

Special Provisions for Long Term Care

PNHP's proposal for Illinois long-term care reform

Based on work by Dr. Christine Cassell, former Professor of Geriatrics & current president, American Board of Internal Medicine; & Charlene Harrington, RN, Ph.D., "A National Long-term Care Program for the United States: A Caring Vision," *JAMA*, 12-4-91.

We propose the incorporation of LTC into the publicly funded state health program, borrowing from the experience in the Canadian provinces of Manitoba and British Columbia, where LTC is part of the basic health care entitlement regardless of age or income. Case managers and specialists in needs assessment (largely non-physicians) evaluate the need for LTC and authorize payment for services.

Specific features and budgeting process

- Establish a state LTC Planning and Payment Board, and a local public agency in each community to determine eligibility and coordination of home and nursing home long term care.
- The local public agency will receive a global budget and contract with long term care providers for the full range of LTC services. Nursing homes, home care agencies, and other institutional providers will be paid a global budget to cover all operating costs and would not bill on a per-patient basis. Individual practitioners may continue to be paid on a fee-for-service basis or could receive salaries from institutional providers. Support for innovation, training of LTC personnel, and monitoring the quality of care will be greatly augmented, as a portion of the funds saved on administrative overhead are shifted into long-term care service provision (see below)
- Separate capital budgets allow for health planning that meets community needs.
- Expand social and community based services, and integrate them with institutional care. Logic dictates that the system emphasize social services, not just medical ones, with social service and nursing personnel rather than physicians often coordinating care
- The public program, with a single, uniform benefit package, would consolidate all current federal and state programs for LTC. At present, 80 federal programs finance LTC services, including Medicare, Medicaid, the Department of Veterans Affairs, and Older Americans Act.
- Coverage would extend to anyone, regardless of age or income, needing assistance with one or more activity of daily living (ADL) or instrumental activity of daily living (IADL). In the first 5 years, priority is given to patients needing assistance with three or more ADL or IADLs, and to those who can avoid institutional care with home and community-based care.
- Clerical and other administrative workers who lose their jobs as a result of the single payer will be given incentives to re-train and take employment in the expanded home and community-based health care sector which is currently understaffed. Training and in-service education of LTC professionals, paraprofessionals, and informal care givers should be expanded. Salaries, working conditions, and skill levels of workers in this area need to be upgraded.
- Removing financial barriers to LTC will increase demand for formal services. In the first year, allow for a 25 percent increase in home and community-based care (in addition to any savings from institutional care). The program is to be financed entirely by tax revenues, without premiums, deductibles, co-payments or coinsurance, with the exception of "room and board" payments by patients who are not low-income needing institutional care.