COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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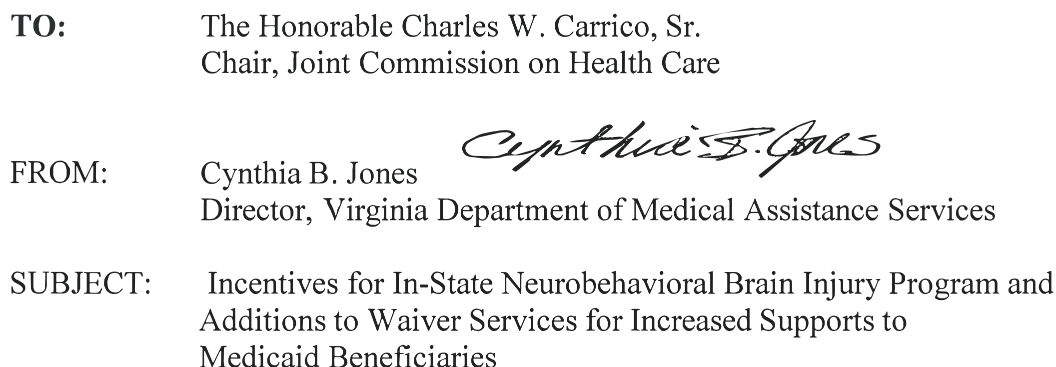
November 1, 2017

MEMORANDUM

TO: The Honorable Charles W. Carrico, Sr.
Chair, Joint Commission on Health Care



FROM: Cynthia B. Jones
Director, Virginia Department of Medical Assistance Services

SUBJECT: Incentives for In-State Neurobehavioral Brain Injury Program and Additions to Waiver Services for Increased Supports to Medicaid Beneficiaries

In a letter dated December 14, 2016 from the Joint Commission on Health Care, the Department of Medical Assistance Services was requested to: 1) determine Medicaid payment rates and methods that would incent the opening and operation of an in-state neurobehavioral/nursing facility units for individuals with Brain Injury (BI) and dementia with challenging and aggressive behaviors and 2) determine a plan, including budget estimates, to add new services to the Medicaid Elderly or Disabled with Consumer Direction (EDCD) waiver to provide needed long-term services and supports for Medicaid beneficiaries. The Commission directed the department to report its findings to the Joint Commission on Health Care by November 1, 2017.

Should you have any questions or need additional information, please feel free to contact me at (804) 786-8099.

CBJ/

Enclosure

pc: The Honorable William A. Hazel, Jr., MD, Secretary of Health and Human Resources

Incentives for In-State Neurobehavioral Brain Injury Program and Additions to Waiver Services for Increased Supports to Medicaid Beneficiaries

A Report to the Joint Commission on Health Care — *November 1, 2017*

Report Mandate:

In a letter dated December 14, 2016 from the Joint Commission on Health Care, the Department of Medical Assistance Services was requested to: 1) determine Medicaid payment rates and methods that would incent the opening and operation of an in-state neurobehavioral/nursing facility units for individuals with Brain Injury (BI) and dementia with challenging and aggressive behaviors and 2) determine a plan, including budget estimates, to add new services to the Medicaid Elderly or Disabled with Consumer Direction (EDCD) waiver to provide needed long-term services and supports for Medicaid beneficiaries. The Commission directed the department to report its findings to the Joint Commission on Health Care by November 1, 2017.

Background

The Department of Medical Assistance Services (DMAS) has engaged in collaborative on-going efforts with providers, stakeholders and other agencies toward establishing a comprehensive system of care in the Commonwealth to meet the complex needs of individuals who have suffered a brain injury (BI). To date, sixteen (16) studies have been completed in order to evaluate available resources and gaps in services for this population. Some studies have recommended the establishment of an in-state, in-patient neurobehavioral program for individuals who demonstrate aggressive and challenging behaviors. Studies have further indicated that the current Virginia Medicaid Home and Community-Based Services (HCBS) waivers do not cover all the services needed to support this population in the community.

Action Taken

DMAS convened a small work group that met from April through June of 2017 to address the specific mandates specified above. The work group included a representative from the Virginia Department for Aging and Rehabilitative Services (DARS), which serves as the lead agency for BI services in the Commonwealth, a representative from the Brain Injury Association of Virginia (BIAV) and DMAS staff. It is important to note that this Medicaid-led stakeholder workgroup operates in conjunction with a workgroup led by DARS, which is charged with developing a statewide service delivery system for individuals living with BI.

Report Directive 1:

Determine Medicaid payment rates and methods that would incent the opening and operation of neurobehavioral/nursing facility units in the Commonwealth for individuals with brain injury and dementia with challenging and aggressive behaviors.

About DMAS and Medicaid

DMAS' mission is to ensure Virginia's Medicaid enrollees receive high quality and cost effective health care.

Medicaid plays a critical role in the lives of over a million Virginians, providing health care for those most in need. Medicaid enrollees include children, pregnant women, parents and care takers, older adults and individuals with disabilities. Virginians must meet income thresholds and other eligibility criteria before qualifying to receive Medicaid benefits.

Medicaid covers primary and specialty health care, inpatient care, and behavioral health and addiction and recovery treatment services. Medicaid also covers long term services and supports, making it possible for thousands of Virginians to remain in their homes or to access residential and nursing home care.

Quick Medicaid facts:

- Covers 1 in 8 Virginians
- Covers 1 in 3 births and 33% of children
- Supports 2 in 3 nursing facility residents

Virginia Medicaid and Children's Health Insurance Program (CHIP) are administered by the Department of Medical Assistance Services (DMAS) and are jointly funded by Virginia and the federal government under the Title XIX and Title XXI of the Social Security Act. Virginia generally receives $1 of federal matching funds for every $1 Virginia spends on Medicaid.

The DMAS Divisions of Provider Reimbursement (PRD) and Aging and Disability Services (DADS) met with a private provider interested in serving this population, and discussed components of a nursing facility-based neurobehavioral program.

The current method of reimbursement for specialized care is prospective (i.e., determined in advance) and is based on provider cost data adjusted for differences in health care wages (based on geographic region) up to a limit (ceiling). DMAS concluded that a variation of the specialized care per diem payment methodology would best serve as an appropriate reimbursement model for a neurobehavioral program in the Commonwealth due to the intensity of services provided.

Information from the private provider was shared with the DARS led workgroup charged with developing a statewide service delivery system for individuals living with brain injury.

DMAS has determined that the following methods would incent the opening and operation of neurobehavioral nursing facility units in the Commonwealth: (1) Authority from the General Assembly to promulgate regulations to establish the neurobehavioral program and establish criteria and industry recognized definitions (e.g. "traumatic" brain injury (TBI), "acquired" brain injury (ABI), and neurobehavioral); (2) Authority and funding to establish additional community services for the individuals who, after treatment, would be transitioning from a neurobehavioral nursing facility unit to the community to ensure successful transitions;
(3) Enhanced funding to increase rates for existing community services to avoid wait lists for these services; and (4) The establishment of an adequate reimbursement rate to encourage providers to develop complex, resource-intensive costly services such as behavioral management and neuropsychological interventions. If funded, further work would be needed to fully prepare and operationalize a successful neurobehavioral unit.

Financial Forecast for an In-State Facility-Based Neurobehavioral Program for TBI Individuals

Year	Fiscal Impact	General Funds
Year 1*	$1,335,718	$ 667,859
Year 2	$1,717,617	$ 858,809
Year 3	$2,465,386	$ 1,232,693
Year 4	$3,619,736	$ 1,809,868
Year 5 **	$4,434,722	$ 2,217,361

Cost estimates provided by DMAS PRD

** Based on the private provider's feedback Year 1 would be no earlier than SFY 2020*
*** Fiscal impact based on a total of 30 admissions at the end of 5 years (to include individuals returning from out of state, individuals transferring from nursing facilities, and individuals transferring from the community)*

With regard to the inpatient unit, DMAS PRD assumed that all of the individuals in current out-of-state placements (12 individuals) would not return to Virginia in year one (FY 2020) due to a variety of factors including: transition issues, stability, and case management needs. Therefore, when DMAS RPD developed the estimate (depicted above), the program predicted that a maximum 5 individuals being treated out of state would return to Virginia for treatment and an additional 5 individuals currently residing in the Commonwealth would avail themselves of this new opportunity for inpatient services.

The DMAS PRD analysis assumes that all individuals with TBI in out-of-state placements will return to Virginia by Year 2 of the program (FY 2021).

Report Directive 2:

Determine a plan, including budget estimates, to add new services to the Medicaid Elderly or Disabled with Consumer Direction (EDCD) waiver to provide needed long-term services and supports for Medicaid enrollees.

On July 1, 2017, individuals who were previously enrolled in the EDCD Waiver and the Technology Assisted Waiver transitioned into a newly-established Medicaid program, the Commonwealth Coordinated Care (CCC) Plus Waiver. This shift results in transition of individuals receiving HCBS long-term services and supports (LTSS) from the fee-for-service (FFS) delivery model into a managed care model. By the end of 2017, all individuals enrolled in the CCC Plus Waiver receive services through Medicaid-contracted health plans.

Discussions in the stakeholder workgroup centered around services that could be offered to meet the behavioral needs of individuals with BI. As a result of these discussions and research into best practices in other states, a list of potential services for inclusion in CCC Plus Waiver was developed. The services identified have been reported to DARS for inclusion in their development of a state-wide long-term plan for BI.

Addition of Potential CCC Plus Services

Potential Services to be Added	Proposed Waiver Service Rates	
	*NOVA	ROS
Community Coaching/Supports	33.53	29.24
Community-based Crisis Supports	101.67	88.41
Center-based Crisis Supports	101.67	88.41
Individual & Family/Caregiver Training	53.35	46.39
Therapeutic Consultation (Psychologist/Psychiatrist)	83.71	72.75
Behavioral Intervention/per 15 minutes	89.00	81.00
Neuropsychological Evaluations	$83.00-$66.00 (qualified health care professional vs. technician administering testing)	

**Information on rates provided by the Division of Provider Reimbursement at DMAS. All service rates are per hour or per session*

Financial Forecast for Added CCC Plus Services

To estimate the cost of adding additional services to the CCC Plus program, DMAS staff considered claims paid in 2016 (prior to the CCC Plus Waiver) to include the services of Community-based Crisis Supports, Center-based Crisis Supports, and Individual and Family/Caregiver Training. Both Behavioral Intervention and Neuropsychological Evaluations services are available as Medicaid State Plan covered services and therefore, would not be an additional cost since they are already covered services.

DARS conducted a survey of the nine (9) providers it contracts with to gather additional information. From that survey, DARS estimated 121 individuals in the Commonwealth will be at risk of institutional placement based on their neurobehavioral needs and would benefit from these services.

Utilizing the identified services proposed by the workgroup and the numbers provided by DARS, DMAS expects that the average additional expenditure would be $16,011 per individual per year. The cost in 2020, including the 8 percent increase applied for the CCC Plus Waiver implementation and a 5 percent per year growth, would be $20,017 per person. DMAS assumed the number of eligible individuals would grow to 151 in 2020. Therefore, the cost of $20,017 per person (based on above methodology) would cost the state a total of $3,022,551 in General Funds in 2020.

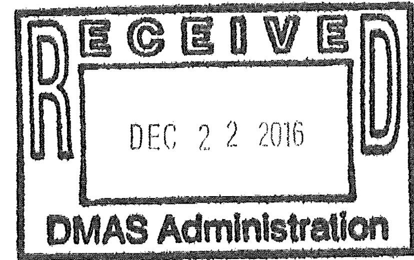
Summary

For the development of this report, the stakeholder workgroup focused on the costs of an in-state, inpatient nursing facility-based neurobehavioral program and the addition of new services to the CCC Plus Waiver. A significant challenge in meeting the LTSS needs of individuals with a BI or dementia who exhibit aggressive and challenging behaviors is identifying an appropriate setting for treatment, in both inpatient and community-based settings, and providing necessary interventions by trained and qualified staff. Numerous studies over the years have conveyed the need for a different system of care to meet the needs of those with BI.

A nursing facility-based inpatient neurobehavioral program would offer another level of care and better serve individuals suffering from brain injury and dementia which would progress those individuals to the goal of reentry into the community. DMAS, based on conversations with a private provider, determined the timeframe of 2020 was appropriate for establishment of the neurobehavioral nursing facility based program.

For those who may be able to live successfully in the community, the need is for the appropriation of authority and funding to permit the development of community-based resources with staff who have the appropriate education and skills to provide services.

Inpatient or community-based services will increase operational costs of the Commonwealth. It is the stakeholder workgroup's recommendation that this report be reviewed in conjunction with the work and forthcoming report to be submitted by DARS, to develop and ultimately implement a statewide program to improve services for individuals with BI.



JOINT COMMISSION ON HEALTH CARE

Senator Charles W. Carrico, Sr., Chair

Senator Rosalyn R. Dance, Vice Chair

December 14, 2016

Mrs. Cynthia B. Jones, Director
Virginia Department of Medical
Assistance Services

Dear Mrs. Jones:

On behalf of the Joint Commission on Health Care (JCHC), based on the policy options approved at the JCHC meeting held on November 9, 2016, I would like to request that the Virginia Department of Medical Assistance Services (DMAS): 1) 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, 2) 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. In addition, I request that DMAS report the findings to the JCHC by November 1, 2017.

I thank you in advance for complying with this request.

Sincerely,

Bill Carrico

Charles W. Carrico, Sr., Chair

CC: Michele Chesser
Paula Margolis

Michele Chesser, Ph.D., Executive Director
Joint Commission on Health Care
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