COLORADO
Department of Health Care Policy & Financing

Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

July 1, 2016

The Honorable Millie Hamner, Chair
Joint Budget Committee
200 East 14th Avenue, Third Floor
Denver, CO 80203

Dear Representative Hamner:

Enclosed please find the Department of Health Care Policy and Financing's statutory report to the Joint Budget Committee regarding conflict-free case management services within the Medicaid waivers for people with intellectual and developmental disabilities.

Section 25.5-6-409.3 (5), C.R.S., requires the Department to develop a plan for the delivery of conflict-free case management services that complies with the federal regulations relating to person-centered planning with input from community-centered boards, single-entry point agencies, and other stakeholders by July, 1, 2016.

Attached with this letter is the Department's plan for complying with conflict-free case management in Colorado. The plan lays out three phases for implementing conflict-free case management and the work to be conducted in each phase. Additionally, the plan has six appendices, which are additional reports of work conducted to develop the final plan.

The attached report identifies that funding may be needed in the future related to transitioning to conflict-free case management. The Department has existing appropriations that will be used in support of the planning activities in this report, and the Department is not requesting additional funding for these activities at this time. If the Department identifies specific needs for additional resources, it would use the regular budget process in the future to request funding.

If you require further information or have additional questions, please contact the Department's Legislative Liaison, Zach Lynkiewicz, at Zach.Lynkiewicz@state.co.us or 720-854-9882.

Sincerely,

Susan E. Birch, MBA, BSN, RN
Executive Director

Enclosure(s): 2016 HCPF Report on Conflict-Free Case Management to the Joint Budget Committee

Cc: Senator Kent Lambert, Vice-chair, Joint Budget Committee
Representative Bob Rankin, Joint Budget Committee
Representative Dave Young, Joint Budget Committee
Senator Kevin Grantham, Joint Budget Committee
Senator Pat Steadman, Joint Budget Committee
John Ziegler, Staff Director, JBC
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Rachel Reiter, External Relations Division Director, HCPF
Zach Lynkiewicz, Legislative Liaison, HCPF

Colorado Department of Health Care Policy and Financing

Colorado Conflict-Free Case Management for Home and Community Based Services

Implementation Plan

(House Bill 15-1318)

July 1, 2016

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NAVIGANT

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I. Executive Summary

This report discusses the results of a collaborative effort to create a roadmap for how to implement conflict-free case management (CFCM) in Colorado. Navigant worked together with individuals with intellectual and developmental disabilities (I/DD), their families and guardians, advocates, Community Centered Boards (CCB), Single Entry Points (SEPs), service providers, and the Colorado Department of Health Care Policy and Financing (Department) to create a plan that complies with federal regulations and meets Colorado's needs.

In March 2014, the Centers for Medicare and Medicaid Services (CMS) implemented a final rule requiring states to separate case management from service delivery functions to reduce conflict of interest for services provided under home and community-based services (HCBS) waivers. This rule addresses conflicts of interest that may arise when one entity is responsible for both performing case management functions and providing direct services. As a result of these federal regulations, Colorado's existing system for its three HCBS waivers supporting individuals with intellectual and developmental disabilities (I/DD) is no longer compliant because case managers and direct service providers are currently part of the same organization. Community Centered Boards (CCBs) are currently the only entities in Colorado that conduct targeted case management (TCM) for the I/DD population, and most also provide or contract for direct services for individuals enrolled in the HCBS waivers.

To continue receiving federal funding for these waivers, Colorado must come into compliance with the CMS conflict-free case management (CFCM) regulations. Colorado *House Bill 15-1318* requires the Colorado Department of Health Care Policy and Financing (the Department) to develop a plan, with input from CCBs, Single Entry Point (SEP) agencies, and other stakeholders, for the delivery of CFCM that complies with federal regulations. As a result, the Department contracted with Navigant Consulting Inc. (Navigant) to assist with development of a CFCM implementation plan.

Overall, there was consensus among stakeholders that the Department should **prioritize maximizing individual choice** when determining future CFCM policies. The majority of stakeholders felt that the Department should **require CCBs to divest itself of either TCM or direct services** to eliminate the potential for conflicts of interest whenever possible, and that the **transition to CFCM should occur gradually**. Most stakeholders also believed that the Department should recruit **new case management agencies and direct service providers** to increase the number of choices for access point waiver individuals while also **preserving the quality of services available to individuals with I/DD**.

CFCM Recommendations for Colorado	Rationale for Recommendation
1) The Department and CCBs should actively work to recruit new case management agencies and direct service providers throughout the state, particularly in rural areas, to increase individual choice between existing and new case management agencies and providers.	✓ Increase freedom of choice ✓ Demonstrate efforts to increase provider availability before applying for CFCM exemptions in rural areas
2) In urban areas, CCBs must choose from one of the following options: a. CCBs operate as a case management agency only	✓ Provide CCBs with multiple options for complying with CFCM to choose the path that

CFCM Recommendations for Colorado	Rationale for Recommendation
(i.e., divests itself of direct services) b. CCBs operate as a direct service provider only (i.e., divests itself of TCM services) c. CCBs continue to provide both TCM and direct services, but never to the same individual d. CCBs discontinue providing services and TCM to Medicaid I/DD waiver individuals	best meets their needs ✓ Bring Colorado's CCB-based I/DD system into compliance with CFCM requirements
3) In rural areas where it has been determined that there are no other available case management agencies and direct service providers, CCBs should be allowed to continue providing both TCM and direct services, as long as appropriate safeguards are put in place to ensure that individuals have freedom of choice to the maximum extent possible. This option requires approval from the federal government in each rural area.	✓ Allow CCBs in rural areas to continue providing both TCM and direct services if there are no other available case management agencies or direct service providers in the geographic area
4) Certain administrative functions should be conducted only by case management agencies that do not provide any direct services to waiver participants or by third party entities that neither conduct TCM nor provide direct services.	✓ Eliminate conflict of interest when direct service providers conduct eligibility determinations, functional assessments and quality assurance activities ✓ Allow third party entities to conduct administrative functions; highly supported by CCBs

The recommended CFCM plan enables individuals to receive TCM services that address their preferences and desired outcomes without a real or perceived conflict of interest and gives CCBs four options for coming into compliance with CFCM. The plan allows the Department and CCBs up to five years to come into compliance with CFCM, including a planning, design and implementation phase. This timeframe accounts for expectations and feedback from stakeholders and considers the minimum time required to update the Colorado statutes. In addition, Department oversight and evaluation will occur throughout the transition process. Regular communication with individuals with I/DD and their families will be critical to a smooth transition, including opportunities for bi-directional feedback. In addition, the Department must conduct the following activities, which are discussed in further detail later in this report, to successfully transition to CFCM:

Regulatory and Policy Changes

- Conduct a cost impact analysis and develop a budget request for costs associated with CFCM
- Conduct assessment of Department staffing
- Review TCM processes and rates
- Consider waiver amendments for rural exception from CFCM
- Update statutes, state regulations, waiver applications and other policies as needed, including for CCB designations, TCM, administrative functions, Organized Health Care Delivery System (OHCDS) functions, and quality assurance functions.
- Develop trainings and technical assistance for existing CCBs and new providers and case management agencies about new policies and procedures
- Identify and plan for gaps in services

Case Management and Provider Network Development

- Conduct provider capacity study of case management and direct service provider supply
- Review and define CMA and direct service provider qualifications
- Enroll new case management agencies and direct service providers
- Develop procedures to faciliate freedom of choice when choosing case management agencies
- Develop ongoing outreach plan for providers
- Coordinate with CCBs on business continuity plans

Communication Priorities

- Establish a communication plan
- Update and maintain the existing Colorado CFCM website
- Hold public meetings as needed

Quality and Evaluation

- Develop a risk matrix to determine the lowest risk target groups to transition first
- Establish deadlines for CFCM transition
- Designate a Department project manager to oversee the CFCM transition
- Oversee CCB implementation of business continuity plans
- Conduct quality surveys

II. Introduction

In March 2014, the Centers for Medicare and Medicaid Services (CMS) implemented *42 CFR 431.301* requiring states to separate case management from service delivery functions, where possible, to eliminate conflict of interest for services provided under home and community-based services (HCBS) waivers. This rule addresses conflicts of interest that may arise when one entity is responsible for both case management functions and direct services. CMS provided examples of potential conflicts resulting from such arrangements, including:[1]

- Incentives for over- and under-utilization of services
- Possible pressure to steer individuals to their own service organization, rather than promoting freedom of choice
- Interest in retaining individuals as clients rather than promoting independence and honoring requested or needed service changes
- Difficulty in self-policing the performance of service providers within the same agency

State compliance with these regulations is essential because the federal government provides about half of Colorado's funding for programs that serve individuals with intellectual and developmental disabilities (I/DD). For Fiscal Year 2014-2015, Colorado received $200,366,246 from the federal government for direct services and case management to support individuals enrolled in these waiver programs, referred to as "access point waivers" throughout this report:

- Home and Community-Based Services Waiver for Persons with a Developmental Disability (HCBS-DD)
- Home and Community-Based Supported Living Services Waiver (HCBS-SLS)
- Home and Community-Based Services Children's Extensive Support Waiver (HCBS-CES)

To continue receiving federal funding for these waivers, Colorado must come into compliance with the conflict-free case management (CFCM) regulations. Colorado *House Bill 15-1318* requires the Colorado Department of Health Care Policy and Financing (the Department) to develop a plan, with input from Community Centered Boards (CCBs), Single Entry Point (SEP) agencies, and other stakeholders, for the delivery of CFCM that complies with federal regulations. As a result, the Department has contracted with Navigant Consulting Inc. (Navigant) to assist with development of such a CFCM implementation plan.

In Colorado, CCBs have served for more than 50 years as the access point for services, including the HCBS-DD, SLS and CES waivers, for individuals with I/DD. The Department contracts with 20 CCBs throughout the state; these organizations exclusively function to determine eligibility for waiver services, provide targeted case management (TCM), and either directly provide or subcontract services and supports for individuals with I/DD.

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[1] See CMS, "Conflict of Interest in Medicaid Authorities," (January 2016). Available online: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/downloads/conflict-of-interest-in-medicaid-authorities-january-2016.pdf

CCBs currently serve as a "one-stop shop" for individuals with I/DD in Colorado, and have developed strong relationships with individuals and their families, service providers, local employers and community resources. However, as a result of the 2014 federal HCBS regulations, Colorado's existing system is no longer compliant because case management and direct services are often offered by the same organization, and because CCBs are the only entities in Colorado that currently provide TCM for the I/DD population. The Department estimates that roughly 50 percent of those currently enrolled in I/DD access point waivers receive services from a CCB that has a conflict of interest, and will be directly affected by the regulation change.

The CCBs provide services to other groups as well. In addition to serving the I/DD population, some CCBs also provide services and supports for other HCBS waivers, including the HCBS-Children with Autism waiver and the Children's HCBS (C-HCBS) waiver. CCBs provide services to veterans and individuals with brain injury, and offer Early Intervention services for infants and toddlers with delays in development. Given the diverse populations CCBs serve and the varied sources of funding they receive, the Department must consider all of these factors when bringing the Colorado I/DD system into compliance with the federal regulations for CFCM.

The Department requested that Navigant determine the best options for carrying out CFCM implementation in four separate steps:

1. Desk reviews to determine CCB functions and financials
2. On-site review of the CCBs
3. Stakeholder meetings to collect feedback on the draft implementation plan
4. Development of the final recommended implementation plan

In addition to holding our own stakeholder meetings and CCB on-site reviews, we were asked to consider input from multiple sources when developing the implementation plan: the Department provided a summary of 15 town hall meetings facilitated by the Department, where individuals, families, guardians, advocates, SEPs, and other providers provided input on how the Department should comply with the regulation. The Department also provided a summary of six meetings between the Department and the CCBs, facilitated by Public Knowledge LLC.

In total, we received a wide range of views from members of the Colorado I/DD community (individuals with I/DD, their families and guardians, advocates, non-CCB providers and CCBs) regarding the potential CFCM compliance options reflected throughout this report, which form the basis for the final recommendations. Overall, there was consensus that the Department should prioritize maximizing individual choice and preserving quality of services and case management when determining future CFCM policies. Some stakeholders felt that the Department should require a CCB to divest itself of either TCM or direct services to eliminate potential conflicts of interest, and that the transition to CFCM should occur gradually. Most stakeholders agreed that new case management agencies and direct service providers should be allowed to enter the markets to increase the number of choices for access point waiver individuals to choose from.

The Department must have a plan for CFCM compliance that meets the needs of Colorado's I/DD population and is responsive to stakeholder desires for increased choice and person-centered approaches. Such approaches were identified by the Community Living Advisory Group and the Community Living Plan (Colorado's response to the Olmstead decision) as a priority for Colorado's Long-Term Services and Supports. Therefore, the recommendations presented in this report were developed with the following goals in mind:

a) Empowering individual choice

b) Preserving the relationships developed by CCBs and their roles in the communities they serve

c) Complying with federal regulations

Clarification of Commonly Used Terms

Below are definitions of terms commonly used throughout this implementation plan.

Person-centered planning: Incorporates information about interests, relationships, preferences, strengths and outcomes desired for his/her life as a result of long term services and supports (LTSS). Service planning processes are focused on the concept of person-centeredness. According to *42 CFR 441.301(c)(1)*, CMS has issued new guidelines about person-centered planning process as following:

1. Assures the individual will lead the person-centered planning process
2. Allows the individual's representative to have a participatory role
3. Includes people chosen by the individual
4. Gives individuals the necessary information and support to ensure they are directing the process
5. Offers informed choices to the individual
6. Includes a method for the individual to request updates to the plan
7. Includes conflict of interest provisions, if such exists, such as conflict of interest in case management
8. Results in a person-centered service plan

Choice: Allows individuals to have full freedom of choice in types of waiver providers, supports and services except where the program has authorized restrictions, such as in managed care.[2] Case managers are responsible for helping the individual and family become well informed about all choices that may address the needs and outcomes identified in the person-centered service plan.

Rural exception: According to federal regulations, CMS only allows exceptions to CFCM requirements when a state "demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS." If CMS approves the rural exception criteria, the State must still demonstrate to CMS how the State will mitigate the conflict of interest issues.

[2] Centers for Medicare and Medicaid Services, Conflict of Interest in Medicaid Authorities, Presented on January 13, 2016, https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/downloads/conflict-of-interest-in-medicaid-authorities-january-2016.pdf

III. Background

Federal HCBS Regulations for Conflict-Free Case Management

The 2014 federal HCBS regulations provide the regulatory framework that drives CFCM implementation for the Department. *42 CFR 441.301(c)(1)(vi)* states:

> *"Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS. In these cases, the State must devise conflict of interest protections including separation of entity and provider functions within provider entities, which must be approved by CMS. Individuals must be provided with a clear and accessible alternative dispute resolution process."*

The regulation became effective as of March 17, 2014, requiring all states receiving Medicaid funding for HCBS waivers to become compliant to this rule. According to CMS, "conflict occurs not just if they are a provider, but if the entity has an interest in a provider or if they are employed by a provider."[3] When a conflict of interest is present under a 1915(c) HCBS waiver, regulations require states to:

1. Demonstrate to CMS that the only willing and qualified case manager is also, or affiliated with, a direct service provider
2. Provide full disclosure to participants and assurances that participants are supported in exercising their right of free choice in providers
3. Describe individual dispute resolution process
4. Assure that entities separate case management and service provision (different staff)
5. Assure that entities provide case management and services only with the express approval of the state
6. Provide direct oversight and periodic evaluation of safeguards

These are the minimum requirement from CMS; states are allowed to impose additional guidelines.

Based on these requirements, Colorado's CCBs are out of compliance and have the following potential conflicts:

- Developing service plans for which the CCB is the provider of the direct services
- Using the provider selection process to steer low-cost participants to CCB services and high-cost participants to other providers

[3] Centers for Medicare and Medicaid Services, Conflict of Interest in Medicaid Authorities, Presented on January 13, 2016, https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/downloads/conflict-of-interest-in-medicaid-authorities-january-2016.pdf

- Using service planning or the provider selection process to steer participants toward CCB services in order to fill service openings
- Unconsciously steering participants toward CCB services because they are more familiar
- Case managers could be responsible for settling grievances and monitoring direct services provided by fellow CCB staff members.

Colorado's Past Work Towards Conflict-Free Case Management

Prior to CMS's issuance of the CFCM regulations, the Department had been pursuing CFCM in Colorado for almost a decade. At the request of the Department, the University of Southern Maine issued a report in December 2007 titled "Addressing Potential Conflicts of Interest, Arising from the Multiple Roles of Colorado's Community Centered Boards." This report pointed out several potential conflicts for CCBs as they carry multiple roles for individuals, and highlighted the following examples:

- As a case management agency, the CCB has the opportunity to act in its own self-interest when developing the individualized service plan and overseeing the selection of providers. If the CCB is also a direct service provider, the CCB has the opportunity to provide referral information that favors its own service offerings rather than other service providers.
- Because CCBs are responsible for evaluating provider performance and conducting quality assurance functions, they can make decisions that favor their own provider agency when hearing officers are tasked with resolving disputes and grievances between the CCB-owned provider agency and an individual. Case managers have the opportunity to dissuade complaints against CCB provider agencies and suppress individual complaints and allegations of abuse and neglect. Lastly, CCBs could hold themselves to a lower service standard than its competitors due to a case manager's potential reluctance to challenge the performance of co-workers who are employed on the provider side of the CCB.
- As the current single entry point for the access point waivers, CCBs have the opportunity to influence and control eligibility criteria.

In 2010 the Department convened a Conflict of Interest Task Force as a result of the State Auditor's Office 2009 Audit. This task force included 24 members comprised of 6 self/family advocates, 4 advocacy agencies, 4 service providers, 1 SEP, 5 CCBs and 4 departmental representatives. The 2010 task force provided 11 recommendations to address areas subject to potential conflicts of interest. The recommendations that had full consensus from the task force included:

- Remove responsibility for eligibility determinations from service providers by using SEPs or similar system of entities contracting with the state
- Remove waitlist responsibility from service providers
- Create a uniform, criteria-based and transparent process for assisting individuals with provider selection
- Require unbiased entity to conduct incident investigations
- Establish an independent third party to handle complaints about quality of services and appeals of decisions affecting services

- Conduct a comprehensive fiscal analysis of these recommendations prior to implementation

In 2014, the Department convened a task group of stakeholders to make recommendations for implementing case management agency choice, and to make recommendations for a CFCM system when the final rule from CMS became effective. The group reached consensus on the definition of a case management agency and its role in a CFCM system. The Task Force also made some non-consensus recommendations to resolve the conflict of interest, including the following:

- Case management should exist in an agency entirely independent of an agency that provides direct services.
- There should be a co-existing option that allows for both case management and HCBS to be provided by the same entity. In this situation, the entity would not be permitted to provide HCBS and case management to the same individual.
- Put a robust informed choice process in place that allows an individual to opt out of CFCM protections.
- An exception process should anticipate the possibility of insufficient access to independent case management agencies when an individual resides in rural or underserved areas. If additional case management agencies emerge, it will increase individual choice and an exception will not be necessary. If no exception is granted, this allows for more case management agencies to emerge further increasing individual choice.

Despite these recommendations and reviews, the transition into CFCM has been difficult for Colorado, as stakeholders could not come to consensus on their recommendations to the Department.

Broad HCBS Reform Efforts in Colorado

Beyond complying with federal regulations for CFCM, Colorado is also pursuing changes to respond to stakeholder desires for increased choice and person-centered approaches throughout the entire HCBS system. In 2012, Governor John Hickenlooper issued an Executive Order to establish the vision that "all Coloradans—including people with disabilities and aging adults—should be able to live in the home of their choosing with the supports they need and participate in the communities that value their contributions." This executive order established the stakeholder-driven Community Living Advisory Group and the Office of Community Living to redesign how supports and services are delivered. The governor's Executive Order summarizes underlying principles leading to an overall vision for Colorado's system:

- Provide services in a timely manner with respect and dignity.
- Strengthen consumer choice in service provision.
- Incorporate best practices in service delivery.
- Encourage integrated home- and community-based service delivery.
- Involve stakeholders in planning and processes.
- Incorporate supportive housing.

Colorado has executed on this vision in recent years and continues to make progress toward

achieving the recommendations identified by the Community Living Advisory Group and the goals identified in Colorado's Community Living Plan (Colorado's response to the Olmstead decision), and the requirements and opportunities for person-centered supports and services presented in the final federal HCBS rule.

In addition, Colorado received a three-year federal grant in 2015 to create a No Wrong Door (NWD) system to streamline how consumers access long-term services and supports. The NWD will serve as the initial entry point for anyone in need of services and supports and will help consumers navigate the system and make decisions about services and providers. NWD entities will provide person-centered options counseling and assistance with gaining access to services and supports. The NWD system has potential to transform how consumers access services by creating one-stop shops for understanding all available options and providing help to determine the best path forward for individuals based not only on their needs, but also on their wants and desires.

Furthermore, the next phase of Colorado's Accountable Care Collaborative will integrate physical and behavioral health care by contracting with Regional Accountable Entities (RAEs) that will focus on coordinating whole person care. Potential exists within the RAEs to add another avenue for consumers to explore options and navigate new choices.

Existing CCB Environment in Colorado

Colorado has a complex, legacy system of financing services and supports for individuals with I/DD. For more than 50 years, CCBs have operated as "one-stop shops," designated by geographical location that work with individuals with I/DD to determine eligibility for services, create a service plan and help the individual obtain services. CCBs receive funding from many sources (e.g., the Colorado Department of Health Care Policy and Funding, Colorado Department of Human Services, local mill levies, fundraising), and provide services and supports for multiple federal and state programs: five Medicaid HCBS waivers (HCBS-DD, HCBS-SLS, HCBS-CES, HCBS-CWA, and the C-HCBS waiver), Early Intervention (Part C of the Individuals with Disabilities Education Act), and other services such as veteran's programs and services for individuals with brain injuries.

The access point waiver enrollment process begins with an assessment conducted by the CCB to determine whether the individuals are eligible to receive waiver services. If eligible for services, individuals seeking HCBS-DD waiver services are first placed on a waiting list due to funding constraints. Once an individual has enrolled in a waiver, his or her CCB case manager works with the individual to develop a person-centered service plan to meet daily and long-term needs. Services are provided either directly by the CCB, via a subcontracted service agency or by an approved Medicaid provider.

Current Colorado statute *Title 27, Article 10.5* outlines the requirements and definitions of CCBs. The existing statute allows a CCB to offer the following functions:

- **Administrative** functions include eligibility determinations, intellectual or developmental disability determinations, Supports Intensity Scale (SIS) assessments, Support Level determination, quality assurance functions, waitlist management activities and enrollment activities. Quality assurance activities include reviews and resolutions of complaints and grievances, Quality Improvement Strategy (QIS) activities and reporting, incident reporting and responses, establishment of a Human Rights Committee, and investigation and documentation of abuse, neglect and exploitation.

- **TCM** includes the initial comprehensive and periodic assessment of individual needs to determine the need for waiver services and supports; the development and periodic revision of a specific care plan that is based on the assessment, specifies the goals and needs of the individual, and specifies the activities and course of action to meet the individual's goals and service needs; referral and related activities to help an individual obtain the necessary services and supports; and monitoring and follow-up activities to ensure that the care plan is implemented and adequately meets the individuals' needs.
- **Organized Health Care Delivery System (OHCDS)** is a public or privately managed service organization that provides, at minimum, TCM and contracts with other qualified providers for services authorized in access point waivers.

  An OHCDS provides a mechanism for reimbursing qualified providers or contractors without requiring every contractor to enter into an agreement with the Department. As an OHCDS, CCBs are currently responsible for executing and maintaining a Medicaid Provider Agreement for all services available through the access point waivers, creating and maintaining documentation of all applicable provider qualifications for services rendered under the CCB's Medicaid Provider Agreement regardless of whether these services are rendered by the CCB's employees or by an independent subcontractor, and complying with *42 CFR 447.10*. Contractors and providers are not required to participate in an OHCDS, and providers who do not participate in an OHCDS have the option to submit claims to Medicaid directly.

IV. Methodology and Findings

We conducted four steps to develop the Colorado CFCM implementation plan, as shown below.

Figure 1. Steps to Develop the CFCM Implementation Plan

The first step was a "desk review" (gathering and analyzing existing information), which required collecting and reviewing documentation from CCBs. In step two, we used the desk reviews to propose five CCBs for on-site review and conducted those reviews. During the five on-site reviews, Navigant conducted a more detailed assessment of the CCB's financial information and observed how administrative, TCM and OHCDS functions operate at the five different CCBs.

Upon conclusion of the on-site reviews, we began step three and attended community stakeholder engagement meetings to obtain feedback on the proposed CFCM implementation plan from individuals, families, guardians, advocates, CCBs, providers, and other stakeholders. Step four was the development of a final report with a proposed plan for CFCM implementation. The report reflects the aggregated the findings from the first three steps, as well as stakeholder input the Department received during town hall meetings and

recommendations gathered from CCBs in 2016. We discuss each of the steps of work in greater detail below.

Step 1: Initial Data Gathering and Desk Review

To collect initial information from the CCBs, we created a cost survey and instructions to gather financial information about the administrative, TCM and OHCDS functions. We provided survey instructions and a set of commonly asked questions and answers to assist the CCBs in completing the survey. To understand how CCBs conduct administrative, TCM and OHCDS functions related to the three I/DD waivers in Colorado, we requested policies and procedures as well as job descriptions related to each of the functions. We also requested other financial documentation, such as audited financial statements and a working trial balance to help us understand the overall picture of CCB operations. With the data collected, we did the following:

1. Evaluated the revenue and costs associated with performing each of these functions
2. Evaluated each CCB's process for performing the aforementioned functions
3. Projected the impact (both financial and recipient impact) of separating these functions
4. Objectively reported the requested CCB information provided to the Department Leadership

This was the first time the CCBs were asked to allocate their revenue into administrative, TCM and OHCDS functions; therefore, we designed the survey to address possible variations in the way CCBs operate as well as how they report their revenue and expenses. We also encouraged the CCBs to submit a cover letter with their surveys to call to our attention any significant or distinct survey responses. We used the survey to capture revenue information to understand other revenue sources available to each CCB. We requested that CCBs specify, by function, the total revenue collected from Colorado Medicaid, federal sources, state sources, mill levy and any other source.

We also looked at organizational charts, job descriptions and policies and procedures to understand how each CCB performs its administrative, TCM and OHCDS functions.

Below is a summary of the findings from the CCB desk review. The details of desk review and on-site results report are located in Appendix A and Appendix E.

CCB Revenue

Navigant collected cost surveys for twenty CCBs as part of the desk review. In the surveys, CCBs accounted for costs and revenue related to administrative, TCM and OHCDS functions for fiscal year ending 2014. Survey results indicated the following:

- TCM and administrative functions combined accounted for less than 7 percent of total revenue for CCBs.
- TCM and administrative functions account for approximately 10 percent of total annual Medicaid dollars received by CCBs.
- CCBs receive the majority of their TCM and administrative revenue from Colorado Medicaid.
- CCBs earn the majority of their revenue for functions other than TCM and

administrative functions. Revenue sources varied across CCBs, and included revenue from access point waiver direct service provision, mill levy, and other services provided outside of the access point waivers (e.g., Early Intervention services). We did not review revenues and costs outside of the access point waivers.

During the desk reviews, we found that in general CCBs did not have documented policies and procedures for their OHCDS function, and were unsure how to account for the revenues gained through OHCDS in the cost survey. We had several conversations with the CCBs about what to include as OHCDS revenue during desk review and on-site reviews.

CCB Staff Roles in Administrative, TCM and OHCDS Functions

As part of the survey process, we requested CCBs to submit policy and procedures for their OHCDS functions and provide information about who performs administrative, TCM and OHCDS functions. During the on-site review with five CCBs, we clarified the staff roles and how each functions operated. Based on discussions with the CCBs, the following CCB roles were noted:

- CCB case managers are responsible for performing all administrative and TCM functions. These two functions are closely related and performing both allows the case manager to develop a relationship with individuals.
- CCB executive directors and/or finance directors are responsible for the OHCDS function, such as managing independent contractor agreements and ensuring contractors meet the Medicaid minimum standards.

Additional Documents Reviewed

In addition to the survey, the desk review included Department documents that reflected previously submitted input from various stakeholders, including individuals with I/DD, their guardians and family members, advocates, direct service providers, Single Entry Point (SEPs) agencies and CCBs. Table 1 lists the additional documents we reviewed in consideration of the implementation plan.

Table 1. List of the Additional Documents Reviewed

File Reviewed	Description of the File
Town Hall Meetings Summary (Appendix B)	Summary of CFCM comments from the 14 town hall meetings and 1 meeting with SEP agencies held during March 2016.
CFCM Implementation Plan Recommendations (Appendix C)	Summary of recommendations on CFCM implementation based on six separate meetings that Public Knowledge LLC facilitated between the Department and the CCBs.

Other State Research

In addition to reviewing CCBs, we researched other states to identify best practices for achieving CFCM within I/DD Medicaid waivers. We conducted telephone interviews with representatives from five states (Minnesota, Montana, Ohio, Virginia and Wyoming) and asked questions pertaining to case management and service delivery processes, state

oversight and current progress or future plans to transition to CFCM.

Similar to Colorado, Ohio and Virginia contract with regional boards to deliver services and provide case management. Ohio has developed a Corrective Action Plan (with CMS approval) to transition to CFCM by 2024 but Virginia has only had preliminary discussions about how to transition toward conflict-free case management.[4] In Minnesota, case management is provided by county or tribal employees, and these organizations do not provide other direct services; thus, their waiver is conflict-free. Montana's case management system is also conflict-free because agencies cannot provide both case management and direct waiver services to the same individuals. Lastly, Wyoming transitioned to a fully conflict-free system in 2015 by requiring that case management be provided by independent agencies that are prohibited from providing other direct services to the participants they serve. A summary of our state research can be found in Appendix D.

Step 2: On-Site Visits

From March 29, 2016 through March 31, 2016, two teams of two consultants from Navigant visited five CCB locations to speak with case managers, executive directors and financial staff members about CCB operations and CFCM options. Prior to the visits, we informed the CCBs of the premise of the site visit and encouraged them to invite individuals to the conversation who could speak about the information reported on the cost survey and how the functions are performed. During the visit, we led detailed discussions of cost survey responses, improved our understanding of TCM, administrative, and OHCDS functions, and gathered concerns and suggestions for the Department regarding options for CFCM compliance.

All CCBs we visited expressed concern for ensuring individual choice and about the lack of choices for individuals residing in rural areas of the state. In addition, all five CCBs were concerned about potential disruptions of service for existing waiver participants as a result of CFCM. Upon conclusion of the site visits, we reflected any needed changes to the cost survey responses in the desk review report and considered CCBs' concerns in our CFCM recommendations and proposed implementation plan. After detailed discussions with the CCBs, we summarized our findings in the on-site visit report, located in Appendix E.

Step 3: Stakeholder Engagement

Stakeholder input was an important part of the development of the final CFCM recommendations. The Department facilitated 15 town hall meetings in March 2016, where individuals, families, guardians, advocates, SEPs, and other providers provided input on how the Department should comply with the CFCM regulation, and Navigant held five stakeholder meetings in April 2016.

During the stakeholder meetings, we held a Q&A session in which the attendees were encouraged to ask questions and speak about any concerns they had. Feedback varied with respect to the option of applying for a rural exception, as some stakeholders felt that all CCBs should be treated equally in the transition to CFCM regardless of their location. Choice was also a heavily discussed topic, as stakeholders felt it was very important for individuals

[4] Because Virginia has not yet developed a plan to achieve CFCM, we have not included a summary of the Virginia interview in this report.

to be able to choose their own case manager without restriction. Finally, many stakeholders wanted CFCM implementation to be completed within one or two years rather than any longer proposed timeframes. Several parties noted the significance of communication, oversight and gathering sufficient information as the implementation steps begin.

A copy of the presentation used during these stakeholder meetings and a summary of the stakeholder comments are included in Appendix F.

Step 4: Final Implementation Report

This report represents all information gathered during the first three steps. Our recommendation for the CFCM implementation plan reflects the various opinions and findings noted during both the stakeholder meetings and CCB on-site reviews. Specifically, our recommendations for CFCM center on maintaining individual choice and ensuring a transition process in which individual and stakeholder feedback is valued throughout the transition process. Details of the implementation plan are found in Section VII of this report.

V. Recommendations for Conflict-Free Case Management

The following are recommendations for Colorado's access point waivers to come into compliance with federal requirements. They are based on input from I/DD stakeholders and created in collaboration with the Department.

Table 2. Conflict-Free Case Management Recommendations and Rationale

CFCM Recommendations for Colorado	Rationale for Recommendation
1) The Department and CCBs should actively work to recruit new case management agencies and direct service providers throughout the state, particularly in rural areas, to increase individual choice between existing and new case management agencies and providers.	✓ Increase freedom of choice ✓ Demonstrate efforts to increase provider availability before applying for CFCM exemptions in rural areas
2) In urban areas, CCBs must choose from one of the following options: a. CCBs operate as a case management agency only (i.e., divests itself of direct services) b. CCBs operate as a direct service provider only (i.e., divests itself of TCM) c. CCBs continue to provide both TCM and direct services, but never to the same individual d. CCBs discontinue providing services and TCM to Medicaid I/DD waiver individuals	✓ Provide CCBs with multiple options for complying with CFCM to choose the path that best meets their needs ✓ Bring Colorado's CCB-based I/DD system into compliance with CFCM requirements

CFCM Recommendations for Colorado	Rationale for Recommendation
3) In rural areas where it has been determined that there are no other available case management agencies and direct service providers, CCBs should be allowed to continue providing both TCM and direct services, as long as appropriate safeguards are put in place to ensure that individuals have freedom of choice to the maximum extent possible. This option requires approval from the federal government in each rural area.	✓ Allows CCBs in rural areas to continue providing both TCM and direct services if there are no other available case management agencies or direct service providers in the geographic area
4) Certain administrative functions should be conducted only by case management agencies that do not provide any direct services to waiver participants or by third party entities that neither conduct TCM nor provide direct services.	✓ Eliminates conflict of interest when direct service providers conduct eligibility determinations, functional assessments and quality assurance activities ✓ Allows third party entities to conduct administrative functions; highly supported by CCBs

We recommend that the Department continue working with CCBs and CMS to determine a date by which access point waivers must be conflict-free in all non-exempt areas of the state. In addition, we recommend the Department establish a date by which all new waiver participants must be enrolled with case management agencies that are conflict-free, possibly as soon as July 1, 2017.

VI. CCB Compliance Options and Feedback

The CFCM plan we recommend enables individuals to receive TCM that address their preferences and desired outcomes without the conflict of interests we described earlier. Our plan addresses the conflict issues and gives CCBs four options for coming into compliance with CFCM. The four options are:

A. CCBs choose to become a case management agency only

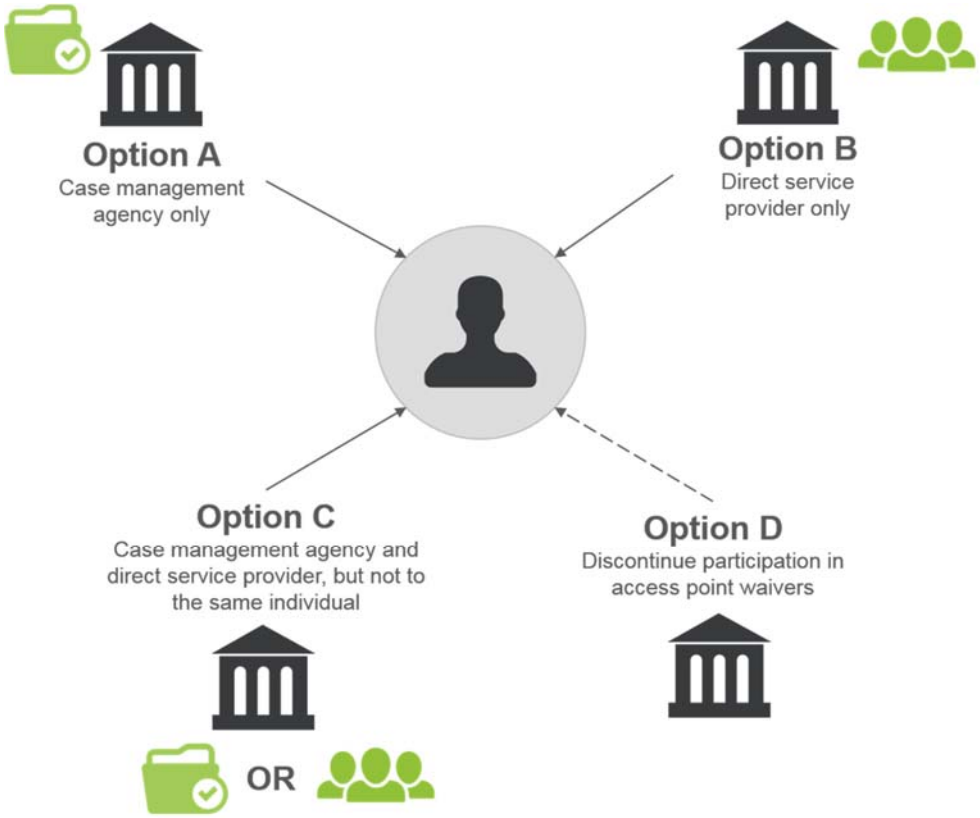
B. CCBs choose to become a direct service provider only

C. CCBs choose to be a case management agency and direct service provider, but never to the same individual, and implement appropriate firewalls and safeguards

D. CCBs discontinue participation as access point waiver case managers and direct service providers

Each CCB must submit a business continuity plan that indicates which of the four CFCM options it selects and details both its plans for transitioning to CFCM and the timeline for meeting the Department's deadlines.

Figure 3. Options for CCBs to Transition to CFCM



This model is similar to that being used in Maine and one that was recently submitted by Missouri for CMS approval.[5,6] In the following sections we detail the implications of these options for waiver individuals and CCBs.

Option A: CCBs choose to become a case management agency only

As a case management agency, the CCB must develop person-centered plans, manage the logistics of the provider selection process, advocate for the individuals they serve and oversee providers in their implementation of person-centered plans. Choosing to exclusively serve as a case management agency has the following potential benefits:

- Strengthen the CCB's focus on serving in a case manager and advocate capacity

[5] Maine's policy preventing case management agencies from providing case management and direct services to the same individual is documented in the Balancing Incentive Program "Summary of Conflict-Free Case Management" developed by Mission Analytics Group in coordination with CMS. [Source: Mission Analytics Group (2015) 19. Available online: http://www.balancingincentiveprogram.org/sites/default/files/CFCM_State_Summary_2015.v2.pdf]
[6] Missouri's 1915(c) application outlining this model is still under review by CMS. [Source: Missouri HealthNet Division (April 2016) 134-38. Available online: https://dss.mo.gov/mhd/waivers/1915c-home-and-community-waivers/files/dd-comprehensive-waiver-renewal.pdf]

- Leverage the CCB's existing knowledge of local supports and services to meet individual needs
- Eliminate conflicts of interest associated with also being a direct service provider

To comply with this option, a CCB must:

- **Divest itself of direct services and related assets.** If a CCB chooses to offer TCM to all individuals, it will no longer be able to own or have a financial stake in direct services. The CCB will need to develop a plan for divestment, which it will provide to the Department as part of the business continuity plan.
- **Transition individuals to new providers.** The CCB must identify new providers for any individuals currently receiving direct services from the CCB.[7] The case manager will provide individuals with information on all available approved service agencies. If the individual does not have a preference for a particular provider agency, the case manager will solicit interest from program-approved service agencies. For interested agencies, the case manager will issue a request for proposals that describes the services and supports needed. Based on responses, the case manager will help the individual make an informed choice of service provider.

With CCBs potentially divesting themselves of direct services, the Department will need to recruit additional providers. The Department will need to focus on regions with an insufficient number of waiver providers, address existing barriers to becoming a waiver provider and actively recruit non-Medicaid providers. We discuss specific implementation steps related to provider outreach later in this report.

Option B: CCBs choose to be a direct service provider only

CCBs may choose to exclusively provide direct services. This choice has potential benefits:

- Strengthens the focus of the CCB on the quality of its direct services
- Reduces the impact of transition on individuals for CCBs offering many direct services
- Eliminates conflicts of interest associated with also being a case management agency

CCBs that choose Option B would need to:

- **Divest themselves of TCM services and related assets.** If a CCB chooses to offer direct services to individuals, the CCB will no longer be able to conduct TCM and administrative functions. The CCB will need to develop a plan for divestment, which will be shared with the Department as part of the business continuity plan. The Department will need to determine if it will allow direct service providers to serve on the boards of directors of case management agencies in a non-voting capacity.
- **Notify individuals of the need to transition to a new case management**

[7] The RFP process described here follows the provider selection process defined in 10 CCR 2505-10 8.602.5. The process takes into account the preferences and needs of the individual who will be receiving services and supports, and provides a fair opportunity to direct service providers.

agency. CCB must notify individuals they may no longer receive TCM from the CCB, explain the transition process to the individual and provide TCM until the effective date of the transfer to a new case management agency. We recommend the Department use neutral third parties to assist individuals with choosing a new agency, such as SEPs, NWD entities, enrollment brokers or Family Health Coordinators.[8] The case management choice process will be finalized during the planning phase of CFCM implementation. It is described further in section VII of this report.

Option C: CCBs choose to be a case management agency and direct service provider, but not for the same individual

The third option for CCBs is to function as both a case management agency and direct service provider, but never for the same individual. This option is proposed to:

- Provide CCBs a mechanism to allow satisfied individuals the choice of receiving TCM or direct services from the CCB
- Acknowledge the CCB's local, institutional knowledge of services and supports for individuals with I/DD

To comply with Option C, any CCB currently providing TCM and waiver services to the same individual must:

- **Notify the individual that he or she can no longer receive both from the same entity.** The CCB should first notify the individual that they may no longer receive both TCM and direct services. If the individual elects to continue to receive direct services rather than TCM, the CCB will refer the individual to the nearest enrollment broker or Family Health Coordinator to assist the individual with the selection of a new case management agency.
- **Develop internal processes for tracking compliance.** CCBs who elect option C will be required to demonstrate how they will avoid providing TCM and waiver services to the same individual in the future. For example, if an individual requests to be transferred to the CCB from a different CCB or case management agency, the CCB could check to see if the individual is already receiving direct services as part of the enrollment process. The Department will check to ensure that claims are not submitted for both TCM and direct services during the same time period from the same CCB.

When the Department recruits new case management agencies, it will also need to determine whether or not the new agencies will also have the option to provide direct services.

Option D: CCBs discontinue participation as access point waiver case managers and direct service providers

CCBs that do not wish to comply with CFCM by divesting themselves of either TCM or direct

[8] Family Health Coordinators, part of the Healthy Communities Program, offer assistance to families applying for Colorado Medicaid and Child Health Plan Plus (CHP+) and provide clients with information and referrals to providers and other community programs and resources. For more information, see: https://www.colorado.gov/pacific/hcpf/healthy-communities

services, or by continuing to provide both but never to the same individual, may choose to discontinue participation in access point waivers. The Department will no longer contract with CCBs that do not select from one of the above three choices for CFCM, except for CCBs located in rural areas that have been granted exception by CMS.

Business Continuity Plan

Each CCB will be required to develop a business continuity plan that specifies how it will comply with requirements for CFCM. The Department will set deadlines for compliance with CFCM, including interim deadlines and a final deadline based on agreement with CMS. The CCB will be responsible for providing sufficient detail and evidence to support their CFCM strategy and steps they will take to achieve compliance. For example, if a CCB elects to discontinue providing direct services to access point waiver individuals, the CCB would need to detail how they plan to divest themselves of their direct service component.

The CCB must also detail in the business continuity plan its communication and education plan for access point waiver individuals. The CCB will document its process for selecting CCB Outreach Team Members and the Outreach Team's plan to meet the Department's outreach goals. The goal of this communication and education plan is to provide information to individuals about the changes that are being made to the waiver program as a result of the CFCM transition plan. The Department will approve each CCB's written communication and education plan and provide recommendations for improvement if needed.

Lastly the CCB will acknowledge that failure to comply with CFCM by the Department's set deadline will be met with penalties to be determined by the Department.

Table 3. CCB Business Continuity Plans

Business Continuity Plans Should Detail CCB Plans For:
• Compliance with CFCM and the Department's CFCM deadlines • Communication and education plan for individuals • Service delivery transition • How individuals transitioning out of the CCB will be supported • An acknowledgement of penalties that will be enforced for failure to comply with the Department's deadlines

CCB and Stakeholder Feedback on Compliance Options

Representatives from CCBs, individuals, families and guardians, and other stakeholders had several opportunities to provide feedback to Navigant and the Department about the proposed CFCM compliance options. During the stakeholder meetings and CCB on-sites, we presented three CFCM compliance options including full separation of TCM and direct services, and heard the following feedback:

- Stakeholder opinions about implementation of CFCM varied by geography. Generally, the eastern portion of the state supported complete separation of TCM and direct service provisions while the western portion strongly expressed the

satisfaction of status quo and showed support for working with CMS on rural exception criteria.

- Most CCBs we visited said they would be unable to choose between TCM and direct services without knowing additional detail and implications. One CCB expressed that it would elect to divest itself of direct services and continue providing TCM services, and that CCBs should be able to provide TCM outside of their current geographic boundaries.
- Each CCB was concerned about the potential loss of jobs if they elect to no longer provide TCM or direct services.
- Each CCB was concerned about the impact of CFCM on rural CCBs. Eliminating either TCM or direct services from a CCB in rural areas could result in the loss of providers and further reduce the number of available providers.

Stakeholders discussed potential challenges that CCBs, the Department and individuals with I/DD might face during the transition to CFCM, including:

- The potential legal and other costs involved for CCBs to divest themselves of either TCM or direct services.
- The potential for the loss of jobs when CCBs divest themselves of direct services or TCM
- Difficulty in coordinating care for individuals due to additional entrants into the delivery system
- The sustainability of TCM as a standalone business
- The impact of CFCM on individuals in rural areas
- An overall resistance to change by some individuals and CCBs

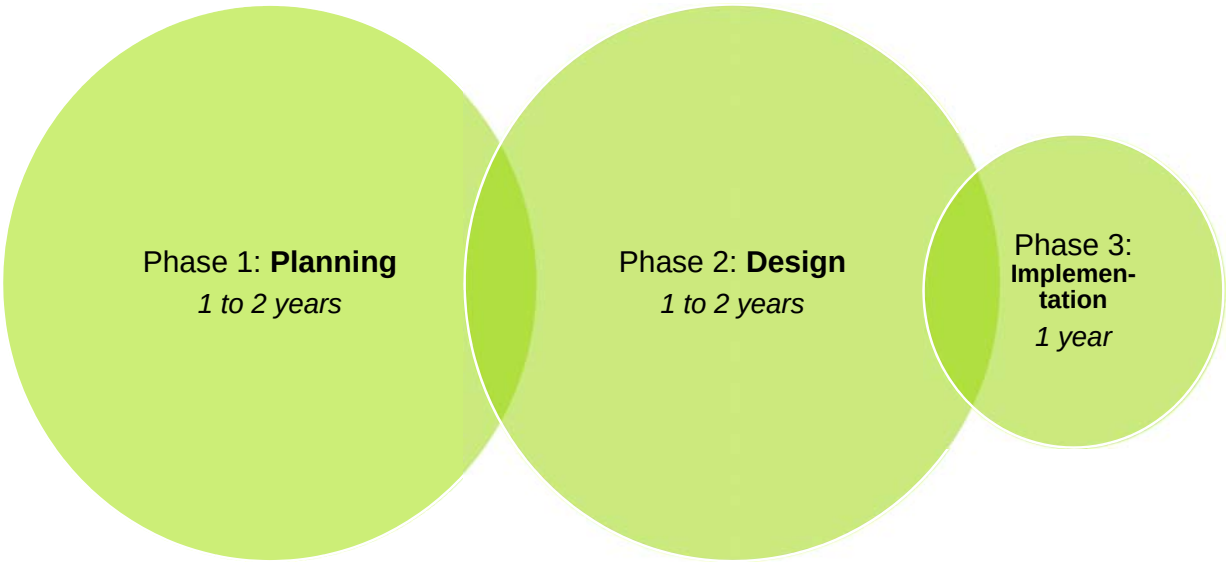
Regardless of CCBs' opinions on the compliance options, we unanimously heard that oversight and training would be critical elements for success of this model. In addition, stakeholders emphasized the importance of frequent communication with individuals and families by the Department and CCBs throughout the transition process.

Additional information about the CCB on-site reviews can be found in Appendix E and additional information about the stakeholder meetings can be found in Appendix F.

VII. Conflict-Free Case Management Implementation Plan

The proposed transition to CFCM is separated into three phases: planning, design and implementation.

Figure 4. Phases for Transition to CFCM



Note: The size of each circle in the graphic is proportional to the maximum amount of time estimated for that phase.

There will likely be overlap between phases because some tasks are not dependent on tasks in a previous phase, and can begin simultaneously. The transition to CFCM will take an estimated three to five years. A few tasks, such as those requiring legislative or budget approval, could take longer than estimated. Below is a description of the three phases.

1. The **Planning** phase aims to resolve outstanding questions related to CFCM. Generally, the Department will:
    - Conduct specific analyses to inform key decisions identified in this report
    - Assess which statutes, regulations, waiver amendments and other policies must change in order to implement the proposed plan
    - Initiate collaborations with stakeholders to move forward with implementation.

    In the Planning phase, CCBs will decide which of the four options they will take to transition to CFCM and develop business continuity plans.
2. The **Design** phase translates the information obtained in the Planning phase into specific requirements for CFCM. The Department will:
    - Develop and submit revisions to existing statutes, regulations, waiver amendments and other policies governing TCM
    - Set specific requirements for compliance with CFCM based on revisions to statutes, the Medicaid State Plan and waivers.

    In this phase, CCBs will begin implementing components of their business continuity plans, including any applicable divestment.
3. The **Implementation** phase includes implementation of all changes developed in the Design phase and a survey of individuals and families to evaluate effectiveness.

The remainder of our report details milestones Colorado will need to achieve in the following key categories:

- Regulatory and policy changes
- Provider development and outreach
- Communication priorities
- Quality and evaluation

Regulatory and Policy Changes

Because the qualifications and functions of CCBs are codified in Colorado's laws and regulations, one of the most time-consuming tasks for the Department will be revising regulations and requirements for CCBs, service providers and case management agencies that serve the three I/DD waivers addressed in this plan. For example, the CCB definition currently in statute will need to be revised, as it directly conflicts with federal CFCM requirements by permitting CCBs to provide both TCM and direct services to the same individual:

> *"'Community-centered board' means a private corporation, for-profit or not for-profit, that, when designated pursuant to section 25.5-10-208, provides case management services to persons with intellectual and developmental disabilities, is authorized to determine eligibility of those persons within a specified geographical area, serves as the single point of entry for persons to receive services and supports under this article, and provides authorized services and supports to those persons either directly or by purchasing services and supports from service agencies."* [9]

Moreover, statutes and the Medicaid State Plan allow only the CCB to conduct eligibility determinations.[10,11] Statutes also govern the existing catchment areas for CCBs. The Department must change these requirements if it wishes to provide individuals with case management freedom of choice by allowing multiple case management agencies per geographic region, or by removing the geographical restrictions and allowing CCBs to serve individuals statewide. The Department will need to determine whether to redefine the CCB designation, to replace the CCB designation with the more generic "case management agency," or both. That is, the Department would recognize that CCBs provide networking and advocacy services beyond TCM, but would also broaden regulations to allow new case management agencies to serve the waiver programs.

The revision of these regulations and policies will involve close coordination with governing entities, including the Colorado General Assembly and CMS, due to the inter-dependencies of any changes. For example, changes to statute and state regulations must be reflected in waiver applications, and statutes must comply with federal regulations. Additionally, changes to regulations require stakeholder input as well as approval from the Medical Services Board (MSB).

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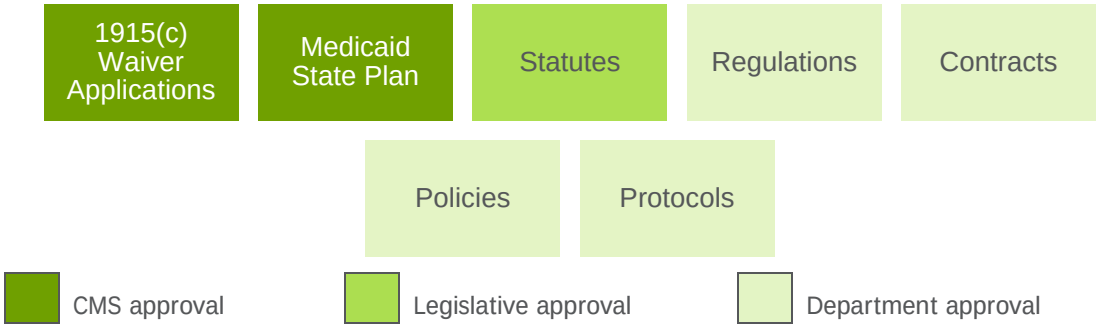
[9] Community Living, Intellectual and Developmental Disabilities, Definitions, CRS 25.5-10-202 (2013).
[10] *Ibid*.
[11] The references to CCBs and TCM for individuals with intellectual and developmental disabilities can be found in Colorado's Medicaid State Plan Supplement to Attachment 3.1-A, TN# 15-0033.

The following figure summarizes items the Department will need to address.

Figure 5. Summary of Documentation Requiring Review



Phase 1: Planning

The Planning phase will require a thorough review of all relevant regulatory and policy documentation to determine what, if any, revisions are required. This phase will also require collaboration with CMS to gain approval for certain aspects of the CFCM protocol.

A. Conduct study / assessment for budget request

The Department should analyze costs associated with implementing the transition to CFCM. Items that will require funding include:

- Dedicated Department staff to manage CFCM activities outlined in this plan
- Resources to conduct assessments needed to make additional decisions
- Assistance from third party entities, such as enrollment brokers or Family Health Coordinators to facilitate the transition to new case management agencies
- Costs for procuring new case management agencies
- Marketing and communication materials
- Additional costs that will be identified during the Planning phase

B. Conduct assessment of Department staffing resources

The Department must ensure that it has the staff in place to manage the transition to CFCM, and assess the staff capacity needed to monitor, manage, and communicate all aspects of a conflict-free service delivery model. In addition, the Department should evaluate its existing internal policies and procedures to identify areas in which CFCM transition may require additional oversight by Department staff.

C. Review TCM process across all Medicaid HCBS waivers and consider potential rate changes

Although all CCBs understand the four components of TCM, our desk and onsite reviews suggested variation in how case managers complete these components. For example, there are no centralized guidelines for the level of detail service plans should contain, and no standardized method for evaluating providers in the service planning process, aside from a suggested list of criteria outlined in the Colorado Code of Regulations. Furthermore, the four components of TCM are defined differently between access point and non-access point HCBS waivers. Therefore, the Department should evaluate and standardize the requirements

for the following TCM functions across all HCBS waivers:

- **Assessment** of need for medical, educational, social or other services
- **Person-centered service plan development** based on the information collected through the assessment that specifies goals and actions to address identified needs
- **Referral** and related activities to help the eligible individual obtain needed services
- **Monitoring** and follow-up activities necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs[12]
- **Freedom of choice:** the TCM system must also be able to facilitate client freedom of choice for a TCM provider, a key element enabling individuals to receive case management and services that address their preferences and desired outcomes.

The Department should also take into consideration the need for revised TCM reimbursement rates and changes to the annual cap on TCM (currently 240 15-minute units) based on any changes to TCM requirements and case manager qualifications. If new rates are warranted, the Department should conduct a rate study in consultation with the Medicaid Provider Rate Review Advisory Committee to develop revised TCM rates.[13] The rate study will analyze:

- Whether the existing rate determination methods lead to rates that promote efficiency, economy and quality of care
- Whether existing rate determination methods are sufficient to enlist enough providers
- The impact, if any, of CFCM compliance on the amount of time that care coordinators need to spend on TCM activities

D. Consider waiver amendment for rural exception

According to *42 CFR 431.301(c)(1)(vi)*, CMS allows exceptions to CFCM requirements only when a state "demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS." In order to demonstrate the need for this rural exception, the Department will need to synthesize the findings of the provider and case manager capacity study. The Department will work closely with CMS to gain approval for such rural CFCM exceptions where appropriate.

E. Review statutes, regulations and waiver applications

The Department must review all statutes, regulations, waiver applications, policies, protocols and contracts pertaining to CCBs and their administrative, TCM and OHCDS functions. After determining the relevant items to be reviewed, the Department should assess what, if any,

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[12] The references to CCBs and TCM for individuals with intellectual and developmental disabilities can be found in Colorado's Medicaid State Plan Supplement to Attachment 3.1-A, TN# 15-0033.
[13] The Medicaid Provider Rate Review Advisory Committee was established in 2015 in Senate Bill 15-228 "Medicaid Provider Rate Review," an act concerning a process for the periodic review of provider rates under the Colorado Medical Assistance Act. One of MPRRAC's responsibilities is to provide input on published reports and assist the Department in the review of provider rate reimbursements.

modifications are necessary to:

- Accommodate the steps outlined in this implementation plan
- Clarify Colorado's conflict-of-interest safeguards
- Bring Colorado into compliance with CMS CFCM mandates

The Department will also need to address outstanding questions regarding CCB functions outside of TCM, which will be indirectly impacted by this implementation plan.

- **OHCDS function:** The Department should determine which types of entities, if any, may continue to conduct OHCDS functions. Current Colorado statute stipulates that entities that function as an OHCDS must also provide TCM. In addition, all Medicaid providers must enroll with and be screened by the Department. This policy, established by the Department in 2016, is to comply with federal regulations ((*42 CFR 455.410*) that require states to screen and enroll all ordering, referring, and prescribing providers that service Medicaid beneficiaries. In light of Colorado's mandatory provider enrollment policy, the Department will need to determine if it will continue to allow agencies to act as an OHCDS, and if so, clarify the provider enrollment and screening policy with respect to independent contractors under OHCDS.

  If the Department continues to allow agencies to act as an OHCDS, we recommend reassigning OHCDS functions to independent financial management services (FMS) contractors.[14] Otherwise, the Department should require all waiver providers and independent contractors to enroll with the Department as a Medicaid provider and submit their own claims to Medicaid directly.

- **Administrative function:** The Department should determine whether and how to transition the following administrative tasks out of CCBs:
  - Eligibility determination for I/DD services
  - Eligibility determination for Medicaid waivers
  - Waiting list management
  - Supports Intensity Scale (SIS) assessments
  - Support Level Determination

  We recommend that these administrative functions be conducted only by case management agencies or third-party entities that neither conduct TCM nor provide direct services. In addition, as previously discussed, we recommend the Department actively work to recruit new case management agencies throughout the state, particularly in rural areas, to increase individual choice.

- **Choice Determination Process:** As new case management agencies are enrolled and CCBs divest themselves of TCM functions, we recommend the Department use neutral third parties to inform individuals about their case management options and manage the case management agency enrollment process. There must be a process in place to outline the options and provide guidance for case management choice. During the Planning phase, the

[14] Most states with OHCDS arrangements contract with FMS entities; however, FMS must be offered as a waiver service in order for this arrangement to be implemented.

Department should determine how and where individuals will choose a case management agency. However, a preliminary analysis reveals a number of potential options.

- The **No Wrong Door (NWD)** system would be a natural fit, as person-centered options counseling is integral to NWD operations. However, because NWD is currently in the pilot phase, details about how and where NWD services will be provided are not yet known and NWD processes may not be finalized in time to meet the federal requirement for CFCM.
- The **Single Entry Point agencies (SEPs)** are another natural fit for facilitating the case management choice process because they currently help Medicaid clients make choices about HCBS providers through options counseling and case management. However, when CFCM is implemented, SEPs could potentially enter the I/DD system as a case management agency, which would make them ineligible to assist with case management choice.
- **Healthy Communities** combines aspects of the Medicaid Early Periodic Screening Diagnostic and Treatment (EPSDT) outreach and administrative case management with the Child Health Plan Plus (CHP+) program into one model that better meets the needs of children. This outreach and case management model takes into account that many families have one child enrolled in Medicaid while another is enrolled in CHP+. Family health coordinators are available statewide to help Colorado Medicaid and CHP+ families through the Healthy Communities program. The case management functions provided by family health coordinators are aligned with the functions needed for the case management choice process, although it is unknown if Healthy Communities can shift to provide the same services to the I/DD population.
- The Accountable Care Collaborative **Regional Accountable Entities** could assist with case management choice. This would make use of an existing Medicaid touch point and create alignment between medical care and functional support. Department contracts with these entities must include a requirement to employ staff with the competency necessary for serving individuals with I/DD.
- The Department could contract with a **statewide vendor** responsible for facilitating case management choice. Contracting with a vendor on a statewide basis could create economies of scale that could lower costs to the state and limit local variability.

Regardless of which entities conduct case management choice determination, we strongly recommend the Department evaluate existing processes for matching individuals to case managers within an agency. For example, some states strongly encourage individuals to meet with potential case managers and ask person-centered questions such as:

- How do you view your role as a case manager?
- How will you get to know me and others involved in my life/supports?
- How would you handle situations when people involved in my supports do not agree?

  - How would you describe your communication styles and strengths?[15]

- **Quality Assurance Functions:** The Department should determine how to transition quality assurance functions, which include monitoring:
  - Delivery and quality of services and supports
  - Health, safety and welfare of the participant
  - Participant's satisfaction with services and choice of service provider

  Quality assurance activities also include:
  - Establishing a human rights committee
  - Review and resolution of complaints and grievances
  - Quality Improvement Strategy (QIS) activities and reporting
  - Investigating allegations of mistreatment, abuse, neglect, or exploitation

  We recommend that case management agencies and the Department maintain responsibility for quality assurance functions. Case managers are most familiar with an individual's care plan and are responsible for ensuring that the services provided are meeting the individual's needs and that his or her health, safety, rights and autonomy are respected. In turn, the Department should develop oversight protocols to monitor case management agency compliance with their quality assurance functions (e.g., case managers should document that they conducted, at minimum, the required number of face-to-face visits with the individual). In addition, individuals should be able to directly express complaints and grievances to the Department. In addition, some individuals and families suggested during stakeholder meetings that the Department should establish a family liaison from the Department, similar to an ombudsman, who would resolve their complaints and grievances.

  The Department should document the distinct quality assurance and oversight responsibilities of the case management agency and the Department. Regarding allegations of mistreatment, abuse, neglect or exploitation, the Department must ensure that any decisions regarding reporting and investigations are carried out in alignment with *SB 15-109,* which addresses mandatory reporting for all adults with I/DD.

The following is a preliminary list of considerations for the Department as it conducts a systemic review of laws, regulations and policies.

Table 4. Laws, Regulations and Policies to Review

Items for Review	Key Considerations for the Department
1. State Statutes Colorado Revised Statutes (e.g., CRS	• CCB designation and requirements • Entities responsible for TCM and service delivery

[15] "Self-Advocates and Families: Take Action," South Dakota Department of Human Services, Division of Developmental Disabilities, accessed May 4, 2016, http://dhs.sd.gov/Action%20Required.pdf

Items for Review	Key Considerations for the Department
Title 27, Article 10.5 and Title 25.5, Article 10, Part 2)	• TCM definitions
2. Access Point Waiver Applications • HCBS-DD: CO.0007 • HCBS-SLS: CO.0293 • HCBS-CES: CO.4180	• Review references to CCBs and TCM[16] • Appendix A: Assessment and oversight of CCBs • Appendix B: Level of care determination responsibilities • Appendix C: Service definitions and provider qualifications • Appendix D: Language related to the service planning process o Appendix D-1: Description of plan to transition to CFCM • Appendix G: Participant rights • Appendix I: Rate setting methodologies for direct services that may be impacted by the transition to CFCM • Appendix J: Cost assumptions and estimates that may be impacted by the transition to CFCM • Quality Improvement – Level of Care: Quality measures related to performance of case management agencies • Quality Improvement – Qualified Providers: Quality measures related to qualifications and performance of direct service providers • Quality Improvement – Service Plan: Quality measures addressing compliance with CFCM
3. Medicaid State Plan Supplement to Attachment 3.1-A, TN# 15-0033	• Entity responsible for eligibility determinations • Definition of TCM, including frequency requirements, service caps and a potential expansion of the target population to include all HCBS waivers • Qualifications for TCM providers
4. State Regulations Code of Colorado Regulations (e.g., 10 CCR 2505-10, sections 8.500, 8.600, and 8.700 et. seq.)	• CCB designation and requirements • Definition of administrative, TCM and OHCDS functions • Entities responsible for administrative, TCM and OHCDS functions and case management choice • Case management agency and provider qualification requirements

[16] Appendices listed in this chart refers to the sections of the Access Point Waiver application.

Items for Review	Key Considerations for the Department
	• Department monitoring and oversight requirements
5. State Contracts • Medicaid provider agreements • Interagency agreements	• Case management agency and provider qualifications and requirements • Department monitoring and oversight requirements • DIDD monitoring and oversight requirements
6. State Policies • Enrollment policies • Billing policies • Quality assurance and monitoring policies • Training policies	• Provider enrollment and billing requirements, including requirements for OHCDS arrangements (see Provider Development and Outreach section) • Training requirements (see Provider Development and Outreach section) • Processes for addressing conflict of interest moving forward • Grievance procedures for individuals • Department monitoring and oversight requirements

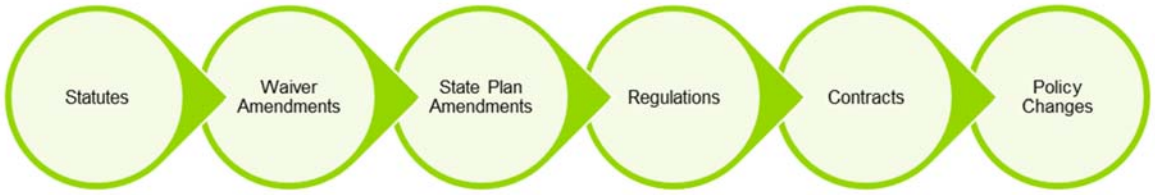
Stakeholders will have an opportunity to provide input on future waiver amendments, including the rural exception, in accordance with existing federal public comment requirements and the communication plan described later in this report.

Phase 2: Design

A. Develop, submit, and receive approval for statute changes, waiver amendments, regulation changes, and policy changes

After the Department has completed its assessment of statutes, regulations, provider capacity and all other relevant guidance, the Department and legislative stakeholders must begin developing and submitting necessary updates. Colorado should follow the order in the diagram below to minimize potential domino effects from any changes made by approving bodies:

Figure 6. Order of Submission for Regulatory and Policy Change



B. Develop technical assistance and training

After the items described above have been finalized, the Department should develop technical assistance and trainings to explain the changes to individuals, families, advocates, CCBs, case management agencies and direct service providers.

C. Identify and plan for any gaps in services and determine CCB responsibilities

The Department should determine CCBs' roles and responsibilities for avoiding gaps in services. CCBs will play a critical role in ensuring that there are no gaps in direct service delivery or TCM services for the individuals they currently serve. For example, if an individual elects to receive direct services with a CCB, a case management choice entity must assist the individual with choosing and enrolling with a new case management agency.

The Department is currently developing a universal web-based case management system that will allow case managers and the Department to record and share information about individuals' service plans. This system will be instrumental in assuring that individuals successfully transition with no gaps in service. The Department should require case management agencies to use this new integrated system when updating case management responsibilities.

Phase 3: Implementation

We recognize the implementation plan may change based on stakeholder and CMS input through the legislative, regulatory, and waiver amendment approval processes. During and after the approval process, it will be critical that the Department identify areas with potential barriers for transition, develop policies to address these and coordinate changes with CCBs.

A. Implement Regulatory and Policy Changes

After the Department is confident that individuals, CCBs, case management agencies, and direct service providers are prepared for the transition to CFCM, the Department will begin implementing all regulatory and policy changes, keeping stakeholders, including CMS apprised of its progress.

Case Management and Provider Network Development

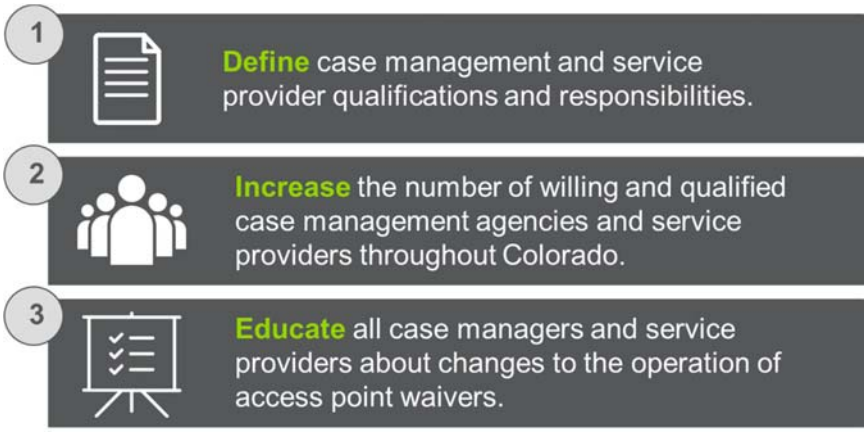
In the transition to CFCM, the Department faces two main challenges regarding providers:

- Colorado has several rural areas with limited provider and TCM options for individuals[17]
- Waiver providers are faced with uncertainty surrounding CFCM regulatory and policy changes

The Department will need to recruit and appropriately train new providers and case management agencies to prevent gaps in services and ensure high quality services and TCM. The following figure highlights three key goals the Department should have for its provider development and outreach efforts.

[17] This is based on individual and CCB input received as part of our desk reviews and stakeholder meetings. The provider capacity study will determine exact limitations, if any.

Figure 7. Provider Development and Outreach Goals



Phase 1: Planning

Provider development and outreach activities should occur concurrently with the regulatory and policy activities discussed in the previous section.

A. Assess provider capacity

We recommend that the Department assess provider capacity to evaluate the number of case management agencies and direct service providers available to serve the access point waiver population. This study will be particularly beneficial for rural areas in the state and will be critical in determining whether the state should pursue a rural exception in certain areas. The provider capacity study will be used during the Planning phase to:

- Determine the number of existing, qualified providers and case management agencies by geographic region
- Systematically evaluate barriers for recruiting additional providers and case managers in underserved areas
- Determine whether to pursue a rural exception from CMS, and if so, for which regions. If the Department discovers that there is adequate provider capacity for individuals in rural communities, the State will not apply for a rural exception. The Department will alert all involved parties of the result of the rural exception decision immediately following notification from CMS.

The first step in the provider capacity study should include working with the CCBs and professional associations to obtain listings of all access point waiver providers in their geographic location. The Department can then reach out in each community to determine if there are any additional providers or new prospective providers that have the capacity and are willing to provide services to waiver participants, and then take the necessary steps to ensure that providers identified in the capacity study are able to meet the needs of the population. This could be accomplished by conducting site visits with providers. During these site visits, the Department could assess whether the provider has sufficient space available for additional individuals, new providers are prepared to provide direct capacity, and that the setting meets federal HCBS requirements and is appropriate for the population. For example, a setting that currently serves only children would not be considered a suitable setting for an adult and therefore would not be considered for HCBS-SLS and HCBS-DD

waiver participants.

B. Review and define qualifications for case management agencies, case managers, and direct service providers

Stakeholders agreed that equally as important as building capacity is preserving and improving the quality of direct service providers and case management agencies. Based on this consensus, we recommend the Department review qualifications for case management agencies and direct service providers, which includes certification and accreditation requirements and responsibilities. For example, the Department should certify case management agencies based on an evaluation of the agency's performance in the following areas:

- The quality of the services provided by the agency
- The agency's compliance with program requirements, including compliance with case management standards adopted by the Department
- The agency's performance of required functions, including timely reporting, service planning, client monitoring, and on-site visits to clients
- Whether intended populations are being identified and served

While we recommend the Department provide additional guidance regarding how performance will be measured, we strongly encourage the Department to make the qualifications as similar as possible across the state's waiver programs. Qualifications for case management agencies should also include a component measuring compliance with CFCM, including:

- Validation of documentation that demonstrate understanding of and compliance with the Department's CFCM requirements, including:
    - Policies and procedures
    - Training materials
    - Handbooks for individuals, families, and advocates
    - Marketing materials and resources
    - Webpages
- Validation of self-attestation forms for all staff members that indicate they meet CMS standards for CFCM services
- Validation of compliance with any new qualification requirements for case managers and direct service providers

Validation of CFCM compliance should be integrated into the Department's ongoing quality reviews and into enrollment requirements for future case management agencies.

The Department should also review and define qualifications for case managers and direct service providers, including educational, certification or licensure, training and competency requirements. The Department should develop oversight policies to ensure case managers and direct service providers meet these qualifications if they are providing or billing for services. The Department should also consider establishing a "grandfather clause" in which existing case managers with a pre-determined amount of experience and minimal qualifications may continue providing TCM, even if they do not meet the newly developed case management qualifications. This clause is essential to maintaining individual choice,

retaining incumbent experienced case managers, and allowing individuals to retain their current case manager if they opt to choose to do so.

C. Enroll new case management agencies and direct service providers

The Department should begin enrolling case management agencies as Medicaid TCM providers and new direct service providers, using the revised qualifications as the basis for enrollment. In addition, the Department should consider whether to expand the definition of TCM to include additional populations beyond those with I/DD, to increase the individuals case management agencies may serve and the number of TCM options available to access point waiver individuals.

D. Develop ongoing outreach plan for providers and case management agencies

The Department should also develop an outreach plan to attract additional direct service providers and case management agencies. This plan would target geographic regions with low capacity and include methods for addressing any systemic barriers to provider enrollment.

E. Coordinate with CCBs on business continuity plans

The Department should require all CCBs to submit business continuity plans based on the four options for transitioning to CFCM. This would mitigate delays if Colorado is not granted a rural exception. The Department should specify requirements and milestone deadlines CCBs must meet in their business continuity plans and be available to provide technical assistance.

Phase 2: Design

A. Build training plans for certifying case managers

Based on the case manager and direct service qualifications defined in the Planning phase, the Department should develop training sessions for case managers about the new certification requirements. As part of this process, the Department should address the delineation of responsibilities for providers of direct service, TCM and administrative functions.

B. Conduct provider outreach and technical assistance for enrollment and claims submission

The Department should establish and implement processes for providing technical assistance for Medicaid enrollment and claims submissions for interested providers.

C. Develop conflict-free policies and procedures for providers

For CCBs in regions that qualify for a rural exception, the Department should require them to develop and submit policies and procedures that indicate internal firewall measures and other safeguards to ensure individuals' eligibility determinations, service planning and monitoring activities comply with conflict-free mandates. For example, according to the federal regulations, entities with a conflict of interest must separate its case management and provider functions within the agency, which must be approved by CMS, and individuals must be provided with a clear and accessible alternative dispute resolution process.

Phase 3: Implementation

A. Implement changes in provider qualifications and changes in enrolling individual direct service providers

The Department will implement all changes pertaining to provider qualifications and enrollment requirements described above, pending approval of the relevant statutes and regulations.

B. Continue to implement the provider outreach plan

The Department will continue to implement its provider outreach plan and note challenges, identify problems and take action if providers are not available as expected.

C. Continue to build provider capacity by offering ongoing trainings

The Department should offer ongoing trainings and technical assistance to potential new providers regarding, for example, staff qualifications and billing requirements. The Department should also work with providers in low-capacity regions to identify and address persistent barriers to provider participation. Should rural regions reach target provider capacity, the Department may revise its request for rural exception to CMS.

Communication Priorities

Phase 1: Planning

During the site visits, town halls and regional forums, stakeholders often said that there is a need for frequent communication between the Department, CCBs and families. Stakeholders requested that there be constant communication during the transition plan to ensure that CCBs are meeting deadlines, individuals are not experiencing gaps during transition in which they go without a case manager or direct service provider and that individuals have a true person-centered experience. The overall goal of the communication plan is to remain in regular contact with individuals and families whom CFCM will directly affect, particularly those who may be resistant to the changes required by the transition to CFCM.

Establish a communication plan

Both the Department and the case management agencies will be responsible for establishing communication protocols about the transition to CFCM. These communications will be regularly disseminated to all involved parties, including individuals, families, guardians, advocates, direct service providers, legislators and other stakeholders.

The Department should consider creating a dedicated communication team that would act as a liaison to communicate updates about CFCM policies and progress and receive and respond to questions from stakeholders. For example, the outreach team would communicate updates about provider capacity updates, CMS decisions, CFCM transition progress, and upcoming training dates.

Case management agencies should also develop outreach teams that would be responsible for communicating CFCM updates to individuals and their families and assist in answering any questions they may have. During the CCB site visits, some voiced a concern that some individuals, particularly those who have been in a waiver program for many years, may have difficulty adapting to change and may have trouble navigating a new system. The case management agency's outreach team would be responsible for addressing potential resistance and providing the education needed for each individual to assure a smooth

transition and for ensuring a person-centered approach is implemented. The figure below summarizes the roles of the Department's communication team and the case management outreach teams.

Figure 8. CFCM Transition Outreach Team Overview

The Department's Communication Team	Case Management Agency Outreach Teams
• Develop Quarterly Report • Maintain mailing list for quarterly report • Receive and respond to stakeholder feedback • Develop marketing materials • Conduct trainings • Communicate transition plan to individuals receiving services in access point waivers	• Alert individuals about CFCM transition progresses • Make individuals aware of their service delivery options post-CFCM • Assist in answering any individual questions about CFCM • Ensure individuals do not experience any temporary loss in service due to CFCM transition

Phases 2 and 3: Design and Implementation

Communication will be an ongoing activity throughout the design and implementation phases. The Colorado service delivery system will continue to evolve as new providers enter the market, and constant communication will allow for a person-centered approach to be fully implemented. The Department and the CCBs should continue to employ communication outreach teams until CFCM is fully implemented across all waivers.

During stakeholder meetings, stakeholders consistently expressed the need for the Department to communicate CFCM updates in a variety of ways: pamphlets and fliers, e-mails, standard mail, social media outreach, a centralized CFCM website, and other creative ways. In addition, the Department should hold meetings with CCBs, case management agencies, providers, and other stakeholders to communicate new policies and answer questions.

A. Update the existing Colorado CFCM website

The Department currently maintains a CFCM website on the Department's website (www.colorado.gov/hcpf/conflict-free-case-management) and uses it to communicate significant updates, provide reference materials, and allow stakeholders to submit comments. The Department will need to update the site as the implementation phases continue, and post information that is easy to find.

B. Hold public meetings

The Department should hold public meetings with individuals and their families/guardians, case managers, direct service providers and advocates on an as-needed basis to provide updates on any changes that have occurred due to the CFCM transition. The Department should also hold mandatory trainings for the CCB outreach teams, which would allow them to express individual and family concerns, discuss the methods they are using to educate stakeholders and any concerns they may have about communicating the CFCM plan to

individuals and families.

Quality and Evaluation

During stakeholder and town hall meetings, some attendees suggested that the Department add an evaluation component to the implementation plan so that feedback and oversight will continue throughout the CFCM transition process.

Phase 1: Planning

A. Develop a risk matrix to determine the lowest risk groups to transition first

The Department should develop a risk matrix to determine the order that waiver populations should be transitioned to new case managers or new providers. The goal of this risk matrix would be to determine the order of transition that would cause the least disruption to individuals.[18] Individuals could be transitioned based upon various group classification including, among others: waiver type, geographic location, living arrangement, age and functional status. Based on discussions with the CCBs, most believe that children should be transitioned first because they are generally more receptive to change and do not typically have the personal connection with case managers that adults may have. Some stakeholders expressed that individuals in the HCBS-DD waiver should be transitioned last because they are more likely to utilize long term residential habilitation services and supports and be more resistant to change. Performing a risk matrix study would account for these concerns. Overall, this approach allows for adequate time to transition individuals that naturally require more time due to a variety of reasons.

B. Establish deadlines for CFCM transition

The Department should set target deadline dates for case management agencies to be in compliance with CFCM. These target dates may be staggered for each access point waiver based on the results of the risk matrix. The Department should distribute the dates to the case management agencies and allow a 30 day period for comment that would allow agencies to voice their concerns if they feel that the proposed transition date is unreasonable. If a case management agency believes that the deadlines are unreasonable, they would draft a memo explaining their reasoning to the Department.

C. Designate a Department project manager to oversee the CFCM transition

The Department should designate a project manager who would be responsible for overseeing the State's transition to CFCM. This project manager would also ensure that CCBs are taking the steps necessary to meet the goals that were outlined in their business continuity plans. For example, if a CCB chooses to divest itself of direct services, the project manager would monitor the CCB's progress towards this goal. Monitoring activities could include reviewing bill of sale documentation for direct service facilities, tracking transition progress and ensuring that the CCB is on track to meet the Department's deadlines.

[18] Disruption is loosely defined as potential interruptions in service, individual discomfort and any other disruptions or setbacks to the person-centered approach.

Phase 2 and 3: Design and Implementation

Quality and evaluation will be an ongoing process, described in the steps below, that will continue during and after full CFCM transition is complete.

A. Oversee CCB implementation of business continuity plans

The Department's project manager should focus primarily on ensuring that each CCB is on the right track for CFCM implementation. The project manager could perform annual evaluation and progress checks by visiting each CCB at least annually during the transition process to ensure that progress meets the Department's deadlines. These progress checks should include: overseeing and reviewing new CCB operations, guidelines, rules, communication plans, and other items that directly correlate with CFCM. At the end of the annual review, the project manager would issue a report detailing their findings. The project manager would also be responsible for communicating to the Department when a CCB is not making the expected progress towards CFCM.

B. Conduct quality surveys

The Department should develop a quality survey that would be distributed to individuals and families to monitor satisfaction with the CFCM process. This monitoring aspect will be essential to ensure that a true person-centered approach is achieved. Quality surveys should be distributed as frequently as the Department sees fit. Each survey should also have a feedback section in which families and individuals can voice their concerns about the transition plan and its progress.

Individuals receiving services from new case management agencies and direct service providers should be surveyed about satisfaction, access to needed services and quality of services provided. The Department should conduct an investigation if surveyed individuals report not receiving quality care, access to needed services, or are continually unsatisfied with the new services and supports that are in place.

VIII. Conclusion

Colorado has a complex, legacy system of financing services and supports for individuals with I/DD. For more than 50 years, CCBs have served as "one-stop shops" for individuals with I/DD to determine eligibility for services, create a service plan, help the individual obtain services, and provide those services. CCBs also serve children with autism and other disabilities, adults with brain injury and veterans. CCBs have developed strong relationships with individuals and their families, waiver service providers, local employers and community resources. However, Colorado's existing structure is no longer compliant with CFCM requirements because case managers and direct service providers are frequently part of the same organizations and because CCBs are the only entities in Colorado that currently conduct TCM for the I/DD population.

During the course of this study, we received a wide range of views from members of the I/DD community regarding potential CFCM compliance options that formed the basis for the final recommendations. Overall, there was consensus that the Department should prioritize maximizing individual choice and preserving quality of services and case management when determining future CFCM policies. Some stakeholders felt that the Department should require CCBs to divest themselves of either TCM or direct services to eliminate conflicts of interest whenever possible, and that the transition to CFCM should occur gradually. Most stakeholders agreed that new case management agencies and direct service providers

should be allowed to enter the markets to increase the number of choices from which access point waiver individuals can choose.

Given the diverse populations they serve and the varied sources of funding they receive, the Department must consider all of these factors when bringing the Colorado I/DD system into compliance with the federal regulations for CFCM. The Department must consider how each case management and provider agency will be funded and monitored under the future system so that all individuals currently served by CCBs will continue to have access to high quality services and case management. The CFCM implementation plan outlined in this report provides a path for the Department to work with CCBs, individuals, their families and guardians, waiver providers, case managers and others over the next three to five years to transition to a conflict-free system that maximizes individual choice.

Appendix A: Community Centered Boards Desk Review Report

Colorado Department of Health Policy and Financing

Community Centered Boards Desk Review Report

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NAVIGANT

Table of Contents

Section I: Background

The Colorado Department of Health Care Policy and Financing (the Department) contracts with 20 Community Centered Boards (CCBs) that provide access to long-term services and supports through Medicaid Home and Community-Based Services (HCBS) 1915(c) waivers. The 20 CCBs function to determine eligibility for services for individuals with intellectual and developmental disabilities, provide case management services and either directly provide or subcontract services and supports. The CCBs also execute entry point functions, such as determining waiver eligibility and providing information and referrals for service. The CCBs serve as the access point for the following reviewed HCBS waivers (referred to as access point waivers throughout this report):

- Home and Community-Based Services Children's Extensive Support Waiver (HCBS-CES)
- Home and Community-Based Services Waiver for Persons with a Developmental Disability (HCBS-DD)
- Home and Community-Based Supported Living Services Waiver (HCBS-SLS)

CCBs operate as a "one-stop shop," where an individual with an intellectual and/or developmental disability works with a CCB, designated by geographical location, that will determine eligibility for services, create a service plan, and help the individual obtain services. The access point waiver enrollment process begins with a determination by the CCB of whether the individual has an intellectual and/or developmental disability and are therefore eligible to receive services. If eligible for services, the individual works with a case manager from the CCB to determine the scope of services and supports needed to meet his or her long-term needs. Individuals seeking access to 24 hour support waiver services are placed on a waiting list before they can receive waiver services, as a result of funding constraints. After the waiting process (if necessary), the individual then works with their case manager to coordinate services. Services are provided either directly by the CCB, via a sub-contracted service agency or individual, or by an approved Medicaid provider.

In March 2014, the Centers for Medicare and Medicaid Services (CMS) instituted *42 CFR 431.301* requiring states to separate case management from service delivery functions to reduce conflict of interest for services provided under 1915(c) waivers. This rule addressed conflicts of interest that arise when one provider is responsible for performing both case management functions and providing direct services. CMS provided numerous examples of potential conflicts resulting from such arrangements, including:

- Over- and under-utilization of services
- Interest in retaining individuals as clients rather than promoting independence
- Instances where the focus is not person-centered

As a result of this ruling, Colorado's existing CCB structure is no longer compliant with CMS regulations as case managers have been in positions in which they were responsible for settling grievances and monitoring direct services provided by fellow CCB staff members. The Department had already convened a Task Group of stakeholders in February 2014 to make recommendations for implementing choice of case management agency, and expanded its scope to include recommendations for a conflict free case management system. Colorado *House Bill 15-1318* requires the Department to develop a plan, with input

from CCBs and other stakeholders, for the delivery of conflict free case management that complies with Federal regulations.

As part of this process, the Department contracted with Navigant Consulting Inc. (Navigant) to evaluate and review the funding for and costs of operating three essential CCB functions: administrative, targeted case management (TCM) and Organized Healthcare Delivery System (OHCDS); and to analyze the impact of complying with the regulation and Colorado legislation. We were also tasked with reviewing and reporting on how each CCB performs these functions. For the purposes of this review, functions are defined as follows:

- Administrative functions include eligibility determinations, developmental disability determinations (DD Determinations), Supports Intensity Scale (SIS) assessments, quality assurance functions, waitlist management activities, and enrollment activities.

  Quality assurance activities include reviews and resolutions of complaints and grievances, Quality Improvement Strategies (QIS) activities and reporting, incident reporting and responses, establishing and participating in a Human Rights Committee, and the investigation and documentation of mistreatment, abuse, neglect and exploitation.

- TCM functions include assessment, service plan development, service plan monitoring and information and referral of information to their respective client.

- OHCDS functions include executing and maintaining a Medicaid provider agreement with the Department for all services available via the three access point waivers. Additionally, OHCDS functions encompass creating and maintaining documentation of all applicable provider qualifications for services rendered, directly or via subcontracts under the contractor's Medicaid provider agreement. For purposes of this review, the Department defined OHCDS as excluding costs and revenue related to direct services to individuals.

To provide anonymity and objectivity to the review, we have hidden both the names and location information for each CCB.

Section II: Methodology

The Department requested that Navigant conduct its work in four separate steps. The first step of work comprises the desk review that requires collecting documentation from CCBs and a review of the information submitted. For step two, we will use the desk reviews to propose five CCBs for on-site review and conduct those reviews; these reviews will allow a more detailed assessment of the CCB's financial information and give us an understanding of how Administrative, TCM and OHCDS functions operate at the CCBs. Upon conclusion of the on-site reviews, we will begin step three and attend Community Stakeholder Engagement meetings to obtain feedback on the implementation plan for Conflict-Free Case Management for Colorado. Step four will be the development of a final report that will aggregate all of our findings from the first three steps, as well as information from meetings with CCBs as well as other providers, individuals in services, families, guardians, advocates, and others, and provide a plan for implementation to the Department regarding conflict free case management. Figure A-1, demonstrates the four steps of our study.

Figure A-1. Steps of Navigant's Study

To collect sufficient information from the CCBs, we created a cost survey and instructions to gather financial information about the administrative, TCM and OHCDS functions. We included instructions to the survey and a list of commonly asked questions and answers to assist the CCBs in completing the survey. To attempt to understand how CCBs operate the administrative, TCM and OHCDS functions, we requested policies and procedures, as well as job descriptions related to each of the functions. We also requested other financial documentation, such as audited financial statements and a working trial balance, to aid in our understanding of the overall picture of CCB operations. In Table A-1, we provide a summary of the documentation that comprised our request of the CCBs for this analysis.

Table A-1. List of Files Sent to CCBs for Desk Review

File Requested	Purpose of File	Appendix
Cost Survey Instructions	Instruction to the cost survey and a list of commonly asked questions	Appendix A3
Documentation Request Listing	Summary list of all files requested	Appendix A4
Cost Survey	Gather financial information about the Administrative, TCM and OHCDS functions	Appendix A5

Cost Survey

Navigant attempted to obtain complete and reliable information from each CCB. In addition to providing detailed survey instructions, in late October 2015, we held a live webinar to guide CCBs through the survey and responded to questions during the webinar. We made clarifications to the survey to respond to CCB feedback and included a frequently asked questions list to document questions from CCBs about the survey and document collection. Navigant provided a dedicated email address for CCBs to reach out with questions throughout the survey collection period and provided technical assistance for completing the cost survey before and after submission. Based on feedback from CCBs about reporting on the OHCDS function, we distributed clarification to all CCBs about reporting on OHCDS. Upon initial review of the CCB submissions, Navigant worked with the CCB contacts to request missing information and ask clarifying questions.

The final documentation submission deadline for the survey and requested documentation was January 22, 2016. All information received up to February 10, 2016 was included in this

report.[1]

The Department has not required the CCBs to report financial information delineated by administrative, TCM and OHCDS functions in previous years. This is the first time the CCBs were asked to allocate their revenue into three separate sources; therefore, we designed the survey to address possible variations in the way CCBs operate as well as how they report their revenue and expenses. CCBs were also encouraged to submit a cover letter with their survey to bring to our attention any significant or distinct survey responses. We also used the survey to capture revenue information, including other revenue sources. We requested that CCBs specify, by function, the total revenue collected from Colorado Medicaid, federal sources, state sources, mill levy and any other source.

All requested documents from the CCBs were compiled, separately reviewed, and analyzed with the objective of determining:

- All sources of "functional" revenue for each CCB - *Functional revenue is the revenue generated from administrative, TCM, and OHCDS functions*
- Whether CCBs would lose revenue if the Medicaid reimbursement methodology changed
- Financial impact to the CCBs if the case management and administrative functions are removed from the CCB's scope of service.

Administrative, TCM and OHCDS Functions

Navigant conducted a qualitative review of each function to determine who is performing each of the administrative, TCM and OHCDS functions at each CCB and how each CCB operates each function. We reviewed organizational charts, job description listing and policies and procedures to obtain an understanding of how each CCB performs these functions.

This report summarizes the results of the desk review, which is our first step of the study. It provides objective analysis and does not include assumptions or recommendations. As described above, in step four we will develop of a final report that will aggregate all of our findings from the first three steps, as well as information from meetings with CCBs as well as other providers, individuals in services, families, guardians, advocates, and others, and provide a plan for implementation to the Department regarding conflict free case management. The final report will include recommendations based on the totality of all work.

Section III: Limitations of the Desk Review

Typical to similar engagements in which cost surveys are part of the study, we encountered a number of limitations in our work, as described below.

Cost Survey

The cost survey was designed to review revenue and expenses reported by each CCB and

[1] One of the 20 CCBs did not return their survey by this date.

draw conclusions about the financial impact to CCBs when implementing conflict free case management. Each CCB is unique in its operations, cost structures and sources of revenue. We attempted to address these variations by allowing each CCB to insert lines into the survey to add additional revenue or cost items that were not captured by the standard survey inputs. We therefore relied on the CCB's methods of revenue and expense allocation reported on the cost survey.

Accounting for the Administrative, TCM and OHCDS Functions

In a financial accounting environment, it is unusual to track revenue and expenses by Administrative, TCM and OHCDS functions. To provide meaningful results, we required each CCB to develop its own methods to allocate revenue and expenses to those functions. We could not provide a standard allocation method for these functions because each organization operates differently for each of the functions. Some CCBs did not disclose their allocation methods in the survey. As a result, we cannot determine how revenue and expenses for the administrative, TCM and OHCDS functions might differ if we had such information.

Data is limited to Fiscal Year End (FYE) 2014

We requested three years of data for this review (FYE 2012-2014), however, CCBs reported that retrieving historical data would be difficult. Nineteen of the 20 CCBs were able to submit a completed survey for 2014.

The OHCDS Function

Pursuant to the Colorado Code of Regulation, an OHCDS is a public or privately managed service organization that provides, at minimum, TCM services, and contracts with other qualified providers to furnish services authorized by the three access point waivers.[2] The OHCDS also maintains a Medicaid provider agreement with the Department to deliver HCBS according to the federally approved waivers that they operate. While the OHCDS has multiple functions, for the purposes of this review, we considered only two:

- Executing and maintaining a Medicaid Provider Agreement with the Department for all services available through the HCBS-CES, HCBS-DD, and HCBS-SLS waivers.
- Creating and maintaining documentation of all applicable provider qualifications for services rendered under the contractor's Medicaid Provider Agreement, whether those services are rendered by the contractor's employees or by a subcontractor.

We noted wide variation in revenue and expenses reported for the OHCDS function, and it appears that this wide variation may be due, in part, to some CCBs reporting revenue and cost information for all OHCDS functions (and, in particular, for direct services). We made this determination by examining the job descriptions, employee counts, revenue totals and cost totals submitted. For example, one CCB reported 107 employees specific to the OHCDS function and another reported having over $4 million in OHCDS revenue. Given the limited

[2] Code of Colorado Regulations, Medical Assistance 10 CCR 2505-10 8.500.1 (2016)

scope of the OHCDS function as we had defined it for the survey, we determined that these examples reflected unreasonably high employee counts and revenue. Noting these potential outliers was essential to our review because the potential inclusion of direct service and support information would not make for accurate comparisons of CCB costs and revenue. This consideration was vital when performing financial impact analysis of the CCBs. As a result, the OHCDS function and its associated revenue and costs will be an important focus of our future on-site reviews.

Accuracy of Data Received

As discussed in previous sections, the reporting of cost survey information required each CCB to create its own allocation methodology and allocate the revenue and expenses for the administrative, TCM and OHCDS functions. We reviewed the survey data and performed a series of reasonableness checks by comparing the total revenue and expenses reported on the CCB surveys to Audited Financial Statements and reports, supplied by the Department, of Colorado Medicaid payments made to CCBs in state fiscal year 2014. However, we found that because of potential differences with how the data was reported on the financial statements, the survey and the state reports, the data did not always match. For example, as a benchmarking activity, we compared CCB reported revenues to the state's payment information. In some cases CCBs' surveys did not match the state's payment information for TCM and administrative functions. This could be due to a variety of reasons including accounting methods used, fiscal periods used, and numerous other factors. Appendix A2 includes a benchmarking analysis spreadsheet that highlights the variances between data reported on the survey and Colorado Medicaid's payment information.

Section IV: Summary of CCB Cost and Revenue Review Results

Using the information reported by each CCB, we analyzed the potential financial impact on CCBs if the Department or the CCB were to remove or separate TCM and administrative functions from CCBs in the pursuit of conflict-free case management. We describe below the financial impact of separating Administrative and TCM functions.

Financial Impact of Separating TCM and Administrative Functions

The financial impact analysis comprised an examination of:

- Impact on total revenue
- Source of revenues for TCM and administrative functions

Impact on Total Revenue

In Table A-2, we display the average CCB unrestricted revenue and average Medicaid revenue that was reported on the Statement of Activities for Fiscal Year End 2014. Unrestricted revenue is a line item on the Statement of Activities that encompasses all sources of revenue for the CCB. All averages were calculated by using the financial information submitted by the 19 reviewed CCBs. We used these figures to get an understanding of the reported revenue per function in comparison to the total CCB revenues reported.

Table A-2. Average CCB Revenue (per Financial Statements) FYE 2014

Year	Average CCB Unrestricted Revenue	Average CCB Medicaid Revenue
2014	$16,175,015	$9,484,287

In Table A-3, we display the average revenue and average Medicaid revenue per function based on data reported on the CCB Survey. This table shows the average revenue and provides context to the pie charts shown in Figures A-2 and A-3.

Table A-3. Average Revenue by Function FYE 2014[3]

	Targeted Case Management	Administrative	OHCDS
Average Revenue	$903,242	$221,167	$1,321,017
Average Medicaid Revenue	$860,990	$72,700	$1,187,339

[3] One CCB was removed from the average calculation due to the CCB including all CCB revenue rather than access point waiver revenue.

In Table A-4, we display TCM Medicaid revenue on a per individual basis for 19 of the 20 CCBs. This table shows the average TCM Medicaid revenue per individual is $1,927.

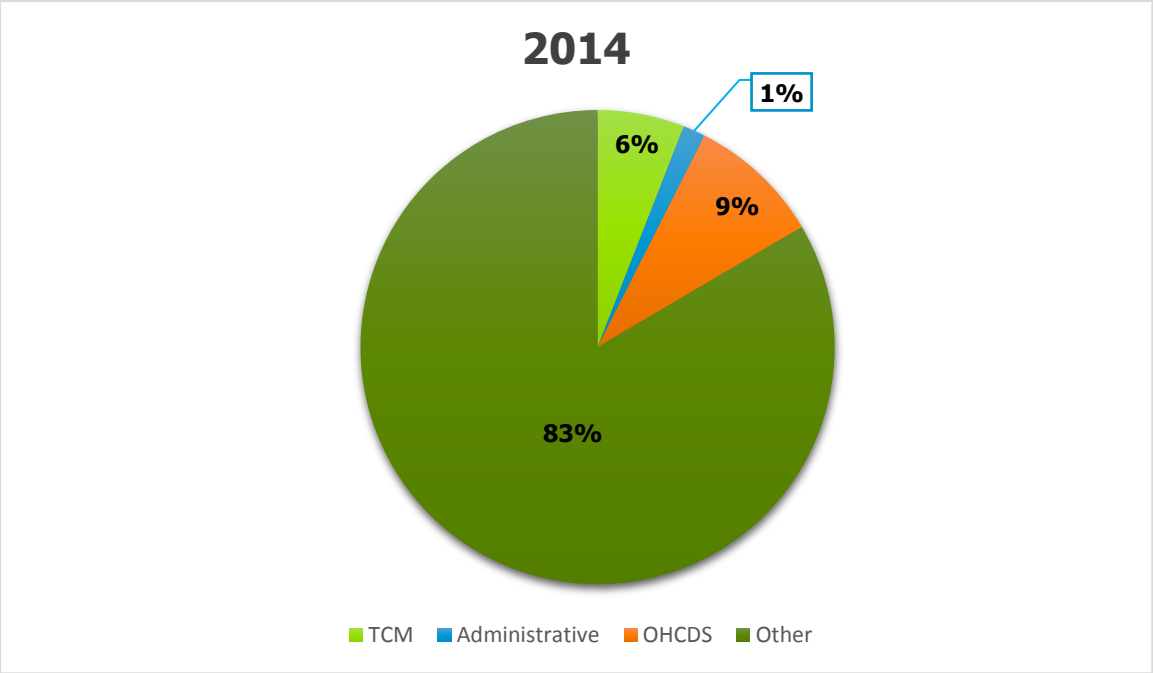
Table A-4. FY 2014 Average TCM Revenue per Individual Served

CCB	Total Individuals Served in Access Point Waivers	TCM Total Medicaid Revenue	TCM Per Individual
1	842	$1,169,724	$1,389
2	161	$304,107	$1,889
3	1117	$2,355,526	$2,109
4	77	$195,270	$2,536
5	1076	$1,932,038	$1,796
6[4]	1103	x	x
7	83	$40,059	$483
8	206	$305,648	$1,484
9	104	$241,724	$2,324
10	393	$906,412	$2,306
11	1115	$2,836,833	$2,544
12	116	$217,269	$1,873
13	562	$1,106,258	$1,968
14	66	$100,000	$1,515
15	728	$1,413,992	$1,942
16	217	$524,627	$2,418
17	151	$416,362	$2,757
18	130	$203,758	$1,567
19	578	$1,026,218	$1,775
20	547	$1,062,995	$1,943
Total	**9372**	**$16,358,820.91**	**N/A**
Average	**469**	**$860,990.57**	**$1,927**

[4] CCB #6 was not included in this calculation. This was due to this CCB reporting all sources of case management revenue rather than TCM revenue alone.

On average, as displayed in Figure A-2, TCM functions and administrative functions accounted for approximately 6 percent of total revenue for CCBs.

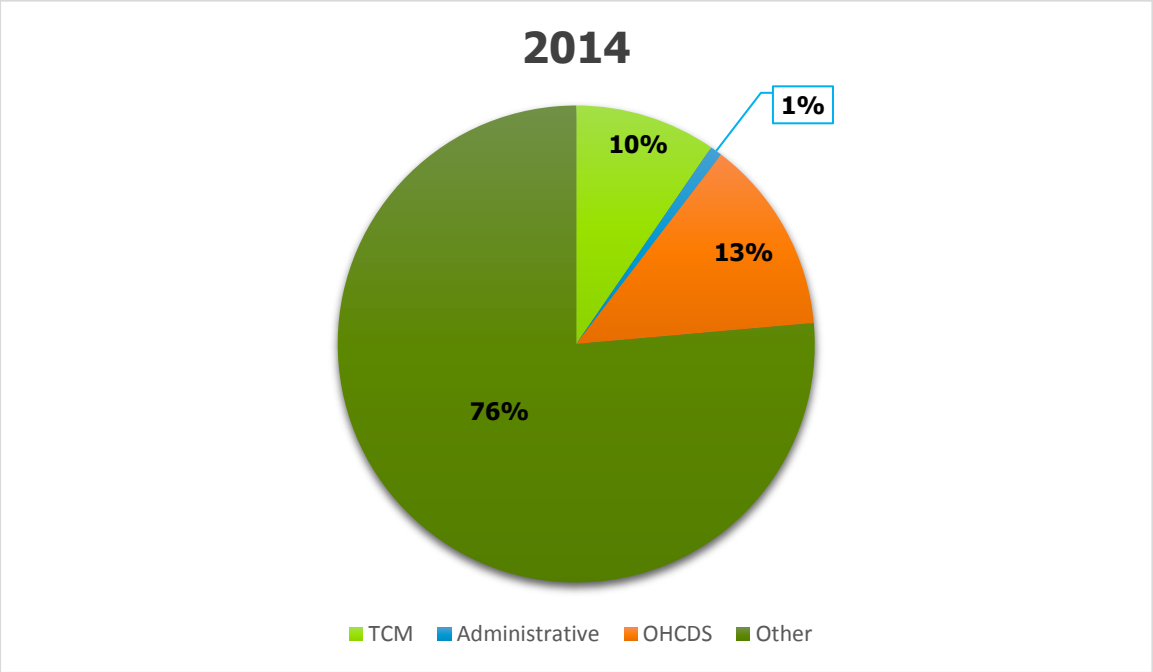
Figure A-2: Percentage of Total Reported Revenue (per Financial Statements) Attributable to TCM, Administrative and OHCDS functions (FYE 2014)[5]



On average, as we indicate in Figure A-3, TCM and Administrative functions account for approximately 10 percent of total annual Medicaid dollars received by CCBs as of FYE 2014.

[5] CCB #6 was not included in this calculation. This was due to this CCB reporting all sources of revenue in the cost survey.

Figure A-3. Percentage of Total Medicaid Dollars Paid to CCBs (per Financial Statements) Attributable to TCM, Administrative and OHCDS Functions (FYE 2014)[6]



Source of Revenues for TCM and Administrative Functions

Eighteen out of 19 CCBs receive the majority of their TCM and administrative revenue from Colorado Medicaid. An additional source of revenue is "mill levy," a type of location-based funding; CCBs receive these funds based on their location and use the funds to provide services to their local communities. Based on the survey results, this type of funding was not common; only two CCBs reported that they receive local mill levy funding for TCM and administrative functions.

Function Analysis Summary Results

We describe below our findings from our qualitative review of the administrative, TCM and OHCDS functions.

Case Manager Role

Case managers or the case management department are responsible for performing all administrative and TCM functions. These two functions are closely related and performing both allows the case manager to develop a relationship with individuals. However, the ability

[6] CCB #6 was not included in this calculation. This was due to this CCB reporting all sources of revenue in the cost survey.

to perform both functions is dependent on the individual caseload for each case manager.

OHCDS Policy Development

Many CCBs have not documented policies and procedures for their OHCDS function. Several CCBs told us that as a result of this review, they would develop these. Further, we found that many CCBs were unaware of what the OHCDS function entails and what data to report in the survey. Additional guidance from the Department clarifying the OHCDS function and the requirement for CCBs to document policies and procedures for each function will help to alleviate this confusion about the OHCDS. This additional guidance will allow both the Department and each CCB to gain a better understanding of the impact of conflict-free case management on CCBs.

Other Information

Navigant used the surveys to gather information on other qualitative data from the CCBs, including:

- Total individuals served in access point waivers
- The percentage of individuals served that live within 25 miles of the CCB main office
- The number of individuals on the waiting list
- The number of employees by functional area

This information provides additional context into the assessment for each CCB and we can consider that information when we decide which CCBs we will visit for on-site reviews.

A closer examination of the distance that individuals live from the CCB main office provides some context to what is required to reach out to individuals in the community. Of the 13 CCBs that provided distance information, we found that on average, individuals lived within 25 miles of the CCB's main office 80 percent of the time. Of the 13 CCBs that supplied this information, 6 of these CCBs served more than 500 individuals. For those CCBs that served more than 500 individuals, we found that on average, individuals lived within 25 miles of the CCB's main office 97 percent of the time. For the other seven CCBs who served fewer than 500 individuals, we found that on average, individuals lived within 25 miles of the CCB's main office 71 percent of the time. Although this analysis does not represent all of the 20 CCBs, it appears that most individuals are within a distance from their CCB that could be considered reasonable for accessing services. This analysis could not take into account CCBs that had satellite locations within their geographic area that would allow for closer proximity to individuals than the actual CCB main office.

Table A-5 shows a summary of this data.

Table A-5. Summary of Other Information across CCBs

Other Factors	Average of all CCBs	Median	Range
Total Individuals Served in Access Point Waivers	468	305	66–1,117
% of Individuals Served who live within 25 miles of the main office	N/A	N/A	22%–98%
Individuals on the waiting list	393[7]	45	4–1,941
Administrative Employees	7	5	1–20
TCM Employees	23	17	2–78
OHCDS Employees	12	4	1–107

[7] Represents the average of the 16 CCBs who submitted wait list information.

Section V: Summary

Our desk review analysis allowed us to better understand the full scope of CCB offerings, specifically related to the TCM, administrative and OHCDS functions. Each CCB varied both operationally and financially and through the desk review we were able to analyze those differences, to the extent the data was available. The analysis of the desk review of the CCB surveys indicated that, on average, TCM and administrative functions accounted for less than 10 percent of total revenue.

Using Medicaid revenue from TCM as the sole determinant, the vast majority of CCBs might elect to divest themselves from TCM services and continue to provide direct services, because the majority of CCB revenue comes from sources other than TCM. As a result of divestment and CFCM, there would be the potential for new providers of TCM to enter the market. Based on the cost survey data received, the average FY 2014 annual TCM revenue from Medicaid per individual was $1,927. Depending on the number of new providers entering the market, TCM may not be a feasible standalone option for some providers. A TCM provider would likely need to ensure that they had an adequate number of individuals to serve if TCM is to be a sustainable business; however, this study does not explore possible revenue outside of the three access point waivers to fully evaluate such a decision.

CCBs were inconsistent in their reporting of OHCDS revenue. We found that most CCBs either combined direct service revenue with its OHCDS revenue or did not include OHCDS revenue at all. However, based on discussions we had with CCBs while providing technical assistance during survey collection, the OHCDS function was not a significant portion of their business or day-to-day operations. This may be one reason CCBs did not report revenue for this function.

Due to the limitations of the cost survey data described above, we were unable to make any definitive conclusions regarding the costs reported by each CCB. We allowed CCBs to choose their approach for allocating their costs across the three functions, within the definitions outlined in the survey instructions. We received a wide variation in cost information, with some CCBs providing extensive cost survey data while others did not report the basic information required on the survey. More detailed cost analysis would be necessary to determine the day-to-day operational cost of providing TCM, administrative and OHCDS function, to support future decision-making for the Department, CCBs or other stakeholders.

In addition to analyses of revenue and costs, we requested other qualitative information on the survey and in the documentation request to inform our review. As part of our review, we examined information about the reported distance individuals lived from the main CCB office location. Although this analysis does not represent all of the 20 CCBs, it appears that most individuals are within a distance from their CCB that could be considered reasonable for accessing services, especially if we were able to take into account satellite locations within the CCB geographic area that provide TCM, direct services or both.

This desk review provided a better understanding of the range of approaches used to perform the three functions that were the focus of the review. CCBs varied in their approaches to separating the duties to perform the three functions, the extent to which CCBs act as an OHCDS, and the overall caseloads of case managers. These are all business decisions made by CCBs over the years that will now impact a CCB's transition to conflict-free case management. Some CCBs will likely have an easier time transitioning to conflict-free case management than others based on how they separate duties for the functions. For example, a CCB that has case managers who perform administrative and TCM functions will

need to reexamine the caseloads their case managers are able to manage if those administrative functions need to be separated. The implementation of conflict-free case management will be a significant change for most CCBs as they have evolved their operations over the years from a focus on TCM to a greater stake in providing direct services. Pulling apart the full array of services will have impacts on individuals. The implementation plan must address these to ensure smooth transitions and continuous coverage of services.

The next step of this study will be to work with the Department to identify five CCBs to follow-up with on-site reviews. The Department would like representation from all areas of the state. Navigant will, in conjunction with the Department, consider location, as well as the size of the CCB, completeness of data received and other factors to arrive at a list of five CCBs that Navigant will visit. We have preliminarily identified several focus areas for these on-site reviews, including:

- A more detailed discussion of costs to better define the costs of operating the Administrative, TCM and OHCDS functions
- A discussion of the caseload of a case manager responsible for performing both Administrative and TCM functions to examine how time is allocated between the two functions
- The variation in separation of duties for large and small CCBs (and how that affects the allocation of costs across the three functions)
- Discussion and review of the qualitative impact of divesting TCM functions from the CCB
- Discussion of the OHCDS function including: how revenue is captured for and allocated to OHCDS functions, the process for executing a Medicaid agreement, maintaining documentation, and the employees responsible for performing this function

In Appendix A1 of this report, we provide a summary of the results of our analysis for each of the CCBs that submitted cost surveys to Navigant. We have assigned random numbers to each of the CCBs in place of their names.

Appendix A1: CCB Desk Review Survey Results Summary

CCB #1

CCB #1 is located in Northeastern Colorado. All information below is taken from the documentation received, survey and financial statements for FYE 2014. Table A1-1 displays population information for this CCB. Table A1-2 displays employee information for this CCB.

Table A1-1. Individuals Served in Access Point Waivers

Population	FYE 2014	Average of all CCBs
Total Individuals Served in Access Point Waivers[8]	842	468
% of Individuals Served that live within 25 miles of the main office	98%	N/A
Individuals on the Waiting list	704	393

Table A1-2. Employee Information

Employee, by function	Total Employees	Average of all CCBs
Administrative employees	12	7
TCM employees	28	23
OHCDS employees	12	12

Overview of the Organization

This CCB reported 51 full-time employees and 1 part-time employee responsible for performing the three functions. CCB #1 provides numerous direct services, including day habilitation, homemaker, personal care, residential habilitation, respite and supported employment.

In Table A1-3, we provide a brief overview of who is responsible for performing activities within the three functions. No specific OHCDS policy and procedure information was

[8] Unduplicated count of individuals who spent the majority of the year receiving services from this CCB.

submitted by this CCB.

Table A1-3. CCB Job Responsibilities Summary

Employee Title	Job Responsibilities
Executive Director	Oversees the Assistant Director CFO, Case Management Director, and QA Investigations Coordinator.
Resource Coordinator	Eligibility determinations, intake and waitlist management, performs service plan development and monitoring/referrals
Associate Director of Resource Coordination	Developmental disability determinations, responds to the needs of people on the waitlist
Placement Managers	Performs SIS assessments
Quality Assurance Coordinator and Resource Coordinator	Perform quality assurance functions
Associate Director	Performs TCM assessments

Revenue by Function

Table A1-4 provides a snapshot of the revenue by function for FYE 2014 as reported in the survey.

Table A1-4. Revenue by Function

FYE 2014	Targeted Case Management Revenue	Administrative Revenue	OHCDS Revenue
Total Revenue from Colorado Medicaid	$1,169,724.00	N/A	N/A
Total Revenue from Federal Sources	N/A	N/A	N/A
Total Revenue from State Sources	N/A	N/A	N/A
Total revenue from Mill Levy	N/A	N/A	N/A
Total Revenues from Other Sources	N/A	$79,472.00	N/A
Total Revenues from Other Sources (On Boarding)	N/A	$275,598.00	N/A
Total	**$1,169,724.00**	**$355,070.00**	**N/A**

N/A – No revenue reported

CCB #1 reported revenues for both TCM and administrative functions, as shown in Table A1-5. Survey results, in comparison to the financial statements submitted by CCB #1, indicate that TCM functions for the access point waivers accounted for 3.8 percent of total revenue and administrative functions accounted for 1.2 percent of total revenue. TCM function Medicaid revenue accounted for 5.9 percent of their total unrestricted revenue from Medicaid. See Table A1-5 for the summary.

Table A1-5. Revenue by Function in Comparison to Revenue Reported per Statement of Activities

FYE 2014	Targeted Case Management	Administrative	OHCDS
Total Revenue (Cost Survey)	$1,169,724.00	$355,070.00	$0.00
Total Unrestricted CCB Revenue (Financial Statement)	$30,385,959.00		
% of total Unrestricted Revenue	**3.8%**	**1.2%**	**0.0%**
Total Revenue from Colorado Medicaid (cost survey)	$1,169,724.00	$0.00	$0.00
Total Unrestricted Revenue from Medicaid (financial statement)	$19,907,032.00		
% of Total Unrestricted Revenue from Colorado Medicaid	**5.9%**	**N/A**	**N/A**

Cost Information

Table A1-6 provides a snapshot of the cost information submitted by CCB #1 for each of the three functions.

Table A1-6. Costs by Function

FYE 2014	Targeted Case Management Costs	Administrative Costs	OHCDS Costs
Occupancy	$105,198.00	$32,002.00	$21,599.00
Supplies	$27,238.00	$8,966.00	$5,163.00
Staff Costs	$20,091.00	$11,630.00	$76,959.00
Professional Services	N/A	N/A	$32,148.00
Salaries and Wages	$853,279.00	$289,901.00	$103,444
Employee Taxes, Insurance, and Benefits	$211,582.00	$77,667.00	$19,907.00
Total	**$1,217,388.00**	**$420,166.00**	**$259,220.00**

N/A – No costs were reported

CCB #2

CCB #2 is located in the Southwestern part of Colorado. All information below is taken from the documentation received, survey and financial statements for FYE 2014. Table A1-7 displays population information for this CCB. Table A1-8 displays employee information for this CCB as of FYE 2014.

Table A1-7. Individuals Served in Access Point Waivers

Population	FYE 2014	Average of all CCBs
Total individuals served in access point waivers[9]	161	468
% of individuals served that live within 25 miles of the main office	86%	N/A
Individuals on the Waiting list	10	393

Table A1-8. Employee Information

Employee information	FYE 2014	Average of all CCBs
Administrative Employees	2	7
TCM Employees	6	23
OHCDS Employees	2	12

Organizational Overview

This CCB reported 9 full-time employees and 1 part-time employee performing the three functions. CCB #2 provides numerous direct services, including: day habilitation, homemaker, personal care, residential habilitation, respite and supported employment.

In Table A1-9, we provide a brief overview of who is responsible for performing activities within the three functions.

[9] Unduplicated count of individuals who spent the majority of the year receiving services from this CCB.

Table A1-9. CCB Job Responsibilities Summary

Employee Title	Job Responsibilities
Case Management Director	Performs quality management
Case Manager	Continued eligibility determinations service plan development and monitoring, referrals
Case Management Assistant	Waitlist management

Revenue by Function

Table A1-10 provides a snapshot of the revenue by function for FYE 2014 as reported in the survey.

Table A1-10. Revenue by Function

FYE 2014	Targeted Case Management Revenue	Administrative Revenue	OHCDS Revenue
Total Revenue from Colorado Medicaid	$304,107.00	N/A	$1,523,329.89
Total Revenue from Federal Sources	N/A	N/A	N/A
Total Revenue from State sources	$23,539.00	$66,837.44	N/A
Total Revenue from Mill Levy	N/A	N/A	N/A
Total Revenues from Other Sources	N/A	N/A	N/A
Total	**$327,646.00**	**$66,837.44**	**$1,523,329.89**

N/A – No revenue was reported from this source

CCB #2 reported revenue for all three functions in FYE 2014, as shown in Table A1-11. Survey results, in comparison to the financial statements submitted by CCB #2, indicate that TCM functions for the access point waivers accounted for 2.6 percent of total revenue, administrative functions accounted for 0.5 percent of total revenue and OHCDS functions accounted for 11.9 percent of total revenue. TCM function accounted for 3.5 percent of total Medicaid dollars received, administrative functions accounted for 0.7 percent, and OHCDS functions accounted for 16.4 percent of total unrestricted revenue from Medicaid.

Table A1-11. Revenue by Function in Comparison to Revenue Reported per Statement of Activities

FYE 2014	Targeted Case Management	Administrative	OHCDS
Total Revenue (Cost Survey)	$327,646.00	$66,837.44	$1,523,329.89
Total Unrestricted CCB Revenue (Financial Statement)	$12,826,291.00		
% of total unrestricted revenue	**2.6%**	**0.5%**	**11.9%**
Total revenue from Colorado Medicaid (Cost Survey)	$304,107.00	$0.00	$1,523,329.89
Total unrestricted revenue from Medicaid (Financial Statement)	$9,280,083.00		
% of Total Unrestricted Revenue from Colorado Medicaid	**3.3%**	**N/A**	**16.4%**

Cost Information

Table A1-12 provides a snapshot of the cost information submitted by CCB #2 for each of the three functions. CCB #2 only provided employee related expenses.

Table A1-12. Costs by Function

FYE 2014	Targeted Case Management Costs	Administrative Costs	OHCDS Costs
Salaries and Wages	$148,845.63	$78,414.17	$89,219.68
Employee, Taxes, and Benefits	$43,989.26	$23,483.56	$26,765.90
Total	**$192,834.89**	**$101,897.73**	**$115,985.58**

CCB #3

CCB #3 is located in the Denver area. All information below is taken from the documentation received, survey and financial statements for FYE 2014. Table A1-13 displays population information for this CCB. Table A1-14 displays employee information for this CCB.

Table A1-13. Individuals Served in Access Point Waivers

Population	FYE 2014	Average of all CCBs
Total individuals served in access point waivers[10]	1,117	468
% of individuals served that live within 25 miles of the main office	98%	N/A
Individuals on the Waiting list	N/A	393

N/A – Information not provided

Table A1-14. Employee Information

Employee Information	FYE 2014	Average of all CCBs
Administrative Employees	13	7
TCM Employees	78	23
OHCDS Employees	3	12

CCB #3 Organizational Overview

This CCB reported 94 full-time employees performing the three functions. These totals were inclusive of the CCB and its related entities. CCB #3 provides numerous direct services, including: behavioral services, homemaker, parental education, personal care, and respite.

In Table A1-15, we provide a brief overview of who is responsible for performing activities within the three functions. This CCB did not provide specifics as to who was responsible for performing OHCDS functions.

[10] Unduplicated count of individuals who spent the majority of the year receiving services from this CCB.

Table A1-15. CCB Job Responsibilities Summary

Employee Title	Job Responsibilities
Vice President	Responsible for overseeing the activities of the CCB.
Placement Case Manger	Performs eligibility determinations, manages the Adult Services waiting list, acts as a liaison between human service agencies, county agencies and Program Approved Service Agencies
Case Management Specialist	Calculates SIS levels, oversees the day-to-day operations of SIS requirements
Investigations/PASA Program Manager	Coordinates and develops quality improvement surveys, creates and maintains reporting for PASA compliance
Case Manager	Service plan development and monitoring

Revenue by Function

Table A1-16 provides a snapshot of the revenue by function for FYE 2014 as reported in the survey.

Table A1-16. Revenue by Function

FYE 2014	Targeted Case Management Revenue	Administrative Revenue	OHCDS Revenue
Total Revenue from Colorado Medicaid	$2,355,526.00	N/A	$3,091,743.00*
Total Revenue from Federal Sources	N/A	N/A	N/A
Total Revenue from State Sources	N/A	$534,659.00	N/A
Total Revenue from Mill Levy	N/A	$1,041,993.00	N/A
Total Revenue from Other Sources	N/A	N/A	N/A
Total	**$2,355,526.00**	**$1,576,652.00**	**$3,091,743.00***

N/A – No revenue was reported from this source

*Includes direct services and support revenue

CCB #3 reported revenues for all three functions in FYE 2014, as shown in Table A1-17. Survey results, in comparison to the financial statements submitted by CCB #3, indicate that TCM functions for the access point waivers accounted for 7.9 percent of total revenues, administrative functions accounted for 5.3 percent of total revenues and OHCDS functions accounted for 10.3 percent of total revenues. TCM function Medicaid revenue accounted for 36.9 percent of total unrestricted revenue from Medicaid. See Table A1-17 for the summary.

Table A1-17. Revenue by Function in Comparison to Revenue Reported per Statement of Activities

FYE 2014	Targeted Case Management	Administrative	OHCDS
Total Revenue (Cost Survey)	$2,355,526.00	$1,576,652.00	$3,091,743.00
Total Unrestricted CCB Revenue (Financial Statement)	$30,013,816.00		
% of Total Unrestricted Revenue	**7.8%**	**5.3%**	**10.3%**
Total Revenue from Colorado Medicaid (Cost Survey)	$2,355,526.00	$0.00	$3,091,743.00
Total Unrestricted Revenue from Medicaid (Financial Statement)	$6,378,944.00		
% of Total Unrestricted Revenue from Colorado Medicaid	**36.9%**	**N/A**	**48.5%**

Cost Information

Table A1-18 provides a snapshot of the cost information submitted by CCB #3 for each of the three functions.

Table A1-18. Costs by Function

FYE 2014	Targeted Case Management Costs	Administrative Costs	OHCDS Costs
Professional Services	$71,228.00	$28,430.00	$2,608.00
Staff Development	$3,943.00	$1,574.00	$144.00
Staff Mileage/Travel	$40,244.00	$16,063.00	$1,473.00
Occupancy Expense	$173,621.00	$69,299.00	$6,357.00
Supplies/Equipment	$33,931.00	$13,543.00	$1,242.00
Telephone	$29,341.00	$11,711.00	$1,074.00
Management Fee	$544,594.00	$303,796.00	$19,939.00
Other	$11,327.00	$4,521.00	$415.00
Salaries and Wages	$1,675,057.06	$669,218.99	$62,435.22
Employee Taxes, Insurance, and Benefits	$348,076.86	$139,063.71	$12,974.04
Total	**$2,931,362.92**	**$1,257,219.70**	**$108,661.26**

CCB #4

CCB #4 is located in the Northwestern part of Colorado. All information below is taken from the documentation received, survey and financial statements for FYE 2014. Table A1-19 displays population information for this CCB. Table A1-20 displays employee information for this CCB.

Table A1-19. Individuals Served in Access Point Waivers

Population	FYE 2014	Average of all CCBs
Total Individuals Served in Access Point Waivers[11]	77	468
% of Individuals Served that live within 25 miles of the main office	54%	N/A
Individuals on the waiting list	35	393

Table A1-20. Employee Information

Employee Information	FYE 2014	Average of all CCBs
Administrative Employees	5	7
TCM Employees	10	23
OHCDS Employees	6	12

CCB Organizational Overview

This CCB reported 3 full-time employees and eighteen part-time employees performing the three functions. This CCB provides numerous direct services, including: assistive technology, day habilitation, personal care, and respite.

In Table A1-21, we provide a brief overview of who is responsible for performing activities within the three functions. This CCB did not provide specific information regarding who is responsible for performing OHCDS functions.

[11] Unduplicated count of individuals who spent the majority of the year receiving services from this CCB.

Table A1-21. CCB Job Responsibilities Summary

Employee Title	Job Responsibilities
Admissions Committee	Determines the eligibility of services
Case Manager/Service Coordinator	Obtains the necessary information about potential clients, Service Plan Development and Monitoring
Executive Director	Supervises all programs and ensures quality
Director of Service Coordination	Coordinates investigations and ensures that Case Managers are providing quality service

Revenue by Function

Table A1-22 provides a snapshot of the revenue by function for FYE 2014 as reported in the survey.

Table A1-22. Revenue by Function

FYE 2014	Targeted Case Management Revenue	Administrative Revenue	OHCDS Revenue
Total Revenue from Colorado Medicaid	$195,270.39	N/A	N/A
Total Revenue from Federal Sources	N/A	N/A	N/A
Total Revenue from State Sources	N/A	$30,358.66	N/A
Total Revenue from Mill Levy	$3,833.44	N/A	N/A
Total Revenues from Other Sources	N/A	N/A	N/A
Total	**$199,103.83**	**$30,358.66**	**N/A**

N/A – No revenue was reported from this source

CCB #4 reported revenues for both TCM and administrative functions, as shown in Table A1-23. Survey results, in comparison to the financial statements submitted by CCB #4, indicate that TCM functions for the access point waivers accounted for 2.9 percent of total revenue and administrative functions accounted for 0.4 percent of total revenue. TCM function Medicaid revenue accounted for 5.9 percent of total unrestricted revenue from Medicaid. See Table A1-23 for the summary.

Table A1-23 Revenue by Function in Comparison to Revenue Reported per Statement of Activities

FYE 2014	Targeted Case Management	Administrative	OHCDS
Revenue from Cost Survey	$199,103.83	$30,358.66	$0.00
Total Unrestricted CCB Revenue (Financial Statement)	$6,839,935.00		
% of Total Unrestricted Revenue	**2.9%**	**0.4%**	**0.0%**
Total Revenue from Colorado Medicaid (Cost Survey)	$195,270.39	$0.00	$0.00
Total Unrestricted Revenue from Medicaid (Financial Statement)	$3,300,314.00		
% of Total Unrestricted Revenue from Colorado Medicaid	**5.9%**	**N/A**	**N/A**

Cost Information

Table A1-24 provides a snapshot of the cost information submitted by CCB #4 for each of the three functions.

Table A1-24. Costs by Function

FYE 2014	Targeted Case Management Costs	Administrative Costs	OHCDS Costs
Professional Services	$662.06	$373.30	$535.00
Staff Development	$224.08	$126.35	$181.07
Occupancy	$2,880.70	$1,624.28	$2,327.84
Insurance	$471.51	$265.86	$381.02
Interest	$570.95	$321.93	$461.37
Travel	$933.02	$526.08	$753.96
Supplies	$785.69	$443.01	$634.90
Depreciation	$606.34	$341.88	$489.97
Salaries and Wages	$130,202.46	$73,414.63	$105,214.16
Employee Taxes, Insurance, and Benefits	$22,160.53	$12,495.21	$17,907.51
Total	**$159,497.35**	**$89,932.54**	**$128,886.80**

CCB #5

CCB #5 is located in the Denver area. All information below is taken from the documentation received, survey and financial statements for FYE 2014. Table A1-25 displays population information for this CCB. Table A1-26 displays employee information for this CCB.

Table A1-25. Individuals Served in Access Point Waivers

Population	FYE 2014	Average of all CCBs
Total Individuals Served in Access Point Waivers[12]	1,076	468
% of Individuals Served that live within 25 miles of the main office	98%	N/A
Individuals on the waiting list	1,190	393

Table A1-26. Employee Information

Employee Information	FYE 2014	Average of all CCBs
Administrative Employees	20	7
TCM Employees	38	23
OHCDS Employees	2	12

CCB Organizational Overview

In Table A1-27, we provide a brief overview of who is responsible for performing activities within the three functions. CCB #5 did not submit any specific policy information regarding the performance of OHCDS functions.

[12] Unduplicated count of individuals who spent the majority of the year receiving services from this CCB.

Table A1-27. CCB Job Responsibilities Summary

Employee Title	Job Responsibilities
Resource Coordinator	Coordinates the screening, referral, and intake processes for individuals receiving services Performs waitlist management activities Develops and monitors service plans Disseminates information to the individuals in which they serve
Senior Resource Coordinator	Performs SIS assessments

Revenue by Function

Table A1-28 provides a snapshot of the revenue by function for FYE 2014 as reported in the survey.

Table A1-28. Revenue by Function

FYE 2014	Targeted Case Management Revenue	Administrative Revenue	OHCDS Revenue
Total Revenue from Colorado Medicaid	$1,932,038.00	N/A	N/A
Total Revenue from Federal Sources	N/A	N/A	N/A
Total Revenue from State Sources	N/A	N/A	N/A
Total Revenue from Mill Levy	N/A	N/A	N/A
Total Revenues from Other Sources	N/A	N/A	N/A
Total	**$1,932,038.00**	**N/A**	**N/A**

N/A – No revenue was reported from this source

CCB #5 reported revenue for TCM, as shown in Table A1-28. Survey results, in comparison to the financial statements submitted by CCB #5, indicate that TCM functions for the access point waivers accounted for 5.2 percent of total revenue. TCM function Medicaid revenue accounted for 8.2 percent of total unrestricted revenue from Medicaid. See Table A1-29 for the summary.

Table A1-29. Revenue by Function in Comparison to Revenue Reported per Statement of Activities

FYE 2014	Targeted Case Management	Administrative	OHCDS
Total Revenue (Cost Survey)	$1,932,038.00	$0.00	$0.00
Total Unrestricted CCB Revenue (Financial Statement)	$36,882,794.00		
% of Total Unrestricted Revenue	**5.2%**	**N/A**	**N/A**
Total Revenue from Colorado Medicaid (Cost Survey)	$1,932,038.00	$0.00	$0.00
Total Unrestricted Revenue from Medicaid (Financial Statement)	$23,610,831.00		
% of Total Unrestricted Revenue from Medicaid	**8.2%**	**N/A**	**N/A**

Cost Information

Table A1-30 provides a snapshot of the cost information submitted by CCB #5 for each of the three functions.

Table A1-30. Costs by Function

FYE 2014	Targeted Case Management Costs	Administrative Costs	OHCDS Costs
Other Professional	N/A	N/A	N/A
Staff Travel	$28,078.80	$17,448.21	$2,917.20
Occupancy Mtce	$15,662.07	$9,732.43	$1,627.19
Occupancy Utilities	$11,746.36	$7,299.21	$1,220.37
Equipment Mtce	$28,701.24	$17,834.99	$2,981.87
Insurance	$14,499.38	$9,009.94	$1,506.39
Depreciation	$27,001.34	$16,778.67	$2,805.26
Other and Allocated Management and General	$171,131.49	$106,341.36	$17,779.43
Salaries and Wages	$1,079,196.72	$670,614.41	$112,121.41
Employee Taxes, Insurance, and Benefits	$439,899.24	$273,354.03	$45,702.62
Total	**$1,815,916.64**	**$1,128,413.25**	**$188,661.74**

CCB #6

CCB #6 is located in the Denver area. All information below is taken from the documentation received, survey and financial statements for FYE 2014. Table A1-31 displays population information for this CCB. Table A1-32 displays employee and salary information for this CCB. This CCB's data includes total CCB revenue and therefore was not included in our aggregate analysis.

Table A1-31. Individuals Served in Access Point Waivers

Population	FYE 2014	Average of all CCBs
Total Individuals Served in Access Point Waivers[13]	1,103	468
% of Individuals Served that live within 25 miles of the main office	98%	N/A
Individuals on the waiting list	1,341	393

Table A1-32. Employee Information

Employee Information	FYE 2014	Average of all CCBs
Administrative Employees	15	7
TCM Employees	62	23
OHCDS Employees	12	12

CCB Organizational Overview

This CCB reported 84 full-time employees and 5 part-time employees performing the three functions. CCB #6 provides numerous direct services, including: behavioral services, day habilitation, homemaker, personal care, residential habilitation, respite and supported employment.

In Table A1-33, we provide a brief overview of who is responsible for performing activities

[13] Unduplicated count of individuals who spent the majority of the year receiving services from this CCB.

within the three functions.

Table A1-33. CCB Job Responsibilities Summary

Employee Title	Job Responsibilities
Intake Worker	Performs eligibility and developmental disability determinations
Placement Manager	Maintains the comprehensive services waiting list and supported living services waiting list
Children's Extensive Support Coordinator	Maintains the Children's Extensive Support Services waiting list
Service Coordinator II	Performs the TCM Assessment, service plan development, service plan monitoring and referrals
Case Manger	Creates and maintains documentation of provider qualifications
Case Aide	Assists with the TCM Assessment

Revenue by Function

Table A1-34 provides a snapshot of the revenue by function for FYE 2014 as reported in the survey.

Table A1-34. Revenue by Function

FYE 2014	Targeted Case Management Revenue	Administrative Revenue	OHCDS Revenue
Total Revenue from Colorado Medicaid	*$12,994,377.00	$408,376.00	$5,501,240.00
Total Revenue from Federal Sources	$4,493,301.00	N/A	N/A
Total Revenue from State Sources	$6,620,560.00	$782,518.00	N/A
Total Revenue from Mill Levy	$12,652,711.00	$130,000.00	N/A
Total Revenues from Other Sources	$3,703,201.00	$520,769.00	N/A
Total	**$40,464,150.00**	**$1,841,663.00**	**$5,501,240.00**

* TCM Revenue reported exceeded total Medicaid dollars per financial statements

N/A – No revenue reported

CCB #6 reported revenues for all three functions, as shown in Table A1-34. Survey results,

in comparison to the financial statements submitted by CCB #6, indicate that TCM functions for the access point waivers accounted for 85.2 percent of total revenue, administrative functions accounted for 3.9 percent of total revenue and OHCDS functions accounted for 11.6 percent of total revenue. TCM function Medicaid revenue accounted for 68.7 percent of total Medicaid dollars received, administrative functions accounted for 2.2 percent and OHCDS functions accounted for 29.1 percent of total unrestricted revenue from Medicaid. See Table A1-35 for the summary.

Table A1-35. Revenue by Function in Comparison to Revenue Reported per Statement of Activities

FYE 2014	Targeted Case Management	Administrative	OHCDS
Total Revenue (Cost Survey)	$40,464,150.00	$1,841,663.00	$5,501,240.00
Total Unrestricted CCB Revenue (Financial Statement)	$47,508,237.00		
% of Total Unrestricted Revenue	**85.2%**	**3.9%**	**11.6%**
Total Revenue from Colorado Medicaid (Cost Survey)	$12,994,377.00	$408,376.00	$5,501,240.00
Total Unrestricted Revenue from Medicaid (Financial Statement)	$18,903,993.00		
% of Total Unrestricted Revenue from Colorado Medicaid	**68.7%**	**2.2%**	**29.1%**

Cost Information

Table A1-36 provides a snapshot of the cost information submitted by CCB #6 for each of the three functions.

Table A1-36. Costs by Function

FYE 2014	Targeted Case Management Costs	Administrative Costs	OHCDS Costs
Legal	$75,357.00	$44,423.00	N/A
Occupancy	$1,474,563.00	$369,283.00	N/A
Interest	$255,212.00	$124,239.00	N/A
Depreciation, Depletion and Amortization	$735,282.00	$304,758.00	N/A
Insurance	$91,279.00	$42,948.00	N/A
Supplies	$488,195.00	$216,137.00	N/A
Travel	$330,739.00	$42,182.00	N/A
Other Expenses	$1,550,146.00	$511,870.00	N/A
Salaries and Wages	$15,884,089.00	$3,270,277.00	N/A
Employee Taxes, Insurance, and Benefits	$2,322,780.00	$723,589.00	N/A
Total	**$23,207,642.00**	**$5,649,706.00**	**N/A**

N/A – No costs were reported for this expense

CCB #7

CCB #7 is located in the southwestern part of Colorado. All information below is taken from the documentation received, survey and financial statements for FYE 2014. Table A1-37 displays population information for this CCB. Table A1-38 displays employee and salary information for this CCB.

Table A1-37. Individuals Served in Access Point Waivers

Population	FYE 2014	Average of all CCBs
Total Individuals Served in Access Point Waivers[14]	83	468
% of Individuals Served that live within 25 miles of the main office	90%	N/A
Individuals on the waiting list	27	393

Table A1-38. Employee Information

Employee Information	FYE 2014	Average of all CCBs
Administrative Employees	1	7
TCM Employees	2	23
OHCDS Employees	107*	12

* Includes direct service support employees

CCB Organizational Overview

This CCB reported 110 full-time employees performing the three functions. CCB #7 provides numerous direct services, including: behavioral services, homemaker, mentorship, personal care, respite, and residential habilitation. Table A1-38 provides a brief overview of who is responsible for performing activities within the three functions.

In Table A1-39, we provide a brief overview of who is responsible for performing activities within the three functions. The CCB allows for directors and supervisors specific to each

[14] Unduplicated count of individuals who spent the majority of the year receiving services from this CCB.

program to perform OHCDS functions. Each program director and supervisor is responsible for maintaining provider files and agreements. No additional OHCDS policy and procedure information was provided.

Table A1-39. CCB Job Responsibilities Summary

Employee Title	Job Responsibilities
Admissions Committee	Determines the eligibility of services
Case Manager/Service Coordinator	Obtains the necessary information about potential clients, Service Plan Development and Monitoring
Executive Director	Supervises all programs and ensures quality
Director of Service Coordination	Coordinates investigations and ensures that Case Managers are providing quality service

Revenue by Function

Table A1-40 provides a snapshot of the revenue by function for FYE 2014 as reported in the survey.

Table A1-40. Revenue by Function

FYE 2014	Targeted Case Management Revenue	Administrative Revenue	OHCDS Revenue
Total Revenue from Colorado Medicaid	$40,059.00	$104,862.00	$3,928,639.00*
Total Revenue from Federal Sources	N/A	N/A	N/A
Total Revenue from State Sources	$9,500.00	$12,649.00	$110,785.00*
Total Revenue from Mill Levy	N/A	N/A	N/A
Total Revenues from Other Sources	$115.00	$268.00	$134,779.00*
Total	**$49,674.00**	**$117,779.00**	**$4,174,203.00***

* Includes direct service support revenue and exceeds Total Medicaid dollars reported in audited financial statements

N/A – No revenue reported

CCB #7 reported revenues for all three functions, as shown in Table A1-41. Survey results, in comparison to the financial statements submitted by CCB #7, indicate that TCM functions

for the access point waivers accounted for 1.1 percent of total revenue, administrative revenues accounted for 2.6 percent of total revenue and OHCDS function revenues accounted for 91.3 percent. TCM function Medicaid revenue accounted for 1.1 percent of total Medicaid dollars received, administrative functions accounted for 2.8 percent and OHCDS functions for 111.3 percent.[15] See Table A1-41 for the summary.

Table A1-41. Revenue by Function in Comparison to Revenue Reported per Statement of Activities

FYE 2014	Targeted Case Management	Administrative	OHCDS
Total Revenue (Cost Survey)	$49,674.00	$117,779.00	$4,174,203.00
Total Unrestricted CCB Revenue (Financial Statement)	$4,573,960.00		
% of Total Unrestricted Revenue	**1.1%**	**2.6%**	**91.3%**
Total Revenue from Colorado Medicaid (Cost Survey)	$40,059.00	$104,862.00	$3,928,639.00
Total Unrestricted Revenue from Medicaid (Financial Statement)	$3,748,077.00		
% of Total Unrestricted Revenue from Colorado Medicaid	**1.1%**	**2.8%**	**104.8%**

Cost Information

Table A1-42 provides a snapshot of the cost information submitted by CCB #7 for each of the three functions.

[15] Medicaid revenue reported for OHCDS functions exceeds Colorado Medicaid revenue reported in financial statements for FYE 2014.

Table A1-42. Costs by Function

FYE 2014	Targeted Case Management Costs	Administrative Costs	OHCDS Costs
Medical Professional Services	$86.00	$202.00	$57,153.00
DDD Expenses	N/A	N/A	$68,308.00
Board & Staff Development & Travel	$1,240.00	$2,894.00	$39,212.00
Occupancy	$2,170.00	$5,063.00	$558,802.00
Equipment	$244.00	$570.00	$30,438.00
Client Assistance	N/A	N/A	$105,791.00
Vehicles	$196.00	$456.00	$128,800.00
Other Supplies	$579.00	$1,351.00	$64,198.00
Other Expenses	$633.00	$1,478.00	$49,581.00
Unallowable Expenses	$381.00	$890.00	$7,424.00
Salaries and Wages	$30,617.00	$71,439.00	$2,528,419.00
Employee Taxes, Insurance, and Benefits	$5,494.00	$12,819.00	$618,861.00
Total Expenses	**$41,640.00**	**$97,162.00**	**$4,256,987.00**

N/A – No costs were reported

CCB #8

CCB #8 is located in the Southwestern part of Colorado. All information below is taken from the documentation received, survey and financial statements for FYE 2014. Table A1-43 displays population information for this CCB. Table A1-44 displays employee and salary information for this CCB.

Table A1-43. Individuals Served in Access Point Waivers

Population	FYE 2014	Average of all CCBs
Total Individuals Served in Access Point Waivers[16]	206	468
% of Individuals Served that live within 25 miles of the main office	80%	N/A
Individuals on the waiting list	42	393

Table A1-44. CCB Employee Information

Employee Information	FYE 2014	Average of all CCBs
Administrative Employees	3.8*	7
TCM Employees	6*	23
OHCDS Employees	1.5*	12

*CCB estimated the number of employees performing these functions by taking the total hours spent on the three functions by employees and dividing these hours by 2,080.

N/A – Information was not available

CCB Organizational Overview

This CCB reported 12 part-time employees performing the three functions. CCB #8 provides numerous direct services, including: behavioral services, day habilitation, homemaker, dental, personal care, and respite.

In Table A1-45, we provide a brief overview of who is responsible for performing activities

[16] Unduplicated count of individuals who spent the majority of the year receiving services from this CCB.

within the three functions. This CCB did not provide specific documentation to address the OHCDS functions.

Table A1-45. CCB Job Responsibilities Summary

Employee Title	Job Responsibilities
Case Management Director	Performs eligibility determinations, performs developmental disability determinations, performs service coordination, and waitlist management
Placement Case Manager	Performs eligibility and developmental disability determinations
Case Manager	Performs eligibility and developmental disability determinations Performs initial assessments, service plan development and monitoring

Revenue by Function

Table A1-46 provides a snapshot of the revenue by function for FYE 2014 as reported in the survey.

Table A1-46. Revenue by Function

FYE 2014	Targeted Case Management Revenue	Administrative Revenue	OHCDS Revenue
Total Revenue from Colorado Medicaid	$305,648.00	$76,637.00	$3,636.00
Total Revenue from Federal Sources	N/A	N/A	N/A
Total Revenue from State Sources	N/A	N/A	N/A
Total Revenue from Mill Levy	N/A	N/A	N/A
Total Revenues from Other Sources	N/A	N/A	N/A
Total	**$305,648.00**	**$76,637.00**	**$3,636.00**

N/A – No revenue reported

CCB #8 reported revenues for all three functions. Survey results, in comparison to the financial statements submitted by CCB #8, indicate that TCM functions for the access point waivers accounted for 3.6 percent of total revenue, administrative revenues accounted for 0.9 percent of total revenue and OHCDS function revenues accounted for less than half of a

percent. TCM function Medicaid revenue accounted for 4.5 percent of total unrestricted revenue from Medicaid dollars, administrative functions accounted for 1.1 percent and OHCDS functions for less than a half of a percent**.** See Table A1-47 for the summary.

Table A1-47. Revenue by Function in Comparison to Revenue Reported per Statement of Activities

FYE 2014	Targeted Case Management	Administrative	OHCDS
Total Revenue (Cost Survey)	$305,648.00	$76,637.00	$3,636.00
Total Unrestricted CCB Revenue (Financial Statement)	$8,576,597.00		
% of Total Unrestricted Revenue	**3.6%**	**0.9%**	**0.0%**
Total Revenue from Colorado Medicaid (Cost Survey)	$305,648.00	$76,637.00	$3,636.00
Total Unrestricted Revenue from Medicaid (Financial Statement)	$6,858,723.00		
% of Total Unrestricted Revenue from Colorado Medicaid[17]	**4.5%**	**1.1%**	**0.0**

Cost Information

Table A1-48 provides a snapshot of the cost information submitted by CCB #8 for each of the three functions.

Table A1-48. Costs by Function

FYE 2014	Targeted Case Management Costs	Administrative Costs	OHCDS Costs
Direct Operational Program Expenses	$30,625.00	$12,993.00	$5,524.00
Audited Agency Management and General	$42,192.00	$36,363.00	$14,358.00
Salaries and Wages	$204,916.00	$182,865.00	$73,080.00
Employee, Taxes, and Benefits	$45,736.00	$46,563.00	$17,118.00
Total	**$323,469.00**	**$278,784.00**	**$110,080.00**

[17] Negligible percentages or percentages under 0.5% were recorded as 0%.

CCB #9

CCB #9 is located in the Southeastern part of Colorado. All information below is taken from the documentation received, survey and financial statements for FYE 2014. Table A1-49 displays population information for this CCB. Table A1-50 displays employee information for this CCB. Table A1-50 displays employee and salary information for this CCB.

Table A1-49. Individuals Served in Access Point Waivers

Population	FYE 2014	Average of all CCBs
Total Individuals Served in Access Point Waivers[18]	104	468
% of Individuals Served that live within 25 miles of the main office	98%	N/A
Individuals on the waiting list	4	393

Table A1-50. Employee Information

Employee Information	FYE 2014	Average of all CCBs
Administrative Employees	1	7
TCM Employees	3	23
OHCDS Employees	1	12

CCB Organizational Overview

This CCB reported 4 full-time employees and 1 part-time employees performing the three functions. CCB #9 numerous direct services, including: day habilitation, homemaker, residential habilitation, respite and supported employment.

In Table A1-51, we provide a brief overview of who is responsible for performing activities within the three functions.

[18] Unduplicated count of individuals who spent the majority of the year receiving services from this CCB.

Table A1-51. CCB Job Responsibilities Summary

Employee Title	Job Responsibilities
Case Manager	Coordinates the initial meeting to determine eligibility Performs Developmental Disability determinations and SIS Assessments Performs quality assurance functions Service Plan development and monitoring Acts as a liaison with other agencies during referrals
Case Management Director	Screens and assists with the determination of appropriate services
Case Management Aid	Performs waitlist management

Revenue by Function

Table A1-52 provides a snapshot of the revenue by function for FYE 2014 as reported in the survey.

Table A1-52. Revenue by Function

FYE 2014	Targeted Case Management Revenue	Administrative Revenue	OHCDS Revenue
Total Revenue from Colorado Medicaid	$241,724.04	$41,709.91	N/A
Total Revenue from Federal Sources	N/A	N/A	N/A
Total Revenue from State Sources	N/A	N/A	N/A
Total Revenue from Mill Levy	N/A	N/A	N/A
Total Revenues from Other Sources	N/A	N/A	N/A
Total	**$241,724.04**	**$41,709.91**	**N/A**

N/A – No revenue reported.

CCB #9 reported revenue for both TCM and administrative functions, as shown in Table A1-53. Survey results, in comparison to the financial statements submitted by CCB #9, indicate that TCM functions for the access point waivers accounted for 3.7 percent of total revenue and administrative functions accounted for 0.6 percent of total revenue. TCM function Medicaid revenue accounted for 4.6 percent of total unrestricted Medicaid revenue and

administrative functions accounted for 0.8 percent. See Table A1-53 for the summary.

Table A1-53. Revenue by Function in Comparison to Revenue Reported per Statement of Activities

FYE 2014	Targeted Case Management	Administrative	OHCDS
Total Revenue (Cost Survey)	$241,724.04	$41,709.11	$0.00
Total Unrestricted CCB Revenue (Financial Statement)	$6,473,053.00		
% of Total Unrestricted Revenue	**3.7%**	**0.6%**	**N/A**
Total Revenue from Colorado Medicaid (Cost Survey)	$241,724.04	$41,709.11	N/A
Total Unrestricted Revenue from Medicaid (Financial Statement)	$5,308,010.00		
% of Total Unrestricted Revenue from Colorado Medicaid	**4.6%**	**0.8%**	**N/A**

Cost Information

Table A1-54 provides a snapshot of the cost information submitted by CCB #9 for each of the three functions.

Table A1-54. Costs by Function

FYE 2014	Targeted Case Management Costs	Administrative Costs	OHCDS Costs
Administrative Allocation	$7,681.57	$15,363.13	$15,363.13
Salaries and Wages	112316.29	$11,950.36	$15,405
Employee Taxes, Insurance, and Benefits	$35,258.67	$3,944.87	$5,287.07
Total	**$155,256.53**	**$31,258.36**	**$36,054.78**

CCB #10

CCB #10 is located in the Northeastern part of Colorado. All information below is taken from the documentation received, survey and financial statements for FYE 2014. Table A1-55 displays population information for this CCB. Table A1-56 displays employee information for this CCB.

Table A1-55. Individuals Served in Access Point Waivers

Population	FYE 2014	Average of all CCBs
Total Individuals Served in Access Point Waivers[19]	393	468
% of Individuals Served that live within 25 miles of the main office	94%	N/A
Individuals on the waiting list	249	393

Table A1-56. Employee Information

Employee Information	FYE 2014	Average of all CCBs
Administrative Employees	2	7
TCM Employees	19	23
OHCDS Employees	12	12

CCB Organizational Overview

This CCB reported 31 full-time employees and 2 part-time employees performing the three functions. CCB #10 provides numerous direct services, including: assistive technology, behavioral services, day habilitation, personal care, and respite.

In Table A1-57, we provide a brief overview of who is responsible for performing activities within the three functions

[19] Unduplicated count of individuals who spent the majority of the year receiving services from this CCB.

Table A1-57. CCB Job Responsibilities Summary

Employee Title	Job Responsibilities
Intake and Waiting List Case Manager	Assists families with the initial application and eligibility process Responsible for compiling and reviewing eligibility information
Adult Case Management Director	Reviews eligibility information with the Intake Case Managers to determine eligibility of individuals referred for services
Compliance and Monitoring Coordinator	Oversees all functions of the SIS process including scheduling, completion of assessments, and data entry into SIS online Performs quality assurance functions, such as monitoring the implementation of plan corrections from quality reviews performed
Case Manager	Provides assistance and information to clients to help identify services and various referral opportunities Service plan development and monitoring
Administrative Coordinators	Prepares contracts and ensures all documents are properly signed and/or notarized, and ensures that all contractor documents are received and maintained

Revenue by Function

Table A1-58 provides a snapshot of the revenue by function for FYE 2014 as reported in the survey.

Table A1-58. Revenue by Function

FYE 2014	Targeted Case Management Revenue	Administrative Revenue	OHCDS Revenue
Total Revenue from Colorado Medicaid	$906,411.88	N/A	N/A
Total Revenue from Federal Sources	N/A	N/A	N/A
Total Revenue from State Sources	$0.00	$228,538.82	$47,952.13
Total Revenue from Mill Levy	N/A	N/A	N/A
Total Revenues from Other Sources	N/A	N/A	$441,076.00
Total	**$906,411.88**	**$228,538.82**	**$489,028.13**

N/A – No revenue reported.

CCB #10 reported revenues for all three functions, as shown in Table A1-58. Survey results, in comparison to the financial statements submitted by CCB #10, indicate that TCM functions for the access point waivers accounted for 9.2 percent of total revenue, administrative functions for 2.3 percent of total revenue and OHCDS functions for 5 percent of total revenue. TCM function Medicaid revenue accounted for 13.6 percent of total unrestricted revenue from Medicaid. See Table A1-59 for the summary.

Table A1-59. Revenue by Function in Comparison to Revenue Reported per Statement of Activities

FYE 2014	Targeted Case Management	Administrative	OHCDS
Total Revenue (Cost Survey)	$906,411.88	$228,538.82	$489,028.13
Total Unrestricted CCB Revenue (Financial Statement)	$9,816,046.00		
% of Total Unrestricted Revenue	**9.2%**	**2.3%**	**5.0%**
Total Revenue from Colorado Medicaid (Cost Survey)	$906,411.88	$0.00	$0.00
Total Unrestricted Revenue from Colorado Medicaid (Financial Statement)	$6,659,491.00		
% of Total Unrestricted Revenue from Colorado Medicaid	**13.6%**	**N/A**	**N/A**

Cost Information

Table A1-60 provides a snapshot of the cost information submitted by CCB #10 for each of the three functions.

Table A1-60. Costs by Function

FYE 2014	Targeted Case Management Costs	Administrative Costs	OHCDS Costs
Professional Services: Legal, Accounting, Interpreters	$13,155.07	$3,726.80	$21,867.62
Business Insurance & Depreciation	$12,070.12	$2,635.07	$9,146.54
Financial Fees: Interest, Investment, Sales Taxes	N/A	$769.19	$11,059.22
Facilities: R&M, Utilities, Janitorial, Supplies	$13,627.32	$3,119.72	$13,029.13
Computers, Software Fees, Computer Supplies, Office Supplies	$5,804.05	$2,288.18	$19,134.27
Equipment Lease, Purchase & R&M	$11,522.44	$3,893.06	$28,835.28
Postage, Printing, Dues & Subscriptions	$2,746.59	$1,972.22	$21,659.71
Staff Recruitment & Development, Transportation	$16,701.30	$3,831.10	$13,823.87
Salaries and Wages	410425.59	$89,962.47	$308,588
Employee Taxes, Insurance, and Benefits	$96,440.00	$20,810.84	$72,450.07
Total	**$582,492.48**	**$133,008.65**	**$519,594.03**

N/A – No costs were reported for this expense

CCB #11

CCB #11 is located in southeastern Colorado. All information below is taken from the documentation received, survey and financial statements FYE 2014. Table A1-61 displays population information for this CCB. Table A1-62 displays employee and salary information for this CCB.

Table A1-61. Individuals Served in Access Point Waivers

Population	FYE 2014	Average of all CCBs
Total Individuals Served in Access Point Waivers[20]	1,115	468
% of Individuals Served that live within 25 miles of the main office	N/A	N/A
Individuals on the waiting list	1,941	393

N/A – Information not provided

Table A1-62. Employee Information

Employee Information	FYE 2014	Average of all CCBs
Administrative Employees	27	7
TCM Employees	36	23
OHCDS Employees	3	12

Overview of the Organization

This CCB reported 62 full-time employees and 4 part-time employees performing the three functions. CCB #11 provides one direct service, behavioral services.

In Table A1-63, we provide a brief overview of who is responsible for performing activities within the three functions.

[20] Unduplicated count of individuals who spent the majority of the year receiving services from this CCB.

Table A1-63. CCB Job Responsibilities Summary

Employee Title	Job Responsibilities
CEO/Executive Director	Responsible for OHCDS functions
Benefits Coordinator	Conduct SIS assessments Conduct eligibility determinations Perform TCM assessments
Enrollment Coordinator	Conduct SIS assessments Assist with the completion of referrals
Quality Assurance Coordinator	Perform quality assurance functions Perform TCM assessments Review service plan development
Quality Improvement Coordinator	Perform quality assurance functions Perform TCM assessments
Navigation Coordinator	Conduct SIS Assessments Conduct eligibility determinations Responsible for waitlist management Perform TCM assessments
Community Coordinator	Responsible for service plan development, service plan monitoring, and referral completion

Revenue by Function

Table A1-64 provides a snapshot of the revenue by function for FYE 2014 as reported in the survey.

Table A1-64. Revenue by Function

FYE 2014	Targeted Case Management Revenue	Administrative Revenue	OHCDS Revenue
Total Revenue from Colorado Medicaid	$2,836,833.00	$87,204.00	N/A
Total Revenue from Federal Sources	N/A	N/A	N/A
Total Revenue from State Sources	$143,916.00	N/A	N/A
Total Revenue from Mill Levy	N/A	N/A	N/A
Total Revenues from Other Sources	N/A	N/A	$47,923.00
Total	**$2,980,749.00**	**$87,204.00**	**$47,923.00**

N/A – No revenue was reported from this source

CCB #11 reported revenue for all three functions, as shown in Table A1-65. Survey results, in comparison to the financial statements submitted by CCB #11, indicate that TCM functions for the access point waivers accounted for 22.8 percent of total revenue, administrative functions accounted for 0.7 percent of total revenue, and OHCDS functions accounted for 0.4 percent of total revenues. TCM function Medicaid revenue accounted for 49.4 percent of total unrestricted revenue from Medicaid, administrative functions accounted for 1.4 percent and OHCDS functions accounted for 0.8 percent. See Table A1-65 for the summary.

Table A1-65. Revenue by Function as Percent of Revenue Reported per Statement of Activities

FYE 2014	Targeted Case Management	Administrative	OHCDS
Total Revenue (Cost Survey)	$2,980,749.00	$87,204.00	$47,923.00
Total Unrestricted CCB Revenue (Financial Statement)	$13,067,706.00		
% of Total Unrestricted Revenue	**22.8%**	**0.7%**	**0.4%**
Total Revenue from Colorado Medicaid (Cost Survey)	$2,836,833.00	$87,204.00	$0.00
Total Unrestricted Revenue from Colorado Medicaid (Financial Statement)	$6,030,733.00		
% of Total Unrestricted Revenue from Colorado Medicaid	**47.0%**	**1.4%**	**0.8%**

Cost Information

Table A1-66 provides a snapshot of the cost information submitted by CCB #11 for each of the three functions.

Table A1-66. Costs by Function

FYE 2014	Targeted Case Management Costs	Administrative Costs	OHCDS Costs
Staff Development	$8,906.28	$6,012.35	$102.49
Leased Equipment	$11,073.70	$7,475.51	$690.34
Communications Systems	$23,457.85	$15,835.67	$2,474.56
Travel & Mileage	$40,797.40	$27,541.06	$58.70
Insurance	$7,977.21	$5,385.17	$649.06
Occupancy Expenses	$18,412.91	$12,429.98	$3,905.16
Office Supplies	$5,770.06	$3,895.18	$1,507.71
Other Expenses	$117,365.44	$79,229.76	$36,206.41
Salaries and Wages	$1,159,706.91	$782,882.09	$111,014
Employee Taxes, Insurance, and Benefits	$190,734.61	$128,759.00	$17,136.46
Total	**$1,584,202.37**	**$1,069,445.77**	**$173,745.33**

CCB #12

CCB #12 is located in the southeastern part of Colorado. All information below is taken from the documentation received, survey and financial statements FYE 2014. Table A1-67 displays population information for this CCB. Table A1-68 displays employee information for this CCB.

Table A1-67. Individuals Served in Access Point Waivers

Population	FYE 2014	Average of all CCBs
Total Individuals Served in Access Point Waivers[21]	116	468
% of Individuals Served that live within 25 miles of the main office	89%	N/A
Individuals on the waiting list	14	393

Table A1-68. Employee Information

Employee Information	FYE 2014	Average of all CCBs
Administrative Employees	1	7
TCM Employees	3	23
OHCDS Employees	1	12

Overview of the Organization

This CCB reported 4 full-time employees and 1 part-time employee performing the three functions. This CCB did not report providing any direct services.

The following Table A1-69 provides a brief overview of who is responsible for performing activities within the three functions. For purposes of our review, we focused mainly on the job duties and responsibilities of the Resource Coordination and Development division.

[21] Unduplicated count of individuals who spent the majority of the year receiving services from this CCB.

Table A1-69. CCB Job Responsibilities Summary

Employee Title	Job Responsibilities
Case Manager	Perform SIS assessments Perform quality assurance functions Responsible for waitlist management Responsible for all TCM functions
Executive Director	Responsible for all OHCDS functions

Revenue by Function

Table A1-70 provides a snapshot of the revenue by function for FYE 2014 as reported in the survey.

Table A1-70. Revenue by Function

FYE 2014	Targeted Case Management Revenue	Administrative Revenue	OHCDS Revenue
Total Revenue from Colorado Medicaid	$217,269.00	$3,363.84	$731.27
Total Revenue from Federal Sources	N/A	N/A	N/A
Total Revenue from State Sources	N/A	N/A	$N/A
Total Revenue from Mill Levy	N/A	N/A	N/A
Total Revenues from Other Sources	N/A	$N/A	N/A
Total	**$217,269.00**	**$3,363.84**	**$731.27**

N/A – No revenue was reported from this source

CCB #12 reported revenue for all 3 functions, as shown in Table A1-71. Survey results, in comparison to the financial statements submitted by CCB #12, indicate that TCM functions for the access point waivers accounted for 4.3 percent of total revenue and administrative and OHCDS functions each accounted for less than 1 percent. TCM functions accounted for 7.6 percent of total Medicaid dollars received and administrative functions each accounted for less than 1 percent. See Table A1-71 for the summary.

Table A1-71. Revenue by Function as Percent of Revenue Reported per Statement of Activities

FYE 2014	Targeted Case Management	Administrative	OHCDS
Revenue from Cost Survey	$217,269.00	$3,363.84	$731.27
Total Unrestricted CCB Revenue (Financial Statement)	$ 5,050,849.00		
% of Total Unrestricted Revenue[22]	**4.3%**	**0.0%**	**0.0%**
Total Revenue from Colorado Medicaid (Cost Survey)	$217,269.00	$3,363.84	$731.27
Total Unrestricted Revenue from Medicaid (Financial Statement)	$2,875,569.00		
% of Total Unrestricted Revenue from Medicaid	**7.6%**	**0.1%**	**0.0%**

Cost Information

Table A1-72 provides a snapshot of the cost information submitted by CCB #12 for each of the three functions.

Table A1-72. Costs by Function

FYE 2014	Targeted Case Management Costs	Administrative Costs	OHCDS Costs
Salaries and Wages	$204,552.00	$5,235.58	$1,138.17
Employee Taxes, Insurance, and Benefits	$33,692.00	$913.46	$198.58
Administrative Costs	$21,246.00	$1,924.73	$418.42
Total	**$259,490.00**	**$8,073.77**	**$1,755.17**

[22] Negligible percentages or percentages under 0.5% were recorded as 0%.

CCB #13

CCB #13 is located in the southwestern part of Colorado. All information below is taken from the documentation received, survey and financial statements FYE 2014. Table A1-73 displays population information for this CCB. Table A1-74 displays employee and salary information.

Table A1-73. Individuals Served in Access Point Waivers

Population	FYE 2014	Average of all CCBs
Total Individuals Served in Access Point Waivers[23]	562	468
% of Individuals Served that live within 25 miles of the main office	N/A	N/A
Individuals on the waiting list	N/A	393

N/A – Information not provided

Table A1-74. Employee Information

Employee Information	FYE 2014	Average of all CCBs
Administrative Employees	2	7
TCM Employees	17	23
OHCDS Employees	N/A	12

Overview of the Organization

This CCB reported 18 full-time employees and 1 part-time employees performing the three functions. CCB #13 provides numerous direct services, including: behavioral services, day habilitation, homemaker, personal care, and supportive employment.

In Table A1-75, we provide a brief overview of who is responsible for performing activities within the three functions.

[23] Unduplicated count of individuals who spent the majority of the year receiving services from this CCB.

Table A1-75. CCB Job Responsibilities Summary

Employee Title	Job Responsibilities
Case Manager	Conduct eligibility determinations
Case Management Specialist	Conduct eligibility determinations
Placement Manager	Respond to all inquiries Conduct DD determinations Conduct SIS assessments Responsible for waitlist management
Case Manager, Case Management Supervisor	Perform quality assurance functions Perform service plan development and service plan monitoring Conduct service plan revisions Assist with referrals
Case Management Specialist, and VP for Quality Assurance	Perform quality assurance functions
Case Management Specialist	Conduct service plan revisions
Program Manager	Assist with referrals

Revenue by Function

Table A1-76 provides a snapshot of the revenue by function for FYE 2014 as reported in the survey.

Table A1-76. Revenue by Function

FYE 2014	Targeted Case Management Revenue	Administrative Revenue	OHCDS Revenue
Total Revenue from Colorado Medicaid	$1,106,258.40	$122,917.60	N/A
Total Revenue from Federal Sources	N/A	N/A	N/A
Total Revenue from State Sources	$128,830.50	$14,314.50	N/A
Total Revenue from Mill Levy	N/A	N/A	N/A
Total Revenues from Other Sources	$55,610.10	$6,178.90	N/A
Total	**$1,290,699.00**	**$143,411.00**	**N/A**

N/A – No revenue was reported from this source

CCB #13 reported revenue for all three functions, as shown in Table A1-77. Survey results, in comparison to the financial statements submitted, indicate that TCM functions for the access point waivers accounted for 7.7 percent of total revenue and administrative functions accounted for 0.9 percent of total revenue. TCM function Medicaid revenue accounted for 8.4 percent of total unrestricted revenue from Medicaid and administrative functions accounted for 0.9 percent. See Table A1-77 for the summary.

Table A1-77. Revenue by Function as Percent of Revenue Reported per Statement of Activities

FYE 2014	Targeted Case Management	Administrative	OHCDS
Total Revenue (Cost Survey)	$1,290,699.00	$143,411.00	$0.00
Total Unrestricted CCB Revenue (Financial Statement)	$16,837,873.00		
% of Total Unrestricted Revenue	**7.7%**	**0.9%**	**N/A**
Total Revenue from Colorado Medicaid (Cost Survey)	$1,106,258.40	$122,917.60	$0.00
Total Unrestricted Revenue from Colorado Medicaid (Financial Statement)	$13,130,112.00		
% of Total Unrestricted Revenue from Colorado Medicaid	**8.4%**	**0.9%**	**N/A**

Cost Information

Table A1-78 provides a snapshot of the cost information submitted by CCB #13 for each of the three functions.

Table A1-78. Costs by Function

FYE 2014	Targeted Case Management Costs	Administrative Costs	OHCDS Costs
Indirect Costs	$73,389.60	$8,154.40	N/A
Salaries and Wages	$623,873.70	$69,319.30	N/A
Employee Taxes, Insurance, and Benefits	$143,741.70	$15,971.30	N/A
Total	**$841,005.00**	**$93,445.00**	**N/A**

N/A – No costs were reported for this expense

CCB #14

CCB #14 is located in the Southeastern part of Colorado. All information below is taken from the documentation received, survey and financial statements FYE 2014. Table A1-79 displays population information for this CCB. Table A1-80 displays employee and salary information.

Table A1-79. Individuals Served in Access Point Waivers

Population	FYE 2014	Average of all CCBs
Total Individuals Served in Access Point Waivers[24]	66	468
% of Individuals Served that live within 25 miles of the main office	95%	N/A
Individuals on the waiting list	8	393

Table A1-80. Employee Information

Employee Information	FYE 2014	Average of all CCBs
Administrative Employees	1	7
TCM Employees	3	23
OHCDS Employees	1	12

Overview of the Organization

This CCB reported 4 full-time employees and 1 part-time employees performing the three functions. CCB #14 provides a multitude of direct services, including but not limited to: day habilitation, homemaker, personal care, residential habilitation, respite and supported employment.

In Table A1-80, we provide a brief overview of who is responsible for performing activities

[24] Unduplicated count of individuals who spent the majority of the year receiving services from this CCB.

within the three functions

Table A1-81. CCB Job Responsibilities Summary

Employee Title	Job Responsibilities
Case Manager	Conduct eligibility determinations Conduct DD determinations Perform SIS assessments Perform quality assurance functions Conduct referrals
Case Management Assistant	Conduct eligibility determinations
Case Management Director	Conduct eligibility determinations Responsible for waitlist management Perform SIS assessments Perform TCM assessments Responsible for service plan monitoring

Revenue by Function

Table A1-82 provides a snapshot of the revenue by function for FYE 2014 as reported in the survey.

Table A1-82. Revenue by Function

FYE 2014	Targeted Case Management Revenue	Administrative Revenue	OHCDS Revenue
Total Revenue from Colorado Medicaid	$100,000.00	N/A	N/A
Total Revenue from Federal Sources	N/A	N/A	N/A
Total Revenue from State Sources	N/A	$45,000.00	N/A
Total Revenue from Mill Levy	N/A	N/A	N/A
Total Revenues from Other Sources	N/A	N/A	N/A
Total	**$100,000.00**	**$45,000.00**	**N/A**

N/A – No revenue was reported from this source

CCB #14 reported revenues for both TCM and administrative functions, as shown in Table A1-83. Survey results, in comparison to the financial statements submitted by CCB #14, indicate that TCM functions for the access point waivers accounted for 3.7 percent of total revenue and administrative functions accounted for 1.7 percent of total revenue. TCM function Medicaid revenue accounted for 4.4 percent of total unrestricted revenue from Medicaid. See Table A1-83 for the summary.

Table A1-83. Revenue by Function as Percent of Revenue Reported per Statement of Activities

FYE 2014	Targeted Case Management	Administrative	OHCDS
Total Revenue (Cost Survey)	$100,000.00	$45,000.00	$0.00
Total Unrestricted CCB Revenue (Financial Statement)	$2,694,871.00		
% of Total Unrestricted Revenue	**3.7%**	**1.7%**	**0.0%**
Total Revenue from Colorado Medicaid (Cost Survey)	$100,000.00	$0.00	$0.00
Total Unrestricted Revenue from Colorado Medicaid (Financial Statement)	$2,251,701.00		
% of Total Unrestricted Revenue from Colorado Medicaid	**4.4%**	N/A	N/A

Cost Information

Table A1-84 provides a snapshot of the cost information submitted by CCB #14 for each of the three functions.

Table A1-84. Costs by Function

FYE 2014	Targeted Case Management Costs	Administrative Costs	OHCDS Costs
Other Expenses	$2,000.00	$1,000.00	$750.00
Salaries and Wages	$98,700.00	$24,800.00	$18,000
Employee Taxes, Insurance, and Benefits	$17,700.00	$4,500.00	$3,500.00
Total	**$118,400.00**	**$30,300.00**	**$22,250.00**

CCB #15

CCB #15 is located in the Denver area. All information below is taken from the documentation received, survey and financial statements FYE 2014. Table A1-85 displays population information for this CCB. Table A1-86 displays employee and salary information.

Table A1-85. Individuals Served in Access Point Waivers

Population	FYE 2014	Average of all CCBs
Total Individuals Served in Access Point Waivers[25]	728	468
% of Individuals Served that live within 25 miles of the main office	95%	N/A
Individuals on the waiting list	N/A	393

N/A – Information not provided

Table A1-86. Employee Information

Employee Information	FYE 2014	Average of all CCBs
Administrative Employees	5	7
TCM Employees	34	23
OHCDS Employees	6	12

Overview of the Organization

This CCB reported 39 full-time employees and 6 part-time employees performing the three functions. CCB #15 provides numerous direct services, including: assistive technology, dental, day habilitation, personal care, and respite.

In Table A1-87, we provide a brief overview of who is responsible for performing activities within the three functions.

[25] Unduplicated count of individuals who spent the majority of the year receiving services from this CCB.

Table A1-87. CCB Job Responsibilities Summary

Employee Title	Job Responsibilities
Director of Client Relations	Head the Care Coordination division Oversee the Assistant Director of Care Coordination
Assistant Director of Care Coordination	Oversee Care Coordination Program Managers, Case Management Supervisors and Case Managers
Care Coordination Program Manager	Oversee Case Management Supervisors
Case Management Supervisor	Oversee Case Managers
Case Manager	Responsibilities related to administrative, TCM, and OHCDS functions not provided
Intake Case Manager	Conduct eligibility determinations Conduct DD determinations Perform SIS assessments
Quality Assurance Coordinators and Quality Assurance Analysts	Perform quality assurance functions Review documentation submitted by PASAs before becoming sub-contractors. Submit recommendation for OHCDS status to Chief Financial Officer.

Revenue by Function

Table A1-88 provides a snapshot of the revenue by function for FYE 2014 as reported in the survey.

Table A1-88. Revenue by Function

FYE 2014	Targeted Case Management Revenue	Administrative Revenue	OHCDS Revenue
Total Revenue from Colorado Medicaid	$1,413,992.00	$283,857.00	$2,883,864.00
Total Revenue from Federal Sources	N/A	N/A	N/A
Total Revenue from State Sources	$138,209.00	$242,552.00	N/A
Total Revenue from Mill Levy	N/A	N/A	N/A
Total Revenues from Other Sources	N/A	N/A	$9,258.00
Total	**$1,552,201.00**	**$526,409.00**	**$2,893,122.00**

N/A – No revenue was reported from this source

CCB #15 reported revenues for all three functions, as shown in Table A1-89. Per our survey, in comparison to the complete financial statements submitted, TCM functions for the access point waivers accounted for 4.8 percent of total revenue, administrative functions accounted for 1.6 percent of total revenue, and OHCDS functions accounted for 9 percent of total revenue. TCM function Medicaid revenue accounted for 8.1 percent of total unrestricted revenue from Medicaid, administrative functions accounted for 1.6 percent, and OHCDS functions accounted for 16.4 percent. See Table A1-89 for the summary.

Table A1-89. Revenue by Function as Percent of Revenue Reported per Statement of Activities

FYE 2014	Targeted Case Management	Administrative	OHCDS
Total Revenue (Cost Survey)	$1,552,201.00	$526,409.00	$2,893,122.00
Total Unrestricted CCB Revenue (Financial Statement)	$32,100,549.00		
% of Total Unrestricted Revenue	**4.8%**	**1.6%**	**9.0%**
Total Revenue from Colorado Medicaid (Cost Survey)	$1,413,992.00	$283,857.00	$2,883,864.00
Total Unrestricted Revenue from Colorado Medicaid (Financial Statement)	$17,544,502.00		
% of Total Unrestricted Revenue from Colorado Medicaid	**8.1%**	**1.6%**	**16.4%**

Cost Information

Table A1-90 provides a snapshot of the cost information submitted by CCB #15 for each of the three functions.

Table A1-90. Costs by Function

FYE 2014	Targeted Case Management Costs	Administrative Costs	OHCDS Costs
Other Direct Costs	$71,420.00	$16,770.00	$2,246.00
Allocated Space & IT costs	$195,696.00	$52,163.00	$5,149.00
M&G	$152,049.00	$47,185.00	$4,975.00
Salaries and Wages	$951,639.00	$299,052.00	$31,536.00
Employee Taxes, Insurance, and Benefits	$298,711.00	$101,096.00	$10,822.00
Total	**$1,669,515.00**	**$516,266.00**	**$54,728.00**

CCB #16

CCB #16 is located in the Northeastern part of Colorado. All information below is taken from the documentation received, survey and financial statements FYE 2014. Table A1-91 displays population information for this CCB. Table A1-92 displays employee and salary information.

Table A1-91. Individuals Served in Access Point Waivers

Population	FYE 2014	Average of all CCBs
Total Individuals Served in Access Point Waivers[26]	217	468
% of Individuals Served that live within 25 miles of the main office	42%	N/A
Individuals on the waiting list	N/A	393

N/A – Information was not provided

Table A1-92. Employee Information

Employee Information	FYE 2014	Average of all CCBs
Administrative Employees	4	7
TCM Employees	11	23
OHCDS Employees	1	12

Overview of the Organization

This CCB reported 16 full-time employees performing the three functions. CCB #16 provides numerous direct services, including but not limited to: day habilitation, non-medical transportation, residential habilitation and supported employment.

[26] Unduplicated count of individuals who spent the majority of the year receiving services from this CCB.

In Table A1-93, we provide a brief overview of who is responsible for performing activities within the three functions

Table A1-93. CCB Job Responsibilities Summary

Employee Title	Job Responsibilities
Case Management Director	Serve on the Board of Directors, which is Responsible for waitlist management Provide oversight of Case Managers for TCM activities
Case Manager	Responsible for performing all administrative and TCM functions Conduct DD determinations Perform SIS assessments Perform quality assurance functions
Case Manager Assistant	Responsibilities related to administrative, TCM, and OHCDS functions not provided
Data Clerk	Responsibilities related to administrative, TCM, and OHCDS functions not provided
Finance Director	Responsible for maintaining contracts with direct service providers
Quality and Compliance Director	Responsible for maintaining contracts with direct service providers Oversees contract compliance issues with direct service providers

Revenue by Function

Table A1-94 provides a snapshot of the revenue by function for FYE 2014 as reported in the survey.

Table A1-94. Revenue by Function

FYE 2014	Targeted Case Management Revenue	Administrative Revenue	OHCDS Revenue
Total Revenue from Colorado Medicaid	$524,627.00	N/A	N/A
Total Revenue from Federal Sources	N/A	N/A	N/A
Total Revenue from State Sources	N/A	$72,424.00	$32,300.96
Total Revenue from Mill Levy	N/A	N/A	N/A
Total Revenues from Other Sources	N/A	N/A	N/A
Total	**$524,627.00**	**$72,424.00**	**$32,300.96**

N/A – No revenue was reported from this source

CCB #16 reported revenue for all three functions, as shown in Table A1-95. Survey results, in comparison to the financial statements submitted by CCB #16, indicate that TCM revenues accounted for 5.9 percent of total revenue, administrative revenues accounted for 0.8 percent of total revenue and OHCDS function revenues accounted for 0.4 percent. TCM function Medicaid revenue accounted for 7.7 percent of total Medicaid dollars received. See Table A1-95 for the summary.

Table A1-95. Revenue by Function as Percent of Revenue Reported per Statement of Activities

FYE 2014	Targeted Case Management	Administrative	OHCDS
Total Revenue (Cost Survey)	$524,627.00	$72,424.00	$32,300.96
Total Unrestricted CCB Revenue (Financial Statement)	$8,848,382.00		
% of Total Unrestricted Revenue	**5.9%**	**0.8%**	**0.4%**
Total Revenue from Colorado Medicaid (Cost Survey)	$524,627.00	$0.00	$0.00
Total Unrestricted Revenue from Colorado Medicaid (Financial Statement)	$6,862,246.00		
% of Total Unrestricted Revenue from Colorado Medicaid	**7.7%**	**N/A**	**N/A**

Cost Information

Table A1-96 provides a snapshot of the cost information submitted by CCB #16 for each of the three functions.

Table A1-96. Costs by Function

FYE 2014	Targeted Case Management Costs	Administrative Costs	OHCDS Costs
Other Pro Services	N/A	$19,697.38	$5,094.15
Staff Dev/Travel	$18,674.55	$3,196.96	$826.80
Vehicles	$11,652.66	$15,024.90	$3,885.75
Occupancy	$25,087.32	$4,742.66	$1,226.55
Telephone/Dues	$11,742.57	$12,211.32	$3,158.10
Insurance	$10,466.82	$7,339.32	$1,898.10
Depreciation	$11,174.76	$5,846.40	$1,620.00
Supplies	$17,520.30	$21,167.10	$5,474.25
Salaries and Wages	$374,515.65	$184,576.88	$47,735
Employee Taxes, Insurance, and Benefits	$87,688.17	$36,977.32	$9,563.10
Total	**$568,522.80**	**$310,780.24**	**$80,482.20**

N/A – No costs were reported for this expense

CCB #17

CCB #17 is located in the Southwestern part of Colorado. All information below is taken from the documentation received, survey and financial statements FYE 2014. Table A1-97 displays population information for this CCB. Table A1-98 displays employee and salary information.

Table A1-97. Individuals Served in Access Point Waivers

Population	FYE 2014	Average of all CCBs
Total Individuals Served in Access Point Waivers[27]	151	468
% of Individuals Served that live within 25 miles of the main office	22%	N/A
Individuals on the waiting list	20	393

Table A1-98. Employee Information

Employee Information	FYE 2014	Average of all CCBs
Administrative Employees	5	7
TCM Employees	6	23
OHCDS Employees	4	12

Overview of the Organization

This CCB reported 11 full-time employees and 4 part-time employees performing the three functions. CCB #17 provides numerous direct services, including but not limited to: behavioral services, day habilitation, homemaker, personal care, residential habilitation and supported employment.

In Table A1-99, we provide a brief overview of who is responsible for performing activities within the three functions

[27] Unduplicated count of individuals who spent the majority of the year receiving services from this CCB.

Table A1-99. CCB Job Responsibilities Summary

Employee Title	Job Responsibilities
Assistant Director of Support Services	Update and document needs of waitlist members
Placement Manager	Responsible for waitlist management
Adult/Child Case Manager	Perform TCM assessment
Adult Services Administrator	Responsible for service plan development
Adult Case Manager, Assistant Director of Support Services, and Children's Case Manager Aid Bilingual	Responsible for service plan development Responsible for service plan monitoring Conduct referrals

Revenue by Function

Table A1-100 provides a snapshot of the revenue by function for FYE 2014 as reported in the survey.

Table A1-100. Revenue by Function

FYE 2014	Targeted Case Management Revenue	Administrative Revenue	OHCDS Revenue
Total Revenue from Colorado Medicaid	$416,361.71	$57,461.00	$54,675.01
Total Revenue from Federal Sources	N/A	N/A	N/A
Total Revenue from State Sources	$86,858.10	$0.00	$9,650.90
Total Revenue from Mill Levy	N/A	N/A	N/A
Total Revenues from Other Sources	$73,260.00	$0.00	$8,140.00
Total	**$576,479.81**	**$57,461.00**	**$72,465.91**

N/A – No revenue was reported from this source

CCB #17 reported revenue for all three functions, as shown in Table A1-101. Survey results, in comparison to the financial statements submitted by CCB #17, indicate that TCM functions for the access point waivers accounted for 6.4 percent of total revenue, administrative functions accounted for 0.6 percent of total revenue and OHCDS functions accounted for 0.8 percent of

total revenue. TCM function Medicaid revenue accounted for 6.4 percent of total unrestricted revenue from Medicaid, administrative functions accounted for 0.9 percent and OHCDS functions accounted for 0.8 percent. See Table A1-101 for the summary.

Table A1-101. Revenue by Function as Percent of Revenue Reported per Statement of Activities

FYE 2014	Targeted Case Management	Administrative	OHCDS
Revenue from Cost Survey	$576,480.00	$57,461.00	$72,466.00
Total Unrestricted CCB Revenue (Financial Statement)	$9,048,563.00		
% of Total Unrestricted Revenue	**6.4%**	**0.6%**	**0.8%**
Total Revenue from Colorado Medicaid (Cost Survey)	$416,362.00	$57,461.00	$54,675.00
Total Unrestricted Revenue from Medicaid (Financial Statement)	$6,478,181.00		
% of Total Unrestricted Revenue from Medicaid	**6.4%**	**0.9%**	**0.8%**

Cost Information

Table A1-102 provides a snapshot of the cost information submitted by CCB #17 for each of the three functions.

Table A1-102. Costs by Function

FYE 2014	Targeted Case Management Costs	Administrative Costs	OHCDS Costs
Staff Travel & Development	$27,091.90	$4,172.48	$27,171.98
Utilities/Equipment	$31,436.10	$16,998.00	$65,063.00
Supplies	$9,224.10	$4,597.60	$26,557.00
Insurance	$2,084.40	$1,411.80	$5,877.70
Interest	$0.00	$0.00	$1,643.30
Other	$4,490.10	$3,538.80	$11,019.90
Depreciation	$2,593.80	$3,747.80	$22,102.40
Professional Expenses	$0.00	$12,752.60	$23,325.20
Salaries and Wages	$146,839.01	$123,838.28	$187,544.97
Employee Taxes, Insurance, and Benefits	$30,716.45	$24,859.33	$36,984.34
Total	**$254,474.86**	**$195,916.69**	**$407,289.80**

N/A – No costs were reported for this expense

CCB #18

CCB #18 is located in the Southwestern part of Colorado. All information below is taken from the documentation received, survey and financial statements FYE 2014. Table A1-103 displays population information for this CCB. Table A1-104 displays employee and salary information.

Table A1-103. Individuals Served in Access Point Waivers

Population	FYE 2014	Average of all CCBs
Total Individuals Served in Access Point Waivers[28]	130	468
% of Individuals Served that live within 25 miles of the main office	30%	N/A
Individuals on the waiting list	97	393

Table A1-104. Employee Information

Employee Information	FYE 2014	Average of all CCBs
Administrative Employees	3	7
TCM Employees	6	23
OHCDS Employees	5	12

Overview of the Organization

This CCB reported 13 full-time employees and 1 part-time employees performing the three functions. CCB #18 provides numerous direct services, including: behavioral services, homemaker, mentorship, personal care, residential habilitation, and respite.

In Table A1-105, we provide a brief overview of who is responsible for performing activities within the three functions

[28] Unduplicated count of individuals who spent the majority of the year receiving services from this CCB.

Table A1-105. CCB Job Responsibilities Summary

Employee Title	Job Responsibilities
Case Management Director	Oversee Case Management Assistant Director Oversee Case Managers Responsible for waitlist management Ensure all TCM functions are performed in accordance with state regulations
Case Management Assistant Director	Oversee Case Managers
Case Manager	Conduct eligibility determinations Conduct DD determinations Conduct internal investigations on behalf of individuals receiving services Responsible for service plan development Responsible for service plan monitoring

Revenue by Function

Table A1-106 provides a snapshot of the revenue by function for FYE 2014 as reported in the survey.

Table A1-106. Revenue by Function

FYE 2014	Targeted Case Management Revenue	Administrative Revenue	OHCDS Revenue
Total Revenue from Colorado Medicaid	$203,758.00	$38,800.00	N/A
Total Revenue from Federal Sources	N/A	$0.00	N/A
Total Revenue from State Sources	$55,666.00	$8,501.00	N/A
Total Revenue from Mill Levy	N/A	N/A	N/A
Total Revenues from Other Sources	N/A	N/A	$40,000.00
Total	**$259,424.00**	**$47,301.00**	**$40,000.00**

N/A – No revenue was reported from this source

CCB #18 reported revenues for all three functions, as shown in Table A1-107. Survey results, in comparison to the financial statements submitted by CCB #18, indicate that TCM functions for the access point waivers accounted for 5 percent of total revenue, administrative revenues accounted for 0.9 percent and OHCDS function revenues accounted for 0.8 percent. TCM function Medicaid revenue accounted for 5.4 percent of total unrestricted Medicaid revenue and administrative functions accounted for 1.0 percent. See Table A1-107 for the summary.

Table A1-107. Revenue by Function as Percent of Revenue Reported per Statement of Activities

FYE 2014	Targeted Case Management	Administrative	OHCDS
Revenue from Cost Survey	$259,424.00	$47,301.00	$40,000.00
Total Unrestricted CCB Revenue (Financial Statement)	$5,211,745.00		
% of Total Unrestricted Revenue	**5.0%**	**0.9%**	**0.8%**
Total Revenue from Colorado Medicaid (Cost Survey)	$203,758.00	$38,800.00	N/A
Total Unrestricted Revenue from Medicaid (Financial Statement)	$3,781,720.00		
% of Total Unrestricted Revenue from Medicaid	**5.4%**	**1.0%**	**N/A**

Cost Information

Table A1-108 provides a snapshot of the cost information submitted by CCB #18 for each of the three functions.

Table A1-108. Costs by Function

FYE 2014	TCM Costs	Administrative Costs	OHCDS Costs
Long Range Service Area Planning	N/A	N/A	$920.00
Community Coordination and MOUs	N/A	$920.00	N/A
Development of Service Area Capacity	N/A	N/A	$920.00
Referral and Placement Committee	$12,000.00	N/A	N/A
Emergency Response Coordination	N/A	N/A	$2,000.00
Administrative Tool	N/A	N/A	$184.00
HCPF Contract requirements (plans)	N/A	N/A	$1,840.00
Legal Council	N/A	N/A	$2,000.00
Training	$5,680.00	N/A	N/A
Office Manager	$7,000.00	N/A	$8,000.00
Mileage	$5,000.00	$1,000.00	N/A
Office Space maintenance	$11,000.00	$3,000.00	$1,000.00
Utilities	$5,000.00	$1,000.00	$500.00
Computers/IT	$15,000.00	$5,000.00	$1000.00
Encryption Software	$250.00	$100.00	$100.00
Receptionist	$15,000.00	$1,000.00	$2,000.00
Filing (including HIPAA)	$4,000.00	$4,000.00	$2,000.00
Property Insurance	$15,000.00	$5,000.00	N/A
Health Insurance (penalty due in 2016 due to cancelling because too expensive)	$70,000.00	$2,000.00	N/A
Mail	$2,000.00	N/A	N/A
Phones	$4,000.00	$1,000.00	$500.00
Board of Directors	N/A	N/A	$2,000.00
Family Support Council	N/A	$2,000.00	N/A
State SLS management	N/A	$19,760.00	N/A
Financial Audit	N/A	N/A	$21,320.00
Local Interagency Coordinating Council	N/A	$8,840.00	N/A
Salaries and Wages	$164,519.00	$101,843.00	$408,160.00
Employee Taxes, Insurance and Benefits	$33,147.00	$21,563.00	$73,055.00
Total	**$368,596.00**	**$178,026.00**	**$527,499.00**

CCB #19

CCB #19 is located in the Southeastern part of Colorado. All information below is taken from the documentation received, survey and financial statements FYE 2014. Table A1-109 displays population information for this CCB. Table A1-110 displays employee information for this CCB.

Table A1-109. Individuals Served in Access Point Waivers

Population	FYE 2014	Average of all CCBs
Total Individuals Served in Access Point Waivers[29]	578	468
% of Individuals Served that live within 25 miles of the main office	N/A	N/A
Individuals on the waiting list	47	393

N/A – Information not provided

Table A1-110. Employee Information

Employee Information	FYE 2014	Average of all CCBs
Administrative Employees	6	7
TCM Employees	30	23
OHCDS Employees	36	12

Overview of the Organization

This CCB reported 72 full-time employees performing the three functions. CCB #19 provides numerous direct services, including: day habilitation, homemaker, personal care, and respite.

In Table A1-111, we provide a brief overview of who is responsible for performing activities within the three functions.

[29] Unduplicated count of individuals who spent the majority of the year receiving services from this CCB.

Table A1-111. CCB Job Responsibilities Summary

Employee Title	Job Responsibilities
Executive Director	Maintain documentation of all applicable provider qualifications and contracts for sub-contracted agencies
Quality Improvement Director	Perform quality assurance functions
Director of Service Coordination	Responsible for oversight and supervision of Service Coordination Division staff
Case Manager	Conduct eligibility determinations Conduct DD determinations
Utilization Review Case Manager	Complete client assessments Arrange for services Responsible for service plan development Responsible for service plan monitoring Conduct referrals Respond to inquiries
Chief Financial Officer	Maintain documentation of all applicable provider qualifications and contracts for sub-contracted agencies

Revenue by Function

Table A1-112 provides a snapshot of the revenue by function for FYE 2014 as reported in the survey.

Table A1-112. Revenue by Function

FYE 2014	Targeted Case Management Revenue	Administrative Revenue	OHCDS Revenue
Total Revenue from Colorado Medicaid	$1,026,218.25	$342,072.75	$11,072,841.00*
Total Revenue from Federal Sources	$7,896.00	$2,632.00	$497,098.00
Total Revenue from State Sources	$73,811.25	$24,603.75	$264,788.00
Total Revenue from Mill Levy	N/A	N/A	$291,069.00
Total Revenues from Other Sources (In Kind)	N/A	N/A	$12,539.00
Total Revenues from other Sources (Misc.)	N/A	N/A	$592,510.00
Total	**$1,107,925.50**	**$369,308.50**	**$12,730,845.00***

* Includes direct service support revenue and Total Medicaid revenue reported exceeds Revenue reported on Audited Financial Statements

N/A – No revenue was reported from this source

CCB #19 reported revenues for all three functions, as shown in Table A1-113. Survey results, in comparison to the financial statements submitted by CCB #19, indicate that TCM functions for access point waivers accounted for 7.2 percent of total revenue, administrative revenues accounted for 2.4 percent of total revenue and OHCDS function revenues accounted for 82.4 percent. TCM function Medicaid revenue accounted for 8.3 percent of total unrestricted Medicaid revenue received, administrative functions accounted for 2.8 percent and OHCDS functions 89.0 percent. See Table A1-113 for the summary.

Table A1-113. Revenue by Function as Percent of Revenue Reported per Statement of Activities

FYE 2014	Targeted Case Management	Administrative	OHCDS
Revenue from Cost Survey	$1,107,925.50	$369,308.50	$12,730,845.00
Total Unrestricted CCB Revenue (Financial Statement)	$15,457,484.00		
% of Total Unrestricted Revenue	**7.2%**	**2.4%**	**82.4%**
Total Revenue from Colorado Medicaid (Cost Survey)	$1,026,218.25	$342,072.75	$11,072,841.00
Total Unrestricted Revenue from Medicaid (Financial Statement)	$12,441,132.00		
% of Total Unrestricted Revenue from Medicaid	**8.2%**	**2.8%**	**89.0%**

Cost Information

Table A1-114 provides a snapshot of the cost information submitted by CCB #19 for each of the three functions.

Table A1-114. Costs by Function

FYE 2014	Targeted Case Management Costs	Administrative Costs	OHCDS Costs
Salaries and Wages	$609,770.25	$203,265.75	$2,403,795.00
Employee, Taxes, and Benefits	$167,678.25	$55,892.75	$723,699.00
Total	**$777,448.50**	**$259,149.50**	**$3,127,494.00**

CCB #20

CCB #20 is located in the Southeastern part of Colorado. All information below is taken from the documentation received, survey and financial statements FYE 2014. Table A1-115 displays population information for this CCB. Table A1-116 displays employee information for this CCB.

Table A1-115. Individuals Served in Access Point Waivers

Population	FYE 2014	Average of all CCBs
Total Individuals Served in Access Point Waivers[30]	547	468
% of Individuals Served that live within 25 miles of the main office	97%	N/A
Individuals on the waiting list	558	393

Table A1-116. Employee Information

Employee Information	FYE 2014	Average of all CCBs
Administrative Employees	15	7
TCM Employees	56	23
OHCDS Employees	12	12

Overview of the Organization

This CCB reported 77 full-time employees and 6 part-time employees performing the three functions. The CCB provides numerous direct services, including: homemaker, personal care, respite and supported employment.

The following Table A1-117 provides a brief overview of who is responsible for performing activities within the three functions. For purposes of our review, we focused mainly on the job

[30] Unduplicated count of individuals who spent the majority of the year receiving services from this CCB.

duties and responsibilities of the Resource Coordination and Development division.

Table A1-117. CCB Job Responsibilities Summary

Employee Title	Job Responsibilities
Comprehensive Case Management Coordinator	Responsibilities related to administrative, TCM, and OHCDS functions not provided
Intake/Eligibility Coordinator	Conduct DD determinations
SLS/CES Case Management Coordinator	Conduct eligibility determinations
Case Manager	Perform SIS assessments Perform quality assurance functions Responsible for waitlist management Responsible for all TCM functions

Revenue by Function

Table A1-118 provides a snapshot of the revenue by function for FYE 2014 as reported in the survey.

Table A1-118. Revenue by Function

FYE 2014	Targeted Case Management Revenue	Administrative Revenue	OHCDS Revenue
Total Revenue from Colorado Medicaid	$1,062,995.24	$222,425.04	N/A
Total Revenue from Federal Sources	N/A	N/A	N/A
Total Revenue from State Sources	$1,735.08	$134,297.87	$N/A
Total Revenue from Mill Levy	N/A	N/A	N/A
Total Revenues from Other Sources	N/A	$N/A	N/A
Total	**$1,064,730.32**	**$356,722.91**	**N/A**

N/A – No revenue was reported from this source

CCB #20 reported revenue for both TCM and administrative functions, as shown in Table A1-119. Survey results, in comparison to the financial statements submitted by CCB #20, indicate that TCM functions for the access point waivers accounted for 5 percent of total revenue and administrative functions accounted for 1.7 percent of total revenue. TCM function Medicaid revenue accounted for 7.4 percent of total unrestricted Medicaid and administrative functions accounted for 2.5 percent. See Table A1-119 for the summary.

Table A1-119. Revenue by Function as Percent of Revenue Reported per Statement of Activities

FYE 2014	Targeted Case Management	Administrative	OHCDS
Revenue from Cost Survey	$1,064,730.32	$356,722.91	N/A
Total Unrestricted CCB Revenue (Financial Statement)	$21,285,600.00		
% of Total Unrestricted Revenue	**5.0%**	**1.7%**	**N/A**
Total Revenue from Colorado Medicaid (Cost Survey)	$1,062,995.24	$222,425.04	N/A
Total Unrestricted Revenue from Medicaid (Financial Statement)	$14,334,352.00		
% of Total Unrestricted Revenue from Medicaid	**7.4%**	**2.5%**	**N/A**

Cost Information

Table A1-120 provides a snapshot of the cost information submitted by CCB #20 for each of the three functions.

Table A1-120. Costs by Function

FYE 2014	Targeted Case Management Costs	Administrative Costs	OHCDS Costs
Salaries and Wages	$827,585.51	$293,067.57	$585,293.11
Employee Taxes, Insurance, and Benefits	$257,083.47	$89,712.02	$126,336.90
Total	**$1,084,668.98**	**$382,779.59**	**$711,630.01**

Appendix A2: Comparison between Cost Surveys versus State Reimbursement Data

In Tables A2-1 and A2-2 on the following pages, we demonstrate variances between the information obtained through the cost surveys and the information provided by the Department regarding reimbursement for Targeted Case Management (TCM) and function revenues.

For TCM functions, the Department supplied total revenue information for State Fiscal Year (SFY) 2014 (7/1/13 – 6/3014) for each CCB. We compared this information to the revenues reported by each CCB for case management in the FYE 2014 cost survey, and calculated the differences. We noted variances for all CCBs that reported data.

For administrative functions, the Department supplied detailed reimbursement data for each CCB for SFY 2014. The reimbursement data for waitlist management, eligibility determinations, SIS assessments, quality assurance, and Preadmission Screening and Residential Review (PASRR) were part of the calculation of the state's total reimbursement amount. We then compared this amount to the amount reported by CCBs in the FYE 2014 cost survey, and calculated the differences. We noted variances for all CCBs that reported data.

There are a number of reasons why these differences may occur, including differences in reporting periods (e.g., state fiscal year vs. CCB fiscal year), different accounting methods of how the CCBs allocated the TCM and administrative revenues in the cost survey, billing lags (e.g., difference in dates of service and dates revenues received). These variances between state and CCB data raises questions about the quality of data we received from the CCB. For example, CCB #6 reported the highest variances for both TCM and administrative revenues and throughout the review, was considered an outlier that might have reported incorrect data. Overall, 12 CCBs reported on the survey Case Management Revenue from Colorado Medicaid that was higher than what the Department provided to us. Also, 15 CCBs reported higher administrative revenues on their survey compared to revenue reported from the Department. Based on these results, one focus during the onsite review will be how the CCBs determined the TCM and administrative revenues on the survey and if any of the possible reasons indicated above (e.g., reporting period differences and billing lags) caused the variance to occur.

In the tables on the following page, we provide a side-by-side comparison of revenues reported on our survey and reimbursements from the state, along with the variance.

Table A2-1. Case Management Revenue Comparison

Agency	CCB Survey: Case Management Revenue from Colorado Medicaid (2014)	State Billing Data: Targeted Case Management Reimbursements (2014)	Variance (State - CCB)	% Variance (State - CCB) / State
CCB #1	$1,169,724	$1,133,449	($36,275)	-3%
CCB #2	$304,107	$243,775	($60,332)	-25%
CCB #3	$2,355,526	$2,357,061	$1,535	0%
CCB #4	$195,270	$189,078	($6,192)	-3%
CCB #5	$1,932,038	$1,835,064	($96,974)	-5%
CCB #6	$12,994,377	$1,988,782	($11,005,595)	-553%
CCB #7	$40,059	$137,817	$97,758	71%
CCB #8	$305,648	$307,290	$1,642	1%
CCB #9	$241,724	$242,226	$502	0.21%
CCB #10	$906,412	$734,152	($172,260)	-23%
CCB #11	$2,836,833	$2,431,151	($405,682)	-17%
CCB #12	No data reported	$161,652	No data reported	No data reported
CCB #13	$923,155	$1,115,946	$192,790	17%
CCB #14	$100,000	$105,708	$5,708	5%
CCB #15	$1,413,992	$1,382,630	($31,362)	-2%
CCB #16	$524,627	$439,538	($85,089)	-19%
CCB #17	$416,362	$334,125	($82,237)	-25%
CCB #18	$203,758	$202,365	($1,393)	-1%
CCB #19	$1,026,218	$1,156,050	$129,832	11%
CCB #20	$1,399,771	$1,061,230	($338,541)	-32%

Table A2-2. Administrative Function Revenue Comparison

Agency	CCB Survey: Administrative Revenues (2014)	State Billing Data: Paid Claims (2014) -Expected through June	Variance (State - CCB)	% Variance (State - CCB) / State
CCB #1	$276,368	$264,253	($12,115)	-5%
CCB #2	$66,837	$58,865	($7,973)	-14%
CCB #3	$534,659	$471,419	($63,240)	-13%
CCB #4	$30,359	$26,490	($3,869)	-15%
CCB #5	$425,146	$391,646	($33,500)	-9%
CCB #6	$477,704	$438,554	($39,150)	-9%
CCB #7	$30,769	$30,082	($687)	-2%
CCB #8	$80,378	$73,242	($7,136)	-10%
CCB #9	$41,709	$38,332	($3,378)	-9%
CCB #10	$226,890	$136,511	($90,379)	-66%
CCB #11	$3,079,836	$402,590	($2,677,246)	-665%
CCB #12	No data reported	$37,159	No data reported	No data reported
CCB #13	$131,390	$153,923	$22,533	15%
CCB #14	$668	$19,514	$18,846	97%
CCB #15	$283,857	$257,821	($26,036)	-10%
CCB #16	$74,336	$76,322	$1,986	3%
CCB #17	$57,461	$49,152	($8,309)	-17%
CCB #18	$38,300	$43,032	$4,732	11%
CCB #19	$233,355	$218,732	($14,624)	-7%
CCB #20	$222,747	$189,529	($33,219)	-18%

Appendix A3: Survey Instructions and Q&A Listing

COLORADO DEPARTMENT OF HEALTH

CARE POLICY & FINANCING

2015 Short Survey

Instructions for Community Centered Boards Survey

If you have any questions concerning the 2015 Short Survey, please contact Derek Knight of Navigant Consulting, Inc. at:

COCCBreview@navigant.com

Note: It is important to read the instructions in their entirety before completing the survey.

The Department of Health Care Policy and Financing (the Department) convened a Task Group of stakeholders in 2014 to make recommendations for a conflict free case management system in Colorado. House Bill 15-1318 requires the Department to develop a plan, with input from Community Centered Boards (CCB) and other stakeholders, for the delivery of conflict free case management that complies with Federal regulations. As part of this process, Navigant Consulting is conducting a survey of CCB costs and funding related to the Targeted Case Management, Administrative, and Organized Health Care Delivery System (OHCDS) functions. Completion of this survey is your opportunity to inform Navigant about both your operational costs and any other additional information related to the delivery of these three aforementioned functions.

This document contains instructions to assist you in completing the survey. Targeted Case Management services are defined as TCM assessment, service plan development, service plan monitoring and information/referral. Administrative services are defined as but not limited to, performing eligibility assessments, waitlist management, authorizing and administering services, quality assurance services, and utilization review services. OHCDS functions are defined as executing and maintaining a Medicaid Provider agreement for all services provided, and creating and maintaining documentation for all applicable provider qualifications for services directly rendered by the CCB, and subcontracted services.

If you have any questions regarding the survey, please contact Derek Knight at the survey hotline: (202) 973-3133.

PLEASE NOTE THAT INDIVIDUALS COMPLETING THIS SURVEY MUST HAVE A WORKING KNOWLEDGE CCB OPERATIONS AND A THOROUGH UNDERSTANDING OF THE ACCOUNTING RECORDS OF THE ORGANIZATION.

Overview

The individual worksheets included in this Excel-based survey provide a mechanism for translating costs reported in your accounting and other operating records into a consistently

reported format that can be easily analyzed for purposes of this study. Currently each worksheet asks for data which may be used in determining the overall costs, revenue, and impact of the Targeted Case Management, Administrative, and OHCDS functions. These instructions explain the information that we are seeking on each line item. We request that you provide data as completely and accurately as possible. Furthermore, it is important that you fill out each worksheet.

CCB Survey Reporting Time Schedule

Please submit the survey to Navigant Consulting by November 30, 2015.

Reporting Period

The reporting period for this survey should be based on fiscal years 2012, 2013, and 2014 audited financial statements.

Review of Surveys

The Division or its agents may perform a desk review on surveys to determine if the financial and statistical information submitted conforms to applicable rules and instructions. Your survey responses will not be shared with anyone outside of the Division or Navigant Consulting.

How to Download and Submit the Survey

The survey is not designed to be completed on the website. Instead, we request you to save the survey on to your computer and complete it in Excel, and then email it to Derek Knight at COCCBreview@navigant.com.

If your survey is not properly completed, the Department or Navigant Consulting, Inc. staff may contact you for clarification.

Resubmission of Surveys

If you have already submitted your completed survey, but wish to submit a revised version for whatever reason (correction of error, more current data, etc.), you may do so by sending a revised version to the abovementioned email address. At the close date of the survey

submission process, we will identify the survey file most recently received from each organization and discard any versions submitted previously. The latest version we receive from your organization will be the version used for CCB cost and funding review.

Specific Instructions, by Worksheet

The following table provides a brief description of each of the Worksheets included in the survey. All applicable forms must be completed.

Table 1: Colorado CCB Survey Worksheets

Worksheet	Description
A. CCB Info	General identifying information about the CCB, including the location, contact information, service area, staffing, and total revenue.
B. Services	A listing of services directly provided by the CCB and services subcontracted by the CCB.
C. Survey	A more in-depth review of costs and other information for the Targeted Case Management, Administrative, and OHCDS functions.

Specific instructions for each of the above Worksheets are provided on the following pages.

WORKSHEET A: CCB INFO

The purpose of this worksheet is to identify the CCB, the main contact, staffing information, and to collect location information, including number of participants served and service radius.

Provider Identification

Line 1: CCB Name. Enter the name of the Community Centered Board.

Line 2: Primary NPI Number. Enter your board's NPI Number.

Line 3: City. Enter the city associated with the Medicaid provider number.

Line 4: County. Enter the county associated with the Medicaid provider number.

Line 5: Survey Period Beginning. Enter the start date of your FYE 2012

Line 6: Survey Period Ending. Enter the end date of your FYE 2014

Contact Information

Line 7: Contact Person. Enter the name of the person responsible for completing this survey.

Line 8: Title. Enter the title of the person responsible for completing this survey.

Line 9: Phone Number. Enter the phone number (XXX-XXX-XXXX) of the person responsible for completing this survey.

Line 10: Email Address. Enter email address of the person responsible for completing this survey.

CCB Location Information

Complete the following information

Lines 11: City. Enter the city where the Community Centered Board is located.

Lines 12: County. Enter the county where the Community Centered Board is located.

Lines 13: Number of Waiver Participants Served. Enter the total number of participants served by the Community Centered Board for the three requested fiscal years.

Lines 14: Percent of Clients That Live Within. Of the participants served by the CCB, indicate the percentage who live within 0-25 miles, 26-50 miles and greater than 50 miles. An estimated percentage should be calculated by dividing the number of participants living within

each service radius category by the total number of waiver participants served at the site for the three most recent fiscal years.

CCB Staffing

Line 15: Total Number of Full-Time Employees. Enter the total number of full-time employees currently employed at the CCB. Full-time employees are defined as employees working 30 hours or more in an average week or 130 hours or more in an average month for the three most recent fiscal years.

Line 16: Total Number of Part-Time Employees. Enter the total number of part-time employees currently employed at the CCB. Part-time employees are defined as employees working fewer than 30 hours in an average week or 130 hours in an average month for the three most recent fiscal years.

WORKSHEET B: SERVICES

The purpose of this worksheet is to report the services provided directly by the CCB and the services subcontracted by the CCB in the **most recent FYE (FY 2014)**.

Use the top half of the worksheet to indicate, by using the check boxes, the services that the CCB provides directly.

For all services that are subcontracted by the CCB, use the check boxes on the bottom half of the worksheet to indicate the specific service types.

If there are any additional services that the CCB either provides or subcontracts, that were not listed above, please indicate at the bottom of the form. Please be sure to specify, the service title, and if the service was provided directly or subcontracted.

WORKSHEET C: SURVEY

The purpose of this worksheet is to report costs for the three functions – Targeted Case Management, Administrative, and OHCDS. Please complete tabs C. Survey FYE 2014, 2013, and 2012 using cost data for each respective fiscal year.

Column 1: Cost Centers

Each cost center line represents a particular type of expenditure. The cost center line is described in Column 1. Cost centers are classified into four major groups:

- Salaries and Wages
- Employee Taxes, Insurance and Benefits
- Subcontracted Services
- Other Costs

Please see the "Line Descriptions" section below for further discussion of each cost center under the four major groupings.

Column 2: Total

This column will automatically calculate based upon data entered in columns 3-5. All total lines (2, 4, 10, 20, 21, 27 and 34) will also automatically populate based upon data entered into the survey.

Column 3: Targeted Case Management Function Costs

Enter all costs associated with providing Targeted Case Management services.

Column 4: Administrative Function Costs

Enter all costs related to Administrative Functions, specifically related to eligibility determinations, Support Level Determinations, and Quality Assurance activities.

Column 5: OHCDS Functions

Enter costs specific to the CCB's Organized Health Care Delivery System (OHCDS) function.

PLEASE NOTE:

- ✓ We expect you to directly allocate costs to columns 3 through 5 whenever possible and develop a systematic method for allocating costs when direct allocation is not possible.
- ✓ We do not need the CCB to allocate all of CCB's costs, e.g., we are not asking for costs related to programs that are operated outside of the Colorado Medicaid ID/DD HCBS waivers (HCBS-CES, HCBS-SLS, and HCBS-DD).

Line Descriptions

Salaries and Wages Lines 1 and 2

Lines 1 and 2 capture total salaries and wages paid and accrued by cost function. Do not include fees associated with subcontracted staff (these costs should be included in the "Subcontracted Services" section of the survey). For employees who perform multiple functions (administration, program support, etc.), gross salaries and wages must be allocated to each of the appropriate cost functions across columns 3, 4 and 5, based on proportions of time spent conducting each type of activity.

Targeted Case Management Employee Salaries and Wages, Column 3 Line 1

This cost center line captures program employee total gross salaries and wages paid and accrued, including bonuses, by employee category. Case Management Employee Salaries and Wages are defined as costs associated with employees who provide Targeted Case Management services for participants. This includes case managers and case manager supervisors.

Administrative Employee Salaries and Wages, Column 4, Line 1

Enter administrative employees' salaries and wages on Line 5. This cost center captures administrative employee total gross salaries and wages, including bonuses. Administrative Employee Salaries and Wages are defined as costs associated with employees who perform eligibility determinations, support level determinations, and quality assurance activities.

OHCDS Function Salaries and Wages, Column 5 Line 1

Enter total gross salaries and wages paid to employees who are responsible for performing OHCDS functions for the CCB. These functions include but are not limited to provider subcontracting, provider monitoring, claims monitoring, and other duties related to performing the OHCDS function.

Employee Taxes, Insurance and Benefits, Lines 3 and 4

Lines 3 and 4 capture costs incurred by the CCB related to employee payroll taxes, insurance and benefits. Please enter costs for all employee payroll taxes, employee health insurance, and any other benefits related to the Targeted Case Management, administrative and OHCDS functions. Only the portion of the employee benefits and payroll taxes paid and accrued by the CCB must be reported on these lines. Do not include costs which are paid and accrued by withholding a portion of the employee's salary or wages (these costs should be included in the appropriate Salaries and Wages cost center lines).

Subcontracted Services, Lines 5 through 10

Lines 5 through 10 capture expenditures for subcontracted services, by type of subcontracted service. Amounts entered must be for subcontracted services only, and must exclude any amounts paid and accrued to employees of the CCB.

Subcontracted SIS Assessment Services, Line 5

This cost center line captures expenditures for subcontracted SIS Assessment Services.

Subcontracted Quality Assurance Services, Line 6

This cost center line captures expenditures for subcontracted quality assurance activities related to recipient care, provider monitoring, and any other quality assurance activities performed by the CCB.

Subcontracted OCHDS Payment to Medicaid Providers, Line 7

This cost center line captures all payments made to Medicaid providers subcontracted by the CCB.

Subcontracted OCHDS Payment to Non-Medicaid Providers, Line 8

This cost center line captures all payments made to Non-Medicaid providers subcontracted with the CCB. Non-Medicaid providers refers to all providers without a Medicaid billing ID number or NPI number.

Other Subcontracted Services, Line 9

This cost center line captures all other payments made to subcontracted entities.

Other Costs, Line 11-20

Lines 11-20, capture all other costs not detailed above. We ask that the CCB use lines 11-18 to fill in the additional cost items that the CCB feels are essential to performing the three functions. An example of other costs would be licenses/taxes, liability and other insurance, non-payroll personnel expenses, supplies, transportation, rentals/property expense, maintenance and repairs, depreciation/amortization expense, utilities, and any other relevant expenses not detailed in lines 1-10.

Grand Total (Costs) Line 21

All costs will be totaled based upon data entered in lines 1-12. No entry is required for this line.

CCB Revenues 22-27

Lines 22-27 captures revenue related to Targeted Case Management, Administration, and OHCD functions.

Total Revenue from Colorado Medicaid, Line 22

Please indicate all payments from Medicaid related to the 3 functions. If unable to allocate revenue to the functions, please estimate to the best of your ability the revenue attributed to these functions.

Total Revenue from Federal Sources, Line 23

Please indicate all payments from Federal sources related to the 3 functions. An example of this would be federal grants. If unable to allocate revenue to the functions, please estimate to the best of your ability the revenue attributed to these functions. Please specify the sources of Federal Revenue, if there are multiple sources, please insert lines as needed to indicate the specific sources of revenue.

Total Revenue from other State Sources, Line 24

Please indicate all payments from State sources related to the 3 functions. If unable to allocate revenue to the functions, please estimate to the best of your ability the revenue attributed to these functions. Please specify the sources of State Revenue, if there are multiple sources, please insert lines as needed to indicate the specific sources of revenue.

Total Revenue from Mill Levy, Line 25

Please indicate all payments from Mill Levy sources related to the 3 functions. If unable to allocate to the functions, please estimate to the best of your ability the revenue attributed to these functions. Please specify the source of Mill Levy revenue, if there are multiple sources, please insert lines as needed to indicate the specific sources of revenue.

Total Revenues from Other Sources, Line 26

Please indicate all payments from other sources related to the 3 functions. If unable to allocate revenue to the functions, please estimate to the best of your ability the revenue attributed to these functions. Please specify the source of other revenue, if there are multiple sources, please insert lines as needed to indicate the specific sources of revenue.

CCB Administrative Revenues

Total Billed Claims for Medicaid Application Determinations, Line 28

Please indicate the total billed amount for Medicaid Applicant Determinations.

Total Billed Claims for Quality Assurance, Line 29

Please indicate the total billed amount for Quality Assurance services. These quality assurance activities include reviews and resolutions of complaints and grievances, Quality Improvement Strategy (QIS) activities and reporting, incident reporting and responses, establish and participating in a Human Rights Committee, and the investigation and documentation of mistreatment, abuse, neglect, and exploitation allegation. If the CCB performs additional quality assurance activities that are not listed above, please provide those costs as well.

Total Billed Claims for Utilization Reviews, Line 30

Please indicate the total billed amount for utilization review services.

Total Billed Claims for Preadmission Screening and Resident Review (PASARR) Services, Line 31

Please indicate the total billed amount for PASARR services.

Total Billed Claims for Omnibus Budget Reconciliation Act (OBRA) Pre-Admission Evaluation, Line 32

Please indicate the total billed amount for OBRA pre-admission evaluations.

Total Billed Claims for SIS Assessments, Line 33

Please indicate the total billed amount for SIS Assessments. Do NOT include SIS assessments which were performed by a subcontractor, only those directly provided by the CCB.

Additional Questions, Lines 36-43 (Lines 36-38 for FYE 2013 and 2012)

Please answer all additional questions.

Q&A Listing

Purpose of this Q&A is to assist the CCBs completing the survey and documentation request checklist. This survey is in limited scope and was created to capture the costs related to Targeted Case Management (TCM) and the three (HCBS-CES, HCBS-DD, HCBS-SLS) access point IDD HCBS waivers. We are not requesting any additional information to costs outside of the aforementioned three waivers or TCM.

If you have any information that warrants further explanation, then we would request that you create a cover letter or an email alongside with other documentation you include.

1. General Questions

Q1: We need more time to complete the survey. What should we do?

A1: Please send your extension request to COCCBReview@navigant.com. Please note that Navigant will not be able to grant extension requests directly. We will contact and discuss with the State and the decision of granting extension requests remains solely with the State.

Q2: OHCDS functions – the definition indicates that this includes all direct service provided by the CCB. However, all direct services provided by the CCB are delivered as an approved PASA, not as an OHCDS function. The OHCDS function itself should only be for maintaining provider agreements, documentation, provider qualifications, subcontracting, and billing for non CCB entities.

A2: The survey has been modified to remove direct services. The OHCDS information provided by CCBs should reflect costs for maintaining provider agreements, documentation, provider qualifications, subcontracting, and billing for non CCB entities. These same OHCDS activities are completed for Host Home providers, so please include information pertaining to Host Homes as well as all other relevant Medicaid services.

Q3: Quality assurance has many facets to it per the contract that are not specifically mentioned in the instructions.

A3: Please see page 1 and 12 of the cost survey instructions for the information regarding definitions of quality assurance. Page 12 reflects quality assurance activities as defined in the contract. If there are additional quality assurance activities that should be reviewed, please include in the documentation submitted and describe the specific activities included.

2. Documentation Request Checklist

Q1: Why does the CCB survey request working trial balance information?

A1: Every CCB has varying sources of revenues and expenses. The working trial balance provides detail that the audited financial statements will not provide. Including the trial balance with your documentation could potentially reduce the number of questions that will arise from the review because the reviewers might be able to locate any required revenues and expenses data from the trial balance instead of requesting additional documentation from the CCB.

Q2: What is considered "administrative functions" for the purpose of the survey?

A2: The administrative functions are related to eligibility determinations, developmental

disability determinations, supports intensity scale (SIS) assessments, quality assurance functions, waitlist management, and enrollment activities not eligible for Medicaid Targeted Case Management reimbursement.

3. Tab A CCB Info

Q1: Line 14 - what is the mileage starting point?

A1: Count the mileage from the program office.

Q2: Line 14 – we have participants who moved during the year. How should we count them?

A2: We do not want any participants to be counted more than once. If the individual relocated, please determine which location the individual spent most of their time. Please include the participant in the area where they spent most of the time during the fiscal year.

Q3: Lines 13 – Waiver participants – is this just SLS, CES, and Comp? Why not the EBD, CWA or C-HCBS waivers?

A3: Please see the opening statement. Our survey is in limited scope and was created to capture the costs related to HCBS-CES, HCBS-DD, and HCBS-SLS programs because that is primarily where the conflict of interest exists.

Q4: Line 13 and 14- It will be difficult if not impossible to determine distances from location. We would have no historical information on how far away someone lived from location.

A4: We are just looking at the costs related to the 3 IDD access point waivers. If you are unable to provide information pertaining to distances, we ask the CCB to document why this information is not available. Your explanation can be a cover letter or an email sent with all the supporting documents.

4. Tab B Services Provided

Q1: Referring to the second half of tab B, what does "services contracted out by CCB" refer to?

A1: We ask that the CCBs simply use the check boxes to denote each service offering that the CCB sub-contracts. Do not include in the second half of this form any services that the CCB has any ownership interest in. This information is requested to provide context to the extent of the CCB's OHCDS offerings.

Q2: Is this provided directly by a CCB or billed by a CCB? There are many services we bill for that we do not provide directly.

A2: We are referring to only the services directly provided by the CCB in the first half of the form. Payments for services billed but not provided directly are captured in the second half of the form.

5. Tab C Cost Survey Data

Q1: Column 1: Cost Centers

It is more than likely that agencies will not have separate cost centers for the information requested as described in this section and the costs could be in different areas depending on the organization. This will require Agencies to allocate expenses in a nonscientific methodology. Previous studies have identified the amount of time spent in various activities, and then based the allocations on this methodology. The timeline in this survey will not allow CCBs to be very accurate in this allocation.

A1: We understand that this is a difficult task, but we ask that you do the best you can when allocating costs. Since this is not an audit, a nonscientific methodology will still give the basic information needed for analysis. Please document your allocation methodology and provide us with a supporting work paper, if available, that shows how the CCB has allocated costs. This would help us greatly in understanding the allocation methodology the CCB has utilized.

Q2: Column 3: CM Function Cost

Here is says TCM. Does this include EI TCM? Also what about the State programs we provide CM activities for through HCPF (State SLS and FSSP)?

A2: For the purposes of this survey, information provided should be for TCM for waiver clients only and should not include EI or State programs.

Q3: Column 5: OHCDS Functions

It says direct service costs which could lead someone to provide the actual direct services costs associated with program delivery for the waivers, beyond that of the OHCDS.

A3: The response to question 1 clarified that responses should not include information regarding services provided directly by the CCB.

Q4: Indirect Costs

The definition is for other costs, and not indirect costs. Indirect costs for management and general need to be included.

A4: Cost survey has been updated. Indirect costs are now "Other Costs". Blank lines have been added to accommodate each CCB's unique cost structure. Please see the cost survey instructions for additional details on how to complete this section.

Q5: Total Revenue from Colorado Medicaid

The Division should have this information

A5: The Division has requested this information be provided by CCBs for comparison purposes. For example, in the FSSP audit, the Division found its data often did not match CCB data and there may be a need for analysis and reconciliation.

Q6: Total Revenue from Federal Sources

Not sure what would be included per the definitions

A6: Please include any supplemental sources of revenues that are from federal government or other state government sources. For state sources, typically we are looking for any sources of revenue from intergovernmental transfers, such as property tax or lottery revenue. For federal sources, typically we are looking for any additional sources of revenue from federal government in a form of grant.

Q7: CCB Administrative Revenues

The Division should have all of this per CCB

A7: The Division has requested this information be provided by CCBs for comparison purposes. For example, in the FSSP audit, the Division found its data often did not match CCB data and there may be a need for analysis and reconciliation.

Q8: Total Billed Claims for Quality Assurance

This should go in the definition as we are paid a flat fee and has no bearing on the additional functions listed here.

A8: Please include flat fee information if applicable. If this cost is **not** part of your administrative function, as defined on page 1 and 12 of the instructions, please input zero.

Q9: Please indicate the number of Full and Part time staff you employ for each Functional Area

Not sure why column 5 under question 27 is now for DSPs and not OHCDS as the previous sections. DSPs are typically for the program delivery side.

A9: The survey and instructions have been updated to include only the OHCDS function information. Please include only the OHCDS information.

Q10: Please specify by waiver, the number of participants currently receiving services under the following waivers

Is this for TCM or program?

A10: This is for Targeted Case Management related to the 3 access point waivers, not for the entire program.

Q11: Wait List

There are many different understandings to what constitutes the waiting list, we strongly recommend an accompanying definition. As the survey is written currently, we feel there is a high risk of widely varied waiting list data reporting. However, all this being said, the state has access to this information. Why are CCBs being asked to recreate it?

A11: In the past, waiting list numbers reported by CCBs and those reported by the Division have not matched. The Division wants to ensure CCBs are tracking waiting list information consistently and is therefore requesting CCBs provide this waiting list information.

Q12: How long are individuals typically on the waitlist?

Should define how we should calculate – and define "typically"?

A12: The phrase "typically" has been removed from the cost survey and cost survey instructions. Please state the time period individuals stayed on the waitlist for each fiscal year. We are looking for average in a fiscal year how long the individuals stayed on the wait list for the three listed waivers above. If the number of waitlisted individuals fluctuated monthly, weekly, or even daily, please provide an annual average. We encourage the provider to include a worksheet if average had to be calculated. However, the worksheet is not a requirement.

Q13: On average, how many providers does the CCB OHCDS contract with annually?

Not sure what they are getting to here.

A13: Please explain how many providers the CCB contract in a fiscal year. Please include the total number of providers contracted in one fiscal year, including host homes. If the number of providers fluctuated every month, then please provide an annual average. We encourage the CCB to include a worksheet if average had to be calculated. However, the worksheet is not a requirement.

Thank you again for your questions and comments. They were very helpful in improving the survey and we have shared your comments and concerns with the State. Please do not hesitate to call or email should you have any further questions.

Appendix A4: Documentation Request Listing

The Colorado Department of Health Care Policy and Financing (HCPF)

Community Centered Boards (CCB) Financial Review

Documentation Request Checklist

For FYE 6/30/12, 6/30/13, 6/30/14

	Documentation Requested		FYE 2012	FYE 2013	FYE 2014
1	Audited Financial Statement prepared by independent CPA for FYE12, 13, and 14				
2	Adjusting entries from the independent CPA to prepare the audited financial statements for FYE12, 13, and 14				
3	Policy and procedures for operating Organized Health Care Delivery System (OHCDS)				
4	Policy and procedures for Case Managers performing Targeted Case Management (TCM) services				
5	Policy and procedures for quality assurance activities performed that fall under the Administrative (Admin) function				
6	CCB organization chart as of FYE12, 13, and 14				
7	Job titles and descriptions for individuals performing any of the three (Admin, TCM, and OHCDS) functions				
8	Waitlist Management Policies and Procedures				
9	Annual subcontractor listing/work performed for FYE12, 13, and 14				
10	Completed cost survey for FYE12, 13, and 14 *(separate instructions are provided with the survey)*				
			Admin	TCM	OHCDS
11	Using this checklist, please report the number of current vacancies for the three functions (admin, TCM, and OHCDS)				
12	*Optional request*: Working Trial Balance for FYE12, 13, and 14				

Appendix A5: Cost Survey

COLORADO CCB COST & WAGE SURVEY
"SHORT" SURVEY
FOR ALL COLORADO CCB

WORKSHEET A: CCB INFORMATION

1. PROVIDER IDENTIFICATION		
1	CCB NAME:	PROVIDER_SAMPLE
2	PRIMARY NPI NUMBER:	XXXXXXXXX
3	CITY:	CITY
4	COUNTY:	COUNTY
5	SURVEY PERIOD BEGINNING:	
6	SURVEY PERIOD ENDING:	
2. CONTACT INFORMATION		
7	CONTACT PERSON:	Ms. Doe
8	TITLE:	Chief Financial Officer
9	PHONE NUMBER:	XXX-XXX-XXXX
10	EMAIL ADDRESS:	msdoe@testproviderA.com

3. CCB LOCATION INFORMATION		FYE 2014	FYE 2013	FYE 2012
11	CITY			
12	COUNTY			
13	NUMBER OF PARTICIPANTS SERVED			
14	PERCENT OF PARTICIPANTS THAT LIVE:			
	0-25 MILES FROM LOCATION			
	26-50 MILES FROM LOCATION			
	GREATER THAN 50 MILES FROM LOCATION			

4. CCB STAFFING		FYE 2014	FYE 2013	FYE 2012
15	TOTAL NUMBER OF FULL-TIME EMPLOYEES (30 or more hours/week or 130 hours/month)			
16	TOTAL NUMBER OF PART-TIME EMPLOYEES			

CCB NAME:	PROVIDER_SAMPLE
NPI NUMBER:	XXXXXXXXXX
REPORT PERIOD BEGINNING:	7/1/2013
REPORT PERIOD ENDING:	6/30/2014

WORKSHEET B: SERVICES PROVIDED DIRECTLY BY CCB

Check all that apply.

- ☐ Adapted Therapeutic Recreational Equipment and Fees
- ☐ Assistive Technology
- ☐ Behavioral Services
- ☐ Community Connector
- ☐ Day Habilitation
- ☐ Dental Services
- ☐ Home Accessibility Adaptations
- ☐ Homemaker
- ☐ Mentorship
- ☐ Non-Medical Transportation
- ☐ Parent Education
- ☐ Personal Care
- ☐ Personal Emergency Response
- ☐ Prevocational Services
- ☐ Professional Services
- ☐ Residential Habilitation
- ☐ Respite
- ☐ Specialized Medical Equipment
- ☐ Specialized Medical Equipment and Supplies
- ☐ Supported Employment
- ☐ Vehicle Modification
- ☐ Vision Services
- ☐ Youth Day Service

WORKSHEET B: SERVICES CONTRACTED OUT BY CCB

- ☐ Adapted Therapeutic Recreational Equipment and Fees
- ☐ Assistive Technology
- ☐ Behavioral Services
- ☐ Community Connector
- ☐ Day Habilitation
- ☐ Dental Services
- ☐ Home Accessibility Adaptations
- ☐ Homemaker
- ☐ Mentorship
- ☐ Non-Medical Transportation
- ☐ Parent Education
- ☐ Personal Care
- ☐ Personal Emergency Response
- ☐ Prevocational Services
- ☐ Professional Services
- ☐ Residential Habilitation
- ☐ Respite
- ☐ Specialized Medical Equipment
- ☐ Specialized Medical Equipment and Supplies
- ☐ Supported Employment
- ☐ Vehicle Modification
- ☐ Vision Services
- ☐ Youth Day Service

Please identify any additional contracted services and/or CCB provided services.

CCB NAME:	PROVIDER_SAMPLE
NPI NUMBER:	XXXXXXXXX
REPORT PERIOD BEGINNING:	7/1/2013
REPORT PERIOD ENDING:	6/30/2014

WORKSHEET C: SURVEY FROM Jul 01,2013 TO Jun 30,2014

	1	2	3	4	5
Line No.	**Cost Centers**	**Total**	**Case Management Function Costs**	**Administrative Function Costs**	**OHCDS Function Costs**
1	Salaries and Wages	$ -			
2	**TOTAL SALARIES AND WAGES**	$ -	$ -	$ -	$ -
3	Employee Taxes, Insurance, and Benefits	$ -			
4	**TOTAL EMPLOYEE TAXES, INSURANCE AND BENEFITS**	$ -	$ -	$ -	$ -
	SUBCONTRACTED SERVICES				
5	Subcontracted SIS Assessment Services	$ -			
6	Subcontracted Quality Assurance Services	$ -			
7	Subcontracted OHCDS Payment to Medicaid Providers	$ -			
8	Subcontracted OHCDS Payment to Non-Medicaid Providers	$ -			
9	Other Subcontracted Services	$ -			
10	**TOTAL SUBCONTRACTED SERVICES**	$ -	$ -	$ -	$ -
11		$ -			
12		$ -			
13		$ -			
14		$ -			
15		$ -			
16		$ -			
17		$ -			
18		$ -			
19					
20	**TOTAL OTHER COSTS**	$ -	$ -	$ -	$ -
21	**GRAND TOTALS (COSTS)**	$ -	$ -	$ -	$ -
	CCB REVENUES	**Total**	**Case Management Revenue**	**Administration Revenue**	**OHCDS Revenue**

CCB NAME:	PROVIDER_SAMPLE
NPI NUMBER:	XXXXXXXXX
REPORT PERIOD BEGINNING:	7/1/2013
REPORT PERIOD ENDING:	6/30/2014

WORKSHEET C: SURVEY FROM Jul 01,2013 TO Jun 30,2014

	1	2	3	4	5
Line No.	**Cost Centers**	**Total**	**Case Management Function Costs**	**Administrative Function Costs**	**OHCDS Function Costs**
22	Total revenue from Colorado Medicaid	$ -			
23	Total Revenue from Federal Sources	$ -			
24	Total Revenue From State Sources (other than CO Medicaid)	$ -			
25	Total Revenue from Mill Levy	$ -			
26	Total Revenues from Other Sources	$ -			
		$ -			
27	**TOTAL CCB REVENUES**	$ -	$ -	$ -	$ -

	CCB ADMINISTRATIVE REVENUES	**Total**
	***Please indicate total billed claims for FYE 14**	
28	Total Billed Claims for Medicaid Applicant Determinations	
29	Total Billed Claims for Quality Assurance	
30	Total Billed Claims for Utilization Reviews	
31	Total Billed Claims for PASARR	
32	Total Billed Claims for OBRA Pre-Admission Evaluation	
33	Total Billed Claims for SIS Assessments	
34	**CCB ADMINISTRATIVE REVENUES**	$ -

ADDITIONAL QUESTIONS

		Total	**Case Management Function**	**Administration Function**	**OHCDS Function**
36	**Please indicate the number of Full and Part time staff you employ for each Functional Area:**				
	Full Time				
	Part Time				

37	**Please specify by waiver, the number of participants receiving services under the following waivers**	
	Home and Community Based Services Children's Extensive Support Waiver (HCBS-CES)	
	Home and Community Based Services Waiver for Persons with a Developmental Disability (HCBS-DD)	
	Home and Community Based Supported Living Services Waiver (HCBS - SLS)	
38	**How many participants were on the waitlist for FYE 14?**	

CCB NAME:	PROVIDER_SAMPLE
NPI NUMBER:	XXXXXXXXX
REPORT PERIOD BEGINNING:	7/1/2013
REPORT PERIOD ENDING:	6/30/2014

WORKSHEET C: SURVEY FROM Jul 01,2013 TO Jun 30,2014

	1	2	3	4	5
Line No.	**Cost Centers**	**Total**	**Case Management Function Costs**	**Administrative Function Costs**	**OHCDS Function Costs**
39	**What was the average monthly targeted case management caseload for FYE 14?**				
40	**Is the Case Manager also responsible for performing some OHCDS and Administrative functions? If so, which functions is the case manager responsible for performing?**				
41	**Are any administrative services contracted to outside parties? If so, which services?**				
42	**On average, how long (days, months, or years) were individuals on the waitlist for FYE 14?**				
43	**Who is responsible for performing OHCDS functions (maintaining Medicaid agreements with providers, creating and maintaining provider qualifications files, etc. ? Does your CCB employ a team or individual specific to this function?**				

CCB NAME:	PROVIDER_SAMPLE
NPI NUMBER:	XXXXXXXXX
REPORT PERIOD BEGINNING:	7/1/2012
REPORT PERIOD ENDING:	6/30/2013

WORKSHEET C: SURVEY FROM Jul 01,2012 TO Jun 30,2013

	1	2	3	4	5
Line No.	**Cost Centers**	**Total**	**Case Management Function Costs**	**Administrative Function Costs**	**OHCDS Function Costs**
1	Salaries and Wages	$ -			
2	**TOTAL SALARIES AND WAGES**	$ -	$ -	$ -	$ -
3	Employee Taxes, Insurance, and Benefits	$ -			
4	**TOTAL EMPLOYEE TAXES, INSURANCE AND BENEFITS**	$ -	$ -	$ -	$ -
	SUBCONTRACTED SERVICES				
5	Subcontracted SIS Assessment Services	$ -			
6	Subcontracted Quality Assurance Services	$ -			
7	Subcontracted OHCDS Payment to Medicaid Providers	$ -			
8	Subcontracted OHCDS Payment to Non-Medicaid Providers	$ -			
9	Other Subcontracted Services	$ -			
10	**TOTAL SUBCONTRACTED SERVICES**	$ -	$ -	$ -	$ -
11		$ -			
12		$ -			
13		$ -			
14		$ -			
15		$ -			
16		$ -			
17		$ -			
18		$ -			
19					
20	**TOTAL OTHER COSTS**	$ -	$ -	$ -	$ -

CCB NAME:	PROVIDER_SAMPLE
NPI NUMBER:	XXXXXXXXX
REPORT PERIOD BEGINNING:	7/1/2012
REPORT PERIOD ENDING:	6/30/2013

WORKSHEET C: SURVEY FROM Jul 01,2012 TO Jun 30,2013

	1	2	3	4	5
Line No.	**Cost Centers**	**Total**	**Case Management Function Costs**	**Administrative Function Costs**	**OHCDS Function Costs**
21	**GRAND TOTALS (COSTS)**	$ -	$ -	$ -	$ -

	CCB REVENUES	**Total**	**Case Management Revenue**	**Administration Revenue**	**OHCDS Revenue**
22	Total revenue from Colorado Medicaid	$ -			
23	Total Revenue from Federal Sources	$ -			
24	Total Revenue From State Sources (other than CO Medicaid)	$ -			
25	Total Revenue from Mill Levy	$ -			
26	Total Revenues from Other Sources	$ -			
		$ -			
27	**TOTAL CCB REVENUES**	$ -	$ -	$ -	$ -

	CCB ADMINISTRATIVE REVENUES	**Total**
	***Please indicate total billed claims for FYE 14**	
28	Total Billed Claims for Medicaid Applicant Determinations	
29	Total Billed Claims for Quality Assurance	
30	Total Billed Claims for Utilization Reviews	
31	Total Billed Claims for PASARR	
32	Total Billed Claims for OBRA Pre-Admission Evaluation	
33	Total Billed Claims for SIS Assessments	
34	**CCB ADMINISTRATIVE REVENUES**	$ -

ADDITIONAL QUESTIONS

	Total	**Case Management**	**Administration**	**OHCDS**

CCB NAME:	PROVIDER_SAMPLE
NPI NUMBER:	XXXXXXXXX
REPORT PERIOD BEGINNING:	7/1/2012
REPORT PERIOD ENDING:	6/30/2013

WORKSHEET C: SURVEY FROM Jul 01,2012 TO Jun 30,2013

	1	2	3	4	5
Line No.	**Cost Centers**	**Total**	**Case Management Function Costs**	**Administrative Function Costs**	**OHCDS Function Costs**
36	**Please indicate the number of Full and Part time staff you employ for each Functional Area:**		**Function**	**Function**	**Function**
	Full Time				
	Part Time				
37	**Please specify by waiver, the number of participants currently receiving services under the following waivers**				
	Home and Community Based Services Children's Extensive Support Waiver (HCBS-CES)				
	Home and Community Based Services Waiver for Persons with a Developmental Disability (HCBS-DD)				
	Home and Community Based Supported Living Services Waiver (HCBS - SLS)				
38	**How many participants were on the waitlist for FYE 13?**				

CCB NAME:	PROVIDER_SAMPLE
NPI NUMBER:	XXXXXXXXX
REPORT PERIOD BEGINNING:	7/1/2011
REPORT PERIOD ENDING:	6/30/2012

WORKSHEET C: SURVEY FROM Jul 01,2011 TO Jun 30,2012

	1	2	3	4	5
Line No.	**Cost Centers**	**Total**	**Case Management Function Costs**	**Administrative Function Costs**	**OHCDS Function Costs**
1	Salaries and Wages	$ -			
2	**TOTAL SALARIES AND WAGES**	$ -	$ -	$ -	$ -
3	Employee Taxes, Insurance, and Benefits	$ -			
4	**TOTAL EMPLOYEE TAXES, INSURANCE AND BENEFITS**	$ -	$ -	$ -	$ -
	SUBCONTRACTED SERVICES				
5	Subcontracted SIS Assessment Services	$ -			
6	Subcontracted Quality Assurance Services	$ -			
7	Subcontracted OHCDS Payment to Medicaid Providers	$ -			
8	Subcontracted OHCDS Payment to Non-Medicaid Providers	$ -			
9	Other Subcontracted Services	$ -			
10	**TOTAL SUBCONTRACTED SERVICES**	$ -	$ -	$ -	$ -
11		$ -			
12		$ -			
13		$ -			
14		$ -			
15		$ -			
16		$ -			
17		$ -			
18		$ -			
19					
20	**TOTAL OTHER COSTS**	$ -	$ -	$ -	$ -

CCB NAME:	PROVIDER_SAMPLE
NPI NUMBER:	XXXXXXXXX
REPORT PERIOD BEGINNING:	7/1/2011
REPORT PERIOD ENDING:	6/30/2012

WORKSHEET C: SURVEY FROM Jul 01,2011 TO Jun 30,2012

	1	2	3	4	5
Line No.	**Cost Centers**	**Total**	**Case Management Function Costs**	**Administrative Function Costs**	**OHCDS Function Costs**
21	**GRAND TOTALS (COSTS)**	$ -	$ -	$ -	$ -

	CCB REVENUES	**Total**	**Case Management Revenue**	**Administration Revenue**	**OHCDS Revenue**
22	Total revenue from Colorado Medicaid	$ -			
23	Total Revenue from Federal Sources	$ -			
24	Total Revenue From State Sources (other than CO Medicaid)	$ -			
25	Total Revenue from Mill Levy	$ -			
26	Total Revenues from Other Sources	$ -			
		$ -			
27	**TOTAL CCB REVENUES**	$ -	$ -	$ -	$ -

	CCB ADMINISTRATIVE REVENUES	**Total**
	***Please indicate total billed claims for FYE 14**	
28	Total Billed Claims for Medicaid Applicant Determinations	
29	Total Billed Claims for Quality Assurance	
30	Total Billed Claims for Utilization Reviews	
31	Total Billed Claims for PASARR	
32	Total Billed Claims for OBRA Pre-Admission Evaluation	
33	Total Billed Claims for SIS Assessments	
34	**CCB ADMINISTRATIVE REVENUES**	$ -

ADDITIONAL QUESTIONS

	Total	**Case Management**	**Administration**	**OHCDS**

CCB NAME:	PROVIDER_SAMPLE
NPI NUMBER:	XXXXXXXXX
REPORT PERIOD BEGINNING:	7/1/2011
REPORT PERIOD ENDING:	6/30/2012

WORKSHEET C: SURVEY FROM Jul 01,2011 TO Jun 30,2012

	1	2	3	4	5
Line No.	**Cost Centers**	**Total**	**Case Management Function Costs**	**Administrative Function Costs**	**OHCDS Function Costs**
36	**Please indicate the number of Full and Part time staff you employ for each Functional Area:**		**Function**	**Function**	**Function**
	Full Time				
	Part Time				
37	**Please specify by waiver, the number of participants currently receiving services under the following waivers**				
	Home and Community Based Services Children's Extensive Support Waiver (HCBS-CES)				
	Home and Community Based Services Waiver for Persons with a Developmental Disability (HCBS-DD)				
	Home and Community Based Supported Living Services Waiver (HCBS - SLS)				
38	**How many participants were on the waitlist for FYE 12?**				

Appendix B: Conflict-Free Case Management Town Hall Summary Report

Conflict-Free Case Management Town Hall Summary Report

Stakeholder Feedback

Office of Community Living

Division for Intellectual and Developmental Disabilities

March 2016

Introduction and Background

In 2014, the Centers for Medicare and Medicaid Services (CMS) enacted a regulation requiring separation of case management activities from direct service provision for each individual enrolled in a Home and Community Based (HCBS) Waiver. Particularly, the rule states,

> *Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan. . .*[1]

In Fiscal Year 2014-2015 Colorado received $200,366,246 from the federal government to support individuals enrolled in the HCBS Children's Extensive Support (HCBS-CES) waiver, HCBS for Persons with Developmental Disabilities (HCBS-DD), and the HCBS Supported Living Services (HCBS-SLS) Waivers. As mentioned before, this represents nearly 50% of the overall budget for these waivers. To continue receiving federal funding, Colorado must come into compliance with the regulation.

The Department estimates that roughly 50% of those currently enrolled in the HCBS-CES, HCBS-DD, or the HCBS-SLS Waivers receive services from an entity that has a conflict of interest and will be directly affected by this change.

As Colorado works to comply with this regulation, town hall meetings were held throughout the state to gather input from stakeholders. The information gathered at these town halls will be incorporated into the final transition plan. Pursuant to Colorado law, an implementation plan must be submitted to the Colorado Joint Budget Committee by July 1, 2016.[2] The plan has not yet been written. Once the plan is available, additional regional meetings will be held to gather feedback on the actual plan.

Throughout March 2016, the Department facilitated 13 in person meetings in different areas of the state to communicate the upcoming changes and receive feedback from those affected. To ensure all voices were heard and consideration was equally given to each region, meetings were held in Fort Collins, Denver, Grand Junction, Steamboat Springs, Pueblo, and Fort Morgan. For those unable to attend the in-person meetings, two statewide online webinar sessions were also held. Additionally, the Department facilitated one meeting in Denver for Single Entry Point agency Administrators. Included as Appendix B1 is the presentation that was given by the Department.

This document is the product of the town hall meetings held throughout the state. It is intended to capture the concerns of the community and inform the final plan.

[1] 42 C.F.R. § 441.301(c)(1)(vi) (2016).

[2] "No later than July 1, 2016, the state department, in collaboration with community-centered boards, shall develop a plan for the delivery of conflict-free case management services that complies with the federal regulations relating to person-centered planning." C.R.S. 25.5-6-409.3 (2015).

Town Hall Process

To facilitate open and honest communication, reduce the potential for any retaliatory actions, and foster full participation; separate meetings were held for: (1) direct service providers, (2) clients with intellectual and developmental disabilities, their guardians, advocates, and family members, and (3) Single Entry Point agencies. Transparency in decision making is essential and thus all meetings were open to anyone wishing to attend. However, the feedback gathered and participation was focused on those invited.

In each town hall, participants were asked to engage in several exercises. Post-It notes were distributed to allow ideas to be communicated to the Department as these ideas occurred. Facilitators directed those in attendance to write down their specific questions and concerns and leave these notes with the Department. This report summarizes those responses.

Attendees were specifically asked to reflect on:

1. What's Working in the Current Case Management Delivery System?
2. What Do You Need More Information On?
3. What Are Your Top Fears or Concerns Surrounding Conflict-free Case Management?
4. What Are the Benefits of Conflict-free Case Management?
5. What Are the Barriers to Conflict-free Case Management?
6. What Are the Implications of Conflict-free Case Management?
7. How Can the Department Improve Communications with Those Impacted?

Overall Input

Overwhelmingly, the majority of stakeholders across all locations and backgrounds indicated that their primary concern surrounding conflict-free case management is ensuring the continuity of services for individuals with intellectual and developmental disabilities. The Department is aware of the need for stability and continuity in the lives of individuals served and will take steps to minimize disruptions. The Department aims to ensure as smooth of a transition as possible. This will require individuals at every level, new and established, coordinating their efforts and supporting clients throughout the transition.

Another major theme that emerged was the importance of relationships. At nearly all of the meetings, it was noted that long-term, close relationships have been built between clients, families, caregivers, case managers, and HCBS providers. The Department recognizes the importance of these bonds and will work to preserve existing relationships as much as possible and help foster new ones.

Regional Input

As the Department conducted these meetings, themes emerged and different concerns were raised in different regions. The remainder of this report is organized by region and addresses those concerns raised in each location.

Pueblo

Attendees at both the Provider's Meeting and Family Meeting in Pueblo noted a number of processes in the current system are working well; specifically, the Human Rights Committee process, requests for proposals, case management, and provider approved service agencies. Responses are received quickly, individuals know who to call in an emergency, and individuals have choice between case managers. Attendees also noted that person-centered thinking has changed the mindset at a number of agencies and throughout the broader community.

Stakeholders were asked to share what they needed more information on. Based on this directive, participants indicated that more information was needed surrounding the web based request for proposal process, who is paying for the restructuring, what will happen to the local Community Centered Board, whether Pueblo is considered rural, questions surrounding billing processes, and questions regarding the timeframes for compliance.

Significant time was spent at the town hall to gather feedback surrounding everyone's fears and concerns surrounding conflict-free case management. Several attendees indicated that they had concerns about Community Centered Boards making deals with each other and swapping case management services. Others expressed fears that case managers will not be easily accessible and the new system will not be person-centered. Both groups are concerned about conflict-free case management causing a breakdown in services, compassion, and communication. Additional feedback reflected concerns surrounding the complexity of the new system and possibility of too many agencies being involved causing confusion for the clients. Providers shared fears about job loss under the new system. Participants were asked to reflect on the benefits of conflict-free case management, the barriers to implementation, and the implications following implementation. Continued funding from the federal government, decreases in conflicts of interest, increased free-market competition for services, potential for clients to have more control over their lives, and opportunities for specialized case management were all identified as potential benefits of the new system. Confusion, misunderstanding, training, resistance from community centered boards, and less personal attention were the barriers shared by the groups. Implications identified by the groups were compliance with the federal regulation, additional funding for smaller agencies, potential loss of community centered boards, and the possibility of case managers re-entering the field who previously left.

Finally, stakeholders were asked to share with the Department their suggestions on how communication could be improved. Door-to-door / face-to-face communications, additional community meetings, community centered boards conducting outreach, email, text messaging, newspaper, television, radio public service announcements were all suggested.

Fort Collins

Meetings were held in Fort Collins for service providers and families, clients, guardians, and advocates. Stakeholders were asked to reflect on what's working in the current system. Here, they identified the extensive case management services available to individuals with IDD, the team approach, the longevity of the relationships between case managers, providers, and clients, the positive and person-centered tone from case managers, and local control as all positives of the current system. Secondly, stakeholders were asked to share what they needed

more information on. Here they identified more information is needed on: whether service agencies will be required to take on the unfunded mandates that the Community Centered Boards have been handling, how conflict-free case management will be monitored, what area are included in the separation, how individuals will be affected, how long-term relationships will be maintained, questions regarding the timeframes on implementation, the contours of the rural exemption, how training for case managers will be handled, what will happen to the mill levy funds, the role and responsibility of case managers, the length of the wait list, and what will happen with eligibility and Supports Intensity Scale (SIS) assessments.

As the discussion surrounding conflict-free case management continued, participants were asked to share their top fears and concerns with the Department. They identified confusion, communication trouble, difficulty navigating a new system, transitions, loss of choice, lack of funding, cherry-picking by Community Centered Boards, case managers not being specialized, individuals without families or guardians getting lost in the system, lack of attention to high risk individuals, retaliation from community centered boards, loss of mill levy funding, loss of case management jobs, breakup of Community Centered Boards, monitoring and enforcement, delays in service delivery, and loss of local control.

Next, attendees shared their thoughts on the benefits, barriers, and implications of conflict-free case management. The benefits identified were: additional federal funding, removal of conflicts in case management, individual perception, increased choices, new jobs, person-centered planning, removing financial incentives, easier to navigate, increased competition, increased transparency. Participants recognized some of the barriers surrounding implementation as: TABOR, timelines, resistance from Community Centered Boards and lobbying efforts, lack of information, legislative barriers, and accessibility for diverse individuals, lack of funding, convenience, training, billing, and knowledge. The implications shared by the groups included, waiver re-design, consistency, increased stress, loss of smaller providers, increased corruption, increased flexibility, delays in services, increased costs, improvement in services, increased options, and a more transparent system. Finally, attendees were asked to share their suggestions on how the Department could improve communications. On this topic they shared: involve a greater number of stakeholders, simplify messaging, distribute a newsletter, improve website navigation, text messaging, publicize contacts at the state level, hold evening meetings, stress the importance of funding and retention of services, utilizing various modes of communication, and implementing a state level family representative.

Denver & Webinars

At the meetings held in Denver, participants were asked to share their opinions on the questions noted above. To identify and preserve, when possible, what is working in the current system, providers and families were asked to write down their thoughts. Here they identified, the tone at Community Centered Boards has become more person-centered, individuals currently have ability to change case managers, current case managers and providers have a high level of clinical expertise, all individuals have a case manager, and Community Centered Boards have an expertise in dual diagnosis individuals. The Department values this feedback and will undertake to preserve these elements in the new plan.

As with all the meetings, the Department asked Denver stakeholders what they needed more information on. Stakeholders indicated more information was needed on: how notifications of changes will be communicated, how conflict-free case management will benefit those currently satisfied with their services, exactly what functions are being separated, when the plan be available, how transition will take place, when will Community Centered Boards decide what they will offer, the future of Community Centered Boards, how this will affect state SLS, what statutory changes are necessary, why can't individuals freely choose to have case management and services from the same entity, are there any exceptions, will there be any state certifications required for case managers, concerns that community centered boards will swap clients, cost of conflict-free case management, how providers will be supported through the transition, what have other states done, how will this impact the Family Caregiver, enforcement, and the number of people actually impacted. Additionally participants were asked to share with the Department their top fears and concerns surrounding conflict-free case management. Stakeholders shared the following: loss of clinical teams, loss of Community Centered Boards, double payments, lack of quality education, frustration from families, individuals and providers, decrease in quality of services, increased wait lists, loss of federal funding, loss of choice, monitoring, resistance from Community Centered Boards and lobbyists, loss of opportunity, lack of knowledge, length of time to obtain provider identification number, timelines, unfamiliarity of case managers, difficulty navigating the new system, rural exemption, potential for corruption, no true conflict-free case management, lack of transparency, eliminating retaliation, need for thorough background checks, challenges of communication, poor execution by the state, lack of funding, loss of expertise, and how additional services such as dental and vision will be impacted.

Next, those in attendance were asked to reflect on the benefits, barriers, and implications of conflict-free case management. Stakeholders shared the following benefits: increased options and choices, independent case management, reduction of the possibility of retaliation and lessening of fear by clients and families, opportunity for niche case management, more providers with smaller caseloads, elimination of catchment areas, equitable distribution of services, higher pay for case managers, cost savings, greater advocacy, expands the rights of individuals, better information, and increased transparency. The following barriers to conflict-free case management were noted: resistance to change, confusion, resistance from community centered boards and lobbying groups, lack of communication, favoritism/nepotism, slow process, lack of funding, no concrete timelines, consistency, stress on families and individuals, and lack of understanding of the changes. The following implications of conflict-free case management were noted: increase complication and confusion, need for continuing education for service providers, delays, disorganization, true choice, independent case management, reduced wait lists, potential for higher quality case management, more state monitoring, increased costs, additional providers and independent contractors, greater flexibility, better advocacy and increased competition driving higher quality.

Lastly, stakeholders were asked to provide suggestions on how the Department could improve communications. Here they shared the following: utilize US mail, engage the non-profits, use community centered boards, contact case managers at schools, distribute brochures and utilize different formats, disseminate information through the website, targeted communication,

traditional media (TV, radio, newspapers), include multiple languages, announcements at annual meetings, phone calls, and text messages.

Grand Junction

The Department traveled to Grand Junction and received feedback from families and providers. At these meetings the attendees were asked to tell the Department what is working in the current system. The responses included: clear communication between clients and case managers, physical accessibility of case managers, good relationships, local case management, efficiency in administration, trust, ease of gathering an individual's team, ease of communication, individual choice, quick emergency response time, and knowledgeable case managers.

Grand Junction attendees were next asked to share with the Department topics on which they need additional information. Responses included: how the transition will be funded, how providers will be selected, information surrounding the rural exemption, need for additional transparency, need for continuity and stability, timelines for compliance, where new case managers will be located, infrastructure, how relationships will be preserved, job loss, loss of Community Centered Boards, quality of service and case management, and serving vulnerable clients.

Participants engaged in an exercise to elicit responses surrounding their top fears and concerns around conflict-free case management. Responses included: how can we avoid making an individual chose between case manager and providers, what is the impact of being physically removed from the individuals served, inability to respond to emergency situations, protecting relationships, loss of community insight, loss of personal connection, disruption to services, who will handle all the functions currently being done by the community centered boards for free, job loss, increased travel, time constraints, difficulty in communications, contours of the rural exemption, accessibility, and serving challenging individuals.

Additionally, stakeholders were asked to reflect on the benefits, barriers, and implications of conflict-free case management. Stakeholders identified the following benefits: increased choice, separation of case management from services, case managers independent, increase confidentiality, increased competition, greater accountability, maintain federal funding, discourages hiring unqualified individuals, services meet the needs of each client, greater transparency and accountability, clarity in job roles and responsibilities, more providers to choose from, and reduced fears of retaliation. When asked about barriers to conflict-free case management, stakeholders shared: proximity, existing relationships and resistance to change, differences between urban and rural providers, rebuilding trust, communication, funding, legislation and regulation, low compensation for case management, small client pool, case managers being unfamiliar with the service area, increased administrative costs resulting in decreases in services, lack of oversight, limitations of qualified people, confusion for parents and individuals, and mechanisms for resolving conflicts between case managers and service providers. Stakeholders were also asked to share their thoughts on the implications of instituting conflict-free case management. Responses included: restructuring, additional capacity, clarification of roles, gaps and the possibility of unmet needs, improved accountability, confusion, increases in caseloads, decreased accountability, loss of jobs and employee turnover,

loss of money for services, loss of relationships, decreased choice, complex system, either increased clarity or increased confusion, challenges surrounding transitions (preschool to elementary, high school and beyond), quality control, reliance on case managers, funding challenges, and oversight.

Finally, participants were asked to provide their suggestions on how the Department could improve their communications. Here stakeholders suggested: Facebook, legislative updates, email, utilizing professional organizations such as National Alliance on Mental Illness (NAMI), short and simple communications, send out "sorry you missed it" communications following events, allow ample time for people to plan, use text messaging, forums, U.S. mail, parent-to-parent communications, traditional mediums such as TV, radio, newspapers, press releases, in-person meetings at agencies, weekend meetings, and offer communications in a variety of languages.

Steamboat Springs

The Department traveled to Steamboat Springs and engaged stakeholders in town hall meetings surrounding conflict-free case management. When asked what is working in the current system, stakeholders replied: coordination of care with case managers being local, strength of relationships, community integration, familiarity of providers with the system, community education, communication and integration with all services, case managers function as a single point of contact, and weekly contacts with clients.

Next, attendees were asked to share topics on which they need additional information. Topics shared with the Department include: how provider capacity can be maintained or increased, the contours of the rural exemption, how cost of living will be considered, including geographic location as a provider qualification, impact on state only programs, whether the transition process has already started, how will conflict-free case management affect clients and families, how will changes impact the mill levy (especially when the community had invested significant mill levy resources to support people with I/DD), maintaining current quality of care, what are the proposed case management agency models, how will for profit case management impact service delivery, what exactly is case management, and what have other states done to eliminate conflicts. Stakeholders were also asked to tell the Department about their fears and concerns surrounding conflict-free case management. Here they identified: loss of local case management, loss of personal care, loss of ability to provide services, less oversight and reduced quality of service, interfering with the continuity of care, lack of choice, lack of funding, loss of Community Centered Board designation, accounting difficulties, disconnect for providers and clients, impact on the local mill levy, clients less likely to report incidents of mistreatment, abuse, neglect and exploitation, loss of local jobs, fragmentation of system, additional regulations, impact on dental and vision services, whether case management will be available at all, qualifications of case managers, potential for fraud, and motivation of for profit case management agencies. The Department acknowledges these fears and concerns and will work to address them as the plan developments and is implemented.

Additionally, participants were asked to reflect on the benefits, barriers, and implications of conflict-free case management. Steamboat Springs participants identified the following benefits: increased transparency and accountability, increased choice, free market competition,

more inputs could lead to greater collaboration, catalyst for improvement, benefits to clients across the country, potential for increased funding, more entities with more ideas, and standardized training. When asked to identify potential barriers, stakeholders indicated: additional agencies doesn't necessarily mean more is getting done, ensuring service delivery and continuity of care, lack of additional providers, cost of living, economies of scale, implementation costs, funding, implementation time, more complaints, loss of staff, difficulty traveling, additional training, making clients choose between providers and case managers, and difficulty coordinating care from a distance. Finally, stakeholders were asked to list the implications of implementing conflict-free case management. Here they shared: impersonal and bureaucratic system, financially motivated decisions, lack of access to services in rural areas, difficulty for small providers to obtain Medicaid identification, high turnover, loss of local knowledge, loss of local jobs and civic engagement, and loss of mill levy funds.

Before the conclusion of the meeting, participants were asked to share with the Department their thoughts on how communication could be improved. Here, participants suggested: utilizing the U.S. mail, emails through the community centered boards, eliminating acronyms, phone calls, text messages, social media, county-wide newspapers, provide a contact at the state for families to speak with, share more about the "why" behind conflict-free case management. The Department has heard these suggestions and will integrate them in future communications.

Fort Morgan

Town hall meetings were held in Fort Morgan to gather information from the community. As with the other meetings, stakeholders were asked to write down their opinions on what is working in the current system. Responses included: a high quality of care, Community Centered Boards have a full understanding of all operations, longevity of relationships, proximity to case managers, and open communication.

Secondly, community participants were asked to tell the Department what questions they have and what they needed more information on. In response to this exercise, stakeholders indicated that additional information is needed on: how rural areas can obtain an exemption, how the changes will ultimately affect clients, how will case managers be held accountable, how far will clients have to travel for good services, can the federal rule be repealed, how will this benefit clients that are currently satisfied, how will this impact the timelines for RFPs, how will case managers be selected and how will quality be assured, can rates be re-evaluated, how will there be enough qualified service providers, and what impact will this have on person-centeredness.

Stakeholders were then guided through an exercise to solicit responses surrounding their top fears and concerns surrounding conflict-free case management. Stakeholders shared concerns surrounding: loss of long-term relationships, impacts on individual clients, cost of implementing new rules and regulations, break in the continuity of care, unfamiliarity of new case managers, decreased quality of care, lack of accountability, lack of accessibility, having to relocate, loss of local knowledge, poor communication, increased government control, loss of jobs, loss of input from local communities, increased costs, who will service challenging clients, lack of choice, and lack of coordination among providers.

Next, participants were asked to identify the benefits, barriers, and implications of conflict-free case management. Benefits identified by the community included: expanded choices in case management, more options resulting in more ideas, and preventing people from taking advantage of the system by recommending unnecessary services. The barriers identified by the participants included: difficulties in communication, breaks in the continuity of care, loss of personalization, loss of relationships, inability for smaller agencies to survive, distance, adequate funding, quality of people, availability, non-local agencies unable to serve all clients, and change. Finally, the implications of conflict-free case management noted by the groups included: loss of long-term employees, loss of communication, clients changing case managers frequently, availability of case managers, loss of local understanding, interfering with the continuity of care, loss of relationships, profits becoming more important than people, and decreased quality.

Finally, meeting attendees were asked to provide input on how communications can be improved. On this topic they indicated that the Department could improve communication by: gathering notification preferences from individuals, employing push notifications, making robo-calls, holding meetings in the afternoon, disseminating information through existing case managers, sharing information through the community centered boards, email, limited use of acronyms, clearly indicate communications are about conflict-free case management, use the U.S. mail, send text messages, hold town halls, utilizing plain language, flowcharts or diagrams that visually depict message, face-to-face contact, ensuring to communicate with those individuals who don't have guardians, multiple contacts, social media, traditional media (TV, radio, newspapers, PSAs).

Single Entry Point Agencies

The Department facilitated a meeting specifically for the Single Entry Point agencies, in an effort to engage this group and gather feedback. In the same method as previous meetings, those in attendance were asked to write down their opinions on what is working in the current system. The responses received included: Having one Single Entry Point per county, all administrative Case Management will be conducted by the same agency, there is more freedom within the agency regarding operations, there is local control, and there is an ability to identify what works for catchment areas and own agency.

Next, the participants of the meeting were asked what they need more information on. The areas that were raised were: No Wrong Door, payments to case management agencies and providers rate structure, case management as a service, how does this relate to No Wrong Door and Affordable Care Collaborative, conflicts between case management and eligibility determinations, when will we all need to come into compliance, effects to relationships with community providers, examples of successful mitigation between other Community Centered Boards and Single Entry Points, what have other states implemented to resolve issues related to conflict-free Case Management?

The group then explored potential benefits, barriers, and implications regarding conflict-free case management. Some benefits of this change that were identified: more person-centered approach to services, it will decrease the chance of fraud, will bring us into federal compliance of regulation, the relationships between the Single Entry Points will leverage more assistance

for individuals receiving and seeking services, the change will allow for growth amongst the Single Entry Points, and it will simplify the system. Some of the barriers that were discussed included: increase in training and education, restructuring current contracts, community outreach, addressing the fear of the unknown, adjusting to changes in Case Management providers, fiscal impacts, and needing more details. Lastly, as part of this discussion, participants were asked to provide what implications may arise from conflict-free case management: more players will be involved, no more financial audits, concerns regarding capacity, potential overhead increased for each agency included, need to increase knowledge base and skill sets regarding new systems and populations.

To end the meeting, the group was requested to provide feedback on how the Department can increase communication efforts. The following suggestions were provided: make communication multi-faceted such as utilizing united states post office for mailing, emails, or providing text alerts/updates, to ensure that it is widely distributed to all providers and through public notices, continue to provide opportunities for face-to-face engagement, be simplistic, clear and direct.

Rural vs. Urban

Although there were clear threads of consistency and uniformity across all of the meetings, there were some distinct themes that presented themselves whether the attendees were from larger metropolitan areas or smaller, more rural settings.

For example, some stakeholders in Denver voiced concerns that the Department would not move forward with complete compliance with the regulations and expressed frustration that the changes weren't moving quickly enough.

Attendees in Fort Morgan, Steamboat Springs, and those from Glenwood Springs expressed concern that the changes were happening too quickly and cautioned against moving too fast, resulting in a destabilization of the service delivery continuum.

Conclusion

The Department thanks everyone for their participation and feedback. All feedback will be considered in the development of the final plan and the Department will ensure the final plan not only complies with the federal regulation but also ensures the transition to conflict-free case management will be conducted in as least disruptive manner as possible, while maintaining continuity of services for individuals and their families.

Appendix B1: Town Hall Meeting Presentation

Conflict Free Case Management

Understanding Colorado's Home and Community Based Services care continuum and its future

Town Hall Meeting

March 2016

COLORADO
Department of Health Care Policy & Financing

Our Mission

Improving health care access and outcomes for the **people** we serve while demonstrating sound stewardship of financial **resources**

Who we are:
The Colorado Department of Health Care Policy and Financing

- Single State Agency responsible for Medicaid
- Department's Executive Director member of Governor's Cabinet
- Contract with Community Centered Boards & Direct Service Agencies (PASAs)

Who We Are:
Office of Community Living

- Focus resources on needs of aging Coloradans and Coloradans with disabilities
- Promote self-direction and person-centered services and supports
- Better align services and supports so system is navigable and cohesive for individuals and their families

Susan Birch
Executive Director
Department of Health Care Policy & Financing

Jed Ziegenhagen
Director
Office of Community Living

Barbara Ramsey
Deputy Office Director

Medicaid Basics

- Social Security Amendments of 1965
- Voluntary Federal-State Partnership
- Medical Care for Americans who are low-income or have disabilities
- Federal Medical Assistance Percentage (FMAP)
  - Colorado FMAP: 50%

Medicaid State Plan

- Contract between State and Federal Governments
- Describes the State's Medicaid Program Administration
- Ensures Compliance with Federal Regulations
- Physician and Hospital Services, Laboratory, X-Ray

Medicaid: Optional Benefits

- Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/ID)

- Home and Community Based Services (HCBS) Waivers for People with Intellectual and/or Developmental Disabilities

What is a Waiver?

- "Waives" provisions of the State Plan
- Eligible individuals must meet specific criteria for enrollment
- All clients in Waivers managed by the Division for Intellectual and Developmental Disabilities must have a developmental disability
- All enrolled clients must meet Medicaid Financial Eligibility
- Federal funding contingent on compliance with federal regulations

Medicaid HCBS Waivers

- Community-based services as an alternative to institutional care
- Targeted Population
- Must be cost effective
  - Less than or equal to the cost of providing institutional care to a comparable population

Colorado's HCBS Waivers Supporting Adults with I/DD

- Persons with Developmental Disabilities Waiver (HCBS-DD)
  - Provide services to individuals who require access to support 24 hours/day
- Supported Living Services Waiver (HCBS-SLS)
  - Provide services to individuals who are able to live independently with limited paid supports or who receive more extensive supports from other sources

Colorado's HCBS Waivers Supporting Children with I/DD

- Home and Community Based Services Children's Extensive Support (HCBS-CES) Waiver

- Supports children (birth through age 17) who have significant medical and/or behavioral needs

Other Related Services and Supports

- State Supported Living Services
- Family Support Services Program
- Family Support Services Loan Fund

HCBS Waivers for People with IDD: Community Centered Boards

- Statutorily designated Activities conducted by CCBs
  - Intake screening and referral
  - Eligibility Determination
  - Service Plan Development
  - Case Management
  - Provide and arrange Direct Services

Medicaid Service Provision: Community Centered Boards

- CCBs enter into a Provider Agreement with the Department in order to deliver and be reimbursed for Medicaid services
- Reimbursed according to the Department's standard fee schedule
- CCBs may currently provide:
  - Direct Services
  - Case Management
  - Billing services for other providers

Provider Agency

- Subject to the Medicaid Provider Agreement
  - Full legal responsibility for claims submitted under its Provider ID(s)
  - Claims submitted only for those covered services rendered personally or by qualified personnel under the provider's supervision
  - Provider must maintain licensure and/or certification requirements
- Provider reimbursed directly according to the Department's standard fee schedule

Federal Regulations and State Statute

- Federal HCBS Final Rule (March 2014)
  - Requires separation of case management and direct services for the same individual at every level of the agency

- House Bill 15-1318
  - Work with CCBs and other stakeholders to develop a plan to resolve conflict of interest
  - Submit plan to the Joint Budget Committee by July 1, 2016

HCBS Waivers for People with IDD: By the Numbers

Home and Community Based Services (HCBS) Waivers for Persons with Intellectual or Developmental Disabilities					
Waiver	**Clients Enrolled***	**Federal Funding**	**State Funding**	**Total****	**Federal Funding as percentage of Total Funding**
HCBS-Children's Extensive Support	1,402	$11,108,871	$11,465,548	$22,574,419	49%
HCBS-Supported Living Services	4,332	$35,785,950	$42,592,426	$78,378,376	46%
HCBS-Persons with a Developmental Disability	4,910	$171,514,031	$171,514,031	$343,028,062	50%
	10,644	**$218,408,852**	$225,572,005	**$443,980,857**	49%

*Total clients with Active Prior Authorization as of January 31, 2016.

**Department of Health Care Policy and Financing Supplemental Bill, Fiscal Year 2015-16 Appropriation, HB 16-0603; total does not include cash funds

Ways to stay informed

- The Provider Directors' Meeting
- The Advocates' Communication Meeting
- Sign up for Department Communications
- Follow us on Facebook and Twitter
- Upcoming Regional Forums regarding CFCM
- The Department's CFCM website

Questions or Concerns?

For More Information/Questions

Conflict-Free Case Management

Website: http://tinyurl.com/qbf6n6q

Feedback Form: http://tinyurl.com/nb8k2kt

Email: cfcm.didd@state.co.us

Voicemail: 303.866.5560

Public Knowledge LLC

Appendix C: CFCM Implementation Plan Recommendations

COLORADO
Department of Health Care Policy & Financing

Conflict-Free Case Management Implementation Planning Assistance Project

April 19, 2016

Public Knowledge LLC
Management Consultants

1580 Logan Street, Suite 745
Denver, Colorado 80203

Table of Contents

1 - Executive Summary

A nationwide system change initiated by the Centers for Medicare and Medicaid Services (CMS) for the delivery of case management entails the separation of case management functions from direct service provision. Conflicts of interest related to case management may exist because of:

- Incentives for over- or under-utilization of services;
- Interest in retaining individuals as clients rather than promoting independence; and
- Issues where the focus is not person-centered.

In order to comply with federal regulations and state legislation, the State of Colorado must convert to Conflict-Free Case Management (CFCM). Currently in Colorado, Home and Community Based Service (HCBS) waiver case management agencies for individuals with intellectual and/or developmental disabilities (I/DD) offer both case management and direct services. This conversion will require the redesign of HCBS waiver programs and the separation of these functions.

Pursuant to House Bill 15-1318, the Department of Health Care Policy and Financing (the Department), with input from Community Centered Boards (CCBs), Single Entry Point Agencies, and other Stakeholders, shall develop a Plan (the Plan as referenced in this report) for the implementation of CFCM that complies with the federal regulations relating to person-centered planning. The Plan is due no later than July 1, 2016, and must include a reasonable timeline for implementation.

Public Knowledge was contracted by the Department to assist with facilitating meetings with CCBs to garner input and recommendations for the CFCM Implementation Plan.

1.1 Purpose and Objectives

This document describes our approach to obtaining CCB input on CFCM and also provides recommendations for CFCM implementation planning based on the six CCB meetings. We also identified guiding principles through these meetings and barriers to successfully transitioning to CFCM. The series of recommendations will be incorporated into the final report being developed by Navigant Consulting, Inc. (Navigant). Navigant's report will couple financial and other data analysis, including Public Knowledge's recommendations from the CCB meetings, to establish the Plan for proceeding with CFCM.

The recommendations in this report do not reflect input from other stakeholder groups or perspectives. They are specifically focused on recommendations from the meetings with CCBs and the Department.

A primary objective identified during the meetings is that the Department must proceed with CFCM based on federal regulation and requirements from CMS. Implementation of CFCM cannot be waived, and therefore, the Department must move forward with describing the approach, tasks, and timeline for CFCM implementation in the Plan.

We identified key themes and areas for recommendations based on CCB input. The prioritized areas as identified by meeting participants are as follows:

- Transition for Existing Clients and On-boarding New Clients
- Regulatory and Policy Changes
- Provider Development and Outreach
- Communication Priorities
- Tracking Mechanisms
- Other

Recommendations for each of these areas are highlighted in Section 3. Public Knowledge heard several barriers to CFCM from CCBs perspectives, including the need for more direction from the Department. As a result, we could not always provide concrete qualitative and quantitative goals and objectives for the Plan. CCBs noted, on several occasion, that they are waiting on Department definition and policy direction in order to plan for transitioning clients and for implementing for new clients. Additional data analysis and policy definition will be required to establish the implementation approach – the planning efforts needed to provide additional direction on CFCM should be reflected in the Implementation Plan.

1.2 Audience

The recommendations in this report will be provided to the Department. The Department will incorporate recommendations and other pertinent information into the Navigant report. The Navigant report will be distributed to CFCM stakeholders, including CCBs.

2 – Methodology

This section highlights the methodology we used to garner input from CCBs on the Plan. We also highlight guiding principles, benefits and barriers to CFCM as identified by CCBs as a result of the facilitated sessions.

2.1 Meeting Approach

We facilitated six meetings between the Department and CCBs. We structured the meetings in a variety of ways including brainstorming on ideas for CFCM, identifying barriers to implementation, and prioritizing implementation components. Participants attended in-person and by conference phone. Section 2.4 below provides additional information on meeting attendance.

The preliminary meetings were focused on understanding CCB perspectives and potential barriers. We also brainstormed in small groups and clustered ideas around the definition of CFCM and what it meant to each representative. We discussed barriers, worries, and fears or concerns about CFCM. The small group discussions helped the CCBs uncover potential challenges to implementation but also benefits for the clients and the CCBs.

We also highlighted ideas and plans from other states based on best-practices research. We reviewed and discussed Ohio's CFCM implementation plan to gain an understanding of implementation approaches in other states. We also reviewed Wyoming and North Dakota's implementation plans to garner ideas on what aspects of these plans might work in Colorado. Reviewing these plans helped determine important benchmarks for a phased approach to implementation.

Another important aspect of the meeting series was the gathering and reviewing of data on services by the CCBs. The data is an essential factor in generating ideas for implementation. The Department and CCBs agree the data is also crucial in helping to support a potential rural exemption. In addition, the data helps identify what the CCBs said was an important aspect of keeping the CCB designation.

As we reached the last few meetings, we discussed components of the Plan, potential timeline, and priority areas/tasks. Additional information on Plan components can be found in Section 3.

2.2 Guiding Principles

Based on the discussions with CCBs, it was apparent that there should be parameters for developing the Plan. We identified Guiding principles for establishing CFCM from a CCB perspective:

1. Maintain safety of the clients.
2. Maintain continuity of care and customer services as a top priority so that clients can continue to receive appropriate care.
3. Carefully plan for the transition of individuals, but realize that certain clients may take more time.
4. Explore rural exemption options on a community basis and reflect this in the Plan.
5. Allow CCBs the opportunity to provide both case management and direct services, but not for the same individual.
6. Allow CCBs to divest of functions, as needed, in order to meet State and Federal regulations.
7. Explore additional or new options to provide clients with choice, but realize that some clients will need more time.
8. Third parties may get involved to assist with the transition, however, they should understand the system and structure.
9. Utilize the current data to establish the benchmarks on an annual basis.
10. CCBs want to continue to have a local presence and may expand that local presence.
11. Continue to assess the current array of services for clients with emphasis on providing value to clients.
12. Develop customized communications/messages for various stakeholder groups.
13. The infrastructure and systems for data collection will develop over-time, but temporary solutions may be warranted (such as Excel spreadsheets).
14. No Wrong Door must be taken into consideration.

2.3 Benefits

CCB participants noted several benefits to CFCM. Key benefits noted during the meetings are as follows:

1. Service provision could improve with CFCM, including greater integration and coordination; simplification of the system; and fewer systems to navigate.
2. Case management could be increasingly professionalized, but additional funding may need to be available.
3. Services can be customized through CFCM, which aligns with person-centered care.

4. CFCM offers greater choices to clients for case management and service provision.
5. CFCM allows providers to enter services that are underserved.
6. CFCM supports families that are currently dissatisfied, including provision of customized services.
7. There is an opportunity for the Regional Collaborative Care Organizations (RCCOs) to get involved in case management.
8. There may be more competition for service delivery, which can help drive improvements in service delivery.
9. Funding for case managers can be improved, which can increase the pool of available case managers. The additional funding can help CCBs.
10. There is an opportunity to streamline operations and infrastructure, including the underlying data systems.
11. Provider agencies could become more competitive.

2.4 Barriers

During our meetings CCBs noted numerous barriers to implementation. Key barriers CCBs noted during the meetings are as follows:

1. There are capacity issues for services and case management provided by CCBs. This is especially apparent in rural communities. In some communities, the CCBs may be the primary entities providing services. Additional capacity will need to be built, especially for rural areas.
2. CCBs provide services that other organizations may not want to provide since the services may not provide sufficient financial incentives. The cost for service delivery in parts of the State could be prohibitive, and CCBs may be the only entities that will provide the services.
3. Individuals and their families may be confused by the transition. Therefore, it is important to establish clear communications with individuals and their families.
4. CCBs expressed concern over backfilling services, including infrastructure. CCBs may need to divest of infrastructure in order to continue services. This could cause a disruption to staff, clients and families.
5. The service delivery and case management system could become more complicated if more entities become involved.
6. The approach to billing will be an issue for some service providers. Currently, CCBs may bill on behalf of other entities and individuals who are not structured as Medicaid providers (they do not have Medicaid Provider Ids). It is not clear how billing will be handled for these service delivery providers.

7. The full effects of implementation are not known, including the quality of CM and service delivery.
8. CCBs have concerns regarding staff retention and potential loss of employment for current employees.
9. CFCM could have implications on local revenue. In addition, the system is currently underfunded, and CCBs fear this will exacerbate the issues.
10. There are concerns over CCBs having to make the choice for case management or services. Considerations should be made for legal counsel in this instance.
11. In reference to planning functions for services, there is concern where it might fall and where the funding will come from.

2.4 Meeting Participation

Table 1 below shows meeting topics and participation for the six facilitated sessions with CCBs.

Table 1 – CCB and Department CFCM Implementation Planning Meeting Information

Meeting Date	Primary Topics	Meeting Attendance by Phone	Meeting Attendance In-Person
Thursday, Nov. 12, 2015	Why are we here? What is CFCM? What do we want to achieve? What are perceived barriers to CFCM? What are the benefits of CFCM? Transition – what is needed to remove the barriers? How do we communicate with stakeholders?	15	11
Tuesday, Dec. 1, 2015	Revisit definition of CFCM. Where is there flexibility/control? Review of Ohio implementation plan. What are change management considerations? How do we transition people?	15	7
Thursday, Jan. 28, 2016	Overview of case management and direct services. Rural exemption clarification and data needs. Review of Ohio benchmarks and North Dakota approach.	18	7

	Clarification from CMS.		
Thursday, Feb. 11, 2016	Transition plan development discussion. How do we afford client choice? Tracking? Dept. overview of billing process. Wyoming plan review. Data discussion, including data for Rural Exemption. Discussion on regulations defining CCBs. Reminder of Town Hall meetings.	20	6
Tuesday, Feb. 23, 2016	Overview of billing process. Data discussion and data received from CCBs. High-level goals of a transition plan.	22	4
Thursday, March 3, 2016	Follow-up on data discussion. What services and which providers are CCBs billing for? How does the data help support Rural Exemption? Goals of the transition plan.	25	7

3 – Recommendations for Plan Development

This section highlights key findings and recommendations for developing the Plan required by House Bill 15-1318. The CFCM Implementation Plan, with input from stakeholders, will need to be concrete, sound, and realistic. We identified key themes and areas for recommendations based on CCB input. The prioritized implementation areas identified by meeting participants are as follows:

- Transition for Existing Clients and On-boarding New Clients
- Regulatory and Policy Changes
- Provider Development and Outreach
- Communication Priorities
- Tracking Mechanisms
- Other

Recommendations for each of these areas are provided in the following subsections. Public Knowledge heard several barriers to implementation during the meetings, which prevented us from providing concrete recommendations for certain areas of CFCM implementation. CCBs noted, on several occasion, that they are waiting on the Department's policy direction and definitions in order to plan for transitioning clients and for implementing CFCM for new clients. As a result, we did not identify specific timelines, quantifiable goals and objectives, and annual benchmarks for implementation. We do, however, provide some recommendations for using a phased approach to implementation. Policy definition and further data analysis will be required to establish quantifiable goals – the ongoing planning efforts that will be necessary in the next six to 12 months should be reflected in the Implementation Plan.

All data referenced in this section is from the Department is from the Department's Medicaid Management Information System (MMIS) in February 2016, but for State Fiscal Year (SFY) 2014-2015

3.1 Transition for Existing Clients and On-boarding New Clients

1. **Approach transition through a phased implementation and collaborate with stakeholders on annual benchmarks for inclusion in the Plan.** Public Knowledge attempted to garner specific approaches and quantifiable benchmarks for implementation, but some of the discussions did not progress beyond high-level ideas for using a phased approach to implementation as well as barriers to CFCM.

CCBs and the Department provided data during the series of meetings to better understand the current conflicts. This baseline data should be incorporated in the Plan so that stakeholders understand the current environment. As of June 30, 2015, 44.15% of statewide Medicaid reimbursements for the HCBS-CES, HCBS-DD, and HCBS-SLS waivers went to the CCB who also provided case management for the same individual. However, for the same time period, 89% of individuals received at least one service from their CCB who provided case management. Going forward, CCBs should continue to be involved in planning processes to help define annual benchmarks for transition.

There were several approaches discussed during the meetings to transition clients. For example, clients could be transitioned in the following ways: by waiver; by Medicaid services; by Medicaid expenditures; by percent of the population in the waivers; and/or by region. The ultimate goal at the end of the implementation would be 0% of clients receiving both CM and services (unless it can be shown there is no other provider of either case management or direct services in the geographical area). The approach to implementation will most likely be multi-faceted. CCBs typically have relationships with waiver service providers to deliver specialized services, such as respite, personal care, and vision. For example, as of June 30, 2015, 99.45%[1] of I/DD waiver clients statewide receive vision services as billed by the CMA, and 98.56% of I/DD waiver clients receive dental services as billed by the CMA. The separation of case management from dental services might be low-hanging fruit as dental services is now a State Plan benefit and managed by Dentaquest. In addition, clients on the HCBS-Children's Extensive Support (HCBS-CES) waiver have the least amount of clients and may have the least disruptive transition since children are living in the family home and may eventually transition into an adult waiver, which often necessitates the need for a new provider and case manager. Meeting participants also noted that the HCBS-Supported Living Services (HCBS-SLS) waiver would be easier to address than the HCBS for Persons with Developmental Disabilities (HCBS-DD) waiver because of the potential need to move residences. Additionally, some individuals enrolled in the HCBS-DD waiver, are higher risk and harder to serve, such as individuals with sexual offense behaviors. These clients may require more time to transition. The most challenging services and clients requiring a higher level of support may be better planned for transition in the long-term.

In addition, the ability to transition current clients may be more difficult for areas in the State that have large service gaps. Therefore, clients may be transitioned by Medicaid

services, by waiver, *and* by region (as well as other variables). Table 2 below highlights the various ways to transition clients as identified during the meetings. Additional data analysis should be done to support the multi-faceted approach to implementation.

Table 2 – Client Transition Approaches

Client Transition Approach	Potential Approach	Potential Issues
Medicaid Expenditures	– Could address bigger budget line items earlier in the implementation, such as residential rehabilitation and day habilitation. – Approach particular billing challenges on a case-by-case basis. – Participants discussed 15% to 20% reduction in Medicaid expenditures on an annual basis.	– This approach might be the most disruptive for certain clients with costlier services in which transition will be more difficult (such as group home services). – This approach should be further assessed to determine the impact on CCBs and clients.
Waiver (HCBS-SLS, HCBS-CES, HCBS-DD)	– The HCBS-CES waiver has the least number of clients. In addition, the majority of their services may be the least disruptive to clients (they are less likely to have a long-term relationship with case managers and/or service providers. In addition, the children would need to transition by the time they are 18 years old). – The HCBS-SLS waiver does not have residential rehabilitation, which may make transition easier in comparison to the HCBS-DD waiver. – I/DD waivers have certain services that may be more restrictive for transition. Statewide, 44.15% of DIDD waiver reimbursements are to CMA as providers. Waiver clients who have "CMA as	– HCBS-DD waiver could be the most challenging for transitioning clients and would most likely need to occur later in the phased implementation.

Client Transition Approach	Potential Approach	Potential Issues
	provider" are higher for certain services, such as vision, dental, and home modifications.	
Medicaid services	– Certain services will be easier to address in comparison to others (for example, CCBs may bill on behalf of third parties -- certain medical service providers may be able to more easily register for a Medicaid provider ID.) 6,145 I/DD waiver participants receive dental services with CMA as provider. This is a large number of services with CMA as provider in comparison to other services, such as respite -- 1,122 I/DD waiver clients receive this service with "CMA as provider". – Consider addressing services that are less restrictive and also do not have a large number of clients receiving that service.	– More restrictive services will require greater effort to transition clients. For example, reductions in personal care may take longer. Statewide, over 900 clients have the CCB as the provider of personal care. – There are certain services in which there are limited providers, other than the CCB: Vision, Parent Education, Dental, Specialized Medical Equipment, and Adaptive Therapeutic Recreational. – If a client receives services from a wide range of providers, CFCM may be more complex to implement
Regional	– Some CMAs have fewer conflicts in comparison to others. There are some CCBs that the majority of reimbursements for I/DD waiver services are "CMAs as providers" (up to 100%), while others are below (less than 50%). – Certain regions of the state have greater resource capacity. – Explore rural exemption for the 47 rural counties discussed during the meetings. – Some clients should be assessed for exemption on a case-by-base scenario. CCBs	– Rural areas have greater service gaps in comparison to urban areas, such as the Denver metropolitan area.

Client Transition Approach	Potential Approach	Potential Issues
	will have to provide this input.	

More detailed data analysis of the case management and services data should be done to determine the appropriate multi-faceted approach to transition. This data analysis and implementation approach should be reflected in the Plan. Implementation tasks will need to take place early in SFY 2017. The Department should decide on a "hard-stop" date to fully transition to the CFCM model, and any exceptions should be addressed with the Department prior to this date.

2. **Allow CCBs to provide CM and direct services (just not for the same individual)**. Allowing CCBs to provide direct services and case management to clients provides greater sustainability. This was noted as being integral for CFCM implementation from a CCB perspective. Some participants suggested utilizing a third party to support this process, but the third party would need to be entity or individual who has intimate knowledge of the service-delivery model. This third party would assist individuals, their guardians, families, and/or authorized representative with the discussion about the ability to choose CM and direct services from any willing and qualified provider and the inability to maintain both CM and direct services from the same agency. CCBs suggested looking at which counties do not have Program Approved Service Agency (PASA) access right now as a starting place for service gaps and also partnering with advocacy agencies and organization to ask for additional help.

3. **Implement changes for onboarding new clients.** As new clients are on-boarded, CCBs can appropriately separate service provision and case management on the frontend (earlier in the phased implementation). Therefore, this could help ensure adherence to CFCM for new clients going forward. However, it is critical to maintain person-centeredness and client safety during implementation. This may be a greater issue in rural communities with less service options. The Department could establish parameters around CCBs no longer accepting an individual for services if the CCB is providing CM for that individual.

4. **Consider Request for Proposals (RFP) for Case Management Services.** The Department could solicit RFPs with the intent of expanding Case Management. The RFPs could focus on assisting clients in navigating the complex system and assuring all supports are in place. As noted above, the top priority should remain person-centered in serving the diverse needs of clients.

5. **Enlist the assistance of the RCCOs.** CCBs should examine the relationship and resources available through the RCCOs. If a potential gap is identified for a client in which the CCB is needing assistance, a RCCO could help fill that gap related to service coordination. This sharing of resources could create an improved service model for clients. The Department should review how these programs work together and the impact the ACC would have on the implementation of CFCM.

6. **Include No Wrong Door (NWD) in transition plan.** The State is currently implementing a statewide No Wrong Door system and piloting three regional sites. This program should be addressed in the Plan to identify any barriers that may arise during implementation and include action plans to address those barriers.

3.2 Regulatory & Policy Changes

1. **Work with CMS to define Rural Exemption.** The Department should work with CMS to develop and communicate a more definitive definition of Rural Exemption. There are 47 counties in Colorado that are considered rural. According to CCB representatives, there are nine CCBs that serve rural only counties. In addition, two CCBs have offices in urban areas yet have some rural counties in their service area. Rural exemption should be explored for rural communities and can be supported by additional data analysis. The Department and CCBs should work closely with CMS to determine if rural exemption could apply to the rural counties and possibly other communities on a case-by-case basis.

2. **Maintain CCB Designation for CCBs**. Many CCB representatives felt that maintaining CCB designation is a critical consideration for service delivery. CCBs also feel they have the network and connectivity to local communities, which makes them prime to serve clients in the community. Therefore, based on CCB input, the group felt this should be maintained going forward. If CCB designation is to be maintained, additional analysis early in the implementation planning (year one) will be needed in order to better understand if and/or how new entities can receive this designation based on meeting credentials for appropriately serving clients.

3.3 Provider Development/Provider Outreach

1. **Define Case Management Agency (CMA) qualifications early in the planning efforts.** The approach to CMA qualifications and case manager certification (if needed)

will need to be determined early in the planning efforts. Defining solid qualifications will help stakeholders understand the qualified case management resources available as clients are transitioned to CFCM.

2. **Build provider capacity over time.** Provider capacity building will be critical before transitioning clients, especially early in the implementation planning. The Department is working to analyze current provider capacity across the state and all waivers. The Department should regularly consider additional training for providers and case managers. Having appropriately trained providers will help with closing resource gaps. CCBs mentioned they could support training of providers to achieve more and better services.

3. **Ongoing provider outreach will be critical.** The Department should develop an approach or plan to support ongoing provider outreach. This will be a critical task for the system as a whole as the implementation plan is formulated and executed.

4. **Provide greater clarification and outreach regarding billing processes.** Currently, CCBs may bill on behalf of other entities and individuals who are not setup as Medicaid providers (they do not have Medicaid Provider IDs or Medicaid Provider Agreement with the Department). If there are any financial relationships between two entities, this would be considered a conflict of interest for CFCM. The billing process is not clear to CCBs for entities that deliver specialized services, such as cleaning staff or recreation centers. CCBs requested greater clarification and outreach to providers. They also requested some level of reasonableness for the billing policies, such as the ability to bill on behalf of another agency using the other provider's ID.

5. **Provide guidance on roles and responsibilities.** The implementation of CFCM has an impact across multiple stakeholder groups, including clients, families, case management agencies, PASAs, Single Entry Points (SEP), regional centers and others. For example, CCBs provide case management for individuals at two regional centers. The roles and responsibilities for the various impacted stakeholders will require ongoing collaborative input. Additional information is provided below in Communication Priorities, Section 3.4.

6. **Provide transparency of provider network.** The Department and CCBs should conduct an overall review of provider qualifications and share the information to increase the level of transparency of available resources. The transparent information could serve as a resource for clients and allows for more client choice. As the overall

review of a provider network takes place, this opens up an opportunity to expand the provider pool.

3.4 Communication Priorities

1. **Establish communication protocols and communication plan.** The Department should designate point person(s) for communications to each stakeholder group and establish a communication plan, including identification of impacted stakeholders, message delivery, frequency, and forum (website, email, direct contact, etc). While identifying stakeholders, the Department should determine the best ways to engage them in order to assure the content is received. This should also include opportunities for the stakeholder to hold an open dialogue.

2. **Plan strategic messaging for each audience and stakeholders.** Every message should be targeted toward the specific audience and/or stakeholder. 'One size does not fit all' should be applied when it comes to messaging to CFCM stakeholders. The CCBs and the Department should work together on topics in order to keep the messaging consistent. Have a communications point person(s) to maintain alliance amongst the groups working to reach stakeholders. A central point of contact will assist in maintaining specific messages to each audience. The Department and service providers need to be conscious of individuals/clients that do not have family or friends and only have their team who works with them. The messaging needs to be well thought out and delivered in a way that keeps the "person-centered" mission a top priority. Rural areas will need additional attention and tactics to engage individuals and clients. Additional data from rural areas will assist in identifying the best approach to targeting individuals and clients. Additional resources or attention should be made to prioritize clients based on the harder to reach populations. The Department should create an informational and educational component of CFCM for clients. The purpose should be to simplify the message of a complex system, so clients can understand "the why" behind CFCM. If a client understands the system, they are better able to engage in their own care.

   Lastly, as part of the communication plan, a key point should be messaging for legislators, who should understand how the regulation is being implemented and tracked as well as the implication on stakeholders.

3.5 Tracking Mechanisms

1. **Utilize current infrastructure to track CFCM and plan for long-term.** The infrastructure and systems for data collection will develop over-time, but temporary solutions may be warranted (such as Excel spreadsheets) for CCBs to report on implementation efforts. In addition, the Department will be able to validate implementation efforts through the current MMIS. Longer-term solutions include case management systems as part of the new MMIS implementation.
2. **Capitalize on the National Core Indicator (NCI) survey to increase tracking ability.** The Department suggested that additional questions could be included in currently survey processes to aid in tracking and monitoring of CFCM implementation.
3. **Tracking of non-Medicaid providers.** The CCBs identified many providers within their infrastructure who have not enrolled with Medicaid. Many of these non-Medicaid providers are an important resource to the CCBs and clients. The Department should work with the CCBs to identify approaches for billing to continue to allow for some of those services.

3.6 Other Recommendations

1. **Take incremental steps to implementation.** CCBs would like a longer-term approach, such as approved on Ohio's plan (around eight years). The Plan must be solid, reasonable, and include concrete annual benchmarks. Whatever the length of time for implementation is, there should be demonstrable performance in each year.

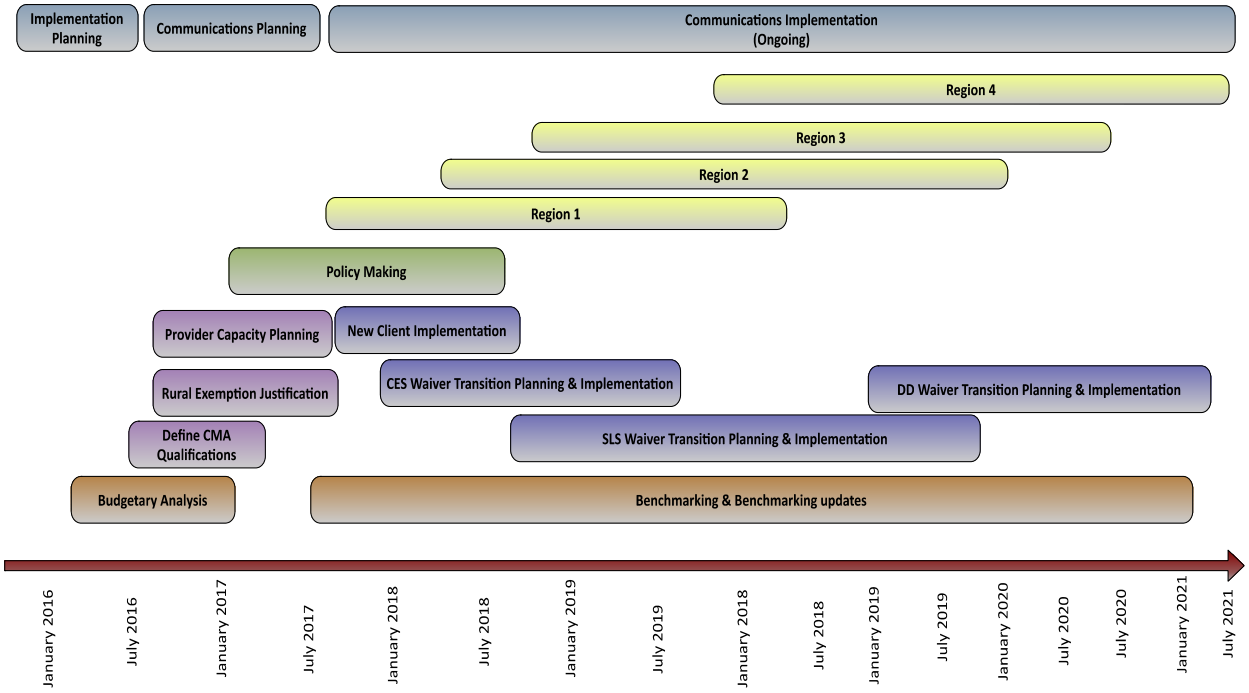
2. **Establish a risk matrix.** A general recommendation we heard from CCB participants is to create a risk matrix for the approach to transitioning clients to CFCM. This will help determine which clients are the lowest risk and which opportunities create the "low hanging fruit." With a phased implementation, participants feel this could be beneficial to transitioning clients while maintaining appropriate service delivery. CCBs noted that the Ohio CFCM Implementation Plan was encouraging as it focused on reducing the number of conflicts over a period of time.

3. **Provide clear direction on the end-result.** The Department should provide clarification on the overall policy direction, requirements for CCBs and other stakeholders, and annual benchmarks. Overall, the Department must develop a State and federally approved Implementation Plan and promote compliance with the regulation. The specific policy and timeline considerations, which should be documented in the Plan, should be specifically communicated to CCBs.

3.7 Phased Implementation

As highlighted above, a phased implementation is critical to success. Some participants suggested that implementation could be done in five to seven years while others suggested the timeline for full implementation should be around seven or eight years. An example of an implementation plan approach with key tasks, including key recommendations above, is shown in figure 1 on the following page. The Department will need to work with stakeholders to define the key tasks for implementation in the next five to seven years.

Figure 1 – Sample Phased Implementation Approach with Key Tasks



As shown in the sample implementation diagram above, a phased approach could be used to implement CFCM. It also shows that tasks and phases could be concurrently completed. However, there are several tasks that will need to take place early in SFY 2017, including budgetary analysis, provider capacity planning, CMA definition, and policy-making. The budgetary analysis will not only inform benchmarking, but also policy making, which is a key area that CCBs eluded to waiting on for direction. In addition, communication planning should be initiated right away so that stakeholders can plan for known impacts of CFCM. As additional information becomes available, having a communication infrastructure will help with ongoing communications with stakeholders.

3.8 Conclusion

One of the key components of the plan is to address the transition through a phased approach. A clear message from the CCBs was the implementation cannot and should not happen too quickly. CCBs should continue to be involved in the implementation process.

An overall objective and top priority throughout the entire implementation is communication. It is recommended the Department and CCBs keep the channels of communication open and continue to collaborate. As part of the communication process, the CCBs can provide crucial feedback from providers, clients, and families to assist in handling any barriers that may arise. The Department should decide upon and communicate milestones to stakeholders. These milestones allow all involved to work towards common goals and discuss any exceptions ahead of time.

Another key component of implementation will be the definition of Rural Exemption. The Department should work closely with CMS to determine the appropriate application of a potential rural exemption.

During the CCB meetings, Public Knowledge identified several barriers to implementation as described in section 2.5 of this report. However, implementation of CFCM cannot be waived. Therefore, the Department will need to continue with planning efforts in order to meet regulatory requirements.

The six meetings provided an opportunity for CCBs to have a voice in planning efforts and ongoing collaboration between the Department and CCBs will support future buy-in. We believe the overall recommendations; transition, policy changes, provider development/outreach, communication and tracking mechanisms, will assist in an efficient and all-inclusive approach to implementation.

CCB meeting participation and summaries are included below for the six facilitated meetings.

CCB Meeting Attendance

First CCB Meeting Attendance:
*Participated Via Phone

- Eastern Colorado Services*
- Blue Peaks Developmental Services*
- Colorado Bluesky Enterprises
- StarPoint
- North Metro Community Services
- Mountain Valley Developmental Services
- Inspiration Field*
- Foothills Gateway*
- Southeastern Developmental Services*
- Horizons Specialized Services*
- Mesa Developmental Services*
- Imagine!
- Rocky Mountain Human Services
- Southern Colorado Developmental Disabilities*
- Community Options, Inc.*
- Envision
- Developmental Disabilities Resource Center
- Developmental Pathways

Second CCB Meeting Attendance:
*Participated Via Phone

- Eastern Colorado Services*
- Blue Peaks Developmental Services*
- Colorado Bluesky Enterprises
- North Metro Community Services
- Mountain Valley Developmental Services
- Inspiration Field*
- Foothills Gateway*
- Imagine!
- Southeastern Developmental Services*
- Horizons Specialized Services*
- Mesa Developmental Services*
- Southern Colorado Developmental Disabilities*
- Community Options, Inc.*
- Envision

- Developmental Disabilities Resource Center

Third CCB Meeting Attendance:
*Participated Via Phone

- Blue Peaks Developmental Services*
- Colorado Bluesky Enterprises
- North Metro Community Services
- Mountain Valley Developmental Services*
- Southeastern Developmental Services*
- Horizons Specialized Services*
- Southern Colorado Developmental Disabilities*
- Community Options, Inc.*
- Community Connections, Inc.*
- Imagine!*
- Envision
- Developmental Disabilities Resource Center
- The Resource Exchange
- Rocky Mountain Human Services
- Developmental Pathways*
- Eastern Colorado Services*
- Inspiration Field*
- Starpoint*
- Eastern Colorado Services*

Fourth CCB Meeting Attendance:
*Participated Via Phone

- Blue Peaks Developmental Services*
- Colorado Bluesky Enterprises
- Mountain Valley Developmental Services*
- Southeastern Developmental Services*
- Horizons Specialized Services*
- Community Options, Inc.*
- Imagine!*
- Envision
- Developmental Disabilities Resource Center*
- The Resource Exchange*
- Inspiration Field*
- Eastern Colorado Services*
- Foothills Gateway*
- Community Connections*
- Starpoint*
- Developmental Pathways

Fifth CCB Meeting Attendance:
*Participated Via Phone

- Blue Peaks Developmental Services*
- Colorado Bluesky Enterprises
- Mountain Valley Developmental Services*
- Southeastern Developmental Services*
- Horizons Specialized Services*
- Community Options, Inc.*
- Imagine!*
- Envision
- Developmental Disabilities Resource Center*
- The Resource Exchange*
- Inspiration Field*
- Eastern Colorado Services*
- Foothills Gateway*
- Community Connections*
- Starpoint*
- Developmental Pathways

Sixth CCB Meeting Attendance:
*Participated Via Phone

- Blue Peaks Developmental Services*
- Colorado Bluesky Enterprises
- Mountain Valley Developmental Services*
- Southeastern Developmental Services*
- Horizons Specialized Services*
- Community Options, Inc.*
- Imagine!*
- Envision
- The Resource Exchange*
- Inspiration Field*
- Eastern Colorado Services*
- Foothills Gateway*
- Community Connections*
- Starpoint*
- Southern Colorado Developmental Disabilities*
- Mesa Developmental Services*

First CCB Meeting Minutes

Conflict Free Case Management Implementation Plan

Community Centered Board Meeting Agenda
Date and Time: Thursday, November 12, 2015; 10:00 – 12:00 PM MT
Location: 303 E. 17th Ave., Denver, CO; 12th Floor, Room 12A
Call-In Number: 1-415-762-9988; 3037850001#; https://zoom.us/j/3037850001
Attendees: * Participated via phone

CCB Attendees	Organization
Rhonda Roth	Eastern Colorado Services*
Pat Rheaume	Blue Peaks Developmental Services*
Louida Allbritton	Colorado Bluesky Enterprises
Bob Arnold	StarPoint
Michael Atlas-Acuna	Colorado Bluesky Enterprises
Randy Brodersen	North Metro Community Services
Bruce Christensen	Mountain Valley Developmental Services
Sharon Church	Inspiration Field*
Sharon Courtney	Foothills Gateway*
Johnnie DeLeon	Inspiration Field*
Dave Harbour	Southeastern Developmental Services*
Brooke Hayden	Blue Peaks Developmental Services*
Amy Ibarra	Horizons Specialized Services*
Sharon Jacksi	Mesa Developmental Services*
Susan Mizen	Horizons Specialized Services*
John Nevins	Imagine!
Sharon Ortiz-Settles	Southeastern Developmental Services*
Kristi Phillips	Colorado Bluesky Enterprises
Shari Repinski	Rocky Mountain Human Services
Duane Roy	Southern Colorado Developmental Disabilities*
Sarah Sharp	Mesa Developmental Services*
Tom Turner	Community Options, Inc.*
Mary Lu Walton	Envision
Beverly Winters	Developmental Disabilities Resource Center
Elaine Wood	Community Options, Inc.*
Melanie Worley	Developmental Pathways
Department Attendees	
Emily Blanford	
Brittani Trujillo	
Mark Wester	
Public Knowledge Attendees	
Angie Anania	
Nicole Wong	

Summary

Topic / Objectives	Notes
Introductions/Background • Why we're here. • Who we are. • What is CFCM? • What we want to achieve out of this meeting and future meetings.	• Meeting to address House Bill 15-1318, which requires the Department of Health Care Policy and Financing (the Department) to collaborate with Community Centered Boards (CCBs) to develop a plan for the delivery of conflict free case management (CFCM). The plan deadline is July 1, 2016 and will include a reasonable timeline to implement the plan. • The series of six meetings will cultivate collaboration of the Department and CCBs to develop the plan with the implementation and transition detail. • The Department and CCBs will look at barriers, concerns, benefits and ultimately solutions to comply with Colorado legislation and federal requirements.
Barriers to CFCM • What have you heard about the transition to CFCM? • What are your worries, fears, or concerns about the transition to CFCM? • What are some of the challenges that may arise when transitioning to CFCM?	**What have you heard about the transition to CFCM?** • There have been rumors and speculation. • What is acceptable to the federal government when it comes to transitioning to CFCM? • Is there flexibility with the federal government? • How urgent is the timeline for the transition? • How will a plan for the transition capture the level of detail, including complexity and necessary to be complete and accurate? • There is disagreement and a lack of clarity about CFCM. • What is the role of the Regional Accountability Entities (RAEs)? • How will No Wrong Door (NWD) come into play for CFCM? • How will federal and local revenue be affected by CFCM? • Is transition time flexible? • Is there a possibility to seek an exemption? • The topic has been out there for a long time, why is there a sense of urgency to move forward? • Is there an ability to provide additional options?

What are your worries, fears, or concerns about the transition to CFCM?

What will it look like if targeted case management (TCM) is separated from administrative activities?
There are rural and financial implications that should be considered.
Individuals and their families may be confused by the transition.
The system could become more complicated with more entities involved and increased complexity.
There should be multiple considerations for implementation:

- Do CCBs remain CCBs? (Do designations change?)
- What about the other tasks CCBs perform? How will those be handled?

Is Mill Levy at risk?
How does rule exemption work?
Too individualized.
CCBs have had long relationships with clients.
Currently doing advocacy case management. How will this work with Single Entry Point (SEP) Agencies?
Will there be unemployment compensation in the event of separation?
Could the 2016 federal elections disrupt CFCM?
Is the case management or services choice a mandate?
CCBs have been able to keep their caseloads low. Can SEPs do this?
Will providers gravitate towards higher dollar services?
Is the solution a one-size-fits-all?
How will a solution be administered?
The timeline for implementation is concerning.
How will CCBs make the choice for case management or services?
There must be consideration for employees of the CCBs.
Families and individuals affected should be considered.
What will be the role of regional centers? Some of the CCBs are providing services at regional centers, currently.
Will the CCBs be able to train providers to achieve more, better services?
Will there be a disruption of services?
Who will work with Social Services on foster care

transition?
What will be the effect on the quality of case management that results from separating from the current system?

What are some of the challenges that may arise when transitioning to CFCM?

System is currently underfunded.
Major cost considerations/decisions that must be made:

- Early intervention
- Family support services
- Other services and functions
- State SLS is always underfunded (not part of Navigant study).

Training will have to occur:

- Initially
- On an ongoing basis
- For technical components

What are the costs of separating case management and services?

- For example: Legal counsel

How will functions be paid for in the future?
How can a plan be developed when there are many unknowns?
How will common messaging be produced? What is the common messaging?
How will the State backfill services, including infrastructure?
The complexity of the issue includes waiver redesign.
How can CCBs continue to provide appropriate services while the changes are occurring?
Staff retention is a challenge, especially in case management.
Customer satisfaction will be a challenge.
Loss of employment is a consideration.
Where will planning functions fall under for services?
If planning goes to another organization, will it be a priority? Where will the funding come from?
How will CCBs divest themselves of infrastructure in order to continue services?

- This will be a big disruption to staff and families.

How will the CCBs handle human resources logistics if they cannot provide services and case management? Will they share staff and have them travel? This is a big concern in rural areas. For example, pay structures are very different.

	There are multiple layers of complexity, how will they structurally change? • Statutes • Waiver redesign • Own organizations
Benefits of CFCM • How will clients benefit from CFCM? What about other stakeholders, including Providers, Case managers, and the Department? • How will service provision improve from CFCM? • What are some problems with the current process? • How will service quality improve from CFCM?	**How will clients benefit from CFCM? What about other stakeholders, including providers, case managers, and the State?** • There is a finite pool of money. Rates may need to be adjusted to support case management. • CFCM doesn't have to happen. o A dispute process should be in place. o Are we moving decision making from one organization to another? o Conflict isn't inherent and won't disappear because of another structure in place. • There is an opportunity for the RCCOs to get involved in case management. o Are there concerns with the RCCO medical model? o Who will perform the case management function? • The playing field will be more level for non-CCBs. • Money for case managers may be better. • Streamline operations and functions. o Is the State the stakeholder who will benefit from this streamlining? • Challenges: o Rural HCBS SLS Support Level 1 – Where will providers be found? • Other entities may be confused. • If more money goes into supporting case management it could potentially help the CCBs. • Provider agencies will be more competitive. This is not necessarily a bonus to the system, but it could be a bonus to providers. • **How will service provision improve from CFCM?** o More integration, coordination ▪ Simplification of the system ▪ Fewer systems to navigate ▪ How can we tap into this benefit? o Would separation improve services? ▪ Need additional funding to provide support. This is especially true in rural areas. o Is there any correlation between CFCM

	and service quality? o Case management could be increasingly professionalized, if more money is available. o CFCM offers choice to clients. o There will be no more contract deliverables if the contracts end. o CFCM will provide a one-stop-shop to clients. o Choice is a benefit of CFCM. o CFCM allows providers to enter services that are underserved. o CFCM supports families that are currently dissatisfied, including provision of customized services. o Offer an option to customize services. o Data systems could be coordinated and can talk to each other.
The Transition • What is needed to remove some of the barriers listed? • How can this effort be best communicated to the right stakeholders? Who are the right stakeholders?	• **What is needed to remove some of the barriers listed?** o A plan will be important for removing barriers. It should be/include: ▪ Timeline ▪ Transparent ▪ Public awareness ▪ Training ▪ Funding mechanism o Thinking about unintended consequences of the transition is necessary. o Is there a long timeline for the plan? ▪ Is there time to sort out the plan in detail? o Policy decisions must be made. ▪ Will CCBs stay the same? o The rule must be discussed. ▪ Who makes the final call? • CMS? • State? • Group? ▪ How much flexibility is there? ▪ Is there any kind of clarification on the rule? o How will local funds be protected (Example, Mill Levy) o Want to understand whether there are predetermined outcomes in mind.

- Additional funding is necessary.
- Statutory changes are needed.
- Need to discuss what change looks like (Change management).
- Need to confirm that entities can continue to do service provision and case management, as long as it is not for the same person.
- Would like to have a discussion about what is and what is not negotiable.
- Is a rural exemption possible?
- Need to have an open discussion and promote transparency.
- What is the vision at the end of the process? Is it open-ended?

- **How can this effort be best communicated to the right stakeholders? Who are the right stakeholders?**
  - The uncertainty right now should not be communicated.
  - The group would like to see the boundaries/limitations of CFCM and the policies in writing.
  - The Department should communicate what it is willing to share/collaborate on.
  - Is the Department willing to discuss rural exemption?
  - Will CCBs be given the opportunity to be case management entities?
  - Questions should be answered first before any communications with stakeholders.
  - Stakeholders include:
    - Families
    - Clients
    - Guardians
    - Policymakers
    - Local entities
    - Counties
    - Providers
    - Employees
    - Advocacy groups
  - A plan should be in place before communicating with stakeholders.
  - The process should be described to

	stakeholders via: ▪ Social media ▪ Website ▪ Q&A forums on sites/forum ▪ Blogspot o Transparency is important. o Need to clarify the intentions of the transition for stakeholders. o Various stakeholder groups should be at the table: ▪ Providers ▪ Advocacy groups ▪ Families/clients ▪ Allow each stakeholder group to discuss in their respective groups and then invite them to join in a larger group discussion. o The Department should take responsibility for the communication effort. o Providers, advocacy groups, and clients should be given time to walk through the same process that the CCBs are going through today.
Wrap Up, Next Steps, and Action Items • Action item review • Next meeting	• Public Knowledge will create a Doodle poll to determine the next two meeting dates. o Tentatively planning to have the 2nd meeting on 12/1 or 12/2: 10-12 or 1-3 o Tentatively planning to have the 3rd meeting on 12/16 or 12/17: 10-12 or 1-3 • There were no action items other than the creation of the Doodle poll.

Second CCB Meeting Minutes

Conflict Free Case Management Implementation Project

Community Centered Board Meeting Summary
Date and Time: Tuesday, December 1, 2015; 1:00 – 3:00 PM MT
Location: 303 E. 17th Ave., Denver, CO; 11th Floor, Room 11B
Call-In Number: 1-415-762-9988;3037850001#; https://zoom.us/j/3037850001
Attendees: * Participated via phone

CCB Attendees	Organization
Rhonda Roth	Eastern Colorado Services*
Pat Rheaume	Blue Peaks Developmental Services*
Louida Allbritton	Colorado Bluesky Enterprises
Michael Atlas-Acuna	Colorado Bluesky Enterprises
Randy Brodersen	North Metro Community Services
Bruce Christensen	Mountain Valley Developmental Services
Sharon Church	Inspiration Field*
Sharon Courtney	Foothills Gateway*
Mark Emery	Imagine!
Dave Harbour	Southeastern Developmental Services*
Brooke Hayden	Blue Peaks Developmental Services*
Anita Kinsey	Blue Peaks Developmental Services*
Amy Ibarra	Horizons Specialized Services*
Sharon Jacksi	Mesa Developmental Services*
Susan Mizen	Horizons Specialized Services*
Rebecca Novinger	Imagine! *
Marsi Mason	Southern Colorado Developmental Disabilities*
Jeremy Topping	Southern Colorado Developmental Disabilities*
Duane Roy	Southern Colorado Developmental Disabilities*
Tom Turner	Community Options, Inc.*
Mary Lu Walton	Envision
Beverly Winters	Developmental Disabilities Resource Center
Department Attendees	
Emily Blanford	
Brittani Trujillo	
Public Knowledge Attendees	
Angie Anania	
Nicole McNeal	

Meeting Summary

Topic / Objectives	Notes

CFCM • Revisit definition of CFCM • Where is there flexibility with how this will be implement? • What do the Department and the CCB's not have control over?	Some of the CCB participants are concerned about whether or not they can provide both service provision and case management for different individuals. They are requesting clarification from the State if they can provide both for different clients. For the Children's Waiver, they cannot provide both direct service provision and case management. This is critical for the CCB representatives. Brittani Trujillo needs to find out some additional information on the ability to do case management and provide direct services. Also, need to determine if CCB designation is still instrumental. This clarification will need to come from management of the Department. Will CCBs be allowed to be the Case Management Agency? As we move forward with case management, are CCBs called the same? Also, looking at the definition of Case Management Agency. One issue is the array of services. Will CCB being the CM Agency, given the choice, will they divest of their services? The CCBs asked about what are some of the key points that the Department wants to see for this. Brittani mentioned that the outcome is to come in compliance with federal regulation. The Department needs to develop a plan by July 1, 2016 with input from CCBs. What can we do to come up with some concrete items to mitigate issues? One suggestion is RFP out case management services. Using other CCBs to provide case management. CCB designation is needed to continue the local dollars flowing and the relationships. Could use RCOs for local communities. The desired outcome should be to end up with a better service model. **Rural Exemption:** Have there been any conversations about rural exemption? What would it look like? The Department has given thought to rural exemption, but need further insight on how this could apply. They would need additional data on service provision

by CCBs.

DDID should be able to show what services are rendered where? But a lot of the service providers bill through the CCBs. It's not clear where there could be a lack of rural exemption.

How many CCBs have more than one provider? The Department has authorized agencies to provide their services in the state of Colorado. They have been designated and can expand.

Eastern Colorado – some of them don't have the services/providers.

Explore ways to gather data for rural exemption. Could this be done on a case-by-case basis?

Get more information from Ohio in terms of their benchmarks.

Need clarifications on definition of provider and agency. Where is the line drawn? CCBs aren't the agency of anyone. Clarification needs to come from Department.

Brittani – may need to go back and see if they have clarification on the definitions.

What's the Department or view on some of questions/concerns? What has the discussion been? What level of staff are involved in the discussion? Department staff, including upper management have been involved in these discussions.

Everyone is onboard with having CCB input to implement CFCM. This is why we are here. Is there an intent to keep us as CCB? Feels like this is construed as a demise of CCBs.

How does the Accountable Care Collaborative fit in? ACC seems to be taking on more of the BHO work. This piece is separate than the CFCM -- this is more about case management and the direct service provision.

The function of the RAES is different than the separation of services and case management.

Some stated they have heard the RAES can provide case

	management. They may help to decide who provides case management. It would be helpful to have more information on this. Is the intent for the ACC and this discussion to come together? We don't know the answer yet.
Ohio Plan • How does it work? • What are some of the benefits? • What are some of the barriers?	For the past 7 years, Ohio has been trying to come into compliance for this model. They have county boards for I/DD. They serve as the single point for CM. They have received services from county boards. Ohio has reported that they don't have enough providers. The boards reduced services from 92% to 52%. They have also expanded the private provider pool. Plan – Adding facility services to newly designed services by 2024. They are redesigning adult day services. Adult day services model – county board will be to help to navigate the employment services and other community organizations. This employment navigation is part of case management. CMS – working with CMS on a compliance plan. Part of this plan is to have no more than 30% of service provision to clients that are also receiving case management by March 2020. The boards must ensure administrative lines exist between those providing services and those who provide case management. Colorado might already be closer to this 30% benchmark. Colorado may also be closer to meeting the employment goals already. It's implied the county is the provider of last resort. Ohio added some services. They redesigned their services – wondering why this was done? The CCBs were curious as to why this was done to support this model. When they are talking about choices, providers are available for home services or services where the reimbursement rate is adequate. When the CCB role becomes important is in those areas where the reimbursement rate doesn't support the service delivery cost.

	Longer timeline is desirable, similar to Ohio. Provider Search – Participants would like to see the list of functions being done in Targeted Case Management that could be make the problem smaller. The more things than you can take out that is left that can't be mitigated. A plan can be done online What does our data say? Split out the percentage of those with multiple providers vs. single provider available. The Department thinks this is a good idea. Some of the data could be skewed – need to look at frequency of provider billing. Ohio put some stop gaps. They aren't adding people. Part of the plan is to look at some of these stop gaps. As part of the plan is that people have to make a decision. You have x amount of time to make this decision. This can get them used to the idea.
The Transition • What are the change management considerations? • How do we transition people? • Other elements of transition?	Other transition questions that came up: • Can we be service providers? • Do we transition case management? • How do you transition individuals to another CM? • Do you want to transition services or CM? They focused on service provider transitions. Change management considerations: • Many like the idea of implementing changes incrementally. • There needs to be that sensitivity to individuals that currently have CM. • There is no grandfathering in. • Can't have the Department provide case management. • One of the things we struggle with is giving people choice. Sometimes we take that to the extreme. • Do we start statewide or start by region?

- For people that are not satisfied, there are options, such as another CCB for large communities.
- While we move towards some benchmarks, need to provide choice. How do you confirm you have happy customers?
- We need to be careful that we aren't putting distance between the person they are supporting and the CM.
- Definition of face to face could change over time.
- There are creative ways to get around some of these barriers.

Something in the plan – change the regulations to open it up. Regulations don't allow for flexibility with CCB. For those people that aren't happy,

If we are gathering data, we should see if we can get the data by county and by CCB.

Third CCB Meeting Minutes

Conflict Free Case Management Implementation Project

Community Centered Board Meeting Summary
Date and Time: Thursday, January 28, 2015; 10:00 – 12:00 PM MT
Location: 303 E. 17th Ave., Denver, CO; 7th Floor, Room 7B
Call-In Number: 1-415-762-9988;3037850001#; https://zoom.us/j/3037850001
Attendees: * Participated via phone

CCB Attendees	Organization
Pat Rheaume	Blue Peaks Developmental Services*
Louida Allbritton	Colorado Bluesky Enterprises
Michael Atlas-Acuna	Colorado Bluesky Enterprises
Randy Brodersen	North Metro Community Services
Bruce Christensen	Mountain Valley Developmental Services*
Dave Harbour	Southeastern Developmental Services*
Brooke Hayden	Blue Peaks Developmental Services*
Susan Mizen	Horizons Specialized Services*
Duane Roy	Southern Colorado Developmental Disabilities*
Jo Ann Card Beam	Southern Colorado Developmental Disabilities*
Tom Turner	Community Options, Inc.*
Elaine Wood	Community Options, Inc.*
Steve Dahlman	Community Options, Inc.*
Julie Dreyfuss	Community Connections, Inc.*
Leslie Rothman	Imagine!*
Mary Lu Walton	Envision
Beverly Winters	Developmental Disabilities Resource Center
Laura Thomas	The Resource Exchange
Shari Repinski	Rocky Mountain Human Services
Karen F.	Developmental Pathways*
Melissa Dassaro	Eastern Colorado Services*
Johnnie Deleon	Inspiration Field*
Bryana Marsicano	Starpoint*
Tara Foristol	North Metro Community Services*
Rhonda Roth	Eastern Colorado Services*
Department Attendees	
Emily Blanford	
Brittani Trujillo	
Public Knowledge Attendees	
Angie Anania	
Jennifer Kraft	

Meeting Summary

Topic / Objectives	Notes
Introductions & Meeting Purpose • Purpose and Desired Outcomes • Review minutes of last meeting	Public Knowledge provided a recap of what was discussed in the first 2 meetings. The purpose of this meeting is to discuss the transition. Some folks didn't receive the minutes from the last meeting so they will be redistributed.
Case Management & Direct Services • Ability to provide both Case Management & Direct Services • CCB Designation	Agencies are able to provide case management and direct services, however, not to the same person. The Department supports this and is allowed by CMS. The Department requested that Community Centered Boards provide data on the number of people they provide case management to as well as direct services. This information will assist in determining how many individuals will actually be impacted during this transition. Want those that will be impacted to have choice. Need to have the conversation to determine how they will be afforded this choice, what that looks like, and how this will happen. What happens when a client wants the services and also case management? Need to let them know they can't have both and what their other options will be. Needs to go into the plan as consistent messaging and talking points for CCBs. What if a client wants to keep current CMA and there isn't another provider? This would potentially fall into the rural exemption. Need to demonstrate that there isn't another qualified provider. The Rule doesn't necessarily say Rural – might be more of a capacity exemption vs. just being rural or geographic. If the person chooses to retain service where they are and they want a different CMA, then some individuals receive CM long distance, which can be difficult to have long distance due to the huge travel distance (hard to schedule and have face-to-face meetings). Limitation placed on case mgmt. units and can eat up a CM plan in a hurry. The Navigant survey had information about distance and looks at restructuring case management including funding. One thing to consider is lifting the CAP in terms of funding. As an outcome, would like to see some level of 'in the community' case management so people don't have to travel for case management services - to show commitment to the local community concept.

Services vs. case management needs to be addressed. It is creating conflict by making an individual choose if they want to keep both with the same agency have a choice. Can an individual sign a waiver and say this is their choice? Others have asked a similar type of question and messaging (factual language) will be included in the plan to address this.

Can this option be put into the plan and let CMS tell the Department "no"? Brittani stated the Department may be hesitant about this as the plan submitted to CMS should be solid. If this is added the group needs to have a backup plan included.

To summarize: It appears that CMS is saying there are 2 roads: complete separation or keep entities intact and offer one choice or the other. Need to be clear about the options. *IF* those are the only 2 choices, then need to determine which has the most room for navigation and success.

What does that information and referral function look like? Where does No Wrong Door fit into this? Once No Wrong Door is up and running (currently in pilot but 3 years out), it will help out the process. Need to have the conversation with the individuals that are currently in the system. Transition will be key.

In the interim, might need to develop additional case management providers – what constitutes qualified case management entity? Emily will need to bring back internally to the Department.

The next 3 meetings need to be about plan development and data that should be gathered now. RFP data would be helpful and useful. Questions to be answered:

- What are the statewide benchmarks?
- How many people are affected?
- What systems need to be put in place to assure that an agency is not providing both CM and direct services? Need to set up some sort of system for accountability.
- Data from RFP process-providers that state they serve an area but don't respond to an RFP, number of providers serving an area, etc.
- Where are clients active?
- Provider capacity – where are they active?

It was requested to have a framework on what the Department is specifically looking for in terms of data. Brittani will send this information to the group over the next couple of days.

Question: In the HCBS-SLS waiver, an individual might have 10 services and 10 different providers in the plan but might only be getting minimal services from the provider and everything else is external. Believe it counts but need to figure out what this problem looks like. % would help to give an idea what the problem is, when creating the plan and how it can be addressed.

Host homes and family care coordinators are (independent contractors) subject to the separation - the money is going to the CCB unless you are working strictly as a billing agent.

Confusion about what billing agent vs. OHCDS means – HCPF can provide some clarification. Recommendation to send clarification sooner rather than later. Emily will do this.

What happens to eligibility? Not sure of the interim step until No Wong Door is implemented. Will want to include phases in the plan.

In this process, there will not be grandfathering. Need to have the final date as to when you can't do both. There is a financial impact to the TCM dollars. Hope this will be considered in the plan. The goal is to capture this information and challenges through the Navigant survey. We know this has an impact on employees/employers. Need the data so we can mitigate this as much as possible. If layoffs need to occur, there will still be a need case management possibly with other entities.

How will systems be put in place:

- Compliance with regulations
- Monitoring of clients
- Could be some flags and penalties – the new MMIS system could do this but would need to define some requirements.

CCB Designation:

- What about CCB designation? It can change as part of the plan or might not need to be in place right now.
- How is the CCB being impacted if they aren't

	providing services anymore? If remain a CCB with the ability to provide to the same person, not sure where this would change. • How is the Department addressing not doing services to both as part of the designation? CCBs would not like to lose the designation • More concerned about the broader role. • The group will think about this some more for the next meeting.
Rural Exemption • Rural Exemption clarification o Data Gathered o Additional Data Needs • Opportunities for Client Choice	For us to present this to CMS (they have to approve this), a solid 'outline' needs to be included in the plan. How do we show/prove that there isn't another willing/qualified provider to provide services and CM services? Is it both? Yes, but Brittani will provide clarification. Changes conversation with providers. Use the language that provider capacity is needed - more providers aren't necessarily needed, but need to build them to meet rural needs. Might not be because adequate funding is not available for individuals with a Support Level 1 or 2. Need clarification from CMS on what 'No Available Provider' really means – is it literally no one is located in that area or that the provider won't accept those clients. Brittani will look into. Other Data: • How many case management agencies do we have serving certain areas? • How many CMAs are out there that are not just CCBs? • Are SEPs a consideration for being one of the CMAs? Brittani believes so but will follow up. SEPs don't provide the same kind of case management services. Could put it in the plan to develop this. • What constitutes qualified CMA? • Housing – can we house with local SEPs? Like the idea of cross training. Opportunity to expand case management to other waivers to EBD, CMHS, etc. • Is there something within the Emergency Enrollment request process that can be duplicated? Could be a foundation to help with rural exemption and choice. In order to get the exemption, CMS states that there is no other qualified CMA available. "Qualified" needs to be defined. Need to have 'presence' in community in order to provide services. Looking at the plan as phased over a # of years. The implementation plan is due July 1st but doesn't need to be

	implemented by July 1st. The plan will layout over *x* amount of time phases that will lead to CFCM. Need to be strategic and thoughtful about how the changes will be made.
State Research and CMS Update • State Research o Ohio Benchmarks o North Dakota Approach/Plan • CMS o Guidance	Last meeting, we discussed Ohio and the need to get information from other States. Part of Navigant's contract is to get info from other states and should have it be the end of the week. Brittani attended a webinar with CMS and they confirmed that both services can be provided but must not to the same individual. Ohio established some safeguards (see the attached for the additional research information from Ohio). Some highlights from the discussion: • Why was Ohio reviewed as a model? They got approved and got an extension to 2024. The group is worried that they are pretty dissimilar to CO. Still good to review the benchmarks and what they have done. • They had to have benchmarks documented by Sept 1 2015. • They can't add anyone new for services at the county boards but then have benchmarks to get the older clients transitioned. • CO can establish benchmarks for new and older individuals • Group felt that CO is further along than Ohio. • It's all about packaging – need to let CMS know what CO has already done. 9 years might not be approvable. CMS has also stated about how different Ohio is. WY did their transition in a year. Colorado will fall into the 1-9-year range. Brittani reviewed the North Dakota information (see the attached for the additional research information from North Dakota). Some highlights from the discussion: • Access issues need to be looked at as part of the exemption. • More focused on if there wasn't another direct service provider vs. CMA. Dept. can look into how their case management is set up and also ask CMS for clarification. • 37 out of 53 counties in ND got the exemption. Some

	states have been designated as rural under Medicare rules. Both states have stated that they are leaving case management intact and just broadening the provider pool. Colorado should look into this as an option.
Provider Services & Data	Need to make quick progress on getting the data. The Dept. requested to provide any data that is already available. Just want to get an idea of what CCBs have and what is available. How many people are receiving both from a CCB? Would like to later on get into more details. Data should be for the 3 HCBS waivers (CES, SLS and DD) overseen by the Division. Are CCBs tracking RFP data – also a rough estimate and good starting point. How many provider agencies are CCBs billing for, using their provider ID vs the provider's provider ID.? Questions will be sent out via email for reference. Hope to have data by the next meeting on February 11.
What's Next • Implementation Planning, including changes to policies and regulations • Town Hall Meetings	Need to start talking about how are we going to implement CFCM. The data will help us determine how large the problem is in Colorado and will help to establish benchmarks. Town Hall meetings: • Discussed need to get input from other stakeholders in the process (families, guardians, etc.). • 4-5 town hall meetings have been scheduled across the state to meet with the non-CCB providers and then meeting with individuals in services, including parents, guardians, and advocates. Need to get their input to include into the plan as well. • Will take place in February and early March. • Regional town hall meetings will be held in the latter part of spring. • The rough plan will be reviewed at that point to gather some initial feedback. • SEP meetings will also be scheduled, but don't have the official dates yet. • The communication brief about the Town Hall meetings will be coming out in the next couple of weeks. Locations will be included in the brief. • Need help from this group to get attendance from individuals and families to the regional town hall

	meetings. Note: If there is a lot of interest in a location that is not scheduled, the Department can schedule additional meetings.
Wrap Up, Next Steps, and Action Items • Action item review • Next meeting	Next meetings will be on: • Thursday, February 11th 10-12 PM • Tuesday, Feb 23rd, 10-12 PM • Thursday, March 3rd, 10-12 PM Will try to get the same location (7B) Brittani will send out research results from OH and ND with the meeting minutes from this and the prior meeting. Let's get ready for the next meeting to develop the plan!

Fourth CCB Meeting Minutes

Conflict Free Case Management Implementation Project

Community Centered Board Meeting Summary
Date and Time: Thursday, February 11, 2016; 10:00 – 12:00 PM MT
Location: 303 E. 17th Ave., Denver, CO; 12th Floor, 12C
Call-In Number: 1-415-762-9988;3037850008# - https://zoom.us/j/3037850008
Attendees: * Participated via phone

CCB Attendees	Organization
Pat Rheaume	Blue Peaks Developmental Services*
Brooke Hayden	Blue Peaks Developmental Services*
Louida Allbritton	Colorado Bluesky Enterprises
Michael Atlas-Acuna	Colorado Bluesky Enterprises
Randy Brodersen	North Metro Community Services
Bruce Christensen	Mountain Valley Developmental Services*
Sara Simms	Mountain Valley Developmental Services*
Brenda Scrimsher	Mountain Valley Developmental Services*
Dave Harbour	Southeastern Developmental Services*
Sara Settles	Southeastern Developmental Services*
Susan Mizen	Horizons Specialized Services*
Tom Turner	Community Options, Inc.*
Steve Dahlman	Community Options, Inc.*
Leslie Rothman	Imagine!*
Mary Lu Walton	Envision
Beverly Winters	Developmental Disabilities Resource

	Center*
Laura Thomas	The Resource Exchange
Shari Repinski	Rocky Mountain Human Services
Johnnie Deleon	Inspiration Field*
Sharon Church	Inspiration Field*
Rhonda Roth	Eastern Colorado Services*
Diana Foland	Foothills Gateway*
Erin Loufeld	Foothills Gateway*
Sharon Jacksi	Mesa Developmental Services*
David Ervin	The Resource Exchange*
Amy Ibarra	Horizons Specialized Services*
Department Attendees	
Emily Blanford	
Brittani Trujillo	
Public Knowledge Attendees	
Angie Anania	
Nicole McNeal	

Meeting Summary

Topic / Objectives	Notes
Introductions & Meeting Purpose • Purpose and Desired Outcomes • Review minutes of last meeting	Purpose: Thinking about transition planning and what that implementation will look like. We need more detail into considerations for implementation. We need CCB input into transition plan development. We'll talk about how do we afford client choice? Dept. will provide info on billing, etc. Then we will discuss data, to help define those benchmarks going forward. Also, we'll discuss how you define qualified case management agency and CCB designation.
Transition Plan Development • How do we afford client choice to transitioning? o Department clarification on waiver of choice • What systems must be in place for tracking CFCM (service delivery and clients)? o Accountability o Compliance o Monitoring of clients.	**Agenda item: How do we afford client choice?** This is an open ended question to get input from the group. Individual receives services through CMA. The group thought that Third Party involvement would be a good idea. Our system isn't set up very well for it, but would be nice if a third party could do it. What would it look like? Can we help each other? Geographically, does it make sense? We don't want a third party who doesn't know our system. We would need a third party who understands the dynamics.

• Department overview of billing process • Expanding case management to other areas (for example, housing with SEPs) • Information on Wyoming's Plan	Some clients will need more time. What is the timeline? Some clients may not have anyone. What do we include in our plan for this? Do we partner with advocacy agencies/organizations to ask for help in this piece of this process? Expand local presence. Information Component: Not sure our customers are starting from a place of clarity. If you ask, "Who's your CM?" they're going to talk about their residential person. We have to do some prep work on the front end. Most clients don't understand situation and complexity of it. Many don't even know what's going on. Add an educational component to the plan with talking points and messaging. Also need timelines established of when we're offering enrollments. Communication: How well will they understand the choices in front of them? Put it in way that's fundamentally simple. It's important to understand the audience. Think of people who really have no one – just their team that works with them. For those individuals, how will we do this transition? Team helps them make decisions so how does that work? Have clients at lower end of functioning level without guardians. How do we help those clients? It's difficult to have Social Services become involved. To have people come out in rural areas will take a lot of time. With rural areas there will have to be alternative ways to engage the clients. In Rural areas – what does the conversation look like? We can sit down with each person and family and discuss options (or lack of options.) Narrow the issue down to how many people are we talking about? We need to go through the data. Mike – in our case having 143 conversations. The data will help determine what those conversations look like and how to approach them.

Some conversations will be easier than others. Add to the plan some sort of timeline prioritizing clients and level of difficulty.
Can you approach by waiver or by service?

Will encounter difficulty because of capacity issue. Having some of the data will help us understand where the gaps are. We have to look at capacity outside of Case management. With all the SLS enrollment our service providers will say they are at capacity. Need data on the service provider side too.

May not have other choices, need to build capacity.
The Accountable Care Collaborative – reads within 2 years' time, CMA's will be available - without regard to what waiver happens to be their home spot.

How do you manage case management entity or case manager working out of trunk of his or her car?

Last time we talked about looking at affording client choice in services and case management agencies. Opens up case management, whether it's Single Entry Points – this helps when someone is making those choices in provider capacity.

Confirms we are expanding the horizon of qualified providers – also greater number of case managers available – important as we address CFCM within the narrow lane of individuals with intellectual or developmental disabilities (I/DD).

Framing this in a way to educate families that CFCM resides in many systems not just in the I/DD.

CCBs have taken on responsibility of developing an array of services, which may lose money. Who is going to be a provider of those services that nobody makes money on if CCBs, as a provider are no longer willing to do that?

Agenda item: What systems must be in place for tracking CFCM (service delivery and clients)?

- **Accountability**
- **Compliance**
- **Monitoring**

No wrong door pilot project – lack of any kind of systems

built into that. How they plan to communicate with each other. In the process of evaluating with NWD pilot – have to arise from those. Wishful thinking that this kind of coordination can happen. Holes will still have to be filled.

We should be able to tie this into the new system we're going to get.

Dept. – having a new case management system built to replace BUS, CCMS – hope it will allow more capabilities to monitor, for accountability, tracking, pull reports, etc.

Funding Available - As 2009 as part of HITECH Act – creating of Electronic Health Records (EHR) – because we have expanded to include long term care services – a fraction has been expended. If we really want to build a new system, - is there a way to work collaboratively – pull down some of that funding to build a new system?

Incentive payments are available for meaningful use of EHRs, but grant funds are going away.

The State is investing in integrated systems infrastructure with the MMIS, PHR, etc., but this is a longer-term consideration. Case Management system will be a component of that.

CORHIO has options for implementing Long-term care services.

Tim Cortez overseeing all that work – Dept. is working together and coordinating as much as possible. This ties in to the bigger vision. Should make sure this model has a seat at the table for systems/infrastructure needs.

This is all very much in the future. CFCM can't wait until that's in place. Excel Spreadsheets may be a temporary fix.

How do we track and monitor – and are they really afforded that choice?

Even just the issue of being able to prove, that a client has made a specific choice is tough to document. We get into conflict as to what is the client's actual choice? "How do we represent this?"

Component of new people coming into the system – we can't

forget that.

We don't want to grow our # - that's more people we have to transition. How do we close the gate now and start a new process with those individuals? Have to think about this in plan – at what point do we say, "no more new individuals?"

(Ties into what constitutes qualified CMA.)

RAEs would be brokers of case management. They would monitor case management.

Has to be contextualized where the broader system is headed.
Don't want to have to introduce a whole new system in 18-20 months.

We didn't answer the original questions yet on monitoring and accountability. There is a bigger system being developed. We want to come back to those as we continue to build the plan. Can put some of those elements into the new data system.
For monitoring have to look at some of the other systems we already have. When they're doing National Core Indicator or NCI, surveys, etc. can they ask these questions with individuals?
Good point to make in the plan. Dept. can add on own questions – could help in monitoring.

Agenda item: Department overview of billing process

Don't have the data today – will present in CFO meeting next week. The Department will send out all materials as soon as they're ready.

Clarify difference between acting as an OHCS versus a billing agent and how does that impact this conversation.

Agenda item: Expanding case management to other areas (for example, house with SEPs)

Looking at different options is great idea. Concern is having that local presence. Can have local presence without having your physical office building right there.

Gives CCB's opportunities to expand and serve larger areas.

Local includes knowledge of the community –
Person would live in that area, but employed elsewhere.
Then figure out how to monitor that employee.

Local governance is important. There's no assurance of local accountability – if there's not local governance.

Agenda Item: Brittani reads through Wyoming's plan

In 2013 – transition to CFCM – phased in May 2014 – June 2015 – (they have less people in the state)

*Please see attached document in email from Brittani.

Big deal to lose insurance for case managers. This could be a deal breaker for those in the field for a long time.

However, CCB's could be an obligation to insure some of those people even though they no longer work for CCB.

Any input for state in terms for what it's like to be working with 120 case management agencies? Brittani will follow-up from Wyoming on this.

Expansion and the number of case managers – worry about – simply by adding more CMA's to field, we've not done anything to increase choice. Adding more doesn't = addressing the need for choice for our clients.

While Wyoming plan is very different, it generates conversations within this group – we can learn what we don't want to do. We want use the benchmarks as a starting place.

Lessons learned from Wyoming would be helpful.

Our CO legislators are involved with the requirements of the preliminary plan – we need to ensure they are as involved as possible.

We have to fill the bridge – connecting those dots with the legislatures. We do have significant work to do there.

Need to include messaging for legislators as well as part of the communication plan.

Communication matrix – audience, timeline, fact sheets – Nicole has examples from Wyoming she can share with

	Brittani.
Data Discussion, including Data for Rural Exemption • CCB Data, including: • Number of clients affected – number and percent of individuals receiving case management • Clients receiving one HCBS waiver service • Provider Capacity – where are clients active? • How many case management agencies do we have serving certain areas (helps to understand rural exemption)? • Data on CMAs from Department	Do we have any data? Brittani has been receiving data from various CCB's. Glance – some agencies that 100% they're providing CM also receiving direct services. The Department will compile the data and Brittani will send the data out before the next meeting. Sherry – some Data is not necessarily by individual, It's by service. Person could be making several choices. CCBs need to send their data to Brittani so she can compile before next meeting. Another way to collect data - thinking about it as a money pass through. If ultimate goal is that money doesn't go through CCB, what are we going to do with those services? Is State SLS intertwined in there? We might have to look at these two areas. Next meeting we'll have more detailed discussion on the data.
Case Management Agency • What constitutes a qualified CMA to provide these services?	We need CCB input on this. What qualifications are there? This is difficult because rules are so different for case management, without looking at regulation structure. Think about it in terms of targeted case management. CCBs try to keep low caseloads -- SEP's don't necessarily have lower caseloads. Don't want to see – massive swings in scope of work between CCB and SEP. If you compare menu of services, we provide within CCB's it will be different as well (value proposition). This is difficult to answer now because the landscape changes so frequently. What are the Clinical pieces that we can break out? What are the Customer service pieces that we do? This

includes local community knowledge.

Why do we need to have local governance?

Local Governance. There wasn't complete agreement on local governance. Florida was using a "working out of car" type of model – CO is so strong because of local accountability. We are a part of a community and that includes governance.

It might depend on how we define local. The relationships CCBs have are critical. Having a connection to the community is a critical factor.

There was also some disagreement on the need to prevent others from coming in and doing the work.

Do we say that to be a CMA you have to employ "x" amount of people, or be able to serve "x" amount of people? We've never done that with service agencies. We have providers that have no storefront. We seem to have more providers and less capacity – more is not better. Start with inane – has to be some critical mass.
Worry about Indiana model taking shape in CO.

We can frame what not to do – rather than what to do.

Values – are we willing to plan and schedule around Person-centered practices?

Knowledge – CM is complex job – how do you measure or set standards for that. Do we use Accreditation models, certification models? Set standards and meet them. How do we measure the knowledge/skill piece?

Model to copy –when we hire new coordinators for EI, they have to go through specific training. It's a good model. Can we incorporate that into adult world?

Let's find good models and working examples – that we could leverage in terms of infrastructure.

Best practices and lessons learned in other states can provide input to help designing this.

Certification and training could work, but it will be a couple of years before we can implement and enforce that.

	Is state going to provide some oversight for these case management agencies that will be formed to make sure the focus is on person-centered care? Yes, what that looks like we don't know. Dept. will be doing CM surveys. Some folks have been asking for CM training for many years, and it's still not available. Surveys are few and far between. Training and certification should be available to make sure people are doing the job correctly and successfully. These are pieces that we'll have to build into this plan. Legislators will want to know how much services and CM cost. The State will need to add FTE and support staff. The State will need to do analysis of budget and resources – this is longer term. Starting this conversation now is good, but there is a lot of work to be done.
CCB Designation • Discussion on regulations defining CCB • Including advantages disadvantages • What do CCB's think about this designation? • Can the model be different?	Statute – what's in there now? A CCB mentioned the struggle with functions of CCB's as described – it simplifies the job. Statute is helpful (what we're required to do, competition, and utilizing variety of services), but it's closely tied to knowing who's coming in the door and eligibility – this could be a disconnect. A CCB said it will be harder if CCB's are not doing intake and eligibility. What do you do if you can't find a provider? SEP's say "we can't find a provider so we can't help". But, CCB's can't and shouldn't do that. CCB's work together to make sure everyone is covered and everyone has an option. There is a concern that CCB's would lose this ability if they lose CCB designation. This is a value, person-centered care approach to service delivery. Opposing view: The CCB business model is not the best because they lose $ - sometimes we have to get comfortable with "no" As a PASA in Denver, an agency never had motivation to serve tough cases because a CCB would step up. Not true in rural areas – The CCB's have to do it –

	PASA's won't do it. It's a culture thing – CCBs will do it when nobody else will. Keep in mind, CCBs are at capacity – 2 weeks ago situation, there was a situation where we couldn't find anyone to help. Value of CCB Designation: Knowledge of what's coming down the pike. Who will be preparing for it if CCB/s don't have designation? CCB's have the knowledge. Five-year plan – we do all those things to provide for that. This is an open conversation – no decisions today. Challenge – we have trouble as CCBs articulating what this is exactly. We've got to figure out what is it exactly and what is the total impact? What will we miss as a state how to fill that gap? Group agrees that CCBs still need some sort of designation – start at highest level. CCBs need some sort of designation for CCBs and/or CMAs. Questions Posed: Does the designation process contemplate new, additional or others coming into the market? If designation is kept, do we expand? That should be part of this conversation. If entity meets all the qualifications why not allow for new CCBs? How does CCB fit into this new conflict free world? Do we need to reframe it? Data is critical to the conversation. There's power in knowing that there's 15 kids coming up. CCBs have that data right now. Continue to capture that data and keep it in a useable format. All CCBs have their own way to track this data. It's not a formalized system, just in institutional knowledge, which is an intangible benefit of CCB designation. This shouldn't be disrupted by CFCM.
What's Next, Wrap Up	Schedule went out to all CCBs

- Town Hall Meetings
  - CCB's – please speak with your individuals and families about upcoming Town Hall meetings.
  - Note: If there is a lot of interest in a location that is not scheduled, the Department can schedule additional meetings.
- Next Meetings:
  - Tuesday, Feb 23rd, 10-12 PM
  - Thursday, March 3rd, 10-12 PM

Next Steps:

Continue to send CCB data to Brittani.

Start thinking of the plan in terms of buckets:

- transition for existing clients
- plan for new clients coming in door
- communications planning
- statute changes/policy implications
- Rural Exemption
- Provider development/Provider Outreach

Focus in on a model: CCB can remain an entity that does both CM and services, just can't provide both to a single person. Agencies still have choice for what they want to do for their business model.

Fifth CCB Meeting Minutes

Conflict Free Case Management Implementation Project

Community Centered Board Meeting Summary
Date and Time: Tuesday, Feb. 23, 2016; 10:00 – 12:00 PM MT
Location: 303 E. 17th Ave., Denver, CO; 12th Floor, 12A
Call-In Number: 1-415-762-9988;3037850003# - https://zoom.us/j/3037850003
Attendees: * Participated via phone

CCB Attendees	Organization
Scott R.	Blue Peaks Developmental Services*
Michael Atlas-Acuna	Colorado Bluesky Enterprises
Bruce Christensen	Mountain Valley Developmental Services*
Dave Harbour	Southeastern Developmental Services*
Susan Mizen	Horizons Specialized Services*
Amy Ibarra	Horizons Specialized Services*
Tom Turner	Community Options, Inc.*
Steve Dahlman	Community Options, Inc.*
Elaine Wood	Community Options, Inc.*
Leslie Rothman	Imagine!*
Mary Lu Walton	Envision
Marty Kennedy	Envision
Pat Jefferson	Developmental Disabilities Resource Center*
Laura Thomas	The Resource Exchange*
Sharon Church	Inspiration Field*
Rhonda Roth	Eastern Colorado Services*
Melissa Dessaro	Eastern Colorado Services*
Tracy Schrade	Eastern Colorado Services*
Diana Foland	Foothills Gateway*
Erin Loufeld	Foothills Gateway*
Sharon Courtney	Foothills Gateway*
Debbie Lapp	Foothills Gateway*
Julie Dreyfuss	Community Connections*
Tara Kiene	Community Connections*
Bob Arnold	Starpoint*
Melanie Worley	Developmental Pathways
Department Attendees	
Tyler Deines	
Brittani Trujillo	
Public Knowledge Attendees	
Angie Anania	
Nicole McNeal	

Meeting Summary

Topic / Objectives	Notes
Introductions & Meeting Purpose Purpose and Desired Outcomes – Focus in on a model: o You can remain an entity that does both, just can't provide both to a single person. o Agencies still have choice for what they want to do for their business model Review minutes of last meeting	Purpose: Need critical thinking about the plan. We'll focus the next two meetings on billing process and data discovery. We'll also talk about expectations of the final meeting, including what does CFCM look like for your CCB? For 6th meeting be prepared to think about and talk about the implications of CFCM. What would your timeline look like? What does the model look like to make this doable?
Billing Process • Overview • Clarify the difference between acting as OHCDS versus a billing agent	Please see PowerPoint attached in email for review. Discussion highlights: What happens to all mom and pop providers, like for SLS, who have been billing to OHCDS for years? Because they don't have provider ID. They need to enroll as a Medicaid provider agency. The impact of that needs to be discussed in this planning group. They need to go through the same as PASA's going through now. Another choice, would be to become employees of an enrolled agency or work out an agreement with an enrolled agency. Should be discussed as impact of this work. Part of broader discussion we need to have. We have a number of "generic vendors" – they will not become PASA's – how do we take care of them? We can help encourage them to enroll. For the plan - It's going to be important to *Maintain access to a network of qualified providers This whole thing seems cockeyed – you have a lot of businesses who work with us that you're trying to wrap in to a government agency. For example – window cleaning service. Are you going to require window cleaning service become a Medicaid provider? It's one thing to be a PASA, but these other businesses don't want to do it. This is an example of government overreach. It's going to limit the services available and hurt the people we're trying to support.

	Why would we not continue to be the OHCDS in this arena? No decision been made on that. However, there's still the CFCM concern with the OHCDS as there still is that financial incentive. Qualified provider assurance is a fundamental assurance. Clarify "qualifications" Whatever is detailed in the waiver, as each service would have different qualifications. Some services require board of nursing checks, etc. Every provider has to be screened. Very basic list but once you get into service it's get detailed and different for each one. Who screens them? Tyler - Enroll with agency and we go through application review. Depends on the service. It is time to re-evaluate those qualifications and they don't impede the network providers. What's the time frame? Tyler – yes, determined in waiver as well. List out who's verified and how often. How many days to screen? Tyler – DPHE does that so don't have standards set on timelines. We have to figure out how it applies within the world of CFCM. Having smaller providers go through process enrollment. What Dept. must show to CMS to get that funding. What can we do to support that outreach, education, billing training? Whatever we can do to support that. Please consider when developing the plan.
Data Discussion ▪ Overview of data received ▪ Do we have Service Provider data? ▪ Where are the gaps? ▪ What does the data tell us regarding the potential Rural Exemption?	Did not get data from all 20 CCB's yet. Out of those people, billed using CCB provider ID – across the state – (fiscal year 2014-2015) 10,313 people enrolled in HCBS-CES, HCBS-SLS, and HCBS-DD waivers 9,229 had at least one service billed by case management agency – your provider ID was used for that service – **that's 89%** - at least one service is billed by their case management agency Thoughts? Greater than they anticipated. When you dive deeper, we'll get into more info. Colorado Bluesky serves directly and provides case management for a certain amount of people, the rest

we can fix. Getting rid of the rest by stop providing billing services for them. Tyler suggested we let them know there are billing classes with Xerox and HP. Please let them know about this resource if they need assistance.
89% is shocking. Due to that one service – when it comes to OHCDS arrangement, under a CCB provider ID. We need to dig into data deeper.
*Get more information (data) on who CCB's are billing on behalf of, which services, etc.
The billing restrictions seem silly. Where's the conflict?
Tyler – the conflict lies in the subcontractor agreement – there's an opportunity for financial incentive. The Dept. doesn't control that subcontractor arrangement, so there's an opportunity for financial incentive that could drive service planning.

Drilling down to impact – we're going to hurt people. Eliminating the ability to get vision services for individual. Keep focus on "we're trying to help people."
They're not going to apply to be a Medicaid provider. **Key point – yes – we need to keep that in mind.**

Curious as to why we're bringing in OHCDS as issue. PASA in Gunnison is called 6 point – model – we are case management agency, we provide no direct services, but we provide billing services for free. When we pull in the billing as a possible conflict – will those PASA be willing and able to become billing agents on their own?

Billing aspect confuses things. If you're a billing agent, what's the difference? Tyler – there's a financial relationship between provider and service provider. That's the line that CMS has drawn. Can't be financial interest between two.

Overall review of provider qualifications and maintain adequate network and make sure people don't lose services. **Need to plan for this.** Waiver redesign efforts, coming soon. Having opportunities to talk about qualifications. Ongoing opportunity to make sure we're providing access state wide.

	For those CCB's closer to 100% in terms of providing both, what are your concerns? We don't know until you pull out those extenuating circumstances. Bob with Starpoint – doing case management for 171 people, handful not getting services for both – so we're close to 98% which is significant. We're representative for smaller size board. Sharon - 100% of our service - No providers in our area Pat at Blue Peak – same as Sharon The rural exemption can be on case by case basis Mike - $400,000 hit to lose case management or lose a service. If it was to be all case management, it would decimate our case management dept. About 15 people would lose their jobs. Bruce – you'll find when you look at state – other than Grand Junction – PASA presence is on the front range. Outside of that – no PASA's available. A lot of communities that don't have these services available. *Will need to be reflected in this plan. **Next steps:** Need to look at slicing and dicing the data Explore rural exemptions and billing questions Need CCB input on what this plan should look like but keep in mind the regulatory considerations. The plan has to be presented no later than July 1, 2016.
High-Level Goals of Transition Plan • Transition for existing clients & new clients o 3rd party involvement? o Communications Priorities • Provider Development/Provider Outreach	Review/Brainstorming on buckets of key areas Based off current waivers, HCBS-CES, HCBS-SLS, HCBS-DD waivers **Provider Development/Provider Outreach** Before a person can stop using current provider – there has to be another provider. Also, other CM providers Dir. Services and CM provider outreach and capacity

• Rural Exemption including Communications Priorities • Tracking Mechanisms/Recommendations • Statute Changes/Policy Implications • Others? • Timeline Considerations	building. Training – for providers/CM – can't add to capacity if people don't know what they're doing. A bus training manual, cultural competency, how to do the job. **Rural Exemption** How many of those areas would fall under Rural exemption? Inspiration Field – SEP refuses to provide – can Inspiration Field get exemption from "both" rule? Info would help frame how many people are we talking about? 47 of 64 counties considered "rural" – so what % of clients is this? **Tracking Mechanisms** Some of the billing stuff – can be fixed relatively easily. Discontinuing billing process for PASA – Should we have something – time when CCB will cease billing for PASA? How do we hang onto providers who don't enroll with Medicaid? Tracking mechanism for billing to allow for some services? **Statute/Policy** Anything to put into plan – *footnote – to be adjusted with new waiver. **Other** Plan - Within first "X" amount of time CCB designation has to be figured out. CCB designation? Hinges – assurance that they do continue to exist? Expectation if you're CCB you are a CM agency. Or be a CCB and be dir. Service provider instead of CM. Will plan provide for local options of what they want to be? We need to address that. When does CCB have to make decision? At such time, agency decides they no longer want to continue to provide both – what does that transition look like? Target percentages – real intent separate actual service delivery (higher cost ones) possible to measure this by amount of Medicaid dollars provided

by someone who is doing both? Some way to separate these out.
*Brittani will get that data.
Have to carve it up some way that makes sense.

Transition of Current Individuals and New People

Do we start based off location, other criteria??
When do we stop creating the conflict? Stop the problem before we have to deal with the problem. B-as of this date, CCB's will no longer care for both – set the date.

Confines of what federal regulation is saying.
Way of not cutting off choice, in terms of third party, there's still a way a person can chose you to do one or the other. 3rd party involvement – has support.

By a 3rd party involved to help that person to make those choices.
Laura – idea – thinking about NWD future – how to help each other. How to make it fair so they're not choosing between "mom and dad"
Neutral person they can talk to.
Communication important for new clients.
Having 3rd party – why do we need it?
Transitioning current people who have that conflict. That's what goes into the plan. Maybe someone who's been with them for 35 years, is transitioned three years down the road. Reduce the % over 2-3 years. What does that timeline look like?

Another group of people – CCB's serve people that no one else will service, intricate problems, what do we do about them? Who's going to deal with them? This group of people should be last on the list. Deal with "low hanging fruit" off the bat, then deal with those tough cases later.
Define this population – problematic sexual behavior individuals. Sex offenders.

CCB designation will be part of this plan? Confirm we're going to remain CCB's – based on private decision. We need that designation to continue that. If not, we're just another provider. Not fair to our communities. Not to mention mill levy $ tied to CCB's.
Along with CCB designation - Do you also just open

that up? Mike not in favor of that.
Plan is going to include CCB status – in some way.

Where do we fit in financial analysis of what's this is going to cost? Footnote in the plan. Navigant is going to take all the work from PK, town hall meetings, etc. and put all that into final plan.

Communication
Communication – you don't get to choose both. It's not an option. This is important in Communication.
Messaging is important for new clients.
Customized communication by stakeholder groups
Website
Canned messages by stakeholders

Current Clients
Plan include % of individual transitioned into either case management or direct services in phases.
Year 1 – is it CES waiver?
By year 1, reduce % by 50% for urban?

Looking at case by case basis.

Clarification on Expectation:

Question:
Do we need to be totally compliant with federal rule – no one can receive both case management and service from CCB? Or are we saying we have to pair that number down? Brittani- No, however, CMS has potential to allow for Rural Exemption. In those rural areas, no other willing, qualified, etc. can provide the services. Then CMS may approve that. Only areas where Rural Exemption is truly determined to have been met.

What is official compliance date?
Brittani - we're already out of compliance. Rule effective March 17, 2014. There's no official transition plan from CMS, like for settings piece of the rule. In order for us to amend waivers, develop new waivers, for CMS to even think about approving that, we have to have solid plan in place for CFCM and on our way to making that happen.

Other states: Wyoming completely Conflict free, Ohio

in process, ND on their way. That we're aware of. Handful in some sort of process or transitioning.

We need to have a solid, reasonable plan with benchmarks in place. It has to be a well defined plan.

If you think about people we support – our concerns about them having to make a decision (if they get both) If total separation between case management and service – that person wouldn't have to make a decision. It would be up to CCB – to make decision on what they want to be. Is it worth it? These are decisions, agencies need to make. Separate so there is no relationship? Then individual won't be choosing. Dir. Services more financially beneficial than case management.

Mike – if I was forced into decision I would take CM, but can't afford it. If that happens there needs to be some resources to cover the costs. What makes us work as CCB is having all those parts. No particular program can function without the other.

CCB, CM, Service Provision – not any one of those can exist on their own, safely/satisfactorily.

*Qualified provider – Brittani working on getting clarification from CMS

Timeline Question and Clarification needed:
Brittani – we probably won't get 9 years like Ohio did. We would rather not put a number on it right now. We won't ask for too little time and/or too much time. The Dept. wants this plan to be thoughtful, insure services for people and be as least disruptive as possible.

What's Next, Wrap Up • Next Meetings: o Thursday, March 3rd, 10-12 PM	Town Hall meetings – welcome to attend, but please remember the meetings are specifically for the providers. As CCB's the Dept. has set aside these 6 meetings to get your input. We want to give the providers the time and input as well. Please hold off on your participation during the Town Hall meetings. We appreciate you being there though as part of the process. Next Meeting: This is our last meeting, with just CCBs and the Department, to provide input into the recommended plan. Please send any additional data to Brittani. Please come prepared to discuss: o What does CFCM look like for your CCB? o What would your timeline look like? o What model can you discuss that makes this doable?

Sixth Meeting Minutes

Conflict Free Case Management Implementation Project

Community Centered Board Meeting Summary
Date and Time: Thursday, March 3, 2016; 10:00 – 12:00 PM MT
Location: 303 E. 17th Ave., Denver, CO; 12th Floor, 11B
Call-In Number: 1-415-762-9988;3037850005# - https://zoom.us/j/3037850005
Attendees: * Participated via phone

CCB Attendees	Organization
Brooke Hayden	Blue Peaks Developmental Services*
Pat Rheaume	Blue Peaks Developmental Services*
Michael Atlas-Acuna	Colorado Bluesky Enterprises
Bruce Christensen	Mountain Valley Developmental Services*
Dave Harbour	Southeastern Developmental Services*
Susan Mizen	Horizons Specialized Services*
Amy Ibarra	Horizons Specialized Services*
Tom Turner	Community Options, Inc.*
Steve Dahlman	Community Options, Inc.*
Elaine Wood	Community Options, Inc.*
Leslie Rothman	Imagine!*
Mary Lu Walton	Envision
Marty Kennedy	Envision
Laura Thomas	The Resource Exchange*
David Irvin	The Resource Exchange*
Sharon Church	Inspiration Field*
Johnnie Deleon	Inspiration Field*
Rhonda Roth	Eastern Colorado Services*
Tracy Schrade	Eastern Colorado Services*
Diana Foland	Foothills Gateway*
Erin Eulenfeld	Foothills Gateway*
Sharon Courtney	Foothills Gateway*
Debbie Lapp	Foothills Gateway*
Tara Kiene	Community Connections*
Bob Arnold	Starpoint*
Duane Roy	Southern Colorado Developmental Disabilities*
Marsi Mason	Southern Colorado Developmental Disabilities*
Sharon Jacksi	Mesa Developmental Services*
Department Attendees	
Tyler Deines	
Brittani Trujillo	
Public Knowledge Attendees	

Angie Anania	
Nicole McNeal	

Meeting Summary

Topic / Objectives	Notes
Introductions & Meeting Purpose Purpose and Desired Outcomes – Receive input from CCBs for recommended CFCM plan o What does this look like for your specific CCB? Review minutes of last meeting	Purpose: Final meeting – the meeting structure was open ended in terms of garnering input for the CFCM Implementation Plan. Everyone was asked to come prepared for this discussion.
Follow-up on Data Discussion • Update on data, including types of services being provided • What services and which providers are CCBs billing for? • How can the data help support Rural Exemption?	Meeting invite was updated with the statewide data. Walkthrough of data from FY 14-15 by Brittani Some of the data is expected regarding percent of individuals where the CCB provides case management and also bills for the service, such as dental, vision, home modifications, etc. The statewide percent of people receiving case management where the CCB bills for at least one of their services is 40.3%. Everyone thought we were below 50% for service provision and case management. - in some areas, the data is bad as we had thought. The data provided by the Department gives direction on how to move forward (determining the benchmarks). However, in the small communities there may not be other providers. A CCB representative mentioned that they would not be doing pass-through billing anymore for PASAs. Tyler mentioned that there are options for this. A CCB asked a question about dental and vision services – this was exclusively a CCB function, yet shown as direct services. With the transition of dental services to DentaQuest, the service provision data wouldn't be evident and next year's data we would see a much lower number. A CCB highlighted 5 categories in which there's not an option to be a PASA. Department stated that we can't restrict to OHCDS. Here's the list: Vision, Parent Education, Dental, Specialized Med Equip., Adaptive Medical (no options there).

	Tyler will explore. Last meeting, CCBs had the impression they would still be in conflict if billing on behalf of other agency. Tyler responded that there are options should an agency decide to provide services – can be service provider and billing agent but not the person doing the CM. CMA cannot also bill on behalf of service provider. Being billing agency and CMA may not be an option as we move forward, as there is conflict when the CMA has a relationship with the agency providing the direct services, if the CMA bills on behalf of the provider. CCBs have a perception that there are different definitions around billing for each meeting. Coming up with a plan is difficult if there are other unknowns. In the plan, CCBS would like some reasonable information for this – services or the ability to bill on behalf of another agency using their provider ID. Is this part of the capacity exemption? If there is any financial relationship between the two entities, there would be a conflict
Goals of Transition Plan CCBs should be prepared to provide input and detail (what should be included in the plan) for each of the following categories: ▪ Transition for existing clients & new clients ▪ Provider Development/Provider Outreach ▪ Rural Exemption including Communications Priorities ▪ Tracking Mechanisms/Recommendations ▪ Statute Changes/Policy Implications ▪ Timeline Considerations ▪ Communication	*Communication should be big part of the plan – PASAs need to know that no CCB will want to bill for them because of that risk of conflict. Transition – start with the biggest conflicts and work our way down. Tracy – many service providers are not going to have their own provider ID # - how will billing be handled for them? We need to look at how providers are enrolled. How we can support in getting those services without being obstructive or cutting off access to services? We will need to sequence the approach to the Plan. CCBs suggested communicating with CMS regarding the barriers. A CCB representative stated this could cost the State resources. We need to have that conversation now. There is already a substantial capacity issue and we need to be

▪ Current Clients ▪ Others?	prepared to discuss that. This could be part of a conversation to have with CMS. CCBs say they are submitting documents to CMS regarding their concerns with CFCM and the Department is aware of this. Could we get individual surveys out to CCBs? What benchmarks are specific to your agency? CCBs didn't fully agree with this -- if we don't know where we're going in the end, a CCB can't give the Department specific answers. Biggest conflict – services and case management – how do we want to define this? Desired Result: Develop an Implementation Plan and Compliance with CMS. It's up to CCBs to define how they deliver services or case management to individuals. Is that the biggest piece that needs to be tackled first? We need CCBs to define what those are. We need to determine where our risk issues are. Example - CCBs that have group homes. How does CCB make determinations about preserving that group home? Finding a provider for individual in HCBS-SLS is lower risk. Consider developing a risk model. Maybe the transition plan should start with low risk – get rid of doing both. Within that the first part would be the HCBS-SLS. Start there and then move to tougher issues. All while setting up a framework. What is our goal? Ensure individuals aren't harmed; provide continuity of care, ensure capacity. Need some type of guideline to structure the plan. Goals - Safety, Continuity of Care, Smooth transition, Address capacity issues. We have to know if CCB is going to continue to exist – if the CCB designation goes away how does any of that happen? CCBs would like to maintain designation in the Plan. If you're thinking about provider capacity, educate providers on billing.

Risk matrix - prioritize low risk and low hanging fruit.

Rural – need to provide CMS with appropriate data to demonstrate this exemption.

Look at which counties do not have PASA access right now – good place to start. We would have to re-create 100% of the capacity to get "conflict free."

Data distributed to the participants would be useful to CMS. 98-100% of people are going to have to choose as they currently receive both.

Show that we've reach out to other HCBS waiver providers – asked if they would enroll to provide other services?

We need to look within our current PASA network. Many PASAs have been approved to provide services in the area but they may not be providing the services.

Conversations with local Dept. Health and Human services – they may not want to provide the services – they are either trying to find other providers or trying to find someone to provide case management. Providers say you need a certain mass to provide services. Also cost of delivering services in some parts of the state is a barrier.

A CCB inquired about the appeal process for rural exemption?

Choice to waive a regulatory decision is not an option – no "opt out" for CFCM – CMS said not an option at webinar last month
CCBs may have this conversation with CMS.

Some options are going to have restrictions. Have to keep this in mind when we communicate with families.

Capacity issue – also issue of rates. We provide services because nobody else wants to provide them because of low rates.

When we ask the Department for an emergency enrollment, we have to go through a number of steps. Can the same kind of process be put in place for rural exemption so we don't disrupt the service for that person and demonstrate we've gone through all the steps?

This will play out differently in each area, depending on what the Boards will do. Ohio - A benchmark was reducing by a certain percentage. That could play out differently depending on what our boards decide they want the corporate structure to look like.

How do we meet the intent of CMS – knowing they're looking at numbers. Will there be some negotiating? Then we can be in a better a place.

Extended timeline to be able to look at all those different decisions/pieces that need to be considered.

Timeline – what does an extended timeline mean?

CCB suggested 8 years from now or 2024 since that is what Ohio got.
The Dept. has to submit a reasonable and solid plan, with concrete benchmarks and phases. The Department has a relationship they must maintain with CMS. *Benchmarks are extremely important.

One suggestion: Rather than saying reduce by certain amount each year, no more than 20% of Medicaid funds will be expended, etc. Include caveat that the ultimate goal being 0, unless it can be shown no other provider in the geographical area.

Provide benchmarks with definitions that CCBs have asked for.
Have CCBs help define input for those benchmarks.

CCB would expect that the Dept. would give Dept. definition first, ex: capacity, etc.

CCB designation should be somewhere in plan –a decision about CCB designation needs to be made. It could jeopardize services.
Data shown earlier was only for HCBS-CES, HCBS-DD, and HCBS-SLS waivers.

Transition – how do we stop the inflow of new people? After certain date, CCB would no longer provide service delivery if they provide CM. Look at PASAs as a choice for individual or we just lock the individual out.

"No longer have that choice" Or they have limitations of their choices.
Feels like we're guiding a plan down the road. The option is providing both services and CM. Or, your organization may decide not to provide both. CCBs thought this may be hard depending on Department direction.

Contracts with Department - there is a closeout plan. Those pieces are in place. Do we put something in this transition plan?

CCBs stated they will be driven to do business differently. There has to be some way to project the ripple effect so the Department is prepared if/when a CCB decides to no longer provide CM or services or both.

Bigger issue – what if the choice was that a CCB is a Service Provider and not a CCB? It's going to impact everyone.

For the Service Providers that are no longer connected to their CCB's, they are now fair game. They will be competing state wide. For those providers in smaller communities who have been protected by CCBs – smaller providers will be put out of business by the larger CCB provider that is now in the free market, and there goes choice.

CCBs make their agencies work through because of the different revenues they receive. If CO Bluesky decided to just be a CM agency, the resources are not there to do that.

In the plan – CCBs are able to make those choices. It will play out differently according to how we've all woven that into communities. CCBs would like an extension and why it's going to take some time.

Definitions on what this looks like in terms of the definition – assignment for CCBs.

No one wants people to lose services, including CMS.

Clients come first – having the resources and evaluate against a risk matrix.

Approach to a priority list – we still need to define that.

How do CCBs give additional feedback?

Report Process - PK recommendations go to Department and then to Navigant – they will combine with community engagement meetings, town hall meetings and financial analysis. All of it goes into a final Plan for the Department

Draft final plan – the entire report will not be available when we do the large community engagement meetings. But the draft recommendations for implementation will be presented to everyone at large to ask, "what did we miss?" Feedback will all go back to Navigant who will then give us their final recommendation for implementation.

PK will go back and look at all other meetings we've had for input to recommendations.

Transition should be done in phases – thoughtful, strategic in how we approach this.

Will CCBs see financial analysis info before going into the final draft plan? Will we see any results compiled?

Brittani will check with Navigant on financial analysis process.

What about funding? Will the funding be able to support our decisions? Navigant analysis will help us figure out all those pieces and help us create the Plan. Any plan will need a fiscal impact analysis conducted.

If CCBs have concerns or additional feedback regarding the Plan do they send letter to Sue Birch or someone else?

No, all concerns or feedback should be sent to Brittani Trujillo.

Community Engagement meetings in April are for everyone, but they are not scheduled yet. Denver, Pueblo, Colorado Springs, Grand Junction (general areas) most likely.

Town Hall meetings are for everyone outside the CCBs. CCB can attend but discussions should be open for the providers who haven't had all these meetings to voice their opinions.

In terms of a plan – An example is: Phase I – Statute, regulatory changes.
Phases can vary depending on what the tasks are within that phase. Phase 2 could be two years as example. Based off what's happening in each phase – phases can be overlapping

How does the Plan direct this change?

Phases or Considerations for Phases (order and priorities were not confirmed during the meeting):

Statute/Regulatory Changes – deciding to maintain CCB designation, sub statutes
Definitions of Rural Exemption – should be included in the implementation plan
Limitations on Choice
Communication Plan – we need a whole plan, statewide plan
Capacity Building
Budgetary Analysis
Implementation and Transition
(ongoing decision making process for CCBs to decide their own future)

Does plan include some kind of check in between Department and CCBs?

Rural exemption – will it be defined within the plan or will defining it be part of the plan?

The plan needs to lay areas out in more detail.

Part of a plan is still flushing out some of these details. Brittani – sees both – I would love to have Rural Exemption definition in plan but don't know if we'll get there. Part of the plan will be within "X" time to finalize those definitions.

Justifying Rural Exemptions – Info from Bruce:

- 9 CCBs that serve only rural counties.
- 2 CCBs office in urban areas that have some rural counties in service area

Show these 9 CCBs serve this % of total Medicaid

As we gather more stakeholder input – it will help define a Rural exemption to include in the final plan.

Implementation plan goes to general assembly July 1– so the Plan will be finalized in May and June.

What notice does a PASA have to give if they are closing their doors?

CCBs noted that it's hard to operate as a business because

	they don't know what's happening here.
Wrap Up	If you can, continue to send Brittani input to the Rural Exemption definition. PK's report is a series of recommendations based on these meetings. It will be paired with the implementation plan. The Department will communicate with CCBs on progress.

Public Knowledge LLC
Management Consultants

Appendix D: Conflict-Free Case Management Other State Research

Colorado Department of Health Care Policy and Financing

Conflict-Free Case Management
Other State Research

30 S. Wacker Drive
Suite 3100
Chicago, IL 60606
www.navigant.com

NAVIGANT

We describe the developmental disability (DD) waiver case management systems in Minnesota, Montana, Ohio, Virginia and Wyoming below, including plans to transition to CFCM where applicable.

Minnesota

Case management in Minnesota's DD waiver is performed by tribes or counties that do not provide any other direct services. Some rural counties might contract out case management to private agencies, but this is rare. The majority of case managers are county employees in Minnesota. Counties/tribes used to contract directly with direct service providers, but beginning in 2014, Minnesota began requiring providers to enroll and contract directly with the State, in response to pressure from CMS over concern that there would be too much variation in available services and rates across the State. Now that the State manages the providers, it can ensure that participants in all counties have access to the same services. CMS also wanted to make sure there was standardized enrollment criteria and quality standards across the state (monitoring quality is a role of case managers).

Montana

TCM for adults in Montana's DD waiver is a state plan service performed by contracted entities who may provide other waivers services. According to Montana rules, the agencies employing the contracted case managers may not provide other waiver services in the same community in which they provide TCM. Because the case manager is either a state employee or an employee of an agency providing only case management services to the individual, Developmental Disabilities Program (DDP) believes there is no conflict in designating the case manager as the Department approval authority. Montana has five regions in the state for DD waiver service delivery, but six regions for TCM. When an agency agrees to provide TCM in a certain region, it must also agree not to provide any other waiver services in that region. Providers who provide case management in one of the six case management areas have to agree to provide case management to all the counties located in a given area, and no other services. This is sometimes a challenge in rural areas because there are not as many providers from which to choose. Three cities in Montana also use state employees as waiver case managers, which also guarantees compliance with conflict-free case management. Montana's waiver also offers case management for children under age 16 as a separate waiver service, and the same conflict-free rules apply.

Ohio

Ohio contracts with 88 county boards to conduct case management, and most of them also provide adult day services for Ohio's four DD waivers. Ohio approached CMS in April 2014 to inquire whether the existing firewalls and other conflict of interest safeguards would be sufficient to meet the new HCBS regulations. CMS informed Ohio that its existing CFCM policies were not sufficient and that they must submit a Corrective Action Plan (CAP) to address the conflict of interest. Ohio initially requested that CMS grandfather existing waiver participants who receive both case management and services from county boards (i.e., allow them to continue receiving both case management and day services from county boards), but CMS did not allow it. CMS gave the State until 2024 to come into full compliance for all boards and waiver participants. CMS approved Ohio's (CAP) in December 2014, which states:

- *Boards have until 2024 to become fully conflict-free. According to the official we spoke with, most, if not all, boards will divest adult day services and retain responsibility for case management because they derive most of their revenue from case management and they view their primary role as advocating for waiver participants.*
- *By March 2020, no more than 30 percent of individuals receiving case management from the county boards may receive other HCBS from the boards.*
- *As part of the transition, boards must establish and implement annual benchmarks for recruitment of sufficient providers and for reducing the number of people for whom they provide HCBS.*
    - *Benchmarks are subject to approval by the Department of Developmental Disabilities (DODD) and the first set are due in June 2016.*
    - *Boards must report twice per year on progress towards achieving benchmarks*
    - *DODD will verify progress reports by reviewing HCBS claims data.*
- *County boards may continue offering services to individuals until another qualified/willing provider is available, but:*
    - *Evidence is required to show that no qualified provider would agree to serve the individual. It is not acceptable for waiver participants to simply decline other available service providers; the providers must decline the participant in order to qualify for the allowance.*
    - *The Boards must ensure administrative separation of staff developing services plans and those providing HCBS*
- *Boards may assume additional oversight/monitoring responsibilities of HCBS providers once they are no longer providing those services.*

Ohio has reduced the percentage of waiver participants who receive both case management and adult day services from county boards from 92 to 52 percent over the past seven years. This reduction has been accomplished through a combination of expanding the private provider pool and transitioning individuals from county boards to other providers when needed. Boards are expected to actively recruit providers in counties with minimal options and they must demonstrate that they are working with providers in their county and neighboring counties to encourage providers to expand their service offerings and/or service area. The boards must consider themselves the provider of last resort.

The Ohio DODD met with the county boards throughout the entire negotiation process with CMS. The boards helped develop the initial CFCM proposal to CMS and provided input on all elements of the final CAP. DODD conducted multiple presentations to the boards and advocates to keep them abreast of negotiations with CMS and discuss options for moving forward. After CMS approved the CAP, DODD began conducting trainings for the boards to educate them about needed changes, documentation, and timelines.

The official we spoke with offered the following lessons learned:

- Including the county boards in the development of the CAP was valuable to gain their support for the final CFCM solution and compliance moving forward.

- CMS will not allow states to grandfather existing waiver participants; states must work toward full compliance with CFCM for all participants and must closely monitor progress towards achieving CFCM.

Wyoming

In 2013, Wyoming state law mandated that the State transition its DD and Acquired Brain Injury (ABI) waivers to conflict-free case management.[1] Wyoming phased in CFCM from May 2014 through June 2015 requiring case managers to be independent from direct service providers and for waiver participants to choose a case manager from a list of conflict-free case managers in their area. Under the new requirement, case managers are prohibited from providing direct services to the individuals they case manage. The following conflict of interest provisions were published by the Behavioral Health Division (BHD):[2]

1. *The CMA and any managing employee may not own, operate, be employed by, or have a financial interest or financial relationship in any entity listed in Title 17 of Wyoming Statutes, if the interest would meet the definition of conflict of interest. If the CMA is a sole proprietorship, then that qualified case manager shall not have a financial interest or financial relationship in another sole proprietorship CMA.*
2. *The CMA may be certified in other waiver services, but shall not provide case management services to any participant that they are providing any other waiver services to, including self-directed services. For any existing conflicts, a third party shall be involved to review and determine that there are no other available providers to provide case management.*
3. *The case manager or CMA may not serve any participant that receives waiver services from a waiver provider if any of the provider's owners, officers, or managing employees are related by blood or marriage to the CMA and any managing employee of the CMA.*
4. *Any employee of a guardianship agency may not provide case management to any participant who is receiving any services from the guardianship agency.*
5. *Also, a CMA may not:*
    a) *Employ case managers that are related to the participant, the participant's guardian, and/or a legal representative served by the agency. Or if a sole proprietor, may not be related to the participant, the participant's guardian, and/or a legal representative served by the agency.*
    b) *Be authorized to make financial or health-related decisions on behalf of the participant receiving services from that agency, including but not limited to a guardian, representative payee, power of attorney, conservator or other position as defined by the Division;*
    c) *Employ case managers, or if a sole proprietor, live in the same residence as the participant in which they provide case management services, nor live in*

[1] Senate Enrolled Act 82, 2013.
[2] Wyoming's CFCM plan, called "BHD Conflict Free Case Management Model," is available for download online: http://health.wyo.gov/DDD/ComprehensiveandSupportsWaiver.html

the same residence of any provider on a participant's plan in which they provide case management service;

d) *Be an approved provider or employee hired through self-directed services*.

Most Wyoming DD/ABI provider agencies chose to spin off case management services and retain HCBS waiver services, except for one that chose to spin off its HCBS and now functions solely as a CMA. Case managers who previously provided waiver services had one year to transition their participants to other HCBS providers or to other case managers. Many case managers who previously worked for a provider agency chose to become self-employed or form small agencies of two or three case managers.[3] Currently, there are approximately 120 CMAs in the State, which includes self-employed individuals who are certified as an "agency."[4]

During the transition to CFCM, BHD also changed the minimum qualifications for case managers.[5] BHD now requires new case managers to have a Bachelor of Arts degree, although existing case managers may have an Associate's degree and sufficient work history. All case managers were required to apply for certification with BHD and to document that they met the minimum education and work experience requirements (e.g., college transcripts and work history).

The CFCM model was distributed to case managers in May 2014 and BHD conducted trainings on the new model in 2014 and 2015.[6] Case managers who wished to remain case managers were required to submit their application to BHD by March 1, 2015 and to have completed the transition to CFCM by July 1, 2015.

BHD received push-back from case managers, families and advocates about certain aspects of the CFCM transition:

- Some case managers were concerned about having to terminate employment with large HCBS providers and become self-employed or join a small business. Some case managers lost their health insurance and retirement benefits when they left large providers, but advocates assisted these case managers with applying for individual health insurance and opening new retirement accounts.
- Some case managers were concerned about the change in minimum education qualifications. As a result, BHD agreed to grandfather existing case managers as long as they had an Associate's degree, sufficient work history, and agreed to complete additional college coursework.
- Waiver providers who chose to spin off case management services were concerned about the loss of case management revenue. Some were also unhappy that case managers began discussing other provider options with participants.

[3] Wyoming did not collect data on how many waiver participants experienced a change in provider or case manager due to the transition to CFCM.
[4] The largest case management agency in the State now has 10 locations across the state and employs approximately 25 case managers.
[5] Wyoming developed the new case manager qualifications based on criteria from nine other states and through consultation with the National Association of State Directors of Developmental Disabilities (NASDDDS).
[6] Training also covered the new federal HCBS regulations (e.g., person-centered planning, settings requirements) and other topics (e.g., billing and documentation) for case managers.

- Many families and advocates were concerned about the impact of abruptly having to change service providers or case managers on waiver participants.
- BHD wanted to develop benchmarks for case managers related to transitioning participants to new service providers, but case managers were resistant to such benchmarks. Therefore, BHD simply required case managers to be fully conflict-free (i.e., to have completed all needed transitions) by July 1, 2015.
- As a result of push-back from case managers and advocates, BHD allowed case managers to provide waiver services to individuals whom they do not case manage, but ultimately, very few case managers elected this option.
- Many were concerned that the transition to CFCM would create a shortage of case managers in Wyoming, but that concern did not come to fruition.

BHD formed a CFCM stakeholder committee that included BHD staff, four case managers, the Wyoming Attorney General, and a Medicaid attorney. BHD senior leadership met with legislators several times during the legislative session to keep them apprised of the process and challenges they were facing. According to the official we spoke with, the legislature might have reversed the CFCM law due to push-back from advocates were it not for the 2014 federal HCBS regulations that required states to transition to CFCM.

Wyoming BHD offered the following lessons learned:

- BHD should have included state legislators on the CFCM stakeholder committee in order to secure their support from the beginning.
- Anticipate push-back and requests for exceptions to new rules.
- Stick to the new model with limited exceptions to ensure its integrity.

In the end, case managers reported positive feedback to BHD regarding the transition to CFCM—particularly around the improved advocacy for participants and person-centered planning as participants are now more free to choose services and providers that best meet their needs.

Appendix E: Community Centered Boards Onsite Review Report

Colorado Department of Health Care Policy and Financing

Community Centered Boards
On-site Review Report

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Section I: Background

The Colorado Department of Health Care Policy and Financing (the Department) contracts with 20 Community Centered Boards (CCBs) that provide access to long-term services and supports through Medicaid Home and Community-Based Services (HCBS) 1915(c) waivers. The 20 CCBs function to determine eligibility for services for individuals with intellectual and developmental disabilities, provide case management services and either directly provide or subcontract services and supports. The CCBs also execute entry point functions, such as determining waiver eligibility and providing information and referrals for service. The CCBs serve as the access point for the following reviewed HCBS waivers (referred to as access point waivers throughout this report):

- Home and Community-Based Services Children's Extensive Support Waiver (HCBS-CES)
- Home and Community-Based Services Waiver for Persons with a Developmental Disability (HCBS-DD)
- Home and Community-Based Supported Living Services Waiver (HCBS-SLS)

CCBs operate as a "one-stop shop," where an individual with an intellectual and/or developmental disability works with a CCB, designated by geographical location, that will determine eligibility for services, create a service plan, and help the individual obtain services. The access point waiver enrollment process begins with a determination by the CCB of whether the individual has an intellectual and/or developmental disability and are therefore eligible to receive services. If eligible for services, the individual works with a case manager from the CCB to determine the scope of services and supports needed to meet his or her long-term needs. Individuals seeking access to 24 hour support waiver services are placed on a waiting list before they can receive waiver services, as a result of funding constraints. After the waiting process (if necessary), the individual then works with their case manager to coordinate services. Services are provided either directly by the CCB, via a sub-contracted service agency or individual, or by an approved Medicaid provider.

In March 2014, the Centers for Medicare and Medicaid Services (CMS) instituted *42 CFR 431.301* requiring states to separate case management from service delivery functions to reduce conflict of interest for services provided under 1915(c) waivers. This rule addressed conflicts of interest that arise when one provider is responsible for performing both case management functions and providing direct services. CMS provided numerous examples of potential conflicts resulting from such arrangements, including:

- Over- and under-utilization of services
- Interest in retaining individuals as clients rather than promoting independence
- Instances where the focus is not person-centered

As a result of this ruling, Colorado's existing CCB structure is no longer compliant with CMS regulations as case managers have been in positions in which they were responsible for settling grievances and monitoring direct services provided by fellow CCB staff members. The Department had already convened a Task Group of stakeholders in February 2014 to make recommendations for implementing choice of case management agency, and expanded its scope to include recommendations for a conflict free case management system. Colorado *House Bill 15-1318* requires the Department to develop a plan, with input

from CCBs and other stakeholders, for the delivery of conflict free case management that complies with Federal regulations.

As part of this process, the Department contracted with Navigant Consulting Inc. (Navigant) to assist with the development of a conflict-free case management (CFCM) implementation plan. An essential component to developing the implementation plan is the evaluation and review of the funding for and costs of operating three essential CCB functions: Administrative, Targeted Case Management (TCM) and Organized Healthcare Delivery System (OHCDS); and to analyze the impact of complying with the regulation and Colorado legislation. We were also tasked with reviewing and reporting on how each CCB performs these functions. For the purposes of this review, functions are defined as follows:

- Administrative functions include eligibility determinations, developmental disability determinations (DD Determinations), Supports Intensity Scale (SIS) assessments, quality assurance functions, waitlist management activities, and enrollment activities.

  Quality assurance activities include reviews and resolutions of complaints and grievances, Quality Improvement Strategies (QIS) activities and reporting, incident reporting and responses, establishing and participating in a Human Rights Committee, and the investigation and documentation of mistreatment, abuse, neglect and exploitation.

  Administrative functions are included in the Department's contracts with the CCBs and are paid either per task or a per member per month.

- TCM functions include assessment, service plan development, service plan monitoring and information and referral of information to their respective client.

  TCM functions are billed as a Medicaid fee-for-service and in units, where one unit equals 15 minutes.

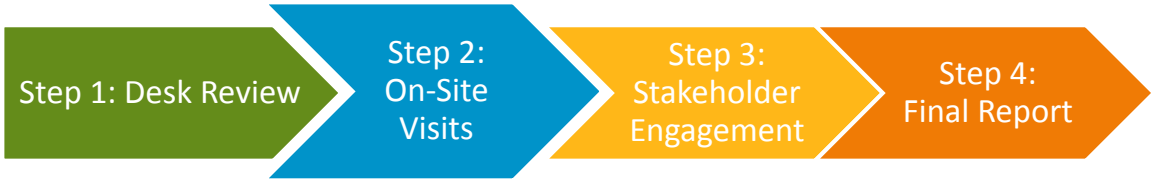
- OHCDS functions include, executing and maintaining a Medicaid provider agreement with the Department for all services available via the three access point waivers. Additionally, OHCDS functions encompass creating and maintaining documentation of all applicable provider qualifications for services rendered, directly or via sub-contracts under the Contractor's Medicaid provider agreement. For purposes of this review, the Department defined OHCDS as excluding costs and revenue related to direct services to individuals.

Section II: Methodology

The Department requested that Navigant conduct its work in four separate steps. The first step comprised the desk review that required collecting documentation from CCBs and a review of the information submitted. Navigant developed a cost survey for CCBs to complete that summarized the revenue and costs of the TCM, Administrative, and OHCDS functions. For detailed results of the desk review, see "Community Centered Boards Desk Review Report." For step two, we used the desk reviews to propose five CCBs for on-site review and conducted those reviews. The five on-site reviews allowed Navigant to conduct a more detailed assessment of the CCB's financial information and gave us an understanding of how Administrative, targeted case management (TCM) and Organized Health Care Delivery System (OHCDS) functions operate at the five different CCBs. Upon conclusion of the on-site

reviews, we will begin step three, which is to conduct Community Stakeholder Engagement meetings to obtain feedback on the implementation plan from individuals in services, families, guardians, advocates, and others. Step four will comprise the development of a final report that will aggregate all of our findings from the first three steps, and provide a plan for CFCM implementation to the Department. Figure I.1 demonstrates the four steps of our study.

Figure E-1. Steps of Navigant's Study



The purpose of Step 2, the CCB on-site visits, was to determine the following:

1. CCB cost survey calculation and allocation basis from Step 1 Desk Review.
2. How CCBs operate the three functions: TCM, Administrative and OHCDS
3. CCBs' feedback on the CFCM compliance options

These discussions are important for us to consider as we develop the final CFCM implementation recommendations as CCBs currently perform all TCM functions for all three access point waivers in Colorado.

Navigant's contract and budget allowed for site visits to five CCBs out of the 20 CCBs operating across the State. To assist in the selection of the five CCBs, we organized information about each of the 20 CCBs based on characteristics of each provider, such as the number of counties each CCB serves and the number of case managers reported by each CCB in the cost survey for Fiscal Year End (FYE) 2014.[1] See Appendix E1 for Navigant's selection methodology for narrowing the list of CCBs for the on-site review. We divided the state into five regions and made recommendations for each region. We selected eight CCBs for Colorado Department of Health Care Policy and Financing ("the Department") staff to review and the Department chose the final five.

- Colorado Bluesky Enterprises (CBE)
- Eastern Colorado Services for Developmental Disabilities (ECSDD)
- Horizons Specialized Services (Horizons)
- Rocky Mountain Human Services (RMHS)

[1] Prior to conducting the desk review and the on-site visits, we conducted a cost survey to gather financial information about each CCB's Administrative, TCM and OHCDS functions. We included instructions to the survey and a list of commonly asked questions and answers to assist the CCBs in completing the survey. In addition, we requested from the CCBs policies and procedures, job descriptions related to each of the functions, and other financial documentation, such as audited financial statements and a working trial balance, to aid in our understanding of the overall picture of CCB operations.

- Foothills Gateway (Foothills)

The on-site visits were held March 29, 2016 through March 31, 2016. Each CCB was given a notification from the Department two weeks prior to their on-site visit, which briefly explained how the CCB was selected for the on-site review and requested documentation to support how the cost survey was completed. A week after the notification, we contacted each CCB to determine logistics for the visit, answer any questions or concerns, and provide a general overview of the questions we would ask and the purpose of the visit. We requested that each CCB have both the survey preparer and experienced employees responsible for performing TCM, Administrative and OHCDS functions available for interview.

Prior to the on-site review, we prepared a list of questions provided in Appendix E2. For each CCB, we also developed a customized set of questions specific to variations they reported in their FYE 2014 cost survey; these questions were intended to evaluate the reasonableness and accuracy of the data submitted, and explore outlier data, differences in allocation bases used to complete the survey, and varying cost information they reported. For each CCB, we interviewed the executive director, case managers, and the financial officer or other individuals who played a significant role in preparing the cost survey that was distributed by Navigant during the desk review.

Section II: Limitations of the On-site Review

Because the scope of work and budget for the project allowed on-site reviews with only five of the 20 CCBs, we were not able to conduct detailed discussions with every CCB to clarify the information they reported on the cost survey. As such, we cannot be sure of the completeness and validity of the reported CCB survey data from the 15 CCBs we did not visit. For example, three of the CCBs we visited incorrectly included all or some direct service costs in their cost survey. This information had to be corrected to determine the correct CCB revenues and costs and to determine the potential impact of separating TCM and direct service functions of the CCBs. During one site visit, we learned that the CCB had included in the cost survey all costs from its general ledger accounts instead of reporting only costs related to conducting Administrative, TCM and OHCDS functions as instructed.[2] We do not know how many of the other 15 CCBs may have made similar mistakes in their cost surveys, and therefore, cannot assume the data collected accurately reflect cost and revenue information for the three functions.

Section III: Summary of CCB On-site Review Findings

During the site visits, we asked each CCB to address the following three topics:

- Recommendations for CFCM implementation
- Operation of TCM, Administrative, and OHCDS functions
- Review of FYE 2014 reported costs to deliver the TCM, Administrative, and OHCDS functions

[2] Unfortunately, the CCB employee who could have updated the survey was out on long-term leave; therefore, this CCB's survey had to be excluded from the analysis.

Feedback on CFCM Compliance Options

The federal regulation for CFCM requires that an agency cannot provide case management and direct services to the same individual, with limited exception for rural areas.[3] To help guide CCBs' recommendations regarding CFCM compliance, we presented two options that would comply with the federal regulation:

1. CCBs must decide whether to provide TCM or direct services
2. CCBs may offer TCM and direct services, but not both to the same individual

The following summarizes CCBs' overall opinions of these two options.

CCBs Must Decide Whether to Provide TCM or Direct Services

Four out of five CCBs did not support the complete separation of TCM and direct services as part of the CFCM compliance plan. CCBs proposed various reasons for these positions. Two CCBs stated that complete separation is not person-centered as it does not allow individuals to have a choice in selecting a case manager and a direct service provider. No CCBs supported the idea of multiple independent case management agencies (CMAs). Some feared that independent CMAs would become a "revolving door" for case managers and individuals, potentially calling continuity of care into concern. They explained their fear that non-local CMAs who enter the market would not stay for very long because they would find the work to be challenging, and that these new CMAs would not have the local relationships necessary to effectively serve individuals and families. This potential turnover in CMAs could leave some individuals having to find a replacement case manager or to potentially have gaps in case management services if a replacement case manager cannot be found quickly.

CCBs also felt that an independent CMA's profit motive could lead to the deterioration of the personal relationships with individuals, with some believing that TCM will turn into a "number's game" in which the number of contracts will be valued more than the relationships formed. Lastly, they also believed that new independent CMAs would not have the local relationships and networks needed to provide individuals with adequate choice of providers.

The CCB that supported separation described case management as their "core competency" and believed it would be feasible to divest direct services. This CCB also stressed the need for the Department to review TCM rates and requirements so that TCM rates are sufficient to support a sustainable standalone business. Additionally, the CCB recommended allowing CMAs to serve individuals outside of the current CCB geographical restrictions.

When asked to identify whether their CCB had considered its options to provide TCM or direct services, three CCBs indicated they would choose to retain TCM and divest direct services. One CCB did not provide a response and one indicated it would choose the direct services option. During discussion, all CCBs were hesitant to identify a specific option, indicating their decision was dependent upon the Department's implementation plan.

Three of the five CCBs supported the rural exception option and wanted to see the Department pursue this option with CMS. If the Department is willing to pursue this option, they will need to determine if rural exception criteria from 42 CFR 441.301(c)(1)(vi) is met, which requires the Department to demonstrate "whether there is only willing and qualified

[3] The full CFCM requirements can be found in 42 CFR 441.301(c)(1)(vi).

entity to provide case management and/or develop person-centered service plans in a geographical area". Reason for the Department CCBs referenced "choice" for individuals receiving services and lack of "provider availability" as the most common reasons for supporting a rural exception pursuit by the Department. Two CCBs located in rural areas stressed that it would be difficult for individuals to find new providers in the new CFCM environment. Representatives from one CCB chose not to comment on the rural exception because this exception would not apply to them, though they did express a concern about provider availability in rural areas. Another CCB expressed that a rural exception may not be supported because other third party entities may be willing to provide case management in rural areas.

CCBs May Offer TCM and Direct Services, but not both to the Same Individual

We requested CCBs' opinion about the second CFCM option, which is to allow CCBs to keep both direct services and TCM, but not allow CCBs to provide both to the same individual. The CCBs that supported this option considered swapping the employees or individuals from neighboring CCBs to preserve existing relationships with case managers and direct service providers as much as possible. During conversations about CFCM options, all CCBs commented on the personal relationship case managers have with individuals and their families. While the amount of time spent between a case manager and individual varied based on the individual's needs, many CCBs attributed the strong emotional attachment to the long-term employment of the case managers.

General Comments about CFCM

Regardless of the CFCM option, CCBs offered the following comments that we summarized into three themes: the importance of oversight and training, the transition timeline and the desire for the grandfather clause.

Oversight and Training

CCBs unanimously expressed that adequate oversight and training would be the most significant elements for success of the new CFCM model. Frequent informational sessions would be necessary to ensure that individuals were aware of new TCM and direct service options and to ensure that individual choice is prioritized throughout the CFCM process. Also, Department oversight would be necessary to ensure that new providers and CMAs are properly qualified and understand the new CFCM delivery system. One CCB explained that new agencies will require more training from the Department than the current CCBs because they will not have historical knowledge of the program. For example, the CCB mentioned that it had implemented several trainings on person-centered planning and the billing process, and emphasized that the Department would need to make sure new case managers not only attended trainings, but were proficient. As the CCBs have been the "go-to" for all individuals with I/DD, new agencies entering the market will need to be trained on the three access point waivers, to include the services available in each, the definition of those services, and any specific waiver requirements. Additionally, new case managers will have to learn the eligibility determination requirements specific for I/DD waivers. CCBs also agree that there should be a training curriculum and certification for case managers, which would require the Department to develop this or find other programs used across the country.

Transition Period

Given the longevity of relationships between case managers and individuals, many CCBs

stressed that if the Department's CFCM implementation plan required an individual to choose between their direct service provider and case manager, some individuals would have a difficult time transitioning to a new case manager, if they chose to receive their direct services from the CCB. All CCB's felt that the CFCM compliance options presented would further restrict choice rather than encourage it, as each would result in some disruption to the current service delivery system. CCBs indicated that five to ten years would be an appropriate length of time to fully complete the transition to CFCM.[4] Other CCBs did not have a reason for estimating the time period for transition. One CCB did not find the emotional attachment between individuals and case managers to be as significant and felt that the transition period could be one or two years, arguing that personal relationships would be developed in an alternate CFCM system as well. However, three CCBs struggled to estimate a timeframe for CFCM compliance without knowing the specifics of Colorado's plan to address CFCM as it was not finalized at the time of the on-site visit.

Grandfather Clause

When considering the ideal CFCM implementation plan, two CCBs mentioned their support for a grandfather clause that would allow the individuals who are already in the system to keep their existing case managers and providers, and enforce the new plan only for newly eligible individuals. The CCBs stated that the grandfather clause would allow existing waiver individuals to opt-in to allowing their CCB to continue providing both TCM and direct services, while the CCB would still have to comply with CFCM for newly eligible individuals. However, CMS denied Ohio's request for this type of grandfather clause, so this is not a viable option for Colorado to pursue. 42 CFR 441.301(c)(1)(vi) states that the only time an individual can receive both case management and direct services from the same provider is when the state has been approved for a rural exception in that area.

[4] One CCB estimated a 10 year timeframe because they heard that Ohio was given 8 to 10 years to transition to CFCM. However, Ohio is planning a complete separation of TCM and direct service provision (that is, the county boards will no longer be able to continue providing both under any circumstances), which may account for the long timeframe that was approved by CMS.

CCB Comments on Administrative, TCM and OHCDS Operations

Another purpose of the on-site visits was to gather information about how each CCB organizes its operations to perform the TCM, Administrative, and OHCDS functions. During the on-site visits, we asked questions about how each TCM, Administrative, and OHCDS function is performed. At the outset of each on-site visit, we reminded the CCBs of the definition of each function as these were described in the cost survey distributed by Navigant. See Figure III.1 for the definition of the three functions. These definitions were set from the start of our work and will not change.

Figure III.1: Overview of Administrative, TCM and Administrative Functions

Administrative Function	Eligibility Determinations
	DD Determinations
	Supports Intensity Scale (SIS) Assessments
	Quality Assurance Functions
	Waitlist Management
TCM Function	Comprehensive Assessment and Periodic Reassessment of individual needs to determine the need for any medical, educational, social or other services
	Development and periodic revision of a specific care plan
	Referral and related activities to help a client obtain needed services
	Monitoring and follow-up activities that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs
OHCDS Function	Executing and maintaining a Medicaid Provider Agreement with the Department for all services available through the HCBS-CES (Children's Extensive Services), HCBS-DD (Developmental Disabilities) and HCBS-SLS (Supported Living Services) waivers
	Creating and maintaining documentation of all applicable direct service provider qualifications for services rendered under the Contractor's Medicaid Provider Agreement, whether those services are rendered by the contractor's employees or by a subcontractor

Administrative Function

In most instances, case managers are responsible for performing administrative functions in addition to their TCM responsibilities. Larger CCBs have separate enrollment departments and contractors that perform administrative functions. Case managers and others who perform the eligibility and DD determinations stated they spend a lot of "unfunded" time to complete their work, as there is a lot of back-end follow-up work for enrollment packages that is not billable to Medicaid.

Three CCBs reported they have a separate quality assurance department and personnel. While case managers are assigned to follow-up on quality assurance duties, such as investigation of the allegation of mistreatment or abuse, one CCB stated they cross-assign the case managers to prevent the individual's case manager from performing investigations for that individual.

Four CCBs said case managers play all or some role in waitlist management by maintaining required waitlist documentation, maintaining waitlist status information and notifying individuals when they have qualified to enroll in an access point waiver and begin receiving services. Only one CCB had separate personnel responsible for waitlist management duties.

CCBs stated that sometimes case managers will perform initial duties associated with waitlist management, such as notifying the individuals, then any questions regarding enrollment would move up the chain of supervisors for further discussion.

TCM Function

All TCM functions are performed by case managers and no CCBs reported using contractors or outside parties to perform TCM functions. The average caseload for case managers was 40, according to the desk review of the cost survey, and case managers felt that the ideal caseload did not vary from the average reported on the cost survey. Two CCBs felt that a caseload above 30 individuals per month would make it very difficult to manage their caseload efficiently, while others felt that 40 to 45 per month was a more suitable threshold. We found that those CCBs who were not tasked with performing administrative functions said they could handle a higher caseload.

All five CCBs expressed dissatisfaction with the current TCM payment rates and the annual cap on TCM (the waivers limit TCM to 240 15-minute units per year). They explained that many waiver individuals require more case management support than the cap allows, resulting in non-reimbursable time because they continue providing TCM to these individuals even after they have exceeded the limit. Some individuals, they said, exceed the TCM cap within the first half of the year. We were also told that CCBs must continue to provide adequate TCM even when an individual transfers from another CCB having exhausted their annual TCM limit.

OHCDS Function

OHCDS functions and job responsibilities varied for each CCB. OHCDS functions, including contract management and the monitoring of provider qualifications were primarily performed by the financial officer or executive director. One CCB said it has a separate department that creates contracts between independent contractors and the CCB, and a separate department that maintains and oversees independent contractors. All CCBs had their own process for subcontracting various services. For example, some perform background checks on subcontractors while others did not because they rely on the subcontractor's "reputation in the community." Some CCBs were confused about the OHCDS function and confused OHCDS activities with their role as a billing agent or as a direct service provider.

Section IV: Conclusion

This CCB feedback is important to the development of the CFCM implementation plan because they are currently responsible for all TCM functions for I/DD populations and play a major role in service delivery. Their knowledge of access point waiver policies and procedures will help to shape the details of the implementation plan that the Department and CCBs will use to comply with CFCM. The on-site visits allowed us to better understand how the CCBs completed the cost surveys, how they conduct TCM, Administrative and OHCDS functions, and their views about the potential impact of CFCM. Although each of the five CCBs had various opinions about how CFCM compliance should be achieved, there were several common themes that emerged from their input, which will be incorporated into the final CFCM implementation plan:

1. **Individual Choice:** CCBs want a plan that values individual choice and allows the

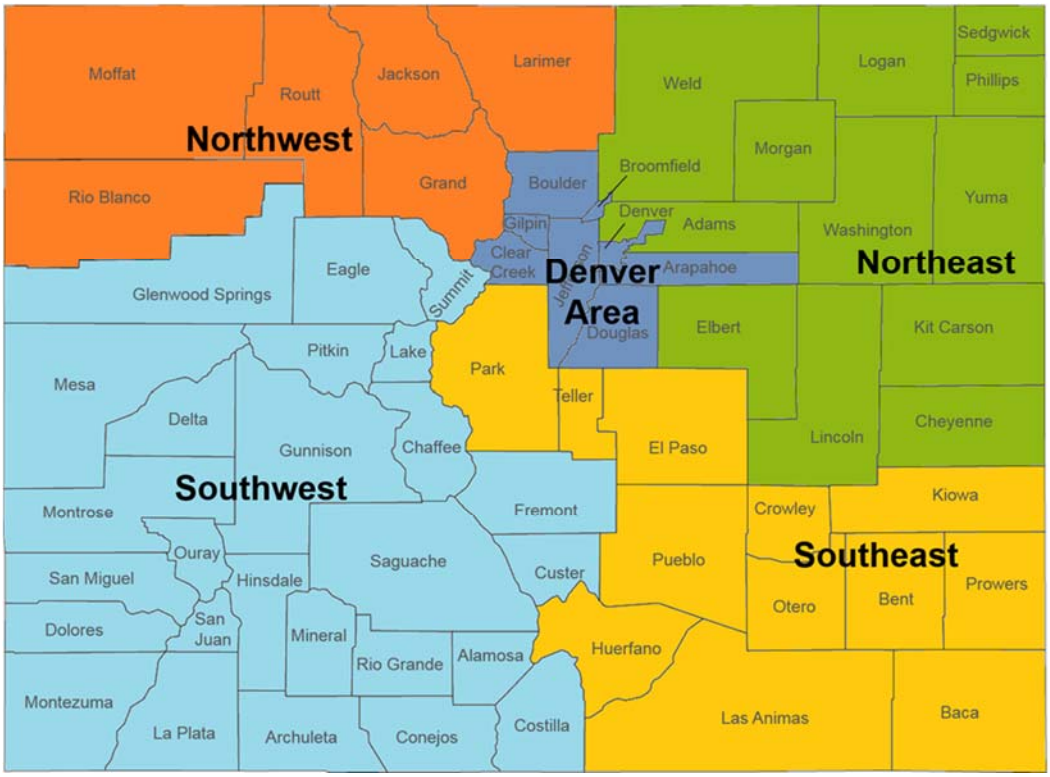
least amount of disruption to the current service delivery system. Specifically, they believe that individuals should have the right to choose both their TCM and direct service providers.

2. **Availability of Providers in Rural Areas:** While all five CCBs voiced concerns about provider availability overall, two rural CCBs stressed their concern that individuals currently receiving services in rural areas could risk losing the face-to-face interaction they currently receive from case managers who also live in their area. In addition, they said that CFCM compliance could result in less provider capacity for these individuals.
3. **Community Presence:** All five CCBs stressed their community ties, and long-term commitment to the community. They all felt a sense of pride serving individuals with intellectual and developmental disabilities.
4. **Oversight and Training:** All five CCBs expressed that training would be critical for individuals and new providers throughout the transition to CFCM. CCBs also wanted to make sure the Department had proper oversight of the qualifications and preparedness of new providers.

Appendix E1: Colorado On-Site Review Proposal

The Colorado Department of Health Care Policy and Financing (the Department) requested that Navigant make recommendations for on-site reviews of five (5) Community Centered Boards (CCBs) upon the completion of our desk review. The following document provides our recommendations for CCBs where we could conduct on-site reviews and a brief explanation for why each CCB should be considered. We divided the State into five regions and make 1-2 recommendations for each region. Our intention is to narrow this list through review and discussion with the Department to determine the final five CCBs to perform on-site reviews later in March 2016. In Figure A.1, we display the counties that comprise the five regions of the State that we considered for our determination for on-site review recommendations.

Figure A.1: Geographical Regions of Colorado Used in Desk Review Report and Selection of On-Site Review CCB Selection



Navigant's goal in recommending CCBs for on-site reviews was to select a mixture of large and small CCBs that covered the State geographically. The first three criteria highlight this goal. The remaining criteria are secondary items that we also considered in our selection of CCBs.

Geographical regions

Navigant assigned geographical regions based on our review of CCB locations.

We attempted to select one large CCB and one small CCB per geographical region. The exception to this rule is the Denver Area, where all CCBs were considered a large CCB.

Number of counties served by each CCB

We obtained County information from the CCB website:
https://www.colorado.gov/pacific/hcpf/community-centered-boards

We favored CCBs with higher numbers of counties served to be able to reach more of the State during our site visits to five CCBs.

Size of CCBs

We determined the size of the CCBs by using the number of Case Managers (CMs) and total Targeted Case Management (TCM) revenue reported in the cost survey for Fiscal Year End (FYE) 2014

We considered any CCB that had 20 or more Case Managers and reported more than $1 million of TCM revenue as a “large” CCB.

We determined there to be 9 large CCBs and 11 small CCBs

In Figure A.2, on the following pages, we provide a summary of CCB data considered for the on-site review determination, including revenue related to TCM. The data source for the information provided in Figure A.2 is the CCB responses from Navigant’s FYE 2014 CCB cost survey.

Figure A.2: Summary of all CCBs and Data Considered

	CCB Size	# of Access Point CMs	Total TCM Revenue	Admin Function Revenue	OHCDS Revenue	Counties	Geo. Region
1	Large	38	$1,932,038	$0	$0	Clear Creek / Gilpin / Jefferson / Summit	Denver Area
2	Large	78	$2,355,526	$1,576,652	$3,091,743	Arapahoe / Douglas	Denver Area
3	Large	34	$1,552,201	$526,409	$2,893,122	Boulder / Broomfield	Denver Area
4	Large	62	$40,464,150	$1,841,663	$5,501,240	Denver	Denver Area
5	Large	28	$1,169,724	$355,070	$0	Adams	Northeast
6	Small	11	$524,627	$72,424	$32,301	Cheyenne / Elbert / Kit Carson / Lincoln / Logan / Morgan / Phillips / Sedgwick / Washington / Yuma	Northeast
7	Small	19	$906,412	$228,539	$489,028	Weld	Northeast
8	Large	56	$1,942,983	$708,163	$6,067,821	Larimer	Northwestern
9	Small	5	$199,104	$30,359	$0	Grand / Jackson/ Moffat / Rio Blanco / Routt	Northwestern

Figure A.2: Summary of all CCBs and Data Considered

	CCB Size	# of Access Point CMs	Total TCM Revenue	Admin Function Revenue	OHCDS Revenue	Counties	Geo. Region
10	Large	30	$1,107,926	$369,309	$12,730,845	Pueblo	Southeastern
11	Large	36	$2,980,749	$87,204	$47,923	El Paso/Park /Teller	Southeastern
12	Small	5	$217,269	$3,364	$731	Huerfano / Las Animas	Southeastern
13	Small	3	$241,724	$41,709	$0	Crowley / Otero / Bent	Southeastern
14	Small	3	$100,000	$45,000	$0	Baca / Bent / Kiowa / Prowers	Southeastern
15	Large	17	$1,290,699	$143,411	$0	Mesa	Southwestern
16	Small	2	$49,674	$117,779	$4,173,203	Alamosa / Conejos/ Costilla / Mineral / Rio Grande / Saguache	Southwestern
17	Small	6	$259,424	$47,301	$40,000	Archuleta / Dolores / La Plata / Montezuma / San Juan	Southwestern
18	Small	6	$305,648	$76,637	$3,636	Delta / Gunnison / Hinsdale / Montrose / Ouray / San Miguel	Southwestern
19	Small	6	$576,480	$57,461	$72,466	Eagle / Garfield / Lake / Pitkin	Southwestern
20	Small	6	$327,646	$66,837	$1,523,330	Chaffee / Custer / Fremont	Southwestern

The following are secondary criteria that factored into our recommendations for consideration for on-site review. We considered:

- CCBs in which Case Managers/Service Coordinators are responsible for performing both Administrative and TCM functions. We reviewed organizational charts, job descriptions, and the CCB's policies and procedures to determine the employees responsible for performing TCM and Admin functions.
- CCBs that either did not provide OHCDS policies or OHCDS policies and procedures were unclear.
- CCBs that reported a higher than average (54) monthly case management case load.
- CCBs that we felt may have included direct services and support revenue with their OHCDS revenue.

We have organized the selected CCBs by geographical region, and recommend the following CCBs for consideration by the Department for on-site review.

Denver Area Selection

In addition to the City of Denver, Boulder, Gilpin, Jefferson, Arapahoe, Douglas, Summit, and Clear Creek counties are considered part of "Denver Area" for the purpose of this review. There are a total of four CCBs in the area, all of them are considered "large" CCBs. We have proposed two of these CCBs for consideration of an on-site review.

Rocky Mountain Human Services (Large CCB)

Rocky Mount Human Services is a large CCB located in Denver, Colorado. They serve the third most access point individuals of all CCBs. They reported the highest revenues of all CCBs. Rocky Mountain Human Services also was one of the CCBs that reported having separate intake and placement workers performing Administrative and intake functions. We were also unable to locate clear policies and procedures for the OHCDS function for this CCB. An on-site review would be beneficial because Rocky Mountain Human Services is one of the five largest CCBs.

Imagine (Large CCB)

Imagine is also a large CCB located in the Denver area. Imagine reported having separate intake case managers performing Administrative functions. They also were one of the few CCBs that provided OHCDS policies and information. Imagine represents a CCB that appears to understand the OHCDS function and would be valuable to review because they could provide a baseline for how we review the OHCDS for other CCBs.

Northeast Area Selection

The Northeast area covers Adams, Elbert, Cheyenne, Lincoln, Kit Carson, Washington, Morgan, and Yuma, Phillips, Sedgwick, Logan and Weld counties. There is one large CCB and two small CCBs that cover this area. We have proposed two CCBs for consideration of

an on-site review.

North Metro Community Services (Large CCB)

North Metro Community Services is a large CCB located in the Northeast area. They reported case managers having the fifth highest monthly case load. They also reported some overlap in which service coordinators were responsible for performing both Administrative and TCM functions. North Metro did not report any OHCDS functions. An on-site review would be beneficial to understanding the operations of a large CCB in the Northeast area. In addition, it would be helpful to understanding how and who is responsible for performing OHCDS functions at this CCB.

Eastern Colorado Services (Small CCB)

Eastern Colorado Services is a small CCB located in the Northeast area. This CCB covers the most counties out of all CCBs reviewed. Eastern Colorado reported case managers performing both Administrative and Case Management functions. However, they did not report on the average monthly case load per case manager. An on-site review would be beneficial to better understanding the operations of a small CCB that covers a large number of counties.

Northwest Area Selection

The Northwest area covers Larimer, Grand, Jackson, Routt, and Rio Blanco and Moffat counties. There are only two CCBs that cover the Northwest area, as such we selected one CCB to propose for consideration of an on-site review.

Foothills Gateway Inc. (Large CCB)

Foothills Gateway is a large CCB located in the Northwest area. Foothills Gateway had some overlap with case managers performing both Administrative and TCM functions. . They did not provide any OHCDS policy and procedure information. An on-site review would be beneficial to better understanding the operations of a large CCB in the Northwest area. In addition, we would use this review to obtain an understanding as to how OHCDS functions are performed.

Southwest Area Selection

Southwest area covers Garfield, Eagle, Pitkin, Lake, Chaffee, Fremont, Custer, Costilla, Alamosa, Conejos, Rio Grande, Saguache, Gunnison, Delta, Mesa, Montrose, Ouray, San Miguel, Dolores, San Juan, Hinsdale, Mineral, Archuleta, La Plata and Montezuma. The Southwest area covers the most counties in Colorado CCB geographical regions. There are six CCBs serving this area. Out of six, five of them are identified as a small CCB. We selected one large CCB and one small CCB to propose for consideration of an on-site review.

Mesa Developmental Services (Large CCB)

Mesa Developmental Services is a large CCB located in the Southwest area. They reported having some overlap with case managers performing some administrative functions. Despite being a large CCB, Mesa did not report any OHCDS policies and procedures or report any OHCDS revenue. An on-site review would be beneficial to obtaining a better understanding of Mesa's operations and to verify that the information on their survey is accurate. They were the only CCB to use the older version of the survey.

Mountain Valley Developmental Services (Small CCB)

Mountain Valley is a small CCB located in the Southwest area. They did not submit much documentation pertaining to the Administrative and OHCDS functions. As a result of this, we were unable to determine the employees responsible for performing these functions. In addition, they also reported having the highest average monthly case load for their case managers at 180 per month. An on-site review would be beneficial to gaining a better understanding as to how Mountain Valley Developmental Services performs the three functions.

Southeast Area Selection

Southeast Area covers Park, Teller, El Paso, Pueblo, Crowley, Kiowa, Otero, Bent, Prowers, Baca, Las Animas and Huerfano counties. There are five CCBs serving the area. We selected one large CCB and one small CCB to propose for consideration of an on-site review.

Colorado Bluesky Enterprises Inc. (Large CCB)

Colorado Bluesky Enterprises Inc. is a large CCB located in the Southeast area. They reported some overlap in which case managers are responsible for performing both Administrative and Case Management functions. We also believe that Colorado Bluesky included direct services and support information with their OHCDS information. However, they did not provide specific OHCDS policy and procedure information. An on-site review would be beneficial to verifying and understanding how the OHCDS function is performed and for verifying the financial data that was received. It also would allow us to obtain a better understanding of how this CCB operates in the Southeast area.

Southern Colorado Developmental Disabilities Services (Small CCB)

Southern Colorado Developmental Disabilities Services is a small CCB located in the Southeast area. They were the only CCB not included in the initial draft of the desk review report because we received their information after February 10, 2016. Southern Colorado also reported having the third highest average monthly case load for their case managers. Performing an on-site review at this CCB would be beneficial because we would be able to perform an in-depth review of a CCB that was not included in the CCB Desk Review Report.

Appendix E2: CCB Interview Questions

List of Guiding Questions for CCB Interviews

Navigant prepared this list of questions to guide the conversations with the CCBs during on-site visits. This list was not shared with the CCBs prior to our meeting. Depending on the flow of the conversations and answers from the CCBs, not all questions were discussed. There were also additional clarifying questions discussed during the meeting that are not part of the below list.

CCB Survey Overview Questions

1. Can you explain your role within the CCB, are you responsible for performing any of the three functions (per our survey she is not, but we would verify during the interview)? If so, can you explain your role?
2. What basis was used to allocate revenue and costs to the three functions? (For example, did you use the financial statements and simply estimate, did you use a square footage approach, did you estimate the time spent by employees, do you already track revenue and expenses to this amount of detail, etc.)
3. Other than allocating costs and revenues to the three functions, were there any other challenges encountered when completing the CCB Survey?
4. Overall, in relation to the operations of the functions, was there any financial item that was not captured in this survey that you felt should be captured?
5. Is there any data in the cost survey that should be corrected?

Targeted Case Management Functions

1. In addition to TCM activities performed, are you responsible for performing any Administrative and/or OHCDS functions?
2. Can you describe some advantages of being responsible for performing both TCM and Administrative or intake functions?
3. Can you describe some negatives that come along with performing both TCM and Administrative or intake functions?
4. Could you estimate using a 40 hour week as the basis, how much time is devoted to performing both TCM and Administrative functions?
5. Targeted Case Management includes performing TCM assessments, service plan development, service plan monitoring, and information/referral. Estimate using a 40 hour work week, how much time is spent performing these activities. Which activity is the most time consuming? Which activity is the least time consuming?
6. Do you provide Case Management services for individuals enrolled in other waivers? If so, estimate how much of your time is devoted to serving individuals in other waivers?
7. Can you specify the job responsibilities that come with having an individual case load? What activities are you responsible for? What would be the ideal caseload?
8. Are you responsible for performing any OHCDS functions?
9. Can you provide some examples of the types of quality assurance and case management monitoring activities you perform?
10. Approximately what percentage of your time is allocated between helping new

individuals v. continuing monitoring functions for existing CCB individuals?

Administrative Function

1. Please explain how the eligibility determination process works at your CCB. Who is responsible for performing eligibility determinations? How do prospective individuals connect with your CCB?
2. Is there ever a time in which an outside entity would be responsible for performing an eligibility determination?
3. Please explain the process for determining if a person has a developmental disability/delay.
4. When would an outside party perform a DD eligibility determination?
5. Can you explain the process for performing SIS assessments?
6. What are considered quality assurance functions? Who is responsible for performing these activities?
7. Is there any period of time in which an outside entity or party would perform these activities?
8. Can you explain your waitlist management process? Specifically, when are individuals placed on the waiting list? How are they removed? Who is responsible for keeping the waitlist updated? How often is the waitlist updated?
9. What are the reasons in which an individual would be on a waiting list?
10. Are there any other enrollment activities performed that are not covered under TCM or that we have not covered so far?

Conflict Free Case Management Questions

1. Based on your personal experiences working with the CCB, what do you feel would be the best way for CCBs to transition to providing conflict free case management?
2. From your estimation, how long would it take for individuals to transition in a scenario in which CCBs could not provide both case management and direct services? What do you feel would be the best way to transition individuals?
3. How do you feel about the creation of independent case management agencies who would be solely responsible for performing Targeted Case Management? What potential challenges do you see with the creation of this new market sector?
4. What do you feel would be most important in the creation of this new market sector for independent case management agencies?
5. What do you think about the potential for another agency or entity administering TCM to individuals in rural locations? What advantages or disadvantages might there be?

CFCM Option 1

Agencies must decide whether to provide case management or HCBS direct services.

1. What is your overall opinion of this proposal? What benefits and/or potential

shortfalls do you foresee with this arrangement?

2. Based solely on financial information, many CCBs may elect to no longer perform case management services. How do you think this would affect you if implemented?

CFCM Option 2

Agencies may offer case management and HCBS but not both to the same individual.

1. What is your overall opinion of this proposal? What benefits and/or potential shortfalls do you foresee with this arrangement?

Appendix F: Conflict-Free Case Management Stakeholder Engagement Report

Colorado Department of Health Care Policy and Financing

Conflict-Free Case Management Stakeholder Engagement Report

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Table of Contents

Section I: Background

The Colorado Department of Health Care Policy and Financing (the Department) contracts with 20 Community Centered Boards (CCBs) that provide access to long-term services and supports through Medicaid Home and Community-Based Services (HCBS) 1915(c) waivers. The 20 CCBs function to determine eligibility for services for individuals with intellectual and developmental disabilities, provide case management services and either directly provide or subcontract services and supports. The CCBs also execute entry point functions, such as determining waiver eligibility and providing information and referrals for service. The CCBs serve as the access point for the following reviewed HCBS waivers (referred to as access point waivers throughout this report):

- Home and Community-Based Services Children's Extensive Support Waiver (HCBS-CES)
- Home and Community-Based Services Waiver for Persons with a Developmental Disability (HCBS-DD)
- Home and Community-Based Supported Living Services Waiver (HCBS-SLS)

CCBs operate as a "one-stop shop," where an individual with an intellectual and/or developmental disability works with a CCB, designated by geographical location, that will determine eligibility for services, create a service plan, and help the individual obtain services. The access point waiver enrollment process begins with a determination by the CCB of whether the individual has an intellectual and/or developmental disability and are therefore eligible to receive services. If eligible for services, the individual works with a case manager from the CCB to determine the scope of services and supports needed to meet his or her long-term needs. Individuals seeking access to 24 hour support waiver services are placed on a waiting list before they can receive waiver services, as a result of funding constraints. After the waiting process (if necessary), the individual then works with their case manager to coordinate services. Services are provided either directly by the CCB, via a sub-contracted service agency or individual, or by an approved Medicaid provider.

In March 2014, the Centers for Medicare and Medicaid Services (CMS) instituted *42 CFR 431.301* requiring states to separate case management from service delivery functions to reduce conflict of interest for services provided under 1915(c) waivers. This rule addressed conflicts of interest that arise when one provider is responsible for performing both case management functions and providing direct services. CMS provided numerous examples of potential conflicts resulting from such arrangements, including:

- Over- and under-utilization of services
- Interest in retaining individuals as clients rather than promoting independence
- Instances where the focus is not person-centered

As a result of this ruling, Colorado's existing CCB structure is no longer compliant with CMS regulations as case managers have been in positions in which they were responsible for settling

grievances and monitoring direct services provided by fellow CCB staff members. The Department had already convened a Task Group of stakeholders in February 2014 to make recommendations for implementing choice of case management agency, and expanded its scope to include recommendations for a conflict free case management system. Colorado *House Bill 15-1318* requires the Department to develop a plan, with input from CCBs and other stakeholders, for the delivery of conflict free case management that complies with Federal regulations.

As part of this process, the Department contracted with Navigant Consulting Inc. (Navigant) to assist with the development of a conflict-free case management (CFCM) implementation plan. Navigant developed a draft implementation plan to be reviewed during stakeholder engagement meetings held throughout the State to garner feedback and input from stakeholders. The sections that follow provide a summary of the stakeholder engagement conducted by Navigant.

Section II: Methodology

The Department requested that Navigant develop a plan for implementing CFCM in Colorado. This plan was developed in several steps, with each step intended to contribute to its development. The first step of our work comprised the desk review that required collecting documentation of costs and functions from Community Centered Boards (CCBs) and reviewing the information submitted. For step two, we used the desk reviews to propose five CCBs for on-site review and conducted those reviews. At the conclusion of the on-site reviews, we created a draft version of the proposed implementation plan for transitioning Colorado's three intellectual and developmental disabled (I/DD) waivers to CFCM based on information collected during the desk reviews, CCB on-site meetings, meetings with CCB Executives, and town hall meetings held by the Department in March 2016.[1] In step three, we attended Community Stakeholder Engagement meetings along with Department staff to obtain feedback on the proposed CFCM implementation plan from individuals, families, guardians, advocates, CCBs, providers, and other stakeholders. Step four will be the development of a final report that will aggregate all of our findings from the first three phases along with the Department's meetings with CCB Executives and town hall meetings and provide a plan for implementation to the Department regarding CFCM. Figure II.1, demonstrates the four steps of our study.

Figure II.1: Steps of Navigant's Study

[1] The Department held 15 town hall meetings in March 2016 and provided a summary of these town hall meetings for Navigant to review prior to drafting the implementation plan.

This report summarizes the feedback received during the stakeholder engagement. The purpose of the stakeholder engagement was to present a draft implementation plan and receive feedback from individuals, families, guardians, advocates, CCBs, Single Entry Point agencies, and other stakeholders, to consider their input during development of the final recommendations and implementation plan. Upon conclusion of step two, we worked with the Department to create an outline of the draft plan. To create this draft plan, we referred to several reports regarding conflict of interest in Colorado's system serving individuals with intellectual and developmental disabilities. Those reports included the University of Southern Maine's 2007 report titled, "Addressing Potential Conflict of Interest Arising from the Multiple Roles of Colorado's CCBs", and the "Conflict of Interest Task Force Report" issued by the Department in September 2010, and the "Report of the Task Group on Conflict Free Case Management" issued in October 2014. We presented the draft plan and background on CFCM in PowerPoint format at the stakeholder engagement meetings. See Appendix F1 for a copy of the PowerPoint slides.

The Department was responsible for informing the public about the CFCM stakeholder meetings and selecting locations for the meetings. The meetings were held in four separate cities (Pueblo, Greeley, Denver, and Glenwood Springs) April 25 through April 28, 2016, with two Department representatives and two Navigant employees in attendance at each. The Department also held a webinar on April 26, 2016, for those who could not attend the meetings in person. Overall, there were 186 attendees across the five meetings, including individuals, family members, advocates, CCB representatives, case managers, and other providers. Each meeting lasted two hours, allowing at least an hour for stakeholders to provide feedback. In Figure II.2, we provide a summary of the meeting details and attendance.

Figure II.2 Summary of Stakeholder Meetings

Pueblo	•April 25, 2016, 2-4 PM •53 Attendees
Greeley	•April 26, 2016, 1-3 PM •35 Attendees
Statewide Webinar	•April 26, 2016, 6-8 PM •42 Attendees
Denver	•April 27, 2016, 2-4 PM •40 Attendees
Glenwood Springs	•April 28, 2016, 6-8 PM •16 Attendees

During the feedback sessions, the Department specifically solicited feedback on:

- What aspects of the implementation plan stakeholders believed would work

- What aspects of the implementation plan stakeholders believed would not work
- What was missing from the implementation plan

This report summarizes the stakeholders' comments obtained at the Community Stakeholder Engagement meetings.

Section III: Summary of the Stakeholder Meetings

The following pages summarize the most commonly received comments, which were mentioned during three or more separate stakeholder meetings.

Person-Centeredness and Choice

Stakeholders agreed that CFCM should involve a person-centered philosophy that prioritizes individuals' choices of providers and case managers. Stakeholders emphasized the importance of having a sufficient number of high quality providers available to offer individuals as much choice as possible. However, one stakeholder commented on the tension that exists between CFCM and person-centeredness and choice because CFCM compliance could prohibit some individuals from keeping the same providers and case managers, even if that is their preference.

Provider Capacity and Qualifications

Stakeholders also agreed that provider capacity is an issue, and in order to increase capacity, one participant commented that the Department should more actively recruit providers under the new system. During recruitment, the Department should clarify billing processes to ensure that independent contractors can understand any changes made because individuals and families would like to see the independent contractor services continue.

Stakeholders commented that they want access to not just any provider, but to quality providers. One commenter stated that it is very difficult to find providers who are willing to serve their rural community and one provider was only willing to work with individuals with specific Support Levels. Stakeholders emphasized that the Department should make an active effort to recruit providers and complete a thorough provider capacity study prior to implementing CFCM.

Stakeholders also requested more details on the new qualification requirements for the case management agencies (CMAs). They also expressed the importance of case managers having a local presence to understand the provider availability and how to match individuals' needs with community offerings.

Rural Exception

Stakeholders in rural areas showed strong interest in the option to apply for a rural exception from the Centers for Medicare and Medicaid Services (CMS) so that existing relationships

between individuals and CCBs can continue. All stakeholders agreed that a thorough evaluation of provider availability would be necessary to determine if rural exception would be an option for Colorado. Stakeholders asked for clarification on CMS rules with respect to the rural exception, and also asked several clarifying questions that included:

- What is the definition of rural exception?
- What is the process of applying for rural exception?
- What data will be required?
- What will happen after CMS approves or denies the rural exception?
- What areas will be impacted? Will this impact the entire state?
- How will CCBs' roles change upon approval of the rural exception?
- What is the status of the rural exception application?
- How often will CMS revisit this?

Consideration for Separating TCM and Direct Services

One participant who supported full separation said that it was necessary to avoid self-policing because CCBs currently investigate their own agency for allegations of mistreatment, abuse, neglect, and exploitation. However, some stakeholders were concerned that full separation would lead to new providers or case managers that either do not know the area well, do not care about the individuals as much as the existing case managers, or both. This sentiment was stronger in the rural areas, where we heard from individuals, families, case managers and CCB representatives about their satisfaction with the existing system. Case managers in rural areas stated that because of low reimbursement rates and a high cost of living, they fear there will be constant turnover in CMAs and direct service agencies that may leave individuals without services. These case managers questioned if a new case manager from another town would feel as strongly about the community and families as they would. One stakeholder from a rural area stated that the separation of TCM and direct services might not matter as long as the existing case manager is still working with them, but is employed by another agency.

In addition, stakeholders commented that individuals and families should not be left with the burden of finding a new case manager or direct service providers on their own if their CCB decides to divest itself of either TCM or direct services. Stakeholders requested that the Department develop a plan to assist individuals and families throughout the process.

Considerations for Allowing CCBs to Offer Both TCM and Direct Services, But Not to Same Individual

In response to the option for CCBs to continue offering TCM and direct services, but not to the same individual, stakeholders expressed concern that CCBs in close proximity to each other would simply trade individuals between their agencies. Stakeholders stressed the importance of allowing individuals to have the option to choose which agencies they want to use for TCM and direct services. Two participants explicitly stated they did not want to see this option offered to CCBs and felt that it is still a conflict of interest, while another felt that it would be a compromise and noted that there are others who supported this option.

Quality Assurance and Enforcement

Many stakeholders commented on the need for the Department to actively enforce the CFCM rules since they are in effect. One stakeholder commented that the proposed implementation plan gave too much latitude to the CCBs, relied too heavily on their business continuity plans and stressed that there should be consistency in how the CFCM compliance is carried out across the State. Another stakeholder commented that there must be some accountability for CCBs that do not follow the CFCM implementation plan.

Other stakeholders suggested the existing quality assurance activities under the administrative functions needed a higher degree of separation. Stakeholders felt existing rules did not allow independence in investigating allegations because case managers and providers could be part of the same CCB. One person suggested using Single Entry Point (SEP) agencies instead of case managers to investigate abuse allegations and conduct incident reporting.

One stakeholder stated an integrated case management system should be used for quality assurance by adding data fields to track the progress of CFCM activities. Another suggestion for quality assurance and enforcement was to review all existing documents related to I/DD services, not just statutes and regulations, and to rescind any documents that do not comply with CFCM.

CFCM Funding and Transition Timeline

Stakeholders asked questions about how the CFCM implementation plan would be funded. They specifically wanted to know where the funding would come from and how the Department will be able to carry out the implementation plan with its existing number of staff. They noted that existing staffing levels at the Department should be reviewed before carrying out the implementation plan. Some stakeholders also expressed concern that the four to six year timeframe for transitioning to CFCM is too long and suggested that this be shortened in the proposed implementation plan. One participant suggested incentives for CCBs to start the CFCM transition immediately.

Communication and Evaluation

Many stakeholders commented on the need for clear communication from the Department and to be able to provide feedback throughout the process. One stakeholder suggested adding an "evaluation" component to the implementation plan where the Department solicits feedback

from families as part of each phase. Another stakeholder suggested the Department designate a family communication liaison who would be assigned to communicate with individuals and families, so that communication comes directly from the Department instead of another entity, such as their local CCB.

Stakeholders also commented on using online communication methods. One commenter recommended the Department create a marketing kit, media kit or both that can be distributed through social media. Another suggested improving visibility of the existing CFCM webpage on the Department's website so it is easier to locate, noting that it is currently difficult to locate the Colorado CFCM website without using a search engine.

Reimbursement Concerns

Stakeholders in some rural areas stated that one of their biggest challenges is finding willing providers because these areas often have a very high cost of living. With the existing rates and system, many providers do not see some rural areas as profitable.

Several stakeholders also asked whether the Department plans to review the annual TCM cap in light of the proposed changes. Some case managers stressed that they often spend more time with individuals and families than what is billable under the annual TCM cap, and that they have often taken another job to make ends meet. Furthermore, they mentioned that case managers would likely incur costs and added time related to establishing new CMAs and taking on new individuals in their caseloads, including costs associated with time spent for new case managers to get to know individuals and families. Stakeholders were concerned this time would exceed the existing cap of 240 units.

Other Notable Comments

A few stakeholders requested the Department publicize a full draft copy of the implementation plan before it is sent to the State Legislature. Two participants asked how the waivers that are in the process of being combined and/or updated and the Colorado No Wrong Door (NWD) initiative would play a role in the CFCM transition and requested the Department use existing systems, like NWD, if possible. One commenter suggested the Department consider conducting a cost impact analysis to determine what the lost revenue would be for CCBs and how much it would cost CMAs and direct service providers to open new agencies and locations as part of the implementation plan.

Section IV: Conclusion

Overall, we heard the following comments from stakeholders that will be considered during development of the final CFCM implementation plan.

1. **Feedback and Communication:** Communication between the Department and individuals and families will be critical in a successful CFCM transition. Stakeholders

made suggestions about hiring communication personnel for the Department, reviewing website and social media related materials, and being able to provide regular feedback to the Department.

2. **Provider Availability and Qualification:** Stakeholders want assurance that the future CFCM system will ensure not just having an adequate number of providers to choose from, but also high quality providers. They were interested in the new provider qualification rules for TCM and direct service providers.
3. **Quality Assurance and Enforcement:** The Department should be able to enforce the CFCM transition plan and be able to hold CCBs, CMAs and providers accountable for the timelines. As part of the enforcement and quality assurance, stakeholders suggested that some of case managers' existing quality assurance functions – such as investigating suspected abuse and fraud – be reassigned to another agencies like SEPs and NWDs that are in development.
4. **Timeline and Rural Exception:** Some who supported the complete separation of TCM and direct services thought the implementation timeline could be shortened, believing the proposed 4 to 6 year timeframe to be too long. Many attendees in rural areas supported the rural exception application, and expressed their satisfaction with the current case management and service delivery structure.
5. **Reimbursement Concerns:** Some stakeholders mentioned that reimbursement rates and the existing cap on TCM should be reviewed when recruiting new CMAs and providers to ensure that rates are sufficient to sustain operations.
6. **Information Gathering:** Stakeholders recommended the Department conduct provider capacity studies and a cost impact analysis. Through these studies, stakeholders want to better understand what providers are available throughout the State and the cost impact of separating functions at CCBs, including how much it would cost for new CMAs and providers to establish themselves.

Appendix F1: Colorado Stakeholder Engagement Presentation

CONFLICT-FREE CASE MANAGEMENT IMPLEMENTATION PROPOSAL

STATEWIDE STAKEHOLDER MEETINGS
APRIL 2016

NAVIGANT

OVERVIEW

- Review background information about Conflict-Free Case Management (CFCM) rules from the Centers for Medicare and Medicaid Services (CMS)
- Clarify commonly used language and definitions related to CFCM
- Review the draft proposal of the implementation plan
- Q&A session

INTRODUCTIONS

Navigant Consulting, Inc.

We are healthcare consultants with more than 25 years of experience working with public payers in the areas of payment system design, cost reporting and analysis for institutional and non-institutional providers, program evaluation, healthcare reform, the development and financing of consumer-directed services and managed care systems.

We provide consulting services related to policy and reimbursement for HCBS services for:

- Arizona
- Colorado
- Centers for Medicare and Medicaid Services (CMS)
- Illinois
- Minnesota
- Nebraska
- North Dakota
- Texas
- Wyoming

NAVIGANT'S WORK – DESK REVIEW

- Collect data from each Community Centered Board (CCB) about the operations and costs for performing Targeted Case Management (TCM), Administrative, and Organized Health Care Delivery System (OHCDS) functions for the three intellectual/developmental disabilities waivers
- With this data:
  - Evaluate the revenue and costs associated with performing each of these functions
  - Evaluate each CCB's process for performing the aforementioned functions
  - Project the impact (both financial and recipient impact) of separating these functions
  - Objectively report the requested CCB information provided to the Department Leadership
  - Additional cost survey data received during site visit is still being reviewed and the report for desk review is not yet final

NAVIGANT'S WORK – ON-SITE REVIEW

- Two teams of two consultants visited five on-site locations from March 29 through March 31
- Agenda for on-site visits
  - Lead detailed discussion of cost survey responses
  - Enhance understanding of CCB operations for TCM, Administrative and OHCDS functions through discussion
  - Gather CCB's concerns and best practice suggestions for the Department regarding for CFCM implementation

BACKGROUND INFORMATION

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WHAT IS CONFLICT-FREE CASE MANAGEMENT (CFCM)?

- CMS issued conflict of interest requirements in the rule for 1915(c) Home and Community Based Services (HCBS) waivers:

  Requirements at *42 CFR 441.301(c)(1)(vi*)

- Per CMS, States are required to separate case management (person-centered service plan development) from service delivery functions[1]

  Conflict occurs not just if an entity is a provider, but if the entity has an interest in a provider or is employed by a provider [1]

[1] This information is from CMS training titled “Conflict of Interest Rules in Medicaid Authorities”, which was conducted by CMS on January 13, 2016. See Sources slide in this presentation for a link to the CMS training.

WHY IS CFCM NECESSARY? [1]

- Per CMS, when the same entity helps individuals gain access to services *and* provides services to that individual, there is a conflict of interest (COI)
- CFCM addresses the possible COI issues related to the following:
  - Oversight of quality and outcomes. "Self-policing" occurs when an organization is charged with overseeing its own performance and creates a COI
  - Fiduciary relationship COI
    - Incentives for either over- or under-utilization of services.
    - Possible pressure to steer the individual to their own organization
    - Possible pressure to retain individual as a client rather than promoting choice, independence and requested or needed service changes
- CFCM ensures and honors free choice for individuals

[1] This information is from CMS training titled "Conflict of Interest Rules in Medicaid Authorities", which was conducted by CMS on January 13, 2016. See Sources slide in this presentation for a link to the CMS training.

CLARIFICATION OF COMMONLY USED TERMS

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CLARIFICATION OF COMMONLY USED TERMS

- Clarify seven terms that are essential in understanding CFCM
- Definitions come from CMS and Code of Federal Regulations (CFR)
- List of seven terms clarified:
  - Choice
  - Person-Centeredness
  - Targeted Case Management (TCM)
  - Administrative functions
  - Organized Health Care Delivery System (OHCDS) functions
  - Rural exception
  - Conflict of Interest (COI) rules for HCBS waivers

WHAT IS CHOICE? [1]

- Full freedom of choice of types of supports and services and individual providers except where the program has authorized restrictions (such as managed care)
- Case manager is responsible for helping the individual and family become well-informed about all choices that may address the needs and outcomes identified in the person-centered service plan
- COI may result in conscious or unconscious “steering,” which can reduce choice
  - Examples of steering include; directing individuals to a certain direct service provider due to personal bias, ownership interests in other providers, and/or any financial incentives

[1] This information is from CMS training titled “Conflict of Interest Rules in Medicaid Authorities”, which was conducted by CMS on January 13, 2016. See Sources slide in this presentation for a link to the CMS training.

WHAT IS PERSON-CENTEREDNESS?

- Person-centered components incorporate information about interests, relationships, preferences, strengths, and outcomes desired for his/her life as a result of LTSS [2]
- Person-centeredness is a core requirement in service planning and plan development for all 1915(c) waivers
- *42 CFR 441.301(c)(1)* details person-centered planning process.
- A person-centered planning process:
  - Assures the individual will lead the person-centered planning process
  - Allows the individual's representative to have a participatory role
  - Includes people chosen by the individual
  - Gives individuals the necessary information and support to ensure they are directing the process
  - Offers informed choices to the individual
  - Includes a method for the individual to request updates to the plan
  - Includes conflict of interest provisions, if such exists, such as conflict of interest in case management
  - Results in a person-centered service plan

WHAT IS TARGETED CASE MANAGEMENT (TCM)?

- Four components of TCM:
  - Comprehensive Assessment and Periodic Reassessment of individual needs to determine the need for any medical, educational, social or other services
  - Development and periodic revision of a specific care plan
  - Referral and related activities to help a client obtain needed services
  - Monitoring and follow-up activities that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs
- In Colorado's intellectual/developmental disabilities waivers, TCM is billed in 15 minute units with a 240 annual unit cap per individual

WHAT ARE ADMINISTRATIVE FUNCTIONS?

- Eligibility Determinations
- DD Determinations
- Supports Intensity Scale (SIS) Assessments
- Quality Assurance Functions
  - Review and resolution of complaints and grievances
  - Quality Improvement Strategy activities and reporting
  - Incident Reporting and Responses
  - Establishment and participation in a Human Rights Committee (HRC)
  - Investigation and documentation of mistreatment, abuse, neglect and exploitation allegations
- Waitlist Management

WHAT ARE ORGANIZED HEALTH CARE DELIVERY SYSTEM (OHCDS) FUNCTIONS?

- Executing and maintaining a Medicaid Provider Agreement with the Department for all services available through the HCBS-CES (Children's Extensive Services), HCBS-DD (Developmental Disabilities) and HCBS-SLS (Supported Living Services) waivers
- Creating and maintaining documentation of all applicable direct service provider qualifications for services rendered under the Contractor's Medicaid Provider Agreement, whether those services are rendered by the contractor's employees or by a subcontractor
- Complying with *42 CFR 447.10*, et sq

  Includes further details about why OHCDS exist

WHAT IS A RURAL EXCEPTION?

For 1915(c) HCBS Waivers, CMS defines rural exceptions at *42 CFR 431.301(c)(1)(vi):*

> "Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS. In these cases, the State must devise conflict of interest protections including separation of entity and provider functions within provider entities, which must be approved by CMS. Individuals must be provided with a clear and accessible alternative dispute resolution process."

COI UNDER HOME- AND COMMUNITY-BASED SERVICES WAIVERS[1]

When COI is present, states must:

- Demonstrate to CMS that the only willing and qualified case manager is also, or is affiliated with, a direct service provider
- Provide full disclosure to individuals and assurances that individuals are supported in exercising their right of free choice in providers
- Describe individual dispute resolution process
- Ensure that entities separate case management and service provision (different staff)
- Ensure that entities provide case management and services only with the express approval of the State
- Provide direct oversight and periodic evaluation of safeguards

[1] This information is from CMS training titled “Conflict of Interest Rules in Medicaid Authorities”, which was conducted by CMS on January 13, 2016. See Sources slide in this presentation for a link to the CMS training.

DRAFT PROPOSAL FOR CFCM IMPLEMENTATION PLAN

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WHAT WILL CFCM MEAN FOR COLORADO?

- Transition of all of the Colorado HCBS waivers to being conflict-free

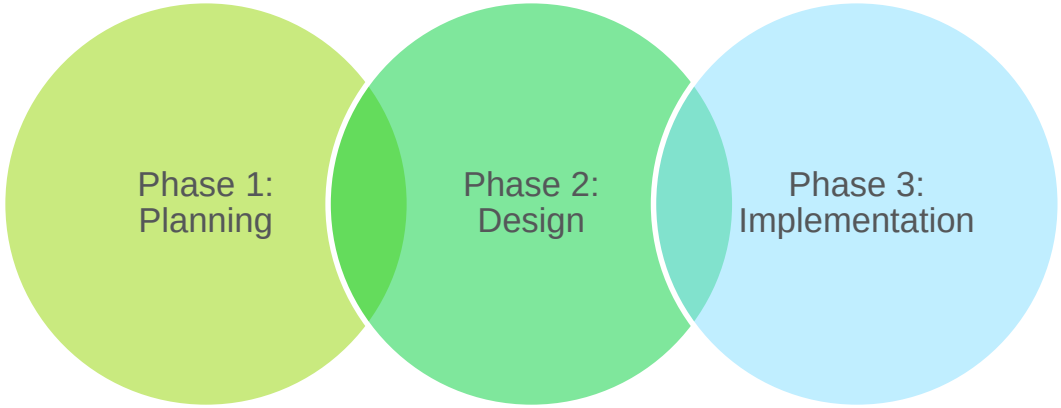
- Changes in the way that CCBs deliver and perform TCM, Administrative and OHCDS functions

- Separation of TCM from Direct Service Provision
  - CCBs have the option to operate both direct service and TCM. However, CCBs cannot provide both to the same individual
  - May foster the creation of additional case management agencies who will provide TCM activities for the State

- Implementation could impact who provides the administrative function, fostering the creation of additional entities responsible for performing administrative activities including eligibility determinations and on-going monitoring activities

DRAFT PROPOSAL FOR TRANSITION TO CFCM FOR I/DD WAIVERS - OVERVIEW

- *This is a draft proposal*
- Three phases for transition to CFCM



- Expect phases to overlap
- Total *estimated* transition time: 4 – 6.5 years
- A few tasks, such as the ones that require legislative or budget approval, could take longer than estimated
- The final implementation plan will recommend deadlines and will include number of days from major legislative approval, instead of a set date

DRAFT PROPOSAL FOR TRANSITION TO CFCM FOR I/DD WAIVERS - OVERVIEW

- Under each implementation phase, there are four categories of consideration:
  - Regulatory and Policy Changes
  - Provider Development and Outreach
  - Communication Priorities
  - Tracking Mechanisms

- Each category highlights specific responsibilities
  - CCB responsibilities
  - State/Department responsibilities
  - Actions that require legislative review and approval

- Throughout the implementation phase, the Department will review any CCB reporting requirements and provide technical assistance to individuals, families, CCBs, and direct service providers

DRAFT PROPOSAL FOR TRANSITION TO CFCM FOR I/DD WAIVERS – PHASE 1: PLANNING

Phase

Phase 1: Planning

Timing

Estimated timeframe: 2 – 3 years

Key Activities

REGULATORY AND POLICY CHANGES

- ✓ Review statutes and regulations
- ✓ Work with CMS to apply for Rural Exception and submit waiver amendment
- ✓ Request input from stakeholders regarding the Rural Exception application
- ✓ Review existing CCB designation written in statute
- ✓ Submit TCM rates for consideration by the Department Medicaid Provider Rate Review Committee
- ✓ Review TCM process across all waivers
- ✓ Conduct on-site visits with remaining CCBs (15)

PROVIDER DEVELOPMENT AND OUTREACH

- ✓ Review and define CCBs and Case Management Agency qualifications
- ✓ Review direct service provider qualifications across all waivers
- ✓ Develop scope of work and RFP for new case management entities
- ✓ Develop ongoing outreach plan for providers
- ✓ Conduct provider outreach and technical assistance for enrollment and claims submission

COMMUNICATION PRIORITIES

- ✓ Establish communication protocols and a communication plan for regular updates to individuals, families, advocates, CCBs, Case Management Agencies, direct service providers, legislators and other stakeholders
- ✓ Define the role and staff CFCM communication liaison(s) at the Department
- ✓ Create regularly scheduled training and education sessions for the individuals, families, advocates, CCBs, Case Management Agencies, and direct service providers

TRACKING MECHANISMS

- ✓ Validate business continuity plan requirements for CCBs
- ✓ Calendar target dates for CCBs to report progress
- ✓ Develop a risk matrix to determine the lowest risk target groups to transition first
- ✓ Consider options for an integrated case management system across the I/DD waiver providers and case management agencies

Milestones that require CCB action
Milestones that require legislative action

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DRAFT PROPOSAL FOR TRANSITION TO CFCM FOR I/DD WAIVERS – PHASE 2: DESIGN

Phase

Timing

Key Activities

Phase 2: Design

Estimated timeframe: 1 – 1.5 years

REGULATORY AND POLICY CHANGES

- ✓ Develop, submit, and receive approval for:
  - Statute Changes
  - Waiver Amendments
  - Regulation Changes
  - Policy Changes
- ✓ Develop procedures, technical assistance, and training
- ✓ Identify and plan for any gap in services and determine CCB responsibilities

PROVIDER DEVELOPMENT AND OUTREACH

- ✓ Build training plans for certifying case managers
- ✓ Define roles and responsibilities for providers of direct care, TCM, and administrative function
- ✓ Determine transition plan for OHCDS functions

Based on Rural Exception Decision:

- ✓ Conduct provider outreach
- ✓ Develop conflict-free policies and procedures for providers
- ✓ Coordinate with CCBs with business continuity plans
- ✓ Require CCBs to submit business continuity plan
- ✓ Provide additional training based on updated case manager qualifications

COMMUNICATION PRIORITIES

Based on Rural Exception Decision:

- ✓ Review and revise communication plan
- ✓ Begin communication with specific target groups about transitioning to CFCM
- ✓ Coordinate with CCBs and direct service providers to provide regularly scheduled updates to individuals and families
- ✓ Update all stakeholders on provider capacity

TRACKING MECHANISMS

- ✓ Determine the last date when individuals may be enrolled while having a conflict of interest
- ✓ Determine the order of transitioning target groups, waivers and/or geographical locations, using the risk matrix
- ✓ Develop an integrated case management system
- ✓ Test the case management system and provide input to the Department

Milestones that require CCB action
Milestones that require legislative action

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DRAFT PROPOSAL FOR TRANSITION TO CFCM FOR I/DD WAIVERS – PHASE 3: IMPLEMENTATION

Phase

Timing

Key Activities

Phase 3: Implementation

Estimated timeframe: 1 – 2 years

REGULATORY AND POLICY CHANGES

- ✓ Review operations for case management, administrative, and direct service providers to ensure they are sufficiently ready for CFCM
- ✓ Implement

PROVIDER DEVELOPMENT AND OUTREACH

- ✓ Implement changes in provider qualifications
- ✓ Implement changes in enrolling new individuals
- ✓ Continue to implement the provider outreach plan
- ✓ Continue to build provider capacity by offering ongoing trainings

COMMUNICATION PRIORITIES

- ✓ Survey individuals and families to determine CFCM effectiveness
- ✓ Implement communication strategies to the targeted groups
- ✓ Provide ongoing education to individuals, families, Case Management Agencies, and direct service providers

TRACKING MECHANISMS

- ✓ CCBs implement their business continuity plan
- ✓ Implement the new integrated case management system and provide training for the users

Key milestones for CCBs
Milestones that require legislative action

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ADDITIONAL CONSIDERATIONS

- CCBs coordinate with their counties regarding mill levy funding
- CCBs transition to conflict-free
- The options are:
  - Provide case management exclusively and establish a process for transitioning individuals to different direct service provider(s)
  - Provide direct services exclusively, and establish a process for transitioning individuals to a different case manager
  - Provide case management and direct services, but not to the same individual, and establish policies and procedures to protect individuals and allow choice

BUSINESS CONTINUITY PLAN

- CCBs submit a Business Continuity Plan to the Department
- The Department will finalize specific requirements for the Business Continuity Plan in Phase 1
- Among other items, the Plan will address:
  - Deadline by which the CCBs will determine which options they will take to comply with the CFCM regulation
  - How the CCB will communicate with and educate individuals and families about the transition
  - How the CCB will mitigate the risk for gaps in service
  - How the CCB will support individuals transitioning out of the CCB
- The Department will establish required deadlines for milestones in the Business Continuity Plan
- CCBs will have flexibility to develop deadlines for sub-tasks to meet the Department's required milestones

SOURCES

1. Centers for Medicare and Medicaid presentation, *Conflict of Interest in Medicaid Authorities,* January 13, 2016

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2. Colorado Department of Health Care Policy and Financing, *Colorado Assessment Tool Projects*, September 17, 2014

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QUESTIONS AND COMMENTS

NAVIGANT

THANK YOU FOR ATTENDING THIS SESSION!

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