PREPARING FOR 2015: AN OVERVIEW FOR STATES

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FLSA Home Care Rule: Prepare for your 2016 Budget Cycle

To preserve their participant direction programs, it is critical that states assess how the rule applies to their programs and plan for compliance with the rule for their 2016 budgets. Act now!

The Fair Labor Standards Act (FLSA) Home Care Rule takes effect January 1, 2015. The Department of Labor (DOL) recently announced a period of non-enforcement from January 1 to June 30, 2015, during which DOL will not prosecute states or other entities who are not yet in compliance with the Rule. Though states may not be immune to private FLSA litigation during the non-enforcement period, DOL encourages states to use this time to actively work toward FLSA compliance. Get more information on the Home Care Rule on our dedicated page at: http://www.bc.edu/schools/gssw/nrcpds/tools/flsahomecaretoolkit.html

The following steps will help states prepare for compliance:

1. Determine whether or not your state will be a joint third party employer. To anticipate how DOL will analyze your state’s program for signs of joint employer status, states are encouraged to use Indicators of Joint Employer Status, a component of NRCPDS’ FLSA Home Care Rule Tool Kit. States may also need to consult with their attorneys general to make a formal determination.

2. If your state is found to be a joint third party employer, your state will be liable for third party overtime and travel time. CMS has urged that funding for third party travel time and overtime should not be paid from a participant’s individual budget but can be considered a reasonable cost of service and the expenses are eligible for Federal match.

3. To determine the impact of paying third party travel time and overtime, prepare cost projections. These projections will help determine how much additional funding must be secured for your program.

4. Secure funding for Fiscal Year 2016. Even if your cost projections are not complete, include an estimate of costs related to FLSA. Even though most Fiscal Year 2015 budgets are closed, seek any possible funding vehicle for costs incurred during Fiscal Year 2015. Securing funding is a critical step toward achieving FLSA compliance.

5. Work with your state’s Financial Management Services providers and managed care entities to develop workable approaches toward claiming and payment of third party overtime and travel time.

6. Consult with your state’s aging and disability advocates, and use their input to help ensure that adverse impact upon participants is minimized.

7. If caps on travel time and overtime are imposed, ensure a robust exceptions policy is implemented for participants with greater needs. Failure to implement an exceptions

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Affordable Care Act Employer Shared Responsibility Mandate

Beginning January 1, 2015, states with Agency with Choice self direction programs will be required to provide funding for health insurance for full-time employees employed by agencies with 100 or more full-time equivalent (FTE) employees. Agencies with 50 to 99 FTEs will be required to offer health insurance to full-time employees effective January 21, 2016. The mandate is extremely unlikely to affect self direction programs operating under a Fiscal/Employer Agent model.²

Conflict Free Requirement

CMS now requires states to separate case management from service delivery functions. Potential conflicts of interest can occur not only if an entity is a provider, but also if the entity has an interest in a provider or is employed by a provider. If only one entity is willing and available to provide both case management and service delivery functions, the state must:

1. Demonstrate to CMS why they are the only qualified and willing entity to provide both;
2. Describe safeguards in place to manage conflicts of interest; and
3. Describe appeal and dispute resolution procedures available.

If an entity develops plans and provides direct services, the state must ensure that the entity separates planning and service delivery functions and provides a clear and acceptable dispute resolution process.³

Section 2402(a)

Section 2402(a) of the Affordable Care Act requires the Secretary of Health & Human Services to ensure all states receiving federal funds develop service systems that:

1. Are responsive to the needs and choices of beneficiaries receiving HCBS;
2. Maximize independence and self direction;
3. Provide support coordination to assist with a community-supported life; and
4. Achieve a more consistent and coordinated approach to the administration of policies and procedures across public programs providing HCBS.

² In the Fiscal/Employer Agent model, the consumer is the common law employer. It is extremely unlikely any consumer would have 50 or more employees at any given time. Thus, the IRS would classify each consumer as a “small employer” and thus exempt from the mandate.
³ Summarized from 42 CFR 441.301(c)(1)(vi).
The Administration for Community Living has issued guidance related to Section 2402(a), including introducing standards, and plans on issuing additional information on person-centered planning and self direction.

**Person-Centered Planning**

CMS requires that service planning for participants in Medicaid HCBS programs under sections 1915(c) and 1915(i) of the Act must be developed through a person-centered planning process that addresses health and long-term services and supports in a manner that reflects individual values, preferences, and goals.

**HCBS Settings Rule**

CMS has published a final rule creates a single definition of a home and community-based setting that applies across Sections 1915(c), 1915(i), and 1915(k) waiver authorities. The Section 1115 Waiver authority of the Social Security Act is used by some states to provide HCBS. CMS has indicated that it intends to align this new home and community-based setting definition with HCBS provided under Section 1115 research and demonstration project authority, as well.

The rule describes home and community-based settings as having the following qualities:

1. The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS;
2. The setting is selected by the individual from among setting options, including non-disability specific settings and an option for a private unit in a residential setting;
3. The setting ensures individual rights of privacy, dignity, and respect and freedom from coercion and restraint;
4. The setting optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact; and
5. The setting facilitates individual choice regarding services and supports, and who provides them.

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4 This guidance is available at [http://www.acl.gov/Programs/CDAP/OIP/docs/2402-a-Guidance.pdf](http://www.acl.gov/Programs/CDAP/OIP/docs/2402-a-Guidance.pdf)