The Dignity Digest

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The Dignity Digest is information compiled by Dignity Alliance Massachusetts concerning long-term services, support, living options, and care issued each Monday.

	***May require registration before accessing article.**
DignityMA Zoom Sessions	Dignity Alliance Massachusetts participants meet via Zoom every other Tuesday at 2:00 p.m. Sessions are open to all. To receive session notices with agenda and Zoom links, please send a request via info@DignityAllianceMA.org.
Spotlight	***For-profit nursing homes are cutting corners on safety and draining resources with financial shenanigans – especially at midsize chains that dodge public scrutiny*** By Charlene Harrington, RN, PhD, University of San Francisco, and investigative journalist Sean Campbell, **The Conversation** March 14, 2024 The care at Landmark of Louisville Rehabilitation and Nursing was abysmal when state inspectors filed their survey report of the Kentucky facility on July 3, 2021. Residents wandered the halls in a facility that can house up to 250 people, yelling at each other and stealing blankets. One resident beat a roommate with a stick, causing bruising and skin tears. Another was found in bed with a broken finger and a bloody forehead gash. That person was allowed to roam and enter the beds of other residents. In another case, there was sexual touching in the dayroom between residents, according to the report. Meals were served from filthy meal carts on plastic foam trays, and residents struggled to cut their food with dull plastic cutlery. Broken tiles lined showers, and a mysterious black gunk marred the floors. The director of housekeeping reported that the dining room was unsanitary. Overall, there was a critical lack of training, staff and supervision. The inspectors tagged Landmark as deficient in 29 areas, including six that put residents in immediate jeopardy of serious harm and three where actual harm was found. The issues were so severe that the government slapped Landmark with a fine of over US$319,000 – more than 29 times the average for a nursing home in 2021 – and suspended payments to the home from federal Medicaid and Medicare funds. **Persistent problems** But problems persisted. Five months later, inspectors levied six additional deficiencies of immediate jeopardy – the highest level –

including more sexual abuse among residents and a certified nursing assistant pushing someone down, bruising the person's back and hip. Landmark is just one of the 58 facilities run by parent company Infinity Healthcare Management across five states. The government issued penalties to the company almost 4½ times the national average, according to bimonthly data that the Centers for Medicare & Medicaid Services first started to make available in late 2022. All told, Infinity paid nearly $10 million in fines since 2021, the highest among nursing home chains with fewer than 100 facilities.

Infinity Healthcare Management and its executives did not respond to multiple requests for comment.

Such sanctions are nothing new for Infinity or other for-profit nursing home chains that have dominated an industry long known for cutting corners in pursuit of profits for private owners. But this race to the bottom to extract profits is accelerating despite demands by government officials, health care experts and advocacy groups to protect the nation's most vulnerable citizens.

To uncover the reasons why, The Conversation's investigative unit *Inquiry* delved into the nursing home industry, where for-profit facilities make up more than 72% of the nation's nearly 14,900 facilities. The probe, which paired an academic expert with an investigative reporter, used the most recent government data on ownership, facility information and penalties, combined with CMS data on affiliated entities for nursing homes.

The investigation revealed an industry that places a premium on cost cutting and big profits, with low staffing and poor quality, often to the detriment of patient well-being. Operating under weak and poorly enforced regulations with financially insignificant penalties, the for-profit sector fosters an environment where corners are frequently cut, compromising the quality of care and endangering patient health. Meanwhile, owners make the facilities look less profitable by siphoning money from the homes through byzantine networks of interconnected corporations. Federal regulators have neglected the problem as each year likely billions of dollars are funneled out of nursing homes through related parties and into owners' pockets.

More trouble at midsize

Analyzing newly released government data, our investigation found that these problems are most pronounced in nursing homes like Infinity − midsize chains that operate between 11 and 100 facilities. This subsection of the industry has higher average fines per home, lower overall quality ratings, and are more likely to be tagged with resident abuse compared with both the larger and smaller networks. Indeed, while such chains account for about 39% of all facilities, they operate 11 of the 15 most-fined facilities.

With few impediments, private investors who own the midsize chains have quietly swooped in to purchase underperforming homes, expanding their holdings even further as larger chains divest and close facilities. As a result of the industry's churn of facility ownership, over one fifth of the country's nursing facilities changed ownership between 2016 and 2021, four times more changes than hospitals.

A 2023 report by Good Jobs First, a nonprofit watchdog, noted that a dozen of these chains in the midsize range have doubled or tripled in size while racking up fines averaging over $100,000 per facility since 2018. But unlike the large, multistate chains with easily recognizable names, the midsize networks slip through without the same level of public scrutiny, The Conversation's investigations unit found.

"They are really bad, but the names – we don't know these names," said Toby Edelman, senior policy attorney with the Center for Medicare Advocacy, a nonprofit law organization.

"When we used to have those multistate chains, the facilities all had the same name, so you know what the quality is you're getting," she said. "It's not that good – but at least you know what you're getting."

In response to The Conversation's findings on nursing homes and request for an interview, a CMS spokesperson emailed a statement that said the CMS is "unwavering in its commitment to improve safety and quality of care for the more than 1.2 million residents receiving care in Medicare- and Medicaid-certified nursing homes."

The statement pointed to data released by the oversight body on mergers, acquisitions, consolidations and changes of ownership in April 2023 along with additional ownership data released the following September. CMS also proposed a rule change that aims to increase transparency in nursing home ownership by collecting more information on facility owners and their affiliations.

"Our focus is on advancing implementable solutions that promote safe, high-quality care for residents and consider the challenging circumstances some long-term care facilities face," the statement reads. "We believe the proposed requirements are achievable and necessary."

CMS is slated to implement the disclosure rules in the fall and release the new data to the public later this year.

"We support transparency and accountability," the American Health Care Association/National Center for Assisted Living, a trade organization representing the nursing home industry, wrote in response to The Conversation's request for comment. "But neither ownership nor line items on a budget sheet prove whether a nursing home is committed to its residents. Over the decades, we've found that strong organizations tend to have supportive and trusted leadership as well as a staff culture that empowers frontline

caregivers to think critically and solve problems. These characteristics are not unique to a specific type or size of provider."

It often takes years to improve a poor nursing home – or run one into the ground. The analysis of midsize chains shows that most owners have been associated with their current facilities for less than eight years, making it difficult to separate operators who have taken long-term investments in resident care from those who are looking to quickly extract money and resources before closing them down or moving on. These chains control roughly 41% of nursing home beds in the U.S., according to CMS's provider data, making the lack of transparency especially ripe for abuse.

A churn of nursing home purchases even during the COVID-19 pandemic shows that investors view the sector as highly profitable, especially when staffing costs are kept low and fines for poor care can easily be covered by the money extracted from residents, their families and taxpayers.

"This is the model of their care: They come in, they understaff and they make their money," said Sam Brooks, director of public policy at the Consumer Voice, a national resident advocacy organization. "Then they multiply it over a series of different facilities."

Investor race

The explosion of a billion-dollar private marketplace found its beginnings in government spending.

The adoption of Medicare and Medicaid in 1965 set loose a race among investors to load up on nursing homes, with a surge in for-profit homes gaining momentum because of a reliable stream of government payouts. By 1972, a mere seven years after the inception of the programs, a whopping 106 companies had rushed to Wall Street to sell shares in nursing home companies. And little wonder: They pulled in profits through their ownership of 18% of the industry's beds, securing about a third of the hefty $3.2 billion of government cash.

The 1990s saw substantial expansion in for-profit nursing home chains, marked by a wave of acquisitions and mergers. At the same time, increasing difficulties emerged in the model for publicly traded chains. Shareholders increasingly demanded rapid growth, and researchers have found that the publicly traded chains tried to appease that hunger by reducing nursing staff and cutting corners on other measures meant to improve quality and safety.

"I began to suspect a possibly inherent contradiction between publicly traded and other large investor-operated nursing home companies and the prerequisites for quality care," Paul R. Willging, former chief lobbyist for the industry, wrote in a 2007 letter to the editor of The New York Times. "For many investors … earnings growth, quarter after quarter, is often paramount. Long-term investments in quality

can work at cross purposes with a mandate for an unending progression of favorable earnings reports."

One example of that clash can be found at the Ensign Group, founded in 1999 as a private chain of five facilities. Using a strategy of acquiring struggling nursing homes, the company went public in 2007 with more than 60 facilities. What followed was a year-after-year acquisition binge and a track record of growing profits almost every year. Yet the company kept staffing levels below the national average and levels recommended by experts. Its facilities had higher than average inspection deficiencies and higher COVID infection rates. Since 2021, it has racked up more than $6.5 million in penalties. Ensign did not respond to requests for comment.

Even with that kind of expense cutting, not all publicly traded nursing homes survived as the costs of providing poor care added up. Residents sued over mistreatment. Legal fees and settlements ate into profits, shareholders grumbled, and executives searched for a way out of this Catch-22.

Recognizing the long-term potential for profit growth, private investors snapped up publicly traded for-profit chains, reducing the previous levels of public transparency and oversight. Between 2000 and 2017, 1,674 nursing homes were acquired by private-equity firms in 128 unique deals out of 18,485 facilities. But the same poor-quality problems persisted. Research shows that after snagging a big chain, private investors tended to follow the same playbook: They rebrand the company, increase corporate control and dump unprofitable homes to other investment groups willing to take shortcuts for profit. Multiple academic studies show the results, highlighting the lower staffing and quality in for-profit homes compared with nonprofits and government-run facilities. Elderly residents staying long term in nursing homes owned by private investment groups experienced a significant uptick in trips to the emergency department and hospitalizations between 2013 and 2017, translating into higher costs for Medicare.

Overall, private-equity investors wreak havoc on nursing homes, slashing registered nurse hours per resident day by 12%, outpacing other for-profit facilities. The aftermath is grim, with a daunting 14% surge in the deficiency score index, a standardized metric for determining issues with facilities, according to a U.S. Department of Health and Human Services report.

The human toll comes in death and suffering. A study updated in 2023 by the National Bureau of Economic Research calculated that 22,500 additional deaths over a 12-year span were attributable to private-equity ownership, equating to about 172,400 lost life years. The calculations also showed that private-equity ownership was

responsible for a 6.2% reduction in mobility, an 8.5% increase in ulcer development and a 10.5% uptick in pain intensity.

Hiding in complexity

Exposing the identities of who should be held responsible for such anguish poses a formidable task. Private investors in nursing home chains often employ a convoluted system of limited liability corporations, related companies and family relationships to obscure who controls the nursing homes.

These adjustments are crafted to minimize liability, capitalize on favorable tax policies, diminish regulatory scrutiny and disguise nursing home profitability. In this investigation, entities at every level of involvement with a nursing home denied ownership, even though the same people controlled each organization.

A rule put in place in 2023 by the Centers for Medicare & Medicaid Services requires the identification of all private-equity and real estate investment trust investors in a facility and the release of all related party names. But this hasn't been enough to surface the players and relationships. More than half of ownership data provided to CMS is incomplete across all facilities, according to a March 2024 analysis of the newly released data.

Even the land under the nursing home is often owned by someone else. In 2021, publicly traded or private real estate investment trusts held a sizable chunk of the approximately $120 billion of nursing home real estate. As with homes owned by private-equity investors, quality measures collapse after REITs get involved, with facilities witnessing a 7% decline in registered nurses' hours per resident day and an alarming 14% ascent in the deficiency score index. It's a blatant pattern of disruption, leaving facilities and care standards in a dire state.

Part of that quality collapse comes from the way these investment entities make their money. REITs and their owners can drain cash out of the nursing homes in a number of different ways. The standard tactic for grabbing the money is known as a triple-net lease, where the REIT buys the property then leases it back to the nursing home, often at exorbitant rates. Although the nursing home then lacks possession of the property, it still gets slammed with costs typically shouldered by an owner − real estate taxes, insurance, maintenance and more. Topping it off, the facilities then must typically pay annual rent hikes.

A second tactic that REITs use involves a contracting façade that serves no purpose other than enriching the owners of the trusts. Since triple-net lease agreements prohibit REITs from taking profits from operating the facilities, the investors create a subsidiary to get past that hurdle. The subsidiary then contracts with a nursing home operator − often owned or controlled by another related party − and

then demands a fee for providing operational guidance. The use of REITs for near-risk-free profits from nursing homes has proven to be an ever-growing technique, and the midsize chains, which our investigation found generally provided the worst care, grew in their reliance on REITs during the pandemic.

"When these REITs start coming in … nursing homes are saddled with these enormous rents, and then they wind up going out of business," said Richard Mollot, executive director of the Long-Term Care Community Coalition, a nonprofit organization that advocates for better care at nursing homes. "It's no longer a viable facility."

The churn of nursing home purchases by midsize chains underscores investors' perception of the sector's profitability, particularly when staffing expenses are minimized and penalties for subpar care can be offset by money extracted through related transactions and payments from residents, their families and taxpayers. Lawsuits can drag out over years, and in the worst case, if a facility is forced to close, its land and other assets can be sold to minimize the financial loss.

Take Brius Healthcare, a name that resonates with a disturbing cadence in the world of nursing home ownership. A search of the federal database for nursing home ownership and penalties shows that Brius was responsible for 32 facilities as of the start of 2024, but the true number is closer to 80, according to BriusWatch.org, which tracks violations. At the helm of this still midsize network stands Shlomo Rechnitz, who became a billionaire in part by siphoning from government payments to his facilities scattered across California, according to a federal and state lawsuit.

In lawsuits and regulators' criticisms, Rechnitz's homes have been associated with tales of abuse, as well as several lawsuits alleging terrible care. The track record was so bad that, in the summer of 2014, then-California Attorney General Kamala Harris filed an emergency motion to block Rechnitz from acquiring 19 facilities, writing that he was "a serial violator of rules within the skilled nursing industry" and was "not qualified to assume such an important role."

Yet, Rechnitz's empire in California surged forward, scooping up more facilities that drained hundreds of millions of federal and state funds as they racked up pain and profit. The narrative played out at Windsor Redding Care Center in Redding, California. Rechnitz bought it from a competing nursing home chain and attempted to obtain a license to operate the facility. But in 2016, the California Department of Public Health refused the application, citing a staggering 265 federal regulatory violations across his other nursing homes over just three years.

According to court filings, Rechnitz formed a joint venture with other investors who in turn held the license. Rechnitz, through the Brius

joint venture, became the unlicensed owner and operator of Windsor Redding.

Brius carved away at expenses, slashing staff and other care necessities, according to a 2022 California lawsuit. One resident was left to sit in her urine and feces for hours at a time. Overwhelmed staff often did not respond to her call light, so once she instead climbed out of bed unassisted, fell and fractured her hip. Other negligence led to pressure ulcers, and when she was finally transferred to a hospital, she was suffering from sepsis. She was not alone in her suffering. Numerous other residents experienced an unrelenting litany of injuries and illnesses, including pressure ulcers, urinary tract infections from poor hygiene, falls, and skin damage from excess moisture, according to the lawsuit.

In 2023, California moved forward with licensing two dozen of Rechnitz's facilities with an agreement that included a two-year monitoring period, right before statewide reforms were set to take effect. The reforms don't prevent existing owners like Rechnitz from continuing to run a nursing home without a license, but they do prevent new operators from doing so.

"We're seeing more of that, I think, where you have a proliferation of really bad operators that keep being provided homes," said Brooks, the director of public policy at the Consumer Voice. "There's just so much money to be made here for unscrupulous people, and it just happens all the time."

Rechnitz did not respond to multiple requests for comment. Bruis also did not respond.

Perhaps no other chain showcases the havoc that can be caused by one individual's acquisition of multiple nursing homes than Skyline Health Care. The company's owner, Joseph Schwartz, parlayed the sale of his insurance business into ownership of 90 facilities between mid-2016 and December 2017, according to a federal indictment. He ran the company out of an office above a New Jersey pizzeria and at its peak managed facilities in 11 states.

Schwartz went all-in on cost cutting, and by early 2018, residents were suffering from the shortage of staff. The company wasn't paying its bills or its workers. More than a dozen lawsuits piled up. Last year, Schwartz was arrested and faced charges in federal district court in New Jersey for his role in a $38 million payroll tax scheme. In 2024, Schwartz pleaded guilty to his role in the fraud scheme. He is awaiting sentencing, where he faces a year in prison along with paying at least $5 million in restitution.

Skyline collapsed and disrupted thousands of lives. Some states took over facilities; others closed, forcing residents to relocate and throwing families into chaos. The case also highlights the ease with which some bad operators can snap up nursing homes with little

difficulty, with federal and state governments allowing ownership changes with little or no review.

Schwartz's lawyer did not respond to requests for comment.

Not that nursing homes have much to fear in the public perception of their reputation for quality. CMS uses what is known as the Five-Star Quality Rating System, designed to help consumers compare nursing homes to find one that provides good care. Theoretically, nursing homes with five-star ratings are supposed to be exceptional, while those with one-star ratings are deemed the worst. But research shows that nursing homes can game the system, with the result that a top star rating might reflect little more than a facility's willingness to cheat.

A star rating is composed of three parts: The score from a government inspection and the facility's self-reports of staffing and quality. This means that what the nursing homes say about themselves can boost the star rating of facilities even if they have poor inspection results. Multiple studies have highlighted a concerning trend: Some nursing homes, especially for-profit ones, inflate their self-reported measures, resulting in a disconnect from actual inspection findings. Notably, research suggests that for-profit nursing homes, driven by significant financial motives, are more likely to engage in this practice of inflating their self-reported assessments.

At bottom, the elderly and their families seeking quality care unknowingly find themselves in an impossible situation with for-profit nursing homes: Those facilities tend to provide the worst quality, and the only measure available for consumers to determine where they will be treated well can be rigged. The result is the transformation of an industry meant to care for the most vulnerable into a profit-driven circus.

The pandemic

Nothing more clearly exposed the problems rampant in nursing homes than the pandemic. Throughout that time, nursing homes reported that almost 2 million residents had infections and 170,000 died.

No one should have been surprised by the mass death in nursing homes − the warning signs of what was to come had been visible for years. Between 2013 and 2017, infection control was the most frequently cited deficiency in nursing homes, with 40% of facilities cited each year and 82% cited at least once in the five-year period. Almost half were cited over multiple consecutive years for these deficiencies − if fixed, one of the big causes of the widespread transmission of COVID in these facilities would have been eliminated. But shortly after coming into office in 2017, the Trump administration weakened what was already a deteriorating system to regulate nursing homes. The administration directed regulators to issue one-

time fines against nursing homes for violations of federal rules rather than for the full time they were out of compliance. This shift meant that even nursing homes with severe infractions lasting weeks were exempted from fines surpassing the maximum per-instance penalty of $20,965.

Even that near-worthless level of regulation was not feeble enough for the industry, so lobbyists pressed for less. In response, just a few months before COVID emerged in China, the Trump administration implemented new regulations that effectively abolished a mandate for each to hire a full-time infection control expert, instead recommending outside consultants for the job.

The perfect storm had been reached, with no experts required to be on site, prepared to combat any infection outbreaks. On Jan. 20, 2020 – just 186 days after the change in rules on infection control – the CDC reported that the first laboratory-confirmed case of COVID had been found at a nursing home in Washington state.

The least prepared in this explosion of disease were the for-profit nursing homes, compared with nonprofit and government facilities. Research from the University of California at San Francisco found those facilities were linked to higher numbers of COVID cases. For-profits not only had fewer nurses on staff but also high numbers of infection-control deficiencies and lower compliance with health regulations.

Even as the United States went through the crisis, some owners of midsize chains continued snapping up nursing homes. For example, two Brooklyn businessmen named Simcha Hyman and Naftali Zanziper were going on a nursing home buying spree through their private-equity company, the Portopiccolo Group. Despite poor ratings in their previously owned facilities, nothing blocked the acquisitions.

One such facility was a struggling nursing home in North Carolina now known as The Citadel Salisbury. Following the traditional pattern forged by private investors in the industry, the new owners set up a convoluted network of business entities and then used them to charge the nursing home for services and property. A 2021 federal lawsuit of many plaintiffs claimed that they deliberately kept the facility understaffed and undersupplied to maximize profit.

Within months of the first case of COVID reported in America, The Citadel Salisbury experienced the largest nursing home outbreak in the state. The situation was so dire that on April 20, 2020, the local medical director of the emergency room took to the local newspaper to express his distress, revealing that he had pressed the facility's leadership and the local health department to address the known shortcomings.

The situation was "a blueprint for exactly what not to do in a crisis," medical director John Bream wrote. "Patients died at the Citadel

without family members being notified. Families were denied the ability to have one last meaningful interaction with their family. Employees were wrongly denied personal protective equipment. There has been no transparency."

After a series of scathing inspection reports, the facility finally closed in the spring of 2022. As for the federal lawsuit, court documents show that a tentative agreement was reached in 2023. But the case dragged out for nearly three years, and one of the plaintiffs, Sybil Rummage, died while seeking accountability through the court.

Still, the pandemic had been a time of great success for Hyman and Zanziper. At the end of 2020, they owned more than 70 facilities. By 2021, their portfolio had exploded to more than 120. Now, according to data from the Centers for Medicare & Medicaid Services, Hyman and Zanziper are associated with at least 131 facilities and have the highest amount of total fines recorded by the agency for affiliated entities, totaling nearly $12 million since 2021. And their average fine per facility, as calculated by CMS, is more than twice the national average at almost $90,000.

In a written statement, Portopiccolo Group spokesperson John Collins disputed that the facilities had skimped on care and argued that they were not managed by the firm. "We hire experienced, local health care teams who are in charge of making all on-the-ground decisions and are committed to putting residents first." He added that the number of facilities given by CMS was inaccurate but declined to say how many are connected to its network of affiliates or owned by Hyman and Zanziper.

With the nearly 170,000 resident deaths from COVID and many related fatalities from isolation and neglect in nursing homes, in February 2022 President Biden announced an initiative aimed at improving the industry. In addition to promising to set a minimum staffing standard, the initiative is focused on improving ownership and financial transparency.

"As Wall Street firms take over more nursing homes, quality in those homes has gone down and costs have gone up. That ends on my watch," Biden said during his 2022 State of the Union address. "Medicare is going to set higher standards for nursing homes and make sure your loved ones get the care they deserve and expect."

Still, the current trajectory of actions appears to fall short of what's needed. While penalties against facilities have sharply increased under Biden, some of the Trump administration's weak regulations have not been replaced.

A rule proposed by CMS in September 2023 and released for review in March 2024 would require states to report what percentage of Medicaid funding is used to pay direct care workers and support staff and would require an RN on duty 24/7. It would also require a

minimum of three hours of skilled staffing care per patient per day. But the three-hour minimum is substantially lower than the 4.1 hours of skilled staffing for nursing home residents suggested by CMS over two decades ago.

The requirements are also lower than the 3.8 average nursing staff hours already employed by U.S. facilities.

The current administration has also let stand the Trump administration reversal of an Obama rule that banned binding arbitration agreements in nursing homes.

It breaks a village

The Villages of Orleans Health and Rehabilitation Center in Albion, New York, was, by any reasonable measure, broken. Court records show that on some days there was no nurse and no medication for the more than 100 elderly residents. Underpaid staff spent their own cash for soap to keep residents clean. At times, the home didn't feed its frail occupants.

Meanwhile, according to a 2022 lawsuit filed by the New York attorney general, riches were siphoned out of the nursing home and into the pockets of the official owner, Bernard Fuchs, as well as assorted friends, business associates and family. The lawsuit says $18.7 million flowed from the facility to entities owned by a group of men who controlled the Village's operations.

Although these men own various nursing homes, Medicare records show few connections between them, despite them all being investors in Comprehensive Healthcare Management, which provided administrative services to the Villages. Either they or their families were also owners of Telegraph Realty, which leased what was once the Villages' own property back to the facility at rates the New York attorney general deemed exorbitant, predatory and a sham.

So, it goes in the world of nursing home ownership, where overlapping entities and investors obscure the interrelationships between them to such a degree that Medicare itself is never quite sure who owns what.

Glenn Jones, a lawyer representing Comprehensive Healthcare Management, declined to comment on the pending litigation, but he forwarded a court document his law firm filed that labels the allegations brought by the New York attorney general "unfounded" and reliant on "a mere fraction" of its residents.

The shadowy structure of ownership and related party transactions plays an enormous role in how investors enrich themselves, even as the nursing homes they control struggle financially. Compounding the issue, the figures reported by nursing homes regarding payments to related parties frequently diverge from the disclosures made by the related parties themselves.

As an illustration of the problems, consider Pruitt Health, a midsize chain with 87 nursing homes spread across Georgia, South Carolina, North Carolina and Florida that had low overall federal quality ratings and about $2 million in penalties. A report by The National Consumer Voice For Quality Long-Term Care, a consumer advocacy group, shows that Pruitt disclosed general related party costs nearing $482 million from 2018 to 2020. Yet in that same time frame, Pruitt reported payments to specific related parties amounting to about $570 million, indicating a $90 million excess. Its federal disclosures offer no explanation for the discrepancy. Meanwhile, the company reported $77 million in overall losses on its homes.

The same pattern holds in the major chains such as the Cleveland, Tennessee-based Life Care Centers of America, which operates roughly 200 nursing homes across 27 states, according to the report. Life Care's financial disbursements are fed into a diverse spectrum of related entities, including management, staffing, insurance and therapy companies, all firmly under the umbrella of the organization's ownership. In fiscal year 2018, the financial commitment to these affiliated entities reached $386,449,502; over the three-year period from 2018 to 2020, Life Care's documented payments to such parties hit an eye-popping $1.25 billion.

Pruitt Health and Life Care Centers did not respond to requests for comment.

Overall, 77% of US nursing homes reported $11 billion in related-party transactions in 2019 − nearly 10% of total net revenues − but the data is unaudited and unverified. The facilities are not required to provide any details of what specific services were provided by the related parties, or what were the specific profits and administrative costs, creating a lack of transparency regarding expenses that are ambiguously categorized under generic labels such as "maintenance." Significantly, there is no mandate to disclose whether any of these costs exceed fair market value.

What that means is that nursing home owners can profit handsomely through related parties even if their facilities are being hit with repeated fines for providing substandard care.

"What we would consider to be a big penalty really doesn't matter because there's so much money coming in," said Mollot of the Long-Term Care Community Coalition. "If the facility fails, so what? It doesn't matter. They pulled out the resources.''

Hiding profit

Ultimately, experts say, this ability to drain cash out of nursing homes makes it almost impossible for anyone to assess the profitability of these facilities based on their public financial filings, known as cost reports.

"The profit margins (for nursing homes) also should be taken with a grain of salt in the cost reports," said Dr. R. Tamara Konetzka, a University of Chicago professor of public health sciences, at a recent meeting of the Medicare Payment Advisory Commission. "If you sell the real estate to a REIT or to some other entity, and you pay sort of inflated rent back to make your profit margins look lower, and then you recoup that profit because it's a related party, we're not going to find that in the cost reports."

That ability to hide profits is key to nursing homes' ability to block regulations to improve quality of care and to demand greater government payments. For decades, the industry's refrain has been that cuts in reimbursements or requirements to increase staffing will drive facilities into bankruptcy; already, they claim, half of all nursing homes are teetering on the edge of collapse, the result, they say, of inadequate Medicaid rates. All in all, the industry reports that less than 3% of their revenue goes to earnings.

But that does not include any of the revenue pulled out of the homes to boost profits of related parties controlled by the same owners pleading poverty. And this tactic is only one of several ways that the nursing home industry disguises its true profits, giving it the power to plead poverty to an unknowing government.

Under the regulations, only certain nursing home expenses are reimbursable, such as money spent for care. Many others − unreasonable payments to the headquarters of chains, luxury items, and fees for lobbyists and lawyers − are disallowed after Medicare reviews the cost reports. But by that time, the government has already reimbursed the nursing homes for those expenses − and none of those revenues have to be returned.

Data indicates that owners also profit by overcharging nursing homes for services and leases provided by related entities. A March 2024 study from Lehigh University and the University of California, Los Angeles shows that costs were inflated when nursing home owners changed from independent contractors to businesses owned or controlled directly or indirectly by the same people. Overall, spending on real estate increased 20.4%, and spending on management increased 24.6% when the businesses were affiliated, the research showed.

Nursing homes also claim that noncash depreciation cuts into their profits. Those expenses, which show up only in accounting ledgers, assume that assets such as equipment and facilities are gradually decreasing in value and ultimately will need to be replaced.

That might be reasonable if the chains purchased new items once their value depreciated to zero, but that is not always true. A 2004 report by the Medicare Payment Advisory Commission found that the depreciation claimed by health care companies, including nursing

	homes, may not reflect actual capital expenditures or the actual market value. If disallowed expenses and noncash depreciation were not included, profit margins for the nursing home industry would jump to 8.8%, far more than the 3% it claims. And given that these numbers all come from nursing home cost reports submitted to the government, they may underestimate the profits even more. Audited cost reports are not required, and the Government Accountability Office has found that CMS does little to ensure the numbers are correct and complete. This lack of basic oversight essentially gives dishonest nursing home owners the power to grab more money from Medicare and Medicaid while being empowered to claim that their financials prove they need more. "They face no repercussions," Brooks of Consumer Voice said, commenting on the current state of nursing home operations and their unscrupulous owners. "That's why these people are here. It's a bonanza to them." Ultimately, experts say, finding ways to force nursing homes to provide quality care has remained elusive. Michael Gelder, former senior health policy adviser to then-Gov. Pat Quinn of Illinois, learned that brutal lesson in 2010 as head of a task force formed by Quinn to investigate nursing home quality. That group successfully pushed for a new law, but Gelder now says his success failed to protect this country's most vulnerable citizens. "I was perhaps naively convinced that someone like myself being in the right place at the right time with enough resources could really fix this problem," he said. "I think we did the absolute best we could, and the best that had ever been done in modern history up to that point. But it wasn't enough. It's a battle every generation has to fight."
Spotlight	***How for-profit nursing home regulators can use the powers they already have to fix growing problems with poor-quality care*** By Charlene Harrington, RN, PhD, University of San Francisco **The Conversation** March 14, 2024 Governments at both state and federal levels have yet to fully wield their authority to fight poor-quality care at for-profit nursing homes nationwide, leaving the pressing need for elder care accountability unmet. Medicare has the power to improve financial accountability at nursing facilities by capping profits while requiring that a percentage of revenues be spent on direct care expenditures. Already, four states – New Jersey, New York, Massachusetts and Pennsylvania – have shown this can be done, passing laws requiring minimum percentages of expenditures on direct care while limiting profits.

	I am a behavioral scientist at the University of California, San Francisco who studies the economics of nursing homes and the implications for care. I am also the co-author of an investigative piece in The Conversation about for-profit nursing homes. States also have the power to suspend and disqualify nursing home owners from the Medicaid program when they provide poor-quality care, commit fraud or harm residents. For example, after the New Jersey comptroller concluded that the abrupt closure of the Princeton Care Center nursing home in September 2023 jeopardized the health and safety of residents, the state took action. It moved in January 2024 to impose an eight-year ban on the owners' ability to receive Medicaid reimbursement at any nursing home and to require them to divest themselves from two other facilities they already ran. The federal government can also take aggressive actions to force the industry to shape up, even without new legislation. A 2023 law review article demonstrates that state and federal governments could use state licensure laws and federal nursing home certification requirements to prevent abuse. The article argues that governments could set clear nursing home ownership and operation criteria for individuals and companies, which can include experience, expertise, reputation, past performance and financial solvency standards. Even federal prosecutors have largely unused powers to crack down on the industry. The Department of Justice has taken actions against many nursing home owners and chains but rarely has moved to remove the certification of facilities despite having the authority to do so. Instead, nursing homes subject to legal action by the department generally are placed under what is known as a corporate integrity agreement and assigned a monitor to oversee regulatory compliance. For example, Saber Healthcare Holdings, which owned 126 nursing homes in 2024, was placed under a corporate integrity agreement in 2021. The question remains: Why haven't governments fully flexed their existing regulatory muscles to enforce vital reforms in nursing homes? With the welfare of vulnerable residents at stake, the urgency for decisive action has never been clearer.
Quotes	*The question remains: Why haven't governments fully flexed their existing regulatory muscles to enforce vital reforms in nursing homes? With the welfare of vulnerable residents at stake, the urgency for decisive action has never been clearer.* Charlene Harrington, RN, PhD, University of San Francisco, *How for-profit nursing home regulators can use the powers they already have*

to fix growing problems with poor-quality care, **The Conversation,** March 14, 2024

"The investigation revealed an industry [for-profit nursing homes] that places a premium on cost cutting and big profits, with low staffing and poor quality, often to the detriment of patient well-being. Operating under weak and poorly enforced regulations with financially insignificant penalties, the for-profit sector fosters an environment where corners are frequently cut, compromising the quality of care and endangering patient health. Meanwhile, owners make the facilities look less profitable by siphoning money from the homes through byzantine networks of interconnected corporations. Federal regulators have neglected the problem as each year likely billions of dollars are funneled out of nursing homes through related parties and into owners' pockets."

Charlene Harrington, RN, PhD, University of San Francisco, and investigative journalist Sean Campbell, *For-profit nursing home owners rebut report that left few untarnished*, **McKnights Long Term Care News,** March 18, 2024

"Quite frankly we are sick of the disturbing pattern of health care administrators in our community taking advantage for their own personal gain."

State Sen. Liz Mirand, in comments sparked by the Edgar P. Benjamin Healthcare Center's planned closure, *Local leaders push to keep Boston nursing home open*, **Boston10News,** March 15, 2024

"UnitedHealth doesn't care about me. I'm a liability, I cost them too much money. They make a profit by not giving me the care I need. The company is in charge of deciding who does and doesn't get care. My doctor says, 'You need this infusion.' UnitedHealth is standing in the doorway saying, 'No you don't.'"

Jenn Coffey, a 52-year-old former EMT from Manchester, NH, *Between You and Your Doctor: How Medicare Advantage Care Denials Affect Patients*, **The American Prospect,** March 6, 2024

“While prisoners were locked in their cells, the ventilation was completely shut off in the housing units. With no air flow, the temperature monitors in the cells showed 98 degrees.” Checking on the elderly population, in their seventies and eighties, “the old guys were getting lightheaded and sweating. The guards wouldn’t even open their cell doors so they could get a little more air.”

Jessie Milo, an elected member of the Inmate Advisory Counsel at Cocroran State Prison in California, commenting about the effect of a planned power outage, *Climate Change Is Turning Prisons Into Death Traps*, **The New Republic,** March 13, 2024

"[Older incarcerated persons have] gone so long with substandard health care or not the right types of health care. For men coming out of prison, 40 is the new 60, 60 is the new 80."

Dan Pfarr, CEO of 180 Degrees, a reentry nonprofit in Minnesota, *The U.S. prison population is rapidly graying. Prisons aren't built for what's coming*, **NPR – Morning Edition,** March 11, 2024

"When you think about geriatric medical needs, many of the prisons across the United States are not equipped or weren't designed that way, and so the systems are grappling with how to retrofit or make do with the facilities that we have."

Nick Deml, commissioner, Vermont Department of Corrections, *The U.S. prison population is rapidly graying. Prisons aren't built for what's coming*, **NPR – Morning Edition,** March 11, 2024

“The vast majority of older people are getting care from people who have little to no training in the care of older adults.”

Louise Aronson, professor of geriatric medicine at the University of California at San Francisco, *The Looming Geriatric Care Crisis: Why Finding a Senior-Focused Doctor is Difficult*, ***Washington Post,** March 17, 2024

Estate recovery “has the potential to perpetuate wealth disparities and intergenerational poverty.”

Katherine Howitt, Medicaid policy director with the Blue Cross Blue Shield Foundation of Massachusetts, State Medicaid offices target

dead people's homes to recoup their health care costs, **AP News,** March 17, 2024

"[Estate recovery] is one of the most cruel, ineffective programs that we see. This is a program that doesn't work for anybody."

Rep. Jan Schakowsky (D-IL), , *State Medicaid offices target dead people's homes to recoup their health care costs*, **AP News,** March 17, 2024

Brian Snell, an elder law attorney in Marblehead, Mass., represents a family whose 93-year-old mother, who had dementia, died in 2022 at her condo in North Andover. Her daughter had cut back on her hours as a beautician to care for her at home, wanting to keep her out of a nursing home because "that was her mother's wish," Mr. Snell said.

When the mother qualified for MassHealth, the state Medicaid program, it enrolled her in a state home care program that provided home health aides (though only sporadically, because the pandemic made workers and agencies hesitant to enter homes).

After her death, MassHealth sought to recover $292,000 for the cost of home care and the program premiums. Because two of her children were low-income, including the caregiving daughter, a state waiver would allow those two to receive $50,000 each from the sale of the mother's condo. But more than half of the $335,000 sales price will go to the state and federal governments.

When Medicaid Comes After the Family Home, ***New York Times,** March 16, 2024

According to the US Department of Veterans Affairs, Virginia, Delaware, and Connecticut have achieved functional zero for homeless veterans. With its soaring housing costs and struggles with homelessness, making Massachusetts the fourth state to house all

veterans and keep them housed would be a real accomplishment.

Ending veteran homelessness is achievable, ***Boston Globe,** March 18, 2024

[W]hen the state made Aetna pay up, it also demanded broader data on childbirth claims. Regulators discovered that the insurer had miscalculated claims related to more than 1,000 births over a four-year period. Aetna issued refunds totaling $1.6 million and agreed to pay a $150,000 fine if it failed to follow conditions listed in a consent agreement.

Health Insurers Have Been Breaking State Laws for Years, **Pro Publica,** November 16, 2023

For seniors and disabled Americans to lose nearly $200 per month of their Social Security and choose between a large payout for supplemental or the risk of bankruptcy, is an injustice when privatized healthcare is stealing hundreds of billions of Americans' tax dollars, payroll deductions, and hard-earned money through out-of-pocket expenses.

Dave Kingsley, *How the Health Insurance Industry is Using Disinformation to Take Over and Defraud Medicare*, **Tallgrass Economics,** March 17, 2024

"We are in a crisis right now in health care, where too many people are putting profit before people and these residents need long-term care. They need us to stand with them."

Boston City Council President Ruthzee Louijeune, *To keep a Mission Hill nursing home open, lawmakers call for government intervention*, **WGBH News,** March 15, 2024

"One of the most effective ways to make housing more affordable is to convert vacant or underutilized office space into housing. This new initiative from MassHousing will be transformative for our downtowns and communities. Combined with the

	proposed investments in our Affordable Homes Act, we can make it easier for first-time homebuyers, renters, seniors and everyone to find affordable places to live." Governor Maura Healey, *Healey-Driscoll Administration Launches New Program to Support Redevelopment of Commercial Properties into Housing*, **Office of Governor Maura Healey and Lt. Governor Kim Driscoll,** March 15, 2024
Closure of the Benjamin Healthcare Center  Sen. Liz Miranda speaks during a press conference outside the Edgar P. Benjamin Healthcare Center on Friday, March 15, 2024, as elected officials called for state receivership of the nursing facility that's slated to close this summer. Photo by Alison Kuznitz	**State House News** March 15, 2024 *Electeds Push To Save Mission Hill Nursing Home* By Alison Kuznitz Lawmakers and city officials in Boston are rallying to prevent the closure of the Edgar P. Benjamin Healthcare Center, a nearly 100-year-old nursing home serving mostly minority residents. They are urging the state to take over the facility's management to assess its viability and find a new operator. With closure slated for July, they fear displacement will harm the well-being of the 76 residents. The center's CEO blames rising costs and staffing issues, but officials accuse him of mismanagement while himself receiving a significant salary increase. **WGBH News** March 15, 2024 *To keep a Mission Hill nursing home open, lawmakers call for government intervention* By Craig LeMoult Weeks after a Mission Hill nursing home told residents and employees it would be closing later this year, several state lawmakers and Boston city councilors are calling for a court-appointed receiver to take over the facility. But the state Department of Public Health says that's not an option. One of the Edgar P. Benjamin Healthcare Center residents facing an uncertain future is Louis Johnson, who stood in front of the facility Friday with the assistance of a walker. Johnson said he didn't want to be kicked out of the facility where he's been for years. "This is where we live," he said. "It closes, where we going to go?" CEO Tony Francis informed the nursing home's 76 residents in February that they planned to close the doors in July as a result of "insurmountable financial challenges." In a written statement, Francis said the center is "focused on assuring appropriate and orderly resident transfers." "The economic climate for long-term care is dismal and continued operation of the facility is simply not sustainable, so the skilled nursing facility is scheduled to close July 1, after all resident transfers are complete," Francis wrote. "We continue to work closely with state and local elected and appointed officials. We appreciate the interest and support of these officials but the fiscal reality remains the same."

But at a press conference Friday in front of the nursing home, State Sen. Liz Miranda blamed Francis for the nursing home's financial problems.

"We have reason to believe that the administrator has used his position solely for his own personal gain, and that has put the facility and its residents in harm's way," said Miranda, who represents residents in the state Senate.

"People came to my community to get health care," added City Councilor Ben Weber, whose district includes Mission Hill. "Their families relied on this facility to provide their relatives with the care that they need, and they deserve better. They deserve transparency. Instead, what they got was a CEO who ran the place into the ground while apparently enriching himself."

Public financial disclosures show Francis was compensated $628,592 in 2021, as staff struggled to keep residents and patients safe through the Covid epidemic.

Miranda called for the state Department of Public Health and Attorney General Andrea Campbell to support the appointment of a receiver "to assess the feasibility of keeping this facility open, to find a new long-term care provider to support continued operations, and to closely monitor the closure process to ensure that these residents — our neighbors — are safe and supported throughout this transition."

But neither the Department of Public Health nor the attorney general's office appear poised to act.

A spokesperson for the attorney general's office pointed to the state Department of Public Health, which has a role it must play in every nursing home's closure.

"The closure of a nursing home in a community is not something anyone wants to see," the spokesperson said in a written statement. "A facility that decides to close must work with the Department of Public Health to safely transfer patients to other facilities where they can receive appropriate care. While the Attorney General's Office does not have a designated role in this closure process, we will continue to use our tools where we can, including to ensure workers get paid."

The AG's office issued a $15,000 citation to the facility earlier this month for failure to make timely payment of wages, and per a spokesperson, secured roughly $190,000 in restitution for workers.

The AG's office does have the ability to ask a court to place a facility under receivership under certain conditions, but the spokesperson for the AG's office declined to publicly discuss when and how that legal tool is used.

And, according to the Department of Public Health, the Edgar P. Benjamin Healthcare Center has complied with closure requirements and doesn't meet the legal threshold for receivership: if there's imminent danger of death or serious physical harm to patients, or if a facility is operating without a license or has had one revoked.

The department says an ombudsman from the Executive Office of Health and Human Services is meeting with residents on-site to assist with transitions, and that DPH is closely monitoring the closure process.

Leslie Henderson has worked at the Edgar P. Benjamin Healthcare Center for 24 years.

"We have come in despite our checks bouncing, despite not being paid for five weeks," Henderson said at Friday's press conference. "We showed up because we care about the residents that we take care of."

Henderson said, in addition to speaking for employees, she was there at the press conference to speak for the residents, who are largely people of color.

"We may be able to find jobs any place that we want to, but these people are being displaced from their homes," she said. "We ask, if this was going on in any other community — if this was Lexington, if this was Weston, if this was Newton, if this man was doing what he was doing to other people that may not have looked like me, or may not have looked like a lot of the residents that we represent — would this be OK?

"We have reached out to the Department of Public Health. We have reached out to the Attorney General's office and we have had silence," she continued. "Crickets. Nothing."

Members of Boston's City Council put the nursing home's crisis in a larger context, as Walgreens pharmacies have left Roxbury and Carney Hospital in Dorchester faces an uncertain future amid parent company Steward Health Care's financial crisis.

"We are in a crisis right now in health care, where too many people are putting profit before people," said City Council President Ruthzee Louijeune. "And these residents need long-term care. They need us to stand with them."

"When we're thinking about all the things that are happening with Walgreens, with our hospitals, it just really feels like gentrification is happening," said City Councilor Julia Mejia. "Not just housing gentrification, but our quality of life and health care is being gentrified. And I think this is an opportunity for us to say no."

WBZ News

March 15, 2024

Boston community and lawmakers call for investigation into nursing home set to close in July

By David Wade

A rally was held on the front lawn of a Mission Hill nursing home on Friday, where community members, staff and lawmakers called for the state to investigate the facility and keep it open.

The Edgar P. Benjamin Healthcare Center is scheduled to close in July.

People at the rally said the nursing home's administrator used the nursing home for his own gain, putting the facility and its residents in harm's way by allegedly mishandling funds. They're calling for an investigation and for an receiver to be appointed to dig deeper into the books.

The Edgar P. Benjamin Healthcare Center has been a part of the community for nearly 100 years and now serves mainly Black and Brown residents in need of long-term care.

"We believe that residents are at significant risk of transfer trauma," said Sen. Liz Miranda (D-2nd Suffolk District). "We know that

residents who are displaced from their long-term care facilities will likely, and I know this firsthand, experience functional decline, increased loneliness and isolation and more hospitalizations and falls, or maybe even worse. We can do more and we should do more, to keep this facility open."

If the facility can't stay open, advocates are asking the state for more resources through the transition of care.

WBZ TV reached out to the administrator of the center but did not hear back.

Boston10News

March 15, 2024

Local leaders push to keep Boston nursing home open

By Alysha Palumbo and Malcolm Johnson

"Quite frankly we are sick of the disturbing pattern of health care administrators in our community taking advantage for their own personal gain," State Sen. Liz Miranda said, in comments sparked by the Edgar P. Benjamin Healthcare Center's planned closure

A Boston nursing home is set to close its doors in July, but local leaders gathered Friday morning to publicly urge action on a receivership petition that would allow the state to take over management of the facility.

The Edgar P. Benjamin Healthcare Center in Mission Hill is scheduled to close on July 1, displacing 76 elderly and disabled residents. Patients have schizophrenia, dementia and a number of medical conditions that make it hard for the home's 76 residents to grasp that the nursing home is closing in a few months.

CEO Tony Francis blames surging labor and other costs as the reason for the planned closure.

Over the past year, staff have complained about going months without paychecks, or having their checks bounce.

At the same time, lawmakers allege Francis gave himself a 300% raise since he came on as CEO in 2014 – reportedly making him the highest paid non-profit nursing home administrator in the city.

“It’s like a dream for me. I wake up every day. I come to work but still…are we really closing after 43 plus years? Is this what it becomes?" said Guerda Cadet, who is concerned about what will happen to the dozens of people who still rely on the facility for care.

“Where are they gonna go? Some of them, all they know is us. So that’s my biggest concern right now is the placement. Where are they going to go?” Marise Colsoul, director of nursing, said.

Lawmakers and community leaders urged action by the Department of Public Health and the Attorney General’s office on a receivership petition that would allow the state to take over management of the facility.

“Our community deserves more and quite frankly we are sick of the disturbing pattern of health care administrators in our community taking advantage for their own personal gain,” State Sen. Liz Miranda said.

Lawmakers allege Francis gave himself a 300% raise since he came on as CEO in 2014 – with an annual salary reportedly over $620,000 -- making him the highest paid nonprofit nursing home administrator in

	Boston. Meanwhile, staff have complained about going weeks without paychecks or having checks bounce. "They take in almost a million dollars a month. He just doesn't pay the bills. So, when he filed a notice….saying that they're having insurmountable financial woes, he is the insurmountable financial woe," former State Sen. Dianne Wilkerson said. Francis responded to a request for comment on Friday. "The Edgar P. Benjamin Healthcare Center continues to provide high-quality skilled nursing care in a safe environment and remains focused on assuring appropriate and orderly resident transfers. The economic climate for long-term care is dismal and continued operation of the facility is simply not sustainable, so the skilled nursing facility is scheduled to close July 1, after all resident transfers are complete. We continue to work closely with state and local elected and appointed officials. We appreciate the interest and support of these officials but the fiscal reality remains the same," he wrote in a statement. There's a hearing scheduled over the Benjamin closure on March 26.
Guide to news items in this week's *Dignity Digest*	**Nursing Homes** *For-profit nursing home owners rebut report that left few untarnished* **(McKnights Long Term Care News,** March 18, 2024) **Housing** *Healey-Driscoll Administration Launches New Program to Support Redevelopment of Commercial Properties into Housing* **(Office of Governor Maura Healey and Lt. Governor Kim Driscoll,** March 15, 2024) **Medicare** *Between You and Your Doctor: How Medicare Advantage Care Denials Affect Patients* **(The American Prospect,** March 6, 2024) **Medicaid** *State Medicaid offices target dead people's homes to recoup their health care costs* **(AP News,** March 17, 2024) *When Medicaid Comes After the Family Home* **(*New York Times,** March 16, 2024) **Healthcare** *The Looming Geriatric Care Crisis: Why Finding a Senior-Focused Doctor is Difficult* **(*Washington Post,** March 17, 2024) *A new kind of hospital is coming to rural America. To qualify, facilities must close their beds* **(AP News,** March 16, 2024) *Health Insurers Have Been Breaking State Laws for Years* **(Pro Publica,** November 16, 2023) *Residents and employees participate in 'standout protest' to keep Mary Lane Hospital open* **(Western Mass News,** March 16, 2024 **Disability Topics** *Their disabled loved ones languished in state institutions. Now, they want the records.* **(WGBH News,** March 1, 2024 (updated)) **Veterans** *Ending veteran homelessness is achievable* **(*Boston Globe,** March 18, 2024) **Incarcerated Persons** *Climate Change Is Turning Prisons Into Death Traps* **(The New Republic,** March 13, 2024)

	The U.S. prison population is rapidly graying. Prisons aren't built for what's coming **(NPR – Morning Edition,** March 11, 2024) **From Our Colleagues from around the Country** *How the Health Insurance Industry is Using Disinformation to Take Over and Defraud Medicare* **(Tallgrass Economics,** March 17, 2024)
Public Hearings	**Massachusetts Department of Public Health** ***Benjamin Healthcare Center, Roxbury*** Public hearing: Tuesday, March 26, 2024, 6:00 p.m. Thelma Burns Building, 575 Warren St, Roxbury There will be language interpreter services in Spanish and Haitian Creole at the in-person hearing. Closure date: July 1, 2024 Notice of Intent to Close (PDF) | (DOCX) Draft of Closure and Relocation Plan (PDF) | (DOCX)
Recruitment	**AARP** ***State Director, Massachusetts*** Apply: *https://careers.aarp.org/careers-home/jobs/5570?lang=en-us* AARP is currently accepting applications for State Director, AARP's top position in Massachusetts. A visionary leader – with a passion for issues that impact people as they age – is needed to lead, manage, and engage staff, volunteers, and people 50+, their families and the communities in which they live. The State Director sets the overall vision and direction of the organization's work in the state to execute organizational priorities. **Massachusetts Law Reform Institute** ***Housing Staff Attorney*** Apply: *humanresources@mlri.org* MLRI seeks an experienced, dynamic, and strategic attorney with a background in housing law and policy to join its Housing Practice Group and advocate on behalf of low-income and marginalized people statewide. Primary Responsibilities: Coordinate and co-lead statewide advocacy on the Emergency Assistance family shelter system and other related programs, including legislative and administrative advocacy and trainings. Coordinate and oversee development and updating of community legal education on housing and homelessness topics. These priorities may change based on the experience and qualifications of the applicant. https://www.mlri.org/
In Person Events	**1. Joint Center for Housing Studies of Harvard University** Wednesday, March 20, 2024, 12:15 p.m. *Meeting Our Housing Needs: Scaling the Impact of Community Land Trusts and Shared Equity Models* Location: Gund 122, 48 Quincy St, Cambridge Speaker(s): Tony Pickett Community Land Trusts (CLTs), Shared Equity Homeownership programs, and other innovative approaches to affordable housing that grew out of the Civil Rights movement can help sustain changing communities and allow them to thrive for generations to come. In this talk, Tony Pickett, CEO of Grounded Solutions Network, will draw on efforts from across the United States to discuss how to scale up these approaches in ways that can help address the nation's ongoing affordable housing crisis.

	This event is in-person only (no registration required) **2. Massachusetts Statewide Independent Living Council** Monday, March 25, 2024 *Independent Living Education Day 2024* Registration: 10:00 a.m. Speakers: 11:00 a.m. Lunch: 12:00 p.m. Legislative Visits: 1:00 to 3:00 p.m. Great Hall, State House **Why:** Funding for Independent Living benefits everyone in the Commonwealth. CART and ASL will be provided. **RSVP and request accommodations here** Download the flyer for IL Education Day **2024 Priorities:** · Support Independent Living Centers · Accessible, affordable housing for people with disabilities · Accessible, affordable transportation for people with disabilities · Support the PCA program & workforce · Align MA AAB regulations with the ADA · Access to Assistive Technology and Durable Medical Equipment · Access to healthcare For more information, please email info@masilc.org This event is supported by the Public Information and Education Committee of the A Statewide Independent Living Council (MASILC) and the Commonwealth's 10 Independent Living Centers
Hybrid Sessions	**3. Joint Center for Housing Studies of Harvard University** Thursday, March 21, 2024, 6:30 p.m. *The Toxic Problem of Poverty + Housing Costs: Lessons from New Landmark Research About Homelessness* Location: Piper Auditorium, Harvard Graduate School of Design and Online Speaker(s): Margot Kushel, James O'Connell, Peggy Bailey, Chris Herbert For over three decades, Dr. Margot Kushel has both cared for people who experience homelessness and studied the causes, consequences, and solutions to homelessness particularly in California, which is home to 30 percent of the people experiencing homelessness in the US. Kushel, who recently led the largest representative study of homelessness in the United States since the mid-1990s, will discuss insights that have emerged from her work as a physician and researcher. Her research has shown that California's homelessness crisis is primarily due to the lack of housing that low-income households can afford. Moreover, contrary to popular beliefs, the majority of people experiencing homelessness in the state were born in California. She will draw on the findings to discuss policies, programs, and practices that would help people experiencing homelessness and those who are at risk of becoming homeless. Following the lecture, Chris Herbert, the Center's Managing Director, will moderate a conversation with Kushel, Peggy Bailey, Vice President for Housing and Income Security at the Center on Budget and Policy Priorities, and Dr. Jim O'Connell, President of the Boston Health Care for the Homeless Program.

	Register here to attend in person at 48 Quincy St, Cambridge, MA. This event will also be livestreamed online; no advance registration is necessary.
Webinars and Other Online Sessions	**4. Consumer Voice** Wednesday, April 10, 2024, 2:00 to 3:00 p.m. *Hidden Profits in the Nursing Home Industry* Consumer Voice has long been a proponent of increased transparency and accountability in nursing home finances. Data and research show that roughly 75% of nursing homes use related party transactions. These common transactions permit some nursing home owners to hide how profitable their facilities really are. On March 4, 2024, a new paper, "Tunneling and Hidden Profits in Health Care" was published by Dr. Ashvin Gandhi and Dr. Andrew Olenski. Their paper looked specifically at related party transactions in nursing homes and "tunneling." Tunneling is the process by which nursing home providers "covertly extract profit by making inflated payments for goods and service to commonly owned related parties." This paper, a first of its kind, found that in 2019, 63% of nursing home profits were "hidden" in related party transactions. In other words, the reported profits by the industry are roughly 1/3 of what they truly are. Join Consumer Voice in welcoming the authors of this groundbreaking study to discuss their methodology, findings, and what steps they recommend be taken to address the lack of transparency and accountability that allows nursing homes to continuously claim poverty as to why they are unable to provide high-quality care. This timely study pulls back the curtain on nursing home finances and challenges the industry narrative that they are not paid enough in Medicare or Medicaid dollars. Importantly, it shows that when money is diverted away through "tunneling" reforms such as a minimum staffing standard face uphill challenges, as the industry claims it cannot do better with more money. **REGISTER** **5. National Association of Social Workers MA & RI Chapters** Thursday, June 20, 2024, 8:30 a.m. to 3:30 p.m. *Getting Up to Speed in Social Work's Role in Elder Care: Challenges and Developments* Keynote: Alice Bonner, Moving Forward Coalition For more information: CMedinaAdames.naswma@socialworkers.org
Previously posted webinars and online sessions	Previously posted webinars and online sessions can be viewed at: https://dignityalliancema.org/webinars-and-online-sessions/
Nursing Homes	**6. McKnights Long Term Care News** March 18, 2024 *For-profit nursing home owners rebut report that left few untarnished* By Kimberly Marselas A recent article by Charlene Harrington and Sean Campbell in The Conversation harshly criticized the for-profit nursing home industry. The article highlighted practices like cost-cutting, low staffing levels, and potential financial exploitation through related-party transactions. **Key Points of the Critique:**

	• **Prioritization of Profits:** The article argues that for-profit facilities prioritize profits over resident care, leading to lower quality care and compromised resident health. • **Weak Regulations and Enforcement:** Weak regulations and insignificant penalties create an environment where corners are cut, jeopardizing resident safety. • **Private Equity Involvement:** The increasing involvement of private equity firms is seen as a negative development, potentially focused on short-term gains rather than long-term quality improvement. • **Related-Party Transactions:** The use of related-party transactions is scrutinized as a potential method for siphoning money out of nursing homes. PruittHealth was specifically mentioned as an example. **Industry Response:** The nursing home industry strongly disputes these claims. Here's how they counter the arguments: • **Investment in Quality:** Industry representatives argue that many for-profit providers are investing heavily in quality and innovation, especially considering historically low margins. They point out the challenges faced during the pandemic as evidence of their commitment. • **Shrinking Non-Profit Sector:** The decline of non-profit and government-run nursing homes due to financial difficulties is highlighted. This shift, they argue, leaves for-profit providers as the only viable option in many cases. • **Misrepresentation of Private Equity:** Industry experts counter that private equity can be a source of much-needed capital for improvements and innovation, particularly for struggling facilities. • **Inaccurate Data and Cherry-Picking:** Providers criticize the use of potentially outdated data and argue that a single data point doesn't reflect the overall quality of care. PruittHealth, for instance, emphasizes its above-average quality metrics in some states. **7. The Conversation** March 14, 2024 *For-profit nursing homes are cutting corners on safety and draining resources with financial shenanigans − especially at midsize chains that dodge public scrutiny* By Charlene Harrington, RN, PhD, University of San Francisco, and investigative journalist Sean CampbellBy
Housing	**8. Office of Governor Maura Healey and Lt. Governor Kim Driscoll** March 15, 2024 *Healey-Driscoll Administration Launches New Program to Support Redevelopment of Commercial Properties into Housing* *The new Commercial Conversion Initiative will accelerate housing production across Massachusetts by transforming vacant and underutilized properties.* Governor Maura T. Healey and Lieutenant Governor Kim Driscoll joined Secretary of Housing and Livable Communities Ed Augustus and MassHousing CEO Chrystal Kornegay to announce the Commercial Conversion Initiative, a new planning program that will revitalize downtown and other commercial areas and spur housing creation. The planning initiative, based at MassHousing, will assist municipalities outside Boston in advancing the redevelopment of vacant and

	underutilized commercial buildings, and position properties to take advantage of new capital funding proposed under the Governor's Affordable Homes Act. MassHousing has allocated up to $1 million in planning funds for technical assistance funding under the program. "One of the most effective ways to make housing more affordable is to convert vacant or underutilized office space into housing. This new initiative from MassHousing will be transformative for our downtowns and communities," said Governor Healey. "Combined with the proposed investments in our Affordable Homes Act, we can make it easier for first-time homebuyers, renters, seniors and everyone to find affordable places to live." "Synergy's Chestnut Place project is a great example of how we can use the resources we already have at our disposal to build more housing and lower costs for all," said Lieutenant Governor Driscoll. "The Commercial Conversion Initiative will help make more projects like this possible across the state." Cities across the United States are responding to changes in the nature of work by promoting residential uses in their downtowns. Examples of successful commercial-to-residential conversions exist across Massachusetts, but small and mid-sized cities face particular barriers in pursuing commercial-to-residential redevelopment at scale. MassHousing's Commercial Conversion Initiative addresses gaps in opportunity, capacity and funding by offering new planning resources that will accelerate the reuse and redevelopment of underutilized commercial buildings across Massachusetts. The new planning program will work with participating municipalities to identify the best candidates for commercial-to-housing conversions; conduct floor plan and feasibility analyses for well-positioned buildings; and assist in lowering regulatory barriers to redevelopment and reuse. The program will create development-ready sites that will be poised to take advantage of implementation financing. "Buildings like One Chestnut Place were home to bustling offices when going to work meant going to an office for many people," said Secretary of Housing and Livable Communities Ed Augustus. "While offices remain a vital part of our cities, they simply don't use as much space as they once did. With the Commercial Conversion Initiative, we can fill them with people who, instead of leaving our cities at 5 o'clock, will live here, shop here and infuse our communities with energy." "Our new Commercial Conversion Initiative will promote growth and vitality in downtown areas, while addressing the statewide need for new housing," said MassHousing CEO Chrystal Kornegay. "MassHousing is excited to support the Healey-Driscoll Administration's efforts to strengthen communities and make Massachusetts a more vibrant and affordable place to live." Governor Healey announced the new planning program at Chestnut Place in Worcester, an underutilized commercial property slated to be redeveloped into 198 new market-rate apartments. With the building's anchor tenant set to relocate to new space elsewhere in Worcester, the Chestnut Place property is primed for conversion to residential uses. The Commercial Conversion Initiative will help position communities for state resources such as the state's Housing Development Incentive

	Program (HDIP) and resources available through the Affordable Homes Act to advance redevelopment projects. The $1 billion tax legislation Gov. Healey signed last year significantly expanded the HDIP program, in order to meet the need for new housing across Massachusetts. The Healey-Driscoll Administration's Affordable Homes Act proposes additional resources to help communities meet the need for new housing. The Affordable Homes Act proposes a new $275 million fund to support innovative housing strategies, including repurposing commercial and office space for housing development. The Affordable Homes Act also proposes creating an $800 million Affordable Housing Trust Fund, which would be used to create or preserve affordable housing, and $100 million for the Commonwealth Builder program. This program creates a permanent capital resource for the construction of affordable single-family homes in Gateway Cities and other similar communities. The Commercial Conversion Initiative is intended to help more properties move through the planning process quickly, positioning them to compete for enhanced resources from last year's tax legislation, as well as proposed capital sources from the Affordable Homes Act. Technical assistance under the Commercial Conversion Initiative is open to all communities outside Boston with walkable downtowns and buildings with underutilized upper-story commercial space. Interested municipalities may access more information and apply to participate by visiting the program page on www.masshousing.com/programs-outreach/commercial-conversion. "Affordable housing is of the utmost importance to us here in the City of Worcester," said Worcester Mayor Joseph M. Petty. "I am incredibly grateful for the work that the Healey-Driscoll Administration has been doing to make sure that the state of Massachusetts can expand sustainably and account for our growing population." "The One Chestnut Place project perfectly illustrates how municipalities can work together with the state and private developers to repurpose underutilized properties to create new housing," said Worcester City Manager Eric D. Batista. "The apartments replacing the former office space will add much needed inventory to our housing stock. Furthermore, the condominiums at 80% Area Median Income constructed next door at Two Chestnut Place will provide critical affordable homeownership opportunities for our residents. Thank you to Governor Healey and her administration, including Secretary Ed Augustus, and David Greaney and Synergy, for their commitment to these projects and providing critical support through HDIP and other community development programs." "Synergy is proud to participate in the Healey-Driscoll Administration's Commercial Conversion Initiative as we begin the largest office-to-residential conversion in Massachusetts at Chestnut Place. We aim to revitalize the area while also providing much-needed housing options for the community of Worcester," says David Greaney, CEO of Synergy. "We look forward to collaborating with the Healey-Driscoll administration, MassHousing, The Planning Office for Urban Affairs, and the City of Worcester to bring new life and economic opportunity to the underutilized properties in in the Commonwealth."

Medicare	**9. The American Prospect** March 6, 2024 *Between You and Your Doctor: How Medicare Advantage Care Denials Affect Patients* By Matthew Cunningham-Cook UnitedHealth is prioritizing profits over patient care. They spend billions of dollars on stock buybacks and dividends for shareholders, while fighting against paying for necessary treatments for their patients. One way they achieve this is through a process called "prior authorization" - forcing patients to get approval from the insurance company before receiving certain treatments. This process can be lengthy and difficult to navigate, often resulting in delayed or denied care. The article details two stories of people who struggled to get the care they needed from UnitedHealth. Jenn Coffey has complex regional pain syndrome, a rare illness. One of the few effective treatments is ketamine infusions, but UnitedHealth has denied coverage and made it difficult for her to get approval. Carly Morton suffers from MALS, a disease requiring surgery. UnitedHealth initially denied coverage because the surgery was performed out-of-state. Both women eventually received treatment after a long struggle, but many others are not so lucky. The article argues that UnitedHealth's practices are causing serious harm to patients and calls for reform of the Medicare Advantage system.
Medicaid	**10. AP News** March 17, 2024 *State Medicaid offices target dead people's homes to recoup their health care costs* By Amanda Seitz This article explores the controversial Medicaid estate recovery program, a federal mandate requiring states to recoup money from the estates of deceased individuals who received Medicaid benefits for long-term care. **The Program:** • Medicaid, a health insurance program for low-income Americans, covers long-term care costs like nursing homes and in-home health aides. • When a Medicaid recipient dies, the state can seek reimbursement for these long-term care expenses from their estate, potentially including their home. • This program was created to encourage people to save for long-term care to avoid jeopardizing their assets. **Criticisms:** • Critics argue the program is: o Cruel: It forces families to sell their loved ones' homes to pay Medicaid bills. o Ineffective: It recovers very little money compared to the total Medicaid spending. o Unfair: Many beneficiaries are unaware of the program and its potential consequences. **Examples:** • Sandy LoGrande's story highlights the emotional and financial strain placed on families who have to fight to keep their homes after a loved one received Medicaid.

- Imani Mfalme's case showcases the racial dimension, with her mother's hard-earned home potentially being taken due to Medicaid debt.

Calls for Reform:

- Some lawmakers propose ending the program entirely, arguing it's a burden on families with minimal financial return.
- Others suggest state-level reforms like:
  - Prohibiting recovery beyond long-term care costs.
  - Implementing clearer communication about program risks.

Challenge to Reform:

- Amending the federal mandate requires congressional action, which is difficult in the current political climate.

The Future of Estate Recovery:

- The program's effectiveness and fairness are being debated.
- Whether it remains in place or undergoes significant reform is yet to be determined.

Additional Notes:

- The article mentions the Medicaid and CHIP Payment and Access Commission's report advocating for making estate recovery optional for states.
- The story includes the perspective of Stephen Moses, the architect of the program, who acknowledges its shortcomings.

11. *New York Times

March 16, 2024

When Medicaid Comes After the Family Home

By Paula Span

When Medicaid Comes After the Family Home: A Cruel and Ineffective Policy

This article explores the controversial practice of Medicaid estate recovery, where states seek reimbursement for long-term care costs from the deceased beneficiaries' estates, potentially including their homes.

The Policy:

- Established in 1993, it requires states to recover Medicaid expenses from estates of deceased beneficiaries who received long-term care (nursing homes or home care) after age 55.
- Aims to save money and promote fairness by preventing asset shielding for Medicaid eligibility.

The Issues:

- Primarily impacts low-income families, including Black and Hispanic communities, perpetuating poverty.
- The average wealth of deceased Medicaid recipients is low, and the recovered amount is minimal compared to program costs (less than 1%).
- Hardship waivers are difficult to obtain, leaving families with the burden of potentially losing their homes.
- Discourages some eligible individuals from seeking needed care due to fear of estate recovery.

Examples:

- A daughter caring for her mother with dementia faces losing the family home due to a $77,000 Medicaid debt.
- Another family loses over half the sale price of their mother's condo to repay $292,000 in Medicaid costs.

	The Debate: • Proponents argue it discourages asset shielding and recovers some program costs. • Critics call it cruel, ineffective, and a burden on low-income families. • Some states are implementing reforms like minimum estate thresholds and clearer communication about consequences. **Potential Solutions:** • Legislation like the Stop Unfair Medicaid Recoveries Act proposes ending the practice entirely. • Amending federal law to allow states to make estate recovery optional is another possibility. **The Road Ahead:** • The federal policy faces opposition in the Republican-controlled House. • Advocates for reform hope to raise awareness and push for changes despite the challenges.
Healthcare	**12. *Washington Post** March 17, 2024 *The Looming Geriatric Care Crisis: Why Finding a Senior-Focused Doctor is Difficult* By Carly Stern The article explores the critical shortage of geriatricians. This lack of specialists creates challenges for older adults seeking appropriate medical care, potentially leading to poorer health outcomes. **The Need for Geriatricians:** • The population aged 65 and over is rapidly growing, placing a greater demand on healthcare systems. • Older adults have complex medical needs often requiring a holistic approach that considers age-related physiological changes and potential interactions between medications. • Research shows geriatricians provide more effective and efficient care for older adults, resulting in lower mortality rates, shorter hospital stays, and reduced healthcare costs. **The Geriatrician Shortage:** • Despite the growing need, there's a significant shortage of geriatricians in the US, with only around 7,300 board-certified specialists. • This translates to roughly 1 geriatrician for every 10,000 older adults, a vast imbalance. • Fellowship positions in geriatric medicine are also facing low fill rates, further exacerbating the problem. **Causes of the Shortage:** • **Limited Exposure in Medical Education:** Geriatrics isn't mandatory in medical school curriculums, leading many doctors to overlook it as a career path. • **Negative Stereotypes About Aging:** Societal views on aging can discourage medical students from specializing in geriatric care. • **Lower Salaries Compared to Other Specialties:** Financial incentives play a role, with geriatricians often earning less than their peers in other specialties. **Impact of the Shortage:**

- Seniors without access to geriatric care may receive inadequate treatment, leading to misdiagnosis, overmedication, and poorer health outcomes.
- The burden falls on primary care doctors who may lack the specialized training to manage complex needs of older adults.

Potential Solutions:

- **Integrating Geriatrics into Medical Education:** Mandating geriatric training in medical schools could expose students to this field and spark interest.
- **Financial Incentives:** Loan forgiveness programs or higher reimbursement rates for geriatricians could make the specialty more financially attractive.
- **Mid-Career Training Programs:** Creating pathways for existing doctors to gain geriatric expertise could address the shortage in the short term.

The Path Forward:

- Addressing the geriatric care shortage requires a multi-pronged approach, including educational reforms and financial incentives.
- By fostering a more robust geriatric workforce, we can ensure better healthcare for our aging population, promoting their well-being and quality of life.
- The article concludes with Pat Early's story, highlighting the importance of finding a doctor who understands and prioritizes the needs of older adults.

Additional Notes:

- The article mentions the "Five M's" of geriatric care: mind, mobility, medications, multi-complexity, and matters most (understanding what matters most to the patient).
- Medicare's role in funding residencies and fellowships is discussed as a potential leverage point to encourage geriatric training.

13. AP News

March 16, 2024

A new kind of hospital is coming to rural America. To qualify, facilities must close their beds

By Devna Bose

This article explores the emergence of rural emergency hospitals (REHs) as a potential solution for struggling rural healthcare facilities in the US.

The Challenge:

- Many rural hospitals face financial difficulties and are at risk of closure.
- Limited access to healthcare services poses a significant problem for rural communities.

The Solution (REHs):

- A new federal program allows qualifying rural hospitals to convert to REHs.
- REHs provide 24/7 emergency care but must close all inpatient beds.
- In exchange, REHs receive:
    - Increased federal funding (over $3 million annually)
    - Higher Medicare reimbursements

Potential Benefits:

- Prevents closure of some rural hospitals, preserving access to emergency care.

- Increased revenue helps stabilize struggling hospitals financially.

Challenges and Concerns:

- **Travel Distance for Inpatient Care:** Patients may need to travel further for treatments requiring hospitalization.
- **Limited Awareness:** Residents might be unclear about the services offered by REHs.
- **High-Risk Gamble:** Financial benefits may not outweigh the cost of conversion, especially for hospitals on the brink.
- **Lost Services:** REHs might have to give up certain benefits like prescription drug discount programs.
- **Geographic Restrictions:** Not all rural hospitals qualify for the REH designation (e.g., distance to larger hospitals).
- **Uncertain Long-Term Impact:** The program is still new, and its long-term effectiveness is unclear.

Case Studies:

- **Irwin County Hospital (Georgia):** Successfully converted to an REH, achieved financial stability.
- **Alliance Healthcare System (Mississippi):** Lost REH designation due to a location technicality, facing potential closure.
- **Warren Memorial Hospital (Nebraska):** Converted to an REH to avoid closure, early signs of financial improvement.

The Road Ahead:

- The National Rural Health Association is advocating for changes to make the REH program more accessible and effective.
- More rural hospitals are considering converting to REHs, but the program's long-term success remains uncertain.

14. Pro Publica

November 16, 2023

Health Insurers Have Been Breaking State Laws for Years

By Maya Miller and Robin Fields

This article exposes how loopholes and weak enforcement mechanisms undermine state laws mandating health insurance coverage for specific treatments.

Key Findings:

- **State Laws Often Violated:** Over the past four decades, states enacted hundreds of laws requiring insurers to cover specific treatments. However, health plans have violated these mandates dozens of times in recent years.
- **Denials Can Be Deadly:** In some cases, denials delayed or prevented access to lifesaving care. The story of Forrest VanPatten, denied FDA-approved cancer medication, exemplifies this tragic consequence.
- **Under-Resourced Regulators:** State insurance departments responsible for enforcing mandates are often understaffed and overwhelmed, prioritizing insurer solvency over consumer protection.
- **Limited Consumer Action:** Many patients remain unaware of their rights or lack the energy to fight denials during critical health moments. A single complaint can expose systemic issues, as shown in the Maine childbirth case.
- **Insufficient Penalties:** Even when violations are found, penalties are minimal compared to insurer profits, making enforcement less effective.

- **Self-Funded Plans: A Major Escape Route:** Employers increasingly use self-funded plans, exempt from state mandates, limiting coverage options for some employees. This case is highlighted by Sayeh Peterson's denied genetic testing.
- **Legislators Struggle to Keep Up:** Even with existing mandates, insurers find ways to limit coverage. California, for instance, has passed multiple laws regarding infertility treatments due to ongoing insurer resistance.

The Result: A Frustrating Maze for Patients

Patients like Samantha Slabyk, who battled her insurer for emergency appendectomy coverage, illustrate the immense burden individuals face navigating the complex system.

Efforts to Improve Enforcement

- **Proactive Review of Insurance Filings:** Some states, like Vermont, are exploring proactive measures to identify potential mandate violations before denials occur.
- **Legislative Fixes:** Lawmakers, frustrated by insurer tactics, may introduce new legislation to clarify mandates and close loopholes.

The Road Ahead

The article concludes with the ongoing struggle between states and insurers. While some states experiment with improved enforcement, patients continue to face denials and financial hardship due to inadequate coverage and a system tilted in favor of insurance companies.

15. **Western Mass News**

March 16, 2024

Residents and employees participate in 'standout protest' to keep Mary Lane Hospital open

By Addie Patterson, Photojournalist: Anthony Garuti and Tyler Beraldi

Over in Ware, Mary Lane Hospital staff and local residents are speaking up and standing out to keep a health care center in Veterans Park.

It all comes as the town's historical commission temporarily blocked demolition on those hospital buildings.

Western Mass News spoke with residents at Saturday's event.

People attending Saturday's standout said that a hospital is desperately needed in that area.

Participant Cynthia Allen told us, "We need to know what's going there first before you start demolishing everything."

Ware residents and former staff of Mary Lane hospital stood out on Saturday to save a hospital their community needs.

Back in 2021, Baystate Health announced that they were phasing out the outpatient center and relocating most of its services miles away to Baystate Wing Hospital in Palmer.

A change that residents told us, could impact the outcome of an emergency health situation.

Participant Stephen Granlund emphasized, "Extra time counts, it's critically important for the patient who's in transit particularly if it's a stroke, a heart attack, a baby who's choking, so it's longer to get there."

The Ware Historical Commission temporarily blocked demolition of the hospital's buildings.

Mary Lane has a long history in the Ware community, dating back to the early 1900′s.

	It started when Lewis Gilbert gave his land and $400,000 to establish a much-needed hospital in the area. A trust was then established, to ensure that the land was permanently used as a hospital with the name “Mary Lane.” Those funds were also intended to support the hospital, and the residents of Ware and Gilbertville. Grandlund told us that he feels like Baystate Health hasn’t been fully transparent with the community. Granlund explained, “Three years ago, they said there’s plenty of staff, plenty of space at Baystate Wing and that is not the truth whatsoever. Enormous backups there. There are delays are emergency departments all across the state, all across the nation but it was made significantly worse. The people here became victims of Baystate Health’s management at that time.” Cynthia Allen added that the hospital closure has left that original trust money in limbo over at Baystate Health, saying, “What we want is that money to come back to the community. We are the beneficiaries of that money and of the hospital and of the land. We need to have that money come back here so that way, we can have some type of healthcare hospital on that land.” It’s more than just money, though. Local resident Steven Hawk said that the hospital is linked to personal memories, recalling, “I suffered a spinal cord injury and thanks to Mary Lane hospital, they saved my life. Had the hospital not been there, I wouldn’t be alive today.” We did reach out to Baystate Health for a statement about the Mary Lane hospital standout on Saturday. They told us: is committed to serving the health needs of its communities. We continue to work with the town of Ware and the Ware Historical Commission on a collaborative transition plan for the site and are currently complying with the historical commission’s demolition delay.” Participants at Saturday’s standout said that demolition should be a last resort, and hope that Baystate will save Mary Lane.
Disability Topics	**16. WGBH News** March 1, 2024 (updated) *Their disabled loved ones languished in state institutions. Now, they want the records.* By Jennifer Moore The Fernald School was the first public institution of its kind in the United States and closed in 2014. Many relatives of people who lived there are now trying to learn more about what happened to their loved ones, but the state says privacy laws prevent them from releasing the records. Laura Zigman is one such relative. Her sister Sheryl lived at the Fernald School in the 1960s and died at the age of seven. Zigman went to the State Archives to try to find Sheryl's records, but was only given a very limited amount of information. David Scott is another relative who is trying to learn more about a family member who lived at the Fernald School. His brother John lived there in the 1950s and died at the age of 17. Scott says he has been told by a teacher that John was abused while at the school. Scott has been trying to get John's records from the state but has been told that he needs a court order. He is planning to hire a lawyer to help him get the records. Secretary of the Commonwealth William Francis

	Galvin says that he would like to release the records to families, but that the public records law prevents him from doing so. The law exempts medical records from public disclosure. Galvin says that he believes the law is unnecessary and that the records should be public. He supports a bill that is currently before the state legislature that would open up state records after they have aged 75 years. State Senator Michael Barrett, who sponsored the bill, says that he believes it is important to be able to learn about the history of the Fernald School and the people who lived there. The bill is currently stalled in the legislature, but Barrett says that he is hopeful that it will eventually be passed. Even if the bill is passed, it would not help Scott and Zigman, whose relatives entered the institution within the past 75 years. Scott says that he is determined to keep trying to learn the truth about his brother.
Veterans	**17. *Boston Globe** March 18, 2024 *Ending veteran homelessness is achievable* By The Editorial Board *Pairing housing with support services is the key to success.* This editorial discusses Governor Healey's plan to achieve "functional zero" veteran homelessness in Massachusetts by 2027. Here are the key points: • **The Goal:** Healey aims to find stable housing for all homeless veterans, including those unsheltered and in temporary housing. This aligns with the national concept of "functional zero," where homelessness is rare and brief. • **Challenges:** Despite existing resources, several issues hinder progress: o Lack of urgency in utilizing allocated funds. o Difficulty for veteran-focused organizations to compete for resources. o Veterans' unawareness of available benefits. o Insufficient rental assistance for veterans. o Challenges for veterans with non-honorable discharges. • **Healey's Plan:** The plan includes: o **Housing Development:** Half the allocated funds will target veteran-specific housing with supportive services like mental health treatment and job training. Partnering with veteran organizations with expertise in housing and support is a key strategy. o **Outreach and Case Management:** Contracting with organizations to connect with homeless veterans, help them navigate housing options, access benefits, and get support services. o **Improved Coordination:** Enhancing collaboration between federal, state, and local entities to streamline resource utilization. • **Reasons for Focusing on Veterans:** o Dedicated resources exist for veterans. o Massachusetts is underutilizing available federal veteran housing vouchers. • **Success Stories:** Cities like Boston have achieved functional zero for veteran homelessness, demonstrating its feasibility.

	• **The Road Ahead:** Challenges remain, but with focused efforts, Massachusetts can join states like Virginia and Delaware in ending veteran homelessness. This plan offers a promising approach, but successful implementation hinges on efficient resource allocation, collaboration, and addressing the specific needs of veterans.
Incarcerated Persons	**18. The New Republic** March 13, 2024 *Climate Change Is Turning Prisons Into Death Traps* By Steve Brooks and Juan Moreno Haines This article highlights the dangerous living conditions faced by incarcerated people in California prisons due to overcrowding, lack of emergency preparedness, and inadequate infrastructure as documented in "The Hidden Hazards Report", produced by the Ella Baker Center for Human Rights and the University of California, Los Angeles. **Key Points:** • **Overcrowding and Poor Conditions:** o Prisons lack proper ventilation, have black mold, leaky roofs, and extreme temperatures during summers. o Overcrowding exacerbates these problems and the spread of diseases. • **Life-Threatening Emergencies:** o A survey revealed that 18 prisons with nearly 46,000 incarcerated people are at risk from wildfires, extreme temperatures, and flooding. o The state's emergency plans lack procedures to address these threats specifically for prisons. o Past incidents like the 2020 Covid-19 outbreak at San Quentin highlight the deadly consequences of unpreparedness. • **Unprepared Responses:** o During emergencies, incarcerated people are typically locked in their cells, increasing their vulnerability. o Prison officials provide minimal information to lawmakers about emergency preparedness. o There's a lack of accountability for past failures to address these issues. **Recommendations:** • **Reduce Incarcerated Population:** The survey suggests halving the population but acknowledges the public resistance to such a large-scale release. • **Improved Emergency Plans:** o Recognize incarcerated people as a vulnerable population in the state's emergency plan. o Establish minimum standards for prison emergency plans with biannual reports. o Track climate hazards at each prison. • **Increased Funding:** Invest in upgrades like proper ventilation, air conditioning, heating, shade structures, and backup generators. The article argues that these improvements are necessary to ensure the safety and well-being of incarcerated people. It emphasizes the responsibility of prison officials and lawmakers to take proactive measures in the face of climate threats and potential emergencies.

	19. NPR – Morning Edition March 11, 2024 *The U.S. prison population is rapidly graying. Prisons aren't built for what's coming* By Meg Anderson This is a compelling NPR segment that sheds light on the aging population in U.S. prisons, largely due to mass incarceration and tough-on-crime policies, such as the 1994 crime bill. This legislation and others, such as mandatory minimums and "three strikes" laws, have significantly contributed to a demographic shift, keeping many incarcerated for decades. This situation has not only exposed the dire unmet healthcare needs of older inmates, but also underscored the scarcity of geriatric or compassionate release options. The proportion of state and federal prisoners who are 55 or older is about five times what it was three decades ago. In 2022, that was more than 186,000 people. There is an urgent need for criminal justice reform to address the consequences of these policies, both on the individuals affected and the prison system struggling to accommodate an aging inmate population.
From Our Colleagues from around the Country	**20. Tallgrass Economics** March 17, 2024 *How the Health Insurance Industry is Using Disinformation to Take Over and Defraud Medicare* By Dave Kinsley **Corporate Greed in the Post-Truth Age** Most Americans have never heard of the Better Medicare Alliance[1] – a Washington, D.C. think tank and front group for big health insurers such as UnitedHealth, Aetna, and Humana. Also, the 2023 Super Bowl TV audience didn't know who paid for a commercial at halftime claiming that President Biden had plans to "cut Medicare." The ad included a message urging viewers to call the White House and "tell President Biden not to cut Medicare,"[2] but they – the TV viewers – didn't know who was asking them to do it. Football fans had to be perplexed. Medicare beneficiaries were most likely upset and worried by what they saw and heard. The ad, funded by Better Medicare Alliance, was a lie. The truth is that President Biden had no intention and no plan to cut Medicare. Contrary to what the ad claimed, he was planning to claw back $4.7 billion from UnitedHealth and other insurers for defrauding the program through false billing practices. One illegal practice health insurers utilize to add unearned value to their Medicare Advantage (MA) reimbursement is called "upcoding." Because sicker patients are reimbursed at a higher rate, the trick is to find ways to lie about how sick a patient is – to make them look sicker than they are.[3] MA beneficiaries tend to be healthier than Traditional Medicare (TM) beneficiaries. Nevertheless, research indicates that when individuals move from TM to MA, their costs to the program increase. The important point is that "total Medicare payments to MA plans in 2024 (including rebates that finance extra benefits) are projected to be $83 billion higher than if MA enrollees were enrolled in FFS Medicare." Furthermore, payments to MA plans average an estimated 122 percent of what Medicare would have expected to spend on MA enrollees if they were in FFS Medicare."[4]

After the Biden Administration's proposal to recoup stolen money from MA insurers and prevent further fraud, the health insurance industry threw a conniption fit and went into overdrive. The Super Bowl ad was only one tactic (costing eight figures, it was super expensive). In addition, they sent their army of lobbyists crawling all over the Washington, D.C. beltway threatening and bribing legislators. HHS backed down. The cheating continues and costs the seniors of America – indeed all wage earners – hundreds of billions from their payroll deductions, premiums, co-pays, and nearly $200 out of every Social Security check.

Pulling Back the Curtain on the Washington D.C. Policy Planning Network: What is the Better Medicare Alliance & Who is Behind It?

The insidious thing about think tanks set up inside the Washington, D.C. beltway is that they enlist the aid of seemingly legitimate advocates and scholars. It is hard to know if the advocates and scholars are merely naïve or whether they are self-serving. Perhaps unwitting would be a kinder word. For instance, the Better Medicare Alliance board consists of Dennis Borel, Executive Director of Texans with Disabilities, Caroline Coats, **Humana, Inc**., Daniel Dawes, Meharry Medical College, Mary Beth Dawes, Former Congresswoman (President & CEO), Joneigh Kaldhun, **CVS Health**, Dan Lowenstein, Visiting Nurse Service, NY, Richard Migliori, **UnitedHealth**, Elena Rios, National Hispanic Medical Association, and Kenneth Thorpe, Emory University.

The organizational structure of these industry front groups is a form of disinformation itself. On the board are big players in the MA industry – Humana, CVS, and UnitedHealth. Interspersed with the representatives of these health insurance behemoths are executives and professionals from organizations with an ostensible mission to improve society in some manner.

By placing their imprimatur on an industry lobbying group, NGOs, nonprofits with a stated humanitarian cause, and universities are participating in a duplicitous tactic to confuse the public about the real purpose of nefarious industry think tanks like Better Medicare Alliance. Their support for various entities with a mission to preserve and strengthen the medical-industrial complex helps divert funds needed for care into the coffers of executives and shareholders.

Privatizing Medicare was Supposed to Reduce Costs and Give Beneficiaries More Choice: It Hasn't Worked Out that Way.

MA is a creature of the Medicare Modernization Act of 2003. The right-wing of American politics accomplished a coup by setting Medicare on the road to privatization. Currently over 50% of all beneficiaries have selected it over Traditional Medicare ™. Federal policy is unfortunately driving Seniors into MA by allowing manipulative practices such as low premiums and a few benefits not available to TA beneficiaries. Seniors are being led like lemmings into the arms of the insurance industry by disinformation and deceit. Organizations like the AARP in partnership with health insurers like UnitedHealth are the Pied Pipers.

MA is one of the most serious threats to the health and well-being of American seniors. It robs money from care and transfers it into the pockets of investors and executives. Many beneficiaries are happy with low premiums and add-ons not available under traditional Medicare such as Silver Sneakers plus some dental and vision care. I can understand

why many people who have it are pleased with their coverage. It works for healthier beneficiaries until it doesn't.

If MA beneficiaries should incur a costly service that is not in network, their assets could be wiped out. Some retirees have no choice in the matter. If their company or institution includes health insurance as a retirement benefit, it is most likely MA. Furthermore, I can't blame anyone who is trying to avoid the premiums for supplemental coverage under traditional Medicare. Avoiding bankruptcy and depletion of assets through a catastrophic sickness makes perfect sense for TA beneficiaries. But the supplemental insurance is a heavy burden that could be avoided if the Medicare program weren't diverting so much funding to MA (see discussion below).

Seniors and People with Disabilities Would not be Struggling as Much If Big Health Insurance were not Stealing from Them.

For seniors and disabled Americans to lose nearly $200 per month of their Social Security and choose between a large payout for supplemental or the risk of bankruptcy, is an injustice when privatized healthcare is stealing hundreds of billions of Americans' tax dollars, payroll deductions, and hard-earned money through out-of-pocket expenses. The Physicians for a National Health Program (PNHP) has estimated that MA overcharged taxpayers by a minimum of 22% or $88 billion and potentially up to 35% for a total of $131 billion in 2022. If the high end of the estimate were correct, all of Part B premiums ($131 billion in 2022) or Part D premiums ($126 billion in 2022) could be covered by excessive corporate extraction of funds from Medicare.[5]

UnitedHealth is noting $25 billion in cash and cash equivalents on its 2023 balance sheet, CVS has noted $12 billion, and Humana is noting $5 billion. They have multiples of these amounts in long-term and short-term investments; they spend hundreds of billions on stock buybacks, dividends, and board and executive compensation. By digging into their assets, the cash rich health insurance business would be able to charge fair prices and stop their criminal behavior without much of a dent in a reasonable return on their investments.

In this Dark Age of Plutocracy, the Superrich & Corporations are Lying and Blaming Government & Ordinary Americans for Poor Healthcare and Excess Expenditures

Americans earning wages and salaries are being subjected to a corporate network of disinformation and gaslighting. President Biden is blamed for cutting Medicare when he is in fact attempting to protect the program. The growing elderly population is blamed for federal debt and deficits when Medicare and Social Security have little impact on the federal budget (SS has none and over half of MC is paid through payroll deductions, premiums, and co-pays). The nursing home industry blames taxpayers for failing to provide them with enough money to adequately care for the elderly and disabled patients in their beds while they spin a false hardship narrative.

The Medical-Industrial Complex has established a network of front groups with a duplicitous message of doing good for Americans and has enlisted the aid of do-gooder nonprofits, universities, and individuals. This system and its apparatchiks aren't all that clever. Their organizational tactics are rather easy to discern. The problem is that it is happening stealthily behind the scenes in Washington, D.C. and the 50 state capitals.

	The media is ignoring it. We intend to expose it and encourage everyone we can to join us in that endeavor. [1] https://bettermedicarealliance.org/ [2] You can see the ad here: https://www.ispot.tv/ad/2UHG/better-medicare-alliance-cutting-medicare-thats-nuts. [3] Reed Abelson & Margot Sanger-Katz (2023), "Biden Plan to Cut Billions in Medicaid Fraud Ignites Lobbying Frenzy," https://w.w.w.nytimes.com/2023/03/22/health/medicare-insurance-fraud.html?searchResultPosition=1. [4] Medicare Payment Advisory Commission (MDPAC), 2024, p. March 2024 Report to the Congress: Medicare Payment Policy – MedPAC [5] Physicians for a National Health Program, (2023), *Our Payments their Profits: Quantifying Overpayments in the Medicare Advantage Program*. MA Overpayment Report (pnhp.org)
Dignity Alliance Massachusetts Legislative Endorsements	Information about the legislative bills which have been endorsed by Dignity Alliance Massachusetts, including the text of the bills, can be viewed at: https://tinyurl.com/DignityLegislativeEndorsements Questions or comments can be directed to Legislative Work Group Chair Richard (Dick) Moore at rmoore8473@charter.net.
Websites	
Blogs	
Previously recommended websites	The comprehensive list of recommended websites has migrated to the Dignity Alliance MA website: https://dignityalliancema.org/resources/. Only new recommendations will be listed in *The Dignity Digest.*
Previously posted funding opportunities	For open funding opportunities previously posted in *The Tuesday Digest* please see https://dignityalliancema.org/funding-opportunities/.
Websites of Dignity Alliance Massachusetts Members	See: https://dignityalliancema.org/about/organizations/
Contact information for reporting complaints and concerns	**Nursing home** Department of Public Health 1. Print and complete the Consumer/Resident/Patient Complaint Form 2. Fax completed form to (617) 753-8165 Or Mail to 67 Forest Street, Marlborough, MA 01752 Ombudsman Program
Nursing Home Closures (pending)	**Massachusetts Department of Public Health** *Benjamin Healthcare Center, Roxbury* Closure date: July 1, 2024 • Notice of Intent to Close (PDF) | (DOCX) • Draft of Closure and Relocation Plan (PDF) | (DOCX) *Bridgewater Nursing & Rehab, Bridgewater* Closure date: May 24, 2024 • Notice of Intent to Close (PDF) | (DOCX) • Draft of Closure and Relocation Plan (PDF) | (DOCX) *Savoy Nursing and Rehabilitation Center,* New Bedford Closure date: April 3, 2024

	• Notice of Intent to Close and Draft Closure and Relocation Plan (PDF)	(DOCX) *New England Sinai Hospital Transitional Care Unit* Closure date: April 2, 2024 • *Notice of Intent to Close (PDF)*	*(DOCX)* • *Draft of Closure and Relocation Plan (PDF)*	*(DOCX)* For more information about each individual facility, please use the Massachusetts Nursing Home Survey Performance Tool and the CMS Nursing Home Compare website.
Nursing Home Closures	**Massachusetts Department of Public Health** *South Dennis Health Care*, Dennis Closure date: January 30, 2024 *Arnold House Nursing Home*, Stoneham Closure date: September 22, 2023 *Willimansett East,* Chicopee Closure date: June 6, 2023 *Willimansett West,* Chicopee Closure date: June 6, 2023 Chapin Center Springfield Closure date: June 6, 2023 *Governors Center*, Westfield Closure date: June 6, 2023 *Stonehedge Rehabilitation and Skilled Care Center*, West Roxbury Closure February 10, 2022 *Heathwood Healthcare*, Newton Closure date: January 5, 2022 *Mt. Ida Rest Home*, Newton Closure date: December 31, 2021 *Wingate at Chestnut Hill,* Newton, MA Closure date: October 1, 2021 *Halcyon House*, Methuen Closure date: July 16, 2021 *Agawam HealthCare*, Agawam Closure date: July 27, 2021 *Wareham HealthCare*, Wareham Closure date: July 28, 2021 *Town & Country Health Care Center*, Lowell Closure date: July 31, 2021
Nursing homes with admission freezes	**Massachusetts Department of Public Health** *Temporary admissions freeze* There have been no new postings on the DPH website since May 10, 2023.
Massachusetts Department of Public Health Determination of Need Projects	**Massachusetts Department of Public Health** ***Determination of Need Projects: Long Term Care*** **2023** **Navigator Homes of Martha's Vineyard, Inc. – Long Term Care Substantial Capital Expenditure** **Royal Wayland Nursing Home, LLC – Conservation Long Term Care Project** **2022**

	Ascentria Care Alliance – Laurel Ridge **Ascentria Care Alliance – Lutheran Housing** **Ascentria Care Alliance – Quaboag** **Berkshire Healthcare Systems, Inc. – Windsor Long Term Care Conservation** **Fairlawn Rehabilitation Hospital-Hospital/Clinic Substantial Capital Expenditure** **Long Term Centers of Lexington – Pine Knoll – Long Term Care Conservation** **Long Term Centers of Wrentham – Serenity Hill – Long Term Care Conservation** **Next Step Healthcare LLC-Conservation Long Term Care Project** **Royal Falmouth – Conservation Long Term Care** **Royal Norwell – Long Term Care Conservation** **Wellman Healthcare Group, Inc** **2020** **Advocate Healthcare, LLC Amendment** **Campion Health & Wellness, Inc. – LTC - Substantial Change in Service** **Heywood Healthcare, Inc. – Hospital/Clinic Substantial Capital Expenditure** **Notre Dame Health Care Center, Inc. – LTC Conservation** **2020** **Advocate Healthcare of East Boston, LLC.** **Belmont Manor Nursing Home, Inc.**
List of Special Focus Facilities	**Centers for Medicare and Medicaid Services** *List of Special Focus Facilities and Candidates* https://tinyurl.com/SpeciialFocusFacilityProgram Updated March 29, 2023 CMS has published a new list of Special Focus Facilities (SFF). SFFs are nursing homes with serious quality issues based on a calculation of deficiencies cited during inspections and the scope and severity level of those citations. CMS publicly discloses the names of the facilities chosen to participate in this program and candidate nursing homes. To be considered for the SFF program, a facility must have a history (at least 3 years) of serious quality issues. These nursing facilities generally have more deficiencies than the average facility, and more serious problems such as harm or injury to residents. Special Focus Facilities have more frequent surveys and are subject to progressive enforcement until it either graduates from the program or is terminated from Medicare and/or Medicaid. This is important information for consumers – particularly as they consider a nursing home. **What can advocates do with this information?** • Include the list of facilities in your area/state when providing information to consumers who are looking for a nursing home. Include an explanation of the SFF program and the candidate list. • Post the list on your program's/organization's website (along with the explanation noted above). • Encourage current residents and families to check the list to see if their facility is included. • Urge residents and families in a candidate facility to ask the administrator what is being done to improve care.

- Suggest that resident and family councils invite the administrator to a council meeting to talk about what the facility is doing to improve care, ask for ongoing updates, and share any council concerns.
- For long-term care ombudsmen representatives: Meet with the administrator to discuss what the facility is doing to address problems and share any resources that might be helpful.

Massachusetts facilities listed (updated March 29, 2023)
Newly added to the listing

- Somerset Ridge Center, Somerset
  https://somersetridgerehab.com/
  Nursing home inspect information:
  https://projects.propublica.org/nursing-homes/homes/h-225747
- South Dennis Healthcare
  https://www.nextstephc.com/southdennis
  Nursing home inspect information:
  https://projects.propublica.org/nursing-homes/homes/h-225320

Massachusetts facilities not improved

- None

Massachusetts facilities which showed improvement

- Marlborough Hills Rehabilitation and Health Care Center, Marlborough
  https://tinyurl.com/MarlboroughHills
  Nursing home inspect information:
  https://projects.propublica.org/nursing-homes/homes/h-225063

Massachusetts facilities which have graduated from the program

- The Oxford Rehabilitation & Health Care Center, Haverhill
  https://theoxfordrehabhealth.com/
  Nursing home inspect information:
  https://projects.propublica.org/nursing-homes/homes/h-225218
- Worcester Rehabilitation and Health Care Center, Worcester
  https://worcesterrehabcare.com/
  Nursing home inspect information:
  https://projects.propublica.org/nursing-homes/homes/h-225199

Massachusetts facilities that are candidates for listing (months on list)

- Charwell House Health and Rehabilitation, Norwood (15)
  https://tinyurl.com/Charwell
  Nursing home inspect information:
  https://projects.propublica.org/nursing-homes/homes/h-225208
- Glen Ridge Nursing Care Center (1)
  https://www.genesishcc.com/glenridge
  Nursing home inspect information:
  https://projects.propublica.org/nursing-homes/homes/h-225523
- Hathaway Manor Extended Care (1)
  https://hathawaymanor.org/
  Nursing home inspect information:
  https://projects.propublica.org/nursing-homes/homes/h-225366
- Medway Country Manor Skilled Nursing and Rehabilitation, Medway (1)
  https://www.medwaymanor.com/
  Nursing home inspect information:
  https://projects.propublica.org/nursing-homes/homes/h-225412
- Mill Town Health and Rehabilitation, Amesbury (14)
  No website

	Nursing home inspect information: https://projects.propublica.org/nursing-homes/homes/h-225318 • Plymouth Rehabilitation and Health Care Center (10) https://plymouthrehab.com/ Nursing home inspect information: https://projects.propublica.org/nursing-homes/homes/h-225207 • Tremont Health Care Center, Wareham (10) https://thetremontrehabcare.com/ Nursing home inspect information: https://projects.propublica.org/nursing-homes/homes/h-225488 • Vantage at Wilbraham (5) No website Nursing home inspect information: https://projects.propublica.org/nursing-homes/homes/h-225295 • Vantage at South Hadley (12) No website Nursing home inspect information: https://projects.propublica.org/nursing-homes/homes/h-225757 https://tinyurl.com/SpeciialFocusFacilityProgram
Nursing Home Inspect	**ProPublica** ***Nursing Home Inspect*** Data updated November 2022 This app uses data from the U.S. Centers for Medicare and Medicaid Services. Fines are listed for the past three years if a home has made partial or full payment (fines under appeal are not included). Information on deficiencies comes from a home's last three inspection cycles, or roughly three years in total. The number of COVID-19 cases is since May 8, 2020, when homes were required to begin reporting this information to the federal government (some homes may have included data on earlier cases). Massachusetts listing: https://projects.propublica.org/nursing-homes/state/MA **Deficiencies By Severity in Massachusetts** (What do the severity ratings mean?) # reported Deficiency Tag 250 **B** 82 **C** 7,056 **D** 1,850 **E** 546 **F** 487 **G** 31 **H** 1 I 40 **J** 7 **K** 2 L
Nursing Home Compare	**Centers for Medicare and Medicaid Services (CMS)** *Nursing Home Compare Website* Beginning January 26, 2022, the Centers for Medicare and Medicaid Services (CMS) is posting new information that will help consumers have a better understanding of certain staffing information and concerns at facilities.

	This information will be posted for each facility and includes: • **Staff turnover:** The percentage of nursing staff as well as the number of administrators who have stopped working at a nursing home over the past 12-month period. • **Weekend staff**: The level of weekend staffing for nurses and registered nurses at a nursing home over a three-month period. Posting this information was required as part of the Affordable Care Act, which was passed in 2010. In many facilities, staffing is lower on weekends, often meaning residents have to wait longer or may not receive all the care they need. High turnover means that staff are less likely to know the residents, recognize changes in condition, or implement preferred methods of providing care. All of this contributes to the quality-of-care residents receive and their quality of life. https://tinyurl.com/NursingHomeCompareWebsite
Data on Ownership of Nursing Homes	**Centers for Medicare and Medicaid Services** *Data on Ownership of Nursing Homes* CMS has released data giving state licensing officials, state and federal law enforcement, researchers, and the public an enhanced ability to identify common owners of nursing homes across nursing home locations. This information can be linked to other data sources to identify the performance of facilities under common ownership, such as owners affiliated with multiple nursing homes with a record of poor performance. The data is available on nursing home ownership will be posted to data.cms.gov and updated monthly.
Long-Term Care Facilities Specific COVID-19 Data	**Massachusetts Department of Public Health** *Long-Term Care Facilities Specific COVID-19 Data* *Coronavirus Disease 2019 (COVID-19) reports related to long-term care facilities in Massachusetts.* **Table of Contents** • COVID-19 Daily Dashboard • COVID-19 Weekly Public Health Report • Additional COVID-19 Data • CMS COVID-19 Nursing Home Data
DignityMA Call Action	• The MA Senate released a report in response to COVID-19. **Download the DignityMA Response to Reimagining the Future of MA**. • **Advocate** for state bills that advance the Dignity Alliance Massachusetts' Mission and Goals **–** **State Legislative Endorsements**. • **Support** relevant bills in Washington **–** **Federal Legislative Endorsements**. • **Join** our **Work Groups**. • **Learn** to use and leverage social media at our workshops: **Engaging Everyone: Creating Accessible, Powerful Social Media Content**
Access to Dignity Alliance social media	Email: info@DignityAllianceMA.org Facebook: https://www.facebook.com/DignityAllianceMA/ Instagram: https://www.instagram.com/dignityalliance/ LinkedIn: https://www.linkedin.com/company/dignity-alliance-massachusetts Twitter: https://twitter.com/dignity_ma?s=21 Website: www.DignityAllianceMA.org

Participation opportunities with	**Workgroup**	**Workgroup lead**	**Email**
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	Behavioral Health	Frank Baskin	baskinfrank19@gmail.com

<table>
<tr><td rowspan="12">Dignity Alliance Massachusetts

Most workgroups meet bi-weekly via Zoom.

Interest Groups meet periodically (monthly, bi-monthly, or quarterly).

Please contact group lead for more information.</td><td>Communications</td><td>Lachlan Forrow</td><td>lforrow@bidmc.harvard.edu</td></tr>
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<tr><td>The Dignity Digest</td><td colspan="3">For a free weekly subscription to The Dignity Digest:
https://dignityalliancema.org/contact/sign-up-for-emails/
Editor: Paul Lanzikos
Primary contributor: Sandy Novack
MailChimp Specialist: Sue Rorke</td></tr>
<tr><td>Note of thanks</td><td colspan="3">Thanks to the contributors to this issue of The Dignity Digest
Wynn Gerhard
Suzanne Lanzikos
Dick Moore
Julian Rich
Norma Swenson
Betty Tegel
Special thanks to the MetroWest Center for Independent Living for assistance with the website and MailChimp versions of The Dignity Digest.
If you have submissions for inclusion in The Dignity Digest or have questions or comments, please submit them to Digest@DignityAllianceMA.org.</td></tr>
<tr><td colspan="4">Dignity Alliance Massachusetts is a broad-based coalition of organizations and individuals pursuing fundamental changes in the provision of long-term services, support, and care for older adults and persons with disabilities.
Our guiding principle is the assurance of dignity for those receiving the services as well as for those providing them.
The information presented in “The Dignity Digest” is obtained from publicly available sources and does not necessarily represent positions held by Dignity Alliance Massachusetts.
Previous issues of The Tuesday Digest and The Dignity Digest are available at:
https://dignityalliancema.org/dignity-digest/
For more information about Dignity Alliance Massachusetts, please visit www.DignityAllianceMA.org.</td></tr>
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