State of Louisiana Department of Health

MCO Case Management Audit
Aetna Better Health

FINAL
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IPRO
Better healthcare, realized.

Corporate Headquarters
1979 Marcus Avenue
Lake Success, NY 11042-1072
(516) 326-7767
ipro.org

Introduction

The purpose of the case management audit was to evaluate the effectiveness of the contractually-required case management program of each managed care organization (MCO). The Louisiana Department of Health (LDH) established case management requirements to ensure that the services provided to enrollees with special health care needs (SHCNs) are consistent with professionally recognized standards of care. IPRO, Louisiana's external quality review organization (EQRO), was tasked to assess each MCO's compliance with the Louisiana MCO contract requirements.

Methodology

The audit addressed MCO contract requirements for case management services including MCO Contract Articles 6.39–6.40 and 6.42. A representative sample of files was selected for review. The audit included three phases: pre-audit activities, offsite audit activities, and post-audit activities.

Phase 1: Pre-audit Activities

Planning

IPRO and LDH discussed the proposed audit methodology, necessary source documents and audit tool. IPRO prepared an audit tool structured to collect requirement-specific information related to the four categories: Identification, Outreach, Continuity of Care and Coordination of Services. The tool included state-specific contract requirements, reviewer guidelines (noting specific elements that required review), reviewer determination ("Yes" or "No"), and reviewer comments (to document findings related to any requirements that were determined not fully compliant).

Population Selection

Using random sampling, IPRO selected 110 enrollees for each MCO (including a 10% oversample required for substitutions or exclusions). Using a conservative assumption of a 65% proportion, a sample size of 100 was selected to yield sufficient statistical power to produce a 95% confidence interval with a 10% margin of error. The confidence interval provides the range within which there is a 95% probability that the true rate falls between the lower rate and the upper rate of the confidence interval. Higher rates lead to smaller ranges in confidence intervals.

The source of this information was the *LA PQ039 Case Management* report provided to IPRO from LDH. The following filters were applied to the data to determine the universe for each plan: Reason Identified for Case Management (SHCN), Date Entered Case Management (2019 or 2020), and Date Exited Case Management (blank). After determining the universe, IPRO selected a random population using the RAND formula in Microsoft® Excel®.[1]

E-mail Notification

The audit included an offsite review of the selected files. Prior to the file review, IPRO sent an e-mail notification to each MCO including:

- a description of the audit process; and
- a file listing the files that needed to be submitted to IPRO, as well as instructions for preparing the files and uploading the files to IPRO's File Transfer Protocol (FTP) site.

Each MCO's case management policies and procedures were also requested.

Phase 2: Audit Activities

IPRO reviewers conducted the file reviews over a 4-week period. Reviewer inter-rater reliability was maintained through use of the standardized audit tool, and ongoing communication and coordination among the review team.

Phase 3: Post-audit Activities

Following the audit, IPRO aggregated each MCO's results and prepared this report. MCOs were not permitted to submit additional information after the offsite audit.

[1] Microsoft® and Microsoft® Excel® are registered trademarks of the Microsoft Corporation.

Audit Results

Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" and "No" determinations. Not applicable (N/A) responses were excluded from the numerator and denominator. Population results, as shown in **Table 1**, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

Aetna Better Health (ABH) 2021 audit results ranged from 87% to 97% for the four audit categories (**Table 1**).

Table 1: Aggregate Results by Category

Determination by Category	2021 (n = 100)
Identification	97%
Outreach	87%
Continuity of Care	92%
Coordination of Services	94%

Population Findings

Identification

A total of 100 files were reviewed. Two enrollees (2%) were enrolled in case management during the entire review period. For the remaining 98 files, IPRO identified three enrollees (3%) as having potential case management needs during the review period that were not identified by the MCO (**Table 2**).

Table 2: Identification

Identification	SHCN-BH				SHCN-MED				Total			
Review Elements	N	D	N/A	%	N	D	N/A	%	N	D	N/A	%
Enrollees enrolled in case management during entire review period (A.1)[1]	0	69	0	0%	2	31	0	6%	2	100	0	2%
Enrollees identified by IPRO as having potential case management needs during the review period that the MCO did not identify (A.2)	1	69	0	1%	2	29	0	7%	3	98	0	3%

[1] Not included in aggregate score calculation.

SHCN-BH: behavioral health special health care need; SHCN-MED: medical special health care need; N: numerator; D: denominator; N/A: not applicable; MCO: managed care organization.

Outreach

Of the 100 cases, initial outreach for completion of an assessment within 90 days of identification of potential special healthcare needs was noted in 88% (88/100) of cases (**Table 3**). Subsequent outreach was evident in 85% (34/40) of the files when the initial outreach was unsuccessful. Almost one-fifth (19%; 19/100) of enrollees declined case management.

Table 3: Outreach

Outreach	SHCN-BH				SHCN-MED				Total			
Review Elements	N	D	N/A	%	N	D	N/A	%	N	D	N/A	%
The outreach for assessment was timely within 90 days of the identification of potential special healthcare needs (B.1)	62	69	0	90%	26	31	0	84%	88	100	0	88%
Subsequent outreach to complete an assessment was needed (B.2)[1]	28	62	0	45%	12	26	0	46%	40	88	0	45%

Outreach Review Elements	SHCN-BH				SHCN-MED				Total			
	N	D	N/A	%	N	D	N/A	%	N	D	N/A	%
When the initial outreach was unsuccessful, subsequent outreach attempts were conducted within 90 days of the identification of potential special healthcare needs (B.3)	23	28	0	82%	11	12	0	92%	34	40	0	85%
The enrollee declined care management (B.4)[1]	16	69	0	23%	3	31	0	10%	19	100	0	19%

[1] Not included in aggregate score calculation.
SHCN-BH: behavioral health special health care need; SHCN-MED: medical special health care need; N: numerator; D: denominator; N/A: not applicable.

Continuity of Care

More than four-fifths (87%; 71/82) of files included a completed assessment (**Table 4**). An assessment was not applicable in 18 cases. About three-fourths (72%; 51/71) of files included a plan of care (PoC). Development of a plan of care was not applicable in 29 cases. Cases that were found not applicable for completion of an assessment and/or a PoC included enrollees that declined case management or that enrolled but who were unable to be reached despite outreach efforts by the case manager. The PoC included all required components and was developed with the involvement of the enrollee and/or authorized family member or guardian in 100% (51/51) of files that included an initial PoC (**Table 4**).

Sixty-three percent (63%; 32/51) of enrollees demonstrated a change in care needs, progress, or outcomes (**Table 4**). For these enrollees, the PoC was updated and was developed with the involvement of the enrollee and/or authorized family member or guardian in 100% (31/31) of the files. One file was not applicable.

A schedule for following up with the enrollee's providers and convening plan of care reviews was evident in 98% (50/51) of the files (**Table 4**).

One-fifth (20%; 20/100) of enrollees demonstrated a need for an individualized treatment plan (**Table 4**). Of these enrollees, 18 files included a treatment plan (95%), while 1 file was not applicable. For the 18 enrollees with a treatment plan, the treatment plan progressed in a timely manner and included all required components for 94% (17/18) of these files (**Table 4**).

Transitions between levels of care was evident in 40 files, and evidence of case manager management of the transition was found in 98% (39/40) of these files (**Table 4**). The case manager offered or arranged for self-management training and health education in 85% (40/47) of cases where the need for such training/education was indicated.

Table 4: Continuity of Care

Continuity of Care Review Elements	SHCN-BH				SHCN-MED				Total			
	N	D	N/A	%	N	D	N/A	%	N	D	N/A	%
An assessment was completed for the enrollee (C.1)	51	59	10	86%	20	23	8	87%	71	82	18	87%
The enrollee declined to complete the assessment (C.2)[1]	2	18	0	11%	0	11	0	0%	2	29	0	7%
A plan of care was developed for the enrollee (C.3)	37	51	18	73%	14	20	11	70%	51	71	29	72%
The plan of care was developed with the involvement of the enrollee and/or authorized family member or guardian (C.4)	37	37	0	100%	14	14	0	100%	51	51	0	100%
The plan of care includes all required components (C.5)	37	37	0	100%	14	14	0	100%	51	51	0	100%

Continuity of Care Review Elements	SHCN-BH				SHCN-MED				Total			
	N	D	N/A	%	N	D	N/A	%	N	D	N/A	%
Enrollee has a change in care needs, progress, or outcomes (C.6)[1]	24	37	0	65%	8	14	0	57%	32	51	0	63%
The plan of care was updated upon a change in the enrollee's care needs, progress or outcomes (C.7)	23	23	1	100%	8	8	0	100%	31	31	1	100%
The plan of care was updated with the involvement of the enrollee and/or authorized family member or guardian (C.8)	23	23	0	100%	8	8	0	100%	31	31	0	100%
A schedule for following-up with the enrollee's providers and convening plan of care reviews at intervals consistent with the identified enrollee care needs and to ensure progress and safety is documented (C.9)	37	37	0	100%	13	14	0	93%	50	51	0	98%
Enrollee demonstrates needs for an individualized treatment plan (C.10)[1]	13	69	0	19%	7	31	0	23%	20	100	0	20%
For enrollees demonstrating needs requiring a treatment plan, a treatment plan is documented (C.11)	13	13	0	100%	5	6	1	83%	18	19	1	95%
For enrollees with a treatment plan, the treatment plan progressed in a timely manner without unreasonable interruption and included all required components (C.12)	12	13	0	92%	5	5	0	100%	17	18	0	94%
When indicated, the case manager managed transitions between levels of care (C.13)	28	28	41	100%	11	12	19	92%	39	40	60	98%
When indicated, the case manager offered or arranged for self-management training and health education (C.14)	29	34	35	85%	11	13	18	85%	40	47	53	85%

[1] Not included in aggregate score calculation.
SHCN-BH: behavioral health special health care need; SHCN-MED: medical special health care need; N: numerator; D: denominator; N/A: not applicable.

Coordination of Services

All seven enrollees (100%) requiring facilitation with service authorization of services received case manager assistance (**Table 5**). The case manager coordinated referrals and assistance to ensure timely access to providers in 91% (48/53) of the applicable files (91%) and coordinated services in 96% (45/47) of the applicable files (96%).

Four-fifths (80%; 80/100) of enrollees were diagnosed with one or more chronic conditions in the target population for the chronic care management program (CCMP; **Table 5**). The MCO identified all 80 enrollees (100%) as enrolled in the CCMP.

Table 5: Coordination of Services

Coordination of Services Review Element	SHCN-BH				SHCN-MED				Total			
	N	D	N/A	%	N	D	N/A	%	N	D	N/A	%
When indicated, the case manager facilitated service authorization of services identified in the plan of care (D.1)	4	4	65	100%	3	3	28	100%	7	7	93	100%
When indicated, the case manager coordinated referrals and assistance to ensure timely access to providers (D.2)	38	40	29	95%	10	13	18	77%	48	53	47	91%
For enrollees demonstrating needs requiring coordination of services, the case manager coordinated needed care/services, actively linking the enrollee to providers, medical services, residential, social, community, and other support services (D.3)	35	36	33	97%	10	11	20	91%	45	47	53	96%
Enrollee is diagnosed with one or more chronic conditions in the target population for the Chronic Care Management Program (CCMP) (D.4)[1]	52	69	0	75%	28	31	0	90%	80	100	0	80%

[1] Not included in aggregate score calculation.
SHCN-BH: behavioral health special health care need; SHCN-MED: medical special health care need; N: numerator; D: denominator; N/A: not applicable.

Discussion

Limitations

Audit results by subpopulation, SHCN-BH and SHCN-MED, should be considered with caution due to small denominators.

Conclusions and Recommendations

Conclusions and recommendation are presented by category below.

Identification

ABH scored 97% for the Identification category. For the 100 files reviewed, 2 enrollees were in case management for the entire review period, 95 enrollees were identified by the MCO as having potential case management needs, and IPRO identified 3 enrollees that should have been identified as having potential case management needs (such as multiple emergency department visits/hospitalizations after closure of case management, or enrollee-reported need that was not addressed).

Outreach

ABH scored 87% for the Outreach category. ABH should ensure that timely initial outreach (within 90 days of identification) and subsequent attempts are made to reach enrollees with SHCNs for completion of an assessment.

Continuity of Care

ABH scored 92% for the Continuity of Care category. Completion of an assessment was evident in 87% of cases, and 72% of cases included a completed PoC. The development of a PoC is noted as an opportunity for improvement.

Development (95%) and progress (94%) of treatment plans were noted strengths for the SHCN-BH population .ABH should ensure development of treatment plans for the SHCN-MED population (83%) to address acute needs.

The offer or arrangement for self-management training and health education was another area identified for improvement (85%).

Coordination of Services

ABH scored 94% for the Coordination of Services category. Requirements for facilitation of service authorization, coordination of referrals, and coordination of services scored above 90%. Although ABH scored 91% overall for the coordination of referrals element, only 77% of enrollees in the SHCN-MED population received coordination as indicated. ABH should ensure that, when indicated, case managers coordinate referrals and assistance to ensure timely access to providers.

Although the MCO identified all enrollees with chronic conditions as enrolled in the CCMP, evidence of coordination between the case manager and CCMP was not readily evident in the files.