

## THE NEW YORK STATE LONG TERM CARE COMPACT

**PROPOSAL:** To redefine the relationship between the citizens of New York and their government concerning the financing of long term care. The focus shall be an agreement that there must be a limit to the liability of both parties. Once the limits have been defined, each citizen may plan in accordance with personal choice, risk tolerance, and need.

## BACKGROUND

**RATIONALE STATEMENTS :** Facts that govern purpose.

- Long term care can be extremely costly. For all but a few, impoverishment is unavoidable given sufficient amounts and lengths of need.
- If not for the need for long term care services, most persons would never become reliant on public funding.
- Impoverishment is neither a desirable nor a rational societal expectation.
- Forced impoverishment leads to avoidance of reasonable private contribution.
- Avoidance leads to increased reliance on public funding.
- Increased reliance on public funding is unsustainable.
- Neither the individual nor the public sectors are capable of managing the anticipated cost of long term care on their own.

THEREFORE, THE SOLUTION MUST REDUCE  
DEPENDENCE ON PUBLIC FUNDING FOR LONG  
TERM CARE SERVICES WHILE RELIEVING  
INDIVIDUALS OF THE THREAT OF  
IMPOVERISHMENT.

**DESIGN PARAMETERS:** Standards that govern design

1. The focus is financing – not services.  
*There are many issues related to the development of better and more efficient LTC services but without a viable payment source, services concerns are moot.*
2. The goal is privatization – not expansion of the public sector.  
*Medicaid now pays over 80% of LTC expenses in NYS. This is unsustainable.*
3. Front coverage would save the most public dollars.  
*The majority of total LTC expenses occur in the first 1-3 years..*
4. Cooperation is preferable to coercion.  
*Approaches may not impose rules, requirements, or expectations that would be unacceptable to a reasonable person or entity.*
5. Operational ease and low administrative cost is central to success.  
*The potential viability of any program is first measured in expense and complexity. Therefore, in as far as possible, it should use products, systems, processes, and people already in place and explainable in one sentence.*
6. Answers should address causes not effects.  
*The problem to address is not about Medicaid or Medicare. The crisis in public financing is an effect not a cause and is driven by demographics. While public programs are important, they are only two more options in creating resolution.*
7. Privatization means following the rules of the private sector.  
*(i) Current and future Medicaid or other government program eligibility rules are not applicable to a private pay solution even if that solution involves such programs.*

- (ii) Joint participation with government does not automatically imply government rights, oversight, or controls greater than would be in place outside the program.*
8. Concentrate on the rule rather than the exception.  
*The percent of persons seeking public financial support for LTC is so high as to render secondary the percent that don't.*
9. Results are more important than form.  
*It is not important the manner in which public support is delayed or avoided as long as it is.*

## **RULES OF PROGRAM PARTICIPATION**

### **GENERAL RULES:**

- Participants under this program shall be considered private payers.
- This program shall be governed by private sector definitions, processes, procedures, and rules except as they relate to specifically defined payments made on behalf of participants.

### **ELIGIBILITY RULES:**

- Persons eligible for participation must be New York State residents residing within the state of New York at the time application for and participation in the program.
- Persons eligible for or currently receiving Medicaid benefits may not participate. Program

### **PARTICIPATION RULES: Eligible Individual**

- Participants may use any private source to meet their financial responsibility, called a Pledge.
- There will be a minimum (Dollar Pledge) and a maximum (Maximum Pledge) participation choice.
- Minimum participation requirements will not exceed more than one-half of non-housing assets with a lower limit that may be retained by the participant.
- The maximum Pledge shall equal 36 times the average facility monthly rate in the region the participant resides.

### **PARTICIPATION RULES: New York State**

- The State shall meet its financial responsibility using Medicaid dollars by subsidizing the LTC costs of participants who have met their Pledge.
- Participants supported under the program shall not be subject to Medicaid rules governing assets, recovery, or eligibility.

# COMPACT DESIGN

## SUMMARY:

1. When an eligible individual is determined to be chronically ill\*
  - a) They may pay the cost of qualified long term care (LTC) services\* in an amount equal to:
    - i) Maximum Pledge: the dollar value of three years of nursing home care at the regional rate, or
    - ii) Dollar Pledge: the dollar value of ½ of the participant's non-housing assets or \$20,000, whichever is less.
  - b) The Pledge may be fulfilled through any non-governmental payment source.
  - c) During the Pledge period, participants remain private, paying the private pay rate. There is no income contribution.
  
2. Once the Pledge is fulfilled the participant remains private.
  - a) They become eligible for the Compact Subsidy. Through the subsidy, the state will provide support for LTC expenses while permitting participants to maintain income, assets, and private status.
    - i) Assets:
      - ◆ Those completing the Maximum Pledge may keep all assets regardless of type or amount.
      - ◆ Those completing the Dollar Pledge may keep their home and assets equal to their Pledge.
    - ii) Income: Participants retain 75% of their income, remitting 25% to the program.
    - iii) Private status: Participants may use any provider willing to accept the Compact rate. They do not have to be Medicaid providers. Participants are not subject to Medicaid management.
  - b) Participants receive state benefits under the program:
    - i) Medicaid will subsidize the cost of any qualified LTC service\* at the Medicaid rate for an equivalent service.
    - ii) Providers of services subsidized by the program may charge only the Compact Rate. It is set 110% of the Medicaid Rate.
    - iii) Only Qualified LTC services are covered by the program. Participants continue to be responsible for any service or co-payment not covered by the subsidy.

\* Definitions of chronic illness and qualified LTC services are taken from HIPAA 1996.

# COMPACT PROGRAM FLOW

STEP	RESPONSIBLE PARTY
1. PARTICIPANT DETERMINED CHRONICALLY ILL	<b>INSURER OR STATE CONTRACTED ASSESSOR</b>
2. PARTICIPANT APPLIES TO COMPACT 3. PARTICIPANT MAKES PLEDGE 4. PAID BILLS TOWARD PLEDGE COLLECTED 5. PLEDGE COMPLETED 6. MEDICAID NOTIFIED	<b>TPA COMPACT ADMINISTRATONN</b>
7. SUBSIDY AND INCOME CONTRIBUTION ESTABLISHED	<b>MEDICAID/TPA COMPACT ADMINISTRATONN</b>
8. INCOME CONTRIBUTION RECEIVED MONTHLY 9. INCOME CONTRIBUTION SENT TO MEDICAID	<b>TPA COMPACT ADMINISTRATONN</b>
10. SUBSIDY BILLS PAID	<b>MEDICAID</b>
11. CO-PAYMENT AND UNCOVERED SERVICES PAID	<b>PARTICIPANT</b>

## **PLEDGE DETAILS**

- (a) Any Compact participant expending an amount equal to three years of nursing home care times the regional average where he resides has completed the Maximum Pledge Amount. Such participant shall receive full protection of all assets.
- (b) Any Compact participant expending an amount equal to ½ their non-housing assets or \$20,000, whichever is less, has completed the Dollar Pledge Amount. Such participant shall receive full protection of his home and assets equaling his pledge amount.
- (c) To count as an expenditure under the Compact, proof of paid (not incurred) expenses for Qualified Long Term Care Services made by or on behalf of a participant who has been assessed as eligible must be submitted. The definition of what is a Qualified Long Term Care service and what constitutes eligibility shall be in accordance with HIPAA rules and regulations.
- (d) The amount to be protected under the Compact program shall be at the discretion of the participant. However, under no circumstance shall the participant be required (they do so voluntarily) to protect more than one half of their assets. Nor participants be required to expend an amount that would leave them less \$20,000.
- (e) Assets shall mean the same as such term is defined in section three hundred sixty-six of the Social Services Law for transfers made after August tenth, nineteen hundred ninety-three unless specifically exempted by Compact rules.

## **APPLYING FOR THE COMPACT BENEFIT**

- (a) The resident consumer or representative of such consumer who believes he/she qualifies as requiring long term care contacts their insurer, or in the case of cash payments, goes directly to a state approved assessment organization. Assessments shall be at the expense of the applicant or their insurer where appropriate.
- (b) The consumer should contact the Compact office to arrange participation and sign appropriate agreements.
- (c) Proof of payment for Qualified Long Term Care services must be submitted to the Compact office or its representative. Qualified Long Term Care services do not need to be covered by or paid at the rates of Medicaid to count towards the agreed obligation. Payment for Qualified Long Term Care services may come from any source including insurance or personal assets.

## **THE COMPACT SUBSIDY**

Participants who have met their pledge are eligible for the Compact Subsidy.

1. Participants are required to contribute  $\frac{1}{4}$  of their net income to receive subsidy payments.
2. The Compact Subsidy applies only to Qualified Long Term Care services.
3. Participants are not subject to Medicaid rules governing assets, recovery, or eligibility.
4. Participants are not required to use providers contracted with the Medicaid program.
5. Participants may receive any Qualified Long Term Care service they wish.
6. Where a service is covered by the state's Medicaid program, he/she will receive a subsidy equal to 100% of what Medicaid would have paid for such service.
7. Compact participants shall be considered private pay. During the Pledge period, they will be liable for the cost of care at the private pay rate. However, when eligible for the Compact Subsidy, the participant will be charged the Compact Rate. The Compact Rate will be set at 110% of the Subsidy Amount (Medicaid rate) paid for the service.
8. The participant will be responsible for any difference between the Subsidy Amount and the Compact Rate.
9. It is assumed that remaining income, residual insurance and/or protected assets will be used to cover the variance between Compact Rate and Subsidy Amounts as well as LTC costs not covered by Medicaid and all non-LTC health care expenses.

## **OPERATIONS/EXPENDITURE**

1. Privatize administration.  
Limit government administrative requirements. Move the program under the aegis of a neutral agency and privatize as much as possible. The design should turn as much work over to a Third Party Administrator as possible and to allow private payment for services to that provider.

Supporting this rationale is the fact that neither Medicaid, the Department of Insurance, nor Office of Aging personnel or programs have the focus, expertise, or sufficient stake to manage a private funding program.

2. Capitalize on existing processes/Laws.  
LTCi is highly regulated by both State and Federal rules and regulations. There is no need to create a parallel or special infrastructure to further protect consumers or regulate insurers.

## EXAMPLE OF POTENTIAL COMPACT OUTCOME

Mrs. Jones is 77 and a widow, frail but in relatively good health. She has an income of \$24,000 a year and assets, including her home, of about \$200,000 (\$100,000 cash, \$100,000 home). At this point in her life, insurance is not an option because coverage would be too expensive and it is doubtful she could pass underwriting.

Mrs. Jones is adamant about remaining in the home. Should she require care for IADL deficiencies, both she and her family believe the need can be managed with the help of their contributions. They currently engage an aide with whom Mrs. Jones is comfortable but who is not a Medicaid provider. The cost of the aide is \$360 a week for 20 hrs). Their concern is the potential eventuality of multiple ADL deficiencies. With the higher level of need, she would quickly expend her savings. She has looked into the idea of a reverse mortgage, but the amount she could get would not be sufficient. She has already told her family that if her care needs increase and Medicaid is needed, she will not accept any more of their financial support.

When Mrs. Jones was 80, she fell and required more support. Her condition progressed to the point where she required substantial assistance in bathing, dressing, and transferring to and from her bed so entered a nursing facility. Mrs. Jones survived there for three more years.

The following are illustrations of the cost to Medicaid of Mrs. Jones' care under both today's program and the proposed Compact.

### SCENARIO

Mrs. Jones receives Medicaid planning advice. In regard to her home, she has been told that recovery is difficult and may not be an issue – but she still worries. She has also been told that while on Medicaid all of her non-LTC health care will be covered. As her drugs alone are \$400 a month, the coverage seems desirable. Her home aside, Mrs. Jones has three choices in planning for her future LTC needs.

- 1) She can spend down her assets. By depleting her savings, she will be able to apply for Medicaid. But, aside from near total impoverishment including the risk to her home;
- 2) She can divest. Because she's currently in home care, she could divest without penalty and receive Medicaid at once. If she could remain in home care for at least three years, her assets would be safe even if she should require nursing home care; or
- 3) She can wait until a need arises. If she needs more home care, she can follow the scenario of (2). If she requires a nursing home, she will expend half of her cash under the "half a loaf" or "rule of halves" concept

**ASSUMPTIONS:**

- Mrs. Jones income is \$24,000/yr or \$2000 per month
- She pays \$150 each month for Medicare coverage
- Home Care will cost \$18/hr
- Facility Care will cost \$150/day
- Non-LTC expenses will equal 10% of her total LTC costs
- Mrs. Jones will spend 3yrs in Home care and 3yrs in the Facility

In the **Current Medicaid Outcome** that follows, Mrs. Jones decides to divest today and apply for Medicaid.

<b>CURRENT MEDICAID OUTCOME</b>				
A.	Home Health Care (\$18x20hr= \$360/wk x 52 x 3yrs)	=	\$56,160	
B.	Facility Care (\$150x365days = \$54,750 x 3yrs)	=	\$164,250	
C.				Total LTC Cost
D.	Other Medical Care (10% (C))		\$22,041	\$220,410
E.				Total Cost of Care
F.	Patient Contribution (HHC: ((\$2000/mo - \$150 Medicare Insurance - \$700 Medicaid Allowance) x 36)	=	(\$41,400)	
	Patient Contribution (HHC: ((\$2000/mo - \$150 Medicare Insurance - \$50 Medicaid Allowance) x 36)	=	(\$64,800)	
G.				Total Patient Contribution
H.				<b>Medicaid Cost</b>
				<b><u>\$136,251</u></b>

In the **Subsidy Medicaid Outcome** below, Mrs. Jones decides to Pledge ½ her non-housing assets and take advantage of the protection the Compact for her home, her independence, and her ability to choose her own providers.

<b>SUBSIDY MEDICAID OUTCOME</b>				
A.	Home Health Care (\$18x20hr= \$360/wk x 4wks) or <b>\$1440/mo</b>			
	Patient: Assuming \$1000 month kept.			Remaining Pledge = \$25,560
	Payment = \$850 Income + \$590 Asset Cash			
B.	Facility Care (\$150x30days = <b>\$4500/mo</b> )			

	Patient: Assuming \$1000 month kept.								Pledge covers 7 mos.
	Payment = \$850 Income + \$3650 Asset Cash								
C.	Medicaid Cost HHC ( <i>Paid in full by patient. See A above</i> )							-0-	
	Facility Care (\$150x30days x 29mos)						=	\$130,500	
	<i>Medicaid Cost Facility Care (7months patient payment. See B. above)</i>								
	Patient Income Contribution								
	Patient Contribution (HHC: ((\$2000/mo - \$150 Medicare Insurance X .25%) = \$925) x 29mos							\$13,412	
D.								<b>Total Medicaid Cost</b>	<b>\$115,238</b>