State of Louisiana Department of Health

MCO Case Management Audit
Aggregate Report

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.

Aggregate 2021 audit results ranged from 96% to 99% for the four audit categories (**Table 1**).

Table 1: Aggregate Results by Category

Determination by Category	2021 (n = 100)
Identification	99%
Outreach	96%
Continuity of Care	96%
Coordination of Services	99%

Population Findings

Identification

A total of 500 files were reviewed. Twelve enrollees (2%) were enrolled in case management during the entire review period. For the remaining 486 files, IPRO identified six enrollees (1%) 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]	4	203	0	2%	8	297	0	3%	12	500	0	2%
Enrollees identified by IPRO as having potential case management needs during the review period that the MCO did not identify (A.2)	2	199	0	1%	4	287	0	1%	6	486	0	1%

[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 500 cases, initial outreach for completion of an assessment within 90 days of identification of potential special healthcare needs was noted in 96% (480/500) of cases (**Table 3**). Subsequent outreach was evident in 96% (182/190) of the files when the initial outreach was unsuccessful. Fewer than one-tenth (8%; 38/499) 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)	192	203	0	95%	288	297	0	97%	480	500	0	96%
Subsequent outreach to complete an assessment was needed (B.2)[1]	83	192	0	43%	107	288	0	37%	190	480	0	40%

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)	78	83	0	94%	104	107	0	97%	182	190	0	96%
The enrollee declined care management (B.4)[1]	23	203	0	11%	15	296	0	5%	38	499	0	8%

[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

Ninety-five percent (95%; 443/465) of files included a completed assessment (**Table 4**). An assessment was not applicable in 35 cases. More than four-fifths (94%; 432/461) of files included a plan of care (PoC). Development of a plan of care was not applicable in 39 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 in 99% (420/426) of files that included an initial PoC. Six cases were not applicable. The PoC was developed with the involvement of the enrollee and/or authorized family member or guardian in 100% (425/425) of files. Seven cases were not applicable. (**Table 4**).

Fifty-two percent (52%; 226/432) of enrollees demonstrated a change in care needs, progress, or outcomes (**Table 4**). For these enrollees, the PoC was updated in 95% (208/219) of the files and was developed with the involvement of the enrollee and/or authorized family member or guardian in 100% (206/206) of the files. Two files were not applicable.

A schedule for following up with the enrollee's providers and convening plan of care reviews was evident in 97% (412/426) of the files (**Table 4**).

More than three-tenths (35%; 175/500) of enrollees demonstrated a need for an individualized treatment plan (**Table 4**). Of these enrollees, 161 files included a treatment plan (95%), while 5 files were not applicable. For the 161 enrollees with a treatment plan, the treatment plan progressed in a timely manner and included all required components for 95% (153/161) of these files (**Table 4**).

Transitions between levels of care was evident in 215 files, and evidence of case manager management of the transition was found in 92% (198/215) of these files (**Table 4**). The case manager offered or arranged for self-management training and health education in 94% (366/388) 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)	170	183	20	93%	273	282	15	97%	443	465	35	95%
The enrollee declined to complete the assessment (C.2)[1]	3	33	0	9%	2	24	0	8%	5	57	0	9%
A plan of care was developed for the enrollee (C.3)	168	184	19	91%	264	277	20	95%	432	461	39	94%
The plan of care was developed with the involvement of the enrollee and/or authorized family member or guardian (C.4)	162	162	6	100 %	263	263	1	100%	425	425	7	100%
The plan of care includes all required components (C.5)	161	162	6	99%	259	264	0	98%	420	426	6	99%

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]	98	168	0	58%	128	264	0	48%	226	432	0	52%
The plan of care was updated upon a change in the enrollee's care needs, progress or outcomes (C.7)	89	92	6	97%	119	127	1	94%	208	219	7	95%
The plan of care was updated with the involvement of the enrollee and/or authorized family member or guardian (C.8)	88	88	1	100 %	118	118	1	100%	206	206	2	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)	157	163	5	96%	255	263	1	97%	412	426	6	97%
Enrollee demonstrates needs for an individualized treatment plan (C.10)[1]	64	203	0	32%	111	297	0	37%	175	500	0	35%
For enrollees demonstrating needs requiring a treatment plan, a treatment plan is documented (C.11)	56	60	4	93%	105	110	1	95%	161	170	5	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)	51	56	0	91%	102	105	0	97%	153	161	0	95%
When indicated, the case manager managed transitions between levels of care (C.13)	93	100	103	93%	105	115	182	91%	198	215	285	92%
When indicated, the case manager offered or arranged for self-management training and health education (C.14)	119	134	69	89%	247	254	43	97%	366	388	112	94%

[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 188 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 98% (348/356) of the applicable files and coordinated services in 99% (261/264) of the applicable files.

More than two-fifths (46%; 229/500) of enrollees were diagnosed with one or more chronic conditions in the target population for the chronic care management program (CCMP; **Table 5**). The MCOs identified 135 enrollees (59%) 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)	51	51	152	100%	137	137	160	100%	188	188	312	100%
When indicated, the case manager coordinated referrals and assistance to ensure timely access to providers (D.2)	136	138	65	99%	212	218	79	97%	348	356	144	98%
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)	104	105	98	99%	157	159	138	99%	261	264	236	99%
Enrollee is diagnosed with one or more chronic conditions in the target population for the Chronic Care Management Program (CCMP) (D.4)[1]	87	203	0	43%	142	297	0	48%	229	500	0	46%

[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

The aggregate scored 99% for the Identification category. For the 500 files reviewed, 12 enrollees were in case management for the entire review period, 482 enrollees were identified by the MCOs as having potential case management needs, and IPRO identified 6 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

The aggregate scored 96% for the Outreach category. Overall, the Outreach category is a strength for both subpopulations.

Continuity of Care

The aggregate scored 96% for the Continuity of Care category. Completion of an assessment was evident in 95% of cases, and 94% of cases included a completed PoC. The completion of an assessment and development of a PoC are noted as opportunities for improvement for the SHCN-BH population (93% and 91%, respectively).

Development with involvement of the enrollee and/or family member (100%) and updates (100%) of plans of care were noted strengths for the aggregate.

Documentation of a treatment plan was noted in 95% of the cases and timely progress of the treatment plan was noted in 95% of files with a treatment plan. Progression of the treatment plan is an area identified for improvement for the SHCN-BH population (91%).

The case manager's management of transitions between levels of care scored 92%. The case manager's offer or arrangement for self-management training and health education (94%) was an area identified for improvement, particularly for the SHCN-BH population (89%).

Coordination of Services

The aggregate scored 99% for the Coordination of Services category. Requirements for facilitation of service authorization, coordination of referrals, and coordination of services scored at or above 98%. Although the MCOs identified 59% of enrollees with chronic conditions as enrolled in CCMP, evidence of coordination between the case manager and CCMP was not readily evident in the files.

The MCOs should ensure that enrollees diagnosed with one or more chronic conditions in the target population for the CCMP, are referred to the CCMP and evidence of coordination between the case manager and CCMP is clearly documented in the enrollee file.