CE 1.5 ANCC Contact Hours

Professional Case Management
Vol. 24, No. 1, 4-16

Long-Term Services and Supports

A Primer for Case Managers: Part 1

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ABSTRACT

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

One example of a newly-enhanced MA member benefit is a program offered by Landmark Health as part of Massachusetts' Blue Cross Blue Shield MA plans. Landmark Health provides home-based medical care to individuals with multiple chronic conditions. Their care team is available 24/7, providing chronic care management and urgent care visits in the comfort a patient's home. The providers are supported by an interdisciplinary team including nurse care managers, behavioral health providers, and social workers, which allows them to integrate medical, behavioral, social, and palliative care for patients (Blue Cross Blue Shield of Massachusetts, 2017).

In order 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. This two-part article provides an overview of LTSS, its current demographic mix and health care footprint, the regulatory and accreditation landscape, and quality measurement and outcomes from the case management perspective. Maintaining care continuity for individuals receiving LTSS is essential to attain the promise that HCBS holds.

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The author reports no conflict of interest.

DOI: 10.1097/NCM.0000000000000331

Introduction

In 2012, the American Association of Retired People (AARP) Public Policy Institute and the United Hospital Fund (UHF) undertook the first nationally representative population-based online survey of family caregivers to determine what medical and/or nursing tasks they perform (Reinhard, Levine, & Samis, 2012). The survey findings challenged common perceptions about family caregiving.

Family caregivers traditionally assist their loved ones with activities of daily living (e.g., bathing, dressing, and eating) and instrumental activities of daily living (e.g., shopping and financial management). These remain critically important supports to maintaining an individual's independence in the community. However, family caregiver roles have evolved. An increasing list of health care tasks, which once would have required an inpatient admission, have landed in the laps of the family caregivers (Reinhard et al., 2012).

LTSS is a critical link to safe home and community care transitions but representation on the patient care team is not routinely present, specifically as pertains to care transitions. LTSS providers are not always informed when someone in their care is sent to the emergency department or admitted to an acute care facility. Connecting with LTSS providers during care transition is left for the family caregiver. Professional case managers must anticipate and embrace interaction with LTSS providers in order to facilitate safe and efficient client care across the continuum.

Definition

LTSS encompasses a wide range of paid and unpaid medical and personal care assistance. This support is essential, especially for frail elders and disabled persons who are faced with ongoing challenges and increasingly difficult self-care tasks. The cause of self-care difficulties includes age, chronic illness, and/or disability (e.g., physical, cognitive) (Reaves & Musumeci, 2015).

LTSS agencies support clients to perform activities of daily living (ADL) and instrumental activities of daily living (IADL). The scope of LTSS service includes, but is not limited to, nursing facility care, adult daycare programs, home health aide services, personal care services, transportation, and supported employment as well as the support and assistance provided by a family caregiver (Reinhard et al., 2012; Reaves & Musumeci, 2015). The engagement of services may be for a period of weeks, months, or even years.

Family caregiver roles have evolved. An increasing list of health care tasks, which once would have required an inpatient admission, have landed in the laps of the family caregivers.

According to the AARP/UHF survey, almost half of the family caregivers perform activities they referred to as medical or nursing tasks (Reinhard et al., 2012). Forty-six percent (777 of the 1,677) family caregivers report tasks as frequently occurring as shown in Figure 1.

Service delivery models and programs vary; however, LTSS generally includes the following services (Reaves & Musumeci, 2015):

- Assistance with ADL and IADL
- Nursing facility care
- Adult daycare programs
- Home health aide services
- Meals and housekeeping
- Personal care services
- Transportation
- Supported employment
- Care planning and care coordination

Client Demographics and Settings

In the general population, there are millions of people in need of LTSS. The major groups of individuals

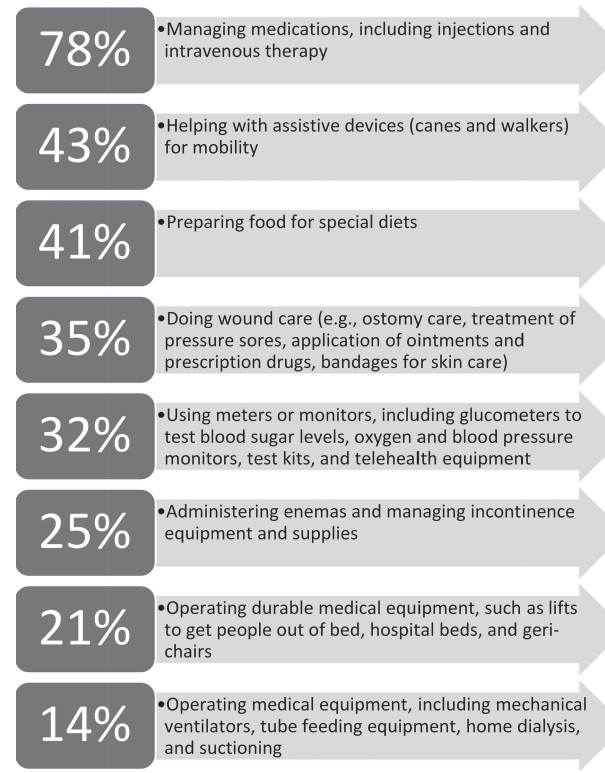

FIGURE 1
Task frequency for family caregivers. Adapted from Reinhard et al. (2012).

break down as follows (Reaves & Musumeci, 2015; Reinhard et al., 2012):

- elderly and nonelderly
- people with intellectual and developmental disabilities,
- people with physical disabilities, and
- people with behavioral health diagnoses (e.g., dementia, spinal cord, traumatic brain injuries, and/or disabling chronic conditions).

Almost seven out of ten dual-eligible beneficiaries have a higher need for LTSS than low-income seniors who do not have Medicaid. The need is higher than among high- or low-income seniors without Medicaid (52% and 36%, respectively) (Garfield, Young, Musumeci, Reaves, & Kasper, 2015). In addition to health and disability status, the person's age, gender, socioeconomic status, living arrangement, and access to information about care options influence the types, amounts, and duration of LTSS utilized (Reaves & Musumeci, 2015; Reinhard et al., 2012).

Between 2012 and 2050, the population aged 65 years and older is anticipated to more than double. This is a rate of more than five times that of the population age range between 50 and 64 years (AARP, 2012).

Let us humanize these rather dry statistics with the story of Mr Marvin Thomas (see Boxes 1–3). Segments of Mr Thomas' story are interspersed throughout this article. Box 4 includes questions intended to activate your critical thinking competency.

Box 1
Introduction to Mr Marvin Thomas

Marvin Thomas is an 82-year-old gentleman residing in major metropolitan area. After working nearly 50 years at an electrical plant, he retired. His wife, Mabel, passed away 5 years ago at the age of 70. Marvin's only child, a son named Mikel, was killed by a stray bullet when rival street gang violence broke out at a Caribbean Festival 15 years ago. Aside from a neighbor across the hall and a couple of friends he knows from his church, Marvin has no obvious support system. He has a pension and a small savings account. He rents his apartment in a low-/moderate-income housing development and lives on the ground floor.

His medical history is extensive and includes diabetes, chronic bronchitis, and peripheral vascular disease. He was diagnosed with colon cancer in his early 50s, undergoing a bowel resection and chemotherapy. He has been cancer-free for 30 years. Lastly, Marvin underwent bilateral total hip replacements over 10 years ago due to degenerative arthritis. His health care is covered by managed Medicaid and Medicare, making him a dual-eligible recipient.

Marvin is stubbornly independent, refusing all in-home assistance until 5 years ago after Mabel passed. As the heart of the family, Mabel took care of cooking, laundry, and cleaning. Marvin and Mabel managed their finances and paid bills. Working as a team, they actively managed their home, errands, getting to health care appointments using public transportation, going to church, and completing activities and instrumental activities of daily living. After Mabel passed away, it became more and more difficult for Marvin to keep up with things. Between his social isolation and loss of his wife, Marvin slipped into depression.

Box 2
Mr Marvin Thomas and the Nurse Practitioner

During a wellness home visit (by his health plan), the nurse practitioner (NP) asked about how he managed to keep track of all the medications he was prescribed. Marvin described how he lined up the medication bottles each day and followed the directions. He showed the NP a list of instructions, mentioning that his wife wrote it up before she got really sick. His voice cracked a bit and it was then that Marvin confessed he had run out of two medications a couple of days ago because his neighbor was sick and unable to get to the pharmacy for him. He continued on that because he felt a little light-headed and unsteady on his feet from time to time, he did not feel comfortable taking the walk to the pharmacy by himself. The NP checked Marvin's vital signs, sitting, and standing. There was no postural change in his vitals. He stated he had not felt dizzy in a couple of weeks.

The NP thanked Marvin for being honest with him and empathized that it must be harder to do most everything since his wife's passing. Marvin nodded silently. Then the NP asked if they could talk over a few ideas that could help him stay at home safely. Marvin looked surprised saying "I thought you were going to send me off to a nursing home" to which the NP replied, "Not if you let me help you." Marvin was all ears. He called the local pharmacy to inquire about having Marvin's medication delivered. By chance, they were able to bring his medication refills within 15 min. The NP supervised Marvin taking those medications and quickly checked the supply of his other medications. Because this visit was intended to be a brief wellness check, the NP scheduled a longer appointment for the following day. This would give him time to review programs which Marvin might qualify for and gather information.

Box 3
Mr Marvin Thomas—the Next Day

Upon his return the following day, the NP checked Marvin's vital signs and no postural change in pressure or pulse was noted. Marvin's lung sounds were notable for mild rhonchi (unchanged since the previous day), which was his baseline according to previous documentation. His last primary care appointment was about a year ago. He had not seen the diabetes or breathing doctors "in a while." When asked, Marvin admitted to getting short of breath when he tried to do too much outside of his unit. He mentioned that the laundry room was at the far end of the hall. Carrying the bag of dirty laundry and detergent was getting harder in the hot weather. He had to sit down and rest before loading the washer.

He had no signs of edema in either foot. Skin was dry but intact and sensation was good in both feet. The NP mentioned to Marvin that he should consider wearing shoes or structured, soled slippers even when in the house to protect his feet. Heart sounds were within normal. His glucometer reading was 188, a bit high according to Marvin. When the NP inquired how often he checked his blood sugar, Marvin replied "maybe once or twice a week, depending on what I'm eating." The NP asked if it was alright to send off some blood word at no expense to him, "It is included in this home visit program." Marvin consents and the task completed.

The NP asked if he could look at the food in his cabinet and fridge. There were no expired foods, but there were no fresh fruit or vegetables and most of the food was canned or frozen. He noted a half package of hot dogs in the meat drawer. A partially eaten piece of chicken was on a plate. The small kitchen was tidy, there were no dirty dishes in the sink, and no food left on the countertop. Returning to the table, the NP asked if Marvin would allow a few visitors to his home over the next couple of weeks. The NP went on to explain that there were programs available that could make it easier for him to stay in his home.

Box 4
Mr Marvin Thomas—Critical Thinking Exercise

Based on the information presented, consider the following:
- What are Marvin's most pressing care opportunities?
- How did the NP personalize his interaction to obtain the optimal collaboration with Marvin?
- What Long-Term Services and Supports would benefit Marvin?
- How would you prioritize Marvin's care opportunities?
- In your opinion, what are the next steps to working with Marvin?

Eligibility and Scope of Services

The primary payor of LTSS is Medicaid. As a result, there is significant variation from state to state regarding available programs and service scope. State Medicaid plans, or state plan amendments, usually spell out the types of services that its Medicaid covers. LTSS is often covered under what is referred to as a Waiver. A Waiver program allows a state to waive certain Medicaid program requirements and permits needed services to people who may not otherwise be eligible for them (CMS, 2018a). Waiver programs must be approved at the federal level. States apply for each waiver program it intends to offer.

In most instances, individuals must meet financial as well as functional/clinical level of care criteria defined by each state. For the purpose of an example, the State of Rhode Island recognizes eligibility as (Executive Office of Health and Human Services, n.d.):

- Individuals must meet both the financial and functional/clinical "level of care" need to qualify for Medicaid Long-Term Care.
- In addition, a person's resources (cash, savings, etc.) must be less than $4,000. Please note: if a person's monthly income is over a certain amount, he/she may have pay toward the cost of his/her LTSS services.

Understanding the requirements for LTSS within one's practice domain is essential. Case managers are strongly encouraged to explore their own jurisdictions' programs. These resources are routinely located within a Health and Human Services department website.

Continuing with the Rhode Island example, services are divided into highest and high Level of care needs. The highest intensity of need qualifies an individual for nursing home care. High level of care qualifies an individual for home and community services, such as included in Figure 2.

Who Pays for LTSS?

Presently, Medicaid pays a major share of LTSS cost. Almost half of the seniors living in a community setting have a need that is classifiable as an LTSS

FIGURE 2
Covered LTSS services. Executive Office of Health and Human Services (n.d.).

(Genworth, 2015; Kaiser Family Foundation, 2015). However, Medicare-insured seniors do not have formal LTSS-specific benefits currently.

LTSS costs often exceed what a patient and a family are able to afford, given other personal and household expenses. In 2015, the median annual cost for nursing facility care was $91,250 and home health care costs were $45,760. Adult day care costs topped out at $17,940. (Garfield et al., 2015; Genworth, 2015; Kaiser Family Foundation, 2015). With $20,090 marking 100% over the Federal Poverty Limit (for a family of three), it is easy to imagine that privately paid LTSS service costs overwhelm an average senior American's budget.

Federal legislative efforts to address LTSS needs floundered. The Community Living Assistance Services and Supports (CLASS) Act was enacted under the Patient Protection and Affordable Care Act (PPACA). Its intent was to offer a national, voluntary LTSS insurance program financed by individual premium contributions (Kaiser Family Foundation, 2015). This legislation was subsequently repealed and replaced by the American Taxpayer Relief Act (ATRA) of 2012, which was a Congressional effort to forestall the "fiscal cliff" crisis (Tax Policy Center, 2016).

A Commission formed in the wake of ATRA issued a report to the Congress (Commission on Long-Term Care, 2013). The report reviewed LTSS policy and program issues and made recommendations regarding service delivery and workforce. There was no agreement as to financing recommendations, instead options were suggested (Kaiser Family Foundation, 2015). Aside from regulatory guidance regarding what is considered home- and community-based care for the purpose of Medicaid payment, no major action on these recommendations was taken.

Medicaid Waiver Programs

States are allowed to develop programs to meet the needs of people who prefer to receive LTSS in their home or community, rather than in an institutional setting. These waivers usually increase the number of people who qualify for a given program. Where LTSS is concerned, by 2009 nearly 1 million individuals were receiving services under HCBS waivers (CMS, 2018a). Waivers are usually referred to by the Federal Register code number in which they are described. The following are examples of LTSS waivers.

1915(c) Waiver (Home and Community-Based Services)

These waivers are entitled Home- and Community-Based Services (HCBS) 1915(c) Waivers. All 1915 Waivers have the following common elements (CMS, 2018a; Medicaid, 2018a):

- are authorized under Section 1915(c) of the Social Security Act,
- are fee-for-service programs, meaning that the provider is paid for each service the patient receives (such as a test or procedure), and
- require individuals to meet criteria that are set by the state and based on a person's level of need.

Virtually all states and Washington, DC, offer 1915(c) Waivers. States may operate as many 1915(c) Waivers as needed; however, each must undergo the aforementioned approval process. Currently, more than 300 HCBS Waiver programs are active nationwide (Medicaid.gov, 2018a). Examples of 1915(c) Waivers are highlighted in Figure 3.

State 1915(c) Waiver programs must (Medicaid.gov, 2018a):

- Demonstrate that providing waiver services will not cost more than providing these services in an institution
- Ensure the protection of people's health and welfare
- Provide adequate and reasonable provider standards to meet the needs of the target population
- Ensure that services follow an individualized and person-centered plan of care

States may also waive certain Medicaid program requirements under 1915(c) Waivers, such as (Medicaid.gov, 2018a):

- Statewideness—this allows states to direct services to those most in need versus forcing the state to cover all Medicaid beneficiaries equally
- Comparability of services—this allows states to restrict waiver services to only those at the highest risk of institutional care
- Income and resource rules—these allow states to provide Medicaid coverage to individuals who may only qualify if institutional care is necessary

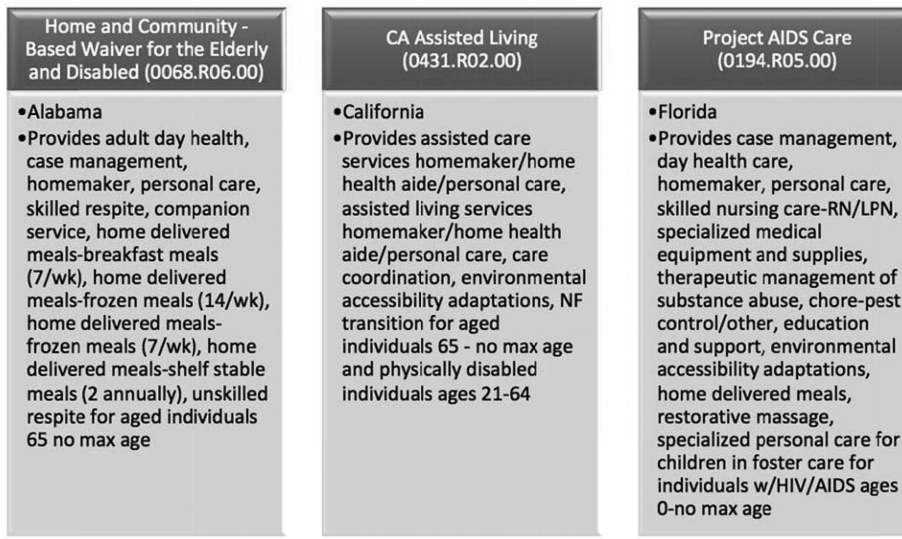

FIGURE 3
Examples of 1915(c) Waiver programs. Medicaid.gov (2018a).

1915(j) Waiver (Self-Directed Personal Assistant Services)

This Waiver focuses on self-directed personal assistance services (PAS). These include personal care and related services provided under the Medicaid State plan and/or 1915(c) Waivers the state already has in place. Participation in 1915(j) is voluntary. Participants set their own provider qualifications and train their PAS providers. In addition, participants determine how much they pay for a service, support, or item (Medicaid.gov, 2018b). Online self-management tools are available.

Under this waiver, states can (Medicaid.gov, 2018b):

- target people already getting section 1915(c) waiver services,
- limit the number of people who will self-direct their PAS, and/or
- limit the self-direction option to certain areas of the state or offer it Statewide.

At the state's option, people enrolled in 1915(j) can (Medicaid.gov, 2018b):

- hire legally liable relatives (such as parents or spouses);
- manage a cash disbursement;
- purchase goods, supports, services, or supplies that increase their independence or substitute for human help (to the extent they would otherwise have to pay for human help); and
- use a discretionary amount of their budget to purchase items not otherwise listed in the budget or reserved for permissible purchases.

The 1915(j) Waiver addresses person-centered and directed planning processes, specified as (Medicaid.gov, 2018b):

- Service plan is based on an assessment of need for PAS.
- Service plan and budget plan are developed using a person-centered and directed process.
- Participants can engage in and direct the process.
- Participants can choose family, friends, and professionals to be involved as needed/wanted.
- Participants' preferences, choices, and abilities, as well as strategies to address these preferences, must be identified in the service plan.
- The plan must include an assessment of contingencies that pose a risk of harm to participants and an individualized backup plan to address those contingencies, as well as a risk management plan that outlines risks participants are willing to assume.

In the Medicaid context, self-directed service means that program participants, or their representatives, have decision-making authority over certain services and take direct responsibility to manage their services with the assistance of available supports (Medicaid.gov, 2018c). This is an alternative to the way services have historically been delivered and managed. Self-direction empowers an individual to take responsibility for managing his or her own health care (Medicaid.gov, 2018c).

Program for All-Inclusive Care for the Elderly

The Program of All-Inclusive Care for the Elderly (PACE) is a type of HCBS that provides medical services and supports everyday living needs for certain elderly individuals, most of whom are dual-eligible for both Medicare and Medicaid. These services are provided by an interdisciplinary team of professionals (e.g., primary care physician, nurse, social worker, physical therapist, dietitian, and pharmacist).

To enroll in a PACE program, an individual must meet the following eligibility requirements listed in the Program Agreement (CMS, 2018b):

1. Be 55 years or older;
2. Be determined by the State Administering Agency to need the level of care required under the State Medicaid plan for coverage of nursing facility services;
3. Reside in the PACE organization's service area;
4. Be able to live in a community setting at the time of enrollment without jeopardizing his/her health or safety based on criteria set forth in the program agreement;
5. Meet any additional program-specific eligibility conditions imposed under its respective PACE Program Agreement.

Eligibility also stipulates that a PACE participant not be concurrently enrolled in any other MA, Medicare Prescription Drug Program, or Medicaid prepayment plan, or optional benefit (e.g., 1915(c) Waiver, Medicare hospice benefit).

Money Follows the Person

The Money Follows the Person (MFP) Rebalancing Demonstration Grant helps States rebalance their Medicaid long-term care systems. Over 75,151 people with chronic conditions and disabilities have transitioned from institutions back into the community through MFP programs, as of December 2016 (Medicaid.gov, 2018d). The PPACA strengthened and expanded the MFP program and opened up so that additional states could apply. This program is designed to give Medicaid beneficiaries in long-term nursing homes and other types of residential facilities more options about where they receive LTSS (Irvin, Denny-Brown, Morris, & Postman, n.d.). There are

currently 43 states and the District of Columbia participating in the demonstration.

Program goals are to (Medicaid.gov, 2018d):

- Increase the use of HCBS and reduce the use of institutionally-based services.
- Eliminate barriers in state law, state Medicaid plans, and state budgets that restrict the use of Medicaid funds to let people get long-term care in the settings of their choice.
- Strengthen the ability of Medicaid programs to provide HCBS to people who choose to transition out of institutions.
- Put procedures in place to provide quality assurance and improvement of HCBS.

Noted in a 2017 report, the MFP rebalancing demonstration program growth continued and saw year-over-year increases in the volume of transitions. States continued increasing expenditure on community-based LTSS (Medicaid.gov, 2017). In 2014, grantee states reported spending $240 million in MFP rebalancing funds; more than double what they spent in 2013, which was $112 million (Medicaid.gov, 2017).

Delivery Models

Far too many Americans are ill-prepared to take on the financial, psychological, environmental, or social implications of long-term disability (Thomas & Applebaum, 2015). The surge of HCBS drives both recognition and expansion of LTSS services across the United States, as does the desire to keep people living in HCBS rather than in institutions. However, service is prone to variation due to the nature of Medicaid as a federal-state endeavor. This section delves into the delivery aspects of LTSS.

Managed Care

It is important to understand how heavily managed Medicaid figures into the LTSS equation.

- In 2012, 16 states operated managed LTSS (MLTSS) programs (Eiken, Sredl, Burwell & Woodward, 2017; Saucier, Kasten, Burwell & Gold, 2012).
- In 2017, that number increased to 24 states, representing a 50% increase (Eiken et al., 2017; Saucier et al., 2012).
- Between 2012 and 2015, Medicaid MLTSS spending more than doubled (Eiken et al., 2017).
- Between 2012 and 2017, the number of MLTSS programs more than doubled from 19 to 41 (Lewis, Eiken, Amos, & Saucier, 2018).
- Between 2012 and 2017, enrollment in Medicaid MLTSS more than doubled, from 800,000 to 1.8 million (Lewis et al., 2018).

Managed Medicaid LTSS program goals focus on five themes, listed in order of frequency percentage in Figure 4.

MLTSS came about because states adopted more MCOs into their respective LTSS designs. The desired outcome is to improve quality and efficiency of services as well as to control cost (Migneault, 2017). In a report issued by Anthem's Public Policy Institute, "MCOs are valuable partners to states as they seek to improve the delivery of services for populations in need of LTSS. MCOs are well-positioned to address the challenges and barriers to LTSS that many Medicaid beneficiaries encounter in the fee-for-service (FFS) system" (Anthem Public Policy Institute, 2017).

States make capitated arrangements with managed care organizations (MCOs) that in turn provide service and support to beneficiaries. Delivery models vary. There are comprehensive programs that include most, or all, Medicaid services as well as fully integrated programs (Lewis et al., 2018).

Qualification for MLTSS program(s) requires an individual to undergo a functional assessment. There is significant variation as to the assessment tool used, the depth of assessment, and who is allowed to conduct the assessment (Lewis et al., 2018).

Benefits vary. Only three MLTSS programs covered all Medicaid-covered benefits under a managed care capitation rate: Arizona LTSS, Kansas KanCare, and

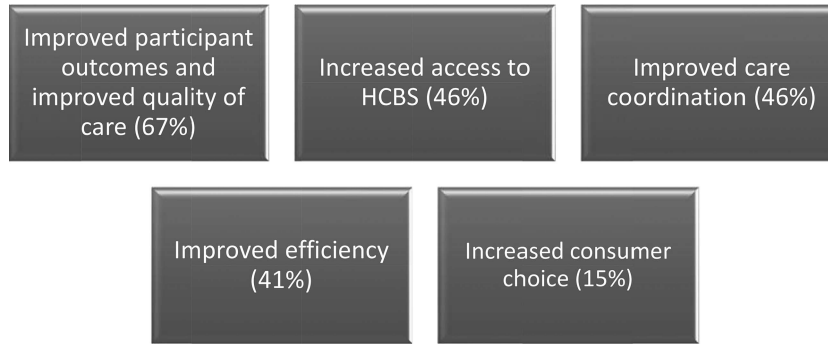

FIGURE 4
LTSS program goals. Adapted from Lewis et al. (2018).

It is important for pediatric case managers to know that there are significantly fewer options for LTSS coverage of children. These programs are developing but at a much slower than programs for adults.

Wisconsin Family Care Partnership (Lewis et al., 2018). Other arrangements use a carve-out method, eliminating one or more benefits from the capitated rate. A common carve-out is intellectual and developmental disabilities institutional care and/or HCBS. Additional carve-out benefits are behavioral health, prescription drugs, and inpatient hospitalization (Lewis et al., 2018). It is important for pediatric case managers to know that there are significantly fewer options for LTSS coverage of children. These programs are developing but at a much slower than programs for adults.

MCOs employ individuals performing care coordination or subcontract care coordination to a community-based organization (Saucier & Burwell, 2015). Usually, a dyad consisting of a registered nurse and a social worker collaborates on care coordination (see Figure 5). This model is sometimes referred to as an in-house model.

As MA plans are poised to incorporate LTSS into its benefit package, case management departments will ultimately experience an influx of nonmedical care coordination requests. This benefit expansion is a game changer for beneficiaries who exist on the precipice of remaining in their homes versus forced institutionalization. However, the rumbling against managed care leverage in the LTSS area is a sore spot for smaller HCBS agencies that have concerns about business viability when they are not part of MCO networks or that are service coordinators that do not actually provide hands-on care.

FIGURE 5
Registered nurse–social worker dyad. Original figure adapted from Saucier and Burwell (2015).

Medicaid's Move to Managed Care

The transition from fee-for-service to managed care has been in Medicaid's sight from many years. It is important to recognize there will be impact related to Medicaid's decision to move from fee-for-service to managed care. The Kaiser Family Foundation and the Health Management Associates conducted a Medicaid survey between June and September 2017. The survey was sent to the Medicaid director in each state. Responses were recorded both in writing and via telephone interviews. All 50 states and District of Columbia completed surveys and participated in telephone interviews.

Findings relating to managed care initiatives included that states are using arrangements with MCOs to focus more attention on social determinants of health and to promote value-based payment. Many states are continuing to advance the expansion of managed Medicaid, payment and delivery system reforms, increase provider payment, and expand LTSS benefits despite an uncertain future relating to the present administration's destabilizing health care activity.

Findings demonstrate:

- states are increasingly requiring MCOs to screen beneficiaries for social needs (19 states in fiscal year [FY] 2017 and 2 additional states in FY 2018);
- to provide care coordination prerelease to incarcerated individuals (six states in FY 2017 and one additional state in FY 2018); and
- to use alternative payment models (APMs) to reimburse providers (13 states in FY 2017 set a target percentage of MCO provider payments that must be in an APM and 9 additional states plan to set targets in FY 2018).

(Gifford et al., 2017)

Figure 6 highlights survey themes.

Case managers should become knowledgeable about these themes and how they impact their service area. Additional discussion of work requirement for coverage, social determinants of health, and workforce shortage follows.

Work Requirements

The State of Kentucky received the first approval for a state waiver, which included a work mandate. In June 2018, a federal judge voided the waiver provision, which forces low-income adults to work in order to qualify for Medicaid (Galewitz, 2018a). This resulted in the State of Kentucky eliminating

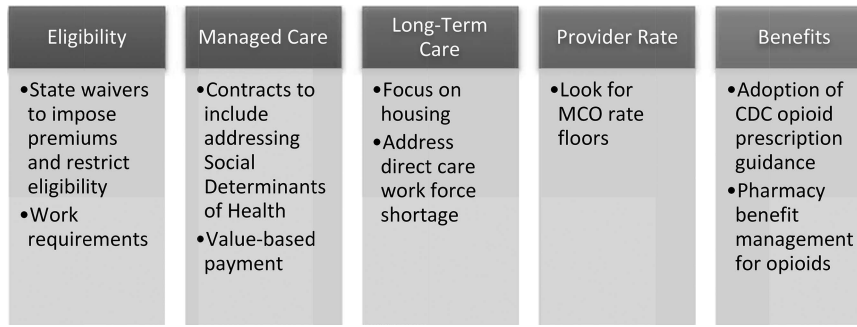

FIGURE 6
Kaiser Family Foundation/Health Management Associates survey themes. Adapted from Gifford et al. (2017).

vision and dental benefits to about 500,000 Medicaid enrollees within 36 hrs of the court's ruling (Galewitz, 2018b). Other states continue to advance the work requirement agenda, but legal action will likely keep some of these initiatives at bay temporarily. The fate of the Kentucky waiver is yet to be determined.

Case managers working with Medicaid enrollees have to monitor benefits and waiver program requirements even more closely as work mandate-related orders and appeals make their way through the courts. At the very least, waiver programs may be delayed in activating however the withdrawal of existing benefits, as seen in the Kentucky case, may have an even more chilling effect on enrollee benefits.

Consider the impact of poor dental hygiene on general health. Mayo Clinic shares that endocarditis, cardiovascular disease, and pregnancy/birth complications contribute to poor oral health. Diabetes, osteoporosis, HIV/AIDS, and Alzheimer may worsen oral health (Mayo Clinic Staff, 2016). The long-term impact of eliminating dental benefits from Medicaid may not be felt immediately but will certainly evidence themselves in the form of higher medical care costs subsequent to the development of serious conditions relating to poor dental hygiene.

Social Determinants of Health

Social determinants of health (SDoHs or SDH) are a long-recognized influence on one's overall health, affecting both physical and psychological domains (Wilkinson & Marmot, 2013).

SDoHs are conditions in which people are born, grow, live, work, and age (World Health Organization, 2017). These conditions are considered to be root causes of health disparities—unfair yet avoidable differences in health care and health status both within and between populations (World Health Organization, 2017).

There is a growing body of evidence supporting the active management of SDoHs, including areas such as employment, social isolation, public health conditions, gender equality, and early childhood development to name just a few. States began leveraging MCO arrangements as a way to focus attention to SDoH, by mandating screening for social needs. In FY 2017, 19 states incorporated this requirement. In FY 2018, two additional states joined.

States use MCO arrangements to increase attention to the SDoH and to promote value-based payment through screen and use APMs. In contrast to Kentucky's approach, more than one in three states have initiatives to expand dental access or improve oral health outcomes (for children and/or adults) as well as to expand the use of telehealth (Gifford et al., 2017). In addition, an emerging Medicaid SDoH-related intervention is to provide prerelease care coordination to incarcerated persons. This is new requirement in seven states (Gifford et al., 2017). Recognition of SDoHs is helping to shape the health benefits provided to millions of Americans.

Workforce Shortage

In conversations with LTSS agencies, one of the biggest challenges is that of worker retention. As more than one person shared, "People come and go; they can make more money working at McDonald's" (personal communication, 2018). In FYs 2017 and 2018, more states made or are planning provider rate increases. Survey responses related to MCO rate setting show that just fewer than half of the MCO states require fee-for-service rate methodology. Twenty-four states reported they had MCO rate floors for some provider types, and five states said they had rate floors for all types of Medicaid providers (Gifford et al., 2017). New methodologies that align with pay-for-performance will appear, as states try to find ways of improving worker pay and subsequently raise retention rates.

Within the current national policy environment, and perhaps in spite of it, states continue efforts to expand use of managed care. Many plan to move ahead with reforms, improve provider payment, enhance benefits, and expand community-based LTSS (Gifford et al., 2017).

Home- and Community-Based Organizations

Home- and community-based organizations serve targeted populations (e.g., intellectual or developmental disabilities, physical disabilities, and mental illness) (Medicaid.gov, 2018e). These agencies provide, as well as coordinate, care and support services. In some instances, responsibility is shared with the MCO where a health plan subcontracts with the agency for service provision and/or care coordination functions. This approach is referred to as a shared model. In other situations, the agency is responsible for case management and service provision functions or simply serves as a coordinator of services.

The CMS collaborates with states, consumers, advocates, and other stakeholders creating a sustainable, person-driven (also referred to as participant-driven) LTSS system. These programs allow people choices, control, and access to a variety of services, which facilitate optimal outcomes (e.g., independence, health, and quality of life) (Medicaid.gov, 2018f). Medicaid cites aims for LTSS, which are shown in Figure 7.

The Delegated Model

In a delegated model, a health plan delegates care coordination functions but retains monitoring and compliance functions (Saucier & Burwell, 2015). This model is implemented through third-party subcontracts. The delegated party is usually a health organization, such as an integrated health system or a large physician practice. People associated with the practice or system are within the delegated population (Saucier & Burwell, 2015). However, the health plan will likely have other members who are not part of the delegated entity, thus maintaining staff to provide care coordination to those individuals. Use of this model is less common. It is undertaken in states with highly evolved managed care arrangements (Saucier & Burwell, 2015).

One example of this model is taking place in Minnesota. Delegation includes working with large residential service providers where primary care and care coordination are available. There are also continuing care options (e.g., independent apartments, assisted living, and nursing facilities) (Minnesota Department of Human Services, 2018). With the introduction of Medicaid Health Homes, some programs include delegation of behavioral health homes. Care coordination takes place at primary medical or behavioral health offices or community mental health centers (Saucier & Burwell, 2015).

As a point of comparison, a private living option is the Erickson Living brand. Erickson offers a community living arrangement on a buy-in basis. Seniors desiring a "worry-free" approach to independent living make a sizable upfront investment and pay a monthly service fee in order to access an Erickson community. Housing options run along the continuum from independent living units to supported units and into continuing care aimed at seniors in need of specialized care or assistance (Erickson Living, 2018a). Brands such as Erickson offer their own health coverage, onsite medical care, 24/7 emergency response teams, an onsite pharmacy, and other health

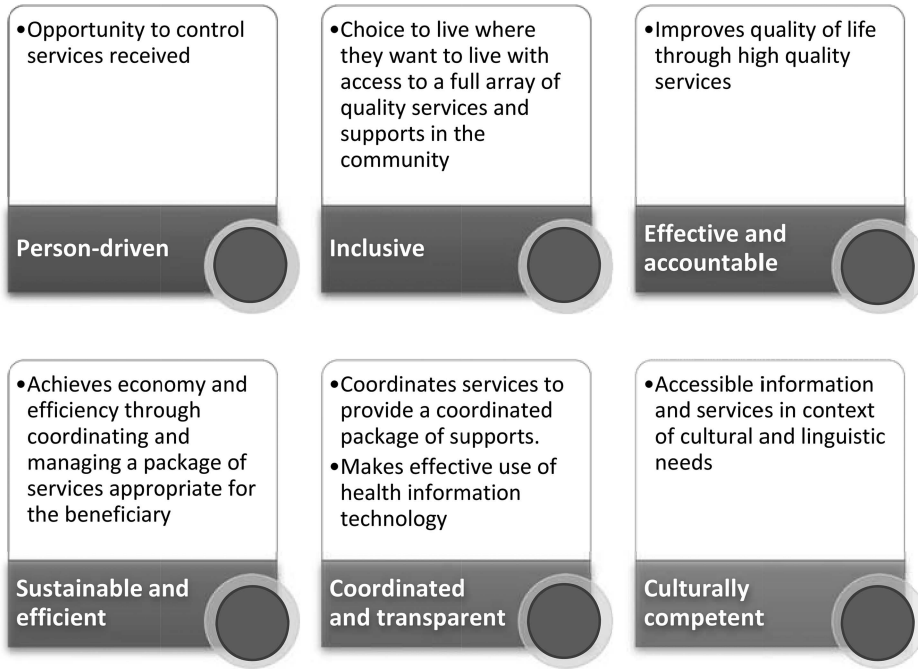

FIGURE 7
Medicaid LTSS aims. Adapted from Medicaid.gov (2018f).

care services. For Medicaid-eligible beneficiaries, an Erickson-like model is unaffordable. The minimum buy-in starts in the low-to-mid $200,000s for a basic, 500-600 ft^2, one-bedroom independent-living apartment. Monthly service package pricing escalates depending upon the size of one's living unit and begins in the low $2,000s (Erickson Living, 2018b). Understanding various living arrangements is of growing importance within case management assessments. Where individuals reside and what types and levels of support are incorporated into these respective community-based arrangements helps shape transition planning.

LTSS providers must be included in transition of care conversations regardless of whether they are the sender or receiver of the client. A major pain point felt by these providers is the lack of communication received when one of their clients goes to the emergency department, is hospitalized and/or discharged. Many LTSS agencies are smaller, community-based providers (e.g., home health agencies, Areas on Aging). They are not part of accountable care organizations or vertically integrated networks. As a result, these agencies were not included in the sweeping information technology improvements associated with the Health Information Technology for Economic and Clinical Health Act, also known as HITECH Act. This makes them more vulnerable to exclusion because they are not part of integrated information systems. The implication for professional case managers is that of asking specific questions regarding services and supports that someone is receiving at home or in the community, then taking the time to actively engage LTSS providers by picking up the phone and speaking to someone at the business office to ascertain more details about the individual and his/her existing services.

For their part, LTSS providers need to be more mindful of at-risk clients who are more likely to transition to an inpatient setting. A transition risk assessment should be part of regular care planning efforts. A simple plan should be put into place, which includes an easy-to-retrieve one-page document communicating the service arrangement and point of contact at the LTSS agency. Family, neighbors, contracted providers, and/or other informal caregivers should be instructed to contact the LTSS agency in the event of an acute episode of care. A brightly colored page or refrigerator magnet with the agency's or case manager's name and phone number should be placed in a conspicuous location. The client should be reminded of the important of agency notification; however, his/her medical condition may be so serious as to negate that as a dependable means of notification. In addition, at-risk clients should be more actively monitored for transition occurrences.

Perhaps the most critical action for the professional case manager is a recurring theme across the care continuum. One must ascertain the credentials of the LTSS staff with whom they are speaking. In the Medicaid population specifically, the case manager job title is used with great variation. Many community case managers are not clinical or licensed workers.

Even if alert instructions are not followed, discovery of a client transition to another facility should be active rather than passive as is currently the case.

Perhaps the most critical action for the professional case manager is a recurring theme across the care continuum. One must ascertain the credentials of the LTSS staff with whom they are speaking. In the Medicaid population specifically, the case manager job title is used with great variation. Many community case managers are not clinical or licensed workers. Although the individual's knowledge and experience are tremendously valuable, conversations with LTSS staff need to be tempered to the education level of the person with whom contact is made. If transition conversations require a clinician-to-clinician conversation, best be absolutely clear who is on the other end of the discussion.

Conclusion

In order 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 holds. This article laid the foundational LTSS overview. Part II expands this discussion to overarching influences on LTSS including accreditation, quality initiatives, measurement, and outcomes, as well as standard-specific case management practice implications.

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DOI: 10.1097/NCM.0000000000000344