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The BENES Act Advances in the House

This week, the House Committee on Ways and Means advanced the Beneficiary Enrollment Notification and Eligibility Simplification (BENES) Act (S. 1280/H.R. 2477) in a markup that considered a series of Medicare-related bills. The BENES Act is now included in a larger bipartisan package that was unanimously reported favorably out of Committee—the Beneficiary Education Tools, Telehealth, and Extenders Reauthorization (BETTER) Act of 2019 **(H.R. 3417).**

The BENES Act is urgently needed to modernize and simplify the Medicare Part B enrollment process. Currently, far too many people make honest mistakes when trying to understand and navigate this confusing system. The consequences of such missteps are significant—including late enrollment penalties, higher out-of-pocket health care costs, gaps in coverage, and barriers to accessing needed services.

The BENES Act would help prevent these costly errors. As included in the BETTER Act of 2019, it would fill long-standing gaps in outreach and education, eliminate needless breaks in coverage, and inform future policymaking on enrollment period alignment.

In addition to these commonsense BENES Act solutions, the BETTER Act includes several other policies that are important to people with Medicare and their families, and priorities for the Medicare Rights Center—such as increasing funding for outreach and enrollment assistance to low-income Medicare beneficiaries, and making the Part D Limited Income Newly Eligible Transition (LI NET) Program permanent.

Together, these and other changes in the BETTER Act bill would significantly improve the health and economic security of people with Medicare today and in the future. Medicare Rights applauds the members of the Ways and Means Committee for advancing these improvements and thank the staff of the Health and Social Security Subcommittees for their tireless work in crafting these complex policy changes.

We are also grateful to Rep. Schneider (D-IL) and Rep. Walorski (R-IN) for championing the BENES Act on the Committee, and to House co-sponsors Representatives Ruiz (D-CA) and Bilirakis (R-FL) for their leadership of the bill on the Energy and Commerce Committee.

We urge lawmakers to prioritize the BETTER Act's critical reforms—including the BENES Act—for immediate passage.

Read Medicare Rights' letter of support for the BETTER Act.

Read a letter of support for the BENES Act as included in H.R. 3417, signed by 85 stakeholder organizations.

Read Medicare Rights' one-pager on the BENES Act.

Elder Care Activists Describe Need for Improved Training at Assisted-Living Facilities

Over the past 20 years, as older Americans began requiring different forms of care, the number of assisted-living centers across the country increased by **nearly 150 percent**. Despite the dramatic change, until now there has been little discussion about updates to the facilities' staffing and training guidelines. Eldercare experts are looking to the federal government to provide uniform guidance for these centers detailing how to appropriately train their staff members.

Without any federal oversight, many states have given assisted-living centers free-reign to decide how to train and hire their staff. Almost half of all states do not require substantial and updated training, and 38 states allow these centers to determine how many staff members they need.

This leads to gaps in the types of care that patients receive from state to state. For instance, Montana law does not require a set amount of instruction for staff members, but staff in Kansas must pass a 90-hour course and an accompanying exam.

Those who advocate for federal intervention are looking to the nursing home model for inspiration - especially when it addresses the role of Medicaid. For nursing homes, the federal government sets care and training standards while many residents finance their care through Medicaid payments. The same is not true for assisted-living patients, but a growing population is beginning to rely on Medicaid waivers to offset medical costs, prompting activists to call for the same federal oversight that nursing homes receive.

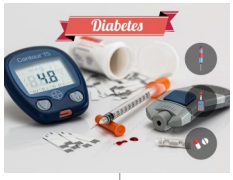
"**Four in ten** assisted-living patients are diagnosed with Alzheimer's disease or other forms of dementia. It is clear that there is a need for specialized care in these facilities that only thoroughly-trained staff members can provide," said **President Roach.** "State-level guidelines are simply not cutting it anymore. It is time to empower the federal government to give these facilities the tools they need so that patients receive the quality of care they deserve."

Robert Roach,

In Canada, insulin costs 90 percent less than in the US

Need insulin? More than seven million Americans with **diabetes** depend on insulin to live. But, many of them can no longer afford the US price. When possible, they travel across the border to Canada where the **Washington Post** reports they can get insulin for 90 percent less than in the US.

The **Health Care Cost Institute** reports that between 2012 and 2016 the cost of an insulin prescription almost doubled in the US, from $344 to $666. Moreover, there was significant variation in price depending upon the state in which it was sold. In Maine, the price of insulin was as high as $865 in 2016. In California, the highest price of insulin was $407.



Why is the price of insulin so high? Insulin was discovered 100 years ago. The cost has almost doubled only because **Congress allows the pharmaceutical companies** to charge what they please for it. There is no meaningful price competition.

In Canada, you don't need a prescription for insulin, so you can also avoid the cost of a trip to the doctor. The Canadian government appreciates that the only people buying insulin are people who need it. Moreover, the price is transparent, predictable and affordable. Diabetics do not have to choose between their insulin and other basic needs as they often do in the US. In the US, you never know what your insurer is paying and what your copays will be. They are always changing. The cost of insulin is so high that people must search for coupons or rebates. And, still they don't know what they will have to pay for it.

Congress is looking at ways to address high drug prices. And, the **Washington Post** reports that there appears to be some bipartisan agreement that people should be able to import their drugs from Canada. Importation is a fine short-term solution. But, **that's already happening**, if not legally, apparently without the US government attempting to stop it or penalize people who import their drugs for personal use.

The long-term solution to high drug prices needs to be government price regulation. The simplest solution is for Congress to set drug prices at the **average of what other wealthy countries pay**, as Senator Bernie Sanders, Congressman Ro Khanna and others have proposed. That's a market-based solution. Today, Pharma holds all the power to set prices.

If you want Congress to rein in drug prices, **please sign this petition.**

Evidence suggests privatized Medicaid long-term care may put people at serious risk

The US health insurance system has become increasingly privatized. One big trend is in the **Medicaid program**. More than two dozen states have contracted with for-profit health insurance companies to deliver home and community-based services to people with Medicaid, crowding out mission-driven non-profit providers. The available evidence suggests that privatized Medicaid **long-term care** may put people at serious risk.

Researchers at the **Claude Pepper Center** express concern both for people with Medicaid and for taxpayers. These large commercial insurers need to drive profits. And, in the health care space, they can do so relatively easily by **delaying and denying people needed care**. What's happening to health care access, quality and costs for people with Medicaid needing long-term services and supports in states that have moved to for-profit Medicaid long-term care?

Today, more than 1.7 million people with Medicaid are in managed long-term care (MLTC) programs operated by for-profit companies or private equity firms. There is precious little evidence to suggest that these programs are more efficient or deliver better care than the non-profits which had been delivering LTC services. There is simply a mindset among some policymakers that for-profit competition is the better model.

What do we know? AARP has **assessed states with the best LTC programs** for people with Medicaid. And, the states which rely most heavily on for-profit long-term care (MLTC) rank at the bottom. Two studies conducted in Texas, which has extremely high MLTC enrollment, found poor quality and a system in need of major intervention. Access to network doctors was inadequate. And, the state has little if any ability to monitor or assess performance by the for-profit insurers.

The federal government, in partnership with powerful corporations who wield undue influence in Congress and in the states, has pushed this move away from the non-profit model of LTC and towards the for-profit model. The GAO has investigated and found serious cause for concern and a lack of needed oversight. The Centers for Medicare and Medicaid Services (CMS) is doing little to ensure appropriate oversight.

According to AARP, Washington, Oregon, Vermont, Minnesota, Arkansas, Wisconsin and Colorado have the best long-term care programs. None are MLTC. These states should resist a move to for-profit managed long-term care.

Below is more information for Medicare & Medicaid recipients.

People with Medicare and Medicaid in Special Needs Plans at extra risk

Medicaid coverage of home and community-based care

Medicare and Medicaid: How they work together

Free local resources to help older adults

How to get free or low-cost dental care

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The only health care prices that matter to consumers

The big picture: One big reason general information on prices has only limited utility to consumers is that what they most want to know is not the price of an MRI, or a knee replacement of any other service at this hospital or that, but what they will have to pay for it themselves out of pocket under their insurance plan.

Some insurance companies have tools consumers can use to figure this out, but that information is not easily available to consumers today. As a recent **Kaiser Family Foundation/Los Angeles Times survey** shows:

- 67% of the American people say it is somewhat or very difficult for them to figure out what a treatment or procedure will cost them.
- 44% said they had difficulty determining what they would actually have to pay.
- 40% had problems figuring out what was even covered.
- Even with the right information, larger medical expenditures generally occur when people are in a medical crisis of some kind, in anything but shopping mode, and generally dependent on their physicians to direct them to hospitals, specialists or tests they need. This is why price transparency and shopping is helpful for some services but not a panacea.
- It's not entirely clear whether

low rates of price shopping today reflect the lack of price and quality information, or larger barriers to shopping in health care. Just 17 percent of people with typical deductibles shop today, and **21% with high deductible plans**. More price transparency will drive these numbers up, but how much is unknown.

- On the other hand, there is some evidence that people want to shop when they can: 47%, for example, asked for a generic drug to save money in the past year; and 36% checked with a provider or health plan on the cost of an office visit.
- But just 23% used an online tool to compare provider costs.

All told, 70% reported some shopping-like behavior in the survey.

It's important to add that the ability to shop based on price is not equally distributed throughout the population. If you are in a rural area, limited to a narrow network of providers, or dependent on emergency rooms or clinics, you may have very limited options to shop around.

The bottom line: Like putting price information in drug ads, the executive order may not have much impact in terms of actually lowering prices, but it will focus greater attention on high medical prices. That is likely the main reason for industry resistance, and potentially its greatest contribution.

To save billions, federal government should set hospital rates

. The **Center for American Progress** has a new report focused on the high cost of hospital care, the biggest health care expense in the US. To save billions of dollars, it recommends federal rate-setting for all hospitals. Commercial health insurers can't rein in hospital rates; **Medicare for All** would.

One third of health care spending is for hospital care. Hospitals have power to drive up their rates in most communities. The many communities with only one hospital tend to have rates 15 percent higher than the relatively few communities with four or more hospitals.

As a result, on average, hospitals earn a hefty margin of nearly eight percent. In the health care space, only pharmaceutical companies and medical device companies have greater margins.

A multitude of **hospital mergers have reduced competition and driven up costs**. But, not all hospitals are winners. One in four hospitals lost money in 2016.

Unlike commercial health insurers, Medicare has leverage over hospital prices. It pays rates that are about half of commercial health insurance rates. That said, Medicare rates overall are fair. According to MedPAC, Medicare rates are eight percent higher than the marginal cost of treating a patient with Medicare.

Note: Hospitals that charge higher rates are not necessarily hospitals that provide better care. They could be less efficient. And, their inefficiency should not be rewarded.

The Center for American Progress report recommends regulating hospital rates so that they are close to costs, an end to surprise medical bills, and transparent information on hospital rates. Rate regulation alone could generate tens of billions of dollars in savings.

New Issue Brief Clarifies When Medicare Should Cover Skilled Care

This week, the Center for Medicare Advocacy released a new resource on the Medicare Improvement Standard. The **issue brief**, "Implementing *Jimmo v. Sebelius*: An Overview," is intended to provide Medicare stakeholders with an overview of the *Jimmo* Settlement, what it means in different care settings, and links and references to helpful resource materials.

In 2013, a federal district court approved a settlement agreement in ***Jimmo v. Sebelius, No. 5:11-CV-17*** (D. VT) agreeing that Medicare coverage for skilled nursing or therapy care is not dependent on a beneficiary's potential for improving under such care. Instead, the coverage depends solely on whether the beneficiary needs the care. The *Jimmo* Settlement and later court decisions apply to everyone with Medicare throughout the country, regardless of whether an individual is in traditional Medicare or a Medicare Advantage plan.

Despite *Jimmo*, many people with Medicare and providers still find themselves struggling with its implementation in home health, skilled nursing facility, outpatient therapy, and inpatient rehabilitation hospital settings across the country. They may face denials of care or coverage for legitimate therapies.

These continuing problems make the issue brief a timely resource for people with Medicare, families, providers, contractors, adjudicators, and other stakeholders to learn about the principles articulated in *Jimmo.* The settlement must be properly implemented in order to ensure proper care is accessible to all people with Medicare, and advocates can use the information to secure that care and coverage.

Read the overview of the *Jimmo* Settlement.

Read the full issue brief.

Medigap Changes in 2020

Access and CHIP Reauthorization Act of 2015 (MACRA), individuals who are newly eligible for Medicare on or after January 1, 2020 will not be able to purchase Medigap Plan C or Plan F (including the Plan F high deductible option). This is because after January 1, 2020, MACRA prevents individuals new to Medicare from purchasing Medigaps that pay for the Part B deductible ($185 in 2019). Both Plan C and Plan F cover the Part B deductible.

This law also applies to the three states (Massachusetts, Minnesota, and Wisconsin) that operate their own Medigap systems. People new to Medicare in those states will not be allowed to purchase Medigaps that pay for the Part B deductible.

Eligible for Medicare before January 1, 2020

These Medigap changes only affect individuals who are newly eligible for Medicare in 2020 and after.

If you are eligible for Medicare before January 1, 2020, you will still be able to purchase Plan C or Plan F. If you were eligible for Medicare before this time but did not enroll, you will be able to purchase Plan C or Plan F as long as you are within your Medigap open enrollment period or have a guaranteed issue right once you enroll in Original Medicare. (Remember that only those with Original Medicare can purchase a Medigap. Medigaps do not work with Medicare Advantage.) Visit Medicare Interactive to learn about **protected times to buy a Medigap.**

If you currently have Medigap Plan C or Plan F, you can continue to renew it from insurers in your state. As always, premiums for Medigaps can change from year to year, and Medigap issuers may choose to discontinue plan offerings. Your right to switch plans if your premiums increase depends on your state's laws. If your Medigap is terminated, you will have a **guaranteed issue period.**

Eligible for Medicare on or after January 1, 2020

If you are newly eligible for Medicare on or after January 1, 2020, you will not be able to purchase Plan C or Plan F. However, **Plan D and Plan G** currently provide coverage for all the same out-of-pocket costs, except for the Part B deductible coverage.

Example: Individual can purchase Plan C or Plan F

Ricky will become eligible for Medicare in 2019. His 65th birthday is in November. He will continue to work and receive coverage from an employer with more than 20 employees, so he wants to delay Medicare enrollment until he retires in June 2020. Ricky can still purchase a Plan C or Plan F because he became eligible for Medicare before January 1, 2020, even though he did not enroll in Medicare or purchase his Medigap until after that date.

Example: Individual cannot purchase Plan C or Plan F

Martha will turn 65 on April 5, 2020, has not received Social Security Disability Insurance (SSDI), and does not have End-Stage Renal Disease (ESRD). She cannot purchase a Plan C or Plan F because she is newly eligible for Medicare after January 1, 2020. Instead, she can purchase Plan D or Plan G for coverage of almost all of the same out-of-pocket costs.

Example: Individuals eligible for Medicare due to disability

Note that **under federal law**, individuals only have the right to buy a Medigap if they are 65 or older. However, some states require companies to sell Medigap policies without medical underwriting (refusing to sell a policy, or charging more, because of a person's health condition) to Medicare beneficiaries under 65. This includes people eligible because they receive SSDI or have ESRD.

Erik and his friend Wynn live in a state that provides Medigap enrollment rights for all individuals eligible for Medicare. Erik receives SSDI for 24 months and becomes eligible for Medicare in the 25th month, on October 1, 2019. He can buy a Plan C or Plan F. Wynn also receives SSDI, but his 25th month of SSDI is May 2020. He will not be able to purchase a Plan C or Plan F.

Erik will also be able to buy a Plan C or Plan F later, including when he turns 65 in 2022 and has his federal Medigap open enrollment period. Wynn will not be able to buy a Plan C or Plan F once he is 65, as he was newly eligible for Medicare after January 2020.

Retiree Pam Parker Makes the Case for ACA Prescription Drug Protections

"Good morning. Thank you, Senator Stabenow, Senator Shaheen and Senator Wyden for drawing attention to a life and death matter that the Supreme Court will be considering in July.

My name is Pam Parker, and I am a member of the **Alliance for Retired Americans.** I am 57 years old and live in Silver Spring, Maryland.

I had a kidney transplant this past Mother's Day. I am grateful to be able to speak with you just 5 weeks after major surgery. My health is so much better but my worries are not over.

For many years I worked as an electrician, helping to wire the Holocaust Museum and the Pentagon until my health slowed me down. I began working as a researcher, but in 2014 I could no longer work at all due to my failing kidneys. I had to go on disability.

I have had diabetes for more than 20 years. I also have high blood pressure and my doctor says that is what caused my kidneys to fail. I underwent dialysis for several years until my transplant last month.

I am one of the lucky ones – I have a new kidney and a great prognosis. I have medical and prescription coverage under Medicare before turning 65 due to my disability. I also have supplemental insurance coverage, meaning that my out-of-pocket costs are relatively low right now.

The retail price of my medicines is more than $6,000 per month. That includes $3,500 a month for the anti-rejection transplant medicines and $1,400 per month for insulin. By the way, I remember when insulin cost about $25 a month.

I am terrified of the high drug prices I will face if the Affordable Care Act is struck down in the courts and the Part D "doughnut hole" is reopened. I truly do not know what I will do if that happens.

And I know I am not the only one. Eliminating the doughnut hole is important to all retirees who are more likely to have multiple health conditions and take more medications. We worked hard all our lives and earned our Medicare.

Please do not take this earned benefit from me and my fellow Americans.

Thank you for listening."

Competitive Bidding Program Temporarily Lapses—Expected to Begin Again in 2021

On January 1, 2019, the **durable medical equipment (DME)** competitive bidding program temporarily ended.

The competitive bidding program was originally designed to reduce out-of-pocket expenses and help ensure that people with Medicare had access to quality DME, supplies, and services from suppliers they could trust. The program benefited people who had Original Medicare, lived in a competitive bidding area, and needed DME that fell under the competitive bidding program.

Under this program, suppliers submitted bids to Medicare to say how much they would charge for DME, and then Medicare used these bids to set DME prices. Suppliers who agreed to provide DME at the rate that Medicare set were called contract suppliers. If an Original Medicare beneficiary lived in a competitive bidding area and was prescribed DME affected by the program, they had to use a contract supplier—one who would supply the product for the price Medicare had determined through the bidding process and meet other Medicare requirements.

The latest supplier contracts ended on December 31, 2018, and Medicare did not move forward with the process needed to continue the program. This temporary end to the competitive bidding program is **expected to last two years, until December 31, 2020**. New proposals for the details of the next bidding process are underway. The revised program, with different bidding rules, should begin in 2021. Bids would be taken in 2020, and new contract suppliers would be named in 2021.

During the lapse in the competitive bidding program, there will be no contract suppliers. This means that a beneficiary can get DME from **any supplier who is enrolled in Medicare**. Most beneficiaries will not need to switch suppliers and can continue to use the same supplier they used in 2018. Instances when a beneficiary may need to switch suppliers include if they permanently move outside of their supplier's normal service area, or if their current supplier is unwilling to continue providing DME on or after January 1, 2019.

Advice from Medicare Rights

If you have Original Medicare and need new DME, you can use the online Medicare Supplier Directory or call 1-800-MEDICARE to locate a supplier. **It is important that you choose a supplier who is enrolled in Medicare and takes assignment.** If the supplier does not take assignment, you could be responsible for paying a higher out-of-pocket cost.

Capped rental items and oxygen equipment

If you have a capped rental item (meaning an item that Medicare covers for rental first, rather than purchase, because of its high cost), your provider must continue to provide your item through the rest of your 13-month rental period. After 13 months, you will own the equipment. Examples of capped rental items include wheelchairs and hospital beds.

If you have **oxygen equipment**, your supplier must continue to provide oxygen and equipment through the rest of your 36-month rental period. After the 36th month in a row, the supplier must continue to provide oxygen and oxygen equipment for the rest of the equipment's lifetime as long as you still have the medical need. The exception is if you travel or permanently move outside of your supplier's service area. In that case, the supplier must connect you with a new supplier in your area once the 36-month rental period is over.

Throughout the temporary gap period, you should be aware of aggressive marketing by suppliers. You should be cautious about anyone trying to persuade you to switch suppliers, and should first speak with your current supplier to determine if you need to make a change.

For more information about durable medical equipment, **visit Medicare Interactive**.

Social Security: What to know before claiming benefits

Bloomberg News reports that Americans lose trillions of dollars because they do not claim Social Security benefits when they should. Here's what you should know before claiming Social Security benefits.

If you need Social Security benefits to meet your daily needs, you should claim them as soon as possible. But, if you can **wait to claim them, you will receive higher Social Security income**. The difference between taking benefits at 62 rather than at 70 is stark. For example, if your monthly check would be $725 at 62, you could get $1,280 if you waited until 70.

Put differently, if your full retirement age (FRA) is 66 and you can wait until 70 to claim Social Security benefits, you get 32 percent more in monthly benefits for your lifetime than you would if you claim benefits at 66. You get 8 percent more for each year you delay claiming benefits after age 66 up to age 70.

If you were born between 1943 and 1954, your full retirement age (FRA) is 66, though you may claim benefits any time between age 62 and 70. (If you were born in 1955, your FRA is 66 and 2 months; your FRA increases by 2 months each year until 1960 when it is 67.) If you claim benefits at 62, you get 25 percent a month less each month for your lifetime than you would if you waited to claim until you are 66. To learn about how **claiming benefits early disproportionately hurts people with low incomes, click here**.

Of course many factors go into when you should claim benefits. If you're in good health and can wait, you will ensure a higher monthly income throughout your life. Moreover, if you're married and earn more than your spouse, delaying your receipt of benefits, will ensure increased Social Security income for your spouse after you pass. On the other hand, if you're in poor health, it might be wise to claim benefits early so you are able to get back as much as possible from Social Security.

...**Read More**

Trump's health care policy could jeopardize his re-election

The Hill reports on a recent poll revealing that most voters in four battleground states would not support a presidential candidate favoring Trump's policies. Voters want the federal government to protect people with pre-existing conditions, people with Medicare, and people needing prescription drugs. President Trump's health care policies could jeopardize his re-election.

President Trump's proposed solutions to high health care costs do nothing to bring down health care prices; rather, they put people's lives and finances at risk if they need complex or costly care. He is working to destroy the Affordable Care Act, including its pre-existing condition protections as well as to slash Medicare spending. He recognizes the need to lower prescription drug costs, but he has not succeeded at doing anything on that front.

In fact as Alex Azar, the US Secretary of Health and Human Services, explains in a **New York Post** op-ed, President Trump is focused on allowing insurance companies to sell low-cost insurance policies that do not provide adequate coverage, for example, not covering prescription drugs. These policies may have lower premiums, but they also come with potentially far higher health care costs.

Trump is also promoting health savings accounts. These accounts do nothing to lower health care costs. They simply force people to choose between spending a lot of money on health care or foregoing care. And, Trump is promoting greater use of physicians' assistants and nurse practitioners. Physicians' assistants and nurse practitioners can be valuable health care providers. But, they are not oncologists or surgeons and they cannot be substituted for them as a way of bringing down health care costs.

Voters in Florida, Pennsylvania, Michigan and Wisconsin want our health care system to work for everyone, including people who need costly care, according to a poll conducted by Protect Our Care. Other polls suggest the **rest of the country is right there with them**.

The poll reveals that more than seven in ten people (72 percent) would not support a candidate who called for doing away with pre-existing condition protections. Nearly eight in ten people (77 percent) said they would not support a candidate who called for ending prescription drug coverage. And, the vast majority of people want Medicare to be able to negotiate drug prices.

Implementing *Jimmo v. Sebelius*: An Overview

In 2013, a federal district court approved a settlement agreement in Jimmo v. Sebelius, No. 5:11-CV-17 (D. VT). The Jimmo Settlement confirmed that Medicare coverage should be determined based on a beneficiary's need for skilled care (nursing or therapy), not on the individual's potential for improvement. The Jimmo Settlement and court decisions pertain to all Medicare beneficiaries throughout the country and apply regardless of whether an individual is in traditional Medicare or a Medicare Advantage plan. The Jimmo case was brought as a national class action by the Center for Medicare Advocacy (the Center) and Vermont Legal Aid. The Settlement required the Centers for Medicare & Medicaid Services (CMS) to confirm that coverage of skilled nursing or therapy is available to maintain or slow decline of an individual's condition for beneficiaries in home health, skilled nursing facility, or outpatient settings. The Settlement also clarified the rules for individuals in inpatient rehabilitation hospitals/facilities (IRH/F). Among other things, the Settlement required CMS to conduct an "Educational Campaign" to inform Medicare providers and decision-makers about the Jimmo "clarification" that Medicare-covered skilled services include care that improves, maintains, or slows decline of a patient's condition. Medicare coverage should not be denied solely because an individual has an underlying condition that won't get better, such as MS, ALS, Parkinson's disease, or paralysis.

Center for Medicare Advocacy

Unfortunately, more than six years after the Settlement's approval, the Center still regularly hears from Medicare beneficiaries and providers about problems with its implementation in home health, skilled nursing facility, outpatient therapy, and inpatient rehabilitation hospital settings across the country. The ongoing lack of knowledge about the Jimmo Settlement among providers, contractors, and adjudicators is unacceptable but, regrettably, not surprising. In late 2018, the Center conducted a national survey of Medicare providers to assess their knowledge about the Jimmo Settlement and their experience with its implementation. Sadly, our survey found that 40% of respondents had not even heard about the Settlement and that 30% of respondents were not aware that Medicare coverage does not depend on a beneficiary's potential for improvement. In the face of enduring barriers to Medicare-covered care for people with longer-term and chronic conditions, the Center compiled this Issue Brief to provide Medicare stakeholders with an overview of the Jimmo Settlement, what it means in different care settings, some of the Center's key implementation work, and links and references to helpful resource materials. The Center hopes this information will help Medicare beneficiaries, families, providers, contractors, adjudicators, and other stakeholders learn about the principles articulated in Jimmo and access relevant resources to ensure the Settlement is properly implemented. For more information about the Jimmo Settlement, please visit the Center's Improvement Standard and Jimmo News webpage.

JIMMO SETTLEMENT & CORRECTIVE ACTION

PLAN Jimmo was brought on behalf of Medicare beneficiaries who had or will have Medicare coverage of nursing or therapy services denied, terminated, or reduced on the basis that they were not improving or not demonstrating a potential for improvement (known as the "Improvement Standard"). The Jimmo Settlement required CMS to undertake the following to remedy the practice of erroneously denying Medicare coverage based on an Improvement Standard: ...**Read More**

RI ARA HealthLink Wellness News

Eat more plants . . . reduce your risk of Alzheimer's

Two studies in the past few years provide the best evidence to date that a largely plant-based diet, with moderate amounts of fish and dairy—a Mediterranean diet—can help keep one's brain healthy and reduce risk of Alzheimer's.

Researchers who studied the MIND diet, a kind of Mediterranean diet, which calls for eating more berries and **leafy green vegetables**, found that even following the diet moderately **reduced participants' risk of developing Alzheimer's disease** by 35% over the four and a half years. In short, they found that you do not need to eat bushels of kale or spinach. Two servings of **vegetables daily**, two servings of berries each week, and one meal of fish each week seemed to be enough. At the same time, you do need to eat less unhealthy food, such as butter and fast food. Those who followed the diet more rigorously **reduced their risk of developing Alzheimer's** by 53%.

In the MIND study, researchers observed people's dietary intake over time. This type of study can't say anything about cause and effect, which can only be learned by dividing people into groups and randomizing some to follow the diet and some not (a control condition). Researchers in Spain completed just such a **study**.

The Spanish researchers showed that those randomized to follow a Mediterranean diet, which they combined with either extra olive oil or nuts, showed improved measures of memory and other brain functions. The participants were tested after a median of four years on the diet. Although they had no memory or other cognitive problems to begin with, they did have risk factors for heart disease, such as smoking, diabetes and obesity.

The food included in a Mediterranean diet is rich in antioxidants and anti-inflammatory compounds, which many studies have shown are good for heart health, and decreasing risk factors like high blood pressure and diabetes. Since these are also risk factors for Alzheimer's disease and other dementias, this is one reason why eating lots of foods high in anti-oxidants and anti-inflammatory compounds helps preserve brain function. Berries, dark, leafy green vegetables, and nuts are especially high in antioxidants and anti-inflammatory action.

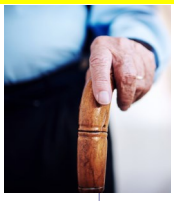
More Seniors Are Dying In Falls. Doctors Could Do More To Reduce The Risk.

Older adults worried about falling typically receive general advice: Take an exercise class. Get your vision checked. Stop taking medications for sleep. Install grab bars in the bathroom.

A new study suggests that sort of advice hasn't proved to be very effective: Nearly three times more adults age 75 and older died from falls in 2016 than in 2000, according to a **recent report** in the Journal of the American Medical Association.

In 2016, 25,189 people in this age group died from falls, compared with 8,613 in 2000. The rate of fatal falls for adults 75 and older more than doubled during this period, from 51.6 per 100,000 people in 2000 to 122.2 per 100,000 people in 2016, the report found.

What's needed to check this alarming trend, experts suggest, is a more personalized approach to preventing falls, more involvement by medical practitioners and better ways to motivate older adults to take action.



Elizabeth Burns, a co-author of the report and health scientist at the U.S. Centers for Disease Control and Prevention, said it's not yet clear why fatal falls are increasing. Older adults are probably more vulnerable because they're living longer with conditions such as diabetes and cardiovascular disease and taking more brain-altering medications such as opioids, she noted.

By 2030, the **CDC projects**, 49 million older adults will fall each year, resulting in 12 million injuries and more than $100 billion in health-related spending.

The steep increase in fatal falls is "definitely upsetting," especially given national, state and local efforts to prevent these accidents, said Kathleen Cameron, senior director of the Center for Health Aging at the National Council on Aging.

Since 2012, the CDC has tried to turn the situation around by encouraging physicians to adopt evidence-based fall prevention practices. But doctors still are not doing enough to help older patients, Burns said.

She cites evidence from two studies. In one, **published in 2016**, researchers found that fewer than half of seniors who were considered high risk — people who'd fallen repeatedly or sought medical attention for falls — received a comprehensive fall risk assessment, as recommended by the CDC and the **American Geriatrics Society**.

These assessments evaluate a person's gait, lower-body muscle strength, balance, medication use, problems with their feet, blood pressure when rising from a sitting position, vision, vitamin D levels and home environment.

In another **study, published last year**, Burns found that physicians and nurse practitioners routinely failed to review older adults' medications (about 40% didn't do so), recommend exercise (48% didn't) or refer people to a vision specialist (about 62% didn't) when advising older patients about falls.

Physicians' involvement is important because older adults tend to take their doctors' advice seriously, said Emily Nabors, program manager of the Fall Prevention Center of Excellence at the University of Southern California.

Also, seniors tend to underestimate their chance of falling.

"It's very easy for people to look at a list of things that they should be concerned about and think, 'That doesn't apply to me. I walk just fine. I don't have trouble with my balance,'" said Dorothy Baker, a research scientist at Yale School of Medicine and executive director of the Connecticut Collaboration for Fall Prevention...**Read More**

FDA's Assessment of Currently Marketed ARB Drug Products

The Food and Drug Administration has once again expanded its recall of widely prescribed blood pressure drugs because of contamination with a chemical linked to cancer.

The latest recall, **announced Wednesday**, targets 32 lots of the drug losartan sold by Macleods Pharmaceuticals. The pharmaceutical company said that it would voluntarily recall the affected batches.

Losartan is a generic angiotensin II receptor blocker, or ARB, and is used to treat high blood pressure as well as heart failure. **Over the last year, scores of batches of generic ARBs have been withdrawn** from the market due to the presence of chemical contaminants called nitrosamines, which have been linked to an increased risk of certain kinds of cancer.

"The FDA is continuing to work with manufacturers to swiftly remove medications from the market if they contain" unacceptable levels of nitrosamines, said Jeremy Kahn, an FDA spokesperson. "We're continuing our investigation as part of our commitment to ensuring adequate and safe supply of ARB medicines for patients."

Kahn told NBC News that the agency has identified 43 ARB medications that are free of nitrosamine impurities, and that this number is expected to "increase as companies continue to manufacture ARBs without nitrosamine impurities and work to **replenish the U.S. supply**."...**Read More**

Related Article

FDA has worked with manufacturers to swiftly remove angiotensin II receptor blocker (ARB) drug products with impurity levels above interim acceptable limits. Those products have been removed from the market and have been posted in our **recall lists for ARB products**. The information below reflects the status of FDA's assessment for other ARB drug products that are currently on the market. The assessment is based on the particular batches/lots of drugs tested by FDA, information provided by applicants and active pharmaceutical ingredient (API) suppliers, and other information available to the agency. In general, FDA's testing of ARBs focused on analyzing API and the highest dosage strength available from firms making drug products for the U.S. market. FDA will update this list as more information becomes available.

In the overall nitrosamine determination column, an indication of "**not present**" means that FDA has completed the comprehensive assessment noted above. An indication of "**TBD**" means that one or more parts of our assessment remain incomplete and the product remains acceptable for distribution and for patient use. For the entries denoted with "**TBD***," certain lots of the product did have impurity levels above interim acceptable limits, however they have already been removed from the market. FDA is prioritizing the assessments by those of highest patient need and in response to credible information about nitrosamine contamination.

Where can I get more information?

Overview of ARB Recalls

More Q&A on ARB Recalls

FDA Updates on ARB Recalls

Midlife functional impairment raises risk of hospitalization, nursing home admission

Middle-aged adults who develop functional impairments—difficulty performing activities of daily living (ADLs) such as bathing and dressing—are at higher risk for hospitalization and nursing home admission than unimpaired adults the same age, according to an NIA-supported study. The findings, published online in *JAMA Internal Medicine,* raise questions about how clinicians can help those in midlife prevent or delay struggles with daily activities that affect health and quality of life.

Researchers at the University of Pennsylvania and the University of California, San Francisco, wanted to find out how middle-aged adults became functionally impaired and if their impairments posed the same risks as in older adults.

Nearly 15 percent of adults age 55 to 64 are functionally impaired, meaning they have difficulty performing one or more of six basic ADLs: bathing, dressing, transferring (such as from a bed to a chair), toileting, eating, and walking across a room.

The researchers analyzed health data for 5,540 adults age 50 to 56 from the nationally representative Health and Retirement Study (HRS). None was functionally impaired when they entered the HRS in 1992, 1998, or 2004, but 1,097 of them (19.8 percent) reported that they developed an impairment in at least one ADL by age 64. Examining data reported every 2 years through 2014, the researchers found that functionally impaired participants had a significantly higher risk of hospitalization and nursing home admission than participants their age without functional impairment. The risk of death in the two groups was about the same after adjusting for factors such as health status and health behaviors like smoking.

The study found similar risks for hospitalization and nursing home admission, as well as for death, in the 857 HRS participants (15.5 percent) who developed trouble performing at least one instrumental ADL. These activities include managing money, managing medications, shopping for groceries, preparing meals, and making telephone calls.

The authors noted that not all functional impairments are permanent; sometimes they are temporary or disappear and then recur. Participants with functional impairments were more likely to be women, racial or ethnic minorities, unmarried, and to have lower socioeconomic status. They also had poorer health status and were more likely to smoke, exercise infrequently, and lack health insurance.

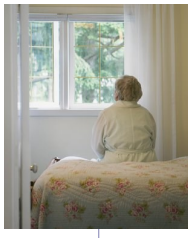
As in older adults, functional impairment in middle-aged adults can affect health and quality of life, the authors concluded. Clinicians could address risk factors such as chronic disease, depression, and obesity to prevent or delay functional impairment, and intervene to prevent adverse outcomes in middle-aged adults who become functionally impaired.

In Secret, Seniors Discuss Suicide

Ten residents slipped away from their retirement community one Sunday afternoon for a covert meeting in a grocery store cafe. They aimed to answer a taboo question: When they feel they have lived long enough, how can they carry out their own swift and peaceful death?

The seniors, who live in independent apartments at a high-end senior community near Philadelphia, showed no obvious signs of depression. They're in their 70s and 80s and say they don't intend to end their lives soon. But they say they want the option to take "preemptive action" before their health declines in their later years, particularly due to dementia.

More seniors are weighing the possibility of suicide, experts say, as the baby boomer generation — known for valuing autonomy and self-determination — reaches older age at a time when modern medicine can keep human bodies alive far longer than ever before.



The group gathered a few months ago to meet with Dena Davis, a bioethics professor at Lehigh University who defends "rational suicide" — the idea that suicide can be a well-reasoned decision, not a result of emotional or psychological problems. Davis, 72, has been vocal about her desire to end her life rather than experience a slow decline due to dementia, as her mother did.

The concept of rational suicide is highly controversial; it runs counter to many societal norms, religious and moral convictions and the efforts of suicide prevention workers who contend that every life is worth saving.

'The concern that I have at a social level is if we all agree that killing yourself is an acceptable, appropriate way to go, then there becomes a social norm around that, and it becomes easier to do, more common," said Dr. Yeates Conwell, a psychiatrist specializing in geriatrics at the University of Rochester and a leading expert in elderly suicide. That's particularly dangerous with older adults because of widespread ageist attitudes, he said.

As a society, we have a responsibility to care for people as they age, Conwell argued. Promoting rational suicide "creates the risk of a sense of obligation for older people to use that method rather than advocate for better care that addresses their concerns in other ways."

A Kaiser Health News investigation in April found that older Americans — a few hundred per year, at least — are killing themselves while living in or transitioning to long-term care. Many cases KHN reviewed involved depression or mental illness. What's not clear is how many of these suicides involve clear-minded people exercising what Davis would call a rational choice.

Suicide prevention experts contend that while it's normal to think about death as we age, suicidal ideation is a sign that people need help. They argue that all suicides should be avoided by addressing mental health and helping seniors live a rich and fulfilling life. ...**Read More**

Cognitive decline: A personalized approach could be key

Researchers have designed a brain aging model to investigate the factors that contribute to cognitive decline, borrowing principles from precision medicine.

Cognitive decline affects a person's ability to focus, remember, and make decisions.

Its severity can range from mild to severe, and it may lead to **dementia**, in the most severe cases.

People with dementia may find it diffcult to perform everyday tasks and live independently.

According to the World Health Organization (WHO), "around **50 million** people have dementia."

In the United States, the Centers for Disease Control and Prevention (CDC) estimate that more than **5 million** people aged 65 or older have **Alzheimer's disease**.

It is important to note that about 85% of older adults only experience a range of age-related cognitive impairments (ARCIs) and will never develop Alzheimer's disease. Nevertheless, mild cognitive decline may decrease quality of life and has socioeconomic consequences.

Age is a major factor in cognitive impairment, but family history, education level, physical inactivity, and chronic conditions such as **heart disease** and **diabetes** may contribute to cognitive decline.

As these factors affect people differently, there is no one-size-fits-all approach when it comes to the aging brain.

Developing a precision model

Researchers recently developed an aging brain model, borrowing ideas from precision medicine. Their findings appear in the journal ***Frontiers in Aging Neuroscience.*** When working with precision medicine, the question is no longer, "Does treatment X work?" but "*Who* does treatment X work for?"

"A number of studies have looked at individual risk factors that may contribute to cognitive decline with age, such as chronic **stress** and cardiovascular disease," says study co-author Prof. Lee Ryan, head of the University of Arizona Department of Psychology in Tucson.

"However, those factors may affect different people in different ways depending on other variables, such as genetics and lifestyle," she adds.

Precision medicine requires a clear goal to be successful. When it comes to the health of the aging brain, researchers have been working on solutions "to maintain brain health across the full extent of the adult lifespan."

The precision aging model investigated risk factors for ARCI and potential targets for prevention and therapy. It consists of three main areas:

1. Risk categories
2. Brain drivers
3. Gene variants

"What we're trying to do is take the basic concepts of precision medicine and apply them to understanding aging and the aging brain. Everybody is different and there are different trajectories."

"Our hope is that the research community collectively stops thinking about aging as a single process and recognizes that it is complex and not one-size-fits-all. To really move the research forward, you need to take an individualized approach," Prof. Ryan concludes.

Widely Prescribed Class of Meds Might Raise Dementia Risk

Doctors often prescribe anticholinergic drugs for a variety of ills. But a new study suggests they may increase the risk of dementia in older patients.

These medicines include everything from Benadryl (diphenhydramine) to certain antipsychotics and Parkinson's meds. They're used to treat a wide range of other conditions, including depression, chronic obstructive pulmonary disease, overactive bladder, allergies, and gastrointestinal disorders.

Anticholinergic drugs help contract and relax muscles, and work by blocking acetylcholine, a chemical that transmits messages in the nervous system.

But the new British study found that people aged 55 and older who took strong anticholinergic medications daily for three years or more had a 50% increased risk of dementia.

"Our study adds further evidence of the potential risks associated with strong anticholinergic drugs, particularly antidepressants, bladder antimuscarinic drugs, anti-Parkinson drugs and epilepsy drugs," said study author Carol Coupland. She works in the division of primary care at the University of Nottingham.

Anticholinergics are known to cause short-term side effects -- including confusion and memory loss -- but it's unclear if long-term use increases the risk of dementia.

To find out, Coupland's team examined the medical records of nearly 59,000 patients in the U.K. with dementia, as well as a control group of more than 225,000 patients without dementia. All the patients were 55 and older. The average age of the dementia patients was 82.

Overall, they study found an increased risk of dementia among those who took anticholinergic drugs. After accounting for other risk factors for dementia, the researchers concluded that strong anticholinergic meds were associated with an increased risk of dementia.

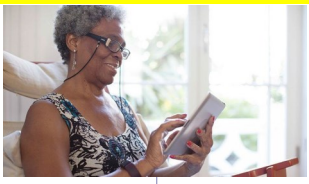
There was no increased risk of dementia among patients who took other types of anticholinergic drugs such as antihistamines (Benadryl) and gastrointestinal drugs.

In the one to 11 years before dementia diagnosis or the equivalent in controls, nearly 57% of dementia patients and 51% of people in the control group were prescribed at least one strong anticholinergic drug, with an average of six prescriptions in dementia patients and four in controls.

The study was published June 24 in the journal *JAMA Internal Medicine*.

The researchers noted that this was an observational study, so it cannot prove that anticholinergic drugs help *cause* dementia. For example, it's possible that the drugs were prescribed to dementia patients to help treat very early symptoms of the disease.….**Read More**

How to Keep Your Brain Sharp and Healthy as You Age



So you've noticed some changes in your thinking. Perhaps you often misplace your keys or have trouble coming up with the right word in conversations. But how do you know if these changes are a normal part of getting older, or if they might be pointing to a health problem such as **dementia**?

How Your Brain Changes as You Get Older

Your brain's volume gradually shrinks as you get older. When this occurs, some of the nerve cells in your brain can shrink or lose connections with other nerve cells. Blood flow within your brain slows somewhat as you age, too. These age-related changes are thought to be behind the differences in cognitive function many people notice as they age. Everyone has lapses in memory from time to time, but significant **memory loss** is not a normal part of getting older. It's important to talk with your doctor if you or a loved one is experiencing memory loss and other cognitive symptoms that interfere with normal activities and relationships.

How Dementia Can Affect Cognitive Skills

Dementia occurs when nerve cells in the brain stop working, lose connections with other brain cells, and die. The **National Institute** on Aging defines dementia as having two or more core functions that are impaired, including memory, language skills, visual perception, and the ability to focus and pay attention. Cognitive skills, such as the ability to reason and solve problems, may also be impaired.

There are several different causes of dementia, including:

- **Alzheimer's disease** The most common cause of dementia, **Alzheimer's disease**occurs when nerve cells in the brain become damaged or die. The disease affects the parts of the brain that are involved in thinking, remembering, problem-solving, using language, and other cognitive skills.
- **Vascular dementia** The second leading cause of dementia, vascular dementia is a decline in thinking skills caused by cerebrovascular disease, a condition in which blood vessels in the brain are damaged and brain tissue injured, depriving brain cells of vital oxygen and nutrients, according to the **Alzheimer's Association**. Individuals at highest risk include those who have had a stroke or a **transient ischemic attack** (TIA, also known as a "ministroke").
- **Lewy body dementia** The third most common form of dementia, **Lewy body dementia** is caused by abnormal protein deposits that accumulate inside nerve cells, forming clumps called Lewy bodies. As a result, nerve cells no longer function adequately and begin to die. This impacts thinking, memory, behavior, sleep, mood, and movement.
- **Frontotemporal dementia** Frontotemporal dementia is the most common form of dementia for people under age 60, and it's caused by degeneration of the frontal and/or temporal lobes of the brain. FTD leads to a gradual, progressive decline in behavior, language, or movement, with memory usually relatively preserved, according to **The Association for Frontotemporal Degeneration**.
- **Other types of dementia** Human immunodeficiency virus (HIV) infection, Huntington's disease, head trauma, and other health conditions can affect nerve cells in the brain, leading to symptoms of dementia….**Read More**