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Long-Term Services and Supports

A Primer for Case Managers: Part 2

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ABSTRACT

Purpose/Objectives: The Centers for Medicare & Medicaid Services (CMS) announced that beginning in 2019, Medicare Advantage (MA) health plans may begin offering additional benefits for nonmedical home services. In 2019, this change impacts the Long-Term Services and Supports (LTSS) landscape dramatically. This 2-part article describes LTSS, its traditional demographic and health care footprint, the regulatory and accreditation landscape, quality measurement and outcomes, and the critical importance of maintaining care continuity for individuals receiving LTSS. The objectives are to:

- define LTSS,
- identify client demographics,
- identify delivery models,
- discuss regulation and accreditation environments,
- discuss quality improvement and outcomes initiatives,
- identify promising practices and best practices, and
- identify useful resources.

Primary Practice Setting(s): Applicable to all health care sectors where case management is practiced.
Findings/Conclusions: Historically, once Medicare recognizes a product or service, managed health plans and commercial insurance carriers follow suit. Professional case managers must become fluent in the language of LTSS, the implications of these CMS changes, and the impact on case management practice across the care continuum.
Implications for Professional Case Management Practice: Professional case managers should understand LTSS, especially as it pertains to care transitions and continuity of health care services to our most vulnerable clients.

Key words: *case management, home care services, Long-Term Services and Supports, LTSS, Medicaid, Medicare Advantage*

The Long-Term Services and Supports (LTSS) payer landscape is destined to expand. The Centers for Medicare & Medicaid Services (CMS) announced that beginning in 2019, Medicare Advantage (MA) plans may begin offering additional benefits for nonmedical home services (CMS.gov, 2018). Although LTSS have been a Medicaid-heavy sector, once Medicare recognizes a product or service, managed health plans and commercial insurance carriers follow suit.

To safely transition and/or maintain people in home- and community-based settings (HCBS), it is essential to have the support and coordination of a knowledgeable care team. Professional case managers play an integral part in supporting clients to remain in the community setting safely. Part II of this article provides a look at how the LTSS setting is rated, regulated, and accredited. Quality measurement and outcomes are addressed. Maintaining care continuity and quality of services for individuals receiving LTSS is essential to attain the promise that HCBS hold. As in Part I, there is a list of resources, available as Supplemental Digital Content at http://links.lww.com/PCM/A9. This details the story of Mrs. Margaret Alden and includes critical thinking questions.

Organization Rating

Information technology and the shift toward HCBS allow people to maintain independence, longevity, and the opportunity to live in home and community

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settings. These factors, in conjunction with the fact that Baby Boomers continue feeding the retirement river, ensure likely the need (and desire) for LTSS for the foreseeable future. As in every other care setting, when demand and utilization rise so too does the need to assure service quality. For LTSS, quality is monitored through ratings, regulation, and accreditation.

The Long-Term Care Spectrum

The long-term care spectrum includes community care and institutional settings. The U.S. Department of Health and Human Services defines long-term care as:

> "Services that include medical and non-medical care for people with a chronic illness or disability. Long-term care helps meet health or personal needs. Most long-term care services assist people with activities of daily living, such as dressing, bathing, and using the bathroom. Long-term care can be provided at home, in the community, or in a facility. For purposes of Medicaid eligibility and payment, long-term care services are those provided to an individual who requires a level of care equivalent to that received in a nursing facility." (U.S. Department of Health and Human Services, 2017)

Generally speaking, long-term care maintains a trajectory. Figure 1 illustrates the movement from relative independence to dependent care, usually moving from the home setting to institutional care. This figure is not intended to be an all-inclusive reflection of long-term care settings nor should it be assumed that people move through this continuum in a linear fashion.

When discussing long-term care, it is important to understand the difference between skilled and custodial care. A brief comparison is given in Table 1.

The Long-Term Services and Supports State Scorecard

The LTSS State Scorecard is a compilation of state data and analysis. It highlights measures of state performance in the process of creating a high-quality system of care. It is intended to drive forward momentum toward service improvement for older adults and people with physical disabilities and their family caregivers (Long-Term Services and Supports State Scorecard, 2018a). The focus is on state-level data because our country does not have a single national system to address LTSS needs.

Scorecard reports have been released in 2011, 2014, and 2017. As LTSS firm their foothold, the frequency of reporting may change. The report has evolved over the years; however, detailed explanations of each indicator and methodology are provided in the methodology overview and detailed indicator

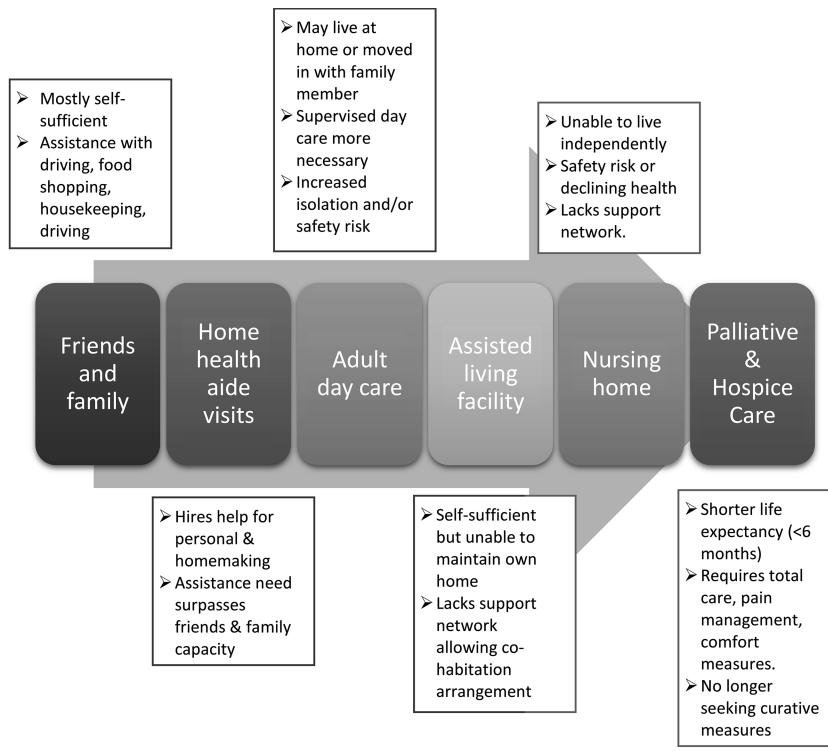

FIGURE 1
Long-term care progression.

TABLE 1
Skilled Versus Custodial Care Comparison

Skilled Care	Custodial Care
• Intensive medical attention and treatment provided by skilled, licensed health care professionals • Generally, ≤100 days length of stay • Involves short-term recoverable medical condition or surgical recovery • Insurance may cover most or all of medically appropriate skilled care needs • Qualification criteria used to determine eligibility • Benefit payment approval generally requires concurrent review that demonstrates skilled nursing and/or therapies received	• Nonskilled care to provide daily living activities (e.g., bathing, dressing, eating) • Chronic condition that is considered unrecoverable • Expected length of stay >100 days • Specialized insurance may cover long-term care • May qualify for Medicaid coverage based on financial eligibility

descriptions on the LTSS Scorecard website (Long-Term Services and Supports State Scorecard, 2018a).

The 2017 measures look at the 25 indicators in five dimensions. Figure 2 offers an overview of these dimensions and indicator types.

An indicator is a means to measure, indicate, or point to something with a general sense of exactness. It is also defined as a sign, symptom, or index of something (Sustainablemeasures.com, 2018). An indicator tells the observer "how much" or "to what extent." Once a target goal is set, an indicator is used to measure progress toward goal achievement. In the LTSS State Scorecard, each dimension includes a number of indicators. The LTSS State Scorecard indicators were selected on the basis of the following:

- clarity,
- importance,
- meaningfulness, and
- availability of comparable data at the state level. (Long-Term Services and Supports State Scorecard, 2018b)

FIGURE 2
LTSS State Scorecard dimensions and indicators (Long-Term Services and Supports State Scorecard, 2018b).
LTSS = Long-Term Services and Supports.

Composite indicators were constructed from a range of data in a related area, which allowed ranking of states in areas of performance that would have otherwise been difficult (Long-Term Services and Supports State Scorecard, 2018b).

In the 2017 scorecard, Washington, Minnesota, Vermont, Oregon, and Alaska were top achieving states. Indiana, Kentucky, Alabama, Mississippi, Tennessee, Florida, West Virginia, and Oklahoma ranked the lowest. To provide perspective, Washington, Minnesota, Oregon, Wisconsin, Hawaii, and Colorado have been in the top 10 across all three editions of the scorecard. Indiana, Kentucky, Alabama, Mississippi, Tennessee, Florida, West Virginia, and Oklahoma remain in the bottom 10 across all three scorecards (Reinhard et al., 2017).

Regulatory Environment

Understanding how Medicaid dominates this provider space is key to grasping the regulatory environment of LTSS. Congress continually modifies statutory provisions affecting eligibility, covered services, and financing. The Centers for Medicare & Medicaid Services drives regulatory control and provides administrative guidance through publications, letters, and other materials posted on the Medicaid website. Individual states implement and carry out programs and changes within the scope of the federal requirements but still peculiar to individual jurisdictions. States also create and maintain waiver programs that were previously discussed (Medicaid and CHIP Payment and Access Commission, 2017).

The CMS website resources pertain to federal initiatives, whereas state-specific websites contain more granular detail regarding programs and services.

The CMS website resources pertain to federal initiatives, whereas state-specific websites contain more granular detail regarding programs and services. To access state-specific LTSS information, one must search that state's website. This is time-intensive and challenging, especially to novice state website explorers. A useful resource that helps simplify searching is the National Association of States United for Aging and Disabilities (NASUAD, 2018a) web site. This association tracks LTSS efforts across the country through a tool, the State Medicaid Integration Tracker.

State Medicaid Integration Tracker

The tracker is updated bimonthly. It highlights the status of the following state actions:

- Managed Long-Term Services and Supports (MLTSS);
- State demonstrations to integrate care for dual-eligible individuals and other Medicare–Medicaid coordination initiatives;
- Other LTSS reform activities, including:
  - Balancing Incentive Program (BIP),
  - Medicaid State Plan Amendments under §1915(i),
  - Community First-Choice Option under §1915(k), and
  - Medicaid Health Homes.

(NASUAD, 2018a)

Resources that inform NASUAD's efforts include the following:

- Medicaid MLTSS,
- Financial Alignment Initiative (FAI),
- Balancing Incentive Program,
- CMS website on Health Homes,
- CMS list of Medicaid waivers,
- State Medicaid Agency websites,
- Interviews with state officials, and
- Presentations by state agencies.

(NASUAD, 2018a)

A brief review of the FAI and the BIP lends helpful perspective at this point.

Financial Alignment Initiative

Medicare and Medicaid have been financially misaligned for a very long time. This asynchrony created barriers to program coordination, especially in situations when an individual was eligible for benefits under both programs. The Centers for Medicare & Medicaid Services began to address this problem under the FAI. Under this initiative, Medicaid partners with states to test models that better align the financing of these programs and support integration of primary, acute, behavioral health, and long-term services and supports for Medicare–Medicaid enrollees, who are referred to by the term "dual-eligible." The categories of care within this initiative include primary, acute, behavioral health, and long-term services and supports (CMS, 2018a).

In the FAI arrangement, either or both capitated or fee-for-service payment model are used to frame the reimbursement model:

- In the capitated model, a state, CMS, and a health plan enter into a three-way contract and the plan receives a prospective blended payment to provide comprehensive, coordinated care (CMS, 2018a).
- In the managed fee-for-service (MFFS) model, a state and CMS enter into an agreement by which the state would be eligible to benefit from a portion of savings from initiatives designed to improve quality and reduce costs for both Medicare and Medicaid. Further clarification of the MFFS opportunity was issued by CMS (CMS, 2018a; U.S. Department of Health and Human Services, 2013):
  - When a state invested in Medicaid in a way that reduced expenditures for dual-eligible enrollees, it would not receive financial benefit from any resulting Medicare savings. Instead, the MFFS model allowed those states to receive Medicare performance payments based on reductions in Medicare spending among Medicare–Medicaid enrollees, contingent on states meeting certain quality thresholds.
  - When a state participated in the MFFS model, it would be carefully evaluated on the basis of a selected set of quality measures. States failing to meet minimum criteria would not be eligible to receive performance payments. If a state met minimum criteria, it was eligible to receive 60% of a maximum potential performance payment. The remaining 40% will be scaled on the basis of state performance.

(U.S. Department of Health and Human Services, 2013)

Balancing Incentive Program

The BIP provides financial incentives to states to allow access to noninstitutional LTSS. The BIP authorized grants to serve more people in HCBS between October 1,

The takeaway message for case managers is to learn how LTSS are financed and regulated to better monitor program changes that may affect the people who we serve. This is especially important for those working in areas where Medicaid figures as a higher percentage in the payer mix at one's facility or agency.

2011, and September 30, 2015. Thirteen states still participate in the program (Medicaid.gov, 2018a).

The BIP supported states in transforming their long-term care systems through:

- Establishing No Wrong Door Systems;
- Utilizing core standardized assessment instruments streamlining access to LTSS; and
- Implementing conflict-free case management through proper firewalls and risk reduction strategies, enabling access to quality LTSS.

(Medicaid.gov, 2018a)

The BIP increased the Federal Matching Assistance Percentage (FMAP) to states making structural reforms to increase nursing home diversions and access to noninstitutional LTSS (Medicaid.gov, 2018a). The enhanced matching payments were tied to the percentage of a state's LTSS spending, with lower FMAP increases going to states that needed to make fewer reforms (Medicaid.gov, 2018a).

The aim of the BIP effort is to assure government payers support value-based case and that individuals have access to quality health and personal care. As LTSS continue to grow, new programs and regulations are inevitable. However, as administrations change, so will health care priorities. As a result, some or all of these programs may cease to exist or may be repackaged as other opportunities.

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Accreditation for Long-Term Services and Supports Providers

As health care consumers, we face a fragmented system; LTSS recipients are no different. Organizations and agencies providing and/or coordinating LTSS are responsible for the support and care for the frail elderly and the disabled, people who are least able to tolerate service interruptions. Medicaid along with other stakeholders (e.g., AARP) seeks to ensure this fragile population's safety through the implementation of high-quality programs, appropriately trained and competent staff, and safe and effective care transitions.

There is an ever-increasing emphasis on value over volume throughout the continuum of care. Health care organizations must demonstrate their ability to coordinate medical and social services for the populations they serve. Accreditation is one way in which to demonstrate an organizational commitment to value-driven quality care. Increasingly, states are being required to attain accredited status in order to do business and receive Medicaid payment for LTSS (Maciejowski, 2017, 2018). Virginia, Pennsylvania, and Massachusetts codified an accreditation mandate into LTSS program requirements (Maciejowski, 2017).

Organizational and/or program accreditation demonstrates that an organization meets baseline administrative and program standards as well as performs quality improvement to improve its services in support of people receiving support and services in their preferred setting. The National Committee for Quality Assurance (NCQA) is a private, 501(c)(3) not-for-profit organization that has dedicated itself to improving health care quality since 1990. The National Committee for Quality Assurance kicked off LTSS recognition programs in 2017 (NCQA, 2018a). Three types of NCQA LTSS case management recognitions are shown in Figure 3.

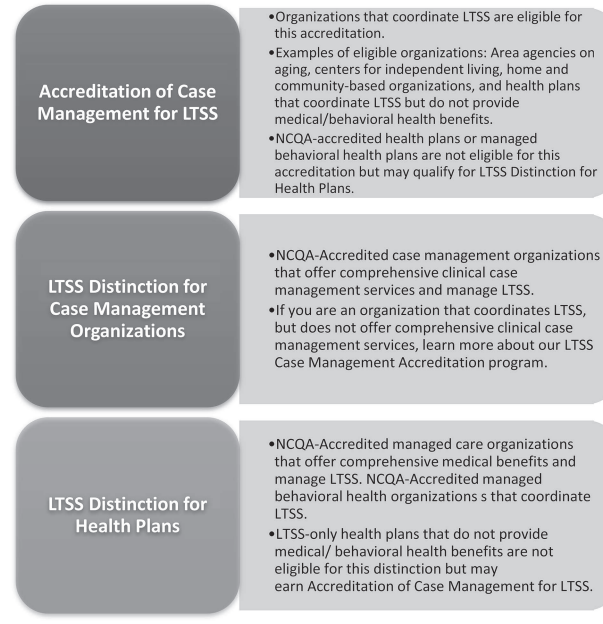

FIGURE 3
LTSS recognition programs (National Committee for Quality Assurance, 2018a). LTSS = Long-Term Services and Supports; NCQA = National Committee for Quality Assurance.

Program accreditation is a growing concern for case managers as states begin requiring LTSS accreditation in order for organizations to be paid by Medicaid. By 2017, at least three states already codified an accreditation requirement into LTSS regulation—Virginia, Pennsylvania, and Massachusetts. The same is likely to be the case for MA plans as nonmedical LTSS benefits launch beginning in 2019.

Becoming accredited is a process that usually requires at least 9 months from application to determination and significantly more time leading up to the application filing. The review includes an extensive documentation examination as well as an onsite visit, followed by a period of preliminary report, remediation, and finally the determination, and the final report. A search of the URAC website, a different accreditation entity, failed to reveal an existing or anticipated LTSS-specific accreditation program as of July 2018.

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Although the provider contracting process is outside the purview of managed care case management, those working in other care settings should be mindful of vendor accreditation and contract status to avoid placing a beneficiary at financial risk or jeopardizing the case management plan of care. Failing to do so is likely to result in service disruption for beneficiaries.

The accreditation process itself is extensive. Anecdotally, small community agencies that have not previously undergone accreditation find themselves unprepared for this level of intense scrutiny of their internal processes and quality improvement.

Focus areas of NCQA accreditation of case management for LTSS include the following:

- Program description;
- Assessment;
- Person-centered care planning and monitoring;
- Care transitions;
- Measurement and quality improvement;
- Staffing, training, and verification;
- Rights and responsibilities; and
- Delegation.

(NCQA, 2018b)

There is a shorter list of standards in the distinction program. This is because organizations seeking distinction have already achieved full NCQA accreditation. The LTSS Distinction for Health Plans explores four standard areas, including:

- Core features,
- Measurement and quality improvement,
- Care transitions, and
- Delegation.

(NCQA, 2018c)

Each recognition program's Standards, Elements, and Factors flesh out the specifics each agency must meet in order to achieve accredited status. NCQA recognizes that many HCBS are new to accreditation. Supporting their effort to achieve accredited status, NCQA created the LTSS Roadmap to Success and the LTSS Best Practices Academy.

LTSS Roadmap to Success

The LTSS Roadmap helps organizations gain an understanding of the accreditation process. It is a guide through the preparatory steps, measurement, process improvement, and the review process. It is an adjunct to, rather than a substitute for, LTSS standards. The Roadmap provides examples, tools, and resources for the accreditation journey (NCQA, 2017). This guide is accessible through the NCQA website.

LTSS Best Practices Academy

The LTSS Best Practices Academy is an interactive forum for LTSS professionals. It utilizes a multilevel approach to foster learning through webinars, informative discussions, shared resources, and enriching information exchange. Organizations joining the Academy may register as many employees as are relevant to their accreditation process. The Academy leverages technology as a means for outreach to its members. Webinars feature guest speakers addressing topics such as measurement and outcomes, person-centered care, social determinants of health, and care transitions. Housed on a private-access site, the Academy's information resources are continually refreshed. Members receive in-advance access to documents, such as the aforementioned Roadmap, discounts to other events, and announcements (NCQA, 2018d).

Quality Measures

The focus on HCBS drives recognition and expansion of LTSS services. Care must be taken to align care and service delivery with quality measures that reflect value-based care. Quality measures evaluate the degree to which evidence-based treatment guidelines are followed (where indicated) and assess the results of care. The use of quality measurement strengthens accountability and performance improvement initiatives. Quality measures are used to demonstrate activities undertaken and health care outcomes achieved (Medicaid.gov, 2018b).

The Centers for Medicare & Medicaid Services contracted Mathematica Policy Research and NCQA to develop quality measures for LTSS received through managed care organizations (MCOs). These measures focus on assessment and care planning processes. States, MCOs, and other stakeholders may use these measures for quality improvement purposes (Mathematica Policy Research, n.d.). The measures were released by CMS in August 2018, shown in Figure 4.

Quality Stakeholders

In addition to CMS and NCQA, there are other quality stakeholders to consider:

MLTSS 1: LTSS comprehensive assessment and update

- Describes the percentage of adult (18 years and older) MLTSS plan members who have documentation of a comprehensive within 90 days of enrollment (new members) or annually.
- Assessment of nine (9) core elements and at least twelve (12) supplmental elements.
- Data collected from case management record review.

MLTSS 2: LTSS comprehensive care plan and update

- The percentage of newly enrolled adult (18 years and older) MLTSS plan members who have documentation of a care plan in the specified timeframe that includes documentation of core elements.
- Care Plan with Core Elements Documented. MLTSS plan members who had a comprehensive LTSS care plan with seven core elements documented within 120 days of enrollment (for new members) or annually
- Care Plan with Supplemental Elements Documented. MLTSS plan members who had a comprehensive LTSS care plan with seven core elements and at least four supplemental elements documented within 120 days of enrollment (for new members) or annually.
- Data collected from case management record review.

MLTSS 3: LTSS shared care plan with primary care practitioner

- The percentage of adult (18 years and older) MLTSS plan members with a care plan for whom all or part of the care plan was transmitted to the primary care practitioner (PCP) within 30 days of the care plan's development or update.
- Data Collection from case management record review.

MLTSS 4: LTSS re-assessment / care plan update after inpatient discharge

- The percentage of discharges from inpatient facilities in the measurement year for MLTSS members resulting in a re-assessment or both a re-assessment and care plan update within 30 days of discharge. The following rates are reported.
- Re-Assessment after Inpatient Discharge. The percentage of discharges from inpatient facilities resulting in a LTSS re-assessment within 30 days of discharge.
- Re-Assessment and Care Plan Update after Inpatient Discharge.The percentage of discharges from inpatient facilities resulting in a LTSS re- assessment and care plan update within 30 days of discharge.

FIGURE 4
LTSS quality measures (Centers for Medicaid & Medicare Services, 2018b; National Committee for Quality Assurance, 2018e). LTSS = Long-Term Services and Supports; MLTSS = Managed Long-Term Services and Supports.

- Institute for Medicaid Innovation (IMI),
- National Association of States United for Aging and Disabilities,
- National Quality Forum (NQF),
- Institute for Healthcare Improvement (IHI), and
- The SCAN Foundation.

The LTSS market is poised to expand in a very significant way. One only needs to look at the population of aging and disabled people as especially vulnerable populations, both of which promise to grow as Baby Boomers mature through retirement and beyond. Consider the end of the Boomer era as somewhere in the range of 1960–1964. This means the last of the Boomers reach the age of 65 years in 2025–2027. It is essential to establish and maintain efficient and effective LTSS care delivery and quality expectations as this age wave appears at LTSS' doorstep. A brief discussion of these organizations and their contributions to the quality landscape provides necessary background to demonstrate attention is being paid to the LTSS sector.

Institute for Medicaid Innovation

This is a relatively new organization, founded in 2016. According to the IMI, its mission "is to improve the lives of Medicaid enrollees through the development, implementation, and diffusion of innovative and evidence-based models of care that promote quality, value, equity, and the engagement of patients, families, and communities" (IMI, 2018a).

The IMI contributes to the quality conversation through its annual questionnaire aimed at managed Medicaid plans. The goal is to capture and report information and data on the Medicaid program that is not currently available through other sources (IMI, 2018b). The Institute publishes an annual best practices summary that features top innovative Medicaid health plan initiatives across the United States. The Institute also leads policy efforts and research projects that focus on the Medicaid population.

National Association of States United for Aging and Disabilities

Founded in 1964, NASUAD was originally known as the National Association of State Units on Aging. The name change occurred in 2010 and formally recognized the work that the state agencies were undertaking in the field of disability policy and advocacy (NASUAD, 2018b).

The National Association of States United for Aging and Disabilities is responsible for the publication of the State Medicaid Integration Tracker, focusing on the state activities status, including:

1. Managed Long-Term Services and Supports;
2. State demonstrations to integrate care for dual-eligible individuals and other Medicare–Medicaid coordination initiatives;
3. Other LTSS reform activities, including:
   - Balancing Incentive Program,
   - Medicaid State Plan Amendments,
   - Community First-Choice Option, and
   - Medicaid Health Homes.

(NASUAD, 2018c).

National Quality Forum

The NQF is a nonprofit, membership-based organization working to catalyze improvements in health care through:

- Setting quality standards,
- Recommending measures for use in payment and public reporting programs,
- Identification and acceleration of quality improvement priorities,
- Advancing electronic measurement, and
- Providing information and tools to help health care decision makers.

(NQF, 2018)

The NQF recommends standardized measures to evaluate quality of care for the more than 74 million adults and children enrolled in Medicaid and CHIP. A significant contribution is the NQF's involvement in the Measure Applications Partnership. This is a stakeholder partnership providing guidance to the U.S. Department of Health and Human Services regarding performance measure selection for federal health programs (NQF, 2018).

Institute for Healthcare Improvement

The IHI is an independent nonprofit organization that is a leading innovator and major driver of health care improvement. The IHI was officially founded in 1991, but our work began in the late 1980s as part of the National Demonstration Project on Quality Improvement in Health Care, led by Dr. Don Berwick. Presently, the IHI is focused in five key areas (IHI, 2018):

- Improvement capability;
- Person- and family-centered care;
- Patient safety;
- Quality, cost, and value; and
- Triple Aim for populations.

One IHI initiative is The Playbook. The Playbook is developed by the IHI and is the result of collaborative efforts of six major organizations: The SCAN Foundation, The Commonwealth Fund, The John A. Hartford Foundation, Milbank Memorial Fund, Peterson Center on Healthcare, and the Robert Wood Johnson Foundation, in conjunction with the IHI (Bettercareplaybook.org, 2018). It provides users with the best available knowledge about promising approaches to improve care for people with complex needs and encourages users to test best practices in their own care settings. This is a great resource for all settings across the care continuum.

The SCAN Foundation

The SCAN Foundation is an independent public charity devoted to transforming care for older adults in ways that preserve dignity and encourage independence (The SCAN Foundation, 2018). The Foundation supports the creation of a more coordinated and easily navigated system of high-quality services for older adults that preserve dignity and independence by funding projects that they consider to be bold, catalytic, and impact-oriented (The SCAN Foundation, 2018). The foundation collaborates with numerous organizations, funding research and programs in support of efficient, high-quality elder care, and publishes informative reports and issue briefs on a variety of topics pertaining to older adult health care.

Outcomes

With all eyes on LTSS, being able to demonstrate meaningful outcomes and cost savings carries significant weight as to continued and future funding and benefits development. Because LTSS cover a great variety of client types, studies are particular to populations. Table 2 includes sampling of study and review findings.

Promising Practices

Promising practices are programs and/or initiatives demonstrating positive outcomes and impact based on pilot projects, demonstration programs, and quality

(Best practices) can be difficult to identify. The competitive nature of business lends itself to secrecy. If an organization has discovered ways in which to bring efficiency to its case management processes that drive better value and outcomes, it is unlikely to be published for widespread knowledge.

TABLE 2
LTSS Study and Review Findings

Title	Objective	Findings
Health Care Expenditures After Initiating Long-Term Services and Supports in the Community Versus in a Nursing Facility (Newcomer et al., 2016)	Compare health care expenditures among users of Medicaid HCBS versus those using extended nursing facility care.	Those initiating extended nursing facility care had, on average, $2,919 higher adjusted total health care expenditures per month compared with those who initiated HCBS. The difference was primarily attributable to spending on LTSS $2,855. On average, the monthly LTSS expenditures were higher for Medicare $1,501 and for Medicaid $1,344 when LTSS were provided in a nursing facility rather than in the community.
The Effects of State-Level Expenditures for Home- and Community-Based Services on the Risk of Becoming a Long-Stay Nursing Home Resident After Hip Fracture (Blackburn, Locher, Morrisey, Becker, & Kilgore, 2016)	This study measures the effect of spending policies for long-term care services on the risk of becoming a long-stay nursing home resident after a hip fracture.	States vary considerably in HCBS spending, ranging from 17.7% to 83.8 % of the Medicaid LTSS budget in 2009. Hip fractures were observed from claims among 7,778 beneficiaries; 34% were admitted to a nursing home and 25% died within 1 year. HCBS spending was associated with a decreased risk of nursing home residence by 0.17 percentage points ($p = .056$).
Does High Caregiver Stress Predict Nursing Home Entry? (Spillman & Long, 2009)	This study estimates how informal care, paid formal care, and caregiver stress or burden relate to nursing home placement.	Initiatives to reduce caregiver stress hold promise as a strategy to avoid or defer nursing home entry.
Do Noninstitutional Long-Term Care Services Reduce Medicaid Spending? (Kaye, LaPlante, & Harrington, 2009)	An analysis of state spending data from 1995 to 2005 shows that for two distinct population groups receiving long-term care services, spending growth was greater for states offering limited noninstitutional services than for states with large, well-established, noninstitutional programs.	Expansion of HCBS appears to entail a short-term increase in spending, followed by a reduction in institutional spending and long-term cost savings.
Long-Term Care Community Diversion Pilot Project (Department of Elder Affairs, State of Florida, 2011)	The State of Florida Diversion Program represented a managed care HCBS alternative model to traditional fee-for-service HCBS Medicaid programs for frail elderly persons at risk of permanent nursing home placement.	The average annual cost for Medicaid to serve an elderly person in a Florida nursing home in fiscal year 2011–2012 was around $61,000 per person. This compares with a cost of $17,000 for alternative diversion services.

Note. HCBS = home- and community-based settings; LTSS = Long-Term Services and Supports.

improvement initiatives. The LTSS Scorecard includes papers on these programs on its website. Figure 5 highlights information about four of these initiatives.

Best Practices

Best practices are processes that produce optimal results as demonstrated in research and by experience. They are frequently proposed as a model suitable for widespread adoption (Merriam-Webster.com, n.d.). For example, an LTSS agency striving for accreditation dedicates itself to learning, establishing, and adopting best practices in order to demonstrate a consistent approach to delivering quality care.

Best practices are sometimes difficult to practice. First, they can be difficult to identify. The competitive nature of business lends itself to secrecy. If an organization has discovered ways in which to bring efficiency to its case management processes that drive better value and outcomes, it is unlikely to be published for widespread knowledge. Second, health care companies are like (or like to think of themselves) as snowflakes. As a result, it is uncommon that an intact best practice in one setting is fully transferrable to another. Failing to understand the difference between Settings A and B but attempting to implement a best practice without significant customization can be a lesson in futility. It requires understanding both

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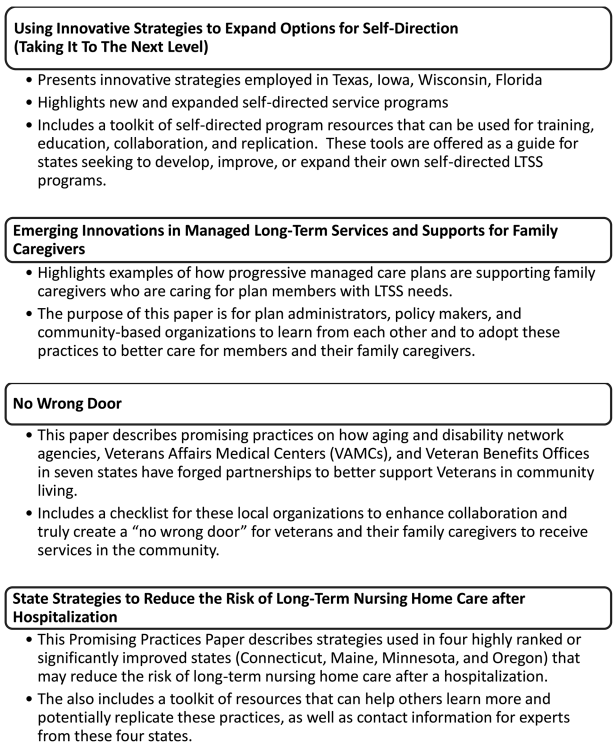

FIGURE 5
LTSS promising practices (Long-Term Services and Supports State Scorecard, 2018c). LTSS = Long-Term Services and Supports.

organizations' similarities and differences, as well as learning about the process and the principles behind it to determine whether there is going to be a fit (Ashkenas, 2010). Finally, the use of a borrowed process, without full leadership support and long-term commitment, allows for the probability that the effort will fail to yield desired results (Ashkenas, 2010).

The LTSS environment appears somewhat different because there are more readily available best practices shared by a number of stakeholders, particularly the IMI. That said, the issue of organizational heterogeneity (perceived or real) and leadership commitment remain hurdles. These factors require leadership capable of committing the proper resources for as long as needed and lending full support to process improvement initiatives.

In small community agencies, resources are always a challenge. Human bandwidth is only so wide. Undertaking a major quality initiative in a company where experience, technology, and staffing are limited may prove too heavy a lift for smaller agencies in the absence of hiring knowledgeable leaders and managers with experience in change management.

The Best Practices Compendium

Under the auspices of the IMI, an annual Best Practices Compendium devotes a significant section to health plan LTSS innovative practices. The report is culled from submissions of what particular plans consider to be their best practices (IMI, 2018c). Programs are categorized into similar domains for the purpose of apples-to-apples comparison. Submissions undergo rigorous review by a panel of independent, national experts. There is a defined scoring process, and the highest ranking initiatives appear in the annual compendium (IMI, 2018c).

Two LTSS-related programs selected as 2017 best practices are United Healthcare Community Plan of Kansas' Community Transitions for the MLTSS Population and Aetna Better Health of Michigan's Dual-Eligible Transition-of-Care Program. Both are presented in Table 3 along with program outcomes.

Case Management Practice Implications

The implications for case managers working in, or collaborating with, the LTSS population are in keeping with those of any other setting. The Case Management Society of America's (CMSA's) Standards of Practice (for general case managers) and the Commission for Case Manager Certification's (CCMC's) Code of Professional Conduct (for CCMC board-certified case managers) guide professional conduct, responsibilities, and expectations regardless of the practice setting.

Table 4 provides a sampling of CMSA practice standards as well as queries and/or concerns worth examination by all professional case managers. Although each consideration may not be fully applicable in all care settings, the conceptual basis for them should be considered in the context of your practice setting. This should not be considered an all-inclusive list; thoughtful examination of case management implications should always be undertaken at both individual and organizational levels.

Board-certified case managers must take the CCMC Code of Professional Conduct into consideration as an additional layer of practice guidance. The Code guides professional conduct, responsibilities, and expectations regardless of practice setting for board-certified case managers. The objective of the Code is to protect the public interest (CCMC, 2015). A sample of the principles guiding board-certified case management practice and discussion points is given in Table 5.

Summary

The LTSS payer landscape is expanding. This has a significant impact on practicing case managers across the continuum of care. To safely transition and maintain people with complex health conditions in HCBS, it requires the support and coordination of a knowledgeable care team. Maintaining care continuity for individuals receiving LTSS is essential to the promise that HCBS hold. This article discussed

TABLE 3
Institute for Medicaid Innovation LTSS Best Practices in 2017

Category	Outcome(s)
Community Transitions for the MLTSS Population In 2015, the program supported 346 members returning to the community, 238 members in 2016, and 20 members in the first 3 months of 2017. The quality-of-life survey was implemented by UHC to measure the effects of this initiative before and after transition (Institute for Medicaid Innovation, 2018d).	Patient and Family Outcomes • In 2015, 3.8% indicated feeling unsafe in their living situation. In 2016, no respondents indicated that they felt unsafe. • Gains in measures of autonomy and independence include an increase in 42% for eating when respondents wanted, an increase of 34% in eating what they wanted, and increases in their ability to watch TV (22%) and use the telephone (23%). • A reduction in the percentage of respondents who indicated that they go without taking their medicine when they need it (from 12.3% to 2.2%). • In 2016, nearly 90% of respondents indicated that they were happy with how they can move about in their community and home, up from 56.6% the previous year. (Institute for Medicaid Innovation, 2018d) Cost Savings • On average, the savings associated with serving someone in the community versus in a nursing facility is approximately $2,000 per member per month. (Institute for Medicaid Innovation, 2018d)
Dual-Eligible Transition of Care Program *A Multistakeholder Collaborative Approach* In January 2016, Aetna Better Health of Michigan and the Aetna Medicaid population health team launched a pilot program with LCN. The focus of the program was to reduce ED utilization, improve access and engagement with medical homes, examine strategies to improve care management engagement, and integrate behavioral health care (Institute for Medicaid Innovation, 2018e). All members assigned to primary care providers at LCN are enrolled in MI Health Link, Michigan's dual-eligible demonstration program (Institute for Medicaid Innovation, 2018e). Note: Some of these program outcomes were not shared in a quantified manner.	Patient/Family Outcomes • Duplicative interactions on the part of the care management team were eliminated and the patient experience improved dramatically. • Patients have been more likely to attend appointments and adhere to treatment recommendations. (Institute for Medicaid Innovation, 2018e) Clinician Outcomes • The continued decline in ED utilization results from the effort to open communication among stakeholders. • Clinics with on-staff care managers saw a decrease in ED use. (Institute for Medicaid Innovation, 2018e) Community Impact • No specific outcomes included in report. • Community participants observed issues with housing and food stability. Conversations regarding how to include shelters, pantries, and other resources in the program are in process, and these issues are being discussed with government and nonprofit entities. (Institute for Medicaid Innovation, 2018e) Cost Savings • Overall, 9% decrease in ED use; one clinic had a 21% drop in ED visits. • The number of high-risk patients at Lakeland with Aetna coverage who are dually eligible increased by >55% since June 2016. • Despite the increase, per member per month medical costs have remained nearly stable for the past year. (Institute for Medicaid Innovation, 2018e)

Note. ED = emergency department; LCN = Lakeland Care Network; LTSS = Long-Term Services and Supports; MLTSS = Managed Long-Term Services and Supports; UHC = universal health coverage.

overarching influences on LTSS including accreditation, quality initiatives, measurement, and outcomes, as well as standard-specific case management practice implications.

As MA plans begin offering nonmedical HCBS benefits as early as 2019, case managers in the managed care and provider settings will feel the impact of submitting and adjudicating requests HCBS authorizations. Hospital-based care coordinators already work with waiver program recipients. The challenge is to actively engage LTSS providers at the time of admission and throughout the transition process. Organizations must be proactive in outreach and collaboration with LTSS providers. The challenge is to improve care transitions both into and out of acute care and other inpatient facilities. The same applies to all other inpatient facilities (e.g., post-acute care, rehabilitation).

Professional case managers must familiarize themselves with the flourishing LTSS care setting. Understanding the population demographics, terminology, available programs (and qualification

Professional case managers must familiarize themselves with the flourishing LTSS care setting. Understanding the population demographics, terminology, available programs (and qualification criteria), and established LTSS operational processes and workflows equip case managers with the ability to proactively advocate for their clients.

TABLE 4
Overview of Practice Standard Considerations in the LTSS Population

Title	Standard	Considerations
Client Selection Process for Professional Case Management Services	The professional case manager should screen clients referred for case management services to identify those who are appropriate for and most likely to benefit from case management services available within a particular practice setting (Case Management Society of America, 2016).	• In waiver programs, are participants consistently identified and selected? • What is the screening process used to identify and select potential participants? • If waiver program criteria exclude a person, are there alternatives that may provide similar support(s)? • In your organization, is there a clearly documented policy regarding referral of waiver program participants from utilization management/episodic care coordination to complex case management?
Client Assessment	The professional case manager should complete a thorough individualized client-centered assessment that takes into account the unique cultural and linguistic needs of that client including the client's family or family caregiver as appropriate (Case Management Society of America, 2016).	• There are a variety of assessments depending on waiver program. • What are the qualifications of the person conducting the LTSS assessment? • Are additional questions needed to supplement a waiver program assessment? • For organizations seeking accreditation/distinction, is the waiver program assessment consistent with accreditation program standards and elements?
Care Needs and Opportunities Identification	The professional case manager should identify the client's care needs or opportunities that would benefit from case management interventions (Case Management Society of America, 2016).	• LTSS recipients may have intellectual disabilities that limit their ability to communicate preferences and needs. Is there a clearly documented process addressing how to demonstrate client and/or family caregiver agreement with care needs and opportunities? • How are needs and opportunities communicated to the client and/or the family caregiver? • How are needs and opportunities communicated to other case managers across the care continuum?
Outcomes	The professional case manager, through a thorough individualized client-centered assessment, should maximize the client's health, wellness, safety, physical functioning, adaptation, health knowledge, coping with chronic illness, engagement, and self-management abilities (Case Management Society of America, 2016).	• How do case management interventions align with desired case management plan of care outcomes? • Is a waiver program assessment sufficiently comprehensive to create an outcome-driven case management plan of care? If not, what is the process for addressing assessment gaps? • Are case management plan-of-care outcomes aligned with desired program outcomes, national performance measures, and accreditation expectations?
Facilitation, Coordination, and Collaboration	The professional case manager should facilitate coordination, communication, and collaboration with the client, the client's family or family caregiver, involved members of the interprofessional health care team, and other stakeholders in order to achieve target goals and maximize positive client care outcomes (Case Management Society of America, 2016).	• Does your organization actively collaborate with LTSS agencies in transitions of care? • Do you notify LTSS agencies of the ED visit or admission and/or impending transition of one of their clients? • In your organization, is there a clearly documented policy regarding care transitions with LTSS providers? • Do you establish and sustain proactive, professional relationships with LTSS stakeholders to maximize outcomes and enhance each client's safe and efficient care experience? • Do you leverage problem-solving skills and techniques to reconcile differing practices and perspectives of LTSS agencies?

(*continues*)

TABLE 4
Overview of Practice Standard Considerations in the LTSS Population (*Continued*)

Title	Standard	Considerations
Qualifications for Professional Case Managers	The professional case manager should maintain competence in her/his area(s) of practice by having one of the following: • 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. OR • In the case of an individual who practices in a state that does not require licensure or certification, the individual must have a baccalaureate or graduate degree in social work 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 (Case Management Society of America, 2016).	• In the Medicaid world, the "case manager" job title does not consistently align with how the term is defined by professional, certification, and accreditation organizations. Special attention should be given to understanding the educational background and credential(s) of LTSS workers identifying themselves as case managers. • In your organization, is there a clearly documented policy regarding case manager qualifications? • Do your organization's staff credentials requirements meet or exceed standard of practice, certification, and/or accreditation standards?
Advocacy	The professional case manager should advocate for the client, client's family, or family caregiver at the service delivery, benefits administration, and policy-making levels. The case manager is uniquely positioned as an expert in care coordination and advocacy for health policy change to improve access to quality, safe, and cost-effective services (Case Management Society of America, 2016).	• In your organization, is there a clearly documented policy regarding the promotion of the client's self-determination, informed and shared decision-making, autonomy, growth, and self-advocacy? • Does the policy address the options when working with an individual with intellectual disabilities? • In appropriate circumstances, does your organization seek to qualify an individual for Medicaid? Once qualified for Medicaid, how is case management responsibility transition between organizations? Is this process clearly documented? • In a situation where a client qualifies for more than one waiver program, how does a case manager facilitate client access to the program and its services?
Cultural Competency	The professional case manager should maintain awareness of and be responsive to cultural and linguistic diversity of the demographics of her/his work setting and to the specific client and/or caregiver needs (Case Management Society of America, 2016).	• Does your organization maintain a cultural competence and/or sensitivity training program? If not, how are professional case managers expected to maintain cultural fluency? • Have you received training in communication techniques in order to be an efficient, effective, respectful, and sensitive communicator? • Do you pursue professional education to maintain and advance your level of cultural competence and effectiveness while working with diverse client populations?
Professional Responsibilities and Scholarship	The professional case manager should engage in scholarly activities and maintain familiarity with current knowledge, competencies, case management-related research, and evidence-supported care innovations. The professional case manager should also identify best practices in case management and health care service delivery and apply such in transforming practice, as appropriate (Case Management Society of America, 2016).	• In anticipation of more LTSS-eligible clients, how will you propose the use of current and relevant research findings into practice at your organization? • As MCOs take on more managed LTSS business, will you propose or seek out participation in possible research activities that support quantification and definition of valid and reliable outcomes? • Will you advocate for publication of your organization's experience and findings in working with the LTSS population?

Note. ED = emergency department; LTSS = Long-Term Services and Supports; MCO = managed care organization.

TABLE 5
Commission for Case Manager Certification's Code of Professional Conduct, Principles of Board-Certified Case Managers, 2015

Principle	Discussion Points
Principle 1: Board-certified case managers (CCMs) will place the public interest above their own at all times (CCMC, 2015)	• Case management is a means for improving client health, well-being, and autonomy. • Does your organization support client self-determination, informed and shared decision-making, autonomy, growth, and self-advocacy in policy and process documentation?
Principle 2: Board-certified case managers (CCMs) will respect the rights and inherent dignity of all of their clients (CCMC, 2015)	• Are you prepared to work with clients of different means (e.g., financial, living situation, intellectual, physical ability) supporting individual dignity, worth, and rights that may differ from your own? • Is your practice guided by the ethical principles of autonomy, beneficence, nonmaleficence, justice, and fidelity?
Principle 4: Board-certified case managers (CCMs) will act with integrity and fidelity with clients and others (CCMC, 2015)	• Do you embrace the underlying premise of case management, "when the individual(s) reaches the optimum level of wellness and functional capability, everyone benefits," without defining "optimal" by your own expectations?
Principle 5: Board-certified case managers (CCMs) will maintain their competency at a level that ensures their clients will receive the highest quality of service (CCMC, 2015)	• Are you committed to professional case management practice and to striving for quality outcomes, appropriate use of resources, and the empowerment of clients in a manner that is supportive and objective? • Do you continually seek educational opportunities, professional development, and work experiences that maintain your level of competence?

BOX 1
Case Study—Mrs. Margaret Alden

Margaret Alden was a genteel 82-year-old woman residing alone in a two-bedroom, single-family home in a midsize suburban setting. Margaret was a stay-at-home mother for most of her young adult life. Her husband, Roger, was 95 years old and lived in a nearby long-term care facility for the past 5 years with advanced Alzheimer's disease. Having homesteaded their home, Margaret planned to remain there as long as she was able. Unfortunately, they did have to spend down their unprotected assets in order for Roger to qualify for Medicaid. Margaret lives on a fixed income with Medicare–Medicaid for health insurance.

Margaret and Roger had 4 adult children. Mary was the oldest child and lived about 2 miles away. She was a divorced, full-time employed mother of two young adults; currently, both were away at college. She stopped in to see her mother at least once each day. Although not as close by, Margaret's other children visit throughout the year. Each contributed financially to home maintenance projects. If her sons were visiting, they would take care of most of the projects themselves. Margaret's fourth child was the wife of a career Air Force officer and currently lived in Germany. She visited once every 12–18 months and kept in touch with her siblings and mother using Skype.

Margaret's medical history included diabetes (controlled with oral agents), rheumatoid arthritis (treated with hydroxychloroquine and methotrexate), and chronic anemia (treated with iron). She was diagnosed with bladder cancer in her mid-50s, undergoing fulguration procedure. Subsequent monitoring showed no recurrence. Margaret underwent a right knee replacement in her early 70s due to degenerative arthritis. Prior to that surgery, Margaret was very active, walking a mile each day. Her postoperative period was complicated by a deep vein thrombosis. Recovering from the surgery required admission to a skilled nursing facility for treatment and therapies before returning to her home with long-term support services.

Three weeks ago, Margaret fell at home, suffering a right hip fracture. She underwent a hip replacement procedure. During the procedure, she received 3 units of packed red blood cells. Her postoperative blood work had been stable. Margaret had an uneventful recovery and was transferred to a skilled facility for continued recovery and therapies. She was able to tolerate 2 hr of therapy a day. Her pain was controlled with acetaminophen. The wound was a bit reddened but otherwise intact. Vital signs and recent laboratory work were unremarkable, and she had been afebrile. It was anticipated that Margaret would return home in the near future.

One afternoon while Mary was visiting, a case manager came to her room to begin talking about transition planning for the next phase of her recovery. Based on the information presented in this scenario, consider the following:

- What are Margaret's most pressing care opportunities?
- How would you prioritize Margaret's care opportunities?
- Would Margaret benefit from long-term services and supports? If so, which ones?
- In your opinion, what are the next steps to working with Margaret?

criteria), and established LTSS operational processes and workflows equip case managers with the ability to proactively advocate for their clients. Case managers should take advantage of educational opportunities pertaining to the LTSS practice setting. The opportunity to meet and interact with LTSS providers not only enhances one's knowledge of this sector but may also pique your interest in making a career change to this dynamic and rewarding care setting (see Box 1).

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