Service Specific Record Review – Support Coordination

CMS ASSURANCE #1 - Level of Care Persons enrolled in the waiver have needs consistent with an institutional level of care				
#	**Performance Measure/Standard**	**Protocol**	**Not Met Reasons**	**Weights**
1	Level of care is reevaluated at least annually.	CMS Level of Care Sub-Assurance iBudget Handbook 1-8 RECORD REVIEW Level of Care is to be reevaluated at least annually using the Medicaid Waiver Eligibility Worksheet. Review the Medicaid Waiver Eligibility Worksheet(s) for the Support Plan (s) effective during the review period to ensure it is complete including: • Name of the person receiving services • Support Plan effective date indicated • Social Security Number indicated • Section I. Level of Care Eligibility - Option A, B or C is checked o If Option B or C are checked, the appropriate Handicapping Conditions and/or Major Life Activities are also checked • Section II. Medicaid Eligibility - Option A or B is checked o If A is checked, the correct Medicaid number is documented o If B is checked, Medicaid eligibility referral date, Result and date of determination are included (*Note: B is only checked if person receiving services is new to the Medicaid Waiver*) • Section III. Eligibility Determination – Option A. is checked o WSC's dated signature and agency (if applicable) are documented • Section IV. Choice – Option A. is checked	1) The complete Medicaid Waiver Eligibility Worksheet is not in the record for the entire period of review. 2) The complete Medicaid Waiver Eligibility Worksheet is in the record, but not for the entire period of review. 3) The Medicaid Waiver Eligibility Worksheet is not signed and dated by person receiving services/legal representative. 4) The Medicaid Waiver Eligibility Worksheet is not signed and dated by Support Coordinator. 5) All required areas of the Medicaid Waiver Eligibility Worksheet have not been completed. 6) One or more of the signatures are dated after the effective date of the Support Plan. 7) Name of person receiving services is not on the Medicaid Waiver Eligibility Worksheet. 8) The Social Security Number of the person receiving services is	3

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		o The dated signature/mark of the person receiving services is present o The dated signature of the legal representative, if applicable, is present o If the person receiving services uses a mark for a signature, the dated signature of a witness is present o Printed name and relationship to the person receiving services, legal representative or witness is present o All signatures are dated prior to the effective date of the Support Plan Note: Support Plan extensions **do not** apply to Medicaid Waiver Eligibility Worksheets. **This standard is subject to potential recoupment.**	not on the Medicaid Waiver Eligibility Worksheet. 9) Section I. Level of Care Eligibility is not completed. 10) Section II. Medicaid Eligibility is not completed. 11) Section III. Eligibility determination is not completed. 12) Section IV. Choice is not completed.	
2	Level of care is completed accurately using the correct instrument/form.	CMS Level of Care Sub-Assurance APD Eligibility Rules: 65G-4.014 - 017 iBudget Handbook Maybe 1-10? RECORD REVIEW • Ask the WSC to describe their system for revaluating Level of Care. • Review the Central Record for Psychological and/or Medical Record(s) used to establish eligibility. • Review the Central Record for most recent QSI summary report. • Review the Medicaid Waiver Eligibility Worksheet and ensure: o The correct form is used for the time period; o For section I, the Option selected is consistent with IQ and/or Disability Category referenced in Psychological and/or	1) Unable to determine - Psychological and/or Medical Record(s) used to establish eligibility were not available in the Central Record. 2) The Option checked under section I was not consistent with the Psychological and/or Medical Record(s) in the record. 3) The Option checked under section I was not consistent with the QSI in the record. 4) The Handicapping Condition(s) checked were not consistent with the Psychological and/or	

		Medical Record(s) filed in Central Record; o If Option B or C are checked, the Handicapping Condition(s) and/or Major Life Activities checked off are consistent with information in the Central Record, including the most current QSI, Psychological and/or Medical Record(s). • Note: Effective date of the current Medicaid Waiver Eligibility Worksheet is 08/01/2011.	Medical Record(s) in the record 5) The Handicapping Condition(s) checked were not consistent with the Psychological and/or Medical Record(s) in the record. 6) The Handicapping Condition(s) checked were not consistent with the QSI report in the record 7) The Major Life Activities checked were not consistent with the Psychological and/or Medical Record(s) in the record 8) The Major Life Activities checked were not consistent with the QSI report in the record. 9) Incorrect or out of date Medicaid Waiver Eligibility Worksheet was in the file. 10) A complete Medicaid Waiver Eligibility Worksheet was not in the record.	

CMS ASSURANCE #2 - Service Plan

Participants have a service plan that is appropriate to their need and that they receive the services/supports specified in the plan

#	Performance Measure/Standard	Protocol	Not Met Reasons	Weights
3	Service/Support Plan includes supports and services consistent with assessed needs.	CMS Service Plan Sub-Assurance iBudget Handbook RECORD REVIEW/PROVIDER INTERVIEW NOTE: For the purposes of this standard, only the “current Support	1) The current Support Plan is not in the record for the entire period of review. 2) The current Support Plan	

		Plan" will be reviewed. This is defined as the Support Plan in effect at the time of the record review. • Review the current Support Plan to identify the supports and services. • Review the Support Plan, QSI report, Progress Notes, Behavioral Assessments & Functional Community Assessments (if applicable) and any other applicable supporting documentation in the central record to determine the assessed needs of the person receiving services. • Conduct a comparative review of documentation to determine if the supports and services indentified in the Support Plan are consistent with the assessed needs of the person receiving services. If PCR, ask the person receiving services to describe needs. Ask how the Support Coordinator has provided support to identify the needs.	included documentation related to some, but not all of the assessed needs. 3) The current Support Plan did not include documentation related to the assessed needs.	
4	Service/Support Plan reflects support and services necessary to address assessed risks.	CMS Service Plan Sub-Assurance iBudget Handbook RECORD REVIEW/PROVIDER INTERVIEW NOTE: For the purposes of this standard, only the "current Support Plan" will be reviewed. This is defined as the Support Plan in effect at the time of the record review. • Review the current Support Plan to identify the supports and services. • Review the Support Plan, QSI report, Progress Notes, and any other applicable supporting documentation in the central record to determine the assessed risks of the person receiving services. • Conduct a comparative review of documentation to determine if the supports and services indentified in the Support Plan are	1) The current Support Plan is not in the record for the entire period of review. 2) The current Support Plan included documentation related to some, but not all of the assessed risks. 3) The current Support Plan did not include documentation related to the assessed risks.	

		consistent with the assessed risks of the person receiving services. If PCR, ask the person receiving services to describe risks. Ask how the Support Coordinator has provided support to identify the risks.		
5	Service/Support Plan reflects the personal goals of the person receiving services.	CMS Service Plan Sub-Assurance iBudget Handbook RECORD REVIEW/PROVIDER INTERVIEW NOTE: For the purposes of this standard, only the "current Support Plan" will be reviewed. This is defined as the Support Plan in effect at the time of the record review. • Review the current Support Plan to identify the goals. • Review Support Plan, Progress Notes, emails, quarterly reviews when applicable, the annual report and any other applicable supporting documentation in the central record to determine whether: o Activities, supports and contacts contain information about working with the person receiving services to identify and define his/her goals. o When the person receiving services does not have a functional means of communication, look for documentation the Support Coordinator has obtained information and recommendations from the circle of supports of the person receiving services. • Compare the information identified in the record with the information reflected in the Support Plan to determine if the Support Plan reflects the personal goals of the person receiving services. If PCR, ask the person receiving services to describe goals. Ask	1) The current Support Plan did not reflect the person's goals. 2) Documentation did not reflect use of a Person Centered approach to determine the personal goals of the person receiving services. 3) Documentation did not reflect use of circle of supports in identifying the personal goals of the person receiving services. 4) Support planning process was driven primarily by circle of supports instead of the person receiving services.	

		how the Support Coordinator has provided support to identify the goals.		
6	The Support Plan was distributed to the person receiving services and/or legal representative and providers within the required timeframes.	CMS Service Plan Sub-Assurance iBudget Handbook RECORD REVIEW Review the signature page of the Support Plan or other supporting documentation in the central record to determine if the Support Plan was: • Provided to the person receiving services/legal legal representative within 10 calendar days of the effective date; • Provided to service provider(s) within 10 calendar days of the effective date; and • If eligible for extension in 7/2011 – 9/2011, the Support Plan was distributed by the appropriate extended due date as identified in APD Memos granting the extension(s). (Memo 6/8/11). Refer to APD memos for specifics. If the Support Plan was not in the record at all, score this standard N/A.	1) No documentation was available to show the Support Plan was distributed to the person receiving services within 10 calendar days of effective/extension date. 2) No documentation was available to show the Support Plan was distributed to the legal representative within 10 calendar days of effective/extension date. 3) No documentation was available to show the Support Plan was distributed to the providers within 10 calendar days of effective/extension date.	
7	The current Support Plan includes natural, generic, community and paid supports for the person receiving services.	CMS Service Plan Sub-Assurance iBudget Handbook RECORD REVIEW/PROVIDER INTERVIEW NOTE: For the purposes of this standard, only the "current Support Plan" will be reviewed. This is defined as the Support Plan in effect at the time of the record review. Funding sources shall be accessed to include but not be limited to the following in this order: 1. Natural and community supports;	1) The current Support Plan did not identify non-waiver supports the person receiving services receives.	

		2. Third Party Payer, such as private insurance; 3. Medicare; 4. Other Medicaid programs; and 5. iBudget Florida, which is the payer of last resort. • Ask the Support Coordinator to describe natural, generic, community, and paid resources that are included in the circle of support for the person receiving services. • Review the current Support Plan to determine if natural, generic, community and paid resources apart from the iBudget Waiver are identified. If PCR, ask the person receiving services about supports received that are not paid for through the iBudget Waiver. If the Support Plan was not in the record at all, score this standard N/A.		

8	Service/Support Plan is updated within 12 months of recipient's last Service/Support Plan.	CMS Service Plan Sub-Assurance
		iBudget Handbook
		RECORD REVIEW
		
		• Review the Central Record for the Support Plan(s) effective during the entire review period.
		
		Determine if:
		• A complete Support Plan is present for each month billed by the WSC for the entire period of review.
		• Directions on the APD Support Plan form are followed for each section and each section is completed.
		• Support Plan must include:
		  • Personal Attributes/Future View page
		  • Life Area page
			1) The complete Support Plan was not in the record for entire period of review.
			2) The complete Support Plan was in the record, but not for the entire period of review.
			3) The Support Plan was not signed and dated by the person receiving services/legal representative.
			4) The Support Plan was not signed and dated by Support Coordinator.
			5) The Support Plan was not signed by the legal	

		• Health Summary page • Personal Goal page • The signature page which must include : ▪ Dated signature of the person receiving services; ▪ Dated signature of the parent/legal representative if the person receiving services is a minor; ▪ Dated signature of the legal representative /Guardian Advocate if the person has one;(Verify via Probate Court documents) ▪ Dated signature of a witness if the person receiving services was unable to sign or signed using a mark; and ▪ Dated signature of the WSC. Per APD memo dated Jun 8th, 2011, July 2011 – June 2012 Support Plans could be updated by the WSC with input from the person, legal representative and providers without having a formal Support Plan meeting (by phone or face to face). • The new Support Plan can be updated by notation on the current Support Plan. • The review/update must be completed at least 20 days prior to the effective date unless granted an extension by APD in writing. • The WSC must document the update of the Support Plan in the Progress Notes. • The signature of the person receiving services and if applicable, the legal representative should be obtained at the next face to face meeting. **This standard is subject to potential recoupment.**	representative and efforts to obtain signature were not documented. 6) The Support Coordinator indicated the person receiving services is unable to sign but did not document this on the Support Plan. 7) The person receiving services was unable to sign, but a witness did not sign. 8) The Support Plan was developed/updated after the extension due date. 9) The Progress Note(s) for the Support Plan developed July 2011 – June 2012 do not document input from the person receiving services, legal representative and providers. 10) The Support Plan developed July 2011 – June 2012 was not signed and dated by the person receiving services at the next face to face contact. 11) The WSC indicated that the person receiving services has a Guardian, but paperwork was not present to confirm guardianship.	

Service Specific Record Review – Support Coordination

9	Service/Support Plan is updated/revised when warranted by changes in the needs of the person receiving services.	CMS Service Plan Sub-Assurance iBudget Handbook RECORD REVIEW/PROVIDER INTERVIEW NOTE: For the purposes of this standard, only the "current Support Plan" will be reviewed. This is defined as the Support Plan in effect at the time of the record review. • Ask the Support Coordinator to describe the process used to update/revise the Support Plan and how discussions are held to determine if the person receiving services has had a change in needs. • Review Support Plan, QSI, Progress Notes, emails, Behavioral reports, Incident reports, Medical reports, quarterly reviews when applicable, the annual report and any other applicable supporting documentation in the central record to determine whether: o Activities, supports and contacts contain information about changes in the needs of the person receiving services. o When the person receiving services does not have a functional means of communication, look for documentation the Support Coordinator has obtained information and recommendations from the circle of supports of the person receiving services. o If any changes in the needs of the person receiving services are noted, review the applicable Support Plan to see if it has been updated/revised accordingly. • If no changes in needs were warranted for the entire period of review, score as N/A. If PCR, ask the person receiving services to describe needs. Ask	1) The complete Support Plan was not in the record for entire period of review. 2) The Support Plan did not include updates or revisions when needs of the person receiving services changed.	

		how the Support Coordinator has provided support to identify the needs.		
10	Services are delivered in accordance with the Service/Support Plan, including type, scope, amount, duration, and frequency specified in the Service/Support Plan.	CMS Service Plan Sub-Assurance iBudget Handbook RECORD REVIEW Since the Support Coordinator's role includes the coordination of services and supports this standard applies to all the services identified on an approved Cost Plan. • Review the current Cost Plan & Service Authorizations to determine type scope, amount, duration and frequency of approved services. • Review record including claims to determine if services are being rendered as approved. If Applicable: • Ask the WSC about any services not being rendered as approved. • If WSC indicates service is not being provided due to lack of available providers or choice of individual/family review for documentation in the record showing WSC's efforts to address. • If documentation supports WSC's reasons for service(s) not being rendered as approved score as Met. If PCR, ask the person receiving services if they are receiving all services approved on their Cost Plan. If any services are not being received/used as approved inquire about reason.	1) One or more services are not being delivered as approved.	

Service Specific Record Review – Support Coordination

11	The Support Coordinator supports the person receiving services to make informed decisions regarding choice of iBudget services & supports.	CMS Service Plan Sub-Assurance iBudget Handbook RECORD REVIEW/PROVIDER INTERVIEW • Ask the provider to describe method used to educate, solicit and document how the person receiving services makes the choice of services & supports. • Ask the provider for examples of how ~~they supported~~ the person receiving services made informed decisions regarding choice of services & supports. • Review file for documentation reflecting the provider's efforts. If PCR, ask person receiving services how they were supported to make informed decisions regarding choice of services & supports.	1) There was no documentation or documentation did not reflect efforts to support/assist the person receiving services to make informed decisions regarding choice of services & supports. 2) Documentation indicated provider was making informed decisions about services and supports with little to no input from the person receiving services. 3) Provider could describe, but did not document education related to making informed decisions.	
12	The Support Coordinator supports the person receiving services to make informed decisions regarding choice among iBudget service providers.	CMS Service Plan Sub-Assurance iBudget Handbook RECORD REVIEW/PROVIDER INTERVIEW • Ask the provider to describe method used to educate, solicit and document how the person receiving services makes the choice among service providers. • Ask the provider for examples of how they supported the person receiving services to make informed decisions regarding choice among service providers. • Review file for documentation reflecting the provider's efforts. If PCR, ask person receiving services how they were supported to make informed decisions regarding choice among service providers.	1) There was no documentation reflecting efforts to support/assist the person receiving services to make informed decisions regarding choice among service providers. 2) Documentation indicated provider was making informed decisions about service providers with little to no input from the person receiving services. 3) Provider could describe, but did not document education related to making informed decisions.	

Service Specific Record Review – Support Coordination

13	Person receiving services is given a choice of waiver services or institutional care at least annually.	CMS Service Plan Sub-Assurance iBudget Handbook RECORD REVIEW Review the Medicaid Waiver Eligibility Worksheet(s) for Support Plan(s) effective during the review period to ensure Section IV is complete including: • A mark indicating the choice of the person receiving services; • The dated signature/mark of the person receiving services; • The dated signature of the legal representative, if applicable; • If the person receiving services uses a mark for a signature, the dated signature of a witness; and • Printed name and relationship to the person if signed by the legal representative or witness.	1) The complete Medicaid Waiver Eligibility Worksheet is not in the record for the entire period of review. 2) The complete Medicaid Waiver Eligibility Worksheet is in the record but not for the entire period of review. 3) Section IV. Choice is not marked. 4) The dated signature of person receiving services is not present. 5) The dated signature of the legal representative is not present. 6) The dated signature of the witness is not present. 7) The relationship and printed name of the legal representative or witness is not present. .	
14	All iBudget services identified in the Service/Support Plan are listed on the approved the Cost Plan.	CMS Service Plan Sub-Assurance iBudget Handbook RECORD REVIEW • Review the Support Plan to determine iBudget services designated to assist person towards achieving their goals. • Review the Cost Plan to determine services approved. Determine if: • All iBudget services identified in the Support Plan on the approved Cost Plan.	1) All approved services on the Cost Plan are not identified in the Support Plan.	

15	Current, accurate and approved service authorizations were issued to provider(s).	CMS Service Plan Sub-Assurance iBudget Handbook 2-13, 3-7, 3-19, 4-103 Review Support Plan(s) and Cost Plan(s) to identify services approved for the review period under review and to determine if: • Service authorization(s) are available for the entire period of review. • Service authorization(s) are in approved status. • The correct rates are on the service authorizations o Refer to the APD Provider rate table as needed. (add date of current approved rate table) • Service authorizations are provided quarterly or more frequently as changes dictate. Note: Hardcopies of the Service Authorizations do not need to be in the record; WSC simply needs to be able to show for each approved service on the Cost Plan that there is an accurate approved Service Authorization in the system and it is was sent to the provider.	1) There was no documentation indicating when/how service authorizations were issued for current Support Plan/Cost Plan. 2) One or more service authorizations were not issued for current Support Plan/Cost Plan. 3) Rates were not correct on one or more service authorization for current Support Plan/Cost Plan.	

CMS ASSURANCE #3 - Qualified Providers

Waiver providers are qualified to deliver services/supports

#	Performance Measure/Standard	Protocol	Not Met Reasons	Weights

CMS ASSURANCE #4 - Health and Welfare

Participants' health and welfare are safeguarded and monitored

#	Performance Measure/Standard	Protocol	Not Met Reasons	Weights
32	The Support Coordinator	CMS Assurance - Health and Welfare	1) Documentation indicated	5

	monitors to ensure the person's health and health care needs are addressed.	iBudget Handbook RECORD REVIEW/PROVIDER INTERVIEW • Ask the Support Coordinator to describe the method used to gain knowledge of person's health needs. • Review file for documentation of gaining knowledge of person's health needs. • Ask the Support Coordinator for person specific heath needs. • Ask the Support Coordinator how the person's health and health care needs have been addressed. • Look for the Support Coordinators method for gathering information concerning doctor visits for preventative, annual and specific health care needs. • Review Progress Notes and other related health care documentation to determine if the health and healthcare needs of the person receiving services are being addressed. • For a person receiving Full Support Coordination health issues should be reviewed and education provided at a minimum of 2x a year. • For a person receiving Limited Support Coordination health issues should be reviewed and education provided at a minimum of 1x a year. If PCR, ask person receiving services how the Support Coordinator has assisted in addressing personal health care needs.	Support Coordinator was aware of but had not addressed the person's health and health care needs. 2) The Support Coordinator was not aware of the person's health and health care needs. 3) The Support Coordinator's documentation did not show how the WSC advocated for the person to receive preventative health care screenings in past 12 months. 4) The Support Coordinator had not advocated for the person to receive annual physicals and/or needed specialists visits or reports. 5) The Support Coordinator did not document follow up on medical doctor visits, results, medication changes, etc. 6) No medical records were in the file and there was no documentation showing Support Coordinator's efforts to obtain medical information.	

Service Specific Record Review – Support Coordination

33	The Support Coordinator monitors to ensure person's safety needs are addressed.	CMS Assurance - Health and Welfare iBudget Handbook RECORD REVIEW/PROVIDER INTERVIEW • Ask the Support Coordinator to describe the method used to gain knowledge of person's safety needs. • Review file for documentation of gaining knowledge of person's safety needs. • Ask the Support Coordinator for person specific safety needs. • Ask the Support Coordinator how she has addressed the person's safety needs. • Look to see if safety issues arose and how they were addressed, was there follow through? • Review Progress Notes and Support Coordinator's documentation of safety needs to determine if the person's safety needs are being addressed. • For person receiving Full Support Coordination safety issues should be reviewed and education provided at a minimum of 2x a year. • For a person receiving Limited Support Coordination safety issues should be reviewed and education provided at a minimum of 1x a year. If PCR, ask person receiving services how the Support Coordinator has provided education on safety needs in relation to natural disasters, community safety and home safety.	1) Documentation indicated Support Coordinator was aware of but had not addressed the person's safety needs and safety skills. 2) Documentation indicated Support Coordinator was not aware of the person's safety needs and safety skills. 3) The Support Coordinator had not advocated for the person to receive additional education/training in the area of safety. 4) The Support Coordinator did not document follow up on safety issues.	5
34	The Support Coordinator assists the person receiving services to define abuse, neglect, and exploitation including how the person receiving services would	CMS Assurance - Health and Welfare iBudget Handbook RECORD REVIEW/PROVIDER INTERVIEW • Ask the Support Coordinator to describe the process used to gather information on how the person receiving services	1) The Support Coordinator had no knowledge of the definition of abuse, neglect, and/or exploitation for the person receiving services. 2) The Support Coordinator had no	5

	report any incidents.	defines abuse. • Ask the Support Coordinator how the person receiving services would report abuse if it were to occur. • Ask the Support Coordinator how the person receiving services has been educated on the definition of abuse neglect and/or exploitation. • Review the Support Plan, Progress Notes and other documentation for documentation on the person's definition of abuse. • Review the Support Plan, Progress Notes and other documentation for documentation on education the Support Coordinator has provided regarding abuse, neglect and/or exploitation. If PCR, ask the person receiving services for a definition of abuse, neglect, and exploitation, how it would be reported, and if the Support Coordinator has provided education and discussion on the topic.	knowledge of how the person receiving services would report any incidents of abuse, neglect, and exploitation. 3) Documentation did not indicate efforts to provide education to the person receiving services in this area. 4) Documentation indicates only limited attempts to provide education on abuse, neglect, and exploitation to the person receiving services in the past 12 months, other than a sign off at the annual Support Plan meeting.	

CMS ASSURANCE #5 - Financial Accountability

Claims for waiver services are paid according to state payment methodologies

#	Performance Measure/Standard	Protocol	Not Met Reasons	Weights
35	Support Coordinator is in compliance with billing procedures and the Medicaid provider agreement.	CMS Assurance – Financial Accountability iBudget Handbook 3-6, 3-19, 4-103 RECORD REVIEW Provider is not to bill for services prior to billing. • Review Claims data • Review dates on Progress Notes	1) Provider billed for services prior to completing/documenting minimum contacts for one month. 2) Provider billed for services prior to completing/documenting minimum contacts for 2-11 months.	

		• Determine whether or not minimum contact requirements were met prior to billing for each month in the review period.	3) Provider billed for services prior to completing/documenting minimum contacts for the entire period of review.	
36	Progress Notes reflect required monthly contact/activities and are in the record.	CMS Assurance – Financial Accountability iBudget Handbook 4-104 RECORD REVIEW For Full support coordination: At a minimum, two billable contacts with or activities on behalf of an individual each month in order to bill Medicaid. For persons in supported living, the provider must conduct monthly face to face visits with a face to face being in the home of the person receiving services at least once every three months. This face to face visit will include a supported living quarterly review. The support coordinator will also conduct at least one other billable activity on behalf of the person receiving services each month. *Individuals receiving supported living services must receive at least full support coordination.* If the person lives in the family home, the face to face contact with the individual in the residence is required every six months for full support coordination and once a year for limited support coordination. For full support coordination, the provider must conduct a face to face visit every three months and have at least one other billable activity. For limited support coordination, the provider must conduct two face to face visits annually and at least one billable contact per month. o The family of the person receiving services may not waive the required visit in the home. For persons residing in a licensed residential facility, the provider	1) Progress Notes for person residing in a licensed residential facility did not include face-to-face contact every month for one or more months. 2) Progress Notes for person residing in a licensed residential facility did not include a home visit contact every three months for one or more months. 3) Progress Notes for person residing in a Supported Living setting did not include face-to-face contact every month for one or more months. 4) Progress Notes for person residing in a Supported Living setting did not include a home visit contact every three months for one or more months. 5) Progress Notes for person residing in a Supported Living setting did not document if the Support Coordinator scheduled and conducted the Supported Living Quarterly meeting for one or more quarters. 6) Progress Notes for person living	

		must conduct face to face visits monthly with a face to face visit being in the individual's place of residence every three months. *Individuals residing in licensed residential facilities must receive at least full support coordination.* For persons residing in their own home and considered to be in an independent living situation, the provider must conduct face to face visits in the individual's place of residence every six months. Face to face contact every three months should occur in a variety of locations. For persons living in the family home, face to face contact with the person receiving services in the residence is required every six months for full support coordination and once a year for limited support coordination. For full support coordination, the provider must conduct a face to face visit every three months and have at least one other billable activity. For limited support coordination, the provider must conduct two face to face visits annually and at least one billable contact per month. One face to face visit must be in the home. For persons preferring Enhanced support coordination, the reason must be specified in the support plan. The individual will receive two face to face visits monthly and at least two additional billable activities. For persons requiring enhanced support coordination for transition purposes, the individual will receive weekly face to face contact visits for the first month after transition to community-based services with one other billable contact. After that month, the visits will be two face to face visits monthly along with at least two other billable contacts monthly. This service delivery format will continue as long as Enhanced Support Coordination is needed but at a minimum of three months following transition.	in his/her own home did not include a home visit contact every three months for one or more months. 7) Progress Notes for person residing in a family home did not include face-to-face contact at least once every three months. 8) Progress Notes for person residing in a family home did not include a home visit contact at least once every six months for one or more times. 9) Progress Notes for person receiving Full Support Coordination did not document at least one other contact or activity per month for one or more months. 10) Progress Notes for person receiving Limited Support Coordination did not document at least one contact or activity per month for one or more months. 11) Progress Notes for person receiving Limited Support Coordination did not include at least two face-to-face contacts per year, with a minimum of one contact being in the person's home.	

		The purpose of the face to face visit is to discuss progress/changes to the individual's goals, status of any resolved issues and satisfaction with current supports received. Each visit should be viewed as an opportunity to give or receive meaningful information that can be used to more effectively assist the individual with achieving goals. Face to face contacts shall relate to or accomplish one or more of the following: 1. Assist the individual to reach individually determined goals on the support plan, including gathering information to identify outcomes; 2. Monitor the health and well-being of the individual 3. Obtain, develop and maintain resources needed or requested by the individual to include natural supports, generic community supports and other types of resources. 4. Increase the individual's involvement in the community; 5. Promote advocacy or informed choice for the individual and/or; 6. Follow up on unresolved concerns or conflicts. ***Allowable Activities for Billing*** Support coordinators must conduct at least one other contact or activity on behalf of the individual each month. These contacts or activities are not merely incidental, but are planned and shall related to or accomplish those items listed above in 1-6 above. These contacts may be with the individual or with persons important to his life including family members, legal representatives, service providers, community members, etc. and can be via telephone, letter writing or email transmission. Any contact or activity on behalf of the individual must be documented in the support coordination notes. The contacts must be individualized and related to services and benefits specific to the person receiving services. Administrative activities such as typing	12) Progress Notes for person receiving Transitional Support Coordination did not include at least weekly face-to-face contacts for first 30 days following discharge. 13) The provider billed for services that were not billable (i.e. leaving messages, scheduling meetings or contacts) for one or more months. 14) The provider billed for services before the required contacts were rendered for one or more months. 15) Progress Notes were not in the file for one or more months.	

		letters, filing, mailing or leaving messages shall not qualify as contacts or activities; nor do calls to schedule meetings, setting up face to face visits or scheduling meetings with the individual's employer, family, providers, etc. Any activity or contact requested by APD on behalf of the individual is counted as a billable activity and should be documented in the support coordination notes. At times, APD issues memos that waive face-to-face contact requirements for Support Coordinators for one or more months to accommodate specific assignments. If a home visit or Supported Living Quarterly is required in the waived month, the Support Coordinator does not need to make this up immediately following the end of the extension. The contact should be made based on when it would be due again had the Support Coordinator completed it in the month waived. • For example: Face to Face contacts are waived for the month of December 2010. If a home visit for someone in Supported Living is due in December but is now waived, the next home visit will not be due until March 2011. The WSC is still expected to make face to face contact with the person if it is needed for health or safety reasons. **This standard is subject to potential recoupment.**		

CMS ASSURANCE #6 - Administrative Authority

The State Medicaid agency is involved in the oversight of the waiver and is ultimately responsible for all facets of the program

#	Performance Measure/Standard	Protocol	Not Met Reasons	Weights