Care Management/Care Coordination

Care Management, also defined as Care Coordination, is a required benefit of Partnership-certified long-term care insurance policies and certificates. The rationale for this requirement is that just providing an insurance benefit payment will not be sufficient in all cases. Some beneficiaries will be unable to secure and coordinate their own care because of their functional/cognitive limitations or the complexity and fragmentation of home and community-based services. Additionally, Care Management, in conjunction with a policy that offers interchangeable benefits and a "bucket of money" is of major value to the policyholder because it provides the opportunity to extend the insurance benefit through the efficient use of coordinated Formal and Informal Care. This, in turn, will result in avoiding or delaying the need for Medi-Cal to fund their long-term care.

Title 22, Chapter 8, Article 1, Section 58059(f) of the California Partnership for Long-Term Care (CPLTC) regulations states:

> "Insurance benefit payments can count toward the Medi-Cal Property Exemption to the extent they are for Long-Term Care Services Countable Toward the Medi-Cal Property Exemption delivered to insured individuals that are part of an individualized Plan of Care approved by the State-approved Care Management Provider Agency as the result of a face-to-face assessment conducted by the Care Management Provider Agency (or its Qualified Official Designee)."

This same section also indicates that charges for the initial assessment and individualized Plan of Care shall not be considered as a claim cost. Charges for care coordination and monitoring may be charged as a claims cost, although several of the Partnership insurers also absorb these costs as an administrative expense. All care management costs, charged as claims costs, are countable towards Medi-Cal Asset Protection.

Statutory Requirements

California Welfare and Institutions Code (W&I), Section 22005.1(b) reads:

> "Only policies and contracts that provide all of the following items shall be certified by the department: (1) Individual assessment and case management by a coordinating entity designated and approved by the department…"

Additionally, W&I Code, Section 22006 states:

> "The State Department of Health Services in determining eligibility for Medi-Cal, and the State Department of Social Services, in determining eligibility for in-home supportive services, shall exclude resources up to, or equal to, the amount of insurance payments or benefits paid by approved and certified long-term care insurance policies…which cover long-term care services to the extent that the benefits paid are for all of the following…"
> "(b) Services delivered to insured individuals in a community setting as part of an

individual assessment and case management program provided by coordinating entitled designated and approved by the State Department of Health Services."

W&I Code, Section 22009 reads as follows:

> "(a) The State Department of Health Services shall adopt regulations to implement this division, including, but not limited to, regulations which establish…" "(4) Which coordinating entities are designated and approved to delivery individual assessment and case management services to individuals in a community setting, as required by subdivision (b) of Section 22006…"

Other Key Partnership Regulatory Requirements:

Title 22, Chapter 8, Article 1, Section 58005 of the CPLTC regulations includes a definition of Care Management that must be used verbatim in all CPLTC-certified policies. The definition is as follows:

> "Care Management/Care Coordination" includes, but is not limited to the following:
>
> (a) the performance of a comprehensive individualized face-to-face assessment conducted in the client's place of residence;
> (b) the development of a Plan of Care
> (c) the performance of a comprehensive, individualized reassessment at least every six months;
> (d) when desired by the individual and determined necessary by the Care Management Provider Agency, coordination of appropriate services and ongoing monitoring of the delivery of such services; and
> (e) the development of a discharge plan when the Care Management Provider Agency services, or the Policy benefits, are about to be terminated and if further care is needed. If the insured is immediately eligible for Medi-Cal, the Care Management Provider Agency shall prepare a transition plan.

Care Management/Care Coordination takes an all-inclusive look at a person's total needs and resources, and links the person to a full range of appropriate services using all available funding sources."

Article 5 of the Partnership regulations contains the Care Management Provider Agency Standards (see attached copy of regulations). Briefly, Article 5 includes:

CPLTC Regulations, Section 58068 - Care Management Provider Agency Functions

Please note in reviewing the regulations that the assessment of the policyholder's needs includes not only physical and cognitive factors, but also the clients' social and emotional functional levels. The individual's functional capacities, family and other support systems, financial status, and current living arrangements are also evaluated. Section 58068(a) includes "…The Care

Management Provider Agency must be able to develop a comprehensive Plan of Care that addresses identified needs in a cost-effective manner."

Partnership-certified policies emphasize consumer choice and flexibility by enabling consumers to purchase an integrated "bucket of money" that can be spent either in the nursing home or at home. While the change in the California Insurance Code change in 1997 required companies to provide a "bucket of money," very few also include a mandatory care management component. If a claimant is able to save money on service costs through a cost effective Plan of Care, their long-term care insurance benefits will stretch further. This is one of several consumer protections built into the Partnership policy that helps to avoid the exhaustion of policy benefits, which in turn, prevents or delays the dependency on Medi-Cal.

Insurers can also benefit from the more efficient use of policy benefits and some provide financial incentives to policyholders that use the Care Management/Care Coordination Agency selected by them. For example, one of the Partnership insurers will waive the elimination period.

CPLTC Regulations, Section 58069 - The Role of the Care Management Supervisor
CPLTC Regulations, Section 58070 - Staff Qualifications
CPLTC Regulations, Section 58071 - Staff Ratios

The above regulations are designed to assure that the Care Management services received under a Partnership policy are of the highest quality. There are no licensure requirements or regulatory oversight for care management organizations in California, except for those that provide services to Partnership policyholders.

CPLTC Regulations, Section 58072 - Client Bill of Rights and Responsibilities

The client Bill of Rights assures the kind of assistance a policyholder and their family require at a time when they may be in an emotional and financial crisis. A common practice, standard in care management, is providing the assurance that the client is able to participate actively in the development of the Plan of Care and to have their wishes and preferences respected. These regulations require that policyholders have a right to actively participate in the development and implementation of the Plan of Care. The client or officially designated representative shall, prior to implementation, receive a copy of the Plan of Care and a written list of all potential service providers to be involved in the implementation of the Plan of Care.

Consumers and policyholders are given assurances in the Bill or Rights that they will be informed of their rights and be given the procedures for filing an appeal on decisions regarding benefit eligibility and the services included in the Plan of Care. It is also required that they be given the procedures for resolving a complaint.

All policyholders must be provided with a discharge plan at the time services are to be terminated or a transition plan, if policyholder is immediately eligible for Medi-Cal. The discharge or transition plan must be completed within 30 days after receipt of notification from the Issuer that coverage will be exhausted.

The CPLTC program staff work very closely with the claims administrators and care managers at the time insurance benefits are close to being exhausted in order to help assure a smooth transition if the policyholder is transitioning immediately to Medi-Cal.

CPLTC Regulations, Section 58073 - Quality Assurance

Partnership regulations require that the Care Management Agency have a written quality assurance program. Included in these requirements is an annual program evaluation, as well as a quarterly service record review. During the quarterly service record review, a committee appointed by the Agency's board of directors, shall review a random sample of active and closed case records. This review is to confirm that the clients and families actively participated in the care planning process, as well as in the decision on how much coordination and monitoring was necessary and desirable. This review looks at whether the informal care was integrated with formal services in the Plan of Care and that the Care Management services are effective in maintaining an appropriate environment for the client. This evaluation also checks to be sure LTC services are coordinated with those provided by other agencies to integrate acute care with chronic care.

CPLTC Regulations, Section 58074 - Annual Report of the Agency's Quality Assurance Program

Annually, Care Management Agencies submit, for the Department's review and approval, a written report of the agency's quality assurance program. The report must summarize all findings and recommendations resulting from the quality assurance activities.

CPLTC Regulations, Section 58075 - Objectivity and Impartiality

It is possible that a Care Management Agency, that develops the Plan of Care, may also provide the actual services. To assure objectivity, the Care Management Agency must document that clients were made aware of the costs and availability of other providers of these services. Additionally, individuals who provide direct care cannot also act as Care Managers for assessment and care planning.

CPLTC Regulations, Section 58076 - Policy Manual

In order to receive Department approval, the Care Management Agency must receive approval from the Department for its Policy Manual. The Department performs a through review to ensure the adequacy of the agencies' organizational structure and staff resources.

CPLTC Regulations, Section 58080 - Preparing a Service Summary

Each Issuer is required to notify the policyholder and the Care Management Agency 120 days prior to the date when coverage under the policy is about to be exhausted. In turn, the Care Management Agency has 30 days from the time the notification is received to complete an assessment and prepare a discharge/transition plan.

Benefit Eligibility – Licensed Health Care Practitioner

Consistent with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and the California Insurance Code, Section 10232.8(c), the Partnership requires that a Licensed Health Care Practitioner must make the determination that the insured is a Chronically Ill Individual, independent of the insured. The major difference between the Partnership and other tax-qualified products is that the Licensed Health Care Practitioner must be an employee or be a Qualified Official Designee of a Care Management Provider Agency approved by the Department.

Care Management/Care Coordination is Not Managed Care

Managed Care is most often associated with what is used by Health Maintenance Organizations (HMOs) or health insurance companies to control costs, particularly for specialty or acute care. In these settings, managed care is often more accurately described as utilization management. For example, it may be used to limit lengths of stay in hospitals and maximize revenues under the diagnosis-related group (DRG) system of Medicare reimbursement. Since most Californians receive care through HMOs, we tend to think of managed care as it relates to having our primary care doctor act as a gate way to specialist care or the need for our health plan to pre-authorize high cost procedures. Such pre-authorization is not only a means of controlling unnecessary utilization of services, but it also is a result of the funding arrangements common to managed care organizations. Most managed care organizations and subsequently, their provider networks, receive capitation, meaning they receive a fixed monthly reimbursement for each patient member who uses their system. This often results in a managed care plan limiting access to a specific network of providers who have agreed to the HMO's reimbursement arrangements.

HMOs are beginning to incorporate Care Management, as it is conducted in long-term care settings, for their high cost plan members. Similar to the process used for LTC care insurance products, an assessment of the patient's needs leads to developing a Plan of Care that incorporates a wide array of home services that will enable the individual to avoid the higher cost of acute care, often in an institutionalized setting.

How the Care Management/Care Coordination Process Works

The following is a generic description of how the process works for policyholders of a Partnership-certified LTC insurance policy.

1) Policyholder contacts the Insurer to seek policy benefits.

2) Upon receipt of a contact from the policyholder, the insurer's Claims Administration department sends a request to the Care Management Provider Agency to complete an assessment to determine eligibility for benefits and determine what should be included on the Plan of Care.

3) The Care Manager completes the face-to-face assessment at the location of the claimant. The assessment document, which is approved by the CPLTC, evaluates the need for ADL and IADL assistance; informal support systems; environment and health history; etc. It is not unusual for the Plan of Care to be completed during this same visit; however, it may not be completed until the insurer has determined the claimant eligible for benefits. The Plan of Care identifies the type, frequency and the providers of all formal and informal LTC services. This includes the need for coordination and monitoring services and the cost of the formal services. Gathering information from the client, family members, personal physician and discharge planners is part of the Care Plan development process. The care plan not only incorporates services covered by the LTC insurance policy, but also Medicare and other health coverage; informal care giving; and community sponsored services (e.g., dial-a-ride, means on wheels, adult daycare, emergency response systems). The Plan of Care must address these needs in a cost-effective manner. The certification that the individual will be chronically ill for at least 90 days is also done at this time.

4) The completed assessment form is sent to the insurer for review.

5) The Insurer's Claims Administration department makes a determination, based on their review of the information presented by the Care Management Provider Agency, that the claimant does meet the definition of the insured event. The final decision on eligibility for benefits rests with the insurer.

6) Insurer sends approval letter to the client and discusses plan of care with client and/or family. A copy of the Plan of Care is forwarded to the client. The Care Plan will identify type and frequency of services the Claimant requires, including services not covered under the policy. At the time that the Care Plan was developed, the Care Manager will assess the need for care coordination and monitoring. If the need is present, and the claimant requests assistance, the Care Management Agency will notify the insurer.

7) Care Manager makes telephone contact every 30 days and written contact every 60 days. The Care Manager also completes face-to-face reassessments every 6 months to make sure current needs are continuing to be met.

Care Coordination

Care coordination is the process used to implement the care plan, using local providers who can best meet a client needs. Information is exchanged between the provider and the care manager. The care manager also negotiates the best rate for the service to help maximize the policies benefits. Care coordination is provided when the Care Management Provider Agency determines it is necessary, but only if desired by the client.

Care Monitoring

Monitoring consists of an on-going evaluation of the client's status and the effectiveness of the care plan. Contact with the client and/or family and service providers usually occurs at least monthly. Monitoring may also include the review of the quality of the direct services provided and whether the client's needs identified in the care plan were met. As with care coordination, monitoring only occurs when the Care Management Provider Agency determines it is necessary and is desired by the claimant.

Approved Partnership Care Management Provider Agencies

Capitated Health Care Services, Inc. (CHCS)
3050 Universal Boulevard, Suite 150
Weston, FL 33331
Contact: Gary Jacobs, President
Sue Zimmerman, Chief Operating Officer
(800) 370-7684

Family Caring Network (Life Plans)
Two University Office Park
51 Sawyer Road, Suite 340
Waltham, MA 02154
Contact: Jocelyn Gordon, Vice President of Benefits, Products and Services
(781) 893-7600

Long Term Solutions
182 West Central Street, Suite 202
Natick, MA 01760
Contact: Noreen Guanci, President
Anne Harrington, Vice President
(508) 907-6290

Evercare Connections
MN008-W130
9900 Bren Road East
Minnetonka, MN 55343
Nancy Williams, Senior Director
(952) 936-6872