



# Mental Health and Disability Services Redesign 2011

## Iowa CMS Performance Measures

Source: DHS/ Iowa Medicaid Enterprise

Date Created: August 31, 2011

### I. Level of Care (LOC) Determination

<i>The State demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with care provided in a hospital, NF, or ICF/MR.</i>		
Sub Assurances	CMS Expectations	Types of Evidence
(a) An evaluation for level of care is provided to all applicants for whom there is reasonable indication that services may be needed in the future.	Number and percent of members that have a valid level of care assessment completed prior to waiver enrollment. (LC-1a)	
(b) The level of care of enrolled participants is reevaluated at least annually or as specified in its approved waiver.	Number and percent of members who have a level of care determination completed within 12 months of their initial evaluation or last annual evaluation. (LC-1b)	
(c) The process and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.	Number and percent of initial level of care determinations made for which the criterion was accurately and appropriately applied for the determination. (LC-1c)	
	Number and percent of reevaluation level of care determinations for which the criterion was accurately and appropriately applied for the determination. (LC-2c)	

## II. Service Plans

<b><i>The State demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.</i></b>		
<b>Sub Assurances</b>	<b>CMS Expectations</b>	<b>Types of Evidence</b>
<p>(a) Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by waiver services or through other means.</p>	<p>Number and percent of service plans which address the member's assessed health needs risks (SP-1a)</p> <p>Number and percent of service plans which address the member's assessed safety risks (SP-2a)</p> <p>Number and percent of service plans which address the member's personal goals (SP-3a)</p>	
<p>(b) The state monitors service plan development in accordance with its policies and procedures.</p>	<p>Number and percent of service plans which include signature of member on the service plan. (SP-1b)</p> <p>Number and percent of service plans which names all of the member's providers. (SP-2b)</p> <p>Number and percent of service plans in which all funding sources are listed for the services identified in the plan. (SP-3b)</p> <p>Number and percent of service plans which lists the amount of services to be received by the member. (SP-4b)</p> <p>Number and percent of service plans which plan for emergencies and supports available to the member in the event of an emergency. (SP-5b)</p> <p>Number and percent of service plans which indicate whether the member has elected the consumer choices option. (SP-6b)</p> <p>How are waiver and all non-waiver services coordinated? Case managers and service workers are responsible for coordinating non-waiver services Any issues of time development that should be included?</p>	

	Not at this time
(c) Service plans are updated / revised at least annually or when warranted by changes in the waiver participant's needs.	Number and percent of service plans which are revised annually. (SP-1c)
(d) Services are delivered in accordance with the service plan, including in the type, scope, amount, and frequency specified in the service plan.	Number and percent of member surveys reporting the receipt of all services identified in the plan. (SP-1d)
	Number and percent of service plan reviews reporting the receipt of all services identified in the plan. (SP-2d)
(e) Participants are afforded choice: 1) Between waiver services and institutional care; and 2) Between/among waivers services and providers.	Number and percent of members whose enrollment indicates that a choice was offered between waiver services and institutional care. (SP-1e)
	Number and percent of members who indicated that they received a choice of waiver providers. (SP-2e)

### III. Qualified Providers

<b><i>The State demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.</i></b>		
Sub Assurances	CMS Expectations	Types of Evidence
(a) The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other state standards prior to their furnishing waiver services.	Number and percent of waiver provider enrollment applications verified against the appropriate licensing and/or certification entity. (QP-1a)	
	Number and percent of provider enrollments that indicate that abuse and criminal background checks were completed prior to employment/direct service delivery. (QP-2a)	
	Number and percent of currently enrolled licensed / certified providers verified against the appropriate licensing and/or certification entity. (QP-3a)	
(b) The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.	Number and percent of non-licensed / non-certified providers who meet the required provider standards. (QP-1b)	
	Number and percent of provider enrollments that indicate that abuse and criminal background checks that completed prior to employment/direct service delivery. (QP-2b)	
(c) The state implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.	Number and percent of providers, specific by waiver, that meet training requirements as outlined in state regulations. (QP-1c)	

## IV. Health and Welfare

<b><i>The State demonstrates, on an ongoing basis that it identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation.</i></b>		
Sub Assurances	CMS Expectations	Types of Evidence
(a) The state, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.	Number, percent, and frequency of major incidents, by type. (HW – 1a)	
	Number and percent of major incidents that involved restraint applications, seclusion, or other restrictive intervention that did not following procedures as specified in the approved waiver (HW-2a)  The recommended options have been reviewed. Iowa will review our current data and consider these for future performance measures.	
	Number and percent of unexplained, suspicious or untimely deaths compared to the total number of deaths. (HW-3a)	
	Number and percent of member survey respondents who reported they feel safe in their living environment. (HW-4a)	
	Number and percentage of service plans that identify safety plans that resolve the issues that are found in the member survey when the member did not feel safe. (HW-5a)	

## V. Administrative Authority

<b><i>The State demonstrates that it retains ultimate administrative authority over the waiver program and that its administration of the waiver program is consistent with the approved waiver application.</i></b>		
Sub Assurances	CMS Expectations	Types of Evidence
(a) The Medicaid agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other State and local/regional non-State agencies (if appropriate) and contracted entities.	Number and percent of quarterly contract management reports, from the Medical Services Contractor, submitted within ten business days of the end of the reporting period. (AA-1a)	
	Number and amount of compensation withholdings, for the Medical Services Contractor, annually applied for inaccurate level of care determinations. (AA-2a)	
	Number and percent of quarterly contract management reports, from the Provider Services Contractor, submitted within ten business days of the end of the reporting period. (AA-3a)	
	Number and amount of compensation withholdings, for the Provider Services Contractor, annually applied for inaccurate provider enrollment functions. (AA-4a)	
	Number and percent of quarterly contract management reports, from the HCBS QA Contractor, submitted within ten business days of the end of the reporting period. (AA-5a)	
	Number and percent of monthly major incident reports, from the HCBS QA Contractor, submitted within ten business days of the end of the reporting period. (AA-6a)	

## VI. Financial Accountability

<b><i>The State demonstrates that it has designed and implemented an adequate system for assuring financial accountability of the waiver program.</i></b>		
<b>Sub Assurances</b>	<b>CMS Expectations</b>	<b>Types of Evidence</b>
(a) State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.	CMS suggests the State change to “Number and percent of paid claims for which the units of service were coded as specified in the approved waiver. (FA-1a)	
	Number and percent of paid claims for which the units of service without supporting documentation. (FA-2a)	