The Dignity Digest

Issue # 201 August 20, 2024

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

	***May require registration before accessing the 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

Donna Cooper is a retired internist with a master's degree from the Harvard School of Public Health. She worked at Outer Cape Health Services and Mass. General Hospital and lives in Provincetown.

A Profit-Driven Health-Care System Is the Problem

The Provincetown Independent

By Donna Cooper M.D.

August 24, 2024

Why not find a way to pay frontline workers more?

I had just returned from a visit with my sister, who has lived at the Seashore Point Wellness Center in Provincetown since 2018, when I saw the *Independent*'s July 25 front-page story "Patients Suffer at Outer Cape's Only Nursing Home." I read it and the subsequent articles with great interest.

I have been very pleased with the care my sister has received over the past six years. With very few exceptions, I have found the staff pleasant, helpful, and understanding. My sister is clean and has no bedsores, which is remarkable for a wheelchair-bound, incontinent person. She is dressed most days (except when she doesn't want to get up), her hair is shampooed and braided regularly by certified nurse aides, and she is fed on schedule and toileted as needed. The CNAs do a terrific job of caring for her.

Still, I have noticed a negative change since Point Group Care took over from Deaconess in 2019. Staffing is variable. I used to know who the administrator, social worker, and nursing supervisor were, but now it is not as easy. Maintenance is poor: light fixtures, heating units, and window blinds are broken. I haven't seen any walls painted or rugs shampooed in years. I have wiped down my sister's wheelchair many times, whereas they used to be power-washed on a regular schedule.

It is difficult for all nursing homes in Massachusetts to find CNAs and nurses to cover every shift. How does a $45,990 penalty imposed on Seashore Point by

	MassHealth help the nursing home find sufficient staffing? Where does the $4 million settlement reached by Attorney General Campbell with Next Step Healthcare go? Why not create a CNA fund and give hefty bonuses (or increase their hourly pay) to those who fill open slots? Find a way to pay more to the frontline workers who change diapers, give showers, and spoon-feed our elderly residents. The issue of potential fraud raised by Christopher Cherney and Ernest Tosh reminds me of the Steward Health Care crisis. "Management" companies, real estate brokers, and marketing outfits that are often just arms of the parent company simply siphon money from patient care into investors' pockets. Nursing homes focus on the custodial care of people who can no longer live on their own. Why would they take on sicker, more complex patients who need short-term rehabilitation? It's the money. By billing Medicare and private insurers for rehab services (physical, speech, and occupational therapy), they can make up the shortfall created by the meager MassHealth custodial care payments. But just because you are good at custodial care doesn't mean you'll be good at rehab. **Dignity Alliance Massachusetts** is right to push for better outpatient rehab and home care, as the *Independent* reported last week. Seashore Point proudly states it is in compliance with federal and state regulations. And that is the problem. The companies that control hospitals, physician groups, nursing homes, medical suppliers, and rehabilitation services focus on producing high profits. They are not part of a unified system of health care and health-care reimbursement. They simply prey on the most vulnerable of our citizens. While you may rail against "socialized medicine," until the U.S. moves away from a profit-motivated health-care model to a system that sees health care as a right, these issues will persist. Baby boomers will not be happy as they enter the golden years. ***Seashore Point Residents Sue Owner, Claiming Fraud and Abuse***

The Provincetown Independent
By Olivia Oldham
October 26, 2024 (updated)

Pointe Group Care is accused of exploiting residents and charging unreasonable fees

When Robert Compton purchased his condominium at the Residences at Seashore Point four years ago, he imagined an ideal retirement. Seashore Point offers "independent living;" residents attend events together, eat together, and make decisions as a community. Compton, now 74, sold his house on Bayberry Avenue with the expectation that, at Seashore Point, "somebody else is going to cut the grass and water the lawn and make sure that the heat's working."

But for the last two years, he's been locked in a conflict with Pointe Group Care, the for-profit owner of Seashore Point, about what services it provides residents and at what cost. In 2019, the group and its subsidiary, Provincetown Holding Company, purchased the property, along with the attached nursing facility, AdviniaCare at Seashore Point, from the nonprofit Deaconess Abundant Life.

Compton says the free parking residents were promised now costs $275 a month, and condo fees have jumped from $250 to $600 a month. Elderly residents on fixed incomes, he says, did not plan for these higher costs and cannot afford them.

Five residents at Seashore Point filed suit on April 6 in Superior Court, accusing Point Group Care of "unchecked elder abuse, fraud, and manipulation." Compton is the lead plaintiff; the others are Robert MacDonald, Robert Hanna, Michael Peregon, and Walter Winnowski.

The suit argues that Pointe Group Care manipulated the value of its ownership of units at Seashore Point to fraudulently claim a majority of seats on the condo's governing board and thus control the board's decisions. The suit also alleges that fees at Seashore Point have grown substantially in the last year even as Point Group has cut services. Compton says the fees subsidize the attached nursing home, which lost $1,129,040 in 2020, according to the company's tax filings. The plaintiffs

claim residents are paying 96 percent of the condominium's $1.4 million budget for 2023 though Pointe Group Care owns roughly 48 percent of the property.

"We have worked very hard to find a resolution to the unit owners' concerns, with no success to date," said David Ball, a spokesman for Provincetown Holding Company. "We are confident that the facts and the law are on our side."

Parking Fees

The conflict began when Pointe Group Care purchased Seashore Point in November 2019 from Deaconess Abundant Life, the nonprofit that had owned the property for 14 years. The change from a nonprofit to a for-profit owner, according to court documents, made the condominium contract untenable.

In early 2020, Pointe Group took control of the outdoor parking area, according to Compton. Only 35 spots in the lot are available to residents of the 81 condominium living units, the suit alleges. Without free parking in the lot, residents are compelled to pay for parking at the Pointe Group Care-owned parking garage. As of 2023, according to the suit, the garage charges a one-time "license issuance fee" of $5,000 to use the garage plus $275 per month. The plaintiffs claim that cumulative license and parking fees paid by residents for the garage will total about $175,000 in 2023. Pointe Group Care says it anticipates earning $108,900 from monthly garage fees this year.

The case hinges on Pointe Group Care's claim that it owns an inflated percentage of the property, according to the suit. Most of Pointe Group's property consists of "service units," including the nursing home and the garage. Compton says Point Group Care overestimates the value of the service units, which are worth less per square foot than residential units. That enables Pointe Group to claim a larger stake than it really has, he says. According to court documents, Pointe Group also calls several spaces "service units" that are actually communal space. This practice began with Deaconess Abundant Life, which also referred to these communal spaces incorrectly as condominiums, according to the

suit. The suit says these spaces “have no rooms or defined physical boundaries,” the plaintiffs charge, yet Point Group devised a fee based on these “fraudulent” service units, thus charging residents to “walk through hallways and lobbies,” the suit says. According to state law, all owners of the condominium are entitled to own common areas and facilities together in proportion to their total ownership.

The Concierge Fee

The final straw for residents was a “concierge fee,” the suit argues, for security services, monitoring of emergency alert systems, social programs, and some transportation, under a residency and services agreement established in 2015. The fee is mandatory for residents, though its value is not listed in the agreement. The plaintiffs say it is currently $631 per month.

Compton says the fee is foisted on unsuspecting new residents. After purchasing a unit, he says, “You’re all excited. You want to move in, and you want to get the key. And that’s when they say, ‘Oh yeah, well, by the way, you have to sign this service agreement. And you can’t have your key or parking space until you sign.’ ”

According to Compton, Deaconess Abundant Life, the previous owner, had supplied the services said to be covered by the concierge fee in the service agreement. But when Pointe Group Care took control, the services began to dwindle. This was partly because of the pandemic, when social distancing made use of common spaces and community programs nearly impossible. Yet Point Group continued to charge residents a “residency and lifestyle” fee each month.

The plaintiffs claim they now pay for all these services themselves. Compton says that support for social programs is lackluster, with residents putting on all social events themselves — for instance, he runs the movie screenings. He says that Pointe Group Care doesn’t offer additional community services “other than once a week they vacuum.”

In July 2021, Pointe Group approached the residents and offered to sell them its service units in the independent living facility for $1.5 million. The residents couldn’t afford that price, Compton says, because “we’re

all retirees living on Social Security and IRAs." After that, Compton and other residents consulted attorneys Edward Allock and Sean Regan of the Braintree firm Allock & Marcus, and Pointe Group "backed off," Compton says. "Everything was quiet for a year."

Nearly a year and a half later, in November 2022, Pointe Group Care approached the residents again, this time offering to sell its service units for $700,000. A Nov. 17, 2022 letter from Ben Berkowitz, CEO of Pointe Group Care, obtained by the *Independent* informed residents that in 2023 the concierge fee would be increased to "make up for the significant losses over the past several years." Alternatively, Point Group offered to sell 26 service units to residents, claiming "the proposal benefits all parties." Compton says Berkowitz rejected an offer to negotiate an agreement.

In January 2023, Pointe Group Care raised the concierge fee from $250 per month to $600 per month, says Compton. The services agreement says Point Group can raise condo fees and service fees but not the concierge fee, he says.

"We categorically deny these assertions," wrote David Ball, the Provincetown Holding Company spokesman. "Fees for some services, which were held steady during the pandemic, have been increased to account for increased operating costs, just as the cost of gas and groceries has increased due to inflation as well. We have adhered to the complex terms of the agreement we made when we purchased this property."

Most residential unit owners at Seashore Point support the lawsuit, according to Compton. In its response to the suit, Pointe Group Care states that, as of 2023, 24 unit owners are not paying any concierge fees, and 18 are paying the rates from before the increase. In total, 42 owners of the 81 residential units are not paying the new fee, the company says. Compton says that around 53 owners of residential units are contributing financially to the legal fund.

The suit is set to go to trial in August 2026, according to Compton. Ultimately, he says, the residents would like to come to an amicable resolution.

	"Nobody wants to go to court," he says. "Can we just sit down and come up with something reasonable that these retirees can afford?"
Spotlight: **The meaning of *dignity*** ***Reader submissions requested.***	Dignity Alliance Massachusetts recently published the 200th edition of *The Dignity Digest*. To mark this milestone, we ask readers to share their understanding of the concept of "dignity" especially as it applies to older persons, persons with disabilities, family members, and caregivers. Submissions can be in the form of a few sentences, a longer narrative, a poem, or a drawing. Text responses can be submitted via: https://forms.gle/1xr65myyCqGxaAsm6 or as attachment to paul.lanzikos@gmail.com. Artwork can be mailed as an attachment to paul.lanzikos@gmail.com. Submissions will be published in*The Digest* as well as on the DignityMA website, www.DignityAllianceMA.org.
Sandy Alissa Novack is a geriatric social worker. She is the chair of the Nursing Home Committee of the National Association of Social Workers-Massachusetts chapter; Vice President of the Board of Directors of the Disability Policy Consortium; a participant in Dignity Alliance Massachusetts, and a regular contributor to ***The Dignity Digest****.*	**What Is the Meaning of Dignity?** By Sandy Alissa Novack, MBA, MSW Sometimes, you can most appreciate what something is when you are being denied it. For example, when there is conflict, you can more deeply appreciate all that defines peace. So, too, it is with dignity. You inherently have it, but others can be quick to chip it away, as if they want to make you feel invisible, unworthy, always "less than." I note it in health care, including my own health care, and consider it discrimination against people with disabilities as well as discrimination against older adults. One example is from the beginning of the pandemic when I was having a non-covid health emergency and was admitted to the hospital after the Emergency Room thought something very serious was going on. Once admitted, they ruled out the issue they had thought I had, and so I thought I would be immediately discharged home, to follow up with doctors as an outpatient. A nurse, however, came into my room and told me that though they had ruled out the issue for which I was admitted, my medical team thought I should be sent to a nursing home because of my walk. I asked what my walk had to do with what I was in the hospital for. The answer was only to repeat that

	they thought I should be discharged to a nursing home. I tried to point out that I walk my normal walk, and it has nothing to do with why I was admitted. I suggested they call my primary care doctor, who would confirm my normal walk. The nurse thought for a moment, and then asked if I would be willing to walk out in the hallway for her, to show her I can walk. Of course I can walk, I said. And I took my assistive device and walked back and forth from one end of the long hallway to the other, and turned around to do another lap when the nurse told me I could stop. I said that I could keep going. No, she said, I don't need to, that she saw me walking and she will tell the doctors that I can be discharged. Because I am a disabled elder who uses an assistive device, without asking me to ever walk down the hallway at all, they were ready to deprive me of life living in the community because of what they assumed about me. Had I not questioned what their plan was, I would have been sent to a nursing home. No wonder so many older adults and people with disabilities end up in nursing homes. Ableism, ageism and discriminatory medical practices stifle dignity. Another example was when my primary care office advised me to get to the Emergency Room at another point in time. I no sooner walked into the ER than I was pegged as less than others. Before I had been examined, two ER doctors already had told me they would admit me and then have me sent to a nursing home. When I pointed out they hadn't examined me to give me a diagnosis, they told me a diagnosis I already have had for years, but that had no relevance to why I was presenting to the ER. I said I don't need to be sent to a nursing home, I need a diagnosis and plan for treatment. During hours and hours in the ER, they told me at least three more times that they will admit me and send me to a nursing home. I asked again what the diagnosis was and they again would only offer the same irrelevant diagnosis I have had for years that had nothing to do with why I was there. I made it clear I was leaving to go home, and they told me they don't think I should do that. I told them I am a geriatric social

	worker and they need to have a true diagnosis to admit me as a patient and then send me to a nursing home, and they have nothing other than I am an elder who uses assistive devices, and that is not a diagnosis nor a reason to admit me to the hospital nor a nursing home. I got up from the exam table, and after seven hours in the ER out I walked, my true issue unaddressed (though let me assure you, dear readers, I got the issue diagnosed and a plan of treatment begun weeks later when I was able to get seen by a doctor in the community, but I suffered weeks more with the condition that should have been addressed in the ER). Would a person who is not a geriatric social worker, or similarly trained, be able to push back at ageism and ableism? Probably not. That is not dignity, which is discrimination in the medical system, and we need to fight against it. You have the right to have your medical issue taken seriously, you have the right to be examined and given a diagnosis. You have a right to stand up for yourself when your only "crime" is not a crime at all: You are an older adult and have disabilities. You have a right to equal medical care treatment that younger people and people without disabilities expect. As a human being, dignity is inherent. Push back when someone is trying to strip it away from you with medical discrimination.
Quotes	*"It's about time."* Kristin Hatch, a former Seashore Point employee, *Private Equity Doesn't Care*, **The Provincetown Independent,** July 31, 2024 *"While you may rail against 'socialized medicine,' until the U.S. moves away from a profit-motivated health-care model to a system that sees health care as a right, these issues will persist. Baby boomers will not be happy as they enter the golden years."* Donna Cooper, M.D., ***A Profit-Driven Health-Care System Is the Problem*, The Provincetown Independent,** August 14, 2024 *Eight ways to improve emergency room performance:*

- *First, insurers, government leaders, and hospital administrators must immediately develop alternatives.*
- *Second, all aspects of hospital staffing and management decisions must consider their impact on the ED.*
- *Third, space must be configured to separate the immunocompromised from the contagious.*
- *Fourth, offer comfort measures.*
- *Fifth, more staff is needed to monitor safety and cleanliness*
- *Sixth, doctors should have the discretion to directly admit certain patients.*
- *Seventh, executive compensation should be tied to improvements in ED care.*
- *Finally, the all-important U.S. News & World Report's ranking system does a gross disservice to patients by excluding emergency departments from its analysis.*

Lauren Stiller Rikleen, *The hellscape of the emergency department*,
***Boston Globe,** August 19, 2024

Not everybody's teeth get brushed every day. People's nails aren't cut like they used to. Beds aren't being made. Staff has to take shortcuts to get things done because there's less of them to provide all those — all the care that the residents need.
The system is so broken and so short-handed and so difficult to manage with the different combinations of patients that you're not able to provide the care for the people that really need it at the moments they really need it.

Bonnie Gaudraeau, Licensed Practical Nurse, *U.S. nursing homes grapple with staffing shortages and requirements*, **PBS News Weekend,** August 17, 2024

Closures are happening across the U.S., but a recent report from the Federal Reserve Bank of Boston found

	that the rate of nursing home closures in New England is three times the national rate *Amidst nursing home closures, relocating residents close to home is a challenge*, **Maine Public Radio,** August 13, 2024 *"When caregivers feel informed and supported, when they receive education and training on the medical and nursing tasks they need to perform, they are better able to carry out their caregiving responsibilities with minimal detriment to themselves and ensure the best medical outcomes for patients. This is true across all caregiving settings."* Dr. Allison Applebaum, Associate Attending Psychologist and Director of the Caregivers, Clinic at the Memorial Sloan Kettering Cancer Center, *Transplant Caregiving in the U.S.: A Call for System Change* **(National Alliance for Caregiving (report),** 2023) *With increasing financial pressures, unpaid wages have become a significant issue throughout the long-term care industry this year.* *Nursing home owes $420K in unpaid wages: attorney general*, **McKnights Long-Term Care News,** August 13, 2024 *Sometimes, you can most appreciate what something is when you are being denied it. . . So, too, it is with dignity. You inherently have it, but others can be quick to chip it away, as if they want to make you feel invisible, unworthy, always "less than."* Sandy Alissa Novack, MBA, MSW, **What Is the Meaning of Dignity?** *"It's looking like [COVID] is probably not a seasonal virus, so it will likely be year round."* Dr. Otto Yang, associate chief of infectious diseases at UCLA and professor of medicine, *COVID is on the rise this summer. Here's why and what else you should know*, **NPR Morning Edition,** August 15, 2024 *The United States has 4% of the world's population but more than 16% of COVID-19 deaths.* *The COVID Tracking Project Part 1*, **Reveal (podcast),** August 3, 2024

	At the height of the pandemic, COVID-19 was talked about as "the great equalizer," an idea touted by celebrities and politicians from Madonna to then-New York Gov. Andrew Cuomo. But that was a myth. The COVID Tracking Project Part 3 **(Reveal (podcast),** August 17, 2024) *"Denying students with disabilities access to their neighborhood schools based on a blanket policy denies such students the opportunity to experience school with their siblings, friends, and neighbors and is discriminatory."* Assistant Attorney General Kristen Clarke of the Justice Department's Civil Rights Division, *Justice Department Secures Agreement with Nebraska School District to End Discriminatory Treatment of Deaf and Hard of Hearing Students* **(U.S. Department of Justice,** August 15, 2024) *"Our concern with the Centers for Medicare and Medicaid Services star ranking system is that surveys aren't being completed on time, or the surveyor pool is limited and that because of the lack of timely surveys, data is lagging significantly. We support surveys and rankings, but we can't do it with old records. If survey data and star rankings prohibit growth and expansion, the industry and patients will be the ones who are negatively impacted the most."* PACS President and Chief Operating Officer Josh Jergensen, *New report urges CMS to deny new certifications based on quality of owners' related nursing homes*, **McKnights Long-Term Care,** August 18, 2024 *The Centers for Medicare and Medicaid Services (CMS) has the authority and responsibility under the Nursing Home Reform Law to deny federal certification to facilities that have a history of poor care. Although CMS could use its existing statutory authority more effectively to prevent some of the poorest operators in the country from acquiring additional nursing facilities, explicit federal criteria for certification could clarify the relevant factors that CMs must consider in certification*

	decisions. Explicit federal rules and guidance about certification would be especially helpful at this critical time when ownership of facilities is shifting to private equity, real estate investment trusts, and multi-facility operators that are frequently found to provide poorer quality of care to residents. The affiliated entities information now publicly reported by CMS provides ample evidence of problem companies whose facilities have a history of poor care. This information should be persuasive to Congress that CMS needs additional legal authority so that it can consider the records of facilities with owners in common when it makes federal certification decisions. *The Urgent Need for Criteria for Federal Certification of Nursing Facilities*, **Center for Medicare Advocacy,** August 15, 2024 *"This is scandalous. Nursing homes are quick to take taxpayer money, but too many are reluctant to pay the taxpayer back when money is owed."* John Hale, a consultant and advocate for older adults, *'This is scandalous:' Iowa auditor asked to examine millions nursing homes owe taxpayers*, **Des Moines (Iowa) Register,** August 19, 2024
Public Information Session: *Independent Assessment Entity* **Registration: Required: https://us02web.zoom.us/webinar/register/WN_17v2QR1KT_eNc27npaDPog**	**Topic: *Independent Assessment Entity: Public Information Session*** **When: *Wednesday, August 21, 2024, 10:30 a.m. to 12:00 p.m.*** **Why:** MassHealth has proposed to secure an "Independent Assessment Entity" to provide clinical assessments for approximately 240,000 Massachusetts residents who rely upon MassHealth services, support, and care to remain living in their homes and communities. The affected programs are: Adult Foster Care, Group Adult Foster Care, Personal Care Management (PCA), Day Habilitation, Adult Day Health, Senior Care Options, PACE, and OneCareHome. Your role in this process is crucial. This is a significant change that will have an enormous impact on consumers and on the longstanding community-based system of care in Massachusetts. Historically, the Executive Office of Health and Human Services (EOHHS and MassHealth) actively solicited public input and engaged with stakeholders to investigate challenges to service systems before changing policy or practices. This collaborative approach has resulted in improved programs and policies, created efficiencies, and engendered stakeholder support and public confidence. Engagement of stakeholders

and other interested parties did not occur before the issuance of a “Request for Response” (RFR) in this instance.

We believe this is a missed opportunity to identify and implement needed changes to current policies and protocols without disrupting relationships with community-based organizations that have been in place for decades.

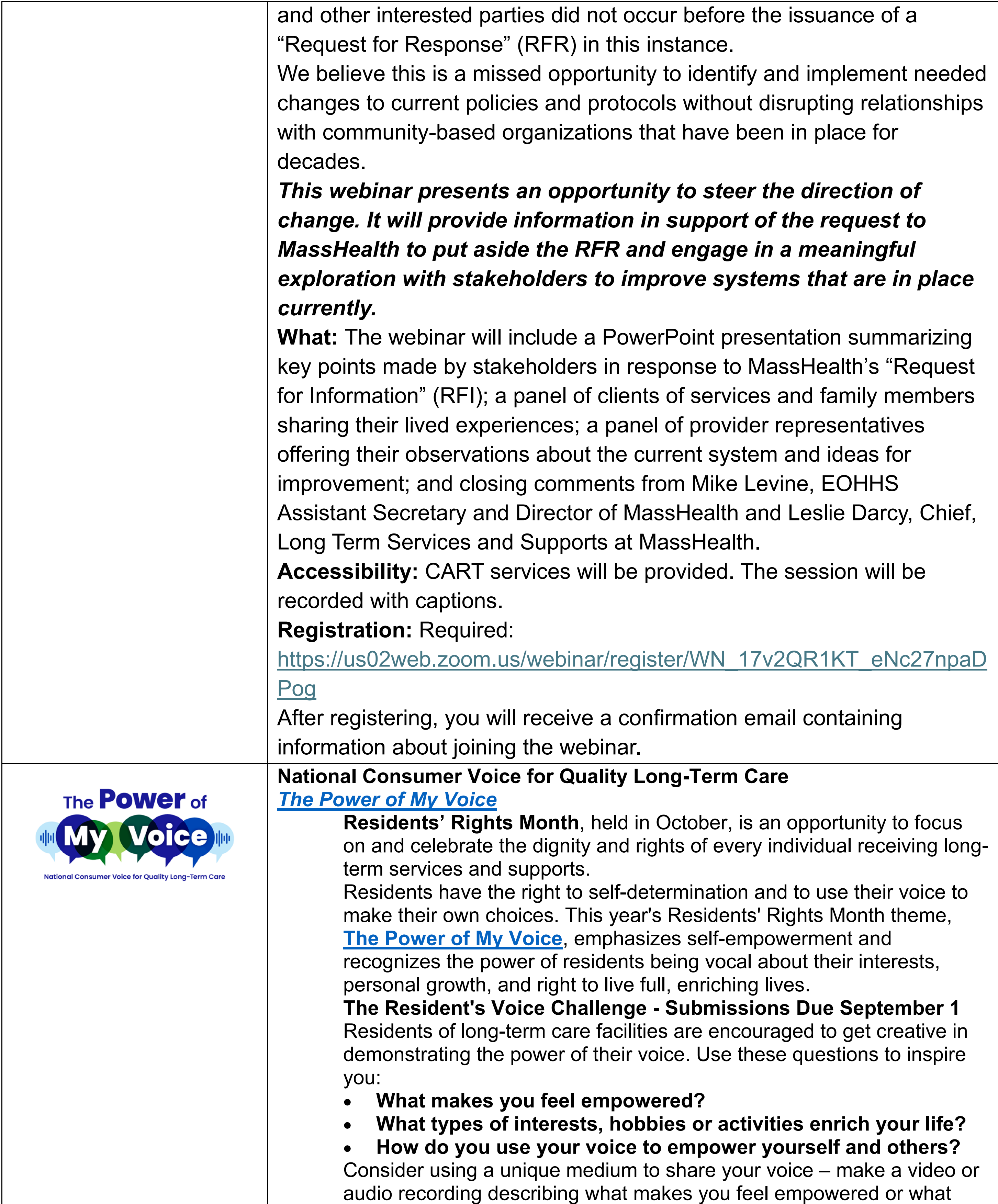
This webinar presents an opportunity to steer the direction of change. It will provide information in support of the request to MassHealth to put aside the RFR and engage in a meaningful exploration with stakeholders to improve systems that are in place currently.

What: The webinar will include a PowerPoint presentation summarizing key points made by stakeholders in response to MassHealth’s “Request for Information” (RFI); a panel of clients of services and family members sharing their lived experiences; a panel of provider representatives offering their observations about the current system and ideas for improvement; and closing comments from Mike Levine, EOHHS Assistant Secretary and Director of MassHealth and Leslie Darcy, Chief, Long Term Services and Supports at MassHealth.

Accessibility: CART services will be provided. The session will be recorded with captions.

Registration: Required:
https://us02web.zoom.us/webinar/register/WN_17v2QR1KT_eNc27npaDPog

After registering, you will receive a confirmation email containing information about joining the webinar.



National Consumer Voice for Quality Long-Term Care

The Power of My Voice

Residents’ Rights Month, held in October, is an opportunity to focus on and celebrate the dignity and rights of every individual receiving long-term services and supports.

Residents have the right to self-determination and to use their voice to make their own choices. This year's Residents' Rights Month theme, **The Power of My Voice**, emphasizes self-empowerment and recognizes the power of residents being vocal about their interests, personal growth, and right to live full, enriching lives.

The Resident's Voice Challenge - Submissions Due September 1

Residents of long-term care facilities are encouraged to get creative in demonstrating the power of their voice. Use these questions to inspire you:

- **What makes you feel empowered?**
- **What types of interests, hobbies or activities enrich your life?**
- **How do you use your voice to empower yourself and others?**

Consider using a unique medium to share your voice – make a video or audio recording describing what makes you feel empowered or what

	enriches your life, read a piece of original poetry or a short story, play original music or sing a song, show and tell us about your artwork, etc. **How to Submit** 1. Read the full Resident's Voice Challenge Criteria before submitting. 2. Email submissions to info@theconsumervoice.org. o Include a mailing address with your submission for residents to receive certificates of participation. o Submissions featuring photo or videos must include completed release forms for each resident.
Guide to news items in this week's *Dignity Digest*	**Legislation** *Advances - Week of Aug. 18, 2024* **(*State House News,** August 16, 2024) **Nursing Homes** *More Government Scrutiny Of Private Equity's Role In Healthcare, Including Nursing Facilities* **(Mondaq,** August 19, 2024) *New report urges CMS to deny new certifications based on quality of owners' related nursing homes* **(McKnights Long-Term Care,** August 18, 2024) *U.S. nursing homes grapple with staffing shortages and requirements* **(PBS News Weekend,** August 17, 2024) *The Urgent Need for Criteria for Federal Certification of Nursing Facilities* **(Center for Medicare Advocacy,** August 15, 2024) *Private Equity Doesn't Care* **(The Provincetown Independent,** July 31, 2024) **Steward Healthcare** *Governor Healey Announces Actions to Save Remaining Steward Hospitals* **(Office of Governor Maura Healey and Kim Driscoll,** August 16, 2024) *Advances - Week of Aug. 18, 2024* **(State House News,** August 16, 2024) **Assisted Living** *CDC releases new profile of assisted living residents* **(McKnights Senior Living,** August 13, 2024) *Residential Care Community Resident Characteristics: United States 2022* **(National Center for Health Statistics,** August 2024) **Covid / Long Covid** *COVID is on the rise this summer. Here's why and what else you should know* **(NPR Morning Edition,** August 15, 2024) The COVID Tracking Project Part 3 **(Reveal (podcast),** August 17, 2024) *The COVID Tracking Project Part 2* **(Reveal (podcast),** August 10, 2024) *The COVID Tracking Project Part 1* **(Reveal (podcast),** August 3, 2024) **Disability Topics** *Justice Department Secures Agreement with Nebraska School District to End Discriminatory Treatment of Deaf and Hard of Hearing Students* **(U.S. Department of Justice,** August 15, 2024) *Born without a right hand, he set his heart on playing the violin. Now he has his own unique sound.* **(*Boston Globe,** August 15, 2024) **Health Care**

	The hellscape of the emergency department **(*Boston Globe,** August 19, 2024) **Caregiving** *Transplant Caregiving in the U.S.: A Call for System Change* **(National Alliance for Caregiving (report),** 2023) **Medicare** *Medicare negotiated drug prices for the first time. Here's what it got* **(NPR Shots,** August 15, 2024) **In Other States** *'This is scandalous:' Iowa auditor asked to examine millions nursing homes owe taxpayers* (**Des Moines (Iowa) Register,** August 19, 2024) *Amidst nursing home closures, relocating residents close to home is a challenge* **(Maine Public Radio,** August 13, 2024) *Nursing home owes $420K in unpaid wages: attorney general* **(McKnights Long-Term Care News,** August 13, 2024) **Public Sessions** **State Plan Committee of the State Rehabilitation Council,** Wednesday, August 21, 2024, 11:00 a.m. Agenda and Livestream **Board of Registration of Allied Health Professionals,** Thursday, August 22, 2024, 9:00 a.m. **MBTA BOARD: MBTA Board of Directors,** Thursday, August 22, 2024, 10:00 a.m.

Accessibility and Voter Rights
 	
Sign Up to receive emails. Stay educated on your rights, and on the Issues, Candidates and Ballot Questions in Massachusetts!
	1. Rev Up Massachusetts
	REV UP – Register! Educate! Vote! Use your Power!
	https://revupma.org/wp/
	2024 Disability Voting Rights Week
	September 9 – 13, 2024
	Learn more about the issues, and how you can help advance the disability agenda at our 2024 Disability Voting Rights Week post.
	2024 Election Calendar
	Visit the Secretary of State's Upcoming Elections page.
	• September 3 – State Primary
	    ○ August 24 – Voter Registration Deadline
	    ○ August 26 – Vote by Mail Application Deadline
	• November 5 – Election Day
	    ○ October 19 – First day of in-person early voting for state election
	    ○ October 26 – Last day to register to vote for state election
	    ○ October 29 5:00 p.m. – Deadline to apply for mail-in ballot for state election
	    ○ November 1 – last day of in-person early voting for state election

Webinars and Other Online Sessions	**1. Boston University School of Social Work Center for Innovation in Social Work & Health** Wednesday, August 21, 2024, 2:00 to 3:00 p.m. *Family-Driven Approach to Understanding Family Well-Being and Its Facilitators* Join the Center for Innovation in Social Work and Health (CISWH) at Boston University School of Social Work (BUSSW) for an interdisciplinary café-style conversation on what matters most to families of children with medical complexity (CMC), as well as meaningful strategies to improve care delivery and mitigate systems-level bias. In this fourth session of six in the Future of Care for Children with Medical Complexity Virtual Café Series**,** speakers Jay Berry, MD, MPH, and Katie

	Huth, MD, MMSc, FRCPC, both of Boston Children's Hospital will briefly share framing around the current state of research priorities for children with medical complexity, including family-driven measurement. Through facilitated discussion in breakouts, participants will explore and learn together where meaningful research opportunities lie to advance policy and practice. The group will reconvene briefly to share high-level takeaways from breakouts. Ideas will then be synthesized thematically using generative AI and distributed widely. **Register** **Learn more and register for the full series here.** 2. **The National Alliance for Caregiving** Tuesday, August 27, 2024, 1:00 to 2:30 p.m. *Champions in Care Forum: Uplifting Caregivers in Transplant Care* Join the Champions in Care Forum for an in-depth exploration of critical reforms shaping the future of transplant care. They'll delve into the OPTN Modernization Initiative and the Organ Transplantation Affinity Group's efforts, with a special focus on the impact of these changes on family caregivers. Engage in dynamic discussions that elevate the essential role caregivers play and advocate for policies that prioritize their needs. Leave equipped with insights for driving the policy and practice change needed to improve transplant care outcomes for both patients and their dedicated caregivers. Register
Previously posted webinars and online sessions	**Previously posted webinars and online sessions can be viewed at:** **https://dignityalliancema.org/webinars-and-online-sessions/**
Legislation	3. ***State House News** August 16, 2024 *Advances - Week of Aug. 18, 2024* The blending of politics and policymaking is more overt than usual this time of year, and this week marks a new chapter in the entanglement of the two. Democrats in the Legislature have a raft of major unresolved business that they say they plan to tackle during sessions where there's not a quorum in either branch. Voters will return incumbents to the House and Senate in the fall, in part because there just aren't choices on many ballots. Votes are already being cast by mail and the in-person voting period before the Sept. 3 primaries starts Saturday, Aug. 24. The lull of the August recess on Beacon Hill was broken up this week by the emergence of a landmark maternal health bill that was rushed to Healey's desk, and which she plans to sign. Legislators say they're still working to advance other major bills, but there's no telling what's happening, or not happening, in conference committees that work in secret. Maybe they'll line up another one to pop out of conference next week, which could help with the optics of partying and glad-handing in Chicago while public priorities gather more dust back in Boston.
Nursing Homes	4. **Mondaq** August 19, 2024 *More Government Scrutiny Of Private Equity's Role In Healthcare, Including Nursing Facilities*

By Christopher J. Churchill

On March 5, 2024, the U.S. Department of Health and Human Services (HHS), Federal Trade Commission (FTC) and U.S. Department of Justice (DOJ) announced a joint agency inquiry into the increased role of private equity...

United States Food, Drugs, Healthcare, Life Sciences

On March 5, 2024, the U.S. Department of Health and Human Services (HHS), Federal Trade Commission (FTC) and U.S. Department of Justice (DOJ) announced a joint agency inquiry into the increased role of private equity in health care, including nursing facilities in particular.

Within hours of this announcement, the FTC conducted a workshop with representatives from all three agencies who listed certain negative consequences resulting from private equity ownership of healthcare facilities, including: lower quality of care, reduced staffing, over-leveraging with debt, less competition and ultimately, higher costs for federal healthcare programs. According to the FTC's Chair, Lina Khan, the consequences for nursing facilities have been particularly adverse, resulting in significantly higher mortality rates. She cited one study estimating that private equity acquisitions of nursing homes, and the staffing cuts that followed, led to "20,000 excess deaths among nursing home patients over the course of just 12 years." At the same time, she acknowledged that private equity investments sometimes can provide an important source of capital and operational improvements.

In January of this year, we reported on the new ownership disclosure requirements for nursing facilities participating in the Medicare and Medicaid programs, with a significant focus on private equity ownership. This additional agency focus on private equity ownership of nursing homes signals even more government scrutiny in the years to come. The FTC has promised a more restrictive antitrust policy with respect to private equity roll-ups and various anti-competitive practices. DHHS has promised to share nursing home ownership data with other agencies and to monitor private-equity owned facilities more closely.

Some experts question whether the increased focus on private equity ownership of nursing homes, based perhaps upon the worst cases, will discourage private investment in an industry that is plagued by financial problems and may be inadequate to meet the growing demands of an aging population. Regardless of these concerns, this increased government scrutiny must be considered in structuring any transaction involving, or resulting in, private equity ownership of nursing homes or other healthcare facilities.

Originally published 22 March 2024

5. **McKnights Long-Term Care**

   August 18, 2024

   New report urges CMS to deny new certifications based on quality of owners' related nursing homes

   By Jessica R. Towhey

   The article argues that if a nursing facility owner or operator consistently fails to provide adequate care, they should not be granted certification to operate more facilities. Nursing facilities must be licensed by their state and certified by the Centers for Medicare & Medicaid Services (CMS) to receive Medicare or Medicaid reimbursement. Historically, CMS has taken a hands-

off approach, certifying any state-licensed facility without considering the performance of facilities under the same ownership.

In February 2022, after the COVID-19 pandemic revealed significant issues in nursing home care, reforms began to address these deficiencies. One key reform is the creation of a federal database identifying nursing facilities under common ownership, highlighting those with poor care records.

Despite having the authority to deny certification to facilities with a history of poor care, CMS has been ineffective in using this power. The article advocates for stronger federal criteria for certification, particularly for facilities under common ownership, to prevent operators with poor records from expanding their network of facilities and further endangering residents.

The report faulted CMS for delegating that responsibility to states since such certification is required for participation in Medicare and Medicaid, which are federal programs.

It also highlighted a series of high-profile provider implosions, including the Skyline Healthcare collapse, in which providers were able to buy buildings in multiple states but then fell apart financially. In the case of Skyline, consumer advocates accused several states of failing to do due diligence and understand how owner Joseph Schwartz was operating elsewhere before transferring licenses to him.

The report cited Syracuse University College of Law Profession Nina A. Kohn, who has identified two, existing federal conditions for certification: disclosure of ownership and management information, and having a quality assessment and assurance committee.

The database now available provides evidence of poor-performing operators, and the article suggests that CMS should deny these operators certification to manage additional facilities. This would help protect residents from substandard care and ensure better use of public funds.

6. **PBS News Weekend**

August 17, 2024

U.S. nursing homes grapple with staffing shortages and requirements

By Ali Rogin and Satvi Sunkara

New federal minimum staffing requirements for nursing homes could eventually require facilities that are paid by Medicare to hire tens of thousands of nurses and aides. But, like many industries around the U.S., these facilities are grappling with staffing shortages. Ali Rogin sits down with Jordan Rau, senior correspondent at KFF Health News, for more.

Read the Full Transcript

Notice: Transcripts are machine and human generated and lightly edited for accuracy. They may contain errors.

- **John Yang:**

This week, Texas sued the Biden administration to try to block new federal minimum staffing requirements for nursing homes. The new rules could eventually require facilities that get money from Medicare to hire tens of thousands of nurses and aides. Ali Rogin looks into this controversial mandate.

- **Ali Rogin:**

The nursing home rule announced in April phases in staffing requirements, including that a registered nurse be on site 24 hours a day, and that each resident get a minimum number of hours of direct care each day. But like many industries around the country, these facilities are grappling with staffing shortages.

We spoke to one nursing home worker who has been on the front lines of care for 34 years.

- **Bonnie Gaudraeau, Licensed Practical Nurse:**

Not everybody's teeth get brushed every day. People's nails aren't cut like they used to. Beds aren't being made. Staff has to take shortcuts to get things done because there's less of them to provide all those — all the care that the residents need.

The system is so broken and so short-handed and so difficult to manage with the different combinations of patients that you're not able to provide the care for the people that really need it at the moments they really need it.

- **Ali Rogin:**

The new rule faces pushback from the nursing home industry for being unrealistic, and from patient advocates who say it doesn't go far enough. Jordan Rau is a senior correspondent at KFF News and has covered nursing homes for more than a decade. Jordan, thank you so much for being here. Why did the Biden administration want to put this role in place?

- **Jordan Rau, Senior Correspondent, KFF News:**

Well, the pandemic really exposed the degree to which nursing homes were in dire straits. Over 200,000 people died in them just from COVID alone, and that put a lot of pressure on it. And so they really, there's been pressure for years, really decades, to improve the core issues there, which are, you know, some of those were mentioned in just before, but also people falling a lot because of low staffing, bed sores or regular problems, people not getting their medication, people not getting food on time and such, and they saw this as an opportunity to really push hard and make some fundamental changes on staffing.

- **Ali Rogin:**

It has been getting some backlash from various stakeholders. Why the backlash?

- **Jordan Rau:**

Well, it's very expensive. I mean, it's going to cost billions of dollars to staff up for the industry as a whole. Now, some of these nursing homes already have enough staff to meet the minimum requirements that the Biden administration is requiring, but most don't, and it's going to be extremely expensive to hire those people, and a lot of people don't want to take these jobs right now.

I mean, if you're a nursing aide, the average pay is about $19 an hour. People don't want to do that. It's a very, very difficult job. So, in some places they'll have to increase the wages. So, the industry claims that they can't afford it, and so they've resisted it, both politically, they've gone to Congress, and they're looking to block and overturn the rule, and also legally and going to the courts.

- **Ali Rogin:**

So, what else is behind these staffing shortages? Because apparently, you know, industry insiders will say there are 99 percent of these nursing homes that have open jobs, but they simply can't find people to fill the jobs. Why is that?

- **Jordan Rau:**

A lot of it is the money, but a lot of it is people also got burned out doing these jobs during the pandemic. I mean, it was brutal work. And, you know, watching your patients die was really, really difficult. The fact that these places are understaffed becomes a really bad cycle, because you — if you

are in a nursing home that doesn't have enough staff, your job is so much harder, and so it becomes harder to recruit people for those.
In most nursing homes, the average turnover in a nursing home is about 50 percent every year. There's also a problem, and if there's not really a career ladder for some of the people, so if you go in at the lower level, you're not really working towards something.
And so, a lot of people are like, hey, I can make, you know, the same amount of money, or more money working at Target or even working at McDonald's, and it's, you know, a much easier job.

- **Ali Rogin:**

The labor unions that represent a lot of these nurses do support this role. And we heard from April Verrett of the Service Employees International Union, SEIU, who said caregivers have been demanding safer staffing for years, and finally, feel heard now.
So, what are nursing home workers who are currently in the industry telling you?

- **Jordan Rau:**

Well, I mean, they've, you know, for a long time, felt undervalued, underpaid, also really resentful, because while there are a lot of nursing homes that are really in dire straits financially and closing up, there are also owners and corporations that have been making a lot of money off of the nursing homes.
There have been, you know, ones that are buying it up, and they just feel like there's a lot of money out there that should be spent on the quality of staffing, and that has sort of been one of the major issues that isn't being addressed in this rule, which is, you know, how much money can these do these nursing homes, or some of them, need to staff up at this level.
And there's no money attached to the rule. It's just, you've got to hit this level or else you're in trouble.

- **Ali Rogin:**

Are these nursing homes equipped to comply?

- **Jordan Rau:**

You know, it's hard to generalize, right? I mean, I think that there's some nursing homes. There's about, let's say 20 percent that are doing it, there's going to be about 20 percent that are going to be able to get a waiver from it, because they're going to be able to demonstrate that there just aren't enough, you know, qualified workers in their area.
And then the other ones, it really depends. It really comes down to what the administration does in terms of penalties, because if you are going to just cite them with a small financial penalty, for instance, it's still in a nursing homes financial just forget the patients right for a second, and just look at the books, it's still cheaper to pay the penalty than it is to staff up.
And so that's the problem that the administration has when they decide exactly how they're going to penalize or enforce this, because, on the flip side, if they penalize them too much, you can drive a struggling nursing home out of business.

- **Ali Rogin:**

What do analysts say about whether this is a band aid on a bigger issue, or is this really getting to the heart of an industry that has been problematic for decades?

- **Jordan Rau:**

It's both. It's a floor, right? This is minimum staffing. So, no one is saying, like, if all your nursing homes are staffed at this level, the care is going to be fantastic. So, it's considered a good first step to bring up some of the worst nursing homes in the country to levels that are acceptable. There's some really good nursing homes out there. There's some really good care being given.

There's some really good owners, but still, overall, the quality of care is not at the same level that you get in a hospital or you get in private pay, you know, at your home. And there's still a long way to go to really get a high quality of care for some of the frailest Americans.

- **Ali Rogin:**

Right at the heart of all of this is the patients who are very vulnerable people. Jordan Rau with KFF Health News, thank you so much for breaking this down for us.

- **Jordan Rau:**

Thanks for having me.

7. **Center for Medicare Advocacy**

August 15, 2024

The Urgent Need for Criteria for Federal Certification of Nursing Facilities

If an owner or operator fails to run its facilities effectively, why give them more?

Nursing facilities must be licensed to do business in their state. To be eligible for reimbursement under the Medicare or Medicaid programs, or both, they must also be certified by the Centers for Medicare & Medicaid Services (CMS).

Historically and to the present, CMS has taken a hands-off approach to certification, essentially granting certification to any facility that is licensed by the state where it operates. CMS has also traditionally looked at each nursing facility individually, refusing to consider patterns of quality of care in facilities under common ownership and across chains.

In February 2022, after the peak of the COVID epidemic resulted in the deaths of hundreds of thousands of nursing home residents, President Biden issued a bold and comprehensive nursing home reform agenda to improve quality of care that called for multiple changes to strengthen federal law and policy governing nursing homes.

One component of the reform agenda is a new federal database that identifies nursing facilities under common ownership and control. As shown below, the new CMS database, called "affiliated entities," highlights the need for a second component in the reform agenda, evaluating whether a facility should be certified when other facilities under common ownership and control have serious deficiencies.

CMS currently has the authority and responsibility under the Nursing Home Reform Law to deny federal certification to facilities that have a history of poor care. Its posting of information about affiliated entities provides ample and dramatic evidence of the need for CMS to use its authority more effectively than it does now to prevent some of the poorest operators in the country from acquiring additional nursing facilities.

Background

President Biden's nursing home reform agenda called for the creation of a new database of nursing home owners and operators "to highlight previous problems with promoting resident health and safety."[1] The White House expected that the ownership database would be useful to the public and

would “empower states to better protect the health and safety of residents.”[2]

On June 28, 2023, CMS implemented this initiative when it began posting (1) affiliated entity information on the federal website *Care Compare*[3] and (2) the Nursing Home Affiliated Entity Performance Measures data on data.cms.gov (combining “inspection, staffing, quality, and other performance metrics across affiliated entities”).[4]

The database provides information that supports a second White House nursing home proposal – seeking explicit statutory authority from Congress so that CMS can enforce standards of care on a corporate-wide basis. As described in the reform agenda, this proposal would enable CMS “to prohibit an individual or entity from obtaining a Medicare or Medicaid provider agreement for a nursing home (new or existing) based on the Medicare compliance history of their other owned or operated facilities (previous or existing).”[5] Since there is no better predictor of how an operator will run a new facility than how the operator runs facilities it already owns or owned in the past, this proposal is a common sense way to prevent operators with poor compliance records from increasing their network of facilities and providing poor care to even more residents.

Affiliated entity information and analyses show some facilities under common ownership provide extremely poor care.

The following information, compiled from data.cms.gov on July 25, 2024, reflects the 15 affiliated entities with the largest number of nursing facilities. The Ensign Group, with the largest number of facilities in the country (266), is listed first. Affiliated entity information documents the poor care, low levels of staffing, high levels of abuse, and high levels of civil money penalties that are pervasive in some facilities under common ownership.

As shown below in Table 1,[6] nursing facilities operated by 11 of the 15 largest affiliated entities have below-average health inspection ratings (2-3 stars on a 1- to 5-star scale). The facilities of only four affiliated entities have an average health inspection rating (3 stars and above). None has an above average health inspection rating (4 or 5 stars).

Nursing facilities operated by 11 of the 15 largest affiliated entities also have below-average staffing levels (2-3 stars). Facilities operated by one affiliated entity have much-below-average staffing levels (1-2 stars). Only facilities operated by two affiliated entities have average staffing levels (3-4 stars). None has an above average staffing level (4 or 5 stars).

Nursing Facilities Associated with Top 15 Affiliated Entities

[See report for detailed table.]

As shown below in Table 2, while the average CMP for nursing facilities in the United States in Calendar Year 2022 was $17,818,[7] the average CMP for the past three years for nursing facilities that are part of affiliated entities was more than double the national average, $38,114.34. Facilities affiliated with Simcha Hyman and Naftali Zanziper have the largest average per facility CMP, $95,979.96, more than five times the national average CMP in 2022.

In addition, nursing facilities connected with affiliated entities (whose 1,830 facilities are 12% of all facilities in the United States) represent 17% of the country’s 86 Special Focus Facilities and 13% of the 440 Special Focus Facility candidates. The facilities represent 13% of all facilities with abuse icons.

Nursing Facilities Associated with Top 15 Affiliated Entities

[See report for detailed table.]

How governments can use affiliated entity information

State licensure

States can enact laws or policies that would enable them to use information about affiliated entities to deny nursing home licensure for a new building, to issue provisional licenses, or to place conditions on state licensure. However, states have not typically been effective in preventing owners with poor records from acquiring new facilities, in part, because operators exploit principles of corporate law to create "new" companies that have no historical records that states can require information about and review in their licensure decisions. There are many examples of operators evading accountability for their performance in this way.

More than 25 years ago, in 1994, Jon Robertson formed Phoenix Health Group and acquired nursing facilities in California. The *Los Angeles Times* reported in 1997, "As the money began to roll in from Medicare and Medi-Cal payments to the more than 300 residents at the facilities, Robertson, who had long displayed a fondness for life's pricier pleasures – from Harley-Davidson motorcycles to diamond rings – began to spend conspicuously."[8] Robertson also "served prison time and owed $150,000 in restitution to the IRS for filing a false tax return as president of another nursing home management company."[9] Robertson's California facilities provided poor care for residents and were cited with numerous deficiencies. The company filed for bankruptcy and abruptly closed its facilities.

Despite this record and sometime after drug rehabilitation for his cocaine addiction and a prison sentence, Robertson formed a new company, Utah-based Deseret Health Group. Multiple states gave Robertson's new company licenses and the federal government certified the facilities for Medicare and Medicaid reimbursement. In early May 2015, Robertson repeated his pattern from California. Deseret abruptly stopped paying for food, medical supplies, and workers' wages and benefits in at least seven nursing facilities owned by the company in Kansas, Minnesota, Nebraska, and Wyoming. States sought court receiverships or otherwise took control of the facilities to protect residents and ensure they received food and medications.[10]

A second example of operators gaming the state licensing system occurred in Illinois in 2018, when William Rothner and Allied Health Services, Inc. sought to purchase and convert to for-profit ownership the Champaign County, Illinois county nursing facility. In August 2018, the County Review Board asked the potential purchasers to identify any adverse actions taken against them or any facilities owned or operated by them. A certification signed by Rothner on August 15, 2018 indicated that no action had been taken against University Rehabilitation Center of CU, LLC and University Rehab Real Estate, LLC. However, neither University Rehabilitation Center of CU, LLC nor University Rehab Real Estate, LLC actually existed on August 15, 2018. These companies, although listed on the state's paperwork, reflected the new name that the applicants intended to give the county nursing facility once they bought it. However, these companies were not created until August 17, 2018.[11] Clearly, no adverse actions could have been taken against companies that did not actually exist.

A third example of state government's allowing a poor-quality operator to gain control of another facility is from Pennsylvania. In the spring of 2018, the New Jersey-based Skyline Healthcare collapsed and abandoned

facilities that it had taken over in seven states across the country in little more than a year. As with the collapse of Robertson's Deseret Health Group, states installed temporary managers or rushed to court to get receiverships so that they could pay staff and vendors and make sure residents had food and medications.[12] On April 27, 2018, Pennsylvania installed a temporary manager at nine facilities operated by Skyline, although it declined to identify the manager.[13]

As reported on May 5, 2018, Pennsylvania then identified, as the new operator of the Skyline facility in Lancaster, a for-profit company that had been created just three days earlier, on May 2, 2018. The so-called new operator was not actually new. It had at least two of the same owners and shared the address of a company, Priority Healthcare Group, which had bought 14 facilities in the state in 2016.[14] Priority's record managing 11 former Golden Living facilities in Pennsylvania was poor. Priority cut staffing levels and reduced other spending at the facilities.[15] Nevertheless, Pennsylvania entrusted the former Skyline facility to the so-called new company, giving the new company a license to operate the facility.

The clean records that operators give themselves by forming new corporate entities make it difficult for states to require the submission of relevant ownership information that could compel the state to deny the bad operators licenses to take over another facility. Many states have sought to strengthen their oversight authority and systems in recent years. It remains to be seen whether these new laws will result in more effective state oversight of nursing home ownership and changes in ownership.

Federal certification

Whether or not states become more effective in their licensure role, the federal government should also take responsibility for nursing home quality under its certification authority. To date, CMS. has largely delegated responsibility to states to determine facilities' eligibility for certification for Medicare and Medicaid reimbursement. Essentially, facilities that are licensed are automatically eligible for certification. Law Professor Nina A. Kohn identifies just two distinct federal conditions for certification: (1) disclosure of ownership and management information and (2) having a quality assessment and assurance committee.[16]

Describing CMS's "unrealized opportunity to use its existing certification authority to improve nursing home quality of care by considering the performance record of facilities' owners and operators,"[17] Kohn suggests that "HHS could use the certification process to steer public funds away from nursing homes owned or operated by entities with a history of abuse and neglect."[18]

Citing 42 U.S.C. §1395i-3(f)(5) (a Medicare provision of the Nursing Home Reform Law that gives the Secretary authority to establish federal criteria for assessing a facility's compliance with administration requirements), Kohn argues that "the Secretary has existing statutory authority to deny certification to facilities that are governed or managed by entities that have shown they are unlikely to administer them in a way that will provide residents with the required quality of care."[19]

Kohn writes:

Denying certification to facilities owned or operated by entities with a history of endangering residents is therefore consistent with the Secretary's statutory mandate to refrain from certifying facilities that are not

administered in a way that enables them to provide residents with high-quality care.[20]

Kohn identifies several options. The Secretary could provide "criteria for how to determine which owners or operators are known to operate facilities in a way that prevents them from meeting residents' needs."[21] Criteria could direct staff "to consider the number and types of deficiencies for which the other facilities owned or operated by the entity are cited."[22] Kohn suggests, "[A] pattern of serious survey deficiencies" could result in a denial of certification "(either outright or by creating a rebuttable presumption of denial)."[23]

Kohn recognizes that facilities would be required to disclose facilities under common ownership. The new final transparency rules[24] require the type of disclosure contemplated by Kohn.

Additional provisions of the Nursing Home Reform Law provide further support for Kohn's position. 42 U.S.C. §§1395i-3(f)(1), 1396r(f)(1), Medicare and Medicaid, respectively, give the Secretary an "affirmative responsibility to ensure that the requirements governing skilled nursing facilities are 'adequate to protect the health, safety, welfare, and rights of residents and to promote the effective and efficient use of public moneys.'"

The Reform Law identifies specific remedies that must be available by states and CMS and also requires the Secretary to "specify criteria, as to when and how each of such remedies is to be applied."[25] In the preamble to the final enforcement rule published in November 1994,[26] the Health Care Financing Administration (predecessor agency to CMS) quoted at length, and stated that it largely agreed with, the enforcement provisions of the final settlement of *Valdivia v. California Department of Health Services* (Oct. 9, 1992).[27] The settlement required the state of California to have a process and guidelines for determining when and which remedies to impose in particular instances of noncompliance. As the Institute of Medicine wrote in its March 1986 report, which is a major part of the legislative history of the 1987 Nursing Home Reform Law, effective enforcement depends on guidelines on when to initiate enforcement actions.[28]

Enforcement is not a collection of remedies that CMS or states randomly impose, without rationale. Deciding which penalties to impose requires a thoughtful process that evaluates the relationship of deficiencies, whether deficiencies are concentrated in a single department or are pervasive throughout the facility, and the facility's history of compliance. An orderly process for imposing remedies in particular cases should, with appropriate statutory authority, include reference to the history of compliance in other facilities under common ownership and control. This history is relevant because corporate policies often drive resources, incentives, and priorities at the facility level, determining whether a facility provides high quality care or not.

Conclusion

CMS has the authority and responsibility under the Nursing Home Reform Law to deny federal certification to facilities that have a history of poor care. Although CMS could use its existing statutory authority more effectively to prevent some of the poorest operators in the country from acquiring additional nursing facilities, explicit federal criteria for certification could clarify the relevant factors that CMs must consider in certification decisions. Explicit federal rules and guidance about certification would be especially helpful at this critical time when ownership of facilities is shifting to private

equity, real estate investment trusts, and multi-facility operators that are frequently found to provide poorer quality of care to residents.[29]

The affiliated entities information now publicly reported by CMS provides ample evidence of problem companies whose facilities have a history of poor care. This information should be persuasive to Congress that CMS needs additional legal authority so that it can consider the records of facilities with owners in common when it makes federal certification decisions. Once Congress enacts legislation to effectively regulate or bar such operators, CMS can, and should, begin with the affiliated entities it has already identified as poor performers and deny them certification to operate additional facilities. If CMS denies these operators the privilege of owning more facilities, surveys and the system will more effectively screen out operators that provide poor care and fewer residents will suffer.

8. ***The *Provincetown* Independent**

July 31, 2024

Private Equity Doesn't Care

By Edward Miller, Editor, **The Provincetown Independent**

Last week's article by Jack Styler on the substandard care at the nursing home at Seashore Point in Provincetown, now formally called AdviniaCare at Provincetown, was one of the more disturbing stories we've reported in these pages.

For more than 50 years, the Outer Cape's only nursing home was known as Cape End Manor. In spite of the somewhat unfortunate name and recurring financial problems, the home was a beloved local institution.

Cape End Manor was owned and managed by the town of Provincetown, and the cost of maintaining the home increasingly outpaced the revenue it generated. By the 2000s, the deficits were approaching $1 million a year, and the old building was in such terrible shape that it needed to be completely replaced.

In 2008, Cape End Manor officially closed, and the 37 residents were moved to a new building called Seashore Point, developed and operated by a nonprofit corporation, Deaconess Abundant Life Communities, which had taken over ownership in 2006.

But Deaconess couldn't balance the books either, and in 2019, under financial pressure, it sold the nursing home and the attached independent-living condominiums to three private investors, Benjamin Berkowitz, David Berkowitz, and Yosef Meystel.

According to the federal Centers for Medicare and Medicaid Services (CMS), which collects data on and rates nursing homes, Benjamin Berkowitz is an owner of 15 homes with an average rating of 1.8 stars out of 5. Seashore Point gets a 2-star rating. Four of Berkowitz's homes have an "abuse flag," meaning that residents have been harmed by shoddy care in the last year.

David Berkowitz is the owner of 66 nursing homes with an average rating of 2 stars; 22 of his homes have abuse flags. Yosef Meystel appears to be an owner of at least 105 homes under different names, although the details in the federal database are murky. Forty-eight of Meystel's nursing homes get one star, the lowest possible CMS rating, and 29 of them have an abuse flag.

Why are these investors buying up money-losing nursing homes? Since 2000, "private-equity investment in nursing homes has grown from five billion to a hundred billion dollars," investigative journalist Yasmin Rafiei

	wrote in a 2022 *New Yorker* article. In the name of "efficiency," the new owners cut nursing staff and other caregivers drastically to drive up profits. Meanwhile, residents are bathed less, they fall more, they suffer dehydration, malnutrition, more pain, and more infections. In 2019, researchers from the University of Pennsylvania studied the effects of nursing home ownership on residents. They examined more than 100 purchases and found that "when private-equity firms acquired nursing homes, deaths among residents increased by an average of ten per cent," Rafiei wrote. Charlene Harrington, an emeritus professor of nursing at the University of California, said of these understaffed homes, "It's criminal." Jack Styler continues his investigation of Seashore Point's finances this week. As Kristin Hatch, a former employee there, told Styler when he called her to confirm stories of residents being neglected and harmed, "It's about time."
Steward Healthcare	**9. Office of Governor Maura Healey and Kim Driscoll** August 16, 2024 *Governor Healey Announces Actions to Save Remaining Steward Hospitals* *Deals in principle reached to transition ownership of four hospitals, administration will take control of Saint Elizabeth's and transition to new operator* Governor Maura Healey announced that deals in principle have been reached to transition operations at four Steward hospitals – Saint Anne's Hospital, Good Samaritan Medical Center, the Holy Family Hospitals and Morton Hospital – to new operators. The Healey-Driscoll administration will then take control of Saint Elizabeth's through eminent domain to facilitate the transition to a new owner and keep the hospital open. . . If the deals are finalized, Lawrence General Hospital will become the new operator for both campuses of Holy Family in Haverhill and Methuen. Lifespan would assume operations of Morton and Saint Anne's, and Boston Medical Center would take over Good Samaritan, as well as Saint Elizabeth's after the taking process is complete. . . These actions do not impact Carney or Nashoba Valley hospitals, which will close after not receiving qualified bids. The administration is focused on supporting workers and connecting them to new jobs while also safely transitioning care. **2. State House News** August 16, 2024 *Advances - Week of Aug. 18, 2024* Top Democrats in the Legislature are hung up on new policies to guard against the damage that the private equity approach to health care can bring, and Massachusetts is learning now about how much taxpayer money it will cost to keep most of Steward Health Care's bankrupt hospitals running. While Steward offered no comment, Gov. Maura Healey declared victory Friday in the state's efforts to keep six of eight Steward hospitals open. The governor offered no life rope to Carney Hospital and Nashoba Valley Medical Center, which are winding down operations this month. The campaign-style announcement, which came as dealings are scheduled to continue playing out next week in federal court, came just before top Democrats plan to decamp for Chicago and the Democratic National Convention. Angered at Steward's mismanagement, Democrats in recent months have ruled out any bailout for the company. But there is a public cost associated with transitioning the Steward hospitals to new owners and

	helping them to improve. It's just starting to come into view, even though Healey didn't seem to want to talk about it Friday. The existing $30 million tab could surge north of $250 million, according to media reports. A Steward attorney told the court Friday that the company hopes to be "reporting a favorable result on signing the asset purchase agreements for Massachusetts on Monday," the same day that Democrats from around the country gather in the Midwest.
Assisted Living	**10. McKnights Senior Living** August 13, 2024 *CDC releases new profile of assisted living residents* By Kimberly Bonvissuto Residents living in assisted living and other residential care communities in 2022 mostly were female (67%), white (92%) and 85 or older (53%), according to a new report from the Centers for Disease Control and Prevention's National Center for Health Statistics. The CDC said that data from the National Post-acute and Long-term Care Study outlined in the profile of residential care community residents in 2022 would help inform policymakers, providers, researchers and consumer advocates planning to help meet the needs of a rapidly growing older adult population. In addition to assisted living communities, settings covered by the profile, released Wednesday, include personal care homes, adult care homes, board care homes and adult foster care. Most residents were aged 85 or more years (53%), followed by 75-84 (31%), 65-74 (10%) and or younger than 65 (6%). The most common activities of daily living residents needed assistance with were bathing (75%) and walking (71%), followed by dressing (60%), transferring to a bed or chair (57%), toileting (51%) and eating (28%). According to the data, 62% of residents needed assistance with three or more activities of daily living, 26% needed help with one or two activities of daily living, and 12% did not require any assistance. A substantial number of residential care community residents had diagnoses of high blood pressure (58%), Alzheimer's disease or other dementias (44%), or heart disease (33%). Other chronic conditions included depression (26%), arthritis (18%), chronic obstructive pulmonary disease (16%), diabetes (16%), osteoporosis (12%), stroke (7%) and cancer (6%). Approximately 18% of residents had received diagnoses of four to 10 of the most common chronic conditions, 55% had diagnoses of up to three chronic conditions, 19% had diagnoses of at least one of those conditions, and the remaining 8% had not received a diagnosis of any chronic condition. Overall, 17% of residents were Medicaid beneficiaries; residents younger than 75 made up the largest percentage of Medicaid beneficiaries (32%), followed by residents aged 75-84 (19%) and residents aged 85 or more years (12%). White non-Hispanic individuals accounted for the majority of residents (92%) in 2022, with only 2% identifying as Black non-Hispanic, and 6% identifying as another race or of Hispanic origin. **11. National Center for Health Statistics** August 2024 *Residential Care Community Resident Characteristics: United States 2022* Amanuel Melekin, Ph.D., Manisha Sengupta, Ph.D., and Christine Caffrey, Ph.D. Key findings

	Data from the National Post-acute and Long-term Care Study • In 2022, most residential care community residents were female (67%), White non-Hispanic (92%), and age 85 and older (53%). • About 17% of residential care community residents were Medicaid beneficiaries, and the percentage of residents with Medicaid varied by age. • Among residential care community residents, 75% needed assistance with bathing, 71% needed assistance with walking, and 62% needed assistance with three or more activities of daily living. • Among residential care community residents, about three in five had a diagnosis of high blood pressure and about two in five had a diagnosis of Alzheimer's disease or other dementias.
Health Care *Lauren Stiller Rikleen, the author of four books and the editor of "Her Honor — Stories of Challenge and Triumph from Women Judges," is executive director of Lawyers Defending American Democracy.*	**12. *Boston Globe** August 19, 2024 *The hellscape of the emergency department* By Lauren Stiller Rikleen *Staff avoided interactions in order to prevent being asked yet again the question they couldn't answer: How long will it be? The avoidance of eye contact added to the inhumanity of the experience.* While experiencing the interminable misery that is the emergency department at a premier Boston hospital, my husband and I saw a statement from its CEO, touting the hospital's recognition by U.S. News & World Report as one of the best in the nation. We wondered whether she has ever spent time in the hell that is her emergency department. The CEO of this Boston hospital would then see what we witnessed over two ED visits in the past two weeks. First is the jarring appearance of two interminably long rows of hard (some broken) chairs where sick people sit dangerously close to each other. No effort is made to separate the contagious from the immunocompromised. A young girl, who arrived eight hours earlier, lay on the floor, vomiting. An older man with a dangerous medical condition — there was no privacy — was sent by a community facility in another state, starting a new wait in increasing discomfort. Several people moaned loudly; others sobbed; one paced while swearing about his predicament. The bathrooms were constantly full. An inebriated man, teetering and incoherent, wandered the ED without attention, coming dangerously close to falling into the laps of crammed patients. A couple watched a violent movie at full volume on their phone, never asked by staff to lower the overpowering sound. Scant attention was paid to the man bellowing at an elderly woman, nor to another woman repeatedly shouting at someone to shut up. Triage nurses performed their assembly line of vital signs, dutifully noting blood pressure, heart rate, and temperature, then sending each patient back to the waiting room hellscape. Other staff avoided interactions as the only way to prevent being asked yet again the constant question they could not answer: How long will it be? The avoidance of eye contact added to the cold inhumanity of the experience. It's critical to appreciate that each day, round-the-clock shifts of ED staff show up to perform their overwhelmingly difficult tasks without the necessary resources and support to manage the flow as the system crashes around them. But there is also no escaping the conclusion that waiting in the ED could make your condition worse. This is a broken system

	where the insistence on revenue and profits has accelerated, leading to a massive failure to deliver care. It is a false narrative to call it an inevitable crisis that must be endured. Change, however, requires a shift in incentives and management approaches. Here are eight proposed ways to begin that process. **First, insurers, government leaders, and hospital administrators must immediately develop alternatives.** Too many patients who are clogging the overwhelmed ED system are there because there are too few available 24-hour urgent care facilities to treat illnesses that do not require a hospital. **Second, all aspects of hospital staffing and management decisions must consider their impact on the E**D. For example, when the discharge of hospitalized patients is delayed, the ED grinds to a halt. Yet patients are frequently told after morning rounds that they can go home, then wait hours before the final orders are completed, exacerbating the ED backup. Accelerating discharge, however, requires lessening the burden on already overwhelmed and overworked staff and hiring dedicated personnel to expedite all aspects of the process. **Third, space must be configured to separate the immunocompromised from the contagious.** **Fourth, offer comfort measures.** Hospitals should retain staff or volunteers to provide blankets, water, crackers, and simple human contact for the mass of terrified patients stuck in the purgatory of the wait and then relegated to **hallway boarding, where no attention is paid to physical needs.** **Fifth, more staff is needed to monitor safety and cleanliness**. Bathrooms should be cleaned frequently and security should be a visible presence throughout the ED, not just behind a barrier at the entrance. **Sixth, doctors should have the discretion to directly admit certain patients**, for example, those who present with symptoms identified in postoperative discharge papers as warranting immediate attention or cancer **patients facing perilous symptoms.** **Seventh, executive compensation should be tied to improvements in ED care.** It is disgraceful that a chief executive can earn millions while understaffed and overstressed hospital workers at every level are left to cope with incessant demands with no authority to manage their way out of the crisis. **Finally, the all-important U.S. News & World Report's ranking system does a gross disservice to patients by excluding emergency departments from its analysis.** My husband was provided with the outstanding care that the CEO touted once he was finally admitted following his first experience in the ED, but the ranking is an incomplete measure. Emergency departments are generally the gateway into a hospital at the outset of a medical problem and the way back if a complication develops after discharge. The failure to subject EDs to the scrutiny of peer comparisons provides tacit permission to CEOs that this critical component of their health care environment need not be among their top strategic priorities. It is a business fundamental that if something is not measured, it is not valued, affirming the lack of substantial investment needed to address the problem. My husband's second ED visit, less than two weeks and a surgical procedure later, was harder to tolerate, and staying felt like it posed more

	risks than leaving. So, after many terrifying hours and no sign of forthcoming care, we left. As we walked out the door in the middle of the night, we wondered when someone would come to clean up the diarrhea splattered on the floor, the humiliating aftereffect of a patient unable to obtain timely access to the bathroom; a patient who continued to sit, forlornly waiting for medical attention.
Covid / Long Covid	**13. NPR Morning Edition** August 15, 2024 *COVID is on the rise this summer. Here's why and what else you should know* By Kaity Kline If it seems like a lot of people are getting COVID right now, you're not imagining it. We're in the middle of a worldwide summer COVID-19 wave. A high or very high level of COVID-19 virus is being detected in wastewater in almost every state, according to data from the Centers for Disease Control and Prevention. At least 10 other states have a high amount of COVID in the wastewater. **This summer's surge, explained** [Dr. Ashish Jha, dean of the School of Public Health at Brown University and former White House COVID-19 response coordinator] said we've settled into what feels like a more familiar pattern with COVID. Recently, the CDC labeled COVID as being endemic, meaning that COVID is here to stay in predictable ways. There are two waves a year: one during summer and another during winter. The summer wave tends to be a little smaller, while the winter wave is bigger. But unlike the flu, which has a wave in the winter and almost no cases after, COVID infections can rise in between waves. "It's looking like this is probably not a seasonal virus, so it will likely be year-round," said Dr. Otto Yang, associate chief of infectious diseases at UCLA and professor of medicine in an interview with Morning Edition. Jha adds that the summer wave this year is still smaller than any of the winter ones, but as far as summer waves go, this has been a substantial one. It started a little earlier than the one last summer, and infections are still rising. Jha is hopeful that the surge will peak and ease soon, but he doesn't know exactly when that will happen. **New dominant variants causing spread** COVID is continuing to evolve very rapidly, and every three or four months we get a new COVID variant. **The role a new vaccine out in September could play** A new vaccine is currently being developed to target these new dominant variants. It is expected to come out in September. **So how often should you get a COVID booster?** Jha said that the recommendation for most people is to get one shot a year, He said there's evidence that for the highest risk people, like elderly people in their late 70s or 80s or people who are immunocompromised, a second shot in the spring can offer an important level of protection "If you look at deaths from COVID so far in 2024, it's down pretty substantially from 2023. So yes, we're getting these surges… but they're not turning into hospitalizations and deaths at the same kind of numbers we've seen in past years," Jha said. "That's progress. That's good news.

	That is immunity being built up over time. And so, each infection just doesn't mean as much as it did four years ago, or even as much as it did two years ago." **14. Reveal (podcast)** August 17, 2024 The COVID Tracking Project Part 3 At the height of the pandemic, COVID-19 was talked about as "the great equalizer," an idea touted by celebrities and politicians from Madonna to then-New York Gov. Andrew Cuomo. But that was a myth. Ibram X. Kendi and Boston University's Center for Antiracist Research worked with The COVID Tracking Project to compile national numbers on how COVID-19 affected people of color in the U.S. Their effort, The COVID Racial Data Tracker, showed that people of color died from the disease at around twice the rate of White people. The COVID Tracking Project's volunteer data collection team waited months for the Centers for Disease Control and Prevention to release COVID-19 testing data. But when the CDC finally started publishing the data, it was different from what states were publishing—in some instances, it was off by hundreds of thousands of tests. With no clear answers about why, The COVID Tracking Project's quest to keep national data flowing every day continued until March 2021. This week on Reveal: We examine the myth of COVID-19 as "the great equalizer," what went wrong in the CDC's response to the pandemic, and whether it's prepared for the next one. **15. Reveal (podcast)** August 10, 2024 *The COVID Tracking Project Part 2* In March 2020, health care technologist Amy Gleason had a daunting task ahead of her. She was a new member of the White House Coronavirus Task Force's data team, and it was her job to figure out where people were testing positive for COVID-19 across the country, how many were in hospitals, and how many had died from the disease. Gleason was shocked to find that data from the Centers for Disease Control and Prevention wasn't reflecting the immediate impact of the coronavirus. At the same time, the country was suffering from another huge shortfall: a lack of COVID-19 tests. The task force also faced national shortages of medical supplies like masks and ventilators and lacked basic information about COVID-19 hospitalizations that would help them know where to send supplies. Realizing that the federal government was failing to collect national data, reporters at The Atlantic formed The COVID Tracking Project. Across all 50 states, hundreds of volunteers began gathering crucial information on the number of cases, deaths, and hospitalizations. Each day, they compiled the state COVID-19 data in a massive spreadsheet, creating the nation's most reliable picture of the spread of the deadly disease. This week on Reveal: The second episode of our three-part series asks why there was no good federal data about COVID-19. **16. Reveal (podcast)** August 3, 2024 *The COVID Tracking Project Part 1* The United States has 4% of the world's population but more than 16% of COVID-19 deaths.

	Back in February 2020, reporters Rob Meyer and Alexis Madrigal from The Atlantic were trying to find solid data about the rising pandemic. They published a story that revealed a scary truth: The U.S. didn't know where COVID-19 was spreading because few tests were available. The Centers for Disease Control and Prevention also didn't have public data to tell citizens or federal agencies how many people were infected or where the outbreaks were happening. Their reporting led to a massive volunteer effort by hundreds of people across the country who gathered the data themselves. The COVID Tracking Project became a de facto source of data amid the chaos of COVID-19. With case counts rising quickly, volunteers scrambled to document tests, hospitalizations, and deaths in an effort to show where the virus was and who was dying. This week on Reveal: We investigate the failures by federal agencies that led to over 1 million Americans dying from COVID-19 and what that tells us about the nation's ability to fight the next pandemic
Disability Topics	**17. U.S. Department of Justice** August 15, 2024 *Justice Department Secures Agreement with Nebraska School District to End Discriminatory Treatment of Deaf and Hard of Hearing Students* The Justice Department announced today that it filed a complaint and proposed consent decree to resolve allegations that Lincoln Public Schools (LPS), in Lincoln, Nebraska, violated the Americans with Disabilities Act (ADA) by denying some deaf and hard of hearing students an equal opportunity to attend their neighborhood schools or participate in the high school choice program. Under LPS' cluster school policy, deaf and hard of hearing students believed to need American Sign Language (ASL) interpretation had to attend cluster schools serving deaf and hard of hearing students. In applying this policy, LPS did not consider the individualized needs of deaf and hard of hearing students, denied them an equal opportunity to participate in neighborhood school and high school choice programs and failed to provide effective communication to some deaf and hard of hearing students. **18. *Boston Globe** August 15, 2024 *Born without a right hand, he set his heart on playing the violin. Now he has his own unique sound.* By A.Z. Madonna This article is about violinist Adrian Anantawan, who was born without a right hand. He was able to learn to play the violin with the help of a prosthetic apparatus designed for him by a team at Toronto's Holland Bloorview Kids Rehabilitation Hospital. Anantawan is now a successful musician and educator, and he is dedicated to helping other musicians with disabilities. He founded the Music Inclusion Ensemble at Berklee College of Music, which provides a space for musicians with disabilities to connect and collaborate with each other.
Caregiving	**19. National Alliance for Caregiving (report)** 2023 *Transplant Caregiving in the U.S.: A Call for System Change* Although most patients recover and resume active lives after a transplant, there is risk of complications and side-effects that require a significant need

	for care. Caregivers, or the unpaid individuals providing care to family, friends, and those in need with illness and disability, are critical to transplant care. In fact, the transplant system heavily relies on caregivers, as transplant recipients are typically required to identify an available caregiver who will provide support during and after transplant. It is well-recognized that caregivers tend to experience negative consequences to their health and well-being due to grappling with a family member's illness while simultaneously adopting the role of caregiver and the associated responsibilities.2 Transplant caregivers tend to report numerous unmet needs and a lack of resources necessary to meet the demands of their role. This not only affects the caregivers' day-to-day functioning but can also impair their ability to carry out caregiving responsibilities and possibly jeopardize the success of the transplant patient. Due to the intensity of the transplant experience, family caregivers of the estimated 60,000 transplant patients in the United States face significant consequences to their health, emotional, and financial well-being. This report explores the experiences of family caregivers of transplant patients to shine a light on this area of unmet need in transplant care and caregiving. Findings are drawn from varied sources including a literature review, a subject matter expert panel, and focus groups and oral histories with family caregivers.
Medicare	**20. NPR Shots** August 15, 2024 *Medicare negotiated drug prices for the first time. Here's what it got* By Sydney Lupkin and Asma Khalid The White House unveiled the fruits of months of negotiations between the government and pharmaceutical companies: new, lower Medicare prices for 10 blockbuster drugs. The discounts range from 79% for diabetes drug Januvia to 38% for blood cancer drug Imbruvica. . . The program selected the first 10 medicines for negotiation last year based on several conditions laid out in the Inflation Reduction Act, which ended Medicare's 20-year ban on negotiating drug prices. The drugs included blockbuster blood thinners, like Eliquis and Xarelto, as well as drugs for arthritis, cancer, diabetes and heart failure. The negotiated prices will go into effect in January 2026. . . In all, these 10 drugs alone cost Medicare $50.5 billion in 2022, or about 20% of the program's gross total drug spending that year, according to HHS. They also cost beneficiaries $3.4 billion in out-of-pocket expenses. Medicare will begin negotiating prices for the next batch of medicines early next year. The process will continue annually with the government negotiating the prices of up to 20 drugs by the end of the decade.
In Other States	**21. Des Moines (Iowa) Register** August 19, 2024 *'This is scandalous:' Iowa auditor asked to examine millions nursing homes owe taxpayers* By Clark Kauffman **Iowa nursing homes owe taxpayers over $10 million in unpaid fees.** These fees are meant to increase staff wages but are often not used for this purpose. • **A single company, Accura Healthcare, owes $3.6 million.** Its executives have donated significantly to state politicians.

- **The state has failed to collect these fees.** The auditor's office can't enforce collection.
- **Advocates call for an investigation.** They believe taxpayers are being cheated and that the state isn't doing enough to ensure fees are used correctly.

The article raises concerns about the lack of oversight in the nursing home industry and the potential misuse of taxpayer funds.

Key issues:

- Nursing homes not paying required fees
- Lack of enforcement by the state
- Potential misuse of funds intended for staff wages
- Political donations from nursing home executives

22. Maine Public Radio

August 13, 2024

Amidst nursing home closures, relocating residents close to home is a challenge

By Patty Wight

A month after Narraguagus Bay Health Care in Milbridge announced its plan to close, nearly all of its 46 residents had been relocated. Only one remained. And early on a Monday morning in June, an ambulance crew arrived to transport her to another facility in Belfast, more than an hour away.. .

Over the past decade, 26 nursing homes in Maine have closed. And as the numbers shrink, it's becoming harder to relocate residents within 60 miles, which state regulations call for.

"That really is the goal, is that you want to place people not more than 60 miles away,"

said Brenda Gallant, Maine's Long-Term Care Ombudsman. Her office advocates for residents of long-term care facilities.

"Sometimes that's impossible if you can't find a provider that has an open bed, or there's a facility that can't meet the resident needs," Gallant said.

That was the case for John Drollett, who was relocated from Narraguagus Bay Health Care nearly three hours away to Lewiston.

"Don't get your hopes up that they're going to find you a place like they say they are, because right now, they're dwindling fast," he said. . .

More than two months after he moved, his long-time partner, Kathy Parsons, hasn't been able to visit. They have to rely on phone calls.

"Having him so far away is awful," she said.

Parsons said they were blindsided by the closure of Narraguagus Bay. And it was made even worse because they felt they had no options.

"They were like, 'well, this is all we've got.' Well, we had no say in it. None. It wasn't even a conversation," she said. "It was just, 'this is gonna happen.'"

Beyond the hardship of a long drive, Gallant, the Long-Term Care Ombudsman, said relocating can be traumatic for residents.

"They can suffer from relocation stress, they can have a decline in condition," she said. "Increase in falls, depression, there are many studies that document this."

Closures are happening across the U.S., but a recent report from the Federal Reserve Bank of Boston found that the rate of nursing home closures in New England is three times the national rate — and Maine had the highest percent of closures in the region. The report also found that from

	2022 to 2023, more than half of facilities in each New England state operated at a loss. . . Jones had already moved her father from another facility into Narraguagus Bay earlier this year. He had only been there for 10 weeks when they announced that it was closing. "The idea of moving him again, it feels unconscionable," she said. "Like, why would you do that to a healthy person, let alone, you know, a person who has memory problems?" Each move is like starting over, and she has to advocate for him all over again. After spending his life as a teacher and giving to the community, she said, it's not fair that her dad keeps losing his. **23. McKnights Long-Term Care News** August 13, 2024 *Nursing home owes $420K in unpaid wages: attorney general* By Jessica R. Towhey A Joliet, IL, nursing home that closed in March still owes 117 employees more than $420,000 in unpaid wages, the state attorney general alleged in a lawsuit — and the total continues to accrue. Attorney General Kwame Raoul filed the suit Aug. 2 against Salem Village Nursing and Rehabilitation Center, alleging that the owners underpaid the employees approximately $350,839. The additional $70,000 is unpaid wages that continue to accrue since the filing date, the lawsuit stated. The amount will continue to grow at $17,496 per month “without limitation until judgment is entered,” per the filing. According to local news reports, all residents had moved out of the facility by mid-February after the census had dropped from a maximum capacity of 272 down to 132 – the lowest in the 40 years Salem Village had been in operation. According to the Illinois Department of Health, 49 nursing homes closed between 2019 and 2022. So far this year, two facilities in Joliet have closed, Salem Village and Our Lady of Angels. Peoria-based Petersen Health Care entered foreclosure proceedings in early 2024, affecting 17 nursing homes and assisted living facilities. With increasing financial pressures, unpaid wages have become a significant issue throughout the long-term care industry this year. The Massachusetts attorney general ordered three long-term care facilities owned by Bluepoint Healthcare into receivership last month after the provider failed to pay employees for weeks. And in July, a Pennsylvania judge levied a $35.8 million judgment against 15 nursing homes, faulting the owner on-site managers, and a shared management firm “routinely” failed to properly compensate nearly 6,000 workers over six years. Workers at several of those facilities were unlikely to ever be paid, given an ongoing bankruptcy sale that could let the owners off the hook.
Public Sessions	**24. State Plan Committee of the State Rehabilitation Council** Wednesday, August 21, 2024, 11:00 a.m. Meets virtually. Agenda includes a review of the Massachusetts Rehabilitation Commission's responses to the SRC's fiscal 2025 recommendations, as well as a review of 2024 annual reports. Agenda and Livestream **25. Board of Registration of Allied Health Professionals** Thursday, August 22, 2024, 9:00 a.m.

	Meets virtually. Agenda includes a discussion on the Unified Recovery and Monitoring Program. The program is a confidential and voluntary effort to monitor the rehab of licensed health care professionals who seek help for their mental health or substance use or are referred to URAMP by a licensing board. Agenda and Livestream **26. MBTA BOARD: MBTA Board of Directors** Meeting Thursday, August 22, 2024, 10:00 a.m. State Transportation Building, 2nd Floor, 10 Park Plaza, Boston Agenda and Livestream
Support Dignity Alliance Massachusetts **Please Donate!**	Dignity Alliance Massachusetts is a grassroots, volunteer-run 501(c)(3) organization dedicated to transformative change to ensure the dignity of older adults, people with disabilities, and their caregivers. We are committed to advancing ways of providing long-term services, support, living options and care that respect individual choice and self-determination. Through education, legislation, regulatory reform, and legal strategies, this mission will become reality throughout the Commonwealth. **As a fully volunteer operation, our financial needs are modest, but also real. Your donation helps to produce and distribute *The Dignity Digest* weekly free of charge to almost 1,000 recipients and maintain our website, www.DignityAllianceMA.org, which has thousands of visits each month.** **Consider a donation in memory or honor of someone.** **Names of those recognized will be included in The Dignity Digest and posted on the website.** **https://dignityalliancema.org/donate/** Thank you for your consideration!
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	
Podcasts	**Consumer Voice Podcast Library** The Consumer Voice maintains an extensive library of podcasts covering an array of long-term care topics.
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/.

<table>
<tr><td>Websites of Dignity Alliance Massachusetts Members</td><td colspan="2">See: https://dignityalliancema.org/about/organizations/</td></tr>
<tr><td>Contact information for reporting complaints and concerns</td><td>Nursing home</td><td>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</td></tr>
<tr><td>Money Follows the Person</td><td colspan="2">MassHealth
Money Follows the Person
The Money Follows the Person (MFP) Demonstration helps older adults and people with disabilities move from nursing facilities, chronic disease or rehabilitation hospitals, or other qualified facilities back to the community.
Statistics as of August 9, 2024:
645 people enrolled, most in nursing facilities
137 people transitioned out of nursing facilities
38 people approved for AHVP (Alternative Housing Voucher Program) nursing home vouchers, 14 currently in use
Open PDF file, 1.34 MB, MFP Demonstration Brochure
MFP Demonstration Brochure - Accessible Version
MFP Demonstration Fact Sheet
MFP Demonstration Fact Sheet - Accessible Version</td></tr>
<tr><td>Nursing Home Closures (pending)</td><td colspan="2">Massachusetts Department of Public Health
Marion Manor, South Boston
Closure date: September 11, 2024
• Notice of Intent to Close (PDF) | (DOCX)
Massachusetts Nursing Home Survey Performance Tool and the CMS Nursing Home Compare website.</td></tr>
<tr><td>Nursing Home Closures</td><td colspan="2">Massachusetts Department of Public Health
Bridgewater Nursing & Rehab, Bridgewater
Closure date: May 24, 2024
Savoy Nursing and Rehabilitation Center, New Bedford
Closure date: April 3, 2024
New England Sinai Hospital Transitional Care Unit
Closure date: April 2, 2024
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</td></tr>
</table>

	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 April 24, 2024** 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)** **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)** • AdviniaCare Newburyport (3) https://www.adviniacare.com/adviniacare-country-center/ Nursing home inspect information: https://projects.propublica.org/nursing-homes/homes/h-225332 • Charwell House Health and Rehabilitation, Norwood (27) https://tinyurl.com/Charwell Nursing home inspect information: https://projects.propublica.org/nursing-homes/homes/h-225208 • Fall River Healthcare (9) https://www.nextstephc.com/fallriver Nursing home inspect information: https://projects.propublica.org/nursing-homes/homes/h-225723/ • Glen Ridge Nursing Care Center, Medford (13) https://www.genesishcc.com/glenridge Nursing home inspect information: https://projects.propublica.org/nursing-homes/homes/h-225523 • Mill Town Health and Rehabilitation, Amesbury (26) No website Nursing home inspect information: https://projects.propublica.org/nursing-homes/homes/h-225318 • Parkway Health and Rehabilitation Center, West Roxbury (7) https://www.bearmountainhc.com/locations/parkway-health-rehabilitation-center/ Nursing home inspect information: https://projects.propublica.org/nursing-homes/homes/h-225497 • Pioneer Valley Health & Rehabilitation Center, South Hadley (24) https://pioneervalleyhealth.com/ Nursing home inspect information: https://projects.propublica.org/nursing-homes/homes/h-225757 • Plymouth Harborside Healthcare (4) https://www.nextstephc.com/plymouth Nursing home inspect information: https://projects.propublica.org/nursing-homes/homes/h-225284/ • Plymouth Rehabilitation and Health Care Center (22) https://plymouthrehab.com/ Nursing home inspect information: https://projects.propublica.org/nursing-homes/homes/h-225207 • Royal Norwell Nursing & Rehabilitation Center (4) https://norwell.royalhealthgroup.com/ Nursing home inspect information: https://projects.propublica.org/nursing-homes/homes/h-225482/ **Massachusetts Facilities that have graduated from the program**

<table>
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- Marlborough Hills Rehabilitation & Health Care Center, Marlborough
https://marlboroughhillsrehab.com/
Nursing home inspect information:
https://projects.propublica.org/nursing-homes/homes/h-225063/
- Oxford Rehabilitation & Health Care Center, Haverhill
https://theoxfordrehabhealth.com/
Nursing home inspect information:
https://projects.propublica.org/nursing-homes/homes/h-225218/

No longer operating

- South Dennis Healthcare, South Dennis

https://tinyurl.com/SpeciialFocusFacilityProgram
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<tr><td>Nursing Home Inspect</td><td>

ProPublica
Nursing Home Inspect

Data updated April 24, 2024
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?)

Deficiency Tag	# Deficiencies in	# Facilities	MA facilities cited
B	284	198	Tag B
C	108	85	Tag C
D	7,496	1,469	Tag D
E	1,965	788	Tag E
F	656	317	Tag F
G	568	384	Tag G
H	44	33	Tag H
I	3	2	Tag I
J	57	27	Tag J
K	8	5	Tag K
L	5	2	Tag L

Updated April 24, 2024
</td></tr>
<tr><td>Nursing Home Compare</td><td>

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.
</td></tr>
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	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.		
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 Dignity Alliance Massachusetts Most workgroups meet bi-weekly via Zoom.	**Workgroup**	**Workgroup lead**	**Email**
	General Membership	Bill Henning Paul Lanzikos	bhenning@bostoncil.org paul.lanzikos@gmail.com
	Assisted Living	John Ford	jford@njc-ma.org
	Behavioral Health	Frank Baskin	baskinfrank19@gmail.com
	Communications	Lachlan Forrow	lforrow@bidmc.harvard.edu
	Facilities (Nursing homes and rest homes)	Arlene Germain	agermain@manhr.org
	Home and Community Based Services	Meg Coffin	mcoffin@centerlw.org
	Legislative	Richard Moore	rmoore8743@charter.net
	Legal Issues	Jeni Kaplan	jkaplan@cpr-ma.org
Interest Groups meet periodically (monthly, bi-monthly, or quarterly).	**Interest Group**	**Group lead**	**Email**
	Housing	Bill Henning	bhenning@bostoncil.org
	Veteran Services	James Lomastro	jimlomastro@comcast.net
	Transportation	Frank Baskin	baskinfrank19@gmail.com

Please contact group lead for more information.		Chris Hoeh	cdhoeh@gmail.com
	Covid / Long Covid	James Lomastro	jimlomastro@comcast.net
	Incarcerated Persons	TBD	info@DignityAllianceMA.org

The Dignity Digest	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
Note of thanks	Thanks to the contributors to this issue of *The Dignity Digest* • Scott Harshbarger • James Lomastro • Dick Moore • Priscilla O'Reilly 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.*

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.