



# 2024

## CASE MANAGEMENT PERFORMANCE MEASUREMENT

AGGREGATE SUMMARY PERFORMANCE REPORT

February 2025



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# EXECUTIVE SUMMARY

<b>49</b>	<b>400,326</b>
Reporting Organizations	Unique Cases Represented

- Organizations addressed 85.25% of complaints of within their specified timeframe
- 12% of organizations with rates in the 90<sup>th</sup> percentile for overall consumer satisfaction
- 22% of organizations with 5,000 or more cases

**Consumer Satisfaction**

**92.73%**

Satisfaction with Case Management Program

**Medical Readmissions**

**15.56%**

Of patients readmitted within 30 days

**Refusal of Case Management Services**

**14.73%**

Of individuals refused *Medical CM Services*

**Complaint Response Timeliness**

**3.47 days**

To respond to a complaint

Presented in this report are the 2023 measurement year (2024 reporting year) results based on URAC’s Case Management (CM) Accreditation program performance measures.

URAC includes performance measures in multiple accreditation programs to align and harmonize with national priorities for healthcare quality and delivery improvement. Our priority of consumer protection and empowerment drives our measurement efforts on outcome measures, composite measures, and flexible measures collection. With the emphasis of the ACA on affordable, quality health care and access, it is imperative that performance measurement programs are in place to ensure that savings from cost cutting efforts in health care are not at the expense of the quality of care delivered to patients. The information provided by measures of performance can help stakeholders monitor the quality and accessibility of care across the nation.

Organizations are required to report data for five mandatory measures and have the option to report data for one exploratory measure.

Below is the list of measures for 2024 reporting:

### MANDATORY MEASURES

1. Medical Readmissions<sup>®</sup> (CM2013-01)
2. Percentage of Participants That Were Medically Released to Return to Work: Disability and Workers' Compensation Only<sup>®</sup> (CM2013-02)
3. Complaint Response Timeliness<sup>®</sup> (CM2013-03)
4. Overall Consumer Satisfaction<sup>®</sup> (CM2013-04)
5. Percentage of Individuals That Refused Case Management Services<sup>®</sup> (CM2013-05)

### EXPLORATORY MEASURES

1. Patient Activation Measure (DM2012-10)\*

\*Fewer than 5 organizations submitted data for this measure. Analysis and benchmarks were not produced given less than five valid data submissions.

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## DATA ANALYSIS PROCEDURES

Kiser Healthcare Solutions, LLC executed standard procedures for data cleaning and validation prior to finalizing the results presented in this report. All organizations' measure submissions were reviewed for measure component quality. For example, numerators and denominators were checked against rates to ensure accuracy. Also, minimum, mean, median, and maximum rates were benchmarked nationally and regionally to ensure accuracy and to identify potential issues at an individual submission level.

### Basic guidelines for identifying valid submissions:

- Measure denominator is greater than zero
- Organization has indeed stated it is submitting the measure

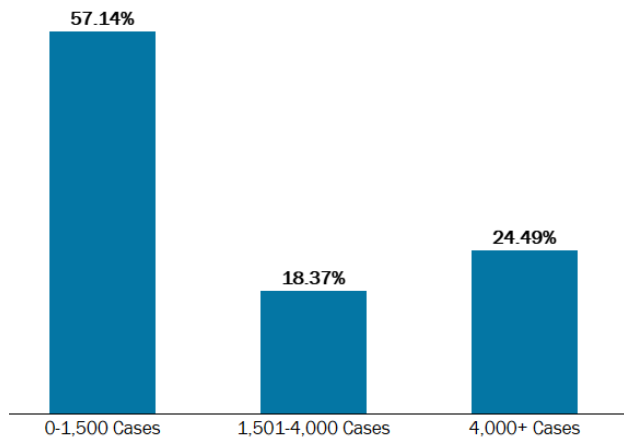
### Basic guidelines for aggregate rates:

- Measure denominator is greater than or equal to 30
- Organization has indeed stated it is submitting the measure
- Minimum of 5 reporting organizations required for analysis

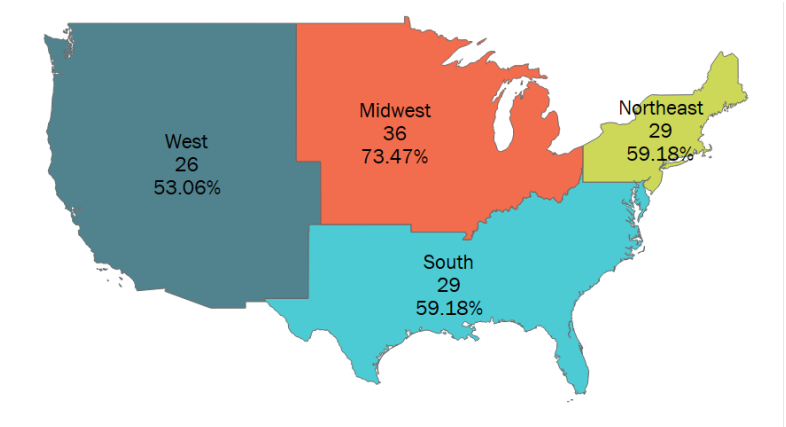
# RESULTS IN AGGREGATE

A total of 49 URAC-accredited Case Management organizations reported 2023 measurement year data for the 2024 reporting year. The number of unique cases represented by responding organizations was 400,326 with organizational case volume ranging from 7 to 163,539. More than half (n=28) of organizations reported managing less than 1,500 unique cases, with most organizations reporting between 0-1,500 unique cases (**Figure 1**). The Midwest represented the largest number of organizations 73.47% (n=36), while the West had the fewest 53.06% (n=26). 42.86% (n=21) of organizations served populations in all four regions (**Figure 2**).

**Figure 1. Reported Unique Case Volume**  
# of cases managed per organization (n=49)



**Figure 2. Regional Areas Served**  
% of reporting organizations by region (n=49)



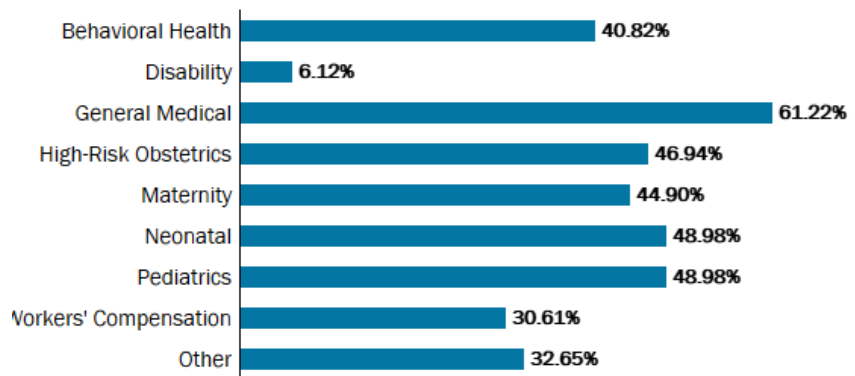
Note: Multiple responses accepted.

## Case Management Types

More than eight types of case management were represented (reporting organizations could offer more than one type of case management). The most represented type was General Medical case management (61.22%, n=30), while Disability case management represented the least (6.12%, n=3) (**Figure 3**).

Responses indicated as “Other” include, but are not limited to Catastrophic, Dialysis, Maternity, Oncology, and Transplant.

**Figure 3. Types of Case Management Represented**  
% of reporting organizations (n=49)



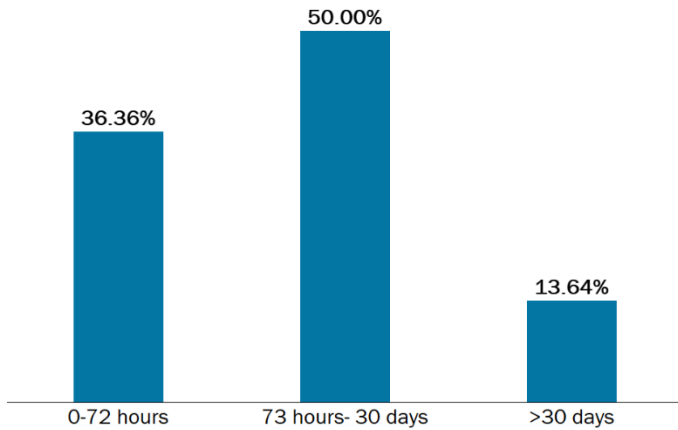
Note: Multiple responses accepted.

### Tracking Hospital Readmissions

Less than half of reporting case management organizations (44.89%, n=22) track the number of patients with a hospital readmission after discharge from an acute care facility. Of those organizations that track readmissions, 86.36% (n=19) become aware of hospital readmissions within 30 days of discharge (**Figure 4**) and 68.18% (n=15) indicated that they verify the readmissions are correctly coded (**Figure 5**). None of the 27 case management organizations, not presently tracking hospital readmissions, has any plans to measure readmissions in the future.

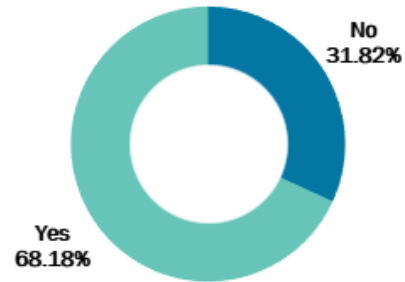
**Figure 4. Time to Become Aware of Readmission**

% of reporting organizations tracking hospital readmissions (n=22)



**Figure 5. Verify Readmissions Coded Correctly**

% of reporting organizations tracking hospital readmissions (n=22)

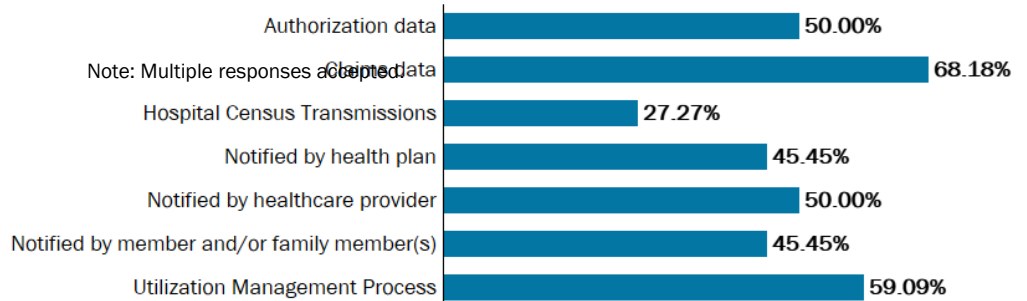


For 2024 reporting, hospital readmissions could be tracked using seven possible methods, and organizations could report the use of more than one method.

Most organizations reported tracking readmissions through claims data and/or a utilization management process, followed by notification from the healthcare provider, member, and/or family, or via authorization data. (**Figure 6**).

**Figure 6. Method for Tracking Readmission**

% of reporting organizations tracking hospital readmissions (n=22)



## MEDICAL READMISSIONS (CM2013-01)

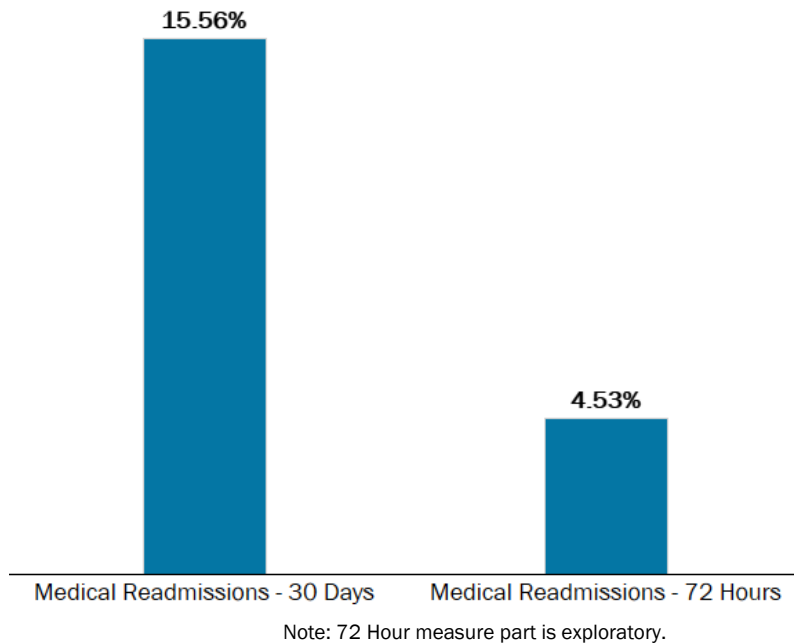
### Measure Description

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 Disability, and Workers Compensation populations. **A lower rate represents better performance.**

### Summary of Findings

Seven organizations submitted valid data for this measure. Of those seven organizations, five organizations reported data for the readmission within the exploratory 72 hours measure part.

Figure 7. Medical Readmissions within 30 Days & 72 Hours



MEASURE	TOTAL NUMERATOR	TOTAL DENOMINATOR	AGGREGATE SUMMARY RATE	MEAN	SUBMISSIONS
Medical Readmissions - 30 Days	2,810	18,060	15.56%	18.89%	7
Medical Readmissions - 72 Hours	748	16,510	4.53%	8.85%	5

MEASURE	MIN	10TH	25TH	50TH	75TH	90TH	MAX
Medical Readmissions - 30 Days	29.63%	24.72%	20.76%	19.12%	15.04%	12.75%	11.90%
Medical Readmissions - 72 Hours	19.91%	17.78%	14.58%	4.44%	2.96%	2.59%	2.34%

## 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 is for participants who received Telephonic Case Management. Part B is for participants who received Field Case Management.

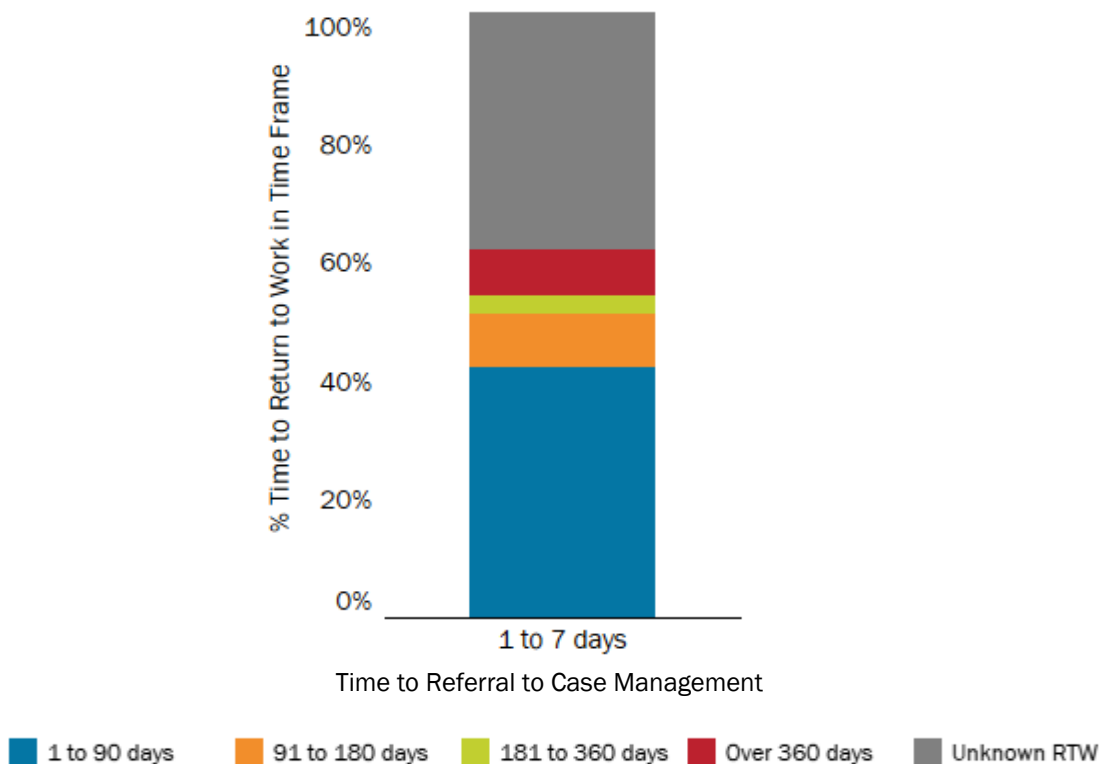
### Summary of Findings

This measure is specified for Disability and Workers Compensation service categories. Because no organization submitted data for a Disability program, analysis was performed for Workers Compensation only. A total of six organizations reported on Part A. Within Part A, the 1 to 7 days onset category is the only group with five or more organizations with reportable denominator. Therefore, only this onset category appears in aggregated reporting. Given, only four organizations reported on Part B, this sub measure is not reported at an aggregate level. Because of sample sizes less than 30 in certain cases, not every organization has a reportable denominator in each time from onset of lost time to referral to case management category; therefore, submission counts may be variable within Figure 8.

### Part A: Telephonic Case Management

Based on the data reported, there is a positive association in return to workdays where referrals occur sooner. Longer return to workdays are seen when cases are not referred 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 statistically significant differences were not conducted given small sample sizes.

Figure 8. Telephonic Case Management for Return to Work







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TIME FROM ONSET OF LOST TIME TO REFERRAL TO CASE MANAGEMENT	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	818	1,928	42.43%	6
	91 to 180 days	176	1,928	9.13%	6
	181 to 360 days	59	1,928	3.06%	6
	Over 360 days	147	1,928	7.62%	6
	Unknown RTW	728	1,928	37.76%	6

TIME FROM ONSET OF LOST TIME TO REFERRAL TO CASE MANAGEMENT	TIME BETWEEN ONSET OF LOST TIME TO MEDICAL RELEASE	MIN	10 <sup>TH</sup>	25 <sup>TH</sup>	50 <sup>TH</sup>	75 <sup>TH</sup>	90 <sup>TH</sup>	MAX
1 to 7 days	1 to 90 days	28.10%	32.11%	43.40%	66.23%	67.29%	67.31%	67.31%
	91 to 180 days	4.47%	8.02%	11.94%	14.69%	17.02%	19.52%	21.79%
	181 to 360 days	0.74%	2.03%	3.77%	5.47%	7.69%	10.25%	12.17%
	Over 360 days	0.00%	0.00%	0.24%	1.76%	7.81%	10.88%	12.20%
	Unknown RTW	0.00%	0.00%	2.40%	9.98%	37.43%	51.74%	57.02%

## 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.**

### Complaint Tracking Summary

A total of 48 organizations submitted data for this measure. Although most of the reporting organizations have a system for tracking complaints (**Figure 10**), more than half the reporting organizations (n=30) do not have a system for prioritizing complaints (**Figure 11**). Only two organizations indicated they do not have a system to track response time (**Figure 12**). Of the 48 reporting organizations, including those that had a denominator size of less than 30, 29.16% (n=14) reported No Complaints.

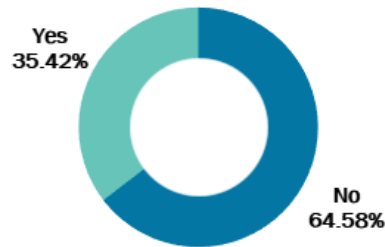
**Figure 10. Tracking Complaints**

% of reporting organizations with a complaint tracking system



**Figure 11. Prioritizing Complaints**

% of reporting organizations with a system for prioritizing complaints



**Figure 12. Tracking Time to Respond**

% of reporting organizations with a system for tracking complaint response time



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

Of the 33 organizations that submitted valid data for this measure, **85.25% of complaints were addressed within the program-specified timeframe**. 11 of those respondents indicated a goal response timeframe of 30 business days or greater, with two responses of 60 days. Twenty-nine of those respondents have denominators of less than 30.

### Part B: Average Time for Complaint Response

Overall, the performance of this measure is moderate in that the complaints received a response within 5 business days (3.47 days). Organizations reported an average response time goal of less than 16 business days. The most reported response time goal is 30 business days (Range: 1 to 60 business days).

MEASURE	TOTAL NUMERATOR	TOTAL DENOMINATOR	AGGREGATE SUMMARY RATE	MEAN	SUBMISSIONS
Part A: Complaint Response Within Program Timeframe	832	976	85.25%	93.23%	33
Part B: Aggregate Summary Time for Complaint Response (Days)	2,961	854	3.47	3.36	32

MEASURE	MIN	10TH	25TH	50TH	75TH	90TH	MAX
Part A: Complaint Response Within Program Timeframe	0.86%	84.00%	100%	100%	100%	100%	100%
Part B: Aggregate Summary Time for Complaint Response (Days)	19.20	6.35	3.00	2.00	1.00	1.00	0.11

## 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.

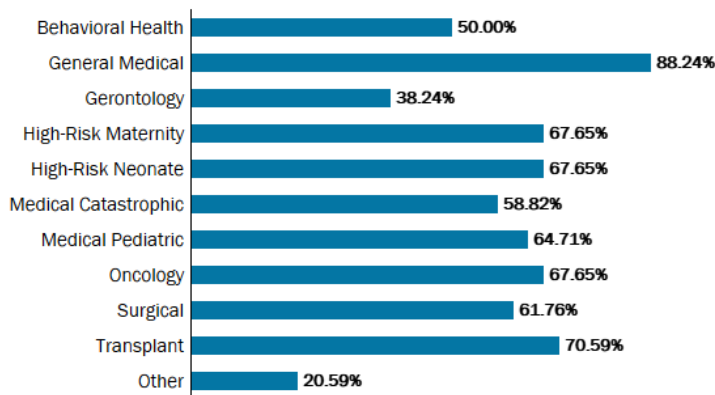
### Consumer Satisfaction Survey Methodology

A total of 34 organizations submitted data for this measure and 9 organizations were removed from analysis due to a denominator of less than 30. Organizations reported that more than 10 case management program types were applicable to overall consumer satisfaction. At least half the organizations reported the use of a consumer satisfaction survey for all case management programs except for gerontology and “other”-defined programs (**Figure 13**).

For 2024 reporting, organizations were able to utilize consumer satisfaction surveys that were developed internally, externally, or a combination of an internal and external survey and were required to report survey methodology such as: survey administration method (e.g., mail, online, telephonic), the point scale used for calculating satisfaction, and the type of survey conducted (e.g., random sampling vs all cases). See **Figures 14-16**.

**Figure 13. Program Types Applicable**

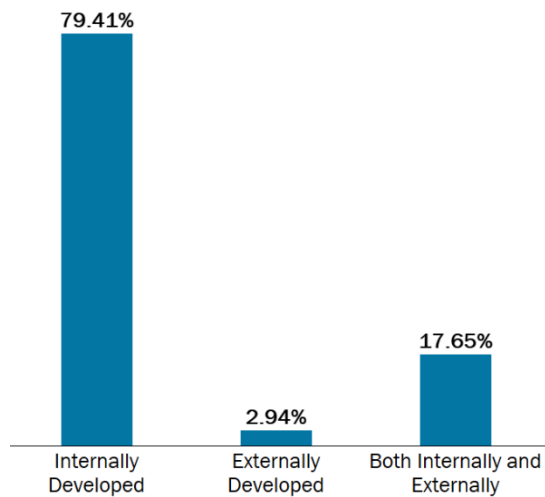
% of reporting organizations applicable to program type



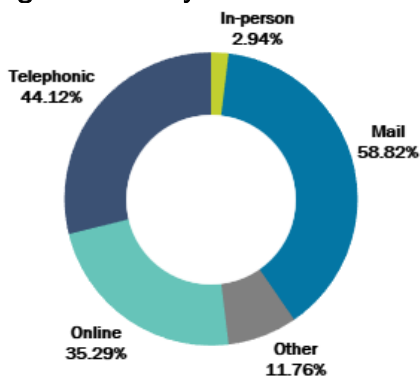
Note: Multiple responses accepted.

**Figure 14. Development of Survey**

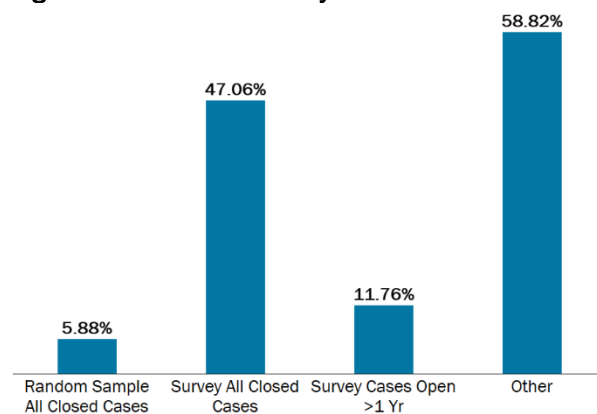
% of reporting organizations (n=34)



**Figure 15. Survey Administration Method**



**Figure 16. Consumer Survey Method**





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Overall Consumer Satisfaction Survey Results

The overall consumer satisfaction survey response rate is 10.24%. Of the surveys returned, most reporting organizations had between 1-40% response rate, while six organizations indicated a 90-100% response rate. The aggregate summary rate for overall consumer satisfaction was 92.73%.

MEASURE	TOTAL NUMERATOR	TOTAL DENOMINATOR	AGGREGATE SUMMARY RATE	MEAN	SUBMISSIONS
Overall Consumer Satisfaction	23,644	25,499	92.73%	95.02%	25
Survey Response Rate	25,591	250,014	10.24%	39.49%	33

MEASURE	MIN	10TH	25TH	50TH	75TH	90TH	MAX
Overall Consumer Satisfaction	84.38%	87.05%	93.42%	96.96%	98.02%	98.65%	100%
Survey Response Rate	1.55%	6.39%	12.29%	25.00%	70.00%	99.39%	100%

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## 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.**

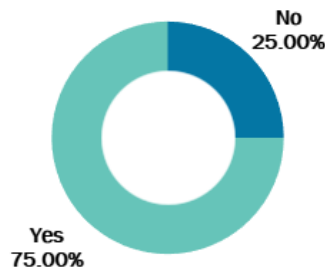
### Summary of Findings

A total of 44 organizations submitted data for at least one part of this measure. Almost all the reporting organizations (98%) indicated they track the number of individuals that refuse case management (**Figure 17**) and 75% documented the reasons for refusal (**Figure 18**). Respondents were able to select more than one reason for refusal of case management services, but the most common reason for declining case management services was refusal by the member/family (93.94%) (**Figure 19**). Only one organization submitted results for disability case management, therefore it is not included in aggregations.

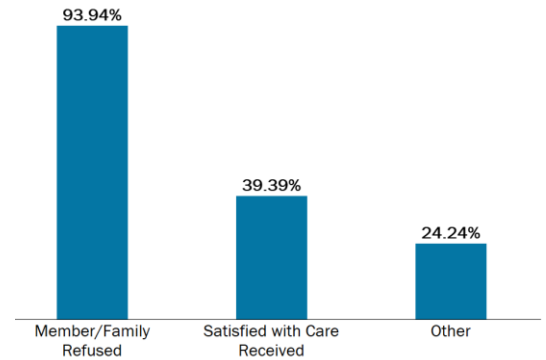
**Figure 17. Track Refusals**



**Figure 18. Document Reasons for Refusals**



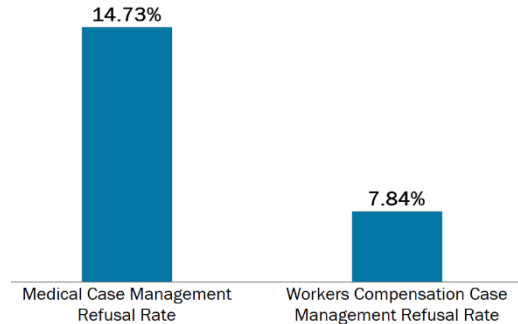
**Figure 19. Reported Reason for Refusal**



### Percentage of Individuals that Refused Case Management (by program)

Individuals refused Medical case management services two times more than Workers Compensation case management (**Figure 20**).

**Figure 20. Case Management Program Refused**



MEASURE	TOTAL NUMERATOR	TOTAL DENOMINATOR	AGGREGATE SUMMARY RATE	MEAN	SUBMISSIONS
Medical Case Management Refusal Rate	74,092	503,101	14.73%	26.15%	34
Workers Compensation Case Management Refusal Rate	478	6,096	7.84%	7.31%	9

MEASURE	MIN	10TH	25TH	50TH	75TH	90TH	MAX
Medical Case Management Refusal Rate	93.38%	69.50%	31.92%	19.43%	4.89%	0%	0%
Workers Compensation Case Management Refusal Rate	33.33%	22.07%	5.29%	2.67%	0%	0%	0%