Executive Summary

Funding Health-Related VR Services: the Potential Impact of the Affordable Care Act on the Use of Private Health Insurance and Medicaid to Pay for Health-Related VR Services

by Robert "Bobby" Silverstein

INTRODUCTION

One of the myriad of issues affecting the administration of the vocational rehabilitation (VR) program by state VR agencies under Title I of the Rehabilitation Act is how to maximize access to and use of all available funding sources to pay for VR services and supports, including health-related services, for VR applicants and clients rather than expend limited federal and state VR funds on such services. For example, in 2011 the total expenditure for diagnoses and treatment of physical and mental impairments by state VR agencies was $263,920,111, which equals 14 percent of the total amount of purchased services. This amount ranged among state VR agencies from less than 1% to 69% of the total amount for purchased services.[1]

In March 2010, Congress passed and the President signed into law the Affordable Care Act (ACA).[2] On June 28, 2012, the United States Supreme Court upheld all of the provisions of the ACA, with the exception of provisions mandating Medicaid expansion. The Supreme Court held that if a state chooses not to participate in this expansion of Medicaid eligibility for low-income adults, the state may not, as a consequence, lose federal funding for its existing Medicaid program.[3]

The ACA includes significant new potential funding sources (including private health insurance and Medicaid) to pay for health-related VR services and supports. Under the ACA, essential health benefits (including rehabilitative and habilitative services and devices; mental health and substance use disorder services, including behavioral health treatment; and chronic diseases management) will be more readily available to an expanded population through the private insurance market. Also, under the ACA an expanded number of people may, at a state's discretion, receive health care services under the Medicaid program.

The purpose of this article is to summarize the key findings, conclusions, and recommendations included in a recent report entitled *Funding Health-Related VR Services: The Potential Impact of the Affordable Care Act on the Use of Private Health Insurance and Medicaid to Pay for Health-Related VR Services* (December 2012).[4] For certain states, pursuing strategies that minimize expenditures for health-related VR services, including physical and mental restoration services,5 assistive

---

1 RSA-2 Financial Report, 2011.

2 The ACA was enacted in two parts: the Patient Protection and Affordable Care Act (Pub. L. No. 111-148) was passed on March 23, 2010, and was amended by the Health Care and Education Reconciliation Act (Pub. L. No. 111-152) on March 30, 2010.

3 National Federation of Independent Business et al. v. Sebelius, Secretary of Health and Human Services, et al., Slip Opinion No. 11-393 (June 28, 2012).

4 This paper was funded in part by a grant from the National Institute on Disability and Rehabilitation Research (NIDRR) and the Rehabilitation Services Administration (RSA) supporting the Rehabilitation Research and Training Center on Vocational Rehabilitation. The opinions contained in this paper are those of the author and do not necessarily reflect those of NIDRR, RSA, or any other office of the U.S. Department of Education, any other agency or department of the Federal Government, any of the states referenced in this paper, or any other organization or individual. This brief is not intended to advocate or lobby for any particular solution.

5 "Physical and mental restoration services" include corrective surgery or therapeutic treatment that is likely, within a reasonable period of time, to correct or modify substantially a stable or slowly progressive physical or mental impairment that constitutes a substantial impediment to employment; diagnosis of and treatment for mental or emotional disorders by qualified personnel in accordance with state licensure laws; dentistry; nursing services; necessary hospitalization (either inpatient or outpatient care) in connection with surgery or treatment and clinic services; drugs and supplies; prosthetic and orthotic devices; eyeglasses and visual services; podiatry; physical therapy; occupational therapy; speech or hearing therapy; mental health services; treatment of either acute or chronic medical complications and emergencies that are associated with or arise out of the provision of physical and mental restoration services, or that are inherent in the condition under treatment; special services for the treatment of individuals with end-stage renal disease, including transplantation, dialysis, artificial kidneys, and supplies; and other medical or medically related rehabilitation services. [34 CFR 361.5(40)]

technology devices and services,6 and personal assistance services,7 may increase the amount of funds available for other VR services and to expand the number of clients served by the VR program.

Below is a summary of the major conclusions and recommendations for maximizing the use of funding sources other than VR funding to pay for the costs of health-related VR services and supports. The paper provides guidance and recommendations regarding the following topics:

- Modernizing the federal and state VR policy frameworks applicable to payment for health-related VR services
- Determining the scope of the benchmark package of essential health benefits and making other ACA implementation decisions
- Determining the Medicaid benchmark plan in Medicaid expansion states
- Ensuring coverage of personal assistance services under the Community First Choice Option in VR programs and employment settings

1. MODERNIZING THE FEDERAL AND STATE VR POLICY FRAMEWORKS APPLICABLE TO THE PAYMENT FOR HEALTH-RELATED VR SERVICES

The potential impact of the ACA and state Medicaid reforms on the responsibilities of state VR agencies to pay for health-related VR services is substantial. The current VR policy framework[8] provides legal and policy bases for facilitating payment for many health-related VR services by private health insurance or Medicaid, rather than by the VR agency. However, the current policy framework should be further clarified in regulation or through policy guidance to include specific references to the ACA. This will provide VR agencies with greater leverage with other state agencies to ensure that private health insurance and Medicaid are used to pay for these health-related VR services prior to payment by state VR agencies.

More specifically, the Rehabilitation Services Administration and state VR agencies should consider modernizing the federal VR policy framework (either through regulation or policy guidance) by clarifying the applicability of the ACA, including Medicaid reforms, to the VR program. The policy guidance should clarify and spell out:

---

6 The term "assistive technology device" means any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve the functional capabilities of an individual with a disability. [34 CFR 361.5(7)] The term "assistive technology service" means any service that directly assists an individual with a disability in the selection, acquisition, or use of an assistive technology device, including:
(i) The evaluation of the needs of an individual with a disability, including a functional evaluation of the individual in his or her customary environment;
(ii) Purchasing, leasing, or otherwise providing for the acquisition by an individual with a disability of an assistive technology device;
(iii) Selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;
(iv) Coordinating and using other therapies, interventions, or services with assistive technology devices, such as those associated with existing education and rehabilitation plans and programs;
(v) Training or technical assistance for an individual with a disability or, if appropriate, the family members, guardians, advocates, or authorized representatives of the individual; and
(vi) Training or technical assistance for professionals (including individuals providing education and rehabilitation services), employers, or others who provide services to, employ, or are otherwise substantially involved in the major life functions of individuals with disabilities, to the extent that training or technical assistance is necessary to the achievement of an employment outcome by an individual with a disability. [34 CFR 361.5(8)]

7 The term "personal assistance services" means a range of services provided by one or more people designed to assist an individual with a disability to perform daily living activities on or off the job that the individual would typically perform without assistance if the individual did not have a disability. The services must be designed to increase the individual's control in life and ability to perform everyday activities on or off the job. The services must be necessary to the achievement of an employment outcome, and may be provided only while the individual is receiving other VR services. The services may include training in managing, supervising, and directing personal assistance services. [34 CFR 361.5(39)]

8 There are four primary legal/policy bases in the current VR policy framework governing the use by VR agencies of other funding sources prior to using VR funds. The first provision is the obligation under the VR policy framework that designated state units must determine the availability of comparable services and benefits (e.g., services and benefits that are provided by other federal, state, or local public agencies, by health insurance or by employee benefits) before providing VR services to an eligible individual using VR funds. In addition, the comparable services and benefits provision requires that the state plan ensure that the governor, in consultation with the VR agency, will enter into an interagency agreement or other mechanism for interagency coordination with, among others, the Medicaid agency. [34 CFR 361.5(10); 34 CFR 361.53] The second primary provision is the applicability of the proviso in the VR policy framework that physical and mental restoration services may be provided only "to the extent that financial support is not readily available from a source other than the designated state unit such as through health insurance," i.e., essential health care benefits mandated under the ACA, or comparable services or benefits, e.g., services and benefits that are provided by other federal, state, or local public agencies such as Medicaid, by health insurance or by employee benefits. [34 CFR 361.4(40); 34 CFR 361.48] The third provision is the obligation under the VR policy framework to develop and maintain written policies covering the nature and scope of the specified VR services and the criteria under which each service is provided also can be used to facilitate use of alternative funding sources under the ACA and Medicaid. [34 CFR 361.50] The fourth provision is the obligation of the designated state unit to maintain written policies regarding an eligible individual's participation in the cost of VR services (to the extent the state includes a requirement that the financial need of the individual be considered). This is also a useful mechanism to facilitate the use of alternative funding sources. [34 CFR 361.54]

- The circumstances under which private health insurance made available in accordance with the ACA and Medicaid must be used, prior to the use of VR funds, to pay for health-related VR services and supports. This should be consistent with the obligation to determine comparable services and benefits and the proviso regarding physical and mental restoration services.
- The specific policies and procedures for maximizing the use of private health insurance and Medicaid for funding health-related services authorized under the VR program. This should be consistent with the obligation to enter into interagency agreements, including state VR agency agreements with agencies administering the Medicaid program and state insurance agencies/agencies administering state health care exchanges.

Specific written policies covering the benchmark package of essential health benefits provided by health care exchanges and the relationship between the VR program and the Medicaid program. This should be consistent with the obligation under the VR policy framework to develop and maintain written policies covering the nature and scope of the specified VR services and the criteria under which each service is provided.

2. DETERMINING THE SCOPE OF THE BENCHMARK PACKAGE OF ESSENTIAL HEALTH BENEFITS AND MAKING OTHER ACA IMPLEMENTATION DECISIONS[9]

Under the ACA, states are authorized to establish state health care exchanges where individuals and small businesses can purchase affordable health insurance. Recognizing that not all states may elect to establish a state-based exchange, the ACA directs the Secretary of Health and Human Services (HHS) to establish and operate a federally facilitated exchange in any state that does not elect to do so.[10]

Effective 2014, qualified health plans participating in exchanges will be required to offer essential health benefits that meet a minimum set of standards promulgated by the Secretary of HHS. The ACA lists ten essential health benefit (EHB) categories[11] that must be covered by new individual and small group plans starting in 2014. The ten benefit categories encompass the "essential health benefits package." This includes services essential for VR applicants and clients, some of which are not consistently covered in the current insurance market.

The policies governing the EHB package must also ensure that, in terms of the benefits covered, payment rates provided, or incentives built into the definition of EHB, there can be no discrimination because of someone's age or expected length of life. Similarly, the EHB-benchmark plan must take into account the health care needs of diverse segments of the population, including women, children, people with disabilities, and other groups. In addition, the EHB-benchmark plan may not allow denials to individuals of benefits against their wishes on the basis of the individuals' age or expected length of life, or of the individuals' present or predicted disability, degree of medical dependency, or quality of life.

Taken collectively, HHS interprets these provisions as a prohibition on discrimination by issuers.[12] The EHB-benchmark plan is also required to ensure an appropriate balance among the categories of EHB so that benefits are not unduly weighted toward any category.[13]

State VR agencies have the opportunity to greatly enhance health care insurance coverage for VR applicants and clients with disabilities by impacting state decisions regarding ACA implementation. State VR agencies should consider working

9 The descriptions of provisions in the ACA included in the paper are generally found at www.healthcare.gov.

10 General Guidelines on Federally-facilitated Exchanges (May 16, 2012), page 3.

11 Section 1302(b)(1) of the ACA defines essential health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; prescription drugs; laboratory services; mental health and substance use disorder services, including behavioral health treatment; rehabilitative and habilitative services and devices; chronic disease management; pediatric services, including oral and vision care; and preventive and wellness services.

12 See Notice of Proposed Rulemaking (NPRM) related to essential health benefits, actuarial value, and accreditation [hereinafter referred to as Essential Health Benefits Final Rule, 78 FR 12384 (February 25, 2013).

13 See Essential Health Benefits Final Rule, 78 FR 12384 (February 25, 2013).

with their governor, state legislators, and state agency officials to develop policies regarding the benchmark package of essential health benefits and define the key terms applicable to the package of essential health benefits.

Specifically, VR agencies should be involved in the following decisions:[14]

1) Choosing the base-benchmark plan.[15]

2) Choosing the essential health benefits (EHB)-benchmark plan16 by supplementing the base-benchmark plan to ensure:

- Inclusion of all ten ACA statutory categories of benefits (including categories of particular importance to VR applicants and clients such as rehabilitative and habilitative services and devices, chronic disease management, and mental health and substance use disorder services).
- Compliance with the non-discrimination provisions of the ACA. The policies governing the essential health benefits package must ensure that benefits are not designed to discriminate against individuals because of their age, disability, or expected length of life; the EHB-benchmark plan must take into account the health care needs of diverse segments of the population, including women, children, people with disabilities, and other groups; and the EHB-benchmark plan may not allow denials to individuals of benefits against their wishes on the basis of the individuals' age or expected length of life, or of the individuals' present or predicted disability, degree of medical dependency, or quality of life.
- Compliance with the provision of the ACA requiring balance among the various benefit categories.

3) Defining key terms, including

- Rehabilitative services[17]
- Habilitative services[18]
- Rehabilitative and habilitative devices[19]
- Durable medical equipment[20]
- Orthotics[21]
- Prosthetics[22]

---

14 For comprehensive guidance regarding advocacy at the state level, see OPEN LETTER TO STATES ON DEFINING ESSENTIAL HEALTH BENEFITS PACKAGE, prepared by several disability organizations. Many of the recommendations included in this section of the paper (including proposed definitions of key terms) are derived from this open letter.

15 Essential Health Benefits Final Rules. In choosing the base-benchmark plan, states are given four options: (1) the largest plan by enrollment in any of the three largest small group insurance products in the state's small group market; (2) any of the largest three state employee health benefit plans by enrollment; (3) any of the largest three national Federal Employees Health Benefits Program options by enrollment; or (4) the largest insured commercial non-Medicaid Health Maintenance Organization operating in the state. If a state does not make a selection using the process described in 156.100, the default base-benchmark plan will be the largest plan by enrollment in the largest product in the state's small group market. See Essential Health Benefits Final Rule, 156.100(c).

16 Essential Health Benefits Final Rule, 156.110 and 156.125.

17 "Rehabilitative services" are health care services and devices that are designed to assist individuals in improving or maintaining, partially or fully, skills and functioning for daily living. These services include, but are not limited to, physical therapy, occupational therapy, speech-language pathology and audiology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

18 "Habilitative services" are health care services and devices that are designed to assist individuals in acquiring, improving, or maintaining, partially or fully, skills and functioning for daily living. These services may include physical therapy, occupational therapy, speech-language pathology and audiology, and other services and devices for people with disabilities in a variety of inpatient and/or outpatient settings. Plans should use Medicaid coverage as a guide where there is a question of whether to cover specific habilitation benefits.

19 "Rehabilitative and habilitative devices" include durable medical equipment, orthotics, prosthetics, low vision aids, hearing aids, augmentative communication devices that aid in hearing and speech, and other assistive technologies and supplies. "Rehabilitative and habilitative devices" also include devices that maintain as well as improve function.

20 "Durable Medical Equipment" (DME) means equipment and supplies ordered by a health care professional for everyday or extended use to improve maintain or prevent the deterioration of an individual's functional ability. Examples of DME include, but are not limited to, manual and electric wheelchairs, oxygen equipment, canes, crutches, walkers, standing system chairs, blood testing supplies for people with diabetes, as well as supplies and equipment to support medically necessary devices.

21 "Orthotics" are leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes, and external breast prostheses incident to mastectomy resulting from breast cancer. Covered services include adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition.

22 "Prosthetic devices" are devices that replace all or part of an internal body organ or all or part of the function of a permanently inoperative or malfunctioning internal body organ. Examples of prosthetic devices include joint replacements, colostomy care, implanted breast prostheses incident to mastectomy resulting from breast cancer, cochlear implants, and osseointegrated implants to replace middle ear or cochlear function. Covered services include adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition.

- Low vision aids[23]
- Augmentative and Alternative Communication devices[24]
- Hearing aids and assistive listening devices[25]

4) Making plan coverage decisions, reimbursement rates, incentive programs, and designing benefits that are consistent with private insurance market reforms.[26] Changes to private insurance include the following:

- Preexisting conditions exclusions[27]
- Premium ratings[28]
- Annual and lifetime limits[29]
- Rescissions[30]
- Coverage of dependents[31]
- Waiting periods[32]
- Preventative services and immunizations and cost sharing[33]

5) Continued incorporation of existing state mandates.[34]

Defining **medical necessity** by incorporating not only improving functioning, but also maintaining and preventing deterioration of physical and cognitive functioning; requiring an individual assessment; basing coverage decisions on best

---

23 "Low vision aids" are aids that help correct for the partial loss of eyesight, making it possible for an individual with impaired vision to accomplish everyday tasks, including reading, writing, driving a car, or recognizing faces. Examples of low vision aids include devices that magnify, reduce glare, add light, or enlarge objects as to make them more visible.

24 "Augmentative and Alternative Communication devices" (AACs) are specialized devices ordered by a health care professional that assist individuals with severe speech or language problems to supplement existing speech or replace speech that is not functional. Examples of AAC devices include, but are not limited to, picture and symbol communication boards and electronic devices.

25 "Hearing aids and assistive listening devices" are medical devices that amplify sound and/or counter the negative effects of environmental acoustics and background noise to assist individuals who have been diagnosed with a hearing loss by a physician and/or hearing health professional.

26 See Essential Health Benefits Final Rule detailing proposed health insurance market rules (February 22, 2013).

27 Health plans and health insurance issuers offering group or individual health insurance coverage cannot limit or deny benefits or deny coverage for a child younger than age 19 simply because the child has a "pre-existing condition," i.e., a health problem that developed before the child applied to join the plan. This rule applies to all job-related health plans as well as individual health insurance policies issued after March 23, 2010. The rule will affect an individual's plan as soon as it begins a plan year or policy year on or after September 23, 2010. The rule does not apply to "grandfathered" individual health policies, i.e., a policy that an individual purchased (and is not a job-related health plan) on or before March 23, 2010. Starting in 2014, these same plans will not be able limit or deny benefits or deny coverage for anyone or charge a higher premium for a pre-existing condition, including a disability. It should be noted that an exclusion of benefits for a condition under a plan or policy is not a preexisting condition exclusion if the exclusion applies regardless of when the condition arose relative to the effective date of coverage.

28 Effective 2014, health plan premiums will no longer be allowed to vary based on experience ratings or health status; instead, premiums will only be allowed to vary based on age (by a 3-to-1 ratio, i.e., an older person will never pay a premium that is more than 3 times the premium paid by a younger person), geographic area, tobacco use (by a 1.5-to-1 ratio), the number of family members, and actuarial value of the benefit.

29 Group health plans and health insurance issuers offering group or individual health insurance coverage are generally prohibited from imposing lifetime or annual limits on the dollar value of health benefits. The ACA prohibits annual limits on the dollar value of benefits generally, but allows "restricted annual limits" with respect to essential health benefits for plan years (in the individual market, policy years) beginning before January 1, 2014. In defining the term "restricted annual limit," HHS should ensure that access to needed services is made available with a minimal impact on premiums. Grandfathered individual market policies are exempted from this provision. In addition, the ACA provides that, with respect to benefits that are not essential health benefits, a plan or issuer may impose annual or lifetime per individual dollar limits on specific covered benefits. Beginning after December 31, 2013, a plan or policy generally may not impose an annual limit for a plan year (in the individual market, policy year). Specifically, the ACA includes a prohibition on lifetime limits applicable to all group health plans and health insurance issuers offering group or individual health insurance coverage for plan years (in the individual market, policy years) beginning on or after September 23, 2010.

30 A group health plan or a health insurance issuer offering group or individual health insurance coverage must not rescind coverage except in the case of fraud or an intentional misrepresentation of a material fact (effective March 23, 2010).

31 Plans and insurers that offer dependent coverage must make the coverage available until a child (married or unmarried) reaches the age of 26 (effective date was September 23, 2010). There is one exception for group plans in existence on March 23, 2010. Those group plans may exclude adult children who are eligible to enroll in an employer-sponsored health plan, unless it is the group health plan of their parent. This exception is no longer applicable for plan years beginning on or after January 1, 2014.

32 Effective in 2014, group health plans and health insurance issuers offering group or individual health insurance coverage are prohibited from including waiting periods for coverage in excess of 90 days in small group or individual markets (including grandfathered plans).

33 All plans must cover certain preventive services and immunizations without any cost-sharing effective September 23, 2010.

34 Under the ACA, in 2014 and 2015, states that choose a benchmark plan that includes state benefit mandates will have those mandated benefits included in their essential health benefits package, and the Federal Government will subsidize the cost of this coverage. However, if a state chooses a benchmark plan that is not subject to state mandates, the state will be responsible for defraying the cost of these nonessential benefits. See Essential Health Benefits Final Rule, 78 FR 12834 (February 25, 2013) and proposed 155.170.

available evidence (lack of Level I medical evidence does not prove the service or device is ineffective or unnecessary); and prohibiting the use of arbitrary visit limits or other limitations or exclusions to impede doctor/patient relationships or stop services prematurely.

3. DETERMINING THE MEDICAID BENCHMARK PLAN IN MEDICAID EXPANSION STATES

The ACA, as enacted, was designed to extend and simplify Medicaid eligibility. Starting in calendar year 2014, the ACA, as enacted, would have replaced the complex categorical groupings and limitations to provide Medicaid eligibility to cover all non-Medicare individuals under age 65, including individuals with disabilities, with income up to 133% of the federal poverty level ($14,404 for an individual and $29,327 for a family of four in 2009) based on modified adjusted gross income, provided that the individual meets certain non-financial eligibility requirements such as citizenship or satisfactory immigration status. This mandatory expansion would have created a uniform minimum Medicaid eligibility threshold across states, and would have eliminated a limitation of the program that prohibits most adults without dependent children from enrolling.

On June 28, 2012, the United States Supreme Court upheld all of the provisions of the ACA, with the exception of the Medicaid expansion. The Supreme Court held that if a state chooses not to participate in this expansion of Medicaid eligibility for low-income adults, the state may not, as a consequence, lose federal funding for its existing Medicaid program. In sum, in light of the Supreme Court decision, the Medicaid expansion envisioned by the ACA is now voluntary, not mandatory.[35]

Under the ACA, for those states electing to participate in the Medicaid expansion, the following key policy changes apply:

- For states electing to expand eligibility to individuals with incomes up to 133% of the federal poverty level, the Federal Government will provide 100% federal funding for the costs of those who become newly eligible for Medicaid for years 2014 through 2016, 95% federal funding for 2017, 94% federal funding for 2018, 93% federal funding for 2019, and 90% federal funding for 2020 and subsequent years. States that have already expanded adult eligibility to 100% of the poverty level will receive a phased-in increase in the Federal Medical Assistance Percentage (FMAP) for non-pregnant childless adults.
- There is no deadline by which a state must let the federal government know of its intention regarding the Medicaid expansion. While states have flexibility to start or stop the expansion, the applicable federal match rates for medical assistance provided to "newly eligible individuals" are tied by law to the specific calendar years outlined above.[36]

A state that expands eligibility to less than 133% of the federal poverty level will not be eligible to receive the enhanced matching rate. The ACA does not provide for a phased-in or partial expansion at the enhanced matching rate. If a state proposes a partial expansion, HHS will consider such a "demonstration" proposal to the extent it furthers the purpose of the program, subject to the regular matching rate.[37]

The Medicaid eligibility expansion group will not be entitled to the full array of state Medicaid benefits. Rather, those dividuals will be entitled to "benchmark coverage" [38] or "benchmark equivalent coverage." [39]

35 National Federation of Independent Business et al. v. Sebelius, Secretary of Health and Human Services, et al., Slip Opinion No. 11-393 (June 28, 2012).

36 Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid (CMS, December 10, 2012) [hereinafter referred to as FAQs] Question 24

37 FAQs, Question 26

38 "Benchmark coverage" is defined in the statute [42 USC 1396u-7(b)(1)] as benefit plans that are: (1) the standard Blue Cross/Blue Shield preferred provider option service benefit plan offered to federal employees; or (2) the health benefits coverage plan offered and generally available to state employees; or (3) the health insurance coverage plan offered by the health maintenance organization in the state that has the largest insured commercial, non-Medicaid enrollment; or (4) such other health benefits coverage as approved by the Secretary upon application by the state.

39 "Benchmark equivalent coverage" is defined at 42 U.S.C. § 1396u-7(b)(2) as: (1) including the following benefits: (a) inpatient and outpatient hospital services; (b) physicians' surgical and medical services; (c) laboratory and x-ray; (d) well-baby and well-child care; and (e) other appropriate preventive services as designated by the Secretary; (2) having an aggregate actuarial

In light of the Supreme Court's decision regarding the ACA, a state's decision whether or not to participate in the Medicaid expansion is voluntary, i.e., a determination not to participate in the Medicaid expansion does not adversely affect a state's receipt of existing Medicaid funding. To the extent a state decides to participate in the Medicaid expansion, the state VR agency may want to participate in decisions regarding the "benchmark coverage" or "benchmark equivalent coverage," because the broader the scope of benefits covered from a disability perspective, the greater the likelihood that health-related services and supports will be paid for by Medicaid rather than the VR agency. It is important to note that the Medicaid eligibility expansion group will not be entitled to the full array of state Medicaid benefits. Rather, those individuals will be entitled to "benchmark coverage" or "benchmark equivalent coverage." All Medicaid "benchmark plans" must cover essential health benefits by 2014.

4. ENSURING COVERAGE OF PERSONAL ASSISTANCE SERVICES UNDER THE COMMUNITY FIRST CHOICE OPTION IN VR PROGRAM AND EMPLOYMENT SETTINGS

Since 2003, the Medicaid statute has included a Medicaid buy-in program for working people with disabilities. This program allows individuals with disabilities to work and get or keep Medicaid. Many people with significant disabilities are unable to obtain employer-funded private health insurance that provides coverage comparable to Medicaid, particularly coverage for personal attendants. In addition, the ACA adds the Community First Choice Option, under which states are authorized to establish a new state Medicaid plan option to provide home and community-based attendant services and supports. It is critical that states that choose to take advantage of these options include policies that authorize payment for personal attendants to accompany and assist individuals with disabilities participating in VR programs as well as in the workplace, and that state VR policies specifically recognize these sources of funding.

CONCLUSION

Once employed the ACA will change how health-related services are paid for in the states. Each state faces the challenge of applying the law to the VR program and choosing among options. This brief is not intended to advocate for any specific action, but to inform state VR directors of their role and of the ACA's potential impact on VR expenditures and ultimately customers. The ACA provides a significant opportunity for state VR agencies to reduce the amount of VR funds used to pay for health-related VR services, thereby increasing the number of individuals with disabilities served by the program and/or enhancing the quality of services provided to current individuals served by the program.

We recommend that VR policy personnel consider the following next steps:

- Evaluate and review your current and past expenditures related to diagnosis and treatment of physical and mental impairments, and cross-walk those with the list of essential health benefits.
- Become informed about key aspects of the ACA, including essential health benefits packages, non-discrimination provisions, definitions of key terms (including medical necessity), Medicaid expansion, and the Community First Choice Option.
- Secure a seat at the table in your state and engage in implementation designs.
- Review your state VR agency's policies, procedures, and interagency agreements for modification and amendment as necessary.

value equivalent to one of the benchmark benefit packages; and (3) having an actuarial value equal to at least 75% of the actuarial value of coverage in a benchmark benefits package for each of the following additional services for which coverage is provided: (a) prescription drugs, (b) mental health services, (c) vision services, or (d) hearing services. Individuals with benchmark coverage or benchmark equivalent coverage must also have access, through that coverage or otherwise, to rural health clinic and federally qualified health center services.

About the Author

Robert "Bobby" Silverstein, is a principal in the firm, Powers Pyles Sutter & Verville PC. He has a federal regulatory and legislative practice in the areas of disability, health care, rehabilitation, employment, education, social security, and civil rights. Mr. Silverstein has over 30 years experience analyzing complex public policy issues and developing comprehensive, innovative, and common sense legislative and regulatory solutions that meet the divergent needs of multiple stakeholders. Mr. Silverstein gained considerable experience negotiating and drafting bipartisan, consensus legislation while serving in various staff capacities in the US House of Representatives and the US Senate, including serving as staff director and chief counsel for the Subcommittee on Disability Policy of the Senate Committee on Labor and Human Resources (currently the Committee on Health, Education, Labor, and Pensions). Mr. Silverstein was the behind-the-scenes architect of more than 20 bills enacted into law, including the landmark Americans with Disabilities Act. Bobby can be reached at Bobby.Silverstein@ppsv.com

Acknowledgement

The author would like to thank John Halliday, Robert Burns, Susan Foley, Kartik Trivedi and Joseph Marrone for their contributions to this brief and to Anya Weber and David Temelini for editorial support and graphic design.

Funding

This report was funded, in part, by a grant (Grant No. H133V070001B) from the National Institute on Disability and Rehabilitation Research (NIDRR) and the Rehabilitation Service Administration (RSA). The opinions contained in this paper are those of the author and do not necessarily reflect those of NIDRR, RSA, or any other office of the U.S. Department of Education, any other agency or department of Federal government, or any other organization or individual.

Suggested Citation

Silverstein, R. (2013). Executive Summary - Funding Health Related VR Services: The Potential Impact Of The Affordable Care Act On The Private Health Insurance And Medicaid To Pay For Health Related VR Services. Boston, MA: University of Massachusetts Boston, Institute for Community Inclusion.

For more information contact

John Halliday
Senior Program and Policy Specialist
Institute for Community Inclusion
University of Massachusetts Boston
john.halliday@umb.edu, (617) 287 4336 (voice)

About the VR-RRTC

The VR-RRTC is a national center developed by ICI that builds the capacity of the public vocational rehabilitation (VR) program to improve employment outcomes for people with disabilities. VR-RRTC provides state VR agencies and others working in this area with, policy research, training and technical assistance. The VR-RRTC also functions as a national hub for policy and operations data pertaining to public employment services for people with disabilities. The VR-RRTC is closely linked with other ICI's initiatives like the Research and Technical Assistance Center (RTAC) on VR and the Substantial Gainful Activity (SGA) Project.

This publication will be made available in alternate formats upon request.

www.VR-RRTC.org