Case Management Recommendations Report

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MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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Executive Summary

The Colorado Department of Health Care Policy & Financing (HCPF or State) solicited the support of Myers and Stauffer LC (Myers and Stauffer) to conduct an environmental scan of how other states provide Medicaid case management services, to solicit feedback directly from Colorado case management agencies (CMA) , and to collect cost and time data from Colorado case management agencies. The intent of this engagement is to provide HCPF with information and resources for a comprehensive analysis of case management compensation as part of Case Management Redesign (CRMD) to achieve the 5 key outcomes of CMRD; Federal Compliance, Simplicity, Stability, Quality and Accountability.

Myers and Stauffer utilized the knowledge gained during the engagement with HCPF, CMAs, and discussions with other states to compile the recommendations outlined in this report. The recommendations are grouped based on which part of the engagement gave rise to the recommendations as follows:

- *Time survey analysis.*
- *Best practice environmental scan and stakeholder outreach.*
- *Quality and value-based purchasing (VBP) framework.*

Throughout the engagement, it was evident that the structure of case management reimbursement is evolving, and that some case management providers themselves face challenges related to detailed reporting of cost and service time. However, there were several areas where it became apparent that Colorado could implement changes in its current case management methodology in order to streamline administrative processes and increase the quality of case management provided to members. To achieve the goals set forth by CMRD, and HB21-1187, a significant realignment of program requirements and structure that serves all members regardless of disability may be necessary. A listing of notable recommendations for HCPF is as follows:

- *In order to ensure that case management services are paid equitably under a singular rate reimbursement structure, and to support the overarching goals of CMRD, HCPF should re-align the service scope, caseload size, and regulatory requirements for current CCB and SEP providers into a singular agency approach regardless of prior populations served.*
- *Collect cost information from agencies on a regular basis (at a minimum, once every waiver renewal) to determine the sufficiency of rates to cover the incurred cost of agencies to provide case management services, and review activity time information from new information systems to determine appropriateness of activity time assumptions used in creating rates.*

- *Continue the use of a rural-travel add-on, and investigate the adoption of an additional urban travel add-on should agency urban travel exceed a state-determined threshold.*
- *Determine an appropriate caseload limitation and enforce maximum allowable caseloads. Caseload standards should be utilized to assist in measuring the quality of case management services delivered from agencies.*
- *Implement a more timely, hands-on training agenda for case management agencies inclusive of live trainings and more frequent, up-to-date webinars.*
- *Examine quality measures addressing access, community integration, health and safety, and person-centered practices in the implementation of future quality programs.*

Background

In January 2014, federal guidance was issued by CMS providing additional requirements for Home and Community Based Services (HCBS) rendered through 1915(c) waivers. CMS's final rule encourages increased person centeredness while also mandating states to implement conflict-free case management systems for HCBS programs.

Colorado, in accordance with the new federal rules, enacted a redesign of case management services rendered through the passage of HB21-1187. The redesign of Colorado's case management system aims to make receiving long-term services and supports a more member-friendly process while also complying with new regulations surrounding conflict-free case management. A large part of CMRD is aligning case management activities across all programs so that all individuals and their families, regardless of disability, have a single CMA.

HCPF worked in partnership with Myers and Stauffer to canvas the stakeholder community and ensure adequate agency feedback was collected and incorporated into the redesign. Through canvasing the CMA community, as well as designing and collecting a time survey, data was collected and analyzed to support the redesign process. In addition to the time survey and stakeholder feedback, extensive research on best practices in various states was amassed and utilized in determining nation-wide best practices. This nationwide and Colorado specific data was reviewed for applicable best practices both currently employed by the state, and that the state could potentially adopt from other state operations. Information and analysis obtained from the environmental scan, subject matter expert conversations, stakeholder meetings, and time survey collection were used to inform case management delivery and reimbursement recommendations that are included in this report for the consideration of HCPF. It should be noted that time-survey specific recommendations included here-in are limited to the existing scope and methodologies of case management provided in the state, and that potential service scope re-alignments or methodology changes may result in the need to revisit these recommendations.

Summary of Recommendations

Time Survey Analysis

Overview

At the direction of HCPF, Myers and Stauffer created, submitted to agencies, and collected a time survey to compile both financial and expected time commitments related to providing case management services. Through communication with HCPF and stakeholders, questions were compiled in an effort to capture all relevant activities that are required in providing case management services. Each Community Centered Board (CCB), Single Entry Point (SEP), and private case management agencies were asked to complete the time survey. Self-reported data was analyzed and compiled to identify clear patterns of potential time and financial expense related to providing required case management services. The data collected varied greatly between each reporting agency and, overall, specific data points from the time surveys should serve as a baseline in review of the current implemented system but may not be considered fully definitive or reliable in nature for any potential re-design activities that fundamentally alter how case management services are provided in the state.

That being said, two distinct recommendations arose from Myers and Stauffer's compilation of the collected time survey data, as follows:

- *In order to ensure that case management services are paid equitably under a singular rate reimbursement structure, and to support the overarching goals of CMRD, HCPF should re-align the service scope, caseload size, and regulatory requirements for current CCB and SEP providers into a singular agency approach regardless of prior populations served.*
- *Collect cost information from agencies on a regular basis (at a minimum, once every waiver renewal cycle) to determine the sufficiency of rates to cover the incurred cost of agencies to provide case management services, and review activity time information from new information systems to determine appropriateness of activity time assumptions used in creating rates.*

Re-align Current SEP and CCB Caseloads, Scope of Services, and Regulatory Requirement to Support an All-encompassing Rate

While specific data points of the collected time survey may vary greatly by individual agencies, one over-arching theme was noted: SEPs and CCBs, under the current scope of services and provision methodologies, require different caseloads and time spent per member to provide case management services to their specific populations. SEPs typically provide services for individuals with mental illness, brain injury, and aged or disabled populations, while CCBs provide services for individuals with intellectual and developmental disabilities (IDD). Review of the time surveys indicated a much lower caseload size for CCBs (as noted in the following recommendations) and generally a greater amount of time spent per member per year by case managers as required by existing program requirements.

Colorado is, however, moving towards a singular agency approach, removing the distinction between CCB and SEPs, and implementing a singular, all-encompassing per member per month rate. A singular rate does offer several budgetary benefits, can result in lower administrative burden, and can create efficiencies for both the state and case management agencies provided that the rate is sufficient to incentivize provision of care for all populations.

Due to the key differences noted through review of the time survey data and from research into other state reimbursement methodologies, Myers and Stauffer recommends that the Department aligns case management program requirements in order to achieve the intended goals and objectives of CMRD. Combining reimbursement for historically separate populations into a singular rate under a per member per month (or monthly billing per member) system without re-aligning service scopes and caseloads risks overpaying for services provided to one population while underpaying services provided to the other. To ensure that case management services are paid equitably under an all-encompassing reimbursement rate for case management services and to support the overarching goals of CMRD, Myers and Stauffer recommends that HCPF re-align the service scope, caseload size, and regulatory requirements for current CCB and SEP providers into a singular agency approach regardless of prior populations served.

Recommendation

1. **In order to ensure that case management services are paid equitably under a singular rate reimbursement structure, and to support the overarching goals of CMRD, HCPF should re-align the service scope, caseload size, and regulatory requirements for current CCB and SEP providers into a singular agency approach regardless of prior populations served.**

Determine Rates Utilizing Time Survey Data and Implement Regular Rate Sufficiency Review

The process of collecting specific provider utilization and financial data is standard across Medicare and Medicaid provider types. It is considered a best practice to derive reimbursement rates from data collected directly from providers, and the consistent collection of this data forces health and social service providers to track and review this information as an on-ongoing practice. With the collection of case management time and cost information from the recent time survey, the state now has the ability to create reimbursement rates utilizing actual time and cost data as a basis. Using state subject matter experts, the state can base any new rates on assumptions of staff time necessary to complete case management activities and, utilizing case management staff and overhead costs from the time survey, determine the estimated cost it would take for agency to complete these activities.

On-going collection of either actual cost or time data from case management agencies can offer additional insight into the sufficiency of assumptions used in the creation of rates, and the financial position of each agency as well as the adequacy of on-going reimbursement rates. Currently, Colorado does not require case management agencies to file specific cost data on a consistent basis, with the

current time survey being the latest in a line of various attempts to determine rate adequacy. The state does, however, intend to implement a new case management information system which can be used to track time necessary to complete case management activities. New systems could allow the state to review the appropriateness of the time assumptions used in creating rates. Due to the variability of the collected time-survey data and the unfamiliarity of case management agencies with reporting data of this nature, Myers and Stauffer recommends utilizing information systems to review the appropriateness of time assumptions used in the creation of reimbursement rates on a regular basis. Additionally, the state should consider implementing a cost collection tool or process, collected and reviewed by the state to review the sufficiency of rates in covering the actual cost necessary to provide case management services. These reviews should be performed on a regular basis, at a minimum once per waiver renewal to ensure a review occurs within each applicable waiver cycle.

Recommendation

2. **HCPF should collect cost information from agencies on a regular basis (at a minimum, once every waiver renewal cycle) to determine the sufficiency of rates to cover the incurred cost of agencies to provide case management services, and review activity time information from new information systems to determine appropriateness of activity time assumptions used in creating rates.**

Best Practice Environmental Scan and Stakeholder Outreach

Overview

HCPF partnered with Myers and Stauffer to review the case management practices of surrounding or comparable states to identify best practices. Through review of Medicaid state plan filings, approved 1915(c) waiver applications, publicly available documents on state websites, conversations with other state agencies, and available published reports, Myers and Stauffer identified best practices for administering case management services nationwide. States were selected based on proximity, mixture of urban and rural environments, unique methodologies, and potential similarity to that of Colorado. After eliminating states that provide case management through managed care arrangements, the following states were chosen:

- *Connecticut.*
- *Montana.*
- *Nebraska.*
- *Ohio.*
- *Oklahoma.*
- *Oregon.*
- *Utah.*

- *Washington.*
- *Wyoming.*

A review of HCPF agreed-upon major topics was conducted and best practices, where identifiable, were denoted from the data collected. Although the compiled research does not illustrate a case management best practice for all topics reviewed, best practices were noted where applicable. Recommendations will be provided for the following major topic areas:

- *Urban and rural travel add-on payments.*
- *Caseload limitations.*
- *Training requirements.*

Urban and Rural Travel Add-On Payments

Travel by case managers to visit members in the normal course of delivering case management services is included in the standard case management reimbursement rates under the Colorado reimbursement methodology. Travel beyond a standard assumption of distance is not included in these standard rates, however. Instead, rural travel beyond the standard assumption of 20 miles of distance traveled, is reimbursed only as an add-on rate for rural case management agencies. In research of surrounding states, rural travel is factored into roughly half of the reimbursement systems reviewed, including Colorado. Discussions with stakeholders made it clear that while this travel add-on was appreciated, it may not go far enough in compensating all agencies for necessary travel. Stakeholders informed Myers and Stauffer that case managers traveling to members located in urban areas can spend as much, if not more time in travel due to the congestive nature of urban traffic. According to data collected through the time survey, while miles traveled in a single direction of a member in-person visit varies between urban and rural agencies (with urban agencies traveling less total miles), the time spent traveling is similar (Table 1).

Table 1: Time Survey Median Travel Mileage and Time

Time Survey Median Travel Mileage and Time		
	Urban Travel	**Rural Travel**
Mileage	15 miles	23 miles
Travel Time	30 minutes	30 minutes

Although rural travel beyond the standard assumption of 20 miles of distance is already considered in add-on reimbursement, additional necessary urban travel is not. Some states, like Washington and Utah, utilize unique approaches to reimburse potential rural travel within their case management reimbursement rates. Washington enacted a differential system of rates based on geographic location as opposed to utilizing a rate add-on, while Utah offers a procedural code that allows for a rural

enhancement modifier to ensure access to waiver services in all parts of the state. Whether the state wishes to consider rural and urban travel as an element included in rates, a reimbursement rate add-on, or through a geographically tiered system, additional urban travel should be factored into case management reimbursement. While urban travel is similar to rural travel in time, the mileage difference is what drove the original need for a rural specific add-on. Due to this, the state should evaluate if it would be reasonable to include an urban travel add-on when travel exceeds a similar threshold (or other state determined threshold) for a member visit, provided an agency is able to produce supporting documentation.

Recommendation

3. **HCPF should continue the use of a rural-travel add-on, and investigate the adoption of an additional urban travel add-on should agency urban travel exceed a state-determined threshold.**

Caseload Limitations

Appropriate member caseloads per case manager are a vital component in maintaining person-centered, effective case management. Although current reported caseloads for CCBs do not appear elevated in comparison to other states, Myers and Stauffer recommends adding a caseload limitation in regulations in order to reduce caseloads shouldered by SEP case managers and ensure that appropriate caseloads are maintained to ensure quality. Additionally, caseload limitations set in regulation, as adopted in other states, have a multitude of benefits including consistent budgeting for rate setting and an enforceable standard for quality assurance.

By codifying a standard caseload limit, a key component to the rate setting process becomes a set factor in comparison to other, more variable components. Additionally, codifying case limits creates a standard of measurable quality to hold agencies accountable and serves as the beginning of a quality framework. Through discussion with case management stakeholders, Myers and Stauffer consistently noted that over-bearing caseloads inhibit the ability of case managers to deliver high-quality case management. SEP agencies, specifically, report high caseloads of over 100 cases per case manager in urban areas (Table 2).

Table 2: Time Survey Average Caseloads by Agency Type

Time Survey Average Caseloads by Agency Type		
	CCB Caseload	**SEP Caseload**
Urban	50 cases per manager	112 cases per manager
Rural	35 cases per manager	77 cases per manager

Based off of the reimbursement discussions Myers and Stauffer held with other state agencies during our environmental research, it was noted that more than one agency believed that a caseload greater

than 100 cases per case manager is unsustainable and leads to increased case manager turn-over and low quality of care. While the caseloads currently imposed on CCB agencies appear reasonable, SEP agencies may require increased rates to implement a lower caseload. During review of the submitted agency time surveys, it was noted that SEP data consistently showed that reimbursement rates would need to be increased should the state wish to lower caseloads to a more sustainable level of approximately 65 cases per case manager. This aligns with feedback received during larger discussions with CMAs and our research of other state caseload limits, where available.

Recommendation

4. **HCPF should determine an appropriate caseload limitation and codify maximum allowable caseloads in regulation. Caseload standards should be utilized to assist in measuring the quality of case management services delivered from agencies.**

Training Requirements

Stakeholders were upfront in their feedback that state-specific training could be more interactive in execution, and updated on a more consistent basis. With an evolving system of reporting and documenting case management services, increased training may help curb confusion and ensure case managers and supervisors have the necessary skills to do their job. Currently, an array of recorded webinars, FAQ documents, and PowerPoint presentations are available to all case management providers through the HCPF website. Although the current resources found on website cover a vast amount of topics, stakeholders report the provided guidance is not enough. In considering the specific feedback provided by stakeholders, the state should consider limiting the amount of training that is provided through pre-recorded, non-interactive webinars and instead hold interactive web-based or live in-person trainings to case management agencies on a regular interval. This schedule allows for timely updating of regulatory changes, and for agencies to adequately train newly hired case managers.

Recommendation

5. **HCPF should implement a more timely, interactive training curriculum for case management agencies inclusive of live trainings and more frequent, up-to-date webinars.**

Quality and Value-Based Purchasing Framework

Overview

Case management, regardless of the mechanism for service delivery, is not a service historically associated with value-based compensation programs. Myers and Stauffer was unable to identify research suggestive of best practices for the establishment of a value-based program framework, specifically for case management during our environmental scan and discussion with stakeholders. Despite the lack of evidence-based best practices, recommendations for best practices may be drawn from other value-based programs and quality measurements designed for use in other Medicaid-funded

programs. CMS' recent release of quality measurements for Medicaid-funded HCBS is an example which may be used as a quality framework to develop a value-based program for case management services covered by HCPF. To supplement the information obtained from the newly released CMS guidance, research was conducted to expand beyond case management services to identify Medicaid-funded value-based program frameworks which may lend themselves to modification for case management. The following information outlines examples of promising practices from several different service paradigms which may help inform HCPF on further development of a value-based program for case management services in Colorado, with the following specific recommendation:

- *Examine quality measures addressing access, community integration, health and safety, and person-centered practices in the implementation of future quality programs.*

Quality and Value-Based Purchasing Framework and Recommendations

CMS released a State Medicaid Director (SMD) Letter in July 2022 regarding the development of standardized quality measures for Medicaid-funded HCBS, with the intention to promote:

- *Common and consistent use within and across states of such nationally standardized quality measures in HCBS programs.*
- *Create opportunities for CMS and states to have comparative quality data on HCBS programs.*
- *Drive improvement in quality of care and outcomes for people receiving HCBS.*[1]

The HCBS Quality Measure Set is comprised of measures assessing quality across multiple domains identified as measurement priorities for HCBS. For a measure to be included in the HCBS Quality Measure Set, the measure must meet specific criteria outlined in the SMD, including having a defined numerator and denominator which clearly identify exclusion criteria from the measurement population. The measures included in the HCBS Quality Measure Set leverage existing standardized assessment and survey tools employed nationwide. Beneficiary surveys, like the HCBS Consumer Assessment of Healthcare Providers and Systems (CAHPs) or the National Core Indicators–Intellectual and Developmental Disabilities (NCI-IDD) allow for the collection and measurement of beneficiary experiences of care, which is increasingly recognized as a critical component to the improvement of quality and outcomes in HCBS.2 Other standardized tools the HCBS Quality Measure Set draws from include the National Core Indicators–Aging and Disability (NCI-AD); Personal Outcomes Measures (POMs); and other nationally standardized and tested measures related to key areas like community integration, health and safety, and person-centered practices.[3] It should be noted that Colorado currently participates in the NCI-AD, NCI-IDD, and CAHPS programs, and that the state will have ready

[1]Centers for Medicare and Medicaid Services. *SMD#22-003. Re: Home and Community-Based Services Quality Measure Set.* (2022). https://www.medicaid.gov/federal-policy-guidance/downloads/smd22003.pdf. Accessed 25 July, 2022, pg. 1.
[2] Ibid, pg. 6.
[3] Ibid. pg. 6

access to these information systems when reviewing standardized data sets for inclusion of future quality programs.

Though CMS anticipates continuing to update the HCBS Quality Measure Set as more advancements are made in the development of quality initiatives for HCBS programs, in the interim HCPF may want to consider the feasibility of using measurements from the HCBS Quality Measure Set to implement a VBP framework. As the HCBS Quality Measure Set is not for exclusive use in 1915(c) HCBS programming, HCPF may consider implementing these measures across all modes of case management delivery and associating them with an established outcome threshold needed to receive an additional payment percentage.

Certified Community Behavioral Health Clinics (CCBHCs) have operationalized quality bonus payments for the achievement of program specific outcomes. While their measurements are designed to reflect behavioral health and substance used disorder outcomes (and not care coordination directly), the process utilized to translate those outcome measures into quality payments can be repurposed for other program categories. Essentially, outcome measures that reflect quality of care are selected and then payment is issued once a provider achieves a certain level of quality. To target care coordination, one could select quality measures that reflect the desired outcome, such as greater community integration and stable housing. The payments can be structured to be quarterly, semi-annually, or annually depending on the individual outcome measure and the time in which one would expect to see progress. Myers and Stauffer recommends HCPF specifically examine measures addressing access, community integration, health and safety, and person-centered practices given these activities association with case management.

Recommendation

6. **HCPF should examine quality measures addressing access, community integration, health and safety, and person-centered practices in the implementation of future quality programs.**

Conclusion

The above recommendations are based on information obtained during Myers and Stauffer's environmental scan of other state case management reimbursement methodologies and discussions with subject matter experts, data collected during the time survey, and feedback provided through stakeholder meetings to prepare for the implementation of Case Management Redesign. Recommendations outlined in this report should be considered by the HCPF in on-going redesign of case management services rendered. The primary goal of Colorado's case management system redesign aims to utilize information about nationwide best practices, informed with Colorado stakeholder feedback and guided by time survey findings, in creating an equitable reimbursement system that drives quality case management to members throughout the state. Current best practices are not well established within the realm of case management offered through Medicaid 1915(c) HCBS waivers; however, the lack of standardized practice leaves the door open for Colorado to enact forward-thinking, unique approaches to providing quality-centered case management services. Initiating a framework for a quality-informed system of case management in the state allows for Colorado to take a leading role in providing high quality, person-centered case management. These recommendations should serve as the first step in re-aligning Colorado's case management system with the needs of its members, and HCPF should re-evaluate this report and its recommendations pending implementation of any future re-design activities