Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Person-Centered 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:

Case Managers develop person centered service plans (PCSPs) for members receiving HCBS waiver services. All Case Managers are required to meet all of the qualifications, requirements, and be accredited as specified in 441 Iowa Administrative Code Chapter 24 and Chapter 90.

Case managers serving LTSS populations that are hired complete the Agency-identified initial training curriculum on the Agency'sLearning Management System (LMS) platform within six (6) months of hire. Case managers serving LTSS populations must also complete the Agency-identified refresher curriculum on an annual basis within 365 calendar days since the most recent completion date of the initial or refresher curriculum.

"Qualified case managers and supervisors" means people who have the following qualifications:

1. A bachelor's degree with 30 semester hours or equivalent quarter hours in a human services field (including, but not limited to, psychology, social work, mental health counseling, marriage and family therapy, nursing, education, occupational therapy, and recreational therapy) and at least one year of experience in the delivery of services to the population groups that the person is hired as a case manager or case management supervisor to serve; or

2. An Iowa license to practice as a registered nurse and at least three years of experience in the delivery of services to the population group the person is hired as a case manager or case management supervisor to serve.

People employed as case management supervisors on or before August 1, 1993, who do not meet these requirements shall be considered to meet these requirements as long as they are continuously employed by the same case management provider.

In addition, Targeted Case Managers (TCM) 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 intellectual disability 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.
- Intellectual disability: 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.

Case Managers serving Enrolled Members that have chosen self-direction through the Consumer Choices Option shall have specific experience with self-direction and additional training regarding self-direction.

Iowa Medicaid reserves the right to establish MCO Community-Based Case Manager to Enrolled Member ratios. Iowa Medicaid reserves the right to require the MCOs to hire additional community-based case managers if it is determined, at the sole discretion of Iowa Medicaid, that the MCO has insufficient CBCM staff to perform its obligations under the Contract

The MCOs are responsible for ensuring that training is also provided on designated topics within the Agency-identified curriculum that are not provided by the Agency.

☐ **Social Worker**

Specify qualifications:

☐ **Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

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:*

Appendix D: Participant-Centered Planning and Service Delivery

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. Informational materials are also available at each of the HHS county offices as well as on the Iowa Medicaid and MCO websites. Iowa Medicaid Member Services Unit remains available during normal business hours to answer questions and offer support to all Medicaid members. Additionally, quarterly member education is provided in an effort to continually educate waiver members about services and supports that are available but may not have been identified during the person centered service plan development process.

During person centered service plan development, the member and/or their representative is strongly encouraged to engage in an informed choice of services. The member determines who is part of the service planning team, often including their representative, case manager, service providers, and other supporting persons. These are individuals with adequate knowledge, training and expertise in community living and person-centered service delivery. The member also chooses who serves as the lead and the main point of contact. If the member chooses to self-direct services, there is the option of an Independent Support Broker to assist with budgeting and employer functions.

The FFS and MCO person-centered planning processes also must:
- Promote self-determination principles and actively engage the member;
- Provide necessary information and support to ensure that the member directs the process to the maximum extent possible, and is enabled to make informed choices and decisions;
- Provide information in plain language and in a manner that is accessible to individuals with disabilities and limited English proficiency, 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 members;
- Include a method for the member to request updates to the plan as needed
- Provide necessary information and support to ensure that the member 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 convenient 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 members;
- 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.

Appendix D: Participant-Centered Planning and Service Delivery

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):

Person centered service plans for FFS and MCO waiver participants are developed by the member, case manager, and an interdisciplinary team. Planning meetings are scheduled at times and locations convenient for the individual. The person-centered service plan must be completed prior to waiver services being delivered and annually thereafter, or whenever there is a significant change in the member's situation or condition.

An independent assessment entity completes the uniform assessment, comprised of interRAI assessment instruments and supplements, is used to collect information to support person-centered service planning. InterRAI assessment instruments review a wide range of areas, including but not limited to, community and social involvement, strengths, relationships and supports, independence in everyday activities and cognition and executive functioning. These instruments are coded using observations across specific timeframes and include multiple scales and algorithms to capture risk levels across areas of need to derive measures of functional status. Collaborative Action Plans (CAPs), evidence informed treatment guidelines, are used to help the interdisciplinary team to identify areas of need and prioritize services. 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 HHS prior approval.

The service planning team lead and case manager use information gathered from the uniform assessment and then works with the member to identify individual and family strengths, needs, capacities, preferences and desired outcomes, health status and risk factors. This guides the scope of waiver and state plan services included within the member's person-centered service plan. A summary of the assessment becomes part of the person-centered service plan.

Case managers are responsible for informing members of all available non-Medicaid and Medicaid services, including waiver services, and reviewing state plan services to avoid service duplication.

The case manager will also discuss with the member 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, as well as availability and appropriateness of services, which become part of the person-centered service plan. In accordance with 42 CFR 441.301 and 441 Iowa Administrative Code Chapters 90 and 83, MCOs must ensure the person centered service plan reflects the services and supports that are important for the member to meet the needs identified through the needs assessment, and are important to the member preferences for the delivery of services and supports, and how those needs will be met by community supports.

Planning meetings are scheduled at times and locations convenient for the individual. 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, reevaluated annually, and whenever there is a significant change in the member's situation or condition, or at a member's request.

For both fee-for-service and MCO members, person centered service plans must use a standard template to:
- Reflect that the setting in which the individual resides is chosen by the member;
- Reflect the member'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 member'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 member to make choices, to experience a sense of achievement, and to modify or continue participation in the person centered service plan;
- Include a description of any restrictions on the member'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 member 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 member in writing, and signed by all individuals and providers responsible for its implementation;
- Be distributed to the member and other people involved in the plan;
- Indicate if the member has elected to self-direct services and, as applicable, which services the member elects to self-direct; and
- Prevent the provision of unnecessary or inappropriate services and supports.

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 by an independent assessor using the assessment tools designated in B-6e. The assessment becomes part of the person-centered service plan, and any risks are addressed by the case manager as part of the person-centered service plan development process. The comprehensive person-centered service plan must identify an emergency backup support and crisis response plan 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. All person-centered service plans must include a plan for emergencies and identification of the supports available to the member in an emergency.

Case Managers work with the member and their providers to develop a backup plan which will provide for the delivery of services to the member in the event that the service provider responsible for providing services does not show up or is otherwise unable to provide the scheduled services. Backup may include accessing the provider's on-call system, contacting family or other natural supports.

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 member or other persons or significant amounts of property damage.

Emergency plans are developed on the following basis:
- Providers must provide for emergency, back-up staff in applicable services.
- Interdisciplinary teams must identify emergency plans in the person-centered service plan, as appropriate for the individual member health and safety issues based on information gathered prior to the team meeting, including a risk assessment.

Personal Emergency Response is 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 person-centered 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 member to acknowledge and accept certain responsibilities for addressing risks.

Iowa Medicaid has developed a computer program named Institutional and Waiver Authorization and Narrative System (IoWANS) to support HCBS programs. For fee-for-service members, this system assists the Medicaid Agency and the case manager with tracking information, monitoring, and approving the person-centered service plan. Through IoWANS the case manager authorizes service and service payments on behalf of the member. There are certain points in IoWANS process that require contacting the designated HHS central office personnel. The case manager is responsible for the development of the person-centered service plan and the person-centered service plan is authorized through IoWANS, which is the Medicaid Agency. (Refer to appendix A and H for IoWANS system processes.)

MCOs have processes to ensure the necessary risk assessments and mitigation plans are completed and made available to all parties.

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.

Information about qualified and accessible providers is available to members on an ongoing basis through the Iowa COMPASS services and resource database, Iowa Medicaid website, MCO websites, and MCO and Iowa Medicaid member services. The case manager first identifies providers to the member and their interdisciplinary team during the person-centered service planning process. Members are encouraged to meet with the available providers before making a selection. Members are not restricted to choosing providers within their community. If an MCO is unable to provide services to a particular member using in-network providers, the MCO is required to adequately and timely cover these services for that member using out-of-network 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 desired 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.

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):

HHS has developed a computer system named the Institutional and Waiver Authorization and Narrative System (IoWANS) to support HCBS programs. This system assists HHS with tracking information, monitoring, and approving service plans for fee-for-service members. (Refer to appendix A and H for IoWANS system processes.) On a monthly basis, Iowa Medicaid QIO MSU conducts service plan reviews to ensure a practice of person-centered service planning in accordance with §441.301(c). The service plan selection size for the waiver has a 95% confidence level. This information 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. IoWANS will only be utilized for fee-for-service members and quality data for managed care participants will be provided by the MCOs.

All members will receive a person-centered service plan using an HHS approved template.

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:

Case managers are responsible for ensuring that copies of the person-centered service plans (PCSP) are maintained for a minimum of 5 years.

MCO and FFS PCSP are developed using a standardized form and the final signed PCSP is stored in a central location, the Iowa Medicaid Provider Access Portal (IMPA), managed by Iowa Medicaid. Case managers are required to upload member's PCSP plans to IMPA as well as store them within their organization’s own case management systems. PCSPs must be made available to all entities acting on behalf of Medicaid.

For FFS members, IoWANS also stores the authorized PCSP information related to service, provider, units, rates, and timeframe of authorization.

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.

Case managers and ultimately HHS are responsible for monitoring the implementation of the person-centered service plan and the health and welfare of fee-for-service members, including:

-When participants first become eligible for the waiver, and when they first enroll with the MCO, at least one face to face contact per month for the first three (3) months.
- After the first (3) months: 1. At least one, in-home, face-to-face contact every other month with Enrolled Members who have a diagnosis of intellectual and/or developmental disability and every three (3) months for all other community-based LTSS members. 2. At least one contact per month with the member or the member's authorized representative. This contact may be face-to-face or by telephone. Written communication does not constitute a contact unless there are extenuating circumstances outlined in the Enrolled Member's person-centered service plan.
- Monitoring service utilization.
- 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 member 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 member 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 case manager will then follow up to solve any problems. Monitoring service utilization includes verifying that:
- The member used the waiver service at least once a calendar quarter.
- The services were provided in accordance with the plan.
- The member is receiving the level of service needed.

IoWANS is also used to assist with tracking information, monitoring services, and assuring services were provided to fee-for-service members. If the member is not receiving services according to the plan or not receiving the services needed, the member and other interdisciplinary team members and providers are contacted immediately.

The HCBS specialists (of the HCBS QIO Unit) monitor how member health and welfare is safeguarded, the degree of person-centered service plan implementation; and the degree of interdisciplinary team involvement of the case manager during the HCBS QIO review. Members 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 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 and offer recommendations for improvements based on the findings. 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 members are surveyed at a 95% confidence level.

The Iowa Medicaid MSU also conducts quality assurance reviews of member person centered service plans at a 95% confidence level and provides recommendations for improvements based on the findings. These reviews focus on the plan development, implementation, monitoring, and documentation that is completed by the case manager. All service plans reviewed are assessed for member participation, whether the member's needs are accurately identified and addressed, the effectiveness of risk assessments and crisis plans, member access to waiver and non-waiver services, as well as coordination across providers to best serve the member's needs.

MCOs are responsible for monitoring the implementation of the person-centered service plan, including access to waiver and non-waiver services, the quality-of-service delivery, and the health, safety and welfare of members and choice of service providers. 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 person-centered service plan.

MCO case managers 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 HHS 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 person-centered service plan for HCBS waiver enrollees within the timeframe mutually agreed upon between the MCO and HHS in accordance with the negotiated contract, the MCO will be assessed a noncompliance fee per occurrence.

b. Monitoring Safeguards. *Select one:*

- (●) **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may provide other direct waiver services to the participant because they are the only the only willing and qualified entity in a geographic area who can monitor service plan implementation.**

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-a1: Number and percent of service plans that accurately address all the member's assessed needs, including at a minimum, health and safety risk factors, and personal goals Numerator = # of service plans that accurately address all the member's

assessed needs, including at a minimum, health and safety risk factors, and personal goals Denominator = # of reviewed person centered service plans

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

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 = 95% confidence level with +/- 5% margin of error
☒ **Other** Specify: Contracted Entity including MCO	☐ **Annually**	☒ **Stratified** Describe Group: IA. Adults with Disabilities Waiver 8% IA. Child and Youth Waiver 8% IA. Elderly Waiver 29% IA. Intellectual Disabilities Waiver 49% IA. Brain Injury Waiver 6%
	☐ **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: Contracted Entity including MCO	☐ **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.

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-c1: Number and percent of CAHPS respondents who responded "YES" on the CAHPS survey to question 53 "In the last 3 months, did this {case manager} work with you when you asked for help with getting other changes to your services?". Please see Main: Optional for the full description, including the Numerator and Denominator

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:
FFS CAHPS and MCO CAHPS databases

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 = 95% confidence level with +/- 5% margin of error
☒ **Other** Specify: Contracted Entity including MCO	☐ **Annually**	☒ **Stratified** Describe Group:

		IA. Adults with Disabilities Waiver 8% IA. Child and Youth Waiver 8% IA. Elderly Waiver 29% IA. Intellectual Disabilities Waiver 49% IA. Brain Injury Waiver 6%
	☐ **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-c2: Number and percent of service plans which are updated on or before the member's annual due date. Numerator: # of service plans which were updated on or before the member's annual due date; Denominator: # service plans due for annual update that were reviewed.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

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 = 95% confidence level with +/- 5% margin of error
☒ **Other** Specify: Contracted Entities including MCO	☐ **Annually**	☒ **Stratified** Describe Group: IA. Adults with Disabilities Waiver 8% IA. Child and Youth Waiver 8% IA. Elderly Waiver 29% IA. Intellectual Disabilities Waiver 49% IA. Brain Injury Waiver 6%
	☐ **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-d1: Number and percent of members whose services were delivered according to

the service plan, including type, scope, amount, duration, and frequency specified in the plan. Numerator: # of members whose services were delivered according to the service plan, including type, scope, amount, duration, and frequency specified in the plan. Denominator: # of member's service plans reviewed.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

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 = 95% confidence level with +/- 5% margin of error
☒ **Other** Specify: Contracted Entity including MCO	☐ **Annually**	☒ **Stratified** Describe Group: IA. Adults with Disabilities Waiver 8% IA. Child and Youth Waiver 8% IA. Elderly Waiver 29% IA. Intellectual Disabilities Waiver 49% IA. Brain Injury Waiver 6%
	☐ **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/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-e1: Number and percent of CAHPS respondents who responded with either "MOST" or "ALL" on the CAHPS survey to question 56 "In the last 3 months, did your service plan include . . . of the things that are important to you". For Full description see Main B Optional

Data Source (Select one):

Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:
FFS CAHPS and MCO CAHPS databases

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 = 95% confidence level with +/- 5% margin of error
☒ **Other** Specify: Contracted entity including MCO	☐ **Annually**	☒ **Stratified** Describe Group: IA. Adults with Disabilities Waiver 8% IA. Child and Youth Waiver 8% IA. Elderly Waiver 29% IA. Intellectual Disabilities Waiver 49% IA. Brain Injury Waiver 6%
	☐ **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-e2: Number and percent of service plans from the HCBS QA survey review that indicated the member had a choice of HCBS service providers Numerator: Number of service plans from the HCBS QA survey review that indicated the member had a choice of HCBS service providers.; Denominator: Total number of service plans from the HCBS QA survey that were reviewed.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

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 = 95% confidence level with +/- 5% margin of error
☒ **Other** Specify: Contracted entity including MCO	☐ **Annually**	☒ **Stratified** Describe Group: IA. Adults with Disabilities Waiver 8% IA. Child and Youth Waiver 8% IA. Elderly Waiver 29% IA. Intellectual Disabilities Waiver 49% IA. Brain Injury Waiver 6%
	☐ **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:

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.

Data and results obtained by the HCBS QIO are reviewed by the Quality Assurance Committee at least annually. Results from the CAHPS and service plan Ride Along process are reviewed for issues and trends that may require corrective actions plans development. 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 HCBS QIO 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. MCOs are responsible for oversite of service plans for their members.

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):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: Contracted entities including MCOs	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

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.