Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:
Individual Service Plan

a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

- ☐ **Registered nurse, licensed to practice in the State**
- ☐ **Licensed practical or vocational nurse, acting within the scope of practice under State law**
- ☐ **Licensed physician (M.D. or D.O)**
- ☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)
- ☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

- ☑ **Social Worker**

Specify qualifications:

Social workers develop service plans for fee-for-service participants.

Qualifications include: graduation from an accredited four-year college or university; or the equivalent of four years of full-time technical work experience involving direct contact with people in overcoming their social, economic, psychological, or health problems; or an equivalent combination of education and experience substituting the equivalent of one year of full-time qualifying work experience for one year (thirty semester or equivalent hours) of the required education to a maximum substitution of four years.

In addition, social workers may be required to have the following specified experience in the following areas if they are specifically working with these populations:

- Developmental disabilities: a minimum of one-year full-time (or equivalent part-time) experience in delivering or coordinating services for persons with developmental disabilities (i.e., severe, chronic mental or physical impairments). Positions that meet the mental retardation background noted above will normally meet this selective area too. Experience in providing services and treatment to autistic children or persons with epilepsy or cerebral palsy will also qualify.
- Mental retardation: a minimum of one year of full-time (or equivalent part-time) experience in delivering or coordinating services for persons with significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior manifested during the developmental period.

MCO community-based case managers develop service plans for members receiving HCBS. MCOs community-based case managers are required to meet all of the qualifications, requirements, and be accredited as specified in 441 Iowa Administrative Code Chapter 24 regarding the accreditation of providers of services to persons with mental illness, mental retardation, and developmental disabilities.

- ☐ **Other**

Specify the individuals and their qualifications:

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b. **Service Plan Development Safeguards.** *Select one:*

◉ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

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

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D-1: Service Plan Development (3 of 8)

c. **Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Information related to waiver services and general waiver descriptions are initially made available following receipt of a waiver application. Service plans are then developed with the participant and an interdisciplinary team, regardless of delivery system. Teams often consist of the participant and, if appropriate, their representative; service worker, case manager, health home coordinator, or community-based case manager; service providers; and other supporting persons selected by the participant. During service plan development, the participant and/or their representative is strongly encouraged to engage in an informed choice of services, and is offered a choice of institutional or HCBS. Planning is timely, occurs when convenient for the participant, and is intended to reflect the participant's cultural considerations. If the participant chooses to self-direct services, an Independent Support Broker is provided to assist with budgeting and employer functions.

The IME Member Services Unit remains available at all times, during normal business hours, to answer questions and offer support to all Medicaid beneficiaries. Further, the Member Services Unit distributes a quarterly newsletter in effort to continually educate waiver participants about services and supports that are available but may not have been identified during the service plan development process.

The IME MSU remains available to answer questions and offer support. Further, the MSU distributes a quarterly newsletter in effort to continually educate participants about services and supports that are available but may not have been identified during the service plan development process.

The interRAI Standardized Assessment Tool or other department designated standardized assessment tool is completed prior to the initiation of services and yearly thereafter for fee-for-service (FFS) and MCO participants.

The fee-for-service person-centered planning processes must:

- Include people chosen by the individual;
- Include the use of team of professionals and non-professionals with adequate knowledge, training and expertise surrounding community living and person-centered service delivery;
- Allow the member to choose which team member shall serve as the lead and the participant's main point of contact;
- Promote self-determination principles and actively engages the participant;
- Provide necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions;
- Be timely and occur at times and locations of convenience to the participant;
- Reflect cultural considerations of the individual and provide information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with 42 CFR 435.905(b);
- Include strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants;
- Offer informed choices to the member regarding the services and supports they receive and from whom;
- Include a method for the member to request updates to the plan as needed; and

- Record the alternative home and community-based settings that were considered by the participant.

MCOs are contractually required to provide supports and information that encourage members to direct, and be actively engaged in, the service plan development process, and to ensure that members have the authority to determine who is included in the process. Specifically, MCO person-centered planning processes must:

- Include people chosen by the individual;
- Include the use of team of professionals and non-professionals with adequate knowledge, training and expertise surrounding community living and person-centered service delivery;
- Allow the member to choose which team member shall serve as the lead and the member's main point of contact;
- Promote self-determination principles and actively engages the member;
- Provide necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions;
- Be timely and occur at times and locations of convenience to the member;
- Reflect cultural considerations of the individual and provide information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with 42 CFR 435.905(b);
- Include strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants;
- Offer informed choices to the member regarding the services and supports they receive and from whom;
- Include a method for the member to request updates to the plan as needed; and Record the alternative home and community-based settings that were considered by the member.

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D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

For fee-for-service participants, service plans are developed by the participant; DHS service worker, case manager or health home coordinator; and an interdisciplinary team. Planning meetings are scheduled at times and locations convenient for the individual. The service plan must be completed prior to services being delivered and annually thereafter, or whenever there is a significant change in the person's situation or condition. The service worker, case manager, or health home coordinator receives the assessment and level of care determination from medical services. A summary of the assessment becomes part of the service plan. The service worker, case manager, or health home coordinator uses information gathered from the assessment and then works with the participant to identify individual and family strengths, needs, capacities, preferences and desired outcomes and health status and risk factors. This is used to identify the scope of services needed. Note: For both FFS and managed care enrollees, the types of assessments used are identified in Appendix B-6-e.

The service worker, case manager, or health home coordinator informs the participant of all available non-Medicaid and Medicaid services including waiver services. There are waiver informational brochures available to share with participants and their parents/guardians. Brochures are available at each of the DHS county offices. Information is also available on the IME and MCO websites. The brochures include information on eligibility, service descriptions, and the application process. Once a participant begins the enrollment process and has a service worker, case manager, health home coordinator, or community-based case manager assigned, a more detailed review of services and providers that are available in the area occurs as part of the planning process for developing a participant's plan of care.

The service worker, case manager, or health home coordinator will also discuss with the participant the self-direction

option and give the participant the option of self-directing services available. The participant and the interdisciplinary team choose services and supports that meet the participant's needs and preferences, which become part of the service plan. Service plans must:

- Reflect that the setting in which the individual resides is chosen by the participant;
- Reflect the participant's strengths and preferences;
- Reflect the clinical and support needs as identified through the needs assessment;
- Include individually identified goals and desired outcomes which are observable and measurable;
- Include the interventions and supports needed to meet participant's goals and incremental action steps as appropriate;
- Reflect the services and supports, both paid and unpaid, that will assist the individual to achieve identified goals, the frequency of services and the providers of those services and supports, including natural supports;
- Include the names of providers responsible for carrying out the interventions or supports including who is responsible for implementing each goal on the plan and the timeframes for each service;
- Include the identified activities to encourage the consumer to make choices, to experience a sense of achievement, and to modify or continue participation in the service plan;
- Include a description of any restrictions on the participant's rights, including the need for the restriction and a plan to restore the rights (for this purpose, rights include maintenance of personal funds and self-administration of medications);
- Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed;
- Include a plan for emergencies;
- Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her;
- Identify the individual and/or entity responsible for monitoring the plan;
- Be finalized and agreed to, with the informed consent of the participant in writing, and signed by all individuals and providers responsible for its implementation;
- Be distributed to the participant and other people involved in the plan;
- Indicate if the participant has elected to self-direct services and, as applicable, which services the participant elects to self-direct; and
- Prevent the provision of unnecessary or inappropriate services and supports.

The service worker, case manager, or health home coordinator will be responsible for coordination, monitoring and overseeing the implementation of the service plan including Medicaid and non-Medicaid services. If a participant chooses to self-direct, the participant, with the help of a service worker, case manager, or health home coordinator, identifies who will be providing Independent Support Broker Services.

For MCO members, service plans are developed through a person-centered planning process led by the member, with MCO participation, and representatives included in a participatory role as needed and/or defined by the member. Planning meetings are scheduled at times and locations convenient for the individual. A team is established to identify services based on the member's needs and desires, as well as availability and appropriateness of services. The team is also responsible for identifying an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed, or when the member's needs change. Service plans are completed prior to services being delivered, and are reevaluated at least annually, whenever there is a significant change in the member's situation or condition, or at a member's request.

In accordance with 42 CFR 441.301 and 441 Iowa Administrative Code Chapters 90.5(1)b and 83, MCOs must ensure the service plan reflects the services and supports that are important for the member to meet the needs identified through the needs assessment, as well as what is important to the member with regard to preferences for the delivery of such services and supports. The service plan must reflect the member's needs and preferences and how those needs will be met by a combination of covered services and available community supports. The service planning process must address the full array of medical and non-medical services and supports provided by the MCO and available in the community to ensure the maximum degree of integration and the best possible health outcomes and participant satisfaction. Services plans must:

- Reflect that the setting in which the individual resides is chosen by the participant;
- Reflect the participant's strengths and preferences;
- Reflect the clinical and support needs as identified through the needs assessment;
- Include individually identified goals and desired outcomes which are observable and measurable;

- Include the interventions and supports needed to meet participant's goals and incremental action steps as appropriate;
- Reflect the services and supports, both paid and unpaid, that will assist the individual to achieve identified goals, the frequency of services and the providers of those services and supports, including natural supports;
- Include the names of providers responsible for carrying out the interventions or supports including who is responsible for implementing each goal on the plan and the timeframes for each service;
- Include the identified activities to encourage the consumer to make choices, to experience a sense of achievement, and to modify or continue participation in the service plan;
- Include a description of any restrictions on the participant's rights, including the need for the restriction and a plan to restore the rights (for this purpose, rights include maintenance of personal funds and self-administration of medications);
- Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed;
- Include a plan for emergencies;
- Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her;
- Identify the individual and/or entity responsible for monitoring the plan;
- Be finalized and agreed to, with the informed consent of the participant in writing, and signed by all individuals and providers responsible for its implementation;
- Be distributed to the participant and other people involved in the plan;
- Indicate if the participant has elected to self-direct services and, as applicable, which services the participant elects to self-direct; and
- Prevent the provision of unnecessary or inappropriate services and supports.

MCO members have appeal rights, including access to a State Fair Hearing after exhausting the MCO appeal process. Members can continue services while an appeal decision is pending, when the conditions of 42 CFR 438.420 are met. MCOs are contractually required to implement a comprehensive strategy to ensure a seamless transition of services during program implementation. Further, MCOs are required to develop and maintain, subject to DHS approval, a strategy and timeline within which all waiver members will receive an in-person visit from appropriate MCO staff and an updated needs assessment and service plan. Services may not be reduced, modified or terminated in the absence of an up-to-date assessment of needs that supports the reduction, modification or termination. Changes to these must receive DHS prior approval.

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 for FFS participants by DHS, and for MCO members by their respective MCO, using the Level of Care Certification, 470-4392 form. A summary of the assessment becomes part of the service plan and any risks are addressed as part of the service plan development process. The comprehensive service plan must identify an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed or the participant's needs change. In addition, providers of applicable services shall provide for emergency backup staff. All service plans must include a plan for emergencies and identification of the supports available to the participant in an emergency.

Emergencies are those situations for which no approved individual program plan exists and which, if not addressed, may result in injury or harm to the participant or other persons or significant amounts of property damage. The service plan must identify an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed or the member's needs change. In addition providers of applicable services shall provide for emergency backup staff.

Emergency plans are developed on the following basis:

- Providers must provide for emergency, back-up staff in applicable services.

- Interdisciplinary teams must identify in the service plan, as appropriate for the individual participant health and safety issues based on information gathered prior to the team meeting, including a risk assessment. This information is incorporated into the service plan.
- The team identifies an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed, or the individual's needs change.

Personal Emergency Response and Portable Locator Services are available under the waiver and it is encouraged that this service be used as part of emergency backup 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 participants choosing the self-direction option will sign an individual risk agreement that permits the participant to acknowledge and accept certain responsibilities for addressing risks.

The IME has developed a computer program named the Individualized Services Information System (ISIS) to support HCBS programs. For fee-for-service participants, this system assists the Medicaid Agency and the service worker, case manager, and health home coordinator with tracking information, and monitoring and approving the service plan. Through ISIS, the service worker, case manager, or health home coordinator authorizes service and service payments on behalf of the participant. There are certain points in ISIS process that require contacting the designated DHS central office personnel. The service worker, case manager, and health home coordinator are 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.)

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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.

While information about qualified and accessible providers is available to participants through the IME website, MCO website, and/or MCO member services call center, the service worker, case manager, health home coordinator, community-based case manager first identifies providers to the participant and their interdisciplinary team during the person-centered service planning process. Participants are encouraged to meet with the available providers before making a selection. Participants are not restricted to choosing providers within their community. Information about qualified and accessible providers is also available to participants through their service worker, case manager, health home coordinator, community-based case manager, IME website, and/or MCO website. If an MCO is unable to provide services to a particular member using contract providers, the MCO is required to adequately and timely cover these services for that member using non-contract providers, for as long as the MCO's provider network is unable to provide them.

The MCOs are responsible for authorizing services for out-of-network care when they do not have an in-network provider available within the contractually required time, distance and appointment availability standards. The MCO is responsible for assisting the member in locating an out-of-network provider, authorizing the service and assisting the member in accessing the service The MCO will also assist with assuring continuity of care when an in-network provider becomes available.. To ensure robust provider networks for members to choose from, MCOs are not permitted to close provider networks until adequacy is fully demonstrated to, and approved by, the State. Further, members will be permitted to change MCOs to the extent their provider does not ultimately contract with their MCO. Finally, MCOs are required to submit to the State on a regular basis provider network reports including, but not limited to network geo-access reports, 24- hour availability audit reports, provider-credentialing reports, subcontractor compliance summary reports, and provider helpline performance reports.

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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):

DHS has developed a computer program named the Individualized Services Information System (ISIS) to support HCBS programs. This system assists DHS with tracking information, monitoring, and approving service plans for fee-for-service participants. (Refer to appendix A and H for ISIS system processes.) On a monthly basis, the IME

MSU conducts service plan reviews. The selection size for the waiver has a 95% confidence level. This info is reported to CMS as part of Iowa's performance measures. The State retains oversight of the MCO service plan process through a variety of monitoring and oversight strategies as described in Appendix D – Quality Improvement: Service Plan section. ISIS will only be utilized for fee-for-service participants and quality data for managed care participants will be provided by the MCOs.

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:

DHS service workers, Iowa Child Health Specialty Clinics, case managers, or health home coordinators maintain fee-for-service participant service plans. MCO community-based case managers maintain MCO member service plans.

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.

DHS is responsible for monitoring the implementation of the service plan and the health and welfare of fee-for-service participants, including:

- Monitoring service utilization.
- Making at least one contact per month with the consumer, the consumer's legal representative, the consumer's family, service providers, or another person, as necessary to develop or monitor the treatment plan.
- Make a face-to-face contact with the consumer at least once every three months.
- Participating in the development and approval of the service plan in coordination with the interdisciplinary team at least annually or as needs change. If services have not been meeting participant'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.

The participant is encouraged during the time of the service plan development to call the service worker, case manager, or health home coordinator, if there are any problems with either Medicaid or non-Medicaid services. The service worker will then follow up to solve any problems. Monitoring service utilization includes verifying that:

- The participant used the waiver service at least once a calendar quarter.
- The services were provided in accordance with the plan.
- The participant is receiving the level of service needed.

The ISIS system is also used to assist with tracking information, monitoring services, and assuring services were provided to fee-for-service participants. If the participant is not receiving services according to the plan or not receiving the services needed, the participant and other interdisciplinary team members and providers are contacted immediately. HCBS specialists monitor the health and welfare, service plan implementation, and service worker, case manager, or health home coordinator, involvement during the home and community quality assurance review process. Participants are asked about their choice of provider, whether or not the services are meeting their needs, whether staff and care coordinators are respecting their choice and dignity, if they are satisfied with their services and providers, or whether they feel safe where they receive services and live. HCBS specialists also review the effectiveness of emergency back-up and crisis plans. These components are monitored through quality oversight reviews of providers, member satisfaction surveys, complaint investigation, and critical incident report follow-up. All providers are reviewed at least once over a five-year cycle and participants are surveyed at a 95% confidence level. Information about monitoring results are compiled by the HCBS Quality Assurance and Technical Assistance Unit on a quarterly basis. This information is used to make recommendations for improvements and training.

The IME MSU also conducts quality assurance reviews of participant service plans at a 95% confidence level. These reviews focus on the plan development, implementation, monitoring, and documentation that is completed by the service worker, case manager, or health home coordinator. All service plans reviewed are assessed for participant participation, whether the participant needs are accurately identified and addressed, the effectiveness of risk assessments and crisis plans, participant access to waiver and non-waiver services, as well as coordination across providers to best serve the participant's needs. Information about monitoring results are compiled by the IME MSU on a quarterly basis. This information is used to make recommendations for improvements and training.

MCOs are responsible for monitoring the implementation of the service plan, including access to waiver and non-waiver services, the quality of service delivery, and the health, safety and welfare of members. After the initiation of services identified in a member's service plan, MCOs monitor the provision of services, to confirm services have been initiated and are being provided on an ongoing basis as authorized in the service plan. At minimum, the care coordinator must contact members within five business days of scheduled initiation of services to confirm that services are being provided and that member's needs are being met. At a minimum, the community-based case manager shall contact 1915(c) HCBS waiver members at least monthly either in person or by telephone with an interval of at least fourteen (14) calendar days between contacts. Members shall be visited in their residence face-to-face by their care coordinator at least quarterly with an interval of at least sixty (60) days between visits. MCOs also identify and address service gaps and ensure that back-up plans are being implemented and are functioning effectively If problems are identified, MCOs complete a self-assessment to determine what additional supports, if any, could be made available to assist the member. MCOs must develop methods for prompt follow-up and remediation of identified problems; policies and procedures regarding required timeframes for follow-up and remediation must be submitted to DHS for review and approval. Finally, any changes to a member's risk are identified through an update to the member's risk agreement. MCOs must report on monitoring results to the State

In the event of non-compliance with service plan timelines, the MCO must: (i) immediately remediate all individual findings identified through its monitoring process; (ii) track and trend such findings and remediation to identify systemic issues of marginal performance and/or non-compliance; (iii) implement strategies to improve community-based case management processes and resolve areas of non-compliance or member dissatisfaction; and (iv) measure the success of such strategies in addressing identified issues. If the MCO fails to develop a plan of care for HCBS waiver enrollees within the timeframe mutually agreed upon between the MCO and the Agency in the course of Contract negotiations the MCO will be assessed a noncompliance fee of $315 per occurrence.

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 including MCO		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-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 *(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 including MCO	☐ **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 including MCO	☐ **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:

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 signuature 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 including MCO	☐ **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, 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 including MCO	☐ **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):*
☐ **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 including MCO		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 including MCO	☐ **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-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 *(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 including MCO	☐ **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 including MCO	☐ **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 *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
	☐ **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 CCO. Numerator = # of reviewed service plans indicaing 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 including MCO	☐ **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 and MCO data 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: Medicaid contracted entity including MCO	☐ **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-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 *(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 including MCO	☐ **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 *(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 including MCO	☐ **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-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 including MCO	☐ **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:

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 and MCO reports to indicate that the milestone was affirmed by the case manager that choice was offered between waiver/institutional care. Data inducitvely 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: Contracted Entity including MCO	☐ 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):*
☐ **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 including MCO	☐ **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 *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
SP-3e: Number and percent of case manager attestations found in service plan 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, 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 including MCO	☐ **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:

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 service worker 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 service worker.

General methods for problem correction at a systemic level include informational letters, provider training, 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 services worker 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 service worker.

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

ii. **Remediation Data Aggregation**

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

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

Responsible Party*(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: Contracted Entity	☐ Annually
	☐ 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.