COMPACT FOR LONG TERM CARE
CASE STUDY

MARY EDWARDS. AGE 80. WIDOW

ASSETS: $200,000
INCOME: $40,000
HOME VALUE: $120,000

THE PLEDGE

STEP ONE: INITIAL CONTACT

Mary[1] believes she may need LTC. She contacts her local Third Party Administration (TPA) office. The TPA briefs her on the program and offers to send her information. Should Mary decide to enter the Compact, she will be responsible for service charges of the TPA

(a) PHYSICAL ASSESSMENT: After reading the information, she again contacts the TPA at which time they take her identifying information and advise her that she will need an assessment to determine if she is chronically ill. If required, the TPA can provide a list of assessors that she might use[2]. The cost of the assessment is Mary's responsibility.

(b) ELIGIBLE?: Mary is assessed according to the conditions and definitions of the Health Insurance Portability and Accountability Act (HIPAA) of 1997.

The term 'chronically ill individual' means any individual who has been certified by a Licensed health care practitioner as—

"(i) being unable to perform (without substantial assistance from another individual) at least 2 activities of daily living for a period of at least 90 days due to a loss of functional capacity,

"(ii) having a level of disability similar (as determined under regulations prescribed by the Secretary in consultation with the Secretary of Health and Human Services) to the level of disability described in clause (i), or

"(iii) requiring substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment. Such term shall not include any individual otherwise meeting the requirements of the preceding sentence unless within the preceding 12-month period a licensed health care practitioner has certified that such individual meets such requirements.

ACTIVITIES OF DAILY LIVING. For purposes of subparagraph (A), each of the following is an activity of daily living:

"(i) Eating.

"(ii) Toileting.

"(iii) Transferring.

"(iv) Bathing.

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[1] It is more likely that contact will be with family but for the purpose of this illustration, it is assumed Mary is able to perform tasks required by the Compact.

[2] Assessment is ongoing. HIPAA requires assessment at least one a year but certain diagnoses may warrant greater frequency. Where LTC insurance is used, assessment charges are generally covered by the contact.

"(v) Dressing.
"(vi) Continence.

If Mary does not meet the terms noted above, the Compact process ceases. If Mary does meet the definition, she proceeds to establish her Pledge.

STEP TWO: ESTABLISH PLEDGE

The TPA works with Mary to establish her countable asset base.

(a) PLEDGE ASSESSMENT: Mary will be asked to document her assets for the past 36 months. Assets and allowable transactions are as stated in S3530.
(b) ESTABLISH PLEDGE ACCOUNT: After review, the TPA determines Mary's countable assets to be $200,000. According to Compact rules, Mary's home is disregarded leaving her a Pledge account of $100,000[3].

Mary is now a full Compact Participant. The TPA will set up an account against which Mary's expenses will be recorded as she begins the process of qualifying to become a Beneficiary. She will have to expend $100,000 on qualified LTC services before she is eligible to become a Beneficiary and the subsidy. Should her assets increase or decrease[4] after the Pledge amount is established such changes will not affect the original Pledge calculation.

STEP THREE: MEET PLEDGE

(a) REVIEW PAID CLAIMS: Mary sends her paid claims to the TPA for review. The funds to pay those claims can be any non-government source. It is not necessary for Mary to use her assets if, for instance, she has long term care insurance. She may use the provider of her choice. The provider may charge her the private pay rate.
(b) QUALIFIED LTC SERVICE?: Whether a claim is for a qualified long term care service is determined according to the conditions and definitions of the Health Insurance Portability and Accountability Act (HIPAA) of 1997.

The term 'qualified long-term care services' means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services, which—
"(A) are required by a chronically ill individual, and
"(B) are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

If Mary's paid claim is not for a qualified service, the process ends. If it is a qualified service, the TPA will check to see if the amount of the claim brings Mary's total payments to her Pledge amount. If the amount doesn't cause Mary to reach her Pledge amount, the TPA will record the payment re-tallying her total. If it does bring Mary's personal expenditure to her Pledge amount, the TPA will notify her that she is eligible for the Subsidy.

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[3] If Mary was married, the Pledge would have been calculated by first dividing total assets between her and her spouse ($200,000/2). This would leave Mary with personal assets of $100,000. Her Pledge would equal half of that amount or $50,000 ($100,000/2).
[4] In the case of a decrease in assets, hardship review will be available.

STEP ONE: INITIATING ACCESS

(a) NOTIFY STATE: The TPA will notify the State that Mary has qualified for the Subsidy. Information regarding Mary will be shared. The State may wish to perform an assessment at its expense at this time.
(b) ESTABLISH SUBSIDY ACCOUNT: The TPA will establish a Subsidy account for Mary. The value of the account is the maximum Subsidy available for Mary's care. Expenditures beyond this amount are Mary's responsibility.
(c) ESTABLISH PARTICIPATION FEE: The TPA will calculate Mary's participation fee[5] and arrange a payment schedule.

Mary is now a Beneficiary under the Compact.

STEP TWO: ACCESSING THE SUBSIDY

The rules of claiming under the Subsidy are somewhat different than those under the Pledge. Mary can still use the provider of her choice (regardless of Medicaid affiliation) for her qualified LTC services, but as a Beneficiary, her TPA is sent unpaid bills and the permissible charge for the service is no longer the private pay rate. The Subsidy available to Mary will equal the regional expense for nursing home care.

(a) SUBMIT CLAIMS: Either Mary or the provider may submit claims to the TPA.
(b) QUALIFIED LTC SERVICE?: The submitted claim must be for a service deemed qualified in accordance with HIPAA definitions.

If the service is not qualified, the Subsidy process ceases. The provider and Mary are notified. Mary will be responsible for the charges for unqualified LTC services.

STEP THREE: PAYING FOR SERVICES

The claim for qualified services is adjudicated. Allowable charges under the Compact equal a Subsidy equal to the Medicaid payment for a comparable service plus 10% co-payment. That is, if the Medicaid rate for the service were $200, the provider would expect to receive $200 from the TPA and $20 from Mary.

(a) SUBSIDY LIMIT REACHED?: After defining the proposed payment, the amount is checked against Mary's Subsidy limit. If she is still under the limit, the claim is paid and the payment is recorded against her Subsidy account. If she is over the limit, the TPA pays up to the limit. The provider and Mary are notified. Any further LTC expenses are Mary's responsibility.

STEP FOUR: BENEFICIARY FINANCIAL OBLIGATIONS

The following are the financial responsibility of the Beneficiary. Beneficiaries who do not fulfill these responsibilities may lose the right to participate in the Compact and in the case of providers, may also be subject to private collection proceedings.

[5] The calculation for the participation fee may vary depending on program rules for minimum income allowances. For example, for a single Beneficiary in a facility, the minimum retained income is $100.