DD Testimony Follow-up Questions

1. **General Instructions/Background #3:** Please provide a written explanation and a presentation focused on the Department's methodology for DD projections by service area. Details may include but are not limited to: growth rates for each service, projected caseload counts, trends, COVID impacts, etc.
    a. When projecting individuals for each service area, please also include a grand total number of DD clients.

    A subtotal and a grand total row for the main grid has been added to BHDDH Tables workbook, tab labeled 1- Distinct Ind+ Exp.

    b. Excel file, tab #1 "FY 2021-2021 Expenditures and FY 2022-2023 Projected Expenditures": What is the adjustment for "Shared Living Arrangement Offline Payments"? How was this adjustment calculated? How has the Department accounted for this item in prior fiscal years?

    Due to the pandemic many individuals living in an SLA are now home all day long. The State recognizes that this is an increased level of support that many of the SLA Contractors did not have pre-COVID. Many SLA Contractors were not providing support services all day, every day, because individuals were engaged in day programs or other types of Community Based Supports during the day. It has now fallen upon the SLA Contractors to provide an increased level of support during this pandemic.

    The SLA Enhanced Stipend funding comes out of the individual's day funding. This program as mentioned in the description provided was trying to account for those individuals who now are staying home due to the PHE. These individuals are not attending day programs or attending only a few days a week. The unused day funding is what is used to pay out the stipend to the SLA Contractors for remaining home during the day to provide needed support to these individuals.

    c. Please also adjust and clarify tab #9 as necessary.

    Tab 9 has been updated to appropriately reflect the changes made to tab 1, with regards to the distinct count of individuals. Note, the individual counts may be higher on tab 9 if they are being summed because an individual can change tiers or living arrangement within a year so they would be counted in both areas and the expenditures would be accounted in the corresponding tier/living arrangement category.

    d. Include backup data to support methodologies/projections.

    Please refer to BHDDH Tables workbook, tab labeled 12- Projection Methodology which contains the information regarding the methodology utilized for the FY 2022 and FY 2023 projections.

    e. Identify and quantify where possible any risks to your projections

COVID is a risk to the projection as the assumption for the current slow-growth calculation to pre-COVID levels is targeted for January. If the pandemic continues at the current state, the slow-growth calculation may be affected for the overall projection. The projection may not be overly realistic for some of the service categories, such as day programming and employment where provider staffing issues are ongoing. We also see this spill over into transportation, because individuals are not getting out as much.

Another major risk to the projections is the uncertainty of the impact of upcoming system changes. While we have not seen an impact of the transition to annual authorizations during COVID, we still need to watch this post-COVID. The impacts of planned system transformation efforts have yet to be determined, including the implementation of conflict-free case management, the shift to a community-based system compliant with HCBS, and the expansion of services as required by the Consent Decree. The review of service definitions is just beginning, but we expect there will be an impact from changes such as the separation of employment from day supports in the funding model. Other new services, such as alternative housing models and options, have yet to be defined.

2. **General Instructions/Background #3:** To what extent do these projections capture outcomes, capacity, access and other requirements outlined in the publicly documented action plan from the consent decree?

   Please refer to Question 1e.

   Action Plan items:

   a. Wage increase (DSP/Supervisor/Overnight Staff)
      The wage increase was not factored into the 2023 projections due to the current enacted wage, $15.75.
   b. Transformation Costs (captured in APRA funding)
      1. The $12 million Transformation fund is now listed under the adjustment section in BHDDH Tables workbook, tab labeled 1- Distinct Ind+ Exp.
      2. The $2 million Technology fund is now listed under the adjustment section in BHDDH Tables workbook, tab labeled 1- Distinct Ind+ Exp.

3. **General Instructions/Background #3a:** Could the Department provide additional information advising the conferees on how to proceed with documenting the FY 2022 Enacted Budget?

   Please refer to BHDDH Tables workbook, tab labeled 7 – Enacted vs Actuals, which has been updated to include a new section labeled FY 2022 Enacted – Proposed Estimation. This outlines the different budget lines consolidated for purposes of merging into the categories from tab 1 - Distinct Ind+ Exp.

   Using the information from tab 7, two new additional columns were added in tab 1 - % of FY 2021 Actuals and Proposed Estimated Enacted. The % of FY 2021 column accounts for any non-hard line enacted number (which excludes PCSEPP, RIPTA, L9 and Non-Medicaid funded line items since these all have their own lines in the budget) and calculates the base percentage from the FY 2021 actuals using the same exact categories. Example – Line 10 (Community Residence Supports) had a $90 million spend in FY21 which represent 42.65% of the overall spend for FY

21. Applying that percentage to the enacted amount for the Package Services line ($261 million), the FY 2022 proposed estimated enacted for that line is $111 million.

4. **General Instructions/Background #6:** Please share all the non-Medicaid items in the DD program with a description and a justification explaining why these items are not eligible for Medicaid and any plans to make the items matchable.

   There is one non-Medicaid funded Out-of-State Placement which this particular provider best meets the needs for the individual.

   The current non-Medicaid matching for PCSEPP will be changed to Medicaid matching funding beginning in FY 2023 as the $2.5 million General Funds will be decreased to $1.5 million in Medicaid matchable employment services.

   The non-Medicaid matching for RIPTA has been an ongoing collaboration with the EOHHS to complete the process to enroll RIPTA for Medicaid allowable matching funds.

5. **COVID-19 and Related Federal Fund #1:** Please provide additional data to quantify the impact of COVID-19 on enrollment, utilization, rates, and expenditures across the DD program.

   Please refer to 2021 Nov CEC Questions - BHDDH Tables workbook, tabs labeled 11a COVID – served and 11b – COVID – expenditures.

   During the PHE we have seen a decrease in applications being submitted, a decrease in support services being offered, and a decrease in the amount of support services being requested. At this point and time in the PHE people are starting to feel a bit more comfortable accessing services so they are slowly starting to reengage, but it is not at full capacity. We have seen a big shift to the Self-Directed service model, which allowed parents to get paid to provide supports. The Fiscal Intermediary agencies were having a difficult time keeping up with the incoming requests to switch service models, so this too led to some delays in getting services.

   The rate increases helped agencies retain staff, but even with the increase they still face staffing shortages. It has been difficult for providers to maintain the same levels of service because some individuals do not want the same level of services currently and others do, but there is not enough staff. Day programs are opening back up, but not in the same way. The day programs have few individuals attending to make it safer for all. There are also many agencies providing day supports only in the community, which means more staff are needed because you have 1:2 or 1:3 staffing ratios vs the center based 1:10 or 1:5 staffing ratios.

   All individuals are given an authorization yearly, but utilization is down a bit because everyone is not actively reengaged in services. There are also outbreaks or exposure issues to contend with. When there is a person who tests positive that has been engaged in programming the program will need to be closed for 2 weeks due to exposure. For all the reasons mentioned above, COVID has had an impact on the Adult Service System, and it continues to have an impact.

6. **Federal Consent Decree #1b:** The testimony outlines that information can be provided at the end of October - please provide an update on how claims are currently trending with projected costs, particularly with the rate increase.

There were 3,279 claims for the month of July that were adjusted to reflect the new rate, which resulted in a net difference of $320,120. There is an outstanding of 58 claims that have not been adjusted by the providers. The current total for July 2021 claims is $20,515,866.

7. **Financial and Operational Questions #1:** Please provide data on authorizations compared to actuals from FY 2019 to FY 2021.

   Please refer to 2021 Nov CEC Questions - BHDDH Tables workbook, tab 13 – Authorization vs Actual.

8. **L9 Supplemental Funding #3c:** Please provide more detail on the $20.9 million for L9 funding in FY 2021. Is this approved funding or actual expenditures? If this is approved funding, how much was actually spent?

   The $20.9 million was the authorized amount for FY 2021, and the total expenditure for L9 for FY 2021 was $15.8 million.

9. **L9 Supplemental funding #5:** What is driving this increase if historical L9 spending falls around $15 million? Is it COVID related or some other operational reason?

   The spending for L9s has stayed around $15,0000,000 for the past 4 years, although in FY19 we did see a decrease to $12,837,589. Currently, there have been requests that are COVID related in FY20, FY21, and FY22, which increased the authorizations and the spend a bit, but there has not been a significant increase in the expenditures. Part of the reason has been that while some individuals need additional supports when out in the community, there has not been as much community activity, therefore decreasing the amount of support individuals may need right now. For others during COVID needs have increased due to routine changes, making some individuals exhibit more behaviors. Some individuals have needed additional in-home supports because the day programs where not open and family members still needed to work. Additionally, with DSP staffing shortages, some individuals needed to get supports from CNA agencies which costs more. Due to COVID there has been an increase in authorizations of L9s, but not everyone is using there L9 funding due to some of the aforementioned reasons.

10. **Private duty nursing at the Executive Office of Health and Human Services #1:** Please provide additional detail on the coordination between EOHHS's private duty nursing program and BHDDH caseload.

    Leadership from BHDDH and EOHHS have been working closely together to collaborate on cases where there is a clinical need for long term nursing supports. The team responsible for the assessment and authorization of private duty nursing (PDN) services has moved from EOHHS to DHS. There was a policy guidance document developed and distributed to the families receiving PDN and Home Care services. EOHHS/DHS/BHDDH met with the Home Care Agencies to go over the new guidance and will continue to coordinate all the cases.

    Additionally, when an individual needs short term nursing supports to assist with recovery from an injury or illness the Providers and/or SCWs will assist the individual and family in getting these in place through the individual's Medicaid (Fee-For-Service or Managed Care). If there is an issue, BHDDH collaborates with our EOHHS partners.