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CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

CMCS Informational Bulletin

DATE: July 3, 2014

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SUBJECT: Self-Direction Program Options for Medicaid Payments in the Implementation of the Fair Labor Standards Act Regulation Changes

This informational bulletin is intended to assist states in understanding Medicaid reimbursement options that will enable them to account for the cost of overtime and travel time that may be compensable as the result of the changes to the Department of Labor's regulations regarding domestic service employment under the Fair Labor Standards Act (FLSA).

In the Final Rule, Application of the Fair Labor Standards Act to Domestic Service, 78 FR 60454 (Oct. 1, 2013), the Department of Labor (DOL) revised its 1975 regulations pertaining to the FLSA's companionship services exemption from minimum wage and overtime, and the live-in domestic service worker exemption from overtime. These regulatory revisions, which will become effective on January 1, 2015, have implications for Medicaid home and community-based programs, including the fact that they may contribute toward a more stable personal care workforce. Notably, DOL modified the "third party employment" regulation, 29 C.F.R. 552.109, to prohibit employers, other than the individuals receiving services or their families or households, from claiming the companionship services exemption from minimum wage and overtime or the live-in domestic service employee exemption from overtime (78 FR 60480-85). [1]

The Medicaid program provides states with the ability to offer individuals receiving home and community based services the choice to direct their own services through several options under the State Medicaid Plan and waivers found at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Self-Directed-Services.html. These models represent an important option for individuals and have helped Medicaid long term services and supports (LTSS) programs better meet the needs and preferences of individuals served. Based on the law described in new DOL guidance, referenced below, it is anticipated that many states will determine that, for purposes of the FLSA, home care workers in self-direction programs have joint third party employer(s) in addition to being employed by the beneficiary. In self-direction models where there is a third party joint employer, the DOL regulation states that all work is subject to minimum wage and overtime requirements.

[1] Descriptions of these FLSA domestic service employment exemptions can be found at : http://www.dol.gov/whd/homecare/factsheets.htm

Economic Realities Test

In order for states to know whether their self-directed[2] programs are impacted by the regulatory changes of the FLSA, they will need to, among other things, determine whether these programs have a third party employer. New DOL guidance, Administrator's Interpretation No. 2014-2 (AI),[3] explains that courts apply an "economic realities" analysis to determine whether an entity is an employer for purposes of FLSA. This "economic realities" test examines a number of factors to determine whether a worker is economically dependent on a purported employer, thus creating an employment relationship. As the DOL guidance describes, the factors considered by the courts include, but are not limited to, whether the potential employer has the power to hire and fire the employees, supervise and control the employees' work, determine the rate of payment, maintain employment records, and control where the work is performed. The DOL guidance describes that no one factor is controlling, and whether a particular entity is an employer for FLSA purposes is based on the totality of the circumstances.

CMS strongly encourages state officials and other potential joint employers to carefully review and develop a working knowledge of the DOL AI, which includes several hypothetical situations that illustrate when there may be a consumer as sole employer, or where there may be one or more third party employers. Each state will need to seek guidance from its own legal counsel, with clarification from DOL, if needed, to determine where the FLSA rules apply in its Medicaid program.

When the DOL regulations become effective on January 1, 2015, the third party employer (whether the state, another public entity, and/or a private entity), may no longer avail itself of the companionship services exemption from minimum wage and overtime compensation, or the live-in domestic service employee exemption from overtime compensation. With the implementation of these regulatory changes regarding the FLSA, many states will need to develop policies and consider programmatic changes in order to address the costs related to overtime and/or worker time spent traveling between worksites (i.e., individuals' homes), to avoid or minimize negative impacts to individual budgets, and to preserve the ability of individuals to self-direct services and supports effectively.

CMS offers technical assistance to states seeking to make adjustments to current or future home and community-based services (HCBS) or other home care programs to accommodate FLSA related costs in Medicaid reimbursement design.

The Intersection of the FLSA with Medicaid Self-Direction Program Requirements

After states and other entities evaluate their status as potential third-party employers, states will need to evaluate their self-directed (and other) program structures and policies to ensure compliance with FLSA requirements, and to continue to assure individual access to necessary services identified in the person-centered plan of care as required under Medicaid authorities. We expect that many states will incorporate the new provisions for overtime and travel in order to ensure that individuals are able to remain in their homes with their preferred workers. However, we understand that some states, due to budgetary constraints, may determine the need

[2] The FLSA guidance references "consumer-direction." We use the terminology "self-direction" in this bulletin to be consistent with CMS regulations at 42 CFR 441.301 and 42 CFR 441.740. Both terms hold the same meaning.
[3] The AI is available at http://www.dol.gov/whd/homecare/joint_employment.htm.

to implement policies to limit the use of overtime or to minimize the need for compensable travel time between beneficiaries.

When states impose limitations on overtime or the use of compensable travel time, they will need to develop strategies that continue to protect individuals' access to the services and supports authorized in his/her person-centered plan. For example, as identified in the 1915(c) Waiver Technical Guide,[4] these strategies may need to include exceptions made in the event of state-defined circumstances, such as worker shortages or when requiring additional caregivers would place an individual at risk of harm due to specialized needs of the individual or in an emergency situation. As always, states should not only consider Medicaid requirements, but also those under the Americans with Disabilities Act and the Supreme Court's decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999).

States that establish an individual budget for each person in self-direction will need to consider how their programs address situations when a worker employed by the third party employer provides services to more than one beneficiary in a given week. States may need to make adjustments to the reimbursement made to the Financial Management Services (FMS) or other third parties to account for the FLSA requirements. The two major issues are:

1. Situations in which the cumulative hours worked for all beneficiaries result in overtime costs that are not attributable to any one person's use of services, but must be paid by the third party employer, and
2. Compensable worker time associated with travel between beneficiaries (e.g., from one person's home to another) that is owed to the worker by the third party employer, but which is not a direct Medicaid service attributable to any one beneficiary.

Through long-standing Medicaid policy, overtime costs and compensable travel time costs that are incurred by a direct care worker cannot be considered administrative costs in the Medicaid program. To be reimbursable under Medicaid, these costs must be allocated as reasonable costs of delivering a covered Medicaid service. The cost of compensable travel time under FLSA may be considered a reasonable cost of delivering a unit of Medicaid service.

In 1915(c) waivers, costs beyond an individuals' control would not be considered part of a self-directed budget[5] and CMS strongly urges states to ensure that overtime or travel costs beyond an individual's control not be deducted from the individual's self-directed budget under any other HCBS Medicaid authority as well. Costs that result from a provider working for multiple beneficiaries may be distributed across all the individuals served by a joint employer without being deducted from the individually controlled self-direction budget.

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[4] 2008. Instructions, Technical Guide and Review Criteria for 1915(c) Home and Community-Based Waivers. Page 252. Retrieved from http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/Technical-Guidance.pdf on June 25, 2014.

[5] 2008. Instructions, Technical Guide and Review Criteria for 1915(c) Home and Community-Based Waivers. Page 215. Retrieved from http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/Technical-Guidance.pdf on June 25, 2014.

Potential Reimbursement Options When Self Direction Programs Involve Direct Service Workers who Provide Services to More than one Individual per Week

The following two options are examples of approaches states may use in self-direction programs where there is a third party joint employer and an individual beneficiary controls a service budget. We note some benefits and deficits of each option that states might consider in deciding how to approach reimbursement design:

Option 1. The state designs a new reimbursement option under which a financial management services agency would submit claims for each self-directed consumer to the Medicaid agency that includes: 1) the actual service costs incurred from each individual (to be deducted from his/her authorized self-directed budget, which could include, if authorized, overtime costs incurred just for that individual beneficiary); and 2) a per member/per month service fee negotiated with the state to cover expected overtime and travel costs across the FMS' book of business.

Considerations:

a. Individuals would still be able to control a budget for individually controllable costs and the rate development would be similar to that of agency-based care.
b. In order to keep actual costs of overtime and compensable travel time at or below the per member/per month fee, the FMS may have an incentive to restrict some individuals' preference for workers.
c. This will also necessitate the ability to create PMPM rate setting that will be new to implement and review.

Option 2. The state/program operating agency/FMS allocates the actual compensable overtime and travel costs that workers accrue across all of the beneficiaries that received Medicaid reimbursable services from the third party employer.[6] Medicaid would reimburse actual overtime and travel costs as a cost of providing service, divided amongst beneficiaries, but the costs would not be deducted from individual self-directed budgets. Under Medicaid, as noted above, the compensable travel and/or overtime costs cannot be billed as an administrative cost. Therefore, the payments for shared overtime and travel will be factored into service cost across all beneficiaries. The overtime and travel time becomes a FFS reimbursement from Medicaid to the operating agency.

Considerations:

a. A formula-based system may be easier than attempting to more discretely allocate shared costs to specific individuals who share a worker.
b. As a fee for service reimbursement from the Medicaid program to the agency, budgeting for the program would be less predictable.

[6] When a third party employer (such as a state or operating agency) has multiple entities who process payroll, the employer will need to have a mechanism to track whether employees are receiving pay from more than one entity and thus possibly should be paid overtime and/or compensable travel between beneficiaries.

Potential Options When the State Sets the Rates and Authorizes the Number of Hours or Other Units an Individual Receives

The following are examples of reimbursement approaches a state Medicaid program could use when the state sets the rates and authorizes the number of hours or other units of service a beneficiary can receive. They are based on use of an hourly or other unit reimbursement rate rather than an overall service budget controlled by the beneficiary.

Option 1. The FMS or other designated entity, through an employment agreement, receives a unit service rate, which includes reimbursement developed to reflect both the FMS activities and the workers' pay (including overtime and travel compensation). This would be a flat unit rate across all beneficiaries.

Considerations:

a. Would be consistent with other community based unit payment methods.
b. The FMS may restrict some beneficiary preference for workers, where the FMS would be at risk for high overtime costs.

Option 2. The state develops tiered payment rates or modifiers to a base rate, which may include multiple factors such as: incremental compensable overtime, distance from town or county center, acuity factors, and provider availability (to account for overtime and travel if needed). A state may choose to implement this as modifiers to procedure codes. This is essentially risk adjustment to Option 1, above, to account for individuals where factors that would increase cost are present.

Considerations:

a. States may already have such systems in place for shift differentials or other added cost.
b. May be administratively complex to monitor appropriate use of modifiers and to control costs to valid use. The state will need to develop documentation standards to properly account for the additional payments.
c. May be administratively complex to determine which individuals qualify for each separate modifier, who can authorize each modifier, and develop and monitor these processes.

Payment When the Individual is the Sole Employer

When a beneficiary is considered a sole employer under the economic realities test as described in the DOL AI, s/he may have new obligations to pay minimum wage and/or overtime compensation due to the new rule's narrowed definition of "companionship services."[7] If the services provided by the worker do not meet this new definition, the DOL guidance clarifies that the beneficiary must now pay minimum wage and overtime compensation for all hours worked,

[7] Descriptions of FLSA domestic service employment exemptions can be found at: http://www.dol.gov/whd/homecare/factsheets.htm.

unless the worker is live-in, in which case there may still be an overtime exemption.[8] Additional cost considerations for overtime must meet state program rules and should be factored into the individual's self-directed budget.

Currently, states have different policies on overtime. Some allow beneficiary discretion within a self-directed budget, and others allow beneficiary discretion only in exceptions where needed for health and welfare. The state will have to consider and account for new FLSA policies in determining the beneficiary budgets for self-directed care when overtime will be a factor. A worker may incur overtime working for just one beneficiary who is considered the sole employer, and, in that situation, treatment of overtime could be rightfully allocated to the beneficiary incurring the cost. It should be noted that transportation to and from the employer at the beginning and end of the work day (i.e., commuting time) is never required to be paid.

* * * * *

In conclusion, CMS reminds states that they should consult DOL's guidance and seek legal counsel in determining where and how FLSA impacts direct care programs operating under Medicaid. CMS is available to offer technical assistance to states seeking to adjust Medicaid reimbursement and other program policies to appropriately support FLSA compliance in home and community based LTSS.

If you have any questions in regard to this bulletin, please contact Dianne Kayala at Dianne.kayala@cms.hhs.gov.

[8] The live-in domestic service employee exemption fact sheet is located at: http://www.dol.gov/whd/homecare/factsheets.htm.

U.S. Department of Labor
Wage and Hour Division

U.S. Wage and Hour Division
(updated June 2014)

Fact Sheet #79F: Paid Family or Household Members in Certain Medicaid-Funded and Certain Other Publicly Funded Programs Offering Home Care Services Under the Fair Labor Standards Act (FLSA)

This fact sheet provides general information regarding how the FLSA's requirements apply to the employment of a family or household member paid through certain Medicaid-funded and certain other publicly funded programs offering home care services.

Who are paid family or household care providers?

Certain Medicaid-funded and certain other publicly funded programs allow a recipient of home care services (or that person's representative) to select and supervise the care provider and further allow the selection of a family or household member of that person as a paid care provider.

Under these programs, the particular services to be provided and the number of hours of paid services are described in a written agreement, usually called a "plan of care," developed with the individual and approved by the program after an assessment of the services the recipient of care requires and that person's existing circumstances, such as unpaid assistance provided by family or household members (often called "natural supports").

What is the significance of an FLSA employment relationship?

The FLSA requires, among other things, the payment of at least the minimum wage as well as overtime compensation to all workers who are employees, i.e., who are in an employment relationship with an employer (and the FLSA applies because in addition, the employer is covered by the FLSA and the employee is not exempt from the Act). See Fact Sheet #13: Employment Relationship Under the Fair Labor Standards Act. Under the FLSA, family or household members can be hired as employees of other family or household members to provide home care services, creating an employment relationship. If such an employment relationship is created (and neither the companionship services nor the live-in domestic service employee exemptions apply, see Fact Sheet # 79A: Companionship Services Under the Fair Labor Standards Act and Fact Sheet #79B: Live-in Domestic Service Workers Under the Fair Labor Standards Act), it is subject to the requirements of the FLSA.

Ordinarily, under the FLSA, including in the context of domestic service work such as home care, if an employment relationship exists, all hours worked by an employee for an employer must be paid. See Fact Sheet #79D: Hours Worked Applicable to Domestic Service Employment Under the Fair Labor Standards Act. For example, if an 80-year-old woman hires a certified nursing assistant (CNA) to provide medical care in her home and the woman and CNA agree that the CNA will work and be paid for 30 hours per week, if the CNA actually works for 35 hours in a given week, she must be paid for all 35 hours.

What is the scope of a paid family or household care provider's FLSA employment relationship?

When a paid care provider is a family or household member of the person receiving home care services, the decision to hire the family or household member does not turn all care provided into employment. There is both

a familial or household relationship and an employment relationship, and only hours worked within the scope of the employment relationship are covered by the FLSA. In these circumstances, the employment relationship is usually limited by a "plan of care" or other written agreement developed with the involvement of the individual and approval of the Medicaid-funded or other program.

For example, a familial relationship, but not an employment relationship, exists where a father assists his adult son with a physical disability with eating dinner and bathing in the evenings. If the son enrolled in a Medicaid-funded program and the father became his son's paid care provider under a program-approved plan of care that funded eight hours per day of services, the father would then also be in an employment relationship with his son for purposes of the FLSA. If the requirements described below are met, the father's employment relationship with his son extends only to the eight hours per day of paid work contemplated in the plan of care. The assistance he provides at other times stems from his familial relationship and is not part of that employment relationship and therefore need not be paid. If, based on the structure of the program, a state or other agency was also an employer of the father, this interpretation would also apply to the employment relationship between the father and that agency.

What are the requirements for the application of this special interpretation limiting the scope of the employment relationship of paid family and household care providers?

(1) Home Care In or About a Private Home

This unique interpretation only applies in the home care services context. Under the FLSA, home care is domestic service employment because workers are providing services of a household nature in or about a private home. See Fact Sheet #79 Private Homes and Domestic Service Employment Under the Fair Labor Standards Act. Work done by family or household members in other contexts, such as for a family business, is subject to the typical FLSA law and regulations regarding the employment relationship and hours worked.

(2) Family or Household Relationship

This unique interpretation also does not generally apply to relationships that do not involve preexisting family ties or a preexisting shared household. Therefore, except as noted below, it would not apply to a direct care worker who did not have a family or a household relationship with the individual in need of services prior to the individual's need arising or the creation of the plan of care. In other words, all services provided by a direct care worker who becomes so close to the consumer as to be "like family," or a direct care worker who becomes part of the consumer's household when hired to be a live-in employee, must be paid pursuant to typical FLSA law and regulations. If the consumer and caregiver enter into a new family relationship during the course of an employment relationship (for example, through marriage or civil union), however, then the FLSA employment relationship would be limited even though the family relationship did not predate the employment relationship.

(3) Reasonableness of the Plan of Care

An employment relationship is limited to the paid hours contemplated in the plan of care or other written agreement developed with the individual and approved by certain Medicaid-funded or certain other publicly funded home care programs only if that agreement is "reasonable." For purposes of an FLSA analysis, "reasonable" does not mean whether the amount or type of services or paid hours to be provided are appropriate for the consumer. Instead, in this context, a determination of reasonableness will take into account whether the plan of care would have included the same number of paid hours if the care provider had not been a family or household member of the consumer. In other words, a plan of care that reflects unequal treatment of a care provider because of his or her familial or household relationship with the consumer is not reasonable. For instance, the program may not reduce the number of paid hours in a plan of care because the selected care provider is a family or household member. In addition, a program may not require an increase in the hours of

unpaid services performed by the family or household care provider in order to reduce the number of hours of paid services.

Examples:

- A 23-year-old man with developmental disabilities is enrolled in a Medicaid-funded program that pays for home care services for him. When he meets with his planning team for an annual reevaluation of his plan of care, he explains that he is considering moving out of his parents' home and into his own apartment. The team determines that if he remains in his parents' home, he will need 40 hours of paid services each week in addition to the natural supports he receives from his parents. If he moves into a nearby apartment, his parents will still provide some natural supports, but he will need 55 hours of paid services. The consumer decides that he would like to live on his own, so the plan of care provides for 55 hours of paid services. As long as the 55-hour allotment remains in place regardless of whether the paid care provider is a family member (such as either or both of his parents) or any other individual (such as a friend or professional identified through a registry), the plan of care is "reasonable" for FLSA purposes. The analysis of reasonableness for FLSA purposes does not depend on the residential setting or the level of natural supports, but instead on treating family members who become paid providers in the same manner as any other provider. In other words, if a program offers fewer hours of services to an individual because he or she selects a family member as a paid provider, the family member's employment relationship will not be limited to the paid hours. In this example, if the man's mother becomes his paid care provider for 40 hours per week and a neighbor is the care provider for the other 15 hours per week, the mother's employment relationship is limited to those 40 hours. Therefore, if she provides additional care to her son, such as by cleaning his apartment or helping him prepare for bed, during time outside of the 40 paid hours, those activities are part of the familial relationship and the time need not be paid.

- A 90-year-old woman who can no longer care for herself enrolls in a Medicaid-funded program administered by the county in which she lives. She is assessed to need paid services for 30 hours per week beyond the existing unpaid assistance she receives from her daughter and other relatives. Had the consumer chosen a neighbor to become her paid care provider, her plan of care would have included those 30 paid hours each week. But because the woman instead chose her daughter to become her paid provider, the county reduced the paid hours in the plan of care to 15 hours per week. In this example, the plan of care is not reasonable for FLSA purposes because it treats the family care provider unequally, and the paid hours in the plan of care will not determine the scope of the FLSA employment relationship.

- A veteran with physical disabilities receives home care services through a publicly funded program. His plan of care provides for 30 hours per week of paid services. Twenty-five of those hours are provided by a care provider the veteran did not previously know and five of the hours are provided by his aunt. The number of paid hours of services the veteran receives was not affected by the aunt's status as his family member. The plan of care also contemplates that he will receive natural supports on evenings and weekends from his father, with whom he lives. One weekend, the veteran's father needs to travel out of town, and the father asks the aunt to stay at the father and veteran's home and assist the veteran while the father is away. The aunt does so, and is not paid. Because the aunt has both an employment relationship and a familial relationship with the veteran and her paid hours of care are delineated in a reasonable plan of care, the additional weekend supports she provides in place of the veteran's father are within the familial relationship, and it does not violate the FLSA to not pay the aunt for that time.

Additional Resources and Relevant Information

For more information about the Fair Labor Standards Act, and in particular, how it applies in the context of home care and other domestic services provided in or about a private home, please see the following resources:

Fact Sheet: Final Rule Concerning Domestic Service Workers Under the Fair Labor Standards Act (FLSA)

Fact Sheet #79: Private Homes and Domestic Service Under the Fair Labor Standards Act (FLSA)

Fact Sheet # 79A: Companionship Services Under the Fair Labor Standards Act (FLSA)

Fact Sheet #79B: Live-In Domestic Service Workers Under the Fair Labor Standards Act (FLSA)

Fact Sheet #79C: Recordkeeping Requirements for Individuals, Families, or Households who Employ Domestic Service Workers Under the Fair Labor Standards Act (FLSA)

Fact Sheet #79D: Hours Worked Applicable to Domestic Service Employment Under the Fair Labor Standards Act (FLSA)

For additional information, visit our Wage and Hour Division Website: http://www.wagehour.dol.gov and/or call our toll-free information and helpline, available 8 a.m. to 5 p.m. in your time zone, 1-866-4USWAGE (1-866-487-9243).

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