BIS Phase 1 Workgroup Meeting
Session I - 8/16/2022
From 1-3pm

Workgroup Member Introductions

Introductions were made between the Brain Injury providers throughout the Commonwealth, and the DMAS lead-team in conjunction with sister agencies (DBHDS, DARS, VCU Health, VAHP, MCO representation, VHHA, VACSB, etc.)

Legislation

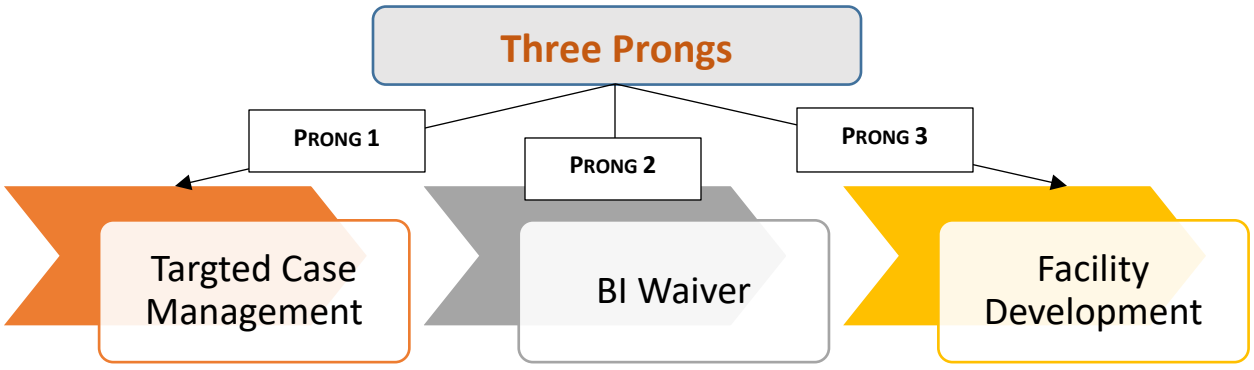
House Bill #680 directs DMAS to update the State Plan for Medical Assistance to incorporate provision for payment of Medicaid targeted case management services for individual with severe traumatic brain injury.

"The workgroup shall make recommendations in the plan related to relevant service definitions, administrative structure, eligibility criteria, reimbursement rates, evaluation, and estimated annual costs to reimburse for neurobehavioral institutional care and administration of the waiver program."

The appropriation act supported the bill by issuing funds in the DMAS medical budget for implementation of the service.

Overview – BIS Project

The DMAS team provided a high-level view of the project, its scope and a basic timeline on deliverables.



Prong 1 → Establish Targeted Case Management to serve individual with Traumatic Brain Injury

Prong(s) 2 & 3 → Convene a workgroup comprised of DMAS, sister agencies, and providers from across the Commonwealth of Virginia. This workgroup is charged with the development of a plan for a neurobehavioral science unit and waiver program for individuals with brain injury and neuro-cognitive disorders.

Timeline

- → Aug – Sept, 2022: Gather input, share project plan and policy overview;
- → Oct, 2022 – June, 2023: Rate development/cost assessments;
- → Nov, 2022 – April, 2023: Populations and program, submit budget request for 2024 session; and
- → Feb – June, 2023: TCM implementation

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Comments and Workgroup Feedback

Most needed services:

- Club House/Day Support Programs (of note, it was mentioned these two programs are somewhat different in scope and delivery)
  - With removal of burdensome restrictions - in many programs, individuals must be able to demonstrate ability to navigate ADLs/IADLs for self. This is true of the S. Hampton Road programs;
  - Transportation to/from program and not restricted to NEMT;
- Step-down unit upon hospital D/C;
- Increased accessibility to neuropsychological exams – currently most are out of pocket;
- Stable housing;
- EHBS/AT/EM
- Community-based residential services for individuals with co-occurring DD and TBI with evidence-based reimbursements methods;
- Behavioral support and respite services specific to TBI;
  - Crisis stabilization – access needed to immediate supports;
- Residential options
  - Need full range of residential services;
  - Currently few options for high need populations;
  - Aging population that has TBI – these types of services critical at a much younger age than their non-disabled peers due to early onset dementia, etc;
  - Aging caregivers need resources earlier vs. later to ensure adequate time for planning for future needs of loved one with TBI; and
  - In-home residential support;
- Transition and transition planning;
- Workforce and workforce development
  - TBI needs are different from other populations. Requires an informed and competent workforce.
  - Consider training needs much earlier in the timeline process.
  - Consider building a career development pipeline for up and coming graduates.
- Conservatorships;

Other comments and barriers identified:

- Consider those programs and/or existing services which may apply or be used;
  - A type of cross pollinating with the MCOs, CCC+, and TBI/TCM groups
- Consider a review and comparison of other states to benchmark Virginia's programs and develop 'best-practice' approaches;
  - In-home
  - Supported living

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  - Club house
  - Individuals seeking residential care for neuro-behavioral issues, etc.
- Clear delineation is critical between TBI and ABI
  - Concern noted that – the way the TBI language appears, it may unintentionally build silos between groups, such as TBI vs. ABI or TCM for TBI vs. other target populations.
- Increased access to medical services through CCC+
- TBI diagnosis is a barrier itself to services in facilities; Can we create a system that supports co-occurring diagnoses (e.g., TBI and SUD, etc)
  - Wrong milieu
  - Facility not equipped to handle the needs, etc.
- Uninformed workforce on TBI characteristics and/or behaviors. In other states they use CARF, JACOA, etc., accreditation;
  - Memory
  - Attention
  - Fabrication vs. confabulation
- Ineffective hospital D/C plan for TBI patients;
  - Need seamless continuum of wrap-around supports and services;
  - WTCSB Region V was recommended as a place to start. Consists of:
    - Residential home only for those D/C from the state hospital
    - Day programs eligible for TBI and cognitive issues;
      - Training was provided via Rehab of VA
- Sheltering Arms worked with agencies across the state in person or virtually. Those connected prior to D/C experience smoother transition back to community. Services pre-D/C are:
  - Family support and education on brain injury;
  - Housing managed by care managers;
  - Rapid placement for those being D/C;
  - Assistance with applying for disability or returning to work; and
  - Financial assistance for augmentative communication devices.

Next Steps

Posting for RFP
Rate Methodology
Consulting with contractor and CMS for HCBS waivers
Homework to come
Introduction to the Waiver system
Potential survey development and dissemination to workgroup for feedback
Begin focused effort on services that should take priority

Next Meeting – August 30, 2022 (hybrid)