Twelfth Subject Matter Expert Report

Agreement to Resolve the Department of Justice Investigation

Covering the Period of 7/1/2024 to 12/31/2024

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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 July 1, 2024, to December 31, 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. 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.

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 may directly validate or verify data in specific areas. To ensure the report's data and other content was factual and accurate, and to receive general feedback, the SME shared a draft report with the State and the DOJ on April 14, 2025.

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

Figure 1. Compliance Rating Options and Associated Criteria

Status	Criteria
Met	LDH has undertaken and completed the requirements of the paragraph--no further activity needed
	LDH has undertaken and completed the requirements of the paragraph--met with updates continuing to occur
Partially Met	LDH has developed deliverables (policies, procedures, training) that indicate the State is actively addressing the requirements of the paragraph
	LDH has provided data that indicates the State is actively addressing the requirements of the paragraph
	LDH has implemented activity and has yet to validate effectiveness
	LDH has begun but has not completed implementation activities
Not Met	LDH has done little or no work to meet the 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 Rated	The provision of the paragraph does not require a rating

Overview of Compliance Assessment Findings. As displayed in Figures 2 and 3, there were 75 paragraphs subject to compliance rating in this reporting period. These paragraphs fall under six domains, aligned with the how the text of the Agreement is structured: Target Population; Diversion and Preadmission Screening; Transition and Rapid Reintegration; Outreach, In-Reach, and Provider Education and Training; Community Support Services; and Quality Assurance and Continuous Quality Improvement. **As displayed in Figures 2 and 3, LDH was found in compliance with 16 paragraphs (21%), in partial compliance with 56 paragraphs (75%), and not in compliance with three paragraphs (4%). There were four paragraphs that were not rated.**

Figure 2. Overview of Compliance Assessment Ratings by Domain for 12th SME Report								
Target Population (4)	**Meeting Compliance**	0	**Partial Compliance**	2	**Not Meeting Compliance**	0	**Not Rated**	2
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**	12	**Not Meeting Compliance**	0	**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**	7	**Partial Compliance**	14	**Not Meeting Compliance**	2	**Not Rated**	0
Quality Assurance and Continuous Quality Improvement (18)	**Meeting Compliance**	2	**Partial Compliance**	16	**Not Meeting Compliance**	0	**Not Rated**	0
Total (79)	**16**		**56**		**3**		**4**	

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 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 three preceding reports, along with the distribution of compliance findings. Among the requirements shared between the 11th and 12th SME Reports, three ratings improved, one worsened, and one was reclassified as "not rated." When comparing the 10th and 12th SME Reports – which both assessed Paragraphs associated with Community Support Services – 12 ratings improved and one worsened.

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

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.

In the 11th SME Report, one of the SME's overarching recommendations was to conduct a multi-faceted Target Population analysis to better understand the service needs of the Target Population, including segments that are not typically included in the SME's Service Review process, and to confirm that those who are afforded Agreement-related services are in fact eligible members of the Target Population, among other aims. This work is underway. While not explicitly included as an overarching recommendation, LDH should complete these analyses and utilize insights to inform shifts in strategy and operations, including requisite improvements to in-reach and transition processes and targets.

The five overarching recommendations for this 12th SME Report include:

1. Given that the 2022 Housing Plan's activities conclude in 2025, LDH should report on progress made toward housing development and rental subsidy goals, specify and quantify housing-related barriers (e.g., lack of disability accessible options, preferred locations not being available), contemplate new or enhanced strategies to address identified barriers, and prepare to develop an updated housing plan. The updated plan should, at a minimum, include housing opportunity development activities and associated projections for 2026 and 2027, designed to reach the Agreement's 1,000 housing opportunity requirement.
2. LDH should continue to build on its progress of developing crisis services, by launching the Crisis Hub, facilitating the presence of all four crisis services in all regions, improving the quality of crisis services (including reducing reliance on emergency departments and inpatient care), and deepening engagement with law enforcement and first responders. Further, given that utilization of crisis services among the Target Population remains very low, LDH should consider the extent to which and under what circumstances they expect Target Population members to utilize crisis services and develop strategies to ensure that individuals in the Target Population and their supporters are aware of and can easily access crisis services.
3. LDH should fully optimize peer services to benefit the Target Population. This includes engaging all members on the Master List with peer in-reach (who have not been engaged by Rapid Reintegration Transition Coordinators), ensuring that Assertive Community Treatment peers are equipped and expected to promote community integration, analyzing the extent to which peers are embedded in Louisiana's Intensive Community Support Services, and educating Community Case Managers and Transition Coordinators on the full range of peer services available to members of the Target Population.

4. 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.
5. LDH should inventory, analyze, and develop plans to address known systemic issues that impede transition performance, with the goal of increasing the number of achieved transitions. This process should leverage cross-agency partnerships, the Transition Support Committee, internal and external quality assurance groups, and other experts to better understand and devise solutions around systemic barriers.

The SME acknowledges that LDH's 2025 Implementation Plan contains many strategies that are responsive to these recommendations.

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.

In prior reporting periods, the former and current SME rated and discussed Paragraphs 24, 25, and 26 collectively. Upon further consideration and advice from the Department of Justice, Paragraph 24 will no longer be rated by the SME given that this provision is descriptive in nature.

Figure 4. Paragraph 24 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Not rated.	Not applicable.

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

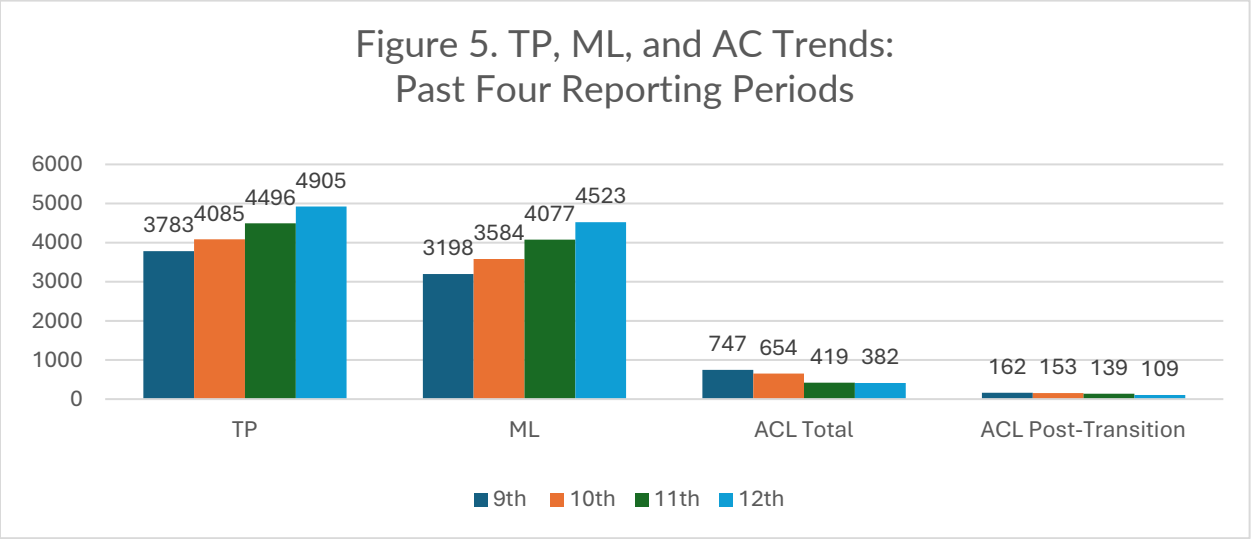
26. The State will develop and maintain a Target Population priority list of individuals who meet the criteria described in Paragraphs 24 and 25.

Analysis: Paragraphs 25 and 26 are discussed together. These paragraphs require LDH to identify the Target Population (TP) in this Agreement. 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. Historically, the AC was mostly constituted[1] by those who indicated an interest in moving from an NF and those who had 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 because they received a PASRR Level II evaluation that indicated SMI.

Starting in 2024, the LDH maintained a separate AC for their Rapid Integration Transition Coordinator (RITC) pilot program. Data on the RITC pilot is not included in the analysis under this Paragraph and is discussed separately under Paragraph 45.

As of December 31, 2024, the TP included 4,905 individuals: 4,523 individuals on the ML and 382 on the AC. The AC included 273 individuals within NFs and 109 who were discharged but still within their 12-month post-transition window. Figure 5 below displays trends across the last four reporting periods, demonstrating a consistent increase in the ML coinciding with a reduction in the AC: 1/1/23-6/30/23 (9th SME Report), 7/1/23-12/31/23 (10th SME Report), 1/1/24-6/30/24 (11th SME Report), and 7/1/24-12/31/24 (12th SME Report).



The number of individuals on the ML for this reporting period is the highest since July 1, 2021, representing an 11% increase between the 11th and 12th periods. As shown in Figure 6, across the past seven reporting periods, the number of individuals on the ML has decreased only once, between the 7th and 8th reporting periods. The figure also provides an ML and AC ratio figure that further illustrates the ML increase and coinciding AC decrease.

At first glance, growth in the ML would suggest that more individuals with SMI are being admitted into NFs, signaling underperformance of Agreement-related processes and programming. However, as described below, admissions of individuals in the TP appear to have decreased between 2023 and 2024. In 2023, there were 27,148 NF admissions statewide, with 1,770 (6.5%) being added to the ML. In 2024, there were 27,072 NF admissions statewide with 1,651 (6.1%) being added to the ML. This reflects a decrease in the percentage of overall

[1] There are limited circumstances in which an individual who has not expressed interest in transition is added to the AC, when they are referred to the AC after a PASRR Level II evaluation associated with a Continued Stay Request.

admissions added to the ML from 2023 to 2024, coinciding with a numeric drop from 1,770 to 1,651.

Figure 6. ML & AC Size Across Reporting Periods			
Reporting Period	***ML Size***	***AC Size***	***Ratio***
12th; 7/1/2024-12/31/2024	4,523	382	8%
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%

For this reason, with support from the SME and DOJ, LDH is investigating why the ML figure is growing year over year. Preliminary analysis suggests at least two issues that relate to identification of individuals on the ML: (1) inadequate procedures to remove individuals from the ML when appropriate (e.g., when discharged, deceased, diagnosed with primary dementia, or no longer on Medicaid), resulting in an inflated ML figure; and (2) inclusion of individuals on the ML who do not meet all Agreement-specified criteria for the TP. For the latter issue, initial analysis shows that nearly a third of individuals on the ML have not been confirmed to meet all the eligibility requirements of the TP under this Agreement; in most cases, this involves lack of confirmation of Medicaid eligibility.

The SME acknowledges that improving the accuracy of the ML is not merely a data cleaning exercise; it has generated larger questions about the best way to implement Agreement-related obligations, which has wide-ranging implications. The SME appreciates the willingness of LDH and the DOJ to collaborate on this matter, be data-driven, and center the experiences of individuals with SMI who are needlessly admitted into NFs or there for unnecessarily long tenures. He will continue to report on this matter in future reports.

As stated above, in this reporting period, there were 382 individuals on the AC: 273 who were awaiting transition and 109 who were still in their 12-month post-transition window. LDH reports that a potential contributor to the decreasing AC over the past few periods is that their in-reach staff have become more skilled at assessing true interest prior to adding members to the AC, resulting in a smaller, but more accurate and right-sized list of members who are seriously interested in transition. Additional analysis is needed to determine whether this "right sizing" effort results in a larger percentage of those on the AC ultimately transitioning, but there is still a relatively large cohort of individuals who are removed from the AC after initially expressing interest in transition, although the number of individuals removed from the AC has decreased over time.

In this reporting period, 269 individuals were removed from the AC, either because they were no longer interested or for other reasons (e.g., discharged prior to transition, closed from the program 12 months after discharge). There were 122 (42%) removed from the AC because "declined transition." This represents a decrease compared to the last period, wherein 355 individuals were removed from the AC (56% of whom "declined transition"). The SME's 2025 Service Review process has been adapted to conduct qualitative interviews with individuals who returned to the ML to better understand their reasoning and inform programmatic improvements, if merited.

Figure 7. Paragraphs 25 and 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, there are questions about the ML's accuracy.	1) LDH should implement the planned analysis to ensure the accuracy of the ML. 2) LDH should continue to support the SME's efforts, and consider independent efforts, to assess why individuals initially added to the AC are later returning to the ML. 3) LDH should implement the recommendation under Paragraph 41, pertaining to reporting on the occurrence of PASRR Level II evaluations after SMI is indicated through post-admission MDS assessments.

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 new services that are set forth in the Agreement, including Mental Health Rehabilitation Services, outpatient mental health services, substance use disorder (SUD) services under the State's 1115 Demonstration Program, and, more recently, the array of crisis, employment, case management, and peer support services. Available supports and processes to access these services are dependent on payer source.

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 8. 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]. **[Note: Paragraph 28 defines "diversion" for the purposes of the Agreement and as such is not appropriate for rating.]**

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 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 has developed the systems, services, and processes necessary to consistently prevent needless institutionalization among the TP, which likely extends beyond its current strategies. To that end, LDH should consider which data indicators suggest that their diversion approaches are working on a broader scale, including trends analysis of NF admissions and re-admissions and PASRR Level II evaluation requests.

This Diversion 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 of preventing 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 evaluation indicated community placement versus an NF admission. In this reporting period, 74 individuals were diverted, adding to the 74 individuals diverted in the first half of the year. By achieving 148 overall diversions, LDH exceeded the calendar year (CY) 2024 target of 122 diversions. In CY2023, LDH diverted 122 individuals, or 92% of their annual target of 132

individuals. The number of 2024 diversions represent about 7% of individuals who received PASRR Level II evaluations.

- One 1135 waiver was granted but ultimately not utilized in this period, waiving the PASRR Level II requirement during Hurricane Francine.
- LDH continued to operate its At-Risk and CCM programs; more information on these programs is provided under Paragraphs 30 and 47. The 11th SME Report included a summary of findings from an annual analysis of diverted individuals' utilization of inpatient and emergency department (ED) services. Diverted individuals engaged in CCM had an 11% decrease in ED utilization compared to their pre-CCM levels but had much higher rates than transitioned individuals. Similarly, individuals deemed "at risk" who accepted At-Risk Program case management had comparable rates of ED and inpatient utilization compared to those who did not accept programming, although there marked reduction in ED presentations when compared to their pre-engagement baseline ED utilization.
- 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. A description and key findings related to this process are provided in Paragraph 34. If findings regarding cases that could have been diverted in the audit sample are extrapolated to all PASRR Level II evaluations, 61 additional diversions may have been possible.
- The proportion of diverted individuals who engaged in outpatient behavioral health services and ambulatory/preventive services increased between quarter 2 of 2024 and quarter 4 of 2024, from 44.1% to 51.8% and 60% to 82.4%, respectively. There was also a slight increase in engagement with crisis services and decrease in engagement in ED and inpatient services, including for behavioral health reasons. These are all positive developments .
- Preliminary findings from the 2025 Service Review show that outcomes for diverted members are poor, including high prevalence of unstable housing or homelessness. Diverted individuals included in the Service Review process are limited to those who accept CCM services; thus, the SME has concerns about outcomes among those who do not elect to participate in CCM. A more detailed analysis will be published in the SME's Service Review Report, slated for completion in the Summer of 2025.

The SME acknowledges that individuals diverted from long-term care may have pre-existing housing instability or other housing-related issues (e.g., homelessness, living in substandard housing or congregate settings). Diverted individuals also have complex healthcare and social histories, and unlike transitioned individuals, do not have multiple months of support to arrange housing and services. However, there may be additional opportunities to facilitate rapid access to housing and services for this group and new innovative approaches (e.g., staff co-location in hospitals) to improve their outcomes.

Further, there may be opportunities to better understand the prevalence and contributors to poor housing outcomes among the diverted population. As a first step, LDH could convene a focus group of CCMs who serve diverted individuals to better understand whether anecdotal findings from the Service Review represent a more widespread issue, and if so, explore prevalence, causes and contributors to poor housing outcomes and strategies to optimize Agreement-related housing options.

Figure 9. Paragraph 29 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. Many of the strategies enumerated in the State's Diversion Plan have been implemented. However, LDH should identify a set of macro-level data indicators that demonstrate diversion/system-of-care rebalancing; continue to increase accuracy of PASRR Level II determinations to consistently identify opportunities for diversion; and better understand and address poor housing outcomes among diverted individuals.	1) With the support of the SME, LDH should identify macro-level data metrics that better assess the outcomes of diversion/systems rebalancing efforts. 2) LDH should continue to make improvements to diversion-related programming and activities, with a special focus on improving housing stability among diverted individuals.

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 have 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). When the at-risk definition was updated in October 2023, 3,703 individuals served by the MCOs at that time met the new criteria. This figure, if annualized, is consistent with the size of the at-risk population in prior years. From July to December 2024, 767 new members were identified as at-risk.

LDH tracks whether members of the at-risk population receive outreach from the MCO, have a successful contact, and ultimately enroll. For the 767 members identified from July to December 2024, 756 (99%) were outreached by the MCOs, 456 (59%) had successful contact, and 124 (16%) enrolled. Compared to the last period, a higher number of individuals were outreached (99% versus 80%) but slightly fewer individuals had successful contact (59% versus 63%) Among those who received a successful MCO contact, a slightly lower percentage enrolled compared to the last period (16% versus 18%). LDH and its MCOs should be credited for outreaching nearly all eligible members.

Based on individuals' needs and 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. Among the 124 who enrolled during this period, 104 (84%) were in tier 3, nine (7%) were in tier 2, seven (6%) were in tier 1, and four (3%) received transitional care coordination.

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 was provided and analyzed in the 11th SME Report, demonstrating minor differences when comparing the two groups. The analysis, however, showed that rates of ED utilization and average days in the ED among those who elected to participate in the At-Risk Program decreased substantially.

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 8th and 9th SME reports. Based on the review's findings, LDH required each MCO to submit plans of correction. A similar review is currently underway, and an evaluation report is expected in September 2025.

Data provided by OAAS for the 11th SME Report indicated a 3% 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.

Figure 10. 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.	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, making refinements if merited.

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. Before March 2025, when an individual is referred to a Medicaid-certified NF, the referring entity completed the Level of Care Eligibility Tool (LOCET). Once the LOCET was received by LDH (specifically the Office of Aging and Adult Services, or OAAS), OAAS conducted a PASRR Level I screening. If SMI was suspected at the Level I phase, OBH oversaw the completion of the Level II evaluation via its MCOs and the organization under contract to conduct Level II evaluations and issued a final placement determination. For non-Medicaid members, OBH currently utilizes the same organization to conduct PASRR Level II evaluations. OBH also coordinates with Office of Citizens with Disabilities to implement PASRR evaluations for those with both SMI and intellectual or developmental disabilities.

As of March 2025, this process changed substantially. LDH onboarded a new vendor – and associated new PASRR Level I tracking, reporting, and training procedures – which enables real-time notifications of NF admissions to the State and equip evaluators to more effectively complete the PASRR Level I process, including more accurate and consistent flagging of potential SMI. Future reports will provide more detailed information on the revised PASRR Level I process and associated data, including whether the new process yields more PASRR Level II requests.

Figure 11. 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 in the process of onboarding a new vendor to improve SMI detection.	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 the 11th 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, 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 SUD history 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 expected to be face-to-face and generally completed prior to admission. In this reporting period, 99% were completed within four days of OBH referral. Among the 669 individuals added in the ML during this reporting period, there were 117 (17%) who did not receive a pre-admission PASRR. This includes 66 cases with a 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) and 51 cases involving the Office of Citizens with Developmental Disabilities where SMI was not identified at the Level I stage.

The SME was provided with audit findings relative to the 127 PASRR Level II evaluations reviewed from July to December 2024. To summarize:

- Twenty-eight (22%) of the 127 evaluations reviewed by OBH had a deficiency; eight (29%) had missing SUD information, 15 (54%) had BH/SUD recommendations misaligned with the needs identified, three (11%) had missing physical health information, and four (14%) had missing referrals for dementia testing. The percentages exceed 100% because some evaluations had more than one deficiency. Like OBH's determination that 28% of evaluations had a deficiency, reviewers from MCOs and the contracted PASRR Level II vendor found that 27% and 26%, respectively, had deficiencies. This represents a significant improvement over the last period, during which 43% of the sample reviewed had a deficiency. LDH attributes improvements to an increase in the number of cases where community options were presented and service recommendations were appropriate.
- OBH also reviews evaluations to determine whether they agree with the NF placement determination. OBH concurred with the placement determination of 103 (81%) of the 127 evaluations. After the more granular review described below, there was ultimate concurrence with 115 (91%) of 127 NF placement decisions. In the last reporting period, LDH concurred with 94% of the NF placement decisions.
- OBH flagged 24 (19%) cases as potentially appropriate for diversion and referred to OAAS for more granular review. OAAS determined that 12 of those cases were appropriately referred to NF placement, nine may have been maintained in the community with additional services, and three were inconclusive given that there was not "enough information to determine if diversion was possible upon referral." Ultimately, nine of 127 were deemed as possible diversions if individual choice, circumstances, and linkage to services allowed for it.
- If these findings can be extrapolated to all PASRR Level II evaluations in the July to December 2024 period (n=868), 61 additional diversions may have been appropriate.

Based on these audit findings, LDH reports that they will make programmatic improvements to educate evaluators on the array of home and community-based services offered by OAAS; increase oversight of evaluators when there is missing BH and SUD recommendations despite identified service needs; continue monthly case reviews of complex cases and cases in which diversion may have been possible; and increase collaboration between MCOs and evaluators to address incongruencies in service and placement recommendations.

Figure 12. 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.	1) 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 – determine whether the individual has a dementia diagnosis or whether additional expertise is needed to render a determination. In all cases where dementia may be present, 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 and LDH 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 there were 145 individuals with a primary or suspected dementia diagnosis. Of these, 69 individuals were determined through the physician review process to have primary dementia and 71 were identified as having suspected dementia. All individuals with suspected dementia maintain eligibility for Agreement-related services and programming. Compared to the 10th SME Report, there was an increase in the number of individuals identified through the PASRR Level II process as having primary or suspected dementia – from 105 to 145. Further, in this reporting period, dispositions of suspected and confirmed dementia were fairly evenly split. In the 10th reporting period, however, 76% of reviewed cases were determined to have primary dementia.

Figure 13. 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 14. 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 short-term authorizations in this reporting period. The average length of stay for these initial authorizations was 90 days for quarters 3 and 4 of 2024, similar to prior reporting periods.

Per LDH, continued stay requests – which include extension and resident review requests – are not to exceed 365 days. For quarter 3 of 2024, the average for extension requests was 347 days and resident review requests was 313 days. For quarter 4, the averages were 352 and 317 days, respectively. This aligns with the prior reporting period.

As noted in the Paragraph above, if a person is authorized beyond the initial stay, the continued stay process must specify the reason and timeframe for the extension. 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.

The continued stay must also identify the specialized behavioral health services needed by the individual. The revised PASRR Level II evaluation instrument, launched in July 2024 and administered as part of the continued stay process, contains a section to identify BH needs, barriers, and recommendations for care/services. However, the current PASRR Level II audit process found that in 15 of the 127 reviewed cases (12%), the behavioral health recommendations misaligned with the needs identified. Further, the SME is unaware of a process

to confirm that such behavioral health services were delivered during an individual's continued stay in the NF, which is vital to improving an individual's emotional wellness while in the NF and could facilitate better post-discharge service connections and life outcomes.

The continued stay process must also specify why an individual cannot be served in the community. The revised PASRR Level II evaluation tool collects information on transition barriers, as well as other barriers across multiple domains (e.g., health, ADL/instrumental ADLs) that necessitate NF placement. Given the structure of the tool, it is difficult to aggregate this information on transition barriers or behavioral health service needs for trends analysis. A sampling approach could be helpful to better understand trends regarding the reasons that PASRR Level II reviewers determine that individuals cannot be served in community settings.

Figure 15. 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 ensure that the behavioral health needs of TP members in NFs are identified, accurately reflected in the PASRR Level II evaluation, 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 continued stay requests 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 continued stay request process developed by LDH for individuals in the TP, which delineates the role of OAAS and OBH. This includes the use of Minimum Data Set (MDS) assessment data to establish continued need for NF level of care. The State continues to report that all continued stay requests are reviewed by OAAS regional staff who are independent and not affiliated with the NF.

Figure 16. 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 evaluations 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 evaluation during their NF stay tenure, including an NF or individual requesting a continued stay 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.

For this period, the SME requested that LDH conduct a special analysis to determine the extent to which individuals who received a PASRR Level II evaluation (as part of their continued stay process) in the month of September 2023 had received another evaluation by September 2024. Out of the 319 annual reviews due, 255 (80%) received one. Among the remaining 64 (20%) cases, 42 individuals had died, 20 were discharged from the NF, and two were not eligible for an annual review due to their private pay status. Therefore, it appears that all individuals in need of an annual review as part of a continued stay request were found to have received one in this one-month analysis. For this reporting period, LDH was unable to report on whether those who need new PASRR Level II evaluations (i.e., resident reviews) due to a change in condition received them but is designing a similar one-month study to enable reporting in future periods. In this reporting period, there were 1,101 NF-initiated and 352 LDH-initiated requests for resident review evaluations in this reporting period due to a change in condition.

Figure 17. Paragraph 39 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. LDH has created processes to comply with this Paragraph and a special analysis indicates that those who require annual PASRR Level II evaluations receive them. However, additional LDH monitoring and reporting is needed for LDH to demonstrate compliance with all aspects of this Paragraph, including the provision of PASRR Level II evaluations due to a change in condition.	1) LDH should finalize and implement a methodology for determining if individuals are receiving their required post-admission resident reviews in the event of a change in condition. This methodology can utilize a sampling time series analysis, similar to the approach described in the discussion above.

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 7th SME 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 TP members 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.

For those who signal and maintain interest in transitioning, a transition coordinator (TC) from OBH or OAAS facilitates an NF Transition Assessment (NFTA), and if interest is sustained, an Individualized Transition Plan (ITP) is initiated. During the 7th reporting period, LDH established timeframe expectations for various TC processes. The prior SME reviewed and agreed with these expectations, and since the 8th 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. 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.

- There were 4.5 days on average that elapsed between an individual being added to the AC and assignment to a TC for those in the legacy program and .5 days for those in the RITC program.
- There were nine days on average between TC referral and NFTA completion, for those in the legacy program. For RITC, there was also a nine-day wait. This is a significant improvement over the last period, which showed 24 days on average between the TC referral and completion of the NFTA, compared to the 14-day benchmark.
- There were 2.2 days on average between NFTA completion and initiation of the ITP for the legacy program, and 1.7 days for RITC, compared to the 30-day benchmark. This represents a significant improvement over the 17-day average in the prior reporting period.
- While LDH does not provide data on whether CCMs are engaged at least 60 days prior to transition, the 2024 Service Review (and the preliminary findings from the 2025 Service Review) demonstrated that this is customary practice.

There appears to be 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. Given the inaccuracy of the ML referenced under Paragraph 26, an exact number and percentage cannot be confirmed, but data as of 12/31/24 shows that 642 individuals on the ML had not yet been contacted by in-reach. If accurate, this constitutes approximately 14% of the ML. Data provided as of June 2024 showed that a similar percentage of the ML had not been reached. However, it is important to note that some of these individuals may have been among the 503 individuals in this period who were engaged by a Rapid Reintegration Transition Coordinator instead.

Figure 18. 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, data suggests that a segment of the ML has yet to be offered transition support services.	1) After improving the accuracy of the ML and cross-referencing engagements from Rapid Reintegration Transition Coordinators, LDH should recalculate the number of individuals on the ML who have yet to receive in-reach and implement measures to reach them. 2) LDH should continue to monitor 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 Minimum Data Set (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 and the last 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. The SME is assigning a partially met rating since the process for compliance with this Paragraph is established. However, data on demonstrate compliance is needed to maintain this rating in future compliance 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.

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

Analysis: TCs are responsible for working with individuals on the AC to assess their comprehensive needs; craft an ITP 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, this Paragraph required 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. In the 10th and 11th periods, there were 266 and 268 individuals with ID/DD across the ML and AC. In the 12th period, there were 272 individuals on the ML and AC; 252 individuals were on the ML and 20 were on the AC.

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 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 27 employed TCs across OBH and OAAS's 30 total positions. OBH holds 10 TC positions; eight were filled and two were vacant. Out of OAAS's 16 TC and four RITC positions, one TC position was vacant and one RITC position was vacant. OBH has three staff positions that provide oversight/support to the TCs and OAAS has three supervisor positions and additional OAAS leaders 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, according to 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. The State accomplished 135 or 41% of its required transitions. 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. The transition goal for 2025 is 287 transitions. LDH views the 2025 transition goal of 287 as an upper-end target, recognizing that actual transitions may vary based on real-world factors.

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. Such enhancements include:

- Technology-enabled tracking (on a weekly basis) of client-specific barriers, to allow for supervisory support and intervention.
- Internal service review process that includes regular review and quality assessment of TC documentation.
- Strengthened oversight to ensure that TCs are introducing housing options to individuals interested in transition.
- Implementation of a supervisor-led audit and TC self-audit.
- Increased focus on updating the ITP based on monthly engagements.

During this reporting period, the average caseload size for TCs was 15 members, consistent with the last period. 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 481 individuals on the AC, or a ratio of 16 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 would have had to effectuate 12 transitions to achieve the goal of 331 transitions.

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 continues to fall beneath annual transition goals.	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 work with other relevant state agencies and stakeholders to identify and remediate systems issues that impact transition performance.

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

46. The transition plans will accurately reflect and include: (a) the individual's strengths, preferences, needs, and desired outcomes; (b) a list of the services and supports the individual currently receives; (c) a description of how the services and supports the individual currently receives will be provided in the community; (d) any other specific supports and services that would allow the individual to transition successfully back to his or her home and to avoid unnecessary readmission to an institutionalized setting, regardless of whether those services are currently available; (e) Case Management services consistent with Section V.E. of this Agreement; (f) the specific Community Provider(s) who will provide

the identified supports and services, and the needed frequency and intensity of services and supports; (g) resources that the individual will call on if she or he experiences crisis in the community; and (h) the date the transition will occur, as well as the timeframes for completion of needed steps to effect the transition.

Analysis: This discussion addresses paragraphs 43 and 46 together. This Paragraph requires LDH to provide an 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 an 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 collaborate 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 of content 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. This improvement coincides with the implementation of several quality assurance initiatives to enhance supervision, training, and monitoring. Given that these initiatives were rolled out in 2024, further improvements are anticipated in future reporting periods. Anecdotally, the 2025 Service Review process is showing such improvement.

Among the 2024 ITPs, the most common gaps include: the ITP not being provided to the member (48%), no evidence of an 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.

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.	1) LDH should continue quality improvement strategies that improve the completeness and quality of ITPs, including reviewing (and reporting on) the presence and quality of the ITP addendum. 2) LDH should 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 amended 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. LDH reports that this is frequent practice and recently implemented a tracking system to enable reporting on the occurrence of virtual or in-person housing walk-throughs.

Figure 22. Paragraph 44 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. While the State has implemented training on person-centered approaches, a review of documentation shows that a person-centered focus needs improvement. LDH reports that TCs are arranging and/or providing virtual or in-person visits to housing, they are not yet able to report on such visits. **Compliance on this Paragraph has improved. It was rated "Not Met" in the 11th SME Report and "Partially Met" in this report.**	1) LDH should retrain TC staff and supervisors regarding person-centered planning using the modules developed in 2020 and use the checklist discussed in paragraph 61. 2) LDH should implement strategies to report on visits to housing and community-based services (e.g., intensive outpatient programs, integrated day programs) and provide data in future reporting periods.

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. 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, however, such functionality was launched in early 2025.

In 2024, LDH also implemented a pilot program – titled the Rapid Integration Transition Coordinator (RITC) program – to more immediately engage individuals after admission into NFs versus referring them to in-reach after admission. The pilot deploys an RITC who makes initial telephonic contact within 3 days of admission and face-to-face contact within 14 days. Until the real-time admission alert process was in place, RITCs were 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 (PIR) follow-up 90 days later. PIR is described in more detail in Section V.

While the RITC pilot was initially conceptualized for five regions, by the end of this reporting period, LDH was able to expand the RITC pilot to seven regions and devise plans to scale statewide in the first quarter of 2025. RITC staff received training, shadowing, supervision, and peer-to-peer coaching consistent with traditional TCs, and participated 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.

As referenced in the discussion under Paragraphs 25 and 26, the Active Caseload – or AC – has historically referred to individuals who were, for the most part, engaged by PIR and then expressed interest in transitioned. The RITC AC works differently. Through the RITC pilot, LDH adds presumed TP members onto the "RITC AC" when they are admitted to a NF. This triggers the engagement process between the RITC TC and the individual who was recently admitted. Thus, while the historical AC reflects individuals who have expressed interest in transition, the RITC TC simply identifies admitted individuals need to be engaged. And as data demonstrates below, a very small percentage of those on the RITC will express or maintain interest in transition.

In the 11th SME Report, the SME provided data for January to August 2024. In this report, LDH has provided data for the entirety of calendar year 2024, which includes:

- LDH added 503 individuals to the AC through the RITC pilot.
- There were 473 (94%) individuals who received the required 3-day contact, and 445 (88%) who received the in-person 14-day contact.
- Of the 445 who received the 14-day contact, 69 (15%) were interested in transition, while the remaining 376 (85%) were either not interested, unable to complete the interview, or unable to engage due to health-related or other issue.
- Seventy-eight individuals went on to complete an ITP, with 53 maintaining interest after ITP completion. The number of ITP completions likely exceeds the number of individuals who received the 14-day contact, because some individuals who received contact after 14 days expressed interest and went on to complete an ITP.

- A look at key outcomes demonstrates that a sparse number/percentage of individuals who are initially added to the RITC AC make it to the end. Of the 503 individuals, 78 (16%) complete an ITP, 53 (11%) maintain interest after the ITP, and 39 (8%) either transitioned or were working toward transition at the end of the year.
- Of note, an additional 125 individuals had stays for less than 90 days and received minimal RITC support in their planned transitions.

Several lessons learned in the pilot were noted in the 11th SME Report. More information on how statewide adoption of the RITC program will impact legacy processes – such as PIR and the current TC approach – is provided under Paragraph 54.

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.	1) LDH should implement the recommendation under Paragraphs 31 and 33. 2) LDH should develop strategies to address lessons learned in the pilot, including adopting a rapid engagement approach, building engagement proficiencies among RITC staff, and considering flexibilities around documentation (e.g., NFTA) until rapport is established. The SME can support training and implementation.

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

Analysis: During the 7th reporting period, LDH, through its MCOs, launched a case management approach called CCM. MCOs contract with 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 7th 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 an extension is granted 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). Service Reviews for 2025 are not slated for completion until summer of 2025; thus, the SME is carrying forward the 2024 Service Review data (which he used in the 11th SME Report) to contribute to the compliance assessment for this Paragraph.

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 24. 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 25. 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 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 is likely a better indication of needed services after community placement. TCs can play a role in assessing whether the transitioned individual is receiving planned services and more generally, whether they are experiencing issues that are not being adequately addressed. To comply with this requirement, LDH has fielded a guidance document for TCs that specifies what each post-discharge visit should cover. TC supervisors also track whether visits occur. While these strategies ensure the occurrence of post-discharge TC visits, a more structured process may be needed to ensure that the visits are achieving their intended outcomes.

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 reviews 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 26. Paragraph 49 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. While LDH has developed a process to ensure the occurrence and focus of post-transition TC engagements, a more structured process is needed to identify service gaps and address issues with post-transition service access and utilization. **Compliance on this Paragraph has improved. It was rated "Not Met" in the 11th SME Report and "Partially Met" in this report.**	1) LDH should implement an approach to ensure that post-discharge TC visits address 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.

There are also circumstances wherein transitioned individuals 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. In the last 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 27. 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. LDH collects barrier information at two stages: (1) during the in-reach process, and (2) during the NFTA for those who express initial interest. Figure 28 provides a synopsis of information gleaned at each of those engagement stages.

Figure 28. Common Barriers Collected During 2024 Quarter 3			
	Most Cited Barrier[2]	*Additional Common Barriers*	*Percentage of Overall Barriers*
In-Reach: Undecided (194 records)	(1) Concerns expressed related to needed supports	(2) Concerns about management of physical health; (3) decline in physical health; (4) concerns expressed related to needed medical services	Most cited and additional common barriers constitute 53% of all reported barriers.

[2] The "Other" category had the most barriers. Given that the category contains a variety of barriers, it is not counted as the "Most Cited" barrier.

In-Reach: Not Interested (683 records)	(1) Decline in physical health	(2) Concerns about management of physical health; (3) family/guardian not supportive of transition; (4) concerns expressed related to needed supports	Most cited and additional common barriers constitute 66% of all reported barriers.
Transition: Barriers Cited in NFTA Process (90 records)	(1) Waiting for a specific housing unit or a housing unit in a specific town	(2) Waiting for housing greater than six months; (3) waiting for an accessible housing unit; concerns about management of physical health concerns; cognitive patterns observed illustrate possible instability (suspected dementia) *(all three barrier types tied for third most cited)*	Most cited and additional common barriers constitute 42% of all reported barriers.

In addition to identifying barriers on an aggregate level, LDH must also address these barriers at the individual and systemic levels. At the individual level, staff must be trained to meaningfully engage individuals around their fears and concerns about transitioning into the community, equipped with knowledge of the full array of service options. 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. Staff must be proficient in building 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. To aid staff in these conversations, LDH has developed a "Prompting Guide" for PIR staff that rolled out in August 2024. While the Prompting Guide includes guidance that likely enhances the person-centeredness of PIR discussions, the SME believes that enhancements are needed to equip PIR staff to fully explore individuals' fears and concerns.

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.

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 five individuals were transitioned to non-PSH settings: one in a group home and four categorized as "other." In the last period, LDH reported that one member of the TP transitioned to a group home but moved into her own apartment a few months later. Even though this Paragraph is not rated, the SME recommends that LDH continue to track non-PSH placements. The SME also recommends that LDH investigates the causes of the increase in non-PSH placements in this reporting period.

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: As described under Paragraph 51, during the in-reach process, peer staff capture barriers among those who are not interested or undecided about transitioning to the community. In addition to capturing and categorizing barriers for individuals who are "undecided" and "not interested" (summarized in Figure 27), LDH also captures reasons that individuals are "unable to make a decision," which may be the most relevant cohort for the purposes of this Paragraph. Data from the third quarter of 2024 demonstrates that 207 individuals were deemed unable to make a decision. Of those, LDH reports that 161 (78%) had a "health condition resulting in the inability to engage in discussion regarding community options" and 88 (43%) were "not able to communicate even with the assistance of communication aides." In quarter 4, there were 167 individuals categorized as unable to make a decision, with similar trends regarding the reasons for such. There were approximately 2,225 in-reaches in the second half of 2024. Assuming these in-reaches reflect unduplicated individuals, a sizable portion (374 or 17%) were deemed unable to make a decision over the same period.

LDH should consider 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. Currently, these individuals only receive annual visits. 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 that present safety issues (whether within or outside of an NF) or that 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 recommendations regarding the feasibility of transition or strategies to ensure safe community tenure. The TSC also reviews cases in which the TC or CCM believes that additional support is needed for transitioned or diverted members after their one-year service window.

LDH provided data regarding TSC activities from July to December 2024. During this period, the TSC received 24 referrals and all reviews were completed by February 2025, resulting in the following dispositions:

- *TSC Referral Rescinded (7).* Referrals were rescinded due to a determination that the individual had primary dementia (3), an individual moving out of state (1), an individual being readmitted (1), and other rescissions after submission (2).
- *SHARe Exception (4).* After additional review, the TSC approved (3) and denied (1) certain individuals for SHARe exceptions, which increase resources (e.g., worker hours, financial support for home modifications) for certain clients beyond established limits in waiver programs.
- *Other Guidance Provided (13).* The TSC determined that health and safety could not be assured in the community with available supports (8), additional evaluations and engagements were needed (3), and that certain individuals could proceed with transition (2).

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 to re-engage those who lack decision making capacity at the time of in-reach. 2) LDH should conduct a small sample study to better understand the circumstances of individuals who are categorized as "unable to decide."

V. Outreach, In-Reach, and Provider Training 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 NFTA and 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, 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 July to December 2024, LDH exceeded that target, with 2,225 in-reach encounters versus the 2,160 target. There were 1,018 initial in-reaches (46%) and 1,207 follow-up in-reaches (54%). This represents a significant improvement over the last period, wherein staff consistently fell beneath the 360-visit monthly target. The 11th SME Report enumerates the strategies deployed by LDH to improve the quality and penetration of in-reach. Figure 32 provides the percentage distribution of in-reach outcomes for this reporting period.

Figure 32. In-Reach Outcomes for Initial and Follow-Up Visits

	Interested	*Undecided*	*Not Interested*	*Unable to Decide*
Initial	10%	19%	56%	15%
Follow-Up	6%	11%	66%	17%

In the 10th reporting period, 18% expressed interest, versus 8% in the 11th period and 10% in this period. LDH reports that PIR staff have increased their proficiency in discerning 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 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, 526 individuals on the ML had not yet been reached, and in this period, 642 individuals had not yet been reached. However, given that LDH is in the process of improving the accuracy of the ML, some of these individuals may not meet TP criteria and thus should be removed from the ML. In future reports, when the accuracy of the ML is confirmed, the SME will provide the percentage of unreached individuals on the ML.

As noted above and discussed more fully in Paragraph 45, some PIR functions are now implemented by RITC staff. During this reporting period, RITC staff will serve as the first point of contact for individuals newly admitted into NFs within the pilot regions. Within those regions, PIR staff only conducted initial 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 33. 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).

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 be especially 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 34. 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.	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. For CY2025, LDH utilized a similar methodology to reach a target of 287.

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 TP, among other limitations. It is the SME's hope that the analysis of the TP 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 three years since. Figure 35 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 35 for the purposes of this report. LDH achieved 135 (41%) of its required 331 transitions for CY2024. While the performance percentage has decreased compared to CY2023, the count of transitions is climbing back toward the highest performing year. As of December 31, 2024, there have been 793 transitions since the beginning of the Agreement.

Figure 35. Multi-Year Transition Performance

Period	*Target*	*Achieved*	*Performance %*
June-Dec 2018 & CY2019	N/A	91	N/A
CY2020	100	38	38%
CY2021	219	94	43%
CY2022	292	200	68%
CY2023	350	174	50%
CY2024	331	135	41%
Total Transitions (June 2018 to December 2024): 732			

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.

During this reporting period, it was 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 36. 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.

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: LDH cites housing as its most common transition barrier and has developed a housing plan to inform the development of housing supply and other key strategies, as described in Paragraph 81. Among those who have the opportunity to transition, the prior and current SME's Service Reviews, as well as information from other data sources, show that the plurality transitioned members is moved into PSH. However, in this reporting period, five individuals transitioned to non-PSH settings, a significant increase over the last reporting period.

This Paragraph requires that individuals be transitioned into integrated housing options in adherence to the timeframes established in their ITPs. The 2024 Service Review showed that TCs generally initially establish a generic transition date 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.

Figure 37. 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 9th 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 July to December 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 into the TSC's 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 38. 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 7th, 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 an 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 reports that as of 12/31/24, there were 124 transitioned individuals and 53 diverted individuals engaged in CCM services. In the last reporting period, there was an average of 176 transitioned individuals and 45 diverted individuals engaged in CCM monthly. The SME would like to meet with LDH to discuss data collection regarding CCM utilization, engagement, and outcomes.

LDH provided information, reflected in the 8th SME 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.

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, reassessments, community plans of care (CPOC), crisis plans, and other documentation that supports the delivery of CCM services.

The SME's service review process involves an in-depth review of diverted and transitioned individuals who are engaged in the CCM program, and as such, sheds light on the CCM program's performance. Figure 40 displays relevant findings from the 2024 Service Review.

Figure 40. CCM-Related Service Review Findings

- 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 enrolling 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 41. 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 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 7th SME Report, the State has developed assessment and plan of care tools that are intended to capture the desires and needs of the TP who have been diverted or transitioned from NFs. Consistent with the two prior Service Reviews, the 2024 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 42. 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. 2) LDH should implement the priority recommendations under Paragraph 60 regarding improvements to CCM documentation.

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: 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. LDH receives 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.

During this reporting period, OAAS and OBH leadership also continued to accompany the service review teams to visit individuals who were transitioned, diverted, or in the NF awaiting transition. This included a review of 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 has now implemented aspects of the Service Review process in their monitoring of TC performance and client outcomes.

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 is important for LDH to incorporate information from the tracking efforts to the overall quality efforts described in paragraphs 98 and 99.

Figure 43. 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

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

Analysis: In December 2019, LDH, with input from the former SME, developed a plan for a statewide crisis response system, which included the crisis services in the Agreement and additional crisis services used in other jurisdictions that have proven efficacy. This framework included the requirements in the Agreement and can be found at https://ldh.la.gov/assets/docs/MyChoice/CrisisFramework.pdf. In the prior SME's reports, he describes the multi-year process undertaken by LDH to build and expand its crisis system, from developing service definitions, to obtaining funding for services, to training selected crisis providers, among numerous other activities. Louisiana's crisis framework includes four service types:

- Mobile Crisis Response (MCR), which deploys teams to provide immediate intensive assessments and deliver interventions to stabilize crisis and refer to ongoing care.
- Community Brief Crisis Support (CBCS), which provides follow-up care after individuals in crisis have received an initial crisis service or have been referred directly from EDs, focused on maintaining the individual in their current living arrangements and preventing ED, hospital, NF, or other institutional placements.
- Behavioral Health Crisis Care Centers (BHCC), which provide site-based crisis services for up to 23 hours to enable an individual to return home with the support of community-based services.
- Crisis Stabilization Units (CSU), which provide site-based crisis services for multiple days and nights to prevent utilization of higher levels of care.

During the reporting period, OBH began implementing MCR and CBCS to individuals 20 and younger in regions where providers had been identified and completed activities to go live. Additional information on these services will be integrated into future reporting. Further, as described under Paragraph 64, Louisiana's six Medicaid MCOs operate toll-free crisis hotlines. LDH also plans to launch its new statewide Crisis Hub in May 2025.

Figure 44 shows the services for individuals 21 and older that are operational or planned in each of the state's 10 regions which align with LGE geographic catchment areas at the end of this reporting period. Cells marked with "x" indicate that the service is operational and those marked with "P" indicate that a provider has been identified and the service is under development. Three regions have no crisis services and no region has all four. Seven regions have at least one service. In addition to the requirement that LDH develop an evidence-based crisis system, this Paragraph envisions that TP members have crisis plans that proactively identify the strategies that should be implemented if they experience a crisis. All individuals who receive CCM, including those who are transitioned and diverted, are required by LDH to have a crisis plan, which identifies situations that may trigger a crisis, strategies the individual has used in the past to resolve the crisis, strategies the individual or provider (including the crisis provider) can deploy to de-escalate the crisis and ensure stabilization, plans for caretaking (e.g. children, pets, etc.) if the individual is hospitalized, treatments (including medications) the crisis responder should avoid, and individuals who should be contacted during a crisis.

Figure 44. Adult Crisis Services Availability

	MCR	*CBCS*	*BHCC*	*CSU*
Region 1	x	x		
Region 2			x	x
Region 3	x	x	x	
Region 4				
Region 5				
Region 6	P	P	P	P
Region 7	x	x	P	P
Region 8				
Region 9	x	x	x	
Region 10	x	x	x	P

The 2024 Service Review identified that, 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 terms of utilization of crisis services among the TP specifically, data reported by LDH for the first quarter of 2024 demonstrates that no transitioned members received a crisis service, and one diverted member received a BHCC service. During the same period, 1.8% of transitioned members visited an ED and 1.5% were admitted into a hospital for behavioral health reasons. Diverted individuals had substantially higher rates of ED and hospital utilization, at 8.6% and 12.3%, respectively. This data suggests that there are likely additional opportunities to avail transitioned and diverted individuals of crisis services to prevent needless utilization of higher levels of care that should result in NF admission.

Figure 45. Paragraph 63 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating and Rationale	***Priority Recommendations***
Partially Met. LDH has made considerable progress in developing a crisis system to benefit the TP, but continued development is needed to ensure that the TP can access all four crisis services across all regions.	1) LDH should continue to expand crisis services until every region has 24-hour access to all crisis services. 2) LDH should develop strategies to ensure that crisis services are optimized among the TP, and especially diverted individuals, to reduce ED and hospital utilization for behavioral health reasons.

64. LDH will ensure that the Target Population has access to a toll-free crisis hotline in each community 24 hours a day, 7 days a week, staffed by qualified providers, with sufficient capacity to preclude the use of answering machines, third-party answering services, and voicemail. Crisis hotline staff will try to resolve the crisis over the phone, and if needed will provide assistance in accessing face-to-face intervention, arranging an urgent outpatient appointment, providing phone consultation with a Licensed Mental Health Practitioner if a higher level of clinical skill is needed, or connecting the caller with peer support services.

Analysis: As discussed in the prior SME's reports, there has historically been a patchwork of toll-free crisis and help lines to assist individuals, including members of the TP, experiencing crisis. This includes the MCO crisis lines, 988, and direct calls to MCR teams. To address this issue, the crisis framework referenced in Paragraph 63 includes the development of a statewide toll-free crisis line to serve the TP and all Louisianans experiencing a behavioral health crisis. After extensive planning and a solicitation process, LDH has selected a vendor to operate the statewide crisis line – called the Crisis Hub – slated for launch in May 2025. A key function of the Crisis Hub will be to dispatch the MCR teams and refer to other crisis services. MCO crisis hotlines will continue to operate as the new Crisis Hub launches though this function will formally cease once the Crisis Hub goes live.

The discussion for this Paragraph will focus on the MCO crisis hotlines since the Crisis Hub has yet to launch. Consistent with this Paragraph's requirements, the MCO crisis hotlines operate 24 hours a day, 7 days a week, are staffed by qualified providers, and do not make use of answering machines, third-party answering services, or voicemail. LDH reports that there were 221 crisis calls across all MCOs from July to December 2024, reflecting an average of 37 calls per month. That is a significant decrease in calls compared to data provided in the 10th SME Report (which analyzed data from January to October 2023), indicating an average of 53 calls per month. The SME concurs with the prior SME that this call volume is low. It is the SME's hope that the Crisis Hub will receive a higher volume, through engagement/education of stakeholders (including providers, family members, individuals experiencing crisis, first responders, and others) and other strategies.

The SME reviewed publicly available data from the New Orleans Mobile Crisis Intervention Unit (MCIU) to provide comparisons regarding call volume and dispositions. There are limitations in the ability to compare the programs, due to potential differences in the characteristics of callers (i.e., level of crisis, Medicaid MCO members versus general population) and well as the method for contact (i.e., calling the MCO crisis hotline versus 911). However, there were 4,882 mental health calls for service referred to the MCIU over the same time period that the MCO crisis hotlines received 221 calls. If anything, this data indicates that there is an entire universe of crisis

events and associated calls that funnel through other systems, further necessitating a centralized crisis call center infrastructure and partnerships with 911, 988, law enforcement, and other systems that interface with individuals in crisis.

Figure 46. Disposition of MCO Crisis Calls		
Disposition	*Number*	*Percentage*
Resolved – Refused Referral	17	8%
Resolved – Appt/Referral to Community Provider	136	62%
Resolved – Returned to Community Provider	36	16%
Dispatched MCR	11	5%
Referred to BHCC	2	1%
Referred to ED/MH/SUD Inpatient	5	2%
Referred to SUD Residential	2	1%
Engaged Law Enforcement	11	5%
Unresolved	1	<1%

Figure 46 displays what happened as a result of the MCO crisis hotline calls. Most calls (86%) were resolved by staff, consistent with prior reporting periods. Approximately 6% of all calls resulted in the dispatch of a local MCR or BHCC provider, compared to 15% calls in the 10th period. There were 8% of calls that resulted in a referral to an ED, inpatient care, or law enforcement. The distribution of dispositions of MCO crisis calls differs substantially from the New Orleans MCIU. For example, 38.7% of calls received through MCIU were referred to MCR versus 5% of those received through the MCO crisis lines. This could be attributable to differences in acuity between the two populations, but could also demonstrate MCOs' under-reliance on MCR, especially given that 7% of individuals were referred to ED or inpatient settings or engaged by law enforcement.

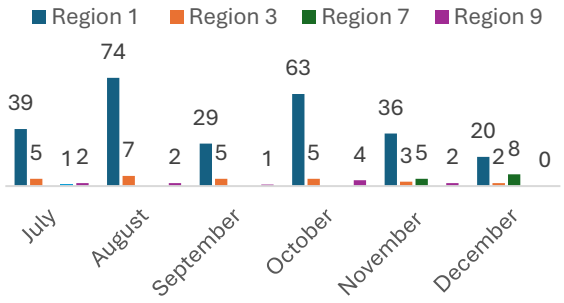
Additional data tracking of dispositions is needed to fully assess compliance with this Paragraph (e.g., phone consultations with licensed mental health practitioners, connection with peer supporters). Such reporting enhancements should be implemented for both the MCO crisis lines and the Crisis Hub.

Figure 47. Paragraphs 64 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating and Rationale	***Priority Recommendations***
Partially Met. During this reporting period, the MCOs continued to operate crisis lines which complied with most of the Agreement's requirements. As LDH launches the Crisis Hub in 2025, there are opportunities to streamline and expand access to crisis services, and report on all required metrics to demonstrate compliance.	1) LDH should fully implement the Crisis Hub, tracking all the metrics required to demonstrate compliance with this Paragraph and engaging a broad range of stakeholders to ensure that individuals, including those in the TP, are aware of the new resource. 2) LDH should ensure that the Crisis Hub, when unable to directly resolve crises, refers to the most integrated crisis solutions possible, fully optimizing MCR and other community-based programs.

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

Analysis: Five of 10 regions had MCR services operational at the end of this reporting period: regions 1, 3, 7, 9, and 10. In the 10th reporting period, MCR was operational in seven regions, but services in two regions 2 and 4 have since discontinued, one of which was due to LDH's requirement that providers deliver 24/7 services as of March 2024. LDH reports they are continuing efforts to recruit and train providers in the regions that do not have an MCR provider. Figure 48 provides the number MCR dispatches from July to December 2024.

Figure 48. MCR Dispatches by Month and Region



LDH reports that there were approximately 315[3] MCR deployments from July to December 2024. From January to October 2023 (data analyzed for the 10th SME Report), 322 individuals utilized MCR. This indicates that there has been growth in the program over time; 52 individuals on average per month utilized MCR in this reporting period versus 32 in the prior analysis period. However, service utilization data from Medicaid claims demonstrates that there were no TP members who utilized MCR in quarter 4 of 2023 or quarters 1 and 2 of 2024.

This presents an opportunity for LDH, as they continue to scale MCR services statewide, to devise strategies to ensure TP members' access to MCR. It is important to note, however, that a significant segment of transitioned and diverted members utilize outpatient behavioral health services, including ACT services, which should be proficient at preventing, de-escalating, and otherwise addressing distress and crisis events among their clients.

Figure 49. Disposition of MCR Engagements

Disposition	*Number*	*Percentage*
Resolved – Refused Referral	13	4%
Resolved – Appt/Referral to Community Provider	64	20%
Resolved – Returned to Community Provider	34	11%
Referred to BHCC	5	2%
Referred to CBCS	3	1%
Referred to ED/MH/SUD Inpatient	175	56%
Referred to SUD Residential	7	2%
Engaged Law Enforcement	10	3%
Unresolved	4	1%

During this reporting period, LDH provided information on the disposition of MCR services for all Medicaid beneficiaries receiving MCR services (see Figure 49). When compared to trends in the 10th SME Report, there was a decrease in resolutions in the community (51% to 35%), a decrease in referrals to other crisis services (6% to 3%), an increase in referrals to ED or inpatient levels of care (42% to 56%), and an increase in referrals to law enforcement (<1% to 3%). The trends in dispositions are the reverse of what the SME would hope to see in maturing MCR programs.

Specifically, the SME has concerns about the high percentage (56%) of MCR engagements that result in an ED or hospital referral. In contrast, an evaluation of the MCIU program (found here: https://www.rhd.org/wp-content/uploads/2024/11/MCIU-1-year-evaluation-FINAL.pdf) showed that only 21% of MCR engagements ended in hospitalization (9% involuntary and 12%

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

voluntary) and less than 1% of in an ED visit. Per LDH, data on the percentage of MCR engagements resulting in ED or hospital referrals might be skewed due to a new MCR provider that has a robust but new collaboration with 911 in their region; this data may level out as processes are refined and implementation matures. The SME will monitor progress in this area.

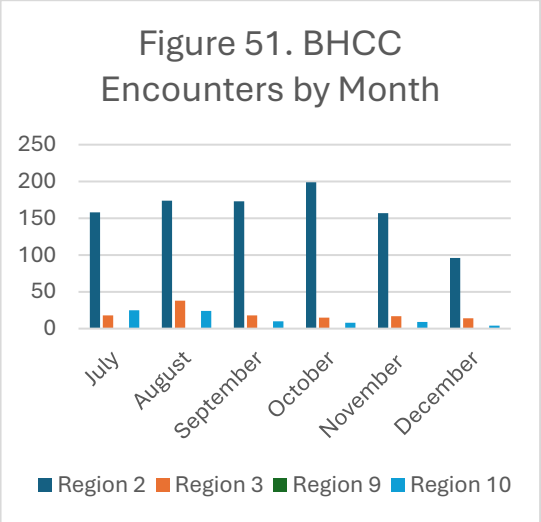
Given that MCIU receives referrals exclusively through 911 and LDH's MCR teams receive 53% through 911, the SME would expect higher-acuity crisis presentations, on average, for the MCIU teams. However, LDH's MCR providers demonstrate a substantially higher reliance on more intensive levels of care that could result in subsequent NF admission. The proportion of transitioned members who utilize ED and hospital services for behavioral health reasons has decreased in past periods, so ensuring MCR teams use the most integrated settings possible for them (should TP utilization of MCR increase), is important to sustain that trend. Outside of the 168 (53%) of LDH's MCR engagements that were dispatched by 911, common dispatch sources include crisis response service providers (47 or 15%), family or friends (39 or 12%), and self-referrals (27 or 9%). An additional 34 (11%) MCR deployments were dispatched by the MCO crisis lines, 988, ED, schools, and medical providers.

Figure 50. Paragraphs 65 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating and Rationale	***Priority Recommendations***
Partially Met. LDH has MCR teams operational in five of ten Louisiana regions. In addition to ensuring statewide coverage, LDH should ensure that MCR teams are not overly reliant on ED and inpatient referrals and that referral sources (e.g., schools, medical providers) are aware of MCR as a resource.	1) LDH should continue to expand and promote MCR services statewide, identifying strategies to increase utilization among the TP. 2) LDH should investigate potential over-reliance of MCR teams on ED and inpatient settings.

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

Analysis: To comply with this Paragraph, LDH included BHCCs as the linchpin of its crisis receiving system. BHCCs are walk-in centers designed to provide relief, resolution, and intervention of initial or emergent psychiatric crises, similar to urgent care models for physical health. At the end of this reporting period, BHCCs were operational in regions 2, 3, 9, and 10 and under development in regions 6 and 7.

LDH reports that 1,158 individuals utilized BHCC services from July to December 2024, reflecting an average of 193 individuals per month, mirroring utilization from the period analyzed in the 10th SME Report. As indicated in Figure 51, region 2 – which includes Baton Rouge and surrounding areas – had the plurality of encounters: 957 or 83%. This does not appear proportional to population size; for example, region 10 is home to heavily populated New Orleans and had only 80 (7%) of BHCC encounters. In addition to expanding the presence of BHCC programs statewide, the SME encourages LDH to analyze whether the encounters in each region are proportionate to population size and the maturity of the programs (e.g., staffing capacity).



Dispositions of BHCC encounters are provided Figure 52. Compared to the analysis in the 10th SME Report, there was an increase in the number of individuals who had their crisis resolved by the BHCC provider (29% to 40%), a decrease in the number of individuals who were referred to other crisis providers (41% to 26%), and a decrease in the number of individuals referred to EDs and inpatient providers (21% to 6%). The SME views these trends as positive, as it appears that BHCCs are improving their capacity to address crises without reliance on higher levels of care.

Figure 52. Disposition of BHCC Encounters

Disposition	*Number*	*Percentage*
Still Receiving Services	15	1%
Resolved – Refused Referral	14	1%
Resolved – Appt/Referral to Community Provider	412	36%
Resolved – Returned to Community Provider	49	4%
Referred to CBCS	3	<1%
Referred to ED/MH/SUD Inpatient	74	6%
Referred to SUD Residential	232	20%
Engaged Law Enforcement	1	<1%
Referred to CSU	347	30%
Unresolved	11	1%

There continues to be low uptake of BHCC services and no utilization by individuals who have been diverted or transitioned from NFs. According to claims data from October 2023 to March 2024, only two individuals received BHCC services – one diverted member and one transitioned member. BHCCs could have provided a diversion opportunity for the 8.6% of diverted individuals who visited an ED and the 12.3% who were admitted to inpatient care for behavioral health reasons in the first quarter of 2024.

CSUs are also a vital part of LDH's crisis system. CSU services are short-term, bed-based crisis treatment and support services for individuals at risk for hospitalization or institutionalization, including NF placement. At the end of this reporting period, as in the 10th period, there was only one region with CSU services (region 2); providers were identified for three additional regions (6, 7, and 10). LDH reports that there were 359 CSU utilizations during reporting period. That represents, on average, 60 CSU encounters per month, which is the exact number of encounters per month from January to October 2023 (data provided in the 10th SME Report).

LDH provided data on dispositions that indicate where individuals are discharged after their CSU stays (see Figure 53). This data shows that 57% are referred to community-based providers. Only 5% are referred to ED or inpatient, but a notable 28% are referred to SUD residential. Data from the 10th SME Report demonstrated a higher percentage of discharges to ED or inpatient (21%) settings. However, the 10th report data did not include a category for SUD residential discharges, so it is unclear whether that data is embedded in the ED or inpatient category or was not collected. No members of the TP utilized CSU services in quarter 4 of 2023 or quarters 1 and 2 of 2024.

Figure 53. Disposition After CSU Stays

Disposition	*Number*	*Percentage*
Still Receiving Services	28	8%
Resolved – Refused Referral	2	1%
Resolved – Appt/Referral to Community Provider	202	56%
Resolved – Returned to Community Provider	2	1%
Referred to ED/MH/SUD Inpatient	19	5%
Referred to SUD Residential	100	28%
Engaged Law Enforcement	1	<1%
Unresolved	5	1%

Figure 54. Paragraphs 66 Compliance Determination and Associated Recommendations

Compliance Assessment Rating and Rationale	***Priority Recommendations***
Partially Met. BHCC and CSU services are not yet statewide, and utilization remains low, especially among the TP. In addition to statewide expansion, additional promotion of the services, including among the diverted population, is needed to prevent needless ED and hospital utilization.	1) LDH should continue to expand BHCC and CSU services until it is fully operational in all regions. 2) LDH should engage stakeholders to inform targeted strategies to increase utilization of BHCC and CSU services among the diverted population.

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

Analysis: As indicated in previous SME reports, LDH has implemented significant changes to their SUD service system through a CMS 1115 Demonstration Waiver, authorizing a continuum of services consistent with the American Society of Addiction Medicine (ASAM) that includes outpatient, intensive outpatient, residential, and withdrawal management services. To assess the performance of LDH's SUD system of care against requirements in this Paragraph, the SME reviewed PASRR Level II audit information, 2024 Service Review findings associated with SUD, SUD-related ACT fidelity scores, MCO network adequacy findings, and LDH performance on relevant Adult Core Set measures required by the Centers for Medicare and Medicaid Services (CMS). A synopsis of findings is displayed in Figures 55 and 56.

Figure 55. SUD System of Care Assessment

Performance Area	*Performance Synopsis*
Identification of SUD and SUD-Related Service Recommendations in PASRR Level II Evaluations	The most common deficiency in LDH's PASRR Level II evaluation audit (15 evaluations/12% of the audit sample) involved a behavioral health/SUD service recommendation that was misaligned with needs. Also, eight evaluations (6%) had missing SUD information.

2024 Service Review Findings Associated with SUD	Among the eight transitioned individuals who were rated as having poor behavioral health wellbeing outcomes, four reported active use of substances, although most were engaged in some type of SUD care. Sixteen percent of those preparing for transition had an identified SUD.
ACT Fidelity with SUD-Related Requirements	ACT teams, who generally serve approximately a third of transitioned and diverted members, performed well on fidelity measures associated with SUD (an average score of 3.9 for having required SUD staffing and 4.3 or provision individualized SUD treatment). On only one measure, involving the engagement of individuals with co-occurring disorders in groups, ACT teams had an aggregate average of less than three points.
Overall SUD Network Adequacy	At the beginning of 2024, there were no ASAM Level 2 withdrawal management services available in two regions, but that was resolved in the second quarter. Otherwise, all ASAM levels of care were present in all regions. As noted under Paragraphs 73 and 74, there was some slippage over 2024 in the timeliness of appointments for emergent and urgent care associated with behavioral health services overall.

As shown in Figure 56, Louisiana exceeds or matches the national average on 12 of the 14 SUD-related CMS reporting measures below, in many cases exceeding the top quartile. However, there are two measures where state performance is in the bottom quartile, both pertaining to follow-up appointments for SUD-related ED visits, including overdoses.

Figure 56. LDH Performance on CMS SUD-Related Measures

Rate Definition	State Rate	Median	Bottom Quartile	Top Quartile
Percentage of ED Visits for SUD or Drug Overdose with a Follow-Up Visit Within 7 Days of the ED Visit: Ages 18 to 64	17.3	28.2	17.3	34.4
Percentage of ED Visits for SUD or Drug Overdose with a Follow-Up Visit Within 30 Days of the ED Visit: Ages 18 to 64	28.5	39.8	29.1	49.2
Percentage of New Episodes of Alcohol Use Disorder with Initiation of SUD Treatment within 14 Days: Ages 18 to 64	54.5	41.3	38.3	45.1
Percentage of New Episodes of Alcohol Use Disorder with Engagement of SUD Treatment within 34 Days of Initiation: Ages 18 to 64	21.9	13.2	9.2	16.3
Percentage of New Episodes of Opioid Use Disorder with Initiation of SUD Treatment within 14 Days: Ages 18 to 64	72.9	60.9	49.9	67.4
Percentage of New Episodes of Opioid Use Disorder with Engagement of SUD Treatment within 34 Days of Initiation: Ages 18 to 64	43.4	32.9	20	42.3
Percentage of New Episodes of Other SUD with Initiation of SUD Treatment within 14 Days: Ages 18 to 64	55.4	41.6	38	46.7
Percentage of New Episodes of Other SUD with Engagement of SUD Treatment within 34 Days of Initiation: Ages 18 to 64	21.6	12.1	9	17.8
Percentage of New Episodes of Total SUD with Initiation of SUD Treatment within 14 Days: Ages 18 to 64	58.1	44.5	40.5	50.8

Percentage of New Episodes of Total SUD with Engagement of SUD Treatment within 34 Days of Initiation: Ages 18 to 64	25.3	15.5	11.5	22.1
Percentage of Current Smokers and Tobacco Users Advised to Quit: Ages 18 to 64 Years	72.2	73	69.4	76.5
Percentage of Current Smokers and Tobacco Users Discussed or Recommended Cessation Medications: Ages 18 to 64 Years	49.9	51.6	46.3	55.8
Percentage of Current Smokers and Tobacco Users Discussed or Provided Other Cessation Methods or Strategies: Ages 18 to 64 Years	48.5	43.3	41.5	48.4
Percentage with an Opioid Use Disorder who Filled a Prescription for or were Administered or Dispensed an FDA-Approved Medication for the Disorder: Total Rate: Ages 18 to 64	70.7	60.2	53.8	71.7

Figure 57. Paragraph 67 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating and Rationale	***Priority Recommendations***
Met. A continuum of SUD services is available in all regions and performance on most CMS-required SUD-related quality measures is strong. Continued efforts are needed to promptly link individuals with SUD to care after ED visits.	1) LDH should continue current efforts to improve the identification of SUD needs and provision of appropriate service recommendations at the PASRR Level II stage. 2) LDH should continue to ensure SUD treatment network adequacy and strengthen post-ED follow-up.

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

Analysis: As indicated under Paragraph 65, 53% of all MCR referrals came from 911, constituting the highest volume referrer to MCR services. This represents a substantial improvement compared to the 10th period, during which 31% referrals came from 911 or law enforcement. Data on referral sources for other facets of the crisis system, including BHCCs and CSUs, was not provided to the SME. LDH has implemented several strategies to boost awareness of crisis services among first responders including:

- Providing start-up funds to MCR and BHCC programs to create entry points into their services through education and partnership development with stakeholders.
- In collaboration with Louisiana State University (LSU), overseeing the development of regional crisis coalitions to ideally include law enforcement, judges, EMS, and other local stakeholders. In some cases, there have been challenges in implementation of these coalitions. LSU has developed technical assistance resources to promote best practices.
- Holding in-person meetings in each region to support regional crisis coalitions and provide information on how to access crisis services, current utilization, and other information specific to ED, inpatient, 988 calls, and utilization of crisis services.
- Convening of regular meetings with prospective and current crisis providers, as well as joint meetings with the MCOs and crisis providers.

- Planning of a media campaign regarding crisis services that will include information regarding regional crisis services and the implementation of the Crisis Hub.

The current SME views Crisis Hub implementation, slated for May 2025, as a high impact organizing framework for deeper engagement of first responders. Plans to promote the Crisis Hub should include a comprehensive set of strategies focused on educating and forming collaborative partnerships with 911, police, emergency medical services (EMS), ED staff, and others, to meet the spirit of this requirement. As part of Crisis Hub rollout, LDH has the opportunity to create bidirectional collaboration processes with first responders to increase access and utilization of crisis services.

Per this Paragraph, the role of first responders should not be limited to referring individuals to crisis services. LDH can also play a role in ensuring that first responders are better equipped to directly address the distress of individuals with behavioral health conditions. The Paragraph explicitly references the evidence-based Crisis Intervention Team (CIT) model, which forges partnerships between law enforcement, hospital emergency services, mental health providers, people with lived experience, and other stakeholders, to improve encounters between law enforcement and individuals in crisis through partnership development and intensive training.

LDH should enhance monitoring of its crisis system to include measurement of referrals from first responders and develop a strategy to improve the interface between people with SMI and first responders, such as the CIT model. This is especially important given that a third of all critical incidents among TP members engaged in CCM involve interaction with law enforcement, as described in Paragraph 95.

Figure 58. Paragraphs 68 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating and Rationale	***Priority Recommendations***
Partially Met. While MCR referrals from 911 are increasing, additional work is needed to ensure that law enforcement personnel and other first responders are proficient in engaging and referring individuals in crisis to appropriate care.	1) In addition to tracking referral sources to MCR, LDH should monitor and report on the referral sources to BHCC and CSU services to assess first responders' reliance on these resources. 2) LDH should create a comprehensive plan for engaging first responders as part of the Crisis Hub rollout, identifying engagement strategies (e.g., listening sessions), key targets/partners, messages, potential partnerships, and other actions likely to strengthen cross-sector collaboration.

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

Analysis: As indicated in prior reports, LDH developed policies, procedures, and training for the MCO crisis lines and the four crisis services. The prior SME advised on these protocols. Further, prior reports indicate that MCOs have developed and trained providers regarding crisis care coordination protocols, conveying the expectation of staff to coordinate across the crisis continuum of care.

For the MCO crisis lines, specifically, LDH monitors their performance in terms of call abandonment rates, calls answered within 30 seconds, and percentage of incoming calls answered. As shown in Figure 59, the MCOs perform well across all metrics. Compared to the 10th reporting period, MCOs improved across all metrics, most markedly in call abandonment rates; the average monthly call abandonment rate from March through December 2023 was 5.3% compared to 1.05% in this period.

Figure 59. MCO Crisis Line Performance

	Jul	Aug	Sept	Oct	Nov	Dec
Call Abandonment Rate	**0.8%**	**2%**	**0.8%**	**0.9%**	**1.4%**	**0.4%**
% of Calls Answered within 30 Seconds	**99.2%**	**98%**	**99.2%**	**99.1%**	**98.6%**	**99.6%**

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

Figure 60. Paragraph 69 Compliance Determination and Associated Recommendations

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

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

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

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

Analysis: Paragraphs 70-72 are addressed together. During this reporting period, there were 44 ACT teams that were operational and available to TP members; per LDH, this is an adequate number of ACT teams to serve diverted and transitioned members. LDH reports that for the 2nd quarter of 2024, 47.3% of transitioned members were engaged in ACT services. More than a third of diverted members utilized ACT in the 2nd quarter of 2024. This represents significant growth in ACT utilization among both groups.

Each of the 44 ACT teams received a fidelity review in 2025, utilizing the Dartmouth ACT Scale (DACTS). Across the 28 categories, the ACT teams received an average score of 3.8 on a one-to-five-point scale. No ACT teams scored beneath an average score of three across all 28 categories. There were six areas in which the ACT teams, on the aggregate, scored beneath three points: involvement in hospital admissions, client retention, face-to-face time with clients, frequency of visits, collaboration with informal supports, and engagement of individuals with co-occurring disorders in groups. To discuss fidelity review findings, programmatic improvements, and other issues, LDH and the MCOs meet with the ACT teams at least monthly.

The 2024 Service Review also produced several findings associated with ACT, including:

- Approximately half of the transitioned members in the service review cohort received ACT services.
- Compared to prior years, TCs more consistently secured referrals to ACT teams prior to an individual's discharge and CCMs improved the regularity of their communication with ACT teams.
- ACT teams were not consistently aware of time limits for CCMs and TCs, resulting in missed opportunities to help the individual navigate the discontinuation of TC and CCM services, including plans to titrate up the intensity of their supports, if necessary.
- ACT services were associated with overall positive behavioral health wellbeing scores for transitioned members, with members reporting that their support around medication management (including ensuring access and providing reminders) was especially helpful.
- Approximately 80% of diverted members in the service review sample were in receipt of ACT, likely resultant from an LDH policy in 2023 that all diverted members are offered ACT.
- Preliminary findings from the 2025 Service Review indicate that ACT teams have room for improvement as it relates to advancing community integration. Further, Agreement-related providers (e.g., TCs, CCMs) may need additional education regarding the circumstances during which an individual can receive both ACT services and Intensive Outpatient Program services.

The data above suggests that ACT teams are of sufficient quantity and quality to meet the needs of TP. In concurrence with the prior SME, the current SME recommends continued refinements to the program, including developing policies and protocols for referring individuals diverted through the PASRR Level II process more promptly after their evaluations and finalization and implementation of step-down criteria to ensure future capacity. Further, the SME recommends that LDH consider strategies to re-offer ACT services to TP members with higher levels of acuity (e.g., diverted members who utilize the ED or are admitted into hospitals for behavioral health reasons) and that LDH continues to build proficiency among ACT teams to advance community integration among TP members.

Figure 61. Paragraphs 70-72 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating and Rationale	***Priority Recommendations***
Met. There is an adequate number of ACT teams to meet the needs of the TP, and the teams perform well on recognized fidelity standards.	1. LDH should continue to make refinements to ACT services, including enhancements to their community integration focus. 2. LDH should consider which subsets of the TP who, because of their vulnerability, should be re-offered ACT services.

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

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

Analysis: Paragraphs 73 and 74 are addressed together. LDH continues to measure the availability of and access to Intensive Community Support Services (ICSS), which include the State's current Medicaid behavioral health services, on a quarterly basis utilizing network adequacy reports. Consistent with the prior SME's approach, the current SME defines ICSS as Community Psychiatric Services and Treatment (CPST), Psychosocial Rehabilitation (PSR), crisis services, ACT, peer supports, Intensive Outpatient Programs (IOPs) and withdrawal management.

Current policies require MCOs to ensure that Medicaid-reimbursed CPST, PSR, IOP and withdrawal management providers have active licenses from LDH Health Standards as a Behavioral Health Service Provider (BHSP) and accreditation from a national accreditation organization. All providers of peer support services (limited to LGE and PSH providers) must also be licensed as a BHSP provider. Across the ICSS program, there appears to be no widespread network adequacy and access issues, but there remain a few gaps. Notable observations from the SME's review of MCO network availability data include:

- At the end of the reporting period, three regions did not have any of the four crisis services in LDH's crisis framework, and there were no regions that had all four.
- ACT, CPST, PSR, behavioral health personal care, and most psychiatric outpatient services remained stable throughout 2024. However, the number of CPST providers dropped slightly from 2023, from 352 in CY2024 quarter 1 to 333 in CY2024 quarter 4.
- There was slight regression in provider performance against appointment availability standards over the four quarters of 2024. In quarter 4, 81% of providers had appointments available for emergent issues within one hour versus 87% in quarter 1 and 82% had appointments available in 48 hours for urgent care versus 92% in quarter 1. Performance in these areas dropped gradually each quarter in 2024 and fell below LDH's benchmarks of 90% for emergent and urgent appointments.
- ASAM level 2 withdrawal management services were not available in regions 6 and 8 in quarter 1, but nine programs were available across both regions by the end of the reporting period.
- Over 2024, there were slight reductions among Licensed Clinical Social Workers and certain specialties for psychologists and psychiatrists.

While the availability of most services is adequate, there remains relatively low utilization of these services among members of the TP outside of ACT. CPST and PSR were utilized by 14.3% of the transitioned population and 5% of the diverted population in the second quarter of 2024. Over the same period, there was no utilization of Medicaid peer support services. The prior SME noted that the current utilization of these services is substantially lower than the projections established through the 2021 Needs Assessment and recommended that LDH conduct an analysis to better understand the drivers of lower-than-expected utilization.

Figure 62. Paragraphs 73-74 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating and Rationale	***Priority Recommendations***
Partially Met. Across most programs, LDH has – through its MCOs – ensured that there is an adequate number of providers to address the needs of the TP. Some gaps persist (e.g., crisis services) and appointment timeliness standards are showing some slippage.	1) LDH should continue efforts to expand crisis services and determine the need or appropriateness to increase utilization of ICSS services among the TP.

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

Analysis: Since the beginning of the Agreement, many TP members have required extensive support in their ADLs and instrumental ADLs. ADLs include day-to-day activities such as bathing, dressing, transferring (e.g., from a bed to a chair), toileting, grooming, and self-feeding. Instrumental ADLs indicate a certain level of functional independence, such as using the telephone, preparing meals, managing household finances, taking medications, doing laundry and other housework, shopping, and managing transportation. The behavioral health services in Louisiana's Medicaid State Plan, such as CPST, PSR, and ACT, offer assistance to improve IADLs. LDH also provides several personal care service options to assist with ADLs, under various Medicaid authorities. This includes the 1905(a) State Plan Personal Care Services, the 1915(c) New Opportunities Waiver (NOW) for individuals with intellectual and development disabilities, the 1915(c) Community Choices Waiver, and an OBH 1915(b) waiver for individuals who do not meet NF level of care requirements or qualify for the NOW waiver.

A sizable proportion of transitioned members receive personal care services through one of these options: 61% in quarter 4 of 2023, 45% in quarter 1 of 2024, and 68% quarter 2 of 2024. The subset of transitioned members receiving OBH personal care services was at 15% in quarter 2 of 2024, increasing from around 8% in prior periods. Among diverted members, utilization of these waivers has also grown; climbing from 10% in quarter 4 of 2023 to 18% in quarter 2 of 2024.

Through the SME and his team's interviews with TP members and the staff who serve them, it is clear that these waiver options are integral to facilitating the types of care people need to avoid NF placement or transition from NFs. Preliminary findings from the 2025 Service Review show that when individuals are denied specific waiver opportunities, it can result in extensive delays in their transition processes. In some cases, they are denied participation in one waiver and then must begin another lengthy assessment process to obtain approval for a different waiver opportunity. The SME recommends that LDH investigate the number and type of waiver rejections and identify strategies (e.g., pre-screening processes, confirmation of qualifying diagnoses) to limit the instances where an individual awaiting transition would have to participate in more than one waiver assessment.

Figure 63. Paragraph 75 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating and Rationale	***Priority Recommendations***
Met. Louisiana government agencies have a number of programs to provide ADL and instrumental ADL support and uptake of these services is increasing among diverted and transitioned members.	1) LDH should investigate the prevalence and causes of waiver denials and identify strategies to address preventable denials.

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

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

The SME recommends that LDH, in partnership with stakeholders, review policies and procedures and make recommendations for improvements, as well as advise on strategies to educate individuals and their families on their rights and recourse options if rights are infringed upon. The scope of this review should include documents and processes associated with Agreement-related programming (e.g., TCs), MCO-related programming (e.g., CCMs), Medicaid waiver services, and the ICSS services enumerated in Paragraphs 73 and 74. Many of these programs likely have established consumer rights protections and protocols. This process should culminate into the articulation of rights of TP members under My Choice Louisiana, a plan for educating stakeholders, and if needed, refinements to consumer rights policies within the other intersecting programs.

Figure 64. Paragraph 76 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating and Rationale	***Priority Recommendations***
Not Met. While LDH programs may have processes regarding the protection of consumer rights, an Agreement-focused process to systematically review and make improvements to such protocols has not occurred.	1) LDH should conduct a systematic review of consumer rights protocols across Agreement-related programming and develop plans to engage stakeholders to make improvements and promulgate among TP members and other relevant parties.

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

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

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

LDH obtained CMS approval for a Medicaid reimbursable stand-alone peer support service as of March 2021. Currently, LGEs and PSH programs are eligible to provide this service, and LDH has implemented several strategies, including an incentive-based payment structure, to spur increased adoption of the new service. At the end of this reporting period, one LGE was delivering the Medicaid peer services and two additional LGEs had peer staff credentialed with MCOs to begin providing services. A new LGE has been added since the last reporting period. Two PSH providers were credentialed by MCOs to deliver the standalone peer service, and one provider runs programs in five regions. LDH's 2025 Implementation Plan includes activities to increase provider adoption of this service. Consistent with prior periods, as of quarter 2 of 2024, there continues to be no utilization of Medicaid peer support among the TP.

This Paragraph requires that peers be embedded in all ICSS services. Currently, LDH has policies (through the existing service definitions) that allow peer specialists to deliver services in various programs, including ACT, CPST, PSR, and the four crisis services discussed above. As of quarter 2 of 2024, 60% of transitioned members and 52% of diverted members were in receipt of ACT, CPST, and PSR services. These services, however, are not all required to include peers. One of LDH's 2025 Implementation Plan activities involves the continued development of a digital platform to track the number of peer specialists employed in Agreement-related services.

Figure 65. Paragraphs 77 and 79 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating and Rationale	***Priority Recommendations***
Partially Met. One provider was delivering Medicaid peer services in this reporting period, and many other programs (e.g., ACT) had peer staff. However, continued expansion of peer services, and a strategy to understand where peers are embedded in Agreement-related services, is needed. **Compliance on one of these Paragraphs has improved. Paragraph 79 was rated "Not Met" in the 11th SME Report and "Partially Met" in this report.**	1) As planned, LDH should complete the infrastructure and processes to identify the number and presence of peer support staff employed in Agreement-related services.

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

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

- LDH's TC documentation facilitates the assessment of prior employment experience and the discussion of interest in employment. In the 8th SME report, LDH identified 136, or approximately 20%, of individuals on the AC who have expressed an interest in employment.
- In October of 2023, LDH oversaw the integration of IPS into ACT teams. As a reminder, in quarter 2 of 2024, ACT teams served 47% of transitioned members and 38% of diverted members. It is unclear how many in the TP utilize ACT IPS. There was no utilization of the standalone IPS service among TP members.
- On average, the ACT teams scored a 3.3 on the "vocational specialist on staff" measure. A score of three means that the ACT team has .8 to 1.39 full-time staff per 100 clients.
- LDH is receiving technical assistance from experts to leverage other in-state employment support options, including helping individuals in the TP access services through Louisiana Rehabilitation Services through the design and promotion of referral pathways.
- LDH has issued guidance for behavioral health providers to offer employment supports and has indicated they will provide training to these agencies on how to best use Medicaid for such.

- As indicated in the 9th SME report, OBH released guidance to providers on strategies to advance employment among individuals they serve, including how to optimize existing services (CPST and PSR) to offer employment supports and coaching that are less intensive than IPS.

Prior SME Service Review findings have suggested that individuals residing in NFs, preparing for transition, may not be best positioned to discuss employment goals. Rather, CCM and ACT providers may be in the best position to identify, refer, and link individuals to activities that match their interests in the early months post transition and diversion.

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

The SME recommends that LDH explore technical assistance from the Temple University Collaborative on Community Inclusion[4] or similar entity, which researches and provides practical guidance on how to support meaningful community participation of individuals with SMI. This could result in a learning collaborative for ACT peers, CCMs, and other staff on strategies to advance community integration.

Figure 66. Paragraph 78 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating and Rationale	***Priority Recommendations***
Partially Met. LDH has implemented several strategies to promote employment among the TP, including incorporating IPS into ACT services. However, more strategies are needed to ensure that TP are effectively engaged, at the right time, around opportunities to participate in community life more fully.	1) LDH should explore a collaboration with an entity like the Temple University Collaborative on Community Inclusion to devise a stronger set of strategies to advance community inclusion among TP members.

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

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

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

development strategies, including optimization of the Low-Income Housing Tax Credit to develop Section 811 housing, as well as non-development strategies, mainly in the form of providing voucher opportunities that subsidize rents. Annual unit and subsidy production projections are provided in the plan up to 2025. LDH reports that it continues to hold regular meetings with the Louisiana Housing Corporation, the entity that administers the housing production and rental assistance programs within the plan. Paragraph 81 provides deeper analysis of the specific strategies enumerated in the housing plan, as well as SME recommendations regarding regular reporting on progress in achieving its goals and quarterly meetings with the SME and his team, which is included in LDH's 2025 Implementation Plan.

Figure 67. Paragraph 80 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating and Rationale	***Priority Recommendations***
Partially Met. LDH has developed a housing plan through CY2025 and meets regularly with LHC to assess opportunities to expand housing.	See recommendations under Paragraph 81.

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

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

Beyond the broad objective of creating housing opportunities for TP members, the Agreement specifies that LDH must create and sustain the availability of 1,000 housing opportunities, inclusive of 125 tenant-based vouchers. This Paragraph also required LDH to directly fund 100 rental subsidies for those who transitioned in the first 18 months of the Agreement, while they

ramp up the availability of mainstream options. The Agreement contemplates a multi-pronged approach, wherein the State leverages incentives to spur rehabilitation and development of housing stock (e.g., the Low-Income Housing Tax Credit, bonds), repurposes existing capacity, and provides voucher opportunities (e.g., Section 8).

As described in reports from the prior SME, the State developed an initial housing plan in 2019 and has since revised it twice, with the most recent update in 2022. The 2022 housing plan provides a summary of past progress as well as a projection of housing opportunities the State wishes to produce from 2022 to 2025. Pertinent details include:

- Out of the 867 opportunities planned for creation from 2019 to 2021, 357 were created. Of those opportunities, 175 (49%) were offered and 120 (34%) were utilized by TP members. Most opportunities were from the Non-Elderly Disabled voucher program and the My Choice Louisiana voucher program. The prior SME expressed concern regarding the delta between created opportunities and offered opportunities.
- The plan includes annual targets for housing opportunity creation for 2022 to 2025, totaling 494 opportunities. These opportunities are sourced from the development and non-development options, heavily leveraging the HOME Tenant-Based Rental Assistance, Section 811, and 2021 Low-Income Housing Tax Credit programs.
- LDH also projected that 336 PSH units would become available to the TP from 2022 to 2025 due to turnover in various programs (e.g., Section 811, Section 8 Project-Based Vouchers).
- The plan adds the 175 opportunities offered to the TP from 2019 to 2022 (noted in the first bullet) with the 830 planned opportunities (noted in the second and third bullets) to slightly exceed the Agreement's required target of 1,000 housing opportunities.

As referenced above, the housing plan aimed to develop 494 housing opportunities from 2022-2025: 172 in 2022, 226 in 2023, 70 in 2024, and 26 in 2025. Based on an LDH housing update from February 2024, there were 116 opportunities developed in 2022 and 2023, reflecting 23% of their four-year goal. However, the number of opportunities offered to and utilized by the TP increased in 2022 and 2023; 180 were offered and 138 were utilized, surpassing data from the 2019, 2020, and 2021.

The current SME did not request data on units created, offered, and leased in 2024 for this report. This was, in part, because LDH committed, via the 2025 Implementation Plan, to meet with the SME and his team quarterly and provide quarterly data in several areas germane to this Paragraph: tracking of housing opportunities created for, offered to, and leased by TP members; analysis of barriers that prevent TP members from leasing the units they are offered; evaluation of progress toward housing plan goals; and revision of the housing plan if needed. In addition to the metrics referenced in their Implementation Plan, LDH should also track and report on the number of accessible units planned, created, offered, and leased. The SME also recommends that LDH analyze information on individuals transitioned and diverted in 2023 and 2024 to determine housing location preferences, accessibility needs, and other housing-related insights to inform future housing development efforts.

LDH should be credited for their work in housing opportunity creation thus far under this Agreement. Given that the current housing plan only includes development goals through 2025, LDH should update the plan to enumerate new strategies and targets – spanning at least 2026 and 2027 – to reach the 1,000-housing opportunity requirement.

Figure 68. Paragraph 81 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating and Rationale	***Priority Recommendations***
Not Met. LDH continues to collaborate with LHC to develop housing opportunities for TP members. In 2025, LDH plans to provide regular information on the outcomes of the strategies in their housing plan.	1) LDH should implement the various housing-related activities referenced in their 2025 Implementation Plan, consider the enhancements recommended by the SME above, and prepare to update the housing plan to include, at a minimum, strategies and projections for 2026 and 2027.

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

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

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

Figure 69. Paragraph 82 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating and Rationale	***Priority Recommendations***
Met. LDH's PSH programming complies with the requirements in this Paragraph.	1) LDH should analyze the housing outcomes of diverted individuals and determine whether improvements are needed to ensure their access to and retention in PSH options.

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

Analysis: At the end of this reporting period, LDH employed eight TSMs to provide statewide coverage to assist members of the TP transitioning from NFs. The 7th SME Report provides an overview of the TSM role, which includes pre-tenancy support, housing search, inspections, landlord negotiation, document gathering, eviction avoidance planning, landlord relationship management and mediation, among other duties. In calendar year 2024, LDH reports that TSMs served 163 individuals, a significant increase over prior years: 68 in 2023 and 71 in 2022. It is unclear whether there were more individuals who requested or needed TSM support.

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

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

Figure 70. Paragraph 83 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating and Rationale	***Priority Recommendations***
Partially Met. LDH has a complement of TSM staff who provide services to other LDH staff and TP members, but it is unclear whether they preserve housing in instances of a TP member's short-term hospitalization or institutionalization.	1) LDH should continue to track TSM activities that support the TP on a semi-annual basis and report to the SME, including information on the number of individuals in the TP who have needed the TSMs to preserve housing and reasons for that. 2) LDH should convene a focus group of TSMs and TCs to discuss housing barriers and identify strategies to address.

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

Analysis: While this Paragraph explicitly references the HOME Tenancy Based Rental Assistance program, LDH and LHC have indicated that other federal and state programs may be more relevant for the TP, given that HOME is a short-term rental assistance program and that

transitioned and diverted individuals typically require longer-term housing assistance. However, LDH does meet the spirit of this Paragraph, providing for housing-related expenses – covering costs for security deposits, utility arrearages, and home necessities – through the Community Choices Waiver, the Permanent Supportive Housing (PSH) program, and direct My Choice Louisiana funds (for those who do not meet NF level of care requirements). LDH reports that 161 individuals received such assistance through the PSH program, but did not provide data on the number of individuals who needed assistance or those who received assistance through programs other than the PSH program.

Figure 71. Paragraph 84 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating and Rationale	***Priority Recommendations***
Partially Met. LDH reports that individuals in the TP have access to financial support for housing-related expenses, but the data provided was limited to individuals who received assistance through the PSH program only.	1) LDH should provide data on need and utilization of all housing expense assistance programs that benefit the TP.

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

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

Figure 72. Paragraph 85 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating and Rationale	***Priority Recommendations***
Met. LDH has leveraged various Medicaid authorities to provide a range of Agreement-related services.	1) LDH should regularly assess the adequacy of reimbursement rates to ensure a robust provider network for TP members.

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 as one strategy to share Agreement-related information with external stakeholders.

LDH implements a number of stakeholder engagement activities, often associated with specific initiatives under the Agreement (e.g., making improvements to PASRR processes, enhancing crisis systems). The SME suggests that these efforts become more strategic, centralized, organized, comprehensive, and efficient. To comply with this Paragraph, LDH should implement a comprehensive stakeholder engagement plan that identifies key messages, strategies, targets, and mechanisms across all aspects of the Agreement. This approach should involve people with lived experience, optimize the existing website, and engage a broad base of internal and external stakeholders regarding My Choice program activities (including law enforcement officials as referenced in Paragraph 88). The stakeholder engagement strategy should also be informed by analysis of systems level barriers; namely, who should be at the table to help solve problems that impede compliance or outcomes associated with this Agreement. OAAS reported that they have launched an internal monthly newsletter that will serve as the basis for a quarterly cross-agency newsletter.

Figure 73. 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 TP. 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 is especially important since 31% of all critical incidents for TP engaged in CCM involve interactions with law enforcement, as noted in Paragraph 95.

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.

Figure 74. 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, especially given that the most common critical incidents type is involvement with law enforcement.

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 75. 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, as well as involve people with lived experience in the design and delivery of trainings.

He 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. The current SME agrees that a centralized repository of trainings and more intentional inclusion of individuals with lived experience in the design and delivery of trainings is an important step to complying with the Paragraph. Further, a more systematic process to assess barriers – as described in many Paragraphs in this report – should inform LDH's training plan under this Agreement.

In their 2025 Implementation Plan, LDH includes an activity to develop a repository to "house all relevant training materials and resources in a single public location to serve as a central reference point, ensuring easy access and organization," slated for launch in April 2025.

Figure 76. Paragraphs 90-92 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. LDH delivers numerous trainings to providers who serve the TP, but would benefit from a centralized training policy, curriculum, and website. Trainings should be informed by those with lived experience and the identification of systemic and provider-level barriers.	1) Per the 2025 Implementation Plan, LDH should develop a single site to facilitate, communicate, and store training opportunities associated with the My Choice program. 2) LDH should implement a strategy and process for soliciting and incorporating consumers in the design and delivery of trainings.

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

Analysis: This Paragraph centers on ensuring that community-based services are of sufficient quality to ensure tenure and quality of life in the community for transitioned individuals. 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. The new SME and his team recently completed the 2025 Service Review process, and a report on key findings and recommendations will be produced in Summer 2025.

To illustrate how the SME Service Review process supports this Paragraph's aim of ensuring the quality of community-based services, Figure 77 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 77. 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 ▪ Improved care team communication	▪ 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
Continued/New Issues	▪ Lack of alignment between CCM assessment and CPOC and lack of duration,	▪ Gaps in ADL/IADL supports immediately	▪ Default transition date 1-year after NFTA

	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	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	▪ 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, including decreased frequency of visits if appropriate ▪ 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 incorporated a "service review mentality" into their management approach, adopting some of the tools and processes designed by the prior SME and his team to strengthen their direct oversight of TC processes and aid in the identification and remediation of systemic issues.

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 an individual is receiving planned/needed services, whether there are issues, what the CCM is doing to address identified issues, and additional narrative for context and detail. 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, IPS – 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 78. 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 to monitor many areas required by this Agreement and continues to review and update 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. 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, and the external committee met quarterly.
- The State completed the first Annual Quality Report for the My Choice Program during the 7th and 8th 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.
- LDH has not yet published the 2023 Quality Report.
- 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 79. 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 publish and post 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. Paragraph 96 includes a discussion on MCO reported CIR data. For this Paragraph, the SME has analyzed data provided by LDH on CIRs associated with diverted or transitioned individuals engaged in CCM, who generally have lived in the community for less than one year.

In the Quality Matrix, LDH reports on the number of critical incidents associated with TP members that accept CCM. 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. Across both quarters in this reporting period, there were 55 critical incidents: 17 for involvement with law enforcement, seven for extortion, seven for major behavioral disturbance, six for neglect, six for abuse, five for major

medication disturbance, and two for eviction. All incidents associated with abuse, neglect, or exploitation were referred to the appropriate agencies. Diverted and transitioned members can also elect to complete a survey on their experiences, and in the quarters in this reporting period, 99% and 98%, respectively, report that they are free from abuse, neglect, and exploitation.

In addition, the State reported all-cause ED and inpatient (IP) visits during quarter 4 of 2023 and quarters 1 and 2 of 2024 for diverted and transitioned members, displayed in Figure 80. 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 80. All-Cause ED/IP Utilization (2023 Q4, 2024 Q1 and Q2)

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)
Q2 CY2024	ED	9.3% (2.1% BH)	17.7% (5.1%)
	IP	4.3% (2.8% BH)	10.1% (7.6% BH)

A slightly larger percentage of transitioned individuals utilized the ED for BH reasons in the recent quarter (2.1% versus 1.6% and 1.8% in prior quarters). Utilization of the ED for BH reasons among diverted individuals decreased (5.1% versus 7.4% and 8.6%). Inpatient admissions for BH reasons for both groups increased between quarter 4 of 2023 and quarter 1 of 2024 but dropped in the most recent quarter (returning to quarter 4 of 2023 levels). For diverted individuals, all-cause hospital admission was lowest in the recent quarter. For transitioned individuals, all-cause hospital admissions ticked up slightly between the last two quarters – 3.7% to 4.3%.

Figure 81. 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.	1) LDH should implement the recommendation under Paragraph 96, pertaining to enhanced reporting on CIRs tied to Agreement-related programming and services.

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

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

To assess compliance with this Paragraph, the SME reviewed an MCO's CIR report for clarity, completeness, and appropriate action. This MCO reported two critical incidents in August 2024, wherein providers appropriately reported instances of observed abusive behavior toward children to children's services. In one case, while the provider promptly referred the incident to children's services, they did not report the incident to the MCO within the required timeframe; the MCO addressed this issue with the provider, re-educated the provider on reporting requirements, and indicated that they will continue to monitor the provider.

While the SME does not doubt that CIR processes are established and operational, the current approach of reviewing a monthly MCO CIR data report does not enable the SME to assess full compliance with this Paragraph. However, the SME acknowledges that aggregating the number, type, and resolutions of all critical incidents across OBH and OAAS programs may not be feasible. As such, he would like to work with LDH and the DOJ to determine an appropriate reporting method, which should include CIR data from both OBH and OAAS programs.

Figure 82. Paragraph 96 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating and Rationale	***Priority Recommendations***
Partially Met. LDH has established and oversees processes for MCOs and long-term supports and service programs, which require critical incident reporting and remediation. **Compliance on this Paragraphs has worsened. It was rated "Partially Met" in the 11th SME Report and "Met" in this report.**	1) LDH should collaborate with the SME and DOJ to devise a reporting strategy for this requirement that includes CIR data from both OBH and OAAS programming.

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

Analysis: The State has developed and implemented a joint mortality review protocol for the My Choice Program, including the creation of a Mortality Review Committee (MRC) and production of mortality review reports. As indicated in the 8th SME Report, OBH, OAAS, Health Standards, and Adult Protective Services, as well as auxiliary members as needed, participate in the MRC. The mortality review reports provide information regarding the scope and structure for mortality reviews, information on the mortality reviews conducted thus far, and remediation strategies undertaken by the State based on these reviews.

As indicated in previous reports, the Integration Coordinator reviews each death and uses established criteria discussed in the 10th SME Report to make a referral to the MRC. Figure 83 provides data on the total number of mortalities associated with the program and the subset that were referred to MRC review.

Figure 83. Mortality Review Data		
Period	*Total Deaths*	*Referred to MRC*
2020-2022	19	13
2023	27	14
2024	12	8

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. As of the writing of this report, the 2023 report is completed and per LDH, will be posted soon. Further, five of the eight planned MRC reviews tied to 2024 mortalities have been completed, with two requiring a remediation plan.

Mortality reviews for quarters 1 and 2 of 2024 took 164 and 106 days on average, respectively, representing a significant improvement compared to past periods, but still exceeding LDH's standard of 90 days. The State reports there are several barriers to expeditious reviews, including delays in acquiring needed documentation from coroner's offices and direct service/healthcare providers and delays as Health Standards, which is bound by its own investigation timelines, completes investigations for cases that are referred to them.

Of note, the 2023 Mortality Report included a breakdown of causes of death for cases subject to mortality review. This information could provide valuable insights. To illustrate, if LDH found that cardiovascular disease and substance use overdoses were common causes, they could implement programmatic, policy, or process strategies (e.g., stronger linkage to ambulatory care, trainings for ACT teams on cardiovascular health, naloxone distribution) to prevent or help individuals manage these conditions. For this to be meaningful, data for all TP mortalities in the community would need to be tracked, not limited to cases referred for MRC review.

Figure 84. 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.	1) The State should post the 2023 mortality report. 2) LDH should collect and report on causes of death among transitioned and diverted individuals in the community, and consider actions based on trends and findings.

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 and identified the following gaps:

- 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 SME 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. LDH's 2025 Implementation Plan committed to finalizing this measure.
- Additional work on the methodology, data sources, and benchmarks for measure 99.f, focused on choice and self-determination, is still needed. LDH's 2025 Implementation Plan committed to finalizing this measure.
- The 2024 Quality Matrix included most of the required data for all four quarters of 2024. 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 15 measures that compared 2024 data to established benchmarks, data from 12 measures met or exceeded the benchmark and two performed lower than the benchmark. The SME was unable to assess performance for the other measure.

Since the last reporting period, LDH developed measures for item 98.1, related to the amount, intensity, and availability of services, leveraging their MCO network adequacy reports. Other recommendations within this report, such as a quality evaluation strategies for key services (e.g., personal care services), additional measures for certain crisis services, and critical incident reporting for waiver programs, may also necessitate enhancements to the Quality Matrix. The SME recommends that LDH convene a meeting in late 2025 with the DOJ to discuss any updates to the Quality Matrix that may be needed to ensure that all components of this Paragraph are being adequately measured. More globally, the SME would like to discuss whether selected measures are the most vital and meaningful to LDH, both in terms of shaping quality assurance efforts and in demonstrating compliance with the Agreement.

The 2024 Quality Matrix is provided in this report as Appendix A.

Figure 85. 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.	1) LDH should work with the SME to address the remaining gaps in the Quality Matrix for 99.d and 99.f., as well as other improvements. 2) LDH should meet with the DOJ and SME in late 2025 to discuss updates to the Quality Matrix and bigger picture priorities for performance measurement.

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

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

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

To fully comply with this Paragraph, LDH should 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. To operationalize the intent of this Paragraph, LDH could identify a narrow set of high-priority interventions on a quarterly basis for implementation and outcomes monitoring.

Figure 86. 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)

LDH provided the SME with utilization information for quarter 4 of 2023 and quarters 1 and 2 of 2024 for individuals who were transitioned and diverted. In the 11th SME Report, the SME provided a comparison of the utilization of services across quarters 1 of 2022, 2023 and 2024. For this report, he added data from quarter 2 of 2024 in some areas for additional comparison.

- There was a decrease in the percentage 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 percentage declined in quarter 1 of 2023 and 2024 to roughly less than 25%. There was a similar decrease in the percentage of diverted individuals who did not receive a behavioral health service. In quarter 1 of 2022, 55% of diverted people did not receive a behavioral health service. This percentage declined in quarters 1 of 2023 (25%) and 2024 (20%).
- There was a continued increase in the percentage of transitioned and diverted individuals with 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 diverted individuals with ACT, reflecting 11.8% in 2022, 21% in 2023, and 27.7% in 2024. In quarter 2 of 2024, both groups had significant increases in ACT utilization: 47.3% for transitioned individuals and 37.9% for diverted individuals.
- 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 (44.7% and 8.3% respectively). In quarter 2 of 2024, percentages in both categories jumped to 67.9% and 14.8%. There was also 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). In quarter 2 of 2024, 17.7% of diverted individuals received CCW services and 6.3% received 1915b services.
- 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%). This percentage increased to 85.3% in quarter 2 of 2024. 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. In the 2nd quarter of 2024, the percentage grew further to 82.4%.

- 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%). It jumped slightly in the 2nd quarter of 2024 to 9.3%. 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. In the 2nd quarter, it decreased again to 17.7%.
- 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 ticked up slightly in the 2nd quarter of 2024 to 2.1%. 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%. First quarter behavioral health ED visits decreased to 8% in 2023 and rose slightly to 8.6% in 2024, declining even further to 5.1% in the 2nd quarter of 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 in the first quarters of 2023 and 2024 (21% and 16% respectively). All-cause admissions for diverted individuals dropped to 10.1% in the 2nd quarter of 2024.
- 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 12.3% respectively). In quarter 2 of 2024, 2.8% of transitioned and 7.6% of diverted individuals were admitted into inpatient behavioral health services.
- There continues to be little or no utilization of new services, including crisis services, peer support services, and IPS.

Overall, this data reflects many positive trends, including increases over time in the proportion of diverted and transitioned individuals who are utilizing ACT and personal care services with concomitant decreases in ED and hospital utilization, including for behavioral health reasons. Some services still have little to no utilization, including IPS, peer services, and crisis services, and per this Paragraph, require plans for improvement.

Figure 87. Paragraphs 101 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating and Rationale	***Priority Recommendations***
Partially Met. LDH continues to track service utilization for transitioned and diverted individuals on a quarterly basis. Service utilization of many outpatient services, including ACT, is steadily increasing, juxtaposed with decreases in ED and inpatient utilization. LDH should investigate low utilization of certain services and develop plans for improvement.	1) LDH should investigate low utilization of certain behavioral health services and develop plans for improvement.

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

Figure 88. Paragraphs 102 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating and Rationale	***Priority Recommendations***
Partially Met. LDH continues to provide information to relevant state agencies and other entities in the course of operating the Agreement, but a more organized and tailored bidirectional information sharing plan is needed.	1) Within the comprehensive stakeholder engagement and communication plan referenced in Paragraphs 86 and 87, LDH should incorporate cross-agency data/information sharing efforts, clearly identifying the data/information to be requested and shared with each agency and communication, coordination, and collaboration structures.

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

Analysis: LDH is tasked through this Agreement to adopt a methodology for assessing the sufficiency of community-based services required under this Agreement. The prior SME worked with the State over the past four years to design a Service Review process, and the current SME has now conducted one Service Review (2025), which will be reported on in summer of 2025. This process involves selecting a representative sample of individuals in the TP within specific regions to understand the effectiveness of Agreement-related processes and services through their lenses. The Service Review Team also interviews TCs, CCMs, and other providers. Three cohorts of TP members are included in the Service Review: individuals awaiting transition, transitioned individuals, and diverted individuals.

As indicated in paragraph 62, LDH staff continued to partner with the SME Service Review Team during this reporting period, providing needed data and documentation, supporting interview and logistical coordination with entities (e.g., NFs, ACT teams), and participating in Service Review interviews. As of the writing of this report, LDH has adopted a "service review mentality," adapting the SME's Service Review tools and processes to enhance TC oversight and quality improvement. To aid in these efforts, the SME has provided a training to LDH staff on the Service Review process and provided access to associated tools (e.g., interview guides, scoring matrices).

During the last reporting period, LDH staff debriefed with the SME Team 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 2025, the SME plans to implement an adapted Service Review approach, focusing on the experiences of new cohorts that have not been included in prior Service Review processes (e.g., individuals who initially expressed interest but returned to the ML, individuals who decline transition support at outreach).

In addition to the SME Service Review report, the Paragraphs above describe other processes to assess the quality and adequacy of services, including network adequacy analyses, service utilization among the TP, CCM monthly monitoring, MCO audits of the CCM program, and ACT fidelity monitoring. However, as noted in Paragraphs 93 and 94, some services (e.g., personal care services) likely require a dedicated quality evaluation effort, given the large proportion of TP members who utilize these services.

Figure 89. Paragraph 103 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 recommendations under Paragraphs 93 and 94, to assess Agreement-related services and make improvements based on findings.	1) LDH should develop a strategy for reviewing the fidelity and/or practice of additional services including IPS, personal care services, peer support, and crisis services. 2) 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. 2024 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	Quarter 1 January-March 2024	Quarter 2 April-June 2024	Quarter 3 July-September 2024	Quarter 4 October-December 2024
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						
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	425	424	424	525
Referral/ Admission	99.a-2	Number and percent of individuals that are admitted into Nursing Facilities that have a completed PASRR Level II upon admission	98% of individuals admitting into the NF have a completed PASRR Level II	Being Discussed and new method finalized	Being Discussed and new method finalized	Being Discussed and new method finalized
Diversion	99.a-3	Number and percent of individuals diverted	33	41	35	39
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	34	44	35	39
Length of Stay	99.a-5	Average length of stay in nursing facility	non-reporting period	Q1-Q2 2024: 3.40 years	non-reporting period	Q3-Q4 2024: 3.43 years

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	8/181 4% (To determine the denominator-looked at total number of people transitioned from March 2023-March 2024; Numerator=number of people on monthly report identified with a closure reason of readmission)	4/167 (To determine the denominator-looked at total number of people transitioned from July 1 2023-June 30 2024; Numerator=number of people on monthly report identified with a closure reason of readmission)	6/131 (To determine the denominator-looked at total number of people transitioned from Oct 1 2023-Sept 30 2024; Numerator=number of people on monthly report identified with a closure reason of readmission	4/135 (To determine the denominator-looked at total number of people transitioned from Jan 1 2024-Dec 31 2024; 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	35/331	35/331 23%	104/334 31%	135/331 41%
Planning	99.b-2	Number and percent of members that have a plan of care that reflects identified needs from the assessment	Service Review Team	Service Review Team	Service Review Team	Service Review Team
Planning	99.b-3	Number and percent of members who participated in the planning meeting	Service Review Team	Service Review Team	Service Review Team	Service Review Team
Planning	99.b-4	Number and percent of members whose plan of care reflect their strengths and preferences	Service Review Team	Service Review Team	Service Review Team	Service Review Team
(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	23 (7 expolitation, 2 eviction, 3 major medication incident, 1 involvement with law enforcement, 4 abuse 4 major behavioral disturbance, 2 neglect)	45 (3 abuse, 7 eviction, 5 exploitation, 9 involvement with law enforcement, 3 neglect, 2 major medication incident, 11 major behavioral disturbance, 1 loss or destruction of home, 1 other)	30 (1 abuse, 6 eviction, 5 exploitation, 10 involvement with law enforcement, 2 neglect, 2 major medication incident, 4 major behavioral disturbance	25 (5 abuse, 1 extortion, 7 involvement with law enforcement, 4 neglect, 2 eviction, 3 major medication incident, 3 major behavioral disturbance)
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	86.6% (1 incident categorized as exploitation was not reported due to unknown source)	100%	100%	100%
death	99.c-3	Number of deaths reported	3	5	4	1
death; investigation	99.c-4	Number of deaths referred for mortality review	2	3	2	1
death; investigation	99.c-5	Number and percent of death investigations that were completed	100% Investigations Completed-2, Total MRC Referrals-2	100% Investigations Completed-3, Total MRC Referrals-3	n/a Investigations Completed-0, Total MRC Referrals-2	n/a Investigations Completed-0, Total MRC Referrals-1

death (timeliness)	99.c-6	Average length of time to complete a death investigation	164 days	106 days	n/a- cases scheduled for review in Q2 2025	n/a- case scheduled for review in Q2 2025
death; resolution	99.c-7	Number and percent of deaths that require a remediation plan	1/2 reviews completed required a remediation plan (50%)	50% 1/2 reviews completed required a remediation plan (50%)	N/A	N/A
	99.c-8	Number and percent of participants whose service plans had strategies that addressed their health and safety risks as indicated in the assessment (s)	Service Review Team	Service Review Team	Service Review Team	Service Review Team
abuse/neglect/ exploiation	99.c-9	Number and percent of members reporting that they have been free from abuse, neglect, or exploitation	97.30%	97.46%	98.76%	98.13%
(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						
ED/Inpatient utilization	99.d-1	Number and percent of members ED Services – All Cause and BH related	10% (n=42) all cause; 3.2% (n=13) BH-related	11% (n=44) all cause; 2.7% (n=11) BH-related	12% (n=47); 3% (n=12) BH-related	12% (n=50); 3.7% (n=15) BH-related
ED/Inpatient utilization	99.d-2	Number and percent of Inpatient –All Cause and BH related	6.4% (n=15) all cause; 5.0% (n=15)	5.5% (n=22) all cause; 3.7% (n=15) BH-related	7.4% (n=29); 4% (n=16) BH related	4.9% (n=15); 2.7% (n=11) BH-related
Physical/BH wellbeing	99.d-3	Number and percent of members reporting good physical health	62% good; 96% good/fair	61% good; 95.8% good/fair	60% good; 94.6% good/fair	54% good; 95.6% good/fair
NNBH wellbeing	99.d-4	Number and percent of members reporting good mental health	60% good; 97% good/fair	62% good; 95.8% good/fair	59.8% good; 97.7% good/fair	55% good; 97% good/fair
Physical/BH wellbeing	99.d-5	Number and percent of members that report taking medications as prescribed	90.30%	94.96%	92.30%	92.06%
use of crisis services	99.d-6	Number and percent of members that utilized crisis services	0.2% (n=1)	0.5% (n=2)	0%	0%
(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	95.00%	95.83%	97.13%	96.06%
maintenance of chosen living arrangement	99 e-2	Number and percent of members reporting no issues with current living situation	93.00%	94.20%	92.93%	95.36%
stability in chosen natural supports	99 e-3	Number and percent of members reporting stability in natural supports network	99.30%	99.46%	98.83%	98.50%

stability in chosen service providers	99 e-4	Number and percent of members reporting stability in service providers	95.50%	95.76	93.96%	94.43%
(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 involvement (99.g-1)				
(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	91.00%	94.50%	95.43%	96.30%
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	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	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	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 communicate even with assistance of communication aides) Health condition resulting in the inability to engage in discussion regarding community option. Other	See Tab	See tab	See tab	See tab

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 curator is unwilling/unable to participate in discussion re: transition Family/Guardian not supportive of transition NF uncooperative Housing: Waiting Greater than 6 months Housing: Accessible housing waiting greater than 6 months Housing: Waiting for a specific unit/town Housing: Waiting on a home inspection (timeframe exceeds typical expectations) Provider Issues: Unable to locate a provider Environmental Mods delayed due to supply issues Home Mods (general) delayed due to supply issues Durable Med Equipment issues/delays Issues obtaining standard documents that exceed typical timeframes Other:	See Tab	See Tab	See tab	See tab
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.)	93.66%	92.70%	93.20%	94.36%