Medicaid Budget Crisis - What It Means for Long-Term Care

Presenters: Ellen Nissenbaum, Jennifer Beeson, Toby Edelman

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Hello, welcome to the Webinar. Welcome to the Center for Personal Assistance Webinar. I'm Lewis Kraus, Director of Training and Dissemination for the Center.

Today's presentation, Medicaid Budget Crisis-What It Means for Long-Term Care is being done in conjunction with the National Consumer Voice for Quality Long-Term Care and is another in a series of Webinars hosted by the Center for Personal Assistance Services.

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This presentation will take about 45 minutes and then we will open the floor to questions about 15 minutes before the hour.

If are you on the telephone, please mute your phone. If you are using the computer audio, please uncheck your audio button, that's the microphone button at the bottom left of the window. It should be gray, not yellow.

Because of the size of this group, we are only going to take written questions. You can write to us in the chat window on the left-hand side of your screen. It is probably best to send the message to moderators. If you have not seen that screen, go to the upper right-hand corner where there's a button, click that, click to where it says "show content" or "show other button," and you'll be able to see the entire window including the chat window.

If you have an issue during the talk, send a message to me or to moderators through the chat window. When there is question time, send those to the chat window as well.

The Center for Personal Assistance Services is funded by the National Institute on Disability and Rehabilitation Research of the U.S. Department of Education. It's a five-year research and training center. It first started in 2003. The current funding cycle began in fall of 2008. The goal of the PAS center is to improve the access, quality and cost of PAS for people with disabilities to live independently, comfortably and safely in the community and to participate in society, including employment.

There are five research projects at the

Center for Personal Assistance Services following five areas. The need for PAS. Home and community-based services, workers and caregivers, which is the PAS workforce, economics and workplace PAS, and emergency preparedness.

The major collaborators on the Center for Personal Assistance Services include the University of California San Francisco with Charlene Harrington as the principal investigator, the Center on Disability at the Public Health Institute in Oakland, California, the Topeka Independent Living Resources Center in Topeka, Kansas, the Paraprofessional Health Care Institute, PHI, in New York, Research Triangle Institute in Washington DC, and the Burton Blatt Institute in Syracuse, New York and Washington DC.

I would like to invite Janet Wells to give an introduction to her organization, the National Consumer Voice for Quality Long-Term Care.

Janet Wells: Hi, this is Janet Wells. Can you hear me? There is a lot of background noise.

I've been unable to hook into the call. You have on your screen a description of the National Consumer Voice. I would like to thank everyone for being on the line today and to thank the speakers especially and also the PAS center. Thank you.

Lewis: Moving forward. Today's speakers will be Ellen Nissenbaum, who is the Senior

Vice President for Government Affairs at the Center on Budget & Policy Priorities. We will also hear from Toby Edelman, the Senior Policy Attorney at the Center for Medicare Advocacy, and Jennifer Beeson who is the Director of Government Affairs at Families U.S.A.

Let me remind you, if you are interested in closed captioning, you can click on the CC button at the top of your screen.

Now, I want to turn it over to Ellen Nissenbaum. Ellen, you are free to go ahead.

Ellen Nissenbaum: Thank you very much. I'm pleased to be here and I appreciate being invited to this. I appreciate Lewis and Janet and the work of everybody on the phone who is working so hard to protect Medicare and other vital programs for our seniors and others.

What I want to do today. I will not take 45 minutes, is step back a little and talk about what is going on in Washington in terms of efforts to reduce the deficit that are related to must-pass legislation that will come up this summer to raise the nation's debt ceiling. And talk a little about how Medicaid is fitting into those conversations. What are the specific threats and perhaps to close with a perspective of the center, what would be the best policy outcome and the best ways for protecting Medicaid as we go through this.

I'm assuming most of you know, have heard

enough about the fact that the Congress every once in the while has to pass legislation that raises the nation's debt ceiling to avoid a default. It has been made clear by the administration that they need that legislation to pass by August 2. Republican leaders in congress as well as with some Democrats have indicated their support for raising the debt ceiling is contingent upon passing legislation that is either on the debt ceiling or passing it concurrently. Legislation that would reduce the deficit by making some immediate changes in policy and looking at other changes down the road that would help bring down the deficit over time. Now this sounds like a big complicated broadbased budget bill. Let me be clear in saying, we think at the center that some of the most policy and budgetary decisions affecting Medicaid and other critical programs will be made in the context of this debt ceiling bill and these negotiations. I will talk a little of the timing later, but we have an intense period between now and August 2. It is quite likely this is not resolved fully by August 2, and they may pass a short-term extension on the debt ceiling and come back and revisit it in the fall. We have at least several weeks, if not a couple of months' worth of major, major work in this venue.

We started this year in a somewhat different place in Medicaid than we are now. It's been

quite the trajectory since the beginning of the year. At the beginning of the process was the Ryan budget resolution that put $700--$800 billion of Medicaid cuts in the form of a block grant on the table and also would have repealed the health reform expansion of Medicaid. Closely following on the heels of that was the introduction in the senate of bipartisan legislation to impose a total cap on federal spending as the way to reduce the deficit, meaning that 100% of deficit reduction would come from cutting federal spending both entitlements as well and appropriated programs over the next decade. Those are still relevant issues, but they are not the immediate threats to medicaid at this point. The threats have really moved now into the context of the debt ceiling dynamics where we will not see an explicit block grant included. There's no question the administration will not a agree to that. And the administration has indicated that they do not support a total cap on federal spending that would be set at levels that would require very deep cuts. This has been referred to in Washington as the global spending cap. It is simply a cap on total federal spending, but the cap is set in ways that would require unprecedented cuts over the next decade. It is a cuts and cap year as we talk about. It is not just the size of the cuts that are under consideration for Medicaid and other related programs, but

the very nature and design of those cuts. We like to say sometimes in the budget world, you can live to fight another day on cuts, but fundamental changes to programs, structural changes to programs or even fundamental changes to our budget process which are very much on the table are much harder to revisit and revise or undo down the road when they often prove to be as bad as many people will project. It will surprise you as I move through the conversation that while we will talk about some specific policy changes being proposed in Medicaid, much of the fate of how well Medicaid fares in the deficit reduction dynamic and the debt ceiling less on revenues, less on whether the administration and congressional Democrats, as part of bipartisan negotiations, will insist that in any major deficit reduction agreement this summer or this fall, that revenues and spending cuts are on the table, not simply just deep spending cuts.

Now until about two hours ago the major venue for the dynamic on the debt ceiling and the major venue for bipartisan discussions was a working group led by vice president Biden. It included key congressional leaders from Republican and Democratic parties in the house and senate. It's a very small group of about ten negotiators that have been meeting almost daily to try to put together an agreement. As of late this morning, the principal Republican negotiator

from the house of representatives withdrew from the talk saying they could not reach agreement on the major issues. He and the speaker have already essentially called on President Obama to personally engage in negotiations with the top Republican leaders and obviously the top Democratic leaders in congress. That is all relatively within the last hour. So we will have to see how that plays out. But since the dynamics and issues affecting Medicaid don't really change, regardless where the meeting is or who is leading the room or who is in the room, let me talk through what the issues were with respect to the bipartisan negotiations. This is, I would note, the Biden working group was trying to reach an agreement by next Friday before the senate goes out for a one-week recess, because when the senate returns on the 11th of July they only have three weeks until they have to act to raise the debt ceiling. There is intense pressure to make decisions and move forward on the process. That will certainly be the case for the president.

There are two overarching components to the deficit reduction discussions and to the kind of package that would either come from the president's negotiations or possibly if the house of representatives goes ahead and moves their own debt ceiling bill.

So let me quickly lay out those two components. First let me say what they are

and then come back and unpack them a little bit. I would note that Medicaid is a significant risk in both components of any likely agreement on the debt ceiling bill.

The first is those series of specific budget cuts and policy changes that would be made now both in entitlement programs and in appropriated programs, or I will come back to appropriations in a second, to secure significant deficit reduction up front. This has sometimes been referred to as the down payment on deficit reduction in the bill in this emerging or the effort to put together this deal. And there is a general sense that Democrats or Republicans in the Biden talks were trying to get $2 trillion worth of cuts or $2 trillion worth of deficit reduction as the first part of this agreement.

I think I need to ask people to mute phones because there is so much background noise. It is all kind of reverberating.

So, within the $2 trillion, this, from view of the administration and Democrats, this is really along the framework of the budget proposal that the administration released in April, which means there would be cuts in discretionary or appropriated programs, there would be savings from entitlements and there would be revenue raised primarily from scaling back what are called tax expenditures or tax loopholes.

The Republican approach to this so-called down payment would be to secure all of the

savings from spending. There would not be any revenues. In fact, when Eric Cantor, the house leader left the talks this morning, he said he was leaving because Democrats were insisting on revenues and they want revenues off the table. The fear here is that you could see an agreement coming out that reaches $2 trillion worth of deficit reduction that would be put into law now with the overwhelming bulk of that coming from spending cuts and a modest amount coming from a few loophole closers of revenues, so the administration and others could say, Republicans could say, well, we all got a deal, everything's on the table, but the reality would be you would be looking very much at spending cuts. And the more the pressure is on spending cuts to comprise, two trillion or whatever it is and the fewer revenues that are in the mix, the more there is pressure to cut Medicaid and other programs. That is the down payment. I will get to the second part of the structure. The second component of a debt ceiling deficit reduction agreement which is a long-term deficit reduction mechanism in a moment.

Let me say another word, however, about what could happen to medicaid in these up front cuts or the down payment, whatever the word is you want to use for it. It is not I think at all likely that we could see Medicaid being fully protected from cuts. President Obama's own budgets in February and April

called for cuts in Medicaid. The president's fiscal commission called for cuts in Medicaid, bipartisan group in senate that was trying to reach agreement called for cuts in Medicaid, so the chance of no cuts is really virtually none. But, there is, however, a great deal of concern about the magnitude of cuts that could be on the table and specifically how those cuts would be secured, what would be the savings, and what would that mean for beneficiaries and for states? The administration's proposal -- we have the Ryan budget on one hand which was $700 billion, and on the other end of the spectrum you have the administration's proposal which called for, quote, at least $100 billion cuts in Medicaid and possibly more as well as at least $200 billion cuts in Medicare. The primary purpose of those reductions was to pay for the "doc fix" that gets done ever year in congress to help stop a cut in reimbursement rates in Medicare. To do a ten-year doctor fix is roughly $300 billion. So Medicare and Medicaid savings would first go to that and then there would be additional savings from the programs to help contribute to deficit reduction not just paying for SGR or the doctor fix. In the administration's proposal there were some small savings, a few things in Medicaid that did not raise eyebrows. There were two major proposals that secured most of the one hundred billion

dollars. We are increasingly hearing that this one hundred billion dollars is very much under consideration. When the administration proposed it, it was coupled with many other changes including a trillion dollars of revenues, it is not clear we will see a trillion dollars of revenues, but, nonetheless, the $100 billion seems as though it may be the starting point on Medicaid. That is before you get Republicans in the room and negotiate.

Of the two major proposals, one was provider tax. I won't spend any time on that. I think people understand that provider tax is used at the state level to help states raise revenues to finance their Medicaid program. There was a new proposal put in the plan that had no details or explanation and no savings associated with it that has to do with a new blended rate in Medicaid. This would blend only the eligibility rates, their various eligibility matching rates that came out of health reform along with CHIP and provide a simplified new blended rate. The problem is, this is not simply a simplification, it is in fact being used as a way to secure major savings in Medicaid in deficit reduction. If a blended rate is being used to save tens of billions of dollars in federal Medicaid savings, that means it is essentially a cost shift to state Medicaid programs. The provider tax, if you scale it back or eliminate that, that is also a cost shift to

states. That means even before the Democrats start negotiating with Republicans, if the starting point is one hundred billion dollars in Medicaid to help put together a big down payment on deficit reduction, the overwhelming bulk of those savings could look like they would be in the form of cost shifts to states. We don't know exactly when they take effect. There is a great deal of sensitivity to the implementation of house reform and what states have to do in 2014. It's possible those cuts wouldn't take effect immediately. The impact on governors and states and state budgets is not going to be that good if we take $100 billion out of Medicaid in 2015 or 2016 versus 2014. I think over time, the danger here is the cuts in Medicaid are so deep that it leads to less support for the Medicaid entitlement and more support on the part of government and policymakers to say, just saying give me a block grant. You've given me all these cuts and no flexibility, I would rather have a block grant. We worry what it this means down the road for undermining the Medicaid program. Tomorrow morning this center will release a paper that explains why we think it's impossible to set a blended rate for every state that is a reasonable rate and an equitable rate without making a lot of estimates about what's going to happen to health reform.

The second threat to Medicaid comes in the

second part of the negotiations and the debt ceiling bill. In addition to wanting to make cuts up front, there is strong bipartisan interest in having some kind of a long-term deficit reduction mechanism, something like a cap. A cap that would say the congress -- you write into law a cap each next ten years, it might be a deficit cap or debt reduction cap, and the congress has to hit that cap each of the next ten years. Under administration's proposal it is a debt cap, meaning that congress could cut spending and raise revenues over the next ten years to comply with this requirement that over time brings our deficit and our debt down. Not only are revenues a part of the debt cap, but the administration would enforce that cap, in other words, let's say they don't assume congress is willing to make tough choices, so both Democrats and Republicans want to have an enforcement mechanism now. This is often referred to as a sequester or trigger. Simple English version of this, you set in law ten year caps of some kind, hopefully not a spending cap. For each year the congress fails to meet that cap automatic budget cuts would take effect, something used in the late 1980's under our old program called the Gramm-Rudman-Hollings program. Under the Obama approach, if there were automatic cuts, they would affect both spendings and revenues, Social Security would be exempt, Medicare beneficiaries would be protected,

and most important, continuing the long-standing tradition of any major deficit reduction since 1985, if they automatic cuts take effect, if the trigger or sequester takes effect, Medicaid and all other low-income entitlement programs are exempt from the sequester. That was put into place by congressman Henry Waxman way back in 1985 or 1987.

The Republican version of a long-term deficit reduction mechanism is essentially a spending cap. They talk about things like a long-term spending control mechanism. They would have automatic cuts to enforce this but would only be on the spending side. To be clear, no one is trying to have a policy that actually brings you to automatic budget cuts. The goal of the automatic cuts or the sequester, is to have such painful policy changes take effect that it forces the congress to step up to the plate and make the tough choices about what we have to do to reduce our deficit. So the sequester is designed to be as bad as possible. If you want to sequester to force congress to make the tough choices, it is has to affect revenues and spending. If this administration and these negotiations produce a spending only automatic trigger, then for people who don't want to raise revenues, they have no incentive to work out a bipartisan agreement and every incentive to let the sequester take effect. I think some

of you have probably heard about global spending cap. This has been introduced by Senator Corker and others that set the cap on total spending for the federal government but set it at such low levels that you would be looking at unprecedented cuts over the next ten years. Something along the lines of that are very much what Republicans are talking about.

Now one more thing. Under the Republican version, your caps would only be about spending and your enforcement would only have automatic cuts in spending, but you probably would not have the long-standing automatic protection for low-income entitlement programs. It would be Medicaid is at risk if it is a spending only solution to the deficit and if the enforcement is spending only and if it is now no longer protected from automatic cuts.

So just to wrap this up a little bit, what would be the best policy outcomes now in a debt ceiling or deficit reduction bill if we understand that Medicaid is at risk for deep cuts, not a block grant, but deep cuts in the so-called down payment or so-called contribution to deficit reduction up front and given that the long-term deficit reduction mechanism could in the long run have profound implications for Medicaid. And the combination of deep cuts up front, especially if they are done primarily by shifting costs to states, coupled with a very

unbalanced long-term mechanism that really focuses on spending, that is the kind of policy combination and perfect storm over time that could lead to governors and others no longer willing to support the Medicaid entitlement and increasingly saying we would prefer a block grant where if we are going to get less money at least we have more flexibility to scale back our programs. So the 3 or 4, or five points I would make in closing would be from the center's perspective the best public policy outcome for Medicaid would be to insure a responsible and a balanced deficit reduction deal would be as follows. In the down payment or the cuts up front, we would actually think it would be very important not to cut Medicaid by one hundred billion dollars. Again, I want to note, the president's proposal for one hundred billion dollars was part of a broader proposal that included a trillion dollars of new revenues. That is clearly not going to happen. So if there are not a trillion dollars of new revenues, our argument is there should not be one hundred billion dollar of cuts in Medicaid. If they reach an agreement, which we hope they will not, that provides deficit reduction now without any revenues, one can make, I think, a strong credible case there should be little if any cuts in Medicaid program if we're going to have a deficit reduction without any revenues. Let's assume there will be

savings in Medicaid because I think that is quite likely. It is fundamentally essential that any deficit reduction deals that includes Medicaid savings in secure savings in ways that do not hurt beneficiaries and do not simply shift costs to the states, because we know that if significant costs are shifted to the states, they will have to turn around and cut providers even more and cut benefits and eligibility to the degree they can. Let me say it again. If there is going to be savings in Medicaid, those savings should be designed to avoid things that hurt beneficiaries and avoiding simply cost shifts to states. It is possible having said all that that we will end up with some savings in Medicaid and some savings that in fact do shift costs to states. If that's the case, the timing of those cuts is absolutely essential. Under no circumstance were states gearing up for the Medicaid expansion and other critical implementation aspects of health reform should we be shifting costs to states now. We may have to look at delaying some savings after that, although, again, the primary goal is reducing the savings in Medicaid and trying to avoid any harmful savings as I just described. Ultimately, as I said, our ability to protect Medicaid is contingent upon a balanced approach to deficit reduction that includes revenues up front and insures that we do not put a long-term global spending cap or an

entitlement cap into place, and if the congress on bipartisan basis for the administration wants to lock in a long-term deficit reduction mechanism, that should be a mechanism that allows both spending cuts and revenues to meet those goals, and if it is going to be, as is likely, coupled with some enforcement mechanism that is some sequester or some automatic cuts, then that cannot simply apply to spending. If we end up with a spending only sequester or spending only automatic cuts, there is no way to protect the Medicaid program. So, it is very important that if they do a long-term deficit reduction mechanism, and one that has automatic cuts, the congress and the president adhere to the long-standing tradition and the long-standing policy that Medicaid and other low-income entitlements would be fully exempt from any automatic budget cuts.

Before I turn it back to the moderator, let me invite my colleague and partner in crime Jen Beeson from Families USA to see if she wants to add anything to this.

Jen Beeson: Thanks, Ellen. I'm going to be introduced in a minute. I'm Jen Beeson from families U.S.A. I don't think you left anything out, Ellen. I just want to highlight your main points. One is that we are facing deep cuts to Medicaid as part of the debt ceiling bill and those cuts will come either up front or in the format of changes

to the structure of the program or changes to how congress deals with the budgets. And that these cuts that we are contemplating are not going to make health care system more efficient, they are not going to reduce health care costs. They will shift the cost on to states and people who depend on Medicaid and their families.

Finally, I think the point you left us with is that what Medicaid advocates want is to make sure that Medicaid is protected from automatic cuts as it has historically been. So I think those are germane points and I think you said them well.

Lewis: Thank you so much Ellen and Jen. I want to, first of all. Apologize for not doing a better introduction of Ellen. As you can tell from Ellen's excellent presentation, Ellen is regarded as one of the leading legislative directors among nonprofit organizations in Washington DC and she frequently provides technical assistance, guidance and support to organizations and coalitions, and she's often sought out by journalists at respected news outlets covering legislative and budget developments for her analyses and commentary on congressional developments. So thanks very much, Ellen.

One thing I want to pass along to you. There was a clarification for you. If you would not mind clarifying this one point, which was a Elizabeth Royal asking you to

explain a little more about what the blended rate proposal is.

Ellen Nissenbaum: Sorry, I think I had my phone on mute.

I want to say, we will have a paper on center's Web site tomorrow morning. People should check www.CBPP.org, Center on Budget and Priorities.org.

The short version of the blended rate is that the administration's proposal would take the different eligibility federal matching rates in medicaid that came out of health reform and blend them into one rate. So, in health reform we had a rate that was higher for new eligibles and then we have a rate that was obviously a little bit lower for people existing eligibles. And there was a rate that served childless adults and individuals, and there is a rate for CHIP. With all these rates there was a fear this is more complicated to implement, so the idea is you create one new blended rate for the different eligibility categories for Medicaid and CHIP. That blended rate, there would be a different blended rate for each state. The blended rate would yield -- or the only way the blended rate yields very significant savings, which is what they are trying to do in deficit reduction, is you have to set the new blended rate at a level that is well below the federal funding that states would otherwise get under the current mix of Medicaid and CHIP. In addition, as you will

see from the paper tomorrow, it is extremely difficult to think about how an adequate and equal blended rate, I don't mean identical, but an equitable rate, could be set for states over time. If you are going to set up a blended rate now, you have to make enormous assumptions, HHS and CMS would have to decide how many people in each state are going to enroll in the Medicaid expansion, what is their health status, how much they will cost, and try to put together their estimates and come up with a blended rate for every state. That blended rate will be very complicated. It would be based on a lot of estimates or guesstimates. Many states will object to their rate arguing that the assumptions and estimates were too low and that some states did better than others. I worry it will create the mother of all formula fights on the Medicaid program. So the administration has not released a formal detailed proposal, and they haven't put a dollar figure on it. The single thing that scares me more than anything about the blended rate proposal, if you decide or if you propose a specific change in Medicaid, you would usually get the congressional budget office to say that X change would generate Y savings. They look at the policy and they figure out what it saves. This is what I like to call a dialable policy in Medicaid. You can set that blended rate in an arbitrary fashion to yield whatever savings you need. In fact, you

might determine the new blended rate by virtue of the amount of money you have to get out of it. It could be driven not by best policy, but driven by the amount of money you need to get out of Medicaid for deficit reduction. Let's say they will cut 110, or one hundred billion. They look at other proposals on the table. They are short. They come in short of what they thought they would have. You can lower that blended rate another percentage point to get more savings or worse yet, worse yet, you could have policymakers-- I think there are people talking on the phone-- Maybe it's possible for people to go on mute.

-- you could have policymakers in the deficit reduction talks who want to protect other parts of the budget that have nothing to do with health care. They could say, let's get more out of Medicaid. If you get more out of Medicaid, the one way to get it is again by lowering that blended rate a little bit. I worry down the road when we need more health care savings, or let's say they set up a long-term mechanism and they fail to reach it one year. They don't meet the cap one year, policymakers could come back and say let's dial the blended rate down a little bit. Something that is that arbitrary you can dial up and dial down puts Medicaid at more risk. I'm hoping that answers the question.

Lewis: Thank you, Ellen.

Another point that came in. Someone wanted you to repeat the web address the paper will be available at.

Ellen Nissenbaum: We will have an announce from the center on the Web site tomorrow morning at some point. It's www.CBPP.org. Let me mention one thing to reinforce it. This is a little unusual for two reasons. This proposal has been out since April. Again, there has never been any details. We, for the first time center's analytic health team started to do a lot of very technical detailed analysis the last 3 or 4 days and figured out there were big problems. Those problems are magnified when we learned there could, in fact, be, at the moment it seems likely, there will be significant cuts in Medicaid. What is ironic about this, we have all been focused on the Republican cuts in Medicaid, which, as I said, were several hundred billion dollars under Ryan budget, this is a proposal from Obama administration and it is the starting point for discussions on Medicaid, not the ending point. So that is worth noting as well.

Lewis: That is great. Thank you, Ellen. I appreciate that. I think we need to move on. For everyone who is on the phone. A couple reminders, if you want to ask a question there is a chat window you can ask your question in. If you are on the phone, if you are on the teleconference line, please look down at your phone, make sure the mute

is on. It was a little interruptive of Ellen's talk. Please be aware we are hearing everything you are saying in addition to our presenters.

Next I want to introduce Toby Edelman a Washington, DC attorney. She's represented the rights and interests of nursing home residents at the national level for more than 30 years. Ms. Edelman advocated for the development and enactment federal Nursing Home Reform Law in 1987, which marked a turning point in federal law and established the right of all residents to receive both high-quality care and a first in Health Care Law, high-quality of life. Ms. Edelman served as lead attorney for a successful litigation against the State of California which preserved the new direction and resident focus of the reform law for all of nation's 1.5 million nursing home residents.

And as a senior policy attorney with the Center for Medicare Advocacy since 2000, Ms. Edelman has worked with federal and state agencies to improve the enforcement of standards of care for residents.

She has been appointed to federal work groups and panels to represent the rights and interests of residents and writes and speaks on a variety of long-term care issues.

So, Toby, would you like to take it from here?

Toby Edelman: Thank you, Lewis. I'm happy to be here. It is hard to follow Ellen

and Jen, but my presentation will be quite different.

Lewis, is going to move my PowerPoint slide? I don't see it yet.

Lewis: I will move it for you.

Toby Edelman: Please move to the next slide.

I want to talk about in my short time is what happens if Medicaid becomes a block grant program.

We want to talk primarily or entirely about what happened in 1995. Janet Wells of Consumer Voice asked me to talk about what happened that year and what happened to nursing home care or what might have happened to nursing home care if Medicaid Transformation Act of 1995 that Congress enacted had not been vetoed by President Clinton.

Of course, as Ellen said, we don't have legislative language now, so we don't know the full implications of these very high level discussions. But, what I want to talk about is what happened in 1995 and how that experience would inform our current expectation of what could happen.

Just to be clear, Medicaid is the most important payer for long-term care. Nearly 900,000 people each day in nursing homes out of a million and a half live in nursing homes rely on Medicaid.

Medicare is a much more limited benefit for long-term care. It pays for on average less

than a month of care, and on any given day fewer than 200,000 people are relying on the Medicare program to pay for their long-term care. Medicaid is the primary payer, especially for people who stay a long time.

I think we could assume even if there were a block grant or one with a kind of proposal Ellen talked about, that there would be nursing home care. Nursing homes are not going to go away. Maybe some of the home and community based alternatives would disappear and no longer be federally funded, but I think no matter what happened to Medicaid, there would be nursing home care. The question is, what kind of financial consequences would the new law have and what would happen to the quality of care with changes?

I want to talk about the financial consequences. There are a number of protections in Medicaid law that would no longer exist in the block grant if the Medicaid statute were repealed. This is what happened in 1995.

One of the most important principles in the Medicaid program since its enactment in 1965 is that Medicaid cannot require facilities to request or accept contributions from families, from the adult children. Families are only responsible to the extent of spouse for spouse and parent for young children. But, adult children are not responsible for their families. Well, if we no longer have Medicaid as we know it, that is a likely

component that would not be reintroduced in new legislation. States could require families to contribute to the cost of care for their relatives, residents or prospective residents who didn't have families who would be both able and willing to help supplement a Medicaid rate could be denied administration to facilities or residents who were there could be asked to leave. Relative responsibility is one of the important protections we had since 1965, that would not continue.

Related is the issue of supplementation. Current Medicaid law says that facilities must accept the Medicaid rate as payment in full for covered services. They cannot ask for supplementation of Medicaid rate. Again, families could be required to supplement Medicaid rate and people without that family to supplement Medicaid payments could lose their ability to stay in the nursing home.

Current law says states cannot place a lien on a home where the spouse lives or a dependent or disabled child or certain siblings. This is interesting, because nursing home residents are the only people who have to pay for their Medicaid coverage or their nursing home care after they die when the state can foreclose on the lien and recover from the estate. There are protections presently for certain family members. These protections would also

disappear under a Medicaid block grant.

Spousal impoverishment is something we had since late the late 80's. This is a provision in the Medicaid law that allows a community spouse of a resident to keep some of the income and assets in order to have some income and assets to survive on. Before other spousal impoverishment provisions were enacted by congress, some of the states literally required all of the income to go to the person in whose name the income was. Usually that was the husband and the wife at home was left with nothing. Some states literally left the community spouse at home completely destitute. All the money had to go to nursing home care for the husband. Spousal impoverishment is the next provision that would disappear as financial protection that we've expected and enjoyed a number of years now.

The Medicare and Medicaid laws do more than set out these financial rules for eligibility and coverage. They also established the standards of care, and nursing home reform law Congress enacted in 1987 created the standards of care by amending the Medicare and Medicaid statutes. The entire federal regulatory structure we have for setting standards of care for nursing homes and determining compliance with those standards and enforcing those standards, all that could be changed. If they were a block grant, they could disappear.

1995 law that President Clinton vetoed changed the nursing home reform law. What it basically did was use the structure of the nursing home reform law but it dramatically changed its content. When nursing home industry talked about that legislation and said that the reform law had been fine-tuned. There were small changes being made. When I read the law, medicaid Transformation Act, to me it was completely gutting the reform law. And some basic principles we have come to expect from the reform legislation were repealed or changed dramatically by the 1995 bill.

Maybe the most important change was the repeal of the language in the law that says facilities must provide services to each resident so that each resident is able to attain and maintain his or her highest practicable, physical, mental and psychosocial well-being. What the law did was say the authority had to provide services to residents. Residents as a group. If the majority of residents got good enough care, that would have been sufficient. But the entitlement of each resident to appropriate care was lost. A very important, critical change to the nursing home law.

The law changed a lot of standards and substantially weakened a lot of the standards that facilities must meet. For example, in assessment, the 1995 bill repealed the requirement that the resident assessment,

each resident assessment, must be based on a minimum data set specified by the secretary. It eliminated any requirement for any federal standards and allowed each state to do whatever it wanted in terms of assessments. That is a big change.

In terms of nurse aide training, the 1995 bill excluded from the definition of a nurse aide any person who performed a task-specific function which would assist residents in daily activities.

That is a big change. We did see the feeding assistants with the kind of one task nurse aide that was going to be excluded from the definition. We have that now, but the nurse aide training requirements would have been substantially weakened, the federal government would have had no authority to establish any standards for nurse aide training.

The 1995 bill repealed the requirement that facilities with 120 beds or more have a professional social worker.

In terms of residents' rights, lots of things were repeal. 30 days' advance notice before transfer and discharge would be repealed. They would have to give notice unless it would be impossible or impracticable. There was exceptions created for voluntary transfers or emergency discharges, which we know would basically eliminate any protections for residents' rights because all transfers would be called

voluntary and all discharges would be called discharges would be called emergencies. It eliminated the requirement of preparation and orientation for transfer or discharge. It said facilities would have to promote a safe and orderly discharge not actually require it.

Discrimination in administration. All the existing protections we had were repealed. Discrimination against Medicare and Medicaid residents, requirements that facilities help people apply for Medicare and Medicaid. Third party guarantees, forfeiting contributions, all that was eliminated.

The secretary's responsibility under the law is to assure the requirements for care and enforcement are adequate to protect health, safety and welfare and rights. And to promote effective and efficient use of public money. The 1995 law substituted the word state for secretary. The federal government no longer had any responsibility for the standards or enforcement.

Since 1977, even predating federal law, required to specify which items and services are covered by the daily Medicaid rate and which residents could be charged for separately from their personal accounts. That language was repealed.

Survey and certification, the second big area, the process by which facilities' compliance with the standard of care is determined, this was also weakened. The

secretary lost authority to establish standards, qualifications for surveys. The secretary would no longer have to provide training for state and federal surveyors, the law reduced the number of validation surveys, and it repealed the ability of the secretary to sanction states for doing an inadequate job.

Enforcement is the last big area of the Nursing Home Reform Law. That also was significantly weakened. The 1995 bill repealed the requirement for federal guidance on enforcement. And it revised the federal role in enforcement. When the secretary found problems, the secretary would have to notify the state. The state would be allowed to take action. The secretary could act only if the state did not act.

Enforcement in the 1995 bill repealed language requiring that the criteria for enforcement sanctions minimize the time between identifying deficiencies and imposing remedies. It repealed the language that came from the Senate Bill about having more serious fines if the deficiencies were repeated or uncorrected. It prohibited retroactive remedies.

The survey was extended to 24 months. The reform law has a survey on a nine to 15 month cycle. There was an extension to 24 months. Specialized survey teams were eliminated, and public disclosure of survey results could

just be required within a reasonable time in contrast to federal law that said 14 days.

Civil money penalty, the 1995 bill deleted the possibility of retroactive penalties and reduced the maximum per day civil money penalty from $10,000 to $5000.

Finally, in enforcement, the 1995 bill went back to what Reagan Administration had proposed in the early 1980's, that there would be deemed status to accredited facilities, and there would be no public oversight of those facilities as long as they were privately accredited. So we were coming full circle to repeal of the nursing home reform law.

Last slide.

You can see the changes were quite significant in changing the content of the Nursing Home Reform Law where we kept structure but not the content of the law and certainly eligibility and coverage could be dramatically changed and were dramatically changed in 1995, but for a veto by President Clinton.

Thank you, Lewis, back to you now.

Lewis: Thank you, Toby. There was one followup question for you. Maybe this is one we can defer to the end. The question is from Diane Coleman is: Home and community-based services HCBS, are, a, a civil rights, as an alternative to nursing facilities in the Olmstead decision and, b, save money on average. Is there a discussion of expanding

HCBS to save Medicaid long-term care dollars, if not, why not?

Toby Edelman: That is an excellent question. Maybe Ellen or Jen has an answer to that. The level of discussion at this point in Washington it is such a high level, they are not talking about the specifics, I don't think, that you are talking about. At least with the Constitutional Olmstead decision that would help people push for the home and community-based services. That's a problem. At least now there are certain services that are mandatory and nursing or states have to provide them if they want the Medicaid dollars. The services that are optional are the kinds of things they are likely to drop if they have to do something. I don't know if they are necessarily thinking as intelligently as that questions poses it about how home and community-based services can be cheaper and better for people than institutional services.

Lewis: Let's move on to Jen Beeson. And Jen, is director of government of affairs at Families USA where she's worked since 2006. Families USA is the national voice for health care consumers and is dedicated to the achievement of high quality affordable heath care for all Americans.

While at Families USA Jen's efforts centered on the reauthorization of the Children's Health Insurance Program and the enactment of comprehensive health reform

legislation.

Jen worked on a range of public policy issues all aimed at improving the lives of low-income families. Prior to Families USA, she was employed at the Coalition on Human Needs, the Children's Defense Fund, and the center on Budget and Policy Priorities.

She served on the Democratic staff of the House Committee on Ways and Means and was at the U.S. Department of Labor during the Clinton Administration.

Jen Beeson: Thank you, Lewis. If I could just tell everyone, if you have a mute button on your phone make sure to hit it. If you don't have a mute button and you don't know how to mute please hit star six. That eliminates the background noise.

I want to thank Janet for inviting me and Ellen and Toby who did a great job describing the situation which we find ourselves. Families USA is quite concerned about the situation Ellen described. In our view Medicaid is more at risk than it has been in many, many years. The consequences are enormous. We at families believe this is a fight we can win at families. We are working with other groups in the community to make sure that we prevent Medicaid from being cut. What I want to talk about this afternoon is what are some of the messages that are important to communicate to the public about Medicaid? What are some of the messages that are important to communicate about the

deficit, which is the context in which all of this is happening? Take a minute or two to describe briefly what we know the public wants, and then conclude by talking about what some of the groups that Families USA are doing around Medicaid to protect it from cuts. So some messages, what the public wants and what some of the groups are doing.

So, what are messages that are important to communicate on Medicaid? First of all, folks on this phone should know what people do and do not know about Medicaid. To me, I find it somewhat surprising some results we saw last month from the Kaiser Family Foundation, a somewhat surprising number of people actually do know what Medicaid is and how it differs from Medicare. However, about 40% of the public don't know what Medicaid is. I think we should keep that in mind.

In general, the conventional wisdom among the public is Medicaid is for poor people, kids and adults. They don't necessarily associate Medicaid with seniors or with people with disabilities. Some do, but a lot of folks don't. Many people think that some people are eligible for Medicaid who are not eligible. A lot of folks assume that childless adults, low-income childless adults, like the homeless population, for example, get Medicaid. And we know that in 42 states they don't. One of the things I would tell this crowd is, don't assume that

the general public or others assume that they know what you know. Don't assume they know what you know about Medicaid. In terms of members of congress, they get and understand the Medicare program because they believe Medicare recipients vote. Many members of congress don't fully understand Medicaid and they don't fully understand that Medicaid makes Medicare work for nearly eight million dual eligible people. One thing we found is useful is to emphasize Medicaid is the primary payer of long-term care. One in four seniors and people with disabilities, their families, their caregivers, people they live with, depend on Medicaid. It is also important to emphasize exactly the message you know that Medicaid helps pay for folks to stay in the home and in their community when they want to avoid institutional care. That is an important message and it resonates with people when they realize that.

Another message that resonates with people is that Medicaid is an important program for seniors in nursing homes. That is something that not everyone knows about. What are some of the important messages to communicate about the deficit? All of the talks of Medicaid reductions are coming in the context of deficit reduction. I can tell you, if you just ask folks, gee, do you think we should reduce the deficit? Should we cut programs to reduce the deficit? Overwhelming numbers of people will say yes. Our deficit is a huge

problem. We need to cut. However, when we describe what those cuts mean and what they are, what they would lead to, people are opposed. They don't want to see cuts in programs like Medicaid. It is very important to describe what Medicaid does.

Here in Washington, I think it is not just enough to say don't cut Medicaid. Because there is so much emphasis on deficit reduction. The conversation has developed so far along the road. It is important to acknowledge up front that we do have to deal with the deficit in some way. But, the way we do that is very important. Any solution to deficit reduction must be fair and balanced. All options should be on the table, including revenue. Ellen talked a lot about revenue and tax increases, including defense. The American public is actually there. That is where they are. They think all options should be on the table. And that a solution to deficit reduction should reflect our national priorities, everyone should share the burden of deficit reduction and that means we may be asking well-off people to pay more in taxes, there may be some oil and gas tax subsidies we get rid of, but the least vulnerable should not bear the burden of deficit reduction. That goes back to Ellen's point when she talked about long-term changes to Medicaid, if there are changes in the structure or the process how we deal with the deficit we should protect

Medicaid from automatic cuts, because it is a program that serves low-income. It is a program that serves the vulnerable. Traditionally we have done that in deficit reduction deals. We should not balance the budget on the backs of those who are least able to bear it.

So what does the public want? As I mentioned earlier, last month the Kaiser Family Foundation did a survey of the public on what they knew about Medicaid and Medicare. And what they thought about Republican budget proposals. In those surveys, Kaiser found that more than half of people said they want zero cuts to Medicaid. They don't want Medicaid to bear any cuts at all. And by nearly 2 to 1 margin they don't want to change the structure of the problem. They did not use the words block grant, but they don't want a block grant; they want a shared responsibility between government and states with the federal government setting a floor for eligibility and program requirements.

Other polling has shown the public overwhelmingly rejects cuts to people in nursing homes. I think there is some public education that needs to get out there in both directions, both explaining to the public what is happening and what is being considered in Washington. And explaining in Washington what the public wants. The public is on the side of protecting Medicaid.

So, just very briefly, let me describe a little bit about what some of the groups who we work with at Families USA are doing. Families USA is part of a number of groups called the Medicaid coalition. In that coalition it is different types of groups that they by and large represent people who depend on Medicaid. It's groups who represent people with disabilities, and seniors, groups who represent low-income children and families, but also providers are in that coalition. It's pediatricians, public hospitals, and Catholic hospitals and nursing homes and folks who use Medicaid dollars to help serve their patients. These groups are incredibly concerned, and we have done things together as a coalition and separately. Things like Op Eds to newspapers describing the Medicaid program and why it is important in your community. Letters to the editor, if you see a letter in a newspaper. We've thought about how can we talk about deficit reduction and bring it back to the personal, "why Medicaid is important for a person?" These groups have done a lot in terms of educating elected officials, setting up phone calls and meetings between the folks on the ground and their representatives so the representatives are educated about what Medicaid does in their communities. Sign on letters among the coalition so different types of groups can sign on together showing the broad

diversity of support for Medicaid, and sending letters to a delegation, an entire state delegation in Congress or to the president. And getting providers on there and the Consortium for Citizens with Disabilities groups like that. A lot of groups are working on social media outreach, doing things on Facebook. We at Families USA have something novel. A twitter petition. If you have a Twitter account, and this has never been done before, we're the only group that's done this, we amass Twitter handles, all these different members of Congress, and if you put in your zip code, it will tell you what all the Twitter addresses are for everyone who represents you, so we have worked with some groups to send that around. We had a call-in day -- we had call-in days last week. A number of groups used 1-800 number families have for that purpose. Resources and education materials. There's a lot of papers and materials out there that describe what Medicaid is in does. Ellen's Web site which is CBPP, center on budget and policy priorities.org. CBPP.org, they have a lot of papers. Our Web site is families.org. FamiliesUSA.org, there is an icon like a budget axe coming down. If you click on that, you get a bunch of papers that talk about the importance of Medicaid for seniors and people who need long-term support and services. There's state level information there.

We have new reports we are releasing this week and next that talks about the job impact and the economic impact of Medicaid in the states. It looks at if the federal government reduced this commitment to Medicaid by five percent or 15% how many jobs would be lost in your state? How much economic activity would be lost in a dollar term? By next Wednesday we will have reports for all 50 states on those numbers. All those resources are being used. That is all I have to say. There is an awful lot going on. The risk to Medicaid is very great. But we also feel like with more information we can combat the attack.

I think I will conclude there, Lewis.

Lewis: Thank you so much. I want to first of all thank all three of you, Ellen, Toby, Jen for your great presentations and of course, Janet, for being my co-host here. It is about quarter after the hour. That is the time we asked-- if you wanted to participate, this is how long we are going to go. We can stay a little longer if you would like to ask some questions. I'm going to open the screen for you now so you can use the chat window on that left-hand side to ask questions. If you are not going to ask questions, I'm going to ask -- I thank you for attending, and ask if you could provide feedback on the Webinar by going to the link listed there. There are four questions that should take no more than two minutes of your time. It's

www.pascenter.org/webcast/feedback.php. That will be used to help improve our future Webinars.

I have a couple questions. Jen, this came in your presentation. I'm not sure if this is exactly what you gave or not. Brian Lee asked what is the Web site address for Medicaid coalition to find the materials you were talking about.

Jen Beeson: There is not a Web site for Medicaid Coalition, because the Medicaid Coalition is pretty informal. Certainly he can go to Families USA Web site. FamiliesUSA.org. Click on the little budget axe.

Lewis: Okay. A question that came up I want to confirm with everyone. There has been a recording of this Webinar. It will be at the PAS Center Web site at PAScenter.org/webcast. You will see the button on the left-hand side when you get to the main screen. It will include not only this recording but also the transcript that our closed captioner has been recording for us. You will have an actual word document you can use as well.

Next question is: From Sarah Slocum. Would contacts from state governors for Medicaid directors about the impact on states to members of congress be useful?

Jen Beeson: It would be very useful indeed. It is important for members to hear from state either Governors or medicaid

directors wherever possible on the impact of federal cuts. There are plenty of states which governors are asking for more flexibility. And are a little bit antagonistic towards the Medicaid program. It depends on the state. Supportive governors, supportive state Medicaid directors, it is helpful to weigh in.

Lewis: Anyone else? Ellen, Toby?

Janet Wells: I want to thank everyone for being on today and I encourage people to watch our Web site Www.consumervoice.org and watch for information from us.

Lewis: That's great, Janet. Thank you for saying that.

I have one more question. It looks like maybe the last question. What can advocates do to make a difference at this point in time?

Anybody want to answer that one? Ellen, Toby, Jen, Janet?

Jen Beeson: The number one thing is make a phone call or ask for a meeting with your member of congress, both your house member and your senators. And talk about Medicaid, talk about how it is important for not just low-income kids and their parents, although that is important, but also it is so important for seniors; it is so important for people who need long-term services. I would say the direct contact with members of congress is the first thing you should do. The second thing is reach out and see if there are others you can sign on to a letter, maybe some

untraditional partners you don't normally work with but who are supportive of the program.

Lewis: Anymore? Ellen, Toby?

Toby Edelman: To stress, it is families that are benefited by Medicaid. To the extent that nursing home residents rely on Medicaid, they have families who are not financially responsible, and that does not mean they are not there all the time and they don't care for their parents, and their grandparents, but they are able to have money to provide for their own children, for their own children's education. If we require adult children to be paying for their parents and grandparents in nursing homes, what does it do to the next generation? If people understood Medicaid really supports families across the board, maybe that would be helpful as a point to make in continued work on this.

Janet Wells: I think it is important to add also, many nursing home residents, their children actually are retirees themselves and probably living on limited incomes or living on money or have savings that will be required for their own care for the rest of their own lives.

Toby Edelman: That is certainly true, Janet. When the Reagan Administration reinterpreted the Medicaid Law in the early '80s and said families could be held responsible for paying for nursing home care for parents, there was a lot of discussion

about that at the time, and they backed off. There was research showing the only way this saved money, there weren't enough adult children with a lot of money that could make this worth while, and if they collected a little bit of money from a lot of people, it cost more to collect the ten dollars a month than states would actually make. The only financial savings the states had was that older people did not get the benefits they needed. They did not apply for care because they did not want to subject their children and grandchildren to financial responsibility. So, it does not help families to have this happen. You are exactly right, Janet.

Lewis: With that, I think we will end our call now. Thank you very much everyone for attending. Thank you to Ellen, Toby and Jen for a great presentation and to Janet for co-hosting this Webinar with me.

Again, all the information here, the recording of this, the slides, the transcript will be at our Web site at www.PAS center.org go under the Webcast button and please do give your feedback at that number right there on the screen. Address on the screen.

(see screen) http://www.pascenter.org/webcast/feedback.php.

To everyone, have a great morning or afternoon depending where you are in the country. That concludes today's

presentation. Bye.