NORTH CAROLINA GENERAL ASSEMBLY

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES

SUBCOMMITTEE ON TRAUMATIC BRAIN INJURY

Co-chairs:
Representative Marilyn Avila
Senator Louis Pate

FINAL REPORT
TO THE
FULL COMMITTEE

DECEMBER 3, 2014

TRANSMITTAL LETTER

DECEMBER 3, 2014

To Members of the Joint Legislative Oversight Committee on Health and Human Services:

The Joint Legislative Oversight Committee on Health and Human Services, Subcommittee on Traumatic Brain Injury, respectfully submits the following final report.

Representative Marilyn Avila
Co-Chair

Senator Louis Pate
Co-Chair

SUBCOMMITTEE MEMBERSHIP

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SUBCOMMITTEE PROCEEDINGS

The Joint Legislative Oversight Committee on Health and Human Services, Subcommittee on Traumatic Brain Injury (TBI), was created pursuant to Session Law 2014-100, Section 12I.2, to study issues related to traumatic brain injury. The Subcommittee was specifically authorized to study the items outlined below.

1) Existing TBI services and any deficiencies in service array, quality of services, accessibility, and availability of services across each age group of persons with TBI regardless of the age at which the trauma occurred.

2) Current inventory, availability, and accessibility of residential facilities specifically designed to service individuals with TBI.

3) Existing TBI-specific service definitions for children and adults who receive services through federally funded programs, including Medicaid, federal block grants, and the Veterans Administration; through State-funded programs, including the Traumatic Brain Injury Trust Fund; through county-funded programs; and through other funding sources, as well as the need for additional or revised service definitions to meet the specific needs of those with TBI.

4) Current reimbursement rates tied to settings that treat adults with TBI and the adequacy of these reimbursement rates.

5) Current accessibility to TBI services, service information, educational materials, and family resources; and any deficiencies that need to be addressed.

6) Current status of TBI-specific screening, assessment, triage, and service referrals for children, adults, and veterans; and any deficiencies that need to be addressed.

7) This State's current organizational model for providing comprehensive needs assessment, information management, policy development, service delivery, monitoring, and quality assurance for children and adults with TBI as compared to TBI organizational structures in other states; and specific organizational models to manage services for persons with TBI that are well coordinated for all citizens, including veterans.

8) Any other matters related to TBI services for children, adults, veterans, and their families.

The Subcommittee met three times from October 16, 2014 until December 3, 2014. This section of the report provides a brief overview of the subcommittee proceedings. Detailed minutes and copies of handouts from each meeting are on file in the legislative library. Handouts from the meetings are also available at the Joint Legislative Oversight Committee website. (http://www.ncleg.net/gascripts/DocumentSites/browseDocSite.asp?nID=144)

Overview of Topics and Presenters

October 16, 2014

- **Department of Health and Human Services Overview of Funding Streams for Services for Individuals with Traumatic Brain Injury (TBI)**
  Dr. Robin Cummings, Deputy Secretary, Health Services, Director, Division of Medical Assistance; Dr. Courtney Cantrell, Director, Division of Mental Health/Developmental Disabilities/Substance Abuse Services (MH/DD/SAS); Sandy Terrell, Chief Operations Officer, Division of Medical Assistance

  Dr. Cummings stated that it is wise to talk with stakeholders to determine how best to serve individuals with TBI. He mentioned that many divisions in DHHS and stakeholders worked together to develop today's presentation. Sandy Terrell, and Courtney Cantrell, spoke next. Ms. Terrell defined brain injury and discussed the possible cognitive, behavioral, and physical problems that may be the result of TBI. She also shared the 2012 incidence rate of TBI in NC, i.e. 76,708 citizens. Ms. Terrell highlighted the existing services under the Medicaid State Plan, the habilitative services under the NC Innovations waiver, the community-based services under the 1915(b) (3) waiver, home-based nursing services under the Community Alternative Program for Disabled Adults (CAP-DA), and the Medicaid Community Alternatives Program for Children (CAP-C). She stated that most individuals with TBI need rehabilitative, rather than habilitative services. Dr. Cantrell described the services under the Division of Vocational rehabilitation and the State Single Stream funds. Ms. Terrell and Dr. Cantrell both indicated that limitations of funding because of services definitions and age and income eligibility resulted in limited services for many people with TBI.

- **LME/MCO TBI Program Overview**
  Ken Jones, CEO and Susan Johnson, Special Populations Specialist, Eastpointe Behavioral Health Services; Sara Wilson, provider, Network Specialist, Alliance Behavioral Health Services

  Mr. Jones shared Eastpointe's approach to address the needs of individuals with TBI including use of the HELPS Screening Tool through a 24 hour/7 day per week call center. Eastpointe maintains data on numbers of individuals with TBI, and the services they receive. Mr. Jones indicated that there are currently 90 individuals with TBI receiving services in Eastpointe's catchment area. Ms. Johnson and Mr. Jones indicated a significant need for residential and emergency placement facilities and for TBI-specific training for residential facility staff. Ms. Wilson agreed with these points and added that providers need training on how to work with individuals with TBI who also have substance abuse problems. The LME/MCO presenters also mentioned that many persons with TBI need prompting or cueing, instead of hands on assistance, and that that type of assistance is not currently covered.

- **Military Personnel and Veterans TBI Program Overview**
  Commander Scott Klimp, Section Chief, Concussion Care Clinic, Defense and Veterans Brain Injury Center, Ft. Bragg

  Commander Klimp provided the incidence rate of TBI within each branch of the US Armed Forces worldwide. Due to the larger numbers of individuals in the Army, this branch has the largest numbers of individuals with TBI. Most of these injuries are caused by concussions resulting from explosions, and are mild-to-moderate in severity. He described the continuum of care provided for active military and service members who are honorably discharged. He said that the Army is reevaluating members who received a dishonorable discharge for behaviors that may be associated with TBI sustained while on active duty. Commander Klimp mentioned that the Army partners with other branches of the military and with civilian trauma and rehabilitation facilities to provide care and services to military and veteran members.

- **Acute Medical and In-Patient TBI Provider Overview**
  Erwin Manalo, MD, Medical Director, and Pamela Hollingsworth, Vocational Services, Brain Injury Unit, Vidant Health Center, Greenville, NC

  Dr. Manalo described the treatment and in-patient rehabilitation services received by patients with TBI in large trauma centers like Vidant. He indicated that there are similar services in Raleigh, Durham, Chapel Hill, Winston-Salem, and Charlotte. Dr. Manalo emphasized that services for patients, once discharged, are very scarce. Ms. Hollingsworth indicated that some of the resultant mental health issues associated with brain injury may be prevented or reduced, if patients had supported employment and other rehabilitative supports.

- **TBI Advocate Overview**
  Sandra Farmer, President, Brain Injury Association of North Carolina (BIANC)

  Ms. Farmer provided incidence rates of several conditions, and TBI occurs at a much greater rate. She said that more people are becoming aware of TBI due to concussive sports injuries and the explosive combat wounds of the Iraq and Afghanistan wars, but feels that most people are still less aware of TBI, than they are other conditions. She also stated that a person with TBI is much more likely to suffer additional traumatic brain injuries. Ms. Farmer provided additional detail about the physical, cognitive, and social/emotional impact of TBI, treatment options, and the role the BIANC plays in helping individuals with TBI and their families. She concluded her presentation by offering the following goals to improve services:
    - DHHS complete the draft of a TBI Medicaid Waiver by February 1, 2015
    - NCGA appropriate funds to cover the match for the TBI waiver implementation
    - NCGA establish a TBI study commission to assist with the development of a comprehensive system of care for persons with brain injury.

- **NC Brain Injury Advisory Council: Findings and Recommendations**
  Carol Ornitz, Chair, NC Brain Injury Advisory Council

  Ms. Ornitz explained that the NC Brain Injury Advisory Council (Council) was established by the NCGA in 2003 to advise the State on issues related to the nature, causes, and management of traumatic and other acquired brain injuries. She stated that there are only three East Coast states, NC included, that do not have some form of dedicated funding program, e.g., waiver or trust fund, for persons with TBI. She summarized the main points of a study the Council had conducted earlier this year. The full report is available on the committee website. Recommendations from the report included successful submission of a TBI waiver to be managed by LME/MCOs, and preservation of current state funding that is used for TBI services. Ms. Ornitz concurred with the BIANC's recommendation to create a TBI Study Commission. She concluded her remarks by pointing out a schematic diagram (also posted on the committee's website) of a proposed System of Care for persons with TBI.

November 17, 2014

- **Health Resources and Services Administration (HRSA) TBI Grant Program**
  Janice White, TBI Program Manager, MH/DD/SAS

  Ms. White indicated that in order to receive a HRSA grant, NC had to have a lead agency, which has been MH/DD/SAS since 1996. NC also has to have a full-time TBI program manager, a functioning advisory board, a state TBI plan, and a needs and resources assessment completed every 5 years. Past HRSA grant have funded an Asheville satellite office of the Brain Injury Association of North Carolina, ongoing training for LME/MCOs and their providers, standardized evaluations of trainings, outreach to Native Americans, free online TBI trainings, and development of "skill packs" for families and professionals. The current HRSA grant is helping to provide technical assistance to TBI "clubhouses," additional TBI-specific training for providers, and development of a TBI Ombudsman program, social support networks, and an annual conference for individuals with TBI and their families. The next grant cycle is for 2014-2018 and cannot be used for TBI prevention activities or direct services. The new grant will focus on TBI screening, information and referral, training, and resource facilitation. Ms. White concluded her remarks with the expectations for the 2014-2018 HRSA grant.

- **HRSA Grant Implementation in an LME/MCO**
  Sara Wilson, Network Development Specialist, I/DD Services, Alliance Behavioral Healthcare

  Ms. Wilson indicated that Alliance Behavioral Health Care, as a part of the 2014-2018 HRSA grant, will begin piloting a screening process to determine if persons referred for mental or behavioral health services may have suffered a brain injury. Alliance is still considering who will complete the screenings, how the data will be collected, and if there will be a pre-screening completed prior to administering a full

screening. The TBI Grant Steering committee, including representatives from MH/DD/SAS, Alliance, Federally Qualified Health Centers, Disability Rights of NC, and TBI service providers, is currently developing a full screening tool. Individuals that have a positive screening would be referred to the Brain Injury Association for additional information.

- **DHHS TBI Waiver Proposal Plan Overview**
  Dave Richard, Deputy Secretary of Behavioral Health and Developmental Disability Services, Kenneth Bausell, I/DD Clinical Policy Manager, and Janice White, TBI Program Manager

  Mr. Richard prefaced the discussion of the development of a TBI Home and Community Based Waiver by saying that he is looking forward to collaborating with many stakeholders in order to craft the best possible waiver application. Mr. Bausell began the discussion by stating that, based on the Center for Disease Control and Prevention estimates, approximately 190,000 people in NC have a TBI. This number would include all levels of TBI and possible resultant effects stemming from the injury, and that there would be approximately 63,000 of these individuals who would need long term care. According to the NC Division of Public Health, 76,708 individuals in NC sustained a TBI in 2012, but the extent of the needs of these individuals is not known.

  Mr. Bausell continued his presentation by showing how many individuals are being served, and the associated costs, of other state's TBI waivers. He indicated that a State appropriation will be required to implement a TBI waiver in NC. He recommended that the waiver begin with a small number of beneficiaries, and be phased in to expand over time. He and Ms. White detailed an array of services that would be available to a total of 122 individuals with TBI over a period of five years. The initial State share of funds would be approximately 2.5 million dollars. To be eligible for services under the waiver, individuals with TBI would be Medicaid eligible, reside in NC, have a TBI occurring on or after their 22nd birthday, meet placement criteria, not be appropriately served under other waivers, and exhibit medical, emotional, behavioral, and cognitive deficits. Ms. White and Mr. Bausell provided a time line for waiver development, submission, and approval with a target date of January, 2016 for initial implementation.

  A copy of the presentation on the proposed TBI Medicaid waiver presented by Mr. Bausell and Ms. White is included in the appendix of this report.

December 3, 2014

- **Discussion and Approval of the Subcommittee Report**
  The Subcommittee reviewed the draft report for presentation to the Joint Legislative Oversight Committee on Health and Human Services. Following discussion and the adoption of an amendment, the report was approved.

SUBCOMMITTEE FINDINGS AND RECOMMENDATIONS

Persons suffering from a severe traumatic brain injury (TBI) require an array of short and long-term treatment, rehabilitation, and home and community support services. Often these individuals and their families have limited or no insurance coverage or other resources to cover the cost of these services. Many states have developed specific programs and infrastructure to address the needs of persons with TBI and their families/caregivers. Data from the National Association of State Head Injury Administrators (NASHIA) indicates that 40 states provide intensive TBI services funded with Medicaid waivers, trust funds, or a combination. North Carolina is one of the ten states which do not use a Medicaid TBI waiver or trust fund.

The findings and recommendations below are based on information provided to the Subcommittee.

FINDING 1: A MEDICAID HOME AND COMMUNITY-BASED WAIVER IS THE PREFERRED APPROACH TO PROVIDE STATE-FUNDED SERVICES TO INDIVIDUALS WITH TRAUMATIC BRAIN INJURY (TBI)

The Joint Legislative Health and Human Services Oversight Committee Subcommittee on Traumatic Brain Injury (TBI Subcommittee) finds that there are currently underserved and unserved North Carolinians with TBI. The Department of Health and Human Services (DHHS), working in collaboration with interested stakeholders, has developed the attached waiver plan. The Subcommittee supports the DHHS plan and anticipates that DHHS will seek legislative authorization and funding for the waiver plan in the 2015 Session.

RECOMMENDATION 1A: DESIGN A STATE MEDICAID TBI WAIVER

The TBI Subcommittee recommends that the Joint Legislative Health and Human Services Oversight Committee supports the Department of Health and Human Services efforts to develop a TBI home and community based Medicaid waiver and to seek legislative authority to submit the waiver to the federal Centers for Medicare and Medicaid Services (CMS), including the necessary funds appropriated for the purposes of waiver implementation.

RECOMMENDATION 1B: AUTHORIZE DHHS TO SUBMIT A STATE MEDICAID TBI WAIVER FOR APPROVAL BY THE FEDERAL CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

The TBI Subcommittee recommends that the Joint Legislative Health and Human Services Oversight Committee support the enactment of legislation to authorize the Department of Health and Human Services to prepare and submit a TBI waiver application for approval by the federal Centers on Medicare and Medicaid Services.

RECOMMENDATION 1C: APPROPRIATE STATE GENERAL FUNDS TO BE USED AS THE STATE MATCH FOR A MEDICAID TBI WAIVER

The TBI Subcommittee recommends that the Joint Legislative Health and Human Services Oversight Committee support the enactment of legislation to appropriate $2.2 million beginning in Fiscal Year 2015-16 to be used as the State matching funds for a Medicaid TBI waiver.

RECOMMENDATION 1D: ESTABLISH A TRAUMATIC BRAIN INJURY SUBCOMMITTEE DURING THE INTERIM FOLLOWING THE 2015 SESSION

The TBI Subcommittee recommends that the Joint Legislative Oversight Committee on Health and Human Services exercise its authority under G.S. 120-208.2(d) to establish a Subcommittee on Traumatic Brain Injury during the interim following the 2015 Regular Session for the purpose of continuing to monitor the development and implementation of a TBI Waiver for the State of North Carolina.

FINDING 2: NEED FOR ONGOING COORDINATION WITH THE U.S. DEPARTMENT OF VETERANS AFFAIRS

The TBI Subcommittee finds that local management entities/managed care organizations (LME/MCOS) need to assess individuals who have been referred to them for mental health and/or behavioral health needs to determine if they are military veterans who may be eligible for federally funded TBI treatment and services of military service. The Subcommittee heard presentations on the array of traumatic brain injury treatment and services provided by the U.S. Department of Defense and the U.S. Department of Veterans' Affairs.

RECOMMENDATION 2: DHHS NEEDS TO PROVIDE MORE SUPPORT FOR LME/MCO EFFORTS TO IDENTIFY VETERANS WHO ARE ELIGIBLE FOR FEDERALLY FUNDED TBI SERVICES

The TBI Subcommittee recommends to the Joint Legislative Health and Human Services Oversight Committee to direct the DHHS to provide needed supports to LME/MCOs to determine veterans' status, and connect veterans to the appropriate resources to address mental and/or behavioral health issues that may be the result of a TBI that occurred prior or subsequent to any type of discharge from the armed forces.

FINDING 3: NEED FOR VALID AND RELIABLE DATA ON THE INCIDENCE RATE OF TBI IN NC

The Joint Legislative Health and Human Services Oversight Committee Subcommittee on Traumatic Brain Injury (TBI) finds that there is a lack of accurate TBI incidence and prevalence rate data specific to the number of North Carolinians diagnosed with traumatic brain injury and in need of subsequent acute, rehabilitative, or long term care services. This data is needed to assess the need for and develop cost efficient and effective care options for this population. Staff from the DHHS Division of Mental Health/Developmental Disabilities/Substance Abuse Services and Alliance Behavioral Healthcare LME/MCO

presented information to the Subcommittee on the development and implementation of a screening tool which will be used by all LME/MCOs to screen, identify, and collect data on individuals with TBI. This effort is being funded by a grant from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA).

RECOMMENDATION 3: DHHS SHOULD ENSURE THAT LME/MCOs SCREEN IDENTIFY, AND COLLECT DATA ON INDIVIDUALS IN NEED OF TBI TREATMENT AND SERVICES

The TBI Subcommittee recommends that the Joint Legislative Health and Human Services Oversight Committee direct DHHS to work with the Brain Injury Association of North Carolina, the Brain Injury Council of North Carolina, and the LME/MCOs and other interested stakeholders to gather valid and reliable data on the number of individuals per county (i) with TBI, (ii) the level of TBI, (iii) the acute, rehabilitation, or long term care needs, and (iv) veterans status.

APPENDIX

Power Point Presentation handout prepared by the Department of Health and Human Services, Divisions of Medical Assistance and MH/DD/SAS: Development of a TBI Home and Community Based waiver in NC, presented to the THE JOINT LEGISLATIVE HEALTH AND HUMAN SERVICES OVERSIGHT COMMITTEE SUBCOMMITTEE ON TRAUMATIC BRAIN INJURY (TBI) ON NOVEMBER 17, 2014.

JOINT LEGISLATIVE OVERSIGHT COMMITTEE
ON HEALTH AND HUMAN SERVICES

Development of a TBI Home & Community Based Waiver in North Carolina

Kenneth Bausell, B.S.N., RN
Janice White, M.Ed., SLP, CBIS

November 17, 2014

Prevalence:

- The Centers for Disease Control & Prevention (CDC) estimates that 2% of the population have a TBI
  - In NC this equates to 190,000 people
- The CDC also estimates that of that 190,000 approximately 1/3 will require long term care
  - In NC this equates to **63,333** people
- We also know that 76,708 NC citizens sustained a TBI* in 2012.

*NC Disease Event Tracking & Epidemiologic Collection Tool (NC DETECT), analysis conducted by the Injury & Violence Prevention Branch, NC Division of Public Health.

Estimated Cost: Comparing NC to New York

- New York is one of the states that serves the most people under their TBI program
- Rationale: The New York State TBI waiver serves 3939 participants. North Carolina has roughly ½ the population of New York State: 9.84 million (NC) / 19.65 million (NY).

DMA Costs – Services

# Beneficiaries	1969
Average annual cost/beneficiaries	$85,000
Total Costs	$167,365,000

Estimated Cost: Comparing NC to Minnesota

- Minnesota has a robust TBI Waiver that includes SNF and Neurobehavioral Hospital Level of Care
- Rationale: The MN TBI waiver serves 2008 participants. North Carolina has roughly 1.8 times the population of Minnesota: 9.84 million (NC) / 5.4 million (MN).

DMA Costs – Services

# Beneficiaries	3614
Average annual cost/beneficiaries	$85,000
Total Costs	$307,190,000

Estimated Cost: Comparing NC to Maryland

- Maryland has a robust TBI Waiver that includes SNF and Chronic and Rehabilitation Hospital Level of Care
- Rationale: The MD TBI waiver serves 122 participants. North Carolina has roughly 1.6 times the population of Minnesota: 9.84 million (NC) /5.93 million (MD)

DMA Costs – Services

# Beneficiaries	195
Average annual cost/beneficiaries	$85,000
Total Costs	$16,575,000

Recommendations if NC Pursues a TBI Waiver

- A State appropriation will be required, as DHHS does not have any current sources of funding for the State match.
- Based upon analysis comparing NC to other states with more robust programs, DHHS recommends that the TBI Waiver begin with a smaller number of beneficiaries with TBI and allow a phased responsive program to expand over time.

TBI Waiver Purpose:

- The waiver will be designed to provide community alternatives for individuals with TBI who are currently in:
  - Skilled Nursing Facilities,
  - Chronic Hospitals, or
  - Specialty Rehabilitation Hospitals, or
  - Those who are in the community and at risk for placement in these facilities
- The objective of the waiver is to integrate and maintain the individual in the community utilizing services that are specifically targeted for individuals with TBI

Potential Target Population:

Medicaid beneficiaries who:

- Reside in the State of North Carolina;
- Must have traumatic brain injury which occurred on or after their 22nd birthday;
- Meet placement criteria for nursing facilities, chronic hospital or specialty rehabilitation hospital;
- Are not more appropriately serviced by any other 1915(c) waiver
- Exhibit medical, emotional, behavioral and cognitive deficits

Veterans and a TBI Waiver:

- Active Duty Service Members are served under Tricare. Veterans are generally served through the Veterans Administration.
  - Any Veteran who meets the Medicaid eligibility requirements for the waiver could be served
  - The TBI Waiver itself will bring more TBI specific providers to the State
    - The Veterans Administration can now contract with private providers to increase access to specific direct care for our Veterans

Estimated Cost:
5 year Project with 122 total participants

DMA Costs - Services

	SFY2015	SFY2016	SFY2017	SFY2018	SFY2019
# Beneficiaries	74	76	98	110	122
Average annual cost/recipient	$85,000	$85,000	$85,000	$85,000	$85,000
Total Costs	$6,290,000	$6,460,000	$8,330,000	$9,350,000	$10,370,000
Federal Share	$4,143,852	$4,279,104	$5,517,792	$6,193,440	$6,869,088
State Appropriation	$2,146,148	$2,180,896	$2,812,208	$3,156,560	$3,500,912
FMAP	0.6588	0.6624	0.6624	0.6624	0.6624

DHHS Costs – Staff (3)

	SFY2015	SFY2016	SFY2017	SFY2018	SFY2019
Total Costs	$256,305	$256,305	$256,305	$256,305	$256,305
Federal Share	$168,854	$169,776	$169,776	$169,776	$169,776
State Appropriation	$87,451	$86,529	$86,529	$86,529	$86,529
FMAP	0.6588	0.6624	0.6624	0.6624	0.6624

Proposed TBI Waiver Assumptions:

- A maximum of 122 people will be served. The full amount will not be served in the first year.
- The maximum annual cost will be less than the average institutional cost. On average, there is an annual cost of $85,000 per recipient.
- The staff position is assumed at a 50/50 administrative match.
- The Federal Medical Assistance Percentages (FMAPs) applied above (for services) are at the normal shares.

Proposed TBI Waiver Assumptions:

- For each year, the majority of individuals will be served at the Skilled Nursing Level of Care.
- A smaller group will be served at the Chronic Hospitalization or Rehabilitation level of Care.
- The assumption is that the individuals receiving the Chronic Hospitalization or Rehabilitation Level of Care will transition over to the Skilled Nursing Level of Care. See the chart below for information:

	Individuals	Hospital LOC	Nursing LOC
Year 1	74	10	**64**
Year 2	86	12	**74**
Year 3	98	13	**85**
Year 4	110	15	**95**
Year 5	**122**	**17**	**105**

State TBI Funds and Waiver Funds

- State TBI Funds and TBI Waiver Funds will both be used to support individuals with TBI in their community.
- An individual could transition from State TBI Funds to the TBI Waiver if s/he meets the waiver criteria. In this scenario state funding would then be available for another individual.
- An individual could also transition from the TBI Waiver to State TBI Funds if s/he no longer meets the critia for the TBI Waiver.

Proposed Services Array:

The following services are in conjunction with any Medicaid State Plan services for which the individual was eligible.

- **Extended Clinical Services** - physical therapy, occupational therapy, speech/language therapy, neurobehavioral and cognitive behavioral interventions, cognitive rehabilitation, mental health and substance abuse services, & similar services performed by credentialed professionals at a level higher or not otherwise covered under the State Plan.

Proposed Service Array:

- **Assistive Technology Equipment and Supplies**
  - Items & systems to increase, maintain, or improve functional capabilities
  - includes adaptive equipment, aides for daily living, environmental control, positioning systems, alert systems, repair of equipment & caregiver training
- **Day Programs**
  - individual or group service that provides assistance to with acquisition, retention, regaining or improvement in self-help, socialization & adaptive skills provided in a non-residential setting.

Proposed Service Array:

- **Respite Care** (in-home or facility)
  - periodic support and relief to the primary caregiver(s) from the responsibility and stress of caring for the beneficiary including overnight, weekend care, or emergency care
- **In-Home Supports**
  - personal care/assistance, medication administration, chore services, night supervision, companion services and homemaker services

Proposed Service Array:

- **Residential Supports**
  - personal care/assistance, medication administration, chore services, night supervision, companion services and homemaker services.
- **Home Modifications**
  - physical modifications to a private residence that are necessary to ensure the health, welfare, and safety of the beneficiary or to enhance the beneficiary's level of independence.

Proposed Service Array:

- **Medical Day**
  - medically supervised, health-related services provided in an ambulatory setting to medically involved adults who, due to their degree of impairment, need health maintenance and restorative services supportive to their community living.
- **Neurobehavioral Programming**
  - assists the individual to change behavior, replacing maladaptive, badly adjusted, or self-destructing behaviors by learning new, more beneficial behaviors.

Proposed Service Array:

- **Family and Caregiver Training**
  - training to families and the natural support network in order to train on intervention/strategies & the use of specialized equipment and supplies.
- **Vehicle Modifications**
  - Alterations to a vehicle to accommodate a person.

Proposed Service Array:

- **Transportation**
  - transportation to community activities and/or other waiver services when transportation is not included in another service rate.
- **Supported Employment**
  - assistance with choosing, acquiring, and maintaining a job when competitive employment has not been achieved and /or has been interrupted or intermittent. This includes pre job training, coaching, and long term follow along.

Proposed Service Array:

- **Supported Living**
  - individualized services and support to enable individuals to reside in a home that is under the control and responsibility of the individual. Includes direct assistance as needed with activities of daily living, household chores essential to the health and safety of the individual/s, budget management, attending appointments, and interpersonal and social skills building to enable the individual to live in a home in the community.

Proposed Service Array:

- **Personal Care**
  - includes support, supervision and engaging participation with eating, bathing, dressing, personal hygiene and other activities of daily living and may include cueing support.
- **Resource Facilitation**
  - A partnership with the individual to be served to assist with information regarding community access and partnership building to allow the individual to make appropriate choices for a full life.

Secondary Benefits of a TBI Waiver:

- New and knowledgeable TBI specific providers will come to NC
- Increase the scope of practice of current NC providers
- The Veterans Administration will have a more robust provider network with which to contract for TBI specific services

DHHS Recommendations if State Submits Waiver:

- Initially serving 122 to 200 individuals and allowing the population served to expand over time.
- Initially serve adults. During future evaluation we will determine if it is appropriate to expand the Target Population to include injuries sustained prior to the 22nd birthday.
- Develop a trained and competent provider network that is able to support the TBI population as the waiver expands.

DHHS Recommendations if State Submits Waiver:

- Assess the TBI waiver at regular intervals to ensure it is meeting the needs of participants, is cost neutral, and sustainable.
- In order for a TBI Waiver to be pursued, a State appropriation would need to be made available to fund the state match.
  - The present TBI State specialty funds will continue to be used for those who do not qualify for Medicaid but demonstrate need
  - The combination of a TBI specific Waiver and specialty TBI State funds will increase the service capacity for this underserved population

Points for Further Discussion:

- Continue to work with Stakeholder groups and in conjunction with the North Carolina Brain Injury Advisory Council for feedback and to ensure the waiver will meet the needs of the TBI community.
- Work with states with successful TBI programs to identify learning lessons and opportunities.
- Determine ways to ensure cost neutrality, contain costs, and establish an upper limit to the waiver benefit.

Points for Further Discussion:

- Investigate starting the TBI Waiver as a phased program and expanding the waiver to the entirety of the state after evaluating the program and making changes based on lessons learned.
- Develop a working relationship between the Veterans Administration and the LME/MCOs to ease the transition burden for our Veterans from program to program.
  - Resource Facilitation can be the conduit
- Choose or develop an appropriate assessment tool.

Proposed Timeline for Waiver Implementation: