2019

URAC CASE MANAGEMENT PERFORMANCE MEASUREMENT:

AGGREGATE SUMMARY PERFORMANCE REPORT

December 2019

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Executive Summary

Presented in this report are the 2018 measurement year (2019 reporting year) results based on URAC's Case Management (CM) Accreditation program performance measures. The report includes summary rates in aggregate.

Organizations were required to report data for five mandatory measures, and they had the option to report data for one exploratory measure. Below is the list of mandatory [M] and exploratory [E] measures for 2019 reporting:

1. Medical Readmissions (CM2013-01) [M]
2. Percentage of Participants That Were Medically Released to Return to Work: Disability and Workers' Compensation Only (CM2013-02) [M]
3. Complaint Response Timeliness (CM2013-03) [M]
4. Overall Consumer Satisfaction (CM2013-04) [M]
5. Percentage of Individuals That Refused Case Management Services (CM2013-05) [M]
6. Patient Activation Measure (DM2012-10)* [E]

*No respondents provided data for this exploratory measure; therefore, only a measure description is included in this report.

The URAC measure specifications are set forth within the 2019 Case Management Reporting Instructions.

Data Analysis Procedures

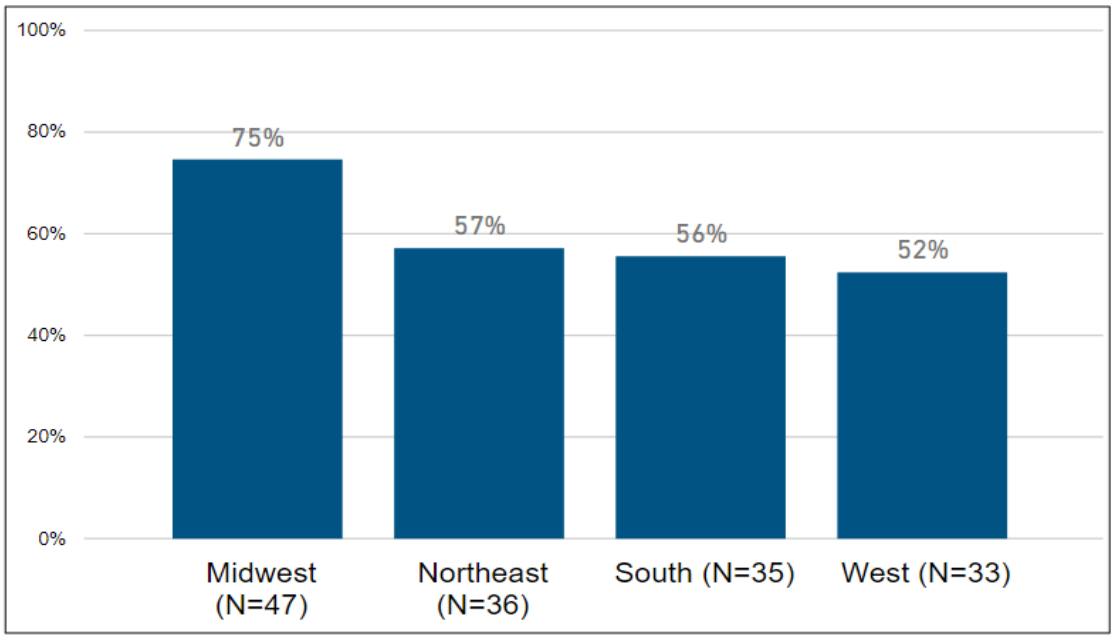
Kiser Healthcare Solutions continued use of a relational database management system, Microsoft SQL Server (MSSQL), implemented in 2017, to capture and normalize all accreditation submission data into a consistent format across programs. This allows for a consistent model to be used year over year and allows for trends to build. In addition, MSSQL aids in consolidating all data objects used for aggregations, guaranteeing consistent logic across programs and ease of updates. Kiser Healthcare Solutions also used Microsoft Power BI as the business intelligence tool to develop the data visuals and tables in the report.

This performance report has been prepared for the URAC Quality, Research and Measurement Department by Kiser Healthcare Solutions, LLC. If you have any questions about the results contained herein, please contact us at: ResearchMeasurement@urac.org.

Case Management Organization Characteristics

A total of 63 URAC-accredited Case Management organizations reported 2018 measurement year data for the 2019 reporting year. The Midwest represented the largest number of organizations at 75% (n=47), and 38% (n=24) of organizations served populations in all four regions. The other three regions were distributed relatively evenly ranging from 52% to 57% (Exhibit 1).

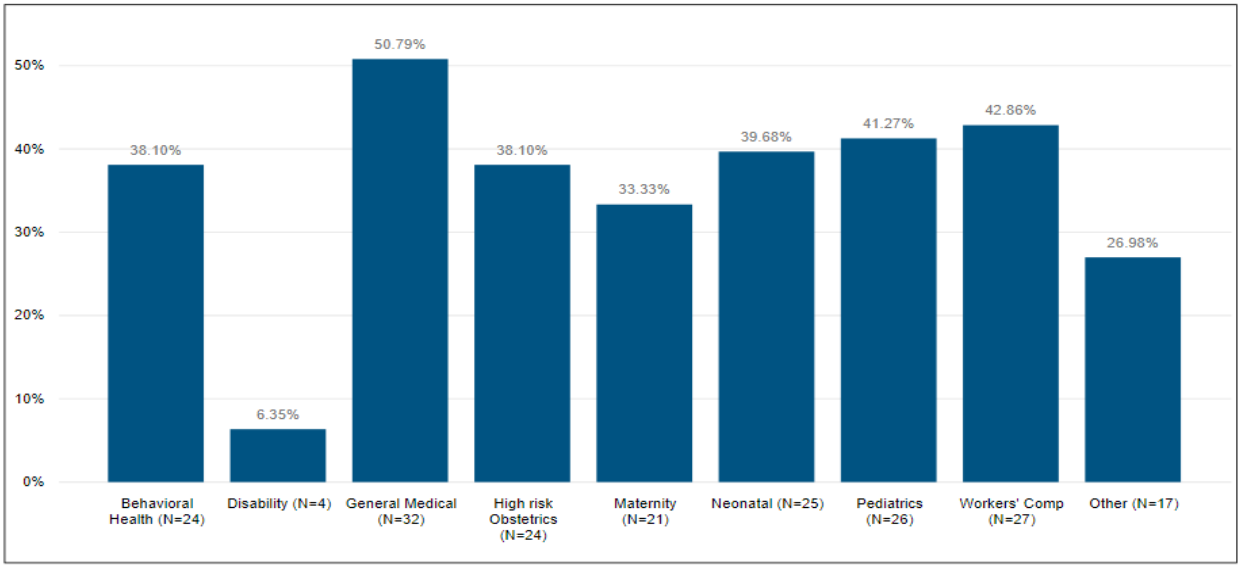
Exhibit 1: Regional Areas Served



Note: Multiple responses accepted.

Most organizations (50.79%, n=32) performed General Medical case management, while Disability case management represented the least (6.35%, n=4)). Responses indicated as “Other” include, but are not limited to, Catastrophic, Dialysis, Maternity, Oncology, and Transplant.

Exhibit 2: Type of Case Management Performed



Note: Multiple responses accepted.

There are 453,383 unique cases represented by the responding organizations, ranging from 25 to 163,879 per organization with a mean of 7,197 and median of 1,229 unique cases. There were 46.03% (n=29) of organizations that reported managing less than 1,000 unique cases, with the most volume ranging from 0-400 cases. There were 53.97% of organizations (n=34) that managed 1,000 or more unique cases (Exhibit 3 and Exhibit 4); of those, the highest volume ranged between 1,000 and 5,000 cases.

Exhibit 3: Case Management Organization Case Volume <1,000 (Number of Unique Cases)

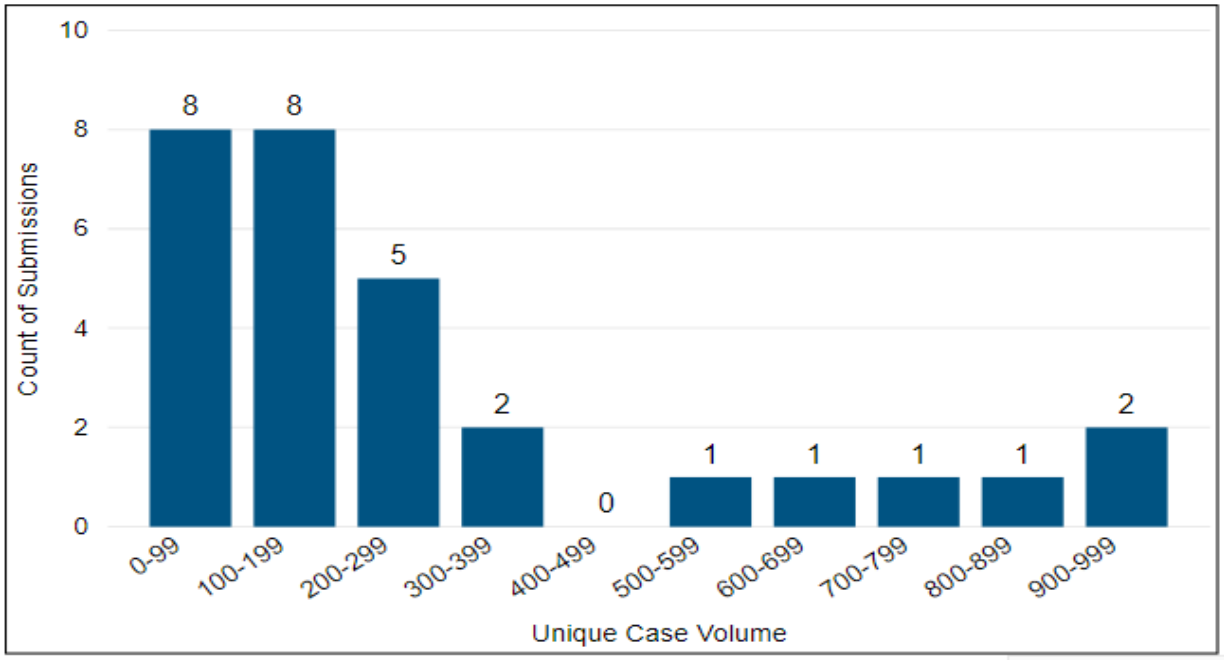
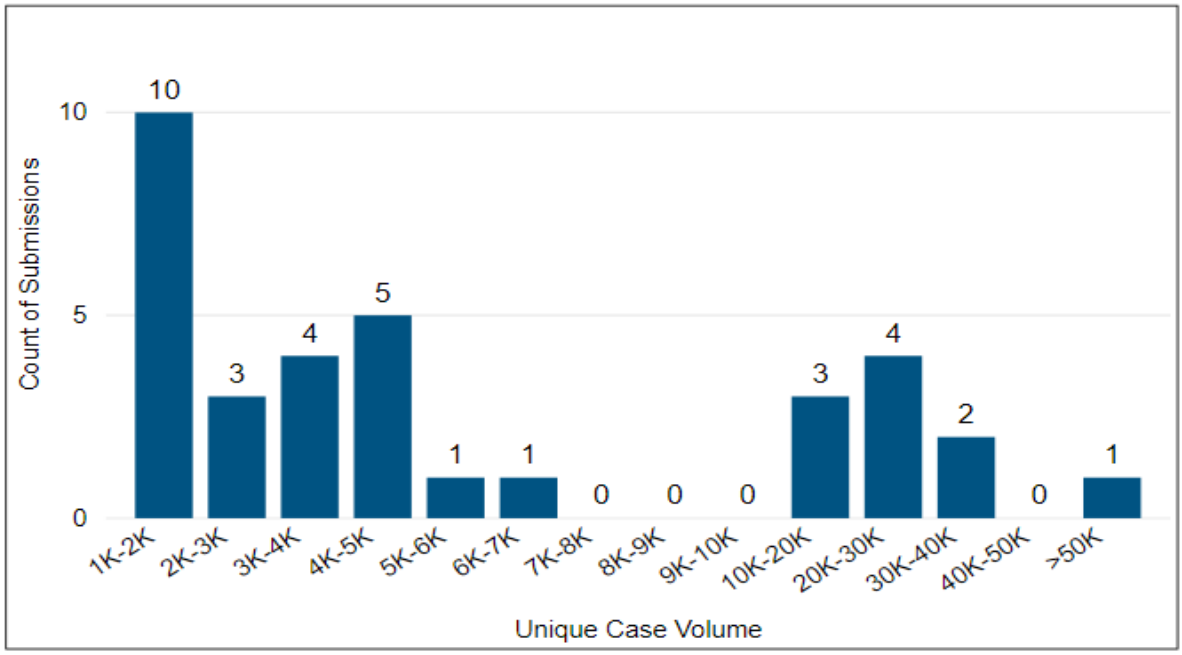


Exhibit 4: Case Management Organization Volume ≥1,000 (Number of Unique Cases)



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Of the 63 organizations that reported this measure, 41.27% (n=26) track the number of consumers with a hospital readmission after discharge from an acute care facility (Exhibit 5). Of those organizations that track readmissions, 65.38% (n=17) indicated that they verify the readmissions are correctly coded (Exhibit 6).

Of the 26 organizations tracking hospital readmissions, 80.77% (n=21) track hospital readmissions through a utilization management process, while the majority of other organizations track using claims data, authorization data, or via notification from the healthcare provider, member, and/or family Exhibit 7). Of the 26 organizations tracking readmissions, there were 84.61% (n=22) that become aware of hospital readmissions within 30 days of discharge (Exhibit 8). In addition, of the 58.73% (n=37) of organizations that indicated they do not track hospital readmissions after discharge, 91.89% of organizations (n=34) are not planning to use this indicator in the future (Exhibit 9).

Exhibit 5: Case Management Organizations that Track Readmissions

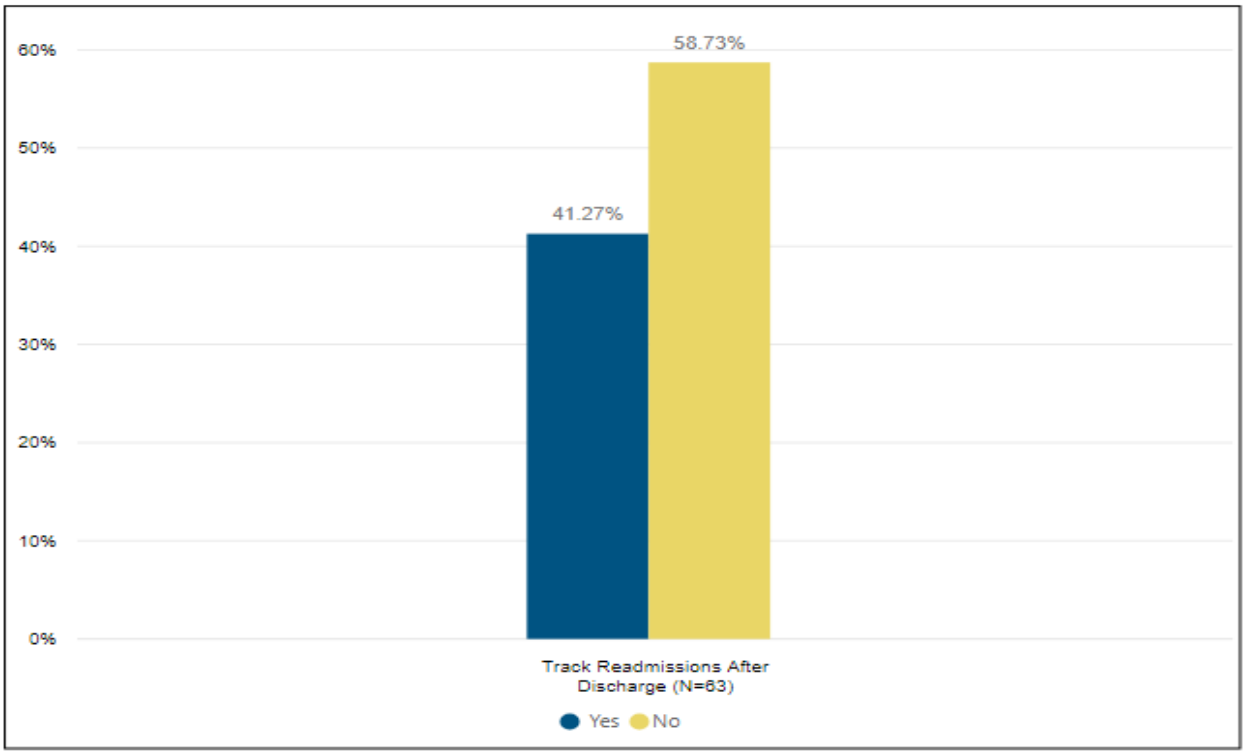


Exhibit 6: Case Management Organizations that Verify Readmissions

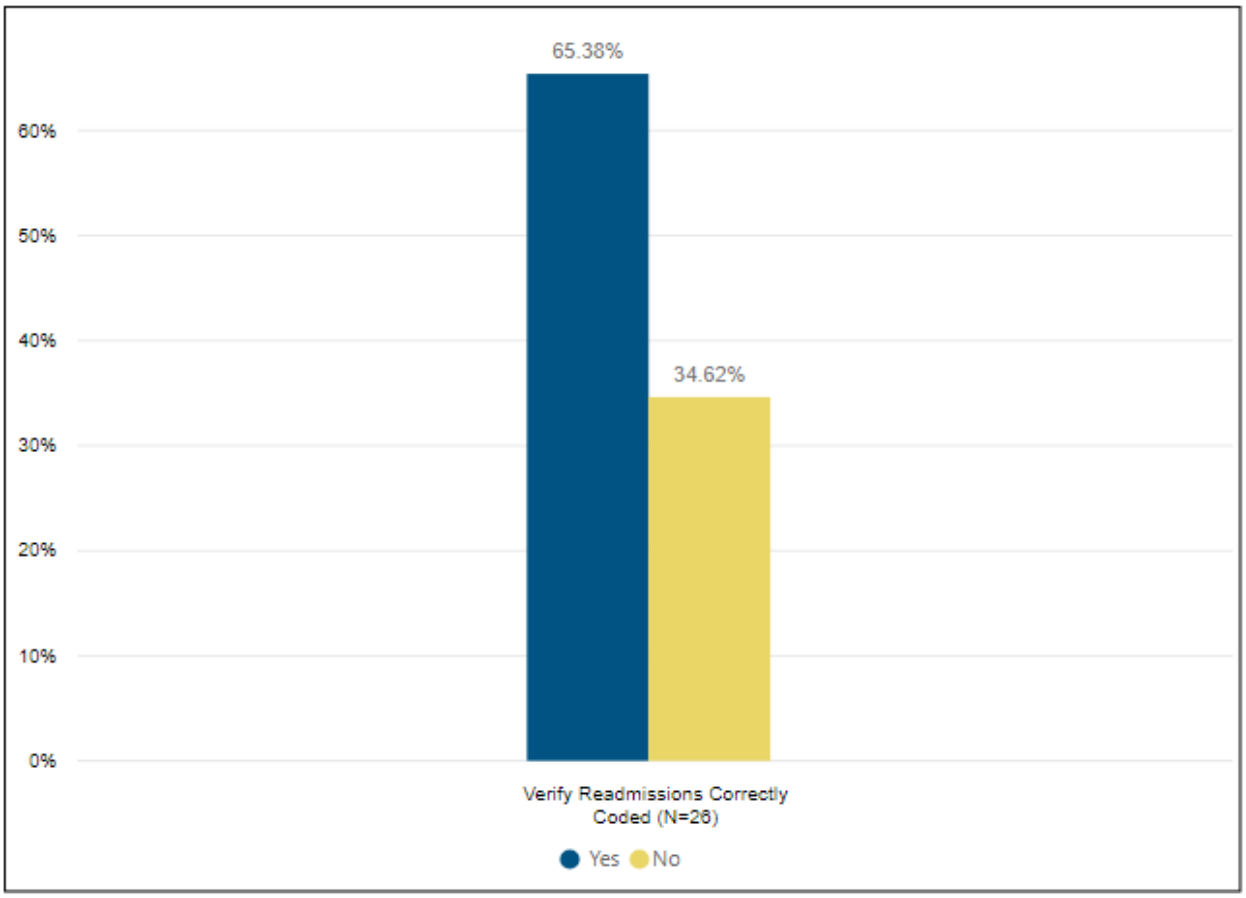
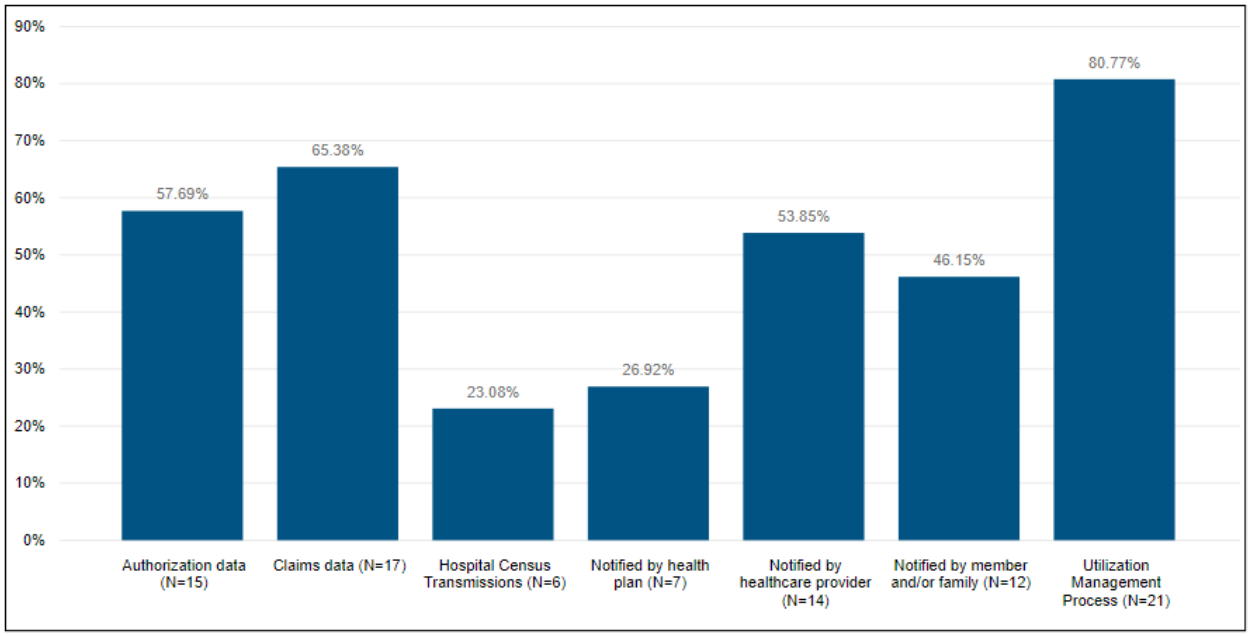


Exhibit 7: Method to Track Hospital Readmissions



Note: Multiple responses accepted.

Exhibit 8: When Organizations Become Aware of Readmission

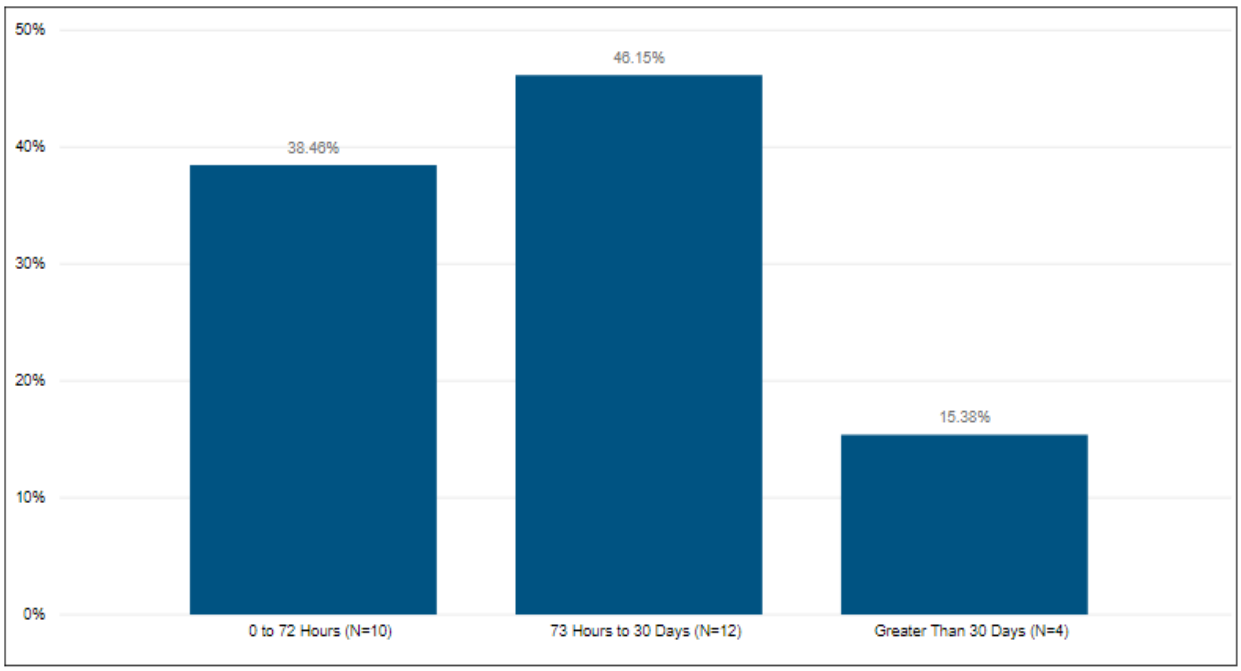
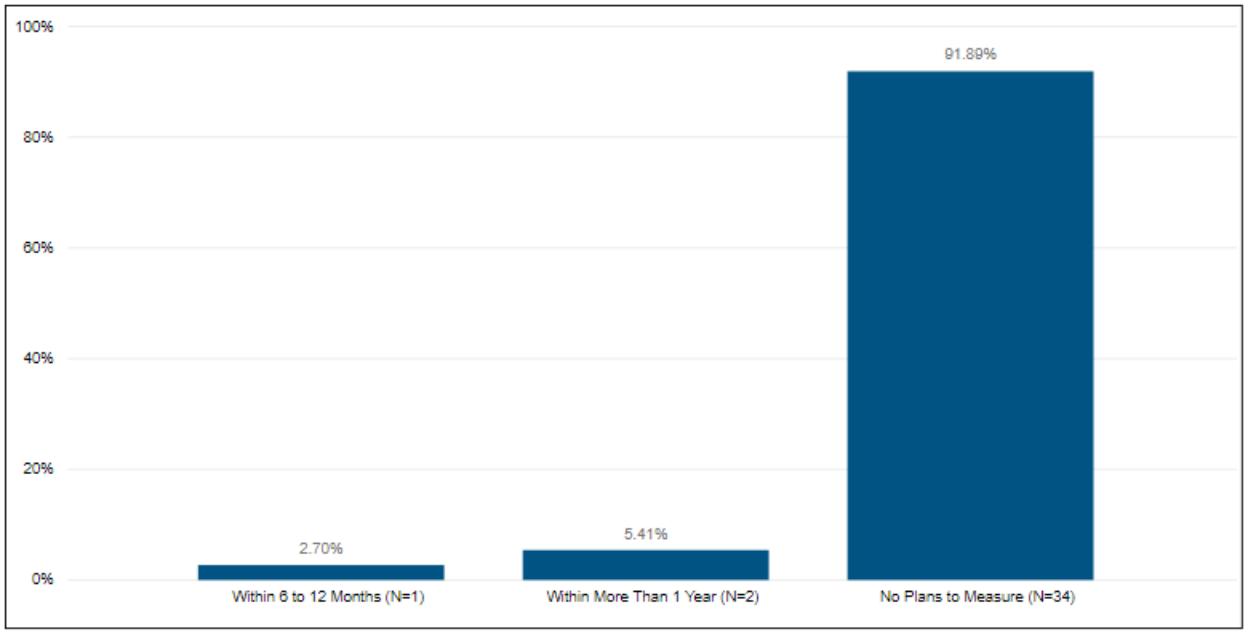


Exhibit 9: Plans for Case Management Organizations Not Presently Tracking Hospital Readmissions to Measure in Future



Results: Case Management Measures

A total of 63 URAC-accredited Case Management organizations reported at least one of the mandatory measures. Not all mandatory measures were applicable for all reporting organizations. Therefore, sample sizes are noted for organizations where the measure was deemed applicable based on adequate sampling.

Measure 1 – Medical Readmissions (CM2013-01)

Measure Description

This measure assesses the percentage of the eligible population that participated in onsite general medical case management services that had an unscheduled readmission to an acute care hospital within 30 days *(mandatory)* and within 72 hours *(exploratory)* of discharge. This measure excludes Behavioral Health, Disability, and Workers Compensation populations. **A lower rate represents better performance.**

Summary of Findings

Given there were fewer than five valid submissions for each rate, analysis results are not included in this report.

Measure 2 – Percentage of Participants That Were Medically Released to Return to Work: Disability and Workers' Compensation Only (CM2013-02)

Measure Description

This *mandatory* measure assesses the percentage of disability or workers' compensation case management cases that were managed for return to work (RTW) and whose participants were medically released to RTW in a specified time frame during the measurement period. This measure has two parts: Part A and Part B. Part A is for participants who received telephonic case management. Part B is for participants who received field case management.

Summary of Findings

This measure is specified for Disability and Workers Compensation service categories. Given only four organizations managed a Disability program, analysis was performed for Workers Compensation only.

Part A: Telephonic Case Management

A total of 17 organizations reported on Part A. Results indicated that 41.23% of cases returned to work within 90 days, if referred to case management within seven days of onset of lost time. For cases referred to case management within eight to 14 days of onset of lost time, 23.84% returned to work within 90 days. For cases referred within 15 to 30 days of onset of lost time, 19.81% returned to work within 90 days. For cases referred after 30 days of onset of lost time, 10.42% returned to work within 90 days. Based on the data reported, there is a positive association in RTW days where referrals occur sooner. Longer RTW days are seen when cases are not referred within 30 days.

The return to work within 90 days rates for Telephonic Case Management (Part A) outperforms Field Case Management (Part B), when referrals occur within 30 days. For Telephonic Case Management, the shorter the time of referral to case management infers the sooner the individual can return to work. Tests of statistical significant differences were not conducted given small sample sizes.

Exhibit 10: Telephonic Case Management – Workers Compensation Case Management (Summary Data)

	Stratification				
Time from onset of lost time to referral to case management (calendar days)	Time between onset of lost time to medical release	Total Numerator	Total Denominator	Aggregate Summary Rate	Submissions
1 to 7 days	1 to 90 days	7,460	18,092	41.23%	17
	91 to 180 days	1,197	18,092	6.62%	17
	181 to 360 days	424	18,092	2.34%	17
	Over 360 days	279	18,092	1.54%	17
	Unknown RTW	8,732	18,092	48.26%	9
8 to 14 days	1 to 90 days	3,765	15,796	23.84%	15
	91 to 180 days	647	15,796	4.10%	15
	181 to 360 days	243	15,796	1.54%	15
	Over 360 days	345	15,796	2.18%	15
	Unknown RTW	10,796	15,796	68.35%	9
15 to 30 days	1 to 90 days	3,248	16,395	19.81%	14
	91 to 180 days	760	16,395	4.64%	14
	181 to 360 days	302	16,395	1.84%	14
	Over 360 days	490	16,395	2.99%	14
	Unknown RTW	11,595	16,395	70.72%	9
Over 30 days	1 to 90 days	2,017	19,362	10.42%	16
	91 to 180 days	1,443	19,362	7.45%	16
	181 to 360 days	1,253	19,362	6.47%	16
	Over 360 days	1,557	19,362	8.04%	16
	Unknown RTW	13,092	19,362	67.62%	9

Exhibit 11: Telephonic Case Management for Workers Compensation by Time to Referral

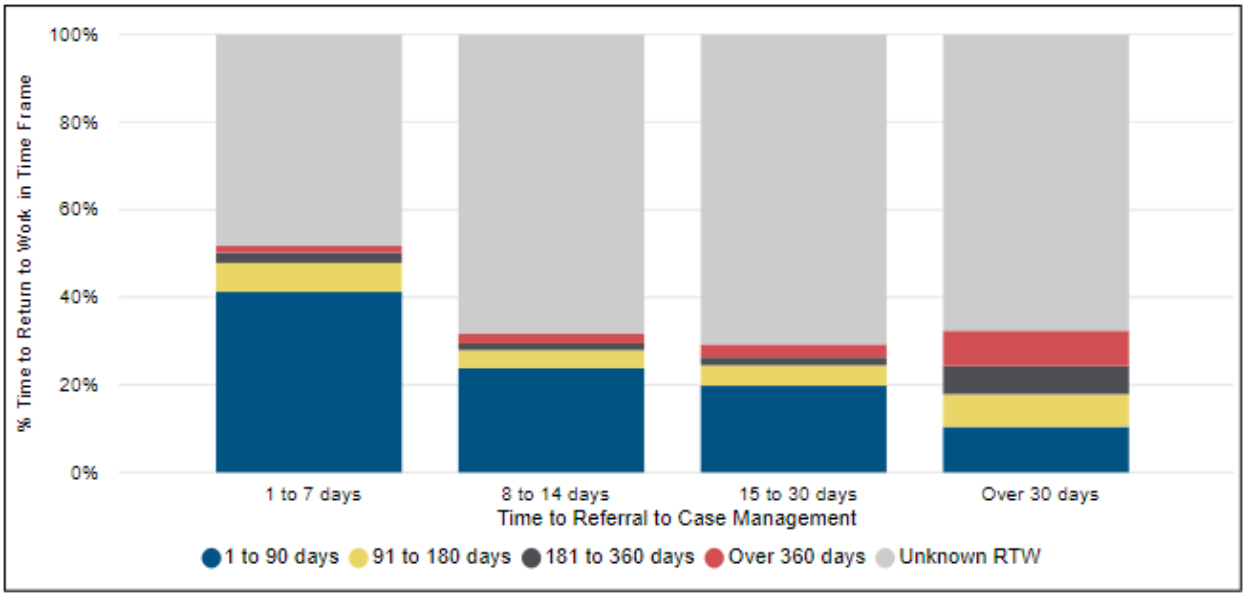
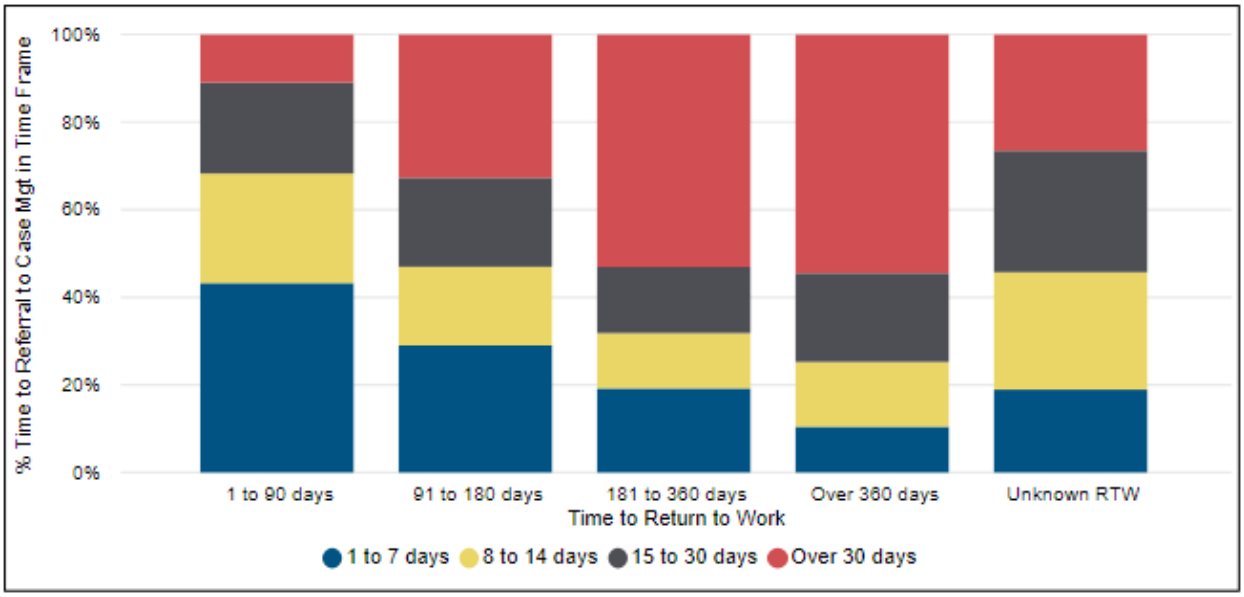


Exhibit 12: Telephonic Case Management – Workers Compensation Case Management (Benchmarks and Percentiles)

	Stratification							
Time from onset of lost time to referral to case management (calendar days)	Time between onset of lost time to medical release	Min	10th	25th	50th	75th	90th	Max
1 to 7 days	1 to 90 days	5.26%	30.51%	36.88%	52.54%	75.92%	83.11%	84.93%
	91 to 180 days	0.00%	4.41%	5.02%	8.60%	12.84%	20.41%	27.12%
	181 to 360 days	0.00%	1.18%	1.60%	2.77%	7.41%	8.33%	10.17%
	Over 360 days	0.00%	0.00%	0.00%	0.54%	3.20%	6.32%	11.42%
8 to 14 days	1 to 90 days	0.00%	1.55%	9.23%	20.80%	64.90%	72.34%	83.33%
	91 to 180 days	0.00%	0.00%	1.14%	4.44%	11.51%	24.16%	29.23%
	181 to 360 days	0.00%	0.00%	0.62%	1.81%	3.18%	6.42%	10.71%
	Over 360 days	0.00%	0.00%	0.00%	0.31%	1.35%	6.34%	15.36%
15 to 30 days	1 to 90 days	0.00%	1.03%	5.81%	12.58%	58.05%	65.32%	67.42%
	91 to 180 days	0.00%	0.35%	1.33%	2.91%	12.18%	17.72%	32.20%
	181 to 360 days	0.00%	0.00%	0.08%	1.32%	6.22%	10.90%	16.22%
	Over 360 days	0.00%	0.00%	0.00%	0.54%	5.94%	13.44%	17.97%
Over 30 days	1 to 90 days	0.00%	1.06%	2.09%	13.53%	30.60%	32.94%	36.14%
	91 to 180 days	0.00%	0.15%	0.85%	3.62%	21.99%	25.78%	39.60%
	181 to 360 days	0.00%	0.00%	0.03%	2.71%	20.90%	29.92%	39.93%
	Over 360 days	0.00%	0.00%	0.00%	3.17%	16.97%	30.41%	38.34%

Exhibit 13: Telephonic Case Management for Workers Compensation by Return to Work



Part B: Field Case Management

A total of 14 organizations reported on Part B. Field Case Management performs lower than Telephonic Case Management when the referral occurs within 30 days; however, there is slightly better performance for RTW within 90 days when the referral occurs after 30 days. Tests of statistical significant differences were not conducted given small sample sizes.

Results indicated that 27.46% of cases returned to work within 90 days, if referred to case management within seven days of onset of lost time. For cases referred to case management within eight to 14 days of onset of lost time, 12.71% returned to work within 90 days. For cases referred within 15 to 30 days of onset of lost time, 15.50% returned to work within 90 days. For cases referred after 30 days of onset of lost time, 16.98% returned to work within 90 days. Based on the data reported, there is a positive association in RTW days where referrals occur sooner. Longer RTW days are seen when cases are not referred within 30 days.

Exhibit 14: Field Case Management – Workers Compensation Case Management (Summary Data)

	Stratification				
Time from onset of lost time to referral to case management (calendar days)	Time between onset of lost time to medical release	Total Numerator	Total Denominator	Aggregate Summary Rate	Submissions
1 to 7 days	1 to 90 days	2,653	9,663	27.46%	14
	91 to 180 days	785	9,663	8.12%	14
	181 to 360 days	524	9,663	5.42%	14
	Over 360 days	358	9,663	3.70%	14
	Unknown RTW	5,343	9,663	55.29%	9
8 to 14 days	1 to 90 days	976	7,676	12.71%	14
	91 to 180 days	378	7,676	4.92%	14
	181 to 360 days	209	7,676	2.72%	14
	Over 360 days	131	7,676	1.71%	14
	Unknown RTW	5,982	7,676	77.93%	7
15 to 30 days	1 to 90 days	1,239	7,993	15.50%	14
	91 to 180 days	408	7,993	5.10%	14
	181 to 360 days	255	7,993	3.19%	14
	Over 360 days	150	7,993	1.88%	14
	Unknown RTW	5,941	7,993	74.33%	8
Over 30 days	1 to 90 days	2,005	11,806	16.98%	14
	91 to 180 days	1,638	11,806	13.87%	14
	181 to 360 days	1,535	11,806	13.00%	14
	Over 360 days	1,912	11,806	16.20%	14
	Unknown RTW	4,716	11,806	39.95%	8

Exhibit 15: Field Case Management for Workers Compensation by Time to Referral

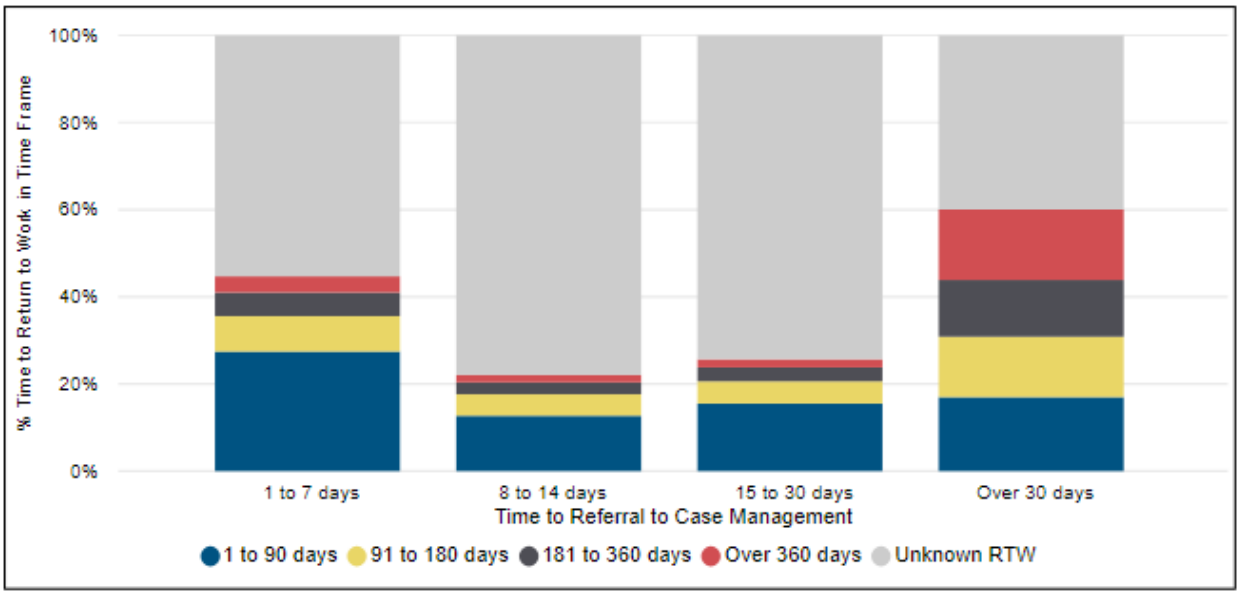
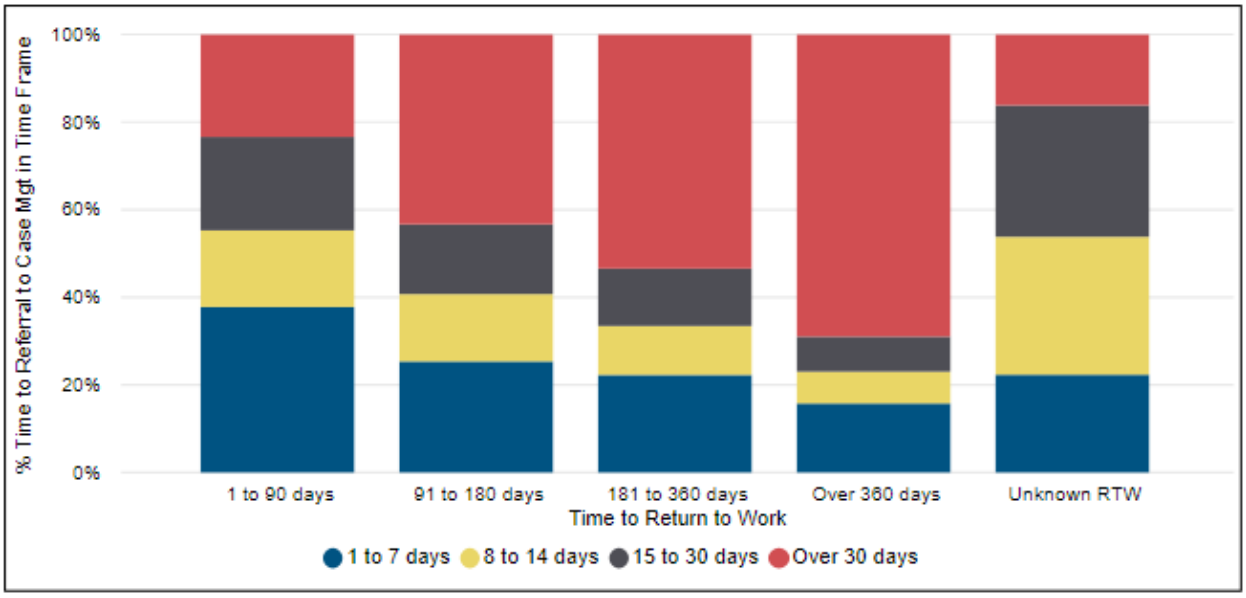


Exhibit 16: Field Case Management – Workers Compensation Case Management
(Benchmarks and Percentiles)

	Stratification							
Time from onset of lost time to referral to case management (calendar days)	Time between onset of lost time to medical release	Min	10th	25th	50th	75th	90th	Max
1 to 7 days	1 to 90 days	0.00%	2.52%	13.43%	36.45%	46.92%	52.70%	63.33%
	91 to 180 days	0.00%	0.32%	2.92%	8.47%	17.32%	22.09%	28.43%
	181 to 360 days	0.00%	0.10%	0.50%	3.30%	14.29%	18.80%	19.12%
	Over 360 days	0.00%	0.00%	0.25%	2.12%	11.27%	27.97%	38.69%
8 to 14 days	1 to 90 days	0.00%	0.14%	4.80%	15.97%	46.32%	53.35%	63.42%
	91 to 180 days	0.00%	0.00%	0.56%	2.74%	21.81%	28.95%	33.17%
	181 to 360 days	0.00%	0.05%	0.28%	1.68%	10.55%	15.66%	27.93%
	Over 360 days	0.00%	0.00%	0.00%	0.37%	8.11%	21.78%	35.38%
15 to 30 days	1 to 90 days	0.00%	0.43%	5.95%	14.65%	49.70%	58.57%	80.89%
	91 to 180 days	0.00%	0.15%	0.79%	3.42%	18.03%	24.09%	30.87%
	181 to 360 days	0.00%	0.00%	0.26%	2.68%	8.33%	14.33%	20.13%
	Over 360 days	0.00%	0.00%	0.00%	0.81%	5.12%	18.75%	38.89%
Over 30 days	1 to 90 days	0.00%	1.62%	7.80%	15.67%	29.57%	45.75%	55.70%
	91 to 180 days	0.00%	1.01%	5.73%	12.26%	22.02%	28.63%	30.97%
	181 to 360 days	0.00%	0.59%	5.03%	10.91%	17.77%	24.49%	31.31%
	Over 360 days	0.00%	0.25%	2.12%	7.41%	21.98%	40.15%	60.54%

Exhibit 17: Field Case Management for Workers Compensation by Return to Work



Measure 3 – Complaint Response Timeliness (CM2013-03)

Measure Description

This measure has two parts and reporting is *mandatory* for both. Part A assesses the percentage of consumer complaints to the case management program to which the organization responded within the time frame that the program has established for complaint response. Part B assesses the average time, in business days, for complaint response. **A lower rate represents better performance for Part B. Responses with a denominator of less than 30 complaints are included given ideal performance is fewer complaints.**

Summary of Findings

A total of 62 organizations submitted data for this measure. Only two organizations indicated they do not have a system to track complaints received from consumers, and three organizations indicated they do not have a system to track response time. Further, the majority of organizations or 53.23% (n=33) do not have a system for prioritizing complaints (Exhibit 18). Organizations typically have an average response time goal of less than 15 business days with the most frequently used 30 business days response time (Range: 1 to 72 business days).

Of the 62 organizations, including those that that had a denominator size of less than 30, 30.65% (n=19) reported No Complaints. Nearly all of the organizations (94.89%) reported having a response within the program's specified time frame. On average, organizations respond to consumer complaints within 3.82 business days.

Exhibit 18: Organizations with Systems for Tracking Complaints

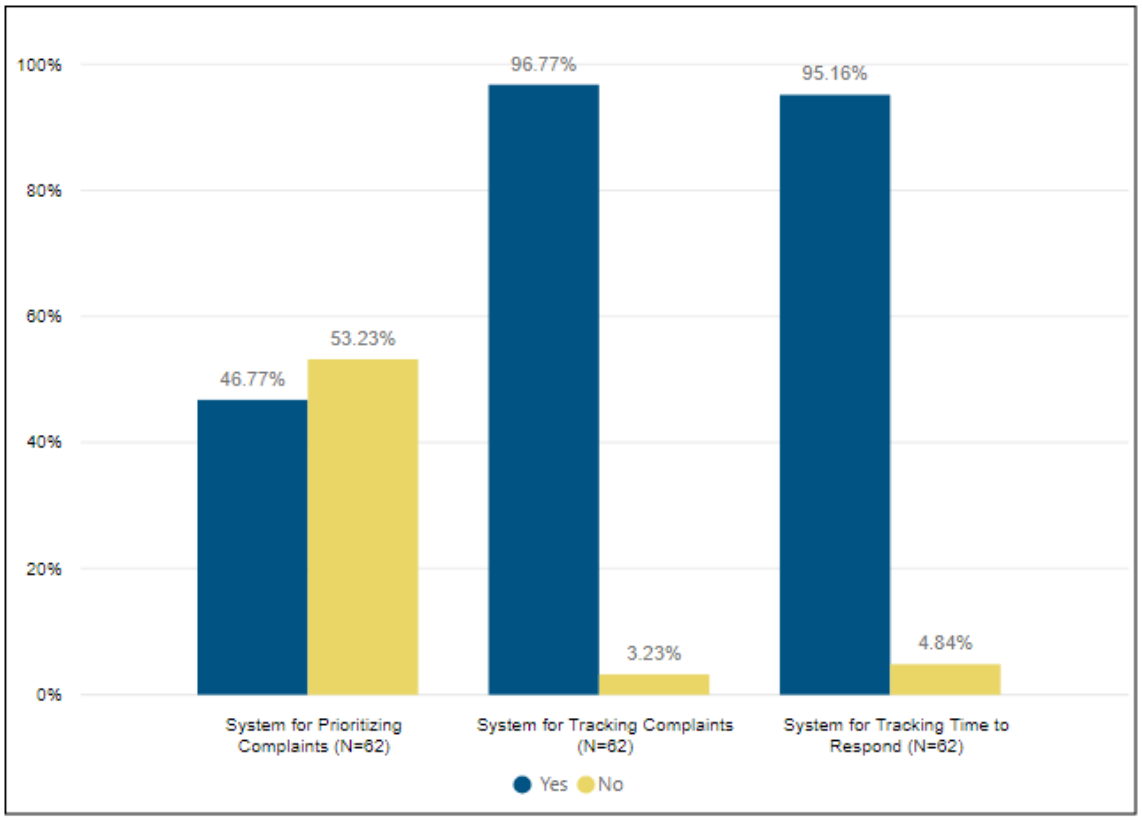
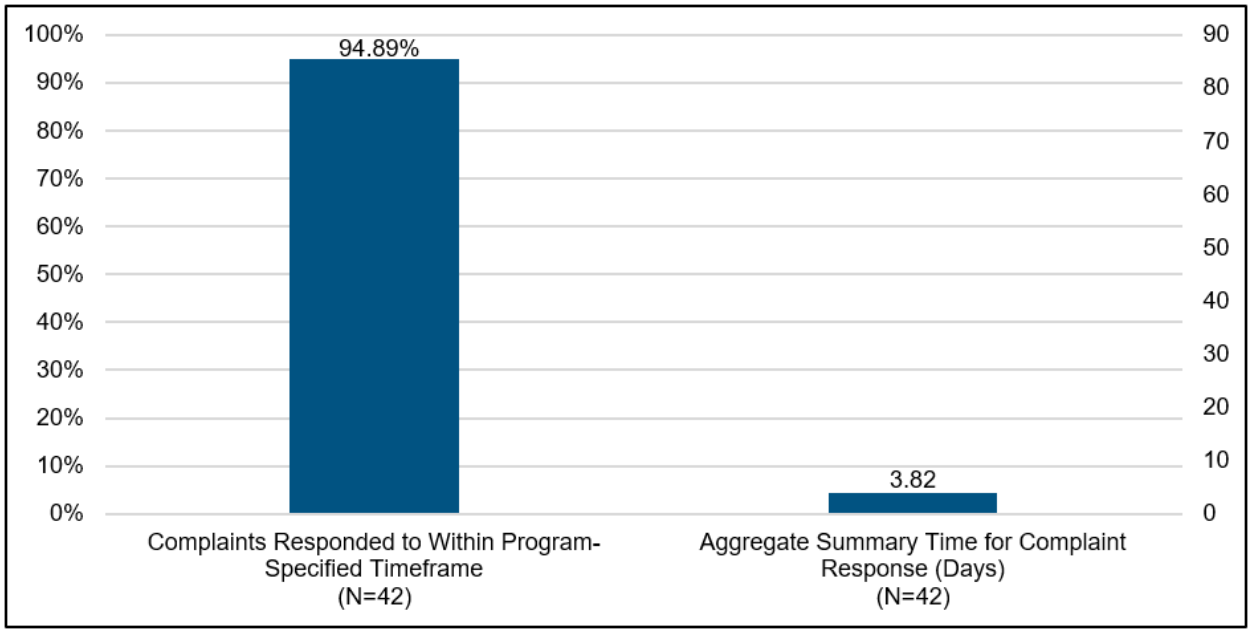


Exhibit 19: Complaint Response Timeliness



Note: Given ideal performance is indicated by no complaints, denominators of less than 30 have been included.

Part A: Percentage of Complaints Responded to Within Program-Specified Timeframe

Of the 42 organizations that reported the measure, 94.89% indicated that they responded to a complaint within the program-specified timeframe. Fifteen of those respondents indicated a goal response timeframe of 20 business days or greater, with one response of 60 days. Forty of those respondents have denominators of less than 30.

Exhibit 20: Percentage of Complaints Responded to Within Program-Specified Timeframe (Summary Data)

Measure	Total Numerator	Total Denominator	Aggregate Summary Rate	Mean	Submissions
Complaints Responded to Within Program-Specified Timeframe	427	450	94.89%	96.51%	42

Exhibit 21: Percentage of Complaints Responded to Within Program-Specified Timeframe (Benchmarks and Percentiles)

Measure	Min	10th	25th	50th	75th	90th	Max
Complaints Responded to Within Program-Specified Timeframe	20.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Part B: Average Time for Complaint Response

Overall, the performance of this measure is moderate in that complaints received a response within 5 business days (3.82 days) across all populations.

Exhibit 22: Average Time for Complaint Response in Business Days (Summary Data)

Measure	Total Numerator	Total Denominator	Aggregate Summary Rate	Mean	Submissions
Aggregate Summary Time for Complaint Response (Days)	1,718	450	3.82	3.21	42

Exhibit 23: Average Time for Complaint Response in Business Days (Benchmarks and Percentiles)

Measure	Min	10th	25th	50th	75th	90th	Max
Aggregate Summary Time for Complaint Response (Days)	34.00	7.71	2.00	1.00	1.00	0.38	0.00

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Measure 4 – Overall Consumer Satisfaction (CM2013-04)

Measure Description

This *mandatory* measure reports the percentage of program participants who completed a consumer satisfaction survey and reported that they were "satisfied" overall with the case management plan during the measurement period. This measure excludes Disability and Workers Compensation populations.

Summary of Findings

A total of 35 organizations submitted data for this measure, and 14 organizations were removed from analysis due to a small denominator. There were 65.71% (n=23) of organizations that reported using an internally developed consumer satisfaction survey, and 17.14% (n=6) indicated using both an internally and an externally developed consumer survey. Further, 74.29% (n=26) of organizations reported that their consumer satisfaction surveys were administered primarily via mail.

On average across all organizations fielding surveys, a 7-question scale was used to assess consumer satisfaction. Most of the organizations, 48.57% (n=17), used a five-point scale. There were 83.33% of organizations that used ten or fewer survey questions.

All organizations with a transplant case management program used a consumer satisfaction survey (100%, n=26). At least 50% of organizations used a consumer satisfaction survey for all case management programs, with the exception of gerontology (34.29%, n=12) and "other"-defined programs.

The majority of organizations (71.43%, n=25) surveyed all closed cases (vs. random sample). Of the surveys returned, most of the organizations had between 0-35% response rate, while four organizations indicated a 95-100% response rate.

Overall results for consumer satisfaction was 96.47% with a mean of 94.83% and median of 97.64%.

Exhibit 24: Development of Consumer Satisfaction Survey

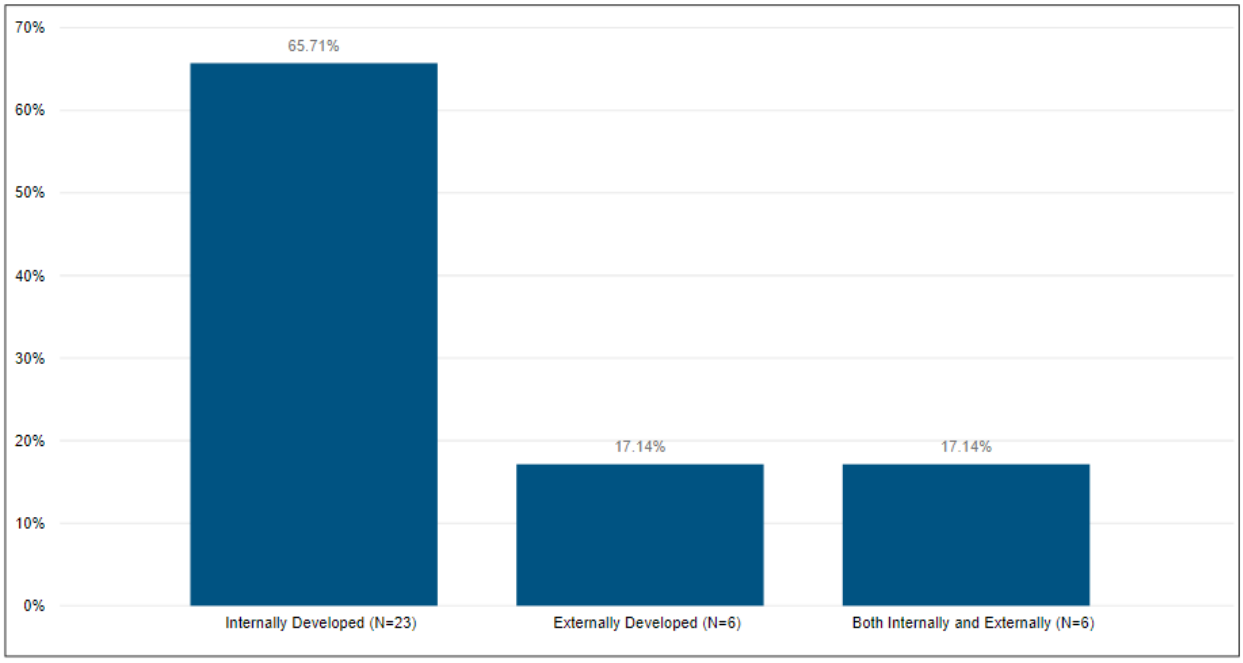
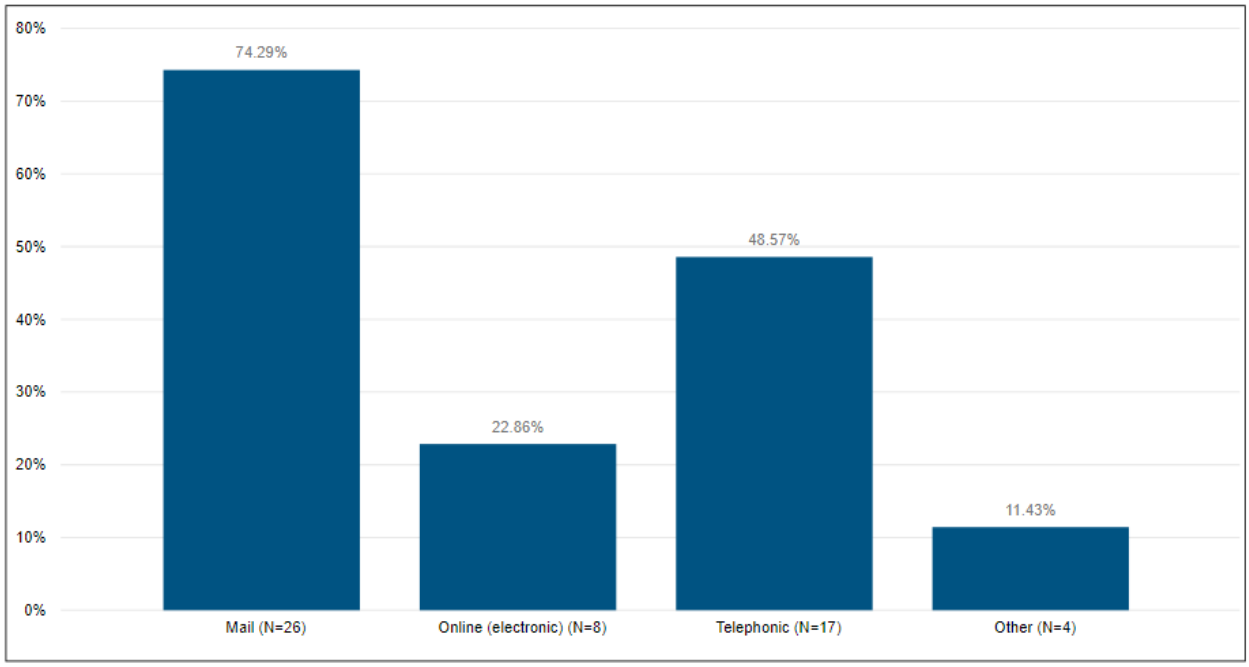


Exhibit 25: Method by Which Consumer Satisfaction Survey Administered



Note: Multiple responses accepted.

Exhibit 26: Survey Response Scale (Point Scale) Used to Calculate Overall Satisfaction

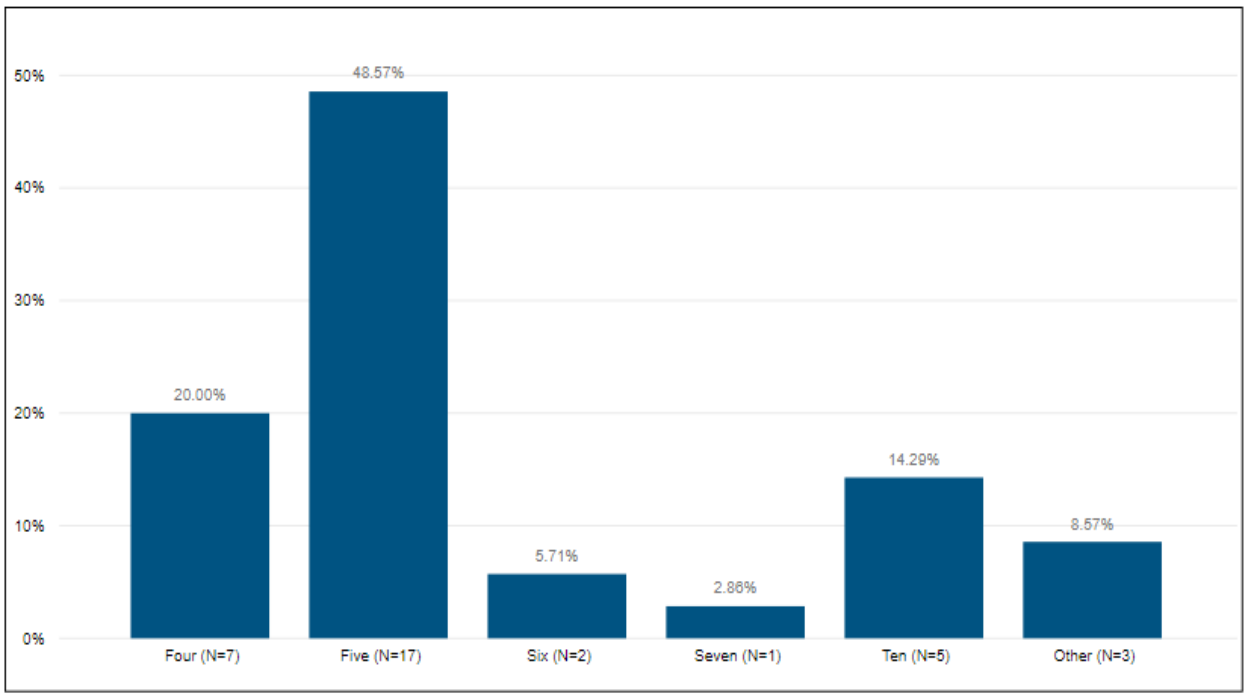
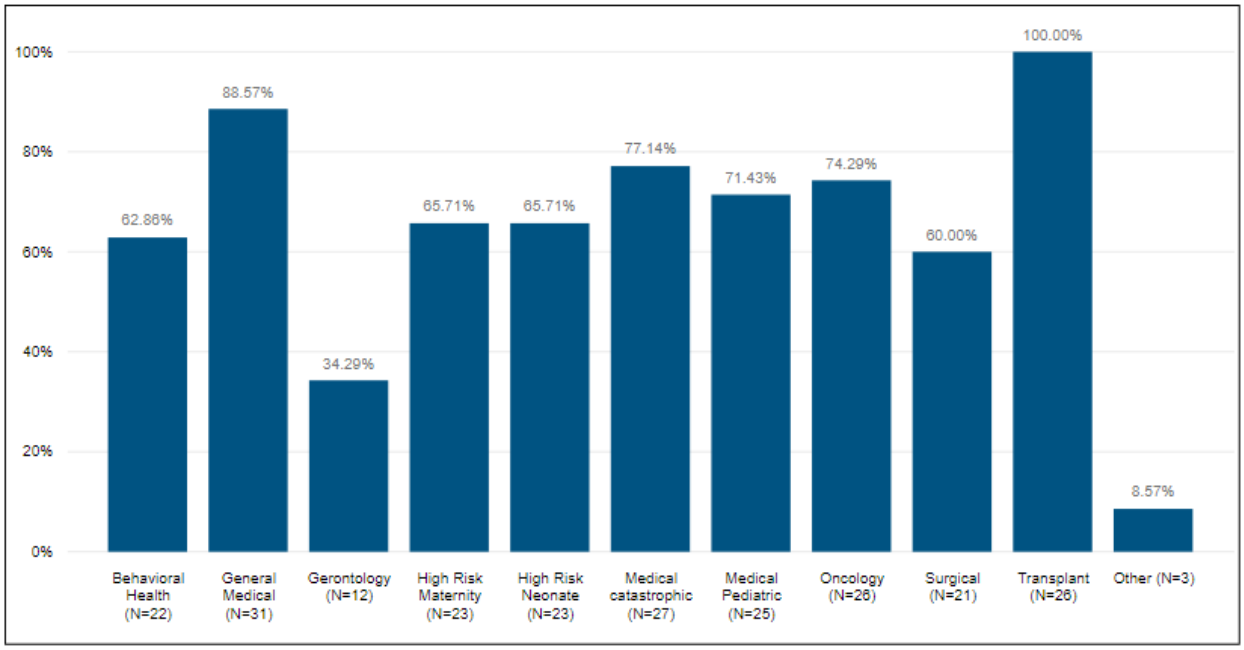
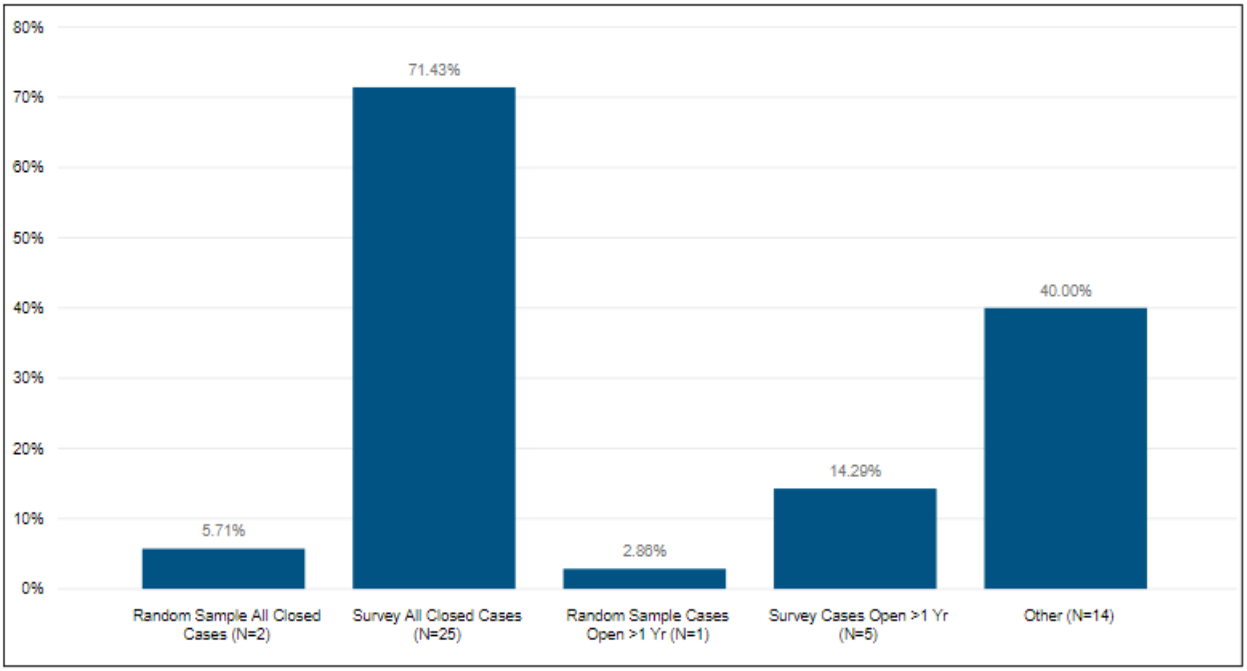


Exhibit 27: Case Management Program Types Applicable to Overall Consumer Satisfaction



Note: Multiple responses accepted.

Exhibit 28: How Consumers are Surveyed



Note: Multiple responses accepted.

Exhibit 29: Customer Satisfaction Survey Response Rate

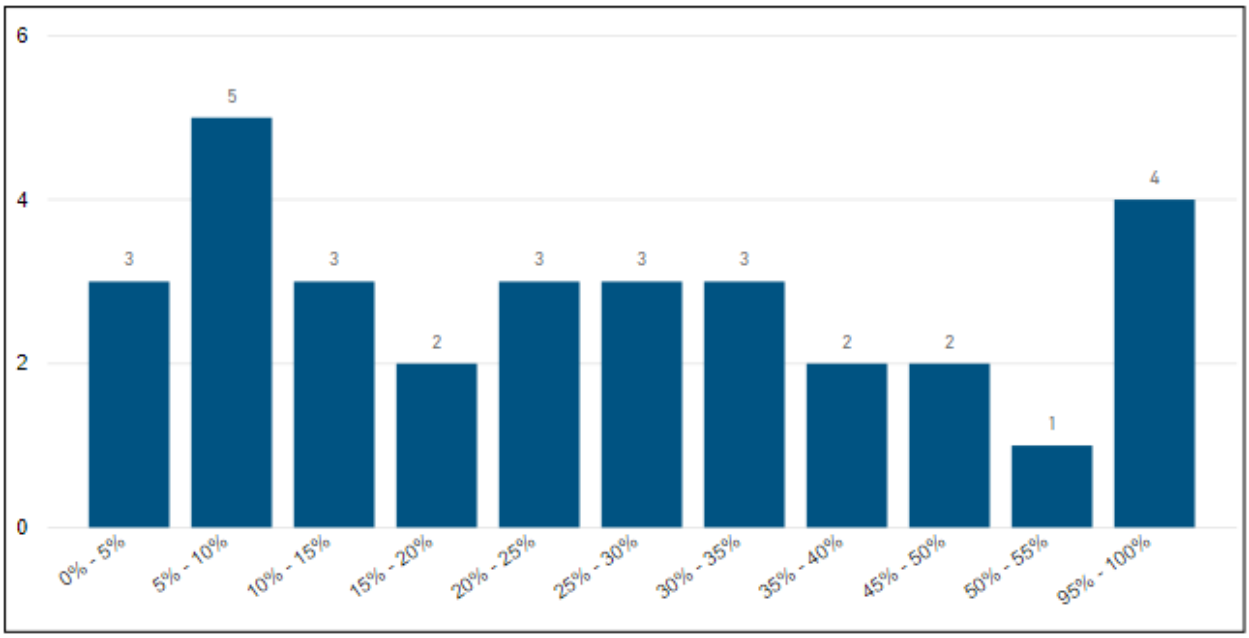


Exhibit 30: Consumer Satisfaction Rate

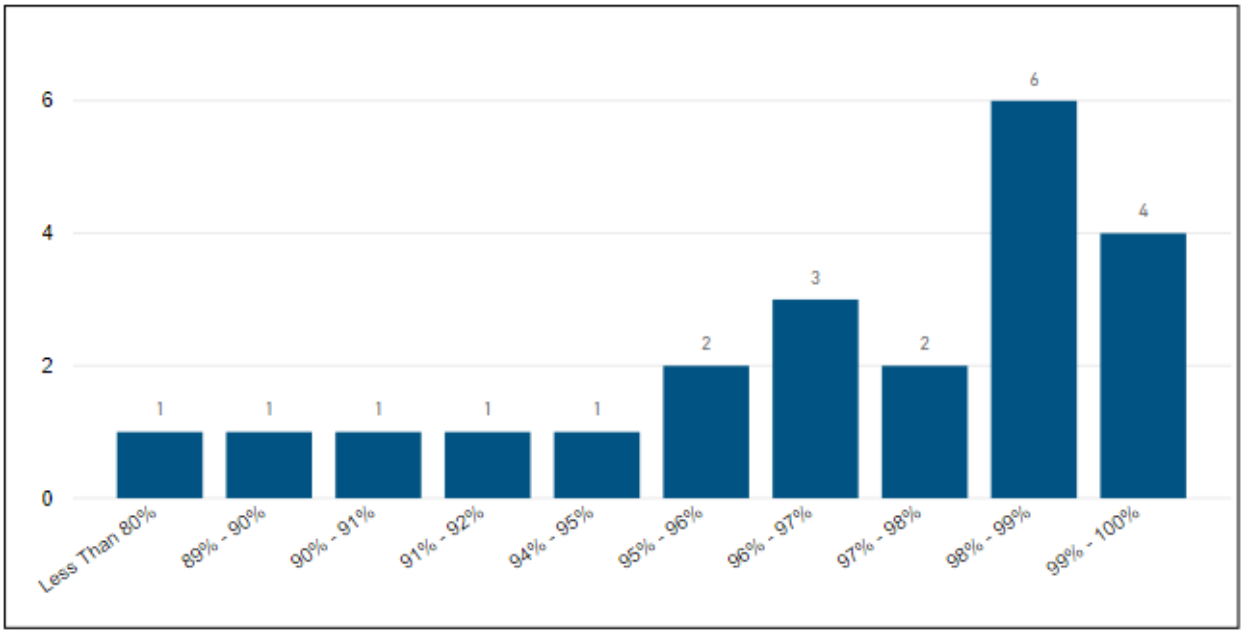


Exhibit 31: Overall Consumer Satisfaction Rate (Summary Data)

Measure	Total Numerator	Total Denominator	Aggregate Summary Rate	Mean	Submissions
Overall Consumer Satisfaction	16,411	17,012	96.47%	94.83%	22

Exhibit 32: Overall Consumer Satisfaction Rate (Benchmarks and Percentiles)

Measure	Min	10th	25th	50th	75th	90th	Max
Overall Consumer Satisfaction	54.76%	90.56%	95.16%	97.64%	98.51%	99.94%	100.00%

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Measure 5 – Percentage of Individuals That Refused Case Management Services (CM2013-05)

Measure Description

This *mandatory* measure assesses the percentage of individuals eligible for and offered case management services that refused services during the measurement period. **A lower rate represents better performance.**

Summary of Findings

A total of 54 organizations submitted data for this measure. Nearly all of the reporting organizations (98.15%) indicated they track the number of individuals that refuse case management, and 67.92% of the organizations documented the reasons for refusal. The two most common reasons for refusal were member/family refused (91.67%), and satisfied with care received (30.56%) (respondents could select more than one reason).

The aggregate summary rate of members that refused case management services is 15.67% for Medical Case Management and 1.38% for Workers Compensation Case Management.

Exhibit 33: Organizations that Track and Document Case Management Refusals

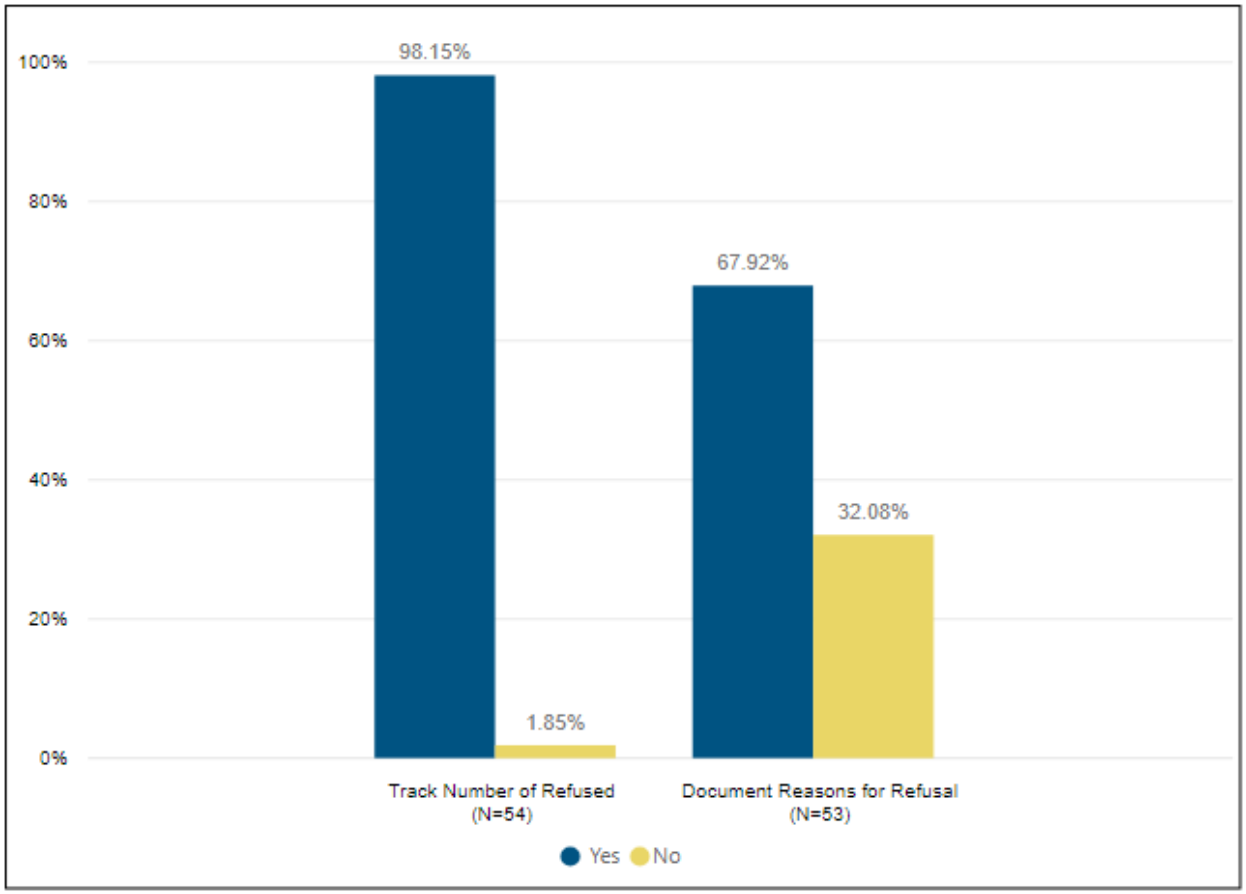

Exhibit 34: Common Reasons for Refusal

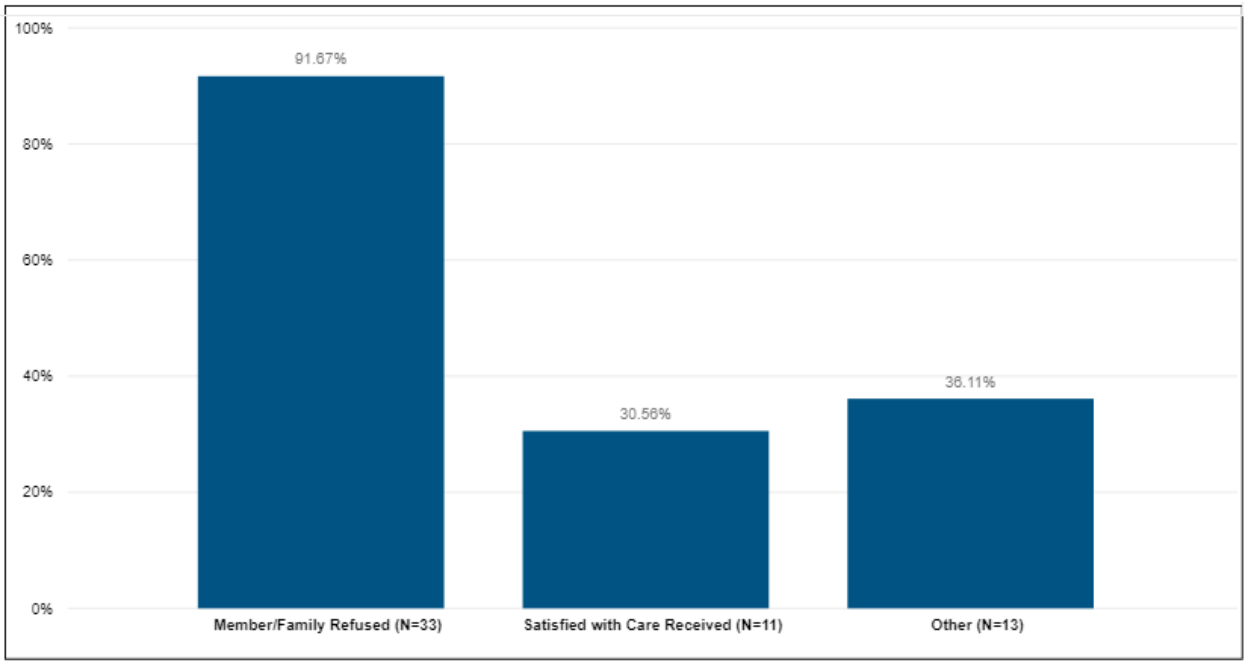

Exhibit 35: Percentage of Individuals That Refused Case Management by Service

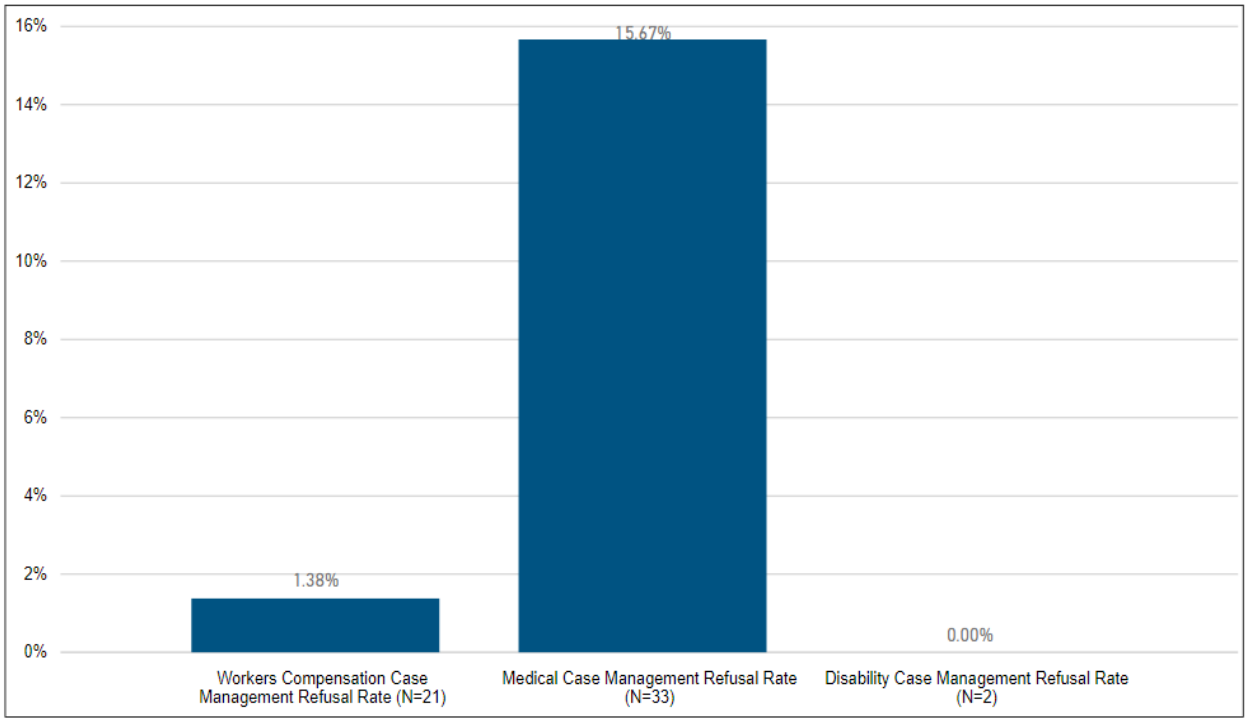

Exhibit 36: Individuals that Refused Case Management Services (Summary Data)

Measure	Total Numerator	Total Denominator	Aggregate Summary Rate	Mean	Submissions
Disability Case Management Refusal Rate	0	2,555	0.00%	0.00%	2
Medical Case Management Refusal Rate	52,374	334,258	15.67%	21.28%	33
Workers Compensation Case Management Refusal Rate	1,366	99,269	1.38%	5.55%	21

Exhibit 37: Individuals that Refused Case Management Services (Benchmarks and Percentiles)

Measure	Min	10th	25th	50th	75th	90th	Max
Disability Case Management Refusal Rate	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Medical Case Management Refusal Rate	92.00%	55.15%	28.55%	11.32%	4.46%	0.89%	0.00%
Workers Compensation Case Management Refusal Rate	44.52%	14.38%	3.92%	1.40%	0.34%	0.00%	0.00%

Measure 6 – Patient Activation Measure (DM2012-10)

Measure Description

This *exploratory* measure is a survey that assesses the knowledge, skills, and confidence integral to managing one's own health and health care. With the ability to measure activation and uncover related insights into consumer self-management competencies, care support and education can be more effectively tailored to help individuals become more engaged and successful managers of their health. This measure is reported to URAC in four parts: Part A measures the total number of responses received to the initial PAM survey; Part B measures the stratification of activation levels across respondents; Part C measures the total number of responses to a re-assessment PAM survey; Part D measures the total number of respondents that moved to a higher activation level at the time of re-assessment from baseline evaluation.

Note: The use of the Patient Activation Measure® (PAM®) requires a license between the submitting organization and Insignia Health (www.insigniahealth.com).

Summary of Findings

No organizations reported results for this exploratory measure.