CEC BHDDH May 2022 Testimony Questions- Follow-Up Items

PSCEPP Program

1. Appendix 1A will be updated to show where the $2.5 million PSCEPP costs appear in the FY2023 estimate (line 28).
    a. The value for the Targeted Employment is $3 million and is now referenced as line 29 in the 2022 May CEC Questions – BHDDH.v2.0.xlsx, tab 1a – BHDDH estimate. This $3 million will be Medicaid matched.

Monthly Caseload Report

2. The most recent monthly caseload report contained an error where data was misaligned- this will be corrected and re-sent. The update will include more recent March data and will identify which providers are located out of state.
   Please see attached revised monthly caseload report that has both changes incorporated.

Consent Decree

3. BHDDH will provide the number of cases for day and employment services that are subject to the terms of the consent decree for individuals who self-direct.
   There are 2,353 individuals receiving day services and 576 receiving employment services, of which, 188 are receiving job coaching or job retention services and 388 are receiving job development services. 415 individuals are self-direct individuals.

4. BHDDH will also provide a count of "Appendix K Waiver" cases.
   There are 365 individuals currently receiving funding under the Appendix K Waiver.

5. Please provide high-level examples of services provided through this process.
   The individuals are receiving day support services and community-based support services. Some of these services could be provided within the individuals home or out in the community.

L9 Services

6. BHDDH will provide a breakdown of providers delivering L9 services.
   Please refer to 2022 May CEC Questions – BHDDH.v2.0.xlsx, tab 13 – L9 Requests by Provider

7. BHDDH will provide data showing utilization changes by L9 service. It should answer the question as to which L9 services grew/which saw reduced utilization to explain significant higher cost per member.
   For the testimony and the accompanying tables, the projection originally listed in FY22 were listed as have 511 distinct individuals for L9 services, and 520 distinct individuals for FY23. These numbers have been revised and should reflect the following: 573 individuals for FY22, and 583 individuals for FY23. This was due to an input/formula error and have also been revised on tab 1a – BHDDH estimates.

Immigration Status

8. Immigration status data will be added under the Non-Medicaid Funded section (State only payments).

This immigration individual noted in the testimony is included in the RICLAS budget so there is no need to include in this caseload estimate. Please disregard this dollar value noted in previous testimony.

Youth in Transition

9. BHDDH will provide historical data, acuity levels, and trends for Youth in Transition. Please refer to 2022 May CEC Questions – BHDDH.v2.0.xlsx, tab 14 – YIT by Tier

10. Please provide high-level examples of the level of need for this population, including Tier levels.

- Youth between the ages of 21 and 22 with aggressive/assaultive requiring 2:1 staffing during transitional period. Person has self-injurious behavior and is an elopement risk. Provider needs to recruit staffing with appropriate skill set to meet the individual's needs. Milieu will need to accommodate safety needs of this individual as well as the entire population. **Tier E**
- Youth aging out of DCYF with sexualized behavior (DCYF requesting early placement due to size and his impact on safety of other DCYF youth). Co-morbid medical issue with strong behavioral management component that requires staffing expertise. Home needs to be ADA compliant. Appropriate milieu will be a significant component in facilitating successful placement for this youth while ensuring current population is not dysregulated. **Tier E**
- Other individuals of considerations whose circumstance increase placement complexities:
    - Deaf or hard of hearing;
    - Prader Willi Syndrome;
    - High medical need (G-tube; tracheotomy, etc.) that require on-site nursing;
    - Co-occurring substance use disorder;

L9 Services-

1. **Please provide high-level examples of services provided through the L9 process. We would like specific examples of the kinds of things that trigger high L9 costs (exceptional services and situations).**

- Adult **(not YIT)** ready for discharge from Eleanor Slater Hospital: History of aggression toward others; incurred felony charges due to past assaults; co-occurring behavioral health component; higher functioning I/DD individual who does not fit into typical DD group home. Safety concerns require 1:1 staffing with specialized skill set for DSPs and clinical team. **Tier C**
- Adult **(not YIT)** ready for discharge from Eleanor Slater Hospital has medical need of diabetes (post-COVID) requiring sliding scale medication treatment. Assaultive with felony charges; requires specialized treatment program for autism; Large person who requires 2:1 staffing with specialized skill set for DSPs and clinical team. **Tier E**
- Other individuals of considerations whose circumstance increase placement complexities:
    - Deaf or hard of hearing;
    - Prader Willi Syndrome;
    - High medical need (G-tube; tracheotomy, etc.) that require on-site nursing;
    - Co-occurring substance use disorder;
    - Past incarceration or court-ordered placement.

Services that above trigger through L-9 funding:

- 1:1, 2:1 DSP staffing
- Clinical/professional services expertise (e.g., behavioral health, nursing, CNA, ASL translation/training);
- Additional respite, particularly for SLA providers;

2. **A handful of providers account for the bulk of the L9s. What drives this?**
   A handful of providers account for the bulk L-9 authorizations as they are the providers with the clinical and/or medical expertise to provide the high-level supports necessary for individuals with complex profiles.