

Department of Justice Agreement Compliance Guide

Updated April 1, 2021



I. Definitions

At Risk Population: The population with Serious Mental Illness and co-occurring physical health conditions who are at risk of nursing home placement. LDH is in the process of operationalizing this definition and this will be updated when finalized.

My Choice Louisiana: Transition Coordination initiative operated through OBH and OAAS in which individuals who meet the target population of the DOJ agreement are transitioned into the community from nursing facilities.

Olmstead: Olmstead v. L.C. is a ruling that requires states to eliminate unnecessary segregation of persons with disabilities and to ensure that persons with disabilities receive services in the most integrated setting appropriate to their needs.

Serious Mental Illness (“SMI”): Is a major mental disorder as described in 42 CFR 483 Subpart C (i)-(iii). Application of this definition should also take into consideration the current Diagnostic and Statistical Manual of Mental Disorders (DSM) definitions such as Schizophrenia Spectrum Disorders, other Psychotic Disorders, Bipolar Related Disorders, Depressive Disorders, Anxiety Disorders, Personality Disorders, Trauma Related Disorders or other major mental disorders that result in functional limitations in major life activities, including within the 6 months prior to nursing facility application, are not a primary diagnosis of dementia or co-occurring with a primary diagnosis of dementia, and are not episodic or situational. Note: this definition is specific to this Agreement.

Transition Assessment: Assessment developed by the Transition Coordinator as a precursor to the transition process. The assessment is developed in an effort to identify strengths, status, and needs for transition.

Transition Coordinator: Employed by OBH or OAAS, the Transition Coordinator will work with individuals identified as being part of the DOJ Target Population residing in nursing facilities and facilitating transition activities including: conducting assessments, developing transition plans, and further providing ongoing follow up, ensuring the enrollee’s needs in the community are met.

Transition Plan: Plan developed through the transition process led by the Transition Coordinator to facilitate and operationalize items needed to effectuate the enrollee’s transition into the community.

II. General Information

In 2014, the Department of Justice (DOJ) initiated an investigation of the state's mental health service system to assess compliance with Title II of the American with Disabilities Act (ADA). The DOJ published the findings of their investigation in 2016, in which they concluded that the State unnecessarily relies on nursing facilities to serve adults with serious mental illness instead of serving them in the most integrated setting appropriate to their needs as required by the ADA. The Louisiana Department of Health (LDH) began working with DOJ on a mitigation plan, and a formal agreement was entered into on June 6, 2018. LDH and DOJ are committed to achieving compliance with Title II of the ADA, which requires that the State's services to individuals with mental illness be provided in the most integrated setting appropriate to their needs. This agreement has the following goals: (1) divert individuals with serious mental illness away from inappropriate nursing facility placements by requiring comprehensive evaluations and services designed to enable them to live in community-based settings; and (2) identify people with serious mental illness who have been admitted to nursing facilities but are able to and would like to transition to the community, and provide them with transition and discharge planning and community-based services sufficient to meet their needs. With this Agreement, LDH intends to achieve the goals of serving individuals with serious mental illness in the most integrated setting appropriate to their needs, to honor the principles of self-determination and choice, and to provide quality services in integrated settings to achieve these goals.

The duration of the Agreement is for five (5) years, culminating on June 6, 2023. However, LDH must have implemented and demonstrated substantial compliance with the terms of the Agreement for at least one (1) year prior to its formal termination.

Given the broad reach of the Agreement and the implications for the Medicaid population, the MCOs shall comply with the terms of the Louisiana Department of Justice (DOJ) Agreement (Case 3:18-cv-00608, Middle District of Louisiana), subsequent implementation plans, the LDH Diversion Plan, and other activities required in order to implement this agreement as directed by LDH.

III. DOJ Target Population

The DOJ target population includes:

1. Medicaid-eligible individuals over 18 with SMI currently residing in a nursing facility and those individuals who have transitioned from a nursing facility and are referred for case management by a My Choice Louisiana transition coordinator.
2. 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.
3. Excludes those individuals with co-occurring SMI and dementia where dementia is the primary diagnosis

IV. At-Risk Population

The MCO shall identify enrollees who meet the at-risk definition/criteria and provide case management services in accordance with the requirements set forth in the statement of work and the DOJ Agreement Compliance Guide. The definition/criteria is as follows:

- Persons not currently admitted to a nursing facility, between 50-79 years old, with a P-linkage to an MCO,
- AND at least one of the following 3 behavioral health diagnoses in the last 2 years,
 - Anxiety Disorder (primary diagnosis ICD10CM codes F40-F48)
 - Major Depressive & Affective Disorders (primary diagnosis ICD10CM codes F30-F39)
 - Schizophrenia (primary diagnosis ICD10CM codes F20-F29)
- AND at least one of the following 4 physical health diagnoses based on CMS Chronic Condition Warehouse (CCW) Condition Algorithms:
 - Chronic Kidney Disease, Chronic Obstructive Pulmonary Disease and Bronchiectasis, Diabetes and/or Heart Disease or Stroke (Note: Heart Disease or Stroke is defined as any one of these 5 CCW conditions: Acute Myocardial Infarction, Atrial Fibrillation, Heart Failure, Ischemic Heart Disease, and/or Stroke/Transient Ischemic Attack)
- AND a combined total of at least six ED or IP visits (without regard to diagnosis) in the last 2 years.

V. PASRR

The MCO shall comply with all portions of the statement of work as they relate to implementation of PASRR activities. This includes requirements associated with staffing and completion of Independent Evaluations for PASRR Level II. Additionally, the MCO shall:

- A. Review all Level II evaluations prior to submission to OBH, ensuring the evaluations are accurate, thorough, and free from contradictory information, include all mandatory supporting documentation, include recommendations for nursing facility placement, and services.
- B. Ensure that PASRR Level II evaluators are familiar with the complete array of home and community-based services available to enrollees and offer community options in a meaningful way to enrollees, providing education about the services available to them as an alternate to nursing home placement.
- C. Through the Level II process, the MCO shall actively link the enrollee to alternate services individualized to their needs and necessary to maintain them in the community. This includes:
 1. Those services needed to address the enrollee's physical and behavioral healthcare needs; and
 2. Community resources necessary to ensure their social needs are met; and
 3. Referrals to home and community-based supports intended to assist the enrollee with their activities for daily living (ADL) and instrumental activities for daily living (IADL) needs.
- D. For individuals denied nursing facility placement, and therefore considered part of the diverted population within the DOJ Agreement, the MCO shall ensure enrollees are referred for case management as a special healthcare needs population.

1. The MCO shall make a referral to community case management within one (1) business day of referral from LDH.
- E. The MCO shall assist in linking with services and/or evaluations necessary to support the determination of SMI and/or an appropriate diagnosis related to an Alzheimer's or dementia-related disorder.
- F. The MCO shall have a process for collecting and tracking service referrals and service utilization for this population, reporting this information as directed by LDH.

VI. MCO Case Management

For at-risk enrollees, as defined in Section IV, the MCO shall offer and provide case management services through high-touch and face-to-face engagement in accordance with the statement of work requirements pertaining to individuals with special healthcare needs. In addition, the MCO shall:

A. Enrollee Engagement

1. Develop a strategy for successfully engaging enrollees using assertive engagement mechanisms to ensure the enrollee is aware and understands the benefit of case management services. Evaluate the effectiveness of the strategy at least annually with updates to the strategy made based on evaluation findings.
 - a. The MCO shall provide the strategy to LDH within 30 days from the issuance of the DOJ Agreement Compliance Guide, and thereafter upon material change.
2. Provide case management services to enrollees for a minimum of 12 months, or longer based on enrollee needs, unless the enrollee declines or dis-enrolls from case management.
 - a. The MCO shall identify the method and criteria that will be used to evaluate the enrollee's need for case management services beyond the 12-month period within 30 days from the issuance of the DOJ Agreement Compliance Guide, and thereafter upon material change. The criteria shall consider the enrollee's interest in continuing to receive case management, enrollee's level of engagement with service providers, use of crisis services and hospitalizations, and critical incidents.

B. Assessment of Enrollee Needs

1. Assess enrollees' needs, risk factors, current health status, current service utilization, gaps and care and medication review within 30 days of referral and every 180 days thereafter. The assessment shall identify need for medical, behavioral health, social/recreational, educational/vocational and other services and supports to meet the daily needs and preferences of the enrollee. These other services and supports include but are not limited to housing and housing supports, health/wellness, transportation, adaptive equipment, nutrition and dental services.
2. The assessment will include inputs from the enrollee, family/natural supports (if available and based on enrollee consent), and providers including peers (based on enrollee consent).

C. Plan of Care Development

1. Refer to the statement of work for minimum plan of care components.
2. Collaborate with the enrollee and others the enrollee chooses to be included to develop a person-centered plan of care within 30 calendar days following the assessment.
3. Update the plan of care upon significant change to the enrollee's needs or change of circumstances. At a minimum, plans of care shall be revised at least annually unless there is a significant change in the enrollee's needs or circumstances.
4. Provide copy of current plan of care to enrollee.

D. Referral and Linkage

1. Actively assist the enrollee with locating and arranging for services supports, scheduling appointments, and arranging for transportation.
2. Provider referral and linkages to community resources, as needed.
3. Coordinate any service authorizations needed from the MCO's Utilization Management (UM) section.

E. Plan of Care Monitoring and Follow-Up

1. Provide at least monthly contacts with the enrollees, or more frequently if needed, to ensure:
 - a. Enrollee is receiving needed services, including medication, and has good access to healthcare services including transportation;
 - b. Individual preferences continue to be sufficiently reflected in the current plan of care and the plan of care meets the enrollee's changing needs.
 - c. Enrollee is satisfied with services and providers;
 - d. Enrollee's living situation is safe and stable, and whether the enrollee is satisfied with the current living arrangement or is interested in changing such arrangements.
 - e. Enrollee health and welfare in the community.
2. Resolve identified issues in a timely manner.
3. Document case management activities in the MCO's case management system and maintain such documentation in accordance with statement of work requirements.

VII. MCO Case Manager Staffing and Training

The MCO shall maintain adequate staffing to ensure compliance with the requirements contained within the statement of work and with the DOJ Agreement Compliance Guide.

In addition to the training required in the statement of work, case managers and supervisors working with DOJ target population enrollees and those at-risk for nursing facility placement, shall receive the following additional training initially and on an annual basis thereafter:

1. Overview of serious mental illness (SMI), substance use disorders, and common chronic conditions impacting the SMI population
2. DOJ Agreement overview and associated monitoring and reporting requirements
3. Principles of and approach to person-centered planning using a strengths-based approach
4. Recognizing signs of abuse, neglect, extortion, and exploitation, and critical incident reporting requirements

5. Motivational interviewing and successful engagement strategies
6. Cultural competency and identification and methods to address social determinants of health

VIII. Community Case Management Program

For the DOJ target population, defined in Section III, the MCO shall develop a specialized community case management program consistent with the DOJ Agreement and LDH-issued guidance using subcontracted community case managers who meet the qualifications established by LDH. The MCO shall maintain ultimate responsibility for ensuring case management needs of the target population are met by community case managers/agencies and community case managers satisfactorily complete required activities.

- ✚ The community case management program will ensure each member identified by OBH as included in the target population, is assigned and has access to a qualified community case manager in the member's region of residence that will help divert the identified member from the nursing facility or facilitate the transition from nursing facility to the community, as well as provide ongoing case management for at least one full year after successful transition or diversion.
- ✚ Case management services and processes shall be individualized and person-centered, reflecting the member's unique strengths, needs, preferences, experiences and cultural background.
- ✚ Services will be comprehensive, culturally competent and of sufficient intensity to ensure community case managers are able to identify and coordinate services and supports to assist members with obtaining good health outcomes, achieve the greatest possible degree of self-management of disability and life challenges, prevent institutionalization or hospitalization, and connect members with resources that are based on their desires and hopes that build stability and enable them to recover and thrive.
- ✚ Services will include assuring access to all medically necessary services covered under the State's Medicaid program and addressing social determinants of health which serve as barriers to good health outcomes, including but not limited to behavioral and physical health services, specialty services, and referrals to community resources.

Part A - Agency Qualifications & Selection Process

1. The MCO shall ensure statewide coverage of community case management services to meet the requirements specified in this guidance. The MCO shall contract with one case management agency per LDH region, in collaboration with other MCOs, unless otherwise prior approved by LDH.
 - a. The MCO shall collaborate with other MCOs to jointly develop a mutually agreed upon request for proposal/request for information to identify and select a community case management agency in each LDH region of the state. MCOs may jointly propose an alternate methodology to the request for proposal/request for information process to identify and select the community case managers to LDH for review and approval. Any such alternate methodology must include LDH in the overall decision-making of which entities will be selected as the community case management agencies.

- b. Each selected community case management agency must have substantial experience providing case management services to members with serious mental illness under Medicaid home and community-based waiver programs, while successfully meeting programmatic requirements and quality standards.
 - c. The agency shall demonstrate capacity to provide 24/7 access to case management activities for the target population.
 - d. The MCO shall ensure the community case management agency and community case managers do not have a conflict of interest between any direct care activities and community case management responsibilities.
2. The MCO shall provide the request for proposal/request for information to LDH for review and approval by **June 14, 2021**.
 3. The MCO shall collaborate with other MCOs to jointly review the proposals and select community case management agencies. The MCO shall include LDH-designated representatives in the request for proposal/request for information review and selection process and provide advance notice of meeting dates and associated documents.
 4. The MCO shall execute a contract with the mutually selected community case management agencies by **September 14, 2021 with community case management services provided to DOJ Agreement Target Population members beginning November 1, 2021**.
 5. The MCO shall ensure there is an adequate number of trained community case managers and supervisors employed by each agency to ensure access and face to face engagement of the target population to case managers in accordance with the minimum contact requirements in Section VIII – Part D, the ability to provide same day responses or next business day responses during weekends and holidays by the assigned case manager, and with no more than a 1:15 ratio of trained community case managers to members in each region.
 6. The MCO shall ensure each contracted community case management agencies include the following staff:
 - a. A supervisor who is a licensed mental health professional (LMHP), with experience working with the SMI population, shall be available at all times to provide monitoring, back up, coaching, support and/or consultation to community case managers.
 - b. Community case managers who meet the requirements outlined in this guide, and
 - c. A registered nurse consultant with adequate expertise to address the medical, behavioral and social needs of the members assigned to the community case managers within the agency.

Part B - Single Point of Contact

1. The MCO shall provide a single point of contact, who has direct access to an LMHP or psychiatrist experienced working with the SMI population for clinical questions, for each community case management agency to coordinate the overall case management activities provided to the target population. The MCO point of contact requirements include, but are not limited to:
 - a. Review and approve the initial and ongoing assessment and plan of care to ensure all requirements are satisfactorily met.
 - b. Coordinate service request/authorizations with UM section and ensure service authorizations, consistent with the plan of care that is agreed upon by the member, the

community case manager, and the MCO are issued to the appropriate providers and authorization information is shared with the community case manager to facilitate monitoring of plan of care implementation. The MCO also has the obligation of performing utilization management on the services authorized and provided to ensure the services rendered are appropriate and necessary to achieve the goals and to meet the needs of the member.

- c. Secure service providers and linkages to other necessary community and social supports to the extent the community case manager is unable to find a service provider or needs assistance.
- d. Assist with arranging for transportation to healthcare appointments to the extent the community case manager needs assistance.
- e. Inform community case managers of the health status and other factors of the member that can be determined from available MCO data, including but not limited to hospitalizations and all-cause emergency department visits, that can contribute to successful community living of the member.

Part C – Community Case Management Activities

1. Engagement

- a. **Members Residing in Nursing Facilities:** For those members residing in a nursing facility, community case management activities will begin at least 60 days prior to the member's discharge from the nursing facility, with an option to engage earlier if recommended by the LDH transition coordinator, in order to plan for an effective and successful transition to a community living setting.
 - i. The community case manager will collaborate with the member, the LDH transition coordinator, 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.
 - ii. The community case manager shall attend transition planning meetings with the transition coordinator and member. At a minimum, the community case manager shall have at least four (4) face-to-face contacts in the 60-day period prior to the member's transition from the nursing facility, with at least two (2) of these face-to-face contacts occurring in the last 30 days prior to the member's transition from the nursing facility.
 - iii. The MCO shall ensure each transitioning member has all services, including prescription medication, in place necessary to transition the member at the appropriate time, with necessary services authorized at the point of transition to the community.
- b. For diverted members, community case management activities shall begin within 1 business day of referral from the MCO.

2. Comprehensive Level of Care/Needs Assessment

- a. The community case manager will conduct an initial assessment within four (4) business days of referral from OBH or the MCO, and a reassessment every ninety (90) days or whenever the condition or needs of the member change using an LDH-prescribed or approved assessment tool(s). For members transitioning from a nursing facility, the initial assessment is conducted by the LDH transition coordinator.

- b. The initial assessment and periodic reassessments of member's needs will identify the need for medical, behavioral health, social/recreational, educational/vocational and other services and supports to meet the daily needs and preferences of members. These other services and supports include, but are not limited to: housing and housing supports, employment, health/wellness, safety, transportation, health care services and adaptive equipment, nutrition and dental services.
- c. Assessments will include inputs from the member, family/natural supports, medical providers, behavioral health providers (including peers), and others important to the member who are identified by the member prior to assessment. Assessments will gather information from the member across several dimensions to identify gaps in care and proactively address such gaps in care to reduce risk of readmission or other negative outcomes including:
 - ✚ Functional Status: The degree to which a person is able to fulfill social responsibilities, to interact with others, maintain their physical functioning (such as sleep, appetite, energy, etc.), as well as a person's capacity for self-care.
 - ✚ Co-morbidities: Identifies potential complications in the course of illness due to level of acuity or disability related to co-occurring medical illness, substance use disorder and/or intellectual/developmental disability. This includes an assessment for information and education needed for management of these co-morbidities.
 - ✚ Recovery environment: This dimension considers factors in the environment, the social and interpersonal determinants of health and wellbeing that may support efforts to achieve or maintain mental health and/or abstinence.
 - ✚ Purpose and productivity: Assessments should include queries about the person's interests, concerns, perceived barriers and preferences about work and education.
 - ✚ Housing preferences: Identification of feelings, choices and supports needed for people to be successful in living independently. This can include choice of living arrangement, neighborhood and other aspects that are important to the person for their housing environment.
 - ✚ Community inclusion and engagement: The system should include opportunities for low demand social engagement, such as settings the public at large uses (i.e., libraries, senior centers, recreation centers, park programs etc.).
 - ✚ Risk of harm: This dimension of the assessment considers a person's potential to cause significant harm to self or others.
 - ✚ Treatment and recovery history: Past experience may be one predictor of future engagement and response to treatment and supports and shall be taken into account in determining service needs and related person centered plan of care.
 - ✚ Crisis and relapse triggers: Some situations or behaviors, called triggers, can lead to a relapse. Identifying triggers through the assessment process will allow the development of strategies to deal with them and reduce the risk of crisis or relapse.

3. Person-Centered Plan of Care Development

- a. The community case manager will develop the person-centered plan of care, based on the principles of self-determination and recovery, that will assist the member in achieving outcomes that promote the member's social, professional and educational growth and independence in the most integrated settings using a strengths-based approach.

- b. The person-centered plan of care shall reflect the member's needs, strengths, preferences, choices and goals as identified in the assessment process.
- c. The development of a plan of care should include family, natural supports, providers and others important to the member that the member identifies and requests to be part of the planning process.
- d. At a minimum, the person-centered plan of care should include the following:
 - ✚ Member's goals, desired outcomes (as stated in the member's own words), needs (including health care needs), strengths, and preferences.
 - ✚ Services and supports to achieve these goals and meet member's needs (formal and informal). This should include medical, behavioral health, housing, social, educational/vocational and other services requested by the member.
 - ✚ Type, amount, duration, and frequency of services, including service providers.
 - ✚ Strategies to address identified barriers.
 - ✚ Crisis resources to prevent unnecessary hospitalization or institutionalization in accordance with member needs and preferences.
 - ✚ Emergency preparedness and backup plan.
 - ✚ Documentation the member participated in the planning process and was offered freedom of choice of services and providers.
- e. For members transitioning from a nursing facility, the plan of care shall be developed within 14 days following the member's discharge from the nursing facility. For diverted members, the community case manager shall connect members with service providers to respond to urgent needs within 7 days following the referral, with the plan of care developed within 30 days following the referral.
- f. Plans of care shall be reviewed at least every 90 days to determine if changes are needed or when there is a significant change in the member's needs or change of circumstances. At a minimum, plans of care shall be revised at least every 6 months.
- g. LDH may prescribe use of a specific plan of care tool and associated documents (e.g., emergency back-up plan, freedom of choice form).
- h. The community case manager shall work with the member and his/her authorized representative to develop a transition plan which shall include the services and supports that will remain in place following discontinuation of community case management services, at least 30 days prior to the member's discharge from community case management services. The transition plan shall also include the contact information for each service provider and the MCO.

4. Referral and Linkage

- a. The community case manager shall refer and link members with necessary services and supports identified in the plan of care, including, but not limited to: primary care and specialty healthcare services, medications, substance use detoxification/treatment, mental health treatment, local housing authorities, supportive employment, education and coordination to ensure enrollment in benefit programs needed by the member.
- b. The community case manager will conduct the following activities with support from the MCO as needed:
 - i. Inform the member of available supports and services, and provide choice of services and service providers.

- ii. Actively assist the member with locating and arranging for services and supports, scheduling appointments, and arranging for transportation.
- iii. Actively assist the member with contacting and accessing community resources as needed, including scheduling appointments for the member.
- iv. Prepare members for appointments, including but not limited to providing education on transportation system and health care related processes, and assisting the member to develop questions to ask the care provider as needed.
- v. Attend appointments with the member, as desired by the member, to assist the member in navigating the healthcare system.
- vi. Ensure services and supports are coordinated between all agencies that provide services to the member, including the MCO.
- vii. Exchange relevant information with agencies or professionals to whom the referral is being made in a manner consistent with confidentiality regulations and professional standards of care.

5. Monitoring and Follow-Up

- a. The community case manager shall monitor and follow up on the services and supports provided to the member to ensure the plan of care is effectively implemented, addresses the needs of the member and that the member is actively engaged. The community case manager shall resolve identified issues in a timely and appropriate manner.
- b. The community case manager shall conduct follow-up with the member, member's providers (based on member's consent), and natural supports (if available and based on member's consent) during the implementation of the plan of care and as needed to ensure the member is sufficiently engaged in the delivery of services as per the plan of care and treatment plan.
 - i. If the community case manager determines the member is not engaged or accessing support services, the community case manager works with the member and supports to update the plan of care to address individualized needs, preferences, and goals.
 - ii. Community case managers advocate for the member and assist the member in achieving the goals in their plan of care.
- c. Community case managers are responsible for responding to the community living needs of members on their caseload. This could include, but not be limited to: providing instruction and direction to individuals during contacts (on site and remotely) regarding use of appliances, equipment, financial questions and other activities. These should support but not supplant instruction and directions provided by other providers (e.g., providers rendering PSH, psychosocial rehabilitation, personal care services, or community psychiatric support and treatment).
- d. Ongoing contact is made with the member at least monthly or more frequently as indicated to ensure:
 - i. Member is receiving needed services, in accordance with the member's plan of care and assessed needs. If this is not the case, the community care manager should follow up with the member and provider to gather information and update the plan or care if needed.
 - ii. Individual preferences continue to be sufficiently reflected in current plan of care and the plan of care meets the member's changing needs.

- iii. Member is satisfied with services and providers (including health, behavioral health and other supports) rendering such services, and if not, the community case manager takes immediate action to discuss other options with the member for alternative services or providers.
- iv. Member has good access to health care including primary and specialty healthcare and pharmacies for prescription drugs.
- v. Member does not feel isolated, and if so, ensure steps to promote better social opportunities and other efforts to promote community inclusion.
- vi. Current living setting is safe, stable and healthy and whether the member is satisfied with the current living arrangement or is interested in changing such arrangements.
- vii. Immediate issues are resolved before they become overwhelming and severely impair the members' ability to function or maintain in the community (e.g., housing eviction). For a mental health crisis, help the member connect with an appropriate treatment provider or crisis center.
- viii. Member health and welfare in the community, including reporting of critical incidents to the appropriate agencies and follow-up activities to ensure the member is protected from harm and prevent similar incidents from reoccurring.

Part D – Community Case Management Contacts

Community case managers are expected to have frequent and ongoing contacts with the members who have transitioned or are diverted from a nursing facility stay. At the point of transition or diversion, community case managers should minimally meet with members and service/support providers as follows:

- ✚ First 60 days: Four contacts per week with the member, with two contacts being face to face with the member. One contact with each service/support provider within the first two weeks.
- ✚ 61 – 180 days: Two contacts per week with the member, one of those contacts being face to face with the member. One contact with each service/support provider each 60 days.
- ✚ 181 – 365 days: Two contacts per month with the member, with one of those contacts being face to face with the member. One contact with each service/support provider each 60 days.
- ✚ 365+ days: Based on assessment to determine ongoing need and desire for case management. A minimum of two contacts per month with the member, with one face-to-face contact with the member. One contact with each service/support provider each quarter.

IX. Community Case Manager & Staff Qualifications

The MCO shall ensure contracted community case management agencies employ only qualified case managers and staff.

- ✚ Satisfactory completion of criminal background checks pursuant to La. R.S. 40:1203.1 et seq., La. R.S. 15:587 (as applicable), and any applicable state or federal law or regulation.
- ✚ Not excluded from participation in the Medicaid or Medicare Program by Louisiana Medicaid or the Office of Inspector General.
- ✚ Does not have a finding on the Louisiana State Adverse Action List;
- ✚ Pass a TB test;

- ✚ Pass a motor vehicle screen if duties include transporting members;
- ✚ Pass drug screening test, as required by the MCO's policies and procedures;
- ✚ Successful completion of First Aid and CPR training with a curriculum based on guidelines published by the American Heart Association (AHA). (Note: psychiatrists, APRNs/PAs, RNs, LPNs, and non-direct care staff are exempt from this training).

In addition, case managers must have a bachelor's-level degree in a human services field OR a bachelor's-level degree in any field with a minimum of two years of full-time experience working with the SMI population or providing case management to other populations (elders, adults with physical disabilities, or individuals with developmental disabilities).

X. Community Case Manager Training Requirements

Each case manager and supervisor must have at least 24 hours of training in the first year, including 16 hours of training before providing direct services (*denotes training that must occur prior to providing direct services). At a minimum, the training will include:

- ✚ Overview of required case management activities, including associated timeframes*
- ✚ Overview of serious mental illnesses, including symptoms, signs someone is doing well/not doing well*
- ✚ Recognizing signs of abuse, neglect, extortion or exploitation, and critical incident reporting requirements*
- ✚ Cultural competency and social determinants of health*
- ✚ Principles of and approach to person-centered planning using a strength-based approach*
- ✚ Motivational interviewing and successful engagement strategies*
- ✚ Identifying and cultivating relationships with formal providers in the community and other community resources
- ✚ Strategies for identifying and addressing crisis*
- ✚ Common physical health conditions impacting the SMI population, including overview of the condition, healthy ranges, modifiable risk factors, and strategies for supporting healthy behavior changes. Strategies to identify co-morbid conditions and likely medical services needed to address such conditions*
- ✚ Benefits and services for adults, including home and community-based services provided the Office of Aging and Adult Services and the Office of Citizens with Developmental Disabilities and MCO-covered services (including in-lieu of services and value add services). For MCO-covered services, training must cover member eligibility criteria, service goals and expected outcomes*
- ✚ Quality improvement expectations for target population and related reporting responsibilities*





In addition, community case managers and their supervisors shall meet any certification or other standards required for using the LDH-prescribed or approved assessment tool. The MCOs shall ensure case managers receive training on an annual basis which addresses at a minimum critical incident management and reporting, strategies for addressing crisis, and other areas determined by the MCO to address

programmatic changes or areas of need. LDH may require the MCOs to provide additional training to community case managers based on identified needs, programmatic/operational changes, best practices, or areas of concern.

The MCO shall develop a training plan and curriculum for addressing the training needs of community case managers and supervisors, and provide plan and curriculum to LDH by **July 1, 2021**. The training plan shall specify the trainings to be offered and required, training dates, training goals/objectives, methods to evaluate case managers and supervisors' proficiency, and person/entity conducting each specific training including a summary of qualifications. It is recommended the MCOs jointly develop the training plan and curriculum to reduce administrative burden on the community case management agencies/staff.

XI. Community Case Management Agency Requirements

The MCO shall ensure community case management agencies complete the following requirements:

-  Arrange for and maintains documentation that all persons, prior to employment, pass criminal background checks and a search of the U.S. Department of Justice National Sex Offender Registry. If the results of any criminal background check reveal that the potential employee (or contractor) was convicted of any offenses against a child/youth or an elderly or disabled person, the community case management agency shall not hire and/or shall terminate the employment (or contract) of such individual. The community case management agency shall not hire an individual with a record as a sex offender nor permit these individuals to work for the agency as a subcontractor. Criminal background checks must be performed as required by La. R.S. 40:1203.1 et seq., and in accordance with La. R.S. 15:587 et seq.
-  Not hire individuals failing to meet criminal background check requirements and regulations. Individuals not in compliance with criminal background check requirements and regulations shall not be utilized on an employment, contract nor volunteer basis. Criminal background checks performed over 30 days prior to the date of employment will not be accepted as meeting the criminal background check requirement. The community case management agency shall maintain the results of an individual's criminal background check in the individual's personnel record and comply with the confidentiality requirements of La. R.S. 40:1203.4.
-  Review the Department of Health and Human Services' Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) and the LDH State Adverse Actions website prior to hiring or contracting any employee or contractor that performs services that are compensated with Medicaid/Medicare funds, including but not limited to licensed and unlicensed staff, interns and contractors. Once employed, the lists must be checked once a month thereafter to determine if there is a finding that an employee or contractor has abused, neglected or extorted any individual or if they have been excluded from participation in the Medicaid or Medicare Program by Louisiana Medicaid or the Department of Health and Human Services' Office of Inspector General. The OIG maintains the LEIE on the OIG website (<https://exclusions.oig.hhs.gov>) and the LDH Adverse Action website is located at <https://adverseactions.ldh.la.gov/SelSearch>.
-  The community case management agency is prohibited from knowingly employing or contracting with, or retaining the employment of or contract with, anyone who has a negative finding placed on the Louisiana State Adverse Action List, or who have been excluded from participation in the Medicaid or Medicare Program by Louisiana Medicaid or the Department of Health and Human

Services' Office of Inspector General. The agency shall maintain the results of completed searches in the LEIE and LDH State Adverse Action databases in the individual's personnel record.

- ✚ Arranges for and maintains documentation that all persons, prior to employment, are free from tuberculosis (TB) in a communicable state via skin testing to reduce the risk of such infections in recipients and staff. Results from testing performed over 30 days prior to date of employment will not be accepted as meeting this requirement.
- ✚ Establishes and maintains written policies and procedures inclusive of drug testing staff to ensure an alcohol and drug-free workplace and a workforce free of substance use.
- ✚ Ensure and maintains documentation that all unlicensed persons employed by the organization complete training in a recognized crisis intervention curriculum prior to handling or managing crisis calls, which shall be updated annually.
- ✚ Maintains documentation of verification of staff meeting educational and professional requirements, as well as completion of required trainings for all staff.
- ✚ Ensure supervisors adequately monitor community case managers to ensure requirements are met. At a minimum, the supervisor shall observe community case managers providing services to members as follows:
 - Three meetings within the first month of hire and,
 - Minimum of one meeting every six months following hire.
- ✚ Not provide direct Medicaid-funded behavioral health services outside of community case management services, or steer members to non-Medicaid funded services provided by the agency or staff.
- ✚ Abide by record-keeping requirements pertaining to retention of records, confidentiality and protection of records, and review by state and federal agencies, as specified in the Behavioral Health Provider Manual. In addition, community case management agencies must ensure staff document all case management activities and maintain such documentation in accordance with LDH requirements.

XII. Standard Operating Procedures

The MCO shall collaborate with other MCOs to mutually develop standard operating procedures for the community case management program, which addresses the following minimum components including any associated timeframes:

- a. Referral processes and documentation requirements should a member or a member's authorized representative reject community case management services, including processes to connect the member to other supports, services, and care coordination.
 - i. Internal protocols to link members diverted from nursing facility care immediately to community case management agencies and for ensuring the PASRR II evaluators make an immediate referral for community case management services.
- b. Intake procedures, including obtaining member permission to coordinate care and obtain healthcare records in accordance with the privacy requirements at 45 CFR, parts 160 and 164, subparts A and E, to the extent they are applicable.
- c. Transition protocols for referral to MCO traditional case management when specialized community case management is no longer needed and transfer procedures if the member moves to another region or enrolls with another MCO.

- d. Assessment and reassessment process, including timelines, LDH-specified/approved assessment tools, certification requirements, documentation of member outcomes, and standardized process to determine when a member no longer requires community case management and member feedback into the process.
- e. Standards for development and documentation of the LDH-specified/approved plan of care, including community case manager coordination with the MCO to ensure services are authorized consistent with the member's needs and MCO prior authorization requirements.
- f. Procedures for offering freedom of choice of services and providers, and freedom of choice form completion.
- g. Process for referring and linking members to service providers that are qualified to provide the services defined in the plan of care.
- h. Process for service authorization and other MCO coordination procedures, including links to medical necessity criteria so community case managers know how to appropriately document services in the plan of care. This will include, but not be limited to:
 - i. Providing a single point of contact at the MCO for the community case managers at an agency to help facilitate service authorization and provider network referrals.
 - ii. Providing access to a network directory that is up to date and reflective of provider's current capacity to accept new members.
 - iii. Assist the community case manager with provider referrals and linkages to the extent needed and requested if they are unable to locate a provider in the MCO network.
 - iv. Assist the community case manager with securing transportation to appointments as necessary.
 - v. Process for accessing out-of-network providers.
- i. Process for monitoring implementation of the plan of care to determine if services are being delivered consistent with the plan of care and meeting member's needs.
- j. Procedures for responding to and reporting critical incidents.
- k. Establishment of minimum contact requirements for the agency case managers based on LDH-established criteria and how those contacts are recorded in the member's record.
- l. Procedures for emergency preparedness and response for case management entities, including a plan for case managers to complete and document the following within the member's record:
 - i. Contact all members within 24-48 hours prior to a known disaster or emergency to review the member's individualized emergency disaster plan, provide resource information, and to assess and address member needs, with the expectation that at least 85% of members are successfully contacted.
 - ii. Contact all members following a disaster or emergency within the timeframe requested by LDH to track the status of each member, including any sustained impacts due to the event, current location if displaced, determine if the current plan of care is meeting the member's needs, and to address any unmet needs, with the expectation that at least 80% of members are successfully contacted upon the initial outreach attempts and with 100% of members successfully contacted following the emergency.
- m. Procedures for access to language assistance services for any language spoken by the member including ASL.

- n. Monitoring and reporting mechanisms, including review elements/criteria, sample size, method of review, and frequency of review, to ensure the agency and case managers meet requirements initially and on a routine basis.
- o. Policies related to reporting from the community case management agency including reporting on assessments, contacts, development and/or updates to the plan of care, if members are receiving services according to the approved plan of care, member health and welfare, as well any other requests from LDH.



The MCO shall submit the standard operating procedures to LDH for approval by **August 1, 2021**, and thereafter prior to implementation of a material change.

The MCO shall educate community case management agencies, in collaboration with other MCOs, on the standard operating procedures initially and when changes are made to the approved plan. The MCO shall provide a copy of the standard operating procedures to community case management agencies initially and when changes are made.

XIII. Monitoring & Reporting

The MCO shall be in frequent contact (i.e., at least weekly) with community case management agencies to oversee community case management activities, review member status, identify and address member health and safety risks, coordinate members' care, address barriers to care or quality of care, develop engagement strategies, and plan for potential discharges.

The MCO shall conduct quality monitoring reviews to ensure community case management agencies/staff adhere to requirements and quality standards, ensure any required remedial actions are completed timely and appropriately, and validate community case management reporting on at least a semi-annual basis (every 180 days). In addition, the MCO shall ensure community case management staff and agencies meet the minimum qualifications and training requirements initially prior to delivering services and on an ongoing basis. The MCO shall collaborate with other MCOs to develop a strategy for monitoring community case management agencies and staff which shall include monitoring review elements, scoring criteria, minimum compliance threshold, sample size, number of charts to be reviewed, review period, validation activities, method of review (i.e., desktop, onsite) and monitoring frequency. In addition, the strategy shall detail the qualifications of staff performing monitoring reviews and methods to determine staff competency initially and ongoing, and inter-rater reliability methods including minimum target rate; at a minimum, staff performing monitoring reviews shall have clinical expertise. The strategy shall be submitted to OBH by **August 1, 2021**. The strategy shall address the following standards:

-  Community case management agencies/staff shall be monitored using the approved review elements and scoring criteria within 30 days following implementation of community case management services, with another monitoring review conducted for those agencies not meeting the minimum threshold within 45 days following the initial review.
-  Agencies not achieving the minimum threshold shall be monitored to ensure necessary corrective actions/improvements are implemented until the minimum threshold is met.

- ✚ MCOs may conduct less frequent monitoring reviews of community case management agencies who achieve high compliance which greatly exceeds the minimum threshold over 2 consecutive monitoring reviews unless the compliance score drops below the minimum threshold or based on the number and degree of grievances or quality of care concerns involving the agency.

The MCO shall collect, track, and review member-level data, perform data validation activities, ensure appropriate remedial actions are taken to address any identified issues, and report information to LDH in accordance with LDH-issued reporting templates and instructions. Data elements include but are not limited to housing stability, community integration, assessment and plan of care timeframes, member satisfaction with services and providers, member health and welfare, critical incidents, member outcomes, and member service utilization.

LDH may require community case managers to use a centralized database for reporting member specific data and case management activities.

XIV. Other Requirements

The MCO shall ensure that payment rates to the community case management agency are sufficient to provide ongoing access to a sufficient number of community case managers to be able to meet the requirements in this section. The MCO shall conduct a review no later than six (6) months after community case management services are implemented to ensure adequate payment rates and annually thereafter. Evidence of sufficient payment rates shall be submitted to LDH upon completion or a description of improvements or changes to be implemented to ensure access.

XV. Appendices

- A. Department of Justice Findings Letter
- B. Department of Justice Agreement
- C. LDH Diversion Plan



U.S. Department of Justice

Civil Rights Division

Office of the Assistant Attorney General

Washington, D.C. 20530

DEC 21 2016

Governor John Bel Edwards
Office of the Governor
State of Louisiana
Post Office Box 94004
Baton Rouge, Louisiana 70804

Re: United States' Investigation, Pursuant to the Americans with Disabilities Act, of
Louisiana's Use of Nursing Facilities to Serve People with Mental Health
Disabilities

Dear Governor Edwards:

We write to report the Department of Justice's findings from its investigation into Louisiana's delivery of services to people with serious mental illness who reside in nursing facilities across the State. Our investigation assessed the State's compliance with Title II of the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12101, *et seq.*, which requires that individuals with disabilities receive services in the most integrated setting appropriate to their needs. The Department of Justice is authorized to seek a remedy for violations of Title II of the ADA. 42 U.S.C. §§ 12133-12134; 28 C.F.R. §§ 35.170-174, 190(e). This letter provides notice of the State's failure to comply with the ADA and the minimum steps it needs to take in order to meet its obligations under the law.

We would like to thank the State for the assistance and cooperation extended to the Department of Justice thus far and to acknowledge the courtesy and professionalism of all of the State officials and counsel involved in this matter to date. We appreciate that the State provided us with helpful documents and information in response to our written requests.

I. SUMMARY OF FINDINGS

We conclude that Louisiana violates the ADA by unnecessarily relying on nursing facilities to serve people with serious mental illness, rather than providing services in the most

integrated setting appropriate to their needs. The State's systemic failure to provide appropriate community services also places individuals who currently live in the community at serious risk of unnecessary institutionalization in nursing facilities.

Approximately 4,000 people with serious mental illness are currently institutionalized in costly Louisiana nursing facilities where they are isolated and segregated from their families, friends, and communities. On average, these individuals are younger and have fewer physical care needs than the broader nursing facility population. They often spend years in nursing facilities that provide minimal mental health services and apart from paid staff, they rarely interact with people who do not have disabilities. The State has failed to ensure that many nursing facility residents with serious mental illness were offered community-based services as an alternative to nursing facilities. Moreover, through its nursing facility admissions process, the State has approved and facilitated their admission to nursing facilities. These individuals live in more than 250 nursing facilities across Louisiana, but individuals with serious mental illness are frequently admitted to at least eight facilities that are well known placements for people with serious mental illness; and they predominantly house people with serious mental illness.

Most of these individuals could be appropriately served in their own homes and communities if they had the mental and physical healthcare services that Louisiana already provides to thousands of people who have similar needs. Serving individuals in the community is also consistent with Louisiana State law, which requires that individuals with disabilities be served in the least restrictive setting in their own communities. LA. REV. STAT. ANN. § 28:476. Nonetheless, the State continues to fund costly nursing facility placements when people could be served in their communities. The contributing factors to these systemic failures include:

- The State does not identify people with serious mental illness prior to nursing facility admission and divert them into effective, community-based alternatives;
- The State does not identify individuals with serious mental illness currently in nursing facilities, inform them about available options, and provide them with effective transition planning and the community services they need to successfully live in the community; and
- The State does not have a sufficient supply of community-based supports to serve people with serious mental illness who wish to transition from nursing facilities or who are at serious risk of placement in a nursing facility. Furthermore, the State does not make the existing supply of community-based supports adequately available to these individuals.

Louisiana's unnecessary reliance on nursing facilities violates the civil rights of people with serious mental illness. By contrast, community integration will permit the State to support these individuals in settings appropriate to their needs and in a cost-effective manner.

II. INVESTIGATION

On October 6, 2014, the Department of Justice notified the State of Louisiana that it was opening an ADA investigation into whether the State unnecessarily uses nursing facilities to serve individuals with serious mental illness. Our investigation focused on (1) whether these individuals in Louisiana nursing facilities are appropriate for community-based alternatives; (2) whether they oppose receiving mental and physical health supports in the community; and (3) whether placing them in appropriate, community-based services constitutes a reasonable modification to the State's service system.

During our investigation, we visited numerous nursing facilities across the State, including rural and urban facilities, small and large facilities, and facilities with varying numbers of people with serious mental illness. During our site visits, we and our expert interviewed nursing facility staff members and residents. We also interviewed staff members at community mental health programs, day programs, State psychiatric hospitals,¹ and private hospitals, as well as officials with Louisiana's regional mental health authorities. We met with leadership from the Department of Health in person and via telephone. We also interviewed individuals with serious mental illness who receive mental health services in the community.

In addition to these visits and interviews, we reviewed the documents and information provided by the State, reviewed publically available data and reports, and considered the opinions of a wide range of individuals knowledgeable about the State's mental health system.

III. LOUISIANA'S PUBLIC MENTAL HEALTH SYSTEM

Louisiana's public mental health system delivers Medicaid- and State-funded services to people with mental illness who meet medical and financial eligibility. The State provides these services through nursing facilities, hospitals, and community-based providers.

A. Louisiana Uses Nursing Facilities to House People with Serious Mental Illness.

Louisiana has 258 nursing facilities that provide Medicaid-funded services. At any given time, roughly 25,000 Medicaid recipients live in these facilities, which, when compared to other states, house some of the largest numbers of Medicaid recipients on average. Louisiana's percentage of Medicaid certified nursing facilities with 100 beds or more is higher than any other state. And people younger than age 70, many of whom have serious mental illness, make up a sizable and growing percentage of these facilities' residents. In 2013, roughly 33% of the nursing facility population was under age 70, up from 22% in 1999.² Moreover, a 2014 AARP

¹ State psychiatric hospitals will hereinafter be referred to as "State Hospitals."

² We note that our investigation did not review the State's compliance with the ADA with respect to people in nursing facilities who have disabilities other than serious mental illness. We

report concluded that about a quarter of all Louisiana nursing facility residents have low-care nursing needs, a higher ratio than all but two other states.³ Individuals with serious mental illness live in nearly all of Louisiana's 258 nursing facilities, which also house people with age-related disabilities. Many live in facilities that are well known for housing individuals with serious mental illness, including the State facilities at Villa Feliciana and at least seven for-profit nursing facilities around the State.

Despite the passage of two federal laws to prevent this type of segregation,⁴ nationally, Louisiana continues to have one of the highest percentages of nursing facility residents with serious mental illness. According to the State, at least 3,856 individuals with serious mental illness—or 14.5% of Louisiana nursing facility residents—lived in Louisiana nursing facilities in October 2014 and roughly the same number continue to live in these facilities as of February 2016.⁵ The additional cost to the State of serving individuals with mental illness in nursing facilities instead of the community can be as high as \$7,000 or more per person, per year. And while the State provides community-based services to 20,000 individuals with serious mental illness, it is approving nursing facility admissions for these individuals at a rate of about 1,000 per year. These are individuals without dementia who may also have medical conditions or physical disabilities, such as diabetes, renal disease, and mobility impairments, which are typically accommodated outside of nursing facilities. On average, people with serious mental illness in Louisiana's nursing facilities tend to be younger than the overall nursing facility population and have less intensive support needs. They are institutionalized in nursing facilities

recognize, however, that some of the systemic failures we identified in this investigation could contribute to the unnecessary institutionalization of people with other types of disabilities. We encourage the State to examine the way these issues impact people with other disabilities and how it can more broadly prevent unnecessary institutionalization.

³ Susan C. Reinhard, et al., AARP, *Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities and Family Caregivers*, 88 (2014).

⁴ See Americans with Disabilities Act of 1990, 42 U.S.C. § 12101, *et seq.*; Nursing Home Reform Act of 1987, 42 U.S.C. § 1396r.

⁵ For purposes of this letter, we adopted the methodology used by the State to estimate the number of people with serious mental illness in Louisiana's nursing facilities. As the State did, we excluded individuals with dementia-related diagnoses from the estimate; but we recognize that some individuals with serious mental illness may be misdiagnosed as having dementia. Furthermore, these numbers reflect only Medicaid beneficiaries with serious mental illness. Because of this and other limitations of the information captured by the nursing facility assessments underlying these data, this estimate may be a conservative approximation of the number of people with serious mental illness in Louisiana's nursing facilities.

by reason of their mental illness and may spend many years of their lives there. At least 73% have been institutionalized for more than a year.

Just like persons without disabilities, these individuals have their own unique needs, stories, and goals, but many share a common desire: to live a life of their choosing. One woman with serious mental illness experienced a crisis after the death of a family member, leading to her nursing facility admission. Four years later and still in her fifties, she remained in the nursing facility, despite needing minimal physical and psychiatric care. She longed to go home saying, “I would like to be normal, complete, whole again—like I used to be.” Another woman in her fifties lived with her siblings before coming to the nursing facility, but her siblings decided that they could no longer assist her on their own. In an interview, the woman, who loves to sing, shared her hopes of returning to her hometown and living in an apartment. With appropriate services in place, both of these women could transition from the nursing facility to the community.

Many people with serious mental illness come to Louisiana’s nursing facilities from private psychiatric hospitals, where they are typically admitted for acute care following a mental or physical health crisis. Others come from State Hospitals, or they are admitted to nursing facilities shortly after leaving State Hospitals. One man’s journey into the nursing facility began when he had a mental health crisis a few years ago and repeatedly called 911 about his blood pressure. Instead of connecting him to community treatment services, he was charged with abusing 911, sent to jail, and then admitted to a State Hospital. The State Hospital eventually discharged him to a nursing facility that primarily houses people with serious mental illness. The State approved a six-month stay. Six years later, the man, who is in his sixties, remains in the same nursing facility, even though he wants to return to the community and could do so with proper physical and psychiatric supports. This man’s story is not unique. In addition to the individuals who are discharged from private hospitals, between 2010 and 2014, State Hospitals discharged 153 people with serious mental illness directly into nursing facilities, including some who were discharged as part of its 2011 hospital downsizing effort.

B. Although Louisiana Redesigned its Mental Health Service System to Provide More Community-Based Services to People with Serious Mental Illness, Services Are Still Inadequate.

Louisiana’s mental health system has historically relied on high-cost, institutional care to serve its citizens with serious mental illness. This unnecessary reliance has had a detrimental effect on the availability of community-based mental health services, both in terms of the adequacy of funding for services and the numbers of individuals with serious mental illness who have access to care.

The State has, for many years, recognized its reliance on institutional care at the expense of its community-based system. In 2006, a State-commissioned report stated, “By all accounts—

governmental, legislative, judicial, provider, advocacy, consumer, and family member—the availability, accessibility, and quality of treatment and services for Louisianans with mental health conditions are woefully inadequate, and in far too many circumstances, simply nonexistent.”⁶ The State again acknowledged in 2011:

Over the last two decades, Louisiana has remained dependent on psychiatric hospital levels of care While other states were re-organizing their funding approach and moving to a greater proportion of high intensity community based programs, Louisiana continued to have greater fiscal resources directed toward inpatient care.⁷

Similarly, in 2012, the Secretary of the Department of Health and Hospitals⁸ stated, “[T]oo many of our resources are invested in large public institutions. This is not the best model of care for our residents or our taxpayers.”⁹ The State also identified the solution: “[When] using community-based services like Assertive Community Treatment (ACT) teams, evidence has shown that lengths of stay in inpatient settings will shorten and recidivism rates will improve. Over time, this will decrease demand on more acute inpatient services, which will improve the [S]tate’s capacity to treat the seriously mentally ill.”¹⁰

Recognizing the urgent need to develop quality, community-based services across the State, the Louisiana Department of Health has worked to redesign its mental health system, to reduce reliance on State Hospitals, and increase access to community-based services. The State consolidated mental health and substance use disorder services in the Office of Behavioral Health and in the ten regional mental health agencies known as local governing entities,¹¹ closed

⁶ Behavioral Health Policy Collaborative & Technical Assistance Collaborative, *A Roadmap for Change: Bringing the Hope of Recovery to Louisianans with Mental Health Conditions*, at v (June 2006).

⁷ Louisiana Office of Behavioral Health, *FY 2012 Combined Behavioral Health Assessment and Plan Block Grant Application*, at 29 (Sept. 1, 2011).

⁸ The Louisiana Department of Health was known as the Department of Health and Hospitals until 2016.

⁹ Louisiana Department of Health and Hospitals, *DHH Outlines Plan to Establish Sustainable Behavioral Health Care Services for Louisiana Residents* (Aug. 14, 2012), <http://new.dhh.louisiana.gov/index.cfm/newsroom/detail/2571>.

¹⁰ *Id.*

¹¹ The local governing entities are independent organizations that locally administer the State’s behavioral healthcare system. They offer a core set of services for people with behavioral

one of its three State Hospitals, and downsized the other two. In 2011, the State began investing in community-based services and moving toward a statewide system of community-based care, rather than only having pockets of evidence-based practices available to people with serious mental illness.

Louisiana has also tried to use managed care to reduce its reliance on institutions and improve access to community-based mental health services. In 2012, the State consolidated public behavioral health services under a single managed care entity, Magellan Healthcare, Inc. The State then changed course and in December 2015 transitioned all public behavioral health services to Healthy Louisiana, the State's existing network of Medicaid managed care organizations, with the intention of integrating physical and behavioral health services under the new plan.

Initially, Louisiana intended to include nursing facilities under the umbrella of managed care. As the State explained in a 2013 concept paper, it was influenced by the "consistent suggestion that benefits coordinated through the [long-term service system managed care organization] should be comprehensive and avoid carve-outs, particularly as it related to behavioral health."¹² Advocates for community-based services supported the move, arguing that more nursing facility residents would be transitioned into community-based services by managed care organizations when those services proved to be less expensive than institutionalization. However, the State has not yet solicited proposals to move long-term services and supports into managed care and nursing facilities, therefore, remain exempt.

While the State has taken steps in recent years to develop its community system, its work is far from complete, and the State recognizes that the availability of community-based mental health services is insufficient. It acknowledged last year: "Services to adults are a critical area of need in the [Office of Behavioral Health] system, as prevalence estimates indicate that only a small proportion of the need is being met by existing [Office of Behavioral Health] services."¹³ The Substance Abuse and Mental Health Services Administration reports that the percentage of

health disabilities. Each entity's budget includes State general funds, self-generated funds, and interagency transfers to support programs and services. Beyond the core services provided, entities offer more or fewer services, depending upon their budgets and the needs of their communities.

¹² Louisiana Department of Health and Hospitals, *Transforming Louisiana's Long Term Care Supports and Services System*, at 6 (Aug. 30, 2013).

¹³ Louisiana Office of Behavioral Health, *FY 2016 Combined Behavioral Health Assessment and Plan* (Draft), at 55 (July 29, 2015).

Louisianans using mental health services in the community per 1,000 people is less than half the national average.¹⁴

C. Louisiana Offers Community-Based Services, Including Assertive Community Treatment, Mobile Crisis Services, Peer Supports, Permanent Supported Housing, and Primary Healthcare.

Louisiana's existing community-based services are currently inadequate to meet the needs of individuals with mental illness who are in nursing facilities or at risk of entering nursing facilities; however, they include the kinds of appropriate, community-based mental health services necessary for individuals with serious mental illness to live in the community. These services include Assertive Community Treatment, Mobile Crisis services, and peer supports. These are critical, evidence-based practices that can be tailored to the needs of each individual and help them avoid costly, unnecessary, and repeated institutionalization.

1. Assertive Community Treatment

Assertive Community Treatment is a community-based service that provides intensive mental health services to individuals with the highest mental health needs and enables service recipients to transition from institutions and live in the community. Assertive Community Treatment teams in Louisiana are designed to address every aspect of an individual's needs, including medication management, therapy, crisis intervention, social support, employment, substance use disorder treatment, and housing. The service is provided by a multidisciplinary team of professionals, including, but not limited to, a licensed mental health professional, housing specialist, employment specialist, substance abuse service provider, nurse, peer support specialist, and psychiatrist. The team is available at all hours, and its members are the primary providers of recovery-oriented services for the individual in the community.

As the State acknowledges in its behavioral health services manual, individuals who have experienced multiple hospitalizations can be successfully served in the community with the assistance of an Assertive Community Treatment team.¹⁵ As of July 2015, there were 14 teams serving only 1,150 people, which is insufficient capacity to serve the needs of individuals with serious mental illness who are currently confined to nursing facilities. Assertive Community Treatment can make all the difference for individuals with a history of institutional placements. One Louisiana woman who had previously been institutionalized in a State Hospital explained the value of her Assertive Community Treatment team in contrast to institutional living:

¹⁴ Substance Abuse and Mental Health Administration, Center for Mental Health Services, *Louisiana 2013 Uniform Reporting System Mental Health Data Results* at 1.

¹⁵ Louisiana Department of Health and Hospitals, *Louisiana Behavioral Health Partnership (LBHP) Service Definitions Manual, Version 9*, at 118-19 (July 2014).

Who wants to be told what to do so much? Who wants to be away from their mother, father, and children? Who wants to be in a place where there are no hugs, no kisses—a place where you can't enjoy momma's cooking? When you're in an institution, it's like someone took you there and then keeps you in this place where it's aggravating, and it's disgusting. You can't take a bath and a shower when you want to. You can't walk outside when you want to. I need freedom, money, transportation, and I've got a lot of those necessities and more because of [my Assertive Community Treatment provider].

2. Community Psychiatric Support and Treatment

Community Psychiatric Support and Treatment and Psychosocial Rehabilitation are two Louisiana Medicaid services that provide individualized mental health supports of varying intensity. Community Psychiatric Support and Treatment is a face-to-face intervention that can take place in community settings and includes supportive counseling, behavioral management and analysis, assistance with identifying crisis triggers, development of crisis management plans, and assistance in restoring the individual's fullest possible integration in the community. Psychosocial Rehabilitation helps people regain independent living and interpersonal skills. While less intensive than Assertive Community Treatment, if implemented in an individualized manner consistent with the person's needs, the combination of Community Psychiatric Support and Treatment and Psychosocial Rehabilitation can be used to provide support similar to the intensive case management services available in other states. In July 2015, 4,845 Louisianans were receiving Community Psychiatric Support and Treatment, and 3,419 people were receiving Psychosocial Rehabilitation.

3. Mobile Crisis Services

Louisiana offers limited crisis prevention and intervention services, which include Mobile Crisis and toll-free crisis lines. Mobile Crisis is an evidence-based intervention designed to provide support to individuals in crisis at their homes and in other community locations. Where available, Mobile Crisis teams in Louisiana provide on-site support to help people remain in their homes and avoid inappropriate institutionalization. A 24-hour crisis telephone line is available statewide. A non-crisis line, staffed by peers in recovery, is also available from 5 a.m. until 10 p.m., seven days per week. Some of the local governing entities provide crisis hotlines or contract with third party providers to offer crisis services after hours, on weekends, and on holidays; and some use staff members to substitute when third party providers are temporarily unavailable.

4. Permanent Supported Housing

Permanent Supported Housing is an evidence-based practice for successfully supporting individuals with serious mental illness in the community. It includes integrated, community-based housing with tenancy rights, coupled with individualized services and supports that are

necessary to help the individual maintain housing. Permanent Supported Housing promotes mental health recovery by enabling individuals to avoid the inherent stress of housing instability. It helps individuals achieve maximum independence, positive health benefits, and an overall higher quality of life. Permanent Supported Housing is also a cost-effective service that reduces expensive hospitalizations, institutionalization, incarceration, and emergency room visits.

Louisiana's Permanent Supported Housing Program was established in the wake of Hurricanes Katrina and Rita, and is concentrated in the areas most affected by the hurricanes. As a result, there is limited availability of Permanent Supported Housing elsewhere in the State, and there is a long waitlist. The goals of the program are the prevention and reduction of institutionalization and homelessness for people with disabilities, and it supports approximately 2,700 households. Eighty-five percent of current Permanent Supported Housing homes have at least one member with a mental illness, some of whom moved directly into the program from institutions. Some of the local governing entities also operate housing programs through third party contracts that provide various housing alternatives and housing supports.

5. Community-Based Primary Healthcare Services

For individuals with serious mental illness who have physical disabilities or chronic health conditions, Louisiana has programs that provide additional supports, such as personal care services, home health, and nursing services, all of which are overseen by the Office of Aging and Adult Services. People with mental illness have higher rates of chronic health conditions than the general population. If these conditions are not properly managed, they often worsen and contribute to the fact that on average, people with serious mental illness die 25 years earlier than those without serious mental illness. Therefore, the need for integrated mental and physical healthcare is critical for people with serious mental illness. Integrating physical and mental healthcare by, for example, embedding primary care providers in mental health centers and coordinating all necessary care through case management has proven successful in reducing hospitalization and adverse outcomes. Accordingly, the State has acknowledged that better coordination of services “increases access to a more complete and effective array of behavioral health services and supports, improves quality of care and outcomes, and reduces repeat emergency room visits, hospitalizations, out-of-home placements, and other institutionalizations.”¹⁶

The State's most comprehensive package of community-based services for individuals with physical disabilities is the Community Choices Waiver Program, which offers priority access to people in nursing facilities. This program provides services for people over age 65 and

¹⁶ Louisiana Office of Behavioral Health, *FY 2016 Combined Behavioral Health Assessment and Plan* (Draft), at 8 (July 29, 2015).

people with physical disabilities as a lower cost alternative to nursing facility care. Depending on each recipient's level of need, he or she is provided funding to create an individual, community-based service package. The program contains an array of services to help the individual avoid institutionalization, including support coordination, nursing and skilled therapy, home modifications and assistive technologies, and personal care services. Those found eligible for the program wait an average of 4.35 years for services, and almost 36,000 people are on the program's waitlist. The program is limited to serving 5,303 people at a time; yet at the end of fiscal year 2014, the State had only 4,185 people in it.

In addition to the Community Choices Waiver Program, which is only available to a limited number of people, personal care services and home health services are available to all Medicaid-eligible individuals who need them. Personal care services assist with activities such as grooming, eating, and toileting, as well as laundry, meal preparation, shopping, and medication oversight. Medicaid-eligible individuals can receive up to 32 hours per week of personal care services,¹⁷ while individuals who need more than 32 hours per week may be eligible for the Community Choices Waiver. The State also offers home health services, including diagnosis and treatment of illness or injury by a registered or licensed professional nurse, and assistance with activities of daily living, which are provided by an aide. Individuals in the program may receive up to 50 home health visits per year by a skilled nurse or aide.

IV. FINDINGS

Nearly 4,000 Louisianans with serious mental illness are confined in costly nursing facilities even though many of them can and want to live in the community and the State system can be reasonably modified to offer placement in the community. We therefore conclude that the State fails to provide services to individuals with serious mental illness in the most integrated settings appropriate to their needs, as required by the ADA.

A. Title II of the ADA Requires States to Serve Individuals with Disabilities in the Most Integrated Setting Appropriate.

Congress enacted the ADA in 1990 “to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities.” 42 U.S.C. § 12101(b)(1). Congress found that “historically, society has tended to isolate and segregate individuals with disabilities, and despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem.” 42 U.S.C. § 12101(a)(2). For these reasons, Congress prohibited discrimination against individuals with disabilities by public entities when it provided that “no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of

¹⁷ Twenty-three thousand Louisianans received personal care services through this program in fiscal year 2014.

the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.” 42 U.S.C. § 12132. Accordingly, the “ADA is intended to insure that qualified individuals receive services in a manner consistent with basic human dignity rather than a manner which shunts them aside, hides, and ignores them.” *Helen L. v. DiDario*, 46 F.3d 325, 335 (3d Cir. 1995).

One form of discrimination prohibited by Title II of the ADA is violation of the “integration mandate.” 28 C.F.R. § 35.130(d); *see also* 42 U.S.C. § 12101(a)(2), (b)(1). That is, under the ADA, public entities are required to “administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.” 28 C.F.R. § 35.130(d). An integrated setting is one that “enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible.” 28 C.F.R. Pt. 35, App. B, 690 (2015).

In *Olmstead v. L.C.*, the Supreme Court held that public entities are required to provide community-based services to persons with disabilities when (a) such services are appropriate; (b) the affected persons do not oppose community-based treatment; and (c) community-based services can be reasonably accommodated, taking into account the resources available to the entity and the needs of other persons with disabilities. 527 U.S. 581, 607. In so holding, the Court explained that unnecessary institutional placement “perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life.” *Id.* at 600.

The ADA’s integration mandate applies both to people who are currently institutionalized and to people who are at serious risk of institutionalization. *Steimel v. Wernert*, 823 F.3d 902, 913 (7th Cir. 2016); *Davis v. Shah*, 821 F.3d 231, 263 (2d Cir. 2016); *Pashby v. Delia*, 709 F.3d 307, 321-22 (4th Cir. 2013); *M.R. v. Dreyfus*, 663 F.3d 1100, 1115-18 (9th Cir. 2011), *opinion amended and superseded on denial of reh’g*, 697 F.3d 706 (9th Cir. 2012). As the Tenth Circuit reasoned, the integration mandate “would be meaningless if plaintiffs were required to segregate themselves by entering an institution before they could challenge an allegedly discriminatory law or policy that threatens to force them into segregated isolation.” *Fisher v. Okla. Health Care Auth.*, 335 F.3d 1175, 1181 (10th Cir. 2003); *see also Pitts v. Greenstein*, No. 10-635-JJB-SR, 2011 WL 1897552, *3 (M.D. La. May 18, 2011) (unpublished) (“A State’s program violates the ADA’s integration mandate if it creates the *risk* of segregation; neither present nor inevitable segregation is required.”). A State’s failure to provide community services may create a risk of institutionalization. *Pashby*, 709 F.3d at 322; *see also Peter B. v. Sanford*, No. 6:10-767-JMC-BHH, 2010 WL 5912259, at *6 (D.S.C. Nov. 24, 2010) (unpublished) (“[A] State’s failure to provide services to a qualified person in a community-based setting as opposed to a nursing home or institution presents a violation of Title II of the ADA”).

B. Nursing Facilities Are Segregated, Institutional Settings.

It is well established that nursing facilities are segregated settings. *Day v. District of Columbia*, 894 F. Supp. 2d 1, 22-23 (D.D.C. 2012); *Rolland v. Cellucci*, 52 F. Supp. 2d 231, 237 (D. Mass. 1999). “The ADA was passed, in part, to combat discrimination against individuals with disabilities, including discrimination in the form of unnecessary segregation of those with disabilities in nursing homes and other institutions.” *Joseph S. v. Hogan*, 561 F. Supp. 2d 280, 285 (E.D.N.Y. 2008) (denying motion to dismiss in case involving plaintiffs with mental illness who were institutionalized in nursing facilities); *accord Day*, 894 F. Supp. 2d at 22-23; *Conn. Office of Prot. & Advocacy for Persons with Disabilities v. State of Conn.*, 706 F. Supp. 2d 266, 276-77 (D. Conn. 2010); *Peter B.*, 2010 WL 5912259, at *6.

Nursing facilities in Louisiana are typically institutional in nature, as evidenced by the physical environment, the lack of privacy and autonomy, and the lack of integrated, adult activities for the residents. Louisiana’s nursing facilities congregate an average of 130 people with disabilities in a setting where they receive all of their services on-site in a way that forecloses the opportunity to interact with people who do not have disabilities or are not paid staff. Most facilities have long hallways and locked exits, and some also have locked gates around the exterior of the building. Paging systems, loud televisions in the common areas, and the sounds of other residents create a steady stream of audible interruption at most facilities. When asked about life in the nursing facility, a male resident in his thirties who loves music and has serious mental illness said he sleeps most of the day, explaining, “I don’t want to see what environment I’m in. It’s depressing.”

Louisiana nursing facilities, as is common elsewhere, afford almost no privacy to residents, other than providing minimal storage spaces like a small closet in their bedrooms. Furthermore, most nursing facilities use security cameras to monitor residents’ movements through the facility. While the cameras do not monitor the relatively small bedrooms, even in there, residents still have little privacy, because staff members often come in and out of rooms after a perfunctory knock on the door. Privacy in the bedroom is also drastically diminished by the fact that residents usually share the space with as many as three other roommates. At one facility, which had numerous available rooms and was only 60% full on average, residents were crowded into rooms with as many as three assigned roommates.

Many aspects of nursing facility life are characterized by segregation from the broader community and a lack of autonomy. For example, residents have no access to a kitchen where they can prepare their own food, and they are rarely permitted to do their own laundry. Residents must also submit to regimented mealtimes, and they are rarely allowed to administer their own medications. Almost all residents see on-site doctors and psychiatrists. Some nursing facilities effectively prevent residents from moving about at will by locking exits after certain hours, requiring visitors and residents to sign in and out, prohibiting residents from leaving the facility unaccompanied, and using alarmed doors locked with key codes, even when these types of restrictions are not necessary. Nursing facilities also maintain control over the residents’ money for their personal needs, which is usually less than \$40 of their state and federal benefits;

and if residents want access to it, they must go to a staff member to get it. As one female resident explained, “When you’re at a place like this, you have to fall in line. You do what they tell you to do . . . They say ‘jump,’ you jump.” In describing the nursing facility, one man said “it feels like you’re doing prison time,” and a female resident similarly said she feels “like a prisoner.”

The activities we observed in Louisiana’s nursing facilities were limited, repetitive, and conducted on nursing facility property, rather than in the community. Weekly events include activities like bingo, arts and crafts, and singing karaoke. For example, a 60-year-old man said his nursing facility hosts “auctions” with play money in which the residents can bid for used clothing. With the lack of meaningful engagement, some residents said they were often bored, and they reported spending their days passing the time by watching television, sleeping, or smoking.

Some nursing facilities take residents on organized trips to nearby shopping centers or restaurants; but such outings are limited, rigidly scheduled, and contribute little to community integration. Residents often travel as a group in the facility’s bus or van, and the number of individuals attending the outings may be limited to however many people can fit in the vehicle. A nurse at one facility explained that when residents go on outings, all staff members wear t-shirts bearing the name of the nursing facility so that people in the community will know where the group is from.

Although nursing facilities across Louisiana demonstrate these institutional, segregated qualities, our investigation found that these qualities were particularly acute in at least eight nursing facilities serving large populations of people with serious mental illness. These facilities are well-known in local communities as placements for people with serious mental illness and particularly stigmatizing for the people living at the facilities. As a staff member at one of these facilities explained, “A lot of people in the community don’t think we’re a nursing facility. . . . People think we’re a psychiatric facility.” The State appears to view these facilities similarly: Approximately 65% of people discharged from State psychiatric hospitals into nursing facilities went to these particular facilities. Some of these facilities advertise locked “behavior units,” which isolate individuals with serious mental illness in one part of the building. One nursing facility openly states on its website that the only substantive admission criteria for its “behavior unit” is that residents must be 40 years or older; able to pay with Medicaid, Medicare, or privately; and have a “[p]sychiatric diagnosis[,] with or without medical diagnosis.”

Given the foregoing, we conclude that Louisiana nursing facilities are institutional settings that segregate individuals with serious mental illness away from their homes and communities.

C. Nursing Facility Residents with Serious Mental Illness Are Appropriate for Community Placement and Do Not Oppose it.

Our investigation revealed that a significant number of nursing facility residents with serious mental illness throughout Louisiana are appropriate for community placement and want to live in the community. After interviewing nursing facility residents across the State and reviewing their medical records, our expert concluded that many Louisianans with serious mental illness who are in nursing facilities could be served in the community with the help of the physical and mental health services and supports that already exist in Louisiana's service system. For example, a man in his thirties who had previously worked and lived independently now spends his days alone in his room listening to the radio. He wants to go home, and according to our expert, he could be served in the community with integrated physical and mental healthcare, including a low level of direct support. A woman in her fifties came to a nursing facility in 2012 after she was hospitalized for one month. She described herself as desperate to return home so that she can work, take part in meaningful recreational activities, and spend time with people her age. In fact, her goals are realistic. Our expert found that with appropriate community-based services, including Permanent Supported Housing, she could live in the community.

There are individuals who live in the community and receive appropriate care, and they have the same mental health disabilities and needs as those in the nursing facilities. One such man who is being served by an Assertive Community Treatment team said that, prior to receiving community services, he was hospitalized and jailed. However, with the assistance of his Assertive Community Treatment team, he now lives in his own apartment that he "loves." Various team members support him in the community with services like therapy and medication management and help him with basic needs like shopping and laundry. Another man currently served by an Assertive Community Treatment team previously experienced severe depression, homelessness, and incarceration. He attempted suicide and became estranged from his daughter. But with the help of his team, he now has a part-time job and rents an apartment. He is also in daily communication with his daughter, who now calls him "Dad," rather than using his first name.

While many nursing facility residents with serious mental illness have low-care physical needs, our expert also concluded that those nursing facility residents with serious mental illness who do have chronic health concerns may also be served in the community with the appropriate and properly coordinated mental and physical health services. For example, we met with a nursing facility resident who had a history of mental illness in addition to obesity and a leg amputation. Our expert found that he could transition to his own home with a combination of basic mental and physical health services, including personal care services, medication management, and dietary support.

In our investigation, we encountered the common misconception that individuals with serious mental illness are particularly inappropriate for community-based treatment if they have chronic illnesses and physical disabilities. However, that perception is undermined by Louisiana's own success with serving, in the community, nursing facility-eligible individuals with physical disabilities. There were 4,185 people with chronic health needs and physical

disabilities on the Community Choices Waiver at the end of 2014 and about 23,000 individuals receive Medicaid personal care services. Louisiana also had relative success with its Money Follows the Person program, which provides access to enhanced federal funding to transition individuals from nursing facilities to the community. The State used the program to transition 910 nursing facility residents with physical disabilities—but not primarily mental illness—into the community over a five-year period.

The misperception that people with serious mental illness are inappropriate for home- and community-based treatment is especially prevalent among nursing facility staff members, who operate from a nearly uniform assumption that institutionalization is the best option for residents with serious mental illness. Furthermore, staff members often have little familiarity with community-based services that are available for Louisianans with serious mental illness. For example, staff members at one facility said that when residents request a discharge and need community-based mental health services, the facility summons a psychiatrist to persuade the person to reconsider, because staff members do not believe such services are available. The administrator at a different nursing facility said, “We don’t know what a lot of the alternatives are to our facilities because that’s not what we do—the people that we take care of usually can’t stay in their homes or be in the community.” The director of social services at another facility said that when residents want to return to the community, she does not help them if she believes they will need assistance with activities of daily living or medication administration. In fact, however, the very obstacles identified by these staff members can often be overcome with the services and supports Louisiana can provide in the community.

In addition to being appropriate for the community, most of the residents we spoke with expressed their desire to return home to their communities, while others were open to exploring the idea of transitioning to the community if appropriate services were available. For example, a nursing facility resident in his sixties said he wants to leave so intensely that it makes him want to cry. A nursing facility resident in his forties said he wants to work and that “it would mean everything to me to be able to leave and have my own place.” And another nursing facility resident in his forties said he wants to live independently and explained, “I would try to find an apartment to stay in if I could. I’d like to move somewhere so I can take care of my own self.” He also noted that although he sometimes experiences symptoms of a mental illness, “I’m a human too.”

As a consequence of the foregoing, people who could and want to be served in community settings—if they had access to appropriate supports in the community—are instead languishing in institutions that do little to help them return to community life.

D. Lack of Sufficient Capacity in Existing Community-Based Services and Supports Leads to Needless Nursing Facility Admissions.

Community-based services, including Assertive Community Treatment, Community Psychiatric Support and Treatment, Permanent Supported Housing, peer support, supported employment, and community crisis services, are essential services for people with serious mental illness in the community. While Louisiana has recognized the critical importance of evidence-based mental health services and included them in its service array, it has fallen short in developing sufficient capacity to meet the needs of individuals with serious mental illness in nursing facilities or who are at serious risk of entering nursing facilities.

One particularly important area where the State has fallen short on service capacity is with its Permanent Supported Housing program. The State acknowledges that the program is a “critical component” of community integration for people with serious mental illness and is making some efforts to expand the program so that it provides housing statewide;¹⁸ however, its capacity is woefully inadequate. Due to the program’s lengthy waitlist and application process, demand outstrips supply and individuals needlessly wait in nursing facilities for Permanent Supported Housing. At least 3,400 people throughout the State need Permanent Supported Housing, and according to the State, because these individuals do not have it, they are institutionalized, living in transitional housing, or homeless. The State recognized a “great need” to expand the Permanent Supported Housing program, particularly in the northern areas of Louisiana,¹⁹ and our investigation confirmed this to be the case. For example, one nursing facility administrator explained that a resident wanted to stay close to his elderly parents, but Permanent Supported Housing was not an option in the area where his parents lived, so he remained in the nursing facility, rather than returning to the community. Similarly, a hospital staff member in northwest Louisiana reported that, because there is neither housing nor support services available in her area, she has sent people to nursing facilities with the State’s assistance. As one of the nursing facility administrators explained, “Some residents could make it in the community and take care of themselves, but you still have to have somewhere for them to go.”

The State has also fallen short in developing other critical evidence-based practices like supported employment, Mobile Crisis services, and Assertive Community Treatment. While the State recognizes the importance of supported employment services to promote recovery of individuals with serious mental illness, it has done little to implement a coordinated statewide program of evidence-based supported employment. Only 10% of adult mental health service recipients in the State (including those with and without serious mental illness) are employed in competitive, full-time jobs.

¹⁸ Louisiana Office of Behavioral Health, *FY 2014 Combined Behavioral Health Assessment and Plan Block Grant Application*, at 9 (Sep. 1, 2013).

¹⁹ *Id.* at 58, 108.

The lack of crisis services is also a particular problem. The State has rightly acknowledged that “[i]ncreasing alternatives by creating a crisis response network may . . . prevent the unnecessary or inappropriate long-term institutionalization of persons . . . [with] serious mental illness.”²⁰ The State lacks both availability and consistency in the practice and delivery of crisis services, as evidenced by the fact that only 21 out of 64 parishes offer Mobile Crisis for adults. Providers across the State told us that, when people with serious mental illness are in crisis, they are frequently taken to jails. Assertive Community Treatment is also an essential service that is both understaffed and underfunded. Multiple community providers told us about the need for and lack of Assertive Community Treatment resources in their community. Critically for this population, Louisiana currently lacks an effective system of coordinated and integrated physical and mental healthcare necessary to provide for individuals with serious mental illness who may need more oversight of their medical, mental health, dietary, and rehabilitative services. The fragmentation of care across different providers and services leads to poor outcomes for individuals with serious mental illness, including institutionalization and premature death.

These gaps in mental health services place individuals with serious mental illness at serious risk of admission to nursing facilities and prevent their successful transition to the community. As one nursing facility staff member explained to us, residents are eager to return home, and “[i]f [Louisiana] had good home- and community-based services, it could work, but it’s not there.” Staff members at another nursing facility described a middle-aged resident who called two days after his discharge and asked that someone come get him because the State did not provide the necessary services to assist him with medication management or meal preparation. After being discharged without the necessary psychiatric and personal care supports in place, the man was eventually admitted to a private psychiatric hospital after a suicide attempt. The hospital then discharged him back into the same nursing facility.

The lack of community-based services has similarly delayed transitions from the State Hospital. One State Hospital staff member reported that the biggest obstacle to transition is a lack of resources to match the needs of the person. She nevertheless recalled a former hospital resident who had high needs but who is now living in the community, socially engaged, and thriving after receiving the proper supports. She concluded, “I wish [Louisiana] had more community services available so [we] could do more discharges like that.”

E. Louisiana Does Not Divert Individuals with Serious Mental Illness from Unnecessary Nursing Facility Placement.

²⁰ Louisiana Department of Health and Hospitals, *A Roadmap for Change: Bringing the Hope of Recovery to Louisianans with Mental Health Conditions*, at 46 (June 2006).

Inadequate capacity in existing services is the primary reason why individuals with serious mental illness are unnecessarily institutionalized in nursing facilities; however, the problem is exacerbated by the State's failure to identify individuals with serious mental illness who are referred for nursing facility admission and promptly connect them with community-based physical and mental health services. Many individuals with serious mental illness are transferred to nursing facilities directly from private psychiatric hospitals or State Hospitals following a physical or mental health crisis, yet most could receive the kinds of community-based services that Louisiana knows how to provide, if these services were made available.

One of the most important tools to divert people from nursing facilities is the Pre-admission Screening and Resident Review process, known as PASRR. Congress enacted PASRR as part of the Nursing Home Reform Act of 1987, which "was passed specifically to end the practice of inappropriately institutionalizing individuals with mental illness . . . in nursing homes." *Joseph S. v. Hogan*, 561 F. Supp. 2d 280, 285 (E.D.N.Y. 2008). An effective PASRR process identifies individuals with mental illness, intellectual and developmental disabilities, or related conditions and determines how those individuals' needs can be met in the community.²¹ See 42 U.S.C. § 1396r(e)(7)(A)(i),(G); 42 C.F.R. §§ 483.128(a); 483.130(l); 483.132(a)(1),(2); 483.134(b)(3),(5),(6); *Preadmission Screening and Resident Review (PASRR)*, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Institutional-Care/Preadmission-Screening-and-Resident-Review-PASRR.html>.

Under PASRR, states must follow "stringent procedures" in implementing a two-level screening and evaluation process prior to nursing facility admission, with limited exceptions.²² *Hogan*, 561 F. Supp. at 285; see also 42 U.S.C. § 1396r(e)(7)(A)(i); 42 C.F.R. §§ 483.104, 483.106, 483.128(a), 483.132(a). The PASRR Level I screen should identify any individual who might have a mental illness or an intellectual disability. 42 C.F.R. § 483.128(a). If the PASRR Level I screen indicates that the individual may have a mental illness, an intellectual disability, or a related condition, the State must apply the more rigorous PASRR Level II evaluation, which is designed to determine (a) whether an individual's needs can be met in the community; or (b) whether, and what, specialized services can be provided in a nursing facility that will meet

²¹ Consistent with federal law, 42 C.F.R. § 483.102, *et seq.*, Louisiana regulations also mandate that a PASRR screening and evaluation must "be performed for all individuals seeking admission to a Medicaid-certified nursing facility, regardless of the source of payment for the nursing facility services or the individual's known diagnoses." La. Admin. Code tit. 50, pt. II, § 501, 50 LA ADC Pt II, § 501.

²² PASRR regulations permit the State to exempt individuals from the evaluation process when they are discharged from a hospital and are expected to be in a nursing facility for less than 30 days. 42 C.F.R. §§ 483.106(b)(2). In order to prevent inappropriate transfers from psychiatric hospitals, however, states can elect to disregard the hospital exemption and require full PASRR evaluations for all individuals with serious mental illness.

the individual's needs. 42 C.F.R. §§ 483.132(a)(1),(2); 483.134(b)(5). The PASRR Level II evaluation requires a "functional assessment of the individual's ability to engage in activities of daily living and the level of support that would be needed to assist the individual to perform these activities while living in the community." 42 C.F.R. § 483.134(b)(5). The assessment "must determine whether this level of support can be provided to the individual in an alternative community setting or whether the level of support needed is such that [nursing facility] placement is required." *Id.* Essentially, every PASRR Level II evaluation should provide a plan for receiving services in the home and community, regardless of the perceived availability of services.²³

In the 2015 PASRR National Report, the federally-funded PASRR Technical Assistance Center stated, "PASRR requires that individuals with [serious mental illness] . . . not be admitted to Medicaid-certified nursing facilities . . . until a full assessment is made, community alternatives are identified, and person-centered services are recommended to meet the individual's medical and PASRR disability-related needs." The report describes the failure to use PASRR to connect individuals to community alternatives as "both a civil rights violation and a personal tragedy" for those who are inappropriately placed in institutional settings. The report concludes, "PASRR is not merely an administrative step in the nursing home admission process—a series of boxes to be checked. On the contrary, PASRR affects lives."

Unfortunately, Louisiana's PASRR program does little to prevent the unnecessary institutionalization of individuals with serious mental illness in nursing facilities; rather, it helps facilitate their admission. In 2007, after finding a nursing facility approval rate of 85% in a five-state survey, the United States Department of Health and Human Services' Office of Inspector General reported that "the PASRR process does not appear to be used as a tool to systematically consider alternative placements to nursing facilities."²⁴ At an 86% approval rate, Louisiana is unfortunately no exception. According to the State, between fiscal years 2010 and 2014, it conducted 6,142 Level II PASRR determinations for people who were suspected of having mental illness. Of those individuals, the Office of Behavioral Health referred 4,595 (75%) for indefinite nursing facility placement and an additional 697 (11%) for temporary nursing facility placement. Only 14% were referred to community-based services.

PASRR Level II evaluations must involve the participation of the individual and be comprehensive, individualized, and conducted by independent assessors. 42 U.S.C. § (e)(7)(F);

²³ In furtherance of their obligations under the ADA, states should use these plans to identify gaps in services on a case-by-case basis and by collating the data and using it to drive the development of evidence-based, cost-effective community supports and services.

²⁴ Department of Health and Human Services, Office of Inspector General, Department of Health and Human Services, *Preadmission Screening and Resident Review for Younger Nursing Facility Residents with Serious Mental Illness*, 28 (January 2007).

42 C.F.R. §§ 483.128, 483.130, 483.134. Louisiana's PASRR Level II evaluations, and thus determinations, fall far short of these requirements, and these shortcomings contribute directly to the State's failure to divert individuals with serious mental illness from unnecessary nursing facility placements.

Many of the 6,142 PASRR determinations between 2010 and 2014 were based almost exclusively on paperwork from hospitals seeking to discharge patients to other locations.²⁵ A mere 25 individuals out of 6,142 received an in-person evaluation by an entity other than the one referring the person to the nursing facility.²⁶ Although Level II evaluations and determinations should involve rigorous consideration of whether an individual's needs can be met in the community, in Louisiana this rarely appears to be the case.

The regulations require comprehensive assessment of the individual's history and current supports, as well as functional assessments of the full range of activities of daily living, including grooming, self-care, managing finances, nutrition, medication management, and the supports needed to provide the necessary level of care in the community. 42 C.F.R. § 483.134(b). Louisiana's PASRR Level II determinations show that the State frequently admits individuals with serious mental illness to nursing facilities or extends their stay without meaningful analysis of whether and how individuals' needs can be met in the community.

The local governing entities, the mental health authorities who could provide or arrange for community services, appear to have no involvement in the screening or diversion process for individuals with mental health needs. Compounding this problem, several nursing facility administrators readily concede that much of their business comes from individuals with serious mental illness who are given no other place to go by the State. Moreover, these facilities admit individuals with temporary Medicaid and/or PASRR nursing facility approvals and then

²⁵ The State may contract with qualified staff at referring entities to conduct PASRR evaluations as long as the entity has no direct or indirect relationship with a nursing facility and has negotiated a payment rate for the evaluation. PASRR Technical Assistance Center, *Can Hospitals Perform Level II Evaluations?*, (June 11, 2014), <http://www.pasrrassist.org/resources/level-ii-personnel/can-hospitals-perform-level-ii-evaluations>.

²⁶ As of February 2016, if the Office of Behavioral Health determines that a further face-to-face PASRR Level II evaluation is warranted, hospitals are required to refer the individual to his or her managed care organization. Department of Health and Hospitals, *Bayou Health Informational Bulletin 16-4*, 1 (Feb. 24, 2016). Louisiana's nursing facilities are not under managed care; therefore, there is little incentive for its managed care organizations to avoid nursing facility placements and create meaningful opportunities for community-based services.

repeatedly file extension paperwork with the State²⁷ until a temporary approval becomes a long-term placement, which effectively precludes a meaningful opportunity to access community services.²⁸

Louisiana has failed to build an effective diversion system, resulting in the unnecessary institutionalization of individuals with serious mental illness. This is likely reflected not only in the nursing facility population, but also in the State's homeless population (1,168 homeless individuals with serious mental illness) and unnecessary incarceration. The State must properly identify qualified people with serious mental illness who are not receiving appropriate services in the community and connect them with services in the most integrated settings appropriate to their needs. It must also identify people with serious mental illness who are referred for admission to nursing facilities; promptly arrange for appropriate community-based services; and for those few who must be admitted to nursing facilities, immediately begin planning to discharge those individuals into appropriate services in the community.

F. Louisiana Fails to Transition Nursing Facility Residents with Serious Mental Illness into the Community.

Louisiana lacks an effective system to identify individuals with serious mental illness in nursing facilities who could be served in the community with appropriate supports. It does not regularly educate and inform individuals about their community-based options, and it does not plan for and implement transitions for individuals admitted to nursing facilities. As a result, once individuals with serious mental illness are admitted into nursing facilities, it is difficult for them to return to their communities, particularly after they have lost their housing and natural supports. As one community provider said, "Once someone goes to a nursing facility, we typically never see them again."

After facilitating admission to a nursing facility, neither the Office of Behavioral Health nor the local governing entities have much ongoing contact or involvement with individuals with serious mental illness who are in nursing facilities. More particularly, the State has minimal involvement in planning for these individuals' transition to the community. To the extent that transition planning does occur, it falls on the nursing facilities, which have neither the expertise

²⁷ To the extent that Louisiana is making PASRR Level II determinations based upon evaluations and medical records created by the nursing facility or its contractor, this runs afoul of PASRR, which prohibits a "nursing facility or an entity that has a direct or indirect relationship with a nursing facility" from completing Level II evaluations. *See* 42 C.F.R. § 483.106(e)(3).

²⁸ PASRR separately requires that, if an individual must be admitted to the nursing facility, the State must ensure that the person receives any needed specialized services for mental health, in order to ameliorate the symptoms that "necessitated institutionalization" in the first place. 42 C.F.R. § 483.120. But our investigation revealed that when Louisiana refers individuals with serious mental illness to nursing facilities, many receive minimal specialized mental health services and little assistance to return to the community promptly.

in navigating the community mental health system nor the incentive to facilitate transitions to the community.

Failure to ensure that individuals who do transition out of nursing facilities have the necessary community-based services can result in significant harm and preventable hospital and nursing facility admissions. For example, a woman in her early fifties who lived in a nursing facility was eventually identified for transition back to the community but was discharged with only a segregated day program to meet her psychiatric needs. Shortly thereafter, the nursing facility received a call from a private psychiatric hospital requesting her readmission because she had been hospitalized following a mental health crisis.

The State's failure to take responsibility for transitioning individuals with serious mental illness to the community, and the unsuccessful transitions that result, often lead nursing facility staff members to conclude that services do not exist in the community to support this population. Consequently, nursing facility staff members sometimes discourage people from leaving or do not respond to their requests for assistance to leave. One man in his early fifties would very much like to move out after ten years in the nursing facility, but his plan of care actually prohibits discharge discussions during quarterly reviews. A woman in her fifties said she prefers to live in an efficiency apartment where she would not need a wheelchair to get around, but she knows that no one is actively looking for a place for her. Her plan of care stated, "[The resident] desires to return to the community, but appropriate placement must be found when she is medically stable enough to care for herself." Her discharge plan, however, said, "[The] resident has no other place to go at this time." Our expert found that, like many other nursing facility residents we interviewed, both of these people could be served in the community with the appropriate services and supports.

The State is also not effectively using the PASRR Level II process to identify people who were admitted to the nursing facility but have subsequently become good candidates for transition. Upon observing a "significant change in the resident's physical or mental condition," nursing facilities must send a referral to the State for a new independent evaluation and eligibility determination. 42 U.S.C. § 1396r(e)(7)(B)(iii). Therefore, a significant improvement of the original conditions that brought the person to the nursing facility should trigger a new PASRR evaluation. However, even in instances where residents' medical conditions improved, we found that PASRR evaluations were often missing from nursing facility resident records or were not done at all. We also found that people with serious mental illness transfer between nursing facilities when their needs change, yet they nonetheless escape detection by the State's PASRR system.

Although PASRR does not require reevaluation for a transfer between nursing facilities, a transfer based on or required by behavioral changes (either positive or negative) should trigger a PASRR Level II reevaluation and provide an opportunity to consider whether the individual's needs might be better addressed with evidence-based community mental health services. *See* 42

U.S.C. § 1396r(e)(7)(B)(iii); 42 C.F.R. § 483.106(b)(4). The State does not do so, thereby missing another chance to connect individuals with essential community-based services.²⁹

The State's efforts to prevent lengthy nursing facility stays and identify individuals appropriate for transition have fallen short. For example, Louisiana offers general webinar and video trainings on the PASRR process and discharge planning for nursing facilities. The State has also begun doing time-limited authorizations of nursing facility placement for individuals with serious mental illness. The lack of sufficient community-based services and the State's failure to facilitate individuals' return to the community ensure that people often remain past the initial authorization period on State-granted extensions.

The State identifies individuals in nursing facilities for transition through its "level of care initiative," but to the degree the initiative is intended to systemically identify people with serious mental illness who are appropriate for the community, it is misguided and results in poorly implemented transitions. The initiative identifies residents for potential discharge if their physical needs do not qualify for nursing facility care. It does not, however, identify all nursing facility residents with serious mental illness who want, and could be served with, appropriate services and supports in the community. Whether individuals with serious mental illness are eligible for institutional care has little bearing on whether they can be served in an integrated setting. And many individuals with serious mental illness who live in Louisiana nursing facilities qualify for nursing facility level of care, but can nonetheless be served in the community with appropriate services and supports.

When individuals are identified for discharge, they are often released with woefully insufficient community services and supports. The State's involvement in, and oversight of, the transition process typically consists of sending notices to nursing facilities and to the resident, informing the nursing facility that it must discharge the resident, and stating that it will cut off Medicaid funding for the resident if he or she remains. As of November 2014, the State's level of care initiative identified 624 nursing facility residents with serious mental illness who no longer qualified for a nursing facility. The State cannot account for what happened to many of these individuals following discharge. The State is aware that about ten of these individuals returned to the same nursing facility where they previously lived, and ten others are known to have accessed community-based services of some kind. These data typify the State's hands-off approach to transition planning, implementation, and oversight. Without comprehensive discharge plans and transition services, many of the individuals discharged through the level of care initiative are at risk of re-institutionalization.

²⁹ The State misses another opportunity to identify individuals for transition by failing to accurately track individuals with PASRR evaluations through the nursing facility assessment data.

One nursing facility administrator expressed his concern that the clock was ticking down for 15 residents who had been identified for discharge as a result of the State's level of care initiative. His staff members were struggling to connect residents with proper services, particularly housing, before the State-imposed deadlines expired. In fact, some nursing facilities report that when they contact the State to ask where residents are supposed to go after discharge, they are told to send them to homeless shelters.

Louisiana also participates in the Money Follows the Person program, which provides access to enhanced federal funding to transition individuals from nursing facilities to the community. However, the program has not significantly benefited people with serious mental illness, because the State has made no particular effort to use this program to transition them from nursing facilities. The Office of Behavioral Health is not a participating agency in the program, and individuals with serious mental illness are not a target population. This program has helped people who have physical disabilities, intellectual disabilities, or traumatic brain injury, and also have co-occurring mental health diagnoses. However, it is not designed to serve individuals whose primary need is for intensive mental health services provided through the Office of Behavioral Health.

Finally, the State also fails to effectively use Section Q of the Minimum Data Set³⁰ to identify individuals interested in transitioning back to the community. All Medicaid-funded nursing facilities are required to use Section Q to make referrals for community-based living from nursing facilities. Section Q is a survey which, "if followed correctly, gives the resident a direct voice in expressing preference and gives the facility means to assist residents in locating and transitioning to the most integrated setting."³¹ Accordingly, when a resident responds to the Section Q survey and indicates that he or she is interested in returning to the community, the nursing facility is required by the State to make a referral to the Local Contact Agency. However, less than 14% of the 137 individuals whom nursing facilities recorded as expressing

³⁰ The Minimum Data Set is a comprehensive assessment of all nursing facility residents' functional capabilities and needs. Section Q of the Minimum Data Set requires nursing facilities to ask residents if they wish to speak to someone about returning to the community and thereafter be referred to the State's designated Local Contact Agency. The Minimum Data Set also allows states to introduce optional questions to gather data points not otherwise included in the assessment. Nursing facilities are responsible for administering this assessment on a regular basis. States can examine Minimum Data Set data to identify individuals with particular characteristics that may suggest they are appropriate for and do not oppose community placement, and these include individuals who respond positively to Section Q's inquiry about community living.

³¹ United States Department of Health and Human Services' Office for Civil Rights, *Guidance and Resources for Long Term Care Facilities: Using the Minimum Data Set to Facilitate Opportunities to Live in the Most Integrated Setting*, 1 (May 20, 2016).

interest in returning to the community in 2014 were even referred to the Local Contact Agency, and only two were actually discharged with community services. Indeed, of the nursing facilities that identified people who were interested in speaking with someone about community services, more than 80% failed to refer any of those individuals to Local Contact Agencies.³²

Our investigation further found that the State's MDS Section Q data significantly underestimates the number of individuals who want to leave nursing facilities. This is likely due to the fact that Louisiana nursing facilities have vastly different methods for recording and using Section Q surveys. For example, some nursing facilities never record "yes" answers, even when there are individuals at such facilities who state that they are eager to return to the community. At one facility, we learned that staff members are actually trained to record an answer of "no" on Section Q, regardless of the resident's wishes, if the staff member does not believe the resident can leave.

The State does not have an effective system of identification, diversion, or transition of individuals with serious mental illness from nursing facilities to appropriate community-based settings. Instead, it often places individuals with serious mental illness in segregated nursing facilities, solely relies on nursing facilities to discharge residents, and fails to ensure that individuals with serious mental illness transition to the most integrated setting appropriate to their needs.

G. Louisiana Can Reasonably Modify its Mental Health System to Serve People with Serious Mental Illness in Integrated Settings.

The Louisiana Office of Behavioral Health has stated: "It is our conviction, that the community where the person chooses to live and work is an appropriate place to provide treatment, supports, and services."³³ Accordingly, the Office of Behavioral Health's mission is "to lead the effort to build and provide a comprehensive, integrated, person-centered system of prevention and treatment services that promote recovery and resilience for all citizens of Louisiana."³⁴ As the State has acknowledged: "Individuals with serious mental illnesses and addictive disorders often have co-occurring chronic medical problems. Therefore, it is important

³² The situation has not substantially improved since 2014. The nursing assessment data reveals that as of February 2016, approximately 240 people expressed interest in learning about community services sometime in the preceding year, but only a quarter were referred to Local Contact Agencies.

³³ Louisiana Department of Health and Hospitals (Division of Planning and Budget), *A Five Year Strategic Plan (FY 2014-2015 through FY 2018-2019)*, 154 (July 1, 2013).

³⁴ *Id.*

to enhance a collaborative network of primary health care providers within the total system of care.”³⁵ These goals align with Louisiana State law, which provides that “persons with mental or physical disabilities are entitled to live in the least restrictive environment in their own community and in normal residential surroundings and should not be excluded therefrom because of their disabilities.” LA. REV. STAT. ANN. § 28:476.

Within the State’s mental health service array, Louisiana already provides many of the services and supports that are essential to helping people with serious mental illness live in their homes and communities, including Permanent Supported Housing, Assertive Community Treatment, Community Psychiatric Support and Treatment, Mobile Crisis services, and peer support. While these services are insufficient to meet demand, the State can redirect money it is currently spending on 24-hour nursing facility placements to fund services that help individuals with serious mental illness transition back to or remain in their own homes.

The State may also save money in doing so. For example, State data indicates it results in a reduction in Medicaid costs for people in the program. More generally, when compared to the estimated annual cost of roughly \$22,000 in State funding for a full year of nursing facility services,³⁶ community services for an individual with serious mental illness can generally be provided for \$15,000 to \$20,000 a year in State costs, even if the person requires the most intensive assistance from an Assertive Community Treatment team, a personal care attendant, and Permanent Supported Housing. This would save the State up to 30% of its nursing facility cost. Moreover, as our expert found, although many Louisianans with serious mental illness would initially need more intensive services upon transition into the community, those needs would likely decrease over time, thus further reducing the costs.

The State’s system for identification, diversion, and transition planning can be strengthened to ensure that people with serious mental illness are placed in appropriate community settings, rather than institutionalized in nursing facilities. Many of the necessary steps forward for the State are already part of the State’s obligations under PASRR, which require the State to identify people with serious mental illness, ensure that accurate evaluations are conducted independently, and connect them to community-based services. 42 U.S.C. § 1396r(e)(7)(B)(i); 42 C.F.R. §§ 483.128(a), (f); 483.130(l); 483.132(a),(b); 483.134(b)(5). Moreover, the State already has mechanisms in place to conduct PASRR evaluations and identify individuals with serious mental illness who should be served in the community. The State can strengthen these mechanisms, for example, by involving the local governing entities in Level II

³⁵ Louisiana Office of Behavioral Health, *FY 2012 Combined Behavioral Health Assessment and Plan Block Grant Application*, at 64 (Sept. 1, 2011).

³⁶ The total Medicaid cost of a full year in a nursing facility is approximately \$59,000 in Louisiana, but the State pays only 38% of that amount—approximately \$22,000—and the federal government pays the remainder.

PASRR evaluations and by providing transition planning for people with serious mental illness, just as the State already does for individuals with intellectual and developmental disabilities. In addition, through its level of care initiative, it has shown itself capable of using available data to identify at least some portion of the nursing facility population that can live in the community.

Given the array of mental health services in Louisiana, the existence of funds that could be directed to community-based settings, and the State's ability to build upon existing processes for diversion and transition, Louisiana can reasonably modify its service system to provide mental health services in the most integrated setting appropriate.

V. RECOMMENDED REMEDIAL MEASURES

The State should promptly implement remedial measures to protect the civil rights of individuals with serious mental illness in, or at serious risk of entering, nursing facilities and to remedy the deficiencies discussed above, taking into account the needs and preferences of each individual with serious mental illness. These remedial measures should include the following:

- The State must improve the capacity of evidence-based community mental health services such as Assertive Community Treatment, Community Psychiatric Support and Treatment, peer support services, supportive employment, Mobile Crisis services, and Permanent Supported Housing. The State should ensure coordination between local government entities and community mental health providers and hospitals, law enforcement, homeless shelters, and jails to avoid unnecessary institutionalization and criminal justice involvement.
- The State must ensure the availability of sufficient home-based medical services and supports, including personal care assistance, home health, and nursing to meet both the needs of individuals with serious mental illness who want to transition to the community from nursing facilities and individuals who are at serious risk of nursing facility admission.
- The State must ensure that necessary physical and mental health services are delivered in an integrated, coordinated fashion.
- The State must develop an effective system of identifying and diverting individuals with serious mental illness from nursing facility placement. To implement an effective process, the State should, at a minimum:
 - Identify people with serious mental illness who are referred for admission to nursing facilities;
 - Ensure that individuals with serious mental illness requesting admission are evaluated by an independent evaluator who is familiar with the available community-based services; and
 - Promptly arrange for necessary behavioral and primary healthcare services in the community where appropriate.

- The State must develop an effective system of identifying and diverting individuals with serious mental illness from nursing facility placement. To implement an effective process, the State should, at a minimum:
 - Identify people with serious mental illness who are referred for admission to nursing facilities;
 - Ensure that individuals with serious mental illness requesting admission are evaluated by an independent evaluator who is familiar with the available community-based services; and
 - Promptly arrange for necessary behavioral and primary healthcare services in the community where appropriate.
- The State must develop a functioning PASRR system that includes comprehensive and meaningful independent assessments and community service planning for all individuals with serious mental illness referred to nursing facilities.
- The State must implement effective, person-centered transition planning for all individuals with serious mental illness institutionalized or at risk of institutionalization in a nursing facility.
- The State must provide quality services in sufficient amount to ensure individuals with serious mental illness receive the services necessary to avoid institutionalization and are integrated in the community.

We are obligated to advise you that if the State declines to enter into negotiations or if our negotiations are unsuccessful, the United States may take appropriate action, including initiating a lawsuit, to ensure the State's compliance with the ADA. However, we would prefer to resolve this matter by continuing to work cooperatively with the State and we are confident that we will be able to do so.

We will contact you soon to discuss the issues referenced in this letter and to set a date and time to meet in person to discuss a remedial framework in which to address any outstanding concerns. Please note that the letter is a public document that will be posted on the Civil Rights Division's website. If you have any questions, please feel free to contact Steven H. Rosenbaum, Chief of the Civil Rights Division's Special Litigation Section, at (202) 616-3244.

Sincerely,



Vanita Gupta
Principal Deputy Assistant Attorney General

cc: Stephanie A. Finley
United States Attorney
Western District of Louisiana

J. Walter Green
United States Attorney
Middle District of Louisiana

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Office of Behavioral Health

AGREEMENT TO RESOLVE DEPARTMENT OF JUSTICE INVESTIGATION

I. INTRODUCTION

1. This matter involves the services, programs, and activities for adults with serious mental illness (“SMI”) available through the public mental health and long-term care systems of the State of Louisiana (the “State”).
2. In 2014, the United States initiated an investigation of the State of Louisiana’s mental health service system to assess compliance with Title II of the Americans with Disabilities Act (“ADA”), 42 U.S.C. §§ 12131-12134.
3. On December 21, 2016, the United States issued its findings and conclusions in a letter to the State of Louisiana, concluding that the State unnecessarily relies on nursing facilities to serve adults with serious mental illness instead of serving them in the most integrated setting appropriate to their needs as required by the ADA.
4. The State and the United States (“the Parties”) are committed to achieving compliance with Title II of the ADA. The ADA requires that the State’s services to individuals with mental illness be provided in the most integrated setting appropriate to their needs. This Agreement has the following goals: (1) divert individuals with serious mental illness away from inappropriate nursing facility placements by requiring comprehensive evaluations and services designed to enable them to live in community-based settings; and (2) identify people with serious mental illness who have been admitted to nursing facilities but are able to and would like to transition to the community, and provide them with transition and discharge planning and community-based services sufficient to meet their needs. With this Agreement, the Parties intend to achieve the goals of serving individuals with serious mental illness in the most integrated setting appropriate to their needs, to honor the principles of self-determination and choice, and to provide quality services in integrated settings to achieve these goals.
5. In order to resolve the issues pending between the Parties regarding adults with serious mental illness living in nursing facilities, without the expense, risks, delays, and uncertainties of litigation, the Parties agree to the terms of this Agreement as stated below. This Agreement resolves the United States’ investigation of the State’s alleged unnecessary institutionalization of individuals with serious mental illness in nursing facilities.

6. This Agreement will become effective on the date upon which it is signed by the Parties and filed with the Court.

II. DEFINITIONS

7. **Case Manager** is an individual with experience in coordinating or providing community-based services and person-centered planning to members of the Target Population, as defined in Section III. Case Managers must be trained and knowledgeable about the resources, supports, services, and opportunities available in the State and be independent of Community-Based Service providers who may provide direct services to their assigned clients, and of nursing facilities.

8. **Community-Based Services** are person-centered services delivered in an integrated and coordinated manner to members of the Target Population provided as necessary to support individuals to live in the community and avoid unnecessary institutionalization.

9. **Community Provider** is an individual or entity who provides Community-Based Services, paid in whole or in part by the State, or through a managed care arrangement, to a member of the Target Population.

10. **Integrated Day Activities** allow individuals within the Target Population to engage in mainstream, community-based recreational, social, educational, cultural, work, volunteer, and training activities at times and frequencies and with persons of their choosing, and to interact to the fullest extent possible with non-disabled peers.

11. **LGEs** are Local Governing Entities, which are created as special districts and which, through their boards, direct the operation and management of community-based programs and services relative to public health, mental health, developmental disabilities, and substance abuse services in each of ten regions.

12. **LDH** is the Louisiana Department of Health.

13. **Medicaid Managed Care Organization (MCO)** is a private entity that contracts with LDH to provide core benefits and services to Louisiana Medicaid MCO program enrollees in exchange for a monthly prepaid capitated amount. The entity is regulated by the Louisiana Department of Insurance with respect to licensure and financial solvency, pursuant to La. R.S. 22:1016; with respect to its products and services offered pursuant to the Louisiana Medicaid Program, it is solely regulated by the LDH.

14. **OAAS** is the Louisiana Office of Aging and Adult Services.

15. **OBH** is the Louisiana Office of Behavioral Health.

16. **Permanent Supportive Housing** is integrated, permanent, affordable housing with tenancy rights and flexible, non-mandatory supports and services that enable the individual to live in the community and avoid unnecessary institutionalization and/or homelessness.
17. **Person-centered planning** is a Medicaid-mandated process driven by the individual that identifies supports and services that are necessary to meet the individual's needs in the most integrated setting. The individual directs the process to the maximum extent possible and is provided sufficient information and support to make informed choices and decisions. The process is timely and occurs at times and locations convenient to the individual; reflects the cultural and linguistic considerations of the individual; provides information in plain language and in a manner that is accessible to individuals within the Target Population; and includes strategies for resolving conflict or disagreement that arises in the planning process.
18. **Recovery** is a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential.
19. **Serious Mental Illness ("SMI")** is a major mental disorder as described in 42 CFR 483 Subpart C (i)-(iii). Application of this definition should also take into consideration the current Diagnostic and Statistical Manual of Mental Disorders (DSM) definitions such as Schizophrenia Spectrum Disorders, other Psychotic Disorders, Bipolar Related Disorders, Depressive Disorders, Anxiety Disorders, Personality Disorders, Trauma Related Disorders or other major mental disorders that result in functional limitations in major life activities, including within the 6 months prior to nursing facility application, are not a primary diagnosis of dementia or co-occurring with a primary diagnosis of dementia, and are not episodic or situational.
20. **Subject Matter Expert** is an individual chosen by the Parties with expertise in administration and financing of states' mental and physical health services and substance use treatment programs. This individual will provide technical assistance to the State as set forth in the Agreement.
21. **Supported Employment** is an evidence-based practice that helps individuals with SMI participate as fully as possible in the competitive labor market. It includes job development, job finding, job carving, job customization, co-worker and peer supports, self-employment supports, re-employment supports, time management training, benefits counseling, job coaching, transportation, workplace accommodations, assistive technology assistance, and specialized on-the-job training.

22. **Tenancy Supports** enable individuals to obtain, maintain, and remain in housing, including, but not limited to assistance as needed with: searching for and securing appropriate, accessible housing; meeting with landlords to discuss rental concerns; completing the application process for housing; negotiating a lease; requesting needed reasonable accommodations and modifications; arranging for home modifications prior to move-in and in response to changing needs over time; the moving process; meeting the obligations of tenancy; and interfacing with landlords and neighbors. Tenancy Supports will be flexible and available as needed and desired, but will not be mandated as a condition of tenancy.

23. **Transition Services** are the non-recurring short-term services and supports necessary to enable a member of the Target Population to transition to a community setting from a nursing facility, including payments for moving expenses such as security deposits, essential furnishings, and fees or deposits for utilities; health and safety measures such as pest or allergen control or cleaning prior to occupancy; timely application and assurance of receipt of benefits including, but not limited to Social Security, Medicaid, Medicare, Temporary Assistance to Needy Families, and the Supplemental Nutrition Assistance Program, and assistance with appeal of benefit denials and connecting individuals with nonprofit Louisiana legal services agencies; and working with the SSI/SSDI Outreach, Access, and Recovery (SOAR) program.

III. 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.

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

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.

IV. DIVERSION AND PRE-ADMISSION SCREENING

A. Diversion

28. Diversion is a set of activities that occur before an individual is admitted to a nursing facility, which seek to provide an appropriate alternative placement to a nursing facility and meet the individual's needs in the most integrated setting.

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, below.

30. Currently, approximately 80% of admissions of persons with SMI to Louisiana nursing homes are from hospitals. 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.

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

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

B. Screening and Evaluation

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.

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.

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.

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.

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 of time 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.

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.

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.

V. 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.

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.

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 which 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.

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.

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.

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.

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.

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.

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

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.

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.

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.

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.

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

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.

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.

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.

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.

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 those barriers cannot be successfully overcome by transition team members working with service providers, the individual, and the individual's informal supports. 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.

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.

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

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.

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.

VI. 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.

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.

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, 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.

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.

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.

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.

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.

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.

71. Members of the Target Population who require the highest intensity of support will be provided with evidence-based ACT services if medically necessary. The State shall review its

level of care or eligibility criteria for ACT services to remove any barriers to access identified by the State or the Expert resulting in inadequate access for the Target Population.

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

C. Intensive Community Support Services (ICSS)

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

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

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.

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.

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

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.

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.

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.

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.

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.

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.

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.

G. Medicaid Authority for Provision of Services to 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.

VII. OUTREACH, INREACH, 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.

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.

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.

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.

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.

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

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

VIII. 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).

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

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.

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.

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 is neither 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.

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

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

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.

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.

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.

IX. SUBJECT MATTER EXPERT

A. Selection of the Subject Matter Expert

104. The Parties agree that John O'Brien shall be the Subject Matter Expert ("Expert") retained by the State to provide technical assistance.

105. In the event the Expert resigns or the Parties agree to replace the Expert, the Parties will meet and confer within ten (10) days to agree upon a replacement.

B. Expert Responsibilities

106. The Expert will provide technical assistance to help LDH comply with its obligations under the Agreement. The Parties will cooperate fully with the Expert. The Expert will also analyze and report on data reflecting LDH's progress in complying with all sections of this Agreement. Where the Expert's review and approval is required under a term of this Agreement, the Expert shall not withhold approval if the State's proposal is consistent with the goals and terms of this Agreement.

107. The Expert and the United States will have full access to persons, employees, residences, facilities, buildings, programs, services, documents, data, records, materials, and things that are necessary to assess LDH's progress and implementation efforts with this Agreement. Access will

include departmental or individual medical and other records. The United States and/or the Expert will provide reasonable notice of any visit or inspection. Advance notice will not be required if the Expert or the United States has a reasonable belief that a member of the Target Population faces a risk of serious harm. Access is not intended, and will not be construed, as a waiver, in litigation with third parties, of any applicable statutory or common law privilege associated with information disclosed to the Expert or the United States under this provision.

108. In addition to reviewing and analyzing data, the Expert will assess the quality and sufficiency of Community-Based Services, by reviewing a representative sample of individuals in the Target Population.

109. At least every six months, the Expert will draft and submit to the Parties a comprehensive public report on LDH's compliance including recommendations, if any, to facilitate or sustain compliance. The LDH shall post these reports on its website.

110. The Expert will provide LDH with technical assistance relating to any aspect of this Agreement.

111. In completing his or her responsibilities the Expert may: (a) hire staff and consultants as necessary to assist in carrying out the Expert's duties and responsibilities; (b) require written reports and data from LDH concerning compliance; (c) testify in enforcement proceedings regarding any matter relating to the implementation, enforcement, or dissolution of the Agreement, including, but not limited to, the Expert's observations, findings, and recommendations in this matter.

112. The Expert, and any staff or consultants retained by the Expert, will not: (a) be liable for any claim, lawsuit, or demand arising out of their activities under this Agreement (this paragraph does not apply to any proceeding for payment under contracts into which they have entered in connection with their work under the Agreement; any such proceeding shall take place solely before this Court.); (b) be subject to formal discovery in any litigation involving the services or provisions reviewed in this Agreement, including, but not limited to, deposition(s), request(s) for documents, and request(s) for admissions, interrogatories, or other disclosure; (c) testify in any other litigation or proceeding with regard to any act or omission of LDH or any of the LDH's agents, representatives, or employees related to this Agreement, nor testify regarding any matter or subject that he or she may have learned as a result of his or her performance under this

Agreement, nor serve as a non-testifying expert regarding any matter or subject that he or she may have learned as a result of his or her performance under this Agreement.

C. Expert's Budget

113. Within 60 days of the Effective Date of this Agreement, the Expert will prepare a proposed budget for the first year under the Agreement, consistent with the Expert's duties pursuant to Section IX.B. The Expert shall annually submit to the Parties a proposed budget for the duration of this Agreement.

114. At any time, the Expert may submit to the Parties a proposed revision to the approved budget, along with any explanation of the reason for the proposed revision. The State shall not unreasonably withhold approval of the Expert's proposed or revised budgets.

D. Reimbursement and Payment

115. The cost of the Expert, including the cost of any staff or consultants to the Expert, will be borne by LDH, but the Expert and the Expert's staff or consultants are not agents of LDH. All reasonable expenses incurred by the Expert or any of the Expert's staff in the course of the performance of the duties of the Expert will be reimbursed by LDH consistent with the agreed-upon budget.

116. The Expert will submit monthly statements to LDH, detailing all expenses the Expert incurred during the prior month, consistent with the annual budget and any revisions authorized pursuant to Paragraph 114.

117. The Expert will not enter into any additional contract with LDH while serving as the Expert. If the Expert resigns from his or her position as Expert, the former Expert may not enter any contract with LDH or the United States on a matter related to this Agreement without the written consent of the other Party while this Agreement remains in effect. LDH will not otherwise employ, retain, or be affiliated with the Expert, or professionals retained by the Expert while this Agreement is in effect, and for a period of at least one year from the date this Agreement terminates, unless the United States gives its written consent to waive this prohibition.

X. IMPLEMENTATION

118. Within 30 days of the Effective Date of this Agreement, LDH will designate an Integration Coordinator to coordinate compliance with this Agreement and to serve as a point of contact for the Parties and the Expert.

119. LDH will take steps to begin implementing this Agreement immediately. LDH may implement selected provisions of this Agreement on a rolling basis. This rolling implementation is intended to allow the State to maintain flexibility, account for and adapt to challenges encountered, and build upon successes during implementation.

A. Implementation Plan

120. LDH will create an Implementation Plan that describes the actions it will take to fulfill its obligations under this Agreement. The Parties contemplate that implementation will be accomplished in phases as outlined in the Implementation Plan.

121. The initial Implementation Plan will primarily focus on implementation of the obligations for the first eighteen months of the Agreement. In the initial Implementation Plan, LDH shall develop the initial eighteen-month Schedule, in which LDH shall: (a) develop and deliver training to LDH staff and providers concerning the provisions of this Agreement, and LDH's commitment to ending unnecessary institutionalization of people in the Target Population, consistent with *Olmstead* principles; (b) identify nursing facility residents in the Target Population who have the fewest barriers to transition and begin to transition those residents to the community using transition planning and community-based services in accordance with the provisions of this Agreement; (c) conduct a gap analysis that identifies gaps in services and proposes goals and timeframes to remedy gaps in services; (d) assess Medicaid services, rates, managed care contracts, and billing structures to identify barriers to the provision of community-based services for the Target Population; (e) identify and implement incentives through Medicaid waiver, managed care, and provider contracts to increase use of community-based services and reduce reliance on institutional long-term care for the Target Population; (f) establish annual targets for diversion and transition of Target Population members to successful placements in the community. For purposes of setting these targets, successful placements are defined as those in which the individual is able to avoid re-institutionalization (not including nursing facility admissions of 30 days or less), incarceration, or homelessness for a period of one year; (f) establish annual targets and strategies for decreasing referrals for individuals with SMI to nursing facilities; (g) assign agency and division responsibility for achieving goals identified in the initial Implementation Plan; (h) establish collaborative problem-solving among State and local government agencies and entities.

122. The State shall seek input from and collaborate with the Louisiana Housing Corporation, and any relevant state, regional or local entities, such as public housing authorities, and LGEs in developing the Implementation Plan.

123. Early on and throughout the planning and implementation process, LDH will engage with stakeholders including Community Providers, members of the Target Population and their families and advocates, healthcare providers, and the Advocacy Center (the State's designated Protection and Advocacy organization) to identify their goals, concerns, and recommendations regarding implementation of this Agreement.

124. LDH will consult with the United States and the Expert on an ongoing basis in developing its Implementation Plan. The initial Implementation Plan will be provided to the United States and to the Expert no more than 100 days after the Effective Date of this Agreement. The United States and the Expert will provide comments regarding the Implementation Plan within thirty days of receipt. LDH will timely revise its Implementation Plan to address comments from the United States and the Expert; the Parties and the Expert will meet and consult as necessary. The Implementation Plan must be approved by the Expert.

125. Eighteen months after the Effective Date of the Agreement, LDH shall set forth a second Schedule that establishes annual goals and targets for achieving the outcomes specified in this Agreement and in the Implementation Plan. Thereafter, LDH, in conjunction with the United States and the Expert, may supplement the Implementation Plan to focus on and provide additional detail regarding implementation activities in the coming years. LDH shall address in its supplements to the Implementation Plan any areas of non-compliance or other recommendations identified by the Expert in his or her reports. Supplements and Schedules to the Implementation Plan will become enforceable provisions of this Agreement.

126. The State will make the Implementation Plan publicly available, including by posting the Plan, and its Schedules and supplements, on the LDH website.

XI. ENFORCEMENT AND TERMINATION

127. The United States will file a Complaint in the District Court for the Middle District of Louisiana, based upon the findings in its letter to the Governor dated December 21, 2016. The Parties agree simultaneously to file this Agreement as an exhibit to a joint motion to dismiss the United States' Complaint, pursuant to Fed. R. Civ. P. 41(a)(2), subject to reinstatement upon the United States' motion for the purpose of resolving a claim that the State materially breached any

provision of the Agreement. The motion to dismiss the Complaint shall request that the Court retain jurisdiction to resolve any dispute under the Agreement.

128. Should the United States move to restore the Complaint to the active docket of the Court for purposes of resolution of a claim of breach, the State consents to and agrees not to contest the United States' motion to restore, and consents to and agrees not to contest the exercise of personal jurisdiction over the State by the Court.

129. If the Action is reinstated, LDH expressly agrees not to count the time during which this Agreement is in place, or use the terms or existence of this Agreement, to plead, argue or otherwise raise any defenses under theories of claim preclusion, issue preclusion, statute of limitations, estoppel, laches, or similar defenses.

130. Before moving to restore the Complaint to the active docket, the United States shall provide LDH notice of any asserted breach in writing. For conditions or practices that pose an immediate and serious threat to the life, health or safety of individuals in the Target Population, LDH shall have 7 days from the date of mailing to cure the default. For all other conditions or practices, LDH shall have up to 60 days from the date of mailing to cure the default. The Notice shall be sent as outlined in the Notifications section of this Agreement.

131. In the event the United States reinstates the Action and the court finds a material breach of the Agreement, the United States may seek the following: 1) an order mandating specific performance of any term or provision in this Agreement; or 2) an order entering this Agreement as an order of the Court and enforceable by the Court; and 3) any additional relief that may be authorized by law or equity.

132. This Agreement shall terminate in five years, if the Parties agree that the State has attained substantial compliance with all provisions and maintained that compliance for a period of one year.

133. The State may seek termination of any subset of provisions that together relate to development of a community-based service. The burden shall be on the State to demonstrate that it has attained and maintained its substantial compliance as to that subset.

134. In any dispute regarding compliance with any provision of this Agreement, the State will bear the burden of demonstrating that it is in substantial compliance.

135. The Parties agree to work collaboratively to achieve the purpose of this Agreement. In the event of any dispute over the language, requirements or construction of this Agreement, the Parties agree to meet and confer in an effort to achieve a mutually agreeable resolution.

136. Nothing in this Agreement is intended to override the right of an individual in the Target Population to refuse offered services.

137. The Parties intend to allow LDH to leverage the funding of the services listed herein to the fullest extent permitted by available federal, State, and private funding. Nothing in this Agreement will preclude LDH from seeking authority from CMS for approval of coverage of Medicaid services under a different name than that used in this Agreement, provided LDH can demonstrate that the coverage for such services is otherwise legally permitted. In the event that the definitions and terms used in this Agreement create any barrier to using funding from any federal, State, or private source, the Parties agree to work collaboratively to maximize LDH's ability to access such funding.

138. Parties have signed this agreement in good faith and the State shall take all appropriate measures to seek and secure funding necessary to implement the terms of the Agreement. In the event that the State concludes that an annual appropriation is insufficient to meet the numerical and percentage targets and time frames set forth in this Agreement and the Implementation Plan, the following shall occur: (a) The State shall notify the United States in writing within the first three months of the State's fiscal year. In that writing, the State shall identify the amount of funds available, describe in detail the plan for expenditure of the available funds to continue implementation of the Implementation Plan and Agreement at a reasonable pace, and specify the resulting impact on the numerical and percentage targets and time frames set forth in the Implementation Plan and the Agreement. If the State does not provide the requisite notice set forth in this paragraph, then the State may not assert insufficiency of funding by the Governor or Legislature as a defense to any allegation of breach during the particular fiscal year at issue. The United States shall at all times have access to all data and documents regarding the costs and savings associated with implementation of the Agreement and the state's assertions regarding the insufficiency of funds and any proposed altered targets and time frames. (b) The Parties shall meet and confer within 20 business days of this notification to discuss the amount of funds available and the plan for expenditure of these funds to continue implementation of the Agreement at a reasonable pace and the resulting effect on the numerical and percentage targets and time frames set forth in the Implementation Plan and Agreement. Before that meeting, the State shall provide all additional underlying documents it is relying on to support its assertion of insufficiency of funds and any proposed altered targets and time frames. (c) If the Parties cannot reach agreement on a

revised plan for continued implementation of the Agreement at a reasonable pace, the United States may move to restore the Complaint to the active docket for the purposes of litigating a claim for breach, or, may withdraw its consent to this Agreement, which would render the Agreement null and void.

139. This Agreement will constitute the entire integrated agreement of the Parties.

140. Any modification of this Agreement, other than modifications to time periods governed by Section XI of this Agreement, will be executed in writing by the Parties before becoming effective.

141. LDH will coordinate with or enter into Memoranda of Understanding with all appropriate State agencies in order for LDH to comply with provisions of this Agreement.

142. The United States and LDH will each bear the cost of their own fees and expenses incurred in connection with this case.

143. All services mentioned or described in this agreement are subject to reasonableness standards and nothing herein shall be interpreted to mean that the provision of services are unlimited in amount, duration or scope.

XII. GENERAL PROVISIONS

144. The Agreement is binding on all successors, assignees, employees, agents, contractors, and all others working for or on behalf of LDH to implement the terms of this Agreement.

145. LDH will not retaliate against any person because that person has filed or may file a complaint, provided assistance or information, or participated in any other manner in the United States' investigation or the Expert's activities related to this Agreement. LDH will timely and thoroughly investigate any allegations of retaliation in violation of this Agreement and take any necessary corrective actions identified through such investigations.

146. LDH will take all necessary measures to ensure that members of the Target Population are not pressured to choose nursing facility services or pressured not to consider or choose Community Based Services, and are not subjected to retaliation in any form by nursing facilities, hospitals, Providers, or LDH staff for seeking alternatives to nursing facilities.

147. Failure by any Party to enforce this entire Agreement or any provision thereof with respect to any deadline or any other provision herein will not be construed as a waiver, including of its right to enforce other deadlines and provisions of this Agreement.

148. The Parties will promptly notify each other of any court or administrative challenge to this Agreement or any portion thereof.

149. The Parties represent and acknowledge this Agreement is the result of extensive, thorough, and good faith negotiations. The Parties further represent and acknowledge that the terms of this Agreement have been voluntarily accepted, after consultation with counsel, for the purpose of making a full and final compromise and settlement of the allegations set forth in the Department of Justice's Complaint and letter of findings under the ADA dated December 21, 2016. Each Party to this Agreement represents and warrants that the person who has signed this Agreement on behalf of a Party is duly authorized to enter into this Agreement and to bind that Party to the terms and conditions of this Agreement.

150. Nothing in this Agreement will be construed as an acknowledgement, an admission, or evidence of liability of the State under the Constitution of the United States or federal or state law, and this Agreement may not be used as evidence of liability in this or any other civil or criminal proceeding.

151. This Agreement may be executed in counterparts, each of which will be deemed an original, and the counterparts will together constitute one and the same Agreement, notwithstanding that each Party is not a signatory to the original or the same counterpart.

152. The performance of this Agreement will begin immediately upon the Effective Date.

153. LDH will maintain sufficient records and data to document that the requirements of this Agreement are being properly implemented and will make such records available to the Expert and the United States for inspection and copying on a reasonable basis. Such action is not intended, and will not be construed, as a waiver, in litigation with third parties, of any applicable statutory or common law privilege associated with such information. Other than to carry out the express functions as set forth herein, both the United States and the Expert will hold such information in strict confidence to the greatest extent possible.

154. "Notice" under this Agreement will be provided by overnight courier to the signatories below or their successors:

FOR THE UNITED STATES:

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Acting Assistant Attorney
General
Civil Rights Division


STEVEN H. ROSENBAUM
Chief, Special Litigation Section

MARY BOHAN
Deputy Chief, Special Litigation Section


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The Louisiana Department of Health Diversion Plan

Introduction

In June 2018, the State of Louisiana and the Louisiana Department of Health (LDH) signed an agreement with the Department of Justice to help ensure compliance with Title II of the American with Disabilities Act (ADA), which requires that the State's services to individuals with mental illness be provided in the most integrated setting appropriate to their needs. LDH is implementing a plan for a diversion system as part of its overall efforts to achieve compliance with the ADA and ensure successful implementation of its *Agreement to Resolve Department of Justice Investigation (Agreement)*.

Consistent with Section IV of the *Agreement*, LDH has developed this diversion plan to outline the steps LDH is taking to promptly identify individuals in the Target Population seeking admission to nursing facilities and provide intervention and services to prevent unnecessary institutionalization. Specifically, LDH is implementing a system to divert:

- Persons with serious mental illness (SMI) from avoidable hospitalizations that place them at risk for subsequent nursing facility admission;
- Persons with SMI who seek admission to, are referred to, and/or receive screenings and/or evaluations for nursing facility placement who do not meet Nursing Facility Level of Care (LOC) criteria or for whom a Pre-Admission Screening and Resident Review Level (PASRR) II review recommends placement in the community; and
- Persons with SMI who are admitted to a nursing facility on a temporary basis and could be transitioned into the community within a short period.

As described in this document, LDH seeks to achieve these diversion objectives through three main strategies:

- Revising eligibility pathways for nursing facility placement;
- Improving PASRR processes and criteria;
- Defining the diversion population;
- Developing a diversion protocol for the Target Population; and
- Implementing and expanding the availability of Community Support Services.

To monitor the performance of these strategies, LDH will establish measurable targets for the diversion and transition of Target Population members. The performance monitoring approach is described in the last section of this plan.

Revising Eligibility Pathways for Nursing Facility Admission

Eliminating the Behavior Pathway

LDH recently eliminated a driver of nursing facility placements for individuals with SMI: the Behavior eligibility pathway. The Behavior pathway provided an avenue for individuals with SMI to be admitted to nursing facilities without having met other LOC criteria for nursing facility placement. Nursing facility residents who were admitted per the Behavior pathway had no other qualifying condition to meet nursing facility LOC other than SMI.

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The Behavior pathway was included among other medical eligibility pathways in the Level of Care Eligibility Tool (LOCET), an initial screening tool used as part of Louisiana’s nursing facility application process, and the Minimum Data Set (MDS) 3.0 and the MDS for Home Care (MDS-HC), instruments used as part of the nursing facility level of care assessment process.

LDH implemented new regulations to effectuate changes to the Behavior pathway effective May 2018.¹ The Behavior pathway was eliminated as a medical eligibility pathway for nursing facility placement for new admissions. The rule included a “grandfather” clause: nursing facility residents who were admitted prior to the implementation of the new rule were (and are) deemed to meet nursing facility LOC as long as they continue to meet only on the Behavior pathway eligibility criteria. Residents lose their “grandfathered” status if they no longer meet on the behavior pathway, are discharged from the facility, or meet on an eligibility pathway other than the Behavior pathway.

LDH undertook steps to provide education and implementation support to providers as part of the elimination of the Behavior pathway. For example, LDH developed presentations and training materials for the state trade group, the Louisiana Nursing Home Association. To provide concrete guidance to nursing facilities on the execution of the new rule, LDH disseminated a list of nursing facility residents who continue to meet the Behavior pathway eligibility criteria and are thus “grandfathered” per new rule as described above.

Developing Policies and Procedures to Implement Temporary Approvals by the Level II Authority

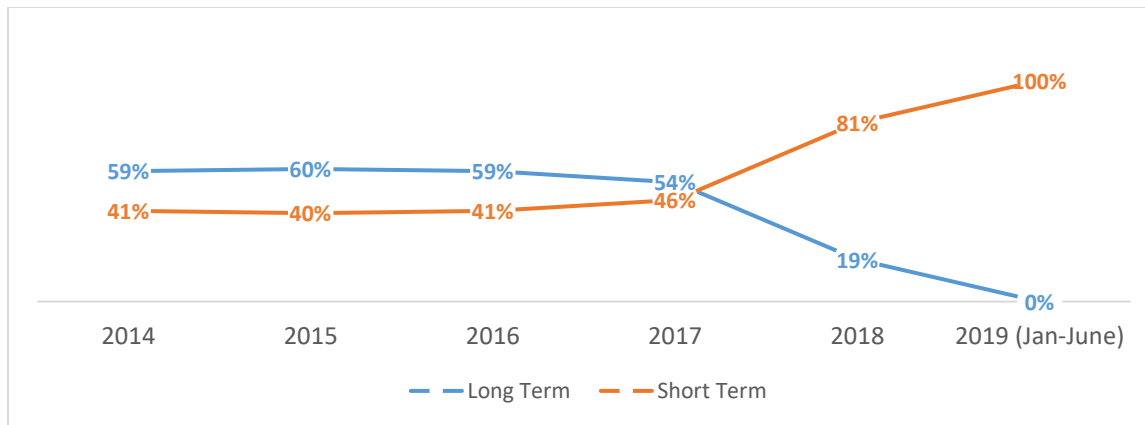
As part of a strategy to divert individuals with SMI from placement in nursing facilities, LDH has implemented changes to the screening process for nursing facility admissions for all individuals, including members of the Target Population members and individuals who would be members of the Target Population were they admitted to a nursing facility. In general, LDH is now primarily authorizing temporary stays rather than long-term “permanent” stays. This means that the need for continued stay in a nursing facility will have to be justified and will come under review more often.

Specifically, the Office of Behavioral Health (OBH) has formally standardized the utilization of temporary authorizations for all positive PASRR Level II reviews it authorizes for NF placement.² For pre-admission PASRR Level II requests, authorization requests will not exceed 90 days (or 100 days for persons approved for convalescent care by LDH). Subsequent re-reviews will not exceed one year, or 365 days. This change in process has resulted in 100% of authorizations issued by the OBH PASRR Level II authority being short term, requiring at least an annual re-review during which time the need for continued NF placement and services can be evaluated.

¹ Louisiana Administrative Code. Title 50, Part II, Subchapter G. Section 10156(I)(1)-(2). Included as attachment.

² OBH PASRR Level II Authorization Rubric. Included as attachment.

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Changing the LOC Determination Process to Implement Temporary Approvals

LDH also implemented changes to its nursing facility LOC determination process to ensure that individuals who meet a temporary pathway for nursing facility admission only receive temporary approval and must reapply for a continued stay. These procedures apply to all persons seeking to enter a Louisiana nursing home, not just applicants who may be members of the Target Population. The value of this change for purposes of the agreement is that a person's history or symptoms of SMI may not be known or readily apparent upon admission. Increasing the percentage of temporary approvals means that a high percentage of person's entering facilities will be reviewed again before a continued stay is approved, increasing the odds of identifying SMI post-admission. If SMI is identified or suspected at the end of a temporary stay, that person can be referred to the PASRR Level II authority for review.

To implement the temporary approval strategy, LDH re-designed the LOCET screening instrument used for initial placements in nursing facilities. The LOCET instrument is comprised of medical eligibility pathways for admission to nursing facilities. Some pathways are indicative of short-term needs (such as rehabilitation or medical management after a hospital stay) while some are indicative of possible longer-term needs (such as eligibility pathways based on cognitive and ADL needs). Independent reviewers performing the LOCET screening move through the various eligibility pathways in a set order to determine if the individual meets LOC. If an individual meets an eligibility pathway, the LOCET screening immediately concludes and a referral is made. Prior to May 2018, the LOCET instrument listed medical eligibility pathways in an order that resulted in the majority of individuals being admitted to nursing facilities on a long-term basis (99%).

In May, 2018, LDH restructured the order in which eligibility pathways appear in the instrument to prioritize temporary admissions over long-term admissions. For example, the eligibility pathways pertaining to assistance with daily living needs and cognitive criteria were previously listed first and second on the LOCET instrument, which resulted in a rate of long-term admission approvals of 99%. To achieve greater rates of temporary approvals, LDH updated the LOCET instrument to list medical eligibility pathways in an order that would result in more individuals being admitted to nursing facilities on a temporary basis, such as admissions for individuals who met eligibility pathways pertaining to physician involvement, medical treatments and health conditions, and skilled rehabilitation therapies. These eligibility pathways, which can only be used for temporary approvals, now appear first, second, and third on the LOCET instrument, respectively. If an individual is determined to meet one of these eligibility pathways during the LOCET screening, the screening immediately concludes and the individual is admitted to the nursing facility on a short-term basis.

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Since the implementation of the temporary authorization strategy, the Office of Aging and Adult Services (OAAS) shows an increase in temporary approvals from 24 per month to 1,650 per month. Among nursing facility residents admitted on a temporary basis who submit a Continued Stay request, only 15% receive a long-term approval (maximum authorization of 1 year), whereas 78% are referred to OBH for determination.³ Fundamentally, only 17% of temporary approvals result in a Continued Stay approval.⁴

Reviewing Continued Stays Beyond 90-100 Days

As part of an overall strategy to divert individuals with SMI from nursing facility placement, LDH has taken additional steps to implement its temporary approval policy. As described above, most individuals who are admitted to nursing facilities under the new policy receive temporary approval for up to 100 days. Since implementation of the temporary approval policy, 85% of all initial approvals are now temporary. For nursing facility residents who request approval for continued stay, LDH requires that OAAS staff verify the need for continued stay.

Nursing facilities are required to submit continued stay requests to OAAS at least fifteen days before the authorized temporary admission ends. As part of the review for continued stay requests, OAAS staff review medical records from the nursing facility, such as ADL documentation, nursing notes, physician orders, etc., in conjunction with the most recent MDS 3.0 available at the time of the submission. If there are questions about documentation provided by a nursing facility, OAAS Regional Staff visit the facility for an onsite review.

Notably, the 90-/100-day reassessment is a valuable opportunity to identify individuals with SMI whose SMI was not identified during the initial PASRR screening. If indications of serious mental illness are present during a review of the documentation submitted as part of the continued stay request process, the individual is referred to the Office of Behavioral Health for an OBH determination of the need for a Level II evaluation. This process can help identify individuals with SMI and provide a basis for referrals for community-based mental health services. In this way, the temporary approval strategy serves as a key intervention in LDH's diversion plan.

Improving PASRR Processes and Criteria

LDH is implementing a number of strategies to improve the PASRR Level I screenings and Level II evaluations to achieve diversion of individuals with SMI seeking admission to nursing facilities. These strategies to improve PASRR processes and criteria include:

- improving the identification of individuals with SMI through PASRR Level I screening;
- improving the delivery of PASRR Level II evaluations;
- performing PASRR Level II evaluations promptly to ensure continued compliance with federal standards regarding the timeliness of PASRR Level II determinations;
- revising PASRR Level II forms to include more information regarding mental health services in the community;
- providing additional training to ensure that PASRR Level II evaluators are familiar with the complete array of home and community-based services available; and

³ Ibid.

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http://ldh.la.gov/assets/docs/BehavioralHealth/PASRR/Louisiana_Nursing_Home_Association_Presentation_Sep_5_2018.pdf

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- strengthening documentation requirements used to establish a primary diagnosis of dementia relative to the PASRR screening process.

Improving the Identification of Individuals with SMI through PASRR Level I Screening

LDH has taken several steps to leverage the PASRR Level I screening process to better identify individuals with SMI who are referred to nursing facilities. These 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.

The PASSR Level I screening instrument was modified in June 2018 to incorporate several changes designed to better identify individuals with SMI for the purpose of diverting them from nursing facility admissions.⁵ LDH revised the form in response to the PASRR Technical Assistance Center's (PTAC) findings that listed Louisiana among the states where too many individuals were identified as having a mental health diagnosis after nursing home admission, suggesting that the pre-admission form may not have been sensitive enough. LDH incorporated best practices from other states in the revision, especially from those states that PTAC found to have better pre-admission identification.

LDH provided training opportunities for nursing facility and hospital staff to introduce the revised PASSR Level I screening tool. Specifically, OAAS held in-person trainings in Bossier City, Lafayette, and Metairie which were attended by 106 individuals. In addition, OAAS held a series of 10 webinars held twice a day for five consecutive days which were attended by 382 individuals. The webinar training and an instruction guide for completing the Level I Screen, including the list of individuals deemed qualified, are maintained on the LDH OAAS website.

Improving the Delivery of PASRR Level II Evaluations

Consistent with the *Agreement*, LDH is taking steps to 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.

In general, PASRR Level II Evaluations are prompted for Louisiana nursing facility residents with SMI through four routes:

- Initial: pre-admission screening PASRR Level II evaluations performed as part of the nursing facility application process and completed prior to admission (for all referrals with SMI indicated by a Level I screen);
- Extension Requests/Annual Reviews: PASRR Level II evaluations performed on NF residents with a previous OBH PASRR Level II issued authorization when a nursing facility requests a continued stay to extend an authorization that is expiring;
- Resident Reviews: Routine PASRR Level II evaluations performed on nursing facility residents with a valid authorization for NF placement who have a verified or suspected SMI diagnosis. Resident Reviews occur when there is a significant change in status which may impact the individual's need for services and/or continued NF placement; and

⁵ <http://ldh.la.gov/assets/docs/OAAS/PASRR/NFA-Level1-PASRR.pdf>

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- *Agreement-specific PASRR Level II evaluations performed for residents that are on the Master List of the Target Population and referred for a PASRR Level II. These are treated like Resident Reviews (described above).*

Level II Evaluation Route	When Does It Occur?	Who Receives It?
Pre-admission Screening	Prior to nursing facility placement.	All nursing facility applicants identified as possibly having SMI per Level I screen.
Extension Requests/Annual Reviews	When the nursing facility requests a continued stay beyond the existing authorization.	All nursing facility residents with an OBH PASRR Level II authorization seeking a continued stay in the NF.
Resident Reviews	When there is a “significant change” in a resident’s status, per federal definition.	Nursing facility residents with a “significant change” in status, including those previously identified and not identified by PASRR as having, or being suspected as having, a SMI diagnosis.
<i>Agreement-specific evaluations</i>	When there is a member of the Master List suspected of having a SMI diagnosis but who has not gone through the PASRR Level II review process; or was previously determined not to meet SMI criteria though it is suspected their behavioral health status has changed or worsened.	Target Population members included on the Master List maintained by OAAS suspected as having a SMI diagnosis.

LDH has undertaken concrete efforts to improve the processes by which PASRR Level II evaluations are prompted through each route.

For pre-admission screening PASRR Level II evaluations, LDH is optimizing the alignment between OAAS, OBH, and MCOs to better identify individuals suspected of having a SMI diagnosis and, as such, in need of a PASRR Level II evaluation conducted by OBH. Individuals referred for nursing facility placement receive a PASRR Level I screening performed by OAAS as the Level I authority. OAAS determines whether or not an individual meets NF LOC. If an individual meets NF LOC and is suspected of having a behavioral health diagnosis, OAAS sends the screening results to OBH as the Level II authority. OBH conducts an initial review to determine if a Level II evaluation is necessary, and when indicated, mandates a Level II evaluation be performed by the Medicaid MCO or its affiliate. When appropriate the individual receives a Level II evaluation performed by the Medicaid MCOs’ Level II Evaluator, a Licensed Mental Health Professional who operates independent of the nursing facility and the state. The Level II evaluation is reviewed and verified by the MCO prior to being returned to OBH for final determination regarding placement needs and recommendations for services.⁶ When appropriate, OBH then provides temporary 90-100 day authorizations for nursing facility admissions.

⁶ See “MCO Role in Evaluations & Determinations” for a flow chart conveying the PASRR Level I and Level II process. Included as attachment.

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For PASRR Level II evaluations performed upon individuals with expiring authorization (i.e. extension requests), LDH is executing the same alignment between OAAS, OBH and MCOs as noted above. For residents approved on a temporary basis who request a continued stay, OAAS reviews the continued stay request to verify LOC and forwards to OBH for a Level II determination to be conducted. If the LOC criteria is met and a PASRR Level II evaluation has been completed, OBH may provide an authorization for up to one year. Under this newly aligned process, OAAS and OBH coordinate efforts to ensure all residents admitted to nursing facilities are regularly reviewed via a process which enables the PASRR authorities to review NF LOC status and behavioral health needs. During this time, a referral will be made to a Transition Coordinator who can engage and discuss transition needs. When this occurs, referrals will be made to OAAS TCs when an individual continues to meet NF LOC and will be referred to an OBH TC when the individual no longer meets NF LOC. In the instance an individual no longer meets LOC, a temporary authorization will be issued with the purpose of facilitating transition back into the community. Under this aligned process, OAAS and OBH coordinate efforts to ensure all residents admitted to nursing facilities with a continued stay authorization who seek a continued stay beyond the initial authorization of up to one year receive a PASRR Level II evaluation on an annual basis. This occurs through managing the length of authorizations which prompt NF to request a re-review and extension to the existing authorization.

For routine PASRR Level II evaluations performed as part of a Resident Review for residents with a significant change in status, LDH recently implemented guidelines to improve and streamline this process. Specifically, in June 2018 OBH published a new set of guidelines for nursing facilities to use when determining whether a Resident Review is required (and whether a concomitant PASRR Level II evaluation would be completed). OBH disseminated these guidelines to nursing facilities in August 2018, and presented these guidelines in a training for the state nursing home association in September 2018.

For *Agreement*-specific PASRR Level II evaluations, LDH is optimizing the alignment between OAAS and OBH to better prompt PASRR Level II evaluations for residents who are identified as potentially being members of the Target Population. In this instance, the resident review process is conducted on individuals who are suspected of being part of the target population but who have either not gone through the PASRR Level II review process or were previously determined not to meet SMI criteria though it is suspected their behavioral health status has changed or worsened. In this instance, OBH screens to determine if a Level II evaluation is warranted. If so, they refer to the MCO for a Level II evaluation. Based on the findings of the evaluation a final determination is made by the PASRR Level II Determination Specialist whether or not the individual meets SMI criteria and what their behavioral health service needs are.

OBH modified the PASRR Level II Independent Behavioral Health Comprehensive Evaluation form to adhere to guidelines outlined in the *Agreement*. To implement the changes to the PASRR Level II evaluation forms and pathways for evaluation as described above, OBH provided in-person training in September 2017 to the Medicaid MCOs and the Medicaid MCO representatives serving as Level II evaluators. In addition, LDH provided training to nursing facilities in September 2016 to clarify the role of MCOs in the PASRR screening and evaluation process. OBH is also working with the Medicaid MCOs to identify and meet the additional training needs of their Level II evaluators. OBH has worked on conducting additional modifications to the Level II tool in an effort to better identify individual needs to remain in the community. The tool has been presented to the MCOs and updated based on their feedback. It will be finalized and implemented by April, 2020.

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Performing PASRR Level II Evaluations Promptly

To ensure that PASRR Level II evaluations are performed promptly, LDH has implemented policies and incorporated specific requirements within its Medicaid managed care contracts to ensure sufficient timeliness of evaluation completion.

Additionally, in an effort to ensure the provision of appropriate documentation needed in order to finalize the determination process, LDH issued a legal memorandum in December 2017 to providers to clarify their responsibilities to submit required documentation to OBH and Medicaid MCOs within a timely manner for the purposes of PASRR Level II evaluations.⁷ Specifically, the memo identifies the minimum data to be submitted as part of a PASRR Level II request and the required timeframes for providers sending requested records and information to the Medicaid MCOs. The memo also clarifies that disclosure of Medicaid enrollee information by a Medicaid provider to a Medicaid MCO is permitted without enrollee authorization for the purposes of PASRR Level II evaluations. The most recent data indicates that Medicaid MCOs are completing PASRR Level II evaluations within four business days of referral from OBH, consistent with state requirements.

Revising PASRR Level II Evaluation Forms to Include Information Regarding Mental Health Services in the Community

LDH recently revised the PASRR Level II evaluation forms to better convey the availability of community-based mental health services that may be appropriate for nursing facility residents with SMI. In addition, LDH is assessing options to align these updates to 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. This will ensure all personnel involved with Level II evaluations and determinations have information about community services and supports available to individuals with SMI. This includes the MCOs, the Level II Determination Specialists, Level I staff, Transition Coordinators, and the member themselves all having access to information about those items needed to maintain the individual in the community.

In order to achieve diversion and ensure nursing facility residents with SMI are offered the opportunity to transition into the community and receive community-based mental health services and supports when medically appropriate, LDH revised the evaluation forms used by PASRR Level II evaluators to display more information regarding the continuum of services that are available in the community. The goal of these revisions is to assist PASRR Level II evaluators with identifying community-based options to meet the needs of residents with SMI when the evaluators are completing the PASRR Level II evaluation and submitting to OBH for determination.

To achieve alignment with these updates to the evaluation forms used by PASRR Level II evaluators within the Medicaid MCOs, LDH will also update 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 used by OBH to better convey information about community-based mental health services and supports. In this way, all parties affiliated with the process will have immediate, better access to information regarding the continuum of services that are available in the community. The goal is to assist individuals with identifying community-based options to meet the needs of residents with SMI when developing a Level II summary, determination of placement, and recommendation for services. LDH seeks to

⁷ LDH Legal Memorandum “Provision of Required Documentation for the Purposes of PASRR”, 12/4/2017. Included as attachment.

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implement these updates to the Level II determination form to achieve alignment with the updated Level II evaluation form by April 2020.

Providing Additional Training to Ensure that PASRR Level II Evaluators Are Familiar with the Complete Array of Home and Community-based Services Available

To complement the updates to the PASRR Level II evaluation forms regarding community-based services as described above, LDH has taken additional steps to ensure that Level II evaluators are knowledgeable about the community-based services that are available for nursing facility residents with SMI.

LDH ensures the Medicaid MCOs are offering sufficient trainings to their affiliates and representatives that perform PASRR Level II evaluations. In this regard, LDH reviews the credentials and training processes for Level II evaluation specialists performing Level II evaluations on behalf of MCOs, including the qualification that each specialist is trained in using the Level of Care Utilization System for Psychiatric and Addiction Services assessment tool developed by the American Association of Community Psychiatrists and participates in regular PASRR trainings.

LDH has also developed directories for community-based resources available to individuals referred for PASRR evaluations, including mental health and substance use disorder services, Medicaid MCOs, local housing authorities, disability and public benefits offices, Local Governing Entities, crisis hotlines, transportation, and other relevant programs. These directories will be maintained and updated with current listing of available services within the behavioral health service array.

In addition, LDH provided training to nursing facilities in September 2016 to clarify that nursing facility residents are eligible to receive Medicaid-covered behavioral health and mental health rehabilitation services, including residents with SMI who are preparing to transition into the community, residents for whom services are recommended through the Level II determination process, and residents identified by MCOs as high service users. This guidance has continued to be shared with NF, MCOs and behavioral health treatment providers.

Strengthening Documentation Requirements Used to Establish a Primary Diagnosis of Dementia

In addition to solidifying the processes and timetables by which PASRR Level II evaluations are prompted, and in addition to enhancing the Level II evaluation forms to provide additional information regarding the availability of community-based services, LDH has also taken steps to strengthen the application and criteria of PASRR Level II evaluations to ensure appropriate identification of dementia as a primary diagnosis. The goal of strengthening these documentation requirements is to ensure that residents presenting with symptoms of dementia, such as overmedication and neglect, are not improperly diagnosed with dementia and accordingly excluded from the Target Population.

In May 2018, LDH issued a legal memorandum clarifying the new documentation requirements to verify dementia diagnoses for the purpose of PASRR Level II evaluation.⁸ As described in the guidance, to ensure the accurate diagnosis of dementia, the referring provider should provide documentation to support the assertion that the dementia symptoms are not due to comorbid mental illness, medication use, or another medical condition. At a minimum, this includes clear documentation reflecting the impact, history, and progression of the dementing illness. If this information is clear, comprehensive, and reasonably substantiates the dementia diagnosis while

⁸ See attached LDH Legal Memorandum “Required documentation to verify dementia diagnoses for the purposes of PASRR through OBH Level II Authority”, 5/30/2018.

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ruling out differential diagnosis possibilities, it will likely be determined additional information is not necessary. However, additional documentation requirements may be requested by LDH, including additional medical history, neurological consultation or examinations, lab tests, and imagery such as CT scans or MRIs.

To ensure successful implementation of this new policy, LDH recently contracted with an independent psychiatrist to review all PASRR Level II requests that include dementia and Alzheimer's diagnoses. In addition, LDH revised the PASRR Level II evaluation form to include an addendum that clearly delineates the documentation required for requests with a dementia diagnosis.

LDH has implemented extensive training on the new dementia diagnosis verification policy. This includes the provision of training to OBH and OAAS Transition Coordinators, PASRR Level II Specialists within OBH, Medicaid MCOs, PASRR Level II evaluators who are representatives/affiliates of the MCOs, nursing facilities, and hospitals.

Implementing and Expanding the Availability of Community Support Services

In addition to implementing improvements to the processes for screening individuals prior to approving nursing facility stays and ensuring that all individuals applying for nursing facility services are provided with information about community options, LDH is undertaking comprehensive efforts to develop, expand, and implement community-based services for individuals with mental illness. Consistent with Section VI of the *Agreement*, LDH is developing a wide range of community options of services and supports designed to serve individuals with SMI in the most integrated setting possible.

The following resources provide information about the planning, development, and implementation progress for services and supports in community-based settings:

- Crisis System
- Assertive Community Treatment
- Intensive Community Support Services
- Integrated Day Activities
- Peer Support Services
- Housing and Tenancy Supports

Projecting the Number of Diversions

As defined in the *Agreement*, diversion is a set of activities that occur before an individual is admitted to a nursing facility, which seek to provide an appropriate alternative placement to a nursing facility and meet the individual's needs in the most integrated setting. As defined by the *Agreement*, the Target Population is comprised of (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 PASRR Level II evaluation of nursing facility placement during the course of the *Agreement*, or have been referred within two years prior to the effective date of the *Agreement*. As indicated above the Target Population definition excludes those individuals with co-occurring SMI and dementia, where dementia is the primary diagnosis.

An initial activity undertaken by LDH was to define the diversion population. Using the definition of diversion and the Target Population in the *Agreement*, the State embarked on a process to review data and other information that would help define the diversion population. Specifically, the state looked at Medicaid claims data and data

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from the Utopia information system (on PASSR) to define the diversion population. Based on this analysis LDH is recommending an initial definition of the diversion population include:

1. Medicaid individuals with SMI admitted to a nursing facility on a temporary approval who could be transitioned to the community within the temporary authorization period (90 days, or 100 days for convalescent care) and without a continued stay request. This would be limited to individuals that were admitted for short term stays and whom the Transition Coordinator had undertaken a Transition Assessment and developed a Transition Plan within the first 90-100 days. While technically, these could be considered an admission versus a diversion, LDH believes that a rapid cycle process for initiating and implementing transition activity should be considered a diversion. Individuals in the Target Population that would have continued stays past 90 days would be considered as “Transition” individuals. The number of individuals that would be considered as diversions for these purposes was low. In 2018, three individuals were identified who would meet this definition.
2. Medicaid individuals with SMI seeking admission to a nursing facility for whom the PASSR level II indicated community placement versus a nursing facility admission. For the first six months of this calendar year there were 58 individuals who would meet this definition.
3. Medicaid individuals with SMI at risk of nursing facility placement. While technically this group of individuals do not meet the definition of the Target Population, LDH feels it is critically important to be proactive to ensure that these individuals are identified and provided the necessary services and supports to remain in the community. This information will also be helpful for establishing annual target for decreasing referrals for individuals with SMI to nursing facilities. LDH is in the process of developing a profile of individuals that would be considered “at risk” for meeting the definition of the Target Population. In addition to claims data, research and data on homelessness and housing instability will also be looked at for possible association with nursing facility placement. LDH will continue to analyze this population, ensuring a targeted focus of those truly at risk of nursing facility placement. Once additional analysis is completed, LDH will develop annual targets for those determined to be at risk. This work should be completed by March 2020.

Projections

To monitor the performance of the diversion strategies described in this plan, LDH is required to establish measurable targets for the diversion of the Target Population members. Specifically, the Agreement requires LDH to establish annual targets for the diversion of Target Population members. For Calendar Year 2020 LDH has developed the following projections for the number of individuals that meet the criteria in #1 and #2 above. These projections are based on the State’s data and experience with identifying these populations over the preceding year.

Population	Projected Diversions
#1 Short Term Nursing Stays	6
#2 PASSR II Recommendation	120
#3 At-Risk	TBD
Total	126

LDH will continue its efforts to define the “at-risk” population. The State has done preliminary analysis regarding this population. Many of these individuals are older (over 50 years old), have three or more chronic conditions and either presented at an Emergency Department or were admitted to an inpatient hospital (for either physical health or behavioral health purposes) — which is a major pathway for individuals to be referred to nursing

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facilities. LDH will continue its efforts and perform additional data analytics on this population including the impact that homelessness has on placing individuals with SMI at higher risk for nursing facility services.

Creating a Diversion Pathway

Meeting the projected numbers of individuals in the Target Population that will be diverted from nursing facilities will require LDH to develop processes and protocols for implementing the diversion strategy. LDH currently has a process in place for working with members of the Target Population that have been admitted into nursing facilities. An improved information system, as referenced in the 2020 Implementation Plan will assist LDH to identify individuals that have been admitted to nursing facilities more expeditiously, therefore allowing Transition Coordinators to rapidly identify Target Population members and begin the transition process sooner. Therefore, the diversion pathway for individuals in group #1 is already in place. The pathway includes the Transition Assessment and the development of the Transition Plan. The Transition Coordinators will implement these and other existing activities to transition these individuals, coordinate the necessary supports and provide case management services in the interim.

The second group of individuals, Medicaid individuals with SMI seeking admission to a nursing facility for whom the PASSR level II indicated community placement versus a nursing facility admission, will benefit from enhanced efforts by LDH, the MCOs and community providers to identify these individuals and triage the services and supports to meet their immediate needs. This will require enhanced attention by the MCOs and community providers to assess the individual's community needs, develop a person-centered plan for addressing these needs, refer individuals to the necessary services and supports and implement a robust case management strategy for these individuals. LDH will implement the following steps during CY 2020 to develop a pathway for these individuals.

Key Milestones/Task	Anticipated Date
Formalize process and protocols for engaging Medicaid individuals into community services who have been identified through the PASRR Level II process as needing community placement.	March 2020
Review current process and protocols for OBH referrals to MCOs for individuals with a PASRR Level II indicating community placement, identifying areas for modification/improvement.	April 2020
Revise process and protocols for referrals from OBH to MCOs based on this review.	April 2020
Draft approach to tracking and monitoring individuals that have been diverted using the revised processes and protocols.	April 2020
Train MCOs on any modifications to the PASRR Level II process and protocols including linking individuals with appropriate services.	May 2020
Implement updates to the Level II determination form to achieve alignment with the updated Level II evaluation form.	June 2020
Modify existing MCO reports related to PASRR to include information on those Level II reviews which recommended community placement.	July 2020
Conduct review of MCO reporting to determine the effectiveness of processes/protocols implemented and fidelity to established PASRR standards including timelines of Level II evaluation completion.	August 2020 and Ongoing
Draft improvement strategies based on review, developing necessary guidance for MCOs to perform critical diversion functions.	Ongoing

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Meet with the MCOs regarding these revised expectations regarding critical diversion functions.	November 2020
Evaluate the effectiveness of changes implemented in 2019 to ensure appropriateness of Level I and Level II determinations (e.g. quarterly data dashboards and other information).	Ongoing
Evaluate the effectiveness of changes implemented to ensure PASRR Level II are conducted promptly upon referral.	Ongoing
Evaluate options to conduct outreach with hospitals regarding diversion efforts.	February 2020
Meet with stakeholders to discuss strategies for working with major referral sources.	May 2020
Meet with leadership from these referral sources to identify potential diversion strategies.	May 2020
Develop and implement diversion strategies.	October 2020
Develop strategies for evaluating the impact of these efforts.	October 2020
Complete analysis of at-risk population including individuals who are homeless.	June 2020
Based on the analysis, develop a profile of individuals that would be considered “at-risk” for meeting the definition of the TP and develop diversion strategies for this group.	September 2020
Develop Methodology for 2021 diversion targets.	September 2020
Develop diversion targets for 2021.	October 2020
Develop and incorporate activities and measures into the new tracking system to monitor individuals that have been diverted using new protocols and processes.	November 2020
Identify and prioritize actions for calendar year 2021 and update implementation plan.	Annually