

# The Independent In-Person Assessment Process

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*The Community Living Assistance Services and Supports (CLASS) Plan – a groundbreaking component of the Affordable Care Act – creates a voluntary federally-administered insurance program to help individuals pay for needed assistance in a place they call home if they become functionally limited. Implementation will require knowledge translation from various sectors, including research and existing public and private programs. This Technical Assistance Brief Series seeks to answer questions pertinent to developing and implementing the program.*

This brief provides information on the benefit eligibility assessment process in the private long term care insurance industry. It focuses on how long-term care insurers use the information in the adjudication process, who is involved in the process, and how Activities of Daily Living and cognition are assessed. This is particularly important because one of the first responsibilities of those charged with implementing the CLASS Plan is to develop an assessment system for eligibility for CLASS benefits.

## Introduction and the Role of the Independent In-Person Assessment in the Adjudication Process

LifePlans interviewed and surveyed managers involved in the claims adjudication process from the majority of long-term care (LTC) insurance carriers selling policies in the market. We asked a series of questions related to the role of the in-person benefit assessment within the claim adjudication process and how individual activities of daily living (ADLs) and cognitive status are measured. We did this by examining a sample of commonly used benefit determination assessment instruments used by carriers.

In the LTC claim adjudication process, insurers focus on managing three types of risks associated with a claim: (1) the risk of a LTC Insured going on claim (“incidence risk”); (2) the risk

associated with the insured receiving the appropriate level of service (“intensity risk”); and (3) the risk associated with making sure that the length of time that the individual is on claim is in line with continued underlying need (“durational risk”).

Benefit eligibility assessments play a critical role in LTC risk mitigation strategy. Many LTC carriers rely on independently-performed in-person assessments to determine whether the “insured-for event,” that is, functional dependence or cognitive decline, has indeed occurred. In essence, information collected on the benefit eligibility assessment serves as the foundation for the proof of loss required to adjudicate the claim. The assessment provides the carrier with independently collected information from a licensed healthcare practitioner and focuses on the following domains: demographics, diagnosis, physical function, cognition and behavior, health service history, home modification, fall history, medication use and administration, current service plans, a general summary of clinical observations, and information on the facility provider or private caregivers (if they are in place).

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The focus of the information is to fully understand and evaluate the individual’s cognitive and functional status, which is a prerequisite to determining whether they are a chronically ill individual and thus eligible for insurance benefits.

Additionally, face-to-face assessments are used not only as the basis for the benefit eligibility determination but also as a tool in managing the intensity risk. The assessment can be a primary source of information in the development of a plan of care. When this is the case, the assessment instrument includes a more detailed health history, evaluation of the Instrumental Activities of Daily Living (IADLs) which include such things as medication management, meal preparation, housekeeping, laundry, grocery shopping, transportation, money management, telephone use, and a needs assessment. Finally, use of periodic in-person reassessments are required to establish that the level of functional or cognitive impairment requires an ongoing need for service and that the individual is receiving services for the correct amount of time. Thus, the assessment is important information source when managing durational risk. The figure on page 3 shows the process in graphic form.

## The Face to Face Assessment Process

To conduct the in-person assessment, an independent field clinician – almost always a Registered Nurse – visits the Insured at his or her residence or in some cases institutional setting. During the visit, the field clinician gathers personal

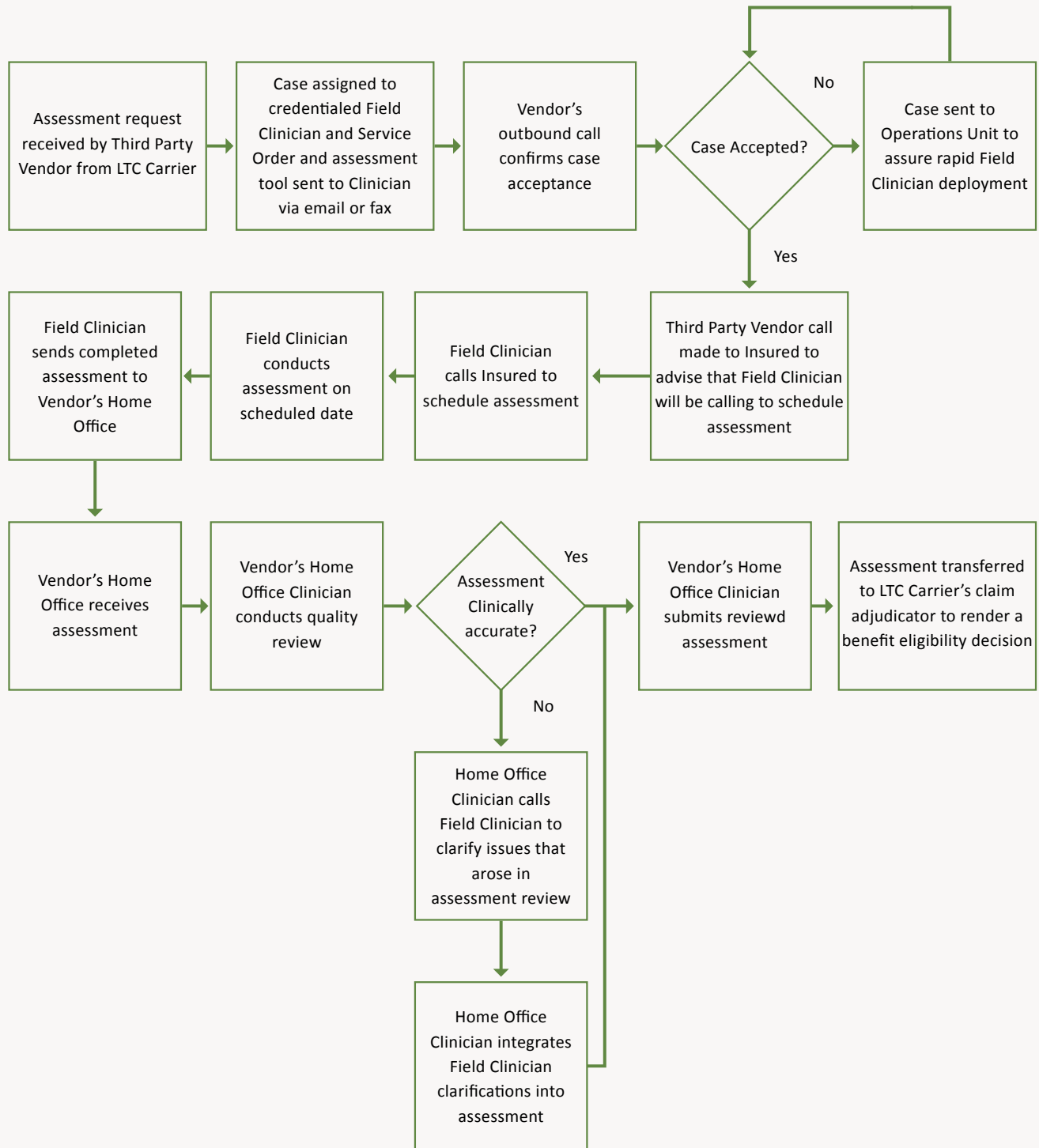
health, service provider and medication information, and conducts a functional, cognitive, and behavioral assessment. Most insurers rely on third-party vendors to supply them with access to a national field network of registered nurses trained to adhere to strict protocols that maximize inter-rater reliability across nurses in various geographical locations and to quickly deploy to the policyholder’s home for the assessment.

The key directive that all clinical assessors must follow is to collect objective information regarding the individual’s status. For this reason, while service providers may provide corroborating information, only rarely is such information relied on as the sole source of benefit eligibility information, especially in home settings. This is because of an inherent conflict of interest for a provider: a finding of functional or cognitive dependence enhances the probability that the individual will receive insurance benefits and that the provider will continue to be reimbursed for the ongoing services that they provide. A finding of functional or cognitive independence puts at jeopardy the provider’s ongoing source of revenue.

### Qualifications of Field Clinicians

Conducting an in-person benefit assessment requires a thorough understanding of chronic illness and the manifestation of specific diagnoses on the functional and cognitive status of the individual. Many LTC carriers require that the clinicians conducting assessments be either registered nurses or licensed social workers, and it is desirable that most have clinical experience working

**FIGURE** Face-to-Face Assessment Process



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with older adults. For the most part, the third party vendors who supply these services to LTC carriers assure that these “field clinicians” are licensed, insured, and cleared through a criminal background check. Typically, specific written and detailed instructions are provided on how to complete each section of the assessment and additional education may be provided through web-based media. As well, most vendors provide clinical support in their home office to assist assessors who may be uncertain about various aspects of process requirements as well as specific assessment items. Field clinicians are instructed not to answer any questions related to the insured’s long-term care coverage, policy or benefit eligibility status but instead, to focus on the collection of objective information. If the Insured asks questions related to the policy, the assessor is instructed to redirect the Insured to the carrier’s claims department.

#### **Quality Assurance**

Quality assurance is a critical component to the success of the assessment data collection process. The performance of field clinicians must be monitored and reviewed closely by the home office clinical staff. As is true in any industry, there are varying levels of quality assurance by providers of assessment services. At a minimum, the vendor should conduct an internal clinical review of each assessment evaluating for clarity, consistency, and completeness of information before sending the information on to the LTC carrier for consideration in the claims adjudication process.

#### **Independent In-Person Assessment Process Flow**

The process begins when the assessment provider receives a request from a carrier via secured website, file feed, telephonic, or fax order. The third party vendor sends the case to a nurse located in the Insured’s area of residence. Special handling instructions along with the precise assessment instrument are typically provided to the assessor electronically to ensure quick turn-around times. The assessor may be required to update the vendor on all steps taken to schedule the appointment with the policyholder so that the information on the progress of the case can be provided to the insurance carrier.

Once the field clinician agrees to take the case, depending on the carrier’s protocols, the vendor notifies the Insured that a nurse will be calling to set up an appointment for the assessment. Typically, the field clinician faxes the completed assessment back to the vendor’s home office shortly after the assessment is conducted. Rapid turnaround is critical in the face-to-face assessment process, and the vast majority of assessments are completed and available for review by the insurer within two weeks. Once the assessment arrives, it undergoes a quality review by a clinician to ensure that all of the functional and cognitive information needed to adjudicate the claim appropriately has been collected. A general work flow process map highlighting the key elements of the assessment process is presented on the page that follows.

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### Assessment Content

As mentioned, the primary purpose of the assessment is to obtain objective information related to the cognitive and functional status of the individual. What follows is a brief description of how this information is collected and scored for the purposes of assessing this status.

### Cognition

Assessments currently employ a number of tools to evaluate the insured’s cognitive ability. The tools most commonly used by long-term care insurers are the Mini-Mental State Exam (MMSE) and the Short Portable Mental Status Questionnaire (SPMSQ).

The Mini-Mental State Examination (MMSE) is the most commonly used quantitative instrument in screening for moderate or severe cognitive impairment.<sup>1</sup> The two part test includes thirty (30) questions that cover the following seven (7) cognitive domains: orientation to time and place, registration, attention, calculation, short term recall, and language and construction (e.g., ability to write a sentence and ability to copy a drawing). The first part of the exam requires solely verbal responses. The second part evaluates the Insured’s ability to write a sentence, name objects, follow verbal and written commands, and copy a complex polygon design.

While the total number of correct answers is summed for a possible maximum score of 30, most normal elderly persons typically score a mean between 27 and 28. Patients with dementia, depression with cognitive impairment, and affective disorders form a continuum with mean

scores for these groups of 9.7, 19, and 25 respectively. While research has found the test to be reliable, other factors like education, occupation, and cultural background also influence MMSE scores. Typically, an individual in the private LTC insurance market, an individual may be coded as having “severe cognitive impairment” if he or she scores less than twenty three (23) on the MMSE. The MMSE is relatively insensitive to early or mild forms of cognitive impairment and is thus an appropriate tool to determine if an Insured is meeting the severe cognitive impairment trigger in tax-qualified LTC policies.

The SPMSQ, developed by Pfeiffer et al. is a second assessment tool used for detecting cognitive impairment.<sup>2</sup> The test requires approximately five to ten minutes to administer and is designed to identify individuals who have intermediate or long-term memory loss or dementia and is accurate over 92% of the time. The SPMSQ is comprised of ten (10) questions that assess the cognitive domains of orientation and working memory.<sup>3</sup> A score of less than six (6) can lead to a classification of severe cognitive impairment.

Neither the SPMSQ nor the MMSE alone can be used to determine severe cognitive impairment for tax-qualified policies. To determine if an insured is severely cognitively impaired, the SPMSQ and MMSE results are considered in conjunction with responses to behavior questions included on the assessment and with the need for verbal cueing assistance with the Activities of Daily Living.

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### Function

In-person assessments evaluate an individual’s functional ability through a comprehensive set of questions about the ability to complete the six standard activities of daily living – bathing, dressing, toileting, transferring, continence, and feeding. The functional review assesses the Insured’s current ability to perform each of these activities with a focus on the nature of assistance that might be required to complete the activity. The assessor renders a judgment about the individual’s capabilities by either requesting that the person demonstrate how the activity is performed and making observations on this performance, or by relying on self-reported information as well as an analysis of the level of assistance received by insured, if services are already in place.

For example, to assess the Transferring ADL, a field clinician may begin with a demonstration request: “Please stand up and sit back down for me,” and documents his or her observations of the Insured’s demonstration. The clinician follows up with a set of questions asking for an Insured self-report or a caregiver report about any assistance to complete each of the component parts of the activity of transferring:

**“Do you receive assistance from another person when transferring?” Including:**

- |                                   |                             |                              |
|-----------------------------------|-----------------------------|------------------------------|
| (a) Getting in and out of bed     | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| (b) Getting in and out of a chair | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

If the Insured responds with a “yes” to either component the clinician may then ask the insured to describe the type of assistance, who provides the assistance, frequency of assistance, start date, and any equipment used. The assessor then integrates direct observation with self-reports and/or caregiver information to determine what type of assistance (if any) is most often required to complete the activity (e.g., no physical assistance, standby assistance, hands-on assistance, or verbal queuing).

## Results of Benefit Eligibility Process

Clearly, while not all companies approach the benefit eligibility and assessment process in exactly the same way, there is a great deal of similarity in approach. The policies and practices of every company comply with HIPAA tax qualification regulations as evidenced by a review of contract language, the approval of such policies by state insurance departments, and the way benefit eligibility triggers are administered by companies.<sup>1</sup> Some degree of variation in how benefit triggers are applied is to be expected given the broad definitions in the law and regulations as well as expected differences in risk management approaches across companies.

<sup>1</sup>Additional considerations for implementing benefit eligibility triggers under the CLASS Plan Design and Implementation are presented in The SCAN Foundation’s CLASS Technical Assistance Series Brief #3: (“Understanding Long-Term Care Benefit Triggers: Contract and Implementation”).



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The key question is whether such variation leads to adverse outcomes for consumers and companies. The empirical evidence is clear on this point: claim denials are relatively low across the industry, consumer satisfaction with the adjudication process is very high, and decisions appear to be consistent with policy language which is in turn consistent with the Health Insurance Portability and Accountability Act (HIPAA) and the National Association of Insurance Commissioners (NAIC) Model LTC Insurance Regulation. More specifically, empirical data derived from an independent review of 1,200 claims decisions made by seven of the largest LTC companies in the U.S. show that auditors only disagreed with 3% of approval decisions and 1% of denial decisions.<sup>4</sup> This suggests that the assessment and benefit eligibility process is enabling claims adjudicators to accurately determine eligibility in line with contract language, which is in conformance with HIPAA eligibility criteria.

Moreover, across the industry, the overwhelming majority of individuals who apply for long-term care benefits meet clinical benefit eligibility triggers and are approved for claim. In fact, on a national level only 4% of claims are initially denied because the Insured does not meet benefit eligibility triggers, which means that 96% are approved.<sup>5</sup> Within a 12 month period, half of the individuals who are initially denied for benefits begin receiving them. Regarding explicit consumer satisfaction with the process, a longitudinal study of a cohort of policyholders who were at the very beginning of the claims process found that

94% either did not have a disagreement with the company or had a disagreement that was resolved satisfactorily; this includes individuals who had their claim approved as well as those whose claim was denied.<sup>6</sup>

Thus, it would appear that the process results in outcomes that are in line with the expectations of consumers themselves regarding benefit eligibility and with HIPAA triggers and NAIC regulations. Finally, the most common reasons why companies seek rate increases relate to assumptions about lapse and interest rates. On an industry wide basis, actual to expected losses (claims) are running slightly below 100%, thus indicating that industry-wide claims experience is somewhat better than what was originally priced into policies.<sup>7</sup> The implication is that insurers have successfully operationalized these benefit eligibility triggers and in conjunction with professional third party vendors, have established an efficient and equitable way to measure them through the in-person assessment process. This helps ensure that actuaries can both price for and adequately measure the underlying risk. This should clearly encourage those charged with implementing similar triggers in the context of the CLASS Plan.

## Considerations for CLASS Plan Design and Implementation

The Community Living Assistance Services and Supports (CLASS) provision

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in the Affordable Care Act requires that an assessment process be developed to determine whether benefits are payable, the degree of impairment that exists, and the amount of benefit that will be paid. The experience of private insurers in applying the HIPAA eligibility criteria in LTC contracts is clearly instructive for policymakers charged with implementing the CLASS Plan. Benefit eligibility triggers in LTC policies have evolved over the past two decades and in a manner that ensures greater consistency and transparency for policyholders. Both the definitions of eligibility triggers as well as the processes used to verify that the triggers have been met have become more precise and enable carriers to

more effectively manage the underlying risk that is being insured. Consumers also have a better understanding of the conditions under which they will receive benefits if and when they become disabled.

A key component in support of a fair and efficient claims adjudication process is the in-person assessment conducted by a licensed health care practitioner, typically a nurse. The assessment tools and training that these individuals receive must be carefully crafted and monitored to ensure that the information that is being collected is clinically accurate, complete, and enables carriers to render decisions that are in line with the underlying policy language related to benefit eligibility.

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