2023-2

LA-DOJ Tenth Subject Matter Expert (SME) Report

COVERING THE PERIOD OF 7/1/2023 THROUGH 12/31/2023

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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 serious 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). On a regular basis, the SME prepares a Service Review of a representative sample of individuals in the Target Population. These reviews are conducted to look at various domains that are central to the Agreement and focuses on an individual's overall quality of life versus the quality of community-based services provided to the member.

The State engaged John O'Brien (formerly of the Technical Assistance Collaborative) in August of 2018 to perform the SME responsibilities. Every six months, the SME drafts and submits 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 tenth SME report, covering the period of 7/1/2023 through 12/31/2023.

While the goal of the agreement is to reduce the inappropriate use of nursing facilities for people with serious mental illness, thus far, the number of people in the Target Population with serious mental illness living in nursing facilities has increased since the beginning of the Agreement. In June 2018, there were 3,964 individuals in the Target Population in nursing facilities. As of December 31, 2023, there are 4,085 individuals in the Target Population in nursing facilities. The number has increased from the ninth period and is at an all-time high over the course of the Agreement. LDH must assertively divert individuals from these facilities and more assertively 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 managers (CCMs) and other services (e.g., Assertive Community Treatment (ACT)) 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. For the CY 2023 Service Review, the SME reviewed 56 individuals who were transitioned (29), diverted (8), or were awaiting transition from NFs (19).
- 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 is the fourth 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 with 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

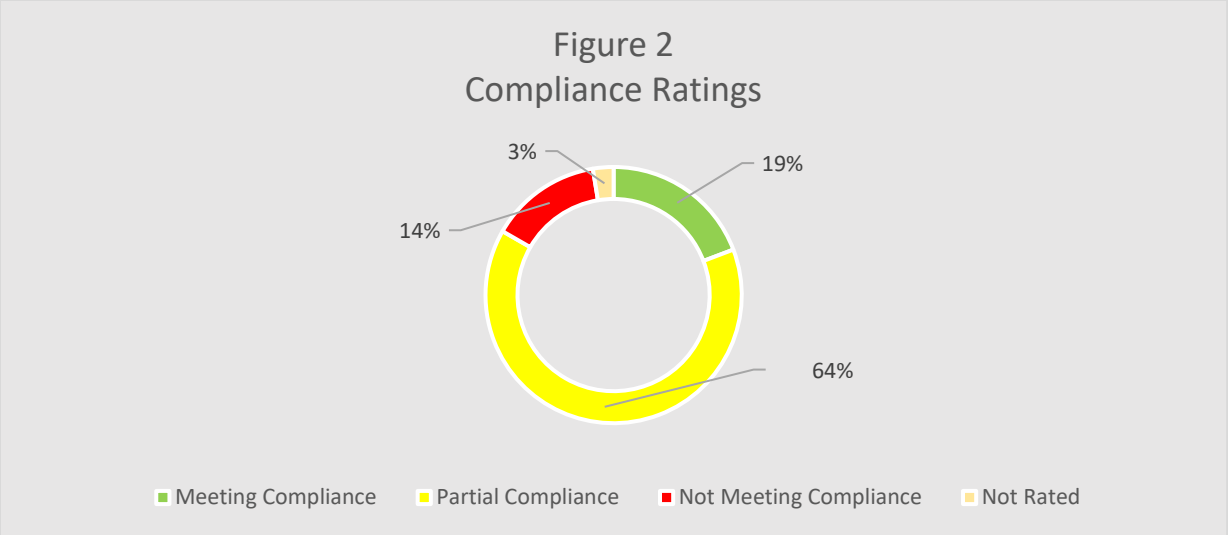
Figure 1 illustrates the Subject Matter Expert's compliance determinations relative to each major section of the Agreement, aggregating to the total number of requirements falling within each compliance category. Within this report, there is a dedicated section for each of the compliance domains listed below, which includes the SME's rationale for each compliance assessment rating. The scores are provided for all paragraphs, including paragraphs that were not reviewed during this reporting period.

Figure 1

Synopsis of Report and Compliance Assessment for the My Choice Program

Target Population (3)	**Meeting Compliance**	0	**Partial Compliance**	2	**Not Meeting Compliance**	0	**Not Yet Rated**	0	**Not Rated**	1
Diversion and Pre-Admission Screening (11)	**Meeting Compliance**	3	**Partial Compliance**	5	**Not Meeting Compliance**	3	**Not Yet Rated**	0	**Not Rated**	0
Transition and Rapid Reintegration (23)	**Meeting Compliance**	4	**Partial Compliance**	13	**Not Meeting Compliance**	5	**Not Yet Rated**	0	**Not Rated**	1
Community Support Services (23)	**Meeting Compliance**	8	**Partial Compliance**	12	**Not Meeting Compliance**	3	**Not Yet Rated**	0	**Not Rated**	0
Outreach, In reach and Provider Education and Training (7)	**Meeting Compliance**	0	**Partial Compliance**	7	**Not Meeting Compliance**	0	**Not Yet Rated**	0	**Not Rated**	0
Quality Assurance and Continuous Quality Improvement 11)	**Meeting Compliance**	0	**Partial Compliance**	11	**Not Meeting Compliance**	0	**Not Yet Rated**	0	**Not Rated**	0
Total	**15**		**50**		**11**		**0**		**2**	
Percent	**19%**		**64%**		**14%**				**3%**	

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. All paragraphs, with the exception of two, have been rated. LDH is in compliance with 15 paragraphs (19%), in partial compliance with 50 paragraphs (64%), and not meeting compliance with 11 paragraphs (14%). There are two paragraphs (3%) not needing a rating (not rated).



The fact that 64% of paragraphs are in partial compliance and 19% of paragraphs meet 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 five years of implementation, a small proportion of those in the Target Population has benefited from the Agreement's ultimate purpose. As of December 2023, LDH has transitioned 597 individuals from nursing facilities since the implementation of this Agreement began in June 2018. As of December 31, 2023, 122 individuals were diverted from NFs based on the State's definition of the diversion population. As indicated above, over 4,000 individuals in the Target Population 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 toward achieving important targets (e.g., transitions) and milestones (e.g., development of new services) that will comply with this Agreement.

However, during this reporting period LDH continues to underperform in efforts to transition individuals in the Target Population in NFs who have expressed an interest in moving. In fact, while LDH has steadily increased the annual transition goals and achievements in each previous year, its performance in Calendar Year 2023 declined. LDH transitioned 174 people from nursing facilities in Calendar Year 2023. This is approximately 50% of the 350 transitions it intended to achieve that year and reflects a decline in total transitions compared to the 200 achieved in 2022. Historical transition data can be found in paragraph 56.

Despite its efforts, LDH projects it will take at least two or more years to transition the more than 556 people who have already expressed a desire to transition, and the hundreds of other individuals on the Active Caseload whom the state has prioritized as potentially interested in transitioning. LDH projects to

transition 331 individuals from NF during this calendar year and has fallen short of their projections for this reporting period. Even if the State meets its annual goal, hundreds of people who have already indicated they want to move will remain institutionalized unnecessarily.

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 actions are necessary in order to accommodate people's desire to live in their own homes and communities without undue delay. Greater participation by external stakeholders such as the Transition Support Committee and the My Choice Quality Resource Subcommittee overseeing 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. Some of 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:

- **Implementing 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 State is launching a pilot project in the next reporting period to implement requirements in the Agreement where individuals newly admitted to an NF will receive an initial contact within 3 days of admission and the Nursing Facility Transition Assessment (NFTA) begins within 14 days of admission. The State should develop a robust data collection strategy to gauge the progress of this effort in order to make mid-course changes and determine how to best expand this effort statewide after the pilot. In addition, there are some enhancements to the Peer In-reach Specialist (PIRS) Program to improve the identification of individuals in the Target Population who may be interested in transitioning and to inform decision-making discussions with individuals who may be reluctant to transition. 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.
- **Increasing the number of individuals transitioned from nursing facilities.** A total of 579 individuals have been transitioned since the beginning of the Agreement. There are 654 individuals on the Active Caseload List (ACL) who are interested in moving. LDH is aiming to transition 331 individuals in CY 2024. This is approximately 60% of the individuals on the Active Caseload List and a much lesser percentage of individuals who are undecided and whom the State has prioritized for transition. As addressed above, this means hundreds of people who have already indicated they want to move will remain institutionalized unnecessarily. To meet the projected transition of 331 individuals, each TC would have to transition 13 individuals over the course of the year (or approximately 1 per month). It is incumbent on LDH to take the necessary actions to assertively monitor TCs' efforts to meet this requirement and take the necessary actions to improve performance.
- **Improving the quality of Individualized Treatment Plans (ITPs).** As discussed in this report and previous SME Service Reviews, the quality of the ITPs is poor. They are not person centered and

are often missing services to address needs in the assessment. LDH should continue training and supervision strategies that improve the quality of NFTAs and ITPs. Specifically, the State should use the findings from the LDH audits of TC transition activity to improve the ITPs. LDH should ensure the acumen of TCs to provide motivational interviewing strategies to encourage individuals to take the necessary steps to increase goals and SUD intervention for individuals with an identified SUD.

- **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 the utilization of the newly created Transition Support Committee (TSC) and ensuring stakeholder input is sought to assist the State to develop strategies to address barriers experienced by the Target Population.
- **Increasing efforts to divert individuals from NFs who are at highest risk of these admissions.** During this reporting period, LDH has implemented a new definition for individuals at-risk of an NF admission. The State has made changes during CY 2023 for how MCOs provide case management to these individuals. The new definition and the MCO case management efforts are critical to decrease the number of individuals who will be admitted to a hospital and possibly referred to an NF. Given the number of the Target Population in NFs is at an all-time high, LDH should ensure MCOs are actively engaging and diverting individuals from emergency departments and inpatient hospitals for any cause. This could include developing incentives for MCOs to better engage individuals in their case management efforts and avoid preventable ED visits and hospitalizations that could eventually lead to an NF referral.
- **Continuing activities to improve diversion process for people being considered for NF admission and receiving a PASRR Level II evaluation.** LDH has made enhancements during this reporting period to improve efforts to divert individuals with SMI from NFs. This includes standardizing an approach to auditing reviews of PASRR Level II Evaluators,' MCOs', and LDH Determination Specialists' decisions regarding admission and diversions from NFs. This audit process also ensures PASRR Level II Evaluators focus on areas that were previously found to be lacking in these reviews. LDH has yet to implement changes to protocols and processes to the PASRR Level II instrument, ensuring evaluators have the tools and the information to be able to have timely and plausible resources for individuals and their caregivers to ensure access to community based services in lieu of NFs. LDH should use information from the audit findings in projecting additional individuals who could be diverted from an NF and in increasing the number of individuals who are diverted. As indicated later in the report, these audits indicate a significant percentage of all individuals sampled for an audit who were admitted to an NF may have been diverted from these facilities.
- **Enhancing and effectively implementing Quality Assurance activities to ensure the quality of community services for Target Population members.** The State continues to collect information to address the quality of services and the experience of care for individuals who have been transitioned from NFs. LDH did reinstate internal and external quality assurance strategies for the My Choice Program. This included convening a new internal quality workgroup and included new members from the My Choice Quality Resource Subcommittee. In addition, LDH developed benchmarks and trend reporting for each measure in the Quality Matrix. .The State has not developed its annual plan for CY 2022 or CY 2023. The State should focus internal and external efforts (e.g., engaging the TSC and My Choice Quality Resource 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 focus additional 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.

- **Addressing the lack of peer supports and employment opportunities.** There continues to be no appreciable utilization of the Medicaid peer support services approved in February of 2021. The SME's service reviews identified many individuals transitioned and diverted 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 are used by a portion (39%) of the Target Population transitioned and 20% diverted from NFs. As indicated throughout this report, individuals who are transitioned or diverted experience loneliness and isolation. Peers could assist individuals to develop strategies for pursuing interests and hobbies as well as identify transportation options for these individuals to pursue those interests and hobbies. Peers can also be helpful by accompanying the individual to initial meetings, classes, or other informal gatherings on a short-term basis. In addition, there is little utilization of the Integrated Placement Supports (to address employment goals). However, LDH is now requiring each ACT provider to offer Integrated Placement Supports (IPS) to all individuals on their teams. In addition, LDH is creating incentives for non-ACT providers to offer IPS during the next reporting period. In CY 2023, LDH released information regarding the importance of employment goals and services for individuals participating in the MHR program (including individuals in the Target Population). LDH will be training MHR providers in the next reporting period on how to use this guidance with their service planning and delivery activities. It will be important for the State to report the number of individuals in the Target Population who are engaged in these activities and are employed.
- **Implement the Housing Plan.** The State has not tracked efforts set forth in their revised CY 2022 housing plan which targets 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 make use of these opportunities. The State created multi-year projections for various federal and state housing programs; however, there is no information on whether the State met or did not meet these annual projections. The State must complete this tracking and address any deficiency in the number of additional housing opportunities so that the State can reach the 1,000, as required by the Agreement.
- **Continue to request additional resources for the My Choice Program.** There are several areas in which the SME recommends additional staffing resources to enhance implementation activities consistent with the Agreement. There are specific staffing resources that were recommended in the ninth report that LDH should pursue, including:
    - Peer In-reach specialists who are needed to continue efforts to meet with individuals on the Master List who are undecided or not interested in transitioning.

- Rapid Integration Transition Coordinators (RITCs) to ensure that every region has sufficient RITC capacity to engage individuals as required by the Agreement within 3 and 14 days from admission.

LDH should also consider resources to support the Integration Coordinator in their quality assurance efforts. Quality Assurance is critical to the success of the My Choice Program and to assuring substantial compliance with the Agreement. The Integration Coordinator is responsible for coordinating and overseeing the overall Agreement. Having dedicated staff resources, specifically for all quality activities, will support but not supplant the activities of the Integration Coordinator's efforts to achieve compliance with this Agreement.

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 January 1, 2024, the State reports that 99% of the individuals on this list continue to have at least one PASRR II evaluation with a confirmed Serious Mental Illness. In the ninth report, LDH reported the same percentage 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 is described in previous SME reports. 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 has divided the list of Target Population members in nursing facilities into two groups. This includes an Active Caseload List (ACL) for individuals who have indicated an interest in moving and whom the State has prioritized for transition. The ACL also included individuals who have been transitioned in the past 12 months. 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.

In the ninth SME report, there were 3,783 individuals in the Target Population in nursing facilities; 3,198 individuals were included on the Master List and 747 individuals on the Active Caseload List. An additional 162 individuals were transitioned from NFs and remained on the Active Caseload List for one-year post-transition. As of December 2023:

- There are 4,085 individuals in the Target Population in nursing facilities during the reporting period, approximately 300 more than the previous reporting period.
- There are 3,584 individuals on the Master List, 386 or approximately 12% more individuals than the ninth reporting period.
- The number of individuals on the Active Caseload List decreased this reporting period from 747 to 654 individuals.
- There was roughly the same number of individuals (153) who were transitioned and remained on the Active Caseload List as there was in the ninth report.

The SME notes the number of individuals in the Target Population on the Master List has continued to increase over the past three reporting periods and overall has fluctuated over the past five reporting periods. The number of individuals on the Master List for this reporting period is the highest thus far since January 1, 2022. LDH has provided the rationale for the increase:

- The high rate of increase was not attributable to an increased rate of new admissions. The number of NF admissions overall decreased slightly from 9,817 in the first quarter of CY 2023 to 9,289 in the third quarter of CY 2023 (most recent data available).
- More referrals from NFs for PASRR Level IIs for individuals already admitted to NFs have occurred this year as a result of recent audits by CMS that has intensified its scrutiny of erroneous schizophrenia diagnoses to justify the use of psychotropic medications. NFs are making referrals for PASRR Level II evaluations to substantiate the presence of schizophrenia and continued use of psychotropic medication. LDH has indicated that NFs have not always indicated a diagnosis of schizophrenia on the MDS and therefore these individuals have not been included on the Master List. Table 1 provides information on changes in the Master List.

Table 1. Number of Individuals on the Master List

Reporting Period	Individuals on the Master List as of 12/31/2023
7/1/2023-12/31/2023	3,584
1/1/2023-6/30/2023	3,198
7/1/2022-12/31/2022	2,902
1/1/2022—6/30/2022	3,256
7/1/2021-12/21/2021	2,795

As noted elsewhere in this report, LDH needs continued, additional focus on diverting individuals from NFs in order to reduce the number of members in the Target Population in NFs.

The ACL decreased by 12% this reporting period. Table 2 provides information on changes in ACL.

Table 2. Number of Individuals on the Active Caseload List

Reporting Period	Individuals on the Active Caseload List as of 12/31/2023
7/1/2023-12/31/2023	654
1/1/2023-6/30/2023	747
7/1/2022-12/31/2022	774
1/1/2022—6/30/2022	598
7/1/2021-12/21/2021	916

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

- During this reporting period, LDH removed 389 individuals from the Active Caseload List and returned them to the Master List.

- As of December 2023, the end of this reporting period, there were 501 individuals on the Active Caseload who were in Nursing Facilities. Of those, 434 (80%) have indicated an interest in transition based on a completed transition assessment.

The State continues to report that there were several major reasons the 389 individuals on the Active Caseload List were removed from that list during this reporting period. This includes:

- 203 individuals or 52% declined transition.
- 67 or 17% were successfully discharged from the My Choice Program (individuals who had been transitioned for 12 months).
- 33 or 8% were unable to be engaged.
- 21 or 5% were re-admitted to the nursing facility.
- 18 or 4% died in the nursing facility.

The State continues to use a process to review each individual being transitioned from the ACL to the Master List. As indicated in the eighth report, the Integration Coordinator and senior staff at OAAS and OBH review each request and determine if the return to the Master List is appropriate. The review occurs every 90 days. Prior to moving the individual from the ACL to the Master List, the Integration Coordinator and leadership from OAAS and OBH:

- Review each individual prior to removing the individual from the ACL
- Identify the rationale of moving the individual to the Master List
- Review the date the individual was placed on the ACL and the number of TC contacts (including the assessment) each individual received to ensure sufficient contact was made to discuss transition options.

The number of individuals removed from the ACL continues to be a concern to the SME. While there are individuals likely to change their mind during the transition process, there continued to be a high percent of individuals removed from the ACL each reporting period. As discussed throughout this report, better scrutiny is needed regarding who gets placed on the ACL to ensure LDH resources (TCs) are effectively used to focus on individuals who are transitioning.

The State continues to add individuals to receive MDS information 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 number and timeliness of when these individuals receive a PASRR Level II evaluation 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. LDH revised the numbers for individuals diverted in the ninth reporting period from 60 to 62. LDH has provided the SME with a list of individuals who were diverted during this review period. Sixty (60) individuals were diverted from July 1, 2023, to December 31, 2023.

Compliance Assessment

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 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 is described in previous SME reports.
- The number of individuals in the Target Population and on the Master List in NFs significantly increased this reporting period. The State reports this was due mainly to an increased number of individuals already in NFs who were referred for a PASRR Level II due to recent guidance from CMS.
- The number of individuals on the Active Caseload has remained relatively unchanged during this reporting period.
- LDH has a process to identify and refer individuals with a possible diagnosis of SMI, adds these individuals to the Master List, and refers them for a PASRR Level II evaluation, as required by paragraph 25.
- LDH continues to use the ACL to prioritize transitioning a subset of people in the Target Population.
- LDH continues to use the methodology developed during this eighth reporting period to measure diversions through the PASRR process.
- LDH maintains a current list of individuals in the Target Population who were diverted from nursing facilities each month and during the reporting period. During CY 2023, LDH diverted 122 individuals, 89% of their projected diversions.
- There was still a significant number of individuals who are returned to the Master List from the ACL. LDH determined that 52% of individuals previously on the Active Caseload List were not interested in moving at various points in the transition process. This continued to be consistently high and suggests LDH should review the effectiveness of the in-reach process.

Recommendations

- LDH should implement strategies identified in paragraphs 29 and 30 to reduce the admissions of individuals with SMI to NFs and therefore decrease the number of individuals in the Target Population in NFs.
- LDH should take measures to reduce the percentage of individuals who are moved from the ACL to the Master List who explicitly indicate they are not interested in transition. This diverts much needed TC resources from performing transition activities for individuals who continue to express interest in transitioning.
- LDH should provide education to NFs (administrators, prescribing physician, and other staff) to better identify individuals who are receiving psychotropic medication and have an SMI.
- LDH should interview a subset of people removed from the ACL to assess why people who were formerly interested in transitioning are changing their minds.

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

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

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 continue to be 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 137 individuals would be diverted from NFs during CY 2023. LDH reports that it diverted 122 individuals in CY 2023, the exact same amount as CY 2022. However, they did not meet their projection of 132 individuals. LDH projects to divert 122 individuals from NFs through the PASRR Level II process in CY 2024. The State applied a methodology based on historical efforts by PASRR Level II Evaluators. As discussed in paragraph 34, LDH should factor in information from their audits to increase this number.

As indicated in paragraph 34, the SME recommended, and the State will require PASRR Level II evaluators to provide uniform information on barriers to diverting individuals from NF placements using a revised PASRR Level II evaluation. LDH planned to release this updated PASRR Level II evaluation in May 2023, and then delayed the release to October 2023. They now have projected a release date of March 2024 .

Developing a Strategy to Address Individuals in the At-Risk Population: LDH developed and implemented a strategy according to the diversion plan for individuals at high risk for NF admission beginning in 2021. In late 2022, LDH changed the definition of the at-risk population. In addition, LDH changed the requirements for MCOs to provide case management to these individuals beginning January 1, 2023. During the ninth reporting period, LDH changed the definition of individuals at-risk of NF placement to better align with the initial at-risk definition. LDH has required the MCO to use the revised definition for at-risk during this reporting period (starting October 2023) but will not have data regarding these efforts until later in CY 2024 (July 2024). These efforts to address this at-risk population are 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 behavioral health services.

In the sixth and seventh 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. To address this recommendation, LDH proposed to enhance the acumen of PASRR Level II evaluators to better identify individuals who had medical and ADL needs and to identify available natural supports who could provide time-limited assistance. This is discussed in more detail in paragraph 32. LDH proposed or implemented two strategies that would provide the PASRR Level II reviewers with information regarding these resources:

- OAAS staff members have proposed providing 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. During this reporting period, the SME provided additional comments and suggestions regarding this training. LDH has stated they will implement this training in May 2024.

- OAAS staff members continue to work with the OBH PASRR team lead in an audit process to review PASRR Level II evaluators' decisions. The audit process identifies whether OAAS agrees with the PASRR Level II evaluator placement recommendation and the PASRR Level II team lead discussed these barriers with the MCOs and the PASRR Level II evaluators. Additional information on the OBH PASRR Level II audit process is discussed in paragraph 34.

The SME understands that some services (e.g., transportation to medical appointments, medication oversight, and some activities of daily living) cannot be immediately available post diversion during the first few weeks of hospital discharge given referral and service engagement timeframes. Some of these services may be provided by natural supports until formal supports can be secured. The Department reports they have trained PASRR Level II evaluators to identify whether the individual has natural supports available to provide these services on a temporary basis. The SME has reviewed training provided to PASRR Level II evaluators and confirms this training continues to include the identification and role of natural supports that may be helpful for diverting individuals from NFs. However, LDH reports that many of the individuals recommended for NF placements do not have natural supports that could be used temporarily to support a recommendation for community placement.

In addition, as indicated in the past three SME reports, meeting existing or new diversion targets is dependent on PASRR Level II evaluations. In previous reporting periods, meeting the diversion targets was challenging given 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 the past three reporting periods, LDH did not have an 1135 Waiver in place.

Developing a Case Management Strategy for Diversions: Since March 2022, LDH has implemented Community Case Management (CCM) for individuals who were transitioned or diverted from NFs. CCMs are responsible for engaging individuals who are diverted from NFs (through the PASRR Level II process), assessing their needs, developing a community and crisis plan, referring individuals to needed services, and tracking individuals for one year post transition. CCMs coordinate services (including services specified in the Agreement) and medical and long-term services and supports to address their healthcare

and activities of daily living needs. The SME received information for CCM activities from May 2023 through September 2023 (most recent data available from LDH). A total of 340 individuals were enrolled in the CCM program, 49 of whom were diverted. (An additional 230 had transitioned from an NF, and 61 were still in an NF). Individuals can receive CCM for 12 months post their diversion. More detailed information regarding the CCM program is provided in paragraphs 47 and 59.

Compliance Assessment

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

- The State has implemented some parts of the diversion plan, including:
  - Generally met the annual projection in CY 2023 for individuals diverted through the PASRR Level II process. The State reported they diverted 122 individuals, which was 89% of their projected numbers of diversions.
  - Developing training and resource materials for community-based options to address ADLs for individuals seeking admission to NFs. The State has not implemented these trainings but projects to train PASRR Level II evaluators in May 2024.
  - Continuing to implement the PASRR Level II audit process, including assistance from OAAS to review individuals who potentially can be diverted from NFs. LDH continues to report information from this audit process to the MCOs and PASRR Level II evaluators to ensure appropriate placement and service recommendations.
  - Continuing to offer CCM for individuals who were diverted from NFs and enrolled in a Healthy Louisiana Plan.
  - Refining and implementing the definition of at-risk and requiring MCO to offer MCO care coordination to these individuals as of October 2023. The State has also developed a process to track MCO delivered case management for this population. Data regarding individuals at-risk will be provided by LDH later in CY 2024 (July).
- There are several areas of the LDH revised diversion plan that have yet to be implemented:
  - The State has not developed a multi-year diversion projection.
  - While LDH has developed an audit process it has not identified whether these processes have increased diversions.
- The State uses a consistent methodology to track diversions.
- The State did not have an 1135 Waiver in place during the last three reporting periods and therefore LDH did not defer PASRR Level IIs during this period.
- 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 an NF to determine if the diversion strategies set forth in the report are effective. This includes information separately on admissions for individuals in the at-risk population, the Target Population being referred to NFs and readmissions by individuals who have been transitioned or diverted.
- LDH should develop longer term targets for diversions as stated in the diversion plan.
- OAAS and OBH should implement the training and provide the supporting materials to PASRR Level II evaluators to address ADL and other medical needs for individuals in the Target Population seeking admission to an NF.

- LDH should track the effectiveness of the current PASRR Level II audit process which is intended to increase PASRR Level II evaluators' decision to divert rather than admit individuals from NFs.
- LDH should provide information regarding the outcome of MCO's efforts to offer care coordination to individuals who are at-risk of NF placement.

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: Not Met

Discussion and Analysis

A major premise for this paragraph is that care coordination is offered and accepted by individuals at-risk of being in the Target Population. This care coordination, provided by the MCOs, can likely prevent unnecessary admission to NFs. As indicated in paragraph 26, the number of individuals in the Target Population in NFs continues to grow.

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. LDH began efforts in CY 2021 to implement a system to identify and divert individuals from avoidable hospitalizations, including requiring MCO to offer MCO care coordination to individuals at-risk of avoidable hospitalizations. The assumption is that many of these individuals, with better care coordination, would avoid hospitalization and thereby have reduced referrals to NFs. 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, and engaging individuals in care coordination, which included assessing and developing plans of care and coordinating services for these individuals.

The State provided service utilization data for at-risk members identified by the MCOs during FY 2021 (N=5,488) and 2022 (N= 5,812). LDH conducted an analysis to determine the extent to which MCO case management influenced the rate of hospitalizations, primary/preventive care, and behavioral health service utilization. The analysis of MCO provided care coordination to the at-risk population that participated in care coordination (those choosing to enroll in MCO case management for at least three months compared to those at-risk members who did not enroll) versus individuals in the at-risk population who did not receive care coordination is provided in Table 3.

Table3. At-risk analysis

	2021 (Prior to Implementation)				2022 (Following Implementation)			
Service Category	**Not Enrolled in CM (N=4890)**	**%**	**Enrolled in CM (N=916)**	**%**	**Not Enrolled in CM (N=4,895)**	**%**	**Enrolled in CM (N=917)**	**%**
# of Members with All-Cause ED Visit	2,416	49.4%	598	65.3%	2,193	44.8%	516	56.3%
# of Members with Non-Urgent ED Visit	338	6.9%	63	6.9%	331	6.8%	75	8.2%
# of Members with All-Cause IP Visit	918	18.8%	210	22.9%	883	18.1%	164	17.9%
# of Members with Potentially Avoidable IP Visits	205	4.2%	54	5.9%	188	3.8%	53	5.8%
Potentially Avoidable IP Visits	257	.	69	.	251	.	70	.
# of Members with Preventive & Ambulatory Care	3,337	68.2%	847	92.5%	3,104	63.5%	807	88.1%
# of Members Receiving BH Services	2,176	44.5%	514	56.1%	2,078	42.5%	484	52.8%

As indicated through this analysis, at-risk individuals who were enrolled in MCO provided case management had greater decreases in ED visits and inpatient stays/admissions. They also had greater engagement in preventative/ambulatory care and behavioral health services. As this analysis indicates, there were no significant changes for individuals at-risk receiving MCO case management regarding non-urgent ED visits or avoidable hospitalizations.

In FY 2022 the State's Medicaid External Quality Review Organization (EQRO) reviewed the MCO case management program for the at-risk population. Findings from these efforts were included in the eighth and ninth SME reports. This review provided findings and recommendations to the State for improvements in offering and providing MCO case management to the at-risk population. LDH followed up with each MCO and required plans of correction to address the EQRO's findings and recommendations. The State has not performed a similar review given the changes made to the at-risk population in FY 2023.

As discussed in the ninth report, the State made changes to the MCO case management approach in January 2023, which impacted how individuals at-risk would be offered MCO case management (using a tiered approach). In addition, LDH changed the definition of the at-risk population. LDH estimated the size of at-risk population would include 5,000 individuals, a 30% decrease from the size of the at-risk population using the previous definition.

Based on conversations with the SME and DOJ early in CY 2023, LDH redefined the at-risk group for January 1, 2023, to include individuals with SMI, two chronic conditions, between 18 and 75, and who had six or more ED visits or inpatient hospitalizations (all cause) in the previous year. This definition was implemented in October 2023. LDH will track MCO provided case management for each individual in the at-risk population. LDH reports this information on the at-risk population will be available in July 2024 for the fourth quarter of CY 2023.

The State has also reported meeting with the Louisiana Hospital Association (LHA) this period. LHA leadership has expressed an interest in developing discharge plans that are alternatives to NFs. During these conversations LDH and LHA identified the following barriers:

- Hospitals often have to make a discharge decision quickly and have little time to explore community options.
- Discharge staff (including hospital social workers) are not familiar with the alternatives to NFs and community behavioral health services.
- There is a greater need for hospital discharge staff to be involved in the PASRR Level II process.

LDH reports they are working with LHA to address these barriers during the next reporting period.

Finally, State Medicaid programs can use managed care and an array of other service delivery and payment system reforms, financial incentives, and managed care contracting requirements to help achieve better outcomes and lower costs. States have the ability to choose the various measures and incentive payments for MCOs. Strategies for these payments can include performance bonuses or penalties, capitation withholds, or value-based state-directed payments to quality measures. States may start with MCOs reporting information on a certain activity at first and then tying a payment reform in later years. LDH payment reform efforts could provide incentives to MCOs to better divert individuals from EDs and inpatient hospitals (all cause) by encouraging plans to better engage at-risk individuals in their case management activities.

Compliance Assessment

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

- The number of individuals in the Target Population in NFs has increased during this reporting period.
- LDH conducted an analysis for FY 2021 and 2022 regarding the original at-risk program that indicated improvements of individuals' overall use of EDs and inpatient utilization.
- LDH had the EQRO undertake a review of MCO case management provided to the initial at-risk population. This review identified opportunities for improvement of the program and LDH required plans of correction for each MCO to implement these improvements. LDH reports the MCOs have made improvements identified in the corrective action plans.
- LDH has revised and implemented in October 2023 a new at-risk definition consistent with the first definition and recommendations from the SME and DOJ.

- LDH does not currently have information regarding ED or inpatient utilization (all cause) and NF admissions to measure the effectiveness to divert at-risk individuals from inpatient hospitals and NFs. The State reports this information will be available in July 2024 for the last quarter of CY 2023.
- LDH and LHA have begun to identify barriers experienced by hospital discharge staff in offering alternatives to NF.
- LDH does have strategies in their current MCO contracts specific to the at-risk population; however, these contracts do not include incentives for plans to divert these individuals from EDs, inpatient hospitals, and NFs.

Recommendations

- LDH should undertake the activities agreed to regarding tracking and monitoring the at-risk population and taking the necessary steps to ensure MCOs adequately perform their case management functions. This includes:
    - Collect and report information quarterly related to the at-risk population including member identification, outreach to offer case management, meeting assessment and plan of care timelines, and MCO case management contacts by tier.
    - Collect and review service utilization data on the at-risk population semi-annually including ED visits, inpatient hospitalization, and NF admissions. ED and inpatient information should be provided for behavioral health and physical health visits and admission.
    - Conduct desktop reviews to evaluate MCO case management provided to the at-risk population.
    - Produce an annual report to evaluate the extent to which the strategy is meeting its intended purposes.

- LDH should develop strategies with LHA to provide information to hospital discharge staff regarding community options as alternatives to NFs. This should include training that LDH is implementing in the next reporting period for PASRR Level II evaluators, CCMs, and others regarding various LDH long term services and support programs (e.g., CCW Waiver, LTPCS).
- LDH should consider adding a strategy to the MCO contracts in FY 2025 or 2026 that provides greater incentives to divert individuals from EDs, inpatient providers, and NFs.

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

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.

In previous SME reports, LDH indicated they trained NF staff who complete the MDS to better identify and provide diagnosis information to LDH. The State has yet to validate the effectiveness of these efforts per the SME's recommendation in the seventh reporting period.

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 to an NF within three days. LDH has selected a vendor for this tracking system but has not developed the new system. In the seventh, eighth, and ninth SME reports, the State anticipated training would occur during those reporting periods as this system was developed and implemented. The new system was not implemented during this reporting period and therefore no training occurred for PASRR Level I reviewers.

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 during this reporting period. The State has yet to validate the effectiveness of these efforts per the SME's recommendation in the seventh reporting period.
- The 2023 Implementation Plan identified PASRR Level I trainings was to occur during the last reporting period. However, this has been delayed due to ongoing contract negotiations. The SME requested dates for new training (training materials and schedule of trainings) for PASRR Level I. The State is proposing to provide this training in April 2024.

Recommendations

- LDH should finalize and implement the contract that will provide the necessary changes in the PASRR Level I tracking process.
- LDH should implement the training for PASRR Level I screeners on new reporting processes and improving acumen for making referrals for a PASRR Level II evaluation.
- 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: Partially Met

Discussion and Analysis

As discussed in the sixth report, the SME reviewed the most recent list of community options and found these to be insufficient to provide information on community-based options for PASRR Level II evaluators to use in their evaluation efforts. During this reporting period, LDH has finalized the training for community options regarding the various Medicaid programs to address ADLs. The SME reviewed and provided additional changes which were incorporated into the final version. The training was primarily

developed for PASRR II evaluators; however, the State reports they will make this training available to other staff including PIRS, TCs, and CCMs. It can also serve to provide information to an additional audience—referral sources for NFs (e.g., general and behavioral health hospitals). LDH reports they will implement this training early in the next reporting period. Having community-based options available and offered to individuals during the PASRR Level II evaluation process may be helpful to divert some individuals with ADL needs from NF for short term rehabilitation.

In addition, LDH reports they have revised the PASRR Level II evaluation instrument to enhance efforts to provide individuals and caregivers seeking NF admission information regarding physical health services and supports (e.g., home health and personal care). The changes are in response to SME discussions with the Department regarding federal PASRR Level II requirements and concerns PASRR Level II evaluators were not identifying resources that could be made immediately available to individuals and caregivers to divert an individual from a potential NF admission. These requirements and concerns were discussed in detail in the eighth SME report.

During this reporting period, LDH provided a revised PASRR Level II Evaluation Instrument to the SME. This tool includes a more targeted focus on services that may be needed to address medical needs (e.g., home health services for wound care) and ADLs (e.g., amount and duration of personal care services needed). The revised tool collects information on barriers to community referrals consistent with LDH recent efforts to collect standardized information regarding these barriers. In addition, the recommendation section includes information on various LDH community programs that are consistent with the training developed by LDH discussed earlier in this section. As indicated in paragraph 29, LDH proposed to finalize the instrument in October 2023. LDH has revised the timeframe for the release of the new PASRR Level II instrument and training for PASRR Level II evaluators regarding the instrument to April 2024.

PASRR Level II trainings and audits continued during this reporting period. Recent training and audit efforts are specifically focusing on improvements to the PASRR Level II evaluators' review of specific areas, identified by the OBH PASRR Level II Coordinator, to better identify SUD, mental health, and physical health care services that may assist in diversion efforts. A more detailed discussion of these efforts is provided in paragraph 34. In addition, the SME has reviewed the most recent PASRR Level II training materials (as of November 2023). The PASRR Level II evaluators continue to be trained and are providing consistent information to LDH regarding the availability of an individual's natural support system to provide community options (e.g., transportation to medical appointments, interim personal care) to assist the individual to determine if diversion from an NF is a possibility.

Compliance Assessment

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

- OAAS and OBH has finalized, but not yet implemented, training and materials that would enhance PASRR Level II evaluators' knowledge and strategies to offer medical and long term services and supports that would address the comprehensive needs of the individual prior to NF admission. LDH reviewed the training and materials with the SME to ensure they provide realistic and useful information regarding these services and supports.
- LDH revised, but has not yet implemented, the PASRR Level II instrument to better collect information regarding medical and ADL needs that are primary drivers to nursing home admissions.

- LDH did not solicit information during this reporting period from external stakeholders and entities that have regular contact with individuals who have been admitted to or diverted from NFs to identify community resources for individuals seeking NF admission.
- LDH has trained and is requesting the PASRR Level II evaluators to evaluate the availability of natural supports to provide interim services and supports to prevent an NF admission. The SME has reviewed the most recent training for PASRR Level II evaluators which includes a continued focus on collecting information on the ability of family and other caregivers to support the individual in the community versus the NF.
- LDH will collect information on barriers to community placement from PASRR Level II evaluators consistent with current efforts by TCs and PIRSs. LDH proposes to use this information to develop strategies for addressing these barriers to improve diversions and transitions.

Recommendations

- OBH and OAAS should immediately (by no later than February) 2024 implement the process to provide training and materials to PASRR II Evaluators and Determination Specialists regarding the current community options for offering medical and ADL assistance to individuals seeking admission to an NF.
- LDH should solicit information from external stakeholders and entities to identify community resources for individuals seeking NF admission during this next reporting period.
- The State should audit/monitor how the training has improved PASRR Level II evaluators' efforts to offer community options and ultimately increase the number of diversions. This was recommended in the ninth report and LDH reports that staff bandwidth issues due to an increased number of PASRR Level II evaluations has delayed this effort.
- LDH should implement the process for PASRR Level II evaluators to identify barriers to obtaining community services for individuals seeking NF admission.
- LDH should use information collected through the PASRR Level II process to identify and address barriers through the My Choice Quality Assurance process that are identified by PASRR Level II evaluators, TCs, and PIRSs.
- LDH should evaluate whether PASRR Level II training and materials are improving the quality and consistency of determinations and recommendations related to services and placement.

33. All screenings and evaluations shall begin with the presumption that individuals can live in community-based residences. For any individual for whom a 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

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 ninth 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 timeframe for implementation of the new PASRR Level I screening is not clear.

Recommendations

- The State should complete the contract negotiation 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 April of 2024.

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: Partially Met

Discussion and Analysis

LDH has made considerable progress toward complying with this paragraph. As indicated in the seventh SME report, the State has included language in the MCO contracts requiring 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 were 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 seven to nine 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. 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 II evaluations were performed prior to an individual's 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. The State reports 6% of PASRR Level II evaluations were performed after admission to an NF (generally occurring within 7 days after the admission). This is double the percentage from the ninth reporting period where 3% were performed after admission. LDH continued to report the reasons for these later PASRR Level II evaluations. These reasons were consistent with information provided in the ninth SME report and included individuals admitted through a hospital exemption that do not require a PASRR Level II evaluation and the PASRR Level I process not identifying a need for Level II, but MDS provided immediately after admission flagged the need for a PASRR Level II evaluation.

Information provided for the reporting period indicated 1,413 PASRR Level II evaluations were completed for new admissions during the second quarter of CY 2023 (latest complete information available for this report). 97% continue to be completed within 4 business days and prior to admission.

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). The SME continues to review the PASRR Level II forms and training for evaluators with the tools to determine if individuals 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. The CY 2023 SME Service Review Report reviewed documentation for 56 individuals. Per this review, the PASRR Level II evaluators continue to 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 a diagnosis of 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. The SME has reviewed this revised evaluation in the eighth report and again for this reporting period. The revised evaluation includes more information on medical services

and services and supports to address ADLs as well as other physical health services including home health and durable medical equipment, including personal emergency response systems. It also collected more detailed information on SUD history and needs.

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, OAAS and OBH has developed, but has not implemented, training and materials 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.

For the past three 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. As discussed in paragraph 32, the State has developed a list of barriers PASRR Level II reviewers will include in the revised PASRR Level II evaluation.

LDH continues their efforts to oversee PASRR Level II evaluators and the LDH PASRR Level II staff who make a recommendation 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 also includes a quality review audit tool and process for pre-admission reviews. The tool and processes 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. In the ninth SME report, the SME reviewed the audit tool and found it to be comprehensive. LDH implemented the tool which focused on several areas PASRR Level II that evaluators did not always including in their reviews. This included whether the individual had SUD service needs, medical conditions that would impact their ADLs and require additional services (e.g., home health and personal care) and whether behavioral health services (other than SUD) recommended in the PASRR Level II evaluation were recommended consistent with the behavioral health needs identified during the evaluation. The review in the ninth report indicated:

- Eleven percent of the evaluation audited did not identify SUD services when the individual had an identified SUD or use of substances including alcohol.
- Twenty-eight percent of the evaluations did not identify physical health services when the individual had significant physical health issues or significant ADL impairments.
- Three percent of the evaluations had recommended behavioral health services that were not appropriate to the behavioral health needs of the individuals.

Based on this audit, LDH provided training and coaching to PASRR Level II evaluators early in this reporting period to improve the quality of evaluations in these areas. LDH continued efforts to perform audits during this reporting period. The same audit tool was used in the ninth reporting period. The State reports to have audited 83 individuals during this reporting period who were seeking NF placement and received a PASRR Level II during the pre-admission process. The LDH PASRR Level II coordinator reviewed PASRR Level II evaluations that were performed by the PASRR Level II evaluators. LDH provided information on these audits showing a marked improvement in several areas including:

- A 36% decrease in PASRR II evaluations audited by LDH where SUD needs were not well identified by PASRR Level II evaluators.
- A 41% increase in the PASRR Level II evaluations audited this reporting period, where other behavioral health needs were being identified consistently.
- A 200% increase in the PASRR II evaluations audited this reporting period that had recommended behavioral health services that were appropriate to the behavioral health needs of the individuals.
- No appreciable change in the percentage of evaluations that did not identify physical health services.

In addition to reviewing this information, the OBH PASRR Level II Coordinator reviews the same sample of PASRR Level II evaluations for individuals who receive prior authorization requests for NF placement to determine if they agree with the admission decision. Of the 156 audits conducted, 120 (77%) had determinations validated by the OBH PASRR Level II Coordinator with the remaining 36 (23% of total) flagged as needing additional review by OAAS to determine whether diversion was possible given OAAS service availability. These additional reviews by OAAS indicated:

- Of the 36 requests referred to OAAS, admission decisions for 20 individuals (55.5%) were warranted and appropriate.
- Of the 36 requests referred to OAAS, OAAS disagreed with 5 (14%) admission decisions.
- Of the 36 requests referred to OAAS, OAAS was unsure whether the admission decision was warranted for 11 individuals (30.5%) and additional documentation would be needed to make that determination.

Combining the OAAS review into the overall audit process, this results in the following:

- Of the 156 audits conducted, 140 (90%) had an authorization determination validated by OAAS and/or OBH staff.
- Of the 156 audits conducted, 5 (3%) had an authorization determination when diversion was possible if the person was able to be linked to alternate services.
- Of the 156 audits conducted, 11 (7%) had an authorization determination when the ability to divert was unclear. Additional information would have been needed to make an appropriate determination regarding the need for NF placement.

LDH reports they will continue to perform these audits and report these findings on a monthly basis. The State has conducted initial audits of PASRR Level II evaluations for individuals who were diverted from NFs. LDH has reviewed 23 PASRR Level II evaluations for these individuals (during July and August 2023). The review process is identifying characteristics and needs of individuals who have been diverted to determine if these findings can be generalizable to all individuals receiving a PASRR Level II to increase the number of diversions. LDH reports this information is too preliminary to make recommendations during this reporting period.

In addition to the process to improve the knowledge and acumen regarding community services of PASRR Level II evaluators, the State is in the process of identifying a process to use current local staff to identify informal and formal supports for additional community options. The State reports they will provide a more detailed strategy during the next reporting period.

Compliance Assessment

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

- There was an increase in the percent of individuals who did not receive a PASRR Level II evaluations at admission to an NF.
- PASRR Level II are completed for individuals seeking admission on a timely basis.
- PASRR Level II evaluations are conducted independent of the proposed NF and the State.
- LDH has made 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 continues to deem the information collected to be sufficient to determine whether an individual has an SMI.
- LDH has revised the PASRR II Level II evaluation to better the focus of the PASRR Level II evaluations to identify the total needs of the individual with a specific concentration on medical and ADL supports. The State reports they will implement this new tool in the next reporting period.
- The State continues to perform audits of the PASRR Level II process to determine if recommendations for NF admission are warranted and addresses these findings with PASRR Level II evaluators, MCO, and LDH Determination Specialists. In addition, OBH continues to include OAAS in their review of admission decisions. The State is concurring with most NF admission decisions made by PASRR Level II evaluators after additional discussions and OAAS review.
- These audits overall indicate 3% had an authorization determination when diversion was possible if the person was able to be linked to alternate services. However, during this reporting period there were higher percentages of authorization determinations when diversion was possible.
- LDH continues to provide training and coaching to mitigate issues found in previous PASRR Level II audits.
- LDH has developed, but not implemented, a process to collect information on barriers from 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.

<u>Recommendations</u>

- LDH should continue to track the percent of individuals who did not receive, but should have received, a PASRR Level II prior to admission. If there continues to be an increase in the percent that did not receive a PASRR Level II, the State should provide information regarding the reasons the PASRR Level II did not occur and take the necessary steps to reduce this percentage.
- LDH should implement the revised PASRR Level II evaluation and 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.
- LDH should implement the new PASRR Level II evaluation instrument that includes a review and recommendations to address the total needs of individuals seeking NF placement and develop community options discussed in paragraph 32.
- LDH should continue its PASRR Level II audit activities for individuals admitted to NFs, continuing to track and address areas of improvement for the purpose of increasing diversions. LDH should report on how these activities are ensuring PASRR Level II evaluators are making appropriate decisions regarding NF or community placement. As discussed above, the percent of authorization determinations indicating when diversion was possible is variable and additional tracking is needed to confirm a trend in these determinations.
- LDH should use the audit process to train PASRR Level II evaluators to increase diversions from NFs.

- LDH should use the information from the audit process in projecting the annual number of individuals who are likely to be diverted. As indicated above, approximately 19% of individuals reviewed were admitted to NFs for whom OAAS and OBH determined a diversion was possible.

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: 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 the eighth reporting period to allow OBH to identify and track individuals who have a suspected or initial diagnosis of dementia. LDH has added "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. As indicated in the ninth report, the LDH consulting psychiatrist verifies whether all individuals with an initial or suspected dementia diagnosis have dementia or if additional information is needed to make a determination of a dementia diagnosis.

LDH continues to require PASRR Level II evaluators to collect additional information from NF staff and family members of individuals who are suspected of having dementia to garner additional information for the consulting psychiatrist to make a dementia diagnosis. A review of the most recent PASRR training provided to the SME indicates PASRR Level II evaluators, MCO reviewers, and OBH Determination Specialists continue to be trained on how to collect this information. As indicated in the ninth report, the consulting psychiatrist reports this information has been helpful to verify a dementia diagnosis.

During this reporting period, LDH reports 106 individuals in the first two quarters of this year (4% of all individuals in the Target Population in NFs) were identified through the PASRR Level II process as having or suspected of having an initial or suspected primary diagnosis of dementia. This compares to over 8% (190 individuals) in the last two quarters of 2022. As discussed in the ninth report, the consulting psychiatrist confirms each individual with a suspected or confirmed diagnosis has been reviewed to determine if they have a primary dementia diagnosis. LDH reports that for the first two quarters of CY 2023 these reviews indicated:

- 81or 76% of the individuals were determined to have a primary dementia diagnosis.
- 22 or 21% of the individuals were suspected of having a primary dementia diagnosis and were reviewed by the consulting psychiatrist during the next continued stay review period.
- 3 or 3% of the individuals were determined not to have a dementia diagnosis.

As discussed in the ninth report, the consulting psychiatrist reports ruling out external causes of dementia but reports that very few individuals present with conditions that would be automatically ruled out. The consulting psychiatrist also indicated improvements in documentation provided by the PASRR Level II evaluator. Specifically, she indicated increased and better quality of information from family members has provided important information for making a determination of dementia.

LDH reports the consulting psychiatrist continues to identify several conditions that may benefit from a re-review, including a substance use disorder (especially alcohol disorder) and other medical conditions such as individuals with a more recent stroke. These individuals continue to have a suspected diagnosis of dementia and are re-reviewed within a year to determine if the individual has dementia.

In the eighth SME report, LDH provided the SME with the results of a historical review of individuals from FY 2019 through FY 2022 to determine if individuals with a suspected or confirmed diagnosis of dementia continued to have this condition. As discussed in the ninth report, a significant majority of individuals were found to continue to have dementia.

In addition to these activities, LDH is reviewing PASRR Level II documents to ensure additional testing is recommended when a suspected diagnosis of dementia is found. Based on these reviews, the OBH PASRR Level II Coordinator has stated that this testing continues to occur.

LDH stated they continue to have a process for providing community options to individuals (and caregivers) who have a primary diagnosis of dementia. Specific information is provided to these individuals and caregivers regarding the local Alzheimer Association chapters and Louisiana State University (LSU), which has developed a repository of information for individuals with dementia and their caregivers. PASRR Level I and OAAS staff provide this information to individuals who have been determined by OBH to have a primary diagnosis of dementia.

Compliance Assessment

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

- LDH has developed a process for reviewing individuals with a dementia diagnosis since the beginning of the Agreement.
- The percentage of individuals with an initial or suspected diagnosis of dementia continued to remain relatively low during the second quarter of CY 2023.
- LDH has strengthened documentation requirements and training used to establish a primary diagnosis of dementia relative to the PASRR screening process.
- LDH has referred all individuals in this reporting period for a PASRR Level II who have a suspected SMI and who are suspected of having a primary diagnosis of dementia to the consulting psychiatrist.
- LDH has conducted a historical review of individuals with a dementia diagnosis and found 85% of previous individuals with a dementia diagnosis were appropriately diagnosed. The State has not undertaken a similar review for FY 2022 or 2023.
- LDH is reviewing and confirming testing is being recommended by the PASRR Level II evaluators for individuals who may have dementia.
- LDH continues to receive information from the questionnaire for family members and other individuals involved in an individual's care to gather information regarding decline in mental status and dementia diagnosis (suspected or actual).

- LDH consulting psychiatrist provides an additional professional evaluation for all individuals with a suspected and primary dementia diagnosis to ensure appropriate diagnosis and differentiation. This includes information from the dementia questionnaire discussed above.
- 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 made changes to the Utopia system to track individuals with a dementia diagnosis. This has allowed them to develop a baseline regarding the number of individuals who have been identified through the PASRR Level II process as having dementia and re-evaluate whether an individual continues to have dementia.
- LDH has a process for individuals who receive a dementia diagnosis to receive information regarding community supports and services.

Recommendations

- LDH continues to track the percent of individuals identified as having dementia against the baseline to determine if changes occurred and if these changes are warranted.
- LDH continues to have the consulting psychiatrist review all individuals with suspected or actual dementia diagnosis to determine if they have a dementia diagnosis.
- LDH should undertake a review to determine if individuals who were identified as having dementia continue to have dementia in later years.

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 during this reporting period 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 NF admission criteria.
- LDH has developed the necessary reports and reporting process for reviewing MDS information to verify individuals admitted to an NF have a sole diagnosis of behavioral health.
- During the reporting period, LDH provided the SME with information which indicated 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

While this paragraph remains partially met, LDH needs to make the needed changes to address the recommendations in this section to remain in partial compliance with this paragraph. 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. The intent of the change in the PASRR Level II tool and process is to incorporate other needs into the recommendation for admission to or diversion from an NF. They are also proposing to train PASRR Level II evaluators on the community options offered through various LDH Medicaid programs aimed at improving the acumen of the evaluator's recommendations regarding NF placement.

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 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). The SME requested information regarding the percent of individuals in the Target Population admitted since July 2023 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). In the eighth SME report, LDH reported the average length of stay for individuals in the Target Population admitted to an NF was 92 days. In this period LDH reported the average length of stay was 89 days.

In the ninth reporting period, LDH provided more detailed information regarding the length of stays for individuals in the Target Population admitted to NFs. For new admissions, 38% stay less than 90 days and LDH reports most of these individuals transition without needing extensive supports. More specifically:

- 21% of the Target Population stay less than 30 days from admission.
- 11% of the Target Population stay between 31 and 59 days from admission.
- 6% of the Target Population stay between 60 and 90 days from admission.
- 62% of the Target Population request and receive a continued stay at 90 days post admission.

While the Department has taken steps to develop a process for reviewing requests for these continued stays, there continue to be no clear policies for determining the length of subsequent stays. The State has indicated that approvals for ongoing lengths of stay are variable and are based on various factors. These factors include whether an individual has a transition date, incomplete documentation, or a suspected dementia diagnosis that will need to be confirmed prior to the next CSR. Currently the average length of approval for subsequent continued stay requests is 281 days. This has not changed from the eighth and ninth SME reports.

In addition, the SME continues to request information 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.
- List of transition barriers for individuals who have requested NF admission and for continued stay.

There continues to be 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. In the ninth report, the SME suggested to have Rapid Integration Transition Coordinators who will work with the Target Population at admission (as discussed in paragraph 45) to collect this information during their initial visit.

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. Information from the addendum is not yet available for review and analysis.

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 and received by individuals in NFs. They track this information for individuals who were recently admitted to an NF (less than 100 days) and for individuals who remain in an NF (greater than 100 days).

For individuals recently admitted to an NF, LDH reports:

- 37% were recommended for a psychiatric evaluation or psychosocial assessment. 12% of these individuals received this service.
- 26% were recommended for outpatient mental health services (individual, family, or group). 8% of these individuals received this service.
- 10% were recommended for Assertive Community Treatment (ACT). 13% of these individuals received this service.
- 10% were recommended for other Mental Health Rehabilitation (MHR) services. 4% of these individuals received this service.

For individuals who remained in NFs for longer than 100 days, the State reports:

- 29% were recommended for a psychiatric evaluation or psychosocial assessment. 10% of these individuals received this service.

- 30% were recommended for outpatient mental health services (individual, family, or group). 4% of these individuals received this service.
- 10% were recommended for Assertive Community Treatment (ACT). 8% of these individuals received this service.
- 18% were recommended for other Mental Health Rehabilitation (MHR) services. 4% of these individuals received this service.

LDH provided the same information for individuals admitted during the second quarter of 2023 to an NF. LDH reports:

- 26% were recommended for a psychiatric evaluation or psychosocial assessment. 13% of these individuals received this service.
- 30% were recommended for outpatient mental health services (individual, family, or group). 13% of these individuals received this service.
- 15% were recommended for other Mental Health Rehabilitation (MHR) services. 13% of these individuals received this service.
- 7% were recommended for Assertive Community Treatment (ACT). 17% of these individuals received this service.

For individuals who remained in NFs for longer than 100 days, the State reports for the second quarter of 2023:

- 27% were recommended for a psychiatric evaluation or psychosocial assessment. 12% of these individuals received this service.
- 16% were recommended for other Mental Health Rehabilitation (MHR) services. 10% of these individuals received this service.
- 33% were recommended for outpatient mental health services (individual, family, or group). 3.7% of these individuals received this service.
- 6% were recommended for Assertive Community Treatment (ACT). 19% of these individuals received this service.

This information continues to indicate a substantial number of individuals in the Target Population need but do not receive critical behavioral health services after admission or continued stay review.

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.
- LDH implemented an addendum to the PASRR Level II collecting information regarding the service needs (physical, behavioral, and community) that impact the ability for the individual to live in the community. Aggregate data and analysis from the addendum has not been performed.
- LDH does not have written standard criteria for determining the length of ongoing stays for individuals that seek a continued stay.
- 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.

- A substantial number of individuals in the Target Population need but do not receive critical behavioral health services after admission or continued stay review. LDH has not undertaken efforts to understand why behavioral health services recommended by the PASRR Level II evaluator are not provided to individuals during their NF tenure.

Recommendation

- LDH should continue to track and report authorization for NF admissions to ensure they comport with the 90–100-day requirement.
- LDH should identify and implement a strategy through the RITC process for collecting and reviewing data regarding reasons for admission.
- LDH should develop written criteria for determining the length of ongoing stays for individuals who seek a continued stay.
- LDH should undertake efforts to understand why behavioral health services recommended by the PASRR Level II evaluator are not provided to individuals during their NF tenure.
- 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 2024.
- LDH should collect and analyze information from the addendum to determine if an individual's needs (as indicated in the NFTA) are being addressed.

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 reports this process has not changed. 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 eighth SME report, the State reported 62% of individuals on the Master List had an annual PASRR Level II evaluation in the last reporting period. LDH also reported that 40% of these individuals received a PASRR Level II for a change in condition. Some individuals received two PASRR Level II evaluations—an annual review and a review due to a change in condition. In the ninth report, LDH states all individuals in NFs had received a PASRR Level II under the three scenarios above. This was a significant change from the previous reporting period and the SME requested and LDH provided the methodology used to track PASRR Level II performed under each scenario. The SME reviewed the revised methodology used for the eighth SME report and recommended the State revise this methodology. LDH revised the methodology during this reporting period. The methodology utilized included matching a listing of all individuals on the Master List and ACL, excluding those individuals with an admission date of 2023, against Utopia data. This indicates if an individual had a PASRR Level II and the date of the evaluation. Individuals who were admitted to an NF during CY 2023 would have a PASRR Level II that would meet the annual requirements. Results produced from this process found that 75% of the Target Population in NFs had an annual review. LDH also reported that 27% of these individuals received a PASRR Level II for a change in condition.

Compliance Assessment

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

- The State reports information regarding the number of individuals who received a PASRR Level II for each of the scenarios.
- The State has revised the methodology for reporting whether individuals in the Target Population in NFs have received an annual PASRR Level II either prior to admission, during a Continued Stay Review (which occurs within a year), or due to a change in medical condition. Additional

information is needed to corroborate this information. The State reports that 75% of individuals received a PASRR Level II annually based on the new methodology.

Recommendations:

- LDH should continue to report quarterly to the SME on the number and percent of individuals in each of the three scenarios.
- LDH should provide the SME with information on the number of individuals who did not get a PASRR Level II evaluation.
- LDH should continue to apply the revised methodology for determining if individuals are receiving a PASRR Level II on an annual basis.
- Identify and address the reasons individuals in NFs are not getting an annual PASRR Level II review and implement strategies to ensure all individuals in NFs get a PASRR Level II annually.

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: Partially Met

Discussion and Analysis

As indicated in the seventh report, the State has developed and implemented in-reach processes and protocols to offer transition options and transition planning for individuals on the Master List. 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 ACL. Although all members of the Master List must be offered comprehensive transition planning services, LDH delivers such services to those individuals on the ACL. As indicated in paragraphs 24-26, individuals on the Master List are currently not interested, undecided, or unable to decide if they are interested in transition. 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 to meet 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).

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.
Date Initial TC Assessment Completed	TC has 14 days to complete the transition assessment from the date of referral.
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 from the start of the ITP.

Date TC referred to MCO for CCM	Done at least 60 days prior to the projected transition date.

The SME has reviewed and agreed with these expectations. These efforts reflect LDH's intent to standardize the transition process. Since the eighth report, LDH has been monitoring these requirements. The State reports on whether TCs in aggregate are meeting these expectations. For this period, LDH reports the following:

- The average number of days from when a person is added to the ACL and is referred to a TC is 24 days, 21 days more than the expectation established by LDH.
- The average number of days from when a person is referred to a TC and a completed NFTA is 28 days, 14 days more than the standard and 10 days longer than the ninth reporting period.
- The average number of days from when a person is referred to a TC and an ITP is completed is 30 days, consistent with the standard.

The FY 2023 service review identified two-thirds of the individuals had a projected transition date within 60 days prior to transition. TCs are not meeting the expectations for engagement and NFTA completion. As indicated in paragraph 45, TCs will no longer have the responsibility for newly admitted individuals in the Target Population in 5 pilot regions. The engagement and NFTA completion will be the responsibility of RITCs. However, there are regions that will not participate in the pilot where TCs will continue this responsibility and require the TCs to meet the expectations regarding engagement and NFTA completion.

Some information reported by LDH is consistent with findings from the CY 2023 service reviews, which found that one-third of the Nursing Facility Transition Assessments (NFTAs) were completed within the 14-day timeframe. However, in contrast to LDH information, the service review did find that less than 25% of ITPs were initiated within the timeframe in which the NFTA was completed.

The State continues to track whether individuals on the Active Caseload List (556) are involved in the necessary transition activities. In the ninth report, LDH data indicated:

- Approximately 80% (474/556) of individuals on the ACL have started an NFTA, an increase of 25% since the ninth reporting period.
- 78% (463/556) of these individuals have a completed NFTA, representing a 20% increase from the ninth reporting period.
- 70% (246/351) of all individuals with a completed assessment who are interested in moving have an ITP in process.
- 59% (207/351) of individuals with an ITP in process have a completed ITP.

For this reporting period, LDH data indicated:

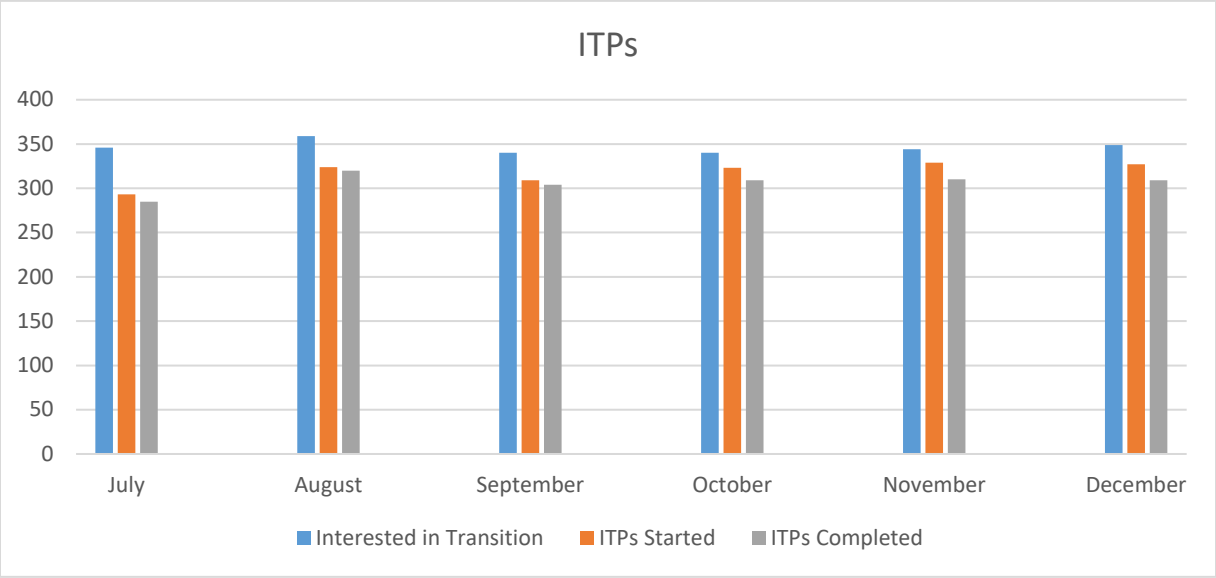
- Approximately 88% (436/505) of individuals on the ACL have started an NFTA, an increase of 10% since the ninth reporting period.
- 86% (434/505) of these individuals have a completed NFTA, representing an 11% increase from the ninth reporting period.
- 93% (327/349) of all individuals with a completed assessment who are interested in moving have an ITP in process, representing a 33% increase from the ninth reporting period.

- 89% (309/349) of individuals have a completed ITP, representing a 51% increase from the ninth reporting period.

This tracker, in the SME's opinion, continued to provide a 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. For the purposes of this analysis, the focus was on ITPs and the extent to which people who were interested had commenced or completed these plans. Chart 1 provides information on transition planning.

Chart 1. Number of individuals Starting or Completing ITPs



A review of this information indicates:

- The number of individuals who have a completed NFTA and subsequently indicated they are interested in transition generally remained the same during this reporting period.
- The percentage of individuals interested in transition with an ITP started increased from 85% in July to 94% in December.
- The percentage of individuals interested in transition who have a completed ITP also increased from 82% in July to 89% in December. It should be noted that there was a marked increase in ITP completions since January (almost a 200% increase).

The State reports the increased efforts by LDH TC supervisors continue to produce this increase. This includes weekly TC-specific reports on transition activities that are provided and discussed with each TC during their weekly (or more frequent) meetings with their supervisors.

LDH is required to offer all individuals the opportunity to transition. As indicated in paragraph 54, PIRSs are to perform in-reach to all individuals on the Master List to determine if they are interested in

transitioning. As indicated in this paragraph, LDH has contacted approximately 76% of individuals on the Master List to gauge their interest in transitioning. LDH has yet to provide in-reach to 24% of approximately 3,584 individuals on the Master List.

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. 76% of individuals on the Master List have received in-reach, 24% have not.
- The TCs are not meeting the expectations for initial engagement and NFTA completion.
- LDH is actively working on transition planning activities for the 94% of individuals on the ACL who have expressed an interest in moving. In the ninth SME report, it was recommended that 80% of all individuals on the ACL who have expressed interest in transitioning should be actively working on an ITP.
- LDH has developed and is assertively managing the expectations for TCs to complete the Transition Assessment and ITP within timeframes the SME finds acceptable; however, TCs have not complied with these expectations. The presence of RITCs may make TCs' compliance with expectations for NFTAs moot for regions participating in the rapid reintegration process. RITCs are required to complete a NFTA within the first 30 days of admission to an NF. The starting of the ITP will still be the TCs' responsibility for everyone on the ACL and the same standards will apply.
- Almost 86% of individuals on the Active Caseload List who have a completed NFTA and have expressed interest in transitioning have a completed ITP.

Recommendations

- LDH should closely monitor the RITCs (in the pilot regions) and TCs (in the non-pilot regions) to ensure they comply with the expectations regarding engagement and NFTA completion.
- LDH should ensure all individuals on the Master List are offered in-reach and the opportunity to transition as recommended in paragraph 54.
- LDH should continue to 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, individuals have been placed on the Master List because MDS data indicates they may have a Serious Mental Illness, but they have yet to 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. LDH has provided MDS information on two cohorts: 1) individuals who are newly admitted (less than 90 days) and have an MDS indicating they have a possible SMI diagnosis and 2) individuals who have been in

NFs longer than 100 days and a subsequent MDS indicated they have a suspected diagnosis of SMI. For this second cohort, these individuals experienced a change in medical condition which prompted a subsequent MDS indicating the individual may have SMI. Information from this reporting period indicated 44 individuals who were recently admitted to an NF and 3 individuals in an NF longer than 100 days had a suspected diagnosis of SMI. For these 47 individuals:

- 33 were discharged within 100 days and did not get a PASRR Level II.
- 3 individuals were deceased.
- 4 individuals received a PASRR Level II evaluation. Of these 4 individuals:
    - 3 individuals, or 75%, had an SMI based on the PASRR Level II evaluation.
    - For one individual, the PASRR Level II indicated the individual did not have an SMI.
    - 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 71 days.
- 4 were still awaiting a PASRR Level II. These individuals have been waiting for a PASRR Level II an average of 25 days.

The length of time for an individual who was identified through the MDS process as needing a PASRR Level II has increased substantially. In the ninth reporting period, it took LDH slightly less than 25 days (quarter 1) and 37 days (quarter 2) for an individual to receive a PASRR Level II evaluation from the date of referral.

In the seventh report, the SME recommended that LDH develop and track timeframe expectations for individuals identified through a subsequent MDS to receive a PASRR Level II. LDH has set an expectation of 30 days for a PASRR Level II to be completed once an individual identified through the MDS process of having a suspected diagnosis of SMI receives a PASRR Level II evaluation. LDH did not meet this requirement during the reporting period.

Compliance Assessment

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

- LDH continues 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 has set a standard timeframe expectation for individuals identified as having a potential SMI to receive a PASRR Level II (30 days). For the 3 who received a Level II, 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 has increased to 71 days.
- LDH has not performed a PASRR Level II for four individuals who were identified post admission during the reporting period as having potential SMI, to confirm their diagnosis. These individuals have been waiting for 25 days to receive a PASRR Level II evaluation.

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 report the number of individuals who do not have a PASRR Level II evaluation and have recently been identified as having a potential SMI and ensure these individuals receive a PASRR Level II evaluation within the recently established timeframe of 30 days.
- LDH should provide information on why individuals are not receiving a PASRR Level II within the established timeframes and develop and implement strategies for meeting this timeframe.

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 the ninth reporting period, the State added two TC positions (one for each office). In addition to the TCs, OBH and OAAS have seven positions to supervise TCs. LDH reports there have been six new positions added during this reporting period. These positions are specific to the rapid integration efforts discussed in paragraph 45.

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, 90, 180, and 270 days post transition or discharge. The State continues to report that all individuals (with the exception of individuals who have been recently admitted to an NF) who have been placed on the Active Caseload List and 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 from the Office for Citizens with Developmental Disabilities (OCDD). In the eighth SME report, there were 22 individuals with co-occurring SMI and ID/DD. During the ninth reporting period there were substantially more individuals with co-occurring SMI and ID/DD in the Target Population (223 individuals). For this reporting period, LDH reports 266 individuals with co-occurring SMI and ID/DD were in the Target Population, 34 on the Active Caseload List and 192 on the Master List. The State reports this increase is due to changes that have been made to identify individuals more accurately with ID/DD. The State reports approximately 200 individuals had a co-occurring SMI and ID/DD in 2017 prior to the beginning of the Agreement. The previous Utopia system did not collect this

information and therefore the number of individuals was reported manually. The new Utopia system now collects this information for individuals with these co-occurring conditions.

If an individual has been identified as having an SMI and ID/DD and is on the ACL, the TC will confirm whether the individual has a statement of approval from OCDD which indicates a referral for the ID/DD Waiver. For these individuals, OCDD will commence the Waiver application process in cooperation with the TC. If an individual on the ACL is identified as having ID/DD, they will be referred to the LGE for OCDD assessment and potential referral to Waiver services. The State reports they have trained all LGE ID/DD staff regarding the My Choice Program during this reporting period. In addition, the State reports they continue to monitor the TC activities specifically regarding referrals for OCDD Waiver services.

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.

The SME continues to recommend 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. During the last reporting period, LDH increased the caseload size from 25 to 45 individuals for CY 2023. The increase would allow approximately 1200 individuals on the ACL to be assigned a TC (assuming a full complement of TCs). LDH rationale for this increase was discussed in the eighth SME report. The State reports the average caseload size continues to be on average 19 individuals for each TC.

LDH reports they have developed and utilized TC specific reports to determine if the caseload size is impacting transitions. These reports are generated on a monthly basis to review the number of transitions and the length of time needed for transitions as discussed in paragraph 40. This includes whether the TC meets the standards for the average length of time for TC engagement, NFTA and ITP completion, and the average length of time per transition. LDH reports this information is used by TC supervisors to discuss whether a change in caseload size is needed or whether the current caseload size is adequate to meet the timeframes established by the Department.

In its 2024 Implementation Plan, LDH committed to transition 331 individuals. Given the methodology discussed in paragraph 56, TCs are expected to transition all individuals on their caseloads who remain interested in transition post implementation of the ITP. However, if the TCs do not meet these transition goals, a significant percentage of individuals currently on the Active Caseload and interested in transition will not transition in CY 2024.

The SME recommended more proactive oversight of transition planning activities to assist LDH in setting and meeting reasonable transition expectations. In the ninth reporting period, LDH set specific expectations for the number of transitions each region must accomplish annually and began tracking each region's performance. Specifically, LDH expected each TC to transition at least one individual on a monthly basis. Based on the target for CY 2024, LDH should expect on average the TCs will transition 13 individuals per year to achieve the goal of 331 transitions.

LDH tracks the number of transitions projected and completed per month by region and TC. In reviewing this tracking information, there is still unevenness in the number of transitions per region. The SME continues to discuss this issue with the State and suggests 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 state where the individuals transitioned to rather than the region the individuals were residing in while in the NF.
- Some regions have a much lower volume of individuals who are interested in transition.
- TC turnover also impacts the number of individuals transitioned by region and newer TCs may not yet have developed the acumen to meet LDH transition expectations.

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 an infrastructure to better identify and address transitions for individuals with a co-occurring ID/DD and SMI. This includes changes in the Utopia system to track individuals in the TP in NFs.
- LDH reports they have a process to identify who on the ACL has an ID/DD, has been referred to OCDD, or would need a referral to OCDD. In addition, LGE ID/DD staff have been trained on the My Choice Program to better understand referrals for services.
- LDH reports they have developed and implemented management tools for meeting the transition targets established by the Department, yet some TCs are falling short of LDH expectations.
- LDH assigned a transition coordinator for every individual on the Active Caseload List.
- While there is still a caseload ratio of 1:19, there were a number of individuals who did not transition in CY 2023.
- LDH has performed an assessment of whether the current TC caseload (currently 1:19) is sufficient to address individuals on the ACL who are interested in transition.

Recommendations

- LDH should continue to track the caseload size for the TCs and ensure that current and future caseload sizes will ensure transition activities are provided within LDH established timelines.
- LDH should also monitor the quality and frequency of the contacts between the TC and individuals on their caseload to determine if additional TC or other staff (e.g., PIRS) resources are necessary.
- LDH should continue tracking information by TC regarding the number of transitions completed throughout the year and take the necessary actions to ensure TCs meet these expectations. The State should report these efforts to the SME and DOJ on a quarterly basis.

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 requires ITPs based on a standardized assessment (NFTA) 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 NFTA and ITP, as revised, also provide more specificity regarding the housing preferences that have been identified by the individual post-transition. During this reporting period (September) LDH has implemented an addendum to the ITP that will provide information on ongoing services and supports that will be needed post transition until the CCM can work with the individual to develop the Community Plan of Care (CPOC). This addendum will provide recommendations regarding the scope, amount, and duration of services needed at transition. LDH reports they do not have information nor have they performed an analysis on whether TCs are completing the addendum or the quality of information in the addendum given its recent implementation.

This paragraph requires all members of the Target Population to have an ITP in order to truly envision their options for community services. LDH has focused its efforts on developing ITPs for members of the ACL and have expressed an interest to transition. While not everyone on the Active Caseload has an ITP, LDH has increased the ITPs in process or completed (discussed in paragraph 40).

In CY 2022, the SME developed a tool for reviewing the presence and quality of ITPs for individuals participating in the SME service reviews. This tool identified whether the individual had a completed NFTA and ITP. It also reviewed the quality of the NFTA and ITP. Reviews of the absence/presence of ITPs are now LDH's responsibility. The SME reviewed the quality of ITPs during the CY 2023 service review and found some of the same issues found in the CY 2021 service review. The review found that major service domains identified as needed in the NFTA such as medical, behavioral supports, community living, relationship supports, and vocational/educations were not addressed in almost all individuals' ITPs. Support services such as transportation and assistance with ADLs and IADLs were not included in the ITP. The ninth SME report and CY 2023 Service Review includes more detailed findings regarding the quality of the ITPs.

The CY 2023 Service Review identified major tenets of a person-centeredness were absent from these plans. For instance, more than three-fourths of all individuals had plans with no goals. Slightly fewer individuals indicated they had a copy of their ITP. One-half of the ITPs were not signed by the individual, which is one indication of their participation in the planning process.

For individuals transitioned or awaiting transition there were several barriers and issues that impacted and are impacting transition. These barriers were discussed in the CY 2023 Service Review. LDH has required TCs to collect and report information on barriers to transition individuals on the ACL. This information is reported in paragraph 51.

A significant issue was service referrals to services to address SUD needs identified in the NFTA. 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 who were transitioned were actively using (mostly alcohol) and did not want to seek or participate in treatment. While the SME understands that individuals who are actively using substances, including alcohol, can elect not to receive these services, there were few referrals to

SUD treatment. Needed SUD services have not been identified or included in most individual's ITPs even though the assessment indicated the individual had an identified SUD or had recently misused substances.

During this period, LDH reports they continue to implement strategies to improve ITPs. LDH reports they provide training and technical assistance through supervision to TCs to ensure the services identified in the NFTA are addressed in the ITP. This included a focus on better identification of services and supports to address individuals' medical and ADL needs. In addition, LDH reports they will provide additional training to TCs regarding the various LDH programs that offer these services when needed. This training is similar to training LDH plans for PASRR Level II evaluators, as discussed in paragraph 32.

While this paragraph is specific to ITPs, the service reviews also assessed the quality of NFTAs. The CY 2023 review found most domains were addressed in the NFTA. Two major domains that were not addressed were specific to medical needs and behavioral health supports. There were several significant areas regarding the NFTA process that were absent from these assessments. Most concerning were assessments that did not include the individual's strengths, which is a critical principle of person centeredness. In addition, the assessments did not identify potential transition barriers for individuals during the assessment. Therefore, the service review team relied exclusively on interviews with the individuals and TCs to garner this information.

Compliance Assessment

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

- The quality of ITPs is poor. ITPs still do not address many of the important details required by paragraphs 43 and 46. In addition, ITPs lack person centeredness. ITPs also often lacked referrals for SUD services when the NFTA identified the need for these services.
- LDH reports they have continued to audit whether ITPs are present and the general quality of these service plans. LDH has not yet provided information regarding these audits to DOJ or the SME.
- The CY 2023 review found most domains were addressed in the NFTA. Two major domains that were not addressed were specific to medical needs and behavioral health supports. NFTAs did not include the individual's strengths or identified potential transition barriers.
- LDH has implemented (October 2023) an addendum to the ITP to collect information on the amount and duration of services.

Recommendations

- LDH should continue training and supervision strategies that improve the quality of NFTAs and ITPs.
- LDH should report the findings from the LDH audits of TC transition activity to the SME and DOJ.
- LDH should ensure the acumen of TCs to provide motivational interviewing strategies to encourage individuals to take the necessary steps to increase goals and SUD intervention for individuals with an identified SUD.
- LDH should ensure each individual transitioned who is actively using substances is provided information regarding SUD treatment services, including alternative treatment settings (e.g., recovery groups).
- Formalize the process of addressing barriers found through services reviews or by TCs. This should include identification of strategies by the My Choice internal quality review team (discussed in paragraph 94) and the Transition Support Committee (discussed in paragraph 58).

- Review the presence and quality of the ITP addendum to determine if the goals of this paragraph are met.

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

During the fourth reporting period, the State, in collaboration with the SME's team, provided training on person-centered transition planning for TCs, MCO case managers, and other providers. LDH has also contracted with a consultant who provided additional support to TCs in CY 2022 to improve their efforts in developing person-centered transition plans. 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 CY 2023 service review continued to indicate the person-centeredness of the ITPs did not improve this period.

LDH continues to provide the SME with information regarding the process deployed to allow individuals an opportunity to visit potential housing options and the surrounding community, to better envision their lives post transition.

As discussed in the ninth SME report, LDH stated that transporting individuals to potential housing options cannot be done by TCs. CCMs are not a viable option since most individuals who apply for housing assistance are not within 60 days of transition. In many instances, the TC and/or the LDH Housing Coordinator provide photos and videos of these options. The preliminary service review conducted for 2024 indicated some in-person visits to housing options have occurred. These TCs indicated they have been able to schedule transportation offered by the NF to perform these on-site visits. However, not all TCs are using this approach.

Compliance Assessment

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

- ITPs are not being completed consistent with a person-centered approach despite several years of training and technical assistance to TCs. LDH has requested the SME provide training to TCs in CY 2024.
- TCs cannot provide transportation for individuals awaiting transition to visit housing opportunities in the community and viable transportation options have not yet been identified. However, several TCs have been able to enlist NF transportation to provide transportation. These TCs indicate they accompany the individual during these visits.

Recommendations

- LDH should retrain TC staff and supervisors regarding person-centered planning using the modules developed in CY 2020 and use the checklist discussed in paragraph 61.
- LDH should determine if strategies that are alternatives to TCs to offer in-person opportunities to review housing and other community opportunities prior to transition can be used by all TCs. In

addition, LDH should continue to explore the use of contracted agencies that offer peer support and ride-sharing opportunities (Lyft and Uber in urban areas) for the TC and individuals to visit housing options.

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 continues to not 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 2024.

During this reporting period, the State began to implement a process for meeting this requirement without the ability to identify individuals promptly at admission. LDH is proposing a pilot in regions of the state with the most individuals in the Target Population admitted to an NF—regions 1, 2, 4, 7 and 9. These admissions account for 65% of the new admissions by the Target Population statewide.

LDH proposes an LDH Rapid Integration Transition Coordinator (RITC) who will be responsible for making the initial contact with the individual and providing the face-to-face visit within the 14-day period. LDH proposes to use the date of the initial MDS (which is usually completed within three days of admission) to begin the engagement process until the vendor can implement the ability to track admissions in real-time. During this face-to-face visit, the RITC will initiate the NFTA and the individual will be placed automatically on the ACL. Similar to other individuals on the ACL, the NFTA will also be used to gauge whether the individual has short-term plans to return to the community (no longer than 60 days) or will likely need a longer stay. The RITC will meet with the individual within 14 days from the MDS and again at 45 and 60 days from admission to determine if they will discharge or may be likely to remain in the NF 90 days or longer. If the individual has an imminent planned discharge, the RITC will identify supports needed at transition and work with NF staff to track when the transition will occur. The State reports they have yet to develop expectations for RITCs to track discharge activities for these individuals. If the individual is likely to remain in the NF longer than 90 days from admission, the RITC will continue to assess their interest in transitioning. If interested, the RITC will engage a TC to begin the ITP process and commence the transition process. If the individual indicates they are not interested in transitioning, they will be placed on the Master List and will receive an in-reach visit from the PIRS within 90 days.

LDH reports they will go live with the RITC pilot in January. The State reports they have posted positions for the RITCs for each region. At the end of this reporting period, the State reports they have interviewed and selected staff for two regional RITC positions. These RITCs will receive training (consistent with current TC training). In addition, the State reports they will have RITCs attend person-centered training occurring in March 2024.

Compliance Assessment

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

- LDH has not developed the necessary functionality to identify when an individual has been admitted to an NF.
- LDH has developed a plan to implement a pilot project in regions 1, 2, 4, 7, and 9 for early engagement efforts required by this paragraph. The State has provided the SME and DOJ with details regarding the specific process for how contact will occur at engagement and other details discussed in the paragraph above. The pilot will begin in January 2024.
- LDH has developed position descriptions for RITCs and onboarded two staff during this reporting period. The other two staff will be onboarded in January.
- The State has not developed specific expectations for RITCs to track discharge activities for individuals who are discharged from NFs prior to 90 days of admission.

Recommendations

- LDH should implement the changes in the contract with the vendor to track the 3-day and 14-day requirement in the next quarter of CY 2024.
- LDH should onboard the additional two RITCs in January 2024.
- LDH should commence the pilot program and provide the SME will information on the pilot program that includes:
    - The number of individuals in the Target Population who were admitted to an NF and received early engagement from the RITC within the established timeframes (3 and 14 days).
    - The number and percent of individuals who were engaged and had an NFTA within the first 30 days post admission.
    - The number and percent of individuals who will remain longer than 90 days.
    - The number and percent of these individuals who had an ITP prior to 90 days.
    - The number and percent of these individuals who did not have an ITP prior to 90 days and reasons why an ITP was not performed.
- LDH should develop specific expectations for RITCs to track discharge activities for individuals who leave the NF within 90 days.
- LDH should develop a strategy for assessing the pilot project by the end of CY 2024.

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

During the seventh reporting period, LDH implemented a case management approach that relies on a community vendor (i.e., 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 prior to discharge from the NF.

In addition, LDH requires the TCs to make a referral for CCM and ensure the individual connects with the CCM within 60 days prior to transition. This will allow the CCMs adequate time to engage the individual and participate in discharge planning meetings and final ITP meetings.

During the SME service reviews conducted during this reporting period for the CY 2024 Service Review, 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. The SME service review found 14 of 29 individuals participating were assigned a CCM prior to transition (15 were scheduled for transition but not within 60 days). Eleven (11) of these individuals had documentation of CCM's participation in the transition planning meeting.

As discussed in paragraph 43, LDH includes 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. Given this is a recent change, there is no substantial information to report on the presence and quality of the addendum. However, preliminary information from the service review identified ITPs for individuals who were transitioned were complete and provided services and providers who were to offer these services. In addition, information from this preliminary review identified frequent team pre-transition team meetings with the individual, TC, CCM, and other providers (e.g., support coordinator and ACT). It should also be noted that in almost all CY 2023 and in all preliminary CY 2024 reviews, individuals had a CPOC.

Compliance Assessment

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

- LDH has implemented an addendum that identifies 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.
- Preliminary CY 2024 service review found CCMs were involved in the transition and transition planning process for all individuals 60 days prior to transition.
- All individuals have a CPOC post discharge or diversion from an NF based on the most recent SME review for CY 2024.
- TCs and CCMs have meetings with the individual and team prior to discharge from an NF.

Recommendations

- LDH should ensure the presence and quality of the addendum to the ITP to ensure its proper use. LDH should seek information from the CCMs to determine if this addendum was helpful.
- Continue to review whether individuals have a CPOC within 30 days of transition or diversion from an NF.

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 CCM. The State has SOPs that provide details 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 2022. The State has developed a tracking system that provides information regarding the timeliness of these referrals and engagement status post referral. As indicated in paragraph 47, all individuals in the 2023 Service Review (yet to be developed) had a CCM at 60 days of transition.

Compliance Assessment

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

- State requires a CCM to be assigned to an individual in the Target Population 60 days before discharge from an NF.
- 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.
- The State reports and the SME service review confirmed all individuals were offered CCM.

Recommendations

- As recommended in paragraph 47, LDH should continue to ensure the process for assigning CCM is consistent with the policies and procedures outlined in the SOP.
- LDH should continue to track if individuals in the Target Population being discharged from NFs are offered CCM.

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

While this paragraph remains partially met, if changes are not made as set forth in the recommendations, LDH will not be in compliance with this paragraph. 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. As indicated in the eighth report, LDH has added two staff members to oversee the My Choice Program, which allows current staff responsible for managing TCs to focus on those activities.

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 a contact log that collects data similar to information collected by the CCMs. This process provides an additional strategy to check-in with individuals who were transitioned and also a strategy to validate information being collected by the CCM.

In the seventh report, the SME recommended LDH develop an oversight process to ensure post-discharge reviews are being conducted by the TC supervisor with the cadence established by the Department. LDH reports TC supervisors review a sample of documentation regarding these post discharge reviews. LDH reports this documentation indicates TCs are not conducting post-discharge reviews consistent with the Department's expectations.

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 provides 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 yet developed this strategy.

LDH management staff who oversee TCs are also included in the SME service reviews. This requires management staff review NFTAs, ITPs, and contact logs for each individual who is awaiting transition or has recently transitioned. OAAS and OBH management staff are also conducting compliance reviews to ensure TCs are performing their transition functions on a timely basis. In addition, these reviews assess the quality of the NFTAs and ITPs, the frequency of contact with the individual, and whether discharge planning team meetings are occurring.

Compliance Assessment

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

- The State has developed and implemented the necessary policies and tools for conducting post-transition follow-up; however, documentation indicates some TCs are not meeting LDH expectations for 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.
- LDH has developed and implemented a strategy to review the quality and cadence of the follow-up activities. LDH reports TCs are not meeting the required timeframes for follow-up, nor have they provided information to assure that services in the community are initiated and delivered to individuals in a fashion that accomplishes the goals of the ITPs or community plans of care.

- LDH management staff are participating in service reviews and conducting compliance reviews of TCs' transition activities.
- There is no post-follow-up strategy similar to that for individuals who are transitioned for individuals who are diverted from NFs.

Recommendations

- LDH should review the presence and quality of the post-discharge contacts, ensuring that information from these follow-ups provides enough information for LDH to assure that services in the community are initiated and delivered to individuals consistent with the community plan of care and act on any concerns being identified by the TC. This information should be reported to the SME during the next reporting period.
- LDH management staff should continue to participate in the service reviews and conduct compliance audits of TCs' transition activities.
- LDH should 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 transitioned from NFs lose 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 for those who reside in the community. Since the beginning of the pandemic, Congress had prevented states from removing Medicaid recipients from the Medicaid program. This requirement lapsed in May 2023.

LDH restarted efforts to track individuals who will lose Medicaid as of May 2023. LDH reports no individuals who transitioned into the community as of September (most recent data available) lost Medicaid eligibility post transition even with this change in federal Medicaid policy.

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 the COVID-19 pandemic policy regarding eligibility has been removed. In previous reports, 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.

In the ninth report, LDH stated TCs and CCMs have recently received training to assess individuals' eligibility for the Medicaid Purchasing Plan and facilitate the referrals when the pandemic coverage ends. Louisiana's Medicaid Purchase Plan (MPP) allows those with severe disabilities to go to work but still qualify for Medicaid.

Compliance Assessment

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

- The State has restarted efforts to track individuals who have lost Medicaid eligibility and reports no individuals, as of September, have lost Medicaid at transition.
- LDH has provided training to TCs and CCMs regarding the Medicaid Purchasing Plan.
- The State has not developed referral protocols to relevant community services for individuals who lose Medicaid eligibility.

Recommendations

- LDH should track and report the number of individuals transitioned from NFs who lose Medicaid eligibility.
- 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.

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: Partially Met

Discussion and Analysis

LDH has developed two points for identifying barriers: 1) during the in-reach process conducted by Peer In-reach Specialist (PIRS) and 2) during the NFTA conducted by TCs. During the in-reach process, PIRSs identify barriers to transition individuals who are not interested or are undecided in transitioning to the community. Information provided by LDH for the fourth quarter of CY 2023 included information from 106 individuals who were on the Master List and received in-reach by PIRS. This information found:

- 40% of these individuals indicated their health condition resulted in the inability to engage in discussion regarding community options.
- 33% of individual were unable to engage in discussion regarding possible transition (not able to communicate even with assistance of communication aides).
- 26% of these individuals stated they were unwilling to participate in discussion regarding transition.

During the NFTA, TCs collect information on barriers for individuals who may not be interested in moving. LDH reports they have initially collected information on 576 unduplicated individuals who were on the ML and ACL regarding barriers. For individuals on the ACL and assessed by TCs, the State reports these barriers included:

- 25% were concerned about management of physical health conditions (e.g., diabetes), unstable medical or behavioral health conditions, or experienced a decline in physical health.
- 17% of individuals had cognitive patterns observed that illustrate possible instability (suspect dementia).
- 13% were waiting for availability in a specific town or unit identified during the NFTA.
- 7% of individuals were waiting 6 months or more for ADA accessible housing options for individuals who were mobility impaired.

LDH reports there are preliminary strategies being considered to address these barriers including:

- Inviting other representatives to meetings to discuss areas of support and transition options
- Scheduling team meetings to discuss options
- Referring for testing/evaluation for dementia
- Work with LHC to coordinate with developers regarding accessible housing.

LDH reports information regarding these barriers will be provided to the My Choice Internal Quality Assurance Committee to review and to develop additional strategies to address these barriers. In addition, LDH reports they will refer some barriers and other transition issues to the Transition Support Committee discussed in paragraph 58.

As indicated in previous paragraphs, everyone on the Master List has not been provided in-reach and therefore information regarding barriers they may be experiencing is not being collected for these individuals.

Compliance Assessment

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

- LDH has implemented a process to collect and report barriers for individuals who are on the ACL or returned to the Master List from the ACL who are not interested in transitioning.
- LDH has not contacted everyone on the Master List using the revised in-reach process and therefore information regarding their barriers is not available. For individuals on the ACL, barriers are identified by the TC for individuals who choose not to transition.
- The State has developed some preliminary strategies to address barriers identified by TCs during the transition period.
- The My Choice Internal Quality Assurance Committee has yet to discuss barriers from the Master List and strategies that would warrant their review and recommendations.

Recommendations

- LDH should ensure they provide in-reach to all individuals on the Master List and obtain information on barriers to transition from these individuals.
- LDH should develop a process to track and report on successful strategies for barriers identified by the TCs including addressing specific gaps in the array of services (e.g., ADA accessible housing and assistance with ADLs).
- LDH should implement the proposed process for the My Choice Internal Quality Assurance Committee and the Transition Support Committee to review and address barriers identified though in-reach.

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: Partially Met

Discussion and Analysis
LDH, through the PIRS process, continues to track the number of individuals on the Master List who are determined not to be able to make a transition decision. LDH has determined that 227, or 15%, of individuals contacted during the in-reach process for this reporting period are unable to make a decision about transition. LDH collects information on the reasons an individual is unable to make a decision. This includes the following categories:

- Individuals are unable to communicate using words (need interpreter or other communication aides).
- Physical health conditions are too significant and result in the TC being unable to engage the individual.
- Individuals are unwilling to participate in the discussion with the TC or PIRS.
- Interdicted/Curator unable/unwilling to participate.
- Individual is unwilling to participate in a discussion regarding transition.
- Individual unable to engage in discussion regarding possible transition (e.g., not able to communicate even with assistance of communication aides).
- Health condition resulting in the inability to engage in discussion regarding community options.

As indicated in paragraph 51, LDH has not provided in-reach to everyone on the Master List and the number of individuals who are unable to make a decision would be greater than what LDH currently reports.

LDH also collects information on individuals who are on the ACL and may not be able to consistently make a decision to transition. For these individuals, LDH reports that TCs, during the early phase of transitions, identify individuals who may present issues relative to safety in the community (e.g., cognitive issues or the need for 24/7 care that may be difficult to address in the community). Historically, these individuals were referred to the Service Review Panel that reviews various documentation to determine if safety issues identified are valid. This is now the purview of the TSC. The TSC is also available for individuals who have been transitioned or diverted and for whom the TC or CCM is seeking recommendations from the TSC for continued community tenure.

Starting in the ninth reporting period, these individuals were to be referred to the Transition Support Committee as discussed in paragraph 58. LDH reports 17 individuals have been referred to the TSC

between July and November 2023. Thirteen reviews were completed and four are pending review by the TSC. The State reports that:

- Ten of the thirteen reviews were specifically for individuals awaiting transition. The TSC reviewed documentation (multiple requests) and concurred that the level of community supports needed by these individuals did not exist in the community. They recommended the individual not be transitioned at this time.
- Three reviews were specific to individuals who were transitioned or diverted from NFs. The TC initiated this request for TSC review. The TSC provided recommendations to the TC, including in one instance, the TC and CCM remain in place longer than the mandatory twelve month period. LDH agreed with this recommendation and reports they continue to provide TC and CCM for the foreseeable future.

Compliance Assessment

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

- LDH tracks monthly the number of individuals on the Master List who are determined through the PIRS process as not able to make a decision regarding transition and has collected information regarding barriers that impact why these individuals are not able to make a decision regarding transition.
- LDH has not provided in-reach to all individuals on the Master List and therefore information regarding potential transition barriers for these individuals is not available.
- LDH has a process for identifying individuals on the ACL who may be unable to consistently make decisions regarding transitions.
- Individuals on the ACL (including individuals who are transitioned) and individuals who are diverted, who present safety issues for transitioning, or who are at risk of returning to an NF are referred to the TSC. The TSC reviews these requests and makes recommendation regarding the feasibility of transition or strategies to ensure community tenure for individuals who are transitioned or diverted.

Recommendations:

- LDH should continue efforts to track and report monthly on the number of individuals on both the Master List and ACL as not able to make a decision regarding transition.
- LDH should develop strategies to assist individuals to make a decision about transition or refer these individuals to the TSC.
- LDH should ensure individuals on the ACL and individuals who are diverted who present safety issues for transitioning continue to be referred to the TSC. LDH should report the committee's decision regarding these individuals on a quarterly basis to the SME during 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 the Master List or ACL, and for individuals who express interest in transition, begin the NFTA 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. The State developed initial and subsequent in-reach plans.

Effective, individualized engagement is critical to supporting people's informed decisions about whether to transition. Since the sixth report, LDH has implemented an in-reach strategy for individuals on the Master List. Regional PIRSs were hired to work in tandem with the TCs across program offices. PIRSs are the primary resource accessed to visit individuals on the Master List in the nursing homes, gauging interest in transitioning into the community, providing education and information regarding community living, advocacy, and support to members related to transitioning. PIRSs are utilized to perform in-reach based on their personal recovery experiences. LDH has created expectations regarding the minimum number of contacts per month for each PIRS. Specifically, LDH continues to 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 51, PIRSs report barriers experienced by individuals who may be uninterested or undecided regarding transition. In reviewing the in-reach contacts for this period, PIRSs do not consistently meet this target.

During this reporting period, 1,483 individuals received in-reach from PIRS. LDH reported that 268, or 18%, of these individuals indicated their interest in moving and were added to the Active Caseload List. Information from in-reach efforts indicated:

- 727 or 49% not interested in moving.
- 261 or 18% undecided about moving.
- 227 or 15%, LDH determined as being 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 on the Master List. LDH has developed the following in-reach schedule for each of these populations.

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

LDH's goal was to engage every member on the Master List during the last reporting period. LDH has not met that goal this reporting period; 26% of individuals on the Master List have not received in-reach. LDH has prioritized in-reach efforts to the following individuals:

- New admissions that have not been contacted
- Individuals transferred from ACL to the Master List (within 90 days)
- Individuals that indicated they are undecided about transition (90 days)
- Individuals that indicated they are not interested in transition (every 6 months).

Currently, 871 individuals on the Master List have not yet gone through the PIRS in-reach process. The SME understands that some of these individuals have been recently added to the Master List and have not received PIRS in-reach. However, there is a significant percent of individuals who have not received PIRS in-reach.

In the eighth report, the SME recommended LDH evaluate the quality of in-reach efforts. As discussed in the eighth report and observed during this reporting period, there continues to be significant variation among regions regarding the percent of individuals who have indicated an interest in moving. LDH reports working with PIRSs to ensure better consistency for making recommendations for referral from the Master List to the ACL. This includes:

- Weekly supervision 1:1 with each PIRS
- Weekly meeting with all PIRSs
- Reconfigured areas of the State where each PIRS is responsible to complete visits
- Monthly collaboration meetings regionally with regional office staff, support coordinators, and TCs
- Pairing each PIRS to shadow/observe TC complete initial transition assessment
- Develop a quality process to shadow each PIRS quarterly
- Develop opportunities for peer to peer mentoring/support
- Identify areas of focus for training
- Develop processes to support implementation of strategies identified on in-reach form.

In the eighth report, the SME recommended regular training of PIRSs and development of resources (such as conversation guides) to support PIRS in-reach efforts to ensure they can provide meaningful information about community options, respond to concerns, and evaluate people's preferences that mirror previous TCs' in-reach efforts. As indicated in paragraph 27, far too many people are returned to the Master List from the ACL due to a lack of interest or ability to make a decision regarding transition. The State reports they have developed conversation guides for the PIRS in the previous reporting period.

Based on feedback from PIRS, LDH is revising these guides using a workgroup of PIRS and TC representatives. The State reports the revised guide should be completed in the next reporting period.

As discussed in paragraph 45, RITCs will be performing NFTAs for all individuals in the Target Population at admission. Similar to initial TC efforts, it is anticipated RITCs will also provide initial in-reach to individuals who are recently admitted to an NF within the first two weeks after admission. Additional information regarding the RITC pilot is provided in paragraph 45. Clarity is needed between the various in-reach roles of PIRSs, TCs, and RITCs, given each of these staff is performing various in-reach activities to the TP during their tenure. However, the availability of RITCs should allow PIRSs to be able to provide in-reach to all individuals on the Master List given this shift in in-reach roles.

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, 26% of the individuals on the Master List have not been contacted using the revised in-reach process.
- LDH is collecting, analyzing, and developing strategies to address barriers identified through the in-reach and NFTA process. Initially the Integration Coordinator will work with OAAS and OBH staff to identify strategies to address these barriers and refer barriers and strategies that present the most challenges to the internal quality assurance committee and the TSC.
- LDH 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 specific targets for each region to provide in-reach to individuals who remain on the Master List. Not all PIRSs meet these expectations.
- LDH continues to track the progress of each regional team's in-reach efforts.
- A significant number of individuals returned to the Master List from the ACL indicated they are not interested in moving or unable to make a decision regarding transition.
- LDH has developed and implemented strategies for ongoing in-reach for individuals who remain on the Master List and have indicated they are undecided, have no interest in transitioning, or are unable to make a decision regarding transition.
- LDH continues to provide training to PIRSs regarding community options for individuals who are on the Master List who have questions and concerns about supports that will be available during and after transition. The State has indicated training on ADLs provided to PASRR II evaluators and TCs will also be available to PIRSs.
- The State reports they are in the midst of a process of revising in-reach information (including talking points for PIRSs) that includes recommendations by PIRSs and TCs.
- LDH has developed more formal management tools and supervisory oversight of PIRSs to ensure better referrals to the Master List.
- TCs continue efforts to provide informed choice through the assessment process.
- LDH has proposed an additional in-reach strategy using RITCs for individuals in the Target Population who are newly admitted to NFs. This in-each is in addition to similar functions performed by PIRSs and TCs.

Recommendations

- LDH should ensure all individuals on the Master List receive an in-reach visit, especially individuals who are relatively newly admitted and have remained in the NF for more than 90 days, and follow-up visits as established by the Department.
- 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, and to ensure that staff are accurately assessing those choices. A test of this effectiveness is a decrease in the percent of individuals returning to the Master List from the ACL due to lack of interest or uncertainty to transition.
- LDH should develop clear roles and responsibilities for in-reach efforts across PIRSs, RITCs, and TCs. This role delineation should ensure there are no gaps or duplication of in-reach efforts.
- LDH should complete, train, and utilize the revised in-reach guide and review these efforts with the SME.

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

Early in the Agreement, LDH proposed 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 FY 2021 Service Review, a number of individuals had transition barriers; however, many 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 new in-reach process for identifying and prioritizing among individuals in NFs who have expressed an interest in moving rather than relying on MDS data. In addition, LDH has:

- Developed targets for transitions for each Transition Coordinator.
- Developed policies for community case managers to be involved in the individual's transition planning 60 days prior to transition.
- Developed timeframes and protocols for TCs to engage with individuals to initiate the assessment and ITP process and have developed specific timeframes for RITCs.
- Ensured TCs are having regular planning meetings with the individual, CCM, NF staff, and community providers within 60 days of transition from an NF.
- Developed a more assertive in-reach strategy by PIRS to focus on individuals who are undecided or had been placed on the Master List from the Active Caseload List.

- Created new service opportunities to address the ADL and IADL needs of individuals transitioning who still need some personal care services but who do not qualify for existing Medicaid programs.
- Reviewed individuals' interests and hobbies that may assist TCs in developing community inclusion strategies for individuals interested in transitioning. LDH has not performed a recent review of these interests and hobbies.

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 the transition policies and practices for this and previous reporting periods.
- The State prioritizes transitions of individuals based on the current in-reach process that identifies individuals who express an interest in transitioning rather than relying on MDS information. However, LDH has not determined whether these efforts meet the intent of having additional individuals transition.
- The State has collected information from the TCs and PIRSs regarding barriers to provide additional information for LDH to use to improve their transition process. However, this process is in its initial phases and LDH does not have enough data to make recommendations to improve transitions.

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.

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: Not Met

Discussion and Analysis

Since the beginning of the Agreement, the State has transitioned 597 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 four 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 is required to 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.

The State developed a new methodology to set a transition target for CY 2024. The State revised the methodology used to develop CY 2023 targets. LDH used information from CY 2022 and CY 2023 (to date) as a basis for the CY 2024 methodology. The new methodology included:

- Projected number of people on AC categorized as "actively working" toward transition.

- Percent of individuals on the ACL who indicated they are not interested in transitioning based on completion of the NFTA.
- Percent of individuals with a completed NFTA, who indicated they were interested, but changed their mind prior to completing ITP.
- Percent of individuals declining transition after completing ITP.

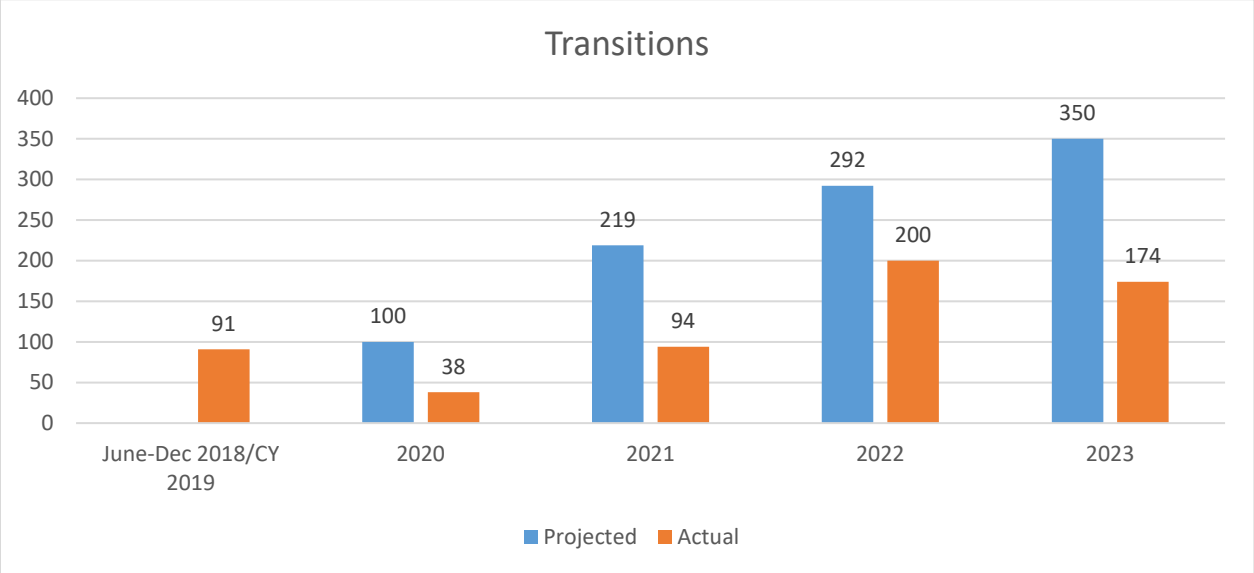
In addition, the methodology took into consideration individuals recently placed on the ACL and who have yet to receive an assessment.

It should be noted, the CY 2023 methodology increased the average caseloads for transition coordinators. The proposed average caseload for the transition coordinators was 1 to 25 individuals and was increased to 1 to 45. The reasons for this change were discussed in the ninth SME report. Despite this increase in caseload size, the State reports TC caseloads remain at 1 to 19 as of the end of this reporting period. The size of the ACL is approximately 515 and the state currently has 27 TCs and plans on 4 RITC for CY 2024.

LDH has proposed 331 transitions for CY 2024, approximately the same number as CY 2023. While the continued number of transitions projected for CY 2024 is encouraging, LDH I has not met in previous years and did not meet its proposed targets for CY 2023. As of December 31, 2023, LDH reports transitioning 174 of the 350 individuals they projected to transition during this reporting period.

Chart 2 below provides a comparison of transition targets versus actual transitions since the Agreement has been in place.

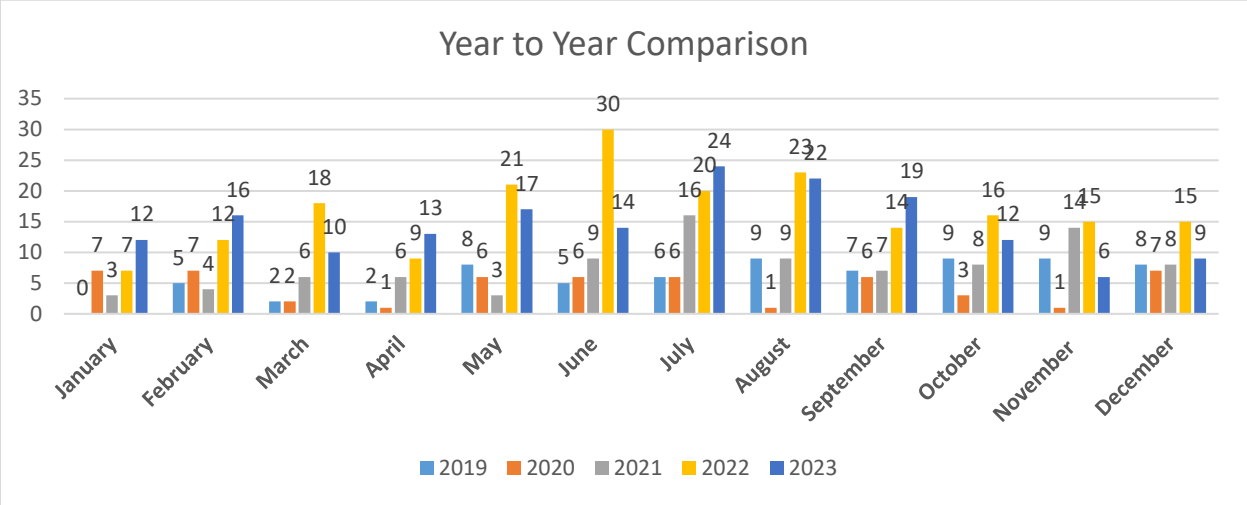
Chart 2. Transition Targets versus Actual Transitions



The SME continues to review information on transitions across years on a monthly basis. Chart 3 below provides a comparison by month of individuals transitioned from NFs for the reporting period of January through December 2023. This chart indicates good improvement in five months when comparing similar

months across years and overall improvement from similar months during the pandemic (2020 and 2021). However, there were significant decreases (40% or more) in four months when compared to CY 2022.

Chart 3. Comparison of Transitions Across Years



In discussions with LDH, the SME has inquired regarding the root cause of the variability of transition during the reporting period. LDH reports the variability in transitions is related to the following factors:

- Barriers to accessible housing as defined by the American with Disabilities Act (ADA)
- Lack of available PCA providers who are interested and willing to service individuals with SMI
- TC vacancies in regions with a large number of individuals in the Target Population.

While the SME understands the impact these and other barriers have regarding the timing of transitions, TCs should be held accountable to meet their target for transitioning 13 individuals per year, as recommended in paragraph 42.

Initially, this Agreement had a five-year horizon for achieving compliance, with transitions from NFs being a foundational premise of complying with this Agreement. While the State has succeeded in implementing numerous activities and initiatives to move toward compliance with the Agreement, it will take LDH much longer to achieve compliance without needed resources. Given that LDH has entered the sixth year of the Agreement, LDH must take more action to change course. Activities proposed to enhance in-reach efforts proposed by the State and discussed in paragraph 54 should also reduce the percent of individuals declining or postponing transition prior to or during the NFTA or prior to the start of the ITP process. The activities discussed in that paragraph are also intended to identify and address barriers so additional individuals may be more interested in transitioning and increase the number of individuals on the ACL who are very interested in transitioning. As this occurs, the State should re-evaluate staff resources needed in CY 2024 and subsequent years to transition these individuals on the Active Caseload.

The rapid integration pilot (discussed in paragraph 45) when implemented early in CY 2024 should net additional transitions from NFs. The goal of the pilot is to quickly engage individuals who are admitted to NFs within the first 14 days and ensure they are offered information and support to transition prior to a longer term stay (post 90 days) in an NF. LDH should assertively track if this goal is being met.

Finally, in the seventh report, the SME expressed concerns regarding the length of time LDH reports for individuals to transition once added to the Active Caseload. This length of time in the seventh reporting period was 295 days. The average days from being added to the ACL to transition was 276 days during the ninth reporting period. The average days from being added to the ACL to transition was 243 days during this reporting period, a decrease of 12% decrease from the previous reporting period. 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 nine 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 is not meeting the transition targets for CY 2023. While LDH has developed a methodology in CY 2022 for projecting transitions for CY 2023, its performance consistently falls short of those projections.
- The actual average caseload size (e.g., 19 individuals) for transition coordinators has not increased significantly over the past two years.
- The State has revised the methodology for CY 2024 using information regarding transitions from the previous two years. The State is projecting to transition 331 individuals in CY 2024. The State will need to ensure that each TC transitions 13 individuals during CY 2024.
- LDH is proposing to implement strategies to rapidly identify and offer transition support to individuals within the first 14 days of being admitted to an NF. This approach is intended to increase transitions by intervening earlier in the admission process.
- LDH is also collecting and analyzing information on barriers that are impacting transitions. The State is proposing to develop strategies to address more frequent barriers to promote more and timelier transitions.

Recommendations

- The State should implement strategies discussed in paragraph 42 to ensure TCs transition a minimum of 13 individuals on their caseload during CY 2024.
- The State should implement the recommendations in paragraph 54 to enhance in-reach efforts to better identify individuals who express interest in moving while at the same time addressing barriers identified by the PIRS to increase the number of individuals who want to transition.
- LDH should evaluate whether the RITC process is providing the correct information as planned and address any changes needed to ensure quality data.
- LDH should ensure it has sufficient staff resources for more expeditious transitions of individuals on the Active Caseload list. As the number of individuals on the ACL increase, 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 transition for all individuals on the Active Caseload List. As indicated in the ninth SME report, there are specific staffing resources that LDH should seek, including additional:

  - Peer In-reach specialists who are needed to continue efforts to meet with individuals on the Master List who are undecided or not interested in transitioning.
  - Rapid Integration Transition Coordinators to ensure that every region has sufficient RITC capacity to engage individuals as required by the Agreement within 3 and 14 days from admission.
- LDH should develop strategies to successfully address the barriers identified through in-reach and NFTAs.
- LDH should aggressively implement the timeliness standards discussed in paragraph 40 for transitioning individuals on the Active Caseload List. No one should have to wait more than nine 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: Met

Discussion and Analysis

This has changed from Partially Met to Met. Preliminary information for the CY 2024 service reviews collected information on whether individuals who were transitioned requested and were returned to their previous living situation or specific communities they were requesting to transition to. Specifically, interviews were conducted with individuals who were transitioned either back to their previous living arrangement or a new apartment in a particular town or parish if their previous living arrangement was unavailable. Preliminary information from the FY 2024 reviews indicated all of the 39 individuals transitioned or diverted either returned to their previous living situation or to a community they chose during the NFTA process.

As indicated in the 2023 service review report, the transition date in the ITP is variable. The final ITP often identified the transition date. However, the date of transition often changed during the ITP development process. The preliminary FY 2024 service review indicated TCs were initially having dates of transitions that were initially uniformed (6 month or 12 months) and were adjusted during the transition period to reflect actual transition dates. These dates were often adjusted based on the ability to get an individual's identification needed for housing or based on the availability of housing (including ADA accessible housing). The State reports individuals' dates of transition were revised with a final date generally around 60 days prior to transition and updated in the ITP.

Compliance Assessment

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

- Individuals either transitioned to their previous living situation or a new apartment if their previous living situation was unavailable.
- While the transition date in the ITP was fluid, individuals generally transitioned very close to the date in their final transition plan.

Recommendations:

- LDH should continue efforts to ensure individuals transition back to their previous community living situation.

- LDH should track move dates for all individuals who are transitioned consistent with the timeframes in the ITP .

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: Partially Met

Discussion and Analysis

As indicated in previous reports, the State developed procedures to fulfill the Agreement's requirement to facilitate a Transition Support Committee (TSC) 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 was provided in the sixth report.

In the ninth reporting period, LDH proposed substantial revisions regarding the SRP roles. including:

- Renaming the committee—specifically having a Transition Support Committee for the My Choice Program rather than relying on the current SRP to address all referrals from LDH.
- Expanding the roles of the committee, focusing on reviews of individuals with significant barriers to transition, systemic barriers, and longer term re-admissions to NFs.
- Revisiting structure and including representatives from the community and other state agencies to assist in addressing systemic and individual-specific barriers. LDH has discussed the need to vary membership on this committee for discussion of barriers experienced by individuals to respect confidentiality.
- Revisiting committee members—identifying potential additional committee members that have specific experience with systemic issues being identified by LDH. The "core" committee would be comprised of LDH staff and focus on individual members with significant barriers to transition and individuals who have been readmitted. Additional community members will be added to discuss systemic issues to be reviewed by the TSC. Individuals referred to the TSC will likely not have community providers due to issues regarding confidentiality.

The State implemented the new Transition Support Committee in May 2023. LDH reports they have reviewed individuals with significant transition barriers. Individuals who were readmitted and remained in an NF for more than 90 days will be reviewed in the next reporting period. In addition, they provide recommendations for individuals who were transitioned and diverted from NFs. The SME requested and received a sample of minutes from the TSC meeting. These minutes focused on specific individuals that

were referred to the TSC for review prior to discharge or post transition. These meetings seem to be reasonably well attended and the minutes indicate the findings and recommendations from the TSC are consistent with the intended goal of the committee.

As indicated in the seventh report, the State proposed strategies for collecting and responding to barriers impacting individuals in the My Choice program. As indicated in paragraphs 54 and 55, LDH implemented the process in which barriers are identified by PIRSs and TCs. PASRR Level II reviewers will begin to collect this information in the next reporting period through the revised PASRR Level II instrument. The State reports their strategy will be to provide information to the My Choice Internal Quality Committee for their review and discussion during this next report period. This Committee will refer certain systemic barriers to the new Transition Support Committee. LDH is in the process of finalizing criteria for referrals to the Transition Support Committee from the Internal Quality Committee. The SME has reviewed these criteria and provided feedback to the Department.

Compliance Assessment

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

- LDH reviewed the adequacy of the SRP process and determined it was not sufficient for the My Choice Program. They have reviewed 17 individuals during this reporting period and have made recommendations on 13 individuals.
- LDH has developed and recently implemented a new Transition Support Committee to review and address individual and systemic transition barriers for individuals on the Active Caseload List.
- LDH has implemented a process (discussed in paragraph 55 and 56) to collect and analyze information on barriers. The State has not yet provided the LDH internal quality assurance committee or the TSC with this information to discuss possible solutions.
- LDH reports they will include external representatives to the TSC to discuss systemic issues regarding barriers experienced by individuals who are awaiting transition or are concerned about transitions. External representatives (other than CCMs) will likely not be included when discussing individual issues (e.g., each readmission) due to HIPAA issues.

Recommendations

- The State continues to provide information on issues discussed and potential resolutions by the TSC to the SME during the next reporting period.
- The State should track if the potential resolutions recommended by the TSC have been implemented and track if previous systemic issues have been addressed.
- LDH should implement the process for TSCs to review individuals who were readmitted to NFs.

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: Met

Discussion and Analysis

The compliance rating has changed from Partially Met to Met. As indicated in the seventh report, LDH implemented the Community Case Management (CCM) program in March 2022. 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 and the individual has to be enrolled with a Medicaid MCO. 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. Table 4 below provides the CCM information for the five month period from May through September 2023 (the most recent data available for the CCM program).

Table 4. Individuals enrolled in CCM

Individuals Receiving CCM	April	May	June	July	August	September
In NF Awaiting Transition	77	88	95	74	74	61
Transitioned	211	209	209	219	227	230
Diverted	51	56	63	59	53	49
Total Individuals Receiving CCM	339	353	367	352	354	340

The SME has also requested information regarding the number of individuals who have declined CCM for the reporting period. The State reports that 18 individuals have declined CCM from January-October 2023, 10 of which were diverted and 8 members who transitioned from an NF. They have yet to provide this information on a monthly basis.

The number of individuals receiving CCM increased slightly during this reporting period. As of April 2023 (the last reporting period available), LDH reports all 211 individuals who had transitioned in the last 12 months were receiving CCM. LDH reports 340 individuals were engaged in CCM as of September 2023. The number of individuals who were transitioned and engaged in CCM increased the most, from 211 in April 2023 to 230 individuals in September 2023. The number of individuals who transitioned and declined CCM has remained consistently low during this reporting period.

The State reports that there were 27 individuals who were diverted from NFs during May through September, who were referred to and accepted CCM.

While this information is helpful to identify the number of individuals receiving CCM (or refusing CCM) in aggregate, a more detailed strategy is needed regarding the number of individuals on a monthly basis who are referred for CCM, engaged in CCM, and closed. This strategy will allow LDH to have an unduplicated count of new individuals referred and accepting CCM.

In the eighth report, the SME recommended LDH conduct in-reach to individuals who were diverted and chose not to engage in CCM. LDH provided information during that reporting period regarding reasons individuals chose not to enroll in CCM. These include:

- CCM is unable to reach the individual post transition or diversion.
- The individual declines participation in the CCM program.
- Individual is readmitted to an NF.

LDH has not done a recent review of why individuals who were diverted (or transitioned) were declining CCM.

LDH provided information regarding the caseload size for CCMs during this reporting period. This information indicates the CCMs' caseloads are consistent with LDH's policies. In addition, LDH reports monthly on the number of individuals who are readmitted to NFs. During the reporting period of January through December 2023, 32 individuals were readmitted to an NF. For the past several reporting periods, readmissions were generally low (5%). During the most recent reporting period (July-December 2023), the percent of readmissions doubled from the previous reporting period (11%).

During this reporting period, TCs no longer provided Intensive Case Management (ICM) to transitioned individuals who had been residing in the community for longer than 180 days.

As indicated above, the Agreement requires an individual to be provided case management, if agreed to by the individual, for one year after transition or diversion. The Department has provided data to indicate individuals receive CCM unless they move to another state or are deceased.

Compliance Assessment

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

- The State continues to report referrals of individuals currently residing, recently transitioning, or diverted from NFs to CCM.
- The State reports information on the number of individuals receiving CCM. However, data is needed to identify the unduplicated count of new individuals offered and engaged in CCM.
- 11% of individuals transitioned or diverted were readmitted to NFs during this reporting period, who were transitioned or diverted from NFs. This percent of individuals is twice the percent from previous reporting periods.
- LDH requires the CCM to remain engaged with members who are readmitted to an NF unless the member declines CCM services or the stay is expected to be long-term (longer than 30 days).
- LDH requires CCMs to offer ongoing MCO case management after the twelve month period required in the Agreement.

Recommendations

- LDH should continue to track and provide the SME with monthly reports regarding the CCM program as requested in the sixth report. This includes the number of new people offered, engaged, and declining CCM (transitioned and diverted).
- LDH should ensure the quality assurance process is in place, as discussed in paragraph 93, and review the number and reasons for readmissions to NFs by the Target Population and develop strategies to continue care coordination either through the TCs or RITCs until the individual returns to the community or declines transition. The increase in the number of readmissions during the last reporting period is concerning and should be addressed and continued to be monitored on a quarterly rather than a semi-annual basis.
- LDH should report to the SME the number and reasons for readmissions of individuals recently discharged from NFs and the strategies to continue care coordination.
- LDH should conduct in-reach to individuals who have been diverted during the next reporting period, to obtain information on why they chose not to enroll in CCM.
- LDH should track and report the number of individuals who are closed from CCM on a monthly basis to better assess the trends in utilization of CCM for individuals who are recently transitioned

or diverted from NFs. Now that the CCM program is over one year old, this information should be tracked to better identify the number of new individuals receiving 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 March 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 MCO provided case management. In addition, the SOP sets forth expectations regarding initial assessments, reassessments, and development of a plan of care and a separate crisis plan.

During this reporting period, the service reviewers 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 CY 2023 service review indicated:

- All individuals reviewed had a CCM and the preliminary FY 2024 service review found there was little turnover of CCMs.
- 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 transitioned individuals, except one, had the required documentation: an initial community assessment, individual plan of care, and crisis plan. However, the preliminary CY 2024 Service Review report found that many individuals did not have an updated CPOC, especially individuals who had a significant change in condition (e.g., rehospitalization or multiple ED visits).
- All diverted individuals had the initial community assessment, plan of care, and crisis plan. This individual was newly diverted (less than 30 days) and the CCM indicated they were in the process of developing these documents.

- The timeliness regarding the rendering of the assessment and the development of the plan of care was variable. Approximately one-fourth (26%) of the individuals received a timely assessment and plan of care. The other 74% were not timely, although the review indicated the delay in these activities was generally less than 5 business days. For the most recent month, LDH reports a greater number and percentage of plans completed on a timely basis (75%).
- 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 that LDH 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 CY 2023 service review of the 37 individuals (29 individuals transitioned and 8 individuals diverted) found that all but one initial plan of care did not specify the amount and duration of services consistently for any individual.

A consistent issue that has been discussed in the eighth and ninth report is the identification, referral, and engagement to SUD treatment or supports of individuals with an SUD history and who are actively using substances post transition or diversion. Similar to the issues discussed in paragraph 43 regarding ITPs, there are often few CPOCs for individuals who are actively using a substance that include a referral to SUD services. As indicated previously, the individual may decide to accept or not participate in treatment; however, some discussion with the individual to at least initiate a referral would be helpful. When reviewing utilization data for SUD services, there continues to be significantly low utilization of SUD services for individuals transitioned (1.2%) or individuals diverted (4.6%).

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. The service review team looked at the type of contacts (face to face, telephonic and collateral). Generally, when contacts occurred, approximately 68% of these were face-to-face contacts, which exceeded the CCM expectation of 50%. Preliminary information from the FY 2024 service review found contacts included regular team meetings facilitated by the CCM with the individual present. CCMs have begun to have more frequent contact with housing coordinators and medical providers to discuss and resolve issues with tardy rent or more complicated physical health conditions (e.g., pain management).

In the ninth report, the SME reviewed the SOPs for CCM this period and provided feedback to LDH regarding changes that would provide flexibility to the CCM program. This included:

- CCMs provide four contacts monthly versus weekly specific contacts.
- Fewer CCM contacts for individuals who are participating in ACT given the robust case management requirements for ACT teams.
- Coordination of regular team meetings with the individual present and team meetings when there is a change of condition.

The State reviewed and has revised the SOPs this reporting period to include these recommended changes as discussed above.

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

- All individuals reviewed had a CCM. The consistency and continuity of CCM within regions was reviewed and the preliminary FY 2024 service review found there was little turnover in CCMs this reporting period.
- The FY 2023 service review found:
    - The required documents were present for all but one individual reviewed. However, only one service plan provided consistent information regarding the scope, amount, and duration of these services.
    - The timeliness regarding the rendering of the initial assessment and the development of the initial plan of care varied. There were differences between what the SME found in the service review and what LDH reports.
    - Individuals' CPOCs did not identify the scope, amount, or duration of services.
    - Reassessments and revised CPOCs did not occur for individuals receiving CCM longer than 90 days and experiencing a significant change in condition.
- LDH has made changes proposed by the SME to the SOP.
- The referral and engagement to SUD services for individuals with an SUD or who misuse substances is very low.

Recommendations

- 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 Standard Operating Procedures.
- LDH should continue to monitor the timeliness of assessments and initial plan of care development with the MCOs and the CCM organization.
- LDH should ensure the acumen of CCMs to provide motivational interviewing strategies to encourage individuals to take the necessary steps to increase goals and SUD intervention for individuals with an identified SUD.
- LDH should ensure each individual transitioned and diverted who is actively using substances is provided information regarding SUD treatment services, including alternative treatment settings (e.g., recovery groups).
- 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. In the preliminary FY 2024 service review conducted this reporting period, the CPOCs continue to

include information regarding the individuals' vision and goals (which was often stated in their own words) and identified the natural and formal supports needed. The assessment solicited information regarding community inclusion, education, and employment needs.

The CY 2023 service review focused on the presence and quality of the assessment and CPOC. 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, including community inclusion, education, and employment. The findings from the service review identified the following:

- As stated in paragraph 60, all individuals who were transitioned had an initial assessment and plan of care. Individuals without a CPOC were recently transitioned or diverted.
- The overall quality of the assessments reviewed for the FY 2024 service review for individuals transitioned or diverted continues to be strong. Specifically,
    - Community assessments included information regarding strengths, vision, interests, and assistance the individual needed to address community inclusion needs.
    - All but one individual were asked to provide information regarding their educational and employment interests.
    - All but one assessment included information regarding the individual's preferences. These preferences were generally stated in the individual's own words.
    - Service domains in the community assessment were complete with the exception of transportation, adaptive equipment, and services to address health and wellness.
    - The natural supports available/unavailable to the individual were identified for all individuals.

- Preliminary information from the FY 2024 service review found the quality of CPOCs was improved. Of note:
    - The goals in the plans of care continued to be stated in the individuals' words and were clear and specific activities and related services were preset to meet these goals.
    - All plans of care reflected strengths and preferences.
    - All individuals had signed their plan of care.
    - As indicated in the previous report, CPOCs did not always identify services and strategies to address all the needs identified in the assessment. The service review team has requested information from the CCMs regarding their process to develop an initial plan of care that includes some but not all services. CCMs are consistently reporting they track other service needs on a monthly basis and make the necessary referrals as needed.
    - The CPOCs continue not to specify the amount, frequency, and duration of services post-transition.
    - As indicated in paragraph 60, revisions to CPOCs did not occur for individuals with a significant change in condition.

In the seventh report, the SME also encouraged the State to use the Person Centered checklist developed in CY 2022 in their efforts to educate CCM providers regarding strategies to ensure plans are person-centered. The State has met with the SME to begin efforts to develop a training module for completing this checklist for CCMs as well as TCs.

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 for reviewing the NFTA and ITP protocols. 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 Person Centered Training developed in CY 2021.
- The FY 2024 service review found that:
    - All individuals who were transitioned and diverted have an assessment and an individual plan of care.
    - Goals identified in the individual plan of care are person centered and that almost all plans identify the individual's strengths and preferences.
    - There was progress by the CCMs to develop activities and services identified in the plan to implement these goals.
    - All plans of care were signed by the individuals and almost 75% of individuals reported they had a CPOC.
    - A good proportion of individuals (friends and families) participated in plan development at the choice of the individual.
- Community plans of care did not include information regarding amount and duration of services.
- The State is working with the SME team to develop a training module for the person-centered checklist in early 2024.
- LDH has not sought input from external stakeholders regarding the community assessment or CPOC documents.

Recommendations

- LDH should ensure all community plans of care reflect the amount and duration of services needed by the individual.
- LDH should train CCMs to use the Person-Centered Checklist developed by the SME team in the next reporting period.
- LDH should seek input from external stakeholders regarding the community assessment and CPOC documents.

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: Met

Discussion and Analysis

This paragraph has changed from Partially Met to Met. LDH continues to receive standardized monthly reports from MCOs regarding similar information previously collected from TCs (as discussed in the third through six reports) as well as more detailed information, reported by individuals, on key case management activities including:

- Initial and ongoing contact with the individual by the CCM
- The date the community assessments and community plans of care were developed
- Whether the individual received all services on his/her plan of care this month
- Whether the individual is making progress toward goals
- If there were services needed but not yet received and, for these individuals, the specific steps the CCM is taking to mitigate service gaps
- Critical Incident Reports and the follow-up actions taken to address the issues identified in the CIR.

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

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

As described in the CCM Standard Operating Procedures, LDH requires a scheduled cadence of face-to-face contacts between the CCM and the individual who has been transitioned. CCMs are to report on each contact and whether the contact was face-to-face or virtual.

During this reporting period, OAAS and OBH leadership, in addition to the Integration Coordinator, continued to accompany the service review teams to visit individuals who were transitioned, diverted, or in the NF awaiting transition. This included a review of individuals' documentation and face-to-face visits with each individual. LDH and the service review teams met with 76 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. 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 a tracking system to identify and monitor all 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 a sample of data reports from MCOs indicates that information collected on almost all individuals transitioned is complete.
- The MCO report monthly on individuals who are not receiving needed medical, behavioral health, or long term services and supports. For each individual, the MCO reports the services needed and the CCM strategy for obtaining access to those services.
- Recently, LDH has revamped the internal quality assurance team and proposes to use the data from the MCO CCM and quarterly service utilization reports in the overall quality improvement process to determine if there are systemic health and safety issues, gaps in services, and efforts that have been successful in addressing these issues.
- LDH also provides quarterly information on the utilization of Medicaid services by individuals who are transitioned and diverted. This is discussed in more detail in paragraph 100.

Recommendations

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

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/assets/docs/MyChoice/CRISIS-PRESENTATION-032921.pdf. 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 are provided to individuals in their home or other community-based settings.

The eighth report provided information regarding LDH's interim process for implementing the crisis line for individuals in the adult Medicaid population (including the Target Population) through the MCOs. LDH reports they have released a procurement for an ongoing crisis line in Fall of 2023. LDH intent is to contract with a vendor that will establish a statewide crisis line in CY 2024 which will work with 988, MCO Behavioral Health Crisis Lines, and other systems.

The State continues to implement all four crisis services throughout the state. These services include Mobile Crisis Response (MCR), Community-based Crisis Stabilization (CBCS), Crisis Stabilization (CS) and Behavioral Health Crisis Care (BHCC). It should be noted, LDH did not receive funding for CS services until July 2022 and therefore implementation of this service did not occur until August 2022. The State reports they are pursuing the federal opportunity in the American Recovery Plan to garner additional federal funding for mobile crisis response services.

LDH has worked closely with the MCOs, LSU, and new providers to stand up four crisis services in select regions of the State. Specifically:

- LDH, MCOs and LSU continue to hold monthly meetings with providers of all crisis services. The State reports these calls have transitioned from implementation issues to topic-specific calls based on issues identified by the crisis providers and LDH.
- During Crisis Response Service (CRS) regional meetings, LDH provided data related to utilization of emergency departments and inpatient hospitalization among the TP members who transitioned in the last 12 months. Data regarding crisis services and 988 was developed and shared with community partners as discussed later in this paragraph.
- LDH meets with new providers (including existing providers that are offering new crisis services) one-to-one on a regular basis (at least once a month).
- LDH meets individually with existing crisis providers on a regular basis to discuss implementation issues and strategies to address these issues.
- LDH has participated in community events related to the implementation of crisis services; this has included the following in CY 2023:
    - Presentations at multiple statewide conferences/learning events:
        - Louisiana NASW Conference
        - Behavioral Health Symposium
        - Louisiana Hospital Association trainings
    - Statewide LA-CRS Regional Meetings comprised of regionally-specific stops and presentations
    - Participation in Northwest Louisiana Crisis Leadership Summit (Region 7).
- 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. This has included allowing MCR providers to expand service delivery options including collaborating with EDs and inpatient hospitals to refer individuals who may be better served in the community rather that an ED or hospital setting.
- As indicated in the eighth report, LDH developed required crisis providers to follow Crisis Care Coordination Protocols developed in CY 2022. The purpose of these protocols is to convey expectations for coordinating crisis care across the continuum, including the MCO crisis line. The protocol content was described in the eighth SME report; it is updated as the need for revisions becomes apparent.

Table 5 provides information regarding the implementation of each crisis service by region as of December 31, 2023.

Table 5. Availability of Crisis Services

Region	Services
Region 1	MCR/BHCC (BHCC closed September 2023)
Region 2	MCR/BHCC/CBCS/CS
Region 6	MCR/CBCS (both services projected to come on-line in 2024)
Region 3	MCR/CBCS/BHCC (closed May 2023); MCR/CBCS/BHCC/CS (all services projected to come online in 2024)
Region 8	MCR/CBCS (both services projected to come on-line in 2024)
Region 9	MCR/BHCC/CBCS
Region 10	MCR/BHCC/CBCS/CS (CS projected to come online in 2024)

The availability of crisis across regions has not changed appreciably since December 2022. Though efforts have been undertaken to identify providers, there continues to be no crisis providers in region 5. Though a provider has been identified for MCR and CBCS in Regions 6 and 8, services have yet to be implemented in those regions. CS providers have not been identified in the majority of the state. Since implementation, LDH reports they have two regions where crisis providers terminated services (Regions 7 and 4). Subsequent to this termination, once a provider was identified, a collaborative process in Region 7 (inclusive of the Shreveport mayor office, local law enforcement, representatives from the coroner's office, and other community stakeholders) resulted in the identification of a plan to support the integration of crisis services within a single provider in Region 7. The collaborative process is discussed more in paragraph 68. For Region 4, LDH reports the crisis provider terminated the contract. Local government, inpatient providers, and an ambulance service had a desire to have a local provider offer these services rather than a provider from another region that does not have familiarity with crisis needs of the local community in that region.

LDH has yet to meet the expectation that crisis services will be available 24/7 as required by the Agreement, but reports they are intent to have all crisis services operational on a 24/7 basis later in CY 2024. Services that will be available 24/7 include mobile crisis response, BHCC, and crisis stabilization. CBCS, as structured, is not intended to be a 24/7 service. The State has reported that some regions (1 and 10) have crisis services available 24/7. Region 3 will have the capacity to offer crisis services 24/7 in the spring of 2024. The State is planning to provide funding for current and future crisis providers to offer 24/7 services. Specifically, LDH will provide these organizations $1.7M each to expand their crisis efforts to comport with this requirement.

LDH reports they have collected and analyzed information regarding the utilization of emergency department services, inpatient admissions, and utilization of crisis services for adult and youth Medicaid enrollees to use for multiple purposes. As discussed in paragraph 68, LDH used this information for regional in-person town hall meetings specific to crisis services. LDH provided the SME with information from a sample of the town halls. The material provided regional information regarding:

- Emergency Department visits for mental health and SUD
- Inpatient hospital admissions for mental health and SUD
- Calls from the 988 Suicide and Crisis Hotlines
- Mobile crisis dispatches
- Utilization of BHCC

The information provided a picture of the demand and current utilization of crisis services. As indicated in paragraph 65 and 66, LDH and MCOs provided this information to agencies offering MCR and BHCC to use in conversations with local hospital systems and other stakeholders.

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 CY 2023 service review identified that all individuals had a completed crisis plan. The quality of the plans were stronger than last year and identified the MCO crisis call line and, in some instances, the new crisis services as a potential strategy for de-escalation and stabilization.

In the ninth report, LDH stated they had revised the initial reimbursement rates for all crisis services based on 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 RFA materials. These new rates should serve as incentive for agencies considering delivering these services. The State reports there was no need to revise reimbursement rates this past reporting period.

Compliance Assessment

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

- LDH has developed a plan for a crisis system of care, consistent with the intent of this paragraph. This includes mobile response, crisis telephone lines, and three other crisis services (CBCS, BHCC, and CSs).
- LDH has developed and revised 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 did not complete the implementation of all four crisis services in all areas of the state during CY 2023. At the beginning of the year, LDH had crisis services in seven of the ten regions. As of this reporting period, services are implemented in five of the ten regions with providers identified and are in the process of being implementing in three additional regions.
- There have been two regions where the initial crisis services provider terminated their contract. One region has Identified an alternate provider to offer crisis services (Region 7). The other region (Region 4) has not developed a specific strategy for replacing the provider.
- LDH has developed and analyzed utilization by region regarding the use of ED, inpatient behavioral health, and crisis services to better understand the demand for these services.
- LDH requires each individual receiving CCM services to have a brief crisis plan, with the quality of these plans improved to identify the crisis call line and in some instances crisis services specific to the region as a strategy to de-escalate the crisis. This is discussed in more detail in paragraph 64.
- Three regions have made crisis services available 24/7. LDH has articulated its intent to have all crisis services be available 24/7 on a statewide basis by the end of CY 2024 and has provided incentive funding to crisis providers to meet this 24/7 expectation.

Recommendations

- Complete the implementation of all four crisis services in all areas of the state during the next reporting period.
- Expand all crisis services to ensure 24/7 access. While providing incentive payments to these providers is a solid strategy, LDH should be working with these providers to ensure sustainability past the funding period. This includes assisting providers to seek reimbursement on a timely basis for services provided to Medicaid beneficiaries.
- Implement a longer-term 24/7 crisis hotline in CY 2024.

- Continue to collect and analyze critical data to identify potential demand for crisis services and provide to local crisis collaboratives in their discussions with law enforcement, EMS, local hospitals, and other stakeholders.

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. To address this issue, the crisis plan, as proposed, would ensure that the Target Population and all Louisianans experiencing a behavioral health crisis would have access to a statewide toll-free crisis line. The crisis line 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. As indicated in paragraph 63, OBH released a Request for Proposal for a single crisis call center and has indicated their interest in having this call center operational in CY 2024.

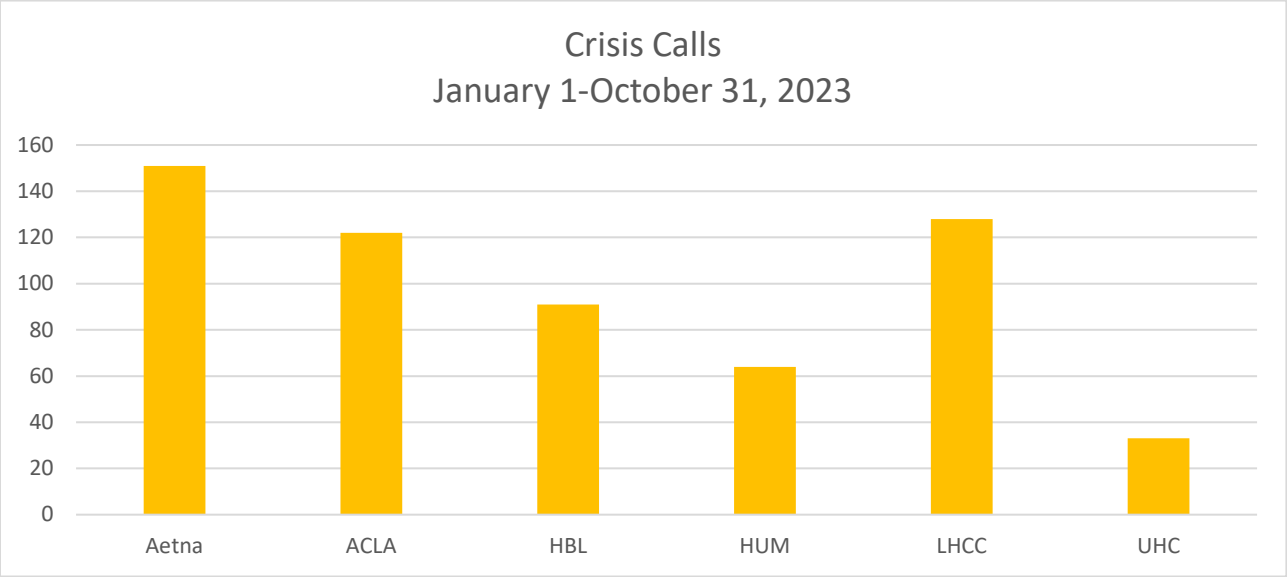
Prior to the development of a statewide crisis call center, LDH is requiring the MCOs to receive crisis calls and dispatch mobile teams and make referrals to other crisis services in the interim. The current LDH contract requires MCOs to have this capacity and each of the MCOs have developed a 24/7 crisis line for their enrollees. The State reports MCOs continue to send letters to all adult Medicaid members to inform them of the crisis line and available crisis services.

As indicated above, LDH will implement a statewide crisis line in CY 2024. The state anticipates there will be some overlap of MCO crisis call centers and the statewide crisis line until the latter becomes fully operational.

In addition, since March 2023, the State encouraged MCR providers to take crisis calls directly from individuals in crisis and from other referral sources such as 988 (that was implemented in Summer 2022) and other providers in their region rather than relying solely on dispatches from MCO crisis lines. This has impacted the number of calls that have been triaged by MCO to MCR providers.

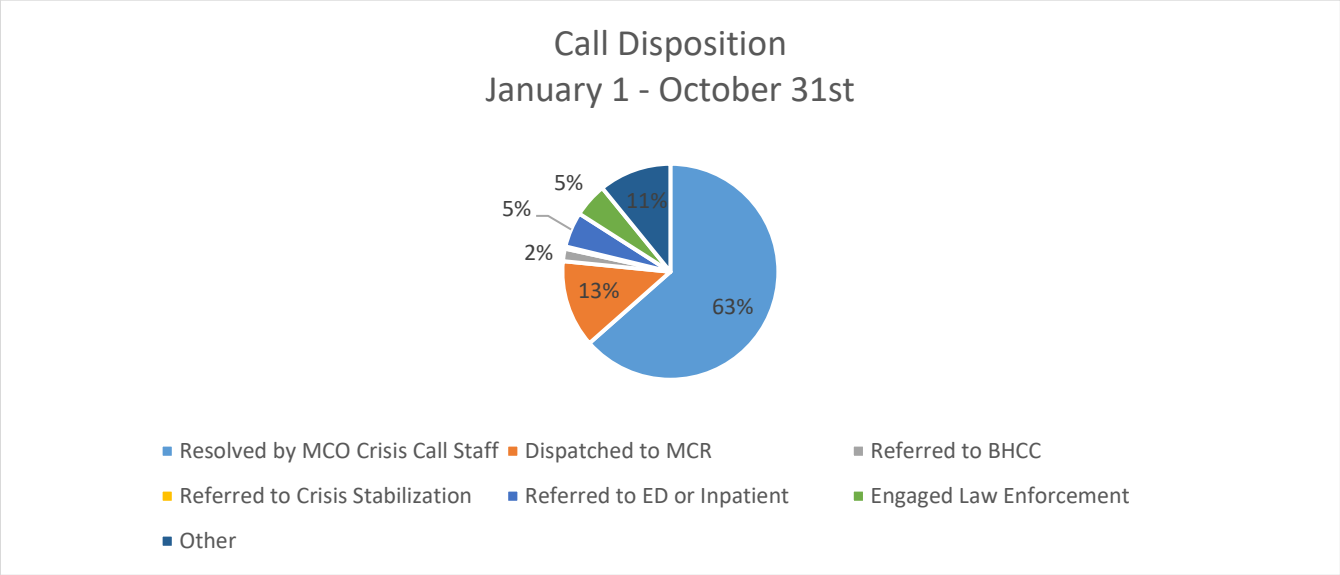
The State reports the total crisis call volume received by MCOs from January through October 2023 was 529. The chart below provides call volume for each MCO:

Chart 4. Number of Total Crisis Calls by MCO for the period of January 1 – October 31, 2023



As this data indicates, the call volume for the MCO crisis lines remains very low. As indicated above, there were 589 calls for the 9 month period of January 1 through October 31, 2023. This compares to 463 calls during the first six months of operation in CY 2022. 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. Chart 5 below provides information on these dispositions.

Chart 5. Call Dispositions



This data indicates that most calls (63%) continue to be 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. Approximately 15% of all calls resulted in a dispatch to a local MCR, BHCC, or CS provider. Five percent of all calls were referred to EDs or resulted in law enforcement being engaged.

LDH continues to monitor the MCO crisis lines to ensure that the call lines can process crisis calls and dispatch mobile teams. In the eighth report, LDH found some MCO call center staff were spending considerable time talking to the caller prior to discussing treatment options. LDH reports that coaching efforts to inform caller of new options early in the call and giving the caller the option of a continued crisis service or continuing to talk to resolve has reduced the length of the calls and increased the timeliness of triaging to MCR services when appropriate.

A major shift from MCO crisis lines to a centralized crisis call line will occur when LDH implements their Crisis Hub. This hub will be responsible for crisis calls on a statewide basis, resolving the crisis or dispatching MCR response of making referrals to community-based behavioral health or other formal and informal supports and services. LDH is still in the process of selecting a vendor and reports they are hopeful to have the hub established by the end of CY 2024.

As indicated above, the State implemented a state-specific 988 hotline in Summer of 2022 for Louisianans in crisis to connect with crisis services and supports. LDH has met with the two 988 crisis line organizations and crisis providers on a regional basis. The intent of these meetings was to initiate collaboration between the crisis lines and crisis providers. The outcome of these meetings has resulted in the two 988 crisis lines making direct referrals to crisis providers across all regions. This statewide effort built off lessons learned from a pilot in region 7 that allows a direct warm telephonic transfer from 988 to the crisis provider for MCR or BHCC services.

Compliance Assessment

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

- MCOs, at the state direction, continue to operate multiple toll-free crisis lines that operate 24/7. However, calls to MCO crisis lines continue to be very low.
- LDH continues coaching to address MCO crisis line staff efforts 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).
- As indicated in paragraph 63, the State is planning to implement a call center that will establish one statewide call number and will eliminate the multiple crisis line calls numbers, making it easier for Medicaid individuals and stakeholders to access crisis services.
- LDH has allowed direct referrals to MCR providers from individuals experiencing a crisis and from other referral sources including 988 and other local providers.

Recommendations

- LDH should implement the statewide crisis line in CY 2024.
- 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 until the statewide crisis call center is fully implemented, with ongoing collaborative activities occurring beyond.
- LDH should continue to work with MCO call center staff, 988, 911, and local crisis providers 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 has partially implemented mobile crisis response capacity in over one-half of its ten regions. As indicated in the eighth SME report, LSU assisted the State in developing network capacity for MCR, CBCS, CS, and BHCC. The network includes MHR providers, other non-profit and for profit providers, and a few LGEs. As indicated in paragraph 63, by the end of the reporting period, 5 out of 10 regions have operational MCR teams. Providers have been identified and are in the process of readying for service implementation in three regions (Regions 6, 7, and 8). Region 5 continues to not have MCR capacity and turnover in provider has created a vacancy in Region 4. This turnover is referenced in paragraph 63, which provides information on the two regions (4 and 7) where the initial MCR provider terminated the contract. The State reports they are continuing efforts to recruit and train providers in the regions that do not have an MCR provider. The SME requested information regarding initial utilization of MCR services. The charts below provide information regarding MCR dispatches from January through October 2023.

Chart 6. MCR Dispatches

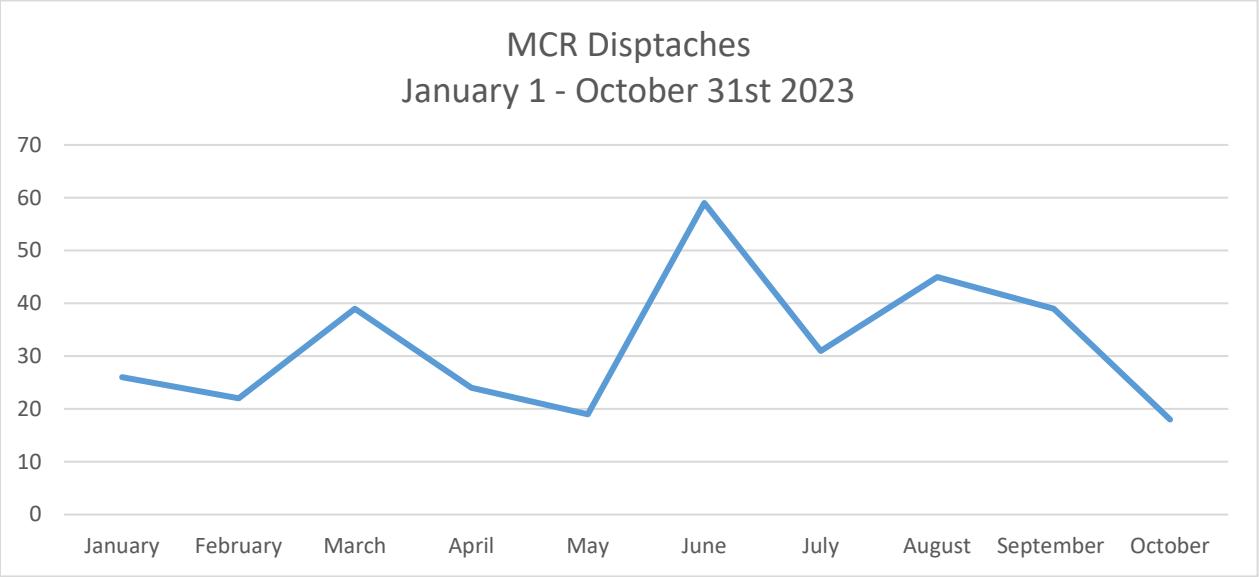
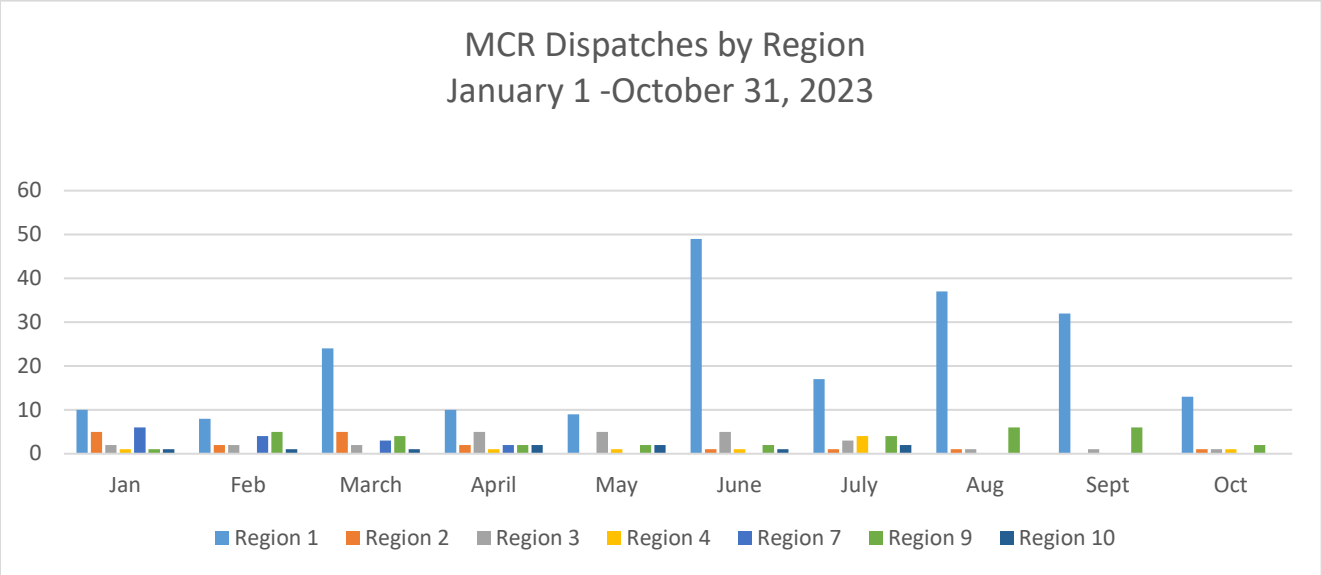


Chart 7. MCR Dispatches by Region

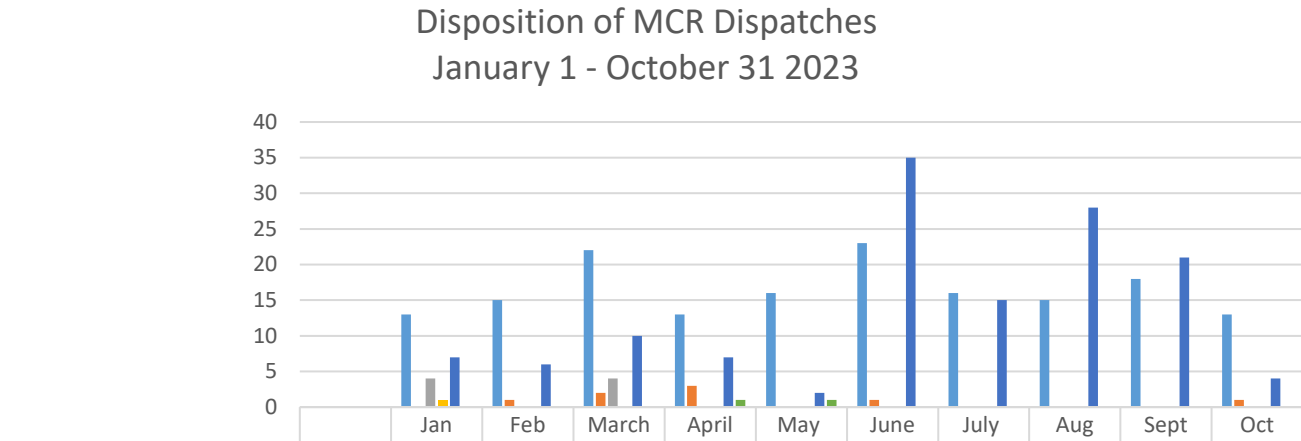


Utilization of services has increased from 72 in the eighth SME report to 322 individuals during this reporting period. There were no individuals in the Target Population who received MCR services in Quarter 2 or 3 of FY 2023 (most recent data available). This does not include crisis experienced and addressed by individuals in ACT (approximately 4,500) or individuals served by the MHR providers who may offer crisis response as part of their program. Region 1 has contributed to most of this increase. The State reports the crisis provider in the region has developed a larger MCR program and has developed a strong relationship with 911 organizations in the area and makes direct referrals to the MCR provider. They were also one of the first teams to offer 24/7 availability of this service. LDH reports they have reviewed the model Region 1 uses to provide MCR services and is adherent to the model.

The SME believe the lower rates of ED visits may be due to the various supports that have been used by individuals that were transitioned or diverted that have prevented various behavioral health crises. Very few individuals who were transitioned (1.3%) visited EDs for behavioral health reasons. Information from the eighth SME report identified 3.7% of individuals transitioned had an ED visit in the third quarter of CY 2022. There was also a decrease in the percent of individuals who were diverted and visited the ED for behavioral health reasons. In the third quarter of 2022, 14% of these individuals had behavioral health related ED visits. In the third quarter of CY 2023, 5.8% had behavioral health related ED visits.

During this reporting period, LDH provided information on the disposition of MCR services for all Medicaid beneficiaries receiving MCR services. Chart 8 below provides this information on MCR dispositions from January 1 through October 31, 2023.

Chart 8. MCR Dispositions



	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct
Resolved by MCR	13	15	22	13	16	23	16	15	18	13
Referred to BHCC	0	1	2	3	0	1	0	0	0	1
Referred to CBCS	4	0	4	0	0	0	0	0	0	0
Referred to CS	1	0	0	0	0	0	0	0	0	0
Referred to ED or IP	7	6	10	7	2	35	15	28	21	4
Engaged Law Enforcement	0	0	0	1	1	0	0	0	0	0

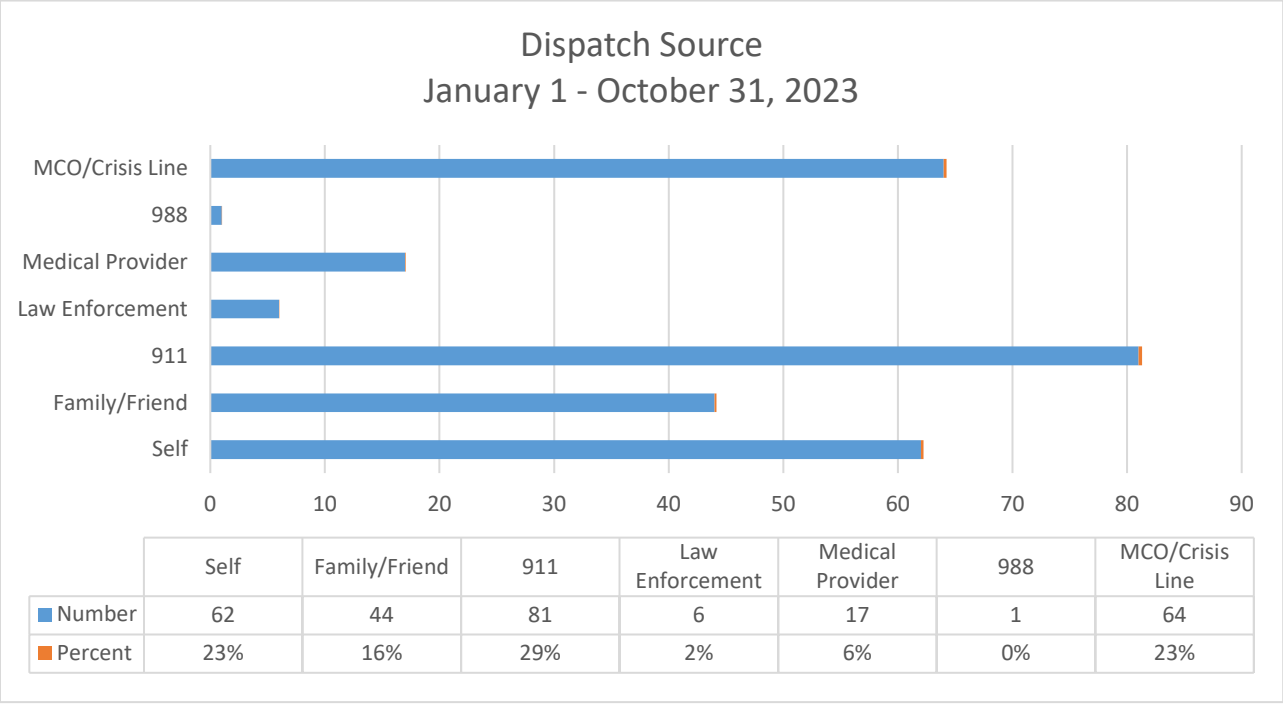
As indicated by this chart, most individuals remained in the community; 164, or 51%, of all MCR contacts were resolved in the community. Seventeen individuals, or approximately 6%, were referred to other crisis services. Law enforcement was engaged by mobile crisis teams only two times. However, a concern is the significant number of individuals 135 (42%) referred to an ED or inpatient hospital.

LDH also provided a regional breakdown of MCR dispositions. Specifically, LDH has data regarding the following resolved dispositions:

- Appointment/Referral made to a community provider
- Referred and linked back to an existing community provider
- Individuals who refused services.

LDH now reports the source of who contacts the MCR for services. Chart 9 below provides this information.

Chart 9. Dispatch Source



	Self	Family/Friend	911	Law Enforcement	Medical Provider	988	MCO/Crisis Line
Number	62	44	81	6	17	1	64
Percent	23%	16%	29%	2%	6%	0%	23%

This is new and useful reporting. The overall volume remains low; however, there are some data points that are worth tracking:

- LDH allowed/directed teams to begin marketing/accepting direct referrals in January 2023.
- Direct referrals to mobile teams have netted benefit and account for 77% of mobile crisis episodes.
- Direct referrals from 911 account for 29% of mobile crisis episodes. This accomplishes an important goal of assuring people receive the least restrictive intervention and use of law enforcement only as an exception rather than as first responder.
- Nearly 40% of requests for mobile crisis services are coming directly from the individual in crisis or from family/friend. This may indicate people are learning of the service from MCO mailings or public information campaigns, though this is not knowable from this data.
- Efforts to increase warm transfer referrals from 988 have either not been successful or 988 has referred individuals to their MCOs and not directly to the team. This is an important system functionality and will be even more so when the call center goes live.

For new MCR providers, LSU continues to provide monthly, agency-specific coaching for a period of at least several months to support implementation. Each MCR team receives six months of team-specific coaching by members of the LSU training team following completion of the initial training. In addition, LSU offered several advanced trainings in 2023 for crisis providers, which included the following topics:

- Working with law enforcement
- Working with LGBTQ+ populations
- Working with individuals living with IDD during a crisis.

Advanced Crisis Training & Workforce Development workshops are offered to crisis staff who have completed the Mental Health Crisis Response training and are employed by one of the agencies providing crisis services.

During the first year of implementation, LDH created multiple opportunities for new crisis providers that included weekly crisis huddles and monthly meetings to discuss and resolve issues and barriers identified during start-up. As discussed in paragraph 63, LDH, MCOs, and LSU continue to meet with crisis providers, including MCR providers, on a monthly basis. In addition, LDH and LSU have developed a strategy for new MCR providers that includes one-on-one meetings on a more frequent basis dependent on the needs of the MCR provider and community.

LDH has provided information to each MCR regarding the utilization of ED, inpatient behavioral health and crisis services, and other information (e.g., 988 calls) by Medicaid beneficiaries in their service area. This data is intended to help teams determine priorities and strategies and for shifting care from EDs to less restrictive mobile and BHCC services and to inform meetings with system partners.

Compliance Assessment

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

- LDH developed MCR capacity in seven regions of the state, with providers operating in five regions as of the end of the reporting period. Though a provider has been identified in Regions 6 and 8, MCR services have not yet been implemented in Regions 5, 6 and 8, and two MCR providers (Regions 4 and 7) have terminated their contract to provide MCR services.
- LSU continues to provide readiness reviews to ensure that new 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. LDH reports they will expand MCR capacity to serve children and youth in CY 2024. The State has provided limited funding during implementation to providers who are rendering services in order to reimburse the non-Medicaid 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 and a small percentage had a behavioral health crisis that led to an ED visit or resulted in a behavioral health inpatient stay.
- LDH developed a process that includes MCOs and LSU in meetings with existing MCR providers to discuss topical areas identified by the MCR teams and LDH.
- LDH collects MCR utilization information at a regional level and has provided information to regional crisis coalitions regarding the demand for and utilization of crisis services.
- LDH and LSU are continuing to provide education and coaching for each new MCR team, including providing information regarding the demand for MCR services.
- There continues to be limited uptake of MCR services. LDH has developed some immediate strategies for MCR providers to increase MCR referrals.
- LDH reports MCR disposition to ED/IP providers as very high; 42% of all individuals are referred to ED or inpatient providers

Recommendations

- LDH should ensure LSU and MCOs identify and/or contract with providers in regions 4, 5, 6, 7, and 8 to offer MCR.
- LDH should ensure coverage of MCR providers to 24/7 access by the end of CY 2024.

- LDH should prepare for implementation of the crisis call center by:
    - Developing strategies for engaging law enforcement agencies, coroners, and EDs regarding the role of the call center in dispatching MCR teams
    - Developing protocols/MOUs with MCOs and crisis agencies
    - Ensuring the technology is in place and functional for dispatching teams
    - Determining what information the call center will gather and report to LSU and LDH.
- LDH should review the reasons MCR dispatches to EDs and inpatient providers have increased substantially since CY 2022 and work with MCR providers to reduce these referrals.
- LDH should address the lack of referrals from 988 to MCR by:
    - Evaluating 988 referral out data
    - Evaluating 988 payor data if available (insurance coverage of callers, specifically what percent of callers have Medicaid)
    - Revisit transfer protocol
    - Prepare for launch of crisis hub/call center and how it will interface with 988.

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

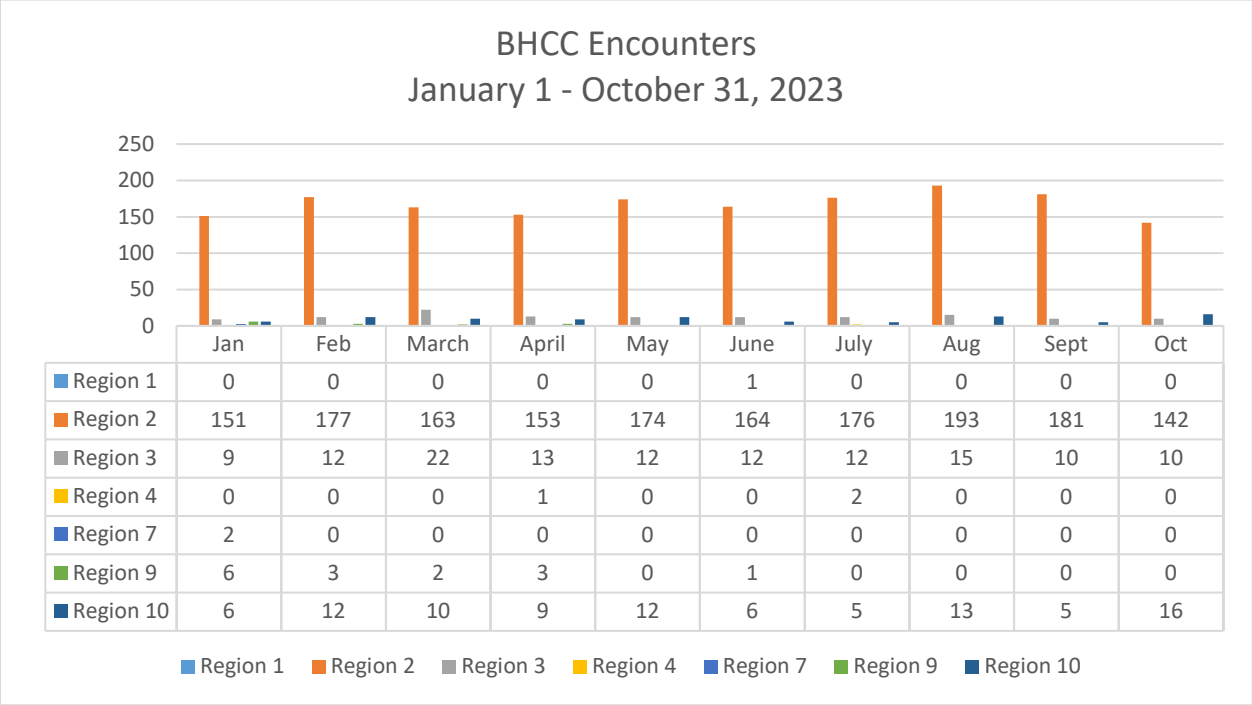
Discussion and Analysis

LDH has implemented Behavioral Health Crisis Care Centers (BHCC) in five regions of 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.

As indicated in paragraph 63, the State initially developed BHCC capacity in seven of the ten regions. Given the turnover in providers (Regions 1, 4, and 7), and those areas where BHCCs are not yet implemented (Regions 5, 6, and 8), four regions have BHCC services as of the end of the reporting period. A provider has been identified in Region 7; they are in the process of implementation and it is expected services will be available in CY 2024.

The SME requested information regarding initial utilization of BHCC services. The State provided information regarding the utilization of BHCC service statewide and by region from January 1 through October 31, 2023, in the chart below.

Chart 10. BHCC Encounters

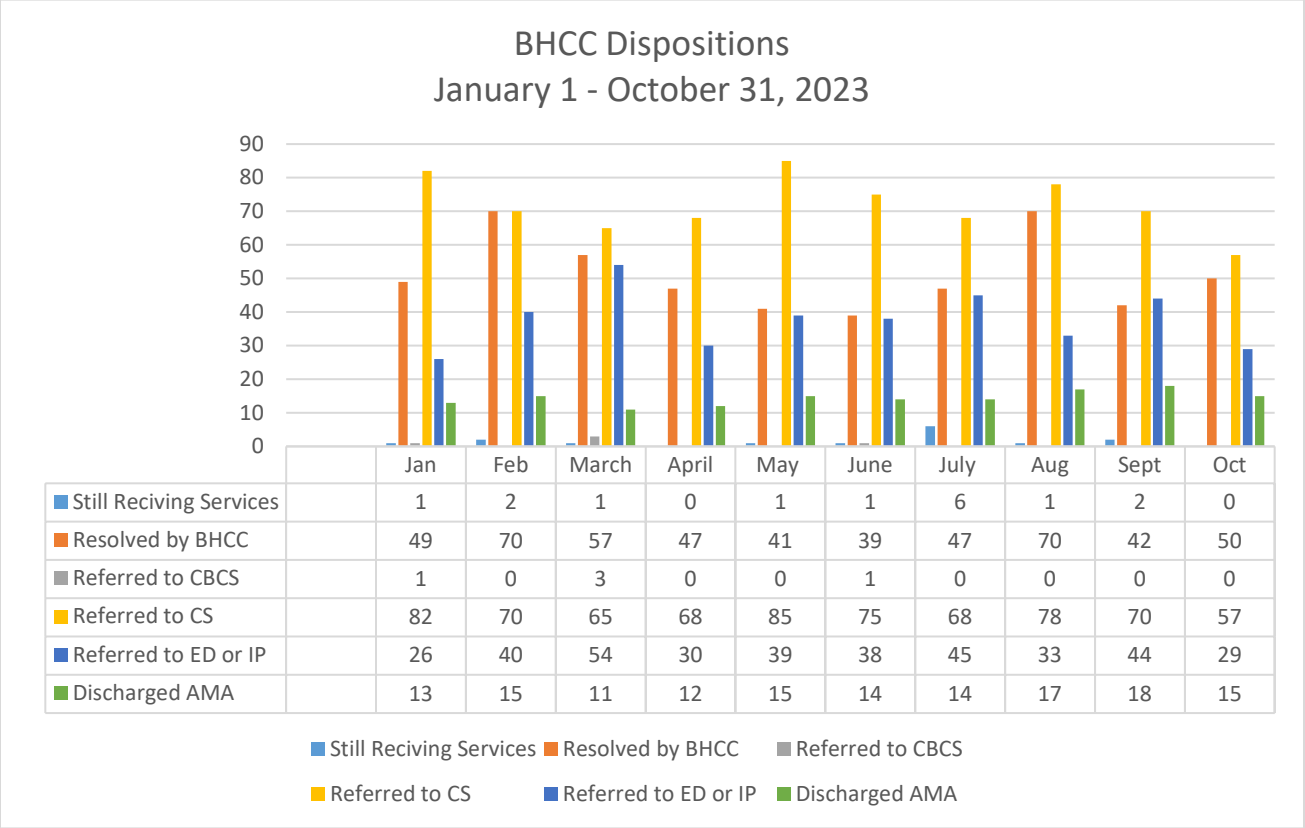


	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct
Region 1	0	0	0	0	0	1	0	0	0	0
Region 2	151	177	163	153	174	164	176	193	181	142
Region 3	9	12	22	13	12	12	12	15	10	10
Region 4	0	0	0	1	0	0	2	0	0	0
Region 7	2	0	0	0	0	0	0	0	0	0
Region 9	6	3	2	3	0	1	0	0	0	0
Region 10	6	12	10	9	12	6	5	13	5	16

The State reports 1,916 individuals have utilized BHCC services from January through October 2023. Utilization of BHCC continues to be greatest in Region 2, where BHCC efforts were in development for more than 18 months prior to implementation. The State reports Region 3 and 10 have provided a low, but relatively stable, volume of BHCC services. The SME has significant concerns regarding the implementation and utilization of BHCC. Similar to MCR, LDH is requiring MCOs and BHCC providers (many of whom also offer MCR) to take immediate steps as discussed in paragraph 64 to ensure the viability and sustainability of BHCC and other crisis services. Similar to MCR, no individuals who were transitioned or diverted from NFs received BHCC services. As indicated in paragraph 65, these individuals rarely presented at EDs for behavioral health issues.

LDH has also provided information regarding the disposition of individuals seeking BHCC services. Chart 11 provides disposition information for the time period January 1 through October 31, 2023.

Chart 11. BHCC Dispositions



	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct
Still Reciving Services	1	2	1	0	1	1	6	1	2	0
Resolved by BHCC	49	70	57	47	41	39	47	70	42	50
Referred to CBCS	1	0	3	0	0	1	0	0	0	0
Referred to CS	82	70	65	68	85	75	68	78	70	57
Referred to ED or IP	26	40	54	30	39	38	45	33	44	29
Discharged AMA	13	15	11	12	15	14	14	17	18	15

LDH reports 1,722 individuals were served by BHCC for the period from January 1 to October 31, 2023. As indicated in this chart, almost all individuals remained in the community. Approximately 29%, or 512 individuals, had their crisis resolved by the CS provider. Forty-one percent, or 723 individuals, were referred to other crisis services. However, 378, or 21% of all individuals, were referred to EDs or inpatient providers, which is considerably more than the 1% that were referred to inpatient services in CY 2022. The SME finds the use of against medical advice (AMA) pejorative. Crisis services are voluntary and therefore the disposition of AMA is inconsistent with the concept of voluntary nature of all behavioral health community services.

Similar to MCR dispositions, the state collects information for BHCC disposition by region. These resolved dispositions are the same as for MCR dispositions discussed in paragraph 65.

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. The State reports they review this data monthly and discuss it with MCOs and crisis providers during their meetings.
- Work with MCOs to ensure 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. The State has not reported on these efforts during this reporting period.

- 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). The State has not reported on these efforts during this reporting period.

The State reports that BHCC providers have performed various community outreach strategies that started in CY 2022 and continued during CY 2023. As discussed in paragraph 69, BHCC providers offered open house tours of their BHCCs and had representation on site at each of the open houses. LDH reports crisis agencies continue to use the LSU Regional Coalition Guide and other strategies in paragraph 68 to increase community engagement efforts by BHCCs and other crisis providers.

As of August 2022, the State began to implement Crisis Stabilization (CS) in various regions of the state. CS services are short-term, bed-based crisis treatment and support services for individuals who have received a lower level of crisis services and are at risk of hospitalization or institutionalization, including nursing home placement.

As indicated in paragraph 63, the State has developed, or is in the process of developing, CS capacity in three regions (2, 3, and 10). There are no CS providers in regions 1, 4, 5, 6, 7, or 8.

The SME requested and the State provided information regarding initial utilization of CS services. LDH only provided information from region 2, which has a long-standing CS service. The data below provides information on CS services for region 2 from January through October (only region that has current data).

Chart 12. Crisis Stabilization Utilization Data

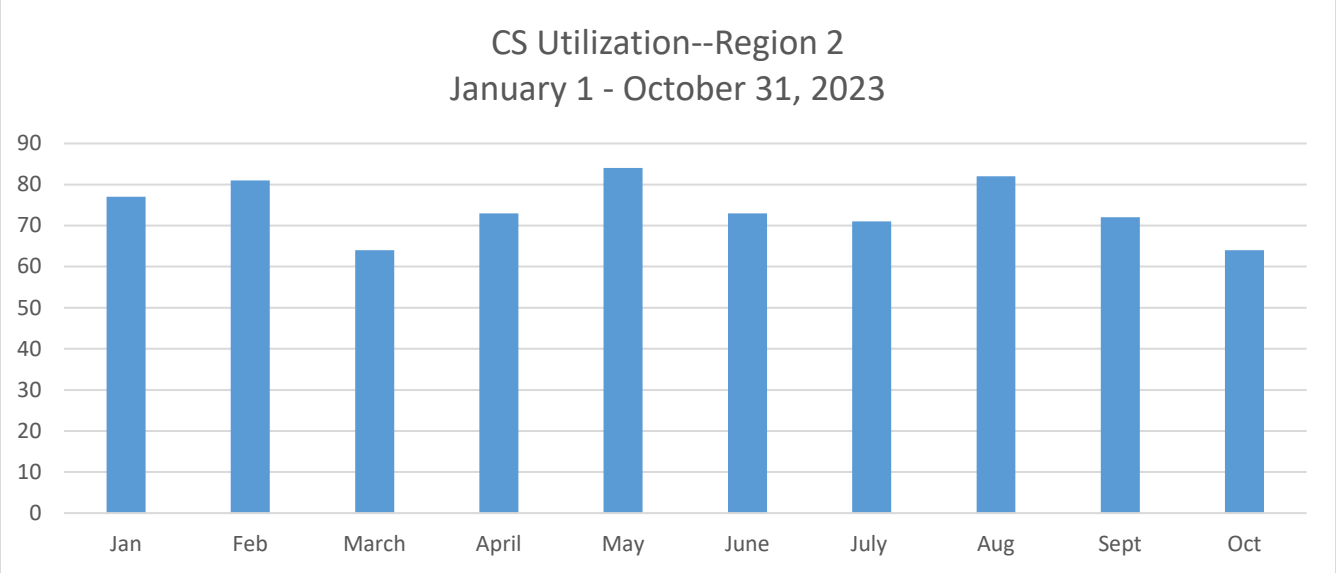
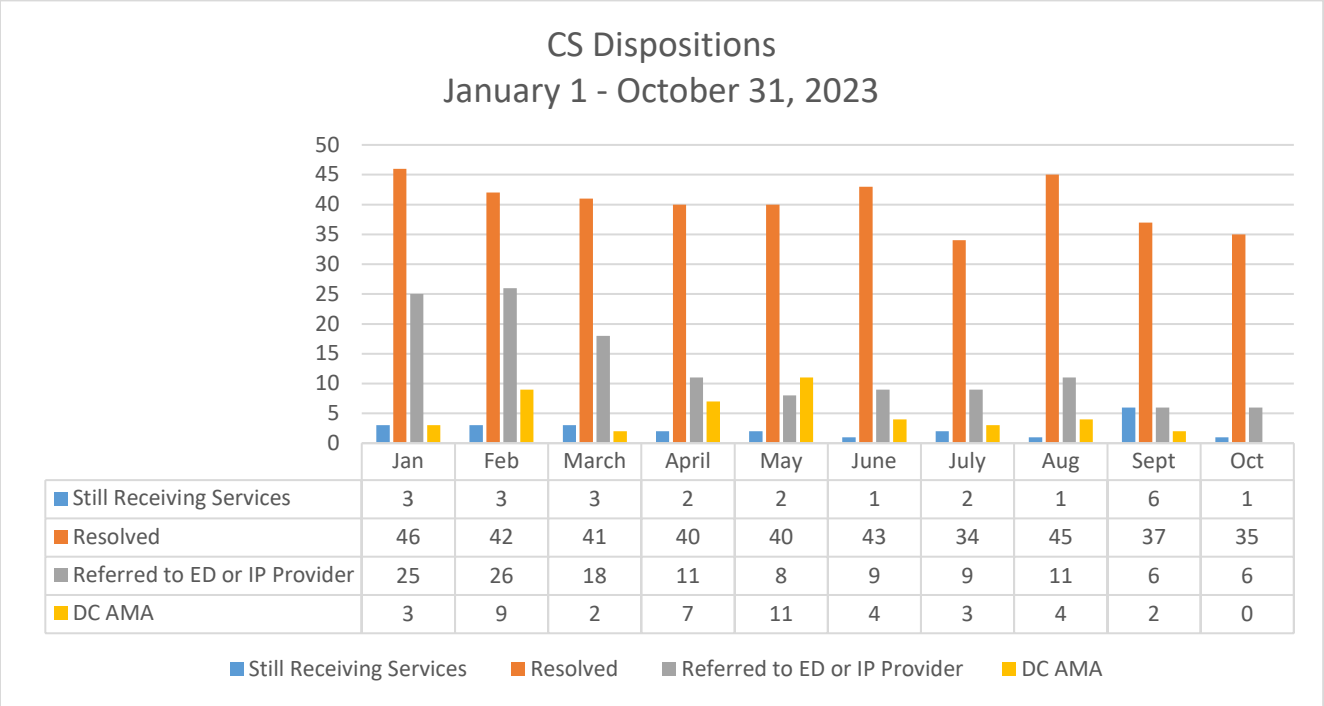


Chart 13 provides information regarding the dispositions post receiving crisis stabilization services.

Chart 13: Crisis Stabilization Dispositions



	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct
Still Receiving Services	3	3	3	2	2	1	2	1	6	1
Resolved	46	42	41	40	40	43	34	45	37	35
Referred to ED or IP Provider	25	26	18	11	8	9	9	11	6	6
DC AMA	3	9	2	7	11	4	3	4	2	0

Only one region is reporting CS utilization information and so these numbers are specific to one agency. CS services have been steadily available in the region. From January to March, there is a high percentage of referrals to ED/IP providers at discharge. Further exploration may be helpful to understand why this occurred.

The State reports that resolved dispositions are aggregated for this report but more detailed information regarding CS resolved dispositions (similar to MCR and BHCC) is available by region.

There continues to be low uptake of BHCC services and no utilization by individuals who have been diverted or transitioned from NFs. According to claims data from July 1 through September 30, no individuals who were transitioned or diverted received BHCC services during this reporting period. As discussed previously in this section, this may be a result of few individuals who have been transitioned or diverted experiencing a behavioral health crisis that precipitated an ED visit for behavioral health.

<u>Compliance Assessment</u>

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

- At the end of the reporting period, LDH has BHCC operability in four regions of the state with service implementation occurring in a fifth where MCOs have contracted with a BHCC provider to serve adults with Medicaid, including individuals in the Target Population.
- BHCCs submit reports on the number of individuals receiving BHCC crisis care.
- LDH continues to meet with MCOs and BHCC providers monthly to identify ongoing issues.
- There is currently only one CS provider (Region 2) that has reported utilization and dispatch data though services are being implemented in two other areas of the state (Regions 3 and 10).

- The State has the ability to provide information on dispositions that have been resolved for individuals discharged from BHCC and CS and has data that is available by region.

Recommendations

- LDH should continue to work with each BHCC to increase referrals, including outreach efforts to law enforcement and additional referral sources.
- LDH should continue efforts to identify providers to render BHCC, further ensuring MCOs contract with providers in the five regions without services.
- LDH/LSU should perform readiness reviews as BHCCs are opened.
- LDH should provide data regarding the utilization of CS from other regions in the next reporting period. In addition, provide information on why there are referrals to EDs/IP.
- LDH should ensure there is the necessary oversight structure to ensure CS services are offered consistent with the Agreement.
- LDH should develop and implement a strategy to identify additional investments for services and strategies discussed in this paragraph.
- LDH should request information from the crisis providers regarding the high percent of ED or inpatient behavioral health dispositions from both BHCC and CS and specifically understand:
    - What are the reasons for these increased dispositions?
    - Are referrals to ED/IP occurring at the point of intake or discharge?
    - Are these referrals planned or unplanned?
    - Ensure if a person is going to IP via ED (for example, for medical clearance), it should be classified as IP. If going to ED for a medical intervention or because needs exceeded the capabilities of the BHCC/CS, it should be classified as ED.
    - Did needs exceed capabilities of the program?
    - Did care become involuntary?
    - Was the reason for referral due to MH or SU related needs?
    - Gather referral-in data for BHCC and CS.
- LDH should provide more detailed information on "resolved" interventions that includes referral, linkage, and utilization of various community behavioral health services.
- LDH should remove the AMA language for these services.
- LDH should begin to evaluate post-BHCC/CS claims to understand what is happening "next" for individuals receiving these services. Specifically:
    - How does this compare to individuals who received an ED/inpatient service?
    - What services were used prior to readmission to ED or CS

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: Partially Met

Discussion and Analysis

The rating for this paragraph changed from Not Met to Partially Met.
In previous SME reports, this paragraph was rated based on service reviews and utilization of services by the Target Population. These reviews focused on the acumen of TCs and CCMs to identify if the individual had a need for and received SUD services. The CY 2023 Service Review identified an individual who was referred but could not receive withdrawal management services. While the latter is clearly an issue with the adequacy of the SUD network, the identification of the need and referral to SUD services is incumbent on the TC or CCM. For individuals receiving ACT, SUD needs should be identified by the ACT provider given these teams are required to have a staff member to address SUD needs or provide a referral to more intensive services (e.g., residential or inpatient withdrawal management). Therefore, the focus of this paragraph is the systemic availability of SUD providers and services. An ongoing service review indicating ongoing access issues to SUD services for individuals in the Target Population will impact the State's compliance rating.

As indicated in previous SME reports, LDH has implemented 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 second half of 2023 (July-December 2023) by the SME indicated that there were no network adequacy issues for the various SUD levels of care during this reporting period.

While this network reporting shows no immediate access issues in the system, it would be helpful for the State to provide information on SUD services similar to crisis services. This would include referrals, dispositions, and the percent of individuals who are either engaged in ongoing treatment or who return to higher levels of care (inpatient or residential services—ASAM 3.7) after discharge from these facilities. There are several measures LDH is required to report to CMS annually that are proxies for network adequacy and engagement of individuals in SUD care. These include:

- Follow-up after discharge from the emergency department for alcohol and other drug dependence (7 day and 30 day).
- Readmissions to inpatient hospitalization within 30 days of discharge.
- Initiation and engagement of alcohol and other drug dependence treatment; this includes initiation of treatment within 14 days of an SUD diagnosis and individuals who continued to receive at least two follow up visits within 34 days.

While these measures are not specific to the Target Population, it does provide a proxy for access and needed follow up for Medicaid enrolled individuals who need this service.

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

- LDH currently has an 1115 SUD Waiver that requires the State to offer all levels recommended by ASAM to Medicaid beneficiaries.
- LDH currently reports measures on network adequacy of services on a quarterly basis.
- LDH currently reports to CMS proxy measures that may support or refute current network adequacy reports. These measures include initiation and engagement into SUD treatment, follow -up after ED visits or inpatient hospitals, and re-use of intensive services shortly after discharge from these services.

Recommendations

- LDH should continue to report network adequacy of SUD services on a quarterly basis.
- LDH should provide information on critical SUD measures that would indicate or refute access issues for SUD services.
- LDH should track SUD-related needs, incidents, and mortalities for the TP through CCM reporting and mortality review.

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.

Compliance Rating: Partially Met

Discussion and Analysis

As indicated in the information in preceding crisis paragraphs and in terms of raw numbers, referrals from police to crisis providers remains low; however, in this reporting period referrals from 911 (29%) and law enforcement (2%) accounted for 31% of referrals and the highest volume referrer to MCR is coming from this important sector. LDH reports outreach efforts to law enforcement have continued to occur during this reporting period. As discussed in the eighth report, LDH, in conjunction with LSU, has created Regional Crisis Coalition meetings, which include regional crisis providers (of all services, including law enforcement, judges, EMS, and other local stakeholders). The State reports these collaboratives exist in various regions. The purpose of these collaboratives is to continue to have crisis agencies form relationships with law enforcement, EMS, judges, and police departments. The State reports there are several regions (1, 2, 3, 7, and 9) that have established crisis coalitions. The State reports they continue to work with regions and providers to develop or enhance local crisis coalitions. There are several issues that are consistently discussed across regions. A major issue focuses on the crisis services needs of individuals who are involuntarily committed to inpatient settings. The crisis system was intentionally designed to serve individuals who were seeking crisis services on a voluntary basis.

In addition, the State reports that one region's crisis coalition has focused on resolving issues identified at the individual versus the systemic level. LDH reports they are working with the coalition to shift to more systemic issue identification and problem solving. Another region's development of consistent agendas for their coalition is problematic and needs continued support from LDH.

In addition, LDH reports they are working with local hospital systems and crisis providers to provide information regarding local opportunities for collaboration. In addition, LDH reports they provide outreach to LGEs who are an additional source of referrals for crisis services and encourage them to participate in regional collaboratives. As indicated in paragraph 64, LDH has also worked with 988 and crisis providers to encourage direct dispatches from 988 to MCR providers.

LDH also reports they are developing a media campaign regarding crisis services that will include information regarding regional crisis services and the implementation of the Crisis Hub scheduled for implementation in CY 2024.

LDH reports there have been a number of efforts to engage system partners by crisis agencies, MCOs, and LDH. These strategies were discussed in paragraph 68.

The change has largely been driven by LDH, and not a broad, cross-sector consensus on the 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 contribute to very low numbers.

LDH reports they have developed a new data collection tool that allows the State, MCO, and providers to see how a person moves through the crisis system and all of the services they receive post crisis.

Lastly, LDH reports undertaking a series of LA-CRS specific regional meetings during the month of August. The purpose of the meetings was to support crisis providers in their efforts to engage critical stakeholders in their regional collaboratives, including law enforcement, EMS, local hospital systems, and other stakeholders. LDH reported they developed presentations that provided regionally specific data regarding:

- Behavioral health (including SUD) emergency department presentations for adults and youth
- Behavioral health (including SUD) inpatient hospital admissions for adults and youth
- Local calls to 988
- Utilization of each crisis service.

Compliance Assessment

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

- The State, in collaboration with crisis providers, has developed collaboratives in all regions, which include many of the parties in this paragraph.
- The regional crisis collaboratives exists in some regions, but not in all regions.
- The State reports they are developing a media campaign specific to crisis services to be implemented in CY 2024.
- The State reports they had in-person meetings in each region to support regional crisis collaboratives and provided utilization and other information specific to ED, inpatient, 988 calls, and utilization of crisis services.
- LDH reports they have developed a new data collection tool that allows the State, MCO, and providers to see how a person moves through the crisis system and all of the services they receive post crisis.
- Referrals from law enforcement to crisis providers remain low, but combined with 911, these diversionary referrals are increasing and this sector is now the highest volume referrer to MCR.
- The State, through existing regional collaboratives, has yet to identify systemic 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, EMS judges, and coroners to better encourage diversions and referrals to crisis services.
- LDH and LSU should collect information, document barriers, and address these barriers identified by regional collaboratives that impede engagement of individuals who are in contact with law enforcement.

- 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 liability issues or other barriers identified by law enforcement personnel.

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 reported initial performance metrics for the call center and crisis providers in CY 2022. The SME has reviewed these metrics and believes they 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:

Table 6: Metrics for MCO Calls Centers

	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Call Abandonment Rate	**7%**	**5%**	**5%**	**7%**	**7%**	**4%**	**3%**	**3%**	**7%**	**5%**
% of Calls Answered within 30 Seconds	**95%**	**97%**	**98%**	**98%**	**98%**	**97%**	**99%**	**98%**	**98%**	**98%**
% of Incoming Calls Answered	**93%**	**95%**	**95%**	**93%**	**93%**	**97%**	**97%**	**97%**	**93%**	**95%**

These ongoing metrics indicate that MCOs are continuing to answer calls within an accepted range.

In addition, as discussed in paragraph 64, the State and MCOs have developed and trained providers regarding the Crisis Care Coordination Protocols. These protocols convey expectations for coordinating across the continuum of crisis care, including the MCO crisis line, and will be updated to include information for the Crisis Hub once implemented.

LDH reports they have developed and posted information from each of the regional crisis meetings discussed in paragraph 65.

Compliance Assessment

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

- The State has implemented policies and procedures and implemented training for crisis call line staff and crisis providers.
- The State continues to report on measures for crisis lines. The State has yet to develop, collect, and analyze information for measuring other crisis services.
- The State continues their efforts to review MCO crisis lines against the established measures. The crisis lines continue to perform well.
- The State has developed protocols to standardize response by MCOs call centers to respond to crises.
- The State is working with MCOs and crisis providers on initiatives that promote 24/7 access.
- The State has developed and posted some reports regarding the need for and utilization of crisis services by region.

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 continue to identify and address performance issues for crisis line staff until the new hub is implemented, through biweekly meetings with crisis providers.
- LDH should develop and implement measures for other crisis services. Once implemented the State should develop benchmarks or trends for each service by which to review crisis provider performance.
- LDH should review the current measures and determine if new measures should be added. At a minimum, this should include measures that identify if and what services individuals receive 7 and 30 days post receipt of crisis services.
- LDH should continue to identify and implement further enhancements if determined necessary.
- LDH should continue efforts to provide performance data so that all MCOs and all crisis agencies see the performance numbers for all parties.
- LDH should continue efforts to disseminate public facing reports.

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

Paragraphs 70-72 are addressed together. As of December 2023, the State continues to report 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 2023 who received ACT. During the third reporting period of CY 2023, LDH reports 146, or 36%, of individuals transitioned from NFs utilize ACT. This is 21% more individuals receiving ACT than the same period during CY 2022.

The State reports that 22 individuals, or 20%, of the diverted population are engaged in ACT. For the same reporting period in CY 2022, two individuals who were diverted utilized ACT. As a reference, the 2022 Needs Assessment indicated that approximately 26% of individuals transitioned from NF received ACT and 17% percent of individuals diverted from nursing facilities received ACT.

The SME requested information on whether any individuals who requested ACT did not receive this service. The best proxy for this information is the number of individuals requesting but not receiving authorization from the MCO to receive ACT. During this period, LDH reports 94% of all requests for ACT have been approved.

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 from May through November 2023 did focus on what services individuals indicated they needed and were receiving to successfully remain in the community. This included a review of the individuals' service utilization, other record reviews, and interviews. During this review, there was a high proportion of individuals whose community plan included and who were receiving ACT. Specifically, 19 of the 39 individuals (49%) that were transitioned or diverted in the sample were receiving ACT. Six of the 8 (75%) individuals diverted and 13 of the 31 (42%) individuals transitioned received ACT. As indicated in these preliminary reviews, ACT team members engage with individuals in the 60 days prior to transition and participate in team discharge meetings coordinated by the TC.

Given the transition projections for CY 2024, approximately 119 individuals (based on 36% of individuals currently receiving ACT) who transition from NFs may need ACT services (assuming 331 individuals will be transitioned from nursing facilities and 122 individuals will be diverted by December 31, 2024). This is based on the percent of individuals who transitioned during FY 2023 and received ACT (42%). The 2023 SME Service Review found many individuals who were diverted and reviewed continued to have acute behavioral health needs. Several were referred directly from inpatient behavioral health units to NFs. These individuals were found to meet NF LOC but the PASRR Level II evaluator recommended community placement. The SME recommended LDH consider offering ACT immediately to these individuals. The

immediate presence of an ACT would support the CCM's efforts to additionally stabilize the individual and prevent an inpatient readmission. The SME has discussed this approach with LDH in 2023 and was informed by the State that CCMs immediately offer ACT to individuals diverted after the PASRR Level II process recommends community tenure versus NF admissions. The SME is encouraged by this decision given the complex needs of individuals who are diverted from NFs. Further information is needed to determine the length of time for individuals who are diverted between engagement with the CCM and engagement with ACT.

In the sixth report, the SME reviewed Louisiana's level of care requirements for ACT against similar requirements in other jurisdictions. LDH has 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 six managed care entities to revise the ACT Service Definition. The state continues to facilitate a subgroup of the MCOs to address ACT in particular, and to address the stepdown. The MCO team is also providing ACT providers with continued instruction of how to complete and use the outcomes data system referenced later in this paragraph. LDH reports they continue to have in person meetings with the ACT teams on a monthly if not more frequent basis. The representative from the SME has raised the need for 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 all ACT teams in CY 2023. The SME requested and received aggregate information regarding the results of these reviews. Information provided by LDH indicates all teams are operating within acceptable fidelity ranges. Eight of the 45 teams (18%) are operating with exceptional practice.

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. As indicated in the eighth report, the State updated the ACT service definition and requires each ACT team to provide Individual Placement Supports (IPS). During this reporting period, the State reports they have provided IPS training for each of the ACT employment specialists and will continue to provide refresher trainings through May 2024. The State is also requiring all ACT providers, as a condition of participation in MCO networks, to offer IPS. It was previously reported that the State adjusted the ACT rate to incentive teams to ensure that ACT employment specialists are well versed to provide IPS. The State reports they are also finalizing plans to determine how IPS fidelity reviews will be incorporated into the current ACT fidelity review tool (Dartmouth Assertive Community Treatment instrument) and process. The State reports they will implement these IPS fidelity reviews during the next reporting period.

In the eighth report, the SME recommended and the state performed on-site reviews of ACT teams in several regions. The State continues to meet with all ACT teams on a monthly basis (with the MCOs) and reports providing technical assistance to several teams regarding issues related to implementing IPS. LDH has not performed on-site reviews during CY 2023. They reported most of their efforts were finalizing policies and providing coaching and technical assistance regarding IPS to teams collectively and individually.

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). MCOs continue to collect data to review the performance of each ACT Team. This information is entered into the ACT Outcomes System. As discussed above, the MCO provides technical assistance to ACT providers if they request assistance with the ACT Outcome System. MCOs continue to report aggregate data regarding these outcomes semi-annually to the LDH. The SME has reviewed these rolled up outcome reports and outcomes are generally consistent with national trends for ACT. Based on this information, LDH and MCOs include quality improvement strategies in their monthly agendas with ACT providers.

Finally, the increase in the number of individuals diverted from NFs and receiving ACT is encouraging. However, as discussed throughout this report, LDH should monitor whether these individuals are offered and receive ACT at the time of diversion.

Compliance Assessment

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

- The State reports they continue to have a sufficient number of ACT team providers statewide to serve individuals who are transitioned or diverted from NFs.
- The percent of individuals transitioned from NFs who receive ACT is 36% and exceeds the projected penetration from the 2021 Needs Assessment.
- There has been a significant increase in utilization of ACT by diverted individuals in the third quarter of 2023 compared to the third quarter of 2022. The SME would expect continued increase as LDH implements policies to offer ACT to all individuals who are diverted from NFs.
- LDH has agreed to develop policies and protocols for referring individuals diverted through the PASRR Level II process to ACT immediately post evaluation.
- The percent of individuals reviewed by the SME and who were receiving ACT during the CY 2023 service reviews continues to increase. Almost one half of the individuals diverted or transitioned were receiving ACT.
- For individuals transitioned from NFs, ACT teams are included in discharge planning meetings coordinated by the TC.
- Ongoing ACT fidelity reviews are conducted by an independent national organization. Information provided by LDH indicates all teams are operating within acceptable fidelity ranges. Eight of the 45 teams (18%) are operating with exceptional practice.
- MCO collects and reports to LDH outcomes associated with ACT and has included discussion for improving performance in monthly meetings with LDH and the MCOs.
- MCOs and LDH have continued in-person meetings with ACT teams to review outcome information and address issues identified by this data.
- The State has revised the service definition and clarified stepdown criteria for ACT.
- LDH has embedded IPS into ACT and requires that each ACT team provide IPS as a condition of their contract with MCOs.
- LDH has developed a process for including fidelity reviews for IPS into the Dartmouth Assertive Community Treatment Scale.

Recommendations

- LDH should continue to perform fidelity reviews of ACT including a review of their efforts to implement IPS.

- LDH should continue to develop strategies to address the findings from future recent fidelity reviews.
- LDH should ensure that ACT is offered to all individuals who are diverted through the PASRR Level II evaluation process in a timely process. LDH should review the length of time between CCM and ACT engagement to determine if ACT teams are meeting the needs of individuals transitioned or diverted from NF on a timely basis as intended by LDH.
- LDH should monitor if ACT is being offered to individuals at diversion.
- LDH should 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 stepdown 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 (IOP)
- Ambulatory Withdrawal Management with Extended On-Site Monitoring (WM)

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 2022 and first two quarters of CY 2023, there continue to be no obvious access issues for all but one Intensive Community Support Services—Peer Support. The number of Community Psychiatric Support and Treatment (CPST) providers generally remained the same in the third quarter of CY 2023 (356) as compared to the second quarter the previous calendar year (360). The number of PSR providers (338) remained generally the same for the third quarter of CY 2023 compared to the second

quarter of CY 2022 (335). 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 has developed a more tailored strategy.

Similar to ACT, the 2021 Needs Assessment reviewed the demand for ICSS services by members of the Target Population who are transitioned or diverted from NFs. Information from LDH for this reporting period indicates that approximately 12% of individuals who were transitioned received other ICSS services (CPST and PSR). The needs assessment identified that approximately 57% of individuals who were transitioned received other ICSS services (CPST and PSR). No individuals diverted from NFs received these services during the third quarter of CY 2023. The Needs Assessment indicated 14% of all individuals diverted used these services. The SME is concerned regarding the low utilization of these services.

Using information from these two data points, approximately 200 additional individuals may need CPST or PSR during CY2024 (assuming, 331 individuals will be transitioned from nursing facilities and 122 individuals will be diverted by December 31, 2024). 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.

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.

The SME reviewed the current process MCOs use to make decisions regarding providers of ICSS services. Current policies require managed care organizations (MCOs) to ensure contracted providers meet minimum qualification requirements including LDH specific licensure and certification requirements. For instance:

- All providers of Medicaid reimbursed crisis, CPST, PSR, IPS, IOP and SUD Withdrawal Management (WM) services must be licensed by LDH Health Standards as a Behavioral Health Service provider (BHSP) and be accredited by a national accreditation organization include the Commission on Rehabilitation Facilities, The Joint Commission, or The Council on Accreditation.
- All providers of peer support services (limited to LGE and PSH providers) must be licensed as a BHSP provider.
- Personal Care Services providers must be licensed by LDH as a Home and Community Based Service provider/Personal Care Attendant agency.

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. The SME recommended LDH review why utilization of these services was low. The State has not performed that analysis.

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 is 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 continue to be over 400 providers of MHR services throughout the State. The State has made changes to the MHR program which focus on all organizations providing ACT to offer IPS (as discussed in paragraphs 71 and 72.) As indicated in paragraph 73, there are 356 CPST and 338 PSR providers (some who provide both). There has 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 this reporting periods that spanned January 2020 through December 2023, there were very few closures of agencies providing MHR services specific to pandemic issues.

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 has made changes to the MHR to include IPS delivered by ACT teams.

Recommendation

- LDH should continue to track the provider network offering MHR services to ensure its ongoing availability.

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: Met

Discussion and Analysis

This paragraph went from Partially Met to Met. 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. The State reports they are making changes to the provider type offering this service and has received approval from CMS to make this change. In addition, the State obtained the appropriate authority from CMS (e.g., through a 1915(b)(3) Waiver) for Personal Care Services in the sixth reporting period for individuals who were not eligible for the 1915c Waivers or the State personal care services offered through the Medicaid State Plan. The State reports the MCOs have enrolled 123 providers as of December 2023, almost 400% more providers than CY 2022 (37 PCA providers). The State reports that 23 individuals transitioned or diverted from NFs have received this new personal care service. Almost 190 individuals have received PCA services through existing Medicaid Waiver programs.

Compliance Assessment

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

- The State has legacy Medicaid State Plan services that offer assistance to improve IADLs (CPST, PSR, and ACT).
- The State has received approval from CMS to include personal care services in their 1915(b) Waiver for individuals who do not qualify for personal care services offered under the 1915c or 1905(a) State Plan Services.
- LDH has included peer support services in their Medicaid State Plan that can also address IADLs and has obtained the approval from CMS to make changes regarding the provider type to offer peer supports.

Recommendations

- LDH should continue to determine if additional Medicaid services are needed for individuals in the Target Population who have transitioned or been diverted from NFs and, if necessary, seek approval from CMS to include these services.
- LDH should develop strategies for addressing imminent ADL needs of individuals who are diverted.

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 continued to not perform 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 including developing strategies and implementation strategies during this reporting period.

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 processes 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 in the next reporting period. All strategies should be implemented by June 30, 2024.

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 are 487 actively recognized (certified) peer support specialists in Louisiana. This is a 62% increase in certified peers since the eighth reporting period. 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 various crisis services discussed above. In addition, the State reports they have trained 68 individuals to become peer support specialists during this reporting period and trained 1,091 individuals overall. The State reports that many individuals choose not to become certified after receiving this training.

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 have executed a contract for various activities that will support peer credentialling and tracking of current peer employment information, including the delivery of services and supports referenced in this paragraph. The State shared the data collection instrument with the SME team this reporting period and provided suggested changes which were incorporated into the data collection tool. The contractor has developed a digital platform for the State to collect information regarding the current peer workforce. LDH reports approximately 50% of peer specialists have provided information into this platform. LDH reports that reminders have been sent out to certified peer specialists to provide information for the platform. Information collected by the

contractor will allow LDH to determine the number of peers that are providing services set forth in sections VI A-C. The State anticipates this information will be available later in CY 2024.

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. LDH has shared anecdotal information regarding the impact of this legislation. Several agencies have requested technical assistance from LDH to operationalize internal policies to allow certain individuals to be exempted from previous criminal background requirements. In addition, other providers have reported they have been able to hire individuals to fill peer positions that they had previously been able to fill due to this legislative change.

In addition, as indicated in several paragraphs, the service reviews identified that many individuals who were transitioned or 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 a meaningful interaction with the individual and assist 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 reports they have 487 peer specialists for CY 2023. This is a 62% increase from CY 2022.
- The State allows, but does not require, peer support specialists to provide services in A-C of this Agreement.
- The State is in the process of tracking the number of peer support specialists who provide services in Section A-C of this Agreement.
- The State has trained over 1,000 individuals in peer support. However, less than 50% have become a certified peer support specialist.
- The State reports anecdotal information regarding the impact of recent legislation that eases background check for agencies seeking to hire peers with certain criminal offenses.

Recommendation

- LDH should finalize collection of information regarding the number of peers employed by MHR programs.
- The State should continue to identify barriers to recruiting and employing peers given 50% of individuals trained do not seek certification.
- 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 includes 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 the ninth reporting period, they focused on enhancing the acumen of ACT teams providing IPS. This includes revisions to the ACT service definition and reimbursement methodology to message and incentivize ACT teams to offer IPS. The State has trained ACT teams in IPS and requires all ACT teams to provide IPS (as part of their contract with MCOs). The State reports ACT teams are all trained and are beginning to provide IPS during this reporting period. The State reports they are tracking the number of ACT service recipients who are employed on a monthly basis but do not yet have initial data regarding the number of individuals receiving IPS from ACT teams, given the status of implementation.

As indicated in the ninth report, the State participates in the federal Department of Labor, Office 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. A goal for LDH's participation in the ASPIRE program is to ensure the TP will receive IPS Medicaid services and Louisiana Rehabilitation Services (LRS). Another 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. LDH has contracted with a consultant to provide specific strategies for individuals with serious mental illness to access services offered by Louisiana Rehabilitation Services (LRS). The consultant is assisting the State to create an expedited supported employment referral process between LRS and LGEs. This consultant is to assist with policy changes that will promote employment throughout the mental health treatment process at LGEs and assist the State to develop braided or sequential funding for IPS services. The State reports that one of the consultant's initial efforts was to train LGEs and CCMs regarding opportunities offered by LRS for individuals served by individuals in the TP. This training occurred early this reporting period.

The State has consulted with the national IPS Employment Center, the creators of IPS, to build an infrastructure to provide IPS services. The IPS Employment Center has provided consultation to OBH staff

regarding IPS. The State also reports the national IPS Employment Center is providing consultation to ACT teams on a monthly basis.

Despite these activities, the Department has not created the necessary demand for these services for individuals in the Target Population. In the eighth SME report, LDH 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, but many individuals who want to work do not have the supports in place to achieve that goal.

As of this report, three individuals in the Target Population transitioned or diverted from NF in the area served by the Capital Area Human Service District LGE are receiving IPS. There were no additional referrals during this reporting period. 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.

As indicated in the ninth report, OBH 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 who may not need the intensity of IPS. LDH has requested training for MHR providers regarding this guidance to offer employment supported for individuals with SMI receiving CPST and PSR, including the Target Population. This training is scheduled for the next reporting period.

In previous reports, the SME recommended that additional services or supports be available to the Target Population for identifying integrated day options during the NFTA and ITP process. The State gathered information to identify drop-in/low-demand social settings that could provide support and engagement to individuals transitioning from NFs. Information from the surveys was added to the resource guide for the Transition Coordinators. While this is an important step, the service review team has indicated CCMs may be in a better position to assess, identify, refer, and link individuals to options in the community post discharge. The service review team's recommendation takes into account several issues:

- Individuals in NFs, while indicating interests and hobbies during the NFTA, often change interests post-transition.
- Activities that are initiated during the initial month (s) post transition focus on more basic needs including securing nutritional and income supports (ensuring individuals are receiving SSI/SSDI) and establishing relationships with primary care, personal care providers, and pharmacies for ongoing medications.
- Referral sources such as LRS, council on aging, and other community organizations generally require the individual be living in the community and suggest waiting to post transition to make the referral.

LDH should ensure that CCMs (or ACT teams for individuals enrolled in ACT) during initial planning activities with the individual obtain information regarding interests, identify possible local organizations that may offer formal and informal activities to address these interests, and offer individuals referrals to these organizations. In addition, CCMs (or ACT teams) should identify transportation options for individuals to attend these activities.

In the eighth report, the State reported they have outreached drop-in centers to determine if they are still operational during the waning of the pandemic. The State continues to report all drop-in centers are operational. The State reports they have met with these drop-in centers to provide information regarding efforts in other states to modernize their approaches and offer activities that will enhance individuals' overall wellness. The State reports they will continue this effort during CY 2024.

Compliance Assessment

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

- The State has undertaken important steps to identify and develop integrated opportunities for individuals during the day, with a focus on IPS. However, few individuals are participating in these opportunities.
- The State reports IPS was integrated into ACT teams in October of 2023. IPS is now available to all individuals receiving ACT, including individuals transitioned or diverted from NFs.
- The State has contracted with a technical assistance vendor to assist with developing pathways for individuals to access LRS services.
- The State has provided information to LGEs and CCMs regarding the referral process to LRS for individuals who express an interest in working.
- The State has released guidance for MHR agencies to offer employment supports and has indicated they will provide training to these agencies on how to best use Medicaid for employment supports.
- The TCs have enhanced efforts to identify individuals who express an interest in working during the transition assessment process.
- The SME Service Review Team has identified CCMs (and ACT providers for individuals engaged with ACT) may be in the best position to identify, refer, and link individuals to activities that match their interests in the early months post transition and diversion.
- There have been no referrals of individuals in TP to IPS this reporting period.
- LGEs have received limited training or technical assistance to launch IPS. The State reports only one LGE, Capital Area Human Service District, has received in-person IPS and job development training. This LGE received ongoing technical assistance from OBH on a monthly basis.
- The State has provided information to drop-in centers regarding approaches to improve the wellness of individuals who participate in their programs. However, it is unclear whether this information sharing has impacted referrals of individuals who have been transitioned or diverted.
- The State will continue to participate in the federal ASPIRE initiative to develop access to IPS services for individuals in the TP.

Recommendations

- LDH should continue to 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 implement the training regarding the recently released guidance for MHR agencies on supported employment.
- LDH should track whether CCMs are initiating referrals to LRS and IPS.
- LDH should track the number of individuals transitioned or diverted from NFs who are working (paid and volunteer employment).

- LDH should train the CCMs and ACT team to identify, refer, and link individuals with integrated activities in the community within the first month(s) of transition.
- LDH continue to provide information on wellness approaches to drop-in centers. And assess whether these efforts have changed approaches by these organizations to offer wellness services.
- The State should develop a formal strategy for supporting drop in centers to engage individuals in the TP.

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. Initially, only LGEs could offer this service. The State has revised policies to allow other providers, specifically agencies that provide Permanent Supportive Housing through the MHR program, to offer this service. The State continues to report one LGE is implementing this service. Two other LGEs have expressed an interest in offering free standing support services. LDH continues to meet monthly with LGEs to discuss barriers and strategies to offer these services. In addition, LDH has surveyed the PSH MHR providers regarding their interest in providing peer services. They have also included PSH providers that have expressed interest in offering peer services in their monthly meetings. LDH does report that all organizations offering ACT have peer support specialists on their teams.

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 there was no utilization of this service by individuals who were transitioned or diverted during this reporting period. 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 to address feelings of loneliness and offer strategies for better community inclusion with individuals during the review. Individuals interviewed through the service review expressed interest in this service.

Based on conversations with LGEs and PSH MHR providers, LDH is creating incentive payments for these two provider types to offer peer support services. This includes funding initially for start-up activities to

deliver peer support services. In addition, LGE and PSH providers that offer peer support services will receive an incentive payment six months after they implement their peer support program. LDH reports their intention is to address some of the concerns that have been raised over the past two years regarding supports needed for implementing this program. LDH reports they are intending to implement these strategies in CY 2024.

Compliance Assessment

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

- There continues to be no significant implementation of a separate peer support service. The lack of utilization of these services over the past two years is discouraging.
- There have been few referrals to LGEs and no utilization of stand-alone peer support services for individuals in the Target Population diverted or transitioned from NFs.
- 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 developed, but has yet to implement, a strategy to add more LGEs and have organizations that offer PSH to Medicaid recipients offer peer support to Target Population and other Medicaid beneficiaries.

Recommendation

- LDH should implement the strategy to increase LGEs' and PSH providers' capacity to offer peer support services. LDH should track the impact this change has on the number of agencies (LGEs and PSH providers) offering this service in CY 2024.
- LDH should review ACT teams serving the TP diverted or transitioned from NFs to include peer support services in ACT-specific plans and offer peer services with some frequency to address issues with loneliness and community inclusion.
- LDH should provide information to TCs and CCMs regarding the availability of peer support services provided by LGEs and PSH providers in their area. The goal of this strategy is to provide peer supports to individuals who have transitioned or diverted and who may not be receiving ACT.

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.[1] The plan identified development of housing and non-development strategies (e.g., vouchers). The plan also

[1] 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 indicate in the seventh report, the State has revised its housing plan through CY 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 included in the original plan. In addition, the State proposed to collect and analyze 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 opportunities. As reported in paragraph 81, this data collection and analysis has not occurred. While it is important to have this plan, it will be important to track progress against this plan frequently (as discussed in paragraph 81). The State posted the revised housing plan for stakeholders during this reporting period.

Compliance Assessment

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

- LDH has revised and posted 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.

Recommendations

- The State should continue to meet with LHC to ensure federal housing resources are leveraged for the Target Population.

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: Not Met

Discussion and Analysis

The paragraph went from Partially Met to Not Met. Over the past five and one-half years, the State has transitioned 597 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 63% will need assistance with housing. The percent of individuals who were diverted during CY 2023 and needed housing assistance was not available for this report.

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 as the use of vouchers to secure housing. Examples of funding sources for non-development opportunities include Section 8 or non-elderly disabled vouchers.

In the eighth report, the SME recommended the State track 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 not provided the SME with information regarding these tracking efforts.

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 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.

LDH stated they would track the progress of implementing the housing plan on a quarterly basis. This would allow the State to identify any significant differences between housing opportunities created, offered, and used. LDH was also to provide clarity regarding the methodology used for tracking to ensure these opportunities are tracked correctly. As indicated above, the SME was not provided information regarding LDH's tracking efforts, including quarterly progress toward meeting the opportunities identified in the housing plan or the methodology used to track this progress.

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 three years (CY 2023 through CY 2025). As discussed in the eighth report, LDH reviewed the number of housing opportunities that became available due to turnover in the overall state regulated housing programs that could be repurposed for the Target Population. The State projected 336 new opportunities will be offered to the Target Population due to turnover. However, these numbers are currently being revised to reflect more recent activity by LDH and LHC.

It should be noted that OAAS and LHC continue to meet monthly 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 determine the feasibility of 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).

LDH has worked closely with LHC to ensure it has met its required goals of ensuring 40 individuals in TP use tenant based vouchers (TBVs). Specifically, LDH tracked the following information:

- Number of individuals on Active Caseload who need housing, have not submitted an application, and are awaiting documentation for housing application
- Number of individuals on Active Caseload with a new admissions packet that has been submitted to LHC
- Number of vouchers issued (based on item b)
- Number of individuals from item b that are actively searching for housing
- Number of individuals from item b that have found a unit and awaiting inspection
- Number of individuals from item b that have found a unit and waiting on a completed Request For Tenancy Approval/HAP execution
- Number of individuals with a leased unit

In addition, LDH reports they have added $800,000 to the state's rental assistance program during CY 2023. This has allowed additional individuals to receive housing or housing supports.

The CY 2023 Service Review identified the lack of affordable accessible housing for individuals transitioning (or in some instances transitioned from NFs). The SME understands the challenges LDH and LHC face in creating physically accessible housing. The SME recognizes LDH and LHC have incentivized developers to create more physically accessible units through various procurement and contracting processes. However, the lack of these opportunities in most areas of the State is causing "bottlenecks" for referrals out of NFs.

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 begun to revise the housing plan as recommended to ensure opportunities were not counted multiple times.
- The State has not developed a process to track opportunities created, offered, and used by the Target Population, including individuals diverted from NFs. Therefore, it is not possible for LDH to determine if they met the stated goals set out in their revised plan.
- The State has not created a tracking methodology to ensure opportunities are not duplicated in an effort to meet their housing goal.
- The State did meet its goal for CY 2023 regarding the number of TBVs.
- The State has yet to report on the percent of individuals who transition and need housing.
- There is a lack of accessible housing for individuals who want to transition from NFs or may need accessible housing soon after they transition.

Recommendations

- The State should complete the revision to the housing plan to more accurately project the number of housing opportunities that will be developed and offered to the My Choice population.
- The State should 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.
- LDH should provide a clear methodology for how the State tracks the progress toward the implementation of the revised housing plan.
- LDH and LHC should meet with developers and property managers at least 60 days before a project is completed to provide specific information regarding the number of accessible units needed. That will require that LDH have up to date information on a regional and subregional basis regarding the needs of individuals awaiting transition who will need physically accessible units.
- LDH should report the percent of individuals who are diverted and need housing at diversion and during the 12 month period they are engaged with CCM.
- The State should also report the number of individuals served with additional findings from OAAS for the My Choice Program.

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: Met

Discussion and Analysis

This paragraph went from Partially Met to Met. Existing federal and state policy allows individuals to voluntarily receive tenancy supports. The current Louisiana Permanent Supportive Housing program is a cross-disability housing and services program that links affordable rental housing with voluntary, flexible, and individualized community-based services to assist people with severe and complex disabilities to live successfully in the community. Individuals cannot be rejected due to the conditions set forth in this paragraph. As indicated in paragraph 81, the State has created and increased the capacity of the Rental Assistance 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). The State has developed an approach to housing for individuals in the Target Population that is integrated and in scattered sites.

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 LDH revised housing plan only offer development and non-development strategies for units that are integrated and in scattered sites.

Recommendations

- LDH should track and report the creation of housing opportunities developed and offered are 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 reports they continue to employ eight TSMs to provide statewide coverage to assist members of the Target Population transitioning from NFs. 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 continues to believe 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.

Table 7. TSM Activities

Calendar Year	2018/19	2020	2021	2022	2023
Number of individuals receiving services from TSM	88	27	72	71	68
Type of Assistance					
Rental Assistance with Rental Assistance Program	74	18	40	64	54
Rental Assistance with NED Vouchers	14	9	32	7	5

The State reports they seek to employ TSMs who have relevant experience with federally funded housing programs and landlord recruitment and relationships. LDH reports they have three new TSMs during FY 2023. Of the three new TSMs, LDH reports:

- One individual was a TC for the past two years and has experience with the Target Population
- Two 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 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 has not 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 their 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 68 individuals in the Target Population during this reporting period who are seeking housing assistance, or approximately 39% 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 needed the TSMs to preserve housing and reasons for that.
- LDH should include TSMs in LDH or LSU developed training for crisis services.

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 2024.

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. Information from the ITPs should identify who needs these supports and TCs should report whether these supports were provided at transition.

In addition, recent conversations with LDH and LHC has indicated that other federal and state programs may be more relevant for the My Choice Population. HOME is a short term rental assistance program and most individuals in the Target Population who have been transitioned or diverted need longer term and sustainability sources for housing.

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 that they fund various housing related expenses.
- The State committed to using HOME TBRA for security and utility deposits for CY 2023. Information regarding the use of HOME TBRA was not available during this report.
- LDH and LHC are continuing to explore the feasibility of the HOME program for the Target Population given these individuals need longer term supports than what HOME may be able to provide.

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.
- LDH and LHC should continue to explore the feasibility of the HOME program for the Target Population.

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. In addition, the State adjusted payments for critical HCBS services (e.g., personal care services) using federal ARPA funds.

As indicated in paragraph 75, the SME recommends LDH identify if new services are needed by the Target Population and the Medicaid authority the State will need to pursue or if these changes can be made using the existing services offered through the State's Medicaid program.

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.
- The Department has provided funding to providers of new crisis services to ensure their sustainability during the initial start-up period.

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.
- Identify the impact ARPA funds had on ensuring access to needed services, especially to support providers that address ADLs and IADLs.

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. 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 outreach plan. However, LDH reports they:

- Have standing meetings with the Louisiana Hospital Association. A major topic of discussion was to inform hospital social workers regarding community services and appropriate NF referrals for individuals with SMI.
- Continue to meet with the Louisiana Nursing Home Association regarding the My Choice Program and the role of TCS and PIRs in performing various functions including in-reach, NFTAs, and ITPs. They have also discussed the implementation of the RITC pilot schedule to be implemented in early 2024.
- Continue to meet with the Louisiana Enhancing Aging with Dignity Through Empowerment and Respect (LEADER) who advocates on behalf of individuals in NFs. Many of LEADER's members are not LNHA members. These meetings are intended to provide information to LEADER's members about the Agreement and address any identified issues.

- Continue to meet with local law enforcement, EMS, and coroners' offices as discussed in paragraph 68 as well as regional townhall meetings conducted during the reporting period specific to crisis services as reported in paragraph 65.
- As discussed in paragraph 88, the State reports meeting with Statewide organizations, including the Statewide Judges and Public Defenders Associations.

The State continues to have bi-monthly meetings of the My Choice Advisory Committee. 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.

The State continues to meet with the crisis subcommittee and has recently convened the quality resource subcommittee. The State did not meet with several subcommittees, or resource groups, within the My Choice Advisory Committee to provide input on key areas, including 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 such as reviewing changes to PASRR Level II instruments and reviewing the community assessment and CPOC forms for potential changes for the CCM program. The State has not restarted efforts regarding subcommittees on community service development or community transitions.

The SME recommended in the previous report that the State convene and meet with the Community Service Development Subcommittee 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. LDH's efforts to restart internal and external quality assurance committees and subcommittees and the activities of the TSC should be a major input for quality assurance efforts. 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. It should be noted the State posted the SME report for the period January 1, 2023-June 30, 2023, in December 2023.

<u>Compliance Assessment</u>

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

- The State developed and implemented the initial outreach plan developed in CY 2018. LDH did not revise the outreach plan as recommended by the SME.

- LDH convened the My Choice Advisory Committee and the My Choice Quality Resource and Crisis Subcommittees this reporting period but no other subcommittees who could provide valuable input into products and processes developed for the My Choice Program.
- LDH continues to meet with some stakeholders on an ongoing basis regarding the My Choice Program, including the Louisiana Hospital Association, the Louisiana Nursing Home Association, and LGEs.
- LDH has not developed an approach to meet with individuals who have lived experience regarding the services and supports offered by the My Choice Program.
- The State has not developed a quarterly newsletter.

Recommendations

- The State should revise the communication plan regarding the My Choice Program during the next reporting period. 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 restart the My Choice subcommittees for community services and community transitions and begin to meet with these subcommittees on a quarterly basis. The State should have clear charters for these subcommittees and have an identified LDH lead who will be responsible for organizing meeting logistics and content. A major focus of this subcommittee work should be on various protocols developed for in-reach and community case management and to discuss barriers and develop solutions to address these barriers.
- The State should make enhancements regarding the My Choice website and decide whether to develop the quarterly newsletter.

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: Partially Met

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 increased efforts to meet with these organizations regionally and on a statewide basis to provide information regarding the availability of crisis services. LDH has not provided an organized strategy for providing information to state and local law enforcement and judges regarding the CCM program. While these organizations could not refer directly to CCMs, they may be a helpful point of contact for individuals on CCM caseloads who become engaged with law enforcement or with judges pre-adjudication. A indicated in paragraph 29, LDH has not included these strategies in their diversion plan.

Compliance Review

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

- The State has regular meetings at the regional and state level with various law enforcement agencies and judges.

- Current meetings are crisis specific and have not provided information on other services (e.g., CCM and TCs) who could assist with diversions from sentencing and incarceration.
- The State has not included these meetings as part of the strategy in the diversion plan.

Recommendations

- LDH should work with law enforcement and judges to develop and implement an outreach that provides tangible information regarding accessing crisis services and the role of the CCM in assisting with strategies to divert individuals from sentencing/adjudication.
- LDH should revise the diversion plan to include these strategies.

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 efforts to train community providers, with a focus on providers of the new Crisis Stabilization Services (CS) which was rolled out in August 2022, and ACT teams to implement IPS. In addition, LDH reports some LGEs have participated in IPS training.

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 reports these trainings continue to 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. Most of this work is discussed in paragraph 78. The State has been accepted into the ODEP Policy Academy which will also provide technical assistance to LDH regarding their IPS training efforts.

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. LDH is requesting assistance from the SME to offer the training to CCMs and MCO trainers early in CY 2024. In addition, the State has requested the SME to develop training regarding the Person Centered Planning checklist discussed in paragraph 61 early in CY 2024. LDH has also stated they will provide training to MHR providers regarding the employment support guidance developed in CY 2022 and train OAAS staff and CCW providers (e.g., organizations offering PCA) on strategies to serve individuals in the Target Population. 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.

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 and implemented training and coaching for crisis and IPS providers (including ACT). The State reports they have trained individuals who are interested in offering peer support as part of a larger peer credentialling process. LDH engaged the SME early in CY 2023 to offer training to peer support supervisors. 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). In the ninth report, the SME recommended 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. LDH has not implemented this recommendation.

Compliance Assessment

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, IPS, peer support, and community case management this period.
- The State included a plan for training direct service workers offering PCS services to the Target Population in their CY 2023 Implementation Plan but did not implement this training. The State now proposes to offer this training in February 2024.

- 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 nor updated the website with these trainings.
- The State, in cooperation with the MCOs, implemented training on person-centered planning for behavioral health providers. The State is proposing to offer this training again to CCMs and MCO training staff in CY 2024.
- 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.
- 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.
- LDH should provide a refresher course on person-centered planning to CCMs, TCs, and other behavioral health providers as planned during the next reporting period.

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 requires the Subject Matter Expert (SME) to assess 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 SME has developed two service review reports and will complete the third report in CY 2024. The initial report by the SME from 2021 was included in the fifth SME report. Similar to the FY 2021 report, the FY 2023 report provides 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.

As indicated throughout this report, the SME has conducted service reviews during this review period for the CY 2024 report and is in the process of determining if issues in the first two reports were addressed and if additional issues are identified for individuals who were recently transitioned or diverted. In addition, these reviews focused on individuals in NF who are awaiting transition and obtaining information

regarding their transition experience. A summary of findings will be provided during the next reporting period. During the ninth reporting period, the CY 2023 SME service reviews found:

- Individuals who were transitioned experienced positive changes in their overall well-being post transition. As indicated in the review, individuals who were transitioned were generally found to have good physical health and behavioral health well-being, stability, and good transition outcomes. There were some improvements, but additional work is needed to improve assessments, person-centered plans, and community inclusion.
- Individuals who were diverted were found to do poorly across all domains. As indicated in the SME service review report, these individuals are very recently discharged from inpatient hospitals and have complex and acute health and behavioral health conditions. In addition, they need housing and other services (e.g., personal care services) immediately after discharge which are not readily available. This presents significant care coordination challenges for the CCM. Recommendations set forth in paragraph 70-72 regarding rapid engagement of these individuals with ACT should assist CCMs with their initial efforts to engage and support individuals who are diverted.
- Individuals who were awaiting transition had generally poor scores for all domains. There were issues regarding the timeliness of transition activities and lack of person-centered plans.

There were a number of systemic issues identified through the most recent service review (SME-Report-July-December-2022.pdf (la.gov)) and a summary of systemic issues was discussed in the ninth report. There were operational and service issues identified in the report that affect the quality of community-based services to ensure individuals in the Target Population can successfully live in, transition to, and remain in the community.

For individuals who were transitioned, specific systemic service issues included the lack of ITPs and CPOCs that addressed integrated day opportunities was consistent with the issues that were identified in the FY 2021 service review. In addition, continued lack of peer support to address loneliness and better community inclusion was a continued theme for most individuals in the FY 2023 review.

For individuals diverted from NFs, several systemic issues were identified in the FY 2023 service review. For instance, CPOCs were often absent of strategies and specific services that addressed the needs of the individual as identified in the community assessment. In addition, individuals who are diverted often need services and supports on demand. Systems are not in place (e.g., PCA services) to provide needed services and supports immediately after diversion.

There were systemic issues for individuals who were awaiting transition. These individuals experienced barriers related to the availability of housing and personal care services. Pain management continues to be an issue for individuals awaiting transition and lack of attention to these pain management strategies (medication and other interventions) may complicate these transitions. Some individuals awaiting transition needed income assistance through the SSDI or SSI benefit program and NF did not complete these applications in a timely manner. In addition, individuals awaiting transition were needing accessible housing that was not often readily available throughout the regions. These issues were discussed in the FY 2023 service review.

The SME meets 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. As discussed in this report, LDH is performing compliance review of various TC activities and working with MCOs to review CCM activities.

LDH also requires CCMs to collect information for individuals who are transitioned or diverted from NFs. This information is tracked and reported monthly by OBH and a summary is included in the quarterly quality matrix (Appendix A). TCs perform an additional review of individuals who are transitioned. As indicated in paragraph 42, TCs meet with transitioned individuals on a regular cadence and collect information on domains similar to CCMs. LDH has indicated they require TCs to collect information for individuals who have transitioned using a consistent form and process. LDH reports that not all TCs are reporting this information. Therefore, the State has yet to compare information from TCs and CCMs on similar activities (e.g., community inclusion, stabilization). LDH reports the renewed internal and external quality assurance efforts will review these issues across the domain identified by the CCMs and TCs in their monitoring efforts.

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. LDH reviews the quality of ACT and new crisis services. The State reports they will perform fidelity reviews of IPS provided by ACT teams in CY 2024. Given the status of other IPS activities, it is unlikely the State will perform fidelity reviews of other IPS providers this reporting period. The SME also recommended LDH develop quality measures regarding peer supports. However, there is little utilization of this service and LDH efforts would be best spent on continued implementation of this service. The State does have data since March 2022 to review the utilization of PCS services offered through various Medicaid programs. As indicated in paragraph 101, utilization of PCA services remained strong for individuals who transitioned from NFs.

Compliance Assessment

The SME assessment of the State's compliance with this paragraph took into consideration the findings from the FY 2023 SME service review. This compliance assessment will be updated in the eleventh report when findings from the CY 2024 service review will be available. The SME assessment of the compliance of this paragraph includes previous findings and additional issues identified since the ninth report, including :

- LDH continues to provide relevant information to the SME for conducting service reviews. These reviews provide LDH with information regarding the experience of care and quality of services.
- While the quality of the NFTA has improved, the quality of the ITPs has decreased. LDH continues efforts to improve the transition activities of TCs. The State has implemented a process for reviewing NFTAs and ITPs.
- The State has developed a process to review the quality of some services (e.g., ACT and crisis).
- The State does not have data to review the quality of most new services included as part of this Agreement.
- CCMs collect and report information on key measures for individuals who are transitioned and diverted.
- The State is requiring TCs to complete logs for individuals who are transitioned from NF for up to one year post discharge. LDH reports that TCs are not consistently reporting information through these logs and is implementing measures to have TCs consistently and accurately report this information.

- LDH has not collected information from TCs regarding post-discharge follow-up and have not made a comparison of similar information from CCMs.
- The State indicated they will review information from various domains regarding the quality of services provided to individuals in their renewed quality assurance efforts.

Recommendations

- LDH should ensure that CCM staff provide the necessary information to review quality of services consistent with the TC strategies over the past two years and provide this information to the internal and external quality assurance process.
- LDH should identify and implement a process to review the quality of personal care services offered to individuals in the Target Population who have transitioned or been diverted from NFs.
- LDH should ensure TC supervisors continue to assertively monitor whether TCs are transitioning individuals as required and take the necessary steps to improve performance if TCs do not meet that requirement.
- LDH should compare information collected by CCMs and TCs regarding key quality measures to determine if information regarding these measures is corroborated.

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 My Choice Program. The quality assurance system has been driven by an initial Quality Assurance Plan that sets forth the measures and processes the State will use to improve quality. LDH has not updated the plan as recommended by the SME in previous reports.

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 four years to include feedback from the My Choice Advisory Committee, the SME, and the Department of Justice.

In the ninth reporting period, the SME recommended LDH reinstate 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 to develop strategies for addressing systemic issues identified by the CY 2023 service reviews. During this period, LDH has restarted internal quality assurance efforts and have met monthly to:

- Develop and agree upon a charter for the internal workgroup to guide their overall quality assurance efforts for the My Choice Program.
- Identify whether new measures should be added to the quality matrix. LDH has added several new measures regarding the barriers to transition (based on information provided by TCs and

PIRS). In addition, staff are in the process of operationalizing a measure to assess how individuals are able to make choices and exert control over their own life.

- Determine whether changes in reported measures would be compared to national benchmarks (identified by CMS or other national organizations) or trends from previous reporting periods to gauge improvements in the measure or identify if further analysis was needed to identify strategies for improving a measure and the overall quality of care.
- Identify staff who will be responsible for each measure including collecting and analyzing data, comparing this analysis to trends or benchmarks and developing potential strategies with the internal workgroup, implementing recommendations, and reporting out on the impact of these strategies.
- Review recommendations by the My Choice Quality Resource Subcommittee for including new measures or making adjustments to current measures. This is a more recent activity and the internal group has yet to make additional recommendations based on the feedback from this subcommittee (discussed below).
- Develop protocols for referring systemic issues to the TSC if the Internal Quality Assurance Committee was unable to identify strategies to address various systemic barriers.

As indicated above, the State has reconvened the external My Choice Quality Resource Subcommittee. LDH has recruited two additional My Choice Advisory Committee members for this Subcommittee, including individuals from the LHA and an additional advocate. This Subcommittee has initially met monthly and:

- Reviewed and agreed upon a charter to guide their work.
- Received an overview of the current measures and the quality matrix for CY 2022.
- Reviewed and provided feedback regarding the benchmarks for each measure.
- Made recommendations regarding additional measures or strategies to collect and analyze data for various measures.

Generally, the Subcommittee agreed on the measures and benchmarks created for each measure. The Subcommittee did not recommend additional measures, but as indicated above suggested alternative strategies for collecting and analyzing this information for certain measures. The Internal Quality Assurance Subcommittee is in the process of reviewing the Subcommittee's recommendations. LDH reports this Subcommittee will meet on a quarterly basis in CY 2024. The SME has attended all Internal Quality Assurance Workgroup and the My Choice Quality Resource Committee meetings and believes these have been helpful for the State to meet the intent of this paragraph and develop a useful internal and external quality assurance process.

The State completed the first Annual Quality Assurance Report for the My Choice Program during the seventh and eighth reporting periods. This plan incorporates the work that has been done to collect and analyze data on some of the measures required in paragraph 99. It also sets forth the processes LDH has put in place to use this information to improve the experience of care for individuals transitioned and diverted from NFs as well as to improve the quality of services that are offered to the Target Population. As indicated in the ninth report, LDH had not developed a subsequent Quality Assurance Annual Plan. During this reporting period, LDH has developed a draft Quality Assurance Plan for 2023 and is proposing to complete this plan by January 2024 and provide this to the My Choice Quality Resource Subcommittee soon thereafter. The State has indicated they will draft the 2024 Quality Assurance Plan in July 2024. LDH

provided the draft 2023 Quality Plan for the SME's review. The SME provided comments during this reporting period.

As discussed in paragraph 58, the State is including the TSC as part of their larger quality assurance effort. The TSC role will be to review strategies developed by the internal quality assurance committee for individual and systemic based on issues related to quality. The State has yet to finalize a process for referring and discussing systemic issues with the TSC.

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.
- LDH has yet to finalize new measures proposed for the CY 2024 Quality Matrix.
- LDH has identified what measures should be benchmarked or trended. These recommendations were reviewed by the My Choice Quality Resource Subcommittee. The State has reconvened the internal cross-agency Quality Assurance committee and external Quality Resource Subcommittee of the My Choice Committee. The internal committee and external Subcommittee has taken steps to improve the quality assurance process including recommending additional data sources for measures. The My Choice Quality Resource Subcommittee concurred with the measures currently in the Quality Matrix.
- The State has developed, but not yet finalized, the second annual Quality Assurance Plan (CY 2023). LDH has proposed, but has not implemented, a process to provide information from the internal Quality Assurance committee to the TSC.

Recommendations

- The State should continue to report and track the measures in the Quality Matrix.
- The State should finalize new measures and the methodology, data source, report frequency, and benchmarks for new measures.
- LDH should implement the internal process to review measures against benchmarks, identify improvements needed, implement strategies to address these improvements and report out on these strategies to the My Choice Quality Resource Subcommittee and include these efforts in the Annual Quality Assurance Plan.
- LDH should implement a process for the TSC to review issues and strategies identified by internal and external committees/subcommittees for their review and make recommendations for additional strategies LDH should consider to address issues identified in the quality assurance process and by the My Choice Quality Resource Subcommittee.
- LDH should develop and solicit feedback from the My Choice Advisory Committee and Quality Assurance subcommittee on the 2024 Annual Quality Assurance Plan.

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

CCMs are responsible for completing critical incidents reports (CIRs) as one of their case management responsibilities. LDH reports the CCMs are trained on CIR processes and requirements. CCMs report critical incidents for individuals transitioned and diverted from NFs. The current definition of critical incidents reported by CCM aligns with and expands on (with the exception of ED and inpatient visits) the definition of critical incidents in use for various federal Medicaid Waiver programs. These include the critical incidents above and:

- Involvement with law/victim of a crime
- Use of restraints or seclusion
- Eviction
- Loss or destruction of home.

It should be noted that CCMs track and report ED visits and inpatient hospitalizations to LDH separately on a quarterly basis even though LDH no longer considers these critical incidents.

The State reports on the number of total critical incidents for individuals enrolled in CCM and provides information on certain types of CIR (e.g., number of abuse, neglect, exploitation referrals made). The State reports there were 18 individuals experiencing a critical incident for Quarters 2 and 3 in CY 2023 (most recent data available).

The SME has requested, and LDH provided, information from MCO CCM activities on the types of critical incidents and response to these CIRs. The SME requested to review a sample monthly report on a quarterly basis to track the response to CIRs. In the most recent report reviewed, MCOs report there were CIRs for four individuals in April 2023. Three incidents were related to exploitation and one CIR was related to neglect by the PCA. All instances of exploitation were reported by the CCM to Adult Protective Services (APS) for follow-up. The CIR for neglect was reported to health standards as the agency providing personal care services was not providing the intensity of services identified in the individuals service plan.

As indicated above, the CCMs report ED visits and inpatient hospital stays (behavioral health and other causes). The April CCM report identified:

- 39 individuals of 383 individuals (10%) receiving CCM had an ED or inpatient visit (all cause).
- 10 individuals of 383 individuals (2%) had multiple ED and/or inpatient visits during April 2023.

This is lower than what LDH reported during the January and February reporting. During that reporting period, LDH reported 52 individuals had either an ED visit or were admitted to an inpatient hospital for any cause.

For the 39 individuals who were reported to have an ED or IP admission, the CCM facilitated appointments for 20 individuals to various specialty medical providers or their PCP upon discharge. Five individuals were referred to ACT for follow-up. Other activities were taken by the CCM for individuals who were not yet discharged from inpatient hospitals (e.g., participating in hospital discharge planning meetings).

The SME continues to encourage LDH to have renewed focus on critical incidents as part of a larger QA strategy, discussed in paragraph 94, during this and subsequent reporting periods.

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, reporting processes, and timeframes.
- LDH has aligned their definition of critical incidents with critical incident categories used for other Medicaid programs. The State reported there were 18 critical incidents for members of the Target Population in the second and third quarters of CY 2023. A review of the sample monthly report found CCMs reported CIRS to appropriate agencies for further review. CCMs referred all CIRs that involve exploitation to APS for follow-up.
- LDH continues to require CCMs to report major medical events, including reports on the utilization of behavioral health crisis services.
- The State tracks and reports information on a monthly basis regarding ED and inpatient utilization, which were previously considered critical incidents.

Recommendations
- The State should continue efforts to identify and respond to CIRs.
- LDH should encourage CCMs to identify alternatives to EDs (e.g., urgent care centers) to address the emergent needs of individuals receiving CCM.
- LDH should provide a summary of findings regarding APS follow-up activities for individuals with critical incidents.
- LDH should incorporate a review of the systemic issues identified through CIRs in the internal quality assurance process discussed in paragraph 94.

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: Partially Met

Discussion and Analysis
This paragraph was changed from Not Yet Rated to Partially Met. The SME met with LDH to discuss the processes, protocols, and contractual language that require community providers and MCOs to report critical incidents to LDH. There are separate but similar processes required by LDH dependent on whether the Medicaid beneficiary participates in long term services and supports through the various Medicaid 1915c Waivers administered by OAAS or OCDD. LDH reports that specialized behavioral health services overseen by Medicaid MCOs.

The OAAS process for reporting and responding to CIRs is similar to the existing process for CCM requirements discussed in paragraph 93. OAAS and OCDD have a manual specific to CIRs for individuals

participating in various Medicaid Waiver programs. The manual describes the responsibilities of the Direct Service Worker, Support Coordinator, Regional Office Director, and regional office staff that follow up on all CIRs. In addition, the protocols are set forth for the reporting timeframes and expectations for follow-up by various staff until the incident is resolved. Support coordinators are required to convene meetings to resolve the CIR or to develop strategies to prevent or mitigate similar CIRs from occurring in the future and revise the Plan of Care (POC) when needed. The OAAS and OCDD standards set forth expectations regarding CIRs that require referrals to APS, Elderly Protective Services, and Health Standards. Instructions regarding CIRs for individuals participating in the OAAS 1915c Program can be found at OAAS_MAN_19_002_Critical_Incident_Reporting_Manual_for_SIMS_I_5_3_19.pdf (la.gov).

For individuals in the Target Population enrolled in a Medicaid MCO, LDH reports that providers are contractually required to report known critical incidents. LDH reports this has been a long-standing provision in provider contracts in the Louisiana managed care program. LDH has provided the SME with an example of the provider contract that requires critical incident reporting.

Per the review of the material, LDH requires all MCOs to use the same standard definition of critical incidents for community providers. These definitions are provided in the MCO Manual (provider manual or contract). The areas that comprise CIRs include:

- Abuse
- Neglect
- Exploitation
- Extortion
- Death

LDH reports MCOs are responsible for training Medicaid specialized behavioral health providers on critical incident reporting forms and processes on a regular basis. The State reports MCOs offer training regarding critical incidents on a monthly basis or on demand when requested from a provider. MCOs are required to perform quarterly monitoring reviews on a sample of behavioral health providers (including community-based behavioral health providers). During these reviews, LDH reports MCO monitoring staff to identify:

- Whether there are critical incidents reported by this provider during the review period, which generally includes a six-month look-back period
- Whether these critical incidents were reported to the MCO
- What strategies the community provider undertook to respond to a critical incident including internal remediation of the issue, when the incident involves a provider/provider's staff, or referral to Adult Protective Services.

Findings from these quarterly reviews of specialized behavioral health providers and facilities providers are provided to OBH. OBH analyzes quality monitoring reports on a quarterly basis to evaluate provider performance by provider type/level of care in general, ensure actions are taken in a timely manner to address performance below the threshold for individual providers, and to determine if system-wide improvements are needed. OBH reports they share feedback and recommendations with the MCOs via the report review/approval process and through participation in quality workgroup meetings with the MCOs.

In addition, MCOs provide LDH with monthly reports regarding critical incidents regarding their individuals who are enrolled in their plans. This includes the number of critical incidents for the month, description of the incident, action plan to address the incident, including summary of the disposition regarding these critical incidents (e.g., reporting to APS, requesting a review by LDH Health Standards), and status of the incident. LDH reports they review this information on a monthly basis to ensure appropriate and timely action is taken by the MCO to resolve all reported incidents. Per this review, LDH indicates that most CIRs do not involve the community provider but rather non-paid caretakers/relatives who may abuse or exploit the individual.

Compliance Assessment

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

- The State has separate but parallel processes for CIRs for OASS and MCOs.
- LDH requires MCOs to have policies for specialized behavioral health providers and community case managers regarding reporting and responding to CIRs.
- MCOs contractually require specialized behavioral health providers to report and respond to CIRs.
- LDH reports MCOs have a process to validate whether a specialized behavioral health provider reports a critical incident and strategies the provider deploys to respond to the critical incident.
- LDH has a quality improvement process to review monthly reports from MCOs regarding critical incidents and provide feedback to the MCOs.
- The overall CIR process includes all members served by specialized behavioral health providers. LDH uses a separate process to collect and report critical incidents involving individuals in the Target Population through community case managers.

Recommendations

- LDH should provide the SME with the number of critical incidents by month that have been reported by specialty behavioral health providers and OAAS.
- LDH should also provide a sample of the monthly MCO and OAAS reports on critical incidents and a summary of the results and analysis LDH has requested MCO to make as a result of these CIRs.

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 drafted the first Mortality Review Report in April 2022, but has not posted it. In its 2023 Implementation Plan, the State was to complete the second annual mortality review report by July 2023. This has been delayed.

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 one year 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 53 deaths among transitioned members of the Target Population: 1 in 2019, 7 in 2020, 2 in 2021, and 18 in 2022. During 2023, LDH has reported 27 deaths (11 deaths in the ninth reporting period and 16 deaths in this reporting period). The Integration Coordinator reviews each death and uses criteria to make a referral to the MRC. This criteria takes into account the individual's circumstance and cause of death. Individuals not referred to the mortality review committee were either transitioned from NF to hospice or had end stage medical conditions (e.g., cancer). For CY 2023, LDH has referred a total of 16 deaths to the mortality review committee. There were 11 individuals who died who were not referred to the committee.

A total of 31 deaths since the beginning of the Agreement have been referred to the mortality review committee; 20 reviews have been completed and 11 are still in process or have not been started. All reviews regarding deaths occurring in CY 2019-2022 referred to the MRC have been completed. On average, the MRC concludes their review within seven months and within the one year period established by LDH. Sixteen deaths occurring during CY 2023 were referred to the MRC; five have been completed, seven are in process, and four have not been started as of this reporting period. The ninth SME report provided a summary of findings from the MRC for CY 2019-2022. The findings from the mortality reviews completed for the five individuals in 2023 are not yet available.

As indicated in the eighth report, OBH, OAAS, and other agencies participated on the mortality review team; there continues to be no representation from MCOs, LGEs, and community providers. Also, the OBH Medical Director does not participate in these reviews.

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.
- LDH has developed and applies various criteria for referrals to the MRC. Since the beginning of the Agreement, this has resulted in an average of 58% of all deaths of individuals who have been transitioned or diverted (for up to a year) being referred to the MRC. During this reporting period, LDH has referred over 63% of all deaths to the MRC.
- LDH completed their review of all individuals who were referred to the mortality committee since December 2022. LDH has implemented a process to collect and send information to the MRC on a timelier basis.
- LDH has begun to conduct a review of five individuals who have died during this reporting period. Reviews by the MRC for four individuals who died have not been started.
- LDH set timeframes for providing information to reduce the time needed to conduct these reviews versus changing the protocol to address lags in information collection.

- There has been a reduction in the average length of time needed for the MRC to conduct the reviews from 326 days at the end of the ninth reporting period to 221 days at the end of this reporting period.
- LDH has not posted the first Mortality Review report.
- LDH has not developed subsequent Mortality Review reports.

Recommendations

- LDH should continue their efforts to complete a timely review of individuals who died during this reporting period.
- 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 post the first Mortality Review Annual Plan and provide a timeframe for completing the second annual report. This should include a review of systemic issues and actions that can be taken by LDH and its partners to address these issues.
- LDH should require the MRC to complete reviews of all individuals who were referred in 2023 by the end of the next reporting period.

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 measures to address the requirements of these paragraphs. There are a total of 60 current measures and 2 new measures (programmatic and operational) LDH reports on or will report on in CY 2024. These were identified in the SME ninth report and added to the 2023 quality matrix. However, as indicated in paragraph 94, these measures need additional information regarding methodology, data sources, and benchmarks, including:

- 99(g): A self-reported measure collected by CCM regarding whether an individual feels involved in their community to the extent they would like to.
- 99(j): Barriers to service individuals in more integrated settings.

As indicated in paragraphs 54-55, the State has implemented a process to more systematically identify and address barriers to address (i) of paragraph 99. LDH has reported information on these barriers in the CY 2023 quality matrix Attachment A and discussed in paragraphs 34 and 37.

These measures and performance data (with the exception of the two new measures) are reflected in the quality matrix provided in Appendix A, which includes information from various quarters of CY 2023. Measures have been developed and continue to be reported for almost all categories (a)-(h) in paragraph 99 and included in the quality matrix. This includes measures that were previously developed but not reported (e.g., PASRR Level II information). There is one area that continues not to have a measure: 99(d): The number of individuals who have used residential treatment facilities. There is no specific designation for these facilities and previous efforts by the SME (as indicated in paragraph 52) have shown few referrals to group homes (that may be considered a residential treatment facility).

There is a current measure that has not yet been collected. This includes the number and percentage of individuals who received services in the amount, frequency, and duration specified in the plan of care. As indicated in paragraph 61, LDH is undertaking strategies for addressing these issues with TCs and CCMs which should allow them to report this information in later quarters of CY 2023. As indicated in paragraph 37, the TCs are completing an addendum to the ITP that provides information regarding the services and recommended amount and duration for individuals who are transitioning to the community. The current SOPs require CCMs to provide information in the CPOC regarding the amount and duration of each service. As indicated in the FY 2023 Service Review, CPOCs did not often include this information.

Initially, the reports for community measures focused on individuals who were transitioned from NFs. In 2022, LDH included individuals who were diverted in their methodology for certain measures. LDH has added various operational measures that focus on in-reach efforts, PASRR Level II, and active caseload activities that provide information to the State regarding progress and issues with these activities.

In the ninth report, the SME reported LDH collected information on almost all measures but did not have a consistent process for reviewing these measures. Specifically, LDH has not developed a baseline and/or a specific expectation or benchmarks for most metrics. As indicated in paragraph 94, LDH has identified measures that will be benchmarked against national benchmarks and have identified which measures should review trends from previous quarters to determine progress or areas of deficiencies that should be reviewed by the internal cross-agency Quality Assurance Committee, TSC, and the My Choice Quality Resource Subcommittee.

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 included the following areas: physical and behavioral health well-being and incidence of health crisis, stability, and community inclusion. Information from the first two quarters of CY 2023 was compared to CY 2022. A comparison of this information indicates:

- The percentage of individuals who self-reported good physical health for the first two quarters varied from 61% (Q1) to 56% (Q2) and decreased as compared to the fourth quarter of CY 2022 (65%).
- The percentage of individuals who self-reported good mental health for the first two quarters varied from 64% (Q1) to 60% (Q2) and decreased slightly as compared to the fourth quarter of CY 2022 (65%).
- The percentage of individuals who self-reported stability on various domains was generally the same from the end of CY 2022 through the first two quarters of CY 2023. This included individuals self-reporting on stable living situations (91%), good living situations (92%), stability in natural support network (99%), and stability in service providers (97%).
- For the first two quarters of CY 2023, LDH reports that 95% of all individuals indicated they are as involved as they like to be. This is in contrast to the SME service review for FY 2023 indicating community integration scores for both individuals who were diverted and transitioned were poor. As indicated in the service review, when interviewed, many of these individuals experienced loneliness, were not aware of community resources that matched their interest or did not have transportation to these community resources.

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 successfully 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. The State has policies in place for TCs to collect this information but reports data collection by TCs is inconsistent and therefore a comparison of TC compared to CCM information has not been done.

<u>Compliance Assessment</u>

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

- The State has reported on all measures added in CY 2022, for a total of 60 measures (programmatic and operational).
- The State continues to collect consistent data to improve the availability, accessibility, and quality of services for areas identified in this paragraph. However, it is not able to collect data on all information. For example, as discussed above, LDH is not yet able to monitor whether individuals received services in the appropriate amount, frequency, and duration.
- The State has reinstated internal and external quality assurance committees but needs to develop additional clarity regarding the role of the TSC in the quality assurance process.
- The State has developed benchmarks or trends for some measures in the DOJ Agreement.
- The State has not implemented a process for analyzing these measures against the benchmarks or trends during the reporting period but states they will begin these efforts early in the next reporting period.

- The State will need to develop measurement specifications for the two measures added this year and determine how to add one measure discussed above.
- The State still has not developed a process to validate the data collected on self-reported measures.
- The State has begun to report information on barriers for individuals to receive services in the most integrated setting and included this information in the quality matrix.
- The State reported the new PASRR measures regarding lengths of stay and readmissions.
- The State has implemented a process to collect information from TCs regarding scope and recommended duration of services in the ITP.
- Information regarding scope and duration of services is not always available in CPOCs although the SOPs require CCMs to include this information.

Recommendations

- The State should develop the measure specifications for the two measures referenced in this paragraph.
- The State should develop the one measure referenced in this paragraph related to individuals referred for residential services.
- The State should implement the TC secondary review of members in the Target Population's self-reported measures to begin efforts to ensure reliability of the process to collect measures.
- The State should report information on barriers from TCs, PIRS, and, eventually, PASRR Level II evaluators in the quality matrix.
- The State should ensure TCs and CCMs are providing information regarding the amount and duration of services in ITPs and CPOCs. The State and MCOs should undertake a sample review of ITPs and CPOCs to ensure this information is included in the plans. The State should report on the findings from this sample review at the end of the next reporting period.
- LDH should continue efforts to coordinate the internal and external quality assurance processes discussed in paragraph 94.

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 and CY 2023 SME Service Review. The State reports they have taken the following strategies to address some, but not all, findings in these reports:

- LDH continues to monitor TCs against timeliness expectations and managers meet monthly with TCs to review this data.
- LDH has communicated the expectation to TCs that meetings should occur with individuals awaiting transition on a monthly basis.

- LDH implemented an addendum to the ITP for the purpose of documenting the discharge planning meeting. It includes instructions on inviting all parties involved in supporting the person at the table as well as collecting various treatment/plan documents to be shared with the team. It was finalized and implemented in September of 2023.
- Clarify the role of TCs and CCMs in the discharge planning process. As discussed in the transition recommendation, LDH and MCOs should have clear policies for transition planning. While the SME understands there may be separate guidance for TCs and CCMs, more explicit language is needed in the standard operating procedures to clearly delineate roles during discharge. The SME recommends that the TCs continue to have a primary leadership role in conducting and overseeing transition planning activities prior to and on the day of transition. This information has been communicated and a formal plan will be established during CY 2024.
- Track referrals to CCM from TCs within SharePoint and have OBH CCM team accessing this information.
- LDH is planning to implement an internal quality review process specifically focused on record review, modeling the service review process. LDH has developed a manual and training for NFTA and ITP reviewers to ensure consistency and understanding regarding the reviews.
- LDH has developed a field in OPTS for the TC to identify a projected transition date. The field is not a locked field and can be modified. LDH is reviewing options with the software development team to identify the best option to display this information and an enhancement to the system will have to be requested.
- Working with LHC to prioritize the development of accessible housing units.

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 and systemic level. LDH has reinstated internal and external quality assurance processes during this reporting period.

The SME will continue to request information from LDH regarding steps to reinstate the quality assurance process. The SME has participated in both internal and external quality assurance meetings this reporting period and will continue to attend these meetings.

Compliance Assessment

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

- During this review period, the LDH reinstated internal and external processes to analyze data and identify trends, patterns, strengths, and problems at the individual, provider, and systemic levels.
- LDH has developed and implemented certain strategies to address issues in the quality matrix or the SME Service Review.
- The State has yet to address some findings from the service review, but has included many of these in their CY 2024 Implementation Plan, including:
    - Developing and implementing training regarding pain medications and alternative pain management strategies.
    - Performing monthly monitor efforts and improving the person-centeredness assessment and planning activities. This would include monthly review of new ITPs to address significant gaps in NFTAs and ITPs regarding:
        - Goals (ITPs)
        - Strengths (NFTAs)
        - Barriers (NFTAs)

        - All services not identified in the ITP that were an indicated need in the NFTA.
    - Clarifying and training to TC and supervisors that ITP development should continue while housing is being secured.
    - Providing training and coaching to TCs regarding strategies to engage NFs to provide the necessary services prior to transition that are most needed by individuals awaiting transition (e.g., medication education and administration, therapies, and other strategies to improve ADLs).
    - Training TCs regarding availability of formal supports regarding employment and education. This includes determining when an individual is a good candidate for referral to Louisiana Rehabilitation Services (LRS), the Medicaid employment benefit available through the MCOs, or for supported employment assistance that should be provided by all ACT teams.
    - Providing training and assistance to TCs regarding assertive strategies for NFs to offer medication training, submit SSA applications, and ensure the NF makes the necessary changes to Medicaid enrollment upon transition.

Recommendations

- LDH should report on the efforts of the internal and external quality assurance committees.
- LDH should develop a tracking process to determine if the strategies the State has put into place to address issues identified through the quality assurance process using data in paragraphs 98 and 99 had the intended outcomes.
- LDH should implement the strategies to address the issues above in the FY 2021 and CY 2023 Service Reviews.
- LDH should develop strategies to address the outstanding issues in the FY 2021 and CY 2023 Service Reviews.

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.

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. This needs assessment can be found at: LouisianaNeedsAssessment-Final-Report.pdf (la.gov)

The State currently collects and reports utilization information to the SME on a quarterly basis. LDH has provided the SME with utilization information for the first and second quarter of CY 2023 for individuals who were transitioned or diverted. A summary table is provided in Appendix B. The SME reviewed this

information and compared this to utilization reported in the ninth SME report. A review of this information indicates:

- There was a decrease in the percent of individuals who were transitioned and did not receive a behavioral health service in the third quarter of CY 2023 (40%) versus the same period in CY 2022 (56%). However, the number of individuals who were transitioned and did not receive a behavioral health services decreased from 75% in the third quarter of CY 2022 to 37% in the same quarter of CY 2023. This is a significant decrease in the number of individuals who were diverted who did not receive behavioral health services.
- There was continued increase in the percentage of individuals who were transitioned and received ACT. There was a significant increase in the percentage of individuals diverted receiving ACT. In the third quarter of CY 2023, 36% of individuals who were transitioned and 20% of individuals diverted received ACT. In the third quarter of CY 2022, 29% of individuals transitioned received ACT and 7% of individuals diverted received ACT.
- There was a decrease in the percentage of individuals who were transitioned receiving other MHR services (CPST or PSR) in the third quarter of CY 2023 as compared to the third quarter of CY 2022. In the third quarter of CY 2023, 11% of individuals received MHR services versus 15% in the third quarter of 2022. There was little change in the percent of individuals diverted receiving other MHR services (3% versus 3.4%) in the third quarter of CY 2023 compared to the third quarter of CY 2022.
- The percentage of individuals receiving outpatient services from a licensed behavioral health practitioner was lower in the third quarter of CY 2023 (5%) versus the same time period in CY 2022 (7%). This continues to be less surprising, given the higher percentage of individuals likely receiving counseling services through ACT.
- The percentage of individuals who were transitioned receiving personal care services through the CCW Waiver was generally the same between the third quarters of 2022 and 2023 (47% versus 45%). There was some utilization of this service by individuals who were diverted in the third quarter of CY 2023 versus the same quarter in CY 2022. In CY 2022 there were no individuals who were diverted receiving CCW personal care services. In the third quarter of CY 2023, 5% of individuals who were diverted received these services. As indicated in the CY 2023 Service Review, individuals who were diverted had more complex behavioral health versus personal care needs.
- There continues to be a marked decrease in the percent of individuals transitioned from an NF who received preventative physical health care, especially primary care. In the third quarter of CY 2022, almost 70% of individuals who transitioned from NF received primary care or preventive services, whereas 59% received these services in the third quarter of CY 2023. There was little difference in utilization of these services for individuals who were diverted. Between the third quarter of CY 2022 versus CY 2023 45% versus 42% of individuals who were diverted received preventive physical health care.
- There continues to be little or no utilization of new services (crisis, peer supports, and IPS). There was a marked increase of almost 400% in the number of individuals receiving 1915b personal care services.
- All cause ED utilization decreased for individuals who were transitioned from the third quarter of CY 2022 (13%) to the third quarter of CY 2023 (11%). ED utilization for individuals diverted from NFs decreased significantly from 31% in the third quarter of CY 2022 to 19% in the same time period for CY 2023.

- ED utilization for behavioral health reasons continued to be low (2.5%) for individuals who were transitioned. Individuals who were diverted had fewer ED visits for behavioral health reasons, from 14% in the third quarter of CY 2022 to 9% during the same period in CY 2023.
- The percent of individuals transitioned utilizing inpatient services (all cause) in the third quarter of 2023 was less than the third quarter of CY 2022 (6.6% versus 9%). Percentages of individuals transitioned who were admitted to a behavioral health inpatient unit remained generally the same (3% in the third quarter of CY 2023 versus 4% in the third quarter of CY 2022).
- The percentage of individuals diverted utilizing inpatient services (general and behavioral health) in the third quarter of CY 2023 (12%) was well below the third quarter of CY 2022 (24%). There was a significant drop in the percent of individuals who were diverted utilizing inpatient behavioral health service in the third quarter of CY 2023 (10%) versus the same time period in CY 2022 (17%).

Compliance Assessment

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

- LDH continues to track service utilization for individuals who are transitioned and diverted more frequently, on a quarterly versus an annual basis.
- There are still a significant percent of individuals who are transitioned not receiving behavioral health services.
- There was a significant decrease in the number of individuals who were diverted and not receiving behavioral health services. Some of this decrease may have been related to an increase in the number of individuals diverted who were receiving ACT services—almost a 400% increase.
- There have been increases in utilization of ACT which may indicate TCs and ACT teams have been successful at increasing referrals and engaging individuals who were transitioned or diverted in these services. In addition, the current LDH policy to offer ACT to all individuals who are diverted and participate in CCM may have resulted in this substantial increase.
- There has been little change in the percentage of individuals transitioned who received CCW services this quarter versus the third quarter of CY 2023. The percentage of individuals who were diverted and received CCW services in the third quarter of CY 2023 was very small.
- The utilization of other MHR services is low and decreased for individuals who were transitioned. While more individuals are participating in ACT, the lack of utilization of MHR services would benefit from additional analysis from LDH.
- There was a decrease in the percent of individuals who were diverted and used preventive health care services. This is concerning given the multiple co-morbidities of these individuals and the CY 2023 service review that saw a number of individuals with poor health conditions.
- As discussed throughout this report, there continued to be no utilization of important community inclusion services such as Peer Support Services and IPS.
- The utilization of EDs and inpatient hospital services has decreased and remains low for individuals who transitioned between the third quarter of CY 2022 and CY 2023. There was a marked decrease in overall and behavioral health utilization of ED services for individuals who were diverted.

Recommendations

- LDH should perform additional analysis on why individuals transitioned or diverted from NFs are not getting behavioral health services. A specific focus of this analysis should be on individuals

who were transitioned. LDH should continue to make improvements in the percent of individuals who were diverted and receiving behavioral health services.

- LDH should perform additional analysis on why individuals diverted from NFs are not getting personal care services. While many of these individuals have more significant behavioral health needs, the CY 2023 service review indicated 50% of these individuals could benefit from these services.
- LDH should analyze why individuals are receiving fewer preventive health services. The decrease is concerning given these providers are likely to be prescribers of important medical, psychotropic, and medication assisted treatment for OUD. LDH should explore possible issues with the TSC:
    - Lack of primary and specialty care providers by region.
    - Lack of connection with existing primary care providers and individuals who are transitioned or diverted.
    - The correlation between individuals who visit an ED and individuals not receiving preventive care.
- LDH should implement the recommendations in paragraph 95 regarding continued strategies for reducing ED and inpatient utilization.

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

Information has been provided 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 goals of this tailored approach are to have each agency review relevant data and information, identify and address individual and systemic issues, and develop strategies to enhance implementation. Information dissemination regarding the My Choice Program should be continued among LDH and other agencies.

Data sharing efforts continue this reporting period among agencies, including Medicaid, OCDD, LHC, and LHA. Medicaid and their contracted MCOs and OBH share data and information regarding various activities, including utilization and quality of CCM and other services identified in the Agreement. OCDD continues to receive information on individuals who are awaiting transition from an NF in an effort to make the most appropriate referrals. OCDD continues to receive information regarding individuals transitioned or diverted from NFs who have been identified as having ID/DD. LHA and LHC participate in monthly calls that update My Choice staff regarding current and proposed housing opportunities. OBH reports they have begun to work more closely with LRS, including identifying and tracking individuals to improve referrals from ACT, LGEs, and other providers for individuals in the TP who are interested in work.

Compliance Assessment

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

- The State collects and disseminates relevant information regarding the progress of the My Choice Program to state partners and MCOs.
- LDH has certain processes in place to provide Medicaid, OCDD, LRS, and LHC with information on select aspects of the My Choice Program.

- Integration Coordinator, OAAS, and OBH have agreed to develop additional and more targeted efforts toward a better use of information sharing between state agencies regarding the My Choice Program.
- The State has not developed data use strategies for other State agencies, including clarity regarding goals for information sharing and a regular cadence of meeting with agencies to review data and to make programmatic and policy decisions.

Recommendation

- The State should continue to identify the key state agencies that are most likely involved and impacted by the My Choice Program and identify data needed by these agencies to support OAAS and OBH's efforts for the My Choice Program.
- The State should develop and implement data use strategies for these agencies, including clarity regarding goals for information sharing and a regular cadence of meeting with agencies to review data and to make programmatic and policy decisions.
- The State should report the progress of implementing these data use strategies during the next reporting period.
- LDH should provide informational sharing efforts with LHC and increase the availability of ADA accessible units.
- LDH should provide information to LRS and begin to develop pathways for LRS employment services.
- OBH and OAAS should request from Medicaid various performance measures referenced in this report regarding SUD.

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). LDH also reports measures on crisis services. In the future, this should be supplemented with reviews of services such as 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 in understanding the experience of individuals awaiting transition, transitioned, or diverted from NFs. In time, there should be improvements to the quality of individual assessments and plans of care to assess whether people are receiving needed services and supports in the appropriate amount, frequency, and duration.

As indicated in paragraph 62, LDH staff continue to partner with the SME Service Review Team during this reporting period to conduct interviews with individuals, caregivers and friends, CCM, TCs, and other

service providers. These efforts have included training and technical assistance from the SME team to LDH regarding the purpose and process of the service reviews. The SME has also provided LDH with a guide for how to conduct the audits of NFTAs and ITPs. The SME has trained LDH supervisors regarding the audit processes and have shadowed TC supervisors in their efforts to review a sample of individuals who are awaiting transition from NFs. The State reports that MCOs are also conducting audits of CCM activities. Specifically, the MCOs are reviewing the following areas:

- Engagement activities, including timeliness of CCM efforts prior to and after discharge from the NF or referral from PASRR Level II (for individuals who are diverted).
- Community assessments and reassessments occur and the needs are reviewed and documented across domains.
- CPOCs are developed, the planning process is documented, the needs identified in the assessment are addressed, and frequency of services is documented.
- Crisis Plans are developed, potential causes and strategies to address a crisis is documented, and crisis contact and resources are identified.

During this reporting period, LDH staff debriefed with the SME team member regarding the findings from the FY 2023 service review. This included a debrief 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 provide 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.
- These reports indicate network adequacy of community based behavioral health services continues to be sufficient.
- CCMs report on services needed but not received by individuals who are receiving CCM. These monthly reports provide information on strategies needed or implemented to address these needs.
- LDH has processes in place to review the fidelity of some evidenced based practices (e.g., ACT). It will need to develop similar processes to review the new services, including personal care services, IPS and Peer Supports.
- 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, personal care services, 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 fourth compliance report from the SME regarding the My Choice Program. As indicated earlier, this report focuses on priority sections and not all paragraphs in the report. There continue to be areas where the State has undertaken significant activities to meet the intent of specific paragraphs and is in partial compliance or is 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 331 individuals for CY 2024.
- Implementing the 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. In addition, recent conversations between the Louisiana Hospital Association and LDH should assist with diverting individuals from NFs. Given the growth in the number of individuals in the Target Population in NFs, it is critical for LDH to successfully divert individuals from NFs to comply with this Agreement.
- Successfully implementing the 3 and 14 day RITC pilot. This pilot, if implemented as proposed, will better identify individuals early in their admission process and transition them quickly and thereby decrease the amount of time needed for individuals to transition.
- Implementing more assertive efforts to create more opportunities for community inclusion with a particular focus on providing peer support and meaningful work and volunteer opportunities.
- Continuing efforts to implement the quality assurance process and measure whether the My Choice Program is making an appreciable impact on individuals in the Target Population. This includes internal and external efforts to identify issues that impact quality and develop real solutions to address these issues. In addition, LDH should increase the transparency of their quality efforts through the posting of the Quality Matrix and the development of annual quality plans.
- Moving the needle on crisis services to establish the Crisis Hub and crisis services in areas that have no providers and ensure existing providers are available 24/7 as required by the Agreement.
- Measuring whether the State tracks and adjusts the efforts set forth in the CY 2022 Housing Plan. This is a substantive requirement in the Agreement that is to be measured—the State must develop and offer 1,000 housing opportunities to individuals in the My Choice Program.

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

99. The State will collect and analyze consistent, reliable data to improve the availability, accessibility, and quality of services to achieve positive outcomes for individuals in the Target Population. The State will create protocols on collection and analysis of data to drive improvement in services, which shall be developed with the technical assistance and approval of the Expert prior to implementation. Data elements shall measure the following areas:

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

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

My Choice Quality Matrix 3.0

Activity related	#	Proposed Measure	Methodology	Data Source	Frequency Measure Reported	Population	Quarter 1 January-March 2023	Quarter 2 April-June 2023	Quarter 3 July-September 2023	Quarter 4 October-December 2023
98. On a regular basis, and as needed based on adverse outcomes or data, the State will assess provider and MCO services, the amount, intensity, and availability of such services, and quality assurance processes, and will take corrective actions where appropriate to ensure sufficient quality, amount, and accessibility of services provided pursuant to this Agreement.										
Amount, Intensity, availability of services	98.1									
99(a) Referral to, admission and readmission to, diversion from, and length of stay in, nursing facilities										
Referral/ Admission	99.a-1	Number of referral to Level II SMI authorities from the Level I authority	Total # of referrals to Level II SMI authorities preadmission (excludes deaths and withdrawns)	Utopia System	Quarterly	Individuals requesting PASRR Level I admission	806 Total Pre Admits 342 Level II Not Required 362 Approvals	840 total Pre-Admits 360 Level II Not Required 378 Approvals	789 total Pre Admits 330 Level II Not Required 386 Approvals	
Referral/ Admission	99.a-2	Number and percent of individuals that are admitted into Nursing Facilities that have a completed PASRR Level II upon admission	# admitted with a PASRR Level II/Total # admitted to NF	New PASRR Level I system	Quarterly	TP members in NF	91% of individuals admitting into the NF have a completed PASRR Level II	97% of individuals admitting into the NF have a completed PASRR Level II	96% of individuals admitting into NF have a completed PASRR Level II	94% of individuals admitting into a NF have a completed PASRR Level II
Diversion	99.a-3	Number and percent of individuals diverted	# of individuals diverted/Total # of diversions projected for annual goal	Utopia System	Quarterly	Individuals defined are referred for NF admission but the PASRR L2 indicates community placement (diversion plan)	31/137 23%	62/137 45%	88/137 64%	122/137 89%
Diversion	99.a-4	Number and percent of PASRR determinations indicating that admission to NF is not recommended as it is not the least restrictive setting	# Level II determinations not recommending NF Admission/# initial Level II referral requests for placement excluding cases identified as withdrawn and not requiring a Level II (deferred to OAAS and OCDD)	Utopia System	Quarterly	TP members identified as diverted	31/464 6.68%	31/480 6.46%	26/459 5.66%	
Length of Stay	99.a-5	Average length of stay in nursing facility	Estimated using MDS data	MDS 3.0 data	Semi-annual	Individuals on the Master List	Not time to pull this data	3.4 years	Not time to pull data	3.4 year
Readmission	99.a-6	Number and percent of transitioned members are re-admitted to a NF for greater than 90 days during the first year post transition	Number of transitioned members readmitted for greater than 90 days during the first year of transition/Total number of transitions	OPTS	Semi-annual	TP members identified as transitioned and that re-admit to the facility greater than 90 days during the first year post-transition.	Semi-annual reporting Report in June and December	11/210 5% (To determine the denominator -looked at total number of people transitioned from June 2022-June 2023; Numerator=number of people on monthly report identified with a closure reason of readmission)	Semi-annual reporting Report in June and December	21/190 11% (To determine the denominator -looked at total number of people with a transition date December 2022-December 2023: Numerator =number of people on monthly report identified with a closure reason of readmission)
99(b) Person-centered planning, transition planning, and transitions from nursing facilities										
Transition	99.b-1	Number and percent of individuals transitioned	# of individuals transitioned/Total # of transitions projected for the annual goal	SharePoint/OPTS	Quarterly	Individuals identified on Active Caseload that have transitioned with support from TCs.	38/350 11%	82/350 23%	147/350 42%	174/350 50%
Planning	99.b-2	Number and percent of members that have a plan of care that reflects identified needs from the assessment	SME review of representative sample of members in the TP	SME Service Review	Semi-annual	Sample of TP members as defined by the Agreement (transitioned/diverted) that accept CCM.	Unable to get this information from the service review as the current plan format does not include amount, frequency, and duration. Team will need to discuss and identify options to collect this information.	Unable to get this information from the service review as the current plan format does not include amount, frequency, and duration. Team will need to discuss and identify options to collect this information.	Unable to get this information from the service review as the current plan format does not include amount, frequency, and duration. Team will need to discuss and identify options to collect this information.	Unable to get this information from the service review as the current plan format does not include amount, frequency, and duration. Team will need to discuss and identify options to collect this information.
Planning	99.b-3	Number and percent of members who participated in the planning meeting	Suggest pulling a sample at specified interval to review. Participation evidenced by presence of the member's signature on the plan of care # number of members signed POC/Total # of TP members included in the sample	SME Service Review	Semi-annual	TP members as defined by the Agreement (transitioned/diverted) that accept CCM	91%	50%	80%	
Planning	99.b-4	Number and percent of members whose plan of care reflect their strengths and preferences	Suggest pulling a sample at specified interval to review the information and comparing information identified in the assessment to the plan to confirm that the plan reflects the member's interests and preferences. # number of members that have a service plan that reflects their interests and preferences/Total # of TP members included in the sample	SME Service Review	Semi-annual	TP members as defined by the Agreement (transitioned/diverted) that accept CCM	86%	50%	90%	
(c) Safety and freedom from harm (e.g., neglect and abuse, exploitation, injuries, critical incidents, and death; timely reporting, investigation, and resolution of incidents);										
Critical incidents	99.c-1	Number of critical incidents, stratified by type of incident	Review and analysis of critical incident reports using provider and member reported CI information	CCM Reports	Quarterly	TP members as defined by the Agreement (transitioned/diverted) that accept CCM	For Q1, 7 critical incidents were reported. 4 were for neglect, 3 were for exploitation. All incidents were reported within 24 hours to protective services within 24 hours of notification.	For Q2, 9 critical incidents were reported. 2 for abuse, 3 for exploitation, 3 for involvement with law enforcement and 1 for Major Behavioral Disturbance. The 5 incidents that were reported for either abuse or exploitation were all reported within 24 hours to protective services within 24 hours of notification.	For Q3, 19 critical incidents were reported. 3 for abuse, 4 for exploitation, 6 for neglect, and 2 for eviction, 2 for Major Behavioral Disturbance and 2 for Involvement with Law Enforcement. The 13 incidents that were reported for either abuse, neglect and/or exploitation were all reported timely (within 24 hours) to protective services within 24 hours of notification.	
abuse/neglect/exploiation	99.c-2	Number and percent of critical incidents involving abuse/neglect/exploitation that were referred to the appropriate protective service and or licensing agency	Number of abuse, neglect, exploitation referrals made	CCM Reports	Quarterly	TP members as defined by the Agreement (transitioned/diverted) that accept CCM	7	5	13	
death	99.c-3	Number of deaths reported	Total number of deaths reported	SharePoint	Quarterly	TP members as defined by the Agreement (transitioned/diverted) that accept CCM and/or are involved with a TC	7	9	8	3
death; investigation	99.c-4	Number of deaths referred for mortality review	Of the reported deaths, total number of deaths that are referred for mortality review	SharePoint	Quarterly	TP members as defined by the Agreement (transitioned/diverted) that were referred to mortality review.	4	5	5	2
death; investigation	99.c-5	Number and percent of death investigations that were completed	# of death investigations completed/Total # of deaths referred for mortality review	SharePoint	Quarterly	TP members as defined by the Agreement (transitioned/diverted) with a completed death investigation.	0/4 new referrals completed 5/15 total reviews completed (33%)	0/5 new referrals completed 11/20 total reviews completed (55%)	0/5 new referrals completed 12/25 total reviews completed (48%)	0/2 new referrals completed 16/27 total reviews completed (59%)
death (timeliness)	99.c-6	Average length of time to complete a death investigation	Average length of time=calculating the sum of the total number of days from the notification date to the date death investigation completed	SharePoint	Quarterly	TP members as defined by the Agreement (transitioned/diverted) referred to MRC with a completed review.	265 days	326 days	155 days	221 days
death; resolution	99.c-7	Number and percent of deaths that require a remediation plan	# of death investigations that result in the need for a remediation plan/Total # of death investigations completed	SharePoint	Quarterly	TP members as defined by the Agreement (transitioned/diverted) referred to MRC with a completed review.	3/5 reviews completed required a remediation plan (60%)	4/6 reviews completed required a remediation plan (67%)	1/1 review completed required a remediation plan (100%)	3/4 reviews completed required a remediation plan (75%) Total reviews completed 2023 requiring remediation plan 11/16 (69%)
	99.c-8	Number and percent of participants whose service plans had strategies that addressed their health and safety risks as indicated in the assessment (s)	SME review of representative sample of individuals transitioned from NFs	SME Service Review	Semi-annual	TP members as defined by the Agreement (transitioned/diverted) that accept CCM	59%	50%	80%	
abuse/neglect/exploiation	99.c-8	Number and percent of members reporting that they have been free from abuse, neglect, or exploitation	Self-Report. CCM collects information from the member during the monthly contact. # of members reporting they were free from abuse, neglect or exploitation/Total # of TP members interviewed	CCM Reports	Quarterly	TP members as defined by the Agreement (transitioned/diverted) that accept CCM	As of March 2023, there are a total of 250 transitioned and diverted members receiving CCM. 99% of members report they are free from abuse, neglect, exploitation, or extortion.	As of June 2023, there are a total of 272 transitioned and diverted members receiving CCM. 99% of members report they are free from abuse, neglect, exploitation, or extortion.	As of September 2023, there are a total of 279 transitioned and diverted members receiving CCM. 98% of members report they are free from abuse, neglect, exploitation, or extortion.	
(d) Physical and mental health and wellbeing, and incidence of health crises (e.g., frequent use of crisis services, admissions to emergency rooms or hospitals, admissions to nursing facilities, or admissions to residential treatment facilities)										
ED/Inpatient utilization	99.d-1	Number and percent of members ED Services – All Cause and BH related	# of members that utilized ED services (all cause)/Total # of transitioned and diverted members # of members that utilized Inpatient (BH related)/Total # of transitioned and diverted members	Claims data	Quarterly	TP Members as defined by the Agreement (transitioned/diverted)	37/424 (all cause ED) 9% 11/424 3%	60/475 (all cause ED) 13% 12/475 3%	66/516 (all cause ED) 13% 20/516 (BH Related) 4%	
ED/Inpatient utilization	99.d-2	Number and percent of Inpatient –All Cause and BH related	# of members that utilized Inpatient (all cause)/Total # of transitioned and diverted members # of members that utilized Inpatient (BH related)/Total # of transitioned and diverted members	Claims data	Quarterly	TP Members as defined by the Agreement (transitioned/diverted)	31/424 (All cause) 7% 19/424 (BH Related) 4%	44/475 (All cause) 9% 20/475 (BH Related) 4%	40/516 (All cause) 8% 23/516 (BH Related) 4%	
Physical/BH wellbeing	99.d-3	Number and percent of members reporting good physical health	Self-Report: CCM collects informaton from the member during the monthly contact. # of members reporting good physical health/Total # of TP members interviewed	CCM Reports	Quarterly	TP members as defined by the Agreement (transitioned/diverted that accept CCM)	As of March 2023, there are a total of 250 transitioned and diverted members receiving CCM. 61% of members report good physical health.	As of June 2023, there are a total of 272 transitioned and diverted members receiving CCM. 56% of members report good physical health.	As of September 2023, there are a total of 279 transitioned and diverted members receiving CCM. 57% of members report good physical health.	

Physical/BH wellbeing	99.d-4	Number and percent of members that report that taking medications as prescribed	Number and percent of members reporting good mental health	CCM Reports	Quarterly	TP members as defined by the Agreement (transitioned/diverted) that accept CCM	As of March 2023, there are a total of 250 transitioned and diverted members receiving CCM. 64% of members report good mental health.	As of June 2023, there are a total of 272 transitioned and diverted members receiving CCM. 60% of members report good mental health	As of September 2023, there are a total of 279 ransitioned and diverted members receiving CCM. 61% of members report good mental health.	
Physical/BH wellbeing	99.d-5	Number and percent of members that report taking medications as prescribed	Self-Report item. CCM collects information from the member during the monthly contact # of members reporting taking medication as prescribed/Total # of TP members interviewed	CCM Reports	Quarterly	TP members as defined by the Agreement (transitioned/diverted) that accept CCM	As March 2023, there are a total of 250 transitioned and diverted members receiving CCM. 92% of members reported taking medications as prescribed.	As June 2023, there are a total of 272 transitioned and diverted members receiving CCM. 93% of members reported taking medications as prescribed.	As September 2023, there are a total of 279 transitioned and diverted members receiving CCM. 90% reported they are taking medications as prescribed.	
use of crisis services	99.d-6	Number and percent of members that utilized crisis services	# of members receiving crisis services/Total # of transitioned and diverted members	Claims data	Quarterly	TP members as defined by the Agreement (transitioned/diverted)	2	0	0	
(e) Stability (e.g., maintenance of chosen living arrangement, change in providers, work or other day stability										
maintenance of chosen living arrangement	99 e-1	Number and percent of members reporting stability in housing	Self-Report. CCM will collect this information during the monthly contact. # of members reporting no change in living situation/Total # of TP members interviewed	CCM Reports	Quarterly	TP members as defined by the Agreement (transitioned/diverted) that accept CCM.	As of March 2023, there are a total of 250 transitioned and diverted members receiving CCM. 88% of members report stability in living situation.	As of June 2023, there are a total of 272 transitioned and diverted members receiving CCM. 91% of members report stability in living situation.	As of September 2023, there are a total of 279 transitioned and diverted members receiving CCM. 87% of members report stability in living situation.	
maintenance of chosen living arrangement	99 e-2	Number and percent of members reporting no issues with current living situation	Self-Report. CCM will collect this information during the monthly contact. # of members reporting no issues with current living situation/Total # of TP members interviewed	CCM Reports	Quarterly	TP members as defined by the Agreement (transitioned/diverted) that accept CCM	As of March 2023, there are a total of 250 transitioned and diverted members receiving CCM. 89% of members report a good living situation.	As of June 2023, there are a total of 272 transitioned and diverted members receiving CCM. 92% of members report a good living situation.	As of September 2023, there are a total of 279 transitioned and diverted members receiving CCM. 93% of members report a good living situation.	
stability in chosen natural supports	99 e-3	Number and percent of members reporting stability in natural supports network	Self-Report. CCM will collect this information during the monthly contact. # of members reporting no change in natural support network/Total # of TP members interviewed	CCM Reports	Quarterly	TP members as defined by the Agreement (transitioned/diverted) that accept CCM	As of March 2023, there are a total of 250 transitioned and diverted members receiving CCM. 97% of members report stability in caregivers.	As of June 2023, there are a total of 272 transitioned and diverted members receiving CCM. 99% of members report stability in caregivers.	As of September 2023, there are a total of 279 transitioned and diverted members receiving CCM. 98% of members report stability in caregivers.	
stability in chosen service providers	99 e-4	Number and percent of members reporting stability in service providers	Self-Report. CCM will collect this information during the monthly contact. # of members reporting no change in service providers/Total # of TP members interviewed	CCM Reports	Quarterly	TP members as defined by the Agreement (transitioned/diverted) that accept CCM	As of March 2023, there are a total of 250 transitioned and diverted members receiving CCM. 94% of members report stability in service providers.	As of June 2023, there are a total of 272 transitioned and diverted members receiving CCM. 97% of members report stability in service providers.	As of September 2023, there are a total of 279 transitioned and diverted members receiving CCM. 95% of members report stability in service providers.	
(f) Choice and self-determination (e.g., service plans are developed through person-centered planning process, choice of services and providers, individualized goals, self-direction of services										
choose how to spend day	99.f	Number and percent of members reporting that they are able to make choices and exert control over their own life	Need to identify a mechanism to collect this information.		Quarterly	TP members as defined by the Agreement (transitioned/diverted) that accept CCM				
(g) Community inclusion (e.g., community activities, integrated day and employment outcomes, integrated living options, relationships with non-paid individuals);										
community activities, how to spend time, etc.	99.g-1	Number and percent of members reporting that they are involved in the community to the extent they would like	Self-Report. CCM will collect this information during the monthly contact. # of members reporting they participated in activities outside of their home/Total # of TP members interviewed	CCM Reports	Quarterly	TP members as defined by the Agreement (transitioned/diverted) that accept CCM	As of March 2023, there are a total of 250 transitioned and diverted members receiving CCM. 90% of members report they are involved in the community to the extent they would like.	As of June 2023, there are a total of 272 transitioned and diverted members receiving CCM. 95% of members report they are involved in the community to the extent they would like.	As of September 2023, there are a total of 279 transitioned and diverted members receiving CCM. 95% of members report they are involved in the community to the extent they would like.	
99(h) Provider capacity (e.g., adherence to provider qualifications and requirements, access to services, sufficiency of provider types);										
Access	99.g-2	Number and percent of specialized behavioral health providers meeting appointment availability standards. 1) Emergent: 1 hour; 2) Urgent: 48 hours (2 calendar days); Routine: 14 calendar days	Statistically significant random sample of providers to obtain next available appointment	MCO Reports Summary of Providers Level of Care Network Adequacy review	Quarterly	All individuals accessing BH services.	See Network Report	See Network Report		
	99.g-2	Number of community based behavioral health providers available to provide services and accepting new Medicaid participants	# of providers accepting new Medicaid patients by level of care stratified by LDH region	MCO Reports Summary of Providers Level of Care Network Adequacy review	Quarterly	All individuals accessing BH services.	See Network Report	See Network Report		
	99.g-3	Number of community based behavioral health providers available to serve BH Medicaid beneficiaries stratified geographically by region	Report analysis # of providers accepting new Medicaid patients by level of care stratified by LDH region	MCO Reports Summary of Providers Level of Care Network Adequacy review	Quarterly	All individuals accessing BH services.	See Network Report	See Network Report		
99(i) Barriers to serving individuals in more integrated settings, including the barriers documented and any involvement of the Transition Support Committee as required by Section V.D .;										
In-Reach Barriers	99.i-1	Number and percent of barriers identified during in-reach contacts for people that indicating they are undecided, not interested, or unable to make a decision. **<u>Undecided/Not Interested Reasons:</u>** Family/Guardian not supportive of transition Decline in PH Concerns about management of PH Concerns about medication management Concerns about transportation Concerns expressed related to housing Concerns related to needed supports (ADL/IADL) Concerns related to making friends and involvement in activities Concerns expressed related to needed BH supports Concerns expressed related to needed Medical Services Other **<u>Unable to make a decision:</u>** Interdicted/curator unable or unwilling to participate Individual is unwilling to participae in discussion re: transition Individual unable to engage in discussion (not able to communicate even with assistance of communication aides) Health condition resulting in the inability to engage in discussion regarding community option. Other	# of contacts by reason noted (Undecided/Not Interested and Unable to make a decision)/Total number of contacts completed during the timeframe	SP-In-Reach Barrier Report	Quarterly	All individuals contacted via in-reach process during the quarter	Only have March data See attached report	See attached report	See attached report	See attached report

Transiton Barriers	99.i-2	Number and percent of barriers identified during transition. **Barriers:** Concerns about medication management Concerns about management of physical health Concerns about transportation Concerns related to needed supports (ADL/IADL) Concerns expressed re: making friends and being involved in activities Concerns related to needed medical services Concerns related to needed BH supports Individual expereinced a decline in health and/or change in health status Individual refusing to meet with TC and/or participate in transition activities Individual unable to communicate using words (needs interpreter, or other communication aides) Individual refusing services impacting ability to transition Unstable med or BH condition resulting in an inability to participate in transition activities Cognitive patterns observced illustrate possible instability (suspect dementia) Individual interdicted the curator is unwilling/unable to participate in discussion re: transition Family/Guardian not supportive of transition NF uncooperative Housing: Waiting Greater than 6 months Housing: Accessible housing waiting greater than 6 months Housing: Waiting for a specific unit/town Housing: Waiting on a home inspection (timeframe exceeds typical expectations) Provider Issues: Unable to locate a provider Environmental Mods delayed due to supply issues Home Mods (general) delayed due to supply issues Durable Med Equipment issues/delays Issues obtaining standard documents that exceed typical timeframes Other:	# of individuals by transition reason noted /Total number of individuals with barriers identified	SP-Transition Barrier Report	Quarterly	Individuals on AC with an identified barrier during the quarter	Did not roll this up first quarter.	See attached report	See attached report	See attached report
99 (j) Access to and utilization of Community-Based Services.										
	99.j-1	Number and percent of members reporting they are receiving the all services they need as specified in the plan of care (waiver, non-waiver, behavioral health, etc.)	Self-Report. CCM collects information from the member during the monthly contact. # of members reporting they received all services needed as specified in the plan of care/Total # of TP members interviewed	CCM reports	Quarterly	TP members as defined by the Agreement (transitioned/diverted) that accept CCM	As of March 2023, there are a total of 250 transitioned and diverted members receiving CCM. 89% of members report that they receive all needed services.	As of June 2023, there are a total of 272 transitioned and diverted members receiving CCM. 94% of members report that they receive all needed services.	As of September 2023, there are a total of 279 transitioned and diverted members receiving CCM. 93% of members report that they receive all needed services.	

Q3 2023

Table 1. DOJ Transitioned Members

# of Target Population members Transitioned with Medicaid
407

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

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 Recivng 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	49	.	.	9	18.4%	2	4.1%	3	6.1%	1	2.0%	.	.	14	28.6%	1	2.0%	25	51.0%	32	65.3%	25	51.02%
Region 2	55	.	.	26	47.3%	1	1.8%	6	10.9%	5	9.1%	.	.	11	20.0%	.	.	17	30.9%	42	76.4%	23	41.82%
Region 3	28	.	.	7	25.0%	1	3.6%	.	.	.	.	.	.	5	17.9%	1	3.6%	16	57.1%	18	64.3%	11	39.29%
Region 4	58	.	.	24	41.4%	1	1.7%	3	5.2%	1	1.7%	.	.	2	3.4%	.	.	27	46.6%	42	72.4%	35	60.34%
Region 5	27	.	.	13	48.1%	.	.	3	11.1%	.	.	.	.	2	7.4%	.	.	11	40.7%	15	55.6%	16	59.26%
Region 6	34	.	.	21	61.8%	.	.	1	2.9%	5	14.7%	.	.	1	2.9%	.	.	11	32.4%	21	61.8%	15	44.12%
Region 7	54	.	.	22	40.7%	1	1.9%	.	.	1	1.9%	.	.	8	14.8%	1	1.9%	25	46.3%	32	59.3%	30	55.56%
Region 8	33	.	.	10	30.3%	1	3.0%	2	6.1%	3	9.1%	.	.	.	.	1	3.0%	19	57.6%	19	57.6%	12	36.36%
Region 9	33	.	.	16	48.5%	.	.	1	3.0%	4	12.1%	.	.	.	.	1	3.0%	16	48.5%	21	63.6%	15	45.45%
Out of State	1	.	.	1	100.0%	.	.	.	.	.	.	.	.	.	.	.	.	.	.	1	100.0%	1	100.00%
Statewide	364	0	0.0%	146	40.1%	7	1.9%	19	5.2%	20	5.5%	0	0.0%	43	11.8%	5	1.4%	162	44.5%	239	65.7%	183	50.27%
% of Total Tra	89.4%		0.0%		35.9%		1.7%		4.7%		4.9%		0.0%		10.6%		1.2%		39.8%		58.7%		44.96%

Table 3. DOJ Transitioned Members - Crisis and Hospital Utilization

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	49	.	.	.	.	.	.	.	8	16.3%	1	2.0%	17	2	6	12.2%	1	2.0%	7	1
Region 2	55	.	.	.	.	.	.	.	7	12.7%	2	3.6%	17	4	6	10.9%	2	3.6%	8	4
Region 3	28	.	.	.	.	.	.	.	2	7.1%	.	.	2	.	1	3.6%	.	.	2	.
Region 4	58	.	.	.	.	.	.	.	11	19.0%	2	3.4%	30	2	7	12.1%	3	5.2%	10	3
Region 5	27	.	.	.	.	.	.	.	3	11.1%	1	3.7%	6	1	.	.	.	.	.	.
Region 6	34	.	.	.	.	.	.	.	5	14.7%	1	2.9%	15	1	2	5.9%	2	5.9%	2	2
Region 7	54	.	.	.	.	.	.	.	5	9.3%	1	1.9%	14	1	3	5.6%	2	3.7%	6	2
Region 8	33	.	.	.	.	.	.	.	3	9.1%	2	6.1%	11	2	1	3.0%	1	3.0%	2	1
Region 9	33	.	.	.	.	.	.	.	1	3.0%	.	.	1	.	1	3.0%	1	3.0%	2	2
Out of State	1	.	.	.	.	.	.	.	1	100.0%	.	.	2	.	.	.	.	.	.	.
Statewide	364	0	0	0	.	.	0	0.0%	45	12.4%	10	2.7%	115	13	27	7.4%	12	3.3%	39	15
% of Total Transitioned members								0.0%		11.1%		2.5%				6.6%		2.9%		

Q3 2023

Table 1. DOJ Diverted Members

# of Target Population members Diverted with Medicaid
109

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

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	12	.	.	2	16.7%	1	8.3%	.	.	.	.	.	.	.	.	1	8.3%	8	66.7%	8	66.7%		0.00%
Region 2	10	.	.	4	40.0%	.	.	1	10.0%	1	10.0%	.	.	.	.	.	.	5	50.0%	6	60.0%	1	10.00%
Region 3	5	.	.	2	40.0%	.	.	.	.	.	.	.	.	.	.	.	.	3	60.0%	2	40.0%	1	20.00%
Region 4	14	.	.	4	28.6%	.	.	1	7.1%	.	.	.	.	.	.	2	14.3%	8	57.1%	8	57.1%		0.00%
Region 5	7	.	.	2	28.6%	.	.	2	28.6%	.	.	.	.	.	.	.	.	3	42.9%	5	71.4%	1	14.29%
Region 6	4	.	.	.	.	.	.	2	50.0%	1	25.0%	.	.	.	.	.	.	2	50.0%	3	75.0%	1	25.00%
Region 7	10	.	.	6	60.0%	.	.	1	10.0%	.	.	.	.	.	.	1	10.0%	3	30.0%	6	60.0%	1	10.00%
Region 8	8	.	.	1	12.5%	.	.	.	.	.	.	.	.	.	.	.	.	7	87.5%	3	37.5%		0.00%
Region 9	6	.	.	1	16.7%	.	.	1	16.7%	1	16.7%	.	.	.	.	1	16.7%	3	50.0%	6	100.0%		0.00%
Out of State	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	
Statewide	74	0	0.0%	22	29.7%	1	1.4%	8	10.8%	3	4.1%	0	0.0%	0	0.0%	5	6.8%	40	54.1%	46	62.2%	5	6.76%
% of Total Di	0.67889908		0.0%		20.2%		0.9%		7.3%		2.8%		0.0%		0.0%		4.6%		36.7%		42.2%		4.59%

Table 3. DOJ Diverted Members - Crisis and Hospital Utilization

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	12	.	.	.	.	.	.	.	1	8.3%	.	.	5	.	.	.	.	.	.	.
Region 2	10	.	.	.	.	.	.	.	7	70.0%	5	50.0%	33	10	4	40.0%	4	40.0%	9	9
Region 3	5	.	.	.	.	.	.	.	2	40.0%	1	20.0%	5	2	1	20.0%	.	.	2	.
Region 4	14	.	.	.	.	.	.	.	2	14.3%	.	.	7	.	2	14.3%	1	7.1%	4	1
Region 5	7	.	.	.	.	.	.	.	1	14.3%	1	14.3%	4	2	1	14.3%	1	14.3%	3	3
Region 6	4	.	.	.	.	.	.	.	1	25.0%	.	.	1	.	2	50.0%	2	50.0%	3	3
Region 7	10	.	.	.	.	.	.	.	2	20.0%	.	.	3	.	1	10.0%	1	10.0%	1	1
Region 8	8	.	.	.	.	.	.	.	2	25.0%	1	12.5%	2	1	.	.	.	.	.	.
Region 9	6	.	.	.	.	.	.	.	3	50.0%	2	33.3%	5	2	2	33.3%	2	33.3%	4	3
Out of State	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Statewide	74	0	-	0	.	.	-	0.0%	21	28.4%	10	13.5%	65	17	13	17.6%	11	14.9%	26	20
% of Total Diverted members										19.3%		9.2%				11.9%		10.1%		