At Home

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Al Norman, Editor

Zero COLA for Social Security?

According to a report from the Social Security Trustees, millions of senior citizens will not see any increase in their Social Security checks as of January, 2016. In their 2015 report, the Social Security Board of Trustees wrote: "projections…do not have a cost of living adjustment for December 2015."

Automatic benefit increases, also known as cost-of-living adjustments or COLAs, have been in effect since 1975. Beneficiaries used to see their check go up in July of each year, but since 1982, COLAs have been effective with benefits payable for December---which beneficiaries see as a higher check in January.

But this January, nearly 60 million Social Security beneficiaries will see no increase. This will be only the 3rd time since 1975 that people on Social Security have received a 0% COLA. The only other two years with no increase were in 2010 and 2011.

The reason the COLA is zero for January of 2016 is because oil prices have dropped so much that there is no increase in the Consumer Price Index for Urban Wage Earners and Clerical Workers, the CPI-W, as calculated by the U.S. Department of Labor. The CPI-W is the basis for measuring the COLA. Inflation

hasn't been enough to justify a COLA. So cheap gas at the pump and in the oil tank has translated into no Social Security check increase for 2016.

The annual COLAs are based on the percentage increase (if any) in the average CPI-W for the third quarter of the current year over the average for the third quarter of the last year. If there were a rise in inflation during July, August, and September of 2015—things could change. But seniors shouldn't count on a COLA this January.

In 2015, there was a 1.7% COLA for Social Security and Supplemental Security Income recipients. The largest Social Security COLA since the year 2000 was in 2009, when beneficiaries got a 5.8% increase—but that was followed by two years of no increase at all. In 2013, 2014 and 2015, the COLAs were 1.7%, 1.5%, and 1.7%--so not much change at all. Since 2010, the COLA has averaged only 1.4%. The Trustees are projecting that 2016 will be the only year with no COLA increase, and that in future years, like 2017, seniors and individuals with disabilities will get a COLA.

However, no COLA in 2016 will result in some good news. Elders enrolled in Medicare Part B will see no increase in their monthly premium of $104.90 deducted from their Social Security checks. New people coming onto Medicare will see a premium rise, as will Medicare beneficiaries with higher incomes. And workers who pay into Social Security based on their earnings will be happy, because when there isn't a COLA increase, there's also no increase in the upper limit on wage income subject to Social Security payroll taxes---which will remain frozen at $118,500 per year. In 2016, any wages earned above that level will not be subject to the Social Security payroll tax, known as FICA.

For many years, elders have argued that the CPI-W, which only measures price changes in food, housing, gas and other goods and services, is not a good indicator of changes in the real cost of living for seniors. The U.S. Bureau of Labor Statistics has collected data since 1983 on the basis of an experimental index (CPI-E) for Americans 62 and older. The CPI-E measures a "basket" of goods and services more relevant to elders, who spend more of their money on items like medical care. If Social Security benefits were measured by the CPI-E instead of the CPI-W, the annual COLA adjustments would be higher. But that would increase Social Security payments to elders—something that many members of Congress are reluctant to do. If the CPI-E index had been used from 1985 to 2014, Social Security benefits last year would have been 6.5% higher than they are today, according to an analysis by J.P. Morgan Asset Management.

Inflation in the health care sector has been relatively restrained in recent years. Annual growth in total Medicare spending averaged 4.1% from 2010 to 2014, compared with 9% from 2000 to 2010 - even though the number of enrolled beneficiaries has risen..

But some analysts warn that there may be much higher Medicare premiums starting next year, according to the Medicare trustees' annual report. The monthly premium for Medicare Part B (outpatient services), which has remained at $104.90 for the past three years, will rise 52%, to $159.30 for those beneficiaries who are not protected by the hold-harmless provision.

Anyone enrolled in Medicare who is not yet taking Social Security benefits due to a decision to delay enrollment would not be protected from these higher premiums. It also would include new enrollees in Medicare next year. The increase also would be applied to low-income beneficiaries whose premiums are paid by state Medicaid programs. High-income retirees---

another group that is not protected by the hold-harmless provision---also will be hit hard if the trustee projections hold. Affluent seniors already pay more for Medicare Part B and also Part D for prescription-drug coverage. This year, higher-income seniors pay between $146.90 and $335.70 monthly for Part B, depending on their income, rather than $104.90. The Medicare trustees now project that to jump even more.

By October of 2015, we will know for sure if the Social Security COLA will rise---but for now, it looks like seniors will have to live with another UN-COLA for 2016.

Feds Issue Guidance Against LGBT Discrimination in Housing

In mid July, the President **Barack Obama's** administration announced new guidance to make clear that anti-LGBT discrimination is unacceptable in government-sponsored and insured housing, including housing for the elderly. HUD Secretary **Julián Castro** said anti-LGBT bias is unacceptable in housing.

Secretary Castro said in a statement the new guidance reinforces the administration's opposition to bias against the LGBT community in housing and elsewhere. "Every American deserves to live with dignity, regardless of who they love or who they are," Castro said. "HUD is committed to fighting unjust discrimination and to expanding housing opportunity for all."

The five page guidance letter from the Department of Housing & Urban Development spells out HUD-assisted multifamily housing as well as housing subject to a mortgage insured by the Federal Housing Administration must be made available regardless of actual or perceived sexual orientation, gender identity or marital status. The new eligibility language at 24 CFR 5.105 (a)(2) reads: "A determination of eligibility for housing that is assisted by HUD or subject to a mortgage insured by the Federal Housing Administration shall be made in accordance with the eligibility requirements provided for such program by HUD, and such housing shall be made available without regard to actual or perceived sexual orientation, gender identity, or marital status."

Such housing includes Section 202 Supportive Housing for the Elderly, which provides rent subsidies for low-income elders to make housing affordable to them. The new language also prohibits an owner or administrator of HUD-assisted housing, from ask about the sexual orientation and gender identity of applicants for such housing: "No owner or administrator of HUD-assisted or HUD-insured housing, approved lender in an FHA mortgage insurance program, nor any (or any other) recipient or subrecipient of HUD funds may

inquire about the sexual orientation or gender identity of an applicant for, or occupant of, HUD-assisted housing or housing whose financing is insured by HUD, whether renter-or owner-occupied, for the purpose of determining eligibility for the housing or otherwise making such housing available. This prohibition on inquiries regarding sexual orientation or gender identity does not prohibit any individual from voluntarily self-identifying sexual orientation or gender identity. This prohibition on inquiries does not prohibit lawful inquiries of an applicant's or occupant's sex where the housing provided or to be provided is temporary, emergency shelter that involves the sharing of sleeping areas or bathrooms, or inquiries made for the purpose of determiningthe number of bedrooms to which a household may be entitled."

An advisor to HUD Secretary Castro told *The Washington Blade* newspaper that the guidance doesn't represent a new administrative policy change, but is a reminder about the Equal Access Rule put in place by HUD in February of 2012.to prohibit anti-LGBT discrimination in housing sponsored by the federal

government. "I think the point that we really want to make clearly to multifamily developers is to make sure they pay attention to the rule, make sure that they know we will not tolerate discrimination against people based on their sexual orientation or their gender identity," the HUD spokesperson said.. "If they have a practice of doing that, we've got tools that we can use to say that's not OK."

According to HUD, the department has filed 349 fair housing complaints based on LGBT discrimination since the rule was instituted in 2012, although the number of complaints that have been successful in court isn't readily available. Violating the rule could result in HUD's determination that an owner has failed to comply with program requirements and the department may pursue any available remedy, including sanctions, to address the violation, the new guidance says.

The Blade noted that HUD periodically issues guidance to reaffirm opposition to anti-LGBT discrimination, such as a memo last February clarifying the Equal Access Rule applies to LGBT people seeking a home loan and transgender individuals seeking access to homeless shelters.

"The sad truth is we can't end discrimination, but we can let organizations know that it's not acceptable and if we find out that they're doing it, we have actions that we can take to force them to correct their behavior…if that's what they're going to do," the HUD spokesperson said. According to a 2014 report by the group Services & Advocacy for GLBT Elders (SAGE) one-in-eight older LGBT adults and one-in-four transgender older adults say they were the victims of discrimination on the basis of their sexual orientation and gender identity when searching for housing. A spokesperson from SAGE said "HUD's announcement is a strong step toward ending discrimination against LGBT people in federally supported senior housing. With a recent report showing that housing discrimination against LGBT elders is rampant, this is just the kind of leadership we need from the federal government. Now we need to make sure that these anti-discrimination protections are effectively implemented."

HUD said the new guidance in place should be a tool to prohibit anti-LGBT discrimination in housing to the furthest extent possible under current law. "The guidance will be a tool that will allow advocates to use it in instances where think there is discrimination that has occurred where they want to do education in terms of what to do. It's an extra tool that allows us to get the word out."

Millionaires Tax, Fair Health Pricing Petitions Filed with AG

By the 5 p.m. deadline on August 5th, , 24 groups filed 35 initiative petitions for proposed laws or constitutional amendments with Attorney General **Maura Healey's** Office.

Of the 35 petitions, 26 were proposed laws for the 2016 ballot and nine were constitutional amendments for the 2018 ballot. Two of the ballot measures have to do with health care pricing.

The Attorney General's Office now is reviewing whether the initiative petitions meet certain constitutional requirements and can be certified to file with the Secretary of State. Decisions on certifications will be released on Wednesday, Sept. 2. Once certified, proponents of proposed laws must gather and file the signatures of 64,750 registered voters by Dec. 2, 2015. Assuming enough signatures have been gathered, a proposal is sent to the state Legislature to enact before

the first Wednesday in May 2016. If the Legislature fails to enact the proposal, supporters must gather another 10,792 signatures from registered voters by early July 2016 to place the initiative on the November 2016 ballot. The process for proposed constitutional amendments requires approval by at least 25 percent of the Legislature in 2016 and then again in 2017-2018 before appearing on the November 2018 ballot.

Two of the petitions filed were organized by 1199 Service Employees International Union (SEIU), with the title "Massachusetts Fair Health Care Pricing Act." These petitions amend Chapter 176 of the General Laws to create a new section on Fair Health Care Pricing, which requires health care carriers to calculate and the Center of Health Information and Analysis (CHIA) to certify specific relative prices that the carrier has agreed to pay each health care providers for every service using the provider categories and uniform methodology for price relativities established by CHIA.

No health care carrier would be allowed to enter into or renew a contract for the provision of a health care service with a health care provider under which the health care provider is paid a rate not in conformity with this new law. Beginning July 1, 2017 through June 30, 2018, no carrier would be allowed to pay a health care provider for a provided service at a rate more than 40% above or more than 30% below the base year carrier-specific average relative price for that service.

Under the Fair Health Care Pricing Act, the Division of Insurance would publish consumer-friendly price information by provider, by service, and to report quality scores for every health care provider under contract with each carrier for the provision of health care services. These prices would be published on a web site to be accessed by consumers. Providers would not be allowed to "balance bill" their patients for costs above the rates in their contracts. Health providers, including certain special hospitals, would be allowed to seek an exemption from the new pricing rules.

One of the constitutional amendments filed with the Attorney General's office is entitled "An Initiative Petition for An Amendment to the Constitution of the Commonwealth to Provide Resources for Education and Transportation through an additional tax on Incomes in excess of One Million Dollars." This petition would amend Article XLIV of the Massachusetts Constitution by adding the following new language: "To provide the resources for quality public education and affordable public colleges and universities, and for the repair and maintenance of roads, bridges and public transportation, all revenues received in accordance with this paragraph shall be expended, subject to appropriation, only for these purposes. In addition to the taxes on income otherwise authorized under this Article, there shall be an additional tax of 4% on that portion of annual taxable income in excess of $1,000,000 (one million dollars) reported on any return related to those taxes. To ensure that this additional tax continues to apply only to the Commonwealth's highest income residents, this $1,000,000 (one million dollar) income level shall be adjusted annually to reflect any increases in the cost of living by the same method used for federal income tax brackets. This paragraph shall apply to all tax years beginning on or after January 1, 2019."

Over the next two fiscal years, prices would be confined to 20% over or 20% under the CHIA rates.

The "Millionaire's Tax" amendment was filed by what the Boston Globe called "A coalition of labor unions, religious organizations, and liberal advocacy groups." Proponents include the SEIU, the Massachusetts Teachers Association, the American Federation of Teachers-Massachusetts, and the Massachusetts AFL-CIO. Other supporters included the Coalition for Social Justice, Progressive Massachusetts,

the Massachusetts Communities Action Network and the Jewish Alliance for Law and Social Action.

This amendment would change the state's flat state income tax — everyone currently pays at a rate of 5.15%—by adding on a new bracket only for taxpayers with, earnings over $1 million taxed with a rate 4% higher. Taxpayers with income below $1 million would not be affected by the higher rate.

"Asking these high-earning individuals . . to pay their fair share would allow us to improve our schools, make public higher education more affordable, and fix our crumbling transportation system," a spokesperson for Raise Up Massachusetts, told *The Globe*. A spokesperson for Governor **Charlie Baker** told the newspaper that "Governor Baker does not support tax increases on our hard-working families."

As of 2013, there are roughly 14,000 Massachusetts taxpayers with taxable income in excess of $1 million. There are only 7 other states with a flat income tax. Efforts in the past to create a "graduated" income tax that rises with income, have all failed. But this tax rate would only impact the rich. Proponents of the change told *The Globe* that attitudes towards the graduated income tax (GIT) have changed, and that the focus on income inequality and the "1%" richest households have changed. "That was a different time," said **Harris Gruman**, a Service Employees International Union official and cochairman of Raise Up Massachusetts. "People didn't feel as threatened by economic insecurity." According to *The Globe*, about a dozen states have raised tax rates on their highest income brackets since 2009.

The current tax rate applied to all Massachusetts taxpayers is 5.15%, and will drop to 5% over time depending on the state's economic performance. Millionaires would pay 9% on their income over $1 million.

Jeb Bush Suggests Phasing Out Current Medicare

According to an article on *The Huffington Post* in July, Republican presidential candidate **Jeb Bush** said that the government ought to phase out Medicare, the federal health insurance program which was created in 1965, and which today, after 50 years, still is the major provider of health insurance for seniors.

"We need to make sure we fulfill the commitment to people that have already received the benefits, that are receiving the benefits," Bush said. "But we need to figure out a way to phase out this program for others and move to a new system that allows them to have something, because they're not going to have anything."

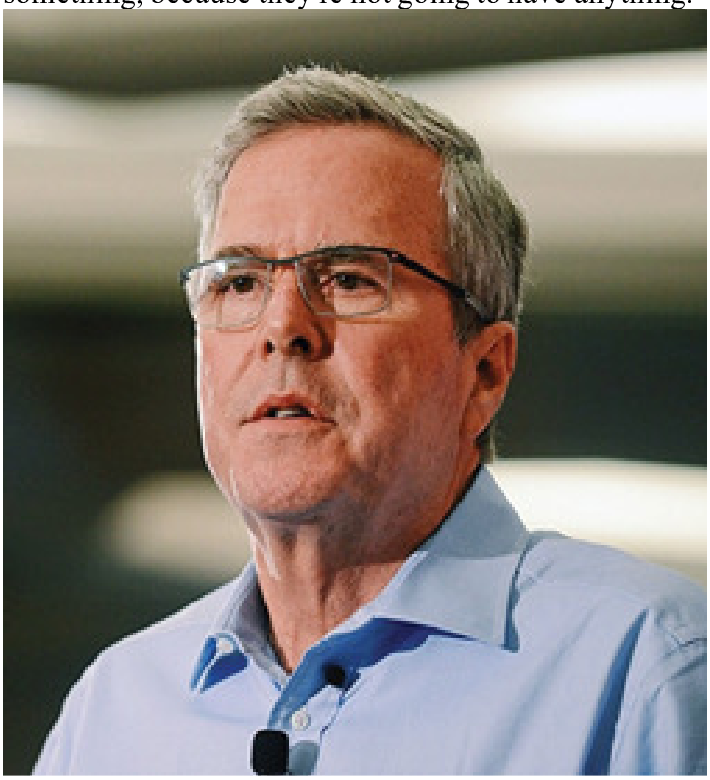


Photo: Slate.com

Bush praised Rep. **Paul Ryan** (R-Wis.) for proposing to change Medicare to a system that gives seniors medical vouchers instead of paying their bills directly. He also lamented that "the Left" reacted with an ad showing a Paul lookalike pushing an old lady's wheelchair off a cliff.

Since 2011, Ryan's name has been closely associated with his Medicare plan, which Democrats have said would "end Medicare as we know it." The **Mitt Romney** campaign in 2012 didn't endorse the plan even after adding Ryan to the ticket as a vice presidential candidate.

"Many people are afraid to act because they're fearful of just getting beat up politically," Bush said at an event in Manchester, New Hampshire.

Obama Signs Medicare Observation Status Bill

President **Barack Obama** has signed a bill into law that requires hospitals to notify Medicare patients when they are receiving "observation status" care---but have not been admitted as inpatients.

The law is meant to help address a recurring problem for beneficiaries who face sticker shock when they go to a skilled-nursing or rehab facility after leaving the hospital and find that Medicare won't cover the cost. That's because to qualify for skilled-nursing facility coverage, beneficiaries must first spend three consecutive midnights as an admitted patient in a hospital; observation days don't count.

As *Kaiser Health News* explains, the new law would explain to patients that they have not been admitted to the hospital, the reasons why, and the potential financial implications. "Those implications can be dire," *KHN* says. "Observation care hurts seniors in two ways: It keeps Medicare's more comprehensive hospitalization coverage from kicking in, and it means they may not get Medicare's limited nursing home benefit if they need care in a facility after being in a hospital…Without that coverage, seniors could pay thousands of dollars for the nursing home care their doctor ordered, or else try to recover on their own. Observation care is a classification used when patients are not well enough to go home but not sick enough to be admitted."

Another common issue is beneficiaries facing unexpected Medicare Part B copays for drugs received during hospital care, since they were never actually admitted into the hospital and the drugs therefore are not covered under Part A.

The Notice of Observation Treatment and Implication for Care Eligibility Act would require hospitals to notify beneficiaries receiving observation services for more than 24 hours of their status as an outpatient under observation. The written notification would have to explain that because the beneficiary is receiving outpatient rather than inpatient services, they will be subject to cost-sharing requirements that apply to outpatient services. The notice also must say that the beneficiary's outpatient stay will not count toward the three-day inpatient stay required for a beneficiary to be eligible for Medicare coverage of subsequent skilled-nursing facility services.

Legal experts worry that the new law may not actually help address these scenarios, as it gives beneficiaries no formal recourse to change their status once they find out they're at a hospital on an observational basis.

"The new law will not cure these problems, but will at least give patients a warning before they spend thousands of dollars on care that will not be covered by Medicare," **Jeff Marshall,** an elder law attorney in Pennsylvania, said. "Some beneficiaries will likely decide to receive a different set of medical services after being notified of their observation status."

Still, advocates are pleased despite the law lacking a formal recourse path. "Medicare beneficiaries need to know what their hospital admission status is and how it affects their out-of-pocket expenses," **Andrew Scholnick**, a senior legislative representative at AARP told *KHN*. .

"While this does not address all the issues associated with observation care, such as counting time

in observation toward the three-day rule for receiving skilled-nursing care, it helps educate consumers and protects individuals from surprise hospital bills," Scholnick added.

"I just wish there was a viable way to appeal the observation categorization and its consequences," said **Diane F Paulson**, Senior Attorney at the Medicare Advocacy Project at Greater Boston Legal Services.

Provider groups such as the American Hospital Association and the American Academy of Family Physicians have expressed support for the law.

The next step is that the CMS must begin the rule-making cycle and release the rule for public comment. The agency has released no timeline for when this process will occur.

A handful of states already require observation care notices, including New York, Connecticut, Maryland, Pennsylvania and Virginia. But Medicare officials have been reluctant to take similar steps.

Hospitals will have to comply with the NOTICE Act 12 months after it becomes law. The number of claims hospitals submitted for observation care continues to skyrocket. According to data from CMS, total claims increased 91% since 2006, to 1.9 million in 2013. Long observation stays, lasting 48 hours or more, rose by 450% to 170,219 during the same period, according to a Kaiser Health News analysis.

In 2013, Medicare officials attempted to control the use of observation care by issuing the so-called "two-midnight rule," which would require hospitals to admit patients who doctors expect to stay at least two midnights. But Congress delayed its enforcement after hospitals said the rule was confusing and arbitrary.

Although it's better for patients to know when they are on observation status, **Toby Edelman**, a senior policy attorney at the Center for Medicare Advocacy said they may not be able to do much about it. She said there is no set process for challenging observation care while in the hospital, unlike issues such as disputing a discharge order when admitted patients feel they are not ready to leave. The only way to switch from observation to admitted status is to persuade a physician or the hospital to make the change, said Edelman. And that decision doesn't apply to the time the patient has already spent on observation."

Plan To Stop Social Security For Felons Is Dropped

Getty Images

According to the newspaper, *The Hill*, which reports on stories from Congress, in late July, Senate Majority Leader **Mitch McConnell** (R-Ky.) persuaded 14 Democrats to switch their votes on a six-year highway deal by agreeing to drop a controversial provision affecting Social Security.

McConnell agreed to scrap an offset that would have raised $2.3 billion by stopping the payment of Social Security benefits to people with felony warrants. Democrats objected to the Social Security offset as a dangerous precedent that might have emboldened Congress to raid Social Security funds in the future for other spending priorities.

"I don't know of any time in our history when the Senate has taken money out of the Social Security fund and put it in some other public purpose," Sen. **Sherrod Brown** (D-Ohio) told a Democratic meeting to discuss the bill. "It's outrageous."

House Democrats also opposed the Social Security provision, which would have made passage of the Senate bill in the lower chamber much harder because a significant number of House Republicans had already complained about its offset covering only three years instead of the full six. After mounting

pressure from Democrats, Senate Republicans removed the controversial Social Security provision from an unrelated bill to fund construction of the nation's highways.

Just before a key vote on the measure, proponents of the bill agreed to cut the Social Security offset in an effort to garner support from more Democrats, according to a Democratic leadership aide. The provision would have saved an estimated $2.3 billion over 10 years by disallowing Social Security retirement, disability or supplemental income benefits to anyone with an outstanding felony warrant being actively pursued by law enforcement. But a number of Democrats weren't happy with it, and raised it as "a major sticking point" during a party meeting.

A spokesman for the Majority Leader said McConnell dropped the measure as part of broader negotiations on the bill.

Report Says CMS Should Negotiate For Better Drug Prices.

New research from Carleton University and the group Public Citizen concludes that the federal government could save between $15.2 billion and $16 billion per year if it negotiated with drug makers for Medicare Part D medicines and obtained the same prices that are paid by Medicaid or the Veterans Health Administration.

According to *The Wall Street Journal,* the authors of the new report say that 27 of 31 countries in the Organization for Economic Cooperation and Development (OECD) have been able to purchase a select group of medications at less than 50% of what is paid in the U.S. They also maintain that U.S. costs per capita for pharmaceuticals are $1,010, which amounts to more than twice the $498 paid, on average, by OECD countries.

"We thought that brand-name medicines were a little bit more expensive for Part D, but we never thought that it would be twice as much as in other developed countries," the report authors said.

The paper claims that Medicare Part D spent $69.3 billion on prescription drugs in 2013, but maintains that most of the spending is for brand-name medicines. The Centers for Medicare and Medicaid Services is precluded from negotiating prices for medicines for Medicare Part D. The Bush administration agreed to that provision in exchange for pharmaceutical industry support for the Part D program, which was created in 2006. Ever since, critics have argued that savings could be realized if negotiations with drug makers were permitted.

Social Security Disability Trust Fund Facing Disability

Photo: makers.com

In late July, after the Social Security and Medicare Trustees released their annual financial reports, the office of House Minority Leader, **Nancy Pelosi** (D-CA) released the following statement:

"The Social Security Trustees report concluded that the Social Security program's fiscal health has improved over the last year, for predictable reasons: The economy is improving, and workers' wages are rising. The trustees moved the projected exhaustion date for the combined trust funds of the program's old-age and disability segments one year further out, to 2034, from the 2033 date in last year's report. But this masks the dire condition of the disability program: Its trust fund, taken on its own, will run out of money at

the end of next year. Eleven million people face a deep, abrupt cut in disability insurance benefits in late 2016 if Congress fails to replenish Social Security's disability trust fund, which is running out of money, the Obama administration said.

Social Security Disability Insurance represents an essential lifeline for millions of Americans; Americans who worked hard, who paid into Social Security, and now have a serious disability that prevents them from working. SSDI is a bedrock promise to every American – that even in the event of a life-changing illness or injury, this basic measure of support and security will be there for them and their family.

We must keep this promise and strengthen Social Security overall. With the Disability fund projected to deplete all reserves before the end of 2016, Congress should act swiftly to improve SSDI and reallocate the needed financing into the fund before the end of this year. Congress must not allow the Trust Fund to be exhausted.

Thanks to the efficiencies of the Affordable Care Act, we have extended the life of the Medicare Trust Fund until 2030 – 13 years longer than was projected in 2009. Together with the reforms of our bipartisan, permanent fix to the Sustainable Growth Rate, we have ensured that seniors will have access to the doctors and health care they need for years to come.

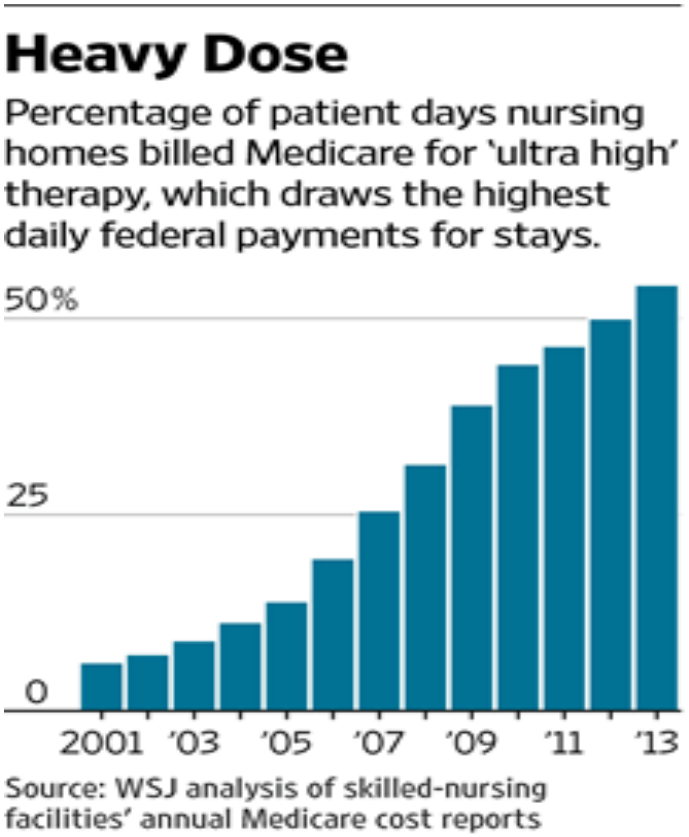
As we mark the 50th anniversary of Medicare and the 80th anniversary of Social Security, let us rededicate ourselves to strengthening, not cutting the security they guarantee each generation of Americans."

Disability rights groups have urged the Obama Administration to transfer funds from the Social Security Trust Fund to cover the Disability Insurance Fund.shortfall, which is a more immediate concern.

Medicare Payments To Nursing Homes Stimulate "Ultrahigh" Spending

A new study by *The Wall Street Journal* released in mid-August concludes that Medicare reimbursement methodology for nursing homes and driven up the percentage of patients who get "ultrahigh" levels of skilled therapy—sometimes of questionable value to the patient.

Medicare changed its payment rules in 1998, allowing nursing homes to bill for increasing levels of therapy. In 2002, nursing homes gave ultrahigh therapy to patients on about 7% of days they billed to Medicare. By 2013, nursing homes were billing 54% of their days as ultrahigh---Medicare's highest nursing-home rates — averaging $560 per day in 2013. Patients who are getting at least 720 minutes a week in therapy are considered "ultra high" under the federal program's rules.



"Since the new system was phased in during the early 2000s," *The Wall Street Journal* reports, "the share of patients getting ultrahigh therapy amounts has soared across the industry. Nursing-home officials say the rise is due to sicker patients, increased demand for therapy services and other factors…Such therapy is sometimes delivered even when patients are unresponsive, aren't likely to benefit or have declined such services, at times distressing vulnerable patients, these people say. "The system really rewards high-intensity care," says **David**

Grabowski, a Harvard University professor who studies nursing-home spending. "There are patients being treated who aren't appropriate." A January report that the Medicare Payment Advisory Commission, an independent congressional agency, produced with the Urban Institute found that "the present payment system continues to encourage providers to furnish clinically-unnecessary services for financial gain."

Medicare paid nursing homes about $28 billion in 2013, 10% more than it would have paid if the proportion of days billed at each therapy level had been the same as in 2008 and 24% more than if the proportions had mirrored 2002 billing patterns, according to the Journal analysis.

State Proposes New Telehealth Service For Home Health Clients

The state Executive Office of Health and Human Services (EOHHS) is holding hearings in early September on its new regulations and rates for Home Health Services, including the addition of an important new service that home health advocates have sought for years.

The state is creating a new set of regulations, 101 CMR 350.00, and the rescission of 114.3 CMR 50.00: Home Health Services. EOHHS is taking over the authority for rate setting and regulation promulgation for Home Health Services from the former Division of Health Care Finance and Policy (DHCFP).

The proposed regulation establishes the rates of payment for home health services pursuant to M.G.L. c. 118E, § 13D, which requires EOHHS to establish rates of payment for non-institutional providers, such as providers of Home Health services, at least every two years. Additionally, the proposed regulation adds a new service and associated payment rate, Remote Patient Monitoring ("RPM"), which would allow home health providers to monitor patients' health status remotely. An installation rate of $50 and a daily monitoring rate of $10 are proposed for this service. The proposed regulation is to go into effect November 1, 2015.

According to the draft regulations, here are the new definitions added to the home health regulations:

• Remote Monitoring Device – a device which uses a variety of wired or wireless peripheral measurement devices such as blood pressure cuffs, scales, and pulse oximetry, to capture user-entered data.

• Remote Patient Monitoring (RPM) – a service that allows home health providers to monitor a patient's health status remotely. Generally, RPM uses a device installed in patients' homes to monitor their physiological conditions such as weight, oxygen saturation measurements, vital signs, and medication adherence. The monitoring device then transmits the information to local storage, a centralized repository, or to a provider of home health services. These systems can transmit user-entered data, store the data in secure records systems accessible to clinicians, flag abnormal readings or responses, and alert clinicians to abnormalities via e-mail or text messages. In response to these alerts, clinicians can log into the system, review data, follow up with patients, or take other appropriate actions.

The proposed rates for remote patient monitoring are $50 installation/removal fee; $10 per day for an RN remote patient monitoring visit; $10 per day for an LPN remote patient monitoring visit.

The new rate for the services of a home health aide is $6.10 for 15 minutes, or $24.40 per hour. A visiting RN rate is $86,99 per visit up to day 60, dropping to $69.59 per visit on day 61 or longer,

Dan O'Leary, president of Mass Home Care, praised the decision by the Baker Administration to add "telehealth" as a new billable service. "Our colleagues in the home health field have been advocating for remote monitoring for years. It's a way to use technology to make home health care more efficient and productive for elders and their workers. Home visits are still critical—but technology can extend and expand access to our clients."

Mass Home Care will address concerns about the need to raise rates for home health aides in relation to home care aides at a September 2nd hearing. "The two roles are not the same, and wage rates need to reflect the difference in these two job descriptions," O'Leary said "both these kinds of positions are vital to keeping elders and individuals with disabilities living at home, and both need to be paid a liveable wage."

Mass Home Care's

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