Thirteenth Subject Matter Expert Report

Agreement to Resolve the Department of Justice Investigation

Covering the Period of 1/1/2025 to 6/30/2025

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Contents

I. Introduction

Background and Context. This report presents the Subject Matter Expert's assessment ratings and relevant discussions of the State of Louisiana's (the State) compliance under the Agreement to Resolve the United States Department of Justice (DOJ) investigation. This report is issued in fulfillment of the Agreement's requirement for a Subject Matter Expert to, "submit to the Parties a comprehensive public report on [the Louisiana Department of Health's] compliance including recommendations, if any, to facilitate or sustain compliance." The period subject to compliance assessment in this report is January 1, 2025, to June 30, 2025. Other significant developments that occurred prior to or after that timeframe are mentioned when deemed relevant to readers' understanding of context, trends, and the like.

Case in Brief. In June of 2018, the State of Louisiana entered into an Agreement with the United States DOJ to resolve its lawsuit alleging the State violated the Americans with Disabilities Act 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 December 1, 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 52 paragraphs subject to compliance rating in this reporting period. These paragraphs fall under five 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; and Quality Assurance and Continuous Quality Improvement.

As displayed in Figures 2 and 3, LDH was found in compliance with 14 paragraphs (27%), in partial compliance with 37 paragraphs (71%), and not in compliance with one paragraph (2%). There were 27 paragraphs that were not rated.

Figure 2. Overview of Compliance Assessment Ratings by Domain for 13th SME Report								
Target Population (4)	**Meeting Compliance**	2	**Partial Compliance**	0	**Not Meeting Compliance**	0	**Not Rated**	2
Diversion and Pre-Admission Screening (11)	**Meeting Compliance**	5	**Partial Compliance**	6	**Not Meeting Compliance**	0	**Not Rated**	0
Transition and Rapid Reintegration (14)	**Meeting Compliance**	3	**Partial Compliance**	10	**Not Meeting Compliance**	0	**Not Rated**	1
Outreach, In-Reach and Provider Education and Training (9)	**Meeting Compliance**	2	**Partial Compliance**	5	**Not Meeting Compliance**	1	**Not Rated**	1
Quality Assurance and Continuous Quality Improvement (18)	**Meeting Compliance**	2	**Partial Compliance**	16	**Not Meeting Compliance**	0	**Not Rated**	0
Total (79)	**14**		**37**		**1**		**4 (+23 associated with Community Support Services)**	

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

For this reason, the distribution of ratings (i.e., in compliance, partial compliance, and not in compliance) across reports with contiguous periods do not provide an "apples to apples" comparison. Figure 3 below provides the number of Paragraphs assessed this report and the three preceding reports, along with the distribution of compliance findings. Among the 52 requirements shared between the 12th and 13th SME Reports, six ratings improved and one rating worsened. When comparing the 11th and 13th SME Reports, 10 ratings improved.

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

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

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. The five overarching recommendations for this 13th SME Report include:

1) LDH should fully launch its new procedure to 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 analyze and devise solutions around systemic barriers.
2) LDH should fully implement quality assurance and oversight structures for the new PASRR Level I vendor, focused on improving the identification of suspected SMI and subsequent referrals to PASRR Level II evaluation and ensuring accurate and timely data submission to trigger early engagements. 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.
3) LDH should continue to make refinements to the Rapid Integration Transition Coordination (RITC) program based on lessons learned during the pilot phase. Rapid Reintegration and other My Choice Louisiana services should deploy a rapid engagement approach, with an emphasis on building rapport, trust, and connection and facilitating motivation and self-efficacy. TCs should take an individualized approach to these engagements, gauging whether members are ready to participate in assessment treatment planning processes and adjusting as necessary. Even though engagements should be relational, flexible, and individualized, it is important that they still have intention, focus, and direction.

4) LDH should continue to improve the accuracy of Master List and collaborate with the SME and Department of Justice to determine whether, or to what extent, LDH should continue to engage individuals that do not have Medicaid status confirmed at the time of admission through the RITC program, with a focus on how to balance the optimization of limited staff resources with the reality that half of those who do not have Medicaid at admission will ultimately meet Target Population criteria.

5) At this stage in the Agreement, given that the Diversion Plan is now six years old, LDH should consider developing an updated diversion plan that identifies enhancements to current initiatives, new initiatives, and system-wide and initiative-specific key performance indicators that would demonstrate that their constellation of diversion efforts are effective and durable.

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 DOJ, 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. Consistent with the process described in this Paragraph, LDH adds individuals to a TP list via two pathways: (1) a PASRR Level II evaluation that indicates SMI, generally conducted prior to NF admission, or (2) a post-admission Minimum Data Set (MDS) assessment that indicates SMI followed by a confirmatory PASRR Level II evaluation. In accordance with Paragraph 24, the TP excludes individuals with co-occurring SMI and dementia when dementia is the primary diagnosis.

This discussion focuses primarily on the LDH's identification and maintenance of rosters of individuals in the TP, which serve as the starting point for deeper engagement in the My Choice Louisiana (MCL) Program. LDH's processes for identifying TP members has not changed substantially since the beginning of the Agreement. However, their implementation of the Rapid Integration Transition Coordination (RITC) program – both in its pilot phase in 2024 and in its full statewide launch in March of 2025 – has resulted in changes to their engagement processes once an individual is identified as a TP member, as reflected in Figure 5.

Figure 5. Basic Workflow of Identifying and Engaging TP Members	
Before the RITC Program *Prior to 2024*	*Since the RITC Program (New Admissions Only)* *Since 2024 (in seven pilot regions) and since March 2025 statewide*
1. TP member identified. 2. TP member added to a roster titled the "Master List (ML)." 3. Members on the ML engaged by peer in-reach (PIR) to assess interest in transition. 4. If member accepts transition support, member is added to a list called the "Active Caseload (AC)," which reflects those who have expressed interest in transitioning. This is often referred to as the "Legacy AC." A transition coordinator is assigned to begin the transition planning process. 5. If member declines transition support (whether at initial PIR stage or after initially expressing interest), the member returns to ML for future re-engagement by peer in-reach.	1. TP member identified. 2. TP member added to a roster titled the "RITC AC." 3. A RITC transition coordinator is assigned to assess interest in transition. 4. If member accepts transition support, the member remains on RITC AC. 5. If member declines transition support (whether at early RITC engagement stage or after initially expressing interest), the member is placed on the ML for future re-engagement by PIR. This process applies to **newly admitted TP members only**. For those who already residing in NFs, the "Before the RITC Program" process is still in place.

There are nuances between how newly admitted TP members identified and engaged versus TP members who are already residing in NFs or decline transition support early in their NF stay. However, LDH complies with this requirements in this Paragraph because all TP members are identified and assigned for some type of engagement from an MCL-affiliated staff person.

As reflected in the Figure above, LDH is manages at least four lists of TP members: the ML, the Legacy AC, the RITC Active Caseload, and a fourth list – the Post-Transition AC – reflecting those who have transitioned through the MCL Program within the last 12 months. Figure 6 provides definitions for these lists. The TP also includes the 61 individuals who were diverted in this reporting period, which is discussed in more detail under Paragraph 29.

Figure 6. TP Cohort Lists
Active Caseload (AC)
ML. Individuals who have either not been engaged by the program to gauge their interest in transition or have declined in-reach or transition support previously and thus are flagged for re-engagement at later time.
Legacy AC. Those who indicated an interest in moving from an NF, usually after receiving peer in-reach (PIR). These individuals are often referred to as "actively working" toward transition.
Rapid Integration Transition Coordinator (RITC) AC. Those who were recently admitted into an NF, and as such, were flagged for an engagement from a RITC, since the inception of their RITC pilot in 2024.
Post-Transition AC. Those who have already transitioned but are still within 12 months of NF discharge.

In prior reports, the SME provided a year-over-year comparison of the size of the ML and the AC. Multi-year trends analysis showed that the number of individuals on the ML grew each year, while the number of those on the AC declined over the same period. At first glance, ML growth suggests that there are more individuals with SMI who are either being admitted into NFs or being identified as TP members after NF admission. If true, this would signal a troubling trend, demonstrating that the program's aims of systems rebalancing were not being achieved. This led the SME to recommend a deeper analysis to better understand why the ML was ballooning and the AC – which represents individuals who are interested in transitioning – was declining. At the SME's recommendation, LDH convened as special workgroup to investigate the contributors of ML growth, and found that:

- Year-over-year ML growth was partially attributable to inadequate procedures to remove individuals from the ML when appropriate (e.g., when discharged, deceased, diagnosed with primary dementia, or no longer on Medicaid).
- A sizable portion of individuals on the ML did not meet all Agreement-specified criteria for inclusion in the TP; more specifically, over a quarter of individuals on the ML did not have confirmed Medicaid eligibility at the point of NF admission.
- Overall statewide NF admissions remained stable between 2023 and 2024. The number of individuals added to the ML, however, decreased slightly, from 1,770 to 1,651. This shows that NF admissions among individuals who meet TP criteria have actually decreased, further reinforcing that ML growth is not due to inadequate diversion systems. In the first half of 2025, there were 961 individuals added to the ML; the 14th SME Report will include data on the full year's admission data to support additional trends analysis.
- Some ML growth is expected as more individuals are admitted year after year, although one might also expect those numbers to be offset by transitions, discharges, deaths, and other TP exclusionary criteria.

Given these methodological flaws, in this report, the SME is not providing the multi-year comparison of the ML. However, all historical data can be found in his 12th SME Report. 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. For example, now that it is understood that over a quarter of individuals on the ML do not have confirmed Medicaid, it is important to determine whether, to what extent, and how these individuals should be engaged by the MCL program. The SME appreciates the willingness of LDH and the DOJ to collaborate on this matter. At the end of this reporting period, there were 5,094 individuals in the TP, excluding diverted individuals, including: 298 individuals in the Legacy AC, 139 individuals on the RITC AC, 130 individuals in the Post-Transition AC, and 4,527 individuals on the ML.

Figure 7. AC Size Over Reporting Periods

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

It is useful to look at year-over-year trends of the AC., particularly the "Legacy AC" that represents the number of individuals who express interest in transitioning after peer in-reach. Figure 7 offers a comparison of the Legacy and Post-Transition ACs over the last several reporting periods, showing that both fluctuated. Multi-year analysis of the RITC is not useful since the program was launched in 2024 and was geographically limited until its statewide rollout in March 2025.

The SME also reports on the number of individuals are 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). In this reporting period, 544 individuals were removed from the AC, representing a substantial increase compared to prior periods. There were 266 (49%) who were removed because they "declined transition." In the prior reporting period, there were 269 removals, with 122 (42%) removed from the AC because "declined transition." The SME's 2026 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 needed. Findings will be summarized in the 14th SME Report and detailed in the 2026 Service Review Report.

There are some individuals who were added to the TP after NF admission. These individuals' SMI was not detected during the PASRR process, but instead through a post-admission MDS assessment. After this MDS assessment, these individuals were referred to receive a PASRR Level II Evaluation to confirm their TP status. Paragraph 41 provides additional analysis on the completion of PASRR Level II evaluations for 50 individuals who were identified in this reporting period as having SMI during the MDS assessment process. The SME has offered a recommendation below, focused on determining whether these individuals should have had their SMI detected during their PASRR evaluations.

Figure 8. Paragraphs 25 and 26 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Met. LDH has established a PASRR Level II and MDS review process to ensure that individuals with SMI are added to the TP.	1) LDH should continue their initiative to improve the accuracy of the ML. 2) LDH should collaborate with the SME and DOJ to develop an engagement approach for individuals on the ML with unconfirmed or pending Medicaid eligibility. 3) LDH should evaluate the 50 individuals identified through the MDS assessment process as having SMI to determine whether SMI should have been captured through their pre-admission PASRR Level I or Level II evaluation process. To further contextualize the scope of this issue, LDH should calculate a denominator that reflects the total number of individuals receiving 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 BH services, the MCO case manager or BH 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 9. 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. In 2019, LDH developed a Diversion Plan (https://ldh.la.gov/assets/docs/MyChoice/DiversionPlan.pdf), reflecting 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.

- 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.
- Establishing a program for earlier engagement of individuals at-risk for future NF placements by preventing avoidable hospitalizations, titled the "At-Risk Program."

Many of these activities were completed prior to this reporting period, as reflected in prior SME reports. These strategies have created important infrastructure to support NF diversions, including evaluation, engagement, and service delivery processes with the objective of preventing needless NF admissions. As displayed in Figure 10, to assess compliance for this reporting period, the SME evaluates the extent to which LDH has maintained these aforementioned efforts, performance data associated with these efforts, and other metrics associated with diversion (e.g., audits of PASRR Level II evaluations that indicate that diversion might be possible).

Figure 10. LDH Performance on Diversion-Related Initiatives	
Diversion-Related Initiative	*Performance Data*
Behavior Pathway	As referenced in Paragraph 36, the behavior eligibility pathway was eliminated in 2018 and has not been utilized since. All who were previously admitted through the behavior pathway (referred to as those who were "grandfathered in") have either gone on to meet NF level of care criteria or been discharged due to not meeting level of care criteria; thus, the "grandfathered in" list now sits as zero.
Initial/Temporary Stays	As referenced in Paragraph 37, all TP members are limited to an initial authorization for NF care for 90 to 100 days. The average initial stay duration of 91 days in Q1 and 92 days in Q2.
PASRR Level II Processes	As referenced in Paragraph 34, in their audit of PASRR Level II evaluations, 14 cases (10%) in the audit sample were initially flagged by OBH for potential diversion consideration, triggering additional review by OAAS. OAAS ultimately determined that five cases (4%) were appropriate for potential diversion consideration. Of these five cases, OAAS determined that diversion was possible for two. For the remaining three cases, OAAS did not have enough information to determine the most appropriate setting for the individuals due to missing documentation. No special waivers were granted during this reporting period that would waive PASRR Level II Evaluation requirements (e.g., due to natural disasters, public health emergencies).
At-Risk Programming: Healthcare Utilization	As described in Paragraph 30, healthcare utilization shifts dramatically for those who participate in at-risk case management for six months, including decreases in all-cause and BH-related inpatient stays and emergency department (ED) interactions and increases in outpatient BH and ambulatory/ preventive care services. After six months in the program, the percentage of those with all-cause hospitalizations dropped by 28.6%, hospitalizations for BH reasons by 7.7%, all-cause inpatient stays by 16%, BH inpatient stays by 6.5%, and avoidable hospitalizations by 2.4%.
At-Risk Programming: NF Admission Rates	There were 3.6% of those in the at-risk program who were admitted into NFs compared to 6.7% of those who did not enroll, demonstrating that the At-Risk Program appears to divert individuals from NFs. The lower rate of NF admissions among the At-Risk Program participants is especially impressive, given that at baseline, those who accept At-Risk Program services have significantly higher rates of inpatient and ED utilization than their counterparts who decline At-Risk Program services.

Diversions	LDH continued to offer diversion services to Medicaid-enrolled individuals with SMI who seek admission to a NF but are not admitted because the PASRR Level II evaluation indicated community placement versus an NF admission. In this six-month reporting period, LDH effectuated 61 diversions toward their 137-diversion target (44.5%) for the year, reflecting 58 unique individuals. This represents 5.8% of all pre-admission cases (n=1,056) that were subject to NF level of care approval in this period. By comparison, in CY2024, there were 148 diversions.
Service Review Findings	Findings from the 2025 Service Review shed some light on the diverted population, but results may be limited in their validity because of the small sample. The Service Review shows that outcomes for diverted members are poor, including high prevalence of unstable housing or homelessness. These individuals were diverted because they did not qualify for care in an NF. Thus, they should be appropriate for permanent supportive housing (PSH) with wraparound supports. Further, given that the Service Review only reviews diverted individuals who accept Community Case Management (CCM) services, the SME has concerns about outcomes among those additional diverted members who do not elect to participate in CCM.
CCM Services Among Diverted Members	During this reporting period, 21 (34%) diverted members accepted CCM and as of 6/30/25, 43 individuals were actively engaged in CCM.

As reflected in the figure above, many of LDH's planned diversion initiatives are underway and effective. However, to assign a "Met" rating in this domain, the SME believes additional initiatives or improvements are needed, including (but not limited to):

- At this stage in the Agreement, given that the Diversion Plan is now six years old, LDH should consider developing an updated diversion plan that identifies enhancements to current initiatives, new initiatives, and system-wide and initiative-specific key performance indicators that would demonstrate that their constellation of diversion efforts are effective and durable.
- It appears that two-thirds of diverted individuals do not accept CCM services. LDH should explore novel approaches to engage them in the CCM program – or the At-Risk Program – to prevent their interface with ED and inpatient services that could lead to subsequent NF admission. LDH should also analyze their ED, inpatient, and NF re-admission rates and compare them to those in the CCM program.
- Given the many benefits of the At-Risk Program, LDH should consider strategies to increase enrollment, given that only 25% of identified "at-risk" members accept the program. The SME acknowledges this represents a nine percent bump in the percentage of eligible individuals who accepted the program compared to the prior reporting period.
- There may be additional individuals who should have been diverted but were not. As noted in Paragraphs 32 and 34, a small percentage of audited PASRR Level II evaluations were flagged by OBH as cases where diversion may have been appropriate.
- Through the SME's Service Review process, the team has anecdotally observed that diverted individuals are more likely to reside in unstable or congregate housing. LDH should analyze the scope of this issue and explore strategies to avail diverted members of PSH resources.

The SME acknowledges that serving diverted individuals is operationally complex and challenging given that unlike transitioned individuals, MCL staff do not have multiple months to arrange housing and services for them. Further, individuals diverted from long-term care may have pre-existing housing instability or other housing-related issues, increasing their baseline

levels of social and medical acuity. 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 more widespread issues, and if so, explore prevalence, causes and contributors to poor housing outcomes and strategies to optimize Agreement-related housing options.

Figure 11. 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, among other efforts.	1) With the support of the SME, LDH should update the diversion plan, inclusive of macro-level data metrics that better assess the outcomes of diversion/systems rebalancing efforts and monitor access to and utilization of services and housing among diverted individuals, including those who do not accept CCM. 2) LDH should continue to make improvements to diversion-related programming and activities, with a special focus on ensuring diverted individuals have access to permanent supporting housing.

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 BH systems rebalancing is to develop upstream services and supports to prevent individuals with rising risk from needing higher levels of care (e.g., NFs). To support this objective, LDH assessed the characteristics and needs of the TP within NFs to identify the needs profile of individuals "at risk" for hospitalizations that may lead to future NF admissions. The State has leveraged MCO case management to serve these "at risk" individuals, in hopes to prevent needless NF admissions. The State began designing this program in CY2021, and has engaged in the following activities to plan for, implement, and improve the program:

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

The State provided counts of at-risk members identified by the MCOs during fiscal year (FY) 2021 (n=5,488) and 2022 (n=5,812). 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. During this reporting period, 896 new individuals were identified as part of the at-risk population.

LDH tracks whether members of the at-risk population receive outreach from the MCO, have a successful contact, and ultimately enroll. For the 896 members identified from January to June 2025, 881 (98%) were outreached by the MCOs, 536 (60%) had successful contact, and 227 (25%) enrolled. Compared to July to December 2024, there were more individuals identified (896 vs. 767), but the rates of successful outreach and contacts were nearly identical. In this period, a higher percentage of members accepted the at-risk program in this period compared to the last period – 25% versus 16%.

Based on individuals' needs and preferences, they are placed in one of three case management intensity tiers, with the vast majority in the highest tier. Among the 227 who enrolled during this period, 155 (68%) were in tier 3, 35 (15%) were in tier 2, and 26 (11%) were in tier 1, with an additional 11 either "not assigned" or "transitional." Transitional case management is delivered to those who need short-term case management support as they transition from a 24/7 facility into the community. In the prior period, there was a greater proportion of members in tier 3 (84%).

To assess the outcomes of this At-Risk Program, LDH analyzes healthcare utilization trends for those who elect to participate in the special case management program, assessing whether healthcare utilization shifts after they participate in case management and comparing healthcare utilization among eligible individuals who did not elect to participate. For those who participate in the program for six months (as of the first quarter of 2025), findings include:

- Those who elect to participate in at-risk case management are, at baseline, higher utilizers of inpatient and ED care, and have more hospitalizations that are deemed as avoidable. For example, prior to receiving at-risk services, 74.7% and 32.1% of those enrolled in case management had all-cause ED and inpatient stays, respectively, compared to 61% and 21.8% of those who did not enroll in case management. Baseline rates of ED and inpatient utilization for BH reasons were similar across the two groups, suggesting that the variance in baseline utilization of ED and inpatient stays is related to physical health.
- There were decreases in all-cause and BH-related inpatient stays and ED interactions and increases in outpatient BH and ambulatory/preventive care services – all reflecting promising trends. After six months in the program, the percentage of those with all-cause ED utilization dropped by 28.6%, ED utilization for BH reasons dropped by 7.7%, all-cause inpatient stays dropped by 16%, BH inpatient stays dropped by 6.5%, and avoidable hospitalizations dropped by 2.4%.
- There were 3.6% of those in the at-risk program who were admitted into NFs compared to 6.7% of those who did not enroll, demonstrating that the At-Risk Program appears to divert individuals from NFs. Again, given that baseline rates of ED and inpatient care are much higher for those who elect to participate in at-risk case management, perhaps signaling a greater medical acuity among this group, the lower rate of NF admissions is notable. The SME appreciates the LDH team's improvement of data collection in this area, including their ability to provide data that compares admission rates between the two cohorts.

These are positive results. In Figure 12, the SME offers recommendations to build on the success of this program.

Figure 12. 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 collaborate with the SME to develop a benchmark for rate of acceptance of At-Risk Program services. 2) Given that differences in ED and inpatient utilization (between those who accept and do not accept At-Risk Program services) is primarily attributable to physical health issues, LDH should ensure that At-Risk Program service providers supporting access to primary and urgent medical care services and implementing other emergency and inpatient hospital diversion best practices.

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.

Before March 2025, when an individual was referred to a Medicaid-certified NF, the referring entity completed the PASRR Level I and a Level of Care Eligibility Tool (LOCET). L Office of Aging and Adult Services (OAAS) then reviewed the LOCET. If SMI was suspected at the Level I phase, OBH oversaw the completion of the Level II evaluation. In cases where intellectual disabilities or developmental disabilities (ID/DD) were present, the Office of Citizens with Developmental Disabilities (OCDD) oversaw the completion of the PASRR Level II evaluation. More information on the PASRR Level II process can be found in the discussion under Paragraphs 32 and 34. As of March 2025, this process changed substantially, due to OAAS procuring a new PASRR Level I vendor. Implementation highlights include:

- Through its vendor, OAAS developed new PASRR Level I tracking, reporting, and training procedures, facilitating more effective and efficient completion of PASRR Level I screenings and the more consistent flagging of potential SMI among TP members.
- After a PASRR is submitted, the vendor's second-level reviewer assesses clinical information associated with the case. If a possible SMI or intellectual disability is detected, the reviewer engages the PASRR submitter for clarification and if warranted, requests a new PASRR Level

I screening that accurately reflects the SMI or intellectual disability. OAAS also conducts a special review of all PASRR Level I screenings, to ensure their completeness and accuracy.
- The vendor also completes a quarterly quality review on a random sample of PASRR Level I screenings and provides the findings to OAAS for review and discussion.
- The new process enables near real-time notifications of NF admission, designed to facilitate earlier engagement of individuals in the TP by MCL staff. Near real-time notifications are integral to the State's compliance with Paragraph 45, which requires them to engage TP members within 3- and 14-day of admission.
- Prior to and since "go live" with the new system, OAAS, through its vendor, held 15 virtual trainings and three in-person statewide trainings, released several virtual and written tools, launched a website with an extensive provider training library, and staffed a helpdesk available to system users.
- In 2026, OAAS is strengthening quality monitoring by hiring two new staff, who will focus, in part, on ensuring that users enter NF admission data into the system timely.

As noted under Paragraph 41, there were 50 cases where SMI was detected during the MDS assessment, and forty-five (90%) of those cases reflected individuals who were admitted to NFs relatively recently (i.e., within 90 days). While it is conceivable that an individual could develop an SMI soon after NF admission, these may also reflect cases where the PASRR Level I screening should have detected SMI. The SME recommends that LDH audit a sample of these cases to determine whether, how, and why SMI was not detected at the PASRR Level I screening stage. If SMI was detected at the PASRR Level I screening stage but not validated through the PASRR Level II evaluation, this inquiry can also shed light as to why.

The SME applauds OAAS for establishing these new processes, which are designed to assess systems users' compliance with PASRR Level I data entry completeness, quality, and timeliness requirements, and ensure that SMI and intellectual disabilities are appropriately detected to trigger a PASRR Level II evaluation. In this early implementation phase, the SME also recommends that OAAS evaluates whether numbers and rates of referrals for PASRR level II screenings, as well as post-PASRR level II detection of SMI (e.g., through MDS), has shifted compared to such rates before implementation of the new vendor and processes.

The establishment of these processes described above are foundational to compliance with this Paragraph. In the next reporting period, the SME requests to review findings associated with these quality assurance efforts (similar to his approach under Paragraphs 32 and 34 relative to PASRR Level II audit findings) to better evaluate the effectiveness of these newly implemented procedures and validate the accuracy and consistency of SMI detection in the PASRR Level I screening process.

Figure 13. Paragraphs 31 and 33 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. LDH has onboarded a new vendor to improve the efficiency and effectiveness of the PASRR Level I screening process and has commenced quality monitoring efforts with the potential to reach compliance with this Paragraph.	1) LDH should fully implement quality assurance and oversight structures for the new PASRR Level I vendor, focused on improving the identification of suspected SMI and subsequent referrals to PASRR Level II evaluation and ensuring accurate and timely data submission to trigger early engagements.

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

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

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

One important function of the PASRR Level II evaluation 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., peer 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 reviewed and offered feedback on various iterations of the PASRR Level II instruments and associated trainings and his SME Service Review process verified that the information collected as part of the PASRR evaluation process is sufficient to inform determination of whether someone has an SMI diagnosis. LDH sought and incorporated additional stakeholder input on the PASRR Level II evaluation instrument and launched it in July 2024.
- The most recent revision was designed to better equip the evaluator to discuss and make referrals relative to the full array of community-based services and housing options available to individuals, as well as uniformly collect barriers that prevent or create risks for NF diversion. The revised evaluation instrument also includes more information on medical services 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 also hold regular meetings with their contracted organization and the MCOs to review and discuss interventions for audit findings, build expertise in BH and SUD levels of care to ensure appropriateness of recommendations, and discuss complex cases and cases flagged for potential diversion.
- To strengthen PASRR processes, LDH requires PASRR Level II evaluators to participate in monthly meetings and "grand rounds" to discuss complex cases. LDH also implemented several other activities in this reporting period germane to PASRR, including (but not limited to): streamlining of PASRR reporting, communication, and information sharing; PASRR-related trainings and presentations to various stakeholders, including the Louisiana Hospital Association, provider association of psychiatric nurse practitioners; and strengthened collaboration with OCDD for cases that involve both mental health and intellectual and developmental disabilities.
- PASRR Level II evaluations are expected to be face-to-face and generally completed prior to admission. In this reporting period, 99.45% were completed within four days of OBH referral. The average pre-admission PASRR Level II completion rate across the two quarters in this reporting period was 96%.

In summary, the PASRR Level II evaluation processes that have been established by LDH are aligned with this Paragraph's requirements. LDH audits a sample of PASRR Level II evaluations with three objectives: to identify the presence and type of deficiencies in completed evaluations, to evaluate the soundness of the placement decisions made by the evaluators, and to assess whether some cases may have been appropriate for diversion. The SME does not independently audit these evaluations but was provided with audit findings relative to the 139 PASRR Level II evaluations administered during this reporting period. Across these three areas, audit findings showed substantial improvement compared to prior periods. To summarize:

- Twenty (14%) of the 139 evaluations reviewed by OBH had a deficiency, mostly related to inadequate recognition of an individual's SUD and/or identification of services needed to address SUD. In the last reporting period, 22% of evaluations had a deficiency, and similarly, most of the deficiencies involved missing SUD information or BH or SUD recommendations misaligned with an individual's identified needs.
- OAAS also reviews evaluations to determine whether they agree with the NF placement determination made by OBH. OAAS confirmed agreement with 96.3% of cases. By comparison, in the last reporting period, OAAS concurred with 91% of placement determinations. Fourteen cases (10%) were initially flagged by OBH for potential diversion consideration, triggering additional review by OAAS. OAAS ultimately determined that five cases (4%) were appropriate for potential diversion consideration. Of these five cases, OAAS determined that diversion was possible for two. For the remaining three cases, OAAS did not have enough information to determine the most appropriate setting for the individuals due to missing documentation.

To improve compliance with this Paragraph, the SME encourages LDH to continue with their continuous quality improvement efforts, focused on reducing the percentage of PASRR Level II evaluations with deficiencies and those flagged for possible diversion.

Figure 14. Paragraphs 32 and 34 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Met. The PASRR Level II evaluation instrument has undergone significant improvements to facilitate reviewers' ability to identify and inform individuals on available community-based services options. LDH's audit findings demonstrate that the majority of placement decisions are appropriate.	1) LDH should continue its PASRR Level II audit activities, continuing to track and address areas of deficiency, including whether PASRR Level II evaluators are making appropriate decisions regarding NF or community placement.

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

LDH has established a process wherein individuals receiving PASRR Level II evaluations who have a suspected SMI and who are suspected of having a primary diagnosis of dementia are referred to a consulting psychiatrist. The consulting psychiatrist provides an additional professional evaluation, in the form of documentation review, for all individuals with a suspected and primary dementia diagnosis to ensure appropriate diagnosis and differentiation, including a determination of whether external factors may be causing the dementia. Consistent with federal standards, the review relies on clinical documentation such as neurological exams or consultation findings, laboratory results, and brain cat scans or magnetic resonance imaging. The consulting psychiatrist also reviews results from a questionnaire completed by individuals in the person's life (e.g., family members) who have directly observed their loved one's symptoms, presentation, and in some cases, cognitive decline. LDH reports that this process is aligned with national standards and best practices.

In some cases, the consulting psychiatrist is able to confirm a primary dementia diagnosis based on the documentation review alone. In cases where a primary dementia diagnosis cannot be established, however, OBH requests dementia testing (from the NF or MCO) and checks if the testing was completed at the next PASRR Level II evaluation (e.g., the evaluation conducted in concert with a continued stay). Even if dementia is suspected, individuals remain eligible for all MCL services until a primary dementia diagnosis is verified.

The SME is assigning a "Met" rating under this Paragraph because LDH's continues to have the consulting psychiatrist review all individuals with suspected dementia. However, to maintain compliance in future periods, the SME would like to collaborate with LDH to improve data reporting in this area, with special focus on the disposition of dementia reviews and multi-year trends regarding the prevalence of suspected and confirmed primary dementia.

Figure 15. Paragraphs 35 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Met. LDH has established a process to confirm whether individuals have a primary dementia diagnosis and avails individuals of all MCL services until primary dementia is confirmed.	1) LDH should collaborate with the SME to improve the clarity of data collection and reporting as it relates to the prevalence of dementia and the outcomes of the reviews of the consulting psychiatrist and other testing administered by the NFs or MCOs.

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 Level of Care 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.

Given multi-year compliance with this requirement, the SME recommends that LDH and the DOJ have a meeting to determine at what point it is appropriate to sunset tracking of this requirement. This principle could also be applied to other requirements with a multi-year history of compliance, allowing for more focused attention on other requirements that have not yet been fully met.

Figure 16. Paragraph 36 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Met. LDH eliminated the BH pathway and regularly reviews MDS to verify that individuals with a sole SMI diagnosis are not being admitted to NFs.	1) Given multi-year compliance with this requirement, the SME recommends that LDH and the DOJ have a meeting to determine at what point it is appropriate to sunset tracking of this requirement.

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

Analysis: In cases where persons with SMI require NF placement, it is important that the duration of their stay in the NF does not exceed what is medically necessary. To that end, the Agreement requires that initial approvals be limited to 90 or 100 days.[1] After the initial approval,

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

approvals for extended stays (referred to as "continued stays") must specify why the timeframe was selected, why NF care for that duration is appropriate, the specialized BH services that are needed, and why such services could not be delivered in the community. The continued stay process must occur 30 days prior to the conclusion of the initial authorization. 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.

Consistent with the last reporting period, virtually all individuals in the TP received short-term authorizations in this reporting period. The average length of stay for these initial authorizations was 91 and 92 days for quarters 1 and 2 of 2025, respectively, 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 1 of 2025, the averages were 358 and 317 days. For quarter 2, the averages were 355 and 325 days. This aligns with averages from the prior reporting periods; for example, the averages for quarter 4 of 2024 were 352 and 317 days, respectively. Figure 17 provides data on the number of continued stay requests, as well as approval rates and dispositions, demonstrating that 84% of cases are ultimately approved for continued stays. Per LDH, even in cases where NF level of care requirements are not met, OBH provides recommendations regarding specialized services to address BH needs, including advising OCDD on BH services in cases where an individual has ID/DD.

Figure 17. Continued Stay Approval Rates and Dispositions

Disposition	*Number*
Extension requests	2,751
Approvals	2,307 (84%)
Not approved	444 (16%)
▪ Extensions deferred to OAAS	401
▪ Extensions deferred to OCDD	18
▪ Extension requests withdrawn	19
▪ Deceased	4
▪ Extension denied due to inadequate information	*2*
Recommended for Specialized Services (SS)	2,335
Not Recommended for SS	426

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

- *The "intended duration of NF admission."* As indicated above, continued stays are approved for less than 365 days. The SME would like to engage with LDH and the SME to explore whether a default continued stay of approximately one year is appropriate in all cases.
- *The "reasons the individual should be in a NF for that duration."* The revised PASRR Level II evaluation instrument, launched in July 2024 and administered as part of the continued stay process, is designed to capture this information, with dedicated sections that identify the needs, barriers, and service recommendations for each individual, across multiple domains (e.g., health, ADL/instrumental ADLs, BH).
- *The "need for specialized BH services."* The PASRR Level II evaluation captures BH-related needs and service recommendations, although LDH's PASRR audit found that 14% of audited evaluations did not have adequate information on BH-related barriers, conditions, or needed services. The prior SME raised concerns about whether BH services that were recommended

to be delivered within NFs for individuals were adequately tracked by LDH. The current SME would like to discuss the feasibility of such an approach with LDH and the DOJ.
- *The "barriers that prevent the individual from receiving community-based services at that time."* The tool has dedicated sections to capture barriers across multiple domains.

Responsive to prior recommendations from the SME, LDH is also developing a database to enable easier aggregation and trends analysis of barriers identified in PASRR Level II evaluations, to capture greater insights into common barriers and strategies to address such barriers.

In summary, LDH's established initial and continued stay processes address many of the requirements in this Paragraph, but consistent inclusion of BH needs and recommended services is needed to reach full compliance.

Figure 18. Paragraph 37 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. LDH's initial and continued stay approval processes are aligned with this Paragraph's requirements. However, 14% of audited PASRR Level II evaluations show inadequate recognition of an individual's SUD and/or identification of services needed to address SUD.	1) LDH should engage in collaborative discussions with the SME and DOJ regarding the default (approximately one year) approval duration for continued stays and tracking of BH services delivered while TP members are in NFs. 2) LDH should continue to improve the quality of PASRR Level II evaluations, as they relate to identification of SUD needs and needed services.

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

As indicated in previous SME reports, the State has developed a process that requires NFs to submit continued stay requests for continued stays beyond the 90 days of an initial stay, using the MDS as the basis to establish NF level of care eligibility. LDH created policies and criteria for individuals who will be provided a continued stay past the initial 90 or 100 days. The fourth SME report provided a description of this process, which delineates the roles of OAAS and OBH, which includes review by OAAS regional staff who are independent and not affiliated with the NF.

Figure 19. Paragraph 38 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Met. LDH's initial and continued stay approval processes are aligned with this Paragraph's requirements.	3) LDH should engage in collaborative discussions with the SME and DOJ regarding the default (approximately one year) approval duration for continued stays and tracking of BH services delivered while TP members are in NFs.

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 independently 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 to 100-day authorized stay; an individual being due for an annual resident review; and an NF or other entity requesting a new PASRR Level II evaluation due to a significant change in an individual at their facility.

During this reporting period, LDH reports that there were 2,725 annual PASRR Level II evaluations completed. There were 10 additional NF residents who did not receive an annual evaluation, but this was due to their private pay or non-Medicaid (e.g., Veterans benefits) payer status. This aligns with a special analysis that was conducted for the 12th SME Report, wherein the SME requested that LDH 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.

This Paragraph also requires PASRR Level II evaluations be readministered "upon knowledge of any significant change" in an individual's health status. These are referred to as resident reviews, and can be requested by OBH, an NF, or a NF resident. If an NF resident requests to discharge, this is referred to as a Section Q referral. As shown in Figure 20, LDH provided data on the number of resident review requests known to LDH during this reporting period (1,149) and the completion rate for the subset of resident reviews requested by NFs. These requests are associated with all NF residents, not just the TP.

Figure 20. Resident Review Requests & Outcomes

Requestor	*Q1 Initiated*	*Q1 Completed*	*Q2 Initiated*	*Q2 Completed*
NF	478	464 (97%)	287	271 (94%)
OBH	195	Not reported	149	Not reported
Section Q	22	Not reported	18	Not reported

There were 735 (96%) NF-initiated resident requests completed in this reporting period. Data on completion rates for resident reviews requested by OBH or associated with Section Q referrals was not reported. Of the 735 completed resident reviews that were requested by NFs, 186 were found to meet criteria for SMI, 549 w did not meet criteria for SMI, 21 were withdrawn by the NF, and nine were discontinued due to an individual's death.

The SME is assigning a "Partially Met" rating to this Paragraph, given that LDH has established a process to ensure the completion of annual PASRR Level II evaluations and resident reviews requested by NFs. However, to reach full compliance under this Paragraph, the SME requests clarity around the feasibility of data reporting on the completion and disposition of outcomes associated with resident reviews requested by OBH and NF residents.

Figure 21. Paragraph 39 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. It appears that those who require annual PASRR Level II evaluations receive them and NF-requested "change in status/condition" resident review requests are consistently completed.	1) LDH should collaborate with the SME on a methodology to enhance reporting on the completion and dispositions of resident reviews not requested by NFs.

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 support process has generally been the same, until the Rapid Reintegration Transition Coordinator (RITC) pilot was implemented, as described in Paragraph 45. If TP members expressed interest in transitioning, they were added to the AC to receive transition support. If they were not interested, undecided, or unable to decide if they are interested in transition, they were maintained on 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 (see Figure 22 for data associated with this reporting period). 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.

Figure 22. Timeliness of Transition Coordination Processes					
Process	*LDH Standard*	*Performance for Legacy AC*	*Performance for RITC AC*	*Last period Legacy*	*Last period RITC*
Member added to AC to TC assignment	1 day	1 day	<1 day	4.5 days	<1 day
TC assignment to initial contact	3 days	Data not available at time of report	Avg. not available but 96% received 3-day contact	Data not available at time of report	Avg. not available but 94% received 3-day contact

TC assignment to NFTA completion	14 days	12 days	16 days	9 days	9 days
NFTA completion to ITP initiation	30 days	6 days	5 days	2 days	2 days
ITP initiation to established transition date	7 days	Transition date entry required to complete ITP; ITPs are typically completed in one day, but members may request or need a break, requiring TC to return for another visit.		Unknown	Unknown
Pre-discharge planning meeting	Within 60 days before transition date	77% of OAAS supported members and 84% of OBH supported members had documentation of discharge planning meeting within 60 days of transition, although performance is likely closer to 100% (per LDH & validated by service review)			

While LDH has established effective processes for comprehensive transition planning services, not all eligible members have been offered such services. LDH reports that 560 individuals on the ML had not been reached as of the end of this reporting period.

Figure 23. Paragraph 40 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. While LDH has set up processes to align with the requirements in this Paragraph and has conducted timely NFTAs and ITPs for the majority of those who express and sustain interest in transition, data suggests that a segment of the ML has yet to be offered transition support services.	1) 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.

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.

LDH reported that five individuals who resided in NFs for greater than 90 days and 45 individuals who resided in NFs for 90 days or fewer had MDS assessments that indicated SMI. Among these 50 individuals, 36 had completed PASRR Level II evaluations in less than 18 days on average. Among the remaining 14, five died, two received evaluations during their Continued Stay Request process due to the NF not responding to OBH requests, and seven were discharged; the latter group was discharged prior to the their PASRR Level II evaluation being due (30 days from MDS assessment that indicated SMI).

As noted above, 45 (90%) of the 50 cases where SMI was detected during the MDS assessment reflect individuals who were admitted to NFs relatively recently (i.e., within 90 days). While it is conceivable that an individual could develop an SMI soon after admission, these may also reflect cases where the PASRR Level I screening should have detected SMI. The SME recommends that LDH audit a sample of these cases to determine whether, how, and why SMI was not detected at the PASRR Level I screening stage. If SMI was detected at the PASRR Level I screening stage but not validated through the PASRR Level II evaluation, this inquiry can also shed light as to why.

Figure 24. Paragraph 41 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Met. LDH has established and implemented a process for post-MDS referrals to PASRR Level II evaluations when SMI is suspected.	1) LDH should audit a sample of these cases to determine whether, how, and why SMI was not detected at the PASRR Level I screening stage, or potentially the PASRR Level II evaluation stage.

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

Analysis: LDH has hired and trained a complement of TCs to provide comprehensive transition planning and facilitation services to individuals who express interest in moving into the community from NFs. As explained above, when engaging with members, TCs collaborate members and their chosen representatives to develop a NFTA that identifies their support needs, followed by an ITP that identifies needed services, supports, and resources to facilitate transition and healthy tenure in the community. After individuals transition into the community, TCs conduct visits for individuals for up to one year post transition, including follow-up visits at 7-, 30-, 90-, 180-, and 365-days post-discharge.

In addition to SMI, some members also have intellectual and developmental disabilities (ID/DD), physical disabilities, other health concerns, and/or 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). Having TCs associated with these agencies would help to ensure that 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 252 individuals on the ML and 20 on the AC. In this reporting period, there were 251 individuals on the ML and 28 on the AC. Since these rates have not increased, 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. This is especially important given that, as noted under Paragraph 51, 10% of all "transition barriers" collected by TCs involve collaboration issues or waiver evaluation delays associated with OCDD. Such issues require resolution for LDH to receive a "Met" rating under this Paragraph.

At the end of this reporting period, there were 32 TC positions across OBH and OAAS. OAAS had 17 positions filled, four positions vacant, and one new TC position approved. OBH has 10 TC positions and all were filled. Further, there were three OBH staff positions that provide oversight/support to the TCs and three OAAS supervisor positions, with other OAAS leaders providing additional 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 considers 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.

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.
- System-related enhancements to client tracking system.
- Automations and shared tracking tools between multiple units involved in transition planning, such as MCL and PSH units.
- Increased focus on updating the ITP based on monthly engagements.

In 2025, according to the Implementation Plan, TCs were responsible for effectuating transitions for 287 members. As discussed under Paragraph 56, this target was informed by a methodology that starts with the number of members on the AC and then uses historical trends to estimate how many members fall out of the transition pipeline at various process points. At the year's midpoint (at the end of this reporting period), LDH has effectuated 70 transitions. Under Paragraph 56, LDH's multi-year transition performance, as well as recommendations regarding the remediation of systemic issues that impede transition performance, are discussed.

Figure 25. 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 work with other relevant state agencies and stakeholders to identify and remediate systems issues that impede impact transition performance. DOJ

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 and complete a NFTA to inform the ITP. While the SME shares the view that extensive transition planning should be reserved for those who have expressed an interest in transition, a semi-structured process that helps a member think through the supports they need, identify their strengths and assets in the community (e.g., formal supports), and envision what life can look like in the community can be a useful exercise. This can help to ensure that the member is fully informed as they are being engaged around interest in transition. 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. OAAS conducted a sample study and determined that addenda were developed for 16 of the 19 cases in their audit sample. Data on OBH addenda was not reported. However, both agencies have planned or implemented process enhancements in 2025 to facilitate more consistent completion of the ITP addenda, including an alert system in the medical record, training on the importance of the ITP addenda, and an internal documentation review process.

Paragraph 46 enumerates the components that must be included in ITPs. Each year, the SME and his team reviews a representative sample of ITPs and assigns 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. The SME's 2025 Service Review process demonstrates substantial year-over-year improvement in ITP completeness and quality: with an average quality score of 23.08% out of 100 in 2023, 50.78% in 2024, and 78% in 2025. Among the 2025 ITP sample, the most common gaps include: the ITP not being provided to the member (62%), no evidence of an ITP planning meeting (27%), missing content regarding medical needs and supports (27%), and lack of member signature (23%).

Figure 26. Paragraphs 43 and 46 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. While the State continues to develop ITPs for individuals who remain interested in transitioning after receiving a NFTA, ITPs do not consistently include all the required components per the Agreement.	1) LDH should continue quality improvement strategies that improve the completeness and quality of ITPs, including reviewing (and reporting on) the presence and quality of the ITP addendum.

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 provides training on person-centered planning and has developed programmatic documentation to capture person-centered information. During this reporting period, both agencies – OAAS and OBH – continued to provide person-centered care trainings and updated practice guidance documents (e.g., the PIR prompting guide) to enhance the person-centered engagement of TP members. In the first quarter of 2025, LDH trained 88 MCL affiliated staff on person-centered care, and offered trainings to staff in other aligned programs, such as OAAS's Home and Community Based Services programs.

As part of the SME's Service Review process, a team of experts reviews a sample of NFTAs and ITPs to evaluate their person-centeredness and overall completeness/quality. Each case is scored using a 1-5 Likert scale (1 being very poor and 5 being excellent) and then an average for the entire cohort is calculated. Relevant data highlights include:

- For the service review cohort that is awaiting transition, LDH made significant strides in improving the quality of NFTAs and ITPs; in 2023, the average quality score was 1.74, in 2024 it was 2.48, and in 2025, it was 3.0. The score of 3.0 is "good" based on the Likert scale. Gaps in the ITPs brought down the average score more so than a lack of person-centered planning. However, there are a few areas for improvement related to person-centered planning; for example, 15% of reviewed NFTAs did not identify the strengths of individuals.
- For the service review cohort that has already transitioned, the average quality score related to assessment and person-centered planning was 2.69 in 2023, 2.9, in 2024, and 3.0 in 2025. For this cohort, the SME and his team evaluated CCM assessments and plans of care.

Another opportunity to enhance the person-centeredness of the transition process is to more consistently assist members to view their 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 implemented a tracking system in August 2025 to enable reporting on the occurrence of virtual or in-person housing walk-throughs. During this reporting period, LDH also encouraged staff to build collaborative relationships with NF staff to increase the likelihood that they will transport members to view their housing options and leverage their state-provided cell phones to take and share pictures and offer FaceTime showings. The SME hopes to provide data on these efforts in future reports.

Figure 27. Paragraph 44 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. The service delivery documentation evaluated by the SME and his team improves each year, in terms of overall completeness and quality, as well as person-centeredness. Improved compliance hinges upon reporting on virtual or in-person housing visits and ensuring all MCL service delivery staff receive person-centered trainings.	1) LDH should implement its new tracking system for virtual and in-person housing visits. 2) LDH should ensure that all MCL service delivery staff receive regular person-centered planning trainings and continue to ensure person-centeredness in their documentation.

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 three 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 was 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. However, as of March 2025, LDH receives near real-time alerts to NF admissions and is able to deploy RITC staff to engage individuals in accordance with this Paragraph. Until the real-time admission alert process was in place in March 2025, RITC operated as a pilot program in seven regions. More information on the pilot program's activities and outcomes is provided in the 12th SME Report.

The reporting period spans the pilot phase (January-February 2025) and full statewide implementation phase (March-June 2025) of the RITC program. Key performance highlights include:

- There were 331 (96%) individuals who received the required 3-day contact, and 316 (92%) who received the in-person 14-day contact.
- Of the 316 who received the 14-day contact, 104 (33%) went on to complete a NFTA, signaling their interest in transitioning.
- Of the 104 who completed a NFTA, 54 (52%) individuals completed an ITP.
- Ultimately, there were 27 individuals transitioned through the program or were still in the transition pipeline at the time of the analysis, representing % 8% of the original pool of individuals who received the three-day contact. Ultimately, 12 transitioned. For comparison, as reported in the 12th SME Report, of the 503 individuals who received a 3-day contact, 78 (16%) completed an ITP, 53 (11%) maintained interest after the ITP, and 39 (8%) either transitioned or were working toward transition at the time of the report.

In the 11th and 12th SME Reports, the SME shared lessons learned from the RITC pilot. One lesson was that early engagements from RITC staff – including those focused on completing NFTAs and ITPs – are viewed as premature and/or overwhelming to individuals who have just been admitted into a NF. For this reason, the SME recommends that LDH refocus RITC early engagements on rapport building, relationship development, and collecting the "minimum viable product" in terms of information needed to deepen engagement, only introducing lengthy documentation when a member is ready for that level of transition planning. However, it is important to acknowledge that early engagement should still have a focus and direction, preventing needlessly long tenures in the NF and helping to preserve pre-admission resources (e.g., family support, housing) that could help an individual with a more seamless discharge from an NF when they are ready.

One of the challenges with meeting the 3- and 14-day requirement in this Paragraph is that some individuals do not have Medicaid at the time of NF admission, technically not meeting the TP eligibility criteria. For these individuals, it takes three months, on average, for them to be authorized for Medicaid. In their review of 551 members engaged by the RITC pilot program from March 2024 to February 2025, LDH found 347 (63%) individuals did not have confirmed Medicaid eligibility or enrollment at the time of admission. Ultimately, 178 of the 347 individuals (51%) were not authorized for Medicaid within four months of admission, despite the average timeframe for authorization being three months. This means that a significant segment of those engaged by RITC staff most likely do not meet TP criteria. LDH estimates that 329 to 403 labor hours (excluded travel time and costs) were spent engaging the sample of individuals included in this analysis.

Based on this analysis, the SME, LDH, and DOJ will need to determine whether, or to what extent, LDH should continue to engage individuals that do not have Medicaid status confirmed at the time of admission through the RITC program, with a focus on how to balance the optimization of limited staff resources with the reality that half of those who do not have Medicaid at admission will ultimately meet TP criteria. The SME is eager to engage in these discussions and appreciates LDH for conducting this analysis to inform our discussions.
The SME is assigning a "Met" rating for this Paragraph. To maintain compliance in future reporting periods, the SME requests that LDH implement refinements to the RITC process consistent with recommendation 3 below and the associated priority overarching recommendation, in hopes that it increases the quality of engagements and the proportion of individuals who elect to transition through the program. The SME also expects LDH to continue to provide data that demonstrates that individuals receive their required 3- and 14-day contacts through the RITC program.

Figure 28. Paragraph 45 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Met. The statewide rollout of the RITC program has enabled LDH to meet the 3- and 14-day contact requirements.	1) LDH should partner with the DOJ and SME to devise an approach to engaging individuals without confirmed Medicaid eligibility at NF admission. 2) LDH should develop strategies to address lessons learned in the pilot, including adopting an individualized rapid engagement approach that meets people where they are. 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 Community Case Management (CCM). All six MCOs contracted with the same vendor 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 2025 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. Data highlights include:

- Of the 16 transitioned members reviewed, CCM documentation – specifically assessments, plans of care, and crisis plans – was present for all members of the cohort, representing an improvement over the prior periods.
- The average quality score of community assessments has improved, from 85% in 2023, to 91% in 2024, to 94% in 2025. For the nine assessments with deficiencies, all of them lacked information from other sources, such as the member's family/natural supports; medical, BH, and waiver providers; and identified MCO care coordinators. Further, one community assessment lacked content on needed housing supports and another lacked information regarding health and wellness needs, particularly around the management of a member's diabetes.
- Average quality scores for CPOCs have also improved year-over-year: 67% in 2023, 73% in 2024, and 84% in 2025. In 2025, it is important to note that several domains of the CPOC were largely complete across the CPOCs reviewed (strengths and preferences, housing, social/recreational needs, educational/vocational needs, member signature, and involvement of other individuals). The most common gaps in the CPOCs include inclusion of plans to address transportation needs (8 members/50%); medical needs (4/25%), health and safety needs (4/25%), BH needs (3/19%), and health and safety needs (3/19%).
- Further, a review of documentation for a cohort of individuals nearing transition showed that there was evidence that pre-transition discharge planning meeting took place between TCs and CCMs across 73% of the cases reviewed.

This Paragraph requires that all services necessary to transition are authorized and provided, and that a plan of care be in place "at the point of transition to the community." CCM assessments are not due until 30 days after transition, so LDH has developed an ITP addendum, completed by the TC, which identifies the services and supports that an individual needs during the vulnerable 30-day gap between NF discharge and CCM assessment and care planning (see more detail in Paragraph 43). The addendum provides recommendations regarding the scope, amount, and duration of services needed at transition. As mentioned in a prior paragraph, OAAS conducted a sample study and determined that addenda were developed for 16 of the 19 cases in the audit sample. In quarter 3 of 2025, OBH implemented a new process to assess whether ITP addenda were completed for all cases and will provide data relative to this requirement in the next reporting period. However, both agencies have planned or implemented process enhancements to facilitate consistent completion of the ITP addenda, including an alert system in the medical record, training on the importance of the ITP addenda, and documentation review process.

In terms of services being "authorized at the point of transition to the community," the SME requests a conversation with LDH to determine the best way to measure this aspect of the requirement, either through inclusion in the SME's Service Review process or other means.

Figure 29. Paragraph 47 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. Cases reviewed as part of the 2025 Service Reviews demonstrate that CCM referrals and the documentation were timely, and that documentation was of good quality. Given that this Paragraph also requires the receipt of services at the point of transition, stronger reporting on the completion and quality of the ITP addenda is needed to fully assess compliance.	1) LDH should implement the recommendations under Paragraphs 43 and 46. 2) LDH should co-create a strategy to monitoring whether needed services are authorized at the point of transition to the community.

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. As indicated in the prior Paragraph, review of documentation for a cohort of individuals nearing transition showed that there was evidence of pre-transition discharge planning meetings – which represents the formalization of the CCM referral – across 73% of the cases reviewed.

The SME is assigning a "Met" rating for this requirement because the process of assigning case management responsibility is established, and per LDH, is standardized and reliable. For future reporting periods, the SME will hinge compliance on whether the TCs' documentation more consistently demonstrates linkage to CCM services.

Figure 30. 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. Documentation reviewed by the SME and his team validates that 73% of transitioned members received a CCM referral within 60 days of their planned transition date.	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-, 90-, 180-, and 365-day time points in the year after transition. Data and information relevant to this Paragraph includes:

- LDH has fielded a guidance document for TCs that specifies what each post-discharge visit should cover. TC supervisors also track whether visits occur.
- OAAS reports that 100% of all visits occurred, but only 77% of all visits were substantiated by documentation. OBH reports that 88% of all visits occurred.
- The 2025 Service Review process assigned an average score of 3.44 for in the "transition outcome" domain, which is between "good" and "very good" on a 1-5 Likert Scale. The average was impacted by four of the 16 members with poor or very poor ratings regarding their transition outcomes, due to housing instability, untreated BH issues, repeated hospitalizations, and a lack of needed DME and medical supplies. However, it is important to note that 12 (75%) of the cohort had good or very good transition outcomes.

If there are concerns regarding staff capacity, LDH may want to consider a risk stratification approach to post-transition visits. Specifically, they could identify the factors that contribute to a transitioned individual's vulnerability – such as CCM staff turnover, critical incidents, hospitalizations and ED visits, or crisis events – and develop a post-discharge visit cadence that is customized to the individual's needs. One major factor would be whether that transitioned member is actively engaged in CCM services.

Figure 31. Paragraph 49 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. LDH can validate, through provider documentation, that the majority of post-transition visits are occurring.	1) LDH should ensure that TCs complete and document all post-transition visits, with a focus on ensuring individuals have the services they need in the community.

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

Analysis: Historically, some individuals who transitioned from NFs lost Medicaid eligibility after transitioning to the community, given that Medicaid has more generous income limits for individuals who meet NF level of care eligibility requirements than for those who reside in the community. There are also circumstances wherein transitioned individuals transfer to a new Medicaid type.

During this period, LDH developed a directory of services and resources for individuals who lose Medicaid after discharge. It provides guidance to TCs on how to determine whether a member is at risk for losing Medicaid after transition, alternative insurance options, free or low-cost BH and medical resources (including crisis services), and other community-based resources. The guide also establishes the expectation that TCs still provide post-transition conduct post-transition engagements at 30-, 90-, 180-, and 365-day time points in the year after transition, as well as monthly calls. This guide was fielded in June 2025 and redistributed to TCs in December 2025. LDH reports that it will create a complementary client-facing resource for individuals who have lost their Medicaid eligibility.

In this reporting period, LDH reports that six individuals lost Medicaid eligibility upon transition but were unable to confirm that the resource was used to guide service and resource linkages for these individuals. In future periods, if LDH is able to confirm that individuals either received the client-facing referral guide or TCs used the internal referral guide to discuss or facilitate service options, they will be found in compliance with this Paragraph.

Figure 32. Paragraph 50 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. LDH continues to track whether individuals have lost Medicaid eligibility and has developed a guide for TCs on resources and services for these clients. However, data is not yet available on whether it was consistently used among the six members who lost Medicaid eligibility during this reporting period.	1) LDH should begin to use its referral guides for individuals who lose Medicaid coverage or change Medicaid types in a way that impact service eligibility.

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 remain 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 33 provides a synopsis of information gleaned at each of those engagement stages, comparing quarter 1 and 2.

Figure 33. Common In-Reach and Transition Barriers		
	Most Cited Barrier	*Additional Common Barriers*
Q1 In-Reach: Undecided (102 records)	(1) Decline in physical health (56%)	(2) Concerns expressed related to needed medical supports (30%); (3) concerns about management of physical health (23%)
Q1 In-Reach: Not Interested (623 records)	(1) Decline in physical health (73%)	(2) Concerns about management of physical health (41%); (3) family/guardian not supportive of transition (34%)
Q2 In-Reach: Undecided (56 records)	(1) Decline in physical health (48%)	(2) Concerns expressed related to needed supports (39%); (3) other (32%)
Q2 In-Reach: Not Interested (446 records)	(1) Decline in physical health (54%)	(2) Concerns about management of physical health (48%); (3) family/guardian not supportive of transition (23%)
Transition: Barriers Cited in NFTA Process (119 records)	(1) Other (29%) *Of the 35 cases, one-third were related to OCDD waiver process delays or coordination issues.*	(2) Waiting for a specific housing unit or a housing unit in a specific town (20%); (3) concerns about management of physical health (10%); (4) waiting for an accessible housing unit (9%)

The SME has raised in prior reports that some individuals may have an institutionalized mindset, meaning that they have either developed or perceive they have developed deficits around life skills due to their tenure in institutional settings. For this reason, MCL service providers must be adept at meaningfully engaging individuals around their concerns and questions related to transitioning, and offering information, resources, and motivational techniques to address those concerns.

In the 2026 Service Review, the SME is conducting an analysis of peer in-reach (PIR) services to determine whether there are opportunities to enhance the program, including by increasing their ability to identify and address barriers at the individual level. Further, the SME continues to recommend that LDH address selected barriers at the systems level. For example, LDH should implement strategies to address issues regarding OCDD collaboration or services, which reflect 10% of all transition barriers. These issues likely necessitate a macro-level intervention, such as improved training for TCs on navigating OCDD services or a formal interdepartmental protocol, versus a case-by-case intervention. As referenced in Paragraph 58, LDH has recently implemented a process to aggregate, analyze, and solution around systemic barriers, which will improve compliance with this Paragraph.

Figure 34. Paragraph 51 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. In-reach and transition barriers are captured, but these barriers are not fully explored and addressed at the individual, programmatic, or systemic levels.	1) LDH should ensure that in-reach, RITC, and TC staff are proficient in motivational interviewing and other approaches to build self-efficacy among the individuals they engage. 2) LDH should implement the recommendations under Paragraph 58 pertaining to tackling systemic barriers, including those related to OCDD collaboration.

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. However, LDH still provides data to the SME on the number of non-PSH placements among transitioned individuals.

During this reporting period, LDH reported that 20 individuals were transitioned to family settings and two were transitioned to group homes. The remaining 48 individuals were transitioned into apartments; for this group, LDH was unable to report on whether those apartment placements qualify as PSH. A new reporting function, implemented in August 2025, will enable improved reporting in this area. In the last reporting period, one individual was placed in a group home and four placements were categorized as "other."

Figure 35. Paragraph 52 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Not rated.	1) Even though this Paragraph is not rated, LDH should continue to track non-PSH placements, fully operationalizing the new reporting feature. 2) LDH should investigate the circumstances surrounding the group home placements for two individuals in this reporting period, as well as any other non-PSH placements.

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. 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. An overview of relevant data includes:

- During this reporting period, there were 354 individuals identified as "unable to make a decision," constituting 18% of the 1,969 in-reach encounters. In the prior period, there were 321 individuals identified as "unable to make a decision," reflecting 17% of all in-reaches.
- For the 142 individuals were deemed as "unable to make a decision" in quarter 2 of 2025, LDH reports that 93 (65%) were "not able to communicate even with the assistance of communication aides," 89 (63%) had a "health condition resulting in the inability to engage in discussion regarding community options," and 43 (24%) were unwilling to participate in discussion regarding transition. An additional 12 cases (85) were either interdicted or marked as "other." These sum of these percentages exceed 100% because an individual can have more than one reason for being unable to make a decision.
- Compared to quarter 3 of 2024, there was a sharp increase in the percentage of individuals who were "not able to communicate even with the assistance of communication aides" (43% to 65%) and a decrease (78% to 63%) in those who had a "health condition resulting in the inability to engage in discussion regarding community options."

This Paragraph requires LDH to implement procedures for engaging people who lack decision-making capacity, centered on facilitating their choice and safety. 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. These individuals typically receive a follow-up visit in six months. This visit could be timed based on when the initial event, condition, or circumstance that rendered them unable to make a decision or diminished their decision-making ability 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.

In some cases, LDH has concerns about the safety or readmission risk among individuals who are awaiting transition or who have already been transitioned or diverted. These cases 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 January to June 2025. During this period, the TSC received 10 referrals and all reviews were completed. In the last period, there were 24 TSC referrals made. The 10 TSC referrals in this period resulted in the following dispositions:

- *TSC Referral Rescinded (2).* Referrals were rescinded prior to the committee meeting. In prior periods, this was due to a determinations that the individual had primary dementia, readmissions, or individuals moving out of the area.
- *SHARe Exception (1).* After additional review, the TSC approved one individual for a SHARe exception, which increases resources (e.g., worker hours, financial support for home modifications) for certain clients beyond established limits in waiver programs.
- *Other Guidance Provided (7).* In these cases, the TSC determined that health and safety could not be assured in the community with available supports, additional evaluations and engagements were needed, or that additional services were needed.

Figure 36. Paragraph 53 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. LDH has protocols in place to ensure the informed choice and safety of members at various stages of MCL programming. The SME recommends that LDH investigate the circumstances and needs of those who are "unable to make a decision" to inform adaptations to PIR protocols for this sizable segment of the TP.	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. Prior to March 2025, these PIR staff were responsible for in-reaching TP members who had been admitted into NFs and handling all follow-up in-reach encounters. However, as discussed more fully in Paragraph 45, some PIR functions are now implemented by RITC staff. During this reporting period, LDH rolled out its RITC program statewide. RITC staff now serve as the first point of contact for individuals newly admitted into NFs. Since this shift, PIR staff have had a more limited in-reach role, to include: (1) conducting follow-up visits for those who decline RITC transition support; (2) responding to direct requests from NF staff or members for in-reach, or (3) engaging individuals who, for various reasons, never received in-reach. The discussion under this Paragraph is limited to the performance of the PIR program. Highlights include:

- There are nine positions in the PIR program, one for each region. As of September 2025, seven positions were occupied.
- PIR staff positions, on average, are budgeted for 24 per week.
- During this reporting period, LDH expected PIR staff to conduct 40 contacts per month, inclusive of initial and follow-up visits, documented through a standardized in-reach log. In January 2025, LDH changed its policy, no longer counting non-completed PIR encounters toward targets and increasing targets to 16 completed engagements per week.

- PIR encounters where the staff was not able to connect with the individual were often because the individual was unavailable due to sickness, sleep, or appointments (e.g., physical therapy).
- After a PIR encounter, members fall into four categories: interested, not interested, undecided, or unable to decide. If the outcome of a PIR engagement is undecided, PIR staff are required to visit the individual again in three months. If the outcome is "unable to decide" or not interested, the individual is visited again in six months. However, exceptions for more prompt visits are made.
- As noted above, there is a subset of individuals on the ML residing in NFs who have yet to be engaged around the opportunity to transition. Given RITC's statewide rollout, it is expected that newly admitted individuals will receive an RITC contact. However, those residing in NFs prior to the statewide rollout may have been missed, as well as individuals who were added to the ML after admission. Per LDH, as of the end of this reporting period, there were 560 individuals on the ML who had not yet been engaged. In the prior two periods, there were 642 and 526 individuals, respectively, who had not been engaged.
- During this reporting period, LDH accomplished 1,969 (91%) of their 2,160 target for PIR engagements. This included 604 (32%) initial engagements and 1,310 (68%) follow-up engagements, as well as an additional 316 contact attempts. For comparison, in the last reporting period (July to December 2024), LDH exceeded their PIR 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%). However, the comparative reduction in PIR encounters in this reporting period may be attributable to LDH no longer counting contact attempts as PIR encounters. If contact attempts were counted, LDH would have had 2,230 encounters in this reporting period, exceeding their goal and last period's performance.
- As shown in Figure 37, LDH also provides data on the disposition – interested, undecided, not interested, or unable to decide – of its initial and follow-up in-reaches. Since the last reporting period, there was a slight uptick in individuals who expressed interest in transitioning at initial in-reach and a decrease in those who were undecided. For follow-up in-reaches, there was a decrease in the percentage of undecided dispositions at in-reach.

Figure 37. In-Reach Outcomes for Initial and Follow-Up Visits								
	12th	*13th*	*12th*	*13th*	*12th*	*13th*	*12th*	*13th*
	Interested		*Undecided*		*Not interested*		*Unable to decide*	
Initial	10%	12%	19%	16%	56%	56%	15%	14%
Follow-Up	6%	6%	11%	6%	66%	68%	17%	18%

The 2026 Service Review has a revised process and focus, which is related to this paragraph. To gain visibility on characteristics and needs of different segments of the TP, the SME and his team are interviewing individuals who were deemed as "undecided" at in-reach, as well as their providers (e.g., PIR staff). The 2026 Service Review Report will include findings from this analysis. The objectives of this component of the Service Review include: capturing insights on the functioning of engagement processes deployed by PIR, RITC, and legacy TC; assessing members' and staff's current knowledge of MCL; assessing members' current interest in transitioning; understanding and cataloguing reasons for members' being undecided; identifying what, if anything, could facilitate a decision and/or increase comfort level in moving; and for those who were undecided because of their self-perception that needs are too great, independently evaluating: (1) alignment between perceived and actual needs and (2) alignment between actual needs and available community supports.

Figure 38. 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.

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 MCL 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 BH 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 39. 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 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 the 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.

As referenced in the discussion under Paragraphs 25 and 26, the AC has historically referred to individuals who, for the most part, were engaged by PIR and then expressed interest in transitioned. This is often referred to as the "Legacy AC." 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 Legacy AC reflects individuals who have expressed interest in transition, the RITC TC simply provides the roster of admitted individuals who need to be engaged. And as data demonstrates below, based on current approaches, a very small percentage of those by RITC will maintain interest in and ultimately transition. For the CY2025 methodology, LDH combined the Legacy and RITC ACs to form the basis of its projection, using the same set of assumptions on how many people will ultimately fall out of the transition pipeline. This approach overestimated how many individuals engaged by RITC would ultimately transition, resulting in an inflated target. The SME flagged this issue, but it was not corrected. For CY2026, LDH is in the process of revising its methodology.

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 seventh year, LDH has consistently underperformed its transition goals. Transition performance seems to have peaked in CY2022 but decreased in the three years since.

Figure 40 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 37 for the purposes of this report. LDH achieved 135 (41%) of its required 331 transitions for CY2024. For this reporting period (January to June 2025), LDH effectuated 70

Figure 40. 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%
Jan-June 2025	143 (half of annual target of 287)	70	49%
Total Transitions (June 2018 to June 2025): 802			

transitions. As shown in Figure 40, this reflects 49% of the 143 transitions needed in the first half of the year to reach 287 transitions by the year's end. At the end of October, LDH had achieved 137 transitions, or 48% of its annual target, with two months remaining in the year.

LDH has invested significant thought and resources into improving TC management, oversight, and support, and the SME's Service Review process has shown that these efforts have paid off; LDH has a strong and committed complement of TCs. However, systemic barriers, mostly barriers outside of the TCs' control, impede their ability to effectuate timely transitions and likely contribute to burnout. The 2025 SME Service Review 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). Notably, these barriers are aligned with the "transition barriers" tracked by LDH.

Figure 41. 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, consistent with recommendations under Paragraph 58. 2) LDH should make planned revisions to its transition target methodology to establish more feasible and attainable transition targets.

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

Analysis: This Paragraph stipulates that members of the TP are transitioned into integrated housing opportunities. During this reporting period, LDH reported that 20 individuals were transitioned into family settings and two were transitioned to group homes. The remaining 48 individuals were transitioned into apartments; for this group, LDH was unable to report on whether those apartment placements qualify as PSH. A new reporting function, implemented in August 2025, will enable more granular reporting in this area.

This Paragraph requires that individuals be transitioned into integrated housing options in adherence to the timeframes established in their ITPs. The Service Review showed that TCs generally 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. However, LDH also reports that issues related to housing represent 34% of all transition barriers, including members waiting for a specific unit or a unit in a specific town and members waiting for accessible housing or housing modifications.

Figure 42. Paragraph 57 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. LDH has developed a program that utilizes PSH 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: The TSC launched in May 2023, and as described in Paragraph 53, has been responsible for the review and provision of recommendations around difficult 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 and other systemic barriers that could be shared with the TSC for discussion and solutioning. In October 2025, LDH drafted a new standard operating procedure that would enhance the TSC's duties by providing a consolidated inventory of systemic barriers to inform their discussion about potential solutions. The SME reviewed and provided feedback on the standard operating procedure. Once implemented and reported on, LDH will move closer to full compliance with this Paragraph.

Figure 43. Paragraph 58 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. The TSC is currently focused on individual case reviews, but LDH has designed a new process to expand their role in identifying and formulating strategies around systemic barriers.	1) LDH should implement their planned process to provide information on systemic barriers to the TSC and gather recommendations to better understand and address identified barriers.

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

Analysis: LDH implemented the CCM program in March 2022. MCOs operate the CCM program through a contracted provider. CCM is provided to individuals projected to be transitioned within 60 days or those 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. Core functions of CCM include an assessment of needs, development of a care plan, referral and linkage to other supports and services, and ongoing monitoring through high-touch, high-frequency contacts with individuals.

LDH reports that as of June 2025, the last month in this reporting period, there were 234 individuals enrolled in CCM: 63 diverted individuals, 139 transitioned individuals, and 39 individuals residing in NFs within 60 days of their projected transition date. During June 2025, there were 15 new members referred to the program and none declined enrollment. LDH reports that as of the end of calendar year (CY) 2024, there were 124 transitioned individuals and 53 diverted individuals engaged in CCM services. LDH evaluates process-oriented performance measures and service utilization outcomes for members who participate in CCM services. Most of the bullets below reflect data that is collected via the CCM's monthly monitoring form, for those who were successfully contracted during the reporting month. Highlights for this reporting period include:

- 96% of eligible members were successfully contacted by the program.
- 94% of members reported stability and satisfaction with their living situations.
- 99% reported stability with caregivers, and 91% report stability with service providers overall.
- 96% reported receiving all services in their care plans.
- 92% reported adhering to their medications.
- 99% reported being free of abuse, neglect, extortion, or exploitation.
- 94% reported good or fair physical health and 98% report good or fair mental health.
- 99% responded "yes" or "somewhat" regarding their participation in community activities as desired, with 62% reporting that they participated to the extent desired.

As displayed in Figure 44, LDH also compares utilization of physical and BH services prior to and after completion of CCM services, to evaluate the impact of CCM on engagement in services that one would expect to increase (e.g., outpatient BH services) or decrease (e.g., inpatient admission) based on effective delivery of care coordination services. This data demonstrates marked increases in outpatient services among both diverted and transitioned cohorts and decreases in ED and inpatient utilization.

Figure 44. CCM Impact on Service Utilization

	Diverted			*Transitioned*		
Service Type	*% of Utilizers in Quarter Before CCM*	*% of Utilizers After Completion of CCM*	*% Improvement*	*% of Utilizers Before CCM*	*% of Utilizers in Quarter After Completion of CCM*	*% Improvement*
Outpatient BH Services	48.5%	66.6%	+18.1%	33.3%	82%	+48.7%
Ambulatory/Preventive Care	73.6%	100%	+26.4%	88.8%	94.4%	+5.6%
ED	37.1%	16.6%	-20.5%	25.6%	14.1%	-11.5%
BH-ED	20%	0%	-20%	6.4%	3.8%	-2.6%
Inpatient	28.5%	8.3%	-20.2%	17.9%	5.1%	-12.8%
BH-Related Inpatient	25.7%	0%	-25.7%	7.6%	2.5%	-5.1%

There were transitioned four individuals who were readmitted into NFs while receiving CCM. In 2025, LDH enhanced the CCM program by sharing educational resources on preventing avoidable ED utilization, strengthening expectations regarding initial engagement and community integration, correcting data issues regarding the classification of certain critical incidents, and developing new measures to assess member choice and self-determination.

Figure 45. Paragraph 59 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Met. LDH has developed a CCM program that supports diverted and transitioned individuals for up to 12 months in the community.	1) LDH should explore strategies to increase uptake of CCM services, particularly among the diverted population.

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

Analysis: As noted above, LDH began to implement the CCM program in March 2022. For transitioned individuals, CCMs engage in multiple monthly contacts (face-to-face and virtual), generally starting two months prior to transition and extending to one year after transition. For diverted individuals, CCMs are engaged after an individual is diverted, and continue to serve diverted individuals for up to one year. For both populations, an assessment is conducted after the initial year to determine whether the individual has a need and desire for extended CCM services. Throughout the CCM engagement, LDH's procedures establish requirements and associated timeframes for community assessments, reassessments, community plans of care (CPOC), crisis plans, and other documentation that supports the delivery of CCM services.

The SME's service review process involves an in-depth review of diverted and transitioned individuals who are engaged in the CCM program, and as such, sheds light on the CCM program's performance. Figure 46 displays relevant findings from the 2025 Service Review.

Figure 46. CCM-Related Service Review Findings
▪ Among those who had transitioned, all members had their required CCM documentation, including community assessments, CPOCs, and crisis plans, representing an improvement compared to the last reporting period. Among those who were diverted, all had required CCM documentation. ▪ Quality of documentation improved compared to prior years. For transitioned members, the average quality score of assessments increased from 85% in 2023, to 91% in 2024, to 94% in 2025. For diverted members, the average quality score of assessments increased from 90% in 2023, to 91% in 2024 to 98% in 2025. The average quality score for CPOC among transitioned members climbed from 69% in 2023, to 73% in 2024 to 84% in 2025. For diverted members, average quality scores increased from 69% in 2023, to 78% in 2024, to 88% in 2025.

- This Paragraph also requires that case management facilitates access to all medically necessary services covered by the State's Medicaid program for members of the TP. To determine whether the State is meeting the intent of this provision, the SME and his team (as part of the Service Review process) reviewed whether there was alignment between what an individual was assessed as needing and what services were planned for, as evidenced by their inclusion in the CPOC. The CPOCs were largely complete (strengths and preferences, housing, social/recreational needs, educational/vocational needs, member signature, and involvement of other individuals). The most common gaps in the CPOCs include inclusion of plans to address transportation needs (8 members/50%); medical needs (4/25%), health and safety needs (4/25%), BH needs (3/19%), and health and safety needs (3/19%).
- For diverted members, most domains of the CPOC were largely complete (strengths and preferences, housing, educational/vocational needs, member signature, and involvement of other individuals). The most common gap in the CPOCs include planning for DME (in two cases). In the 2024 Service Review, one-third of CPOCs did not have reference to medical services and one-third did not include BH services. Further, nearly all CPOCs lacked information on the frequency and duration of specified services, which is needed for a CCM to adequately assess whether an individual is getting the intensity and dosage of care that is needed beyond initial linkage. CCMs indicate that the CPOC is an initial planning document, and they track other service needs monthly (outside of the CPOC), making referrals as needed.
- LDH reports that four individuals enrolled in CCM were re-admitted and six transitioned members overall were re-admitted.

This Paragraph also underscores the role of case management in promoting community integration. The SME calculated an average community integration score via the service review process. In 2023, the score was 2.66, in 2024 it was 3.0, and in 2025 it was 3.06, which is corresponds with a "good" rating in the five-point Likert scale. For diverted members, the community integration score was lower (2.1 in 2025) but the sample size was too small to extrapolate broadly.

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

Figure 47. Paragraph 60 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. LDH's CCM programming has steadily improved in several areas since 2023, including the quality and completeness of assessments and CPOCs. LDH should continue to drive improvements in CCM documentation, focused on ensuring that needs identified during assessment are addressed in the CPOC, and that CPOCs specify the duration and frequency of planned services.	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.

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 three prior Service Reviews, the 2025 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 2025 Service Review's average score for Assessment and Person-Centered Planning is 3 among both the diverted and transitioned cohorts, representing the midpoint – or a "good" rating – on the Likert scale. 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. Also, a person-centered planning checklist was distributed to CCMs in June of 2024.

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 BH system of care, both as a standalone service and a service embedded within other programs. Given that CCMs are expected to coordinate across multiple services/programs, CCMs should be able to clearly delineate which care team members are responsible for supporting community integration.

Figure 48. Paragraph 61 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. Based on the 2025 Service Review, CCMs have improved the person-centeredness of their documentation, but further improvements in the quality of documentation as well as additional person-centered trainings are needed.	1) LDH should implement the priority recommendations under Paragraph 60 regarding improvements to CCM documentation. 2) LDH should implement the priority recommendations under Paragraph 44 regarding person-centered trainings.

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

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

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

The combination of these strategies ensure the appropriate monitoring of TP members. However, as described under Paragraph 95, the SME has concerns about the number and types of critical incidents associated with members served by CCM and has provided recommendations to better understand and prevent such incidents.

Figure 49. Paragraph 62 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Met. LDH has established processes to monitor the experiences and outcomes of TP members who have transitioned into the community.	1) LDH should continue to review data from CCMs to ensure that the cadence required for face-to-face and other visits is being met. 2) LDH should implement recommendations associated with Paragraphs 49 and 95, regarding post-transition TC visits and addressing critical incidents.

VI. Quality Assurance and Continuous Improvement

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

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

Analysis: Paragraphs 86 and 87 are addressed together. The State developed an initial outreach plan for this Agreement in CY2018. Since then, LDH has continued to engage stakeholders germane to the Agreement. Stakeholder groups include the My Choice Advisory Committee, the My Choice Quality Resource Group, various My Choice subcommittees, the Louisiana Hospital Association, the Louisiana Nursing Home Association, LGEs, and other groups. The State also continues to post the SME reports and quality matrices as one strategy to share Agreement-related information with external stakeholders.

LDH stakeholder engagement activities are often associated with specific initiatives under the Agreement (e.g., making improvements to PASRR processes, enhancing crisis systems). 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 MCL 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.

Figure 50. 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: In the 12th SME Report, the SME flagged that a third of critical incidents among TP members served by CCM involved interactions with law enforcement. Recently, LDH clarified that a portion of those incidents were misclassified, but 2024 data shows that 23% of CCM critical incidents involved interaction with law enforcement, demonstrating that TP members

continue to interface with the criminal justice system, sometimes due to the commission of crimes and other times as victims. Relationships between MCL service providers and criminal justice stakeholders can support better coordination if individuals are victimized or need other types of support or intervention from law enforcement and also help those who are arrested or at risk for arrest with diversionary programming or other resources. There are likely other benefits to partnership. Building on its extant collaborations with law enforcement, courts, and other justice-related entities regarding implementation of the new crisis services system, LDH should engage with stakeholders to identify opportunities and goals for deepened collaboration.

Figure 51. Paragraph 88 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. LDH has continued to engage stakeholders in law enforcement, corrections, and courts, but a more organized collaboration is needed to increase local collaboration between these stakeholders and My Choice program providers.	1) LDH should design a strategy to increase local collaboration between Agreement-related providers (e.g., ACT teams, CCMs) and local law enforcement, courts, and correctional stakeholders, perhaps starting with a focus group of MCL staff to better understand opportunities for collaboration.

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

Paragraph 54 provides the discussion and compliance rating associated with the PIR program. However, this Paragraph contemplates an additional role for PIR – group presentations in community settings and NFs. In other Olmstead-related cases nationally, trained outreach staff convene group presentations in NFs to promote transition programming, augmenting direct one-on-one in-reach. LDH could identify NFs with a high volume of TP members to test out such an approach. LDH could also use innovative methods – such as a video testimonial campaign or visits to community-based settings (e.g., ACT groups) – to increase engagement, promote interest, and ensure consistency in messaging. In terms of non-NF community settings, LDH could also identify common NF referral sources to determine if there are opportunities for persons with lived experience or other affiliated staff to conduct in-service trainings to staff or clients. For example, if there are psychiatric or medical units in hospitals that generate a relatively considerable number of NF referrals for TP members, LDH could implement more focused strategies to educate staff and patients about the MCL program.

Figure 52. Paragraph 89 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. As noted under several Paragraphs herein, LDH has designed and implemented a statewide PIR program, but enhancements could increase its reach and effectiveness.	1) LDH should implement recommendations identified under Paragraph 54. 2) LDH should consider innovative strategies, including group educational sessions and multimedia, to augment its one-on-one in-reach approach.

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

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

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

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

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

In the 12th SME Report, the SME recommended that LDH develop a centralized repository of trainings and more intentional inclusion of individuals with lived experience in the design and delivery of trainings. In their 2025 Implementation Plan, LDH committed to developing a repository to "house all relevant training materials and resources in a single public location to serve as a central reference point, ensuring easy access and organization." Since then, the MCL website has been updated to include PowerPoint slide decks for seven trainings, but it is likely that additional trainings need to be added, including recordings. Further, as LDH implements processes to quantify, assess, and address systemic barriers – as referenced in many Paragraphs in this report – specialized trainings could be provided in response to identified barriers (e.g., trainings on OCDD waiver processes and associated timelines, trainings on how CCMs can access PSH for diverted members).

Figure 53. 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 complete the development of a single site to facilitate, communicate, and store training opportunities associated with the My Choice program. 2) LDH should implement a strategy and process for soliciting and incorporating consumers in the design and delivery of trainings.

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

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

- Overall SUD treatment network adequacy reports (see Paragraph 67 in 12th SME Report) show whether all American Society of Addiction Medicine levels of care are present across Louisiana.
- Performance on Centers for Medicare and Medicaid Services SUD measures provides insights on whether people are linked to needed care after visits to the ED, nonfatal overdoses, or recent SUD diagnoses, likely related to the adequacy and quality of SUD care.
- Critical incidents among members served by CCM (see Paragraph 95 in this report) can point to unmet service needs.
- Information gleaned from CCM monthly monitoring and TC post-transition monitoring (see Paragraph 49) evaluates whether transitioned individuals are getting the support they need after NF discharge. During these monthly contacts, CCMs collect information from the member on whether they are receiving the services specified in their plan of care. In quarters 1 and 2 of 2025, 90% and 96% of members, respectively, reported that they were receiving planned services.
- ACT and Individualized Placement and Support (IPS) fidelity ratings (see Paragraph 67 in 12th SME Report) evaluate whether providers are functioning in alignment with national standards around staff credentials and expertise, caseload size, and other service delivery best practices.
- Service utilization patterns of individuals engaged in CCM and the TP overall might signal how effectively individuals are being engaged and served by the community-based system of care.
- LDH also collects whether individuals can get BH appointments within one hour (for emergent care), two days (for urgent care), and 14 days (for routine care). According to their Quality Matrix, 92% of individuals in quarter 1 of 2025 got needed emergent care, 81% got needed urgent care, and 94% got needed routine care.

In summer of 2025, the new SME and his team completed the 2025 Service Review process and issued a report on key findings and recommendations. LDH management participates in the Service Review process, and a broader LDH leadership group reviews findings from the Service Review process to discuss systemic, management, and other interventions to address Service Review findings. 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.

The 2025 Service Review enables the SME and the Parties to look at the Agreement's functioning, including services, through the lens of individuals' experiences – including TP members and the dedicated individuals who serve them. The findings showed that LDH has

made substantial progress in designing and implementing pre-transition, post-transition, and post-diversion supports for individuals with complex medical, social, and BH needs. The review culminated into 10 priority recommendations, which were shared with LDH in August 2025, including:

(1) In partnership with the Office of Citizens with Developmental Disabilities, develop strategies to strengthen coordination, communication, and expediting of SUN waiver screenings. If necessary, develop a formal interdepartmental protocol.
(2) Implement measures to enhance communication and coordination between TCs and other entities/staff involved in waiver evaluations and programming and continue to educate TCs on waiver processes and associated timelines, so they can better serve members who are navigating these processes.
(3) Reinforce the expectation and equip TCs to engage nursing facility and MCO staff to ensure that transitioned members receive appropriate illness self-management training (including medication education and self-administration), as well as access to needed medical supplies upon transition.
(4) Leverage LDH's internal service review process, as well as other oversight mechanisms, to continue to improve the quality and completeness of TC and CCM documentation.
(5) Continue to enforce the requirement that TCs make meaningful monthly contacts with members in the transition preparation process.
(6) Ensure that TCs make timely CCM referrals and hold interdisciplinary discharge planning meetings for those preparing for transition.
(7) Develop a strategy to ensure that diverted individuals can access PSH resources, reducing reliance on segregated and substandard housing.
(8) Continue to enforce the expectation that CCMs support community integration activities in collaboration with a member's other providers (e.g., ACT, peers), offering additional training and making revisions to documentation, if necessary.
(9) Given the service review team's finding that most transition barriers are related to systemic barriers versus TC underperformance, LDH should catalog the type and frequency of systemic barriers and assertively develop responsive system-level strategies and solutions, while continuing their TC management and quality improvement approach.
(10) Develop a region-specific resource guides for CCMs and TCs on pain management resources, including prescribers and other providers that offer alternatives to pain management.

While most of these recommendations involve improvements to processes (e.g., making timely referrals to CCMs), they will likely have impact on ensuring that individuals receive the care they need. Further, some recommendations – such as seven, eight, and 10 – involve making improvements facilitate greater access or quality of services.

While the SME's Service Review and post-discharge TC and CCM 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)."

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 and IPS services, but other services – such as personal care services (PCS) and peer services – 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. Behavioral Health PCS is also reviewed by Health Standards. Further, MCOs conduct a quarterly review of a representative sample of BH providers, which may include PCS.

Figure 54. 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: LDH's quality assurance system for this Agreement includes a constellation of activities, many of which are covered in more detail in specific Paragraphs within this report. For this discussion, the SME will provide information that is not covered elsewhere or is covered later in this report, including:

- As described in Paragraphs 98 and 99, LDH has developed a Quality Matrix to monitor many areas required by this Agreement and continues to review and update measures in the Quality Matrix to incorporate feedback from stakeholders.
- In this reporting period, LDH convened the Internal My Choice Quality Committee each month in this reporting period. The External Quality Resource Group was not convened. Responsibilities of these groups include refining the Quality Matrix and reviewing SME Service Review findings to advise on strategies to address systemic issues.
- In January of 2022, LDH issued its Annual Quality Report for the My Choice Program. This report sets forth the processes LDH has put in place to use this information to improve the experience of care for individuals transitioned and diverted from NFs as well as to improve the quality of services that are offered to the TP. No annual quality reports have been posted since. However, in August 2025, the SME recommended an alternative approach. Instead of producing an additional report, the SME recommended synthesizing existing data and reports – such as the Quality Matrix, MCO critical incident reports, the SME Service Review, ACT and IPS fidelity reports – and producing an executive summary that includes plans for improvement based on the data. The SME recommends finalizing an approach in 2026.
- As described under Paragraph 93 and in more detail in the 12th SME Report, LDH utilizes a number of additional strategies to evaluate the performance of specific services.

Figure 55. Paragraph 94 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. LDH has implemented several activities to oversee and evaluate the quality of Agreement-related programming and processes. As recommended by the prior SME, data and information collected and analyzed through these efforts should be shared with the TSC to inform quality improvement activities.	1) LDH should implement the planned process 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.

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

Analysis: The Agreement requires the State develop a critical incident report (CIR) management system for the TP, as well as evaluate data on MCL services as part of its ongoing quality improvement efforts. Paragraph 96 includes a discussion on MCO-reported CIR data. For this Paragraph, the SME has analyzed data provided by LDH on critical incidents associated with diverted or transitioned individuals engaged in CCM, who typically have lived in the community for up to one year.

CCMs are responsible for completing CIRs as one of their case management duties. As indicated in previous reports, the State defines critical incidents consistent with various federal Medicaid Waiver programs. LDH reports on the number of critical incidents associated with TP members that accept CCM. In 2024, there were approximately 121 incidents, compared to 54 in 2023. This may be due to improved reporting as the CCM program has matured and an expansion of CIR categories, but LDH should investigate whether this level of increase is expected based on those changes. Figure 56 provides a breakdown of the CIR types in 2024, showing that most are related to involvement with law enforcement (23%), a major BH disturbance (18%), exploitation or extortion (15%), or eviction (14%). In the first half of 2025, there were 86 critical incidents. There were 34 (40%) related to a major medication incident, 21 (24%) related to involvement with law enforcement, nine (10%) related to eviction, eight (9%) related to a major medication issue, five (6%) related to neglect, five (6%) related to abuse, three (3%) related to exploitation, and one (1%) related to loss or destruction of a home.

Figure 56. CCM Critical Incident Frequencies & Types	
Critical incident category	*Number and percentage*
Involvement with law enforcement	27 (23%)
Major BH disturbance	22 (18%)
Exploitation or extortion	18 (15%)
Eviction	17 (14%)
Abuse	13 (11%)
Neglect	11 (9%)
Major medication incident	10 (8%)
Loss or destruction of home	1 (<1%)
Other	1 (<1%)

LDH provided a snapshot of CIRs for the month of March 2025, so the SME could conduct a more granular review of specific CIRs and the evaluate the appropriateness of actions taken resultant of the CIR. In March 2025, two CIRs were associated with law enforcement involvement and two with a major emotional disturbance. After reviewing these cases, the response from MCL providers

(e.g., CCMs, TCs, ACT teams) were appropriate. There was one case where the SME wonders if crisis services could have been utilized (e.g., mobile crisis, crisis stabilization unit) versus calling 911 and utilizing EMS for transport for a member who was expressing suicidality.

The State also reports on all-cause ED and inpatient (IP) visits, as displayed in Figure 57. 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 BH reasons. For the transitioned population, all-cause ED utilization has fluctuated, but Q2 2025 is substantially higher than other quarters. BH-related ED utilization, all-cause inpatient utilization, and inpatient utilization for BH reasons have remained relatively stable. For the diverted population, ED utilization rates have been relatively stable, but inpatient rates – both all-cause and for BH reasons – have dropped in the last two periods. LDH should investigate the spike in ED utilization among the transitioned population in 2025.

Figure 57. All-Cause ED/IP Utilization

Time Period	Level of Care	Transitioned	Diverted
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)
Q2 CY 2025	ED	13% (1% BH)	18% (7% BH)
	IP	5% (2% BH)	12% (7% BH)

Figure 58. 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 investigate the increase in critical incidents in 2024 and the first half of 2025, as well as the increase in ED utilization among the transitioned population.

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 typically reviews a monthly MCO CIR report for clarity, completeness, and appropriate action. However, for this period, LDH reports that there were no critical incidents reported by MCOs associated with the TP. 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 the universe of OBH and OAAS programs that serve TP members 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 59. Paragraph 96 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating and Rationale	***Priority Recommendations***
Partially Met. LDH has established and oversees processes for MCOs and long-term supports and service programs, which require critical incident reporting and remediation.	1) LDH should collaborate with the SME and DOJ to devise a reporting strategy for this requirement that includes CIR data from both OBH and OAAS programming.

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

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

Figure 60. Mortality Review Data		
Period	*Total Deaths*	*Referred to MRC*
2020-2022	19	13
2023	27	14
2024	12	6
First half of 2025	4	1

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 60 provides data on the total number of mortalities associated with MCL over the past five years, and the subset that were referred to MRC review. For this discussion, the SME will provide highlights from the 2024 Mortality Review Report, as well as the number and dispositions of reviews in this reporting period (January to June 2025), to include:

- In 2024, there were 12 mortalities reported; six were referred to the MRC and the remaining six were not, given that all were receiving hospice care at the time of death.
- Of the six referred cases, three were referred because they had unexplained deaths more than 60 days after NF discharge; two had unexplained deaths within 60 days of discharge; and one was a diverted member with CCM.
- There were two cases where, after the review, individual case remediation or correction action plans from services providers were required. None were referred to LDH's Health Standards Section. For the two cases requiring remediation, one provider was not promptly

entering critical incident data into the critical incident system, and the second provider had documentation issues as well as performance issues regarding securing a member's access to durable medical equipment.

- The report also provides causes of death for each individual, which typically involves more than one condition. For this 2024, the causes of death for each individual were: shock, sepsis, and renal failure; congestive heart failure; sudden cardiac death; acute chronic respiratory failure and severe chronic obstructive pulmonary disease; cardiorespiratory arrest and cerebrovascular accident; and myocardial infraction, arteriosclerotic heart disease, and hypertension.
- In the first half of 2025, there were four overall deaths, and one was referred to the MRC. The remaining three deaths were not appropriate for MRC review because two were receiving hospice care and the third death was nearing one-year post-discharge and had a documented heart condition.

Timeliness of mortality reviews has improved, from an average of 172 days in 2023 to 134 days in 2024. 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.

The 2023 and 2024 Mortality Report added new information: the 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 61. 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) LDH should continue its MRC process and consider collecting cause of death information for all mortalities to support trends analysis and, if merited, programmatic strategies to address mortality risk.

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

99. The State will collect and analyze consistent, reliable data to improve the availability, accessibility, and quality of services to achieve positive outcomes for individuals in the Target Population. The State will create protocols on collection and analysis of data to drive improvement in services, which shall be developed with the technical assistance and approval of the Expert prior to implementation. Data elements shall measure the following areas: (a) referral to, admission and readmission to, diversion from, and length of stay in, NFs; (b) person-centered planning, transition planning, and transitions from NFs; (c) safety and freedom from harm (e.g., neglect and abuse, exploitation, injuries, critical incidents, and death; timely reporting, investigation, and resolution of incidents); (d) physical and mental health

and wellbeing, and incidence of health crises (e.g., frequent use of crisis services, admissions to emergency rooms or hospitals, admissions to NFs, or admissions to residential treatment facilities); (e) stability (e.g., maintenance of chosen living arrangement, change in providers, work or other day activity stability); (f) choice and self-determination (e.g., service plans are developed through person-centered planning process, choice of services and providers, individualized goals, self-direction of services); (g) community inclusion (e.g., community activities, integrated day and employment outcomes, integrated living options, relationships with non-paid individuals); (h) provider capacity (e.g., adherence to provider qualifications and requirements, access to services, sufficiency of provider types); (i) barriers to serving individuals in more integrated settings, including the barriers documented and any involvement of the Transition Support Committee as required by Section V.D.; and (j) access to and utilization of Community-Based Services.

Analysis: Paragraphs 98 and 99 are addressed together. As discussed in paragraph 94, LDH collects and reports on several quality measures that align with the specific elements in these Paragraphs. They also convene internal and external committees to refine measures, discuss findings, and consider policy, process, and programmatic changes based on review of the quality assurance data. There are a total of sixty-two measures, which are reported through LDH's Quality Matrix. For each measure in the Quality Matrix, LDH identifies the methodology, data sources, and data collection and analysis process. LDH also identifies whether they should compare measures to trends from previous quarters to assess progress or compare them to a national or LDH-established benchmark. Out of the 62 overall measures, several are internal and operational to LDH, including measures on PIR, PASRR Level II, and AC activities. For this report, the SME reviewed the public-facing 38 measures 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.
- 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. At the time of authoring this report, the 2025 Quality Matrix was being re-populated due to a data loss issue. 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.

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 as an Appendix in the 12th SME Report.

Figure 62. 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.	1) LDH should meet with the DOJ and SME in 2026 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. Informed by this data, LDH management has implemented strengthened supervisory approaches, clarification of expectations, new documentation (e.g., ITP addendum), and training resources. LDH implements other continuous quality improvements as a result of their review of data, both formally and informally.

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

Figure 63. Paragraph 100 Compliance Determination and Associated Recommendations	
Compliance Assessment Rating & Rationale	***Priority Recommendations***
Partially Met. LDH collects a robust set of data to inform program operations and systemic improvements. A structured and systematized process would support improved tracking and impact analysis of interventions.	1) In alignment with their new procedure to inventory and address systemic barriers (described in Paragraph 58), LDH should develop a tracking process to determine if the strategies the State has put into place to address issues identified through their quality assurance mechanisms 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)

For this report, LDH provided the SME with service utilization information for quarters 1 and 2 of 2025. Figure 64 provides a comparison between quarter 2 of 2024, quarter 4 of 2024, and quarter 2 of 2025, distinguishing between transitioned and diverted members.

Figure 64. Service Utilization Rates Among TP Members

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

Utilization has remained stable over the three periods for most service types, but the SME notes increases in ED and inpatient utilization among the transitioned population (see red text), continued low utilization of crisis services across both groups, and a decline in ambulatory/preventive care among the diverted population.

Figure 65. 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. LDH should investigate whether and why utilization for certain services (e.g., crisis services) is different from what is expected.	1) LDH should investigate and explore strategies to prevent potential over-reliance on ED and inpatient services among the TP, particularly transitioned individuals.

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 66. 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 completed one service review. 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).

In 2025, LDH staff debriefed with the SME Team regarding the findings from the 2025 Service Review. This included a debrief with LDH leadership and the My Choice Advisory Committee regarding the outcome of these reviews. For the 2026 Service Review, the SME is implementing 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., PCS) likely require a dedicated quality evaluation effort, given the sizable proportion of TP members who utilize these services.

Figure 67. 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 personal care services and peer support.

Appendix A. Acronym List

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