Private Caregivers: Turning Lemons into Lemonade
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Turning lemons into lemonade

Speakers:
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  Long Term Care Partners  
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- Cheryl Robertson, Manager, Rehab & Case Management  
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Private Caregivers: Turning lemons into lemonade

Theme:

Private/Independent caregivers offer a cost-effective opportunity for our claimants to receive quality care from people they know & trust.

These claims should cost less and provide similar care to an agency.

Unfortunately, these claims seem to cost more, have more fraudulent behavior & financial abuse, and cause administrative hassles for the LTCI and the claimants.

With the proper controls and processes in place, Private Caregivers can be good for the claimant and good for the insurer.

Here’s what some carriers are doing.
A note about our survey

Survey Disclaimer:
The survey conducted as part of the preparation for this presentation should be considered anecdotal and unscientific. The survey respondents represent a cross-section of the LTCI industry, both high-volume and lower volume claims payers. We will only present aggregated or averaged data, and no specific company or respondent data will be disclosed.

Companies whose claims representatives responded to some or all survey questions include:

- Ability RE
- CNO Financial
- Genworth Financial
- John Hancock
- Lifecare Assurance
- Lifesecure
- LTC Partners
- MedAmerica
- MetLife
- New York Life
- Northwestern Mutual
- Prudential
- Senior Health Insurance of Pennsylvania (SHIP)
- Transamerica
- Univita
Private/Independent/Informal Caregivers

• The PCG Experience – what we saw that caused us to take action
• New tools and tactics – what we tried to help manage these issues
• Actual Results – what we accomplished using these new capabilities
• Looking Forward – what we’re working on next

Note: for this presentation, the following will be used interchangeably:
“Private Caregivers” = “Independent Providers” = “Informal Care Providers”
and “PCG” = “IP” = “ICP”
Also, “fraudulent behavior” has been shortened to “fraud” throughout the presentation.
The PCG Experience

- Fraud & Abuse (Unnecessarily/Improperly inflated claims)
- Elder Financial Abuse
- Administrative Difficulties in Claims Processing

Presenter: Cheryl Robertson
Our Experience (Fraud/Abuse)

Answer: For us, too many!

- In our reimbursement products, multiple cases of identified fraud and abuse came from informal or privately-hired caregivers in 2010 and 2011
- Concerning scenarios found:
  - Hours inflated by the claimant/ICP to meet maximum daily benefit
  - Claims same hours worked every day, 7 days/wk, 52 wks/yr
  - No certainty whether certain services were actually provided
  - No certainty who is providing the care (possibly a family member)
  - Claimant/ICP invoicing LTCI for non-ADL care or for ADL care not given
  - Unclear whether caregiver has actually been paid the amount represented in ICP invoice
  - ICP rates equivalent to or higher than area agency rates
  - PCG not present in the home during supposed working hours
  - No real recourse for LTCI other than costly investigation
“The Good”

- 83 year old female. Lives alone in private home. She has Rheumatoid Arthritis and COPD. She has IADL and ADL impairment. She requires assistance with Bathing & Dressing. She is Cognitively intact and has good family support.
- Has two PCG’s, the first is from her church and works for a few hours in the morning. The second is her granddaughter’s friend who is in Nursing School and works for a couple of hours in the evening.
- PCG’s also perform IADL’s while present as would be expected.
- Hours and charges for services billed are reasonable. The cost is less than agency care which allows the Claimant to maximize her LTC benefit. PCG forms are filled out correctly with rare exception.
- Insured is able to stay in her home. Her care needs are being properly met. She is pleased to enjoy the consistency of having the same caregivers which is frequently not the case with agency care. The caregivers truly care for the Claimant. The caregivers report to the family whenever they have a health or environmental concern regarding the Claimant. The caregivers assist and encourage the Claimant in advocating for herself and expressing her needs and desires.
“The Bad”

• 87 year old male. Resides alone in a private apartment. He has arthritis and this prevents him from performing Bathing and Dressing independently. He uses a walker. Cognitively his Folstein score is 22/30 on the initial BDA. His son/POA, lives out of state but he visits every 4 to 6 months. Claimant does not want move into a facility of any type and son does not want to upset Claimant by forcing him to do so.

• The son hires a PCG that is the neighbor of a friend’s mother and seems to be nice. The PCG states she has worked in this capacity for years but has no formal employment.

• The care billed is 12 hours a day, 7 days a week. All weekly PCG sheets submitted bill for exactly the same hours for months at a time without any variation. There are never any sick or missed days or hours.

• A call is made to the Claimant to advise he is due for reassessment. During this call we ask the Claimant how he is doing. He states he is doing fairly well. He goes on to describe his PCG and her services. He mentions that he appreciates her being there on most days for him and he makes do on the days she is not there. We contact the son to advise of the situation.

• In the end the PCG was fired for billing for hours and days she was not there. The Claimant simply signed the PCG forms because he thought he was supposed to and did not question what he was signing. What is most disturbing is the Claimant was not being cared for properly and his benefit was being essentially stolen from him.
“The Ugly”

- End Stage Huntington’s Disease.
- Claimant “rescued” by two individuals who purchased his POA from his daughter, sold his home and then took him to live in a home they owned and rented to the Claimant.
- The 2 POA’s served as the Informal Providers who were billing 24x7x365 for his care, maxing out a healthy DMB.
- FL Adult Protective Services report went in but no action taken.
- This case that gives us nightmares both from the policy and the claimant perspective but there just is not enough proof to stop the PCG participation and what they are doing.
Our Experience (Elder Financial Abuse)

We have seen see multiple cases of this type of Elder Abuse

- We have seen some cases where PCG’s exert inappropriate influence on elderly claimants.
- Several (anecdotal) scenarios:
  - A PCG that doesn’t work the full hours being claimed but tells the claimant that if they don’t pay them they won’t come back (being strong armed).
  - A PCG looks over the shoulder of the claimant as she is writing the check and says “can you put in a little more this week, my daughter is sick”.
  - A PCG exerting pressure to be put in the claimant’s will.
  - A PCG asking to become the claimant’s POA.
- We care about the claimants and would help if we could!
Most Individual families are not good at billing an insurance company!

- We have found that Informal/Private Caregiver claims take longer to process than agency/facility claims
- Frequent issues our claims processors face:
  - Incomplete caregiver invoices
  - Copied or duplicated invoices/care notes
  - Missing proof of payment
  - Missing caregiver and claimant signatures
  - Care listed on invoice is not consistent with the POC
  - Care listed on invoice is non-covered care
  - Multiple calls back to claimant/POA/caregivers to resolve issues
  - Multiple escalations between claims processing and care management staff
  - Unhappy claimants due to their perception of “changing requirements”
- Some claimants eventually learn, some never do.
New tools and tactics

- Proof of Services
- Proof of Payment
- Streamlined Processing

Presenter: Cheryl Bush
Our Experience (Tools/Tactics)

Proof of Service: A real eye-opener

• Before intervention:
  – No verification of dates/times in home
  – No verification of provider
  – Lack of timeliness on claim submission
  – Relied on claimant/POA-submitted forms
• Tools/Tactics:
  – 3rd party verification of services via telephonic timecard system
    • Shows that caregiver was actually present in the home
    • Proximity of service dates with date invoiced improved
    • Timecard system verifies actual start and end times of services
    • Improved documentation of care provided
• Primary effects and findings:
  – Decreased number of hours billed
  – Identified cases of claimant recovery-no care received
  – Did not pay for days care not verified and received
  – Several claimants elected to go off claim
  – Enables timing of calls to the home to coincide with times time PCG is “checked in”
Our Experience (Tools/Tactics)

Proof of Service: Example

Log Sheet prior to using timecard
- Claiming 7 AM – 7 PM every day (?)
- Utilizing max benefit every day

After 4 weeks of using timecard
- Claiming 7.2 avg hours each day
- Billing for 40% fewer hours of care
Our Experience (Tools/Tactics)

Proof of Payment

• Before intervention:
  – Proof of payment not required
  – AOB sometimes accepted

• Tools/Tactics:
  – 3rd party verification of payment of caregiver wages and appropriate taxes via payroll service
  – Stopped accepting AOB for Private Caregivers
  – Increased accuracy of billing and timeliness of claim submission

• Primary effects and findings:
  – Proof of Payment 100% of the time
  – Exposed inappropriate use of insurance
    • Caregiver pay dependency on insurance payment
    • Family member providing care
    • Claimant paying lower actual wages than invoiced to insurer
  – Identified many cases of Elder Financial Abuse-caregiver “threatening” claimant
    • 3rd party paying electronically takes pressure of “writing the check” away
  – Exposed illegal caregivers not authorized to work in U.S.
  – Exposed caregivers committing unemployment fraud
  – Decreased claimants household employment liabilities
Streamlined Processes

• Before intervention:
  – Standardized forms implemented – no improvement
  – Many errors and incomplete/missing forms led to frequent escalation, multiple calls back to claimants and extended processing time while waiting for resubmission of documents

• Tools/Tactics:
  – 3rd party creation of standardized invoices and backup material
  – 3rd party review and Q/A check of all submitted documents

• Primary effects and findings:
  – Timely Submission of Invoices
  – Reduced incidence of claims requiring escalation
  – Reduced time to process claims-faster reimbursement to claimant
  – Dates of service reimbursed in close proximity to date care provided
  – Improved effectiveness of care manager follow-up calls knowing times caregiver in home and can speak with both caregiver and insured.
Actual Results

- Claimant Acceptance (Optional vs. Mandatory)
- Claims Savings and Administrative Efficiency Results
- Greater Fraud Identification and Actions

Presenter: Mary Lou McGuinness
Will they accept it if it’s not mandatory?

The case for optional (LTCP):

**Pros:**
- Encouraging initial level of acceptance
- Easier to implement
- Still yields substantial claim savings
- Pay for program within benefit pool

**Cons:**
- Likely adverse selection
- Harder to “sell” to claimants
- Harder to move over existing problem claims

The case for mandatory (MedAmerica):

**Pros:**
- Can oversee all troubled claims (no adverse selection)
- Some claimants simply go off claim
- Some claimants move to formal providers

**Cons:**
- Likely more complaints from existing PCG claimants
- More administrative work and notifications

Note: Approval of PCGs under APOC affords greater flexibility.
Where the rubber meets the road: FLTCIP Program

- Positive financial results
  - Overall NET savings estimated at 12% for ICP claims
  - Exceeded targeted 3%-8% savings from initial pilot proposal
  - Includes all cost of 3rd party fees and employer taxes paid through claims, subject to MDB

- Recognized savings in 42% of all cases going through this process

- Primary savings mechanisms
  - 59% of savings primarily due to identified fraud
  - 41% of savings primarily due to timecard/reduced overbilling

- Additional savings/benefit not quantified:
  - Identified multiple cases of potential claimant recovery
  - Claimants receiving more care for same MDB
Substantially improved identification of fraud and financial abuse

- New program proved very effective in identifying fraud
  - 3 fraud cases prosecuted in all of 2010 (prior to new program)
  - 7 new fraud cases documented during 6-month optional pilot with <10% of claims
  - Average projected 1-year savings for these fraud cases: 34,600/claim!!
- These cases would likely not have been caught without the new controls – here’s how they were caught:
  - Voice recording fraud (telephonic examples)
  - Frequent timecard system mismatch
  - Banking setup identifies false caregiver
  - Multiple caregivers overlapping care at the same time
  - Unemployment fraud
  - ICP leaving and not providing services
  - ICP unable to provide proof of eligibility for employment in U.S.
What do we do when we identify fraud/financial abuse

• Initial/adamant refusal of program creates potential “red flag”
• Deny claims where frequency/amount of timecard issues meets pre-set triggers
• Mandate 3rd party verification services for repeat offenders or evidence of fraudulent activity
• Step up frequency of calls to coincide with times PCG is “checked in” via timecard system (+1 hour)
• Re-establish waiting period if waived due to hospice status
• Disqualify from using informal providers – mandate formal care providers
• Call adult protective services if warranted
• Initiate fraud investigation, if appropriate
• Some claimants simply go off claim!
Administrative Efficiency Improvement

• Claims processing time study: 54% reduction in processing time
  – Reduction in “dirty” claims (requiring escalation) by 50%
  – Reduction in time to process dirty claims: >60%
  – Reduction in time to process clean claims: 20%

• “Clean” claims allowed better focus
  – Allowed claims processors to focus only on highest priority items
  – Allowed more rapid decision making and escalation
Claimant Acceptance

• Optional Program:
  – Encouraging initial level of claimant acceptance
    • How program is presented drives acceptance
    – Non-fraudulent claimants see this as a benefit!

• Mandatory Program:
  – New claims: High level of claimant acceptance
  – Open claims transitioning to new process: More pushback and complaints
    • >50% accepted and moved forward
Looking Forward

- Lessons Learned
- Expanding Adoption
- Process Improvements

Presenter: Mary Lou McGuinness, with commentary from Cheryl Bush and Cheryl Robertson
“News from the front”

• Defined an “internal procedure” for these claims requiring 3 things
  – 3rd party verification of services
  – Proof of payment
  – Completion and verification of log sheets
• Set clear criteria to determine which claims will be denied
  – Number of total manual/erroneous shifts
  – Number of times retrained
• Set clear criteria where it’s appropriate to waive the requirement for open claims (analyze requirements deeply)
  – When benefits will exhaust in next 9 months
  – Existing claimant currently on hospice
• Beware of those who protest too much about process
"News from the front" (continued)

• When making the program mandatory:
  – Staged, methodical approach with adequate scripting
  – Make reasonable exceptions
  – Be prepared for some complaints when making it mandatory
    • New claimants will go with it much more easily
    • Existing claimants will make it more difficult

• To justify program/support expansion:
  – Analyze specific claims savings data to support expansion of program
  – Measure/verify efficiencies for claim processing

• Look to build 3\textsuperscript{rd} party verification into future policy language!
Process Improvements / Enhancements

• Consistency of process and messaging across all staff
  – Measurement, tracking and feedback loop
• Using 3rd Party verification service to educate claimants on R&C pay rates
• Implementing caregiver training programs integrated with BEA and ICP evaluation processes
• Evaluate creating “Incentives” for claimants to use 3rd-party verification
  – Faster payment due to electronic submission
  – EFT transfers
  – Paying 3rd party verification fees as an administrative expense
  – Reduce waiting period
• Setting up claims to deal with only this new documentation – what improvements does this enable?
• Implementing electronic transfer of documents and straight-through processing
• Integrating new requirements earlier in the eligibility and POC process
• Expanding the program to include Registry claims
Private/Independent/Informal Caregivers

Summary of Presentation

• Like the rest of the industry, Independent Providers have been a big issue
• We addressed opportunities to implement controls and oversight using 3rd party verification of services and verification of payment
• As a result, over the last year we have seen:
  – Hard dollar claims savings
  – Improved administrative efficiency
  – Increased fraud identification
  – High level of claimant acceptance (squeaky wheel = red flag)
• This is good for the claimant, and good for the LTCI industry!