

## 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:

JOHN M. GORE  
Acting Assistant Attorney  
General  
Civil Rights Division

STEVEN H. ROSENBAUM  
Chief, Special Litigation Section

MARY BOHAN  
Deputy Chief, Special Litigation Section



C. ADRIENNE MALLINSON  
NH Bar No. 17126  
Trial Attorney  
Special Litigation Section  
Civil Rights Division  
U.S. Department of Justice  
950 Pennsylvania Avenue, N.W.  
Washington, DC 20530  
Telephone: (202) 353-1142  
adrienne.mallinson@usdoj.gov

FOR THE STATE OF LOUISIANA:



---

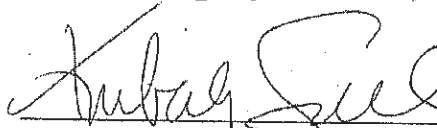
STEPHEN RUSSO

LA Bar No. 23284

Executive Counsel

Louisiana Department of Health

stephen.russo@la.gov



KIMBERLY SULLIVAN

LA Bar No. 27540

Deputy General Counsel

Louisiana Department of Health

628 N. 4<sup>th</sup> Street, P.O. Box 3836

Baton Rouge, LA 70821

(225) 342-1128

kimberly.sullivan@la.gov