

>>>: Hello everyone. We'll get started. My name is David Lipshutz, and along with my colleague Scott Perkins co-director at the center for Medicare advocacy. And it is my honor and to kick off our annual National Voices of Medicare Summit and to welcome all of you who are here in the room, and those of you watching online and those of you that might be looking at a recording later on. We had a little discrepancy in the recollection about what anniversary this was of the annual National Voices of Medicare Summit. But we do believe it is our 13th we welcome you to 13 of the National Voices of Medicare Summit. As thank you, gentlemen for your fix our slide said the 12th thank you for that. And as we gather today, our mistake. There are some milestones to celebrate. And as these numbers I am positive about. And last year, and we celebrate sixty anniversary of the Medicare and Medicaid program, and today the 40th Anniversary for the center of Medicare advisory.

[APPLAUSE].

Thanks in large part to our founder Judy Stein who is with us today and anything that had to do with the center over years while we celebrate these milestones however our critical healthcare program and systems of support are under threat. Medicare is our name we'll be talking about Medicare today, but we'll be looking more broadly at federal and state policy issues Medicare does not exist in a vacuum it is interconnected with other social insurance and adjacent programs both how it operates and the providers and stakeholder involved, and most important the beneficiaries who rely on Medicare to help them meet their needs Medicaid and Social Security. And so our agenda will be more broad. And our first panel which I will introduce will be the

importance of social insurance. And our second panel will discuss threats to Medicare focusing on privatization after a break our next longer panel healthcare challenge and say opportunities morbid generally including the impact of HR one, so-called one "Big Beautiful Bill". And to another break couple of voice of Medicare we'll have a short panel discussing challenges of long-term care. And then our keynote lecture will feature and Dr. Natalia Chalmers will discuss, and intersection of oral and medical care, I want to thank our presenters and moderators who is bioare in the program our sponsor, and thank all of who are attending today. At this point, I would like to start thanking our sponsor which we'll be doing throughout the day. By offering appreciation for the Christopher and Dana Reeve foundation for their support.

[APPLAUSE]. Now, to introduce our first panel on the premise of social insurance which will moderator discussing between rectangle value and, she's the CEO of social insurance otherwise known as and brings decades of experience shaping economic policy and social insurance ranging from work as legal aid attorney to the center for American office, I think we are next to each other, and Martin O'Malley, extense active public service includes time as the Mayor of Baltimore, governor of the great state Maryland and most be renal Commissioner of the Social Security Administration in the previous administration. Rebecca and Martin thank you.

>>>: Thank you.

>>>: It's a pleasure to be with everyone today just a huge thank you National Voices of Medicare Summit for having us want to start the conversation in this day of conversation with really the why behind

social insurance, especially in Washington space toss get right the policy and the kind of debate and say all of that stuff I know that a lot of up will come up today, but I know that, I have a hard time calling him governor, he was Commissioner but Commissioner O'Malley and I, often have these conversation why do we have these programs? What is the mission we share, that's where we'll start the conversation. And before we do that I want to say, just happy anniversary to CMA 40 years is remarkable thank you for your leadership over many decades, is the 86 was that was the year the academy was founded and we are doing our shindig I look forward to seeing you there, and we look forward to tasting age and disability health policy later this evening, so nothing like starting off a panel by inviting for drinks at the rooftop come by and hang out. And Commissioner, you and I and then the a lot of time last year marking the 90 anniversary of Social Security, 90 years of the new deal, and David mentioned of Medicare and Medicaid, and maybe it's because I am fresh off annual pilgrimage to the, and but the origin of these programs, where they came from and why, that amazing crew of Francis Perkins and FDR in the 30's start the journey we call social insurance when you think about the origin of Social Security, which he oversaw most recently as your Commissioner of the agency, and programs like Medicaid and Medicare, what do you think, about, why those programs were founded and what they are fundamentally trying to say about who we are in this society?

>>>: Well. Let me thank you for having me here. And congratulations, David on 40 years, that's a long time. I am sure it doesn't seem that long thank you, and thank you for your advocacy. You never more important than right now. A lot of times we think about advocates as people that move the ball down the field. And

importantly and times like as these that advocacy is making sure that ball is not pushed back, you know, into safety zone. So, as I think about the origin of this and really comes down to the fundamental core beliefs that we share as Americans, that we are all in this together that we need each other we have to help each other, if we are going to succeed. That's the nation from the great Maryland of Frederick Douglass, we had that on a big and image of a fierce Frederick Douglass up in the security status room and inside the room we had FDR, image, and his quote which was, that our first principle is the security of the men women and children of our nation. And that's really, that's really the bottom line. Been watching a lot of watching Ken better than series on Benjamin Franklin and the Constitution, and that, and pre-amble we the people, the mark of whether or not the society is, and compassionate and care society is how it takes from hitting the great Americans it takes care of those from the dawn and dusk of life it's about every soul. And that's why I had, such a gratifying fulfilling experience leading them under staffed men and women of Social Security, the only reason they stayed was because of the mission they shared with all of, that, andness, we choose as free people to feed the hungry to heal the sick to clothe the nation to care for widows and or orphans, ours is not some genesis view of human beings somehow reaches a stage in their lives where they are per se weight, because they do not contribute to the economic large at, of the captains of industry of the day. No we believe in the dignity of every person that's who we are as Americans we often times fall short of that. And certainly no one understand that better than than the black neighbors. But, the fact remains the dignity of every person that's why Medicare is

important and Social Security is are important that's why we can't allow any temporary are mortal to dismantle that.

>>>: As you are using some of that, very moral base and had spiritually based language, and deeply resonate for Francis Perkins.

>>>: The Francis Perkins.

>>>: Who had the feeses day in the church last week, and who, if you are a fan.

>>>: Or Episcopalian,.

>>>: But, when I hear you describe these programs and those terms, it really, it brings me back to one of the ways I think about the moment that we're in and I wonder how much this resonates for you, a lot of folks are understanding this particular moment which is a challenging moment which is a moment of retrenchment of real, and revisiting and reviewing even our social contract, it feels very much to a lot of people like we're in the middle of a ballots of imagination about what kind of society we are choosing to be, that's what under pins debates over solvency, and sort of DC term. Which really is about what kind of society are we choosing to be? Talk to us, and how show up in this moment what it looks like to show up in this moment, yes to hold the line, as you were describing. But also as people connecting to that North Star, who are ideally, aiming to hold that vision of what kind of society we could choose to be.

>>>: Okay. So much of what we are going through right now is to your point of battle of the imagination, most Americans have much easier time imagine of a feature of less than a feature of more, by more I don't necessarily mean more in your bank account although that's a

piece of that, especially if you are getting by day by day. And cost of living is out stripping the clone on your Social Security benefits that you live upon. I think part of what it means to show up in this moment, Rebecca is through imagine that feature whether or not there is greater health and greater prosperity and greater well-being for all, for a long time, and I believe that those of you in the western mind, European American etc., equated increased consumption with increased happiness. They are not the same thing. But all around the globe I think you are seeing the displacement of that worn out theory of more is better, more and more and more, and instead, being replaced by well-being, health and well-being of the whole our children understand in the I think the ethic of the earth they understand that, very, and intrinsically and intuitively, but we are trapped in this battle of fierce ti, when tomorrow is going to be worse than today, and people turn on each other, and resort to tribalism, and the authoritarian will preserve your tomorrow where there is less. Part of what it means to show up in this moment, with the smile with honesty and integrity, say we live in a time of enormous opportunity. Never before in the species, the technology and the know how to create a tomorrow with greater health and well-being for all. For more people rather than less. Third of American century of fast moving third Industrial Revolution. We need to embrace the moment, obviously China the first election of Donald Trump, and the head of the guy on who was the head of international relation, said to me, let me ask you a question, governor since you were out there, how is that Americans seem to have so become so afraid of future when this runs contemporary to what we thought about the American character? That's the real deficit we

confront. It's not making the math work. Yet, it's about making our hearts and imagination work.

putting forward that vision in fact, tomorrow can be better than today, there is no people on the planet that have more power to make it so than we.

>>>: With that forward looking perspective and I know you have got a couple of slides that you want to show.

>>>: You said that with a scolding, didn't she have a scolding face?

>>>: Anyone that knows me, what kind of conference I ban Powerpoints but you get a exception.

>>>: It's not a PowerPoint, it's two slides.

>>>: I will allow it. For the two slides, I will tee up to talk about this by asking you and are, and out there, in a lot of settings right now. Really kind of, yes preaching the gospel of Social Security, but talking about how misunderstood the future what's possible within Social Security really is. And a lot of that is, misinformation that gets pushed by folks who want to cut that it and dismantle it and kind of austerity preachers, worp describe we are in the middle of a conversation that's only going to accelerate in the coming years what do we do to secure the future of Social Security? And, you really been out there helping people understand it's actually not all that difficult to address. Talk to us little bit what you see for the future of Social Security what the American people want some of you what you have been out there helping people understand.

>>>: This is a great time. We are at moment as we face the so-called cliff for that moment of insolvency in 2033, Social Security will not be able to pay 80% of benefits that creates, and an action inducing events for legislative, unless, deadlines have a way of doing that. So right now every person, running for the United States Senate is going to be in office when they let that cliff hit people or, when they come together with an enormous consensus among American toss strengthen Social Security and make it better. How about this? In a time deep division and polarization, 87% of Americans want Social Security to be strengthened. Made better. And wants benefits increase want it to be there for their kids and grandkids, so that's an that's why, this is a such a great opportunity right now for us to advance these conversation and in our own table of democracy, I know we are preaching to the choir, but as Dr. King it's important to preach choir, otherwise they stop singing as I do town halls in addition to 12 million people getting checks of Social Security, that's a load of bullshit, ought ited every year, doesn't happen two of the big myth we, and kind of ingrained to us, and one of them is that, it's a Ponzi scheme they are going to go bankrupt it's going to happen and the other one, you know the customer service is bad but it's always been bad, you a contrary, it's not all, and there was a time 12 years ago the agency according to the fed employee viewpoint survey which we stopped doing because we don't care about the viewpoint of the people doing the jobs, when they listened one of the best place in the Federal Government, that over ten-years of the non-neglect, malignant intently, and Social Security staffing was reduced to 50 year low, the baby boomers we have a new all time high. And get that, when they operated well they operated 1.2% overhead for the benefits they paid out. And at all state ratio,

19%, liberty liberty is, it's 23%, and now they are struggling to offer, aid on 7 tenths of one percent overhead, no wonder you have hour and a half wait times and the horror stories that you are network will tell you about. First slide. This is a slide you can't unsee. The blue graph is us, we the people. And we the people become active beneficiaries. That red, line, is staffing. Where you see it taken nose dive, that's the Trump administration. And Elon Musk, and DOJ DOGE who took your money to paid, if they quit in March and not let the door hit their ass it's probably worries than that when I was there, the fire dragon was the high attrition rate from burn out, these guys that it's great to have a high attrition rate, leave, leave he, leave. The solution here is, if Congress want to, they can take right now about 75% of overhead is taking from the same trust fund dollars working people and contribute they can take it all and take the agency back up to 1.2% they can take it from the trust fund and do that it wouldn't advance that date by any more than 30 days, your we doing this to ourselves? There is a solution. But the solution isn't going to come from, you know selling the Woodlawn campus to the highest bidder. Next one. Next slide. This is on the solve venti thing, I tried to come up with a better phrase, and guaranteeing Social Security will be pay 100% of benefits earned because the truth any of us when we talk about solvency if you had a company and small business you run and your sister-in-law that does your books told you that you have 20% shortfall in revenues in 2033 you wouldn't rush out and slap a bank going bankrupt going over your business and you would make adjustment and every 30-years, Congress made adjustment, but I asked, once I was confirmed I asked Steve Goss, I said, what did you get wrong in 1982, such that we're having this depletion in 203030 now instead of 2050, you know what the answer

was? There was a longevity it wasn't birth rate global, and Ronald Reagan, to and to suppress wages flat lined for, and that wasn't the way the economy worked prior to that time he said we were asked to set a cap on the income in which Social Security tax would be applied. To set that cap is set your rate we capture 90% for the next 40 years. And but, with the changes to the tax code and the economy, and only the highest earning people actually seeing appreciable gains we only captured about 82%. So that's why, that surplus reserve intended to cover the baby boomer demographic is running out sooner than we thought. There is an increasing phrase that more and more people understand in America to scrap the cap, why is it the family making \$182,000 and paying \$11,000 into Social Security that \$11,000 is the same amount that a single man making 182 million paying in to the Social Security, most Americans think that's not fair, so this graph is from the John Larson bill which shows you could actually increase benefits in a CP ie., cost of living for elderly people. You could, and the base sort of amount. And it would extend the ability of Social Security to pay 100% of benefits into the far future, 2090, anybody planning their future by that time. The solution is there. Get this, we recently, this is my last point on that, recently, then no more slides. A senator named Bernie, not that one, and open hearing, said I just I don't understand why wealthy people shouldn't pay the same rate as everybody else in Social Security, Bernie Moreno from high know, and, having met with many of the folk both side of the aisle as part of the confirmation process I know that the, if you know anything in American politics that's a big dis plainer my gut tells there is some pretty broad based alter of the deal for scrapping the capita certain income level to

solve the problem for the future, that's the bottom line, but the ability to pay 100% of benefits solvable problems.

>>>: Just to say, you have laid that out beautifully Commissioner and you approached to have no more slides. I was giving you a hard time. They were worth it. I think to put a fiern point what you are yieferg right, not just something that has had one Republican member of Congress agree with it when you ask the American people what they want from policymaker this is exactly what they say, that's not folks that are progressive it's folks across the political spectrum folks across it's income spectrum even the wealthy say, yes this makes really good sense to many.

>>>: That's what made them back off from the deeper harm they want to cut, 50% of the IT staff at Social Security. And, when some of you rang alarms that would interrupt benefits including Mike aster, George bush Commissioner, they'll put benefits at risk if they cut 50% of that, they backed off of that, rescinded paid to leave sort of incentive some people in IT had taken and then the paper check they said they wouldn't send paper checks that receive their benefits the democracy broad based and, they backed off of that, and enthis the where they would have showed 50%, 40% of people, over the age of 50 disability roles so the good news, Trump administration, politically understand that this is the huge vulnerabilities for them. You didn't hear him talk all the big lice lies, talk about the Social Security in the second State of the Union, did you, that's because Americans want them to AstraZeneca enor private ties that.

>>>: I feel like we have given a food set of thought before the next trustee comes out and Social Security and Medicare, people know what

they want Washington to do, it is really, it seems like we were in the people can't agree on anything, this is something that people agree on, it is worth remembering that. Given that sort of defies the wisdom, so Commissioner, and want to close out a, and higher level of forward looking question for you, and I mentioned I disclosed I have thinking about the origin of these programs and one of the quotes that sticks with me and I will give to this FDR, I could do all day on Francis Perkins, when he was signing the Social Security and act in 1935 that new big deal moment he called that program, a Cornerstone in a structure, which is being built but by no means complete. In a lot of ways even though we are 90 years on the other side of that feels like that's still true. We still have huge gaps, and in our social insurance, system. And even relative to what FDR and Francis Perkins were talking about, things like long-term care, which I know is going to come up later today a huge hole for probably many people in this room. Personally affected by that in one way or another, as you think about this moment that we are in, where we are facing yes action forcing and Social Security, on Medicare as well, and but also, and retrenchment and this challenging moment politically, and how should we think not just about preserving what we already have, but continuing to build on that structure that's by no means complete.

>>>: Paid family leave and there are other things, obviously I was in Nebraska, recently and gentlemen said, why don't we use Social Security to make sure that the college is affordable for all. I was God smacked by that, I hadn't had the imagination to think of that as I unpacked that on the plane, you know what? Probably not, a logistical reason or, any reason math or technology thank that would prevent us from doing that. To imagine that how this program can be

strengthened the long-term care the paid family leave, and perhaps even, as the all of of the concerns about AI and how that retains the economy comes up, and there -- there is a story about what that next chapter of Social Security beyond better cost of living increases. That's this moment. And I think the long-term care. And I think it is the paid family leave. Perhaps other things as well. Certainly changes you said that people aren't penalized when they take time off of work and sometimes it's the women and family to take care of elderly parent or a sick child, that's we are talking about the -- this core earlier that's a certainly critically needed addition for what we need right now. Not just about preserving what we used to have, about creating more.

>>>: So just will close with some words from a spiritual mentor, and share at different what I think about every morning when I wake up, these are not easy times to do this work. Those words which were shared with me early in the pandemic which I feel are truer every single day than the day before, living at this time in human history is either an affliction or it's an assignment it's up to each of us to choose the assignment. And that's what I wake up thinking about every day, I know that's true of every single person in this room choosing the assignment that's why we are here, still showing up doing this work, a lot of gratitude to you, Commissioner for your continued leadership and a lot of gratitude to the center for Medicare for your continued leadership, and I know the rest of the day conversation are going to be the right ones for this moment, thank you.

[APPLAUSE].

>>>: Thanks.

>>>: Thank you, Rebecca and Governor O'Malley you have given us a lot to think about.

Before, starting this next panel, and I would like to thank couple of more sponsor AARP and Mansfield family practice for their support today pretty much appreciated. Now joining the stage we are lucky to have a repeat guest to our summit. And Wendell Potter one of the nation reform advocates, he was a former health insurance company executive, and earned whistle blower turned advocate someone who I am proud to call both a colleague and a friend. Now, there is much to celebrate in the history of Medicare. It helped produce property among older adult played a key roll in integrate the hospital in our country and upon the role of security of tens of millionses of people, there are short comes and challengings including gaps in coverage, and challenges with affordability. And sustainability program. And some of has been exasbated by HR one the one "Big Beautiful Bill" that will be touched more in upcoming panel. And one major story line of the Medicare program has been the rapid growth in enrollment in advantage plans for the last 20 years 19% of the population to over 50%, 54%. And, so what I want focus on now, and time together privatization of the program what that means for Medicare beneficiaries and program as whole, starting with Medicare beneficiaries, as an organization that represent Medicare beneficiary and we know that and run into barriers in the traditional Medicare program all the time. That ranges from improper use of so-called sphriew. standard to get certain or diminishing of the home health aids and, on, and people on Medicare advantage have access to some services that traditional Medicare doesn't cover, on the other hand, there are additional barriers that people on America advantage face

that owes and traditional Medicare largely do not, such as prior authorization and network limitation let's start talking about and those two prior authorization, what it is meant to do, does it really work, does it help contain healthy cost or deter medley necessary care.

>>>: It does both, and prior authorization, and at least, is to, reduce unnecessary and harmful care. It's been used by and big insurance companies as they have gotten more and more full of the healthcare system have a need to make money for the investors, and has become a big tool of denying necessary care, we have seen a lot of data that shows that, and big insurance companies that operate Medicare advantage plans, and making use of prior authorization. And more in Medicare advantage in case than the commercial health insurance plans. And it is a tool that they have using now, to try to make sure that they are staying the good grace of the investors and they are for profit by far the dominant players health group, ate in a and other, which owns Blue Cross plans and Humana where I used to it's a dial of leverage they can use to, and adjust when they are faced as they had in recent quarters, with rising medical expenses. They ramp up through use of prior authorization to control or limit the access to healthcare goods and services. Actually, two ways to control or manage within the cost, one is to have an influence on the unicorrespondence of healthcare and other, and is utilization and, and healthcare companies have focused on on the latter, and in fact, and they don't care about controlling the unicost of goods and services, and as those cost go up, and big insurance companies just calculate what medical trend is next year, as the demand their customers pay more in premiums it's a way of maximizing the revenue, and they tried to reduce medical exposure by reducing the care, and that people need. In many cases, and the

care that is denied, is medically necessary care, few people know they have the ability to appeal a denial, and as a consequence, and they are not getting the care they need and the companies are pocketing money they shouldn't be pocketing.

>>>: So, we know from KFF, maybe data generated in this building, and as you mentioned, and few people bother to appeal. When they face denial. And but among those who do appeal, they tend to be pretty successful. Which suggests there is an all of lot of care even because the first level of appeal, they go back to the insurance company themselves. There is a significant level of denials that are happening within the insurance company disagrees on, what does that look like for the consumer.

>>>: It's daunting. Keep in mind, too when you are, needing care and you are faced with prior authorization you are probably sick you are not well you maybe older and not aware of how to even begin to approach appealing a denial. If you don't have some, someone in your family or network to help you it's really daunting, to navigate that part of healthcare system. Or even to know what your rights are. Very few people have an understanding of their ability to appeal. Insurance companies know that, it's baked into their revenue and profit expectation are, they know that a very small percentage of people for one reason or another, whether appeal a denial, they go without the care they need.

>>>: One, phenomenon related to prior authorization, we are trying to bring more information to, care is initially approved then prematurely terminated we see that in like skilled nursing facility or home health settings there's no question that someone needs some

care in a nursing facility for a little while, clinicians and week later in the Medicare advantage enrollee, will get a, and of the people that bother to appeal we have seen multiple repeat denials in the same episode of care. Two times, three times, five times, ten times in the same episode of care, skilled nursing facility, people, we keep getting denial and say force to appeal, and win those appeals but eventually break down,.

>>>: Either they are get the care they need or they give up. It's in fact, my own family my mother experienced that. I had been advocate of Medicare advantage in my career in the health insurance business, in fact, I joined Humana, and the center of advocacy was formed in the late eighties, and I saw, at Humana, how profitable it is for these companies, I saw first hand what it is like for a patient who needs care, who needs skilled nursing care, my brother broke her hip she was in a Medicare advantage plan, I had encouraged mom and dad to do, enroll in one, not thinking what would happen when they needed a plan. She needed, and utilization review nurse was constantly looking at the, and whether they was responding to and the care she was getting. Whether she needed further care. And, like you said ,she and many other beneficiaries who enrolled in Medicare advantage plans find that the they are denied the care they need in the skilled nursing facility, and, and completely difference from the, if they were in traditional Medicare am there is always someone on behalf of insurance company, who is monitoring the care that person is getting. Not necessarily basing those decision on need. Your needs.

>>>: So now, unfortunately we have to add a little asterisk to the people in traditional Medicare not generally facing prior authorization, we have seen with this wise I go demonstration, that's going forward in about six states, where right now, very few services are subject to prior

authorization in traditional Medicare, but this model expands that list, and employing some of the same vendors that Medicare advantage plans use to make determination of coverage employing AI or algorithm tools and those vendors have a financial incentive because they get the savings. Could that corrupt the traditional Medicare program?

>>>: Absolutely as a way of getting in there, I think the experience certainly is to for that to expand to much broader set of services that, and the person might need. And I think it's as you noted it's a model itself, -- is designed for corruption. If the entities that are involved in this, many of them it's hard to find what they are track record is what they have done in the past, but they have a association with sometimes are part of these big conglomerates that I write about in the newsletter. But they have it is in their financial interest they make more money, when they deny care. Because they capture a percentage of the so-called savings.

>>>: Where we sit, as organization, that provides services for Medicare beneficiaries, the people contact us are pretty self selected they call is when this are care is well coordinated when they have wonderful experience with the plans, it's undeniable there are barriers to care through and private Medicare advantage plans that, what about the impact of the growing privatization of Medicare, and on the and Medicare program itself you alluded to payment of Medicare advantage plans. Talk about that.

>>>: It's a very lucrative part of the health insurance and for most of them, and I follow the earns reports for the big companies. And every quarter one of my responsibility when I was at Cigna, handledling financial communication, I did that for ten-years I became familiar with

the earnings report I have noticed just how much Medicare advantage equate to earnings for the company, it's significant. United Health Group for example, and healthcare the insurance arm it's about 77% of its revenue now from public programs even though it is the largest insurer the largest commercial insurer, people enroll in the commercial plans, it gets way more revenue from the public programs, it's because of the way they've been manipulated to risk scoring system and other ways of overcharging the government, it's extraordinarily profitable. Now the company have had some problems on Wall Street, they are continuing to be profitable but for investors point of view and Wall Street, not profitable enough. And so, they had a hit with the stock price. So now they are pulling some of the things to try to improve the profit margins return on equity. That affecting beneficiaries in ways that most beneficiaries wouldn't have any idea it's happening. But we will see are seeing an uptick of prior authorization, even as these companies are pleading or saying and telling the administration they are voluntarily reducing the prior authorization, there is no way of auditing that, and, but they are out there with their public relation campaigns to try to get people to think they are doing that. But the other things they are doing, they are reducing their network the composition of the network. And a lot of healthcare providers voluntarily are dropping out, because they are complaining, rightly of not being reimbursed by insurance companies. Some of the major hospitals in the country, are dropping out of managed care network Medicare advantage networks. And others are being dropped in voluntarily and physician practices as well too. Provider networks are shattering, and they are also exiting a lot of markets this past year I think about 4 million Medicare advantage beneficiaries had to scramble to find another health plan, their insurer,

exited those and markets they deemed they were not as profitable as they want them to be, they cut people loose. They also are reducing the PPO, and now you can find an HMO has a much more restricted network of providers, they are doing a lot of these things. And they are not required to disclose any of this, they are advertising it is not anything like what even drug companies have to do, drug companies advertising, they have to at least someone speak what side effects are, you don't see any of that in the Medicare advantage plans and traditional Medicare can't advertise. So, traditional Medicare has hands tied behind its back when it's trying to compete with the big companies that are able to go out there advertising the so-called extra benefits they get and obscure the downsides of enrolling.

>>>: I think really important point traditional Medicare doesn't have its own lobby. There are few people pushing to preserve and protect traditional Medicare. And now, because of the way of program is structured people have to essentially purchase a private plan, if you want prescription drug coverage you have to purchase a private drug plan if you can afford a met da gap policy, many of the same, and offer those plans too, you noted it's far more lucrative on Medicare advantage plan. Medicare advantage is costing Medicare more for beneficiaries, med pack and, and advisory commission, which might be a, and conservative estimate, says that in 2025 Medicare paid \$76 billion more for Medicare advantage than traditional Medicare was spent on the same beneficiaries. And in part due to manipulation of the risk adjusted payment system and bonus programs that don't improve quality or measure that. That cost more for everybody, increase part bsm premium, and you have done a and, you have done a lot of work exposing the, how do they maintain the status quo, you

made a reference this administration saying it's cracking down on prior authorization, we heard things being said about, and attacking overpayment. But how is the insurance industry maintain this what does that mean for Medicare in the long run? Traditional Medicare, didn't have anything close to the representation of Capitol Hill. These companies do. And.

>>>: Campaign contribution, one of the things that I launched tracker looking at how much these big companies are donating to candidates. Members of Congress, it's astonishing when you look how much money they are, actually you don't have to spend a lot of money to buy influence in this town, they be spend enough money to buy considerable throw to keep the status quo going to keep the cash cow alive. And, and public relation, and advertising. They spend normal amount of money I know this I was part of the machinery of working through public relation firms and advertising firms. To persuade people that Medicare advantage plans are superior. And again to obscure the things about Medicare advantage that the industry does not want people to know, until it's too late until they are trapped into one of the plans and find out then this is what I wish I had known. They spent so much money, they are making so much money, what they spend on campaign contribution and lobbying is the cost of doing business, it's actually a pretty small percentage of what they rake in from the government. You are right. They are able to get overpaid, the promise of for privatizing Medicare was that, it would save money. Save beneficiaries and the program in the country taxpayer money, it's never saved the company or anybody a dime. They'll argue that, it's beneficial to Medicare beneficiaries but they pay, taxpayers pay more for every enroll IEE it was the believe that private, companies can do a

much better job of administering benefit and say manage the program, it was based on fall premise it was never going to happen, again mainly because of the way that these big for profit corporation were able pretty quickly to take the program over.

>>>: So, recent column you wrote for healthcare and coverage, your blog which is excellent, argue that health insurance is a market failure, can you talk more about that?

>>>: Well when you look at other sectors of the economy, and I was recently invite to do testify of all place in Austin at a house hearing on healthcare affordability. I made the comparison of looking at the all of that industry Ford, and now, and you can buy a \$27,000 for, average cost of a family premium. You can buy that car for that, premiums go up every year, and cost of the Ford, at least you have some expectation the car would be safe and the look cooler have some bells and whistles something that you are getting some additional benefits. It's Exact opposite in health insurance. Plus, and there is, and no ability, very little transparency. You don't -- comiewrmsz are not equipped with the information they need to make informed choice the industry always said that we need more transparency. They say that but behind the scenes to make sure there is not transparency. They benefit from the complexity and the confusion that people face in, ins. And so, it does not have the element that functioning industry that is benefiting consumers, and it fails them, and we are constantly paying more and getting less value, there is a term called benefit buy down, I never use that with reporters, but that's what executives talk about, and behind closed doors, with analyst. And this is what happened. Always raising premiums again, back to anticipating what medical trend will be, but to, and try to make sure that we are also capturing more of that money

giving more of that money, being able to reward shareholders with the premium we take in, we'll reduce the value of the coverage in some way. And it takes, it can be higher out of pocket cost which are a lot in commercial plans. Even in Medicare advantage there is a limit on how much you have to pay out of pocket but if you are in a HMO or PPO and go out of network, you will pay a lot of money out of pocket. The use of prior authorization the limited networks that I talked about, these are all ways that these companies are devaluating a healthcare policy. And we are not able to have the information that we need. I was part of the effort back 20 years ago to create the impression the belief that what we need in this country was consumer driven healthcare, if we gave people more skin in the game, also, the tools to be able to shop for healthcare, problem solved. It was never the intention for there to be adequate transparency. Or to give people the tools they need to make the decisions it was never it was a good talking I even believed it myself for a while until I realized I was telling people a lie. One of the reasons I left was because of the industry wide effort to, has quickly, it gets these companies off the hook from paying for care they otherwise and had recently been paying.

>>>: Okay. So what you just outlined pretty much the way that our entire healthcare system works, reliance on private plans. All that's available through the Affordable Care Act the vast majority of Medicare is available for private plans now we cross the threshold in Medicare, over 50% of in private planses what is lost, as neck is this.

>>>: We are not thrown to the wolves yet if it withers on the vine, as, privatization of the program and hoped for even said out loud in the early days of the movement to create the modern version of Medicare advantage prior to the 2003 privatization, you had Medicare plus

choice but that law was put into place that made it much more lucrative for private companies to participate in the program. And to do what they are able to do, to over charge the government. To capture all the extra bills of dollars we lose the ability to -- to keep from over paying, as fewer people enroll in traditional Medicare more money is going to the companies we as taxpayers are losing out on it, it's not every going to save the country money. It is just not. It is not in the cards to do that. For beneficiary they are losing an option that many people value. And even with the majority of goods and services are not subject to prior authorization that will change. And it's already beginning to change in traditional Medicare, hopefully that -- that can be halted in a not go further, maybe not even to be continued. But I think it would require change with administration for that to happen. We lose the ability as a benchmark of the determining how much Medicare advantage plans should be paid. It is based on the traditional Medicare programming in certain ways in terms of compensation to the provider. You lose a lot as that diminishes.

>>>: In traditional Medicare, and it seems like it would be safe to say, we rely for whether or not healthcare is going to be relied more on clinician judgment and insurance driven healthcare rely more on insurance company judgment, which includes clinician. Traditional Medicare you can see whatever provider you want you are largely not subject to prior authorization. But it seems there are other things that could be lost. As traditional Medicare, and the healthcare system, and we are setting quality measure and say standards, supporting graduate medical education, and supporting rural providers, as the system becomes more private tides.

>>>: It will continue to fade, these big companies have no interest in continuing that, it's all about making money for shareholders I keep talking about shareholders because again the big players are these for profit entities. Whether we are talking about Medicare advantage or the plans right now the things they are doing, they are saying this out loud to investors they don't say that that much on Capitol Hill, they are doing to control Medicare expenses is to reduce the composition size of the network. Ratch it up utilization management tools. And make people pay more out of pocket, and the out of pocket cost go up every single year, one of the things I established -- couple of years ago is the lower out of pocket now coalition, out of pocket is, the reason we have hundred million people in this country who are saddled with medical debt and the vast majority of those folks have health insurance they can't afford to get the care they need without spending a lot of money out of pocket. It's often money they don't have, so they go into debt because of that. Or they don't get the care they need. That is a reality for a lot of people in commercial plans, that is increasing I think going to be the reality for people who are in a public program as well.

>>>: What, what can policymakers do, to rebalance things between traditional Medicare and Medicare advantage, so-called level the playing field? What can be done policy wise?

>>>: A lot of follow the membranes of med pack and I talked to, the lot of the reports they send to Capitol Hill, and ignored, and do something about the overpayment for one thing. You have got, the no up code act. Senator Cassidy which will not be in the Senate very much longer it is a bipartisan bill that's one thing, addressing the overpayment is important, I am seeing and bipartisan interest in addressing prior authorization. And some of the Members of Congress

are physicians who see this have seen it in their own practices and hear from their constituent what a burden that is for providers as well as for patients. There is some interest in the addressing out of pocket cost. To do things, that would save people money and enable them to get the care they need. But there is not enough I don't think attention focused on the problem of Medicare advantage for beneficiaries and for taxpayers. We're seeing that change, I think that's a consequence of the work that you all have done, and many of us have done in and raising it's awareness of the things we talked about. And I am seeing more attention focused on that now than I would say five years ago for sure, it takes a lot of effort as you know, a lot of meetings with staffers and just trying to compete with those many, many lobbyists for the companies that, are always present and have, because of the campaign contribution the companies make.

>>>: So long we have private plans in Medicare, and we need to address payment, we need payment parity, we need and out of pocket cap. We need to allow traditional Medicare to cover some of the things that Medicare advantage doesn't cover, vision, hearing and dental. As long as we have private plans in Medicare we need far greater and meaningful oversight, and hold plans accountable for more than just the cost of doing business.

>>>: They need to be far more accountable and you are right the traditional program needs to be updated. It needs to have, from here on up, we need vision, dental and hearing benefits. And the program was created in the sixties hasn't change add lot, we need a out of pocket cap, there are some things that would be great value to beneficiaries it needs to be improved and I think expanded as well, too. It's a program that works very, very well has far lower administrator

cost, much more fair. And doesn't involve taxpayers. The taxpayers are being ripped off by the private companies. You are not seeing that with the traditional program.

>>>: So, in closing, and trying to draw some of the energy from Governor O'Malley call to us, and strengthen our resolve to protect the public program, and envision better future, closing thoughts on how we get there with Medicare or healthcare more broadly?

>>>: Just keep up the advocacy. And the word, advocacy in your title is absolutely essential. We need to bring people together and help educate advocates to understand how they can be more effective in their advocacy. Bring try to expand the choir to get more people to understand, that'sy started the newsletter. A lot of what we are talking about now, not adequately covered by the media. Not very much of the awareness of what we talked about during our time here today. We need to educate the public and lawmakers too. As well as I do if you are on Capitol Hill you find that the understanding of healthcare system even those are on committees of jurisdiction, have been shallow, and about the only information they get, day in and day out is the lobby is that are giving them campaign contribution, advocacy is essential, and figuring out ways to educate the public and the media to try to influence how stories are covered, reported and to make sure this is something that people are aware of. It's worth a try to keep more people from unwittingly being moved into Medicare advantage and a lot of people as you know are being moved against their wishes. Sometimes because their employer, whether it's a corporation or municipality or state, and will just move people into if they are retirees with benefits, and into Medicare advantage plans, we need to address that. A lot of work to do.

>>>: That sounds like a good place to stop, Wendell Potter, thank you so much for today.

[APPLAUSE]

>>>: So for those both here in the room and watching online, we'll enter a 30-minute break. So see you after that. Grab a beverage and enjoy yourself and we'll be back shortly. Thank you.

[MUSIC] Please Standby.

We'll resume shortly.

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[MUSIC].

We'll resume shortly.

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Thank you for joining us.

[MUSIC]

>>>: Thank you for joining us.

We're back from break shortly.

[MUSIC]

>>>: We'll get started.

Welcome back from the break welcome to our next panel.

Healthcare challenges and opportunities. Our dear colleague Kata Kertesz has worked hard to put this panel together was set to moderate

it but unfortunately had to attend to a family emergency. And as part of our ongoing efforts to thank our sponsor at this point we would like to thank justice and aging and thank all of you the panelist particularly to Tim Engelhardt for agreeing to step in as moderator at the very last minute. And so, he's very skilled at this, but if he messes up -- fluesered.

>>>: Thank you for lowering that bar.

>>>: Just, knowing that, he is doing us a service and filling in at the last minute. Thank you, Tim. And I can quickly introduce the panelist, then let you take it from here, Tim Engelhardt from the aging and disability health lab. And Leo Cuello for this center for children and families at Georgetown, and Arianna and Sarah Coombs, and.

>>>: Thank you, and sufficiently expectation lowered we'll talk about healthcare challenges and opportunities. Which means, and we'll depress you for a few minutes and uplift you at the very end. So help us. He have an esteemed panel here we'll jump into questions and I want to start with Leo. Reflecting that time moves very slowly and quickly it's been about a year since the budget reconciliation bill that Congress passed the vast consequences on tax policy and social safety and more. Where, and Medicaid was a particularly point of focus, you have been tracking HR 1, more than anyone, where are we now?

>>>: Great question. And I know there is a lot of Medicaid experts in the room, the summer of 2026 the summer that you will dig and wrap your head around with Medicaid policy, some bad news for you, those of you that are working on, do not understand what's going on, the people at CMS doesn't understand what's in the regulation that's being released two-weeks from now, big picture, HR 1 was made

historic cuts to Medicaid, and number one, putting a gigantic implementation job on states, a lot of state and, state Medicaid agency are the ones running the program, they are really really distracted by implementing this. And coverage loss associated with HR 1, you are looking at predicted ten million people, a lot of coverage loss. And I think we can get into, there is a lot of reasons 55-64-year-old will bare the brunt of that loss. And then, states are going to lose a lot of money if this law cuts a trillion dollars out of the Medicaid budget. And that's going to have very serious consequence at the state level to do programming for senior and say people with disabilities. So at the, and we're absorbing that HR 1, we have a fraud narrative going on. And we have, tax on immigrant coverage. And we have got some additional clouds on the horizon in terms of threats, we have 4 pretty major regulation that will be coming out in the next weeks, some of them are rumored to have some very bad things then we have the risk of another reconciliation package this summer. Where, some more cuts could happen. In the Medicaid world a lot of it's instabilit and uncertainty.

>>>: I want dig in on those things. Like I key feature of the bill is the deployment of administrator burden to ration healthcare coverage. That's, and multiple mechanisms related to enrollment and eligibility. I can't keep up with it, so remind us what those, redetermination, how they'll affect different population to whom they'll apply and tell us a little bit what your focused on some of the upcoming policy?

>>>: So if you are looking at big picture HR 1, 21 different provision hitting Medicaid, and eight of those hit the Medicaid expansion you see them, we are afraid to repeat, attempt to repeal it, they are trying to throw a lot of the sand in the gears of expansion. So, the biggest one by far is the work requirement. And the second biggest one in terms of

that's going to result in five-six people losing their health insurance and second, and this is making redetermination be every six months. And that's from a year, so doubling the amount of redetermination, then the third, and probably biggest one is limiting Retroactive coverage, some requirement to add cost sharing. And kind of an assortment of things that are going to degrade coverage. Now it's important to remind everybody in the room we are talking here about Medicaid expansion. Remember that, and Medicaid is big house, you get into a lot of different doors, different categories of people that are eligible in. Expansion is just one category. And so, who are we not talking, we are not talking about people 65 they don't fall into Medicaid expansion we are not talking about people that are ask for Medicaid on the base of a disability of a functional impairment. And now, there are a whole bunch of people that go into the Medicaid expansion, and are not otherwise getting into Medicaid through one of the other doors. So they might have a disabling condition they might have a functional impairment they are in Medicaid expansion these policies will apply to them. A lot of risk there, right now the work requirement is where everyone is very focused because it's the biggest impact but it's also the biggest absolute nightmare of implementation job for the states.

>>>: There are you talked about over 65 you talked about the disability, and other exception that are written into the law, medical frailty. There is an exception for areas of, with high unemployment rates, what do we know so far how those are going to be implemented and what do you think?

>>>: Right. We're talking about specifically about the work requirement. And you sort of get passed the work requirement one of

two ways you can comply, eighty hours of work or work program, or community service. Or halftime education. Or eighty hours of those in combination or if I have hundred eighty dollars a month any of those you are compliant you are get around that by getting an exception there is a long list of exceptions. One of those, is in particular, and is what is termed medical frailty. And that within it includes, disability, substance use disorder and ADL needs, daily living needs. And somebody who has a serious or complex medical condition. So that's the very broad definitions that would include a lot of people. If interpreted correctly. We have been told there is a regulation that CMS is required to issue by June 1 that will detail everything about these work requirements so it's expected any day now, probably just guessing two-weeks from now, something like that. What we have heard, is that the White House has pushed very hard to tighten those definition a lot so two things they are, medical frailty definition turning more of a work ability definition. So it's not just that you have the chronic condition that you showed you can't work. Very, very much a problem. Second, the other critical factor how you show you have that condition. And what the law actually says, states do not have though caregiver the details around people who are requesting one of the exception for example if you raise your hand in self attest to activity of daily living needs urn the law I should be able to get that exception, we are told that CMS will push quite aggressively require people to have documentation, etc. They narrow the standard then they create a much harder process and now a lot of people are at risk of not being able to qualify for the exception and the other exception that you mentioned, so that exception for medical frailty is one of the mandatory exception every state has to offer that. There are a sweet

of four exception that are optional that states can choose whether or not to implement. Right now the good news most states seem to be heading towards implementing there is a KFF, survey that can tell you what states, that survey is available on the KFF website as well. Those exceptions include one for somebody who had recent medical attention. And so like was in the hospital during the month of application, it includes one for an area that has high unemployment rate. And there is sort of a numerical figure but a relative figure, if your state, unemployment but your stay is way up, your region/state is way up you could get an exception, and one more emergency declaration, if you have an emergency declaration or storm or flood, those are all optional.

>>>: The literature, administrator barriers tend to disadvantage those with the greatest needs. I want to pivot to something else. And at the risk of being booed like a commencement speaker let's talk about artificial intelligence. Arianna you look at how technology impacts people with disabilities. Technology playing a bigger role in the healthcare space right now, automated decision systems and say algorithms affecting benefit coverage. As I preface for Leo, where are we setting the stage for the state of played AI healthcare especially for people with disabilities. And then, what should a group of advocates be thinking about, when we learn about these things?

>>>: Thank you for the question, I don't think you gave yourself enough timing for people to laugh at your joke it was a go ahead good joke.

>>>: Thank you.

>>>: Yes. So the question of where are we? I would say there is a few sort of top line trends you can think, when you are thinking about the intersection expansion of AI in general, and then sort of kind of like more down how it will impact healthcare Medicaid, Medicare, and so sort of, first on the general side of things. This is something everyone in the room probably knows, we're seeing AI being incorporated and integrated into more and more systems more and more often. And something I say, a lot, we are far past the point where if a people with disabilities said, I do not want to use AI, I don't want to use let's say a large language model, and I want to use ChatGPT, that doesn't mean that you will not going to interact with AI systems they are being incorporated pretty much every aspect of our lives. And including healthcare. Then, so like that's sort of one top line trend. We are seeing these tools being incorporated more and more across systems they are impacting people across disability. Also this is not this sort of thing that's only impacting let's say folk that are blind or low vision or deaf and hard-of-hearing, and the second thing that I'll say, also could have me booed like a commencement speaker, I don't see that trend changing anytime soon. I don't think that particularly in systems like where there is some element of dis satisfaction, whether you are talking about a ways in which healthcare services impact people with disabilities multiply marginalized people with disabilities, something I say a lot as a disabled person myself I never with insurance company, and say that's the best time ever, you never have that experience, so when you are thinking about healthcare and as something that is suboptimal, and that maybe particularly suboptimal for people with disabilities, and multiply marginalized people who are facing various sorts of things that are incorporated into the system, ripe nor AI tools,

there is the idea that AI can make it better, unfortunately what we tend to see more often when these tools are not incorporated in a way that's thoughtful and in ways that are really centering the affected population they service a force multiplier, they can make things worse instead of better, and the idea of lot of my work is to think about when and where these tools are incorporated, how to ensure we can maximize the benefits mitigating any of .

>>>: Some of the tools are being deployed in government programs right now. And tell us about those and what you see?

>>>: Sure, yes so you can think about my colleague Kevin who runs an organization tech tonic justice, several years ago at this point, filed a lawsuit on H CBS and benefit determination that were determined using analogy rhythm system and I will take a step back, when we are talking about artificial intelligence, and one of the things that matters is to set the stage for what do we mean when we are talking about that. So, are we talking algorithm, are we talking about a large language model Chatbot that is being used for customer system as SSA. And the answer to the certain extent we're talking about all of those things. But, how we talk about it and the recommendation for implementation and for and deployment and for auditing, might be different because these are different used cases. And but yes we are seeing, we have seen it used at the state level for benefits determination. I believe we'll see much more in the way of customer service chat bot, pretty much and government services and private services. Just in general I think we'll see more and more chat bots, some of you have interacted with AI Chatbot with a customer service Chatbot that you feel like might be AI. It very well might be. So those are all some top line trends and I can I see, future where there is more and more AI being incorporated into

decision-making. And into, and coverage determination into appeals that sort of thing.

>>>: Now, put it in CMS context, we heard about the wiser model earlier.

>>>: I was not here for that. But I can share maybe take a step back and just, say a little bit about, C MMI, center for Medicaid and Medicare innovation. And has a mandate to test payment and care delivery model that reduce spending while preserving or improving quality of care. And if model are able to lead those really strick statutory requirements, they have the potential to expand and scope and services. So, with wiser, I guess I will share that wiser one of the new pilot program that started in January. It runs for six years, and six states, not name all of them, Arizona Ohio and -- Washington I am missing a few others. It's specifically allows CMS to test AI led prior authorization requests for certain procedures that are deemed by the administration low value or vulnerable to fraud waste and abuse, some of those conditions I don't have them off the top of my head, epidural injection for pain management and skin and tissue substitute, treatment for spinal, sleep apnea and others. So what is interesting about this model, of course this is like the first time that C MMI testing prior authorization, with traditional Medicare beneficiaries. And how it works, healthcare providers that are treating those certain conditions will have to submit prior authorization requests. To CMS contractors, those CMS contractors then review the service and either deny or approve that. Then, the clinician will have to review the denial decision. And patients there are some beneficiaries protection. So I guess one of them is there is a limit to how long, time limit for prior authorization decision and what we have already seen in some states

like Washington state, and patients are experiencing two-four times longer delays in prior authorization decisions. For care that they never had to experience prior authorization before. And, of course, you know that increasing administrator burden on providers. That's increased scrutiny by lawmakers by and advocates by, and physicians and clinicians. Because we know that there is a risk at delaying and denying care for people that need it. So, I would say that for wiser, it's one of those models where we have to -- your we using AI led programs to review prior authorization and traditional Medicare, I think that's the big question there is the potential to expand to include other services and potentially other states. So that's just one of the models that C MI, I can give you a concrete example of where they are testing those.

>>>: Okay. Back to Arianna. Very little regulatory structure in place for AI systems and very often technology out strips the pace with which we make new regulation and guard railings and policies, what should a room full of advocates be thinking about, in terms of like the government role to place guardrails on some of the things here?

>>>: So so I will answer that, but I want to jump off on an example, just to say as a sort of like a level setting, one of the concerns of using AI in the sort of context, there is this idea that AI and algorithm are the clinical "black box"es and it's hard to tell, they come out with decision based on training, and each tools, put out a response based on the training data that is input into them. And so, when we have training data that is under inclusive, and let's say, particular conditions or particular types of disabilities, and you're going to get output that are under inclusive as well. So, I'm not saying for sure that's the case of what's going on, but we have seen sort of in general a under inclusive data, I have written a paper on this, and who focused specifically on

disability data. All of narrative reasons why disability data is under represented in a lot of these data sets. That's kind of as a level setting, if you are an advocate you are thinking about, okay, why should I may be be skeptical about the incorporation of AI into this sort of arena, that's one reason why, and like fundamentally how do these tools work? Then secondarily, these tools are brave pattern recognition and when you are feeding them that is maybe not like the typical pattern, with the rare disease or whole bunch of co-disability that sort of thing, they also may not be the best tool to come up with the best outcome. So, again that's sort of like the level setting here. And thinking, if you are an advocate, and what can you advocate for. One of the big things I believe is transparency. So that people know when they are interacting with an AI tool, and sort of in the beginning of things, not later not after they have a denial. I do believe that that is something that should be legally required if it's not already, if it's not already, is it a legal question? Because it's highly dependent. But transparency is a big one, and another one that I specifically make this as policy recommendation all the time is audit I ting for disability bias, these tools especially in the systems that disproportionate serve people with disabilities, they audit for bias towards people with disabilities. And both pre-deployment before the system is incorporated but also afterwards. What I call post deployment. The reason for that, you would never hire someone and then do a performance review, and say okay you have got it good job. Right you would hire someone then you see how they are doing. And if they weren't doing well you do something about it. Right. We can do that with AI tools, it's not like once you incorporate that into system, well it's too far gone we have to let it deny people the healthcare now until the end of time, we can do

the pre-audit and sometimes post, sometimes it's hard to tell, how they are going to work until we are in the system.

>>>: We are in a room where swept schism dominates knowing many of you, arrest Anna can you give, and there is some potential here to, and deploy the improve equity and access, right?

>>>: I think I will choose the chat bought as an example, I don't think it's every necessary about the tool itself, something that I say, AI is not good, it's not good, but never neutral. What I mean by that, the tools themselves, they are just tools they are not good or bad but in theses into systems. And it's never neutral so we need to think what that looks like and what it's impacting and the Chatbot, and it could help someone that needs customer service, who has a hard time waiting for a long time on the phone. And however, the Chatbot are not going to be useful they are train on data that is inclusive of people with disabilities, and it hallucinate as little as possible, which it can never be zero, it's an LLM that they hallucinate, there are privacy things taking place. And so, when you are feeding this Chatbot maybe sensitive information you know it's not going to be used as part of a training data set or sold to a data broker it would need to be trained, people that don't have English as their first language, they can interact with it there is no potential, but, and deployment really matters. I am skeptical at this point in time, that with all the focus on like winning the AI race we kind of made up there is a race to incorporate this into all of other social services in particular, that we are not focusing on how to do it well. It's too important to not do well.

>>>: Sarah, let's take it back to payment model innovation. Incorporating AI or not incorporating AI. What has worked well, what should we be optimistic or pessimistic about the payment model?

>>>: Um. Yes as I said, CMS can expand model, C MI, very small handful model have met the criteria, not very many model has really succeeded as well, there have been mixed result, however I think I would say, that C MI, has proven that care coordination can really improve patient experience, patient outcomes to some degree to the cost of care. And so, I think I remain optimistic because I think in the safer service system that traditional Medicare is reliant on, it really does limit the flexibility that providers and clinician need to provide patients the kind of care they need that's personalized. That includes interdisciplinary care teams that, and address social drivers of health and whole person care, I think it's too often too limited in fee-for-service, that has like misaligned incentives, but there are some miss steps, and I think one of them I am seeing on the theme of technology, one model that I am just really wary and cautious is the access model, I don't know if you have been familiar with. I don't know the acronym, it's advancing chronic care with effective scalable solution model, it's a model that reimburses tech care enabled companies that have patients that use their products and services. To better manage some of the chronic conditions like diabetes and hypertension and obesity, and other things, and. With that, it's voluntary, there are two ways that patients can enter the model. The first primary care physician can refer patients to these tech supported enabled healthcare companies. Or that, patients can self select without a referral. So that makes me think which Medicare beneficiary are going to be aware of of those models? How are they going to select themselves into the model, who does that

leave behind? We know that these companies traditionally right now are contracting with employer population that was look very different compared to Medicare beneficiaries that are older, that have more complex conditions that may have lower health literacy. What comes to mind for me, when we are designing and building model it needs to have equity at the inner center, this model hasn't launched yet, it launches in July and it will run for ten-years, there is less to be determined a lot to be determined but I think when you think about, integrating technology into payment model we have to think about health literacy Internet access and access to technology. People with limited English proficiency, and how, these kinds of models exerserbate disparity and I can only imagine this model will work for a subset of Medicare beneficiaries and will leave others behind, there are some promising ones.

>>>: Please.

>>>: Is that the guide model, many of you more than I do. And unlike the many C MI model that are testing, and how to use total cost of care, this particular model is really has the goal to improve the quality of life for people with dementia reduce people that are caring fo their family members, enable people it's meant for people to live at home as long as possible, and it provides respite care and 24/7 help line and navigator, and patient navigator and the things that people need to comprehensively take care of people with dementia. And, of course, and whereby we're a women's health organization and caregivers are unfortunately women, they are often unpaid. And, it's a bright spot we'll see how the model goes, if you are more familiar with the model I would love to chat to see how it's going.

>>>: At the risk of breaking the spot momentum, the reconciliation it wouldn't affect Medicare, how true or false, is that?

>>>: So, it's false in a lot of ways. The first thing that's really important, people in this room probably understand it most of the people out there these two programs overlap. So, about fifth of Medicare enroll and Medicare providing a set of services, and that, Medicaid that's not essential, we know about the transportation services, and right, there are other services that Medicaid is providing. And when you cut Medicaid, you really really hurt huge population of people on Medicare. And in some case the people who have the most challenges already facing them on Medicare. So specifically you have the provision that cut funding, which put a lot of pressure on Medicaid services targeting seniors and people with disabilities. But then you have direct things, right, repealing regular law or moratorium on regulation that were and use data to increase enrollment in the Medicaid or savings program that are, and they reduce Medicare cost, I'm embarrassed to say, you and I have been talking about enrollment in the programs. So, your pulling back regulation that we'll address that. We have a long-term historic problem that the eligibilities rules for the non-seniors and people with disabilities are more complicated than the rules than the imagine enjoy, and what this rule will do, align those rules, by making the imagine rules, and several things that would improve the eligibility process for older adult and people with disabilities. That's been held back, and some of the changes will be made permanent over the coming year, you had provision pulled back and provision dealing with nursing home staffing. You had pull back on provision dealing with Medicaid home equity rules which are rules that allow people to have some assets and still remain eligible and they are

freezing those assets limits over time through inflation will become more and more ununhelpful.

>>>: In addition, ending immigrant and the staffing thing, but it will affect a lot of Medicare beneficiaries all the estimates would, and result in increasing mortality, among the population, I think Leo to sum it up you are saying it's true. That there are no impacts on Medicare, as long as we ignore the things that increased cost for Medicare beneficiaries increase their administrator burden, and kick them off the program or kill them, is that fair?

>>>: Very good.

>>>: You alluded to it earlier, but how concerned should we be about further Medicaid cuts?

>>>: I think you have to think about this in two ways the first is immediate threats through another reconciliation package. Right now, so what's happening right now reconciliation package moving on immigrant order stuff, so far doesn't have a lot of toxic stuff in it there is conversation about another reconciliation package that after goes through. And it doesn't have, seem to have critical mass yet, so hopefully it never turns into. But I think people should be prepared to talk to the American public what this means for their coverage. However, so that's kind of new problem. But we've got an existing problem historic to Medicaid financing, your state, is going to lose Medicaid money that it thought it had. And it's also going to lose the ability to raise none money that it thought be it could raise if things went wrong at any time, and what that means, and Medicaid, in a state has a balanced budget the state has to address the problem somehow, we have a big problem which is that a lot of services that senior and say

people with disabilities rely upon, are optional services that are quite expensive. So when states are states are looking to make cuts, where can we make cuts that we can pull back some money, and in certainly how home and community-based programs are the target, and the other thing we should say, when they are not target the eligibility or services those are the second and third things that get, and the first thing is provider rates. And anybody who works with seniors, who try to get home tenantENT cares know you can get hours prescribed it doesn't mean we can fill the houser we have a shortage of home healthcare workers if you take the payment rates that currently exist and you make them lower, that makes it harder to get the home health aids and you layer on to that, the fact that, and those home health aid worker is disproportionate done, and by immigrants. So when you attack immigrants, you also hurt that workforce. Huge impact.

>>>: Thank you. You are pivoting into I want to hit two other issues then we'll -- get optimistic. You touched on immigration I want to see if the other panels about the interplay of immigration policy and health policy at this moment in time in 2026?

>>>: Okay. I will add that again, everyone at the organization we look at immigrant justice, and I know that I'm talking to room of advocates. I think important to view as I think we just fundamentally agree with regardless of their status, and should, access to healthcare, bodily autonomy, and the right to give birth and raise children in a safe community, while we are not a leading immigrant association, we support our partners in this work, you know the health system can't work if everyone doesn't have.

>>>: For anyone that wants it?

>>>: The Federal Government has made a big focus on fraud. Especially in the Medicaid program. And I suspect that I speak for everyone in this room by saying fraud is bad. With that said, how should we be thinking right now about the pervasive focus on and fraud waste?

>>>: So fraud was the dominant talking points in the HR 1 effort. And the historic one trillion cuts in HR 1 are by our calculation 2.5% about fraud. That should tell you already, where the narrative is, and compared to where the things that are happening are. Ten million people that lose coverage under HR 1 has nothing to do with fraud, what we are seeing right now pretty historic attack on state Medicaid programs. And with the Federal Government basically saying to them we'll deif he ever payment to you, meaning we are going to not give you Medicaid match for some things that you have already paid for, we are going to withhold future Medicaid payment until we get what we want. That is very different than the manner which fraud has been dealt with in Medicaid over time and the states and the Federal Government collaborating through state Medicaid fraud units where every dlawr invest in them saves three dollars of losses. In fact, what we see is the Federal Government threaten to punish some of the state Medicaid fraud units. So we have a wildly different environment than we normally have and the important thing this audience needs to understand -- the epicenter for the fraud allegation is home-based care. Home and community care. Of 1.3 billion withheld or defer for California and is .1 is home care. And why is that happening, it's happening because these are non-traditional providers. It's happening because sometimes people run their own budget. And it's happening because sometimes people are employing family members, and the

people who are making these decisions do not understand what home and community-based care what it means for seniors and for people with disabilities. All have to do a really bang up job of telling that story so people can understand what these services are. And part of the reason this is important, one of the things that this administration is saying, it's reason for being suspicious about these home based services, is that usage of the services is growing. That's literally what we have been trying to do the last 20 years right, that is what we want, what everybody wants is more of these home based services. Because they are where people want to be treated and, save money because we reduce institutional care. So literally, their justification itself, wildly misunderstanding what is happening, so, this narrative is going to be there under the umbrella for a lot of the different specific things that happen and we have to tell the story of who are these people that are going to be hurt by this fraud attack, and guess what a lot of American who are going to be upset when they find out, mom home attendant was being for by Medicaid and they just cut that. They don't understand that, we have to tell the story.

>>>: Everyone gets one minute.

>>>: Okay.

>>>: Tell us something we should be focusing on, and and inspire us to feel good and excited and motivated?

>>>: Well, Wendell, and said that in the last panel, simple advocacy educating the lawmakers and there are a lot of things you do not know. Kind of going back to the wiser model for a second. I think that's an example where advocating on the Hill and sharing stories what's happening to people on the ground, because of that model, though it's

led criticism has force the CMS to definitely, and delay or just cut back some of the services they intended to include into the bill procedures that were in the model in the first place. The wiser model it's been ruled, they conclude that the wiser model is a rule under the crsm C RA, that could lead to Congress limiting funding for the wiser model, all together. That's one example where I think, that's bipartisan. Both Democrat and Republicans. They have been scrutinizing that model. I think it's one of the ways that we can share stories collect stories and educate lawmakers and maybe that's not the most visionary example. But it's one to say, I think we have to continue doing this.

>>>: Sure, on the tech stuff, what I will say, there is a tendency when advocates or start interact withing they are trying to understand the role in which AI rules are playing whatever area of expertise, to sort of back off and to say, that feels like the tech stuff feels like the own straight thing that you need a coder or computer scientist to really understand. And the thing that I'll say, that is not the case. I get asked this question when I talk to students a lot, what will set me apart by the time I graduate, what's going to set me apart, I think the thing that sets apart when it comes to AI, a good advocate where AI is being incorporated is actually not understanding so much the tool itself, and but understanding very deeply the system. So, people with disabilities advocates for Medicaid and for Medicare, for all the things that's led to really big slides in the disability rights movement over time, we actually know how to address disability discrimination, we know how to expand programs and services make it we live in a better world, I am in of the ADA generation I'm very grateful to the people that fought for the law, and we already vs a community know to you to do this, and the AI, we can use the same strategy and the same organize and the same

principles. And to move forward. And then you just tap into people as you need them to know a little bit about the tool and how it works. But fundamentally we're not talking about anything different here. It looks a little bit different.

>>>: Leo.

>>>: So, just like I said, I think we can use this moment to teach the nation what home and community-based services are, we have got to work requirement that will launch on January 1, that work requirements is on stereotypes about Medicaid, who is using Medicaid and why. And the stereotype they would like to put out there, 22-year-old gamer sitting on the couch, we'll call it like it is, who is using Medicaid, it's working families who kind get a work insurance. Because low-income employers do not offer health insurance. That's data will show you if you look at it. That's what the facts are, if you will look at them. Who is a population that really really depends on this Medicaid coverage? 5-64-year-old who are dealing with the on set of chronic conditions and that are, and impacting their employment, and impacting their function. In many cases, it can continue to work they can continue to function if we get them the care they need. Right? I look at this as an opportunity to let's you want to have a conversation about fraud and H CBS I will tell you the stories about the people that are benefit and you want to have a conversation about work requirement we'll tell you who is in the Medicaid population I think this is the opportunity to really and win that part of the narrative. Which will make it much harder for them to do damage to the program when it comes.

>>>: All right I will do this. Leo mentioned HR 1 that put a moratorium of federal enforcement of rules to get into Medicaid savings program I want to expand on this for a second. Medicaid eligibility categories, and they cover your part A and B and cost sharing by making those harder to access, HR 1 makes Medicaid coverage more expensive for more people --

Stop, we should recognize too, that for far longer as Leo also alluded to, we have been disenfranchising people through red tape, and for decades. Likening rolling in these subsidies, by all estimates no more than sixty percent of the eligible people are actually enrolled, which means we literally have millions of Americans living at or near the poverty level, \$12,000 a year, they have \$2,400 of part B premiums taking off their Social Security checks, every year, and they are exposed can't afford a Medicare product, these realities are small, but these realities are big reasons why over a third of Medicare beneficiaries going without a needed service because of cost related barriers and those financial barriers and medical debt burden are prevalent among Medicare beneficiaries under the age of 65, so it's like a pervasive cost related program that program that we care about. So if we care about reducing profit and improving access to Medicare, like we do need to make sure we can get people into the program that exist for them, HR 1 stopped some of that, it does not stop that at the state level, there is action and possibility and optimism that, it is not a partisan issue, there are states from Louisiana, and Oregon, Maine, and, and with these programs, there is a lot of good reasons for including some very small ones that made it to the current challenges reducing their own administrator burden to administrators these programs, reducing their own error rates, that will subject them to future financial penalties and

Louisiana and Mississippi eliminate the asset test, and and Maine and eliminate the Medicare cliff that fall off, these are like, these are pop things even in today's environment and I hope many of you will join me in trying to shine more light and make progress, but first I hope you will join me in a round of applause for our wonderful panel.

[APPLAUSE] .

>>>: Welcome to the stage --

[APPLAUSE]

>>>: Good afternoon, I'm honored to be with all of you today I'm so pleased to be attending the second submit, and it's truly inspiring to be a part of a community of professional so deeply commit to do protecting and strengthening Medicare not just as a healthcare program, but as a promise to older adult people with disabilities and future generation who have worked and paid into the system that is meant to pay them back by providing the care they need and deserve. Up next we're sharing a community voice this is a moment to hear from someone that CMA help to win coverage for necessary care in the following video we'll hear from Kara Medicare beneficiary who had to fight and keep the care she needs and deserves and senior attorney at the center who has assisted Kara with fighting for necessary care including her recent battle to obtain for air matted teres and rolling share chair to maintain her health and independence, Kara initially contacted the center several years for help when her home health aid services had been terminated despite no change in he her condition, sending her scrambling to patch together privately pay aid services to avoid institutionalization. And, and in adequate and in consistent home care contributed to the serious health and proceed tracked hospital

stays and multiple surgeries she experienced, and everyone today that situation like Kara are unfortunately not uncommon, but Kara continues to fight for the care she deserves has allowed us to share her story as Kara just wants to make the system better for others. And I am so grateful to be a part of the center's incredible team of advocates and of this broader community of partners and allies who fight alongside people like her and dignity and access and justice remain at the heart of our healthcare system. And I am so proud to introduce this year's community voice segment who we are here of the promise we are fighting to fulfill. Thanks.

[APPLAUSE].

>>>: Hello, Kara, how are you this morning?

>>>: Good.

>>>: Thank you so much for joining us. Doing this interview with us. Please. Could you tell us a little bit about yourself.

>>>: Well, I will be 50 this year I was diagnosed with MS when I was 17 so I had MS for 38 years. I went to school and got my education. I had a bachelor's of education and I taught school for 18 years. I taught middle school and I taught math and English. I talk from a scooter and the wheelchair. And I went out on Social Security disability at that point. And because I need to describe to write things on the board and do different things for myself. At that point, I was getting worse so I went on Social Security and disability. I have two kids. I should say I have gotten quite a bit worse with my MS. And technically I am quadriplegic I can't use my arms or legs.

>>>: Kara, how long have you been enrolled in Medicare.

>>>: When I went out on disability in 2012, that's when I started Social Security disability. And the Medicare. At that point, in time, I took retirement disability which gave me the Medicare advantage plan. With Blue Cross. Could you tell us what medical issues or problems with Medicare you were having that led you to contact the center for Medicare advocacy?

>>>: Well. Medicare doesn't like to approve many items. They make the very difficult. Shower chair I needed that because I couldn't get a lift into my bathroom and put me in the shower. Chair per se, like a bench I need the rolling shower chair. And I needed to be brought out to a bed and I need to to be put in the bed. I can't sit straight up, I needed it that my legs, they would fall off, Medicare didn't see that was necessary. At that point, though, I did contact the Medicare advocacy and they helped me come up with ideas in ways to start doing the process.

>>>: Okay. The first time a prescription was put in for the shower chair I was denied and I appealed it was denied. We went through the ALJ judge it was still denied. So at that point, in time, we got a different prescription. The Medicare advocacy they come up with different coding to put down with it. And then they denied that again. They looked at it as a shower bench for a tub, that is not exactly what it was. We appealed, and at that point in time, with the help of Medicare advocacy I realized it was more of a be mobility device. That it was necessary for my care. Because I had received I want you to from surgery you have to keep them washed and clean, I need a shower.

>>>: How did it make you feel when you were being denied for something, so important to you this rolling shower chair?

>>>: Well, personal hygiene is necessary, and otherwise you will get more infections and more issues and more sick. And I feel like insurance even Medicare doesn't look at the whole point of everything, they want to deny and it wasn't contact are for Medicare advocacy and going through the process I think it would still be denied in reference to the battle they fought me on that and thought that was a wound.

>>>: Have you had experiences with Medicare appeals that you found much difficult?

>>>: One of the ones that I tried was for a lift. They kept denying it. And that of course I think they denied many things. That are necessary that should be approved.

>>>: I agree there, was it helpful to you to have someone attend your hearing with you?

>>>: Yes. It was. Because with lift it was on me, ALJ judge, when I was working -- I had Blue Cross Blue Shield, and Medicare person, another doctor, it was three against one. They pushed their buttons and I pushed mine I didn't have the necessary documentation that the Medicare advocacy group came up with for me. Through the Medicare advocacy group, they were able to help gather up all the necessary doctors letters and prescription and everything necessary and actual got the shower chair approved.

>>>: Okay.

[APPLAUSE]

>>>: Thank you.

I want to thank Melanie and way way, and particularly, Kara for sharing her story with us. And I feel like I am going to say the same thing that I said last year when we highlighted one of the stories of someone we were able to help. This should not happen. This should be rare, and if ever. It should occur, but unfortunately it is not. We are in a healthcare system, where it takes a team of advocates and attorneys to find exactly the right way to code item or medical equipment the right citation to try to convince someone who is making a decision about Medicare coverage that this is something that this person needs. It is warranted we should not be in a system that puts a barrier at the barrier to someone that needs basic services and amenities rather we should have a system that goes out of its way to accommodate people and get them what they need, we are a long way from that. Well continue to try to fight for it and I know you will continue to help us and work in your own ways to try to find that better system. We'll take another 30-minute break both here in the room and online. We'll see you again shortly, thank you.

[MUSIC] we're on break so we'll be back shortly.

Enrollees.

Community-based.

[MUSIC].

Please Standby we'll resume shortly after the break.

[MUSIC].

>>>: Here we are.

>>>: Before we start this next panel I want take a quick moment to thank some of the sponsor including Medicare rights and Jonathan here. Similar to, and how too close to the sun, and abundance of somehow I thought it would be a good idea to schedule a 30 minute panel to talk about the challenges of long-term care and how we fix them. Buckle up, hopefully this could be of some use for somebody at some point in time, I am thrilled to moderate this panel of three experts who can really speak on this topic for hours. But they are being greatly truncated in what we are asking them to do. We'll try to be succinct, I have with me Allison Barkoff, professor --

At George Washington and senior fellow and immediate past and administrator --

Administration for community living. We have gnat ti keen from justice and aging the managing director in DC we have our very own Toby Edelman, who has been --

Emphasis has been representing older people in long-term care facility since 1977 thank you for being here. And earlier today, we heard about some of the challenges facing our healthcare system and how some of the challenges have become more pronounced and now we want to spend a little bit time talking about perhaps one of the biggest most and longest running challenges in that, that is, and access to meaningful accessible and affordable long-term care coverage. And which expands access to care in the home, assisted and living and nursing facility given the limited time we'll try to stick to the broad things. At the same time, long-term care is more challenging as we heard in the panel and we'll touch on that, make sure we are on the

same page, let's start with the basics, when we say long-term care, what are we talking about? Allyson for people with disabilities?

>>>: So first of all, I am thrilled to be at a Medicare conference talking about LTSS we'll spend as much time the glass half full why it matters and why y'all might be in the middle of where we might be going on long-term. What do we mean by long-term services and supports the other side the services that help people with activity of daily difg thinking and and eating and bathing and eating bathing getting dressed as well as what we call instrumental activity of daily living managing your finances and cooking and going out in the, and community those are the things that if we are looking on the community side of helps people stay in their own home and participate, in their critical supports to people in institutional settings. Major funder, Medicare, the Medicare is pretty much been the only game in town. And maybe looking not so much yet the vast majorities of people think Medicare covers it when they find out it is very late for them, private insurance doesn't cover and most people can't private pay. We have shifted over time where most people receive long-term services and supports with the vast majority of people receiving them in the community. More than sixty percent of spending yet Medicare the game in town right now has on institutional bias is the word we use, where institutional care is mandatory and and home and community-based services are, and that's why we have a lot of people on the waiting list and from the disability perspective, and covers people with all types of disability. And across the life-span, children, and the older adults with disabilities. And as well as all types of disabilities from physical disabilities and intellectual disabilities and psychiatric disabilities. And really as a Civil-rights lawyer, this is not just seen as

access to healthcare, and this is a civil and human rights protected in disability rights laws, that's has been a big particularly the Supreme Court decision in helping expand and pushing access towards home and community-based services, and everything I talked about is as risk, how is that?

>>>: Natalie, what would you add to what Allyson said about LTSS for older adult?

>>>: So, for old adult as Allyson said, Medicare is the only game in town, a lot of people are surprised when they reach Medicare age that Medicare isn't going to cover everything they need to be able to stay-at-home. So Medicare is covering home and community-based services, things like adult day care as well as personal care at home. It's so important because these services are simply unaffordable for most older adult. Thanks to KFF we know a lot of about Medicare beneficiary and say their financial well-being, about 75% of Medicare beneficiaries are living on \$80,000 a year or less of income. And, very little disposable income much less enough to cover the cost of personal care aid or nursing facility care. Also, for older adult we know people overwhelming want to age in place, and this is true for people with disabilities of all ages, but for older adult like that is, becoming more and more something people are expecting they want, but we see a lot of gaps and disparity who gets to do that. The Medicare program spending has been changing over time. You spend more money on home based on care, but for older adult that rebalancing ratio is slower to come over to the home-based care side. I think a lot of it is that when people have say a stroke or they have Alzheimer's or dementia their caring needs increase, they don't really have a choice they can't afford to be on a waiting list. So they end up going into a nursing

home. People of Alzheimer's and dementia especially are cared for in their nursing homes. Extremely high rates compared to their peers of the same age. And we heard earlier about like the guide model as something that's maybe helping reverse that trend as well. Older women, and older adults are more likely to live alone, and don't have family caregivers family caregivers, even with Medicare, we have to recognize the role of unpaid family caregiving in our long-term care system. So if you don't have a family caregiver, that's also putting you at risk and the program is yeah, under threat, but we're here to talk about some solutions, too.

>>>: Okay. So, Toby much of the focus on long-term care has been keeping people in their homes as Natalie mentioned an important piece of that are assisted living, where does that fit into the long-term care?

>>>: Most people probably all of us want to live at home, but there is always going to be a need for some settings for people that don't want to live alone or with their family or don't have any families, for some people nursing homes can be a better alternative, they might like the championship activity and say the fact this can, food there three times a day and, that somebody will be cleaning their living space. Home care has some problems especially those that are living alone, they worry that the caregiver won't be able to get to them in a snowstorm or have a family crisis and not show up. Nursing homes can be a good place and as somebody who is looked on trying to make nursing homes better for 459 years I like to think there are some, I know there are some that do a good job, and most people want to live at home, and at least the 12 years Medicare has spent more money on ATBS than on nursing homes even nursing homes aren't and H CBS services are optional, I know what home means, but what is

community-based, nursing homes are not considered, community-based services although physically located in community. And what I what community base services in H CBS is assisted living that's a type of living really expanded after the 1898 and control in the economy, what they didn't take with any of the standards of care and certainly not the regulatory oversight system, and, and but assisted living residents look like nursing home residents, increasing they look like nurse home residents, and yesterday, and there was a public policy institute released a new paper which I am starting to read, and yesterday, and that is the percentage of people in assisted living who have Alzheimer's or dementia, is larger percentage of people with those disability is larger in the assisted living than nursing homes 44%, compared to 41%, a lot of these people look like nursing home residents there is no federal regular lace of assisted living, residents are left at the to enforce standards, and some states and assisted living I think as a private pay, and setting. But, there was some conversation that came about as a result. Imagine putting your mother in assisted living and saying what happened when my mother life saiches of hundred thousand dollars is used up, what happens, assisted living has to say you have to leave, this is private pay only, they started asking for Medicare,, money and I checked yesterday, 18% of the assisted living residents are using Medicare, only one out of five, but again no federal standards no oversight. More than 25 years at the first hearings an assisted living a senator maybe we should have some federal regulation. And we don't usually give private businesses public money and say do whatever you want, we have some strings attached, well, and that is who was obviously more serious today than it was 25 years ago. We have more residents, in assisted living, more Medicare money, the rest dentsdz of

assisting look like nurse home residents from my perspective it is long passed time too to enabout some new regulation.

>>>: In the last panel, and some of the things going on with respect to care in the home, in particularly and community-based services, so, and Allyson and nadtly, you want to elaborate on the challenges that are facing long-term care as it pertains to people in the home?

>>>: Yes. I will start on a few high level things and Natalie can add in, we came in as we were talking about many, many people who would prefer to receive services in their home and community because it's optional, all 7 100,000 people sitting on waiting list and direct workforce crisis and growing number of family caregivers 45% increase over last decade. And because of the lack of access to services. That's where we were before HR1 the reconciliation bill that was passed over the summer, as was talked about in the last panel, the 3:00 a.m. hearings where we were told you are this bill is about protecting Medicare and for the most vulnerable people there will be no cuts, we call came in with our research, every single time states have budget shortfalls the first thing to go because it is what can go is optional services. Sadly, a trillion dollars in cuts the worst even happening until 2027 is already starting to have impact in states. I am excite and had my whole team of research assistants in the back corner we were like we need to be ready to show what is happening and what is happening in realtime. We got a planning grant, we thought we had plenty of time because we weren't going to see things until next year, we have seen sixty actions in 25 states the vast majority are cut. And cuts to provider rates, and lower aware of, and higher level of care, that we are already seeing. That is the tip of the iceberg because as Leo talked about most of the funding cuts haven't started yet, number 2 we can talk more

about it and I thought Leo did a great job talking about 30-years of bipartisan support, and of we balancing towards home and community-based and promise to protect and older adult and people with disabilities as recently as July to suddenly narrative that H CBS is providing things that families should do and that is fraud. That increases that are intention successes equals fraud I would encourage you to read the letter to California that is how thin the evidence is, it is pretty sad, right now. I would just say we are in a really critical point. Where Leo point we have got to talk about what the services are. What they mean. What cuts will mean and the huge cost it will have to our system, we do not have quality nursing homes for people to go, when we start cutting services, it is having done 30-years of advocacy, and I feel like we are on the shakist ground that we have been on in a very long time.

>>>: Thank you.

>>>: I will just add, specific example, also from California, and about, how if the state were to cut it's H CBS program despite a few percentage points in terms of spending, the nursing facility would fill up there are not enough beds in nursing facilities to serve everyone. And the state spending more money and the Federal Government would be spending more money, it's very short sighted to be cutting home and community-based services but it is the the largest target it's what's available for states, I want to talk a little bit about caregivers. And other ways they are being attacked. And threatened in from HR1, in terms of the work requirement. Leo explained that applies to people under age 65 involved in the Medicare expansion, a lot of family caregivers are in that population as well. Thanks to some research that Allyson and others did, and showed, really the average person who is

not working and is subject to the work requirement is older woman who is likely caregiving for another adult in their household. Having those work requirements directly impact those caregivers but that also is going to impact the older adult and people with disabilities who need their care. So it's many different attacks coming from different angles. And also, I want to -- this optional nature of H CBS, it puts that into target. And it's been this way for 40 years, right? It's been a demonstration. We have demonstrated -- that it works. It's what people want. I think we really have to be thinking forward we'll get to that setting that up.

>>>: Toby, nursing home context, more challenging?

>>>: They are definite state and the Medicare cuts, and residents, and Medicaid is a limited benefit, and is hundred days that's the maximum you can get the average is 20, 20 days in Medicare advantage even fewer days, and so, people then become privately pay and become poor. And become eligible for Medicaid, so cuts in Medicaid are devastating and the nurse homes are going to cut back to the extent they can. And the immigration issues are really challenging for nursing home residents as well. About a quarter of the staff are immigrants. The various types of legal and non-legal standing, even people that are here with every single paper they are supposed to have are afraid to go to work the raids are started at nursing homes as well. If it's a devastating time for residents and the people that I work to, and talk to residents every day the staffing levels have never been lower. They were always way too low. It's bad.

>>>: So, now comprehensive understanding of long-term care and the challenges that we face what can we do to make it better? Where

do we go from here, Toby, I think you might have historical observation to make?

>>>: I think some pasts nurse, establish principles that I would consider universal, wherever people live, and and they retain their right to citizen if they are at home they are citizens. And they have their rights protected they should be able to participate in their healthcare decisions. Meet with whoever they want to meet with, that's a big deal in nursing homes whenever they want to meet with them, they shouldn't be given other inappropriate drugs when they don't have a psychosis. These drugs are not meant for people with dementia, caregivers they should know how to provide care, you need an oversight system to make sure people are getting what they need, when public funds are involved, and certainly the long-term care industry would be nothing without Medicare and Medicaid, there needs some systems in place assure that the fund are spent on care, and not on accessive private profit or the owners or operators with private equity and real estate investment trust and whole variety of operators. My second point I think nursing home advocates have a lot of experience working with residents talking to them, learning from them about what they want and need, we have experienced in the establishing and trying to implement standards of care trying to implement that in 1987, we are in terrible times and I don't want to be a policy Anna, but we had, and bad times before, but I want to leave on a positive note. And right after the election in 2024 I prepared a PowerPoint hosted a webinar on the prior experience with bad times. On day one of the ri began administration, January 21, 1981 the first order of business at the healthcare financing, and was repealing residents rights regulation that Carter administration had proposed and

implemented and it went downhill from there, we had a rumor that residents might, were going to be removed because the nursing home industry, doesn't have statutory authority to give the residents right and when the government had to back down on changing the standards of care they said, okay we won't do the survey the way we used to, we'll do less than annual survey we'll have self survey, Dean status for the Joint Commission which at that point used to schedule their survey, their analysis of whether the facility were in compliance with the requirement, we'll commission those survey result would never be public, we were schools alarmed but we knew we were out numbered and then we knew we had to keep going, we had to do what we need to do do to try to turn things around. And by December 1987 we had the nursing home reform act, it was extremely detailed it goes on for page and say pages people that are used to Medicare laws having a few words, this law some of the provision look like regulation because they were, they were detailed. Very detailed. And that law changed everything about nursing homes the standard of care and the residents certainly had definite rights specified it was the first federal law to talk about quality of life recognized the nursing homes are homes where people get, not where they get healthcare, we had nurse aid training the law was passed half the states did not require that nurse aids didn't have any training, be hired and start working, we had a survey process to determine whether or not the facility were meet the standard and enforce the system to take action. And so that was an extraordinary law. Rerealized we had a lot going for us that made that law possible, there were people inside the administration, and who much been sending us in plain envelopes those weak drafts of proposed regulation, we knew what was going on, it was be Robert pair

an extraordinary highly respected reporter at the New York Times who covered domestic policy, nursing homes were his issues but he reported on that issue repeatedly on the front page of the paper, we had a very thoughtful and independent report by the institute of medicine, and Dr. That described what was wrong, we had Kirk Douglas an actor who was the chair of our advocates campaign for quality care, it was a coalition organize by the resident advocates group now consumer voice to make the institute of medicine report the results, and when Kirk Douglas came to be the honorary chair the Members of Congress, they showed up, the nursing home industry participated in our campaign. And the Congress we had, and was very different from today's Congress, they were informed, it wasn't perfect, but they were informed they were respectful to each other, they worked together, all members of the Senate aging committee, Democrats and Republicans alike, signed letters to President Regan saying the regulation are terrible you have to stop this, we'll not approve it now we didn't know we had these things in the eighties we didn't know we had these positive points our challenges seem, we had a hospital administration who was saying to the nursing home industry, by point we know our challenges now, what we don't know, is what will work to get us the system and care that we believe are critical for the people we care about, we don't know who are champions will be, with you we need to press forward with the advocate on behalf of the people we care about, maybe these difficult times will lead to better future, and on our planning call Allison Barkoff had a phrase, she said maybe we'll go from the quote the politically impossible to the politically inevitable, that's what happened with the reform law, from complete accost, and everything, dis happened and we are losing everything we had to the

best law we ever had at the federal level, so I think we have to try and I believe, eventually ultimately, we will prevail and get you know what we need thank you.

[APPLAUSE]

>>>: Natalie, how do we get there?

>>>: I deeply in my soul believe which have pass the threshold of long-term services and supports being the politcally impossible to the politically inevitable and the huge movement around caregiving and defamation of Medicaid has create the momentum of people to be nebligly bold, and we have to fix Medicaid, we have to get at least, and nursing home care on another footing there were bills that Natalie and I have been part of, that are picking up in, we need to be thinking outside of Medicaid, a poverty program as our only solution and the momentum is growing. And to match people expectations. To what is in Medicare, to have some kind of home care benefit, and Natalie can talk more about it, but today we just this happens, years of work, years of work to say, healthcare reform we need big pillars and one of them has to be long-term services and supports. Today the Senate finance committee put out a dear colleague letter with said, ranking member, 17 other senators, of course, at the moment all Democratic, but putting the stake in the ground to say we are going to work with the community we'll think outside of the Medicaid, we are going to come up with a big bold ideas, so when that window opens, we can move and do, what we need to do.

>>>: Yeah. I will add, we know we're seeing, we can't go back to the status quo that's not the goal, we are not trying to reappeal HR1, we are trying to reimagine and rebuild, really excited that Medicare is

coming into this conversation in many ways, thinking about strengthening and enforcing the existing home healthcare benefits but adding home-based care for people on Medicare to -- our goal North Star is get to coverage, everyone that needs long-term services and supports can get that when and where they need it.

>>>: Well that is a perfect place to stop. Thank the panel for this -- great conversation. In-depth on long-term care. Thank you for agreeing to participate about the impossible task, and thank you. Now the litigation director, Josh Norris.

[APPLAUSE]

>>>: Good afternoon, how is everybody do -- thank you for being here, this is my first, Josh Norris I'm the litigation director here at the center. And, and talk to you a little bit about the role of litigation legal advocacy and in the context of human services systems like Medicare. So, first, this is kind of going back to basics a little here. I want everyone to consider for a moment, what keeps them safe and well? Beyond simply the activity and habit that you have adopted and so beside eating well and we've eaten well today getting enough sleep and staying active, what are the things in your life that keep you safe and well? It's not a hard question I don't believe to answer. But I don't think we can consider that question enough. Particularly invoking for and with vulnerable people. Eventually for most of you their safety and well-being derive from the people in your lives, family and friends, and maybes and co-workers, these are people you are engaged with in some form of reciprocal relationships of care and common interests. And they are there when the times are good, and more importantly when times are bad. And they are there when they provide

connection, support, assistance, and hopefully some laughter and joy, too. They challenge you inspire you and actually provide really important safeguards around your thinking and the decision you make in your life. These three relationships provide context meaning and purpose in our lives through our family life and our community life and our work life. Also to venture to guess for movie having a home is a big part of your safety and well-being, it gives you a sense of place in the world. It's yours, and it will be there when you get home tonight when you get back from this trip to DC. This is where you maintain yourself and your family and you know where you will lay your head down, and your family will be at the end of the day. And when we ask where you are from, you have a already answer for them with lots of context and lots of details. And of that home. Finally it is a safe place where you can retreat find solitude and care for yourself. I want to pause it that what each of us has, and I presume everybody has these things, a home, and meaningful relationships, and making meaningful contribution to the family and your community, these are the things that every human being needs to live a life of meaning and of value and dignity. In our advocacy for vulnerable people whether they are older adult or people with disabilities, I don't think we talked about these fundamental issues enough. And I think they can provide an in valuable tool to frame and guide our advocacy. As we saw in the video about Kara, it all comes down to the importance of taking a shower. And a shower that gets her clean for her health and well-being for her sense of dignity as a human being. So she can feels presentable to her friends and family, but Medicare system which is supposed to be focused on maintaining her well-being and preventing the decline of her condition, wasn't focused on either of those things. It was concerned with the

bureaucratic processes. And astoundingly, it's saw the taking of a shower as convenience for her. And not a necessity. To her health and her dignity. But, creative committed advocacy, now she can take a shower in her home home, I have been mitigating against human systems for most of my legal career, so 30-years now, that experience has taught me these systems often become incoherent, what I mean by that, they gradually than others, and lose sight of the needs of the people they report to server and begin to serve their own bureaucratic needs for efficiency and simplicity, and cost reduction, and outcome that are not tied in anyway shape or form to the people they are supposed to be serving. This is the people serve, they are the means, and the outcome the end become whatever the system values. So our job as advocates, is to keep our own advocacy and these -- Humes human services systems like Medicare, and focused on the basic human needs of the people we and they serve. Your these services important to this person, beyond simply treating their condition? How do they support the person to maintain their dignity? How are they part of the equation of the person maintaining meaningful relationships in their life? How do they support a person to live at home?

This is why services like durable medical equipment for example or home health services are so important. And they can each provide vital care, and that allows a person to live at home and live a life of dignity as Kara case shows. And over the last 40 years we have provided legal advocate for old adult and say people with disabilities. And our primary mission remains, how to make this big unwieldy Medicare system accountable to the most vulnerable people it purports to serve? Mitigation is one of the advocacy tools we use when the policy is broken down. And the system is not the responding coherently to

people's needs. And that's why we fought for Miss Jena who were denied skilled care because they were no longer expected to do improve. And this threatened her ability to live at home and maintain her health and well-being, through litigation efforts the CMA we were able to enter into a settlement to directly address the practices and implement policy that are focused on maintaining a person's condition. And preventing their decline, and creating real opportunities for people to maintain their lives at home with family and friends. But today our battle lines are shifting a bit, as Medicare increasingly becomes private pay, and the threat of a system and I believe grows exponentially, and corporate algorithm and profit margins dictate the human being that's at the inner of the system quickly disappears the system desire for efficient and cost reduction, and goes into automated denials and, and CMA and the capacity of our friends and AI in the know how to bring system change litigation is more crucial now than ever. And our clients stories and their basic human needs must continue to guide our legal advocacy, and towards remedies that are both relevant and potent, and must continue to prevent the human story in the face of a dehumanizing system we don't we are fighting for care to feel clean and to serve her dignity and independence, and we are not litigating for home health services we are protecting the person's right to lay their head down in their own bed in their home tonight, so important. As I step into the role of litigation director I promise there are legal strategies will be guided by the client's human basic human needs, we will keep pursuing remedies that are relevant and potent never stop trying to remember, what keeps the client safe and well, and it keeps all of us safe and well a place to call home, a community to belong to and preservation and basic human dignity, thank you.

[APPLAUSE].

Thank you, before I turn it over to Scott I want to take a brief moment to for our sponsor for thinking, American medical rehabilitation providers, association, and society of America, and the national community to preserve Social Security and Medicare, and the consortium for medical oral health coverage, thank you now I will turn it over to Scott Perkins.

[APPLAUSE].

>>>: Thank you. Thank you, Josh.

So, for anybody who doesn't know, every year the center for Medicare and advocacy staff, update the Medicare handbook. Which is published through Walters and we have some door prizes for folks, including eligible folks for door prize of a handbook or the over 130000 people that are watching us online from all across the country. So first, we have Tom Lieberman.

[APPLAUSE] we have 1300 people.

Right that on your bed stand. So you can read before you sleep every night.

The next one is Randi from Colorado, you will be getting a Medicare handbook in the mail. Then, last is AB di., they'll be getting a handbook in the mail. I want to take a moment and acknowledge the role of generosity in advocacy. As I was thinking about that earlier I remember that I came across a Buddhist phrase when I was reading a while back that goes, generosity was the virtue that produces peace. And, the generosity of individuals and foundations, colleagues other

organizations all of our sponsors, that generosity allows advocacy organization to move society towards peace. I think we all know that the lack of peace that we have in our minds, when things are difficult for us, when we are encountering obstacles and the peace that can come when those things are resolved. Kara she fought for a day or week or month, about about a rolling shower chair, peace that arises by absence of discord. Advocacy generosity allows advocacy to do this through systemic change. By creating a more just society and increasing health and well-being for human beings. Health and well-being, from advocacy, systemic change, and advocacy, can provide individuals with moment of peace just as we are noting by meeting their basic needs. That Josh was talking about. Those needs aren't met there is discord and lack of peace. So we like to thank all of our sponsor all of funders and all the individuals that support us and in fact, all of those individuals foundations and organizations that support all advocacy organizations in the work they are doing in creating peace for others. Now I would like to specifically thank the Santa Fe group the sponsors of the chip land social and advocacy award. And to tell us a little bit about that award, about Alfred Chiplin, who it was named, I would like to invite CMA founder the Judy stein, to say a few words about her award.

[APPLAUSE]

>>>: Thank you. Josh, to David Scott, Melanie Pollyanna Toby, I have to say proud and relieved and grateful for this center for Medicare advocacy clearly successfully moving forward happily together in our community. The extraordinary work that David and Scott are doing in leading the organization and in our incredible colleagues, many of whom are here and I put this, have put this together and put the

community of, online, able to be with us today. I'm so moved and proud and thank you, Scott and David, everyone and having a litigation director that gets TEARY eyed talking about our work is the icing on the cake. So speaking of remarkable people, Alfred Chiplin, I'm happy to bring his spirited to you, He was a be loved and admired leader in the elder law and civil rights community, and he was also the long time managing attorney of the center for Medicare advocacy Washington, D.C. office. He was a manager there for many years, followed by David, who managed and actual office.

To honor Alfred Chiplin advocacy and commitment to civility and justice for all the center for Medicare advocacy established an award in his honor when he died. Went too soon in 2017. I have loss a lot of people in my life, he was right up in being with me, every day. To honor Alfred Chiplin advocacy and his award, to advance civility and society and social justice for all, as he did, including during his 40 year career as an attorney. And he worked tirelessly for systemic change. And for, and countless individuals. As key architect of the centers ongoing commitment to Medicare advocacy access for people with chronic and debilitating and long-term his influence in is felt in everything that we do, chip brought hiss humanity to the work that he loved to our community at the center for Medicare advocacy. As order deigned minister, coral sing are and poet he grace you had in the world with his life and smile. And he treated everyone he encountered with respect and kindness. And even when he hadn't received that to begin with. Chip lived the full life too short a time. He lit every room he entered he continued to encourage us to bring more light to all our fellow humans and to work to enhance all their lives. In his honor

today we'll be honoring Dr. Natalia Chalmers my friend and colleague to come and tell us a little bit about that. Thank you.

[APPLAUSE]

>>>: Thank you. Thank you, Judy. So, it means so much to me, to be able to honor and tell you about a cherished individual who I many, respect and admire deeply. And as you know, this is Dr. Natalia Chalmers, and she's a dentist a scientist, and researcher and change leader. I once heard her say, her original mission when she started career, and she want to permanently the universal sciewrnlg of cavity. And so thank you, that gives you a sense of her natural to tackle big challenges it's certainly tracks with the person that I come to know. Now while Dr. Chalmers may not have wiped out the problem of cavities yet she strives passionately and tirelessly to educate about the importance of oral health to overall systemic health. To find pathways for achieving equitable access to dental care, because let's face it, dental care should note be a luxury. Natalia earned her dental degree in Bulgaria at the Medical University of Sophia where a dental students are exposed to the full medical curriculum, that's because dentistry is not segregated from medicine there, the way it is here in the United States. She went on to earn a PhD in oral microbiology at the University of Maryland completing a fellow, her residency in pediatric dentistry, she did a clinical fellowship there she guide the development and secured funding for novel research and cared for medical compromised children enrolled in NIH clinical trials. Now to gain more understanding about how big data can be used to improve delivery systems for patients, she pursued a master degree in regulatory health science at Duke University School of Medicine. She applied this learning by lending her data and analytic expertise to campaign led by

the Maryland dental action coalition to get a comprehensive adult dental benefit into that state Medicare program. So, since 1976, Maryland had been one of the those states that only covered emergency dental care for low-income adult. And Dr. Chalmers worked closely with the coalition to assess it's data needs and develop policy recommendations. The data she harness and had realized that the state was spending \$26 million a year, for ineffective emergency room visits that could have been avoided accessible preventive dental care. I say ineffective because emergency rooms do not generally provide dental care, they send patients with antibiotic and painkillers. So, the data also revealed that 15 people had died from complication of poor oral health that the counties with the highest rates of emergency department visits for dental conditions were the same counties with the same rates of overdosed death and Dr. Chawl testified before the state how's house and Senate regarding, this ground breaking study. She also guide the network of stakeholders had a leverage the cost saves data to the relationships and delegates and, due to the efforts of this large and diverse advocacy community, Maryland state legislative unanimously passed a bill that mandated comprehensive dental benefits in Medicare. And then dental care became accessible 8 100,000 adult, and Dr. Chalmers, served at the U.S. Food and Drug Administration in 2020 she was detailed for the Medicaid and Medicare services where she stayed on as chief dental officer and, when she arrived at CMS there had not been a single dentist, chief dental officer employed there since esteemed dentist, Dr. Lynn retired from the post in 2017. And, and so, oral health was largely absent from the conversation and culture, at CMS at that time. And it didn't factor into policy considerations. But Dr. Chalmers said about presenting to her

colleagues factual evidence on how oral and dental infections can complicate the management of chronic and major health conditions like diabetes and kidney disease and cancers. She highlighted compelling research and data showing that appropriate dental care can discover kin call outcome and reduce cost. And the first time I met Dr. Chalmers, I was immediately taken by her warm and energetic and down to earth personality. And, and her clear commitment to advancing health and eliminating disparity. And at that meeting she described how CMS was engaged with a wide range of stakeholder including clinician and researchers and patient advocates and insurance leaders, to understand the landscape of medley necessary dental care to chart a thoughtful path forward. Now what stayed with me from that conversation was her instinct to bring all perspectives to the table. And her conviction that, good policy is grounded in good data. While, fast forward to year later in 2021 when the door enclosed to include a full Medicare dental benefit inflation reduction act a window of opportunity opened for advocates to press for medley necessary dental coverage, at this point CMS leadership invited us to host a series of listening sessions for them to hear from and engage with stakeholder about what constitute s medley necessary dental care. And shortly after that, in 2022 the agency propose and a rule clarifying that Medicare payment is available to dental services that are important to certain medical services that applies also to people enrolled in Medicare advantage. CMS specified that Medicare would pay for services to diagnosis and treat dental and oral infections and patients who need solid STEMM and marrow, and the, and the agency recognized payment for dental care needed by patients under going certain cancer treatments and people receiving dialysis for end stage

kidney disease, and these were and landmark achievement that would not have happened without Dr. Cham leadership. Advocates were celebrating these victories, but Dr. Chalmers knew they were the first step that the architecture and competency, to implement and, that would have to be created so that beneficiaries could benefit from it. As a dentist she knew that most dental providers have no experience with using medical diagnosis codes and submitting medical claim forms or just billing Medicare. So this was a problem because she knew that the process had to work for dentist if it was going to work for patient and say among the solution was to develop the Medicare claim form that was important to dentist, and launching this form, this new form, was a formidable task that involved pushing through agency hierarchy and defending funding and staffing requests, assembling a dedicated team building trust and more, but thanks in great part to Dr. Chalmers visions and determination, and dentist can now successfully get reimbursed for having this care to Medicare patients. So, it really pain me to tell you that there are currently forces that play which may threaten to rollback this progress and the investment that have been made in Medicare dental coverage. If that should happen, well absolutely fight to defend that coverage. That could be a story for another day. Hopefully it won't have to be. But today is a fitting day to recognize Dr. Chalmers and the impactful contribution she's made to improve Medicare and Medicaid for current and future generations. Natalia, where are you?

[APPLAUSE].

>>>: Natalia? Yeah. Thank you. For your wise compassionate and strategic leadership. I know it's been your guiding truth that dental care is essential healthcare. And it's been your aim to ensure access to oral healthcare for those that need it the most. And I just know chips

heart would be filled with joy, to know you were receiving this award in his name. Thank you.

[APPLAUSE].

>>>: Thank you. Thank you. I think this space has some tearing guests. A few months ago, I was sitting on the top of a mountain I had no business standing on, I had never skied, in my life, the conditions perfect, brilliant blue sky, there was only one way down. And learn how to ski. At that moment, with the wind unmy face and the valley below, my phone rang. It was someone to tell me about this award. I have been thinking about that moment. Because, so much of this work has felt exactly like that. You find yourself judge you did not entirely plan to be. And there is one way forward, the sky is clear, and there is always good people by your side. That honestly is how the rest of it went. And I am a pediatric dentist I'm a students. But when I side of the at CMS, I had never read, written or edited a federal rule. That happened. I had never set a across the table full of engineers building a claim system. I can tell you that is the long story for another day. Or, our lawyers who are drafting the regulatory language around any of these changes what we needed to do. And or the policy expert we had to work together and, get down implementation challenges that were talked about. But I knew who I was working for. That I knew, the American people. So we did, we learned way you learn how to ski, from the top of the mountain. And there is only one way forward. I want to honor chip, I didn't know him in person, from what I heard, sounds like an amazing person and inspiration to have known. I was so moved to read his poetry it's your program but I feel the finger principal of has stayed with us, the handbook is one great example that started in your program poem when you consider the sky, and reach with all

you have, and give your very best and taste your dreams. I can't think of those lines without going back to that mountain. And that morning on the mountain, we don't always choose when sky is open up. But we do choose what we do when that happens. Chip if he chose every day to show his finest to bring the best, so to receive this honor in his name is humbling. Thank you. I have received many recognition in my career. And but this one feels different, and because it's name after an I want to thank the center for Medicare advocacy in Washington, we're here we are now, it's easy to confuse motion with progress. Motion. Not a lot of progress. But this center, and I think, is doing something rare. Because you are able to do this unglamorous decades long work, this has been in the work to move and work for the advocates for the beneficiaries. To ensuring what is on paper is delivered to the patients of and that requires a lot of discipline. And dedication and commitment. None of this work, none of my work, other work, is possible the work we are honoring tonight without a team of people. Who show up every day and service to someone else. And we're fortunate when we land with people. If I may, I would like to give the credit where it belongs. The recognition belongs to much larger community of advocates first the patients who told us their stories as clinician the advocates you see here the Santa Fe group has done a lot of work and the center for Medicare advocacy and others, and the clinician that take care of the patient and say tell me the stories of how their patients suffered terrible consequences for oral health when they had to start treatment for a cleaning they couldn't a nurse, after we published the chemotherapy treatment, came to me and said, if this would have happened five years ago, -- so the credit belongs to the clinician the researchers who gathered the evidence and the my

colleagues for center for Medicare and Medicaid services, who work alongside me to make sure that oral health had a a real part in the conversation around overall health chronic disease and management. We still have a long way to go, but moment like this remind us how far we have come together. I learned advocacy from about maintaining vigilance for those who can't be present in the rooms for the Medicare beneficiaries navigating a transplant evaluation or dialysis patient who is dental infection went untreated or the family that is trying to make sense of their denial letter. This work is for that, I carry with me in every meeting when I look at every data and I look at a lot of data, every policy memo, and they are who I will keep showing up for. I think we all show up for. I was given early in my life, way of seeing this work and that's never left me. That, the highest thing any of us can do, and is to be of service to others. And that work done in that spirit can be worship. I wonder I suspect, and chip had that, knowing what he did. That conviction is important, it can reorient us when the politics get small. And I also want to acknowledge what's so many of you already know the games we make, have just begun. Dentist are trying to figure out how to bill for this, patients are still learning there is such coverage, this architecture is young, and young things are fragile. So, I accept this award, and not as a closing chapter but as a charge. And the work of integrating oral health into the rest of healthcare in policy and practice, and the mouth is part of the body, it's not finished. I would say, it's just begun, and I am committed to that work today, and whatever role I'm asked to play, as long as it takes. And I will end with to my family, who have carried more than their share, to my colleagues, at NIH, FDA and now here, who trussed me with hard problems. To everyone in this room and there are a lot of friends and colleagues who taught me that

advocacy actually looks like, thank you consider the sky and how we show up every day, that morning on the mountain I made it down, wasn't very grateful but made that down, people who knew what they were doing, skied beside me, and waited where the slope got really steep. And the work ahead I would say is longer descent on the harder terrain, and but the principle hold forward only, and clear skies and the people on your side. So the sky is still open and let's not waste it, thank you so much, what an honor.

[APPLAUSE].

>>>: Thank you. Dr. Chalmers it's an honor to present you with the Alfred Chiplin award. For everyone it reads, presented to Dr. Natalia Chalmers in recognition of her dedication and advocacy to achieve greater equity in oral healthcare access and quality and outcomes.

>>>: Thank you so much.

[APPLAUSE].

>>>: Can I take a picture?

>>>: Yes you may.

>>>: Thank you so much.

>>>: Thank you.

[APPLAUSE].

>>>: With that I would like to thank everybody here, I would like to thank the presenter our awardees, our attendees in this room. Our 1300 attendees from around the country watching from their homes or as you and the hundreds that will be watching on YouTube as well as

the folks in this room and the sponsor, thank you and we look forward to seeing you next year.

[APPLAUSE].