Fourteenth Subject Matter Expert Report

Agreement to Resolve the
Department of Justice Investigation

Covering the Period of 7/1/2025 to 12/31/2025

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I. Introduction

Background and Context. This report presents the Subject Matter Expert's (SME) assessment ratings and relevant discussions of the State of Louisiana's (the State) compliance under the *Agreement to Resolve the United States Department of Justice Investigation* (the Agreement). This report is issued in fulfillment of the Agreement's requirement for a SME to, "submit to the Parties a comprehensive public report on [the Louisiana Department of Health's] compliance including recommendations, if any, to facilitate or sustain compliance." The period subject to compliance assessment in this report is July 1, 2025, to December 31, 2025. Other significant developments that occurred prior to or after that timeframe are mentioned when deemed relevant to readers' understanding of context, trends, and the like.

Case in Brief. In June of 2018, the State of Louisiana entered into an Agreement with the United States Department of Justice (DOJ) to resolve its lawsuit alleging the State violated the Americans with Disabilities Act (ADA) by failing to serve people with mental illness in the most integrated setting appropriate to their needs. The complaint alleges that the State relies on providing services to these individuals in institutional settings – specifically, nursing facilities (NFs) – rather than in the community. Under this Agreement, the State is required to create and implement a plan that will either transition or divert individuals with serious mental illness (SMI) from these facilities by expanding the array of community-based services, including crisis services, case management, integrated day services, and supportive housing.

The Target Population for the Agreement is comprised of (a) Medicaid-eligible individuals over age 18 with SMI currently residing in NFs; and (b) individuals over age 18 with SMI who are referred for a Pre-Admission Screening and Resident Review (PASRR) Level II evaluation for NF placement during the course of this Agreement, or who have been referred within two years prior to the effective date of this Agreement. It excludes those individuals with co-occurring SMI and dementia, where dementia is the primary diagnosis.

Subject Matter Expert (SME) Duties. The Agreement sets forth the requirement for a SME. In addition to producing a comprehensive public report every six months on Louisiana Department of Health's (LDH) compliance, the SME also interviews a sample of Target Population members, interviews their providers, and reviews their clinical documentation, to evaluate the quality and sufficiency of Agreement-related programs and processes and assess the quality of life and outcomes of selected members. This process is known as the SME Service Review and serves as the basis for assessing compliance to certain paragraphs. The SME also provides recommendations and technical assistance to help the State comply with the Agreement.

Compliance Assessment Report Development, Structure, and Compliance Rating Criteria. The SME relied upon a variety of information and data sources in developing this report, including information provided by the State during meetings and via various data reports and documents. He did not audit or otherwise independently verify data provided by the State or other sources. In future periods, the SME may directly validate or verify data in specific areas. To ensure the report's data and other content was factual and accurate, and to receive general feedback, the SME shared a draft report with the State and the DOJ on April 14, 2026. He collected feedback in writing and during several meetings.

This report sets out the SME's compliance findings related to the terms of the Agreement. Each section below is organized as follows: (1) text of the paragraph (in blue italics), which reflects the Agreement's requirements; (2) relevant data and information used by the SME to reach the compliance determination and assessment rating; and (3) a table that provides the assigned compliance rating, the SME's rationale for the assigning the selected rating, and associated priority recommendations to foster improved compliance. Figure 1 defines the criteria for each compliance rating option.

Figure 1. Compliance Rating Options and Associated Criteria	
Status	**Criteria**
Met	LDH has undertaken and completed the requirements of the paragraph – no further activity needed
	LDH has undertaken and completed the requirements of the paragraph – met with updates continuing to occur
Partially Met	LDH has developed deliverables (policies, procedures, training) that indicate the State is actively addressing the requirements of the paragraph
	LDH has provided data that indicates the State is actively addressing the requirements of the paragraph
	LDH has implemented activity and has yet to validate effectiveness
	LDH has begun but has not completed implementation activities
Not Met	LDH has done little or no work to meet the requirements of this paragraph.
	LDH has made little progress to meet the targets set forth in the Agreement, Implementation Plan, or other plans
Not Rated	The provision of the paragraph does not require a rating

Overview of Compliance Assessment Findings. As displayed in Figures 2 and 3, there were 75 paragraphs subject to compliance rating in this reporting period. These paragraphs fall under six domains, aligned with the how the text of the Agreement is structured:

- Target Population
- Diversion and Preadmission Screening
- Transition and Rapid Reintegration
- Outreach, In-Reach, and Provider Education and Training
- Community Support Services
- Quality Assurance and Continuous Quality Improvement.

As displayed in Figures 2 and 3, LDH was found in compliance with 25 paragraphs (33%), in partial compliance with 47 paragraphs (63%), and not in compliance with three paragraphs (4%). There were 5 paragraphs that were not rated.

Figure 2. Overview of Compliance Assessment Ratings by Domain for 14th SME Report								
Target Population (4)	**Meeting Compliance**	2	**Partial Compliance**	0	**Not Meeting Compliance**	0	**Not Rated**	2
Diversion and Pre-Admission Screening (12)	**Meeting Compliance**	7	**Partial Compliance**	4	**Not Meeting Compliance**	0	**Not Rated**	1
Transition and Rapid Reintegration (14)	**Meeting Compliance**	3	**Partial Compliance**	10	**Not Meeting Compliance**	0	**Not Rated**	1
Outreach, In-Reach and Provider Education and Training (9)	**Meeting Compliance**	2	**Partial Compliance**	5	**Not Meeting Compliance**	1	**Not Rated**	1
Community Support Services (23)	**Meeting Compliance**	8	**Partial Compliance**	13	**Not Meeting Compliance**	2	**Not Rated**	0
Quality Assurance and Continuous Quality Improvement (18)	**Meeting Compliance**	3	**Partial Compliance**	15	**Not Meeting Compliance**	0	**Not Rated**	0
Total (80)	**25**		**47**		**3**		**5**	

As noted above, the SME is responsible for producing two compliance reports per year. The report covering the first six months of the year (January to June) does not include an assessment of most the paragraphs in the Agreement associated with community support services. The report covering the second half of the year (July to December) includes an assessment of all requirements.

For this reason, the distribution of ratings (i.e., in compliance, partial compliance, and not in compliance) across reports with contiguous periods do not provide an "apples to apples" comparison. Figure 3 below provides the number of paragraphs assessed in this report and the five preceding reports, along with the distribution of compliance findings. Among the 52 requirements shared between the 13th and 14th SME Reports, three ratings improved. When comparing the 12th and 14th SME Reports, 10 ratings improved and one worsened.

Figure 3. Compliance Overview Comparisons for 9th through 14th SME Reports						
	9th Report (1/1/23-6/30/23)	***10th Report (7/1/23-12/31/23)***	***11th Report (1/1/24-6/30/24)***	***12th Report (7/1/24-12/31/24)***	***13th Report (1/1/25-6/30/25)***	***14th Report (7/1/25-12/31/25)***
Paragraphs Assessed/Rated	51	77	54	75	52	75
Paragraphs Not Rated	28	2	25	4	27	5
Paragraphs in Compliance	4 (8%)	14 (18%)	10 (19%)	16 (21%)	14 (27%)	25 (33%)
Paragraphs in Partial Compliance	35 (69%)	51 (66%)	40 (74%)	56 (75%)	37 (71%)	47 (63%)
Paragraphs Not in Compliance	12 (23%)	12 (16%)	4 (7%)	3 (4%)	1 (2%)	3 (4%)

Compliance Rating Thresholds and Multi-Year Compliance. Some paragraphs have compliance indicators that are quantitative or numeric in nature. For example, to inform his compliance rating for certain PASRR Level II evaluation requirements, the SME calculates the percentage of audited PASRRs that have concurrence regarding placement decisions and the percentage that are absent of deficiencies. To promote greater clarity of expectations and transparency in compliance ratings, in these cases, the SME would like to engage the DOJ and LDH to establish a percentage threshold that would result in an "in compliance" rating. This could result in an overarching rule regarding percentages (e.g., 95% results in an in-compliance rating) or paragraph-specific thresholds. Further, the SME is open to discussions regarding the de-prioritization of requirements that have a multi-year history of being in compliance (such as Paragraph 36), allowing for more focused attention on other requirements that have not yet been fully met.

Snapshot of Key Figures. During this reporting period, there were 14,449 NF admissions statewide. Of those, 934 (6.5%) were identified as meeting Target Population criteria and flagged for engagement. There were 468 newly admitted individuals who were engaged by Rapid Integration Transition Coordinators and 1,940 peer in-reach engagements. Ultimately, there were 96 transitions.

Recommendation Development Approach. For each of the paragraphs below, the SME has offered no more than three recommendations. These recommendations are not comprehensive; other strategies and activities are likely needed for the State to reach compliance. However, the priority recommendations herein reflect activities that the SME views as the most important, highest impact, most urgent, or foundational to other work that needs to happen to ultimately reach compliance.

Five Overarching Priority Recommendations. The SME appreciates the enormous level of effort required to implement an Agreement of this size and scope amid competing priorities and societal, systemic, provider, and individual-level challenges. To manage limited resources and maximize impact, the SME offers this narrower set of five overarching recommendations. The SME acknowledges that LDH's 2026 Implementation Plan contains many strategies that are responsive to these recommendations. The five overarching recommendations for this 14th SME Report are:

1. LDH should fully implement its newly developed process of engaging various planning bodies (including the Transition Support Committee) to inventory, analyze, and develop plans to address systemic issues that impede transition performance, with the goal of increasing successful transitions.
2. As outlined in LDH's 2026 Implementation Plan, LDH, together with the Louisiana Housing Corporation, should develop a new housing plan covering at least 2026–2028 to formalize strategies to progress toward the Agreement's requirement to create and sustain 1,000 housing opportunities. The plan should be informed by LDH data on housing-related barriers and on the housing needs and preferences of Target Population members, including ADA-accessible units and preferred neighborhoods.
3. LDH should implement strategies to expand crisis system capacity, including identifying new providers in regions lacking crisis services, fully implementing and reporting on the Louisiana Crisis Hub, and advancing emergency department (ED) diversion initiatives.
4. LDH should identify and develop strategies to engage Target Population members who have yet to be reached by My Choice Louisiana's in-reach or transition coordination programming and create mechanisms to ensure, moving forward, that all eligible members are engaged around the opportunity to transition.
5. Consistent with its 2026 Implementation Plan, LDH should develop an updated diversion plan that outlines enhancements to existing initiatives, identifies new initiatives, and establishes system-wide and initiative-specific key performance indicators to demonstrate that its diversion efforts are effective and sustainable.

In the sections to follow, the SME provides each paragraph of the Agreement, an analysis of LDH's performance relative to the paragraph, and priority recommendations to improve or sustain compliance. Section II below begins with requirements related to the Target Population.

II. Target Population

25. Members of the Target Population shall be identified through the Level II process of the Pre-Admission Screening and Resident Review (PASRR), 42 C.F.R. 483.100-138. LDH shall perform additional analysis of the assessment information contained in the Minimum Data Set (MDS) of information reported to the Centers for Medicare and Medicaid Services (CMS), to identify individuals who may have required a Level II screen but did not receive one.

26. The State will develop and maintain a Target Population priority list of individuals who meet the criteria described in Paragraphs 24 and 25.

Analysis: Paragraphs 25 and 26 are discussed together. These paragraphs require LDH to identify the Target Population (TP) in this Agreement. The TP is comprised of Medicaid-eligible adults with SMI who reside or are applying to reside in NFs, excluding individuals with dementia. Consistent with the process described in these paragraphs, LDH adds individuals to a TP list via two pathways: (1) a PASRR Level II evaluation that indicates SMI, generally conducted prior to NF admission, or (2) a post-admission Minimum Data Set (MDS) assessment that indicates SMI followed by a confirmatory PASRR Level II evaluation. This discussion focuses primarily on the LDH's development and maintenance of a census of individuals in the TP, which serves as the starting point for deeper engagement in the My Choice Louisiana (MCL) program. The MCL program refers to the constellation of planning, stakeholder engagement, and service delivery approaches implemented by the State to comply with the terms of the Agreement.

As of March 2025, LDH implemented a revised approach, the Rapid Integration Transition Coordination (RITC) program, for identifying and engaging TP members, after piloting the approach in seven regions since 2024. After LDH receives notification that someone who meets the TP criteria[1] is admitted into a NF, the member is added to the Active Caseload (AC) and assigned a transition coordinator (TC). The TC is expected to make telephonic contact within three days and in-person contact within 14 days. If they decline transition support at any point during the RITC's engagement, they are added to the Master List (ML), which tracks TP members in NFs who are not currently interested in transition but should be re-engaged at a later time.

Prior to implementing the RITC program, LDH deployed peer in-reach (PIR) staff to engage NF residents who were part of the TP. Since the full statewide adoption of the RITC program in March 2025, as described under Paragraph 54, PIR staff are primarily responsible for engaging TP members who were admitted to NFs prior to the RITC program or those who declined transition support from the RITC program and need to be engaged later. If a TP member is interested in transitioning after being engaged by a PIR staff, they are added to the "Legacy Active Caseload."

Figure 4. TP Cohort Lists
Active Caseload (AC)
Master List (ML). Individuals who have either not been engaged by the program to gauge their interest in transition or have declined in-reach or transition support previously and thus are flagged for re-engagement at later time.
Legacy Active Caseload (AC). Those who indicated an interest in moving from an NF, usually after receiving peer in-reach (PIR). These individuals are often referred to as "actively working" toward transition.
Rapid Integration Transition Coordination (RITC) Active Caseload. Those who were recently admitted into an NF, and as such, were flagged for an engagement from a RITC, since the inception of their RITC pilot in 2024.
Post-Transition Active Caseload. Those who have already transitioned but are still within 12 months of NF discharge.
Diverted. Those who, after their PASRR Level II evaluations, are determined as not meeting NF level of care requirements and thus referred to community-based services and housing.

Figure 4 reiterates the TP cohorts described above, along with two additional TP cohorts: diverted individuals within one year of diversion and transitioned individuals within one year of NF discharge. For the latter group, they are availed of TC and care management support for at least one year after discharge.

At the end of this reporting period, there were 5,489 individuals in the TP overall, excluding diverted individuals. This includes 383 individuals in the Legacy AC, 179 individuals on the RITC AC, 146 individuals in the Post-Transition AC, and 4,781 individuals on the ML. As displayed in Figure 5, this reporting period's Legacy AC is the highest since the 9th reporting period, which will hopefully result in strong transition performance in subsequent periods. The Legacy AC is a helpful figure to compare across reporting periods, because it reflects the number of individuals who, after PIR, express interest in transition.

Figure 5. AC Size Over Reporting Periods

Period	Legacy AC	Post-Transition AC
9th	585	162
10th	348	153
11th	280	139
12th	273	109
13th	298	130
14th	383	146

A portion of individuals added to the AC are later removed for various reasons, including loss of interest, discharge prior to transition, or automatic case closure 12 months after discharge. During this reporting period, 677 individuals were removed from the AC – a notable increase

[1] The RITC approach also engages individuals who do not have confirmed Medicaid eligibility or enrollment at NF admission. See related discussion below.

compared to the two prior periods (544 in the 13th period and 269 in the 12th period). Of those removed, 359 (53%) declined transition support. Per LDH, one major contributor to the increase in the number of individuals removed from the AC involves the RITC program. As described under the SME's analysis of Paragraph 45, through the RITC program, individuals are now automatically added to the AC upon admission to an NF, whereas in prior periods they were only added after expressing interest in transitioning. This results in a greater number of individuals who are initially added to the AC but then drop off due to a lack of interest in transitioning.

The SME finds that LDH complies with these paragraphs because all TP members are identified and assigned for some type of engagement from an MCL-affiliated staff person. The 13th SME Report provides an overview of LDH's important efforts to ensure that these lists, especially the ML, are accurate and maintained. It also discusses the need to formalize LDH's approach to engaging individuals who, during their early engagements with the MCL program, do not have confirmed Medicaid. Continued efforts relative to both of these issues is recommended.

Figure 6. Paragraphs 25 and 26 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Met. LDH has established a PASRR Level II and MDS review process to ensure that individuals with SMI are identified as TP members and engaged by the MCL program.	None.

III. Diversion and Preadmission Screening

29. The State shall develop and implement a plan for a diversion system that has the capability to promptly identify individuals in the Target Population seeking admission to NFs and provide intervention and identify services to prevent unnecessary institutionalization. The State's plan shall include, but not be limited to, development of services identified in Section VI [of the Settlement Agreement].

Analysis: The Agreement requires that the State promptly identifies individuals in the TP seeking admission to NFs to provide intervention and services to prevent unnecessary institutionalization. In 2019, LDH developed a Diversion Plan, reflecting several strategies that have been implemented since 2016, including:

- Eliminating the behavior pathway to NF admissions.
- Authorizing a limited and temporary NF stay for the TP and requiring a reauthorization process for longer-term stays.
- Improving the proficiency of PASRR evaluators to understand community-based alternatives to NF admission.
- Developing a diversion target based on the number of individuals whose PASRR Level II evaluations indicate that NF level of care is not the least restrictive setting appropriate to their needs.
- Establishing a program for earlier engagement of individuals at-risk for future NF placements by preventing avoidable hospitalizations, titled the "At-Risk Program."

Many of these activities were completed prior to this reporting period, as reflected in prior SME reports. These strategies have created important infrastructure to support NF diversions, including evaluation, engagement, and service delivery processes with the objective of preventing needless

NF admissions. As displayed in Figure 7, to assess compliance with this paragraph in this reporting period, the SME evaluated the extent to which LDH has maintained these aforementioned efforts, performance data associated with these efforts, and other metrics associated with diversion (e.g., audits of PASRR Level II evaluations that indicate that diversion might be possible).

Figure 7. LDH Performance on Diversion-Related Initiatives	
Diversion-Related Initiative	*Performance Data*
Behavior Pathway	As referenced in Paragraph 36, the behavior eligibility pathway was eliminated in 2018 and has not been utilized since. All who were previously admitted through the behavior pathway (referred to as those who were "grandfathered in") have either gone on to meet NF level of care criteria or been discharged due to not meeting level of care criteria; thus, the "grandfathered in" list now sits as zero.
Initial/Temporary Stays	As described in Paragraph 37, the average length of initial authorizations was 94 and 91 days for quarters 3 and 4 of 2025, respectively, similar to prior reporting periods, overperforming the 100-days standard.
Diversions	LDH continued to offer diversion services to Medicaid-enrolled individuals with SMI who seek admission to a NF but are not admitted because the PASRR Level II evaluation indicated community placement versus an NF admission. For CY2025, LDH effectuated 102 (74%) of their 137-diversion target for the year. By comparison, in CY2024, there were 148 diversions. Diversions represented 4.9% of all cases subject to NF level of care approval in this period.
PASRR Level II Processes	As detailed in Paragraph 34, in their audit of PASRR Level II evaluations, 20 cases (11%) in the audit sample were initially flagged by the Office of Behavioral Health (OBH) for potential diversion consideration, triggering additional review by the Office of Aging and Adult Services (OAAS). OAAS ultimately determined that three cases (2%) were appropriate for potential diversion consideration. No special waivers were granted during this reporting period that would waive PASRR Level II Evaluation requirements (e.g., due to natural disasters, public health emergencies).
At-Risk Programming: Healthcare Utilization	As described in Paragraph 30, healthcare utilization shifts dramatically for those who participate in at-risk case management for six months, including decreases in all-cause and BH-related inpatient stays and ED interactions and increases in outpatient BH and ambulatory/preventive care services. After six months in the program, the percentage of those with all-cause hospitalizations dropped by 28.6%, hospitalizations for BH reasons by 7.7%, all-cause inpatient stays by 16%, BH inpatient stays by 6.5%, and avoidable hospitalizations by 2.4%.
At-Risk Programming: NF Admission Rates	As referenced in the 13th SME Report, 3.6% of those in the At-Risk Program were admitted into NFs compared to 6.7% of those who did not enroll, demonstrating that the At-Risk Program appears to divert individuals from NFs. The lower rate of NF admissions among the At-Risk Program participants is especially impressive, given that at baseline, those who accept these services have significantly higher rates of inpatient and ED utilization than those who decline the services.
Service Review Findings	The 2025 SME Service Review evaluated six diverted individuals. Unlike the transitioned and awaiting transition cohorts, the small sample size in this cohort limits broader interpretation. Community Case Management (CCM) assessments and community plans of care (CPOCs) were present and of good quality for all diverted members, though planning for durable medical equipment represented a gap. The SME team also observed that diverted individuals continue to face significant barriers to stability and integration in the community, particularly those with complex medical needs, unstable housing, or ongoing behavioral health crises, highlighting areas where additional support and system improvements may be needed.

As reflected in the figure above, many of LDH's planned diversion initiatives are underway and effective. However, to assign a "Met" rating in this domain, the SME believes additional initiatives or improvements are needed, including:

- The SME reiterates its recommendation from the 13th SME Report that LDH update its six-year-old Diversion Plan to strengthen existing initiatives, plan for new ones, and establish system-wide and initiative-specific performance indicators that can demonstrate whether diversion efforts are effective and sustainable. LDH's 2026 Implementation Plan committed to developing an updated Diversion Plan.
- The most recently available data, provided in the 13th SME Report, showed that roughly two-thirds of diverted individuals decline CCM services, which suggests the need for new engagement strategies to reduce avoidable ED, inpatient, and potential NF admissions. Further, although a growing share of identified at-risk members choose to enroll in the At-Risk Program, the most recent acceptance rate specific to the diverted population remains low (although overall acceptance rates have improved significantly, as referenced under Paragraph 30). Continued collaboration with MCOs will be important to improve participation in both programs, which remain LDH's most effective tools for preventing unnecessary NF admissions.
- The SME's 2025 Service Review process suggested that diverted individuals are more likely to live in unstable or congregate housing. LDH should assess the extent of this issue and explore ways to connect diverted members to Permanent Supportive Housing (PSH) resources.

The SME recognizes that serving diverted individuals is operationally challenging, as My Choice Louisiana staff do not have the extended planning window available for transitioned individuals, and many diverted individuals already face significant housing instability and high social and medical acuity when they enter the community.

Figure 8. Paragraph 29 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. Many of the strategies enumerated in the State's Diversion Plan have been implemented. However, LDH should identify a set of macro-level data indicators that demonstrate diversion/system-of-care rebalancing.	1) With the support of the SME, LDH should carry out its planned updates to the Diversion Plan, inclusive of macro-level data metrics that better assess the outcomes of diversion/systems rebalancing efforts and monitor access to and utilization of services and housing among diverted individuals, including those who do not accept CCM.

30. LDH will therefore develop and implement an evidence-based system that seeks to divert persons with SMI from the avoidable hospitalizations that place them at risk for subsequent NF admission.

Analysis: The Agreement recognizes that a key component of BH system rebalancing is the development of upstream services that prevent individuals with rising risk from requiring higher levels of care, including nursing facility placement. To support this goal, LDH analyzed the characteristics and needs of TP members residing in NFs to identify a profile of individuals "at risk" for hospitalizations that could lead to future NF admissions. Using this information, the State leveraged MCO case management to serve these at-risk individuals and reduce avoidable NF entry. This is referred to as the At-Risk Program. The program went live through the MCOs in July 2021, establishing ongoing identification of at-risk members and the provision of care coordination. LDH has twice updated the at-risk criteria, most recently in October 2023. The current definition includes adults with full Medicaid MCO benefits who have a qualifying mental

health condition, at least two chronic conditions, six or more ED or hospital visits in the prior year, and who do not reside in a NF. LDH also developed a process to monitor MCO case management for all individuals meeting these criteria.

The State reported that 5,488 individuals were identified as at-risk in FY 2021 and 5,812 in FY 2022. When the definition changed in October 2023, 3,703 individuals met the new criteria—an annualized figure consistent with prior years. In the last three reporting periods, 767, 896, and 1,749 individuals were newly identified as at-risk. LDH tracks outreach, successful contact, and enrollment. Among the 1,749 individuals identified from July to December 2025, 1,689 (97%) were outreached, 1,360 (78%) had successful contact, and 965 (55%) enrolled – nearly double the prior period's 25 percent enrollment rate. Enrolled individuals are assigned to one of three case management intensity tiers based on their needs, with most placed in the highest tier. Of the 965 enrollees, 748 (77%) were assigned to tier 3, 127 (13%) to tier 2, and 69 (9%) to tier 1, with 21 categorized as "not assigned" or "transitional." This distribution is consistent with the previous reporting period.

The 13th SME Report provided an outcomes evaluation associated with the At-Risk Program. To summarize, those who elected to engage in the At-Risk Program had significantly higher baseline utilization of inpatient and ED services — approximately three-quarters (74.7%) had an ED visit and one-third (32.1%) had an inpatient stay in the prior year, compared with 61% and 21.8% among non-participants. Despite this higher acuity, participants showed meaningful improvements after six months of engagement in the At-Risk Program: all-cause ED use declined by 28.6%, ED use for behavioral health reasons by 7.7%, all-cause inpatient stays by 16%, behavioral health inpatient stays by 6.5%, and avoidable hospitalizations by 2.4%. The program also appears to reduce NF admissions; only 3.6% of participants entered a NF compared with 6.7% of non-participants, a notable difference given participants' higher baseline medical complexity. Overall, these findings indicate that the At-Risk Program is producing positive shifts in utilization and may be helping prevent unnecessary NF admissions. LDH plans to repeat this analysis in summer 2026, and the SME will report findings in the 15th SME Report.

The SME assigns a "Met" rating for this paragraph, in acknowledgement of growing acceptance rates and positive healthcare utilization outcomes associated with the At-Risk Program. However, he encourages LDH to continue to explore strategies to increase acceptance of the program among qualifying individuals.

Figure 9. Paragraph 30 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Met. The At-Risk Program is fully operational and has resulted in improved healthcare utilization trends and NF diversion.	1) LDH should collaborate with the SME to explore strategies to increase acceptance of At-Risk Program services.

31. LDH shall also implement improvements to its existing processes for screening individuals prior to approving NF placement.

33. All screenings and evaluations shall begin with the presumption that individuals can live in community-based residences. For any individual for whom a NF placement is contemplated, the PASRR Level I screening will be conducted by a qualified professional prior to NF admission to determine whether the individual may have a mental illness. To improve identification of persons with mental illness through the PASRR Level I screening, LDH shall develop and implement standardized training and

require that all personnel who complete any part of the Level I screening, excepting physicians, receive this training.

Analysis: This discussion pertains to Paragraphs 31 and 33. An effective PASRR process is integral to preventing needless NF admissions for individuals with SMI. The PASRR Level I process should flag instances of suspected SMI, resulting in a more thorough evaluation to verify SMI. If SMI is indicated, NF placement should only occur if the NF is the least restrictive setting appropriate to the individual's needs. Otherwise, the individual should be referred to community-based options, including housing and services.

Before March 2025, when an individual was referred to a Medicaid-certified NF, the referring entity completed the PASRR Level I and a Level of Care Eligibility Tool (LOCET). The OAAS then reviewed the LOCET. If SMI was suspected at the Level I phase, OBH oversaw the completion of the Level II evaluation. In cases where intellectual disabilities or developmental disabilities (ID/DD) were present, the Office of Citizens with Developmental Disabilities (OCDD) oversaw the completion of the PASRR Level II evaluation.

As of March 2025, this process changed substantially, due to OAAS procuring a new PASRR Level I vendor, resulting in the implementation of new tracking, reporting, and training procedures that improve the accuracy and consistency of identifying potential SMI among TP members. The vendor now conducts second-level clinical reviews, requests corrected screenings when needed, and performs quarterly quality reviews, with OAAS providing additional quality oversight. In this reporting period, the vendor delivered Level I determinations with an average two-hour turnaround time with accuracy rates above 97 percent. Stakeholder communication has expanded through memos, newsletters, Q&A sessions, and updated training materials, and OAAS is further strengthening its Quality Assurance framework, including hiring two new staff in 2026 to ensure timely NF admission data entry. The new vendor also enables near real-time NF admission notifications to OAAS – critical for meeting 3- and 14-day engagement requirements in Paragraph 35. During this reporting period, there were 21,654 Level I submissions, with nine percent referred to Level II and an additional seven percent submitted as hospital exemptions.

The establishment of these processes described above are foundational to compliance with these paragraphs, and LDH's 2026 Implementation Plan includes enhanced reporting that will further bolster compliance. Additional reporting will enable the SME to better evaluate the effectiveness of these newly implemented procedures and validate the accuracy and consistency of SMI detection in the PASRR Level I screening process.

Figure 10. Paragraphs 31 and 33 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. LDH has onboarded a new vendor to improve the efficiency and effectiveness of the PASRR Level I screening process and has commenced quality monitoring efforts with the potential to reach compliance with these paragraphs.	1) Consistent with LDH's 2026 Implementation Plan, LDH should fully implement quality assurance and oversight structures for the new PASRR Level I vendor, focused on improving the identification of suspected SMI and subsequent referrals to PASRR Level II evaluation and ensuring accurate and timely data submission to trigger early engagements.

32. The State will ensure that all individuals applying for NF services are provided with information about community options.

34. For each individual identified through the Level I screen, LDH will promptly provide a comprehensive PASRR Level II evaluation that complies with federal requirements. It shall be conducted by an evaluator independent of the proposed NF and the State. This evaluation will confirm whether the individual has SMI and will detail with specificity the services and supports necessary to live successfully in the community. It shall address options for where the individual might live in the community. LDH shall provide additional training to ensure that PASRR Level II evaluators are familiar with the complete array of home and community-based services available to provide and maintain community-integration and shall revise Level II forms to include more extensive and detailed information regarding services in the community.

Analysis: An indication of suspected SMI during the PASRR Level I screening should result in a PASRR Level II screening, which is administered by MCOs or the PASRR Level II evaluation organization with which OBH contracts, resulting in the issuance of a final placement determination. LDH's PASRR Level II evaluation processes is aligned with this Paragraph's requirements, including:

- PASRR Level II evaluations are performed by the Medicaid MCOs' Level II evaluators who are Licensed Mental Health Professionals who operate independently of the NF and the State.
- The prior SME reviewed and offered feedback on various iterations of the PASRR Level II instruments and associated trainings and his SME Service Review process verified that the information collected as part of the PASRR evaluation process is sufficient to inform determination of whether someone has an SMI diagnosis. LDH sought and incorporated additional stakeholder input on the PASRR Level II evaluation instrument and launched it in July 2024.
- The most recent revision was designed to better equip the evaluator to discuss and make referrals relative to the full array of community-based services and housing options available to individuals, as well as uniformly collect barriers that prevent or create risks for NF diversion. The revised evaluation instrument also includes more information on medical services, supports to address ADLs, home health services, and durable medical equipment. It also collects more detailed information on SUD history and needs. LDH has provided guidance and associated trainings to PASRR evaluators – as well as other key service delivery staff involved in this Agreement – on available home and community-based service options that could obviate the need for NF placement.
- LDH conducts regular audits of the PASRR Level II process, described in more detail below. They also hold regular meetings with their contracted organization and the MCOs to review and discuss interventions for audit findings, build expertise in BH and SUD levels of care to ensure appropriateness of recommendations, and discuss complex cases and cases flagged for potential diversion.
- To strengthen PASRR processes, LDH requires PASRR Level II evaluators to participate in monthly meetings and "grand rounds" to discuss complex cases. LDH also implemented several other activities in this reporting period germane to PASRR, including (but not limited to): streamlining of PASRR reporting, communication, and information sharing; PASRR-related trainings and presentations to various stakeholders, including the Louisiana Hospital Association and the provider association of psychiatric nurse practitioners; and strengthened collaboration with OCDD for cases that involve both mental health and ID/DD.
- LDH reports that there were 3,669 pre-admission PASRR Level II evaluations administered in 2025. PASRR Level II evaluations are expected to be face-to-face and generally completed prior to admission. In this reporting period, 95% were face-to-face and 96% were completed

prior to an individual's NF admission. Further, 99% were completed within four days of OBH referral. This data mirrors prior reporting periods.

LDH audits a sample of PASRR Level II evaluations with three objectives: to identify the presence and type of deficiencies in completed evaluations, to evaluate the soundness of the placement decisions made by the evaluators, and to assess whether some cases may have been appropriate for diversion. The SME does not independently audit these evaluations but was provided with findings relative to an audit sample consisting of 177 PASRR Level II evaluations.

Thirty of the 177 evaluations (17 percent) reviewed by OBH had a deficiency, mostly related to inadequate recognition of an individual's SUD and/or identification of services needed to address SUD. In the last reporting period, 14 percent of evaluations had a deficiency, and similarly, most of the deficiencies involved missing SUD information or BH or SUD recommendations misaligned with an individual's identified needs. OAAS also reviews evaluations to determine whether they agree with the NF placement determination made by OBH. Twenty cases (11 percent) were initially flagged by OBH for potential diversion consideration, triggering additional review by OAAS. OAAS ultimately determined that three cases (2 percent) were appropriate for potential diversion consideration, compared to four percent for the last reporting period.

OBH continued efforts to improve PASRR preadmission efficiency throughout the reporting period. The telehealth assessment pilot with four hospital partners remained active, with monthly check-ins and demonstrated reductions in turnaround times (from 6-7 days to 4-5 days). OBH also streamlined PASRR processes by integrating existing database platforms with MCOs and the Level II evaluator. A new PASRR Level I process was implemented to more quickly identify categorical requests, such as respite, temporary emergency placements, and temporary hospice, that do not require a full Level II review, and internal discussions began regarding a potential rule change to formalize this approach. OBH also updated its PASRR Quality Audit Review process to include review by contracted psychiatrists, adding clinical perspective on diversion opportunities and trends in complex cases.

Figure 11. Paragraphs 32 and 34 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Met. The PASRR Level II evaluation instrument has undergone significant improvements to facilitate reviewers' ability to identify and inform individuals on available community-based services options. LDH's audit findings demonstrate that the majority of placement decisions are appropriate.	1) LDH should continue its PASRR Level II audit activities, continuing to track and address areas of deficiency, including whether PASRR Level II evaluators are making appropriate decisions regarding NF or community placement.

35. LDH shall refer all persons screened as having suspected SMI but also suspected of having a primary diagnosis of dementia, including Alzheimer's disease or a related disorder, for PASRR Level II evaluation, including those aged 65 or older. LDH shall strengthen documentation requirements used to establish a primary diagnosis of dementia relative to the PASRR screening process. For individuals without sufficient documentation to establish the validity of a primary dementia diagnosis, LDH shall provide an additional professional evaluation to ensure appropriate diagnosis and differentiation. The evaluation shall rule out external causes of the symptoms of dementia such as overmedication and neglect. Individuals with a primary diagnosis of dementia shall be provided with information regarding community-based service options but shall not be included within the Target Population for the purposes of this Agreement.

Analysis: LDH has established a process wherein individuals receiving PASRR Level II evaluations who have a suspected SMI and who are suspected of having a primary diagnosis of dementia are referred to a consulting psychiatrist. The consulting psychiatrist provides an additional professional evaluation, in the form of documentation review, for all individuals with a suspected and primary dementia diagnosis to ensure appropriate diagnosis and differentiation, including a determination of whether external factors may be causing dementia. Consistent with federal standards, the review relies on clinical documentation such as neurological exams or consultation findings, laboratory results, and brain computed tomography scans or magnetic resonance imaging. The consulting psychiatrist also reviews results from a questionnaire completed by individuals in the person's life (e.g., family members) who have directly observed their loved one's symptoms, presentation, and in some cases, cognitive decline. LDH reports that this process is aligned with national standards and best practices. In some cases, the consulting psychiatrist is able to confirm a primary dementia diagnosis based on the documentation review alone. In cases where a primary dementia diagnosis cannot be established, however, OBH requests dementia testing (from the NF or MCO) and checks if the testing was completed at the next PASRR Level II evaluation (e.g., the evaluation conducted in concert with a continued stay).

In this reporting period, there were 127 individuals (reflecting 2 percent of all PASRR Level II evaluations) who were determined to have primary dementia during the PASRR Level II evaluation process. An additional 150 cases were referred to the consulting psychiatrist for deeper analysis, resulting in 38 additional determinations of dementia (a quarter of those subject to special review). All individuals with confirmed dementia were offered information about relevant community-based services and programs as part of the PASRR Level II evaluation process. There were an additional 43 individuals who were flagged as suspected dementia, but LDH is unable to provide data on whether they received a follow-up evaluation, given that the responsibility for additional testing is delegated to NFs or MCOs. In these cases, however, individuals remain eligible for all MCL services until a primary dementia diagnosis is verified.

The SME is providing a "Met" rating for this Paragraph because LDH's processes ensure that individuals who do not have confirmed primary dementia are not excluded from the services and benefits of the TP. Individuals without primary dementia should be offered the opportunity to live in the community whenever it is safe and feasible, consistent with their preferences and support needs. Even as cognitive impairment progresses, many people retain the ability to make choices about their daily lives, participate in meaningful activities, and benefit from familiar environments and natural supports. Ensuring access to community living honors the "dignity of risk," autonomy, and self-determination.

However, a more consistent and reportable protocol to identify whether individuals with suspected dementia have primary dementia could be beneficial. If primary dementia is present but not verified, continued MCL engagement could prove confusing, frustrating, or distressing for individuals and their families, while also consuming limited staffing and other resources. As of the writing of this report, LDH reports that they are reviewing the protocol, in partnership with their contracted psychiatrists, to identify opportunities for refinement, as well as specific documentation and evidence that could assist in case review and determinations.

Figure 12. Paragraph 35 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Met. LDH has established a process to confirm whether individuals have a primary dementia diagnosis and avails individuals of all MCL services until primary dementia is confirmed.	1) LDH should consider whether a more consistently applied protocol to evaluate those with suspected dementia would be beneficial to TP members and their families and preserve LDH staffing and other resources.

36. LDH will implement changes to its Level of Care determination process to assure that individuals meeting on a temporary pathway eligibility for NF services receive only temporary approval and must reapply for a continued stay. Within 18 months of the execution of this agreement, LDH will eliminate the behavioral pathway as an eligibility pathway for new admissions to NFs.

Analysis: As noted in previous reports, LDH eliminated the behavior eligibility pathway in 2018. This pathway had allowed individuals with SMI to be admitted to NFs without meeting any other NF level-of-care criteria. Residents admitted under this pathway had no qualifying condition other than SMI. For this reporting period, LDH's review of MDS data indicates that no individuals with a sole diagnosis of SMI were admitted to a NF, consistent with the pattern observed since the fifth reporting period. Given this multi-year record of compliance, the SME recommends that LDH and the DOJ discuss when it may be appropriate to sunset tracking of this requirement. A similar approach could be considered for other requirements with a sustained history of compliance, allowing attention to shift toward areas where progress is still needed.

Figure 13. Paragraph 36 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Met. LDH eliminated the behavior pathway and regularly reviews MDS to verify that individuals with a sole SMI diagnosis are not being admitted to NFs.	1) Given multi-year compliance with this requirement, the SME recommends that LDH and the DOJ have a meeting to determine at what point it is appropriate to sunset tracking of this requirement.

37. LDH, following approval of a Level II determination that in accordance with 42 CFR 483.132(a)(1) includes assessment of whether the individual's total needs are such that they can be met in an appropriate community setting, will initially approve NF stays for no more than 90 days (or 100 days for persons approved for convalescent care by LDH) for an individual in the Target Population. If NF admission for a limited period is approved by LDH, the approval shall specify the intended duration of the NF admission, the reasons the individual should be in a NF for that duration, the need for specialized behavioral health services, and the barriers that prevent the individual from receiving community-based services at that time.

Analysis: In cases where persons with SMI require NF placement, it is important that the duration of their stay in the NF does not exceed what is medically necessary. To that end, the Agreement requires that initial authorizations be limited to 90 or 100 days.[2] After the initial stay, approvals for extended stays (referred to as "continued stays") must specify why the timeframe was selected, why NF care for that duration is appropriate, the specialized BH services that are needed, and why such services could not be delivered in the community. The continued stay process must also occur 30 days prior to the conclusion of the initial authorization.

[2] Persons approved for convalescent care by LDH can be authorized for up to 100 days. Everyone else is subject to the 90-day requirement.

The 4th SME report provided a description of the continued stay request process developed by LDH for individuals in the TP, which delineates the role of OAAS and OBH. Minimum Data Set (MDS) assessment data is used to establish continued need for NF level of care. If a continued stay is warranted, it is not to exceed 365 days. Per LDH, when a continued stay is not approved, OBH provides recommendations regarding specialized services to address BH needs, including advising OCDD on BH services in cases where an individual has ID/DD. Relevant LDH data for this reporting period includes:

- All continued stay requests were reviewed by OAAS staff not affiliated with the NF.
- Consistent with prior reporting periods, virtually all individuals in the TP received initial authorizations of less than 100 days.
- The average length of stay for these initial authorizations was 94 and 91 days for quarters 3 and 4 of 2025, respectively, similar to prior reporting periods, falling beneath the less than 100-days standard.
- For both quarters 3 and 4 of 2025, the averages for continued stays were 352 and 318 days. For quarter 4, the averages were 355 and 325 days, aligning with prior periods.

Figure 14 provides data on the number of continued stay requests, as well as approval rates and dispositions, demonstrating that 81% of cases are ultimately approved for continued stays, compared to 84% in the last reporting period.

Figure 14. Continued Stay Approval Rates and Dispositions

Disposition	*Number*
Extension requests	3,049
Approvals	2,469 (81%)
Not approved	580 (18%)
▪ Extensions deferred to OAAS	543
▪ Extensions deferred to OCDD	11
▪ Extension requests withdrawn	19
▪ Deceased	6
▪ Extension denied due to inadequate information	1
Recommended for specialized services (SS)	2,475
Not recommended for SS	546

This Paragraph specifies the type of information that must be collected to justify a continued stay and to ensure the continued stay addresses the needs of the individual. Below, the SME provides each required information element and his analysis of whether the current process complies with the specified element.

- *The "intended duration of NF admission."* As indicated above, continued stays are approved for less than 365 days. The SME would like to engage with LDH and the SME to explore whether a default continued stay of approximately one year is appropriate in all cases.
- *The "reasons the individual should be in a NF for that duration."* The revised PASRR Level II evaluation instrument, launched in July 2024 and administered as part of the continued stay process, is designed to capture this information, with dedicated sections that identify the needs, barriers, and service recommendations for each individual, across multiple domains (e.g., health, ADL/instrumental ADLs, BH).
- *The "need for specialized BH services."* The PASRR Level II evaluation captures BH-related needs and service recommendations, although LDH's PASRR audit found that 17 percent of audited evaluations did not have adequate information on SUD-related barriers, conditions, or needed services. In March 2026, LDH began an SUD alignment workgroup with representation from MCOs, OBH and vendor PASRR staff, and contracted psychiatrists. The workgroup's goals include improving alignment between SUD service recommendations and identified needs, improving quality audit outcomes in this area, and developing tools and processes to improve PASRR evaluator performance in this area.

- *The "barriers that prevent the individual from receiving community-based services at that time."* The tool has dedicated sections to capture barriers across multiple domains. Figure 16 displays the most common barriers, collected from an evaluation sample across all PASRR requests.

Figure 15. Transition Barriers (in 80% or More of Cases) Identified During PASRR Level II Process	
2025 Quarter 3	*2025 Quarter 4*
• Needs supports to live independently • Concerns about medication management • Concerns expressed related to needed supports	• Needs supports to live independently • Concerns expressed related to needed supports • Concerns about management of physical health • Concerns about medication management • Co-occurring complex medical issues • Concerns related to behavioral health supports

Figure 16. Paragraph 37 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. LDH's initial and continued stay approval processes are aligned with this Paragraph's requirements. However, 17% of audited PASRR Level II evaluations show inadequate recognition of an individual's SUD and/or identification of services needed to address SUD.	1) LDH should fully leverage its SUD alignment workgroup to continue to improve the quality of PASRR Level II evaluations, particularly as it relates to identification of SUD needs and needed services.

38. For the Target Population, LDH shall require that the MDS responses used to establish level of care for stays beyond 90 days (or 100 days for persons approved for convalescent care by LDH) be verified by a qualified party unaffiliated with the NF.

As indicated in previous SME reports, the State has developed a process that requires NFs to submit continued stay requests for continued stays beyond the 90 days of an initial stay, using the MDS as the basis to establish NF level of care eligibility. LDH created policies and criteria for individuals who will be provided a continued stay past the initial 90 or 100 days. The fourth SME report provided a description of this process, which delineates the roles of OAAS and OBH, which includes review by OAAS regional staff who are independent and not affiliated with the NF. Continued stays are typically approved for one year, although LDH approves shorter stays when warranted. This includes circumstances during which a member's NF transition is planned to take place sooner than a year and when a person has a significant change in condition.

Figure 17. Paragraph 38 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Met. LDH's initial and continued stay approval processes are aligned with this Paragraph's requirements.	None.

39. In addition, LDH will ensure that each individual with SMI who has been admitted to a NF receives a new PASRR Level II evaluation conducted by a qualified professional independent of the NF and the State annually, and upon knowledge of any significant change in the resident's physical or mental condition, to determine whether the individual's needs can be met in a community-based setting. Examples of significant change that can occur subsequent to NF admission include but are not limited

to improvements or declines in physical or mental health; behavioral incidents triggering facility transfers or other change in an individual's living conditions; changes in mental health diagnosis or in dosage or type of psychotropic medication; and requests for community placement.

Analysis: As noted in the response to Paragraph 34, PASRR Level II evaluations are conducted by the Medicaid MCOs' PASRR Level II evaluators – licensed mental health professionals who operate independently from both the NF and the State. This paragraph requires that an additional PASRR Level II evaluation be completed during an individual's nursing facility stay when certain conditions arise, including continued stay requests, situations in which a person remains in the NF a year after their last evaluation, or when the NF or another entity requests a new evaluation due to a significant change in the individual's condition.

During this reporting period, LDH reports that there were 3,049 annual PASRR Level II evaluations due and 3,022 (99 percent) were completed. For the 19 cases that were not completed, this was due to their private pay or non-Medicaid (e.g., Veterans benefits) payer status. LDH reports that 99 percent of evaluations were completed within four days of the request.

This Paragraph also requires PASRR Level II evaluations be readministered "upon knowledge of any significant change" in an individual's health status. These are referred to as resident reviews, and can be requested by OBH, an NF, or a NF resident (typically associated with their request to discharge, known as "Section Q"). Figure 18 provides data on the completion rates, timeliness, and outcomes associated with resident reviews. An approved outcome refers to instances where SMI was confirmed through the review. Resident reviews that are not approved can be referred to other agencies – including the Office for Citizens with Developmental Disabilities (OCDD) – for additional review or follow-up.

Figure 18. Resident Review Completions, Timeliness, and Dispositions

	Resident Initiated (Section Q)	*NF Initiated*	*OBH Initiated*
Total Number	34	1,047	279
Average Turnaround Time	8 days	12 days	7 days
Number/Percentage Approved	8 (24%)	349 (33%)	103 (37%)
Number/Percentage Not Approved	26 (74%)	698 (67%)	176 (63%)
Dispositions of Not Approved	One withdrawn, 24 deferred to OAAS, one deceased	27 withdrawn, 646 deferred to OAAS, 19 deferred to OCDD, six deceased	84 withdrawn, 81 deferred to OAAS, seven deferred to OCDD, four deceased

This is the first SME report that includes robust data on resident review completions, timeliness, and dispositions. If LDH continues to provide such data, the SME will conduct comparative analysis as part of his regular reports. However, given that LDH has established and implemented a process to ensure that annual PASRR Level II evaluations and "change in status" resident reviews are consistently and timely completed, the SME finds this paragraph as "Met."

Figure 19. Paragraph 39 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Met. It appears that those who require annual PASRR Level II evaluations receive them and "change in status/condition" resident reviews are also consistently completed.	None.

IV. Transition and Rapid Reintegration

40. LDH will offer comprehensive transition planning services to all individuals in the Target Population who are admitted to a NF in Louisiana. LDH's approach to transition planning shall address two distinct situations: (1) the need to identify and transition members of the Target Population already in NFs at the effective date of this agreement, and (2) the need to identify and transition members of the Target Population admitted to NFs after the effective date of this agreement.

Analysis: Per this Paragraph, all individuals in the TP must be offered the opportunity to transition. For most of the Agreement period, the transition support process remained consistent until the introduction of the Rapid Integration Transition Coordination (RITC) pilot described in Paragraph 45. Before RITC implementation, TP members who expressed interest in transitioning were added to the AC to receive transition support, while those who were not interested, undecided, or unable to decide were kept on the ML for future re-engagement. For individuals who continued to express interest, a transition coordinator (TC) from OBH or OAAS conducted an NF Transition Assessment (NFTA), and if interest persisted, initiated an Individualized Transition Plan (ITP). LDH has established timeframe expectations for each point of contact between a TC and a TP member. Figure 20 presents this period's performance data, comparing outcomes for legacy TCs and RITCs and comparing performance with the last reporting period.

Figure 20. Timeliness of Transition Coordination Processes (Calculated as Averages)					
Process	*LDH Standard*	*Performance for Legacy AC*	*Performance for RITC AC*	*Last period Legacy*	*Last period RITC*
Member added to AC to TC assignment	1 day	2 days	<1 day	1 day	<1 day
TC assignment to initial contact	3 days	7 days	5 days	Data not available at time of report	Avg. not available but 96% received 3-day contact
TC assignment to NFTA completion	14 days	11 days	12 days	12 days	16 days
NFTA completion to ITP initiation	30 days	2 days	<1 day	6 days	5 days
ITP initiation to established transition date	7 days	Transition date entry required to complete ITP; ITPs are typically completed in one day, but members may request or need a break, requiring TC to return for another visit.		Unknown	Unknown

Pre-discharge planning meeting	Within 60 days before transition date	OBH reports that 29 of the 34 individuals preparing for transition received their discharge planning meeting, but the remaining five left the NF earlier than expected. OAAS reports that 39 out of 63 received their discharge planning meeting, and 16 of the remaining 21 left earlier than expected.	

LDH should be credited with complying with most of its established timeliness standards. There are minor improvements needed in three areas: timeliness between AC and TC assignment for legacy program, timeliness of TC assignment to initial contact for legacy program, and consistent convening of pre-discharge meetings. However, the SME is assigning a "Partially Met" rating for this requirement because there remains a segment of TP members who have not yet been engaged by any PIR or TC staff. LDH was unable to provide a figure to reflect the size of that group during this reporting period. As noted in Figure 21, the SME encourages LDH to determine who has not yet been reached and deploy an initiative to ensure they are offered the opportunity to participate in the MCL program.

Figure 21. Paragraph 40 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. While LDH has set up processes to align with the requirements in this Paragraph and has conducted timely NFTAs and ITPs for the majority of those who express and sustain interest in transition, data suggests that a segment of the ML has yet to be offered transition support services.	1) LDH should recalculate the number of individuals on the ML who have yet to receive in-reach and implement measures to reach them. 2) LDH should continue to monitor and improve the timeliness of key transition support processes.

41. If the State becomes aware of an individual in a NF who should have received a PASRR Level II evaluation, but did not, the State will refer the individual to the Level II authority for evaluation.

Analysis: NF residents may be flagged as having a suspected SMI through the NF's regular MDS assessment process. In this circumstance, they must be referred to a PASRR Level II evaluation to confirm their SMI, to be completed within 30 days. If SMI is confirmed, the individual is added to the TP. This process provides a backstop to ensure that individuals whose SMI was not identified during their PASRR Level II evaluations or those who develop SMI after NF admission are appropriately added to the TP, and as such, receive the benefits stipulated in this Agreement.

LDH reports that 45 individuals who resided in NFs had MDS assessments that indicated SMI. Three individuals were in the NF for greater than 90 days and 42 were in the NF for 90 days or fewer. Among these 45 individuals, 43 received their evaluations and two did not; for the latter group, one died and one was discharged. Evaluations were administered within 11 days on average in quarter 3 and 19 days on average for quarter 3. This data demonstrates that LDH is in compliance with this requirement.

Figure 22. Paragraph 41 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Met. LDH has established and implemented a process for post-MDS referrals to PASRR Level II evaluations when SMI is suspected.	None.

42. LDH shall form transition teams composed of TCs from the LDH Office of Aging and Adult Services, the LDH Office of Behavioral Health, and the LDH Office for Citizens with Developmental Disabilities. The relative number of TCs hired or otherwise provided by each of these LDH offices will be based upon an analysis of the characteristics of the Target Population residing in Louisiana NFs as well as trends in NF admissions relative to the Target Population. This approach builds upon the State's experiences and success within its existing Money Follows the Person program that transitions roughly 300 people per year from NFs. The addition of OBH TCs to the State's existing transition framework is to assure that the comprehensive transition plan fully identifies and addresses behavioral health needs. OBH TCs shall facilitate medically necessary community behavioral health services for members of the Target Population whose behavioral health services are covered under Medicaid. Similarly, OAAS TCs shall assess, plan for, and facilitate access to home and community-based services (HCBS) overseen by OAAS, such as long-term personal care services (LTPCS), Community Choices Waivers, and Permanent Supportive Housing. OCDD TCs shall provide this same assistance for members of the Target Population who have a co-occurring developmental disability.

Analysis: LDH has hired and trained a team of transition coordinators (TCs) to provide comprehensive transition planning and support for individuals in NFs who express interest in moving to the community. As described above, TCs work with members and their chosen representatives to complete an NF Transition Assessment (NFTA) that identifies support needs, followed by an Individualized Transition Plan (ITP) outlining the services, supports, and resources required for a successful transition and sustained community tenure. After a member transitions, TCs continue to provide follow-up for up to one year, including scheduled check-ins at 7, 30, 90, 180, and 365 days post-discharge.

Because some TP members have co-occurring ID/DD, physical disabilities, other health conditions, or aging-related needs, the Agreement requires LDH to employ TCs across three state agencies, OBH, OAAS, and OCDD, to ensure that individuals receive support from staff familiar with the specialized services available to these subpopulations. Since the start of the Agreement, however, TCs have been hired only by OBH and OAAS, not OCDD. LDH initially reviewed the prevalence of ID/DD within the TP and found it to be relatively low, and this pattern has remained stable. In the current reporting period, 258 individuals on the ML and 22 on the AC had an ID/DD, mirroring rates observed since the 10th reporting period. Given the continued low prevalence, the SME does not recommend that OCDD directly employ TCs at this time but encourages LDH to continue monitoring ID/DD representation within the TP. The SME requests that LDH continues to track ID/DD prevalence among the TP as well as service utilization among the TP of OCDD-related waivers.

Instead of hiring TCs within OCDD, OBH TCs should continue supporting members with ID/DD by coordinating directly with OCDD program staff when those services may be needed. This includes confirming whether a member has previously been involved with OCDD and, when appropriate, obtaining OCDD approval to refer the individual to OCDD waiver options. This coordination remains important because, as noted under Paragraph 51, TCs report that collaboration challenges and waiver evaluation delays within OCDD continue to be common

barriers to timely and smooth transitions. Addressing these issues is necessary for LDH to achieve a "Met" rating for this Paragraph. LDH's 2026 Implementation Plan includes an activity to develop and execute a formal collaboration strategy with OCDD.

At the end of the reporting period, there were 32 TC positions across OBH and OAAS. OAAS had 18 filled positions and four vacancies, while OBH had all 10 TC positions filled. OBH also had three staff providing oversight and support to TCs, and OAAS had three supervisors, supplemented by additional leadership oversight. During this period, the average caseload was 20 individuals per TC. OAAS reports that based on their review of caseload sizes and anticipated client volume, additional TCs are not currently needed.

When individuals are added to the AC, OBH and OAAS management jointly review the case and determine which TC is best suited to serve the individual. Assignments are generally based on TC capacity, but other factors are also considered, such as whether the individual has previously worked with a particular TC, the outcomes of that prior engagement, or whether the TC has experience with the individual's nursing facility. Individuals with prior OCDD involvement are automatically assigned to OBH.

LDH has also implemented a range of management tools – both during and after this reporting period – to support progress toward transition targets and enhance processes, productivity, and oversight. Enhancements include strengthened internal service review processes, expanded documentation review prior to case closure, improved reporting infrastructure, real-time progress tracking through Monday.com, TC workgroups to identify process improvements, and "ride-alongs" to reinforce person-centered practices and strengthen collaboration with nursing facility staff.

In 2025, according to the Implementation Plan, TCs were responsible for effectuating transitions for 287 members. LDH completed 166 (58 percent) of these transitions. As discussed under Paragraph 56, this target was informed by a methodology that starts with the number of members on the AC and then uses historical trends to estimate how many members fall out of the transition pipeline at various process points. This methodology was further refined in late 2025 to generate a more feasible transition target for CY2026. Under Paragraph 56, LDH's multi-year transition performance, as well as recommendations regarding the remediation of systemic issues that impede transition performance, are discussed.

Figure 23. Paragraph 42 Compliance Determination and Associated Recommendations

Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. While the State has developed transition teams to fulfill the job functions referenced in this Paragraph and is implementing management tools to enhance TC performance, the number of achieved transitions continues to fall beneath annual transition goals.	1) In alignment with LDH's 2026 Implementation Plan, LDH should work with other relevant state agencies and stakeholders to identify and remediate systems issues that impede impact transition performance. 2) LDH should continue to track ID/DD prevalence among the TP and also include utilization of OCDD waivers in future service utilization reports.

43. LDH's transition teams as described in Paragraph 42 above shall be responsible for developing an Individualized Transition Plan (ITP) for each member of the Target Population who is residing in an NF. The ITP shall address the service needs identified through the PASRR Level II process as well as additional needs identified by transition team members.

46. The transition plans will accurately reflect and include: (a) the individual's strengths, preferences, needs, and desired outcomes; (b) a list of the services and supports the individual currently receives; (c) a description of how the services and supports the individual currently receives will be provided in the community; (d) any other specific supports and services that would allow the individual to transition successfully back to his or her home and to avoid unnecessary readmission to an institutionalized setting, regardless of whether those services are currently available; (e) Case Management services consistent with Section V.E. of this Agreement; (f) the specific Community Provider(s) who will provide the identified supports and services, and the needed frequency and intensity of services and supports; (g) resources that the individual will call on if she or he experiences crisis in the community; and (h) the date the transition will occur, as well as the timeframes for completion of needed steps to effect the transition.
Analysis: This discussion addresses Paragraphs 43 and 46 together. Paragraph 43 requires an Individualized Transition Plan (ITP) for every member of the TP residing in the NF. Since the beginning of the Agreement, however, LDH has developed ITPs to a smaller subset of the TP: those who are added to the AC and complete a NFTA. The SME shares the view that the ITP, in its current form, should be reserved for those who have expressed an interest in transition. However, LDH can comply with the spirit of this paragraph by ensuring that staff who engage TP members earlier in the process (i.e., peer in-reach workers and RITC staff) effectively introduce the MCL program; help TP members think through their strengths, assets, and support needs should they live in the community; and guide them to envision what life can look like in the community.

Paragraph 46 outlines the required elements of Individualized Transition Plans (ITPs). As noted in prior reports, LDH has revised the ITP template several times to better capture the information required under this paragraph. Each year, the SME reviews a representative sample of ITPs and assigns a quality score based on inclusion of required components and adherence to standards such as meaningful member involvement, referred to as the SME Service Review. The 2025 SME Service Review shows substantial year-over-year improvement in ITP completeness and quality: average scores increased from 23.08% in 2023 to 50.78% in 2024 and 78% in 2025. Among the 2025 sample, the most common gaps were: the ITP not being provided to the member (62%), no evidence of an ITP planning meeting (27%), missing information on medical needs and supports (27%), and lack of a member signature (23%).

In 2023, LDH introduced an ITP addendum, which was designed to ensure that appropriate services and supports were in place at the time of transition and within the first 30 days. In 2025, LDH implemented new processes to promote consistent completion of these addenda, including an alert system in the medical record, additional training, and internal documentation reviews. Of the 97 members who required an addendum during this period, 68 had completed addenda, 20 left the NF before the ITP addenda were completed (earlier than expected), and one elected not to participate in TC documentation. It appears that eight addenda were not completed.

SME Service Reviews over the past several periods have evaluated ITP quality, completeness, or timeliness. However, the 2026 SME Service Review (slated for release by June 2026) focused specifically on peer in-reach processes, and whether those processes adequately facilitate the opportunity for informed consent among TP members. Moving forward, the SME would like to

explore whether LDH's Internal Service Review process can be used to inform compliance ratings for this requirement, particularly in years when the SME's Service Review has a different scope.

Figure 24. Paragraphs 43 and 46 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. While the State continues to develop ITPs for individuals who remain interested in transitioning after receiving a NFTA, ITPs do not consistently include all the required components per the Agreement.	1) LDH should continue quality improvement strategies that improve the completeness and quality of ITPs, including reviewing (and reporting on) the presence and quality of the ITP addendum. 2) LDH should collaborate with the SME on the process to report on internal service review findings given that the SME's Service Review may continue to have a different scope and focus.

44. Transition planning will begin with the presumption that with sufficient services and supports, individuals can live in the community. Transition planning will be developed and implemented through a person-centered planning process in which the individual has a primary role and based on principles of self-determination and recovery. LDH shall ensure that the transition planning process includes opportunities for individuals to visit community settings.

Analysis: To support this requirement, LDH provides training on person-centered planning and has developed documentation tools to capture person-centered information. During this reporting period, both OAAS and OBH continued offering person-centered care trainings and updated practice guidance documents, such as the PIR prompting guide, to strengthen person-centered engagement with TP members. LDH held two trainings during this period, reaching 74 MCL-affiliated staff. As part of the SME's 2025 Service Review, experts evaluated a sample of NFTAs and ITPs for person-centeredness and overall quality using a 1–5 Likert scale (1 = very poor; 5 = excellent). For individuals who had already transitioned, the average score for assessment and person-centered planning was 2.69 in 2023, 2.9 in 2024, and 3.0 in 2025.

Another strategy to promote person-centeredness is ensuring that members are consistently supported to view potential housing options, helping them make informed decisions about life after transition. LDH reports that in-person visits are not always feasible, but all TCs are instructed to conduct at least a virtual walkthrough. LDH implemented a tracking system in August 2025 to monitor virtual and in-person housing tours. LDH also encouraged TCs to collaborate with NF staff to facilitate transportation when possible and to use state-issued cell phones to share photos or conduct FaceTime tours. During this reporting period, among the 36 individuals transitioned into PSH, 31 received either virtual or in-person housing tours.

The SME finds this paragraph as "partially met," given that there are some individuals transitioned to PSH for whom LDH cannot verify the occurrence of a virtual or in-person housing tour. Further, the SME suspects that there are additional transitioned members who, even though they were not transitioned to units in LDH's PSH program, moved to independent and integrated settings (other than prior or family residences); those individuals should also receive housing tours. Finally, the SME believes that providing housing tours earlier in the MCL engagement process could help members envision what life can look like in the community so they can make an informed choice about participating in the MCL program.

Figure 25. Paragraph 44 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. The service delivery documentation evaluated by the SME and his team improves each year, in terms of overall completeness and quality, as well as person-centeredness. Improved compliance hinges upon reporting on virtual or in-person housing visits and ensuring all MCL service delivery staff continue to receive person-centered trainings.	1) LDH should ensure that all TP members preparing for transition to PSH or integrated, independent settings receive a virtual or in-person tour of housing options. 2) LDH should continue to build on progress by enhancing the person-centeredness of MCL documentation. 3) LDH should consider strategies to provide virtual or in-person housing tours during the PIR or RITC processes to help members make informed choices about participation in the MCL program.

45. The process of transition planning shall begin within three working days of admission to a NF and shall be an interactive process in which plans are updated to reflect changes in the individual's status and/or goals and in the strategies or resources identified to achieve those goals. The State shall assign a transition coordinator who shall initiate contact with the individual within three working days of admission. A face-to-face meeting shall occur within 14 calendar days of admission for new admissions. The Implementation Plans described in Section X shall specify timeframes for transition planning for members of the Target Population residing in NFs as of the Effective Date.

Analysis: The Agreement requires that TP members be engaged at two early time points to assess their interest in transition: within three days of admission and again at 14 days after admission. Early outreach helps staff build rapport and reduces the risk that prolonged NF stays erode individuals' confidence, skills, and natural supports needed for community living. Historically, the State could not meet this requirement because it lacked real-time NF admission alerts. As of March 2025, LDH now receives near real-time NF admission notifications and can deploy RITC staff accordingly. Key performance results for this reporting period include:

- 469 individuals were identified for RITC engagement; 454 (97 percent) received the required 3-day contact and 430 (92 percent) received the in-person 14-day contact.
- After the 14-day visit, 75 (17 percent) were interested in transition, 175 (41 percent) were not interested, 117 (27 percent) were unable to complete the interview, 58 (14 percent) were unable to engage, and 5 (1 percent) were undecided.
- 118 individuals ultimately completed an NFTA and 77 completed an ITP. Even though 77 completed an ITP, only 75 (as noted above) were interested in transitioning at the conclusion of the 14-day visit.
- 83 individuals were either still in the transition pipeline (n=58) or transitioned by the end of the reporting period (n=25), reflecting 18 percent of the original cohort.
- Among those who returned back to the ML, 43 percent declined transition, 14 percent discharged before TC involvement, and 10 percent did not meet TP criteria (e.g., Medicaid ineligible, primary dementia, no SMI).
- For comparison, the 13th SME Report documented 331 (96 percent) receiving the 3-day contact, 316 (92 percent) receiving the 14-day contact, 54 (52 percent) completing an ITP, and 27 individuals transitioning or still in the pipeline (with 12 ultimately transitioned), representing 8 percent of the original cohort.

The 12th and 13th SME Reports noted that early RITC engagements, particularly those involving NFTAs and ITPs, can feel premature or overwhelming for newly admitted NF residents. The SME therefore recommended that early contacts focus on rapport-building and gathering only the minimum information needed to support continued engagement, while still maintaining a clear direction to prevent unnecessarily long NF stays and preserve pre-admission supports. LDH's 2026 Implementation Plan includes a process to consider application of early engagement best practices. The 13th SME Report also provided data on the percentage of individuals engaged by RITC who did not meet TP criteria, predominantly due to not having Medicaid. As reflected in their 2026 Implementation Plan, LDH intends to meet with the DOJ and SME to determine how to best serve these individuals.

The SME is assigning a "Met" rating for this Paragraph. To maintain compliance, LDH should continue to ensure 3- and 14-day contacts are occurring.

Figure 26. Paragraph 45 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Met. The statewide rollout of the RITC program has enabled LDH to meet the 3- and 14-day contact requirements.	1) LDH should implement the recommendation under Paragraph 25 and 26 regarding a service delivery approach for individuals who do not meet TP criteria. 2) Consistent with LDH's 2026 Implementation Plan, LDH should consider and apply early engagement best practices to the RITC program.

47. The transition teams shall interface with case managers for each transitioning individual to assure that all services necessary to transition the individual are provided at the appropriate time and that all persons transitioned have a community plan of care in place with necessary services authorized at the point of transition to the community.

Analysis: During the 7th reporting period, LDH, through its MCOs, launched a case management approach called Community Case Management (CCM). As stipulated in this Paragraph, transitioned and diverted members are eligible for CCM. In prior periods, LDH developed standard operating procedures to guide the CCM approach, including LDH's expectations for how CCMs should collaborate with an individual's assigned TC and other MCO staff and their role in securing providers, resources, and supports in the community to commence immediately upon a member's transition. LDH requires the TCs to make a referral for CCM to begin engagement within 60 days before individual's transition, allowing CCMs adequate time to engage the individual and participate in discharge planning meetings and final ITP meetings. CCMs continue services for up to one year post NF discharge, unless an extension is granted based on individual circumstances and need.

The 13th SME Report detailed findings from the 2025 SME Service Review as it relates to CCM documentation quality. To summarize, the average assessment and community plan of care (CPOC) quality scores were 94% and 84%, respectively. This represents significant improvement compared to prior years. Additionally, among individuals nearing transition, documentation showed evidence of a pre-transition discharge planning meeting between TCs and CCMs in 73% of reviewed cases. The 2026 Service Review did not evaluate CCM documentation, so the SME would like to explore whether LDH's internal service review findings could be shared in future periods to demonstrate compliance.

This Paragraph requires that all services necessary to transition are authorized and provided, and that a plan of care be in place "at the point of transition to the community." CCM assessments are not due until 30 days after transition, so LDH has developed an ITP addendum, completed by the TC, which identifies the services and supports that an individual needs during the vulnerable 30-day gap between NF discharge and CCM assessment and care planning (see more detail in Paragraph 43). The addendum provides recommendations regarding the scope, amount, and duration of services needed at transition. In this reporting period, the majority of addenda were completed for transitioned individuals; of the 97 members who required an addendum during this period, 68 had completed addenda, 20 left the NF earlier than expected (and thus did not complete the addenda), and one was self-directed and did not participate in TC documentation. It appears that eight addenda that were not completed.

In the 2025 Service Review, the SME team did not observe any major issues regarding services not being authorized for transitioned individuals. However, they did observe insufficient collaboration between the TC and the NF or managed care organization to ensure the members received training to manage health issues (e.g., checking blood sugar, self-administering medications) or obtained needed supplies (e.g., incontinent supplies) prior to transition.

The SME provides a "Partially Met" rating for this paragraph. Future evidence of minor improvements in the completion of ITP addenda and quality of CCM documentation, along with stronger protocols to ensure effective collaboration between TCs and NF or MCO staff, will improve compliance.

Figure 27. Paragraph 47 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. Documentation designed to ensure that individuals get the services and supports they need after transition is relatively consistent and of good quality, but minor improvements – along with strengthened collaboration with NFs and MCOs – is needed.	1) LDH should continue to improve the consistency and quality of CCM documentation and ITP addenda, with special focus on ensuring collaboration with NFs and MCOs for those with medical needs.

48. The Implementation Plan, described in Section X, shall define the process for assigning case management responsibility to support individuals in the Target Population.

Analysis: LDH requires MCOs to develop internal protocols to promptly link members transitioning or diverted from NFs to CCM. The State implemented this process in March 2022 and developed a tracking system that provides information regarding the timeliness of these referrals and engagement status after referral. The 2025 Service Review observed that 73% of cases among those awaiting transition included linkages to CCM, although LDH asserts that virtually all members awaiting transition are linked to CCM.

The SME will provide a "Met" rating for this reporting period. To maintain compliance in future periods, he requests documentary evidence that at least 95% of those awaiting transition were connected to CCM approximately two months prior to their planned transition date. Further, the SME would like to better understand the CCM linkage process for diverted individuals, including whether those linkages qualify as warm handoffs (i.e., the PASRR Level II evaluator conducts a virtual or in-person warm handoff with the CCM and member present). Evaluation of the effectiveness of this process will impact future compliance ratings.

Figure 28. Paragraph 48 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Met. LDH continues to require the assignment of a CCM to individuals 60 days prior to discharge.	1) LDH should provide data to demonstrate that CCM linkages are consistently occurring for members awaiting transition. 2) LDH should provide additional information on the CCM referral process for diverted members.

49. Transition teams and the LDH managerial staff who oversee their work will also conduct post-transition follow-up to assure that services in the community are initiated and delivered to individuals in a fashion that accomplishes the goals of the transition plan.

Analysis: This Paragraph requires LDH to monitor and support transitioned individuals to ensure they receive the services needed for successful community tenure. To meet this requirement, TCs conduct post-transition follow-ups at 30, 90, 180, and 365 days after discharge to verify service delivery and address emerging issues. LDH has issued guidance outlining the required components of each visit, and TC supervisors track visit completion.

OBH and OAAS TCs completed 301 post-transition visits and attempted another 66. With 146 members in their one-year post-transition window, this equates to roughly two completed visits per member, suggesting that some required visits may not have occurred or were not documented or reported. A precise calculation would require additional data on transition dates and which follow-up intervals fell within the reporting period. The subset of members served by CCM (including transitioned and diverted members) also receive visits on at least a monthly basis. Of note, during these visits, more than 90% of CCM clients self-reported good or fair physical health, medication adherence, housing stability, no issues with current living situations, natural supports stability, and adequate community involvement. This aligns with 2025 Service Review findings that rated the transition outcomes of the sample between "good" and "very good."

Figure 29. Paragraph 49 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. LDH has designed protocols to require TCs and CCMs to conduct post-transition visits. However, additional data reporting is needed to demonstrate that all TC post-discharge engagements are occurring.	1) LDH should ensure that TCs complete and document all post-transition visits, with a focus on ensuring individuals have the services they need in the community.

50. Members of the Target Population who will lose Medicaid financial eligibility upon transition to the community shall be referred for services through safety net behavioral health providers such as the LGEs and Federally Qualified Health Care providers.

Analysis: Historically, some individuals who transitioned from NFs lost Medicaid eligibility after moving to the community, as Medicaid income limits are more generous for those meeting NF level-of-care criteria than for community residents. In some cases, transitioned individuals also shift to a different Medicaid category. During the last reporting period, LDH developed a resource directory for individuals who lose Medicaid post-transition. The guide instructs TCs on how to identify members at risk of losing eligibility, outlines alternative insurance options, and lists free or

low-cost behavioral health and medical resources, including crisis services, and other community supports. The guide also stipulates that TCs must continue conducting post-transition engagements at 30, 90, 180, and 365 days even when a member loses Medicaid. The guide was issued in June 2025 and redistributed to TCs in December 2025. In LDH's 2026 Implementation Plan, they committed to creating and distributing a client-facing version to share directly with individuals who lose Medicaid.

In this reporting period, five individuals lost Medicaid eligibility after transition, and LDH reports that four received information on non-Medicaid resources. The SME is assigning a "Partially Met" compliance rating for this Paragraph. Compliance in future periods will hinge on whether LDH can demonstrate that all members who lose Medicaid coverage receive information on non-Medicaid resources.

Figure 30. Paragraph 50 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. LDH continues to track whether individuals have lost Medicaid eligibility and has developed a guide for TCs on resources and services for these clients. Four of the five individuals who lost Medicaid eligibility received guidance from TCs on non-Medicaid resources.	1) LDH should release the client-facing companion guide, consistent with its Implementation Plan commitment, and ensure that all relevant individuals receive guidance on non-Medicaid services and resources.

51. For members of the Target Population who are eligible to remain in the NF and choose to do so, LDH will document the steps taken to identify and address barriers to community living, and document efforts to ensure that the individual's decision is meaningful and informed. This same procedure will also apply for members who choose to move to a setting that is not community based.

Analysis: For TP members in NFs who choose to remain there, LDH must ensure that their decision is informed by complete and accurate information and that any barriers to community services are clearly identified and discussed. LDH collects barrier information during in-reach, when staff document barriers for individuals who are undecided or not interested in transitioning. TCs also capture anticipated and unresolved barriers for those in the transition process. Unresolved barriers are identified when a person is nine months into their transition process and the TC still observes barriers that will impede transition. Figure 31 summarizes common in-reach barriers for quarters 3 and 4 and transition barriers identified in September 2025.

Figure 31. Common In-Reach and Transition Barriers		
	Most Cited Barrier	*Additional Common Barriers*
Q3 In-Rach: Undecided (72 records)	(1) Decline in physical health and concerns related to needed supports (49%) (tied)	(2) Concerns about management of physical health (35%); (3) Family and guardian not supportive (29%)
Q3 In-Reach: Not Interested (652 records)	(1) Decline in physical health (63%)	(2) Concerns about management of physical health (59%); (3) Concerns expressed related to needed supports (19%)
Q4 In-Reach: Undecided (58 records)	(1) Concerns related to needed supports (47%)	(2) Concerns about management of physical health (45%); (3) Decline in physical health (41%)

Q4 In-Reach: Not Interested (616 records)	(1) Decline in physical health (44%)	(2) Concerns about management of physical health (37%); (3) Family/guardian not supportive of transition (21%)
Transition: Barriers: 127 records	(1) Waiting for a specific unit/town (29%)	(2) Other (27% *; (3) Waiting for accessible housing for greater than six months (8%) **Most common barriers categorized as "other" include housing barriers (e.g., awaiting home modifications), delays related to waiver assessments or determinations, income issues (e.g., waiting for SSI), and medical issues.*

Similar to the quarter 1 data provided in the 13th SME Report, decline in physical health is still one of the most common barriers associated with members who are undecided or not interested in transitioning. Another common barrier across both periods is family and guardians not being supportive of transition.

This paragraph not only requires capturing barriers but also taking steps to address barriers. On the member level, the SME has raised that some individuals may have an institutionalized mindset, meaning that they have either developed or perceive they have developed deficits around life skills due to their tenure in institutional settings. For this reason, MCL service providers must be adept at meaningfully engaging individuals around their concerns and questions related to transitioning, and offering information, resources, and motivational techniques to address those concerns. The 2026 Service Review Report, slated for release in May 2026, will shed more light on PIR programming and processes, including to what extent the SME team observed them addressing barriers. At the systems-level, consistent with their 2026 Implementation Plan, LDH should implement strategies to address more universal issues that impede individuals' ability to transition.

Figure 32. Paragraph 51 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. In-reach and transition barriers are captured, but additional planning and strategizing is needed to address barriers at the systems level.	1) Consistent with LDH's 2026 Implementation Plan, LDH should implement its systemic barrier referral procedure, focusing on analyzing and addressing barriers that impede transitions.

52. To assist the State in determining whether Target Population members are offered the most integrated placement appropriate to their needs, the Subject Matter Expert ("Expert") will review all transition plans that identify an assisted living facility, personal care home, group home, supervised living house or apartment, rooming house, or psychiatric facility as the individual's residence, for the first two years of this Agreement. Thereafter, the State and the Expert will determine the appropriate scope of review as part of the State's quality assurance efforts.

Analysis: This Paragraph expired in June of 2020 and applied to the SME's review of cases wherein an individual is referred to a housing setting outside of their own apartment or family home. LDH reports that there were two cases of members being transitioned into group homes, and one additional out-of-state placement.

Figure 33. Paragraph 52 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Not rated.	None.

53. LDH will develop procedures for addressing safety and choice for members of the Target Population who lack decision-making capacity.

Analysis: This Paragraph requires LDH to implement procedures for engaging individuals who lack decision-making capacity, with an emphasis on supporting their choice and safety. During the PIR process, LDH tracks reasons why individuals are "unable to make a decision," which is particularly relevant for this Paragraph. There were 350 individuals who were identified as "unable to make a decision," representing 18% of the 1,940 in-reach encounters. In the prior period, 354 individuals (also 18%) were identified out of 1,969 encounters. Among the 350 individuals in this category, 218 (62%) had a health condition that prevented meaningful discussion of community options; 182 (52%) were "not able to communicate even with the assistance of communication aides"; 68 (19%) were unwilling to participate in transition discussions; and 13 (4%) were interdicted or categorized as "other." Percentages exceed 100% because individuals may span multiple categories. This distribution is consistent with prior periods. In future periods, the SME will request similar data from the RITC program.

LDH should consider strategies to ensure that individuals who are unable to decide during in-reach receive more focused, and potentially timelier, follow-up. Currently, these individuals typically receive a six-month follow-up visit. Instead, follow-up could be timed to when the condition or circumstance affecting decision-making is likely to improve. These engagements should reassess decision-making capacity and identify supports that could facilitate informed choice and, when appropriate, participation in transition planning and discharge preparation.

LDH also identifies cases where there are concerns about safety or readmission risk for individuals awaiting transition or those already transitioned or diverted. These cases are referred to the Transition Support Committee (TSC), which reviews them and recommends strategies to support safe community tenure or determine transition feasibility. The TSC also reviews cases where TCs or CCMs believe additional support is needed after the one-year service window. From July to December 2025, the TSC received 18 referrals, compared to 10 referrals in the prior period. The dispositions of TSC are as follows:

- *TSC Referral Rescinded (5).* Referrals were rescinded prior to the committee meeting. In prior periods, referrals were rescinded when individuals had primary dementia, were readmitted, or moved out of the area.
- *SHARe Exception (2).* After additional review, the TSC approved one individual for a SHARe exception, which increases resources (e.g., worker hours, financial support for home modifications) beyond established limits in waiver programs.
- *Other Guidance Provided (8).* In these cases, the TSC determined that health and safety could not be assured in the community with available supports, additional evaluations and engagements were needed, or that additional services were needed.
- *Other (3):* One referral was in process/pending, one was a duplicate, and one did not receive a formal TSC decision but was referred back to the TC for additional intervention.

The 2026 SME Service Review evaluated PIR processes, but through the lens of members who were undecided, not those who were "unable to make a decision." However, some findings, insights, and recommendations will likely be applicable to the "unable to decide" cohort. The SME assigns a "Partially Met" rating merely because more information is needed about this cohort, including a more granular assessment of their needs and circumstances, as well as an exploration of whether there are any programmatic enhancements (in PIR and RITC programs) that could

facilitate their informed choice and participation in the program. As of the writing of this report, LDH reports that they are training PIR staff on how to engage NF staff to better understand members' baseline cognitive functioning to put their engagements in context and inform their follow-ups.

Figure 34. Paragraph 53 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. LDH has protocols in place to ensure the informed choice and safety of members at various stages of MCL programming. The SME recommends that LDH investigate the circumstances and needs of those who are "unable to make a decision" to inform adaptations to PIR and RITC protocols for this sizable segment of the TP.	1) LDH should determine whether additional procedures are needed to engage those who lack decision making capacity at the time of in-reach. 2) LDH should conduct a small sample study to better understand the circumstances of individuals who are categorized as "unable to decide."

V. Outreach, In-Reach, and Provider Training & Education

54. Within dates to be specified in the Implementation Plan, LDH will analyze MDS data to identify members of the Target Population residing in NFs. LDH will begin outreach to these individuals according to timeframes to be specified in the Implementation Plan. Outreach shall consist of face-to-face assessment of the individuals by one or more members of the transition team using a process and protocols to be agreed upon by LDH and the United States.

Analysis: Per the Agreement, LDH must engage and educate TP members in NFs about their interest in transitioning and the availability of community-based services and supports. In this reporting period, engagement of TP members is conducted by peer in-reach (PIR) staff and RITCs. For clarity, the SME uses the term *in-reach* to describe LDH's engagement process, consistent with LDH's terminology, even though the Agreement uses "in-reach" and "outreach" interchangeably.

Since the sixth report, PIR staff, drawing on their lived experience, have visited individuals on the ML to gauge interest in and provide education around community living. Prior to March 2025, PIR staff conducted all in-reach for newly admitted TP members and handled all follow-up encounters. With the statewide rollout of RITC in 2025, RITC staff now serve as the first point of contact for new NF admissions. PIR staff now focus on: (1) follow-up visits for individuals who decline RITC support; (2) responding to direct requests for in-reach from NF staff or members; and (3) engaging individuals who, for various reasons, never received in-reach. The discussion below focuses on PIR program performance.

- The PIR program has nine positions, one per region; as of September 2025, seven were filled.
- PIR positions are budgeted for 24 hours per week on average.
- During this reporting period, LDH expected PIR staff to complete 40 contacts per month, including initial and follow-up visits, documented in a standardized log. In January 2025, LDH revised its policy to stop counting non-completed encounters toward targets and increased expectations to 16 completed engagements per week.
- Non-completed encounters typically occurred because individuals were unavailable due to illness, sleep, or appointments (e.g., physical therapy).

- After each PIR encounter, individuals are categorized as *interested*, *not interested*, *undecided*, or *unable to decide*. Undecided individuals receive a follow-up visit in three months and those "unable to decide" or not interested receive follow-up in six months, with exceptions for earlier visits when appropriate.
- Some individuals on the ML have not yet been engaged. With the statewide RITC rollout, newly admitted individuals should receive an RITC contact, but those admitted before the rollout, or added to the ML after admission, may have been missed. There remain individuals on the ML who have never been engaged by MCL programming. LDH was unable to provide data on the number of individuals in this circumstance, but there were 560 in the prior period.

During this reporting period, LDH completed 1,940 PIR engagements, constituting 90% of the 2,160 target. The shortfall is mostly attributable to a staff vacancy in one region; otherwise, PIR staff, on average, were close to or met their monthly targets, except for November and December 2025. The 1,940 engagements include 608 initial engagements (31%) and 1,332 follow-ups (69%), plus 295 additional contact attempts. In the prior period (January–June 2025), LDH completed 1,969 in-reach encounters toward the same target, with 604 initial (32%) and 1,310 follow-up (68%) engagements. As shown in Figure 35, LDH also tracks the disposition of initial and follow-up in-reach encounters. Over the last two reporting periods, there has been a gradual increase in individuals expressing interest at initial in-reach and a decrease in those not interested. For follow-up in-reach, disposition patterns remained relatively stable, with a slight increase in individuals categorized as not interested.

Figure 35. In-Reach Outcomes for Initial and Follow-Up Visits

	12th	*13th*	*14th*	*12th*	*13th*	*14th*	*12th*	*13th*	*14th*	*12th*	*13th*	*14th*
	Interested			*Undecided*			*Not interested*			*Unable to decide*		
Initial	10%	12%	16%	19%	16%	13%	56%	56%	53%	15%	14%	17%
Follow-Up	6%	6%	7%	11%	6%	4%	66%	68%	71%	17%	18%	19%

The SME credits LDH for their continued implementation of the PIR program with strengthened processes and supervisory structures. Ongoing efforts are needed to ensure full and consistent engagement of all members of the TP, as well as consistent attainment of PIR staff's monthly visit benchmarks. This results a "Partially Met" rating for this paragraph.

Figure 36. Paragraph 54 Compliance Determination and Associated Recommendations

Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. LDH continues to implement the PIR program with strengthened processes and supervisory structures. However, a segment of the TP has yet to be reached and slight improvements are needed in reaching monthly visit benchmarks.	1) LDH should continue to enhance PIR management and quality assurance strategies, with the goal of improving overall performance and reaching all eligible members on the ML.

55. Based upon information gained as a result of outreach, as well as other information available to LDH, LDH may develop a plan to prioritize individuals for transition based upon such factors as location or concentration of members of the Target Population in certain facilities or regions, likelihood of successful transition as measured by MDS-based tools, individual access to housing or availability of housing in the area in which the person wishes to reside, and other factors. The goal of such prioritization will be to effect multiple successful transitions within two years of the effective date, on a schedule specified in the Implementation Plan, and to incorporate lessons learned into the State's practices.

Analysis: This provision applied only to the first two years of implementation and is therefore not rated. In July 2018, LDH proposed a prioritization process to identify individuals with fewer transition barriers using MDS Q+ data and follow-up conversations with TCs. Since then, LDH has prioritized individuals based solely on their expressed interest in transitioning, not on perceived transition barriers. Individuals who indicate interest are added to the AC, assigned a TC, and receive transition support as long as they maintain interest. As demonstrated in prior SME Service Reviews, even individuals with significant physical, behavioral health, or other complex needs have successfully transitioned and remained stable in the community. LDH's decision to include individuals on the AC regardless of perceived barriers is therefore appropriate.

Figure 37. Paragraph 55 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Not Rated.	None.

56. LDH will transition members of the Target Population according to timelines agreed upon by LDH and the United States and set forth in the Implementation Plan.

Analysis: This Paragraph is implemented through LDH's annual Implementation Plan, which sets a yearly transition target based on a methodology developed in consultation with the SME. For the 2024 target, LDH worked with the prior SME to develop a methodology using CY2022 and most of CY2023 data. The approach began with the number of individuals on the AC categorized as "actively working" toward transition and then adjusted downward based on historical fall-off rates at each stage of the transition pipeline. This produced a CY2024 target of 331, similar to CY2023. Using the same methodology, LDH set a target of 287 for CY2025. For CY2026, LDH made additional adjustments to produce a more feasible target of 177.

As discussed under Paragraphs 25 and 26, the AC historically reflected individuals engaged by PIR who expressed interest in transitioning, called the "Legacy AC." The RITC AC functions differently: under the RITC pilot, LDH adds presumed TP members to the "RITC AC" upon NF admission, triggering RITC engagement. Thus, the Legacy AC includes individuals who have already expressed interest, and the RITC AC includes all new admissions, most of whom will not ultimately transition.

Transition performance remains one of the most critical compliance indicators. Although the Agreement originally anticipated a five-year timeline, LDH is now in its seventh year and has consistently underperformed its transition targets. Performance peaked in CY2022 and has declined since. As noted elsewhere in this report, the SME believes that ongoing systemic barriers, outside of the realm of control of TCs and other MCL-affiliated staff, are the major contributors to the number and speed of transitions.

Figure 38. Multi-Year Transition Performance			
Period	***Target***	***Achieved***	***Performance %***
June-Dec 2018 & CY2019	N/A	91	N/A
CY2020	100	38	38%
CY2021	219	94	43%
CY2022	292	200	68%
CY2023	350	174	50%
CY2024	331	135	41%
CY2025	287	166	58%
Total Transitions (June 2018 to December 2025): 898			

As reflected in Figure 38 for CY2025, LDH achieved 166 of 287 required transitions (58%). LDH has invested heavily in improving TC management, oversight, and support, and the SME's Service Review confirms that these efforts have strengthened the TC workforce. However, systemic barriers, largely outside TC

control, continue to impede timely transitions and contribute to burnout. The 2025 Service Review identified persistent challenges, including: barriers affecting individuals with ID/DD (e.g., long OCDD screening wait times, unrecognized ID/DD needs), housing barriers (e.g., long waits for preferred units, limited ADA-accessible housing), and documentation barriers (e.g., unclear NF staff roles, difficulty obtaining SSI/SSDI verification or resolving benefits issues). These issues align closely with the transition barriers LDH tracks and continue to limit transition performance. In Spring 2026, LDH plans to implement a new systemic barrier referral procedure, which would catalog systemic barriers and refer them to internal and external experts to devise remediation strategies.

Figure 39. Paragraph 56 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Not Met. LDH should be credited for the development of transition support infrastructure, including supervision, staffing, and service delivery protocols, as well as the piloting of the RITC approach. However, LDH has consistently not met its transition performance goals, with declining performance in the last two years.	1) LDH should implement the recommendation under Paragraph 51 related to addressing system barriers.

57. Members of the Target Population will be transitioned back to their previous community living situations whenever viable, or to another community living situation, according to the timeframes set forth in the Individual Transition Plan.

Analysis: This Paragraph requires that TP members be transitioned into integrated housing, including previous community living situations LDH reports that some regions utilize community living options that are not part of LDH's PSH program, such as Section 8, senior living, and other low-income housing programs. These settings may qualify as PSH in principle but are not currently captured as such. It is also unclear how many individuals returned to prior or family residences. LDH is able to confirm that 45 (47%) the 96 individuals transitioned during this period were placed in PSH. An additional three individuals (3%) were placed in congregate or out-of-state settings. That leaves another 48 individuals who were either placed in other low-income housing programs, returned to prior residences, or transitioned to family homes.

The Paragraph also requires that transitions occur within the timeframes established in each individual's ITP. TCs typically set an initial transition date six or twelve months after ITP initiation, then adjust it based on the person's needs, progress toward transition, and barriers that slow the process, such as limited housing availability in preferred neighborhoods or the need for ADA-accessible units.

The SME is assigning a "Partially Met" compliance rating because, in his review of a September 2025 transition barriers report, 45% of individuals experienced transition delays and barriers associated with housing issues. This includes members waiting for specific units, preferred locations, accessible housing, or needed modifications.

Figure 40. Paragraph 57 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. LDH has established processes to transition individuals to previous living situations and modify transition dates based on individual readiness and barriers, but housing is still a major contributor to transition delays.	1) LDH should specify and quantify housing-related barriers (e.g., lack of ADA, accessibility, preferred locations not being available) in partnership with the TSC and other stakeholders and develop strategies to address identified barriers. 2) LDH should consider more granular tracking of housing placements, such as quantifying the number of transitioned individuals placed in PSH, other integrated housing situations (e.g., Section 8), congregate settings, prior residences, and family residences.

58. LDH will create a Transition Support Committee to assist in addressing and overcoming barriers to transition for individual members of the Target Population when transition team members working with service providers, the individual, and the individual's informal supports cannot successfully overcome those barriers. The Transition Support Committee will include personnel from OAAS and OBH, and ad hoc representation as needed to address particular barriers in individual cases as well as systemic barriers affecting multiple members of the Target Population. Additional members with experience and expertise in how to successfully resolve barriers to discharge may include OCDD, Assertive Community Treatment team members, Permanent Supportive Housing staff and/or providers, community physical and home health providers, representatives of agencies responsible for benefits determinations, Adult Protective Services staff, LGEs, and certified peer specialists. A list of such ad hoc members shall be approved by the Expert.

Analysis: The TSC launched in May 2023, and as described in Paragraph 53, has been responsible for the review and provision of recommendations around complex individual cases. In October 2025, LDH drafted a new standard operating procedure that would enhance the TSC's duties by providing a consolidated inventory of systemic barriers to inform their discussion about potential solutions. The SME reviewed and provided feedback on the standard operating procedure, which, per LDH's 2026 Implementation Plan, will be implemented in 2026. The 2026 Implementation Plan also includes a new role for the TSC around the review of readmissions among transitioned and diverted members. Once implemented and reported on, LDH will move closer to full compliance with this Paragraph.

Figure 41. Paragraph 58 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. The TSC is currently focused on individual case reviews, but LDH has designed a new process to expand their role in identifying and formulating strategies around systemic barriers.	1. LDH should implement the recommendation under Paragraph 51 related to addressing systemic barriers.

59. Ongoing case management in the community shall be provided to members of the Target Population for a minimum of twelve months following discharge from the NF.

Analysis: LDH launched the CCM program in March 2022. MCOs operate the program through contracted providers, offering CCM to individuals projected to transition within 60 days or to those diverted from NFs. Participation is voluntary and limited to Medicaid MCO members. CCM is available for up to 12 months post-transition or diversion, with extensions permitted on a

case-by-case basis. LDH requires CCM caseloads to remain at 15 individuals or fewer. If a CCM participant is readmitted to an NF, the CCM must remain engaged unless the individual declines services or is expected to stay in the NF for more than 30 days. Core CCM functions include needs assessment, care plan development, referral and linkage to services, and ongoing monitoring through high-touch, high-frequency contact.

In 2025, LDH shared educational materials on reducing avoidable ED use, reinforcing expectations for initial engagement and community integration, correcting data issues related to critical-incident classification, and developing new measures to assess member choice and self-determination.

As of December 2025, there were 244 individuals enrolled in CCM: 44 diverted, 146 transitioned, and 34 residing in NFs within 60 days of their projected transition date. As of June 2025, enrollment was 234. In December, 25 new members were referred; 21 enrolled, three declined, and one referral was rescinded. The 13th SME Report summarizes CCM performance measures and service-utilization outcomes, showing high rates (above 90%) of self-reported satisfaction, stability, receipt of planned services, medication adherence, safety, and physical and mental health. The data also show that CCM participation correlates with positive shifts in service use: increased outpatient behavioral health utilization and decreased inpatient and ED utilization among both diverted and transitioned cohorts.

The SME assigns a "Met" rating for this Paragraph because the CCM program is established and is achieving positive outcomes. As described under other Paragraphs, LDH should continue to make continuous quality improvements to the program, including devising and implementing strategies to increase uptake among TP members.

Figure 42. Paragraph 59 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Met. LDH has developed a CCM program that supports diverted and transitioned individuals for up to 12 months in the community.	1) LDH should explore strategies to increase uptake of CCM services, particularly among the diverted population.

60. The Implementation Plan shall describe LDH's plan to ensure case management services are provided to the Target Population. Case management services shall provide consistency, and continuity, both pre- and post-transition. Services will be of sufficient intensity to ensure case managers are able to identify and coordinate services and supports to help prevent re-institutionalization and assist the individual to maintain community placement. This will include assuring access to all medically necessary services covered under the State's Medicaid program, including but not limited to assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs), behavioral and physical health services, substance use disorder services, integrated day activities such as supported employment and education, and community connections. LDH shall ensure capacity to provide face-to-face engagement with individuals in the Target Population, through case management and/or through the appropriate behavioral health provider.

Analysis: As noted above, LDH began to implement the CCM program in March 2022. For transitioned individuals, CCMs engage in multiple monthly contacts (face-to-face and virtual), generally starting two months prior to transition and extending to one year after transition. For diverted individuals, CCMs are engaged after an individual is diverted, and continue to serve diverted individuals for up to one year. For both populations, an assessment is conducted after the initial year to determine whether the individual has a need and desire for extended CCM services.

Throughout the CCM engagement, LDH's procedures establish requirements and associated timeframes for community assessments, reassessments, community plans of care (CPOC), crisis plans, and other documentation that supports the delivery of CCM services.

The SME's service review process involves an in-depth review of diverted and transitioned individuals who are engaged in the CCM program, and as such, sheds light on the CCM program's performance. Figure 43 displays relevant findings from the 2025 Service Review.

Figure 43. CCM-Related Service Review Findings

- Among those who had transitioned, all members had their required CCM documentation, including community assessments, CPOCs, and crisis plans, representing an improvement compared to the last reporting period. Among those who were diverted, all had required CCM documentation.
- Quality of documentation improved compared to prior years. For transitioned members, the average quality score of assessments increased from 85% in 2023, to 91% in 2024, to 94% in 2025. For diverted members, the average quality score of assessments increased from 90% in 2023, to 91% in 2024 to 98% in 2025. The average quality score for CPOC among transitioned members climbed from 69% in 2023, to 73% in 2024 to 84% in 2025. For diverted members, average quality scores increased from 69% in 2023, to 78% in 2024, to 88% in 2025.
- This Paragraph also requires that case management facilitates access to all medically necessary services covered by the State's Medicaid program for members of the TP. To determine whether the State is meeting the intent of this provision, the SME and his team (as part of the Service Review process) reviewed whether there was alignment between what an individual was assessed as needing and what services were planned for, as evidenced by their inclusion in the CPOC. The CPOCs were largely complete (strengths and preferences, housing, social/recreational needs, educational/vocational needs, member signature, and involvement of other individuals). The most common gaps in the CPOCs include inclusion of plans to address transportation needs (8 members/50%); medical needs (4/25%), health and safety needs (4/25%), and BH needs (3/19%).
- For diverted members, most domains of the CPOC were largely complete (strengths and preferences, housing, educational/vocational needs, member signature, and involvement of other individuals). The most common gap in the CPOCs include planning for DME (in two cases). In the 2024 Service Review, one-third of CPOCs did not have reference to medical services and one-third did not include BH services. Further, nearly all CPOCs lacked information on the frequency and duration of specified services, which is needed for a CCM to adequately assess whether an individual is getting the intensity and dosage of care that is needed beyond initial linkage. CCMs indicate that the CPOC is an initial planning document, and they track other service needs monthly (outside of the CPOC), making referrals as needed.
- This Paragraph also underscores the role of case management in promoting community integration. The SME calculated an average community integration score via the service review process. In 2023, the score was 2.66, in 2024 it was 3.0, and in 2025 it was 3.06, which is corresponds with a "good" rating in the five-point Likert scale. For diverted members, the community integration score was lower (2.1 in 2025) but the sample size was too small to extrapolate broadly.

During this reporting period, among the nine transitioned individuals were readmitted to NFs, six were receiving CCM. For individuals engaged in CCM, CCMs utilize a monthly monitoring form to assess whether an individual is receiving planned/needed services, whether there are issues, what the CCM is doing to address identified issues, and additional narrative for context and detail. Of note, through these monthly visits, a plurality of CCM clients report that they have the services they need and that were planned for.

The SME is assigning a "Partially Met" rating because of 2025 Service Review findings that suggest additional improvements need to be made regarding CCM documentation. However, he

acknowledges that: (a) this data was collected prior to the reporting period, and (b) the new service review scope (in fall 2025) did not evaluate CCM performance. If SME service reviews continue to evaluate other aspects of the MCL program, a new reporting approach (e.g., review of documentation sample, provision of MCO oversight data) is needed to demonstrate compliance with this Paragraph.

Figure 44. Paragraph 60 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. LDH's CCM programming has steadily improved in several areas since 2023, including the quality and completeness of assessments and CPOCs. Additional minor improvements are needed.	1) LDH should collaborate with the SME to identify a reporting approach for this Paragraph, given a shift in scope in the SME service review.

61. The case manager will assure that each member of the Target Population receiving Medicaid services has a person-centered plan that will assist the individual in achieving outcomes that promote individual's social, professional, and educational growth and independence in the most integrated settings.

Analysis: To fully participate in community life, TP members may need support to plan for and participate in activities related to school, employment, recreation, culture, volunteering, faith communities, interest clubs, public transportation, and other key community inclusion activities. As indicated in the 7th SME Report, the State has developed assessment and plan of care tools that are intended to capture the desires and needs of the TP who have been diverted or transitioned from NFs.

The 2025 Service Review assessed the extent to which CCM assessments and CPOCs facilitate person-centered planning. The review revealed that individuals' goals in the CPOCs continued to be stated in their own words, and the CPOCs contained individuals' strengths, preferences, and signatures. The 2025 Service Review's average score for Assessment and Person-Centered Planning was 3 among both the diverted and transitioned cohorts, representing the midpoint – or a "good" rating – on the Likert scale. The State also continues to require MCOs to ensure CCMs receive regular person-centered planning training and utilize a person-centered planning checklist. In monthly meetings with their CCMs, over 95% report that they are involved in the community to the extent that they prefer.

While not directly associated with the CCM program, it is important to underscore the importance of Assertive Community Treatment (ACT) and other services in achieving the broad intent of this Paragraph, helping individuals fully participate in the community. ACT teams generally include peer specialists, who can play a significant role in providing recovery and community integration support, informed by their lived experiences. As described under Paragraph 79, peer services also exist in other parts of the BH system of care, both as a standalone service and a service embedded within other programs. Given that CCMs are expected to coordinate across multiple services/programs, CCMs should be able to clearly delineate which care team members are responsible for supporting community integration.

The SME assigns a "Partially Met" rating to this requirement based on 2025 Service Review findings and carries forward the recommendations under the preceding Paragraph.

Figure 45. Paragraph 61 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. Based on the 2025 Service Review, CCMs have improved the person-centeredness of their documentation, but further minor improvements are needed.	1) LDH should implement the recommendation under Paragraph 60.

62. By the date specified in the Implementation Plan, LDH will develop and implement a system to identify and monitor individuals in the Target Population who remain in Louisiana Medicaid after their transition from a NF in order to: ensure health and safety in the community; assess whether supports identified in the individual's discharge plan are in place and achieving the goals of integration; identify any gaps in care; and address proactively any such gaps to reduce the risk of readmission or other negative outcomes. The monitoring system shall include both face-to-face meetings with individuals in the Target Population and tracking by service utilization and other data.

Analysis: LDH utilizes multiple strategies to monitor the health and wellbeing of transitioned and diverted members. Such strategies include:

- *CCM Engagements.* As described in the CCM standard operating procedures, LDH requires a scheduled cadence of face-to-face contacts between the CCM and the individual who has been transitioned or diverted. LDH receives standardized monthly reports from MCOs that indicate the initial and ongoing contacts between the individual by the CCM; the date community assessments and CPOCs were developed; whether the individual received all services on his/her plan of care in a given month; whether the individual is making progress toward goals; if there were services needed but not yet received and, for these individuals, the specific steps the CCM is taking to mitigate service gaps; and critical incident reports and the follow-up actions taken to address the issues identified in the reports.
- *TC Engagements.* As described in Paragraph 49, TCs are also responsible for regular visits with transitioned members for up to 12 months post-transition. This provides another opportunity to ensure that members are safe and receiving needed supports.
- *Participation in SME Service Review Process & Implementation of Internal Service Reviews.* In 2024 and 2025, OAAS and OBH leadership also continued to accompany the service review teams to visit individuals who were transitioned, diverted, or in the NF awaiting transition. This included a review of documentation and face-to-face visits with each individual. LDH and the service review team met with individuals to discuss their transition experience, current goals and interests (e.g., community inclusion, employment), services received, and gaps in care. LDH has now implemented an internal service review process to monitor TC performance and client outcomes.

The combination of these strategies is sufficient to merit a "Met" compliance rating for this Paragraph. However, related requirements (pertaining to critical incidents and post-transition TC visits) require additional improvement.

Figure 46. Paragraph 62 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Met. LDH has established processes to monitor the experiences and outcomes of TP members who have transitioned into the community.	1) LDH should implement recommendations associated with Paragraphs 49 and 95, regarding post-transition TC visits and addressing critical incidents.

VI. Community Support Services

63. LDH will develop and implement a plan for its crisis services system. LDH will ensure a crisis service system that provides timely and accessible services and supports to individuals with SMI experiencing a behavioral health crisis within their local community. The services shall include a mobile crisis response capacity, crisis intervention services, and crisis telephone lines, consistent with the principles outlined below. Crisis services shall be provided in the most integrated setting appropriate (including at the individual's residence whenever practicable), consistent with community-based crisis plans developed for individuals receiving services, or in a manner that develops such a plan as a result of a crisis situation, to prevent unnecessary hospitalization, incarceration, or institutionalization.

Analysis: In December 2019, LDH, working with the former SME, developed a statewide crisis response framework that incorporates the crisis services required under the Agreement as well as additional evidence-based services used in other jurisdictions. The framework, available at https://ldh.la.gov/assets/docs/MyChoice/CrisisFramework.pdf, outlines four core crisis service types:

- Mobile Crisis Response (MCR): Provides immediate, intensive assessment and intervention to stabilize crises and connect individuals to ongoing care.
- Community Brief Crisis Support (CBCS): Offers short-term follow-up after an initial crisis service or ED referral, with a focus on maintaining individuals in their current living arrangements and preventing ED, hospital, NF, or other institutional placements.
- Behavioral Health Crisis Care Centers (BHCC): Delivers site-based crisis services for up to 23 hours to support a safe return home with community-based services.
- Crisis Stabilization Units (CSU): Provides multi-day, site-based stabilization to prevent higher-level care utilization.

Crisis service availability varies by region. Below, the SME has provided an overview of which services are available in each region, comparing service capacity in this reporting period to service capacity during the 12th reporting period (one year ago). Overall, there is only one region with all four crisis service types, one region with three crisis services, and four regions with two crisis services. The remaining five regions have no LDH crisis services, although LDH reports that providers have been identified for at least one service in all but one region. The regional breakdown is as follows:

- Region 1: All four crisis levels of care are now in place (two services began in February 2026 after this reporting period). Last year, only MCR and CBCS were available.
- Region 2: BHCC and CSU operational with providers now identified for MCR and CBCS. Last year, BHCC and CSU were operational but no MCR and CBCS providers were identified.
- Region 3: MCR and CBCS are operational; a BHCC provider has been identified as of the writing of this report.
- Region 4: BHCC and CSU were implemented in January 2026 (after this reporting period); both are new since last year.
- Region 5: No crisis services planned or implemented, consistent with last year.
- Region 6: MCR, CBCS, and BHCC are planned; last year, a CSU provider had been identified, but they decided not to proceed with implementation.
- Region 7: MCR and CBCS are operational and BHCC is planned. A CSU provider had been identified, but they decided not to proceed with implementation.

- Region 8: Providers are identified for MCR and CBCS; last year, no providers were identified for any services.
- Region 9: This region lost MCR, CBCS, and BHCC programs since last year, but providers have now been identified to resume MCR and CBCS.
- Region 10: Providers continue to operate MCR, CBCS, and BHCC; CSU is still planned but the provider is working toward service implementation.

A major development in 2025 that reshapes the functioning of Louisiana's crisis system is the launch of the Louisiana Crisis Hub (LCH) in May 2025. LCH now serves as the statewide single point of access for behavioral health crisis services. It operates a 24/7 crisis line and manages triage, referral, and dispatch to ensure callers are connected to appropriate community-based supports. The Hub also collects crisis episode data in the Crisis Safety Platform to support coordination, risk analysis, and systemwide monitoring. LCH has engaged crisis providers, Medicaid MCOs, Local Governing Entities, the LSU Center for Evidence to Practice, 988 centers, and other system partners. LCH also engages with local communities through coalition meetings, public events, and collaboration with healthcare providers, law enforcement, judges, government leaders, and faith-based organizations.

Consistent with prior reporting periods, very few TP members use these crisis services. Across the first three quarters of 2025, only 0.3%[3] of the transitioned members used the crisis system (in quarter 2), and no diverted members used any crisis services. However, a quarterly average of 8% of diverted individuals and 2% of transitioned individuals utilized the ED for BH reasons. Even though EDs are overused for BH crises, they are often not clinically appropriate and could further destabilize or even traumatize individuals experiencing crisis. It is important that LDH not only continues to build out its statewide crisis services capacity but also implement measures to divert TP members from EDs toward those services, which will likely be more clinically effective.

While LDH continues its efforts to expand crisis services availability through provider expansion, they should explore other strategies for linking individuals to these services that decrease reliance on ED care. These include, but are not limited to, improved collaborations with community partners and further integration with the LCH.

Figure 47. Paragraph 63 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating and Rationale	***Priority Recommendations***
Partially Met. LDH has made considerable progress in developing a crisis system to benefit the TP, but continued development is needed to ensure that the TP can access all four crisis services across all regions.	1) LDH should continue its efforts to expand crisis services until every region has access all crisis services. 2) LDH should develop strategies to ensure that crisis services are optimized among the TP, and especially diverted individuals, to reduce ED and hospital utilization for behavioral health reasons.

64. LDH will ensure that the Target Population has access to a toll-free crisis hotline in each community 24 hours a day, 7 days a week, staffed by qualified providers, with sufficient capacity to preclude the use of answering machines, third-party answering services, and voicemail. Crisis hotline staff will try to

[3] Based on the number of transitioned individuals within their 12-month post-discharge window, the SME suspects that 0.3% equates to no more than 4 transitioned individuals.

resolve the crisis over the phone, and if needed will provide assistance in accessing face-to-face intervention, arranging an urgent outpatient appointment, providing phone consultation with a Licensed Mental Health Practitioner if a higher level of clinical skill is needed, or connecting the caller with peer support services.

Analysis**:** As noted in prior SME reports, Louisiana historically relied on a patchwork of toll-free crisis and help lines, including MCO crisis lines, 988, and direct calls to MCR teams, to support individuals, including TP members, experiencing behavioral health crises. As described under Paragraph 63, LDH has addressed this fragmentation through LCH. A core function of the Hub is dispatching MCR teams and referring callers to other crisis services.

Consistent with the requirements in this Paragraph, LCH operates 24/7, is staffed by qualified providers, and does not use voicemail, answering machines, or third-party answering services. From June to December 2025, the Hub received 3,729 total calls, including 2,115 crisis calls and 1,615 calls associated with MCO members contacting their MCOs for non-crisis reasons. This is nearly ten times the volume across all MCO crisis hotlines from July to December 2024 (221 calls). Further, because one MCO has not yet transitioned to LCH, additional crisis calls likely occurred but are not captured in the LCH data above. The increase could be partially attributable to the fact that LCH is the crisis hotline for Louisianans regardless of their insurance, whereas the MCO crisis hotlines were designed for Medicaid beneficiaries served by those MCOs. LDH also reports whether LCH callers' crises were de-escalated, stayed the same, or escalated. Call center staff report that the vast majority of calls (1,591/75%) were de-escalated, while 516 (24%) stayed the same, and eight (<1%) escalated.

To fully assess compliance with this paragraph, more granular disposition data is needed. This includes the number of callers who are referred to outpatient appointment or triaged to a phone consultation with mental health practitioner or peer support staff. LDH's reporting on MCO crisis calls included more detailed dispositions (e.g., return to community provider, MCR dispatch, ED referral), but those data were not provided for this period.

Figure 48. Paragraphs 64 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating and Rationale	***Priority Recommendations***
Partially Met. LDH launched its new Crisis Hub in 2025, which centralizes crisis hotline services and crisis response, but full reporting on all Agreement-required metrics is not yet available.	1) LDH should ensure that the Crisis Hub reports on all of this paragraph's required elements.

65. LDH will, through the Implementation Plan, ensure that a face-to-face, mobile crisis response capacity is available statewide before termination of this agreement. Mobile crisis response shall have the capacity to respond to a crisis at the location in the community where the crisis arises with an average response time of one hour in urban areas and two hours in rural areas, 24 hours a day, and seven days a week. Mobile crisis response will have the capacity to support resolution of the crisis in the most integrated setting, including arranging urgent outpatient appointments with local providers, and providing ongoing support services for up to 15 days after the initial call.

Analysis: Four of 10 regions had MCR services operational by the end of this reporting period: regions 1, 3, 7 and 10. In the 12th reporting period, MCR was operational in these regions as well as region 9. From July to December 2025, there were 1,233 MCR dispatches, including 844 (68%) in region 1, 307 (25%) in region 7, 68 (6%) in region 10, and 14 (1%) in region 3. By comparison,

there were approximately 315[4] MCR deployments from July to December 2024. From January to October 2023 (data analyzed for the 10th SME Report), 322 individuals utilized MCR. This indicates that there has been growth in the program over time; 206 individuals on average were served by MCR per month in this reporting period compared to 53 in the 12th reporting period. However, TP members are rarely using these services; across quarters 1-3, no diverted members used any crisis services and only 0.3% of transitioned members used a crisis service in quarter 2.

This presents an opportunity for LDH, as they continue to scale MCR services statewide, to devise strategies to ensure TP members' access to MCR. LDH provided information on the disposition of MCR services for all Medicaid beneficiaries receiving MCR services (see Figure 49). The most common dispositions are referrals to ED and inpatient services. As stated under the prior Paragraph, the SME has concerns about the continued high reliance on ED. SAMHSA's National Behavioral Health Crisis Care Guidance (2025) emphasizes that mobile crisis teams are designed to resolve most crises in the field and minimize ED utilization. While SAMHSA does not prescribe a specific percentage how many MCR engagements should result in ED referrals, published evaluations of state and local mobile crisis programs commonly report that 70–90% of crises are resolved in the community. MCR's ED over-utilization could happen for a variety of reasons (e.g., medical clearance requirements for admission into inpatient services, lack of service options for individuals who are not on Medicaid, under-utilization of ACT teams), and this is worth investigating further.

Figure 49. Disposition of MCR Engagements

Disposition	*Number*	*Percentage*
Resolved – Refused Referral	141	11%
Resolved – Appt/Referral to Community Provider	92	4%
Resolved – Returned to Community Provider	54	7%
Referred to BHCC	6	<1%
Referred to CBCS	31	3%
Referred to 911	5	<1%
Referred to ED	493	40%
Referred to MH Inpatient	158	13%
Referred to SUD Inpatient or Residential	41	3%
Engaged Law Enforcement	82	7%
Unresolved	50	4%
No Linkage Made	65	5%
No Info Available	15	1%

For the TP specifically, there was a quarterly average of 2% and 8% of transitioned and diverted members, respectively, who utilized EDs for BH reasons. This is a decrease compared to prior periods, potentially related to an increasing segment of transitioned and diverted members that utilize outpatient behavioral health services, including ACT services, which could be preventing, de-escalating, and otherwise addressing distress and crisis events among their clients.

LDH also analyzes the referral sources for MCR. Self-referrals (71%) and 911 (26%) are the two most common referral sources to Louisiana's MCR programs. The remaining three percent are distributed across 988, EDs, family/friends, law enforcement, unknown, and transfers from the statewide information and referral line. This distribution of MCR referral sources differs substantially from the 12th reporting period, wherein 53% of referrals came from 911, 15% came from crisis response service providers, 12% came from families/friends, and nine percent were self-referrals. An additional 34 (11%) MCR deployments were dispatched by the MCO crisis lines, 988, ED, schools, and medical providers. LDH reports the differences in the distribution of referral sources is likely attributable to data quality and accuracy issues that they are actively working to resolve.

[4] The SME qualifies this data as "approximately" because there is a discrepancy between data sources. Dispatches by month and region indicate a sum of 312, while dispositions indicate a sum of 315.

Figure 50. Paragraphs 65 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating and Rationale	***Priority Recommendations***
Partially Met. LDH has MCR teams operational in four Louisiana regions. In addition to ensuring statewide coverage, LDH should ensure that MCR teams are not overly reliant on ED referrals.	1) LDH should continue to expand and promote MCR services statewide, with focused outreach to TP members, their families, and MCL-affiliated staff. 2) LDH should conduct an analysis on the drivers of MCR referrals to EDs and identify strategies to address the underlying causes.

66. LDH will, through the Implementation Plan, ensure that a crisis receiving system is developed statewide with capacity to provide community-based de-escalation and recovery services to individuals experiencing crisis. The State shall conduct a gap analysis and develop crisis receiving system components in community-based settings designed to serve as home-like alternatives to institutional care, such as walk-in centers and crisis or peer respite apartments, or other evidence-based practices. LDH shall discourage co-locating in an institutional setting any new crisis receiving services developed during the term of this Agreement. Crisis or peer respite apartments developed through the Implementation Plan will have no more than two beds per apartment, with peer staff on site and licensed clinical staff on call 24 hours per day, seven days per week.

Analysis: To comply with this Paragraph, LDH included BHCCs as the linchpin of its crisis receiving system. BHCCs are walk-in centers designed to provide relief, resolution, and intervention of initial or emergent psychiatric crises, similar to urgent care models for physical health. In the 12th reporting period, BHCCs were operational in regions 2, 3, 9, and 10 and under development in regions 6 and 7. In this reporting period, BHCCs are only present in regions 2 and 10. Despite the loss of BHCC capacity in regions 3 and 9, overall BHCC utilization has increased from 1,158 engagements from July to December 2024 to 1,717 engagements from July to December 2025. Across both periods, the plurality of BHCC encounters (93%) were in Baton Rouge and surrounding areas, while 7% were in the New Orleans region, a distribution not proportional to population size.

Figure 51. Disposition of BHCC Encounters		
Disposition	*Number*	*Percentage*
Resolved – Refused Referral	15	<1%
Resolved – Appt/Referral to Community Provider	329	19%
Resolved – Returned to Community Provider	304	18%
Referred to CBCS	9	<1%
Referred to ED/MH/SUD Inpatient	441	26%
Engaged Law Enforcement	3	<1%
Referred to CSU	602	35%
No Linkage Needed	1	<1%
Unresolved	11	1%
No Information Available	2	<1%

Dispositions of BHCC encounters are provided Figure 51. Compared to the analysis in the 12th SME Report, disposition rates are very similar in terms of the percentages of encounters that were resolved, referred to CBCS, and referred to ED/MH/SUD inpatient. There was a slight uptick in referrals to CSU – from 30% to 35%. Data on TP members' utilization of BHCC services was not available in time for this report, but as indicated in the paragraphs above, service utilization data demonstrates that no more than four transitioned individuals utilized any crisis service in the first three quarters of 2025.

CSUs are also a vital part of LDH's crisis system. CSU services are short-term, bed-based crisis treatment and support services for individuals at risk for hospitalization or institutionalization,

including NF placement. At the end of this reporting period, there was only one region, region 2, with CSU services. The same region had CSU services during the 12th period, but at that time, LDH reported that three additional regions (6, 7, and 10) had plans for expansion; that does not appear to have come to fruition. LDH reports that there were 258 CSU utilizations during the reporting period, potentially undercounted due to a Medicaid claims data lag. In the 12th reporting period, there were 359 CSU utilizations; thus, unlike MCR and BHCC (which experienced significant increases in utilization), utilization of this facet of the crisis system has decreased substantially in the number of encounters since the 12th period.

In the 12th period, LDH provided data on dispositions that indicate where individuals are discharged after their CSU stays, demonstrating that 57% were referred to community-based providers. Only 5% were referred to ED or inpatient, but a notable 28% were referred to SUD residential. Such data for the 14th reporting period was not provided. Similar to his analysis and recommendations around MCR, BHCCs and CSUs can likely be more fully leveraged to prevent needless ED utilization, although there is limited statewide capacity for these services. The SME assigns a "Partially Met" rating for this requirement primarily due to the lack of BHCC and CSU availability in most regions.

Figure 52. Paragraphs 66 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating and Rationale	***Priority Recommendations***
Partially Met. BHCC and CSU services are not yet statewide, and utilization remains low, especially among the TP. In addition to statewide expansion, additional promotion of the services, including among the diverted population, is needed to prevent needless ED and hospital utilization.	1) LDH should continue to expand BHCC and CSU services until it is fully operational or available in all regions. 2) Similar to his analysis and recommendations around MCR, LDH should fully leverage BHCCs and CSUs to serve as alternatives needless ED utilization.

67. LDH is working to address the State's opioid crisis and other co-occurring substance use disorders affecting the Target Population. As part of this effort, LDH shall ensure statewide network adequacy of detoxification, rehabilitation, and intensive outpatient substance use disorder (SUD) recovery services. SUD services shall have sufficient capacity to accept walk-ins and referrals for the Target Population from crisis services, emergency services, and law enforcement personnel. With the technical assistance and approval of the Expert, the State shall develop policies, procedures, and core competencies for substance use recovery, rehabilitation, and detoxification service providers.

Analysis: As indicated in previous SME reports, LDH has implemented significant changes to their SUD service system through a CMS 1115 Demonstration Waiver, authorizing a continuum of services consistent with the American Society of Addiction Medicine (ASAM) that includes outpatient, intensive outpatient, residential, and withdrawal management services. While an analysis of SUD prevalence among the TP has not been done in recent years, the 2025 Service Review showed 19% of the awaiting transition cohort, 13% of the transitioned cohort, and 33% of the diverted cohort had SUD diagnoses. To assess the performance of LDH's SUD system of care against requirements in this Paragraph, the SME reviewed PASRR Level II audit information, SUD-related ACT fidelity scores, MCO network adequacy findings, and LDH performance on relevant Adult Core Set measures required by the Centers for Medicare and Medicaid Services (CMS). A synopsis of findings is displayed in Figure 53.

Figure 53. SUD System of Care Assessment	
Performance Area	*Performance Synopsis*
Identification of SUD and SUD-Related Service Recommendations in PASRR Level II Evaluations	Thirty (17%) of the 177 evaluations reviewed by OBH had a deficiency, mostly related to inadequate recognition of an individual's SUD and/or identification of services needed to address SUD. In the last reporting period, 14% of evaluations had a deficiency, and similarly, most of the deficiencies involved missing SUD information or BH or SUD recommendations misaligned with an individual's identified needs.
ACT Fidelity with SUD-Related Requirements	ACT teams, who generally serve approximately a third of transitioned and diverted members, performed well on fidelity measures associated with having required SUD staffing (4.2/5) and provision of individualized SUD treatment (4.3/5). On only one measure, involving the engagement of individuals with co-occurring disorders in groups, ACT teams had an aggregate average of less than three points.
Overall SUD Network Adequacy	In the last quarter of 2025, there were no ASAM Level 2 withdrawal management services. Otherwise, all ASAM levels of care were present in all regions. As noted under Paragraphs 73 and 74, there was fluctuation in the timeliness of appointments for emergent and urgent care associated with behavioral health services across the four quarters of 2025.
SUD-Related Adult Core Set Measure Performance	Louisiana 2024 performance on four of five key SUD-related Adult Core Set measures places them above the 50% percentile nationally, including follow-up after high intensity SUD care (71% compared to 56%), pharmacotherapy for SUD (35% versus 27%), initiation of SUD treatment (59% versus 46%), and engagement in SUD treatment (27% vs. 15%). Louisiana falls below the 50% percentile in one area: follow-up after ED for SUD (25% vs. 39%) and a performance improvement plan is underway to improve performance.

The SME assigns a "Met" rating because a continuum of SUD services is available to TP members, consistent with the requirements in this Paragraph.

Figure 54. Paragraph 67 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating and Rationale	***Priority Recommendations***
Met. A continuum of SUD services is available in all regions and performance on most CMS-required SUD-related quality measures is strong. Continued efforts are needed to promptly link individuals with SUD to care after ED visits.	1) LDH should continue current efforts to improve the identification of SUD needs and provision of appropriate service recommendations at the PASRR Level II stage. 2) LDH should continue to ensure SUD treatment network adequacy and strengthen post-ED follow-up.

68. LDH will collaboratively work with law enforcement, dispatch call centers, and emergency services personnel to develop policies and protocols for responding to mental health crises in the community and will support development and training of Crisis Intervention Teams and other initiatives that increase the competency of officers and emergency services personnel when engaging individuals with mental illness or substance use disorders.

Analysis: As described in the 12th SME Report, prior to the launch of LCH, LDH implemented several strategies to boost awareness of crisis services among law enforcement, dispatch call centers, and EMS. Per LDH, LCH scope of work involves a robust stakeholder engagement and education effort aligned with this paragraph. This paragraph also contemplates LDH's role in ensuring that law enforcement and EMS are better equipped to directly address the distress of individuals with behavioral health conditions, explicitly referencing the evidence-based Crisis

Intervention Team (CIT) model. CIT forges partnerships between law enforcement, hospital emergency services, mental health providers, people with lived experience, and other stakeholders, to improve encounters between law enforcement and individuals in crisis through partnership development and intensive training.

Figure 55. Paragraphs 68 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating and Rationale	***Priority Recommendations***
Partially Met. While LCH is engaging the stakeholders referenced in this Paragraph, additional work is likely needed to ensure that law enforcement personnel and other first responders are proficient in engaging and referring individuals in crisis to appropriate care.	1) In addition to continuing to engage law enforcement and EMS personnel to educate them about the crisis system, LDH should implement strategies and programming (like the CIT model) to forge deeper partnerships and more effective crisis responses from first responders.

69. The State shall develop policies, procedures, and core competencies for crisis services providers, which shall be developed with the technical assistance and approval of the Expert prior to implementation. The State shall also develop quality assurance measures for all Providers of community-based crisis services, including, at a minimum, tracking response times, and dispositions at the time of crisis and at post-crisis intervals of 7 and 30 days. The State shall consult with the Expert in selecting its quality assurance measures for providers of community crisis services.

Analysis: LDH monitors their performance in terms of call abandonment rates, calls answered within 30 seconds, and percentage of incoming calls answered, consistent with common crisis line performance metrics. As shown in Figure 56, when comparing the MCO crisis line performance (from the 12th period) and the LCH crisis line performance (from this reporting period), the call abandonment rates are fairly similar, except for a spike in call abandonments at LCH in December 2025 (2.7%) compared to December 2024 (0.4%). The percentage of answered calls were also similar between the two periods except for December (99.6% in 2024 and 95% in 2025). This performance exceeds the standards established by Vibrant Emotional Health, which serves as the national administrator of 988 in partnership with SAMHSA; Vibrant's targets require that 90% of calls are answered within 30 seconds and less than 5% are abandoned.

Figure 56. LCH Crisis Line Performance						
	Jul	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**
Call Abandonment Rate	**0.2%**	**0.4%**	**0.9%**	**0.5%**	**1.2%**	**2.7%**
% of Calls Answered within 30 Seconds	**99.7%**	**99.4%**	**98%**	**98.2%**	**96%**	**95%**

The development of additional performance measures is needed to comply with this Paragraph. The Paragraph requires tracking response times, which should include tracking the length of time between LCH deployment requests and MCR engagements and the length of time between referrals to CBCS and first CBCS engagement. The Paragraph also requires LDH to track dispositions at 7- and 30-days post-crisis. The SME, in partnership with a crisis expert, would like to collaborate with LDH to identify a measurement strategy for this requirement. Other measures, although not explicitly required, would also be helpful to assess system performance, such as MCR time on scene, primary presentation (for MCR, BHCC, and CSU), referral sources for all levels, and demographic data (e.g., housed versus unhoused, race, diagnoses).

Figure 57. Paragraph 69 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating and Rationale	***Priority Recommendations***
Partially Met. Policies, procedures, and core competencies have been developed for all facets of the crisis system, but LDH has not implemented a measurement approach that complies with all aspects of this Paragraph.	1) LDH should collaborate with the SME and his team to develop additional measures to comply with this Paragraph.

70. The State will expand Assertive Community Treatment ("ACT") services to ensure network adequacy and to meet the needs of the Target Population.

71. Members of the Target Population who require the highest intensity of support will be provided with evidence-based ACT services if medically necessary. The State shall review its level of care or eligibility criteria for ACT services to remove any barriers to access identified by the State or the Expert resulting in inadequate access for the Target Population.

72. ACT teams will operate with high fidelity to nationally recognized standards, developed with the technical assistance and approval of the Expert.

During this reporting period, 44 ACT teams were operational and available to TP members, which LDH considers an adequate number to serve both diverted and transitioned individuals. The SME concurs with this assessment. In the second quarter of 2024, nearly half of transitioned members and one-third of diverted members were engaged in ACT services. Although LDH no longer reports ACT utilization separately, they do track outpatient behavioral health utilization among the TP, an umbrella category that includes ACT. Across the first three quarters of 2025, quarterly utilization rates showed that 62%–67% of transitioned individuals and 53%–57% of diverted individuals received outpatient behavioral health services.

All 44 ACT teams received fidelity reviews in 2025 using the Dartmouth ACT Scale (DACTS), which evaluates structural and operational components, and the General Organizational Index (GOI), which assesses organizational supports needed to implement the model. ACT teams are rated across 40 items, and none scored below an average of 3.4 in any category. Seven areas, however, received aggregate scores below three points: individualized treatment planning, supervision, involvement in hospital admissions, face-to-face time with clients, frequency of visits, collaboration with informal supports, and engagement of individuals with co-occurring disorders in groups. These findings mirror results from the 12th period, though client retention showed slight improvement.

To address fidelity results, programmatic needs, and other issues, LDH and the MCOs meet with ACT teams at least monthly. In addition to ongoing efforts to strengthen fidelity, the SME recommends that LDH explore strategies to re-offer ACT services to TP members with higher acuity – such as diverted individuals who use the ED or experience behavioral health-related hospitalizations – and continue building ACT team proficiency in promoting community integration for TP members.

Figure 58. Paragraphs 70-72 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating and Rationale	***Priority Recommendations***
Met. There is an adequate number of ACT teams to meet the needs of the TP, and the teams perform well on recognized fidelity standards.	1. LDH should continue to make refinements to ACT services to improve fidelity. 2. LDH should consider which subsets of the TP who, because of their vulnerability, should be re-offered ACT services.

73. In Louisiana, [Intensive Community Support Services ("ICSS")] are provided through a variety of community-based mental health rehabilitation services as described below. Managed Care Organizations (MCOs) manage Medicaid reimbursable services for the treatment of mental health and substance use disorders. LDH shall monitor the MCOs, LGEs, and Medicaid provider network to ensure the number and quality of community mental health service providers are sufficient to enable individuals in the Target Population to transition to and live in the community with needed Community-Based Services. LDH will take into account rates and billing structure for Community-Based Services to ensure that all members of the Target Population have access to ICSS of sufficient intensity to support their transition, recovery, and maintenance in the community.

74. LDH will continue to provide services comparable to the following services currently provided: (a) Community Psychiatric Support and Treatment (CPST) services are goal-directed supports and solution-focused interventions intended to achieve identified goals or objectives as set forth in the individual's individualized treatment plan; (b) Psychosocial rehabilitation (PSR) services are designed to assist the individual with compensating for or eliminating functional deficits and interpersonal and environmental barriers associated with his or her mental illness. The intent of PSR is to restore the fullest possible integration of the individual as an active and productive member of his or her family and community with the least amount of ongoing professional intervention; and (c) Crisis intervention (CI) services are provided to a person who is experiencing a psychiatric crisis and are designed to interrupt and ameliorate a crisis experience, via a preliminary assessment, immediate crisis resolution and de-escalation, and referral and linkage to appropriate community services to avoid more restrictive levels of treatment.

Analysis: LDH continues to monitor the availability of and access to Intensive Community Support Services (ICSS) – defined as Community Psychiatric Support and Treatment (CPST), Psychosocial Rehabilitation (PSR), crisis services, ACT, peer supports, Intensive Outpatient Programs (IOPs), and withdrawal management – through quarterly network adequacy reports. Current policy requires MCOs to ensure that Medicaid-reimbursed CPST, PSR, IOP, and withdrawal management providers hold active licenses from LDH Health Standards and maintain national accreditation. Peer support providers (limited to LGEs and PSH providers) must also be licensed.

Overall, the ICSS network shows no widespread adequacy or access issues, though some gaps remain. Key data includes:

- At the end of the reporting period, five regions lacked all four crisis services in LDH's crisis framework, and no region had all four until Region 1 reached full coverage in February 2026.
- ACT, CPST, PSR, and most psychiatric outpatient services remained stable throughout 2025.
- Behavioral health PCS capacity increased from 152 to 174 staff over the year.
- The number of CPST providers continued a gradual decline when comparing year-end totals: 352 in 2023, 333 in 2024, and 327 in 2025.
- ASAM level 2 withdrawal management services were unavailable in Regions 6 and 8 in quarter 1, although other ASAM levels were represented statewide.

- Over 2025, the network also saw slight reductions in psychologists and increases in LPCs, while other licensed outpatient providers – including LCSWs, psychiatrists, and LACs – remained relatively stable.
- Provider performance on appointment availability standards fluctuated across 2025, falling below LDH's 90% benchmark for emergent appointments in quarter 2 (87%) and for urgent appointments in quarters 1, 2, and 4 (81%, 83%, and 85%).

Service utilization among the TP in some areas is moving in a positive direction. As indicated above, approximately two-thirds of transitioned members utilize outpatient BH services. There is also high utilization (85% in Q1 and 78% in Q2) of OAAS or OBH's PCS services and ambulatory and preventive care (83% in both quarters) among transitioned members. For diverted individuals, utilization rates are also high for outpatient behavioral health services (over half) and ambulatory and preventive services (over two-thirds), but utilization for PCS services is significantly lower. Only 21% and 22% of diverted members were served by OAAS or OBH's PCS programming in Q1 and Q2, respectively.

Figure 59. Paragraphs 73-74 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating and Rationale	***Priority Recommendations***
Partially Met. Across most programs, LDH has – through its MCOs – ensured that there is an adequate number of providers to address the needs of the TP. Some gaps persist (e.g., crisis services) and appointment timeliness standards are showing some slippage.	1) LDH should continue efforts to expand crisis services and determine the need or appropriateness to increase utilization of ICSS services among the TP.

75. LDH will seek necessary waivers and/or CMS approvals to ensure that individuals in the Target Population identified as needing assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) are provided with services sufficient to meet their needs.

Analysis: Since the beginning of the Agreement, many TP members have required extensive support with both Activities of Daily Living (ADLs) – such as bathing, dressing, transferring, toileting, grooming, and self-feeding – and Instrumental Activities of Daily Living (IADLs), which reflect higher levels of functional independence, including using the telephone, preparing meals, managing finances, taking medications, performing household tasks, shopping, and managing transportation. Louisiana's Medicaid State Plan behavioral health services, including CPST, PSR, and ACT provide support to improve IADLs. LDH also offers personal care service (PCS) options to assist with ADLs through multiple Medicaid authorities. These include 1905(a) State Plan PCS, the 1915(c) New Opportunities Waiver (NOW) for individuals with intellectual and developmental disabilities, the 1915(c) Community Choices Waiver, and an OBH 1915(b) waiver for individuals who do not meet nursing-facility level of care or qualify for NOW.

A substantial share of transitioned members now receive PCS through OAAS and OBH PCS programs: 84% in Q1 2025 and 78% in Q2 2025, representing a significant increase from earlier periods. As noted in the 12th SME Report, PCS utilization among transitioned members was 61% in Q4 2023, 45% in Q1 2024, and 68% in Q2 2024. Utilization among diverted members has also grown, with 21% receiving PCS in Q1 2025 and 22% in Q2 2025, compared to 10% in Q4 2023 and 18% in Q2 2024. Most of the growth of PCS utilization is attributable to more transitioned and diverted individuals being served by the OAAS PCS program; OBH PCS utilization has remained steady.

In prior reports, the SME has requested an evaluation of PCS, given the significant proportion of TP members who utilize that service. Evaluation data for OBH's PCS program – which represents a small segment of overall PCS utilization – was provided by LDH for this report. The evaluation provided the number of TP members utilizing the service (54 in each quarter of 2025), the criteria and training criteria for staff, and details about the MCO provider monitoring approach. The monitoring approach involves evaluating a sample of providers, reviewing service plan quality and follow-through, member health and welfare, provider participation in team meetings, adequate staff coverage and back-up planning, emergency evaluation plans, and overall documentation and record keeping.

Ten of 19 providers were evaluated in 2025 and eight providers received an 80% or above evaluation score, which is deemed a "successful score." Two providers received scores below 80%, requiring corrective action. LDH reports that no systemic compliance concerns are evident across this pool of providers; instead, deficiencies were related to individual provider performance issues.

Given the widespread availability of PCS, this paragraph is rated as "Met." To maintain compliance under this Paragraph, the SME would like to review similar evaluation results from OAAS's PCS program, which constitutes the majority of TP member PCS utilization. OAAS reports a robust monitoring and evaluation approach for PCS, inclusive of monthly calls, quarterly home visits, and independent quality audits of documentation. In other sections of this report, the SME discusses OCDD PCS programs, and the need for improved collaboration with OCDD to facilitate more expeditious and efficient OCDD waiver evaluations for TP members with ID/DD, as well as a request to track the number of transitioned and diverted members who receive OCDD waivers.

Figure 60. Paragraph 75 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating and Rationale	***Priority Recommendations***
Met. Louisiana government agencies have a number of programs to provide ADL and instrumental ADL support and uptake of these services is increasing among diverted and transitioned members.	1) LDH should provide OAAS PCS evaluation results to the SME for review.

76. LDH, in partnership with stakeholders, will review and recommend improvements to existing provisions governing the fundamental, personal, and treatment rights of individuals receiving community-based mental health services.

Every behavioral health treatment provider should observe the rights of the people they serve. These rights include (but are not limited to): receiving complete information, accessing medical records, being informed of treatment options, having privacy and confidentiality, participating in treatment plans, reporting mistreatment, and involving loved ones. The prior SME indicated that LDH had not developed a process to meaningfully engage stakeholders – including individuals with lived experience, TP members, and family members – to review the rights of individuals receiving treatment services.

The SME recommends that LDH, in partnership with stakeholders, review policies and procedures and make recommendations for improvements, as well as advise on strategies to educate individuals and their families on their rights and recourse options if rights are infringed upon. The scope of this review should include documents and processes associated with Agreement-related programming (e.g., TCs), MCO-related programming (e.g., CCMs), Medicaid waiver services, and

the ICSS services enumerated in Paragraphs 73 and 74. Many of these programs likely have established consumer rights protections and protocols. This process should culminate into the articulation of rights of TP members under My Choice Louisiana, a plan for educating stakeholders, and if needed, refinements to consumer rights policies within the other intersecting programs.

Figure 61. Paragraph 76 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating and Rationale	***Priority Recommendations***
Not Met. While LDH programs may have processes regarding the protection of consumer rights, an Agreement-focused process to systematically review and make improvements to such protocols has not occurred.	1) LDH should conduct a systematic review of consumer rights protocols across Agreement-related programming and develop plans to engage stakeholders to make improvements and promulgate among TP members and other relevant parties.

77. Staff for each of the services in VI A-C shall include credentialed peer support specialists as defined by LDH.

79. LDH shall ensure certified Peer Support Specialists will continue to be incorporated into its rehabilitation services, CPST, PSR, CI, ACT, Crisis Services, Residential Supports, Integrated Day, SUD Recovery, and Supported Employment systems. Peer support services will be provided with the frequency necessary to meet the needs and goals of the individual's person-centered plan. LDH shall ensure peer support services are available to all individuals with SMI transitioning from NFs, both prior to and after transition to the community.

Analysis: Paragraphs 77 and 79 are discussed together. Peer support is an evidence-based practice for individuals with mental health conditions. Research demonstrates that peer support lowers the overall cost of mental health services by reducing re-hospitalization rates, reducing days spent in inpatient services, and increasing the use of outpatient services. Peer support also improves quality of life, increases and improves engagement with services, and increases whole health and self-management. The prior SME, based on his prior Service Reviews, asserted that the expansion of peer support should be a top priority, based on the high prevalence of loneliness and social isolation cited by individuals and their supporters during interviews.

LDH obtained CMS approval for a Medicaid reimbursable stand-alone peer support service as of March 2021. Currently, LGEs and PSH programs are eligible to provide this service, and LDH has implemented several strategies to spur adoption, including flexibilities around peer supervisor roles, allowing programs to bill a certain number of units before service authorizations were required, and an incentive-based payment structure. At the end of this reporting period, five organizations submitted Medicaid claims. One year ago, only one organization was delivering the Medicaid peer services and two others had staff credentialed with MCOs to begin providing services. However, consistent with prior periods there continues to be no utilization of Medicaid peer support among transitioned or diverted members.

This paragraph also requires that peers be embedded in all ICSS services. Currently, LDH has policies (through the existing service definitions) that allow peer specialists to deliver services in various programs, including ACT, CPST, PSR, and the four crisis services discussed above. However, all programs are not required to incorporate peer specialists, and there is no current inventory of where peer specialists work across ICSS services.

The spirit of this requirement is that all individuals transitioning from NFs have access to peer support. Given that the majority of transitioned members utilize outpatient behavioral health services, and peer services embedded in various ICSS services, many likely have access to peer support services. This is especially true for members served by ACT. However, there is no visibility on whether there is actual peer service availability within those programs, and if so, whether members have been offered such services.

There are several strategies, with varying degrees of complexity and effort, that could improve transitioned members' access to peer support, including: focused conversations between MCL-affiliated staff (TCs, CCMs) and members to develop a peer support plan that leverages available peer support resources in a given region, development of an inventory of peer support resources in each region for use by members and MCL providers, analysis of the availability of peer support roles within ICSS programming, and embedding of peer support staff on CCM teams, among others. The SME encourages LDH to devise strategies to improve compliance on this paragraph.

Figure 62. Paragraphs 77 and 79 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating and Rationale	***Priority Recommendations***
Partially Met. LDH continues to expand its Medicaid-billable peer support programming, but additional strategies are needed to ensure that all transitioned members are meaningfully offered peer support services.	1) LDH should devise and implement strategies to increase the availability of peer support.

78. The State will develop and implement a plan to ensure that all individuals in the Target Population have access to an array of day activities in integrated settings. Integrated Day activities shall include access to supported employment and rehabilitation services, which may include but are not limited to competitive work, community volunteer activities, community learning, recreational opportunities, and other non-congregate, integrated day activities. These activities shall: (a) offer integrated opportunities for people to work or to develop academic or functional skills; (b) provide individuals with opportunities to make connections in the community; and (c) be provided with high fidelity to evidence-based models. The Implementation Plan will provide for development of supported employment services in the amount, duration, and intensity necessary to give members of the Target Population the opportunity to seek and maintain competitive employment in integrated community settings consistent with their individual, person-centered plans.

Analysis: To support employment readiness and opportunities among the TP, LDH has implemented several strategies to scale the availability of Individualized Placement and Support (IPS) model, the gold standard of employment support for individuals with behavioral health needs. IPS starts with the assumption that an individual can work and provides person-centered support to help individuals find and maintain employment, as well as navigate benefits changes. Activities to implement IPS and other employment-related supports include:

- In October of 2023, LDH oversaw the integration of IPS into ACT teams. LDH has also implemented a fidelity monitoring process with IPS, evaluating each ACT team across 24 measures related to organizational and service delivery standards on a 5-point scale. The SME appreciates LDH's commitment to delivering high fidelity IPS services.
- The average overall fidelity score across all teams was 2.9. The major deficiency areas (scores of 2.0 or less) include collaboration between employment specialists and vocational

rehabilitation counselors, role of employment supervisors, work incentives planning, frequent employer contact, and quality of employer contact.
- LDH reports that 98 TP members are receiving IPS services, based on ACT team self-reporting.
- As indicated in the prior reports, OBH has implemented other strategies to increase employment supports among TP members, including releasing guidance to providers on strategies to advance employment among individuals they serve (less intensive than IPS) and participating in a technical assistance initiative to strengthen collaboration between LDH and the Louisiana Rehabilitation Services.

Prior SME Service Review findings have suggested that individuals residing in NFs, preparing for transition, may not be best positioned to discuss employment goals. Rather, CCM and ACT providers may be in the best position to identify, refer, and link individuals to activities that match their interests in the early months post transition and diversion. To that end, LDH should ensure that these staff are educated on employment resources. LDH's 2026 Implementation Plan reaffirms its commitment to IPS and includes an activity to train MCL-affiliated staff on resources for benefits counseling.

With regard to non-employment focused integrated day activities, LDH has identified drop-in and low-demand social settings that could be visited by TP members. TCs are encouraged to make referrals and information on these resources are included in their TC resource guide. However, TCs are likely not the best positioned to promote socialization and recreation, given that interests and hobbies often change after an individual discharges and stabilizes in the community. As such, LDH should ensure that CCMs and ACT teams are equipped with this information and understand their role in linking individuals to socialization and recreational activities.

Figure 63. Paragraph 78 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating and Rationale	***Priority Recommendations***
Partially Met. LDH has implemented several strategies to promote employment among the TP, including incorporating IPS into ACT services. However, more strategies are needed to ensure that TP are effectively engaged, at the right time, around opportunities to participate in community life more fully.	1) LDH should continue to enhance IPS fidelity on ACT teams and ensure that MCL-affiliated staff are equipped to make referrals to other less intensive employment services. 2) LDH should implement recommendations under Paragraph 61 related to community integration planning.

80. The State will develop a plan to provide access to affordable, community-integrated housing for members of the Target Population. This includes but is not limited to expansion of the State's current Permanent Supportive Housing Program, which includes use of housing opportunities under the State's current 811 Project Rental Assistance (PRA) demonstration. Housing services will ensure that members of the Target Population can, like Louisianans without disabilities, live in their own homes, either alone, with family members, or with their choice of roommates.

Analysis: In December 2019, the State developed a Housing Plan, as required under the Agreement. It has since been updated twice, most recently in 2022. This plan sets forth specific actionable strategies with specific annual targets for the creation of additional affordable housing units and rental subsidies to be made available to members of the TP.[5] The plan includes development strategies, including optimization of the Low-Income Housing Tax Credit to develop

[5] https://ldh.la.gov/assets/docs/MyChoice/Resources/MyChoice-2023-Revised-Housing-Plan.pdf

Section 811 housing, as well as non-development strategies, mainly in the form of providing voucher opportunities that subsidize rents. Annual unit and subsidy production projections are provided in the plan up to 2025. In LDH's 2026 Implementation Plan, LDH commits to developing a new multi-year housing plan.

Paragraph 81 provides deeper analysis of the specific strategies enumerated in the housing plan, as well as SME recommendations regarding regular reporting on progress in achieving its goals and quarterly meetings with the SME and his team, which is included in LDH's 2026 Implementation Plan.

The SME is assigning a "Partially Met" rating under this Paragraph, because of the expiration of their prior housing plan. Although the plan did not technically expire until the end of 2025, a new plan should have been developed prior to the plan's expiration, to guide housing development opportunities in 2026.

Figure 64. Paragraph 80 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating and Rationale	***Priority Recommendations***
Partially Met. LDH's housing plan expired at the end of 2025. Plans for 2026 housing development should have already been developed.	1. Consistent with LDH's 2026 Implementation Plan, LDH should develop new multi-year housing plan in 2026.

81. In the Implementation Plan, the State shall set annual targets for creation of additional housing units and rental subsidies to be made available to members of the Target Population, for a combined total of 1,000 additional units and rental subsidies before termination of the Agreement. Once targets are achieved, the State shall maintain the availability of units and/or subsidies at the achieved target level for the term of this Agreement. Mechanisms to accomplish these targets shall be specified in the State's Implementation Plan, and include, but are not limited to, the following: (a) the State shall use some portion of the existing capacity in its current Permanent Supportive Housing program to house members of the Target Population through the institutional preference that prioritizes access to PSH units for persons in institutions; (b) the State shall use tenant-based vouchers in conjunction with Tenancy Supports offered through the Louisiana Permanent Supportive Housing Program to create supported housing opportunities for members of the Target Population; a portion of 125 existing vouchers shall be used for members of the Target Population; (c) through its statutory relationship with Public Housing Authorities, the State may seek to make available additional tenant-based vouchers for the Target Population; (d) the State, through the Louisiana Housing Corporation (LHC), shall continue to use existing incentives in the Low Income Housing Tax Credit (LIHTC) Qualified Allocation Plan (QAP) to create new units for the State's Permanent Supportive Housing Program; (e) the State shall additionally establish state-funded short or long term rental subsidies as needed to meet the requirements of this agreement. Within 18 months of the execution of this agreement, the State shall establish a minimum of 100 State-funded short-term rental subsidies to assist with initial transitions.

Analysis: This Paragraph requires LDH to collaborate with other housing agencies to ensure an adequate supply of housing opportunities to individuals in the TP. As noted in Paragraph 51, the three most cited barriers for individuals preparing for transition involve waiting for a housing unit or a housing unit in a specific town, waiting for housing greater than six months, and waiting for an accessible housing unit. Historical data, including from the SME's Service Review process, demonstrates that most individuals who transition through the My Choice Louisiana program will need housing opportunities.

Beyond the broad objective of creating housing opportunities for TP members, the Agreement specifies that LDH must create and sustain the availability of 1,000 housing opportunities, inclusive of 125 tenant-based vouchers. This Paragraph also required LDH to directly fund 100 rental subsidies for those who transitioned in the first 18 months of the Agreement, while they ramp up the availability of mainstream options. The Agreement contemplates a multi-pronged approach, wherein the State leverages incentives to spur rehabilitation and development of housing stock (e.g., the Low-Income Housing Tax Credit, bonds), repurposes existing capacity, and provides voucher opportunities (e.g., Section 8). As described in reports from the prior SME, the State developed an initial housing plan in 2019 and has since revised it twice, with the most recent update in 2022. An overview of the housing plan, which includes a summary of past progress as well as a projection of housing opportunities the State wished to produce from 2022 to 2025, was provided in the 12th SME Report.

Figure 65. Housing Opportunities Created, Offered, and Utilized 2019-2025

	2019-2021 Target	*2019-2021 Achieved*	*2022-2025 Target*	*2022-2025 Achieved*	*YTD Totals Achieved*
Created	867	357	494	200	557
Offered	N/A	175	N/A	256	431
Utilized	N/A	120	N/A	194	314

The housing plan aimed to develop 494 housing opportunities from 2022-2025: 172 in 2022, 226 in 2023, 70 in 2024, and 26 in 2025. For this report, LDH provided an update on LDH's performance relative to the plans for 2022 to 2025. As displayed in Figure 65, out of the 494 opportunities planned for creation, 200 were created, 256 were offered, and 194 were utilized by TP members. The figure also includes data on housing opportunities created, offered, and utilized from 2019 to 2021. In total, LDH has developed 557 of the 1,000 opportunities required under the Agreement.

During the period from 2022 to 2025, LDH reports that there were significant barriers to achieving the targets included their housing plan. A key ongoing barrier is the insufficient supply of affordable and accessible units. This is exacerbated by the exhaustion of Louisiana Housing Corporation's (LHC's) HOME funds and the shortfall status of their Section 8 Voucher program during this period. Significant staffing changes occurred at both LDH and LHC, which reduced overall capacity and caused delays that furthered the mismatch of housing availability and discharge readiness. Additional technical assistance has been obtained to seek expansion of opportunities via application to the 2026 HUD 811 NOFO and exploration of alternative strategies to improve the MCL program.

The SME acknowledges the significant policy and financing barriers hindering LDH's PSH development efforts. Due to LDH's falling short of the 1,000 housing opportunity benchmark, as well as continued housing-related barriers described elsewhere in this report, this paragraph is "Not Met."

Figure 66. Paragraph 81 Compliance Determination and Associated Recommendations

Compliance Assessment Rating and Rationale	***Priority Recommendations***
Not Met. LDH has not developed the required supply of housing opportunities specified under this Agreement, and housing-related barriers continue to impede the pace of transitions.	1) LDH should continue its efforts to develop an adequate supply of PSH, despite the challenging housing policy and financing environment.

82. Consistent with the State's current Permanent Supportive Housing Program: (a) tenancy supports shall be voluntary; refusal of tenancy supports shall not be grounds for denial of participation in the Permanent Supportive Housing Program or eviction; (b) individuals shall not be rejected categorically for participation in Louisiana Permanent Supportive Housing due to medical needs, physical or mental disabilities, criminal justice involvement, or substance use history; and (c) in order to satisfy the requirements of this Section E, housing shall be community integrated and scattered site. For purposes of this Agreement, to be considered scattered site housing, no more than two units or 25% of the total number of units in a building, whichever is greater, may be occupied by individuals with a disability referred by or provided supports through the State's permanent supportive housing program or individuals who are identified members of the Target Population under this Agreement. For purposes of this Agreement, and consistent with provisions of the State's existing permanent supported housing program, community-integrated housing shall not include licensed or unlicensed personal care, boarding, or "room and board" homes, provider-run group homes, or assisted living facilities. It may include monitored in-home care provided to individuals in the Target Population eligible for Medicaid waiver services.

Analysis: As referenced in prior SME reports, the Louisiana PSH program is a cross-disability housing and services program that links affordable rental housing with voluntary, flexible, and individualized community-based services to assist people with severe and complex disabilities to live successfully in the community. Individuals cannot be rejected due to the conditions set forth in this Paragraph. Further, as reflected in the housing plan described in Paragraph 81, the State's approach to housing for individuals in the TP relies on integrated and scattered site settings.

Findings from the SME's Service Review process reinforces the State's consistent utilization of PSH for transitioned individuals, although as noted above, more granular tracking is needed. Members of the SME's Team have reported that during recent Service Reviews, there have been instances in which diverted individuals end up residing in personal care and other group homes, live in generally substandard housing, or are experiencing homelessness. Given that diverted individuals are part of the TP, to maintain compliance with this Paragraph, LDH should investigate whether this is a widespread trend and if so, develop strategies to ensure more consistent access to PSH for diverted individuals.

Figure 67. Paragraph 82 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating and Rationale	***Priority Recommendations***
Met. LDH's PSH programming complies with the requirements in this Paragraph.	1) LDH should develop a methodology to analyze the housing outcomes of diverted individuals (including those who do not accept CCM) and determine whether improvements are needed to ensure their access to and retention in PSH options.

83. The State shall employ Tenancy Supports Managers (TSMs) sufficient to conduct landlord outreach, provide tenancy supports when Medicaid enrolled providers are unable to do so, provide technical assistance and support to landlords and/or tenancy supports providers during the leasing process, and address crises that pose a risk to continued tenancy. TSMs shall have demonstrated experience finding and securing integrated housing and providing Tenancy Supports to individuals with mental illness. The State shall take steps to assure the preservation of existing housing for members of the Target Population when a member of the Target Population is admitted to a hospital or nursing facility or is known to be incarcerated in connection with a mental health crisis or behavioral incident.

Analysis: At the end of this reporting period, LDH employed 12 Tenancy Support Managers (TSMs) to provide statewide coverage to assist members of the TP transitioning from NFs. The 7th SME Report provides an overview of the TSM role, which includes pre-tenancy support, housing search, inspections, landlord negotiation, document gathering, eviction avoidance planning, landlord relationship management and mediation, among other duties. From July to December 2025, LDH reports that TSMs served 176 TP members, a substantial increase compared to CY2024, during which TSMs served approximately 153 for the full year. It is unclear whether there were more individuals who requested or needed TSM support.

As noted in Paragraph 51, the three most cited barriers for individuals preparing for transition involve waiting for a housing unit or a housing unit in a specific town, waiting for housing greater than six months, and waiting for an accessible housing unit. These barriers are likely, to some extent, outside of the TSMs' control. However, LDH should engage with TCs and TSMs to assess whether there are opportunities (e.g., TSM capacity building/training, TC and TSM role clarity, support strategies) that could help to address these barriers. TSMs may also be equipped to assist CCMs when transitioned or diverted members face eviction; fourteen critical incidents in this reporting period were related to eviction. The SME and his team would be happy to support this effort, perhaps in the form of a focus group.

An important aspect of this Paragraph involves the preservation of housing for TP members when they experience a short-term hospitalization or institutionalization. To demonstrate compliance, LDH should report on the number of instances this occurs and whether TSMs successfully preserved their housing.

Figure 68. Paragraph 83 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating and Rationale	***Priority Recommendations***
Partially Met. LDH has a complement of TSM staff who provide services to other LDH staff and TP members, but it is unclear whether they preserve housing in instances of a TP member's short-term hospitalization or institutionalization.	1) LDH should continue to track TSM activities that support the TP on a semi-annual basis and report to the SME, including information on the number of individuals in the TP who have needed the TSMs to preserve housing and reasons for that. 2) LDH should convene a focus group of TSMs and TCs to discuss housing barriers and strategies.

84. The State shall seek funding to cover such expenses as security deposits and other necessities for making a new home. The State shall use HOME Tenancy Based Rental Assistance for security and utility deposits for members of the Target Population.

Analysis: While this Paragraph explicitly references the HOME Tenancy Based Rental Assistance program, LDH and LHC have indicated that other federal and state programs may be more relevant for the TP, given that HOME is a short-term rental assistance program and that transitioned and diverted individuals typically require longer-term housing assistance. However, LDH does meet the spirit of this Paragraph, providing for housing-related expenses – covering costs for security deposits, utility arrearages, and home necessities – through the Community Choices Waiver, the Permanent Supportive Housing (PSH) program, and direct My Choice Louisiana funds (for those who do not meet NF level of care requirements). LDH reports that for this reporting period, all transitioned members received financial support related to furniture, security deposits, utilities, or other expenses.

Figure 69. Paragraph 84 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating and Rationale	***Priority Recommendations***
Met. LDH reports that individuals in the TP have access to financial support for housing-related expenses.	1) LDH should provide data on need and utilization of all housing expense assistance programs that benefit the TP.

85. LDH may seek federal approval of an 1115 or other Medicaid waiver to provide comprehensive services to the Target Population. LDH shall ensure its Medicaid rates are adequate to achieve and sustain sufficient provider capacity to provide HCBS and mental health services to the Target Population.

Analysis: As described in various Paragraphs of this report, LDH has obtained federal approval – via 1115 waivers, 1915 waivers, and State Plan Amendments – for several services associated with the Agreement. While the SME has not independently assessed the adequacy of reimbursement rates for these services, the overall network adequacy of most of the services (described under Paragraph 67) suggests that reimbursement rates are sufficient for providers to operate services. LDH should analyze the adequacy of reimbursement rates as they continue to launch new crisis services, particularly if they struggle to attract providers. Further, if certain services/programs report consistently high staff turnover, LDH should investigate whether turnover is associated with low staff compensation and the extent to which low staff compensation is related to inadequate reimbursement.

Figure 70. Paragraph 85 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating and Rationale	***Priority Recommendations***
Met. LDH has leveraged various Medicaid authorities to provide a range of Agreement-related services.	None.

VII. Quality Assurance and Continuous Improvement

86. LDH shall conduct broad stakeholder outreach to create awareness of the provisions of this Agreement and actions taken by LDH to accomplish the goals of the agreement. Such outreach may include, but shall not be limited to, existing forums such as meetings of the Developmental Disabilities Council, Behavioral Health Advisory Council and regularly scheduled meetings between LDH, provider associations, and advocacy groups. LDH will conduct outreach specifically to individuals currently receiving mental health services for the purpose of sharing this information and collecting feedback on the service array.

87. Within six months of execution of this Agreement, LDH will develop and implement a strategy for ongoing communication with community providers, NFs, and hospitals on issues related to implementation of this Agreement. This strategy will include engaging community providers, NFs, and hospitals so that LDH learns about challenges encountered in the implementation of this Agreement and can engage the providers in addressing such challenges. This will, when needed, include the provision of technical assistance related to State policies and procedures that affect compliance with the Agreement.

Analysis: Paragraphs 86 and 87 are addressed together. The State developed an initial outreach plan for this Agreement in CY2018. Since then, LDH has continued to engage stakeholders germane to the Agreement. Stakeholder groups include the My Choice Advisory Committee, the My Choice Quality Resource Group, various My Choice subcommittees, the Louisiana Hospital

Association, the Louisiana Nursing Home Association, Louisiana Enhancing Aging with Dignity Through Empowerment and Respect (LEADER), LeadingAge Southeast, LGEs, and other groups. The State also continues to post the SME reports and quality matrices as one strategy to share Agreement-related information with external stakeholders.

LDH stakeholder engagement activities are often associated with specific initiatives under the Agreement (e.g., making improvements to PASRR processes, enhancing crisis systems). One area that is underdeveloped is the leveraging of stakeholders to discuss and strategize around issues that impede compliance or outcomes associated with this Agreement. LDH's new systemic barrier tracking process could be helpful in this regard. Based on identified barriers, when appropriate, LDH could convene working groups of stakeholders to address specified issues. In response to the SME's recommendation, LDH has also agreed to develop a stakeholder engagement and communication plan that identifies key messages, strategies/activities, communications mechanisms (e.g., webinars, newsletter), frequency, target audiences (i.e., internal staff, specific committees), timelines, and other key operational details, with the goal of providing timely and targeted information regarding the My Choice Program.

Figure 71. Paragraphs 86-87 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. LDH has continued to engage integral stakeholders, but more targeted stakeholder engagement around systemic issues is needed to comply with this Paragraph.	1) Leveraging its new systemic barrier tracking process, LDH should convene working groups to address identified systemic issues.

88. LDH will incorporate into its plan for pre-admission diversion (Section IV.C.) any targeted outreach and education needed to successfully implement that plan, including outreach to law enforcement, corrections, and courts.

Analysis: In the 12th SME Report, the SME flagged that a third of critical incidents among TP members served by CCM involved interactions with law enforcement. In this reporting period, 16% of critical incidents were related to law enforcement, sometimes due to the commission of crimes and other times as victims. Relationships between MCL service providers and criminal justice stakeholders can support better coordination if individuals are victimized or need other types of support or intervention from law enforcement and also help those who are arrested or at risk for arrest with diversionary programming or other resources. There are likely other benefits to partnership. Building on its extant collaborations with law enforcement, courts, and other justice-related entities regarding implementation of the new crisis services system, LDH should engage with stakeholders to identify opportunities and goals for deepened collaboration.

Figure 72. Paragraph 88 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. LDH has continued to engage stakeholders in law enforcement, corrections, and courts, but a more organized collaboration is needed to increase local collaboration between these stakeholders and My Choice program providers.	1) LDH should design a strategy to increase local collaboration between Agreement-related providers (e.g., ACT teams, CCMs) and local law enforcement, courts, and correctional stakeholders, perhaps starting with a focus group of MCL staff to better understand opportunities for collaboration.

89. Within six months of execution of the Agreement, LDH will develop a plan for ongoing in-reach to every member of the Target Population residing in a NF, regular presentations in the community in addition to onsite at NFs, and inclusion of peers from the Target Population in in-reach efforts. In-reach will explain LDH's commitment to serving people with disabilities in the most integrated setting; provide information about Community-Based Services and supports that can be alternatives to NF placement; provide information about the benefits of transitioning from a NF; respond to questions or concerns from members of the Target Population residing in a NF and their families about transition; and actively support the informed decision-making of individuals in the Target Population.

Paragraph 54 provides the discussion and compliance rating associated with the PIR program. However, this Paragraph contemplates an additional role for PIR: group presentations in community settings and NFs. In other Olmstead-related cases nationally, trained outreach staff convene group presentations in NFs to promote transition programming, augmenting direct one-on-one in-reach. The 13th SME Report recommended innovative outreach strategies and LDH's 2026 Implementation Plan includes an activity to explore strategies.

Figure 73. Paragraph 89 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. As noted under several Paragraphs herein, LDH has designed and implemented a statewide PIR program, but additional strategies could improve reach.	1) LDH should implement recommendations identified under Paragraph 54. 2) Consistent with LDH's 2026 Implementation Plan, LDH should consider innovative strategies, including group educational sessions and multimedia, to augment its one-on-one in-reach approach.

90. Training for services provided pursuant to this Agreement will be designed and implemented to ensure that Community Providers have the skills and knowledge necessary to deliver quality Community-Based Services consistent with this Agreement.

91. With the technical assistance and approval of the Expert, LDH will establish a mandatory training policy, qualifications, and curriculum for Community Providers. The curriculum will include initial training and continuing training and coaching for Community Providers.

92. The curriculum will emphasize person-centered service delivery, community integration, and cultural competency. The curriculum will incorporate the provisions of this Agreement where applicable. LDH will seek input from individuals receiving services regarding the training curriculum and will include such individuals in the training where appropriate.

Analysis: Paragraphs 90, 91, and 92 are addressed together. LDH continues to provide training in several areas, including, but not limited to:

- Trainings to IPS, peer support, CCM, crisis, and providers on service delivery best practices.
- Trainings and guidance from the IPS Employment Center and ODEP Policy Academy to spur adoption and improve delivery of IPS.
- Person-centered planning trainings for PIR, TCs, CCMs, and other OAAS and OBH staff.
- MCO-led trainings to community providers on foundational competencies in BH care delivery (e.g., responding to trauma, administering the Level of Care Utilization System in addition to operational trainings (e.g., prior authorization processes, reimbursement).

- Trainings to implement the new PASRR Level I screening system, as well as trainings to improve quality of PASRR Level II evaluations.
- In their 2026 Implementation Plan, LDH committed to person-centered care and IPS trainings to various MCL-affiliated providers, as well as training retreat for TCs and PIRs.

In the 12th SME Report, the SME recommended that LDH develop a centralized repository of trainings and more intentional inclusion of individuals with lived experience in the design and delivery of trainings. In their 2025 Implementation Plan, LDH committed to developing a repository to "house all relevant training materials and resources in a single public location to serve as a central reference point, ensuring easy access and organization." Since then, the MCL website has been updated to include PowerPoint slide decks for several trainings, but the training inventory does not appear exhaustive nor does it include recordings. Further, as LDH implements processes to quantify, assess, and address systemic barriers – as referenced in many Paragraphs in this report – specialized trainings could be provided in response to identified barriers (e.g., trainings on OCDD waiver processes and associated timelines, trainings on how CCMs can access PSH for diverted members).

Figure 74. Paragraphs 90-92 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. LDH delivers numerous trainings to providers who serve the TP, but would benefit from a centralized training policy, curriculum, and website. Trainings should be informed by those with lived experience and the identification of systemic and provider-level barriers.	1) LDH should complete the development of a single site to facilitate, communicate, and store training opportunities associated with the My Choice program. 2) LDH should implement a strategy and process for soliciting and incorporating consumers in the design and delivery of trainings.

93. Community-Based Services will be of sufficient quality to ensure individuals in the Target Population can successfully live in, transition to, and remain in the community, and help individuals achieve positive outcomes, including avoidance of harms, stable community living, and increased integration, independence, and self-determination in all life domains (e.g., community living, employment, education, recreation, healthcare, and relationships).

Analysis: This Paragraph centers on ensuring that community-based services are of sufficient quality to ensure tenure and quality of life in the community for transitioned individuals. There are several data sources that contribute to the picture of whether community-based services are of sufficient quality for the TP, including (but not limited to):

- Overall SUD treatment network adequacy reports (see Paragraph 67 in 12th SME Report) show whether all American Society of Addiction Medicine levels of care are present across Louisiana.
- Performance on Centers for Medicare and Medicaid Services SUD measures provides insights on whether people are linked to needed care after visits to the ED, nonfatal overdoses, or recent SUD diagnoses, likely related to the adequacy and quality of SUD care.
- Critical incidents among members served by CCM (see Paragraph 95 in this report) can point to unmet service needs.
- Information gleaned from CCM monthly monitoring and TC post-transition monitoring (see Paragraph 49) evaluates whether transitioned individuals are getting the support they need after NF discharge. During these monthly contacts, CCMs collect information from the member on whether they are receiving the services specified in their plan of care. In quarters

1 and 2 of 2025, 90% and 96% of members, respectively, reported that they were receiving planned services.
- ACT and Individualized Placement and Support (IPS) fidelity ratings evaluate whether providers are functioning in alignment with national standards around staff credentials and expertise, caseload size, and other service delivery best practices.
- Service utilization patterns of individuals engaged in CCM and the TP overall might signal how effectively individuals are being engaged and served by the community-based system of care.
- LDH also collects whether individuals can get BH appointments within one hour (for emergent care), two days (for urgent care), and 14 days (for routine care). According to their Quality Matrix, 92% of individuals in quarter 1 of 2025 got needed emergent care, 81% got needed urgent care, and 94% got needed routine care.

In summer of 2025, the new SME and his team completed the 2025 Service Review process and issued a report on key findings and recommendations. LDH management participates in the Service Review process, and a broader LDH leadership group reviews findings from the Service Review process to discuss systemic, management, and other interventions to address Service Review findings. Findings can be found in the 13th SME Report. LDH has also incorporated an internal service review approach into their management strategies, adopting some of the tools and processes designed by the prior SME and his team to strengthen their direct oversight of TC processes and aid in the identification and remediation of systemic issues.

Figure 75. Paragraphs 93 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. LDH supports and participates in the SME's Service Review process, conducts independent quality/fidelity reviews for some Agreement-related services, and has established other processes with TCs and CCMs to assess the service adequacy and outcomes for transitioned individuals. However, there remains gaps as it relates to the quality assessment of certain Agreement-related services and TC reporting of services-related issues.	1) LDH should implement the recommendation under Paragraph 75. 2) LDH should implement the recommendation under Paragraph 49, strengthening oversight on the occurrence and quality of post-transition TC visits, and collecting, tracking, and implementing actions based on insights from those visits.

94. Accordingly, by December 2019, the State will develop and implement a quality assurance system consistent with the terms of this Section.

Analysis: LDH's quality assurance system for this Agreement includes a constellation of activities, many of which are covered in more detail in specific Paragraphs within this report. For this discussion, the SME will provide information that is not covered elsewhere or is covered later in this report, including:

- As described in Paragraphs 98 and 99, LDH has developed a Quality Matrix to monitor many areas required by this Agreement and continues to review and update measures in the Quality Matrix to incorporate feedback from stakeholders.
- In this reporting period, LDH convened the Internal My Choice Quality Committee each month. The External Quality Resource Group met twice. Responsibilities of these groups include refining the Quality Matrix and reviewing SME Service Review findings to advise on strategies to address systemic issues.

- In January of 2022, LDH issued its Annual Quality Report for the My Choice Program. This report sets forth the processes LDH has put in place to use this information to improve the experience of care for individuals transitioned and diverted from NFs as well as to improve the quality of services that are offered to the TP. No annual quality reports have been posted since. However, in August 2025, the SME recommended an alternative approach. Instead of producing an additional report, the SME recommended synthesizing existing data and reports – such as the Quality Matrix, MCO critical incident reports, the SME Service Review, ACT and IPS fidelity reports – and producing an executive summary that includes plans for improvement based on the data. Per LDH's 2026 Implementation Plan, they will be finalizing an approach and producing the report in 2026.
- As described under Paragraph 93 and in more detail in the 12th SME Report, LDH utilizes a number of additional strategies to evaluate the performance of specific services.

Figure 76. Paragraph 94 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. LDH has implemented several activities to oversee and evaluate the quality of Agreement-related programming and processes. As recommended by the prior SME, data and information collected and analyzed through these efforts should be shared with the TSC to inform quality improvement activities.	1) LDH should implement the planned process to review information that emanates from various quality assurance activities to inform quality improvement activities, in addition to considering other opportunities to leverage data insights to improve programming. 2) Consistent with LDH's 2026 Implementation Plan, LDH should finalize and publish its 2025 Annual Quality Report.

95. For individuals in the Target Population receiving services under this Agreement, the State's quality assurance and critical incident management system will identify and take steps to reduce risks of harm; and ensure the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings, consistent with principles of self-determination. The State will collect and evaluate data; and use the evaluation of data to identify and respond to trends to ensure continuous quality improvement.

Analysis: The Agreement requires the State develop a critical incident report (CIR) management system for the TP, as well as evaluate data on MCL services as part of its ongoing quality improvement efforts. Paragraph 96 includes a discussion on MCO-reported CIR data. For this Paragraph, the SME has analyzed data provided by LDH on critical incidents associated with diverted or transitioned individuals engaged in CCM, who typically have lived in the community for up to one year. CCMs are responsible for completing CIRs as one of their case management duties. As indicated in previous reports, the State defines critical incidents consistent with various federal Medicaid Waiver programs. LDH reports on the number of critical incidents associated with TP members that accept CCM.

Figure 77. CCM Critical Incident Frequencies & Types	
Critical incident category	*Number/ %*
Major BH disturbance	94 (50%)
Involvement with law enforcement	30 (16%)
Major medication incident	15 (8%)
Exploitation or extortion	15 (8%)
Eviction	14 (7%)
Abuse	10 (5%)
Neglect	8 (4%)
Loss or destruction of home	1 (<1%)
Total	187

There were 187 total critical incidents in 2025, compared to 121 incidents in 2024, and 54 in 2023. Per discussion with LDH staff, the increase in CIRs between 2023 and 2024 is partially attributable to maturity of the program, expansion of CIR categories, and

increased client volume. Figure 77 provides a breakdown of the CIR types in 2025, showing that most are related to major BH disturbance (50%), involvement with law enforcement (16%), a major medication incident (15%), exploitation or extortion (15%), or eviction (14%). Compared to 2024, there was a decrease in CIRs related to law enforcement (16% versus 23%) and a significant increase in CIRs related to major BH disturbances (50% versus 18%). LDH reports that all incidents involving abuse, neglect, or exploitation were referred to appropriate licensing or protective services authorities. Other categories remained relatively stable. It is important to note that the involvement with law enforcement category includes instances wherein a TP member was arrested or reported a potential crime to authorities.

A deeper analysis of CIRs might facilitate greater insights and spur programmatic or other solutions. For example, analyzing the number of individuals associated with the 187 critical incidents could provide opportunities to avail specific individuals of more support. Understanding the circumstances surrounding evictions might inform strategies to prevent them. Understanding trends associated with exploitation could inform approaches to educate TP members on how to protect themselves.

LDH provided a sample of CIR reporting forms from this reporting period to enable a more granular review by the SME, specifically to evaluate the clarity of information and the appropriateness of actions taken resultant of the CIR. The SME found that the CIR forms were of adequate clarity and that responses were appropriate. Per CCM monthly reports, 98% of CCM clients (inclusive of both diverted and transitioned members) self-report freedom from abuse and exploitation.

Figure 78. Paragraph 95 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating and Rationale	***Priority Recommendations***
Met. LDH has developed various CIR reporting requirements and continues to provide the SME with detailed information regarding CIRs.	1) LDH should conduct deeper analysis of CIRs to capture insights, including programmatic interventions to prevent future CIRs among TP members.

96. The State will require that professional Community Providers implement critical incident management and quality improvement processes that enable them to identify service gaps and to timely identify, address, and remediate harms, assess the effectiveness of corrective or remedial actions, and reduce risk of recurrent harm. The State will require that MCOs implement critical incident management and quality improvement processes that enable them to identify and address service gaps and to timely identify, address, and remediate harms, assess the effectiveness of corrective or remedial actions, and reduce risk of recurrent harm.

Analysis: The Agreement requires the state to implement CIR and quality improvement processes for community providers and the State's Medicaid MCOs. As discussed in the 10th SME Report, LDH has established processes, protocols, and contractual language that stipulates CIR requirements for community providers, MCOs, and waiver programs. The 10th SME Report provides specificity on the quarterly reviews undertaken by OBH, wherein they analyze monthly quality monitoring reports, evaluate provider performance, oversee corrective actions if performance is substandard, and determine if systemwide improvements are needed based on reviews. OAAS implements a similar process for its programs, including key waiver programs.

For the first part of this requirement (community provider CIR reporting), the SME acknowledges that aggregating the number, type, and resolutions of all critical incidents across the universe of

OBH and OAAS programs that serve TP members is likely not feasible. As such, he would like to work with LDH and the DOJ to determine an appropriate reporting method, which should include CIR data from both OBH and OAAS programs. For the second part of this requirement (MCO CIR reporting), the SME reviewed an MCO's August CIR report for clarity, completeness, and appropriate action. None of the five incidents involved TP members.

Figure 79. Paragraph 96 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating and Rationale	***Priority Recommendations***
Partially Met. LDH has established and oversees processes for MCOs and long-term supports and service programs, which require critical incident reporting and remediation.	1) LDH should collaborate with the SME and DOJ to devise a reporting strategy for this requirement that includes CIR data from both OBH and OAAS programming.

97. The State will establish reporting and investigation protocols for significant incidents, including mortalities. Mortality reviews will be conducted by multidisciplinary teams and will have at least one member who neither is an employee of nor contracted with OAAS, OBH, the LGEs, MCOs, and Community Providers. The reporting and investigation protocols for significant incident and mortality reviews shall be developed with the technical assistance and approval of the Expert.

Analysis: The State has developed and implemented a joint mortality review protocol for the My Choice Program, including the creation of a Mortality Review Committee (MRC) and production of annual mortality review reports. As indicated in the 8th SME Report, OBH, OAAS, Health Standards, and Adult Protective Services, as well as auxiliary members as needed, participate in the MRC. The mortality review reports provide information regarding the scope and structure for mortality reviews, the status and disposition of reviews, and remediation strategies undertaken by the State based on these reviews. LDH posts the reports on its MCL website, and both the 2023 and 2024 reports have been posted. The 12th SME Report includes a summary of several enhancements made to MRC reports, including causes of death.

As indicated in previous reports, the Integration Coordinator reviews each death and uses established criteria discussed in the 10th SME Report to make a referral to the MRC. Figure 80 provides data on the total number of mortalities associated with MCL over the past six years, and the subset that were referred to MRC review. For 2025, there were eight cases referred to the MRC – seven transitioned members and one diverted member. One case involved a member receiving hospice care, but rest were deemed unexpected. As of the writing of this report, two were completed and six were still under review.

Figure 80. Mortality Review Data		
Period	*Total Deaths*	*Referred to MRC*
2020-2022	19	13
2023	27	14
2024	12	6
2025	13	8

Timeliness of mortality reviews has improved, from an average of 172 days in 2023 to 134 days in 2024. An annual figure for 2025 is not yet available, but based on quarterly data, the timeliness has further accelerated. The State reports there are several barriers to expeditious reviews, including delays in acquiring needed documentation from coroner's offices and direct service/healthcare providers and delays as Health Standards, which is bound by its own investigation timelines, completes investigations for cases that are referred to them.

Figure 81. Paragraphs 97 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating and Rationale	***Priority Recommendations***
Met. LDH has designed and implemented a mortality review process that complies with this Paragraph.	None.

98. On a regular basis, and as needed based on adverse outcomes or data, the State will assess provider and MCO services, the amount, intensity, and availability of such services, and quality assurance processes, and will take corrective actions where appropriate to ensure sufficient quality, amount, and accessibility of services provided pursuant to this Agreement.

99. The State will collect and analyze consistent, reliable data to improve the availability, accessibility, and quality of services to achieve positive outcomes for individuals in the Target Population. The State will create protocols on collection and analysis of data to drive improvement in services, which shall be developed with the technical assistance and approval of the Expert prior to implementation. Data elements shall measure the following areas: (a) referral to, admission and readmission to, diversion from, and length of stay in, NFs; (b) person-centered planning, transition planning, and transitions from NFs; (c) safety and freedom from harm (e.g., neglect and abuse, exploitation, injuries, critical incidents, and death; timely reporting, investigation, and resolution of incidents); (d) physical and mental health and wellbeing, and incidence of health crises (e.g., frequent use of crisis services, admissions to emergency rooms or hospitals, admissions to NFs, or admissions to residential treatment facilities); (e) stability (e.g., maintenance of chosen living arrangement, change in providers, work or other day activity stability); (f) choice and self-determination (e.g., service plans are developed through person-centered planning process, choice of services and providers, individualized goals, self-direction of services); (g) community inclusion (e.g., community activities, integrated day and employment outcomes, integrated living options, relationships with non-paid individuals); (h) provider capacity (e.g., adherence to provider qualifications and requirements, access to services, sufficiency of provider types); (i) barriers to serving individuals in more integrated settings, including the barriers documented and any involvement of the Transition Support Committee as required by Section V.D.; and (j) access to and utilization of Community-Based Services.

Analysis: Paragraphs 98 and 99 are addressed together. As discussed in paragraph 94, LDH collects and reports on several quality measures that align with the specific elements in these Paragraphs. They also convene internal and external committees to refine measures, discuss findings, and consider policy, process, and programmatic changes based on review of the quality assurance data. There are a total of sixty-two measures, which are reported through LDH's Quality Matrix. For each measure in the Quality Matrix, LDH identifies the methodology, data sources, and data collection and analysis process. LDH also identifies whether they should compare measures to trends from previous quarters to assess progress or compare them to a national or LDH-established benchmark. Out of the 62 overall measures, several are internal and operational to LDH. Of the 15 measures that compared 2025 data to established benchmarks, data from 11 measures met or exceeded the benchmark and four performed lower than the benchmark.

The SME assigns a "Partially Met" rating for this Paragraph but acknowledges that the many of the required metrics in this Paragraph are being monitored. To improve compliance, LDH needs an organized structure to implement and report on corrective actions based on Quality Matrix and other data. The 2025 Quality Matrix is provided as Appendix II in this report.

Figure 82. Paragraphs 98-99 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. The State continues to collect data across a number of metrics, but an organized process to make corrective actions based on data needs to be established and reported on.	1) LDH should implement the recommendation under Paragraph 100 below.

100. The State will use all data collected under this Agreement to: (a) identify trends, patterns, strengths, and problems at the individual, provider, and systemic levels, including, but not limited to, screening and diversion from NF admission, quality of services, service gaps, geographic and timely accessibility of services, individuals with significant or complex needs, physical accessibility, and the discharge and transition planning process; (b) develop and implement preventative, corrective, and improvement strategies to address identified problems and build on successes and positive outcomes; and (c) track the efficacy of preventative, corrective, and improvement strategies and revise strategies as needed.

Analysis: As discussed in paragraph 94, the State has developed an internal quality assurance process to track and analyze information from multiple sources to identify trends and issues at the individual, provider, and systemic levels. A full picture of the Agreement's functioning requires review of several data/information sources, including the Quality Matrix, the SME's Service Review process, MCO-provided data on service utilization and critical incidents, PASRR data, and several other sources. Implementation of the SME's recommendations with respect to Paragraphs 93 through 99, as well as the special TP analysis recommendation in the 11th SME Report, will equip LDH with more data to inform programmatic improvements.

This Paragraph requires that LDH utilize its data to develop strategies to influence change at the individual, provider, and system levels. It also requires LDH to track the efficiency of these interventions. One example that illustrates LDH's use of data is their improved oversight of TC processes in response to the SME Service Review reports. Informed by this data, LDH management has implemented strengthened supervisory approaches, clarification of expectations, new documentation (e.g., ITP addendum), and training resources. LDH implements other continuous quality improvements as a result of their review of data, both formally and informally.

To fully comply with this Paragraph, LDH should fully implement a formal tracking process that identifies the macro-, mezzo-, and micro-level interventions that are being attempted as a result of their review of quality data. This can be incorporated into their new procedure to collect and remedy systemic barriers, referenced in Paragraph 58. This process should also track whether those interventions achieve their desired impact. To operationalize the intent of this Paragraph, LDH could identify a narrow set of high-priority interventions on a quarterly basis for implementation and outcomes monitoring.

Figure 83. Paragraph 100 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. LDH collects a robust set of data to inform program operations and systemic improvements. A structured and systematized process would support improved tracking and impact analysis of interventions.	1) In alignment with their new procedure to inventory and address systemic barriers (described in Paragraph 58), LDH should implement an organized process to review quality data, take corrective actions, and report on impact.

101. At least annually, the State will report publicly, through new or existing mechanisms, on the data collected pursuant to this Section, and on the availability and quality of Community-Based Services (including the number of people served in each type of Community-Based Service described in this Agreement) and gaps in services and will include plans for improvement.

Analysis: The Agreement requires the State to report publicly on all data collected pursuant to this section. Since the sixth SME report, LDH provides information regarding service utilization by the TP who have been transitioned or diverted from NFs. The State reports the data consistent with the 2021 needs assessment for the My Choice Program, found at: LouisianaNeedsAssessment-Final-Report.pdf (la.gov)

Figure 84 provides a comparison between quarter 2 of 2024, quarter 4 of 2024, quarter 2 of 2025, and quarter 3 of 2025, distinguishing between transitioned and diverted members. Utilization across all categories has experienced minor fluctuations.

Figure 84. Service Utilization Rates Among TP Members

Service Type	*Quarters*			
	Q2 2024	*Q4 2024*	*Q2 2025*	*Q3 2025*
Outpatient BH - Transitioned	Data not available	65%	62%	63%
Outpatient BH - Diverted	Data not available	55.6%	55%	53%
ED - Transitioned	9.3%	9.5%	13%	12%
ED - Diverted	17.7%	22.7%	18%	23%
BH ED - Transitioned	2.1%	1.5%	1%	2%
BH ED - Diverted	5.1%	11.3%	7%	8%
Inpatient (IP) - Transitioned	Data not available	2.5%	5%	5%
IP - Diverted	10.1%	13.6%	12%	15%
BH IP - Transitioned	2.8%	.9%	2%	2%
BH IP - Diverted	7.6%	9%	7%	11%
Crisis services - Transitioned	0%	0%	.3%	0%
Crisis services – Diverted	0%	0%	0%	0%
OAAS PCS - Transitioned	67.9%	Data not available	65%	Data not available in this format[6]
OAAS PCS - Diverted	17.7%	Data not available	10%	Data not available in this format
BH PCS - Transitioned	14.8%	13.3%	13%	9%
BH PCS - Diverted	6.3%	13.6%	12%	10%
Ambulatory/Preventive Care - Transitioned	85.3%	85.2%	83%	87%
Ambulatory/Preventive Care - Diverted	82.4%	79.4%	66%	75%

[6] OAAS PCS data is not broken out by quarters, but LDH reports that one diverted member and 42 transitioned members received OAAS PCS from July to December 2025.

The SME assigns a rating of "Met" for this requirement, as LDH continues to track service utilization across multiple categories. In other Paragraphs, the SME provides recommendations around addressing service gaps (e.g., crisis services) and additional service utilization data reporting (e.g., OCDD waiver services).

Figure 85. Paragraphs 101 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating and Rationale	***Priority Recommendations***
Met. LDH continues to track service utilization for transitioned and diverted individuals on a quarterly basis.	None.

102. The State will ensure that all relevant State agencies serving individuals in the Target Population have access to the data collected under this Agreement.

Analysis: The prior SME has reported that LDH has provided information to other relevant state agencies since the inception of the Agreement. This includes data sharing between LDH and MCOs, OCDD, the Louisiana Housing Corporation. The 10th SME Report provides more detail on the specific information that LDH provides to the various agencies (e.g., OCDD receiving information on transitioned and diverted individuals with ID/DD). The prior SME recommended that LDH employ a more tailored, organized, and nuanced information sharing strategy with other state agencies that have a significant role in the My Choice Program, enabling them to review relevant data and information, identify and address individual and systemic issues, and develop strategies to enhance implementation. Further, this approach be bidirectional, identifying and creating procedures to access the data and information LDH needs from other state agencies to be effective in this Agreement.

Figure 86. Paragraphs 102 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating and Rationale	***Priority Recommendations***
Partially Met. LDH continues to provide information to relevant state agencies and other entities in the course of operating the Agreement, but a more organized and tailored bidirectional information sharing plan is needed.	1) Within the comprehensive stakeholder engagement and communication plan referenced in Paragraphs 86 and 87, LDH should incorporate cross-agency data/information sharing efforts, clearly identifying the data/information to be requested and shared with each agency and communication, coordination, and collaboration structures.

103. Beginning no later than the fourth year following the Effective Date, the State will, with the technical assistance of the Expert, begin to adopt and implement an assessment methodology so that the State will be able to continue to assess the quality and sufficiency of Community-Based Services and the processes required in this Agreement, following the Termination of this Agreement. The State will demonstrate that it has developed this capacity prior to the Termination of this Agreement.

Analysis: LDH is tasked through this Agreement to adopt a methodology for assessing the sufficiency of community-based services required under this Agreement. The prior SME worked with the State to design a Service Review process, and the current SME has now completed two service reviews. This process involves selecting a representative sample of individuals in the TP within specific regions to understand the effectiveness of Agreement-related processes and services through their experiences. For the 2026 Service Review, the SME implemented an

adapted Service Review approach, focusing on the experiences of new cohorts that have not been included in prior Service Review processes (e.g., individuals who initially expressed interest but returned to the ML, individuals who decline transition support at outreach). As indicated in paragraph 62, LDH staff have continued to partner with the SME team around the service review process, providing needed data and documentation, supporting interview and logistical coordination, participating in service review interviews, and validating findings and recommendations.

Starting in 2025, LDH adopted an internal service review process, based partially on SME training to LDH staff and access to associated tools (e.g., interview guides, scoring matrices). The paragraphs above describe other processes to assess the quality and adequacy of services, including network adequacy analyses, service utilization among the TP, CCM monthly monitoring, MCO audits of the CCM program, and ACT fidelity monitoring.

The SME is assigning a "Partially Met" rating to this Paragraph. To improve compliance, the SME has provided recommendations under Paragraphs 93 and 94. Further, he recommends the reporting of internal service review findings, which will allow SME Service Reviews to focus on other areas of the Agreement.

Figure 87. Paragraph 103 Determination and Associated Recommendations	
Compliance Assessment Rating and Rationale	***Priority Recommendations***
Partially Met. LDH has developed a multi-pronged approach to monitor address the quality and sufficiency of community-based services, but enhancements are needed to reach full compliance.	1) LDH should implement recommendations under Paragraphs 93 and 94 and report on key findings from the internal service review process.

Appendix A. Acronym List

Active Caseload (AC)	Critical Incident Report (CIR)	Managed Care Organization (MCO)	Permanent Supportive Housing (PSH)
Activities of Daily Living (ADL)	Department of Justice (DOJ)	Master List (ML)	Personal Care Services (PCS)
Americans with Disabilities Act (ACT)	Emergency Department (ED)	Mortality Review Committee (MRC)	Pre-Admission Screening and Resident Review (PASRR)
American Society of Addiction Medicine (ASAM)	Individualized Placement and Support (IPS)	My Choice Louisiana (MCL)	Rapid Integration Transition Coordination (RITC)
Assertive Community Treatment (ACT)	Individualized Transition Plan (ITP)	Nursing Facility (NF)	Serious Mental Illness (SMI)
Behavioral Health (BH)	Intellectual Disability/Developmental Disability (ID/DD)	Nursing Facility Transition Assessment (NFTA)	Subject Matter Expert (SME)
Calendar Year (CY)	Level of Care (LOC)	Office for Citizens with Developmental Disabilities (OCDD)	Substance Use Disorder (SUD)
Centers for Medicare and Medicaid Services (CMS)	Local Governmental Entity (LGE)	Office of Aging and Adult Services (OAAS)	Target Population (TP)
Community Case Management (CCM)	Louisiana Department of Health (LDH)	Office of Behavioral Health (OBH)	Transition Coordinator (TC)
Community Plans of Care (CPOC)	Louisiana Housing Authority (LHA)	Peer In-Reach (PIR)	Transition Support Committee (TSC)

APPENDIX II. 2025 QUALITY MATRIX

My Choice Quality Matrix 3.0						
Activity related	**#**	**Proposed Measure**	**Quarter 1 January-March 2025**	**Quarter 2 April-June 2025**	**Quarter 3 July-September 2025**	**Quarter 4 October-December 2025**
99(a) Referral to, admission and readmission to, diversion from, and length of stay in, nursing facilities						
Referral/ Admission	99.a-1	Number of referral to Level II SMI authorities from the Level I authority	839 Preadmissions	874 Preadmissions	966 Preadmissions	990 Preadmissions
Referral/ Admission	99.a-2	Number and percent of individuals that are admitted into Nursing Facilities that have a completed PASRR Level II upon admission	253 93%	279/297 93%	278	347
Diversion	99.a-3	Number and percent of individuals diverted	37/137 37%	52 diverted inividuals 52/137=38%	26 Diverted Individuals 85/137=62%	16 Diverted Individuals 102/137=74%
Diversion	99.a-4	Number and percent of PASRR determinations indicating that admission to NF is not recommended as it is not the least restrictive setting	37/513 7.2%	52/1055=4.9% diversion rate	85/1587=5.4% Diversion Rate	102/2177=4.7%
Length of Stay	99.a-5	Average length of stay in nursing facility	1337 days/3.7 years	1301 days/3.56 years	1005 days/2.75 years	1383
Readmission	99.a-6	Number and percent of transitioned members are re-admitted to a NF for greater than 90 days during the first year post transition	2/130	6 /132 (To determine the denominator-looked at total number of people transitioned from July 1 2024-June 30 2025; Numerator=number of people on monthly report identified with a closure reason of readmission)	4/149 3% (To determine the denominator-looked at total number of people transitioned from Oct 1 2024-Sept 30 2025; Numerator=number of people on monthly report identified with a closure reason of readmission	4/166 2% (To determine the denominator-looked at total number of people transitioned from Jan 1 2025-Dec 31 2025; Numerator=number of people on monthly report identified with a closure reason of readmission
99(b) Person-centered planning, transition planning, and transitions from nursing facilities						
Transition	99.b-1	Number and percent of individuals transitioned	28/287 10% of annual goal	42/287 15% of annual target	Q3=46/287 Total Transitions 116/287 40%	49/287 Total Transitions 166/287 58%
(c) Safety and freedom from harm (e.g., neglect and abuse, exploitation, injuries, critical incidents, and death; timely reporting, investigation, and resolution of incidents);						

Critical incidents	99.c-1	Number of critical incidents, stratified by type of incident	36 (2- abuse, 2 eviction, 2 exploitation, 9 involvement with law enforcement, 2 neglect, 18 major behavioral disburbance, 1 major medication incident)	62 (3 abuse, 8 eviction, 3 exploitation, 15 involvement with law enforcement, 2 neglect, 23 major behavioral disturbance, 7 mejor medication incident, 1 loss or destruction of home)	(56 2 abuse, 2 eviction, 8 exploitation, 3 involvement with law enforcement, 2 neglect, 35 major behavioral disturbance, 3 major medication incident, 1 extortion)	33 (4 major medication incident, 18 behavioral disturbance, 2 neglect, 1 exploitation, 3 involvement with law enforcement, 2 eviction, 3 abuse)
abuse/neglect/exploiation	99.c-2	Number and percent of critical incidents involving abuse/neglect/exploitation that were referred to the appropriate protective service and or licensing agency	7-100% reported to appropriate authority	100%	100%	100%
death	99.c-3	Number of deaths reported	2	4	5	3
death; investigation	99.c-4	Number of deaths referred for mortality review	0-both mortalilities did not meet criteria for Mortality Review	1- met criteria and referred for mortality review	4	3
death; investigation	99.c-5	Number and percent of death investigations that were completed	4	3	1/1 100%	0 (1 reviewed but not complete)
death (timeliness)	99.c-6	Average length of time to complete a death investigation	111 days	134 Days	54 Days	0-none completed this quarter
death; resolution	99.c-7	Number and percent of deaths that require a remediation plan	1	1	0	0(1 reviewed but not complete)
abuse/neglect/ exploiation	99.c-9	Number and percent of members reporting that they have been free from abuse, neglect, or exploitation	98.30%	98.20%	98.10%	98.90%
(d) Physical and mental health and wellbeing, and incidence of health crises (e.g., frequent use of crisis services, admissions to emergency rooms or hospitals, admissions to nursing facilities, or						
Physical/BH wellbeing	99.d-3	Number and percent of members reporting good physical health	95.63% reporting good or fair PH; 52.7% reporting good PH	93.75% reporting good or fair PH; 50.4% reporting good PH	50.06% report good physical health; 92.06% report good or fair physical health	56.5% report good physical health; 92.4% report good or fair physical health
NNBH wellbeing	99.d-4	Number and percent of members reporting good mental health	96.0% reporting good or fair MH; 51.96% reporting good MH	97.9% reporting good or fair MH; 52.75% reporting goof MH	55.06% report good mental health; 97.06% report good of fair mental health	60.9% report good mental health; 95.9% report good or fair mental health
Physical/BH wellbeing	99.d-5	Number and percent of members that report taking medications as prescribed	93.5%	91.55%	92.23%	93.60%

(e) Stability (e.g., maintenance of chosen living arrangement, change in providers, work or other day stability						
maintenance of chosen living arrangement	99 e-1	Number and percent of members reporting stability in housing	97.50%	94.46%	94.83%	98.30%
maintenance of chosen living arrangement	99 e-2	Number and percent of members reporting no issues with current living situation	93.63%	95.46%	96.70%	96.80%
stability in chosen natural supports	99 e-3	Number and percent of members reporting stability in natural supports network	98.53%	98.80%	98.73%	99.80%
stability in chosen service providers	99 e-4	Number and percent of members reporting stability in service providers	90.10%	90.50%	90.00%	87.40%
(g) Community inclusion (e.g., community activities, integrated day and employment outcomes, integrated living options, relationships with non-paid individuals);						
community activities, how to spend time, etc.	99.g-1	Number and percent of members reporting that they are involved in the community to the extent they would like	95.30%	98.50%	97.70%	96.10%
99 (j) Access to and utilization of Community-Based Services.						
	99.j-1	Number and percent of members reporting they are receiving the all services they need as specified in the plan of care (waiver, non-waiver, behavioral health, etc.)	89.73%	94.76%	93.60%	97.60%