

Case Management Agencies Role in Colorado's LTSS System

Prepared for the Colorado Medicaid Commission — September 17, 2026

Colorado's Long-Term Services and Supports (LTSS) system relies on 15 Case Management Agencies (CMAs) covering 20 Designated Service Areas (DSAs) statewide. CMAs are the single point of contact ensuring people are eligible for services, assessing their needs, building a service plan, connecting them to services, and monitoring those services on an ongoing basis. Developmental Pathways (DP) offers this brief on behalf of Colorado's CMAs to describe who we are, what the work actually requires, and the role we play in the LTSS system. CMAs are core infrastructure in Colorado's LTSS system and where LTSS policy becomes real for supported individuals, families, providers, and the state.

15 <u>CMAs</u> <u>statewide</u>	20 <u>DSAs</u> <u>covered</u>	93,294 <u>Individuals in</u> <u>LTSS statewide</u> <u>(JBC, Jan. 2026)</u>	~2,352 <u>Estimated</u> <u>statewide CM</u> <u>workforce (DP)</u>	\$161.2M <u>Total LTSS CM Spend</u> <u>FY25-26 (HCPF</u> <u>Presentation, Sept. 2026)</u>
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Federal

HHS / CMS — Health & Human Services

Oversees Medicaid; funds HCBS waivers, matched and distributed through the state.

Case Management in Colorado's Disability System

State

HCPF — Health Care Policy & Financing

Administers Medicaid & HCBS waivers; oversees CMAs and RAEs.

CDHS — Dept. of Human Services

Office of Adult, Disability & Aging Services; regional centers, DD Council, disability determination.

Local

CMA — Case Management Agency

Provides case management for LTSS: HCBS waivers, non-waiver programs, and state general fund programs.

RAE — Regional Accountable Entity

Oversees coordination of medical and behavioral health services.

BHASO — Behavioral Health Administrative Organizations

Coordinates community care and handles administrative functions.

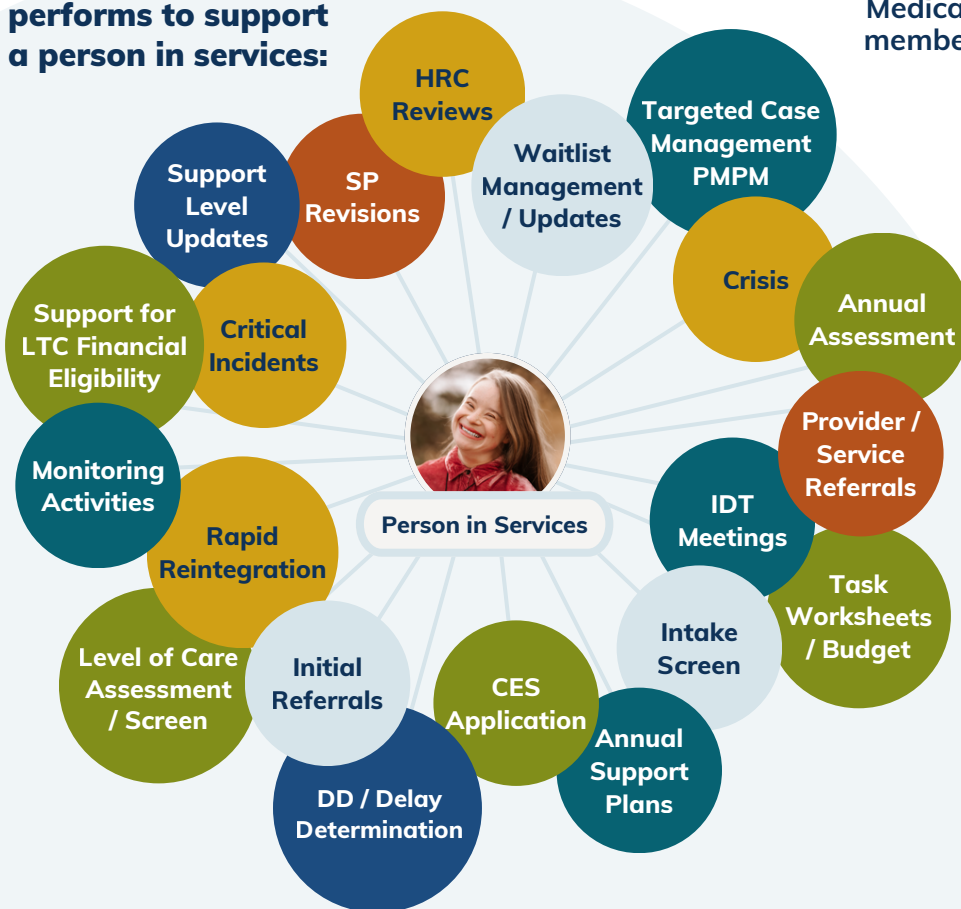
A System Under Growing Strain

Colorado's LTSS system has grown significantly over the past decade — in population, dollars, and complexity — while case management funding has remained a small fraction of total LTSS spend.

What the Work Actually Requires

In its simplest form, case management sounds straightforward. In practice, a single case manager (CM) coordinates dozens of distinct, statutorily timed functions for every person on their caseload, each with its own deadline, its own trigger, and often its own external party (the county, the state, or another agency) controlling the clock.

Activities that a CM performs to support a person in services:



As Needed

- Ad Hoc Support Needs

Annually

- Financial Eligibility
- Functional Eligibility
- Service Planning / Coordination

Growth Impacting Medicaid & LTSS

FY2018

Projected FY2027

CO State Budget

\$28.7B



\$50.7B

Medicaid (HCPF) Budget

\$9B



\$20.6B

Long-Term Services & Support (LTSS)

\$2.58B

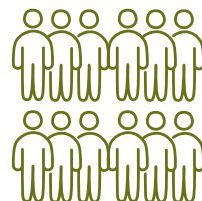


\$6.67B

Individuals in LTSS

63,881

1.3M total
Medicaid
members



93,294

1.3M total
Medicaid
members

DP estimates approximately 400,000 billable case management tasks performed annually across our caseload alone — roughly 17% of the statewide LTSS population. Based on statewide estimates, this suggests CMAs collectively perform over 2 million tasks per year. This figure does not capture the additional time CMs spend helping individuals and families during the intake process and when accessing services. Deadlines range from as tight as 24 hours (critical incident reporting) to two business days (hospital-to-HCBS Level of Care screens), and many are set not by the CMA, but by counties, the state, or other entities in the process.

For Reference: HCPF Memos

- [CM role and responsibilities](#)
- [CMA role and responsibilities](#)

18

Programs

Distinct LTC programs a single CMA may administer - not just the waivers.

75+

Services

Distinct services across those waivers and programs, combined.

~1,700+

Providers

Contracted service providers a CM may need to coordinate with.

4

Delivery Models

Agency-based, Family Caregiver, IHSS, or CDASS - a choice for many services.

11

Technology Systems

7 logged in to directly — CCM, Bridge, Telligen, CO Learn, PEAKPro, FMS Vendor, Wayfinder; plus 4 more that shape the work without a login of their own: CBMS, interChange, Salesforce (HCPF escalations, routed through PQ staff), and SharePoint.

Multiple Channels of System Changes

- 2025 Memo Series
 - 116 Memos
 - 65 Memos with operational impact or call out to CMAs
- Monthly CM's Corner
- 92 CCM Job Aides of varying lengths

**24 Hours
- 90 Days**

Deadline Range

Statutory timelines stacked on one caseload, all running at once.

2 Days

Reply Standard

Average response time expected for every member, every message.

1-by-1

Rollout Method

Every regulation or system change gets implemented person by person - no bulk update (e.g., the CFC transition, done one Continued Stay Review at a time).

65

Caseload



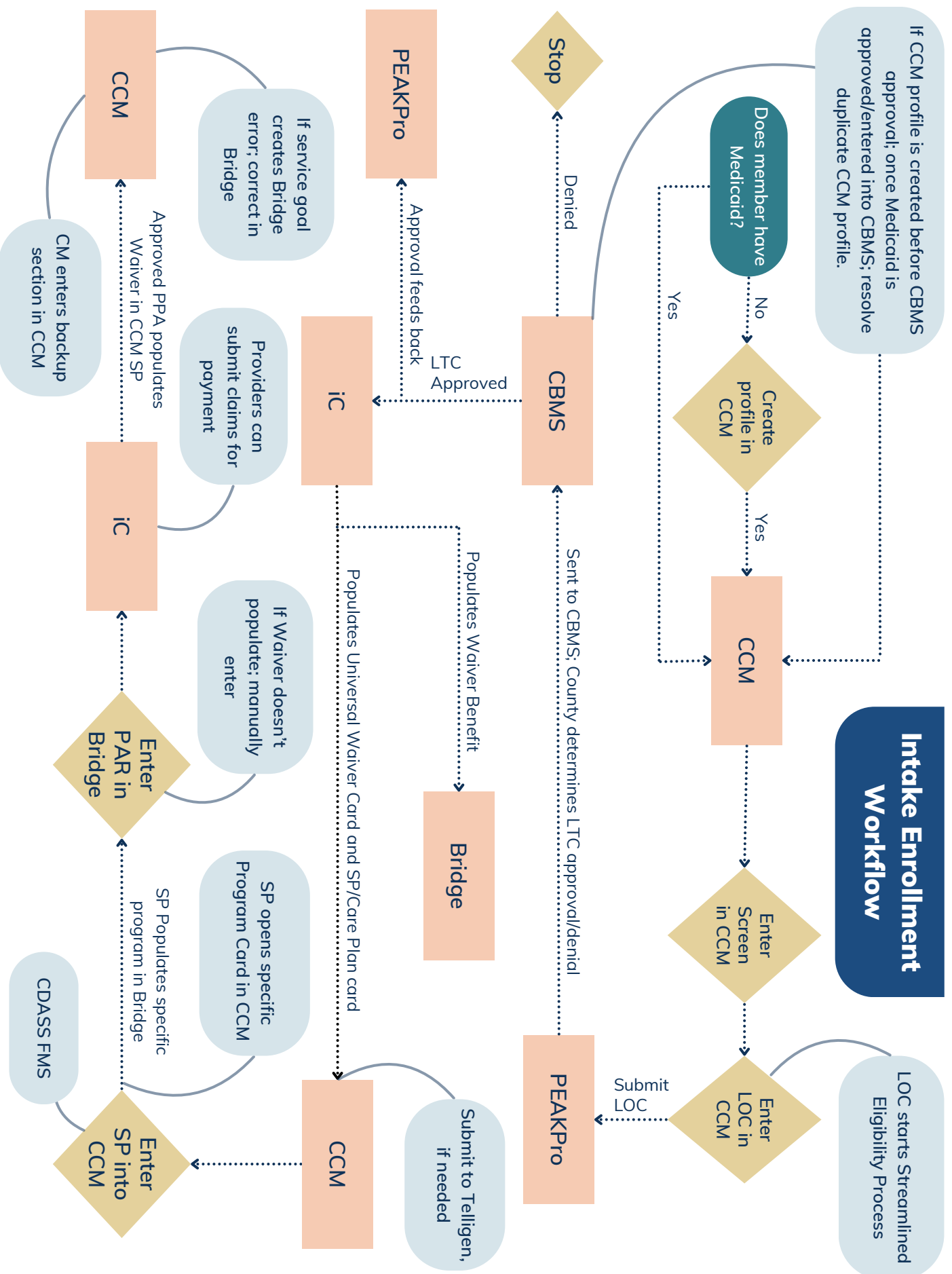
**1 Case
Manager**

**130+
Hours**

Trainings

High Statewide CM Turnover
(constant pressure)

The number of behind-the-scenes systems a CM needs to navigate in order to get an individual enrolled in services:



Enrollment Roadmap

Intake Phase



Step 3

Medical Form Submission

Member provides a signed Medical Information Page (PMIP) within

30 days of the

screening date as part of determining functional eligibility. Completed form needed to move forward with enrollment.

Step 4

Level of Care Assessment

The Intake CM schedules and conducts an in-person level of care assessment within **2, 5, or 10 business days** (based on referral type and date) to determine functional eligibility. Developmental disability or delay determination is needed for I/DD specific waivers.



Enrollment Phase



Ongoing/Active Phase

Step 1

Referral & Screening

DP's Intake team receives member referral. Intake Case Manager (CM) contacts member **within 2 business days** to complete a screening for Long-Term Service and Support needs.

Step 2

Applications

As applicable, member submits all needed applications to the county including their Medicaid Application (Health First Colorado) and Disability Application (if needed)



Step 5



If eligibility is approved and depending on program enrollment type, the member will either immediately move to next step, or if Long-Term Care (LTC) Medicaid approval is needed, the Intake CM submits the assessment level of care form to Medicaid for LTC approval. Approval may take **up to 90 days**. With both paths, the member moves to Enrollment Phase and is assigned an Enrollment CM.

Step 6

Medicaid Monitoring/Confirmation & Provider Selection

Enrollment CM monitors and confirms appropriate Medicaid status and will notify members of the outcome. Enrollment CMs will provide the member with a list of eligible services and providers to begin selection process.

Step 7

Service Plan Meeting

Enrollment CM schedules a Service Plan meeting **within 15 business days** of Medicaid approval (LTC or CFC type) to discuss service needs and goals for the year. A start date is set with authorized service providers. *Enrollment complete! Move to Active Case Management.*

Member Expectations During Intake/Enrollment:

- Provide accurate information throughout the process
- Respond promptly to CM communications
- Schedule all needed screenings, assessments, and meetings within the required timelines
- Complete the PMIP form and any other required documentation and return to DP as soon as possible
- Act promptly on any notifications from the County regarding LTC Medicaid
- Contact providers and arrange for needed services

DP's Experience with Systems Change

Case Management Redesign (CMRD) merged two systems with different histories: a CCB-based model built for low caseloads and high oversight of an I/DD-focused population, and the Single Entry Point (SEP) model built for higher caseloads and less oversight. Combined with outdated caseload assumptions, an untested new technology system, and unwinding pandemic-era Medicaid coverage, the result has been high caseloads and heavy regulatory burden, leaving less room for person-centered practices and dignity of risk. This has reshaped the CM role: CMs support members while navigating complex rules, documentation requirements, tech barriers, service limits, and family frustrations. The system and role have changed drastically, straining the case management workforce.

The Same Process, Radically Different Needs

Every person served moves through the same fixed sequence of deadlines and paperwork, regardless of how complex or acute their needs are. Two examples from real caseloads illustrate the range:

EBD Waiver — Age 80

An 80-year-old woman with severe arthritis is enrolled in the EBD waiver and lives in a senior community with social and transportation support. Her children frequently check in, accompany her to medical appointments, assist with medications, and run errands. She maintains independence, requiring only minimal homemaker and personal care support. She tells her CM that she feels no additional assistance is needed and is confused by the frequent meetings and check-ins.

DD Waiver — Age 25

A 25-year-old man with autism and bipolar disorder, enrolled in the DD waiver, requires high support due to severe behavioral issues. He has frequent Interdisciplinary Team (IDT) meetings due to weekly incidents of self-harm and aggression toward housemates. He has been served and discharged by three residential providers due to his intensive needs. Currently, he is involved in Complex Service Solutions calls with the CMA, RAE, and HCPF, and is being evaluated for Regional Center placement.

Both individuals move through the same statutory intake, assessment, and monitoring sequence shown below, regardless of the vast difference in acuity, risk, and time actually required.

The people we support are not widgets. The range of needs across this population makes a one-size-fits-all model difficult to sustain. The system is complicated, overwhelming, and inefficient for all involved.

We share this brief to give the Commission a clearer picture of the role CMAs play and the complexity involved in that work, not to advocate for a specific policy change.

Questions:

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