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DOL Issues Final Rule on Companionship Exemption

The U.S. Department of Labor (DOL) has released its Final Rule implementing a new, narrowed interpretation of the Companionship Exemption to the wage and hour requirements of the Fair Labor Standards Act (FLSA). Most significantly, DOL is revising the definition of "companionship services" to clarify and narrow the duties that fall within the term; in addition third party employers, such as home care agencies, can no longer claim either the companionship exemption to wage and hour rules or the exemption from the FLSA's overtime provision for domestic service employees who reside in the household in which they provide services. The Final Rule indicates that any direct care worker who is employed by a third party can no longer be considered a companion for purposes of the FLSA and must be paid according to federal minimum wage and overtime requirements. DOL has confirmed that the rule applies to individuals who receive stipends or difficulty of

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50 Years

of Leadership and Support to States

Building person-centered systems of services and supports for people with developmental disabilities and their families

The year 2013 marks the 50th anniversary of a number of key events that have had a positive impact on the lives of people with intellectual and developmental disabilities and their families. In October 1963 Congress adopted the Maternal and Child Health and Mental Retardation Planning Amendments (P.L. 88-156) and the Mental Retardation Facilities and Community Mental Health Centers Construction Act (P.L. 88-164) which provided a foundation for our service systems. In the same month, October 1963, after several months of planning, the National Association of Coordinators of State Programs for the Mentally Retarded, the fore runner of NASDDDS, formally adopted articles of incorporation and bylaws. The association was then officially incorporated in January 1964. NASDDDS is 50 years old!

Beginning this month and throughout 2014, NASDDDS will be featuring articles in both of our journals — *Federal Perspectives* and *Community Services Reporter* — that tell the story of our past. We will

- Recall major advances in public policy
- Tell the story of how services evolved in states
- Recognize our early state leaders

Bob Gettings, the founding executive director of NASDDDS, past and current NASDDDS members, and NASDDDS staff will provide a look back in history.

IN THIS ISSUE "A Historic Turning Point in I/DD Services: October 1963" by Bob Gettings

NASDDDS
National Association of State Directors of Developmental Disabilities Services

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care payments, such as in shared living or other similar arrangements, as well as shift workers.

The new regulatory text precludes third party employers (e.g., home care agencies) from claiming the exemption for companionship services or live-in domestic service employees. The Final Rule also updates the definition of "companionship services" to restrict the term to encompass only workers who are providing "limited, nonprofessional services" DOL believes Congress envisioned when creating the exemption. Specifically, the rule provides that "companionship services" means "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 also defines "fellowship" as "engaging the person in social, physical, and mental activities" and "protection" as "being 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." Under the rule, companionship services also includes the provision of care if the care is provided attendant to and in conjunction with the provision of fellowship and protection and if it does not exceed 20 percent of the total hours worked per person and per workweek. "Care" is defined as assistance with activities of daily living and instrumental activities of daily living. The term "companionship services" does not include general domestic services performed primarily for the benefit of other members of the household, or medically related services. The determination of whether the services performed are medically related is based on "whether the services typically require and are performed by trained personnel, such as registered nurses, licensed practical nurses, or certified nursing assistants, regardless of the actual training or occupational title of the individual providing the services."

Third Party Employment

The regulation addresses questions about determining whether there is a third party employer, or joint employment, by referring to "long-standing case law from the U.S. Supreme Court and other federal appellate courts interpreting the language of the FLSA and applying the 'economic realities' test." Factors to consider under the test, DOL says, "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

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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." An economic realities test, the rule stresses, does not depend on "isolated factors but rather upon the circumstances of the whole activity."

In response to concerns submitted to DOL by NASDDDS, the rule directly addresses how a home care services scenario may be assessed utilizing the economic realities test by providing a hypothetical example in which an individual is part of a self-direction program that allows them to hire a direct care worker through an entity that has contracted with the state to serve as the "fiscal/employer agent" for program participants who employ direct care workers. In the scenario, the "fiscal/employer agent" performs tasks similar to those that commercial payroll agents perform for businesses, such as maintaining records, issuing payments, addressing tax withholdings, and ensuring that workers' compensation insurance is maintained for the worker, but "is not involved in any way in the daily supervision, scheduling, or direction of the employee," and the individual "has complete budget authority over how to allocate the funds she receives under the Medicaid self-direction program, negotiates the wage rate with the direct care worker, is wholly responsible for day-to-day duty assignments, and has the sole power to hire and fire her direct care worker." In this scenario, DOL indicates, the fiscal/employer agent is likely not an employer of the direct care worker, and the consumer is likely the sole employer, and, assuming the other requirements are met, may use the companionship exemption in regard to this employee. However, the rule does not directly address the likelihood that there is a Medicaid rate, determined by the state, for the services that the employee has been hired to provide. It is unclear whether DOL would consider setting the Medicaid reimbursement rate equivalent to setting the wage rate for the employee, or how an individual having the

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NASDDDS

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Subscription requests and correspondence should be sent to NASDDDS
113 Oronoco Street
Alexandria, VA 22314-2015
Tel: (703) 683-4202
Fax: (703) 684-1395

Writer/Editor
Dan Berland
Director of Federal Policy
dberland@nasddds.org

Layout, Design, and Distribution
katherine karol snyder
Director of Administrative Services
ksnyder@nasddds.org

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authority to negotiate wages within a range set by Medicaid would affect the determination of who is the employer; nor does it make clear how this different distribution of authority might impact the determination that there is no third party employer. DOL does stress that "any change in the specific facts of this scenario…may lead to a different conclusion regarding the employer status of the fiscal/employer agent." In a second example, "the state has a 'public authority model' under which the state or county agency exercises control over the direct care workers' conditions of employment by deciding the method of payment, reviewing worker time sheets and determining what tasks each worker may perform. The agency also exercises control over the wage rate either by setting the wage rate." Here, DOL says, the state or county agency is likely an employer of the direct care workers under the FLSA.

DOL also addresses the concept of joint employment (again to be determined by the economic realities test), offering as an example that "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." Under the revised regulation, in joint employment situations "the individual, member of the family or household employing the direct care worker or live-in domestic service worker will be able to claim an exemption provided that the employee meets the duties requirements for the companionship services exemption or the residence requirements for a "live-in" domestic service worker exemption," but "the third party employer will not be able to claim that exemption." The practical implications for this appear to be that "the family or household member would not be subject to joint and several liability" for back wages, but the third party employer would.

Shared Living

In response to NASDDDS' concerns, DOL also directly addresses shared living and other similar service arrangements, although the rule points out that "the Department cannot address all shared living arrangements raised in the comments because the circumstances are different under countless factual scenarios." However, the rule provides guidance "regarding how these established rules will likely apply under the most commonly raised shared living arrangement — live-in roommates." DOL describes this arrangement as one in which "the consumers appear to be living in their own home and a roommate moved in to the consumer's home in order to provide services on an as needed basis;…the person receiving services owns the home or leases the home from an independent third party," rather than the state or agency providing the services maintaining the residences or otherwise providing the essentials of daily living. DOL describes that "the cost/value of the services does not appear to be substantial based on the comments that suggested that live-in roommates provide only intermittent or infrequent care services, "and are therefore "a small portion of the total costs of maintaining the living unit." DOL also specifies that in this scenario, "the consumer hires the roommate and determines who will live in his or her home and is free to come and go as he or she pleases." Under this very specific fact pattern, DOL says, "the live-in domestic service employee overtime exemption will likely be available to the individual, family, or household using the worker's services." Moreover, to the extent the live-in roommate meets the duties test for the companionship services exemption, that exemption will likely also be available to the individual, family, or household using the worker's services. Crucially, however, neither exemption would be available to a third party employer of the live-in roommate, rendering the above considerations moot in a great many instances of shared living, where a provider agency employs and/or provides a stipend or other payment to the live-in roommate.

The rule also indicates that "it is possible that certain shared living arrangements may fall within the department's exception for foster care parents." According to the rule, "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." Only if an individual scenario meets those specifications, the arrangement might be covered by Wage and Hour Opinion Letter WH-298,

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in which the Wage and Hour Division (WHD) concluded that "where a husband and wife agree to become foster parents on a voluntary basis and take a child into their home to be raised as one of their own, the employer-employee relationship would not exist between the parents and the state where the payment is primarily a reimbursement of expenses for rearing the child."

Paid Family Caregivers

DOL suggests that "in most circumstances a paid family caregiver is providing services in a private home." In the circumstances where the paid family caregiver lives with the consumer, the overtime exemption will be available to the individual, family, or household. If employed, jointly or solely, by a third party, the paid family caregiver would be entitled to overtime compensation for all hours worked over 40 from the third party employer. However, DOL stresses that "not all time spent on the premises is necessarily considered hours worked," and also points out that "there may be circumstances where the third party will not be considered a joint employer of the paid family caregiver because the third party is not engaged in the factors that indicate an employer-employee relationship exists," as indicated in the above discussion of third-party employment and the economic realities test.

According to a fact sheet accompanying the Final Rule, "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." DOL recognizes "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 limited by a plan of care or other written agreement developed with the involvement and approval of the Medicaid-funded or other program "if that agreement reasonably defines the hours for which paid care services will be provided." The determination of whether such an agreement is reasonable, the rule states, "includes consideration of whether it would have included the same number of paid hours if the paid care provider had not been a family or household member of the consumer." This interpretation "does not generally apply to relationships that do not involve preexisting family ties or a preexisting shared household," according to the fact sheet. If the consumer and caregiver enter into a new family relationship during the course of an employment relationship, however, then the FLSA employment relationship would be limited even though the family relationship did not predate the employment relationship.

The department also recognizes in the rule "that some paid or unpaid caregivers who are not family but are household members, meaning they live with the person in need of care based on a close, personal relationship that existed before the caregiving began — for example, a domestic partner to whom the person is not married — are the equivalent of family caregivers."

Effective Date

The rule will become effective on January 1, 2015. DOL "believes that this extended effective date takes into account the complexity of the federal and state systems that are a significant source of funding for home care work and the needs of the diverse parties affected by this Final Rule (including consumers, their families, home care agencies, direct care workers, and local, state and federal Medicaid programs) by providing such parties, programs and systems time to adjust." In the rule, DOL commits to "work closely with stakeholders and the Department of Health and Human Services to provide additional guidance and technical assistance during the period before the rule becomes effective, in order to ensure a transition that minimizes potential disruption in services and supports the progress that has allowed elderly people and persons with disabilities to remain in their homes and participate in their communities."

FMI The Final Rule and accompanying FAQs and Fact Sheets are available at www.dol.gov/whd/homecare/finalrule.htm.

LTC Commission Issues Final Report

Last month the federal Commission on Long-Term Care completed its work on a package of recommendations and issued a Final Report on long-term services and supports (LTSS). Per statutory requirements requiring a vote on September 12, a majority of commissioners from appointee offices on both sides of the political aisle voted in favor of a package of recommendations to be submitted to Congress, which seeks to renew a national discussion on long-term care.

Since beginning its work on June 10, the commission developed a series of recommendations as well as potential financing frameworks reflecting a diversity of opinions on the commission on how to best to deliver and finance needed long-term services and supports. The full list of ideas that were considered appears as an appendix in the Final Report.

The recommendations approved by the commission include:

- Promote services for persons with functional limitations in the least restrictive setting appropriate to their needs — building a system, including Medicaid, with options for people who would prefer to live in the community.
- Create livable communities building on models that can improve access to services and health care-LTSS coordination.
- Completion of a simpler and more usable standard assessment mechanism across care settings (acute, post-acute, and LTSS).
- Expand the "No Wrong Door" approach to provide enhanced options counseling for individuals to navigate LTSS; and provide the support needed to make this approach effective nationally.
- Improve focus on quality across settings of LTSS — with particular attention to home and community-based services.
- Maintain and strengthen a person- and family-centered LTSS system with both the person with cognitive or functional limitations and the family caregiver (spouse or partner, child or grandchild, parent, sibling, or other unpaid assistant) as a focus for services and supports. Include family caregivers and their needs in assessment and care planning processes.
- Create meaningful career ladders and lattices for direct care workers that result in access to career advancement opportunities and improved compensation.
  Create a demonstration project to provide workers with disability coverage for the LTSS they need to remain employed.
- Assist the states to achieve greater uniformity of eligibility and benefits in State Medicaid Buy-In programs for LTSS for workers with significant disabilities.
- A subsequent national advisory committee be created to continue this work and consider the commission's recommendations and potential financing frameworks as a starting point for its own assessments and recommendations.

Separately, five commissioners have released alternative recommendations, expressing their conviction that "no real improvements to the current insufficient, disjointed array of LTSS and financing can be expected without committing significant resources, instituting federal requirements, and developing social insurance financing." Chief among their recommendations is the creation of a public social insurance program.

FMI The final report is available at www.ltccommission.senate.gov/Commission%20on%20Long-Term%20Care-%20Final%20Report%209-26-13.pdf.

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Knowing Our History...

A Historic Turning Point in I/DD Services: October 1963

by
Bob Gettings

This month marks the 50th anniversary of the enactment of two pieces of federal legislation that dramatically changed the course of public services for people with developmental disabilities in the United States.

On October 24, 1963, President John F. Kennedy signed into law the Maternal and Child Health and Mental Retardation Planning Amendments (P.L. 88-156). One week later on October 31st he signed the Mental Retardation Facilities and Community Mental Health Centers Construction Act (P.L. 88-164). These two measures were based on recommendations of the President's Panel on Mental Retardation, a blue ribbon study group appointed by Kennedy in 1961 shortly after assuming office.

In its landmark, 1962 report, the president's panel proposed the creation of a nationwide network of research, training, and service centers to spearhead efforts to improve services to individuals with intellectual disabilities. This and other panel recommendations were translated into legislative language and packaged with a separate set of proposals growing out of the 1961 report of the Joint Commission on Mental Illness and Mental Health. The entire legislative package was transmitted to Capitol Hill on February 5, 1963, along with the first ever presidential message to Congress on mental health and mental retardation services.

In addition to expanding access to maternal and child health services, P.L. 88-156 authorized grants to assist states in developing comprehensive state and community action plans "to combat mental retardation." Grant funds totaling $2.2 million was set aside over an 18-month period to support planning grants to the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, and American Samoa. The legislation was amended in 1965 to authorize $5.5 million over two fiscal years to assist states in implementing their comprehensive mental retardation plans.

P.L. 88-164 authorized federal funds to support the construction of facilities for the "diagnosis, treatment, training and custodial care" of persons with mental retardation, including community day and residential centers, university-affiliated facilities (UAFs) to serve as interdisciplinary training

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hubs, and a network of mental retardation research centers. The UAF and research center grants were awarded directly to universities on a competitive basis, while funds for community facilities were allocated among the states on a formula grant basis.

Prior to the passage of the Kennedy legislation, the states received virtually no financial aid from the federal government to help them furnish public services to persons with mental retardation. Modest amounts of federal dollars were available to support basic and applied research and train professionals (primarily special educators and vocational counselors). Collectively, the component units of the U.S. Department of Health, Education, and Welfare expended a total of $48 million on mental retardation-related activities in FY 1960, about two-thirds of which represented Social Security payments to disabled adult beneficiaries.

Over the succeeding five decades, the federal government has become a major force in financing services to persons with intellectual and other lifelong disabilities. In 1965, at the urging of President Johnson, Congress enacted the first broad-based aid to elementary and secondary schools and created the Medicare and Medicaid programs. A national floor on cash benefits to low-income elders and persons with disabilities and blindness was added to the Social Security Act in 1972 and a few years later Congress enacted a law mandating education for all children with disabilities. Specialized benefits for individuals with intellectual disabilities were added to the Medicaid program in 1971 with the enactment of the ICF/MR coverage option; and a decade later (in 1981) Congress afforded states
the option of covering home and community-based services under federally approved waivers. In 2011, 61 percent of the $56.7 billion being expended developmental disabilities services nationwide was derived from federal sources, with Medicaid payments accounting for the largest share (www.stateofthestates.org). This outpouring of federal largesse, however, started with the passage of the Kennedy legislation.

FMI To learn more about the impact of the 1963 mental retardation legislation, see *Forging a Federal-State Partnership: A History of Federal Developmental Disabilities Policy*, by Bob Gettings. Copies of the later publication can be ordered by visiting the AAIDD online bookstore at aaidd.org/publications/bookstore-home/management#.UiaGin8biBk.

Yudin Nominated to OSERS Assistant Secretary

President Obama has nominated Michael Yudin as the Assistant Secretary for the Office of Special Education and Rehabilitative Services (OSERS) at the U.S. Department of Education (ED).

Mr. Yudin has led OSERS as the Acting Assistant Secretary since August 2012. He previously served as the Principal Deputy Assistant Secretary for Elementary and Secondary Education, where he also served as acting assistant from June 2011 to May 2012. Prior to joining the Department of Education, Yudin served as Legislative Director for U.S. Senator Jeanne Shaheen from 2009 to 2010, Senior Counsel to U.S. Senator Jeff Bingaman from 2003 to 2008, and Counsel to U.S. Senator James Jeffords on the U.S. Senate Committee on Health, Education, Labor and Pensions from 2001 through 2002. Yudin served as Director of Employment Policy for the organizations The Arc and United Cerebral Palsy in 2002. Yudin worked in the Office of the General Counsel at the Social Security Administration from 1994 to 2001 and in the Office of Administrative Law Judges at the U.S. Department of Labor from 1991 to 1994. He received a B.A. from State University of New York at Albany and a J.D. from the Western New England College School of Law.

PRIME Act Intended to Combat Medicaid Waste Fraud and Abuse

Senate Homeland Security and Governmental Affairs Committee Chairman Tom Carper (D-DE) and ranking member Tom Coburn (R-OK), together with Representatives Peter Roskam (R-IL) and John Carney (D-DE), have introduced legislation to combat and prevent waste, fraud and abuse in Medicare and Medicaid. The "Preventing and Reducing Improper Medicare and Medicaid Expenditures Act of 2013," or the PRIME Act, would address a set of problems that "lead to billions of dollars lost to waste and fraud in Medicare and Medicaid every year." In the Senate, the PRIME Act is cosponsored by Senators Michael Bennet (D-CO), Chris Coons (D-DE), Amy Klobuchar (D-MN), Mary Landrieu (D-LA), Claire McCaskill (D-MO), and Mark Warner (D-VA). In the House of Representatives, the bill is cosponsored by Representatives Ron Barber (D-AZ), Randy Hultgren (R-IL), Tom Reed (R-NY), and Kurt Schrader (D-OR).

Among its provisions, the PRIME Act would:

- enact stronger penalties for Medicare and Medicaid fraud;
- curb improper or mistaken payments made by Medicare and Medicaid;
- establish stronger fraud and waste prevention strategies within Medicare and Medicaid to help phase out the practice of "pay and chase;"
- curb the theft of physician identities;
- expand the fraud identification and reporting work of the Senior Medicare Patrol;
- take steps to help states identify and prevent Medicaid overpayments; and
- improve the sharing of fraud data across state and federal agencies and programs.

FMI To read the bill or track its progress, go to thomas.loc.gov and search for bill number H.R. 2305 or S. 1123.

MPR Reports on MFP Progress

Mathematica Policy Research (MPR) has released a chart book summarizing the implementation progress of the Money Follows the Person (MFP) Demonstration by 37 active grantee states for the six-month period from July 1 to December 31, 2012. It presents the number of transitions, progress towards annual transition goals, reinstitutionalization rates, home and community-based services (HCBS) expenditure levels, rates of self-direction among MFP participants, and type of housing. The summary is based on information self-reported by state grantees in their 2012 end-of-year progress reports, which were submitted on March 1, 2013.

By the end of 2012, the fifth full year of the MFP demonstration, Mathematica found that "the number of MFP transitions continued to grow by all measures." From July to December 2012, the number of new transitions (4,882) increased by 13 percent compared to the previous six month period. Enrollment at the end of December 2012 was 9,201, an increase of 18 percent over June 2012. Among those who transitioned during this period, 40 percent were older adults aged 65 and older, 38 percent were younger than 65 with physical disabilities, 13 percent have intellectual disabilities, 6 percent have mental illness, and 2 percent were "other" individuals.

FMI The report is available at www.mathematica-mpr.com/publications/PDFs/health/mfp_july-dec2012_progress.pdf?spMailingID=7043783&spUserID=MTU3ODMzNTQzMwS2&spJobID=90194295&spReportId=OTAxOTQyOTUS1.

CMS Clarifies Medicaid Funding Available for LTC Ombudsman Programs

The Centers for Medicare and Medicaid Services (CMS) recently issued an Informational Bulletin reviewing existing policy regarding Medicaid funding for administrative costs related to activities conducted by state Long-Term Care Ombudsman (LTCO) programs that benefit the state's Medicaid program. The bulletin summarizes the basic requirements for Medicaid administrative claiming of LTCO program activities and provides a link on the CMS Medicaid.gov website where states and LTCO programs can find more detailed information regarding specific LTCO program activities that may be eligible for Medicaid administrative funding.

Examples of LTCO activities that could be supported by Medicaid funding include assistance to individuals in applying for Medicaid, benefits review, and service planning for Medicaid beneficiaries. Specific examples listed in the bulletin include:

- Information provided to potential enrollees regarding Medicaid eligibility and facilitation of the enrollment process.
- Identifying and referring individuals who may be eligible for and in need of Medicaid services.
- Tracking and reporting to the Medicaid agency consumer requests for assistance in obtaining medical, dental, mental health, or long-term care (including home and community based) services that are covered by Medicaid.
- Consultation and direct case advocacy to assist individuals participating in home and community-based waiver programs.
- Identifying and reporting suspected instances of Medicaid fraud to federal and state agencies for investigation and action.

LTCO program costs can be recognized as allowable Medicaid administrative costs only to the extent that the state has documented that the costs directly benefit the Medicaid program and are claimed consistent with federal cost allocation principles.

FMI The Informational Bulletin is available at www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-06-18-2013.pdf.

CMS Announces Changes to Eligibility Reviews

The Centers for Medicare and Medicaid Services (CMS) has released a letter to state health officials to provide guidance to states on eligibility reviews under the Payment Error Rate Measurement (PERM) and the Medicaid Eligibility Quality Control (MEQC) programs. In light of substantial changes to the way states adjudicate eligibility for applicants for Medicaid and the Children's Health Insurance Program (CHIP) starting in 2014, CMS will be substituting an annual 50-state strategy with rapid feedback for improvement, in place of the PERM and MEQC eligibility reviews, starting January 1, 2014, for fiscal years (FY) 2014-2016.

The letter announces an interim change in methodology for conducting Medicaid and CHIP eligibility reviews under PERM for FY 2014-2016 (cycles 3, 1, and 2, respectively). Instead of the current PERM and MEQC eligibility review requirements, during this time, all states will participate in the Medicaid and CHIP Eligibility Review Pilots to provide more targeted, detailed information on the accuracy of eligibility determinations. During this period, PERM managed care and fee-for-service payment

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MPR Assesses Ticket to Work

Mathematica Policy Research (MPR) has issued a report providing statistics on employment and benefit outcomes for Ticket to Work (TTW) participants since the inception of the program in 2002 and comparing them to outcomes for other Social Security Disability (SSD) and Supplemental Security Income (SSI) beneficiaries. It also provides statistics on payments to Employment Networks (EN) under the payment systems introduced under TTW and how beneficiary employment outcomes and related provider payments vary by the nature of the EN business model.

The report is the first to produce statistics on changes in work activity and payments to ENs following substantial revisions to the TTW program regulations in July 2008. MPR analyzes a monthly indicator of whether the beneficiary was in nonpayment status following suspense or termination for work (NSTW); and, for SSD beneficiaries, the dollar amount of benefits forgone for work (BFWDI). The analysis was designed, in part, "to provide information about how the revised regulations affected NSTW and BFWDI," although MPR points out that "the effects of those regulatory changes are confounded by the large recession that was essentially contemporaneous with the implementation of the new regulations." Nonetheless, according to MPR, "it is clear that after the implementation of the revised regulations, there was renewed interest in the TTW program, with a doubling of EN providers from 2007 to 2010 and a quadrupling of participant assignments during that time in the payment systems established by TTW."

Center for STUDYING DISABILITY POLICY

Reflecting the growth in participants, the number of participants experiencing NSTW months increased, as did total BFWDI. Per participant, however, both outcomes declined over this time period. One notable change since 2008 MPR attributes to "regulatory changes [that] increased the attractiveness to providers of the milestone-outcome payment system relative to the outcome only (OO) system:" the already low percentage of assignments under the OO system dropped sharply after the change. MPR also investigated participant outcomes by the business model of the EN providing services, assessing implications for the financial viability of TTW providers.

FMI The report is available at www.mathematica-mpr.com/publications/PDFs/disability/TTW_Part_Provid_outcomes.pdf?spMailingID=7043783&spUserID=MTU3ODMzNTQzMwS2&spJobID=90194295&spReportId=OTAxOTQyOTUS1.

(Eligibility Reviews continued from page 10)

reviews will continue uninterrupted on the normal cycle schedule, and CMS will continue to report Medicaid and CHIP improper payment rates based on that data. In addition, PERM eligibility component measurements through the FY 2013 cycle will continue as scheduled. Beginning in FY 2014, the 50-state Medicaid and CHIP Eligibility Review Pilots will take the place of the PERM state eligibility determination reviews; albeit not for reporting comprehensive Medicaid and CHIP program error rates which will use an estimated eligibility component rate based on historical data.

The Medicaid and CHIP Eligibility Review Pilots will use targeted measurements to: (1) provide state-by-state programmatic assessments of the performance of new processes and systems in adjudicating eligibility; (2) identify strengths and weaknesses in operations and systems leading to errors; and (3) test the effectiveness of corrections and improvements in reducing or eliminating those errors. The pilots will also provide a testing ground for different approaches and methodologies for producing reliable results and help inform CMS's approach to rulemaking that the agency says it will undertake prior to the resumption of the PERM eligibility measurement component in FY 2017.

FMI The letter is available at www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-005.pdf.

FDA Warns Against Hyperbaric Oxygen Therapy for Autism

The Food and Drug Administration (FDA) recently issued a warning that hyperbaric oxygen treatment (HBOT) is not an approved or effective treatment or cure for autism, cancer, diabetes, and a number of other conditions and diseases. Companies and websites claiming hyperbaric oxygen can treat or cure autism are misleading the public, according to the FDA. HBOT is a scientifically supported treatment for decompression sickness that is being increasingly recommended as a treatment for autism.

The journal Research in Autism Spectrum Disorders reports the results of a randomized double-blind placebo-controlled trial study comparing HBOT to placebo in children with autistic disorder who received 80 sessions of treatment over a 15-week period. Multiple standardized instruments and direct behavioral observations were used to evaluate treatment effects on Autism Spectrum Disorder (ASD) symptoms. The results indicated no significant differences between HBOT and placebo groups across any of the outcome measures (social reciprocity, communication, and repetitive behaviors). The study concludes that HBOT does not result in a clinically significant improvement of the symptoms of autism and that it is not recommended for the treatment of ASD symptoms.

Thirteen uses of a hyperbaric chamber for HBOT have been cleared by FDA. They include treatment of air or gas embolism (dangerous "bubbles" in the bloodstream that obstruct circulation), carbon monoxide poisoning, decompression sickness (often known by divers as "the bends"), and thermal burns (caused by heat or fire).

FMI The FDA warning is available at www.fda.gov/forconsumers/consumerupdates/ucm364687.htm.

DOL Finalizes Disability Employment Requirements for Federal Contractors

The U.S. Department of Labor (DOL) has finalized rules that makes changes to the regulations implementing Section 503 of the Rehabilitation Act of 1973, as amended at 41 CFR Part 60-741. Section 503 prohibits federal contractors and subcontractors from discriminating in employment against individuals with disabilities, and requires these employers to take affirmative action to recruit, hire, promote, and retain these individuals.

The Final Rule adds specific measurements for meeting the affirmative action provisions of the regulations and makes changes to the nondiscrimination provisions of the regulations to bring them into compliance with the ADA Amendments Act of 2008.

The Final Rule establishes a nationwide 7 percent utilization goal for qualified individuals with disabilities. Contractors must apply the goal to each of their job groups, or to their entire workforce if the contractor has 100 or fewer employees, and must conduct an annual utilization analysis and assessment of problem areas, and establish specific action-oriented programs to address any identified problems.

FMI More information, including links to the rule itself, can be found at www.dol.gov/ofccp/regs/compliance/section503.htm.

ACL Funds Community Transportation Projects

Seventeen communities have been awarded grants to improve coordinated transportation services for older adults and people with disabilities. Funding for these projects was provided by the Strengthening Inclusive Coordinated Transportation Partnerships to Promote Community Living, a project funded by the U.S. Administration for Community Living (ACL) and administered by the Community Transportation Association of America (CTAA).

The intent of the projects is to demonstrate that when engaged from the onset, older adults and people with disabilities, including people with intellectual and developmental disabilities, are valued stakeholders in the planning and delivery of transportation services specifically designed for them.

The 17 selected projects include:

- Community Action Commission of Fayette County, Washington Court House, OH
- Toledo Metropolitan Area Council of Governments, Toledo, OH
- Area Agency on Aging 1-B, Southfield, MI
- Knoxville-Knox County Community Action Committee, Knoxville, TN
- Ride Connection, Inc., Portland, OR
- City of Helena, Helena, MT
- Montgomery County Maryland, Rockville, MD
- Area Agency on Aging of Tarrant County, Fort Worth, TX
- Lifestream Services, Inc., Yorktown, IN
- Alaska Mobility Coalition, Anchorage, AK
- Indian Nations Council of Governments, Tulsa, OK
- Columbia County Health and Human Services, Portage, WI
- Mountain Empire Older Citizens, Inc., Big Stone Gap, VA
- National Participant Network, Taos, NM
- Marin Transit, San Rafael, CA
- Des Moines Area Metropolitan Planning Authority, Des Moines, IA
- The Arc of Connecticut, Hartford, CT

FMI More information about the program can be found at web1.ctaa.org/webmodules/webarticles/anmviewer.asp?a=3265.

SSA Reports SSI Recipients by State and County

The Social Security Administration (SSA) has released its 2012 report on Supplemental Security Income (SSI) recipients by state and county. The report is a resource for Social Security Administration (SSA) staff in formulating policy and for local service providers and economic planners. The data presented in this document are for federal and federally administered state payments only.

The tables present SSI data by eligibility category (aged, blind, and disabled) and age.
State data on the number of recipients and amount of payments are shown in Tables 1 and 2, respectively. SSI recipients who also receive Social Security (Old-Age, Survivors, and Disability Insurance) benefits are shown in Table 1 and in Table 3, which presents data at the county level. For the applicable states, Table 4 shows state-level data on persons receiving federally administered state supplementation payments by the recipient's living arrangement.

FMI The report is available at www.ssa.gov/policy/docs/statcomps/ssi_sc/2012/ssi_sc12.pdf.

NASDDDS
Directors Forum & Annual Conference

Rising Expectations —
A Systemic Response to the Community Integration Mandate

November 13-15, 2013
Hotel Monaco, Old Town Alexandria, Virginia

We are moving beyond the time when states can focus exclusively on one aspect of their service system: moving people from institutions, finding people jobs, or expanding services for the waiting list.
With ADA and the Olmstead decision maturing into a mandate for full community integration for everyone in all dimensions of life, states must now focus on their entire system at once.

The conference will provide opportunities to:

- Learn about the overall environment: the combination of DOJ actions; CMS policy statements and guidance to states; the recent report from Senator Tom Harkin; and advocacy initiatives
- Gain insight into the implications and expectations for state I/DD systems to implement a full integration mandate systemically
- Participate in a dialogue with CMS, DOJ, and other federal officials
- Hear from public leaders who have immersed themselves in comprehensive system reform and how to go about it
- Gain insights and ideas from state I/DD agencies engaged in current, large scale systems transformation

In addition to the Delaware's Governor Jack Markell's Ben Censoni Award Luncheon, some featured speakers include:

Joette Katz	Commissioner, Connecticut Department of Children and Families
Ari Ne'eman	President and Co-founder, Autistic Self-Advocacy Network; Member, National Council on Disability and Chair, Policy and Program Evaluation Committee

If you have any questions regarding program content,
please email Barbara Brent or call
(703) 896-0043.
For registration or exhibit questions, email Megan Rose or call (703) 683-4202.

Additional Information and Registration are Available at
register.nasddds.org/registration