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DEPARTMENT OF HUMAN SERVICES

Performance-Based Contracting for Residential Services Provider Preparedness Summit 1

June 3, 2024

Overview

- Review of performance standards:
  - Continuum of services
  - Referral and Discharge
  - Administration
  - Data Management
  - Risk Management
- For each performance area review:
  - Measure
  - Data sources
  - Additional measure-related specifics
  - P4P
  - When available, relevant statewide data

New Terms

- **Selective Contracting –** a 1915(b)4 Waiver allows state Medicaid programs to determine specific criteria for provider contracting under their fee-for-service delivery system, thereby creating restrictions on who can provide the service. The Department is referring to this as **Performance-Based Contracting**

- **Pay For Performance** - a payment approach that gives added incentive payments to provide high-quality and cost-efficient care.

- **Performance Area –** general categories of quality standards and measures used in ODP's model for PBC.

- **Standards –** a measurable requirement that indicates quality

- **Measure –** a description of how a standard is evaluated, completed, or scored

Continuum of Services (CoS)

Definition of Standard: Provide (two of three) services in residential continuum (Residential Habilitation and either Life Sharing or Supported Living; Life Sharing and either Residential Habilitation or Supported Living; Supported Living and Life Sharing or Residential Habilitation).				
PM Code	**Performance Measure (PM)**	**Applies to Primary Providers**	**Applies to Select Providers**	**Applies to Clinically Enhanced Providers**
CoS.01	**Provide two of the three services during the review period.**		✓	
Process Details (How and What?)	ODP will use authorization and claim data to determine if the residential provider has rendered at least 2 of 3 residential services during the review period. *To meet the measure for Select upon initial implementation, providers must be rendering two of three residential services by July 1, 2024.			
Data Source	Claims	**Pay for Performance Measure?**		No

Residential Providers by Service Type

Residential Service Type	Number of Providers
Residential Habilitation (Licensed and Unlicensed)	390
Life Sharing (Licensed and Unlicensed)	78
Supported Living	28
Provide 2 or more residential service types	90

HCSIS: Extract for December 31, 2023

Continuum of Services (CoS)

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Definition of Standard: Evaluate and assess individuals who may be better served in a more independent setting.				
PM Code	**Performance Measure (PM)**	**Applies to Primary Providers**	**Applies to Select Providers**	**Applies to Clinically Enhanced Providers**
CoS.02	**Report on the number of individuals with a successful transition from Residential Habilitation to Life Sharing and Supported Living.**	✓	✓	✓
Process Details (How and What?)	Via provider survey, provider will respond to questions related to number of individuals transitioned. ODP will validate through use authorization data, claim data and provider submitted *Transition to Independent Living Request Forms* to determine if the residential provider has supported individuals to transition from residential habilitation to life sharing or supported living during the review period.			
Data Source	Provider survey; Claims; Submitted Transition to Independent Living Request Forms	**Pay for Performance Measure?**		Yes

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Questions and Answers

Referral and Discharge Practices (RD)

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Definition of Standard: Service initiation occurs within: an average of 90 days or less post-referral acceptance for Community Homes; average of 180 days or less post-referral acceptance for Supported Living and Life Sharing.				
PM Code	**Performance Measure (PM)**	**Applies to Primary Providers**	**Applies to Select Providers**	**Applies to Clinically Enhanced Providers**
RD.01.1	Attest that a system will be in place January 1, 2025, to track and report time to service after post-referral acceptance Providers may not accept NEW referrals for individuals NG4 or greater. This does not apply to individuals NG4 or greater receiving residential services prior to January 1, 2025, or individuals where the needs assessment results in an increase.	✓		
RD.01.2	Residential service providers serving a minimum of 10 individuals for the review period (providers serving less than 10 individuals January 1, 2025, will not be eligible for Select or Clinically Enhanced tiers) must attest that a system will be in place beginning January 1, 2025, to report current average days for service initiation May accept NEW referrals for individuals NG4 or greater.		✓	✓
RD.01.3	Demonstrate timeliness of response to referrals: ─ Attest that a system will be in place beginning January 1, 2025 to track and report • Referrals received and accepted • Time to service after post-referral acceptance • Circumstances surrounding each circumstance in which 90-day timeline is not met for Residential Habilitation and 180-day timeline is not met for Life Sharing and Supported Living• Referrals denied, reason (age, gender, clinical needs, location/geography, vacancy status workforce) • Report number of provider initiated discharges to other residential providers or ICFs and reason for discharge(s)─ Attestation to confirm the above requested data provided is accurate, a procedure is in place to review referrals, and the procedure is in practice.		✓	✓

Referral and Discharge Practices (RD)

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Definition of Standard: Service initiation occurs within: an average of 90 days or less post-referral acceptance for Community Homes; average of 180 days or less post-referral acceptance for Supported Living and Life Sharing.				
PM Code	**Performance Measure (PM)**	**Applies to Primary Providers**	**Applies to Select Providers**	**Applies to Clinically Enhanced Providers**
RD.01.1	**Attest that a system will be in place January 1, 2025, to track and report time to service after post-referral acceptance. Primary providers may not accept NEW referrals for individuals NG4 or greater. This does not apply to individuals NG4 or greater receiving residential services prior to January 1, 2025, or individuals where the needs assessment results in an increase.**	✓		
Process Details (How and What?)	**1.** The provider is responsible to develop and implement a system that meets all of the below requirements by no later than January 1, 2025. For tier determination, the provider will submit attestation of completion of system to track service initiation. Beginning 1/1/25, provider will begin documenting and tracking receipt of all referrals received and accepted for residential services (community home, Life Sharing and Supported Living). Including the following information: **a.** All referrals for residential services by type and determination of acceptance or rejection. . **b.** Time to service initiation from date of referral acceptance to date of service start by residential service type. **c.** Report number of provider-initiated discharges to other residential providers or ICFs and document reason for discharge(s).**d.** Report number of referrals denied and document reason (age, gender, clinical needs, location/geography, vacancy status workforce). **3.** Primary Provider will establish policy to ensure new residential services referrals for individuals NG4 or greater are not accepted. **4.** Provider will provide referral data measuring the average days for all referrals for the reporting time period requested by ODP beginning with CY24 data.			
Data Source	Initially Provider survey and documentation review; ECM.	**Pay for Performance Measure?**		No

Referral and Discharge Practices (RD)

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Definition of Standard: Service initiation occurs within: an average of 90 days or less post-referral acceptance for Community Homes; average of 180 days or less post-referral acceptance for Supported Living and Life Sharing.				
PM Code	**Performance Measure (PM)**	**Applies to Primary Providers**	**Applies to Select Providers**	**Applies to Clinically Enhanced Providers**
RD.01.2	**Residential service providers must serve a minimum of 10 individuals for the review period.** **Select and Clinically Enhanced providers may accept NEW referrals for individuals NG4 or greater. Providers serving less than 10 individuals January 1, 2025, will not be eligible for Select or Clinically Enhanced tiers.**		✓	✓
Process Details (How and What?)	ODP will use authorization and claim data to determine if the residential provider has rendered services to 10 or more individuals as 12/31/2024			
Data Source	ODP authorization and claims data	**Pay for Performance Measure?**		No

Referral and Discharge Practices (RD)

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Definition of Standard: Service initiation occurs within: an average of 90 days or less post-referral acceptance for Community Homes- average of 180 days or less post-referral acceptance for Supported Living and Life Sharing.

PM Code	Performance Measure (PM)	Applies to Primary Providers	Applies to Select Providers	Applies to Clinically Enhanced Providers
RD.01.3	**Demonstrate timeliness of response to referrals: ─ Attest that a system will be in place beginning January 1, 2025 to track and report • Referrals received and accepted • Time to service after post-referral acceptance • Circumstances surrounding each circumstance in which 90-day timeline is not met for Residential Habilitation and 180-day timeline is not met for Life Sharing and Supported Living• Referrals denied, reason (age, gender, clinical needs, location/geography, vacancy status workforce) • Report number of provider initiated discharges to other residential providers or ICFs and reason for discharge(s)─ Attestation to confirm the above requested data provided is accurate, a procedure is in place to review referrals, and the procedure is in practice.**		✓	✓

Process Details (How and What?)	**1.** The provider is responsible to develop and implement a system that meets all of the below requirements by no later than January 1, 2025. For tier determination, the provider will submit attestation of completion of system to track service initiation. Beginning 1/1/25, provider will begin documenting and tracking receipt of all referrals received and accepted for residential services (community home, Life Sharing and Supported Living). Including the following information: **a.** All referrals for residential services by type and determination of acceptance or rejection. . **b.** Time to service initiation from date of referral acceptance to date of service start by residential service type. **c.** Report number of provider-initiated discharges to other residential providers or ICFs and document reason for discharge(s).**d.** Report number of referrals denied and document reason (age, gender, clinical needs, location/geography, vacancy status workforce). **4.** Provider will provide referral data measuring the average days for all referrals for the reporting period requested by ODP beginning with CY24 data. **5.** For community home, the average time for service initiation from referral date should be no more than 90 calendar days. **6.** For supported living and life sharing, the average time of service initiation from referral date should be no more than 180 calendar days. For individuals transitions that exceed the timeframes significantly, the provider should supply description of circumstances.		
Data Source	Initially Provider survey and documentation review; ECM.	**Pay for Performance Measure?**	No

Questions and Answers

Administration (ADM)

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Definition of Standard: Demonstrate transparent and sound corporate governance structure.				
PM Code	**Performance Measure (PM)**	**Applies to Primary Providers**	**Applies to Select Providers**	**Applies to Clinically Enhanced Providers**
ADM.01.1	Attestation and required documentation supporting attestation questions regarding the required elements to meet the standards: **1.** Successful passage of a fiscal readiness review. **2.** Submission of current financial statements (audited if available). **3.** Disclosure of the following: **A.** Conflict of Interest Policy and associated documentation. **B.** Criminal convictions of officers and/or owners. **C.** Licensing status in Pennsylvania for non-ODP licensed settings. **D.** History of licensing/revocations/ enforcement actions in other states in which provider renders services to individuals with intellectual and developmental disabilities, if applicable New providers that are not enrolled to provide residential services through ODP by December 31, 2024, with licenses revoked in other states, will not be eligible for contracting.	✓	✓	✓
ADM.01.2	Documentation that governance by the Board of Directors is informed by voices of people with lived experiences by: ─ Including at least one individual with intellectual and developmental disabilities/ autism (inclusive of family members) on the Board or ─ Operating an advisory committee or subcommittee that is comprised of people with lived experience ─ Evidence that Board deliberations are informed by input of people with lived experience.		✓	✓

Administration (ADM)

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Definition of Standard: Demonstrate transparent and sound corporate governance structure.				
PM Code	**Performance Measure (PM)**	**Applies to Primary Providers**	**Applies to Select Providers**	**Applies to Clinically Enhanced Providers**
ADM.01.1	**Attestation and required documentation supporting attestation questions regarding the required elements to meet the standards: 1. Successful passage of a fiscal readiness review. 2. Submission of current financial statements (audited if available). 3. Disclosure of the following: A. Conflict of Interest Policy and associated documentation. B. Criminal convictions of officers and/or owners. C. Licensing status in Pennsylvania for non-ODP licensed settings. D. History of licensing/revocations/ enforcement actions in other states in which provider renders services to individuals with intellectual and developmental disabilities, if applicable. New providers that are not enrolled to provide residential services through ODP by December 31, 2024, with licenses revoked in other states, will not be eligible for contracting.**	✓	✓	✓
Process Details (How and What?)	1.Provider submission of current financial statements (audited if available) . 2. Provider completion of the following sections of the provider survey: financial, conflict of interest disclosure, criminal conviction disclosure; licensing and regulatory status disclosure. 3 Provider submission of attestation to factual representation of financial documentation, conflict of interest, criminal backgrounds and licensing and regulatory status disclosures.			
Data Source	Provider attestation, survey, and documentation submission. Financial statements previously submitted during FY23-24 will not require resubmission.	**Pay for Performance Measure?**		No

Administration (ADM)

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Definition of Standard: Demonstrate transparent and sound corporate governance structure.				
PM Code	**Performance Measure (PM)**	**Applies to Primary Providers**	**Applies to Select Providers**	**Applies to Clinically Enhanced Providers**
ADM.01.2	**Documentation that governance by the Board of Directors is informed by voices of people with lived experiences by: – Including at least one individual with intellectual and developmental disabilities/ autism (inclusive of family members) on the Board or – Operating an advisory committee or subcommittee that is comprised of people with lived experience – Evidence that Board deliberations are informed by input of people with lived experience AND ADM.01.1.**		✓	✓
Process Details (How and What?)	1. Via provider survey, providers will submit documentation that reflects board/advisory/subcommittee membership and documentation such as meeting minutes to reflect board deliberations are informed by input of people with lived experience. For example: Board membership requirements and sample of meeting minutes			
Data Source	Provider survey; Documentation review.	**Pay for Performance Measure?**		No

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Questions and Answers

Data Management (DM)

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Definition of Standard: Demonstrated production of data reports (including ad hoc) through adopted technology platform.				
PM Code	**Performance Measure (PM)**	**Applies to Primary Providers**	**Applies to Select Providers**	**Applies to Clinically Enhanced Providers**
DM.01.1	Submit completed test case file in format required/requested by ODP.	✓		
DM.01.2	Provide one sample of operational report or quality report used for internal monitoring and implementation of QM initiatives (written description of use and analysis of data such as, incidents, medication errors, health risks, restrictive procedures, staff retention, effectiveness of behavioral support, employment, Information Sharing and Advisory Committee recommendation strategies, billing accuracy — must be from one or more of these categories).		✓	✓

Data Management (DM)

Definition of Standard: Demonstrated production of data reports (including ad hoc) through adopted technology platform.				
PM Code	**Performance Measure (PM)**	**Applies to Primary Providers**	**Applies to Select Providers**	**Applies to Clinically Enhanced Providers**
DM.01.1	**Submit completed test case file in format required/requested by ODP.**	✓		
Process Details (How and What?)	Providers will be required to submit a test case file upon the development of the PAS provider portal. **Implementation targeted for 2026.**			
Data Source	Provider survey and/or documentation submission.	**Pay for Performance Measure?**		No

Data Management (DM)

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Definition of Standard: Demonstrated production of data reports (including ad hoc) through adopted technology platform.				
PM Code	**Performance Measure (PM)**	**Applies to Primary Providers**	**Applies to Select Providers**	**Applies to Clinically Enhanced Providers**
DM.01.2	**Provide one sample of operational report or quality report used for internal monitoring and implementation of QM initiatives (written description of use and analysis of data such as, incidents, medication errors, health risks, restrictive procedures, staff retention, effectiveness of behavioral support, employment, Information Sharing and Advisory Committee recommendation strategies, billing accuracy — must be from one or more of these categories).**		✓	✓
Process Details (How and What?)	Via provider survey, providers will upload a sample of one operational or quality report currently in use.			
Data Source	Provider survey; Documentation review.	**Pay for Performance Measure?**		No

Data Management (DM)

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Definition of Standard: Demonstrated data capability with use of a HIPAA compliant EHR.				
PM Code	**Performance Measure (PM)**	**Applies to Primary Providers**	**Applies to Select Providers**	**Applies to Clinically Enhanced Providers**
DM.02	**Report the EHR in use and what functions of the software are utilized (e.g., that includes medication records, physician notes, integrated care pathways, etc.) and demonstrated use of EHR.**		✓	✓
Process Details (How and What?)	Via provider survey, providers will report information regarding EHR and provide evidence of use.			
Data Source	Provider survey; Documentation submission.	**Pay for Performance Measure?**		Yes

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Questions and Answers

Risk Management (RM)

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Definition of Standard: Demonstrated fidelity to incident management procedures as outlined in ODP policy.				
PM Code	**Performance Measure (PM)**	**Applies to Primary Providers**	**Applies to Select Providers**	**Applies to Clinically Enhanced Providers**
RM-IM.01.1	Maximum number of critical incidents (potentially indicative of abuse or neglect) not reported may not exceed 1% of overall reported incidents by provider.		✓	✓
RM-IM.01.2	Maximum number of critical incidents (potentially indicative of abuse or neglect) not reported timely may not exceed 10% of overall reported critical incidents by provider.		✓	✓
RM-IM.01.3	Timely finalization of incidents demonstrated by at least 90% of incidents finalized within 30 days of discovery.		✓	✓
RM-IM.01.4	At least 95% of all incidents must be finalized by the due date, and the due date may only exceed 30 days in no more than 5% of those incidents (due dates may exceed 30 days when the provider has notified the Department in writing that an extension is necessary and the reason for the extension).		✓	✓

Risk Management (RM)

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Definition of Standard: Demonstrated fidelity to incident management procedures as outlined in ODP policy.				
PM Code	**Performance Measure (PM)**	**Applies to Primary Providers**	**Applies to Select Providers**	**Applies to Clinically Enhanced Providers**
RM-IM.01.1	**Maximum number of critical incidents (potentially indicative of abuse or neglect) not reported may not exceed 1% of overall reported incidents by provider.**		✓	✓
Process Details (How and What?)	Medicaid claims for treatment by a medical professional, that are indicative of abuse, neglect, or serious injury are compared to incident management data, through a claims to incident matching process, to identify unreported incidents. 1.An extract of incident management data is pulled for Performance Based Contracting based on the time period specified for Providers rendering residential services. 2. At the MPI level, the number of incidents reported per Provider during the specified calendar year is calculated using "Discovery Date". Only incidents with a status of "Open" or "Closed" are included. Incidents with a status of "Deleted" are excluded. 3. At the MPI level, the number of incidents identified as unreported, through the claims to incident matching process, are recorded per Provider during the specified calendar year. 4. Each MPI now has been associated with the number of incidents that were discovered as unreported, as well as the total number of incidents they have entered for the associated calendar year (total number of incidents reported inherently INCLUDES the number of incidents entered through the claims to incident matching process). 5. A percentage of unreported incidents are calculated per MPI: [NUMBER OF UNREPORTED INCIDENTS] / [TOTAL NUMBER OF INCIDENTS REPORTED] * 100 = PERCENTAGE OF UNREPORTED INCIDENTS. EXAMPLE: MPI 123456789: [5 UNREPORTED INCIDENTS] / [10 TOTAL INCIDENTS REPORTED] * 100 = 50% OF INCIDENTS WERE UNREPORTED.			
Data Source	Claims; Enterprise Incident Management (EIM)	**Pay for Performance Measure?**	No	

RM-IM.01.1

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Maximum number of critical incidents (potentially indicative of abuse or neglect) not reported may not exceed 1% of overall reported incidents by provider.

CY 2023 Quarters 1-3

Percent of Unreported incidents (Unreported/Total Reported)	Number of Residential Providers (Unique MPI)
0.00%	281
0.2-1.0%	33
1.1-5%	61
5.1-10%	21
10.1-20%	<11
20.1-50%	<11
50.1-100%	<11

Risk Management (RM)

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Definition of Standard: Demonstrated fidelity to incident management procedures as outlined in ODP policy.				
PM Code	**Performance Measure (PM)**	**Applies to Primary Providers**	**Applies to Select Providers**	**Applies to Clinically Enhanced Providers**
RM-IM.01.2	**Maximum number of critical incidents (potentially indicative of abuse or neglect) not reported timely may not exceed 10% of overall reported critical incidents by provider.**		✓	✓
Process Details (How and What?)	1. At the MPI level, the number of incidents reported "Late" per Provider during the specified calendar year is calculated using the data element "First Section Compliance Status". Only incidents with a status of "Open" or "Closed" are included. Incidents with a status of "Deleted" are excluded. 2. At the MPI level, the number of incidents reported per Provider during the specified calendar year is calculated using "Discovery Date". Only incidents with a status of "Open" or "Closed" are included. Incidents with a status of "Deleted" are excluded. 3. Each MPI now has been associated with the number of incidents that had a late First Section document, as well as the total number of incidents they have entered for the associated calendar year (total number of incidents reported inherently INCLUDES the number of incidents that had late First Section documents). 4. A percentage of late incidents is calculated per MPI: [NUMBER OF LATE INCIDENTS] / [TOTAL NUMBER OF INCIDENTS REPORTED] * 100 = PERCENTAGE OF LATE INCIDENTS. EXAMPLE: MPI 123456789: [5 LATE INCIDENTS] / [10 TOTAL INCIDENTS REPORTED] * 100 = 50% OF INCIDENTS REPORTED LATE			
Data Source	Enterprise Incident Management (EIM)	**Pay for Performance Measure?**	No	

RM-IM.01.2

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Maximum number of critical incidents (potentially indicative of abuse or neglect) not reported timely may not exceed 10% of overall reported critical incidents by provider.

CY 2023 Quarters 1-3

Percent of incidents reported late (Reported late/Total Reported)	Number of Residential Providers (Unique MPI)
0.00%	93
0.1-10%	92
10.1-20%	72
20.1-30%	39
30.1-40%	36
40.1-50%	25
50.1-60%	12
60.1-70%	<11

Risk Management (RM)

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Definition of Standard: Demonstrated fidelity to incident management procedures as outlined in ODP policy.				
PM Code	**Performance Measure (PM)**	**Applies to Primary Providers**	**Applies to Select Providers**	**Applies to Clinically Enhanced Providers**
RM-IM.01.3	**Timely finalization of incidents demonstrated by at least 90% of incidents finalized within 30 days of discovery.**		✓	✓
Process Details (How and What?)	1. At the MPI level, the number of incidents reported "Compliant" per Provider during the specified calendar year is calculated using the data element "Final Section Compliance Status". Only incidents with a status of "Open" or "Closed" are included. Incidents with a status of "Deleted" are excluded. 2. At the MPI level, the number of incidents reported per Provider during the specified calendar year is calculated using "Discovery Date". Only incidents with a status of "Open" or "Closed" are included. Incidents with a status of "Deleted" are excluded. 3. Each MPI now has been associated with the number of incidents that had a Compliant Final Section document, as well as the total number of incidents they have entered for the associated calendar year (total number of incidents reported inherently INCLUDES the number of incidents that had a compliant Final Section document). 4. A percentage of incidents finalized timely is calculated per MPI: [NUMBER OF INCIDENTS WITH TIMELY FINALIZATION] / [TOTAL NUMBER OF INCIDENTS REPORTED] * 100 = PERCENTAGE INCIDENTS FINALIZED TIMELY EXAMPLE:MPI 123456789: [5 INCIDENTS WITH TIMELY FINALIZATION] / [10 TOTAL INCIDENTS REPORTED] * 100 = 50% INCIDENTS FINALIZED TIMELY			
Data Source	Enterprise Incident Management (EIM)	**Pay for Performance Measure?**	No	

RM-IM.01.3

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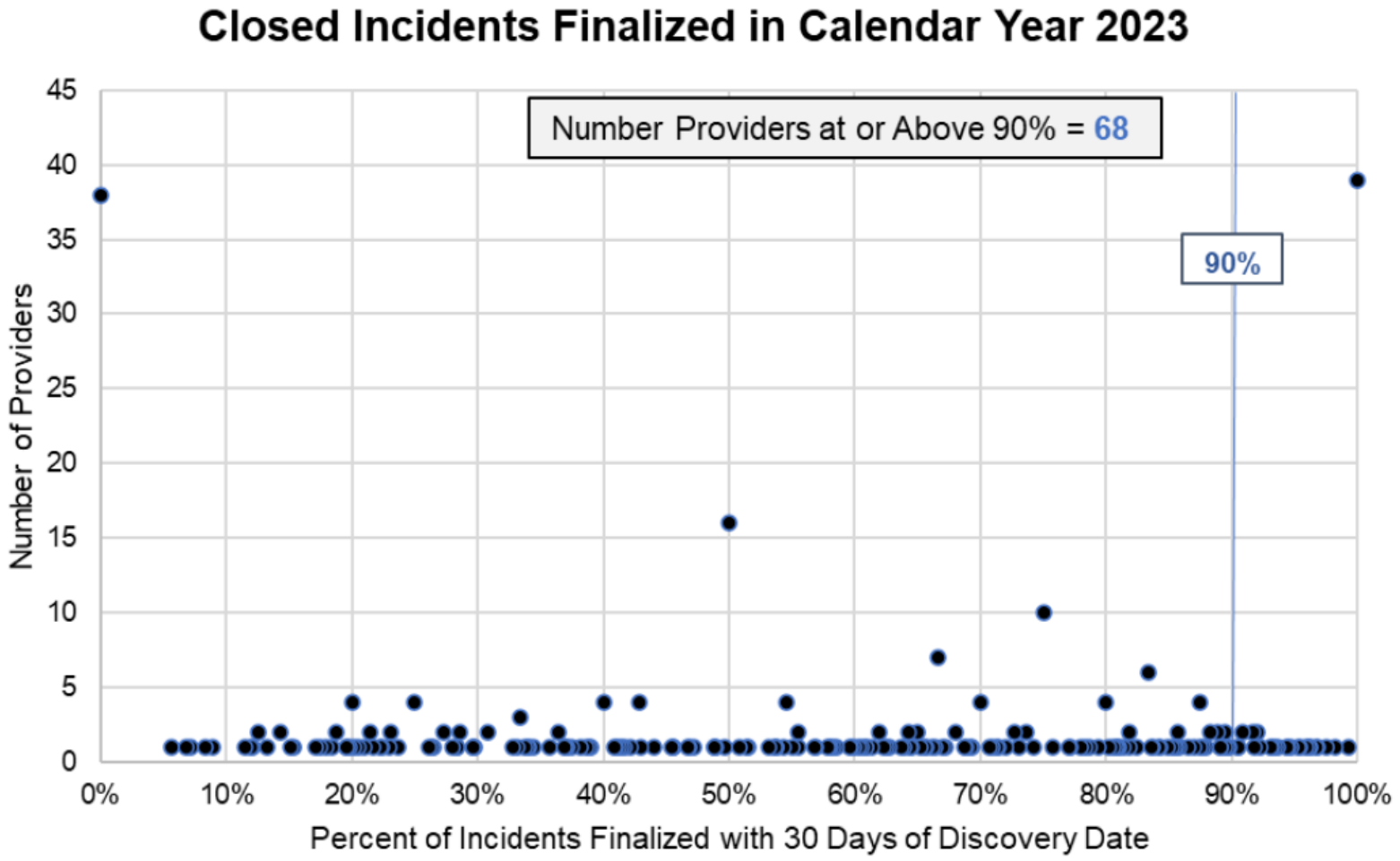
Timely finalization of incidents demonstrated by at least 90% of incidents finalized within 30 days of discovery.



Risk Management (RM)

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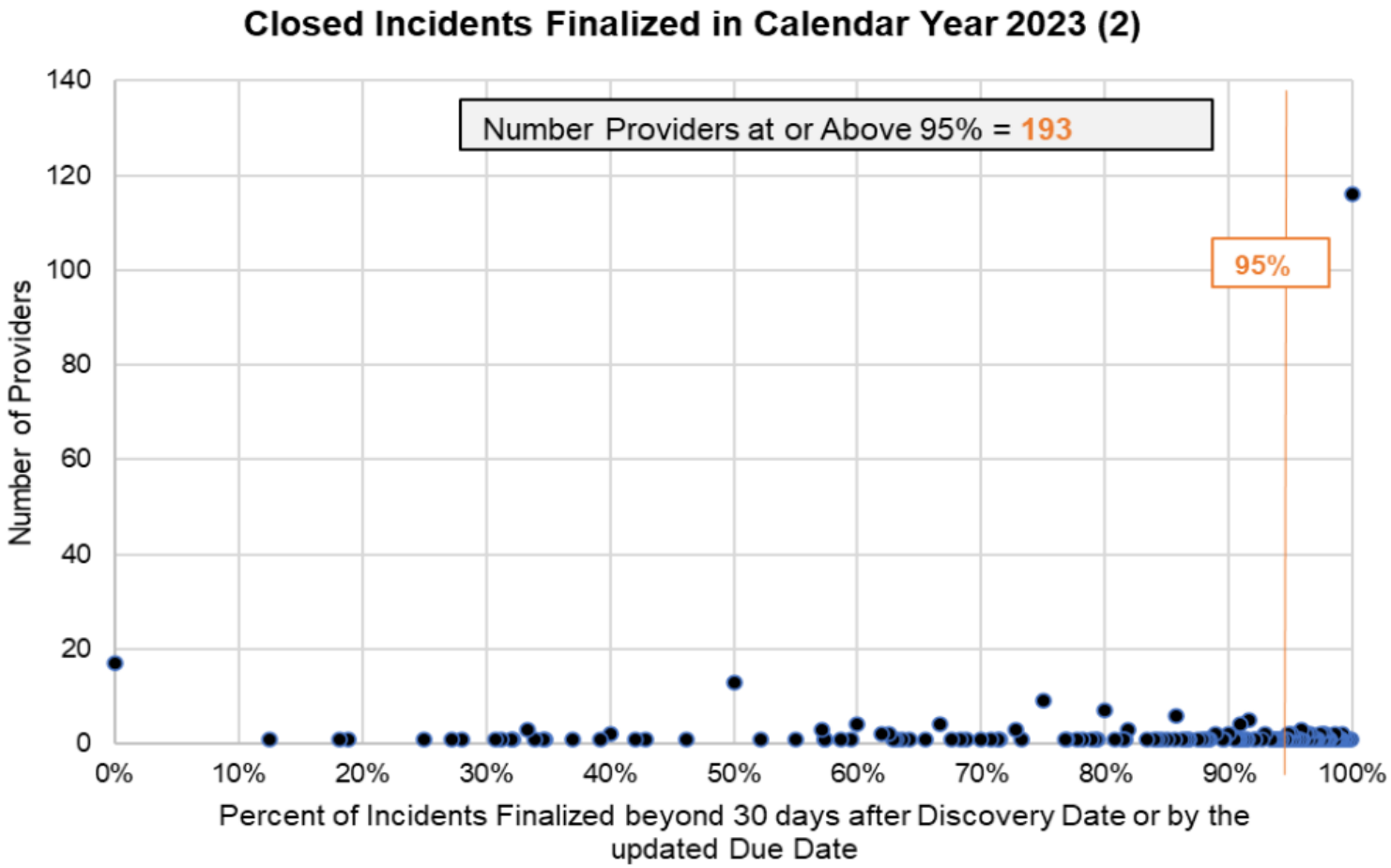
Definition of Standard: Demonstrated fidelity to incident management procedures as outlined in ODP policy.				
PM Code	**Performance Measure (PM)**	**Applies to Primary Providers**	**Applies to Select Providers**	**Applies to Clinically Enhanced Providers**
RM-IM.01.4	**At least 95% of all incidents must be finalized by the due date, and the due date may only exceed 30 days in no more than 5% of those incidents (due dates may exceed 30 days when the provider has notified the Department in writing that an extension is necessary and the reason for the extension).**		✓	✓
Process Details (How and What?)	1. At the MPI level, the number of incidents reported per Provider during the specified calendar year is calculated using "Discovery Date". Only incidents with a status of "Open" or "Closed" are included. Incidents with a status of "Deleted" are excluded. 2. Each MPI now has been associated with the number of incidents that had a Compliant Final Section document, as well as the total number of incidents they have entered for the associated calendar year (total number of incidents reported inherently INCLUDES the number of incidents that had a compliant Final Section document). 3. A percentage of incidents finalized timely is calculated per MPI: [NUMBER OF INCIDENTS WITH TIMELY FINALIZATION] / [TOTAL NUMBER OF INCIDENTS REPORTED] * 100 = PERCENTAGE INCIDENTS FINALIZED TIMELY EXAMPLE: MPI 123456789: [5 INCIDENTS WITH TIMELY FINALIZATION] / [10 TOTAL INCIDENTS REPORTED] * 100 = 50% INCIDENTS FINALIZED TIMELY 4. Of the incidents which were finalized timely (by due date assigned by system) for each MPI, the data element "Extension filed" will be examined. If an extension has been entered, the due date assigned will be 31+ days after the Discovery Date. 5. A percentage of incidents finalized timely more than 30 days from the Discovery Date of the incidents is calculated per MPI: [NUMBER OF INCIDENTS WITH TIMELY FINALIZATION AND EXTENSION FILED] / [TOTAL NUMBER OF INCIDENTS FINALIZED TIMELY] * 100 = PERCENTAGE INCIDENTS FINALIZED TIMELY WITH AN EXTENSION EXAMPLE:MPI 123456789: [5 INCIDENTS WITH TIMELY FINALIZATION AND EXTENSION] / [10 TOTAL INCIDENTS FINALIZED TIMELY] * 100 = 50% INCIDENTS FINALIZED TIMELY WITH AN EXTENSION			
Data Source	Enterprise Incident Management (EIM)	**Pay for Performance Measure?**	No	

RM-IM.01.4

At least 95% of all incidents must be finalized by the due date, and the due date may only exceed 30 days in no more than 5% of those incidents (due dates may exceed 30 days when the provider has notified the Department in writing that an extension is necessary and the reason for the extension).



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Questions and Answers