Eleventh Subject Matter Expert Report

Agreement to Resolve the Department of Justice Investigation

Covering the Period of 1/1/2024 to 6/30/2024

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I. Introduction

Background and Context. This report presents the Subject Matter Expert's 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 (DOJ) investigation. This report is issued in fulfillment of the Agreement's requirement for a Subject Matter Expert 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 January 1, 2024, to June 30, 2024. 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 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 Duties and Transition. The Agreement sets forth the requirement for a Subject Matter Expert (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. He uses this and other information to provide recommendations and technical assistance to help the State comply with the Agreement.

From August 2018 to June 2024, John O'Brien (formerly of the Technical Assistance Collaborative) served as the SME. Starting in May 2024, Mr. O'Brien began transitioning his duties to Jake Bowling, Chief Executive Officer of Bowling Business Strategies. This is Mr. Bowling's first SME report. Mr. Bowling would like to express his deep gratitude to Mr. O'Brien for his skill and dedication in supporting and advising the State, the DOJ, and other stakeholders to advance the objectives of this Agreement. Also, Mr. O'Brien's support during the transition, including (but not limited to) orienting Mr. Bowling to the SME role, providing information on all aspects of the Agreement's history and current operations, providing strategic guidance and coaching, and drafting and reviewing this report, is gratefully acknowledged.

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 Parties and other ad-hoc meetings and various data reports and documents issued by the State. He did not audit or otherwise independently verify data provided by the State or other sources. In future periods, the SME plans to 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 December 11, 2024.

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 not completed implementation activities
Not Met	LDH has done little or no work to meet the requirement as set forth in the paragraph of the Agreement
	LDH has made little progress to meet the targets set forth in the Agreement, Implementation Plan, or other plans
Not Yet Rated	SME has not reviewed the provisions of the paragraph sufficient to determine compliance and will have a compliance rating in the future
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 54 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; and Quality Assurance and Continuous Quality Improvement. **As displayed in Figures 2 and 3, LDH was found in compliance with 10 paragraphs (19%), in partial compliance with 40 paragraphs (74%), and not in compliance with four paragraphs (7%). There were 25 paragraphs that were not rated.**

Figure 2. Overview of Compliance Assessment Ratings by Domain for 11th Report								
Target Population (4)	**Meeting Compliance**	0	**Partial Compliance**	3	**Not Meeting Compliance**	0	**Not Rated**	1
Diversion and Pre-Admission Screening (11)	**Meeting Compliance**	3	**Partial Compliance**	8	**Not Meeting Compliance**	0	**Not Rated**	0
Transition and Rapid Reintegration (14)	**Meeting Compliance**	1	**Partial Compliance**	10	**Not Meeting Compliance**	2	**Not Rated**	1
Outreach, In-Reach and Provider Education and Training (9)	**Meeting Compliance**	3	**Partial Compliance**	4	**Not Meeting Compliance**	1	**Not Rated**	1
Community Support Services (23)	**Meeting Compliance**	0	**Partial Compliance**	0	**Not Meeting Compliance**	1	**Not Rated**	22
Quality Assurance and Continuous Quality Improvement (18)	**Meeting Compliance**	3	**Partial Compliance**	15	**Not Meeting Compliance**	0	**Not Rated**	0
Total (79)	**10**		**40**		**4**		**25**	

As noted above, the SME is responsible for producing two compliance reports per year. Historically, the report covering the first six months of the year (January to June) did not include an assessment of most[1] of the Paragraphs in the Agreement associated with community support services. The report covering the second half of the year (July to December) included an assessment of all requirements. The current SME has adopted the same approach. 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 this report and the two preceding reports, along with the distribution of compliance findings. Compared to prior periods, LDH has improved its performance; specifically, between the 10th and 11th reports, nine Paragraphs received improved compliance ratings and one had worsening performance.

[1] The prior SME rated select Paragraphs in the Community Support Services section of the Agreement the 9th SME Report. The current SME elected to rate only one Paragraph in the Community Support Services section (pertaining to peer services) in the 11th Report.

Figure 3. Compliance Overview Comparisons for 9th, 10th, and 11th 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)***
Paragraphs Assessed/Rated	51	77	54
Paragraphs Not Rated	28	2	25
Paragraphs in Compliance	4 (8%)	14 (18%)	10 (19%)
Paragraphs in Partial Compliance	35 (69%)	51 (66%)	40 (74%)
Paragraphs Not in Compliance	12 (23%)	12 (16%)	4 (7%)

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 creating demand and challenges for the behavioral health field. To manage limited resources and maximize impact, the SME offers this narrower set of five overarching recommendations:

1. LDH should conduct an analysis of the Target Population to better understand their characteristics, including data analyses adapted from the at-risk population analysis that consider demographics, diagnoses, clinical and social needs, prior healthcare utilization, and other information. This will help LDH accurately measure and understand patterns and trends, identify contributors to the enlargement of the Target Population, and use current data and information to inform policy and programmatic improvements.
2. LDH should continue to assess utilization and outcomes tied to the At-Risk Program to inform potential improvements to the model.
3. LDH should fully scale the Rapid Reintegration program statewide, making refinements based on lessons learned during the pilot phase. Rapid Reintegration and other My Choice services should deploy a rapid engagement versus transactional approach, which emphasizes building rapport, trust, and connection; facilitating motivation and self-efficacy; and revisiting documentation requirements to center on organic relationship development.
4. LDH should fully optimize peer services to benefit the Target Population. This includes engaging all members on the Master List with peer in-reach, ensuring that Assertive Community Treatment peers are equipped and expected to promote community integration, and educating Community Case Managers and Transition Coordinators on the full range of peer services available to members of the Target Population.
5. LDH should inventory, analyze, and develop plans to address known systemic issues, leveraging cross-agency partnerships, the Transition Support Committee, internal and external quality assurance groups, and other experts to devise solutions.

II. Target Population

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

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 24, 25, and 26 are discussed together. These paragraphs require LDH to identify the Target Population (TP) in this Agreement. Individuals are added to the TP 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. The TP definition excludes individuals with co-occurring SMI and dementia when dementia is the primary diagnosis.

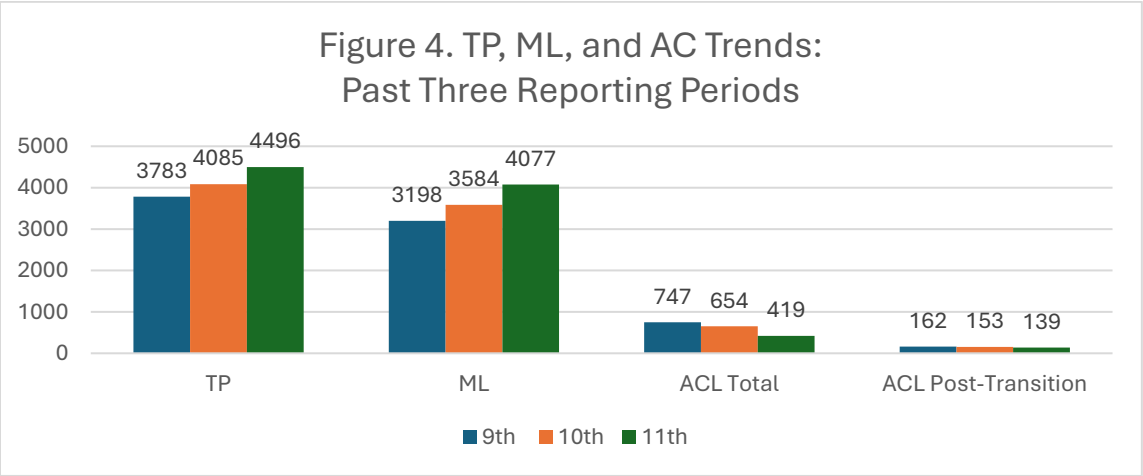
Individuals in the TP fall into three categories: the Active Caseload (AC), the Master List (ML), and diverted individuals. The AC reflects individuals who have indicated an interest in moving from a NF or who have been transitioned within the past 12 months. The ML includes individuals who have declined to move or have not yet been engaged to assess interest in transition. Diverted members are those who were not admitted into NFs but are still included in the TP by virtue of having received a PASRR Level II evaluation that indicated SMI.

As of June 30, 2024, the TP included 4,496 individuals: 4,077 individuals on the ML and 419 on the AC. The AC included 280 individuals within NFs who had expressed interest in transition and 139 who were still within their 12-month post-transition window. 99.5% of individuals on the ML had at least one PASRR Level II evaluation that confirmed SMI, consistent with the rate in prior reporting periods.

One area of potential concern is the increasing size of the ML juxtaposed with the decreasing size of the AC. Compared to the last reporting period, the TP increased by eight percent and the ML increased by 14 percent, while the AC decreased by 36 percent. Figure 4 below displays trends across the last three reporting periods: 1/1/23-6/30/24 (9th SME Report), 7/1/23-12/31/23 (10th SME Report), and 1/1/24-6/30/24 (11th SME Report).

At first glance, this data suggests a multi-period trend wherein more individuals with SMI are being admitted or residing in NFs and fewer on the AC are engaging in the transition process. That is likely true to some extent. However, as described in more detail below, recent efforts to ensure that individuals added to the AC are fully informed about and interested in transitioning have likely contributed to the decrease in AC size. Further, the Rapid Reintegration Pilot, also

described in more detail below, engaged individuals who may have been added to the AC through the standard in-reach program. Individuals who express interest in transitioning through the pilot are not included in the 419 AC figure.



The number of individuals on the ML for this reporting period is the highest since July 1, 2021. As shown in Figure 5 below, across the past six reporting periods, the number of individuals on the ML has decreased only once, between the seventh and eighth reporting periods. The figure also provides an ML and AC ratio figure that further illustrates the ML increase and coinciding AC decrease. Additional analysis is needed to determine whether the size of the TP is proportional to the overall number of new admissions in NFs among Medicaid-eligible individuals over the same time periods.

Figure 5. ML and AC Size Across Reporting Periods

Reporting Period	*ML Size*	*AC Size*	*Ratio*
11th: 1/1/2024-6/30/2024	4,077	419	10%
10th: 7/1/2023-12/31/2023	3,584	654	18%
9th: 1/1/2023-6/30/2023	3,198	747	23%
8th: 7/1/2022-12/31/2022	2,902	774	27%
7th 1/1/2022-6/30/2022	3,256	598	18%
6th: 7/1/2021-12/21/2021	2,795	916	33%

One potential contributor to the increase in the TP size, however, is the United States' Centers for Medicare & Medicaid Services' (CMS') new requirement for NFs to confirm schizophrenia or related diagnoses to initiate or continue the prescribing of psychotropic medications to NF residents. Released in January of 2023, this new policy may have caused NFs to make referrals for PASRR Level II evaluations for residents to substantiate schizophrenia diagnoses to continue their medications. Per LDH, schizophrenia diagnoses were not consistently captured in the MDS and therefore these individuals would not have been referred to PASRR Level II evaluations and added to the TP if SMI were confirmed. The SME recommends an analysis of the TP that would assess the extent to which this policy has contributed to TP growth.

As stated above, in this reporting period, there were 419 individuals on the AC: 280 who were awaiting transition and 139 who were still in their 12-month post-transition window. As shown in Figure 5, the size of the AC has decreased over the past three reporting periods. LDH reports that a potential contributor to the decreasing AC is that their in-reach staff have become more

skilled at assessing true interest prior to adding members to the AC, resulting a smaller, but more accurate and right-sized list of members who are seriously interested in transition. Fewer members returned to the ML from the AC in this reporting period compared to the last reporting period (355 versus 389). This decrease could be partially attributable to LDH's efforts to ensure that those added to the AC are in fact more serious about transitioning and thus less likely to return to the ML. However, LDH should continue to investigate this trend to determine why a smaller percentage of the TP is engaging in the transition process, either by not expressing interest after receiving outreach or initially expressing interest but subsequently declining and returning to the ML.

As referenced above, in this reporting period, 355 individuals who had initially expressed interest in transition either returned to the ML or were removed from the AC for other reasons. LDH reports that 199 of these individuals (56%) declined transition, 51 (14%) were successfully discharged from the My Choice Program after receiving 12-months of post-transition support, 34 (10%) were unable to be engaged after being added to the AC, 27 (8%) died in the NF, and 44 (12%) were either discharged, determined as not part of the TP, court-ordered to remain in the facility, deceased after transition, or re-institutionalized.

Figure 6. Paragraphs 24-26 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. LDH has established a PASRR Level II and MDS review process to ensure that individuals with SMI are added to the TP. However, the growth of the TP, amid a decreasing AC, is cause for further investigation and remediation.	1) LDH should conduct an analysis of the TP to: (a) better understand trends related to demographics, needs, conditions, and other characteristics; (b) assess the extent to which growth in the TP is commensurate with overall increases in NF admissions statewide (including specifically among the Medicaid population); (c) understand the impact of the 2023 CMS policy requiring substantiation of schizophrenia diagnoses for those on or needing psychotropic medications on TP growth; and (d) address other key questions. 2) LDH should interview a subset of people removed from the AC to assess why people who were formerly interested in transitioning are changing their minds.

27. People in the State who have SMI but are not in the Target Population may request services described in Section VI of this Agreement or, with their informed consent, may be referred for such services by a provider, family member, guardian, advocate, officer of the court, or State agency staff. Once LDH receives a request or referral, the person with SMI will be referred for services in accordance with the State's eligibility and priority requirements and provided notice of the State's eligibility determination and their right to appeal that determination.

Analysis: In previous reports, the prior SME requested information from the State regarding activities that have been completed to meet the requirements of this paragraph. Per LDH, individuals who have SMI but are not in the TP may request and receive some existing and some new services that are set forth in the Agreement, including Mental Health Rehabilitation Services, outpatient mental health services, substance use disorder services under the State's 1115 Demonstration Program, and, more recently, the array of crisis services, employment, community case management, and peer supports. Available services and processes to access these services are dependent on payer source. For instance, individuals with SMI who are

enrolled in the Medicaid program may receive the current array of existing and new Medicaid services. These individuals must maintain Medicaid eligibility and meet the medical necessity criteria established by the State or their contracted managed care organizations (MCOs) to receive these services. For services managed by LDH (e.g., services in the Community Choice Waiver), the individual must apply and be determined to meet eligibility criteria set forth by the State.

For individuals who are Medicaid eligible and who seek behavioral health services, the MCO case manager or behavioral health provider seeks authorization (as necessary) from the MCO to determine if the individual meets medical necessity criteria. If an individual is denied participation in the Waiver or is denied services from their MCO, LDH reports they have the required processes for the individual to appeal that decision. If an individual is not Medicaid eligible and has an SMI, the individual will be encouraged to enroll in the Medicaid program. If the individual is determined to be ineligible for the State's Medicaid program, LDH has the required processes to appeal that decision. If found ineligible, the Office of Behavioral Health (OBH) will refer the individual to a Local Governing Entity (LGE) for services and supports. The array of services and supports available to those individuals without Medicaid is dependent on the services offered by the LGE and the availability of funding for expanded services beyond that which they are mandated to provide.

Figure 7. Paragraph 27 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Not rated.	Not applicable.

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. To assess compliance for this paragraph, similar to the approach of the prior SME in past reports, the new SME reviewed whether the State is adequately implementing the strategies identified in their Diversion Plan, found here: https://ldh.la.gov/assets/docs/MyChoice/DiversionPlan.pdf. The SME also reviewed outcomes associated with diversion-related programming, including the At-Risk Program. While compliance discussions for this Paragraph are centered on LDH's performance relative to their Diversion Plan, compliance will ultimately hinge on whether the State had developed the systems, services, and processes necessary to consistently prevent needless institutionalization among the Target Population, which likely extends beyond its current strategies.

This plan, produced in 2019, reflects several strategies that have been implemented since 2016, including eliminating the behavior pathway to NF admissions; primarily 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; and developing a diversion target based partially 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. Further, LDH's diversion plan contemplates the development of a program for earlier engagement of individuals at-risk for future NF placements by preventing avoidable hospitalizations. 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 to prevent needless NF admissions.

During this reporting period, the State implemented the following activities related to diversion:

- The State 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 indicated community placement versus a NF admission. In this reporting period, 74 individuals were diverted, reflecting 61% of the 122 individuals they were aiming to divert in calendar year (CY) CY2024. With six months remaining, LDH is on track to meet or exceed this target. In CY2023, LDH diverted 122 individuals, or 92% of their annual target of 132 individuals. Their diversion performance for this reporting period constitutes 14% of individuals for whom SMI was indicated in their PASRR Level II evaluations.
- No 1135 waivers were granted in this period, which would waive PASRR Level II evaluations for certain individuals and thus reduce the pool of individuals who could potentially be diverted.
- The State continued to offer community case management (CCM) to diverted individuals (described in more detail in paragraphs 47 and 49) for 12 months post-diversion. During this reporting period, 39 newly diverted individuals were enrolled in CCM, constituting 53% of those who were diverted overall. They joined other diverted individuals from prior periods actively enrolled in CCM, ranging between 34 and 54 active CCM participants each month in this reporting period.
- For the diverted population engaged in CCM, data from the two quarters in this reporting period demonstrates that 26% and 20% respectively utilized the emergency department, with 11% and 6% using it for behavioral health reasons. Nineteen percent and 25% respectively had an inpatient admission, with 19% (across both quarters) utilizing inpatient care for behavioral health reasons. Utilization of these levels of care among the diverted population in CCM far exceeds that of the transitioned population in CCM. However, it is important to note that diverted individuals' utilization of the emergency department dropped by 11 percentage points when comparing their utilization rates prior to receiving CCM services.
- The State audits a sample of PASRR Level II evaluations to determine whether they agree with PASRR Level II evaluators' decisions regarding the appropriateness of NF placement versus diversion. This is an important oversight approach, as a finding that a NF is not the appropriate level of care for a member is what triggers referral to the diversion program. A description and key findings related to this process are provided in paragraph 34.
- Another key component of diversion – engaging and intervening with individuals with SMI and other chronic conditions at rising risk for NF admission – continues to be implemented and is summarized, analyzed, and assessed in paragraph 30.
- Changes to the PASRR Level II evaluation instrument related to diversion are captured in relevant sections herein.

Many of the strategies enumerated in the diversion plan have been implemented and LDH should be credited for being on track to meet its CY2024 diversion target, after robust performance in CY2023. However, some diversion-related programming – particularly the At-Risk Program– should continue to be monitored and refined based on outcomes data provided to the SME. Rates of emergency department (ED) and inpatient utilization, including for behavioral health reasons, remain high among those served by individuals deemed "at risk" who accept At-Risk Program case management. Data provided by LDH for quarters 1 and 2 of 2024 demonstrate that ED and inpatient utilization is similar between those engaged by the At-Risk Program for three months and those who were eligible but who did not enroll in the At-Risk Program. While individuals in these programs have complex healthcare and social histories and needs – by virtue of their eligibility for the programs – their utilization of the types of services that could result in subsequent NF admission should continue to be monitored and, if practicable, impacted by program improvements.

However, it is important to note that individuals who participate in the At-Risk Program for three months have a marked reduction in ED presentations when compared to their pre-engagement baseline ED utilization; 71% used the ED in the first quarter of 2024 compared to a 92% baseline. LDH also asserts that ED utilization continues to decrease in subsequent quarters of case management engagement.

There may also be opportunities to divert more individuals from NF placement. As referenced in Paragraph 34, in their audit of PASRR Level II evaluations, OAAS determined that six percent of the sample was potentially appropriate for diversion. If that trend is extrapolated to all PASRR Level II evaluations, a potential 25 to 30 additional individuals may have been appropriate for diversion within this reporting period.

Figure 8. Paragraph 29 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. While many of the strategies enumerated in the State's Diversion Plan have been implemented, the State must make additional improvements to its system of care to address known diversion barriers and improve the quality of care and housing and associated outcomes among the population to prevent future NF admissions.	1) LDH should identify why ED and inpatient utilization, including for behavioral health reasons, is relatively high for the diverted and at-risk populations, and in acknowledgement that engagement with these levels of care increases risk for future NF admissions, identify strategies to prevent avoidable admissions or ED visits. 2) LDH should identify, report on, and develop remediation plans for key diversion barriers.

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: This Agreement acknowledges that an important part of behavioral health systems rebalancing is to develop upstream services and supports to prevent individuals with rising risk from needing higher levels of care (e.g., NFs). To support this objective, LDH assessed the characteristics and needs of the TP within NFs to identify the needs profile of individuals "at risk" for hospitalizations that may lead to future NF admissions. The State has leveraged MCO case management to serve these "at risk" individuals, in hopes to prevent needless NF admissions.

The State began designing this program in CY2021, and has engaged in the following activities to plan for, implement, and improve the program:

- LDH launched the At-Risk Program via their MCOs in July 2021, which included ongoing identification by the MCOs of individuals in the at-risk population and provision of care coordination services.
- As described in previous reports, LDH's criteria for the at-risk population has shifted twice since the original definition. The most recent change took effect in October 2023. This definition includes members 18 and above with full Medicaid MCO benefits who have a qualifying mental health condition, two or more qualifying chronic conditions, six or more all-cause ED or hospital visits within the previous year, and do not currently reside in a NF.
- LDH developed an approach to monitor MCO-provided case management for everyone in the at-risk population.

The State provided counts of at-risk members identified by the MCOs during fiscal year (FY) 2021 (N=5,488) and 2022 (N=5,812). Because of the shift in the at-risk definition in October, they have provided eight months of data (from October 2023 to May 2024) as a comparison, indicating that there were 3,703 individuals identified as at-risk. This figure, if annualized, is consistent with the size of the at-risk population in prior years. Of this number, approximately 80% were outreached by the MCOs, with 63% resulting in successful contact. Of those successfully contacted, 18% ultimately enrolled in MCO case management. Based on the individual's needs and their preferences related to frequency of case manager contacts, they are placed in one of three tiers, with the vast majority in the highest intensity case management tier.

To assess the outcomes of this At-Risk Program, LDH analyzes healthcare utilization trends for those who elect to participate in the case management program, assessing whether healthcare utilization shifts after they participate in case management and comparing healthcare utilization with eligible individuals who did not elect to participate. LDH analyzed the impact of three months of MCO case management on members' utilization of hospital, primary/preventive care, and behavioral health services, compared to those who did not receive the At-Risk Program intervention, covering the period of January to June 2024. This data showed that there were minor differences when comparing the two groups. For example, members enrolled in case management were slightly more likely to utilize crisis response, ambulatory/preventive care, ED, and inpatient levels of care, but rates of avoidable hospitalizations were similar. One would expect that those engaged in case management would be less likely to use certain levels of care (e.g., ED for behavioral health reasons, crisis response services) than those who are eligible but did not elect to participate. However, increased utilization could be partially attributed to differences between the populations; for example, individuals who reject case management may have fewer needs that would result in lesser use of these levels of care.

On a positive note, prior ED utilization and average days in the ED per person among diverted individuals engaged by MCO case management in this reporting period have improved compared to prior reporting periods. For January to June 2023 (the period prior to implementation of the new at-risk criteria), approximately 92% of members had an ED visit, dropping to 70.8% and 66.2% respectively for quarters 1 and 2 of 2024. Further, the rate of ED visits decreased from an average of 4.47 days per person in January to June 2023 to a rate of 3.33 days per person in January to June 2024.

Data provided by OAAS indicates a three percent admission rate among those in the At-Risk Population. LDH reports that most of these individuals were not engaged in case management. The SME has requested data from LDH that compares admission rates between those engaged and not engaged in At Risk case management, and if provided, will include in future reports.

In FY2022, the State's Medicaid External Quality Review Organization (EQRO) reviewed the MCO case management program for the at-risk population. Findings from these efforts were included in the eighth and ninth SME reports. Based on the review's findings, LDH required each MCO to submit plans of correction. A similar review is currently underway and slated for finalization in November of 2024.

Figure 9. Paragraph 30 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. While the At-Risk Program is fully operational, there are opportunities to improve engagement, utilization, and outcomes to divert people from avoidable hospitalization. **[Paragraph 30 moved from Not Met in the 10th SME Report to Partially Met in the 11th (this) SME Report.]**	1) LDH should continue to analyze the effectiveness of the At-Risk Program, including acceptance rates, impact on healthcare utilization, and the extent to which it prevents inappropriate hospitalizations and NF admissions. 2) Based on the results of the analysis, LDH should consider enhancements to the At-Risk Program or alternative strategies to advance the objective of this Paragraph, including strategies to increase uptake among the at-risk population.

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. This 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. As noted by the prior SME in his reports, over the past several years, LDH has made several improvements to its PASRR process to strengthen its potential to achieve these objectives. Accurate detection of SMI at the PASRR Level I stage is an integral process step in preventing needless NF admission, and given the number of individuals who are suspected as having SMI after admission through the Minimum Data Set (MDS) assessment process (see more in Paragraph 41), improvements to this process are clearly needed.

In Louisiana, when an individual is referred to a Medicaid-certified NF, the referring entity completes the Level of Care Eligibility Tool (LOCET). Once the LOCET is received by LDH (specifically the Office of Aging and Adult Services, or OAAS), OAAS conducts a PASRR Level I screening. If SMI is suspected at the Level I phase, LDH's OBH oversees the completion of the Level II evaluation via its MCOs and Merakey and issues a final placement determination. For non-Medicaid members, OBH utilizes Merakey to conduct PASRR Level II evaluations.

In prior reporting periods, LDH revised and provided guidance to improve the PASRR Level I screening process, with the goal of accurately identifying individuals with suspected SMI who should be referred for a PASRR Level II evaluation. LDH, however, is planning a new PASRR Level I screening approach, which will enable them to more accurately and consistently flag potential SMI through a new PASRR Level I vendor. This new vendor – which would create new PASRR Level I tracking, reporting, and training procedures – was originally slated for implementation in CY2021. It is now anticipated to launch in early 2025, after multi-year contracting delays. The State indicates the new vendor will play a significant role in training staff that complete the LOCET and PASRR Level I evaluations once changes to the tracking system are complete. The analysis under Paragraph 34 details LDH's efforts to improve the PASRR process overall.

Figure 10. Paragraphs 31 and 33 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. In acknowledgement that LDH's PASRR Level I process necessitates improvements, LDH is onboarding a new vendor to improve SMI detection. **[Paragraphs 31 and 33 moved from Not Met in the 10th SME Report to Partially Met in the 11th (this) SME Report.]**	1) LDH should finalize, implement, and develop 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. As part of its quality assurance approach, LDH should collect the number and percentage of cases with suspected SMI at the PASRR Level I stage (comparing rates pre- and post-implementation of the new process), and the impact of the new process on later detections of SMI (e.g., during post-admission MDS assessments), among other metrics.

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: This discussion pertains to Paragraphs 32 and 34. One important function of the PASRR process is to ensure that individuals referred for NF placement receive information on options for community-based housing and services. During this reporting period, key changes were made to the PASRR Level II evaluation instrument to identify holistic needs, including medical and activities of daily living (ADL) needs, better capture barriers to community referrals, and point evaluators to LDH community programs that could be responsive to identified needs. Such changes were recommended by the prior SME and informed by LDH's engagement of PASRR staff. Training and guidance were provided to PASRR evaluators and other key staff (i.e., in-reach staff, Transition Coordinators (TCs), MCO staff) on extant home and community-based service options during this period.

LDH has designed and implemented a PASRR Level II evaluation approach in alignment with many of the requirements in Paragraph 34, 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 has reviewed and offered feedback on various iterations of the PASRR Level II forms 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 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 and services and supports to address ADLs as well as other physical health services including home health and durable medical equipment, such as personal emergency response systems. It also collects more detailed information on substance use disorder history (SUD) and needs.
- LDH 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 held regular meetings with Merakey and the MCOs to review and discuss interventions for audit findings, build expertise in behavioral health (BH) and SUD levels of care to ensure appropriateness of recommendations, and discuss complex cases and cases flagged for potential diversion.
- PASRR Level II evaluations are face-to-face and timely. In this reporting period, 99% were completed within four days of OBH referral. Consistent with prior reporting periods, 97% were completed prior to NF admission and three percent were not. A small number of post-admission PASRR Level II evaluations were still necessary due to the hospital discharge exemption (wherein a PASRR Level II evaluation is waived when an individual is discharged to a NF for a stay of no more than 30 days); an admission occurring prior to a Level II determination; and an incorrect coding issue that categorized a continued stay request PASRR as a preadmission PASRR.

The SME was provided with audit findings relative to the 141 PASRR Level II evaluations reviewed from January to May 2024. To summarize:

- Sixty-one (43%) of the 141 evaluations reviewed by OBH had a deficiency; of this 61, 19 (31%) had missing SUD information, 18 (30%) had missing BH information, 37 (61%) had BH/SUD recommendations misaligned with the needs identified, and two (3%) had a missing referral for dementia testing. The percentages exceed 100 percent because some evaluations had more than one deficiency.
- For each month's evaluations, OBH indicates the percentage of evaluations with which they agree with the NF placement determination. Despite the deficiencies in the evaluations, the average concurrence rate with the placement determination across the five-month period was 81 percent.
- OBH flagged 26 (18%) cases as potentially appropriate for diversion and in need of OAAS review for level of care and need for NF placement. Upon more granular review of the 26 cases, OAAS determined that 14 of those cases (54%) were appropriately referred to NF placement and eight (31%) were inappropriately referred to NF placement. OAAS was unable to make a determination for the four remaining evaluations in the sample (15%) due to lack of information, need for additional assessment, and other reasons. If these findings can be extrapolated to all PASRR Level II evaluations in the January to June 2024 period (n=525), there could be 25 to 30 cases where diversion was appropriate.

The findings above were from the PASRR Level II independent evaluator. MCO reviewers and the OBH PASRR Determination Specialist reviewed the same sample of cases resulting in fairly similar findings, although OBH PASRR Determination Specialist found that only 46 cases (compared to 61 cases) had deficiencies.

Based on these audit findings, LDH identified several trends and remediation strategies. In addition to ensuring the completeness of the evaluations regarding BH and SUD needs, LDH identified the need to re-educate evaluators on BH and SUD levels of care to ensure that those with histories of receiving intensive BH/SUD services (e.g., psychiatric inpatient stays) are recommended services commensurate with their needs. In cases wherein dementia, functional decline, or other neurocognitive issues are detected, LDH also identified the need to ensure that dementia testing is consistently recommended and available.

Figure 11. Paragraphs 32 and 34 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially 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. Continued progress is needed to correct deficiencies in the completeness and quality of evaluations, use aggregated data from the PASRR Level II process to inform the development and enhancement of services, and ensure that evaluators are effectively providing information on community-based services and housing options/alternatives.	1) Using information collected through the new PASRR Level II evaluation tool, LDH should analyze the most common barriers, needs, and recommended services to inform development or enhancement of community-based options, including strategies to rapidly provide such services to support diversions. This could be done in alignment with the TP analysis recommended under Paragraphs 24-26. 2) LDH should continue its PASRR Level II audit activities, continuing to track and address areas of improvement (e.g., whether needs were identified, and appropriate referrals were made), 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: To comply with this Paragraph, LDH has developed a system whereby PASRR Level II evaluators – informed by their review of collateral documentation, engagement of the individual and his or her loved ones, and review of a dementia questionnaire completed by supporter in the individual's life – determines whether the individual has a dementia diagnosis or whether additional expertise is needed to render a determination. In either case, a consulting psychiatrist conducts a professional evaluation to ensure appropriate diagnosis, including identifying other conditions or circumstances that may mimic, mask, or cloud a dementia diagnosis (e.g., alcohol use disorder or recent stroke). Individuals who receive a diagnosis of suspected dementia are re-reviewed within a year to determine if the individual has dementia.

PASRR Level I and OAAS staff connect individuals and caregivers impacted by dementia to the local Alzheimer Association chapters and Louisiana State University (LSU), which has developed a repository of information for individuals with dementia and their caregivers.

During this reporting period, LDH reports that 122 individuals (or 3% percent of the TP) were identified through the PASRR Level II process as having or suspected of having a dementia diagnosis, compared to 4% the first half of 2023 and 8% in the second half of 2022. Comparative data for the second half of 2023 was not requested for this report. Among the cases identified during this reporting period, 91 (75%) were determined to have a primary dementia diagnosis, 27 (22%) were suspected of having a primary dementia diagnosis and were reviewed by the consulting psychiatrist during the next continued stay review period, and five (4%) were determined not to have a dementia diagnosis. This distribution of dispositions is almost identical to data from past reporting periods provided in the prior SME's tenth report. As reported in the eighth SME report, LDH conducted a historical review of individuals with a dementia diagnosis and found 85% of individuals were appropriately diagnosed. The State has not undertaken a similar review since.

Figure 12. Paragraph 35 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Met. LDH has complied with this Paragraph and should continue implementation and quality assurance of its current processes.	1) LDH should continue implementation of its current protocol and track the percentage of individuals identified as having dementia against the baseline to assess multi-year trends.

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 indicated in previous reports, LDH eliminated the behavior eligibility pathway in 2018. The behavior pathway provided an avenue for individuals with SMI to be admitted to NFs without having met other level of care criteria for NF placement. NF residents who were admitted per the behavior pathway had no other qualifying condition to meet NF LOC criteria other than SMI. For this reporting period, after review of MDS data, LDH reports that no individual with a sole diagnosis of SMI was admitted to an NF, aligning with the consistent practice since the fifth reporting period.

Figure 13. Paragraph 36 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Met. LDH eliminated the behavioral health pathway and regularly reviews MDS to verify that individuals with a sole SMI diagnosis are not being admitted to NFs.	1) LDH should continue to collect, analyze, and report on MDS data to ensure that no person with a sole behavioral health diagnosis is admitted to an NF.

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 approvals be limited to 90 or 100 days. Approvals for extended 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.

As indicated in previous SME reports, LDH has developed a system for authorizing temporary stays rather than long-term "permanent" stays. OBH requires a temporary authorization for all individuals for whom the PASRR Level II evaluation confirms SMI. Such temporary authorizations do not exceed 90 days, except for persons approved for convalescent care by LDH, who can be authorized for up to 100 days. Consistent with the last reporting period, 100% of individuals in the TP received a short-term authorization in this reporting period. The average length of stay for these initial authorizations was 91 days for those whose temporary stays ended in April to June 2024, 92 days for January to March 2024, and 92 days for October to December 2023.

A special analysis in the ninth reporting period showed that 38% of the TP stayed less than 90 days with most transitioning without the need for extensive support, with 62% having been authorized for a continued stay at 90 days post admission. Continued stay requests are not to exceed 365 days, and the average length of continued stay requests was 341 days from April to June 2024 and 339 days from January to March 2024. This exceeds the average length of stay for prior reporting periods of 281 days.

As noted in the Paragraph above, if a person is authorized beyond the initial stay, the continued stay process must specify the timeframe for the extended stay and why it is necessary, identify

which specialized BH services the individual needs, and justify why the individual cannot instead be served in the community instead. Per the prior SME, there is no clear policy that ensures that determinations for the recommended duration for an individual's stay are individualized and informed by relevant factors. The State has indicated that approvals for ongoing lengths of stay are variable and are based on numerous factors, including an individual's health, functional, daily living, and other needs; status of participation in the My Choice Louisiana program; availability of natural supports; and other factors. This policy was implemented starting in May 2024.

This Paragraph also requires continued stay requests (CSRs) to include a justification for why individuals cannot be served in the community and an indication of BH needs. The new PASRR Level II evaluation tool, launched in July 2024, should improve compliance with this Paragraph. The instrument collects information on transition barriers, as well as other barriers across multiple domains (e.g., health, ADL/instrumental ADLs) that necessitate NF placement. Further, the instrument has a section to identify BH needs, barriers, and recommendations for care/services. LDH should ensure that the PASRR evaluators identify BH services that can be delivered while an individual is residing in the NF and develop a process to ensure that such services are delivered. Based on his review of data, the prior SME found that a substantial number of individuals in the TP needed but did not receive critical BH services during their continued stays.

Figure 14. Paragraph 37 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. LDH's initial approval process complies with this Paragraph. Further, the new PASRR Level II evaluation has the potential to improve compliance with other aspects of the Paragraph, including identification of transition barriers and behavioral health needs.	1) LDH should continue to implement and report on its continued stay process. 2) LDH should ensure that the behavioral health needs of TP members in NFs are identified and delivered while in the NF.

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.

Analysis: As indicated in previous SME reports, the State has developed a process that requires NFs to submit CSRs for continued stays beyond the 90 days of an initial stay, at least 15 days before the authorized temporary stay ends. 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 the CSR process developed by LDH for individuals in the TP, which delineates the role of OAAS and OBH. This includes the use of MDS to establish continued need for NF level of care. The State continues to report that all CSRs are reviewed by OAAS regional staff who are independent and not affiliated with the NF.

Figure 15. Paragraph 38 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Met. LDH has developed a process that complies with this Paragraph, including ensuring an independent review of MDS data to approve continued stay requests.	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 indicated in the response to paragraph 34, PASRR Level II reviews are performed by the Medicaid MCOs' PASRR Level II evaluators, licensed mental health professionals who operate independent of the NF and the State. This paragraph provides several scenarios for an individual receiving an additional PASRR Level II during their NF stay tenure, including an NF or individual requesting a CSR after the initial 90–100-day authorized stay; an individual being due for an annual resident review; and an NF requesting a new PASRR Level II evaluation due to a significant change in an individual at their facility.

The SME requested and LDH provided information regarding the number of individuals in the TP who received a PASRR Level II evaluation in each of these scenarios. The most current data provided by LDH was from October to December 2023. During this period, 1,273 evaluations, or nearly half, were administered based on a NF's request for an annual review/continued stay, 489 (18%) were administered based on a NF's request due to significant change in medical condition, and 889 (32%) were not captured in the two categories above.

The prior SME had questions regarding the methodology used by LDH to assess whether all eligible members received their required annual evaluations. LDH is now working to develop a new methodology to facilitate more accurate tracking. Findings will be included in future reports.

Figure 16. Paragraph 39 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. While the State reports information regarding the number of individuals who received a PASRR Level II evaluation for each of the scenarios, the State cannot verify that all members of the TP receive the required annual PASRR Level II evaluations, including in cases where a significant change in condition has occurred.	1) LDH should confer with the SME regarding the methodology for determining if individuals are receiving their required annual PASRR Level II evaluation and provide regular reports. 2) LDH should identify and address the reasons individuals in NFs are not getting an annual PASRR Level II evaluation and implement strategies to ensure all individuals in NFs receive such evaluations.

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 of the TP must be offered the opportunity to transition. LDH, as described in the seventh report, developed in-reach and transition support processes for members of the TP. Since the inception of the Agreement, the transition process has generally been the same, except for the Rapid Reintegration Transition Coordinator (RITC) pilot described in Paragraph 45. If they express interest in transitioning, they are added to the AC to receive more intensive transition support. If they are not interested, undecided, or unable to decide if they are interested in transition, they are added to the ML to be re-engaged later. In addition to those on the ML who have declined the opportunity to transition, there are individuals on the ML who have been residing in NFs but have not yet been contacted by in-reach.

For those who signal and maintain interest in transitioning, a TC from OBH or OAAS facilitates a NF Transition Assessment (NFTA), and if interest is sustained, an Individualized Transition Plan (ITP) is initiated. During the seventh reporting period, LDH established timeframe expectations for various TC processes. TCs are required to contact an individual within three days of assignment, complete the NFTA within 14 days of an individual's assignment to a TC, and initiate the ITP within 30 calendar days of NFTA completion. Further, the TC must establish a projected transition date within seven calendar days of ITP initiation and refer the individual to CCM at least 60 days prior to the projected transition date. The prior SME reviewed and agreed with these expectations, and since the eighth report, LDH has monitored TCs' adherence to these requirements.

For this and prior reporting periods, LDH has provided data on the TCs' performance relative to these timeframe expectations. The SME has synthesized and summarized data provided by LDH as of August 2024 (near the end of this reporting period) and data from the 2024 SME service review to assess performance relative to this Paragraph. The SME service review's methodology, process, and an overview of findings are included in Paragraph 93.

- There were 6.2 days on average that elapsed between an individual being added to the AC and assignment to a TC.
- There were 24 days on average between the TC referral and completion of the NFTA, compared to the 14-day benchmark. This correlates with the SME's CY2024 service review, which found that only 66% of reviewed individuals received a NFTA on a timely basis. This represented an improvement compared to the CY2023 service review, which showed that only 37% received a timely NFTA.
- There were 17 days on average between NFTA completion and initiation of the ITP, compared to the 30-day benchmark. The CY2024 service review demonstrated that 59% received an ITP timely, reflecting an improvement compared to the CY2023 service review, which showed that only 21% of individuals included in the review received a timely ITP.
- The FY2024 service review found that all individuals received their required discharge planning meeting and 69% had their date of transition established within 7 days of ITP completion. This performance was consistent with the prior reporting period.

Over the course of January to June 2024 (this reporting period), LDH also provides a monthly analysis of the percentage of individuals who, after their NFTA, initiate and complete their ITPs. This analysis shows that 80-96% of individuals initiated their ITPs and of those initiated, 87-90% complete them. Similarly, in the last period, 85-94% initiated their ITPs and 82-89% completed them. Taken together, this data suggests that the majority of those on the AC go on to complete NFTAs and ITPs.

There is a cohort of individuals residing in NFs who have yet to have been reached by LDH's in-reach program, and thus remain on the ML. Data provided as of June 2024 showed that 526 individuals on the ML had not yet been contacted, constituting approximately 13% of the ML. This is a major improvement compared to the last reporting period; as referenced in the 10th report, 24% of individuals on the ML had not yet been reached. At any given moment, all individuals on the ML may not be reached due to a lag in TC assignment/engagement and population churn, so LDH should create a data-driven target for ML penetration and a target date by which these individuals will be engaged.

In early 2025, LDH intends to mainstream the Rapid Reintegration approach to modify the in-reach and TC support approaches described above. The design and current performance of this program is described in more detail under Paragraph 45.

Figure 17. 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 NFTAs and ITPs for the majority of those who express and sustain interest in transition, 13% of individuals on the ML have yet to be offered transition support services. However, it is laudable that LDH has made such considerable progress reaching individuals on the ML, closing the gap by 11%. Further validation is needed to determine whether in-reach and other engagements facilitate fully informed choice.	1) LDH should create a target percentage and due date for ML in-reach penetration and implement measures to meet the target. 2) LDH should continue to monitor the timeliness of key transition support processes, incorporating new timeframe expectations for the RITC program.

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 with SMI 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. In the prior SME's reports, LDH provided data regarding the number of individuals for whom SMI was indicated through the MDS assessment and whether they received timely PASRR Level II evaluations, as required. For this reporting period, however, a cross-agency data issue was discovered that cast doubt on the validity of the data. LDH is working internally to address the data issue to report on performance in future periods.

Figure 19. Paragraph 41 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. LDH has established and implemented a process for post-MDS referrals to PASRR Level II evaluations when SMI is suspected. However, data to demonstrate compliance is not available for inclusion in this report.	1) LDH should work with the SME to ensure the provision of accurate data to demonstrate compliance with this Paragraph, as well as additional analysis to understand the increase in individuals identified as potentially having SMI through the MDS process.

42. LDH shall form transition teams composed of TCs from the LDH Office of Aging and Adult Services, the LDH OBH, 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: TCs are responsible for working with individuals on the AC to assess their comprehensive needs; craft an Individualized Transition Plan in partnership with the individual and their informal and formal supports; and facilitate referrals for individuals who are transitioning from NFs to community-based housing and services, among other duties. TCs are also responsible for regularly scheduled follow up visits for individuals for one year post transition, including follow-up visits at 7-, 30-, 60-, 90-, 180-, and 365-days post-discharge. All individuals on the AC are assigned to a TC.

While SMI is a requirement for inclusion in the TP, some members also have intellectual and developmental disabilities (ID/DD), physical disabilities and other health concerns, and aging-related concerns. In acknowledgement of the diverse needs profile of the TP, the Agreement requires LDH to employ TCs across three state agencies that serve these key subpopulations: OBH, OAAS, and the Office for Citizens with Developmental Disabilities (OCDD). The Agreement contemplated that having TCs associated with these agencies would ensure the transition process for these members is supported and guided by staff with expertise in the specialized needs and available supportive services for these subpopulations.

However, since the beginning of the Agreement, TCs have been hired by OBH and OAAS, but not OCDD. At the Agreement's outset, LDH reviewed information regarding the number of individuals in the TP who had an ID/DD to determine if additional TCs were necessary from the OCDD. The initial analysis revealed a relatively low prevalence of individuals with ID/DD in the TP. The number of members with identified ID/DD has grown substantially since. In the 10th report, there were 266 individuals with co-occurring SMI and ID/DD in the TP; thirty-four were on the AC and 192 were on the ML. As of the end of this reporting period, there were 268 individuals with ID/DD on either the AC (16) or ML (252). This represents 4% of members on the AC and 5% of the ML. The increasing rates of ID/DD in the TP may not reflect an actual increase in members with ID/DD; it may, in some part, be attributable to improved data collection and identification of ID/DD, including changes in the Utopia system to track the characteristics of individuals in the TP residing in NFs.

Currently, the SME does not recommend that OCDD directly employ TCs but encourages LDH to continue to analyze the prevalence of ID/DD among the TP. Instead of hiring TCs within OCDD, OBH and OAAS's TCs should continue to serve members with ID/DD by coordinating with OCDD program staff for services potentially needed by these individuals. More specifically,

TCs should continue to investigate and confirm a member's prior involvement in OCDD services and if appropriate, obtain a statement of approval from OCDD to refer the member to OCDD waiver options.

At the end of this reporting period, there were 29 total TCs across OBH and OAAS. OBH holds 10 TC positions; nine were filled and one was vacant. Out of OAAS's 16 TC and four RITC positions, one RITC position was vacant, and the rest were filled. OBH has three staff positions that provide oversight, with one position vacant and the other two filled. For OAAS, all three supervisor positions were filled, with two additional OAAS staff providing oversight.

When individuals are assigned to the AC, TC management staff at OBH and OAAS review the case and determine which TC can best serve the individual. Generally, individuals are assigned to a TC based on which TC has capacity at the time, regardless of which agency that TC represents. When making a TC assignment, OBH and OAAS management may consider other factors beyond which TC currently has capacity to serve the individual, such as whether the individual has been served by a specific TC before and the outcomes of that engagement, or whether an individual resides in a NF that is familiar to a specific TC. All individuals with prior OCDD involvement are automatically assigned to OBH.

In 2024, per the Implementation Plan, TCs were responsible for effectuating transitions for 331 members. As discussed in 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. As noted in other sections, it is very unlikely that the State will meet its 2024 transition target, given that only seventy-two individuals have been transitioned in the first half of the year. This necessitates continued focus and creative strategies on how to remediate systems- and staffing-related issues that are impeding transition performance. Annual transition performance is provided under Paragraph 56.

LDH has developed and implemented a range of management tools, both during this compliance assessment period and after, to support meeting established transition targets. While some of the TCs have not fully met these goals, there has been notable progress in enhancing processes, productivity, and oversight. During this reporting period, the average caseload size for TCs was 15 members, with an average of 12 in the pre-transition phase and three in the post-transition phase. This is a drop from the last reporting period, during which the average caseload was 19 individuals. It was previously determined that caseloads should range between 25 and 45 to allow approximately 1,200 individuals to be served, assuming a full complement of TCs. At the end of this reporting period, there were 419 individuals on the AC, or a ratio of 14 individuals per TC position. Operating with higher caseloads, if appropriate, would be important to accommodate hundreds of additional individuals if the AC should grow, which is expected as the RITC program moves from pilot status to full statewide implementation.

Based on the transition target for CY2024, on average, TCs must effectuate 13 transitions to achieve the goal of 331 transitions. In the ninth reporting period, LDH set specific expectations for and began tracking the number of transitions that must be accomplished in each region annually. Tracking shows that performance across Louisiana's nine regions is uneven. Analysis is needed to identify whether this may be attributable to a higher volume of individuals interested in moving to specific regions, staffing turnover that impacts specific regions, or other factors.

Figure 20. 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 is low – substantially lower than those achieved through the Money Follows the Person program which this program is modeled after.	1) LDH should continue to enhance its management and support strategies for TCs – including caseload management, coaching around systems issues that impede transitions, and performance monitoring – designed to optimize TC performance. 2) LDH should analyze whether increasing rates of members with ID/DD necessitate OCDD-based TCs or new/enhanced strategies to ensure stronger partnerships resulting in smooth and prompt access to OCDD services for such members.

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 a 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. This Paragraph requires LDH to provide an Individualized Transition Plan (ITP) to every member of the TP, not just those who express interest in transition. Since the beginning of the Agreement, however, LDH has limited development of ITPs to those who are added to the AC. Those on the AC receive a NF Transition Assessment (NFTA) that informs the ITP. As noted in prior reports, LDH has made several revisions to the ITP template to capture more specificity in certain areas (e.g., housing preferences, interest in integrated day activities), as well as be more person-centered.
In September 2023, LDH developed an addendum to the ITP designed to provide information on services and supports needed after transition but before the CCM can work with the individual to develop the Community Plan of Care (CPOC). The addendum provides recommendations regarding the scope, amount, and duration of services needed at transition. The ITP addendum is currently in Word document form, and as such, the capability for LDH to analyze, on an aggregate level, the completeness and quality ofcontent of addenda is not yet in place.

Paragraph 46 enumerates the components that must be included in ITPs. The prior SME and his team reviewed a representative sample of ITPs and assigned a quality score to each based on whether the ITP included the required components and met other standards, such as meaningful involvement of the individual. In 2023, the sample of ITPs reviewed as part of the service review

process had an average quality score of 23.08 out of 100. ITPs reviewed in CY2024 had a quality score of 50.78, reflecting a significant improvement. While the 2024 ITPs were improved, the score of 50.78 still suggests mediocre quality of the ITPs subject to review. The most common gaps in the 2024 sample of ITPs include: the ITP not being provided to the member (48%), no evidence of ITP planning meeting (42%), no plans regarding transportation needs (39%), and no BH supports identified (39%). The prior SME's service review report reflects other important findings and recommendations for improvement. The current SME's service review process is underway and will assess the extent to which these and other themes persist later in 2024 and in early 2025. Findings will be reported in the 2025 service review report, as well as future SME reports.

Figure 21. 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, these ITPs do not consistently include all the required components per the Agreement. **[Paragraphs 43 and 46 moved from Not Met in the 10th SME Report to Partially Met in the 11th (this) SME Report.]**	1) LDH should continue training and supervision 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 analyze ITP addenda to determine if services in the addenda were received by individuals who transitioned.

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 operationalize this objective, LDH has provided training on person-centered planning and made changes to programmatic documentation to capture person-centered information. In past reports, the prior SME recommended that LDH validate the effectiveness of these efforts on the quality and the person-centeredness of the ITPs, but this has not been implemented. The SME team, in their review of a sample of NFTAs and ITPs to assess their person-centeredness, found that the 2023 sample had an average person-centered score of 1.74 (on a five-point scale with five being highest) and the 2024 sample had an average quality score of 2.48. While the 2024 score represents an improvement, further progress is needed.

An opportunity to enhance the person-centeredness of the transition process is to facilitate member visits to housing options, allowing individuals to better envision their lives post-transition and make informed decisions. LDH reports that transporting individuals to housing options is not always practical, but that all TCs are directed to, at a minimum, conduct a virtual walkthrough with the individual. Since the writing of this report, this practice has been monitored by TC management.

Figure 22. Paragraph 44 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Not Met. While the State has implemented training on person-centered approaches, a review of documentation shows that a person-	1) LDH should retrain TC staff and supervisors regarding person-centered planning using the

centered focus needs significant improvement. Further, LDH is not consistently arranging and/or providing visits to housing and services in the community.	modules developed in 2020 and use the checklist discussed in paragraph 61. 2) LDH should develop strategies to standardize visits to housing and community-based services (e.g., intensive outpatient programs, integrated day programs), including leveraging technology for virtual visits, NF-provided transportation, and ride sharing services.

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 members of the TP be engaged at 3 days and 14 days post-admission to assess their interest in transition. This approach to prompt post-admission outreach allows staff to build rapport with members early in their NF stay. Unnecessarily long NF stays can result in the erosion of a person's self-efficacy in the skills, supportive relationships, and other facilitators of transition and community life.

The State has made key investments in the data and staffing infrastructure necessary to comply with this requirement, likely to improve compliance in future reporting periods. Historically, this requirement has been unattainable because the State did not receive real-time alerts of NF admissions that would help them identify new admissions quickly enough to meet the three-day contact requirement. After extensive contract delays, such functionality is finally slated for implementation in early 2025. Further, during this reporting period, the State operated a pilot in seven regions with the most individuals in the TP.

The pilot involves the deployment of a Rapid Integration Transition Coordinator (RITC) that makes initial telephonic contact within 3 days of admission and face-to-face contact within 14 days. Until the real-time admission alert process is in place, RITCs are assigned to members based on their completion of the initial MDS, which generally is completed within 3 days of admission. If a member is interested in transition during the 14-day visit, the NFTA is initiated. For members with short-term stays (less than 90 days), the RITC visits them at 45- and 60-days post-admission to plan for and support the transition process in partnership with NF staff. Such members also receive post-discharge follow-ups from RITCs. Members with longer-term stays who sustain their interest in transitioning at 45 and 60 days are referred to another TC to complete an ITP. Members who are not interested at any time point are placed on the ML for peer in-reach follow-up 90 days later. Peer in-reach is described in more detail in Section VI.

At the end of this reporting period, the RITC pilot was underway in seven regions and positions were posted in the other two. RITC staff received training, shadowing, supervision, and peer-to-peer coaching consistent with traditional TCs, and participate in standard TC trainings, as well as specialized training in warm handoffs with TCs and post-discharge follow-ups for those with short-term stays.

Data from January to August 2024 shows that 326 members were added to the AC through the RITC pilot. Of those, 97% received a 3-day contact and 95% received a 14-day in-person visit. Among the 310 who received the 14-day visit, 91 (or 29%) completed an NFTA. After the NFTA, 51 members (56%) maintained interest in transition, 29 (32%) were no longer interested, and 11 (12%) were unable to engage due to a health issue or other reason. Fifty-six members went on to complete an ITP, with 39 sustaining their interest in transition after the ITP process. It is unclear why the number of members completing ITPs exceeds the number of members who expressed interest in continuing with the transition process after receiving their NFTAs.

Based on this data, 39 of the 326 initially added to the AC (or 12%) progressed to a completed ITP. The transition outcomes of all these specific 39 members are not known by the SME as of the writing of this report, but the pilot yielded five transitions as of August 2024. An additional 69 members left the NF after short-term stays and were tracked and received follow-up contacts from the RITCs.

LDH reports several lessons learned thus far in the pilot. They report that intensive transition assistance may not be needed for those admitted for short-term skilled therapies, some individuals are not interested in completing the lengthy NFTA so soon after admission, and that Medicaid status (a condition for TP eligibility) is not always known until after multiple RITC engagements, sometimes not until 90 to 100 days after admission. Further, they indicate that the warm handoff between the RITC and TC may be disruptive to the engagement and transition planning process. Planned refinements to the RITC program, as it scales statewide in early 2025, will address some of these challenges, but the SME provides additional recommendations below. One recommendation to underscore is that early engagements are not solely focused on assessing interest in transitioning or completing documentation. Instead, staff should focus on building a foundation of trust, rapport, and safety for individuals to fully and honestly explore their options. More information on how statewide adoption of the RITC program will impact legacy processes – such as peer in-reach and the current TC approach – is provided under Paragraph 45.

Figure 23. Paragraph 45 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. The RITC pilot represents a crucial step in complying with this Paragraph. However, statewide implementation (supported by real-time NF admission alerts) is needed to ensure that all TP members receive the required, prompt post-admission contacts. **[Paragraph 45 moved from Not Met in the 10th SME Report to Partially Met in the 11th (this) SME Report.]**	1) LDH should identify and track key metrics to monitor RITC utilization and outcomes and effective implementation of the new PASRR Level I vendor and associated processes. 2) LDH should develop strategies to address lessons learned in the pilot, including adopting Oregon's Rapid Engagement philosophy, building engagement proficiencies among RITC staff, and considering flexibilities around documentation (e.g., NFTA) until rapport is established.

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 seventh reporting period, LDH, through its MCOs, launched a case management approach called community case management (CCM). MCOs contract with Merakey, a community behavioral health organization, to deliver CCM services. As stipulated in this Paragraph, transitioned members are eligible for CCM. Diverted members can also access CCM, as described in Paragraph 29. As stated in the seventh SME report, LDH developed standard operating procedures to guide the CCM approach. Procedures include 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 LDH grants an extension based on individual circumstances and need.

In the 2024 service reviews, the SME team examined documentation from the TC and CCM logs specifically to determine if the CCM was included in the ITP planning process. The service review also evaluated whether the TC and CCM had ongoing contact post transition to ensure a "warm handoff" occurred. Of the 23 transitioned members reviewed, CCM documentation – specifically assessments, plans of care, and crisis plans – was present for 19 (or 83%) of the cohort. Among the four remaining members without completed documentation, one member was experiencing a crisis (which delayed documentation completion), two members had documentation in process, and one member was still evaluating his interest in CCM services. The quality of the documentation was relatively high, with an average assessment quality score of 91% and an average plan of care score of 73%. Further, a review of documentation for a cohort of individuals nearing transition showed that referrals to CCM and pre-transition discharge planning meetings were performed in accordance with LDH's expectations, although the sample size was small (n=2).

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 and plans of care are not due until 30 days after transition, so LDH has developed an ITP addendum, completed by the TC, that 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). Because ITP addenda are completed outside of LDH's medical record system, they are not subject to the SME's service review and LDH is unable to easily report on the quality, completeness, or presence of ITP addenda for transitioned members. Thus, compliance with this Paragraph cannot be fully evaluated yet.

Figure 25. Paragraph 47 Compliance Determination and Associated Recommendations

Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. Cases reviewed as part of the 2024 service reviews demonstrate that CCM referrals and the development of documentation were timely, and that documentation was of decent quality. Given that this Paragraph also requires the receipt of services at the point of transition, reporting on the completion and quality of the ITP addendum is needed to fully assess compliance. Further, additional data on service authorizations and provision are needed to fully assess compliance.	1) LDH should develop a strategy to oversee and report on the presence and quality of ITP addenda to ensure that individuals have needed services at the point of transition. 2) LDH should develop clear expectations for CCM involvement in the ITP addenda and consider other opportunities for collaborative and streamlined TC and CCM documentation more broadly.

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. All individuals in the 2024 service reviews were engaged by a CCM within 60 days of transition, although documentation was not completed for all individuals due to the reasons referenced in Paragraph 47.

Figure 26. 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 and the SME service review confirmed that, among the sample reviewed as part of the 2024 service review, all individuals were in receipt of CCM per LDH's expectations.	1) LDH should continue tracking adherence to its expectations with respect to prompt linkage to CCM services for transitioned and diverted individuals.

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: Per this Paragraph, LDH is required to monitor and support transitioned individuals, with the focus of ensuring that they get the services they need to be successful in the community. As such, LDH requires TCs to conduct post-transition follow-ups to verify that the individual is receiving needed services in the community and to identify and remediate any issues during the first year of the transition. Specifically, LDH requires TCs to conduct post-transition engagements at 30-, 60-, 90-, 180-, and 365-day time points in the year after transition.

The prior SME recommended that TC supervisors review a sample of documentation to ensure that post-discharge visits are occurring. Further, he recommended a supervisory review of the TC documentation completed during these visits to ensure that collected information is sufficient to alert LDH to any concerns about whether an individual is receiving needed services/supports, spur action on such concerns, and inform potential follow-ups with CCM providers, if necessary. During the writing of this report, LDH indicated that TC supervisors conduct "spot checks" to determine whether TCs are completing the required visits, producing quality documentation, and intervening when individuals need more support, but there is no formal procedure or reporting approach. In the tenth SME report, the prior SME indicated that unless LDH formalized the process to ensure occurrence and quality of post-transition TC engagements, and reported on such, he would rate the Paragraph as Not Met.

The current SME recommends that post-transition follow-ups center on whether the individual is receiving services consistent with the CCM assessments and community plans of care (CPOCs) versus the ITPs. ITPs are generally focused on what an individual needs at the point of and soon after transition, whereas the CCM documentation should be a better indication of needed services after community placement. As such, the TC's monitoring should involve assessment of alignment between the ITP and CCM documentation; quality assurance to ensure that CCM assessments and CPOCs are complete, appropriate to the individual's needs, and being acted

upon; and an assessment of whether the transitioned individual is experiencing issues that are not being adequately addressed.

The SME's service review process also provides an opportunity for LDH management staff to assess whether a transitioned individual is receiving needed services. While the SME and his team do not conduct review of post-discharge TC documentation, they do collect and conduct review of individuals' NFTAs, ITPs, contact logs, CCM assessments, CCM plans of care, crisis plans, and other documentation. The transitioned individuals and their TCs, CCMs, and ACT providers (if applicable) are also interviewed as part of the SME's service review process. This has historically offered actionable insights for LDH related to the individual's post-transition experience.

Figure 27. Paragraph 49 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Not Met. While LDH has developed a process for post-transition TC engagements, they cannot provide data to demonstrate the occurrence and quality of such engagements, particularly as it relates to identifying whether individuals are getting what they need in the community. **[Paragraph 49 from Partially Met in the 10th SME Report to Not Met in the 11th (this) SME Report.]**	1) LDH should implement an approach to ensure that post-transition engagements are occurring at the LDH-established cadence and that these engagements are addressing the objective of ensuring that transitioned individuals are receiving needed services.

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 transitioning to the community. Medicaid has more generous income limits for individuals who meet NF level of care eligibility requirements than for those who reside in the community. Since the beginning of the pandemic, Congress had prevented states from removing Medicaid recipients from the Medicaid program, but the requirement lapsed in May 2023. At that time, LDH restarted efforts to track the loss of Medicaid eligibility among the transitioned members, and despite the change in policy, LDH reports that no individuals have lost Medicaid eligibility post transition since.

LDH acknowledges that while transitioned individuals have not lost Medicaid eligibility, they may transfer to a new Medicaid type. The current SME is not aware of how, if at all, a change in Medicaid type would impact eligibility for certain services/supports used by members of the TP. However, for those who may in the future lose eligibility for Agreement-related services, the prior SME recommended that LDH develop clear pathways for making referrals to LGEs for follow-up services. During this reporting period, LDH made noteworthy progress in developing a referral guide for transitioned individuals who lose Medicaid, but it has not yet been finalized and promulgated to TCs.

Figure 28. 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, but a referral guide has not yet been finalized or made available.	1) LDH should identify the service eligibility impacts of changing Medicaid types. 2) LDH should finalize its referral guide, to identify services that individuals who are impacted by changes to their Medicaid type or are no longer on any form of Medicaid are eligible for.

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 residing in NFs who elect to stay there, LDH must ensure that their decision is based on receipt of complete and accurate information and that barriers to community services, which may prevent an individual from leaving the NF, are concretely identified and discussed. As such, during the NFTA, TCs collect information on barriers for individuals who may not be interested in moving. LDH reports they have initially collected information on 576 unduplicated individuals who were on the ML and AC regarding barriers.

In his tenth report, the prior SME shared this data for the fourth quarter of 2023. LDH has not provided more current data on in-reach and transition barriers, so the new SME is using the same data provided in the last report to assess compliance with this Paragraph. The most common transition barriers cited were concerns about management of physical health (17%), observed cognitive issues including suspected dementia (14%), waiting for housing in a specific town (14%), and durable medical equipment issues (6%). Another 17% were categorized as "other." In his tenth report, the prior SME stated that LDH was developing a process to share identified barriers with the My Choice Internal Quality Assurance Committee so they can review and formulate strategies to address them. Some barriers are also provided to the Transition Support Committee (TSC) discussed in Paragraph 58.

The new SME interprets this requirement as an opportunity to meaningfully engage individuals around their fears and concerns about transitioning into the community. 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. Transactional outreach encounters are likely inadequate to help these individuals fully process and if interested, explore strategies to overcome their real or perceived barriers. It is important that peer in-reach, TC, and RITC staff are skilled in building the requisite trust and rapport to elicit an individual's fears and concerns; fully exploring the contours of those concerns; clearly communicating available supports; and building self-efficacy, hope, and motivation. LDH is developing tools and strategies to address these concerns, including a "Prompting Guide" for peer in-reach staff that rolled out in August 2024. The SME can also assist in developing other strategies that deepen engagement and facilitate informed choice.

Figure 29. Paragraph 51 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. Transition barriers are captured through the in-reach process, but it is unclear whether such barriers are fully explored and addressed at the individual, programmatic, or systemic levels.	1) LDH should ensure that in-reach, RITC, and TC staff are proficient in motivational interviewing and other approaches to build self-efficacy among the individuals they engage. 2) LDH should implement the proposed processes to share barrier trends with the Internal My Choice Quality Committee and the TSC to inform strategies to address identified barriers at the programmatic and systemic levels.

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. In prior reporting periods, LDH discussed these cases with the prior SME, despite the sunset of the requirement. The new SME will discuss ongoing tracking with LDH. During this reporting period, LDH reported that one member of the TP transitioned to a group home but moved into her own apartment a few months later.

Figure 30. Paragraph 52 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Not rated.	Not applicable.

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

Analysis: During the in-reach process, peer staff capture barriers among those who are not interested or undecided about transitioning to the community. The prior SME's tenth report included a summary of barriers cited for the 106 individuals who received in-reach during the fourth quarter of 2023. More current data has not been provided as of the writing of this report, so the new SME is relying on the same data for his compliance assessment. Among those who were not interested or undecided about transitioning, 40% were reported to be unable to engage in discussion regarding community options due to their health condition; 33% were reported to be unable to engage in discussion regarding possible transition (not able to communicate even with assistance of communication aides); and 26% were reported as unwilling to participate in discussion regarding transition.

Full compliance in this area in future periods will be contingent on the provision of more current data regarding those who are unable to decide. Further, the SME would like to discuss with LDH strategies to ensure that individuals who are unable to decide during in-reach encounters receive a more focused, and perhaps more prompt, follow-up visit. This visit could be timed based on

when the initial event, condition, or circumstance that rendered them unable to make a decision is likely to be resolved. This follow-up engagement should also focus on re-evaluating their decision-making capacity and identifying strategies to support their informed choice and if appropriate, participation in the transition planning process and preparation for discharge and tenure in the community.

Individuals on the AC – including those preparing for transition, who have been diverted, or have been transitioned – who present safety issues or who are perceived as at risk of returning to an NF are referred to the Transition Support Committee (TSC). The TSC reviews these cases and makes recommendation regarding the feasibility of transition or strategies to ensure community tenure for individuals who are transitioned or diverted. The TSC is responsible for reviewing these cases to determine if they are valid. The TSC also reviews cases in which the TC or CCM is requesting to provide additional support to transitioned or diverted members after their one-year service window.

LDH provided data regarding TSC activities from December 2023 to June 2024. During this period, the TSC received 16 referrals for case reviews; 15 were completed and one was pending. After review, the TSC recommended additional evaluations, services, or engagements for six individuals; additional home modifications for one individual; and determined that eight could not be served in the community due to safety concerns. Data in the tenth report showed that of the 17 referred to the TSC between July and November 2023, with 13 reviews completed and four pending. The TSC recommended that 10 of the 13 not be transitioned to the community. The remaining three reviews involved recommendations for increased support, including one instance where TC and CCM support was approved beyond the 12-month mandatory period.

Figure 31. Paragraph 53 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. For those who express interest in transition, the TSC referral and review process appears to meet the objective of this Paragraph. However, for those who are indicated as "lacking decision-making capacity" at the in-reach phase, additional procedures may be appropriate to support prompt re-engagement and safety planning.	1) LDH should determine whether additional procedures are needed for those who lack decision making capacity at the time of in-reach. 2) LDH should continue to ensure that individuals who present safety issues are referred to the TSC, and that cases and their outcomes are reported on.

V. Outreach, In-Reach, and Provider Training and 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 establish and implement a process to engage and educate the TP in NFs around their interest in moving and the availability of community-based services and supports. Based on the individual's response, they are assigned to either the ML or AC. If assigned to the AC, they are referred to TCs to begin the Nursing Facility Transition Assessment (NFTA) and Individualized Transition Plan (ITP) processes. For clarity, the SME uses

the term “in-reach” to describe the process used by LDH to engage individuals around their interest in transition; this is consistent with the terminology used by LDH despite the Agreement’s interchangeable use of “in-reach” and “outreach.”

Since the sixth report, peer-in reach (PIR) staff, informed by their lived experiences, have visited individuals on the ML in NFs, gauging their interest in transitioning into the community and providing education and information regarding community living. Historically, PIR staff have conducted initial in-reach as well as follow-up in-reaches based on a schedule LDH developed in consultation with the prior SME. Undecided individuals are required to receive quarterly face-to-face visits, not interested individuals receive face-to-face visits every six months, and “unable to decide” individuals receive annual visits. This process may undergo alterations due to the statewide scalability of the RITC program in 2025. However, given that the RITC was still in its pilot phase during this reporting period, this section of the report will center on the performance and quality of the PIR program.

LDH expects PIR staff to conduct 40 contacts per month, inclusive of initial and follow-up visits, documented through a standardized in-reach log. From January to June 2024, the number of monthly contacts ranged from 184 to 319, consistently falling beneath the 360-visit monthly target (based on 40 monthly contacts for each of the 9 PIR staff). There was a staff vacancy in region one that decreased the overall number of monthly visits. However, the PIR staff in place in the other regions only completed a range of 53% (March 2024) to 97% (May 2024) of their required contacts. LDH has implemented program improvements to this which will be reflected in future reporting.

During this reporting period, 1,557 individuals received initial or follow-up contacts, compared to 1,483 in the prior reporting period. Of the 1,128 individuals who received initial contacts, 90 (8%) were interested in transitioning, 189 (18%) were undecided, 626 (55%) were not interested, and 191 (17%) were deemed unable to make a decision. Comparison with the last reporting period shows similar rates of individuals who were unable to decide or undecided, but the percentage of individuals interested in moving declined significantly in this reporting period. In the last reporting period, 18% expressed interest, versus 8% in this period. LDH reports that PIR staff have increased their proficiency in discerning of the seriousness of individuals’ interest in transitioning and obtaining fully informed consent prior to adding them to the AC, which may have contributed to the 10-point drop in the proportion of individuals who express interest. This merits further investigation. The SME intends to independently review in-reach and other processes to ensure informed choice and overall effectiveness.

An important function of peer in-reach (PIR) is to engage everyone on the ML, some of whom have yet to be engaged around the opportunity to transition. In the last reporting period, 871 individuals on the ML had not yet been reached. As of the end of this reporting period, 526 individuals on the ML had not yet been reached, constituting about 13% of the ML. The SME understands that some of these individuals have been recently added to the ML and thus are not due for in-reach yet. However, it is likely that some, if not most, should have received in-reach. In the eighth report, the prior SME recommended that LDH design and implement several strategies to boost the quality of PIR, including (but not limited to): weekly supervision and team meetings, opportunities for mentoring/support (including shadowing of TCs), and revisiting of regional parameters in increase efficiency. He also recommended that LDH provide regular trainings and develop conversation guides to ensure that the PIR staff can more skillfully provide accurate and complete information about community housing and services options and respond

to concerns about moving expressed by individuals. LDH reported that they now provide individual supervision once every two weeks, with a full team meeting in the intervening weeks. They also convene a peer and TC workgroup to encourage cross-pollination of best practices, and this has resulted in peers inviting TCs to join them on PIR visits. LDH management has also convened regular trainings, shadowed PIR staff, and developed conversation guides, which were finalized and fielded in August 2024.

As noted above and discussed more fully in Paragraph 45, some PIR functions are now implemented by RITC staff. In its current pilot phase, RITCs serve as the first point of contact for individuals newly admitted into NFs within the pilot regions. Within those regions, PIR staff only conduct in-reach to those who were admitted to NFs prior to the launch of RITC or are not receiving transition support from the RITCs. This approach will be implemented in all regions when the RITC approach is scaled statewide in early 2025. As more in-reach obligations shift to RITCs, this should allow PIR staff to increase in-reach penetration of the ML and LDH to re-envision their optimal role in the Agreement overall.

Figure 32. 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, PIR staff are not meeting their monthly visit benchmarks, and a segment of the TP has yet to be reached.	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 (see related recommendation under Paragraph 40). 2) LDH should work with the SME and his team to develop an adapted role for the PIR staff, given the forthcoming shift to RITC.

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: Given that this provision applied to the first two years of implementation, the Paragraph is not rated. However, given that the spirit of the requirement is still relevant and important to the My Choice Louisiana program, the SME offers discussion and recommendations in this area.

LDH proposed a prioritization process in July 2018 to identify a cohort of individuals who had fewer transition barriers, based on information gathered from the MDS Q+ index and follow-up conversations between identified individuals and TCs. However, since this early stage in the Agreement, LDH has prioritized certain individuals based on their perceived level of interest in transition but not based on other perceived transition barriers. Individuals who indicate they want to transition are added to the AC, assigned a TC, and are in receipt of transition support, if they maintain interest throughout the process. As evidenced by the prior SME's service reviews,

even those with significant transition barriers and complex physical and behavioral health conditions have been able to successfully transition and maintain stability in the community. Therefore, LDH's decision to include people on the AC regardless of perceived barriers is appropriate.

While prioritization may not be necessary, equal access to opportunities to transition among all members of the TP must remain a priority. LDH should develop mechanisms to ensure that "creaming" does not occur, safeguarding that staff do not prioritize individuals who are perceived as easier to help or more likely to achieve positive outcomes. This will especially be important as the RITC program launches statewide and more attention is focused on newly admitted members. Those on the ML who were admitted prior to RITC, or those who initially declined RITC, must continue to receive assertive and skilled in-reach to ensure that they can transition if interested.

Figure 33. Paragraph 55 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Not Rated. This Paragraph indicates that LDH may utilize a prioritization approach. Since the initial stages of the Agreement, LDH has instead provided transition support to any individual who expresses interest in transition, regardless of likelihood of successful transition, location, availability of housing, or other factors. **[Paragraph 55 moved from Partially Met in the 10th SME Report to Not Rated in the 11th (this) SME Report. This Paragraph was intended to expire after the first two years of the Agreement's implementation.]**	1) Amid a shift to the RITC approach, LDH should create safeguards to ensure that all segments of the TP continue to receive equal access to in-reach and transition support services.

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 operationalized through the development of an annual implementation plan that establishes an annual transition target, reflecting the number of individuals LDH expects to transition within a given year. LDH utilizes historical data to develop a projection for how many individuals they believe can be feasibly transitioned within a given year. For the 2024 target, the State consulted with the prior SME to develop a new methodology to set a transition target, using information from CY2022 and most of CY2023 as a basis. This methodology started with the number of people on AC categorized as "actively working" toward transition, and adjusted the figure downward based on the percentage of individuals who have historically fallen out of the transition pipeline at various steps in the process. This methodology generated a transition target of 331 for CY2024, approximately the same transition target as CY2023.

It is important to note that a long-term timeline for transitions, including multi-year targets, has not been established by the Parties. The DOJ has expressed concerns about the methodology's reliance on past performance as a basis for projecting future transitions and its focus on the AC segment of the Target Population, among other limitations. It is the SME's hope that the analysis of the Target Population referenced herein can inform an improved approach to identifying the

number of potential transitions, including the potential development of timelines and targets that span multiple years.

Transition performance is one of the most important aspects of complying with this Agreement. The Agreement initially had a five-year projected end date, if the State had achieved compliance within that time, but now in the sixth year, LDH has consistently underperformed its transition goals. Transition performance seems to have peaked in CY2022 but decreased in the two years since. Figure 34 below provides a comparison of transition targets versus actual transitions since the Agreement has been in place. While there are minor discrepancies in various documents/records regarding exact transition figures, the parties have agreed to use the figures in Figure 34 for the purposes of this report.

Figure 34. 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	123 YTD	37% YTD
Totals	1,292	720	56%

Since CY2024 is not yet complete, Figure 34 displays the year-to-date actual transitions as of November 14, 2024 (n=123). Thus, the totals in the figure – including the number of achieved transitions and related performance percentage – will increase when the CY2024 data is finalized. Adjusted totals will be included in the 12th report.

One major development in LDH's approach to transition support is the implementation and scaling of the RITC program. As described in Paragraph 45, the RITC is designed to rapidly engage individuals newly admitted to NFs, ensuring telephonic contact within 3 days and in-person contact within 14 days. RITC staff gauge individuals' interest in transition, and if interested, commence assessment and transition support activities to prevent unnecessarily long tenures in NFs.

As of the writing of this report, the RITC is still in its pilot phase, operating in seven of the nine Louisiana regions. LDH plans to scale the program statewide in early 2025, concomitant with implementation of a new PASRR Level I process that will enable real-time notification of NF admissions to trigger RITC staff to be deployed to NFs in adherence to the three- and 14-day timeframe requirements. This replaces the legacy approach of deploying PIR staff to NFs to engage individuals already residing in NFs. PIR staff will now support the program by engaging individuals who have yet to be reached on the ML and conducting follow-ups for those individuals who decline transition support from the RITC staff.

LDH has invested significant thought and resources into improving TC management, oversight, and support. However, systemic barriers, including barriers outside of the TCs' control, also impede their ability to effectuate timely transitions and likely contribute to burnout. A sample of systemic barriers can be found under Paragraph 93's analysis section. The SME service review currently underway for 2025 has highlighted systemic barriers faced by individuals with intellectual or developmental disabilities (e.g., long wait times for OCDD screenings, unrecognized ID/DD issues), housing-related barriers (e.g., long wait-times for desired locations/units, lack of ADA accessible housing), issues with documentation gathering (e.g., lack

of clear role of NF staff, difficulty obtaining SSI/SSDI income verification or resolving benefits-related issues). In future service reviews, the SME's team will quantify systemic issues to assist LDH in understanding the magnitude and impact of these systemic issues, in hopes that addressing these barriers will improve overall transition performance.

Figure 35. 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 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 identify and develop specific plans to address known and ongoing systemic barriers that impede transitions. 2) LDH should implement the recommendations under Paragraph 40 to improve transition timeliness.

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: Per the 2024 service reviews, all 39 individuals (transitioned or diverted) included in the review sample either returned to their previous living situation or to community-based housing of their choosing. Service review data, as well as information from other data sources, demonstrates that the plurality of transitioned members is moved into permanent supportive housing. During this reporting period, one member of the TP transitioned to a group home but moved into her own apartment a few months later.

The second part of the requirement involves transitioning individuals to integrated housing options in adherence to the timeframes established in their ITPs. The FY2024 service review showed that TCs generally initially establish a generic transition date at six or twelve months after ITP initiation, but then made date adjustments based on the individual's needs, the timeliness and progress of transition readiness tasks, and the presence of hurdles that slow down the process (e.g., availability of housing in an individual's preferred neighborhood or ADA-accessible housing). This means that, by virtue of updating the transition dates, technically, LDH is moving individuals into housing by the dates specified in their ITPs. However, as referenced in Paragraphs 40 and 56, the timeliness of transitions is declining.

The Paragraphs pertaining to housing are not assessed in this six-month reporting cycle but will be included in the 12th SME report. However, it is important to note that LDH considers housing as its most common transition barrier and has developed a housing plan to inform the development of housing supply and other key strategies. Future reports will provide more analysis on housing-related barriers and analyze LDH's efforts to increase ADA-accessible housing supply and housing units in the neighborhoods in which transitioned and diverted individuals prefer to live, optimize and braid funding to ensure voucher availability, improve the efficiency of housing search and matching processes, and other activities to develop and secure housing for members in the TP.

Figure 36. Paragraph 57 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Met. LDH has developed a program that utilizes permanent supportive housing as the default housing option. LDH completes transitions within specified and individualized timeframes, although the transition date is adjusted to account for the timeliness of specific transition activities, barriers, and other factors.	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.

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: After utilizing another group to execute the functions in this Paragraph, in the ninth reporting period, LDH established what is now known as the TSC. The TSC launched in May 2023, and is responsible for providing input/guidance on difficult cases, exploring and identifying solutions for known systemic barriers, and analyzing the causes and potential remedies for readmissions after community placement, among other duties. Paragraph 53 provides a summary of the cases referred to the TSC and their dispositions, from December 2023 to June 2024.

It appears that the TSC's work centers on the review of and provision of recommendations around individual cases. However, this Paragraph contemplates an additional role for the TSC, the review and remediation of systemic barriers that impact multiple members of the TP. As discussed in Paragraphs 51 and 53, LDH has extant data sources that point to trends in transition barriers that could be shared with the TSC. LDH reports that in the first quarter of 2025, they plan to incorporate this function to the TSC duties by providing a consolidated inventory of systemic barriers to inform their discussions about potential solutions. The SME's service review process often highlights additional systemic barriers, as noted under Paragraph 56, which could be provided to the TSC for further investigation and solutioning. In 2025, the TSC will also adopt the review of all NF readmissions among individuals who were transitioned under the My Choice Louisiana program, to inform strategies to prevent needless readmissions.

Figure 37. Paragraph 58 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. The TSC appears to be focused on individual case reviews, but the Agreement requires them to play a role in identifying and formulating strategies around systemic barriers.	1) LDH should implement their planned process to provide information on systemic barriers to the TSC and gather recommendations to better understand and address identified barriers. 2) LDH should finalize the TSC's scope as it relates to analyzing the causes of readmissions and providing individual and systemic findings to prevent needless readmissions.

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: As indicated in the seventh report, LDH implemented the CCM program in March 2022. MCOs operate the CCM program through regional providers that offer case management to individuals who are projected to be transitioned within 60 days or who have been diverted from NFs. Participation in CCM is voluntary and is limited to individuals enrolled in Medicaid MCOs. CCM is available for up to twelve months from the date of transition or diversion, but can be extended for beyond 12 months on a case-by-case basis. Per LDH, CCM programs must ensure caseloads of no more than 15 individuals per CCM. Should an individual be readmitted to a NF while receiving CCM services, LDH requires the CCM to remain engaged unless the member declines services or is expected to remain in the NF for longer than 30 days.

LDH provided the SME with information regarding the CCM engagement rates of individuals nearing transition, transitioned, or diverted. Figure 38 provides this data for the January to June 2024 reporting period. Overall, the number of active CCM members has decreased compared to the prior reporting period. A range of 243 to 296 individuals per month were engaged in CCM from January to June 2024, while a range of 339 to 367 were engaged from April to September 2023. LDH reports that the decrease is attributable to a drop in transition performance, thereby decreasing the pool of individuals offered and ultimately accepting CCM.

Figure 38. CCM Engagement by Month

Individuals Receiving CCM	*Jan*	*Feb*	*March*	*April*	*May*	*June*
In NF Nearing Transition	55	43	36	36	40	31
Transitioned	196	179	173	174	167	167
Diverted	42	45	34	44	51	54
Total Individuals Receiving CCM	296	267	243	254	258	252

Ninety-four individuals were referred to the program from January to June 2024, 55 individuals preparing for transition and 39 diverted individuals. Eighteen individuals declined CCM, including five diverted individuals and 13 transitioned individuals, consistent with the number of declines in the prior reporting period. LDH provided information, reflected in the eighth report, on reasons individuals did not enroll in CCM. Individuals did not enroll because they were unable to be reached by the CCM, were not interested, or were readmitted to an NF. LDH also provided disenrollment data for April to June 2024, showing that most disenrollments occur due to completion of the 12-month CCM program, deaths, or loss of Medicaid eligibility. Additional data on the CCM program can be found under Paragraph 60 in this report.

While this information is helpful to identify the number of individuals actively receiving CCM within a given month, improvements in data reporting are needed for the SME to better understand engagement and utilization tied to the CCM program. Metrics of interest to the SME include: (1) how many individuals within the given month should have been referred to CCM (i.e., those within their 60-day pre-transition window, outside of that window but deemed by the TC as appropriate for referral, or those diverted), (2) how many of those individuals were offered CCM, (3) how many of those individuals accepted versus declined CCM, (4) how many engaged in CCM after initial acceptance, and (5) how many are approved to remain in CCM services after one year. LDH reports that some of these metrics are already tracked, and enhancements and streamlining of data collection and reporting may be helpful to fully demonstrate program impact.

Figure 39. 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 collaborate with the SME to improve CCM utilization, engagement, and outcomes monitoring and reporting.

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 indicated in this report, 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 the diverted individual 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 standard operating procedures establish requirements and associated timeframes for community assessments, re-assessments, 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. The 2024 service review found:

- There was little staff turnover among CCMs for the individuals participating in the 2024 review, representing an improvement over CCM turnover issues observed in the 2023 review.
- Among those who had transitioned, 19 of 23 (83%) had their required CCM documentation, including community assessments, CPOCs, and crisis plans; the remaining four had valid reasons for the absence of documentation, including documentation not yet being due for two individuals who had recently transitioned, documentation being delayed due to an individual experiencing a crisis, and documentation being delayed for an individual who was unsure about participating in the program. In the 2023 service review, CCM documentation was present for all 29 members reviewed except for one individual who was lacking a crisis plan.
- Among those who were diverted, all had required CCM documentation except for a member who, after enrollment in CCM, was admitted into a NF for rehabilitative purposes.
- Quality of documentation improved in 2024 compared to 2023. For transitioned members, the average quality score of community assessments increased from 85% to 91% and for

community plans of care, 69% to 73%. For diverted members, average quality scores increased from 90% to 91% for community assessments and 69% to 78% for community plans of care.

- While there were improvements in the CCMs' sharing of the CPOC among treatment team members and convening of team meetings, there were some individuals in the 2024 service review for whom there were few or sporadic team meetings to discuss changes in condition or services.
- One goal of the CCM program is to prevent needless readmissions. During this reporting period, there were 11 readmissions, constituting 3% of all transitions, which was an improvement over the 11% readmission rate in the last reporting period. Readmission rates for several preceding periods hovered around 5%.

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) review whether there is alignment between what an individual is assessed as needing and what services are planned for, as evidenced by their inclusion in the CPOC. The 2024 review found that for transitioned members, 20% of CPOCs did not contain referrals to medical services and 16% did not contain referrals to behavioral health services, despite individuals' needs in these areas made evident in their assessments. For diverted members, one-third did not have reference to medical services and one-third did not include behavioral health services. It is important to note that the 2024 service review showed improvements in these areas compared to 2023, but further progress is needed. 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 2024 service review provided an average community inclusion score of 2.66 out of five for transitioned individuals, compared to 2.38 in 2023. These scores reflect the SME and his team's impression of overall community inclusion outcomes versus the CCM's specific performance in this area. The 2024 service review also showed that CPOCs have improved with respect to incorporating community integration activities, but the SME team was not clear whether community integration-related goals were being implemented.

Figure 40. 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 compared to 2023, including around the quality and completeness of CPOCs. However, to meet the intent of this Paragraph, CPOCs should more consistently reflect the comprehensive service needs, the frequency and duration of needed services, and activities to facilitate community integration. CCMs should also confirm that individuals are in receipt of such services, including in the appropriate frequency, intensity, and modality (e.g., in-person versus telehealth).	1) LDH should clearly communicate its expectations that CCM CPOCs specify the duration and frequency of planned services and provide appropriate guidance and monitoring to improve performance. 2) LDH should determine the role of various service providers (e.g., ACT teams, peers, PCS) in facilitating community integration, and monitor implementation of the new policy that CCMs have dedicated discussions with individuals around 60 days after discharge.

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 seventh 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. Consistent with the two prior service reviews, the CY2024 service review assessed the extent to which CCM assessments and CPOCs facilitate person-centered planning. The review revealed that goals in the CPOCs continued to be stated in the individuals' words, and the CPOCs contained individuals' strengths, preferences, and signatures. As noted in Paragraph 60, the CPOCs did not consistently identify services and strategies to address all the needs identified in assessments and specify the amount, frequency, and duration of services post-transition. They also did not consistently include revisions when there was a significant change in condition.

The State has also required MCOs to ensure CCMs receive the person-centered planning training that was developed and implemented in the fifth reporting period. The State reports that CCMs are required to complete person-centered planning training prior to delivering CCM services. In June of 2024, the last month of this reporting period, CCM agencies were provided with a person-centered planning checklist, designed to educate CCM providers regarding strategies to ensure plans are person-centered. LDH, in consultation with the SME, also developed a complementary training module. It is expected that CCMs will receive training in the use of this checklist beginning in the next reporting period.

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 community life. Per LDH's Service Utilization Report, more than a third of all transitioned individuals utilize ACT. 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 behavioral health 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, consistent with recommendation two under Paragraph 60, CCMs should be able to clearly delineate which care team members are responsible for supporting community integration.

Figure 41. Paragraph 61 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. Based on the 2024 service review, CPOCs include many person-centered planning components. However, more consistent training, including use of the person-centered planning checklist, should be fully implemented.	1) LDH should implement the person-centered planning checklist (with associated trainings), consider providing person-centered planning training more regularly, and ensure that CCMs are equipped to arrange for other community integration supports and services.

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 continues to receive standardized monthly reports from MCOs that includes initial and ongoing contact between the individual by the CCM; the date community assessments and community plans of care were developed; whether the individual received all services on his/her plan of care this 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. Information collected through the tracking system is discussed in more detail in paragraphs 98 and 99.

The prior SME reviewed a sample of standardized monthly reports on a quarterly basis to determine if these reports were complete. The most recent monthly report the SME reviewed was April 2023. The SME reviewed this report to determine whether information was complete for individuals who were transitioned or diverted from an NF. The review found that almost all the 338 individuals had complete information in the tracking system. Individuals who were pre-transition or readmitted to an NF and stayed longer than 90 days did not have completed information, given they had yet to transition or were no longer receiving CCM.

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. CCMs are to report on each contact and whether the contact was face-to-face or virtual.
During this reporting period, OAAS and OBH leadership 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 individuals' documentation and face-to-face visits with each individual. LDH and the service review teams met with individuals to discuss their transition experience, current goals and interests (e.g., community inclusion, employment), services received, and gaps in care. LDH reports participating in these service reviews is beneficial to understand the impact the My Choice Program has on individuals as well as drawing on the lived experiences of these individuals to make changes to the program.

The combination of the CCM tracking system and LDH's participation in service reviews provides valuable information regarding the My Choice Program. LDH should use this information in a structured way to make future decisions regarding the My Choice Program. Specifically, it will be important for LDH to incorporate information from the tracking efforts to the overall quality efforts described in paragraphs 98 and 99.

Figure 42. Paragraph 62 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Met. LDH has established MCO reporting requirements to ensure that CCMs are effectively monitoring the experiences and outcomes of TP members who have transitioned into the community.	1) LDH should continue to review data from CCMs to ensure that the cadence required for face-to-face and other visits is being met.

	2) The State should report how they are incorporating the data from the MCO CCM and quarterly service utilization reports in the overall quality improvement process to determine if there are systemic health and safety issues, gaps in services, and efforts that have been successful in addressing these issues.

VI. Community Support Services

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: 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.

The State received 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, including an incentive-based payment structure, to spur increased adoption of the new service. As of the end of this reporting period, two LGEs and two PSH programs were credentialed by MCOs to deliver the standalone peer service. Of note, one of the credentialed PSH programs operates in six of Louisiana's eight regions. Data as of March 2024 shows that this service has not yet been utilized.

However, it is important to underscore that peer support is also embedded in other behavioral health programs in Louisiana, including LGE and ACT services. TCs, CCMs, and other supporters should be made aware of the full range of peer services available to members of the Target Population, including accessibility by region, eligibility rules, peer support specialty (e.g., substance use, mental health), if the peers support can be accessed by individuals residing in NF and/or in the community, and other details. Further, LDH should ensure that ACT teams continue to be staffed with peers and that these peers are addressing community integration. Further, as noted in the recommendation under Paragraph 54, LDH should consider refining its PIR model given the shift to RITC.

Figure 43. Paragraph 79 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Not Met. Four programs were credentialed to deliver standalone Medicaid-reimbursable peer services	1) LDH should develop a comprehensive region-specific inventory of peer services for TCs

during this reporting period, and peer services embedded in other parts of the system of care serving the TP continued to operate. However, continued expansion of peer services, and a coordinated strategy to link TP members with such services, is needed.	and CCMs, to better equip them to link TP members to peer services. 2) LDH should continue to implement strategies to increase LGEs' and PSH providers' willingness and capacity to offer Medicaid billable peer support services. 3) LDH should ensure that ACT teams include peer support services, and that ACT peers are expected and equipped to address issues of loneliness and lack of community inclusion.

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 and 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, LGEs, the Louisiana Enhancing Aging with Dignity Through Empowerment and Respect (LEADER), local law enforcement, EMS, coroners' offices, the Statewide Judges and Public Defenders Associations, and other groups. The State also continues to post the SME reports and quality matrices.

The prior SME identified gaps in LDH's stakeholder engagement approach. To comply with this Paragraph, he recommended that LDH develop and effectuate an approach to engage persons with lived experience, enhance its website, and develop a quarterly newsletter or similar communication effort to update a broad base of internal and external stakeholders regarding My Choice program activities. OAAS reported that they have launched an internal monthly newsletter that will serve as the basis for a quarterly cross-agency newsletter, but it is unclear whether the newsletter is internal or external.

Figure 44. Paragraphs 86-87 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. LDH has continued to engage integral stakeholders. To ensure that all relevant stakeholders are engaged with targeted messages to support the aims of the Agreement, LDH should develop a comprehensive outreach and communications plan.	1) LDH should develop a revised comprehensive 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. This plan should leverage the voices of individuals with lived experience and LDH's existing committee structures.

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: As reported by the prior SME, LDH has collaboratively engaged with law enforcement, courts, and corrections officials to educate them about the new crisis services system. Beyond coordination with the crisis system, collaboration with justice system stakeholders has other benefits to the Target Population. LDH should develop an organized strategy that ensures that service providers under the Agreement (e.g., ACT teams, CCMs, TCs) understand their role in preventing, limiting, and/or providing support around criminal justice system involvement among members of the TP. This strategy should be bidirectional, ensuring that Agreement-related service providers have identified local points of contact with justice system stakeholders, and apprising justice system stakeholders of the services and supports provided to the Agreement's TP members. Relationships between these service providers and criminal justice stakeholders may also support better coordination if individuals are victimized or need other types of support or intervention from law enforcement. The monthly sample of CCM critical incidents provided to the SME for review included events where TP members had interactions with law enforcement.

Figure 45. 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.

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.

See paragraph 54 for discussion.

Figure 46. Paragraph 89 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. See the compliance determination rationale in Paragraph 54.	See recommendations in Paragraph 54.

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 to IPS, peer support, CCM, crisis, and other behavioral health providers. They have also collaborated with the IPS Employment Center and ODEP Policy Academy to spur adoption and improve delivery of IPS. Of note, LDH also provided a series of person-centered planning trainings for PIR, TCs, CCMs, and other OAAS and OBH staff. They plan to extend this training to OAAS Home and Community Based Services staff in 2025. Further, MCOs continue to train community providers on foundational competencies in behavioral health care delivery (e.g., responding to trauma, administering the LOCUS) in addition to operational trainings (e.g., prior authorization processes, reimbursement).

Over the past several reports, the prior SME has recommended that LDH establish a centralized provider training policy and associated curriculum, to include initial and continuing training requirements. He has also recommended that LDH develop a training website with an events calendar, recordings of past trainings, and other resources. He also proposed that people with lived experience participate in the design and delivery of these trainings. These enhancements are needed to improve compliance with this Paragraph.

Figure 47. 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. Additional strategies are also needed to ensure that these trainings are achieving their desired outcomes in terms of the delivery of quality services.	1) The State should develop a single site to facilitate, communicate, and store training opportunities associated with the My Choice program. 2) The State 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. The SME service review is designed to assess the quality and sufficiency of community-based services for members of the TP. As a part of the service review, the SME is responsible for reviewing a representative sample of individuals in the TP. The current service review process assesses members' experiences with and outcomes related to the services they receive as part of the Agreement. The prior SME conducted three service reviews and issued accompanying reports in 2021, 2023, and 2024. These reports provide information regarding the service review approach and methodology, key findings, and recommended improvements that are responsive to the issues he and his team identified. As of the writing of this report, the new SME is conducting the 2025 service reviews.

To illustrate how the SME service review process supports this Paragraph's aim of ensuring the quality of community-based services, Figure 48 below provides a synopsis of the prior SME's service review findings, comparing them with the 2023 service review's findings to identify improved or worsened performance. Further, the table contains recommendations made by the former SME to address identified issues, many of which involve enhancements to the quality of services. This is intended as a summary of information; more detailed and nuanced information can be found in the 2024 service review report. The information is organized around the three cohorts that are subject to service reviews: transitioned individuals who are still within one year of their NF discharge date, diverted individuals still within one year of their NF diversion, and individuals still residing in NFs who are preparing for transition.

Figure 48. 2024 Service Review Improvements, Issues, and Recommendations

	Transitioned	**Diverted**	**In NF**
Improvements	▪ All individuals transitioned into their own apartments or back to their homes ▪ Less CCM turnover ▪ Fewer individuals lost Medicaid coverage or had SSI/SSDI issues ▪ Fewer individuals had all-cause admissions ▪ Better coordination across interdisciplinary care teams ▪ Better inclusion of community integration goals ▪ Fewer issues accessing pain management medication	▪ More likely to receive physical and behavioral health services ▪ Fewer all-cause admissions ▪ Prevention of medication access issues ▪ Improved quality in community plans of care, including goals related to community integration ▪ Less turnover among CCMs	▪ Identification of transition date within 7 days of ITP ▪ Engagement of CCM within 60 days of planned transition ▪ Presence of both NFTA and ITP ▪ More complete, high quality, and timely NFTAs and ITPs ▪ Less TC turnover

		▪ Improved care team communication	
Continued/New Issues	▪ Lack of alignment between CCM assessment and CPOC and lack of duration, frequency, or specified provider for needed services ▪ Lack of peer/alternative supports ▪ Potential over-reliance on TC support post-transition ▪ Need for enhanced discharge planning to prepare for TC and CCM service termination after 12 months	▪ Gaps in ADL/IADL supports immediately following diversion ▪ Lack of alignment between CCM assessment and CPOC and lack of duration, frequency, or specified provider for needed services ▪ Lack of peer/alternative supports ▪ Lack of preparation for independent living for those living with aging family members	▪ Default transition date 1-year after NFTA ▪ Meaningful monthly conversations not captured ▪ Delays in transition support activities until housing is secured ▪ Lack of person-centered approach ▪ Lack of uniformity in housing search process ▪ Lack of clear NF role in transition support
Recommendations	▪ Complete required CPOC updates ▪ Ensure required interdisciplinary team meetings are occurring at cadence specified in SOPs ▪ Enhanced CCM support around community integration ▪ More judicious use of TCs post discharge ▪ Improved pain management resources ▪ Clarity regarding division of labor between ACT and PCA providers ▪ ACT awareness of CM and TC time limits and overall improved termination process		▪ Improved timeliness and quality of TC documentation ▪ Better process for TCs to identify and escalate transition barriers ▪ Enhanced person-centeredness ▪ Clearer role identification and support for TC advocacy regarding NF roles in transition preparation

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. LDH has also embarked on incorporating "service review mentality" into their management approach, planning to adopt some of the tools and processes designed by the prior SME and his team to strengthen their direct oversight of TCs, continuously review and refine Agreement-related processes, and address systemic issues.

Another strategy to ensure the quality of services involves the TCs' monitoring of individuals after they have transitioned. As noted in Paragraph 49, LDH requires post-discharge TC engagements at a specified cadence, partly to understand whether transitioned individuals are getting the support they need after NF discharge. The consistent occurrence and the quality of these engagements has not been reported by LDH, including whether there is alignment between TC and CCM documentation with respect to whether the individual is receiving planned and needed services.

For individuals engaged in CCM, CCMs utilize a monthly monitoring form to assess whether planned/needed services are being received by an individual, whether there are issues, what the CCM is doing to address identified issues, and additional narrative for context and detail. Per LDH, CCM supervisors are engaged in this process, and MCOs have weekly rounds, designed to address other issues that emerge among individuals living in the community, including unmet service needs.

While the SME's service review and post-discharge TC visits are helpful tools to understand the quality of community-based services, a more robust approach is needed to ensure that services are supporting the outcomes envisioned in this Agreement: the "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)." The prior SME and his team observed a particular lack of focus on supporting community integration among transitioned individuals. The new SME shares that concern based on preliminary findings in the 2025 service reviews.

LDH should develop a more robust evaluation strategy of the existing services delivered under or associated with the Agreement. LDH currently conducts fidelity reviews and evaluation of its ACT teams, but other services – such as personal care services (PCS), peer services, Individualized Placement and Support – do not appear subject to programmatic evaluation, beyond standard oversight by Health Standards (if applicable), inclusion in MCO quarterly oversight reporting, and LDH utilization tracking. Given that nearly half of transitioned individuals receive PCS, evaluation of the quality of that service should be prioritized. LDH reports that PCS services delivered through OAAS are reviewed and surveyed by their licensure authority, LDH's Health Standards. For behavioral health PCS, MCOs conduct a quarterly review of a representative sample of behavioral health providers, which may include PCS. During this reporting period, one PCS provider was part of the sample, and this provider required corrective action.

Figure 49. 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 develop a quality evaluation approach for additional Agreement-related services, such as PCS. 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: The State has implemented a quality assurance system, including the following efforts:

- As described in Paragraphs 98 and 99, LDH has developed a Quality Matrix (Appendix A) to monitor many areas required by this Agreement and continues to review and make changes to measures in the Quality Matrix to incorporate feedback from stakeholders. Paragraph 98 and 99 identifies areas where additional work on the Quality Matrix is needed, such as developing methodologies, developing data collection and analysis procedures, defining benchmarking or trending indicators, and other refinements.
- In the last reporting period, LDH reconvened the Internal My Choice Quality Committee and the external Quality Resource Group. Charters were developed for both committees. Responsibilities include refining the Quality Matrix and reviewing SME service review findings to advise on strategies to address systemic issues. The internal committee met monthly during this reporting period, except for in January due to a holiday. The external committee was not convened during this reporting period but met three times in the second half of 2024.
- The State completed the first Annual Quality Report for the My Choice Program during the seventh and eighth reporting periods. This plan incorporates the work that has been done to collect and analyze data on some of the measures required in paragraph 99. It also 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. The State has developed, but not yet finalized, the second Annual Quality Report for CY2023. As of the writing of this report, it is still not finalized.
- LDH has developed procedures for the Internal My Choice Quality Committee to provide data and information from LDH's quality assurance data collection and analysis activities to the TSC, but this process has not yet been operationalized.

Figure 50. 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, and the 2023 Quality Report should be finalized.	1) LDH should implement a process for the TSC 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) LDH should finalize the 2023 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 in receipt of the services required in the Agreement, as well as evaluate data on these services as part of its ongoing quality improvement efforts. For the purposes of this paragraph, LDH has applied this requirement to individuals in the TP who have been diverted or transitioned from NFs in the last 12 months.

CCMs are responsible for completing CIRs as one of their case management responsibilities. As indicated in previous reports, the State defines critical incidents consistent with various federal Medicaid Waiver programs. In addition, CCMs track and report ED visits and inpatient hospitalizations to LDH separately on a quarterly basis, even though LDH no longer considers these critical incidents. LDH reports on the total number of critical incidents for individuals enrolled in CCM and provides a sample report to the SME for review. For June 2024, there were 16 individuals who experienced 19 critical incidents, which were categorized as major behavioral disturbances (6), law enforcement interactions (5), major medication incidents (2), loss or destruction of property (1), exploitation (1), abuse (1), neglect (1), eviction (1), and other (1). These incidents triggered four Adult Protective Services referrals and two referrals to Health Standards.

In addition, the State reported all-cause emergency department (ED) and inpatient visits (IP) during quarter 4 of 2023 and quarter 1 of 2024 for diverted and transitioned members, displayed in Figure 51. The figures reflect the percentage of diverted and transitioned members (within 12 months after diversion or transition) who utilized these levels of care, including for behavioral health reasons.

Figure 51. All-Cause ED/IP Utilization (2023 Q4 & 2024 Q1)

Time Period	Incident	Transitioned	Diverted
Q4 CY2023	ED	7.6% (1.6% BH)	20.6% (7.4% BH)
	IP	5.1% (2.8% BH)	13.2% (8.8% BH)
Q1 CY2024	ED	7.4% (1.8% BH)	22.2% (8.6%)
	IP	3.7% (1.5% BH)	16.0% (12.3% BH)

A comparison between this data and data from quarters 2 and 3 of 2023 offers mixed results. A smaller percentage of transitioned individuals utilized the ED and IP in the more recent quarters; for instance, there was a 3.5% drop in ED utilization and a 1.5% drop in IP utilization between quarters 3 and 4 in 2023. However, there was more ED and IP utilization in the more recent period among the diverted population. For example, there was a 10.5% increase in ED utilization and 4% in IP utilization between quarters 3 and 4 of 2023.

Figure 52. 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 the CIRs and major medical/behavioral incidents. **[Paragraph 95 moved from Partially Met in the 10th SME Report to Met in the 11th (this) SME Report.]**	None.

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 critical incident management and quality improvement processes for community providers and the State's Medicaid MCOs. As discussed in the tenth report, LDH has established processes, protocols, and contractual language that stipulates CIR requirements for community providers and MCOs. Similar requirements are in place for long-term supports and services overseen by OAAS and OCDD. The tenth report also provides more 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. OBH reports they share feedback and recommendations with the MCOs via reports and quality workgroup meetings.

For this reporting period, the MCOs provided LDH with information on the first quarter of 2024 on critical incidents among individuals enrolled in their plans. The State reports seventeen (17) critical incidents during Quarter 1 of 2024. Three (3) incidents involved staff at a youth residential/inpatient facility who were not members of the TP. These three incidents were investigated by the MCO and were reported timely and referred to the respective authorities (e.g., protective services, Health Standards Section). None were reported for Medicaid behavioral health community providers. As indicated in the tenth SME report, the State indicates that most CIRs do not involve the community provider but rather non-paid caretakers/relatives who may abuse or exploit the individual.

Figure 53. Paragraph 96 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating and Rationale	***Priority Recommendations***
Met. LDH has established and oversees processes for MCOs and long-term supports and service programs, which require critical incident reporting and remediation, and provides such information to the SME on a regular basis. **[Paragraph 96 moved from Partially Met in the 10th SME Report to Met in the 11th (this) SME Report.]**	None.

97. The State will establish reporting and investigation protocols for significant incidents, including mortalities. The protocols will require a mortality review of deaths of individuals in the Target Population in specified circumstances, including any unexplained death, any death within 60 days of discharge from a NF, and any death in which abuse, neglect, or exploitation is suspected. 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 mortality review reports. As indicated in the eighth 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, information on the mortality reviews conducted thus far, and remediation strategies undertaken by the State based on these reviews. The State has not posted either of the two completed Mortality Review Reports for public review or comment.

LDH reports that there were nineteen deaths from 2020 to 2022 and 27 deaths in 2023. As indicated in previous reports, the Integration Coordinator reviews each death and uses established criteria discussed in the tenth SME report to make a referral to the MRC. A total of 27 deaths were referred to the MRC from 2020 to 2023. All reviews have been completed except for one that was still in process as of October 2024. The 2023 Mortality Review Report indicated that five of the 14 deaths reviewed by the MRC were referred to Health Standards. For eight additional deaths, the MRC recommended and LDH required corrective action plans from providers who were serving the decedents.

On average, the MRC concludes their reviews within seven to eight months, within the one-year period established by the Agreement. The State reports there are several barriers, however, 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 54. 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. **[Paragraph 97 moved from Partially Met in the 10th SME Report to Met in the 11th (this) SME Report.]**	1) LDH should investigate the contributors to increased mortalities in 2023 when compared to prior years. 2) The State should post the first two mortality reports and produce and post future reports in a timelier fashion.

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. Per the prior SME, as of the last reporting period, there were 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 sixty-two overall measures, several are internal and operational to LDH, including measures on PIR, PASRR Level II, and AC activities. For this report, the SME reviewed the public-facing thirty-eight measures in the Quality Matrix (see Appendix A) and identified the following gaps:

- The measure tied to Paragraph 98 has yet to be finalized or collected. This measure is designed to collect whether provider and MCO services are available and delivered in the appropriate amount and intensity to members of the TP. The new SME has not discussed this measure specifically with LDH. He acknowledges that it may be difficult to capture, but several data sources (e.g., CPOCs prepared by CCMs, ITP addenda) could be better leveraged to determine whether TP members are accessing needed services at the right intensity. Also, implementation of the recommendation in Paragraph 49 regarding improved LDH oversight of the delivery of services post-transition is aligned with the intent of this Paragraph.
- LDH has yet to develop a measure for 99(d): The number of individuals who have used residential treatment facilities. The prior SME noted in his 10th report that LDH does not designate residential treatment facilities. Additional discussion may be needed to determine whether LDH should capture TP individuals' engagement with comparable levels of care (e.g., group homes) to comply with the spirit of this Paragraph.
- Additional work on the methodology, data sources, and benchmarks measure 99.f, focused on choice and self-determination, is still needed.
- The 2023 Quality Matrix included data for all four quarters of 2023. LDH should determine a feasible timeframe to provide quarterly updates, factoring in claims and other data lags, and provide data to the SME and DOJ on that established schedule.
- Of the fifteen measures that compared 2023 data to established benchmarks, data from nine measures met or exceeded the benchmark and four performed lower than the benchmark. The SME was unable to assess performance in the other two measures.

Figure 55. Paragraphs 98-99 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. The State continues to collect data on the availability, accessibility, and quality of services, but gaps to comply with this Paragraph remain. For example, as discussed above, LDH is not yet able to monitor whether individuals received services in the appropriate amount, frequency, and duration.	1) LDH should work with the SME to address the remaining gaps in the Quality Matrix for 98.1, 99.d and 99.f., as well as other improvements.

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 Target Population analysis recommendation under Paragraph 24, 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 TCs in response to the SME service review reports. 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.

However, to fully comply with this Paragraph, LDH should develop 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 process should also track whether those interventions achieve their desired impact. One way to operationalize the intent of this Paragraph is for LDH to identify a narrow set of high-priority interventions on a quarterly basis for implementation and outcomes monitoring.

Figure 56. 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) LDH should develop a tracking process to determine if the strategies the State has put into place to address issues identified through the quality assurance process have achieved their intended outcomes.

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)

The State has provided the SME with utilization information for the fourth quarter of calendar year (CY) 2023 and the first quarter of CY2024 for individuals who were transitioned and diverted. The SME has compared utilization of services across quarters 1 of 2022, 2023 and 2024. Appendix B provides the percentage of diverted and transitioned members who engage with numerous services, comparing utilization rates between the first quarters of 2022, 2023, and 2024. Highlights include:

- There was a decrease in the percent of transitioned and diverted individuals who did not receive a behavioral health service. In quarter 1 of 2022, 59% of transitioned individuals did not receive a behavioral health service. This percent declined in quarter 1 of 2023 and 2024 to roughly less than 25%. There was a similar decrease in the percent of diverted individuals who did not receive a behavioral health service. In quarter 1 of 2022, 55% of diverted did not receive a behavioral health service. This percent declined in quarters 1 of 2023 (25%) and 2024 (20%).
- There was a continued increase in the percentage of transitioned and diverted individuals who received ACT. In quarter 1 of 2022, 24.3% of transitioned individuals received ACT. This percentage increased in quarter 1 of 2023 (32%) and 2024 (38.8%). There was a similar increase in the percentage of individuals who were diverted and received ACT, reflecting 11.8% in 2022, 21% in 2023, and 27.7% in 2024.
- There was a slight increase in the percentage of transitioned individuals receiving outpatient behavioral health services (services provided by a LMHP or SUD services) between quarter 1 of 2022 (2%) and quarter 1 of CY2023 (5%). In quarter 1 of 2022, 31.4% of diverted individuals received these services. In quarter 1 of CY2023, this dropped significantly to no utilization and then increased 8.8% in 2024. The SME suggests that the State review this data given these significant discrepancies.
- There was variation (mostly increasing) in the percentage of transitioned individuals who received PCA services (CCW and 1915b) from quarter 1 of 2022 (43% and 0% respectively) versus 2023 (42% and 2% respectively) and 2024 (47% and 8.3% respectively). There was an increase in the percentage of diverted individuals who received PCA services (CCW and 1915b) from quarter 1 of 2022 (3.9% and 0% respectively) through quarters 1 of 2023 (4% and 4% respectively) and 2024 (14.8% and 8.3% respectively). The lack of 1915b PCA service may be due to the program starting in CY2022.
- There was minor change in the high percentage of transitioned individuals receiving preventative services (including primary care) from quarter 1 of 2022 (84%) compared to 2023 (76%) and 2024 (83.9%). However, there was a more significant increase in the percentage of diverted individuals receiving preventative services: in the first quarters, 62% in 2022, 73% in 2023, and 76.7% in 2024.

- As indicated in Paragraph 95, all cause ED utilization was lower for transitioned individuals in the first quarters of 2023 and 2024 (7% and 7.4% respectively) compared to 2022 (14.6%). All-cause ED utilization varied for diverted individuals. In the first quarter of 2022, the percentage of all-cause ED visits for this population was 33%. All cause ED utilization decreased to 13% in CY2023 and rose to 22.2 % in the first quarter of CY2024.
- As indicated in Paragraph 95, ED utilization for behavioral health reasons was lower for transitioned individuals in the first quarters of 2023 and 2024 (2% and 1.8% respectively) compared to 2022 (4%). ED utilization also decreased for individuals diverted from NFs. In the first quarter of 2022, the percentage of behavioral health ED visits for this population was 23%. Behavioral health ED visits decreased to 8% in 2023 and rose slightly to 8.6% in 2024.
- The percentage of transitioned individuals utilizing inpatient services (all cause) in the first quarter of 2022 (22.7%) was greater than the first quarters of 2023 and 2024 (5% and 3.7% respectively). The percentage of individuals diverted from NFs and utilizing inpatient services (all cause) in the first quarter of 2022 was greater (27.5%) than the first quarters of 2023 and 2024 (21% and 22.2% respectively).
- The percentage of transitioned individuals admitted to inpatient care for behavioral health reasons was higher in the first quarter of 2022 (5.7%) than the first quarters of 2023 and 2024 (3% and 1.5% respectively). The percentage of individuals diverted from NFs and utilizing behavioral health inpatient services was greater in the first quarter of CY2022 (25.5%) than the first quarters of 2023 and 2024 (17% and 6.6% respectively).
- There continues to be little or no utilization of new services, including crisis services, peer support services, and Individualized Placement and Support.

Figure 57. Paragraphs 101 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating and Rationale	***Priority Recommendations***
Partially Met. The State continues to track service utilization for transitioned and diverted individuals on a quarterly basis. However, LDH should investigate low utilization of behavioral health services and high rates of ED utilization among the diverted population.	1) As indicated in paragraph 95, the LDH should review the higher rates of ED utilization by individuals diverted from NFs to develop strategies to reduce those visits.

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, LHC, and the Louisiana Housing Authority (LHA). The tenth 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, ensuring that they 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 58. 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: The State 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 over the past four years to design a service review process to measure the quality of a representative sample of individuals who have been transitioned or diverted from NFs. These reviews play a critical role in assessing the quality and sufficiency of services, and in understanding the experience of individuals awaiting transition, transitioned, or diverted from NFs. In time, there should be improvements to the quality of individual assessments and plans of care to assess whether people are receiving needed services and supports in the appropriate amount, frequency, and duration.

As indicated in paragraph 62, LDH staff continue to partner with the SME service review team during this reporting period to conduct interviews with individuals, caregivers and friends, CCM, TCs, and other service providers. These efforts have included training and technical assistance from the SME team to LDH regarding the purpose and process of the service reviews. The SME has also provided LDH with a guide for how to conduct the audits of NFTAs and ITPs. As of the writing of this report, LDH is exploring adopting a "service review mentality," adapting the SME's service review tools and processes to enhance TC oversight and quality improvement. As indicated in the 10th SME report, the State reports that MCOs are also conducting audits of CCM activities. Specifically, the MCOs are reviewing the quality of CCM activities. During this reporting period, LDH staff debriefed with the SME team members regarding the findings from the 2024 service review. This included a debrief with LDH leadership and the My Choice Advisory Committee regarding the outcome of these reviews.

In addition to the SME service review report, the State tracks the network adequacy of community based behavioral health services quarterly and has determined the network (except for peer support and IPS) to be sufficient. On a monthly basis, CCMs continue to report on services needed but not received by individuals who are receiving CCM. These monthly reports provide information on strategies needed or implemented to address these needs. LDH has processes in place to review the fidelity of some evidence-based practices (e.g., ACT). It has also developed similar processes to review the IPS provided by these ACT teams.

Figure 59. Paragraphs 103 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating and Rationale	***Priority Recommendations***
Partially Met. LDH has developed a multi-pronged approach to address the quality and sufficiency of community-based services, including network adequacy review, service utilization monitoring, and participation in the SME service review process. LDH incorporates the findings from these various processes into the quality improvement efforts at LDH, MCOs and their contractors (e.g., CCMs). However, LDH should fully implement the "service review mentality" and other strategies, such as the recommendations under Paragraphs 93 and 94, to assess Agreement-related services and make improvements based on findings.	1) LDH should continue to collect and analyze network adequacy information from MCOs regarding Medicaid services offered to individuals transitioned or diverted from NFs. 2) LDH should develop a strategy for reviewing the fidelity and/or practice of new services including IPS, personal care services, peer support, and crisis services. 3) LDH should continue to participate in the SME service reviews and begin to operationalize the "service review mentality" into their operational oversight of TCs and other Agreement-related services.

APPENDIX A. 2023 QUALITY MATRIX

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:

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 nursing facility 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.

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.

My Choice Quality Matrix 3.0

Activity related	#	Proposed Measure	Benchmark/Trend	Quarter 1 January-March 2023	Quarter 2 April-June 2023	Quarter 3 July-September 2023	Quarter 4 October-December 2023
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.							
Amount, Intensity, availability of services	98.1						
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	None	806 Total Pre Admits 342 Level II Not Required 362 Approvals	840 total Pre-Admits 360 Level II Not Required 378 Approvals	789 total Pre Admits 330 Level II Not Required 386 Approvals	805 total Pre-Admits 349 Level II Not Required 378 Approvals
Referral/ Admission	99.a-2	Number and percent of individuals that are admitted into Nursing Facilities that have a completed PASRR Level II	Trend	91% of individuals admitting into the NF have a completed PASRR Level II	97% of individuals admitting into the NF have a completed PASRR Level II	96% of individuals admitting into NF have a completed PASRR Level II	94% of individuals admitting into a NF have a completed PASRR Level II
Diversion	99.a-3	Number and percent of individuals diverted	Benchmark 2023 target=137	31/137 23%	62/137 45%	88/137 64%	122/137 89%
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	Trend	31/464 6.68%	31/480 6.46%	26/459 5.66%	34/456 7.46%
Length of Stay	99.a-5	Average length of stay in nursing facility	Trend	Not time to pull this data	3.4 years	Not time to pull data	3.4 year

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	Trend	Semi-annual reporting Report in June and December	11/210 5% (To determine the denominator-looked at total number of people transitioned from June 2022-June 2023; Numerator=number of people on monthly report identified with a closure reason of readmission)	Semi-annual reporting Report in June and December	21/190 11% (To determine the denominator -looked at total number of people with a transition date December 2022-December 2023: 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	Benchmark 2023 Target=350	38/350 11%	82/350 23%	147/350 42%	174/350 50%
Planning	99.b-2	Number and percent of members that have a plan of care that reflects identified needs from the assessment	Trend	Unable to get this information from the service review as the current plan format does not include amount, frequency, and duration. Team will need to discuss and identify options to collect this information.	Unable to get this information from the service review as the current plan format does not include amount, frequency, and duration. Team will need to discuss and identify options to collect this information.	Unable to get this information from the service review as the current plan format does not include amount, frequency, and duration. Team will need to discuss and identify options to collect this information.	Unable to get this information from the service review as the current plan format does not include amount, frequency, and duration. Team will need to discuss and identify options to collect this information.
Planning	99.b-3	Number and percent of members who participated in the planning meeting	Trend	91%	50%	80%	94%
Planning	99.b-4	Number and percent of members whose plan of care reflect their strengths and preferences	Trend	86%	50%	90%	100%
(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	None	For Q1, 7 critical incidents were reported. 4 were for neglect, 3 were for explolitation. All incidents were reported within 24 hours to protective services within 24 hours of notification.	For Q2, 9 critical incidents were reported. 2 for abuse, 3 for exploitation, 3 for involvement with law enforcement and 1 for Major Behavioral Disturbance. The 5 incidents that were reported for either abuse or exploitation were all reported within 24 hours to protective services within 24 hours of notification.	For Q3, 19 critical incidents were reported. 3 for abuse, 4 for exploitation, 6 for neglect, and 2 for eviction, 2 for Major Behavioral Disturbance and 2 for Involvement with Law Enforcement. The 13 incidents that were reported for either abuse, neglect and/or exploitation were all reported timely (within 24 hours) to protective services within 24 hours of notification.	For Q4, 10 incidents that were reported to protective services. 1 for abuse, 6 for exploitation, and 3 for neglect. All incidents were reported timely (within 24 hours) to protective services within 24 hours of notification.
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	Benchmark 100%	7	5	13	10
death	99.c-3	Number of deaths reported	None	7	9	8	3
death; investigation	99.c-4	Number of deaths referred for mortality review	Trend	4	5	5	2
death; investigation	99.c-5	Number and percent of death investigations that were completed	Benchmark 100%	0/4 new referrals completed 5/15 total reviews completed (33%)	0/5 new referrals completed 11/20 total reviews completed (55%)	0/5 new referrals completed 12/25 total reviews completed (48%)	0/2 new referrals completed 16/27 total reviews completed (59%)
death (timeliness)	99.c-6	Average length of time to complete a death investigation	Benchmark 90 days (look at the procedure guide)	265 days	326 days	155 days	221 days

death; resolution	99.c-7	Number and percent of deaths that require a remediation plan	Trend	3/5 reviews completed required a remediation plan (60%)	4/6 reviews completed required a remediation plan (67%)	1/1 review completed required a remediation plan (100%)	3/4 reviews completed required a remediation plan (75%) Total reviews completed 2023 requiring remediation plan 11/16 (69%)
	99.c-8	Number and percent of participants whose service plans had strategies that addressed their health and safety risks as indicated in the	Trend	59%	50%	80%	78%
abuse/neglect/ exploiation	99.c-9	Number and percent of members reporting that they have been free from abuse, neglect, or exploitation	Trend 95%	As of March 2023, there are a total of 250 transitioned and diverted members receiving CCM. 99% of members report they are free from abuse, neglect, exploitation, or extortion.	As of June 2023, there are a total of 272 transitioned and diverted members receiving CCM. 99% of members report they are free from abuse, neglect, exploitation, or extortion.	As of September 2023, there are a total of 279 transitioned and diverted members receiving CCM. 98% of members report they are free from abuse, neglect, exploitation, or extortion.	As of December 2023, there are a total of 243 transitioned and diverted members receiving CCM. 98% of members report they are free from abuse, neglect, exploitation, or extortion.
(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 admissions to residential treatment facilities)							
ED/Inpatient utilization	99.d-1	Number and percent of members ED Services – All Cause and BH related	Trend 20%	37/424 (all cause ED) 9% 11/424 3%	60/475 (all cause ED) 13% 12/475 3%	66/516 (all cause ED) 13% 20/516 (BH Related) 4%	38/384 (all cause ED) 10% 10/384 (BH Related) 3%
ED/Inpatient utilization	99.d-2	Number and percent of Inpatient –All Cause and BH related	Trend 20%	31/424 (All cause) 7% 19/424 (BH Related) 4%	44/475 (All cause) 9% 20/475 (BH Related) 4%	40/516 (All cause) 8% 23/516 (BH Related) 4%	25/384 (all cause ED) 7% 15/384 (BH Related) 4%
Physical/BH wellbeing	99.d-3	Number and percent of members reporting good physical health	Benchmark 50%	As of March 2023, there are a total of 250 transitioned and diverted members receiving CCM. 61% of members report good physical health	As of June 2023, there are a total of 272 transitioned and diverted members receiving CCM. 56% of members report good physical health.	As of September 2023, there are a total of 279 transitioned and diverted members receiving CCM. 57% of members report good physical health	As of December 2023, there are a total of 243 transitioned and diverted members receiving CCM. 56% of members report good physical health

NNBH wellbeing	99.d-4	Number and percent of members reporting good mental health	Benchmark 50%	As of March 2023, there are a total of 250 transitioned and diverted members receiving CCM. 64% of members report good mental health.	As of June 2023, there are a total of 272 transitioned and diverted members receiving CCM. 60% of members report good mental health	As of September 2023, there are a total of 279 ransitioned and diverted members receiving CCM. 61% of members report good mental health.	As of December 2023, there are a total of 243 transitioned and diverted members receiving CCM. 59% of members report good mental health
Physical/BH wellbeing	99.d-5	Number and percent of members that report taking medications as prescribed	Benchmark 86%	As March 2023, there are a total of 250 transitioned and diverted members receiving CCM. 92% of members reported taking medications as prescribed.	As June 2023, there are a total of 272 transitioned and diverted members receiving CCM. 93% of members reported taking medications as prescribed.	As September 2023, there are a total of 279 transitioned and diverted members receiving CCM. 90% reported they are taking medications as prescribed.	As of December 2023, there are a total of 243 transitioned and diverted members receiving CCM. 91% reported they are taking medications as prescribed.
use of crisis services	99.d-6	Number and percent of members that utilized crisis services	None	2	0	0	1
(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	Benchmark 86%	As of March 2023, there are a total of 250 transitioned and diverted members receiving CCM. 88% of members report stability in living situation	As of June 2023, there are a total of 272 transitioned and diverted members receiving CCM. 91% of members report stability in living situation.	As of September 2023, there are a total of 279 transitioned and diverted members receiving CCM. 87% of members report stability in living situation	As of December 2023, there are a total of 243 transitioned and diverted members receiving CCM. 92% of members report stability in living situation.
maintenance of chosen living arrangement	99 e-2	Number and percent of members reporting no issues with current living situation	Benchmark 86%	As of March 2023, there are a total of 250 transitioned and diverted members receiving CCM. 89% of members report a good living situation.	As of June 2023, there are a total of 272 transitioned and diverted members receiving CCM. 92% of members report a good living situation.	As of September 2023, there are a total of 279 transitioned and diverted members receiving CCM. 93% of members report a good living situation.	As of December 2023, there are a total of 243 transitioned and diverted members receiving CCM. 95% of members reported they are in a good living situation.
stability in chosen natural supports	99 e-3	Number and percent of members reporting stability in natural supports network	Benchmark 86%	As of March 2023, there are a total of 250 transitioned and diverted members receiving CCM. 97% of members report stability in caregivers	As of June 2023, there are a total of 272 transitioned and diverted members receiving CCM. 99% of members report stability in caregivers.	As of September 2023, there are a total of 279 transitioned and diverted members receiving CCM. 98% of members report stability in caregivers	As of December 2023, there are a total of 243 transitioned and diverted members receiving CCM. 99% of members reported stability in caregivers.

stability in chosen service providers	99 e-4	Number and percent of members reporting stability in service providers	Benchmark 86%	As of March 2023, there are a total of 250 transitioned and diverted members receiving CCM. 94% of members report stability in service providers.	As of June 2023, there are a total of 272 transitioned and diverted members receiving CCM. 97% of members report stability in service providers.	As of September 2023, there are a total of 279 transitioned and diverted members receiving CCM. 95% of members report stability in service providers.	As of December 2023, there are a total of 243 transitioned and diverted members receiving CCM. 98% of members reported stability in service providers.
(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							
choose how to spend day	99.f	Number and percent of members reporting that they are able to make choices and exert control over their own life -Person centered planning process (see 99.b-1-99.b4) -services (see 99.j-1) -choice specific to community					
(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	Benchmark 68%	As of March 2023, there are a total of 250 transitioned and diverted members receiving CCM. 90% of members report they are involved in the community to the extent they would like.	As of June 2023, there are a total of 272 transitioned and diverted members receiving CCM. 95% of members report they are involved in the community to the extent they would like.	As of September 2023, there are a total of 279 transitioned and diverted members receiving CCM. 95% of members report they are involved in the community to the extent they would like.	As of December 2023, there are a total of 243 transitioned and diverted members receiving CCM. 94% of members reported they are involved in the community to the extent they would like.
99(h) Provider capacity (e.g., adherence to provider qualifications and requirements, access to services, sufficiency of provider types);							
Access	99.g-2	Number and percent of specialized behavioral health providers meeting appointment availability standards. 1) Emergent: 1 hour; 2) Urgent: 48 hours (2 calendar days); Routine: 14 calendar days	Benchmark Emergent=90% Urgent=90% Routine=70%	See Network Report	See Network Report	See Network Report	See Network Report

	99.g-2	Number of community based behavioral health providers available to provide services and accepting new Medicaid participants	None	See Network Report	See Network Report	See Network Report	See Network Report
	99.g-3	Number of community based behavioral health providers available to serve BH Medicaid beneficiaries stratified geographically by region	None	See Network Report	See Network Report	See Network Report	See Network Report
99(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 .;							

In-Reach Barriers	99.i-1	Number and percent of barriers identified during in-reach contacts for people that indicating they are undecided, not interested, or unable to make a decision. **<u>Undecided/Not Interested Reasons:</u>** Family/Guardian not supportive of transition Decline in PH Concerns about management of PH Concerns about medication management Concerns about transportation Concerns expressed related to housing Concerns related to needed supports (ADL/IADL) Concerns related to making friends and involvement in activities Concerns expressed related to needed BH supports Concerns expressed related to needed Medical Services Other **<u>Unable to make a decision:</u>** Interdicted/curator unable or unwilling to participate Individual is unwilling to participae in discussion re: transition Individual unable to engage in discussion (not able to	Trend	Only have March data See tab labeled Q1 In-Reach Barrier	See tab labeled Q2 In-Reach Barrier	See tab labedl Q3 In-Reach Barrier	See tab labeled Q4 In-Reach Barrier

Transiton Barriers	99.i-2	Number and percent of barriers identified during transition. **Barriers:** Concerns about medication management Concerns about management of physical health Concerns about transportation Concerns related to needed supports (ADL/IADL) Concerns expressed re: making friends and being involved in activities Concerns related to needed medical services Concerns related to needed BH supports Individual expereinced a decline in health and/or change in health status Individual refusing to meet with TC and/or participate in transition activities Individual unable to communicate using words (needs interpreter, or other communication aides) Individual refusing services impacting ability to transition Unstable med or BH condition resulting in an inability to participate in transition activities Cognitive patterns observced illustrate possible instability (suspect dementia) Individual interdicted the	Trend	Did not roll this up first quarter.	See tab labeled Q2 Transition Barrier	See tab labeled Q3 Transition Barriers	See tab labeled Q4 Transition Barriers
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.)	Benchmark 86%	As of March 2023, there are a total of 250 transitioned and diverted members receiving CCM. 89% of members report that they receive all needed services.	As of June 2023, there are a total of 272 transitioned and diverted members receiving CCM. 94% of members report that they receive all needed services.	As of September 2023, there are a total of 279 transitioned and diverted members receiving CCM. 93% of members report that they receive all needed services.	As of December 2023, there are a total of ??? transitioned and diverted members receiving CCM. 95% of members report that they receive all needed services.

APPENDIX B. QUARTERLY SERVICE UTILIZATION

Quarterly Comparison of Service Utilization Among Transitioned Individuals											
Time Period	**No BH Service**	**Service Utilization**									
	No BH Service	*ACT*	*MHR*	*Outpatient*	*PCA (CCW)*	*PCA (1915b)*	*Preventative*	*ED (All-Cause)*	*ED (BH Reasons)*	*Inpatient (All-Cause)*	*Inpatient (BH Reasons)*
Q1 2022	55.0%	24.3%	15.4%	2.0%	43.0%	0.0%	84.0%	14.6%	4.0%	22.7%	5.7%
Q1 2023	25.0%	32.0%	13.0%	5.0%	42.0%	2.0%	76.0%	7.0%	2.0%	5.0%	3.0%
Q1 2024	20.0%	38.8%	11.8%	2.7%	47.0%	8.3%	83.9%	7.4%	1.8%	3.7%	1.5%

Quarterly Comparison of Service Utilization Among Diverted Individuals											
Time Period	**No BH Service**	**Service Utilization**									
	No BH Service	*ACT*	*MHR*	*Outpatient*	*PCA (CCW)*	*PCA (1915b)*	*Preventative*	*ED (All-Cause)*	*ED (BH Reasons)*	*Inpatient (All-Cause)*	*Inpatient (BH Reasons)*
Q1 2022	58.8%	11.8%	3.9%	31.4%	3.9%	0.0%	62.0%	33.0%	23.0%	27.5%	25.5%
Q1 2023	23.0%	21.0%	4.0%	0.0%	0.4%	0.4%	73.0%	13.0%	8.0%	21.0%	17.0%
Q1 2024	24.0%	27.1%	2.4%	8.8%	14.8%	8.3%	76.7%	22.2%	8.6%	16.0%	8.6%