The Dignity Digest

Issue # 288 June 16, 2026

The Dignity Digest contains 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.

Reflection

Alzheimer's and Brain Awareness Month is a reminder that while a disease may alter memory, it can never diminish a person's worth, dignity, or the deep impact of their life's journey. We honor the resilience of individuals, families, and caregivers who remind us every day that love does not require a perfect memory to be deeply felt.

"Remember the relationship is not lost. It has simply changed. We must learn to meet them where they are today, in the warmth of the present moment."

Paraphrased from the work of **Dr. David Troxel**, Alzheimer's care expert and author

Guide to news items in this week's *Dignity Digest*

Nursing Homes

- *Hospital-Nursing Home Cost-Cutting Collaborations Grow, Lowering Readmissions but Driven by Referral Volume and Geography* **(Skilled Nursing News,** June 10, 2026
- *Ensign's business model relies on delivering inadequate care to patients while gaming data on quality, according to Hunterbrook's five-month investigation. Patients are dying.* (**Hunterbrook,** June 8, 2026)

Home and Community Based Services

- *Why Meals on Wheels America Desperately Needed the $70 Million It Got From MacKenzie Scott* **(*Time,** May 20, 2026)

Health Care Topics

- *Restarting Medications After Deprescribing in Adults Discharged From Hospital to Skilled Nursing* **(JAMA Network,** June 8, 2026)

Private Equity

- *After nursing home crises, states target private equity's role* **(The Gilmer Mirror,** June 9, 2026)

	Ageism • *Confronting Ageism As A Driver Of Health Inequity* **(Health Affairs,** June 11, 2026) Medicare • *Seniors needed long-term care and rehab. Their private Medicare plans said no.* **(*Washington Post,** June 11, 2026) Workforce • *America Is Running Out of Nurses, and DACA Recipients Are Helping Provide Critical Care to Communities Despite Threats of Deportation From the Trump Administration* **(Center for American Progress,** June 15, 2026) Office of Governor Maura Healey and Lt. Kim Driscoll • *Governor Healey Signs Legislation Modernizing State Law and Promoting Respect for People with Disabilities* **(Office of Governor Maura Healey and Lt. Governor Kim Driscoll,** June 12, 2026) Federal Policy • *Medicare Should Pay Docs More, Cut Nursing Home and Home Health Pay, MedPAC Says* **(MedPage Today,** June 15, 2026) • *Medicaid Work Requirements: Who's Affected and What's at Stake* **(Health Affairs (podcast),** June 12, 2026) • *Medical Frailty Rule Contravenes HR 1, Burdens The Health Care System, Ad Threatens Public Health* **(Health Affairs,** June 12, 2026) • *Regulating Corporate Control in the U.S. Health Care System* **(*New England Journal of Medicine,** May 30, 2026) From Around the Country • *A New Option for Long-Term Care Costs* **(New York Times (free access),** June 13, 2026) From Our Colleagues from Around the Country • **In this Issue** **(The Consumer Voice,** June 9, 2026)
Policy Insight	**Policy Insight: Rethinking the Fight Against Corporate Healthcare Consolidation** As advocates and state lawmakers scramble to erect guardrails against the rapid expansion of private equity and corporate control over our healthcare infrastructure, policy experts warn that simply banning specific corporate structures may not be enough. Writing in the *New England Journal of Medicine*, Loren Adler of the Brookings Institution argues that corporate aggregation is a symptom of a deeper systemic flaw. To truly protect consumers and patients from the documented harms of corporatization—including severe staffing shortages, reduced quality of care, and hidden profits—regulators must shift their focus toward dismantling the very financial rewards

	that make medicine such an attractive target for Wall Street investors. As Adler notes: ***"Rather than attempting to micromanage corporate structures or ownership forms directly, a more sustainable regulatory approach would target the underlying financial incentives, distorted payment policies, and anticompetitive market advantages that make healthcare consolidation uniquely profitable in the first place."*** *Source: Adler, L. (2026). "The Corporatization of Medicine — Addressing the Root Causes." New England Journal of Medicine, 394(24).*
Quotes	***Congress is full of old people. Why do they not care?*** *When you talk to individual members of Congress, they're very supportive, but when it comes to making decisions, it's difficult to get together. Things used to be much more bipartisan than they are now. The staff that they bring in are also younger, and we have to educate them too, because there's a lot of turnover. Many of them just don't have any idea that there are issues around seniors and hunger and social isolation in our country.* Ellie Hollander, CEO, Meals on Wheels America, *Why Meals on Wheels America Desperately Needed the $70 Million It Got From MacKenzie Scott* **(*Time,** May 20, 2026) *"An Act Dignifying Individuals with Intellectual or Developmental Disabilities represents a significant step forward—not only in how we talk about disability, but in how we affirm the value and dignity of every person across the Commonwealth."* State Senator Robyn Kennedy (D-Worcester) Senate Chair of the Joint Committee on Children, Families, and Persons with Disabilities, *Governor Healey Signs Legislation Modernizing State Law and Promoting Respect for People with Disabilities* **(Office of**

Governor Maura Healey and Lt. Governor Kim Driscoll, June 12, 2026)

But greater life expectancy has not been accompanied by increases in healthy years of life. In 2023, more than nine in ten older adults had at least one chronic condition, such as high blood pressure, high cholesterol, arthritis, and diabetes, and more than three-quarters of them had two or more chronic conditions. About one-third of older adults have cognitive, visual, auditory, or ambulatory limitations, and about 20 percent have difficulty with self-care activities. In addition, the longevity revolution is unequal. There are major disparities in life expectancy by race, ethnicity, sex, socioeconomic status, and residence. On average, women live five years longer than men, White people live five years longer than Black people, and low-income adults ages sixty and older die, on average, nine years earlier than those in the highest-income group.

Confronting Ageism As A Driver Of Health Inequity **(Health Affairs,** June 11, 2026)

Elderly people on privatized Medicare plans were routinely denied coverage for long-term hospital care and inpatient rehab by a trio of for-profit insurers that dominate the program, according to a government watchdog report released Thursday, raising concerns that some patients may have been refused medically necessary care.

Seniors needed long-term care and rehab. Their private Medicare plans said no. **(*Washington Post,** June 11, 2026)

The investigation revealed Ensign's $10 billion empire is built on a dubious foundation: Its profits are heavily dependent on understaffing facilities. It performs better than average on self-reported quality

metrics but worse on independently verifiable measures. It regularly violates state minimum staffing laws, and routes taxpayer dollars to its executives and to its own affiliates. Meanwhile, Ensign patients suffer and sometimes die.

Ensign's business model relies on delivering inadequate care to patients while gaming data on quality, according to Hunterbrook's five-month investigation. Patients are dying. (**Hunterbrook,** June 8, 2026)

An estimated 70 percent of Americans will need long-term care at some point in their lives, but "they haven't planned for it or saved for it."

Cathleen MacCaul, advocacy director for AARP Washington State, *A New Option for Long-Term Care Costs* **(New York Times (free access),** June 13, 2026)

"Long-term care is the largest area of unprotected health risk in the United States. Most people have nothing."

Richard Frank, director of the Center on Health Policy at the Brookings Institution, *A New Option for Long-Term Care Costs* **(New York Times (free access),** June 13, 2026)

"DACA recipients are fundamental [to] every single community. … We are very determined, hardworking, we want to expand our careers and there are a lot of barriers to it, but we are still doing it."

Ingrid, DACA nurse, *America Is Running Out of Nurses, and DACA Recipients Are Helping Provide Critical Care to Communities Despite Threats of Deportation From the Trump Administration* **(Center for American Progress,** June 15, 2026)

"To bring fee-for-service Medicare's overall payment levels closer in line with providers' costs, the commission ... recommends slightly increasing (above current law) payment rates for the hospital outpatient and inpatient prospective payment systems and the Physician Fee Schedule, modestly

decreasing payment rates for outpatient dialysis services and hospice services, and ***substantially decreasing payment rates for post-acute care providers (i.e., skilled nursing facilities, home health agencies, and inpatient rehabilitation facilities, which have high Medicare profit margins of 24%, 21%, and 17%, respectively****)."*

[*Medicare Should Pay Docs More, Cut Nursing Home and Home Health Pay, MedPAC Says*] **(MedPage Today,** June 15, 2026)

Take Charge of Your Brain Health: An Alzheimer's & Brain Awareness Month Series

Presented by the Alzheimer's Association Massachusetts and New Hampshire Chapter virtually on Zoom. Co-hosted by AARP Massachusetts.

Commentary Offered by DignityMA Participants

Richard T. Moore is Chair of the DignityMA Legislative Workgroup and a member of the Coordinating Committee. He is a former Massachusetts State Senator.

The views expressed by individuals are their own and do not necessarily reflect the policy position or perspective of Dignity Alliance Massachusetts.

Beyond Margins: Why Nursing Home Finance Transparency Matters for Aging Policy

By Richard T. Moore
June 15, 2026

For decades, policymakers, journalists, advocates, and the public have been told that nursing homes operate on razor-thin margins. Whenever proposals emerge to strengthen staffing standards, improve transparency, expand resident protections, or enhance regulatory oversight, industry representatives frequently respond with a familiar argument: nursing homes simply cannot afford additional requirements. This narrative has become one of the most influential assumptions shaping long-term care policy in the United States. It is reinforced by widely cited financial reports and industry analyses that portray nursing facilities as struggling enterprises operating on the edge of financial viability. Yet a recent report by David Kingsley, *The Myth of the "Low Margin": A Rebuttal to the Nursing Home Industry's Accounting Firm*, challenges the foundations of this assumption and raises a critical question for policymakers: Are we measuring nursing home profitability in a way that accurately reflects the financial realities of modern long-term care enterprises?[1]

The question deserves serious consideration because the answer has profound implications for public policy, workforce investment, quality improvement, and the future of long-term care. Kingsley's report examines the methodology used in the annual Skilled Nursing Facility Cost Comparison and Industry Trends Report published by CliftonLarsonAllen (CLA), one of the nation's largest accounting

firms and a frequently cited source of industry financial information. According to Kingsley, the report relies heavily on facility-level operating margins derived from Medicare and Medicaid cost reports while failing to account adequately for increasingly complex ownership structures that characterize much of the nursing home industry. [1]

Whether one agrees with every aspect of Kingsley's critique, his central observation highlights an important policy challenge. Today's nursing homes are often part of intricate networks of corporations, limited liability companies, management organizations, and real estate entities. The licensed nursing facility may no longer represent the true economic unit of the enterprise. Researchers and policymakers have increasingly recognized that ownership structures in long-term care have become more complex over time. A growing body of literature has documented the expansion of private equity investment, real estate investment trusts (REITs), management companies, and related-party transactions within the nursing home sector.[2] [3] [4] These arrangements can make it difficult for regulators, residents, families, and even policymakers to understand how public funds ultimately flow through nursing home enterprises.

The issue is not merely academic. Medicaid remains the primary payer for long-term nursing home care in the United States. Federal and state governments collectively spend billions of taxpayer dollars each year supporting long-term services and support. When public funding is involved, transparency becomes a prerequisite for accountability.

Kingsley's report argues that facility-level operating margins may provide an incomplete picture because revenues can be transferred to related entities through rents, management fees, consulting agreements, and other financial arrangements before profitability is measured at the facility level.[1] If that assertion is correct, policymakers relying exclusively on facility-level margins may be making decisions based on only part of the financial picture. This concern echoes findings from other national investigations. The National Academies of Sciences, Engineering, and Medicine concluded in its landmark 2022 report on nursing home quality that greater transparency regarding ownership, finances, and accountability is essential to improving quality and restoring public trust in the long-term care system.[5] Similarly, federal agencies including the Government Accountability Office and the Centers for Medicare & Medicaid Services have identified challenges associated with opaque ownership arrangements and related-party transactions.[6] [7]

These concerns became particularly visible during the COVID-19 pandemic. The pandemic exposed longstanding weaknesses in the nation's nursing home system, including inadequate staffing levels, workforce instability, infection control deficiencies, and uneven

quality outcomes. It also intensified scrutiny of how nursing homes allocate resources and whether public investments are reaching the bedside. In response, federal policymakers initiated reforms aimed at improving ownership transparency and increasing public access to information about nursing home finances and corporate relationships. [7]

Understanding where money goes matters because financial decisions directly affect the daily lives of residents. Staffing levels, wages, benefits, training opportunities, behavioral health services, recreational programming, facility maintenance, and quality improvement initiatives all depend upon the availability and allocation of resources. When discussions about reimbursement rates occur without a clear understanding of how funds move through nursing home enterprises, policymakers may struggle to determine whether additional public funding will improve resident care or simply flow elsewhere within complex corporate structures.

This is particularly important as the nation confronts unprecedented demographic change. The population age 85 and older is expected to grow substantially over the coming decades, increasing demand for long-term services and supports. At the same time, providers face workforce shortages, rising labor costs, and growing expectations regarding quality and accountability. Meeting these challenges will require both public investment and public confidence.

Transparency should not be viewed as an attack on providers. Rather, it should be viewed as an essential component of a sustainable and trustworthy long-term care system. Most stakeholders—including providers, residents, families, advocates, and policymakers—share a common interest in ensuring that public resources are used effectively to support high-quality care. Kingsley's report ultimately argues that policymakers should look beyond facility-level margins and examine consolidated financial information that captures the full economic reality of nursing home enterprises. [1] Whether policymakers adopt that recommendation in its entirety or pursue alternative approaches, the broader principle remains compelling: effective policy requires accurate information.

The future of aging policy will depend not only on how much society invests in long-term care, but also on how clearly, we understand where those investments go. As debates continue regarding Medicaid reimbursement, staffing requirements, workforce development, and nursing home quality, policymakers should ensure that financial transparency keeps pace with the increasingly sophisticated ownership structures that characterize modern long-term care. Only then can decisions be grounded in a complete understanding of the resources available to support older adults and people with disabilities.

The conversation about nursing home finances should therefore move beyond margins alone. The larger issue is accountability,

transparency, and the responsible stewardship of public resources in service of those who depend upon long-term care.

References

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6. U.S. Government Accountability Office. (2023). *Nursing Homes: CMS Should Improve Efforts to Monitor Ownership and Financial Transparency.*
7. Centers for Medicare & Medicaid Services. (2023). *Medicare and Medicaid Programs; Disclosures of Ownership and Additional Disclosable Parties Information for Skilled Nursing Facilities and Nursing Facilities.*

Affordability Must Include Aging and Disability: A Response to Senate President Spilka's Address to the Greater Boston Chamber of Commerce

By Richard T. Moore
June 15, 2026

Senate President Karen Spilka is right to place affordability at the center of Massachusetts public policy. Housing, healthcare, energy costs, and workforce challenges are affecting families across the Commonwealth, and her remarks to the Greater Boston Chamber of Commerce on June 11, 2026, recognize the very real pressures facing residents and employers alike.

Yet one of the largest and fastest-growing populations in Massachusetts was largely absent from the discussion: older adults and people with disabilities.

By 2030, one in four Massachusetts residents will be age 60 or older. At the same time, hundreds of thousands of residents with disabilities depend upon healthcare, housing, transportation, and long-term services and supports to remain active members of their communities. Any affordability agenda that does not address their needs is incomplete.

	The Senate President's focus on strengthening primary care is welcome. Access to primary care has become increasingly difficult, particularly in underserved communities. However, improving access alone is not enough. Massachusetts must also invest in geriatric medicine and workforce training so that healthcare providers are prepared to meet the complex needs of an aging population. Older adults frequently live with multiple chronic conditions, cognitive impairment, mobility limitations, and behavioral health needs that require specialized knowledge and coordinated care. Healthcare affordability also means more than controlling insurance premiums and reimbursement systems. For thousands of nursing facility residents, the Commonwealth's Personal Needs Allowance has remained virtually unchanged for two decades despite dramatic increases in the cost of clothing, toiletries, communication services, and other necessities. Residents who depend on this allowance are expected to survive on an amount that no longer reflects economic reality. At the same time, budget decisions continue to send mixed signals about Massachusetts' commitment to community living. Programs that help older adults and people with disabilities remain independent—including Elder Community Options Program services, Personal Care Attendant supports, and behavioral health services for older adults—have not received the level of investment necessary to meet growing demand. Behavioral health services specifically designed for older adults remain unavailable in much of the Commonwealth despite well-documented needs related to depression, anxiety, substance use disorders, and social isolation. The Senate President correctly identifies rising energy costs as an affordability challenge. But for many older adults and people with disabilities, energy affordability is not simply about heating costs in winter. Increasingly dangerous summer temperatures pose serious health risks. Massachusetts has long provided heating assistance through LIHEAP, yet cooling assistance remains inadequate despite climate change making extreme heat a growing public health emergency. No resident should be forced to choose between running an air conditioner and paying for food or medication. Perhaps the most significant omission from the affordability discussion is long-term care. For decades, Massachusetts has responded to long-term care challenges by increasing payments to nursing facilities while accepting a system that too often delivers understaffing, poor quality care, social isolation, excessive reliance on psychotropic medications, and preventable declines in residents' health and well-being. The Commonwealth continues to spend billions of dollars annually on institutional care while thousands of older adults and

people with disabilities would prefer to remain in their homes and communities.

The evidence is clear: most people want to age in place. Home and community-based services are generally preferred by consumers, often produce better outcomes, and can be delivered more cost-effectively than institutional care. Yet access remains uneven and insufficient.

A true affordability agenda should include a long-term care rebalancing strategy that shifts resources from institutional care toward home and community-based services, caregiver supports, accessible housing, transportation, behavioral health services, and direct care workforce investments. Such a strategy would improve quality of life while helping Massachusetts manage the fiscal pressures associated with an aging population.

The Senate President spoke about the importance of making Massachusetts a place where people can build a future. We agree. But that future must include the ability to grow older with dignity, independence, and security.

Affordability cannot be measured solely by the cost of housing, healthcare premiums, or energy bills. It must also be measured by whether older adults can remain in their homes, whether family caregivers receive adequate support, whether people with disabilities can participate fully in community life, and whether nursing home residents are treated with dignity and respect.

Massachusetts has long been a national leader in healthcare, innovation, and social progress. The next frontier of leadership should be creating a Commonwealth where aging and disability are not afterthoughts, but central considerations in every major policy discussion.

If affordability is truly the defining challenge of our time, then older adults and people with disabilities must be part of the solution—and part of the conversation

Equal Rights Should Not Expire with Age or Disability: It's Time to Amend the Massachusetts Constitution

By Richard T. Moore
June 14, 2026

Massachusetts has long prided itself on being a leader in civil rights. From the abolitionist movement to marriage equality, our Commonwealth has often been ahead of the nation in recognizing the dignity and worth of every person. Yet one glaring omission remains in our Constitution.

The Massachusetts Constitution contains no explicit protection against discrimination based on age or disability. For nearly

two million older adults and more than one million residents living with disabilities, that omission matters. It matters because discrimination based on age and disability is not a relic of the past. It is a daily reality in employment, housing, health care, transportation, voting access, public accommodation, and long-term care. While federal and state laws prohibit many forms of discrimination, those protections are statutory—not constitutional. They can be weakened, narrowed, or repealed by future legislatures. Constitutional rights stand on firmer ground.

Massachusetts first popularly ratified its Constitution on June 15, 1780, and amended it 121 times since. We should further amend our State Constitution to guarantee that no person shall be denied equal protection of the laws or discriminated against because of age or disability. Such an amendment would not create special rights. It would fully recognize equal rights.

Today, the law treats age and disability differently from other protected characteristics. Courts generally apply a lower level of scrutiny when reviewing laws or policies that disadvantage older adults or people with disabilities. In practice, this means governments and institutions often have greater latitude to justify unequal treatment. The consequences are visible across society.

Older adults encounter mandatory age-based barriers in employment and access to services. People with disabilities continue to face obstacles to full participation in community life despite decades of progress since passage of the Americans with Disabilities Act. Residents of nursing homes and other congregate care settings frequently experience restrictions on autonomy and self-determination that would be unacceptable in other settings. The COVID-19 pandemic exposed these vulnerabilities with devastating clarity. Thousands of older adults and people with disabilities died in long-term care facilities across the nation. Crisis standards of care in some states raised troubling questions about whether age or disability could influence access to lifesaving treatment. The pandemic reminded us that legal protections are only as strong as the values embedded in our governing institutions.

A constitutional amendment would send a clear message that every resident of Massachusetts possesses equal worth and equal dignity under the law. This is not a radical idea.

Several states have already moved in this direction. Connecticut and Illinois include disability protections in their

constitutions. In 2024, New York voters overwhelmingly approved a constitutional amendment prohibiting discrimination based on age and disability, among other characteristics. Their action reflects a growing recognition that equal protection should evolve to address contemporary realities. Massachusetts should do the same.

The need is especially urgent as demographic change reshapes our Commonwealth. By 2030, one in four Massachusetts residents will be age 60 or older. At the same time, advances in medicine and technology are enabling more people with disabilities to live, work, and participate fully in their communities than ever before. These trends should be celebrated. Instead, they often expose gaps in public policy and persistent stereotypes. Too often, aging is viewed as decline rather than continued contribution. Disability is too often viewed through a lens of limitation rather than capability. Constitutional protections can help challenge these assumptions by affirming that neither age nor disability diminishes a person's claim to equal treatment.

Critics may argue that existing laws already provide adequate protection. But history teaches otherwise. Many rights that Americans now consider fundamental were first protected by statute before being recognized as constitutional principles. Constitutional amendments are reserved for values that a society wishes to place beyond ordinary politics. If equality is one of those values—and surely it is—then age and disability deserve constitutional recognition.

Others may worry that such an amendment would lead to excessive litigation. Similar concerns have accompanied nearly every expansion of civil rights in our nation's history. Yet constitutional guarantees do not create conflict; they provide a framework for resolving it fairly. They establish principles that guide lawmakers, courts, businesses, and public institutions toward more equitable outcomes. At its core, this proposal is about the kind of Commonwealth we aspire to be. Every Massachusetts resident will experience aging if fortunate enough to live long enough. Disability can touch any family at any time through birth, illness, injury, or the natural process of growing older. These are not issues affecting a small minority. They are part of the human condition.

A constitutional amendment protecting against age and disability discrimination would acknowledge that reality. It would affirm that equal rights do not diminish with advancing years. They do not depend on physical ability, cognitive

capacity, or health status. They belong to every person simply because they are human. Massachusetts has an opportunity to lead once again. The question is whether we are willing to declare, according to our law, that equality has no age limit and no disability exception.

The answer should be yes.

Protecting Access to the Ballot for Older Adults and People with Disabilities

By Richard T. Moore
June 12, 2026

The right to vote is the foundation upon which all other rights rest. For older adults and people with disabilities, however, exercising that right often requires accommodations that many other voters take for granted.

For a resident of a nursing facility in Worcester, a homebound older adult in Springfield, or a person with a disability living independently in Pittsfield, voting by mail is often not a matter of convenience. It is the means by which they remain full participants in our democracy.

That is why a recently proposed United States Postal Service rule should concern every Massachusetts resident who values both election integrity and equal access to the ballot box.

The proposal would permit the Postal Service to refuse delivery of mail ballots in states that do not comply with certain federal voter-information requirements. It would also involve Postal Service employees in screening ballots before they enter the mail stream. Election officials and voting-rights advocates have warned that these changes could create delays, confusion, and barriers for voters who rely on mail ballots. The proposal would represent a significant departure from the Postal Service's traditional role as a neutral carrier of election mail.

For older adults and people with disabilities, the consequences could be profound.

Massachusetts is home to nearly two million residents age 60 and older and hundreds of thousands of residents living with disabilities. Tens of thousands reside in nursing facilities, assisted living residences, rest homes, and other congregate care settings. Many thousands more remain in their homes with the support of family caregivers, personal care attendants, and community-based services.

For these residents, voting by mail is often the most practical—and sometimes the only—way to exercise the right to vote.

Over the past several decades, Massachusetts has worked diligently to make voting more accessible while maintaining strong safeguards to ensure election integrity. Polling places have become more accessible. Absentee voting has been strengthened. Mail voting has expanded. Election administrators have demonstrated that security and accessibility are not competing values but complementary responsibilities.

Dignity Alliance Massachusetts commends Secretary of the Commonwealth William F. Galvin, the Commonwealth's Chief Elections Officer, for his longstanding efforts to protect both the integrity and accessibility of Massachusetts elections. Under his leadership, Massachusetts has earned a reputation for conducting elections that are secure, fair, accurate, and accessible to all eligible voters.

The Commonwealth's experience demonstrates an important truth: protecting election integrity does not require making it harder for older adults and people with disabilities to vote.

Indeed, the opposite is true. A strong democracy depends upon ensuring that every eligible citizen can participate.

The Postal Service proposal introduces uncertainty into a process that many older adults and people with disabilities depend upon. Any disruption in ballot delivery can disproportionately affect individuals who cannot easily adapt to last-minute changes.

> A younger voter with access to transportation may be able to drive to a polling place if a mail ballot is delayed. A resident of a nursing home may not have that option. A homebound voter with significant disabilities may not have that option. A person who relies on caregivers or accessible transportation services may not have that option.

For these voters, a delayed ballot can become a lost vote.

This issue is particularly important for residents of long-term care facilities. Too often, society treats nursing home residents as passive recipients of care rather than as citizens with voices that matter. Yet they remain taxpayers, veterans, parents, grandparents, advocates, and voters. Their right to participate in civic life should be protected with the same vigor as that of any other citizen.

Massachusetts has made significant progress in recognizing that civic participation is essential to dignity, independence, and

community inclusion. Older adults and people with disabilities are not defined by their limitations. They are members of our communities whose perspectives help shape public policy on health care, housing, transportation, aging services, disability rights, and countless other issues.

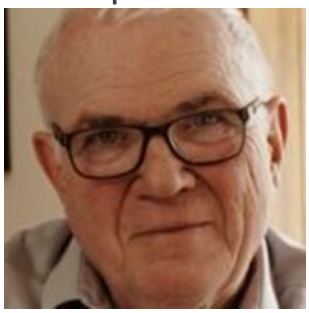
At a time when policymakers frequently speak about promoting dignity, independence, and community integration, we should be removing barriers to democratic participation—not creating new ones.

This should not be a partisan issue. Regardless of political affiliation, Americans should be able to agree that election systems must be both secure and accessible. Government policies should strengthen public confidence in elections while ensuring that eligible voters can exercise their fundamental rights.

The Postal Service's role has long been straightforward: deliver the mail fairly, reliably, and without political influence. That mission has served our democracy well for generations.

For the sake of democracy—and for the hundreds of thousands of Massachusetts older adults and people with disabilities who depend upon voting by mail—the Postal Service should continue to do exactly that.

Commentary Offered by DignityMA Participants



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Medical Debt, Aging, and Disability: The Hidden Crisis

Generations Now – American Society on Aging
By James Lomastro, PhD
June 10, 2026

Medical debt is a consumer finance issue and also disability rights and housing stability issues

Summary:

This *Generations Now* article frames the $220 billion U.S. medical debt crisis not merely as a peripheral consumer finance dilemma, but as a structural failure that directly threatens housing stability, aging policy, and disability rights. An estimated 100 million Americans carry medical debt—including roughly 4.5 million older adults aged 65 and older—creating an economic paradox where a person's period of highest healthcare utilization directly intersects with fixed incomes and reduced earning capacity. The crisis falls disproportionately on disabled individuals who manage persistent out-of-pocket costs alongside interrupted employment, as well as older adults living just above Medicaid thresholds who are financially precarious enough to struggle with out-of-pocket gaps but not poor enough to qualify for public assistance. While recent federal and state credit-

an extensive career in healthcare administration and academia.

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reporting protections address the downstream symptoms of collections, they leave intact predatory mechanisms like Medicaid estate recovery—which the article criticizes as treating illness and dependency as opportunities for downstream financial extraction—ultimately forcing vulnerable seniors to compromise their health, deplete retirement savings, and risk unnecessary institutionalization.

Before the Fall: What Massachusetts Refuses to Count

James A. Lomastro, PhD

The federal cuts are an accelerant. The structure they are igniting was built here.

Lieutenant Governor Driscoll called Washington's Medicaid cuts "mean and dumb" at a health equity summit this spring, drawing laughter from a room full of advocates who recognized both the accuracy and the political choreography of the phrase. She was right about Washington. But the laughter is worth examining. It releases tension. It creates solidarity between state officials and the advocates in the room. It positions Massachusetts as a victim of federal policy. And it makes it significantly harder, in that moment and afterward, to ask what Massachusetts itself has done — and failed to do — for the residents who will bear the cost of both the federal cuts and the state's own response to them.

Massachusetts did not wait for the One Big Beautiful Bill to underfund home care. It did not need federal instruction to leave elder abuse tracking off its public dashboards. It did not require a Washington mandate to produce a state budget in which the community infrastructure of one million older residents is described, charitably, as maintained. The federal government is cutting. Massachusetts built the conditions that make those cuts catastrophic. One is an act of cruelty. The other is a longer history of negligence that the political class has never been asked to account for, in part because we have never built the measurement systems that would make accountability possible.

Three documents arrived together this spring that reveal this not as opinion but as architecture. A national academic report card. A $61.4 billion state budget. A fiscal warning from the state's own health officials. None was designed to say what they say together: Massachusetts has become very good at funding the systems that serve people after they fall, and has made a sustained, documented, bipartisan choice not to build the community infrastructure that keeps them standing. A fourth document, a federal law signed on July 4, 2025 will accelerate a collapse that Massachusetts chose, over decades, not to prevent.

The fall was always going to happen. Massachusetts just kept declining to build the floor.

What the Report Does Not Count

The *State of the States* report, published by the bipartisan State of the Nation Project in honor of America's 250th anniversary, tells us that Massachusetts is exceptional in the ways we have always preferred to hear. First in education. First in violence prevention. Fifth overall among all fifty states on the composite ranking. Read longer, and a different picture emerges. Massachusetts ranks forty-sixth in income inequality. Forty-third in life satisfaction. The report's sophisticated poverty measure — one that accounts for housing costs, medical expenses, and the actual texture of economic life shows the Commonwealth falling further behind the national average. A state that leads the nation in academic test scores is simultaneously failing to translate that excellence into security or contentment for a growing share of its residents. This is not a paradox. It is a measurement problem. And measurement problems are, at their root, problems of value.

The report covers fourteen topic areas across 31 measures and more than 4,000 indicators. It is serious, bipartisan, and methodologically careful. What it does not contain, not a single measure or indicator is anything about aging, disability, caregiving, or the community infrastructure that makes independent living possible. No measure of nursing home quality. No indicator of home care availability. No tracking of elder abuse investigations, guardianship prevalence, assisted living affordability, or community-based support capacity.

This omission is not the report's failure alone. It reflects what Massachusetts itself has chosen not to produce. We do not publish statewide indicators of caregiver burden. We do not maintain public dashboards on elder abuse investigations. We do not routinely track whether people with disabilities can obtain the supports necessary to live where they choose. In a state where more than one million residents are over sixty-five and the population over eighty-five is growing at a rate that will reshape every institution we have built, the absence of these measures is not an oversight. It is a choice — made consistently, across administrations, for decades. We measure what we value. We fund what we measure. We govern what we fund. Massachusetts has governed accordingly.

The national picture confirms the pattern. Across all fifty states, no one is improving on the following eight measures: life satisfaction, adult depression, youth depression, fatal overdoses, trust in the federal government, income inequality, long-term unemployment, and hourly earnings growth. Read that list through the experience of an older adult on a fixed income, a person with a disability dependent on federal programs, or a family caregiver balancing paid

work against unpaid obligation. Every measure describes their daily reality with precision. We are measuring the symptoms nationally. We have declined to name the patient.

What the Budget Reveals

The Senate's FY2026 budget makes those choices visible. The numbers are substantial. MassHealth is funded at $22.41 billion, covering more than one in four Massachusetts residents and seven out of every ten nursing facility residents. The Personal Care Attendant program receives $1.73 billion. Another $3.2 billion supports people with intellectual and developmental disabilities. These are genuine commitments.

But they are almost entirely channeled through MassHealth, and the acute and institutional financing system. They address what happens after people lose their footing. They do not address the community infrastructure that would help people keep it. This is not a new pattern forced on Massachusetts by federal circumstance. It is the pattern Massachusetts has chosen, year after year, in budget after budget, across Republican and Democratic administrations alike.

Mass Senior Care testified this spring that even on the institutional side the budget falls $280 million short of fully implementing the Long-Term Care reform law's workforce requirements, a law Massachusetts passed, governing Massachusetts facilities, funded through Massachusetts's own budget choices. AARP Massachusetts described the elder care investments as maintaining rather than expanding essential programs. Maintenance is not transformation. And the gap between maintaining and transforming is not Washington's creation. It is Beacon Hill's.

The community-based programs most at risk, home care, adult day health, the Community Choices program, Councils on Aging supplemental funding have been chronically underfunded by Massachusetts not because federal law required it but because Massachusetts has never built the political and measurement architecture that would make that underfunding visible and therefore costly. You cannot be held accountable for failing people you have never counted.

The Warning and What It Conceals

At the Health Equity Trends Summit this spring, state health officials disclosed that the Health Safety Net Fund, the Commonwealth's payer of last resort for uninsured and underinsured residents faces a projected $600 million deficit by FY2028, driven by federal eligibility changes stripping Medicaid coverage from hundreds of thousands of Massachusetts residents. Lieutenant Governor Driscoll called the

federal cuts “mean and dumb.” The audience laughed. The laughter is worth examining.

It releases tension and creates solidarity between state officials and certain advocates in the room. It positions Massachusetts as a victim of federal policy. And it makes it significantly harder, in that moment and afterward, to ask what Massachusetts itself has done — and failed to do — for the residents who will bear the cost of both the federal cuts and the state’s response to them.

The $600 million hole will not be closed by cutting nursing home rates, which are federally mandated and politically protected. It will migrate, as pressure always migrates in Medicaid architecture, toward the lines that can be characterized as optional which is to say, toward the people the state has never gotten around to counting. Massachusetts will reach for the optional. It will find the community infrastructure of older adults and people with disabilities waiting there, as it always is — unmeasured, undefended, and already underfunded by state choice before Washington touched a single line.

That is not federal cruelty landing on a well-prepared state. That is federal cruelty exposing a state that was already failing the same people, more slowly, with better press releases.

Medicide: A Shared Responsibility

Writing in *Nonprofit Quarterly* with Margaret Morganroth Gullette, we used the term Medicide, the systematic, policy-driven elimination of healthcare access for the most vulnerable to describe what the One Big Beautiful Bill codifies at the federal level. The bill cuts $1.02 trillion from Medicaid while extending $3.3 trillion in tax cuts disproportionately benefiting wealthy individuals and corporations. It imposes work requirements structured not to verify work but to thin the rolls through administrative burden. It is healthcare apartheid formalized: a two-tier system in which the top tier receives massive government subsidies without conditions while the bottom tier faces punitive compliance requirements and bureaucratic humiliation.

Medicide is the right word for what Washington has done. But Medicide has a state-level version, and it does not require a federal bill. It requires decades of budget choices that treat community care as optional, measurement systems that render older adults and people with disabilities statistically invisible, and a political culture that finds it easier to call Washington cruel than to examine what Beacon Hill has built and refused to build — with the authority it already has.

Massachusetts did not wait for the One Big Beautiful Bill to underfund home care. It did not need federal instruction to leave elder abuse tracking off its public dashboards. It did not require a

Washington mandate to produce a budget in which the community infrastructure of one million older residents is described, charitably, as maintained. The federal cuts are an accelerant. The structure they are igniting was built here.

What Counts

The residents most dependent on the community infrastructure we have chronically underbuilt older adults on Social Security, people with disabilities relying on SSDI or SSI, family caregivers balancing paid work against unpaid obligation are precisely those for whom the gap between Massachusetts's reputation and its reality is widest. They may have access, in theory, to world-class healthcare institutions. They may lack, in practice, the housing, transportation, and personal care necessary to remain in their own homes and communities. Massachusetts made those choices. Massachusetts can unmake them.

The young people experiencing the highest rates of depression in Massachusetts — worsening faster here than the national average are the same people we are counting on to become tomorrow's home health aides, nurses, and direct support professionals. The caregiving crisis policymakers describe as a workforce shortage is structurally deeper: a crisis of social capital, arriving on schedule, untracked by the state, underfunded by the state, and now accelerated by a federal law that will push hundreds of thousands of people out of coverage and into community systems the state chose not to adequately build.

By 2035, the questions that will determine the character of Massachusetts will not be whether our eighth graders lead the nation in math scores though that matters but whether our oldest residents can remain in their communities with dignity, whether family caregivers can sustain their own economic lives while caring for people they love, and whether the institutions we trust to measure our progress have the honesty to tell us what they chose not to build.

The State of the *State of the States* report is a valuable document. The Senate FY2026 budget is a serious one. The Health Safety Net Fund warning is a genuine alarm. The One Big Beautiful Bill is a moral catastrophe dressed in fiscal language. But the catastrophe it is about to produce in Massachusetts is built on a foundation of state choices, choices about what to measure, what to fund, what to call optional, and whose lives to treat as peripheral until they become a crisis. No federal administration, however cruel, can be held solely responsible for a collapse that Massachusetts chose, year after year in budget after budget, not to prevent.

The federal government is cutting. Massachusetts built the conditions that make those cuts catastrophic. One is an act of cruelty. The other has a Beacon Hill address, a forty-year record,

	and better press releases. The fall was always going to happen. Massachusetts just kept declining to build the floor.
Recruitment	**See: Listings on MASSterList.com's Job Board** for all current listings
In Person and / or Online Events	• **Bridgewater State Hospital Transfer Advocacy** Tuesday, June 16, 2026, 10:00 a.m. Room 428, State House, Boston, MA Rep. Barber and Sen. Creem join the Massachusetts Association for Mental Health, Disability Law Center and National Alliance on Mental Illness of Massachusetts in explaining and advocating for legislation (H 3291, S 1386) that would transfer Bridgewater State hospital oversight from the Department of Correction to the Department of Mental Health. The Senate version of the fiscal 2027 budget would require the state to come up with an "implementation plan" outlining what's necessary from a transfer by June 30, 2027, but that budget rider's fate hinges on the outcome of House-Senate talks. A February 2026 Disability Law Center report recommended that the state "immediately" place the facility under DMH authority and "urgently" construct a modern DMH hospital facility for patients. • **Veterans Homes Council** Tuesday, June 16, 2026, 11:00 a.m. to 1:00 p.m. *June Meeting* Agenda includes informational presentations from Massachusetts Veterans Homes at Chelsea and Holyoke. Veterans Homes Council June Meeting • **Ounce of Prevention Conference** Department of Public Health Wednesday, June 17, 2026, 9:30 a.m. Third Floor, DCU Center, Worcester, MA Department of Public Health holds its Ounce of Prevention Conference that's focused on building "healthier and more equitable communities." Public Health Commissioner Dr. Robbie Goldstein gives remarks. Sessions will explore the impact of a hotline in preventing overdose deaths, working in rural communities, the public benefits cliff, data to shape behavioral health prevention and promotion initiatives, the impact of community health workers, public health approaches to gun violence and more. Ounce of Prevention Conference • **Special Commission on Pappas Rehabilitation Hospital for Children** Wednesday, June 17, 2026, 10:00 a.m., Room B-2, State House, Boston, MA and virtual Special Commission on Pappas Rehabilitation Hospital for Children holds a hearing, with members seeking testimony from invited stakeholders and the public. The Massachusetts Nurses Association says family members of current and former Pappas patients are expected to speak, as well as Pappas staff. Gov. Healey in January 2025 proposed shuttering the state-run hospital as a cost-cutting measure, though she walked back that plan amid public outcry. Located

on about 166 acres in Canton, the hospital provides medical, rehabilitative, educational and recreational services for patients ages 7-22 with serious physical and cognitive disabilities. A separate Pappas work group released a report last fall that recommended "near-term" facility upgrades to address life safety and quality issues, plus longer-term ideas to modernize the hospital's infrastructure, lower the level of care offered at Pappas, close the hospital or invest in pediatric care at Western Massachusetts Hospital. That work group laid the foundation for the commission, created through a fiscal 2026 budget policy rider. The commission is supposed to file a report by Dec. 31 on the hospital's finances, programs, pediatric services and infrastructure.
Pappas Rehabilitation Hospital for Children

- **Primary Care Access, Delivery, and Payment Task Force**
  Wednesday, June 17, 2026, 10:00 a.m., Health Policy Commission offices, 50 Milk Street, Boston and Livestream
  Primary Care Access, Delivery, and Payment Task Force convenes to discuss final recommendations for "Statutory Deliverables #6: monitoring and tracking primary care need and service delivery, and #7: creating short- and long-term workforce development plans for primary care clinicians and workers," according to the Health Policy Commission. The commission co-chairs the task force with the Executive Office of Health and Human Services. Organizers plan to close the meeting by discussing next steps. The Senate plans to vote Thursday on legislation requiring a gradual but major shift in healthcare spending toward primary care.
  Primary Care Access
- **Alzheimer's and Brain Awareness**
  Wednesday, June 17, 2026, 10:00 a.m., Room 437, State House, Boston, MA
  Alzheimer's Association hosts an event recognizing Alzheimer's and Brain Awareness Month, meant to raise awareness, advance public policy solutions, and highlight the Alzheimer's Act (H 4302, S 2554). Breakfast and registration begin at 10 a.m. Speaking program begins at 10:30 a.m. Panelists include BU School of Medicine Associate Professor of Neurology and Boston Medical Center neurologist Dr. Hugo Aparicio, Association VP of Programs and Services Susan Antkowiak, MGH Alzheimer's Disease Research Center Coordinator Judy Johanson, and advocate living with Alzheimer's Marc Ehrlich.
- **Center for Health Information and Analysis Oversight Council**
  Wednesday, June 17, 2026, 2:00 p.m., Livestream
  Center for Health Information and Analysis Oversight Council meets. The body meets quarterly to discuss the agency's research and analytical priorities. CHIA released an updated primary care dashboard Thursday that looked into spending, workforce capacity, access to care and equity, among other metrics. CHIA also releases reports on total medical spending and health insurance coverage
  CHIA
- **Community Living Initiative Report**
  Massachusetts Executive Office of Human Services
  Monday, June 29, 2026, 10:00 to11:00 a.m.

	Grand Staircase, State House, Boston, MA RSVP and more information: molly.doris-pierce@mass.gov
Webinars and Online Sessions	**1. The Studio Harvard T. H. Chan School of Public Health** Thursday, June 18, 2026, 1:00 p.m. *Reframing exercise: How simple physical activity boosts health* For many people, consistent exercise feels daunting — an all-or-nothing proposition in which setbacks signal failure and advice overwhelms. This discussion reframes physical activity as something accessible and sustainable by challenging common myths about exercise and the amounts needed for health and well-being. Speakers will explore how different "doses" of activity, from light movement to more intense training, influence health — and how adapting routines can help people avoid burnout and keep exercising over a lifetime. A panel of specialists in epidemiology, sports cardiology, athletics, and health journalism will weigh in, drawing on both research and real-world experience. Watch the premiere on the Harvard Chan YouTube page. The video will remain on demand for future viewing. **2. Restoring Social Security solvency and reducing elderly poverty** **Brookings** Wednesday, June 24, 2026, 1:15 to 4:00 p.m. In its current form, Social Security will run out of money in 2032. On June 24, the Brookings Center on Health Policy will host an event on the urgent need to ensure that Social Security remains solvent for decades, and how to accomplish this—while at the same time reducing elderly poverty. Initiated by Brookings Visiting Fellow and longtime senior Hill aide Wendell Primus, the event will focus on how Congress can work together to protect Social Security in a time of deep polarization. The event will feature two panels. The first, will include prominent former members of Congress including Richard Gephardt, former Democratic majority leader; Jim McCrery, former Republican chair of the Ways and Means Committee; Tom Downey, former Democratic congressman from New York, and Larry Bucshon, former Republican congressman from Indiana. David Wessel, director of the Hutchins Center on Fiscal and Monetary Policy, will moderate. The second panel will include officials from a range of key stakeholders including AARP, the National Council on Aging, the U.S. Chamber of Commerce, and the AFL-CIO. Brookings Visiting Fellow Amy Goldstein will moderate. Jack Lew, former secretary of the Treasury and former director of the OMB, will deliver concluding remarks. **Social Security Solvency** **3. Using AI to close documentation gaps and manage compliance risks** McKnights Long-Term Care News Tuesday, June 30, 2026, 1:00 p.m. As regulatory scrutiny and liability risk continue to increase, skilled nursing organizations face growing pressure to maintain documentation that is complete, accurate and survey ready. This pressure is

	compounded by the difficulty of sustaining traditional compliance and chart review processes in today's staffing and operational environment. Join skilled nursing leaders and PointClickCare experts as we discuss how AI is helping skilled nursing organizations get ahead of compliance risk and stay survey ready. In this session, we will explore: • The increasing compliance and documentation burden in skilled nursing and the limitations of traditional review and audit processes; • How AI is enabling earlier identification of documentation and compliance risk while reducing reliance on manual audit preparation; and • Insights and examples from organizations using Chart Advisor, PointClickCare's AI-powered risk management solution, to strengthen documentation quality and improve survey readiness **Speakers:** • Sarah Samek, Product Marketing Manager, PointClickCare • Eugene Gonsiorek, VP of Clinical Regulatory Standards, PointClickCare **Using AI**
Previously posted webinars and online sessions	Previously posted webinars and online sessions can be viewed at: https://dignityalliancema.org/webinars-and-online-sessions/
Nursing Homes	**4. Skilled Nursing News** June 10, 2026 *Hospital-Nursing Home Cost-Cutting Collaborations Grow, Lowering Readmissions but Driven by Referral Volume and Geography* By Zahida Siddiqi Collaborative partnerships between hospital systems and skilled nursing facilities (SNFs)—specifically through Post-Acute Network (PAN) programs—are rapidly expanding across the Midwest and South as a proven strategy to cut healthcare costs and elevate patient outcomes. Led by major systems like Advocate Health, Northwestern Medicine, and Rush University Medical Center, these models embed dedicated medical teams, including physicians and advanced practice nurses, directly into participating nursing homes to streamline care transitions. This closer integration has yielded dramatic financial and clinical successes; for example, Advocate Health achieved $13 million in Medicare Accountable Care Organization (ACO) savings in 2024 by slashing its network's 30-day rehospitalization rate to 15.8% and dropping the average SNF length of stay to 16.6 days—well below the national average of 27.5 days. However, hospital executives emphasize that network expansion is highly selective and strict, prioritizing high-quality facilities based almost entirely on geographic proximity to existing physician practices and high existing referral volumes rather than quality metrics alone. **5. Hunterbrook** June 8, 2026

	Ensign's business model relies on delivering inadequate care to patients while gaming data on quality, according to Hunterbrook's five-month investigation. Patients are dying. By Michelle Cera, Andrew Ford, and Laura Wadsten A June 2026 investigation by *Hunterbrook Media* reveals that The Ensign Group ($ENSG), America's largest operator of skilled nursing facilities with 334 locations across 17 states, has built its $10 billion empire on a business model that systematically relies on severe understaffing and data manipulation. The five-month investigation found that while Ensign maximizes government reimbursements by admitting high-acuity (severely ill) patients, it aggressively cuts nursing hours below legal state minimums, resulting in an estimated 5-million-hour care gap between July and November 2024 alone—a deficit that saved the company roughly $386 million annualized, which exceeds its entire annual net income. Furthermore, the report alleges that Ensign games the federal "star" rating system by performing well on unverified, self-reported quality metrics but scoring poorly on independent government inspections, all while "tunneling" over $339 million in taxpayer funds to its own real estate and management affiliates to hide profits. Former employees also detailed pressure to falsify therapy billing minutes and downgrade patient injuries, leaving a trail of severe clinical neglect, patient suffering, and fatal outcomes across its facilities.
Home and Community Based Services	**6. *Time** May 20, 2026 *Why Meals on Wheels America Desperately Needed the $70 Million It Got From MacKenzie Scott* By Belinda Luscombe Billionaire philanthropist MacKenzie Scott's surprise $70 million unrestricted donation to Meals on Wheels America arrived at a critical turning point for the organization, which has been severely straining under flat federal funding, rising food and gas costs, and a sharp decline in volunteers. Despite serving over two million seniors annually, the rapid growth of America's aging population has left nearly 14 million older adults facing food insecurity and social isolation. Currently, one in three local providers must maintain waitlists—with seniors waiting an average of four months for assistance—and 98% of providers face urgent infrastructure needs. Rather than spending the entire wind-fall immediately to temporarily clear those waitlists, Meals on Wheels plans to use a phased, multi-year approach to strengthen long-term technology and infrastructure across its 5,000 community programs, though leadership emphasizes that sustained public and private partnerships are still desperately needed to fully close the gap.
Health Care Topics	**7. JAMA Network** June 8, 2026 *Restarting Medications After Deprescribing in Adults Discharged From Hospital to Skilled Nursing* By Thomas J. Reese, PharmD, PhD; Sandra F. Simmons, PhD; Eduard E. Vasilevskis, MD, MPH, *et al* A June 2026 cohort study published in *JAMA Network Open* reveals that while hospital-initiated deprescribing efforts successfully eliminate many

	unnecessary medications for older adults, the durability of these reductions sharply declines during care transitions. Analyzing data from 598 patients aged 50 or older who were taking five or more pre-hospital medications and discharged to a skilled nursing facility (SNF), researchers found that roughly 1 in 6 (15.9%) of the 8,734 deprescribed medications were restarted within 90 days, causing nearly 70% of participants to reinitiate at least one drug. Strikingly, close to half of these restarts (48.5%) occurred after patients transitioned from the SNF back to their homes, with higher baseline medication burdens, a greater number of individual prescribers, and lower health literacy strongly driving the reinitiations. Crucially, the study establishes a significant clinical penalty for fragmented care, noting that patients who had medications restarted during their initial SNF stay experienced a much higher rate of 90-day hospital readmissions—a finding that underscores the urgent need for enhanced transitional support and tight coordination between pharmacists and community providers to prevent reflexive re-prescribing.
Private Equity	**8. The Gilmer Mirror** June 9, 2026 *After nursing home crises, states target private equity's role* By Anna Claire Vollers In the wake of severe patient safety crises and evacuations at facilities operated by investment-backed chains like Genesis HealthCare, a growing number of states are enacting strict regulations to curb private equity's rapidly expanding control over the long-term care sector. Recognizing a federal regulatory vacuum and facing research that links private equity buyouts to an 11% increase in patient mortality alongside severe cuts to frontline care staff, at least seven states—including Connecticut, Illinois, and Massachusetts—have passed or are weighing legislation to demand greater financial transparency and block investors from dictating day-to-day clinical decisions. State lawmakers are particularly targeting predatory financial practices like "sale-leaseback" maneuvers, where private equity firms sell a nursing home's underlying real estate for a quick profit and force the facility into high-rent leases that starve operations of funds needed for patient care. This regulatory push comes at a critical juncture; industry advocates argue that targeting private equity distracts from chronic Medicaid underfunding, yet experts warn that impending federal Medicaid cuts to optional home-based services could force more vulnerable seniors into institutional care, ultimately turning financially distressed safety-net nursing homes into cheap acquisition targets for opportunistic investors.
Ageism	**9. Health Affairs** June 11, 2026 *Confronting Ageism As A Driver Of Health Inequity* **Key Points** • People ages sixty-five and older are the highest users of hospitals, physician services, and pharmaceutical drugs. Discrimination against older adults in health care settings is commonplace. • Ageism, or bias against older people on the basis of their age, is associated with worse health outcomes. The excess cost to the US

	health system of ageism has been estimated at $63 billion each year, or about 15 percent of annual medical expenditures. • Ageism, including age discrimination, affects health care use, quality, and costs through undertreatment, overtreatment, and inappropriate care. • Proven interventions to counter ageism in health care include efforts to strengthen the geriatric care workforce and to implement new health care delivery models that provide more appropriate care to older adults. • To reduce the adverse impact of ageism in health care, policy makers and health system leaders should require health professional educators to devote more time to geriatric training, implement financial incentives to promote the use of age-friendly care practices and effective geriatric care models, and mount multisector public awareness campaigns to combat ageist beliefs and attitudes.
Medicare	By Christopher Rowland A newly released federal watchdog report from the Department of Health and Human Services Office of Inspector General (OIG) reveals that the nation's largest for-profit Medicare Advantage insurers—UnitedHealth Group, Humana, and CVS Health—are denying prior authorization requests for post-hospital care at alarmingly high rates compared to their smaller peers. Focusing on post-acute care such as admissions to long-term care hospitals, inpatient rehabilitation facilities, and skilled nursing homes, the OIG found that these three insurance giants collectively denied between 51% and 80% of specialized rehabilitation requests. Investigators highlighted that financial incentives might be driving these discrepancies and expressed profound concern over the fact that when patients actually appealed these decisions, the denials were overturned up to 95% of the time—including a staggering 99.7% overturn rate for skilled nursing care handled by a UnitedHealth subsidiary. This pattern strongly indicates that elderly patients are routinely being blocked from receiving medically necessary care, leaving millions of frail seniors to navigate complex insurance hurdles during critical recovery windows while insurers maximize premium profits
Workforce	**10. Center for American Progress** June 15, 2026 *America Is Running Out of Nurses, and DACA Recipients Are Helping Provide Critical Care to Communities Despite Threats of Deportation From the Trump Administration* By Rosa Barrientos-Ferrer *Through in-depth interviews with three registered nurses who have DACA, this report examines the vital contributions of DACA nurses to the health care workforce amid a growing national nursing shortage.* A June 2026 report by the Center for American Progress highlights the vital role that Deferred Action for Childhood Arrivals (DACA) recipients play in mitigating America's worsening nursing shortage, even as they face intensifying legal threats and deportation pressures. An estimated 3,400 DACA recipients currently serve as registered nurses nationwide, providing critical, culturally competent, and multilingual care in hospitals,

	skilled nursing facilities, and rural communities. However, the report emphasizes that these professionals face immense structural obstacles, including severe renewal processing delays by federal immigration services, recent state-level financial aid restrictions on graduate nursing programs via the "One Big Beautiful Bill Act," and fragmented state licensing laws that force some nurses to cross state lines just to practice legally. Complicating these career hurdles, aggressive immigration policies and enforcement actions under the Trump-Vance Administration have significantly elevated deportation risks for these individuals, prompting the authors to argue that Congress must establish a permanent pathway to citizenship and that states must broaden licensing access to secure this indispensable segment of the healthcare workforce.
Office of Governor Maura Healey and Lt. Governor Kim Driscoll	**11. Office of Governor Maura Healey and Lt. Governor Kim Driscoll** June 12, 2026 *Governor Healey Signs Legislation Modernizing State Law and Promoting Respect for People with Disabilities* Governor Maura Healey signed "An Act Dignifying Individuals with Intellectual or Developmental Disabilities," a piece of legislation that updates the Massachusetts General Laws by removing outdated, demeaning, and offensive terminology regarding people with disabilities. Championed by advocates and lawmakers for over a decade, the new law replaces archaic terms like "mentally retarded" and "handicapped" with modern, person-first language such as "person with an intellectual or developmental disability." While these changes do not alter eligibility for any state programs, services, or benefits, they ensure that the state's legal framework aligns with modern standards of respect, inclusion, and dignity for all residents.
State Policy	**12. CommonWealth Beacon** June 11, 2026 By Alison Kuznitz, State House News Service *Experts discuss work requirement, outreach, exemptions, rural health, and an earnings wrinkle* Summary: At the 2026 Medicaid Summit, co-hosted by organizations including the Massachusetts Developmental Disabilities Council, healthcare experts and state administrators detailed the looming local impacts of the federal One Big Beautiful Bill Act ahead of its January 1, 2027 implementation. The federal overhaul mandates a monthly 80-hour work or engagement requirement for Medicaid adults aged 19 to 64 alongside a strict six-month eligibility redetermination cycle, threatening to trigger massive administrative coverage losses. However, an unexpected "earnings wrinkle" in the federal law allows members to satisfy the requirement by earning at least $580 monthly; because Massachusetts maintains a high $15 minimum wage, workers can meet this threshold in fewer than 10 hours per week, shielding a significant portion of the roughly 360,000 MassHealth members subject to the mandate. To insulate vulnerable residents—particularly those with complex conditions who qualify for medical frailty exemptions—MassHealth is preparing an aggressive, multilingual direct-outreach campaign and

	automated data-matching system to verify eligibility and automatically confirm exemptions without forcing individuals through burdensome paperwork. Beyond the work mandates, state officials highlighted the rapid deployment of $162 million in federal rural health transformation funds that must be obligated by October 2026, while national researchers warned that impending federal funding cuts could pressure states to restrict optional home and community-based services, a counterproductive move that ultimately drives long-term care costs up by forcing seniors into institutional nursing home placements.
Federal Policy	**13. MedPage Today** June 15, 2026 *Medicare Should Pay Docs More, Cut Nursing Home and Home Health Pay, MedPAC Says* By Joyce Frieden *Better data needed from Medicare Advantage plans, MedPAC tells Congress* In its June 2026 report to Congress, the Medicare Payment Advisory Commission (MedPAC) reiterated its call for structural payment reforms that would increase Medicare reimbursements for physicians while significantly cutting funds for post-acute care providers. Specifically, the commission recommends aligning fee-for-service payment updates with the Medicare Economic Index inflation rate to boost doctor pay, alongside modest increases for inpatient and outpatient hospital systems. Conversely, citing exceptionally high Medicare profit margins—24% for skilled nursing facilities, 21% for home health agencies, and 17% for inpatient rehabilitation facilities—MedPAC urged substantial payment reductions for these post-acute sectors. Additionally, the report advocates for the expansion of "site-neutral" payments to equalize service costs regardless of setting, a policy estimated to save over $170 billion over a decade, while simultaneously pressing the Centers for Medicare & Medicaid Services (CMS) to collect more accurate encounter data from Medicare Advantage plans to better evaluate care quality. **14. Health Affairs (podcast)** June 12, 2026 *Medicaid Work Requirements: Who's Affected and What's at Stake* By Jeff Byers and Alison Barkoff Topics covered: • What Medicaid work requirements are and how they work • Who qualifies—and who may lose coverage • State-level variations and policy design • Administrative complexity and compliance challenges • Potential impacts on access to care and health outcomes **15. Health Affairs** June 12, 2026 *Medical Frailty Rule Contravenes HR 1, Burdens The Health Care System, Ad Threatens Public Health* By Sara Rosenbaum, Feygele Jacobs, Alison Barkoff, Allyson Crays, Caitlin Murphy, Caroline L. Farrell, Jane Tavares, and Marc A. Cohen

	In this *Health Affairs Forefront* article, the authors argue that the Trump-Vance Administration's June 2026 interim final rule implementing the Medicaid community engagement provisions of HR 1 (the "One Big Beautiful Bill Act") unlawfully and harmfully alters the statutory definition of "medical frailty." While HR 1 established an 80-hour-per-month work or engagement requirement for ACA-expansion adults, it explicitly exempted individuals with a "serious or complex medical condition" without tying that specific subcategory to functional daily living impairments or an explicit inability to work. However, the administration's new rule applies a strict "inability-to-comply" gloss across all categories, creating a highly restrictive, unprecedented test that the authors argue effectively excises the safety net for millions of vulnerable, older working-age adults who suffer from significant, chronic health limitations but do not qualify for traditional disability benefits. Ultimately, the authors contend that this rule overburdens state Medicaid agencies and safety-net clinicians—who lack the occupational training to conduct complex job-readiness evaluations—while threatening to strip essential health coverage from the very populations who rely on it to remain healthy enough to work. **16. *New England Journal of Medicine** May 30, 2026 *Regulating Corporate Control in the U.S. Health Care System* By Loren Adler, M.S. In this *New England Journal of Medicine* perspective piece, author Loren Adler of the Brookings Institution addresses the systemic drivers behind corporate consolidation and the expanding corporate control of the U.S. healthcare system. Arguing that corporatization does not stem from a single root cause, Adler explains that predictable harms arise because large corporate entities and private equity firms successfully capitalize on fragmented regulatory landscapes, market power advantages, and distorted federal payment incentives—such as "site-of-service" payment differentials. While some states have actively attempted to counter this trend by reinforcing historical "corporate practice of medicine" statutes to block third-party corporate ownership of clinician practices, Adler notes that these legal workarounds are notoriously difficult to enforce. Ultimately, the author suggests that rather than narrowly trying to regulate corporate form or private equity structures directly, regulatory strategies must fundamentally target and eliminate the underlying financial incentives, distorted payment policies, and anticompetitive market advantages that make healthcare consolidation uniquely profitable in the first place.
From around the Country	**17. New York Times (free access)** June 13, 2026 *A New Option for Long-Term Care Costs* By Paula Span *Washington has launched the first program to help cover home care and other supports. A number of states are paying attention.* This June 2026 article from The New York Times examines the escalating financial and emotional crisis surrounding long-term care costs in the United States, illustrating how the soaring expenses of

	aging are systematically draining family savings. With the median annual cost of a private nursing home room now exceeding $120,000 and full-time home health aides climbing past $60,000 annually, the vast majority of older adults face a severe gap between their actual needs and what they can afford, especially given that the typical Medicare recipient lives on roughly $36,000 per year. The report highlights a widespread public misconception: many families mistakenly assume Medicare covers long-term custodial care, only to discover too late that it only funds short-term rehabilitation, leaving them to deplete their personal assets down to poverty levels to qualify for Medicaid. This "five-alarm fire" places an overwhelming, uncompensated burden on informal family caregivers, who frequently must compromise their own careers and retirement security, while chronic staffing shortages, inflation, and the predatory encroachment of private equity investment continue to drive care costs further out of reach for average Americans.
From Our Colleagues from around the Country	**18. The Consumer Voice** June 9, 2026 **In this Issue:** 1. Senators Push CMS to Reinstate Nursing Home Ownership Transparency Rule 2. World Elder Abuse Awareness Day is June 15 3. Participate in the 2026 Resident's Voice Challenge 4. Elder Justice Awareness Month Webinar Series 5. Listen to the Pursuing Quality Long-Term Care Podcast
A Raise for Mom: Campaign to Increase the Personal Needs Allowance (PNA)	***The Campaign to Increase the Personal Needs Allowance (PNA)*** For nearly 20 years, the Personal Needs Allowance for Nursing Home and Rest Home residents has been stuck at $72.80 per month. **If** inflation had been factored since the amount was last set, the allowance should now be about $113.42. Costs for everything have increased over the last two decades, but the PNA has remained unchanged. That means that folks residing in nursing homes and rest homes have been paying ever higher prices for their personal needs – items not covered within the care, room, and board required to be provided by nursing and rest homes. These residents are obligated to pay almost all their monthly Social Security and other income for their basic care leaving the PNA to cover all other life's necessities. Amplifying this situation, Massachusetts has the highest cost of living of any state in the continental United States – meaning these vulnerable residents can afford less each and every year. Three similar bills have been filed in the Massachusetts Legislature this year and are awaiting a public hearing with the Joint Committee on Health Care Financing, chaired by Senator Cindy Friedman and Representative John Lawn. The bills to raise the PNA are Senate Bill 887 by Senator Joan Lovely and others; Senate Bill 482 by Senators Patricia Jehlen and Mark Montigny and others; and House Bill 1411 by Representative Thomas Stanley and others. As of the middle of May, twenty-nine legislators (11 senators, 16 representatives) have already co-sponsored one or more of these bills. DignityMA, AARP Massachusetts, and LeadingAge Massachusetts are among the statewide organizations that have indicated support of the PNA legislation. There's still time for other legislators to become co-sponsors. Please contact your state senator and representative using this link: https://dignityalliancema.org/take-action/#/25. It literally takes less than a minute to deliver the message.

	If you are a nursing or rest home resident, family member, or caregiver and have a story about the inadequacy of the current PNA, your story can help put an important human face on why this raise is so necessary. Please submit your story via https://tinyurl.com/ForgetMeNotPNA or you can email your story to Dignity Alliance MA (info@DignityAllianceMA.org), noting at least your first name and town where you live so that we can include your story in the testimony submitted to the Legislature. **We selected the Forget-me-not as our symbol to encourage legislators to remember older adults in nursing and rest homes who have gone so long without a raise in the PNA.*
Books by DignityMA Participants	***A Perfect Turmoil: Walter E. Fernald and the Struggle to Care for America's Disabled*** By Alex Green **Buy the book here** Alex Green teaches political communications at Harvard Kennedy School and is a visiting fellow at the Harvard Law School Project on Disability and a visiting scholar at Brandeis University Lurie Institute for Disability Policy. He is the author of legislation to create a first-of-its-kind, disability-led human rights commission to investigate the history of state institutions for disabled people in Massachusetts. ***American Eldercide: How It Happened, How to Prevent It*** By Margaret Morganroth Gullette **Buy the book here.** **Margaret Morganroth Gullette** is a cultural critic and anti-ageism pioneer whose prize-winning work is foundational in critical age studies. She is the author of several books, including *Agewise*, *Aged by Culture*, and *Ending Ageism, or How Not to Shoot Old People*. Her writing has appeared in publications such as the *New York Times*, *Washington Post*, *Guardian*, *Atlantic*, *Nation*, and the *Boston Globe*. She is a resident scholar at the Women's Studies Research Center, Brandeis, and lives in Newton, Massachusetts.
Bringing People Home: The Marsters Settlement	Webpages: https://www.centerforpublicrep.org/court_case/marsters-et-al-v-healey-et-al/ https://marsters.centerforpublicrep.org/ Marsters data for the calendar year 2025: • 499 people who have returned and are active in the community • Efforts to validate status of 63 others who are in the community • Target for 2025 and 2026 is 600 transitions • 1,369 currently enrolled • 100 AHVP vouchers issued for transitions: 71 used, 10 in process. The Alternative Housing Voucher Program (AHVP) is a state-funded rental assistance program in Massachusetts specifically designed for non-elderly (under age 60) people with disabilities who have low incomes.

Support Dignity Alliance Massachusetts	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

Please Donate!	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.** **The 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 dickmoore1943@gmail.com.
Websites	• **Center on Health Policy at Brookings** **https://www.brookings.edu/centers/center-on-health-policy/** The Center on Health Policy at Brookings produces rigorous evidence and analysis to inform health care policy debates by illuminating how the health care system works and how policymakers can improve it. The Initiative's work focuses on four areas: **Health Care Services** The Center studies how to reduce health care costs and improve quality, through strengthened competition and improved provider payment in public programs and private insurance. **Prescription Drugs** The Center identifies strategies to ensure affordability of and access to existing and future drugs through improved regulation of prescription drug markets, bolstered pharmaceutical supply chains, and better targeted public investments in research and infrastructure. **Health Insurance** The Center investigates how to expand access to care, promote financial security, and reduce the cost of insurance coverage by improving the design of Medicare and Medicaid and reforming how we subsidize and regulate private insurance. **Mental Health and Addiction** The Center develops innovative approaches to confront the mental health and addiction crises by reforming coverage and payment for behavioral health care and improving integration of behavioral health care with other health and human services.

Blogs		
Podcasts		
YouTube Channels		
Previously recommended websites	The comprehensive list of recommended websites has migrated to the Dignity Alliance MA website: https://dignityalliancema.org/resources/. Only new recommendations will be listed in *The Dignity Digest*.	
Previously posted funding opportunities	For open funding opportunities previously posted in *The Tuesday Digest* please see https://dignityalliancema.org/funding-opportunities/.	
Websites of Dignity Alliance Massachusetts Members	See: https://dignityalliancema.org/about/organizations/	
Contact information for reporting complaints and concerns	**Nursing home**	Department of Public Health 1. Print and complete the Consumer/Resident/Patient Complaint Form 2. Fax completed form to (617) 753-8165 Or Mail to 67 Forest Street, Marlborough, MA 01752 Ombudsman Program
MassHealth Eligibility Information	**MassHealth / Massachusetts Medicaid Income & Asset Limits for Nursing Homes & Long-Term Care** **Table of Contents** (Last updated: December 16, 2024) **Massachusetts Medicaid Long-Term Care Definition** **Income & Asset Limits for Eligibility** **Income Definition & Exceptions** **Asset Definition & Exceptions** **Home Exemption Rules** **Medical / Functional Need Requirements** **Qualifying When Over the Limits** **Specific Massachusetts Medicaid Programs** **How to Apply for Massachusetts Medicaid**	
Money Follows the Person	**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 March 31, 2025: 344 people transitioned out of nursing facilities in 2024 49 transitions in January and February 2025 910 currently in transition planning Open PDF file, 1.34 MB, MFP Demonstration Brochure MFP Demonstration Brochure - Accessible Version MFP Demonstration Fact Sheet MFP Demonstration Fact Sheet - Accessible Version	
Nursing Home Closures	List of Nursing Home Closures in Massachusetts Since July 2021: https://dignityalliancema.org/2025/04/07/nursing-home-closures-since-july-2021/	
Determination of Need Projects	List of Determination of Need Applications regarding nursing homes since 2020: https://dignityalliancema.org/2025/04/07/list-of-determination-of-need-applications/ Recent approval: **Town of Nantucket – Long Term Care Substantial Capital Expenditure** Approved May 5, 2025	

<table>
<tr><td>List of Special Focus Facilities</td><td>Centers for Medicare and Medicaid Services
List of Special Focus Facilities and Candidates
https://www.cms.gov/files/document/sff-posting-candidate-list-march-2025.pdf
Updated March 26, 2025
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.</td></tr>
<tr><td>Nursing Home Inspect</td><td>ProPublica
Nursing Home Inspect
Data updated October 15, 2025
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 (July 1, 2022 through September 30, 2025.
Massachusetts listing:
https://projects.propublica.org/nursing-homes/state/MA
Deficiencies By Severity in Massachusetts
(What do the severity ratings mean?)
<table>
<tr><th>Deficiency Tag</th><th># Deficiencies</th><th>in # Reports</th><th>MA facilities cited</th></tr>
<tr><td>B</td><td>257</td><td>187</td><td>Tag B</td></tr>
<tr><td>C</td><td>77</td><td>63</td><td>Tag C</td></tr>
<tr><td>D</td><td>5,993</td><td>1,193</td><td>Tag D</td></tr>
<tr><td>E</td><td>1,872</td><td>630</td><td>Tag E</td></tr>
<tr><td>F</td><td>446</td><td>226</td><td>Tag F</td></tr>
<tr><td>G</td><td>420</td><td>278</td><td>Tag G</td></tr>
<tr><td>H</td><td>54</td><td>30</td><td>Tag H</td></tr>
<tr><td>I</td><td>2</td><td>1</td><td>Tag I</td></tr>
<tr><td>J</td><td>64</td><td>31</td><td>Tag J</td></tr>
<tr><td>K</td><td>30</td><td>9</td><td>Tag K</td></tr>
<tr><td>L</td><td>7</td><td>2</td><td>Tag L</td></tr>
</table>
Updated October 15, 2025</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.
https://tinyurl.com/NursingHomeCompareWebsite</td></tr>
<tr><td>Data on Ownership of Nursing Homes</td><td>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.</td></tr>
</table>

<table>
<tr><td>DignityMA Call Action</td><td colspan="3">

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

</td></tr>
<tr><td>Access to Dignity Alliance social media</td><td colspan="3">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</td></tr>
<tr><td>Participation opportunities with Dignity Alliance Massachusetts

Most workgroups meet bi-weekly via Zoom.

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

Please contact group leaders for more information.</td><td colspan="3">
<table>
<tr><th>Workgroup</th><th>Workgroup lead</th><th>Email</th></tr>
<tr><td>General Membership</td><td>Bill Henning
Paul Lanzikos</td><td>bhenning@bostoncil.org
paul.lanzikos@gmail.com</td></tr>
<tr><td>Assisted Living</td><td>John Ford</td><td>jford@njc-ma.org</td></tr>
<tr><td>Behavioral Health</td><td>Frank Baskin</td><td>baskinfrank19@gmail.com</td></tr>
<tr><td>Communications</td><td>Lachlan Forrow</td><td>lforrow@bidmc.harvard.edu</td></tr>
<tr><td>Facilities (Nursing homes and rest homes)</td><td>Jim Lomastro</td><td>jimlomastro@comcast.net</td></tr>
<tr><td>Home and Community Based Services</td><td>Meg Coffin</td><td>mcoffin@centerlw.org</td></tr>
<tr><td>Legislative</td><td>Richard Moore</td><td>Dickmoore1943@gmail.com</td></tr>
<tr><td>Legal Issues</td><td>Stephen Schwartz</td><td>sschwartz@cpr-ma.org</td></tr>
<tr><th>Interest Group</th><th>Group lead</th><th>Email</th></tr>
<tr><td>Housing</td><td>Bill Henning</td><td>bhenning@bostoncil.org</td></tr>
<tr><td>Veteran Services</td><td>James Lomastro</td><td>jimlomastro@comcast.net</td></tr>
<tr><td>Transportation</td><td>Frank Baskin
Chris Hoeh</td><td>baskinfrank19@gmail.com
cdhoeh@gmail.com</td></tr>
<tr><td>Covid / Long Covid</td><td>James Lomastro</td><td>jimlomastro@comcast.net</td></tr>
<tr><td>Incarcerated Persons</td><td>TBD</td><td>info@DignityAllianceMA.org</td></tr>
</table>
</td></tr>
<tr><td>Bringing People Home: Implementing the Marsters class action settlement</td><td colspan="3">Website: https://marsters.centerforpublicrep.org/
Center for Public Representation
5 Ferry Street, #314, Easthampton, MA 01027
413-586-6024, Press 2
bringingpeoplehome@cpr-ma.org
Newsletter registration: https://marsters.centerforpublicrep.org/7b3c2-contact/</td></tr>
<tr><td>REV UP Massachusetts</td><td colspan="3">REV UP Massachusetts advocates for the fair and civic inclusion of people with disabilities in every political, social, and economic front. REV Up aims to increase the number of people with disabilities who vote.
Website: https://revupma.org/wp/
To join REV UP Massachusetts – go to the SIGN UP page.</td></tr>
<tr><td>The Dignity Digest</td><td colspan="3">For a free weekly subscription to The Dignity Digest:
https://dignityalliancema.org/contact/sign-up-for-emails/
Editor: Paul Lanzikos
Primary contributor: Sandy Novack
MailChimp Specialist: Sue Rorke</td></tr>
<tr><td>Note of thanks</td><td colspan="3">Thanks to the contributors to this issue of The Dignity Digest:

Wynn Gerhard
Jim Lomastro
Dick Moore

</td></tr>
</table>

	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.