Meeting Minutes

Brain Injury Services Workgroup Minutes

Date: 8-30-2022

Time: 1:00 – 3:00

Link:

https://covaconf.webex.com/covaconf/j.php?MTID%3Dm36153b8a35595af5af8811742b307bd6&sa=D&source=calendar&ust=1662309107877061&usg=AOvVaw2ZYiR2sL6IiPiKd_9gD0ow

Meeting Minutes

Attendees:

In-Person Attendees:	Virtual Attendees:	
Angie Vardell	Linsey Mangilit	
Brian Campbell	Benson Pulfer	
Adam Goldman	April Payne	
Izaak Funke	Christy Evanko	
Katie Morris	Dana Parsons	
Barbara Seymore	Daniela Pretzer	
Nichole Martin	Elizabeth Seward	
Kross Kaai	Erin Haw	
Alexis Aplasca	Jason Young	
Chris Miller	Jennifer Fidura	
Jamie Swann	Joani	
Ivan Velickovic	John Morgan	
Amol Karmarkar	Joshua Myers	
Karin Addison	Lisa McCarthy	
Heidi Dix	Lisa Walker	
	Lucy Cantrell	
	Maureen Hollowell	
	Rachel Evans	
	Sonja Lee-Ausin	
	Joe Fisher	

Agenda Items:

- Medicaid 1915c vs. 1915i comparison
- Waiver Options/Waiver Overviews
- 1115 Waiver Overview
- HCBS Settings rule
- Service Continuum Discussion
- Homework-Continuum Survey

Welcome and Introduction – Brian Campbell

- Brief overview of the upcoming topics:
  - Service needs, continuum of care, level of care
  - Report to GA on Dec 15th, meeting to discuss on the 13th w/ copy and draft for review
  - Waiver program, RFP live as of Friday, rate study/design in progress
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Speaker 1 – Nichole Martin, Waiver Comparison

- 1915(c) Waiver and 1915(i) State Plan Amendments
  - 4 1915(c) waivers, DE waiver and CCC+ waiver
- 1915(i) is a state plan amendment, we'll discuss differences
- The (i) does not require an alternate institution
- But what's being waived?
  - With the (c) waiver, you don't have to offer the service in a state wide capacity. You may also be able to target a specific population
  - For an (i) waiver you may not have to account for comparability of income
- The (c) and (i) waiver templates are fairly intensive, with the (c) waiver being around 100 pages
- The (i) waiver is a one-time approval, the (c) waiver lasts for 3 years at first, then requires renewal every 5 years
- The (i) waiver will also require 5 year renewal if it targets a specific population
- Otherwise, they both share a lot of requirements, such as annual reporting
- (c) and (i) have different Medicaid Eligibility, Institutional criteria may cover different income groups
- **See comparison table PDF**
- The (c) Waiver may require an alternate institution (nursing home, etc), with the (i) waiver it will not require that and it will open up the 300% SSI category. I waivers are generally better for targeting specific populations.
- **Neither can cover room and board except with specific exception**
- The (c) waiver can limit the number of people served, while the (i) waiver cannot have a limit placed upon it. The (c) Waiver can have a waitlist, the (i) waiver cannot, everyone must be served.
  - Case management will be on the state plan, no wait list. With the (i) waiver, without a wait list the cost estimate could be less predictable.
- CMS says you can target or decrease the targeted population as needed.
- Case management is separate from either the (i) or (c) waivers. (i) and (c) waivers share allowable services.
- (c) waivers must be defined as "cost effective"
  - Annual cost cannot exceed average annual cost of institutional care for each target groups. There is no such requirement for the (i) waiver.
- (c) waivers must use the state plan first, I waiver may be eligible for the state plan as well.

Post-Presentation Review and Q/A

- State plan services and clinically directed services don't have to be included in the cost effective calculations.

- Q: If we select an institution, how do we screen?
  - A: Screening would be based on level of care
- Q: What would be the comparable institution, I assume not an ICF?
  - A: We don't really have an established facility base for brain injuries. We'd need either an IBCED(?) Site, or a nursing home. This is why we're developing the institutional rate and structure as a part of the workgroup in the hopes of coming up with a structure for this.
- Q: Does there actually have to be an institutional placement in VA or can we just go by cost if there was one?
  - A: I think it would have to be in VA.
  - Q: But couldn't a state identify what the cost would be in state without having a facility developed?
    - A: I think we would need a facility because we have to be able to track and report our costs and I don't think we could do that unless we had the facility data in the first place.
- Q: I know we talked about nursing facilities but how would a nursing facility fit the criteria?
  - A: For a neuro-rehab center we'd have to develop and identify the costs. A lot of states are doing it as part of a nursing facility, but if we target psych, for example, then it might be more of an 1115 waiver topic.
- Q: For brain Injury clubhouses, none of the mental health clubhouses are nationally accredited and that's because they do psychosocial rehab for Medicaid. PSR is sort of antithetical to the clubhouse model.
  - A: Yes, I'm just using the clubhouse model as an example. We may be able to use something like that a model for state plan.
- Q: What do you mean by clinically led services?
  - A: A service must be led or overseen by a licensed clinician. If a clubhouse is led by a clinician then it may be eligible. Day support is not usually led by a clinician, and that's why it wouldn't qualify for the waiver.
- Q: So for day support we would need someone with brain injury support?
  - A: Right, and that's why we're targeting the waivers as a solution.
- **Note: clubhouses are not usually clinician led**
- Q: We talked about caps and these caps are aggregate, right?
  - A: Yes.
- Q: So it doesn't matter what the individual cost is then? So we would need the General Assembly to add a new state plan service, right?
  - A: In terms of cost reporting what we're trying to focus on is the member cost and financial eligibility, but we should bring up the aggregate cost later because that is important too.
- Q: I just think that all that stuff needs to be considered by advocates and if we can avoid having to go back and ask for more things the better.
- Q: I would strongly consider that we don't look at nursing facilities for cost effectiveness because they are going to be significantly cheaper than what a facility focused on this would be.
  - A: For cost comparisons we wouldn't just pick any nursing facilities. We would use a specific specialty facility.
  - A (cont): We would use a nursing facility that focuses on neurological issues.
  - A: And we would use those new costs for comparisons.
- Comment: If we are doing an (i) waiver then there is no waiting list and that eliminates the issues and concerns about the waiting list issues we have. I don't know how many people are going to be eligible, but we should strongly consider measuring our capacity with facilities and workforce and expertise. If people are eligible but still not able to get services then we won't
- Comment: Targeted case management is already a thing we're dealing with. We have an (i) plan with 22,000 people with severe TDI, and this would layer targeted case management without the associated certifications.

Speaker 2 – Katie Morris, HCBS Presentation

- HCBS Published Jan 16 2014, meant to catch people who may have been previously isolated and referred to as the “Final Rule”. All 1915C rules must be fully compliant with the Final Rule before receiving CMS approval to operate.
- Individuals can still be isolated in a community if every aspect of their lives is scheduled and they lack autonomy or individual choice. HCBS is meant to take into account the individual’s quality of care and life.
- HCBS community based settings:
    - 1. Integrated into the greater community
    - 2. Provides opportunities to seek employment
    - 3. Ensures the individual receives services in the community to the same degree of access as individuals not receiving Medicaid HCBS services
    - 4. Chosen by the individual
    - 5. Uses person-centered plans
    - 6. Ensures individual’s rights of privacy, dignity, respect.
    - 7. Optimizes autonomy and independence
    - 8. Facilitates individual choice
- Specific rights for individuals that choose to receive services in a provider owned or controlled setting (someone whose housing is tied to the services they receive, eg. A group home)
    - Privacy, lockable doors, lease with legally enforceable agreement, furnishing, freedom of autonomy, access to food, right to have visitors
    - Q: Regarding to access to food, how do we enforce that with regards to people with impulse control?
        - A: See modifications. (Below)
- Modifications:
    - For certain services the rights can be adjusted on a time-limited basis. If all less restrictive options have been tried, a provider can implement a modification with agreement from the person or a designated decision maker.
    - All modifications must be person centered. EG. If a person has a problem with impulse control regarding food, their access to food can be limited based on medical necessity.
    - DBHDS A: DBHDS settings must be compliant with human rights regulations.
    - Modifications are not expected to last forever, they must be reviewed periodically (roughly every quarter) and an individual must consent to the modification.
- Clear definitions are required to avoid issues and concerns, especially regarding modifications & coercion.
- Q: There is a whole human rights committee and process that needs to be followed, correct? When changing the behavior plan
    - There is an office of human rights for waivers, however this is TBD as the process is being built.
- Q: Given that we have developed brain injury specific Clubhouse, day programs, case management and employment services in Virginia, how would the final rule impact them regarding disability specific services provisions and requirement that setting being integrated?
    - A: We’re looking for settings that are integrated into the community. We would want a setting to be accessible in a normal way.
- Q: What happens if this (rights & modifications) is not followed by a provider? Is there a reporting/complaint process?
    - A: The office of human rights, if folks have a concern, then they can reach out to a Human Rights advocate.
- Q4 A: ALFs used to be a program for the alzheimer’s waiver. After much research and conversations with CMS, they did not meet compliance because in a lot of cases they did have a secure/locked unit that had people separated from the general community. They would be not be considered.
- Q: Would a college be considered a public institution.

- A: No, they would not.

Speaker 3 – Adam Goldman

- Medicaid Section 1115 Demonstrations
- CNOM – Cost Not Otherwise Matchable
- Features of 1115
  - Medicaid Authority of Last Resort
  - May waive certain provisions of Medicaid law
  - Requires public/tribal notice
  - Special terms and condictions, in this case how would the 1115 compliment the 1915 waivers. A lot of moving pieces and interlinking state initiatives and processes.
  - Cost neutrality issues associated with the 1115 waivers in light of the cost initiatives associated with the 1915 waivers.
  - Typically approved for 5 year periods, subject to renewal
- Current examples of 1115 authorities
  - Can not change the IMD settings without congressional approval.
  - Home and community based services have been recently authorized under the 1115 waiver rules. CMS is typically intended to mirror the programs in the diabled health groups.
  - VA has a few 1115 in existence
    - EG. With the ARTS service, we use the IMD to allow us to reimburse for adults because adults would be otherwise excluded from this service
- Level of Care determination, 1915 Waivers/SPAs
  - If we have a service or facility that can be run, but it fails to meet a specific qualification, we may have a workaround by adjusting specific authorities. Eg. We can't usually have a waitlist, but we could request one from CMS and get an exception or authorized workaround.
- Examples of ABI/TBI in 1115s
  - CA, CalAim
  - NJ, FamilyCare Comprehensive
  - NM, Centennial Care 2.0
  - VT, Global Commitment to Health
    - VT Law passed to allow a specifically run a "waiver of reasonable promptness"
  - NC Medicaid Reform
    - Reform adjusted to accommodate freedom of choice, see handout.
- The "Rulebreaker" (policies) generally let us move faster
- Q: How are we going to integrate these kind of programs, or are we going to measure the outcomes?
  - A: We're going to have to develop a system for measuring outcomes, demonstrations, and adapting which goals and measure sets to use. In this case, the majority of the authority would be under 1915, so there would not be as much division of authority under the 1115. There is always a cost based analysis when money is involved as associated stakeholders want to know what their bang for their buck is going to be.
- Q: If we're expected to show the functional level gains because that's what we're working for. Are we talking about a wide range of measure, some based on what Medicaid provides and some of our own choosing?
  - A: CMS may want to see what the quality of care metrics are, there's going to be a little bit of a push and pull involved, and there are going to be cost analysis as well. It's a mix of standard quality metrics and unique hypotheses based on the project that you're managing.

    - A (cont): It's also going to be based on the amount of risk from CMS's perspective. If under the 1115 authority they requested a waitlist then they may request more detailed information based on that exception, associated with that waitlist. Generally, they're going to want information associated with anything that is non-standard.
- Q: The only other type of delivery system I've heard in other places are specialty plans? Is that something we're considering if, say, an MCO serves a specific population with a specific plan?
    - A: With our current MCO contracts we do allow for pilot programs or enhanced services outside/beyond what the state plan includes. We currently use a B-waiver to handle freedom of choice.
    - T. Whitlock A: We can do/there are states that do specialty plans. This is usually done at the beginning of a procurement. This would still need to be done as a waiver because we don't currently have the required structure. Specialty plans are an option, we would have to get authority to do it, but these don't usually start in the middle of a contract. If we did it right now we would have to convert one of our 6 plans to a specialty plan or start a procurement to get a new plan to specialize in, and we would need to use the 1915 or 1115 waiver.

Speaker 4 – Brian Campbell, Review and Next Steps

- At this point we're not making decisions, we're just discussing options to get this report out before doing more robust activity such as rate studying or structure discussions.
- We're going to look at the continuum of services right now.
    - In the chart (shared online live) we can see how the services are sorted based on the intensity of care.
    - **Please review the chart.**
    - After, we will send out survey questions regarding the continuum of care thoughts and ideas.
    - What we want to think about is what services are needed to effectively transition someone out of the hospital and back into their community. What's going to make that transition easier, more humane, and more effective.
    - Comment: What we're going for here is that we want to think of what this whole plan could/should look like for this population. I guarantee we won't get all the services we want approved at the start, but we will still benefit from having a master-plan to work towards. We can make cost-based decision making *after* we have an idea of what a full plan would look like.
    - We're developing the waiver for people based on need, but the state plan is for what medical supports people may need temporarily. In general, people should be able to easily and functionally transition between these different categories, but some people may need long-term support or not be able to transition below.
- Q: When you say facility, that can be a hospital, but then a hospital might provide some of these other services.
- A: For the moment we're going to focus on the facility and if the facility has the ability/units needed to provide those services.
- Suggested additions to the chart:
    - Inpatiant Rehab
    - Acute Hospital Care
    - LTACS (Medicaid doesn't cover this)
- Comment: We may want to consider making the facilities level one, and keep the services at different levels of intensity to account for the fact that multiple services may be provided within a single facility.
- Comment: The licensure of each building will dictate what kind of services you can provide. Also different facilities that fit the same category may simply have different subfacilities, eg. Not every hospitals are going to be equipped to provide the same rehabilitation services.
- Ann Comment: When we talk about neurorehabilitation we're thinking about neurorehab provided by a qualified therapist. There are categories of those models across the continuum as well.
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Conclusion/Next Steps –

- Surveys will be sent out, please answer them.
- Documents will be sent out for your own use.
- Ann from the Brain Injury Association would like to discuss a brain injury survey.

Chat Log:

from Izaak Funke to everyone: 1:03 PM
Thank you for joining, if you have any questions feel free to add them in the chat. I'll be monitoring the chat for you.
from Angie Vardell to everyone: 1:09 PM
Can you all see the PDF?
from Christy Evanko to everyone: 1:09 PM
I can't, but you sent it to us
from tammy whitlock to everyone: 1:36 PM
Maureen is correct. We count ALL services in the cost effectiveness
from Christy Evanko to everyone: 1:53 PM
There is a whole human rights committee and process that needs to be followed, correct? When changing the behavior plan
from Izaak Funke to everyone: 1:55 PM
A: There is an office of human rights for waivers, however this is TBD as the process is being built.
from Jason Young to everyone: 1:57 PM
Given that we have developed brain injury specific Clubhouse, day programs, case management and employment services in Virginia, how would the final rule impact them regarding disability specific services provisions and requirement that setting being integrated?
from Rachel Evans to everyone: 1:57 PM
What happens if this (rights & modifications) is not followed by a provider? Is there a reporting/complaint process ?
from LINSEY MANGILIT to everyone: 2:01 PM
What would ALF's fall under? Compliant HCBS or not?
from Brain Injury Association of Virginia to everyone: 2:03 PM
What is meant by public institution?
from Brain Injury Association of Virginia to everyone: 2:39 PM
A survey would be helpful, I think
from Christy Evanko to everyone: 2:42 PM
Is the spectrum for a person as s/he improves after having an injury or is it a spectrum of people with different needs. It seems like the latter but I think you said it was the former. Some of the services don't seem like they are short term