ODP's CMS Performance Measures

For each program in the Office of Developmental Programs (ODP), there are expectations for quality assurance and improvement activities that are mandated through federal and/or State requirements. Per expectations of the Center for Medicaid and Medicare Services (CMS), ODP has developed performance measures (PMs) for each of these CMS waiver assurance areas, for which we must track, analyze, and report performance over time:

- **Administrative Authority (AA)**
- **Level of Care (LOC)**
- **Qualified Providers (QP)**
- **Service Plans (SP)**
- **Health and Welfare (HW)**
- **Financial Accountability (FA)**

On the next pages you will find two sets of ODP CMS PMs for all waiver assurance areas. The intellectual disability/autism waivers all share the same PMs. The Adult Autism Waiver (AAW) has its own set of PMs. The PMs highlighted in blue, are considered more "person-centered" outcomes focused because the data specifically targets **people outcomes**—not compliance outcomes—and focuses on positive results for the individuals ODP serves. These PMs are located in the following waiver assurance areas:

- **SP measures** - generally related to individuals being informed about and given available choices. Also, service plans must be actively, effectively, and ongoingly used to address an individual's needs and goals.

- **HW measures** - generally about ensuring an individual's health and safety by addressing identified health care needs; taking responsive and timely actions to mitigate and reduce/prevent future occurrences of incidents, by using risk management and quality improvement strategies; and providing individuals with information and raising awareness about identifying when abuse, neglect and exploitation is happening and what to do about it.

Assurance Area/PM#	ID/A WAIVERS: CONSOLIDATED, P/FDS & COMMUNITY LIVING Performance Measures (PMs)
AA1	# and % of waiver openings distributed equitably across all geographic areas covered by the waiver using criteria identified in Appendix B-3.
AA2	# and % of eligible applicants having an emergency need or who have been identified as being in reserved capacity status who receive preference in waiver enrollment.
AA3	# and % of waiver participants issued fair hearing and appeal rights in accordance with policies and procedures.
AA4	# and % of AEs that qualify providers using qualification criteria as outlined in the current approved waiver.
AA5	# and % of AEs that monitor providers using the standard tool and monitoring processes developed by ODP.
LOC1	# and % of new enrollees who have a level of care (LOC) completed prior to entry into the waiver.
LOC2	# and % of initial LOC determinations where the instrument and process described in Appendix B-6 of the waiver is used
QP1	# and % of providers that initially and continually meet required licensure and/or certification standards and adhere to other state standards.
QP2	# and % of non-licensed, non-certified providers that meet waiver requirements.
QP3	# and % of providers delivering Participant Directed Services that meet requirements.
QP4	# and % of providers that meet annual training requirements in accordance with state requirements in the approved waiver.
SP1	# and % of participants who have all assessed needs and personal goals addressed in the service plan through waiver funded services or other funding sources or natural supports.
SP2	# and % of participants whose service plans are updated or revised at least annually.
SP3	# and % of participants whose needs changed and whose service plans were revised accordingly.
SP4	# and % of participant service plans in which services and supports were delivered in the type, scope, amount, duration, and frequency specified in the service plan.
SP5	# and % of participants whose records document choice between and among waiver services and providers was offered to the participant/ family.
SP6	# and % of new participants who are provided information on participant-directed services.
HW1	# and % of confirmed incidents of abuse, neglect, exploitation, and unexplained death for which corrective actions were executed or planned by the appropriate entity within the required time frame.
HW2	# and % of participants who received information about how to identify and report abuse, neglect, and exploitation.
HW3	# and % of critical incidents finalized, including strategies to mitigate/prevent future incidents, within the required time frame.
HW4	# and % of participants with restrictive procedures where proper procedures were followed.
HW5	# and % of participants whose identified health care needs are being addressed.
FA1	# and % of claims that are supported by documentation that services were delivered.
FA2	# and % of claims paid for participants who were eligible on the date the service was provided and where services were consistent with those in service plans.
FA3	# and % of claims paid using rates developed according to the rate methodology in Appendix I-2-a.
FA4	% of waiver claims paid using rates that follow the rate methodology in the approved waiver application.

Assurance Area/PM#	ADULT AUTISM WAIVER Performance Measures (PMs)
AA1	# and % of waiver amendments, renewals and notices in the PA Bulletin reviewed and approved by the State Medicaid Director.
AA2	# and % of providers with signed Medical Assistance Provider Agreements and AAW Supplemental Agreements.
AA3	# and % of waiver openings distributed equitably across all geographic areas covered by the waiver using criteria identified in Appendix B-3.
LOC1	# and % of new enrollees who have a level of care (LOC) completed prior to entry into the waiver.
LOC2	# and % of initial LOC determinations where the instrument and process described in Appendix B-6 of the waiver are used.
QP1	# and % of providers who meet licensing requirements.
QP2	# and % of providers who meet age, education, experience, and criminal background check requirements per Appendix C prior to service delivery.
QP3	# and % of providers who completed required training.
SP1	# and % of participants who have all documented needs and personal goals addressed in the service plan through waiver funded services or other funding sources or natural supports.
SP2	# and % of participants whose service plans are updated/revised at least annually.
SP3	# and % of participants whose needs changed and whose service plans were revised accordingly.
SP4	# and % of participants whose services were delivered in the type, scope, amount, duration, and frequency specified in the service plan.
SP5	# and % of participants whose records document choice between and among waiver services and providers was offered to the participant/family.
HW1	# and % of confirmed incidents of abuse, neglect, exploitation, and unexplained death for which corrective action was taken.
HW2	# and % of participants who received information about how to identify and report abuse, neglect, and exploitation.
HW3	# and % of critical incidents finalized, including strategies to mitigate/prevent future incidents, within the required time frame.
HW4	# and % of confirmed incidents which are reported and reviewed at quarterly risk management meetings to determine any patterns related to participants or providers.
HW5	# and % of incidents related to restrictive interventions where proper procedures were followed.
HW6	# and % of participants whose identified healthcare needs are being addressed.
FA1	# and % of claims supported by documentation that services were delivered.
FA2	# and % of claims paid for participants who were eligible on the date the service was provided and where services were consistent with those in service plans.
FA3	# and % of claims paid using rates developed according to the rate methodology in Appendix I-2-a.