



Case Management Model Act

Supporting Case Management Programs

Case Management Model Act ¹

(CM Model Act)

PREAMBLE

The Case Management Model Act establishes the key elements of a comprehensive **Case Management Program** that should be implemented at both the federal and state levels. The Case Management Society of America (CMSA) encourages public policymakers to review and use the provisions of this CM Model Act for legislative and regulatory initiatives geared to reducing health care costs, improving the coordination and transitions of care, enhancing quality, and promoting better clinical outcomes.

Case Managers are health care professionals and pioneers of health care change. They serve as health care team leaders that open up new areas of thought, research and development. **Case Managers** positively impact and improve **Consumer** well-being and health care outcomes.

Case Management is a **Consumer**-centric, collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes. **Case Management** serves as a means for achieving **Consumer** wellness and autonomy through advocacy, communication, education, identification of service resources, and service facilitation. The **Case Manager** helps identify appropriate providers and facilities throughout the continuum of services, while ensuring that available resources are being used in a timely and cost-effective manner in order to obtain optimum value for both the **Consumer** and the reimbursement source.

Case Management also supports the goals of value-based purchasing by promoting cost-effective strategies that promote better quality, improved outcomes, and higher **Consumer** satisfaction.

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SECTION I: SHORT TITLE

For purposes of the Case Management Model Act, the short title shall be “CM Model Act.”

SECTION II: DEFINITIONS

- 2.1 Case Management:** A collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual and family’s comprehensive health needs through communication and available resources to promote quality cost-effective outcomes, according to the Case Management Society of America (CMSA). Related activities to **Case Management** include care coordination, complex condition management, **Population Health Management** through wellness, disease and chronic care management, and promoting transitions of care services.²
- 2.2 Case Managers:** Providers of care who meet the qualifications outlined in Section III of the CM Model Act.
- 2.3 Certified/Certification:** A professional credential, granted by a national organization, signifying that an individual has met the qualifications established by that organization. To qualify under these standards, the *certification* program must:
- (a) Establish standards through a recognized, validated program;
 - (b) Be research-based; and
 - (c) Include an evaluation process, examination, or practicum with an established baseline score.

² See also “Standards of Practice for Case Management,” (publication pending 2009/2010), Case Management Society of America, Little Rock, Arkansas, U.S.A. For a copy of this publication, please send a written request to policy@cmsa.org.

2.4 Client: **[Insert federal agency, entity, or business]** that purchases services from the **Program** pursuant to the CM Model Act.

Editor’s note: The term client can mean the **Consumer**, patient or the individual receiving **Case Management** services. For purposes of the CM Model Act, the term **Client** is used to reflect the agency, organization, or entity sponsoring the **Program**; and the term **Consumer** is used to refer to the individual receiving case management services. (See below for a full definition of **Consumer**.)

2.5 Complaint: An expression of dissatisfaction regarding the **Program’s** products or services.

2.6 Consumer: An individual person who is the recipient of **Case Management** services offered by the **Program**. Depending on the context, **Consumers** may be identified by different names which includes, but is not limited to, beneficiaries, injured worker, claimant, patient, enrollee, member, resident, or health care consumers. The use of this term also infers the inclusion of the **Consumers’** support systems if applicable, which may include family, legal guardian(s), or significant others.

Editor’s note: Please note that under CMSA’s *Standards of Practice* (SOP), the term “Patient/Client” has the same meaning as the term **Consumer**.

2.7 Credentialing Verification. A process of reviewing and verifying specific credentialing criteria of a **Case Manager** and other clinical **Staff**.

2.8 Criteria: A broadly applicable set of standards, guidelines, or protocols used by the **Program** to guide the **Case Management** process. Criteria should be:

- (a) Written;
- (b) Based on professional practice;
- (c) Literature-based;
- (d) Applied consistently; and
- (e) Reviewed annually.

2.9 Contractor: A business entity or individual that performs delegated functions on behalf of the **Program**.

2.10 License or Licensure: A legal credential or permit (or something equivalent) to practice medicine or engage in a defined health care field that is:

- (a) Issued by any state or jurisdiction in the United States; and
- (b) Required for the performance of job functions.

2.11 Population Health Management: Strives to address health needs at all points along the continuum of health and well-being, through participation of, engagement with, and targeted interventions for the population. The goal of a population health management program is to maintain and/or improve the physical and psychosocial well-being of individuals through cost effective and tailored health solutions.³

2.12 Program: An organization that provides **Case Management** services pursuant to the CM Model Act.⁴

³ See www.dmaa.org.

⁴ Editor’s note: The focus of the CM Model Act is the **Case Management Program** itself. Depending on the legislative circumstances, the CM

2.13 Quality Management: A systematic data-driven effort to measure and improve **Consumer** and **Client** services and/or health care services.

2.14 Staff: The **Program's** employees, including full-time employees, part-time employees, independent contractors, and consultants.

SECTION III: STAFF QUALIFICATIONS⁵

3.1 Case Manager Qualifications: **Case Managers** should maintain competence in their area(s) of practice by having one of the following:

- (a) Current, active, and unrestricted licensure or certification in a health or human services discipline that allows the professional to conduct an assessment independently as permitted within the scope of practice of the discipline; *and/or*
- (b) Baccalaureate or graduate degree in social work, nursing, or another health or human services field that promotes the physical, psychosocial, and/or vocational well-being of the persons being served. The degree must be from an institution that is fully accredited by a nationally recognized educational accreditation organization; and the individual must have completed a supervised field experience in **Case Management**, health, or behavioral health as part of the degree requirements.

Editor's note: Specific Case Manager qualifications will be selected depending on the focus and scope of the Case Management services being established in the proposed legislation.

3.2 Supervisor Qualifications: Individuals who directly supervise **Case Management** practices:

- (a) Have at least one of the following qualifications:
 - (i) A bachelors (or higher) degree in a health-related field or human services profession, and advanced **Licensure** as a health professional; or
 - (ii) Certification as a **Case Manager**; or
 - (iii) Professional certification in a clinical specialty and at least five (5) years experience as a **Case Manager**; and/or
- (b) If they have directly supervised the **Case Management** process for three (3) or more years, hold a certification as a **Case Manager**.

Editor's note: The qualifications of a Case Management Supervisor can be fine-tuned depending on the focus and scope of the Case Management services being established in the proposed legislation.

Model Act could be modified to address a legal entity or health care organization that provides the **Case Management** services.

⁵ The term "case management" can mean many different things depending on the setting and circumstances. As applied to the management of health care conditions, both at the population and individual levels, it is important that case managers meet baseline professional requirements. Since many case management programs are funded in part by government agencies, these programs should establish baseline requirements in the applicable legislation or regulations. Individuals, who are not qualified case managers, could jeopardize the health and safety of **Consumers**, or otherwise not fully understand how to support the needs of those with complex medical conditions.

3.3 Clinical Oversight: The organization running the **Program** designates at least one senior clinical **Staff** person who has:

- (a) A current, unrestricted clinical **License(s)** (or if the **License** is restricted, the **Program** has a process to ensure job functions do not violate the restrictions imposed by the State Board); and
- (b) Qualifications to perform clinical oversight for the services provided; and
- (c) Post-graduate experience in direct **Consumer** care; and/or
- (d) Board certification (if the senior clinical **Staff** person is an M.D. or D.O.).

Editor's note: The applicability and qualifications of the senior clinical **Staff** member can be further defined in the proposed legislation (or regulations) – which could include an advanced practitioner, PhD, and/or physician.

3.4 Written Job Descriptions: The **Program** shall provide written job descriptions for **Staff** that address:

- (a) Required education, training, and/or professional experience;
- (b) Expected professional competencies;
- (c) Appropriate licensure/certification requirements; and
- (d) Scope of role and responsibilities.

3.5 Credentialing Verification: The **Program** shall verify the credentials of **Case Managers** and other clinical **Staff** as follows:

- (a) Upon hire, verify the current licensure, certification, and academic degrees of **Case Managers** and other clinical **Staff**;
- (b) At least every three years, re-verify the current licensure, certification, and degrees of **Case Managers** and other clinical **Staff**;
- (c) At least every five years, document at least 80 hours of continuing education (or the appropriate level of hours as required by a nationally recognized certification body or a state licensing board) for each **Case Manager** and other clinical **Staff**; and
- (d) At any time, implement corrective action in response to adverse changes in licensure or certification status.

Editor's note: The specific primary and secondary source verification requirements can be identified in the proposed legislation or accompanying regulations. The CM Model Act assumes that Case Managers are qualified health care professionals, who should be reimbursed for their services.

SECTION IV: CASE MANAGEMENT FUNCTIONS

4.1 Case Management Goals: The **Case Manager** shall facilitate coordination, communication, and collaboration with **Consumers**, providers, ancillary services, and others in order to achieve goals and maximize positive **Consumer** outcomes based upon individual assessments of **Consumers'** needs.

4.2 Case Management Functions: Pursuant to Section V of this CM Model Act, **Case Managers** shall/should:

- (a) Implement population identification processes when appropriate;
- (b) Use a **Consumer**-centered, strengths-based, collaborative partnership approach;
- (c) Promote **Consumer** self-determination through advocacy;
- (d) Use a comprehensive, holistic approach;
- (e) Practice cultural competence, with awareness and respect for diversity;
- (f) Implement collaborative practice models to include physician and support-service providers;
- (g) Facilitate informed choice, consent, and decision-making;
- (h) Promote the **Consumer's** self-care management;
- (i) Focus on facilitating **Consumer** self-advocacy, education, and anticipatory guidance;
- (j) Promote the use of evidence-based care, as available;
- (k) Promote optimal **Consumer** safety;
- (l) Promote the integration of behavioral change science and principles;
- (m) Link with community resources;
- (n) Assist with navigating the health care system to promote effective care particularly during transitions;
- (o) Pursue professional excellence and maintain competence in practice; **and/or**
- (p) Use process and outcome measurement, evaluation, and management tools to improve quality performance.

4.3 Supervision: Pursuant to this CM Model Act, the senior clinical **Staff** person shall be responsible for clinical aspects of the **Program**, and should have periodic consultation with practitioners in the field.

SECTION V: AUTHORIZED SCOPE OF SERVICES

5.1 Case Management Process: The **Program** shall/should:

- (a) Establish and implement **Criteria** for identifying individuals for **Case Management** services;
- (b) Identify and select **Consumers** who can most benefit from **Case Management** services available in a particular practice setting;
- (c) Require notice (and/or consent) to the **Consumer** regarding the purpose of the **Case Management** services and related information about the **Program**;
- (d) Provide notice of the availability of a **Complaint** process and the method by which to access it;
- (e) Complete a comprehensive, culturally and linguistically appropriate assessment of each **Consumer**;
- (f) Identify problems that would benefit from **Case Management** intervention;
- (g) Identify immediate needs, as well as develop appropriate and necessary **Case Management** strategies to address those needs;
- (h) Strive to develop a treatment plan for each **Consumer** in collaboration with each **Consumer**, her or his support system, respective treating providers, and other key stakeholders;
- (i) Support the physician or practitioner/**Consumer** relationship and plan of care;

- (j) Emphasize prevention of exacerbations and complications utilizing evidence-based practice guidelines and **Consumer** empowerment strategies;
- (k) Employ ongoing assessment and documentation to measure the **Consumer's** response to the plan of care;
- (l) Maximize the **Consumer's** health, wellness, safety, adaptation, and self-care;
- (m) Implement policies to promote the autonomy of **Consumer**, and support **Consumer** and family decision-making;
- (n) Establish guidelines for reasonable **Case Manager** caseloads with supporting rationale based on factors such as severity of cases, complexity of cases, role requirements of **Case Managers**, and other relevant factors;
- (o) Promote smooth transitions of care whenever possible;⁶
- (p) Establish and implement **Criteria** for discharge of **Consumers** or termination of **Case Management** services; **and/or**
- (q) Appropriately terminate **Case Management** services.

Editor's note: The CM Model Act may be further revised to highlight specific issues and goals to be addressed by the Program.

⁶ The National Transitions of Care Coalition (NTOCC) is a coalition of 30 diverse organizations dedicated to providing solutions that improve the quality of health care with better collaboration between providers, **Consumers**, and caregivers. Transitions of care occur when a health care consumer leaves one care setting (i.e., hospital, nursing facilities, assisted living facility, primary care physician, home health, or specialist) and moves to another.

NTOCC strives to achieve the following goals:

- Improve communication during transitions between providers, **Consumers**, and caregivers;
- Implement electronic medical records that include standardized medication reconciliation elements;
- Establish points of accountability for sending and receiving care, particularly for Hospitalists, SNF Physicians, Primary Care Physicians, and Specialists;
- Increase the use of case management and professional care coordination;
- Expand the role of the pharmacist in transitions of care;
- Implement payment systems that align incentives; and
- Develop performance measures to encourage better transitions of care.

See www.ntocc.org, for additional details.

SECTION VI: PAYMENT OF SERVICES⁷

6.1 Payment:

Editor's note: The funding source and/or sponsoring agency needs to be identified. Funding sources could include one or more of the following options:

- (a) Medicare. Under Medicare Part B, the payment for **Case Management** services could be provided under Sec. 186(S). [42 U.S.C. 1395x] which addresses "Medical and Other Medical Service" to explicitly reference the provision of **Case Management** services;⁸
- (b) Medicaid, including Medicaid waivers for home and community-based services;
- (c) Department of Defense/Tricare/Department of Veterans Affairs;
- (d) Federal Health Employee Benefit Program;
- (e) State/County Employee Programs;
- (f) Private Insurance
 - (i) Commercial
 - (ii) Self-funded
 - (iii) Taft-Hartley
 - (iv) Multiple Employer Welfare Associations (MEWAs); and/or
- (g) Other?

6.2 Payment Methodologies:

Editor's note: Funding methodologies might need to be identified which could include:

- (a) Fee-for-service;
- (b) Bundled or unbundled rates;
- (c) Case-based payments (e.g., prospective payment system for hospital reimbursement);
- (d) Capitated payments (fixed payments per enrollee/covered beneficiary life for all covered medical services during a specified period of time); and/or
- (e) Pay for Performance.

⁷ CMSA submitted requests and comments to the Centers for Medicare and Medicaid Services' (CMS) to address the interim final rule regarding revisions to payment policies under the proposed 2008 Medicare Physician Fee Schedule. Case managers work collaboratively with physicians and pharmacists to coordinate and provide assessments and management services through individualized care planning and care coordination in collaboration with beneficiaries, caregivers, and families. In support of those interventions and services, CMSA has presented public comment asking for reconsideration of the interim payment rule on CPT codes 99441, 99442, 99443, 98966, 98967 and 98968, requesting the status of each code be changed from "N" to payable by Medicare.

Failure to provide appropriate incentives and funding for these codes affects the alignment of care coordination quality between providers, especially at the various levels for transitions of care within settings, between settings, and between health states. Poor transitions of care may result in outcomes such as incorrect treatments, medication errors, delay in diagnosis and treatment, readmissions, **Consumer** complaints, and increased health care costs. CMSA believes that by requesting funding support for these six codes, providers will integrate case/care managers in support of the care coordination concepts such as the Medicare Medical Home Demonstration (MMHD), pay for performance programs, and various collaborative care models which CMS and other regulatory agencies are discussing. See www.cmsa.org/CPT for more information.

⁸ See http://www.ssa.gov/OP_Home/ssact/title18/1861.htm

6.3 Funding:

Editor's note: As appropriate, the CM Model Act could include legislative language describing/authorizing the funding/budget used to support the Program – hopefully as applied over a **multi-year** basis.

SECTION VII: OTHER PROGRAM REQUIREMENTS

The following section applies to the **Programs** providing **Case Management** services:

- 7.1 Interdepartmental Coordination:** The **Program** shall/should establish and implement mechanisms to promote collaboration, coordination, and communication across disciplines and departments within the **Program**, with emphasis on integrating administrative activities, quality improvement, and where present, clinical operations.
- 7.2 Information Management:** The **Program** shall/should implement information system(s) (electronic or paper) to collect, maintain, and analyze information necessary for organizational management that:
- (a) Provides for data integrity;
 - (b) Provides for data confidentiality and security;
 - (c) Includes a disaster recovery plan; and
 - (d) Includes a plan for storage, maintenance, and destruction.
- 7.3 Confidentiality:** Pursuant to federal and applicable state law, the **Program** shall protect the confidentiality of individually identifiable health information that:
- (a) Identifies how individually identifiable health information will be used;
 - (b) Specifies that individually identifiable health information is used only for purposes necessary for conducting **Case Management**, including *evaluation* activities;
 - (c) Addresses who will have access to the individually identifiable health information collected by the **Program**;
 - (d) Addresses communications and records transmitted or stored, including cellular phone, fax, or electronic systems; and
 - (e) Requires employees of the **Program** to sign a statement that they understand their responsibility to preserve **Consumer** confidentiality.
- 7.4 Regulatory Compliance:** The **Program** shall implement a regulatory compliance program that:
- (a) Tracks applicable laws and regulations in the jurisdictions where the **Program** conducts business; and
 - (b) Ensures the **Program's** compliance with applicable laws and regulations.

SECTION VIII: TRAINING

8.1 Training Activities: The **Program** shall offer a training program that includes:

- (a) Initial orientation and/or training for all **Staff** before assuming assigned roles and responsibilities;
- (b) Ongoing training as needed to maintain professional competency and cultural competence;
- (c) Training in state and regulatory requirements as related to job functions;
- (d) Documentation of all training provided for **Staff**;
- (e) Standards of practice governing the case manager's profession and/or the practice of professional case management;⁹
- (f) Conflict of interest;
- (g) Confidentiality;
- (h) Organizational structure; and
- (i) Delegation oversight, if necessary.

SECTION IX: QUALITY MANAGEMENT

9.1 Quality Management: The **Program** shall/should maintain a **Quality Management** function that promotes objective and systematic monitoring and evaluation of the **Case Management** services rendered pursuant to the **Program**.

9.2 Quality Management Documentation: The **Program**, as part of its **Quality Management** activities, shall/should provide:

- (a) Written documentation of the quality/performance improvement goals and activities utilized in the monitoring and evaluation of activities;
- (b) Tracking and trending of data related to **Case Management** services and the quality performance goals; and
- (c) The implementation of follow-up action plans to improve or correct identified opportunities for improvement.

9.3 Deeming Authority: The **[insert federal agency]** shall have authority to develop and implement a process to recognize and deem the quality standards from nationally recognized accreditation agencies that accredit **Case Management** programs as meeting Section IX.

⁹ See, for example, the Case Management Society of America's *Standards of Practice for Case Management* (First Edition 1995, 2nd revision publication pending 2009/2010), www.cmsa.org; *Standards for Social Work Practice in Health Care Settings* (2005); and other standards developed by professional groups including the National Association of Social Workers, www.socialworkers.org.

SECTION X: ANTIFRAUD AND CONSUMER PROTECTIONS

10.1 Antifraud Provision: The *Program* shall establish and implement an antifraud program that educates *Case Management Staff*, no less than annually, on policies and procedures supporting the ethical framework for *Case Management* practice, including:

- (a) Advocacy for *Consumer* needs;
- (b) Guidance for professional relationships with *Consumers*;
- (c) Prohibition of relationships that could compromise professional objectivity;
- (d) Resolution of conflicts of interest between the *Case Manager, Consumer, payer* (or federal agency), providers, or other entities;
- (e) Business, financial, and marketing practices;
- (f) Resolution of perceived lapses in quality of care resulting from actions by *Consumers, payers, Case Managers, providers, organizations, or other entities* affecting the *Case Management* process;
- (g) Policies that address *Case Managers'* handling of *Consumer* needs when such needs extend beyond the scope of the *Program*; and/or
- (h) Prohibition of discrimination against a *Consumer* or group of *Consumers* by the *Case Manager* or the *Program*.

10.2 Consumer Safety: The *Program* shall implement a *Consumer* safety initiative to protect the welfare and safety of *Consumers* and *Case Managers*. Such policies and procedures address:

- (a) For *Consumer* protection:
 - (i) The Americans with Disabilities Act, workers' compensation, and other laws protecting the rights of *Consumers*;
 - (ii) Identification and reporting of suspected abuse, neglect, or other *Consumer* mistreatment;
 - (iii) Informed consent for services, advance medical directives, and power of attorney for health care;
 - (iv) Health benefits and benefits administration;
 - (v) Seeking resources for resolution of legal questions; and
 - (vi) Prevention of harmful acts.
- (b) For *Consumer* and *Case Manager* protection:
 - (i) Prevention of violence;
 - (ii) Prevention of infectious diseases; and
 - (iii) Reporting incidents of unusual occurrences.

SECTION XI: COMPLAINTS

11.1 Grievance Procedures: The *Program* shall maintain a system to receive and respond in a timely manner to *Complaints* and, when appropriate, inform *Consumers* of their rights to submit an appeal. In addition, the *Program* establishes and implements a policy for resolving disagreements regarding *Consumer* care options.

SECTION XII: REGULATORY OVERSIGHT & IMPLEMENTATION

- 12.1 Establishment of Regulations:** **[Insert federal regulatory agency]** shall have oversight of this *Program* and is authorized to develop regulations pursuant to the CM Model Act. Such regulations shall be promulgated within six months after the adoption of the CM Model Act, which shall include a public comment period.
- 12.2 Implementation Date:** This Program shall be implemented by **[insert applicable date]**.



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