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June 3, 2016

The Honorable Thomas E. Perez
Secretary
U.S. Department of Labor
200 Constitution Ave, NW
Washington, DC 20210

Dear Secretary Perez,

On behalf of the National Association of Medicaid Directors, the National Association of State Mental Health Program Directors, the National Association of State Directors of Developmental Disabilities Services, and the National Association of States United for Aging and Disabilities, we are writing with concerns about the policies your Department adopted when issuing the Fair Labor Standards Act "white collar" exemptions final rule (RIN 1235-AA11).

Our primary concern is with the inequities that manifest from the non-enforcement policy that DOL announced at 29 CFR Part 541 on May 18, 2016. This policy indicates that the Department of Labor (DOL) will not enforce the new wage thresholds for employees at providers of Medicaid-funded services for individuals with intellectual or developmental disabilities in residential homes and facilities with 15 or fewer beds. While we appreciate that DOL acknowledged the unique needs of Medicaid home and community based services (HCBS) and is attempting to support state Medicaid initiatives to strike a better balance between facility and home and community based settings, the final policy does not support these goals for a number of reasons. The policy misunderstands the Medicaid program, does not clearly articulate the entities who would be covered by the non-enforcement period, is discriminatory against some populations that receive HCBS, and may have the effect of limiting the available community providers for Medicaid beneficiaries. Furthermore, the non-enforcement policy is not likely to protect providers from private right of action and could create challenges regarding litigation from employees. Lastly, we have concerns about the effective date of the regulation since it occurs in the middle of every state's fiscal year; however, the rule was finalized after the end of many state legislative sessions.

Because of these concerns, we request that the DOL:

- Expand the non-enforcement policy to cover all government-funded HCBS services;

- Delay the effective date for all Medicaid services until after the end of the next state legislative session; and
- Provide support for HCBS providers against the threat of litigation or other private action.

**The policy misunderstands fundamental policy, programmatic and financing aspects of the Medicaid program.** There are a wide range of populations and providers in the Medicaid HCBS system. It is true that Medicaid HCBS has historically been divided into targeted groups such as seniors, people with behavioral health conditions, and people with intellectual or developmental disabilities. However, Medicaid policy has been moving away from these distinctions over the past decade. New options such as the Community First Choice benefit, the 1915(i) state plan option, and 1115 waivers have been developed in manners that meet the needs of individuals rather than their diagnosis. These options allow states to enroll individuals with many different types of health conditions and disabilities in the same program and have been developed under the strong encouragement of the federal government. The non-enforcement policy would require states to re-segregate their HCBS options if they wish to create differentiated rate structures based on the cost of the labor for employees of HCBS providers.

**The policy does not clearly articulate covered entities.** DOL's release refers to providers of Medicaid-funded services for individuals with intellectual or developmental disabilities in residential homes and facilities with 15 or fewer beds. While some providers may be easily identified, there are many companies that deliver services to individuals with a wide range of long term services and supports (LTSS) needs regardless of their primary diagnosis.

Further, DOL seems to premise its non-enforcement policy on the notion that these groups are neatly divided into "individuals with intellectual or developmental disabilities" and those with other conditions. In reality, many individuals have co-occurring disabilities and would qualify as having a physical disability and/or mental illness in addition to their intellectual disability. Similarly, many individuals with intellectual and developmental disabilities are reaching, or nearing, retirement age and could be considered to qualify for services under an aged category rather than a disability category. It is unclear how these individuals would be categorized for purposes of the regulation.

These dynamics lead to a series of complex policy and operational questions. For example:

- Would a provider qualify based on the source of funding (i.e.: only if they are enrolled in a Medicaid 1915(c) waiver targeted to people with developmental disabilities)?
- Would a provider that delivered care primarily to seniors be eligible if they served one individual with a developmental disability?
- Will the threshold be set at half of the clients served, or would the provider need to have a customer base of only individuals with intellectual and/or developmental disabilities?
- Would providers that primarily serve individuals with behavioral health conditions qualify if some clients have a dual diagnosis of a developmental disability?

The issues and questions identified here impact state agency relationships and contractual, financial arrangements with these providers. Therefore we ask DOL to provide clarifications to address the unique and diverse state Medicaid rules and program structures.

**The policy is discriminatory against some populations that receive HCBS.** In the statement of policy on non-enforcement, DOL expresses concern that the new overtime exemption could undermine compliance efforts of HCBS providers as they work to ensure that individuals are integrated into the community. We agree. However, we note that the rule referenced (See 79 FR 2948; Jan. 16, 2014) applies to *all populations that receive Medicaid funded HCBS*. Furthermore, federal Medicaid data shows a much higher proportion of Medicaid spending for individuals with developmental disabilities occurs in community settings compared to older adults, people with physical disabilities, or individuals with traumatic brain injuries.[1] If the goal of this non-enforcement is to continue to promote community integration, we believe DOL should revise the guidance to include all community-based LTSS providers for the populations currently excluded, including individuals with mental illness.

Additionally, the policy creates a real and significant incentive for providers to forego services to other populations and to focus solely on serving individuals with intellectual or developmental disabilities. Serving such populations will allow those providers to be covered by this non-enforcement policy, which provides a distinct financial benefit. This financial incentive to provide services to some types of people with LTSS needs instead of others is inherently discriminatory. Further, it could undermine state initiatives to ensure timely access to appropriate, high-quality services to all populations eligible for LTSS.

**This policy may have the effect of limiting the available community providers for Medicaid beneficiaries.** This policy appears to solely focus on HCBS residential care providers, as it specifically refers to, "homes or facilities with 15 or fewer beds." Medicaid HCBS programs have developed a wide range of services and supports that focus on promoting community integration. Many of these services are not delivered by the home or facility of an individual's residence. As one example, an agency manager may be responsible for individuals who get services in their home as well as in the community. Agencies may feel that they cannot co-manage residential services and employment or community integration services, and eliminate services not focused on residential.

The rule also states that the providers in question are "Medicaid-funded residential homes." If that is the case, then the same concerns apply to services provided to individuals who live in a private residence but who have Medicaid-funded service providers. These home-based services have been actively encouraged by the Centers for Medicare & Medicaid Services and the Department of Justice as ways to promote community integration and comply with the Medicaid HCBS final rule as well as the Supreme Court ruling in *Olmstead vs. LC.*

The guidance could put agencies providing services not-covered by the non-enforcement policy at a competitive disadvantage compared to those that qualify for non-enforcement. As such, this policy may have the unintended consequence of forcing more individuals into provider owned or operated settings rather than in their own private residence or their family home. This outcome is completely contrary to the policy goals of the Medicaid HCBS final rule and the *Olmstead* ruling, both of which focus on

[1] https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/downloads/ltss-expenditures-2014.pdf

maximizing individuals' choices and ensuring that people who require long term services and supports can receive services in the most integrated setting appropriate to their needs and preferences.

**The non-enforcement policy does not protect employers from private action.** Under the FLSA, DOL enforcement is not the only mechanism that ensures employer compliance with minimum wage and overtime requirements. Employees also have the option to pursue individual or collective right of action, which would continue to be available under this policy. The non-enforcement policy may give some HCBS providers a false sense of security during the transition period, as DOL's non-enforcement will not impact workers' rights to pursue private action. If these employers take advantage of the non-enforcement, it could make them vulnerable to lawsuits or other types of legal action. We request that, in addition to expanding the policy to cover all HCBS providers, DOL also provide guidance or support to assist employers as they work towards compliance without subjecting them to the threat of litigation or other private action. This guidance should be included in DOL's regulatory and educational roll-out materials and should include mechanisms to demonstrate and document efforts to become compliant in a manner that protects employers from private action.

**The regulation's effective date is problematic for state budgets.** In addition to our requests to ensure the non-enforcement policy sufficiently protects all Medicaid-eligible clients receiving LTSS, we ask DOL to amend the effective date. A December 1, 2016 effective date of the rule is problematic for states for several reasons. The rule may require many states to modify provider rates to reflect the cost of delivering services. However, this effective date occurs in the middle of every state's fiscal year. At this point in the year, FY2017 budgets are largely established and many state legislative sessions have already ended. State agencies were not afforded sufficient opportunity to request the funding and contract modifications that this rule may require.

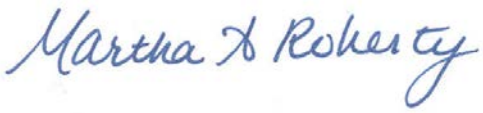
In addition to challenges posed by the effective date, we wish to reiterate a key issue identified in our earlier correspondence regarding the homecare exemption: state budgets must fit within a defined set of revenue and expenditure projections since states are barred from deficit spending. The requirement for balanced budgets, coupled with the sluggish revenue growth over the past several years, means that increasing spending for one programmatic area almost always necessitates reductions in other areas. This rule will likely impact a wide range of state-funded services beyond just HCBS and will compete with new resources needed to comply with new federal mandates from the Medicaid mental health parity and managed care regulations as well as states' work to transition away from fee-for-service and towards value-based purchasing arrangements. We have serious concerns about the resulting impact on state finances and corresponding reductions to government services.

As such, we request that you delay the enforcement of this regulation for state government-funded services until the first day of the state fiscal year occurring after the next legislative session in such state. This would give an opportunity for state legislatures to properly allocate funding in order to meet the requirements of this rule.

We look forward to continuing these discussions to ensure that the rule does not have serious unintended consequences on providers and beneficiaries of HCBS.

Sincerely,

Mary Lee Fay
Executive Director
National Association of State Directors of Developmental Disabilities Services



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