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**COMMENTS BY
THE AMERICAN ACCREDITATION HEALTHCARE COMMISSION/URAC**

RELATED TO

**FILE CODE CMS-2237-IFC
“PROVISIONS OF THE INTERIM FINAL RULE”**

**MEDICAID PROGRAM
OPTIONAL STATE PLAN CASE MANAGEMENT SERVICES**

**CENTERS FOR MEDICARE AND MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES**

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CONTACT: MARA OSMAN (202/962-8838)
URAC GOVERNMENT RELATIONS DIRECTOR

The American Accreditation Healthcare Commission/URAC (URAC) appreciates the opportunity to comment on the interim final rule (Rule) regarding Optional State Plan Case Management Services under the Medicaid Program (File Code CMS-2237-IFC), which addresses case management and targeted case management services for eligible Medicaid beneficiaries. URAC is one of the leading national accrediting bodies that serve the managed health care industry, and is the only accreditation organization offering standards that specifically address the rapidly evolving field of case management. As an authority in the field, URAC would like to suggest several modifications to §§ 440.169 and 441.18 of the Rule that will enhance its consistency with industry terminology, practices and standards.

Suggested Modifications to Provision of the Interim Final Rule

Definition of Case Management

URAC's definition of Case Management is adopted from the Case Management Society of America (CMSA), the national professional association for case managers:

Case Management: A collaborative process of assessment, planning, facilitation and advocacy for options and services to meet a consumer’s health needs through communication and available resources to promote quality cost-effective outcomes.

Comparatively, case management services are defined in §440.169 of the Rule as “services furnished to assist individuals ... in gaining access to needed medical, social, educational, and other services...” It is important to note that case management involves more than enabling access to services. The URAC and CMSA definitions more accurately reflect industry practice of case management, which includes:

- Patient education and information so that patients can make informed decisions;
- Facilitating access to services (e.g., getting appointments in a timely manner) in order to best suit health care needs and promote quality and cost-effective outcomes;
- Routine follow-up with the patient to more closely monitor patient progress with the care plan;
- Encouraging and enabling coordination among different providers in order to promote consistency in patient care and to avoid duplication of medical services and negative drug interactions.

URAC suggests that CMS modify the regulatory language and interpretative commentary to reflect the broader role that case management plays in the delivery of health care services. We also recommend that CMS provide the URAC and CMSA definitions of case management as references for state Medicaid agencies.

Case Management Plan vs. Care Management Plan

URAC recommends that CMS replace the term “care plan,” which is employed throughout the Rule, with the term “case management plan.” There is a critical distinction between these two terms. In the health care arena, a “care plan” relates to the direct provision of care and reflects what the health care provider does to physically take care of the patient. As CMS points out in its commentary, case managers do not perform direct care. Case managers maintain a close relationship with the patient and support the medical plan of care. A case management plan reflects what the case manager will do to help a patient reach his/her goals, such as facilitating collaboration between the treating physician and members of the health care team; regular contact and collaboration with the patient; and patient education regarding self-care and treatment options. Following are two examples that illustrate the distinction between care plans and case management plans:

Example #1: Goal is pain management.

A. The care plan involves the prescription of pain medication.

B. The case management plan involves (1) contact with the patient on a regular basis to monitor how well the pain is being managed; and (2) educating the patient about related methods of pain relief.

Example #2: Goal is treatment of congestive heart failure.

A. The care plan involves (1) the prescription of diuretics by the physician; (2) the performance of EKGs; and (3) recording the patient's weight.

B. The case management plan involves (1) weekly contact with the patient to ensure that the patient is weighing him/herself daily; (2) ensuring that the patient knows to contact the physician if there is a weight gain of more than three pounds in one day; (3) follow-up on whether the patient is taking medication as prescribed by the physician; and (4) educating the patient to watch for signs of edema (i.e. swelling in the lower legs), which may indicate heart failure.

Case Management Plan

Section 440.169(d)(2) of the Rule addresses the development of specific case management plans. URAC encourages CMS to add language to this section regarding short and long-term goals for the patient with specific timeframes. Currently, the regulation does not distinguish between short and long-term goals nor does it mention timeframes, which would provide direction and measurements for completion of the goals. URAC Case Management Accreditation Standards Version 3.1, 2007 include language regarding distinct goals and timeframes:

URAC Case Management Standard 19 – Case Management Plan

The organization establishes and implements a policy to document for every consumer a case management plan specific to the individual consumer that:

- (a) Is developed by a case manager in collaboration with the consumer and members of the health care team; and
- (b) Identifies:
 - (i) Short term goals;
 - (ii) Long term goals;
 - (iii) Time frames for re-evaluation (follow-up) and response to services;
 - (iv) Resources to be utilized; and
 - (v) Collaborative approaches to be used (including family and physician participation).

A short-term goal typically addresses the acute or immediate health status of the patient. A long-term goal aims to achieve sustaining health improvement or optimal health status. A goal is patient-specific and is stated as a measurable activity with a designated timeframe for achievement. URAC's Case Management Accreditation Guide recommends that these timeframes be depicted as a date or within a designated period (e.g., within two weeks or 30 days). URAC standards also require that the case management plan include timeframes for when the case manager will follow up with the patient and the health care providers. We suggest that CMS include a similar requirement for identified timeframes in §440.169(d)(4), which addresses monitoring and follow up activities.

Freedom of Choice, Disclosure and Consent

Section 441.18(a) of the Rule and CMS commentary refer to the beneficiary's free choice of qualified providers as well as the beneficiary's right to refuse case management services. URAC Case Management Accreditation Standards similarly seek to protect the autonomy of patients, recognizing that case management is quintessentially a collaborative process between patients and their case managers and other health care providers. (See URAC Case Management Accreditation Standards, Version 3.1, 2007 10(a)(iii), 11, 15 and 16 below.) URAC encourages CMS to strengthen this aspect of the regulations, by adding language to require disclosure and written consent for case management services in order to initiate the case management process.

In particular, we have two recommendations regarding §§ 440.169 and 441.18. First, we suggest that another subsection be added to §440.169(d), to require that the "assistance that case managers provide in assisting eligible individuals obtain services" include: educating the individual about the purposes and benefits of case management in order to allow for the individual's informed consent to participate in the case management program. Secondly, we suggest that §441.18(a)(7) be modified to include an additional subsection that requires documentation of an individual's (preferably written) agreement to participate in the case management program, including documentation of the date of consent. These modifications would ensure that initiation of the case management process involves disclosure and informed consent for case management services.

CM 10 – Consumer and Case Manager Protection

The organization establishes and implements policies and procedures to protect the welfare and safety of consumers and case managers. Such policies and procedures address;

- (a) For consumer protection:
 - (i) Informed consent for services, advance medical directives, and power of attorney for health care;

CM 11 – Consumer Rights

The organization establishes and implements policies to promote the autonomy of consumers and support consumer and family decision-making. Such policies address:

- (a) Education of consumers on their rights;
- (b) The process by which consumers are informed of choices regarding services;
- (c) The right of consumers to have input into the case management plan;
- (d) The right of consumers to refuse treatment or services, including case management services and the implications of such refusal relating to benefits eligibility and/or health outcomes;
- (e) The use of end of life and advance care directives by the organization, as applicable;
- (f) The right of consumers to obtain information regarding the organization's criteria for case closure;
- (g) The right of consumers to receive notification and a rationale when case management services are changed or terminated; and
- (h) Alternative approaches when the consumer and/or family is unable to fully participate in the assessment phase.

CM 15 – Case Management Disclosure

The organization establishes and implements a policy that requires case managers to disclose the following information to consumers at the onset of the case management relationship:

- (a) The nature of the case management relationship, particularly when a third party payer is involved;
- (b) The circumstances in which information obtained in the case management relationship will be disclosed to third parties;
- (c) How and when consumers are to be provided with written notification of case management actions and recommendations;
- (d) The availability of a complaint process and the method by which to access it; and
- (e) If requested, a description of the rationale for selecting the consumer for case management services.

CM 16 – Case Management Consent

The organization establishes and implements a policy to obtain consumers' consent for participation in case management activities that:

- (a) Requires documentation of oral consent;
- (b) Requires at minimum an attempt to obtain written consent;
- (c) Indicates the time frame in which the consent(s) must be obtained; and
- (d) Indicates the duration of validity of the consent(s).

Minimum Qualifications for Case Managers

In the commentary accompanying §441.18, CMS notes that the Social Security Act does not set any minimum educational or professional qualifications for the provision of case management services. CMS therefore directs States to establish qualifications for providers of case management services in the State plan. These qualifications relate to minimum age requirements, education, work experience, training, and other requirements (e.g., licensure or certification) which the State may create. CMS gives States flexibility to establish qualifications that are reasonably related to the demands of the Medicaid case management services to be furnished and the population being served.

URAC strongly urges CMS to provide greater direction in this area. Minimum qualifications set a baseline for professional competency, and promote patient safety through nationwide consistency of professional case management qualifications that identify appropriately educated and trained providers. URAC Case Management Accreditation Standards Version 3.1, 2007, address minimum qualifications for case management professionals:

CM 4 – Case Manager 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 and licensure as a health professional (where such licensure is available); or
 - (ii) Certification as a case manager; or
 - (iii) Professional certification in a clinical specialty and at least three (3) years experience as a case manager; and
- (b) If they have directly supervised the case management process for three or more years, hold a certification as a case manager.

CM 5 – Case Manager Qualifications

Case managers have the following qualifications:

- (a) At least one of the following:
 - (i) A bachelors (or higher) degree in a health-related field and licensure as a health professional (where such licensure is available); or
 - (ii) Certification as a case manager; or
 - (iii) RN licensure and three (3) years clinical practice experience; and
- (b) Practice case management within the scope of their licensure (based on the standards of the discipline).

URAC recommends that CMS modify the Rule and its commentary to provide URAC Case Management Accreditation Standards as a reference to guide States in establishing minimum educational or professional qualifications for the provision of case management services. States may also access the URAC website (www.urac.org) as a resource, where a list is posted of case manager certifications that URAC accepts as meeting the requirements in URAC Case Management Accreditation Standard 5: Case Manager Qualifications. The URAC definition of “certification” may also be helpful for general criteria regarding industry acceptability of certifications:

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:

- Establish standards through a recognized, validated program;
- Be research-based; and
- Be based (at least partially) on passing an examination.

Providing URAC Case Management Accreditation Standards as guidance for States in establishing minimum qualifications for the provision of case management services would be consistent with the direction thus far provided in the Rule and commentary. For example, URAC defines “certification in a clinical specialty” as a credential, which is consistent with the URAC definition of certification and is generally related to the population served.

Overview of URAC

URAC is an independent, nonprofit organization whose mission is to promote continuous improvement in the quality and efficiency of health care management through the processes of accreditation and education. To support this goal, our Board of Directors represents the full spectrum of stakeholders interested in our health care system, including consumers, employers, health care providers, health insurers, purchasers, workers’ compensation carriers and regulators.

Incorporated in 1990, URAC pioneered utilization management accreditation by creating a nationally recognized set of standards to ensure accountability in managed care determinations of medical necessity. As the health care industry evolves, URAC continues to address emerging issues: we now offer 22 accreditation and certification programs across the health care spectrum (i.e., Case Management, Claims Processing, Consumer Education and Support, Core Organizational Quality, Credential Verification Organization, Credentialing Support Certification, Disease Management, Drug Therapy Management, Health Call Center, Health Content and Personal Health Management Providers, Health Network, Health Plan, Health Provider Credentialing, Health Utilization Management, Health Web Site, HIPAA Privacy, HIPAA Security, Independent Review Organization, Medicare Advantage Health Plan, Pharmacy Benefit Management, Workers' Compensation Utilization Management and Vendor Certification.). Four new programs in development are Pharmacy Benefit Management for Workers Compensation and Property and Casualty; Specialty Pharmacy; Mail Service Pharmacy; and a Wellness Accreditation Program.

Many states have found URAC accreditation standards helpful in ensuring that managed care plans and other health care organizations are meeting quality benchmarks. Thirty-eight states and the District of Columbia currently reference one or more URAC accreditation programs in their statutes, regulations, agency publications or contracts, making URAC the most recognized national managed care accreditation body at the state level.

At the federal level, four federal agencies recognize URAC accreditation. The Centers for Medicare and Medicaid Services recognize URAC Medicare Advantage Health Plan Accreditation for the Medicare Advantage (formerly Medicare+Choice) Program; the Office of Personnel Management recognizes all URAC accreditation programs under the Federal Employee Health Benefits Program; TRICARE/Military Health System recognizes URAC's Health Network Accreditation; and the Department of Veterans' Affairs recognizes URAC's Health Call Center Accreditation.

URAC Standards: Establishing Quality Benchmarks

URAC accreditation serves as a symbol of excellence in the health care industry, promoting prevailing industry standards and consumer protections. In the rapidly evolving field of health care, URAC standards are developed through a dynamic process that identifies best practices and promotes high quality performance measurement. All stakeholders in the health care arena actively participate with URAC in developing these quality benchmarks through an inclusive process that incorporates an opportunity for public comment.

URAC's standards development process begins with a period of careful research, debate and discussion among stakeholders. An initial set of standards is then

proposed and made available for a public comment and review. URAC's Advisory Committee reviews the submitted comments, makes appropriate changes, and the draft standards are then beta tested with a discrete group of companies in order to ensure that they work in practice. After beta testing, the standards may be modified again, and then they are forwarded to URAC's Board of Directors for consideration and approval. URAC revises its standards through a similar process at least every two years.

As URAC standards are implemented through the accreditation process, organizations have an opportunity to validate their commitment to quality and accountability. In order to earn accreditation, these companies voluntarily undergo a rigorous and periodic review that evaluates their operations and services against the contemporary standards developed by health care experts and stakeholders.

Conclusion

URAC appreciates this opportunity to share our comments regarding the Rule with CMS. We hope that you will find our recommendations useful in strengthening the regulations addressing case management and targeted case management services for eligible Medicaid beneficiaries. As a trusted and independent resource for monitoring the safety, effectiveness and service quality of case management programs, our comments stem from URAC Case Management Accreditation Standards and the URAC Case Management Accreditation Guide. Pursuant to our Case Management Accreditation Program, URAC currently accredits over 130 case management programs in more than 200 offices nationwide. As stated by Jeanne Boling, former Executive Director of the Case Management Society of America, "URAC accreditation serves the critical function of establishing the organization's policies, procedures and structure needed for optimal case management performance."

For agency review, we have attached a copy of URAC Case Management Accreditation Standards (Version 3.1, 2007). For further URAC information or resources, please do not hesitate to contact URAC Government Relations Director Mara Osman (202/962-8838, mosman@urac.org).

Again, thank you for your time and consideration.

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Attachments: URAC Case Management Accreditation Standards (Version 3.1, 2007).