CALLING UNCLE SAM AND ALEXA

Federal programs that include Medicare and Medicaid, along with technology developments in the private sector such as Alexa are two sets of forces that represent enormous influences on the health care domain. Apart from furnishing health services and paying for them, parallel activities by other government entities play essential roles in generating innovations (e.g., National Institutes of Health) and ensuring safety of new health products (e.g., Food and Drug Administration).

The Medicare Board of Trustees reported on June 5, 2018 that in 2017, Medicare covered 58.4 million individuals, 49.5 million aged 65 and older, and 8.9 million who are disabled. Total expenditures in 2017 were $710.2 billion and total income was $705.1 billion. Medicare is the nation’s public health insurance program for individuals with low income. It covers more than 70 million Americans, including many with complex and costly needs for care. The program accounts for one in six dollars spent on health care in the United States and more than half of all spending for long-term services and supports. Plus, it drives state budgets and is the largest source of federal revenues to states.

Amazon Echo and Dot devices are improving patients’ lives by enabling those who are bedridden and unable to reach a wall thermostat to regulate room temperature. When issuing commands to a device, the software can be rearranged to accommodate whatever words a patient is capable of using to perform various household tasks and set medication reminders. An Alexa app called Marvee can translate voice snippets into text messages and deliver them to pre-specified contacts. Meanwhile, Amazon has filed a patent for the Alexa voice assistant to recognize coughs or colds. That firm also has been exploring options that would allow it to mine medical records to diagnose patients and it has been exploring the possibilities of testing patients for disease at home.

Technology developments impinge on the government both directly and indirectly. For example, the Apple Watch can generate data as a consumer health tracker. The company touts the ability of this device to detect atrial fibrillation, although evidence is gathering that it does so less accurately for users below the age of 55. Efforts currently are underway to determine if private Medicare plans are interested in subsidizing the watch for beneficiaries.

As devices of this nature collect consumer and patient health information, concerns are raised about how adequately current policies protect privacy. Congress could play a useful role by clarifying the amount of authority and ownership patients have over their own records, and the extent to which patient information can be held by a health system. Steady advances in germline gene editing and artificial intelligence also call into question whether existing policies suffice to ensure that patients are protected from possible harm. A congressional in-house think tank, the Office of Technology Assessment (OTA), was disbanded in 1995. As legislators increasingly are called upon to deal with technology issues, restoring the OTA may be warranted as a means of assisting them to perform satisfactorily.
In my message in the November 2017 issue, I indicated that I will be asking some of you to send a photo and answer a series of “fun” questions to be shared with our membership so that we can continue our collegiality through our newsletter. The 9th of many profiles and the first in 2019 is presented as follows:

**Name and Title:** Brooke Hallowell, Dean of Health Sciences and Rehabilitation Studies

**University:** Springfield College

**How long have you been in your position?** 1 year

**If I could teach in another field, which one and why?** Counseling/coaching/hypnotism. To be at the heart of empowering people to be their best, authentic selves, thus enhancing their roles as vehicles of service to others.

**Before I retire I want to:** Start doing a lot of the things I dream of doing after I retire.

**In college, I was known for:** Being president of our university orchestra.

**What music is playing in my car/office?** Francis Cabrel

**My favorite trip was:** In southern India, with my daughter

**If I could travel anywhere it would be:** Fiji

**The best advice I ever received was:** Put on your own oxygen mask before assisting others.

**My hobby is:** Improv acting, arm wrestling, sculpting, collaborative storytelling

**My passion is:** Hanging out with older people and babies.

**Beach or mountains?** Both! Why choose?

**Only my friends know I:** Am a certified heavy equipment operator and an arm-wrestling pro.

**My favorite saying is:** Choose the joy!
**FEDERAL BUDGET AND THE OPERA**

An inability to reach agreement on federal budget priorities resulted in a partial government shutdown to mark the start of the year 2019. The current shutdown occurred because of an inability to reach agreement on how much should be spent and for what purposes to increase security measures along the nation’s southern border with Mexico. This 21st stoppage in the past 43 years conjures up thoughts about how efforts to produce a budget each fiscal year can assume qualities of an operatic nature. As an illustration, divas and divos from both major political parties are accustomed each year to performing dramatic roles involving the equivalent of singing enthusiastic arias that reflect their distress at pet projects being denied adequate funding.

History shines some light on the nature of the basic problem. Only on four occasions since 1977 has Congress been able to pass all 12 appropriations bills on time before a new fiscal year begins on October 1. Another 16 years have been characterized by an inability to pass a single bill on time. The usual remedy is to enact short-term continuing resolutions (CRs) to enable the government to continue operating, but as the present situation exemplifies, even that approach has not been possible on 21 different occasions.

It also is worth acknowledging that squabbles over the federal budget are restricted to only one-fourth of total spending. Referred to as discretionary expenditures, amounts have to be debated and agreed upon for purposes, such as aid to education, the military, National Institutes of Health, and the provision of agricultural subsidies. The remaining three-fourths of the budget essentially is on automatic pilot where spending is allocated among major entitlement programs, including Social Security and Medicare. Once individuals qualify to become recipients, their benefits must be paid as regularly as clockwork. Given the steady numerical and proportional growth in the segment of the population age 65 and older, the provision of adequate support for such programs will continue to pose significant future challenges.

Apart from funding, individual members of Congress either singly or in combination will introduce a large number of bills in 2019. Committees and subcommittees will conduct hearings and also carry out oversight activities of the executive branch. The educational community has been waiting patiently since 2013 for reauthorization of the Higher Education Act (HEA). This major piece of legislation that became law in 1965 last was reauthorized in 2008. Whether agreement can be reached on producing a reauthorization this year remains to be seen.

Both chambers are off to a quick start proposing other legislative action. **Senate:** S.3—stabilize the individual insurance market, make insurance coverage more affordable, lower prescription drug prices, and improve Medicaid. **S.12**—improve access to health care through expanded health savings accounts. **House:** **H.R. 64**—intensify stem cell research showing evidence of substantial clinical benefit to patients, and for other purposes. **H.R. 83**—repeal the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010.

Now that Democrats are the majority in the House of Representatives, considerable interest is being expressed in moving toward a single payer system. Expanding Medicare eligibility to a wider segment of the U.S. population would be a step in that direction.

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**2019-2020 ASSOCIATION CALENDAR OF EVENTS**

**February 2019**—Institutional Profile Survey To Be Conducted

**October 16-18, 2019** —ASAHP Annual Conference in Charleston, SC

**October 26-30, 2020** —ASAHP Annual Conference in Long Beach, CA
HEALTH REFORM DEVELOPMENTS

It does not amount to the least bit of hyperbole to suggest that a great many pieces of legislation that are enacted into law might conveniently be subtitled: *The Attorneys, Accountants, and Lobbyists Relief Act* (fill in the year of enactment). The Patient Protection and Affordable Care Act of 2010 (commonly referred to as either the ACA or Obamacare) fits this description perfectly. To cite just one example, in February last year, 20 attorneys general filed a lawsuit claiming that the 2017 Tax Cut law and the Jobs Act’s reduction of the individual responsibility tax penalty to zero, in effect made the ACA’s individual mandate unconstitutional. Proceeding from that line of reasoning, it means that the entire ACA was invalid because of the disappearance of the tax penalty. In December of 2017, a federal court judge in Texas agreed with this argument, entering a judgment that if it is upheld, the entire ACA would become invalidated. What comes as no surprise is that supporters of the Affordable Care Act have mounted their opposition to this ruling. Democratic attorneys general in 17 states have intervened to defend the entirety of the health reform law.

Apart from this specific example, it is worth noting that once it became apparent that Republicans in Congress in 2017 were unable to repeal and replace the ACA, since then the Trump Administration has used its powers to issue several regulations and guiding principles aimed at crippling the law. Opponents have responded by unleashing countersuits to prevent or delay these administrative actions. Thus, it is safe to assume that the future appears to remain quite bright when it comes to the financial health of many law firms and advocacy groups since additional litigation already can be detected hovering on the near horizon.

**Administration Initiative To Create Association Health Plans Faces Challenges**

One Trump Administration regulatory initiative is aimed at creating Association Health Plans that do not have to comply with either ACA individual or small-group requirements. In June 2018, the Labor Department finalized a rule to expand the ability of employers, including sole proprietors without common law employees, to join together and offer health coverage through Association Health Plans. These short-term limited duration vehicles can be in effect for one year and also be subject to renewal for as many as 36 months while continuing to be exempt from the Affordable Care Act’s consumer protections. Opponents have reacted in New York and other states by bringing a lawsuit to challenge the health plan rule on the basis that it violates the ACA, the Employee Retirement Income Security Act (ERISA) of 1974 that regulates group health plans, and the Administrative Procedures Act. Oral arguments in federal district court for the District of Columbia were scheduled to begin in January 2019.

**Transgender Protections And Religious/Moral Objections To Contraception Coverage**

Increased attention is being paid by policymakers to the issue of whether the health care needs of transgender individuals are being addressed satisfactorily. One concern is whether current regulations provide adequate protection from discrimination against transgender patients by insurance companies and health care providers. Federal courts have weighed in on this matter in the past and can be expected to continue doing so in the future. Mandated benefits under the ACA sometimes trigger opposition for moral and religious reasons. Contraception coverage offers an example whenever religious groups are compelled to provide this benefit because doing so may conflict with core spiritual beliefs.

**Pursuing The Realization Of Health Care Priorities In Congress**

Major differences exist between Democrats and Republicans in Congress, and despite that each party enjoys a majority in only one chamber, it still may be possible to achieve bipartisan agreement on certain issues that could be enacted into law. An example is lowering the cost of prescription drugs. President Trump also has signaled his desire to see constructive action taken in that regard. Recent years have involved a series of proposed buy-outs and mergers among drug companies, insurance firms, and health care providers. Through its oversight powers, committees in Congress may be able to work in an effective bipartisan way to determine if such transactions have the potential either to weaken competition or have a negative impact on health care consumers and taxpayers. Fixing a maldistribution of health resources in the form of an insufficient supply of clinicians and health care facilities in rural areas is a chronic problem that also should be of interest to legislators from both political parties.
DEVELOPMENTS IN HIGHER EDUCATION

Similar to legislative and regulatory initiatives pertaining to health reform that are described on the previous page of this newsletter, higher education also is affected by events that occur in those two arenas. A most important piece of legislation in need of concerted action is reauthorization of the Higher Education Act. Last reauthorized in 2008, since 2013 it has been sustained by a series of short-term continuing resolutions (CRs). Whether this important task will be completed in 2019 is uncertain.

One way of assessing what may unfold involving higher education is to chart the activities of key officials when they appear in public to make presentations. Secretary of Education Betsy De Vos on December 19, 2018 met with leaders of the American Council of Education (ACE) at that organization’s headquarters to discuss higher education policy. She used accreditation as an example of how to approach the current educational system. She requested her listeners to rethink which parts of the Department’s accreditation regulations and guidance are related directly to educational quality and student experience, and which parts are ambiguous, repetitious, or unnecessarily burdensome. She also asked how the Department could clarify the roles and responsibilities of each entity within the higher education “triad,” consisting of the federal government (which has a focus on administrative and fiscal integrity of student financial aid programs), state governments (which issue licenses to academic institutions), and accreditation organizations (which assure acceptable levels of quality in teaching and learning).

Rethinking Higher Education
As part of her remarks, the Secretary released the document “Rethinking Higher Education,” which identifies the following goals:

- It is time to challenge our past practices, assumptions, and expectations about what “college” is, what it should be, and how it should operate.
- It is time to restore institutional autonomy and respect for an institution’s unique mission.
- It is time to value the unique goals and challenges that each student brings to the postsecondary experience.
- It is time to include in our assessment of institutions the contributions that each school makes to help its students’ success.
- It is time to streamline regulations so as to avoid government intrusion.
- It is time to promote innovation.
- It is time to allow new entrants to educational delivery and reject efforts to maintain the status quo.

Rethinking Higher Education: Accreditation
A second document also was released that outlines some of the following goals:

- Restore “substantial compliance” as the standard for recognition.
- Restore the regulatory triad by more clearly defining the roles and responsibilities of accreditors, the states, and the Department in oversight of Title IV participating institutions of higher education.
- Increase academic and career mobility for students by eliminating artificial boundaries between institutions due to credential levels an institution offers or the agency that accredits the institution or its programs.
- Provide greater flexibility for institutions to engage in innovative educational practices and meet local and national workforce needs.
- Within the confines of law, protect institutional autonomy, honor individual campus missions, and afford schools the opportunity to build campus communities based on shared values.
- Reward institutional value-added, not student selectivity.
- Modify “substantive change” requirements to provide greater flexibility to institutions to innovate and respond to the needs of students and employers.
- Streamline and clarify the Department’s accreditor recognition process.
- Encourage and enable accreditors to support innovative practices, grant limited accreditation to experimental pedagogies, provide support to accreditors when they take adverse actions, and allow sanctions that do not mandate “all or nothing” access to Title IV.
**QUICK STAT (SHORT, TIMELY, AND TOPICAL)**

**Lower Wages And Benefits Of Female Health Care Workers**
According to a report appearing in the January 2019 issue of the *American Journal of Public Health*, a study carried out by researchers at Massachusetts General Hospital (MGH) and the Perelman School of Medicine at the University of Pennsylvania finds that low wages and poor benefits leave many female health care workers living below the poverty line. Projecting the survey's results across the entire U.S. population suggests that 5% of all women health care workers, including 10.6% of Black and 8.6% of Latina women health care workers, live in poverty. Overall, 1.7 million women health care workers and their children lived below the poverty line in 2017, accounting for nearly 5% of all individuals living in poverty in the U.S. The researchers also found surprisingly high numbers of female health care workers surveyed lack health insurance. Overall, 7%, projected to represent more than 1 million women nationwide, were uninsured, including more than 10% of Black and Latina women employed in health care.

**Physical Therapy In Relation To Opioid Usage**
According to a study by researchers at the Stanford University School of Medicine and the Duke University School of Medicine published on December 14, 2018 in *JAMA Network Open* that was based on an analysis of private health insurance claims for care and prescriptions between 2007 and 2015, patients who underwent physical therapy soon after being diagnosed with pain in the shoulder, low back, or knee were approximately 7 to 16% less likely to use opioids in subsequent months. For patients with shoulder, back, or knee pain who did use opioids, early physical therapy was associated with a 5 to 10% reduction in how much of the drug they used, the study found. Amid national concern about the overuse of opioids and encouragement from the Centers for Disease Control and Prevention, and other groups to deploy alternatives when possible, the findings provide evidence that physical therapy can be a useful, nonpharmacologic approach for managing severe musculoskeletal pain.

**HEALTH TECHNOLOGY CORNER**

**Robotic Activity Support System For Elderly Patients With Dementia**
A robot created by Washington State University (WSU) scientists could help elderly patients with dementia and other limitations to live independently in their own homes by performing basic and instrumental activities of daily living (ADLs). The *Robot Activity Support System*, or RAS, represents a collaboration between a smart home and a mobile robot. It functions by using sensors embedded in a WSU smart home to determine where its residents are, what they are doing, and when they need assistance with daily activities. RAS combines the convenience of a mobile robot with the activity detection technology of a WSU smart home to provide assistance in the moment, as the need for help is detected. A description of the project appears in advance in the May 2019 issue of the journal *Cognitive Systems Research*. Technologies that automatically assist with activity of daily living may relieve some of the strain on the health care system as well as caregivers, allowing individuals to remain functionally independent and age in place.

**Research On Roundworms May Lead To Motor Function Improvement In Humans**
As animals and humans age, motor functions progressively deteriorate. Millimeter-long roundworms called nematodes exhibit aging patterns remarkably similar to those of other animals and they live only about three weeks, making them an ideal model system for studying aging. A report on January 2, 2019 indicated that research from the University of Michigan Life Sciences Institute has uncovered a cause of declining motor function and increased frailty in tiny aging worms and a way to slow it down. The findings, published that day in *Science Advances*, identify a molecule that can be targeted to improve motor function and indicate that similar pathways may be at play in aging mammals as well. Age-dependent motor activity decline is a prominent feature of normal aging. Motor deficits represent one of the main risk factors for falling in elderly humans, which leads to injury and mortality. It would be beneficial to delay or slow motor aging to improve the quality of life and, ideally, to extend a life span, which has remained a challenge. Using *C. elegans* as a model, targeting aging motor neurons can slow motor aging and promote longevity.
AVAILABLE RESOURCES ACCESSIBLE ELECTRONICALLY

Faculty Attitudes On Academic Technology

Inside Higher Ed’s 7th annual Survey of Faculty Attitudes on Technology aims to understand how professors and digital learning leaders view online learning and other aspects of academic technology. A new report presents findings from a quantitative survey research study that Gallup conducted on behalf of Inside Higher Ed. Some findings are: The proportion of faculty members who have taught online courses continues to increase. Currently, 44% report having taught an online course, up from 30% in 2013. Meanwhile, 38% have taught a hybrid or blended course that has elements of face-to-face and online teaching. The vast majority of instructors who have taught online courses, 89%, say they have been involved in the design of those courses. More than 7 in 10 faculty members who have taught online courses say the experience has taught them skills that have improved their teaching. Most commonly, they say their online teaching has caused them to think more critically about how to engage students with course content and to make better use of multimedia content. The report can be obtained at https://www.pearson.com/us/content/dam/onedot-com/one-dot-com/us/en/files/IHE_2018_Survey_Faculty_Technology.pdf?utm_medium=email&utm_source=TOP_eNews_Dec2018_VersionA&utm_campaign=7010N000000CrZw&cmpid=7010N000000CrZw.

State Strategies For Establishing Connections To Health Care for Justice-Involved Populations: The Central Role Of Medicaid

Prior to the Affordable Care Act, most individuals leaving prison or jail weren't eligible for Medicaid, since coverage generally wasn't available to childless adults. With Medicaid expansion taking hold in more states, health coverage is becoming more available for those upon release from incarceration facilities. With coverage as a foundation, states are seeking to address the complex health and social issues many of these individuals face, including opioid addiction, mental illness, and barriers to stable housing and employment. In a new Commonwealth Fund report, experts with Manatt Health explore the latest developments in comprehensive primary care for adults leaving jail or prison and the role Medicaid can play in financing and supporting the most effective practices. In a number of states, "in-reach" services are helping inmates establish relationships with providers prior to release, identifying health conditions, and setting up community-based care. The report can be obtained at https://www.commonwealthfund.org/publications/issue-briefs/2019/jan/state-strategies-health-care-justice-involved-role-medicaid?omnicid=EALERT1543844&mid=thomas@asahp.org.

Public Health Trends Plaguing The U.S. Population

The United Health Foundation released its annual population health report, documenting a number of concerning public health trends that have continued to plague the U.S. population. The rate of obesity in the U.S. increased by 5% from 2017 to 2018, which equates to one in three Americans being affected by the disease. The increasing prevalence of obesity coincides with a greater number of deaths due to cardiovascular disease (112,403) and other chronic diseases. Mental and behavioral health issues also have been on the rise, as feelings of mental distress were self-reported 7% more often than in 2016. Rising behavioral health issues are exacerbated by the barrier of access to care. Currently, 124 million Americans live in areas where there are shortages of formal mental health care. The report notes various other disparities in health that can be attributed to social determinants of health. It can be obtained at https://www.americashealthrankings.org/learn/reports/2018-annual-report?utm_campaign=General%20Newsletter&utm_source=hs_email&utm_medium=email&utm_content=68564533&hsenc=p2ANqtz-9StZV5xWFE2DVv5gIWWV2S3a-GOhDSg6KuXmO9usPhc3HbboYowuDJxeyepe4n14A4GBK54abH9fP1ZaUVnFTa_6hhQ&hsmi=68564533.
DETECTING BS IN HEALTH CARE

Given its noticeable abundance, it is likely that even individuals who are barely sensate realize that quite a bit of BS exists in this world, even in health care. Fortunately, Lawton Burns and Mark Pauly from the Department of Health Care Management at The Wharton School University of Pennsylvania have arrived on the scene with a timely remedy in the form of a detection tool to offset a variety of preposterous claims that clutter up the landscape. Their position is buttressed by a belief that in the past several months, they have observed several notable signs of deceptive, misleading, unsubstantiated, and foolish statements that they call “BS” in the health care industry (e.g., fraudulently marketed products, ridiculous assertions of ways to reduce health care costs by huge percentages, and purported wonders that are supposed to occur as a result of business mergers).

A starting point is to ask the question, why does this kind of behavior occur? While flat-out dishonesty for short term financial gains is an obvious answer, a more common explanation is the need to say something positive when there is nothing positive to say. The two researchers present their Top 10 BS candidates, in both pictures and words. Each picture is presented untitled and without text, thereby inviting readers to discern what the BS message is and engage them in the BS detection process. Then, they offer an explanation of what the picture conveys, which aims at helping readers to become more skilled “BS Hunters.” They also note that they reserve the option to expound further since there is a likelihood of the danger of wading into even more BS in the future. (https://ldi.upenn.edu/sites/default/files/pdf/LDI%20Detecting%20BS%20in%20Healthcare_7.pdf)

PHYSICAL THERAPY AND OCCUPATIONAL THERAPY GUIDELINES

Page four of this newsletter provides information about health reform from the perspective of legislation and regulations that follow the enactment of laws. Since many policy guidelines also are formulated to improve health care by clarifying legislative intent, they may be considered useful aspects of health reform. As described in a manuscript published in the January 2019 issue of the journal Archives of Physical Medicine and Rehabilitation, the objective of a study was to determine if there was a change in the number of outpatient physical therapy (PT) and occupational therapy (OT) visits for Medicare beneficiaries, and in the number of beneficiaries receiving extended courses of >12 therapy visits, after the Jimmo vs Sebelius settlement.

Medicare Part-B helps to cover outpatient physician, PT, OT, speech therapy, and home health services. Policy is designed to cover rehabilitation services that require the skill of a PT or OT to restore function, or when no improvement is expected, to slow deterioration and maintain current levels of functioning. Beneficiaries are able to receive outpatient OT and PT services until a monetary threshold, or cap is reached. If the cap is met, and treatment is medically necessary to further improvement or to prevent a worsening of function, Medicare guidelines state that reimbursement of care can continue. Historically, however, this process was not always followed.

Coverage determination is delegated to Medicare administrative contractors (MACs) who make local decisions to ensure that therapy is medically necessary. Policy manuals developed to help interpret regulations became more restrictive and in some cases contradicted federal regulations. Beneficiaries were being denied access to and payment for therapy if their chronic conditions precluded improvement. Regional local coverage decision manuals for outpatient PT incorrectly noted that coverage depended on the “expectation that the patient’s condition will improve significantly in a reasonable and generally predictable period of time.” If there was no expectation that the condition would improve and there was no measurable change in function, MACs would deny coverage.

After the Jimmo settlement was reached, Part B Medicare beneficiaries were likely to receive about one additional therapy visit per year. An estimate is that at a minimum, the settlement will increase utilization by about 12 million visits per year. Patient therapies help minimize functional decline, avoidable hospitalizations and nursing home admissions, which may result in lower costs.