
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

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DECEMBER 2012

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December 2012



Report Prepared for the Rehabilitation Research and Training Center on Vocational Rehabilitation (VR RRTC)
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This paper was funded, in part, by a grant (Grant No. H133V070001B) from the National Institute on Disability and Rehabilitation Research (NIDRR) and the Rehabilitation Services 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 the Federal government, or any other organization or individual.

TABLE OF CONTENTS

PART I INTRODUCTION	1
I. OVERVIEW	1
II. METHODOLOGY	2
III. SUMMARY FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS	3
1. Modernizing the Federal and State VR Policy Frameworks	4
2. Determining the Scope of Essential Health Benefits Under the ACA	5
3. Determining the Medicaid Benchmark Plans in Medicaid Expansion States	5
4. Ensuring Funding of Personal Attendants in VR Programs Under Medicaid Buy-in and Community First Choice Options	6
PART II HEALTH-RELATED SERVICES AUTHORIZED UNDER TITLE I OF THE REHABILITATION ACT (THE VR PROGRAM)	7
I. FOCUS OF STATE VR PROGRAM, IN GENERAL AND DEFINITIONS	7
II. COOPERATION AND COORDINATION WITH OTHER ENTITIES	10
III. ASSESSMENT FOR DETERMINING ELIGIBILITY AND PRIORITY OF SERVICES ..	11
IV. CONTENT OF INDIVIDUALIZED PLAN FOR EMPLOYMENT	11
V. SCOPE OF VOCATIONAL REHABILITATION SERVICES	11
VI. WRITTEN POLICIES GOVERNING THE PROVISION OF SERVICES	19
VII. COMPARABLE SERVICES AND BENEFITS	20
VIII. PARTICIPATION OF INDIVIDUALS IN COST OF SERVICES BASED ON FINANCIAL NEED	24

PART III PROVISIONS IN THE AFFORDABLE CARE ACT APPLICABLE TO THE VR PROGRAM.....	26
I. INDIVIDUAL MANDATE, FINANCIAL PENALTY, FEDERAL SUBSIDIES AND TAX CREDITS.....	27
II. EMPLOYER REQUIREMENTS.....	27
III. HEALTH CARE EXCHANGES AND ESSENTIAL HEALTH BENEFITS.....	28
IV. CHANGES TO PRIVATE INSURANCE.....	33
V. EXPANSION OF PUBLIC PROGRAMS (MEDICAID).....	35
1. Extension of Medicaid Eligibility.....	35
2. Long Term Care and Home and Community-Based Services.....	38
PART IV RECOMMENDATIONS FOR MAXIMIZING THE PAYMENT FOR HEALTH-RELATED VR SERVICES AND SUPPORTS UNDER THE ACA, INCLUDING MEDICAID.....	41
I. CURRENT VR POLICIES APPLICABLE TO PAYMENT FOR HEALTH-RELATED SERVICES.....	41
II. HEALTH CARE EXCHANGES AND THE SCOPE OF THE BENCHMARK PACKAGE OF ESSENTIAL HEALTH BENEFITS.....	43
III. MEDICAID EXPANSION AND MEDICAID BENCHMARK PLANS.....	50
IV. NEW OPTIONS UNDER THE MEDICAID PROGRAM, INCLUDING THE COMMUNITY FIRST CHOICE OPTION.....	51
APPENDIX I GLOSSARY OF KEY TERMS USED IN THE ACA.....	52
APPENDIX II STATE VR POLICY FRAMEWORKS REGARDING HEALTH-RELATED VR SERVICES.....	63
▪ CALIFORNIA.....	64
▪ FLORIDA.....	84
▪ MASSACHUSETTS.....	105
▪ NORTH CAROLINA.....	114

PART I

INTRODUCTION

I. OVERVIEW

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 for VR applicants and clients. In March 2010, Congress passed and the President signed into law the “Affordable Care Act” (ACA).¹ 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.²

The ACA includes significant new potential funding sources to pay for health-related VR services and supports, including private health insurance and Medicaid. Under the ACA, essential health benefits, including rehabilitative and habilitative services and devices, will be more readily available to an expanded population of persons through the private insurance market. Also, under the ACA an expanded number of persons may, at a State’s discretion, receive health care services under the Medicaid program.

The purpose of this paper is to analyze the potential impact of the ACA on the payment for certain health-related VR services, including physical and mental restoration services, assistive technology devices and services, and personal assistance services. According to RSA-2 (Financial Report) for 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 percent to 69 percent of the total amount for purchased services. For example, the Florida General Agency expended \$34,414,379 for diagnosis and treatment of physical and mental impairments, which represented 30 percent of the total amount expended for purchased services. Thus, for certain States, pursuing strategies that minimize expenditures for physical and mental restoration and other health-related services and supports may increase the amount of funds available for other VR services and to expand the number of clients served.

More specifically, the paper will address the following issues:

¹ The ACA was enacted in two parts—The Patient Protection and Affordable Care Act (Pub. L. No. 111-148) on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act (Pub. L. No. 111-152) On March 30, 2010.

² *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).

1. In general, the potential impact of the ACA on the responsibilities of State VR agencies to provide and/or pay for:
 - Physical and mental restoration services (e.g., therapies and mental health and substance abuse disorder services);
 - Rehabilitation technology, assistive technology devices, and assistive technology services; and
 - Personal assistance services.
2. The applicability of the obligation under the VR regulations that designated State units must determine the availability of **comparable services and benefits** (such as health care benefits available through private health insurance mandated by the ACA and services and benefits that are provided by other Federal, State, and local programs, such as Medicaid) before providing VR services to an eligible individual using VR funds and the exemption for assistive technology devices and services.
3. The applicability of the proviso in the VR regulations 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” (e.g., essential health care benefits mandated under the ACA) or a comparable service or benefit.
4. The impact of the ACA on the obligation under the VR regulations that the designated State unit must 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.
5. The impact of the ACA on **interagency agreements**, including agreements with agencies administering the Medicaid program, State insurance agencies, and agencies administering State Health Care Exchanges.

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.

II. METHODOLOGY

The approach and methodology used for completing this policy analysis included the following steps. First, I communicated with representatives from the Council of State Administrators of Vocational Rehabilitation (CSAVR) before the policy analysis design was finalized.

Second, I researched and described the Federal policy framework under Title I of the Rehabilitation Act (VR program) concerning the provision and/or payment for physical and mental restoration services, assistive technology devices and services, and personal assistance services. The comparable services and benefits provision, and the responsibility to ensure interagency coordination, collaboration and cooperation between State VR agencies and other State and local agencies with respect to funding VR services.

Third, I researched and described the policy framework under the ACA that may impact the provision and/or payment for VR services, particularly physical and mental restoration services, assistive technology devices and services, and personal assistance services.

Fourth, I selected four states for the policy analysis based on discussions with the Institute of Community Inclusion (ICI) and CSAVR staff. The states are: California, Florida, Massachusetts, and North Carolina. The states were selected based on the existence of health reform legislation comparable to the ACA, substantial expenditures for physical and mental restoration services, assistive technology devices and services, and personal assistance services, size, geographical diversity, and the existence of a comprehensive State policy framework governing these health-related VR services.

Fifth, I researched and described State policy frameworks based on a review of State policies, rules, and programmatic requirements. These descriptions are set forth in Appendix II of the paper.

Sixth, I conducted a thematic review of the various State policy frameworks and identified examples of State policies that clarify or expand on Federal policies.

Finally, I analyzed the potential impact of the ACA on Federal and State policies applicable to the VR program.

III. SUMMARY FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

The enactment of the Affordable Care Act (ACA) provides State VR agencies with an opportunity to work with their respective Governors, State legislatures, and other State agencies to establish policies that maximize the payment for medically necessary health-related VR services (including mental and physical restoration services, personal assistance services, and certain rehabilitation technology and assistive technology devices and assistive technology services) used by VR applicants and clients through private health insurance or Medicaid rather than through the State VR program. This opportunity is currently open because states are still in the process of making key policy decisions regarding State Health Care Exchanges and the scope of the benchmark package of essential health benefits; Medicaid expansion and Medicaid benchmark plans; and new options under the Medicaid program, including the Community First Choice option. The opportunity to influence State policymakers

will be ongoing because State policies regarding ACA implementation will experience modification overtime.

In order to educate State policymakers regarding the potential impact of ACA on the State VR program, the State VR agencies should become knowledgeable about the opportunities presented by ACA to ensure that other sources of funding are used to pay for the health-related services VR applicants and clients may need, thereby increasing the funding available to pay for more traditional VR services (such as counseling and guidance, job-related services, supported employment, and specific post-employment services) and to serve additional VR clients. Below is a summary of the major recommendations for maximizing the use of funding sources other than VR funding to pay for the costs of health-related VR services and supports, particularly physical and mental restoration services, assistive technology devices and services, and personal assistance services.

1. Modernizing the Federal and State VR Policy Frameworks

The potential impact of the ACA and State Medicaid reforms on the responsibilities of State VR agencies to pay for health-related VR services, including physical and mental restoration services (e.g., surgery, therapies and mental health and substance abuse disorder services); rehabilitation technology, assistive technology devices and assistive technology services; and personal assistance services is substantial.

The current VR policy framework provides legal and policy bases for facilitating payment for many of these 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 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 VR agencies. More specifically, the Rehabilitation Services Administration (RSA) should consider modernizing the Federal VR policy framework (either through regulation or policy guidance) by clarifying the applicability of ACA, including Medicaid reforms, to the VR program. The policy guidance should clarify:

- The circumstances under which private health insurance made available in accordance with the ACA and Medicaid may be used prior to the use of VR funds to pay for health-related VR services and supports;
- 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, spell out 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; and
- 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, spell out 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.

2. Determining the Scope of Essential Health Benefits Under the ACA

ACA lists ten essential benefit categories that must be covered by new individual and small group plans moving forward in 2014. The ten benefit categories encompass what is called the “essential health benefits package,” which includes services essential for VR applicants and clients, some of which are not consistently covered in the current insurance market. 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 with their Governor, State legislature, and other State agencies 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 decisions relating to:

- Choosing the base-benchmark plan.
- Choosing the essential health benefits (EHB)-benchmark plan 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, and the provision of the ACA requiring an appropriate balance among the various benefit categories.
- Defining key terms, including rehabilitative services, habilitative services, rehabilitative devices, habilitative devices, durable medical equipment, orthotics, prosthetics, low vision aids, and augmentative and alternative communication devices.
- Continuing inclusion of existing State benefit mandates.
- Defining medical necessity to include not only improving functioning but also maintaining and preventing deterioration of functioning.

3. Determining the Medicaid Benchmark Plans in Medicaid Expansion States

In light of the Supreme Court’s decision regarding ACA, a state’s decision whether or not to participate in the Medicaid expansion is now voluntary i.e., a decision not to participate in the Medicaid expansion does not adversely affect a State’s existing Medicaid funding. Whether or not a State VR agency decides to participate in this decision is beyond the scope of this research project. To the extent a State decides to expand its Medicaid program, 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, at a minimum, to “benchmark coverage” or “benchmark equivalent coverage.” The State VR agency may want to participate in decisions regarding the “benchmark coverage” or “benchmark equivalent coverage” selected by the State 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.

4. Ensuring Funding of Personal Attendants in VR Programs Under Medicaid Buy-in and Community First Choice Options

Since 2003, the Medicaid statute has authorized States to adopt a Medicaid Buy-In program for working persons with disabilities. This program allows individuals with disabilities to work and get or keep Medicaid, including personal attendant services and supports. In addition, ACA adds the Community First Choice State Plan Option under which States are authorized to establish a new State Medicaid plan option to provide home and community-based attendant services and supports. In States that choose to take advantage of these options, State VR agencies should participate in decisions whether to include policies governing these options that authorize payment for personal attendants to accompany and assist individuals with disabilities participating in VR programs as well as in the workplace. In addition, policies issued by State VR policies should specifically recognize these sources of funding.

PART II

HEALTH-RELATED SERVICES AUTHORIZED UNDER TITLE I OF THE REHABILITATION ACT (THE VR PROGRAM) AND EXAMPLES OF STATE POLICIES

This section of the paper describes the Federal VR policy framework governing the circumstances under which individuals with disabilities are eligible to receive specific VR services that may also be considered health benefits under private health insurance or Federal health care programs such as Medicare or Medicaid. This section also includes relevant examples of State policies that clarify or expand on the Federal VR policy framework. An understanding of whether and under what circumstances a State VR program must/may provide health-related VR services to eligible individuals with disabilities is of particular significance in light of the recent enactment of the Affordable Care Act (ACA) under which essential health benefits, including rehabilitative and habilitative services and devices will now be more readily available to an expanded population of persons through the private insurance market and under which an expanded number of persons may, at a State's discretion, receive health care services under the Medicaid program.

I. FOCUS OF STATE VR PROGRAM, IN GENERAL AND DEFINITIONS

The State Vocational Rehabilitation Services program (VR program) is authorized by Title I of the Rehabilitation Act of 1973, as amended [29 USC 701-744]. The VR program provides support to each State to assist it in operating a statewide, comprehensive, coordinated, effective, efficient, and accountable State program, as an integral part of a statewide workforce investment system. The VR program assesses, plans, develops, and provides vocational rehabilitation services (VR services) for individuals with disabilities so that those individuals may prepare for and engage in gainful employment consistent with their strengths, priorities, concerns, abilities, capabilities, interests, and informed choice. [34 CFR 361.1]

An individualized plan for employment (IPE) must be developed and implemented for each individual determined eligible to participate in the VR program. [34 CFR 361.45(a)] The IPE must include, among other things, a description of the specific **VR services** that are needed to achieve the individual's employment outcome, including **assistive technology devices, assistive technology services, personal assistance services**, [34 CFR 361.46(a)] and **physical and mental restoration services** [34 CFR 361.48(e)] The VR services can be provided directly by the VR agency or indirectly through contract or other arrangement with a community rehabilitation program. The IPE must also specify the terms and conditions of the IPE, including, as appropriate, information describing the responsibilities of the VR agency and other agencies as well as the responsibilities of the individual. [34 CFR 361.46(a)]

Below are definitions for the key terms used in the Federal VR policy framework. In general, the State policy frameworks use the Federal definitions.

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)]

The term “community rehabilitation program” means a program that provides directly or facilitates the provision of one or more of the following vocational rehabilitation services to individuals with disabilities to enable those individuals to maximize their opportunities for employment, including career advancement:

- (A) Medical, psychiatric, psychological, social, and vocational services that are provided under one management.
- (B) Testing, fitting, or training in the use of prosthetic and orthotic devices.
- (C) Recreational therapy.
- (D) Physical and occupational therapy.
- (E) Speech, language, and hearing therapy.
- (F) Psychiatric, psychological, and social services, including positive behavior management.
- (G) Assessment for determining eligibility and vocational rehabilitation needs.
- (H) Rehabilitation technology.
- (I) Job development, placement, and retention services.
- (J) Evaluation or control of specific disabilities.
- (K) Orientation and mobility services for individuals who are blind.
- (L) Extended employment.
- (M) Psychosocial rehabilitation services.

- (N) Supported employment services and extended services.
- (O) Services to family members if necessary to enable the applicant or eligible individual to achieve an employment outcome.
- (P) Personal assistance services.
- (Q) Services similar to the services described in paragraphs (A) through (P) of this definition.
- (ii) For the purposes of this definition, the word program means an agency, organization, or institution, or unit of an agency, organization, or institution, that provides directly or facilitates the provision of vocational rehabilitation services as one of its major functions. [34 CFR 361.5(9)]

The term “**comparable services and benefits**” means

- (i) Services and benefits that are--
 - (A) Provided or paid for, in whole or in part, by other Federal, State, or local public agencies, by health insurance, or by employee benefits;
 - (B) Available to the individual at the time needed to ensure the progress of the individual toward achieving the employment outcome in the individual's individualized plan for employment in accordance with Sec. 361.53; and
 - (C) Commensurate to the services that the individual would otherwise receive from the designated State vocational rehabilitation agency.
- (ii) For the purposes of this definition, comparable benefits do not include awards and scholarships based on merit. [34 CFR 361.5(10)]

The term “**extreme medical risk**” means a probability of substantially increasing functional impairment or death if medical services, including mental health services, are not provided expeditiously. [34 CFR 361.5(21)]

The term “**personal assistance services**” means a range of services provided by one or more persons 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 vocational rehabilitation services. The services may include training in managing, supervising, and directing personal assistance services. [34 CFR 361.5(39)]

The term “**physical and mental restoration services**” means--

- (i) 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;
- (ii) Diagnosis of and treatment for mental or emotional disorders by qualified personnel in accordance with State licensure laws;
- (iii) Dentistry;

- (iv) Nursing services;
- (v) Necessary hospitalization (either inpatient or outpatient care) in connection with surgery or treatment and clinic services;
- (vi) Drugs and supplies;
- (vii) Prosthetic and orthotic devices;
- (viii) Eyeglasses and visual services, including visual training, and the examination and services necessary for the prescription and provision of eyeglasses, contact lenses, microscopic lenses, telescopic lenses, and other special visual aids prescribed by personnel that are qualified in accordance with State licensure laws;
- (ix) Podiatry;
- (x) Physical therapy;
- (xi) Occupational therapy;
- (xii) Speech or hearing therapy;
- (xiii) Mental health services;
- (xiv) 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;
- (xv) Special services for the treatment of individuals with end-stage renal disease, including transplantation, dialysis, artificial kidneys, and supplies; and
- (xvi) Other medical or medically related rehabilitation services. [34 CFR 361.5(40)]

The term “**rehabilitation engineering**” means the systematic application of engineering sciences to design, develop, adapt, test, evaluate, apply, and distribute technological solutions to problems confronted by individuals with disabilities in functional areas, such as mobility, communications, hearing, vision, and cognition, and in activities associated with employment, independent living, education, and integration into the community. [34 CFR 361.5(44)]

The term ‘**rehabilitation technology**’ means the systematic application of technologies, engineering methodologies, or scientific principles to meet the needs of, and address the barriers confronted by, individuals with disabilities in areas that include education, rehabilitation, employment, transportation, independent living, and recreation. The term includes rehabilitation engineering, assistive technology devices, and assistive technology services. [34 CFR 361.5(45)]

The term “**vocational rehabilitation services**”

- (i) If provided to an individual, means those services listed in Sec. 361.48; and
- (ii) If provided for the benefit of groups of individuals, also means those services listed in Sec. 361.49. [34 CFR 361.5(58)]

II. COOPERATION AND COORDINATION WITH OTHER ENTITIES

The State plan must describe the designated State agency's cooperation with and use of the services and facilities of Federal, State, and local agencies and programs to the extent that

those agencies and programs are not carrying out activities through the statewide workforce investment system. [34 CFR 361.24]

III. ASSESSMENT FOR DETERMINING ELIGIBILITY AND PRIORITY OF SERVICES

The designated State unit must determine an individual's eligibility for the VR program and priority of services based on—

- A review and assessment of existing data, including counselor observations, education records, information provided by the individual or the individual's family, particularly information used by education officials, and determinations made by officials of other agencies; and
- To the extent existing data do not describe the current functioning of the individual or are unavailable, insufficient, or inappropriate to make an eligibility determination, an assessment of additional data resulting from the provision of vocational rehabilitation services, including trial work experiences, assistive technology devices and services, personal assistance services, and any other support services that are necessary to determine whether an individual is eligible. [34 CFR 361.42]

IV. CONTENT OF INDIVIDUALIZED PLAN FOR EMPLOYMENT

Each individualized plan for employment (IPE) must include, among other things, the terms and conditions of the IPE, including, as appropriate, information describing--

- The responsibilities of the designated State unit;
- The responsibilities of the eligible individual, including--
 - The responsibilities the individual will assume in relation to achieving the employment outcome;
 - If applicable, the extent of the individual's participation in paying for the cost of services; and
 - The responsibility of the individual with regard to applying for and securing comparable services and benefits; and
- The responsibilities of other entities as the result of arrangements made pursuant to the comparable services or benefits requirements. [34 CFR 361.46(a)]

V. SCOPE OF VOCATIONAL REHABILITATION SERVICES

As appropriate to the vocational rehabilitation needs of each individual and consistent with each individual's informed choice, the designated State unit must ensure that the following vocational rehabilitation services are available to assist the individual with a disability in preparing for, securing, retaining, or regaining an employment outcome that is consistent with

the individual's strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice:

- Physical and mental restoration services (see definition), to the extent that financial support is not readily available from a source other than the designated State unit (such as through health insurance or a comparable service or benefit (see definition)).
- Orientation and mobility services for individuals who are blind.
- Personal assistance services (see definition).
- Rehabilitation technology (see definition), including technological aids and devices.
- Other goods and services determined necessary for the individual with a disability to achieve an employment outcome. [34 CFR 361.48]

With respect to physical and mental restoration services, the State policy frameworks reiterate the general policy that such services may be provided by the VR agency to the extent that financial support is not readily available from a source other than the designated State unit, such as through health insurance or a comparable service or benefit.

In addition, the California regulations [7160] specify that for clients eligible for vocational rehabilitation services, the service is necessary to both:

- Correct or substantially modify, within a reasonable period of time, a physical or mental condition that is stable or slowly progressive. A reasonable period of time shall be determined based upon factors related to the nature of the disability.
- Prepare the client for suitable employment.

The California regulations also require the submission of evaluations/progress reports and final treatment reports from physicians, hospitals, rehabilitation centers and other facilities or appropriate providers. These reports must be received and reviewed for recommendation by the Medical/Psychiatric Consultant or the Vocational Psychologist to determine the client's status/progress related to the likelihood of achieving the desired physical/mental restoration objective. Progress/final treatment report(s) submitted as a result of a service purchased by the Department must include an evaluation of the client's progress, prognosis, functional limitations and capacities.

In addition to these report(s), initial evaluations and report(s) submitted for physical/occupational/speech therapy or for psychiatric therapy/psychological counseling must include a limited history, diagnosis, summary of functional limitations and capacities and the recommended therapy plan based upon the results of the evaluation or the provision of subsequent services.

The California regulations also provide that all service(s) must be limited to six sessions/visits, except when:

(1) Physical therapy training in the use of a prosthetic or orthotic appliance has been recommended by the prescribing physician, or

(2) The need for additional sessions/visits has the concurrence of the Medical Consultant and approval of the District Administrator. A written justification prepared by the provider of service shall be submitted to the Department for review and shall include the following:

(A) The basis on which the additional treatment is recommended.

(B) The anticipated number of visits/sessions in excess of six.

When treatment is recommended beyond six sessions/visits the Counselor must seek alternate ways to provide service based upon available resources.

The California regulations [7160.5] also include specific limitations applicable to acupuncture, chiropractic services and psychiatric therapy and psychological counseling.

The Massachusetts policy [6.06] specifies, among other things, that physical and mental restoration services can be provided only if financial participation has been determined, any comparable benefit available to meet, in whole or in part, the cost of restoration services has been explored and:

1. An individual had an examination by an appropriate physician, psychiatrist, psychologist or other professional who meets applicable State licensure requirements, at least ninety (90) days prior to the provision of restoration services and restoration is consistent with examination findings.
2. The specific services are authorized in writing by the Commission prior to provision. However, in a medical emergency the Commission may first make an oral authorization to a vendor before issuing a written authorization.
3. Restoration services shall be provided only at institutions and facilities meeting all statutory, regulatory, accreditation, licensing, certification, approval, health and safety, and related standards applicable to such institutions and facilities and by qualified personnel who meet applicable licensing requirements of the Commonwealth of Massachusetts.
4. Fees for restoration services are determined in accordance with applicable regulations of the Commonwealth of Massachusetts.

The North Carolina policy separates mental from physical restoration services. Mental restoration services [Section 2-13] are those services that are necessary to correct or substantially modify a mental impairment that is stable or slowly progressive. Mental restoration is subject to the client's financial need and comparable benefits, when available. The North Carolina policy notes that the implementation of Mental Health Reform has led to the creation of target and non-target populations. Mental Health consumers falling into the non-target population will no longer be eligible for outpatient therapy services under the public

mental health system. Because of this significant change, it is anticipated that more individuals with mental health disabilities will need Division assistance with outpatient therapy than before so that they can reach and maintain a level of stability that will enable them to successfully complete a program of vocational rehabilitation services.

In many areas of the state, especially in rural areas, a shortage of mental health therapists exists. Recognizing this fact, the North Carolina Division of Medical Assistance has expanded the types of mental health therapy providers that it will pay for outpatient behavioral health services. Expanding the Division's list of psychotherapy provider types to bring it into line with revised policy from the Division of Medical Assistance will help in addressing the shortage in therapists.

If outpatient therapy is available through the public mental health system, this, as in the past, would be considered a comparable benefit. Also, it must be emphasized that psychotherapy can only be sponsored if it is required by the client so that the objective of the IPE can be achieved.

Division clients needing psychological or psychiatric treatment to address a **primary** or **secondary** disabling condition in order to meet the objectives on the IPE should be referred to the local mental health system whenever feasible. [Section 2-13-1] When public mental health services are not available, the Division may sponsor private therapy on an outpatient basis. Counselors may authorize up to twenty-four sessions for psychotherapy. Additional sessions may be authorized with the approval of the Unit Manager/Facility Director and the Chief of Policy. In addition to the documentation required for eligibility determination and treatment updates, a written treatment plan, justification for additional sessions, and ongoing progress reports are required when more than twenty-four sessions are authorized. Medication monitoring may also be sponsored by the Division when comparable benefits are not available. Psychotherapy will not be authorized to cover case management or other services managed by the Mental Health System. Inpatient therapy will not be provided.

In North Carolina, physical restoration services may be provided as part of a rehabilitation program to correct or substantially reduce a physical impairment that is stable or slowly progressive and that results in substantial impediments to employment [Section 2-16]. A slowly progressive condition is one in which the client's functional capacity is not expected to diminish so rapidly as to prevent successful completion of vocational rehabilitation services, and/or employment for a reasonable period of time. This service is also referred to as —*Diagnosis and Treatment of Impairments*—. Such services are subject to the individual's financial need and comparable benefits, when available. Restoration services are considered substantial vocational rehabilitation services when they are provided within the supportive counseling and guidance relationship.

Intercurrent illnesses are defined as those illnesses that arise during the course of the rehabilitation program and interfere with completion of the intermediate program objectives. Illnesses may be either acute or chronic. Treatment of such illnesses may be sponsored by the

Division. Specialty medical information is required along with a treatment plan. Financial need must be ascertained and comparable benefits used when available.

Secondary restoration refers to an acute or remediable condition that exists concomitantly with a chronic impairment (that makes an individual eligible for Division services), is present at the time of eligibility, and presents a definite obstacle to progression and accomplishment of the rehabilitation program. The rehabilitation counselor may sponsor the recommended treatment in these circumstances to remove the acute condition so that the individual can benefit, in a timely manner, from other planned Division services.

Some individuals have stable or slowly progressive conditions of long duration. The Division does not provide long-term or ongoing physical treatment. Accordingly, Division funds cannot be used to initiate treatment that is reasonably anticipated to last more than six months (per case) unless Unit Manager approval has been obtained. Agreed upon extensions may be approved only if the client maintains reasonable progress toward achieving the vocational goal. An exception can be when the purchase of medication/medical supplies is expected to exceed six months duration in support of training as a major service on the Individualized Plan for Employment. It is expected that the counselor would work jointly with the client to identify comparable benefits for long term medical care.

North Carolina includes specific policies for each of the following physical restoration services:

- Morbid obesity [2-16-1]
- Hearing aids [2-16-2]
- Orthotics [2-16-3]
- Prosthetics [2-16-4]
- Podiatry [2-16-5]
- Visual services [2-16-6]
- Chiropractic services [2-16-7]
- Hospitalization [2-16-8]
- Drugs and Medical supplies [2-16-9]
- Dental [2-16-10]
- Home health [2-16-11]
- Speech therapy [2-16-12]
- Physical therapy [2-16-13]
- Occupational therapy [2-16-14]
- Durable medical equipment [2-5-3]

All of the states reiterate the general policy regarding rehabilitation technology, assistive technology devices and assistive technology services. For example, Massachusetts's policy [6.17] includes specific provisions regarding legal title and transfer of legal title to equipment. (9) Under the State policy, the VR Commission retains legal title and control of any equipment purchased for an individual as a rehabilitation technology service. Such legal title and control

will be in accordance with all applicable Massachusetts laws, regulations and related requirements governing title, use, replacement, disposition, and transfer. Equipment will not be attached, confiscated, or otherwise encumbered by creditors or other sources however:

- The Commission may require the return of such equipment, in good condition, if it determines that equipment is not being utilized for the purposes for which it was provided; and
- At such time as an individual is performing successfully in employment and considered to have attained his/her vocational rehabilitation goals, title to and control of the equipment may be transferred to the individual.

Rates, fees, and expenditures for rehabilitation technology services are subject to all applicable Commonwealth of Massachusetts' statutory, regulatory, and related requirements governing purchases of services and goods. The VR Commission may establish maximum dollar limits designed to ensure the lowest reasonable cost for rehabilitation technology services. The maximum dollar limits will include a waiver process so that rehabilitation technology services that are essential to vocational rehabilitation and employment of otherwise eligible individuals are not precluded by the maximum dollar limits established to control costs

Provision of rehabilitation technology services is subject to determination of financial participation rehabilitation technology services do not require a determination that comparable benefits and services are unavailable under any other program. However, resources from other programs may be utilized when readily available.

In addition, several states include a policy regarding telecommunication, sensory and other technological aids and devices. For example, the California regulations [7172] specify that telecommunication, sensory and technological aids and/or devices may be provided when all of the following conditions exist:

- (1) The client's disability warrants such aids or devices.
- (2) There is no other method of accommodating the client's disability which is more efficient or less expensive.
- (3) The aid or device is necessary to the client's vocational rehabilitation program.
- (4) No medical contraindication exists.
- (5) The client's disability is stable enough so that the client will benefit from the aid or device over a prolonged period of time.

Prior to the provision of the aid or device the Counselor shall determine both of the following:

(1) Whether the client is eligible for similar benefits in accordance with sections 7190 through 7193. If eligibility exists, the Counselor shall follow the procedures specified in those regulations.

(2) The ability of the client to financially participate in accordance with sections 7190 through 7193. If the client is able to financially participate, the procedures for payment specified in those regulations shall be followed.

Massachusetts also includes specific policy [6.15] applicable to telecommunications, sensory, and technological aids and devices. Telecommunications, sensory and other technological aids and devices include: alerting and signaling devices, amplified or text telephones and personal and large area FM assistive listening devices for individuals who are deaf or hard of hearing. Such devices or aids may include but are not limited to: visual or vibrating alerts for doorbells; kitchen timers; alarm clocks and smoke detectors. These aids may be needed by an individual with hearing loss instead of or in addition to hearing aids.

- Telecommunications, sensory and other technological aids and devices may be provided only to the extent necessary to enable an individual to attain a suitable employment outcome or as necessary to enable an individual to complete an assessment, trial work experience or extended evaluation to determine eligibility and vocational rehabilitation needs
- The Commission may retain legal title and control of any aids and devices purchased for an individual. Such legal title and control shall be in accordance with all applicable Massachusetts laws, regulations and related requirements governing title, use, replacement, disposition, and transfer. The Commission may require the return of such aids and devices if it determines the aids or devices are not being utilized for the purposes for which it was provided. All aids and devices shall be returned to the Commission in good condition upon request. Aids and devices shall not be attached, confiscated, or otherwise encumbered by creditors or other sources. At such time as an individual is performing successfully in employment and considered to have attained his/her vocational rehabilitation goals, title to and control of aids and devices may be transferred to the individual. Rates, fees, and expenditures for telecommunications, sensory and other technological aids and devices are subject to all applicable Commonwealth of Massachusetts statutory, regulatory, and related requirements governing purchases of services and goods.
- Telecommunications, sensory and other technological aids and devices are subject to the determination of financial participation and to consideration of any comparable benefit available to an individual to meet, in whole or in part, the cost of telecommunications, sensory and other technological aids and devices.

The North Carolina policy [2-5-5] includes a specific section regarding telecommunication devices. The Division will evaluate the needs of all eligible sensory impaired clients for telecommunications, sensory, and other technological aids and devices. These services include the widest range of electronic or assistive listening devices that are available and have demonstrated an ability to aid a person's chances of going to work or living more

independently. Assistive listening devices include hardware devices, FM systems, loops, infrared devices, direct audio input hearing aids, telephone aids and speech assistance devices. Such services are subject to an individual's financial need and comparable benefits, when available. The Division of Services for the Deaf and Hard of Hearing has the Equipment Distribution Service, which provides access to telecommunications devices for people who are Deaf, Hard of Hearing, Deaf-Blind, and Speech Impaired but whom have difficulty affording these devices.

With respect to rehabilitation technology, the Florida Manual [14.02] specifies that the VR agency must provide appropriate rehabilitation technology services including consultation with a rehabilitation engineer that is necessary for the applicant or eligible individual to participate in VR agency services, assessments or achievement of an employment outcome. Prior to providing repairs to rehabilitation technology, the VR agency must determine whether maintaining equipment or replacement is appropriate. More specifically, the counselor must, among other things:

1. Inform the individual that rehabilitation technology services are available. The counselor must discuss all relevant policy pertaining to the provision of these services including the individuals' responsibilities and participation in the services.
2. Discuss costs of insurance, maintenance and repairs so that individuals understand their responsibilities.

In addition, the counselor is encouraged to explore comparable benefits to the degree that it does not delay services or reduce the quality of rehabilitation technology services.

With respect to personal assistance services, the states generally reiterate the policy included in the Federal policy framework. North Carolina policy [Section 2-15-1] specifies that personal assistance services may be sponsored at any time during the rehabilitation process to enable clients to fully participate in the assessment for determining eligibility and vocational rehabilitation needs, planning, service provision, and employment. It is a support service that can only be provided in relation to and in support of another vocational rehabilitation service. Sponsorship of this service is not intended to supplant services traditionally provided by the client's family.

- Personal assistance services are not subject to financial need, but comparable benefits must be utilized when available.
- Under no circumstance shall the Division sponsor co-pays for personal assistance if the client is utilizing Medicaid or another similar benefit to acquire personal assistance.
- Personal assistance can be provided by establishing the VR client as a household employer or by authorizing to Home Health agencies or medical service organizations. When home health care agencies are utilized, the Division shall authorize payment directly to the home health care vendor, and a concurrent case with IL is not opened.

- The VR counselor cannot authorize greater than 28 hours per week for personal assistance. Requests to exceed 28 hours per week shall be submitted to the Unit Manager.

VI. WRITTEN POLICIES GOVERNING THE PROVISION OF SERVICES

The designated State unit must develop and maintain written policies covering the nature and scope of each of the specified vocational rehabilitation services and the criteria under which each service is provided. The policies must ensure that the provision of services is based on the rehabilitation needs of each individual as identified in that individual's IPE and is consistent with the individual's informed choice. The written policies may not establish any arbitrary limits on the nature and scope of vocational rehabilitation services to be provided to the individual to achieve an employment outcome. The policies must be developed in accordance with the following provisions:

- (1) The State unit may establish a preference for in-State services, provided that the preference does not effectively deny an individual a necessary service. If the individual chooses an out-of-State service at a higher cost than an in-State service, if either service would meet the individual's rehabilitation needs, the designated State unit is not responsible for those costs in excess of the cost of the in-State service.
- (2) The State unit may not establish policies that effectively prohibit the provision of out-of-State services.
- (3) The State unit must establish and maintain written policies to govern the rates of payment for all purchased vocational rehabilitation services.
- (4) The State unit may establish a fee schedule designed to ensure a reasonable cost to the program for each service, if the schedule is not so low as to effectively deny an individual a necessary service; and not absolute and permits exceptions so that individual needs can be addressed.
- (5) The State unit may not place absolute dollar limits on specific service categories or on the total services provided to an individual.
- (6) The State unit may establish reasonable time periods for the provision of services provided that the time periods are not so short as to effectively deny an individual a necessary service; and not absolute and permit exceptions so that individual needs can be addressed.
- (7) The State unit may not establish absolute time limits on the provision of specific services or on the provision of services to an individual. The duration of each service needed by an individual must be determined on an individual basis and reflected in that individual's individualized plan for employment. [34 CFR 361.50]

In general, the State policy frameworks adopt the policies in the Federal policy framework. As noted in the previous section, certain states have established specific time periods for the provision of services, with authority to extend the time period under specified circumstances.

VII. COMPARABLE SERVICES AND BENEFITS

The Federal policy framework regarding comparable services and benefits includes five subjects:

- Determination of availability
- Exempt services
- Provision of services
- Interagency coordination
- Responsibilities under other laws

Determination of availability [34 CFR 361.53(a)] The State plan must assure that prior to providing any vocational rehabilitation services to an eligible individual (except those exempt services described below), or to members of the individual's family, the designated State unit must determine whether comparable services and benefits exist under any other program and whether those services and benefits are available to the individual unless such a determination would interrupt or delay:

- The progress of the individual toward achieving the employment outcome identified in the IPE;
- An immediate job placement; or
- The provision of vocational rehabilitation services to any individual who is determined to be in extreme medical risk, based on medical evidence provided by an appropriate qualified medical professional.

Exempt services [34 CFR 361.53(b)]: The following vocational rehabilitation services are exempt from a determination of the availability of comparable services and benefits:

1. Assessment for determining eligibility and vocational rehabilitation needs;
2. Counseling and guidance, including information and support services to assist an individual in exercising informed choice;
3. Referral and other services to secure needed services from other agencies if those services are not available under Title I of the Rehab Act;
4. Job-related services, including job search and placement assistance, job retention services, follow-up services, and follow-along services;
5. Rehabilitation technology, including telecommunications, sensory and other technological aids and devices; and
6. Post-employment services consisting of services listed under 1-5 above.

Provision of services [34 CFR 361.53(c)]. If comparable services or benefits exist under any other program and are available to the individual at the time needed to ensure the progress of the individual toward achieving the employment outcome in the individual's IPE, then the designated State unit must use those comparable services or benefits to meet, in whole or in part, the costs of vocational rehabilitation services. If comparable services or benefits exist under any other program, but are not available to the individual at the time needed to ensure the progress of the individual toward achieving the employment outcome in the individual's IPE, the designated State unit must provide vocational rehabilitation services until those comparable services and benefits become available.

Interagency coordination [34 CFR 361.53(d); see also 34 CFR 363.50] The State plan must assure that the Governor, in consultation with the entity in the State responsible for the vocational rehabilitation program and other appropriate agencies, will ensure that an interagency agreement or other mechanism for interagency coordination takes effect between the designated State vocational rehabilitation unit and any appropriate public entity, including the State responsible for administering the State **Medicaid program**, a public institution of higher education, and a component of the statewide workforce investment system, to ensure the provision of vocational rehabilitation services (other than exempt services) that are included in the IPE, including the provision of those VR services during the pendency of any interagency dispute. The interagency agreement or other mechanism for interagency coordination must include:

- An identification of, or description of a method for defining, the financial responsibility of the public entity for providing the vocational rehabilitation services (other than exempt services) and a provision stating the financial responsibility of the public entity for providing those services;
- Information specifying the conditions, terms, and procedures under which the designated State unit must be reimbursed by the other public entities for providing VR services based on the terms of the interagency agreement or other mechanism for interagency coordination;
- Information specifying procedures for resolving disputes; and
- Information specifying policies and procedures for public entities to determine and identify interagency coordination responsibilities of each public entity to promote the coordination and timely delivery of VR services (other than exempted services).

Responsibilities under other law [34 CFR 361.53(e)] If a public entity (other than the designated State unit) is obligated under Federal law (such as the ADA, Section 504 or WIA) or State law, or assigned responsibility under State policy or an interagency agreement to provide or pay for any services considered VR services (e.g., interpreter services), the public entity must fulfill that obligation or responsibility through:

- The terms of the interagency agreement;
- Providing or paying for the service directly or by contract; and
- Other arrangement.

If the public entity other than the designated State unit fails to provide or pay for VR services for an eligible individual, the designated State unit must provide or pay for those services to the individual and may claim reimbursement for the services from the public entity that failed to provide or pay for those services.

The State policy frameworks generally reiterate the Federal policies regarding comparable services and benefits. Additional State policies of interest are set out below.

The California regulation [7196] provide for similar benefit review and procedure for informing the client of his or her responsibilities. The completion of a similar benefit review is required prior to the authorization of any service not exempt. Upon a determination by the Counselor that a similar benefit is available, the Counselor shall advise the client that he/she is required to apply for and use such benefit. If the client refuses to apply for or use the similar benefit, the Counselor shall:

- (1) Deny provision of the service(s) for which the similar benefit is available.
- (2) Continue the provision of other services for which there is no similar benefit, providing the IWRP remains viable and will most likely succeed without the provision of the service(s) that was denied.

With respect to extreme medical risk, the California regulations [7198(c)(2)] include a construction clause which specifies that nothing in this section shall be construed to mean that the Department must become a primary health care payment program or take the place of other primary health care payment programs, such as the Medi-Cal program.

The Massachusetts policy [6.04] includes a specific list of services subject to the comparable services and benefits provision:

1. Physical and mental restoration services;
2. Maintenance and transportation services;
3. Services to members of an eligible individual's family;
4. Occupational licenses, tools, equipment, and initial stocks and supplies;
5. Vocational training services including books, tools, and other training materials;
6. Personal assistance and auxiliary aids and services including interpreter services for the deaf, reader services, note taker, personal care attendant; and rehabilitation teaching services;
7. Employment services including supported employment and post employment services that are necessary to
8. Maintain, regain or advance in employment;
9. Rehabilitation technology, adaptive housing, motor vehicle modification, telecommunications, sensory and other technological aids and devices;
10. Transition services;
11. Other goods and services not listed.

The North Carolina policy specifies that the provision of assistive technology devices is subject to the individual's financial need and comparable benefits [2-17-2] and assistive technology services is subject to the individual's financial need but not comparable benefits. [2-17-3]

North Carolina includes a comprehensive policy regarding comparable services and benefits. [Section 3-11-3] The VR agency will provide rehabilitation services only when such services are not available from some other source as a comparable benefit or service. Comparable benefits are to be investigated and used for all rehabilitation services (with certain exemptions specified in Federal regulations). The policy contains examples of comparable benefits; others may be available and must be considered.

Medicaid

The Division cannot supplant resources available through Medicaid. Therefore, Medicaid eligibility must be verified at the time of application and throughout the rehabilitation process. When appropriate, the counselor should refer the applicant or client to the local DSS for determination of eligibility. Medicaid may continue for SSI recipients who are disabled and earn over the SSI limits if they cannot afford similar medical care and depend on Medicaid in order to work. A threshold test and Medicaid use test will be applied to the individual situation to determine continuation of Medicaid eligibility (1619B). The Division, regardless of the individual's financial need, cannot authorize Medicaid deductibles. If the client meets financial need but has a deductible and is unable to meet the deductible thus jeopardizing the ultimate rehabilitation goal, the counselor may elect to sponsor the necessary medical services without Medicaid as a comparable benefit. The rationale for sponsoring necessary medical services without utilizing Medicaid is required in the case record. If the counselor determines that the client can meet the deductible, the Division will not contribute toward the cost of the medical services. Individuals who qualify for Medicaid because they are eligible for SSI are not subject to a spend-down.

Medicare

Medicare is an available comparable benefit for those individuals who meet the eligibility requirements for this program.

Health Insurance

Medical and related health insurance should always be used for any service applicable to the benefit. The counselor must assure that the vendor or the client pursues this benefit prior to payment for a rehabilitation service. Insurance paid directly to the individual must be used to offset Division payments, and the counselor must complete a SUBROGATION RIGHTS-ASSIGNMENT OF REIMBURSEMENT FORM.

Workers' Compensation

If Workers' Compensation benefits are available, such benefits must be used prior to the expenditure of Division funds. If Workers' Compensation eligibility is pending or if there is an undue delay in service provision necessary for rehabilitation, the counselor may

authorize services if Subrogation Rights: Assignment of Reimbursement form has been completed. (See section 1-18)

Children's Special Health Services

Individuals 21 years old or younger, who require medical and related support services, including equipment needed for medical reasons, should apply for services from this resource. [See section for children and youth]

The North Carolina policy also includes a section regarding comparable Benefits for Equipment Purchases [Section 2-5]. Comparable benefits must be utilized when available in the purchase of Durable Medical Equipment. [Section 2-5-4] Assistive listening devices include hardware devices, FM systems, loops, infra-red devices, direct audio input hearing aids, telephone aids and speech assistance devices. Such services are subject to an individual's financial need and comparable benefits, when available. The Division of Services for the Deaf and Hard of Hearing has the Equipment Distribution Service, which provides access to telecommunications devices for people who are Deaf, Hard of Hearing, Deaf-Blind, and Speech Impaired but whom have difficulty affording these devices. The Equipment Distribution Service Hearing Aid Program provides one hearing aid that allows individuals with hearing loss to communicate on the telephone using a hearing aid telecoil (T-coil). The goal is to provide equal access through the telephone system and Relay Service. Devices are free to qualified individuals. [Section 2-5-5]

VIII. PARTICIPATION OF INDIVIDUALS IN COST OF SERVICES BASED ON FINANCIAL NEED [34 CFR 361.54]

There is no Federal requirement that the financial need of individuals be considered in the provision of vocational rehabilitation services. The designated State unit may choose to consider the financial need of eligible individuals or individuals who are receiving services through trial work experiences or during an extended evaluation for purposes of determining the extent of their participation in the costs of vocational rehabilitation services, other than those services identified below. If the State unit chooses to consider financial need:

- It must maintain written policies explaining the method for determining the financial need of an eligible individual; and specifying the types of vocational rehabilitation services for which the unit has established a financial needs test;
- The policies must be applied uniformly to all individuals in similar circumstances;
- The policies may require different levels of need for different geographic regions in the State, but must be applied uniformly to all individuals within each geographic region; And
- The policies must ensure that the level of an individual's participation in the cost of vocational rehabilitation services is reasonable; based on the individual's financial need, including consideration of any disability-related expenses paid by the individual; and not so high as to effectively deny the individual a necessary service.

The designated State unit may not apply a financial needs test, or require the financial participation of the individual as a condition for furnishing, among other things, the following vocational rehabilitation services: personal assistance services and as a condition for furnishing any vocational rehabilitation service if the individual in need of the service has been determined eligible for Social Security benefits under Titles II or XVI of the Social Security Act.

All of the four states have chosen to include cost sharing responsibilities. For example, in California, the regulations include a comprehensive policy describing the circumstances under which an individual must pay his or her fair share for certain VR services and includes exemptions for specified classes of individuals, consistent with Federal policy. The California regulation [7029.9] also includes a reference to the comparable services and benefits requirement under its cost sharing policy: Any applicant or eligible individual, as appropriate, shall have the responsibility to apply for, secure and use comparable services and benefits to the extent to which the individual is eligible for such benefits [7029.9(b)(6)].

In Florida, the Manual specifies that the responsibilities of the eligible individual include:

- If applicable, the participation of the eligible individual in paying for the costs of the plan;
- The responsibility of the eligible individual with regard to applying for and securing comparable services and benefits; and
- The responsibilities of other entities as the result of arrangements made pursuant to comparable services or benefits.

The Florida Counselor Policy Manual specifies the circumstances under which an applicant or client is considered to have assigned his or her rights to the VR agency for payments for specified services. [9.06] An applicant for or a recipient of vocational rehabilitation and related services is deemed to have assigned to the DVR her or his rights to any payments for such services from a third party (e.g. private insurance, Medicaid, and Medicare).

Massachusetts policy [6.14], consistent with Federal law, specifies that auxiliary aids and services are not subject to the determination of financial participation when they are necessary to enable an individual to access the VR program as required under Section 504 of the Rehabilitation Act and/or the Americans with Disabilities Act. Massachusetts policy [6.03] also specifies services that are provided by the Commission without consideration of an individual's financial resources. This however, does not eliminate the requirement to use all available comparable benefits the individual is eligible to receive before providing Commission funds. This list includes, among other things, personal assistance services and auxiliary aids and services such as interpreter services for individuals who are deaf or hard of hearing including sign language and oral interpreter services, reader services, note taker, personal care attendant services, and rehabilitation teaching services as necessary for an individual to participate in the VR program as required under section 504 of the Rehabilitation Act or the Americans with Disabilities Act.

PART III

PROVISIONS IN THE AFFORDABLE CARE ACT APPLICABLE TO THE VR PROGRAM

In March 2010, Congress passed and the President signed into law the “Affordable Care Act” (ACA). The ACA was enacted in two parts: The Patient Protection and Affordable Care Act³ was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act⁴ on March 30, 2010. The name Affordable Care Act (ACA) is used to refer to the final, amended version of the law. A Glossary of key terms used in ACA is included in Appendix I.

The ACA includes the following key policies applicable to individuals, employers, health care exchanges and essential health benefits, private health insurance, and expansion of Medicaid:

- Most individuals will be required to have health insurance beginning in 2014 or pay a financial penalty.
- For those individuals who cannot afford health insurance, premium and cost-sharing credits will be available.
- Employers will be required to provide insurance or pay penalties for employees who receive tax credits for health insurance through the Exchange with exceptions for small employers.
- States are authorized to establish Health Care Exchanges and offer essential health benefits that meet minimum standards established by the Secretary of Health and Human Services (HHS). If a State decides not to establish a State-Based Exchange, the Secretary of HHS is authorized to establish a Federally-facilitated Exchange in the State.
- Individuals who do not have access to affordable employer coverage will be able to purchase coverage through a Health Insurance Exchange.
- New regulations will govern health plans and health insurance issuers, including policies regarding pre-existing conditions exclusions, preventing health plans and insurers from denying coverage to people for any reason, including health status and from charging higher premiums based on health status and gender, and rescissions of coverage.
- At a State’s discretion, Medicaid may be expanded to 133% of the Federal poverty level for all individuals under age 65 and receive an enhanced Federal matching rate. A State may also take advantage of new options to provide home and community-based services in the setting they choose.

³ Pub. L. 111-148.

⁴ Pub. L. 111-152.

On June 28, 2012, the United States Supreme Court upheld all of the provisions of the ACA, with the exception of the Medicaid expansion.⁵ 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.

The following summary of the law and implementing regulations, as interpreted by the U.S. Supreme Court, focuses on provisions in ACA that expand access to coverage, make changes to insurance market rules, and expand access (on a voluntary basis) to public programs (Medicaid). These changes could impact the financial responsibilities of State VR agencies with regard to the provision of certain health-related VR services, including physical and mental restoration services, rehabilitation technology, assistive technology devices, assistive technology services, and personal assistance services.

I. INDIVIDUAL MANDATE, FINANCIAL PENALTY, FEDERAL SUBSIDIES AND TAX CREDITS⁶

Individuals will be required to have health insurance, with some exceptions, beginning in 2014. Those who do not have coverage will be required to pay a yearly financial penalty of the greater of \$695 per person (up to a maximum of \$2,085 per family), or 2.5% of household income, which will be phased-in from 2014-2016. Exceptions will be given for financial hardship and religious objections and to people who have been uninsured for less than three months, those for whom the lowest cost health plan exceeds 8% of income, and if the individual has income below the tax filing threshold (\$9,350 for an individual and \$18,700 for a married couple in 2009).

- Premium subsidies will be provided to families with incomes up to 40% of the poverty level (\$29,327 to \$88,200 for a family of four in 2009) that do not have access to other coverage to help them purchase insurance through Exchanges. These subsidies will be offered on a sliding scale basis and will limit the cost of the premium to between 2% and 9.5% of income for eligible individuals.
- Cost-sharing subsidies will also be available to people with incomes between 100-250% of the poverty level to limit out-of-pocket spending.

II. EMPLOYER REQUIREMENTS⁷

Effective January 1, 2014, employers with 50 or more full-time employees will be assessed a fee of \$2,000 per full-time employee (in excess of 30 employees) if they do not offer coverage and if they have at least one employee who receives a premium credit through an Exchange.

⁵ *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).

⁶ See generally www.healthcare.gov; *Summary of New Health Reform Law*, Kaiser Family Foundation, www.kff.org.

⁷ See generally www.healthcare.gov; *Summary of New Health Reform Law*, Kaiser Family Foundation, www.kff.org.

Employers with 50 or more employees that offer coverage but have at least one employee who receives a premium credit through an Exchange are required to pay the lesser of \$3,000 for each employee who receives a premium credit or \$2,000 for each full-time employee (excluding the first 30 employees from the assessment).

Effective January 1, 2014, employers with 50 or more full-time employees that offer coverage but have at least one full-time employee receiving a premium tax credit, will pay the lesser of \$3,000 for each employee receiving a premium credit or \$2,000 for each full-time employee, excluding the first 30 employees from the assessment. Employers with up to 50 full-time employees are exempt from all of the above penalties

Employers to which the FLSA applies, and who have more than 200 full-time employees, are required to automatically enroll new full-time employees in one of the employer's health benefits plans (subject to any waiting period authorized by law), and to continue the enrollment of current employees in the employer's health benefits plan. In addition, employees must be provided adequate notice and the opportunity to opt out of any coverage in which the employee was automatically enrolled. Any applicable State laws regarding payroll, such as permissible deductions of wages, will continue to be in effect except to the extent the State law prohibits employers from implementing automatic enrollment under the FLSA provisions.

III. HEALTH CARE EXCHANGES AND ESSENTIAL HEALTH BENEFITS⁸

The ACA allows each State the opportunity to establish an Affordable Insurance Exchange to help individuals and small employers purchase affordable health insurance coverage. Exchanges will allow individuals and eligible employers to compare and select from qualified health plans (QHPs) for their families and their employees that meet benefit design, consumer protection, and other standards. Exchanges are designed to increase access to coverage by providing a single point of access for individual consumers to receive eligibility determinations for enrollment in the Exchange and for insurance affordability programs, and select a QHP that best meets their needs. By permitting consumers and employers to easily compare health plans, Exchanges will increase competition among issuers and improve the affordability of coverage. Exchanges are also integral to the ACA's goals of prohibiting discrimination against people with pre-existing conditions and insuring all Americans. Coverage through the Exchange will begin in every State on January 1, 2014, with enrollment beginning on October 1, 2013.⁹

⁸ See generally www.healthcare.gov; *Summary of New Health Reform Law*, Kaiser Family Foundation, www.kff.org. See also *Final Rule and Interim Final Rule; Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans*, 77 Federal Register 18310 (March 27, 2012). See also *Essential Health Benefits—Balancing Coverage and Cost*, Institute of Medicine Report (October 7, 2011).

⁹ *General Guidelines on Federally-facilitated Exchanges* (May 16, 2012) at page 3.

The deadline to operate a State-Based Exchange for calendar year 2014 is December 14, 2012; the deadline to operate a State partnership exchange is February 15, 2013. A state may apply at any time to run an Exchange in future years.¹⁰

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, or will not have an operable Exchange for the 2014 coverage year.¹¹

States that elect not to establish a State-based Exchange will have the option to enter into a partnership with a Federally-facilitated Exchange. Under a State Partnership model, a State may administer plan management functions, in-person consumer assistance functions, or both. In non-Partnership Federally-facilitated Exchange States, the Federally-facilitated Exchange will perform all Exchange functions, including these functions.¹² A Federally-Facilitated Exchange's role and responsibility are limited to certification and management of participating qualified health plans. Its role and authority do not extend beyond the Exchange or affect otherwise applicable State law governing which health insurance products may be sold in the individual and small group markets.¹³

To offer a seamless consumer experience, each Federally-facilitated Exchange must also allow consumer to receive eligibility determinations of multiple programs using a single, streamlined application, regardless of where consumers submit their applications. A well-coordinated eligibility process is essential to the consumer experience and HHS believes that it can be accomplished through the following eligibility process. There will be two approaches for determining applicants' eligibility for Medicaid and CHIP for applications submitted to a Federally-facilitated Exchange.¹⁴

- 1) The Federally-facilitated Exchange will determine Medicaid and CHIP eligibility and electronically transmit the determination and all information for any eligible applicants to the State Medicaid and CHIP agency. The Medicaid and CHIP agency will accept the Federally-facilitated Exchange's determination and provide for enrollment in Medicaid or CHIP coverage.
- 2) The Federally-facilitated Exchange will conduct assessments of Medicaid and CHIP eligibility. The Federally-facilitated Exchange will electronically transmit all information to any potentially eligible applicants to the State Medicaid and CHIP agency, which will make the final determinations and notify the Exchanges if the State Medicaid or CHIP agency finds that the applicant is ineligible.

¹⁰ Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid (CMS, December 10, 2012) [hereinafter referred to as [FAQs](#)], Question 1.

¹¹ [General Guidelines on Federally-facilitated Exchanges](#) at page 3.

¹² [General Guidelines on Federally-facilitated Exchanges](#) at pages 3-4.

¹³ [FAQs](#), Question 7; See also [General Guidelines on Federally-facilitated Exchanges](#) at page 8.

¹⁴ [General Guidelines on Federally-facilitated Exchanges](#) at page 13

Under either option, a Federally-facilitated Exchange will also assess or determine Medicaid and CHIP eligibility based on the State's applicable Medicaid and CHIP income standards, citizenship and immigration status, other eligibility requirements, and standard verification rules and procedures.¹⁵

The Exchanges will provide consumers with information to enable them to choose among plans.¹⁶ Premiums and cost-sharing subsidies will be available to make coverage more affordable.

According to the ACA, effective 2014, plans 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 defines essential health benefits to include at least the following ten general categories and the items and services covered within the categories:

- 1) Ambulatory patient services;
- 2) Emergency services;
- 3) Hospitalization;
- 4) Maternity and newborn care;
- 5) Mental health and substance use disorder services, including behavioral health treatment;
- 6) Prescription drugs;
- 7) Rehabilitative and habilitative services and devices;
- 8) Laboratory services;
- 9) Preventive and wellness services and chronic disease management; and
- 10) Pediatric services, including oral and vision care.

Insurance policies must cover these essential health benefits in order to be certified and offered in Exchanges, and all Medicaid "benchmark plans" must cover these services by 2014. [See below under "Expansion of Public Programs (Medicaid)"]

- In defining the essential health benefits packages, the Secretary of HHS must start with a typical employer plan and then ensure that all of the categories of benefits are included. In addition, the Secretary of HHS must define the essential health benefits package so that:
 - Benefits are not designed to discriminate against individuals because of age, disability or expected length of life;
 - The health care needs of diverse segments of the population are accounted for;
 - The essential benefits are not denied due to an individual's health status; and
 - Benefits are not unduly weighted toward one category of benefits.

¹⁵ [General Guidelines on Federally-facilitated Exchanges](#) at page 13.

¹⁶ See [Final Rule, Summary of Benefits and Coverage and Uniform Glossary](#), 77 Federal Register 8668 (February 14, 2012).

- Effective in 2014, insurers will offer four levels of coverage¹⁷ that vary based on premiums, out-of-pocket costs and benefits beyond the minimum required plus a catastrophic coverage plan for young adults.
- Effective in 2014, limits deductibles for health plans in the small group market to \$2,000 for individuals and \$4,000 for families unless contributions are offered that offset deductible amounts above these limits. This deductible limit will not affect the actuarial value of any plans.
- States are permitted to add on benefits not included in the essential health benefits package at their own cost.

Below is a more detailed description of these key ACA provisions. In advance of issuing final regulations regarding the essential health benefits package, the Department of Health and Human Services released non-binding guidance instructing states to choose an existing plan as a benchmark for their essential health benefits package and also asks states to enhance that plan where it does not cover all 10 of the required benefit categories. [[Essential Health Benefits Bulletin, December 16, 2011](#)]. On November 26, 2012, the Department of Health and Human Services published in the *Federal Register* a Notice of Proposed Rulemaking (NPRM) detailing proposed standards related to essential health benefits, actuarial value, and accreditation [hereinafter referred to as the [Essential Health Benefits NPRM](#)].¹⁸

In accordance with the [Essential Health Benefits NPRM](#), States are given four options for selecting their base-benchmark plan:¹⁹

- 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 Plan options by enrollment; or
- (4) The largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the State.

¹⁷ The plans must meet specific actuarial value. A plan must cover 60 percent of the value of services for a bronze plan, 70 percent for a silver plan, 80 percent for a gold plan, and 90 percent for a platinum plan. The AV tiers are called "metal levels" and are meant to help a plan consumer understand and compare the relative generosity of plans.

¹⁸ 77 Federal Register 70644-70676 (November 26, 2012).

¹⁹ [Essential Health Benefits NPRM](#) 156.100(a). 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 NPRM](#) 156.100(c)

In May, HHS also released a proposed rule²⁰ that would establish data collection for health plans that represent potential essential health benefits benchmarks in the States. Specifically, the issuers of the three largest small group market plans in each State would be required to report to HHS information regarding all the health benefits in the plan, treatment limitations, drug coverage, and enrollment. This data will inform states and stakeholders of the details of benchmark plans and aid in both choosing and enhancing the essential health benefit package for their states. If states opt not to choose a benchmark plan, the default benchmark plan for that State will be the largest plan by enrollment in the State's small group market.

In accordance with the [Essential Health Benefits NPRM](#), once a State has selected its base-benchmark plan, it is then required to “supplement” the package of benefits to comply with the ACA by selecting an essential health benefits (EHB)-benchmark plan. To meet the ACA requirements, the EHB-benchmark plan must include all ten categories of benefits.²¹ If a base-benchmark plan option does not cover any items and services within an EHB category, the base-benchmark plan must be supplemented by adding that particular category in its entirety from another base-benchmark plan option. For example, if the base-benchmark plan does not currently cover rehabilitative and habilitative services and devices, it must be supplemented by adding this category starting in 2014. The resulting EHB-benchmark plan would then cover all 10 EHB categories.²²

To satisfy the ACA requirements, the EHB-benchmark plan must also meet standards for non-discrimination and provide for appropriate balance.²³ In terms of the benefits covered, payment rates provided, or incentives built into the definition of EHB, there can be no discrimination because of their age, disability, 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, persons 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. EHB-benchmark plan is required to ensure an appropriate balance among the categories of EHB so that benefits are not unduly weighted toward any category.²⁴

²⁰ [Final Rule; Patient Protection and Affordable Care Act; Data Collection to Support Standards Related to Essential Health Benefits](#); 77 FR 42658 (July 20, 2012).

²¹ [Essential Health Benefits NPRM](#), 156.110(a).

²² [Essential Health Benefits NPRM](#) 77 FR 70649 (November 26, 2012). HHS proposes that if the base-benchmark plan does not include coverage of habilitative services, the State may determine the services included in the habilitative services category. If the State chooses not to define the habilitative services category, plans must provide habilitative benefits that are similar in scope, amount, and duration to benefits covered for rehabilitative services or decide which habilitative services to cover and report on that coverage to HHS.

²³ [Essential Health Benefits NPRM](#), 156.110(d) and (e) and 156.125. See also Sections 1302(b)(4)(A) through (D) of the ACA.

²⁴ [Essential Health Benefits NPRM](#), 77 FR 70652 (November 26, 2012).

The ACA²⁵ explicitly permits a State to require qualified health plans to offer benefits in addition to EHB, but requires the State to make payments, either to the individual enrollee or to the issuer on behalf of the enrollee, to defray the cost of these additional benefits. HHS proposes that State-required benefits enacted on or before December 31, 2011 (even if not effective until a later date) may be considered EHB, which would obviate the requirement for the State to pay for these State-required benefits. HHS also proposes that State-required benefits that are not included in the benchmark would apply to qualified health plan markets in the same way they apply in the current market. For example, a benefit that is only required in the individual market by a State law enacted prior to December 31, 2011 would only be considered EHB (and exempt from the requirement that the State pay the cost of the benefit) with respect to the individual qualified health plan market in 2014. This policy regarding State-required benefits is intended to apply for at least plan years 2014 and 2015. In this proposed rule, HHS interprets State-required benefits to be specific to the care, treatment, and services that a State requires issuers to offer to its enrollees. Therefore, State rules related to provider types, cost sharing, or reimbursement methods would not fall under HHS' interpretation of State-required benefits. Even though plans must comply with those State requirements, there would be no Federal obligation for States to defray the costs associated with those requirements.²⁶

IV. CHANGES TO PRIVATE INSURANCE.²⁷

On June 28, 2010, HHS published an [Interim Final Rule](#) regarding patient protections, including preexisting conditions exclusions, lifetime and annual limits, rescissions. On November 26, 2012, HHS published in the *Federal Register* a [Notice of Proposed Rulemaking \(NPRM\)](#) detailing proposed health insurance market rules. Changes to private insurance include the following:

- Preexisting conditions exclusions
- Premium ratings
- Annual and lifetime limits
- Rescissions
- Coverage of dependents
- Waiting periods
- Preventative services and immunizations and cost sharing
- Existing plans.

²⁵ Section 1311(d)(3)(B) of the Affordable Care Act.

²⁶ [Essential Health Benefits NPRM](#), 77 FR 70647 (November 26, 2012).

²⁷ See generally www.healthcare.gov; *Summary of New Health Reform Law*, Kaiser Family Foundation, www.kff.org. See also [Preamble to Interim Final Rule Patient Protection and Affordable Care Act: Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections](#), 75 Federal Register 37188 (June 28, 2010). See also [Notice of Proposed Rulemaking Patient Protections and Affordable Care Act: Health Insurance Market Rules; Rate Review](#), 77 FR 70584-70617 (November 26, 2012).

Pre-existing conditions. 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.

Premium ratings. 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.

Annual and Lifetime limits. 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.

- Specifically, 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.

Rescissions. 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).

Coverage of Dependents. 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.

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

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

Existing Plans. Existing individual and employer sponsored insurance plans will be allowed to remain essentially the same, except that they will be required to extend dependent coverage to age 26, eliminate annual and lifetime limits on coverage (see rules above), prohibit rescission of coverage and eliminate waiting periods for coverage of greater than 90 days.

V. EXPANSION OF PUBLIC PROGRAMS (MEDICAID)²⁸

I. Extension of Medicaid Eligibility

Currently, individuals who fall into certain “categories” or “categorical groups” are eligible for Medicaid, including low-income children, pregnant women, parent and other caretaker relatives, seniors, and people with disabilities. Federal minimum eligibility standards vary by category. All states currently cover pregnant women and children under age 6 at or below 133 percent of the Federal poverty level (FPL). In some states, the minimum eligibility level is 185 percent FPL for pregnant women and children under one and children age 6 through age 18 with family incomes at or below 100 percent of the FPL, though many states have implemented higher standards for pregnant women and children.

The current Federally specified minimum eligibility levels for parents, people with disabilities and the elderly are significantly lower, although states have the option to expand coverage to people within these categories at higher income levels. Prior to ACA, states could not cover non-disabled, non-elderly adults who do not have dependent children, regardless of their

²⁸ See generally [Preamble to Final Rule and Interim Final Rule; Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010, 77 Federal Register 17144 \(March 23, 2012\)](#).

income level, except through a Medicaid demonstration under Section 1115 of the Act. As a result of the varying Federal minimum standards and State options, eligibility for Medicaid is complicated and significant gaps continue to exist even among the lowest income Americans.

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 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 in the program. Under the ACA, as enacted, eligibility for Medicaid and the Children's Health Insurance Program (CHIP) continues at their current eligibility level under 2019. People with incomes above 133% of the poverty level who do not have access to employer-sponsored insurance will obtain coverage through the newly created State Health Insurance Exchanges.

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.²⁹

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 percent 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 FMAP for non-pregnant childless adults.
- States will have the option to expand Medicaid eligibility to childless adults beginning on April 1, 2010, but will receive their regular FMAP until 2014.

²⁹ *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).

- 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 specific calendar years outlined above.³⁰
- A State which expands eligibility to less than 133 percent 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.³¹
- States are required to maintain current income eligibility levels for children in Medicaid and CHIP until 2019 and extend funding for CHIP through 2015. Beginning in 2015, states will receive a 23-percentage point increase in the CHIP match rate up to a cap of 100%.
- Regardless of whether a State adopts the Medicaid expansion, the provisions of the ACA related to coordination with the Exchange, including the use of standard income eligibility methods, apply. An Exchange in each State will make either a Medicaid eligibility determination or a Medicaid eligibility assessment (at the state’s discretion) based on the Medicaid rules in the State, including the income levels at which the State’s Medicaid program provides coverage.³²

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.”³³

“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.

“Benchmark equivalent coverage” is defined at 42 U.S.C. § 1396u-7(b)(2) as:

³⁰ [FAQs](#), Question 24

³¹ [FAQs](#), Question 26

³² [FAQs](#), Question 28

³³ [FAQs](#), Question 33.

- (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 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.

2. Long Term Care and Home and Community-Based Services

Under Section 1915(i) of the Social Security Act, a State may provide through a State plan amendment for the provision of medical assistance for home and community-based services. While this State plan service package includes many similarities to options and services available through Section 1915(c) HCBS waivers, a significant difference is that section 1915(i) provides states an opportunity to offer services and supports before individuals need institutional care, and also provides a mechanism to provide State plan HCBS to individuals with mental health and substance abuse disorders.³⁴

As originally enacted States were unable to target 1915(i) services to particular populations within the State, and could only serve individuals whose incomes did not exceed 150 percent of the Federal poverty level. Additionally, the original service package available under 1915(i) included some, but not all, of the HCBS available through waivers. In order to promote increased State utilization of 1915(i), the Patient Protection and Affordable Care Act (Affordable Care Act)³⁵ includes changes to section 1915(i) that enable States to target HCBS to particular groups of people, to make HCBS accessible to more individuals, and to ensure the quality of HCBS.

³⁴ CMS Letter to State Medicaid Directors Re "[Improving Access to Home and Community-Based Services](#)" (August 6, 2010).

³⁵ Section 2402(b) through 2402(f) of P.L. 111-148, as amended by P.L. 111-152.

With regard to services, section 1915(i) allows states to include any or all of the HCBS services listed in the statute [section 1915(c)(4)(B)]. These services include, among others, habilitation services such as supported employment services. The Affordable Care Act revised section 1915(i) so that states may now offer “such other services requested by the State as the Secretary may approve.” As a result of this change, States will now be permitted to propose “other services” (not including room and board)) in a 1915(i) State Plan Amendment that CMS will evaluate and possibly approve.³⁶ As with all 1915(i) services, the provision of these services must be in accordance with an individualized plan of care, which is based upon an independent assessment and a person-centered process driven by what is important to the participant.

Under Section 2402(a) of the Affordable Care Act, the Secretary of HHS is directed to promulgate regulations to ensure that all States develop service systems that are designed to:

- Allocate resources for services in a manner that is responsive to the changing needs and choices of beneficiaries receiving non-institutionally-based long-term services and supports (including such services and supports that are provided under programs other than the Medicaid program), and that provides strategies for beneficiaries receiving such services to maximize their independence, including through the use of client-employed providers;
- Provide the support and coordination needed for a beneficiary in need of such services (and their family caregivers or representative, if applicable) to design an individualized self-directed, community-supported life; and
- Improve coordination among, and the regulation of, all providers of such services under Federally and State-funded programs for specified purposes.

Since 2003, the Medicaid statute has included a Medicaid Buy-In program for working persons with disabilities. This program allows individuals with disabilities to work and get or keep Medicaid. Many persons with significant disabilities are unable to obtain employer-funded private health insurance that provides coverage comparable to Medicaid, particularly coverage for personal attendants. The fear of losing Medicaid and/or Medicare is one of the greatest barriers keeping individuals with disabilities from maximizing their employment, earnings potential, and independence. For many Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) beneficiaries, the risk of losing health care through work activity can be a greater work disincentive than the risk of losing cash benefits through work activity.³⁷

³⁶ CMS Letter to State Medicaid Directors Re “[Improving Access to Home and Community-Based Services](#)” (August 6, 2010).

³⁷ See Section 2 of the Ticket to Work and Work Incentives Improvement Act, Pub. L. No. 106-170.

In addition to the Medicaid Buy-In program, Section 2401 of the ACA adds the Community First Choice State Plan Option. [Section 1915(k) of the Social Security Act] Under the Community First Choice option states are authorized to establish a new State plan option to provide home and community-based attendant services and supports. This option, available October 1, 2011, allows states to receive a 6-percentage point increase in Federal matching payments for expenditures related to this option. Under this option, states can provide home and community-based attendant services and supports for individuals who are eligible for medical assistance under the State plan whose income does not exceed 150 percent of the Federal poverty level or, if greater, the income level applicable for an individual who has been determined to require an institutional level of care to be eligible for nursing facility services under the State plan and with respect to whom there has been a determination that, but for the provision of such services, the individual would require the level of care provided in a hospital, a nursing facility, an intermediate care facility for the mentally retarded, or an institution for mental diseases, the cost of which could be reimbursed under the State plan.

Under the Community First Choice option, the individual must choose to receive such home and community-based attendant services and supports to eligible individuals, under a person-centered service plan agreed to in writing by the individual, or his or her representative, that is based on a functional need assessment. This assessment will determine if the individual requires assistance in activities of daily living, instrumental activities of daily living, or related tasks. The services and supports must be provided by a qualified provider in a home or community setting under an agency-provider model or through other methods for the provision of consumer controlled services and supports. In addition, the legislation requires that states make available additional services and supports including the acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish ADLs, IADLs, and health-related tasks, back-up systems or mechanisms to ensure continuity of services and supports and voluntary training on how to select, manage, and dismiss attendants. [See [Proposed Rule Medicaid Program: Community First Choice Option, 76 FR 10736](#) (February 25, 2011)]

PART IV

RECOMMENDATIONS FOR MAXIMIZING THE PAYMENT FOR HEALTH-RELATED VR SERVICES AND SUPPORTS UNDER THE ACA, INCLUDING MEDICAID

The enactment of the Affordable Care Act (ACA) provides State VR agencies with an opportunity to work with their respective Governors, State legislatures, and other State agencies to establish policies that maximize the payment for medically necessary health care-related VR services (including mental and physical restoration services, personal assistance services, and certain rehabilitation technology and assistive technology devices and assistive technology services) to VR applicants and clients through private health insurance or Medicaid rather than through the State VR program. This opportunity is currently open because states are still in the process of making key policy decisions regarding State Health Care Exchanges and the scope of the benchmark package of essential health benefits; Medicaid expansion and Medicaid benchmark plans; and new options under the Medicaid program, including the Community First Choice option. The opportunity to influence State policymakers will be ongoing because State policies regarding ACA implementation will experience modification overtime.

In order to educate State policymakers regarding the potential impact of ACA on the State VR program, the State VR agencies should become knowledgeable about the opportunities presented by ACA to ensure that private health insurance, Medicaid, and other sources of funding are used to pay for the health-related VR services VR applicants and clients may need, thereby increasing the funding available to pay for more traditional VR services, such as counseling and guidance, job-related services, supported employment, and specific post employment services and to serve additional clients

This part of the paper analyzes and provides guidance and recommendations regarding the following topics:

- Current VR Policies Applicable to Payment for Health-Related Services;
- State Health Care Exchanges and the Scope of the Benchmark Package of Essential Health Benefits;
- Medicaid Expansion and Medicaid Benchmark Plans; and
- New Options Under the Medicaid Program, Including the Community First Choice Option.

I. CURRENT VR POLICIES APPLICABLE TO PAYMENT FOR HEALTH-RELATED 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, including physical and mental restoration

services (e.g., surgeries, therapies, and mental health and substance abuse disorder services); rehabilitation technology, assistive technology devices and assistive technology services; and personal assistance services is substantial. The current VR policy framework provides legal and policy bases for facilitating payment of these many of these health-related VR services by entities other than the State VR agency. However, the current policy framework should be further clarified in regulation or through policy guidance to provide State VR agencies with greater leverage with other State agencies to ensure that private health insurance, Medicaid, and other funding sources pay for these health-related VR services prior to payment by VR agencies.

As explained in Part II, 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 assure 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.

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 a 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.

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.

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) is also a useful mechanism to facilitate the use of alternative funding sources.

Consistent with these four provisions, RSA should consider modernizing the Federal VR policy framework (either through regulation or policy guidance) by clarifying the applicability of ACA, including Health Care Exchanges and the benchmark package of essential health benefits, Medicaid expansion and the “benchmark coverage” or “benchmark equivalent coverage”, and the Community First Choice option to the VR program. In particular, the policy guidance should clarify the circumstances under which private health insurance, Medicaid, and other

funding sources may be used prior to the use of VR funds to pay for health-related VR services and supports.

The policy guidance should also describe how interagency agreements, including State VR agency agreements with agencies administering the Medicaid program and State insurance agencies/agencies administering State Health Care Exchanges, should spell out the specific policies and procedures for maximizing the use of private health insurance, Medicaid, and other sources for funding health-related services authorized under the VR program. [As possible model policies, see Part II of the paper which describes a comprehensive policy regarding comparable services and benefits developed by North Carolina and the policy developed by Florida regarding the assignment of rights to the VR agency for payments for specified health-related services and supports.]

II. HEALTH CARE EXCHANGES AND THE SCOPE OF THE BENCHMARK PACKAGE OF ESSENTIAL HEALTH BENEFITS

As explained in Part III, the ACA allows each State the opportunity to establish a State-Based Health Care Exchange. HHS must establish and operate a Federally-facilitated Exchange in any State that does not elect to do so and perform all exchange functions that would have been performed by the State-Based Exchange. The ACA also provides for the establishment of an essential health benefits (EHB) package. In December 2011, HHS disseminated an [Essential Health Benefits Bulletin](#). In November 2012, HHS published a [Notice of Proposed Rulemaking](#) that proposes a process for determining standards related to essential health benefits.

Under the proposed regulations, a State must first select its “base-benchmark plan.” The State then is required to “supplement” the package of benefits to comply with the ACA by selecting an “essential health benefits (EHB)-benchmark plan.” To meet the ACA requirements, the EHB-benchmark plan must include all ten categories of benefits. If a base-benchmark plan option does not cover particular items and services within an EHB category, the base-benchmark plan must be supplemented by adding that particular category in its entirety from another base-benchmark plan option. The resulting EHB-benchmark plan would then cover all 10 EHB categories.

To satisfy the ACA requirements, the EHB-benchmark plan must also meet standards for nondiscrimination and provide for appropriate balance. In terms of the benefits covered, payment rates provided, or incentives built into the definition of EHB, there can be no discrimination because of their age, disability, 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, persons 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. 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.

There are multiple issues that states will have to consider in determining the EHB-benchmark plan. A coalition of disability groups, including the Consortium for Citizens with Disabilities (CCD), the Habilitation Benefits Coalition, the Coalition to Preserve Rehabilitation, and the Independence Through Enhancement of Medicare and Medicaid Coalition have drafted an [OPEN LETTER TO STATES ON DEFINING ESSENTIAL HEALTH BENEFITS PACKAGE](#). The letter provides technical assistance, recommendations, and guidance, including:

- Definition of rehabilitation services and habilitation services
- Definition of rehabilitative and habilitative devices
- Scope of benefits, nondiscrimination, and appropriate balance
- State benefit mandates
- Establishing limits and medical necessity

Definitions of Rehabilitation and Habilitation Services

CCD and others recommend that states define “rehabilitation services” and “habilitation services” in legislation, regulation and guidance related to their benchmark plan consistent with the definitions adopted by the National Association of Insurance Commissioners (NAIC) as well as those adopted by HHS in its glossary of medical terms, required by the Affordable Care Act. (See, 76 Fed. Reg. 52,442; 76 Fed. Reg. 52,475).

The NAIC definition of **habilitation** reads:

“Health care services that help a person keep, *learn* or improve skills and functioning for daily living. Examples include therapy for a child who isn’t walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.” (See, NAIC Glossary of Terms for the Affordable Care Act.) [Emphasis added.]

The NAIC definition of **rehabilitation** reads:

“Health care services that help a person keep, *get back* or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.” (See, NAIC Glossary of Terms for the Affordable Care Act.) [Emphasis added.]

Based on these references, CCD and others believe the definition of rehabilitation and habilitation should read:

"Rehabilitative services means 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."

"Habilitative services means 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."

Definition of Rehabilitative and Habilitative Devices

According to CCD and others:

"Rehabilitative and habilitative devices include durable medical equipment (DME), orthotics, prosthetics, low vision aids, hearing aids, augmentative communication devices that aid in hearing and speech and other assistive technologies and supplies. States should define "rehabilitative and habilitative devices" to explicitly include devices that *maintain* as well as *improve* function, consistent with the definitions for rehabilitative and habilitative services adopted by the National Association of Insurance Commissioners (NAIC) as well as those adopted by HHS in the proposed rule on the definition of medical and insurance terms for purposes of comparing health plans in the state exchanges." (See, 76 Fed. Reg. 52,442; 76 Fed. Reg. 52,475)

Based on extensive analysis of multiple health care programs and plans, CCD believes states should adopt the following definitions:

The definition of ***Durable Medical Equipment (DME)*** should read:

"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."

The definition of ***Orthotics and Prosthetics*** should read:

"Orthotics and Prosthetics 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.”

The definition of ***Prosthetic Devices*** should read:

“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, and 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.”

The definition of ***Low Vision Aids*** should read:

“Low Vision Aids 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 which magnify, reduce glare, add light or enlarge objects as to make them more visible.”

The definition of ***Augmentative and Alternative Communication Devices*** (AACs) should read:

“Augmentative and Alternative Communication Devices are specialized devices ordered by a health care professional which 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.”

The definition of ***Hearing Aids and Assistive Listening Devices*** should read:

“Hearing aids and Assistive Listening Devices are medical devices which 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.”

Scope of Benefits, Nondiscrimination, and Appropriate Balance

In addition to adopting definitions of key terms that will ensure coverage of benefits that meet the needs of VR applicants and clients, the VR agency should focus its attention on the scope of benefits covered by the EHB-benchmark plan. When establishing the EHB-benchmark plan, CCD and others recommend that States must ensure that their plan’s coverage decisions,

reimbursement rates, incentive programs, and benefit design avoids discrimination against individuals because of, among other things, disability and provides for an appropriate balance among the categories of EHB so that benefits are not unduly weighted toward any category.

According to CCD and others:

“Non-discrimination provisions under the ACA, as well as guidance from HHS, dictate that states enhance benchmark plans to adequately cover mandated essential health benefits, such as habilitation, which are not generally covered by existing individual and small group plans. In addition, states should ensure that plans are not arbitrarily restricting certain essential benefits, or covering them in a manner that is not balanced across the categories of covered benefits. This may be typical with rehabilitative services and devices that are disproportionately used by a specific population. For example, a restrictive limitation on the number of covered rehabilitation therapies for a joint replacement patient will likely be totally inadequate for a person who has sustained a moderate or severe traumatic brain injury. States must ensure that limitations they impose on certain benefits do not violate the non-discrimination provisions of the ACA by failing to accommodate the rehabilitative needs of persons with particularly disabling diagnoses or conditions.”

CCD and others also explain that:

“States must also be careful not to discriminate against persons with certain conditions by limiting or omitting coverage for certain treatments that are only relevant to people with that particular condition. For example, failing to include coverage of dialysis treatments clearly discriminates against people with kidney failure. Failing to include coverage of prosthetic limbs discriminates against people with limb loss. States must develop certain process protections to ensure that they fully examine the final EHB package they adopt to ensure that it conforms to the letter and spirit of the Affordable Care Act. If, in fact, a state’s essential health benefits package does not comply with these ACA protections against discrimination based on—among other things—disability, then the HHS Secretary should reject that state’s essential health benefits plan and direct the state to amend its package before federal subsidies begin to flow to the Health Insurance Exchange effective in that state.”

Finally, with respect to states that do not proactively adopt an essential health benefits package but simply default to the state’s largest small group insurance plan, CCD and others believe that:

“It is critical that these states ensure that a relevant and appropriate state agency engage in the process of assessing that plan to ensure it covers all 10 categories of benefits required by the ACA. The state agency must also conduct the non-discrimination analysis discussed above. Even if the federally facilitated exchange implements that state’s EHB package, the state must still be accountable to ensure that

the EHB package complies with federal law. In the alternative, HHS, through the authority granted to the federally facilitated exchange, should have the responsibility to complete the EHB design process before permitting federal subsidies to flow into that state.”

State Benefit Mandates

As explained in Part III, in 2014 and 2015 States that choose a benchmark plan subject to State benefit mandates will have those mandated benefits included in their EHB package and the Federal government will subsidize the cost for 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 excess benefits.

According to CCD and others:

“HHS intends to evaluate the benchmark approach in 2016, and is expected to develop an approach that may exclude some State benefit mandates from inclusion in the State EHB package, unless the State agrees to pay for them. As such, a designation as a State mandate does not permanently qualify that benefit as an essential health benefit. To avoid disruption of benefit coverage in the future, States should strive to adopt EHB packages that already treat benefits they have found to be essential for their State residents—by mandating coverage of that benefit by law—as essential health benefits in their benchmark plan.”

Establishing Limits and Medical Necessity

According to CCD and others:

“When evaluating the coverage limitations on and exclusions of rehabilitative and habilitative services and devices, states should ensure these decisions are evidence based and not arbitrarily imposed to reduce short term cost to the health plan. The ACA (Section 1302(b)(4)(B)) explicitly prohibits essential health benefits coverage decisions and benefit designs that discriminate against individuals based on disability. The ACA (Section 1302(b)(4)(D)) further prohibits any service established as essential from being subject to denial based on disability.

States must carefully evaluate both quantitative and non-quantitative limits on services and devices to ensure such limits do not restrict access to essential health benefits and violate these nondiscrimination requirements of the ACA. Patient’s individual needs should be the foundation of coverage decisions. Additionally, states must ensure an appropriate balance of coverage between categories of benefits under the ACA, meaning that coverage for rehabilitative and habilitative benefits should be no more restrictive than other benefit categories in the state’s EHB package.”

According to CCD, the ACA does not require the HHS Secretary to establish a uniform definition of medical necessity but the nondiscrimination provisions mentioned above provide strong protections for people with disabilities and chronic conditions with respect to coverage of benefits under the EHB.

“To ensure plan limits and coverage decisions are in compliance with the nondiscrimination requirements for the essential health benefits and do not restrict patients’ access to evidence based, individualized care, states should consider the following:

- The focus of many benefits for people with disabilities and other chronic conditions is to improve a patient’s health status through improvement in their ability to function in daily life. The focus is not on “curing” the condition but rather on enabling, improving, maintaining or preventing deterioration of a patient’s capacity to function. Coverage decisions, therefore, must include consideration of an individual’s functional needs.
- Coverage decisions must refer to the individualized care needs for a particular patient, and hence entail an individual assessment rather than a general determination of what works in the ordinary case. This is critical for people with disabilities whose conditions (or combinations of conditions) often affect individuals in very different ways.
- Evidence based medicine or comparative effectiveness research should be applied in a manner that does not lead to inappropriate restrictions in coverage of and access to therapies, treatments, medications, assistive devices and long-term services and supports for people with disabilities and chronic illnesses. Use of the best evidence available should be the standard. A *lack* of Level I medical evidence does not prove the service or device ineffective or unnecessary. This is particularly important with treatments that address low prevalence conditions or conditions that are difficult to assess and treat, such as traumatic brain injury and other similar conditions.

Health plans should not use arbitrary visit limits or other limitations or exclusions to impede or intrude on the patient and physician relationship, interfere with communication regarding the treatment options between the patient and physician, prevent access to rehabilitation or habilitation altogether, or stop rehabilitation or habilitation prematurely.

The complex nature of disabilities and chronic diseases often leads to a wide breadth of treatment from a range of providers. Services are often considered appropriate as long as:

- Separate and distinct goals are documented in the treatment plans of physicians, nurses and therapists providing concurrent services;
- The specific services are non-overlapping; and
- Each discipline is providing some service unique to the expertise of that discipline and not reasonably expected to be provided by other disciplines.

States should review plans' proposed limits and exclusions to ensure coverage decisions focus on the individualized health care needs of each particular patient and comply with all nondiscrimination requirements set forth under the law. Evaluation of plans' limits and exclusions should consider more than just physical health but also a person's ability to function in his or her environment.

Health care interventions should enhance, maintain, and prevent deterioration of cognitive and physical functioning to enable individuals with disabilities and other chronic conditions to live as independently as possible, to attain and maintain employment, avoid homelessness, avoid medical indigence, reduce lifetime cost of care, reduce caregiver burden and attendant care requirements, improve overall health and quality of life, and participate in the community to the maximum extent of their abilities and capabilities. In addition, it is important to note that the rate of progress across time and developmental expectations for the growing child are also highly variable and specific to the individual. Recovery is often divergent qualitatively and quantitatively, and as such is not always predictable.”

III. MEDICAID EXPANSION AND MEDICAID BENCHMARK PLANS

As explained in Part III, under the ACA, a State's decision to participate in the Medicaid expansion program is voluntary. For States electing to expand eligibility to individuals with incomes up to 133 percent 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 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 specific calendar years outlined above. A State which expands eligibility to less than 133 percent 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. Also, as explained in Part III, 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.”

Whether or not a State decides to participate in the Medicaid expansion program is beyond the scope of this research project. 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.

IV. NEW OPTIONS UNDER THE MEDICAID PROGRAM, INCLUDING THE COMMUNITY FIRST CHOICE OPTION

As explained in Part III, since 2003 the Medicaid statute has included a Medicaid Buy-In program for working persons with disabilities. This program allows individuals with disabilities to work and get or keep Medicaid. Many persons 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, ACA adds the Community First Choice State Plan 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.

APPENDIX I

GLOSSARY OF KEY TERMS USED IN THE ACA38

A

Actuarial Value: The percentage of total average costs for covered benefits that a plan will cover. For example, if a plan has an actuarial value of 70%, on average, a plan participant would be responsible for 30% of the costs of all covered benefits. However, a plan participant could be responsible for a higher or lower percentage of the total costs of covered services for the year, depending on one's actual health care needs and the terms of one's insurance policy.

Affordable Care Act: The comprehensive health care reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is used to refer to the final, amended version of the law.

Annual Limit: A cap on the benefits an individual's insurance company will pay in a year while enrolled in a particular health insurance plan. These caps are sometimes placed on particular services such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service. After an annual limit is reached, an individual must pay all associated health care costs for the rest of the year.

B

Benefits: The health care items or services covered under a health insurance plan. Covered benefits and excluded services are defined in the health insurance plan's coverage documents. In Medicaid or CHIP, covered benefits and excluded services are defined in State program rules.

C

Catastrophic Plan: Currently, some insurers describe these plans as those that only cover certain types of expensive care, like hospitalizations. Other times insurers mean plans that have a high deductible, so that an individual's plan begins to pay only after the individual first paid up to a certain amount for covered services.

Children's Health Insurance Program (CHIP): Insurance program jointly funded by State and Federal government that provides health insurance to low-income children and, in some

³⁸ Glossary, <http://www.healthcare.gov>. See also Final Rule, *Summary of Benefits and Coverage and Uniform Glossary*, 77 Federal Register 8668 (February 14, 2012).

states, pregnant women in families who earn too much income to qualify for Medicaid but cannot afford to purchase private health insurance coverage.

Chronic Disease Management: An integrated care approach to managing illness which includes screenings, check-ups, monitoring and coordinating treatment, and patient education. It can improve one's quality of life while reducing one's health care costs if you have a chronic disease by preventing or minimizing the effects of a disease.

Co-insurance: The percentage of allowed charges for covered services that an individual is required to pay. For example, the health insurance may cover 80% of charges for a covered hospitalization, leaving an individual responsible for the other 20%. This 20% is known as the coinsurance.

Community Rating: A rule that prevents health insurers from varying premiums within a geographic area based on age, gender, health status or other factors.

Copayment: A flat dollar amount an individual must pay for a covered program. For example, an individual may have to pay a copayment for each covered visit to a primary care doctor.

Cost Sharing: The share of costs covered by an individual's insurance that the individual pays out of one's own pocket. This term generally includes deductibles, coinsurance and copayments, or similar charges, but it doesn't include premiums, balance billing amounts for non-network providers, or the cost of non-covered services. Cost sharing in Medicaid and CHIP also includes premiums.

Creditable Coverage: Health insurance coverage under any of the following: a group health plan; individual health insurance; student health insurance; Medicare; Medicaid; CHAMPUS and TRICARE; the Federal Employees Health Benefits Program; Indian Health Service; the Peace Corps; Public Health Plan (any plan established or maintained by a State, the U.S. government, a foreign country); Children's Health Insurance Program (CHIP) or a State health insurance high risk pool. If an individual has prior creditable coverage, it will reduce the length of a pre-existing condition exclusion period under new job-based coverage.

D

Deductible: The amount an individual must pay for covered care before the individual's health insurance begins to pay. Insurers apply and structure deductibles differently. For example, under one plan, a comprehensive deductible might apply to all services while another plan might have separate deductibles for benefits such as prescription drug coverage.

Dependent Coverage: Insurance coverage for family members of the policyholder, such as spouses, children, or partners.

Disability: A limit in a range of major life activities. This includes activities like seeing, hearing, walking and tasks like thinking and working. Because different programs may have different disability standards, please check the program you're interested in for its disability standards. The list of activities mentioned above isn't exhaustive. A legal definition of disability can be found at <http://www.ada.gov/pubs/ada/htm>. For the final EEOC regulations implementing the ADA Amendments Act see 76 Federal Register 16978 et seq. (March 25, 2011).

E

Early Periodic Screening, Diagnostic & Treatment Services (EPSDT). A term used to refer to the comprehensive set of benefits covered for children under Medicaid

Employer Responsibility. Under ACA, starting in 2014, if an employer with at least 50 full-time employees doesn't provide affordable health care insurance and an employee uses a tax credit to help pay for insurance through an Exchange, the employer must pay a fee to help cover the cost of the tax credits.

Essential Health Benefits. Essential health benefits are a set of health care service categories that must be covered by certain plans, starting in 2014. The Affordable Care Act 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; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care." Insurance policies must cover these benefits in order to be certified and offered in Exchanges, and all Medicaid State plans must cover these services by 2014.

Exchange: A new transparent and competitive insurance marketplace where individuals and small businesses can buy affordable and qualified health benefit plans. Affordable Insurance Exchanges will offer an individual a choice of health plans that meet certain benefits and cost standards. Starting in 2014, Members of Congress will be getting their health care insurance through Exchanges and individuals will be able buy insurance through Exchanges too.

Exclusions: Items or services that aren't covered under an individual's contract for insurance and for which an insurance company won't pay. For example, an individual policy may not cover pregnancy care or any services related to a pre-existing condition.

F

Federal Poverty Level (FPL): A measure of income level issued annually by the Department of Health and Human Services. Federal poverty levels are used to determine your eligibility for certain programs and benefits.

Fee for Service: A method in which doctors and other health care providers are paid for each service performed. Examples of services include tests and office visits.

G

Grandfathered: As used in connection with the Affordable Care Act: Exempt from certain provisions of this law.

Grandfathered Health Plan: As used in connection with the Affordable Care Act: A group health plan that was created—or an individual health insurance policy that was purchased—on or before March 23, 2010. Grandfathered plans are exempted from many changes required under the Affordable Care Act. Plans or policies may lose their “grandfathered” status if they make certain significant changes that reduce benefits or increase costs to consumers. A health plan must disclose in its plan materials whether it considers itself to be a grandfathered plan and must also advise consumers how to contact the U.S. Department of Labor or the U.S. Department of Health and Human Services with questions. (Note: If you are in a group health plan, the date you joined may not reflect the date the plan was created. New employees and new family members may be added to grandfathered group plans after March 23, 2010).

Guaranteed Issue: A requirement that health plans must permit an individual to enroll regardless of health status, age, gender, or other factors that might predict the use of health services. Except in some states, guaranteed issue doesn't limit how much an individual can be charged if the individual enrolls.

Guaranteed Renewal: A requirement that an individual's health insurance issuer must offer to renew one's policy as long as you continue to pay premiums. Except in some states, guaranteed renewal doesn't limit how much an individual can be charged if the individual renews his or her coverage.

H

Home and Community-Based Services (HCBS): Services and support provided by most State Medicaid programs in one's home or community that gives help with such daily tasks as bathing or dressing. This care is covered when provided by care workers or, if an individual's State permits it, by his or her family.

Health Status: Refers to an individual's medical conditions (both physical and mental health), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability.

Home Health Care: Health care services and supplies a doctor decides an individual may get in one's home under a plan of care established by an individual's doctor.

I

Individual Health Insurance Policy: Policies for people that aren't connected to job-based coverage. Individual health insurance policies are regulated under State law.

Individual Responsibility: Under the Affordable Care Act, starting in 2014, an individual must be enrolled in a health insurance plan that meets basic minimum standards. If an individual isn't enrolled, he or she may be required to pay an assessment. An individual won't have to pay an assessment if he or she has very low income and coverage is unaffordable, or for other reasons including one's religious beliefs. An individual can also apply for a waiver asking not to pay an assessment if he or she doesn't qualify automatically.

J

Job-based Health Plan: Coverage that is offered to an employee (and often his or her family) by an employer.

L

Lifetime Limit: A cap on the total lifetime benefits an individual may get from his or her insurance company. An insurance company may impose a total lifetime dollar limit on benefits (like a \$1 million lifetime cap) or limits on specific benefits (like a \$200,000 lifetime cap on organ transplants or one gastric bypass per lifetime) or a combination of the two. After a lifetime limit is reached, the insurance plan will no longer pay for covered services.

Long-Term Care: Services that include medical and non-medical care provided to people who are unable to perform basic activities of daily living such as dressing or bathing. Long-term supports and services can be provided at home, in the community, in assisted living or in nursing homes. Individuals may need long-term supports and services at any age. Medicare and most health insurance plans don't pay for long-term care.

M

Medicaid: A state-administered health insurance program for low-income families and children, pregnant women, the elderly, people with disabilities, and in some states, other adults. The Federal government provides a portion of the funding for Medicaid and sets guidelines for the program. States also have choices in how they design their program, so Medicaid varies State by State and may have a different name in a particular state.

Medical Loss Ratio (MLR): A basic financial measurement used in the Affordable Care Act to encourage health plans to provide value to enrollees. If an insurer uses 80 cents out of every premium dollar to pay its customers' medical claims and activities that improve the quality of care, the company has a medical loss ratio of 80%. A medical loss ratio of 80% indicates that the insurer is using the remaining 20 cents of each premium dollar to pay overhead expenses, such as marketing, profits, salaries, administrative costs, and agent commissions. The Affordable Care Act sets minimum medical loss ratios for different markets, as do some State laws.

Medically Necessary: Services or supplies that are needed for the diagnosis or treatment of an individual's health condition and meet accepted standards of medical practice.

Medical Underwriting: A process used by insurance companies to try to figure out an individual's health status when an individual is applying for health insurance coverage to determine whether to offer an individual coverage, at what price, and with what exclusions or limits.

Medicare: A Federal health insurance program for people who are age 65 or older and certain younger people with disabilities. It also covers people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).

Medicare Advantage (Medicare Part C): A type of Medicare health plan offered by a private company that contracts with Medicare to provide an individual with all one's Medicare Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. If an individual is enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan and aren't paid for under Original Medicare. Most Medicare Advantage Plans offer prescription drug coverage.

Medicare Part D: A program that helps pay for prescription drugs for people with Medicare who join a plan that includes Medicare prescription drug coverage. There are two ways to get Medicare prescription drug coverage: through a Medicare Prescription Drug Plan or a Medicare Advantage Plan that includes drug coverage. These plans are offered by insurance companies and other private companies approved by Medicare.

Medicare Prescription Drug Donut Hole: Most plans with Medicare prescription drug coverage (Part D) have a coverage gap (called a "donut hole"). This means that after an individual and his or her drug plan have spent a certain amount of money for covered drugs, an individual will have to pay all costs out-of-pocket for your prescriptions up to a yearly limit. Once an individual has spent up to the yearly limit, the individual's coverage gap ends and one's drug plan helps pay for covered drugs again.

Minimum Essential Coverage: The type of coverage an individual needs to have to meet the individual responsibility requirement under the Affordable Care Act. This includes individual market policies, job-based coverage, Medicare, Medicaid, CHIP, TRICARE and certain other coverage.

N

Nondiscrimination: A requirement that job-based coverage not discriminate based on health status. Coverage under job-based plans cannot be denied or restricted. An individual also can't be charged more because of one's health status. Job-based plans can restrict coverage based on other factors such as part-time employment that aren't related to health status.

New Plan: As used in connection with the Affordable Care Act: A health plan that is not a [grandfathered health plan](#) and therefore subject to all of the reforms in the Affordable Care Act. In the **individual health insurance** market, a plan that your family is purchasing for the first time will generally be a new plan. In the **group health insurance market**, a plan that an individual's employer is offering for the first time will generally be a new plan. Please note that new employees and new family members may be added to existing grandfathered group plans – so a plan that is “new to you” and your family may still be a grandfathered plan. In both the individual and group markets, a plan that loses its grandfathered status will be considered a new plan. A plan loses its grandfathered status when it makes significant changes to the plan, such as reducing benefits or increasing cost sharing for enrollees. A health plan must disclose in its plan materials whether it considers itself to be a grandfathered plan and must also advise consumers how to contact the U.S. Department of Labor or the U.S. Department of Health and Human Services with questions.

O

Out-of-Pocket Limit (OOP): The maximum amount an individual will have to pay for covered services in a year. Generally, this includes the deductible, coinsurance, and copayments. This definition may vary from plan to plan. For example, in some plans the out-of-pocket limit doesn't include cost sharing for all services, such as prescription drugs. Plans may have different out-of-pocket limits for different services. In Medicaid and CHIP, the limit includes premiums.

Open Enrollment Period: The period of time set up to allow an individual to choose from available plans, usually once a year.

Out-of-Pocket Costs: An individual's expenses for medical care that aren't reimbursed by insurance. Out-of-pocket costs include deductibles, coinsurance, and copayments for covered services plus all costs for services that aren't covered.

P

Plan Year: A 12-month period of benefits coverage under a group health plan. This 12-month period may not be the same as the calendar year. To find out when one's plan year begins, an individual can check one's plan documents or ask one's employer. (Note: For individual health insurance policies this 12-month period is called a “policy year”).

Point-of-Service Plan (POS) Plan: A type of plan in which an individual pays less if you one's doctors, hospitals, and other health care providers that belong to the plan's network. POS plans also require an individual to get a referral from your primary care doctor in order to see a specialist.

Policy Year: A 12-month period of benefits coverage under an individual health insurance plan. This 12-month period may not be the same as the calendar year. To find out when one's policy year begins, an individual can check one's policy documents or contact one's insurer. (Note: In group health plans, this 12-month period is called a "plan year").

Pre-Existing Condition (Job-based Coverage): Any condition (either physical or mental) including a disability for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on an individual's enrollment date in a health insurance plan. Genetic information, without a diagnosis of a disease or a condition, cannot be treated as a pre-existing condition. Pregnancy cannot be considered a pre-existing condition and newborns, newly adopted children and children placed for adoption who are enrolled within 30 days cannot be subject to pre-existing condition exclusions.

Pre-Existing Condition (Individual Policy): A condition, disability or illness (either physical or mental) that an individual has before he or she enrolled in a health plan. Genetic information, without a diagnosis of a disease or a condition, cannot be treated as a pre-existing condition. This term is defined under State law and varies significantly by state.

Pre-Existing Condition Exclusion Period (Job-based Coverage): The time period during which a health plan won't pay for care relating to a pre-existing condition. Under a job-based plan, this cannot exceed 12 months for a regular enrollee or 18 months for a late-enrollee.

Pre-Existing Condition Exclusion Period (Individual Policy): The time period during which an individual policy won't pay for care relating to a pre-existing condition. Under an individual policy, conditions may be excluded permanently (known as an "exclusionary rider"). Rules on pre-existing condition exclusion periods in individual policies vary widely by state.

Pre-existing Condition Insurance Plan (PCIP): A new program that will provide a health coverage option for an individual if he or she has been uninsured for at least six months, an individual has a pre-existing condition, and he or she has been denied coverage (or offered insurance without coverage of the pre-existing condition) by a private insurance company. This program will provide coverage until 2014 when individuals will have access to affordable health insurance choices through an Exchange, and individuals can no longer be discriminated against based on a pre-existing condition.

Preferred Provider Organization (PPO): A type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. An individual pays less if his or her providers belong to the plan's network. An individual can use doctors, hospitals, and providers outside of the network for an additional cost.

Premium: A monthly payment an individual makes to one's insurer to get and keep insurance coverage. Premiums can be paid by employers, unions, employees or individuals or shared among different payers.

Prevention: Activities to prevent illness such as routine check-ups, immunizations, patient counseling, and screenings.

Preventive Services: Routine health care that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems. [Learn more about preventive care and services.](#)

Primary Care: Health services that cover a range of prevention, wellness, and treatment for common illnesses. Primary care providers include doctors, nurses, nurse practitioners, and physician assistants. They often maintain long-term relationships with an individual and advise and treat one on a range of health related issues. They may also coordinate an individual's care with specialists.

Q

Qualified Health Plan: Under the Affordable Care Act, starting in 2014, an insurance plan that is certified by an Exchange, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. A qualified health plan will have a certification by each Exchange in which it is sold.

R

Reinsurance: A reimbursement system that protects insurers from very high claims. It usually involves a third party paying part of an insurance company's claims once they pass a certain amount. Reinsurance is a way to stabilize an insurance market and make coverage more available and affordable.

Rescission: The retroactive cancellation of a health insurance policy. Insurance companies will sometimes retroactively cancel an individual's entire policy if he or she made a mistake on one's initial application when an individual buys an individual market insurance policy. Under the Affordable Care Act, rescission is illegal except in cases of fraud or intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage.

Rider (exclusionary rider): A rider is an amendment to an insurance policy. Some riders will add coverage (for example, if you buy a maternity rider to add coverage for pregnancy to your policy.) In most states today, an exclusionary rider is an amendment, permitted in individual health insurance policies, that permanently excludes coverage for a health condition, body part, or body system. Starting in September 2010, under the Affordable Care Act, exclusionary riders cannot be applied to coverage for children. Starting in 2014, no exclusionary riders will be permitted in any health insurance.

Risk Adjustment: A statistical process that takes into account the underlying health status and health spending of the enrollees in an insurance plan when looking at their health care outcomes or health care costs.

S

Self-Insured Plan: Type of plan usually present in larger companies where the employer itself collects premiums from enrollees and takes on the responsibility of paying employees' and dependents' medical claims. These employers can contract for insurance services such as enrollment, claims processing, and provider networks with a third party administrator, or they can be self-administered.

Special Enrollment Period: A time outside of the open enrollment period during which you and your family have a right to sign up for job-based health coverage. Job-based plans must provide a special enrollment period of 30 days following certain life events that involve a change in family status (for example, marriage or birth of a child) or loss of other job-based health coverage.

Special Health Care Need: The health care and related needs of children who have chronic physical, developmental, behavioral or emotional conditions. Such needs are of a type or amount beyond that required by children generally.

U

Uncompensated Care: Health care or services provided by hospitals or health care providers that don't get reimbursed. Often uncompensated care arises when people don't have insurance and cannot afford to pay the cost of care.

V

Value-Based Purchasing (VBP): Linking provider payments to improved performance by health care providers. This form of payment holds health care providers accountable for both the cost and quality of care they provide. It attempts to reduce inappropriate care and to identify and reward the best-performing providers.

W

Waiting Period (Job-based coverage): The time that must pass before coverage can become effective for an employee or dependent, who is otherwise eligible for coverage under a job-based health plan.

Wellness Programs: A program intended to improve and promote health and fitness that's usually offered through the work place, although insurance plans can offer them directly to their enrollees. The program allows an individual's employer or plan to offer an individual premium discounts, cash rewards, gym memberships, and other incentives to participate. Some examples of wellness programs include programs to help an individual stop smoking, diabetes management programs, weight loss programs, and preventative health screenings.

APPENDIX II

STATE VR POLICY FRAMEWORKS REGARDING HEALTH-RELATED VR SERVICES

The Appendix of the report describes the State VR policy frameworks regarding health-related VR services for four states:

- California
- Florida
- Massachusetts
- North Carolina

The descriptions of each State policy framework use the same format and topics:

- In General
- Physical and Mental Restoration Services
- Assistive Technology Devices and Services
- Personal Assistance Services
- Comparable Services and Benefits
- Cost Sharing by VR Clients
- Third party Payee Agreements

CALIFORNIA
POLICY FRAMEWORK—HEALTH-RELATED
VR SERVICES
[California Code of Regulations, Title 9, Division 3]

I. IN GENERAL

The regulations describe and then define key consultants who help the VR agency determine the appropriateness of expending VR funds for health-related services, including:

- Chief medical consultant
- Medical services officer
- Psychiatric consultant

§ 7004.3. Chief Medical Consultant.

“Chief Medical Consultant” means a licensed physician and surgeon employed by the Department to provide statewide technical supervision of medical services, including recommendations in the formulation of medical policies and procedures.

7019.1. Medical Consultant.

“Medical Consultant” means a licensed physician and surgeon who is either employed by the Department or under contract with the Department as a staff member and who is administratively responsible to the District Administrator while under the technical supervision of the Chief Medical Consultant. He or she functions to interpret medical information, provide consultation and appropriate medical recommendations, give training to Counselors in the medical aspects of the rehabilitation process, and establish cooperative relationships with the medical community.

§ 7019.2. Medical Services Officer.

“Medical Services Officer” means a Rehabilitation Supervisor who is administratively responsible to the District Administrator and has the responsibility for coordinating the provision of medical services in the district. He or she communicates frequently with the Chief Medical Consultant and his or her staff to ensure statewide uniformity in the provisions of medical services.

7022. Psychiatric Consultant.

“Psychiatric Consultant” means a licensed physician and surgeon who is either employed by the Department or under contract with the Department as a staff member and who is administratively responsible to the District Administrator while under the technical supervision of the Chief Medical Consultant. He or she functions to interpret primarily psychiatric medical information, to provide consultation and training to counselors in aspects of psychiatry, and to establish cooperative relationships with the psychiatric community.

II. PHYSICAL AND MENTAL RESTORATION SERVICES

The State regulations include a comprehensive definition of the term “physical and mental restoration services” and prescribe the limitations on such services.

§ 7020. Physical and Mental Restoration Services.

(a) “Physical and Mental Restoration Services” means -

(1) 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;

(2) Diagnosis of and treatment for mental or emotional disorders by qualified personnel in accordance with State licensure laws;

(3) Dentistry;

(4) Nursing services;

(5) Necessary hospitalization (either inpatient or outpatient care) in connection with surgery or treatment and clinic services;

(6) Drugs and supplies;

(7) Prosthetic and orthotic devices;

(8) Eyeglasses and visual services, including visual training, and the examination and services necessary for the prescription and provision of eyeglasses, contact lenses, microscopic lenses, telescopic lenses, and other special visual aids prescribed by personnel that are qualified in accordance with State licensure laws;

(9) Podiatry;

(10) Physical therapy;

(11) Occupational therapy;

(12) Speech or hearing therapy;

(13) Mental health services;

(14) 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;

(15) Special services for the treatment of individuals with end-stage renal disease, including transplantation, dialysis, artificial kidneys, and supplies; and

(16) Other medical or medically related rehabilitation services, including wheelchair and hearing aids.

(b) 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 Department (such as through health insurance or a comparable service and benefit as defined in Section 7006 of these regulations).

7160. Physical and Mental Restoration Services/Purchases -General.

(a) Physical and mental restoration services/purchases shall be subject to all provisions specified in this section. Services/purchases shall be:

(1) Provided only in accordance with an IWRP.

(2) Unavailable in cases of Interim Determination of Eligibility, as defined in Section 7063.

(3) Subject to the similar benefit provisions of Sections 7196 through 7198 and the client financial participation provisions of Sections 7190-7194.

(4) Prescribed/recommended by the attending physician, except as provided in Section 7160.5(a)(4).

(5) Reviewed/approved in writing prior to the provision of the service/purchase, except as provided in 7160.5(c) and in accordance with (b), by one or more of the following as appropriate to the service being rendered or the purchase being authorized:

(A) The Medical Consultant or Psychiatric Consultant.

1. The approving Medical/Psychiatric Consultant shall not be the prescribing/recommending physician specified in (4).

(B) The Vocational Psychologist (if licensed by the Board of Psychology and only in districts that do not have a Psychiatric Consultant).

(C) The Rehabilitation Supervisor.

(D) The Medical Services Officer.

(E) The District Administrator, if services or purchases cost in excess of \$5,000 and when renting a wheelchair.

(F) The District Administrator and the Director or the Director's designee in cases of maxillo-facial surgery costing in excess of \$5,000.

(G) The Chief Medical Consultant.

(H) The Statewide Psychiatric Consultant.

(I) The Statewide Optometric Consultant.

(J) The Statewide Dental Consultant.

(b) Approval shall occur only after reaching a conclusion, based upon a careful review of the diagnostic study, that the IWRP will be jeopardized if the service/purchase is not provided and the conditions in either (1) or (2) exist:

(1) For persons in extended evaluation, the service is necessary to determine eligibility for vocational rehabilitation services.

(2) For clients eligible for vocational rehabilitation services, the service is necessary to both:

(A) Correct or substantially modify, within a reasonable period of time, a physical or mental condition which is stable or slowly progressive. A reasonable period of time shall be determined based upon factors related to the nature of the disability.

(B) Prepare the client for suitable employment.

(c) Evaluations/progress reports and final treatment reports from physicians, hospitals, rehabilitation centers and other facilities or appropriate providers shall be received and reviewed for recommendation by the Medical/Psychiatric Consultant or the Vocational Psychologist (if the conditions specified in 7160(a)(5)(B) exist) to determine the client's status/progress related to the likelihood of achieving the desired physical/mental restoration objective.

(1) Progress/final treatment report(s) submitted as a result of a service purchased by the Department shall include an evaluation of the client's progress, prognosis, functional limitations and capacities.

(2) In addition to the report(s) specified in (1), initial evaluations and report(s) submitted for physical/occupational/speech therapy or for psychiatric therapy/psychological counseling

shall include a limited history, diagnosis, summary of functional limitations and capacities and the recommended therapy plan based upon the results of the evaluation or the provision of subsequent services.

(d) All service(s) shall be limited to six sessions/visits, except when:

(1) Physical therapy training in the use of a prosthetic or orthotic appliance has been recommended by the prescribing physician, or

(2) The need for additional sessions/visits has the concurrence of the Medical Consultant and approval of the District Administrator. A written justification prepared by the provider of service shall be submitted to the Department for review and shall include the following:

(A) The basis on which the additional treatment is recommended.

(B) The anticipated number of visits/sessions in excess of six.

1. When treatment is recommended beyond six sessions/visits the Counselor shall seek alternate ways to provide service based upon available resources.

7160.5. Limitations on Physical and Mental Restoration Services.

(a) In addition to the conditions specified in Section 7160:

(1) Acupuncture services shall:

(A) Require referral for treatment by a physician licensed by the Medical Board of California or a comparable agency of another state when service is provided out of state. The referring physician shall be a specialist in the appropriate specialty area to diagnose and treat the disabling condition.

(B) Only be authorized in those cases for the control of pain when, in the opinion of the referring physician, all other modalities have been tried and failed.

(C) Be provided by a qualified physician, including but not limited to, an anesthesiologist, neurologist, physiatrist or orthopedist.

(2) Chiropractic services shall be authorized only if:

(A) The treatment has the concurrence of the examining or treating physician.

(B) The treatment is utilized for the correction of a subluxation of the spine that has been demonstrated to exist by a radiologist.

(3) Psychiatric therapy/psychological counseling services shall include the initial evaluation and report specified in 7160(c)(2), testing as necessary, and counseling/therapy, and shall be subject to the following restrictions:

(A) Psychiatric therapy shall only be provided by physicians and surgeons licensed by the Medical Board of California who practice psychiatry.

(B) Psychological counseling services shall only be provided by one of the following:

1. A physician and surgeon licensed by the Medical Board of California who practices psychiatry.
2. A Psychologist licensed by the Board of Psychology.
3. Other professionals, as allowed within the scope of their licensure, following a special certification from the Chief Medical Consultant, as specified in Section 7295.7. Such professionals shall be licensed by the Board of Behavioral Science Examiners and may be either of the following:
 - a. A Clinical Social Worker.
 - b. A Marriage, Family and Child Counselor.

(C) Psychological testing services shall only be provided by one of the following:

1. A physician and surgeon licensed by the Medical Board of California who practices psychiatry.
2. A Psychologist licensed by the Board of Psychology.
3. A Vocational Psychologist, as defined in Section 7029.3.
4. An Educational Psychologist, if certified in accordance with Section 7295.7.

(4) Services provided by allied health professionals or independent health care professionals shall be provided within the scope of their licensure. Such services, including but not limited to, speech pathology, physical therapy, occupational therapy, or the provision of hearing aids, visual aids, and durable medical equipment and devices, when determined by the Department to be medical in nature, shall:

(A) Be prescribed by a physician before authorization except when:

1. Visual aids are prescribed by an Optometrist.

2. Rental is necessary while the permanent equipment/device is being repaired.
3. Repairs cost 20% or less of the purchase price and do not change the fit of the equipment/device to the client.

(B) Meet the following applicable conditions:

1. Prior to the provision of a wheelchair or a vehicle device to be used as a wheelchair, a wheelchair evaluation must be completed by a person recognized by the Department as a specialist, working under the supervision of a physician as applicable to his/her licensure.

2. Physical/occupational/speech therapy shall be supervised by a physician.

3. Transcutaneous nerve stimulators shall be subject to the following conditions:

- a. Before any purchase, a device shall be rented for a minimum of 30 days and its use must have a demonstrated therapeutic benefit in the relief of pain.

- b. The rental period shall not exceed three months or rental charges exceed \$1,000, whichever comes first. The rental costs shall be deducted from the purchase price.

(b) Dental services shall be provided after receipt of a dental plan and x-rays submitted by a dentist/orthodontist. Prior approval of the State Dental Consultant is required if the dental restoration program is in question, if service has been denied by Medi-Cal or if service includes extensive treatment such as maxillo-facial dental service, maxillo-facial prosthetics, gold or porcelain/gold crown, root canal treatment, surgical gum treatment, full or partial dentures or bridges.

(c) Treatment of an intercurrent illness, which is an acute medical/dental/psychiatric condition not considered a new, permanent disability and which interrupts other planned services, shall be considered a physical and mental restoration service. Service may include, but is not limited to, office visits, medication, surgical procedure and hospitalization while the client is in the rehabilitation program. Services shall not be:

- (1) Subject to prior written approvals but shall be provided after consulting with and getting verbal approval from the Rehabilitation Supervisor with written approvals, as specified in Section 7160(a)(5), to follow within 15 days of the authorization for service.

- (2) Provided in excess of 30 days.

III. ASSISTIVE TECHNOLOGY DEVICES AND SERVICES

The State regulations generally adopt the Federal definitions for the terms assistive technology device and assistive technology services. The State regulations also specify the circumstances

under which telecommunications, sensory and other technological aids and devices may be provided by the VR program.

§ 7002. Assistive Technology Device.

(a) “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.

(b) Assistive technology devices may be used to modify vehicles or vans, as a rehabilitation technology service pursuant to Section 7024.7 of these regulations. Assistive technology does not include the purchase and repair of a vehicle because that is included in the definition of transportation pursuant to Section 7029 of these regulations.

(c) Installation of assistive technology devices on real property at the individual’s home or workplace may not involve or require construction as defined in Section 7149.1 of these regulations.

§ 7002.5. Assistive Technology Service.

“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:

(a) The evaluation of the needs of an individual with a disability, including a functional evaluation of the individual in his or her customary environment;

(b) Purchasing, leasing, or otherwise providing for the acquisition by an individual with a disability of an assistive technology device;

(c) Selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;

(d) Coordinating and using other therapies, interventions, or services with assistive technology devices, such as those associated with existing education and rehabilitation plans and programs;

(e) 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

(f) 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.

§ 7172. Telecommunication, Sensory and Other Technological Aids and Devices.

(a) Telecommunication, sensory and technological aids and/or devices may be provided when all of the following conditions exist:

- (1) The client's disability warrants such aids or devices.
- (2) There is no other method of accommodating the client's disability that is more efficient or less expensive.
- (3) The aid or device is necessary to the client's vocational rehabilitation program.
- (4) No medical contraindication exists.
- (5) The client's disability is stable enough so that the client will benefit from the aid or device over a prolonged period of time.

(b) Any telecommunication, sensory or other technological aid or device provided to a client shall meet all established Federal and State health, engineering and safety standards of general applicability that govern that type of aid or device.

(c) Prior to the provision of the aid or device the Counselor shall determine both of the following:

- (1) Whether the client is eligible for similar benefits in accordance with Sections 7196 through 7198. If eligibility exists, the Counselor shall follow the procedures specified in those regulations.
- (2) The ability of the client to financially participate in accordance with sections 7190 through 7193. If the client is able to financially participate, the procedures for payment specified in those regulations shall be followed.

IV. PERSONAL ASSISTANCE SERVICES

The State policy framework includes a definition of personal assistance services and specifies that readers, notetakers, attendants and drivers will be provided when necessary to provide VR services.

7019.7. Personal Assistance Services.

“Personal Assistance Services” means a range of services provided by one or more persons 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 for the achievement of an employment outcome and may be provided only while the individual is receiving other vocational rehabilitation services. The services may include training in managing, supervising, and directing personal assistance services.

7169. Readers, Notetaker Services, Attendants and Drivers.

(a) The following services shall be provided when necessary to provide vocational rehabilitation services:

- (1) Readers for blind or other severely disabled applicants or clients.
- (2) Notetaker services for deaf or other severely disabled applicants or clients.
- (3) Attendants and/or drivers for severely disabled applicants or clients.

(b) Prior to provision of any of the services specified in (a), the Counselor shall determine whether either of the following conditions exist:

- (1) The applicant or client has a family member or other closely associated person who is able to provide the service without pay and who volunteers to do so. In this case the Department shall not provide the service.
- (2) The applicant or client is eligible for similar benefits in accordance with sections 7196 through 7198. If eligibility exists, the Counselor shall follow the procedures specified in those regulations.

(c) When a family member or other closely associated person is able to provide the service but refuses to do so without pay, the approval of the District Administrator shall be obtained prior to authorizing such individual to provide the service. The District Administrator's approval shall be based upon verification that:

- (1) The applicant or client meets the qualifications specified in (a) for receipt of the specific services.
- (2) The conditions specified in (b)(2) have been met.
- (3) No provider, other than a family member or other closely associated person, is available to provide the necessary service(s).

V. COMPARABLE SERVICES AND BENEFITS

The State policy framework defines the term “comparable services and benefits” and specifics the general requirements applicable to the provision and exceptions to the general policy

§ 7006. Comparable Services and Benefits.

(a) “Comparable Services and Benefits” means services and benefits that are:

(1) Provided or paid for, in whole or in part, by other Federal, State, or local public agencies, by health insurance, or by employee benefits;

(2) Available to the individual at the time needed to ensure the progress of the individual toward achieving the employment outcome in the individual’s Individualized Plan for Employment (IPE); and

(3) Commensurate to the services that the individual would otherwise receive from the Department.

(b) For the purposes of this definition -

(1) Comparable services and benefits do not include awards and scholarships based on merit.

(2) A Plan for Achieving Self-Support (PASS) issued to an individual with a disability by the Social Security Administration (SSA) does not constitute a comparable service and benefit.

(3) A “ticket” issued to an individual with a disability under the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA) (42 USC 1320b-19) is considered a comparable service and benefit under the vocational rehabilitation program to the extent that a ticket holder is receiving services from another entity that is serving as that individual’s employment network.

(4) If the individual initially chooses the Department as its employment network under TWWIIA or otherwise transfers his or her ticket to the Department, the ticket would not be considered a comparable service and benefit.

7196. General Requirements.

(a) Clients eligible for similar benefits shall apply for and fully utilize those similar benefits to the extent required by these regulations.

(b) The utilization of similar benefits shall not apply to the following services, including when those services are received as post-employment services:

(1) Evaluation of rehabilitation potential.

(2) Counseling, guidance and referral.

(3) Vocational and other training services including, personal and vocational adjustment training, books, tools and other training materials provided by a resource other than an institution of higher education.

(4) Placement.

(5) Rehabilitation engineering services.

(6) Job Coaching Services.

(c) Unless the conditions specified in Section 7198 exist, the completion of a similar benefit review shall be required prior to the authorization of any service not specified in (b). Upon a determination by the Counselor that a similar benefit is available, the Counselor shall advise the client that he/she is required to apply for and use such benefit. If the client refuses to apply for or use the similar benefit, the Counselor shall:

(1) Deny provision of the service(s) for which the similar benefit is available.

(2) Continue the provision of other services for which there is no similar benefit, providing the IWRP remains viable and will most likely succeed without the provision of the service(s) that was denied.

(d) When a client:

(1) Is denied eligibility to a similar benefit, the Counselor shall:

(A) Verify the ineligibility through telephone contacts with the appropriate agency representatives or by viewing a copy of the denial notice.

(B) Document the verification in the case record.

(C) Authorize the service.

(2) Has a similar benefit reduced or terminated, the Counselor shall:

(A) Verify the reduction or termination by one of the methods specified in (1)(A).

(B) Document the verification in the case record.

(C) Assess the circumstances with the client and take one of the following actions, as appropriate:

1. Authorize a supplement to the reduced benefit.
2. Authorize the service that has been terminated by the other source.
3. Amend the IWRP in accordance with the provisions in Chapter 2, Article 5 (commencing with Section 7130).

7198. Extreme Medical Risk.

(a) The determination of availability of similar benefits under any other program shall not apply if the determination would delay the provision of vocational rehabilitation services to any client who is at extreme medical risk.

(b) A determination of extreme medical risk shall be based upon medical evidence provided by a licensed physician and verified by the District Medical Consultant. For purposes of this section “extreme medical risk” means a risk of substantially increasing functional impairment or risk of death if medical services are not provided expeditiously.

(c) Nothing in this section shall be construed to mean that the Department shall either:

(1) Be required to provide services to persons who no longer meet the conditions of eligibility specified in Section 7062.

(2) Become a primary health care payment program or take the place of other primary health care payment programs, such as the Medi-Cal program.

VI. COST SHARING BY VR CLIENT

The State policy framework specifies the financial responsibilities of applicants and eligible clients.

7029.9. Responsibilities of Individuals with Disabilities; Applicants; Eligible Individuals.

(a) Any individual with a disability who wishes to receive vocational rehabilitation services from the Department is responsible for completing the application process in accordance with the requirements of Section 7041 of these regulations.

(b) Any applicant or eligible individual, as appropriate, shall have the responsibility to:

(1) Participate and cooperate in obtaining and providing the information needed by the Department to:

- (A) Determine eligibility and priority for services in accordance with Section 7062 of these regulations;
 - (B) Determine level of significance of disability (LSOD) for the purposes of an Order of Selection in accordance with Section 7054 of these regulations;
 - (C) Determine whether the individual's chosen employment outcome is consistent with the individual's strengths, resources, priorities, concerns, abilities, capabilities, and interests;
 - (D) Determine the nature and scope of vocational rehabilitation services to be included in the Individualized Plan for Employment (IPE) in accordance with Section 7130.5 of these regulations; and
 - (E) Make any other determinations that are required by or consistent with Federal or State statutes and regulations.
- (2) Be an active and full partner in the vocational rehabilitation process and exercise informed choice throughout the vocational rehabilitation process, with assistance from the Rehabilitation Counselor as appropriate, by engaging in the following activities to the extent possible:
- (A) Gathering and evaluating information and participating in planning and problem solving and decisions related to the assessment process, selection of the employment outcome and settings in which employment occurs, vocational rehabilitation services, service providers, settings in which services will be provided, and methods for procuring services;
 - (B) Seeking or identifying needed resources;
 - (C) Evaluating the consequences of the various options;
 - (D) Making decisions in ways that reflect the individual's strengths, resources, priorities, concerns, abilities, capabilities, and interests; and
 - (E) Taking personal responsibility for implementing the chosen options and achievement of the employment outcome the individual selected.
- (3) Report any changes in circumstances that may affect:
- (A) Eligibility for vocational rehabilitation services;
 - (B) Priority category under an Order of Selection;
 - (C) The services and/or the employment outcome specified in the Individualized Plan for Employment (IPE); and

(D) The Department's ability to contact the individual.

(4) Cooperate in the assessment process and in developing and meeting the objectives identified in the IPE including, but not limited to, active participation, reasonable effort, regular attendance at scheduled appointments and training, and regular communication with the Rehabilitation Counselor regarding progress toward achievement of the employment outcome. Failure to cooperate, make reasonable effort, lack of regular attendance, or failure to maintain regular communication may result in loss of further services and closure of the record of services.

(5) Participate in the cost of services under conditions specified in Chapter 5, Article 1 of these regulations.

(6) Apply for, secure and use comparable services and benefits to the extent to which the individual is eligible for such benefits in accordance with Chapter 5, Article 3 of these regulations.

7190. Client Financial Participation -General.

(a) Clients shall financially participate to the extent required by this article in the cost of vocational rehabilitation services.

(b) The Department shall deny authorization of a specific service(s) to any client when it has been determined pursuant to this article that client financial participation is required and the client refuses or fails to do so. The Counselor shall record in the case record the reason for denying authorization of the service(s). Other services may continue to be authorized if the IWRP remains viable without the provision of the service(s) that was denied.

(c) For the purposes of this article, the following definitions shall apply:

(1) "Client income" means all money, before deductions except for a deduction equal to the amount paid for any court ordered child or spousal support payments, received by any of the persons specified in (A) through (D) during a calendar month. "Client income" does not mean financial assistance defined as a similar benefit in accordance with Sections 7026 and 7197.

(A) The client.

(B) The client's spouse, providing the client and spouse reside together.

(C) The parent(s) of a client under the age of 18 years with whom the client resides.

(D) The parent(s) of a client of any age who claim the client as a dependent for Federal or State income tax reporting purposes, unless the only monies made available to the client are court

ordered child support payments. In this case, only the monies received by the client are considered.

(2) “Household member” means only the following persons:

(A) If the client is 18 years of age or older, except as specified in (C):

1. The client.
2. The client's spouse, providing the client and spouse reside together.
3. The client's minor children under the age of 18 years residing with the client.
4. Any other person the client claims as a dependent for Federal or State income tax reporting purposes.

(B) If the client is a minor under the age of 18 years:

1. The client.
2. The client's parent(s) and minor sibling(s) under the age of 18 residing with the client.
3. Any other person the client's parent(s) claims as a dependent for State or Federal income tax reporting purposes.

(C) If the client is 18 years of age or older and is claimed by his/her parent(s) as a dependent for State or Federal income tax reporting purposes:

1. The client.
2. The following persons, unless the only monies made available to the client by the parent(s) are court ordered child support payments:
 - a. The client's parent(s).
 - b. Any other person the parent(s) claims as a dependent for State or Federal income tax reporting purposes.

(3) “Liquid assets” means cash, savings, checking accounts less any current month's income which has been deposited, or similar accounts, credit union funds, stocks, and negotiable bonds owned by any of the persons specified in (1)(A) through (D).

(4) “Medical exemption” means the monthly medical expenses that are necessary for a client to function independently including, but not limited to, medication, treatment, equipment,

assistive devices, and special diet. “Medical exemption” also means the costs for extraordinary medical care incurred by other household members, providing the costs are not subject to payment by a third party, such as insurance, Medicare or Medicaid. It does not mean the cost of routine medical and dental care, or insurance premiums.

(5) “Routine medical and dental care” means care which would be received by a person without a substantial handicap, such as periodic checkups, treatment for influenza or a virus, or the filling of dental caries.

(6) “Surplus income” means the client’s monthly income that exceeds the appropriate amount specified in section 7192.

(7) “Surplus liquid assets” means liquid assets that exceed \$2,000.00 in value plus \$750.00 additional value for each of the client’s household members.

7191. Exemptions from Client Financial Participation.

(a) A client shall be exempt from client financial participation in the cost of any vocational rehabilitation services if the client is a recipient of any of the following:

(1) SSDI.

(2) SSI/SSP.

(3) Public Assistance, including General Relief, General Assistance, or Aid to Families with Dependent Children.

(b) Clients who are not exempt in accordance with (a) shall complete a Statement of Financial Status form DR 233, part I, Rev. 1/90. In the case of a client whose parent meets the definition of “household member” in section 7190(c)(2), the form shall be completed by the client’s parent, unless the parent refuses to do so. When the parent refuses, the client may complete the form; however, the parent’s income and liquid assets shall continue to be considered. The client shall:

(1) State his/her name and Social Security number, the source and amount of his/her liquid assets and the type and amount of medical expenses that qualify for the medical exemption.

(2) Sign a certification that the income, liquid assets, number of household members and medical expenses used by the Counselor in the financial participation computation are correct to the best of his/her knowledge.

(3) Acknowledge that he/she understands that any changes in income, household composition and medical expenses, as well as changes of \$100 or more in liquid assets, must be reported to the Department and that such changes may result in a change to the amount of the client financial participation obligation.

(c) The following vocational rehabilitation services shall be exempt from the client financial participation requirement and under no circumstances shall any client be asked to participate in the cost of these services:

- (1) Evaluation of rehabilitation potential including diagnostic services and related services.
- (2) Counseling and guidance, and referral services.
- (3) Placement.
- (4) Training, tutoring, books, and other training materials.
- (5) Tools necessary for performance of an occupation.
- (6) Personal services including attendant care, deaf and language interpreter, Notetaker, driver, and reader services.
- (7) Transportation costs up to the rate charged by the most economical public transportation available, or reimbursement for the operation of a private motor vehicle on a per mile basis at a rate established by the Department.
- (8) Job Coaching Services.

7192. Computation of Client Financial Participation.

(a) Client financial participation in the cost of vocational rehabilitation services shall be determined in accordance with the provisions of this section.

(b) The client financial participation shall cover a one month period and be determined as follows:

(1) Subtract the appropriate monthly income exemption, based on the number of household members, specified in (c) from the client's total monthly income. This is the client's surplus income. If the remainder is less than zero, the client has zero surplus income.

(2) Subtract \$2,000.00 plus \$750.00 for each of the client's household members from the client's total liquid assets. These are the client's surplus liquid assets. If the remainder is less than zero, the client has zero surplus liquid assets.

(3) Combine the client's surplus income from (1) and surplus liquid assets from (2).

(4) Subtract the client's total medical exemptions from the amount determined in (3). The remainder, if any, is the amount of the monthly client financial participation that the client

shall be required to contribute toward the cost of vocational rehabilitation services not exempt pursuant to section 7191(c).

(c) The client and his/her household members shall be allowed a monthly income exemption of the following amount:

Size of Household (including client)	Monthly Income Exemption
1 person.....	\$1,344.00
2 persons.....	\$1,502.00
3 persons.....	\$1,660.00
4 persons.....	\$1,818.00
5 persons.....	\$1,976.00
6 persons.....	\$2,134.00
7 persons.....	\$2,292.00
8 persons.....	\$2,450.00
9 persons.....	\$2,608.00
10 persons.....	\$2,766.00
More than 10 persons.....	Add \$158 for each Additional person

(d) Client financial participation shall be recomputed anytime a change in monthly income, liquid assets, number of household members or medical expenses is reported.

(e) The amounts specified in (c) shall be adjusted to reflect changes in the California median income level for a household consisting of one individual as most recently calculated by the State Department of Finance. An additional \$158 shall be added for each household member other than the client.

7193. Client Financial Participation -Payment

(a) The client shall directly purchase a service that is subject to client financial participation when both of the following conditions exist:

(1) The amount of the monthly client financial participation computed pursuant to section 7192(b) equals or exceeds the cost of the service to the client.

(2) The client has not yet fulfilled his/her financial participation obligation for the month.

(b) The client shall pay the amount of the monthly client financial participation to the Department in cash, money order or cashier's check prior to receipt of the service when all of the following conditions exist:

(1) The client requires a service that is subject to financial participation.

(2) The amount of the monthly client financial participation is less than the cost of the service to the client.

(3) The client has not yet fulfilled his/her financial participation obligation for the month.

(c) For ongoing services that are subject to client financial participation, such as speech therapy or short term psychotherapy, the client shall fulfill his/her financial participation obligation in accordance with (a) or (b) each month prior to the authorization of the services by the Department.

(d) The client shall not be required to contribute toward the costs of equipment or other items loaned to him/her by the Department unless, and until such time as, the title and/or legal ownership is transferred to the client in accordance with section 7194.

(e) A client who must pay the amount of his/her monthly financial participation to the Department in accordance with (b) shall sign an agreement to pay the Department prior to authorization of the service(s). The agreement shall specify the service(s) toward which the payment will be applied.

FLORIDA
POLICY FRAMEWORK—HEALTH-RELATED VR SERVICES
[Florida Counselor Policy Manual]

I. IN GENERAL

The Counselor Policy Manual defines the term “physical and mental restoration services” and then describes the responsibilities of consultants, the qualification standards of the providers, and the circumstances under which the VR agency will pay for specific physical and mental restoration services.

II. PHYSICAL AND MENTAL RESTORATION SERVICES [CHAPTER 12]

Definition: Physical and mental restoration services are provided to correct or substantially modify a physical or mental condition that is stable or slowly progressive. Examples include:

1. Surgery or treatment necessary to correct or substantially modify a physical or mental condition that constitutes a substantial impediment to employment,
2. Necessary hospitalization in connection with surgery or treatment,
3. Special services (including transplantation and dialysis), artificial kidneys, and supplies necessary for the treatment of individuals with end-stage renal disease,
4. Prosthetic and orthotic devices,
5. Eyeglasses and visual services.
6. Prescription drugs necessary to correct or treat a physical or mental condition that constitutes a substantial impediment to employment.
 - a. The counselor should obtain a written report from the prescribing physician that details the purpose of the medication, length of projected use and any side effects. Questions regarding these reports may be discussed with the medical or psychological consultant. [Reference Section 12.01(4)]
 - b. The counselor must determine whether comparable services and benefits are available under any program other than DVR to cover the costs of services. [Reference Chapter 9, Section 9.03]

Medical, Dental, and Psychological Consultation [12.01]

1. Consultants are available in each area to assist the counselor in interpreting records and to provide advice regarding appropriate treatment.

2. Prior to treatment, medical, psychological, or dental consultation is required for extraordinary or experimental procedures or when required by the supervisor. [Reference Chapter 15] Consultation is available for all case questions and may be utilized by counselors, except as required above.
3. Eligibility for DVR, the nature and scope of services to be provided, and closure of the case are decisions that rest with the counselor. Consultants are available to assist the counselor in making these decisions but in no case will the consultant make the decision for the counselor.
4. Consultants may assist the counselor in:
 - a. Interpreting medical, dental, or psychological reports.
 - b. Determining the need for further diagnostics or for confirming the suitability of restoration services as recommended by a qualified physician, dentist, or psychologist.
 - c. Determining whether a physical or mental condition is chronic and stable or slowly progressive.
 - d. Determining the implication of the applicant's physical or mental condition for rehabilitation potential.
 - e. Determining the appropriate fees for medical, dental, or psychological procedures.
 - f. Determining the best option for various medical procedures.
 - g. Determining the most appropriate hospital and the most cost-efficient fee.
 - h. Monitoring the average hospital per diem cost to assure that individuals are admitted and discharged as early as medically appropriate.
 - i. Developing and maintaining relationships with the medical/psychological community at large.
 - j. Training staff in the medical/psychological aspects of disabilities.
5. In order to avoid even the appearance of a conflict of interest, consultation shall not occur with the actual provider of either a diagnostic or a treatment service unless no other provider is available.
6. The consultant will sign and date the consultation response. The minimal acceptable documentation is the completed consultation form. In some instances, a more thorough explanation in a narrative case entry may be required.

Treatment Provider [12.02]

1. A Provider, who provides physical and mental restoration services, must meet the DVR's Standards for Vendor Qualifications prior to providing services to an individual.

Mental Health Services [12.03]

1. DVR may pay for psychotherapy from the implementation of an IPE to receive services or from the time of extended evaluation certification.
2. The counselor should consider the local community mental health center as a comparable service for long-term psychotherapy or when the individual no longer requires services from DVR to affect an employment outcome. [Reference [DVR's Guideline for the Use of Psychological Services](#)]

Dental Services [12.04]

1. Dental services may be provided to an individual if the individual's dental condition is a substantial impediment to employment; is slowly progressive; is contributing significantly to the complication of another physical condition; and that condition constitutes a substantial vocational impediment.
2. Dental services are primarily provided to prevent the exacerbation or deterioration of a primary disability. Impairments that have the potential for being markedly affected by severe dental conditions include, but are not limited to cardiac conditions, arthritis, diabetes, tuberculosis, and cleft palate.
3. The use of a dental condition as a primary disability is not prohibited but would be unusual and limited to the following instances:
 - a. When the dental condition creates toxicity and causes physical symptoms in other systems of the body. **This determination must be made by a physician and treatment approved by the medical consultant.**
 - b. When the dental condition results in a cosmetic problem that is severe enough to prevent an individual from obtaining or retaining a job in which the individual would be serving the public.
4. A dental condition may be classified as a secondary disability but only when it constitutes a substantial vocational impediment.
5. Preventive dental services may be provided only as an adjunct to dental treatment. Preventive dental service in and of itself is prohibited.

Hearing Aid [12.05]

The choice of hearing aids shall be based on the recommendation of a licensed audiologist and the individual's current hearing and speech capabilities. The selected hearing aid(s) must enable the individual to successfully complete the services in the IPE that are needed to secure, retain or regain employment.

1. If the individual prefers a more expensive hearing aid(s), the individual must pay the difference in cost between the required hearing aid(s) and the chosen one. (Reference [VR Guide On Serving Individuals Who Are Deaf, Late-Deafened, Hard-of-Hearing or Deaf-Blind](#), Appendix A (Guide on Hearing Loss and Purchase of Hearing Aids))
2. The purchase of hearing aid(s) shall be based on the “Manufacturers’ Single Unit Price”. The itemized invoice from the audiologist or hearing aid specialist must list the price of the hearing aid based on the “Manufacturer’s Single Unit Price Sheet” plus a DVR established professional fee. The DVR professional fee shall cover programming, fitting, dispensing, up to 2 follow-up visits after the initial 30-day trial period, ear mold(s), and a 1 year warranty. The counselor must verify the hearing aid price with the “Manufacturer’s Single Unit Price” posted on DVR’s Intranet.
3. An Individual may purchase an additional warranty for the hearing aid(s).

Bariatric Surgery [12.06]

1. DVR may consider providing bariatric surgery only if an individual’s weight constitutes a substantial impediment to employment. DVR may consider providing surgery to those individuals for whom it is medically necessary, because their medical condition will not allow them the time to lose weight by conservative approaches, (a balanced eating program and therapy for one year), or for whom more conservative approaches have failed to result in weight loss. The medical risks involved in the surgery and risk of surgery failure justify the imposition of the following conditions.
 - a. DVR recognizes that there are individuals for whom this surgery is not an option, but is necessary because of their medical condition and their need to lose weight very quickly. DVR encourages therapeutic counseling before and after the bariatric procedure to ensure the individual is thoroughly educated about the risks and the realities of living after the surgery.
 - i. The individual must provide documented evidence of vocational impairments that exist at the time of request. (Anticipated impairments do not meet eligibility requirements);
 - ii. An individual requesting bariatric surgery as an elective procedure must provide records of nutritional counseling and attempted weight loss with a balanced diet (may be through a weight loss program or in consultation with a nutritionist or doctor) for at least one year prior to DVR considering sponsoring bariatric surgery. DVR may assist with the costs of counseling and weekly fees for weight loss programs;
 - iii. The individual must submit to psychological evaluation and therapeutic counseling, if recommended, regarding the individual’s current psychological status, expectations

about the surgery and ability to maintain the extreme dietary discipline required after surgery. DVR may assist with these expenses if there are no comparable services and benefits available to the individual;

- iv. The individual must present documented denial, reason for denial and appeals from insurance companies and/or other sources of comparable services and benefits available to the individual;
- v. The individual must provide documentation from a doctor that the individual can safely undergo the surgery and be expected to return to employment; and
- vi. The individual must agree to work with a nutritionist after surgery for six months. DVR may assist with these expenses if there are no comparable services and benefits available to the individual.

III. ASSISTIVE TECHNOLOGY DEVICES AND SERVICES/REHABILITATION TECHNOLOGY SERVICES [CHAPTER 14]

The Counselor Policy Manual defines key terms (rehabilitation technology, assistive technology device and assistive technology service) and for each device or service specifies the circumstances under which the device or services will be provided by the VR agency.

DEFINITIONS

Rehabilitation Technology is the systematic application of technologies, engineering methodologies, or scientific principles to meet the needs of and address the barriers confronted by individuals with disabilities in areas that include education, rehabilitation, employment, transportation, independent living and recreation. The term includes rehabilitation engineering, assistive technology devices, and assistive technology services. [Reference: 1992 Amendments to the Rehab Act of 1973] [14.00]

Scope of Services [14.02]

1. DVR shall provide appropriate rehabilitation technology services including consultation with a rehabilitation engineer that is necessary for the applicant or eligible individual to participate in DVR services, assessments or achievement of an employment outcome. Prior to providing repairs to rehabilitation technology, DVR shall determine whether maintaining equipment or replacement is appropriate.
2. The counselor will inform the individual that rehabilitation technology services are available. The counselor shall discuss all relevant policy pertaining to the provision of these services including the individuals' responsibilities and participation in the services.

3. Consultation services are available through a contract for DVR customers. This contract specifies standards for services. Consultations are required for all building, worksite, customized wheelchairs, and vehicle modification services.
4. The counselor will initiate all rehabilitation technology assessments, consultations and services by referring the individual to the RE Technician and provide applicable case notes, medical reports and relevant evaluations as requested by the RE.
5. Based on the assessment, the rehabilitation engineer will submit a detailed report to the counselor. The report will outline the most cost effective and appropriate rehabilitation technology and services to achieve the desired result to support an employment outcome. The counselor may consult with the RE and request additional information and technical assistance. The counselor will utilize the rehabilitation technology report in the context of the IPE to determine whether the recommendations are appropriate and justifiable for the individual to achieve an employment outcome.
6. The counselor has the responsibility to discuss costs of insurance, maintenance and repairs so that individuals understand their responsibilities.
7. Any modification of the rehabilitation technology recommendations must be approved in writing by the rehabilitation engineer. Changes should not be made to the recommendations without discussion with the rehabilitation engineer.
8. If the individual needs changes after a recommendation has been provided or implemented, the counselor will work with the RE and individual to revise the recommendation of rehabilitation technology as necessary.
9. Once rehabilitation technology services are approved and authorized by the counselor, the rehabilitation engineer will coordinate the work with the vendor(s) according to the established timeline. They will conduct necessary inspections to ensure the work is provided in compliance with the specifications and payments. [Reference Section 14.09]
10. Rehabilitation technology services must be completed and the referral closed before the individual's case record is closed.
11. The counselor is responsible to ensure that the individual is an active participant in every aspect of the vocational rehabilitation process including the provision of rehabilitation technology consistent with informed choice. [Reference Chapter 4, Section 4.03]
12. The counselor is encouraged to explore comparable benefits to the degree that it does not delay services or reduce the quality of rehabilitation technology services.

Wheelchairs, Scooters and Mobility Aids [14.05]

1. Customized Wheelchairs/Mobility Devices consist of wheelchairs and mobility devices that require specialized seating such as customized cushions, tilt/recline systems or control systems such as sip/puff and head controls. Customized wheelchairs require a consultation with an engineer and the use of a vendor with an Assistive Technology Suppliers (ATS) certification.
2. DVR may purchase wheelchairs and other mobility aids that are medically necessary to enable the individual to support his/her employment outcome.
3. For non-customized wheelchairs (DME), the counselor may request consultation from rehabilitation engineer. In considering mobility aids, the counselor must take into consideration other activities (e.g., driving, working), as well as accessibility to the home and the environment.
4. For customized wheelchairs, the counselor will consult with the rehabilitation engineer for technical assistance prior to purchasing wheelchairs and other mobility aids.

Equipment, Vendor Selection, Purchasing and Procurement of Services [14.08]

1. Durable Medical Equipment (DME) means any product as defined by the Federal Drug Administration, Devices and Cosmetics Act, any products reimbursed under the Medicare Part B Durable Medical Equipment Benefits, or any products reimbursed under the Florida Medicaid Durable Medical Equipment Program (F.S. 400.925). This includes personal transfer systems, specialty beds and non-customized wheelchairs.
2. Used Equipment means any equipment that has previously been sold to an individual or utilized as a demonstration product. DVR will not purchase used equipment or reimburse any portion of costs towards the equipment, where a sale or delivery has occurred prior to authorization of services.
3. Prescriptive assistive devices for the purpose of medical, developmental, or vocational rehabilitation of individuals are excepted from competitive-solicitation requirements and shall be procured pursuant to an established fee schedule or by any other method which ensures the best price for the state, taking into consideration the needs of the individuals. Prescriptive assistive devices include, but are not limited to, prosthetics, orthotics, and wheelchairs. For purchases made pursuant to this paragraph, State agencies shall annually file with the department a description of the purchases and methods of procurement. [Reference Florida Statute 257.087 9 (e)]
4. If more than one qualified vendor exists within the same or neighboring counties, a quote should be obtained from at least two vendors to ensure competitive pricing without causing undue hardship or delays for services.

5. The counselor will provide the individual with a list of all the qualified vendors that are available.
6. If an individual chooses to use a specific vendor and this vendor is not the lowest bidder, the vendor can be used only if this vendor meets DVR's Standards for Vendor Qualifications.
7. The individual must agree to pay the full difference in cost. The individual will pay the difference in cost to the vendor prior to DVR authorizing any funds.

IV. PERSONAL ASSISTANCE SERVICES [Chapter 11]

The Counselor Policy Manual describes the range of services considered “personal assistance services” and specifies the circumstances under which such service may be provided by the VR agency.

Personal Assistance Services encompass a range of services, provided by one or more persons, designed to assist an individual with a disability to perform daily living activities on or off the job that the individual would typically perform if the individual did not have a disability. Such services shall be designed to increase the individual's control in life and ability to perform everyday activities on or off the job. [11.05]

1. Personal Assistance Services may only be provided in support of other planned service(s); such as an individual who is engaged in a training program, including supported employment, or in an employment situation prior to rehabilitation.
2. An individual shall be paid or reimbursed for personal assistance services when these services are listed in the IPE.
3. The individual shall employ and train the personal assistant. The personal assistant will not be an employee of DVR.
4. The individual and the counselor shall jointly determine if the individual requires training in the selection, compensation, and training of a personal assistant.

V. COMPARABLE SERVICES AND BENEFITS [9.03]

The Counselor Policy Manual defines the term “comparable services and benefits” and specifies the circumstances under which comparable services and benefits must be used and exceptions to the rule.

Comparable Services and Benefits.

Comparable services and benefits means services and benefits that are:

1. Provided or paid for, in whole or in part, by other Federal, State, or local public agencies, by health insurance, or by employee benefits;
2. Available to the individual at the time needed to achieve the employment outcome in the individual's IPE;
3. Commensurate to the services that the individual would otherwise receive from DVR.
4. Consideration of comparable services and benefits is necessary and must be documented in the record of services.

Required Use. [9.04]

DVR will determine whether comparable services and benefits are available under any program other than DVR to cover costs of services and utilize such services and benefits, unless such a determination would interrupt or delay:

1. The progress of the individual toward achieving the employment outcome identified in the IPE;
2. An immediate job placement, or
3. The provision of such service to any individual at extreme medical risk based upon medical evidence provided by an appropriate licensed medical professional; or,
4. If the comparable services and benefits are **not available** to the individual at the time needed to achieve the employment outcome identified in the IPE or if the benefits exist but are not available at the time needed to satisfy objectives in the IPE, the counselor may authorize funding directly only until the comparable benefits and service become available.
5. If an eligible individual is a SSA Ticket to Work holder whose Ticket is assigned to an Employment Network (EN), DVR shall consider all goods and services referenced in the IPE to be comparable services and benefits to be purchased or provided by an EN with which the eligible individual's Ticket is assigned. [Reference Chapter 16, [Section 16.04](#), [16.05](#) and [16.07](#)]

Exceptions. [9.05]

Exceptions to DVR's determination of the availability of comparable services and benefits include:

1. Uses of awards and scholarships. Comparable services and benefits do not include awards and scholarships based on merit that are granted without restrictions as to their use by the individual.
2. Information and referral services
3. Assessment for determining eligibility and vocational rehabilitation needs
4. Counseling and guidance, including information and support services to assist an individual in exercising informed choice
5. Job-related services, including job search and placement assistance, job retention services, personal assistance services, follow-up, and follow-along services
6. Rehabilitation technology including telecommunications, sensory and other technological aids and devices
7. Post employment services listed in 9.05(1) – 9.05(6) above, necessary to assist eligible individuals to maintain, regain or advance in employment

VI. COST SHARING BY VR CLIENT

The Counselor Policy Manual specify the circumstances under which an applicant or client is responsible for the costs associated with the receipt of specified VR services, including clients exempt from the cost sharing responsibility.

Components of the IPE.

Regardless of the option selected by the eligible individual, the IPE must contain, among other things, the terms and conditions of the IPE, including, as appropriate, information describing:

The responsibilities of the eligible individual, including:

- The responsibilities the eligible individual will assume in relation to the individual's employment outcome;
- If applicable, the participation of the eligible individual in paying for the costs of the plan;

- The responsibility of the eligible individual with regard to applying for and securing comparable services and benefits (Reference [Chapter 9, Section 9.03](#)); and
- The responsibilities of other entities as the result of arrangements made pursuant to comparable services or benefits as described in [Chapter 9, Section 9.03](#);

Financial Participation Determination [9.02]

1. DVR will consider the financial need of individuals to determine the extent of their participation in the costs of vocational rehabilitation services.

a. Exemption Status:

- Individuals who meet the following exemption status are not required to participate or make a contribution toward the cost of vocational rehabilitation services.
- Individuals who receive SSDI, SSI, public assistance (Temporary Assistance for Needy Families [TANF]), Food Stamps and/or other General Assistance), **or**
- Any individual who has annual income less than 185% of the Federal Health and Human Services Poverty Guidelines, **or**
- Individuals who were not legally required to file a U.S. Tax Return in the year prior to application.

b. Status:

- Individuals are considered Independent if the individual's own earnings constitute a majority of his or her financial support, is single and was not claimed as a dependent on someone else's U.S. Tax Return in the prior year.
- The parents' or guardians' income will not be considered when determining financial need for individuals who are considered independent under this standard.
- The individual will be considered Dependent if he or she was claimed on the parents' or guardians' U.S. Tax Return in the prior tax year. Parents' or guardians' income will be considered as an available resource.
- Spouse's income will be considered as an available resource if the individual has filed a U.S. Tax Return as married, filing separately or jointly.

2. Income Data

- The determination of the individual's participation is an integral part of the rehabilitation planning process between the individual and the counselor. The individual and counselor will determine if the individual is independent, a

dependent on another tax return, or married and collect the appropriate U.S. Tax Return. The counselor will review the U.S. Tax Return to determine the Total Gross Income of the individual, parents', guardians' or individual and spouse, as applicable. If the individual claims to be independent from family resources and single, he or she will be asked to demonstrate this by providing the most recent IRS tax filings or U.S. Tax Return. **Note: The counselor will NOT maintain a copy of the U.S. Tax Return in the individual case record.**

- b. If an individual did not file a return in the prior year, or the individual (parent, guardian or spouse) has had a significant change in income since the last tax filing, he or she must provide information to reflect the change or demonstrate means of self-support. Sources of verification may include:
 - i. Employment Security Wage Reports,
 - ii. Employer generated pay stubs,
 - iii. Retirement program documents, or
 - iv. Documentation from public or private economic support programs.
 - c. The individual or their representative may request modification to the Financial Participation Assessment at any time, as needed to adjust for changes in income or other economic circumstances. Changes in the amount of financial participation must be reflected in the IPE amendment. If modification is requested, the Division reserves the right to obtain verification from the sources listed above.
3. If an individual or family member refuses to provide the information necessary to determine participation, or if the individual or family refuses to accept responsibility for their expected contribution, DVR cannot authorize non-exempt services.
 4. DVR will strictly observe the confidentiality of all financial information obtained from the individual and family members.

5. Exempt Services

- a. Assessment for determining eligibility and vocational rehabilitation needs
- b. Vocational rehabilitation counseling and guidance
- c. Referral and other services to assist individuals in securing services from other agencies
- d. Job-related services including job search and placement assistance
- e. Personal assistance services
- f. Any auxiliary aid (e.g. communication boards, speech synthesizers, telephone handset amplifiers, TDDs) or service (e.g. interpreter services for individuals who are deaf or hard-of-hearing, reader services, communication assistance in the individual's native language)
- g. Supported employment services
- h. Trial work services

- i. On-the-job training
- j. Vocational and other training services (e.g. tuition, books, supplies, fees)
- k. Community Based Work Experience for transition school to work

6. **Non-Exempt Service Types**

- a. Physical and mental restoration services
- b. Maintenance
- c. Transportation
- d. Services to family members
- e. Post employment services
- f. Occupational licenses, tools, equipment, stock and supplies
- g. Rehabilitation technology
- h. Technician assistance for small business
- i. Other goods and services

7. **Individual's Cost Responsibility**

- a. The type of services, the total cost for rehabilitation services and the amount of participation should be provided by both the individual and DVR. This must be clearly written in the IPE or IPE amendment.
- b. The individual's payment(s) will be made directly to the vendor. The amount that the individual must pay will be included on the Authorization and Billing Invoice and the IPE for services. The counselor may seek an exception to the policy. (Reference Chapter 15)

8. **Total Income Excluded.** It is the Income Exclusion Allowance plus exclusion of disability related expenses, which must be entered by the counselor. The Division utilizes the Social Security Administration's definitions of impairment related work expenses. The Division will deduct any impairment related work expenses from the individual's total gross income prior to determining the individual's cost responsibility.

9. **Impairment Related Work Expense (IRWE)**

- a. An IRWE is an expense for an item or service, which is directly related to enabling an impaired individual to work and which is necessarily incurred by that individual because of a physical or mental impairment. To qualify as an IRWE, the expense must be paid by the individual. Expenses paid by sources such as health insurance, vocational rehabilitation and the employer are not considered for exclusion for the individual with the impairment.

- i. Examples include, but are not limited to:

1. The cost of attendant care services rendered in the work setting or in assisting the individual in making the trip to and from work. (Attendant care rendered on non-work days or those performed at any time, which involve shopping or general homemaking are not considered IRWE's. Additionally attendant services performed for other family members, such as babysitting, are not considered IRWE's).
2. Durable medical equipment which can withstand repeated use, used to serve a medical purpose and generally not useful to a person in the absence of an illness or injury, such as wheelchairs, hemodialysis equipment, respirators, pacemakers, and traction equipment.
3. The cost of the modification of a vehicle (but not the cost of the vehicle) in order to drive or be driven to work, where the modification is critical to the vehicle's operation or its accommodation of the individual. The modification must be directly related to the impairment (without the modification the individual would either be unable to drive or would be unable to ride in the vehicle).
4. Expenses paid by a person for owning a guide dog or a trained service animal including the costs of purchasing a dog, food, licenses and veterinary services.
5. Prosthetic devices that replace internal body organs or external body parts (a prosthetic device that is primarily for cosmetic purposes usually is not considered an IRWE).
6. The cost of drugs and medical services that are necessary for control of the disabling condition, thereby enabling the individual to work (drugs and medical services used for minor physical or mental problems not resulting in any significant loss of function such as yearly routine physical examinations, dental examinations, and optician services and eyeglasses when unrelated to a disabling visual impairment are not considered IRWE's).
7. Work equipment and assistants that are required to accommodate the impairment and perform the job such as a one-handed typewriter, telecommunications device and a job coach paid for by the individual.

10. For further examples, see SSA Program Operations Manual System available at Web site: <http://www.ssa.gov/ssi/spotlights/spot-work-expenses.htm>.

11. **Certification.** The individual or his/her representative providing the financial participation determination information will be asked to verify by signature that the information provided is true and correct. The printed template will then be signed by the counselor and retained in the case record.
12. A budget study shall be utilized when maintenance is being considered [Reference Chapter 11].

VII. THIRD PARTY PAYEE AGREEMENTS

The Counselor Policy Manual specifies the circumstances under which an applicant or client is considered to have assigned his or her rights to the VR agency for payments for specified services.

Assignment of Rights. [9.06]

An applicant for or a recipient of vocational rehabilitation and related services is deemed to have assigned to the DVR her or his rights to any payments for such services from a third party (e.g. private insurance, Medicaid, and Medicare).

Third Party Payer: Private Insurance [9.07]

1. Necessary information:
 - a. The name of the company
 - b. The group policy number
 - c. The company representative
 - d. The expiration date of the policy
 - e. What is covered and what percentage would be paid
2. Counselors should request that vendors file against the insurance company rather than bill DVR.
3. If DVR has paid a vendor for services and the vendor is paid for those services by a third party, the vendor shall reimburse DVR.
4. If the third party policy only partially pays or a co-payment deductible must be paid, DVR may supplement the third party payment or the co-payment deductible.
5. The supplement to third party insurance or co-payment/deductible must be documented by the insurance carrier or vendor and DVR shall not authorize an amount in excess of DVR's maximum allowed amount.

Third Party Payer: Medicaid or Medicare [9.08]

1. Individuals who receive SSI or Temporary Assistance for Needy Families (TANF) automatically receive Medicaid. The medically needy may also be eligible for Medicaid.
2. Necessary information:
 - a. Verify the Medicaid or Medicare number
 - b. Send the individuals to vendors who will accept Medicaid or Medicare
 - c. Ensure that the vendor bills Medicaid or Medicare directly
3. If the vendor will not accept Medicaid or Medicare, DVR may pay the vendor for services and recover from Medicaid. In this instance, a cover memo and the invoice should be submitted to Medicaid providing the individual's:
 - a. Name
 - b. Social Security number
 - c. Date of birth
 - d. Current Address
4. If a co-payment/deductible must be paid, DVR may pay the co-payment/deductible.
5. The co-payment/deductible must be documented and shall not exceed DVR's maximum allowed amount.

Recovery from Third Parties [9.09]

1. DVR shall seek the recovery of monies spent on behalf of an individual from a third party:
 - a. Whenever a third party is liable for the payment of such services
 - b. From the individual if the individual has already received third-party payments
 - c. From the provider of the services if the provider recovers from the individual or a third party on behalf of the individual
2. Counselors should determine if an individual or applicant has any rights to third-party payments as a result of the circumstances that caused them to seek services.
3. When there is a possibility of a liable third party, the counselor, with the assistance of the individual, shall complete the Subrogation Form. The individual shall be requested to read and sign the Subrogation Form. Services to the individual provided through DVR shall not be contingent upon the signing of this form nor shall the subrogation rights of DVR be contingent upon the individual signing the form.
4. When the Subrogation Form is completed, it shall be immediately forwarded to DVR Legal Counsel.

5. If the DVR attorney and DVR believe that there is an expectation that subrogation monies could likely be recovered, DVR attorney may either file a lien meeting the requirements of F.S. Section 413.445 or notify the individual's attorney by letter of DVR's right to subrogation. The failure of the counselor and the individual to complete a Subrogation Form, or the failure of DVR's attorney to file a lien or notify the individual's attorney in writing, shall not affect DVR's subrogation rights.
6. Under special circumstances, where undue financial hardship would result to the individual, DVR may consider, in its sole discretion, whether to seek reimbursement or to seek reimbursement for less than all of such funds expended. Under such circumstances, DVR shall consider the following factors in determining whether to seek less than full or no reimbursement:
 - a. The amount of reimbursement being offered by any party liable therefore;
 - b. Cost to DVR of services rendered to the individual;
 - c. Types of services rendered to the individual;
 - d. Employment status of the individual;
 - e. Cost to the individual of living independently;
 - f. Additional liens against the individual resulting from medical or rehabilitation services provided to such individuals;
 - g. Whether any other lienors have reduction of their liens;
 - h. Whether any attorney representing the individual has reduced his/her fee;
 - i. Other sources of income available to the individual; and
 - j. The cost effectiveness of pursuing the recovery.
7. DVR shall have the sole discretion, after consideration of such factors, to reduce or waive any claims DVR may have under Section 413.445, Florida Statutes.
8. If DVR receives a third party payment on either a pending SSDI/SSI claim or for which reimbursement has been received, then this must be reported to the Social Security Administration [Reference Chapter 16].

PRIOR APPROVAL

Prior Approval.

Certain services require prior approval before they can be provided to applicants or eligible individuals [9.00; See Chapter 15].

Definition[15.00].

Prior approval means that approval is obtained from the State or Area Office of the Division of Vocational Rehabilitation prior to initiating certain vocational services for individuals. If prior approval or policy exception is approved, then the services requested will be included in the IPE or IPE amendment, as appropriate.

State Office Approvals. [15.01]

Services that require prior approval at the State Office level are:

1. Extraordinary or experimental medical/ psychological services. These include:
 - a. All Transplants
 - b. All procedures to be performed on persons with cancer
 - c. Cochlear implants and other implantable hearing devices (CI and BAHA speech/sound processor [external device]) replacements or repairs do not require State prior approval)
 - d. Gastrointestinal procedures (e.g. stomach stapling) for morbid obesity
 - e. Hyperbaric oxygen treatments for any condition
 - f. Intrathecal baclofen infusion for Cerebral Palsy (cerebral dystonia)
 - g. Brain surgery
 - h. Comprehensive In Patient/Out Patient Pain Management Programs conducted by a multi-specialty team or by an individual physician. The program could utilize single or multiple modalities such as narcotics, indwelling drug administration devices, acupuncture, implanted stimulation devices, TENS units, physical and massage therapy, and/or psychological support. Epidural injections beyond a 3-injection trial requires a prior approval at the State Office level.
 - i. Penis prosthesis
 - j. Any cosmetic/reconstructive surgery
 - k. Any medical conditions with uncertain prognosis or outcome
 - l. Sterilization, abortion, sex change operations or treatment
 - m. Bone Stimulator

2. Policy Exceptions require prior approval of the State Office:
 - a. An individual, through his or her counselor, may seek an exception to policy that is needed in order to meet an individual's unique rehabilitation requirements to secure, maintain or advance in employment. Such exceptions may be sought to provide medical, transportation, maintenance or other vocational rehabilitation services.

 - b. The policy exception(s) shall only be granted if the request meets the following criteria:
 - i. Needs of an individual: The exception(s) to the policy must be necessary because of the unique needs of an individual. The request for the exception

must explain why the policy should not apply to the particular individual's services. For example: A service may have a specified fee amount. However, because of a very significant complication, the individual may need the services of a vendor who will not accept the fee amount. Other qualified vendors are not available to the individual.

- ii. **Legality:** The granting of a policy exception must not violate any Federal or State law or regulation.
 - iii. **Intent of the policy:** Granting an exception must not violate the intent of the given policy. For example: Policy requires that there be evidence in the case file and on the IPE that an individual can succeed in training before that training can be provided. The intent of the policy is to ensure that individuals are moving appropriately toward a viable vocational goal and to ensure the prudent and efficient use of public funds. An exception to this policy would violate its intent.
 - iv. **Fairness and Equity:** The granting of the exception must not violate fairness to other individuals. For example: If an individual is granted an exception(s) for a certain type of service(s) other individuals that fall within that same category and circumstance shall be granted an exception(s). Consideration for other individual(s) will require that an exception prior approval request be submitted since all services are based upon individual need.
3. **Financial Participation Determination -** In exceptional cases, circumstances may occur where rigid adherence to the financial participation assessment procedures could seriously jeopardize the individual's opportunity to achieve rehabilitation objectives and an employment outcome. For example, the individual may need immediate medical intervention and may not have the funds immediately available. In such cases, the counselor may elect to seek an exception to the policy.
- a. **Note:** Each IPE where the service expenditures are estimated to be in excess of \$20,000 (\$30,000 Brain and Spinal Cord Injury) will be reviewed by the Area Director or designee for a request for financial participation Policy Exception at the time of Area Prior Approval.

State Office Procedures [15.02]

1. Forward the signed prior approval request to the Bureau of Field Services where it will be reviewed by the appropriate medical consultant and staff member. Prior approval for policy exception will be reviewed by the Bureau Chief of Field Services.
2. The decision to approve or deny the request will be recorded, dated, signed, and returned to the originating area for inclusion in the individual's case file.
3. The prior approval request will include:
 - a. The Request for State Office Prior Approval form completed in RIMS that includes employment information, counselor signature and the dated signature of the Area Director or designee indicating approval at the Area Office level.
 - b. Any supporting documentation that is not in the data system that the counselor feels is pertinent.
4. The request for policy exception(s) must include a justification as to why it is needed and how it will benefit the individual in terms of an employment outcome.

15.03 **Area Office Approvals.** Those Services requiring prior approval at the Area Office are:

1. Services to Division of Vocational Rehabilitation staff and family members.
2. Services on an IPE or IPE amendment, which can reasonably be expected to require expenditures totaling \$20,000 or more. Approval will be required for each increment of \$10,000 thereafter.
3. Services on an IPE or IPE amendment for eligible individuals with brain and spinal cord injury (BSCI), which can reasonably be expected to require expenditures totaling \$30,000 or more. Approval will be required for each increment of \$20,000 thereafter.

15.04 **Area Office Procedures**

1. Forward the prior approval request to the Area Director.
2. The decision to approve or deny the request will be recorded, dated, signed by the Area Director or designee, and returned for inclusion in the case record.
3. The prior approval request will include:
 - a. The Request for Area Office Prior Approval form completed in RIMS that includes employment information, the dated signature of the Supervisor or designee indicating approval at the unit level.

- b. Any supporting documentation that is not in the data system that the counselor feels is pertinent.

Authorization for Services [9.01]

1. DVR's highest allowable fee for health care services is the amount payable for such services in Florida under the Medicare Part B system or, for hospital per diem payments, the amount payable under the Medicaid system. In setting its highest allowable fee for all other services, DVR shall ensure such fee is not set so low as to deny individuals the right to make informed choices among service providers.

**MASSACHUSETTS
POLICY FRAMEWORK—HEALTH-RELATED
VR SERVICES
[Massachusetts Regulations]**

I. IN GENERAL

The State regulation specifies that rates, fees, and expenditures for VR services are subject to general State laws and regulations applicable to the purchase of goods and services.

6.23 Rates and Expenditures for Vocational Rehabilitation Services

Rates, fees, and expenditures for vocational rehabilitation services are subject to all applicable Commonwealth of Massachusetts statutory, regulatory, and related requirements governing purchases of services and goods.

II. PHYSICAL AND MENTAL RESTORATION SERVICES

The State regulation specifies that VR services includes physical and mental restoration services and defines the term.

Vocational rehabilitation services means any goods or services necessary to render an individual with a disability employable, including, but not limited to, the following:

(d) Physical and mental restoration services, including but not limited to:

1. Corrective surgery or therapeutic treatment necessary to correct or substantially modify a physical or mental condition which is stable or slowly progressive and constitutes a substantial impediment to employment, but is of such nature that such correction or modification may be expected to eliminate or reduce such impediment to employment with a reasonable length of time,
2. Necessary hospitalization in connection with surgery or treatment,
3. Prosthetic and orthotic devices,
4. Eyeglasses and visual services as prescribed by a physician skilled in the diseases of the eye or by an optometrist, whichever the individual may select,
5. Special services (including transplantation and dialysis), artificial kidneys, and supplies necessary for the treatment of individuals with end stage renal disease, and
6. Diagnosis and treatment for mental and emotional disorders by a physician or licensed psychologist in accordance with State licensure laws;

Physical and Mental Restoration [6.06]

(1) Physical and mental restoration services means:

(a) Corrective surgery or therapeutic treatment likely to correct or substantially modify a physical or mental impairment which is stable or slowly progressive within a reasonable length of time;

(b) Necessary in or outpatient hospitalization, clinic services and/or drugs and supplies; in connection with surgery or treatment;

- (c) Prosthetic and orthotic devices;
 - (d) Eyeglasses, contact lenses, microscopic lenses, telescopic lenses, and other visual aids
 - (e) Special services (including transplantation and dialysis), artificial kidneys, and supplies necessary for the treatment of individuals with end stage renal disease;
 - (f) Diagnosis and treatment for mental or emotional disorders and mental health services;
 - (g) Dentistry;
 - (h) Nursing services;
 - (i) Podiatry;
 - (j) Physical or occupational therapy;
 - (k) Speech or hearing therapy;
 - (l) Treatment of acute or chronic medical complications and emergencies; and
 - (m) Other medical or medically related rehabilitation services.
- (2) Physical and mental restoration services can be provided only if financial participation has been determined, any comparable benefit available to meet, in whole or in part, the cost of restoration services has been explored and:
- (a) An individual had an examination by an appropriate physician, psychiatrist, psychologist or other professional who meets applicable State licensure requirements, at least ninety (90) days prior to the provision of restoration services and restoration is consistent with examination findings.
 - (b) The specific services are authorized in writing by the Commission prior to provision. However, in a medical emergency the Commission may first make an oral authorization to a vendor before issuing a written authorization.
 - (c) Restoration services shall be provided only at institutions and facilities meeting all statutory, regulatory, accreditation, licensing, certification, approval, health and safety, and related standards applicable to such institutions and facilities and by qualified personnel who meet applicable licensing requirements of the Commonwealth of Massachusetts.
 - (d) Fees for restoration services are determined in accordance with applicable regulations of the Commonwealth of Massachusetts.

III. ASSISTIVE TECHNOLOGY DEVICES AND SERVICES

The State regulation defines the term rehabilitation technology and specifies that the term includes assistive technology devices and assistive technology services. The State regulation also specifies the circumstances under which these services may be provided by the VR agency. The State regulation also includes a separate policy applicable to telecommunications, sensory, and technological aids and devices.

Rehabilitation technology means the systematic application of technologies, engineering methodologies, or scientific principles to meet the needs and address the barriers confronted by individuals with disabilities in areas that include employment, transportation, independent living, and recreation. The term includes rehabilitation engineering, assistive technology devices, and assistive technology services.

Rehabilitation Technology Services [6.17]

(1) Rehabilitation technology services assist individuals with disabilities to overcome barriers to full participation in rehabilitation, employment, transportation, independent living and recreation. The Commission will only support rehabilitation technology that is necessary to achieve an individual's vocational objectives and goals. An individual's need for rehabilitation technology should be considered at any stage of the vocational rehabilitation process.

(2) Rehabilitation technology refers to the systematic application of technologies, engineering methodologies, or scientific principles to address the barriers confronted by individuals with disabilities. The term includes rehabilitation engineering, assistive technology devices, and assistive technology services.

(a) Assistive technology device is 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 functional capabilities of individuals with disabilities.

(b) Assistive technology service is any service that directly assists an individual in the selection, acquisition, or use of an assistive device and includes:

1. Evaluating the needs of an individual, including functional evaluation of the individual in the environment where the device will be used, such as the home or worksite;
2. Purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices
3. Selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing of assistive technology devices;
4. Coordinating and using other therapies, interventions, or services with assistive technology devices, such as those associated with existing education and rehabilitation plans and programs;
5. Training or technical assistance for an individual or, where appropriate, the family of an individual; and
6. Training or technical assistance for professionals (including individuals providing education and rehabilitation services), employers, or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of individuals with disabilities.

(3) Rehabilitation technology services, including evaluation of the need for rehabilitation technology services, shall be provided when necessary to assess eligibility and vocational rehabilitation potential, especially when the disabling condition of the individual is so severe that the absence of rehabilitation technology services could result in a determination of ineligibility.

(4) In the development and review of the IPE, rehabilitation technology services shall be considered to eliminate barriers to and/or enhance opportunities for the development of capacities for successful job performance. Rehabilitation technology services provided to individuals to assist them to attain intermediate objectives and long-range rehabilitation goals, including supported employment, shall be specified in the individual's IPE.

(5) Reviews of ineligibility or inability to attain a vocational goal due to the severity of the disability shall include consideration of rehabilitation technology services. The effect of

rehabilitation technology services on the determination of eligibility shall be considered in any review initiated by the individual and in annual reviews initiated by the Commission.

(6) Annual reviews and evaluations of extended employment in rehabilitation facilities to identify individuals capable of competitive employment shall, include consideration of rehabilitation technology services.

(7) Review of post employment services shall include consideration of rehabilitation technology services.

(8) Evaluation of the need for rehabilitation technology services and the provision of those services shall be performed by personnel who are skilled in rehabilitation technology and who meet applicable licensing or certification requirements of the Commonwealth of Massachusetts.

The Commission may review or conduct studies to evaluate rehabilitation technology services and the provision of such services. Such reviews and studies may evaluate utilization, cost effectiveness, fee schedules, safety and reliability.

(9) The Commission shall retain legal title and control of any equipment purchased for an individual as a rehabilitation technology service. Such legal title and control will be in accordance with all applicable Massachusetts laws, regulations and related requirements governing title, use, replacement, disposition, and transfer. Equipment will not be attached, confiscated, or otherwise encumbered by creditors or other sources however:

(a) The Commission may require the return of such equipment, in good condition, if it determines that equipment is not being utilized for the purposes for which it was provided; and

(b) At such time as an individual is performing successfully in employment and considered to have attained his/her vocational rehabilitation goals, title to and control of the equipment may be transferred to the individual.

(10) Rates, fees, and expenditures for rehabilitation technology services are subject to all applicable Commonwealth of Massachusetts ' statutory, regulatory, and related requirements governing purchases of services and goods.

The Commission may establish maximum dollar limits designed to ensure the lowest reasonable cost for rehabilitation technology services. The maximum dollar limits will include a waiver process so that rehabilitation technology services that are essential to vocational rehabilitation and employment of otherwise eligible individuals are not precluded by the maximum dollar limits established to control costs

Provision of rehabilitation technology services is subject to determination of financial participation rehabilitation technology services do not require a determination that comparable benefits and services are unavailable under any other program. However, resources from other programs may be utilized when readily available.

6.15: Telecommunications, Sensory, and Technological Aids and Devices

(1) Telecommunications, sensory and other technological aids and devices include: alerting and signaling devices; amplified or text telephones and personal and large area FM assistive listening devices for individuals who are deaf or hard of hearing. Such devices or aids may include but are not limited to: visual or vibrating alerts for doorbells; kitchen timers; alarm clocks and smoke detectors. These aids may be needed by an individual with hearing loss instead of or in addition to hearing aids.

Telecommunications, sensory and other technological aids and devices may be provided only to the extent necessary to enable an individual to attain a suitable employment outcome or as necessary to enable an individual to complete an assessment, trial work experience or extended evaluation to determine eligibility and vocational rehabilitation needs

(2) Evaluations, prescriptions, installations, and fittings for telecommunications, sensory, and technological aids and devices must be performed by skilled personnel who meet applicable licensing or certification requirements of the Commonwealth of Massachusetts. Aids, devices and related services must meet established State or Federal health and safety standards. The Commission may establish criteria and limits designed to ensure product quality, durability, safety, and reliability.

(3) The Commission may retain legal title and control of any aids and devices purchased for an individual. Such legal title and control shall be in accordance with all applicable Massachusetts laws, regulations and related requirements governing title, use, replacement, disposition, and transfer. The Commission may require the return of such aids and devices if it determines the aids or devices are not being utilized for the purposes for which it was provided. All aids and devices shall be returned to the Commission in good condition upon request. Aids and devices shall not be attached, confiscated, or otherwise encumbered by creditors or other sources. At such time as an individual is performing successfully in employment and considered to have attained his/her vocational rehabilitation goals, title to and control of aids and devices may be transferred to the individual.

(4) Rates, fees, and expenditures for telecommunications, sensory and other technological aids and devices are subject to all applicable Commonwealth of Massachusetts statutory, regulatory, and related requirements governing purchases of services and goods.

(5) Telecommunications, sensory and other technological aids and devices are subject to the determination of financial participation and to consideration of any comparable benefit available to an individual to meet, in whole or in part, the cost of telecommunications, sensory and other technological aids and devices.

IV. PERSONAL ASSISTANCE SERVICES

The State regulation defines the term personal assistance services and specifies the circumstances under which the VR agency will provide these services.

Personal assistance services means a range of services, provided by one or more persons, designed to assist an individual with a disability to perform daily living activities on or off the job that the individual will typically perform if the individual did not have a disability. Such services shall be designed to increase the individual's control in life and ability to perform everyday activities on or off the job.

Personal Assistance, Auxiliary Aids and Services [6.14]

(1) Personal assistance services are a range of services to assist an individual with a disability to perform daily living activities on or off the job that the individual would typically perform if he or she did not have a disability. These services increase the individual's control in life and ability to perform everyday activities leading to greater independence and achievement of the individual's vocational goal.

(2) The Commission will provide personal assistance services for a maximum of 40 hours per week. However, additional hours may be approved by personnel designated by the Commission when necessary for the individual to participate in the vocational rehabilitation services described in the IPE.

(3) Personal assistance services may only be provided to enable an individual to participate in an eligibility determination or in a vocational rehabilitation service in accordance with requirements for Order of Selection and an IPE. The IPE must describe all needed vocational rehabilitation services including the required personal assistance services and describe how the services support the achievement of an employment outcome.

(4) Auxiliary aids and services include interpreter services for individuals who are deaf or hard of hearing such as sign language, oral interpreter services, reader services and rehabilitation services.

(5) Auxiliary aids and services do not include personal devices such as wheelchairs, individually prescribed devices such as prescription eyeglasses or hearing aids, readers for personal use or study, personal attendants, or other devices or services of a personal nature.

(6) These aids and services may only be provided when necessary to enable an individual to participate in a vocational rehabilitation service. The case record must describe the purpose, costs, duration and how the aids and services support the vocational rehabilitation service(s).

(7) Auxiliary aids and services are not subject to the determination of financial participation when they are necessary to enable an individual to access the VR program as required under Section 504 of the Rehabilitation Act and/or the Americans with Disabilities Act.

Rates, fees, and expenditures for personal assistance, auxiliary aids and services are subject to all applicable Commonwealth of Massachusetts statutory, regulatory, and related requirements governing purchases of services and goods.

Comparable benefits that are available to meet, in whole or in part, the cost of personal assistance, auxiliary aids and services must be used prior to Commission funding.

V. COMPARABLE SERVICES AND BENEFITS [6.04]

The State regulation defines the term “comparable benefits and services” and then specifies the circumstances under which applicants and clients are required to apply for comparable benefits and services and exceptions to the general rule.

(1) Comparable benefits and services are those appropriate services or financial assistance from a source other than the Commission that will meet, in whole or in part, the cost of vocational rehabilitation services to be provided under an Individualized Plan for Employment (IPE).

(2) Individuals are required to apply for any comparable benefits or services for which it appears they may be eligible. When and to the extent that, comparable benefits are available to the individual the Commission shall require such services to be used before the Commission provides funds to meet, in whole or in part, the cost of vocational rehabilitation services except when:

(a) It will result in an interruption or delay in achieving the employment outcome identified in the IPE; or

- (b) An immediate job placement would be lost; or
- (c) In the provision of services to an individual who is at extreme medical risk. Extreme medical risk means a risk of death or substantially increasing functional impairments if immediate medical services are not provided. A determination of extreme medical risk must be based on medical evidence provided by an appropriate licensed medical professional.
- (3) Comparable benefits and services are:
 - (a) Provided or paid for in whole or in part to the individual, by other public agencies, health insurance, or employee benefits;
 - (b) When needed to assure progress toward achievement of the employment outcome specified in the IPE of the individual; and
 - (c) Similar in scope and quality to services provided by the Commission; but
 - (d) Do not include awards and scholarships based on merit.
- (4) Comparable benefits and services do not have to be considered when providing:
 - (a) Counseling and guidance;
 - (b) Information and referral; and
 - (c) Placement services.
- (5) Comparable benefits and services shall be used before the Commission provides funds for the following services:
 - (a) Physical and mental restoration services;
 - (b) Maintenance and transportation services;
 - (c) Services to members of an eligible individual's family;
 - (d) Occupational licenses, tools, equipment, and initial stocks and supplies;
 - (e) Vocational training services including books, tools, and other training materials;
 - (f) Personal assistance and auxiliary aids and services including interpreter services for the deaf, reader services, note taker, personal care attendant; and rehabilitation teaching services;
 - (g) Employment services including supported employment and post employment services that are necessary to maintain, regain or advance in employment;
 - (h) Rehabilitation technology, adaptive housing, motor vehicle modification, telecommunications, sensory and other technological aids and devices;
 - (i) Transition services;
 - (j) Other goods and services not listed.

VI. COST SHARING BY VR CLIENT-- Participation in Cost of Vocational Rehabilitation Services [6.03]

The State regulation specifies the financial responsibilities (cost sharing) of an applicant or client regarding the payment for a VR service or part thereof.

- (1) The Federal regulations governing the vocational rehabilitation program give the Commission the option to consider the financial need of individuals with disabilities when determining who should pay for the cost of rehabilitation services except for those individuals who receive SSI or SSDI benefits. The Commission will measure the financial need of individuals other than those individuals who receive SSI or SSDI benefits to determine the extent of their participation in the cost of their services. In this way, the Commission's resources can be targeted to individuals most in need.

(2) An individual's financial participation must be determined before the Commission can fund any service. Financial participation must be determined at least once annually and whenever there is a change in the financial status of the individual, a dependent of the individual, and/or the person(s) claiming the individual as a dependent.

(3) The individual is responsible to inform the Commission of any changes in financial circumstances and provide the appropriate documentation within thirty days of the date of such changes. Failure to do so may result in termination of paid vocational rehabilitation services.

(4) Federal regulation prohibits requiring the financial participation of an individual who is an SSDI/SSI recipient regardless of his or her family's income or assets. However, the individual may be asked under certain circumstances to contribute to the costs of his or her services but this contribution cannot be required. Individuals who receive SSDI or SSI benefits must provide documentation, sign and date the Commission's financial participation form. For those individuals who have verified SSDI and/or SSI benefits, their mandated contribution to the cost of their vocational rehabilitation services is zero.

(5) Financial participation is based on cash assets and annual income. Cash assets and annual income include: checking accounts; savings accounts; mutual funds; stocks and bonds; and the annual taxable income of the individual, the individual's spouse, dependents of the individual and the person(s) claiming or allowed to claim the individual as a dependent, such as the individual's parents, stepparents or legal guardians as documented by the most recent Internal Revenue tax forms. Cash assets do not include pension funds or individual retirement accounts.

(6) A dependent is any individual who for Federal income tax purposes is claimed or allowed to be claimed as a dependent of another.

(a) When the individual is 18 years or older and is not claimed or allowed to be claimed as a dependent of another person, financial participation will be based on the individual's income and assets alone.

(b) When the individual is married, financial participation is based on the combined incomes and assets of the individual and the spouse, regardless of age.

(c) When the single individual is under 18 years old, financial participation is based on the combined incomes and assets of the parent(s) and the individual.

(d) When the parent(s) claim or are allowed to claim a single individual 18 years or older as a dependent because the individual has received more than one half of his or her support during the most recent calendar year from the parents; financial participation is based on the combined income and assets of both the individual and the parent(s).

(7) When the income of the individual is subject to income tax, the individual shall provide copies of the most recent applicable portions of the Internal Revenue forms as required by the Commission. If an individual's income changes so significantly that the most recent Internal Revenue forms are no longer valid; verification of income shall be provided by other means. When income is not subject to income tax, the individual must provide verification including copies of benefit eligibility notifications and most recently received checks or notices of direct deposit. This non-taxable income may include but is not restricted to:

(a) Supplemental Security Income; (Title XVI of the Social Security Act as amended)

(b) Transitional aid to families with dependent children (M.G.L. c. 118);

- (c) Emergency aid to elderly, disabled and children (M.G.L. c. 118 A);
 - (d) Emergency assistance (M.G.L. c. 117);
 - (e) Veterans services (M.G.L. c. 115);
 - (f) Federal food stamp program and State supplemental food stamp program.
- (8) An individual's financial participation shall be determined by deducting the annual dollar standard from the sum of cash assets in excess of allowable cash assets and annual net income.

Documentation includes:

- (a) Most recently filed Internal Revenue Service forms (Form 1040, Form 1040A and/or Form 1040EZ); and
 - (b) Verified annual income for individuals not subject to filing income tax.
- (9) The annual dollar standard and allowable cash assets are each 300% of the Poverty Threshold by size of family as reported by the United States Census Bureau. The annual dollar standard and allowable cash assets will be disseminated by the Commission as instructions to staff.

When an individual's annual resources exceed the financial participation requirements, the Commission shall, after consideration of comparable benefits including financial aid for higher education, require the individual to apply the annualized excess to the annual cost of vocational rehabilitation services.

(10) The Massachusetts Wage Reporting System Statute (G.L.c.62) may be used by the Commission for the verification of wages and assets.

(a) The wage information, including name, social security number, employer name, employer address, employer identifying number, and amount of wages and assets may be used by the Commission in the administration of the Vocational Rehabilitation (VR) Program to identify fraud, error, and abuse relative to financial eligibility of clients.

(b) Identification of such fraud, error, and abuse could result in termination of Commission assistance.

(11) The following services are provided by the Commission without consideration of an individual's financial resources. This however, does not eliminate the requirement to use all available comparable benefits the individual is eligible to receive before providing Commission funds.

- (a) Information, referral and other services;
- (b) Services to determine eligibility and order of selection priority for vocational rehabilitation services;
- (c) Services to determine vocational rehabilitation needs;
- (d) Counseling and guidance;
- (e) Placement services;
- (f) Personal assistance services and auxiliary aids and services such as interpreter services for individuals who are deaf or hard of hearing including sign language and oral interpreter services, reader services, note taker, personal care attendant services, and rehabilitation teaching services as necessary for an individual to participate in the VR program as required under section 504 of the Rehabilitation Act or the Americans with Disabilities Act.

(12) Services that are not listed above may be provided only after determining an individual's financial participation in the cost of services.

**NORTH CAROLINA
POLICY FRAMEWORK—HEALTH-RELATED
VR SERVICES**

[North Carolina Caseworker Service Delivery Policy Manual for VR Services]

I. IN GENERAL [Section 1-15]

1-15-2: Medical Specialists

A medical specialist must be certified in a specialty recognized by the American Board of Medical Specialists or eligible for certification through post-graduate education, and must be a member of the staff of a hospital approved for participation in the DVRS program. Physicians wishing to provide services should complete the vendor review form DVR-0308 or DVR-0309, which must be approved by the Section Chief for Program Policy, Planning and Evaluation. *[10 NCAC 20D .0302]*

1-15-3: Psychologists

The N. C. Psychology Board must license psychologists providing services as VR vendors, and the Section Chief for Program Policy, Planning and Evaluation must approve a DVR-0308. In addition to the above, Masters level Psychological Associates also must provide evidence of an active supervisory contract.

1-15-4: Prosthetists and Orthotists

The American Board for Certification in Prosthetics must certify these vendors, indicating that the shop meets the Board's various standards. These vendors must complete a DVR-0304, and the form must be approved by the Section Chief for Program Policy Planning and Evaluation. *[10 NCAC 20D .0308]*

1-15-5: Dentists

Dentists must be approved by the N.C. State Board of Dental Examiners. A DVR-0308 must be completed and approved by the Section Chief for Program Policy Planning and Evaluation. *[10-NCAC 20D .0303]*

1-15-7: Hearing Aid Vendors

Such vendors must sign a Letter of Agreement with the Division indicating acceptance of payment rates and other requirements. They must be licensed by the N.C. State Hearing Aid Dealers and Fitters Licensing Board. These vendors must also complete a DVR-0304 and be approved by the Section Chief for Program Policy, Planning and Evaluation. *[10 NCAC 20D .0307]*

1-15-8: Speech and Language Pathologists and Audiologists

Such vendors must be licensed by the N.C. Board of Examiners for Speech and Language Pathology and Audiology. They must complete a DVR-0304 and be approved by the Section Chief for Program Policy, Planning and Evaluation. *[10 NCAC 20D .0206]*

1-15-9: Chiropractors

These vendors must be licensed by the N. C. Board of Chiropractic Examiners. They must complete a DVR-0304 and be approved by the Section Chief for Program Policy, Planning and Evaluation.

1-15-10: Occupational Therapists

These vendors must be licensed by the N. C. Board of Occupational Therapy. They must complete the DVR-0304 and be approved by the Section Chief for Program Policy, Planning, and Evaluation.

[10 NCAC 20D .0302]

1-15-11: Physical Therapists

These vendors must be licensed by the N. C. Board of Physical Therapy Examiners. They must complete the DVR-0304 and be approved by the Section Chief for Program Policy, Planning, and Evaluation.

[20 NCAC 20D .0302]

1-15-12: Optometrists

These vendors must be licensed by the N. C. State Board of Examiners in Optometry. They must complete the DVR-0308 and be approved by the Section Chief for Program Policy, Planning and Evaluation.

1-15-13: Opticians

These vendors must be licensed by the N.C. State Board of Opticians. They must complete the DVR-0304 and be approved by the Section Chief for Program Policy, Planning and Evaluation.

1-15-14: Podiatrists

These vendors must be licensed by the N.C. Board of Podiatry Examiners. They must complete a DVR-0308 and be approved by the Section Chief for Program Policy, Planning and Evaluation.

1-15-15: Massage and Bodywork Therapists

These vendors may render services prescribed by a physician. Therapists must be in compliance with any local ordinance that pertains to such vendors and must be licensed by the North Carolina Board of Massage and Bodywork Therapy. These vendors must complete a DVR-0304 and be approved by the Section Chief for Program Policy, Planning and Evaluation.

1-15-16: Acupuncturists

These vendors must be licensed by the N. C. Acupuncture Licensing Board. They must complete a DVR-0304 and be approved by the Section Chief for Program Policy, Planning and Evaluation.

Medical Consultations [Section 1-16]

The North Carolina Division of Vocational Rehabilitation Services contracts with practicing physicians to provide consultation services to all unit offices. Consultation is often necessary to interpret, clarify, expedite, and make decisions regarding medical aspects of the case. The responsibilities of the Unit Medical Consultant are as follows:

1. Interpret medical terms and medical information on clients;
2. Clarify and explain physicians' reports in terms of client disability;
3. Assess the adequacy of medical information and advice on the need for specialist consultation or further medical evaluation;
4. Advise on nature and extent of functional impediments and improvement from proposed interventions;
5. Advise on likelihood of residual impediments after treatment;
6. Assess medical prognosis related to rehabilitation potential;
7. Provide staff education regarding disease or injury and current methods of treatment; and
8. Serve as liaison with colleagues in the medical community.

The consultant's role is to review and advise on medical evaluation and treatment. It remains the counselor's responsibility to determine eligibility, provide/arrange for all appropriate services and set employment objectives. All counselors must have access to medical consultation to aid them in proper decision-making and to keep informed concerning current diagnostic and treatment methods. Formal sessions with the Unit Medical Consultant should be scheduled at least once a month and provide for face-to-face meetings with counseling staff for case consultation and staff education. Additional meetings may be scheduled depending upon the need. It is the responsibility of the Unit Manager/Facility Director to schedule, set the agenda for, and conduct medical staff meetings. Case consultation on an interim basis should be obtained by telephone or by a visit to the Unit Medical Consultant's office, as appropriate to the complexity and urgency of the individual client. Medical situations that must be staffed with the Unit Medical Consultant include those in which:

- (1) A second opinion regarding chronic pain or chronic fatigue syndrome is considered desirable;
- (2) Differentiation of an acute versus chronic condition is difficult;
- (3) Unusual studies or treatment are involved;
- (4) Severe disabilities that may render an eligibility determination difficult to establish, e.g. head injury, spinal cord injury, stroke, and chronic progressive conditions such as MD and MS;
- (5) An elective hospital admission under VR sponsorship is requested when preadmission certification has been denied for a Medicaid recipient;
- (6) There is question as to the appropriate level of care or reasonable length of stay for specific procedures or conditions;
- (7) Require more than 7 days diagnostic hospitalization; or questions arise regarding inpatient -vs. - outpatient services or treatment.

II. PHYSICAL AND MENTAL RESTORATION SERVICES

Mental Restoration Services [Section 2-13]

Mental restoration services are those services that are necessary to correct or substantially modify a mental impairment that is stable or slowly progressive. Mental restoration is subject to the client's financial need and comparable benefits, when available. The implementation of Mental Health Reform has led to the creation of target and non-target populations. Mental Health consumers falling into the non-target population will no longer be eligible for outpatient therapy services under the public mental health system. Because of this significant change, it is anticipated that more individuals with mental health disabilities will need Division assistance with outpatient therapy than before so that they can reach and maintain a level of stability that will enable them to successfully complete a program of vocational rehabilitation services.

In many areas of the state, especially in rural areas, a shortage of mental health therapists exists. Recognizing this fact, the North Carolina Division of Medical Assistance has expanded the types of mental health therapy providers that it will pay for outpatient behavioral health services. Expanding the Division's list of psychotherapy provider types to bring it into line with revised policy from the Division of Medical Assistance will help in addressing the shortage in therapists.

If outpatient therapy is available through the public mental health system, this, as in the past, would be considered a comparable benefit. Also, it must be emphasized that psychotherapy can only be sponsored if it is required by the client so that the objective of the IPE can be achieved.

[10A NCAC 89C, Section .0303]

2-13-1: Psychotherapy

Division clients needing psychological or psychiatric treatment to address a **primary** or **secondary** disabling condition in order to meet the objectives on the IPE should be referred to the local mental health system whenever feasible. When public mental health services are not available, the Division may sponsor private therapy on an outpatient basis. **Counselors may authorize up to twenty-four sessions for psychotherapy.** Additional sessions may be authorized with the approval of the Unit Manager/Facility Director and the Chief of Policy. In addition to the documentation required for eligibility determination and treatment updates, a written treatment plan, justification for additional sessions, and ongoing progress reports are required when more than twenty-four sessions are authorized. Medication monitoring may also be sponsored by the Division when comparable benefits are not available. Psychotherapy will not be authorized to cover case management or other services managed by the Mental Health System. Inpatient therapy will not be provided. Psychotherapy may be provided by psychiatrists, psychologists, Licensed Psychological Associates (LPA), Licensed Professional Counselors (LPC), Licensed Marriage and Family Therapists (LMFT), Certified Clinical Supervisors (CCS), Licensed Clinical Addictions Specialist (LCAS), Licensed Clinical Social Worker (LCSW), or Advanced Practice Nurses licensed by the State of North Carolina to deliver individual these services. The rates for sponsorship of psychotherapy and medication monitoring are found in Volume V.

Physical Restoration Services [Section 2-16]

Physical restoration services may be provided as part of a rehabilitation program to correct or substantially reduce a physical impairment that is stable or slowly progressive and that results in substantial impediments to employment. A slowly progressive condition is one in which the client's functional capacity is not expected to diminish so rapidly as to prevent successful completion of vocational rehabilitation services, and/or employment for a reasonable period of time. This service is also referred to as —*Diagnosis and Treatment of Impairments*”. Such services are subject to the individual's financial need and comparable benefits, when available. Restoration services are considered substantial vocational rehabilitation services when they are provided within the supportive counseling and guidance relationship. [NCAC 20C, Section .0303]

Intercurrent Illness

Intercurrent illnesses are defined as those illnesses that arise during the course of the rehabilitation program and interfere with completion of the intermediate program objectives. Illnesses may be either acute or chronic. Treatment of such illnesses may be sponsored by the Division. Specialty medical information is required along with a treatment plan. Financial need must be ascertained and comparable benefits used when available.

Secondary Restoration

Secondary restoration refers to an acute or remediable condition that exists concomitantly with a chronic impairment (that makes an individual eligible for Division services), is present at the time of eligibility, and presents a definite obstacle to progression and accomplishment of the rehabilitation program. The rehabilitation counselor may sponsor the recommended treatment in these circumstances to remove the acute condition so that the individual can benefit, in a timely manner, from other planned Division services. *Secondary restoration* differs from inter-current illness because the need is evident at intake and/or eligibility, and prior to development of the IPE; whereas, intercurrent illness occurs during the course of the rehabilitation program (IPE). A condition for which *secondary restoration* is being provided cannot be coded as a secondary disabling condition because it is acute and does not result in *substantial* impediments to employment. Specialty information is required along with a treatment plan. The financial needs criteria must be applied and comparable benefits used when available. The counselor must document in the case file the rationale for addressing a secondary restoration issue to include the diagnosis and necessary restoration services. In most cases, this should be done on the Written Rehabilitation Analysis Page (WRAP). However, in situations in which sponsorship of secondary restoration is needed in order to complete the comprehensive assessment (status 10), the counselor should document the rationale for sponsorship on a case note.

Physical Restoration as a —Substantial Vocational Rehabilitation Service

VR sponsorship of a physical restoration service(s) would be viewed as a *substantial* service when it is:

A. Provided to substantially reduce or eliminate limitations/impediments associated with a chronic impairment AND

B. Required by the individual in order to begin work, return to work, or maintain employment, AND

C. Provided within a supportive counseling and guidance relationship and/or in conjunction with other *Core* VR services.

The following are examples of supportive guidance and counseling interventions:

- Helping the client understand their diagnosis/impairment, impediments and what to expect during and after treatment.
- Helping the individual understand the vocational implications of their diagnosis/impairment; i.e., need for part-time or modified duties following treatment, need for job re-assignment or job change because of impediments.
- Career and educational guidance to help the individual select suitable jobs and/or type of training.
- Assisting the individual in dealing with and adjusting to the emotional issues surrounding the diagnosis/impairment.
- Referral to other community resources to assist with issues associated with physical restoration.
- Liaison or interventions with medical providers to facilitate the individual's treatment, and medical needs.
- Discussion and exploration of an individual's strengths, interests and abilities in relation to recommendations from the assessment data (medical and vocational) and other case information.
- Providing supportive guidance and follow-up on specific impairment related issues after return to work.

Typically, two or more *Core* services (See Section 2-3 for listing of the *Core* services) are necessary to address an individual's rehabilitation needs. However, if only one *Core* service (e.g. physical restoration) is determined necessary, the supportive counseling and guidance provided by the rehabilitation counselor, or other Division support staff, and documentation of such becomes even more important. This supportive element distinguishes the VR service from that of simply serving a medical insurance function, or paying a medical bill. The presence of a *chronic impairment* and provision of the physical restoration service *within a VR guidance and counseling relationship* distinguishes this situation from those where VR would simply be *paying a bill* for an acute or otherwise temporary medical condition. The client's need for the *guidance and counseling relationship* must be established as part of VR eligibility; specifically, in relation to the —*requires VR services*” component of the eligibility criteria.

Guidelines Regarding Anticipated Duration of Medical Treatment

Some individuals have stable or slowly progressive conditions of long duration. The Division does not provide long-term or ongoing physical treatment. Accordingly, Division funds cannot be used to initiate treatment that is reasonably anticipated to last more than six months (per case) unless Unit Manager approval has been obtained. Agreed upon extensions may be approved only if the client maintains reasonable progress toward achieving the vocational goal. An exception can be when the purchase of medication/medical supplies is expected to exceed six months duration in support of training as a major service on the Individualized Plan for Employment. It is expected that the counselor would work jointly with the client to identify comparable benefits for long term medical care.

2-16-1: Morbid Obesity – Medically Managed Weight Loss Programs and Surgical Intervention VR Sponsorship of Medically Managed Weight Loss Programs

Medically managed weight-loss programs provide treatment in a clinical setting with a licensed healthcare professional, such as a medical doctor, nurse, registered dietitian and/or psychologist. These programs typically offer services such as nutrition education, physical activity and behavior modification/therapy. In some situations, closely related programs such as cardiac rehabilitation programs may be utilized to accomplish this purpose as they have many of the same essential components. Before VR will sponsor services for a client through a medically managed weight loss program, medical records must document that the client has attempted other organized weight loss programs for a period of 9 months or more. VR may sponsor these programs for clients at the established Medicaid rate and subject to the individual meeting the Division's financial criteria. With regard to the duration of VR sponsorship, the guidelines in Section 2-16 Physical Restoration apply (*see under Guidelines for Anticipated Duration of Treatment*). Approval of extensions of VR sponsorship beyond 6 months may be approved by the Unit Manager if the individual is demonstrating acceptable progress in their weight loss as evidenced by the progress reports from the program.

VR Sponsorship of Surgery

VR sponsorship of surgery for morbid obesity may be considered when it is determined to be a medical necessity by the appropriate specialist and when the following conditions are met:

- The individual is at least 19 years old, **and**
- Medical record documentation substantiates that the individual:
 - Has a BMI greater than or equal to 40 with serious complications/limitations in at least two of the following areas: documentation of primary diseases such as arteriosclerosis, diabetes, heart disease, hypertension, pseudo-tumor cerebri, etc., is significantly complicated by clinically severe obesity.
 - The obesity causes substantial orthopedic or physical impediments as documented by the medical history records including x-ray findings and other diagnostic test results.
 - There is significant respiratory insufficiency or sleep apnea documented by respiratory function studies, blood gases, or sleep studies.
 - There is significant circulatory insufficiency documented by objective measurements; **and**
- Clinically severe obesity must be present for a period of at least three years; **and**,

- The individual must have made consistent efforts to lose weight over a period of 9 months or longer under physician supervision or in an organized weight loss program and failed; **and**
- The individual has no correctable cause for the obesity, e.g.; an endocrine disorder; **and**,
- The surgery is Medicaid approved. Counselors should verify the Medicaid status of the surgical procedure before agreeing to sponsor. The accounting technician in fiscal services is available to assist in determining the Medicaid status of surgical procedures. The Counselor must provide the CPT code of the procedure. Situations regarding surgical procedures that are not Medicaid approved must be staffed with the Chief of Policy.

Case Documentation Requirements - VR Sponsorship of Surgical Intervention for a Client

1. Documentation of a continuous nine month period or longer of all medical treatment modality therapies attempted by the client under the supervision of a physician or in an organized weight loss program to reduce weight, the duration of each therapy and the results of each treatment
2. Documentation of the client's weight for each of the three previous years
3. The client's present weight, height, skeletal frame, body mass index and gender
4. Medical history of the entire client's diagnoses such as heart disease, pulmonary problems, arthritis, diabetes, etc.
5. Medical test results
6. Documentation that all correctable causes of obesity have been ruled out with test results of laboratory tests performed
7. Documentation of a psychological evaluation assessing the recipient's suitability for surgery and his/her ability to comply with lifelong dietary changes and medical follow-up. Components of such an assessment should include: levels of depression, eating behaviors, stress management, cognitive abilities, social functioning, self-esteem, personality factors or other mental health diagnoses that may affect treatment, readiness and ability to adhere to required lifestyle modifications and follow-up social support
8. Documentation of a fully developed, 5-year psychosocial, nutritional, and activity- based follow-up plan
9. Certification that the individual has been informed about all surgery risks, surgical sequelae, the need for extensive follow-up care, expectancy of weight loss and a signed statement that the individual has been informed of the risks and results and still desires a surgical procedure

10. Description of the type of gastro-bariatric surgery planned and CPT code that describes the surgery planned

11. VR may authorize follow-up surgeries if deemed to be medical necessities – ex: surgical skin flap removal. However, surgeries that are purely elective with no medical necessity cannot be sponsored by the Division.

12. The Division cannot authorize —up-front administrative fees that are sometimes required by surgical clinics

2-16-2: Hearing Aids

CROSS REFERENCE: Appendix Entry - Hearing Disabilities; Section 2-5-5

Telecommunicative Devices

Hearing aids may be sponsored for those clients who meet the eligibility criteria listed in the Hearing Disabilities section of the Appendix and who require such devices to meet the needs of a training program or employment. A hearing aid may be purchased for a primary or secondary disability if the hearing loss meets the criteria for a hearing disability (See Appendix – Hearing Disabilities). The Division will utilize vendors who provide a full range of services including servicing and loaner aids. Physicians who meet this requirement may provide ear, nose and throat (ENT) examinations, hearing evaluations, hearing aid evaluations and may dispense hearing aids (see Volume V for rates). Such services are subject to the individual's financial need and comparable benefits, when available. (See Section 2-5-5 Telecommunicative Devices – Comparable Benefits).

In order to purchase a hearing aid, the counselor will authorize to an otologist and audiologist licensed to practice in the State of North Carolina for an ear, nose, and throat (ENT) exam, hearing evaluation, and a hearing aid evaluation. Medical clearance for fitting of an aid must be obtained from a physician skilled in diseases of the ear (ENT exam). The Division cannot accept a waiver for medical clearance from an audiologist, a physician's assistant, a hearing aid dealer, or a family member. The Division may purchase any kind of hearing aid (behind the ear, in the ear, programmable, or digital) recommended by a licensed audiologist or Board Certified Hearing Aid Specialist. The user's hearing aid should be equipped with a telecoil switch (T-coil switch). The T-switch functions like an antenna, picking up the electromagnetic energy and transferring it to the hearing aid that converts it into sound. With a —T-switch, the consumer will be able to utilize additional assistive technology devices and have access to the telephone. (See Volume V – Hearing Aid Fees). Purchase of a hearing aid is not subject to equipment purchasing procedures.

Clients are expected to follow the manufacturer's directions in using and maintaining a hearing aid. The client is responsible for safe storage of the hearing aid when it is not in use and should pay close attention to the safe handling of the device. Replacement hearing aids will **not** be purchased due to negligence that results in damage or loss. A hearing aid can be repaired if feasible and cost effective, and the needed repair is not due to negligence. A replacement hearing aid may be purchased when an individual's current hearing aid is not sufficient to meet

his/her needs due to a rapidly progressive hearing loss (See Appendix – Hearing Disabilities and Section)

2-5-5 Telecommunicative Devices – Comparable Benefits).

Rehabilitation Counselors may also approve sponsorship of a replacement hearing aid if the client meets **two or more** of the following criteria:

- A. The hearing aid is four years or older and has been properly maintained by the consumer.
- B. The client has been accepted for the purchase of one hearing aid through the TEDP Hearing Aid program.
- C. The client has been denied acceptance into the TEDP Hearing Aid program (letter must be put in the client's file).
- D. The client is working and needs a hearing aid to maintain employment (a letter from the supervisor/employer is recommended for establishing the need).
- E. The client has a documented rapidly progressive hearing loss (see Appendix – Hearing Disabilities).

For exceptions to this policy or extenuating circumstances, please contact the Chief of Policy or the Program Specialist for Deafness and Communicative Disorders.

2-16-3: Orthotics

Orthotic devices may be sponsored for clients who require such services in order to complete the rehabilitation program. A prescription from the appropriate medical specialist is required. Purchases and repairs are subject to the rates maintained in Volume V. Exceptions to these rates must be approved by the Chief of Policy. A replacement orthosis may be purchased when repairs to the existing orthosis are not feasible or cost effective. This service is subject to financial need and comparable benefits.

34 CFR 361.4; NCAC 20C Section .0303]

2-16-4: Prosthetics

Prosthetic devices may be sponsored for clients who require such services in order to complete the rehabilitation program. Purchases and repairs are subject to the rates maintained in Volume V. Exceptions to these rates must be approved by the Chief of Policy. A prescription from the appropriate medical specialist is required. Outpatient and inpatient gait training (with documented medical need) may be provided. Replacement prosthesis may be purchased when repairs to the existing prosthesis are not feasible or cost effective. Replacements, as with initial devices, must be prescribed by an appropriate medical specialist. Repairs may be recommended and prescribed by a prosthetist. This service is subject to financial need and comparable benefits.

34 CFR 361.4; NCAC 20C, Section .0303]

2-16-5: Podiatry

If the client so chooses, services from a podiatrist may be sponsored if required to complete the rehabilitation program. Podiatrists may render a diagnosis for determination of impairment. As a treatment service, this service is subject to both financial need and comparable benefits. *[NCAC 20C, Section .0303; 20D, Section 0302; 34 CFR 361.4]*

2-16-6: Visual Services

CROSS REFERENCE: Appendix Entry - Blind and Visually Impaired

Visual services may be sponsored for individuals who require such services in order to complete the rehabilitation program. This service is subject to financial need and comparable benefits. Services are subject to the rates and procedures established in Volume V. A prescription from an appropriate medical specialist is required.

[34 CFR 361.42 and 364.4]

2-16-7: Chiropractic Services

The Division may utilize the services of any legally licensed doctor of chiropractic. This service is subject to financial need and comparable benefits. The following conditions must exist:

1. The client has signs or symptoms that are considered by a chiropractor to be related to spinal subluxation, and are not shown in the general or special examination to be due to other causes;
2. The client chooses the services of a chiropractor for spinal subluxation and/or spinal manipulation; and
3. There are no contraindications to spinal manipulations imposed by disorders other than spinal subluxation.

Chiropractors may not be utilized during the assessment to determine eligibility and vocational rehabilitation needs. *[RSA-PRG-77-5; PL 92-603, Section 275 (Medicaid); G.S. 90-143 and 157.1; NCAC 20C Section .0303; 20D Section .0302]*

2-16-8: Hospitalization (Diagnostic, Inpatient and Outpatient)

Diagnostic

A hospitalization for diagnostic services is not subject to the client's financial need but is subject to comparable benefits. Counselors should be aware that any treatment service provided during the diagnostic hospitalization is subject to both financial need and comparable benefits. When questions as to whether a diagnostic procedure requires inpatient hospitalization, consultation from the unit medical consultant is required.

Inpatient

Inpatient hospitalization may be provided as part of a rehabilitation program requiring such services leading to employment. Elective hospitalizations will not be sponsored. Such services are subject to the client's financial need and comparable benefits. The unit medical consultant should be utilized when questions arise regarding length of stay.

Outpatient

Outpatient hospitalization may be provided as part of a rehabilitation program requiring such services leading to employment. Such services are subject to the client's financial need and comparable benefits. *[State Plan]*

2-16-9: Drugs and Medical Supplies (Prescription and Non-Prescription)

CROSS REFERENCE: Appendix Entry - North Carolina Division of Vocational Rehabilitation Prescription Narcotic Pain Medication Contract

Prescription and non-prescription drugs and medical supplies may be provided to meet the rehabilitation need of the client. This service is subject to financial need and comparable benefits. Drugs may be purchased when a prescription is received and there is a reason for the use of the drug recorded in the client's file. Whenever possible a copy of the prescription should also be retained. Drugs may be purchased only for those conditions directly related to the client's impairment.

Prescription

Generic prescription drugs will be purchased unless specified "dispensed as written" or in words of similar meaning. Payment is made according to the AWP (average wholesale price) plus the current Medicaid dispensing fee. There are some drugs with a maximum allowable charge (MAC) or estimated allowable charge (EAC) that have been mandated by Federal regulations. The established rates will be used for these drugs with MAC taking precedence over EAC. The Counselor, in authorizing, should specify that the generic is to be dispensed unless otherwise specified by physician. Authorizations should be issued for the estimated monthly requirement for medications. Advise pharmacist to bill on a monthly basis for all drugs dispensed in that month for that client. Request that the pharmacist include on the invoice the NCD number, drug name, strength, and amount dispensed. The charges for drugs and for dispensing must be itemized, or we cannot pay the dispensing fee.

Prescribed Over-the-Counter Drugs

These drugs will be reimbursed at the OTC charge without any dispensing fee and should be so authorized.

Non-Prescription Drugs

Non-prescription medications and supplies may be purchased upon a physician's recommendation if related to the individual's impairment, secondary restoration issue, or intercurrent illness. Authorizations should be made directly to the vendor.

[SBI6, 1977 General Assembly; 34 CFR (a)(16); 34 CFR 361.42 and 364.4; NCAC 20C, Section .0303]

VR Sponsorship of Prescription Narcotic Pain Medications

The purpose of VR sponsorship of physician prescribed narcotic pain medication is to make a client's pain more tolerable during the recovery process from physical impairments and/or to help the individual be more functional and able to participate in his/her vocational rehabilitation program. These medications have very strong addictive potential. There is the

potential for overdose if not taken as instructed by a physician. They also present significant risk for abuse and misuse.

The following guidelines must be followed by rehabilitation counselors when authorizing this service:

1. The client must sign a NCDVR Prescription Narcotic Pain Medication Contract that will be in effect for the duration of the service. **A NCDVR Prescription Narcotic Pain Medication Contract is not required for narcotic medications that are prescribed within two weeks post-surgery if the surgical procedure has been sponsored by the Division, however the other guidelines in this directive are still applicable to clients requesting sponsorship of post-surgery narcotic pain medications.**

2. All prescriptions for narcotic medications for the client must be provided by one treating physician. If the client has a history or current diagnosis of substance abuse/dependence, he/she must sign VR Consent for Release of Confidential Information Form allowing the Division to release this information regarding past or current substance abuse to the treating physician.

3. VR sponsorship of narcotic medications should not exceed a period of sixty consecutive calendar days. The one exception is that a unit manager may approve an extension of the sixty-day limit for a specified, limited, time if the client is actively being treated in a chronic pain clinic and under the medication protocols of that clinic. However, the Division is unable to purchase prescription narcotic pain medications on a long-term basis for chronic pain disorders. In these situations, efforts must be made to identify long term funding sources for the prescribed medications.

4. The treating physician will provide the vocational rehabilitation counselor with a brief treatment plan for the patient. The counselor will be notified in writing of any significant changes or amendments to this plan.

5. If the patient is referred to another physician who will become the treating physician, the patient will sign VR Consent for Confidential Information Form allowing notification of the new physician of the patient's controlled substance use.

6. VR will not authorize replacements of narcotic medications that are lost, stolen, damaged, destroyed, thrown away, etc.

7. The client must inform the treating physician and rehabilitation counselor if he/she is receiving prescriptions for narcotic pain medications from any other physician. Failure to do so will result in the Division terminating sponsorship of this service.

The treating physician should provide periodic blood or urine testing of the patient. This helps to identify patients who are using additional drugs, using excessive amounts of the prescribed drug or not using any medication at all.

2-16-10: Dental Services

CROSS REFERENCE: Appendix Entry - Dental Impairments

Treatment for dental conditions may be sponsored for those clients who require this service to complete the rehab program. This service is subject to financial need and comparable benefits. Treatment of such conditions may be necessary because of cosmetic appearance, dental caries and severe dental problems, and for orthodontic conditions. When orthodontic appliances are indicated, the teeth on which they are to be used should be in good condition, and restoration of those teeth may be necessary. Evaluation of the dental condition should be provided by the dentist of the applicant or client's choice or, in certain cases (e.g., orthodontics or oral surgery), by a specialist for the problem under consideration.

The dentist and the client must be notified prior to the examination that this Division will sponsor only that portion of the dental restoration that is essential to relieve the impairment resulting in the impediment to employment and that the client is responsible for any additional services and for any prophylactic care. The dentist must be informed that even when an estimate of the cost is submitted and an authorization issued, the amount of payment may not exceed the amount allowed by the Medicaid schedule.

[34 CFR 361.42 (a) (16); Rehabilitation Services Manual, 1519.01-1519.06; NCAC 20C, Section .0303]

2-16-11: Home Health

Home health services may be sponsored for those individuals who require this service to complete the rehab program. This service is subject to financial need and comparable benefits. Home medical treatment often helps facilitate successful vocational rehabilitation or a greater level of independence. Only Home Health agencies meeting Medicaid certification standards may be used and authorizations shall not exceed the Medicaid rate. Each agency provides skilled nursing services and physical, occupational, and speech therapy; medical social work; home health aide; orderly; or nutritional guidance.

Home health services must be authorized by a prescription for such services written by the client's physician. The type of service and the number of visits must be specified on the prescription, which is kept in the client's record. The Counselor must receive a report of the visit(s) from the Home Health Agency before the bill may be submitted to the State Office for payment.

[NCAC 20C, Section .0303]

2-16-12: Speech Therapy

Speech therapy may be sponsored for those individuals who require such services in order to overcome or reduce vocational impediments caused by speech impairment. The impediment must be severe enough to warrant therapy. Therapy must be recommended by a speech pathologist licensed to practice in this State. The following information should be included by the speech pathologist in every speech report:

1. A statement presenting the speech/language problem;
2. Case history;
3. A statement regarding the tests administered; and
4. Summary of the test results including the diagnosis, potential impact on employment, and recommendations and prognosis for speech.

This service is subject to both the individual's financial need and comparable benefits.
[State Plan-Section 9.3, House Bill 526; NCAC 20C, Section .0303; 20D, Section .0303]

2-16-13: Physical Therapy

Physical therapy services may be provided for those individuals who require this service to complete the rehab program. This service is subject to financial need and comparable benefits. Physical therapy must be prescribed by an appropriate medical specialist. The therapist must be appropriately licensed and certified.

[34 CFR (a) (16); NCAC 20C, Section .0303]

2-16-14: Occupational Therapy

Occupational therapy services may be provided for those individuals who require this service to complete the rehab program. This service is subject to financial need and comparable benefits. Occupational therapy must be prescribed by an appropriate medical specialist. The therapist must be appropriately licensed and certified. *[34 CFR (a)(16); NCAC 20C, Section .0303]*

2-16-15: Physical Capacity Assessment (PCA)/Functional Capacity Evaluation (FCE)

This assessment establishes the client's functional level and limitations in returning to work. It measures such functions as strength, maximum effort, endurance, and forms the framework for the therapeutic work hardening program. This may be conducted over a period of one to four hours. As an assessment, this service is not subject to financial eligibility; however, as many injuries requiring this service are occupational or accident related, comparable benefits may be available for use.

Section 2-5-3 Durable Medical Equipment

Durable medical equipment (DME) is that which (a) can withstand repeated use; (b) is primarily and customarily used to serve a medical purpose; (c) generally is not useful to a person in the absence of an illness or injury; and (d) is appropriate for use in the home. See DME purchasing procedures in this section for more information (Section 2-5-4).

[34 CFR 364.4; NC G.S. 143-53; NC G.S. 143-55; §1861(s) (6) of the Social Security Act]

Revised 10/1/2011

2-5-4: Procedures to Purchase Durable Medical Equipment

A prescription is required to purchase durable medical equipment and must be included with the authorization or purchase order and specifications to the vendor. For purchase of Durable Medical Equipment that is on a State Term Contract, the Rehabilitation Counselor must purchase the equipment using the established rate, or in the absence of such, the Medicaid rate. The normal bidding process does not apply since the Division is limited to paying a fixed rate. Approval by the Chief of Policy is not required when purchasing Durable Medical Equipment costing \$2501.00 or greater on State Term Contract or when using an established Medicaid rate. The Counselor issues the authorization to a State Term Contract vendor or, with justification approved by the Unit Manager, a vendor outside of the State term contract process that accepts the State Term Contract or Medicaid rate, whichever is greater.

Moreover, purchase of Durable Medical Equipment from a State contract vendor is required when the specific item is available through this means. If equipment is not available through the State Term Contract, or justification for purchasing outside of the State contract is approved by the Unit Manager, the counselor in partnership with the client selects a reputable dealer and issues authorization for the item using the established State Term Contract rate, or in the absence of such, the Medicaid rate (In some instances, State contract rates are negotiated at a slightly higher rate than the established Medicaid rate).

Comparable benefits must be utilized when available in the purchase of Durable Medical Equipment.

The following procedures apply to the purchase of Durable Medical Equipment that does not have an established Medicaid rate or State Term Contract rate:

Durable Medical Equipment Without an Established Medicaid Rate Costing \$2501.00 or more (Wheelchairs, Scooters, etc.)

1. A prescription is required in order to purchase.
2. Comparable benefits must be utilized when available.
3. The Unit Manager reviews and provides initial approval for the request for purchase of equipment.
4. If the UM approves, the request is forwarded to the Chief of Policy for final review and approval. If approved, the Chief of Policy, in consultation with the Fiscal Services and Purchasing Sections, will determine the rate of payment and method of purchase.

Durable Medical Equipment Without an Established Medicaid Rate Costing \$2500.00 or less:

1. A prescription is required in order to purchase.
2. Comparable Benefits must be utilized when available.
3. The Unit Manager reviews and approves the requests for purchases greater than \$500.00.
4. The Rehabilitation Counselor contacts Fiscal Services (<mailto:dvr.m.fiscalservices@dhhs.nc.gov>) for consultation on setting the rate of payment.
5. The Rehabilitation Counselor issues the authorization for the Durable Medical Equipment.

For all other Durable Medical Equipment and Medical Equipment, the Medicaid rate or the Division's set rate will be paid. If there is no rate, contact Fiscal Services (dvr.m.fiscalservices@dhhs.nc.gov) for clarification of the Medicaid rate or for the Division's set rate.

2-5-5: Telecommunicative Devices

The Division will evaluate the needs of all eligible sensory impaired clients for telecommunications, sensory, and other technological aids and devices. These services include the widest range of electronic or assistive listening devices that are available and have demonstrated an ability to aid a person's chances of going to work or living more independently. Assistive listening devices include hardware devices, FM systems, loops, infrared devices, direct audio input hearing aids, telephone aids and speech assistance devices. Such services are subject to an individual's financial need and comparable benefits, when available. Individuals needing telecommunication systems and devices should be referred to the Assistive Technology Consultant for the Deaf who will contact and involve appropriate Division resources and vendors prior to assessing client need and making recommendations. The counselor should submit an authorization to the North Carolina Assistive Technology Program for services rendered. Contact the North Carolina Assistive Technology staff for rates.

Requirements for purchasing such devices are as follows:

A. The client must have a telephone or be able to afford the cost of telephone installation, monthly bill and maintenance in order to receive assistance with assistive devices requiring a telephone.

B. Text Telephones-Teletypewriters (TTYs) and other assistive devices are registered with property control if they cost \$500 or more. The client must sign *Form DVR-1015 - Acknowledgment/Equipment Security Agreement* for any equipment costing \$500 or more indicating that the device remains the property of the Division for a period of five years from the date of purchase and that the device must be used as indicated in the IPE. The Division will maintain ownership of all assistive listening devices, and will repossess all assistive devices if the client discontinues their use as outlined in the IPE.

Assistive Listening Devices for Students in Post-secondary Education

The Division can encourage educational institutions to provide assistive listening devices for students who are deaf and hard of hearing. Most students who use a hearing aid have difficulty understanding speech due to background noise. Hearing aids have a tendency to enhance all sounds at the same time, thereby drowning out the sounds of speech.

Several amplification systems are available to improve hearing ability in large areas, such as lecture halls and auditoriums, as well as in interpersonal situations (group discussions, and instructor conferences). These systems work by delivering the speaker's voice directly to the ear (with or without personal hearing aids), thus overcoming the negative effects of noise, distance, and echo, thereby improving understanding ability. It is the educational institution's responsibility to provide these large FM systems.

Assistive listening devices for students in post-secondary educational programs should not be purchased without the recommendation of the Assistive Technology Consultant for the Deaf and counselor documentation that such a system is not available from the educational institution for use by the student. The Counselor should submit an authorization to the North

Carolina Assistive Technology Program for services rendered. Contact the North Carolina Assistive Technology staff for rates.

The Assistive Technology Consultant for the Deaf will contact the client, the postsecondary institution, and involve appropriate vendors prior to making recommendations. Equipment may be purchased under the following conditions:

A. The device is required for the student to achieve the academic goal and is part of the IPE;
AND

B. The device is mobile and can be used in a work environment after obtaining the degree.

Comparable Benefits

The Division of Services for the Deaf and Hard of Hearing has the Equipment Distribution Service, which provides access to telecommunications devices for people who are Deaf, Hard of Hearing, Deaf-Blind, and Speech Impaired but whom have difficulty affording these devices. The Equipment Distribution Service Hearing Aid Program provides one hearing aid that allows individuals with hearing loss to communicate on the telephone using a hearing aid telecoil (T-coil). The goal is to provide equal access through the telephone system and Relay Service. Devices are free to qualified individuals. Types of Devices Available Through the Equipment Distribution Service:

- TTY
- Loud Ringers
- Volume Amplifiers
- Large Visual Displays
- Artificial Larynx
- Stutter Inhibitors
- Light Phone Signalers
- Other

Types of Hearing Aids Available Through the Equipment Distribution Service Hearing Aid Program: (one hearing aid per person)

- Digital Hearing Aid
- Analog Hearing Aid
- Behind-the-Ear Hearing Aid
- In-the-Ear Hearing Aid

To apply, contact one of the following sources:

- Division of Services for the Deaf and Hard of Hearing in Raleigh
- Regional Resources Center in your area
- Rehabilitation Counselor for the Deaf in your area

Processing Invoices [Section 1-11]

ADDITIONAL INFORMATION REQUIRED ON INVOICES:

ANESTHESIA INVOICES: Must include length of time the service lasted, in the Description of Service portion of the bill.

DENTAL INVOICES: Require the same information as medical claims, but the procedure codes are paid according to American Dental Association (ADA) codes. Preventive procedures, as noted in Volume V of the Reference Library, should not be authorized: if invoiced without adequate justification, these procedures will not be considered for payment.

EYEGLOSS INVOICES: Eyeglasses Ordering/Claim Forms require much the same information as a medical claim but the amounts paid are according to rates established by a contract entered into between DHR and a selected vendor. The optometrist or ophthalmologist should complete and sign this form. Detailed instructions for the purchase and payment of eyeglasses are on the reverse side of each page of the form DVR-0199.

HOSPITAL INVOICES: For inpatient and outpatient services shall be submitted on the hospital's billing form and are graded at the Medicaid rate according to the rate effective on the date of discharge. A copy of the authorization must be attached to the invoice since dates of service are verified against the authorization. If the invoice has a beginning date prior to the effective date of the authorization, the invoice will be returned to the counselor for verification/correction. Invoices extending three days beyond the number of days authorized will be returned to the counselor for review and explanation. Hospitals can bill the client for any days not covered by the Division of Vocational Rehabilitation, but cannot bill the client for additional monies for days and services authorized by the DVR. Hospitals also cannot bill the client for remaining balances from payments made on services covered. Although inpatient and outpatient services can be authorized as separate line items on the same R2, inpatient services cannot be invoiced against an outpatient authorized line item. Physician services being billed by the hospital must be billed on the physician's invoice with a complete description of the service. Reports will be requested for clarification purposes. Payments for physician services cannot be made unless these services are specified on the authorization. For example, physician charges cannot be paid from an outpatient service line item on the authorization. These charges must be specified as a separate line item on the authorization.

MEDICAL INVOICES: At this time, only a Current Procedural Terminology (CPT) code is required to determine appropriate payment. If a code is not allowed or there is no listed rate, a report may be requested for grading purposes. Additional supporting information may sometimes be requested to confirm or assure proper payment. Preventive procedures will be removed from the invoice unless appropriate justification is received. Counselors and/or managers must keep medical service providers current on the Division's payment policies in order to help prevent misunderstandings.

PHARMACY INVOICES: The Division changed its billing procedure for pharmacies, effective 03/15/06, to conform to the standard form and process already utilized by NC Department of Public Health. Invoices must have the prescription number, the brand or generic name, the National Drug Code (NDC) number, strength, the concentration of drug per unit, the quantity of drug dispensed (e.g., number of tabs, caps ml, cc. oz.), the date the prescription order was

actually filled and amount billed for each drug. The prescription drug-dispensing fee will be based on brand (b) or generic (g) which are required fields on the invoice form. The pharmacy invoice form is on the automated case management system. Drug bills should be submitted to Case Service Accounting on a monthly basis to assure dispensing fees are paid only once per month per drug purchased. Dispensing fees are established by Medicaid and will not be paid unless listed separately on the invoice. Over-the-counter drugs are paid at over-the-counter prices with no dispensing fee allowed even if a prescription is written. Generic rates will be paid unless the physician writes "Dispense as Written" on the prescription order. This is a Medicaid rule. If a physician simply signs under or checks an identified heading, marking a specific block, or any other method, it will not be allowed by Medicaid policy or VR policy and the generic equivalent fee will be paid. Overpays must be approved as stated earlier in this policy.

PROSTHETIC AND ORTHOTIC INVOICES: Should be itemized with a complete description of the service provided and coded according to fee schedules found in Volume V. Fees for items not found in the fee schedule should receive prior approval as specified in those policies.

INVOICES FOR SERVICES PROVIDED AFTER JULY 1, 1991 MUST INCLUDE THE CLIENT'S DATE OF BIRTH as the fees are different.

SPEECH THERAPY INVOICES: Must include length of each session and number of sessions.

PSYCHOLOGICAL SERVICES INVOICES: Must indicate the assessment level as specified in Volume V. Psychotherapy invoices must include the number of sessions and the length of each session. Neuropsychological invoices must reflect the amount of time and be within the limits stated in Volume V. All invoices submitted by psychologists are reviewed to assure the providers are on the Approved Panel of Psychologists and to determine if they are listed as a dual employment provider. If appropriate, a CP-30 Dual Employment form must be completed, signed and attached to the invoice. The authorizing counselor signs the form as the Division representative.

SURGICAL ASSISTANT AND FREESTANDING SURGICAL FACILITY INVOICES: Cannot be paid until the surgical invoice is processed. The authorization number for the related surgery should be recorded under Description of Service portion on the surgical assistant or facility invoice.

III. ASSISTIVE TECHNOLOGY DEVICES AND SERVICES

Rehabilitation Technology includes but is not limited to assistive technology devices; repair, customizing, adapting or maintaining assistive technology devices; coordinating and using other therapies and interventions with assistive technology; training and technical assistance to clients, family members, employers, other agencies or rehabilitation professionals and modifications to vehicle, home, or worksite. As one of the VR *Core* services, assistance with rehabilitation technology becomes a substantial rehabilitation service when it is provided within the supportive counseling and guidance relationship. [Section 2-17]

2-17-1: Rehabilitation Engineering

The term "rehabilitation engineering" means: the systematic application of technologies, engineering methodologies or scientific principles to meet the needs of and address the

barriers confronted by individuals with disabilities in areas which include rehabilitation, education, employment, transportation, independent living and recreation." Applicants and clients who are in need of and can benefit from rehabilitation engineering services and devices should be referred to the Rehabilitation Engineer. This includes services and devices which can supplement and enhance individual functions such as adapted computer access, augmentative communication, special seating and mobility, vehicle modifications, and services which can have an impact on the environment, such as accessibility, job re-design, work site modification and residence modification. Other requirements are noted in specific policy statements elsewhere in this manual. Application of engineering services and technologies is important when making determinations of eligibility particularly for individuals with severe impairments. A rehabilitation engineering evaluation is not subject to an individual's financial need; however, devices, equipment and modifications recommended by the engineer are subject to financial need. Federal regulations stipulate that rehabilitation engineering services can be provided without consideration of comparable benefits. However, where rehabilitation engineering services are readily available to the individual from other sources, they should be used.

[34 CFR 361.32; the 1992 Amendments to the Rehabilitation Act of 1973, Sec. 103 (13); 34 CFR 364.4; NCAC 20C, Section .0315]

2-17-2: Assistive Technology Devices

An assistive technology device is 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 functional capacities of individuals with disabilities. The provision of this service is subject to the individual's financial need and comparable benefits.

[The 1992 Amendments to the Rehabilitation Act of 1973, Sec. 103 (13); 34 CFR 364.4]

2-17-3: Assistive Technology Services

This service is defined as any service that directly assists an individual with a disability in the selection, acquisition, or use of an assistive technology device. The provision of this service is subject to the individual's financial need but not comparable benefits.

Purchase of Equipment [Section 2-5]

These services involve the provision of all equipment required for the Individualized Plan for Employment (IPE) including devices or durable medical equipment such as TTYs, wheelchairs, Hoyer lifts, or assistance to obtain these services from other sources. The Rehabilitation Engineer must be involved if the equipment is to be modified to accommodate the individual's disability. Such services are subject to both financial needs criteria and comparable benefits.

Equipment may be purchased under the following conditions:

- A. The client has the knowledge to use or can be trained to use the equipment;
- B. The equipment is required to meet the client's employment goal or is required to complete a specific training curriculum planned on the IPE in which the client is enrolled and making satisfactory progress towards successful completion of the program; AND

C. The client has the resources to safely store, insure, and adequately maintain the equipment as documented by client signature on *DVR-1015*. This security agreement will remain in effect until the Division, at the Unit Manager's request, dissolves the agreement. Such request should not be made until the equipment has been used for at least 5 years or unless unusual circumstances necessitate release of Equipment. If available items are not suitable for the individual rehabilitation need, the State term contracts must be considered for purchasing if the item costs more than \$100.00 or exceeds the cost of the minimum order of the State term contract. If the item needed is not available on a State term contract or if purchase outside the State term contract is justifiable, utilize the informal bid (quotations) procedure described in this section.

[G.S.148-7; G.S. 143-55]

2-5-1: Purchase of Equipment

All equipment that costs more than \$100.00 or that exceeds the cost of the minimum order for the State term contract must be purchased from mandatory State term contracts unless there is a valid justification (See purchasing procedures in 2-5-6). Equipment is any equipment required by the individual for employment or training purposes. The purchase of equipment is subject to the financial needs criteria and comparable benefits, when available. Firearms will not be purchased for any reason. Equipment cannot be purchased to enhance a client's leisure activity or hobby unless such equipment is required to enhance an individual's independent living goals and is purchased by the IL program. The Rehabilitation Engineer must be involved if either the equipment or the workspace is to be modified to accommodate the individual's disability. The purchase of equipment must be part of the client's IPE. Each client receiving equipment that costs more than \$500 will be required to sign FORM DVR-1015 – Acknowledgement/Equipment Security Agreement indicating Division ownership and lien information. All equipment remains the property of the Division until such time as it is released by the Division. Equipment should not be used by Division staff for their personal use nor stored at the private residence of Division employees. Available repossessed equipment from the

TRAINING AND PLACEMENT

EQUIPMENT LIST will be considered before buying new equipment.

Assistive Technology may be purchased for individuals who require adaptive software, hardware, augmentative communication, environmental controls, voice recognition, or equivalent adaptive input devices when they are absolutely required for the individual to access or participate in a post-secondary training program. This service is subject to financial need. The Counselor, Rehabilitation Engineer, or Assistive Technologist should individually assess the client's need for assistive technology. Adequate planning should be provided to ensure that any computer model owned or purchased is fully compatible with the adaptive software or assistive devices required. The Chief of Policy must approve the purchase of assistive technology to support an individual's participation in training. Counselors should refer to section 2-5-6 for purchasing procedures. [Section 2-5-2]

Computers and assistive technology such as adaptive software, hardware, augmentative communication, environmental controls, voice recognition, or equivalent adaptive input devices may be purchased when they are absolutely required for the individual to access or participate in his/her rehabilitation program according to the conditions listed above. This service is subject to financial need. The client's need for assistive technology should be individually assessed by the Counselor and Rehabilitation Engineer or Assistive Technologist. Adequate planning should be provided to ensure that there is compatibility between all system components. The Chief of Policy must approve the assistive technology requested to support an individual's job goal. The Counselor should refer to Section 2-5-6 for the purchasing procedures for purchasing computers, adaptive software, adaptive hardware, or adaptive devices required for job placement. [Section 2-5-2]

Processing Invoices [Section 1-11]

Technological aids and devices invoices. For prosthesis and orthotics must not exceed allowable rates as specified in Volume V. Invoices for environmental control units, augmentative communication devices, etc., must be accompanied by an itemized list of items purchased.

Repossession of Purchased Equipment [Section 1-10]

The counselor should repossess equipment purchased for clients when the equipment is not being used for the intended purpose and it is unlikely that the equipment will be used for such in the foreseeable future or for reasons as specified on the DVR-1015. When equipment costing more than \$500 is repossessed, the Counselor should consult with the Purchasing Manager on disposal of the equipment and arrangements for storage. In some cases, repossessed equipment may be of use to another client. The equipment should be safely stored until reassignment is made. In other situations, equipment may not be feasibly transferred to another client because of the customization or general condition of the equipment. The Purchasing Manager can advise on the disposition of equipment in such cases. If necessary, the Unit Manager may designate staff to pick up and safely transport repossessed equipment to another location. The Unit Manager should arrange for the transportation of equipment items that staff cannot safely move by contacting the Assistant Regional Director. Repossessed equipment that might be of use to another client may be stored locally or in a regional storage area or in the purchasing section of the State office. If such storage space is not available, the Purchasing Manager and/or Assistant Regional Director should be consulted regarding other options for storage of the equipment.

IV. PERSONAL ASSISTANCE SERVICES

Personal Assistance Services [Section 2-15]

Personal assistance is hands on assistance with two (2) or more major activities of daily living (ADL). The Division shall not sponsor chore worker or housekeeping services as a sole service.

Housekeeping or chore worker services shall be secondary to the hands on ADL activities and shall not be the only assistance that is needed. ADL tasks are basic daily living activities that must be performed to assure or support one's physical well-being. Examples of the major ADL activities include body/oral hygiene, bathing, toileting, dressing, grooming, eating, transferring, and moving about as needed in the environment. Housekeeping and chore worker activities involve basic activities that help to provide a safe and healthy living environment and promote community inclusion. Examples include cleaning, laundry, preparing meals, shopping, bookwork, and transportation. Workers that provide ADL and housekeeping/chore worker services do not require any State licensure or certifications.

2-15-1: Vocational Rehabilitation Program

Personal assistance services may be sponsored at any time during the rehabilitation process to enable clients to fully participate in the assessment for determining eligibility and vocational rehabilitation needs, planning, service provision, and employment. It is a support service that can only be provided in relation to and in support of another vocational rehabilitation service. Sponsorship of this service is not intended to supplant services traditionally provided by the client's family. Personal assistance services are not subject to financial need, but comparable benefits must be utilized when available. Under no circumstance shall the Division sponsor co-pays for personal assistance if the client is utilizing Medicaid or another similar benefit to acquire personal assistance. Personal assistance can be provided by establishing the VR client as a household employer or by authorizing to Home Health agencies or medical service organizations. When home health care agencies are utilized, the Division shall authorize payment directly to the home health care vendor, and a concurrent case with IL is not opened. **The VR counselor cannot authorize greater than 28 hours per week for personal assistance. Requests to exceed 28 hours per week shall be submitted to the Unit Manager.**

Criteria

In order for a VR client to receive personal assistance services, the individual must be eligible for VR services and determined to be either SD or MSD based on a physical disability with functional limitations in the areas of self-care and/or mobility. The individual must require personal assistance services (PAS) in support of one or more of the CORE VR services planned on the Individualized Plan for Employment (IPE).

Concurrent Records of Service

When the counselor and VR client elect to pursue personal assistance by establishing the client as a household employer, the client will have a dual VR/IL case with IL providing the personal assistance services for the individual. The funding for the PAS will come from VR case service funds. For purposes of opening an IL case, the IL Counselor will utilize the eligibility determination made by VR as the basis for IL eligibility (in lieu of the standard IL eligibility decision) and development of the Individualized Plan for Independent Living (IPIL). No IL funded services will be provided in these cases because all services will be coordinated and funded by the VR case.

Transition of Personal Assistance and Personal Assistance in a Post-Employment Plan

During the comprehensive assessment, the VR Counselor shall consider factors related to the transitioning of personal assistance services. In cases where personal assistance is needed to support training, the counselor shall discuss and document a client's stated needs related to transitions such as school breaks, completion of training, beginning a job search, and job placement. In cases where personal assistance is needed in support of job placement, the Counselor shall discuss and document any stated needs related to post-employment personal assistance services. This includes a discussion of comparable benefits, including the client's ability to private pay using the client's earned income. When referring a client to IL for coordination of personal assistance, the VR Counselor shall notify the IL counselor of the client's stated needs as related to transitions in personal assistance services so that the IL Counselor may effectively consider the service as part of a plan for independent living. Communication and coordination shall continue throughout service provision regarding personal assistance transitions.

At the point in which the client has achieved all other requirements for a successful employment outcome other than the termination of personal assistance services, the VR Counselor shall coordinate with the IL Counselor to determine whether the client is likely to meet the IL program's financial eligibility to continue personal assistance. If it is unlikely that the individual will qualify for this or other comparable benefits, the VR Counselor may continue to refer the client to the IL program for personal assistance coordination to be paid for out of VR case service funds as part of a VR post-employment plan.

In concurrent records of service,

The VR counselor will:

1. Identify that personal assistance service may be needed for the individual to complete their Individualized Plan for Employment (IPE).
2. Contact the IL Office to staff the case with the IL counselor covering that geographical area where the individual will be receiving the personal assistance service.
3. Notify the client that the IL program will complete an Assessment of the Individual's Personal Assistance Needs and coordinate personal assistance services.
4. Grant full CATS access for the VR case to the appropriate IL staff and provide copies of the VR eligibility decision, SD/MSD documentation, supporting medical documentation, and information related to any transitions required for personal assistance services.
5. Upon the IL counselor's completion of the Assessment of the Individual's Personal Assistant Needs, update the IPE to indicate that the personal assistance service is coordinated by the IL program and is funded by VR. The IPE should include the statement —Personal assistance service that is funded by VR, will be terminated when the VR case is closed.

The IL counselor will:

1. Take an IL application

2. Complete the eligibility decision using, to the extent possible, preliminary assessment data from the VR case file. The IL counselor will obtain from VR the:

- (a) VR eligibility decision
- (b) SD/MSD documentation
- (c) Supporting medical documentation
- (d) DVR-0116 or verification that client is an SSI/SSDI recipient

3. Complete an IPIL outlining the services. Minimum jointly agreed upon services on the IL plan should include:

- (a) Guidance and counseling provided by IL.
- (b) Number of personal assistance service hours and rate of pay with VR Funded as Comparable benefit.
- (c) Include the statement on the IPIL —Personal assistance service that is funded by VR will be terminated when the VR case is closed.

4. Issue the authorization for personal assistance service on the State fiscal year **from VR case using RCC 1281 / CS code T27**. The R2 is maintained in the IL case file until the case is closed.

5. Enter the VR information into the —Client Data Entry Screen using the VR icon. The IL staff will key in the VR number, VR caseload number, VR counselor code number, vendor number, client ID number, select the IL office code, and the RCC 1281 will be filled in automatically. This information and the CS code T27 will print onto the case service invoice. The case service invoice should be printed on green paper for VR and the IL counselor will sign the case service invoice.

6. Keep the IL case open for the duration of IL coordinated personal assistance services.

7. Maintain all fiscal information (R2, case service invoices, timesheets, receipts for paying personal assistant(s) and Federal/State taxes) in the IL case file until the IL case is closed. At that time, a copy of this information will be provided to the VR counselor so that this information is maintained in the VR case, in keeping with the record retention schedule.

2-15-2: Suspension and Termination from Personal Assistance Services

All incidences of Client non-compliance with personal assistance policies shall be documented in the case record.

Individuals shall be suspended from receiving personal assistance for any of the following reasons:

- A. Evidence of misuse of funds and/or use of funds for purposes other than personal assistance. Examples of misuse include not paying the assistant(s), not paying the Federal/State mandated employer taxes, falsifying *Form DVR-1019 Record of Personal*

Assistant Hours, misrepresenting personal assistance needs, or paying other bills with these funds;

B. Failure to have a checking account to be used only for personal assistance transactions, making transactions in cash, or not keeping copies of personal assistance records;

C. Failure to cooperate with program staff in efforts to implement policy and procedures; AND

D. Refusal to sign or conform to the *Form DVR-1021 Personal Assistance Services and Reimbursement Agreement*.

Upon suspension, the Counselor shall contact the IL Program Specialist who will collaborate with the Chief of Policy to identify strategies to be included in a corrective plan for the particular incident of non-compliance. The Counselor shall partner with the client to develop the steps and timeframes required to be included in the corrective action plan. The corrective action plan shall be documented in the case record. The Division shall not reimburse the client for any personal assistance services provided during the period of suspension. The Counselor shall document the progress of the client in completing the corrective action plan in the case record. The Division shall resume service provision upon completion of the corrective action plan **within** the specified timeframe. Individuals shall be terminated from receiving personal assistance for any of the following reasons:

- Financial gains to the point that the client can pay the full cost of personal assistance needs as documented by *Form DVR-0116 Financial Statement*
- Significant change in the disabling condition, as determined by the personal assistance evaluation, which eliminates the need for this service
- Completion of the Individualized Plan for Independent Living (IPIL), unless personal assistance is negotiated as an IL post-outcome service
- Identification of a comparable benefit (e.g., CAP-DA, Medicaid, Division of Aging) for this service in a manner compatible with the IL goal
- Relocation out-of-State unless approved by the DVR Chief of Policy
- Death or incapacitation that requires institutionalization
- Insufficient case service funds
- Failure to complete the corrective action plan in the specified timeframe
- Continued and repeated incidences of noncompliance that have resulted in two (2) or more suspensions within a two (2) year period of time

The suspension and termination decision must be made in partnership with the client. In cases of death or institutionalization when no executor, Power of Attorney, or guardian exists, the Counselor shall contact the Chief of Policy, who can advise on final payment procedures. Should the client disagree with the Division's decision to suspend or terminate personal assistance services due to a breach in the personal assistance agreement, then the counselor must inform the client of the Division's administrative review and appeals process. Record of service documentation is required when personal assistance is suspended or terminated.

Processing Invoices [Section 1-11]

Attendant Care/Personal Assistance Services Invoices. Must be accompanied by time sheets for invoiced period.

V. COMPARABLE BENEFITS AND SERVICES [Section 3-11-3]

The Division will provide rehabilitation services only when such services are not available from some other source as a comparable benefit or service. Comparable benefits are to be investigated and used for all rehabilitation services except those noted in Chapter 2 in this manual. This paragraph contains examples of comparable benefits; others may be available and must be considered. Comparable benefits must be recorded on the IPE/IPIL under the COMPARABLE BENEFITS section. **By marking —none, the rehabilitation counselor signifies that comparable benefits have been investigated but are not available for the stated service.** Comparable benefits must also be added to the IPE/IPIL whenever new services are added.

[34 CFR 361.53; State Plan Section 6.11; Comparable Benefits: 10 NCAC 20C .0204]

Medicaid

The Division cannot supplant resources available through Medicaid. Therefore, Medicaid eligibility must be verified at the time of application and throughout the rehabilitation process. When appropriate, the counselor should refer the applicant or client to the local DSS for determination of eligibility. Medicaid may continue for SSI recipients who are disabled and earn over the SSI limits if they cannot afford similar medical care and depend on Medicaid in order to work. A threshold test and Medicaid use test will be applied to the individual situation to determine continuation of Medicaid eligibility (1619B). The Division, regardless of the individual's financial need, cannot authorize Medicaid deductibles. If the client meets financial need but has a deductible and is unable to meet the deductible thus jeopardizing the ultimate rehabilitation goal, the counselor may elect to sponsor the necessary medical services without Medicaid as a comparable benefit. The rationale for sponsoring necessary medical services without utilizing Medicaid is required in the case record. If the counselor determines that the client can meet the deductible, the Division will not contribute toward the cost of the medical services. Individuals who qualify for Medicaid because they are eligible for SSI are not subject to a spend-down.

Medicare

Medicare is an available comparable benefit for those individuals who meet the eligibility requirements for this program.

Health Insurance

Medical and related health insurance should always be used for any service applicable to the benefit. The counselor must assure that the vendor or the client pursues this benefit prior to

payment for a rehabilitation service. Insurance paid directly to the individual must be used to offset Division payments, and the counselor must complete a SUBROGATION RIGHTS-ASSIGNMENT OF REIMBURSEMENT FORM.

Workers' Compensation

If Workers' Compensation benefits are available, such benefits must be used prior to the expenditure of Division funds. If Workers' Compensation eligibility is pending or if there is an undue delay in service provision necessary for rehabilitation, the counselor may authorize services if Subrogation Rights: Assignment of Reimbursement form has been completed. (See section 1-18)

Children's Special Health Services

Individuals 21 years old or younger who require medical and related support services, including equipment needed for medical reasons, should apply for services from this resource. More information can be obtained at <http://www.dhhs.state.nc.us> [See section for children and youth]

Comparable Benefits for Equipment Purchases [Section 2-5]

Comparable benefits must be utilized when available in the purchase of Durable Medical Equipment. [Section 2-5-4]

Assistive listening devices include hardware devices, FM systems, loops, infra-red devices, direct audio input hearing aids, telephone aids and speech assistance devices. Such services are subject to an individual's financial need and comparable benefits, when available.

Comparable Benefits

The Division of Services for the Deaf and Hard of Hearing has the Equipment Distribution Service, which provides access to telecommunications devices for people who are Deaf, Hard of Hearing, Deaf-Blind, and Speech Impaired but whom have difficulty affording these devices. The Equipment Distribution Service Hearing Aid Program provides one hearing aid that allows individuals with hearing loss to communicate on the telephone using a hearing aid telecoil (T-coil). The goal is to provide equal access through the telephone system and Relay Service. Devices are free to qualified individuals. [Section 2-5-5]

Invoice Processing

COMPARABLE BENEFITS: When comparable benefits are listed on the authorization form, they must be clearly addressed on the invoice. Because of the variety of invoice forms received, there is no single area for comparable benefits to be noted. For example, if medical insurance is listed on the authorization as a comparable benefit, the counselor must indicate either the amount of the payment and specify the procedure(s) for which the payment is to be applied towards, or indicate denial of benefit. The insurance denial letter or payment stub must be forwarded with the invoice. If a legal settlement is pending, the counselor shall review the

financial situation with the attorney and advise the State office of the current status of the legal action when submitting the invoice for payment. An Assignment of Reimbursement should be attached to the invoice, when appropriate, in order to expedite the payment process. If Medicare is the comparable benefit, a copy of the Explanation of Benefit (EOB) is required prior to payment. Diagnostic or treatment invoices for cancer must indicate eligibility/ineligibility for the Division of Health Services Cancer Control Project. Division funds cannot be used to complement or supplement a comparable benefit that pays at the Medicaid rate. If a comparable benefit pays more than the allowable State established rate, the Division is unable to contribute any payment towards the cost of the service. Invoices with Medicaid as the comparable benefit should not be forwarded for processing until Medicaid status is ascertained. [Section 1-11]

VI. COST SHARING; THIRD PARTY PAYEE [Section 3-11 Financial Need and Client Resources]

3-11-1: Financial Statement

The scope of rehabilitation services available to an individual is determined by the services required by that individual in order to reach the VR or IL goal. All services provided must be directly related to the achievement of the goal established in concert between the client/participant and Rehabilitation Counselor. For both VR and IL, financial need must be established prior to the planning and provision of any service subject to the financial needs test. The determination of financial needs is not applicable nor is completion of the Financial Statement necessary for the following services (unless otherwise specified, comparable benefits apply but would be addressed on the IPE, not on the Financial Statement):

- Assessment (regardless of case status) *
- Guidance and counseling (*not subject to comparable benefits*)
- Core Services sponsored by IL (*IL Skills Training only when provided by IL program staff*)
- Consultation and technical assistance provided by Rehabilitation Engineers (*not subject to comparable benefits*)
- Recreation Therapy provided by IL staff
- Referral and collaborative efforts with other agencies
- Community Based Assessment
- Job Related Services (*not subject to comparable benefits*)
 - Job development,
 - Placement,
 - Job retention,
 - Follow along
 - In-school work experience/adjustment
- Personal Assistance services sponsored by VR
- Driver's Evaluation
- Foreign Language Interpreter/Translator
- Interpreter Services (*Sign Language and Oral*)
- Reader Services

- Notetakers
- Supported Employment Services
- Work Adjustment Job Coaching (*not subject to comparable benefits*)
- Employment Marketing Skills Training (*not subject to comparable benefits*)

****Assessment includes any diagnostic/evaluative services provided:***

- ***For the purpose of diagnosing or clarifying impairments (including secondary restoration issues) in applicant status (status 02 for VR, status 52 for IL), |***
- ***As part of the VR comprehensive assessment (status 10), or IL needs assessment (status 60) for the purpose of determining rehabilitation needs,***
- ***In the service delivery statuses for either VR (status 12), or IL (statuses 62, 64, 66) for the purpose of further diagnosing, clarifying, or establishing treatment/rehabilitation needs for a primary/secondary impairment, or inter-current illness***
- ***In VR post-employment (status 32), or IL post-outcome (status 82)***

In cases in which the IPE/IPIL consists entirely of services from the above list (not subject to financial need), it would not be necessary to have a completed Financial Statement in the case file. The counselor only addresses the appropriate financial need category (covered below) on the automated case management system's financial statement screen. Determination of financial need is required and the Financial Statement must be completed for the following services. Additionally, comparable benefits apply unless specified otherwise.

1. Assistive Devices/Equipment

- Durable Medical Equipment
- Training, Placement, IL Equipment
- Tele-communicative Devices
- Equipment Repairs

2. Day Care

3. Driver's Training

4. Residence Modifications

5. Purchase of Furniture and Appliances

6. Maintenance

7. Mental Restoration/Psychotherapy

8. Other Goods and Services

9. Personal Assistance Services sponsored by IL

10. Physical Restoration (hearing aids, orthotics, prosthetics, podiatry, visual services, surgical assistants, work hardening, chiropractic services, intercurrent illness, hospitalization treatment only, drugs and medical supplies, dental services, home health, speech therapy, physical therapy, occupational therapy)

11. Recreational and Social Services not provided by IL staff

12. Assistive Technology Services (*not subject to comparable benefits*)

13. Vehicle and Worksite Modifications

14. Services to Family Members

15. Small Business Operations

16. Training (except for work adjustment job coaching, supported employment training, employment marketing skills training, and in-school work experience/adjustment)
17. Tutors
18. Transportation (*unless in conjunction with an assessment service*)
19. Contribution Towards Vehicle Purchase
20. Purchase of Vehicle Insurance
21. Sponsorship of Vehicle Repairs
22. IL Skills Training unless provided by IL program staff members

If services subject to the financial needs test are being provided, the counselor must continuously monitor financial need throughout the rehabilitation process with changes documented appropriately. Check stubs, State and Federal income tax forms and other information must be requested to document income or other financial resources. Counselors are required to request this information routinely when services requiring financial need are being planned or provided. Copies of the documents used for verification must be in the case record. If the individual does not have tax returns or check stubs, they will complete a verification form signed by their last employer, the individual who supports them, or the agency representative who processes the individual's public support. A letter from the agency, hospital or individual who can verify income status is an acceptable form of verification. Financial Needs Worksheet A should be completed and document the income of all applicable family members. Income documented on Financial Needs Worksheet A can include: wages, SSI/SSDI (for other family members), pensions, commodities sold and other type's income including interest, stock, inheritances, etc. Worksheet B should be completed if tax returns are used to document income. Whenever the financial situation of the individual is unclear, the counselor will consult with the Unit Manager/Facility Director who must approve exceptions.

DETERMINATION OF FINANCIAL NEED CATEGORY: Prior to completion of the IPE or IPIL, one of the following financial need categories must be selected on the automated case management system. Additionally, the following description of the categories provides instructions regarding:

- The sections to be completed on the Financial Statement for each category
- When it is necessary to print the completed Financial Statement for signatures and placement in the case file
- When Unit Manager/Facility Director approval is necessary

A. Yes-Financial Needs Test Met: Financial need is established to receive services subject to the financial needs test. Sections A - E are completed. The DVR 0116 Financial Statement must be printed for signatures and placed in the case record.

B. No-Financial Needs Test is Not Met: The client's excess resources exceed the cost of the rehabilitation program. Sections A-G are completed. The Division will not authorize or sponsor any services subject to the financial needs test. The Financial Statement must be printed, with appropriate signatures and placed in the case record.

C. Not Applicable: Services planned are not subject to meeting the financial needs test. It is not necessary to complete any sections on the form, print the form, or obtain any signatures.

D. SSI/SSDI

· For Vocational Rehabilitation services, SSI/SSDI recipients are exempt from the financial needs test. Verification of the client's eligibility for disability benefits is required. It is not necessary to complete any sections on the form, print the form, or obtain any signatures. In selecting this category, the counselor certifies that the SSI/SSDI recipient does not have a comparable benefit to apply to the rehabilitation program; otherwise, category 6 must be selected. For Independent Living Services, SSI/SSDI recipients are subject to a financial needs test. **This category is not valid for IL.**

E. Extenuating Circumstances: Client has excess resources but meets the financial needs test due to extenuating circumstances. All or part of the excess resource amount is waived. Sections A – G and the Remarks- Extenuating Circumstances-Justification Section are completed. The amount of the client's contribution must be recorded. The Financial Statement must be printed with appropriate signatures and placed in the case record. Unit Manager/Facility Director approval is required.

F. SSI/SSDI Recipient with Comparable Benefits: For VR services, SSI/SSDI recipient has contributions to contribute to the cost of the rehabilitation program. Enter amount of the contribution in section E. It is not necessary to enter any information in the Remarks-Extenuating circumstances section. In the last section enter the amount of the contributions and how they will be utilized. When covered by a comparable benefit, medical coverage amounts (example – Medicaid, Medicare) are not listed as a contribution in section E and costs of the treatment are not listed in the Section G. The comparable benefits counting as contributions for this category will mainly apply to postsecondary training (example – Pell Grant). The Financial Statement must be printed with appropriate signatures and placed in the case record. Unit Manager/Facility Director approval is required. **This category is not valid for IL.**

G. Excess Income Applied: Complete Sections A – G. It is not necessary to enter any comments in the Remarks-Extenuating Circumstances- Justification Section. Enter amount to be contributed and document details of the contribution on the form. The Financial Statement must be printed with appropriate signatures and placed in the case record. Unit Manager/Facility Director approval is required.

RESURVEY REQUIREMENTS: Financial need, once determined, must be continuously monitored throughout the rehabilitation process. A completed Financial Statement must be resurveyed when there is a significant change in the individual's financial status, or when the time period established in Section F has expired. There are two methods for resurveying Financial Need if there is no significant change in income: (1) on the second page of the Financial Statement, or (2) as part of the IPE/IPIL Annual Review. Whether using the second page of the Financial Statement or IPE/IPIL Annual Review, these two options may be used only for the first annual resurvey of the form and if there have been no significant changes in

income. However, a new Financial Statement must be documented every two years or whenever an individual's financial resources change to the degree that financial need is affected. Once a new Financial Statement is completed, the aforementioned options for conducting the initial annual resurvey via the second page of the form, or the IPE/IPIL Annual Review are available under the conditions described above. During the annual resurvey, income must be verified if there are significant changes. When services subject to the Financial Needs Test are added, the cost of the rehabilitation program must be recalculated with the additional cost of services included and excess income applied to the entire cost of the program.

THE FINANCIAL STATEMENT IS COMPLETED IN THE FOLLOWING MANNER: NAME and VR/IL NUMBER: As noted in the record of service. **EFFECTIVE DATE**

DETERMINATION OF FAMILY UNIT AND INCOME:

A client is considered a family of one if:

A. Client is twenty-three years of age or older (unmarried, not a tax dependent, and has no dependents); OR

B. Client is less than twenty-three AND one of the following:

- Ward of the court;
- Emancipated minor;
- Honorably discharged Veteran of the US Armed Forces;
- Can verify self-supported income and can produce receipts for basic living expenses (to include rent and utilities, medical payments, health insurance premiums, child care expenses, and legally mandated payments) for a minimum of three months. If the client is married, the client's family shall include:

A. The client's spouse if residing in the same home;

B. The client's children, but not to include step-children; AND

C. Other individuals related to the client by blood, marriage, or adoption **if the other individuals have no income.**

If the client is less than twenty-three years old and is not married, **or** if the client is 23 years of age or older and is being claimed as a dependent by the parents for tax purposes regardless of place of residence, the client's family shall include:

A. Client's parents, not including stepparents;

B. Siblings or half-siblings of the client, but not step-siblings, if the siblings are unmarried and less than 23 years of age;

C. Siblings or half-siblings of the client, but not step-siblings, if the siblings are 23 years of age or older and have no income; AND

D. Other individuals related to the client by blood, marriage, or adoption if the other individuals have no income.

A. MONTHLY RESOURCES

(A1) NET INCOME OF ALL APPLICABLE FAMILY MEMBERS

Net Wages - Record the name and net monthly (biweekly x 2.17; weekly x 4.33) pay of all members of the family unit. Net income is typically considered for the thirty-day period prior to the date of the Financial Statement. In situations in which income cannot be determined on

that basis, the Counselor should calculate a fair representation of net monthly income. Income includes all cash income received from wages, salaries, or self-employment. Net income is computed by subtracting **mandatory** deductions from gross wages. Income does not include cash that minor children earn from babysitting, lawn mowing, or other miscellaneous tasks or gifts. Also, do not include Work Adjustment training earnings or work-study as income. Check stubs must be requested to document income. If the individual does not have check stubs, the counselor will obtain a **WAGE VERIFICATION FORM** signed by the current or last employer or a **SOURCE OF SUPPORT FORM** completed by the person who supports the individual, or the agency representative who processes the individual's public support. In lieu of this form, a letter from the agency, hospital or individual whom can verify income status is an acceptable form of verification. Tax forms are acceptable if other documents are unavailable.

Pensions (SSDI, SSI, VA, etc.) - Identify and record the total amount of the benefits received by all applicable family unit members. Included in this category are monetary benefits received from public assistance, retirement, and other pension benefits. Others may also apply.

Compensation Payments (Unemployment, Workers' Compensation, etc.) -

Identify and record the total amount of the benefits received by all applicable family unit members.

Commodities Sold - Commodities are frequently produced and sold seasonally. The profit (income minus production costs) should be computed on a monthly basis.

Other - Identify and record all other available financial resources. Examples are income from stocks, bonds, savings accounts, investments, rentals, alimony, child support, GI Bill training benefits, sick pay, inheritances, life insurance payments, payments from trust funds, etc. Identify the source of the income and the amount.

NOTE: Student loans are not recorded as income, assets or contributions on the Financial Statement. The use of loans to cover training expenses is a part of the verification and counseling process to make sure that students have sufficient resources from other resources that are not covered by the Division. (Subsection 2-20-1, Postsecondary Training)

SUBTOTAL (A1) - Total lines 1 through 5

(A2) ALLOWED DEDUCTIONS

Identify the recurring deductions and record the amount of monthly payments the family unit is making for any family member for the items or services listed below. If recurring deductions vary in amount from month to month, the average of the past three months will be calculated to determine the monthly-allowed deductions. **Deductions must be verified by receipts, bill statements and other information.** Documentation that the expense is actually being paid by a member of the family unit is needed as opposed to a verification of the expense with no evidence of payment. Include only those expenses not covered by a third party payer. Copies of the documents used to verify deductions must be in the record. **If it is not possible to verify deductions, the Unit Manager/Facility Director must approve exceptions to this requirement.**

Medical Expenses – medical expenses, dental expenses, medical supplies, prescription and non-prescription items. Special diets/foods that are related to the individual's disability may be considered. Also included are medical/health insurance premiums, if not already deducted from gross wages. Vision and Dental insurance premiums are allowed; **however, do not**

deduct optional health insurance premiums including flexible spending accounts, disability, cancer or long term care.

Equipment Expenses – Examples include disability-related clothing, devices and equipment including necessary maintenance of such devices and equipment.

Personal Assistance Services (PAS) – Examples include domestic, chore, and other attendant-related services required to assist family unit members with activities of daily living and self care needs. Note: If the client will require personal assistance services to achieve independent living or employment outcome, an assessment of the individual's resources will occur. For Independent Living, if the individual meets the financial needs test, the individual's financial contribution toward the costs of the personal assistance services shall be one-half the excess net monthly family income, if applicable. For Vocational Rehabilitation, personal assistance is not subject to the financial needs test. For both programs, comparable benefits must be utilized.

****NOTE FOR IL PERSONAL ASSISTANCE SERVICES (PAS) ONLY:**

Participants for whom the IL Program is contributing or is considering contributing toward the cost of PAS, the PAS service must not be counted as an allowed deduction/disability-related expense on the part of the participant. See below under Excess Net Monthly Income for further instructions on determining the client's contribution to PAS.

Housing/Vehicle Expenses:

Housing - Payments for additional expenses necessitated by residing in an accessible residence; payments for specialized equipment in the residence. Examples are auditory alarms, specialized ventilation equipment, etc.

Vehicle - Due to the increased costs associated with purchasing and maintaining adapted vehicles, the Division has developed rates for modified automobiles and vans. If the individual owns or is purchasing a modified vehicle, a monthly deduction is granted, based on the information below:

COST OF MODIFICATION AUTOMOBILE VAN

< \$1,000.00 \$10.00 \$149.00

> \$1,000.00 but < \$6,000 \$60.00 \$199.00

> \$6,000.00 \$90.00 \$229.00

Child Care Expenses - Actual costs not to exceed \$175.00 per month per child may be deducted for any child fourteen years old or younger, provided parents or other responsible adults are unavailable or unable to care for a child in the family unit.

Post secondary Training Expenses - Actual costs not to exceed Division allowed maximums for tuition, fees, books, and maintenance expenses may be deducted for applicable family unit members. Note: Prorate the amount of training expenses to get a monthly amount to report as deduction.

Legally Mandated Expenses - Alimony, child support or Social Security reimbursements may be deducted if required of any applicable family member. Other legally mandated payments cannot be deducted.

Other - Others may also apply.

SUBTOTAL (A2) - This figure represents the total of allowed deductions as determined on the ALLOWED DEDUCTIONS - WORKSHEET.

TOTAL MONTHLY RESOURCES (A1 - A2) = (A) - This figure represents the individual's total monthly resources.

B. ALLOWABLE NET MONTHLY INCOME

The Allowable Net Monthly income amounts for family size one through eight are listed on the form. Add \$363.00 per family member for each over eight. The appropriate amount should be recorded as **TOTAL B** on the form.

C. EXCESS NET MONTHLY INCOME (A) - (B) = (C)

This amount represents the monthly income available from the family unit, which can be applied toward the cost of the rehabilitation program. **TOTAL (C)** represents the excess CASH that can be applied toward the cost of the rehabilitation program.

*****NOTE FOR IL PERSONAL SERVICES (PAS) ONLY:** Participants for whom the IL Program is contributing or is considering contributing toward the cost of PAS, the PAS service must not be counted as an allowed deduction/disability related expense on the part of the participant. The Counselor computes net income and family unit size to determine excess monthly income. The Counselor exempts ½ of the excess monthly income figure and applies the other half as the portion to be assumed by the participant in the cost of rehabilitation services. The remaining cost of PAS services are sponsored by the IL Program.*

D. AVAILABLE ASSETS

Cash - Includes cash in checking or savings accounts, which exceeds an amount three times the ALLOWABLE NET MONTHLY INCOME (B) for the appropriate family size. Assets may include stocks, bonds, inheritances, lump sum insurance settlements, life insurance proceeds, gifts, or other resources the individual or the individual's family may have readily available to access.

Real Property - Such property is an available asset to the extent it can be converted to cash or used as collateral, in a timely manner, to meet the cost of rehabilitation services. The local county tax office can verify property information. Real property, excluding the individual's home site, will be recorded at the fair market value or purchase price; whichever is less, minus the amount owed for mortgages or liens. Any amount over \$25,000.00 will be recorded as excess resources. If the residence is in a rural area, home site is defined as the house and land on which the residence is located up to a maximum of one-acre including all buildings on the acre. If the residence is in the city, home site is defined as the family unit's principle place of residence, including the house and lot plus all buildings on the lot.

TOTAL (D) represents the amount of AVAILABLE ASSETS that can be applied towards the cost of the rehabilitation program.

E. CONTRIBUTIONS

Record the total amount of scholarships educational grants, community funds, or other resources that the individual has available to contribute to the rehabilitation program. Note: scholarships based on at least 50% academic performance are exempt from being counted as an educational contribution. Contributions need to be reviewed during the resurvey with changes recorded. *Revised 05-01-02*

TOTAL (E) represents the amount of CONTRIBUTIONS available for the family unit.

F. EXCESS RESOURCES

Complete this section when the amount in **(C)**, **(D)**, or **(E)** is greater than \$0.00. The section addressing appropriate time period is the actual length of time for services planned on the

rehab program, with three months as the minimum and twelve months is the maximum number of months. For example, restoration services may include the estimated recuperation period, etc., while training services would include the length of the training period. **TOTAL (F)** represents the sum of all EXCESS RESOURCES that can be applied toward the cost of the rehabilitation program.

G. ESTIMATED COST OF REHABILITATION PROGRAM

If the amount in (F) is greater than \$0.00, the counselor will estimate the cost of the entire rehabilitation program during the time period identified under EXCESS RESOURCES. All services being planned on the rehab program should be recorded along with an estimated cost. **TOTAL G** represents the ESTIMATED COST of the rehabilitation program. If **TOTAL (G)** is less than **TOTAL (F)**, the individual does not meet the criteria for the financial needs test. If **TOTAL (G)** is more than **TOTAL (F)**, the individual does meet the criteria for the financial needs test and the Division may participate in the cost of certain services. The counselor must negotiate the actual amount of Division participation, as all of client's resources must be accounted for in the cost of the rehabilitation program.

REMARKS - EXTENUATING CIRCUMSTANCES – JUSTIFICATION: This section is provided to allow the counselor to identify other information related to the individual's financial situation that will affect the individual's ability to participate in the cost of the rehabilitation program. If there are extenuating circumstances that prohibit the individual's application of part or all the excess resources toward the cost of rehabilitation, the Division may waive all or part of these resources. Such circumstances may include: the inability to sell property, the fact that the amount of funds would be so small that it would provide little substantial financial help toward the cost of rehabilitation program, or the fact that the conversion of the excess resources may result in undue delay in proceeding with the rehabilitation program. If the individual's monthly resources change during the period of rehabilitation due to an inability to work, this should be recorded in this section. Written approval of the Unit Manager/Facility Director is required for the waiver. Verification of the particular circumstances must be provided by the individual and must be maintained in the record. When there are excess resources of any type and financial need is reported as, **Extenuating Circumstances**, this indicates that services subject to financial needs testing are planned on the IPE/IPIL and there are extenuating circumstances that justify waiving all or part of the individual's contribution. Approval of the Unit Manager/Facility Director is required for the waiver. Documentation of the particular circumstances must be provided by the individual and maintained in the record. The counselor will identify the services for which the client's resources will be responsible and record the amount the individual is expected to contribute toward the cost of the rehabilitation program. The counselor will record the amount the individual is expected to contribute and towards which service(s). The counselor and individual must always sign the form once it is completed. The parent, guardian, or other representative must sign the form when appropriate. The Unit Manager/Facility Director is required to sign the form in all cases when there are excess resources, including resources that are due to comparable benefits such as educational grants.

[34 CFR 361.54; 10 NCAC 20C .0205 and .0206: VR State Plan Section 6.12(c)(2); IL State Plan; 34 CFR 364.59] Revised 07-02-08

H. SIGNATURES

The Financial Statement requires that the individual, or as appropriate, the individual's parent, guardian, other representative or advocate sign the completed form. The signature indicates that the financial information provided is correct and that the individual and/or the appropriate representative participated in the completion of this financial statement. The original Financial Statement and subsequent annual resurveys require the client or other appropriate signature as specified above.

3-11-2: SSI and SSDI Recipients

Vocational Rehabilitation will not apply a financial needs test or require the financial participation of any individual who receives Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI). Verification of these benefits must be documented in the case record. Services provided by Vocational Rehabilitation for these individuals must be directly related to the completion of the Individualized Plan for Employment or trial work experience. VR counselors must explore Social Security work incentives with these individuals as a part of the planning and development of the IPE. Comparable benefits must be utilized when available. Independent Living will apply a financial needs test for all participants requiring cost services regardless of the source of income. *[34 CFR 361.54(b)(3)(ii)]*