

used for the annual CSR for children.

The case manager informs the member and Interdisciplinary Team of all available non-Medicaid and Medicaid services including waiver services. The case manager will also discuss with the member and team the self-direction option and give the member the option of self-directing services available. The member and the Interdisciplinary Team choose services and supports that meet the member's needs and preferences. This becomes part of the service plan. The service plan shall include:

- 1) All Medicaid and non-Medicaid services and supports
- 2) The funding source for each service and support
- 3) The name of the service provider responsible for providing the service
- 4) Who is responsible for implementing each goal on the plan. The responsibilities of the member, case manager, providers and others involved in the service plan will be outlined
- 5) Time frames and frequency for each service
- 6) Health and safety concerns, including an emergency backup plan

The case manager will be responsible for coordination, monitoring and overseeing the implementation of the service plan including Medicaid and non-Medicaid services. The service plan is reevaluated at a minimum annually or when the member's needs change.

If a member chooses to self direct, the member, with the help of a case manager, will identify the independent support broker. This selection will also become part of the service plan. The independent support broker helps the member plan for their individual budget, which is independent of the plan developed by the case manager.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

- e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

During the evaluation/reevaluation of level of care, risks are assessed using the Home and Community Based Comprehensive Assessment form. A summary of the assessment becomes part of the service plan. The case manager, the member and the Interdisciplinary Team address any risks as part of the service plan development and create a plan to mitigate risks including designating appropriate service providers who are available to reduce risk.

Personal Emergency Response and Portable Locator Services are available services under the waiver and it is encouraged that these service be used as part of emergency back up plan when a scheduled support worker does not appear. Other providers may be listed on the service plan as source of back up as well. All members choosing the self direction option will sign an individual risk agreement that permits the participant to acknowledge and accept certain responsibilities for addressing risks.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

- f. **Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

The member is informed of their choice of providers when the services plan is developed. All available qualified providers are identified to the member and their Interdisciplinary Team. Members are encouraged to meet with the available providers before choosing a provider. Members are not restricted to choosing providers within their local community. Information about qualified and accessible providers is available to members through their case managers, service workers, and the IME website.

Appendix D: Participant-Centered Planning and Service Delivery**D-1: Service Plan Development (7 of 8)**

- g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The IME has developed a computer program named the Individualized Services Information System (ISIS) to support HCBS programs. This system assists the Medicaid agency and the case manager with tracking information, and monitoring and approving the service plan. Through ISIS, the case manager authorizes service and service payments on behalf of the member. There are certain points in ISIS process that require contacting the designated Iowa Department of Human Services central office personnel. The case manager is responsible for the development the service plan and the service plan is authorized through ISIS, which is the Medicaid Agency. (Refer to appendix A and H for ISIS system processes.)

Appendix D: Participant-Centered Planning and Service Delivery**D-1: Service Plan Development (8 of 8)**

- h. Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

Every three months or more frequently when necessary

Every six months or more frequently when necessary

Every twelve months or more frequently when necessary

Other schedule

Specify the other schedule:

- i. Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (*check each that applies*):

Medicaid agency

Operating agency

Case manager

Other

Specify:

Appendix D: Participant-Centered Planning and Service Delivery**D-2: Service Plan Implementation and Monitoring**

- a. Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

During the evaluation/reevaluation of level of care, risks are assessed using the Home and Community Based Compressive Assessment form. A summary of the assessment becomes part of the service plan. The case manager, the member and the Interdisciplinary Team address any risks as part of the service plan development and create a plan to mitigate risks including designating appropriate service providers who are available to reduce risk.

Intellectual Disabilities Waiver case managers are responsible for monitoring the member's health, safety and welfare. They are also responsible for the following:

1. Monitoring service utilization
2. Making a face-to-face visit to the member at least quarterly and a collateral contact concerning the member at least monthly. In addition, case managers must make at least one contact per month with the member, member's representative, member's family, or service provider. IAC 90.5 states the following: The case manager shall perform activities and make contacts that are necessary to ensure the health, safety, and welfare of the member and to ensure that the service plan is effectively implemented and adequately addresses the needs of the member.
3. Developing, approving and revising the service plan in coordination with the interdisciplinary team at least annually or as member's needs change. If services have not met the member's needs, the plan is changed to meet those needs. The effectiveness of the emergency backup plan is also addressed as the service plan is developed and revised.

The member, or their legally responsible guardian, is encouraged during the time of the service plan development to call the Case Manager if there are any problems with either Medicaid or non-Medicaid services. The CM is responsible for conducting the assessment of need and identifying and authorizing services to get needs met. If there is a change in the member's need at any time, the member should be communicating with the CM to address the identified need. CMs are required to have quarterly face-to-face meetings with a member and monthly collateral contacts. This is designed to allow regular communication for any changing needs that may arise. The Case Manager will follow up to address any service related issues. Monitoring service utilization includes verifying:

1. That the member used a waiver service, at a minimum of once a calendar quarter
2. That the services were provided in accordance with the individual service plan
3. That the member is receiving the level of service needed.

The member will first address service planning problems with the CM working with directly with the member. CM units have processes in place to respond to member problems and complaints. CM units have a formal grievance process, with actions steps and timelines for response, in place to address any disagreements that cannot be resolved at the CM level. All adverse actions taken by a CM may be appealed by the member according to DHS appeal process in Ch. 7 and identified on all NODs with adverse actions.

The Iowa Department of Human Services has developed a computer program, the Individualized Services Information System (ISIS), to support waiver programs. This system assists the Medicaid Department and the case manager by tracking information, monitoring services, assuring services were provided, and authorizing payments on behalf of the member. The case manager has access to a variety of tools in ISIS to assist with monitoring, including report functionality and claims queries. Many of these tools can be used for a quick review or to generate a report spanning a time frame. ISIS can be accessed as frequently as desired by the case manager. ISIS allows case managers to view service plans both current and past, and paid claims history as related to accessed services. If the member is not receiving the services according to the plan of care or the services are not addressing the assessed needs, the case manager will contact the member and IDT in order to address the situation.

The Department of Human Services, Division of Mental Health and Disability Services (MHDS), is responsible for the oversight of case management services. MHDS personnel regularly reviews all case management entities throughout the state in accordance with the case management standards established in Iowa Administrative Code 441 - 24.4(9) and 441-90.1(249A). Case management reviews assure that case management services are provided according to measureable standards. Deficiencies that are identified during reviews will require corrective actions plans be developed by the case management unit to come into compliance with the case management standards.

The IME Medical Services Unit and the HCBS Specialists monitor service plans during the home and community based services quality assurance review process. During interviews, members are asked about their choice of providers and whether or not the services meet their needs. Emergency backup plans are reviewed for effectiveness.

Monitoring results are compiled by the quality assurance manager. This information is used to make recommendations for improvements and training.

b. Monitoring Safeguards. *Select one:*

Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.

Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery
Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

- a. *Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

SP-1a: Number and percent of service plans reviewed which address the member's assessed health risks. Numerator = # of reviewed service plans addressing assessed health risks Denominator = # of reviewed service plans.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Member service plans are reviewed at a 95% confidence level on a three year cycle. Data is inductively analyzed and reported to the state.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = 5%
Other Specify:	Annually	Stratified

Contracted Entity		Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually
	Continuously and Ongoing
	Other Specify:

Performance Measure:

SP-2a: Number and percent of service plans reviewed which address the member's assessed safety risks. Numerator = # of reviewed service plans addressing assessed safety risks Denominator = # of reviewed service plans

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Member service plans are reviewed at a 95% confidence level on a three year cycle. Data is inductively analyzed and reported to the state.

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review

Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = 5%
Other Specify: Contracted Entity	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually
	Continuously and Ongoing
	Other Specify:

Performance Measure:

SP-3a: Number and percent of service plans reviewed which reflect the member's assessed personal goals. Numerator = # of reviewed service plans reflecting assessed personal goals Denominator = # of reviewed service plans.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Member service plans are reviewed at a 95% confidence level on a three year cycle. Data is inductively analyzed and reported to the state.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = 5%
Other Specify: Contracted Entity	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually
	Continuously and Ongoing
	Other

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	Specify:

b. *Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

SP-1b: Number and percent of service plans reviewed which include signature of member on the service plan. Numerator = # of reviewed service plans with member signature Denominator = # of reviewed service plans.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Member service plans are reviewed at a 95% confidence level on a three year cycle. Data is inductively analyzed and reported to the state.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = 5%
Other Specify: Contracted Entity	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:

	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually
	Continuously and Ongoing
	Other Specify:

Performance Measure:

SP-2b: Number and percent of service plans reviewed which list all services received by the member. Numerator = # of reviewed service plans listing all services Denominator = # of reviewed service plans.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Member service plans are reviewed at a 95% confidence level on a three year cycle. Data is inductively analyzed and reported to the state.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = 5%

Other Specify: Contracted Entity	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually
	Continuously and Ongoing
	Other Specify:

Performance Measure:

**SP-3b: Number and percent of service plans reviewed which list all of the member's providers. Numerator = # of reviewed service plans listing all providers
Denominator = # of reviewed service plans.**

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Member service plans are reviewed at a 95% confidence level on a three year cycle. Data is inductively analyzed and reported to the state.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
	Weekly	100% Review

State Medicaid Agency		
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = 5%
Other Specify: Contracted Entity	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually
	Continuously and Ongoing
	Other Specify:

Performance Measure:

SP-4b: Number and percent of service plans reviewed in which all funding sources are listed. Numerator = # of reviewed service plans listing all funding sources Denominator = # of reviewed service plans.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Member service plans are reviewed at a 95% confidence level on a three year cycle. Data is inductively analyzed and reported to the state.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = 5%
Other Specify: Contracted Entity	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	Continuously and Ongoing
	Other Specify:

Performance Measure:

SP-5b: Number and percent of service plans reviewed which list the amount of services to be received by the member. Numerator = # of reviewed service plans listing amounts of all services Denominator = # of reviewed service plans.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Member service plans are reviewed at a 95% confidence level on a three year cycle. Data is inductively analyzed and reported to the state.

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = 5%
Other Specify: Contracted Entity	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually
	Continuously and Ongoing
	Other Specify:

Performance Measure:

SP-6b: Number and percent of service plans reviewed with a plan for supports available to the member in the event of an emergency. Numerator = # of reviewed service plans listing all supports available in event of emergency Denominator = # of reviewed service plans.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Member service plans are reviewed at a 95% confidence level on a three year cycle. Data is inductively analyzed and reported to the state.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = 5%
Other Specify: Contracted Entity	Annually	Stratified Describe Group:

	Continuously and Ongoing	Other Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually
	Continuously and Ongoing
	Other Specify:

Performance Measure:

SP-7b: Number and percent of service plans reviewed which indicate that the member was presented choice regarding the consumer choices option. Numerator = # of reviewed service plans indicating choice regarding CCO Denominator = # of reviewed service plans.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Member service plans are reviewed at a 95% confidence level on a three year cycle. Data is inductively analyzed and reported to the state.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample

		Confidence Interval = 5%
Other Specify: Contracted Entity	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually
	Continuously and Ongoing
	Other Specify:

- c. *Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how

themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

SP-1c: Number and percent of service plans which are revised on or before waiver member's annual due date. Numerator = # of service plans revised prior to due date Denominator = # of service plans revisions due.

Data Source (Select one):

Program logs

If 'Other' is selected, specify:

Reports are pulled from ISIS to illustrate the number of service plans that were revised prior to the due date. Data is inductively analyzed at a 100% level.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
Other Specify:	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually
	Continuously and Ongoing
	Other Specify:

Performance Measure:

SP-2c: Number and percent of service plans reviewed which were revised when warranted by a change in the member's needs. Numerator = # of reviewed service plans revised when warranted by change in need Denominator = # of reviewed service plans.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Member service plans are reviewed at a 95% confidence level on a three year cycle. Data is inductively analyzed and reported to the state.

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = 5%
Other Specify: Contracted Entity	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:

	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually
	Continuously and Ongoing
	Other Specify:

- d. *Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

SP-1d: Number and percent of member surveys reporting the receipt of all services identified in the plan. Numerator = # of survey respondents reporting receipt of all services in service plan Denominator = # of suvey respondents.

Data Source (Select one):

Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

The IPES survey is conducted at a 95% confidence level and responses recorded in a database. Data is pulled and inductively analyzed.

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = 5%
Other Specify: Contracted Entity	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually
	Continuously and Ongoing
	Other Specify:

Performance Measure:

SP-2d: Number and percent of service plan reviewed reporting the receipt of all services identified in the plan. Numerator = # of reviewed service plans reporting receipt of all services Denominator = # of reviewed service plans.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Member service plans are reviewed at a 95% confidence level on a three year cycle. Data is inductively analyzed and reported to the state.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = 5%
Other Specify: Contracted Entity	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other	Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
Specify:	
	Continuously and Ongoing
	Other Specify:

- e. *Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

SP-1e: Number and percent of members whose enrollment indicates that a choice was offered between waiver services and institutional care. Numerator = # of member enrollments indicating choice between waiver services and institutional care Denominator = # of member enrollments.

Data Source (Select one):

Program logs

If 'Other' is selected, specify:

Data is pulled from ISIS reports to indicate that the milestone was affirmed by the case manager that choice was offered between waiver/institutional care. Data inductively analyzed.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =

Other Specify:	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually
	Continuously and Ongoing
	Other Specify:

Performance Measure:

SP-2e: Number and percent of experience/satisfaction survey respondents who indicate that they received a choice of waiver providers. Numerator = # of survey respondents indicating choice of provider Denominator = # of survey respondents.

Data Source (Select one):

Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

The IPES survey is conducted at a 95% confidence level and responses recorded in a database. Data is pulled and inductively analyzed.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
	Weekly	100% Review

State Medicaid Agency		
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = 5%
Other Specify: Medicaid contractor entity	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually
	Continuously and Ongoing
	Other Specify:

Performance Measure:

SP-3e: Number and percent of case manager attestations found in service plans that provider choice was offered to the member during service plan development.
Numerator = # of reviewed service plans with case manager attestations

indicating choice of provider was offered to the member Denominator = # of reviewed service plans.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Member service plans are reviewed at a 95% confidence level on a three year cycle. Data is inductively analyzed and reported to the state.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = 5%
Other Specify: Contracted Entity	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	Continuously and Ongoing
	Other Specify:

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The Medical Services Unit utilizes criteria to grade each reviewed service plan component. If it is determined that the service plan does not meet the standards for component(s), the case manager is notified of deficiency and expectations for remediation. Development of a mechanism to collect service worker remediation request response is in development.

The HCBS Quality Oversight Unit has identified questions and answers that demand additional attention. These questions are considered urgent in nature and are flagged for follow-up. Based on the responses to these flagged questions, the HCBS interviewer performs education to the member at the time of the interview and requests additional information and remediation from the case manager.

General methods for problem correction at a systemic level include informational letters, provider trainings, collaboration with stakeholders and changes in policy.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

The Medical Services Unit utilized criteria to grade each reviewed service plan component. If it is determined that the service plan does not meet the standards for component(s), the case manager is notified of deficiency and expectations for remediation. Development of a mechanism to collect service worker remediation request response is in development.

The HCBS Quality Oversight Unit has identified questions and answers that demand additional attention. These questions are considered urgent in nature and are flagged for follow-up. Based on the responses to these flagged questions, the HCBS interviewer performs education to the member at the time of the interview and requests additional information and remediation from the case manager.

General methods for problem correction at a systemic level include informational letters, provider trainings, collaboration with stakeholders and changes in policy.

- ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
Contracted Entities	
	Continuously and Ongoing
	Other Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability (from Application Section 3, Components of the Waiver Request):

Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.

No. This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested (select one):

Yes. The State requests that this waiver be considered for Independence Plus designation.

No. Independence Plus designation is not requested.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

- a. Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Iowa offers two self-direction services to members on the ID waiver: Consumer Choices Option (CCO) and consumer directed attendant care (CDAC) service

Consumer Choices Option:

CCO offers both employer and budget authority to the member in self-directing services.

At the time of the service plan development and/or at the members request, members enrolled in the ID waiver will have the option of converting the following services into an individualized self-direction budget based on services

that are authorized in their service plan:

1. Consumer Directed Attendant Care (unskilled)
2. Day Habilitation
3. Home and Vehicle Modification
4. Prevocational services
5. Basic individual respite care
6. Supported community living
7. Supported employment
8. Transportation

Iowa's self-direction program is called the Consumer Choices Option (CCO). CCO gives members control over a targeted amount of waiver dollars. Under CCO a member may convert specific waiver services that have been authorized in the member's service plan to create an individual monthly budget. Members that choose to use CCO will use the individual monthly budget to meet their assessed needs by directly hiring employees or purchase other goods and services.

A member may use three types of self-direction services to meet their assessed needs. Optional service components within CCO include the following:

- Self-directed personal care services.
- Self-directed community supports and employment
- Individual-directed goods and services

The member has authority over the individual budget that is authorized by the department to perform the following tasks:

- Contract with entities to provide services and support
- Determine the amount to be paid for services with the exception of the independent support broker and the financial management service whereas reimbursement rates are subject to the limits in 441-sub rule 79.1(2)
- Schedule the provision for services
- Authorize payment for waiver goods and services identified in the individual budget
- Reallocate funds among services included in the budget

Individual monthly budget development includes the following costs:

- The costs of the financial management service
- The costs of the independent support broker
- The costs of any services and support chosen by the consumer as optional service components

All members choosing CCO will work with an Independent Support Broker (ISB) who will help them plan for their individual budget and services. The ISB works at the direction of the member and is a person that assists the member with his/her budget. For example, the ISB may help develop a monthly budget, recruit and interview potential employees, or assist with required paperwork. The ISB is required to attend an ISB training approved by the Department prior working with members. The ISB cannot be the guardian, power of attorney, or a provider of service to the member (this would cause potential conflicts of interest).

Members will also work with a Financial Management Service (FMS) provider which will receive the Medicaid funds on behalf of the members. The FMS provider receives the electronic funds transfer (EFT) from DHS on a monthly basis. The EFT is for the members' monthly budget amount. The FMS pays the payroll taxes, etc. as required because the member is an "employer" of this person and required to pay FICA, etc. Employees of the members are required to submit timecards within 30 days of providing the service for payment. The FMS is a Medicaid provider.

The monthly budget includes a monthly per member per month fee for the financial management services (FMS) provider (currently \$66.95). Veridian Credit Union is the only enrolled FMS in Iowa. The remainder of the budget is used by the member to purchase goods and services.

A utilization adjustment factor (UAF) is used to adjust the CCO budget to reflect state-wide average cost and usage of waiver services. Annually, the Department determines the average cost for each waiver service. The average service cost is used to determine the "cap amount" of the CCO budget. The cap amount is used to ensure the member stays within the program dollar cap limits within each waiver. The department also determines the percentage of services that are used, compared to what is authorized within a waiver service plan. This percentage is