

**The Future of Long-Term Care and Medicaid**  
**Small Business Roundtable**

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Chairman Manzullo and Vice Chairman Barlett -- thank you for inviting me to speak before you today. I am here to talk about my thoughts on Medicaid issues and the recent Medicaid reforms.

Medicaid was conceived as an acute care program, serving recipients of welfare and their children. While long-term care services were covered, the rapid growth we see today began only decades after the creation of Medicaid. Today, long-term care expenses for the elderly and individuals with disabilities account for a large bulk of Medicaid expenses, and these costs are growing at rates that surpass state revenues.

Maryland, like most other states, has been forced to implement cost containment initiatives to deal with the growing Medicaid budget. Maryland's approach to cost containment is to minimize the negative impacts on beneficiaries to the extent possible -- such as avoiding cuts in services or programs and focusing primarily on reducing provider-rate increases. But with the continued rise in long-term care expenditures, a radical system change must occur. Key components of this change include providing community alternatives to institutional care and creating more accountability and integration within long-term care services.

The Deficit Reduction Act of 2005 (DRA) is an important step forward. It provides options to serve more individuals through community services instead of institutional services; it affords individuals greater control over their own care; and, it guarantees greater protections to ensure Medicaid serves our most vulnerable populations.

Today, I'm going to focus mostly about this last benefit of the DRA -- the protections to ensure Medicaid serves our most needy. The DRA closes loopholes exploited by some individuals in order to qualify for Medicaid long-term services. For instance, if individuals inappropriately transfer assets for less than their fair market value within five years before applying for Medicaid, the DRA requires that penalties be imposed. The penalties delay Medicaid payments for long-term care expenses. Previously, states examined a three-year period rather than a five-year window. Another change is that penalties now begin on the day individuals are determined eligible or when the transfer occurred, whichever is later. Previously, penalties began when the transfer occurred, which oftentimes was before the individual applied for Medicaid. The result was that there was often no impact on Medicaid payments for the individual's long-term care and that the asset was successfully shielded. To provide states the flexibility to exempt individuals from penalties, the DRA permits a state to grant a hardship waiver when warranted.

A second provision of the DRA requires that states consider home equity when determining a nursing home resident's Medicaid eligibility status. Prior to the DRA, a nursing

home resident could own a home and remain eligible for Medicaid regardless of the value of the home. Now a resident is ineligible for Medicaid nursing home payments when that person retains more than a \$500,000 equity-stake in a home. The DRA permits states to raise this limit to \$750,000. By considering an individual's home equity, the DRA provides an additional safeguard to ensure that Medicaid is the payer of last resort. The DRA ensures, however, that undue hardship is not placed on spouses or a minor or disabled child – in such cases the housing equity limits are inapposite.

Both of these DRA provisions demonstrate the need for balancing the individual's circumstances against the purposes of the DRA. We recognize that not everyone has intentionally diverted assets in order to qualify for Medicaid, and the DRA's hardship waiver provision provides a mechanism to make specific exceptions when necessary.

Although the federal requirements do not allow states the flexibility to establish minimum limits when examining resources and gifts, we are seeking to reassure citizens that the rules will be applied fairly. In Maryland, we are looking for payments where the perceived intent is to circumvent the eligibility rules. *De minimus* amounts, reasonable gifts, or routine donations do not create anomalies in one's financial condition and normally would not trigger the penalty provisions. Of course, in circumstances where a one-time payment is made but equity requires that we not apply the penalties, we are able to utilize the DRA's hardship waiver provisions.

Additional reform efforts are needed, however. Medicaid cannot sustain being the nation's long-term care insurer. Maryland encourages reform efforts that would make it easier for a senior to execute reverse mortgages. In particular, the application process needs to be easier for seniors and we recommend reexamining the administrative requirements associated with such mortgages, *i.e.*, reducing required paperwork and simplifying regulatory forms. In addition, we suggest reducing the upfront costs associated with obtaining reverse mortgages. Tackling these issues should, we believe, promote the use of these helpful financial tools.

Finally, much more needs to be done to integrate Medicare and Medicaid services. This includes financing, delivery, and administration of primary, acute, long-term care, social and behavioral health services. Many elderly persons and individuals with disabilities are served under both programs, and too many existing barriers prevent us from providing a totally integrated care plan for these populations. To address this issue, Maryland submitted an 1115 waiver to the federal government last August, which seeks approval to operate a managed long-term program. Under the waiver, individuals would enroll in Community Care Organizations (CCOs). While we cannot require individuals to enroll in a CCO for Medicare services, we would require that the CCOs be licensed as Medicare Advantage Plans. Doing so would ensure that individuals have the option to receive all of their care under one organization, which creates a seamless care plan. Although barriers will continue to exist regarding enrollment, marketing, quality assurance, and data sharing, we need to integrate all of these areas into one comprehensive program for Medicare and Medicaid.

Thank you for the opportunity to speak today.