

# Michigan Department of Community Health Traumatic Brain Injury (TBI) Waiver Stakeholder Meeting

---

## Meeting Minutes

March 30, 2015  
10:00 a.m. – 12:00 noon  
Capitol Commons Center – Lower Level

### New Direction for TBI Waiver

**Facilitator:** Elizabeth Gallagher

**Attendees:** Brian Barrie, Carol Hansen, Amy Willing, Heather Hill, Tiffaney Romelus, Heather Slawinski, and Jacqueline Coleman (MDCH)

Dana Rogers (UofM Rehab), Lynn Brouwers (Rainbow Rehab), Kerry Williams (Region VII AAA), Steve Velzen-Haner (HHS Health Options), Kimberly Stove and Lauren Costello (Sparrow Hospital Rehab), Joe Richert and Animesh Anand (Special Tree Rehab), Michael Dabbs, Gina Aldredge and Kathy Sell (BIAMI), Cheryl Burda and Tracie Sebastian (Neuro Restorative), Tammy Goulding (Rehabs Without Walls), Melissa Lubbers (Siporan and Assoc.) Tammy Hannah (Origami Rehab), Margaret Kroese (Hope Network Rehab).

**VIA Phone:** Marie Baloga (AAA 1B), Mayra Ramos (Rescare)

#### MDCH Discuss New Direction

- After review of stakeholder input and MDCH internal review, change from 1915(c) waiver to 1115 Demonstration seemed best option
- Include some persons with an Acquired Brain Injury (ABI)
- Refocus services and supports and include only specialized services not available through other programs
- Make this a fee for service program
  - Fee service screens will be implemented (not per diem), would work similar to current MOU program where Prior Authorization claims will be submitted to CHAMPS
- Providers enroll in CHAMPS directly
- Review of purpose and hypothesis
- Must be signed by governor, anyone wanting to approach governor would be helpful!
- Budget is 2M for first year
- Intent to submit application no later than Oct 1, but will work on submitting this summer
- Reminder – this is a draft to review and make adjustments now in order to continue moving forward

### **Questions/Comments**

Q: Is there still a requirement for within how many months a brain injury must occur?

*A: We still think 15 months because of our budget.*

Q: Would there be caps on services?

*A: Yes, still working this out.*

Q: Would a person still transition out of waiver to MI Choice?

*A: We can set up person to be jointly enrolled in these programs. This is one reason for using the 1115.*

Q: Would waiver agencies be needed?

*A: Another reason for 1115 is there would not be a waiver agency because not needed, small population.*

Q: Do you feel comfortable with the date of submission?

*A: At this point yes.*

Q: Is this taking place of the current MOU?

*A: Yes, there will be no more MOU. Will also have more control over timeline because no RFP and other rules tied in to other waiver requirements.*

Q: Would it be helpful to lobby for more money?

*A: Yes, you can argue we can do better with more money.*

Q: If someone rotates off waiver, how will slots work?

*A: If 2 M budget, probably just 100 slots per year. Needs more discussion.*

Q: What is average cost per client in the current MOU program?

*A: About \$68,000 if using the full six months.*

Q: Any way to tap into Healthy MI money?

*A: Not sure, but they have big hurdles and we may not want to tie this into that program. This money was already identified in the budget and we are not asking for new money. This is easier sell to leadership and the state budget office because the money is already there. Once established, may be able to obtain more money in future. We can't have people in both Healthy MI and Brain Injury program because they are both 1115 demonstrations.*

ADDENDUM: Since the meeting, MDCH has learned that persons can be in two 1115 demonstration programs at the same time. This means it is possible to be enrolled in Healthy Michigan Plan AND the future 1115 Brain Injury Demonstration Program.

Q: Can a person be currently eligible as program is now, but would not be eligible in future?

A: *Would need disability determination if not on Medicaid originally. A Person needs medical disability determination approved with DHS, soon departments will be combined and hopefully will gain efficiencies in processes.*

ADDENDUM: *The requirement to have a disability determination no longer exists since we can have both the Healthy Michigan Plan and the 1115 Brain Injury Demonstration Program.*

Q: There is a five or 10 day window often to get into the program when a person is injured. Is there an appeal process?

A: *Everything with Medicaid has an appeal process.*

Comment: Understanding that TBI is under ABI, MDCH did not define in this well and it needs to be clarified.

Comment: Any brain injury is due to medical reason, so there are always other medical reasons for brain injuries.

*Response: Usually people have other resources to cover other medical issues, not brain injury. Perhaps there is a better way to word this. Exceptions used now were the base for this wording. MDCH will consider different wording options if you would like to email suggestions.*

### **Section 1115 Demonstration Program**

#### **Section I – Program Description**

- Review program description. Once in community, access to other programs such as MI Choice.

#### ***Questions/Comments***

Comment: CARF accreditation should be a specific list. Can be provided to MDCH.

Comment: This demonstration is good because person can be home and get rehab, good addition. Make sure there is flexibility with intensity of services in case family would like to provide home based services right at beginning and person still needs intensive rehab.

#### **Section II – Demonstration Eligibility**

- Priority for TBI who suffered injury within 15 months
- List of qualifying injuries (would like assistance with this list)
- Limit persons with ABI to no more than 25% of population served through 1115

### **Questions/Comments**

Comment: All TBIs are ABIs, so need language changes. Concern that numbers have been low for TBI.

*Response: We don't want to fill program with ABI and not serve TBI.*

Comment: This is why we go back to 15 month mark, don't want to not spend money on people who need it. Want to open door to service people who need it, especially with low TBI numbers.

Comment: If slots not being filled, we don't want money to be cut further.

Comment: Suicide and drug overdose used in past (in paper), don't like defining exceptions. It is tough to make those calls. There are metrics, but data is not always searchable. Could mine data annually for ABI vs TBI data. Would get better handle on needs. Could come up with % of ABI, but age would not necessarily correspond with ABI to connect all the dots.

### **Section III – Demonstration and Cost Sharing Requirements**

- No intent to have cost sharing requirements at this time
- Asterisk on some services because not enough time to determine if these were in the home and community based services portion that we have eliminated with this proposal. Some would need parameters, such as Environmental Accessibility Adaptations.

### **Questions/Comments**

Q: Is this similar to what nursing facilities do, provide state level cost share so more funds can come into state?

*A: Cost sharing is done in MOU. Person uses income for room and board and MDCH covers the services. Could set up a copay for services. Could set up what nursing facilities have, patient pay amount, look at income and have certain dollar amount to pay towards room and board, etc. Cost sharing means what beneficiaries have to pay for, such as copays.*

Q: We talked about neuro psych evaluation being barrier. Is this being considered?

*A: We can consider this but are not at that level of detail yet. Needs to be hashed out.*

Comment: Part of problem is delay in getting in to see a psych, would not make 15 month timeline. Access issues because not getting costs covered by providers. How can we go about working on access issue that is financial? In program now 5 hours treatment per day. We know needs to be in organized and structured program, does not always have to be OT and PT, etc. Could hone down on what therapies person actually needs to be more independent. One way to try to be more efficient. Also, still dealing with people with brain injury who need one therapist at a time, one-on-one and more expensive. Could find out what standard of therapy is and share with MDCH to allow you to see what median charge is for brain injury rehab. Maybe would be helpful for those looking at fee screens.

*Response: Yes, would be helpful for us to have.*

#### **Section IV – Delivery System and Payment Rates for Services**

- Envision all enrollments and services will be prior authorized at MDCH
- Fee screens will be established for services
- Providers will bill CHAMPS directly

#### ***Questions/Comments***

Comment: This would require providers to be enrolled in CHAMPS because this is the reimbursement system for Medicaid FFS.

Q: Are providers enrolled by facility or professional? If Facility, that sometimes becomes a catch because many brain injury facilities are not Medicaid certified.

*A: Up to provider to be entire facility or provider.*

#### **Section V – Implementation of Demonstration**

- Statewide once CMS approval granted

#### **Section VI – Demonstration Financing and Budget Neutrality**

- Moving forward with \$2,000,000 budget for first year
- Working with budget department to increase budget for additional years
- Comparing service costs to hospital level of care

#### **Section VII – List of Proposed Waivers and Expenditure Authorities**

- Will waive these items
- Full list yet to be determined

#### **Section VIII – Public Notice**

- Will have public comment and at least two public hearings
- Must have application complete for public hearings

#### **Section IX – Demonstration Administration**

- MDCH will administer

#### ***Other Questions/Comments***

Q: Back to ABI, strokes won't get services is my take away. Can we define target for strokes and see how that goes? Just because not done before, does not mean we can't do this. Should roll out treatment language.

*Response: How, ideas?*

Q: How many ABI do you see as referrals?

*A: About 25%.*

Q: What is biggest reason can't serve people now? What is limiting TBI? What is biggest barrier?

*A: Hospitals are discharging quickly and referral is the day before. We don't have enough information to continue with referral because person discharged quickly. Most referrals lately from nursing facilities because hospitals won't hang on to them.*

Comment: Many times TBI more related to auto, and no fault is available. ABI does not have this resource and this is the concern. Don't want TBI to slip through crack but want to help people get services and not be denied. Percentage for ABI should minimally be 50% as estimate.

Comment: The 1115 gives flexibility, more control, easier to figure out payment because not capitation. Last bullet is biggest concern. Most people have an underlying medical issue. Suicide and substance abuse could all be disqualified and that is not the intent. Comfortable with most of ABI limitations listed because we don't know how this will play out, but current ABI language still has flexibility and seems quickest way to get us started.

Comment: One caution on looking at other states. Federal money originally TBI oriented which was a mistake and is now acknowledged. Other states may be struggling.

Comment: Other element - MI is very different with auto no fault.

Comment: Maybe reserve time at all brain injury conferences to talk about the 1115 to make sure people are aware of this. Consumers need to be taught how to use appeal process, perhaps this group could do this.

*Response: In Medicaid, individuals are sent appeal notice for denials.*

Comment: How resolve issue with hospitals discharging quickly and we don't have time to process? Sparrow – 3-5 days. Pressure, 20 min per day per patient. Know info when enter, not at discharge. Where patient discharged, that place needs education. Also, can make a referral to MDCH and don't know what happens for 2 weeks.

*Response: Takes that long because MDCH not getting the documents needed.*

Q: If in Healthy MI, are they eligible for MOU program?

*A: Now, yes, in future no. Can't be in two 1115 because of research and keep funding separate.*

ADDENDUM: Since the meeting, MDCH has learned that persons can be in two 1115 demonstration programs at the same time. This means it is possible to be enrolled in Healthy Michigan Plan AND the future 1115 Brain Injury Demonstration Program.

Q: At FFS level, do providers independently negotiate?

A: *No, will be set by service.*

Q: Where would provider go to understand more about CHAMPS and FFS, etc.?

A: *DCH website, provider link, can search website. Elizabeth can help navigate.*

Comment: Challenges with coding in HCBS. Sometimes codes don't reflect actual care. Sometimes hard to identify appropriate code to match right service. Other states not using HCPCS codes. No other state examples to look at.

Q: Envision codes will be at current rates? Will have to think of cap of 2M.

A: *Not sure yet.*

Comment: Can group think of ABI numbers? How pick these people? Pilot a number and figure out a cap and see where it goes.

Q: Do you believe will be issue to get through CMS if says ABI instead of TBI? Seems like a huge leap and appreciate this, but will be hung up on terminology of past?

A: *Not worried about CMS but worried about Governor because he authorized TBI.*

Q: Would MDCH Director be able to effectively tell Governor that ABI and TBI is one of the same? Let's fill slots and not get hung up on TBI vs. ABI. Still likely to have a waiting list.

A: *We can't say all ABIs, we need guidance of what you are thinking. Need criteria.*

Comment: Time since injury looks like a distinguishing factor right now. A lot of calls are 2 years plus since injury. Time post injury is factor you are looking for.

**Adjourned**