

Your Medicaid Matters: Serious Threats From Capitol Hill

First in a series of Public Policy webinars

National Spinal Cord Injury Association Webinars

United Spinal Association Public Policy Program

JOSEPH ISAACS: Let me say that this is the first in a series of webinars we are holding for our own constituency in preparation for what we expect to be a very exciting role on Capitol Hill this June. As we bring in members of our chapters and the leaders from our support groups to participate in an advocacy day and conference in Washington, D.C.

I should tell you at the outset that the title Your Medicaid Matters: Serious Threats from Capitol Hill, reflects that the target for that effort will be Congress, but the assaults are also coming from, as you may well know, the administration and individual states already when it comes to Medicaid.

We hope this webinar will provide a solid primer. And I say primer because we both expect that this will be an effort to reach lobbyists. Already it is an effort to reach our constituents or members and those with disability to help them better prepare their own arguments when they advocate on behalf of Medicaid, because we think the assaults are as serious in the coming year as they have been in the past year.

Let me begin by gratefully acknowledging the two sponsors that make this webinar possible, the prescription drug manufacturer, Allergan, and the device manufacturer, Permobil. Thank you to those sponsors.

To raise questions in dealing with the housekeeping question is to use your ask a question box. That is good for your comments; that's good for your questions. If we don't get to your question in

this broadcast, we certainly will make every effort to get to them thereafter. They are not lost and will be kept in our records. We will get back to you individually with as good an answer as we possibly can, and accept your comments to further edify us in terms of our creating our own arguments as we go to Capitol Hill.

So what are we doing today? We are going to discuss why Medicaid matters, and we are going to discuss what is driving federal policy maker actions to cut Medicaid support, what cuts have been proposed and how they are harmful to you. What alternative approaches to savings are available without necessarily undermining needed care, and lastly what messages should we send to policy makers about preserving Medicaid as we know it? Why Medicaid matters and what is at stake.

Well, for those who aren't appreciative of what Medicaid is, Medicaid is a federal-state healthcare financing partnership and delivery mechanism that currently expends \$400 billion dollars to provide coverage to 67 million low income people in the United States.

Medicaid underwrites healthcare benefits for the poor or near poor children, expectant mothers and families. But, and more importantly to our crowd, it provides basic healthcare and long-term care services and supports for people with disabilities and low-income seniors, both institutionally under the mandatory benefits and within the home and community on the optional side of the equation. I will explain that further in a future slide.

It is important to realize that Medicaid accounts for almost a fifth of all healthcare coverage in the United States, and almost a fifth as well of all healthcare spending. You will see that, as I

suggested, it is a federal-state partnership and there is a federal Medicaid match.

The federal government is actually the bigger partner financially in 70 percent of the states. The federal government share ranges from 50 to 74 percent of the Medicaid costs in each state. As I said, it is a larger partner in 35 states and the District of Columbia. It pays at least two thirds of the cost in 12 states.

Medicaid is the largest source of federal revenue to states, contributing to local business activity and jobs. The 45 percent figure in this area here shows that by large amount the federal government provides most of the Medicaid funding that is available to the states.

In all other programs that the federal government supports, only 43 percent of those dollars are expended on all other programs. Clearly Medicaid is a big ticket for the states, not only in terms of providing healthcare, but also providing jobs and ancillary business activity.

This is a slide that suggests to you how important a role that Medicaid plays in terms of the healthcare system and our safety net. In the left box you will see that 29 million children and 15 million adults, who are low-income families, are covered; 15 million elderly and persons with disabilities; and 20 percent of all those with severe disabilities are covered by Medicaid.

The assistance to Medicare beneficiaries is a critical point that has to be made. The 8.9 million aged and disabled are included in those that are what we call here in Washington DC the dual-eligibles, those who are enrolled both in Medicare and Medicaid; 3.4 million of those obtain Medicare coverage after being approved for social security disability benefits, and are under the age of 65.

Twenty-one percent of all Medicare beneficiaries receive Medicaid support.

In terms of long-term care assistance, Medicaid covers **[unintelligible - 0:06:55]** 40 percent of all long-term care costs expended in the United States. It covers one million or 70 percent of the residents in nursing homes and 2.8 million individuals who receive long-term care services and support in their community.

We have an important veteran's population that we assist and represent within the Spinal Cord Association. In terms of veterans and those dually eligible for VA benefits and Medicaid benefits, it comprises 10.2 percent of all VA annual patient load that receive Medicaid benefits, which is about 612 thousand Veterans.

Medicaid covers one in 12 military children and one in nine with special needs; critically important as well on the disability side of the equation.

What people don't realize as well is that there are two programs, Medicaid Infrastructure Grants and Medicaid Buy-in programs in the states that promote higher employment rates in more than two thirds of the states for those on Medicaid, without necessitating those individuals or enrollees lose their eligibility.

I put this out there because these are the mandatory Medicaid services that must be provided by all plans in all states. It is a robust plan. It provides major medical. It provides basic physician services. It will give you what a good large small business insurance plan will provide, but it also provides nursing home or nursing facility services for beneficiaries aged 21 and older; very key to our population. It also provides Home Health services for those beneficiaries who are entitled to nursing facility services but

can receive those benefits in the home, as many with disabilities do.

On the optional side of the equation are tremendous benefits that really are taken advantage of by our disability community, ranging from Mental Health services to nursing home care for those under the age of 21. The key to this and what we have made much of our advocacy focus on of late is the home- and community-based services.

When we talk about optional, there is community first choice option, which promotes de-medicalized care which focuses on personal care assistance and activities of daily living. We are talking about key areas of need for our population. These are optionally offered by most states, but you will see in the schema that in some of these Medicaid cut proposals they could be eliminated very easily. That includes prescription drug coverage, as well as rehabilitation therapy services as well, which are considered optional and not mandatory benefits of Medicaid. They exist now, and they are very, very important.

The elderly and those with disabilities account for the bulk of overall Medicaid expenditures. Disabled and elderly account for 25 percent of the enrollees, but expend 68 percent of the dollars, with 43 percent of the overall dollars being accounted for by the services provided to those with disabilities.

As I alluded to before, Medicaid plays a crucial role for Medicare beneficiaries. This is important because there are potential cost savings related to this population with dual eligibility for both Medicaid and Medicare and because a big chunk of Medicaid spending is for this population.

Unlike Medicaid, there are premiums, co-payments and deductibles that have to be met by Medicare beneficiaries, and Medicaid pays for those when you are dually eligible. It also underwrites the non-skilled long-term care services and supports that are achieved in home and community. It also provides for nursing home care, up to a level of private pay, semi-private pay, which now is about \$75 thousand plus dollars yearly. It provides dental services and others. It is a crucial gap filler for those under Medicare when they don't have Medi-Gap services and are of such low income they could not afford it.

The dual-eligible population comprises 15 percent of all Medicaid enrollees. As you can see from the left circle on the pie chart, it accounts for 39 or close to 40 percent of all Medicaid spending, with the greatest proportion of the spending going to long-term care by far.

Medicaid acute care spending for those with disabilities is about three times higher than other enrollee populations within Medicaid. When long-term care costs are added, enrollees with disabilities present Medicaid with its highest cost per enrollee. This is trying to convey to you the true value of Medicaid to our population and what truly is at stake.

Here looking further into the long-term care side of it, which isn't offered unless you can afford private insurance for this purpose and many don't, very few do have private insurance for long-term care coverage. You will see that in 1995, 80 percent of Medicaid long-term care expenditures supported institutional care. Some 12 years later, we look at the breakout of institution-based care, which includes nursing facilities and intermediated care facilities for those with mental retardation.

Rather than 80 percent, we have reduced it to 60 percent, but by and large – and this is an important point I am going to come back to, the bias for institutional coverage within the long-term care context of Medicaid is still there. Now looking at this from the perspective of a state-by-state emphasis on home- and community-based spending versus institutional care, you will see that we have a long way to go to achieving a more balanced approach to long-term care, in ways that we believe we will save expense by going further into the home- and community-based services.

Half of the states provided less than 40 percent of their long-term care benefits in the home or community. There continues to be a bias for institutional care, which is still mandatory under Medicaid, the home- and community-based care optional. We still have a long way to go to move that balance in the other direction.

What is driving the current proposal to cut Medicaid support? Using a phrase that was used during the Clinton administration campaigns, “It’s the economy, stupid.” We all know how our economic situation has led us to record federal budget deficits of currently \$1.3 trillion dollars. We are hovering at a national debt of about \$16 trillion dollars.

Our population is aging with the coming of the baby-boomer generation to senior status. That will occur over the next 20, 25 years. It will come to a point where the population is one-fifth 65 years and older.

We have a poor population. Recent studies have demonstrated that one in six families now live in poverty. It is creating additional stress and need in our population under economic stress. More people are on Medicaid because we have had an economic downturn. It is what is called an Accounts Reciprocal

Programming. Under such programs, when you see an economy falter you will see an increase in need.

You are also going to see a lot of discussion in terms of resistance to new tax revenues in Congress as we look at preserving payroll taxes and President Bush's tax cuts, and a lot of discussion as you heard after the State of the Union about class worker. But the point is there is still tremendous resistance to raising taxes on Americans, regardless of how much they earn. It has placed additional pressure on spending cuts.

There is general opposition that continues to persist on the Affordable Care Act, Healthcare Reform, and the expansion of Medicaid under it. The reality is that Medicaid is the states' fastest growing expenditure per capita.

This slide is drawn from the very conservative Heritage Foundation. You will see that between 1989 and 2009, state per capita spending on Medicaid has risen by nearly 200 percent, far outdistancing roads and other spending categories.

Since the recession, Medicaid has added more than 20 million enrollees, going from about 42 million in 2007 to the current estimate level of 67 million in 2012. This is interesting, because while the number of those in need in Medicaid has been the primary driver, the primary driver has been the number of those in need, and not really the fact that expenditures within Medicaid have been growing by virtue of the inability to contain costs.

Interestingly enough, the bulk of the total spending growth is achievable to [unintelligible - 0:18:21] growth, that 20 million I described to you. Even before then, the period of 2007 to 2009, we saw enrollment growth being the primary factor. In fact, spending

per enrollee grew by about 3.8 percent. In fact, this only goes through 2009.

In the last two years, spending within the Medicaid program per enrollee has been at about a growth rate of about 2.6 percent, so it's even more limited in terms of actual expenditures on individuals; it is purely volume that is really growing the program.

To add emphasis on this point, between 2000 and 2009, although Medicaid benefits are as much as other small business or better insurance plans in the private sector, or more robust than most employer-based health insurance plans, Medicaid has been more efficient, with total Medicaid per capita costs rising on average by only 4.6 percent, compared with an average rise during this period of 7.7 percent in employer-based plan premiums.

One would be hard pressed to argue that Medicaid has not been an efficient program in trying to contain costs. Here is the concern that we hear from our detractors, in terms of the future of federal spending. The impact of the Entitlement Programs, Social Security, Medicaid and Medicare is projected as a proportion of overall federal spending to reach half of federal spending, or nearly half, by 2021 if all current policies continue and no new revenues are provided to supplement that spending.

The belief is that in the long run this will be unsustainable and we have to cut programs vastly to ensure that those programs still exist, despite the fact that they may be so poorly undermined in terms of breadth of benefits.

Current policies are not fiscally sustainable. We all can acknowledge that. You look at that revenue line right here, and you will see that to put it another way, without additional federal revenues it is projected that existing revenue levels would meet

less than half of the government's obligations by 2050, and that interest on our debt to meet those obligations would grow to nearly more than one third of our obligation of federal spending.

So that gives you the context of what we are up against in terms of the current discussion. It is largely being driven by the efforts to control federal spending and to reduce the deficit.

While the federal government continues to look at how best to do that, the states have already been containing their Medicaid expenses, though our focus today is on potential federal actions that undermine Medicaid.

They have been busy. They are raising your cost-sharing responsibility, a higher copayment. They are reducing payments to physicians, hospitals, nursing homes and home health care providers and others to the point where we're also very concerned about access to care in the future.

More and more providers scratch their heads and ask themselves, is there enough in this for me to be able to put up with the paperwork burden and the regulatory burden of staying in a program that is paying me potentially 60 cents on the dollar and scaling it back routinely and whether or not that is helping or hurting my practice.

There is expanding patient enrollment in Medicaid managed care plans. The train has left the station in that regard. Many of the advocates in Washington DC are busy trying to create the principles for Medicaid managed care, dealing with more of our disability population, many of them in that dual-eligible population that isn't touched by managed care efforts.

Managed care efforts, as some of you may recall, began back in the day when HMOs were created and more pressure was brought to bear on creating managed care organizations to contain costs by making more efficient the coordination of care without hopefully hurting the delivery of quality care.

The states are limiting benefits. They are looking first at not what can't be cut mandatorily, but what can be cut from the optional side of the equation. We are seeing large states like California and others, who have had very serious deficit problems, looking at the key benefits like home- and community-based services and supports to scale back in any way they can the extent of that coverage, whether it be in terms of visitations and other needs.

The only saving grace we have had to not see deep cuts, as could have been on the state side, is the fact that under the Affordable Care Act there is a maintenance of effort requirement that limits the capacity for states to reduce enrollment and breadth of benefit without federal oversight. In some instances, some of the changes that have been suggested that would lop off those eligible and reduce enrollment have been rejected by the federal government, as in the case of Arizona. Those protections are being challenged by federal efforts as well from Congress. We are going to see that battle continue with the discussions of potential repeal of the Affordable Care Act. The future of that protection is in doubt as well.

What about these attacks at the federal level, and the focus of what we are discussing today? We are probably going to see a repeat of a lot of the effort that was brought to bear last year to cut Medicaid.

Whatever form or fashion you have heard it, the efforts at bipartisan panels, whether it be the Simpson Bowles, or the **[unintelligible - 0:25:51]** committee or other efforts, there are many. It ranged in terms of Medicaid hits from \$100 billion, which the White House put on the table, to as much as \$375 billion over 10 years. I can tell you that the end result of this discussion was a decision that was passed in the Deficit Reduction Act, which agreed to \$1.2 trillion dollars in cuts.

We dodged a bullet in Medicaid in that one. There will be automatic cuts made beginning in 2013 that exempt Medicaid, but only right now. There is a great deal of discussion on Capitol Hill about reopening that legislation and amending the law to take out the agreed-upon automatic cuts that are called sequestration, and I would take too long to explain what all that means, but essentially the spending cuts that would occur over 10 years. They want to go back at Medicaid and go more deeply into the cuts in Medicare and potentially put Social Security on the table as well, in an effort to soften the blow on defense spending, which will take a lot of the brunt of these original automatic cuts. That story isn't closed, and we're likely to have that revisited before 2013 onset when these automatic cuts come into play. That is \$175 billion that has been discussed in that context.

There are also global spending caps proposed. There was a proposal that... well, it doesn't matter, it was **[unintelligible - 0:27:49]** in the Senate that was the most prominent, but it would essentially say, "Okay, government, we are going to arbitrarily decide that we are not going to spend any more than a certain percentage of our Gross Domestic Product." Right now, the federal spending in terms of our Gross Domestic Product runs about 22.6 percent of our overall economy. In that instance it

would set at 20.6 percent, a figure actually that hasn't been seen since the Eisenhower administration, in terms of federal spending.

If that were approved, and there is discussion of new spending cap proposals like that, that would arbitrarily set the targets that would produce automatic cuts. That proposal alone would have cut Medicaid by \$547 billion over 10 years. We are looking at even a harder hit that will be discussed in the context of new legislation.

Lastly, within the context of the budget, there was a House-approved budget that contained a proposal led by Representative Ryan from Wisconsin, who is the Chair of the House Budget Committee that would have changed the construct of Medicaid entirely and thrown out Medicaid as you know it by virtue of moving into a block grant program. Saying, okay states, here is what the federal government is prepared to give you; no more than this amount. If it falls short of your needs, unlike with current Medicaid you give a percentage from the federal level towards whatever the expense is, we would say, no, that's it. The rest would be left to the states to determine how to meet.

With states constrained in their own budgets, what this would lead to is heavy cost shifting to the states, which they would be shifted to the providers, who would then shift it to beneficiaries. We wouldn't contain costs; we would just be shifting costs. That would be a terrible remedy because of the mandatory and optional benefits that I described before, many of the optional being important to the disability community and they would be thrown out the door, because Medicaid as we know it would not be any longer. It would be a block grant program. It would give greater flexibility to the states to recreate Medicaid. If it was a more conservative governor in the administration of states, we would see dramatic changes to Medicaid.

A projection of what would occur, even in the Ryan proposal, which is intended to be brought back in this year's budget, would be a \$1.4 trillion dollar budget to Medicaid alone over 10 years, or enrollment dropping by 31 to 44 million people by 2040. That is a steep hit, when I described 67 million people currently enrolled. It would be more than half of those enrollees dropped. That is what is at stake. That is what is going on here at the federal level. Are there any approaches that we see that could remedy this concern about costs without sacrificing needed care? We think so.

One way to do it is to rebalance the federal Medicaid payment formula and plan requirements to shift a greater long-term care emphasis, which I will remind you that the Medicaid program is a defacto long-term care financing system. It pays for 70 percent of those in nursing homes today. Shifting that emphasis from the institutional care, which is considerable cost averaging \$150 thousand dollars a year for a private room, to lower-cost home- and community-based services and support.

There's a litany of programs you see on this slide that would enable and incent states to move in this direction. I won't go into detail about each of them, but they are existent now. It removes barriers to home- and community-based services and targets benefits to particularly populations of needs. They would reinforce the percentage and increase emphasis on activities of daily living and instrumental activities of daily living in a manner that respects the disabled population.

There is consideration as much about function as there is about the medical side of the equation. There are efforts to give more early money to the states to restructure their programs to allow for more home- and community-based services in their states. The federal government already has on its books several means by which to

enable individuals to self direct their care and promote a grant to individuals. Those have already demonstrated savings.

In fact, the Lewin Group, a major private sector think tank that does a lot of studies for the federal government, states and the private sector, found in a 2011 study of Rhode Island, which was looking at their Medicaid and saying why are we achieving savings? Let's understand this. They attributed most of the savings to the shift in policy in that state to home- and community-based services and away from more costly institutional care. What we are saying here is, if you remove the emphasis of institutional care and shift the emphasis to home- and community-based care, there are savings in the offing.

A second approach we would promote is improving the care coordination for Medicare and Medicaid dual-eligible enrollees in managed long-term care services plans. Now, there is a great deal of concern in this regard. Not in the disability community, largely included in this construct, and **[unintelligible - 00:34:44]** that some in our population will never fit well in the construct of achieving more efficient coordinated care.

On the side of the physical disability, we believe that greater coordination and continuity of care can be achieved, can achieve greater cost savings. Right now among the dual-eligible population, less than 10 percent of those covered enrollees are in managed-care programs.

We think there is a lot of room for adding additional members of this population in managed care without hurting care, as long as – and those are the bullets here – there are strict principles and requirements ensuring patients' rights, protections and due process; that state systems are truly prepared and can phase in this

introduction and not go full stop before they know what they are doing; that there are adequate provider networks because of the specialty needs that are considerable within disability communities.

The care continuity integration occurs at all ages across the whole continuum of care, from acute care to long-term care. That there is strong government oversight in quality management and that stakeholder involvement, that is the constituents and their care giving family members are all involved throughout the development process from onset of planning, to implementation, to quality management, to innovation. If that occurs, we believe there is real opportunity for cost savings without reducing benefits.

A third major approach is in the arena of the dual eligibles again. We think we ought to make available Medicaid's discounted pharmacy pricing to dual eligibles and low-income Medicare Part B enrollees. Right now that benefit isn't available to those who are dual eligible; even though they have Medicaid enrollment, they are captured under the Medicare pharmacy benefits within Medicare, and do not enjoy that rebate.

There is a bill called the Medicare Drug Savings Act of 2011 that would change this and allow for the rebate to be applied to that population. Remember, that population is 39 percent of the spending in Medicaid and could save \$112 billion dollars over the next 10 years, if applied. It would require drug companies to offer Medicaid discount pricing to dual eligibles for them to continue within the Part D program under Medicare.

We think this is going in the right direction. Frankly, before Part D was created in 2006, all Medicaid enrollees, including those that

were dual eligible, had this rebate; it was altered at that time. We think it needs to be renewed.

We ask ourselves, how do we simply say this to our congressional policy makers, to the White House and others that will listen? First of all, we have to make it personal. We have to start with My Medicaid Matters, which is a clarion call that we have been using with other groups. We had a marvelous rally here in Washington this past year, and continue through multiple organizations to stand firm in that regard in terms of motivating at all levels, states and federal government, to appreciate that the services and supports provided by Medicaid are a lifeline, a genuine lifeline for millions with severe disabilities to more healthy and productive independent lives in our homes and communities.

In fact, as you see in the footnote, it reinforces the law. Under the Olmstead decision that reinforced the Supreme Court ruling on integrated provision of services in public accommodation under the Americans with Disabilities Act, the promotion of integration of those with disabilities in their community settings is key. We certainly believe that it is critical that Medicaid continue that reinforcement.

Frankly, there is no truer statement than cutting Medicaid hurts people. They are not on Medicaid because they desire to be. They are on there because they are low income or they are disabled in a manner that they are in need of provision of care they can't have otherwise. Many of them want employment opportunities, but it is a challenge when 18 percent of those who are employable among disabilities can't get jobs.

The unemployment rate is more than three times higher for those with disabilities than they are in the able population. It is an

efficient program. It is containing its spending per enrollee far better than the private sector spending occurring with employer-based programs. It is fulfilling its historic purpose of giving care to people who are most in need. When the economy improves, it should improve in terms of reduced volume and reduced expense. Right now, what we are seeing is need, a genuine need.

Thirdly, we are all concerned about our economy. I don't think anybody isn't, but the burden of the deficit reduction and ever-rising healthcare costs shouldn't be placed on the shoulders of those most vulnerable, and these are the most vulnerable of our population. Medicaid was set up to address those most vulnerable. It is unfair to expect that those most vulnerable and already largely below poverty level, would take the burden of these cuts.

Fourthly, Medicaid's **[unintelligible - 00:41:17]** structure is effective. Those who are on Medicaid, 70 percent say that it is meeting their needs, 70 to 80 percent of all Medicaid constituents say it's effective. Arbitrary cuts will merely shift the costs to states, which cannot afford to have them occur. Healthcare providers, which are already threatening in droves to leave the program because of discounted pricing, and beneficiaries, because of the expectation they will have to undertake greater costs payments on their own or find other means of finding care if Medicaid reduces enrollment.

It contributes to hurting local businesses in jobs. As you will see in that second footnote, Families USA did a study in June, 2011, which shows for every \$1.00 that Medicaid expends locally, it returns \$4.00 in business activity. If you take away that \$1.00 and you are losing \$4.00 in gains that provide for the economy in those localities.

For every five percent cut in Medicaid, they looked at large states that have the largest employment of Medicaid enrollees, New York, California, Pennsylvania, Florida, Ohio, Illinois, North Carolina, Michigan and Massachusetts. If we cut Medicaid by just five percent, and believe me, some of the proposals I have suggested to you would go far deeper than that. Just five percent would cut jobs by 144,000 in just those states alone. In all of the other states, the other 41 states, you would probably see an equal number cut. We are looking at close to 300,000 jobs lost because Medicaid would be cut. That would not help our economy.

Point five is to wrap our arms around the solutions that we offer. The government can achieve cost savings without undermining Medicaid's coverage, finances and service delivery. We can advance use of home- and community-based services support over more costly long-term care, and deliver on the care that is needed and where people most want it and prefer it.

We can expand Medicaid managed care into populations more deeply, including the disability populations as appropriate. We can achieve, we believe, greater coordination and efficiencies across the continuum of care as long as there is strict oversight inpatient protections and we'll achieve great savings.

Going back to another Lewin report I saw in 2010, they suggested the immediate return on moving to managed care for more of the Medicaid dual eligibles would return an immediate eight percent cut, or about \$15 billion dollars in savings. That is real savings and yet they felt that it would not reduce the quality or continuity of care.

We need to available eligibles of Medicaid discount pricing, which they had before. If they had it again it would enable over \$100

billion dollars in savings over 10 years. It would exceed the amount the White House offered on the table during the deficit reduction negotiations.

And, to go to our last point... oh, I'm sorry, one more point on the other, to go back, and I didn't discuss this a great deal. There is a great deal of what is called fraud and abuse in Medicaid and Medicare. I have seen numbers on this range from \$23.7 billion for the two programs to \$60 billion from the states' estimate of the impact to Senator Coburn's recent testimony.

Senator Coburn is a Republican from Oklahoma. He suggested that that number was \$100 billion dollars. Whatever that figure is in reality just in 2007 the split between Medicare and Medicaid in that footnote is \$23.7 billion dollars in excess or improper payments. If we went after that on the Medicaid side in that year, we would save somewhere between one and 12.9 billion dollars alone. If the estimates from the states are real, and the figure is somewhere around \$60 billion dollars, there is more savings to be achieved by intensified efforts from program integrity and efforts at the state level to save expense.

We believe in intensifying that fraud and abuse effort. Last but not least, we believe our message resonates with what the general public has been saying. Consistently 60 to 70 percent of Americans polled, and this is from polls done by Pew Research Center and Kaiser Family Foundation, suggests that people don't want to see Medicaid cut. They support the program.

Frankly current estimates suggest that without Medicaid we would fragment an already fragmented system of healthcare even worse. I think people appreciate that. I think what we hear is an acceptance of a more balanced approach to financing Medicaid.

What I mean by that is, as I suggested to you, if we stay at flat revenues, we are in a boatload of trouble. We need to look at both cost savings, such as those we have offered up here, and the need for additional revenue, because volume may change.

As a baby boomer, I hope and pray that my Social Security and Medicare will be there someday, when I am ready, and that it will be there for my kids. We have to be prepared for that.

Denying the fact that solvency of the program and taxable revenue needs to increase means by which to ensure that those programs exist for our future generations is living in denial. We believe the approach needs to be a balanced one that includes both cost savings and new revenues.

I appreciate your patience. I thank you for going through this rather lengthy primer. I wanted to really present it to you in a manner that has you appreciate truly what is at stake, what is on the table, what is already occurring in some states and also try to get inside of some of the justifications we have created for our advocacy and hope you will join us in that effort. I will tell you that the presentation that you are hearing will be available on the United Spinal website, www.spinalcord.org in the next week or so with the capacity to hear it as well.

We will in the future as things like the next federal budget is introduced and activity occurs in February be reaching out to you and asking you to join us in activities to reach Congress with these kinds of messages. We hope you will support us in that regard and that we will join together with a unified voice to let them know that our Medicaid matters, and that there are better ways to achieving cost savings without undermining needed care and really fulfilling the needs of those most vulnerable in our society.

Again, to raise questions and to share comments, go to your “ask a question” box and we will do our best to respond to your questions. Thank you all for listening. I hope you have gained from this presentation and we look forward to working with you in the future towards preserving Medicaid as we know it as best we can and making changes in a manner that fulfills the needs and interests of those with disabilities. Thanks again. [Pause for two minutes]

We are still awaiting questions. If you have any, please just type them in and we will respond to you directly or via this phone call.

ALEX: Joe, this is Alex Bennewith. I work at United Spinal with you, just to let everyone know who I am. I just received a question from Jessica. Hopefully she is still on the call. She wanted an update on the Class Act.

JOSEPH ISAACS: Okay, the Class Act, which was community living assistance program. It was a component of the Affordable Care Act. Recently the Department of Health and Human Services, which was determining how best to make this occur and implement this in a financially sustainable manner, acknowledged that, as proposed, it was not in that condition as yet. Unfortunately that is the product of those who unfortunately labeled the program among other things a Ponzi scheme.

It was really an effort to have private sector coverage occur and make available insurance coverage to meet the costs of long-term care services in the gap between one’s own insurance and those of Medicaid if one spins down to it. Unfortunately the proposal is up for repeal. It is in committee now being marked up. A vote will occur on it any day. The status is in question. I can tell you

unfortunately there are detractors on both sides of the aisle about its future.

There is another question we have gotten about what future webinars we may be engaging in. I just happen to have a slide ready for that. Thank you to whoever asked.

I said this was a series of webinars that we are engaged in. This is the first of those that would be policy oriented, for those participating in our role on Capitol Hill. There is one occurring in March on Medicare issues. There is one in May, occurring on employment and government's role in helping those with disability with employment. We have some others in the interim. In March, there is one that will deal with getting the appropriate wheelchair, and your rights to getting the appropriate wheelchair, for those who are in our population. I am sorry. I don't know what just happened. There it is again. There is a series of them. Those are the dates they will typically happen. I believe the last Thursday, as this is in every month up through July for now. We welcome for you to jot them down. For those who are on this call and have registered for this webinar, we will be getting out messages to you about these upcoming ones. This is the list. Are there any other questions with regard to the presentation?

ALEX: Joe, this is Alex again. There are some questions on the role on Capitol Hill. How can folks get involved and reach out to their chapters and etcetera?

JOSEPH ISAACS: Thank you Alex. I forgot to mention that this is our inaugural role on Capitol Hill. Just recently in this past year, the United Spinal Association joined forces with the National Spinal Cord Injury Association and thereby gained wonderful chapters across the

country, as well as support groups. There are 62 chapters and support groups across the nation.

If you are, and this is in terms of the role on Capitol Hill, a member of United Spinal or the National Spinal Cord Injury Association, and you are interested in participating, I encourage you to go to our website and check your nearest chapter listed. Inquire with the leadership there about participating. We are, in this instance, the first role on Capitol Hill inviting from within our own organization. In future years we hope to open it up to a larger population of participants. Right now we want to get it off on the right foot and ensure the logistics work for our population. We are very excited about it.

If you are a member of the United Spinal Cord/National Spinal Cord Injury Association family, we would invite you to make contact with your chapters. You might find them on the website www.spinalcord.org or by contacting me, Jisaacs@unitedspinal.org and I will do my best to put you in touch with the appropriate individual to see what we can do. Any others, Alex?

ALEX: Yes, we do have some other questions. Obviously we can always follow up as well. We have all of these questions logged. One of the questions that came up is regarding managed care and adequate consumer protections or inadequate consumer protections at the state level. How can consumers and advocates push for more effective consumer protection?

JOSEPH ISAACS: It is a great question. You know consumer protections are typically achieved at the state level. Usually they are overseen by the Attorney General's office. In some instances the Attorney General has a specific office that addresses consumer protection

interest. That would be the first place I would inquire with, your state Attorney General's offices. See if there is such a Consumer Affairs Division and inquire there.

If there is need to help identify where those consumer affairs divisions exist in states, we would be happy to, based on that previous email address I offered, to help identify where that might occur and help you reach out. Typically that is where you would find it. At the federal level, it would be kind of a challenge. It is really the state purview to look at commerce within their states in that regard. The best outreach would be as I suggested, through the Attorney General's offices, and within that the Consumer Affairs Division.

ALEX: Joe, there is another good question. Somebody is asking about the status of the Able Act.

JOSEPH ISAACS: The status of the Able Act. It has been introduced. There are increasing numbers of cosponsors. It is still in play. It is an act that, for those who aren't familiar with it, would enable individuals with disabilities to put tax advantage savings away for purposes of supplementing their health needs, transportation needs, their educational needs, their dependent children and etcetera, in a manner that's tax-advantaged. As is the case with many 401ks, the IRA, although those are retirement benefits purely. It has been reintroduced. It is gaining support in terms of individual cosponsors.

We are hoping to generate enough support to bring it to the floor for a vote this year. With the constraints on expenditures, as I have suggested, the whole context of this year's policy environment will be hard pressed to push for something that will require additional funding to administer. I think it is being respected increasingly as

a program that will truly give people a chance to fulfill the life experience. The Able Act is an abbreviation for the Ability to Be Able to Live a Better Life Experience. I have hope that we will generate more and more sponsors that will drive impetus for achieving this in the coming year. If not this year, then we will promote as hopefully the economy improves the capacity to make this a reality.

ALEX: Thank you Joe. That was a good question.

JOSEPH ISAACS: I see one question that says, you know, there are so many important issues to be brought to bear, how are you going to choose among them to take to Congress? You have to keep it simple. I will tell you that a lot of what you are seeing in these slides are going to be left behind. We want to really focus on three areas for the upcoming role on Capitol Hill. We haven't prioritized them, but clearly Medicaid, since it is so critical to the underwriting of care to those with disability, is a primary concern.

We are going to present this as one of the major issues. We are going to condense our speaking points. We want those who are visiting their members to be able to add their own life experiences to this equation. Much of the discussion will be **[unintelligible - 1:03:09]** with major points and messages expressed. We don't want to forget, and I'll steal some of the thunder from our future webinars.

Under Medicare we have an archaic approach to the medical equipment and the availability of wheelchairs, and the capacity to have a wheelchair only for use within the home. If it is a complex wheelchair that needs to be customized to you so you won't end up in the hospital with bedsores and far greater costs healthcare-wise. The Medicare program does not address that adequately. We will

be discussing things like that. That is a key issue for us as well. That would be a lead behind.

There is this whole issue of in this economy, while others have suffered, the disability population has suffered more. Seventy percent of those with disabilities are not employed. Among those who are employable, in terms of the downsizing and the layoffs that have occurred, one in three are people with disability. It is hard to determine among those issues and issues like transportation.

I'll put a feather in our own cap: we recently had a big victory in New York, with the help of Senator Harkin and Mayor Cuomo and **[unintelligible - 01:04:43]** greater taxicab accessibility for individuals in the Big Apple. It was a big deal. The all new modalities for cabs. The 4000 new ones will have to be accessible cabs. We would love to see that happen nationally. Transportation could be an issue. It could be veterans' issues.

Right now, in terms of the answer to this question, we are looking at three major concerns for the role on Capitol Hill. Medicaid's future, Medicare and its approach to dealing with the needs of those with physical disability, both particularly with wheelchair use and **[unintelligible - 01:05:27]** concerns, and rehabilitation therapy concerns and lastly the employment issue.

If we are true to our motto about really fostering quality lives and in that regard the independence of individuals, independence is about mobility as well as the capacity to work. We want to be true to that and have our government help those individuals gain employment in ways that they deserve and achieve the equality that was promised under the Americans with Disabilities Act to

achieve that equality in all public accommodations, including employment.

ALEX: I just wanted to clarify to folks that an easy way to get involved is to join NFCIA, which is the way you can join our more than 60 chapters and support groups. It is an easy way to find the contact information for your state for chapters and support groups. Go to www.spinalcord.org and you are always welcome to follow up with Joe Isaacs or me Alex Bennewith. abennewith@unitedspinal.org. We can follow up with some other folks after the webinar. I see a couple of questions here. Are there any other final questions?

JOSEPH ISAACS: We have probably time for one more.

ALEX: Yes, do you see Joe on your screen, there is a question about the ADA? “Managed care failed to show compliance with the ADA and adversely affects people with disabilities. Does your organization oppose managed care?” That is the question that is coming in.

JOSEPH ISAACS: I think we need to get back to that individual asking. We don’t oppose managed care. We certainly support fulfillment of the Americans with Disabilities Act to its fullest. I would love to talk to the individual. We believe that managed care if done properly with the proper patient protections and strict governmental oversight can achieve greater coordination and continuity of care without depriving individuals of care. But without being able to flesh out that question further I don’t know how really to respond at this point to that individual. We will certainly get back to that individual. We have your email address and would love to hear your further insights.

ALEX: Those were the questions that came in.

JOSEPH ISAACS: I just noticed there is one person that said can we use these slides for our own purposes? Let's wrap it up on this. This is a good note to wrap it up. As soon as we are able to download it and put it up there. Yes, believe me I drew from many other wonderful presentations to put this together. Yes, it is available to you, as soon as it is up there. If you have difficulty pulling the slides out for your own presentation, let us know. These are drawn from many excellent presentations.

If you have interest in contacting the sources or references you have seen on a number of these slides, we would be happy to put you in touch with them to gain further insight. We hope you do replicate it. We hope our chapters will replicate it at the local level to the extent possible and at least share it with others so they can use it at their own pace. We encourage people to go to our website, www.spinalcord.org and listen to it again. Have others listen to it so that they can run it at their own pace and hear it all if they couldn't hear it now.

On that note, I will say the witching hour is about upon us. We thank you for your patience. I know I was long, but we got some great questions. I thank you all. I am looking at some of the comments thanking me for the useful information. I am grateful to you for listening to this and for your support of our advocacy. We are there for you and hopefully together we will achieve the end result we all desire. With that, I will bid you a fond adieu until our next webinar. I welcome your contact directly at jisaacs@unitedspinal.org. Thank you everyone./AT/jf/jk/sg