

Commission for Case Manager Certification

The content of the CCM® examination is based on an ongoing, nationwide validation research project. The research has identified six major domains of essential knowledge. Additionally, each of the six domains is further defined into sub-domains. These domains are considered core knowledge areas that are used by case managers across the continuum of activities and functions typically associated with case management (i.e., assessment, planning, implementation, coordination, monitoring, and evaluation) and match the six knowledge domains of case management (as listed below).

The content of the examination remains constant for each administration of the examination. The questions will vary from administration to administration, in order to protect the integrity of the examination process. The 2025 exam blueprint will go into effect starting with the August 2025 CCM examination.

Content and Blueprint of the CCM Examination - 2025		Number of Items
Domain 1: Care Management	30%	45
 Recognize the criteria associated with caseload assignment/selection 		
Develop a client-centered plan of care		
Understand differences in and application of age specific care		
 Apply evidence-based case management and/or care management models, processes, and tools 		
Apply cost containment principles		
 Understand management of clients based on length and type of care (e.g., acute, chronic illness(es), disabilities, behavioral health) 		
 Address medication management (e.g., access, reconciliation, education) 		
 Perform a comprehensive assessment of needs, including assessment of social, behavioral, and physical function 		
Assess client's acuity or severity levels		
 Understand levels of care (e.g., inpatient, observation, outpatient) 		
 Understand the features of care settings (e.g., hospital, skilled nursing facilities, group home, rehabilitation) 		
 Understand palliative, hospice, and end-of-life care including chronic pain management principles 		
Collaborate with interdisciplinary/interprofessional care teams		

_			_
•	Understand key concepts of population health (e.g., pediatrics,		
	geriatrics, maternity care)		
•	Identify key aspects of transitions of care		
•	Understand key aspects of care coordination through the		
	continuum		
•	Understand advanced care planning (e.g., power of attorney, health		
	care surrogate, living wills)		
•	Collaborate with community-based support service agencies and		
	providers		
Domai	n 2: Reimbursement Methods	12%	18
•	Recognize reimbursement and payment methodologies (e.g.,		
	bundled payment, case rate, prospective payment systems, value-		
	based care, financial risk models, worker's compensation)		
•	Recognize key features of accountable care organizations and		
	managed care concepts		
•	Identify private benefit programs (e.g., pharmacy benefits		
	management, indemnity, employer-sponsored health coverage,		
	individually purchased insurance, home care benefits, COBRA)		
•	Identify military and veteran benefit programs (e.g., TRICARE and		
	Veterans Administration)		
•	Identify public benefit programs (e.g., SSI, SSDI, Medicare, Medicaid)		
•	Recognize available financial resources (e.g., waiver programs,		
	special needs trusts, viatical settlements)		
•	Apply utilization review/management principles, guidelines, and		
	tools		
•	Recognize coding methodologies (e.g., Diagnosis-Related Group,		
	Diagnostic and Statistical Manual of Mental Disorders, International		
	Classification of Diseases, Current Procedural Terminology)		
•	Identify negotiation techniques (e.g., single case agreement,		
	individual insurance policy, fee schedule agreements)		
•	Define key features of insurance principles (e.g., benefit, copays)		
Domai	n 3: Psychosocial Concepts and Support Systems	20%	30
•	Recognize the signs of abuse and neglect		
•	Understand how behavioral change theories and models impact		
	client readiness (e.g., readiness for lifestyle behavioral change)		
•	Understand the behavioral health concepts (e.g., diagnosis, dual		
	diagnoses, co-occurring disorders, substance use) that influence		
	client care needs		
•	Promote client empowerment, engagement, and self-care		
	management (e.g., self-advocacy, self-directed care, informed		
	decision making, shared decision making, health education)		
•	Apply tools and techniques to promote client engagement (e.g.,		
	motivational interviewing, goal-setting, active listening, reflection,		
	person-centered care approach, health coaching)		
•	Apply crisis intervention strategies		

lantify booth rainted costal peods and accostated recourses		
lentify health-related social needs and associated resources		
ognitive capacity		
nderstand psychosocial aspects of chronic conditions and disability		
lentify supportive care programs (e.g., health-related support		
oups and organizations, bereavement, spiritual/pastoral,		
aregiver-related)		
nderstand wellness and illness prevention concepts and strategies		
escribe the key factors of social drivers of health (i.e., social		
	6.007	4=
	10%	15
nderstand accreditation standards and requirements (e.g., The pint Commission, CMS, NCQA)		
escribe the basic elements of cost-benefit analysis		
nderstand role in data gathering, interpretation, evaluation, and eporting (e.g., readmission rates, denials, population volume		
eports)		
eports) escribe health care analytics (e.g., health risk assessment,		
escribe health care analytics (e.g., health risk assessment, redictive modeling, Adjusted Clinical Group) Jentify the sources of quality indicators (e.g., Centers for Medicare and Medicaid Services, HEDIS, URAC, National Committee for quality Assurance, National Quality Forum, Agency for Healthcare		
escribe health care analytics (e.g., health risk assessment, redictive modeling, Adjusted Clinical Group) lentify the sources of quality indicators (e.g., Centers for Medicare and Medicaid Services, HEDIS, URAC, National Committee for quality Assurance, National Quality Forum, Agency for Healthcare research and Quality, National Quality Strategy) escribe quality indicators, applications, performance improvement and evaluation methods (e.g., clinical, financial, productivity,		
escribe health care analytics (e.g., health risk assessment, redictive modeling, Adjusted Clinical Group) lentify the sources of quality indicators (e.g., Centers for Medicare and Medicaid Services, HEDIS, URAC, National Committee for quality Assurance, National Quality Forum, Agency for Healthcare research and Quality, National Quality Strategy) rescribe quality indicators, applications, performance improvement and evaluation methods (e.g., clinical, financial, productivity, stilization, client experience of care) Inderstand the application of quality and performance improvement methods, tools, and processes Inderstand the impact of case management practices (e.g., care		
escribe health care analytics (e.g., health risk assessment, redictive modeling, Adjusted Clinical Group) lentify the sources of quality indicators (e.g., Centers for Medicare and Medicaid Services, HEDIS, URAC, National Committee for quality Assurance, National Quality Forum, Agency for Healthcare research and Quality, National Quality Strategy) escribe quality indicators, applications, performance improvement and evaluation methods (e.g., clinical, financial, productivity, tilization, client experience of care) inderstand the application of quality and performance improvement methods, tools, and processes inderstand the impact of case management practices (e.g., care pordination, transitional planning) on value-based care	10%	15
escribe health care analytics (e.g., health risk assessment, redictive modeling, Adjusted Clinical Group) lentify the sources of quality indicators (e.g., Centers for Medicare and Medicaid Services, HEDIS, URAC, National Committee for quality Assurance, National Quality Forum, Agency for Healthcare research and Quality, National Quality Strategy) rescribe quality indicators, applications, performance improvement and evaluation methods (e.g., clinical, financial, productivity, stilization, client experience of care) Inderstand the application of quality and performance improvement methods, tools, and processes Inderstand the impact of case management practices (e.g., care	10%	15
	ecognize client supports and informal supports assess health literacy, education needs, and language barriers anderstand interpersonal communication strategies (e.g., conflict asolution, group dynamics) accognize cultural, spiritual, and religious factors that may affect asolution's care needs anderstand the assessments that measure psychological and agnitive capacity anderstand psychosocial aspects of chronic conditions and disability anticentify supportive care programs (e.g., health-related support aregiver-related) anderstand wellness and illness prevention concepts and strategies ascribe the key factors of social drivers of health (i.e., social atterminants of health, health equity, health disparity) accognize how gender health influences care needs (e.g., sexual attentation, gender expression, gender identity) apply Trauma-Informed Care Principles account of the principles account of	ecognize client support system dynamics, including both formal and informal supports seess health literacy, education needs, and language barriers inderstand interpersonal communication strategies (e.g., conflict solution, group dynamics) ecognize cultural, spiritual, and religious factors that may affect see client's care needs inderstand the assessments that measure psychological and signitive capacity inderstand psychosocial aspects of chronic conditions and disability entify supportive care programs (e.g., health-related support soups and organizations, bereavement, spiritual/pastoral, surgiver-related) inderstand wellness and illness prevention concepts and strategies escribe the key factors of social drivers of health (i.e., social eterminants of health, health equity, health disparity) ecognize how gender health influences care needs (e.g., sexual sientation, gender expression, gender identity) inderstand accreditation standards and requirements (e.g., The sint Commission, CMS, NCQA) escribe the basic elements of cost-benefit analysis

	sic functional capacity to identify care needs (e.g., ognitive status)		
	coordination needs related to rehabilitation settings		
	ute rehab, SNF)		
	nique rehabilitation aspects of care for people with		
	d chronic illnesses (e.g., job analysis and		
	on, life care planning, developmental)		
	ocational rehabilitation programs and resources (e.g.,		
	pensation, catastrophic injuries)		
	petween types of rehabilitation programs and		
_	., medical rehabilitation, substance use rehabilitation,		
	non-governmental organization, return to work		
strategies, sch			
	gal, and Practice Standards	18%	27
· · ·	cal standards related to care management (e.g.,		
	d of life, refusal of treatment/services)		
	fessional conduct (e.g., cultural and linguistic		
•	ope of practice, education, license, and/or		
certification)			
	ne application of health care and disability related		
	g., Americans with Disabilities Act, Occupational Safety		
	Iministration regulations, Health Insurance Portability		
	bility Act, Affordable Care Act, No Surprises Act,		
EMTALA Act, F			
	gal and regulatory requirements applicable to case		
	practice (e.g., corporate compliance, mandatory		
	of technology)		
	best practices associated with privacy and		
confidentiality • Understand in			
	dustry best practices associated with risk		
management • Understand re	esponsibilities associated with documentation and		
	'		
• Practice self-ca	are, safety, and well-being as a professional		
	ds of practice (e.g., Case Management Society of		
1 1 1	dards of Practice for Case Management, National		
	Social Work Standards for Case Management)		
	the client and their support systems		
- Advocate for t	and and their support systems		