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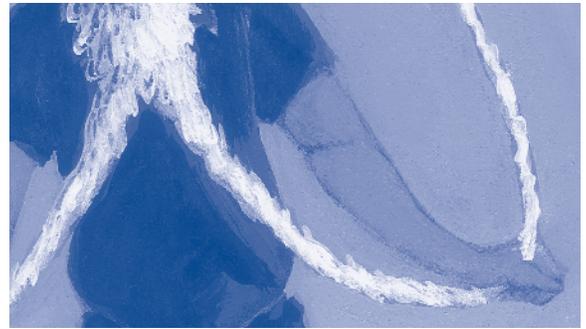
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# The Changing Nature of Long-Term Care in Maine

by Paul Saucier  
Julie Fralich



*The increase in the proportion of older adults, many with one or more chronic medical conditions, will increase the demand for long-term care. Paul Saucier and Julie Fralich discuss the socio-demographic factors affecting long-term care policy, and describe various state and federal options for providing and financing long-term care. They note that Maine's long-term care system has so far been able to absorb considerable growth in people by serving increasing numbers in lower-cost settings. Cost sharing has been introduced, and tax policy has been changed to provide incentives for long-term care insurance. Policymakers must now consider whether the current balance of public and private financing of long-term care is sustainable in the long run. 🐉*

Maine's baby boomers will begin reaching retirement age around 2010.<sup>1</sup> By 2030, they will swell the ranks of the very old, those 85 years of age or older. Their sheer numbers have given the baby boomers unprecedented influence in politics, the work place, design and marketing of consumer goods, and many other aspects of our society. In the very near future, they will become the drivers of Maine's long-term care services.

Long-term care (LTC) refers to a variety of supports provided to people who need ongoing assistance due to disability or chronic conditions. The supports include: in-home services, such as home health; personal assistance with chores, bathing, cooking and cleaning; adult day center services; residential care in assisted living facilities, adult foster homes or boarding homes; and nursing home care. Long-term care is provided to people of all ages who need ongoing supports, but in this article, we focus on services provided to older people. Nationally, 63% of those who use LTC are 65 years of age or older (Georgetown University 2003).

Long-term care use increases with age. Fourteen percent of all people age 65 and over use LTC. Among the subset of people 85 and older, the percent jumps to 50% (Georgetown University 2003). Even the most optimistic scenarios for an increasingly healthy older population are not likely to offset the impending massive increase in the number of older persons. Absent an immediate breakthrough in treatment or prevention that would reduce the need for LTC (e.g., a cure for Alzheimer's disease), health and medical advances are not likely to save the day. In fact, medical advances may result in people living longer with greater levels of disability, resulting in greater need for long-term care.

### DEMOGRAPHY DRIVES DEMAND

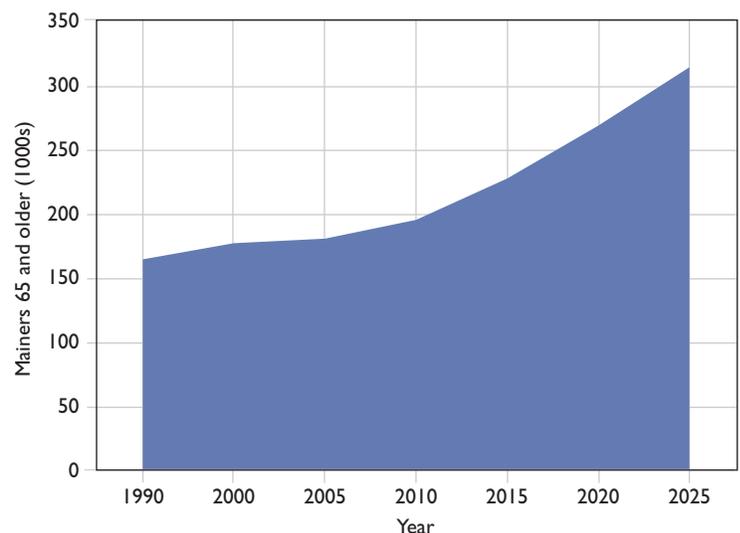
In 2000, 176,000 Maine citizens were 65 years of age or older. By 2025, the number will have increased by 78% to 313,000 people, making older people nearly a quarter of the state's total population (Figure 1). The subset of older people most likely to use LTC, those 85 and older, will increase from 22,500 to 34,600 people

(54%) in the same period. In 1999, 14% of Maine citizens were over 65 compared with 12.7% nationally (Public Policy Institute 2000).

The rising number of older people will increase the overall demand for LTC, and accompanying social trends are likely to amplify it. The great distances that separate extended families in today's mobile society and increasing participation of women in the paid workforce are making it more challenging for families to provide informal care. From 1980 to 2000, the percentage of older people living alone has increased only modestly, but it is likely to increase at a greater rate as the baby bust generation (caused by the decline in fertility rates that began in the 1960s) becomes the informal support system for the baby

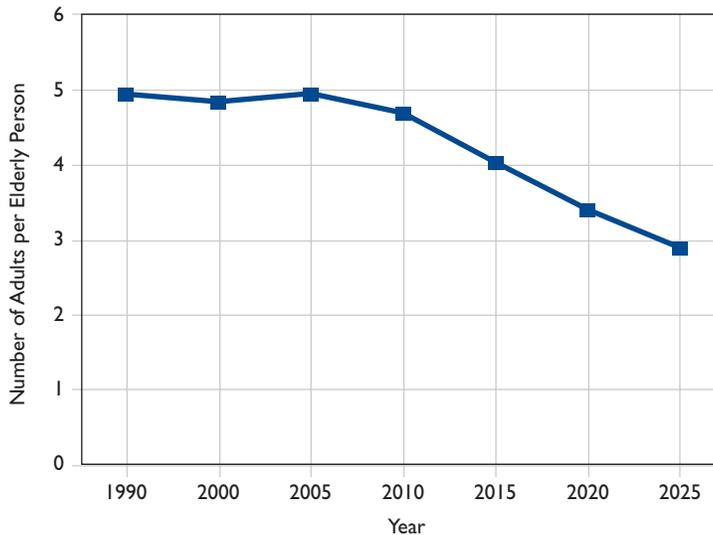
The rising number of older people will increase overall demand for LTC [long-term care], and accompanying social trends are likely to amplify it.

FIGURE 1: **Ageing of the Maine Population Will Accelerate Beginning in 2010**



Source: Colgan 2002

**Figure 2: The Number of Maine Adults (age 19-64) per Elderly Person (age 65 and over) Will Decline by 42% Between 2000 and 2025**

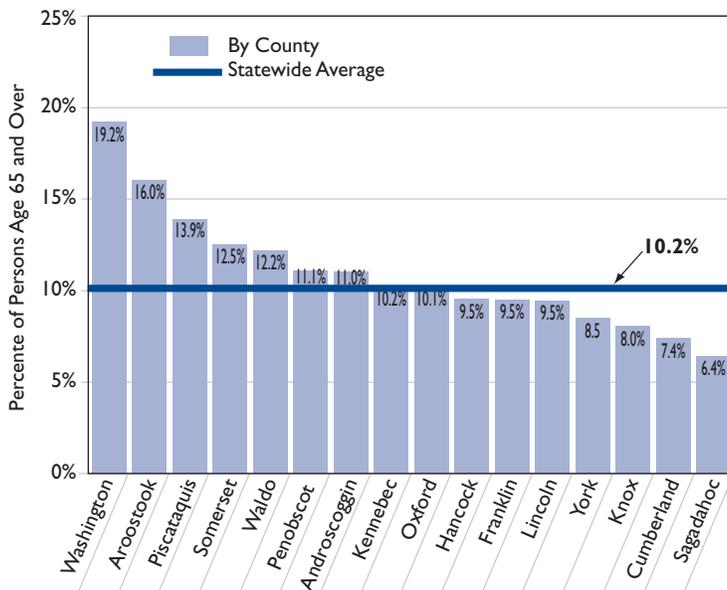


Source: Colgan 2002

boomers (AARP 2002, 32). In Maine, 29.5% of people over 65 live alone compared with 28.2% nationally. Figure 2 shows the declining number of adults between the ages of 19 and 64 relative to older people in Maine. The declining ratio is the cumulative effect of increases in older people (the baby boom), decreases in younger people (the baby bust), and Maine’s disproportionate out-migration of younger people to other states.

The increase in the proportion of the older population will be accompanied by an increase in the number of people with one or more chronic conditions. This will have an impact on the overall health care system, not just long-term care. A recent report of the Institute of Medicine reported that the health care needs of the American people have been shifting from predominantly acute care to chronic care. The report cited the need to redesign the existing health care systems to deliver the type of planned, proactive care needed to prevent and manage chronic illness (Institute of Medicine 2001, 17). The changes in demography will have an impact on the overall health care system in Maine and the long-term care system in particular.

**FIGURE 3: Persons Age 65 and Over Whose Family Income Was Below the Federal Poverty Level in 1999**



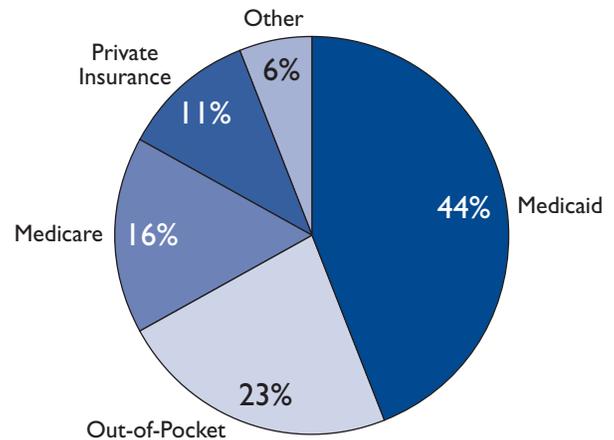
Source: U.S. Census 2000, Summary File 3 (SF3) Sample Data, Table P87

*How Will Socio-Demographic Factors Affect Long-Term Care Policy?*

Maine has an above-average percentage of people over the age of 65 who live in poverty. One in 10 people over 65 in Maine have an income below the poverty level. In addition, one-third of people over 65 live in families with incomes below 200% of poverty, reflecting the generally lower than average income of Mainers. For those needing nursing home level of care, eligibility through the state Medicaid program extends to people with incomes up to 300% of poverty who also have limited assets. Thus, the availability of long-term care benefits is not only an issue of importance to people below the poverty level, but for those with low to moderate incomes as well. The high cost and duration of chronic care services and supports means that publicly funded LTC programs are a critical component of the safety net for older people in Maine.

The rate of poverty among people over 65 varies greatly by county and region in the state (Figure 3).

FIGURE 4: **Medicaid Is the Single Largest Payer of Long-Term Care**



Source: Georgetown University 2003

In Washington County, for example, 19%, or almost one in five people over 65, have household incomes below 100% of poverty. In contrast, in Cumberland County, 7% of people over 65 live at or below the poverty level.

Given these sociodemographic factors, Maine is more likely than higher income states to rely heavily on public financing of LTC. Strategies to shift a greater proportion of the LTC cost burden to consumers through cost sharing or private insurance may have limited application. Given differences in income across the state, a diminishing state role in financing could also lead to increasing disparity between Maine's urban and rural communities.

### *Who Pays for Long-Term Care Provided to Older People?*

Long-term care policy is primarily a state responsibility. A state shares public financing with the federal government through the Medicaid program, known in Maine as MaineCare. Each state is responsible for establishing Medicaid policy within boundaries set by federal law, and the federal government matches state contributions to the program. Nationally, 44% of LTC expenditures are paid for by state Medicaid programs. Twenty-three percent of LTC expenditures are paid out-of-pocket by consumers. Medicare, the federal insurance program that provides primary and acute care coverage to nearly all older people, accounts for only 16% of national LTC expenditures (Georgetown University 2003) (Figure 4). This generally comes as a surprise to older people, who expect that Medicare will address all of their needs. Private insurance accounts for only 11% of national long-term care expenditures. People who develop LTC needs often rely first on family members and friends. When needs no longer can be fully met by informal supports, people pay for services out-of-pocket, turn to Medicaid or other state programs, or use a combination of private and public resources.

### **PUBLIC POLICY RESPONSES TO INCREASING DEMAND**

Maine expenditures for LTC in 2002 totaled \$333 million, Medicaid and state General Fund programs

combined (Maine Department of Human Services 2002). Modest but steady increases in the number of people aged 65 and older since 1990 have already begun to place pressure on the state's LTC budget, and by the end of this decade (2010), sharply rising numbers of older people will challenge the state's ability to sustain its current contribution to LTC financing.

The legislature recognized the looming fiscal challenge when it created the Blue Ribbon Commission to Address the Financing of Long-Term Care in 2002.<sup>2</sup> The preamble to the Commission's authorizing legislation states that "the increased rate of growth in the state contribution for these services requires a comprehensive plan that will anticipate future need and creatively design a solution for financing this need while maintaining high quality in the system and ensuring choice and independence for the consumer..." The Commission's Interim Report, issued in the midst of the state's 2002-03 budget shortfall, endorsed a licensing fee on LTC facilities designed to draw down federal Medicaid matching funds, but noted that "this is a short-term fix for a system that is in crisis due to perennial under-funding" (Maine Legislature 2002). The Commission's final report is due to the legislature on November 6, 2003.

Below we discuss three categories of policy options for consideration, as follows:

- Dedicate a larger share of public revenues to LTC;
- Increase public revenues to address increasing public costs; and
- Reduce per-person public costs.

These options are not mutually exclusive, and Maine is likely to adopt multiple strategies that span the categories.

*Option A:  
Dedicate a Larger Share of Public Revenues to Long-Term Care*

One option is to allow LTC to grow faster than other areas of the state budget, making its slice of the public pie bigger over time. Table 1 shows that the opposite occurred between 1995 and 2002. In 1995, Maine state dollars expended on LTC (exclusive of mental retardation services) represented 5.7% of all state General Fund appropriations, and by 2002, the number had dropped to 4.7%. (State LTC expenditures were calculated by adding the state’s share of Medicaid expenditures to expenditures in state-only funded LTC programs.)

**TABLE 1: Maine State Long-Term Care Expenditures (Excluding Mental Retardation) and Total General Fund Appropriations, 1995 and 2002**

	SFY 1995	SFY 2002
Long-Term Care State Expenditures (excludes federal matching funds)	\$96 million	\$121 million
Total General Fund Appropriations	\$1.673 billion	\$2.565 billion
State LTC Expenditures as Percent of General Fund Appropriations	5.7%	4.7%

Source: Maine Department of Human Services (1999, 2002); total General Fund appropriations: Correspondence from Maine Bureau of the Budget, May, 2003

State LTC expenditures increased during this period, but General Fund appropriations grew twice as fast. Given the substantial growth in the state budget during this period of robust economic growth and increasing state revenues, higher levels of LTC spending have been accommodated without increasing LTC as a percent of the budget. The current fiscal climate is far more challenging, with all program areas fighting to protect current budgets against cuts. When the economy expands again, there may be room to increase the share of the state budget going to LTC, but the legislature and governor will need to balance LTC needs against many other demands, such as universal access to health care, increased funding to education and property tax relief.

*Option B:  
Increase Public Revenues to Address Increasing Public Costs*

Another option is to identify ways that new public revenue can be raised and used to finance increasing LTC needs. Included under this option are strategies that:

- Increase federal funding for LTC and related services;
- Increase state general revenues;
- Create dedicated revenues for LTC; and
- Create a social insurance program for LTC.

**Increase Federal Funding**

From the perspective of Maine taxpayers, increasing federal funding for LTC is perhaps the most attractive option, and it has been pursued aggressively for several years. For every dollar Maine spends on Medicaid services, the federal government provides a match of two dollars. Table 2 shows that between 1995 and 2002, Medicaid LTC programs increased by \$34 million, compared with a \$14 million increase in state-only funded programs.

In the past decade, Maine has pursued several strategies designed to maximize federal Medicaid matching funds. These have included exercising

**TABLE 2: Medicaid and State-Only Funded Long-Term Care Program Expenditures, 1995 and 2002**

	1995	2002	Increase, 1995 to 2002
Medicaid LTC programs (state and federal funds)	\$278 million	\$312 million	\$34 million
State-only funded LTC programs	\$7 million	\$21 million	\$14 million

Source: Maine Department of Human Services (1999, 2002)

optional Medicaid benefits, notably the Private Non-Medical Institution (PNMI) benefit to fund services provided in residential care facilities, and Private Duty Nursing/Personal Assistance Services (PDN), both of which now federally subsidize services that were previously provided with state-only dollars. More recently, the licensing fee on nursing homes adopted as part of the 2003 supplemental budget is used as state match to generate federal matching funds equal to twice the amount of the licensing fee. Medicaid reimbursement to the nursing homes is increased, ensuring that most facilities at least break even, and additional funds remain to increase funding of other parts of the LTC system and to decrease the state budget deficit.

However, federal Medicaid reimbursement does come with strings attached. The services may only be provided to people who are eligible for Medicaid services, which generally excludes older people who may need a relatively low level of service in their homes but whose income or assets or both are too high to qualify for Medicaid. Medicaid funding is also less flexible than state-only funding regarding the specific services that can be provided, and requires providers to maintain extensive documentation for billing and quality assurance purposes. For these reasons, some providers have resisted Maine's moves to expand Medicaid's role in LTC financing.

Given Maine's aggressive efforts to date, further opportunities to maximize Medicaid may be limited. The federal agency that oversees Medicaid (the Centers for Medicare and Medicaid Services, known as CMS) has expressed increasing concern about states' ability to exploit Medicaid reimbursement and is seeking ways to limit federal funding for the program.

The federal government may relieve pressure on state LTC programs in a less direct but potentially substantial way if it creates a Medicare prescription drug benefit. Maine's public expenditures on prescription drugs are growing much more rapidly than public spending on LTC. Adoption of a Medicare drug benefit would reduce the state's drug costs, freeing up funds for LTC. Also, research has linked access to prescription drugs to the prevention of nursing home and hospital admissions, so expanded access to drugs may reduce the demand for LTC (Soumerai et. al 1991, 1072-7).

### Increase State General Revenues

The state always has the option of increasing general revenues through the income tax, sales tax or other broad-based taxes. Given the general unpopularity of taxes and the common perception that Maine is already a high tax state, this may not be a feasible strategy.

Paying for increasing LTC through increases in general revenue is a pay-as-you-go strategy, in which current taxpayers are providing the financing for current LTC users. This approach may not be sustainable by 2025, when the number of working-age adults relative to retired adults will have dropped from almost five (in 2000) to fewer than three (Figure 2). This approach, in which a subsequent generation is likely to experience higher levels of taxation and lower disposable income to support the needs of a previous generation that paid taxes at lower rates, raises issues of intergenerational equity.

### Create Dedicated Revenues for Long-Term Care

An alternative to expanding general revenues is to create special revenues dedicated to supporting LTC. Examples of special revenues that could be dedicated to LTC are lottery proceeds, tobacco or other settlement funds from class action suits, real estate transfer taxes, and sales tax on goods and services currently exempt.

The underlying rationale of dedicated revenue is that it has some logical tie to the group that will benefit from it. For example, a state may decide to dedicate a portion of the tobacco tax to LTC because smoking is associated with chronic conditions prevalent among LTC users, such as chronic obstructive pulmonary disease.

Dedicated revenue is often opposed by executive and legislative policymakers who oversee the state's finances, because it limits policymakers' ability to change fiscal policy as state priorities change. A dedicated revenue for LTC also establishes precedent for interest groups to invoke when they pursue dedicated revenue for children, higher education, economic development zones, or any other need that is important to some segment of the population.

Maine's public LTC [long-term care] system has absorbed considerable growth in people by serving increasing numbers in lower-cost settings.

#### Create a Social Insurance Program for Long-Term Care

Several countries, including Japan, France, New Zealand and Germany, provide LTC through social insurance programs, in which all or most citizens contribute through general or dedicated taxation and, as a right of citizenship, qualify to receive benefits from it. Social insurance can take various forms, as shown by the different approaches taken by New Zealand and Germany.

New Zealand includes LTC in its national health program, Vote Health. Vote Health is financed through general taxation and is available to anyone who meets residency requirements. Long-term care and disability services are capped at 25% of the Vote Health budget. Applicants must meet clinical criteria as determined by a needs assessment process, and services are delivered through contracted agencies, much as they are in Maine.

By contrast, Germany established a separate social insurance program for LTC financed through a combination of employer/employee and retiree contributions. People who meet clinical criteria for LTC are offered a choice of traditional services (e.g., agency-delivered home care or nursing home services) or a cash allowance. The cash alternative is provided to support private family-based arrangements and payments are

generally lower than for professional services. In the early years of the program, the cash alternative has been preferred over the services option. More recently, Germany and other European countries have moved to reduce the level and availability of social services—including pensions and health care coverage—due to the cost of supporting those services for an increasingly older population. This has produced protests from workers who are being asked to work more years with reduced benefits (Bernstein 2003).

Is it feasible for a single state to adopt a social insurance approach to long-term care? Hawaii's legislature recently enacted and sent to the governor a LTC social insurance program, funded by an income tax of \$10 per working person per month, to be collected through the state's withholding system and deposited into a special account controlled by appointed trustees guided by actuarial analysis. The fund would accumulate for a few years before any benefits were paid. Workers would pay into the system for at least three years before drawing benefits. Those who prefer to purchase private LTC insurance could do so and receive a tax credit. The bill was vetoed by the governor, who opposed creation of a new tax.

Creation of a social insurance program raises important questions for any state attempting to move forward on its own. States compete with one another for businesses and workers, and do not want to be viewed as having a relatively high tax burden. In creating new social programs, they also do not want to become magnet states, places where people move when they need social benefits not available in their states. Hawaii's geographic isolation may insulate the state from these concerns, but Maine would need to consider how a LTC social insurance program would affect perceptions of the state.

Whether considered state-by-state or nationally, taxes dedicated to a LTC social insurance program may be more politically feasible than general taxes. This is so because of the U.S. experience with Social Security and Medicare, which are among the most popular government programs, and because citizens tend to be more supportive of taxes if they know specifically where the money is going. If created soon, a LTC social insurance program could also address the inter-

generational equity problem by taxing tomorrow's LTC users today, while they are still working. However, the youngest boomers have now turned 40, so the opportunity to require their participation will be short-lived.

Unlike private LTC insurance, participation in a social insurance program is mandatory, eliminating the moral hazard of people delaying participation until they need or are close to needing the benefit. Hawaii's legislation was perhaps a good compromise for those who favor private insurance. It would have required citizens to participate one way or another, but those who chose to purchase private insurance would have had their public contributions returned to them through a tax credit. For those who fear monopolistic government programs, the Hawaii approach also provided for competition between a state social insurance program and products offered by the private insurance industry.

### *Option C: Reduce Per-Person Public Costs*

The third option focuses on reducing per-person costs as greater numbers of people receive services. Included under this option are strategies that:

- Direct people to lower levels of care;
- Increase cost effectiveness of services;
- Reduce payments to providers; and
- Reduce the publicly funded share of consumer benefits.

As Table 3 shows, per-person costs have been reduced in the seven years following Maine's 1994 LTC reforms.

### **Direct People to Lower Levels of Care**

Decreased per-person expenditures were realized in large part by shifting the LTC system toward less reliance on nursing homes and greater reliance on home care and intermediate-level residential care (assisted living, adult foster care, board and care homes). Between 1995 and 2002, the number of people receiving publicly subsidized care in nursing homes decreased from 9,945 to 8,175, while the

number of people receiving publicly subsidized home care rose from 7,623 to 12,690. People in residential care more than doubled, from 2,174 to 4,976. Maine's public LTC system has absorbed considerable growth in people by serving increasing numbers in lower-cost settings (Maine Department of Human Services 2002).

This was achieved by making the clinical standards for nursing home admission more stringent and strengthening the state's preadmission assessment process, changes that were and remain controversial with providers who now have less control over admissions to their facilities. In order to receive publicly subsidized LTC services in Maine, a person must receive a uniform assessment from the state's assessment contractor. Each person is counseled as to his or her options, based on the results of the assessment. As admissions to nursing homes decreased following the 1994 reforms, the state offered incentives to convert excess nursing home capacity to intermediate residential care capacity.

It remains to be seen whether per-person costs will continue to decrease absent any additional policy changes in Maine. The average acuity level (degree of clinical need) of people in Maine nursing homes increased as a result of the 1994 reforms, and the proportion of people served in nursing homes may now have reached its balance point.

### **Increase Cost Effectiveness of Services**

It may be that other opportunities exist to make Maine's LTC services more cost effective, however. For example, adult day center services have been very slow to develop in Maine, in part because consumers and

**TABLE 3: Maine's Per-Person Public Expenditures for LTC, 1995 and 2002**

	1995	2002	Percent Change
Public expenditures per person served	\$14,423	\$12,988	(10)%
Number served	19,742	25,650	30%

Source: Derived from Maine Department of Human Services (2002).

families often prefer the convenience of home-based services to those provided at a central day facility. However, the centralized staffing of the day services model can be operated more efficiently, and it can be a convenient form of care for family members who provide informal LTC but work outside the home during the day. Table 4 illustrates the relative cost per person of adult day center services and home-based care services in Maine in SFY 2002.

**TABLE 4: Relative Cost Per Person of State-Funded Adult Day Center and Home-Based Care Services in Maine, SFY 2002**

	Expenditures, 2002	Number of People Served, 2002	Cost Per Person Per Year, 2002
Adult day center services	\$388,927	155	\$2,509
Home-based care	\$12.8 million	3,873	\$3,304

Source: Derived from Maine Department of Human Services (2002)

More analysis is required to determine whether the characteristics of people served in these programs are similar. If they are, the services may be substitutable, and policy makers may want to fashion strategies that make cost effective service options more attractive to consumers and family members.

More generally, technology advances may make home care more cost effective in the future. Already, some agencies in Maine deploy home care workers from their homes (to reduce travel to and from administrative offices), and some nurses carry laptop computers to document their visits, and download data to a centralized record from their homes via the Internet. Some states are experimenting with “smart boxes” that are installed in people’s homes. The boxes, about the size of a microwave oven, can take vital signs and transmit them back to an agency office, call for help, and remind people to take medication.

### Reduce Payments to Providers

One simple way to decrease per-person costs is to reduce per-unit payments to providers. This strategy

carries the risk of underpayment, and should be employed only in specific service areas where the state has reliable data showing that providers have a sufficient margin to absorb a price cut without impacting quality or damaging infrastructure.

Reducing price may create pressure to move toward larger and larger providers who can achieve economies of scale in their administrative costs. This may be desirable from a cost perspective, but must be weighed against the reduction in consumer choice (stemming from fewer providers) and long-range impact on price if the state becomes dependent on a small number of monopolistic providers. Consideration must be given to the impact on Maine’s vast rural areas, which may be less attractive to large organizations that depend on large volume.

Of particular concern is the impact that price reductions would have on the direct-care workforce, the personal care workers and nurse aides who assist people in their homes, residential care facilities and nursing homes. Direct care workers earn between \$8.12 and \$10.18 per hour in Maine, and often are without health coverage themselves (Pohlmann 2003, 34-5). Even in the current economic downturn, providers in Maine and across the country are experiencing high turnover rates and staff shortages among personal assistance workers and nurse aides. The causes of this problem go beyond wages and benefits to include workplace culture, training, job status and labor demographics, but reduced reimbursement to providers is clearly an important factor.

### Reduce the Publicly Funded Share of Consumer Benefits

Private contributions to formal LTC services already represent 37% of LTC expenditures nationally. In 2001, this included out-of-pocket contributions (23%), private insurance (11%) and other private sources (3%) (Figure 4). Not included in these totals is the informal care provided by family members and friends. It has been estimated that 78% of adults receiving home care have unpaid care only, and another 14% have a combination of paid and unpaid care. Only 8% of adults receiving home care have paid care only (Georgetown University 2003).

Nonetheless, policymakers must consider whether the current balance of public and private contributions is sustainable in the long run. Approaches to increase private contributions include:

- Expanded cost sharing requirements. Cost sharing, in which the consumer pays for a portion of the service provided, can be structured on a sliding-fee scale, basing each person's contribution on ability to pay. Maine already requires cost sharing in its state-funded LTC programs and could consider expanding the approach to include Medicaid programs, but past efforts to increase cost sharing have been stiffly resisted by consumer and provider organizations;
- Stricter asset tests. Some of Maine's LTC programs (in general, those not tied to Medicaid eligibility) have high or no asset limitations. Older people with low income can receive publicly subsidized LTC even if they have substantial savings. Rather than making these individuals ineligible, the state may want to consider assets more fully in establishing sliding-fee scales for consumers. This would allow consumers to use savings gradually over time, rather than forcing consumers into poverty in order to qualify for public subsidies;
- Greater choice in return for reduced public subsidy. When Germany offered its citizens a choice of traditional agency-based LTC or a cash benefit of lesser value, a large majority chose the cash benefit. The socio-demographic background of the baby boomers makes a similar experience very plausible in the United States. In a recent survey of persons 50 years of age and older, the AARP found that 77% would prefer to direct their own services rather than receive agency-managed services (AARP 2002). But it will require a significant shift in the attitudes of policymakers, many of whom have concerns about fraud, abuse and quality of cash-based systems. Offering consumer direction as an

option holds great promise nonetheless; it allows the consumer to consider the tradeoff (more public subsidy v. greater control), rather than imposing a single policy solution on all consumers; and

- Expansion of LTC insurance. The price of long-term care insurance continues to make it inaccessible to lower income consumers, but the numbers of people with private policies have increased steadily over the past decade. The number of new policies sold nationally increased from 315,000 in 1988 to 582,000 in 1997 (Tilly, Goldenson, and Kasten 2001,

...policymakers must consider whether the current balance of public and private contributions is sustainable in the long run.

52). Penetration is still not significant enough to make insurance a major source of LTC financing, particularly in Maine, where income levels are relatively low. Coverage may grow, however, if more people gain access to group policies through employers, prices fall with increasing volume, insurance tax credits or subsidies are expanded, or public policy limits the amount of public financing for LTC.

## SUMMARY

Maine has taken many steps to prepare for the increasing LTC demand expected over the next 30 years as the baby boomers age. The service delivery system has been developed with a greater emphasis on home- and community-based care and, as a result, many more people have received service at a lower cost per person. Cost sharing has been introduced in most of Maine's LTC programs. Tax policy has been changed to provide incentives for LTC insurance.

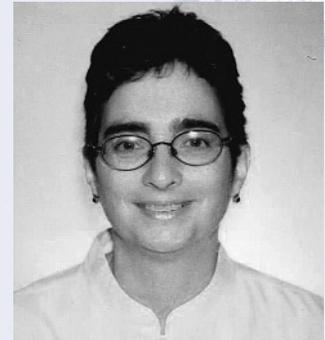
A special commission has been created to fashion a sustainable financing policy.

All of these efforts must now be accelerated and coordinated to fashion a coherent plan for the future of LTC in Maine. Furthermore, the interrelated nature of LTC and acute care must be considered as Maine moves ahead with a comprehensive approach to health care financing and reform through Dirigo Health. An expanded LTC system could play a vital role in controlling acute care costs, but if the two systems are not coordinated, the result of acute care cost containment is likely to be an unfunded cost-shift to the LTC sector.

We have argued that sustainable financing is the key issue, but as policymakers struggle with the appropriate balance between public and private financing, they must not lose sight of the goal: to provide good access to high-quality long-term care services in all parts of the state. 🐟



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**Julie Fralich** is Associate Director of the Institute for Health Policy and a senior research associate at the Edmund S. Muskie School of Public Service, University of Southern Maine. She has worked for over 15 years in the design, development and analysis of health policy options, with a focus on long-term care, and on policy, quality and financing issues for programs that serve older adults and people with disabilities through the Medicare and Medicaid programs. Fralich has lived in Germany, where she was able to get a close look at that country's social long-term care program.

## ENDNOTES

1. The authors would like to thank Stuart Bratesman for providing background research for this article. The authors also appreciate the insightful comments provided by Andrew Coburn, Elise Bolda and Jane Orbeton.
2. The Commission was created by Resolve 1999, chapter 114, effective April 11, 2002.

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