Expanding Access to Brain Injury Services

and

Barriers to Placement of Virginians who have Challenging Behaviors Resulting from Traumatic and Non-Traumatic Brain Injuries and Post-Traumatic Stress Disorder

Joint Commission on Health Care
September 7, 2016 Meeting

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Study Mandate

- In 2014, Senate Joint Resolution 80 (Senator Ruff) directed the JCHC to determine the extent of progress made in implementing the recommendations of the 2007 Joint Legislative and Audit Review Commission report, *Access to State-Funded Brain Injury Services in Virginia*
  - An interim report was given by JCHC staff at the October 8, 2014 JCHC meeting
- In 2016, Senator Carrico instructed the JCHC to identify barriers and options for placement of individuals with:
  - Traumatic brain injuries (TBI)
  - Non-traumatic brain injuries (e.g., caused by degenerative conditions, stroke or anoxic events)
  - Post traumatic stress disorder (PTSD)

Levels of Care

Level 1

Acute inpatient medical and psychiatric hospitals (short-term stabilization)

Level 2

Nursing facilities (24 hour medical and support needs)

Neurobehavioral programs - acute patient institutional rehabilitation centers (intensive behavioral & support needs)

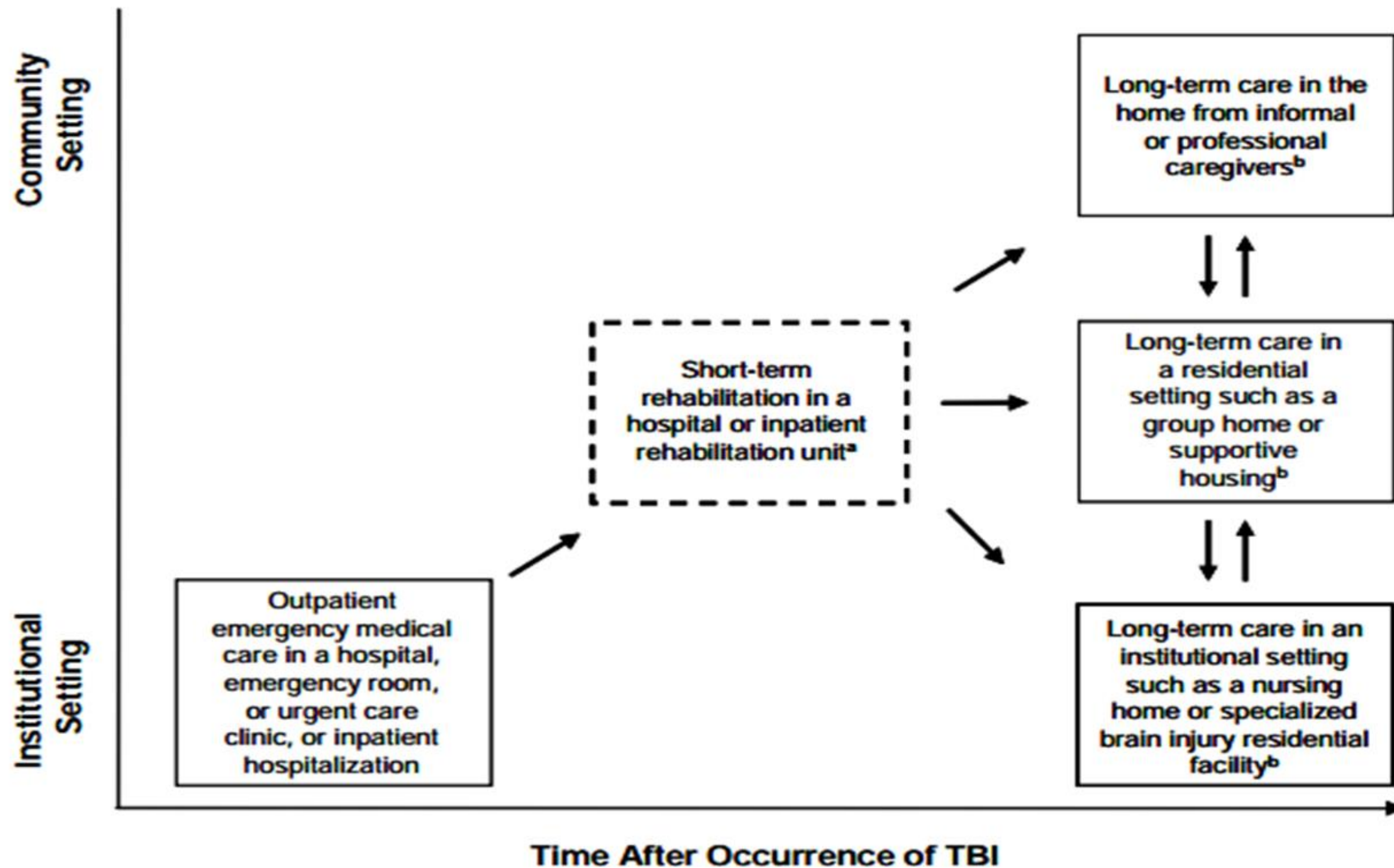
Level 3

Intensive sponsored residential and congregate group homes (moderate to high need for 24 hour support and levels of therapy)

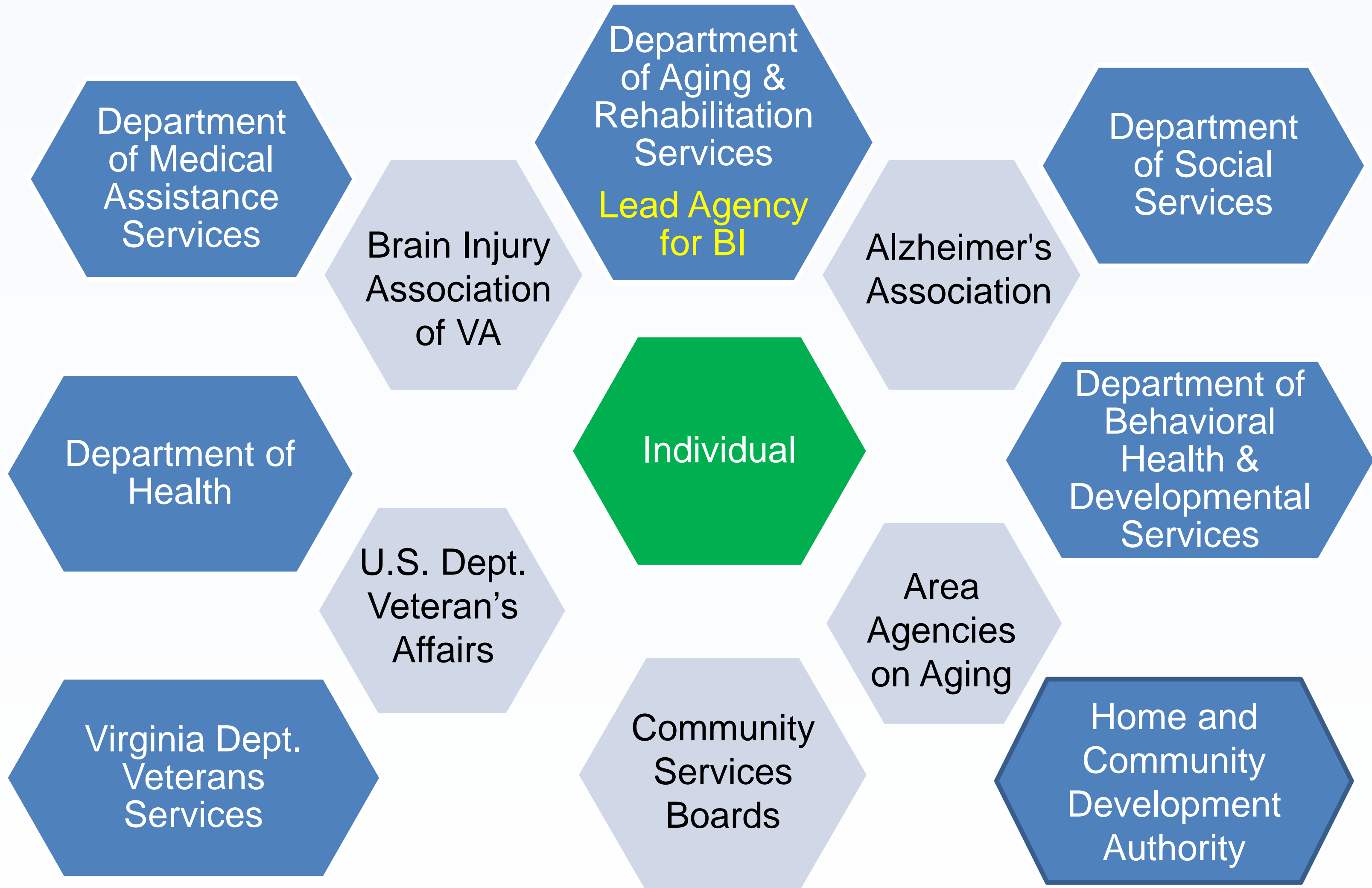
Level 4

Long-term community supported living, supported apartments, home-based services (community-based, low level of behavioral & support needs)

Individuals may move to different levels in a non-linear way



Several State and federal agencies and their contractors may play a role in serving individuals with brain injury, dementia and post-traumatic stress disorder in Virginia

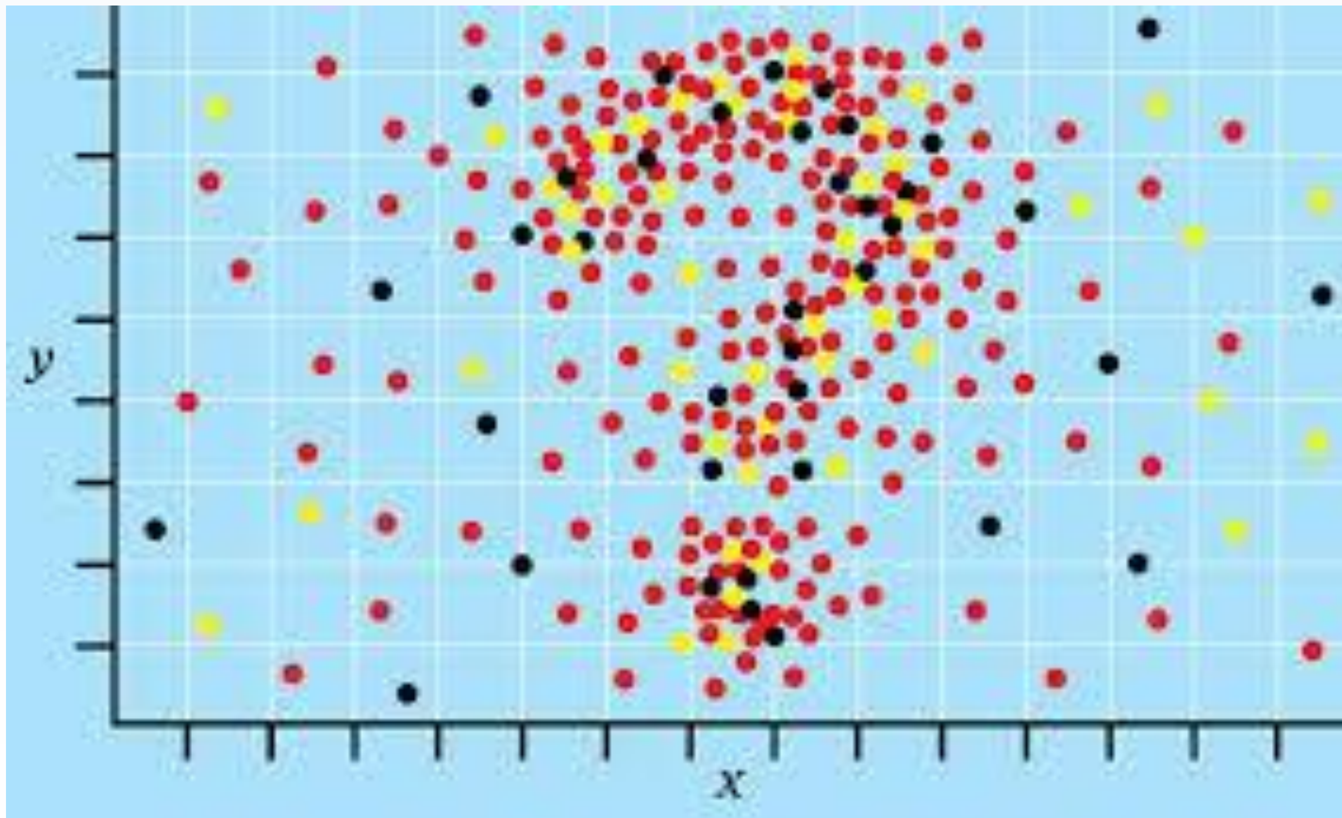


Brain Injury, Dementia and Post-Traumatic Stress Service Structures in Virginia

DARS	DBHDS and CSBs	DMAS	VDH	Department of Veterans Serves.	DSS	Home & Com. Deve. Authority
• Dementia services coordinator • Direct Services Fund • Neurotrauma Trust Fund • Centers Indep. Living • Aging and Disability Resource Centers – no wrong door • Personal assistance • Vocational rehabilitation • Woodrow Wilson Ctr. • Brain Injury Ass. of VA • Brain Injury information, referral, case management, and supported living • Clubhouses & day programs • Virginia Supported Housing • Assistive technology • Behavioral Health & Supportive Services • BI 1st Software System • VA Alzheimer's Disease Commission • Counsel on Aging	• State MH Facilities • Community Services Boards • My Community My Life ID/DD waiver redesign, management, data warehouse & pre-admission screening • Piedmont Geriatric Hospital • Community Centered Behavioral Health Homes • Permanent Supportive Housing	• Acute medical & behavioral health care payments • Nursing facility and EDCD, DD, ID, Alzheimer's Assisted Living, day support & Technology Assisted Waivers payments • Commonwealth Coordinated Care • Governor's Access Plan • Substance use waiver • MLTSS • PACE • DSRIP • Medicaid Works	• Licenses nursing facilities • Statewide Trauma Registry • Home Health • Certificate Of Public Need • Behavioral Risk Factor Surveillance Survey • Minimum Data Set (nursing facility case mix)	• Virginia Veteran & Family Support Services • Depart of Veterans Affairs	• Nursing facility & Medicaid waiver pre-admission screening • Licenses assisted living facilities & adult day services • Medicaid eligibility • Auxiliary grants for assisted living facilities	• Affordable & special needs housing • Accessible housing • Home modification grant funds for veterans • Housing Choice Voucher Program

One individual may access services administered by several agencies and be subject to different eligibility rules

Demographic and Cost Data: Brain Injuries, Dementias, Cognitive Decline, Cerebrovascular Accidents, and Post Traumatic Stress Disorder

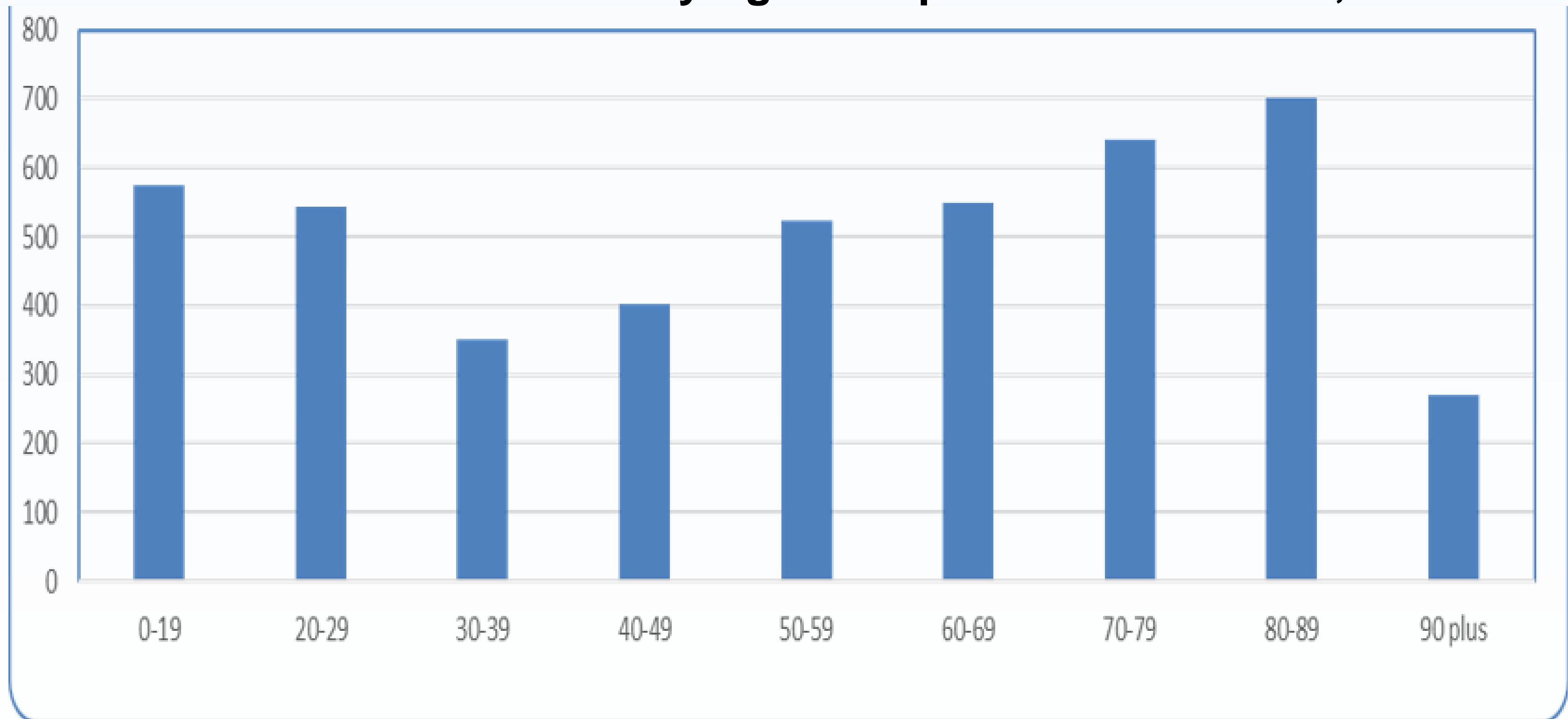


Barriers to Data Access

- There is no single source of data; data exist at several state agencies, but coordination and resource issues have resulted in data that is not standardized and difficult to access. As a result:
  - The extent of unmet need for services is difficult to ascertain
  - There is an inability to share data across agencies
- Elimination of the Brain Injury Registry resulted in data access issues
- The Virginia State Trauma Registry is now used, but there have been interruptions due to staffing and technical issues (e.g., change from ICD-9 to ICD-10 codes in 2015)
- In 2016, the General Assembly passed HB 30 Item #310M which requires state agencies to identify a coordinated data collection method and report the results by December 1, 2016

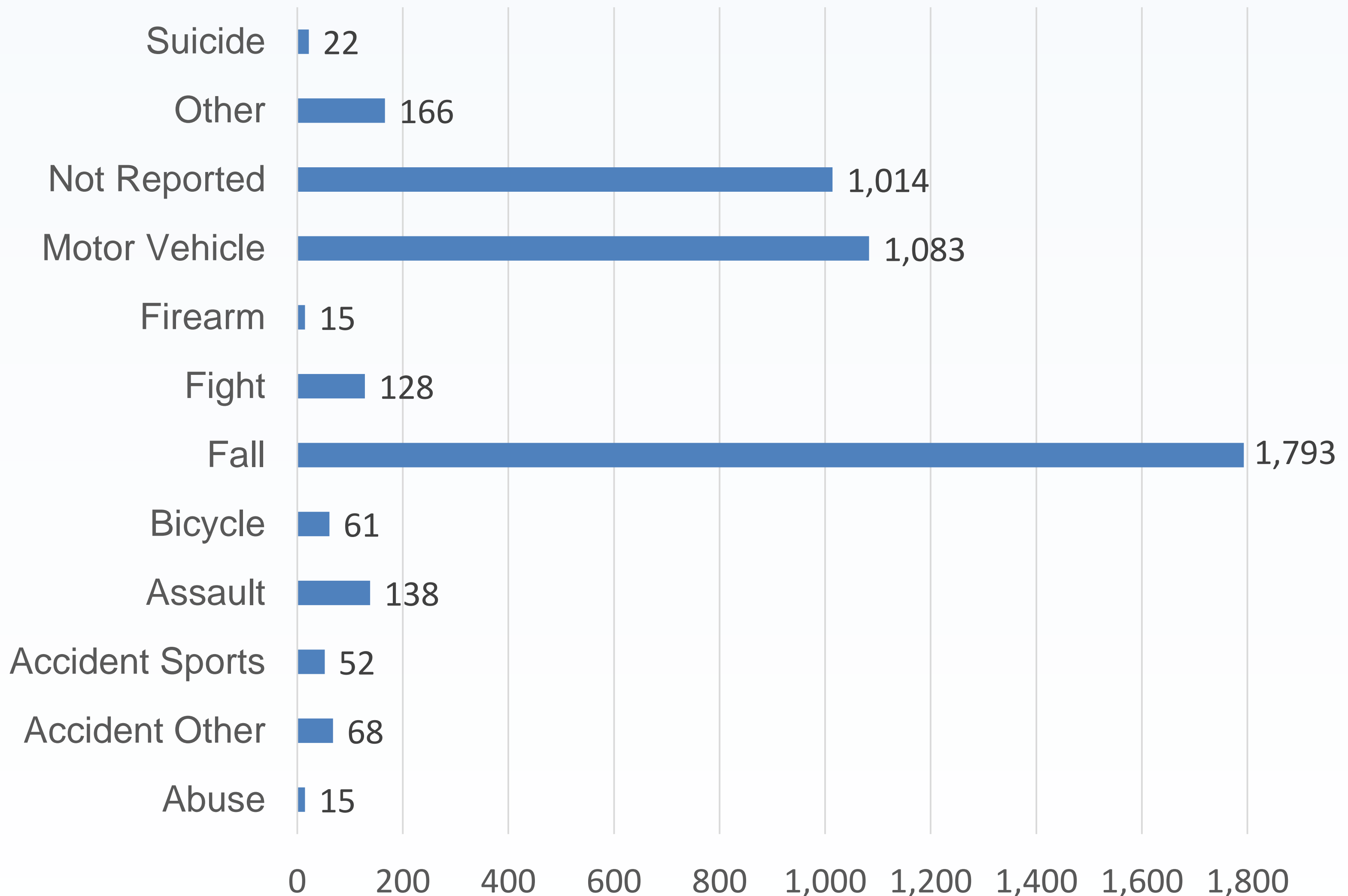
Brain Injury
Virginia Statewide Trauma Registry (VSTR)
April 1, 2015 – March 31, 2016

Number of Individuals by Age Group: Total Number = 4,554



The majority of injured was over the age of 50 years

Traumatic Brain Injury Causes
Virginia Statewide Trauma Registry April 2015 - March 2016



Brain Injury
Virginia Statewide Trauma Registry April 2015 - March 2016
Glasgow Comma Score (GCS)

The GCS is a reliable and objective way of recording the initial and subsequent level of consciousness in a person after a brain injury

	Score	Number	Percent
Severe	3	160	3.7%
	4	10	0.2%
	5	20	0.5%
	6	32	0.7%
	7	35	0.8%
	8	17	0.4%
Moderate	9	26	0.6%
	10	23	0.5%
	11	35	0.8%
	12	60	1.4%
Mild	13	125	2.9%
	14	416	9.6%
	15	2,751	63.2%
	Not Reported	1,604	36.8%
	Grand Total	4,355	100%

Severe: GCS 3-8
Moderate: GCS 9-12
Mild: GCS 13-15

- **Six percent scored in the severe range (274)**
- **Three percent scored in the moderate range (144)**
- **Seventy-five percent scored in the mild range (3,292)**
- **Thirty-seven percent were unscored or unreported**

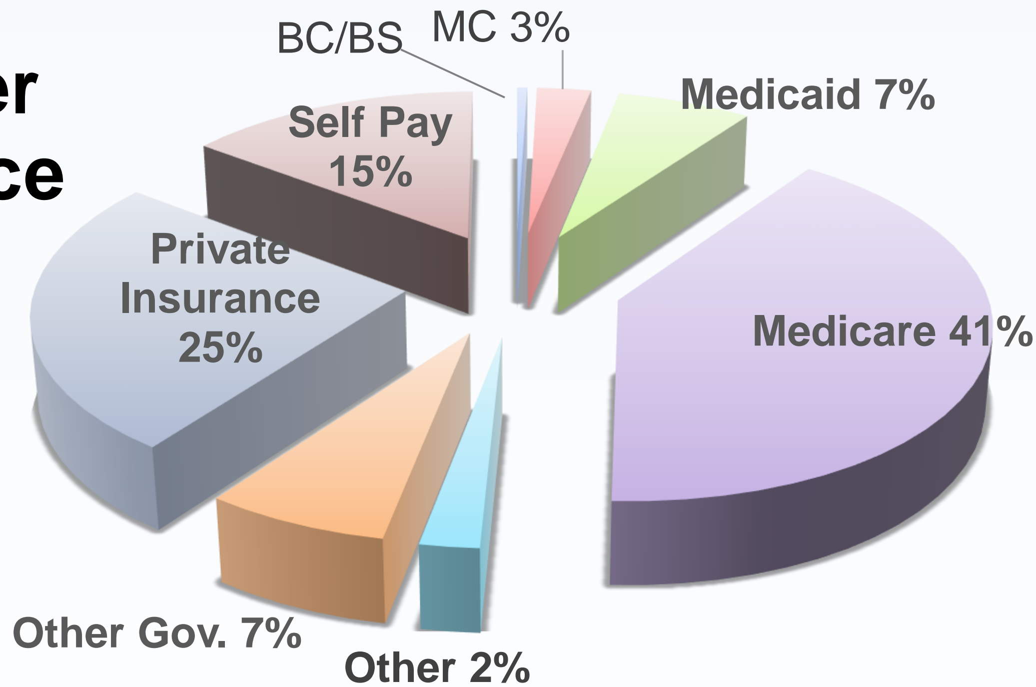
Brain Injury Discharge Setting
Virginia Statewide Trauma Registry April 2014 - March 2015

Discharge Setting	No.	Pct.
Home or self-care	**1,689**	**37%**
Home with home health services	**370**	**8%**
Other acute care general hospital	**902**	**20%**
Skilled nursing facility	**602**	**13%**
Rehabilitation or long-term facility	**74**	**2%**
Inpatient rehabilitation unit	236	5%
Against medical advice	20	0.4%
Other Institution	16	0.4%
Correctional Facility	16	0.4%
Short-term hospital	14	0.3%
Hospice care	52	1%
Intermediate care facility	21	0.5%
Long term care hospital	18	0.4%
NA	509	11%
Psych Visit	15	0.3%
Grand Total	4,554	100%

The majority of discharges were to home followed by other acute care hospitals and skilled nursing/rehabilitation facilities

Traumatic Brain Injury
Virginia Statewide Trauma Registry April 2015 – March 2016

Payer Source



Blue Cross/Blue Shield
Managed Care
Medicaid
Medicare
Other
Other Government
Private Insurance
Self Pay

Medicare is largest payer = 41%; private insurance = 25%; self pay = 15%; Medicaid and Other Government each = 7%

Cerebrovascular Accidents (Stroke)
2011 Virginia Hospital Discharges

Type of Stroke	Discharges	Percent of Total
Acute Ischemic	11,394	55%
Hemorrhagic	2,793	13%
Transient Ischemic Attach	4,418	21%
Other Cerebrovascular Accident	2,188	11%
Total Cerebrovascular Accidents	**20,793**	**100%**

http://www.vdh.virginia.gov/livewell/collaborative/documents/2013/pdf/Cerebrovasc%20Disease%20-%20Stroke%20Burden%20Report.pdf

Alzheimer's Disease

Projected Number in Virginia by Age Group

Year	65 – 74	75 – 84	85+	Total
2016	22,000	59,000	54,000	140,000
2020	26,000	69,000	59,000	150,000
2025	29,000	89,000	68,000	190,000

http://www.alz.org/documents_custom/facts_2016/statesheet_virginia.pdf

Subjective Cognitive Decline (SCD)

Virginia Behavioral Risk Factor Surveillance Survey (BRFSS) 2016*

Adults age 45 and older who reported SCD in the past year

Age Group	Number Asked	Number "Yes"	Percent "Yes"
45-54	1,361	154	11%
55-64	1,635	201	12%
65-74	1,317	109	8%
75+	881	128	15%
Total	5,194	592	11%

Fifty-six percent of those with SCD reported needing assistance with day-to-day activities

Nine percent of those needing assistance reported receiving it

*The BRFSS is a national survey administered annually by each state. In Virginia, the Department of Health administers the survey. The SCD module is optional for the states and not included every year.

Department of Medical Assistance Services
Individuals Enrolled in Virginia Medicaid by Diagnosis
State Fiscal Years 2013 - 2015

Diagnosis	SFY 2013	SFY 2014	SFY 2015
Alzheimer's & Dementia	53,618	61,674	58,997
Post-Traumatic Stress Disorder	34,688	39,098	37,425
Stroke	20,681	22,693	21,829
Traumatic Brain Injury	5,752	6,251	5,997
Grand Total	**114,750**	**129,727**	**124,260**
Total Medicaid Payments	$2.8 Billion	$3.1 Billion	$2.9 Billion

Data Source: Department of Medical Assistance Services fee-for-service claims, including Magellan and crossover claims, consumer directed services claims, Medicaid managed care encounter data and capitation payments made by DMAS to MCOs as of September 2, 2016

Data from Commonwealth Coordinated Care are not included – these data have not yet been made available to the states by the Centers for Medicare and Medicaid Services

Individuals are unduplicated within each year and placed in the category of highest severity if they have multiple diagnoses. One individual may be counted in multiple years.

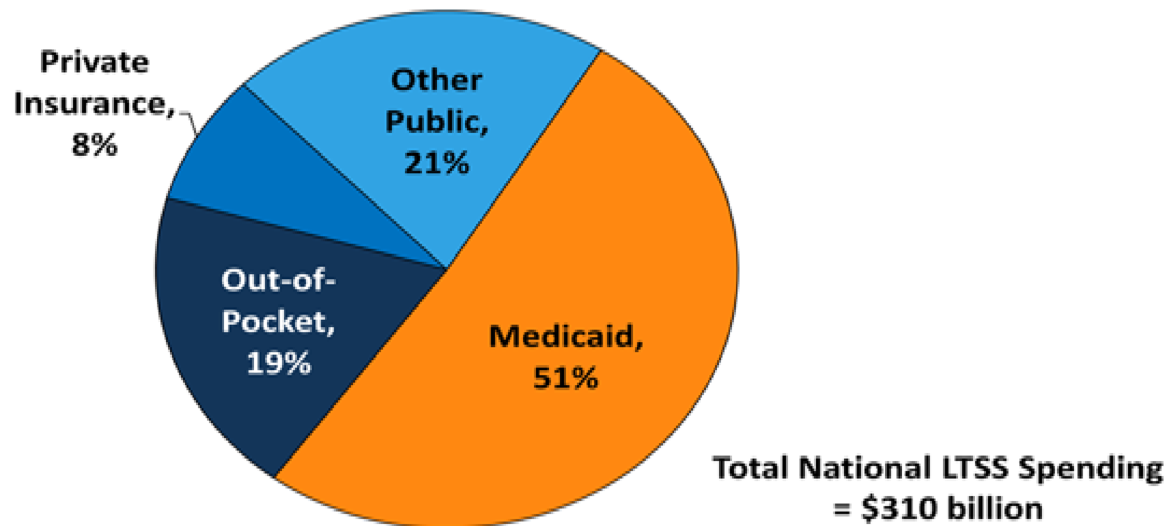
Cost of Long Term Care in Virginia
Genworth 2014 Cost of Care Survey

Setting	Service	Minimum	Median	Maximum	Median Annual	5 Year Annual Growth Rate
Level 4: Home	Homemaker Hourly Rate	$8	$18	$26	**$41,184**	2%
	Home Health Aide Hourly Rate	$13	$19	$26	**$43,472**	1%
Level 3: Community	Adult Day Care Daily Rate	$46	$61	$107	**$15,860**	1%
Levels 1 & 2: Facility	ALF Single Occupancy Monthly Rate	$1,159	$3,990	$6,681	**$47,800**	5%
	NF Semi-Private Room Daily Rate	$117	$211	$362	**$77,015**	4%
	NF Private Room Daily Rate	$160	$231	$399	**$84,315**	3%

https://www.genworth.com/dam/Americas/US/PDFs/Consumer/corporate/130568_032514_CostofCare_FINAL_nonsecure.pdf

Long Term Services and Supports

Only eight percent of Americans have private long term care insurance



NOTE: Total LTSS expenditures include spending on residential care facilities, nursing homes, home health services, and home and community-based waiver services. Expenditures also include spending on ambulance providers and some post-acute care. This chart does not include Medicare spending on post-acute care ($74.1 billion in 2013). All home and community-based waiver services are attributed to Medicaid.
SOURCE: KCMU estimates based on CMS National Health Expenditure Accounts data for 2013.

THE HENRY J. KAISER FAMILY FOUNDATION

Data - Post Traumatic Stress Disorder

Adults*

- About 8 million adults in the United States experience PTSD during a given year which is only a small portion of those who have gone through a trauma

Children**

- 14% to 43% of children go through at least one trauma, children more likely to have PTSD include:
  - Children entering foster care
  - Female
  - Those who experienced the most trauma
  - Those who experienced rape and assault

Veterans*

- Virginia is home to approximately 780,000 veterans - over 25% served during the Vietnam Era

- The estimated percent of veterans with PTSD in a given year by operation are:
  - Iraqi and Enduring Freedom – 11% to 20%
  - Desert Storm – 12%
  - Vietnam War – 15% to 30%

**http://www.ptsd.va.gov/public/PTSD-overview/basics/how-common-is-ptsd.asp*

**http://www.ptsd.va.gov/public/family/ptsd-children-adolescents.asp

Current Virginia Resources and Gaps in Services

Level 1 — Acute inpatient medical and psychiatric hospitals (short- term stabilization)

Virginia has over 100 hospitals; 15 are designated trauma centers

Trauma Level I Centers (highest Level)

Carillion Roanoke
Inova Fairfax Hospital
Sentara Norfolk General Hospital
UVA
VCU Health Systems

Trauma Level II Centers

Central Lynchburg General Hospital
Mary Washington – Fredericksburg
Riverside
Winchester
Chippenham Medical Center (Richmond)

Trauma Level III Centers

Johnston-Willis Hospital
Carillion New River
Lewis Gale Hospital Montgomery
Southside Regional Medical Center
Sentara Virginia Beach General

GAPS

- Lack of appropriate providers in acute care settings (psychiatrists, psychologists, geriatricians)
- Lack of discharge options may result in inpatient stays that are longer than necessary

Level 2: Nursing Facility and Neurobehavioral Programs (24 hour medical and support needs)

- **Facilities in Virginia decline to admit Medicaid enrollees with brain injuries and dementias who exhibit challenging behaviors**

Feedback from Virginia facilities regarding barriers to admitting individuals with challenging behaviors

- "Nursing facilities are under tight scrutiny when resident-to-resident altercations occur; it becomes a cost/benefit decision on admitting them; the cost is higher than the benefit"
- "Medicaid allows for semi-private rooms only; we have to protect the roommate"
- "Often traumatic brain injury patients are much younger than the typical population"
- "Neurology services are not consistently accessible in long term care"
- "Lack of mental health services when needs are beyond the nursing facility's ability to manage them"
- "Staffing levels are not high enough in most nursing facilities to care for these patients"

Virginia Medicaid Enrollees Residing in a Massachusetts Neurobehavioral Rehabilitation Facility 2013 - 2015

Calendar Year	No. of People per Year	Total Bed Days per Year	Average No. Days per person per Year	Total Cost per Year	Ave. Cost per Day
2013	19	5,559	293	$2,176,146	$391
2014	21	5,989	285	$2,374,542	$396
2015	21	5,638	268	$2,359,700	$419

Data Source: Department of Medical Assistance Services (DMAS) Facility Claims as of September 1, 2016

As of August, 2016, ten Virginia Medicaid enrollees were being served out-of-state, none were ready for discharge

DMAS SFY 2017 nursing facility rates range from approximately **$145** to approximately **$220** per day, depending on facility size, location and severity of case mix

From SFY 2013 through SFY 2016, sixteen of the total Virginia Medicaid enrollees served out-of-state were discharged and repatriated*

DMAS staff reports that lack of in-state discharge options has not been a barrier to repatriation

	Discharge Setting				
SFY Year	HOME	ALF	NF	Deceased	Grand Total
2016 (as of 08/23/16)		2	1	1	4
2015	2		1	2	5
2014	1	1		2	4
2013				3	3
TOTAL	3	3	2	8	16

KEY: ALF = Assisted Living Facility NF = Nursing Facility

- DMAS staff perform hands-on case management and discharge coordination for individuals returning to Virginia
- All individuals who were ready to be discharged returned to Virginia

*Data provided by the Department of Medical Assistance Services August 25, 2016

Level 2: Nursing Facility and Neurobehavioral Programs (24 hour medical and support needs)

- Sentara Life Care Corporation has expressed an interest in opening an eight to twelve bed neurobehavioral unit in Virginia; the key barriers expressed by Sentara representatives include:
  - Medicaid payment rates are too low
  - The need for a reliable census to sustain the program
  - Access to appropriate discharge options and community supports

Levels 2 & 3: Cost of Care (care may be provided in nursing units or assisted living facilities)

Auxiliary Grant (AG) and Medicaid assisted living facilities (ALF) reimbursement equal about 66% of the average ALF cost

- The AG provides supplemental income to individuals living in ALFs, adult foster care homes or in community supportive housing *(Code of Virginia* §51.5-160)
- The average monthly cost of an ALF in 2014 was **$4,342***
- 2016 AG payments for ALFs range from **$1,219 to $1,402 per month** based on location**
- The 2016 Medicaid rate for ALFs is **$49.50 per day** (excluding skilled nursing)

*https://www.genworth.com/dam/Americas/US/PDFs/Consumer/corporate/130568_032514_CostofCare_FINAL_nonsecure.pdf

**(http://www.dss.virginia.gov/files/division/dfs/as/auxillary_grants/intro_page/alf_accepting_auxgrants/public_jul_agfacilities16.pdf)

Levels 3 and 4

- Levels 3 and 4 Include group homes, board and care homes, adult foster care, adult care facilities and supported apartments and other residential settings
- Individuals may receive rent subsidies, in-home assistance and respite care services
- **Medicaid home and community based services waivers pay for some long term services and supports that allow individuals to live in non-institutional settings**

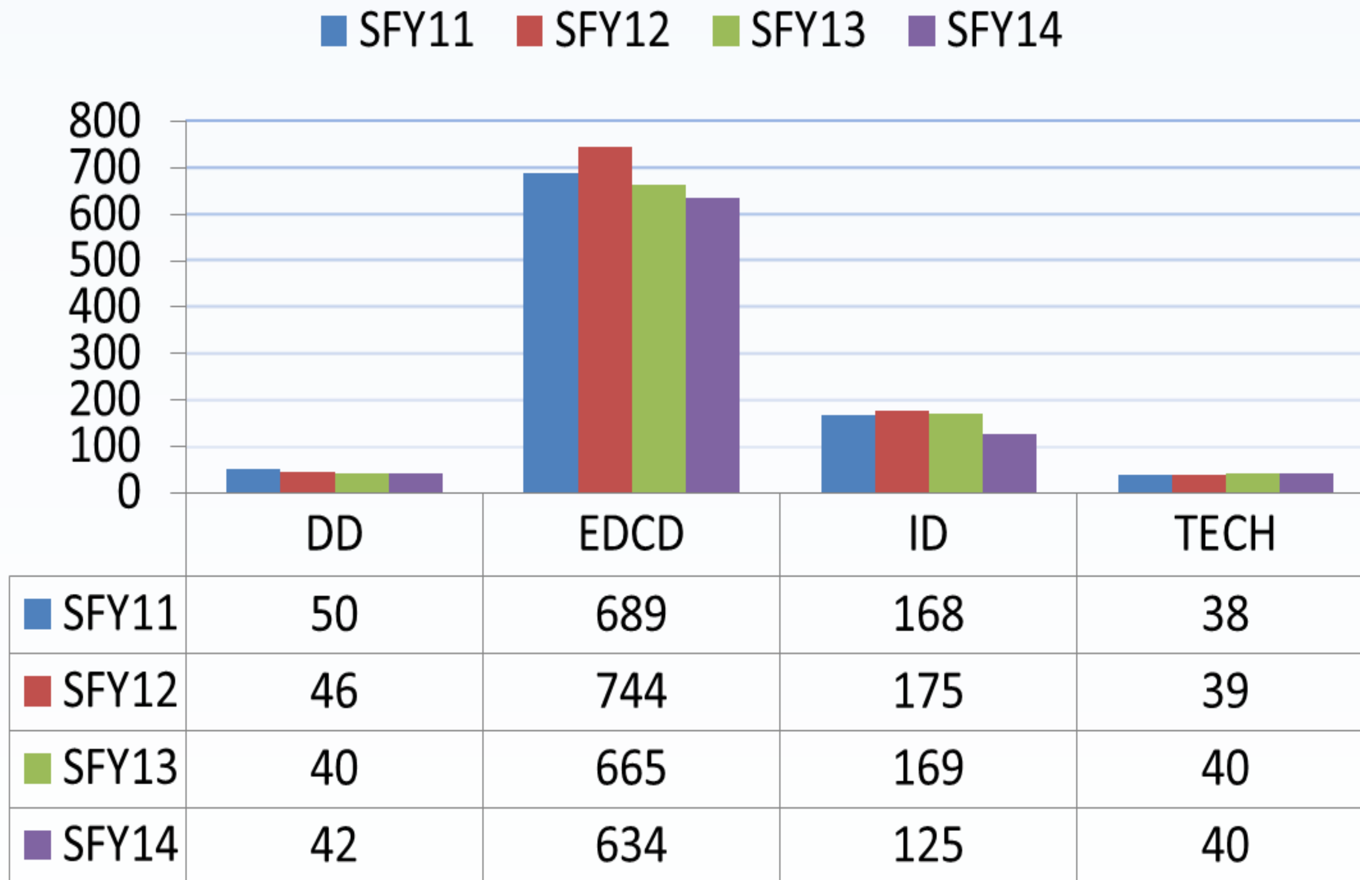
Gaps

- Current waivers do not cover all the services needed to support some individuals in the community
- There is a lack of supported apartments and other residential options
- Transportation and access to social and recreational opportunities are lacking in many parts of the state
- There is a lack of paid caregivers and family supports

In 2009, it was estimated that **more than 8 in 10** of Americans who need long-term care received it from informal caregivers

Level 4: Virginia Medicaid Home & Community Based Services Waivers

Numbers of Individuals Enrolled with Brain Injury 2011 – 2014



	DD	EDCD	ID	TECH
SFY11	50	689	168	38
SFY12	46	744	175	39
SFY13	40	665	169	40
SFY14	42	634	125	40

Data source: Department of Medical Assistance Services.

Definition of "*Community-Based*" versus *"Institutional"* Settings; Centers for Medicare and Medicaid Services Final Rules (CMS 2249-F/2296-F)

By March, 2019, to qualify for Medicaid Home and Community-Based Services payment, individuals must have certain rights, including:

- A lease or other legally enforceable agreement
- Access to privacy in their sleeping unit and lockable entrances
- Choice in selecting a roommate and in decorating their sleeping unit
- The ability to control schedules and activities
- Access to visitors and food at any time

Settings that are *not* community based include:

- Those on the grounds of, or adjacent to, a public institution
- A setting that isolates individuals from the broader community (e.g., designed specifically for individuals with disabilities)

Virginia Compliance

- Medicaid assisted living facilities are out of compliance; DMAS is in the process of transitioning Alzheimer's wavier enrollees to other settings - Virginia's transition plan is at: http://www.dmas.virginia.gov/Content_pgs/hcbs.aspx

Managed Long Term Services and Supports (MLTSS) Waiver

- DMAS is implementing a §1915(b)/(c) combination waiver scheduled to launch in 2017
- When fully implemented, approximately 212,000 members will be enrolled, including individuals who are:
  - Aged, blind and disabled
  - In the EDCD, Alzheimer's and Technical Assistance waivers
  - Enrolled in, or eligible for, Commonwealth Coordinated Care
- CMS rule on the definition of *community-based* applies
- MCOs will be required to operate a Medicare Dual Eligible Special Needs Plan (DSNP) so that dual eligibles can enroll in the same MCO's Medicaid and Medicare products - DSNP enrollment is voluntary

*http://www.dmas.virginia.gov/Content_atchs/rfp/RFP2016-01MLTSSApril29,2016.pdf

Other Level 4 Resources

Home and Community No Wrong Door & Caregiver Intervention Grant 2014 - 2017

- A $846,520* federal grant awarded to DARS to ensure a sustainable, integrated long-term services and supports system
  - Since September 2014, 121 caregivers enrolled to provide services to persons with cognitive impairment

Aging and Rehabilitative Services Virginia Dementia Specialized Supportive Services Project

- Develop and pilot an integrated, coordinated care system
- Provide a 40 hour program on Effective Strategies for Cognitive Impairment
- Implement *Family Access to Memory Impairment and Loss Information, Engagement and Supports* in Charlottesville (UVA) and Williamsburg (Riverside Health System) areas– Since 2015, forty-five persons with dementia and caregivers have enrolled

*http://www.acl.gov/Programs/CIP/OCASD/ADRC/index.aspx#Initiatives

Level 4

Long-term community supported living, supported apartments, home-based services (community-based, low level of behavioral & support needs)

- **Virginia Supportive Housing (VSH)** is a private non-profit organization subsidized by the U.S. Department of Housing and Urban Development Section 811 supportive housing for persons with disabilities*
  - 2015 revenues exceeded $12M from donors, government grants, rental fees, etc.
  - VSH develops supportive housing for persons with brain injuries, serving approximately 20 individuals (Bliley House and Independence House)
  - Supportive services (partially funded by DARS) are available to tenants to access community resources for basic needs, to re-learn skills, participate in educational activities and employment

*http://portal.hud.gov/hudportal/HUD?src=/program_offices/housing/mfh/progdesc/disab811

Level 4

Long-term community supported living, supported apartments, home-based services (community-based, low level of behavioral & support needs)

Permanent Supportive Housing (PSH)

Rent Subsidies Administered by the Department of Behavioral Health & Developmental Services

- Provides stable, supportive housing for persons with serious mental illness (including those with brain injuries and dementia*)
- In the current biennium, the General Assembly added $2.1M in each fiscal year to support rental subsidies and services
- Current units in Virginia = 2,886
- Estimated need of an additional 2,232 – 2,463 units*

*Kristin Yavorsky, MSW Homeless Projects Coordinator Virginia Department of Behavioral Health and Developmental Services

All Levels
Program for All-Inclusive Care for the Elderly (PACE)

- Serves individuals 55 years or older living in a PACE service area who qualify for Medicaid, meet the criteria for nursing facility care, and can live safely in the community at the time of enrollment
- PACE provides all covered acute, long term and behavioral health benefits regardless of site of care
- There are currently thirteen PACE sites in Virginia and one in development
- In 2015 there were 1,475 individuals enrolled in Virginia PACE, 752 with diagnosis of Alzheimer's Disease or dementia*

*DMAS Program of All-Inclusive Care for the Elderly (PACE) 2015 Annual Report

Services for Veterans

- Virginia Veteran and Family Support Services
  - A five-region consortia
  - 23 offices offering nursing, assisted living and domiciliary care, and coordination and referral services

- Operation Family Care
  - A collaboration between the Riverside Center for Excellence in Aging and Lifelong Health, the Virginia Veterans and Family Support Services, and the Virginia Department of Veterans Services
  - Operates in Northern Virginia and Hampton Roads
  - Includes a personalized program that teaches military families the skills needed to best navigate their challenges

- New Virginia Beach Veterans Care Center – Scheduled to Open in 2019
  - 120 bed facility in Hampton Roads will provide skilled nursing care, Alzheimer's/dementia care and short-term rehabilitation

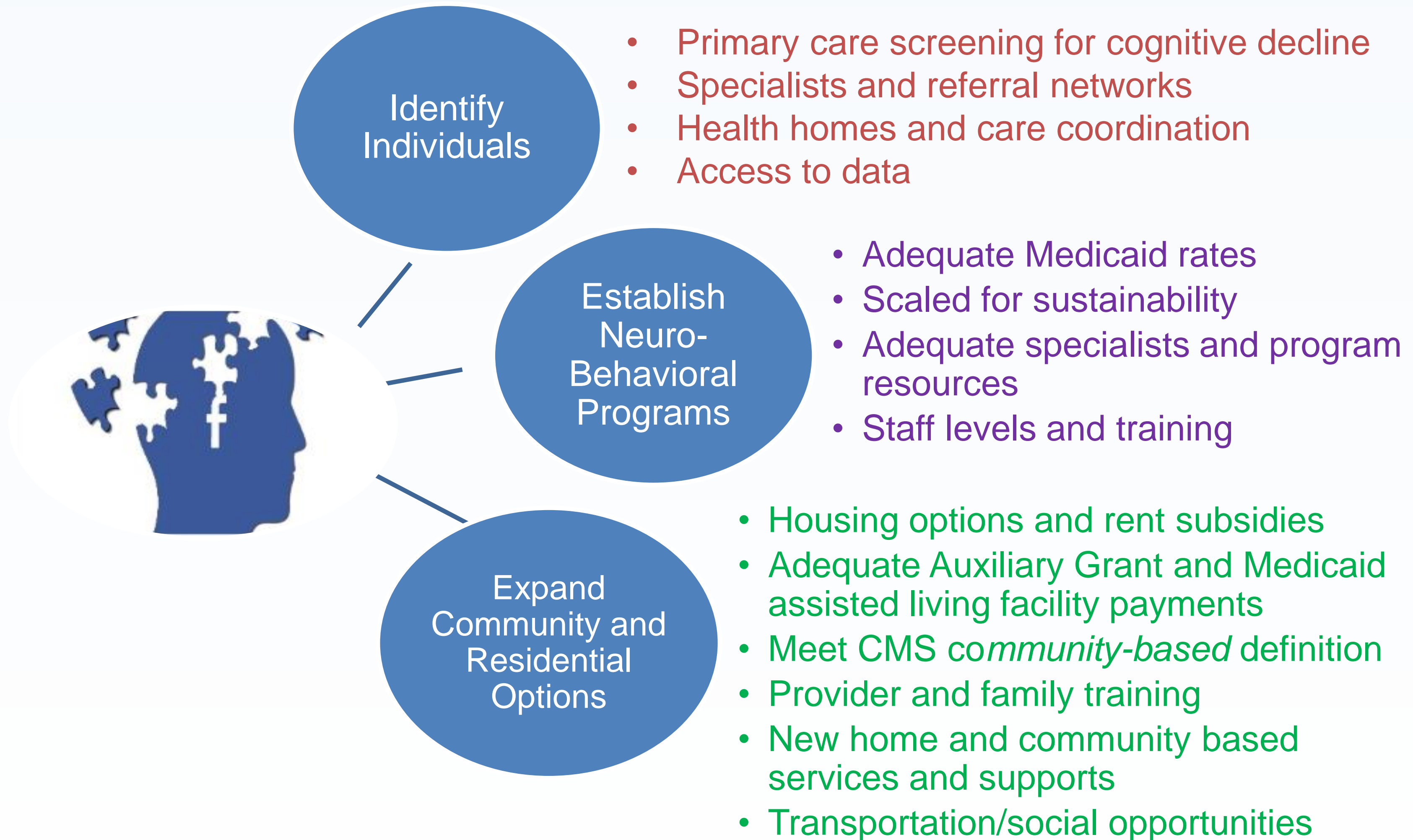
Veterans Dockets

Senate Bill Number 317 (Senator Alexander)
Offered January 13, 2016
Continued to 2017 in Courts of Justice

- *“Veterans dockets are specialized criminal court dockets...*
- *…Veterans dockets shall address underlying offender needs and conditions that contribute to criminal behavior*
- *…shall include, but not be limited to, veteran's status, mental illness, and societal reentry*
- *…shall employ evidence-based practices to enhance public safety, reduce recidivism, ensure offender accountability, and promote offender rehabilitation in the community…”*

Findings and Recommendations

Expanding Access Requires Resources at Several System Levels and Coordination Across Multiple Agencies



- Primary care screening for cognitive decline
- Specialists and referral networks
- Health homes and care coordination
- Access to data

- Adequate Medicaid rates
- Scaled for sustainability
- Adequate specialists and program resources
- Staff levels and training

- Housing options and rent subsidies
- Adequate Auxiliary Grant and Medicaid assisted living facility payments
- Meet CMS *community-based* definition
- Provider and family training
- New home and community based services and supports
- Transportation/social opportunities

Numerous studies have been published addressing the problems in Virginia over the past several years…

Study Year/Author	Study Title
2007/JLARC	Access to State-Funded Brain Injury Services in Virginia
2008/Kindred Healthcare	Commonwealth of Virginia Neuro-Behavioral Program Proposal
2010/Virginia Brain Injury Counsel	Neurobehavioral Treatment for Virginians with Brain Injury
2011/VA Board People w/Disabilities	Assessment of the Disability Services System in Virginia
2012/JLARC	Funding Options for Low-Income Residents of Assisted Living Facilities
2013/VCU	VA Statewide Acquired BI Services, Needs and Resources Assessment
2014/DARS	Update on the 2007 JLARC report
2014/DARS	Dementia & Cognitive Impairment: Interagency Collaborative Data Collection Efforts
2014/DARS	2009-2013 Brain Injury Action Plan
2014 DARS	Dementia Care Best Practices in the Commonwealth
2015/JMU	Access to Neurobehavioral Services in Virginia
2015/JLARC	Operation and Performance of the Department of Veterans Services
2015/disABILITY Law Cr. of VA	Report on Deficiencies in Virginia's Adult TBI Services
2015/VA Alzheimer's Disease & Related Disorders Commission	Dementia State Plan 2015 – 2019
2016/GMU	Access to Neurobehavioral Services in Virginia
2016/DBHDS	Decision Brief - Traumatic Brain Injury Work Group Recommendations
2016/UR	Resources for Improving Data Capture & Sharing Across State Agencies and Nonprofits that Support Virginians with Brain Injuries

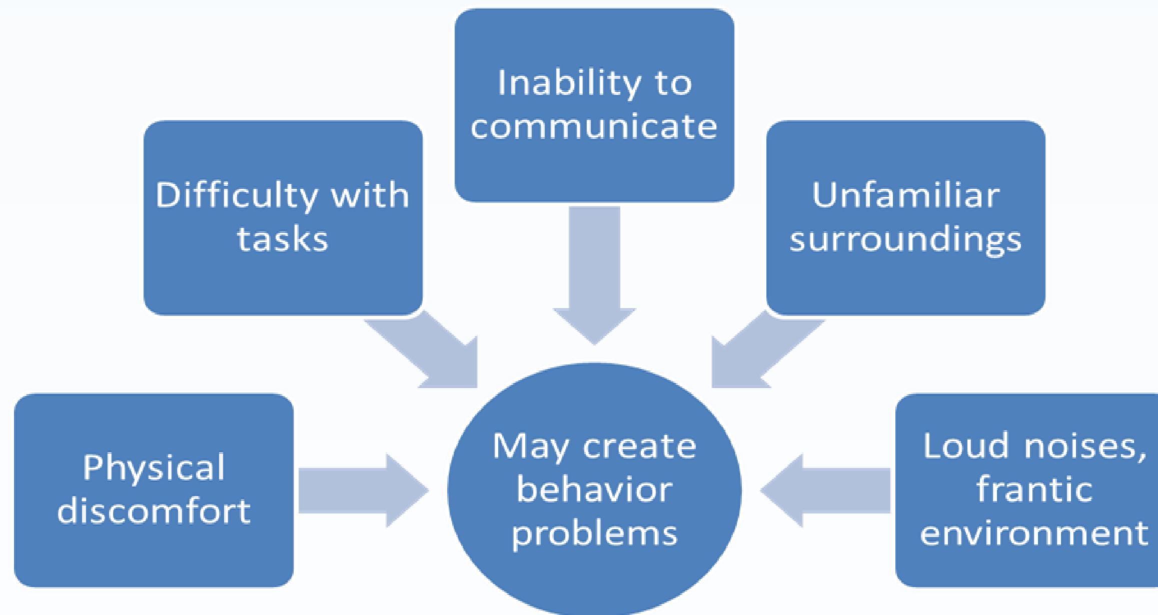
Recommendations Status Summary - JLARC 2007 Report *

Recommendations	Implemented
Relevant state agencies should develop a plan to address care coordination and access to services by active and retired military	Yes
The Department of Rehabilitation Services (DRS) should perform or contract with a 3rd party to annually preform program evaluations for at least two State-contracted brain injury providers	Yes
DRS brain/spinal cord injury unit should require submission of annual independent audit in all State-funded brain injury contracts	Yes
The General Assembly may wish to consider amending §32.1-116.1 of the *Code of Virginia* to require all licensed hospitals rendering emergency services to report patient-level information on all persons with brain injury to the Virginia Statewide Trauma Registry (VSTR) and that the VSTR transmit information to DRS	Yes but interrupted due to staffing & switch to ICD-10
The General Assembly may wish to consider amending the *Code of Virginia* to eliminate the requirement that hospitals reporting to the VSTR also report directly to DRS	Yes
DRS should convene a work group to identify the appropriate data elements needed and electronic format for transmitting information from the VSTR	Yes
DRS should require all State-funded brain injury service programs to provide information each time a provider has contact with a new person with brain injury	No; determined to be redundant to VSTR
DRS should integrate the brain injury information it collects into the Department's program, policy and fiscal planning	Yes

*See 2014 JCHC Interim Report: Progress in Expanding Access to Brain Injury Services for details

Recommendations:
"Dementia Care Best Practices in the Commonwealth 2014" and
"Virginia Alzheimer's Disease Commission Dementia State Plan 2015 – 2019"

- Regularly assess individuals for behavioral and psychological symptoms so behaviors can be addressed before they become problematic



- Ensure that primary care providers screen patients and appropriately refer them to specialists or interdisciplinary memory care practices

- Develop a statewide interdisciplinary assessment, treatment and care coordination program using credentialed patient navigators

Findings and Recommendation:
2012 JLARC Report
Funding Options for Low-Income Residents of Assisted Living Facilities

- "The availability of assisted living for low-income Virginians is declining"

- "The number of assisted living facilities that accept the Auxiliary Grant has decreased"

- "Fewer than ten percent of Auxiliary Grant recipients have access to third-party payments"

- **"The options most likely to provide significant financial assistance to assisted living facilities serving low-income individuals will require state funding"**

Recommendation:
Add New Services to the Existing Medicaid Elderly and Disabled (EDCD) Waiver

Advantages:

- No need to create a new wavier program
- The EDCD waiver has no enrollment limit and serves all ages
- Enrollment in the EDCD waiver is large (approximately 35,000); therefore, costs are unlikely to exceed the cost neutrality limit, due to only a few very high-cost enrollees
- EDCD waiver enrollees would be enrolled in managed long-term services and supports (MLTSS); managed care organizations will provide care coordination and be held to performance standards

Consideration:

- ***New waiver services cannot be limited to enrollees with brain injuries or dementias***; therefore, costs may increase beyond that of serving the population of interest

Virginia Medicaid EDCD Wavier Gaps – Current and Additional Home and Community- Based Services Needed to Serve the Brain Injury Population

Service	Included in EDCD	Not Included
Consumer Direction	X	
Adult Day Health Care	X	
Assisted Living	X	
Assistive Technology	X*	
Case Management	X**	
Environmental Modifications	X*	X
In-home Supports	X	
Personal Care – Agency Personal Care – Consumer Directed	X X	
Personal Emergency Response Systems, including GPS Tracking and Medication Monitoring	X	

*Currently only available to individuals transitioning from an institution to the community through *Money Follows the Person*
**Available to beneficiaries in managed care plans

Level 4: Virginia Medicaid EDCD Wavier Gaps – Current and Additional Home and Community- Based Services Needed to Serve the Brain Injury Population (cont'd)

Service	Included in EDCD	Not Included
Respite Care	X	
Transition Coordination	X	
Companion Services		X
Medication Administration		X
Private Duty Nursing		X
Supervision 24/7		X
Therapeutic Consultation		X
Transition Services		X
Vocational Services and Supported Employment		X

Recommendation:
Apply for a New §1915(c) or §1115 Medicaid Waiver Specific to Brain Injury

Advantages:

- New services would not have to be available to everyone in the EDCD waiver
- §1115 waiver advantages:
  - Enrollees do not have to meet institutional level of care criteria
  - States can mandatorily enroll individuals in managed care without combining it with a 1915(b) waiver
  - States may include housing-related services to enrollees already living in the community

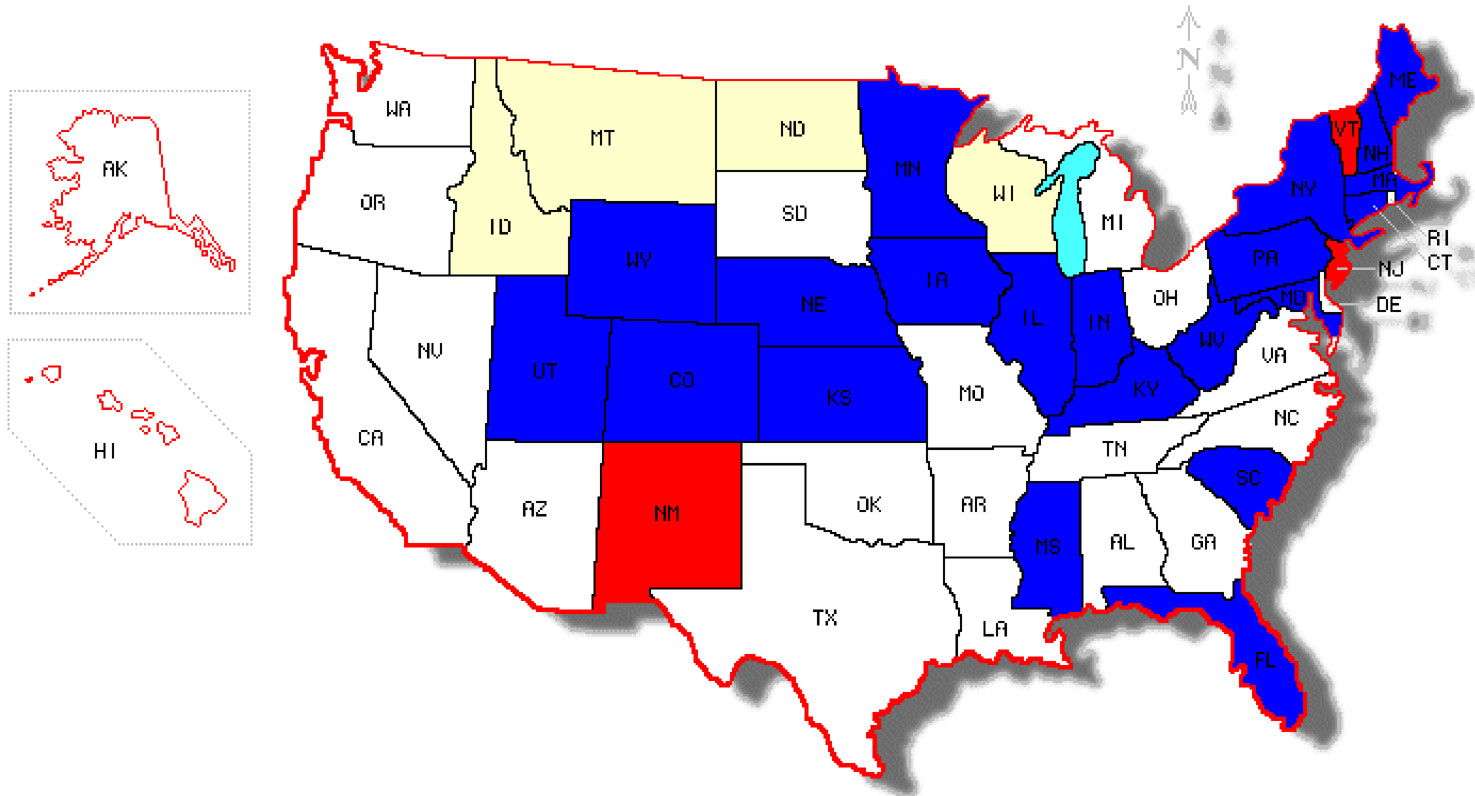
Considerations:

- Significant DMAS resources would be required and it could take a year or more to get CMS approval and develop and implement a new program

Brain Injury Waiver Programs in Other States

- As of June 2015, there were 25 brain injury waiver programs in 21 states and 3 states included brain injured in 1115 waivers (NJ, NM, and VT)
- Services typically include:
  - Adult day care
  - Personal assistant
  - Cognitive rehabilitation
  - Homemaker
  - Home accessibility modifications
  - Durable medical equipment
  - Therapies
  - Respite care
  - Prevocational and supported employment services
  - Personal emergency response systems
- In some states, a non-Medicaid agency may be responsible for administering the operational aspects, while the Medicaid agency is responsible for submitting the wavier application and general oversight

Brain Injury Waiver Programs in the U.S.



Blue – TBI/ABI Medicaid HCBS Waiver Program
Yellow – Previous TBI/ABI HCBS Waiver
Red – 1115 Demonstration Waiver, includes TBI/ABI

Recommendation:
Apply for a Section 1915(i) Home State Plan Amendment

Advantages:

- Allows states to offer home and community based services as state plan services, versus using a waiver

- States can limit services to particular groups

- Beneficiaries with significant needs can receive waiver services without meeting institutional level-of-care criteria

Considerations:

- Services must be provided to all enrollees who meet the meet inclusion criteria
  - Enrollment cannot be limited

Recommendation: Apply for a Section 1915(k) Medicaid Community First Choice State Plan Amendment

Advantages:

- Allows states to receive a six percentage point enhanced federal match for attendant services
- Individuals with incomes above 150% of the federal poverty level can receive services if they meet institutional level-of-care criteria
- Can include transition cost and security deposits for those transitioning from an institution
- Providers can be family members

Considerations:

- It may be difficult to predict and control costs
- The need for waivers is not eliminated, due to the limited new state plan service (attendant services only)

Recommendation:
Apply to Participate in the Program for All-Inclusive Care for the Elderly (PACE) Innovation Act Demonstration

- The PACE Innovation Act of 2015 allows the Centers for Medicare & Medicaid Services (CMS) to develop pilot programs using the PACE model to serve:
  - Individuals under age 55 and
  - those *at risk* of needing nursing facility care versus meeting the criteria for nursing facility care
- Individuals with traumatic brain injury may also be included in some demonstrations
- It is expected that a request for proposals will be issued by CMS in late 2016

Recommendation:
Modify Language from 2016 HB 30 Item #310M
Interagency Task Force on Brain Injury

- "The DMAS, ~~in collaboration with the~~ DBHDS and DARS, shall ~~develop a~~ *form an* ~~work group~~ *Interagency Implementation Team* with community stakeholders to ~~create~~ *implement* a *statewide program* ~~five-year strategic plan~~ for delivering comprehensive brain injury services…"

- The ~~department~~ *Interagency Implementation Team* shall report progress annually on achievement of measurable objectives, including, but not limited to:

  - **improving data capture of annual incidence of brain injury as defined in the *Code of Virginia* (the final 2016 language included this sub-section)**

  - analysis of instate and out-of-state health care utilization and expenditure data of Virginians with brain injury

  - projections of need and costs of a comprehensive array of brain injury services within Virginia *and new Medicaid authorities needed to implement* ~~including a publicly funded instate neurobehavioral treatment program and a brain injury~~ home and community-based *services* ~~waiver~~ for persons with brain injury

  - *Establish Medicaid payment rates that are adequate to support the operation of a publically funded, in-state neurobehavioral rehabilitation program and* ~~the design and implementation of a pilot project to~~ repatriate Virginians receiving care out of state…"

Policy Options	
Option 1	Take no action
Option 2	Request by letter of the JCHC Chair that DARS, DMAS and DBHDS form an Interagency Implementation Team to ultimately implement a statewide program to serve individuals with brain injury, including determining whether, and if so, which new Medicaid authorities need to be sought. The Team's first task will be to determine program structure and cost, and report progress back to the JCHC by November 2017.
Option 3	Request by letter of the JCHC Chair that DMAS determine Medicaid payment rates and methods that will incent the opening and ongoing operation of in-state neurobehavioral/nursing facility units for individuals with brain injury and dementias with challenging and aggressive behaviors; and report back to the JCHC by November 2017.
Option 4	Request by letter of the JCHC Chair that DMAS determine a plan, including budget estimates, to add new services to the Medicaid Elderly and Disabled with Consumer Direction Waiver to provide needed long term services and supports for Medicaid beneficiaries; and report back to the JCHC by November 2017.

Policy Options	
Option 5	Request by letter of the JCHC Chair that DMAS determine budget estimates for applying for a Medicaid wavier specific to brain injury; and report back to the JCHC by November 2017.
Option 6	Request by letter of the JCHC Chair that DMAS determine budget estimates for applying for a state plan amendment [1915(i) or 1915(k)] to provide additional home and community based services for Medicaid recipients not enrolled in a 1915(c) HCBS waiver; and report back to the JCHC by November 2017.
Option 7	Request by letter of the JCHC Chair that DMAS apply for the PACE Innovation Act pilot program.
Option 8	Introduce budget amendment (language and funding) to increase state funds for the Auxiliary Grant.
Option 9	By letter of the JCHC Chair, express support for Senate Bill 317, carried over to 2017, to create Veteran's Dockets.

Public Comments

Written public comments on the proposed options may be submitted to JCHC by close of business on September 28, 2016.

Comments may be submitted via:

- ❖ E-mail: jchcpubliccomments@jchc.virginia.gov
- ❖ Fax: 804-786-5538
- ❖ Mail: Joint Commission on Health Care
P.O. Box 1322
Richmond, Virginia 23218

Comments will be provided to Commission members and summarized and presented during JCHC's October 5th meeting.

Visit the Joint Commission on Health Care website
http://jchc.virginia.gov

Contact Information

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Richmond, Virginia 23218
pmargolis@jchc.virginia.gov
(804) 786-5445 ext. 4

Appendix A: Summary Chart of Medicaid Options for Covering HCBS

Feature	State Plan Personal Care 1915(i)	HCBS Waiver 1915(c)	State Plan HCBS 1915(k)
Entitlement	Cannot target services by age/diagnosis Must provide services to all categorically eligible individuals who meet eligibility criteria Must be provided statewide	Can target services by age/diagnosis Can limit the number of people Can limit the geo-graphic area	Can target services by age/diagnosis Must provide services to all in an eligibility group who meet the eligibility criteria Must be provided statewide
Financial Criteria	Beneficiaries must meet community financial eligibility standards	States may set financial eligibility criteria up to 300% of the SSI benefit	States may set financial eligibility criteria at 150% of the FPL or 300% of the SSI benefit
Eligibility Criteria	Beneficiaries must have functional limitations, specified by the state, that result in a need for the services covered	Beneficiaries must meet the minimum institutional level-of-care criteria and have a medical/ functional need for the specific service	Beneficiaries under 150% of the FPL can meet functional eligibility criteria that is less stringent than institutional level-of-care criteria Beneficiaries under the 300% of SSI must meet institutional level-of-care

Summary Chart of Medicaid Options for Covering HCBS, Cont'd

Feature	State Plan Personal Care 1915(i)	HCBS Waiver 1915(c)	State Plan HCBS 1915(k)
Services	Only those specified in the Federal defini-tion of personal care services	Can include a broad array of state-defined services, only some of which are specified in statute	Can include a very broad array of state-defined services, only some of which are specified in statute
Payment of Relatives	Relatives, other than legally responsible relatives, may be paid to provide personal care	Relatives, including those legally responsible, may be paid to provide personal care and other services determined by the state	Relatives, including those legally responsible, may be paid to provide personal care and other services determined by the state
Federal Match	Regular rate	Regular rate	Six percentage point enhanced rate for attendant services

Appendix B

Level 4	Virginia Medicaid Section 1915(c) Home and Community Based Waivers - Key Features
Elderly and Disabled with Consumer Direction (EDCD)	• Individuals must meet nursing facility criteria; may be served while on waiting list for other waivers; cannot be receiving Auxiliary Grant funds, or live in an assisted living facility
Individual and Family Developmental Disabilities Support and Intellectual Disabilities under redesign by DBHDS	• Must be 6 years or older with a diagnosis of DD, MR/ID, meet at least two level-of-functioning indicators and require care provided by ICF/MR • May be 21 or older (if injured before 22) or under 6, if at risk of a developmental disability • May be placed on waiting list and enroll in EDCD waiver
Alzheimer's Assisted Living	• Alzheimer's or related dementia, no serious mental illness or intellectual disability, must be an Auxiliary Grant recipient, and reside in an assisted living facility (ALF); will sunset in 2018
Day Support	• Must have intellectual disability, be on a wait list for the ID/DD waiver, meet criteria for ICF/MR, and have at least two level-of-functioning indicators
Technology Assistance	• Individuals who require substantial, ongoing skilled nursing care or dependent on technology to substitute a vital body function and have exhausted 3rd party insurance. Will be folded into EDCD waiver in 2017