CARE MANAGEMENT & QUALITY ASSURANCE
UNDER LONG TERM CARE INSURANCE

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EXECUTIVE SUMMARY

Long-term care insurance has emerged in recent years as a significant component of efforts to finance the care of older adults with disabilities. Yet, little is known regarding how well services provided under long-term care insurance actually meet the needs of elderly policyholders.

This project examined the adequacy of current policies and practices for protecting the rights and meeting the needs of elderly consumers under long-term care insurance policies purchased through the California Partnership for Long Term Care (CPLTC), a public-private partnership between long-term care insurance carriers and Medi-Cal (California’s Medicaid program). In particular, this project: (1) investigated the experiences of consumers in light of existing regulations and standard practices in long-term-care case management, (2) examined the adequacy of existing quality assurance procedures, (3) developed recommended protocols and processes for assuring the quality of services provided under long-term care insurance, and (4) formulated policy recommendations for insurance carriers, care management organizations, regulatory agencies, and consumer groups in order to facilitate implementation of these quality assurance procedures. The project involved a collaboration of the University of California at Berkeley’s Center for the Advanced Study of Aging Services, the California Department of Health Services, and participating insurance carriers and care management provider agencies.

Methods

The research sample consisted of 35 California residents, ages 54 to 86, who had purchased long-term care insurance through the California Partnership for Long Term Care, and who attempted to activate their benefits between August 1, 1998, and June 30, 1999. These 35 policyholders were followed for six months from the date of their initial eligibility assessment, including detailed reviews of individual eligibility assessments, care plans, progress notes, and insurance claims.

Nineteen of the 35 policyholders also received two in-person interviews and four telephone interviews over a six-month period. These interviews assessed their positive and negative experiences with long-term care insurance, including their satisfaction with
care management services, changes in their condition and corresponding changes to their care plans, and the adequacy of care plan implementation and monitoring. Information about the care management services offered under LTCI was also gathered from family members, care managers, care management provider agency (CMPA) personnel, and insurance company representatives.

**Major Findings**

**Claims Process**

Policyholders generally reported being satisfied with the process of filing a claim. In a number of cases, caregivers apparently provided care without assistance until they felt overwhelmed or became physically ill, or until policyholders fell and fractured a bone, leading to residential care. Earlier intervention might have relieved some of the burden on caregivers, perhaps reducing the likelihood that they would have become overwhelmed or ill, or that policyholders would have required placement in institutions.

**Eligibility Determination**

CPLTC regulations require policyholders to meet certain functional, cognitive, or medical requirements to qualify for benefits under their insurance policies. Assessment information and other available documentation supported insurer eligibility determinations in 32 out of the 35 cases reviewed. No one appeared to have been denied benefits inappropriately, although three policyholders considered eligible by insurers did not appear sufficiently disabled to exactly meet CPLTC criteria. Eligibility assessment protocols had a number of inconsistencies that could reduce the accuracy of eligibility determinations.

**Assessment of Client Needs**

CPLTC regulations specify that care management should take “an all-inclusive look at a person’s total needs and resources.” A review of case records found that the assessment instruments currently being used do not appear sufficiently comprehensive. Deficits were identified with regard to such areas as emotional and psychological well-being, health maintenance, environmental safety, social activity, culture and ethnicity, rehabilitation potential, and need for care management.
Care Plans

Care plans, which determine which services are reimbursable and eligible for asset protection, included all assessed home-care needs, but only 27 percent of day-care needs, 24 percent of transportation needs, 20 percent of caregiver education needs, 12 percent of mental health needs, and 11 percent of caregiver support needs. Most care plans included problem and goal statements, although they tended to lack sufficient specificity. Services, providers, and sources of payment were indicated for most formal services, but cost, frequency, and potential informal supports were often omitted.

Policyholders and their families generally reported being involved in care plan development, although many policyholders expected or wanted services that were not included in the final care plan. Potential conflicts of interest were present in a number of cases that might have contributed to unmet policyholder needs.

Care Plan Implementation

Interviews with policyholders found that many care plans were not implemented fully. Possible reasons included lack of information about available services, confusion about coverage, unaddressed familial or cultural factors affecting use of formal service providers, undocumented changes in policyholders’ needs or conditions, and confusion about what to expect from care managers. CPLTC regulations presume a discussion between policyholders and care managers concerning the need and desire for service coordination and monitoring; however, there was little evidence that such discussions occurred.

Care Monitoring

A review of case records and policyholder reports indicated that care managers typically had limited contact with policyholders, often consisting of one in-person visit to assess eligibility and develop a care plan, followed by periodic telephone calls (frequently from a care manager other than the one who developed the initial care plan). These contacts did not always appear sufficient to identify and respond to policyholder needs and service problems, as our review identified a number of cases in which more intensive care monitoring or more appropriate services may have helped to avoid
deleterious policyholder outcomes. Moreover, progress notes almost never included evaluations of the effectiveness of recommended interventions or assessments of client progress toward meeting the goals identified in care plans.

**Policyholder Knowledge**

Policyholders typically understood the general types and amount of coverage their LTCI policies provided, although fewer than half knew the specific daily or monthly reimbursement limits. Only about one in five policyholders knew what criteria needed to be met for eligibility, fewer than one in three knew that their care plan determined what services would be covered, and only one in six knew that their Partnership policy included a unique asset protection feature. Fewer than half knew how to file an appeal if they had concerns regarding an eligibility decision or regarding their care plan.

**Service Utilization and Its Impact**

Policyholders’ basic service needs appeared to be met in most cases, although two-thirds of policyholders were found to have at least some unmet needs. Long-term care insurance claims paid and assets protected for the 33 policyholders in our study who were eligible for benefits amounted to $234,542 over the period of the study. The median amount of benefits claimed by a policyholder was $4,022, although 11 of the 33 policyholders had no insurance claims at all. Policyholders reported using a number of potentially-covered services for which LTCI claims apparently were not made, suggesting that policyholders may be paying out of pocket for some covered services.

Family members continued to provide about the same amounts of care as they had before benefits were enacted, although they generally spent less overall time doing so. They also continued to pay for a substantial amount of the policyholders’ care, with family members’ out-of-pocket expenditures ranging as high as $5,000. Caregiver strain tended to decrease at the onset of LTCI benefits, but was as apt to increase as to decrease during the ensuing months.

**Quality Assurance Procedures**

CPLTC regulations invest the primary responsibility for quality assurance with care management organizations, which are charged with approving care plans, assessing
client satisfaction, identifying unmet needs, conducting quarterly service record reviews, and assuring that care managers receive adequate training and supervision. Quality assurance policies and procedures established under CPLTC regulations were generally found to be useful for consumer protection, although research identified a number of gaps in implementation.

Care managers were invested with very broad responsibility, yet actually were found to have relatively limited authority and little knowledge regarding the benefits available to clients under their LTCI policies. In some cases, insurers or third-party administrators apparently assumed responsibility for approving care plans and monitoring care, raising the possibility of a conflict of interest. Moreover, few policyholders were familiar with the consumer protection features of their LTCI policies, or understood the role of care management in helping them to meet their needs.

**Products**

This project resulted in a number of specific products that may be useful for enhancing the quality of care management under long-term care insurance, and which are available from the Center for the Advanced Study of Aging Services: (1) a standardized eligibility assessment tool, reflecting CPLTC and Kassebaum-Kennedy tax-exempt criteria, (2) protocols and procedures for developing care plans, (3) protocols and procedures for implementing care plans and monitoring care, (4) recommended quality assurance processes for care management under long-term care insurance, and (5) recommended actions that could be taken by insurers, care management organizations, regulatory bodies, and consumer groups. In so doing, this project contributes to the development and implementation of policies and procedures that can improve the quality and consistency of care management services provided under long-term care insurance.
INTRODUCTION

Long-term care insurance (LTCI or LTC insurance) has emerged in recent years as a significant component of efforts to meet the needs of older adults with chronic health conditions. Policy improvements and tax-qualified status have made private long-term care insurance an increasingly attractive means for older persons to protect themselves from the risk of catastrophic long-term care expenses. Yet relatively little attention has been given to how long-term care insurance benefits are actually used. It has not been known, for example, how well the services provided under long-term care insurance actually meet policyholders’ long-term care needs, or the role of care management services in helping to assure that policyholders’ needs are met and their rights protected. Policymakers, insurance carriers, care management agencies, service providers, and consumers all share a common interest in the development and maintenance of high quality care management and quality assurance programs to assure that client needs are met in an equitable, effective, and efficient manner.

This research project examined provisions for protecting the rights and meeting the needs of elderly consumers who purchase long-term care insurance through the California Partnership for Long Term Care (CPLTC, the California Partnership, or the Partnership), a public-private partnership between long-term care insurance carriers and Medi-Cal (California’s Medicaid program). CPLTC is one of four such partnerships supported by the Robert Wood Johnson Foundation in an effort to make LTC insurance more available to middle-income persons, improve the quality of available LTC insurance products, and increase consumer protection.

These Partnerships for Long Term Care involve:

- model long-term care insurance policies designed to meet established standards of quality and coverage;
- mechanisms for consumer protection and quality assurance;
- asset protection coupled with eligibility for state Medi-Cal programs upon exhaustion of long-term care insurance benefits; and
- extensive consumer education about the risks of needing long-term care, ways to finance care, and the role of LTC insurance.
This project focused on
- investigating the experiences of long-term care insurance policyholders in light of existing regulations and standard practices in long-term care case management;
- developing protocols and processes for assessing consumer satisfaction with services provided under long-term care insurance; and
- formulating policy recommendations regarding the development of quality assurance procedures.

The project involved a collaboration of the California Department of Health Services, participating insurance carriers, care management provider agencies, and the University of California at Berkeley’s Center for the Advanced Study of Aging Services.
As of 1998, 119 companies had sold more than 5.8 million long-term care policies, more than five times as many as in 1990 (HIAA, 2000). Growth in the sale of policies is attributed to many factors, including: increased consumer awareness; growth in the number of insurance companies offering policies; improvements in affordability; and improvements in the policies themselves, such as inflation protection, coverage of a wider range of benefits, and the promise of increased consumer protections. Moreover, with passage of the Kassebaum-Kennedy Health Insurance Portability and Accountability Act (HR 3103) and resulting tax-qualified status, the long-term care insurance market is expected to mushroom in the coming years.

Promotional materials typically promise that long-term care insurance policies will enable purchasers to maintain independence, protect assets, and guarantee that long-term care services will be both affordable and available when needed. Yet, there is little evidence to date regarding the ability of long-term care insurance to deliver on these promises. Indeed, significant concerns have been raised regarding the quality of long-term care insurance policies and the protections actually afforded consumers. Even in states that have adopted the model standards of the National Association of Insurance Commissioners (NAIC), eligibility criteria, policy terms, and definitions frequently are expressed in language that is vague and inconsistent across policies. Moreover, many consumers remain confused regarding the adequacy of existing policies (Cohen et al, 1993), and there is evidence that a high percentage of policyholders drop policies or let them lapse (GAO, 1993).

To date, little is known about the ability of long-term care insurance to meet elderly consumers’ health and financial needs. In particular, it is not known in what ways the availability of long-term care insurance may enhance, or limit, policyholders’ ability to obtain the services they need and for which they originally purchased the insurance. A recent study conducted by Lifeplans, Inc., for the U.S. Department of Health and Human Services Office of Disability, Aging and Long-Term Care Policy (Lifeplans, 1999) found that 35% of individuals receiving benefits under long-term care insurance reported unmet or undermet needs with ADLs and/or IADLs.

Many long-term care insurance policies identify care management services as a key component of their consumer protection provisions, and as a way to increase patient advocacy.
Care Management & Quality Assurance under LTCI

and prevent institutionalization (McSweeney, 1995; Arneson, 1996). “Care management takes an all-inclusive look at a person's total needs and resources, and links the person to a full range of appropriate services using all available funding sources” (from the regulations authorizing the Partnership for Long Term Care in California). In so doing, care management is intended “to assist you in planning and securing the services you want and need” (from Partnership promotional materials). Moreover, the Kassebaum-Kennedy Health Insurance Portability and Accountability Act (HR 3103) requires that every tax-qualified long-term care insurance policy include eligibility determination and the development of a plan of care by a licensed health professional.

Partnership insurance carriers typically contract with care management organizations to make recommendations for benefit eligibility, develop plans of care, and coordinate and/or monitor the quality of care. However, the majority of insurers offering non-Partnership policies provide their own care management services rather than contracting with external organizations, and they do not offer the full spectrum of care management services (McSweeney, 1995). For example, while most non-partnership companies offer screening and assessment services, only thirty percent of companies in the individual market offering care management services provide follow-up or reassessment.

Variations in the nature and implementation of care management have prompted questions regarding its ability to deliver on the promise of promoting both effectiveness and efficiency in the provision of long-term care services. Indeed, our earlier research (Scharlach, Robinson, & Merrill, 1996) revealed the potential for deviations from state regulations as well as from established principles of care management practice, particularly with regard to eligibility determination and care plan development and implementation.

Variations regarding eligibility assessment procedures are of concern because criteria utilized to determine eligibility for long-term care services have been shown to be important determinants of client access as well as the overall cost of long-term care (Capitman, MacAdam, & Abrahams, 1991; Jackson, Burwell, Clark, & Harahan, 1992; Weiner, Hanley, Clark, & Van Nostrand, 1990). Yet, a growing body of literature indicates the presence of substantial variations among long-term care programs with regard to their eligibility criteria and the manner in which those criteria are assessed (Jackson, Burwell, Clark, & Harahan, 1992; Leutz, Abrahams, & Capitman, 1993; Spector & Kemper, 1994). Eligibility assessment criteria and assessment
instruments that assure equitable treatment of beneficiaries and efficient assessment require
better specification of the timing and setting of assessments, the language of assessment items,
the training and qualifications of assessors, and the procedures for review, appeals and
exceptions (Leutz, Abrahams, Capitman, 1993).

Adequate processes for assuring quality in the development of care plans also are needed.
The limited work that is available focuses primarily on structural components of the care plan
such as problem statements, types of help needed, and available services (Geron & Chassler,
1994; Schneider, 1989; National Association of Professional Geriatric Care Managers, 1992;
National Council on Aging/National Institute on Community-Based Long Term Care, 1988;
National Association of Social Workers, 1992; Rothman, 1992; St. Coeur, 1996). However,
while regulations specify certain structural and process requirements related to the care planning
process, compliance with these requirements alone does not guarantee that the care plan is
adequate, i.e., that it accurately reflects the needs of the policyholder. Nor do they provide
adequate guidelines for the development of systematic quality assurance (Geron & Chassler,
1994).

To a large extent, quality assurance in long-term care services, although receiving
increasing attention, remains a relatively new and largely undeveloped area. Of particular
importance are consumers’ own evaluations of the services they receive, especially since client
satisfaction may lead to improved service utilization (Geron, 1996). Moreover, consumer
satisfaction is an important indicator of service quality (Davies & Ware, 1988), and therefore has
become an essential component of Total Quality Management and Continuous Quality
Improvement efforts as they have been applied to the provision of health care services (Gold &
Wooldridge, 1995).
METHODOLOGY

The research methodology for this project consisted of an in-depth process analysis of policyholders' experiences under long-term care insurance. The analysis included longitudinal case studies involving interviews with policyholders, care managers, care management provider agency directors, and insurance company representatives. The case studies involved primary data collection from detailed case record reviews as well as comprehensive interviews with policyholders and their family members.

Sample

Holders of CPLTC policies who attempted to activate their benefits between August 1, 1998, and June 30, 1999, were eligible to participate in the study. CPLTC policyholders who lived within 100 miles of either San Francisco or Los Angeles could participate in the in-person interview portion of the study. Once eligible policyholders were approved or denied for benefits, they were sent a letter from the insurer or the researchers requesting their participation in the research project per the protocol approved by the University of California’s Committee for the Protection of Human Subjects. Of 45 policyholders contacted, 35 agreed to participate. Of these 35, 19 were interviewed; 13 policyholders lived outside the interview area, 2 were denied LTCI benefits and one died prior to being contacted (Table 1). Only the case records of these 16 non-interviewed participants were reviewed for the research study.

Table 1. Project Participant Sample Summary

<table>
<thead>
<tr>
<th>Total Number of Participants in Study</th>
<th>35</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants who Completed In-Person Interview</td>
<td>19</td>
</tr>
<tr>
<td>Non-Interviewed, Out of Area Participants</td>
<td>13</td>
</tr>
<tr>
<td>Participants who were Denied LTCI Benefits</td>
<td>2</td>
</tr>
<tr>
<td>Deceased Prior to In-Person Interview</td>
<td>1</td>
</tr>
</tbody>
</table>
The research also included eight CPLTC-approved insurers, three CPLTC-approved CMPAs, and 22 care managers. Only three insurers had policyholders who were eligible to participate in the research project.

A summary of the 35 research project participants shows that the majority were over 70 years of age (n=29) and female (n=23). Most of the study participants were married (n=18) and living at home (n=26). The events that resulted in policyholders making a claim included acute conditions in 14 cases, chronic conditions in 14 cases and accidents in 7 cases (Table 2).

| Table 2. Demographic Characteristics of Research Project Participants |
|-----------------------------|------------------|
|                             | Frequency        |
| **Age**                    |                  |
| \(\leq 60\)               | 1                |
| 61-70                      | 5                |
| 71-80                      | 18               |
| \(>80\)                   | 11               |
| **Gender**                 |                  |
| Male                       | 12               |
| Female                     | 23               |
| **Marital Status**         |                  |
| Single                     | 1                |
| Married                    | 18               |
| Separated/Divorced         | 7                |
| Widowed                    | 9                |
| **Residence**              |                  |
| Home                       | 26               |
| SNF                        | 6                |
| Other                      | 3                |
| **Claim Event**            |                  |
| Acute condition (includes CVA & surgery) | 14 |
| Chronic condition (includes dementia) | 14 |
| Accident                   | 7                |

**Data Collection Procedure**

The policyholders were followed for a total of six months from the date of their initial eligibility assessment. The data collection methods included detailed record reviews and policyholder interviews.
Policyholders’ records were reviewed in light of the CPLTC 1993 Care Management Regulations applying to their LTCI policies and quality indicators developed for this project based on established practice standards. The documentation requested by researchers and supplied by insurers and CMPAs included individual eligibility assessments, care plans, progress notes, and insurance claims.

The research methodology called for policyholders to receive an initial in-person interview, four telephone interviews, and an exit interview during a six-month period. The in-person interviews were conducted by trained licensed clinical social workers, and the monthly interviews were conducted by a trained PhD student. The initial in-person interview was typically conducted within two to three months of the policyholder’s eligibility assessment by a CMPA case manager. Interviews could not be scheduled until after the benefit determination was made, which typically occurred one to two weeks after the eligibility assessment. Three policyholders were not initially interviewed for as long as 5 months after eligibility determination because of the severity of their illnesses and difficulties in scheduling.

The four monthly telephone interviews generally began one month after the first in-person interview and continued until five months after the date of the policyholder’s initial eligibility assessment. The second in-person interview was conducted with each policyholder and/or primary caregiver approximately six months after the date of the policyholder’s initial eligibility assessment.

An attempt was made to have all interviews conducted with the policyholder as the primary informant. However, family members were substituted for policyholders when information from the case record and consultation with the CMPA determined that the policyholder was unable to participate due to severe physical and/or cognitive impairment, or if policyholders requested that a family member speak with the interviewer instead.

Measurement

Case Record Reviews

Case records were reviewed to determine the adequacy and comprehensiveness of the needs assessment, care plan development, and implementation. A detailed analysis of the assessment tools was conducted to evaluate whether the information collected was adequate to provide an “all inclusive look” at policyholders’ total needs. Deficits in these assessment tools
were noted, including the omission or inconsistent collection of relevant information in important domains, including: informal supports, medications, cognitive status, emotional status, ADLs and IADLs, nutritional status, safety/environmental hazards, emergency response system, tobacco and alcohol use, social activity, potential for rehabilitation, and need or desire for case management.

Care plans were examined for components that were (1) required under Partnership regulations, (2) necessary for quality assurance and consumer protection, or (3) consistent with good care practices. Some of these important components reviewed included translating assessment data into meaningful information, developing care plans in a timely manner, avoiding potential conflict of interest issues, getting approval of plans, and involving consumers.

Care plan documents also were reviewed to determine the presence of problem statements; corresponding goal or outcome statements; service descriptors for recommended interventions for each problem (i.e., type, frequency, cost, and payor); and the role of informal supports. Case records were reviewed regarding how these care plans were implemented, including the role of the care manager in providing coordination and other related activities.

**Claims Records**

Claims records were examined with regard to service utilization as well as economic impact. Services received were determined by examining Uniform Data Set (UDS) records of claims reported to the Department of Health Services (DHS) by the insurance carriers. Services actually received were compared with those specified in the care plan. Discrepancies between services received and the care plan were evaluated for the existence of consistent patterns (e.g., particular types of services included in care plans but seldom actually received, or services received that were not listed in the care plans). UDS data on assets protected also were examined to determine the economic impacts of LTCI.

**Policyholder Interviews**

**Initial Interview**

The initial interview protocol was developed with the assistance of recognized experts in the field of long term care services research (Drs. Robert Applebaum, Scott Geron, and Kevin Mahoney). The initial in-person interview included the following types of questions: the types
and amount of long-term care services utilized; satisfaction with the services received; policyholder knowledge concerning the provisions of their long-term care insurance policies (e.g., benefits covered, limitations, etc.); and satisfaction with the different facets of the entire long-term care insurance process. The in-person interview was pilot tested using a sample of three policyholders who applied for benefits within the three months prior to the start of the data collection period.

**Monthly Interviews**

Monthly telephone contacts were made with the policyholders or primary caregivers to collect data regarding changes in the policyholders' condition, and changes to the care plan. These telephone interviews recorded policyholder experiences and satisfaction with the implementation and monitoring of the care plan, including the amount and adequacy of the services policyholders received. The telephone interviews asked about the specific services listed in the care plan, whether or not these services had been received in the previous month, and whether or not the policyholders had used services not listed in the care plan. Policyholders were asked to rate their overall experiences with the process of receiving services under long-term care insurance.

**In-person Exit Interview**

Policyholders were asked at the end of the six-month study period their satisfaction with the long-term care insurance process. An augmented version of the Home Care Satisfaction Measures (HCSM) developed by Scott Geron (Geron, 1997) was administered to assess policyholders’ satisfaction with the case management services they received through long-term care insurance. The HCSM are brief, multi-item measures designed to assess the satisfaction of frail elders who receive home care services. Scoring of the HCSM is based on a five-point Likert scale converted to a 0-100 scale. The Case Management Service measure consists of thirteen items covering four dimensions: competency, service choice, positive interpersonal contact, and negative interpersonal contact. Policyholders also were asked about their satisfaction with the information and assistance they received from their long-term care insurance carrier. In addition, the interview included open-ended questions designed to assess
other positive and negative aspects of policyholders’ experiences in receiving services under long term care insurance.

**Family/caregiver interview**

At the time of the in-person interview, the interviewer asked policyholders to identify the family member most involved in their care and requested permission to contact him/her. If the family member was present at the time of the in-person interview, an attempt was made to interview the family member then; if not, a researcher contacted the family member by telephone. The purpose of the family interview was to obtain information about how the Partnership case management services had impacted family members in: the amount and type of care provided, their out-of-pocket expenses, and level and type of stress they experienced. Family members also were interviewed at the end of the six-month data collection interval, and again asked to assess the impact of caregiving.