



## **Building State Service Delivery for Individuals with Brain Injury: Identifying funding Streams: PowerPoint Script**

### **Administration for Community Living's Traumatic Brain Injury Grantees Workgroup on Waivers & Trust Funds**

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**Note:** This script accompanies a PowerPoint on the same topic, which can be tailored to a state's needs. Please feel free to insert state specific information and to delete information which may not be pertinent.

#### **Slide 1: Cover, acknowledgements (ACL)**

**Title:** Building State Service Delivery for Individuals with Brain Injury: Identifying funding Streams; produced by Susan L. Vaughn, Director of Public Policy, National Association of State Head Injury Administrators (NASHIA)

The PowerPoint and accompanying script are the result of the Administration for Community Living (ACL) workgroup on Medicaid TBI Home and Community-based Services (HCBS) Waiver and State Trust Fund Programs led by Colorado and Iowa, Mentor State Grantees from the Federal ACL Traumatic Brain Injury (TBI) State Partnership Program, and Partner State Grantees: Arkansas, Idaho, Kansas and Ohio.

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#### **Slide 2: Objectives of this presentation**

- To discuss incentives for state government to offer services to individuals with brain injury
- To provide overview of funding services and resources to support service delivery
- To provide tips for pursuing funding

**Background:** (can tailor to fit the state)

#### **Slide 3: Why is Traumatic Brain Injury (TBI) a State Government Concern?**

In 2014, there were approximately 2.87 million Americans treated for a traumatic brain injury (TBI) in emergency department visits and hospitals or that resulted in death. Individuals with a moderate or severe TBI with lower incomes or who are uninsured may face a difficult road to recovery, according

to the Centers for Disease Control and Prevention (CDC). (This is the latest CDC statistics available. You may wish to add or substitute your own state's statistics.)

#### **Slide 4: TBI Impacts**

A brain injury can lead to short- or long-term problems that may affect all aspects of a person's life, including the ability to work, returning to school, relationships with others, activities of daily living -- and it can change how a person thinks, acts, feels, and learns. While anyone is at risk for getting a brain injury, some groups have a greater likelihood of dying from a brain injury or living with long-term problems that resulted from the injury.

#### Who is at risk?

- Older adults and children (1-4 yrs. of age) due to falls, both with regard to hospitalizations and emergency department visits; and
- Adolescents and adults aged 15 to 44 years of age due to motor vehicle crashes, which were the leading cause of hospitalizations.

#### **Slide 5: Overall impact may result in:**

**Unemployment and loss income** – CDC estimates that the lifetime economic cost of TBI, including direct and indirect medical costs, to be approximately \$76.5 billion in 2010 dollars.

**Homelessness** – In a February 6, 2020, article featured in *Neurology Today*, researchers found the lifetime prevalence of any severity of TBI in homeless and marginally housed individuals was 53.1 percent, and the lifetime prevalence of either moderate or severe TBI was 22.5 percent based on studies conducted and reviewed. The article cited a recent *Lancet Public Health* study that noted that an estimated six million people experience homelessness annually in the U.S. and the European Union and that homeless individuals are more likely to have a host of mental and physical health problems, including depression, drug and alcohol dependence, HIV, and hepatitis C.

**Incarceration** – CDC in its review of jail and prison studies, noted that 25-87% of inmates report having experienced a head injury or TBI, as compared to 8.5% in a general population reporting a history of TBI.

**Institutional and nursing home placement** due to lack of alternatives. The July 2013 study titled, "Medicaid Expenditures for Persons with Traumatic Brain Injury while residing in Maryland Nursing Facilities: A follow-up Study," conducted by the Hilltop Institute at University of Maryland Baltimore County found that approximately 3,000 Maryland Medicaid beneficiaries with a history of brain injury had nursing facility (NF) stay during the Fiscal Year (FY) 2010 to FY 2012 study period. Medicaid costs for persons with a TBI and/or anoxia diagnosis while residing in a nursing facility were \$16,000 higher per person than those of their non-TBI diagnosed counterparts.

#### **Slide 6: State incentives/motivators** – what has prompted states to pursue funding options?

- Costs savings
  - Inappropriate placements
  - Out-of-state placements

New York implemented a Medicaid Home and Community-based Waiver for purposes of returning individuals who were placed in out of state facilities to New York to save costs and provide services and supports closer to home, family and community.

- Olmstead Decision
  - Community alternatives
  - Lawsuits

Massachusetts Rehab Commission was sued under Olmstead with regard to the number of individuals with brain injury residing in nursing facilities. The state implemented the Money Follows the Person program to assist with transition and Medicaid Home and Community-based Services (HCBS) Waiver programs to provide community alternatives.

- Data, State Planning

Federal TBI grants have assisted states in determining and assessing needs and resources for addressing gaps in service delivery. These needs assessments help to determine the numbers of individuals needing services; demographics, availability of providers; and service programming and development. The work that North Carolina did with its federal TBI grant, for example, led to a 1915(c) Medicaid HCBS waiver for individuals with brain injury.

- Strong advocacy

States that have been successful in obtaining funding and state infrastructure have had strong advocacy organizations that have made the case for the needs, pointing out how state systems for individuals with other disabilities or health care needs are not designed to offer services specific to the needs of individuals with brain injury. This has resulted in state legislative committees and studies; support from agencies to convene task forces; and ultimately legislation and funding to support the array of needs.

### **Slide 7: What are the type of services needed?**

- Rehabilitation/therapies (PT, OT, SL, cognitive rehab, behavioral)—these are likely to be needed for recovery, as well as to maintain functioning
- Academic accommodations – a student who is injured may need accommodations, which may be provided within a regular classroom settings, or special education and related services should the student need that
- Job training, accommodations—whether returning to his/or his place of employment or seeking a job for the first time or needing to change vocations
- Home and community services and supports
- Service coordination to coordinate resource; Information & Referral to help link individuals to services

### **Slide 8: Building blocks to services**

- Advisory Board/Council to assess needs and resources; state plan
- State infrastructure (lead agency)
- Funding streams, resources

### **Slide 9: Advisory Boards/Councils**

May be established by:

- Legislation, often in concert with funding stream, to oversee or advise on use of funds
- Executive Order
- Appointed by state agency
- Other, such as a charter or nonprofit corporation

Purpose:

Advisory boards/councils may have several purposes, often cited in state law or Executive Order, such as:

- Planning, program/funding oversight, policy recommendations, public awareness, etc. and is also a federal grant requirement in accordance with the TBI Act of 1996, as amended.

**Slide 10 – State Infrastructure**

- State agency responsible for program administration
- Staff and other resources
- Willing to seek funding, coordinate policies to support seamless system
- Data and informational systems to collect information on individuals served and outcomes

Most states have designated a state agency that would be the “lead” agency for assisting and supporting the council with state planning; applying for federal grants; providing staff/resources for administering services, supports, resources and programs. These agencies vary across the country and maybe the state agency on health, vocational rehabilitation, education, Medicaid, behavioral health or intellectual/developmental disabilities.

In some states, there are specific services for individuals with brain injury in multiple agencies, for example, the HCBS waiver program may be administered by the Medicaid agency, while the state or trust fund program is administered by the health, vocational rehabilitation or other agency. In a few states, all the brain injury services are administered by one agency that has multiple funding sources and populations, e.g., Medicaid HCBS waiver, state funding, trust fund, grant funding, and also supports the advisory council or board.

**Slide 11: Funding streams**

- State revenue
- Dedicated funding (a.k.a. trust funds)
- Medicaid
- Other state and federal programs
- Federal grants
- Combination

**Slide 12: State revenue**

1) Both MA and MO programs were started in 1985 with general (state) revenue through an annual appropriation. Both continue to receive funding today, along with other revenue sources (i.e., Medicaid, trust fund). Some states receive state funding for specific services, such as service coordination, or to supplement lost funding due to declining revenue for the trust fund program.

- 1) State funding provides flexibility to
  - Designed systems to fit the state agency – meaning the program may take on the culture of the state agency. For example, MO’s program is in a health agency and uses provider

agreements and contracts with county health depts., similar to their other programs. The AL program is housed in the VR agency and has a strong job and employment bias.

- Set eligibility – some states may only serve adults; may have a financial eligibility criteria that may differ from the Medicaid program; may have annual caps
- Define services
- Define provider qualifications

### **Slide 13: Trust Fund programs**

Trust funds are accounts established by law with dedicated funding and earmarked for specific purposes. Pennsylvania was the first state to enact legislation creating a fund from surcharges on traffic violation fines in 1985, known as the Catastrophic Medical and Rehabilitation Fund. Trust fund legislation usually:

- Designates fund generator or designated funding source (e.g., traffic related fines and drivers license surcharges)
- Allows for a non-reverting account, which allows funds to accumulate across state fiscal years (do not have to start over each year)
- Defines use of funds, eligibility
- Designates state agency responsible to administer the funds, in a few states, it is a pass through to a nonprofit association/organization
- Often an advisory board/council is created under the law to oversee the use of the funds
- Requires an annual report to the governor and/or state lawmakers as to how the funds were used is often required.

### **Slide 14: Medicaid**

The Medicaid program was established in Title XIX of the Social Security Act in 1965, the same time as the Medicare program (Title XVIII). It is a joint federal-state health care program to provide health and related medical services to individuals with low income. State participation is voluntary, although all states and the District of Columbia participate in the federal program.

The state must name a state Medicaid agency to administer the program, which is \_\_\_\_\_ **in the state of** \_\_\_\_\_. The federal government determines annually the match rate that each state receives for the Medicaid program, known as the Federal Medical Assistance Percentage (FMAP). FMAP is determined by a formula that compares the state's average per capita income level with the national average. In our state, that rate is: \_\_\_\_\_

### **Slide 15: Medicaid's Role for Certain Populations**

Medicaid plays an especially critical role for certain populations covering: nearly half of all births in the typical state; 83% of poor children; 48% of children with special health care needs and 45% of nonelderly adults with disabilities (such as physical disabilities, developmental disabilities such as autism, traumatic brain injury, serious mental illness, and Alzheimer's disease); and more than six in ten nursing home residents. Kaiser Family Foundation Medicaid Brief, March 2019)

### **Slide 16: Eligibility and services**

In all states, Medicaid provides health coverage for some low-income people, families and children, pregnant women, the elderly, and people with disabilities. States have additional options for coverage and may choose to cover other groups, such as individuals receiving home and community-based services and children in foster care who are not otherwise eligible.

The Affordable Care Act (ACA) allowed states to expand Medicaid to cover people with income up to 133% of the poverty line qualify for coverage, including working adults without dependent children. The federal government pays 100% of costs for three years. (Note: On November 10, 2020, the U.S. Supreme Court began reviewing whether the entire ACA is unconstitutional or just some of the provisions, or that it is in fact, a constitutional law.)

### **Slide 17-18: Mandated Services**

States are required to provide the following mandatory Medicaid benefits under federal law. The benefits listed on the slides are the ones that may be pertinent for individuals with brain injury. (Physician services are listed on Slide 18.)

**1. Inpatient hospital services**

**2. Outpatient hospital services**

**3. EPSDT: Early and Periodic Screening, Diagnostic and Treatment Services**

EPSDT is especially important for children with disabilities because private insurance is often inadequate to meet their needs.

**4. Nursing facility Services**

**5. Home health services**

### **Slide 18:**

**6. Physician services**

7. Rural health clinic services

8. Federally qualified health center services

9. Laboratory and X-ray services

10. Family planning services

11. Nurse midwife services

12. Certified pediatric and nurse practitioner services

13. Freestanding birth center services (when licensed or otherwise recognized by the state)

14. Transportation to medical care

15. Tobacco cessation counseling for pregnant women

### **Slide 19-20: Optional Services**

States may choose to provide the following optional Medicaid services at their discretion – which these are the most likely to be services/benefits accessed by individuals with brain injury. (**Note:** Services that are bold indicate services most likely used by individuals with brain injury.)

- **Prescription drugs**
- **Clinic services**
- **Physical therapy**
- **Occupational therapy**
- **Speech, hearing and language disorder services**
- **Respiratory care services**
- **Other diagnostic, screening and rehabilitative services**

### **Slide 20:**

- Podiatry services
- Optometry services

- Medicaid dental coverage
- Dentures
- Prosthetics
- Eyeglasses
- Chiropractic services
- Other practitioner services
- **Private duty nursing services**
- **Personal care**
- Hospice
- **Case management**
- Services for individuals age 65 or older in an institution for mental disease
- Services for an intermediate care facility for individuals with intellectual disability
- **State Plan Home and Community Based Services – 1915 (i)**
- **Self-directed Personal Assistance Services – 1915 (j)**
- **Community First Choice Option – 1915 (k)**
- TB Related services
- Inpatient psychiatric services for individuals under age 21
- Other services approved by the Secretary including services furnished in a religious nonmedical health care institution, emergency hospital services by a non-Medicare certified hospital, and critical access hospital (CAH).
- **Health Homes for Enrollees with Chronic Conditions – Section 1945**

### **Slide 21: State Plan**

The designated Medicaid agency submits a State Plan, and any subsequent amendments (SPA) to the federal agency, Centers for Medicare and Medicaid Services (CMS), for approval. The State Plan describes how the state administers its Medicaid program, including groups of individuals to be covered, services to be provided, methodologies for providers to be reimbursed and the administrative requirements that states must meet to participate. In some states, legislation is required. In other states, the Medicaid agency can make determination for benefits covered without legislative approval. The State Plan provides:

1. eligibility standards;
2. type, amount, duration, and scope of services; and
3. the rate for payment for services. The designated state Medicaid agency submits a

### **Slide 22: Medicaid Home and Community-Based Services**

More than half of all Medicaid spending for long-term care is now for services provided in the home or community that enable seniors and people with disabilities to live independently rather than in institutions. (Kaiser Family Foundation Medicaid Brief, March 2019). These services include:

#### **1) State Plan Mandatory/Optional Benefits**

- Home Health (mandatory: skilled nursing, home health aide, medical supplies & equipment & appliances; optional: PT/OT/Speech/Audiology), 1905(a)
- Personal Care (including self-directed), 1905(a)
- Rehabilitative Services, 1905(a)

State Plan requires that these services be made available to all eligible beneficiaries, although states may include level of care criteria)

## 2) HCBS State Plan Benefit

States can also offer a variety of services under a State Plan Home and Community Based Services (HCBS) benefit. People must meet state-defined criteria based on need and typically get a combination of acute-care medical services (like dental services, skilled nursing services) and long-term services (like respite, case management, supported employment and environmental modifications) in home and community-based settings.

## 3) HCBS Waivers

Within broad Federal guidelines, states can develop home and community-based services waivers (HCBS Waivers) to meet the needs of people who prefer to get long-term care services and supports in their home or community, rather than in an institutional settings.

### Slide 23: HCBS Services and Waivers

These HCBS services listed t will be discussed further:

- 1915(c) HCBS waiver services
- 1915(i) State Plan HCBS
- 1915(j) Self-Directed Personal Assistant Services
- 1915(k) Community First Choice
- Section 1115 Medicaid Demonstration Waiver
- Section 1332 State Innovation Waiver

### Slide 24:1915(c) HCBS Services

States can develop home and community-based services waivers (HCBS Waivers) to meet the needs of people who prefer to get long-term care services and supports in their home or community, rather than in an institutional setting. Individuals must be eligible for Medicaid.

Under the 1915(c) provision, states can waive certain Medicaid program, including:

- **Statewideness**, which means states can target waivers to areas of the state where the need is the greatest, or where certain types of providers are available.
- **Comparability of services** -- states can make waiver services available only to certain groups of people who are at risk of institutionalization. For example, States can use this authority to target services needed by individuals with brain injury who otherwise would be residing in nursing level of care—these services are above and beyond which is provided in the State Plan.
- **Income and resource rules applicable in the community** -- lets states provide Medicaid to people who would otherwise be eligible only in an institutional setting, often due to the income and resources of a spouse or parent. States can also use spousal impoverishment rules to determine financial eligibility for waiver services.

### Slide 25: 1915(c) HCBS Waivers

#### HCBS Waiver services must

- Be cost neutral and must demonstrate that providing waiver services won't cost more than providing these services in an institution
- Ensure the protection of people's health and welfare
- Provide adequate and reasonable provider standards to meet the needs of the target population



- Ensure that services follow an individualized and person-centered plan of care

### **Slide 26: 1915(c) Brain Injury HCBS Waivers**

Almost half of the states administer a brain injury Medicaid HCBS waiver program, with a couple of states administering more than one brain injury waiver.

- Most states base eligibility on nursing facility level of care
- Some waivers are targeted to ABI
- Vary considerably with regard to numbers served (size of waiver programs)
- Vary with regard to ages covered, although most do not cover past the age of 65, when individuals may be eligible for HCBS waivers for persons who are elderly.

### **Slide 27-28: 1915(c) Brain Injury HCBS Waiver Services**

Waiver participants must be Medicaid eligible and have full access to State Plan services. Waiver services are above and beyond what is offered in the State Plan. Most services covered under TBI/ABI HCBS Waiver programs include:

- adult day care
- personal assistant
- case management
- cognitive rehabilitation
- homemaker
- home and vehicle modifications
- durable medical equipment

### **Slide 28**

Therapies

- behavioral programming
- family counseling, respite
- prevocational services
- supported employment, and
- personal emergency response systems.

Waivers cannot cover room and board. In some states, a non-Medicaid agency may be responsible for administering the program aspects of the waiver program, while the Medicaid agency is responsible for submitting the waiver and general oversight. At least in New York, state funding is appropriated to cover housing and related services not covered by Medicaid.

### **Slide 29: 1915 (i) HCBS State Plan Option**

The Affordable Care Act (ACA) expanded financial eligibility for 1915(i) services, first established by the Deficit Reduction Act of 2005 (DRA), and created as a new optional Medicaid eligibility group that allows people not otherwise eligible to access full Medicaid benefits in addition to State Plan HCBS. This provision allows the state to provide certain HCBS to people who have incomes lower than 150% of the Federal Poverty Level and do not need to live in an institution to receive care.

States can set additional requirements for the waiver to target services to groups of people with specific needs. States can also choose to allow the HCBS to be self-directed, meaning that individuals receiving services can direct their own care.

The State Medicaid Agency must submit a State Plan Amendment to CMS for review and approval to establish a 1915(i) HCBS benefit.

- Target the HCBS benefit to one or more specific populations
- Establish separate additional needs-based criteria for individual HCBS
- Establish a new Medicaid eligibility group for people who get State Plan HCBS
- Define the HCBS included in the benefit, including state- defined and CMS-approved "other services" applicable to the population
- Option to allow any or all HCBS to be self-directed

During the 2019 legislative session, North Dakota lawmakers passed S.B. 2012, which authorized the North Dakota Department of Human Services to create a Medicaid 1915(i) State Plan amendment to allow North Dakota Medicaid to pay for additional home and community-based services to support individuals with behavioral health conditions, including individuals with brain injury. Medicaid enrollees age 18 and older who have a behavioral health condition and/or brain injury and currently are experiencing one or more of the following needs-based criteria are eligible: housing instability, intensive service utilization such as frequent emergency room (ER) visits, and/or criminal justice involvement.

Youth under age 21 and diagnosed with a mental health condition and/or a substance use disorder and/or brain injury who do not qualify for developmental disabilities case management and meet certain home and community-based services (HCBS) criteria are also eligible.

**Slide 30:** Overall, states who participate under this provision offer benefits which generally include, depending on the population: home-based services, day services, and supported employment (I/DD); case management, home-based, and other mental/behavioral health services (mental illness); and home-based services. Day services, case management, and round-the-clock services are the most frequently covered services for seniors/people with physical disabilities (KFF 2020).

### **Slide 31: 1915(j) Self-directed Personal Assistance Services (State Plan)**

Self-directed personal assistance services (PAS) are personal care and related services provided under the Medicaid State plan and/or section 1915(c) waivers the state already has in place.

- Participation in self-directed PAS is voluntary
- Participants set their own provider qualifications and train their PAS providers Participants determine how much they pay for a service, support or item

At the states option, people enrolled in 1915(j) can:

- Hire legally liable relatives (such as parents or spouses)
- Manage a cash disbursement
- Purchase goods, supports, services, or supplies that increase their independence or substitute for human help (to the extent they'd otherwise have to pay for human help)
- Use a discretionary amount of their budget to purchase items not otherwise listed in the budget or reserved for permissible purchases

### **Slide 32: 1915(k) Community First Choice Option**

Section 2401 of the Affordable Care Act (ACA) established a new state option to provide home and community-based attendant services and supports, known as Community First Choice Option (CFC), at a 6 percentage point increase in the Federal Medical Assistance Percentages (FMAP) – federal match.

To be eligible, individuals must be in need of an institutional level of care. The state cannot target populations or disabilities, areas of the state or cap the number served. Five states participate in this program — Oregon includes individuals with TBI.

### **Slide 33: HCBS Settings rule**

In 2014, the Centers for Medicare & Medicaid Services (CMS) released the “settings rule” to ensure that Medicaid-funded HCBS programs provide people with disabilities opportunities to live, work, and receive services in integrated, community settings where they can fully engage in community life.

The rule:

- defines person-centered planning requirements;
- provides states with the option to combine multiple target populations into one waiver to facilitate and streamline administration of HCBS waivers;
- clarifies the timing of amendments and public input requirements when states propose modifications to HCBS waiver programs and service rates, and
- provides CMS with additional compliance options for HCBS programs.

### **Slide 34: HCBS Rule – Conflict free case management**

Further, the 2014 rule requires conflict free case management. Providers of HCBS, or those who have an interest in or are employed by a provider of HCBS, may not provide case management to or develop the person-centered service plan for people receiving services. CMS requires that HCBS programs use a person-centered planning process which includes ways to solve conflict or disagreement and that the guidelines around conflict of interest are clear to everyone involved in the planning process.

### **Slide 35: Section 1115 Waivers**

Section 1115 Medicaid demonstration waivers provide states an avenue to test new approaches in Medicaid that differ from what is required by federal statute.

In November 2017, CMS, under the Trump administration, posted revised criteria for Section 1115 waivers that no longer includes the goal of increasing coverage, as in prior administrations. In January 2018, CMS posted new guidance to allow state Section 1115 waiver proposals to condition Medicaid on meeting a work requirement and subsequently has approved the first waivers of that type in the history of the Medicaid program. The waivers do continue to help states address the opioid epidemic as well as broader behavioral health initiatives.

### **Slide 36: Section 1332 State Innovation Waiver**

Section 1332 of the Affordable Care Act (ACA) permits a state to apply for a State Innovation Waiver (now also referred to as a State Relief and Empowerment Waiver) to pursue innovative strategies for providing their residents with access to high quality, affordable health insurance while retaining the basic protections of the ACA.

Before recent changes by the Trump administration, this provision had been used to implement state reinsurance programs to help reduce the cost of ACA-compliant individual market policies. However, new guidance (2018) encourages states to make broader changes to insurance coverage for their residents, including promoting the sale of, and apply subsidies to, ACA non-compliant policies, meaning insurance coverage do not need to comply with the essential healthcare benchmarks and

other ACA provisions and may apply to short-term, limited duration plans and association health plan.

The new guidance lays out principles to direct states to develop innovation waiver proposals to prioritize private coverage over public coverage, encourage sustainable spending growth by eliminating regulations that limit competition, foster state innovation, support and empower those in need by providing financial assistance to purchase private insurance, and promote consumer-driven health care.

### **Slide 37: Other State and Federal Programs**

Individuals with brain injury may be eligible for services provided by other state and federal programs. For example, individuals may be served in waiver programs designed for individuals with intellectual/developmental disabilities, physical disabilities, and waivers offering private duty nursing beyond what is offered in the Medicaid State Plan.

In Missouri, the state brain injury programs bills Medicaid for administrative case management services, a State Plan service, for service coordination provided to program participants who may be Medicaid eligible. This enabled the state program to significantly expand service coordination statewide due to the additional revenue. Before the state Medicaid program reduced overall services, the program billed for other similar State Plan services such as post-acute rehabilitation, day program, and non-emergency transportation.

Children may also be eligible for services provided by the Special Health Care Needs Program (Title V). In Alabama, the program developed PASSAGES for purposes of providing case management services specifically for children with brain injury.

Other programs include vocational rehabilitation and in some states, behavioral health programs have offered specific services to address behavioral health and substance use needs.

### **Slide 38: Federal Grants**

The Medicaid Money Follows the Person (MFP) demonstration provides states with enhanced federal matching funds for services and supports to help seniors and people with disabilities move from institutions to the community. A few states have used and continue to use this funding to transition individuals with brain injury residing in nursing homes to community services, usually in concert with the brain injury Medicaid HCBS waiver programs and/or state program which has resources and service coordinators to support individuals to living in the community.

In Sept. 2020, the Centers for Medicare & Medicaid Services (CMS) announced the availability of up to \$165 million in supplemental funding to 33 states currently operating MFP demonstration programs.

Administration for Community Living (ACL) TBI State Partnership Program grants provide funding to assist states in expanding access to service delivery. The program is authorized by the TBI Act, first enacted in 1996, and more recently reauthorized in 2018.

ACL funds a number of programs which are administered by state programs that may provide additional opportunities, such as the state respite coalition grants; Older Americans Act funding programs for health promotion, Aging and Disability Resource Centers (ADRCs), and National Family Caregiver Program.

### **Slide 39: Resources**

The National Association of State Head Injury Administrators (NASHIA) is a partnering agency in these federal projects funded by the ACL which may be of assistance with technical assistance and resources, which includes:

- **Traumatic Brain Injury Technical Assistance and Resource Center (TBI TARC)** is a national technical assistance center funded by the ACL to help states promote access to integrated, coordinated services and supports for people who have sustained a TBI, their families, and their caregivers. The Human Services Research Institutes (HSRI) is serving as the Center's administrator along with NASHIA. <https://www.hsri.org/project/traumatic-brain-injury-technical-assistance-and-resource-center>
- **National Center on Advancing Person-Centered Practices and Systems (NCAPPS)**, is an initiative funded by ACL and the Centers for Medicare & Medicaid Services (ACL) that helps states, implement person-centered thinking, planning, and practice through technical assistance, webinars and resources. A Brain Injury Learning Collaborative was established to assist with the project. Also administered by the HSRI, NASHIA is a partnering agency. <https://ncapps.acl.gov/home.html>
- **National Disability Employment Training and Technical Assistance Center**, funded by ACL's Administration on Disability, is established to provide comprehensive source for informational and technical resources on disability employment for AoD grantees, which includes ACL TBI State Grant Partnership Program grantees. NASHIA is a partnering agency. The TA contract is administered by TASH and the Lewin Group.
- **NASHIA** also provides technical assistance, webinars, national conference and resources to states. ([www.nashia.org](http://www.nashia.org))

### **Slide 40: Summary**

States have implemented several funding streams, with some states having access to more than one funding stream. These include:

- Half of the states have implemented separate Medicaid HCBS, with three states administering more than one brain injury waiver program.
- Almost half of the states have enacted legislation earmarking fines, fees, surcharges, usually related to traffic fines, which is then available for TBI programs.
- A few states have the benefit of state revenue appropriation specifically for a TBI program that offers services, supports and service coordination (e.g., AK, MA, MO, ND, NC, and VA).

### **Slide 41: Summary**

- One state provides services to individuals with TBI with complex needs through the state's Medicaid 1915(k) plan (OR).
- One state bills Medicaid for administrative case management, a State Plan service (MO).
- One state just received approval for the 1915(i) HCBS State Plan that includes individuals with brain injury, in addition to individuals with behavioral health needs (ND).
- 27 states receive federal grants to assist with creating and expanding systems through the U.S. Administration for Community Living (ACL) TBI State Partnership Program.

**Slide 42: Summary**

- At least 4 states (IA, MA, MO and VT) use or have used Money Follows the Person program to transition people with brain injury from nursing homes to community-based programs.
- States have also worked with existing, I/DD, behavior health or mental health, substance use, juvenile justice, education, and vocational rehabilitation to expand and improve services through training, screening, and identifying resources that are available to individuals with TBI.

**Slide 43: Tips and Considerations for Pursuing Funding**

- Is data available to help determine the extent of TBI and the needs of individuals?
- Are the ways to assess how many individuals with brain injury may be in institutional settings (e.g., nursing homes, correctional facilities)?
- Is there a state agency which would be amenable to developing and administering services and programs for brain injury? Is there infrastructure to support new programs?

**Slide 44: Tips and Considerations for Pursuing Funding**

- Are there existing state and community programs that would be willing to expand to accommodate individuals with brain injury?
- Are there state efforts to change or expand Medicaid long-term services and supports (LTSS) to ensure that persons with TBI is included?
- Are there champions and advocates? State brain injury associates/alliances have been most effective in engaging lawmakers and other policymakers in addressing the needs of individuals with brain injury and their families. Legislators have often convened special committees to study the issue. Agency heads have convened task forces. Governors have issued Executive Orders calling for a state plan.
- Are there opportunities to form coalitions to assist? Coalitions are an excellent way to broaden advocacy in order to pursue legislation and funding. These may be comprised of traffic safety advocates; hospital and healthcare providers/associations; rehabilitation providers/associations; insurance; other disability organizations/councils, which may have mutual interests and can engage their grass roots advocacy, thus expanding the work.