 2013

We wanted to bring your attention to two notable federal-level activities related to long term services and supports and home and community-based services. The first is the forthcoming Center for Medicare & Medicaid Services (CMS) regulation concerning home and community based services. The other is a Department of Labor (DOL) rule issued earlier this Fall that will impact wages for home-based services in certain states.

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HCBS Regulation: Overview

The Administration has signaled that it will shortly release a rule to finalize the remaining provisions of CMS regulations for 1915(c) waivers, 1915(i) state plan amendments and the 1915(k) community first choice option. The rule is intended to align and provide certainty around the federal definition for a HCB setting. No specific date has been set, but it could be issued before the end of the year. While state Medicaid agencies will need to review the entirety of the regulation once issued, we expect that the provisions around the characteristics of a home and community-based (HCB) setting will be of particular interest and focus for states.

NAMD has been in close contact with CMS and other stakeholders to discuss and plan for the forthcoming rule. The following sections summarize some of the key themes and activities we believe states can anticipate pertaining to the definition of HCB setting.

Preliminary Outlook. The forthcoming rule addresses issues that have been highly controversial for the Administration and a high priority for the provider, consumer and patient advocacy groups and other stakeholders. CMS has worked closely with its sister agencies in the Department and very closely with the Department of Justice. The rule is intended to align and provide certainty around the federal definition for a HCB setting.

Senior CMS staff have signaled that they anticipate many states – and providers and consumers – will be "relieved" of what they were most concerned about in the proposed regulation. NAMD also anticipates that CMS will leverage the rule and its roll-out to send a very strong message about what it means to be in a HCB setting.

Further, NAMD has learned that the rule will raise the bar high enough that there will be some states or providers challenged by the new standards. States may wish to be similarly prepared to respond to the positive aspects of the rule, highlight your ongoing work to meet the intent of the rule, and manage expectations about the intensity of any additional work that may be needed to come into compliance.

Based on the NAMD staff's conversations with CMS officials, it is our impression they have spent considerable time trying to define what it will mean for states to come into compliance. We anticipate that the final rule will lay out CMS' compliance framework and approach for working with states. More specifically, we expect it will address a process for states to assess their current status with regard to HCB setting characteristics. As needed, CMS will work with states on a process, including a timeline and glide path, for coming into compliance. While we expect these are state specific discussions, we also expect CMS to require a prompt transition among all affected states. If states encounter particular challenges in meeting the needs of consumers and coming into compliance, Medicaid agencies – and sister state agencies as appropriate -- will need to work closely with CMS on a plan to address them.

Issues for Consideration

At this time, we do not have specific insight into how CMS has modified the rule. However, should Medicaid staff find it helpful, you may wish to review the proposals other states recently negotiated with CMS.

As one example, Florida recently worked with CMS to obtain approval for its Medicaid managed long term care 1915(c) waiver. The application is posted here: http://ahca.myflorida.com/medicaid/statewide_mc/pdf/LTC_1915c_Application.pdf

The parts that are most relevant to the home and community-based characteristics are:

- p. 98, starting at the 2nd paragraph
- p. 125-127 –section ii
- p. 147-151 – section d

NAMD has begun to identify other issues states may need to consider as they read the forthcoming rule and enter into discussions with CMS. These issues may include, but are not limited, to the following:

- Sufficiency of timelines for incorporating changes into the state plan or waiver and implementing prior to go-live;
- Sufficiency of time to prepare providers and develop and conduct training;
- Expectations for person-centered planning and what constitutes compliance with this requirement;
- Expectations and guidance for negotiated risk agreements; and
- Opportunity to respect the individual's choice of living arrangement and facilitate continuity of care, even if it does not meet the HCB setting parameter.

Roll Out

CMS has also focused on the federal agency's roll-out and implementation plan, including its ongoing role to ensure compliance. We expect that CMS will launch a more robust roll-out for this rule as compared to previous efforts. In particular, CMS is focused on identifying those issues for which it expects states will be challenged to come into compliance and how it plans to work with states to do so. Agency staff also have acknowledged that they anticipate many other complex issues will come to light in their discussions with individual states. They are working to incorporate this dynamic in the roll-out and technical assistance plans.

DEPARTMENT OF LABOR FLSA RULE: BACKGROUND

On September 17, the U.S. Department of Labor's Wage and Hour Division announced a final rule expanding the Fair Labor Standards Act's (FLSA) minimum wage and overtime protections to direct care workers. This rule was highly controversial and continues to be the subject of congressional inquiries.

The impact for state Medicaid programs will vary depending on the design of their programs. It also may vary across a single state's programs for older adults and individuals with disabilities. As compared to the HCB rule, patient and consumer advocacy groups raised strong concerns about the direct and indirect impact the DOL rule will have for the Medicaid program and consumers with intense disability-related service needs. In addition, we are aware that groups in some states have already begun to mobilize to pursue legal action.

Based on NAMD's own analysis and our conversations with officials within the U.S. Department of Health and Human Services (HHS), we believe all state Medicaid agencies should review the final rule and assess any implications for their respective programs. Our conversations with CMS reinforce the need for states to confirm their compliance with the new DOL rule. Further, the federal agencies lack good data on the number of states that refer to personal care attendants as companions. We expect they

will work with states to better understand the terminology and roles of providers included in state plan programs and waivers.

CMS has stated that it wants to work with states to minimize disruptions that may stem from any changes they may make to the Medicaid program. States may not need to file a change, unless the change is fundamental to the program. States should work with CMS to determine if a filing is required. States may decide to take a gradual approach and monitor programmatic impacts from any changes that are made, including by temporarily slowing enrollment in programs. CMS has advised that slowing enrollment on a permanent basis could trigger ADA compliance issues.

CMS may raise these issues with states in conjunction with discussions on other HCBS issues, including the forthcoming HCB setting rule. However, of note, this is a DOL rule. The DOL and the Department of Justice are responsible for oversight and enforcement, and as such, states may be subject to litigation.

Key Provisions

Should it be helpful to you enclosed with this memo is a more detailed summary of the regulation produced by the national ANCOR group. Please be mindful that this is intended for internal state Medicaid agency use only. In addition, you may also be interested in the enclosed opinion piece written by the Executive Director for the National Association for State Developmental Disability Directors (NASDDD). Her piece highlights some of the program issues the DOL rule raises.

It is notable that the rule does not take effect until January 1, 2015. NAMD – along with other state associations and HHS – requested an extended implementation date to accommodate the range and intensity of changes that this rule could require, including identification of necessary modifications, capacity building, and worker training.

CMS, and its partners at the Administration for Community Living (ACL), have been using the time thus far to work with their DOL colleagues to unpack the complex issues in many state programs.

Issues for Consideration

DOL has significantly narrowed the exemption for the FLSA. This is particularly true for Medicaid programs, because it is not likely that state programs are paying only for companionship services. Because most states have minimum wage statutes, the bigger challenge may be the new policy to extend overtime pay requirements to certain Medicaid service providers.

NAMD
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The following questions are intended to help guide the state Medicaid agency's initial review of its HCBS programs in light of the DOL rule. Please note, this is not a comprehensive account of the potential issues that could impact each individual state's various programs.

- Are there differences in how the program is designed in your state plan and how it is administered by the operating agency, if applicable?
- If the state allows for "companionship" services, what services are permitted?
    - To what extent do the activities performed fall in the "incidental" category as defined in the DOL rule? In other words, are these workers actually providing personal care services per the DOL definition?
    - If such workers exceed 20 hours of care, are they receiving OT compensation, when applicable? Or does your state already limit the number of hours worked?
    - Will the state newly pay OT or restrict workers to 40 hours? If so, what are the programmatic and financial implications? Will you need to modify enrollment capacity? Will you need to hire and train more workers? What, if any, program design changes may be needed?
- Does your state currently utilize a co-employer model (i.e. home care staffing agencies) for provision of personal care services?
- If so, has your state undertaken an assessment to determine whether or who is the co-employer, particularly in consumer directed models?
    - If so, what if any modifications are needed to comply with the DOL's compensation rules since third party employers are no longer permitted to claim the exception for companionship services for live-in domestic service workers?
    - Will your state need to redesign its program? Will this require a state plan amendment?
    - Are additional workers required to meet the needs of Medicaid clients? What is the timeline for hiring and training?
    - Does this arrangement still qualify for the exemption?
    - If your state intends to transition away from a co-employer design, will you need to file a SPA/waiver? What, if any, disruptions might this create for consumers?
    - Does your state need to make changes for the consumers and their workers?
    - What other financial and programmatic impact might any changes have?
- If your state has a consumer directed program, have you assessed your state's compliance with the DOL rule for arrangements that include live-in workers? For transportation time between clients?

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Roll Out

DOL has created a state –specific resource page. They've also held two webinars to date. Information about the rule and compliance assistance materials can be found at www.dol.gov/whd/homecare.

NAMD'S ROLE

NAMD continues to work with our sister state associations representing the aging and disability and developmental disability directors to assess and respond to the rules referenced above and related issues on an ongoing basis. For example, we are currently working with them to help inform CMS' roll out and technical assistance plans for the HCB setting rule. We also issued a joint statement with these groups in response to the DOL rule and continue to work together to understand the impact to states' programs. In addition, NAMD has met with officials at the Office of Management and Budget to convey specific concerns with the rules and to make recommendations on the implementation timelines and technical assistance needs.

NAMD will continue to address several outstanding questions and needs related to LTSS, including the following:

- Understand how to design sustainable LTSS programs;
- Develop and apply measures appropriate to these programs; and
- Set expectations consistent with the magnitude of change required in the marketplace.

NAMD expects the federal level focus on Medicaid long term services and supports to intensify in the years ahead. We will continue to highlight the significant headway states have made in transitioning their programs to focus on the individual needs of each enrollee.

ANCOR American Network of Community Options and Resources

SHAPING POLICY • SHARING SOLUTIONS • STRENGTHENING COMMUNITY

To: ANCOR Membership *(PROPRIETARY AND CONFIDENTIAL – Do not distribute)*
From: Katherine Berland, Esq., Director of Government Relations
Date: October 8, 2013
Re: Department of Labor Final Rule RIN 1235-AA05, Application of the Fair Labor Standards Act to Domestic Service

INTRODUCTION

On September 17, 2013, the Department of Labor (DOL) issued final rule RIN 1235-AA05[1], which alters the application of the Fair Labor Standards Act (FLSA) to domestic service. The rule will go into effect on January 1, 2015. Of particular interest to ANCOR members is the way the rule changes the "companionship exemption", which has previously exempted individuals who provide companionship services from wage and overtime laws that apply to other workers. ANCOR will hold a session at its Leadership Summit: *Workforce Matters*, November 19, 2013, that will focus on the changes to the companionship exemption[2].

This analysis was prepared to inform ANCOR members of changes in the rule and the potential impact on various service delivery models used by providers of services to individuals with significant disabilities. This document should not be construed or relied upon as legal advice on any specific facts or circumstances.

ANCOR submitted comments during the comment period prescribed by the Notice of Proposed Rule Making (NPRM) in 2011[3]. In addition, ANCOR submitted a letter to the Office of Management and Budget (OMB) in 2013, during the period the rule awaited finalization, requesting that the OMB return the rule to DOL for further financial impact analysis prior to finalization and, if the rule was to be finalized as proposed, requesting the rule to provide for a three year implementation period. ANCOR reiterated these requests to the DOL at an invitational listening session with Secretary of Labor Thomas

[1] The final rule had not been published in the Federal Register as of the publication date of this paper. The rule is available in electronic format at http://www.dol.gov/whd/homecare/final_rule.pdf.
[2] For more information on the 2013 Leadership Summit, visit http://www.ancor.org/training-events/2013-ancor-leadership-summit-workforce-matters.
[3] 76 FR 81130, *available at* http://www.gpo.gov/fdsys/pkg/FR-2011-12-27/pdf/2011-32657.pdf.

Perez. The DOL received more than 26,000 comments on the proposed rule from various stakeholders, and makes specific reference to ANCOR's comments, as well as those from several other organizations.

This paper contains several parts. It begins with a high-level summary of changes, followed by the history of the companionship exemption in the FLSA, DOL's stated purpose in revising the regulations, detailed analysis of each topic area of changes within the rule, followed by a conclusion. Detailed analysis begins on page 6.

SUMMARY OF CHANGES

The new rule is split into four sections: 1) Domestic Service Employment/Private Home, 2) Companionship Services, 3) Live-In Domestic Service Employees, and 4) Third-Party Employers. This section is a broad overview of the rule. Later, this paper will go in depth into each section and explain changes to the regulations.

Domestic Service Employment/Private Home

The rule revises the language of "domestic service employment" to clarify the language and update the list of examples of professionals that fall into that category. It also defines private home. Providers of services should be familiar with what is and is not included in the definition of "private home", as only domestic service employees performing work in private homes are potentially subject to overtime exemption under the rule.

Companionship Services

The rule clarifies and narrows the definition of "companionship services", and revises who may claim the exemption to **exclude third-party employers such as home care agencies**. It also defines "care" as "assistance with activities of daily living [ADLs] and instrumental activities of daily living [IADLs]", and limits use of the companionship exemption to workers providing services to individuals, families, or households who spend no more than twenty-percent of their weekly hours performing other services, including "care", as opposed to companionship.

As will be discussed later, third-party employers will no longer be able to claim the exemption from minimum wage and overtime law, regardless of the percentage of time the employee spends performing non-companionship services. The rule also clarifies that "companionship services" do not

include any medically-related services. Any worker who provides medically-related services as defined in the rule may not be considered a companion for any time worked.

Live-In Domestic Service Employees

The rule clarifies that live-in domestic service employees provide services of a household nature in or about a private home, as defined in the rule. They live permanently in the home, or for extended periods of time. The rule distinguishes these workers from those who work twenty-four hour shifts, including those that work several consecutive twenty-four hour shifts. To be considered "live-in", a worker must not have a home other than the home in which they provide services, or must sleep on the premises at least five days a week and spend 120 hours or more there.

Live-in domestic service employees who primarily (defined as at least eighty percent of time worked) provide companionship services and who are employed directly by the individual, family or household **rather than a third-party**, remain exempt from overtime requirements.

Additionally, the rule imposes new recordkeeping requirements for employers. The rule requires that records show the actual hours worked by live-in domestic employees, bringing the requirements for these workers in line with those of other workers.

Sleep time rules are not altered with the new rule. The rule goes into some detail about the difference between live-in domestic service workers and workers that are scheduled for twenty-four hour shifts, and the wage and hour laws that apply to each, but the DOL notes that the already existing regulations governing these situations are not changed by the final rule.

Third-Party Employers (including Joint Employment, Independent Contractors, and Family Caregivers)

Of extreme significance to ANCOR members are the provisions in the rule that exclude any third-party employer from claiming the exemption. This rule applies across the board, including to shared living or roommate models that are based on an employment relationship, where a third party employer is involved. It is important to note that this rule does not change existing labor and employment law that determines whether an employment relationship exists. If an individual performing services on a contractual basis meets the criteria for being classified as an independent contractor, this new rule will not change that determination. If no third-party employer is involved, the exemption may continue to be claimed for employees under narrowed circumstances, as explained more fully in other sections of this analysis. The DOL provides various fact patterns to illustrate these

changes, which impact situations that are often not thought of in the field as "employer/employee" relationships. The rule also discusses the unique situations that arise when family caregivers are paid to provide some or all services to an individual.

HISTORY OF THE COMPANIONSHIP EXEMPTION UNDER THE FLSA

The Fair Labor Standards Act of 1938, often called the "Wages and Hours Bill", established a federal minimum wage, guaranteed overtime paid at one-and-one-half the normal wage rate for certain jobs, prohibited child labor, and established a 40-hour seven-day workweek as a maximum before overtime must be paid. The FLSA has undergone several amendments over the decades.

Significant to this analysis was the addition of the companionship exemption, which was created in a 1974 amendment to the FLSA. The main purpose of the amendment was to include domestic workers in wage and hours protection under the law. However, the amendment created specific exemptions for "domestic service workers who provide companionship services" and "live-in domestic service workers". The new law exempted companions from both wage and overtime protections, and exempted live-in workers from overtime (but not wage) protection. According to the legislative history of the 1974 act, "the changes were intended to expand the coverage of the FLSA to include all employees whose vocation was domestic service, but to exempt from coverage casual babysitters and individuals who provided companionship services"[4].

PURPOSE OF THE NEW RULE

The DOL explains the need to change and update the rule by saying, "[t]he home care industry ... has undergone dramatic expansion and transformation in the past several decades", due to several factors, including increased funding for home and community based services (HCBS), the rising cost of institutional care, and the disability civil rights movement. The increase in the number of direct care workers and the increased professionalization of the workforce led the DOL to seek these changes to the regulations.

The DOL goes on to explain that "direct care workers are for the most part not the elder sitters that Congress envisioned when it enacted the companionship services exemption in 1974, but are

[4] *See* 119 Cong. Rec. S24733, S24801 (daily ed. July 19, 1973) (statement of Sen. Williams).

instead professional caregivers" (p. 5)[5]. It specifies that it intends to construe the availability of the exemption narrowly, saying,

> These changes are intended to **clarify and narrow the scope of duties** that fall within the definition of companionship services **in order to limit the application of the exemption**. The Department intends for the exemption to apply to those direct care workers who are performing 'elder sitting' **rather than the professionalized workforce for whom home care is a vocation**. In addition, by **prohibiting employers of direct care workers other than the individual receiving services or his or her family or household from claiming the companionship services or live-in domestic service employment exemptions,** the Department is giving effect to Congress's intent in 1974 to expand coverage to domestic service employees rather than to restrict coverage for a category of workers already covered. (Emphasis added) (p.6)

The DOL says that "as home-based services continue to expand, employers will have clear guidance about the need to afford most direct care workers the protections of the FLSA, and the continued growth of home-based services will occur based on a realistic understanding of the professional nature of the home care workforce" (p.21). It says that it anticipates the rule will help to reduce the rate of high turnover among direct care workers by extending wage and hour protections to them (p.10). It also expects that the requirement to pay minimum wage will have a minimal impact as most direct care workers already receive minimum wage (p.9). This opinion was not shared by many commenters, who anticipate that the actual impact will be that workers will have hours cut, resulting in lower overall wages, as well as many direct care workers working multiple part-time jobs for different employers to compensate. Several commenters noted that there is already a shortage of direct care workers, and that this rule is likely to exacerbate the problem. Additionally, many commenters believe there will be disruptions of care for people served who will either have to increase the number of direct care workers attending to them, or forgo services.

Normally, a rule would go into effect within 60 days of being published in the Federal Register. However, the DOL set an implementation date of January 1, 2015 in order to allow federal, state, and local agencies, as well as private entities, to apply for changes to public funding structures (including Medicaid). "The Department recognizes that the multiple federal and state programs that often fund, administer, and oversee direct care for consumers will require a period of time to adjust to the new regulations" (p. 152).

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[5] Because the final rule had not yet been published in the Federal Register at the time this paper was published, page citations throughout refer to the electronic file referenced in footnote 1.

ANALYSIS

Domestic Service Employment/Private Home

The rule amends the definition of "domestic service employment". The new definition reads:

> The term domestic service employment means services of a household nature performed by an employee in or about a private home (permanent or temporary). The term includes services performed by employees such as companions, babysitters, cooks, waiters, butlers, valets, maids, housekeepers, nannies, nurses, janitors, laundresses, caretakers, handymen, gardeners, home health aides, personal care aides, and chauffeurs of automobiles for family use. This listing is illustrative and not exhaustive. (p. 354)

The new definition of "domestic service employment" removes a reference to the companionship exemption, which is not applicable to all domestic service employees, as well as the phrase "of the person by whom he or she is employed" in reference to the home worked in. The DOL explains these changes by saying that the previous language could "impermissively narrow" the coverage of domestic workers. Additionally, the new language removes the outdated occupations "governesses", "footmen" and "grooms", replacing them with modern occupations such as "nannies", "home health aides" and "personal care aides" (p. 25).

The DOL says that because many domestic service employees "are employed either solely or jointly by an entity other than the person in whose home the services are provided" (p. 27), it is necessary to revise the language to clarify that this category of workers is covered by the FLSA's wage and hour protections.

The rule does not change the definition of "private home" as applicable in the definition of "domestic service employment". However, because it is important to understand what the DOL considers a "private home" for purposes of applying the companionship exemption, the rule does discuss at length how to interpret the current definition. A private home may be fixed or temporary. In other words, apartments, hotels, and condominiums may be private homes, even if they are not permanent places of residence. It is important to distinguish the permanent nature of the residence from the permanent nature of employment, which will be discussed later in the live-in domestic service employees section. Whether a home is permanent has no bearing on whether the employee is considered live-in. (In other words, you may have a live-in domestic service employee residing permanently with a family in a temporary residence.)

The DOL lays out a six-prong test that has long been established at common law for determining whether a residence is a private home (p. 29). The factors deal with who owns, maintains, resides in, and otherwise controls the property. Briefly, the questions to ask to determine if a residence is "private" are:

1) Did the client live in the home before receiving services?
2) Who owns the unit?
3) Who manages and maintains the residence?
4) Would the client be allowed to live in the unit if the client were not receiving services from the service provider?
5) What is the relative difference in the cost/value of the services provided and the total cost of maintaining the unit?
6) Does the service provider use any part of the residence for the provider's own business purposes?

If the residence is not a "private home" controlled by the individual, family, or household receiving services, but is rather owned or otherwise controlled by the service provider or a third-party, services provided in the home are not considered provided by "domestic service employees," and the companionship exemption will not apply. The DOL also specifically addresses group homes, referring to an opinion letter it issued that concluded "'adult homes' designed for individuals who are in need of assistance with certain day-to-day functions, such as meal preparation, housekeeping, and medications, were not private homes."[6]

The DOL again highlights its intention to narrow the use of the companionship exemption, saying that the definition of "private home" remains unchanged, and that "employees who are working in a location that is not a private home were never properly classified as domestic service employees under the current regulations, and employers were not and are not entitled to claim the companionship services or live-in worker exemptions for such employees" (p. 33).

Companionship Services

Who May Claim the Exemption

As will be discussed more fully in the section about third-party employers, the new rule limits the application of the companionship exemption *only* to domestic service employees, working in a private home, who are not employed by a third-party. **In other words, only individuals, families, or**

[6] *See* Wage and Hour Opinion Letter, FLSA 2001-14, 2001 WL 1869966 (May 14, 2001).

households who directly employ a domestic service employee for companionship services may claim the exemption. In these very narrow circumstances, the direct care worker would not be subject to wage and overtime provisions of the FLSA. Third-party employers, employment relationships, and family caregivers will be discussed more detail later, and will be relevant to providers and persons self-directing their services, either independently, or through a third-party intermediary.

Definitions of Terms

Before getting into substantive analysis, it is important to understand the specific definitions of terms within the companionship services section. The revised section defines "companionship services" as "the provision of fellowship and protection for an elderly person or person with an illness, injury, or disability who requires assistance in caring for himself or herself." It defines the "provision of fellowship" as "to engage the person in social, physical, and mental activities" and includes several examples. It defines the "provision of protection" as "to be present with the person in his or her home or to accompany the person when outside of the home to monitor the person's safety and well-being" (p. 355).

Provision of Care Services

The proposed rule had included a list of activities that could be included under "fellowship and protection", and described "intimate personal care services" that could be considered "companionship" if they were "incidental" to fellowship and protection. However, in the final rule, the DOL instead narrowed the scope of what is properly allowed under "companionship".

The DOL again points to Congress' original intent, noting that, "The legislative history indicates that Congress intended to remove from the FLSA's minimum wage and overtime compensation protections only those domestic service workers for whom domestic service was not their vocation and whose actual purpose was to provide casual babysitting or companionship services" (p. 38). To conform with its understanding of the intent behind the exemption, the DOL specifies that exemptions should be "narrowly interpreted and limited in application to those who are clearly within the terms and spirit of the exemption" (p. 39).

Twenty Percent Limitation on "Care Activities"

The DOL recognizes that some non-companionship "care activities" may be performed "attendant to and in conjunction with fellowship and protection". The new rule allows care activities, defined as "assist[ing] the person with activities of daily living [ADLs]... and instrumental activities of daily living [IADLs]..." (p. 355), so long as those activities do not comprise more than twenty percent of the companion's total hours.

The DOL opted to use ADLs and IADLs in its definition of "care" rather than the language originally proposed, which would have included a list of intimate personal care services. The DOL reasoned that the proposed list could cause confusion and raise additional questions about what activities are and are not permissible under the rule. For that reason, the DOL instead decided to adopt ADLs and IADLs, which are commonly used industry terms (p. 46).

The twenty percent limitation applies per workweek, and per person served. The language in the proposed rule did not account for situations where a single worker was working for multiple "consumers", and where "the consumer would not typically know what percentage of time the direct care worker spent performing assistance with ADLs and IADLs for any other consumer" (p. 53). To remedy this, the final rule clarifies that "the twenty percent limitation applies to the work performed each workweek for a single consumer" (p. 54). This means the consumer must only account for the amount of care he or she has received, and need not consider what other services the worker has performed for other consumers when determining whether he or she can claim the exemption. The DOL again notes in this section that this is only a concern for individuals, families, and households, since under the new rule, "a third-party employer of a direct care worker is not permitted to claim the exemption regardless of the duties performed" (p. 54).

Also included in this limitation is any work performed that does not *primarily* benefit the person receiving companionship services. Any work that is performed that benefits the household as a whole will cause the exemption to not apply for that week. An example given in the rule is a direct care worker who performs fellowship and protection for the consumer Monday through Thursday, but then spends Friday performing light housework for the household as a whole. In that example, the exemption would be lost for the entire week, even though only twenty percent was not spent on companionship services, because any general household services performed makes the exemption not apply (p. 57).

Exemption of Medically Related Services

Finally, the new rule excludes from companionship services "medically related services", which are defined as services that "typically require and are performed by trained personnel such as nurses, licensed practical nurses, or certified nursing assistants [CNAs]" (p. 355). *Any* medically related services performed by the worker will cause the exemption to not apply. The DOL explains that whether a service is considered "medically related" depends on the nature of the service itself, and not on the occupational title or actual training of the person performing it.

The DOL discusses at length the training and credentialing of CNAs, and notes that home health aides (HHAs) and personal care assistants (PCAs) do not undergo the same training. It notes that:

> If in the future the same sort of professionalization that has occurred in the nursing assistance field extends to HHAs or PCAs such that either or both of these occupations require the training and perform the duties of CNAs today ... it is the Department's intent that such fields could properly be considered 'trained personnel'... If a state or employer refers to a direct care worker by a title other than RN, LPN, or CNA, but his or her training requirements and services performed are roughly equivalent to or exceed those of any of these occupations, that worker does not qualify for the companionship services exemption. (p. 69)

The DOL acknowledges that emergency situations may arise, and says that a direct care worker that performs a medically related task, such as CPR or administering an epi-pen, in an isolated, emergency situation, would not be excluded from the exemption (p. 70).

Live-In Domestic Service Employees

Who May Claim the Exemption?

Under the new rule, live-in domestic service employees are exempt from overtime requirements, but still must be paid minimum wage for all hours worked. The overtime exemption is only available to individuals, families, or households that employ the domestic service employee. If there is a third-party employer, the exemption does not apply.

The rule defines "live-in domestic service employee" as a worker who meets the definition of "domestic service employment" and provides services in a "private home" *and* resides on his or her employer's premises on a "permanent basis" or for "extended periods of time". The rule sets forth the definition, but notes that the new rule does not change the existing definition.

> Employees who work and sleep on the employer's premises seven days per week and therefore have no home of their own other than the one provided by the employer under the employment agreement are considered to 'permanently reside' on the employer's premises. Further, in accordance with the Department's existing policy, employees who work and sleep on the employer's premises for five days a week (120 hours or more) are considered to reside on the employer's premises for 'extended periods of time.' If less than 120 hours per week is spent working and sleeping on the employer's premises, five consecutive days or nights would also qualify as residing on the premises for extended periods of time. (Internal references omitted) (p. 74)

The DOL notes that some commenters appeared to confuse "live-in" with 24-hour care, and clarified that for purposes of the FLSA, only employees who are providing domestic services in a private home and are residing on the employer's premises under the criteria listed above are considered "live-in" and therefore exempt from overtime requirements (p. 76).

The DOL notes that existing regulations regarding when employees must be compensated for sleep time, meal periods, or off-duty time have not changed with the new rule. For clarity, it does discuss existing law at length for these non-compensable periods.

Shared Living/Host Homes/Adult Foster Care

The new rule potentially impacts shared living models where an employment relationship exists. Labels such as shared living, host home, housemate, mentor, host family, etc. are irrelevant. If the living arrangement is structured as an independent contractor arrangement and meets the existing tests for such, then wage and hour provisions of the FLSA do not apply. If the arrangement is structured as employment, or is found to be defacto employment under the existing economic realities test, then wage and hour law applies unless there is an exemption, but, consistent with the rule change, if a third-party employment relationship exists, the exemption may not be claimed by the third-party employer.

Stated slightly differently, this rule change does not change current employment law that determines whether an employment relationship exists. If an individual performing services on a contractual basis meets the criteria for being classified as an independent contractor, this new rule will not change that determination. With this rule, the DOL rejected the suggestion to categorically exempt shared living situations from minimum wage and overtime requirements, stating that whether an exemption can be claimed relies on the specific fact pattern and must be determined on a case-by-case

basis. This treatment by the DOL is independent of current Internal Revenue Service (IRS) tax treatment of stipends or difficulty of care payments made to the person or family providing services[7].

States and provider agencies do not use uniform language to describe shared living models. The DOL says that "Shared living arrangements may also be known as mentor, host family or family home, foster care or family care, supported living, paid roommate, housemate, and life sharing. Under a shared living program, consumers typically live in the home of an individual, couple, or family where they will receive care and support services based on their individual needs" (p. 80).

The DOL notes that one commenter specifically requested that shared living providers, including those that receive compensation from a third-party provider agency or directly from a state's Medicaid program, be deemed by the DOL as performing companionship services and thus excluded from the application of minimum wage and overtime rules under the FLSA (p. 80). The same commenter also described "host families" as "a family that accepts the responsibilities for caring for one to three individuals with developmental disabilities" who "typically must comply with state licensure or certification regulations" (p. 80). Another commenter suggested that "such living arrangements should fall under the Department's foster care exemption or should be exempt from the requirements" under the FLSA (p. 81). The DOL also received comments specifically about Medicaid-paid roommates, who live with an individual and are available to address that individual's intermittent needs.

The DOL first addresses these models by stating that while the live-in requirements for domestic employees is almost certainly met, whether the services provided are in a "private home" may be more problematic. As discussed previously, the determination of whether the home is "private" is made by applying the existing fact-specific tests under case law, the factors of which are based largely on the amount of control over the residence the person receiving the services exercises (p. 84).

Certain foster care arrangements and independent contractors that meet the DOL standard will not be subject to the FLSA, whereas models that create an employment relationship (such as those that involve a third-party employer) will. As discussed more fully in the section below pertaining to independent contractors, the DOL states clearly that a fact-specific assessment must be conducted on a case-by-case basis to determine whether an independent contractor is truly independent of a third-party employer. Certain foster care arrangements may also be exempt: "it is possible that certain shared living arrangements may fall within the Department's exemption for foster care parents, provided

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[7] *See* I.R.C. Section 131.

specific criteria are met" (p. 86). The DOL refers to guidance it issued previously regarding foster care[8], in which it concluded that an employment relationship would not exist in a case where a husband and wife become foster parents to a child and the payment by the state is primarily a reimbursement of expenses for rearing the child. The rule reads:

> it is possible that certain shared living arrangements may fall within the Department's exception for foster care parents, **provided specific criteria are met.** In contrast to shared living arrangements that are not foster care situations, **individuals in foster care programs are typically wards of the state; the state controls where the individuals will live, with whom they will live, the care and services that will be provided, and the length of the stays.** (Internal references omitted, emphasis added) (p. 86)

The DOL specifically notes in other sections of the rule that IRS regulations do not have any bearing on the application of the FLSA to those that the DOL considers employees. In other words, the DOL's position is that it is possible for a person to not be an employee for purposes of federal or state tax law, but that the same person in the same circumstances could be an employee for purposes of the FLSA. This treatment of shared living participants as "employees", if an employer relationship exists as determined by the specific fact pattern, could impact providers that are currently using adult foster care, host homes, and other shared living models. The IRS has not proposed any changes to the Internal Revenue Code that would impact the tax treatment of payments made under these models.

As explanation for the changes in the rule that apply to shared living, the DOL says, "As stated throughout this rule, the Department believes that the positions taken in the Final Rule are more consistent with the legislative intent of the companionship services and live-in exemptions and that protecting domestic service workers under the Act will help ensure that the home care industry attracts and retains qualified, professional workers that the sector will need in the future" (p. 86).

Recordkeeping Requirements

The rule revises the recordkeeping requirements for live-in domestic service employees. Prior to the new rule, employers were not required to keep records of the actual hours these employees worked, but could instead maintain a copy of an employment agreement that set forth agreed-upon hours (p. 88). Any variance from the agreement was required to be recorded, reflecting the actual hours over or under worked.

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[8] *See* Wage and Hour Opinion Letter WH-298. *See also* Field Operations Handbook Section 10b29.

The proposed rule did not permit employers to require employees to records and submit hours, instead requiring the employer to maintain a record of actual hours worked. Based on comments received, the DOL believes this would place too great a burden on some employers, specifically those with Alzheimer's disease or developmental disabilities, and instead revised the final rule to permit employers to require employees to record hours and submit that record to the employer (p. 89).

The final rule requires that actual hours must be recorded and those records maintained by the employer. This includes recordkeeping by all individuals considered employees by the DOL, including those that are in shared living situations.

Sleep Time

The rule does not change existing sleep time rules. However, because the DOL received many comments and questions from stakeholders regarding the application of the FLSA to sleep time for domestic service workers, including several that conflated live-in employees with employees working one or more 24-hour shifts, it sets forth clarifications in the rule on existing law (p. 135).

This paper will not go into the details of sleep time rules, as they have not changed. For more information, see ANCOR's Wage and Hour Handbook[9].

Third-Party Employers

Prior to this new rule, third-party employers were permitted to claim the companionship exemption and pay companions less than minimum wage and no overtime. Additionally, third-party employers were permitted to claim the live-in domestic service employee exemption and not pay overtime (p. 96). The stated intent of the DOL with this rule is to disallow both of these exemptions for third-party employers, as it believes they are not consistent with Congress' original intent. To that end, **the new rule forbids *any* third-party employer from claiming the companionship exemption**, regardless of the types of duties performed or the amount of time spent performing them.

[9] The 2009 ANCOR Wage and Hour Handbook is available for purchase at http://www.ancor.org/resources/publications/wage-hour-handbook. ANCOR plans to update the handbook for 2013 to reflect changes to the FLSA under the new rule. An estimated release date for the updated version has not yet been determined.

Who is a "Third-Party Employer"?

The critical piece to this part of the new rule is understanding what the DOL considers a "third-party employer". This has two components: 1) what is a "third party"? and 2) what is an "employer"? The former is simpler to define than the latter. The DOL states, **"a 'third party' will be considered any entity that is not the individual, member of the family, or household retaining the services"** (emphasis added) (p. 109).

What constitutes an "employer" is more complex. The DOL refers to case law that has established an "economic realities test" to be used to determine when an employment relationship exists. The application of this test is highly fact specific, and will look to the totality of facts in a particular situation. Because the determination is subjective based on the circumstances, there is no specific list of conditions that must be satisfied to make a determination. However, pulling from case law, the DOL establishes several factors that may be considered in order to determine whether an employment relationship exists.

> Factors to consider may include whether an employer has the power to direct, control, or supervise the worker(s) or the work performed; whether an employer has the power to hire or fire, modify the employment conditions or determine the pay rates or the methods of wage payment for the worker(s); the degree of permanency and duration of the relationship; where the work is performed and whether the tasks performed require special skills; whether the work performed is an integral part of the overall business operation; whether an employer undertakes responsibilities in relation to the worker(s) which are commonly performed by employers; whose equipment is used; and who performs payroll and similar functions. (p. 109)

The DOL gives two examples of fiscal/employer agent scenarios to illustrate what would or would not be considered employment. In the first, a person who self-directs care and makes all decisions over how to allocate funds received through a state Medicaid self-direction program, negotiates the wage rate with the worker, has sole authority to hire and fire workers, and sets hours and duties for the workers is considered the sole employer, even though a fiscal/employer agent maintains records, withholds taxes, and processes payroll, among other administrative tasks (p. 110). The DOL notes that in this instance, the fiscal/employer agent is not a third party because it has no ability to hire or fire, direct, control, or supervise the worker, and cannot modify the pay rate or employment conditions. Additionally, the work is not performed on the fiscal/employer agent's premises, and it provided no tools or materials for the tasks performed.

This is followed by a second example where the individual contacts her state government about services. The hypothetical individual lives in a "public authority model", where the state or county agency sets the wage rate, sets conditions of employment by deciding the method of payment, reviews time sheets, and determines what tasks each worker performs. Under these circumstances, the state or county agency is likely an employer of the direct care workers (p. 111).

The DOL notes that the economic realities test will be applied based on the facts and circumstances of a situation, and an employment relationship or lack thereof will not be determined by the title or name used by the third party.

Independent Contractors

As stated above, the new rule does not change current law with regard to classification of independent contractors. The rule discusses the use of an independent contractor model, and makes clear that the DOL's stance is that the classification of someone inappropriately as an independent contractor will not alleviate the employer's responsibility under the law. The rule states, "With regard to potential misclassification of employees as independent contractors or other non-employees, the Department will continue its efforts to combat such misclassification" (p. 112). The DOL again notes that there is "no single test for determining whether an individual is an independent contractor or an employee for purposes of the FLSA" (p. 112). As with the definition of "employer", there are several factors to consider, including

> the extent to which the services rendered are an integral part of the principal's business; the permanency of the relationship; the amount of the alleged contractor's investment in facilities and equipment; the nature and degree of control exerted by the principal; the alleged contractor's opportunities for profit and loss; the amount of initiative or judgment required for the success of the contractor; and the degree of independent business organization and operation. (p. 112)

The new rule does not change how independent contractors are treated for purposes of the FLSA. The DOL states clearly that a fact-specific assessment must be conducted on a case-by-case basis to determine whether an independent contractor is truly independent of a third-party employer. Because the FLSA is federal law, state-level criteria and state determinations of independent contractors will not be given deference by the DOL if they do not meet the criteria set forth in the FLSA.

Joint Employment

The rule defines "joint employment" as "employment by one employer that is not completely disassociated from employment by other employers" (p. 109). The determination of whether employment is joint will be based upon the facts and circumstances of a particular case. The rule gives an example, saying, "an individual who hires a direct care worker or live-in domestic service worker to provide services pursuant to a Medicaid-funded consumer directed program may be a joint employer with the state agency that administers the program" (p. 109).

Generally, a joint employment relationship would mean that all parties would have to comply with the rule. However, the rule makes an exception for individuals, families, and households that employ a direct care worker or live-in domestic service worker, saying that they may claim the exemption, "provided that the employee meets the duties requirements for the companionship services exemption..." but that the third-party employer will not be able to claim the exemption.

The rule addresses liability in the circumstances where one party in a joint employment relationship could property claim the exemption and the other could not, saying that joint and several liability would only occur in instances where the employee does not meet the duties requirement for the companionship exemption or the residence requirements for the live-in domestic service worker exemption (p. 113). In other words, if an individual is in a joint employment relationship with a third-party employer, and both claim the exemption, the individual is protected from liability claims if he or she was entitled to claim the exemption, but the third-party employer would be liable. However, if both the individual and the third-party employer in a joint employment relationship improperly claim the exemption, they would be jointly and severally liable.

The rule emphasizes the liability that would attach for a live-in domestic service worker that is jointly employed by an individual, family, or household and a third-party employer regarding overtime pay. Assuming the employee meets the residency requirements under the rule, the individual, family, or household would be able to claim the overtime exemption. The third-party employer, however, could not, and would be liable for overtime pay owed to the employee (p. 114).

Family Caregivers

The rule addresses situations in which family member is paid to provide care to an individual. It does not define familial relationships, saying that the DOL's intent is that "the phrase 'member of the family or household' be construed broadly, and no specific familial relationship is necessary" (p. 115).

The DOL acknowledges that family members are at times paid to provide home care services in certain Medicaid-funded or other publically-funded programs that allow the consumer to self-direct care. Additionally, other Medicaid-funded programs will hire family or household members to serve as paid direct care workers (p. 123).

Several commenters expressed concern that if family members were to become entitled to wage and overtime for all time spent providing services, "the costs of care would far exceed those Medicaid will reimburse, making the paid family caregiving model unsustainable" (p. 123). In response, the DOL acknowledges the importance of family caregivers, but says that it "cannot adopt the suggestion of several commenters that the services paid family care providers typically perform be categorically considered exempt companionship services" (p. 124). Instead, it says that "there is no basis in the FLSA for treating domestic service employees who are family members of their employers differently than other workers in that category" (p. 124).

Under the new rule, the DOL again looks to the "economic realities test" referenced previously, to determine when an employment relationship exists. While a family member may be deemed to be in an employment relationship with the individual receiving services, the DOL notes that "the FLSA does not necessarily require that once a family or household member is paid to provide some home care services, all care provided by that family or household member is part of the employment relationship" (p. 125). It clarifies, however, that "**the decision to select a family or household member as a paid direct care worker through a Medicaid-funded or certain other publicly funded program creates an employment relationship under the FLSA**" (emphasis added) (p. 126), causing the activities paid for under the program to likely not be exempt companionship services.

Acknowledging that often family members are willing and able to provide care for an individual because of their familial, rather than their employment, relationship, the DOL distinguishes between paid and unpaid care provided by family members. In such situations, the family member will be considered in an employment relationship only for the hours specified within a plan of care that "reasonably defines and limits the hours for which paid home care services will be provided" (p. 125).

The DOL acknowledges that sometimes a paid or unpaid caregiver is a member of the household, but is not a family member, "meaning they live with the person in need of care based on a close, personal relationship **that existed before the caregiving began**" (emphasis added) (p. 124). In this narrow circumstance, non-family members will be considered the equivalent of family members. However, if a person grows close to an individual, becoming "like family" after caregiving is started, that

does not create a personal relationship that would make it the equivalent of a familial one for purposes of the FLSA (p. 129).

Travel Time

As with sleep time, the DOL did not make any changes to existing rules regarding travel time. As has been the case prior to the new rule, employees must be paid for the time they spend travelling from one worksite to another (when working for a single employer), as well as time for any travel undertaken for the benefit of the employer (p. 146). Home-to-work and work-to-home travel time remains non-compensable time. The DOL notes that the IRS has certain regulations regarding the deductibility of travel expenses, but says that those regulations "have no bearing on whether such commute time is compensable under the FLSA" (p. 145).

Many commenters noted that Medicaid does not reimburse travel time. The DOL responds by saying, "nothing in the Medicaid law prevents a third party employer from paying for that time" (p. 146). It does note that Medicaid may reimburse travel costs when "necessary...to secure medical examinations and treatment for a recipient" (p. 146).

For purposes of the FLSA, any time spent travelling by the employee that is required as part of the employee's duties, whether it be travel from one job site to the next, or driving a person served to a medical appointment, or to run errands, or to visit friends, it is time that must be compensated for.

CONCLUSION

The new rule seeks to provide wage and hour protections to nearly all home care workers. Unfortunately, the rule carries with it certain provisions that will have serious, negative impacts on direct service professionals, service providers, and people served. Though the DOL acknowledges that many providers will now likely engage in "overtime management" (p. 181) and other scheduling changes to manage their workforce, it does not adequately address the reality in the field, which is that there is already a shortage of skilled workers, that the demand for skilled workers is expected to dramatically increase over the next several decades, and that this rule does not offer practical solutions for increasing funding necessary to fully comply with the rule.

While this analysis discusses at length the criteria to meet the live-in domestic service employee and the companionship exemptions, it is important to remember that these exemptions are *only* available to individuals, families, and households, and not to third-party employers, as defined in the

rule. If a third-party employer is involved, including in cases of joint employment, the third-party employer *may not* claim either exemption regardless of the percentage of time spent performing companionship activities.

The other important piece that ANCOR members must become familiar with is what constitutes an "employer" under the law.. Some service delivery models that were assumed to not create employment relationships in the past are on notice that DOL may classify them as such, with all the employer responsibilities that attach. While the FLSA does allow for independent contractors who are exempt from wage and hour provisions, **the new rule highlights the intent of the DOL to ensure that these workers are truly independent and not in reality working for a third-party employer.**

The short time period until the implementation date of January 1, 2015 will be problematic at the state level, as states will have to scramble to adjust Medicaid funding structures to allow them to comply with the rule. Most state legislatures are only in session for a few months out of the year, with some meeting only every other year. There are some states that will not have their state legislatures back in session until after the rule goes into effect. ANCOR members should be aware of what the legislative schedule is in their state, and begin reaching out now to state legislators to work on procuring appropriate funding to comply with the new rule's obligations. As always, the ANCOR government relations department is available for you to discuss legislative strategy with as you work with your state government and Medicaid program administrators.

ANCOR will continue its dialog with the DOL and continue pressing for guidance and the answers to specific questions that arise as our members navigate the requirements of the new rule.

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NASDDDS
National Association of State Directors of Developmental Disabilities Services

HELP Committee Report Says States Have Failed to Fulfill Olmstead Mandate

The U.S. Senate Health, Education, Labor, and Pensions (HELP) Committee has released a report taking states to task for "failing' to fulfill the Americans with Disabilities Act (ADA) community living mandate as expressed in the Olmstead case. The report provides an overview of the states' "ongoing struggle to fulfill the community living promise of the ADA and Olmstead." While the HELP Committee acknowledges " a fundamental rebalancing of spending" on individuals with disabilities in institutions as compared to HCBS, the report suggests that "these numbers fail to paint a complete picture," pointing out that only 12 states spent more than 50 percent of Medicaid long-term supports and services (LTSS) dollars on home and community-based services (HCBS) by 2010 and that the population of individuals with disabilities under 65 in nursing homes actually increased between 2008 and 2012 despite 38 studies over the past seven years that have "clearly demonstrated that providing

(HELP Report continues on page 7)

CMS Releases Model Streamlined Application for Exchanges, Medicaid

The Centers for Medicare & Medicaid Services (CMS) recently released the model single, streamlined application to determine eligibility for enrollment into Qualified Health Plans (QHPs) and for insurance affordability programs including advance payments of the premium tax credit (APTCs), cost-sharing reductions (CSRs), Medicaid, and the Children's Health Insurance Program (CHIP). Beginning on October 1, 2013, as mandated by the Affordable Care Act (ACA), the new Health Insurance Marketplace, also known as the Affordable Insurance Exchange, and state Medicaid and CHIP agencies must use a single, streamlined application for determining eligibility. States may choose to use the model application, or may develop an

(CMS Application continues on page 9)

INSIDE THIS ISSUE...

2012 Report of the President's Committee for People with Intellectual Disabilities

The 2012 report of the President's Committee for People with Intellectual Disabilities (PCPID) has been transmitted to the White House. The report provides recommendations regarding managed long-term services and supports (MLTSS) for individuals with intellectual and developmental disabilities.

The purpose of the PCPID 2012 report to the president is to:

- Provide background on MLTSS to assist the intellectual and developmental disability community with understanding the changes occurring and ways to influence outcomes.
- Provide recommendations to the president and the secretary of the Department of Health and Human Services for consideration and possible action.

The report contains 15 recommendations in the following areas:

- Disability stakeholder engagement
- Choice and self-determination
- Consumer protections and rights
- Quality measurement, data collection, and research

It also recommends that states and the federal government engage disability stakeholders in the design, implementation, and oversight of MLTSS program to ensure consumer protections.

FMI The report is available at www.acl.gov/NewsRoom/Publications/docs/PCPID_FullReport2012.pdf and a summary at www.acl.gov/NewsRoom/Publications/docs/PCPID_AccessibleSummary2012.pdf.

NASDDDS

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EDITORIAL

Why the Companionship Rule May End Shared Living/Adult Foster Care and Payment to Family Caregivers

By
Nancy Thaler,
Executive Director
NASDDDS

In December of 2011, the U.S. Labor Department (DOL) proposed regulations that will dramatically limit the companionship exemption to the wage and hour requirements of the Fair Labor Standards Act. Most significantly, the rules would make the exemption inapplicable to persons employed by third-party employers, who would instead be entitled to be paid not less than the federal minimum wage and overtime standards for all hours they are considered to be working. NASDDDS has provided comments to DOL addressing how the new rule will impact service systems for people with intellectual and developmental disabilities. We have met with numerous federal agencies, from the National Council on Disability to the Office of Management and Budget to Labor Secretary Tom Perez himself. Throughout, we have raised the concern that the rules will put at risk our members' ability to continue important service arrangements, including Shared Living and payment to family caregivers, that do not involve a conventional "employer-employee" relationship and that play a crucial part in state's efforts to fulfill the Olmstead mandate and its expression of the rights of people with disabilities to live and receive services in the most integrated setting possible. We now understand that publication of a final rule is imminent and states must be prepared for the likely outcomes of implementation.

Many people with intellectual and developmental disabilities (I/DD), particularly those with developmental disabilities, cannot live independently and need more than intermittent supports. Even though they may have considerable conversational skills or hold a part time job, the need for assistance with executive functions and self-care require that they be in the presence of someone who can step in to guide and support them promptly.

Groups homes developed for people leaving institutions in the 1970s have proliferated for people with I/DD up until the last decade. Group homes have become costly and are too often not really "home." Shift work, a growing shortage of direct care workers as the demand in long-term care systems grows, and group home regulations have led to regimented routines and sometimes impersonal care and as a result, dissatisfaction among self-advocates and families. Some group homes may be physically located in the community but are operated in such a manner that people are still segregated from community relationships and activities in ways that may challenge the Olmstead definitions of integration.

This dissatisfaction with group homes coupled with the inability of states to finance the expansion of group homes to keep up with the demands of the waiting lists have compelled states to develop other support options — ones that build on personal relationships. These options enable people with disabilities to live a typical life in their community, in relationship with people they know and know them. The activities and supports are individualized to their personal situation and are focused on their personal outcomes — and these options are less costly than group homes. The people providing support care about them outside the paid relationship.

Two common forms of "relationship based options" are Shared Living and Paying Family Caregivers the person lives with.

(EDITORIAL continues on page 4)

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Shared Living

Shared Living is a situation in which the person with I/DD is invited into a family home, similar to the child foster care system. The primary difference between child foster care and Shared Living is that the Shared Living sponsoring agencies work to match the person with a disability and the people they will live with and there is an expectation that the relationship and arrangement will be long term. And indeed, many are — lasting more than a decade. Shared Living can be with a young couple or a retired couple, a family, a widow or widower, or a college student. Like child foster care, the life of the person with a disability is completely integrated with the life of the people they live with. They eat together, everyone cleans the house, they go shopping together, they celebrate birthdays, holidays are full of rituals, and they share social networks. Care is integrated into life's routines. The caregiver might fold the family's laundry while overseeing the person with a disability as they do their physical therapy exercises, or assist the person eating at the dinner table while eating with the whole family. It is not clear that one person provides assistance — the oldest son in the family might go to the store with the person; the husband might help the person take a bath but the wife might help make lunch.

Supports for the caregivers include training, a supervising coordinator to offer advice and assistance, a fixed number of respite care days and if the person's needs are significant, there may also be additional support people. If working age, the person may have a job coach.

Payment is typically a flat monthly rate to the designated caregiver. The amounts can range from $1500 per month ($18,000 annually) to $3200 per month ($38,400 annually) depending on the needs of the person. A number of states make use of section 131 of the Internal Revenue Code that permits certain provider reimbursements, called "difficult of care" payments, to be exempt from taxation. The costs of the supervising agency, training for the caregivers, respite care, and other services are in addition to the payment to the Shared Living provider.

The caregivers may have an outside job or may not. But they get compensation for incorporating the person into their family's life and routines. They don't keep time cards and in fact, that activity would be contrary to the experience. The support is merged into life's routines.

Most states have a model of Shared Living or Adult Foster Care in place in both disability and aging service systems. The state of Vermont, which has virtually no group homes in their DD system, used the Shared Living model called Developmental Homes to close their only institution.

Providers of Shared Living do not think they are using the companionship exemption to the wage and hour requirements in the Fair Labor Standards Act (FLSA) because the relationships and payments are so foreign to the wage and hour model. But the rule promulgated by the Department of Labor (DOL) and currently under consideration by the Office of Management and Budget (OMB) that would restrict the application of the companionship exemption will apply to these providers and fundamentally impact their ability to provide these types of service arrangements.

After the regulation is in effect, Shared Living and Adult Foster Care sponsoring agencies will evaluate their capacity to comply with the regulation. As "third-party employers," they will realize that at any time, an individual providing Shared Living or other similar supports can claim that the rule applies and that they should be paid for all hours up to 24 hours they are overseeing the person. Shared Living agencies cannot recoup the cost of back wages from any payer including Medicaid. The back wages are the agencies' liability. Realizing their financial liability with this model of service and their inability to defend

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against a back wage claim, they will have to determine whether they can continue to provide Shared Living services within the existing payment rate. Why not just pay caregivers all the hours they are supporting the person? The cost of supporting each person with 24-hour paid supports will, at minimum wage rates for multiple employees in order to avoid overtime, cost $75,000 per year (8736 hours x $7.25 = $63,000 + $12,000 for benefits) without factoring in the additional costs of supervision, training, respite services. This cost quickly surpasses the cost of a 24-hour staffed group home.

The only potential solution is to revise the program to make Shared Living a contracted service. This arrangement may avoid the impact of the companionship rule (although that is not certain) and provides full flexibility to the Shared Living provider. However, a direct contract eliminates the role of the sponsoring agency which recruits, trains, supervises and supports the Shared Living provider, arranges respite services and is responsible for emergencies and for arranging for a transition should the Shared Living provider discontinue providing services.

Paying Family Caregivers

Almost every state currently makes payments to family members that the person with a disability lives with. Initially employed in rural areas and for people with extraordinary health needs, the practice has expanded to all situations for both children and adults in almost all states.

Payments to family caregivers have enabled family members to stay at home rather than go out to work and therefore enabled them to provide support to their family member. In almost all states, these arrangements occur within an individual budget limit and within guidelines that often limit the number of family members that can be paid and the number of hours they may be paid. These restrictions are to ensure that the person receiving support is not overly dependent on paid family members and has the opportunity to receive supports from people outside the family and also to control costs.

If DOL's new rule applies to family caregivers, any family caregiver who receives their compensation through a provider agency, rather than directly from the family member they support, will need to be paid minimum wage and overtime for every hour they might possibly be called upon to support their family member. If DOL maintains what we understand to be their current understanding of "third party employer," this would even include family members who receive their paychecks through a fiscal intermediary, and may very possibly include any family member whose income is provided or reimbursed through Medicaid.

For purposes of evaluating the impact of the DOL's new Companionship Exemption Rule on individuals, the situation with paid family caregivers is somewhat different than Shared Living Providers. Since the person has been living with the family prior to a family member being paid, when the state terminates the practice of paying family caregivers to avoid claims for 24-hour payment and over time, the person will continue to live with the family. In place of paying family members, the state may pay outside caregivers to provide service in the home. When the worker's shift is over, they will leave the home, avoiding claims that they have worked additional hours beyond those scheduled.

An additional option is to engage families as independent contractors. As with Shared Living, this arrangement provides flexibility to the family caregiver but eliminates the fiscal intermediary and oversight agency. Given the recent investigations by the Office of Inspector General into fraud in personal care services, a state would be advised to develop some mechanism for assuring that services contracted for are provided.

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A Different Paradigm of Support

Clearly, Shared Living and Paying Family Caregivers are both practices that add much value to our system for supporting individuals with developmental disabilities. These practices have played a key role in our efforts toward satisfying the mandate of Olmstead and fulfilling our responsibility to respect and honor the rights of people with disabilities to live and receive settings in the most integrated setting possible. But, as important as this consideration is, the argument for making sure the broadening of wage and hour protections for direct support workers does not lead to the end of Shared Living and paid family caregivers does not end there. NASDDDS has argued that these arrangements should be exempt from the new rule because they are fundamentally different from the types of employer/employee relationships DOL is seeking to effect. The arrangements differ in that:

1. No one is being denied a fair wage. Shared Living caregivers and family caregivers are providing supports in their own home, are not required to reserve their time exclusively for the person they are supporting, are doing tasks that benefit everyone in the household at the same time they are providing care, and their care giving responsibilities are often shared with others in the household. There is a level of convenience for the caregiver that distinguishes these relationships from a formal employer-employee relationship.

2. They are founded on personal relationships and commitment which provide the richness of family and community, a typical life rather than a "group home" life, and opportunities for "belonging." People with disabilities are part of a relationship and as such experience reciprocity — they give as well as receive which allows for the opportunity to experience dignity. This experience suffers from shoehorning these relationships into an employer-employee paradigm.

3. They represent a different way of thinking about support: it integrates natural supports and the need for financial assistance to sustain those natural supports. The arrangement is advantageous for both the person with a disability and the caregivers.

4. The impending long-term care crisis demands that we find less costly models to provide services to people needing care. Without services, families are the fall back. While families are committed, they do not have unlimited reserves to provide care and will give up, resulting in the need for facility-based care for the person. By supporting families and Shared Living caregivers financially, but within some reasonable bounds, everyone wins: the person continues to live in the community with people he/she has relationships with; the families maintain their care giving role and receive an income that enables them to remain at home in that role; and public funds will support more people.

Without the ability to continue to use public funds to support people who care about and for a person with a disability or who is older, who provide support because they value the relationship but need reimbursement to sustain their ability to support the person, congregate care may ironically become the only affordable option.

Responding to this editorial, a DOL spokesperson said, "We are not in a position to comment right now because we are in the rulemaking process. As you may know, after the public comment period for a proposed rule is closed, the department analyzes the input it has received and may make changes to the rule before it is issued as final. We take all of the comments we receive very seriously, including those

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we received that raised concerns about the issues your editorial addresses. Because this process is ongoing, it is premature to make any assumptions about the impact of the final rule. WHD [Wage and Hour Division] will of course work with stakeholders such as your organization to answer questions about the impact of the rule and provide compliance assistance once the final rule has been published."

FMI The Notice of Proposed Rulemaking promulgating the regulation can be found at webapps.dol.gov/FederalRegister/HtmlDisplay.aspx?DocId=25639&Month=12&Year=2011. NASDDDS' comments on the NPRM are available at www.nasddds.org/pdf/CompanionshipExemptionComments.pdf.

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HCBS is more cost-effective than providing services in an institution."

Section 1 of the report includes information on terminology used throughout the report, background on HCBS generally, and a description of the Olmstead decision and its subsequent impact on federal and state activities. Section 2 explores states' experiences with federal HCBS tools. Section 3 provides information on the states' spending on institutions, HCBS, and the populations served by HCBS. Section 4 analyzes the states' progress in moving individuals with disabilities into the community. Section 5 discusses the states' Olmstead planning efforts and suggestions for effective Olmstead implementation. Finally, section 6 sets forth the committee's recommendations for moving forward.

Committee Chairman Tom Harkin (D-IA) "generally found that many state leaders and Medicaid directors are working hard to provide more HCBS in an era of rising costs and growing populations." However, the report argues that "most states continue to approach community living as a social welfare issue and not as a civil rights issue," contending that "state leadership appears not to view the provision of HCBS as a means to guarantee that individuals with disabilities are able to exercise their civil rights as citizens by receiving supports that allow them to make their own decisions and fully participate in the life of their communities." The report also points out "a continued focus on providing care in settings that are 'less institutional' but also are not the most integrated setting." The committee acknowledges difficulty assessing states' progress "because of a lack of consistent classification, tracking, and reporting of both eligible populations and populations served." HCBS, the committee says, "are fragmented between states and within states, and coverage for certain individuals with disabilities lags behind others."

The report urges state leaders to "approach Olmstead implementation efforts by first focusing on the concept of the most integrated setting, and then setting reasonable timeframes and measurable goals to ensure that all individuals with disabilities are offered the most integrated setting." While many of the states have "laudable paper plans," the committee writes, "they lack enforceable benchmarks and targets directed at consistently transitioning people with all types of disabilities out of institutional settings and into living situations that allow individuals to exercise the autonomy and the rights guaranteed by the Constitution and the ADA in a way that is cost-effective for that state."

Following a hearing last year before the HELP Committee to assess the progress that had been made to implement the Olmstead decision, Chairman Harkin sent letters to the governors of all 50 states requesting information on HCBS, to "clarify whether states are ensuring that all populations of individuals with disabilities have the opportunity to live independently, while also providing the necessary services and supports in a cost-effective manner." The chairman asked for six specific sets of information about different aspects of the Olmstead initiative:

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1. For each year from fiscal year 2008 to present: the number of people who moved from nursing homes, intermediate care facilities (ICFs) for individuals with intellectual or developmental disabilities, long-term care units of psychiatric hospitals, and board and care homes (often called adult care homes or residential health care facilities), to living in their own home, including through a supportive housing program.
2. The amount of state dollars that will be spent in the current fiscal year serving individuals with disabilities in each of these settings: nursing homes, ICFs for individuals with intellectual or developmental disabilities, board and care homes, psychiatric hospitals, group homes, and their own homes, including through a supportive housing program.
3. For each year from fiscal year 2008 to present, the extent to which the state has expanded its capacity to serve individuals with disabilities in their own homes, including through a supportive housing program, along with the amount of state dollars spent on the expansion (which may include reallocated money previously spent on segregated settings) and the specific nature of the capacity added.
4. The contents of each state's Olmstead plan for increasing community integration.
5. Any policy recommendations for measures that would make it easier for the state to implement Olmstead's integration mandate effectively and take advantage of new available federal assistance.
6. Any successful strategies that the state has employed to implement Olmstead effectively, particularly strategies that could be replicated by another state or on a national scale.

The chairman received substantive responses from 31 states, and letters from two declining to provide a substantive response due to pending litigation related to the Olmstead decision. Committee staff held follow-up discussions with 11 states selected based on geographic diversity, number and types of programs used, spending on programs, length of time in programs, and population in programs. The follow-up discussions included requests for additional information about spending, as well as broad questions related to the cost-effectiveness of various HCBS programs. Committee staff also reviewed existing reports on state spending on HCBS and consulted with stakeholders involved in Olmstead advocacy and implementation.

State and federal efforts, the committee says, should focus on helping people live in their own homes. Virtually all people with disabilities, the report states plainly, "can live in their own apartment or house with adequate supports. Accordingly, for virtually all people with disabilities, the most appropriate integrated setting is their own home." The report calls for Congress to amend the ADA to clarify and strengthen the law's integration mandate in a manner that accelerates Olmstead implementation and clarifies that every individual who is eligible for LTSS under Medicaid has a federally protected right to a real choice in how they receive services and supports. Further, according to the report, Congress should amend the Medicaid statute to end the institutional bias in the Medicaid program by making HCBS a mandatory service, and require "clear and uniform" annual reporting of the number of individuals served in the community and in institutions, together with the number of individuals transitioned and the type of HCBS living situation into which they are transitioned.

The committee calls on states to "more fully examine the enhanced federal funding available under new federal programs designed to encourage states to transition more individuals into community-based settings and shift away from waivers, which allow states to set caps on the number of individuals served." The Centers for Medicare & Medicaid Services (CMS) should finalize its proposed rule defining what type of setting qualifies as home and community-based, and should require incremental state

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spending goals for national Medicaid LTSS for 2015, 2020, and 2025 to ensure that the proportion of spending on HCBS continues to increase, according to the report, and Congress should increase the federal share of Medicaid expenditures for states that achieve these benchmarks and reduce the federal share for states that do not. The Department of Justice (DOJ) should expand its Olmstead enforcement efforts, to include investigations of segregated employment settings for individuals with disabilities and the inappropriate placement of young people with disabilities in nursing homes, according to the report.

The HELP Committee calls for CMS, the Administration on Community Living (ACL) at the Department of Health and Human Services (HHS), the Office for Civil Rights (OCR) at HHS, the Department of Housing and Urban Development (HUD), the Civil Rights Division at the Department of Justice (DOJ), the National Council on Disability (NCD), and the National Institute on Disability and Rehabilitation Research (NIDRR) to create "a high-level interagency task force within six months of the issuance of this report...and should deliver a consistent message to states about their Olmstead obligations and the federally created tools that can help them comply with the decision." The task force should review and comment on proposed federal regulations and proposed sub-regulatory guidance that have the potential to impact Olmstead implementation, and collaborate with the National Governors Association (NGA) and other appropriate entities to create a technical assistance program for states that helps them to develop and implement Olmstead plans. ACL and HUD should collaborate to develop and implement a national action plan to expand access to affordable, integrated, accessible, and "scattered site" housing for people with significant disabilities, consistent with the Olmstead decision.

FMI The report is available at www.harkin.senate.gov/documents/pdf/OlmsteadReport.pdf.

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"alternative" application that is approved by CMS. For states in which there is a federally facilitated marketplace, the state's Medicaid/CHIP agency must accept the model form and may, in addition, develop an alternative application approved by CMS.

Section 1413 of the ACA directs the Secretary of Health and Human Services (HHS) to develop and provide to each state a single, streamlined form that applicants may use to apply for coverage in QHPs and insurance affordability programs, including APTCs, CSRs, Medicaid, and CHIP. Individuals must be able to submit the application online, by mail, over the telephone or in person and the application may be submitted to a marketplace, state Medicaid agency, or to a CHIP agency. The application must be structured to maximize an applicant's ability to complete the form satisfactorily, taking into account the characteristics of individuals who may qualify for the programs by developing materials at appropriate literacy levels and ensuring accessibility. A state may develop and use its own single, streamlined application if approved by the secretary.

The marketplace will begin accepting applications for coverage on October 1, 2013, for coverage that starts on January 1, 2014. This initial open enrollment period extends to March 31, 2014, but the marketplace will also accept applications and make eligibility determinations (including a determination as to whether an individual qualifies for a special enrollment period) throughout the course of the year. Medicaid and CHIP agencies must also make available the single streamlined application as of October 1, 2013, in addition to their applications already in use for those who want to apply for coverage effective before January 1, 2014.

Individuals whose eligibility is established by their participation in the Supplemental Security Income (SSI) program will not be affected by this change. However, individuals whose income exceeds SSI

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eligibility but who participate in Medicaid through a special eligibility program (e.g., Medicaid Buy-In), and those individuals living in the nine "209(b)" states that do not tie Medicaid eligibility to SSI eligibility, will now use the new application for eligibility redeterminations. To the extent that the model application, and any alternative application, does not clearly ask questions about whether a person has a disability in order to determine whether they should be eligible for Medicaid on the basis of that disability, Medicaid applicants with disabilities in states that are taking advantage of the opportunity in the ACA to expand their Medicaid programs run the risk of being assessed on the basis of their modified adjusted gross income (MAGI) and enrolled in the Medicaid expansion plan. These plans must be benchmarked against major health insurance plans in the state and are unlikely to have a robust long-term services and supports (LTSS) component. Therefore, working LTSS recipients, as well as those living in 209(b) states, run the risk of being mis-enrolled and losing access to crucial supports.

FMI To view the application, go to www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/AttachmentB_042913.pdf.

DSM-5 Updates Autism, MR Definitions

The American Psychiatric Association (APA) has released the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) at its annual meeting beginning Saturday in San Francisco. The new version marks the first major update since 1994. The DSM-5 contains much-discussed changes to the definition of autism, as well as less controversial changes to the diagnosis formerly known as "mental retardation," now known as "intellectual disability."

The DSM-5 eliminates the diagnosis of Asperger's syndrome and instead folds it, along with childhood disintegrative disorder and pervasive developmental disorder, not otherwise specified, into the broader category of "autism spectrum disorder," with clinicians indicating a level of severity. Individuals will have to meet a more specific set of criteria to obtain the new diagnosis. In response to concerns that some with the developmental disorder could lose the label entirely and, with it, needed services, the new DSM includes a note specifying that "individuals with a well-established DSM-IV diagnosis of autistic disorder, Asperger's disorder or pervasive developmental disorder not otherwise specified should be given the diagnosis of autism spectrum disorder."

The new manual also includes a change to its listing for "mental retardation," replacing the term with the more commonly accepted "intellectual disability." Additionally, plans called for the diagnosis to be adjusted to put less emphasis on IQ score and allow more consideration for clinical assessment, with the severity of impairment based on adaptive functioning rather than IQ test scores alone. By removing IQ test scores from the diagnostic criteria, but still including them in the text description of intellectual disability, DSM-5 seeks to "ensure that they are not overemphasized as the defining factor of a person's overall ability, without adequately considering functioning levels." The authors of the DSM-5 note that IQ or similar standardized test scores should still be included in an individual's assessment. In DSM-5, intellectual disability is considered to be approximately two standard deviations or more below the population, which equals an IQ score of about 70 or below.

FMI More information on the DSM-5 can be accessed online at www.dsm5.org. A fact sheet describing the new intellectual disability diagnosis can be found at www.dsm5.org/Documents/IntellectualDisabilityFactSheet.pdf.

NIDRR Announces Research Priorities on Community Living, Employment

The National Institute on Disability and Rehabilitation Research (NIDRR) has announced new research priorities for the Disability and Rehabilitation Research Projects (DRRP) and Centers Program. The new priorities include Community Living and Participation of Individuals with Disabilities (Priority 1), Health and Function of Individuals with Disabilities (Priority 2), and Employment of Individuals with Disabilities (Priority 3). The Assistant Secretary for the Office of Special Education and Rehabilitative Services (OSERS) may use these priorities for competitions in fiscal year (FY) 2013 and later years, either to limit grantees to focusing only on the priority or to award extra points to grant applications that will focus on the particular priority. Essentially, the priorities are a way for NIDRR to express its research funding goals. The priorities are effective June 6, 2013.

The first new priority DRRPs is on Community Living and Participation of Individuals with Disabilities. To meet this priority, a DRRP must contribute to the outcome of maximizing the community living and participation outcomes of individuals with disabilities by conducting either research activities or development activities in one or more of the following areas, focusing on individuals with disabilities as a group or on individuals in specific disability or demographic subpopulations of individuals with disabilities:

i. Technology to improve community living and participation outcomes for individuals with disabilities.

ii. Individual and environmental factors associated with improved community living and participation outcomes for individuals with disabilities.

iii. Interventions that contribute to improved community living and participation outcomes for individuals with disabilities.

iv. Effects of government policies and programs on community living and participation outcomes for individuals with disabilities.

v. Practices and policies that contribute to improved community living and participation outcomes for transition-aged youth with disabilities.

The DRRP must also conduct knowledge translation activities (i.e., training, technical assistance, utilization, dissemination) in order to facilitate stakeholder (e.g., individuals with disabilities, employers, policymakers, practitioners) use of the interventions, programs, technologies, or products that result from the research or development activities conducted under this priority, and involve key stakeholder groups in the activities "in order to maximize the relevance and usability of the research or development products to be developed under this priority."

The priorities on Health and Function of Individuals with Disabilities and Employment of Individuals with Disabilities carry the exact same requirements regarding areas of research, knowledge translation activities, and stakeholder involvement.

FMI The new priorities were announced in the *Federal Register* at www.gpo.gov/fdsys/pkg/FR-2013-05-07/html/2013-10829.htm.

GAO Offers Alternative Methods for Calculating FMAP

The Government Accountability Office (GAO) has issued a report discussing alternative methods for determining Federal Medical Assistance Percentage (FMAP) rates for states. Prior GAO work has expressed concerns about the FMAP, noting that per capita income (PCI) "does not accurately represent states' populations in need of Medicaid services or states' ability to finance services, and does not account for geographic cost differences among states." In its analysis, GAO considered whether available data sources could be used to develop measures to more equitably allocate Medicaid funding. GAO reviewed its prior reports and other studies, examined data sources produced by federal agencies, and illustrated how selected data could be used to develop measures to allocate Medicaid funding. GAO based its analysis on "commonly used equity standards" and "focused its efforts on readily available data sources, which are not inclusive of all possibilities."

GAO's analysis indicates that measures of the demand for services, geographic cost differences, and state resources can be combined in various ways to provide a basis for allocating Medicaid funds more equitably among states. GAO identified multiple data sources that could be used to develop measures to allocate Medicaid funding to states more equitably than the current funding formula. To be equitable from the perspective of beneficiaries and allow states to provide a comparable level of services to each person in need, GAO asserts, "a funding allocation mechanism should take into account the demand for services in each state and geographic cost differences among states." To be equitable from the perspective of taxpayers, "an allocation mechanism should ensure that taxpayers in poorer states are not more heavily burdened than those in wealthier ones, by taking into account state resources," the agency says.

GAO identified at least one federal data source that could be used to develop measures of each of these aspects. Nationally representative federal surveys, such as the U.S. Census Bureau's American Community Survey (ACS) and Current Population Survey (CPS), are available data sources that can be used to directly estimate the number of persons residing in each state with incomes low enough to qualify them as potentially in need of Medicaid services, the report points out. These estimates "can then be adjusted to reflect variation in health services needs within the identified population, using additional information collected in the surveys or from data sources external to the surveys, such as Medicaid data on enrollment or spending." A measure of geographic cost differences should account for all components of health care costs, including the cost of the personnel who provide services, which represents the greatest share of costs, GAO argues. National data that can be used to estimate average wages for health care personnel by state include the Occupational Employment Statistics survey conducted by the Bureau of Labor Statistics (BLS). As a measure of state resources, GAO suggests accounting for all income, regardless of whether or not the state taxes the income. The Total Taxable Resources (TTR) measure, as generated by the Department of the Treasury from multiple data sources, comprises not only the income included in PCI but also other significant sources of taxable income. GAO points out that nationwide, the TTR measure of income was 42 percent larger on a per capita basis than PCI in 2010, and provided a more comprehensive measure of state resources.

FMI The GAO report is available at www.gao.gov/assets/660/654477.pdf.

PPI Report Describes State Dual Initiatives

The Public Policy Institute (PPI) has released a report describing efforts by two-thirds of the states to integrate Medicare and Medicaid services over the next two years to remove adverse incentives and improve care coordination. To contain the growth of costs and improve care, the report indicates, many are moving to risk-based managed long-term services and supports models. This research, based on a

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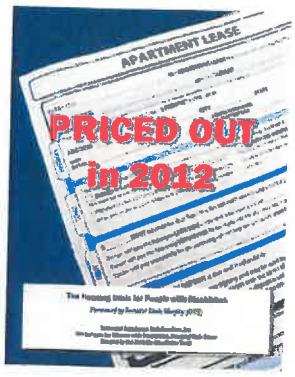
Priced Out in 2012 Examines Housing Issues for People with Disabilities



The Technical Assistance Collaborative (TAC) and the Consortium for Citizens with Disabilities (CCD) Housing Task Force have released the latest edition of their annual study of housing issues for individuals with disabilities study, *Priced Out in 2012*. The study demonstrates that the national average rent for a modestly priced one-bedroom apartment is greater than the entire Supplemental Security Income (SSI) payment of a person with a disability.

Priced Out in 2012 compares the monthly SSI payments received by more than 4.8 million non-elderly Americans with disabilities to the Fair Market Rents for modest efficiency and one-bedroom apartments in housing markets across the country, as determined by the U.S. Department of Housing and Urban Development (HUD). According to HUD, rent is affordable when it is no more than 30 percent of income; *Priced Out in 2012* reveals that as a national average, people with disabilities receiving SSI needed to pay 104 percent of their income to rent a one-bedroom unit priced at the Fair Market Rent.

The study, which was funded by the Melville Charitable Trust, notes that the reform and expansion of HUD's Section 811 Supportive Housing for Persons with Disabilities program and appropriations for the National Housing Trust Fund could help to create more integrated housing linked with community-based services and supports. TAC and CCD urge Congress to provide sufficient funding over the next five years to expand HUD's Section 811 approach and to expand affordable housing opportunities for SSI recipients.

FMI The report is available at www.tacinc.org/media/33368/PricedOut2012.pdf.

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survey of 50 states and the District of Columbia conducted in the fall of 2012, finds that two-thirds of the states either have or will launch new initiatives to better coordinate care for people who are dually eligible for Medicare and Medicaid services over the next two years. PPI also points out that while some states are taking the opportunity extended by the Centers for Medicare & Medicaid Services (CMS) to test new models, a number of states are exploring or implementing alternative approaches to dual services integration outside of the CMS models.

The three key findings from the survey regarding state dual integration initiatives are:

- Two-thirds of all states are integrating or planning to integrate Medicaid and Medicare services for dual eligibles in state fiscal years 2013 and 2014.
- Most integration programs are broad in scope — statewide initiatives targeting all full-benefit duals and spanning most long-term services and supports.
- Most states are turning to risk-based managed care models to deliver integrated services to duals.

FMI The report is available at www.aarp.org/content/dam/aarp/research/public_policy_institute/health/2013/states-integrating-medicare-and-medicaid-AARP-ppi-health.pdf.

Tavenner Confirmed as CMS Administrator

Marilyn Tavenner

The U.S. Senate has confirmed Marilyn Tavenner as administrator of the Centers for Medicare & Medicaid Services (CMS). She is the first CMS administrator to be confirmed in more than nine years. Ms. Tavenner was the acting administrator for CMS, and previously served as principal deputy administrator.

Prior to assuming her CMS leadership role, Ms. Tavenner served for four years as the commonwealth of Virginia's Secretary of Health and Human Resources. Ms. Tavenner also spent 25 years working for the Hospital Corporation of America (HCA). She began working as a nurse at the Johnston-Willis Hospital in Richmond, Virginia, in 1981 and steadily rose through the company as the hospital's Chief Executive Officer and, by 2001, had assumed responsibility for 20 hospitals as president of the company's Central Atlantic Division. She finished her service to HCA in 2005 as group president of outpatient services, where she spearheaded the development of a national strategy for freestanding outpatient services, including physician recruitment and real estate development.

Michigan Focus of First CMS Survey of Direct Care Workforce

Through a grant from the Centers for Medicare & Medicaid Services (CMS) to the Michigan Office of Services to the Aging, PHI (Paraprofessional Healthcare Institute) Michigan conducted surveys of providers in the Medicaid MI Choice home and community-based services (HCBS) waiver, community mental health (CMH) waiver, and Home Help programs in 2012 to determine the size, stability, and compensation of the direct-care workforce. Information on health care coverage, core competencies, and training was also gathered through the surveys. Surveys were also completed by direct-care workers supporting participants in MI Choice and CMH self-determination waiver programs, and allowed for analysis of these workers based on their relationship to the participant. The surveys, the first statewide surveys of Medicaid-funded, (HCBS) providers designed to capture data and information on the direct-care workforce, have identified low wages, part-time hours, and the need for enhanced training as significant challenges to attracting and retaining direct-care staff to these programs.

Nearly 17,000 direct-care workers are employed by the 1000-plus provider organizations that responded to the three surveys. The starting hourly wage in the CMH program is $8.73, and $9.09 for the Home Help and MI Choice program; 60 percent of direct-care staff are employed part-time, at less than 36 hours per week; and only one third of HCBS providers reimburse their direct-care staff for mileage and or gas for travel between participants. The average annual turnover rate is 34 percent for direct-care workers. Fifty-eight percent of responding organizations offer health insurance to their direct care staff, although many have low participation rates as a result of the high cost for workers.

PHI Michigan also conducted companion surveys to learn more about the workers hired and supervised directly by participants in the MI Choice and CMH self-determination programs. Among the findings:

- Workers supporting self-directing participants are, overall, satisfied with their jobs.
- The majority of CMH workers supporting self-directing participants believe that training in certain core competencies should be mandatory.

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Equal Employment Opportunity Commission Issues Revised Publications on the Employment Rights of People with Specific Disabilities

The U.S. Equal Employment Opportunity Commission (EEOC) has issued four revised documents on protection against disability discrimination. The documents address how the Americans with Disabilities Act (ADA) applies to applicants and employees with cancer, diabetes, epilepsy, and intellectual disabilities. These documents are available on the EEOC website at "Disability Discrimination, The Question and Answer Series." The revised documents reflect the changes to the definition of disability made by the ADA Amendments Act that make it easier to conclude that individuals with a wide-range of impairments, including cancer, diabetes, epilepsy, and intellectual disabilities, are protected by the ADA. Each of the documents also answers questions about topics such as: when an employer may obtain medical information from applicants and employees; what types of reasonable accommodations individuals with these particular disabilities might need; how an employer should handle safety concerns; and what an employer should do to prevent and correct disability-based harassment.

EEOC U.S. Equal Employment Opportunity Commission

FMI The documents are available at www.eeoc.gov/laws/types/disability.cfm.

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- In MI Choice, 49 percent of workers are family members, compared to only 27 percent in the CMH-waiver programs.
- Most family members (65 percent) do not live with the program participant for whom they care.
- Family members who are paid caregivers tend to earn less than workers with no prior relationship to the participant.

Results of the three provider surveys are reported in an executive summary, "Findings from Surveys from Medicaid Home and Community-Based Provider Organization Surveys: Understanding Michigan's Long-Term Supports and Services Workforce." More on the survey findings on self-directed workers is reported in "Findings from Surveys of MI Choice and CMH Self-Directed Workers Executive Summary."

FMI The survey results are available at phinational.org/policy/state-activities/phi-michigan/resources/publications.

Mathematica Examines Transition Policies in U.S. and 10 Other Countries

Mathematica Policy Research has released a report summarizing policies and programs of the United States and 10 other countries in the Organisation for Economic Co-Operation and Development (OECD) that aim to improve the transition of youth with disabilities to "appropriate and gainful employment." Although Mathematica points out that "the evidence of whether these policies and programs are effective is missing in most cases," the authors suggest "they have the potential to offer promising ideas for implementation or testing by the United States."

The paper resulted from work performed pursuant to a grant from the U.S. Social Security Administration (SSA), funded as part of the Disability Research Consortium. Mathematica health researchers are examining the barriers that inhibit a large portion of young Americans with disabilities from transitioning into adulthood with "gainful and stable" employment. They have identified four salient sets of barriers that prevent youth with disabilities from accessing support systems that would facilitate a successful transition from adolescence to adulthood:

- Insufficient employment supports (only 3 percent of youth with disabilities ages 14 to 24 exit services from vocational rehabilitation agencies in a given year).
- Few services targeted specifically to the needs of youth and young adults.
- Issues with access to adult services, a result of the adult service landscape's fragmentation — service agencies and benefit programs have different and varied eligibility requirements.
- Insufficient coordination of the transition from youth to adult services.

To identify policy solutions that will assist youth with disabilities in overcoming these barriers, the Mathematica team undertook an extensive literature review of the broad range of programs and policies that the United States and 10 other Organization for Economic Cooperation and Development (OECD) countries are using to provide income support and vocational rehabilitation to transition-age youth with disabilities. As a result of this literature review, the researchers identified programs and policies "that promote independence, and specifically employment, among program participants and that develop successful linkages among programs to coordinate targeting of, access to, and transitioning from youth to adult services."

According to Mathematica, several themes emerged from their review. First, countries have engaged in a range of efforts to promote employment, such as offering financial incentives to workers with disabilities and expanding employer supports. Second, investment in large-scale pilot projects has helped governments to identify what works in their countries. Third, most countries are operating programs at various government levels that are designed to improve access to adult services for people with disabilities (such as consolidating supports, improving the coordination of benefits and services, and promoting automatic eligibility for or access to programs). Finally, all countries have actively pursued solutions (such as increasing linkages to postsecondary education and increasing vocational supports) to the problem of inadequate coordination of youth and adult services. As the next stage of this study, Mathematica plans to conduct case studies on Germany and the Netherlands to provide "an in-depth review of the systems for supporting youth with disabilities and facilitating their transition to gainful employment."

FMI The report is available at mathematica-mpr.com/publications/PDFs/disability/Youth_Transition_WP.pdf?spMailingID=6150368&spUserID=MTU3ODMzNTQzMwS2&spJobID=73615626&spReportId=NzM2MTU2MjYS1.