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Medicare Would Save Billions a Year Just by Negotiating Insulin Prices

New research confirms that not allowing Medicare to negotiate lower drug prices is hurting beneficiaries and taxpayers. In fact, Senate Majority Leader **Mitch McConnell's** refusal to bring up for a vote a bill requiring the Department of Health and Human Services to negotiate prices is costing the government **at least $4 billion each year**

The research was published in the ***JAMA Internal Medicine***, a medical journal published by the American Medical Association, this month. Researchers calculated that in 2017 Medicare Part D spent $7.8 billion (after rebates) on 31 different types of insulin, which is used to treat diabetes. They then compared the prices paid to the prices negotiated by the United States Department of Veterans Affairs (VA). If Medicare had used the same prices and list of approved drugs as the VA, it would have saved $4.4 billion in just one year.

H.R. 3, the Lower Drug Costs Now Act passed by the House in December, would require Medicare to negotiate lower prices for 250 drugs, including insulin. Not only would seniors and the government save money, annual out of pocket drug spending for Medicare would be capped at $2,000, and traditional Medicare would include hearing, dental and vision benefits. Majority Leader McConnell and President Trump say they will not support the bill.

Joseph Peters, Jr.

"How much more evidence do we need?" asked **Joseph Peters, Jr.**, Secretary-Treasurer of the Alliance. "The Senate needs to pass H.R. 3 now."

President Goes 0-for-4 for Retirees
Fiscal 2021 Budget Would Cut Health Care for Older Americans

Rich Fiesta

The following statement was issued by Richard Fiesta, Executive Director of the Alliance for Retired Americans, regarding President Trump's budget proposal for fiscal 2021:

"President Trump has had four chances to deliver a budget that protects retirees and each time he has proposed brutal cuts. Each time he has failed to deliver. His FY 2021 budget proposes cutting **hundreds of billions of dollars from Medicare, even more from Medicaid and $70 billion from Social Security disability benefits**. Together these cuts will strip health care and basic income from millions.

"These cuts are cruel and would hurt millions of older Americans. Retirees have paid for Medicare over a lifetime, and depend on these benefits to stay healthy. The average Medicare beneficiary is already paying more than $5,000 in out of pocket health care costs per year while the average Social Security retirement benefit is just $16,656 per year.

"Hundreds of thousands of seniors depend on Medicaid to pay for nursing homes and health care expenses. **Nearly 2 in 3 nursing home residents** receive care through Medicaid. Seniors can also get services through Medicaid such as home health care, mental health and therapy services, as well as durable medical equipment and some dental services.

"If the President were serious about health care, he would fully fund Medicaid. He would take action to help seniors afford their prescription drugs, which would also strengthen Medicare's future solvency. The solution is staring him in the face. H.R. 3, the Lower Drug Costs Now Act, has been passed by the House of Representatives but President Trump promised to veto it. This bill would limit out of pocket drug costs for seniors to $2,000 per year and require the government to negotiate lower prices for 250 prescription drugs, including insulin. The bill would save so much money that coverage for current and future seniors would be expanded to include hearing, dental and vision benefits.

"A president's budget reflects their values. President Trump is raiding retirees' earned benefits to pay for the tax cuts he passed for the wealthiest Americans and profitable corporations. Every time he has had a chance to fight for older Americans he has not. Our 4.4 million members will work to make sure every senior understands the President's record, not just his tweets."

Trump Deficit Forecast Is Built on Shaky Assumptions, Experts Say

WASHINGTON—The Trump administration's proposed budget projects federal deficits would be cut in half as a share of the economy by 2024, and in half again by 2029. While White House officials say they are serious about fulfilling President Trump's promise to reduce swelling deficits, budget experts say the projections are built on questionable assumptions.

The $4.8 trillion budget for fiscal 2021, released Monday, assumes that economic growth will be stronger than most forecasters project. To hit its targets, the budget excludes tax cuts the administration may propose later and includes spending cuts that are vague, unlikely to advance in Congress, or both.

"A lot of specific policies are meaningful, but the overall numbers are largely phony," said Marc Goldwein, senior vice president at the Committee for a Responsible Federal Budget, a group that favors deficit reduction…

For the next decade, the administration projects $50.7 trillion in federal revenue. That is 7% more than a Congressional Budget Office forecast ....**Read More**

On Drug Pricing, The President's Numbers Are Still Off

"I was pleased to announce last year that, for the first time in 51 years, the cost of prescription drugs actually went down."

President Donald Trump, during his Feb. 4 State of the Union address.

During the 2020 State of the Union address, President Donald Trump zeroed in on prescription drug prices, arguing that his administration is "taking on the big pharmaceutical companies."

Among the evidence for that claim: a talking point the administration has been using since last April.

"I was pleased to announce last year that, for the first time in 51 years, the cost of prescription drugs actually went down," Trump said.

We've examined this claim **twice** before, rating it **Mostly False**. But prescription drug prices are a major voter concern. So we wanted to take another look, in case things had changed.

Experts told us the data remains essentially unchanged. Drug prices are still not going down.

The Old Talking Point

Last spring, Trump's team pulled this claim from two sources: a 2018 report from the president's **Council of Economic Advisers** and data comparing the January 2019 Consumer Price Index for drugs to that of January 2018. The CPI data suggested a decline in drug prices.

But when we spoke to experts, they quickly debunked this position. For one thing, CPI data is imperfect — it shows list prices, rather than what consumers pay at the pharmacy counter. For another, it covers only drugs sold through retail, which accounts for about three-quarters of all prescriptions. That misses high-priced specialty drugs that are sold only through the mail.

Plus, other metrics showed that drug prices had, in fact, gone up, although by very little. Last April, for instance, the same CPI data indicated an increase — between April 2018 and April 2019, drug prices had increased by 0.3%. Data from the Kaiser Family Foundation also suggested an increase in total spending on drug prices that year, even if growth had slowed. (KHN is an editorially independent program of the foundation.)

What's Changed?

Today, prices aren't going up as fast as they were before, said Stacie Dusetzina, an associate professor at Vanderbilt University who studies drug pricing. But they're still going up.

"That probably doesn't provide the average person with much relief," she said.

Meanwhile, there's the question of individual list price increases. (List prices are defined as what's charged before rebates — an amount few people pay but that dictates negotiations.) The CPI data paints with a broad brush, drug pricing analysts said, obscuring just how many drugs have seen and continue to see their prices go up.

In 2019, 4,311 prescription drugs experienced a price hike, with the average increase hovering around 21%, according to data compiled by Rx Savings Solutions, a consulting group. Meanwhile, 619 drugs had price dips.

And already in 2020, 2,519 drugs have increased prices. The average hike so far this year is 6.9%. Meanwhile, the prices of 70 drugs have dropped. Typically, branded drugs increase their prices early in the year, and generics do so later, said Michael Rea, the CEO of Rx Savings Solutions. When generics post their price increases, the 2020 average price hike will likely go up.

"As a broad brushstroke, the story remains the same. Drug prices are going up, not down," Rea said.

Our Ruling

President Trump said that in 2018, "for the first time in 51 years, the cost of prescription drugs went down."

Nothing has changed since our previous rulings on this statement. And the continued drug pricing trend suggests that prices may be stabilizing, but they are not coming down. And consumers are not experiencing that relief.

We rate this claim Mostly False.

Column: Trump's budget proposal shreds Social Security and Medicaid benefits

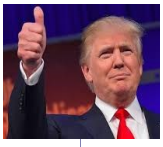
In accordance with the old adage that budgets are political documents, President Trump's budgets are windows into his political id.

Trump's **proposed $4.8-trillion budget for the 2021 fiscal year** makes his intentions crystal clear: He means to shred the federal safety net for the poor and the sick.

The budget proposal released Monday calls for drastic cuts in Social Security and Medicaid benefits, as well as in a program protecting defrauded student loan borrowers.

Medicare spending will also be cut, although the extent to which the reductions would affect benefits is unclear.

These cuts all are presented under the heading, "Restrain spending to protect and respect American taxpayers." Who are the taxpayers Trump is talking about? The wealthy, whose take from the 2017 tax cuts won't be affected one whit.



Trump's budget proposal was depicted in some media coverage as **a walk-back of his promises** to protect social insurance programs from cuts. ("We will not be touching your Social Security or Medicare in Fiscal 2021 Budget," **he tweeted Monday**.)

This is the wrong reporting approach for two reasons.

First, no one in his or her right mind should ever have taken Trump at his word. **He has lied** about pretty much everything else about his administration, so why should his treatment of programs for the poor, disabled and elderly be any different?

More important, however, this depiction places a merely political spin on what is fundamentally a catastrophe for tens of millions of Americans.

If there's a saving grace in this year's budget proposal, it's that many of its most draconian provisions will be dead on arrival. To the extent they require congressional approval, they won't get it from the Democrat-controlled House. Indeed, some of Trump's proposals couldn't even make it through Congress when Republicans controlled both chambers. Among other proposals, some cuts to the Supplemental Nutrition Assistance Program and Medicaid have failed to win much favor from the GOP.

Other proposals, however, may be amenable to administrative action that circumvents Congress. These include efforts to impose work rules on Medicaid and tighten eligibility for disability coverage. Advocates of Americans needing the safety net will have to remain vigilant against such end-runs.

As one would expect of a political manifesto masquerading as an administrative spending plan, Trump's budget is lathered with weasel words aiming to distract and conceal his intentions.

The term for a 10-year, $193-billion cut in Medicaid and the Children's Health Insurance Program is "modernize." Cuts in welfare, student loan forgiveness and disability benefits are described as "reforms," as is a cut in postal service support. "Modify" is the word for cuts in federal employee retirement and health benefits. ...**Read More**

Medicare Advantage plans offer no real choice

In the context of health insurance, choice may sound good, but it is a loaded word. The only time any of us has real choice is when we can actually distinguish among our health insurance options and at least one of them guarantees us affordable care from the doctors and hospitals we want to use. For that reason, **Medicare Advantage** plans, corporate health plans that contract with the government to provide Medicare benefits, offer no real choice.

Indeed, most Americans, whether working or retired, have **no real choice of corporate health insurance plan**. And, here, I'm not talking about the fact that employers often give people one choice. It's that even when you have multiple choices, as you do with Medicare Advantage, you cannot distinguish among them in a meaningful way. And, more important, there's no evidence that any of them will meet your needs if you get sick.

Because no one can predict future health care needs, the only health insurance that makes sense is health insurance that will cover us, no matter what care we need. at a cost we can afford. Consequently, the notion that we should **pick a health insurance plan that's right for us is preposterous.** Not only do we not know what care we will need down the road, we also do not know what doctors and hospitals we will want to use to treat that care.

But, no private health insurer is willing or able to guarantee us affordable access to care from the doctors we want to use. Even when premiums are reasonable, deductibles and coinsurance payments can be sky high for people who need a lot of care. In Medicare Advantage, they can be as high as $6,700 a year for medical care alone.

Private health insurers cannot control costs. What's equally problematic is that if any one of them offers high-value care for people with costly conditions, everyone with those conditions will join, their costs will rise, and they will not generate the profits they need to survive as a commercial business. So, Aetna, UnitedHealth and others will never promote the quality of care they deliver for people with costly conditions.

With Medicare Advantage, the good news is that the government pays for a large part of the premium. But, the problem remains that Medicare Advantage plans cannot compete to deliver high-value care to people with costly conditions or they would not survive as businesses. In fact, as should be expected, they do their best to avoid providing care to people with complex health care needs.

Government audits show "**widespread and persistent … performance problems related to denials of care and payment**," and Medicare Advantage plans "threatening the health and safety" of their members. And, though Medicare Advantage plans are required by law to turn over data that would allow the government to know whether they are delivering appropriate levels of care–e.g., enough physical therapy, home care, cancer care–the data the Medicare Advantage plans disclose is **unreliable and incomplete**.

Only **traditional Medicare**, public health insurance, social insurance, guarantees you coverage for reasonable and necessary care from the doctors and hospitals you want to use. And, it reins in provider rates. But, it's still expensive and requires you to have supplemental coverage to protect yourself from financial risk if you do not have Medicaid or retiree coverage that fills gaps.

Medicare for all strengthens and improves traditional Medicare, eliminating all premiums, deductibles and coinsurance, so you can go to the doctors and hospitals you want to use without worry about the cost. It covers vision, hearing, dental and long-term care. And, it costs less than our current health care system because everyone is in it. And, private health insurers are out. It reduces **administrative costs** by $600 billion a year and drug costs by another $250 billion a year.

Social Security Rule Change Would Harm Older Adults with Disabling Conditions

Last week, the Medicare Rights Center submitted **comments** in opposition to a **proposed rule** from the Social Security Administration (SSA) that would harm people with disabilities, especially people who are approaching age 65. The proposal would make the current problems in the SSA determination and review system even worse and put up additional barriers for people who already spend years trying to access the benefits they need because of their physical or mental conditions.

Currently, everyone who receives disability benefits from two federal programs, the Social Security Disability Insurance program (SSDI) or the Supplemental Security Income program (SSI), is put into one of three categories based on SSA's judgment of their likelihood to have medical improvement that will make them no longer qualify as disabled. How an individual is categorized is very important as it controls how often SSA will review their files and require them to submit information or undergo medical examinations to show that their disabilities are ongoing. While a person's physical or mental condition is by far the most important factor, some of this likelihood is currently also based on the individual's age and education, both of which can influence how employable they are in the national workforce.

When SSA believes an individual has a very good chance of medical improvement, they are placed in a category that is subject to review every 6-18 months. People SSA categorize as having little to no chance of medical improvement are subject to review every 5-7 years. Those SSA places in the middle category are reviewed every three years.

SSA is proposing to create a new category that would be reviewed every two years and to shift many older adults out of the 5-7 year category and into this new category. This would mean many more cycles of review for individuals who have little likelihood of being able to find work based on their combination of physical or mental conditions, age, and education.

At Medicare Rights, we recognize that some people do see medical improvement once they are receiving SSDI or SSI benefits. However, we cannot support this move to create more burdens for people who need the stability of these programs and access to care. The current system forces applicants to wait for months or years to gain benefits, with innumerable forms and burdensome medical documentation requirements. This rule change would only create more delays and more burdens, and would likely result in more people losing their disability benefits for failure to meet unnecessary and punitive bureaucratic hurdles. We urge SSA to withdraw this rule in its entirety.

Read Medicare Rights' comments.

Understanding Home Health Care Access After Recent Medicare Payment Changes

A new article from Kaiser Health News (KHN), **"What To Do If Your Home Health Care Agency Ditches You**," shines a light on confusion regarding recent changes to Medicare home health payments and beneficiary access to those services.

Under Medicare, **home health care** includes a wide range of health and social services delivered in the home to treat illness or injury. Covered services include intermittent skilled nursing care, therapy, and care provided by a home health aide.

To qualify for services under Part B, individuals must meet certain **eligibility requirements** including being homebound and in need of skilled care. To receive coverage under Part A, individuals must also have spent at least three consecutive days as a hospital inpatient or had a Medicare-covered skilled nursing facility (SNF) stay. In such instances, Part A will cover the first 100 days of home health care.

The article shares the experience of Medicare beneficiaries Craig Holly and his wife, Effie Costas-Holly. Effie has advanced multiple sclerosis and was receiving a relatively minimal amount of home health care. The agency abruptly ended her services last month and told Craig this was due to Medicare's new home health payment system.

While CMS did adopt a new payment structure on January 1, known as the Patient-Driven Groupings Model (PDGM), the underlying benefit and coverage rules were not affected. All that changed is how Original Medicare pays home health agencies.

Under the old system, Medicare's home health rates reflected the amount of therapy delivered, so that more visits meant higher payments. Under the PDGM, therapy isn't explicitly factored into the reimbursements. Instead, payments are based on several factors that result in agencies being paid higher rates for serving beneficiaries who require complex nursing care and lower rates for providing care to people with long-term chronic conditions.

Such financial incentives would seem to put those who need lower amounts of care at risk. In response to this concern, CMS **said** that it does "not expect home health agencies to under-supply care or services; reduce the number of visits in response to payment; or inappropriately discharge a patient receiving Medicare home health services as these would be violations of [Medicare] conditions of participation."

However, **reports** suggest that is indeed happening. Further, the article notes that "therapists, home health agencies and association leaders say that patients across the country are being told they no longer qualify for certain services…or that services have to be cut back or discontinued."

Craig and Effie were, fortunately, able to have her services restored. Since home health agency confusion appears to be widespread, the KHN article outlines steps people can take if they find themselves in a similar situation. The recommendations include getting as much information from the agency as possible, enlisting the assistance of the physician who ordered the home health care services, and reaching out to 1-8000-Medicare and consumer advocates for help.

If you are experiencing a coverage disruption or have questions, counselors at Medicare Rights' National Helpline are available Monday through Friday at 800-333-4114. Medicare Rights is concerned about the impacts of the new home health payment system on beneficiary access and will continue to monitor its implementation.

Read the article, "What To Do If Your Home Health Care Agency Ditches You."

Read more about Medicare's Home Health benefit.

The link below will take you to the official Medicare page that tells you exactly what is covered regarding home health care.

https://www.medicare.gov/Pubs/pdf/10969-Medicare-and-Home-Health-Care.pdf

A Quarter of Middle-Aged Americans Worry They Can't Afford Health Care

A large fraction of Americans nearing retirement age are worried they can't afford health insurance now, much less when they quit working to enjoy the good life, a new survey shows.

One in every four people between 50 and 64 are not confident they'll be able to afford health insurance during the next year, and nearly half worry they won't be able to afford coverage once they retire, researchers report.

"That number was a lot higher than I thought it would be," said study author Dr. Ren

he innovations and protections created by the Affordable Care Act, also known as Obamacare, do not appear to have eased people's concerns about insurance costs, Tipirneni added.

"I thought that more people would have access to health insurance and perhaps for that reason they would be more confident about affording health insurance," she said.

These numbers come from the National Poll on Healthy Aging, an online survey of more than 1,000 Americans in their 50s and early 60s conducted in late 2018. The survey was sponsored by AARP and the University of Michigan.

The poll occurred shortly after the Republicans' plan to repeal the Affordable Care Act failed in Congress, at about the same time as the open enrollment period for employers' insurance plans, Medicare, and plans sold through federal and state marketplaces.

High out-of-pocket costs associated with health plans could be one reason why people fret about affording medical care, researchers found.

About 1 in 5 people said out-of-pocket costs had prompted them to not receive care for a health problem or skip filling a prescription during the past year, survey results showed.

Further, people in fair or poor health were four times more likely to have avoided care. Those who purchased an insurance plan on their own, rather than through an employer, were three times more likely to have not received care or not filled a prescription due to cost.

"When people are talking about affording health insurance in retirement, I think they're not just thinking about premiums," Tipirneni said. "They're thinking about other costs they'd have to pay out of pocket, like copays for medications, being able to afford the copays when you see the doctor. Even if you have health insurance and it's a good plan, there are still a lot of costs."

The political uncertainty surrounding the Affordable Care Act is also driving some of this worry, the survey found.

Two-thirds of the survey respondents said they were concerned how potential changes to national health care reform could affect them.

These concerns aren't trivial -- they've had real consequences on people's decisions regarding retirement.

Nearly 1 in 5 people said they've kept a job in the past year to maintain their employer-sponsored health insurance, and 15% of those working say they've either delayed retirement or thought about it to preserve their insurance coverage.

"This is a serious issue and has been for many years," said Cheryl Fish-Parcham, director of access initiatives for Families USA, a health care consumer advocacy group. "

Patients Stuck With Bills After Insurers Don't Pay As Promised

The more than $34,000 in medical bills that contributed to Darla and Andy Markley's bankruptcy and loss of their home in Beloit, Wisconsin, grew out of what felt like a broken promise.

Darla Markley, 53, said her insurer had sent her a letter preapproving her to have a battery of tests at the Mayo Clinic in neighboring Minnesota after she came down with transverse myelitis, a rare, paralyzing illness that had kept her hospitalized for over a month. But after the tests found she also had beriberi, a vitamin deficiency, Anthem Blue Cross and Blue Shield judged that the tests weren't needed after all and refused to pay — although Markley said she and Mayo had gotten approval.

While Darla learned to walk again, the Markleys tried to pay off the bills. Even after Mayo wrote off some of what they owed, her disability and Social Security checks barely covered her insurance premiums. By 2014, five years after her initial hospitalization, they had no choice but to declare bankruptcy.

Anthem Blue Cross and Blue Shield spokesperson Leslie Porras said company "records do not indicate that Ms. Markley had tests authorized that were later denied."

Markley said she never would have had the tests done if she had known insurance was not going to pay for them. "I feel for anyone that finds themselves in that predicament," said Markley, a nurse who was pursuing her Ph.D. in education. "You can go from an upstanding middle-class American citizen to completely under the eight ball."

The billing quagmire into which the Markleys fell is often called "**retrospective denial**" and is generating attention and anger from patients and providers, as insurers require preapproval — sometimes called "prior authorization" — for a widening array of procedures, drugs and tests. While prior authorization was traditionally required only for expensive, elective or new procedures, such as a hip replacement or bypass surgery, some insurers now require it for even the renewal of some prescription drugs. Those preapprovals are frequently time-limited. While doctors and hospitals chafe at the administrative burden, insurers contend the review is necessary to ferret out waste in a system whose costs are exploding and to ensure physicians are prescribing useful treatments.

But patients face an even bigger problem: When insurers revoke their decision to pay after the service is completed, patients are legally on the hook for the bill.

Prior authorizations may now include a line or two saying something like: "This is not a guarantee of payment." This loophole allows insurers to change their minds after the fact — citing treatments as medically unnecessary upon further review, blaming how billing departments charged for the work or claiming the procedure was performed too long after approval was granted.

In other cases, a patient will be told that no prior authorization is needed for a certain intervention, only to hear afterward that the insurer wanted one in this particular case. It then refuses to pay. Oftentimes, approval conversations happen primarily between the insurer and the provider — leaving the patient further in the dark when the bill appears.

The American Medical Association **drafted model legislation** to combat the problem for lawmakers to introduce, but the measure has not been widely picked up.

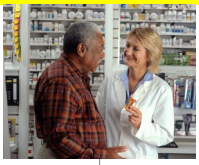
Martha Gaines, director of the Center for Patient Partnerships at the University of Wisconsin Law School, **co-authored an article** in the Journal of the American Medical Association on the issue and sees firsthand the time and money patients lose fighting such retrospective denials — for coverage they thought they had.

"How broken can you get?" she asked. "How much more laid bare can it be that our health care insurance system is not about health, nor caring, but just for profit?"….**Read More**

Real risk of medication errors at CVS and other chain pharmacies

Ellen Gabler writes for **The New York Times** about the risk of medication errors from using chain pharmacies, such as CVS and Walmart. At a larger level, Gabler's story highlights the dangers of for-profit health care. With a desire to maximize revenues, health care corporations aim to do more for less. But, in the process, more too often means more harm to Americans.

Medication mix-ups have become increasingly common at chain pharmacies, which dispense about 70 percent of drugs in the US, along with supermarkets and megastores. Pharmacists have given people blood pressure medicine instead of asthma medicine, ear drops instead of eye drops and chemotherapy drugs instead of antidepressants. The chain pharmacies are very busy and understaffed, while under tremendous pressure to meet company quotes.



To drive profits, chain pharmacies expect pharmacists to push refills on patients who don't need them and dispense more drugs than people need. For example, CVS pharmacists have been requested to dispense three-month supplies of some medicines–more pills means more money–to people with mental health issues. The American Psychiatric Association worries that dispensing so much medicine can lead to overdosing.

State pharmacy boards are hard-pressed to oversee these chain pharmacies to the extent necessary. They have little power to begin with. Often, representatives of the chain pharmacies sit on their boards. This creates conflicts of interest. Pharmacists fear losing their jobs if they speak up about issues. State legislatures do not seem to have the ability to regulate the pharmacies appropriately either.

Chain pharmacies, such as CVS, deny there is a problem. Shockingly, there is no way to know the frequency or gravity of medication errors. As with most health care information, reporting is not what it needs to be and a lot of errors never become public. They are settled between pharmacy and patient, with an agreement on the part of the patient to not disclose the settlement terms.

But, one **Institute of Medicine** study on medication errors conducted in 2006 found that they hurt at least 1.5 million Americans a year. And, Gabler compiled a long list of grievances filed by pharmacists to state boards, suggesting that pharmacists face grave difficulties ensuring they are filling prescriptions appropriately.

At the end of the day, it's probably advisable to steer clear of chain pharmacies. In addition to evidence suggesting that they put you at greater risk of receiving the wrong medicines, they tend to be the **most expensive place to get your drugs**.

If you do use a chain pharmacy and your pharmacy misfills your prescriptions, do what you can to publicize it. Call your local newspaper and ask for an investigation. No company wants these errors broadcast. Over time, it could help lead to the company addressing the problem or new consumer protections.

Governors Warn Trump Rule Could Lead to Big Medicaid Cuts

Governors of both major political parties are warning that a little-noticed regulation proposed by the Trump administration could lead to big cuts in Medicaid.

Governors of both major political parties are warning that a little-noticed regulation proposed by President Donald Trump's administration could lead to big cuts in Medicaid, reducing access to health care for low-income Americans.

The arcane fiscal accountability rule proposed by the Centers for Medicare and Medicaid Services, or CMS, would tighten federal oversight and approval over complex financing strategies states have long used to help pay for their share of the $600 billion program. Also targeted are certain payments to hospitals that treat many low-income patients. Public comments closed last week amid a chorus of criticism from hospitals, nursing homes, insurers, doctors, and advocates for the poor.

Against the backdrop of an election year, governors are warning the administration of potentially dire consequences.

"States may be unable to adequately fund their Medicaid programs, which could lead to unintended consequences that would negatively impact Medicaid beneficiaries across the country," wrote Govs. Kate Brown, D-Ore., and Charlie Baker, R-Mass., in official comments on behalf of National Governors Association.

But CMS administrator Seema Verma says the vast health care program needs closer scrutiny and has expressed concerns about "shady" financing schemes that abuse the system and drive up taxpayer costs.

In a statement Wednesday, Verma said her agency recognizes the "critical importance" of the state financing but said it has to lead to better value and improved care for Medicaid beneficiaries. Under the proposed rule, "we are increasing transparency, integrity and clarity," she said.

An agency spokesman said the rule is not intended to reduce Medicaid payments.

But the policy comes from an administration that has repeatedly moved to scale back Medicaid. Trump has tried to repeal the program's Obama-era expansion, supported block grants that would cap federal spending, and allowed states to impose work requirements on Medicaid recipients.

The latest proposal could lead to cuts of $37 billion to $49 billion a year in total Medicaid spending, or 6% to 8% of program funds, according to a study by Manatt Health consultants for the American Hospital Association. Payments to hospitals could be cut as much as 17%.

A CMS spokesman said the agency doesn't believe those estimates are credible. In the rule, CMS says that the fiscal impact of its plan is "unknown." Critics say the agency did not do a full analysis.

If the federal government curtails financing methods states now rely on, governors would have to seek broad tax increases, cut payments to hospitals and doctors, reduce benefits, restrict eligibility, or some combination of such measures. States can set their own Medicaid policies within federal requirements.

Medicaid covers more than 70 million people, or about 1 in 5 Americans. That includes many pregnant women, newborns, elderly nursing home residents, and severely disabled people. In states that have accepted the Affordable Care Act's Medicaid expansion it's also a mainstay of coverage for low-income adults.

"Medicaid is the backbone of the U.S. health care system; you weaken the backbone and the whole system gets scoliosis," said Matt Salo, head of the nonpartisan National Association of Medicaid Directors, which has also raised concerns.

Trade associations for hospitals and nursing homes are asking the administration to withdraw its proposal entirely. So is the American Medical Association, saying "access to care for Medicaid beneficiaries would be at risk and health outcomes for such patients could worsen." Governors and the health insurance industry are asking the administration go back to the drawing board and gather more information before attempting such sweeping changes.

"These proposed cuts to providers and states are clearly part of an ongoing assault on Medicaid and will endanger Americans when they fall on tough times," Sen. Ron Wyden of Oregon, top Democrat on the panel that oversees the program, said in a statement.

Overall the federal government pays about 60% of Medicaid costs, and states the rest. Medicaid ranks along with education as a top budget items for states. At issue are strategies that states use to raise their share of Medicaid spending, enabling them to tap federal matching funds that stretch the services they can provide.

They include:

— Business taxes on hospitals, nursing homes and insurers — also called "provider taxes." The money raised is plowed back into Medicaid. The Trump administration says it is concerned that some of these arrangements skirt federal laws.

— Payments from local governments to a state that then help the state draw down federal Medicaid matching funds. The Trump administration says those payments must be funded with state or local tax revenues and currently that's not always clear.

Also in the cross-hairs of the proposed rule are Medicaid "supplemental"payments to hospitals that treat a large share of low-income patients. Those could be curtailed.

Governors and state Medicaid directors say they agree with the Trump administration's goal of greater accountability for Medicaid financing. But they're concerned the administration hasn't done its homework.

When Your Doctor Is Also A Lobbyist: Inside The War Over Surprise Medical Bills

When Carol Pak-Teng, an emergency room doctor in New Jersey, hosted a fundraiser in December for Democratic freshman Rep. Tom Malinowski, her guests, mostly doctors, were pleased when she steered the conversation to surprise medical bills.

This was a chance to send a message to Washington that any surprise billing legislation should protect doctors' incomes in their battle over payments with insurers. Lawmakers are grappling over several approaches to curtail the practice, which can leave patients on the hook for huge medical bills, even if they have insurance.

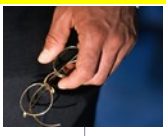
As Congress begins its 2020 legislative session, there is evidence the doctors' message has been received: The bills with the most momentum are making more and more concessions to physicians.

As surprise medical billing has emerged as a hot-button issue for voters, doctors, hospitals and insurers have been lobbying to protect their own money flows. All that lobbying meant nothing got passed last year.

Television and internet ads are the most visible manifestation of the battle. But in taking their cause to politicians, doctors like Pak-Teng have waged an extraordinary on-the-ground stealth campaign to win over members of Congress. Their professional credentials give them a kind of gravitas compared with other lobbyists, who are merely hired guns….**Read More**

RI ARA HealthLink Wellness News

Many Seniors Think They See Better Than They Actually Do



Many older people could improve their vision by getting glasses or a new prescription, a new study suggests.

Swedish researchers assessed 1,200 70-year-olds and found that most were content with their eyesight, but many overestimated how well they actually see.

The study found that 61.5% could significantly improve their vision by getting glasses or changing the power of the ones they already had, researchers said.

We're really healthy and have good eyesight in Sweden, and being 70 doesn't have to mean your vision is poor," said co-author Lena Havstam Johansson, a doctoral student at Sahlgrenska Academy at the University of Gothenburg.

"Visual impairment can creep up on you, making it difficult to notice that your eyes are getting worse. So it's a good idea to visit an optician regularly when you get older, even if you don't feel your sight is deteriorating," Johansson said in a university news release.

The findings show that many older people who think their eyesight is good might be mistaken.

"Above all, it was reduced contrast sensitivity that made people think their sight was poor. Impaired visual acuity or visual field defects had less of an impact on how they perceived their own eyesight," said study co-author Madeleine Zetterberg, a professor of ophthalmology at Sahlgrenska.

Having glasses of incorrect power was equally common among men and women, but men's sight tended to be slightly better. Researchers said that could be due to a higher rate of cataracts among women.

Slightly more than 27% of women had cataracts, compared with just over 19% of men.

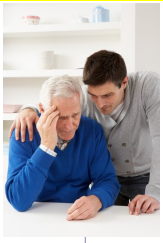
The most common eye diseases were cataracts (23.4%); age-related macular degeneration (4.7%), and glaucoma (4.3%). In all, 1.4% had diabetic retinopathy, changes in the retina due to diabetes.

The study was recently published in the journal *Acta Ophthalmologica*.

More information

The U.S. National Institute on Aging has more about **the eyes and aging.**

What to know about vascular dementia



Vascular dementia is damage in the brain that occurs due to reduced blood flow. People most often develop vascular dementia following a stroke, but there are several other potential causes and risk factors.

Vascular dementia is the **second most common** form of dementia after Alzheimer's disease. It often affects memory, reasoning, and other thought processes.

Treatment may help slow or sometimes prevent the progression of the condition.

This article discusses the causes, symptoms, and methods of diagnosis of vascular dementia, as well as some treatment options.

What is vascular dementia?

Vascular dementia occurs when restricted blood flow to the brain damages brain cells. Without enough fresh blood flowing into the brain, cells can become damaged or die. The repair process in these cells is slow, and the body cannot always replace them.

The symptoms may occur suddenly, such as after a stroke or ischemic event. In other cases, cell damage can build up over time. If this is the case, the symptoms will gradually become worse.

The effects of vascular dementia may range from mild to severe. The symptoms can greatly impact a person's quality of life and affect their ability to live independently.

Causes and risk factors

The cause of vascular dementia is a lack of blood flow in the brain. There are several different conditions that may cause this restriction, either gradually or straight away:

Stroke

A stroke occurs when a blood vessel leading to the brain bursts or becomes blocked by a clot. Stroke can have many effects on the body, one of which is the development of vascular dementia.

Damaged or narrowed blood vessels

Damaged or narrowed blood vessels leading to the brain may also cause vascular dementia. Because of this, conditions that damage the blood vessels over time or cause them to narrow may also increase the risk of vascular dementia.

Other risk factors

The risk of vascular dementia tends to increase as a person gets older. In fact, the **National Heart, Lung, and Blood Institute** state that the condition affects almost one-third of people over the age of 70. Also, a number of other factors and conditions may increase the risk of damaged blood vessels and vascular dementia, **including:**

- smoking
- **obesity**
- abnormal heart rhythms
- high **cholesterol**
- high **blood pressure**
- **atherosclerosis**
- **diabetes**
- a history of **heart attack** or stroke

Symptoms

The effects of vascular dementia vary from person to person depending on where the blood flow in the brain is most limited. Some possible symptoms of vascular dementia include:

- trouble concentrating
- general confusion
- a sudden headache or numbness or paralysis on one side of the face or body, which mirror the symptoms of stroke
- difficulty paying attention
- difficulty analyzing problems or situations
- difficulty making decisions
- irritation
- depression or mood changes
- personality changes
- In some cases, such as when the symptoms appear following a stroke, the cause may be easy to pinpoint. In these cases, a doctor may refer to the symptoms as "post-stroke dementia."
- In other cases, however, the symptoms come on slowly over time, and they may not be immediately obvious to the person.

Diagnosis

There is no single test to determine whether or not someone has vascular dementia. A doctor will perform a physical exam and ask about the person's medical history and symptoms. They may also perform tests to rule out other potential causes of the symptoms, including:

Neurocognitive tests

A doctor will likely recommend neurocognitive tests to examine the person's mental abilities, including their:

- reasoning
- memory
- problem solving
- judgment
- Planning

...**Read More**

Traditional Medicare Doesn't Pay For Dental Care

Traditional Medicare doesn't pay for dental work, so to get coverage you have to buy a stand-alone plan or enroll in one of the Medicare Advantage plans that offer some dental benefits. Yet most of this coverage is basic and leaves people underinsured against this major expense, according to a new study.

Just over a third of Medicare beneficiaries are enrolled in Medicare Advantage, **according to the Kaiser Family Foundation**. That's 22 million people, and if you're one of them, now's a great time to examine your coverage. The **Medicare Advantage Open Enrollment Period runs through March 31**, and during this time beneficiaries in Medicare Advantage can switch to a new Medicare Advantage plan or leave the program altogether and enroll in traditional Medicare. Beneficiaries currently in traditional Medicare can't change their coverage during this window. (The difference between Medicare Advantage, also known as Part C, and traditional Medicare is that the former is managed by private companies that contract with the federal government to provide Parts A and B, while the latter is administered directly by the government.)

Sixty-two percent of Medicare Advantage consumers were in plans that included a dental benefit in 2016, **according to a new study in the journal Health Affairs**. By comparison, just 21% of beneficiaries in traditional Medicare had bought a stand-alone dental plan, the study found.

The premium for stand-alone dental coverage often runs in the vicinity of $30 a month. By contrast, many Medicare Advantage plans have $0 premiums, so you get some dental care for no extra cost. This benefit "gets people in the door" to see the dentist, says Amber Willink, associate professor of health policy at the University of Sydney in Australia and one of the co-authors of the Health Affairs study, along with researchers at Johns Hopkins University.

But once they get in the door, most patients find that dental coverage doesn't put that much of a dent in their bills. In 2016, Medicare beneficiaries with dental coverage averaged $894 in out-of-pocket spending, compared to $928 for those without, according to the study.

"The coverage is very minimal," says Dr. Margaret Gingrich, DDS, president of the Michigan Dental

Association and a dentist with a private practice in Big Rapids, Mich.

For example, many dental plans will cover a basic cleaning or two each year. That sounds good, until you consider that many older adults aren't even candidates for a basic cleaning, Gingrich says. Over half of adults age 60 and over have a condition, such as bone loss or gum disease, that requires a more specialized cleaning, she notes. What's more, many patients haven't been to the dentist in years, and when they finally get coverage and come to her office, they need a more intensive cleaning. Gingrich has patients puzzled why they can't use their dental benefits, and she has to explain that their plan doesn't cover the level of services they need.

Mary Johnson recently experienced the limitations of dental coverage. A Social Security and Medicare policy analyst at The Senior Citizens League, Johnson is on traditional Medicare and bought a stand-alone dental plan online from one of the few providers in her rural Virginia area.

She has gum disease, and the uncovered cost for her periodontal surgery and follow up was $5,000. Last year, she needed implant surgery, and the uncovered cost for that was $3,500, Johnson says. (The replacement tooth itself was covered for $1,250, she notes.) Even with her insurance, "the largest out-of-pocket cost remained uncovered," Johnson says.

So what can you do, given these limitations? If you decide against dental coverage, look into low-cost treatment at a local dental school or clinic, or ask your dentist about cash and upfront discounts and payment plans. While cost can be a big barrier, it's important not to neglect your oral health. "I don't think people appreciate the extent to which oral health is a part of general health, and it can wreak havoc if you don't take care of it," Willink says. In just a couple examples, poor oral health can exacerbate cardiovascular and respiratory diseases.

Know What You're Buying

- **What does the plan cover?**
- **How does the plan cover services?**
- **How much does the plan cost?**

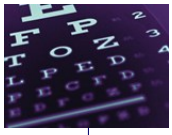
Select Your State to Find a Dental Policy
Dental Insurance Plan at a Reasonable Rate

With Macular Degeneration, 1 Missed Visit to Eye Doc Can Mean Vision Loss

Missing just one eye doctor appointment can result in vision loss in older adults with macular degeneration, a new study warns.

Age-related macular degeneration (AMD) is a leading cause of vision loss in the elderly, and these findings show the need for patients to keep all scheduled appointments with an ophthalmologist, the University of Pennsylvania School of Medicine researchers said.

For the study, the investigators analyzed data from nearly 1,200 AMD patients across the United States who were part of a two-year clinical trial of anti-VEGF (intravitreal anti-vascular endothelial growth factor) treatment. It involves injections into the eye by a doctor



Patients were required to visit an ophthalmologist once every four weeks, for 26 visits. Not all visits involved injections.

The study found that patients who missed scheduled appointments had greater declines in vision, with each missed visit associated with an average visual acuity letter score decline of 0.7. Compared to patients who made all visits, those who averaged 36 to 60 days between visits lost 6.1 letters, and those who went more than 60 days between visits lost 12.5 letters, according to the study published online Feb. 6 in *JAMA Ophthalmology*.

These findings show the need to "reframe" how doctors think about treating AMD patients, said study author Dr. Brian VanderBeek, a professor of ophthalmology.

"Let's worry less about predicting a specific number of injections a patient needs and more about getting them into the doctor's office," he said in a university news release.

AMD is the leading cause of permanent vision loss among Americans over age 50. About 1.8 million people in the United States have AMD and another 7.3 million are at risk for the disease, according to the U.S. Centers for Disease Control and Prevention

Panic Attack vs. Heart Attack: How to Tell the Difference

A sharp pain in the chest. Shortness of breath. Tingling in the arms or hands. Nausea, sweating, shaking and a racing heartbeat. Is it a heart attack? It might well be. But it could also be a panic attack. The two conditions have some similarities, and it can be tricky to tell them apart sometimes.

What Is a Heart Attack?

Dr. Tamara B. Horwich, associate clinical professor of medicine, cardiology/ cardiovascular disease at the David Geffen School of Medicine at UCLA, says "a typical heart attack occurs when one of the coronary arteries, which are arteries that supply blood to the heart muscle, becomes blocked or obstructed. This leads to a decrease in blood supply to the heart muscle."

A **heart attack** is also sometimes referred to as a myocardial infarction.

Typical **signs and symptoms of a heart attack** include:

- Chest discomfort that may feel like pressure, squeezing or pain.

- Pain in the upper body, particularly in one or both arms, the neck, back, jaw or stomach.
- A feeling of fullness in the chest.
- A feeling of severe indigestion.
- Shortness of breath.
- Palpitations or a pounding heart.
- Nausea or cold sweats.
- Lightheadedness.
- Flu-like symptoms.
- Paleness in the face or looking unwell.
- A sense of doom.

Dr. Tamer I. Sallam, assistant professor of medicine at the David Geffen School of Medicine at UCLA, says that while pain in the chest or arm is a common sign of a heart attack, it's not always present, and **women** in particular "are less likely to experience chest pain and may present with other signs like unusual fatigue or upper body discomfort."

Heart attacks occur in both **men** and women, and tend to occur later in life than panic attacks. "The average age of heart attack onset is 65 in men and 72 in women," Horwich says. "However, heart attacks can occur much earlier in life – in one's 30s – for people who have very high cholesterol." Symptoms of a heart attack typically last 30 minutes or longer. Other risk factors for heart attack include:

- Smoking.
- **High blood pressure**.
- High cholesterol.
- Lack of physical activity.
- Smoking.
- Chronic stress.

Some individuals are also at higher risk, including:

- People with **diabetes.**
- Post-menopausal women.
- People with high-stress jobs.
- People who have **atrial fibrillation**, a heart condition that causes palpitations.
- People with a family history of heart disease or heart attacks.

Heart attacks are typically addressed with a combination of lifestyle interventions (changing diet, increasing **exercise)** and medications (drugs to lower blood pressure and cholesterol). Some people will also need to have surgery to open up blocked arteries.

Some heart attacks can be instantly fatal, while others are much smaller events that may serve as warning signs to make some changes, such as lowering cholesterol and blood pressure levels, improving your diet and increasing exercise….**Read More**

How to Help Someone With Depression

Have you ever had a friend or family member struggle with depression, and you weren't sure how to help? Maybe you were afraid of saying or doing the wrong thing, in fear of making the person feel worse. Or maybe you just ignored it, hoping the person would get better on their own. As a society, we're working to change the conversation surrounding mental health, including **depression** and suicide prevention. I'm encouraged by efforts of national organizations such as the National Alliance on Mental Illness and Mental Health America to help reduce the stigma that surrounds mental illness.

As a psychiatrist at the Ohio State University Wexner Medical Center, I'd like to offer these six suggestions of what you can do when you encounter someone who is depressed:

- Listen.
- Ask.
- Love.
- Act.
- Link.
- Advocate.

Listen. The first important step is to simply listen. Listening encourages the person to open up more, so that they'll tell you about **signs of depression** and desperation. A major cause of suicide is depression.

Ask. Encourage more conversation by asking more, which further shows that you care enough to know more about their struggles and depression.

Specifically ask: "Are you thinking about killing yourself?" This is one of the most important questions because asking decreases (not increases) suicidal thoughts. Asking about the possibility of suicide may save the person's life.

Love. Listening and asking show that you care. Listening with compassion and empathy and without dismissing or judging reflects love. That feeling of being loved may help someone reach out for help.

Act. Keep the person safe. Ask if they know how they would commit **suicide**, and separate them from anything they could use to hurt themselves.

Work to put time and distance between the person and their chosen method, especially dangerous ones such as firearms and medications.

Stay with the person until the crisis passes or they're connected to resources that can help them.

Link. If you think they might be in immediate danger, call 911.

Link them to National Suicide Prevention Lifeline: 1-800-273-TALK (or 1-800-273-8255).

Link them to **mental health treatment**, as treatment works. We know that treatment decreases depression and reduces suicide.

Link them to other people who can provide support. Research has also shown connectedness with others acts as a buffer against hopelessness and psychological pain.

And remember to follow up after the immediate crisis passes, and repeat: Listen, Ask, Love, Act.

Advocate. Get informed and get involved. Start conversations to reduce the stigma.

Everyone can help raise awareness about the suicide epidemic. Did you know that each day, nearly 130 people in our country die by suicide? Equally important is raising awareness about suicide prevention.

Advocate for better **access to mental health care**. Advocate for more resources and treatments. Advocate for more funding for research to better understand and treat depression and suicide.

*If you or someone you know is considering suicide, please contact the National Suicide Prevention Lifeline at 1-800-273-TALK (8255), text "help" to the Crisis Text Line at 741-741 or go to **suicidepreventionlifeline.org**.*

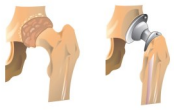
Veterans Suicide Hotline or call 988

Warning: Your hip replacement could kill you

Jeanne Lenzer writes for the **New York Times** about the danger of getting a hip replacement. In some cases, your hip replacement could cause serious harm. In general, as we have reported, **FDA-approved medical devices may not be safe**.

Stephen Tower, an orthopedic surgeon, had a metal-on-metal hip implanted, the ASR XL, made by Johnson & Johnson. Dr. Tower specializes in complex hip replacements, but he was not aware that the hip he chose for himself had a serious defect. He ended up needing another surgery because of the pain his artificial hip was causing him.

Dr. Tower's artificial hip had turned the tissue around it black. The artificial hip leaked cobalt causing Dr. Tower to suffer from metallosis. Muscles, tendons and ligaments near the hip were destroyed. Worse still, Dr. Tower suffered damage to his heart and brain.



Afterwards, Dr. Tower warned Johnson & Johnson of the serious defect in the hip but the medical device company did nothing about it. Rather, it continued to market metal-on-metal hips. It finally withdrew the ASR XL model from the market in 2010, but it sold another metal-on-metal hip, the Pinnacle, until 2013.

Thousands of people received a Johnson & Johnson metal-on-metal hip replacement during this time. Six of them won a $247 million verdict because of the Pinnacle's harmful side effects and because Johnson & Johnson did not warn doctors or patients about these side effects.

Unfortunately, these metal-on-metal hips are one of many FDA-approved medical devices on the market that put patients at risk for dangerous side effects. A provision of the Federal Food, Drug and Cosmetic Act, known as **510 (k),** allows medical device companies to market many new products without having to do any clinical trials. All that the medical device company need do is claim that the device is "substantially equivalent" to a medical device already on the market.

While the FDA can recall the product if it is deemed to cause harm, it can take a long time for that recall to happen. Hundreds of thousands of people can end with the device implanted before it is recalled. And removal of the device once recalled can also jeopardize patients' health.

In 2016 alone, the FDA recalled 117 medical devices because of a "reasonable probability" that they would "cause serious adverse health consequences or death."

Medical devices that undergo clinical trials are also not guaranteed to be risk free. Indeed, the FDA may conditionally approve them even when the clinical trials show potentially harmful side effects, including a high death rate. That's what happened with a Cyberonics device designed to treat epilepsy. The FDA did not require that patients who received this device be told about the risk of dangerous side effects.

The FDA's approval process appears to put profits before patients. Yes, more devices get to market more quickly. But, at what cost to human life and health?

What's a dementia directive?

You may have heard of an advance directive, a document all adults should prepare, naming a person to speak for them if they cannot speak for themselves and setting forth their care wishes. Now, the **New York Times** reports that a group of experts in care for older people have developed a dementia directive. It is designed specifically to honor the care wishes of people living with dementia, a cohort of about **5.3 million older Americans**.

Unlike an advance directive, with a **dementia directive,** people specify their care wishes at each stage of dementia. It explains the effects of mild or early-stage dementia, as well as moderate or mid-stage dementia, and severe or end-stage dementia. And, it asks people to set forth the kind of medical interventions they would want at each stage, offering a set of options.

Advance directives can be enormously helpful in most instances in which patients are unable to express their care wishes. But, the creators of the dementia directive say that advance directives do not address the care needs of patients with dementia. They tend to be written for people who have been deemed to be terminally ill, with six months or less to live.

People may live for many years with dementia. So, the dementia directive offers four different types of care options for people with dementia at each stage, ranging from "full efforts to prolong my life" to "comfort-oriented care only, focused on relieving suffering."

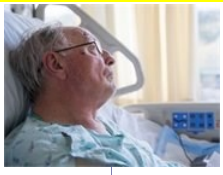
The dementia directive is a new concept and time will tell whether it takes off or not. Regardless, people should speak with the people they know and trust about their care wishes down the road. You should have those conversations to help ensure you enjoy the quality of life you want to enjoy and are not forced to live a life that you would find unacceptable. Whatever your age, share your views on the kinds of medical interventions you would want and those you would not want if you could not express your wishes yourself.

Bedside 'Sitters' May Not Prevent Hospital Falls

Many hospitals use bedside "sitters" to protect patients from falling, but a new review finds little evidence the tactic works.

However, researchers said the problem is a lack of rigorous studies -- and not proof that bedside sitters are ineffective. So it would be premature to abandon the practice.

"We've been doing this for years," said Dr. Cathy Schubert, a geriatrics specialist at Indiana University School of Medicine and the Richard L. Roudebush VA Medical Center, both in Indianapolis.



"I was surprised there really has been little study of it," she said. "That was the eye-opening part."

Schubert wrote an editorial published with the review Feb. 3 in the *Annals of Internal Medicine*.

Falls are an enduring problem in hospitals. Each year, between 700,000 and 1 million Americans fall in a hospital, according to the U.S. Agency for Healthcare Research and Quality

Schubert said it's a particular problem among elderly patients -- especially those who have dementia or are suffering from delirium.

The rationale behind bedside sitters is simple, Schubert said: "If we keep a close eye on them, we can prevent falls."

So for years, many U.S. hospitals have had nurses or other staff stay in the room with patients at high risk of falls -- helping them in and out of bed, and making sure they move safely around the room.

Not surprisingly, it's expensive. A U.S. hospital may spend more than $1 million a year on bedside sitters, according to study author Dr. Adela Greeley and colleagues at the West Los Angeles VA Medical Center….**Read More**