COLORADO
Department of Health Care Policy & Financing

303 E. 17th Avenue
Denver, CO 80203

October 25, 2024

Developmental Pathways
Attn: Matt VanAuken

Matt,

Thank you for submitting a modified backlog reduction plan to Health Care Policy & Financing (HCPF).

HCPF is provisionally approving the modified backlog reduction plan with the mutual agreement that Developmental Pathways will continue working collaboratively with HCPF in addressing root causes to resolve the backlog on or before December 31, 2024

In addition, Developmental Pathways must provide HCPF with an update monthly on Developmental Pathways findings related to the review of internal processes and procedures contributing to the agency's backlog of case management activities. This information will be provided in addition to the required monthly stabilization data metrics.

Please contact Brent Salner or I with any questions or concerns.

Sincerely,

Rhyann Lubitz

Rhyann Lubitz
Section Manager
Case Management Quality Performance

Case Management Agency (CMA) Backlog Reduction Plan

The purpose of the Backlog Reduction Plan is to identify tangible actions and timelines to reduce a CMAs backlog and meet case load ratio requirements no later than December 1, 2024. A backlog exists when a CMA is not meeting contractual and/or regulatory requirements within the timelines. See Appendix below. Example: Level of Care (LOC) Assessments that are past the required 2-, 5-, or 10-day timeline.

Case Management Agency: Developmental Pathways

*CMA may submit information requested on a separate document following the template provided

DP is submitting the following documents:

1. *CMA Backlog Reduction Plan (HCPF template)*
2. *System Navigation Backlog Specifics*
    - *This document provides a more detailed overview of work happening for DP's referral, intake, enrollment, and non-HCBS sections.*
3. *Active Backlog Specifics*
    - *This document provides a more detailed overview of work happening for DP's active case management department.*
4. *CM, SN, PQ Structure Revamp Project*
    - *This document provides a general project overview of future-focused work underway for departments that support the CMA contract (Case Management, System Navigation, and Program Quality).*

CMA Backlogged Activities as of June 2024

Case Management Activity	**Number**	**Comment**
Pending Referrals	*1,410*	*May to June = 6.8% decrease in the backlog*
Intake Screens	*1,410*	*May to June = 6.8% decrease in the backlog*
Initial LOC Assessments	*345*	*Increase in backlog due to moving more intake screens to this step.*
Continued Stay Review LOC Assessments	*375*	*This number increased due to the Agency 09 report being fixed.*
Monitoring Contacts	*1,874 (for members with zero monitoring contacts since*	*May to June = 6.8% decrease in the backlog*

	11.1.23)	
Service Plan Completion	*1) 375 (SP Meetings); all backlogged CSRs captured as more work needs to be completed to track meetings separate from 100.2 and SP data entry/completion.* *2) 629 (SP documentation processing)*	*Data changed from previous report, so no reduction comparison provided.*

Support Processes and Contacts

HCPF requires each CMA to identify points of contact within their respective agencies to work with Health Management Associates (HMA) to receive technical assistance in developing, submitting for approval, and implementing Backlog Reduction Plans. Each CMA is required to meet with HMA every other week, at a minimum following HCPF's approval of the Backlog Reduction Plan through September 2024. If appropriate progress is not made in reducing the backlog, the frequency and duration of HMA meetings may increase and changes to the approved plan may be required.

The CMA is required to submit monthly data and participate in monthly monitoring meetings with HCPF until backlog is resolved and the CMA has demonstrated at least two quarters where no additional backlogs are identified.

CMA Backlog Reduction Plan Point of Contact(s): Michelle Bauman and Amy Grogan

Michelle Bauman, VP of Case Management Operations | 720-326-6871 | m.bauman@dpcolo.org

Amy Grogan, VP of Case Management | 720-362-0605 | a.grogan@dpcolo.org

Root Cause Analysis

A root cause analysis must be conducted by the CMA to identify why the CMA backlog has occurred, including internal processes and workflows within CMA control. The CMA must report a root cause for each backlogged case management activity they currently have.

In addition to the root cause noted below for each CM activity, there are a few general root causes to make note of.

Within CMA control:

1. *Internal training program: need for additional trainings and resource creation to support knowledge building for all waivers and non-HCBS programs.*
    - *Actions DP has taken toward this include:*
        - *DP has a dedicated training team; this team has done outreach with CM staff to identify training and resource needs and has worked to build and implement new trainings based on staff feedback.*
        - *All trainings are available for all staff (new or tenured).*
        - *The following Waiver Trainings are available for staff:*
            - CLLI Waiver
            - CHRP Waiver
            - BI Waiver
            - CIH Waiver
            - CMHS Waiver
            - CHCBS Waiver
        - *New trainings*
            - *CDASS and IHSS – April 2024*
            - *PD Waiver Referral Process – March 2024*
            - *Telligen Review – March 2024*
            - *DocuSign*
            - CCM exploration/practice sessions including:
                - Activity Log/Log Notes
                - 100.2/Program Card
                - Care Plan/Service Plan
        - *Training in development:*
            - *Benefits and Eligibility Course*
        - *Additional avenues of support implemented and available to staff:*
            - *Technical Assistance time (virtual and in person).*
            - *Small team meetings, department meetings, all staff meetings - spaces where we have and can weave in specific topics.*
            - *Office hours (in person & virtual) via specific topics available for staff to access.*
            - *Example: CCM office hours, Admin office hours.*
            - *Open house days at the office, dedicated to staff (with a virtual option as well) to receive on the spot support with any caseload or workload issues and to answer questions or concerns staff have. For CM teams these occur 1 – 2 times per month.*
            - *Ongoing listening sessions and check-in meetings with teams (every 3 months) to discuss concerns or questions related to work.*
            - *Dedicated zoom channels by topic and/or team to foster connection and established avenues of support.*
            - *Various topic-specific committees and workgroups.*

        - *Regarding trends via complaints, escalations - we have a dedicated CM Care Team (CMCT) to support with elevated customer service needs, and tracking/trend analysis is available via this work/team as well.*
        - *Group sup and small team discussions re: responsiveness, conflict / de-escalation techniques etc.*
    - *DP reviews and analyzes complaints, grievances and escalations and incorporates any needed changes into operations.*
    - *DP CM Directors meet weekly with the escalation team at HCPF to collaborate and solution together, the team has resolved approximately 300 escalations.*
2. *Holding all staff accountable to work outcomes in a consistent and formal manner, in the following ways:*
    - *Actions DP has taken toward this include:*
        - *Tech change - DP now has an Active Caseload Management application that incorporates CM metrics, which are now visible and accessible to all staff.*
        - *Training - Leaders have been training on contract requirements, metrics, and compliance.*
        - *Accountability - monthly conversations with teams and individual staff about expectations and following a formal CA process when expectations are not upheld.*
        - *Greater visibility and transparency via sharing of our backlog reporting - solutions / commitments / progress across teams.*
3. *Need for more dynamic internal technology applications to support task management.*
    - *Actions DP has taken toward this include:*
        - *DP is currently working to shift our approach to the internal tech solutions needed based on current functionality and data needs within the CCM. This includes utilizing internal technology solutions such as CaseWorthy, Power Apps, Smartsheet trackings/workflows, and Power BI.*
        - *Have implemented short-term and mid-term solutions for the following workflows/trackings:*
            - *Non-HCBS referral tracking, assignment management, and reporting via Smartsheet and Power BI*
            - *Intake Call tracking, assignment management, and reporting via Power Apps and Power BI*
            - *Active Caseload Management via Power Apps, caseload management app for CMs and supervisors and member hub app for other supports teams and leaders, noted elsewhere in this report.*
            - *CCM daily download reporting and oversight (for daily churn) via Power BI*
4. *Increase in staff turnover and increase in extended staff leave.*
    - *Actions DP has taken toward this include:*
        - *Staff retention efforts, noted elsewhere in this report.*
        - *Training and technical support, noted elsewhere in this report.*

        - *Evaluating and shifting coverage needs to better meet the needs of temporary staff leave and increased staff turnover. This includes hiring additional coverage FTE and improving workflow efficiencies for members in coverage.*
    - *For members in coverage:*
        - *DP remains committed to work to improve access to a member's CM (being solved for via the Active Caseload Management App and a Member Hub App that provide quick reference to CM and/or supervisor names)*
        - *Updates to the website for quick reference to needed information.*
        - *Implementation of the CM Care Team (that helps to improve timely customer service support for members)*
        - *Increasing reception staff to answer calls and route members to the right person.*
        - *Daily / dedicated in-office support for members that seek support via walking in/dropping by our office.*

Outside of CMA control:

- *Not having reliably accurate CCM access for individuals, creating the need to complete work outside of CCM and later re-enter/redo work when access was received. At times, work was also lost between access fluctuations and CMs would have to redo / resubmit creating costly duplication of effort and work for CMs.*
- *Not having valid reporting data and related reporting crosswalks from the CCM to provide necessary oversight.*
- *Additional time needed to complete work in the CCM, which was not anticipated.*
- *Taking on a significant backlog of work from the previous CMA.*
    - *Example: Intake backlog 1,059 at the time of transition.*
- *In retrospect, DP lacked key information leading up to the new contract to appropriately prepare for certain elements of the work.*
    - *Need for clear data to understand volume of work in various areas prior to new contract starting (i.e. intake call volume). Despite asking for more detailed census data, only overall member census information was shared.*
        - *DP took various other actions prior to the execution of the contract, including:*
            - *Meetings with HMA (Boyd Brown and Mary Lou Bourne) to receive needed guidance, with both signaling confidence that DP was prepared and adequately planning*
            - *Having HMA review all documented planning efforts. Engagement with Mary Lou (6.2022-10.2022) and Boyd (4.2023-12.2023).*
            - *Meetings/conversations with TRE and RMHS to prepare DP's internal operations to be ready for the new contract, asking operational questions, tips and tricks, any information other CMAs currently doing the expanded work could offer.*

        - *Engaged with DP's platform vendor, Case Worthy, to discuss process and technology improvements needed.*
    - *Guidance to hire staff by the start date of the contract, combined with financial constraints in hiring early—in addition to our unique terrain as a CMA not positioned to transition existing staff from an outgoing agency—rendered it difficult to ensure staff were adequately prepared to effectively manage the complexity, volume, and unanticipated challenges of CMRD (and the PHE unwind), as listed here.*
        - *DP hired over 210 new staff to prepare for the new contract. Total number of staff hired was based on data provided via the RFP as well as through conversations with TRE and RMHS about their experiences with expanding work.*
        - *This work including over hiring in various areas. Currently, each area is being reassessed to determine staffing need changes that have occurred since the start of the contract. DP has and will continue to aim to over-hire whenever possible and when appropriate, for our intake and active CM roles.*
    - *A foundational hypothesis of case management redesign was that having previous case management skills and experience in one sector of community supports (such as the I/DD waivers) would be directly transferrable to supporting members in other sectors of the LTC community. While all members and programs are unique, CMAs with experience supporting non-I/DD versus I/DD focused case management have found skills and experience are less transferable than hypothesized and that team members require more specialized training, support, and access to key subject matter experts – which has complicated training, onboarding, and other workflows.*

In addition to the above, DP is currently working on a strategy for evolution of the CM ecosystem structure that supports the completion of core work within and across departments – ensuring quality and timeline requirements are met and that our process is agile and meets the needs of our community.

- *DP recognizes the need to evaluate and shift the current case management approach, including the referral stage, intake, enrollment, and active case management.*
- *This work is being project managed, began May 2024, and will continue through FY25 and beyond.*

Case Management Activity	**Root Cause**

Pending Referrals	• *Took on 1,059 intakes in the backlog from previous agency.*
	• *Issues with CCM access impacted ability to research and complete work for cases.*
	• *Lack of reporting/data needed for oversight.*
	• *Hiring large volume of new staff in a short period of time created additional strain.*
	  ○ *Underestimated needed training for new waivers for CMs.*
	  ○ *Lack of tenured staff to leverage for expanded population.*

Intake Screens	
Initial LOC Assessments	

Continued Stay Review LOC Assessments	• *Larger volume of staff requesting extended leave than anticipated.*
	• *Issues with CCM access impacted ability to research and complete work for cases.*
	• *Staff confusion completing work within the CCM; did not anticipate extended time to complete work in CCM.*
	• *Lack of reporting/data needed for oversight.*
	• *Hiring large volume of new staff in a short period of time created additional strain.*
	  ○ *Underestimated needed training for new waivers for CMs.*
	  ○ *Lack of tenured staff to leverage for expanded population.*

Monitoring Contacts	
Service Plan Completion	

CMA Action Steps to Reduce Backlog

CMA is required to identify CMAs processes or actions that will positively influence and/or impact the overall backlog.

This must include:
1) A minimum of one internal process improvement
2) The percentage or number the backlog will be reduced by each month
3) How the CMA is using stabilization funding to reduce the backlog.
*Please note, CMAs who do not meet their Backlog Reduction Plan action steps or reduce their backlog may be subject to corrective action.

Case Management Activity	**CMA Action being taken**	**Monthly Reduction Goal**
Pending Referrals Intake Screens	• *Hired a new Intake CMS for administrative support.* • *Hiring a new System Navigation Coverage team that will support this work (8 FTE).* • *Tech improvement: Creation of internal intake/referral app to process and have oversight of all intake calls/emails/online forms received.*	*Reduce by 235 each month to meet the goal of 0 by 12.31.2024.* **Details provided in the supplemental System Navigation document.*
Initial LOC Assessments		*Reduce by 58 per month to meet the goal of 0 by 12.31.2024.* **Details provided in the supplemental System Navigation document.*

Continued Stay Review LOC Assessments	• *Multi-prong approach to catching up on LOC assessments and monitoring contact that haven't occurred:*
	  ○ *Utilize data within a newly launched Caseload Management application that enables Case Managers to see all outstanding tasks for members on their caseloads, including 100.2s and monitoring contacts that have not been completed.*
	  ○ *Creation of an internal tracking specific to members who have not had any monitoring contacts and ensuring these are completed / log noted.*
	  ▪ *This includes holding CMs accountable to members assigned to them, validating members in the CCM who are assigned to non CMs and ensuring they are assigned out appropriately and terming members who are no longer active in services.*
	  ▪ *For monitoring contacts, we are validating 541 members who are assigned to DP, have not had a monitoring conducted but require additional follow up to determine if they are in the Intake/Enrollment phase, non HCBS or not active in services any longer. Additionally, 472 of the members are currently enrolling into services and are waiting to select providers.*
	  ▪ *Utilizing leadership and other support with conducting monitoring contacts and holding monitoring in-office days to make good headway on the monitoring completions.*
	  • *7 Active Case Manager teams were given 15 monitoring contact to complete each in June = 105 monitorings*
	  • *Program Managers/ Associate Directors/ Directors /VP stepping in to conduct 115 monitoring contacts in June to support CM staff as they continue to work on the backlog of monitoring contacts and CSRs, while meeting current caseload duties.*
	  • *Cross agency support implemented; other qualified staff are completing 92 monitoring contacts in June.*
	  • *Additional strategies include doing our research/outreach to members to ensure they are active in services. If there is no response to our request*
		Reduce by 63 each month to meet goal of 0 by 12.31.24.

Monitoring Contacts		*Reduce by 313 each month to meet goal of 0 by 12.31.24.* **Details provided in supplemental Active documentation.*

	for a monitoring and they aren't actively receiving services, we will move to terminate the individual from services. • *Creation of internal technology Caseload Management application which tracks all members to ensure forward progress and completion of required contractual obligations, including LOCs. CMs and supervisors will have access to this, and data along with progress/completion of required tasks will be reviewed during bi-weekly supervisory 1:1s.* • *Caseload Validation to ensure every CM has clarity on their caseload.* • *To provide oversight to monitoring activities, teams utilize the following:* o *Internal PMPM/Monitoring Tracking* o *Internal Caseload Management Power App* o *CCM daily download* o *COGNOS reporting* o *Working to meet with Clara Rapp (on Joanne's team) to further discuss reporting needs.*	
Service Plan Completion	• *Multi-prong approach to catching up on SP meetings that haven't occurred:* o *Continue to work with HCPF to understand the updates to the Agency Report 09.* o *Utilize this data within a newly launched Caseload Management application that enables Case Managers to see all outstanding tasks for members on their caseloads, including 100.2s or SPs that have not been renewed.* • *Continue to monitor the progress in processing SPs based on recent adjustments to Case Managers entering data themselves (vs. Admin. teams), and Program Quality staff supporting Case Managers.*	*SP Meetings: Reduce by 63 each month to meet goal of 0 by 12.31.24.* *SP Processing: Reduce by 105 each month to meet goal of 0 by 12.31.24.*

Current CMA stabilization funds are being utilized to directly offset:

1. *Pre-award sunk costs*
2. *Significant, unplanned revenue loss in FY24*

To reduce the backlog in a 6-month timeframe additional staffing resources are needed.

Case Management Activity	**June Backlog**	**Staffing**	**Estimated Staffing Cost**

Pending Referrals	*1,410*	*Additional resources currently being hired to address the backlog. This System Navigation Coverage Team (8 FTE) will be fully ready to provide support in August (team will be partially ready in July; fully staffed in August). It is important as work is completed and focused on intake tasks that we do not unintentionally create a backlog within enrollments or as we assign to active CMs. Focus on getting individuals fully enrolled into services will require backlog focus from the intake process through all stages of enrollment. Once these additional resources are in place, we believe it will take 6-9 months to eliminate the backlog.* **Please see supplemental System Navigation documentation for further details related to the System Navigation Coverage Team.*	*This team has a one-year cost of approximately $600,000.*
Intake Screens	*1,410*		
Initial LOC Assessments	*345*		
Continued Stay Review LOC Assessments	*375*	*Additional active staffing resources are needed to support backlogs in these three areas by indicated deadlines of Dec. 2024. Hiring, onboarding, and training for Active CM roles has not been finalized or started yet. We are aiming to hire 6 new active CM roles for our coverage teams.* **Please see supplemental Active documentation for further details related to the System Navigation Coverage Team.*	*These FTE have a one-year cost of approximately $360,000.*
Monitoring Contacts	*1,874 (for members with zero monitoring contacts since 11.1.23)*		
Service Plan Completion	*1) 375 (SP Meetings)* *2) 629 (SP documentation processing)*		
Additional temporary staffing	*DP is actively working to bring on 25-35 temporary staff, with a 6-month contract to support completing backlog tasks.* *Following the discussion with HCPF, DP will not fully train each temporary staff member but rather train them for specific tasks. Due to the limited training, temp staff will complete work for the first two weeks in the office full time with access to other leaders and subject matter expert. Following the first two weeks, temporary staff will work two days a week in the*		*These FTE have an estimated cost of $998,660 - $1,398,124 for the 6-month contract period.*

	office with an option to work the remaining two days at home if there are no performance concerns. *DP will request CCM access for each of these staff and is working toward these being expedited.*	

Following the elimination of the backlog DP is committed to remaining within contract expectations. This includes the following:

- *Utilizing new and existing technology to provide oversight.*
- *Creating, communicating, and upholding clear expectations.*
- *Continuing to provide training for all staff and leaders being hired/onboarded.*
- *Create monthly compliance measures and reports and implement compliance meetings/action plans to review and oversee compliance (creating more opportunity to problem solving early and often).*

Monthly Data on CMA Staffing

In accordance with Operating Memo 23-068 CMAs are required to maintain a 1:65 member to case manager ratio unless approval has been granted by HCPF for an alternative caseload ratio.

Please identify your CMA current caseload ratio (including approved alternative ratio). In addition, provide information on a recruitment, retention plan and timeline for complying and maintaining these caseload ratio requirements. This includes a coverage plan for vacancies and extended leave.

Current caseload ratios:

- *Active Case Managers: Average 1:64*
    - *We also have a caseload composition survey underway with our teams as while the ratio (caseload size) is important we are learning that caseload composition (what ages and waivers are on the same caseload) is impactful. We will gather input from our CMs, complete analysis, and determine ideal caseload composition.*
        - *Of note, this survey will also compile information pertaining to how much time it takes CMs to complete various core work tasks.*
    - *This survey is currently being finalized and will be sent out late June to early July.*
- *Coverage Case Managers:*
    - *DP manages coverage through a multi-tiered approach.*
    - *DP currently has 2 dedicated Active Coverage Teams and is finishing building out a new System Navigation Coverage Team (for intake, enrollment, benefits, and non-HCBS coverage support needs). Our CM Care Team is also able to support with coverage tasks, when needed.*
        - *The Active Coverage Teams consist of the following FTE:*

    - *1 AD*
    - *2 PMs*
    - *1 PA*
    - *1 Transfer Liaison*
    - *7 SCMs*
    - *2 CMs*
  - *Coverage cases are not assigned directly to coverage Senior Case Managers (SCMs) but rather assigned to the coverage POC. This POC then works to assign all needed coverage tasks to one of the Senior Case Managers on the Coverage Team. Coverage SCMs focus on case work needed during a given month until an ongoing active CM is hired and trained, which is currently happening on a monthly cadence. If there are ongoing coverage needs for the remainder of the month, the Coverage SCM will be assigned as the POC for that month.*
  - *In times where coverage needs exceed coverage capabilities, Active PMs are assigned a caseload and work with their teams to complete core work. This is not the desired long-term strategy to manage coverage but is a part of our multi-tiered approach. While we work to ensure PMs are assigned one caseload (1:65), this is not the current reality in some cases.*

Recruitment and retention plan:

- *DP has a robust recruitment and retention plan, including:*
  - *An employee referral bonus program, various supports toward career advancement, spot bonus program, succession planning & professional development, and merit-based performance increases, to name a few.*
  - *A dedicated Talent Acquisition Team that supports recruitment, screening, interviewing, and onboarding for all new staff. This team is consistently monitoring the market, leveraging technology, utilizing job boards with the most significant return on our investment, and staying up to date with position sponsorship/campaign specials across the various platforms.*
- *A dedicated Training Team. This team supports all training efforts, including developing online training courses and facilitating instructor-led training. In addition, this team, in partnership with key program leaders and staff, supports updating and managing many of our internal resources for staff.*
- *Additional retention items:*
  - *Technical Assistance time (virtual and in person).*
  - *Small team meetings, department meetings, all staff meetings.*
  - *Office hours (in person & virtual) via specific topics available for staff to access.*
  - *Open house days at the office, dedicated to staff (with a virtual option as well) to receive on the spot support with any caseload or workload issues and to answer questions or concerns staff have. For CM teams these occur 1 – 2 times per month.*

- *Ongoing listening sessions and check-in meetings with teams (every 3 months) to discuss concerns or questions related to work.*
- *Dedicated zoom channels by topic and/or team to foster connection and established avenues of support.*
- *Various topic-specific committees and workgroups.*

Appendix:
Please see below for contractual requirements regarding LOC Assessments and Continued Stay Review Assessments:

3.2.4. The Contractor shall conduct an Initial Level of Care Assessment in accordance with the following timelines:
3.2.4.1. 10 Business Days for individuals residing in the community, upon completion of the DD determination, when the individual requests HCBS waiver services, and upon verifying Medicaid eligibility or submission of a Medicaid application.
3.2.4.2. Five Business Days from the date of referral for individuals residing in a nursing facility or ICF-IID.
3.2.4.3. Two Business Days from the date of referral for individuals residing in a hospital.
3.2.4.4. 10 Business Days after receiving confirmation that the Medicaid application has been received by the county Department of Human or Social Services for individuals residing in the community.
3.2.4.5. 10 Business Days after receiving a referral from a provider for PACE.
3.2.4.6. 5 Business Days after receiving a completed referral from the nursing facility.
3.2.4.7. 5 Business Days after receiving a completed approval for the CLLI Waiver.
3.2.4.8. Two Business Days after receiving a completed referral from the hospital.
3.2.5. The Contractor shall enter and verify the evaluation into the Department's prescribed system within 10 Business Days of completing the evaluation.

3.2.6. The Contractor shall conduct a Continued Stay Review Assessment every 12 months for Clients who are continually enrolled for the HCBS waivers, PACE, Nursing Facilities, Hospital Back-Up, LTHH only, and ICF-IDD. The Contractor shall enter the review into the Department's prescribed system within 10 Business Days of completing the evaluation.
3.2.7. The Contractor shall enter and verify the Continued Stay Review into the Department's prescribed system within 10 Business Days of completing the assessment. Failure by Contractor to complete the annual Level of Care Assessment shall cause a break in payment authorization for waiver services for the individual or Member.

Please see below for regulatory requirements regarding Monitoring Contacts:
8.7202.K Monitoring
1. Case Management Agencies shall be responsible to monitor the overall provision of services and supports authorized by Case Managers to ensure the rights, health, safety and welfare of Members, quality services, and that service provision practices promote Member's ability to engage in self-determination, self-representation, and self-advocacy. Monitoring is required for

all waivers in accordance with federal waiver requirements and §§ 25.5-6-1701 — 25.5-6-1709. §§ 25.5-6-1702(3)
2. Monitoring activities shall include but not be limited to the following:
a. Case Managers shall monitor service providers and the delivery of services and supports identified within the Person-Centered Support Plan and the Prior Authorization Request (PAR) for potential rights violations, risks to health, safety and welfare; changed needs, issues with utilization or provision of services, quality of service deliver, or issues with statutory or legal compliance. This may include, but is not limited to:
i. Reviewing and following up on Incident reports, individualized service plans, Rights Modifications, and other provider documentation.
ii. Observing the environment(s) where services are being provided.
iii. Contacting Provider Agency staff about service provision and Member satisfaction
iv. Contacting Members and/or their Legally Authorized Representative about service provision and Member satisfaction
b. The Case Manager shall contact service provider(s) to perform monitoring no less frequently than every 6 months.
c. The Case Manager shall, at a minimum, perform quarterly monitoring contacts with the Member, as defined by the Member's certification period start and end dates.
i. At a minimum, Member monitoring contacts shall include the following:
1) A review of the Member's Level of Care Screen, Needs Assessment and Person-Centered Support Plan, with the Member, to determine whether their Level of Care or needs have changed, or needs are not being met.
2) A review of the Member's service utilization to determine whether services are being delivered/utilized as outlined in the Person-Centered Support Plan /Prior Authorization Request (PAR).
3) An evaluation of the Member's satisfaction with services, to include whether service provision practices promote self-determination, self-representation, and self-advocacy and are person-centered.
4) An evaluation of the Member's health, safety and welfare, including respect for individual rights.
5) A review of the Member's goals, choices and preferences
a) An in-person monitoring contact is required at least one (1) time during the Person-Centered Support Plan certification period not to include the annual Long-Term Services and Supports Level of Care Reassessment. The Case Manager shall ensure the one (1) required in-person monitoring contact occurs, with the Member physically present, in the Member's place of residence or location of services. Case Managers shall contact service providers and Members to coordinate the monitoring.
ii. The Case Manager shall contact service provider(s) to perform monitoring no less frequently than every six (6) months.
iii. Upon Department approval in advance, contact may be completed by the Case Manager at an alternate location, via the telephone or using virtual technology methods.
iv. Such approval may be granted for situations in which in- person face-to-face meetings would pose a documented safety risk to the Case Manager or individual (e.g. natural disaster, pandemic, etc.).

1) The Case Manager shall perform three monitoring contacts each certification period in addition to the one required in-person monitoring. The three additional monitoring contacts shall be either in-person, on the phone, or through other technological modality based on the Member preference of engagement. Additional monitoring contacts may also be performed based on any Critical Incident Reports or other needs that arise throughout the service plan year.
v. Contacts shall be directly with the Member and/or their Legally Authorized Representative.
vi. Contacts shall be bidirectional, i.e., questions and responses, conversation between the Case Manager and the Member and/or their Legally Authorized Representative; letters, emails or voicemails to the Member and/or their Legally Authorized Representative shall not constitute a monitoring contact for purposes of this requirement.