THE ELIGIBILITY DETERMINATION PROCESS

Eligibility for services under long-term care insurance policies and most other public and private long-term care programs is triggered by the determination that a policyholder has sustained sufficient physical or cognitive impairment to require long-term care services. Consistency in the determination of eligibility is essential, therefore, to assure equitable access to benefits. Moreover, eligibility determination directly affects the liability experienced by insurance companies, as well as the state’s eventual financial obligations under the asset protection feature of California Partnership for Long Term Care (CPLTC, the California Partnership, or the Partnership) policies. Benefit eligibility also determines whether long-term care insurance policies qualify for federal tax deduction status under the 1996 Health Insurance Portability and Accountability Act (HIPAA), also known as the Kassebaum-Kennedy Act and HR 3103.

In this chapter we summarize the experiences of California Partnership policyholders with the process of eligibility assessment and determination, based on a careful review of 35 case records and interviews with 19 policyholders. Particular attention is given to how eligibility criteria are operationalized and their implications for implementation under (1) CPLTC and (2) insurance policies that meet the tax-qualified (TQ) requirements under HIPAA. We offer recommendations for actions that can be taken by insurers, care management organizations, and state regulators to help assure quality in the benefit eligibility assessment process. We also provide examples of standardized eligibility assessment instruments illustrating our recommendations. This chapter is organized around the three main components of the eligibility process: the claims procedure, eligibility determination, and reassessment.
Claims Procedure

Decision to File a Claim for Long-Term Care Insurance Benefits

Policyholders or their spokespersons were asked to describe how they decided to file a claim to activate their long-term care insurance (LTCI) benefits. Of the 19 policyholders interviewed, 7 filed a claim following an acute event that necessitated home care or upon discharge from a rehabilitation facility or acute care hospital. The other 12 had been receiving care at home for some time prior to filing a claim. In five of these 12 cases, a claim was filed when the policyholder entered a nursing home or residential care facility; in three cases, caregivers became so overwhelmed by increasing care responsibilities that they sought assistance; in two cases, caregivers were no longer available to provide care, either because of their own health problems or because they had exhausted their leave time from work; and in two cases, no clear reason for filing a claim was given. In one of these cases, a hospital discharge planner gave the policyholder the incorrect information that his LTCI policy would not cover home care, causing the policyholder’s spouse to provide care for 3 months before making a claim.

Time Between Initial Disability and LTCI Claim

Case records were examined to determine the approximate date on which policyholders first became disabled in relation to the time a long-term care insurance claim was filed. Sufficient data to estimate the approximate onset of the disabling condition were available for 32 out of 33 cases in which policyholders were approved for benefits. Time periods varied considerably for policyholders. Almost half of the policyholders (15 out of 32) filed a claim within 12 weeks (3 months) of their initial disability. Ten policyholders filed a claim between 13 and 52 weeks (3 months to 1 year) after they were
initially disabled, while 7 policyholders did not file a claim for benefits until after a year had passed since their initial apparent disability.

Six of the seven policyholders who filed a claim more than a year after the initial onset of a disabling condition had a progressive neurological disease, such as irreversible dementia or Parkinson’s disease. In four of these cases, the spouse who was caring for the policyholder decided to file a claim for benefits because s/he was feeling overwhelmed by the policyholder’s increasing care needs and wanted assistance. In the other two cases, policyholders with progressive neurological diseases fell and fractured a bone, leading to placement in a care facility because the caregiver did not feel able to provide the increased level of care required. The seventh case involved a policyholder with a spinal injury followed by a CVA, whose spouse was caring for him until her own health problems made it difficult for her to continue to provide care.

**Satisfaction with the Application Process**

Ten of the 19 policyholders interviewed initiated the claim process themselves by calling the insurance carrier directly, while one called his/her insurance broker. Calls were made to the insurance company by family members in five cases and by residential care facilities in two cases. The majority of policyholders indicated that they knew whom to contact from printed materials such as insurance paperwork or booklets, while a few relied on information from people they knew.

Policyholders or their spokespersons were asked to evaluate the process of filing a claim to activate their long-term care insurance benefits. Of the 19 policyholders interviewed, only 3 reported experiencing any problems with the application process. One policyholder indicated s/he had to wait a month from the first call until the start of
coverage; another policyholder had to wait while the company gathered information from
the SNF; a third policyholder complained about receiving misinfor-mation from a
hospital discharge planner. The average amount of time from assessment until
notification of the eligibility decision was 20.5 days, ranging from a minimum of 6 days
to a maximum of 60 days.

Seven of the policyholders offered recommendations for improving the claims
process. One was that the claims process be made clearer:

“I could have used someone from [the insurance carrier] to talk/walk [me] through the
process, but this is a minor complaint.”

“I was unsure . . . if the claim had been approved. There is some ambiguity about actual
approval.”

Another recommendation was to reduce or speed up the processing of paperwork:

“Seemed like a lot of red tape. I feel overwhelmed—eliminate paperwork to make the
process easier.”

“Use a fax machine to speed up the process of getting paperwork submitted. The transition
from filing claims to the time of coverage should be faster, so that help in the home can
begin ASAP.”

“There should be simpler forms . . .”

“Send fewer papers . . . I had six shopping bags of papers when all of this was done.”

Summary Regarding Claims Procedures

In general, policyholders reported being satisfied with the process of filing a claim,
although some policyholders would have benefited from additional assistance with the
claims process or information about what to expect.

In a number of cases, caregivers apparently provided care without assistance until
they felt overwhelmed or became physically ill, or until the policyholder fell and
fractured a bone, leading to residential care. Earlier intervention might have relieved
some of the burden on the caregivers, perhaps reducing the likelihood that they would
have become overwhelmed or ill, or that policyholders would have required placement.

**Recommendations Regarding Claims Procedures**

We recommend that policyholders be informed of the importance of contacting their
insurance carrier or agent as soon as they become disabled, so that preventive services
may be offered that might alleviate subsequent problems for policyholders and their
caregivers. Examples of such preventive services include caregiver training, support
groups, respite care, and a small amount of home care to reduce the burden and isolation
caregivers often experience. Such services may be especially important when policy-
holders experience irreversible dementia or other progressive neurological diseases.

Some policyholders delayed making a claim to preserve their benefits. In so
doing, they did not avail themselves of the assessment and care planning services
available through their long-term care insurance policies, which would not have
diminished their benefit amount. Moreover, given the unique feature of Partnership
policies that allows policyholders to shelter assets and still qualify for Medi-Cal, there
seems little reason for most policyholders to be concerned about exhausting their benefits
prematurely.

**Eligibility Determination**

CPLTC regulations require enrollees to meet certain functional, cognitive, or medical
requirements to qualify for benefits under their insurance policies.

The 1993 CPLTC eligibility criteria pertain to the policyholders in this study,
while more recent policies are governed by 1999 CPLTC criteria. Face-to-face, in-person
eligibility assessments based on these criteria are administered by representatives of the three care management provider agencies (CMPAs) that contract with participating long-term care insurance carriers to perform eligibility assessments and care planning services. Assessment information is forwarded to the insurers, who make the final eligibility decisions.

**CPLTC 1993, § 58019.** “Insured Event” means that insured is eligible to receive insurance benefits and to have these benefits qualify for a Medi-Cal Property Exemption if any one (1) of the following criteria is met:

(a) The insured has at least two Deficiencies in Activities of Daily Living (ADLs) (to qualify for home and community-based services including but not limited to Home Health Care, Adult Day Health/Social Care, Personal Care Services, Homemaker Services Incidental to Personal Care Service, Respite Care and Residential Care Facility) or three Deficiencies in Activities of Daily Living (ADLs) (to qualify for nursing facility care); or

(b) The insured has a Cognitive Impairment; or

(c) The insured has a Complex, Yet Stable Medical Condition.

**CPLTC 1999, § 58003(b).** The insured will be considered a Chronically Ill Individual when one of the following criteria are met:

(1) The insured is unable to perform, without Standby Assistance or Hands-On Assistance from another individual, [2 Activities of Daily Living] due to a loss of functional capacity and the loss of functional capacity is expected to last at least 90 days; OR

(2) The insured has a Severe Cognitive Impairment requiring Substantial Supervision to protect the insured from threats to health and safety.

**Analysis of Case Records**

According to individual-level benefits eligibility information reported to CPLTC by insurance carriers, 33 of the 35 policyholders in our sample were reported as having experienced an “insured event,” while 2 policyholders were reported as not experiencing an insured event. We reviewed the benefit eligibility assessment completed by the care manager, as well as other available documentation about each policyholder’s level of functional and cognitive impairment and need for nursing care. Of the 33 policyholders reported as having experienced an insured event, our review of available documentation
found that 30 appeared to meet one or more of the CPLTC benefit eligibility criteria, while 3 did not appear to meet any of the CPLTC criteria (Table 1). Of the three policyholders who did not appear to meet CPLTC criteria, one (#03) was reported by the insurer to have met eligibility criteria for functional impairment, cognitive impairment, and a complex, yet stable medical condition; one (#29) was reported to have met eligibility criteria for functional impairment only; and one (#47) was reported to have met eligibility criteria for cognitive impairment only. Neither of the two policyholders reported by insurers as having failed to experience an insured event was found to have met any of the CPLTC eligibility criteria. No one found to meet CPLTC criteria was denied benefit eligibility.

<table>
<thead>
<tr>
<th>Table 1. Insured Event Reporting</th>
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<tbody>
<tr>
<td>Insured Event</td>
</tr>
<tr>
<td>Met at least one criterion</td>
</tr>
<tr>
<td>Did not meet at least one criterion</td>
</tr>
</tbody>
</table>

**Policyholder Interviews**

Policyholders were asked whether they knew the purpose of the assessment visit. Fourteen of the 19 policyholders interviewed understood that the assessment was needed to determine whether or not they were qualified for benefits, while 5 provided a different response. Interestingly, only 6 of the 19 understood that the assessment was also for the purpose of monitoring the level of their illness or care needs.

Policyholders were asked whether they knew what criteria their insurance company used to decide whether or not they were eligible to use their long-term care insurance benefits. Only 5 of the 19 persons interviewed knew that eligibility decisions
were based on the policyholder’s need for assistance with ADLs and on the level of cognitive impairment.

Policyholders or their representatives were asked whether there was anything that might have prevented the assessor from getting an accurate picture of the policyholder’s level of functioning. Six of the 19 respondents identified factors that might have led to an inaccurate assessment. Three respondents cited fluctuations in the policyholder’s capacity for self-care; two cited the failure of the assessor to observe directly the policyholder’s actual functioning; one cited the assessor’s apparent impatience.

Seven of the 19 policyholders interviewed offered recommendations about possible changes in the assessment process. Suggestions included providing the assessor with the policyholder’s medical information ahead of time, so that s/he would better understand the policyholder’s condition; having the assessor do a better job of introducing and explaining the assessment process; repeating the assessment at a different time or on a different day; and observing the policyholder doing ADLs rather than relying only on a self-report.

**HIPAA**

Under the 1996 Health Insurance Portability Assurance Act, long-term care insurance policies that qualify for tax deductibility must also meet certain requirements regarding the assessment for benefit eligibility. Under HIPAA, a “qualified long-term care insurance contract” must only cover “qualified long-term care services,” defined as necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services. Qualified long-term care services must be required by a “chronically ill individual” and provided pursuant to a
plan of care prescribed by a licensed health care practitioner. A chronically ill individual is defined by functional and cognitive impairment criteria. These criteria are outlined in the law and are clarified in an interim IRS release (IRS, 1997).

Twenty-nine of the 30 policyholders in our sample who appeared to meet one or more of the CPLTC benefit eligibility criteria would also have qualified under HIPAA functional impairment criteria. One policyholder (#14) met CPLTC eligibility criteria for an insured event based solely on the presence of a complex, yet stable medical condition, which is not defined as an insured event under HIPAA criteria.

**Functional Impairment**

*CPLTC 1993, § 58013.* “Deficiency in Activity of Daily Living” means that the insured cannot perform one or more of the following six (6) Activities of Daily Living without substantial human physical assistance and/or constant supervision:

(a) Bathing, meaning cleaning the body using a tub, shower or sponge bath, including getting a basin of water, managing faucets, getting in and out of tub or shower, reaching head and body parts for soaping, rinsing, and drying.

(b) Dressing, meaning putting on and taking off, fastening and unfastening garments and undergarments, and special devices such as back or leg braces, corsets, elastic stockings/garments and artificial limbs or splints;

(c) Toileting, meaning getting on and off a toilet or commode and emptying a commode, managing clothing and wiping and cleaning the body after toileting, and using and emptying a bedpan and urinal;

(d) Transferring, meaning moving from one sitting or lying position to another sitting or lying position; e.g., from bed to or from a wheelchair, or sofa, coming to a standing position and/or repositioning to promote circulation and prevent skin breakdown;

(e) Continence, meaning the ability to control bowel and bladder as well as use ostomy and/or catheter receptacles, and apply diapers and disposable barrier pads; and

(f) Eating, meaning reaching for, picking up, grasping a utensil and cup; getting food on a utensil, bringing food, utensil, and cup to mouth; manipulating food on plate; and cleaning face and hands as necessary following meal.

*CPLTC 1999, § 58000.* “Activities of Daily Living” means the verbatim definitions of California Insurance Code Sections 10232.8(f) [tax qualified] and 10232.8(g) [not tax qualified] which must be used verbatim in Partnership Policies.
**CIC § 10232.8(f).** The definitions of "activities of daily living" to be used in policies and certificates that are intended to be federally qualified long-term care insurance shall be the following until the time that these definitions may be superseded by federal law or regulations:

1. **Eating,** which shall mean feeding oneself by getting food in the body from receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.
2. **Bathing,** which shall mean washing oneself by sponge bath or in either a tub or shower, including the act of getting into or out of a tub or shower.
3. **Continence,** which shall mean the ability to maintain control of bowel and bladder function; or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for a catheter or colostomy bag).
4. **Dressing,** which shall mean putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
5. **Toileting,** which shall mean getting on and off the toilet, and performing associated personal hygiene.
6. **Transferring,** which shall mean the ability to move into or out of bed, a chair or wheelchair.

**CIC § 10232.8(g).** (g) The definitions of "activities of daily living" to be used in policies and certificates that are not intended to qualify for favorable tax treatment under Public law 104–191 shall be the following:

1. **Eating,** which shall mean reaching for, picking up, and grasping a utensil and cup; getting food on a utensil, and bringing food, utensil, and cup to mouth; manipulating food on plate; and cleaning face and hands as necessary following meal.
2. **Bathing,** which shall mean cleaning the body using a tub, shower, or sponge bath, including getting a basin of water, managing faucets, getting in and out of tub or shower, and reaching head and body parts for soaping, rinsing, and drying.
3. **Dressing,** which shall mean putting on, taking off, fastening, and unfastening garments and undergarments and special devices such as back or leg braces, corsets, elastic stockings or garments, and artificial limbs or splints.
4. **Toileting,** which shall mean getting on and off a toilet or commode and emptying a commode, managing clothing and wiping and cleaning the body after toileting, and using and emptying a bedpan and urinal.
5. **Transferring,** which shall mean moving from one sitting or lying position to another sitting or lying position; for example, from bed to or from a wheelchair or sofa, coming to a standing position, or repositioning to promote circulation and prevent skin breakdown.
6. **Continence,** which shall mean the ability to control bowel and bladder as well as use ostomy or catheter receptacles, and apply diapers and disposable barrier pads.
7. **Ambulating,** which shall mean walking or moving around inside or outside the home regardless of the use of a cane, crutches, or braces.
Analysis of Case Records

Reports to CPLTC by insurance carriers indicated that 29 of the 35 policyholders in our sample reportedly experienced deficiencies in activities of daily living (ADLs) sufficient to qualify as an insured event, while 6 policyholders did not experience such deficiencies in ADLs. Our review of benefit eligibility assessments (BEAs) found that 27 policyholders appeared to meet the CPLTC functional impairment criteria. Two policyholders, reported by insurers as having deficiencies in ADLs sufficient to qualify as an insured event, were not found to completely meet CPLTC functional impairment criteria. Of the six policyholders reported by insurers as not having deficiencies in ADLs sufficient to qualify as an insured event, none were found to meet CPLTC functional impairment criteria (Table 2).

<table>
<thead>
<tr>
<th>Functional Impairment</th>
<th>Reported as Having ADL Deficiency</th>
<th>Reported as Not Having ADL Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Met criteria</td>
<td>27</td>
<td>0</td>
</tr>
<tr>
<td>Did not meet criteria</td>
<td>2</td>
<td>6</td>
</tr>
</tbody>
</table>

The records of the two policyholders reported by insurers as having deficiencies in ADLs but not found to meet CPLTC functional impairment criteria were examined carefully to identify the source of the discrepancy. One of these policyholders (#03) was reported by the insurer as having deficiencies in the areas of dressing, bathing, toileting, and incontinence. BEA records indicated that this policyholder “can dress him/herself and is independent in mobility,” but “needs cuing” at times. With regard to incontinence, the policyholder was “unable to control bowel and/or bladder function but does not require supervision or assistance.” The other policyholder (#29) was reported to have deficiencies in the areas of dressing and bathing. BEA records indicated that this
policyholder was “able to complete the entire process of dressing and undressing without assistance but with difficulty,” taking her 30 to 45 minutes to complete the dressing process; s/he required hands-on assistance with bathing.

**Findings Regarding Benefit Eligibility Assessments**

The benefit eligibility assessment instruments found in the case records vary somewhat with regard to how each ADL is defined, and these definitions seldom match those specified in CPLTC regulations.

The BEAs appear to differ for some ADLs. For example, for dressing, one BEA states that the ability to dress and undress oneself “DOES NOT INCLUDE support hose, socks or tie/buckle shoes” (capitalization in the original), whereas the other two BEAs appear to include fastening shoes. With regard to bathing, one BEA states that “BATHING DOES NOT INCLUDE WASHING BACK OR HAIR” (capitalization in the original), whereas one BEA specifically includes “washing body/hair” and another BEA refers to “washing all parts of the body.”

There appears to be some question with regard to the conditions under which the following constitute an inability to perform an ADL “without substantial human physical assistance and/or constant supervision”:

- The inability to perform a task in a reasonable amount of time (e.g., requiring 30 minutes to get dressed because of arthritis)
- The occasional inability to perform an ADL (e.g., as a result of fluctuating health conditions or periodic treatments such as chemotherapy). In this regard, one BEA explicitly defines “substantial assistance” as “hands-on assistance at least 50 percent of the time”
- The need for “standby assistance/oversight supervision” but not on a continual basis
- The need for “occasional reminding or intermittent assistance with some parts of the activity (zippers, tying shoes, etc.)”
- The need for periodic cuing or reminders
- The inability to perform an ADL because of psychological rather than physical reasons (e.g., the need for assistance with transferring or bathing because of a fear of falling)
- Major disabilities to which an individual has accommodated to reduce or eliminate the need for human physical assistance or supervision (e.g., a blind person who arranges her/his living environment to remove the need for human assistance; a paraplegic person who utilizes mechanical aids to transfer or bathe).

One BEA asked assessors to observe the direct performance of ADLs, while the other two BEAs provided room for noting “clinical observations.” Our review of case records found evidence of direct observation of one or more ADLs in 12 of the 35 cases; in 21 cases, there was no specific documentation indicating whether or not ADLs had been observed; and in 2 cases, documentation appeared to indicate the absence of any direct observation of ADL performance.

Information on ADL functioning was obtained from caregivers for each of the nine policyholders who were cognitively impaired. ADL assessment was also based on information from caregivers rather than policyholders for 7 of the remaining 26 cases, even though those policyholders were not cognitively impaired.
**HIPAA**

Under HIPAA, “qualified” long-term care services must be needed by a “chronically ill individual.” The functional impairment requirement of the definition of chronically ill requires an individual to be certified by a licensed health care practitioner as “being unable to perform (without substantial assistance from another individual) at least two activities of daily living for a period of at least 90 days due to a loss of functional capacity”; or having a similar level of disability (HIPAA, § 321c2A). Substantial assistance is defined as “hands-on assistance” or “standby assistance.” Standby assistance involves the presence of another person within arm’s reach that is necessary to prevent, by physical intervention, injury to the individual while performing the ADL (IRS, 1997).

All of the 27 policyholders in our sample who experienced deficiencies in activities of daily living sufficient to qualify as an insured event under the CPLTC functional impairment criteria would also have qualified under the HIPAA functional impairment criteria.

**Comparison of CPLTC and HIPAA Criteria**

The CPLTC and HIPAA functional impairment eligibility criteria are quite similar:

- The *level* of assistance with ADLs required by the two criteria are operationally the same; hands-on assistance or constant supervision or standby help is required under both programs.
- The HIPAA criteria are less stringent than the CPLTC criteria in the *number* of required ADL impairments, requiring only *two* ADL impairments for all types of long-term care.
The HIPAA criteria are somewhat less inclusive than the CPLTC criteria in the scope of activities required to perform each ADL. For example, whereas criteria for tax-qualifying policies (TQ) for eating allow use of a tube or IV to get food into one’s body, criteria for non-tax-qualifying policies (NTQ) require that an individual be able to eat independently, including cleaning one’s face and hands as necessary following a meal.

The HIPAA criteria require that the client have the ADL impairment for at least 90 days, while the CPLTC criteria do not specifically establish a time period. However, because CPLTC clients do not actually receive benefits until a 90-day elimination period has passed, the HIPAA 90-day rule is met under CPLTC policies. (Note that HIPAA tax-qualified policies are not required to have an elimination period, as under the CPLTC.)

HIPAA criteria require that a qualified long-term care insurance contract take into account at least five out of six of the ADLs, while CPLTC requires assessing impairment in six ADLs.

**Recommendations Regarding Functional Impairment**

Slight differences between NTQ and TQ functional impairment eligibility criteria suggest that different assessment instruments may be required for pre-1997 and post-1996 policies. We recommend using a revised version of the Katz index of dependency in ADLs, with some additions, to assess ADL impairment under both CPLTC and HIPAA criteria, as displayed in the Standardized Eligibility Assessment Tool in Appendix B.

Developed in 1963, the Katz scale is a widely used and validated instrument to measure basic functioning. The scale establishes three categories for each ADL—
independence, assistance, and dependence—by asking about the help received for specific tasks and components of an ADL. While the Katz scale does not specifically ask about “substantial assistance” or “constant supervision,” as worded in the CPLTC and HIPAA regulations, any ruling of “dependent” or “assistance” from the Katz scale usually meets these requirements. We recommend asking additional information about the need for “substantial human assistance and/or constant supervision” if a client reports needing assistance or dependence with an ADL. Also, to meet the HIPAA criteria, we recommend determining how long a client has had his/her current level of functional impairment, thus assessing whether the client has had the functional impairment for at least 90 days or if the impairment is expected to last at least 90 days.

The original Katz scale asks about “receiving” help in ADLs; however, the CPLTC and HIPAA regulations specify the inability to perform tasks without help. Both frames of reference have been widely used, with little evidence to suggest whether one is more useful than the other (Kovar & Lawton, 1994). Questions asking about the “need” for assistance attempt to account for contextual factors that might also contribute to a deficiency assessment. We recommend that whenever possible assessment instruments ask for comments/explanations and any contextual factors that might affect the need for “substantial” human help or constant supervision. For example, a patient in a nursing home may receive help in an activity, regardless of his/her ability to perform it independently (Kovar & Lawton, 1994).

When possible, assessments should include the direct observation of ADLs and the type of assistance needed to perform them. While specific performance tests of certain ADLs (e.g., toileting) may be unavailable, others can be easily observed (e.g., transferring or eating). Space should be provided in the assessment instrument for direct
The literature suggests that the client’s self-report of functional limitations should be the primary data source for clients without cognitive impairment, as they have been found to be more accurate than family or physician reports (Elam, 1991; Kovar & Lawton, 1994). However, if the client shows signs of cognitive impairment or is unable to answer ADL questions, we recommend that the augmented Katz ADL questions be asked of caregivers to supplement self-report information and direct observations. For patients with moderate or severe dementia, patient self-reports provide important clinical data but should be supplemented with caregiver reports, as the capacity for self-observation of ADL dependence may only be partially preserved (Kiyak, Teri, & Borson, 1994).

Finally, we recommend that a “safe harbor” be established for insurers who wish to certify as eligible for benefits those individuals needing assistance equivalent to what is required by someone with two ADL impairments, but who do not explicitly meet existing CPLTC (or HIPAA) criteria. Examples are persons with multiple partial ADL deficits (requiring periodic hands-on assistance or supervision in a number of areas) or persons with one qualifying ADL deficit and multiple IADL deficits (e.g., taking medications, preparing meals, handling money).

Cognitive Impairment

**CPLTC 1993, § 58010.** “Cognitive Impairment” means confusion or disorientation resulting from a deterioration or loss of intellectual capacity that is not related to, or a result of, mental illness, but which can result from Alzheimer’s disease, or similar forms of senility or irreversible dementia. This deterioration or loss of intellectual capacity is established through use of standardized tests or instruments prescribed or approved by the California Partnership for Long-Term Care.

**CPLTC 1993, § 58059.** The Mental Status Questionnaire (MSQ), and the Folstein Mini Mental State Examination will be used to assess Cognitive Impairment. Policy and Certificate holders will be deemed to have met the Cognitive Impairment criteria for the Insured Event by:
(1) Failing to answer correctly at least seven of the ten questions on the MSQ test; or,

(2) Exhibiting specific behavior problems requiring daily supervision, including but not limited to wandering, abusive or assaultive behavior, poor judgment or uncooperativeness which poses a danger to self or others, and extreme or bizarre personal hygiene habits, and failing to answer correctly at least four questions on the MSQ or achieving a score of 23 or lower on the Folstein Mini Mental State Examination.

_CPLTC 1999, § 58035._ “Severe Cognitive Impairment” means a loss or deterioration in intellectual capacity that:

(a) is comparable to (and includes) Alzheimer’s disease and similar forms of irreversible dementia and;

(b) is measured by clinical evidence and standardized tests prescribed or approved by the California Partnership for Long-Term Care.

**Analysis of Case Records**

Reports to CPLTC by insurance carriers indicated that 12 of the 35 policyholders in our sample reportedly experienced cognitive impairment sufficient to qualify as an insured event, while 23 policyholders did not experience such cognitive impairment. Our review of benefit eligibility assessments found that nine policyholders appeared to meet the CPLTC cognitive impairment criteria. Three of the policyholders reported by insurers as having cognitive impairment sufficient to qualify as an insured event were not found to meet all of the CPLTC cognitive impairment criteria. Of the 23 policyholders reported by insurers as not having cognitive impairment sufficient to qualify as an insured event, none were found to meet CPLTC cognitive impairment criteria (Table 3).

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<thead>
<tr>
<th>Cognitive Impairment Reported as Having Cognitive Impairment</th>
<th>Reported as Not Having Cognitive Impairment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Met criteria</td>
<td>9</td>
</tr>
<tr>
<td>Did not meet criteria</td>
<td>3</td>
</tr>
</tbody>
</table>
The records of the three policyholders reported by insurers as having cognitive impairment but not found to meet CPLTC cognitive impairment eligibility criteria were examined carefully to identify the source of the discrepancy. One of these policyholders (#03) was reported to have a score of 10 on the Short Portable Mental Status Questionnaire (SPMSQ) and a score of 28 on the Folstein Mini-Mental State Examination (MMSE), although copies of these tests could not be found in the case records provided to us. However, the policyholder apparently was sufficiently cognitively intact to sign a form indicating that s/he agreed to the service plan prepared by the care manager. The policyholder’s spouse indicated that the policyholder had a “tendency to wander,” although the interviewer indicated that “it was difficult to determine the extent of his/her deficit being related to cognitive impairment or difficulty [in] hearing.” A second policyholder (#33) had an SPMSQ score of 6 and an MMSE score of 19; however, there was no evidence of specific behavior problems requiring daily supervision. A third policyholder (#47) had an SPMSQ score of 7 and an MMSE score of 25. Although reported by the insurer as requiring daily supervision because of poor judgment, case records did not provide evidence of impaired judgment or other specific behavior problems. Problems in living independently were attributed to “drinking heavily and not eating well,” rather than to a deterioration or loss of intellectual capacity resulting from irreversible dementia.

Findings Regarding Benefit Eligibility Assessment

BEA instruments do not directly assess changes in cognitive functioning over time (e.g., “deterioration or loss of intellectual capacity”); nor can such changes be determined from scores on the SPMSQ or MMSE.
The MMSE and SPMSQ are administered to every policyholder. However, the MMSE does not appear to be required in cases in which scores on the SPMSQ are less than 4 or greater than 7. Nor does the MMSE appear to be required when policyholders do not exhibit specific behavior problems requiring daily supervision. Moreover, the initial 10 items on the MMSE are redundant with the SPMSQ. Copies of the SPMSQ and MMSE may be found in the Standardized Eligibility Assessment Tool in Appendix B.

All BEAs collect information about the presence of the specific behavioral problems indicated in the CPLTC regulations. But one of the BEAs does not appear to assess whether these behavior problems necessitate supervision.

Although two BEAs ask assessors to provide an explanation or description of any observations of behavior problems or the need for supervision, we could find no evidence of such observations. One BEA excludes observations from the list of desired information sources, instructing assessors to “obtain information . . . either from the patient’s professional caregiver, medical records/chart, or relative.”

Only one BEA instrument assesses whether “depression appear[s] to be the primary cause of any difficulty in functioning . . . exhibited by the client;” however, no guidelines are provided to assist the assessor in making this determination, which can be difficult even for experienced practitioners. One BEA instrument asks only whether the client “appears to be depressed, lonely, or isolated.” The other BEA instrument does not appear to gather any information that might be used to determine whether cognitive impairment is “related to, or a result of, mental illness.”

None of the BEA instruments addresses other possible reversible causes of dementia, such as polypharmacy, malnutrition, dehydration, thyroid dysfunction, or bacterial infection.
**HIPAA**

Under HIPAA, a person may be defined as “chronically ill” if s/he has been certified as “requiring substantial supervision to protect [the] individual from threats to health and safety due to severe cognitive impairment” (HIPAA, § 321c2Aiii). Severe cognitive impairment means “a loss or deterioration in intellectual capacity that is (a) comparable to (and includes) Alzheimer’s disease and similar forms of irreversible dementia, and (b) measured by clinical evidence and standardized tests that reliably measure impairment in the individual’s (i) short-term or long-term memory, (ii) orientation as to people, places, or time, [or] (iii) deductive or abstract reasoning” (IRS, 1997). Substantial supervision means “continual supervision (which may include cuing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect the severely cognitively impaired individual from threats to his or her safety.” The regulations and interim guidance memo do not specify the clinical evidence or standardized tests that should be used to assess cognitive impairment. All of the nine policyholders in our sample who experienced cognitive impairment sufficient to qualify as an insured event under CPLTC criteria would also have qualified under HIPAA criteria.

**Comparison of CPLTC and HIPAA Criteria**

The HIPAA cognitive impairment criteria are more general than the CPLTC criteria. However, almost all of the HIPAA criteria can be met with the use of CPLTC instruments. Our review of current BEA instruments used to assess CPLTC eligibility found the following:

- One BEA assessed “threat to health or safety,” but not the need for continual supervision.
Two BEAs assessed the need for supervision, and whether there were “cognitive deficits that pose a threat to [the policyholder’s] ability to remain in the community.”

The HIPAA criteria do not require specific standardized instruments to measure cognitive impairment. The SPMSQ and the MMSE, required under CPLTC, could be used to meet the HIPAA requirement of the use of a reliable standardized test to measure short- and long-term memory and orientation, but only the longer MMSE somewhat meets the HIPAA requirement for assessment of deductive or abstract reasoning. In cases in which only the SPMSQ is used to determine severe cognitive impairment under CPLTC criteria, the HIPAA eligibility criteria will not explicitly be met.

While the CPLTC regulations specify the scores that qualify an individual as cognitively impaired, the HIPAA does not. However, the scores specified by the CPLTC are typically the cutoffs used to define “severe” impairment under these tests, and have been adopted as such for CPLTC TQ policies.

HIPAA criteria require “clinical evidence” of cognitive impairment, while CPLTC does not. However, if evidence from the standardized instruments is considered “clinical,” then the CPLTC assessment does meet this HIPAA criterion.

The HIPAA criteria do not specifically exclude cognitive impairment that may be a result of mental illness. However, they do require that impairment be an irreversible form of dementia. To the extent that cognitive impairment due to mental illness is reversible, then the CPLTC and HIPAA criteria are similar;
otherwise, the CPLTC criteria require a more detailed assessment of the *reasons* for the client’s cognitive impairment.

- Under the HIPAA criteria, cognitive impairment requires substantial supervision to protect the individual from threats to health and safety, whereas CPLTC criteria can be met based on the SPMSQ score alone. If behavioral disturbances are assessed under CPLTC, then they may meet the HIPAA criteria, as long as one treats the CPLTC requirement for “daily supervision” the same as the HIPAA requirement of “continual supervision.”

- It is not clear whether certain deficits, such as an inability to take medications or perform IADLs because of memory impairment, constitute a “need for continual supervision to protect the severely cognitively impaired individual from threats to his or her safety.”

*Recommendations Regarding Cognitive Impairment*

*Assessing cognitive impairments through standardized instruments*

We recommend using the original 10-item SPMSQ from Duke University (1978) and Folstein’s 11-item version of the MMSE for English-speaking clients (1975). The literature on both the SPMSQ and the MMSE indicate that these scales are widely used and reliable and valid (Albert, 1994). The CPLTC eligibility criteria can in some cases be met with the SPMSQ alone, but in other cases require administering both the SPMSQ and the MMSE, whereas the HIPAA criteria can be met by administering the MMSE alone. Therefore, we recommend that the SPMSQ be utilized as a screening tool in all pre-1997 policies, accompanied by the MMSE for all policyholders scoring less than 7 out of 10
correct on the SPMSQ. Although CPLTC TQ regulations appear to require the SPMSQ for post-1996 policies, other TQ policies require only the MMSE.

However, there are issues in using these short assessment instruments among different populations, such as those with a low level of education and non-English-speaking populations. For example, when using these scales, it should be recognized that scores vary by education (Pfeiffer, 1975; Murden et al., 1991; Albert, 1994). In the original SPMSQ (Pfeiffer, 1975), the scoring should allow one more error if the subject has had only a grade school education (8 years or less), and allow one less error if the subject has any education beyond high school (more than 12 years). The literature on the MMSE also suggests adjusting scores for education. A score of 23 or less to identify cognitive dysfunction is appropriate for groups with 9 or more years (junior high or more) of education, while a score of 17 or less is appropriate for those with less than 9 years of education. These cutoffs maximize sensitivity and specificity at 93 percent and 100 percent for the high education group, and 81 percent and 100 percent for the low education group, respectively (Murden et al., 1991). Therefore, we recommend that all eligibility assessment instruments collect information on the client’s educational background in order to allow for the adjustment of cognitive impairment screening scores.

Another issue concerning the use of these established scales is their validity and reliability among ethnic and minority groups. In addition to differences in education and literacy, differences in language and cohort experiences may influence the assessment process and outcome. While both the SPMSQ and MMSE have been translated into different languages, items such as (repeating) “no ifs, ands, or buts” probably cannot be properly translated from English into other languages (Tang, 1996). Nevertheless,
Spanish-language versions, the S-MMSE and the S-MSQ, have been found to be reliable in discriminating between Alzheimer’s and non-demented Spanish-speaking elderly populations (Taussig, Mack, & Henderson, 1996). For the purposes of CPLTC criteria, which require the use of these specific instruments, we recommend using the S-MMSE and S-MSQ with clients who prefer to speak Spanish. Research suggests that the scores from the S-MMSE, like the English version, should be adjusted for educational level (Taussig, Mack, & Henderson, 1995; Mungas, 1996). Mungas (1996) found that differences in MMSE scores among English-speaking Hispanics, English-speaking non-Hispanics, and Spanish-speaking Hispanics were no longer statistically significant after controlling for the effects of education and age. Spanish versions of the MSQ and the MMSE from Taussig, Mack, & Henderson (1996) are included in the Standardized Eligibility Assessment Tool (Appendix B).

For the purposes of assessing eligibility under HIPAA criteria, instruments other than the MMSE and SPMSQ may be used. The Cognitive Abilities Screening Instrument (CASI), for example, is a short assessment instrument available in English, Spanish, Chinese, and Japanese that assesses the domains required under HIPAA eligibility criteria (Tang, 1996). Among these populations, different versions of the CASI can be used for literate versus illiterate populations. Also, since most of the CASI items were taken or modified from the MMSE, the MMSE score that can be calculated from the English version CASI has been found to be very close to scores from an independently administered MMSE (Tang, 1996).

We recommend that a “safe harbor” be established for insurers who wish to utilize the CASI or a comparable standardized instrument for assessing cognitive functioning other than the MMSE or SPMSQ. We also recommend that a safe harbor be
established for insurers who wish to certify as eligible for benefits those individuals who have levels of cognitive impairment requiring assistance equivalent to what is required by someone who “fail[s] to answer correctly at least four questions on the MSQ or achiev[es] a score of 23 or lower on the Folstein Mini Mental State Examination” (e.g., individuals with intermittent cognitive impairment, or individuals with mild cognitive impairment that poses a threat to health or safety).

**Behavioral disturbances**

Many instruments are available to measure behavioral disturbance that have been tested to be both reliable and valid, as reviewed by Teri & Logsdon (1994). Many of the instruments are designed to assess patients who have already been diagnosed with Alzheimer’s disease or cognitive dysfunction.

We recommend using an aggregated version of the Behavioral Pathology in Alzheimer’s Disease (BEHAVE-AD) scale (Reisberg, 1987) to assess behavioral disturbances and threats to individual safety. The BEHAVE-AD scale, reviewed by Teri & Logsdon (1994), is administered to the caregiver by an interviewer. It has been found useful with both outpatients and nursing home residents and with patients with moderate to severe dementia. The original BEHAVE-AD includes 26 assessment measures covering characteristic behavioral symptoms that commonly occur in an Alzheimer’s patient. The symptoms assessed reflect behaviors that are frequently disturbing to caregivers and that are presently thought to be potentially remediable, but which are largely independent of the primary, currently unremediable, cognitive symptomology (Reisberg, 1987).
Questions about behavioral disturbances should be asked of the individual identified as the primary caregiver, rather than the client. However, the interviewer should also be instructed to note any potential behavioral problems that may be observed. An aggregation of the BEHAVE-AD could include a question for each of the seven subgroups identified in the BEHAVE-AD: paranoid and delusional ideation, hallucinations, activity disturbances, aggressiveness, diurnal rhythm disturbances, affective disturbances, anxieties, and phobias. While the original BEHAVE-AD scale asks only if the behaviors in the scale are present or not, to meet CPLTC and HIPAA criteria we recommend asking if supervision is required because of the reported behavior problems. The BEHAVE-AD includes no cutoff points for “scoring” behavioral difficulties; however, CPLTC and HIPAA criteria are met if the client exhibits any behavioral problems that require daily supervision. An example of a revised, aggregated BEHAVE-AD scale, for the purposes of CPLTC and HIPAA criteria, is included in the Standardized Eligibility Assessment Tool in Appendix B.

Exclusion of reversible cognitive impairment

CPLTC and HIPAA regulations require that cognitive impairment be “irreversible,” and CPLTC criteria also require that impairment not be due to mental illness. The short assessment instruments used to determine cognitive impairment are not designed to distinguish irreversible organic deterioration from mental illness or other reversible causes of the impairment. Nor is any “standardized” assessment instrument designed for these purposes.

Among the major causes of reversible dementia are polypharmacy, malnutrition, dehydration, thyroid dysfunction, bacterial infection, and depression. Potential
physiological causes can and should be ruled out through laboratory tests (e.g., T4) and a careful history.

Accurate assessment of irreversible dementia versus depression is often difficult in elderly subjects. However, Ware & Carper (1982) identify a number of criteria that can help to distinguish dementia from depression. For example, in the case of depression, patients and families are often aware of psychiatric dysfunction and can date its onset; but in dementia, patients and families are often unaware of the slow, insidious onset of cognitive dysfunction (Ware & Carper, 1982). Also, patients with dementia are more apt to attempt to answer questions, even if they don’t know the answers, while depressed patients will often answer “don’t know.”

Common manifestations of depression in the elderly include psychomotor retardation and impairment of attention, concentration, memory, and initiative. These manifestations are easily mistaken for Alzheimer’s disease, but in depressed patients are more amenable to therapeutic intervention (Ware & Carper, 1982). Moreover, dementia and depression often co-exist together (Pancha, Gallagher-Thompson, & Thompson, 1994; Teri & Logsdon, 1994); an estimated 20 to 30 percent of patients with dementia are also depressed, and 20 percent of patients with depression exhibit cognitive impairment.

In cases where reversible cognitive impairment may be present, we recommend that eligibility assessment include laboratory tests and a medical review to rule out possible physiological causes of reversible dementia. We also recommend that the eligibility assessment instrument include probes to attempt to detect the possibility of depression or other forms of mental illness. Answers to these questions cannot definitively determine that cognitive impairment is due to mental illness or that cognitive
impairment is reversible, but they can indicate the need for a more detailed, clinical
assessment (e.g., by a physician or neuropsychologist). For example, the caregiver might
be asked if the client has had a history of mental illness or depression, and could then be
asked a number of questions about the history and characteristics of the client’s cognitive
dysfunction that might distinguish between cognitive impairment due to dementia and
due to depression. The Standardized Eligibility Assessment Tool (Appendix B) includes a
suggested list of questions based on clinical features differentiating depression from
Alzheimer’s disease identified by Ware & Carper (1982).

If the answers to these questions indicate that the patient’s dysfunction may be due
to depression, if the client had many answers of “don’t know” in the SPMSQ or MMSE
tests, or if the caregiver reports a history of depression or other mental illness, then we
recommend administering the 15-item Geriatric Depression Scale (GDS). The GDS is a
sensitive and widely accepted self-report scale for screening in a geriatric population
(Pancha, Gallagher-Thompson, & Thompson, 1994). A score of 5 to 9 on this scale
indicates mild depression, while a score of 10 to 15 indicates severe depression. If the
answers on this scale indicate either mild or severe depression, a more thorough clinical
assessment with a physician or neuro-psychologist should be conducted to rule out the
possibility that the cognitive impairment is “related to, or a result of” depression. The
GDS is included in the Standardized Eligibility Assessment Tool (Appendix B).
Translations of the GDS into more than 16 languages are available on the Internet at
http://wings.buffalo.edu/~drstall/>. 
Complex, Stable Medical Condition

*CPLTC 1993, § 58011.* “Complex, Yet Stable Medical Condition” means that [a] twenty-four (24) hour a day nursing observation, or professional nursing intervention more than once a day, in a setting other than the acute care unit of a hospital is medically necessary, that is, the observation or intervention has been prescribed by a physician and it is not designed primarily for the convenience of the insured or the insured’s family.

Note: CPLTC 1999 and HIPAA regulations do not include “complex, stable medical conditions” as an eligibility criterion.

Analysis of Case Records

Reports to CPLTC by insurance carriers indicated that 5 of the 35 policyholders in our sample reportedly experienced a complex, yet stable medical condition, while 30 policyholders did not. Our review of benefit eligibility assessments found that four of these five policyholders appeared to meet all CPLTC criteria for a complex, yet stable medical condition (Table 4). The one policyholder (#03) that did not appear to meet CPLTC criteria for having a complex, stable medical condition apparently required a home health aide rather than professional nursing observation or intervention. None of the 30 policyholders reported by insurers as not having a complex, yet stable medical condition appeared to meet CPLTC criteria for this condition. One policyholder (#14) met CPLTC eligibility criteria for an insured event based solely on the presence of a complex, stable medical condition; i.e., this policyholder did not also meet CPLTC functional or cognitive impairment criteria.

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<th>Table 4. Complex, Stable Medical Condition Reporting</th>
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<tr>
<td>Complex, Stable Medical Condition</td>
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<td>Met criteria</td>
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<td>Did not meet criteria</td>
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Summary of Findings Regarding Medical Condition

Information about the need for professional nursing observation or intervention was frequently found in a physician’s order for home health care or skilled nursing care, rather than as a part of the standard BEA. In most cases, it could not be determined whether or not professional nursing care was required on a daily basis. None of the care plans specifically included professional nursing care as a needed service.

Only one BEA specifically indicated whether a policyholder required continual nursing observation or daily professional nursing intervention. Another BEA asked the assessor to indicate the presence of a “complex unstable condition,” but apparently did not provide guidance on how this was to be determined. At least 10 of the 35 benefit eligibility assessments reviewed did not address whether professional nursing observation or intervention was needed.

The professional nursing care needed included administering medications (e.g., insulin injections for diabetes, analgesics for pain control, IVs for cellulitis) and observation (e.g., monitoring of cellulitis, coordination of terminal care). In one case, a BEA indicated that “professional nursing intervention at least once a day” was needed, but in fact the assessor was referring only to the policyholder’s need for assistance with ADLs. None of the BEAs apparently assessed either the client’s or the family’s ability to provide care.

Recommendations Regarding Medical Condition

There are no established geriatric assessment instruments that assess the presence of a complex, yet stable medical condition. In gathering information on this eligibility criterion, questions should attempt to assess the need for nursing observation or profes-
sional nursing care without having to rely on “physician certification.” However, if the complex, stable medical condition eligibility criterion cannot be definitively assessed using the information collected, a physician will need to verify eligibility. Therefore, we recommend that the eligibility assessment interview should include the name and number of the treating physician(s).

We recommend including in the eligibility assessment instrument a set of questions asking if the client has specific medical conditions that may require professional nursing care. The assessment should ask about the date of onset, the nature of the condition, and if the nursing care has been prescribed by a physician. A second set of questions could ask about the receipt of specific skilled nursing tasks, such as IV treatments, infusion therapy, inhalation therapy, injections, and medication management. For each treatment that the client reports needing, the assessment could ask about the frequency and the provider of the care (professional or informal caregiver), and whether the treatment could conveniently be provided by the policyholder’s family. Examples of these questions are included in the Standardized Eligibility Assessment Tool (Appendix B).

Qualifications of Assessors

*CPLTC 1993, § 58007.* “Care Manager” means a person who, either alone or as part of a team, is responsible for performing assessments and reassessments, developing Plans of Care, coordinating the provision of care, and monitoring the delivery of services.

*CPLTC 1993, § 58070.* Care Managers shall meet or exceed both of the following qualifications:

1. be a registered nurse and/or graduate of an accredited four year college or university with a degree in nursing, health, social work, gerontology or other related area: and

2. have a minimum of two years of experience in the human service field, ideally in community-based care. A master’s degree in nursing, health, social work, gerontology or a related field may be substituted for one year of experience.
Analysis of Case Records

BEAs were examined to identify the name and professional qualifications of the person performing the assessment. In 25 of the 35 cases reviewed, assessments were performed by an RN, PHN, or BSN. In two cases, assessments were performed by a licensed social worker. In the other eight cases, assessments were conducted by either an LVN (two cases) or an unlicensed, baccalaureate social worker with at least 2 years of experience (six cases).

HIPAA

The HIPAA criteria for assessor qualifications are more restrictive than CPLTC criteria. HIPAA requires that policyholders be certified as “chronically ill” by a licensed health care practitioner, which includes physicians, registered professional nurses, and licensed social workers.

In 27 of the 35 cases reviewed, assessors met HIPAA criteria as licensed health care practitioners. In the eight cases in which the assessor did not meet HIPAA criteria, documentation indicated that the benefit eligibility decision was made by an RN or licensed social worker based on the assessment report.

In 12 of the 35 cases, a physician’s assessment was also present in the case record. In six of these cases, the physician’s assessment concurred with the finding of the care manager, whereas in six cases it did not. Case records did not show any documentation indicating any attempts to resolve these discrepancies. However, it is notable that the discrepancies were always resolved in favor of the care manager rather than the physician, even when the care manager did not meet HIPAA criteria as a licensed health care practitioner.
**Recommendations Regarding Assessors**

It is not clear from the HIPAA regulations whether “certification” requires actual assessment and face-to-face contact with a policyholder, or whether a physician, professional nurse, or licensed social worker can certify an individual as chronically ill based on an assessment performed by an unlicensed assessor. However, given the expertise necessary to gather accurate information for making a complicated assessment of policyholders’ functional and cognitive impairment, we recommend that only trained professionals perform eligibility assessments to best assure the accuracy and reliability of the assessments. Moreover, given the finding that even some licensed health professionals (e.g., physicians) appear to disagree about policyholders’ level of impairment and eligibility for benefit, we recommend that assessors receive training in performing accurate assessments of functional and cognitive impairment. We also recommend that each BEA include the name and credentials of the person performing the assessment. Practice Standard 10 in Table 1 of Appendix D calls for assessments to be performed by trained professionals.

**Reassessment**

*CPLTC 1993, § 58004c, and CPLTC 1999, § 58005c.* “Care Management . . .” includes, but is not limited to the following:

(c) the performance of a comprehensive, individualized reassessment at least every six months.

**Analysis of Case Records**

During the 6-month period of data collection, 17 of the 33 policyholders received a reassessment. Of the 17 reassessments completed, 16 were scheduled 6-month follow-up reassessments completed within or at 6 months, and one
was completed before 6 months due to a change in the policyholder’s condition. Of the remaining 16 cases, 14 were closed before the scheduled reassessment, either because the policyholder died (4) or because benefits were terminated (10). Two policyholders were reassessed after 6 months because of extenuating circumstances—one policyholder was hospitalized and unavailable, and the other one was in the midst of appealing the denial of benefits.

Policyholder Interviews

At the time of their initial interview by a member of the research team, policyholders were asked whether they knew how soon the next assessment of their situation would be done, and under what circumstances. Seven of the 19 policyholders interviewed knew that the assessment would be done, but only five knew why it was to be done. The remaining policyholders did not know or confused the reassessment with coordination and monitoring done by the care advisor.

When interviewed at the end of our study period, 8 out of the 19 policyholders stated that their care managers/care advisors had visited them recently. Seven of these eight policyholders accurately understood the purpose of the reassessment visit. Of the eight policyholders reassessed recently, seven of them indicated that the care manager/care advisor had an accurate picture of their abilities and disabilities as a result of the reassessment interview. Two of these seven policyholders stated that the care manager was “very thorough.” One policyholder stated that the care manager did not ask about all ADLs, specifically toileting. One policyholder stated that the care manager did not seem to have an accurate picture, “She did not really go into it . . . a quickie visit that skimmed the surface.”
When asked whether there was anything that might have prevented the care manager/care advisor from getting an accurate picture of their abilities and disabilities, three of the eight policyholders stated that there were obstacles. They mentioned the care manager’s lack of time, the policyholder’s difficulty in accurately communicating his/her functioning level, and fluctuations in the policyholder’s condition. One daughter indicated that her mother, the policyholder, has “such highs and lows . . . Mother can be clear one day and not at all the next day . . . time of day makes a difference.”

Two of the eight policyholders who were reassessed had suggestions for changing the reassessment process. Their suggestions included carefully choosing care managers according to particular clients’ needs, for example using someone with “sensitivity” to handle policyholders with dementia, and having the same person conduct all assessments and reassessments for the same policyholder.

**Summary of Findings Regarding the Eligibility Determination Process**

In this chapter we examined the experiences of California Partnership policyholders with the process of eligibility assessment and determination, based on a careful review of 35 case records and interviews with 19 policyholders. We examined these experiences in light of eligibility criteria for long-term care benefits under the California Partnership for Long-Term Care and for “tax-qualified” status under the Health Insurance Portability and Accountability Act of 1996.

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 the policyholder fell and fractured a bone, leading to residential care. In each of these cases, it seems possible that earlier
intervention might have relieved some of the burden on the caregiver, perhaps reducing
the likelihood that caregivers would become overwhelmed or ill, or that policyholders
would require placement.

Our review of assessment information and other available documentation found
support for insurer eligibility determinations in 32 out of 35 cases reviewed. Three
policyholders deemed eligible by insurers did not appear to meet a strict interpretation of
CPLTC criteria, although each of them displayed sufficient impairment to warrant
receiving assistance. No one was found to have been denied benefits inappropriately.

A review of eligibility assessment protocols found a number of inconsistencies
that could reduce the accuracy of eligibility determinations. For example, the Benefit
Eligibility Assessment instruments currently in use differ somewhat with regard to how
each ADL is defined and what is considered indicative of an ADL deficiency; moreover,
they seldom include direct observation of ADL performance or of behavior problems
necessitating supervision. Potentially reversible causes of dementia, such as depression,
polypharmacy, and malnutrition, were seldom assessed. Finally, the need for
professional nursing care, a CPLTC eligibility criterion, was seldom assessed.

In general, the CPLTC benefit eligibility criteria were found to be more stringent
than the HIPAA criteria; that is, a client found eligible under a CPLTC policy for a
functional or cognitive impairment would also meet HIPAA criteria, although slight
differences between Tax-Qualified (TQ) and Non-Tax-Qualified (NTQ) policies
regarding functional impairment eligibility criteria suggest that different assessment
instruments may be required for post-1996 and pre-1997 policies.

Since the HIPAA eligibility criteria consider only functional and cognitive
impairment, while the CPLTC includes an additional criterion of a complex, yet stable
medical condition, clients who qualify for CPLTC benefits under this last criterion may not meet HIPAA eligibility criteria. Our study found one policyholder who met this last eligibility criterion alone, and who therefore would have qualified for eligibility under CPLTC criteria but not under HIPAA criteria. It should be noted that policyholders who qualify for eligibility under CPLTC policies are considered to have met the “tax-qualified long-term care services” requirement under HIPAA.

**Recommendations Regarding the Eligibility Determination Process**

Based on our analysis of current eligibility determination procedures and a review of the geriatric assessment literature, we have identified the following recommendations for enhancing the eligibility determination process in accordance with CPLTC and HIPAA regulations:

- When assessing ADL functional impairment, include information on the degree of help needed (e.g., hands-on versus stand-by), as well as the expected duration of each ADL deficit.
- Directly observe ability to perform ADL tasks whenever possible.
- Supplement client self-reports of functional impairment with information from caregivers in cases in which clients show signs of cognitive impairment or confusion.
- Assess cognitive impairment utilizing standardized instruments with proven reliability and validity, such as the Folstein Mini-Mental State Examination (MMSE).
- Adjust cognitive impairment scores on the SPMSQ and MMSE for number of years of formal education, so as to remove bias related to educational background.

- Use linguistically and culturally appropriate cognitive assessment instruments. When English is not a client’s primary language, use translated versions of the SPMSQ and the MMSE or a cognitive assessment instrument designed specifically for cross-cultural use (such as described in Tang, 1996).

- Collect information from family members or other caregivers regarding client behavioral disturbances and safety threats when these behaviors are not directly observed. Assess the degree of supervision needed, if any.

- Collect information needed to distinguish between cognitive impairment due to irreversible dementia and cognitive impairment due to depression or other potentially reversible causes.

- Assess for the presence of a “complex, yet stable” medical condition, especially in those cases in which clients do not otherwise qualify for eligibility under functional or cognitive impairment criteria.

- Use trained professionals to conduct eligibility assessments in order to assure the integrity of the assessment and to meet HIPAA requirements.

In Table 1 of Appendix D, we identify “quality indicators” for each of these recommendations. The quality indicators are objective, measurable items that can be found in the eligibility assessment instrument and the client’s eligibility assessment records, and that can serve as a checklist that a thorough and competent eligibility assessment has been performed.
In Appendix B, we give examples of augmented, well-established assessment tools that can be used to assess the specific eligibility criteria identified under CPLTC and HIPAA regulations. We also provide an example of a summary sheet for recording the results of the entire assessment, including: the number of ADLs requiring assistance; the score, adjusted and unadjusted, on the MMSE and SPMSQ or translated versions; results from the aggregated BEHAVE-AD scale, if administered, indicating the presence of behavioral problems requiring supervision; results from the questions to rule out depression as a cause of cognitive impairment, if administered, and any recommendation for further psychiatric screening; the score on the GDS, if administered; medical conditions; the need for constant nursing observation or daily nursing intervention, and whether this care has been prescribed by a physician; and the need for medication management.