2022-2

LA-DOJ Eight Subject Matter Expert (SME) Report

COVERING THE PERIOD OF 7/1/2022 THROUGH 12/31/2022

JOHN O'BRIEN

Contents

I. Introduction

In June of 2018, the State of Louisiana (the State) entered into an Agreement with the United States Department of Justice (DOJ) to resolve its lawsuit alleging the State violated the Americans with Disabilities Act (ADA) by failing to serve people with mental illness in the most integrated setting appropriate to their needs. The complaint alleges that the State relies on providing services to these individuals in institutional settings – specifically, Nursing Facilities (NFs) – rather than in the community. Under this Agreement, the State is required to create and implement a plan that will either transition or divert individuals with mental illness 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 serious mental illness (SMI) currently residing in nursing facilities; and (b) individuals over age 18 with SMI who are referred for a Pre-Admission Screening and Resident Review (PASRR) Level II evaluation of nursing facility 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.

The Agreement sets forth the requirement for a Subject Matter Expert (SME). The SME is to provide technical assistance to help the State comply with its obligations under the Agreement. The SME has various responsibilities, including analyzing and reporting data on the State's progress in complying with all sections of this Agreement. In addition, the SME is responsible for assessing the quality of community-based services for members of the Target Population (defined in the Agreement). The State engaged the Technical Assistance Collaborative in August of 2018 to perform the SME responsibilities. Every six months, the SME will draft and submit to the Parties a comprehensive public report on Louisiana Department of Health (LDH) compliance, including recommendations, if any, to facilitate or sustain compliance. This is the eighth SME report, covering the period of 7/1/2022 through 12/31/2022.

While the goal of the agreement is to reduce the use of nursing facilities for people with serious mental illness, thus far, the number of people with serious mental illness living in nursing facilities has slightly decreased since the beginning of the Agreement. In June 2018, there were 3,964 individuals in the Target Population in nursing facilities. As of 12/8/2022 there are 3,676 individuals in the Target Population in nursing facilities. While the fact that the number has decreased is a step in the right direction, there is still much work to be done to divert individuals from these facilities and more aggressively transition individuals with serious mental illness from nursing facilities.

The SME uses various sources of information for these semi-annual reports. This includes:

- Information from Managed Care Organizations (MCOs) regarding Community Case Management (CCMs) and other services (e.g., Assertive Community Treatment (ACT) are responsible for ensuring the total needs of the individual are identified and addressed.
- Information from claims and other administrative data (Utopia, OPTS, and MCO provider network reports).
- Information from the SME Service Reviews on the experience of care for individuals who have been diverted, have transitioned, and are awaiting transition. During this reporting period, the SME reviewed 52 individuals who were transitioned, diverted, or were awaiting transition from NFs.
- Information from critical incidents including referrals to the mortality review committee.

- Information provided by LDH on a quarterly basis regarding the quality of services and other information included in the Quality Matrix.

The following report is the second report that provides a compliance rating regarding the State's progress in each area of the Settlement Agreement. The report is organized using the language of the Agreement as a framework, with paragraphs from critical areas of the Agreement (by number) included in italics. Each of these paragraphs is provided a compliance rating, followed by a discussion and analysis of the State's progress in these areas. The report also includes recommendations by the SME for the State to address in the next reporting period. The SME used the following criteria for determining if LDH was in compliance with each paragraph:

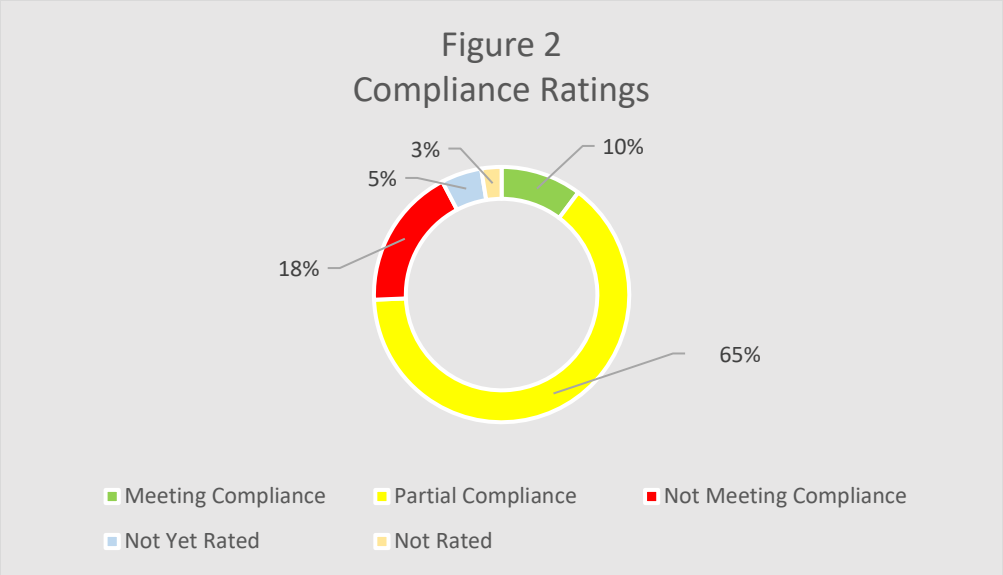
Status	Criteria
Met	LDH has undertaken and completed the requirements of the paragraph--no further activity needed, or
	LDH has undertaken and completed the requirements of the paragraph--met with updates continuing to occur
Partially Met	LDH has developed deliverables (policies, procedures, training) 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, or
	LDH has begun but not completed implementation activities
Not Met	LDH has done little or no work to meet the requirement as set forth in the paragraph of the Agreement, or
	LDH has made little progress to meet the targets set forth in the Agreement, Implementation Plan, or other plans
Not Yet Rated	SME has not reviewed the provisions of the paragraph sufficient to determine compliance and will have a compliance rating in the future
Not Rated	The provision of the paragraph does not require a rating

Figure 1 illustrates the Subject Matter Expert's compliance determinations relative to each major section of the Agreement, aggregating to the total number of requirements falling within each compliance category. Within this report, there is a dedicated section for each of the compliance domains listed below, which includes the SME's rationale for each compliance assessment rating.

Figure 1:
Synopsis of Report & Compliance Assessment for the My Choice Program

Target Population (3)	**Meeting Compliance**	0	**Partial Compliance**	2	**Not Meeting Compliance**	0	**Not Yet Rated**	1	**Not Rated**	0
Diversion and Pre-Admission Screening (11)	**Meeting Compliance**	2	**Partial Compliance**	6	**Not Meeting Compliance**	3	**Not Yet Rated**	0	**Not Rated**	0
Transition and Rapid Reintegration (23)	**Meeting Compliance**	1	**Partial Compliance**	12	**Not Meeting Compliance**	7	**Not Yet Rated**	1	**Not Rated**	2
Community Support Services (23)	**Meeting Compliance**	5	**Partial Compliance**	14	**Not Meeting Compliance**	4	**Not Yet Rated**	0	**Not Rated**	0
Outreach, In reach and Provider Education and Training (7)	**Meeting Compliance**	0	**Partial Compliance**	6	**Not Meeting Compliance**	0	**Not Yet Rated**	1	**Not Rated**	0
Quality Assurance and Continuous Quality Improvement 11)	**Meeting Compliance**	0	**Partial Compliance**	10	**Not Meeting Compliance**	0	**Not Yet Rated**	1	**Not Rated**	0
Total		**8**		**50**		**14**		**4**		**2**

Figure 2 summarizes the Subject Matter Expert's compliance determinations relative to many of the paragraphs in the Agreement. There are 78 distinct paragraphs applicable to this reporting period. LDH is in compliance with 8 paragraphs (10%), in partial compliance with 50 paragraphs (65%), and not meeting compliance with 14 paragraphs (18%). There are 6 (8%) paragraphs that are either not rated or not yet rated.



The 65% of paragraphs in partial compliance continues to reflect valuable, foundational work that LDH has undertaken to accomplish the requirements in this Agreement. This progress is the result of significant effort and commitment on the part of LDH staff, for which they should be commended. However, it is important to emphasize that significant work remains to achieve full compliance on the paragraphs rated in partial compliance.

The parties entered into this Agreement with a shared commitment to achieve compliance with Title II of the ADA. LDH was to accomplish this by transitioning and diverting people with serious mental illness away from unnecessary nursing facility placements, providing them the community-based services and supports sufficient to meet their needs. After more than four years of implementation, a small proportion of those in the Target Population has benefited from the Agreement's ultimate purpose. As of December 2022, LDH has transitioned 441 individuals from nursing facilities since this Agreement was implemented in June 2018. As of December 31st, 122 individuals were diverted from NFs based on the State's definition of the diversion population. As indicated above, more than 3800 individuals continue to remain in NFs. During CY 2020 through early in CY 2022 the pandemic, various storms, as well as workforce shortages for behavioral health and support services created barriers for LDH to achieve some of the projected targets for transition and diversions. As the public health emergency has eased, LDH has made better progress to achieving important targets (e.g., transitions) and milestones (e.g., development of new services) that will comply with this Agreement.

Despite these efforts, LDH projects it will take three years to transition the more than 778 people who have already expressed a desire to transition or were identified as potentially interested through the Continued Stay Review process. An additional 221 individuals who are on the Master List are undecided. LDH projects to transition 350 individuals from NF in CY 2023.

LDH accomplished 200 (68%) of the 292 transitions it committed to complete in CY 2022. While the State did not meet the transition targets for this calendar year, during this reporting period the State significantly increased the number of transitions as compared to previous years.

It is likely that many more individuals will express a desire to transition in the future, as LDH continues to admit new people to NFs, and as improved in-reach should uncover more people who want to move. As

discussed in more detail below, there have been improvements to LDH's diversion, in-reach, and transition practices. However, more are necessary in order to accommodate people's desires to live in their own homes and communities without undue delay. Greater oversight by external stakeholders such as the My Choice Quality Subcommittee over the quality of community services will also be critical to ensuring positive outcomes for those who are diverted and transitioned from nursing facilities.

There are several areas of focus that the SME recommends for the next six months and beyond. These priority areas have not changed significantly since previous SME reports. These priority areas include transitions, diversions, quality, and continued implementation of community services. Therefore, the SME recommends that LDH concentrate most of its efforts over the next reporting period on the following activities:

- **Increasing the number of individuals transitioned from nursing facilities.** The State projects approximately 919 individuals in the current Target Population in NFs may be interested in moving in the near future. It is aiming to transition 350 individuals in CY 2023. This is approximately 38% of the individuals on the Active Caseload List.
- **Identifying and addressing major barriers that impede transitions.** While the State has taken steps to implement a more consolidated approach to identify and report barriers for diverting or transitioning individuals from NFs, there is still much work to be done to strengthen and merge these efforts into a streamlined effort as part of a larger quality assurance process. This includes better utilization of the Service Review Panel (SRP) and ensuring stakeholder input is sought to assist the State to develop strategies to address barriers experienced by the Target Population.
- **Building upon ongoing efforts to contact individuals on the Master List to gauge their interest in moving from NFs and developing follow up in-reach.** This includes the implementation of efforts to address requirements in the Agreement to contact individuals within 3 and 14 days of NF admission. The significant delay in contracting for a system and other resources needed to implement these requirements likely contribute to little decline in the Target Population who are in NFs. There are a number of individuals who continue to express no interest in moving, were undecided through in-reach efforts, or have difficulty in making decisions about moving. While the percent of individuals who are interested in moving has increased during this reporting period, the SME continues to recommend LDH evaluate the quality of the in-reach engagements, consider additional in-reach strategies, and identify training needs of staff performing in-reach. These actions are necessary to ensure that all members of the Target Population are offered a meaningful, informed choice about transition, consistent with the requirements of this Agreement.
- **Increase efforts to divert individuals from NFs who are at highest risk of these admissions.** During this reporting period, LDH has reviewed the efforts of the MCOs to provide case management to individuals with SMI who are most likely to be admitted to an NF generally through inpatient hospitals for any cause and has determined additional efforts are needed by the MCOs to decrease inpatient hospitalizations and therefore increase diversions. During this reporting period, the State has requested that each MCO develop a corrective action plan to better engage individuals who are at-risk of NF admission. The State should ensure these actions produce the intended result of fewer inpatient admissions and ultimately fewer admissions to NFs. These efforts are critical to addressing the relatively unchanged number of individuals who are admitted to NFs and become part of the Target Population. In addition, the State reports they will make changes to the at-risk definition and MCO case management requirements for this

population during the next reporting period. The State will need to closely track how these changes will support historical efforts by LDH to work with MCOs regarding this population and also address support for new MCOs who will implement these strategies during the next reporting period.

- **Undertaking planned activities to improve the diversion process for people being considered for NF admission and receive a PASRR Level II evaluation.** This includes changes to protocols and processes for PASRR Level II evaluators to review the total needs of the individual with a potential SMI seeking admission to NFs. This includes changes to the PASRR Level II instrument and ensuring evaluators have the tools and the information to be able to have timely and plausible resources for individuals and their caregivers to address their total needs and ensure access to community-based services in lieu of NFs.
- **Enhancing and effectively implementing Quality Assurance activities to ensure the quality of community services for Target Population members.** The State has made important changes to collecting information to address the quality of services and the experience of care for individuals who have been transitioned from NFs. Over this past reporting period they have also tracked and analyzed information on individuals who have been diverted. LDH has also developed a process for systematically identifying barriers to transitions and diversions. During this next reporting period, the State will need to implement these tracking efforts. In addition, the State should focus internal and external efforts (e.g., engaging the My Choice Quality Subcommittee) to review and make recommendations regarding the quality of care provided to members of the Target Population. A significant number of resources have been expended on creating the infrastructure to capture and report critical information on the My Choice Program. LDH should now turn its attention on how to best use this information for program improvement purposes. Finally, the State is now an active participant in the SME Service Reviews. They are participating in reviewing documentation and interviewing individuals and their formal and informal supports regarding the quality of care provided to individuals who have been transitioned or diverted from NFs. This has allowed them to better understand individual and systemic issues that have impacted transitions and diversions. The SME and the State will continue these efforts during the next reporting period.
- **Increasing the utilization of new community-based crisis services that have been implemented this year.** There has been low utilization of crisis services. LDH has spent considerable time and energy to design and implement these services. They have partnered with Louisiana State University to identify and support the network, worked with law enforcement and other referral sources to make them knowledgeable of these services, and have made changes to reimbursement to better support providers to deliver quality services. LDH and their MCO partners will need to implement strategies discussed in this report to increase utilization of crisis services and expand the availability of these services to ensure the 24/7 access required by this Agreement. In addition, the State will need to ensure the procurement of resources to provide a statewide crisis line rather than relying on five (soon to be six) separately operated MCO crisis lines.
- **Addressing the lack of peer supports.** The SME's service reviews identified many individuals who transitioned from NFs experienced loneliness and described their lack of connection to the community at-large. As discussed in previous reports, quantitative and qualitative evidence indicates that peer support lowers the overall cost of mental health services by reducing re-hospitalization rates and days spent in inpatient services and by increasing the use of outpatient services. Peer support improves quality of life, increases and improves engagement with services, and increases whole health and self-management. The State does have peer specialists embedded in ACT teams which is used by a portion (30%) of the Target Population transitioned and diverted from NFs. However, no appreciable utilization has occurred of the Medicaid peer support services

approved in February of 2021. The State limited the network of providers of these services to Local Governing Entities (LGEs) that did not always have the experience, staff, or knowledge to implement these services. This service has languished and LDH needs to revisit its approach to developing the network of peer support providers.

- **Better address the housing needs of individuals in the Target Population.** This includes ensuring individuals have a real choice in where they want to live. While many individuals participating in the SME Service Review stated they were content with their housing, several individuals cited they were not provided a choice in housing, would prefer to live in some other geographic location, or their housing could be more ADA accessible. In addition, the State should more assertively track efforts set forth in their revised housing plan regarding the creation of housing opportunities (new units and vouchers), whether these created units are appropriately offered to individuals who are transitioned or diverted and whether individuals actually make use of these opportunities. LDH and the Louisiana Housing Corporation (LHC) have made progress in revising the housing plan and developing more realistic development opportunities. Ensuring progress in reaching the goal of offering 1,000 units to the Target Population will require this enhanced tracking.
- **Improving the quality of Community Case Management provided to individuals who are diverted or transitioned from NFs.** LDH has taken important steps to ensure the availability of this service statewide. They have also created policies that provide important parameters to ensure individuals receive viable and robust case management services. The SME Service Review has identified needed improvements in the CCM process. This includes ensuring re-assessments and updates to community plans of care are done on a timely basis given a significant number of individuals have been receiving CCM for more than 90 days. In addition, LDH should work with the MCOs to improve the quality of the plans of care. This includes a more focused effort to implement existing policies regarding regular team meetings and sharing of critical information across providers regarding goals and services needed to achieve these goals. This will ensure better identification of potential service gaps and potential duplication of efforts. In addition, the State should work with the MCOs to ensure that revised plans of care identify the amount and duration of services needed by the individual.
- **Implement meaningful services that integrate individuals into the community.** As discussed above, peer support specialist can play an important role to identify and develop the necessary informal resources that can improve community inclusion. However, other services are yet to be implemented in a meaningful way. This includes supported employment and other strategies that can improve the wellness of individuals in the Target Population. During the next reporting period, the State should begin to make available Individual Placement Supports (IPS), in limited areas of the State and provide guidance and supports to Mental Health Rehabilitation (MHR) providers to offer employment supports to individuals in the Target Population who want to return to the workforce but may not necessarily need the intensity of IPS. The State should also take planned efforts to develop opportunities for existing drop-in centers to consider more modern approaches in improving wellness services that are embedded in other states' efforts to develop population health strategies for individuals with SMI.

II. Target Population

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

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

Compliance Rating: Partially Met

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

Compliance Rating: Partially Met

Discussion and Analysis

The SME assessment of Paragraphs 24 through 26 is combined. As one of the initial activities, LDH created a list of individuals in NFs who are members of the Target Population. The list includes individuals with an SMI identified through a PASRR Level II evaluation and individuals who do not have a PASRR Level II evaluation, but the MDS indicates they have an SMI. As of December 15, 2022, the State continues to report that 96% of the individuals on this list had at least one PASRR II evaluation with a confirmed Serious Mental Illness. In the seventh report, LDH reported 93% of individuals on this list had at least one PASRR Level II evaluation. The State regularly analyzes and reviews data from the MDS for current NF residents for an SMI diagnosis to add to this list. The MDS purpose and process are described in previous SME reports.

The State has divided the list of Target Population members in nursing facilities into two groupings. This includes an Active Caseload List for individuals who have indicated an interest in moving and whom the State has prioritized for transition. LDH has also created a Master List for the remaining individuals who have indicated they are not interested in moving at this time and for individuals who have not been contacted recently about transition. As of December 1, 2022, there were 3,676 individuals in the Target Population in nursing facilities, with 774 of those individuals on the Active Caseload List and the remaining 2,902 individuals on the Master List. It should be noted that an additional 200 have been transitioned and remain on the Active Caseload List for one-year post-transition.

In the previous SME report, there were 3,737 individuals in the Target Population in nursing facilities. 3,139 individuals were included in the Master List and 598 individuals on the Active Caseload List. An additional 117 individuals were transitioned and remained on the Active Caseload List for one-year post-transition. This information indicates:

- There was a decrease in the number of individuals in the Target Population in nursing facilities.

- There was a change in the proportion of individuals who were on the Master List and Active Caseload List. Specifically:
    - There were 237 or approximately 7.5% fewer individuals on the Master List
    - There were 176 or approximately 29% more individuals in the Active Caseload List
- There was also a notable change in the number of individuals who were transitioned and remained on the Active Caseload List in CY 2022. Specifically, 200 or approximately twice as many individuals transitioned during CY 2022 than in the previous year.

The SME notes the number of individuals in the Target Population has remained relatively flat across the past four reporting periods. As noted, there was a decrease in the Master List from last reporting period, but the Master List has increased since reporting period 5 (an increase by 11%) and reporting period 6 (an increase by 12%). As noted elsewhere in this report, LDH needs additional focus on diverting individuals from NFs in order to reduce the number of members in the Target Population in NFs.

As indicated above, there was an increase in the Active Caseload List this reporting period, reflecting LDH in-reach efforts to identify individuals who expressed clear interest in transitioning. While this increase is positive, the number of individuals on the Active Caseload List has been variable over the past four reporting periods. For instance, individuals on the Active Caseload List for this reporting period is lower than reporting period 5 (15% less) but higher than reporting period 6 (7% increase). Hopefully, the changes LDH has made regarding its in-reach efforts will decrease the number of individuals who remain on the Master List and increase the numbers of individuals who are interested in transition and actually transition.

The State continues to review individuals on the Active Caseload List to confirm their continued interest in transitioning. These reviews conducted during this reporting period determined:

- 316 individuals who were previously on the Active Caseload List were not interested in moving and were returned to the Master List. This is a 60% decrease of individuals returned to the Master List from the previous reporting period.
- 478 individuals on the Active Caseload List in December indicated their interest in moving. This is a substantial increase from June when 187 individuals indicated interest in transitioning.

The State continues to report there were several major reasons that individuals on the Active Caseload List were removed from the list:

- 56% declined transition and were returned to the Master List
- 11% were discharged from the NF and were in the community for longer than twelve months.
- 8% were discharged within a short period and were not engaged by the TC.

In the previous report the SME raised concerns about the number of individuals returned to the Master List from the original Active Caseload List. The State reported that many of these individuals were automatically placed on the Active Caseload List based on information (from the MDS data or previous conversations) that indicated their interest in moving. Many of these individuals reportedly declined transition when contacted through the recent in-reach process. The State has indicated they have developed a process to review each individual that is being transitioned from the Active Caseload list to the Master List. The Integration Coordinator and senior staff at OAAS and OBH review each request and determine if the return to the Master List is appropriate. In addition, the SME recommended and LDH is

prioritizing individuals moved from the Active Caseload List to the Master List for in-reach activities. According to LDH, these individuals will receive in-reach on a quarterly basis to gauge their continued interest in transitioning. The outcome of this subsequent in-reach visit would determine the cadence of visits.

As indicated in the sixth SME report, the State has developed and implemented a referral system and prioritization to complete Level II evaluations for individuals on the Master List who were identified by MDS information as having an SMI. The State reports an increase in individuals on the Master List who have received a PASRR Level II. As of the June 2022 report, 92% of the individuals on the Master List had received a PASRR Level II. As of this reporting period, 96% of the individuals on the Master List have received a PASRR Level II evaluation, representing a 4% increase. The SME understands that a small number of individuals may be identified as having a potential SMI after they are admitted to the NF. Therefore, the percentage of individuals who have an identified SMI and a PASRR Level II will not be 100%.

The State continues to add individuals to the Target Population list on a daily basis. MDS information is provided to LDH daily for individuals at admission and at other times during their NF stay. Individuals who are identified by the MDS as having SMI are added to the Master List the next day. On a regular basis, the State matches MDS data on individuals who are newly identified as having an SMI to current PASRR Level II data to identify individuals who may have required a Level II screening but did not receive one. The State has developed a process to track the timeliness of when these individuals receive a PASRR Level II as discussed in paragraph 41.

LDH is also required to maintain a list of individuals who are diverted from NF, given these individuals are also part of the Target Population. As indicated in the previous report, the SME raised concerns regarding the reliability of the number of individuals who were diverted from NFs as a result of the PASRR Level II process. The SME has worked with LDH over the past reporting period to further refine the methodology to improve this reliability. This revised methodology includes:

- Removing individuals from the count who did not meet Level of Care for an NF admission.
- Removing individuals who withdrew their NF application.
- Removing individuals where the PASRR Level II evaluator determined the PASRR Level II was not needed.
- Removing individuals who died prior to the NF admission.

As discussed above, LDH diverted 122 individuals from NFs in CY 2022 through the PASRR Level II pre-admission process. The SME believes this methodology is solid and should be used in subsequent reports. LDH maintains a list of individuals who have been diverted on an ongoing basis.

<u>Compliance Assessment</u>

Overall, the SME's assessment for these paragraphs indicates:

- LDH has developed and actively maintains a Target Population list of individuals currently residing in nursing facilities.
- The number of individuals on the Active Caseload grew this reporting period.
- Significantly fewer number individuals were removed from the Active Caseload List and returned to the Master List.
- The SME and LDH have developed a methodology to identify all individuals diverted from nursing facilities as required by Paragraph 26.

- LDH has a process to identify and refer individuals with a possible diagnosis of SMI for a PASRR Level II evaluation, as required by Paragraph 25. However, individuals are not receiving timely PASRR Level II evaluations if they are in NFs and subsequently identified as potentially having an SMI. As indicated in paragraph 41, almost 36% of the individuals added to the Master List this reporting period who were identified as having a presumed SMI have yet to receive a PASRR Level II.
- LDH continues to use its Active Caseload to prioritize transitioning a subset of people in the Target Population.
- There is still a significant number (56%) of individuals previously on the Active Caseload List that LDH determined were not interested in moving at this time. However, this is lower than the previous reporting period and may indicate LDH's process to better vet these transitions may be working. Additional time is needed to see if this trend continues to decrease movement from the Active Caseload List to the Master List.

Recommendations

- LDH should continue the process developed to assertively review requests to move individuals from the Active Caseload List to the Master List.
- LDH should continue to use the methodology developed during this reporting period to measure diversions through the PASRR process.
- LDH should implement strategies identified in paragraphs 29 and 30 to reduce the admissions of individuals with SMI to NFs, therefore decreasing the number of individuals in the Target Population in NFs.
- LDH should ensure individuals identified by the MDS as having an SMI who do not have a recent PASRR Level II (within the past year) receive timely PASRR Level II evaluations (within 30 days of being placed on the Master List).
- LDH should develop a process to track the timeliness for individuals to receive a PASRR Level II when indicated by the MDS.
- LDH should maintain a current list of individuals in the Target Population who were diverted from nursing facilities and include the number of diverted individuals in the total count of the Target Population.

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.

Compliance Rating: Not Rated

Discussion and Analysis:

In previous reports, the 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 Target Population may request and receive some existing and some new services that are set forth in the Agreement, including Mental Health Rehabilitation Services, outpatient mental health services, substance use disorder services under the State's 1115 Demonstration Program, and, more recently, the array of crisis services, employment, community case management, and Peer Supports. Available services and processes to access these services are dependent on payer source. For instance, individuals with SMI

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

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

III. Diversion and Pre-Admission 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 nursing facilities and provide intervention and 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].

Compliance Rating: Partially Met

Discussion and Analysis:
This rating has changed from Not Met to Partially Met. As discussed in the seventh SME report, the State submitted a revised diversion plan to outline the steps LDH will take to promptly identify individuals in the Target Population seeking admission to NFs and to provide intervention and services to prevent unnecessary institutionalization. The initial and revised State's plan can be found at: https://ldh.la.gov/assets/docs/MyChoice/DiversionPlan.pdf. The plan discusses several strategies that will be critical to implementing an effective diversion system as required by this paragraph. This compliance rating considers the extent to which each of these strategies is being implemented effectively.

Defining the Diversion Population: Similar to the CY 2019 Diversion Plan, the revised plan sets forth definitions for individuals who would be considered diverted from NFs and individuals who are at high-risk for NF placement. Currently LDH has defined the diversion population as Medicaid enrolled individuals with SMI who seek admission to a nursing facility but are not admitted because the PASRR Level II indicated community placement versus a nursing facility admission. The revised plan used past performance to project that 120 individuals would be diverted from NFs during this calendar year. LDH reports that it has diverted 122 individuals this calendar year and met the annual projection. LDH expects to divert 137 individuals from NFs through the PASRR Level II process in CY 2023. LDH has not developed longer term diversion targets during this reporting period.

As indicated in paragraph 34, the SME recommended, and the State is in the process of requesting PASRR Level II evaluators to provide uniform information on barriers to diverting individuals from NF placements. LDH has indicated they will revise the PASRR Level II Evaluation to capture information on barriers and strategies to address these barriers.

Developing a Strategy to Address Individuals in the At-Risk Population: LDH has also developed and implemented a strategy according to the diversion plan for individuals at high risk for NF admission. These efforts to address this at-risk population is discussed in paragraph 30.

Improving PASRR Processes and Criteria: LDH's Diversion Plan contains several goals related to this, including improving the identification of individuals with SMI through the PASRR Level I, conducting prompt PASRR evaluations, and ensuring PASRR evaluations consider community mental health services.

In the last two SME reports, it was recommended that LDH develop a process for identifying individuals prior to admission and during the PASRR process (Level I screening and Level II evaluation) who have few barriers to receiving services in the community even though they meet NF Level of Care. The recommendation took into consideration that there may be individuals with an SMI who seek NF admissions who may have lower physical health needs and home and community-based services and natural supports are readily available to meet their needs. In the past two SME reports, the SME recommended Office of Aging and Adult Services (OAAS) and OBH should develop a strategy for how to best identify and divert this population during this reporting period to further increase diversions from NFs. The State has begun to discuss but has not developed these strategies, which will be important to determine if individuals are inappropriately in NFs.

In addition, as indicated in the past two SME reports, meeting existing or new targets for diversions is dependent on PASRR Level II evaluations. In previous reporting periods, meeting the diversion targets was challenging given that LDH had requested 1135 Waivers due to the Covid-19 pandemic which waive requirements to complete a PASRR Level II for new NF admissions. For several reporting periods, the State received approval for these Waivers, which impacted the ability for the State to implement its diversion strategy. During this reporting period, LDH did not have an 1135 Waiver in place and met the diversion projections they set for CY 2022.

Further, in the seventh SME report, it was recommended that LDH develop strategies to ensure that PASRR Level II reviewers were well versed in their knowledge of community-based services to be able to offer options to meet the total needs of individuals seeking NF admission. This includes behavioral and physical health as well as community-based long-term services and supports such as personal care and home health to address activities of daily living and medical conditions (e.g., wound care) that are often needed post-hospitalization. LDH has begun initial discussion on strategies that would provide the PASRR Level II reviewers with information regarding these resources. OAAS and OBH are in the process of developing a strategy to assist PASRR Level II evaluators to review and address the total needs of an individual during the PASRR Level II process. The State reports it will undertake the following activities in the next reporting period:

- OAAS staff members will provide face-to-face training to PASRR Level II evaluators to better understand the community long term supports, how to access these supports, and timeframes generally for an individual to receive these services. This information is intended to provide PASRR Level II evaluators with information to be used in discussion with individuals who are being referred for NF placement and their caregivers.

- Include OAAS staff members in the audit process developed by OBH to review PASRR Level II evaluators' decisions. The intent is to identify if additional community service options could have been identified by the PASRR Level II to increase the likelihood of a diversion.

Having PASRR level II evaluators understand the availability of services and supports that may be provided by caregivers immediately post hospital discharge and prior to receiving services from community-based providers is critical in conveying alternatives to NFs. The SME understands that some services cannot be available during the first few weeks of hospital discharge given referral and service engagement timeframes. Therefore, some services (e.g., transportation to medical appointments, medication oversight and some activities of daily living) may be performed by caregivers in the interim. As indicated in the seventh report, LDH initiated efforts to train PASRR Level II evaluators to improve competencies with engaging caregivers during the PASRR Level II process.

Developing a Case Management Strategy for Diversions: Over the past eight months, LDH has implemented Community Case Management (CCM) for individuals who were transitioned or diverted from NFs. This is discussed in more detail in paragraph 47. CCMs are responsible for engaging individuals who are diverted from NFs (through the PASRR Level II process), assessing their needs, developing a community plan, referring individuals to needed services, and tracking individuals for one year post transition. CCMs are to coordinate services including services in the Agreement and medical and long-term services and supports to address their healthcare and activities of daily living needs. As discussed in paragraph 59, the State reports that as of August 2022 (latest information provided), 51 individuals were diverted and 43 engaged in CCM. In addition, the State tracks and reports what services are utilized by individuals who were diverted.

The diversion plan also included an approach to ensure individuals who were diverted from NFs received care coordination and services. Information from paragraph 59 regarding care coordination offered to the diverted population and paragraph 101 regarding service utilization of diverted individuals was also used to inform LDH's activities regarding this paragraph.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- The State worked with the SME to revise the diversion methodology and tracking to ensure more reliability in reporting diversions against the diversion targets for CY 2022.
- The State met the diversion target for PASRR Level II evaluators for this calendar year.
- The State continues to implement an OBH PASRR Determination Specialists Quality Audit Tool and perform monthly audits as an internal quality improvement process including the addition of OAAS staff to the audit process. The tool, initial implementation activities, findings, and remediation strategies are discussed in paragraph 34 of this report.
- OBH and OAAS are developing a process to support PASRR Level II evaluators with information regarding assessing the total needs of the individual to better identify community options needed by these individuals.
- The State did not have an 1135 Waiver in place during this reporting period and therefore LDH did not defer PASRR Level IIs during this period.
- The State has implemented some parts of the diversion plan including:
    - Establishing and meeting the annual target for individuals diverted through the PASRR Level II process.
    - Continuing implementation of the at-risk strategy discussed in paragraph 30.

  - Providing training to PASRR Level II reviewers regarding engagement of caregivers in the PASRR Level II evaluation to determine natural supports that may be available to individuals which increases the likelihood of diversions.
- The State has not developed a multi-year diversion projection.
- LDH does not track common barriers to diversion in order to identify strategies to address those barriers.
- The diversion plan does not specifically address outreach to organizations identified in paragraph 68 including law enforcement, corrections, and courts regarding diversion strategies.

Recommendations

- LDH should continue to implement the elements of the Diversion Plan, including developing multi-year diversion targets aimed at maximizing the number of diversions to community-based services, as appropriate.
- LDH should track and report the number of individuals who have an SMI who are admitted to NF to determine if the diversion strategies set forth in the report are effective. While the SME is encouraged that LDH diverted 122 individuals in CY 2022, LDH should determine how these efforts compare to total admissions.
- LDH should report on how the PASRR Level II audit process ensures appropriate placement and service recommendations and identify whether these processes have increased diversions.
- LDH should ensure that PASRR Level II evaluators routinely report information on barriers and strategies to address barriers for individuals seeking NF admission.
- OAAS and OBH should finalize and implement the process for PASRR Level II evaluators to address the total needs of individuals seeking admission to an NF.
- OAAS and OBH should finalize the strategy for how to best identify and divert individuals with an SMI who seek NF admissions who may have lower physical health needs when home and community-based services and natural supports are readily available to meet their needs, during the next reporting period to further increase diversions from NFs.

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 nursing facility admission.

Compliance Rating: Partially Met

Discussion and Analysis:

This rating has changed from Not Yet Rated to Partially Met. LDH has developed and begun efforts to implement a system to identify and divert individuals from avoidable hospitalizations. While working with hospitals is an important strategy (as required in paragraph 87), it continues to be the SME's opinion that LDH's initial effort would be better spent on working with MCOs versus hospitals directly to prevent avoidable hospitalizations. The SME continues to believe that MCOs have the fiscal incentive to identify these individuals and develop strategies that prevent admission or readmissions for individuals with significant co-morbid conditions and SMI. This strategy is also necessary to increase diversions. While the efforts in paragraph 29 regarding the PASRR Level II process produce some diversions from NFs, this is a relatively small number. In addition, referrals to NFs happen quickly and PASRR Level II evaluators and CCMs may not be able to put supports into place for some individuals on a timely basis.

A major strategy for diverting individuals from NF admissions is to identify individuals who may be at high risk for hospitalizations that would lead to an NF admission. As indicated in the fifth SME report, the Department finalized a definition for an "at-risk" population in 2021 that included individuals with an SMI who had chronic physical health conditions and who had recent and multiple EDs and inpatient admissions (all cause). The assumption is that many of these individuals, with better care coordination, would avoid hospitalization and thereby have reduced referrals to NFs. The State had identified 7,150 individuals in FY 2021 who met the definition of the at-risk[1]. LDH worked with the MCOs to put the at-risk effort into place starting July 2021, which included ongoing identification by the MCOs of individuals in the target population, engaging individuals in care coordination which included assessing and developing plans of care and coordinating services for these individuals. Recently, the State reports they will make changes to the definition of the at-risk population. Specifically, the State will continue to require individuals in the at-risk population to have an SMI but will not require the individual to have another chronic condition. In addition, LDH is proposing to shorten the timeframe for multiple ED and inpatient admissions that would be used to define the at-risk population. Currently, the "look back" period is two years. LDH recommends that this period be shortened from two years to six months. This change is concerning to the SME as it will likely decrease the size of the at-risk population.

Over the previous reporting periods and during this reporting period, the SME requested and LDH provided aggregate information tracked and analyzed by LDH regarding the at-risk population for the first year of the MCO's efforts to enhance efforts to provide case management to the at-risk population to reduce preventable hospitalizations that could lead to nursing home admissions.

The SME has reviewed and analyzed reports from February through July 2022. The most recent aggregate report indicated:

- 6,260 individuals were identified by MCOs as at risk. This was a 26% increase since February.
- 1,259 (20%) of individuals were enrolled in MCO case management. This was a 31% increase since February.
- Of the 1,259 enrolled, 92% had a plan of care developed. This was an increase of 43% from February. It should be noted that there was no information to determine if these care plans adequately addressed the needs identified in the assessment.

The SME is requesting ongoing detailed monthly information from LDH regarding each MCO's at-risk activities.

During this reporting period, the State' External Quality Review Organization (EQRO) provided a review of the MCOs' efforts to provide care coordination to individuals who meet the at-risk definition. This report indicated:

- Fewer than one-fifth of members (18.06%) in the at-risk population were offered MCO CM services, with a wide variability across MCOs.
- 18% of the at-risk group were unable to be contacted by the MCO and therefore not offered case management.
- 64% of at-risk individuals were still considered open and were not yet engaged by the MCO in case management.

[1] OBH Presentation to MCOs 3/19/2021

The EQRO also reviewed a sample of charts (128 individuals) for individuals who were at-risk and enrolled in case management. This chart review indicated:

- 96% had an assessment—approximately 50% of these individuals received an assessment within 30 days of being identified as at risk.
- 92% of individuals reviewed had physical health needs, 43% had behavioral health needs, and less than 20% identified needs related to social or vocational interests.
- 67% of individuals reviewed had a care plan; however, more than one-third of members in the chart review sample lacked a timely care plan based on the needs assessment.
- 53.49% of care plans were updated to monitor progress; 52.32% documented timely resolution of issues.
- 52.34% of members received care coordination that actively assisted the member with locating and arranging for services/supports, scheduling appointments, and arranging for transportation, as needed.
- 15% of individuals reviewed had a crisis plan to avoid unnecessary hospitalization, incarceration, or out-of-home placement.

Over the past several months, LDH has requested a plan of correction for each MCO to address the findings of the EQRO report. The State has requested MCOs address 26 areas in their plans of corrections, including:

- Developing and implementing assertive engagement strategies for the at-risk population
- Improving the number and percent of at-risk members offered case management.
- Increasing the number of assessments completed
- Increasing assessments that include member physical health, behavioral health, and social/functional needs, and needs are reassessed based upon significant change in member needs in these areas.
- Documenting and reflecting the needs of the individual from the assessment in the care plan
- Completing the care plan within 30 days of the assessment
- Ensuring a personalized care plan was developed that included the individual and family.
- Ensuring the care plan identified member goals, strengths, needs, and barriers to treatment.
- Ensuring care coordination actively assisted the member with locating and arranging for services/supports, scheduling appointments and arranging for transportation.
- Including a crisis plan in the care plan to avoid unnecessary hospitalization, incarceration, or out-of-home placement.

<u>Compliance Assessment</u>
The SME assessment of the State's compliance with this paragraph took into consideration:

- LDH is proposing to make significant changes to the definition of the at-risk population that will likely reduce the size of the at-risk population and could impact a major LDH diversionary strategy for individuals with SMI being admitted to NFs.
- LDH has implemented the policies and expectations for MCOs to implement their at-risk strategy.
- MCOs have initiated efforts to implement the at-risk strategies.
- MCOs have not performed their responsibilities for at-risk members consistent with LDH policies and MCO contracts .

- LDH has assertively monitored MCO efforts to engage at-risk individuals and provide the necessary care coordination to address physical health, behavioral health, and other needs as well as ensuring that MCOs develop strategies to avoid unnecessary hospitalization, incarceration, or out-of-home placement.
- LDH is in the process of taking the necessary actions with MCOs to improve their performance.
- Data is lacking regarding the effectiveness of MCOs' at-risk strategies. Information regarding ED or inpatient utilization (all cause) and NF admissions is needed to measure the effectiveness of these efforts.

Recommendations

- LDH should consider redefining the at-risk population to allow for a one year look back on ED visits and inpatient admissions versus a six month look back period. Evidenced based approaches such as eligibility criteria for ACT recommend a one year look back period.
- If LDH chooses not to expand the look back period, the State should provide evidence the 6 month look back is sufficient.
- LDH report on the impact of the new at-risk definition as compared to the current at-risk definition. Specifically, the State should provide the following:
    - The total number of individuals in the new at-risk population versus the current at-risk population.
    - The number of individuals in the current at-risk population who will no longer be considered at-risk given the new definition.
- LDH should obtain and analyze information from the MCOs that were set forth in their plans of correction. If this information does not show improvement, further corrective actions will need to be taken.
- LDH should collect information to develop a baseline for the new at-risk population and track information for determining the effectiveness of the at-risk strategy including ED and IP utilization and NF admissions. This should include:
    - Number of individuals with SMI who seek admission to an NF as captured through the PASRR Level II process.
    - The number of individuals who are admitted to an NF and placed on the Master List.
- LDH should include the at-risk population as part of its overall diversion methodology if the at-risk strategy is determined to be effective. This would include information on:
    - Number of individuals with SMI who seek admission to a NF as captured through the PASRR Level II process.
    - The number of individuals who are admitted to a NF and placed on the Master List

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

Compliance Rating: Not Met

Discussion and Analysis

This rating has changed from Partially Met to Not Met. LDH reported that it has implemented a number of strategies to improve the PASRR Level I screenings to achieve diversion of individuals with SMI seeking admission to NFs. These steps included modifying the Level I screening instrument, developing and implementing standardized training for personnel (except physicians) who complete any part of the PASRR Level I screening process, and specifying the credentials of individuals deemed qualified to

complete the PASRR Level I Screen. Information regarding these specific three steps was provided in previous SME reports.

LDH efforts have focused on trainings for PASRR Level I screeners to improve the identification of individuals with an SMI. However, no large-scale additional PASRR Level I trainings have been conducted since 2018. The State continues to report they will develop and implement training for PASRR Level I screeners when the tracking system is implemented. The new tracking system will identify individuals in the Target Population who were admitted into an NF within three days. LDH has selected a vendor for this tracking system but has not developed this new system. In the seventh SME report, the State anticipated training would occur during this reporting period as this system was developed and implemented. Given the delays in implementation, no substantial PASRR Level I trainings have occurred in the past four years.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- The State identified and implemented strategies early in the Agreement to improve the PASRR Level I screening process in 2018 but has not appreciably revised these strategies since 2018 due to delays in contracting with a vendor to make the necessary system changes.
- LDH has also trained staff completing the MDS to better identify and provide diagnosis information to LDH from the MDS.
- The State has yet to validate effectiveness of these efforts per the SME's recommendation in the seventh reporting period.
- The SME requested information regarding the implementation of this new training (training materials and schedule of trainings) for PASRR Level I during this reporting period; however, due to delays, these materials and schedules were not developed.

Recommendations

- LDH should finalize and implement the contract that will provide the necessary changes in the PASRR Level I tracking process. The SME requests information regarding the implementation of this new training (training materials and schedule of trainings) for PASRR Level I during the next reporting period.
- The SME continues to recommend LDH develop goals for these improvements to PASRR Level I training and an evaluation strategy to ensure that these trainings are producing the intended outcome.

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

Compliance Rating: Not Met

Discussion and Analysis

According to the State, individuals are asked about their interest in and need for community services by PASRR Level II evaluators and are provided information about community options at the time of the evaluation. In the past several reports, the SME requested, but has not received, information from the State regarding their efforts to ensure that the evaluators offer community options in a meaningful way. The SME believes the State's oversight and evaluation of these strategies are important. LDH states this process will be part of the evaluation and possible changes to the PASRR Level II Program. The State

reports that PASRR Level II evaluators, as described in paragraph 29, provide information regarding community options for individuals with an SMI seeking NF placement.

In the sixth report, the SME requested and LDH provided the most recent list of community options. The SME reviewed the list of community options the State provided and found these to be insufficient to provide information to PASRR Level II evaluators. The State provided regional resource guides that are used by transition coordinators and do not provide important options for PASRR Level II evaluators to consider when making their recommendations regarding NF placement to OBH. The seventh SME report recommended the State should develop or require the MCOs to develop a viable list of community options that would be helpful for individuals who seek NF admission. Based on conversations with LDH, this has not occurred and as discussed below there may be alternatives to developing these lists and options.

The SME and the State have discussed strategies for enhancing the knowledge and competencies of the PASRR Level II reviewers to discuss and recommend community options for individuals seeking NF admission. The SME has reinforced the requirement that PASRR Level II evaluations are to consider the total needs of the individuals seeking NF admission. In addition, the federal PASRR regulations require:

- The state mental health authority to determine whether, because of the resident's physical and mental condition, the individual requires the level of services provided by an NF.
- If the individual with mental illness is determined to require an NF level of care, the state mental health must also determine whether the individual requires specialized services for the mental illness.
- The PASRR Level II evaluators are to perform:
    - A comprehensive history and physical examination of the person including a complete medical history.
    - A comprehensive psychotropic drug history, a psychosocial evaluation, a comprehensive psychiatric evaluation
    - A functional assessment of the individual's ability to engage in activities of daily living and the level of support that would be needed to assist the individual to perform these activities while living in the community. The functional assessment must address:
        - Self-monitoring of health status
        - Self-administering and scheduling of medical treatment, including medication compliance, or both
        - Self-monitoring of nutritional status, handling money, dressing appropriately, and grooming.
- The regulations allow, but do not require, a qualified mental health professional to perform the PASRR Level II evaluation.

In reviewing the current PASRR Level II tool, it collects all of the federally required information on behavioral health, medical, and supports needed to address ADLs and independent activities of daily living (IADLs). The current process used by LDH does involve OBH in determinations about whether the individual requires NF level of care. That determination is made by OAAS. The current process used by the State does determine, through the PASRR Level II process, whether specialized behavioral health services are needed and the specialized behavioral health services recommended for the individual. What is less clear is how PASRR Level II evaluators use this information to identify the need for home and community-based services and other medical resources that may be made immediately available to individuals and

caregivers to divert an individual from a potential NF admission. LDH has raised concerns that these evaluators are licensed mental health practitioners and inherently do not have the acumen to determine what medical and long-term services and supports could be made immediately available to divert individuals from NF placement. OAAS and OBH have identified the need for better information regarding resources for PASRR Level II evaluators regarding physical health and long term supports that could be available in the community. In addition, as discussed in paragraph 29, OBH is also providing training to PASRR Level II evaluators to engage caregivers to determine the availability of natural supports that may be provided if an individual is diverted to the community.

Currently, there is a bifurcated and not well coordinated process for reviewing the total needs of the individual and making a determination of whether the individual is recommended for NF placement or community tenure. Through discussions with the State, OAAS and OBH are developing a strategy that will support PASRR Level II evaluators in recommending services and supports that can be immediately available to individuals to address their total needs and the determination of whether the individual is recommended for an NF placement.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- LDH does not maintain a list of regional and local community options that could be used for PASRR Level II evaluators to provide to individuals and caregivers during the evaluation process that could deter an admission.
- Level II evaluators do not have the acumen to determine what medical and long-term services and supports could be made immediately available to divert individuals from NF placement and therefore individuals applying for NF admission are not provided with adequate information regarding community options.
- OAAS and OBH have discussed but have not yet implemented strategies that would enhance PASRR Level II evaluators' knowledge of medical and long term services and supports that would address the total needs of the individual.

Recommendations

- OBH and OAAS should implement the process to support PASRR II Evaluators and Determination Specialists to review the total needs of the individual and factor these reviews and decisions regarding NF admissions.
- The State should develop a viable list of community options that would be helpful for individuals who seek NF admission. This should include information regarding medical and support services (such as personal care) as well as housing, housing supports, behavioral health services, and other services and supports most frequently requested or discussed during the PASRR Level II process.
- The State should review the list with the SME to ensure it provides realistic and useful community options.
- LDH should develop and implement training for evaluators regarding these services and engagement about community options.
- The State should audit/monitor this on an ongoing basis to ensure that individuals are, in fact, being provided with this information.

33. All screenings and evaluations shall begin with the presumption that individuals can live in community-based residences. For any individual for whom a nursing facility placement is contemplated, the PASRR Level I screening will be conducted by a qualified professional prior to nursing facility 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.

Compliance Rating: Not Met

Discussion and Analysis

This rating has changed from Not Yet Rated to Not Met. As indicated in paragraph 31, LDH has not taken recent steps to change the PASRR Level I screening process to better identify individuals with SMI who are referred to NFs. No large-scale PASRR Level I trainings have been conducted since 2018. The State is proposing new training for PASRR Level I reviewers once changes are finalized for the tracking system. The tracking system was to be operational during CY 2021; however, due to procurement delays the vendor was procured and under contract during the seventh reporting period. The State indicates the new vendor will play an important role in training staff that complete the Level of Care Eligibility Tool (LOCET) and PASRR Level I once changes to the tracking system are complete. In the seventh report, the State reported materials may be available during this reporting period. This material was not available.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration a similar focus as paragraph 31:

- The State identified and implemented strategies early in the Agreement to improve the PASRR Level I screening process in 2018.
- The State has not substantially developed or implemented new training for PASRR Level I screeners since 2018.
- The State has not completed their contracting efforts with the new vendor that will inform the PASRR Level I screening process and the timeframes for implementation of the new PASRR Level I screening is not clear.

Recommendations

- The State should complete the contracting process and provide the SME information regarding the implementation of this new training (training materials and schedule of trainings) for PASRR Level I during the next reporting period.
- The SME recommends that training of PASRR Level I evaluators begin no later than the next reporting period and be completed by CY 2023.

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 nursing facility 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.

Compliance Rating: Not Met

Discussion and Analysis

Although LDH has begun some initial efforts in this area, its progress toward complying with this paragraph continues to be insubstantial. As indicated in the seventh SME report, the State has included language in the MCO contracts standardizing the use of face-to-face PASRR II for individuals seeking admission to NFs. Prior to these contracts, the occurrence of face-to-face meetings was relatively rare.

LDH has implemented policies and incorporated specific requirements within its Medicaid managed care contracts to ensure timeliness of the evaluations. Federal regulations require a preadmission screening determination to be made in writing within an annual average of 7 to 9 working days of referral of the individual. The most recent data provided to the SME continues to indicate that Medicaid MCOs continue to complete PASRR Level II evaluations within four business days of referral from OBH, consistent with State requirements. The SME continues to request and LDH provides information on the timing of PASRR Level II evaluations. Specifically, the SME requested information on whether PASRR Level IIs evaluations were performed prior to an individual seeking admission into an NF. LDH provided recent information regarding the timing of PASRR Level II evaluations and whether these evaluations were performed prior to admission (or diversion) from an NF.

Information provided for the reporting period indicated 990 PASRR Level II were completed for new admissions. 93.85% were completed within 4 business days and prior to admission and37, or 4%, were performed after admission to an NF (occurring within 7 days after the admission). This is significantly lower than the seventh reporting period where 14% were performed after admission. LDH reports there are several reasons for these later PASRR Level II evaluations, including individuals admitted through a hospital exemption that does not require a PASRR Level II evaluation and the PASRR Level I process not identifying the need for Level II, but MDS provided immediately after admission flagging the need for a PASRR Level II evaluation. In addition, there were several continued stay requests included in the count (which in future reports will be removed from the total count).

As indicated in previous reports, the PASRR Level II reviews are performed by the Medicaid MCOs' Level II Evaluators, Licensed Mental Health Professionals who operate independently of the NF and the State. The MCOs have contracted with Merakey, an organization that provides behavioral health services in Louisiana and other states. They do not provide services for the NFs, nor do they provide services directly with the State.

As indicated in paragraph 32, the PASRR Level II evaluation is used to confirm whether an individual referred for nursing facility admission, or identified post admission, has a serious mental illness (SMI). As indicated in the seventh report, the SME has reviewed the PASRR Level II forms and training for evaluators with the tools to determine if they have an SMI, including referrals for additional diagnostic evaluations. These trainings and forms require the PASRR Level II to collect information regarding the presence of an SMI diagnosis more reliably.

The ongoing SME Service Reviews examine the PASRR Level II evaluations that provide additional background information regarding the needs of the individual and supporting documentation that supports whether an individual has a mental illness. In reviewing this documentation, PASRR Level II evaluators collect and review information to determine whether the individual has an SMI. The SME Service Review Team deemed this information to be sufficient to determine whether an individual has an SMI.

The paragraph requires LDH to detail with specificity the services and supports necessary to live successfully in the community and requires that the State address options for where the individual might live in the community. To be able to meet this requirement, the PASRR Level II tool must collect information on an individual's needs and services to meet these needs. As discussed in prior SME reports, LDH revised the PASRR Level II evaluation forms in 2017 and again in 2019 to include information on physical/medical, behavioral health and social history, work history, and functional status (ADLs and IADLs). LDH also updated the OBH PASRR Level II Evaluation Summary and Determination Notice, which is submitted, along with the final authorization, to the individual seeking NF placement at the completion of the determination. The determination forms are intended to better convey information about community-based mental health services and supports. OBH is undertaking a third revision to the PASRR Level II evaluation to gather more information to include more extensive and detailed information regarding services in the community. This will include more information on medical and long-term services and supports. During this reporting period, the SME reviewed and provided recommendations to OBH regarding revisions to the PASRR Level II process for collecting and analyzing physical health and long-term services and supports similar to behavioral health needs and recommendations included in the current PASRR Level II evaluation.

Once information is collected, PASRR Level II evaluators must make a recommendation as to whether the individual requires the level of services in an NF. To make these determinations, PASRR Level II evaluators must have an understanding and acumen to determine if services and supports to meet the individual's total needs are readily available in the community. As indicated in paragraph 32, LDH has not sufficiently developed information on resources available to individuals referred for PASRR evaluations that would assist with reviewing the services available to meet the individual's total needs. As indicated in paragraph 32, OAAS and OBH have begun discussion on resources and strategies to be deployed to improve the acumen of PASRR Level II reviewers to identify and recommend physical health and supports to address ADLs and IADLs that would be immediately available to potentially divert individuals from NFs.

In addition, for the past two reports, the SME recommended the acumen of the PASRR Level II reviewers should be enhanced to better identify and address barriers during the evaluation and recommend a decision to divert the individual from an NF admission. The State has developed a list of barriers PASRR Level II reviewers could identify during their evaluation. LDH has stated they will implement this barrier identification process during the next reporting period.

In previous discussions with the State, the SME suggested that higher scrutiny be applied for individuals that had a lower level of physical health and rehabilitative needs as determined by the LOCET and other documentation. This would require the State to make changes to the admission processes and potentially various tools used by OBH and OAAS to enhance the number of individuals recommended for community placement. The State has not developed strategies to address this recommendation.

The State has and continues to develop quality improvement processes, including trainings for PASRR Level II evaluators. As indicated in the seventh report, LDH has revised and implemented trainings to staff that perform PASRR Level II evaluations to be more person-centered and focused on reviewing information on medical and physical health conditions that precipitated the NF admissions. A review of the training did identify some areas that PASRR Level II trainings should focus on, including substance use disorder (SUD), social, housing, and other lesser physical health needs such as occupational therapies, vision and dental exams, primary care provider (PCP) linkage, home health, and durable medical equipment (DME) that will assist the individual to function with success in the least restrictive setting or

when a community placement is more appropriate. During the reporting period, a training was provided which was intended to capture some of these topics. It covered the following: definitions and eligibility for all behavioral health services covered under the MCOs (including SUD), eligibility and services differences between ACT and Mental Health Rehabilitation services, and the array of community resources utilized by case managers to assist individuals residing in community settings. Additional trainings should be sought in future reporting cycles. In addition, the State reports they have developed training for PASRR Level II evaluators to meet the following objectives:

- Understand how to obtain thorough histories needed in the assessment of the individual (Behavioral, Substance Use, Medical, Social, Family, and Trauma)
- Understand definition, medical necessity/admission criteria and intensity of services for all levels of care for behavioral health and alcohol and drug treatment.
- Understand what a typical presentation of function/symptoms is for Assertive Community Treatment vs other Mental Health Rehabilitation Services.
- Provide information regarding community resources utilized by MCO Case Managers and Community Case Management professionals that are to assist individuals in maintaining the least restrictive/community setting.
- Understand the federal regulatory requirements of PASRR, the purpose of PASRR, and the major components of PASRR Level I and II.
- Understand the Developmental Stages of Older Adults
- Understand best practices for assessment, priorities, and barriers of assessing older adults.

LDH continues their efforts to oversee PASRR Level II evaluators and the LDH PASRR Level II staff who make recommendations regarding an NF admission or a continued stay. This oversight process includes an independent review by the OBH PASRR Level II manager of supporting documentation and admission decisions using the PASRR Level II evaluation to support the admission decision. This process includes a quality review audit tool for Pre-Admission reviews this reporting period. The audit tool and oversight process review the quality and appropriateness of PASRR Level II placement and service recommendations of the PASRR Level II Independent Evaluator, Managed Care Organization Review, and OBH PASRR Determination Specialist. As indicated in the seventh SME report, the initial audit efforts identified two issues for improvement. This included the need to solicit better engagement of families and informal supports to identify the potential for availability of natural supports to support the individual in the community. The audit also found conflicting information in various documents (MDS and PASRR Level II) regarding Activities of Daily Living (ADL) information to determine level of functioning and possible community supports that could address ADL in the community versus needing NF care. During this reporting period, LDH conducted 91 audits of PASRR Level II evaluations. The State reported the following information from these findings:

- Improvements made by PASRR Level II evaluators regarding recommendations of home and community-based services that should be available for an individual who is diverted or for individuals expressing a desire to return to the community after specialized therapies in the NF are completed.
- Improvements in identifying physical health needs and developing recommendations for Durable Medical Equipment (DME), medical therapies, and wound care.
- Despite these improvement, PASRR Level II Evaluators and LDH Determination Specialists need additional prompting for reviewing additional information for individuals who were readmitted.

This includes identifying supports in the community that were not available and may have contributed to the readmission.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- The majority of initial PASRR Level II evaluations for individuals seeking admission to an NF are provided promptly. There are 4% of individuals who were identified through the PASRR Level I as potentially having an SMI but who did not receive an evaluation prior to admission.
- PASRR Level II evaluations are conducted independent of the proposed NF and the State.
- LDH has undertaken ongoing efforts to ensure PASRR Level II evaluators receive ongoing training to identify whether individuals referred for these evaluations have a serious mental illness. The SME Service Review Team deemed the information collected to be sufficient to determine whether an individual has an SMI.
- The focus of the PASRR Level II evaluations seems to be more on verifying a diagnosis of SMI and determining specialized behavioral health services once the individual is admitted rather than identifying the total needs of the individual.
- The State has focused recent audits to address the ongoing issue that the evaluation process is not sufficient to detail with specificity the services and supports necessary to live successfully in the community, and the options for where the individual might live in the community. The State reports there is improvements in the identification of physical health conditions that would warrant additional specialized medical care and home and community-based services.
- LDH has developed training efforts to enhance PASRR Level II evaluators but it is unclear whether these trainings have netted the intended improvements sought by LDH.
- Information regarding community options that would support PASRR Level II evaluators' recommendations regarding NF admission is not sufficient.
- LDH reports they will coordinate support to PASRR Level II evaluators to better address the total needs of an individual seeking admission to an NF.
- The State is revising the PASRR Level II forms to enhance the collection of information to support a PASRR Level II recommendation.
- LDH has developed a list of barriers for PASRR Level II evaluators to use during the evaluation process but has yet to implement the strategy for PASRR Level II evaluators to collect information on these barriers for individuals seeking NF admission.

Recommendations

- The State should develop an evaluation process to determine how their renewed training efforts have improved the PASRR Level II evaluations and ultimately how it will improve diversions from NFs.
- LDH should initiate the process to collect information on barriers through the PASRR Level II process using the list of barriers discussed in paragraph 58 and use this information in developing mitigation strategies to address these barriers.
- If LDH anticipates requesting future 1135 Waivers, LDH will need to develop a better strategy for tracking individuals who need but did not receive a PASRR Level II prior to admission and completing them quickly.
- LDH should continue to review and report out the reasons for individuals receiving a PASRR Level II post admission, especially when there is no approved 1135 Waiver.

- LDH should develop the approach to addressing the total needs of individuals seeking NF placement and develop community options discussed in paragraph 32.
- The State should revisit the PASRR Level II process based on the results of the quality audits and a more strategic focus on physical health and ADLs that may be addressed in the community rather than an NF.
- LDH should provide the revised PASRR Level II auditing forms and processes to the SME for review during this next reporting period.

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.

Compliance Rating: Partially Met

Discussion and Analysis

According to LDH, steps were taken in 2018 to strengthen the application and criteria of PASRR Level II evaluations to ensure appropriate identification of dementia as a primary diagnosis. These steps were documented in the fourth SME report (December 2020). The State revised the Utopia system in this reporting period to allow OBH to identify and track individuals who have a suspected or initial diagnosis of dementia. Specific revisions the State proposes include adding "Suspected Dementia" to Utopia to allow for an additional review by the consulting psychiatrist of an individual when there is insufficient documentation to render a determination of primary dementia. The LDH consulting psychiatrist verifies whether the individual has a dementia diagnosis and would benefit from behavioral health services. The State reports they now require PASRR Level II evaluators to gather additional, more reliable information regarding suspected dementia that will allow the consulting psychiatrist to determine if an individual has dementia. This questionnaire is rendered to NF staff and family members by an OBH Determination Specialists. All Level II evaluators, MCO reviewers, and OBH Determination Specialists have been trained on this document. It has been incorporated into the 2021 Updated OBH Dementia training as well as the 2022 OBH Assessment training.

LDH reports 501 individuals were identified through the PASRR Level II process during this reporting period as potentially having a primary diagnosis of dementia. The State reports that each of these individuals have been reviewed by the consulting psychiatrist to determine if they have a primary dementia diagnosis. LDH reports that:

- 404 or 81% of the individuals were determined to have a primary dementia diagnosis.
- 88 or 18% of the individuals were suspected of having a primary dementia diagnosis.
- 11 or 2% of the individuals were determined not to have a dementia diagnosis.

In the sixth report, the SME requested information on LDH's efforts to review these individuals who continue to have dementia or for whom there is no longer dementia present. LDH has not finalized the

necessary system changes to report whether individuals with dementia have been re-reviewed to determine if they continue to have dementia. As indicated in the seventh report, the SME, in discussion with the consulting psychiatrist, identified several conditions that may benefit from a review, including a substance use disorder (especially alcohol disorder) and other medical conditions. It was also discussed that individuals who have a dementia diagnosis need to be re-reviewed in a year. In addition, OBH stated they will conduct re-reviews of individuals with a primary diagnosis of dementia and co-morbid conditions that may be "rehabilitated" and with adequate supports, the individual may be successfully transitioned into the community. In the seventh report, the specific conditions that would trigger a re-review were identified.

In the seventh SME report, the State reported they were doing an historical review to determine if previous dementia diagnoses were appropriate. OBH reviewed 139 cases from the 2015-2019 Master List. An OBH Determination Specialist initiated PASRR Level II evaluations on these individuals by facility. They requested all required Level II documents, dementia documentation, and additional information from the facility and, when appropriate, family members. Once collected, this information was re-reviewed by the consulting psychiatrist to see if there are any differences in determinations. The following results of these reviews indicated:

- 37 or 27% were identified as having a primary diagnosis of dementia.
- 15 (or 11%) individuals were suspected as having dementia.
- 4 individuals (3%) had a primary diagnosis of SMI.
- 4 individuals or (3%) had a primary diagnosis of a physical health issue.
- 51 individuals (37%) of individuals had died .
- 10 individuals (7%) were discharged from an NF.
- 10 individuals (7%) were unable to locate.
- 8 individuals (6%) withdrew their request for admission to a NF and LDH was unable to obtain information.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- LDH has strengthened documentation requirements and training used to establish a primary diagnosis of dementia relative to the PASRR screening process.
- LDH has referred individuals for a PASRR Level II who have a suspected SMI and are suspected of having a primary diagnosis of dementia.
- LDH has developed several trainings to PASRR Level II evaluators to better identify individuals with a dementia diagnosis.
- LDH consulting psychiatrist provides an additional professional evaluation for all individuals with a potential primary dementia diagnosis (not just individuals with insufficient documentation) to ensure appropriate diagnosis and differentiation.
- LDH's consulting psychiatrist reviews each individual who has been identified as having or suspected of having dementia to determine if external factors may be causing the dementia.
- LDH has developed a process for reviewing individuals with a dementia diagnosis since the beginning of the Agreement.
- LDH tracks the number of individuals who have been identified through the PASRR Level II process as having dementia and now has a baseline for tracking changes regarding the number of individuals identified as having dementia.

- LDH does not have an existing process to track individuals with a dementia diagnosis which would allow them to re-evaluate whether an individual continues to have dementia but has stated they have developed a plan to revise the Utopia system to collect and track this information.
- LDH does not have a process or information for individuals who receive a dementia diagnosis to receive information regarding community supports and services.

Recommendations

- Continue to track the percent of individuals identified as having dementia against the baseline to determine if changes occurred and if these changes are warranted.
- Ensure the new UTOPIA process is able to track individuals with dementia for the purposes of re-reviewing whether they have a primary diagnosis of dementia.
- Implement the process for re-reviewing individuals with dementia who displayed initial characteristics that may indicate dementia may not be long term. These individuals should be identified and referred for in-reach efforts to determine interest in transitioning.
- Report out on whether the changes that were developed in this paragraph were effective. This should include changes in individuals identified as having dementia and whether re-reviews of the conditions discussed in this paragraph are resulting in fewer ongoing dementia diagnoses.
- Develop a process or information for individuals who receive a dementia diagnosis to receive information regarding community supports and services.

36. LDH will implement changes to its Level of Care determination process to assure that individuals meeting on a temporary pathway eligibility for nursing facility 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 nursing facilities.

Compliance Rating: Met

Discussion and 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 (LOC) criteria for NF placement. NF residents who were admitted per the behavior pathway had no other qualifying condition to meet NF LOC other than SMI. The SME continues to request and receives information from LDH to determine if individuals with a sole diagnosis related to behavioral health (BH) have been admitted to NFs since 2018. Information from the MDS, which is provided prior to admission, collects information on diagnosis, including behavioral health diagnosis. Since the fifth reporting period, the SME has requested and received information from MDS data to identify if anyone was admitted to an NF in CY 2022 who had only a BH diagnosis. The State reports that no individual in this reporting period with a sole diagnosis of behavioral health was admitted to an NF.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- LDH has eliminated the behavioral health pathway for admission criteria into NFs.
- LDH has developed the necessary reports and reporting process for reviewing MDS information to verify individuals admitted to an NF who have a sole diagnosis of behavioral health.
- During the reporting period, LDH reported that no individual was admitted to an NF with solely a behavioral health diagnosis.

Recommendations

- LDH should continue to collect and analyze MDS data at admission to ensure this provision continues to meet the intent of this paragraph.
- LDH should continue to provide the SME with this information for each reporting period.

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 nursing facility 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 nursing facility admission for a limited period is approved by LDH, the approval shall specify the intended duration of the nursing facility admission, the reasons the individual should be in a nursing facility 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.

Compliance Rating: Partially Met

Discussion and Analysis

As indicated in paragraph 34, LDH is in the process of revising the PASRR Level II tool to better collect information regarding the total needs of the individual and enhance decision making regarding whether the needs are such they can be met in the community setting. While the current PASRR collects information on heath, behavioral health, and long-term services and supports, the major focus of the PASRR Level II reviewer is on behavioral health needs and services. The intent of the change in the PASRR Level II process is to incorporate other needs into the recommendation for admission to or diversion from an NF.

As indicated in many of the previous SME reports, LDH has developed a system for authorizing temporary stays rather than long-term "permanent" stays. This allows the State to review the ongoing need for NF services in a shorter period of time. OBH now requires a temporary authorization for all individuals where the PASRR Level II confirms that they have an SMI. For pre-admission PASRR Level II requests, authorization requests do not exceed 90 days (or 100 days for persons approved for convalescent care by LDH). This timeframe does not exceed 365 days for those individuals who are already residing in an NF. As indicated in the last several SME reports, this change in process has resulted in 100% of authorizations issued by the OBH PASRR Level II authority being short-term and requiring continued stay requests thereafter. The SME requested information regarding the percent of individuals in the Target Population admitted since November 2022 who received a short-term authorization request. For this reporting period, the State continues to report that 100% of authorizations issued for this reporting period do not exceed 90 days (or 100 days for persons approved for convalescent care).

The SME continued to be concerned by the length of stay for initial approvals. The State reports that initial authorizations are capped at 90-100 days. The current average length of stay is 96 days, which may indicate that individuals exceed their initial authorization and/or individuals are not transitioned from NFs shortly after admission. Therefore, most of the individuals on the Master List stay in the NF for the full 90 days.

While the Department has taken steps to develop a process for reviewing requests for continued stays, they do not have clear policies for determining the length of subsequent stays. It was the SME's understanding that each individual who meets level of care during the continued stay review process receives a 365-day authorization. However, the State has indicated that approvals for ongoing lengths of

stay are variable. Currently the average length of approval for subsequent continued stay requests is 275 days. There is little change from the seventh SME report.

In the previous report, the SME recommended the Department develop protocols for determining the additional length of subsequent NF stays based on an individual's needs versus a re-review at annual intervals. The Department agrees to this change in re-authorization policy but has yet to develop or implement these policies.

In addition, the SME requested information in the sixth SME report regarding:

- Aggregate information on reasons for admission into a nursing facility for members in the Target Population.
- Aggregate information on reasons for continued stay approvals for members in the Target Population.
- The average length of initial and ongoing approvals (intended duration of the NF admission).
- List of transition barriers for individuals who have requested NF admission and for continued stay.

There is limited information available regarding the reason for an NF admission. Understanding the reasons for admission and ongoing stay will be helpful to determine if additional services and supports should be made available for certain individuals to divert or reduce the length of stay in an NF. As indicated in the seventh SME report, a review of the PASRR Level II tool does not provide specific information regarding the reasons for admission. The Level of Care Eligibility Tool does provide information regarding the various pathways (e.g., skilled rehabilitation, Independent Activities of Daily Living (IADLs), cognitive performance) that may be helpful in discerning the reason for admissions and continued stays for NF placement. In meetings with the State during this period, it was determined that LOCET will not provide the information needed for the purposes of this paragraph. LOCET only provides information if one pathway (versus several pathways) is met and does not provide the major pathway (among several) that was the cause for the admission. The SME will work with the State during the next reporting period to discuss reasonable alternatives to gathering this information.

During this reporting period, OBH has developed and implemented an addendum to the PASRR Level II which is an Evaluation Summary that collects information regarding the service needs (physical, behavioral, and community) that impact the ability for the individual to live in the community. This is a new process and information is not yet available for the SME review during this reporting period.

In the two previous reports, the SME requested additional information from OBH during this reporting period regarding the number and percent of individuals who received specialized behavioral health services identified in the PASRR Level II process while in an NF. The Department has made the necessary changes to the Utopia system and is now able to report what specific specialized behavioral health services were recommended through the PASRR Level II process. The State will report whether these services were provided to these individuals and has provided the SME with the process and format for these reports. These formats should allow LDH to track services recommended by the PASRR Level II evaluator.

Finally, the State has developed the list of barriers for PASRR Level II evaluators to use during the initial pre-admission review. As indicated in previous paragraphs, the State has not implemented the strategies to have PASRR Level II evaluators to identify and report on barriers.

Compliance Assessment
The SME assessment of the State's compliance with this paragraph took into consideration:

- LDH continues to implement a process to initially approve nursing facility 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; however, data provided by LDH indicates that initial lengths of stay are almost 96 days.
- LDH continues to have an authorization process for ongoing stays for individuals that seek a continued stay. The State reports that the average length of stay for these individuals is approximately 275 days.
- LDH does not currently have sufficient information on the reason for an NF admission and continued stay, the need for specialized behavioral health services, the barriers that prevent an individual from receiving community-based services at the time, or the intended duration for continued stays.
- LDH is revising the current PASRR Level II evaluation form and process to better account for the total needs of the individuals seeking admission to an NF.

Recommendation
- LDH should complete the revisions to the PASRR Level II to ensure that the evaluation includes an assessment that an individual's total needs are such they can be met in an appropriate community setting.
- LDH should continue to track authorization for NF admissions to ensure they comport with the 90–100-day requirement.
- LDH should identify a source for collecting and reviewing data regarding reasons for admission.
- LDH should implement the strategy in paragraph 51 for collecting and reporting information regarding barriers that impact the individual's ability to live in the community and develop a strategy to address these needs for CY 2023.
- LDH should report on the percent of individuals who received the PASRR Level II recommended services post admission to an NF.

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

Compliance Rating: Met

Discussion and Analysis
As indicated in previous SME reports, the State has developed a process that requires NFs to submit continued stay requests (CSRs) for continued stays beyond the 90 days of an initial stay, at least 15 days before the authorized temporary admission ends. LDH created policies and criteria for individuals who will be provided a continued stay past the initial 90 or 100 days. The fourth SME report provided a description of the CSR process LDH has developed for individuals in the Target Population and delineates the role of OAAS and OBH. This includes the use of MDS to establish continued 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 nursing facility.

Compliance Assessment
The SME assessment of the State's compliance with this paragraph took into consideration:

- LDH has developed a process to establish a level of care beyond 90-100 days.
- The process is conducted by a PASRR Level II reviewer that is independent of the NF.

39. In addition, LDH will ensure that each individual with SMI who has been admitted to a nursing facility receives a new PASRR Level II evaluation conducted by a qualified professional independent of the nursing facility 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 nursing facility 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.

Compliance Rating: Partially Met

Discussion and Analysis

As indicated in the response to paragraph 34, PASRR Level II reviews are performed by the Medicaid MCOs' Level II Evaluators, licensed mental health professionals who operate independent of the NF and the State.

This paragraph provides several scenarios for an individual receiving an additional PASRR Level II during their nursing facility stay tenure:

- A PASRR Level II is performed by an independent reviewer when a provider requests a subsequent continued stay for an individual (instances where the individual seeks an ongoing stay).
- Annual resident reviews, as required by the Agreement, are being performed on individuals in the Target Population who were admitted to an NF prior to 2018 and for individuals who were admitted after 2018 who did not have a continued stay review during the year. For individuals admitted after the beginning of the Agreement, the PASRR Level II rendered through the CSR process is the annual resident review.
- A PASRR Level II is also done when a nursing facility requests a Level II due to a significant change in an individual at their facility.

The SME requested and LDH provided information regarding the number of individuals in the Target Population who received a PASRR Level II based on each of these scenarios over the past year. As discussed in the sixth SME report, preliminary data from the State identified that approximately 55% of individuals on the Master List had an annual PASRR Level II review in FY 2021. This did not meet the requirement of the Agreement to have everyone in the Target Population in an NF receive an annual resident review.

Since the seventh SME report, LDH has made changes to the Utopia system to report on the above scenarios. Information from LDH on the three scenarios was collected for the time period from July to November 2022. This information indicated:

- 1,811 or 62% received an annual PASRR Level II review.
- 1,161 or 40% received a PASRR Level II review due to a change in condition[2]

[2] The percentage includes individuals who may have received multiple PASRR Level II (annual review and change in condition)

The SME is requesting information regarding the number of individuals who received a CSR during the next reporting period.

Performing these subsequent PASRR Level II evaluations will be necessary to meet the commitment to ensure that everyone in the Target Population receives an annual PASRR Level II and, more importantly, to identify the ongoing specialized behavioral health needs for these individuals. Subsequent PASRR Level II evaluations will also allow LDH to have an additional "touchpoint" with the individual regarding community alternatives and gauge possible interest in transitioning from the NF.

Compliance Assessment
The SME assessment of the State's compliance with this paragraph took into consideration:

- The State has completed the changes to the Utopia system necessary to meet the intent of this paragraph during this reporting period.
- The State had provided initial information regarding two of the three scenarios in this paragraph.

Recommendations:

- Continue to report quarterly to the SME on the number and percent of individuals in each of the three scenarios, including the number of individuals who received a PASRR Level II through the CSR process.
- Identify and address the reasons individuals in NFs are not getting an annual PASRR Level II review.

IV. Transition and Rapid Reintegration

A. Comprehensive Transition Planning

40. LDH will offer comprehensive transition planning services to all individuals in the Target Population who are admitted to a nursing facility 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 nursing facilities at the effective date of this agreement, and (2) the need to identify and transition members of the Target Population admitted to nursing facilities after the effective date of this agreement.

Compliance Rating: Not Met

Discussion and Analysis
As indicated in the previous SME reports, the State has developed an enhanced process for in-reach and transition planning services for individuals in the Target Population in NFs. This process was based off the State's Money Follows the Person (MFP) program and consists of a transition assessment and an Individual Transition Plan (ITP). In addition, the State has developed in-reach processes and protocols to offer transition options and transition planning for individuals on the Master List. Over the past two years (CY 2021 and 2022) LDH has developed and implemented an in-reach process and protocols. These efforts are described in more detail in paragraph 54. As discussed in paragraphs 24-26, individuals who express an interest in moving are placed on the Active Caseload List.

The transition process is generally the same for individuals who were in NFs prior to the Agreement and for individuals in the Target Population who were admitted after the Agreement.

There are three major issues the Department will need to address for meeting the requirements of this paragraph. The first is to ensure that everyone in the Target Population is offered comprehensive transition planning services. The second is to ensure that everyone who is on the Active Caseload List has a Transition Assessment. The third is to ensure that all individuals who have an assessment also have an Individualized Transition Plan (completed or in progress). LDH should ensure the quality of these ITPs to reflect a person-centered planning process that accurately reflects the individuals' desires and needs. The second issue is discussed more thoroughly in paragraph 43.

During the seventh reporting period, LDH created expectations for the timeframe the TCs have to complete the Assessment, develop the ITP, and transition the individual. Specifically, LDH has set the following expectations:

Activity	Expectation
Date of Referral to TC	TC has 3 calendar days to make initial contact with Member once the individual is placed on the Active Caseload List and an OCET is completed.
Date Initial TC Assessment Completed	TC has 14 days to complete the transition assessment.
Date ITP Completed	TC has 30 calendar days to initiate the transition plan from the date assessment was completed.
Proposed Transition Date	TC has 7 calendar days to identify the projected transition date.
Date TC referred to MCO for Community CM	Should be done at least 60 days prior to the projected transition date.

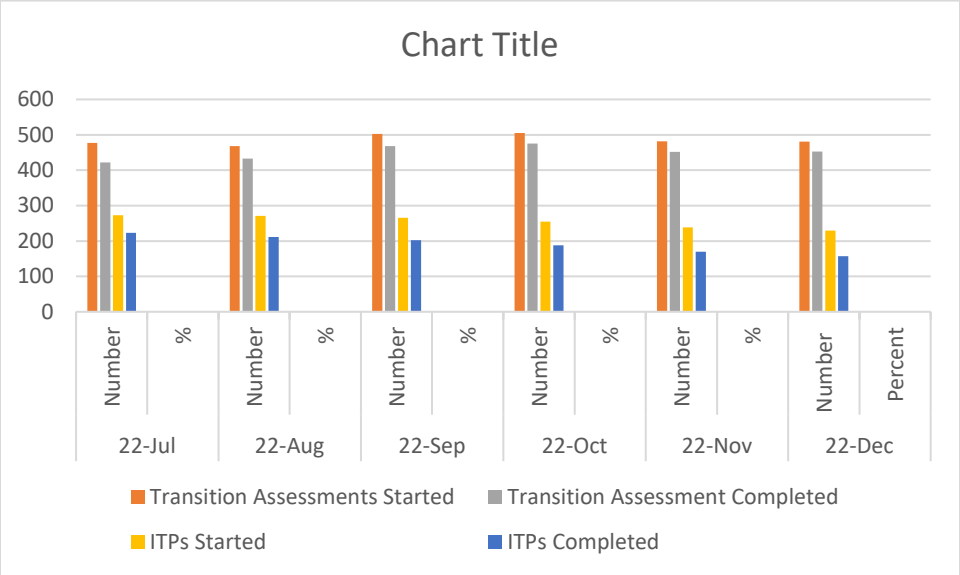
The SME has reviewed these expectations and believes this is a good starting point for LDH to continue efforts to standardize the transition process and should develop a process to monitor these requirements.

The State continues to track whether individuals on the Active Caseload List are involved in the necessary transition activities. The LDH status tracker provides (by region) the following information:

- The number of Transition Assessments started and completed.
- The number of individuals based on Transition Assessments who are no longer interested in transitioning
- The number of Transition Plans started and completed.
- Number of individuals projected to transition.
- The number of individuals that need assistance with housing to successfully transition.

This tracker, in the SME's opinion, provides a very valuable management tool for LDH executive and management staff to determine the progress of transitions and any "bottlenecks" the State may be experiencing regarding transition activities.

As requested, LDH provides the SME with information on a monthly basis. The activities specifically regarding transition planning are presented in the chart below.



A review of this information indicates:

- Approximately 66% of individuals on the Active Caseload List have started an assessment.
- The number of individuals with a completed assessment has continued to increase during the reporting period (from 55% to 65%).
- However, less than 40% of individuals have initiated an ITP and approximately 25% of all individuals have a completed ITP.

The reported ITP development is generally lower than the previous reporting period. LDH states the addition of a significant number of individuals on the Active Caseload List resulted in delays in ITP development.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- LDH has not yet offered transition planning to everyone in the Target Population. LDH is actively working on engagement and transition activities for the 774 people on the Active Caseload.
- As discussed further in paragraphs 43 and 44, current transition planning services are not comprehensive, as the ITPs do not address many important details.
- LDH has developed the expectations for TCs to complete the Transition Assessment and ITP within timeframes the SME finds acceptable.
- LDH has developed tracking tools to identify the number of individuals who have a Transition Assessment and ITP.
- The percent of individuals who have a completed assessment increased slightly during this reporting period.
- Almost 60% of individuals on the Active Caseload List do not have an ITP (in process or completed).

Recommendations

- LDH should ensure that almost all individuals on the Active Caseload have a completed Transition Plan the next reporting period. The SME understands that some individuals who are very recently placed in the Active Caseload List over the next six months will likely not have an ITP (in progress or completed).
- LDH should provide the SME information regarding the percentage of TCs that are meeting the timeframe expectations regarding completed Transition Assessments and ITPs and what the plan is to ensure TCs comply with these timeframes.

41. If the State becomes aware of an individual in a nursing facility 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.

Compliance Rating: Partially Met

Discussion and Analysis

As indicated in previous SME reports throughout the course of this agreement, many individuals have been placed on the Master List because MDS data indicates they should have a Serious Mental Illness, but they did not receive a PASRR Level II evaluation to confirm this diagnosis. Consistent with the provision of this paragraph, the State must refer these individuals for a PASRR Level II. The Level II evaluation should confirm whether the individual had an SMI as initially identified through MDS data and verify they are a member of the Target Population. LDH provided information for this reporting period regarding the number of individuals who were placed on the Master List when an MDS indicated they may have SMI. Specifically, there are individuals who were currently in an NF and a change in medical condition prompted an MDS, where the MDS indicated an individual may have SMI. This information indicated:

- 70 individuals during the reporting period who were residing in NFs were identified as having a potential SMI and referred for a PASRR Level II evaluation.
- 45 individuals or 64% received a PASRR Level II evaluation.
- 25 individuals or approximately 56% of these individuals had an SMI based on the PASRR Level II evaluation.
- The average length of time between identifying if an individual had an SMI (through the subsequent MDS) and the receipt of a PASRR Level II evaluation was 55 days.

Ensuring a prompt PASRR Level II for all individuals with a potential SMI who are admitted to an NF is an important practice, and it is necessary to meet the terms of the Agreement. Information from the Level II may suggest that an individual should be included in the Active Caseload and prioritized for transition. Based on this information, 36% of individuals who had a potential SMI did not receive a PASRR Level II to confirm their diagnosis. LDH has significantly reduced the length of time for an individual who was identified through the MDS process as needing a PASRR Level II. It took slightly less than two months for an individual to receive a PASRR Level II evaluation from the date of referral. In the previous reporting period, there was a five-month lag time between the MDS assessment and the PASRR Level II evaluation. However, the number and percent of individuals who did not receive a PASRR Level requires additional focus on ensuring individuals receive a PASRR Level II on a timely basis. In the seventh report, the SME recommended that LDH develop and track timeframe expectations for individuals identified through subsequent MDS to receive a PASRR Level II. LDH has developed these timeframe expectations. These PASRR II evaluations are to be completed within 30 days of an individual being identified as having a possible SMI.

Compliance Assessment
The SME assessment of the State's compliance with this paragraph took into consideration:

- LDH continues to make progress to ensure that every individual in the Target Population receives a PASRR Level II.
- LDH has not performed a PASRR Level II for a significant portion of individuals who were identified post admission during the reporting period as having potential SMI to confirm their diagnosis.
- While LDH has reduced the length of time for an individual to receive a PASRR Level II evaluation from the date of referral when they have a potential SMI, the two-month period is still too long.
- LDH had developed the expectation that all PASRR Level II evaluations will be completed within 30 days of an individual identified as having a possible SMI.

Recommendations

- LDH should continue to track and report the number of individuals who are in an NF and have subsequently been identified through the MDS process as having an SMI.
- LDH should continue to track and report the number of individuals who are in an NF and have subsequently been identified through the MDS process as having an SMI and have received a PASRR Level II evaluation.
- LDH should develop and track timeframe expectations for individuals identified through subsequent MDS to receive a PASRR Level II.
- LDH should reduce the percent of individuals who do not have a PASRR Level II evaluation and have recently been identified as having a potential SMI.

Transition Teams

42. LDH shall form transition teams composed of transition coordinators 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 transition coordinators 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 nursing facilities as well as trends in nursing facility 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 nursing facilities. The addition of OBH transition coordinators to the State's existing transition framework is to assure that the comprehensive transition plan fully identifies and addresses behavioral health needs. OBH transition coordinators shall facilitate medically necessary community behavioral health services for members of the Target Population whose behavioral health services are covered under Medicaid. Similarly, OAAS transition coordinators 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 transition coordinators shall provide this same assistance for members of the Target Population who have a co-occurring developmental disability.

Compliance Rating: Partially Met

Discussion and Analysis
The State initially established 18 positions to assist with transitions. The State recruited, hired, and trained all Transition Coordinators (TCs). In FY 2020, the State expanded the number of TCs to 25 individuals;

OAAS has 16 TCs and OBH has 9 TCs. During this reporting period, the State added two TC positions (one for each office). In addition to the TCs, OBH and OAAS have 7 positions to supervise TCs.

TCs are responsible for working with individuals on the Active Caseload List to assess their community-based needs (including behavioral health needs) and for working with the individual and informal and formal supports to develop a transition plan. They are responsible for facilitating referrals for individuals who are transitioning from nursing facilities to community-based services. TCs are also responsible for regularly scheduled follow up visits for individuals for one year post transition. This includes follow up visits 30, 60-, 60-, 180- and 270-days post transition or discharge. The State reports 871 out of XX individuals who have transitioned within the last year or on the Active Caseload List awaiting transition have been assigned a TC.

At the beginning of the Agreement, LDH reviewed information regarding the number of individuals in the Target Population who had a co-occurring intellectual and/or developmental disability (ID/DD) to determine if additional TCs were necessary for the Office for Citizens with Developmental Disabilities (OCDD). There were 22 individuals with co-occurring SMI and ID/DD. During this reporting period there were 23 individuals with co-occurring SMI and ID/DD, with 8 on the Active Caseload List and 15 on the Master List. The State has continued their decision not to have specific TCs for ID/DD and to coordinate with OCDD program staff for services potentially needed by these individuals. LDH has indicated that it would revisit the need for OCDD Transition Coordinators if the number of individuals with ID/DD and SMI increased.

In the sixth report, the SME recommended LDH reassess its TC capacity. The SME noted various factors that LDH should consider when reassessing this capacity. In addition, the SME recommended LDH use newly developed management tools (and any other information) to determine whether the existing TCs can serve more individuals on the Active Caseload List or if the department will need to add staffing to transition individuals on the Active List from NFs (which was recommended in the sixth report). This additional capacity could include additional peer specialists, transition coordinators, or even community case managers who are to engage individuals within 60 days of transition.

The State has not hired or contracted with additional Peer Specialists who can support TCs and CCMs in their efforts to transition individuals. Rather, LDH reassessed the current TC capacity and decided to increase caseload ratios for TCs to have all individuals on the Active Caseload List in NF be on a TC caseload. The State reports that as of December 1, 2022, there are 774 individuals on the Active Caseload in NFs awaiting transition.

In order to have all individuals on the Active Caseload assigned a TC, the Department increased the caseload size from an average of 25 to 45 individuals for CY 2023. The increase would allow approximately 1200 individuals to be on the TC caseloads (assuming a full complement of TCs). This increase was based on the following factors:

- Transition Coordinators will no longer provide intensive case management for the vast majority of individuals who have transitioned and can re-focus efforts to perform transition activities (in-reach, transition assessments, and ITPs). TCs will continue to perform ICM for individuals who lose Medicaid eligibility at transition or within the 12 months post discharge from the NF facility.

- Previously, a number of the individuals on the Active Caseload List were placed on the list without going through the formal in-reach process that identified their interest in transitioning. Therefore, TCs needed to perform multiple in-reach visits to gauge the individual's interest to transition. The current Active Caseload has fewer individuals who require this in-reach and allows the TCs to focus on initiating transition activities.
- TCs' efforts to locate and secure housing will now be more supported by Tenancy Support Managers who will undertake various activities, including identifying housing, assisting the individual to complete a housing application, and facilitating some pre-tenancy support activity.

In its 2023 Implementation Plan, LDH committed to transition 350 individuals in CY 2023. This would still mean that approximately 55% of the individuals currently on the Active Caseload would not transition in CY 2023. If LDH meets its goal, up to 423 individuals who are on the Active Caseload List will likely remain in NFs past 2023, underscoring that many individuals who have indicated they are, or may be, interested in moving in the near term will not be offered transition assistance by the TCs over the next six months.

The SME recommended more proactive oversight of transition planning activities to assist LDH in setting and meeting reasonable transition expectations. LDH has specific expectations for the number of transitions each region must accomplish annually and began tracking each region's performance. The tracking information includes data on the number of transitions projected and completed per month. It reflects the progress on transitions and identifies, by region, whether LDH is meeting its transition targets. The tracking information reveals that there is still unevenness in the number of transitions per region. The SME continues to discuss this issue with the State and suggested further analysis for this variation in the number of transitions per region. LDH has identified the variability may be to several factors, including:

- The report is designed to identify where the individuals transitioned to rather than the region the individuals was residing while in the NF.
- Some regions (e.g., Region 5) have a much lower volume of individuals who are interested in transition.
- TC turnover also impacts the number of individuals transitioned by region.

While the SME understands these factors may explain the variability, LDH is encouraged to track as part of its internal management strategy information by TC (rather than region) and specifically the number of individuals each TC transitioned during the year to identify variability in any TC transition approach.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- LDH has developed transition teams that are composed of transition coordinators from OAAS and OBH, who are responsible for assessing, planning, and facilitating access to necessary community-based services.
- LDH has developed a strategy for addressing transitions for individuals with a co-occurring intellectual or developmental disability and a behavioral health condition.
- LDH has developed better management tools for meeting the transition targets established by the Department.
- LDH has hired some additional staff for transition purposes.

- LDH has reviewed and adjusted caseload sizes for each Transition Coordinator so that every individual on the Active Caseload List in an NF will be assigned a TC. This is a substantial increase in caseload size from previous years.
- Despite the change in caseload size, there are a number of individuals who will not transition in CY 2023. The current projections for CY 2023 are that 350 individuals will transition and therefore over 420 individuals will remain in NFs without additional transition capacity. This number does not account for additions to the Active Caseload based on in-reach.

Recommendations

- The Department should assess the "doability" of the new caseload size for the TCs. This will include some of the recommendations below (timeliness of transition activities) as well as the quality and frequency of the contacts between the TC and individual on their caseload.
- The Department should ensure that transition activities (e.g., assessment and ITPs) are performed within the timeframes discussed in paragraph 40.
- LDH should reconsider additional peer supports or other staff to assist TCs with various transition activities. This would support LDH's decision to have TCs have higher caseloads.
- Continue to assess information on the number of individuals with ID/DD over the past several years to determine if the current approach for assigning TCs continues to make sense.
- Continue to track internally transition information by TC to assure either that TCs are complying with the expectation or the expectation needs to be adjusted (and therefore the number of transitions need to be adjusted).
- Ensure all individuals on the Active Caseload List who have an ITP have a projected timeframe for transitioning.

Transition Planning

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

Compliance Rating: Not Met

Discussion and Analysis

This discussion addresses paragraphs 43 and 46 together. Since the beginning of the Agreement, LDH has developed ITPs based on a standardized assessment that is completed prior to discharge. The State has made revisions to the assessment and ITP over the past several years to be more person-centered and to gather additional information regarding individuals' interests and desires about integrated day opportunities. The assessment and ITP, as revised, also provides more specificity regarding the housing options that are available in the community post-transition.

Ultimately, as required by this paragraph, all members of the Target Population should have an Individualized Transition Plan in order to truly envision their options for community services. LDH has focused its initial efforts on developing ITPs for members of the Active Caseload. However, not everyone on the Active Caseload has an ITP. As indicated in paragraph 40, 25% of these individuals have a completed ITP. In addition, the ongoing SME Service Review conducted during this period's service review identified

that all individuals in the sample had a transition assessment. However, 8 of the sample of 11 individuals in NF participating in the service review this reporting period and on the Active Caseload List do not have an ITP. It should be noted that these individuals had assessments that were completed after 60 days or longer and would have been expected to have an ITP according to LDH requirements.

The service reviews conducted during this reporting period evaluated the quality of assessment and ITP. In contrast to previous reviews, the transition assessments were much improved for the sample (11) of individuals on the Active Caseload List reviewed during this reporting period. For almost all of the assessments reviewed, information regarding the individuals' needs in all domains was identified. This was in contrast to previous reviews where information for critical domains (employment, community integration) was either lacking or insufficient.

Similar to previous service reviews, the quality of the ITPs varied. Similar to previous reviews:

- The transition plans did not specify the amount, frequency, and duration of services post-transition.
- The transition plans did not accurately reflect and address all of the individuals' needs and desired outcomes.
- The transition plans did not identify all appropriate services and supports. For instance, very few ITPs identified natural supports or other informal supports.
- Few ITPs reviewed included employment or community integration goals and services to support these goals, which is a shortcoming in the current assessment process.
- There was a lack of clarity as to whether the individual had an active role in choosing where they would live post transition.

Over the reporting period, LDH reports they continue to implement several strategies recommended by the SME. LDH reports they continue to provide training and technical assistance through supervision to TCs regarding important areas established in the Transition Assessment, including identifying services and supports that will enhance community integration (including employment) and medication information and adherence. LDH has also contracted with an individual who will work with the TCs on-site to improve their efforts to perform assessments and develop person-centered transition plans.

The service reviews conducted this reporting period continue to identify services that were identified in the ITP that were not immediately available at transition. Both Community Case Managers and TCs indicated that a number of transitions were not smooth, mostly because community providers who were originally identified in the plans were not available during the first few weeks of the transition. This required the TC and CCM to immediately identify an alternative provider or develop other strategies to bridge the gap until these supports were available.

The SME also recommended in the sixth report that LDH should develop strategies to enhance the acumen of TCs to identify and address physical health conditions and resources during the transition process to ensure the individuals who are transitioning have the resources in place to address their physical health needs. This was not developed during this reporting period.

Over the past few reporting periods, the SME requested the existing ITP be revised to include detailed information regarding scope, amount, and duration of community services and supports that will be provided to individuals at transition. LDH has begun to initiate changes to the ITP document that will capture information on ongoing services and supports that will be needed post transition until the CCM

can work with the individual to develop a community plan of care. LDH reports this process will be initiated the next reporting period.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- LDH has not developed an ITP for each member of the Target Population who is residing in a nursing facility. In the most recent service review, ITPs were not developed for 73% of the individuals on the Active Caseload.
- All individuals reviewed as part of the sample had a transition assessment and the quality of these assessments were markedly improved.
- ITPs continue to still not address many of the important details required by paragraphs 43 and 46.
- The SME requested revisions to the existing ITP form to include detailed information regarding the amount and duration of services. LDH is in the process of developing an amendment to the ITP to include this information.

Recommendations

- Ensure all individuals who have a transition assessment have an ITP within the timeframes established by the Department.
- Implement the revisions to the ITP form to better identify services and supports that are needed and linked to the individual's goals at transition and for the first 30 days post NF discharge.
- Ensure that the ITP includes information regarding the appropriate amount and duration of services initially identified for at least the first 30 days post-discharge.
- LDH should develop training and other materials for TCs and CCMs regarding this addendum to ensure implementation during the next reporting period.

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.

Compliance Rating: Not Met

Discussion and Analysis

This rating has changed from Partially Met to Not Met. During the fourth reporting period, the State, in collaboration with the SME's team, revised its training materials related to person-centered transition planning. These new training materials specifically reframed the approach for TCs, MCO case managers, and other providers for engaging the individual during the assessment process (focusing on strengths and needs versus diagnoses and barriers) and for developing a meaningful process for working collaboratively with the individual to develop a transition plan. The State and the SME team provided trainings to the TCs regarding person-centered assessments and planning. The SME recommended LDH validate the effectiveness of this training on the quality and the person-centeredness of the ITPs in this reporting period. This validation did not occur, and the service review indicated the quality of the ITPs did not improve this period.

Previously, the SME service reviews found the quality of the assessments and ITPs were generally poor, but the process used for developing plans had some components of a person-centered approach. However, during this period's service review, the lack of ITPs discussed in paragraph 43 precluded the ability of the SME service review efforts to determine if the ITPs were developed using a person-centered approach.

In response to the SME's previous requests, LDH continues to provide the SME with information regarding the process deployed to allow individuals an opportunity to view potential housing options and the surrounding community, to better envision their lives post transition. These do not include in-person visits to the housing options. Rather, the TC and/or the LDH Housing Coordinator will provide photos and videos of these options.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- The lack of ITPs for many members of the Target Population and the quality of the ITPs did not provide the necessary information to determine if transition planning was performed consistent with a person-centered approach.
- LDH does not offer opportunities for individuals to visit community settings. While photos and videos may be useful to begin the housing search process, these are not sufficient proxies for in-person visits to prospective housing opportunities.

Recommendations

- LDH should implement the recommendations in paragraph 43 to ensure ITPs are developed and are high quality.
- Given the turnover in TCs, and the hiring of the additional TCs and TC supervisors, LDH should consider a retraining for TC staff regarding person-centered planning using the modules developed in CY 2020.
- LDH should develop in-person opportunities to review housing and other community opportunities prior to transition.

45. The process of transition planning shall begin within three working days of admission to a nursing facility 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 nursing facilities as of the Effective Date.

Compliance Rating: Not Met

Discussion and Analysis

The State does not currently have a real-time way to identify when individuals are admitted to a nursing facility. Therefore, the State is not able to meet the 3-day and 14-day requirements in this paragraph. Based on work that the State has set forth in its implementation plan for CY 2021, the State was to have this much-needed functionality in place by October 2021. However, based on contract delays, LDH has stated the tracking system will likely not be operational until CY 2023. The State indicates they are developing a staffing plan and process for meeting the requirements of this paragraph.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- The State has not developed the necessary functionality to meet the requirements of this Agreement.
- The State has begun to develop a staffing plan for meeting the 3-day and 14-day requirements of this paragraph and states it will be implemented during the next reporting period.

Recommendations

- Implement the contract that will allow the provisions of this paragraph to be met.
- Provide the SME with a reporting template the State will use to be able to track the 3-day and 14-day requirement.
- Provide the SME with details regarding the specific process for how contact will occur at both the 3-day and 14-day timelines. Specifically, the process should address:
    - Who will provide the 3-day and 14-day contacts?
    - How will these staff be notified of new admissions to ensure there is contact within three days?
    - What will be the purpose of the contact and an outline of what should occur during the first contact—specifically if this will be an initial introduction and/or beginning of an assessment process.
    - How will the content of these contacts be assessed?
    - How will LDH ensure that contacts are occurring within these timeframes?
    - What is the disposition of these contacts (e.g., immediate discharge, placement on Active Caseload List, etc.)?

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.

Compliance Rating: Not Met

See the response to Paragraph 43.

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.

Compliance Rating: Partially Met

Discussion and Analysis

At the beginning of the Agreement, the State did not have a community case management strategy for individuals transitioning from NFs. During the last reporting period, LDH implemented a case management approach that relies on a community vendor (e.g., Merakey) under contract to the MCOs to provide community case management. As stated in the seventh SME report, LDH developed Standard Operating Procedures (SOPs) that provide an approach for how community case managers (CCM) will interface with the TCs. Specifically, the SOPs require:

- The CCM to collaborate with the individual's assigned TC, as well as the MCO, to develop a transition plan and secure providers, resources, and supports in the community that will begin immediately upon the member's transition to the community.
- The CCM to attend transition planning meetings with the TC and the individual.

During the SME Service Reviews conducted during this reporting period, the SME Service Review 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. As indicated in paragraph 59, CCMs had individuals on their caseloads who were in the process of transitioning from an NF or who had already transitioned from the NF and were previously receiving intensive case management from the TC. The SME service review found:

- Of a sample of ten individuals participating in the service review and assigned a CCM prior to transition, seven had documentation of CCM's participation in the transition planning meeting.
- Of the five individuals who were receiving intensive case management from a TC and were subsequently assigned a CCM, four individuals had information in their records that the TC and CCM were in contact during the initial phase of this "warm handoff."

The documentation did not include information regarding ongoing meetings between the CCM, TC, other providers, and the individual to review and update the plan of care. As recommended in the initial service review and as required in the SOP, LDH should ensure that CCMs coordinate care plan meetings per LDH policy and ensure the TC is invited to these care planning meetings. As indicated in paragraph 49, the TCs are required to be engaged in an oversight capacity with the individual for twelve months post transition from an NF.

In paragraph 43, the SME recommended that ITPs or other pre-transition planning documents (e.g., CCW plans) identify the services and supports that should be available to individuals for the first 30 days post discharge from an NF. The plan should specifically identify the services and supports needed and the organization responsible for providing these services and supports. As indicated in that paragraph, the ITP does not have a short term (30-day plan) for initial community-based services. This short-term plan is needed given that the CCM is required to do an assessment and develop a plan of care within the 30 days post transition that will more clearly address the needs of the individual as they re-enter the community and additional needs and desires are identified.

As discussed in paragraph 43, LDH is in the process of developing an addendum to the ITP that will identify the services, support (including natural supports), and providers needed and requested by the individual during transition planning meetings. LDH states they will incorporate this addendum into the ITP process during the next reporting period.

Compliance Assessment
The SME assessment of the State's compliance with this paragraph took into consideration:

- The sample review showed the CCM was involved in the transition and transition planning process for most individuals 60 days prior to transition.
- Documentation from logs, notes, and interviews indicated TCs and CCMs have contact when the TC is transferring the individual from intensive case management offered by the TC to ongoing case management offered by the CCM.
- At the point of transition, individuals do not have a community plan of care in place with necessary services authorized for the first 30 days. LDH is in the process of developing an addendum that will identify services and supports that are needed for 30 days post transition. This plan will be helpful to the CCM in their efforts to work with the individual to develop a community plan of care within 30 days post discharge.
- The CCMs do not generally have team meetings to update the community plan of care.

Recommendations
- LDH should implement the requirements in the SOP that require ongoing team meetings post-discharge to address changes to the individual's plan of care.
- LDH should finalize the addendum to the ITP to address services and supports needed and desired 30 days post discharge as indicated in the discussion of paragraph 43.

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

Compliance Rating: Met

Discussion and Analysis
LDH required MCOs to develop internal protocols to link members transitioning from nursing facilities or diverted from nursing facility care immediately to community case management agencies and to ensure the PASRR II evaluators make an immediate referral for community case management services. The State has provided information on the SOP that provides detail on the process MCOs use to refer individuals who were transitioned or diverted to CCM on a timely basis. The State implemented this process in March of 2022. The State has developed a tracking system that provides information regarding the timeliness of these referrals and engagement status post referral.

Compliance Assessment
The SME assessment of the State's compliance with this paragraph took into consideration:

- The State has defined, developed, and implemented a process for providing CCM to support individuals in the Target Population who have transitioned or been diverted from NFs.

Recommendations
- As recommended in paragraph 47, LDH should ensure the process for assigning CCM is consistent with the policies and procedures outlined in the SOP.

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.

Compliance Rating: Partially Met

Discussion and Analysis

LDH requires TCs to conduct post-transition follow-up to determine if the individual was receiving services in the community and to generally identify any issues an individual had during the first year of the transition. Specifically, LDH requires TCs to perform post transition assessments at 30, 60-, 90-, 180-, and 365-days post transition. The State developed the necessary protocols and trackers to collect this information. The State reports TCs use the same contact log as currently used for intensive case management that will collect data similar to the CCMs from the individual, as an additional strategy to check-in with individuals who were transitioned and also a strategy to validate information being collected by the CCM. The State has not developed a similar process for individuals diverted from NFs.

In the sixth report, the SME recommended LDH should increase the management staff that are overseeing TC activity to address issues identified during and post transition more effectively. LDH has added an additional two staff members to oversee the My Choice Program, which allows current staff responsible for managing TCs to focus on those activities.

In the seventh report, the SME recommended LDH develop an oversight process to ensure post-discharge reviews are being conducted by the TC with the cadence established by the Department.

In addition, the SME recommended LDH develop a process for reviewing the quality of the post-discharge contacts, ensuring that information from these follow-ups provide enough information for LDH to review and act on any concerns being identified by the TC, including a process to report this information to the CCM organizations. The Department has not developed this strategy.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- The State has developed the necessary policies and tools for conducting post-transition follow-up.
- Consistent with the SME's recommendation, LDH has added My Choice Program management staff that will allow staff that oversee TCs to focus on ensuring follow-up activities are implemented within the LDH timeframes and review the quality of these follow-up activities.
- However, LDH has not developed the recommended strategy to review the quality and cadence of the follow-up activities. As a result, the SME has yet to determine whether these follow-ups are sufficient to "assure that services in the community are initiated and delivered to individuals in a fashion that accomplishes the goals of the transition plan."
- There is no similar post-follow-up strategy for individuals who are transitioned and for individuals who are diverted from NFs.

Recommendations

- Develop a process for staff overseeing TCs to include a review that post-discharge reviews are being conducted with the cadence established by the Department.
- LDH should build in a review of the quality of the post-discharge contacts, ensuring that information from these follow-ups provide enough information for LDH to review and act on any concerns being identified by the TC, including a process to report this information to the CCM organizations.

- Develop a follow-up process for individuals who are diverted from NFs.

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.

Compliance Rating: Partially Met

Discussion and Analysis

Historically, some individuals who are transitioned from NFs are at risk of losing Medicaid eligibility when transitioning to the community. Medicaid has more generous income limits for individuals who meet the level of care for a nursing facility than those who reside in the community. Since the beginning of the pandemic, Congress prevented states from removing Medicaid recipients from the Medicaid program. It is anticipated this requirement will end in CY 2023. LDH continues to track individuals who may lose Medicaid when these pandemic policies are lifted. During this reporting period, no individuals who transitioned into the community were at risk of losing Medicaid eligibility post transition due to the federal pandemic policy that require states to continue eligibility for most individuals previously enrolled in the Medicaid program during Covid-19.

As recommended in previous SME reports, LDH should develop clear pathways for making referrals for these individuals to LGEs for follow-up services, especially as Congress removes the current pandemic policy regarding eligibility. In the previous report, the SME also requested information on whether individuals who have lost Medicaid prior to the pandemic were referred to LGEs and, if available, any information regarding their engagement in services provided or coordinated by the LGE. The State has not provided this information. The SME continues to request this information.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- The State tracks individuals who would have lost Medicaid eligibility if pandemic policies were not in place.
- The State has not provided the pathways for referrals to the LGE and other local agencies (e.g., Federally Qualified Health Centers).

Recommendations

- LDH should develop a referral protocol to other community providers (e.g., LGEs and FQHCs) prior to the end of eligibility coverage under the pandemic.
- LDH should require TCs and CCMs to consistently assess individuals' eligibility for the Medicaid Purchasing Plan and facilitate the referrals when the pandemic coverage ends.

51. For members of the Target Population who are eligible to remain in the nursing facility 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.

Compliance Rating: Not Met

Discussion and Analysis

In the seventh report, the SME recommended LDH should develop an approach that ensures all individuals on the Master List receive in-reach using the revised approach. LDH reports that of the 2,904 individuals on the Master List, about one-half have not been contacted using the revised in-reach process discussed in paragraph 54. This includes individuals newly added to the Master List (new NF admissions and individuals identified through subsequent MDS information) and individuals who were transferred from the Active Caseload List to the Master List. LDH has stated they will prioritize these individuals for in-reach using the revised process over the next calendar year.

While LDH has developed a formal in-reach process, the State is just beginning efforts to identify and address barriers to community living for individuals in NFs on the Master List. The State has developed a list of barriers to be used by in-reach staff in their engagement with individuals who are undecided regarding transitioning, who are not interested in transitioning, or who are unable to make a decision regarding transition. LDH has developed a tailored list of barriers for each of these scenarios. LDH has also developed a list of potential strategies to be deployed to address these barriers. The SME has reviewed and provided recommendations regarding these lists of barriers and potential strategies.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- The State has not contacted everyone on the Master List using the revised in-reach process.
- The State has not implemented the necessary steps to collect information regarding the barriers to transition for individuals on the Master List who may be undecided or are not interested due to these barriers, or to ensure that the individual's decision is meaningful and informed.
- The State has yet to develop a streamlined process for addressing these barriers.

Recommendations

- LDH should require in-reach staff to identify and submit information on barriers to transitions identified through the in-reach process.
- LDH should develop a streamlined process for reviewing and addressing barriers identified though in-reach.
- At the individual level, LDH should document efforts to identify and address barriers to community living and to ensure a decision to remain in the nursing facility is meaningful and informed.

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.

Compliance Rating: Not Rated

Discussion and Analysis

This paragraph will not be rated, given it is the responsibility of the SME to perform the review of individuals who have requested alternative settings for transition. This provision sunsetted in June 2020; however, the State continues to report and review these requests with the SME. The SME developed a

protocol and process to meet the requirements of this paragraph. During this evaluation period, LDH reported no members of the Target Population expressed an interest in transitioning from an NF and requested to be transitioned to a setting other than their family's home or their own housing (single family home or apartment).

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

Compliance Rating: Not Yet Rated

Discussion and Analysis

As noted below, LDH has determined 17% of individuals contacted during the in-reach process are unable to make a decision about transition. LDH must develop procedures to ensure these members of the Target Population have the supports needed to make an informed choice about where they want to live and receive services. In addition, LDH continues to report that Transition Coordinators during the early phase of transitions have identified individuals who may present issues relative to safety in the community (e.g., cognitive issues that may be difficult to address in the community). These individuals have been referred to the Service Review Panel that reviews various documentation to determine if safety issues identified are valid. In addition, the State reports the Transition Coordinators engage the individual's MCO to obtain additional evaluations/assessments to identify or ameliorate concerns that may have been identified as a barrier to transition.

In the fourth report, the SME requested information from the State to better understand how the provisions of this paragraph are operationalized. While this continues to be a request, the State has focused efforts on other areas. As indicated in the sixth report, the SME will work with the State to obtain and review this information in the next reporting period.

B. Outreach and Transition for Target Population Members in Nursing Facilities

54. Within dates to be specified in the Implementation Plan, LDH will analyze MDS data to identify members of the Target Population residing in nursing facilities. 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.

Compliance Rating: Partially Met

Discussion and Analysis

Paragraphs 54 and 89 are addressed together. As indicated in the sixth report, the SME notes that the terms "outreach" and "in-reach" are both used in this Agreement to describe the activities at issue in this provision. However, LDH policies and documents use the term "in-reach" to describe such activities. These include efforts to engage with individuals who are in the Target Population in NFs to discuss their interest in moving, assign them to either Master or Active Caseloads, and begin the transition assessment and ITP processes. For clarity, the SME uses the term "in-reach" to describe such activities throughout this report. The SME uses the term "outreach" to describe efforts to engage with community stakeholders.

Pursuant to paragraph 89, within six months of the execution of this Agreement, LDH was to develop a plan for ongoing in-reach to every member of the Target Population residing in a nursing facility.

Consistent with the requirements in this Agreement, LDH must regularly inform members of the Target Population about the community-based services and supports that can be alternatives to nursing placement, using a variety of strategies, so that they may make meaningful and informed decisions about where to live and receive services.

In the first several years of implementation, the State's in-reach activities focused on members of the Active Caseload. As indicated in the response to Paragraphs 24 through 26, LDH developed a list of individuals in the Target Population who resided in NFs using information provided by the PASRR Level II evaluation or the MDS. As these paragraphs indicated, individuals are either included in the Master List or Active Caseload List. The State's initial processes for adding people to the Active Caseload are discussed in Paragraph 55. Transition Coordinators were responsible for conducting conversations about transition with those on the Active Caseload.

Recognizing the need to enhance in-reach efforts and ensure better engagement with all members of the Target Population in NFs, LDH developed an initial in-reach strategy to engage with every member on the Master List at least once between April 2021 and March 2022. Within the Office of Behavioral Health (OBH) regional Peer In-reach Specialists (PIRSs) were hired to work in tandem with the TCs across program offices. As a result of in-reach enhancement, the PIRSs are the primary resource accessed to visit individuals in the nursing homes, gauging interest in transitioning into the community and providing education and information regarding community living, advocacy, and support to members related to transitioning. Assertive engagement mechanisms are utilized in conjunction with the PIRS's personal experience, modeling recovery in action to perform these in-reach functions.

As discussed in the seventh report, as of March 2021 the Master List included 2,972 individuals. LDH reported that approximately 1,000 of these individuals were admitted after LDH implemented its Continued Stay Review (CSR) process in August 2020. LDH did not prioritize formal in-reach to these individuals in the first year because they should have received some information about community options from a medical certification specialist through the CSR. An additional 1,939 individuals were on the Master List as of March 2021. Over the subsequent year, Transition Coordinators (TC) and Peer Support Specialists (PSS) conducted formal in-reach to those 1,939 individuals.

Of the 1,939 individuals who received in-reach from TC or PSS staff, LDH reported that 478 or 25% of these individuals indicated their interest in moving and were added to the Active Caseload List. 1,461 individuals remained on the Master List. This included:

- 197 or 14% who are undecided about moving.
- 941 or 64% who are not interested in moving.
- For 323 or 22%, LDH has determined these individuals are unable to make a decision about moving, meaning they do not have the ability to make a decision regarding relocation.

LDH has continued in-reach efforts for individuals who remain on the Master List. From May through November 2022, PSS have provided in-reach to 1,484 individuals on the Master List. These are individuals who indicated that were undecided about moving, not interested in moving, or who lacked the ability to make a decision regarding relocation. Of these 1,484 individuals, 436 (29%) indicated they were interested in moving and were placed on the Active Caseload List. This is a 16% increase in the number of individuals

this reporting period who indicated they were interested in moving. However, 1,048 individuals remained on the Master List. This included:

- 221 or 21% of these individuals who are undecided about moving.
- 607 or 58 % of these individuals who are not interested in moving.
- For 220 or 21% of these individuals, LDH has determined these individuals are unable to make a decision about moving, meaning they do not have the ability to make a decision regarding relocation.

In the seventh report, the SME recommended LDH develop a schedule regarding the follow-up in-reach strategy for all individuals in the Master List. The Master List includes individuals who were identified through previous in-reach efforts as:

- Undecided regarding transition. Many of these individuals were originally on the Active Caseload List and indicated they were not sure if they were interested or ready to transition. LDH is requiring in-reach be performed on these individuals on a quarterly basis.
- Not interested in moving during conversations with either the PSSs or PASRR Level II evaluators last year. LDH is requiring these individuals receive in-reach on an annual basis.
- Unable to make a decision. Individuals who may not have the cognitive capacity or other decision-making capacity to transition.

For this reporting period, LDH intends to complete at least one in-reach visit with everyone on the Master List who has not yet been engaged through the new in-reach process. In addition, LDH is prioritizing in-reach efforts to individuals who have indicated they are undecided, including individuals who were recently moved back to the Master List from the Active Caseload List. LDH plans to visit everyone who was moved back to the Master List within 90 days, and to complete at least quarterly visits with those who are undecided. The SME agrees with this approach. Given limited in-reach resources during this period and the foreseeable future, focusing additional efforts on undecided individuals may prove to be a good return on investment of these limited resources.

Currently, 1,263 of the 2,902 individuals on the Master List have not yet gone through the newer in-reach process. These are individuals who were admitted after March 2021.

Further review is needed to evaluate the quality of this initial in-reach effort. There continues to be significant variation among regions regarding the percent of individuals who have indicated an interest in moving. For instance, in Region 7, 51% of individuals provided in-reach indicated an interest in moving, while Region 9 had only 7% of individuals who were interested in moving.

In the seventh report, the SME expressed concern regarding a significant number of individuals (772) who were not interested in transitioning and who were moved from the Active Caseload List to the Master List. The SME recommended LDH should implement a process for enhanced oversight of decisions regarding individuals who are proposed to be removed from the Active Caseload List to ensure these decisions are consistently made using specific criteria. LDH states they have developed and implemented a process for overseeing each recommendation for moving an individual from the Active Caseload List to the Master List. Specifically, the LDH My Choice Integration Coordinator and OAAS or OBH staff responsible for oversight of TC activities review each request for moving someone from the Active Caseload List to the Mater List. This includes reviewing the TC logs and supporting documentation to determine whether the

individual should remain on the Active Caseload List or be moved to the Master List. Information that is used by the Integration Coordinator and TC supervisor to make the decision includes:

- Reviewing original information from the referral that indicated the individual should be on the Active Caseload List (e.g., in-reach documentation, MDS information) to determine if the individual indicated they were interested in moving.
- Identifying the date the individual was added to the Active Caseload List. LDH reports individuals added earlier in the transition process were less likely to want to transition than individuals who went through the formal in-reach process established in 2021.
- Review the TC's efforts to ascertain whether the individual was engaged and made an informed decision regarding transition.
- Have a face-to-face meeting with a sample of individuals recommended by the TC to transition to the Master List.

LDH reports this new process has significantly reduced the number of individuals who are transitioned from the Active Caseload List to the Master List. During the reporting period the number of individuals transitioning back to the Master List is projected to be 150 individuals during this reporting period, rather than 772 individuals last reporting period.

In the seventh report, the SME requested information as to why individuals who were previously on the Active Caseload List are no longer interested or undecided about transitioning. LDH reports there are three major reasons individuals are moved to the Master List. This includes:

- Individuals experienced a decline in physical health and needed this continued level of care.
- Individuals needed 24/7 care and such care was not available in the community.
- Individual was not interested in self-care or medication management for certain conditions (e.g., diabetes).

Effective, individualized engagement is critical to supporting people's informed decisions about whether to transition. As indicated above, TCs were responsible for performing in-reach efforts as part of the Transition Assessment process. These efforts provided individualized conversations to learn about a person's interests, preferences, and service and support needs. The TCs were also expected to have sufficient knowledge of the service array to respond to questions and concerns about transition, and ultimately identify specific options and locations that address a person's needs and preferences.

These individualized conversations are of great import and provide the information needed to support decision-making. Now that LDH is also relying on PIRSs to inform people about their options and assess individual interest in transition, it is important that both the PIRSs and the TCs receive regular training and resources (such as conversation guides) to ensure they can provide meaningful information about community options, respond to concerns, and evaluate people's preferences.

In the sixth and seventh reports, the SME requested LDH develop a subsequent in-reach strategy during this reporting period for individuals who remain undecided or indicate they are not interested. The SME suggested LDH consider specific timeframes for performing in-reach for individuals who remain on the Master List, taking into account that some individuals may benefit from in-reach within a shorter time frame, to encourage transitions. LDH has developed a longer term strategy for ongoing in-reach for individuals who remain on the Master List who are undecided, not interested, or unable to decide about

transition. Specifically, LDH reports they will implement the following strategy and frequency of contact for individuals who are on the Master List and received previous in-reach efforts:

Outcome of Visit	Type of Contact	Frequency of Contact
Undecided	Face to Face	Minimally quarterly
Not Interested	Face to Face	Minimally every six months
Unable to decide	Face to Face	Minimally once a year

Given this cadence, LDH projects they will provide almost 3,500 in-reach visits for CY 2023.

LDH has created expectations regarding the minimum number of contacts per month for each PIRS. Specifically, LDH will require each PIRS to have 40 contacts per month. Each of these visits will be documented through a standardized in-reach log completed by the PIRS after each in-reach visit. As indicated in paragraph 54, PIRSs are also the first wave of staff who will be reporting these barriers in these logs.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- LDH has conducted face to face in-reach with a substantial portion of the Target Population. However, about half of the 2,904 individuals on the Master List have not been contacted using the revised in-reach process.
- The State has developed a longer term in-reach strategy for individuals on the Master List that sets forth expectations regarding frequency of in-reach efforts and monthly contact expectations by the PIRS.
- LDH continues to set and achieve specific targets for each region to provide in-reach to individuals who remain on the Master List.
- LDH continues to track progress of each regional team's in-reach efforts.
- LDH implemented a process for enhanced oversight of decisions regarding individuals who are proposed to be removed from the Active Caseload List to ensure these decisions are consistently made using specific criteria.
- This process has decreased the number of individuals removed from the Active Caseload List and placed on the Master List. LDH has provided the SME with information regarding the reasons individuals were removed from the Active Caseload List and placed on the Master List. They have also prioritized these individuals for more frequent in-reach efforts.
- LDH has developed and implemented strategies for ongoing in-reach for individuals who remain on the Master List and who have indicated they are undecided, have no interest in transitioning, or are unable to make a decision regarding transition.

Recommendations

- All individuals on the Master List should receive an in-reach visit—especially individuals who are relatively newly admitted and have remained in the NF for more than 90 days.
- The State should continue to evaluate the effectiveness of its in-reach strategy to ensure that all members of the Target Population are afforded a meaningful, informed choice about whether to transition.

- The State should continue training efforts for PIRS regarding community options for individuals who are on the Master List and may have questions and concerns about supports that will be available during and after transition.

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.

Compliance Status: Partially Met

Discussion and Analysis

LDH began a prioritization process in July 2018 to identify a cohort of individuals who had fewer transition barriers and thus were more likely to experience a successful transition. The State reports that individuals were initially identified using information gathered from the MDS Q+ index and follow-up conversations with the Transition Coordinators. It is unclear how these processes identified individuals with few transition barriers. Per the SME Service Reviews, a number of individuals did have very few transition barriers; however, several individuals had fairly complex physical health and behavioral health conditions and were also able to transition from the NFs.

In the seventh report, the SME encouraged the State to develop a process for identifying and prioritizing among individuals in NFs those who have expressed an interest in moving. As recommended in paragraph 42, there are several strategies the State could undertake to identify individuals with lower transition barriers who may be moved more quickly. While the State has yet to develop these strategies, they collect and use information to develop strategies regarding future transitions. These decisions include:

- Developing practical targets for transitions for each Transition Coordinator
- Developing policies for community case managers to be involved in the individual's transition planning 60 days prior to transition.
- Identifying strategies to increase more accessible units for the significant number of individuals with mobility issues due to physical health issues
- Developing timeframes and protocols for TCs to engage with individuals to initiate the assessment and ITP process
- Developing a more assertive in-reach strategy to focus on individuals who are undecided or who had been placed from the Active Caseload List to the Master List
- Creating new service opportunities to address the ADL and IADL needs of individuals transitioning who still need some personal care services but who do not quality for existing Medicaid programs
- Reviewing individuals' interest and hobbies that may assist TCs in developing community inclusion strategies for individuals interested in transitioning.

In addition, as indicated in paragraphs 54 and 55, the State is implementing a process to have PIRSs and TCs identify barriers and strategies to address barriers faced by individuals in NFs who may be interested in transitioning.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- The State did garner lessons learned from early transitions to establish better transition policies and practices for future transitions.
- The State prioritizes individuals for the revised in-reach process that prioritizes individuals who may be more likely to transition, focusing on individuals who are undecided or had indicated interest but recently had indicated they were not interested in transitioning.
- The State has begun to collect barrier information from the TCs to provide additional information for LDH to use to improve their transition process.

Recommendations

- LDH should determine whether their efforts to prioritize individuals for in-reach meet the intent of having additional individuals' transition.
- LDH should collect and analyze information on barriers as recommended in paragraphs 54 and 55 to make changes to transition policies and community resources to increase transitions and the timeliness of these transitions.
- LDH should recreate efforts to review individuals' community integration interests to assist the TCs and CCMs to better focus on developing resources that may address these needs when transitioned to the community.

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.

Compliance Rating: Partially Met

Discussion and Analysis

This rating has changed from Not Met to Partially Met. Since the beginning of the Agreement, the State has transitioned 441 individuals. Per the Agreement, the State is required to establish annual targets for successful transitions of Target Population members to the community. As indicated in the five previous SME reports, annual targets should be developed in conjunction with a longer term, aggressive plan for accomplishing "rapid reintegration," consistent with the goals of this Agreement. LDH should set forth a timeline for allowing *everyone* who is able to and would like to transition to the community to do so – with sufficient transition, discharge planning, and community-based services to meet their needs – within a set amount of time.

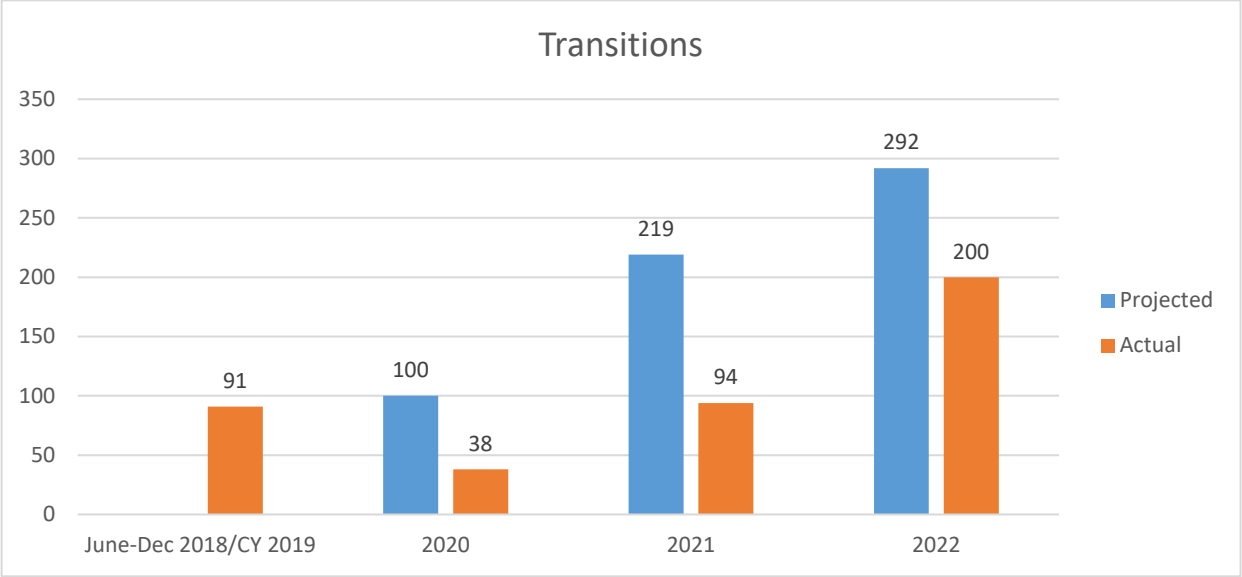
There were several main drivers LDH used to establish transition targets for CY 2022, including:

- The number of individuals in the TP who currently reside in a nursing facility on the Master List and Active Caseload who have indicated they are interested in transitioning via the in-reach process and have confirmed SMI (as indicated by a PASRR Level II evaluation).
- Staff resources (the current number of transition coordinators statewide).
- The average caseloads for Transition Coordinators. The proposed average caseload for the Transition Coordinators was 1 to 25 individuals who are actively working towards transition.
- The percent of individuals with significant transition barriers impacts the number of individuals who will move in a given year. Currently, LDH reports that 23% of individuals have significant barriers that impact moving. This includes individuals who:

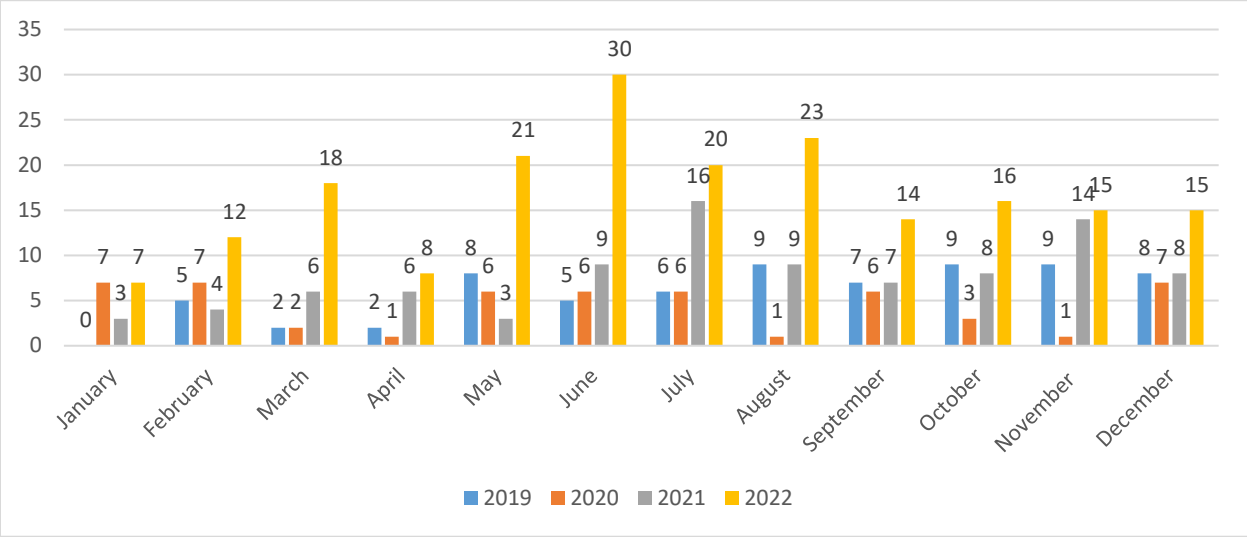
  - Expressed an interest in moving but may have significant legal issues (e.g., felonies or sexual offenses).
  - Have significant health and safety issues (e.g., the level of medical supports may not be readily available in the community where they are choosing to move).
- Length of time from application for the CCW Program to transition for individuals on the OAAS Active Caseload. Currently, this average length of time is approximately four months (down from nine months in 2018) from initial completion of the CCW application to transition. LDH has estimated that one-third of the individuals who apply for the CCW in the last four months of CY 2022 may not have the approval and services and supports in place to transition this coming year.

Based on these assumptions, LDH committed to transition at least 292 individuals in the Target Population from NFs in 2022. As of the end of December 2022, the State has transitioned 200 individuals. While this number is less than what was projected for the year overall, LDH has increased transitions from year to year. The SME is encouraged by this increase in transitions but is cautiously optimistic LDH will maintain the pace of transitions to continue to meet its monthly targets.

The chart below provides a comparison of transition targets versus actual transitions for the first four and one-half years of the Agreement.



The SME continues to review information on transitions across years on a monthly basis. The chart below provides a comparison by month of individuals transitioned from NFs for the full calendar year. This chart continues to indicate good improvement when comparing similar months across years.



It should be noted that LDH has developed and implemented new management tools over the past twelve months that set specific expectations regarding transitions and track whether these expectations are being met. The increase in transitions, while below the target for the year, is generally increasing on a month-to-month basis compared to previous years, indicating these tools may continue to be the catalyst for this increase.

The State developed a methodology to set these longer-term transition targets during this reporting period for FY 2023. The State revised the methodology discussed above to develop these transition targets. The major change in the methodology was an increase in the average caseloads for Transition Coordinators. The proposed average caseload for the Transition Coordinators was 25 individuals and will be increased to 45. LDH indicated this change was due to:

- Newer members being placed on the Active Caseload List who recently expressed an interest in transitioning. In prior years, LDH assigned individuals where documentation indicated they would be likely candidates to transition. Therefore, TCs spent a good deal of time doing in-reach to these individuals to discuss transitioning and in many instances the individual did not express an interest in transitioning.
- TCs no longer performing intensive case management for the vast majority of individuals who were transitioned. In some instances, 20-25% of the TC's time was focused on providing weekly or more frequent contacts with individuals who were transitioned.
- Additional staff resources to provide supervision of TCs to better assist them in their job responsibilities.
- Additional staff resources to assist TCs with time-intensive activities including locating housing and assisting the individual to apply for housing and for assistance with landlords during the transition.

LDH has stated the change in caseload size will allow LDH to assign each individual on the Active Caseload List a TC. The SME has expressed concern regarding the revised caseload size and, as indicated in the recommendations, is requesting LDH to assertively monitor if this change adversely impacts the TCs' efforts and ability to effectively carry out their responsibilities.

The increase in the number of transitions projected in FY 2023 is encouraging and represents a 20% increase over FY 2022 projections. However, if LDH meets the proposed targets for CY 2023, the State will need at least two years to successfully transition current members of the Active Caseload. This number does not account for additional individuals who are likely to be placed on the Active Caseload List during these years.

As discussed in the seventh SME report, the State should re-evaluate staff resources in CY 2023 to transition greater numbers of individuals on the Active Caseload over the next several years. Initially, this Agreement had a five-year horizon for achieving compliance, with transitions from NFs being a foundational premise of complying with this Agreement. At the current pace it will take LDH much longer to achieve compliance. LDH must continue to take action to change course. This should include identifying what additional resources are needed to increase the number of transitions projected long-term rather than projecting transitions based on current staffing capacity.

Finally, in the seventh report, the SME expressed concerns regarding the length of time an individual took to transition. The SME recommended LDH aggressively implement the timeliness standards discussed in paragraph 48 for transitioning individuals on the Active Caseload List. As stated in the previous report, no one should have to wait more than 6-9 months to transition from an NF if they have expressed an interest in moving.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- The State met approximately 68% of the targets for this reporting period; however, the State will not meet the overall target of 292 individuals during FY 2022.
- The State is not on track to accomplish the necessary transitions within the five-year timeframe originally contemplated. It will take the State a minimum of three years to transition individuals on the Active Caseload List or individuals on the Master List who are still undecided about moving. The projected number of individuals on the Active Caseload List does not account for new members of the Target Population who will likely be admitted to NFs over the course of the next several years and who may want to transition in the near future.
- The CY 2023 transition projections are 20% more than CY 2022 projections.
- The CY 2023 projections are still less than the 919 individuals on the Active Caseload List (or soon to be placed on the Active Caseload List) who have expressed an interest in moving.
- While LDH has developed a sounder methodology for projecting transitions, its performance consistently falls short of those projections.

Recommendations

- LDH should review the TCs' activities (timely assessments and ITP development) to ensure the increase in caseload size has not adversely impacted these activities.
- LDH should ensure it has sufficient resources for more expeditious transitions of individuals on the Active Caseload list. Existing assumptions regarding the number of TCs or other staff that

could perform transitions and caseload size should be revisited for future years to improve the timeliness of transitions for all individuals on the Active Caseload List.

- LDH should aggressively implement the timeliness standards discussed in paragraph 48 for transitioning individuals on the Active Caseload List. No one should have to wait more than 6-9 months to transition from an NF if they have expressed an interest in moving.

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.

Compliance Rating: Not Yet Rated

The previous service reviews did not collect information on whether individuals who were transitioned requested and were returned to their previous living situation. The SME has not requested LDH to track this information but will work with the State to develop and implement a strategy to track this information and to report on the State's compliance.

C. Transition Support Committee

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.

Compliance Rating: Not Met

Discussion and Analysis

This rating has changed from Partially Met to Not Met. As indicated in previous reports, the State has developed procedures to fulfill the Agreement's requirement to facilitate a Transition Support Committee using the My Choice Louisiana Service Review Panel (SRP). The SRP is a cross-agency process that works to identify systemic barriers that impede or prevent transitions and work through individual case-related issues (for all NF transitions). A description of the SRP functions and process were described in the sixth report. Currently, there are eight members (including chairs and co-chairs) of the Transition Support Committee consisting of OAAS, OBH, and OCDD staff, including health care professionals, TCs, and central office and regional staff. There are no external or ad-hoc members of the SRP that are recommended in this paragraph.

The SME continues to request and LDH provides information regarding the number of individuals in the My Choice Program who have been referred to the SRP during this reporting period and if the SRP was effective in addressing these barriers. LDH reported that one individual from the My Choice Program was

referred to the SRP. The State reports the individual needed and was approved and provided the needed equipment to transition.

As indicated in the seventh report, SME continues to be concerned about the very low volume of individuals who are referred to the SRP. As indicated in this paragraph, a Transition Support Committee is responsible for 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. Given the barriers listed throughout this report, the SME would anticipate that the number of individuals who will need to have transition barriers addressed would be greater than the one individual referred to the SRP this reporting period, and the six individuals referred in the previous reporting period.

As indicated in the seventh report, the State has current and proposed strategies for collecting and responding to barriers impacting individuals in the My Choice program. However, these strategies would benefit from more organization. For instance, LDH collects (or will collect) information on barriers five ways: TCs, PIRSs performing in-reach, CCMs, PASRR Level II evaluators, and the SRP. As indicated in paragraphs 54 and 55, LDH is standardizing the process in which barriers are identified. However, there still does not seem to be an identified "home" to be able to organize, identify, and address systemic barriers. In addition, there is little external input from stakeholders regarding barriers and potential solutions to address these barriers.

As recommended in the last four SME reports, the State should consider additional SRP members who can identify systemic barriers affecting multiple members of the Target Population and ad hoc representation to address particular barriers in individual cases. This would include adding members with lived experience and expertise related to successfully resolving barriers to discharge. The State has not added these members.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- LDH has created a Service Review Panel to address transition barriers for individuals on the Active Caseload List.
- The composition of the SRP has not changed significantly since the creation of this panel and does not include ad-hoc members or individuals external to the State.
- The SRP performed only one review for the My Choice Program. Given the information from the SME service reviews, TCs, and others, the SME would expect these reviews to be higher.
- The State has recently developed a list for various individuals (TCs, PIRSs, CCMs, PASRR Level II Evaluators) to report barriers, but there is no single process for addressing these barriers.

Recommendations

- The State should include additional members for the SRP as recommended in previous reports.
- The State should review the adequacy of the SRP process to identify and address barriers for many of the individuals transitioning to the community from NFs and individuals who are diverted from NFs.
- Based on this review, the State should either enhance the SRP's role for the My Choice Program or develop an alternative process that will be the "home" for receiving and addressing systemic barriers.

D. Post-Discharge Community Case Management

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 nursing facility.

Compliance Rating: Partially Met

Discussion and Analysis

As indicated in the seventh report, LDH implemented the Community Case Management (CCM) Program. The CCM program has been implemented through MCOs who have selected regional providers that will offer case management for individuals who are awaiting transition (projected to be transitioned within 60 days), transitioned, or diverted from NFs. Participation in CCM is voluntary. LDH contractually requires MCOs to offer CCM to individuals who choose to participate, for a period up to twelve months from the date of transition or diversion.

The SME continues to request, and the State provides information regarding all individuals awaiting transition, transitioned, or diverted from NFs over the past twelve months and who are either engaged or not engaged in CCM. The SME has also requested information regarding the number of individuals who have declined CCM for the reporting period. The table below provides the CCM information as of September 2022, the most recent for this reporting period.

Individuals Receiving CCM	**April**	**May**	**June**	**July**	**August**	**September**
In NF Awaiting Transition	39	57	49	53	64	58
Transitioned	69	78	108	129	139	151
Diverted	3	7	29	43	50	43
Total Individuals Receiving CCM	*111*	*142*	*186*	*225*	*253*	*252*
Not Engaged in CCM						
Transitioned	1	0	0	0	0	0
Diverted	1	3	0	2	5	8
Total Not Engaged in CCM	2	3	0	2	5	8

The number of individuals receiving CCM has increased since implementation in March 2022. During April, 111 individuals were receiving CCM. As of September (the last reporting period available), LDH reports 252 individuals were receiving CCM. The number of individuals who are not engaged in CCM has remained consistently low during this reporting period, with the exception of September, when 8 out of 13 individuals (61%) who were diverted from NFs were not engaged in CCM. LDH also provided information regarding the caseload size for CCMs. This information indicates the CCMs' caseloads are consistent with LDH's policies.

As indicated earlier in this paragraph, TCs continue to provide CCM to transitioned individuals who had been residing in the community for longer than 180 days. At the beginning of this reporting period, there were 23 individuals who continued to receive intensive case management from the TCs. At the end of this reporting period, 5 were receiving intensive case management from TCs.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- The State has established the CCM program and has good uptake of referrals for individuals currently residing or recently transitioning from NFs.
- Approximately 20% of individuals who diverted from NFs and referred to CCM were not engaged in CCMs during May through September of this reporting period.
- Three individuals were readmitted to NFs during this reporting period who were transitioned or diverted from NFs.

Recommendations

- Continue to track and provide the SME with monthly reports regarding the CCM program as requested in the sixth report.
- Work with the SME to identify the reasons for readmissions of individuals recently discharged from NFs and determine strategies for CCMs to continue to be involved with these individuals post their readmission.
- Conduct outreach to individuals who have been diverted since March of 2022 to obtain information on why they chose not to enroll in CCM.

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 reinstitutionalization 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.

Compliance Rating: Partially Met

Discussion and Analysis

As indicated in this report, LDH began to implement CCM in February 2022. CCM, as designed, is individualized, person-centered, and reflects the individual's unique strengths, needs, preferences, experiences, and cultural background. It allows individuals to participate in decisions that affect their care and ensures they are provided options regarding their services and supports, including the option to refuse services. The State has developed SOPs that guide the activities of the CCMs and the cadence of CCM contacts prior to and one year after transition. Specifically, the SOP requires CCM involvement and multiple monthly contacts (face to face and virtual) to continue for no less than 365 days, at which time an assessment is conducted to determine ongoing need and desire to continue CCM. In addition, the SOP sets forth expectations regarding initial assessments, reassessments, and development of plan of care and a separate crisis plan.

During this reporting period, the service reviews collected and analyzed information regarding consistency and continuity of CCM pre and post transition. Specifically, the service review team requested and LDH provided contact logs and other documentation to determine whether CCM activities were being delivered as required by the SOP. The service review indicated:

- All 25 individuals reviewed had a CCM; however, there was unevenness regarding the consistency and continuity within regions reviewed. In one region there was high turnover of CCMs which resulted in having individuals receiving CCM from multiple individuals in a short span.
- There was variability in whether the CCMs met the contact requirements developed by the State. While the majority of individuals (57%) received the required contacts, many did not. The review indicated there were gaps in the dates of contacts that spanned several weeks and in one instance, two months.
- All 25 individuals reviewed had the required documentation: an initial community assessment, individual plan of care, and crisis plan.
- There were no individuals in later reviews who had reassessments or revised plans of care. Most individuals reviewed in November had been transitioned from an NF for more than 90 days when a reassessment and revised plan of care are required by the State.
- The timeliness regarding the rendering of the assessment and the development of the plan of care was variable. Approximately one-third (32%) of the individuals received a timely assessment and plan of care. The other 68% were not timely, although the review indicated the delay in these activities was generally less than 5 business days.
- The service review also identified several issues with the quality of the assessments and plans, which are discussed in Paragraph 43.

This paragraph also requires LDH to assure that individuals have access to all medically necessary services covered by the State's Medicaid program. One proxy for determining if the State is meeting the intent of this provision is to determine whether the individual is accessing services identified in the plan of care and if they are receiving these services in the amount and duration identified in the plan. The service review of the 25 individuals found that initial plans of care did not specify the amount and duration of services consistently for any individual. There were some plans that indicated Assertive Community Treatment was recommended monthly and in some instances the plan indicated the frequency of other recommended services. This was generally the exception and not the rule. Therefore, it is difficult to assess if the State is complying with this provision.

The final sentence in this paragraph requires the State to ensure the capacity of face-to-face engagement with individuals in the Target Population through case management efforts. The State has specified face-to-face requirements for CCM. Generally, when contacts occurred, approximately 75% of these were face-to-face contacts, which exceeded the CCM expectation of 50%.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- All individuals reviewed had a CCM; however, there was unevenness regarding the consistency and continuity within region reviewed.
- There was variability in whether the CCMs met the contact requirements developed by the State.
- The required documents were present for all individuals reviewed. However, service plans do not provide consistent information regarding the scope, amount, and duration of these services.
- No individuals who had been transitioned for greater than 90 days had reassessments or revised plans of care.
- The timeliness regarding the rendering of the assessment and the development of the plan of care was variable.

Recommendations

- LDH should continue to provide the CCM report to the SME on a monthly basis.
- LDH should review reasons for disenrollment and determine strategies to address these enrollees' concerns.
- LDH should work with the MCOs to ensure that reassessments and updates to the plans of care are occurring within LDH policy.
- LDH should work with the MCOs to ensure contacts with individuals are consistent with the Departments Standard Operating Procedures.
- LDH should closely monitor the turnover of CCM staff to identify any significant disruptions in the continuity of case management.
- LDH should address the timeliness of assessments and plans of initial plan of care development with the MCOs and the CCM organization.
- Plans of Care should also address the scope amount and frequency of the services included in the plan.

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.

Compliance Rating: Partially Met

Discussion and Analysis

As indicated in the seventh report, the State has developed assessment and individual plan of care tools that are intended to capture the desires and needs of the Target Population who have been diverted or transitioned from NFs. The State has also required the MCOs to ensure CCMs receive the Person-Centered Planning training that was developed and implemented in the fifth reporting period. The State reports this training is mandatory for CCMs and must occur before staff commence their case management efforts.

The service reviews focused on the presence and quality of the assessment and individual plan of care. While this paragraph focuses on the plan of care, it is important to assess the quality of the assessment and determine if the individual plan of care adequately addressed needs identified in the assessments. The findings from the service review identified the following:

- As stated in paragraph 60, all 25 individuals reviewed had an initial assessment and plan of care.
- The overall quality of the assessments was high. A review of the assessments ascertained:
    - The natural supports available to the individual were identified for all individuals.
    - Almost all domains in the assessment were addressed.
- The goals in the plans of care were stated in the individuals' words and were clear; however, what was less clear were the specific activities and related services that would meet these goals.
- 86% of the 25 plans of care reviewed reflected strengths and preferences.
- 78% of the plans of care reviewed included strategies that addressed the health and safety needs of the individual.
- All individuals had signed their plan of care.
- 74% of individuals had other individuals (other than the CCM) present during the development of their plan of care.

In the seventh report, the SME also encouraged the State to use the checklist developed earlier this year in their efforts to educate CCM providers regarding strategies to ensure plans are person-centered. This has yet to occur.

In the seventh report, the SME also recommended CCM providers and advocates/members of the advisory committee review the proposed tools and suggest revisions to these tools, similar to the process. This has yet to occur.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- The State continues to require all CCMs to be trained using the LDH My Choice Persons Centered Training developed in CY 2021.
- All individuals had an assessment and an individual plan of care.
- The service reviews found that goals identified in the individual plan of care are person-centered and that almost all plans identify the individual's strengths and preferences.
- The service reviews also indicated that activities and services identified in the plan were not sufficient to implement these goals.
- All plans of care were signed by the individuals.
- A good proportion of individuals (74%) included other individuals chosen by the individual in plan development.
- Care plans generally included strategies that addressed the health and safety needs of the individual.

Recommendations

- LDH should work with the MCOs to improve the timeliness of initial plans of care and requirements regarding updates to these plans.
- LDH should work closely with the MCOs and CCM staff to improve the plans of care, specifically to address the scope, amount, and duration of services needed by the individual.
- LDH should work closely with the MCOs and CCM staff to improve the plans of care, specifically to develop activities and services that are consistent with the stated goals and, in particular, address the individual's concerns regarding loneliness and lack of meaningful activities to do during the day.

E. Tracking

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 nursing facility 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.

Compliance Rating: Partially Met

Discussion and Analysis

LDH developed and implemented a system to identify and monitor individuals who have transitioned from nursing facilities for the reporting periods three through six. This relied on TCs collecting information regarding everyone enrolled in intensive case management. The information was collected through monthly logs. These indicators were included in the Department's Quarterly Quality Matrix (as discussed in paragraphs 98-99) and reviewed jointly by OAAS and OBH leadership monthly to identify individual and systemic issues. In addition, as discussed in paragraph 98 and 99, LDH has shared and discussed these indicators with a subset of their My Choice Advisory Committee.

LDH continues to receive standardized reports from MCOs regarding similar information collected from TCs as well as more detailed information, reported by individual, on key case management activities including:

- Initial and ongoing contact with the individual by the CCM
- The date the assessments and plans were developed.
- Whether the individual received all services on his/her plan of care this month
- Whether the individual is making progress toward goals
- If there were services needed but not yet being received
- For individuals needing services, the specific steps the CCM is taking to mitigate service gaps.

Information collected through the tracking system is discussed in more detail in paragraphs 98 and 99.

The SME reviewed each MCO's standardized monthly reports to determine if these reports were complete. These reports focus on individuals transitioned and receiving CCM which includes all individuals who were transitioned. The most recent monthly report the SME reviewed was July 2022. The SME reviewed this report to determine whether information was complete for individuals who were transitioned from an NF. The review found that almost all individuals had complete information in the tracking system. Several individuals who were transitioned within the previous two weeks did not have complete information, given they were in the process of developing plans of care and coordinating services.

As described in the CCM Standard Operating Procedures, LDH requires a scheduled cadence of face-to-face contacts between the CCM and the individual who has been transitioned. CCMs are to report on each contact and whether the contact was face-to-face or virtual. As indicated in paragraph 60, this contact was variable, and the SME recommends LDH work with MCOs to ensure consistency with the SOPs.

During this reporting period, OAAS and OBH leadership, in addition to the Integration Coordinator, accompanied the service review teams to visit individuals who were transitioned, diverted, or in the NF awaiting transition. This included a review of the individual's documentation and face to face visits with each individual LDH. The service review teams met with approximately 40 individuals to discuss their transition experience, current goals and interests (e.g., community inclusion, employment), services received, and gaps in care. LDH reports participating in these service reviews is beneficial to understand the impact the My Choice Program has on individuals as well as drawing on the "lived" experiences of these individuals to make changes to the program.

The combination of the CCM Tracking System and participation of LDH in service reviews provides important information regarding the My Choice program. As the CCM program matures, LDH should use

this information in a structured way to make future decisions regarding the My Choice Program. Specifically, it will be important for LDH to incorporate information from the tracking efforts to the overall quality efforts described in paragraph 98 and 99.

Compliance Assessment
The SME assessment of the State's compliance with this paragraph took into consideration:

- LDH has developed a tracking system to identify and monitor individuals receiving CCM in the Target Population.
- LDH requires TCs and CCMs to report information on a monthly basis regarding key areas. The TCs and CCMs have been reporting this information on the required basis.
- A review of the initial data reports from MCOs indicates that information collected on all individuals transitioned is complete.
- While some of the information CCMs are providing is consistent with previous reports from the TCs, there is yet to be enough information to be confident that LDH is using this information to proactively address some of the negative outcomes.

Recommendations

- Review data from CCMs to ensure that the cadence required for face-to-face and other visits is being met.
- The State should incorporate the data from the MCO CCM reports in the overall quality improvement process to determine if there are systemic health and safety issues, gaps in services, and efforts that have been successful in addressing these issues.
- The State should continue to participate in the service reviews.

V. Community Support Services

A. Crisis System

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

Compliance Rating: Partially Met

Discussion and Analysis
In December 2019, LDH, with input from the SME, developed a plan for a statewide crisis response system, which included the crisis services in the Agreement and additional crisis services used in other jurisdictions that have proven efficacy. This framework included the requirements in the Agreement and can be found at https://ldh.la.gov/assets/docs/MyChoice/CrisisFramework.pdf. There are four crisis services that LDH seeks to create for individuals enrolled in Medicaid through a program called the Louisiana Crisis Response System. These include mobile crisis response, community brief crisis support, behavioral health crisis care

centers, and crisis stabilization units. Additional information regarding these crisis services can be found at https://ldh.la.gov/crisis. As indicated in the seventh report, LDH has taken various steps to implement the plan. This has included developing service definitions, obtaining funding for services, obtaining approval from CMS, developing training for crisis providers (in partnership with Louisiana State University), and initial steps to develop the network of crisis providers. The general approach LDH has developed for crisis services requires crisis services be provided in the most integrated setting, with a major focus on ensuring access to mobile crisis services provided to individuals in their home or other community-based settings.

In addition, LDH has developed a process of triage, dispatch, and referral to crisis services via the managed care organization's 24 hour Behavioral Health Crisis (BHCC)lines and has worked with 988 providers about direct dispatch to services. LDH is working on the development of a plan for a single triage/dispatch system to be used statewide.

The State has begun efforts to implement all four crisis services {(Mobile Crisis Response (MCR), Community Brief Crisis Support (CBCS), Crisis Stabilization (CS)] on a rolling basis. The State has also reviewed their crisis service definitions to align with federal opportunities in the recently passed American Recovery Plan to garner additional federal funding for these new services. LDH has worked closely with the MCOs, LSU, and new providers to stand up four crisis services in select regions of the State. MCR and CBCS services are currently available at varying days and times. The State reports CS is taking almost 12 months to stand-up given the need to locate, site, and renovate facilities to comply with CS requirements. LDH has yet to implement an expectation these services will be available 24/7 as required by the Agreement. As of this reporting period, the State has implemented crisis services in select regions.

Region	Services
Region 1	MCR/CBCS (Implemented 6/2022) BHCC
Region 2	MCR/CBCS/BHCC (Implemented 4/2022) and CS (implemented 8/2022)
Region 3	MCR/CBCS/BHCC (Implemented 4/2022)
Region 7	MCR/CBCS (Implemented 3/2022) and BHCC (Implemented 4/2022)
Region 9	MCR/CBCS/BHCC (Implemented 6/2022)
Region 10	BHCC/CBCS (Implemented 4/2022) and MCR (Implemented 6/2022)

LDH continues to work with LSU to identify a provider for Regions 5, 6, and 8. In addition, the State reports that LSU has received numerous applications to provide additional services in current regions that have some crisis services and in regions where no crisis services are available. However, the majority of submitted applications are incomplete. As this occurs, LSU notifies the applicant of the steps the provider must take if they wish to reapply.

Currently all individuals who receive CCM are required to have a crisis plan. These plans identify the following areas:

- Events or other situations that may trigger a crisis.
- Strategies the individual has used in the past to resolve the crisis
- Strategies the individual or provider (including the crisis provider) can deploy to de-escalate the crisis and ensure stabilization
- Plans for caretaking (e.g., children, pets etc.) if the individual is hospitalized

- Treatments (including medications) the crisis responder should avoid.
- Individuals who should be contacted during a crisis.

The service review identified that all individuals had a completed crisis plan. However, the quality of the plans were variable and none of the plans reviewed identified using the new crisis services as a potential strategy for de-escalation and stabilization.

LDH has also recently revised the initial reimbursement rates for all crisis services. Information provided by agencies offering crisis services allowed LDH to adjust the assumptions used to develop the initial rates. These adjustments were made in December 2022. The rates have been posted in the fee schedule and are also included in the rolling Request for Application (RFA) materials. These new rates should serve as incentive for agencies considering delivering these services.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- LDH has developed service definitions messaging that mobile crisis services are a community-based service delivered in the member's natural setting with some exceptions for office-based delivery.
- LDH has developed a crisis plan consistent with the intent of this paragraph. This includes mobile response, crisis telephone lines, and three other crisis services (CBCS, BHCC, and CS).
- LDH began implementation of CS during this reporting period.
- LDH continued to implement crisis services during this reporting period in seven of the ten regions.
- LDH required each individual receiving CCM services to have a brief crisis plan; however, the quality of these plans are variable and do not reference existing crisis services as a strategy to de-escalate the crisis.
- LDH has revised reimbursement rates to reflect the implementation experience of crisis providers over the past eight months of implementation.

Recommendations

- Complete the implementation of all crisis services (with the exception of CS) in all areas of the state during the next reporting period.
- Develop a projected timeline for CS development throughout the state given the length of time needed to develop these facilities.
- Expand MCR and BHCC services to ensure 24/7 access.
- Develop a strategy to improve the quality of the crisis plans and, when appropriate, recommend crisis services available in the individual's area.
- Continue efforts to implement a longer-term 24/7 crisis hotline.
- Continue efforts to work with LSU to provide information to potential crisis applicants regarding the application, training, and onboarding process.

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

Compliance Rating: Partially Met

Discussion and Analysis

As discussed in previous SME reports, there is a patchwork of toll-free crisis and help lines currently available to assist individuals, including members of the Target Population, who are experiencing crisis. In order to streamline the process of service access for individuals in crisis, LDH is working on the development of a plan for a single triage/dispatch system to be used statewide. This will be an important component for the State's crisis system. A key function of the crisis line will be dispatch of the mobile crisis response teams discussed in paragraph 65 and referral to other crisis services.

At present, LDH is requiring the MCOs to receive crisis calls and dispatch mobile teams and make referrals to other crisis services in the interim. The current LDH contract requires MCOs to have this capacity. The MCOs continue to send letters to all adult Medicaid members to inform them of the crisis line and available crisis services.

OBH continues to work with the MCOs during this reporting period on the following:

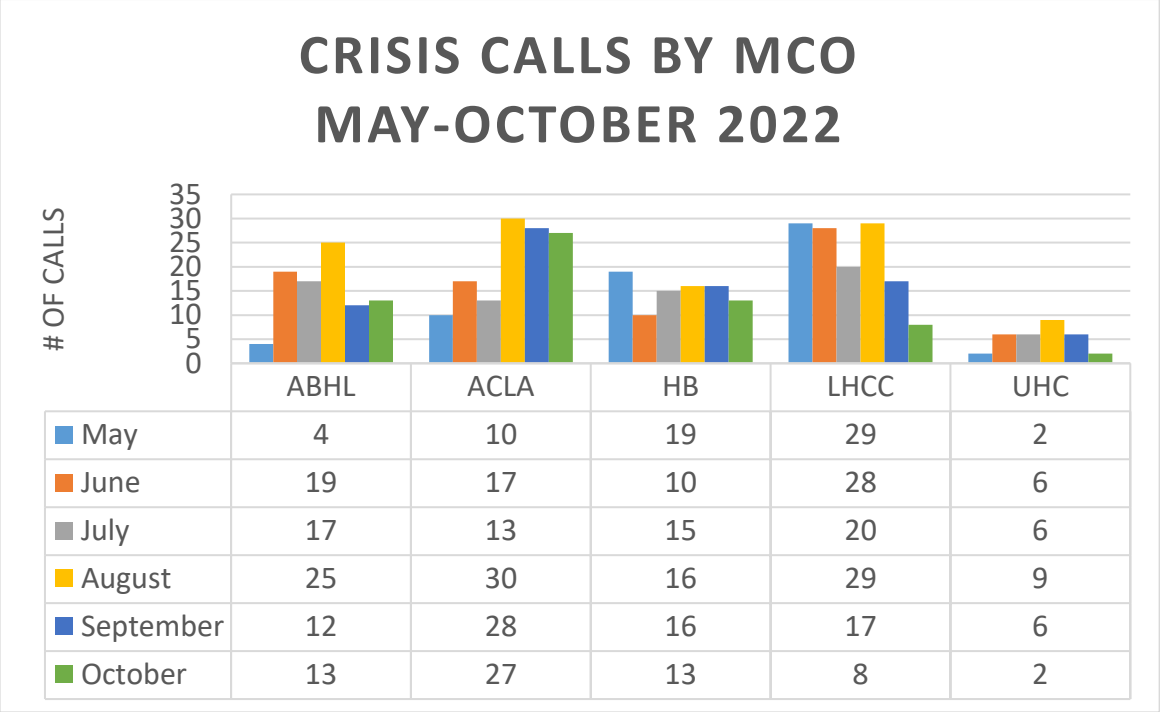
- Continued outreach to members about new crisis services and access to services using a variety of MCO specific strategies.
- LDH and LSU continuing to hold weekly meetings with MCOs/crisis providers.
- MCOs, in collaboration with LSU, have jointly developed a data template to evaluate usage of emergency departments and inpatient hospitalization.
- MCOs will use this information in the previous bullet in local conversations with healthcare systems and other stakeholders as indicated by the data.
- MCOs and LDH have begun to review options to incentivize the delivery of crisis services in the community when the emergency department is not a medically necessary admission.

The State reports the total crisis call volume for May through October. The chart below provides this information.

Number of Total Crisis Calls for the 6-month period (May 1 – October 31, 2022)

The chart below provides call volume for each MCO:

Number of Total Crisis Calls by MCO for the 6-month period (May 1 – October 31, 2022)

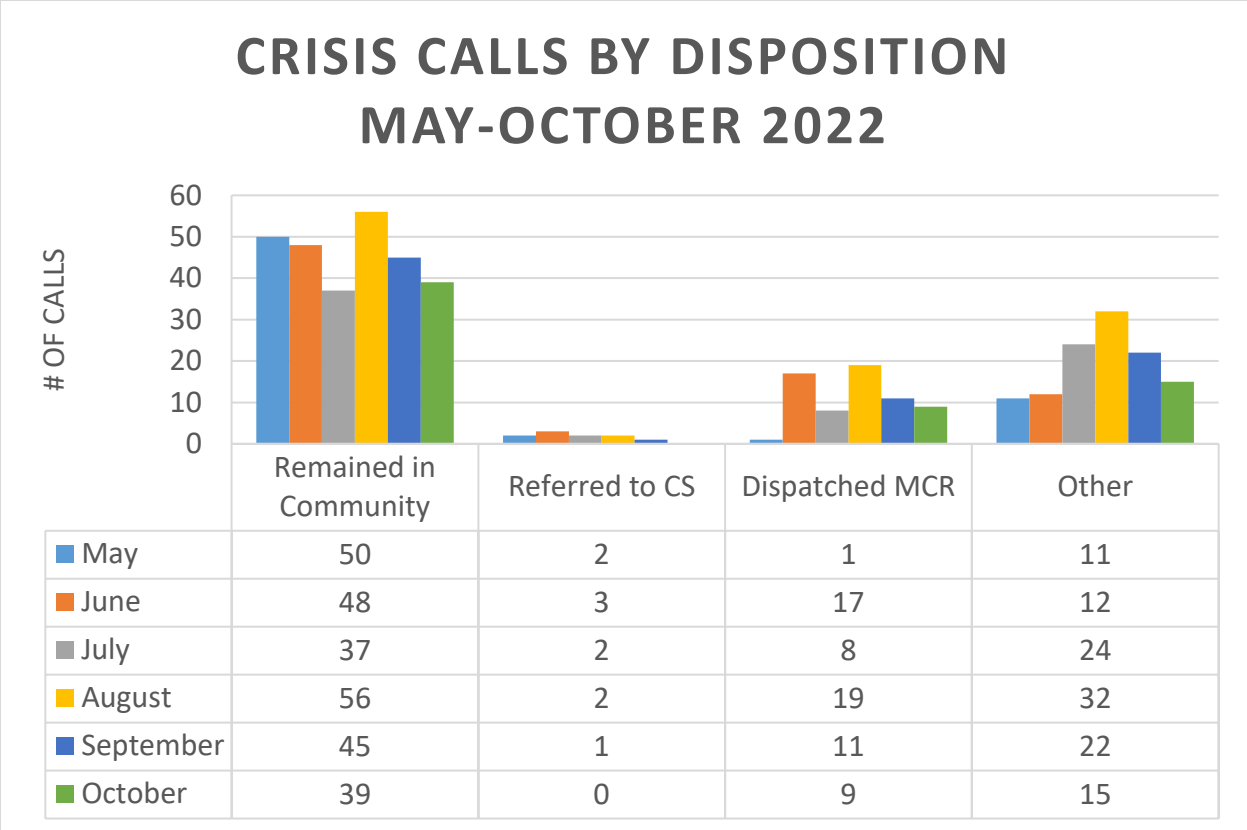


	ABHL	ACLA	HB	LHCC	UHC
May	4	10	19	29	2
June	19	17	10	28	6
July	17	13	15	20	6
August	25	30	16	29	9
September	12	28	16	17	6
October	13	27	13	8	2

As this data indicates, the call volume for the MCO crisis lines remains low. The State reports there were only 466 calls. The State and LSU have worked with the MCOs to identify systemic barriers; however, the MCOs have not sufficiently addressed these barriers. The regional crisis teams are beginning to identify additional barriers that will need to be addressed during the next reporting period. This includes addressing ambulance policies that require transport to only hospital versus the ability to transport to BHCC. Another barrier is addressing law enforcement agency concerns about liability if the team responds in lieu of law enforcement authorities. Some of these factors are idiosyncratic to the region. For most of the crisis agencies, the type of cross-sector/systems development work that is required to shift community practice is unfamiliar. This is not unusual, particularly in a state in which a crisis system of care is relatively new.

While the MCOs have worked to improve the performance of these crisis lines, and all parties have worked to establish care coordination protocols, the crisis call volumes are very low and having five crisis lines dispatching teams is inefficient. It was nonetheless—and continues to be--the best interim option until a single, statewide option is identified.

Data was also available on the disposition of these calls to the MCO crisis lines. Disposition indicates what the MCOs did in response to these calls.



	Remained in Community	Referred to CS	Dispatched MCR	Other
May	50	2	1	11
June	48	3	17	12
July	37	2	8	24
August	56	2	19	32
September	45	1	11	22
October	39	0	9	15

This data indicates that most calls were resolved by staff at the MCO crisis line. This is generally an acceptable trend with crisis call centers where the level of crisis may be resolved telephonically versus having mobile crisis dispatched or generating a referral to a crisis service.

LDH and the SME continue to monitor the MCO crisis lines to ensure that the call lines can process crisis calls and dispatch mobile teams. In discussions between crisis agencies and MCOs, it became apparent that some MCO call center staff were spending considerable time talking to the caller prior to discussing treatment options. LDH reports that MCO staff have been coached to inform caller of new options early in the call and then giving the caller the option of a crisis service or continuing to talk to resolve.

In partnership with MCOs and crisis agencies, LDH has developed a comprehensive, working document called the Crisis Care Coordination Protocols. The purpose of this protocol is to convey expectations for coordinating crisis care across the continuum of crisis care including the MCO crisis line. The protocol content addresses:

- Role of the MCO related to crisis services and responsibilities of operating their crisis line
- Guidance on decisions to dispatch MCR from the crisis line including:
    - How to identify mobile crisis providers to dispatch
    - Dispatching process
    - Information sharing between the crisis line and with MCR providers.

In addition, LDH reports providing technical assistance to all MCOs, and facilitated ad-hoc and topical calls that seek to improve practice, encouraged more creativity, and furthered the engagement of MCOs in

crisis systems development. The level of investment and creativity of MCO activity is increasing. For instance, the State reports an MCO has hired a Crisis Outreach Specialist and is recruiting another. These specialists will specifically be working on outreach within regions and building demand for services.

LDH no longer conducts "secret shopper" calls to all the crisis lines. The State reports the early factors that led to concerns (insufficient staffing, undeveloped protocols) have largely been resolved.

In addition to these efforts, the State continues their efforts to implement a state-specific 988 hotline for Louisianans in crisis to connect with crisis services and supports. The State reports they have made significant progress in the 988 initiative and have launched on time with two call center providers covering the state. Both call centers are actively involved with nationally offered technical assistance through Vibrant and have taken advantage of funding opportunities that allowed for expansion of the teams. There is, at a minimum, weekly interface between 988 and crisis system leads and in the SME's opinion both entities are well-versed in the purpose and development of both projects. In November, LDH initiated a pilot in region 7 that allows a direct warm telephonic transfer from 988 to the crisis provider for MCR or BHCC services. This was done with agreement by the provider. 988 does inquire about Medicaid status but does not have a mechanism to verify Medicaid status.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- The State through the MCOs have implemented multiple toll-free crisis lines that operate 24/7; during the reporting period the State worked with a new MCO which began operations in January 2023.
- LDH has identified and have developed strategies to address MCO crisis line staff to reduce the triage time and refer individuals for MCR through dispatch protocols.
- The State continues to track the callers and dispositions, although additional dispositions or information is needed to meet the terms of the Agreement (e.g., providing phone consultation or connecting with peers).
- MCOs have collaborated on gathering parish-specific data on ED/inpatient hospital utilization to promote constructive conversations with regional hospitals, MCR providers, and other stakeholders.
- As indicated in paragraph 63, the State is LDH is working on the development of a plan for a single triage/dispatch system to be used statewide.

Recommendations

- LDH should continue to provide 1:1 technical assistance to MCOs to enhance outreach efforts to identify individuals who are in need of crisis services.
- LDH, MCOs, and crisis providers should continue to engage system partners to educate about the availability of crisis services and how to access these services.
- LDH should finalize a plan for a single triage/dispatch system to be used in conjunction with the Louisiana Crisis Response System.
- LDH should continue to work with 988 and 911 to ensure warm handoffs to the newly developed crisis lines or directly with crisis providers.

65. LDH will, through the Implementation Plan, ensure that a face-to-face, mobile crisis response capacity is available statewide before termination of this agreement. Mobile crisis response shall have the capacity to respond to a crisis at the location in the community where the crisis arises with an average response

time of one hour in urban areas and two hours in rural areas, 24 hours a day, and seven days a week. Mobile crisis response will have the capacity to support resolution of the crisis in the most integrated setting, including arranging urgent outpatient appointments with local providers, and providing ongoing support services for up to 15 days after the initial call.

Compliance Rating: Partially Met

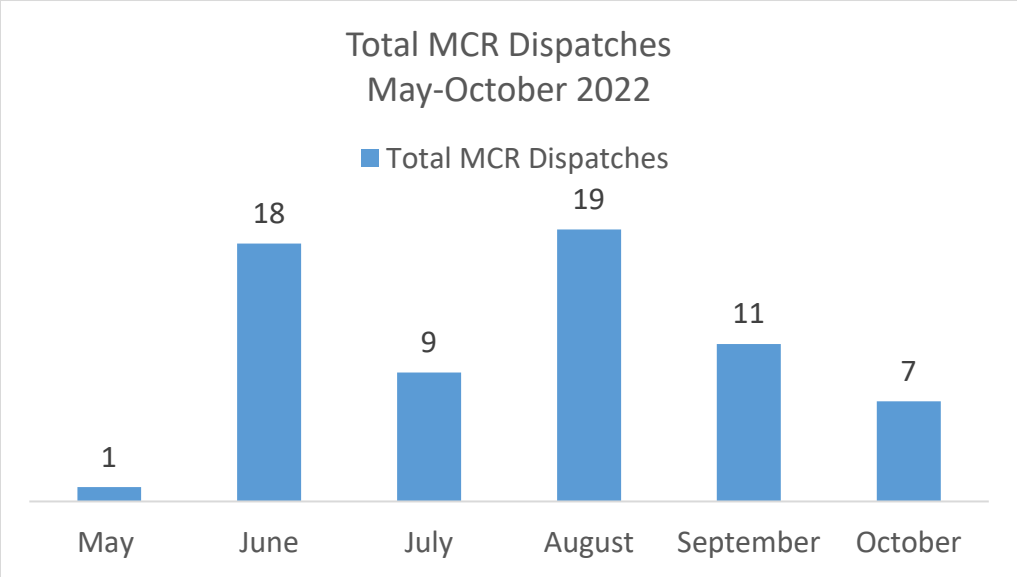
Discussion and Analysis

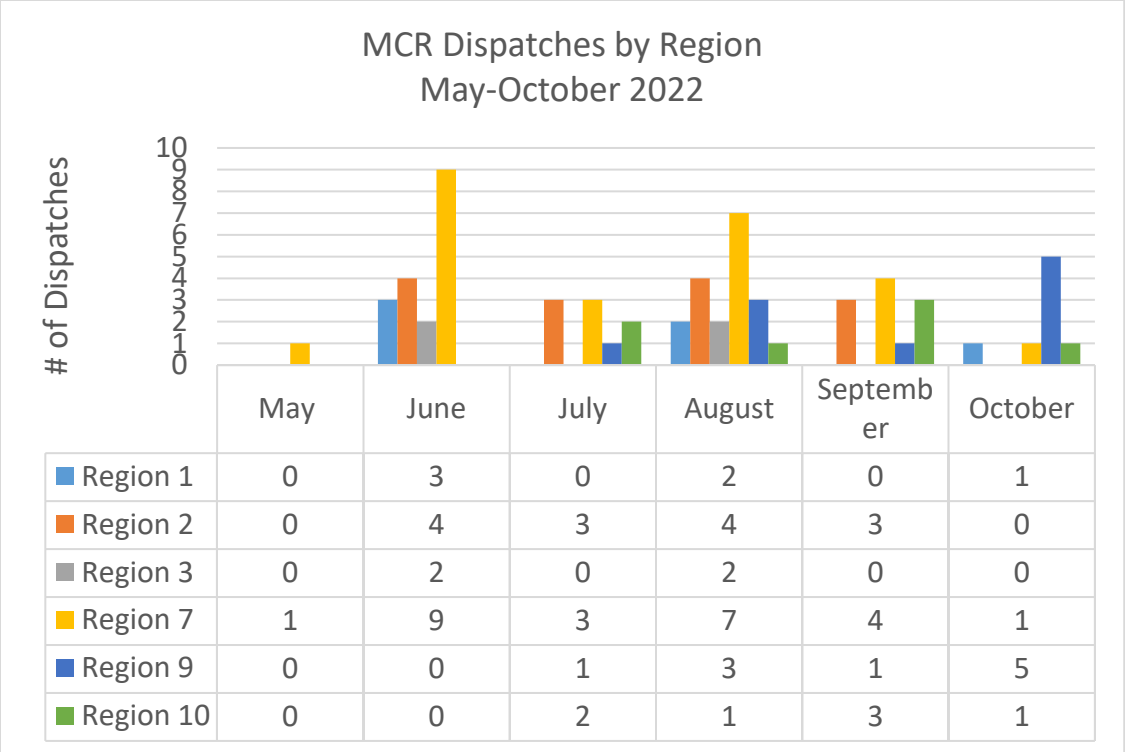
As indicated in paragraph 63, the State partially implemented the mobile crisis response capacity in March. Louisiana State University (LSU) has also been developing network capacity for MCR, CBCS, CS, and BHCC. During this reporting period, the State reports that LSU has fully trained 106 staff who will be receiving crisis calls or providing crisis services. This includes:

- 48 staff of various crisis services
- 58 MCO call center staff.
- Region 4 staff from crisis agencies that are preparing to launch in early CY 2023.

As indicated in paragraph 63, MCOs have contracted with service providers offering MCR. MCR teams are available in all regions except region 5, 6, and 8.

The SME requested information regarding initial utilization of MCR services. The charts below provide information regarding MCR dispatches from May through October 2022.

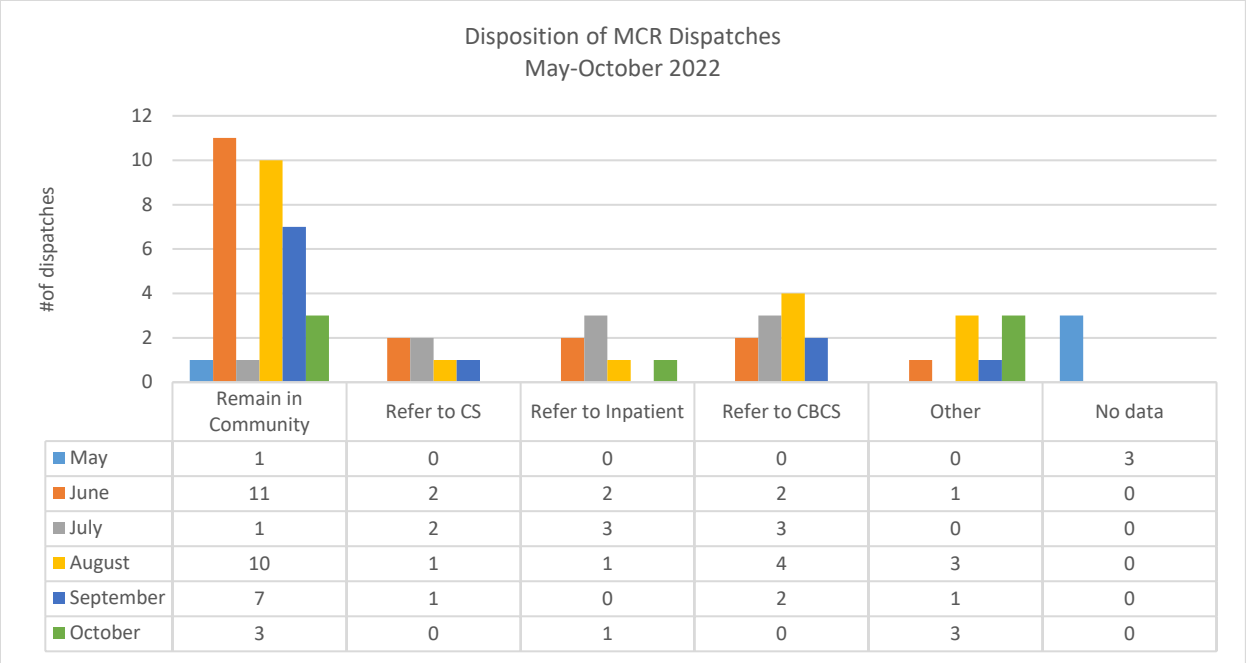




	May	June	July	August	September	October
Region 1	0	3	0	2	0	1
Region 2	0	4	3	4	3	0
Region 3	0	2	0	2	0	0
Region 7	1	9	3	7	4	1
Region 9	0	0	1	3	1	5
Region 10	0	0	2	1	3	1

While utilization of services has increased from the previous report, volumes remain unacceptably low and LDH certainly concurs with this. Only 65 individuals received MCR services during this reporting period. As described earlier in the report, there are recent initiatives to identify any incentives to practice change, including the development of parish-specific data sets to stimulate local conversation.

During this reporting period, LDH provided information on the disposition of MCR services. The chart below provides this information.



	Remain in Community	Refer to CS	Refer to Inpatient	Refer to CBCS	Other	No data
May	1	0	0	0	0	3
June	11	2	2	2	1	0
July	1	2	3	3	0	0
August	10	1	1	4	3	0
September	7	1	0	2	1	0
October	3	0	1	0	3	0

As indicated by this chart, almost all individuals remained in the community. Seven or 11% of the individuals were referred to an inpatient behavioral health provider.

It will be imperative that LDH require MCOs and MCR providers take these steps immediately to ensure the viability and sustainability of MCR and other crisis services.

As indicated in paragraph 63, the State in cooperation with MCOs have developed protocols for dispatching MCR teams through their crisis call centers, for collecting and communicating data between the call center and MCR providers, and for authorizing next level crisis services (CBCS and CS).

In addition, LSU has started to provide monthly, agency-specific coaching for a period of at least several months to support implementation. Each team receives six months of team-specific coaching by members of the LSU training team following completion of the initial training. LSU is now developing two enhancements: advanced training modules and service-specific (MCR, CBCS, BHCC, CS), cross-agency, learning collaboratives. In the sixth report, the SME recommended LDH develop a strategy to monitor the roll-out of these new crisis services. As discussed in the seventh report, LDH has developed and continues to lead a process for facilitating a standing, brief, semi-weekly huddle of MCOs and crisis teams (via phone conference line) to check in on service demand, access issues, implementation hiccups, and to continue to hone the working protocol. LDH continues these efforts which include:

- 30-minute weekly crisis huddles that focus on:
    - Review of previous seven days of data from crisis teams and MCOs
    - Review broader performance data set.
    - Identify key accomplishments.
    - Identify key barriers.
    - Streamlining warm handoff between call center and MCR team
    - Adherence to key principles of least restrictive care.
- Monthly 60-minute joint meetings that focus on systemic issues between entities rendering crisis services.

- Monthly 60-minute meeting with crisis agencies to build demand and regional coalitions.

LDH also reports they are monitoring the number of referrals to MCR teams on a weekly basis and working with the SME team member to request that each MCR team provide the actual number of referrals each week.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- LDH has developed MCR capacity in seven regions of the state, with a provider identified in an additional region.
- LSU has undertaken activities, including readiness reviews, to ensure that MCR providers are prepared to offer MCR and continues to offer coaching to these providers.
- MCOs have contracted with MCR providers to serve adults with Medicaid, including individuals in the Target Population.
- According to claims data from July 1 through September 30, no individuals who were transitioned or diverted received MCR services during this reporting period, though a number did have behavioral health crises that led to hospital visits.
- LDH developed a process to meet with MCOs and providers frequently during implementation to identify issues.
- LSU has developed and implemented coaching for each of the MCR teams.
- There continues to be minimal uptake of MCR services. LDH has developed some immediate strategies for MCR providers to increase MCR referrals.

Recommendations

- The State should identify individual(s) dedicated to aid in cross-sector relationship development and to build service demand.
- Increase the utilization of MCR services by individuals who have been transitioned or diverted from NFs.
- LDH should develop a specific strategy (statewide and local and in conjunction with stage sheriff and police associations) for engaging law enforcement partners for the purposes of reducing the use of emergency departments and jails and initiation of involuntary treatment and increasing referrals to voluntary, community-based crisis centers as well as develop model protocols.
- LDH should develop a specific strategy (statewide and local) for engaging healthcare providers, including Louisiana Hospital Association and MCOs, in the process to identify categories of persons who can be well-treated in community based locations and strategies to shift habits of practice.
- LDH should develop a specific strategy to collaborate with EMS/fire providers, including but not limited to EMS providers participating in the Medicare ET3 pilot project, to address barriers to transporting to non-ED locations.
- LDH should convene a meeting with parish coroners for purposes of understanding their involuntary commitment practices, how they collect/use data, whether there is a repository for data accessible to LDH/LSU and if not, seek to develop this data repository.
- Review the crisis plans, similar to the CCM review discussed in paragraph 60, for each individual receiving CCM and ensure that each plan, where appropriate, includes information regarding the MCO crisis line and MCR services.
- Identify and contract with providers in regions 5 and 6 to offer MCR.
- LDH should expand coverage of MCR providers to 24/7 access.

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

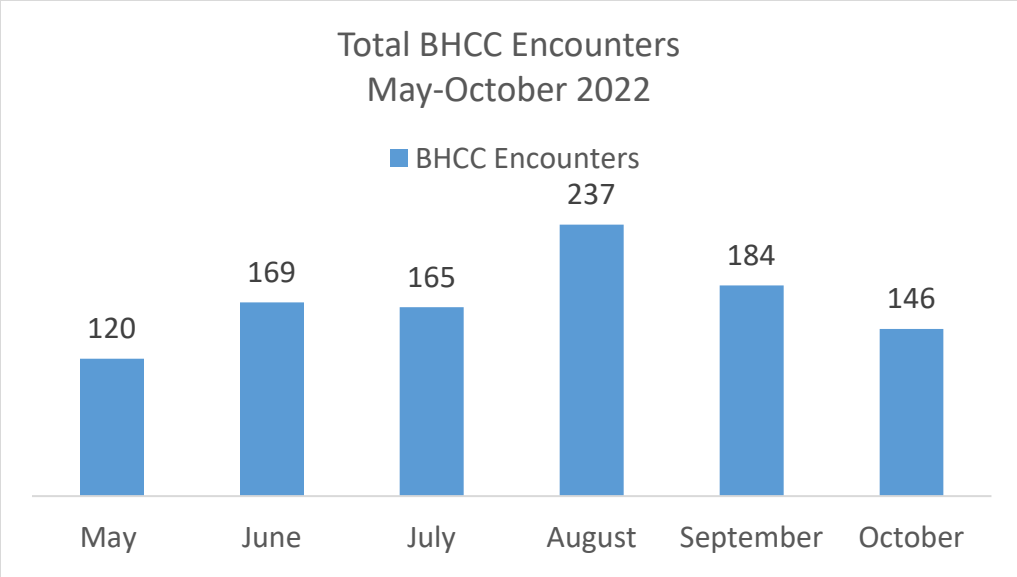
Compliance Rating: Partially Met

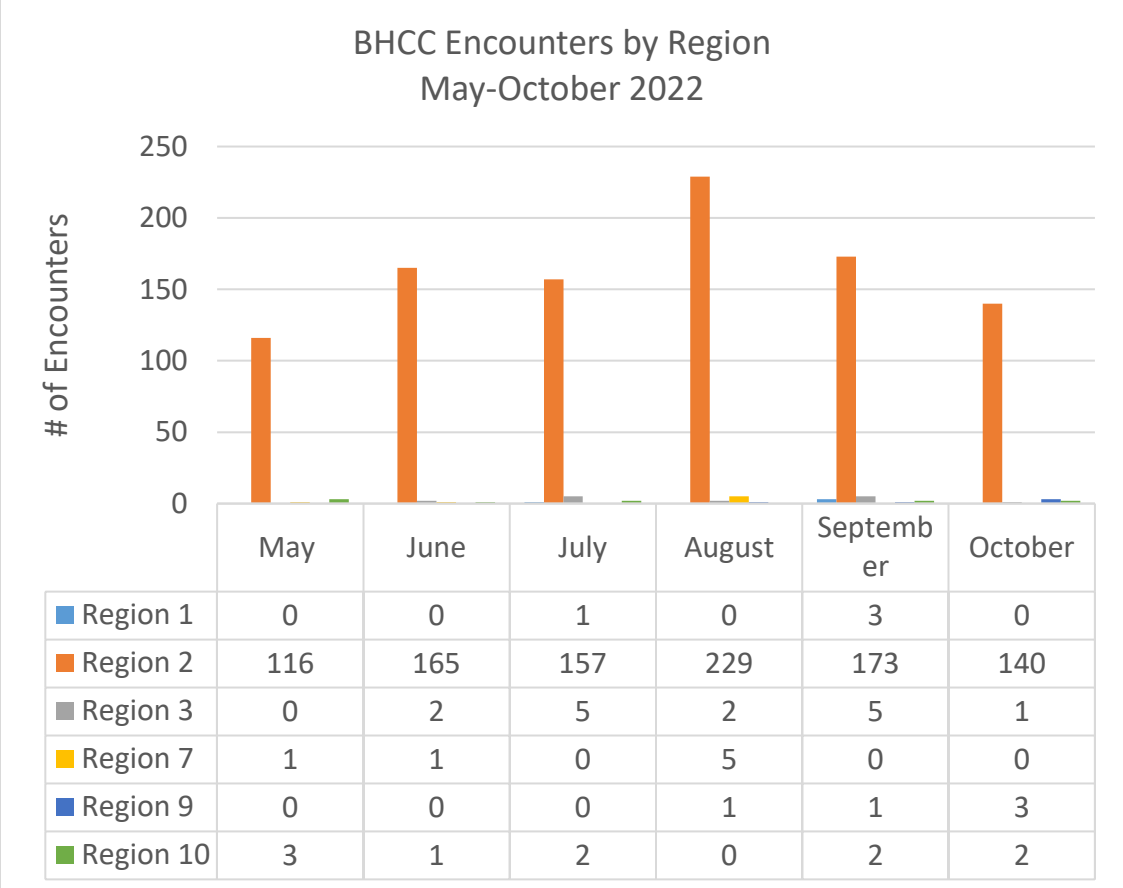
Discussion and Analysis

LDH has developed and has begun to implement Behavioral Health Crisis Care Centers (BHCC) throughout the state. The BHCCs vary in capacity based on the region's Medicaid population and informed by the 2021 Needs Assessment discussed in the sixth SME report. BHCCs serve as walk-in centers to address initial or emergent psychiatric crisis intervention response intended to provide relief, resolution, and intervention through crisis supports and services during the first phase of a crisis for adults. The State received approval from CMS in August 2022 to include CS as a service in the Medicaid State Plan. Prior to that time, CS providers would need to negotiate with MCOs for alternative payment approaches.

As indicated in paragraph 63, the State has developed, or is in the process of developing, BHCC capacity in seven areas. There are no BHCC providers in regions 4, 5, 6 and 8. As indicated in the seventh report, LDH and the SME conducted readiness reviews of the BHCC centers in regions 1, 2, 3, 4, 7, 9, and 10 to assess the BHCC's readiness to receive and provide crisis care for individuals.

The SME requested information regarding initial utilization of BHCC services. The State provided information regarding the utilization of BHCC service statewide and by region in the tables below.

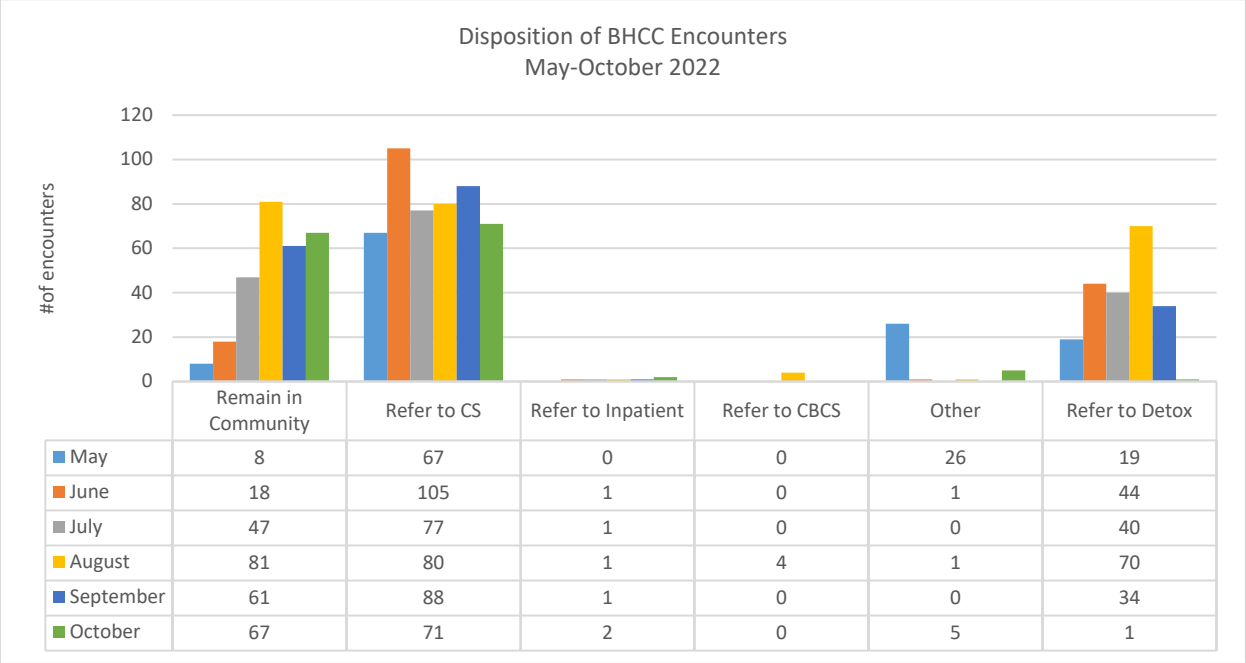




	May	June	July	August	September	October
Region 1	0	0	1	0	3	0
Region 2	116	165	157	229	173	140
Region 3	0	2	5	2	5	1
Region 7	1	1	0	5	0	0
Region 9	0	0	0	1	1	3
Region 10	3	1	2	0	2	2

The State reports 1,021 individuals have utilized BHCC services. Utilization of BHCC continues to be greatest in Region 2, where BHCC efforts have been in development for more than eighteen months. The SME has significant concerns regarding the implementation of BHCC. Similar to MCR, LDH is requiring MCOs and BHCC providers (many of whom also offer MCR) to take immediate steps discussed in paragraph 64 to ensure the viability and sustainability of MCR and other crisis services.

LDH has also provided information regarding the disposition of individuals seeking BHCC services. The table below provides disposition information.



	Remain in Community	Refer to CS	Refer to Inpatient	Refer to CBCS	Other	Refer to Detox
May	8	67	0	0	26	19
June	18	105	1	0	1	44
July	47	77	1	0	0	40
August	81	80	1	4	1	70
September	61	88	1	0	0	34
October	67	71	2	0	5	1

As indicated in this chart, almost all individuals remained in the community. Approximately 70% were referred to other behavioral health services. 48% of all individuals receiving BHCC services were referred to other behavioral health community services. An additional 20% were referred for detoxification. Less than 1% were referred to inpatient services.

In the sixth report, the SME recommended LDH pursue the following activities:

- Collect data by agencies and MCOs to determine where to target future investments. For example, understanding the nature of the crisis that individuals are experiencing may lead to further investments in peer-delivered services, housing supports, or specialized brief crisis services for individuals with co-occurring disorders.
- Work with MCOs to assure that post-crisis services and supports are accessible and effective. This includes timely appointments with prescribers, clinical staff, and peer supports following crisis care, to increase the likelihood of stabilization in the community.
- Develop other "upstream" and less restrictive strategies within outpatient services agencies to develop skills and capacity to provide suicide-specific care in the community and to assure agencies are adequately meeting urgent care needs of their existing clients (timely access for an urgent appointment, meaningful 24/7 crisis support telephonic support, and non-traditional appointment models such as Open Access that allow for same day scheduling).

Given recent implementation of BHCC, LDH does not have sufficient information to develop future investments in crisis services recommended in this paragraph. Nor does LDH have information regarding the availability and utilization of post-crisis supports and other upstream services.

As discussed in paragraph 69, LSU and LDH have prompted agencies to offer Open House tours of their BHCCs and had representation on site at each of the open houses. LSU has developed a Regional Coalition Development Guide as a resource for crisis agencies, including BHCCs, in conceptualizing and formalizing cross-sector relationships and a working crisis coalition and, along with LDH leadership, has provided significant telephonic and onsite TA, coaching, and modeling of how to engage system partners.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- LDH has developed BHCC capacity in most regions of the state.
- LSU has undertaken activities to ensure that MCR providers are prepared to offer BHCC and continues to offer coaching to these providers.
- BHCCs submit reports and LDH monitors the number of individuals receiving BHCC crisis care on a weekly basis.
- MCOs have contracted with BHCC providers in select regions to serve adults with Medicaid, including individuals in the Target Population.
- LDH developed a process to meet with MCOs and BHCC providers frequently during implementation to identify issues.
- There continues to be low uptake of BHCC services.

Recommendations

- Continue to work with each BHCC to increase referrals, including outreach efforts to law enforcement and additional referral sources.
- LDH should review the crisis plans for each individual receiving CCM and ensure that each plan, where appropriate, includes information regarding the MCO crisis line and BHCC.
- Identify and contract with providers in regions to offer BHCC.
- Continue readiness reviews as BHCCs are opened.
- Develop the necessary oversight structure to ensure these services are offered consistent with the Agreement.
- Develop and implement a strategy to identify additional investments for services and strategies discussed in this paragraph.

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

Compliance Rating: Not Met

Discussion and Analysis

Since 2018, LDH has been implementing significant changes to their SUD service system through a CMS 1115 Demonstration Waiver. The State has developed a continuum of services consistent with the American Society of Addiction Medicine (ASAM) that includes outpatient, intensive outpatient, residential, and withdrawal management services. A review of MCO network adequacy reports for the first half of 2022 (January-June 2022) by the SME indicated that there were no network adequacy issues for the various SUD levels of care during this reporting period. Yet, information suggests that SUD services are underutilized by the Target Population. A finding from the needs assessment is the "extremely low" penetration of SUD service utilization for members of the Target Population. As indicated in the fifth SME report, 48% of individuals with an SMI may have a substance use issue or disorder[3]. As indicated in the needs assessment, less than 5% of individuals who transitioned or were diverted received an SUD service. The SME's service review continues to find that over one-half of the individuals participating in the review had an SUD history. Several individuals were actively using (mostly alcohol) and did not want to seek or participate in treatment. The State reports that 6 individuals (1.6%) transitioned from NFs and 1 individual (3.4%) received SUD treatment for the period from July 1, 2022, to September 30, 2022.

In the fifth report, the SME recommended the State identify and address barriers to individuals in the Target Population who have an SUD who may benefit from treatment and recovery services. The SME requested this information for the sixth and seventh reporting period and has not received this information.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- There is a significantly low utilization rate of individuals in the Target Population (transitioned or diverted) who need but do not receive SUD services despite the availability of SUD services.
- SUD services have not been identified or included in most individuals' ITP or plans of care, even though the assessment and service reviews indicate a need for SUD treatment.
- The State has not identified and addressed barriers regarding access to SUD treatment for individuals in the Target Population.

Recommendations

- Ensure the acumen of TCs and CCMs to assess the need for SUD and provide motivational interviewing strategies to encourage individuals to take the necessary steps to increase goals and SUD intervention for individuals with an identified SUD that have CCM.
- Ensure each individual transitioned or diverted with an existing SUD is provided information regarding SUD treatment services, including alternative treatment settings (e.g., recovery groups).
- Increase the number of plans of care developed by CCMs that have identified goals and interventions for individuals in the Target Population with an SUD.
- Continue to provide information regarding the utilization of SUD services on a quarterly basis for individuals in the Target Population.

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

[3] https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-01-004_Final_508.pdf

Compliance Rating: Partially Met

Discussion and Analysis

LDH has continued outreach efforts to law enforcement during this reporting period. LDH, in partnership with LSU, has focused on building regional collaboratives rather than ad-hoc regional meetings. The purpose of these collaboratives is to continue to have crisis agencies form relationships with law enforcement, judges, and police departments. The State reports there has been modest success in some regions that were some of the first regions to go live with crisis services. The State reports they continue to work with other regions that had more recent crisis implementation efforts. In addition to these efforts, LDH reports:

- Law enforcement leadership were invited to all of the BHCC open houses.
- LDH/LSU have invited law enforcement to attend early, local collaborations where they have been developed and are providing technical assistance to providers in regions where these collaboratives do not exist.
- Crisis agencies are beginning to undertake ride-alongs with law enforcement and accepting direct requests for response.

The regional collaboratives have identified several issues that were raised by law enforcement agencies and coroners. These conversations led to the identification of several barriers. These barriers vary across regions. The major barriers are:

- Liability to police departments if they take an individual to BHCC or contact a MCR rather than taking the individual to an ED.
- Less than 24/7 service hours for crisis services
- Current policy/procedures that direct law enforcement to bring individuals to emergency departments.

Some of these barriers will be addressed as crisis services are implemented throughout the State and expand to 24/7 coverage. Some of these other barriers may take some time to address given crisis agencies are just developing competencies and relationships with law enforcement and others. Some of these policies have been long standing and will take time to address at the regional level, which is likely the most appropriate focus given local law enforcement policies may be specific to a certain geographic region.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- The State has been working with regional crisis providers to develop regional collaboratives which include many of the parties in this paragraph.
- The regional crisis collaboratives exist in some, but not all, regions.
- The State reports they are working with regions with newer crisis providers to establish these collaboratives.
- The engagement of law enforcement varies across regions.
- The State, through these regional collaboratives, have identified policy and service barriers that hinder the use of crisis services by law enforcement and others.

Recommendations

- LDH should continue their efforts to support crisis providers to develop and maintain regional collaboratives that include law enforcement, judges, and coroners to better encourage diversions and referrals to crisis services.
- LDH and LSU should work with local crisis providers to address barriers identified by regional collaboratives that impede engagement of individuals who are in contact with law enforcement. This could include tapping into law enforcement expertise to address some of these regional barriers.
- The State should continue their efforts to provide timely information and meet with State law enforcement agencies regarding the implementation of crisis services and implications for State law enforcement personnel, including addressing the liability issues discussed in this paragraph.

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

Compliance Rating: Partially Met

Discussion and Analysis

As indicated in paragraph 63, the State, with the assistance of LSU and the SME, has developed policies, procedures, and training for the MCO crisis lines and the four crisis services. The State has finalized the necessary performance metrics for the call center and crisis providers. The SME has reviewed these metrics and believes that are a good starting point for monitoring the crisis lines and crisis services.

In the sixth report, the SME recommended the State finalize how the MCOs will oversee the provider network against these performance metrics to increase the accountability and performance of all crisis providers. The State has started tracking these metrics, especially the MCO call lines. The most recent data for this reporting period indicates the following:

Behavioral Health Crisis Line	
% Of Incoming Calls Answered	96%
% Of Calls Abandoned	4%
% Of Calls Answered within 30 Seconds	97%

These initial metrics indicate that MCOs are answering calls within an acceptable range.

LDH is actively working with MCOs and crisis agencies on initiatives that promote access to crisis services and is addressing any specific barriers to care as they arise. Communication between MCOs and crisis agencies is good, with well-established lines of communication. One of these strategies includes clear processes for service authorization (CBCS, CS) that providers report is working smoothly.

In addition, as discussed in paragraph 64, the State and MCOs have developed Crisis Care Coordination Protocols to convey expectations for coordinating crisis care across the continuum of crisis care including the MCO crisis line.

LDH reports there have been a number of efforts to engage system partners by crisis agencies, MCOs, and LDH. These include:

- Open houses to better inform the community of newly developed crisis services.
- Development and distribution of marketing materials
- Conference presentations
- Direct information to MCO members
- LSU/LDH technical assistance to crisis agencies on building collaborations with community partners.

The change has largely been driven by LDH, and not a broad, cross-sector consensus on a need for change. Other systems have yet to identify the need for new crisis services. There are concerns about the limited hours and population served. Crisis services is also a new concept for most law enforcement entities. In addition, there is a perception of financial disincentive in shifting care from EDs and ongoing concerns about liability by the hospitals if they allow crisis providers to treat in their facilities. All of these factors paired with still-developing skills in coalition-building may be contribute to very low numbers.

LDH reports to be developing a new data collection tool on a more sophisticated platform. The collection methodology will allow the user to see how a person moves through the crisis system and all of the services they receive.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- The State has developed the policies and procedures and developed and implemented training for crisis call line staff and crisis providers.
- The State has developed measures for crisis lines and for all four crisis services, including mobile crisis response, and worked with the SME to develop these measures.
- The State has begun efforts to review MCO crisis lines against the established measures and initially the crisis lines are performing well.
- The State has developed protocols to standardize response by MCOs and providers (including CS) to crises.
- The State is working with MCOs and crisis providers on initiatives that promote access.
- LDH is developing a new data collection tool to monitor how a person moves through the crisis system.

Recommendations

- LDH should continue to track and review the performance of the crisis lines against the current measures and provide a report to the SME on a monthly basis.
- LDH should identify and address performance issues for crisis line staff and crisis providers based on these reviews.
- LDH should implement the new data collection tool referenced in this paragraph.
- LDH should continue efforts to provide performance data so that all MCOs and all crisis agencies see the performance numbers for all parties; move to dissemination of these reports.

- LDH should develop access to performance information for crisis agencies, MCOs, and LSU that allows for sorting/refining data.
- LDH should develop format/method of disseminating public facing reports.
- LDH should finalize a process for collecting/dashboarding key data.

B. Assertive Community Treatment

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

Compliance Rating: Met

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

Compliance Rating: Met

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

Compliance Rating: Met

Discussion and Analysis

These ratings have changed from Partially Met to Met. Paragraphs 70-72 are addressed together. As of December 2022, the State reports there are 45 ACT teams operating within Louisiana that are and will be serving individuals in the Target Population. The SME requested, and LDH provided information on, the number and percent of individuals transitioned from NFs during FY 2022 who received ACT. Currently, 94 individuals transitioned from NFs, or approximately 29%, utilize ACT. The State reports that 2 individuals or 7% of the diverted population are engaged in ACT. During the seventh reporting period the State informed the SME regarding the number and percent of individuals transitioned from NFs and diverted during the first six months of FY 2022 who received ACT. During that period, 60 individuals in the Target Population, or approximately 24%, utilize ACT. The State reports that 12% of the diverted population were engaged in ACT. The 2021 Needs Assessment indicated that approximately 26% of individuals transitioned from NF received ACT and 17% percent of individuals diverted from nursing facilities received ACT. While there is an increase in the percent of individuals who were transitioned receiving ACT, there was almost 60% fewer individuals who were diverted receiving ACT during the first half of this reporting period. Given the initiation of CCM this reporting period, the SME would hope to see higher ACT engagement rates for individuals diverted from NFs.

In the seventh report, the SME requested information on whether any individuals who requested ACT did not receive this service. LDH has not provided the SME with this information during the last reporting period. In addition, the SME recommended that LDH review policies and other efforts to better identify individuals who will be or have been recently transitioned to determine if these individuals (based on their previous behavioral health ED and IP utilization) should be referred to ACT teams. This would require that

TCs or CCMs review data or information (e.g., PASRR Level II) to determine if the individual has frequent crises, ED visits, or long hospitalizations for mental health reasons.

The SME's service review performed during this period did focus on what services individuals indicated they needed and were receiving to successfully remain in the community. This included a review of the individual's service utilization, other record reviews, and interviews. During this review, there was a high proportion of individuals whose community plan included and they were receiving ACT. Specifically, 10 of the 27 individuals or 37% of the individuals in the sample were receiving ACT. Per the SME's review there was no one in the sample that needed or requested ACT who did not receive ACT.

Given the transition projections for CY 2023, approximately 105 individuals who transition from NFs may need ACT services (assuming 350 individuals will be transitioned from nursing facilities by December 31, 2023). This is based on the percent of individuals who have been transitioned during 2018 and 2019 (pre-pandemic) and received ACT (26%) and will be expected to increase over time as transitions continue to increase. Given current utilization, only a small number of individuals diverted would need ACT; however, this is based off of very low utilization.

In the sixth report, the SME reviewed Louisiana's level of care requirements for ACT against similar requirements in other jurisdictions. LDH has not made changes to these requirements and, as constructed, the SME continues to believe the admission criteria for ACT are reasonably consistent with other states.

In the fourth SME report, the SME identified that the State does not have defined exit or stepdown criteria. The SME has provided examples of other states' exit/stepdown criteria. The SME reports LDH is working with all 6 Managed Care entities to revise the ACT Service Definition. The state has organized a subgroup of the MCOs to address ACT in particular, and that group will be addressing step-down and use of the Outcomes data system referenced later in this paragraph. LDH reports they have resumed in person meetings with the ACT teams (which had been suspended due to Covid) and agenda items include discussion of their use of outcomes and other data to ensure that there is a path to stepdown for individuals who no longer need this level of care.

As indicated in previous SME reports, the State, through its MCOs, conducts fidelity reviews of ACT providers on an ongoing basis. During the sixth reporting period, fidelity reviews were conducted on 21 ACT Teams. The balance of the reviews (24) were to be conducted in this reporting period. The SME requested and received these fidelity reviews on the 21 teams.

Previous fidelity reviews highlighted the lack of employment focus for some of the ACT teams. In the SME's opinion, with respect to the employment area, the ACT teams are singularly positioned to provide intensive supported employment services because the teams already include a dedicated employment specialist. The State is in the process of exploring options related to enhancement of employment programming as it relates to ACT services.

In the previous report, the SME identified recent summary fidelity reports that indicate continued weakness in some areas concerning assessments, individualized treatment plans, and individualized treatment. As indicated in the seventh report, these are major areas for ensuring fidelity that is concerning given previous fidelity reviews where these were not identified as weaknesses. The SME recommended and the State performed on-site reviews of ACT teams in several regions. SME reviewers had the opportunity to "ride along" on several ACT visits in the last reporting period and witnessed several instances of assertive, clinically sound, thoughtful attention to the members by the team. The SME

assessment indicates critical documentation (service plans and ongoing notes) could be improved to reflect the actual provision of services, which in the SME's opinion was consistent with the delivery of ACT. As with all Evidenced Based Practices, continuous quality improvement efforts are important to overcome turnover and the changing environment. The SME believes LDH's resumption of in-person meetings with ACT team leadership is helpful in these efforts.

As indicated in the sixth report, the State has developed critical performance measures that are specific to ACT. The purpose of these measures is to determine if high fidelity for an ACT team is associated with better outcomes and if lower fidelity is associated with poorer outcomes (e.g., low intensity services or lack of individualized plans for individuals on an ACT team). OBH collect data to review the performance of each ACT Team. This information is entered into the ACT Outcomes System. Teams continue to have occasional technical glitches with this system, but it is now in use consistently, and the MCOs are reporting data to the LDH. Outcomes measurement will be an agenda item for the upcoming (early spring, 2023) in-person ACT leadership meetings.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- The State continues to have a sufficient number of ACT team providers statewide.
- The percent of individuals transitioned from NF who receive ACT slightly exceeds the projected penetration from the 2021 Needs Assessment.
- There is very low utilization of ACT by diverted individuals during this reporting period.
- Individuals reviewed by the SME who were good candidates for ACT were offered and received ACT.
- Ongoing ACT fidelity reviews are conducted by an independent national organization.
- The State has done reviews of ACT teams to address the issues identified in the fidelity review.
- The State collects important data on outcomes associated with ACT and has analyzed this data to determine what outcomes could be improved.
- MCOs and LDH, during the next reporting period will begin in-person meetings with ACT teams to review outcome information and address issues identified by this data.
- The State has begun to revise the service definition and clarify step-down criteria for ACT.

Recommendations

- Continue to perform fidelity reviews of ACT including a review of efforts to implement IPS.
- Continue to develop strategies to address the findings from recent fidelity reviews.
- Consider offering ACT to all individuals who are diverted from NFs (even if on a limited basis). These individuals are high risk for continued issues that could assist the CCMs to stabilize these individuals during the first six months of engagement in CCM.
- Continue to analyze information from the ACT Outcome System, including ED and inpatient utilization to identify individuals in the Target Population that could be referred to ACT and develop the step-down criteria to create additional future capacity.

C. Intensive Community Support Services (ICSS)

73. In Louisiana, [Intensive Community Support Services ("ICSS")] *are provided through a variety of community-based mental health rehabilitation services as described below. Managed Care Organizations (MCOs) manage Medicaid reimbursable services for the treatment of mental health and substance use disorders. LDH shall monitor the MCOs, LGEs, and Medicaid provider network to ensure the number and*

quality of community mental health service providers are sufficient to enable individuals in the Target Population to transition to and live in the community with needed Community-Based Services. LDH will take into account rates and billing structure for Community-Based Services to ensure that all members of the Target Population have access to ICSS of sufficient intensity to support their transition, recovery, and maintenance in the community.

Compliance Rating: Partially Met

Discussion and Analysis

The State continues to measure the availability of and access to Intensive Community Support Services, which include services in the State's current Medicaid behavioral health services, on a quarterly basis utilizing network adequacy reports. For the purposes of this report, the SME has identified the following services to be intensive community supports:

- Community Psychiatric Services and Treatment
- Psycho-Social Rehabilitation
- Crisis Services (current crisis intervention services)
- Assertive Community Treatment
- Peer Supports
- Intensive Outpatient Programs
- Ambulatory Withdrawal Management with Extended On-Site Monitoring

The State provides the findings of MCO-generated reports on network adequacy quarterly to the SME. It is also included in the quarterly Quality Assurance matrix developed by LDH. Based on the review of these reports for the CY 2021 and the first two quarters of CY 2022, there are no obvious access issues for all but one Intensive Community Support Service. The number of Community Psychiatric Support and Treatment (CPST) providers generally remained the same in the two quarter of CY 2022 as compared to the previous calendar year. While Intensive Community Support Services could be defined as inclusive of case management services, for the purposes of this report case management is being considered as a stand-alone service for which the State is developing a more tailored strategy. During the seventh reporting period, LDH has proposed changes to the CPST service, to better differentiate the role of this service versus Psycho-Social Rehabilitation (PSR), which had overlapping service definitions.

Similar to ACT, the current needs assessment reviewed the demand for ICSS services by members of the Target Population who are transitioned or diverted from NFs. Recent information from LDH indicates that approximately 14% of individuals who were transitioned received other ICSS services (CPST and PSR). Approximately 3.4% of individuals diverted from NFs received these services. The needs assessment identified that approximately 57% of individuals who were transitioned received other ICSS services (CPST and PSR). Using information from these two data points, approximately 200 additional individuals may need CPST or PSR during CY2023 (assuming, 350 individuals will be transitioned from nursing facilities and 144 individuals will be diverted by December 31, 2023). This continues to be a relatively small number compared to the 14,000 adults who utilized this service in CY 2021 and the current capacity in the network should be sufficient. LDH has performed rate analysis and adjustments for some services (e.g., crisis and ACT); however, the SME is not recommending that the State perform an analysis of rates and billing structures for the MHR services. While rates can be an indicator of barriers to access, the needs assessment and review of the MCO's network adequacy report does not imply there are issues with accessing CPST.

The SME has not reviewed the quality of some of these services. Unlike ACT and IPS (discussed later in this section) there are no fidelity review tools for these services. LDH does license these providers and reviews whether they are meeting agency and service-specific standards on a regular basis. For the next reporting period, the SME requested information on the process used to review providers of ICSS services and determine how licensing agencies and MCOs review the quality of the providers. LDH has recently provided the SME with this information but the SME has not had an opportunity to review these requirements and will do so early in the next reporting period.

As discussed later in paragraph 79, an ICSS that is not being utilized continues to be Peer Support. The lack of any appreciable utilization of this service is very concerning to the SME, given the importance of this service in offering support from people with lived experience in their day-to-day life.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- The Department has a process for monitoring the MCOs' efforts regarding the availability of ICSS on a regular basis.
- With the exception of peer supports, ICSS services are generally available to the Target Population.
- Utilization of ICSS services is lower than the projections established through the Needs Assessment.

Recommendations

- LDH should continue to implement the activities in paragraph 79 to develop peer supports.
- LDH should develop a strategy to determine why utilization of CPST and PSR services are significantly lower than what was identified in the Needs Assessment.

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

Compliance Status: Met

Discussion and Analysis

The State continues to offer and provide these services through the Mental Health Rehabilitation (MHR) program. There are over 400 providers of MHR services throughout the State. The State has made some legislative changes to better delineate the differences between CPST and PSR. The SME has reviewed these changes and feels as if these changes will further delineate the role of agencies that are providing

these services. There have not been significant changes in the number of providers that are offering these services. In previous reports, the SME recommended LDH track agency closures that could be directly related to the pandemic. For the third through sixth reporting periods that spanned January 2020 through December 2022, there were very few closures of agencies providing MHR services. The SME has not requested this information during this reporting period due to the easing of the pandemic and very few changes in the number of MHR providers.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- The State continues to ensure that MHR services exist in the community.
- The number of MHR providers is robust, and the network of MHR providers remains stable.
- The State reviews and makes changes to the MHR to improve the intent of the program.

Recommendation

- LDH should continue to track the provider network offering MHR services to ensure its ongoing availability.
- LDH should develop a process to ensure the proposed changes to CPST and PSR had the desired impact.

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

Compliance Rating: Partially Met

Discussion and Analysis

Several existing Medicaid services, such as PSR and CPST, do assist individuals with various IADLs and have been in the State's Medicaid program for almost twenty years. The State received approval to offer peer support services which can also provide assistance to individuals with IADLs such as shopping, transportation, and managing finances. However, as indicated in paragraph 72, these services have yet to be actively implemented.

A major pathway for individuals to receive personal care services is through the CCW program and the Long-Term Personal Care Services Program. These programs support individuals who meet nursing facility level of care with various services, including personal care. LDH reports that 144 individuals transitioned received PCS services through either of these programs during the first half of this reporting period.

As discussed in the seventh report, the State began to stand up a third pathway for individuals in the Target Population who needed personal care but did not meet NF level of care. The State obtained the appropriate authority from CMS (e.g., through a 1915(b)(3) Waiver) for this service in the sixth reporting period. The State reports the MCOs have enrolled 37 providers and continue the process of identifying enrolling providers to this newer personal care service. The State reports that only one individual transitioned from NFs have received this new personal care service. The SME is concerned about this low utilization but understands this service was implemented during the third quarter of this calendar year. The Department reports claiming for this service may lag (meaning claims may not have been submitted during the period from July 1 through September 30) and may not reflect more recent utilization.

The SME recommended and LDH provided information collected by CCMs that identify gaps in personal care services. Information collected by the CCMs specifically identifies if there are services the individual needs but has yet to receive. Information reviewed as of July 2022 (the most recent data available) reported 10 of 172 (approximately 6%) individuals who were diverted or transitioned needed but had not yet received personal care services.

As discussed in the seventh report, there were several issues with the existing personal care services offered through the Community Choices Waiver and State Plan. Perhaps the major issue with existing personal care services is the lack of timely access for individuals transitioning from NFs. As indicated in the previous SME report and supported by the current service reviews, there have been instances where personal care was not provided on a timely basis for individuals transitioning from NFs. In some instances, personal care services were provided at transition, but gaps in care occurred post transition. OAAS reports these gaps have been and continue to be related to ongoing workforce issues. The State and providers report the pandemic has impacted the ability to recruit and retain qualified individuals to provide these services. The State requested and disbursed additional federal funds through the American Recovery Plan Act (ARPA) to increase salaries for personal care and other direct care service workers as a strategy to address these gaps. The impact of these actions has not been assessed given their recent implementation. During the next reporting period, The SME is requesting information to measure if these efforts positively impacted the availability of these services.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- The State has disbursed enhanced reimbursement for personal care services that is aimed at addressing workforce shortages.
- A significant number of individuals are receiving personal care services through the CCW or LTPCS program; however, only one individual received the new personal care benefit for those individuals who are not eligible for current Medicaid PCS.
- MCOs continue to develop the personal care network for individuals in the Target Population who do not meet NF level of care.
- There is a small percent of individuals (6%) who need but have yet to receive PCS services.

Recommendations

- LDH should continue to track and provide 1915(b)(3) personal care services to all individuals in the Target Population who have been transitioned from an NF who do not meet the level of care for the other personal care benefits.
- LDH should ensure that each individual where the Transition or Community Assessment identify the need for assistance with ADLs have personal care services in their ITP or their Plan of Care.
- LDH should continue to monitor whether individuals who are transitioned or diverted and who needed PCS receive these services in their monthly plan-specific reviews.

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

Compliance Rating: Not Met

Discussion and Analysis
LDH has not performed structured activities that address this paragraph. The SME is unaware of engagement and subsequent discussions with stakeholders regarding a review and possible changes to these provisions. In previous reports, the SME recommended LDH develop an organized process to engage stakeholders to review current provisions, make recommended changes, and develop the necessary policy guidance to address these rights. The State has not undertaken these activities. The SME is recommending the State initiate steps to meet the requirements of this paragraph during the next reporting period.

Compliance Assessment
The SME assessment of the State's compliance with this paragraph took into consideration:

- LDH has not taken steps to address the requirements of this program.

Recommendations

- LDH should undertake the following activities during this next reporting period to meet the requirements of this paragraph:
    - Identify members of the existing My Choice Advisory Committee and several additional individuals with lived experience, including individuals in the Target Population, to meet as a subcommittee to address this paragraph.
    - LDH should provide information and solicit recommendations regarding changes to the current protocols and process used to ensure personal and treatment rights of individuals receiving behavioral health services.
    - LDH should develop a strategy(s) to address the proposed changes and present these changes to the LDH My Choice Advisory Committee for their review.
    - LDH should develop a timeline for implementing these strategies this next reporting period. All strategies should be implemented by June 30, 2023.

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

Compliance Rating: Partially Met

Discussion and Analysis
The State has a process to credential peer support specialists who could provide the services in this Agreement. As of this report, there continues to be approximately 300 credentialed peer support specialists in Louisiana. Currently, the State, through the MHR program, has policies (through the existing service definitions) that allow peer specialists to provide services, including all four new crisis services: ACT, Community Psychiatric Support and Treatment, Psychosocial Rehabilitation, and Crisis Intervention.

As indicated in the seventh report, there is no information readily available to determine the extent to which peer specialists offer these services. LDH states they are currently developing a contract for various activities that will support peer credentialing and tracking of current peer employment information including the delivery of services and supports referenced in this paragraph. The State anticipates this information will be available later in CY 2023 (likely in the tenth SME reporting period).
As discussed later in paragraph 79, a significant reason for the lack of utilization of the new peer support service was an issue with applicants with lived experience passing background checks. There was

legislation passed in June to ease criminal background requirements for peer support specialists that may increase the number of peers. There is no information that is currently available to assess the impact on this legislation given its recent passage.

In addition, as indicated in several paragraphs, the service reviews identified that many individuals who were transitioned or were diverted experienced isolation and loneliness. Having a robust peer support service available to these individuals would be helpful to address these concerns. Specifically, peer services would provide meaningful interactions with the individual, assisting the individual to identify resources in the community (formal and natural supports) that could be leveraged to address this isolation and loneliness.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- The State does have policies to credential peer support specialists.
- The State allows, but does not require, peer support specialists to provide services in A-C of this Agreement.
- The State is not able to track the number of peer support specialists who provide services in Section A-C of this Agreement.
- The State reports they are implementing activities in CY 2023 that will allow them to report on peers delivering services referenced in this paragraph.
- There are barriers to agencies interested in hiring peers (e.g., background checks).

Recommendation

- LDH should implement the strategies discussed to obtain information on the number of peers employed by MHR programs.
- The State should continue to identify barriers to recruiting and employing peers.
- Based on this information, the State should identify strategies to address any significant barriers to recruiting and employing peers.
- LDH should also provide the SME with information on peers delivering new services (e.g., crisis and supported employment) during the next reporting period.

D. Integrated Day Activities

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

Compliance Rating: Not Met

Discussion and Analysis

The State defined a preliminary set of integrated day services for members of the Target Population that include employment supports, drop-in centers, and adult day opportunities. The State's primary focus continues to be on developing employment opportunities for individuals in the Target Population. These opportunities are to enhance State efforts to offer integrated opportunities for people to work and be provided with high fidelity to evidence-based models, such as Individual Placement Supports (IPS). As indicated in the seventh report, the State finalized a definition for IPS, received approval to include it in the State's Medicaid program, finalized a reimbursement methodology for IPS, trained providers on the importance of employment, and is participating in a National Learning Collaborative on IPS. During this reporting period, they have focused on enhancing the acumen of ACT teams providing employment supports, exploring ways in which tenants of the IPS model can be utilized. In addition, the State has been accepted into the federal Department of Labor, Officer of Disability Employment Policy's ASPIRE program which provides a learning community for states to enhance access to IPS for individuals with serious mental illness. The first goal for LDH's participation in the ASPIRE program is to ensure the TP will receive IPS Medicaid services and Louisiana Rehabilitation Services (LRS). The second goal is for LDH to Implement and expand utilization of IPS programming for the TP through the expansion of Local Governing Entities (LGEs) rendering the service.

Despite these activities, the Department has not created the necessary demand for these services for individuals in the Target Population. LDH has reviewed information from the Transition Assessments and identified 136 or approximately 20% of individuals on the Active Caseload List who have expressed an interest in employment. This represents a substantial number of individuals who would benefit from employment related supports, including IPS. It should be noted, this is a significant improvement on TCs' efforts to discuss and identify interest in employment through the transition assessment process and therefore many individuals who want to work do not have the supports in place to achieve that goal.

As of this report, there are no individuals in the Target Population receiving IPS. As indicated in the sixth SME report, a low volume of demand will provide LGEs with fewer incentives to dedicate staff resources to the delivery of IPS, which will impact the availability of this service.

Creating the demand for IPS will need to be coupled with an approach that trains LGEs on how to deliver IPS. As indicated in the seventh report, LGEs have received preliminary training on employment supports. The State reports LGEs have received additional training and technical assistance from the State to implement IPS. The State has yet to contract with the national IPS Employment Center, the creators of IPS, to build an infrastructure to provide IPS services. The IPS Employment Center will focus on select, but not all, areas of the state to provide technical assistance regarding IPS.

While IPS and the MHR program can provide valuable employment supports to individuals in the Target Population, Louisiana Rehabilitation Services (LRS) can provide another avenue for employment supports. LDH does not have a strong working relationship with LRS. LDH has not yet contracted with a consultant to assist with linkages between OBH and Louisiana Rehabilitation Services to ensure that referrals for IPS are appropriate and LDH does not duplicate efforts or funding for this service.

As discussed in paragraphs 70-72, the State has increased its emphasis on employment services through ACT. OBH has released guidance to providers regarding employment services, including the use of existing services (CPST and PSR) to offer employment supports and coaching through the MHR program. This

guidance is essential for having MHR providers understand they can offer employment supports to individuals that may not need the intensity of IPS.

In previous reports, the SME recommended that additional services or supports be available to the Target Population for ensuring additional integrated day options. The State gathered information to identify drop-in/low-demand social settings that could provide support and engagement to individuals transitioning or being diverted from NFs. Information from the surveys was added to the resource guide for the Transition Coordinators. Given that some of these programs have limited operations during the pandemic, the SME recommended in the fifth report that the State identify which of these programs are still operational and update the resource guide for the next reporting period. The State reports they have done outreach to these drop-in centers to determine if they are still operational during the waning of the pandemic. The State reports all drop-in centers are operational. The State reports they will develop a process in CY 2023 to provide information to these drop-in centers regarding efforts in other states to modernize their approaches and offer activities that will enhance individuals' overall wellness.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- The State has undertaken important initial steps to identify and develop integrated opportunities for individuals to do during the day, with a focus on IPS.
- The State has yet to contract with a technical assistance vendor to assist with developing pathways for individuals to access LRS services.
- The TCs have enhanced efforts to identify individuals who express an interest in working during the transition assessment process.
- There continues to be no referrals of individuals in TP to IPS since the launch of this service.
- The State has not released the guidance for MHR agencies to offer employment supports.
- LGEs have received limited training or technical assistance to launch IPS.
- The State has gathered important information regarding the current status of drop-in centers.
- The State has plans to provide information to drop-in centers regarding approach to improve the wellness of individuals who participate in their programs.
- The State will participate in the federal ASPIRE initiative to develop access to IPS services for individuals in the TP.

Recommendations

- LDH should leverage the ASPIRE program to address the needs of the TP on the Active Caseload List who have indicated an interest in employment.
- LDH should develop a process to track whether the recently released guidance and changes to the ACT definition has resulted in more individuals participating in the MHR program becoming employed.
- LDH should ensure that TCs and CCMs are initiating referrals to LRS and IPS and track the specific referrals and engagement with IPS.
- LDH should track the number of individuals transitioned or diverted from NFs who are working (paid and volunteer employment).
- LDH should execute the contracts for enhancing the partnership with LRS and training of LGEs on IPS.
- LDH should implement efforts to provide information on wellness approaches to drop-in centers.

- LDH should ensure that MCOs implement strategies for assessing the fidelity of IPS for LGEs who are providing IPS.

E. Peer Support Services

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

Compliance Rating: Not Met

Discussion and Analysis

Peer support is an evidence-based practice for individuals with mental health conditions or challenges. Both quantitative and qualitative evidence indicates that peer support lowers the overall cost of mental health services by reducing re-hospitalization rates and days spent in inpatient services and by increasing the use of outpatient services. Peer support improves quality of life, increases and improves engagement with services, and increases whole health and self-management. The State and the SME believe there is an interest in increasing access to and involvement of peer support specialists.

The State has received CMS approval for a Medicaid reimbursable stand-alone peer support service as of March 2021. Currently, only LGEs can offer this service. The SME requested and received recent information on the number of individuals in the Target Population who received the new peer support services during this reporting period. The State reported very little utilization of this service by individuals who were transitioned or diverted during this reporting period. The State reports only one LGE is implementing this service. As discussed in the sixth report, the State identified several barriers to this slow implementation. LDH does report that all organization offering ACT have peer support specialists on their teams.

As indicated in the seventh report, LDH reports they undertook various activities to enhance peer supports services:

- Conducted individual meetings with LGEs as needed to provide guidance and technical assistance regarding billing and reimbursement.
- Passed legislation that will not have minor offenses included in background checks.
- Explored additional provider types for expansion of Peer Services, including outpatient providers.
- Partnered with the Louisiana Peer Action Advocacy Coalition (LaPAAC) and The Extra Mile IV to host a virtual peer job fair in December 2022 to introduce qualified peers who are seeking employment to the LGEs.

Despite these efforts, there is no real utilization of this service and therefore it is not adequate to meet the needs of the individuals in the Target Population. As discussed in paragraphs 61, the SME service review indicated peer support was the most needed service in discussions with individuals participating in the review. Many individuals expressed feeling lonely and not feeling well integrated into their community. The SME service review team discussed the possibility of peers addressing feelings of

loneliness and offering strategies for better community inclusion with individuals during the review. Individuals interviewed through the service review expressed interest in this service.

The SME continues to believe LDH, and the State should pursue an alternative strategy for implementation of a new peer service, developing a provider type that is specific to peer supports similar to other state's approaches. While the SME understands this will delay the implementation of this service it is highly unlikely, in the SME's opinion, that LGEs will have the interest to develop this service.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- There has been no significant implementation of a separate peer support services. The lack of utilization of these services over the past two years is discouraging.
- While there are promising efforts (e.g., legislation that changes criminal background checks), it is still too soon to determine the positive impact of these changes.
- Individuals participating in the SME service reviews identified significant periods of loneliness and a general lack of identifying and accessing activities that would enhance community inclusion.
- LDH has yet to pursue a strategy recommended by the SME to have organizations (in addition to LGEs) deliver peer services.

Recommendation

- LDH should increase LGEs' capacity to offer peer support services.
- LDH should have ACT teams serving the TP diverted or transitioned from NFs include peer support services in ACT-specific plans and offer peer services with some frequency to address issues with loneliness and community inclusion.
- The SME continues to believe LDH State should continue to pursue alternative strategies that do not rely exclusively on LGEs so that access to peer support services can be expanded.

F. Housing and Tenancy Supports

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

Compliance Rating: Partially Met

Discussion and Analysis

In December 2019, the State developed a Housing Plan, as required under the Agreement. The plan set forth specific actionable strategies with specific annual targets for the creation of additional affordable housing units and rental subsidies to be made available to members of the Target Population.[4] The plan identified development of housing and non-development strategies (e.g., vouchers). The plan also

[4] http://ldh.la.gov/assets/docs/MyChoice/MyChoiceHousingPlan.pdf

included housing opportunities under the 811 PRA, Low Income Housing Tax Credit (LIHTC) Section 8 programs, and the State Rental Assistance Program.

As indicated in the seventh report, the State has revised its housing plan through 2025. In revising the plan, LDH worked with LHC to better identify the development and non-development strategies for the next three years. The State included similar development and non-development opportunities in the original plan. In addition, the State collected and analyzed information regarding the Planned Permanent Supportive Housing (PSH) opportunities created, including units/subsidies offered to the Target Population and individuals who took advantage of these housing opportunities. The analysis of this information is provided in paragraph 81. LDH has met with the SME and DOJ to discuss the implementation of the plan. While it is important to have this plan, it will also be important to track progress against this plan frequently (as discussed in paragraph 81).

The State has yet to post the revised plan for stakeholders.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- LDH has revised the 2022 housing plan for individuals in the Target Population.
- The housing plan only provides rental assistance for units that are integrated into the community.
- LDH has developed a good working relationship with LHC staff to leverage their resources to access various housing strategies.
- The State has not posted the most recent housing plan.

Recommendations

- LDH should post the current housing plan.
- LDH should track and update its plan on an annual basis and provide information to the SME and stakeholders regarding the efforts each year to meet the intent of paragraph 81.

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

Compliance Rating: Partially Met

Discussion and Analysis

Over the past four and one-half years, the State has transitioned 441 individuals. Historically, 60% of these individuals have needed assistance with housing. The most recent information on all individuals currently on the Active Caseload with a Transition Assessment has identified approximately 44% will need assistance with housing.

The State, in its original housing plan, set forth the annual targets for creating additional housing units or rental subsidies that would be available to the Target Population. This includes development opportunities, where the unit or units will need to be created by developers and may include building new structures or rehabilitation of existing units. Sources of funding for these development opportunities include bonds and low-income housing tax credits. The plan also included non-development opportunities such the use of vouchers to secure housing. Examples of funding sources for non-development opportunities include Section 8 or non-elderly disabled vouchers.

The State tracks several activities to determine if it is meeting the intent of this paragraph in the Agreement. This includes:

- PSH opportunities created by each strategy within the LDH My Choice Housing Plan
- PSH offered to the Target Population by each strategy within the LDH My Choice Housing Plan
- Target Population housed by each strategy within the LDH My Choice Housing Plan.

The State has determined the second measure, the number of PSH offered to the Target Population, will determine if the State has met the goal of this paragraph to make 1,000 units available to the Target Population. While the SME understands this is the measure, it will be important to ensure that there are not significant differences between opportunities created, offered, and used by the Target Population. As indicated in the seventh report, there were relatively large differences between the number of opportunities created and offered (50% difference) and the number of opportunities created and used by the Target Population (30% difference). The SME believes the variance between offering and using housing opportunities should be small. Very few housing opportunities created as part of the Agreement should go unused.

The seventh SME report provided progress towards meeting the intended development of housing opportunities. The seventh report also indicated the State was not on track to meet a planned target of creating 867 opportunities by June of 2023. The State reported they created 357 opportunities. Of these 357 opportunities, 175 were offered to individuals in the Target Population and 120 individuals utilized these housing resources.

In the seventh report, LDH stated the primary reason for fewer opportunities being offered to individuals in the Target Population relates to a low demand by individuals both identified and ready to transition. Low demand and readiness were exacerbated by the COVID-19 pandemic, which limited staff ability/options to get into nursing facilities to complete assessments and plan for transition. For many of the opportunities available, the offers had to be utilized or risk losing them completely.

The initial revised housing plan discussed in the seventh SME report projected over 946 new opportunities (for a total of 1,121 opportunities) to be offered to individuals in the Target Population over the next three years (CY 2023 through CY 2025). A large number of housing opportunities included turnover estimates from existing PSH opportunities that would be repurposed for the Target Population. Turnover may occur for a variety of reasons, such as the person obtained non-PSH housing, moved out of state, moved to another region, moved in with family member, is no longer interested in the PSH program, refused all properties, is ineligible, lost eligibility, is unable to locate, was evicted, abandoned unit, or passed away. The State initially projected 452 opportunities would be created through turnover.

During this reporting period, LDH revisited these projections given that some of these new opportunities were duplicative and should not be counted as a new opportunity. The State now projects 336 new opportunities will be offered to the Target Population due to turnover. Therefore, the revised housing plan projects a total of 1,005 housing opportunities created. The chart below provides a breakdown of the production of permanent supportive housing opportunities from 2019 through 2025.

PSH	PSH Production Actual # or Estimate
Documented PSH offers to the Target Population from 2019-2021	175
Future PSH opportunities to be created from 2022 to 2025	494
PSH turnover estimate from existing PSH	336
Total estimated PSH offers	**1,005**

It should be noted OAAS and LHC continue to meet bi-weekly to increase opportunities under the HOME Rental Assistance Program. As indicated in the seventh report, LHC has committed $1 million of HOME funds in CY 2023 to provide 100 tenant-based rental subsidies to the Target Population. LHC Is in the process of working with LDH to implement this strategy during the next reporting period. In addition, OAAS has increased the number of opportunities for the State Rental Assistance program, an increase of nearly 80% for the next two years. This is encouraging since these opportunities provide the most flexibility regarding eligibility criteria (the State and not federal agencies develop this criteria).

As indicated in the previous SME report, the plan projects 172 opportunities being developed for CY 2022. While transitions have significantly increased, the State was not able to take advantage of housing opportunities created this year. An additional source of referrals to housing will be from individuals who have been diverted from NFs. As indicated in this report, these individuals are now receiving CCM, which is tasked with identifying housing needs and facilitating access to these resources. The State reports that 5 individuals (12% of the diverted population engaged in CCM) have housing needs and were connected with PSH opportunities created under the Agreement.

Given the revised housing plan is complete, LDH has stated they will track the progress of implementing the plan on a quarterly basis. This will be important to identify any significant differences between housing opportunities created, offered, and used. As part of this analysis, it will also be important for LDH to provide clarity regarding the methodology used for tracking to ensure these opportunities are tracked correctly.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- The State has undertaken various steps to increase integrated housing opportunities for individuals in the Target Population: a significant increase (80%) has been opportunities created through the State's Rental Assistance Program.
- The State has revised the housing plan as recommended to ensure opportunities were not counted multiple times.
- The State did not meet the stated goals for CY 2022 for developing housing opportunities for the Target Population.
- There are major differences between the housing opportunities created, offered, and utilized by the individuals in the My Choice Program.
- TCs are creating additional demand that has increased the housing opportunities offered and utilized by the Target Population.
- The State is developing a process to track opportunities created, offered, and used by the Target Population, including individuals diverted from NFs.

Recommendations

- Track opportunities on a quarterly basis to determine if opportunities are being created and offered to individuals in the Target Population. The goal should be to have good alignment between opportunities created and used by the individuals in the My Choice Program.
- Continue to work with LHC to develop the 100 opportunities under the HOME Program.
- Provide a clear methodology for how the State tracks the progress toward the implementation of the revised housing plan.

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

Compliance Rating: Partially Met

Discussion and Analysis

Existing federal and state policy allows individuals to voluntarily receive tenancy supports. The current Louisiana Permanent Supportive Housing is a cross-disability housing and services program that links affordable rental housing with voluntary, flexible, and individualized community-based services to assist people with severe and complex disabilities to live successfully in the community. Individuals cannot be

rejected due to the conditions set forth in this paragraph. As indicated in paragraph 81, the State has created and increased the capacity of the RAP program to provide housing and housing supports for individuals with conditions and backgrounds that have often created a barrier to housing (e.g., criminal background).

As indicated in paragraph 81, the State has revised the My Choice Housing Plan. The plan proposes to include development strategies for CY 2023-2025 that ensure that projects meet the intent that units being developed are integrated and in scattered sites.

Compliance Analysis

The SME assessment of the State's compliance with this paragraph took into consideration:

- The State has current policies and programs that allow an individual to reject housing supports and ensures individuals with certain conditions are not denied participation in the program.
- Current and projected opportunities identified in the LDH revised housing plan only offer development and non-development strategies for units that are integrated and scattered site.

Recommendations

- LDH should track and report the creation of housing opportunities developed and offered, consistent with this paragraph.

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

Compliance Rating: Partially Met

Discussion and Analysis

The State employed eight TSMs to provide statewide coverage to assist members of the Target Population transitioning from NFs. This is an increase of two TSMs since the previous reporting period. As discussed in the seventh report, TSMs perform the following functions:

- Meeting with the client to perform housing needs assessment
- Assisting the client in finding appropriate rental housing
- Performing the HUD quality standards inspection of the unit
- Negotiating with the landlord on the client's behalf, including seeking reasonable accommodation under the Americans with Disabilities Act and Fair Housing laws
- Assisting the client in gathering documents necessary for housing applications and lease signing
- Helping the client accomplish move-in, including working with team members and assisting individuals to obtain items needed for move-in
- Working with the client to develop crisis action plans and eviction avoidance plans
- Serving as point of contact for the property manager/landlord mediation

- Addressing problems that may arise between the client and landlord
- Assisting households with community referrals as needed
- Implementing eviction avoidance plans, seeking to prevent housing instability and rehousing
- Providing ongoing tenancy support and community-living skills training during lapses in Medicaid coverage or when the Medicaid provider is unable to successfully engage
- Maintaining files on all households and providing data as requested on households served.

The SME's opinion is that TSMs should provide a valuable function on behalf of the Target Population and for landlords and local housing authorities. In the sixth report, the SME requested additional information on how the TSMs assisted members of the Target Population to find appropriate housing. The State provided the SME with the following information during this reporting period.

Calendar Year	2018-19	2020	2021	2022
Number of individuals receiving services from TSM	88	27	72	71
Type of Assistance				
Rental Assistance with Rental Assistance Program	74	18	40	64
Rental Assistance with NED Vouchers	14	9	32	7

The State reports they seek to employ TSMs who have relevant experience with federally funded housing programs and landlord recruitment and relationships. Of the eight TSMs, LDH reports:

- Three previously worked for contracted PSH providers
- One worked for the local Continuum of Care and also had housing assistance experience
- One worked for a referral source for PSH
- Two worked for housing providers in another state
- One had housing assistance and social services experience.

In addition to supporting individuals in the Target Population, TSMs also support landlords and PSH providers. The State reports that TSMs often serve as the initial contact with landlords. Landlords tend to reach out to a TSM when issues arise since they were the first point of contact. They recruit landlords who are willing to accept vouchers that require compliance with federal housing guidelines and state funded rental assistance. TSMs also negotiate unit rental amounts, collect all paperwork required to become a vendor for both LHA and LDH, provide guidance on bringing units up to standards (when needed) to pass a housing inspection, and provide support through the leasing process and request reasonable accommodations when needed. They also provide support to the individual in the Target Population and provider throughout the housing search and lease up process. TSMs also assist providers with addressing unit issues, including repairs during tenancy. TSMs also assist the individual in completing recertification paperwork.

The State also reports, TSMs intervene when there is a crisis related to the housing unit or if the household is at risk of eviction due to lease violations, utility disconnections, or unpaid rent. They will work to identify solutions and resources and if a landlord is still wanting to proceed with eviction, they will mediate to keep everyone from going to court and work to rehouse someone as quickly as possible. TSMs are also tasked with maintaining a unit in a client's absence. Per federal guidelines, individuals are initially allowed up to 90 days for a unit to be unoccupied. During this time, a TSM works with the landlord to let them know the unit hasn't been vacated and ensures payments will continue. Depending on the circumstances, they will either revise paperwork to have the voucher cover the full rent or submit payments to LDH to

pay on behalf of the client. In addition, the TSM will make sure the utilities are maintained during the absence. If the end of 90 days is nearing and the client hasn't returned to the unit, they will work to request a reasonable accommodation if there appears to be a solution for the client to return in the near future.

Compliance Analysis
The SME assessment of the State's compliance with this paragraph took into consideration:

- LDH has employed TSMs that perform the duties outlined in this paragraph, including support to landlords and PSH providers.
- TSMs have provided assistance to 170 individuals in the Target Population who are seeking housing assistance or approximately 40% of all individuals who have been transitioned.
- LDH reports TSMs have experience with federal housing programs and delivering housing assistance prior to employment.
- TSMs address crisis situations that are directly related to housing and LDH reports TSMs preserve housing (including utilities) when an individual has not returned to the unit.

Recommendations
- LDH should continue to track TSM activities that support the Target Population on a semi-annual basis and report to the SME, including information on the number of individuals in the Target Population who have housing-related needs and the actions the TSMs to preserve housing.
- LDH should provide the SME with the strategy deployed to ensure that TSMs are well aware of the newly created crisis providers.

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

Compliance Rating: Partially Met

Discussion and Analysis
As discussed in the sixth SME report, the State funds housing-related expenses such as security deposits and other necessities for making a new home through the CCW program for individuals who meet NF level of care, MFP, and the RAP program. In addition, the Tenant-Based Rental Assistance (TBRA) administered by LHA is currently being used for security and utility deposits for persons transitioning to 811 PRA Units.

The SME requested information on the number of individuals in the Target Population who received HOME based rental assistance. As indicated in paragraph 81, the State has deferred this program until CY 2023.

In the seventh report, the SME requested information regarding the number of individuals in 2022 and previous calendar years who needed and received housing-related expenses.

Compliance Assessment
The SME assessment of the State's compliance with this paragraph took into consideration:
- The State currently has policies in place and reports they fund various housing related expenses.
- The State has committed to using HOME TBRA for security and utility deposits for CY 2023.

Recommendations

- LDH should develop a strategy to determine if individuals diverted from NFs need and receive similar housing supports.
- LDH should provide information regarding the needs of individuals transitioned and diverted in CY 2022 and that should be used to inform the use of HOME TBRA and additional RAP resources for housing related expenses.

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

Compliance Rating: Met

Discussion and Analysis

As indicated in paragraph 75 of the Agreement, the State has pursued both Medicaid state plan and waiver authorities for several new services. During this reporting period the State received approval of a Medicaid State Plan Amendment for Crisis Stabilization Units. In the seventh report, the State distributed funds to support various My Choice services. This reporting period, the State adjusted payments for critical HCBS services (e.g., personal care services) using federal ARPA funds.

As indicated in the sixth report, the State worked with the Medicaid actuaries to develop reimbursement rates for each new service. The SME was engaged in some of these discussions or provided input regarding the assumptions for rate setting based on other strategies that have been used in other states that have mature and well utilized services. The State has recently reviewed these rates and made some changes for various crisis services to reflect the experience of the roll-out of these services. LDH factored the gradual roll out of these services and newer information regarding the costs of delivering these services to adjust these rates.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- LDH has pursued the necessary Medicaid changes thus far to meet the intent of this paragraph.
- LDH has implemented and revised reimbursement strategies for new services that should support providers offering these services.
- The Department has provided funding to providers of new crisis services to ensure their sustainability during the initial start-up period.
- The Department has implemented the strategies for increasing reimbursement for much needed HCBS.
- The Department has reviewed the rates for newer services and made adjustments based on the roll out experience.

Recommendations

- Determine if new providers of My Choice services will need ongoing support during start-up in the next reporting period and pursue funding strategies to ensure service sustainability.

VI. Outreach, In-reach, and Provider Education and Training

A. Outreach

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.

Compliance Rating: Partially Met

87. Within six months of execution of this Agreement, LDH will develop and implement a strategy for ongoing communication with community providers, nursing facilities, and hospitals on issues related to implementation of this Agreement. This strategy will include engaging community providers, nursing facilities 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.

Compliance Rating: Partially Met

Discussion and Analysis

Paragraphs 86 and 87 are addressed together. The State developed an initial communication plan for stakeholders to learn about challenges encountered in the implementation of this Agreement, addressing those challenges, and targeted outreach and education needed to implement the plan. A summary of the plan was provided in the seventh SME report. In addition, since the fourth report, the SME has recommended the State revise its outreach plan given its proposed renewed efforts as discussed throughout this report. The outreach plan, at a minimum, should involve NFs, hospitals, LGEs, law enforcement, and other resources the Target Population will need to live independently in the community. The State has not revised the communication plan. One of the issues identified during the service review is the need for ongoing information and education to NF administrators and staff. Interviews with TCs and SME contact with NF administrators indicated NF staff were not aware of the My Choice Program, the process for engagement and transitions. Given the ongoing turnover of NF staff, more targeted educational/informational strategies are needed in any revised outreach plan.

The State began to implement this plan early in the Agreement but has not completed major tasks identified in the Outreach Plan. The State reports they are in the process of revising the Outreach Plan during the next reporting period.

The current outreach efforts continue to focus on disseminating information to the My Choice Advisory Committee, LGEs, and various stakeholders regarding new services such as crisis services.

The State continues to have bi-monthly meetings of the My Choice Advisory Committee. Initially, the Committee was composed of two representatives from LGEs, advocacy organizations, and providers. During this past year, LDH has added several family members and peers and an individual who has been transitioned from an NF as part of the My Choice initiative.

The State meets with all LGEs on a monthly basis regarding behavioral health issues, including the My Choice Program. In addition, the State meets with the LGEs to have more targeted conversations regarding their responsibilities to provide specific services to individuals in the Target Population. These efforts were discussed in more detail in paragraphs 78 and 79.

As discussed in the sixth SME report, the State previously developed a number of subcommittees, or resource groups, within the Advisory Committee to provide input on key areas, including crisis services, community service development, quality management, and community transition. In the SME's opinion, these meetings have been helpful to the State in their efforts to get specific feedback on important areas and activities, as the meetings are interactive and subcommittee members provide helpful comments regarding the subjects of discussion. The SME is continuing to request information regarding the rationale for not holding these meetings more recently, given the barriers identified in Paragraphs 51.

The only exception to the lack of outreach efforts is the ongoing meetings regarding crisis services. The Crisis Resource Group and weekly meetings with the crisis providers continue to provide feedback to the State regarding the implementation of crisis services. The State continues their efforts this reporting period regarding engaging law enforcement, specific to crisis services. These efforts were discussed in more detail in paragraph 68.

The SME recommended in the previous report that the State convene and meet with the Community Transitions Resource Group to discuss the issues that have been identified by the Needs Assessment, TCs, and other individuals regarding barriers to transition, given the low number of individuals transitioned during previous reporting periods. This group would be helpful in the State's efforts to collect information and feedback regarding the array of services needed for individuals in the Target Population. The State has not met with this group.

The State has not met with individuals currently receiving mental health services for the purpose of sharing this information and collecting feedback on the service array available to the Target Population.

In the past four reports, the SME recommended that the State enhance its My Choice website and develop a quarterly newsletter (or a similar communication effort) to keep stakeholders beyond the Advisory Group informed of the progress regarding the Agreement. This did not occur during this reporting period. The planned revised communication plan, including the newsletter, would be beneficial especially during this time when LDH is standing up services and developing strategies for awareness and referrals for this service.

As requested by the SME, and as required by this Agreement, the State continues to post their Quality Report and Matrix for the My Choice Program. This report can be found here: https://ldh.la.gov/assets/docs/MyChoice/myCHOICE-Annual-Quality-Report-2021-22.pdf. It should be noted the State posted the SME report for the period January 1, 2022-June 30, 2022, in January 2023.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- The State developed and implemented the initial communication plan developed in CY 2018.
- LDH continues to convene the My Choice Advisory Committee.
- LDH continues to meet with a limited group of stakeholders regarding the My Choice Program. These conversations have been limited to creating awareness and capacity of crisis services.
- LDH states they are in the process of revising the communication plan as recommended by the SME.
- LDH has not developed an approach to meet with individuals who have lived experience regarding the services and supports regarding the My Choice Program.
- The State has not met with most of the My Choice Subcommittees during this period.
- The State has not developed the quarterly newsletter.

Recommendations

- The State should revise the communication plan regarding the My Choice Program. To the extent possible, this should include statewide and regional strategies for providing timely information regarding the My Choice Program. These efforts should be a combination of in-person and virtual strategies.
- LDH should re-assess the My Choice subcommittees and begin to meet with these committees on a quarterly basis. These subcommittees have been useful in providing LDH feedback on important issues regarding the My Choice Program.
- The State should make enhancements regarding the My Choice website and develop the quarterly newsletter, based on recommendations made by the My Choice Advisory Committee, to provide information regarding the new service development and information on how individuals, caregivers, and providers can access these services.

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.

Compliance Rating: Not Yet Rated

Discussion and Analysis

During the sixth reporting period, the State conducted meetings with law enforcement as discussed in Paragraphs 68 and 86. Most of these efforts focus on the development of the new crisis services system, which is the likely interface between these systems and diversion. LDH has been appropriately cautious about efforts to meet with these organizations until the appropriate crisis and case management capacity is in place to enhance diversions. The SME will track LDH activities in this area in future reports to assess compliance.

B. In-Reach

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 nursing facility, regular presentations in the community in addition to onsite at nursing facilities, 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 nursing facility placement; provide information about the benefits of transitioning from a nursing facility; respond to questions or concerns from members of the Target Population residing in a nursing facility and their

families about transition; and actively support the informed decision-making of individuals in the Target Population.

Compliance Rating: Partially Met

See paragraph 54 for discussion.

C. Provider Training

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.

Compliance Rating: Partially Met

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.

Compliance Rating: Partially Met

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.

Compliance Rating: Partially Met

Discussion and Analysis

Paragraphs 90-92 are addressed together. The State continues their efforts to train community providers, with a major focus on providers of the new Crisis Stabilization Units (CS) which was rolled out during this reporting period. In addition, new crisis providers will receive training as these services are brought online in newer regions. As indicated in the paragraphs in Section V.A, the State has worked with LSU to develop organized and well attended training opportunities for providers offering various crisis services. Those training opportunities are discussed in paragraphs 63 through 66.

The State continues to report they have implemented training for agencies and their staff that will provide CCM. As indicated in the seventh report, the SME has reviewed the training materials developed for CCMs and feels these materials are sufficient for initial training for these providers. The State expects these trainings will occur on a regular basis as CCMs are onboarded to meet the increased number of transitions and diversions.

As discussed in paragraph 78, the State continues efforts to contract with the national IPS Employment Center, the creators of IPS, to build an infrastructure to provide IPS services. The State has also been accepted into the ODEP Policy Academy which will also provide technical assistance to LDH regarding their

IPS training efforts. The State has concrete plans to offer training and technical assistance regarding IPS for some LGEs in the next reporting period. Specifically, the State is engaging the IPS Center from Columbia to provide intensive training to LGEs regarding IPS services. In addition, LDH will be training ACT providers regarding the delivery of IPS services.

In the sixth report, the State, in cooperation with the MCOs, implemented training on person-centered planning for behavioral health providers. An overview of the development and piloting of this training was discussed in the sixth SME report. MCOs have conducted six additional trainings from June to December throughout the state for behavioral health providers. The SME requested information on the number of attendees who participated in this training and any strategy the State or the MCOs have considered to evaluate the effectiveness of this training. The State has provided this information and 107 individuals, and 48 provider organizations participated in the training. It should be noted that the State has yet to seek input regarding the training from individuals receiving services nor has it included training by individuals who were receiving services.

In the sixth report, the SME also recommended in the SME Service Review a training approach to CCW support coordinators and personal care staff that were serving individuals with a serious mental illness. The State has not developed these training efforts but has committed to provide these trainings as part of the CY 2023 Implementation Plan.

Over the past several reports, the SME has requested LDH establish a mandatory training policy, qualifications, and curriculum for Community Providers. In addition, the curriculum is to include initial training and continuing training and coaching for Community Providers. The State has developed training and coaching for crisis providers but has not developed similar approaches for other community services. The SME understands that MCOs continue to train community providers on foundational information regarding various approaches to delivering behavioral health services (e.g., responding to trauma, administering the LOCUS) in addition to operational trainings (e.g., prior authorization processes, reimbursement). As discussed above, LDH is developing a training approach for various new services and new service providers. Having a site for providers to have access to topics and dates would be helpful for these providers to be aware of these offerings and would also allow LDH to have a more streamlined approach in notifying providers about training opportunities from this site.

<u>Compliance Assessment</u>

The SME's assessment of the State's compliance with this paragraph took into consideration:

- The State continues to implement training for agencies offering crisis services and community case management this period.
- The State will be participating in IPS through ODEP that is intended to support select LGEs in the delivery of IPS.
- The State has included a plan for training direct service workers offering PCS services to the Target Population in their CY 2023 Implementation Plan.
- The State has developed a list of training opportunities for new services but has not developed a consolidated list of trainings and training dates for providers.
- The State, in cooperation with the MCOs, implemented training on person-centered planning for behavioral health providers.
- The State has not solicited or incorporated consumer feedback regarding its person-centered planning training or included a strategy for consumers to deliver this training.

Recommendations

- The State should develop a single site for State facilitated training opportunities for providers who serve the Target Population. The State should use this site to communicate opportunities to existing and potential providers of the My Choice program.
- The State should include a process for soliciting and incorporating consumer feedback regarding the person-centered training curriculum and implement a strategy for including consumers in the training.
- LDH should implement the training efforts offered through ODEP for select LGEs.
- The State should provide training regarding mental health and recovery to direct service workers that offer personal care services to individuals in the Target Population as indicated in the CY 2023 Implementation Plan.

VII. Quality Assurance and Continuous Improvement

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).

Compliance Rating: Partially Met

Discussion and Analysis

The Agreement sets forth the requirement for a Subject Matter Expert (SME). Among other duties, the SME is responsible for assessing the quality and sufficiency of community-based services for members of the Target Population. As a part of this quality assessment, the SME is responsible for reviewing a representative sample of individuals in the Target Population. The initial report by the SME from 2021 provided information regarding the design of the service reviews, the process of conducting the reviews, the findings of these reviews, and recommendations that the State should consider to make improvements to the My Choice Program that serves individuals in the Target Population. This report was included in the fifth SME report. A summary of findings from this report indicated:

- Positive changes in many individuals' overall well-being post transition, with almost all expressing a strong desire to never return to the nursing facility.
- Critical services not available on a timely basis, such as specialty physical health services, in-home nursing, essential transportation to primary care and specialty care providers, and personal care services.
- Lack of accessible housing for individuals with mobility issues and evidence of housing instability for some individuals in the review.
- Significant concerns with post discharge care coordination, including the absence of an overarching community plan post-transition and unevenness in care coordinate efforts, especially for individuals with significant physical health issues.
- The absence of crisis plans to address behavioral health issues.
- Poor community engagement and an inadequate focus on community inclusion in the planning process.

- No individuals were employed despite work histories and interest expressed during the interviews.
- Evidence that most people received services in transition plan, but transition plan does not establish amount, frequency, and duration of service.
- Lack of information or understanding regarding individuals' mental health conditions and related service needs.

As indicated throughout this report, the SME has conducted additional service reviews and has identified similar ongoing issues as well as additional issues for individuals who were recently transitioned or diverted. In addition, these reviews are focusing on individuals in NF who are awaiting transition and obtaining information regarding their transition experience. The SME will provide more detailed findings from the service review in the ninth report (6/20/2023). However, the SME does meet with LDH on a quarterly basis to discuss the findings of the service review with recommended actions the State should consider to address issues identified during these reviews. As discussed in paragraph 103, the State has been participating in these service reviews over the past year and is seeing first-hand the quality of life for individuals who have been transitioned, diverted, or awaiting transition.

The State has begun to address several areas identified in the SME Report. As indicated in the seventh report, LDH has developed training for TCs to address issues with transition assessments and ITPs. Through subsequent reviews, the service review team has seen improvements in the transition assessment but little change in the presence or quality of the ITPs. Other findings regarding the TCs were specific to their intensive case management responsibilities which transitioned to the CCMs in March of 2022. However, the SME believes there are important lessons learned regarding the review of the TCs' case management efforts that are applicable to the CCMS. This includes:

- Assessments and community plans are person-centered.
- Team meetings with the individual present and other members of the team occur on a regular basis (as outlined in the CCM SOP).
- There is an effort to ensure that team members (including the individual) have relevant plans, especially if they are participating in the CCW or OCDD Waiver, ACT, or intensive supports provided through a MHR provider.

As TCs begin to return to their original roles, the State is requiring they provide information on a quarterly basis on various areas identified in paragraph 99 regarding the quality of community-based services. They have developed service logs (previously used when the TCs were providing ICM). The State reports they are collecting this information and will report this during the next reporting period.

In addition to the service reviews, the SME, in previous reports, has recommended LDH develop a process to review the quality of newer services created under the Agreement. While services such as ACT have fidelity reviews, LDH should have a process to review the quality of the providers of these services and the services. Information currently collected by LDH could inform these reviews, including:

- Measures regarding the timeliness of calls to each MCO's crisis line.
- Measures regarding the timeliness and dispositions of various crisis interventions.
- Fidelity reviews for IPS.

- State-developed measures regarding the effectiveness of peer supports. While this service does not have a standardized fidelity instrument, there are existing instruments used by other states to measure the effectiveness of this service.

Compliance Assessment

- The State has addressed some, but not all the findings from the SME initial report that are applicable to both TCs and CCMs.
- While the quality of the transition assessments has improved, the quality of the ITPs has decreased.
- The State has yet to develop a process to review newer services included as part of this Agreement.
- The State continues to provide relevant information to the SME for conducting service reviews.
- The State is collecting information from TC logs to use as a third party to review the quality of services provided to individuals who have been transitioned.

Recommendations

- Continue to incorporate the findings from the initial SME Service Review and ongoing reviews that identified a number of issues and recommendations for improving the quality of services offered to the Target Population.
- Develop a process to review the quality of new services. Some of these services (e.g., ACT and IPS) have fidelity instruments that can be used to evaluate quality of services. As indicated in paragraph 69, crisis services have performance measures the State will collect to determine whether providers are initially meeting these standards.
- Ensure that CCM staff provide the necessary information to review the quality of services consistent with the TC strategies over the past two years. While this information was self-reported, it does provide LDH with information on how best to target its quality efforts and improve the quality of services for the Target Population.
- Work with the SME to develop a process for reviewing transition assessments, ITPs (performed by the TCs), and assessments and plans of care developed by the CCMs to ensure that the assessment instrument and processes address several major issues and recommendations from the SME Service Review.

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

Compliance Rating: Partially Met

Discussion and Analysis

The State has implemented a quality assurance system to address this paragraph. The quality assurance system includes the process of collecting and analyzing measures and internal and external activities to review and implement strategies to improve the quality of the program. The quality assurance system is driven by a Quality Assurance Plan that sets forth the measures and processes the State will use to improve quality.

Since the third report, the State has developed measures for a substantial portion of the Agreement. As discussed in paragraphs 98 and 99 below, the State tracks information on a quarterly basis that is specific to the quality of various elements of the My Choice Program (e.g., diversions and transitions) as well as

other quality indicators. The State has made changes to the measures over the past three years to include feedback from the My Choice Advisory Committee, the SME, and the Department of Justice.

The State has continued to collect and analyze information on some of the measures required by this section of the Agreement. During this reporting period, OAAS and OBH continued their cross-agency internal quality assurance workgroup that reviews the changes in the measures each quarter, identifies measures that seem to indicate there are individual or systemic issues, and discusses strategies for further analyzing and addressing these issues.

The State completed the first Annual Quality Assurance Report for the My Choice Program during the previous reporting period. This plan incorporates the work that has been done to collect and analyze data on some of the measures required in paragraph 99. It also sets forth the processes LDH has put in place to use this information to improve the experience of care for individuals transitioned and diverted from NFs as well as to improve the quality of services that are offered to the Target Population. LDH states they are in the process of developing the second Annual Quality Report, but it was not ready for review by the SME during this reporting period.

The State reported the cross office quality assurance committee continues to meet regularly to discuss data from the Quality Matrix (see Attachment A) for the first two quarters of the calendar year. These meetings identify areas of concern and make recommendations to address areas of concern.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- LDH has developed a quality matrix to monitor many topics required by this Agreement. LDH continues to review and make changes to measures in the quality matrix to continue to address the Agreement and feedback from multiple individuals and organizations.
- The State continues their regular meetings of the cross-agency Quality Assurance committee to review the quarterly measures discussed in paragraph 99.
- The State is in the process of developing the second Quality Assurance Plan.
- LDH has not developed a process for information from the internal Quality Assurance committee to be reviewed by the SRP and the external subcommittee of the My Choice Advisory Committee.
- Additional work is needed to develop and implement a quality assurance system consistent with the terms of this section, as discussed in the paragraphs that follow.

Recommendations

- The State should continue to report and track the measures identified in the first quality assurance plan.
- LDH should continue cross agency quality assurance efforts to review the data from the Quality Matrix and barriers that have been identified through the recent process created by LDH and develop strategies for addressing systemic issues identified by the group.
- LDH should develop a process for information from the internal Quality Assurance committee to be reviewed by the SRP and the external subcommittee of the My Choice Advisory Committee.
- The SME continues to recommend LDH identify the next area(s) of focus for the internal quality assurance committee and design and begin to implement an approach for analyzing and developing strategies to remediate the area selected.
- Develop and implement the second Quality Assurance Report/Plan and solicit feedback from the My Choice Advisory Committee and Quality Assurance subcommittee.

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.

Compliance Rating: Partially Met

Discussion and Analysis

The State had a critical incident report (CIR) process that is used by both agencies (OAAS and OBH). The program offices aligned definitions and processes for individuals transitioned from NFs. Over the past two years, OBH TCs, as part of their Intensive Case Management responsibilities, completed the CIRs, and captured the elements and measures that align with the definitions and formats used by OAAS. LDH then combined the critical incidents across program offices and provides aggregate information for the quality matrix.

In the seventh reporting period, LDH reports the CCMs were trained on CIR processes and requirements. CCMs through the MCOs are responsible for providing CIR reports on individuals who have been transitioned or diverted from NFs. The SME requested and LDH provided CIRs for individuals who were receiving CCM. This request resulted in one CIR being provided to the SME. In previous reports, the CIRs reported by LDH were significantly higher. The SME is concerned about the lack of CIR reporting from the CCM program.

During this reporting period, OBH reports they have made changes to the CIR process for CCMs. The first change was to align the definition of critical incidents with the previous critical incident definition used by the TCs. This includes major medical events, damage to personal property, eviction and lack of housing and other incidents. In addition, the CCM is required, as part of the reporting process to document actions taken as a result of the incident. OBH does report the number of individuals receiving CCM who presented in an ED or was hospitalized (all cause) on a monthly basis.

LDH was previously performing reviews of CIRs. The focus of the internal Quality Assurance Committee for the last two reporting periods was on CIRs. In the seventh reporting period, LDH, in cooperation with the SME review team, developed a process to review individuals who had significant CIRs during CY 2021. The reviews focused on CIRs that were related to major medical issues (ED and inpatient utilization) since these were reported most often for individuals receiving ICM. The review determined if all incidents were identified, whether CIRs documentation was complete, and what actions were taken or could be taken to prevent these incidents. Six members of the quality assurance workgroup performed this review, along with the SME review team, using a consistent tool to identify issues and possible strategies for reducing ED visits and hospitalizations.

The review process completed in the seventh reporting period and LDH's Quality Assurance staff presented an overview of process and initial findings to OAAS and OBH leadership during this review. The State is in the process of reviewing the findings and developing strategies for mitigating utilization of EDs and inpatient services.

While the SME was encouraged by the work of the quality assurance workgroup, no additional work was reported to have been done in this reporting period. Low reporting of CIRs by CCMs this reporting period is very concerning.

Compliance Assessment
The SME assessment of the State's compliance with this paragraph took into consideration:

- The State has developed a CIR process for CCMs that includes standardized definitions that align with the previous CIR reporting performed by the TCs, reporting processes, and timeframes.
- The State also requires the CCMs to provide information regarding specific actions taken to address the critical incident.
- The State reported almost no critical incidents for members of the Target Population on a quarterly basis. The SME is concerned about the lack of reporting.
- The State has not developed nor implemented the recommendations from the CIR reviews completed in the seventh report.
- While the State's quality assurance staff previously conducted reviews of critical incidents, they have not done similar work this reporting period.

Recommendations
- The State should develop and implement recommendations regarding their review of critical incidents in the seventh report.
- The SME is requesting a summary of all critical incidents for individuals participating in CCM. This should include the number of unduplicated individuals and individual incidents during the next reporting period.
- The SME is requesting examples of completed CIRs for individuals in CCM during the next reporting period
- The State should mandate and ensure tracking of CIR information regarding ED and inpatient utilization to determine if the proposed strategies are successful.
- The State should review the process for CIRs reported by CCM and use a similar process to identify whether certain reportable events (e.g., claims information on ED and inpatient utilization) are being reported by CCMs.

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.

Compliance Rating: Not Rated

Discussion and Analysis
The SME has not reviewed the processes, protocols, or contractual language that may require community providers to implement critical incident management and quality improvement processes and has been more focused on CIR reporting from TCs and CCMs. This will be done by the end of this calendar year.

97. The State will establish reporting and investigation protocols for significant incidents, including mortalities. The protocols will require a mortality review of deaths of individuals in the Target Population in specified circumstances, including any unexplained death, any death within 60 days of discharge from a Nursing Facility, and any death in which abuse, neglect, or exploitation is suspected. Mortality reviews will be conducted by multidisciplinary teams and will have at least one member who neither is an employee of nor contracted with OAAS, OBH, the LGEs, MCOs, and Community Providers. The reporting and investigation protocols for significant incident and mortality reviews shall be developed with the technical assistance and approval of the Expert.

Compliance Rating: Partially Met

Discussion and Analysis

As discussed in the sixth and seventh reports, OBH and OAAS have developed a joint mortality review committee protocol for the My Choice Program. The State has drafted, but has not released, the first Mortality Review Report.

As discussed in the seventh report, the Mortality Review Report provided information regarding the scope and structure for mortality reviews, information on the mortality reviews conducted thus far, and remediation strategies undertaken by the State based on these reviews. Under the current protocol, the mortality review committee is to review any death within 60 days of discharge from an NF, any unexplained death, and any death in which abuse, neglect, or exploitation is suspected.

Since the beginning of the Agreement, LDH has reported there have been 28 deaths among transitioned members of the Target Population: 1 in 2019, 7 in 2020, 2 in 2021, and 18 in 2022. LDH has referred 15 deaths to the mortality review committee. There were ten individuals who died and were not referred to the committee. These individuals transitioned from NF to hospice or had end-stage medical conditions (e.g., cancer). One individual died in December and LDH is reviewing these circumstances to determine if this death will be referred to the mortality review committee.

Of the 15 deaths referred to the mortality review committee, 4 reviews have been completed and 11 are still in process. Of the deaths that occurred in CY 2019-2021 that were referred to the morality review committee, three out of four reviews have been completed. The findings from these earlier mortality reviews were discussed in the seventh report.

The State reports that of the 18 deaths in 2022, 9 occurred during this reporting period. Three of these deaths have been reported to the mortality review committee. As indicated above, one death is still being reviewed for a possible referral to the committee. Five individuals were receiving hospice at the time of their death and were not referred to the mortality review committee.

The State reports the CY 2022 deaths and one CY 2020 deaths reported to the mortality review committee were still in review. The State has indicated the committee is still awaiting records to finalize their work or are in the process of finalizing the summary from the committee.

While there were a number of OBH, OAAS, and other agencies participating on the mortality review team, there was no representation from MCOs, LGEs, and community providers. Also, the OBH Medical Director was not reported to be part of the service reviews. In addition, the mortality review process seems lengthy, and reviews are not being conducted on a timely basis. While the SME understands collecting information from third parties is challenging (especially during a pandemic), these reviews are taking a

year or longer to complete, with many months spent collecting and aggregating information to send to the committee. The State reports that it intends to revise the protocol. The Mortality Review Committee will convene to discuss possible methods to reduce timelines or adapt the protocol to account for such delays.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- The State has developed and implemented reporting and investigation protocols for mortality reviews.
- The mortality reviews are conducted by an interagency team comprised of OAAS and OBH; however, members of the team do not include some individuals in this paragraph nor the OBH medical director.
- The mortality review process is lengthy, generally taking one year to complete.
- LDH completed their review of the four individuals who were referred to mortality committee who died in CY 2019/2020 and 2021 (with one exception).
- LDH has begun to conduct a review of three individuals who have died during this reporting period.

Recommendations

- LDH should complete the review of the one individual who died in CY 2020.
- LDH should complete the review of the seven individuals who died during the previous reporting period in CY 2022.
- LDH should add individuals to the Mortality Review Committee as required by this paragraph. This should include regular participation by the OBH Medicaid Director and/or an MCO's Medical Director.
- LDH should determine processes for streamlining information gathering to reduce the time needed to conduct these reviews versus changing the protocol to address lags in information collection. Given the volume of additional deaths in CY 2022, the SME is concerned that the current process will increase the length of time needed to finish these reviews.
- LDH should post the first Mortality Review Annual Plan and provide a timeframe for completing the second annual report.

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.

Compliance Rating: Partially Met

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, nursing facilities; (b) person-centered planning, transition planning, and transitions from nursing facilities; (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 nursing facilities, 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.

Compliance Rating: Partially Met

Discussion and Analysis

Paragraphs 98 and 99 are addressed together. As discussed in paragraph 94, the State has developed a process for collecting and reporting on initial measures to address the requirements of this paragraph. These measures and performance data are reflected in the quality matrix provided in Attachment A which includes Quarter 1 and 2 information from CY 2022. Measures have been developed and continue to be reported for portions of categories (a)-(h) in paragraph 99 and included in the quality matrix. There are a significant number of measures that do not yet have data reported.

Initially, the reports for community measures focused on individuals who were transitioned from NFs. As indicated in the seventh report, LDH has added various measures that focus on in-reach efforts and active caseload activities. In Quarter 2 of CY 2022, the Department also included individuals who were diverted from NFs. It should also be noted that many measures are now reported by the CCM as of the second quarter of this calendar year, rather than TCs who have reduced their efforts to provide intensive case management.

As indicated in paragraphs 54-55, the State has implemented and is expanding a process to more systematically identify and address barriers to address (i) of paragraph 99. Item j, access to and utilization of community-based services, is discussed in more detail in paragraph 101.

Several of the areas in paragraph 99 were discussed in other sections of the report (e.g., (a) in paragraphs 24-27, and (c) in paragraph 97). Other measures focused on outcomes for individuals who were transitioned or diverted from NFs. These are discussed below.

There were measures consistently reported that indicated positive outcomes for individuals who were transitioned or diverted. These outcomes did not vary from Quarter 1 or Quarter 2 when the CCMs began to track and report this information. These measures include:

- Number and percent of members reporting stability in natural supports network (96%)
- Number and percent of members reporting that they are involved in the community to the extent they would like (84-85%).

There are several measures that have notable changes between quarters for individuals who were transitioned or diverted. This includes:

- Number and percent of members reporting good physical and BH health (approximately a 20% decrease between Q1 and Q2).
- A 30% decrease in the number and percent of members reporting stability in housing.

The Department reports that these two issues have been prioritized for further review by the internal Quality Assurance Committee.

The SME also reviewed critical information regarding the use of physical health care services. As indicated in previous reports, the individuals in the Target Population often have multiple chronic conditions that place them at high-risk for hospitalization or NF admission/re-admission. Specifically, the SME reviewed information on primary care appointments and hospitalizations (all cause) for individuals who were transitioned or diverted from NFs. The primary source of this information was the most recent individual MCO monthly reports available for June and July of 2022. This information indicated:

- 91% of the individuals transitioned or diverted from NFs had a recent (within the previous 60 days) appointment with their primary care practitioner. The balance were mostly individuals who had recently been transitioned and were awaiting an appointment.
- Approximately 20% of the individuals were hospitalized during the months of June and July. The State reported 50% who were hospitalized during Q1 of 2022. These hospitalizations occurred across multiple months and were therefore difficult to compare. However, 20% hospitalization rate is a significant percent of hospitalizations in a month's period.
- Of all hospitalizations in June/July time period, a significant majority (87%) occurred for physical health versus behavioral health causes (27%). There were several individuals who were hospitalized for both physical health and behavioral health causes. This is consistent with previous reports from TCs over the past 18 months.

There are several data sources used to populate the matrix that provide the State with reliable information (e.g., Medicaid claims, OPTs, or UTOPIA PASRR information). There are a number of measures that are self-reported by the CCM or TC. It should be noted that in Quarter 2, TCs continued to provide intensive case management and continued to self-report measures for individuals on their caseloads in addition to individuals being newly served by CCMs. While having this self-reported information is helpful, it may be biased and may not accurately reflect the experiences of individuals who have been transitioned from NFs.

In previous reports, the SME recommended that the State develop a process to offset any reliability concerns regarding self-reported data in the quality matrix. The State proposed, but has not implemented, a process to have the Transition Coordinators perform interviews with the Target Population member as a second level review to verify that the information being reported by CCMs is accurate. TCs should be able to collect and review information through a more independent review of the quality of services provided, assessing Target Population members' satisfaction of services, transition, and community tenure more generally. This process was not implemented during this reporting period.

As part of the service reviews, the SME was to assess whether individuals are receiving services consistent with their plan of care. The source for this information is the SME Service Reviews which found:

- Little information regarding the number and percent of transitioned members who received services in the amount, frequency, and duration specified in the CCM Plan. A major factor that may have affected this was the newness of the implementation of CCM and the lack of information available to include in an initial plan of care. Almost all individuals reviewed had not been transitioned for more than 90 days and only the initial plan of care was available to review. These plans were often developed within 30 days post transition and the CCM had made referrals to providers that would stipulate the amount, scope, and duration to include in updated plans.
- The service review found that individuals (86%) reported receiving services identified in the initial plan of care. However, most individuals reported they were receiving additional services not included in the initial plan of care.
- The service review found 19 or 76% of the individuals had service plans that addressed their health and safety risks as indicated in the assessments.

During this reporting period, the State has developed additional data measures related to 99(i), which requires the State to collect and analyze data to measure "barriers to serving individuals in more integrated settings, including the barriers documented and any involvement of the Transition Support Committee." To meet this objective, the State has developed a list of frequent barriers that have been historically reported by TCs and from the SME Service Review Report for TCs to use during their transition efforts. The State had reported this information will be collected by PIRs on a quarterly basis, beginning this reporting period. The State has begun efforts to collect this information starting with in-reach staff and during the next reporting period will collect similar information from TCs and PASRR Level II evaluators. Ultimately, this information will be provided to the SRP for review and recommendations to develop strategies to mitigate these barriers.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- The State has not developed an annual quality assurance plan for CY 22.
- There are a significant number of measures that have been identified but not data has been reported.
- The State continues to collect and analyze consistent data to improve the availability, accessibility, and quality of services for areas identified in this paragraph.
- The State has added measures that address this paragraph more fully, however additional measures may need to be developed to comply with this paragraph.
- The State has created and updated protocols on collection and analysis of data to drive improvement in services which the SME has been involved with since the beginning of the Agreement.
- The State still has not developed a process (other than the SME Service Review reports) to validate the data collected on measures self-reported by the TCs and now the CCMs.
- The State has yet to collect the additional information on measures regarding PASRR Level II information.
- There are still major issues with inpatient hospital services utilization. The State reports that as of December 2022 14% of individuals transitioned in 2022 were hospitalized (all causes). 8 percent of the individuals who were diverted were hospitalized in CY 2022. The State has not reported the number of individuals who presented at an ED during the calendar year.
- The State has developed PASRR measures to better report information regarding lengths of stay and readmissions.
- The State does not have a consistent approach in identifying barriers for individuals to receive services in the most integrated setting, including information from the SRP.

Recommendations

- The State should develop a quality assurance plan during the next reporting period that incorporates information and work from the CY 2022 and the first six months of CY 2023.
- The State should provide the quality matrix on a quarterly basis to the SME and DOJ. The matrix should include all data for the quarter. The data should reflect up to date information (no later than a one quarter lag in data. The quality matrix should be provided no later than 120 from the final quarter reported (e.g., quality matrix for Q4 for 2022 should be provided no later than May 1st of 2023.
- The State should finalize the reporting measures for CY 2023 in the next reporting period based on a crosswalk developed by the SME to ensure accurate measures exist for each of the subsections in this paragraph.
- State should continue its efforts during this next reporting areas to focus on reasons and strategies to address the higher use of ED and inpatient hospital services, including a focused review to determine if various service gaps are driving this utilization.
- The State should implement the TC secondary review of members in the Target Population's self-reported measures to begin efforts to determine the reliability of the process to collect these measures.
- The State should fully implement the strategies for collecting information on barriers from TCs and PASRR Level II evaluators.
- The State should provide data on barriers to the LDH Quality Assurance Committee and to the SRC in the next reporting period. The State should report the number of individuals experiencing more frequent transition barriers and separately provide information in paragraph 54 on SRP efforts to address these barriers.
- The State should report the new PASRR measures regarding lengths of stay and readmissions.

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

Compliance Rating: Partially Met

Discussion and Analysis

In the seventh report, the SME reported on activities undertaken by LDH to address the findings and recommendations from the FY 2021 SME Report. There were several areas from the SME report the State did not address, specifically revising the ITP to collect information on the frequency and duration of services needed for transition and the need for certain staff (e.g., support coordinators and direct service workers offering personal care services) to receive training regarding mental health conditions to have better insight on providing or coordinating services for individuals with these conditions. As indicated in paragraphs 59 and 92, the State is undertaking activities to address these areas.

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 problems at the individual, provider, and

systemic level. The information collected for the quality assurance process is discussed in paragraph 99. Sources for the data include:

- Information from the CCMs who are responsible for ensuring the total needs of the individual are identified and addressed.
- Information from claims and other administrative data (Utopia, OPTS and MCO provider network reports).
- Information from the SME Service Reviews that provide information on the experience of care for individuals who have been diverted, transitioned, and awaiting transition.
- Information from critical incidents.

During this reporting period, the State's internal Quality Assurance committee, as discussed in paragraph 94, continues to review data from the first two quarters of CY 2022 from the quality matrix. As discussed in paragraph 99, there were several issues the QA Committee focused on:

- The decreasing number and percent of members reporting good physical and behavioral health.
- The decreasing number and percent of members reporting stability in housing.
- Reviewing the timeliness of assessment, plans, transition
- Proposing to make revisions to improve the presence and quality of the ITP
- Implementing internal quality audit processes both for transition and PIRS work
- Developing a process to include the review of barriers that will be provided by PIRS and TCs
- Reviewing recent NF readmissions by individuals who were transition or diverted.

The SME will be requesting information from LDH regarding any follow up and recommendations from the internal Quality Assurance Committee.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- The State has developed an internal process to analyze data and identify trends, patterns, strengths, and problems at the individual, provider, and systemic levels.
- The State has not addressed many of the findings from the first SME Service Review Report.
- While the State has developed and implemented certain strategies to address issues in the quality matrix or the SME Service Review, information on the effectiveness of these strategies has yet to be reported.

Recommendations

- Continue efforts to review, analyze, and act on data provided by the quality matrix and SME Service Reviews. As indicated in paragraphs 98-99, housing stability and a decrease in individual's reported physical and mental health are major issues identified in the quality matrix.
- As indicated in paragraph 94, the State should release its second Quality Assurance Report and specifically discuss what strategies were developed and implemented to address concerns in the preceding bullet.
- Report on the efforts from the internal quality assurance as discussed in the bullets in the paragraph above.
- Implement strategies discussed throughout this report to include stakeholder feedback and SRP review of issues identified through the quality assurance process and proposed strategies to address these barriers.

- Develop a tracking process to determine if the strategies the State has put into place to address issues identified through the quality assurance process using data in paragraphs 98 and 99 had the 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.

Compliance Rating: Partially Met

Discussion and Analysis

As discussed above, the State utilizes a Quality Matrix to collect and report on the data and performance measures required by paragraph 99 of the Quality Assurance and Continuous Improvement Section of this Agreement. In January 2022, the State published its first Annual Quality Assurance Report, which includes the My Choice Quality Matrix Data for 2020. Additional enhancements are needed to report on all measures required by paragraph 99.

The State is required to report publicly on all data collected pursuant to this section. Other provisions in the section require LDH to collect data regarding mortalities, critical incidents, and the availability and quality of community-based services. In August 2021, LDH released a needs assessment for individuals in the Target Population. The needs assessment provided data on the utilization of community-based services, including the number of individuals in the Target Population who received various community-based services. The findings from the initial needs assessment found:

- A greater proportion of the group that had transitioned to the community received support services (ACT, CPST, and PSR) compared to the SMI population as whole.
- The most utilized services for both the transitioned and diverted group were:
    - Assertive Community Treatment (26% and 17%, respectively).
    - PSR (32% and 7%, respectively)
- There were certain services that received a much smaller proportion of behavioral health services: crisis intervention, SUD screening, and treatment.

In the sixth report, the State reported its intent to collect information on the utilization of community services by individuals who were transitioned or diverted. In the sixth report, the SME recommended the State develop these same reports in the third quarter of the fiscal year (ending March 30th) of each year, to review and determine if additional capacity is needed and whether additional budget requests will need to be made the following summer based on the State's budget cycle. The State has agreed to report utilization information on a semi-annual basis to align with the budget cycle and the SME report.

As indicated previously in this report, LDH has provided the SME with utilization information for the third quarter of CY 2022 for individuals who were transitioned or diverted in CY 2022. A summary table is provided in Attachment B. The SME reviewed this information against the information provided in the needs assessment from 2021 and information provided in the previous SME report. A review of this information indicates:

- There continues to be a significant portion (52%) of individuals who are not receiving Medicaid behavioral health services. While some of these individuals may have Medicare as a payer, this is higher than what would be expected.

- There continues to be a marked decrease in the percent of individuals receiving other MHR services (CPST or PSR) for both transitioned and diverted individuals as compared to the Needs Assessment.
- The percent of individuals transitioned from NFs continue to receive ACT at slightly higher levels, although there continue to be fewer individuals who were diverted and received ACT than were identified as needing ACT in the Needs Assessment.
- The percent of individuals receiving outpatient services from a licensed behavioral health practitioner was consistent with the information from the needs assessment.
- There was a marked increase in the percent of individuals (transitioned and diverted) who received preventative physical health care, especially primary care. Almost 70% of the individuals transitioned from NF received primary care or preventive services. A smaller percent (44%) of individuals diverted from NFs received this service. It should be noted that almost all individuals participating in the service reviews had a recent visit with a primary care provider.
- There were significant decreases in the percent of individuals (diverted and transitioned) utilizing EDs and inpatient services (general and behavioral health).

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- LDH has begun an annual effort to publish the Quality Matrix (which contains some of the data and performance measures required by paragraph 99) and other information regarding the utilization of services by individuals in the Target Population.
- The State has yet to review and analyze the data to identify trends that would lead to individuals not receiving services. The fact that 42% of the individuals transitioned or diverted from NFs are not receiving any behavioral health services is problematic.

Recommendations

- LDH should perform additional analyses on these individuals' needs and the reasons individuals with behavioral health needs are not getting services.
- LDH should perform additional analyses on why individuals transitioned or diverted from NFs are not getting newly created services.
- LDH should track service utilization for individuals who are diverted more frequently, to determine if CCM is improving identification of behavioral health needs and subsequent utilization of these services.
- LDH should implement the recommendations in paragraph 95 regarding continued strategies for reducing ED and inpatient utilization.
- LDH should timely publish its mortality review reports, and all other reporting required by this section, on an annual basis.

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.

Compliance Rating: Partially Met

Discussion and Analysis

This rating has changed from Not Met to Partially Met. While data has been generally available to other relevant state agencies over the past several years, including the SME Report and Quality Assurance Plan, LDH and the SME have discussed the importance of more tailored information sharing with other state

agencies that have a significant role in the My Choice Program. The goal of this tailored approach is to have each agency review relevant data and information, identify and address individual and systemic issues, and develop strategies to enhance implementation. Continued information dissemination regarding the My Choice should be continued among LDH and other agencies. Other states have developed a data use plan to share and develop actionable strategies for program improvements. These data use plans often include:

- Understanding of the shared goal between two or multiple agencies
- Identifying what are important data to collect and review to determine if the shared goal is being met.
- Identifying the source for data that is to be shared among state agencies
- Developing processes to review and act on data to improve efforts to meet the shared goal
- Continuing to determine if revised or additional data is needed for the review process.

Currently, there exist data sharing efforts among agencies, including OCDD, LHC, and LHA. OCDD receives information on individuals transitioned or diverted from NFs who have been identified as having I/DD. LHA and LHC participate in bi-weekly calls that update My Choice staff regarding current and proposed housing opportunities.

While these efforts provide value, it will be important for the integration coordinator, OAAS, and OBH to identify existing and additional state agencies that should have a more tailored data use strategy and build upon existing efforts to share and process data. Initially the LHC, LHA, and LRS may be a focus for developing a data use strategy. These agencies have the oversight of key community integration efforts including integrated housing and employment opportunities. For LHC and LHA, the focus should be on providing data and information specific to the My Choice goals that are set forth in the My Choice Housing Plan. For LRS, it will be important to have a somewhat different approach, an organized strategy for reviewing and meeting the employment interest of individuals transitioned or diverted from NFs.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- The State collects and disseminates some information regarding the progress of the My Choice Program.
- LDH has certain processes in place to provide some state agencies with information on select aspects of the My Choice Program.
- There is not a formal data use plan developed for the My Choice Program with other state agencies.
- Integration Coordinator, OAAS, and OBH have agreed to develop additional and more targeted efforts regarding better use of information sharing between state agencies regarding the My Choice Program.

Recommendation

- The State should identify the key state agencies that are most likely involved and impacted by the My Choice Program.
- The State should develop and implement data use strategies for these agencies, including clarity regarding goals for the information sharing and a regular cadence of meeting with agencies to review data and to make programmatic and policy decisions.

- The State should report out the progress of implementing these data use strategies during the next reporting period.

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.

Compliance Rating: Partially Met

Discussion and Analysis

The State is ultimately responsible for ensuring the quality and sufficiency of services provided under this Agreement. Quality can be assessed through various qualitative approaches the State is currently undertaking and expanding (e.g., monitoring outcomes for individuals in the Target Population who are transitioned and diverted, the existing ACT fidelity reviews referenced in paragraph 72). In the future, this should be supplemented with reviews of new services such as crisis services, IPS, and peer supports.

The Service Reviews that are conducted by the SME will eventually be conducted by the State. These reviews play a critical role in assessing the quality and sufficiency of services, and understanding the experience of individuals awaiting transition, transitioned, or diverted from NFs. In time, there should be improvements to the quality of individual assessments and plans of care are needed to assess whether people are receiving needed services and supports in the appropriate amount, frequency, and duration.

As indicated in paragraph 62, LDH staff have partnered with the SME during this reporting period to conduct interviews with individuals, their caregivers and friends, CCM, TCs, and other service providers. These efforts have included training and technical assistance from the SME team to LDH regarding the purpose and process of the service reviews. In addition, LDH staff debrief with the SME team member as these reviews occur and are included in debriefing discussions with LDH leadership regarding the outcome of these reviews.

In addition, efforts will need to continue to measure the sufficiency of community-based services provided to individuals transitioned or diverted from NFs. LDH efforts have looked at sufficiency of services through network adequacy reports, which provides information on whether service providers are available (geographically and accepting service referrals) but are not specific to this Target Population.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration:

- LDH has tracked and continues to track the sufficiency of services that are managed by the MCOs through network adequacy reports.
- For the past four years, network adequacy of community based behavioral health services have been sufficient.

- LDH has processes in place to review the fidelity of some evidenced based practices (e.g., ACT). It will need to develop similar processes to review the new services including IPS, Peer Supports, and all four crisis services.
- LDH has participated in the SME Service Reviews, including interviews with individuals transitioned or diverted from the community. Such participation will help prepare LDH to adopt and implement the reviews in the future.

Recommendations

- Continue to collect and analyze network adequacy information from MCOs regarding Medicaid services offered to individuals transitioned or diverted from NFs.
- Develop a strategy for reviewing the fidelity and/or practice of new services including IPS, Peer Supports, and all four crisis services.
- Continue to participate in the SME Service Reviews with the eventual goal of having a greater leadership role in these reviews.

Conclusion

This is the second compliance report from the SME regarding the My Choice Program. As this report indicates, there are many areas where the State has undertaken significant activities to meet the intent of specific paragraphs and are in partial compliance or are in compliance with the Agreement. In other instances, the State has not met the intent of the requirements set forth in various paragraphs. It should be noted these paragraphs are essential to the Agreement, such as transitions, diversions, and implementation of new services.

The recommendations in this report provide potential strategies for LDH to improve the areas that are not met or partially met. The major areas of focus for the next reporting period should include:

- Continuing to increase the number of individuals who will be transitioned over the next six months to meet the goal of 350 individuals for CY 2023.
- Developing a renewed approach for increasing the number of diversions, especially at-risk individuals, and therefore decreasing the number of individuals in the Target Population still in NFs. This will be critical for LDH to successfully comply with this Agreement and not add individuals to the Master List.
- Developing better acumen of TCs and CCMs to identify and include services, especially new services created under this Agreement, that truly integrate individuals into the community. The State has developed services that could assist in this endeavor, but there are few, if any, individuals in the Target Population referred for these services. The State has to create the demand for these services through better assessments, plans of care, and referrals to these services.
- Continuing efforts to expand the implementation of new services, including crisis services, IPS, and personal care services.
- Tracking the Housing Plan to ensure units/voucher opportunities are being developed consistent with this plan, and that opportunities are offered to and accepted by the Target Population.
- Improving the quality assurance process, including renewed focus on CIRs, deaths, and barriers to transitions. This should include input by external stakeholders and connection to the SRP.

Attachment A

My Choice Quality Matrix 2022 Data					
	Proposed Measure	**Quarter 1 January-March 2022**	**Quarter 2 April-June 2022**	**Quarter 3 July-September 2022**	**Quarter 4 October-December 2022**
Masterlist and In-Reach Efforts					
1.a	Total number of people on Master List (ML)	3452	3278		
1.b	Number and percent of new individuals added to the ML	438/3452 13%	437/3278 13%		
1.c	Number and percent of new individuals added to ML based on PASRR Level II	323/438 74%	297/437 68%		
1.d	Number and percent of new individuals added to ML based on MDS	115/438 26%	140/437 32%		
1.e	Number and percent of individuals on Master List that have been engaged via LDH in-reach process	1856	2331		
1.f	Number and percent of individuals identified via in-reach indicating they are interested in transitioning	459/1856 25%	693/2331 30%		
1.g	Number and percent of individuals identified via in-reach work indicating they are undecided regarding transition	189/1856 10%	350/2331 15%		
1.h	Number and percent of individuals identified via in-reach work indicating they are not interested in transitioning at this time	912/1856 49%	1313/2331 56%		
1.i	Number and percent of individuals identified on Master List indicating interest in transition via in-reach that have been added to Active Case Load	Need some additional time to work on this one.	Need additional time to work on this item. Should be available next quarter.		
Active Caseload					
2.a	Total number of individuals on Active Caseload	572 (working on engagement/transition activities) 108 (transitioned) Total AC=680	662 (working on engagement/transition activities) 117 (transitioned) Total AC=779		
2.b	Total number of individuals added to Active Caseload	223	308		
2.c	Total number of individuals removed from Active Caseload	270	241		
2.d	Number and percent of individuals removed from Active Caseload Reasons for removal: Successfully closed (transitioned) Declined Transition Discharged prior to TC led transition Court Ordered to Stay in Facility Not Target Population Re-institutionalization	**Successfully Closed:** 18 - 7% **Declined Transition:** 183 - 68% **D/C prior to TC led transition:** 12- 4% **Court Ordered to stay in facility:** 0 - 0% **Not TP:** 23 - 9% **Re-institutionalized:** 3 - 1%	**Successfully Closed:** 11 - 4% **Declined Transition:** 151 - 62% **D/C prior to TC led transition:** 8- 3% **Court Ordered to stay in facility:** 0 - 0% **Not TP:** 21 - 9% **Re-institutionalized:** 5 - 2%		
2.e	Number of individuals on AC with a completed initial transition assessment	415	412		
2.f	Average length of time to complete initial transition assessment	70 days	61 days		
2.g	Number of individuals on AC with a completed transition plan	255	226		
2.h	Average length of time to complete a transition plan	109 days	68 days		
2.i	Average length of time of transitions	317 days Looking at informaion for people transitioned with an add to AC date of 2021/2022 191 days	324 days (all) Looking at information for people transitioned with an add to AC date of 2021/2022 199 days		
2.j	Number and percent of individuals transitioned	37/292 13%	97/292 33%		
2.k	Number and percent of individuals diverted	29/120 24%	72/120 60%		

Provider Capacity, Access to, and Utilization of Community Services					
3.a	Number of community based behavioral health providers available to provide services and accepting new Medicaid participants	See Network Report	See Network Report		
3.b	Number of community based behavioral health providers available to serve BH Medicaid beneficiaries stratified geographically by region	See Network Report	See Network Report		
3.c	Number and percent of specialized behavioral health providers meeting appointment availability standards. 1) Emergent: 1 hour; 2) Urgent: 48 hours (2 calendar days); Routine: 14 calendar days	See Network Report	See Network Report		
3.d	Number and percent of members reporting they are receiving the all services they need as specified in the plan of care (waiver, non-waiver, behavioral health, etc.)	62/75 82% During this quarter CCM implemented. For the purposes of reporting utilized ICM data from TC logs as previously reported (only includes transitioned individuals)	As of June 2022, there are a total of 137 transitioned and diverted members. 72% of members report they received all needed services		
3.e	Number and percent of members that have a plan of care that reflects identified needs from the assessment	Information will come from Service Reviews not available now	Information will come from Service Reviews not available now		
3.f	Number and percent of transitioned members who received services in the amount, frequency and duration specified in the plan of care	Information will come from Service Reviews not available now	Information will come from Service Reviews not available now		
Referrals to, admission and readmission to, diversion from, and length of stay in NF					
4.a	Number of persons that request PASRR Level I admission to NF	9179	8810		
4.b	Number of Level I PASRRs that indicate presence/history of SMI	945	918		
4.c	Number of referral to Level II SMI authorities from the Level I authority	538 Total Pre Admits 211 Level II Not Required 150 Approvals	710 Total Pre Admits 225 Level II Not Required 267 Approvals		
4.d	Number of individuals on the master list that have a PASRR Level II	3179 92%	2999 91%		
4.e	Number and percent of individuals that are admitted into Nursing Facilities that have a completed PASRR Level II upon admission	New Level I system not available yet	New Level I system not available yet		
4.f	Number and percent of individuals in the target population that have a PASRR Level II (within the past year) annual review	New Utopia System not implemented-data not available yet	New Utopia System not implemented-data not available yet		
4.g	Number and percent of individuals in the target population that had a PASRR Level II (within the past year) due to a change in medical status	New Utopia System not implemented-data not available yet	New Utopia System not implemented-data not available yet		
4.h	Average length of time to complete PASRR Level II due to a change in a medical status (resident review)	New Utopia System not implemented-data not available yet	New Utopia System not implemented-data not available yet		
4.i	Number and percent of specialized services recommended by PASRR Level II for new admissions	New Utopia System not implemented-data not available yet	New Utopia System not implemented-data not available yet		
4.j	Number and percent of specialized services recommended by PASRR Level II for ongoing stays	New Utopia System not implemented-data not available yet	New Utopia System not implemented-data not available yet		
4.k	Number and percent of individuals that are new admissions that received each specialized service	New Utopia System not implemented-data not available yet	New Utopia System not implemented-data not available yet		
4.l	Number and percent of individuals identified as having an ongoing stay that received each specialized service	New Utopia System not implemented-data not available yet	New Utopia System not implemented-data not available yet		

4.m	Number and percent of PASRR determinations indicating that admission to NF is not recommended as it is not the least restrictive setting	29/203 14%	43/326 13%		
4.n	Average length of stay in nursing facility	Pull this data annually-December	Pull this data annually-December		
4.o	Number and percent of transitioned members are re-admitted to a NF for greater than 90 days during the first year post transition	Semi-annual report Report June and December	8/168 5% (To determine denominator - looked at total transition numbers from June 2021-June 2022)		
Person Centered Planning, Transition Planning, and Transitions from Nursing Facilities					
5.a	Number and percent of members whose plan of care addresses their needs	Information will come from Service Reviews not available now	Information will come from Service Reviews not available now		
5.b	Number and percent of members who participated in the planning meeting	71/75 95% During this quarter CCM implemented. For the purposes of reporting utilized ICM data from TC logs as previously reported (only includes transitioned individuals)	Information from this item planned to be gathered via MCO quality monitoring. Implementation of that monitoring planned for early next year. Working with SME to pull this information as part of the Service Review. Information will not be available unti		
5.c	Number and percent of members whose planning meeting included notice of or participation in planning meeting by individuals chosen by the member	72/75 96% During this quarter CCM implemented. For the purposes of reporting utilized ICM data from TC logs as previously reported (only includes transitioned individuals)	Information from this item planned to be gathered via MCO quality monitoring. Implementation of that monitoring planned for early next year. Working with SME to pull this information as part of the Service Review. Information will not be available until Quarter 4		
5.d	Number and percent of members whose plan of care reflect their strengths and preferences	72/75 96% During this quarter CCM implemented. For the purposes of reporting utilized ICM data from TC logs as previously reported (only includes transitioned individuals)	Information from this item planned to be gathered via MCO quality monitoring. Implementation of that monitoring planned for early next year. Working with SME to pull this information as part of the Service Review. Information will not be available until Quarter 4		
Safety and Freedom from harm					

6.a	Number of critical incidents, stratified by type of incident	During this quarter CCM implemented. For reporting purposes utilized data as previously report (includes only transitioned individuals): Total # of Critical Incidents = 58 Total # of people = 35 Major Medical: 32 Major Medication issue: 1 Falls: 15 Major BH incident: 3 EPS: 2 Death: 4 Loss of Home: 1 Acute Hospitalizations: 17 Emergency Department: 21 Psychiatric Hospitalization: 1 CCM Reporting for March 2022, 4 critical incidents reported. All incidents reported to protective services within 24 hours.	For Q2 2022, there were 8 critical incidents reported. All incidents were reported to protective services within 24 hours of notification.		
6.b	Number and percent of members that utilized crisis services		Team is in process of pulling Quarter 1 Service Utilization report. Quarter 2 Service Utilization report will not be available until October due to lag in claims data		
6.c	Number and percent of critical incidents involving abuse/neglect/exploitation that were referred to the appropriate protective service and or licensing agency	During this quarter CCM implemented. For reporting purposes utilized data ar previously reported (2). CCM reporting for March 2022, 1 incident reported.	8		
6.d	Number of deaths reported	5	3		
6.e	Number of deaths referred for mortality review	4	3		
6.f	Number and percent of death investigations that were completed	0	1		
6.g	Average length of time to complete a death investigation	0	231 days		
6.h	Number and percent of deaths that require a remediation plan	0	1		
6.i	Number and percent of participants whose service plans had strategies that addressed their health and safety risks as indicated in the assessment (s)	Information will come from Service Reviews not available now	Information will come from Service Reviews not available now		
6.j	Number and percent of members reporting that they have been free from abuse, neglect, or exploitation	74/75 98% During this quarter CCM implemented. For the purposes of reporting utilized ICM data from TC logs as previously reported (only includes transitioned individuals)	As of June 2022, there are a total of 137 transitioned and diverted members. 98% of members report free from abuse, neglect, expoitation, or extorsion		
Physical and behavioral health wellbeing and incidence of health crisis					

7.a	Number and percent of members reporting good physical and BH health Number and percent of members Inpatient/ED Services – BH Utilized Number and percent of Inpatient/ED Services – PH Utilized	68/75 90% During this quarter CCM implemented. For the purposes of reporting utilized ICM data from TC logs as previously reported (only includes transitioned individuals) For March, there are 0 hospitalizations report for those enrolled in CCM for the full month	As of June 2022, there are a total of 137 transitioned and diverted members. 67% of members report good physical health 71% of members report good mental health		
7.b	Number and percent of members that report that they need assistance taking medications as prescribed	12/75 15% During this quarter CCM implemented. For the purposes of reporting utilized ICM data from TC logs as previously reported (only includes transitioned individuals). Question in TC log specific to whether there was a change in medication/treatment, side effects, etc.	As of June 2022, there are a total of 137 transitioned and diverted members. 14% of members report they need assistance taking medication		
Stability					
8.a	Number and percent of members reporting stability in housing	73/75 97% During this quarter CCM implemented. For the purposes of reporting utilized ICM data from TC logs as previously reported (only includes transitioned individuals)	As of June 2022, there are a total of 137 transitioned and diverted members. 69% of members report stability in living situation. It should be noted that the great majority of moves were for members moving from NFs to home and community-based settings.		
8.b	Number and percent of members reporting no issues with current living situation	Information not available yet.	As of June 2022, there are a total of 137 transitioned and diverted members. 85% of members report a good living situation		
8.c	Number and percent of members reporting stability in natural supports network	72/75 96% During this quarter CCM implemented. For the purposes of reporting utilized ICM data from TC logs as previously reported (only includes transitioned individuals)	As of June 2022, there are a total of 137 transitioned and diverted members. 96% of members report stability in caregivers		
Community Inclusion					
9.a	Number and percent of members reporting that they are involved in the community to the extent they would like	64/75 85% During this quarter CCM implemented. For the purposes of reporting utilized ICM data from TC logs as previously reported (only includes transitioned individuals)	As of June 2022, there are a total of 137 transitioned and diverted members. 84% of members report they are involved in the community to the extent they would like		

Attachment B Utilization of Community Services

# of Target Population members Transitioned with Medicaid
374

Table 2. DOJ Transitioned Members - Home and Community-Based Service Utilization - Q3 2022

Home and Community-Based Service Utilization																						
Member Region of Residence	# of TP Members Transitioned with rendered services	# of TP Members Transitioned Receiving Peer Support Services	% of TP Members Transitioned Receiving Peer Support Services	# of TP Members Transitioned Receiving ACT	% of TP Members Transitioned Receiving ACT	# of TP Members Transitioned Receiving Psychiatrist Services in Outpatient Settings	% of TP Members Transitioned Receiving Psychiatrist Services in Outpatient Settings	# of TP Members Transitioned Receiving LMHP Services in Outpatient Settings	% of TP Members Transitioned Reciving LMHP Services in Outpatient Settings	# of TP Members Transitioned Receiving Personal Care Services	% of TP Members Transitioned Receiving Personal Care Services	# of TP Members Transitioned Receiving Individual and Placement Support Services	% of TP Members Transitioned Receiving Indiviual and Placement Support Services	# of TP Members Transitioned Receiving CPST/PSR	% of TP Members Transitioned Receiving CPST/PSR	# of TP Members Transitioned Receiving SUD Treatment Services	% of TP Members Transitioned Receiving SUD Treatment Services	# of TP Members Transitioned Not Receiving BH Services	% of TP Members Transitioned Not Receiving BH Services	# of TP Members Transitioned Receiving Preventive or Ambulatory Care	% of TP Members Transitioned Receiving Preventive or Ambulatory Care	# of TP Members Transitioned Receiving Waiver Personal Care Services	% of TP Members Transitioned Receiving Waiver Personal Care Services
Region 1	47	.	.	12	25.5%	1	2.1%	.	.	.	.	.	.	13	27.7%	.	.	27	57.4%	26	55.3%	23	48.94%
Region 2	46	.	.	18	39.1%	1	2.2%	6	13.0%	.	.	.	.	15	32.6%	1	2.2%	17	37.0%	36	78.3%	16	34.78%
Region 3	26	.	.	5	19.2%	.	.	1	3.8%	.	.	.	.	4	15.4%	1	3.8%	16	61.5%	20	76.9%	8	30.77%
Region 4	47	.	.	13	27.7%	.	.	2	4.3%	1	2.1%	.	.	4	8.5%	.	.	30	63.8%	28	59.6%	21	44.68%
Region 5	25	.	.	7	28.0%	.	.	1	4.0%	.	.	.	.	.	.	.	.	17	68.0%	17	68.0%	10	40.00%
Region 6	49	.	.	16	32.7%	.	.	8	16.3%	.	.	.	.	1	2.0%	2	4.1%	25	51.0%	34	69.4%	27	55.10%
Region 7	45	.	.	12	26.7%	3	6.7%	2	4.4%	.	.	.	.	6	13.3%	1	2.2%	28	62.2%	34	75.6%	19	42.22%
Region 8	28	.	.	2	7.1%	1	3.6%	3	10.7%	.	.	.	.	1	3.6%	1	3.6%	22	78.6%	20	71.4%	13	46.43%
Region 9	32	.	.	8	25.0%	.	.	1	3.1%	.	.	.	.	3	9.4%	.	.	22	68.8%	20	62.5%	14	43.75%
Out of State	1	.	.	1	100.0%	.	.	.	.	.	.	.	.	.	.	.	.	.	.	1	100.0%		0.00%
Statewide	324	0	0.0%	94	29.0%	6	1.9%	24	7.4%	1	0.3%	0	0.0%	47	14.5%	6	1.9%	182	56.2%	224	69.1%	151	46.60%

Table 3. DOJ Transitioned Members - Crisis and Hospital Utilization - Q3 2022

Crisis and Hospital Utilization																			
Member Region of Residence	# of TP Members Transitioned with rendered services	# of TP Members Transitioned Utilizing Mobile Crisis	# of TP Members Transitioned Utilizing Behavioral Health Crisis Care (Urgent Center)	# of TP Members Transitioned Utilizing Community Brief Crisis Support	# of TP Members Transitioned Utilizing Crisis Stabilization Services	# of TP Members Transitioned Utilizing Crisis Intervention Services	Unduplicated # of TP Members Transitioned Utilizing Crisis Services	% of TP Members Transitioned Utilizing Crisis Services	# of TP Members Transitioned with ED Visit	% of TP Members Transitioned with ED Visit	# of TP Members Transitioned with BH-ED Visit	% of TP Members Transitioned with BH-ED Visit	Total Number of ED Visits for TP Members Transitioned	Total Number of BH-ED Visits for TP Members Transitioned	# of TP Members Transitioned with IP Visit	% of TP Members Transitioned s with IP Visit	# of TP Members Transitioned with BH-IP Visit	% of TP Members Transitioned with BH-IP Visit	Total Number of IP Visits for TP Members Transitioned	Total Number of BH-IP Visits for TP Members Transitioned
Region 1	47	.	.	.	.	.	.	.	5	10.6%	1	2.1%	6	1	4	8.5%	2	4.3%	5	2
Region 2	46	.	.	.	.	.	.	.	9	19.6%	2	4.3%	19	2	4	8.7%	.	.	7	.
Region 3	26	.	.	.	.	.	.	.	2	7.7%	2	7.7%	2	2	1	3.8%	1	3.8%	1	1
Region 4	47	.	.	.	.	.	.	.	2	4.3%	.	.	3	.	1	2.1%	1	2.1%	1	1
Region 5	25	.	.	.	.	.	.	.	3	12.0%	1	4.0%	9	1	1	4.0%	1	4.0%	1	1
Region 6	49	.	.	.	.	.	.	.	8	16.3%	3	6.1%	22	3	7	14.3%	3	6.1%	8	3

Region 7	45	.	.	.	.	.	.	.	8	17.8%	2	4.4%	20	4	5	11.1%	2	4.4%	7	2
Region 8	28	.	.	.	.	.	.	.	4	14.3%	1	3.6%	10	1	3	10.7%	1	3.6%	3	1
Region 9	32	.	.	.	.	.	.	.	3	9.4%	.	.	10	.	3	9.4%	2	6.3%	6	4
Out of State	1	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Statewide	324	0	0	0	.	.	0	0.0%	42	13.0%	12	3.7%	101	14	29	9.0%	13	4.0%	39	15

Table 1. DOJ Diverted Members

# of Target Population members Diverted with Medicaid
42

Table 2. DOJ Diverted Members Home and Community-Based Service Utilization - Q3 2022

Home and Community-Based Service Utilization																							
Member Region of Residence	# of TP Members Diverted with rendered services	# of TP Members Diverted Receiving Peer Support Services	% of TP Members Diverted Receiving Peer Support Services	# of TP Members Diverted Receiving ACT	% of TP Members Diverted Receiving ACT	# of TP Members Diverted Receiving Psychiatrist Services in Outpatient Settings	% of TP Members Diverted Receiving Psychiatrist Services in Outpatient Settings	# of TP Members Diverted Receiving LMHP Services in Outpatient Settings	% of TP Members Diverted Reciving LMHP Services in Outpatient Settings	# of TP Members Diverted Receiving Personal Care Services	% of TP Members Diverted Receiving Personal Care Services	# of TP Members Diverted Receiving Individual and Placement Support Services	% of TP Members Diverted Receiving Indiviual and Placement Support Services	# of TP Members Diverted Receiving CPST/PSR	% of TP Members Diverted Receiving CPST/PSR	# of TP Members Diverted Receiving SUD Treatment Services	% of TP Members Diverted Receiving SUD Treatment Services	# of TP Members Diverted Not Receiving BH Services	% of TP Members Diverted Not Receiving BH Services	# of TP Members Diverted Receiving Preventive or Ambulatory Care	% of TP Members Diverted Receiving Preventive or Ambulatory Care	# of TP Members Diverted Receiving Waiver Personal Care Services	% of TP Members Diverted Receiving Waiver Personal Care Services
Region 1	4	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	4	100.0%	.	.	.	.
Region 2	2	.	.	.	.	.	.	1	50.0%	.	.	.	.	.	.	.	.	.	1	50.0%	.	.	.	.
Region 3																								
Region 4	6	.	.	1	16.7%	.	.	.	.	.	.	.	.	.	.	1	16.7%	4	66.7%	4	66.7%	.	.
Region 5	1	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	1	100.0%	1	100.0%	.	.
Region 6	2	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	2	100.0%	1	50.0%	.	.
Region 7	6	.	.	1	16.7%	.	.	1	16.7%	.	.	.	.	.	.	.	.	4	66.7%	1	16.7%	.	.
Region 8	6	.	.	.	.	.	.	.	.	.	.	.	.	1	16.7%	.	.	5	83.3%	5	83.3%	.	.
Region 9	2	.	.	.	.	.	.	1	50.0%	.	.	.	.	.	.	.	.	1	50.0%	1	50.0%	.	.
Out of State or N/A																							
Statewide	29	0	0.0%	2	6.9%	0	0.0%	3	10.3%	0	0.0%	0	0.0%	1	3.4%	1	3.4%	22	75.9%	13	44.8%	0	0.0%

Table 3. DOJ Diverted Members - Crisis and Hospital Utilization - Q3 2022

Crisis and Hospital Utilization

Member Region of Residence	# of TP Members Diverted with rendered services	# of TP Members Diverted Utilizing Mobile Crisis	# of TP Members Diverted Utilizing Behavioral Health Crisis Care (Urgent Center)	# of TP Members Diverted Utilizing Community Brief Crisis Support	# of TP Members Diverted Utilizing Crisis Stabilization Services	# of TP Members Diverted Utilizing Crisis Intervention Services	Unduplicated # of TP Members Diverted Utilizing Crisis Services	% of TP Members Diverted Utilizing Crisis Services	# of TP Members Diverted with ED Visit	% of TP Members Diverted with ED Visit	# of TP Members Diverted with BH-ED Visit	% of TP Members Diverted with BH-ED Visit	Total Number of ED Visits for TP Members Diverted	Total Number of BH-ED Visits for TP Members Diverted	# of TP Members Diverted with IP Visit	% of TP Members Diverteds with IP Visit	# of TP Members Diverted with BH-IP Visit	% of TP Members Diverted with BH-IP Visit	Total Number of IP Visits for TP Members Diverted	Total Number of BH-IP Visits for TP Members Diverted
Region 1	4	.	.	.	.	.	.	.	1	25.0%	.	.	1	.	1	25.0%	.	.	1	.
Region 2	2	.	.	.	.	.	.	.	2	100.0%	2	100.0%	6	2	2	100.0%	2	100.0%	5	5
Region 3																				
Region 4	6	.	.	.	.	.	.	.	3	50.0%	1	16.7%	5	1	3	50.0%	3	50.0%	3	3
Region 5	1	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Region 6	2	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Region 7	6	.	.	.	.	.	.	.	1	16.7%	.	.	1	.	.	.	.	.	.	.
Region 8	6	.	.	.	.	.	.	.	2	33.3%	1	16.7%	4	1	1	16.7%	.	.	1	.
Region 9	2	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Out of State or N/A																				
Statewide	29	0	-	0	.	.	-	0.0%	9	31.0%	4	13.8%	17	4	7	24.1%	5	17.2%	10	8