COLORADO

Department of Health Care Policy & Financing

Care and Case Management Report Crosswalks: Case Management Agencies

Created: January 29, 2024
Revised: April 18, 2024; April 29, 2024

Agency 05 Report – Critical Incident Report

Report Name: Agency Report 05 - Critical Incidents Report (CIR)

Purpose: Used to process monthly State Supported Living Services Program (State SLS), Omnibus Reconciliation Act of 1987 Specialized Services Program (OBRA-SS), and Family Support Services Program (FSSP) Critical Incident payments.

Criteria for Inclusion on the Report: Report includes all State General Fund (SGF) critical incidents entered within the Incident Management section.

Primary Source for Member Inclusion on Report: Critical Incident Reports (CIRs) entered within the Incident Management Section within the specified time frame.

How to Run the Report: Enter a start and end date for when the CIR was entered into the Care and Case Management (CCM) system **and*** a start and end date for when the incident occurred. You may choose to make these dates the same or expand the dates on either range. Both dates must be entered in order to run the report.

*The Department of Health Care Policy and Financing (HCPF) has submitted a change request for this report to change the 'and' statement in the filter to an 'or' statement to simplify the way CMAs can run and use this report. This document will be updated to reflect that change once complete.

Filters for Running the Report:
- Entry Start Date (Date CIR entered into CCM)
- Entry End Date (Date CIR entered into CCM)
- Incident Start Date (Date incident occurred)
- Incident End Date (Date incident occurred)
- Agency
- Program Waiver
- Incident Type
- Incident Status
- Incident Location
- Provider Involved
- Preventable
- Disposition
- Restrictive Information

Data Shown on Report:
- CCM Member ID
- Medicaid ID
- Member Name
- Incident Date
- Case Manager (CM) Notification Date
- Incident ID
- Entry Date
- Incident Type
- Abuse Type

- Case Manager
- Agency Name
- Reporting Agency / PASA
- Provider Involved
- Program Type
- Incident Loc Desc
- ER
- Hospitalization
- Hospitalization Type
- M-1 Hold
- Restrictive Intervention
- RI Appropriate?
- HRC
- RDI
- SNF-Rehab
- NF
- Substantiated
- Other Person Involved?
- APS / CPS
- Law Enforcement
- CDPHE Occurrence
- Add / Change Services
- Preventable
- Client's Health Prior
- Root Cause
- CCB Investigation? (Incident Type Death)
- CCB Investigation? (Complete Incident Type Death)
- CCB Substantiated? (Incident Type Death)
- CCB Investigation? (Incident Type MANE)
- CCB Investigation? (Complete Incident Type MANE)
- CCB Substantiated? (Incident Type MANE)
- HCPF Review Disposition

Report Logic: All Critical Incident Reports created by a case manager associated with their agency.

Determining which Case Management Agency: Case Management Agency (CMA) assigned is based on:

1. The CMA associated with the case manager who created the incident record.

Page Resources ▷

📄 **Documents (0)** ➕

No Records found

📞 **Activity Log (0)**

No Records found

Detail History

Created By:Holly Warner
Created On:Dec 22, 2023 at 9:06:42 AM
Updated By:InRule System
Updated On:Dec 22, 2023 at 2:42:11 PM

🕑 All History

2. If the case manager is not tied to a CMA, then it looks for the CMA on the member's program card.

3. If there is not a CMA listed on the program card, the primary CMA is pulled from the Care Team.

4. If there is no primary CMA on the Care Team, it pulls the CMA with the most recent start/admit date.

Further Restrictions Applied to the Report for Processing Payments:

1. The programs are restricted to:
   a. FSSP
   b. NF - OBRA-SS
   c. State SLS

2. The Date of Incident must fall within the month of payment.

3. Critical Incidents are categorized as Mistreatment Abuse Neglect Exploitation (MANE) or NON-MANE based on the Incident Type Selected.

Billing 01 Reports – Appeals Court Decision

Report Name: Billing Report 01 - Appeals Payment Report - Court Decision Dates

Purpose: Used to process monthly CMA Appeal Court Decision Hearing payments.

Criteria for Inclusion on the Report: Appeal Records entered in the Appeals Section with a date entered in the Court Decision Date field within the Office of Administrative Court Hearing Details screen.

Primary Source for Member Inclusion on Report: Appeals Section

Filters for Running the Report:
- Start Date (Based on Court Decision Dates)
- End Date (Based on Court Decision Dates)
- Program

Data Shown on Report:
- Agency
- Medicaid ID
- Member First Name
- Member Last Name
- Member SSN
- Member DOB
- Court Decision Date
- Program
- Appeal Program
- County
- County Designation

Report Logic: All appeals created by a case manager associated with their agency.

Determining which Case Management Agency: Case Management Agency assigned is based on:

1. The CMA associated with the case manager who created the appeal record.

2. If the case manager is not tied to a CMA, then it looks for the CMA on the member's program card.

3. If there is not a CMA listed on the program card, the primary CMA is pulled from the Care Team.

4. If there is no primary CMA on the Care Team, it pulls the CMA with the most recent start/admit date.

Further Restrictions Applied to the Report for Processing Payments:

1. The Court Decision Date field must be filled out.

2. The Appeals are restricted to these programs for payment:
   a. CHCBS - Effective July 1, 2024
   b. HCBS-BI
   c. HCBS-CES
   d. HCBS-CHRP
   e. HCBS-CIH
   f. HCBS-CLLI
   g. HCBS-CMHS
   h. HCBS-DD
   i. HCBS-EBD
   j. HCBS-SLS
   k. HCBS-SLS Buy-In
   l. HBU
   m. LTHH
   n. NF
   o. PACE

3. The payment is based on the program in the "Appeal Program" field. If the case manager does not complete this field, the "Program Name (Required)" field is used for payment. If both are blank, the appeal will not be included in the payment.

Billing 01 Reports – Appeals Packets

Report Name: Billing Report 01 - Appeals Payment Report - Packet Dates

Purpose: Used to process monthly CMA Appeal Packet payments.

Criteria for Inclusion on the Report: Appeal records entered into the Appeals screen with a date entered in the Date Appeal Packet Sent to the Office of Administrative Courts field under the Claims section.

Primary Source for Member Inclusion on Report: Appeals Section

Filters for Running the Report:
- Start Date (Based on Appeal Packet Sent Dates)
- End Date (Based on Appeal Packet Sent Dates)
- Program

Data Shown on Report:
- Agency
- Medicaid ID
- Member First Name
- Member Last Name
- Member SSN
- Member DOB
- Date Packet Sent
- Program
- Appeal Program
- County
- County Designation

Report Logic: All appeals created by a case manager associated with their agency.

Determining which Case Management Agency: Case Management Agency assign is based on:

1. The CMA associated with the case manager who created the appeal record.

2. If the case manager is not tied to a CMA, then it looks for the CMA on the member's program card.

3. If there is not a CMA listed on the program card, the primary CMA is pulled from the Care Team.

4. If there is no primary CMA on the Care Team, it pulls the CMA with the most recent start/admit date.

Further Restrictions Applied to the Report for Processing Payments:

1. The Date Appeal packet sent to the Office of Administrative Courts field must be filled out.

2. **The Appeals are restricted to these programs for payment:**
   a. CHCBS – Effective July 1, 2024
   b. HCBS-BI
   c. HCBS-CES
   d. HCBS-CHRP
   e. HCBS-CIH
   f. HCBS-CLLI
   g. HCBS-CMHS
   h. HCBS-DD
   i. HCBS-EBD
   j. HCBS-SLS
   k. HCBS-SLS Buy-In
   l. HBU
   m. LTHH
   n. NF
   o. PACE

3. The payment is based on the program in the "Appeal Program" field. If the case manager does not complete this field, the "Program Name (Required)" field is used for payment. If both are blank, the appeal will not be included in the payment.

Billing Report 06 – LOC Assessments Payment

Report Name: Billing Report 06 – LOC Assessments Payment – OAD Edits – Legacy 100.2 Assessment

Purpose: Used to process monthly CMA 100.2 assessment payments.

Criteria for Inclusion on the Report: The report includes all ULTC 100.2 assessments entered in the LTC Level of Care Eligibility Assessment (Legacy ULTC 100.2) that have an assessment date within the specified search criteria.

Report is cached each night at 1:00 a.m. MT for the previous three months and all days of the current month.

Primary Source for Member Inclusion on Report: LTC Level of Care Eligibility Assessment (Legacy ULTC 100.2) card.

Filters for Running the Report:
- Assessment Start Date
- Assessment End Date
- Program
- HCBS
- Case Management Agency

Data Shown on Report:
- Agency
- Medicaid ID
- CCM Member ID (GUID)
- Member First Name
- Member Last Name
- Member SSN
- Member DOB
- Assessment ID
- Assessment Date
- Assessment Case Manager
- Assessment Status
- Date Verified
- Completed/Verified Date
- LOC Certification Span End Date
- Event Type
- Event Group Type
- Assessment Outcome
- County
- County Designation
- Program
- HCBS
- Potential Program
- Buy-In
- Primary Case Manager

Report Logic: If an assessment is entered into the Assessment/Support Plan section with an assessment date within the specified date range. Includes completed and in progress assessments. All assessments created by a case manager associated with their agency.

Determining which Case Management Agency: Case Management Agency assigned is based on:

1. The Primary Case Manager or Case Manager Supervisor from the member's Care Team.
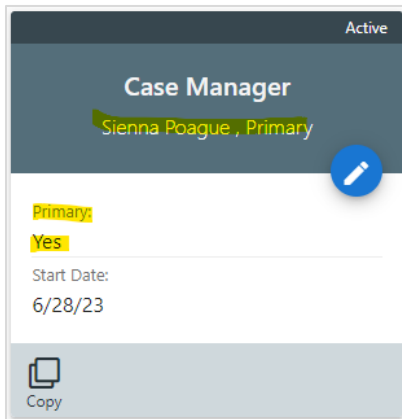
2. If the case manager is not tied to a CMA, then it is pulling the CMA from the program card that matches with the program on the 100.2.

3. If no CMA is assigned to the program card, then the primary CMA on the Care Team.

Determining whether the member is categorized as Buy-In or Non-Buy-In:

1. The Buy-in column in the report should be determined as follows:
   a. If the member has active health coverage with *Buy-in WAwD* Plan (aid code = AIDB3), then set the value as Buy-In.
   b. Any other active health coverage, set the value as Non-Buy-In.
   c. Used to differentiate HCBS-SLS and HCBS-SLS Buy-In members.

Further Restrictions Applied to the Report for Processing Payments:

1. The assessment must have a Verified Date.
   a. Any assessment without a Verified Date will not be included in the payments.

2. HCPF removes duplicate assessments as appropriate for processing payments:
   a. Any duplicate initial assessments for the member that are for the same program and same month are removed from the report for payment.
   b. If there are duplicate CSR assessments, depending on the data available they may be removed from the payment report (full duplication of all dates, assessment type, etc.).
   c. If the member has a duplicate assessment for an initial/CSR and also a waiting list assessment within the same month for the same member it will be removed from the payment report.

3. Assessments are restricted to these programs for payment:
   a. CHCBS - Effective July 1, 2024
   b. HCBS-BI
   c. HCBS-CES
   d. HCBS-CHRP
   e. HCBS-CIH
   f. HCBS-CLLI
   g. HCBS-CMHS
   h. HCBS-DD
   i. HCBS-EBD
   j. HCBS-SLS

k. HCBS-SLS Buy-In
l. HBU
m. LTHH
n. NF
o. PACE

Billing 07 – DD and Delay Determinations

Report Name: Billing Report 07 - DD and Delay Determinations

Purpose: Used to process monthly DD and Delay Determination payments.

Criteria for Inclusion on the Report: Report includes all DD Delay and DD Determinations with a Determination Date entered in the DD Delay or DD Determination Screen within the specified timeframe.

Primary Source for Member Inclusion on Report: Determination Date and Determination Type on the Developmental Delay or Developmental Disability Determination screen.

Filters for Running the Report:
- Start Date (Based on Determination Dates)
- End Date (Based on Determination Dates)
- Agency

Data Shown on Report:
- Agency Name
- Request Date
- Decision Date
- Medicaid ID
- CCM Member ID
- First Name
- Last Name
- DOB
- Min Age on Determination
- Determination Type
- Determination Decision

Report Logic: All DD Delay and DD Determinations created by a case manager associated with their agency.

Determining which Case Management Agency: CMA listed as the "Determining Agency" on the Developmental Delay or Developmental Disability Determination screen.

If "Other" is selected for the Determining Agency, the CMA name is pulled from the "Other Determining Agency" field.

Further Restrictions Applied to the Report for Processing Payments:

1. The Determination Date field must be filled out.

2. The Determination Type must be:
   a. Developmental Delay
   b. Intellectual/Developmental Disability

3. The Determinations are restricted to these programs for payment:
   a. HCBS-CES
   b. HCBS-CHRP
   c. HCBS-DD
   d. FSSP
   e. State SLS
   f. NF OBRA – SS
   g. HCBS-SLS

Billing 12 – Case Management Activities

Report Name: Billing Report 12 - Case Management Activities

Purpose: Used to process monthly State General Fund program case management and monitoring payments.

Criteria for Inclusion in the Report: Report includes all activity logs entered within the specified timeframe.

Report is cached each night at 1:00 a.m. MT for the previous three months and all days of the current month.

Primary Source for Member Inclusion on Report: Activity log screen

Filters for Running the Report:
- Call Log Contact Date Begin (Activity Log)
- Call Log Contact Date End (Activity Log)
- Case Management Agency
- Program

Data Shown on Report:
- Case Management Agency
- Program
- Member First Name
- Member Last Name
- Medicaid ID
- CCM Member ID (GUID)
- County
- County Designation
- Contact Date
- Event Date
- Method of Contact
- Type of Contact

Report Logic: All activity logs created by a case manager associated with their agency.

Determining which Case Management Agency: Case Management Agency assigned is based on:

1. The case manager who entered the activity log

2. If the case manager is not tied to a CMA then it pulls in the CMA from the program card.

3. If no CMA on the program card, it pulls in the primary CMA from the Care Team.

4. If there is no primary CMA on the Care Team, it pulls the CMA with the most recent start/admit date.

Further Restrictions Applied to the Report for Processing Payments:

1. **For Ongoing Case Management Payments:**

   a. The activity logs are restricted to these programs for payment:
      i. FSSP
      ii. State SLS
      iii. NF OBRA - SS

   b. The following fields must be completed on the activity log for payment purposes:
      i. Contact Date
      ii. Program
      iii. Method of Contact
         1. Email
         2. Face to Face
         3. Fax
         4. Mail
         5. Telephone
         6. Text
         7. Virtual

iv. Type of Contact
1. Case Assigned
2. Case Conference
3. Case Documentation
4. Complaint
5. Correspondence
6. Critical Incident
7. Discharge and Termination
8. Enrollment
9. Financial Eligibility
10. Hospitalization
11. Mandatory Report
12. Medical
13. Nursing Facility Placement
14. Referral
15. Rights Modification
16. Risk Mitigation Planning
17. Risk Mitigation Response
18. Summary Report – Closure
19. Summary Report – CSR
20. Summary Report – Initial
21. Summary Report – Monthly Contact
22. Summary Report – 6 Month Review
23. Summary Report – Quarterly Contact
24. Support Plan Development
25. Transition Coordination
26. Waiting List/Enrollment

Activity Log

Targeted Case Management	Confidential Note?	* Contact Date	Contact Time	Event Date
Yes	- Select -	12 / 12 / 2023	10 : 38 AM	mm / dd / yyyy

* First Name	Last Name	* Person Contacted
		Member / Self

Cell Phone Number	Home Phone Number	Work Phone Number

Fax	Email Address	Agency / Organization

Activity Log Details

Program	Program Type
Family Support Services Program	Family Support Services Program

Method of Contact	Category	* Type of Contact
Telephone	- Select -	Correspondence

Narrative

c. Only one activity log per member is included on the payment each month. All duplicate activity logs for members are excluded for payment purposes.

d. If the Program field is left blank, these activity logs are excluded from the payment.

2. **For Monitoring Payments:**

a. The activity logs are restricted to these programs for payment:
   i. State SLS
   ii. NF OBRA-SS

b. The following fields must be completed on the activity log for payment purposes:
   i. Contact Date
   ii. Program
   iii. Method of Contact
      1. Face to Face
      2. Telephone
      3. Virtual
   iv. Type of Contact
      1. Monitoring Contact – Scheduled
      2. Monitoring Contact – Unscheduled

c. Only one activity log per member is included on the payment each month. All duplicate activity logs for members are excluded for payment purposes.

d. Payments are restricted to four monitoring contacts per member per year.

e. If the Program field is left blank, these activity logs are excluded from the payment.

Billing 13 – FSSP Most in Need Assessments

Report Name: Billing Report 13 - FSSP Most in Need

Purpose: Used to process monthly FSSP Most in Need assessments.

Criteria for Inclusion on the Report: Report includes all FSSP MIN assessments entered within the Assessment/Support Plan.

Primary Source for Member Inclusion on Report: FSSP Most in Need Assessment in the Assessment/Support Plans section.

Filters for Running the Report:
- Agency
- Start Date (Based on Most in Need Assessment Dates)
- End Date (Based on Most in Need Assessment Dates)

Data Shown on Report:
- Case Management Agency
- Program
- Member Name
- CCM Member ID (GUID)
- Assessment Date

Report Logic: All Most in Need Assessments created by a case manager associated with their agency. The date filter is based on the Assessment Date for the Most in Need Assessment.

Determining which Case Management Agency: Case Management Agency assigned is based on:

1. The case manager who entered the FSSP Most in Need Assessment.

2. If the case manager is not tied to a CMA then it pulls in the CMA from the FSSP program card.

3. If there is no CMA on the program card, it pulls in the primary CMA from the Care Team.

4. If there is no primary CMA on the Care Team, it pulls the CMA with the most recent start/admit date.

Further Restrictions Applied to the Report for Processing Payments:

1. The Assessment Date field must be filled out.

2. Payments are limited to one Most in Need Assessment per year.

Agency Report 06 – Log Note Monthly Summary by Type

Report Name: Agency Report 06 - Log Notes Monthly Summary by Type

Purpose: To allow CMAs to review the amount of activity logs entered by your CMA in total or by contact type for a specified time period. Can use this report to cross reference monitoring and Ongoing Case Management activities that should be reimbursed for your agency. Also allows CMAs to review Activity logs entered by specific case managers for a specified time period. No narrative of the activity log is included in this report (use Agency 08 for any narrative reviews required).

Criteria for Inclusion on the Report:
- CMA who entered the activity log in CCM.
- CMA who is active on member record in care team/care provider tab.
- Activity log must be entered in the timeframe specified.

Primary Source for Member Inclusion on Report:
- Activity Log

Filters for Running the Report:
- Start Date
- End Date
- Agency
- Case Manager/User (Entered Log Note)
- Case Manager

Data Shown on Report
- Case Manager Entered Log Note (activity log, case manager who entered log note)
- Case Manager (see hierarchy below)
- Year (activity log, contact date)
- Month (activity log, contact date)
- Member First Name
- Member Last Name
- Face To Face Visits (Activity log, method of contact)
- Contact Date (Activity Log)
- Call Log Type (Activity log, contact type)
- Entered User Agency (CMA attributed to user who entered the activity log)

Report Logic: All activity logs entered in CCM for identified timeframe. CMA that is active on the member record can run the report and all activity logs will pull into the report regardless of CMA who entered the activity log. If a CMA entered an activity log on the member record for the specified timeframe those activity logs will also be accessible to that CMA.

Determining which Case Management Agency: Activity log is tied to the CMA that entered the activity log. The report identifies that CMA in the Entered User Agency column on the report. As noted above, both the active CMA on the member record and CMA who entered activity logs will be able to access that data for the member.

Determining Case Manager on the report:

The case manager listed on the report will be identified through the following logic:

1. Primary Case Manager on the Care Team/Staff Member tab
2. If no primary in the Care Team/Staff Member tab, then the most recent effective case manager with no end date in the Care Team/Staff Member tab.
3. If two case managers with the same most recent effective date with no end date, both case managers will pull into the report.
4. If no case manager with any of these criteria pulls in the case manager from the most recent open program card.

Data Shown on Report:

1. Data on Report from fields in the Activity Log:
   a. Contact Date
   b. Method of Contact
   c. Type of Contact

Agency Report 08 - Detailed Log Notes Report

Report Name: Agency Report 08- Detailed Log Note Reports

Purpose: This report allows CMAs to pull all activity logs entered by their agency for a specific time period. It can be pulled for the agency as a whole or can be filtered to be run for specific programs, contact types, by an identified case manager/User or by a single member. Can be used for case reviews with full narrative or to cross check billable contacts for specified contact types and monthly TCM contacts as well as ongoing case management as a whole for a CMA.

Criteria for Inclusion on the Report:
- CMA is active on member record.
- Activity logs must be entered in the timeframe specified.
- CMA must have entered the activity log.

Primary Source for Member Inclusion on Report: CMA is active on member record and entered the activity log.

Filters for Running the Report:
- Report Start Date (Contact Date in Activity Log)
- Report End Date (Contact Date in Activity Log)
- Agency
- Program
- Contact Type
- Case Manager/User
- MDCAID (Medicaid) (if run with (_) in the field all records for CMA will pull into report)

Data Shown on Report
- Log note ID
- Case Manager Name (Case manager who entered activity log)
- Member First Name
- Member Last Name
- Member State ID
- Social Security Number
- Member Id
- Member Program Area Current (program card that is tied to the activity log)
- Program Status (status of the Member Program Area Current)
- Program Type (Program Type of the Member Program Area Current)
- Event Date (activity log) (optional)
- Contact Date (activity log)
- Date log note entered (populates based on date entered in CCM)
- Person Contacted (activity log)
- Contact Type (activity log)
- Number of Billable Units (time tracking tab)
- Number of Non-Billable Units (time tracking tab)
- TCM (Targeted Case Management field in activity log)

- Number of TCM units (Billable + Non-Billable from time tracking when it is a confidential activity log)
- Number of Non TCM units (Billable + Non-Billable from time tracking when it is not a confidential activity log)
- Contact Face to Face (activity log)
- Method of Contact (activity log)
- Restrictive Intervention/Rights Modification on Service Plan Y/N (activity log)
- Rights Modification Authorized Plan Y/N (activity log)
- Log notes entered Agency Name (Agency of the case manager who inserted the activity log, if no longer an active CMA, then CMA from the Program Card, if no CMA on program card then CMA from the Care Team)
- Show Log Notes Narrative (activity log)

Report Logic: All activity logs entered in CCM for identified timeframe that have been entered by the CMA who is running the report. CMA must be active on the members record to run the report for the member. The report will only display activity logs that have been entered by a user affiliated with your CMA.

Determining which Case Management Agency: The CMA that entered the Activity Log in CCM. Will only display those activity logs that a user affiliated with your CMA entered.

1. Contact Date - Report will populate chronologically from most recent contact date to least recent contact date on the activity log.

2. Data on report from fields in the activity log

Activity Log Details

Program

- Select -

Program Type

- Select -

Method of Contact

- Select -

Category

- Select -

Type of Contact

- Select -

* Narrative

Activity Log Additional Details

* Is this activity log note related to a restrictive intervention?

○ Yes ○ No

* Does the member have a restrictive intervention/Rights Modification Plan?

○ Yes ○ No ○ N/A

* Was the restrictive intervention/Rights Modification implemented according to the authorized plan?

○ Yes ○ No ○ N/A

3. For TCM Billable Units and Billable Units the case manager will need to use the time tracking time tab in addition to entering the activity log.

Time Tracking Detail

Back Save

Member

Activity
- Select -

Sub-Activity
- Select -

Start Date
04 / 10 / 2024

Start Time
02 : 26 PM

End Date
04 / 10 / 2024

End Time
02 : 26 PM

Total Time (Hour:Min)
00:00

Total Units

Billable Units
- Select -

Non-Billable Units

Program
- Select -

Program Type
- Select -

4. For the billable units to populate on the Agency 08 report, the case manager will need to ensure that activity log contact date and time matches the time tracking date and time. If they do not match the billable units will display as 0 on the Agency 08 reports.

5. For TCM billable units the case manager will also need to ensure the Targeted Case Management field is marked as yes on the activity log.

Activity Log

Back Save

Targeted Case Management
Yes

Confidential Note?
- Select -

* Contact Date
04 / 10 / 2024

Contact Time
03 : 11 PM

Event Date
mm / dd / yyyy

Agency Report 08 - Detailed Log Notes Report - Member Search

Report Name: Agency Report 08 - Detailed Log Note Reports - Member Search

Purpose: This report allows CMAs to pull all activity logs entered in the CCM for a specific member search. This report will display all activity logs entered by any CMA for the member and is not limited to activity logs entered by the CMA who is running the report. Will assist in the ability for case managers to review all activity logs with narrative in one view for a specific member.

Criteria for Inclusion on the Report:
- CMA is active on the member record.
- Activity logs must be entered in the timeframe specified.

Primary Source for Member Inclusion on Report: CMA is active on member record.

Filters for Running the Report:
- Report Start Date (Contact Date in Activity Log)
- Report End Date (Contact Date in Activity Log)
- MDCAID

Data Shown on Report:
- Log note ID
- Case Manager Name (Case manager who entered activity log)
- Member First Name
- Member Last Name
- Member State ID
- Social Security Number
- Member ID
- Member Program Area Current (program card that is tied to the activity log)
- Program Status (status of the Member Program Area Current)
- Program Type (Program Type of the Member Program Area Current)
- Event Date (activity log) (optional)
- Contact Date (activity log)
- Date log note entered (populates based on date entered in CCM)
- Person Contacted (activity log)
- Contact Type (activity log)
- Number of Billable Units (time tracking tab)
- Number of Non-Billable Units (time tracking tab)
- TCM (Targeted Case Management field in activity log)
- Number of TCM units (Billable + Non-Billable from time tracking when it is a confidential activity log)
- Number of Non TCM units (Billable + Non-Billable from time tracking when it is not a confidential activity log)
- Contact Face to Face (activity log)
- Method of Contact (activity log)
- Restrictive Intervention/Rights Modification on Service Plan Y/N (activity log)
- Rights Modification Authorized Plan Y/N (activity log)

- Log notes entered Agency Name (Agency of the case manager who inserted the activity log, if no longer an active CMA, then CMA from the Program Card, if no CMA on program card then CMA from the Care Team)
- Show Log Notes Narrative (activity log)

Report Logic: All activity logs entered in CCM for identified timeframe. CMA that is active can run the report and all activity logs will pull into report with narrative regardless of CMA who entered the activity log.

Determining which Case Management Agency: Any CMA that is active on the member record will be able to run this report.

1. Contact Date: Report will populate chronologically from most recent contact date to least recent contact date on the activity log.

2. Data on report from fields in the activity log.

Activity Log Details

Program

- Select -

Program Type

- Select -

Method of Contact

- Select -

Category

- Select -

Type of Contact
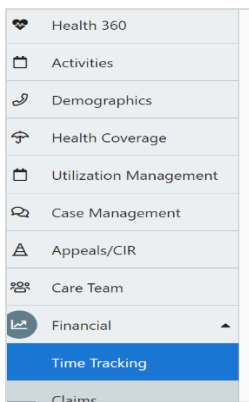
- Select -

* Narrative

Activity Log Additional Details

* Is this activity log note related to a restrictive intervention?

○ Yes   ○ No

* Does the member have a restrictive intervention/Rights Modification Plan?

○ Yes   ○ No   ○ N/A

* Was the restrictive intervention/Rights Modification implemented according to the authorized plan?

○ Yes   ○ No   ○ N/A

3. For TCM Billable Units and Billable Units the case manager will need to use the time tracking time tab in addition to entering the activity log.

Health 360
Activities
Demographics
Health Coverage
Utilization Management
Case Management
Appeals/CIR
Care Team
Financial ▲
    Time Tracking
    Claims

Time Tracking Detail

Member

* Activity
- Select -

Sub-Activity
- Select -

Start Date
04 / 10 / 2024

* Start Time
02 : 26 PM

* End Date
04 / 10 / 2024

End Time
02 : 26 PM

Total Time (Hour:Min)
00:00

Total Units

Billable Units
- Select -

Non-Billable Units

Program
- Select -

Program Type
- Select -

4. For the billable units to populate on the Agency 08 report the case manager will need to ensure that activity log contact date and time matches the time tracking date and time. If they do not match the billable units will display as 0 on the Agency 08 reports.

5. For TCM billable units the case manager will also need to ensure the Targeted Case Management field is marked as yes on the activity log.

Activity Log

Targeted Case Management
Yes

Confidential Note?
- Select -

* Contact Date
04 / 10 / 2024

Contact Time
03 : 11 PM

Event Date
mm / dd / yyyy

Department 11 Report – Total Enrollment By Program

Report Name: Department 11 - Total Enrollment by Program

Purpose: This report provides all members with open or pending program cards. It excludes members with program cards that are closed or voided. The report also provides summary counts of the Member Programs by Program Type and Case Management Agency.

Criteria for Inclusion on the Report (all must be true):
- CMA is active on member record.
- CMA is assigned on the Program Card, or hierarchy noted below.
- Program Card is in appropriate open or pending status.

Primary Source for Member Inclusion on Report: Program Card

Filters:
- Case Management Agency

Data Shown on Report:
- Member First Name
- Member Last Name
- DOB
- Member GUID
- Medicaid ID
- Program (Program Record Program Type field)
- Program Status (Program Record, all but closed)
- Case Management Agency (see logic below)
- Primary Case Manager Name (see logic below)
- Program Start Date
- Program Close Date
- County
- Buy-In (Health coverage record, see logic below)

Summary Shown on Report:
- Program Count Summary by Program Type:
  - Program Type
  - Number of number of non-closed, non-voided Member Program Cards for each Program Type
- Program Counts Summary by Program Type and Agency:
  - CMA Name
  - Program Type
  - Number of number of non-closed, non-voided Member Program Cards for each Program Type

Report Logic:

Restrictions to ensure only Case Management Agencies are pulled into the report:
Case Management Agency: List all active Providers with Provider Type = 'MCCMA'. MCCMA is the provider type that is used for Case Management Agencies when they are configured into the CCM, which differentiates CMAs from other types of agencies such as a RAE. When a CMA runs this report, it will only return members associated with the agency based on the report logic below.

Determining which Case Management Agency is associated to the member:
The Case Management Agency should be determined in the following order:

1. Provider with Provider Type MCCMA (Agency) listed on the Program Card
   a. If multiple agencies are present, pick the Primary Agency
   b. If no primary agency is listed or if multiple primary agencies are present, pick the agency with the most recent effective date
   c. If no agency is present, then proceed to 2
2. Case manager's CMA association listed on the Program Card, if no case manager is on the Program Card, then proceed to 3
3. Primary CMA on Care Team, if no primary selected, then proceed to 4
4. CMA on Care Team with most recent Start/Admit Date

Determining which case manager is associated to the member:

The case manager listed on the report is determined based on the logic below:

1. Primary Case Manager if a primary is identified, if no primary then proceed to 2.
2. The most recently added case manager associated to the program.

Determining whether the member is categorized as Buy-In vs. Non-Buy-In:

The Buy-in column in the report should be determined as follows:

- If the member has an active health coverage with *Buy-in WAwD* Plan (aid code = AIDB3), then set the value as Buy-in
- Any other active health coverage, set the value as Non-Buy-in
- Used to differentiate HCBS-SLS and HCBS-SLS Buy-In members

Summary Count Logic:

Program Counts Summary by Program Type

- The Program Counts by Program Type summary will list the number of non-closed, non-voided Member Program Cards for each Program Type.

Program Counts Summary by Program Type and Agency:

- The Program Counts by Program Type and Agency summary will list the number of non-closed, non-voided Member Program Cards for each Program Type and Agency combination. Since the Agency is also a filter parameter in the UI, the counts will be adjusted according to the Agencies selected and will only list the Agencies selected in the report.
- Because the report will only show members associated with the CMA, this summary is duplicative when run by the CMAs. This summary is specifically beneficial to state users where all data is present.

Troubleshooting Missing Members Within Department 11:

A member is not showing up on Department 11 that should be:
1. Check to make sure the member has a program card and that it is in *open or pending* status. Only open and pending program cards will be visible in this report.
   a. The program statuses listed below will show on Department 11:
      1. Open
      2. Appeal Period
      3. LOC Appeal
      4. Not DDD Funded
      5. Pending Annual
      6. Pending Assessments
      7. Pending Department Review
      8. Pending Financial Eligibility
      9. Pending TC Review
      10. Service Appeal
      11. Pending TRAILS
      12. Supervisor HLOC Review
      13. Supervisor LOC Alternative Review
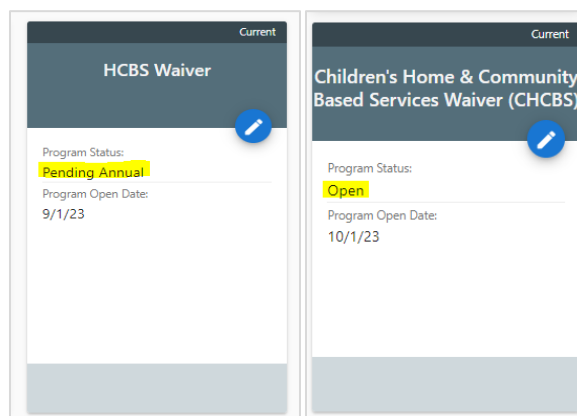
b. Program cards that are in Closed Status will not show up on the report.
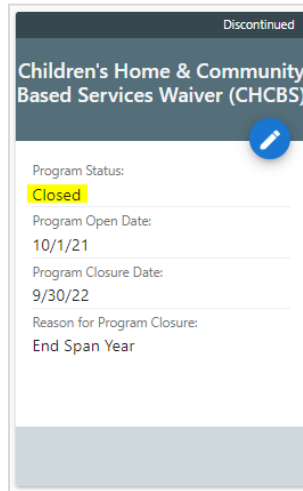
2. Check the program card to see which provider is assigned on the open/pending program cards. If your agency is not assigned, add your agency as the provider on the program card and mark it primary.
   a. The first determination for CMA assignment for Department 11 is CMA listed on the program card:
      i. Open Program Card
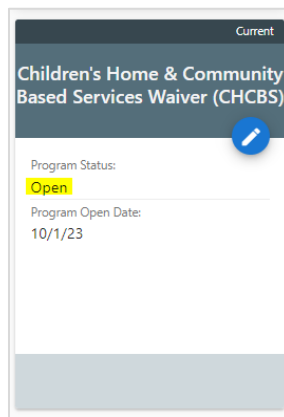
      ii. Provider (CMA) listed on the Program Card
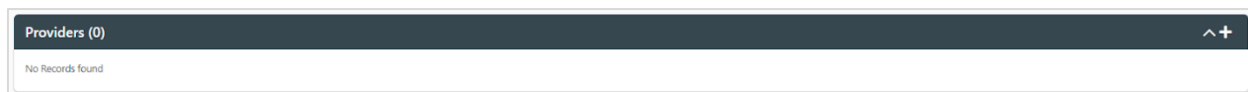
      iii. To add a provider (CMA):

         1. Select the "+" button:
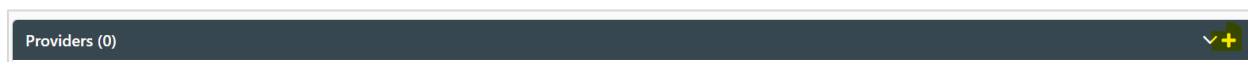
2. Select the "Provider" box.

Program Provider Details

* Provider

[search box]

* Effective Date
mm / dd / yyyy

Expiration Date
mm / dd / yyyy

Primary Provider
No ⬤ Yes

3. Fill out the necessary search fields:
   a. Make sure the "Zip" field is blank.
   b. Enter the "Organization Name" as used in the CCM.
   c. Select MedCompass CMA under "Provider Type" to speed up the search functionality.
   d. Then select "Search".

Provider Search

| Search | Map Search |

Narrow by Location

Zip

Distance
- Select -

Area Served - State
- Select -

Area Served - County
- Select -

Area Served - Location

Include Non-Par and Inactive Providers
No ⬤ Yes

Search Undefined Providers

Narrow by Organization Details

Organization Name: CMA NAME HERE   Or   Last Name   First Name

Organizational Affiliation
- Select -

Provider Id   NPI   Federal Tax Id   Phone Number

City   State   Zip
- Select -

By Type, ISP, Network or LOB

Provider Type: MedCompass CMA   Or   Specialty: - Select -

Close   Clear   **Search**

4. Select the correct agency type (do not select TCA).

Provider Search

| Search | Map Search |

Provider Name	NPI	Provider Id	Provider Type	Specialty	Address
Rocky Mountain Human Svcs-TCA			MedCompass CMA		
Rocky Mountain Human Services			MedCompass CMA		

5. Enter the "Effective Date" and select the toggle to set the "Primary Provider" before saving.

6. The provider (CMA) will now be saved on the program card. This change can be seen in the report the following day once the data has cached.

Pending Change Requests:
This report has the following pending Change Requests:
- A new field will be added to show whether the CMA assigned in the report is flagged as the primary CMA in the system.

Notes: Both Department 11 and the Member Status report are program card driven for determining the CMA that will show up on the report. Please follow the CMA determination logic above for more details. This is different from the CMA Universal File where the CMA is being pulled directly from the Care Team, and if there are multiple CMAs on the Care Team the member will show up on the file for all of the CMAs listed on the Care Team.

Member Status Report

Report Name: Member Status Report-Draft

Purpose: To provide CMAs with a member-centric report that shows all members associated with the CMA. Can be used to filter down to meet individual needs.

Criteria for Inclusion on the Report:

- CMA is associated with the member within CCM
- CMA is assigned on the Program Card (CMA hierarchy noted below)
- Member has active record in CCM (Member Status hierarchy noted below)

Primary Source for Member Inclusion on Report:

- Member Status:
  - Program Card
  - Waiting List
  - Intake Assessment

Filters for Running the Report: Case Management Agency

Data Shown on Report:

- Case Management Agency
- Primary Case Management Agency Flag (Addition Pending Change Request)
- Member SSN
- Medicaid ID
- Member First Name
- Member Last Name
- Date of Birth (DOB)
- Date of Death (DOD)
- Member GUID
- Line of Business (LOB) (Health Coverage Type)
- Program (Program Card)
- Program Closure Date (Program Card)
- Program Closure Reason (Program Card) (Additional Pending Change Request)
- Waitlist Status
- Member Status
- Intake Created Date (Colorado Intake Screen)
- LOC Start Date (Program Card, Level of Care Certification Information tab)
- LOC End Date (Program Card, Level of Care Certification Information tab)

Report Logic: All unduplicated Members and their overall status who are associated with a given case management agency, based on hierarchy.

Determining which Case Management Agency:

The Case Management Agency should be determined in the following order:

1. Provider with Provider Type MCCMA (Agency) listed on the Program Card
   a. If multiple agencies are present, pick the Primary Agency
   b. If no primary agency is listed or if multiple primary agencies are present, pick the agency with the most recent effective date
   c. If no agency is present, then proceed to 2
2. Case manager's CMA association listed on the Program Card,
   a. If no case manager is on the Program Card, then proceed to 3
3. Primary CMA on Care Team, if no primary selected, then proceed to 4
4. CMA on Care Team with most recent Start/Admit Date

Determining Member Status:

The Member Status column is determined in the following order:

If the member has a Program in Closed status and there are no other Programs that are not Closed (meaning if there are programs in any other status), then the Member Status will be set to Closed. If there are Programs that are not Closed, proceed to 2:

1. If the Member has a Program in Pending Assessments, Pending Financial Eligibility (PFE), Pending Department Review, Pending TC Review, Supervisor HLOC Review, Supervisor LOC Alternative Review status and there are no other Programs that are in Open, Service Appeal, LOC Appeal, Appeal Period, Pending Annual status then the Member Status will be set to Pending. If there are Programs that are in Open, Service Appeal, LOC Appeal, Appeal Period, Pending Annual status, proceed to 3:

2. If the member has a Program in Open, Service Appeal, LOC Appeal, Appeal Period, Pending Annual status then the Member Status will be set to Open. If there are no Programs that are in Open, Service Appeal, LOC Appeal, Appeal Period, Pending Annual status, proceed to 4:

3. If the member has no Programs in any other status other than Closed AND the member is present in the Waiting List (has an active WaitingListItem record), the Member Status will be set to Waiting. If the criteria is not met, proceed to 5:

4. When the member does not have any Program Cards, AND if the member has an Intake Assessment in Process, then set the Member Status to Intake. If this criteria is not met, then proceed to 6:

5. When the member does not have any Program Cards, and no Intake Assessment In Progress, the Member Status will be blank.

Pending Change Requests:

This report has the following pending Change Requests:

1. A new field will be added to show whether the CMA assigned in the report is flagged as the primary CMA in the system under the Care Team.
2. A new field added to the report for "Program Closure Reason" which will be pulled from the program card.
3. Rename the report to remove "draft" from the title.

CMA Filtering to Access Necessary Data:
- The report may need to be filtered to meet the needs of the CMA. Likely filters include:
  - Exclusion of members with a Date of Death (DOD).
  - Restriction to Open programs to view only open programs.
  - Restriction to Pending programs to view only programs pending action.
  - Restriction to Closed programs to view programs that have closed - can be used in conjunction with the pending "Program Closure Reason" field to determine if action is needed.
  - Restriction to blank Member Statuses to identify members with no Program Cards created in the CCM to identify potential errors or inactive members attributed to the agency.

Please note: Both the Member Status and Department 11 reports are program card driven for determining the CMA that will show up on the report. Please follow the CMA determination logic above for more details. This is different from the CMA Universal File where the CMA is being pulled directly from the Care Team, and if there are multiple CMAs on the Care Team the member will show up on the file for all of the CMAs listed on the Care Team.

Contact Information

For questions regarding the CCM Reports, please contact the staff below from the Office of Community Living:

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