Sustainability and Viability of Long-Term Care Report

Executive Office of Health and Human Services

July 2025

DRAFT & CONFIDENTIAL; FOR POLICY DEVELOPMENT PURPOSES ONLY

Legislative Language, Section 31 of Chapter 197 of the acts of 2024

- Review the viability and sustainability of long-term care facilities in the commonwealth. Report due **July 31, 2025.**

In making recommendations, the task force shall consider issues including, but not limited to:

- (i) the demand for long-term care facilities over the next 5 and 10 years and the ability to meet that demand in a cost-effective manner;
- (ii) the geographic accessibility of such facilities;
- (iii) staffing challenges and workforce initiatives to support such facilities including, but not limited to, childcare;
- (iv) the utilization of pharmacists and other health care providers in long-term care;
- (v) any policy reforms to strengthen long-term care in the commonwealth including, but not limited to, maintaining quality of care;
- (vi) the adequacy of payor rates;
- (vii) costs and impacts of financing for facility construction and maintenance including, but not limited to, private equity and real estate investment trusts;
- (viii) costs associated with transportation options to and from facilities for individuals

Importance of the Commonwealth's Community First Policy

Massachusetts has a strong history of providing a robust set of home and community-based services aimed at rebalancing services away from nursing facilities and toward community settings. The task force members all agreed that the Commonwealth must ensure access to community-based services so that older adults and individuals with disabilities and mental illness are served in the most appropriate and least restrictive settings.

This task force was charged with reviewing the viability and sustainability of long-term care facilities, its recommendations do not negate or reduce the importance of ensuring access to long term services and supports in the community, including, but not limited to, personal care, home health, day programs and Home and Community Based Waivers. Availability of and access to community-based services have a direct impact on the demand for facility based care. The Commonwealth's continued commitment to community supports is critical to ensuring that available long-term care beds can meet demand, given the current infrastructure. *(see demand model on pages 7 and 8).*

The task force expressed concern over the heavy reliance on MassHealth to fund long term care and agreed that there is a need for additional long term care financing options. The group acknowledged the Long Term Services and Supports Feasibility Study conducted by Milliman but did not opine on the merits of the various proposals discussed in the study.

Consensus recommendations:

As part of its deliberations, the Task Force reviewed and discussed the recommendations and work completed thus far by various other task forces established in the LTC bill, including, the Rest Home Task Force, the Assisted Living Residence Commission, and the Transitions from Acute Care to Post Acute Care Task Force. In making its recommendations, the Task Force avoided duplicating work that had already been done.

Rates

Ensuring funds are appropriated to support adequate rates is the most important issue for the legislature to focus on to ensure quality care and avoid further skilled nursing facility and rest home closures. A long-term care facility's ability to invest in quality resident care and staff is directly tied to adequate funding.

The Commonwealth has made significant investments in both skilled nursing facilities and rest homes in the past several years. The Commonwealth has a significant amount of data that it can rely upon to determine the adequacy of rates based upon the level of care being provided in a specific setting. The Commonwealth should utilize this rich data set to conduct a review of the adequacy of rates. The legislature could direct EOHHS or CHIA to conduct this analysis, in consultation with independent researchers and stakeholders.

a) The Commonwealth should review its skilled nursing facility and rest home rate setting methodology to ensure that it is rewarding and incentivizing quality improvement, efficient placement of complex members, and other important policy goals.

b) As statutorily required, the Commonwealth should fully fund the base year update requiring the Commonwealth to pay nursing facilities based on allowable costs no more than 2 years from the rate year.

Quality

The Commonwealth should drive sustained improvements in long-term care quality by actively collaborating on and implementing evidence-based quality improvement initiatives focused on areas such as, but not limited to, reducing avoidable hospital admissions, safe care transitions, reducing antipsychotic medication use, implementing falls prevention strategies, and advancing person-centered care strategies that enhance resident outcomes, elevate care experiences, and strengthen staff engagement and satisfaction.

Consensus recommendations:

Access to Capital

The Commonwealth has an aging long-term care infrastructure. The Commonwealth must be careful to ensure existing facilities are able to invest in that infrastructure to continue to provide adequate care. *See demand model on pages 7 and 8*. Skilled nursing facilities and rest homes report lack of access to capital funding in the market for critical maintenance and large capital investments, to address things such as roof replacement, window replacement, heating and air conditioning, on this aging infrastructure. Facilities need access to capital to plan for capital needs and to avoid emergency repairs, current rates do not allow for adequate capital reserves. Incentives in the rate-setting method and staffing regulations encourage facilities to prioritize staffing and defer maintenance, given available resources. Numerous nursing facilities and rest homes have closed over the past several years due to deferred maintenance issues.

a) The Commonwealth should implement policies to increase private and public access to capital funding for long term care facilities to support planning for ongoing maintenance and large capital investments. This could be through grant programs or through zero interest or low interest loans.

Consensus recommendations, continued:

Workforce

Frontline caregivers are the backbone of the state's long-term care facilities, providing vital care and companionship to our residents. Long-term care facilities continue to uniformly identify staffing as one of their biggest challenges, especially considering recent federal immigration policies. Many Massachusetts nursing facilities today are not able to staff to their licensed bed capacity. Nursing facilities today urgently need to hire over 5,000 direct care workers to meet the growing demand for nursing facility care, and this may increase if there is further workforce loss. Massachusetts rest homes also struggle with recruitment and retention and compete directly with nursing facilities for staff.

a) The Commonwealth should invest in Medicaid rates for nursing facilities and DTA rates for rest homes to allow facilities to pay a more competitive wage for frontline staff, 90% of whom are women and more than 50% of whom are people of color. The Commonwealth should fund the LTC Workforce and Capital fund established in chapter 197 of the Acts of 2024 to:
   - Fund nursing career ladder advancement through non licensed and licensed nursing roles including resident care assistant, certified nursing assistant, certified medication aide, licensed practical nurse and registered nurse.
   - Implement supervisory and leadership training programs to improve accountability, employee retention and quality of care.

b) Staffing is important to providing high quality care. The Commonwealth should consider how it can financially support and incentivize facilities to reduce reliance on overtime and reduce use of temporary nursing staff.

c) As the Commonwealth works to address childcare, transportation, and housing issues, LTC direct care workers need to be a focus in these broader conversations. These barriers contribute to the significant workforce challenges in the LTC industry.

i. Demand for long term care beds over the next 5 and 10 years and the ability to meet that demand in a cost-effective manner

Summary of data reviewed in producing recommendations

- The task force reviewed the UMass Donahue Institute demographic projections as well as a demand model for skilled nursing facility (SNF) beds.
  - The task force was interested in reviewing a demand model for rest home beds but was unable to do so given that occupancy data is not available for rest homes

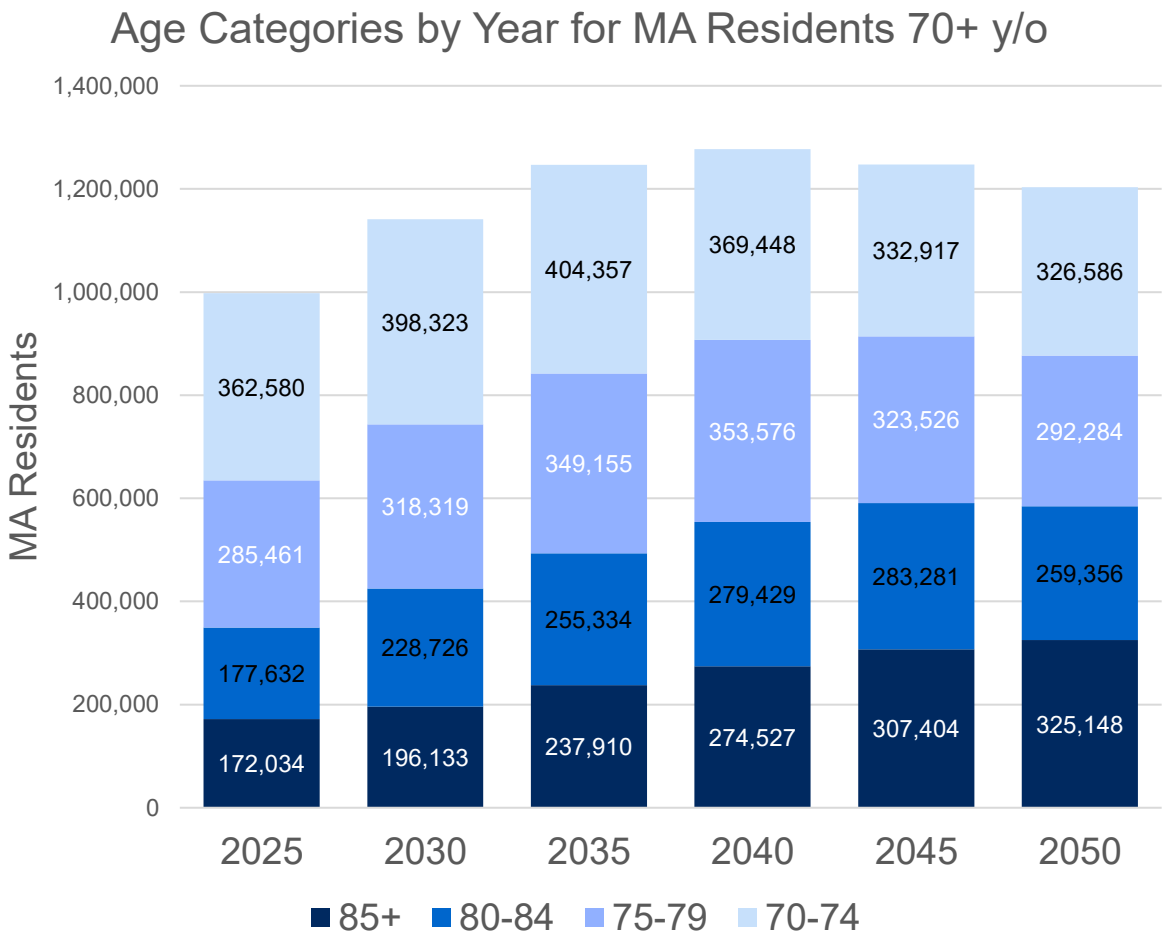
- While the demand model based on actual licensed beds demonstrated that EOHHS estimates that there will be sufficient overall statewide SNF capacity until 2034, there was extensive discussion about drivers that would cause a bed shortage to occur earlier or later than 2034.

  - Staffing challenges resulting from new immigration or other policies, as well as an overall decline in eligible caregivers (e.g., available family members or paid caregivers) in the next decade and beyond, could significantly reduce the availability of beds forcing a bed shortage earlier.
  - Further skilled nursing facility (SNF) closures and full implementation of the state's dedensification regulations would cause a bed shortage to occur earlier.
  - Certain parts of the state could face a bed shortage earlier than other parts of the state. Resulting in consumer access challenges in certain regions of the state. For example, an open bed in the Berkshires does not address the need of a patient in Haverhill.
  - To maintain and balance acute to post acute flow and allow for isolation space for infectious illness, nursing facilities consistently maintain 3 to 5 empty beds, which is equal to a facility ideally operating at 95 to 97% occupancy and not 100%.
  - The Commonwealth’s continued and ongoing investment in Home and Community Based Supports and waiver programs could cause the bed shortage to occur later, if more individuals are able to remain in the Community.
  - Delivery care model shifts, such as a move towards SNF at home and increases in enrollment with Program for All -inclusive Care for the Elderly (PACE), could cause the bed shortage to occur later or not at all.
  - Delivery care model shifts in the way the Commonwealth cares for individuals, such as creating more flexibility in populations eligible for outpatient cardiac rehabilitation or expanding clinical competency in other residential settings like substance use disorder care could change the crossover point where supply falls short of assessed need.

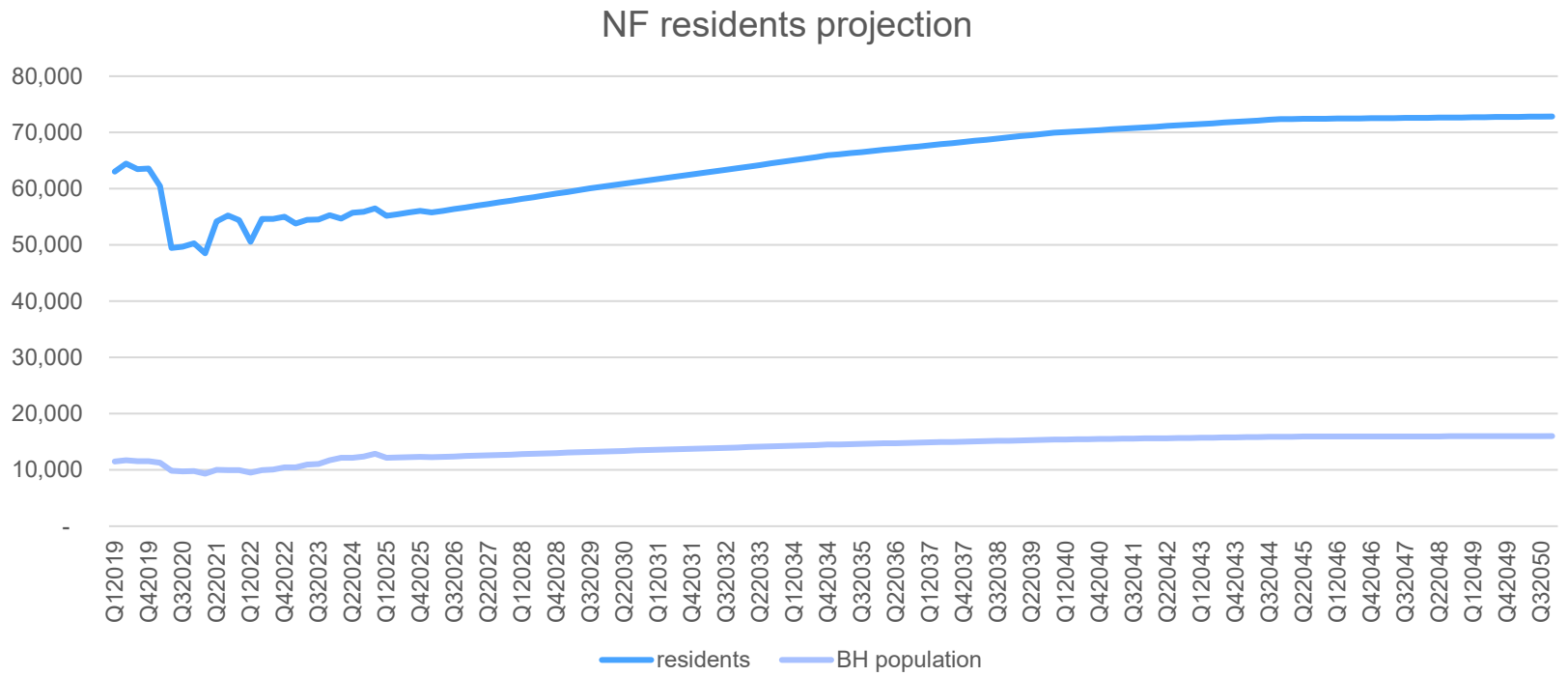
Population projections

- The UMass Donahue Institute projects that the state-wide population of MA residents age 70 years and above will increase by about 28% over the next 15 years, as Baby Boomers age.
- After 15 years, the 70+ population in MA will start to decline.
- The 85+ category shows significant growth, however, as this category is cumulative, the number of people may be overestimated.
- The typical nursing home resident is 80 years old

Age Group	2025	2030	2035	2040	2045	2050
70-74	362,580	398,323	404,357	369,448	332,917	326,586
75-79	285,461	318,319	349,155	353,576	323,526	292,284
80-84	177,632	228,726	255,334	279,429	283,281	259,356
85+	172,034	196,133	237,910	274,527	307,404	325,148



NF Residents Projection *(All residents)*



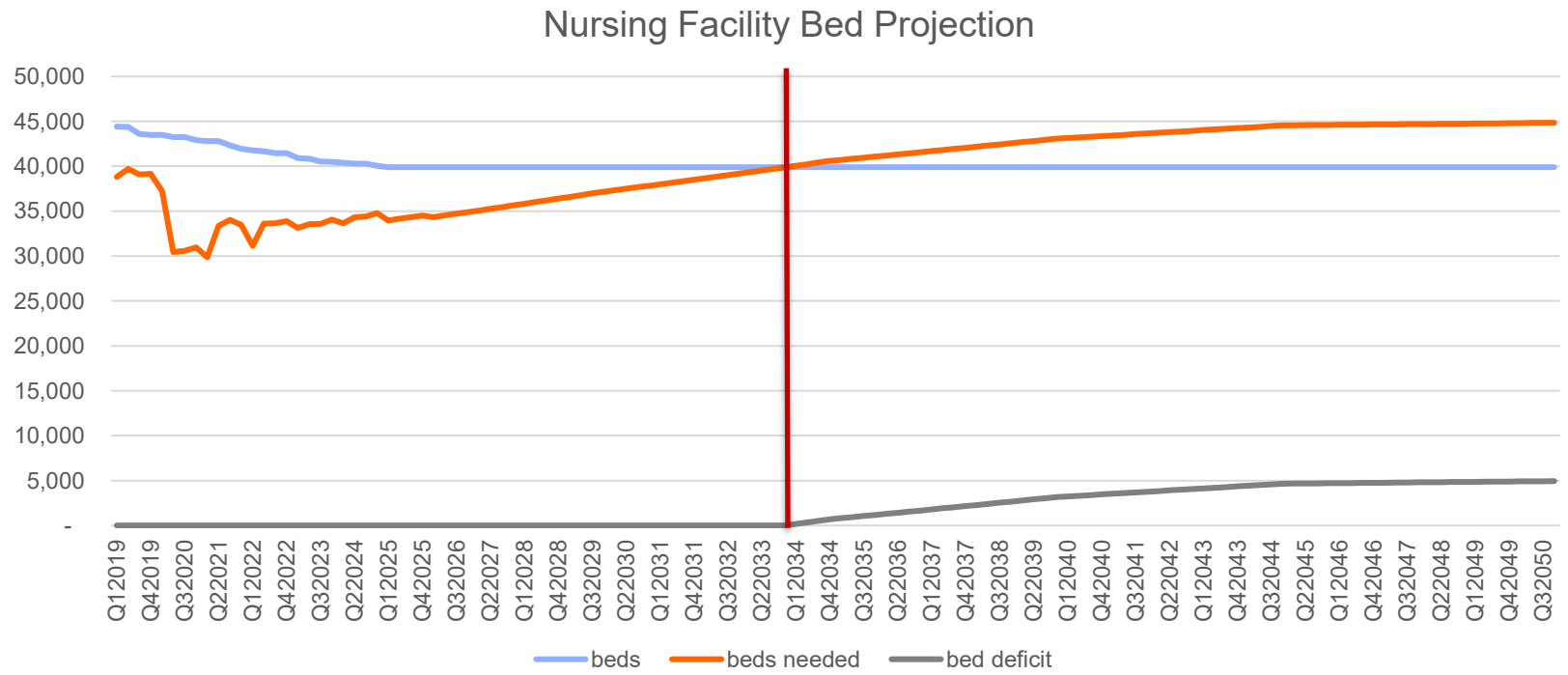
- Nursing Facilities served approximately 55k residents over the course of Q1 2025 – this includes long-stay (29k) and short-stay (26k) residents
- Using UMass Population projection data and assuming no other policy changes:
  - By 2030, NF are projected to serve 61k residents within a quarter
  - By 2035, NF are projected to serve 67k residents within a quarter
  - By 2050, NF are projected to serve 72k residents within a quarter

- The percent of NF population with BH needs is projected to remain flat – on average 22% of residents have BH needs. The commitments made by the Commonwealth as part of the Marster's settlement will support BH residents in the community.
- Over the next 10 years there will be an increase in the number of individuals in need of dementia care. The Massachusetts Alzheimer's Association has indicated that Alzheimer's prevalence will increase by 25% in Massachusetts over the next decade

Data Source: Umass Donahue Institute Population Estimates Project (https://donahue.umass.edu/business-groups/economic-public-policy-research/massachusetts-population-estimates-program/population-projections)

Nursing Facility Bed Projection

- As Q1 2025, Nursing Facilities had 39,899 staffed beds – model assumes no change to bed count
- On average, **a single NF bed will see approximately 1.6 residents** within a quarter due to turnover and short-stay residents
  - This is based on occupancy and residents per bed data
  - This does not account for any changes in the average duration of stay
- Given the NF population projections, EOHHS estimates that there will be sufficient capacity until 2034



Key Considerations:

This projection is based on assuming the following key considerations remain the same over time.

If they do change over time each could move the red line (indicating the bed availability crossover point) in either a positive or negative direction.

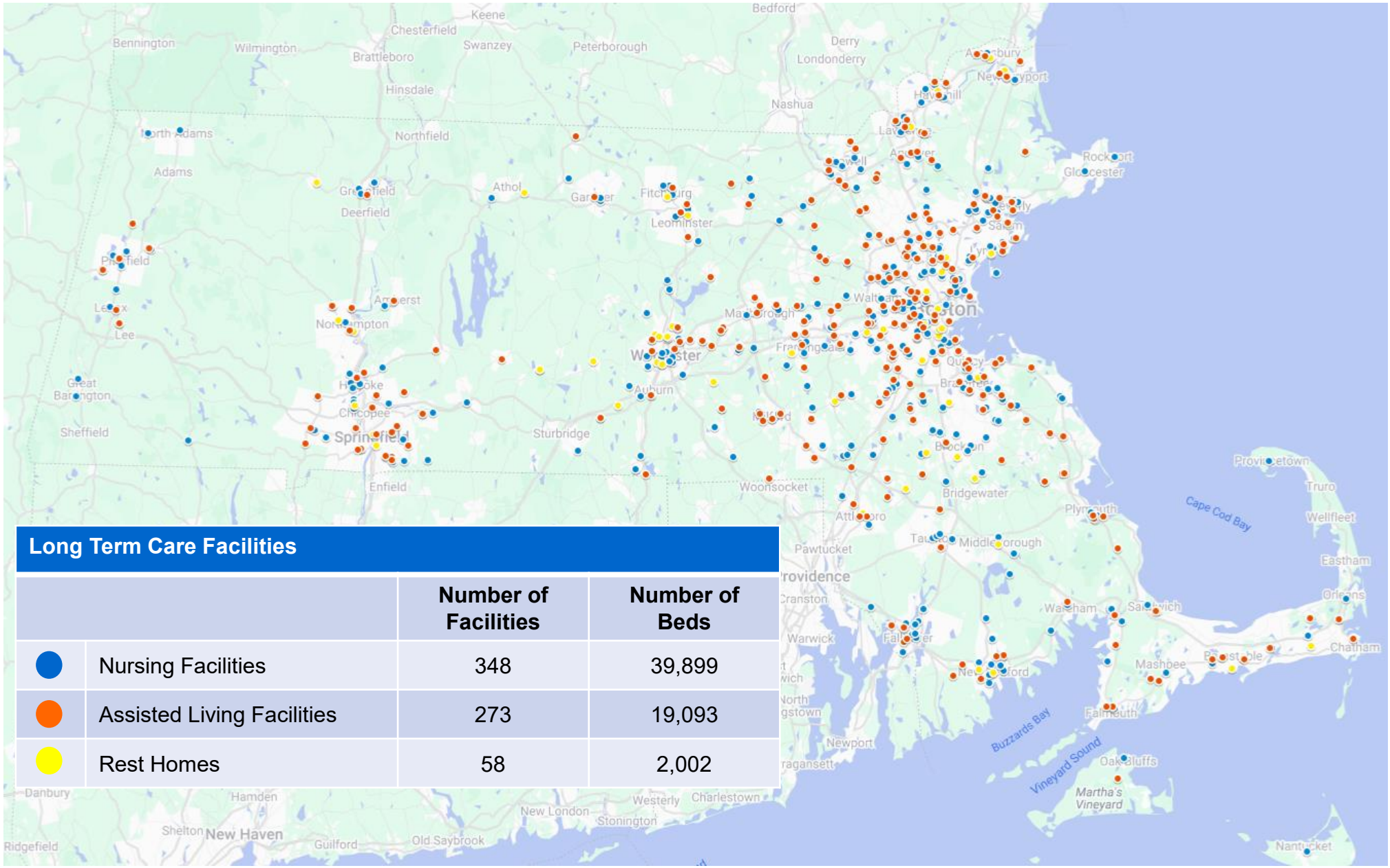
- Proportion of the state population utilizing nursing facility services
- Proportion of nursing facility residents that require increased staffing or capital supports (e.g., Behavioral Health or Alzheimer's populations)
- Number of available licensed beds, which is dependent on the number of nursing facility closures year over year, as well as implementation of dedensification
- Availability of clinical staffing workforce
- Geographic availability of beds, which could limit patient choice and result in full capacity in certain geographies sooner than others
- Structural need for empty beds for patient flow/churn, isolation rooms, or single rooms for certain patients (e.g BH acuity)

ii. Geographic accessibility of long-term care facilities

Summary of data reviewed in producing recommendations

- The task force reviewed bed availability data for skilled nursing facilities (SNF), assisted living facilities and rest homes.
- The task force reviewed SNF and rest home closure lists
- There was a significant discussion about staffed capacity versus licensed capacity in skilled nursing facilities data as well as regional variance in capacity.

Distribution of Nursing Facilities, Assisted Living Facility and Rest Homes



Long Term Care Facilities			
		Number of Facilities	Number of Beds
●	Nursing Facilities	348	39,899
●	Assisted Living Facilities	273	19,093
●	Rest Homes	58	2,002

Nursing Facility Beds & Occupancy

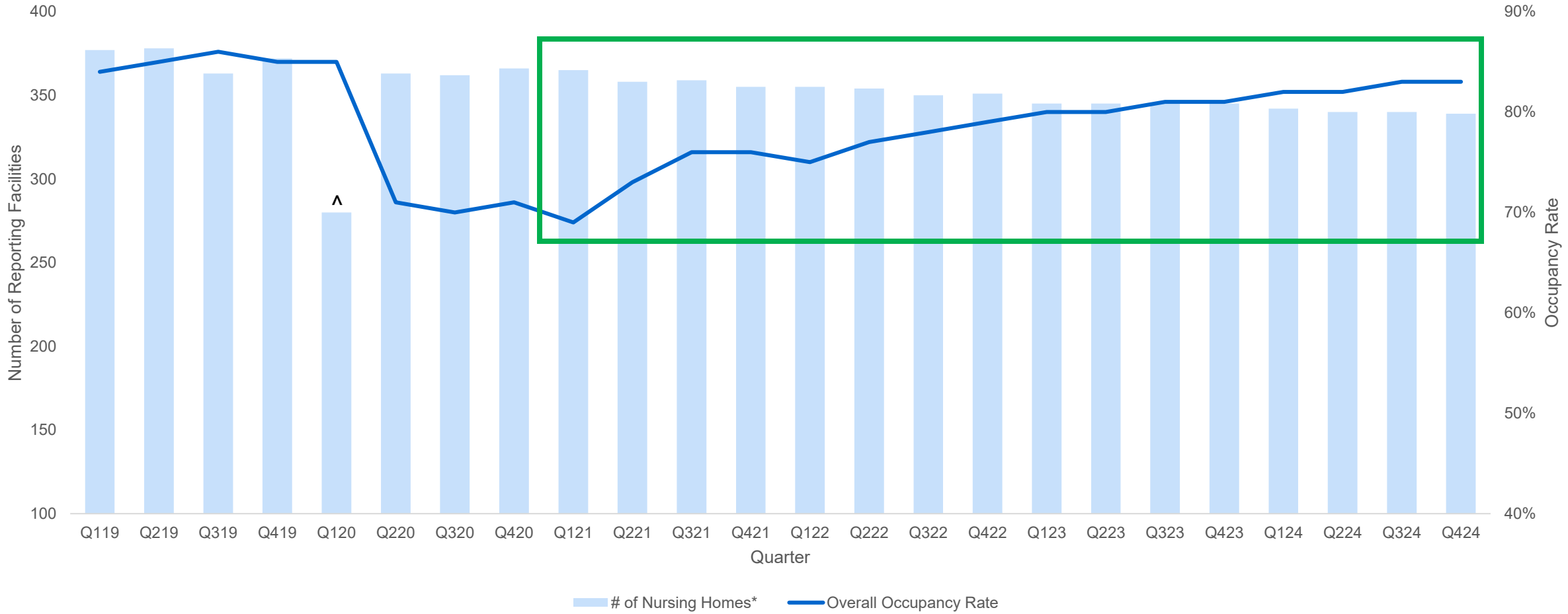
Nursing Facility Occupancy *(as of January 2025*)*				
	Total Number of Beds	**Total Number of Occupied Beds**	**Average Occupancy Percentage**	**Average Staffed Bed Occupancy Percentage**
All Facilities	*38,782*	*33,574*	*86.47%*	*88.28%*
By County:				
Barnstable	1,652	1,437	87.45%	89.89%
Berkshire	1,330	1,195	89.95%	91.41%
Bristol	3,631	3,087	84.52%	86.87%
Dukes	61	29	47.54%	90.63%
Essex	4,996	4,321	86.37%	88.20%
Franklin	306	261	85.03%	85.03%
Hampden	2,680	2,448	91.73%	91.61%
Hampshire	602	558	92.84%	92.84%
Middlesex	8,284	6,971	84.02%	85.39%
Nantucket	45	35	77.78%	77.78%
Norfolk	3,652	3,106	84.49%	87.32%
Plymouth	3,292	2,859	87.09%	88.51%
Suffolk	2,426	2,170	88.56%	93.54%
Worcester	5,825	5,097	87.92%	88.59%

*There has been documented seasonal variation in nursing home occupancy, where occupancy in the winter months is often higher than in the summer months.

- While the total number of licensed beds across all nursing facilities is 38,782, the total number of beds that are staffed is lower at ~38,000 beds
- This leads to a higher average occupancy of 88% of all available staffed beds

Count of nursing homes reporting to CMS's Payroll Based Journal and occupancy rate

The occupancy rate (83%) across CMS certified nursing homes has been increasing since the start of 2021 (69%) approaching to pre-covid level (84% in 2019)



^Required reporting paused during COVID-19

Nursing Facility Occupancy Data – by Sub-HSA

There are 6 HSAs, with community subareas totaling 26. Various cities and towns are part of each Sub-HSA. Median staffed occupancy on January 1, 2023, was 90.3%

Nursing Facility Sub-HSA Occupancy % for January 1, 2025 *(Licensed Beds)*

Sub-HSA Name	Sub-HSA	# of NFs	Total # of Beds	Total # of Occupied Beds	Average Occupancy %	Median Occupancy %
Pittsfield Sub Area	11	13	1,330	1,195	89.8%	94.3%
Northampton Sub Area	12	8	913	827	90.6%	91.0%
Springfield/Holyoke Sub Area	13	26	2,812	2,560	91.0%	92.0%
Fitchburg/Leominster Sub Area	21	12	1,342	1,229	91.6%	93.1%
Worcester Sub Area	22	21	2,564	2,241	87.4%	91.3%
Millbury/Webster Sub Area	23	15	1,751	1,488	85.0%	85.0%
Lowell Sub Area	31	13	1,524	1,333	87.5%	89.1%
Lawrence/Methuen Sub Area	32	10	1,191	994	83.5%	83.2%
Haverhill Sub Area	33	12	1,220	1,002	82.1%	85.9%
Boston Metro Sub Area	41	22	2,546	2,261	88.8%	89.9%
Cambridge/Lexington Sub Area	42	19	2,118	1,806	85.3%	88.0%
Waltham/Needham Sub Area	43	34	3,621	3,049	84.2%	89.1%
Norwood/Wrentham Sub Area	44	14	1,101	910	82.7%	84.1%
Quincy/Weymouth Sub Area	45	20	2,459	2,111	85.8%	86.3%
Attleboro Sub Area	51	3	353	301	85.3%	89.0%
Brockton Sub Area	52	11	1,325	1,173	88.5%	89.4%
Plymouth Sub Area	53	8	977	862	88.2%	90.4%
Taunton Sub Area	54	7	777	636	81.9%	78.7%
Fall River Sub Area	55	10	1,403	1,229	87.6%	86.9%
New Bedford Sub Area	56	11	1,380	1,152	83.5%	86.4%
Cape Cod Sub Area	57	19	1,862	1,597	85.8%	88.7%
Beverly/Gloucester Sub Area	61	6	766	679	88.6%	88.2%
Danvers/Salem Sub Area	62	14	1,441	1,298	90.1%	90.3%
Lynn Sub Area	63	5	378	348	92.1%	88.2%
Melrose/Wakefield Sub Area	64	8	810	632	78.0%	80.8%
Malden/Medford Sub Area	65	5	818	661	80.8%	79.5%
Total		346	**38,782**	**33,574**	86.6%	88.9%

Nursing Facility Sub-HSA Occupancy % for January 1, 2025 *(Staffed Beds)*

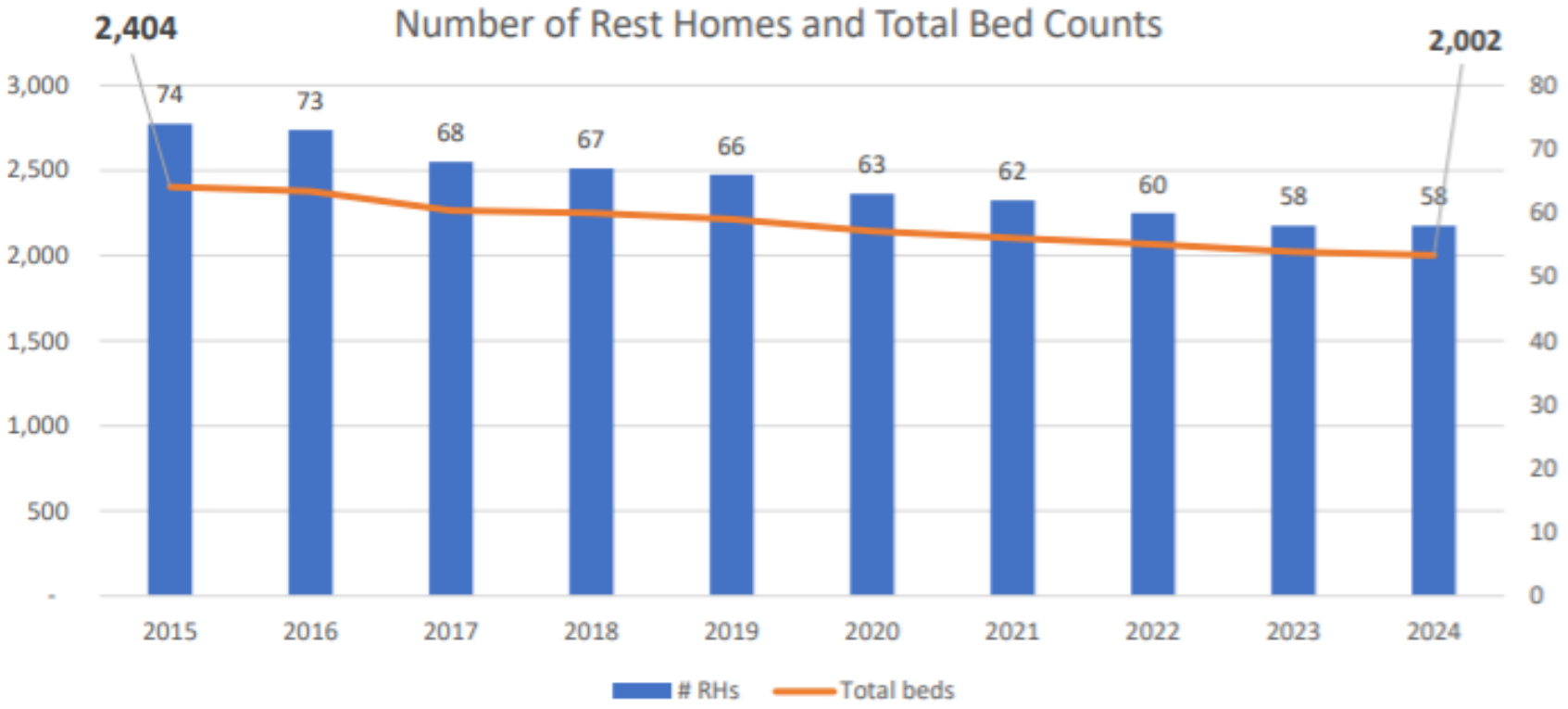
Sub-HSA Name	Sub-HSA	# of NFs	Total # of Staffed Beds	Total # of Occupied Beds	Average Occupancy %	Median Occupancy %
Pittsfield Sub Area	11	13	1300	1195	91.9%	94.9%
Northampton Sub Area	12	8	913	827	90.6%	91.0%
Springfield/Holyoke Sub Area	13	26	2816	2560	90.9%	91.7%
Fitchburg/Leominster Sub Area	21	12	1342	1229	91.6%	93.1%
Worcester Sub Area	22	21	2527	2241	88.7%	91.3%
Millbury/Webster Sub Area	23	15	1737	1488	85.7%	85.7%
Lowell Sub Area	31	13	1505	1333	88.6%	92.8%
Lawrence/Methuen Sub Area	32	10	1161	994	85.6%	88.4%
Haverhill Sub Area	33	12	1171	1002	85.6%	88.2%
Boston Metro Sub Area	41	22	2439	2261	92.7%	93.1%
Cambridge/Lexington Sub Area	42	19	2114	1806	85.4%	88.0%
Waltham/Needham Sub Area	43	34	3516	3049	86.7%	91.0%
Norwood/Wrentham Sub Area	44	14	1023	910	89.0%	85.7%
Quincy/Weymouth Sub Area	45	20	2449	2111	86.2%	86.3%
Attleboro Sub Area	51	3	339	301	88.8%	90.2%
Brockton Sub Area	52	11	1291	1173	90.9%	93.9%
Plymouth Sub Area	53	8	943	862	91.4%	92.4%
Taunton Sub Area	54	7	777	636	81.9%	78.7%
Fall River Sub Area	55	10	1383	1229	88.9%	89.5%
New Bedford Sub Area	56	11	1337	1152	86.2%	87.1%
Cape Cod Sub Area	57	19	1784	1597	89.5%	90.3%
Beverly/Gloucester Sub Area	61	6	768	679	88.4%	87.7%
Danvers/Salem Sub Area	62	14	1451	1298	89.5%	90.3%
Lynn Sub Area	63	5	378	348	92.1%	88.2%
Melrose/Wakefield Sub Area	64	8	750	632	84.3%	85.6%
Malden/Medford Sub Area	65	5	818	661	80.8%	79.5%
Total		346	**38,032**	**33,574**	88.3%	90.3%

Nursing Facility Closures *(since 2020)*

Name of Facility	City/Town	# of Beds	Closure Date
GREAT BARRINGTON NURSING AND REHABILITATION	GREAT BARRINGTON	54	2020
FARREN CARE CENTER	MONTAGUE	122	2020
WINGATE AT NORTON	NORTON	106	2020
WINGATE AT WESTON	WESTON	160	2020
SWEET BROOK OF WILLIAMSTOWN NURSING HOME	WILLIAMSTOWN	146	2020
AGAWAM HEALTHCARE	AGAWAM	176	2021
WINGATE AT CHESTNUT HILL	BROOKLINE	135	2021
TOWN AND COUNTRY HEALTH CARE CENTER	LOWELL	80	2021
Heathwood	Newton	73	2021
Vero of Revere	Revere	119	2021
WAREHAM HEALTHCARE	WAREHAM	175	2021
BEAUMONT AT UNIVERSITY CAMPUS	WORCESTER	164	2021
ATTLEBORO HEALTHCARE	ATTLEBORO	120	2022
Park Place	Boston	53	2022
Stonehedge	Boston/West Roxbury	79	2022
DEDHAM HEALTHCARE	DEDHAM	123	2022
GLOUCESTER HEALTHCARE	GLOUCESTER	99	2022
Wingate at Needham	Needham	164	2022
CHETWYNDE HEALTHCARE	NEWTON	71	2022
QUINCY HEALTH AND REHABILITATION CENTER LLC	QUINCY	126	2022
Sea View Convalescent	Rowley	62	2022
Willimansett East	Chicopee	85	2023
Willimansett West	Chicopee	103	2023
Chapin	Springfield	160	2023
Governor	Westfield	100	2023
South Dennis	Dennis	128	2023
Arnold House	Stoneham	22	2024
Emerson Hospital TCU	Concord	20	2024
Savoy Nursing Home	New Bedford	39	2024
NE Sinai Hospital TCU	Stoughton	21	2024
Bridgewater	Bridgewater	43	2024
Marian Manor	Boston	238	2024
Highview of Northampton	Northampton	120	2024
Philips Manor	Lynn	29	2024

Rest Home Beds

The total number of Rest Homes and beds has declined since 2015 however the number of closures has begun to plateau over recent years.



Rest Home Closures *(since 1998)*

Name of Facility	# of Beds	Closure Date
Ashburnham RH	17	Pre-2001
Beech Manor	12	Pre-2001
Berkley RH	27	Pre-2001
Bertha Young	18	Pre-2001
Blue Spruce	19	Pre-2001
Caldwell Home	28	Pre-2001
Catherine	27	Pre-2001
Garland RH	9	Pre-2001
Lee RH	27	Pre-2001
Magnolia RH	16	Pre-2001
Maryland RH	32	Pre-2001
Nancy Patch RH	12	Pre-2001
Newburyport	19	Pre-2001
Norwegian RH	18	Pre-2001
Park Dale RH	27	Pre-2001
Plainview	26	Pre-2001
Primus Mason	20	Pre-2001
Reagan's RH	37	Pre-2001
Rodgers RH	20	Pre-2001
Sunbridge-Rosewood	57	Pre-2001
Rol-Ann RH	17	Pre-2001
Roxbury Home	24	Pre-2001
Sanfillippo RH	17	Pre-2001
Swedish Home	26	Pre-2001
Tiffany Rest Home	43	Pre-2001
Varnum Park	32	Pre-2001
Wellham House	20	Pre-2001
Wintrop Road RH	31	Pre-2001
Pine Hill	28	2001
Bartlett	40	2002
Cedar Street RH	25	2002
Fischer in Amherst	6	2002
Frasier	23	2002
Hilltop	22	2002

Name of Facility	# of Beds	Closure Date
Lynn	30	2002
Marshall RH	18	2002
Rita's RH	10	2002
Schusser RH	25	2002
Vernon House	14	2002
Battles Home	11	2004
Belknap House	11	2004
Bethel	17	2004
Clinton	12	2004
Forest Manor	13	2004
Grandview	20	2004
Green Hill RH	27	2004
Heritage Hall North	31	2004
Mansion RH	27	2004
Mill Pond-Hanover	38	2004
Waterford Manor	16	2004
Pleasant View RH	19	2004
Community	17	2005
Fergeson	17	2005
Gardner	24	2005
Higland Manor	30	2005
Shady Lawn	23	2005
St. Anthony's	18	2005
Tower Hill	21	2005
Whitney Homestead	25	2005
Wheelwright House	10	2005
Allen House	16	2005
Edgell RH	22	2005
Barnard	84	2006
Florence	25	2006
Hanover	33	2006
Pioneer Valley	28	2006
Mt Vernon Winchester	17	2006
Berkshire Place	20	2006

Rest Home Closures *(since 1998)*

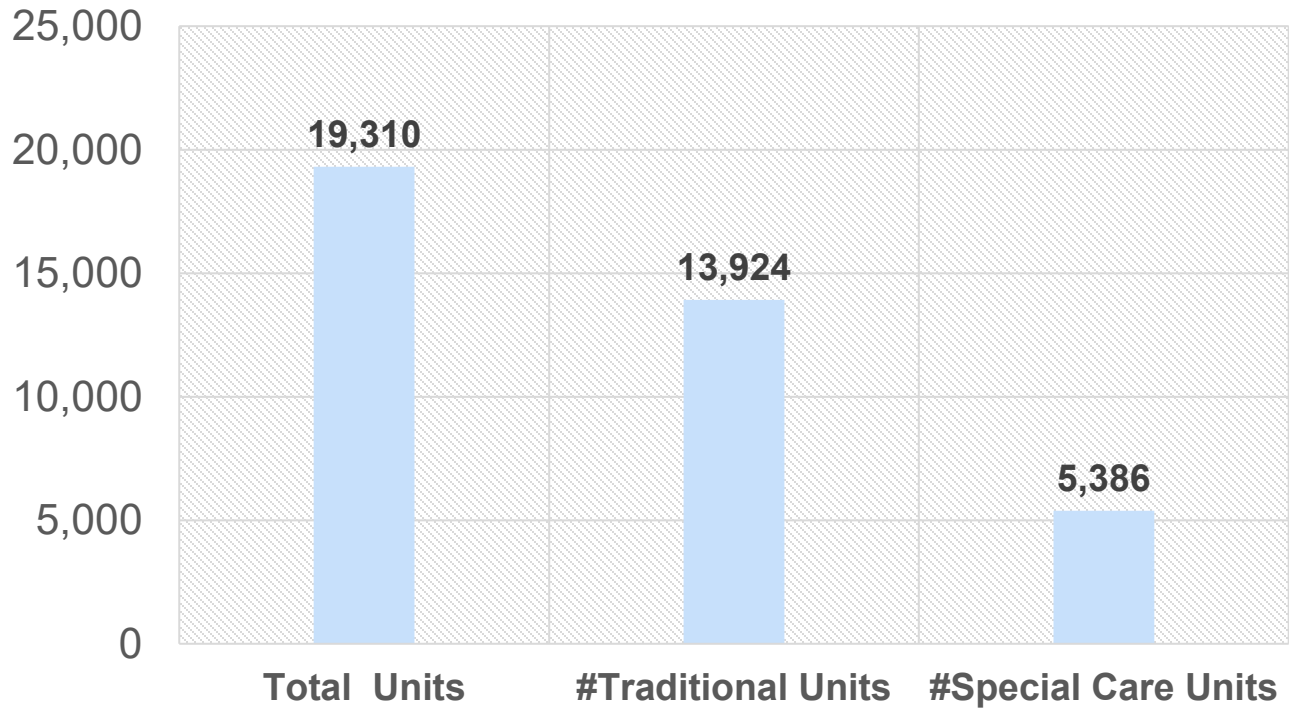
Name of Facility	# of Beds	Closure Date
Our Lady of Mercy	28	2007
Rivercrest LTCF	52	2007
Chicopee	38	2008
Mohawk Manor	22	2008
Mother St. Joseph	2	2008
Sunnyvale	19	2008
Washburn House	31	2008
Anna Maria	64	2010
E. Bolt	12	2010
E. Ann-Kingston Place	15	2010
Dana Home	15	2011
Lord Nathan	19	2011
Swansea	16	2011
Weeks	20	2011
Curtis Manor	23	2012
Hampton House	158	2012
Arlington	19	2013
Maple Hill	32	2013
Sunbridge/Rosewood	57	2013
Baker Manor	15	2014
Fairhaven	28	2014
Melville	16	2014
Old Colony	50	2014
Horn	14	2015
River Valley-Merrimack	36	2015
Westbrook Heights	26	2015

Assisted Living Residences (ALRs)

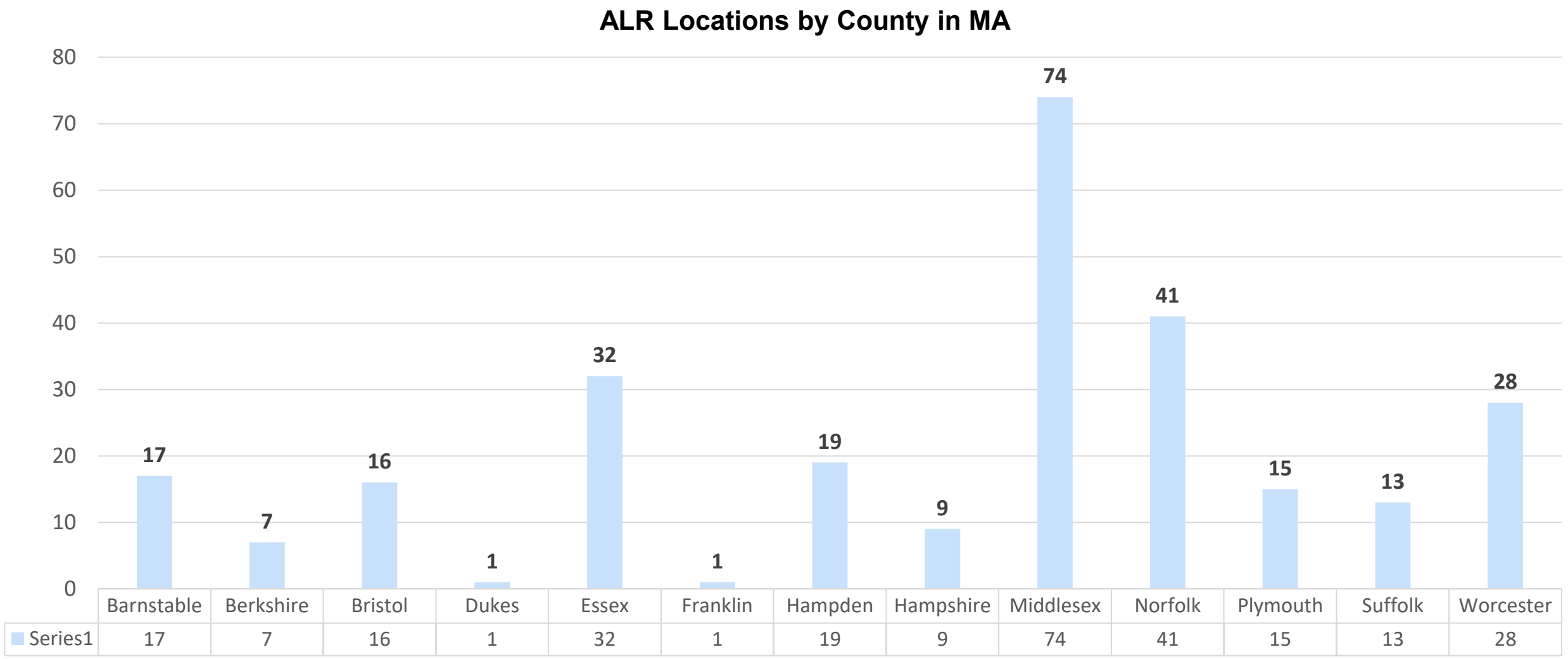
- **Certified ALRs: 273**
  - 169 offer Traditional & Special Care Residence (SCR)
  - 69 have Traditional only
  - 35 have Special Care only

- **Total # Certified Units: 19,310**
  Traditional ALR Units: 13,924
  Special Care Resident Units: 5,386

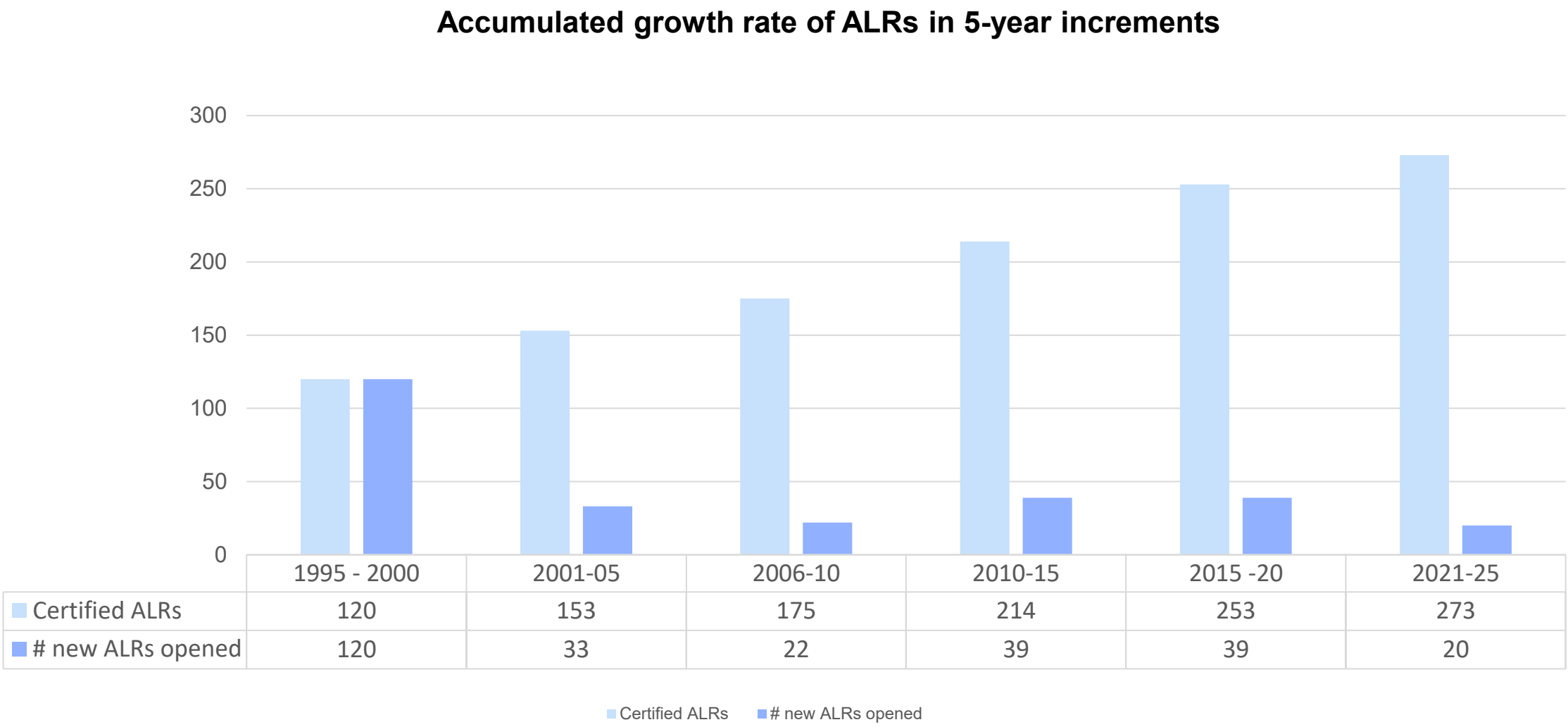
- **ALR Unit Capacity:**
  - Average # all ALRs: 70 (range 8 – 173)
  - Average # Trad only: 59 (range 8 – 150)
  - Average # SCR only: 26 (range 7- 72)



ALR – Distribution across Counties



ALR – Growth Trends

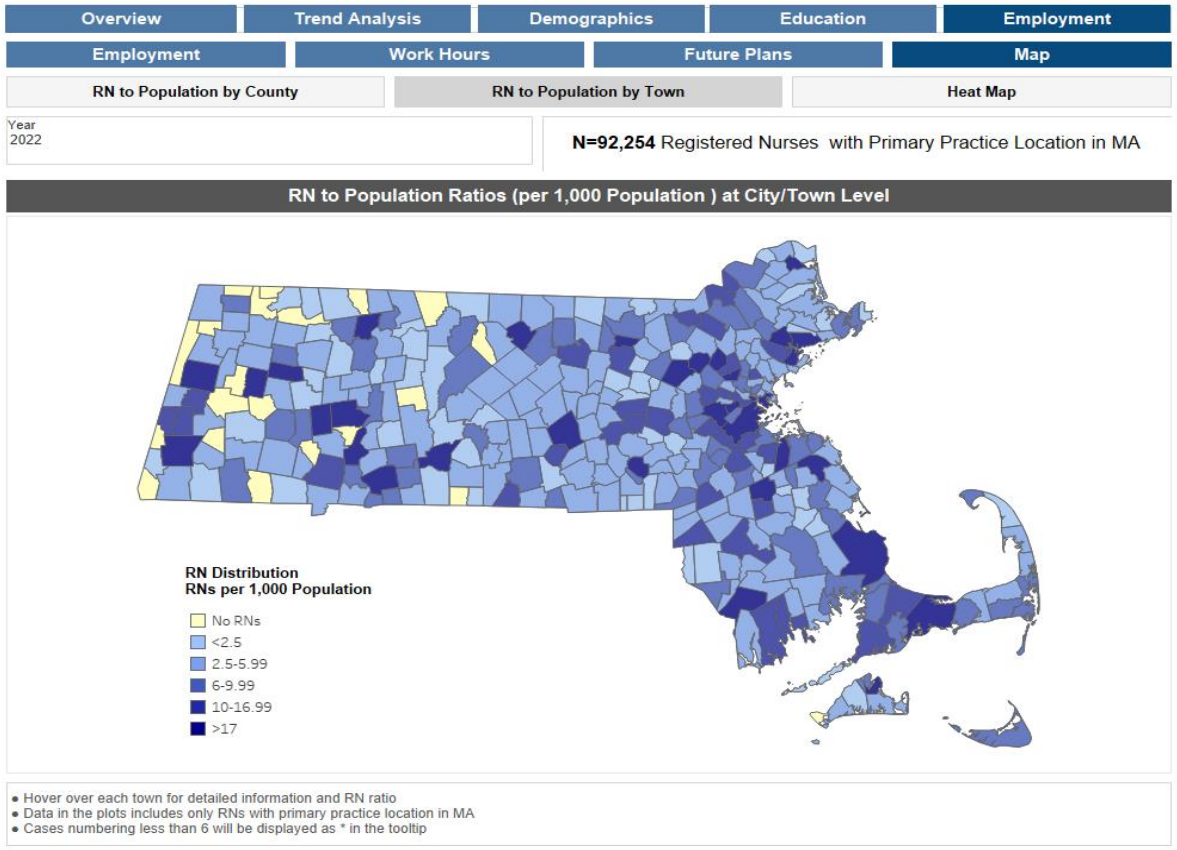


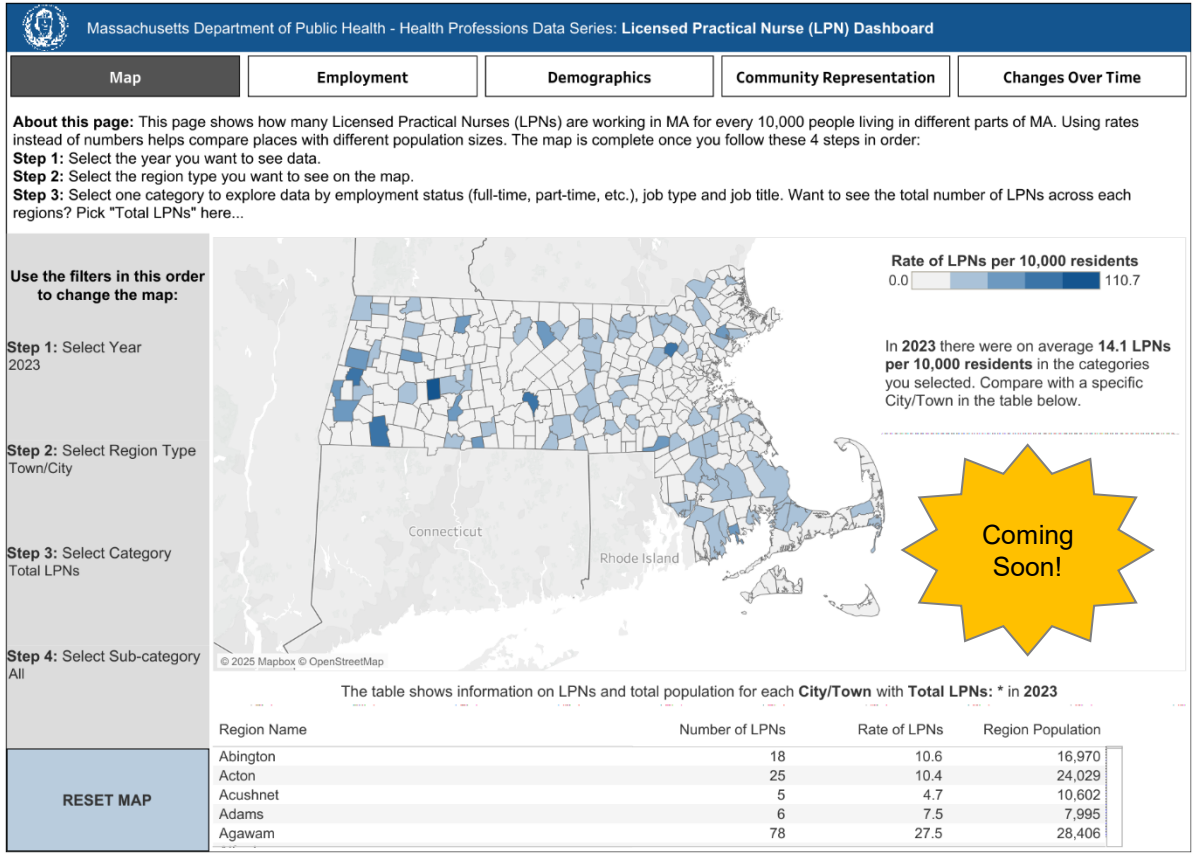
iii. Staffing challenges and workforce initiatives to support such facilities including, but not limited to, childcare

Summary of data reviewed in producing recommendations

- The task force reviewed DPH Registered Nurse (RN) health professions interactive data dashboard
- DPH is in the process of releasing LPN data.
- The task force reviewed a catalogue of existing workforce initiatives that are ongoing in the state

Health Professions Interactive Data Dashboards: RN and LPN



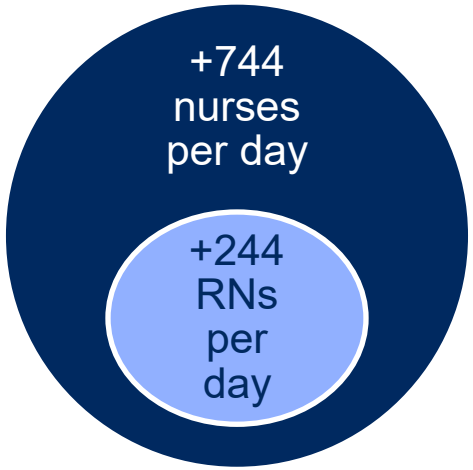


- These dashboards provide an overview of Registered Nurse (RN) and Licensed Practical Nurse (LPN) re-licensure data from 2017 onward. Licenses are renewed every other year and currently include data through 2023.
- These dashboards characterize the workforce from a supply perspective. They identify trends and patterns that impact access to health care professionals and services. These tools can drill down into specific care settings, including long-term care, as well as geographic areas.
- The data helps inform long-term care health care workforce development, education, training, recruitment, and retention. It also monitors the diversity, cultural, and linguistic competence of the workforce to meet state needs.
- The RN dashboard can be found at: https://www.mass.gov/lists/health-professions-data-series
- The LPN dashboard is anticipated to be publicly posted in fall of 2025

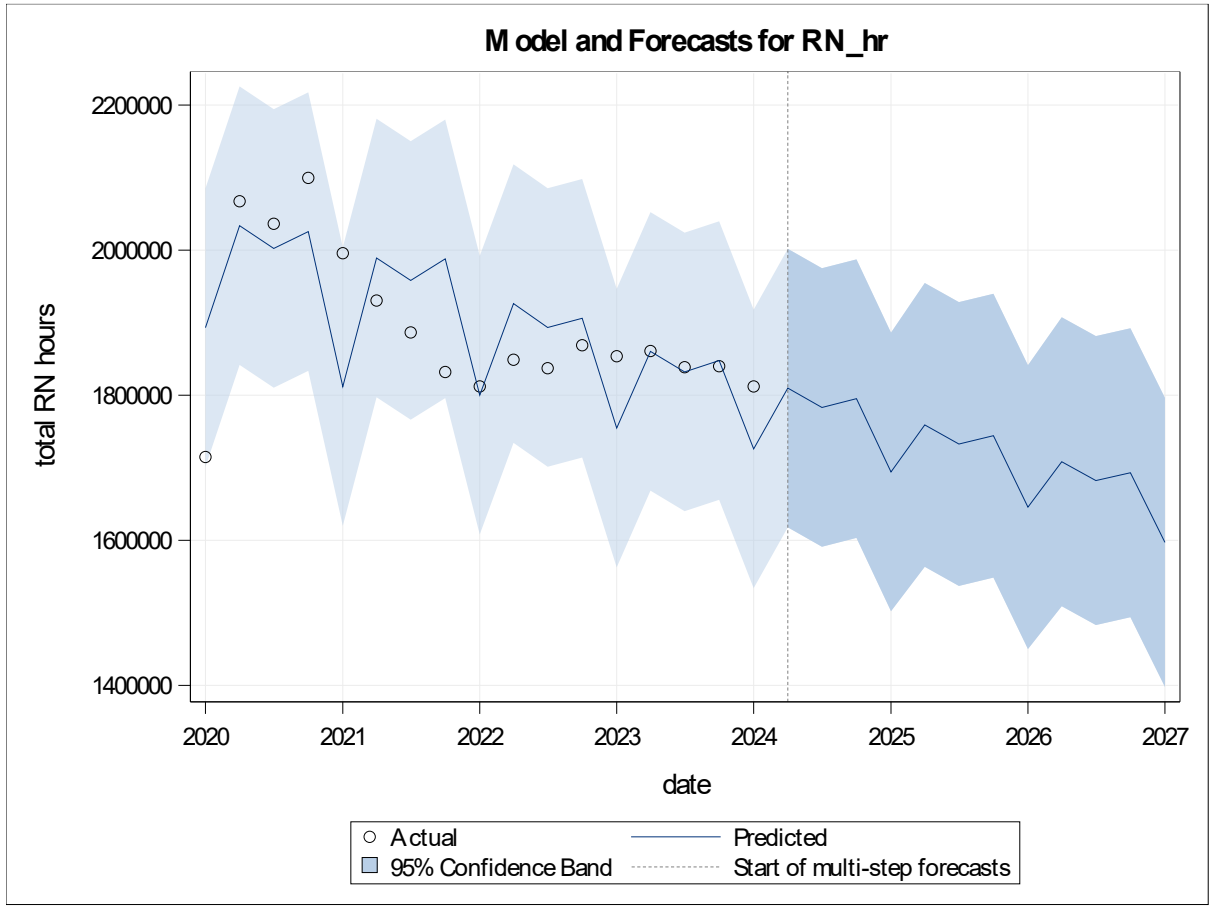
Facilities are currently unable to meet staffing minimums, RN staffing expected to worsen

Per 105 CMR 150, on and after April 1, 2021, sufficient staffing must include a minimum number of hours of care per resident per day of 3.580 hours, of which at least 0.508 hours must be care provided to each resident by a registered nurse. The facility must provide adequate nursing care to meet the needs of each resident, which may necessitate staffing that exceeds the minimum required PPD.

Based on Q4 2024 reporting, in order for all facilities to meet the state minimum staffing requirements, we would need to add on average 744 nurses working 8 hours, of which 244 must be RNs, each day across Massachusetts. *Note: total nurses include RNs, LPNs, and CNAs.*



Based on historical staffing trends, predictive modeling shows an expected decline in the RN hours provided, while CNA and LPN hours increase. Investments in nursing workforce development pathways are critical to reversing this trend.



EOHHS workforce initiatives

To support the growing demand for long term care services, EOHHS has launched the following workforce initiatives to support training, hiring and increased education for direct care workers across industries. MARCH suggested further outreach should be done by EOHHS to all LTC facilities.

Project Name	Agency	Brief Project Description
Certified Nursing Aide Exam	DPH	CNA exam may now be taken in Haitian Creole, Spanish and Chinese in addition to English. https://www.mass.gov/info-details/information-for-nurse-aide-training-programs#:~:text=As%20of%20December%202%2C%20the,page%20of%20the%20D%26S%20website.
Certified Nursing Aide Program*	ORI	This is a 200-hour ESOL supported CNA/HHA training program. Participants learn CNA/HHA theory and clinical skills as well as English and job readiness skills for working in the healthcare field. The participants develop resumes and sample cover letters. The program offers job placement services upon completion of the program. Employment services have developed partnerships with area nursing homes including d'Youville Life & Wellness Community, Sunny Acres Nursing Home, and Benchmark Senior Living. – Certified Nursing Aid Program
Certified Nursing Aid Program-Caring For Our Seniors Training*	ORI	The 14-week program serves non-native, Intermediate ESOL students and includes 100 hours of ESOL training, in addition to core nurse's aid training. Prepares students to pass the Massachusetts State Nursing Exam to become Certified Nursing Assistants. -- Certified Nursing Aid Program
Career Ladder Program*	MassHealth	Trains direct care workers while they maintain employment in their HCBS setting or skilled nursing facility. They will be paid to a portion of their wages to allow for their attendance in the LPN program and then return to their employer for a commitment of 4 years - Massachusetts Career Ladder Program - Social Finance
Direct Care Career Pathway*	EHS	Designs and implements a direct care career pathway for a Health Care Aide, combining CNA and HHA roles into a new credential - Health Care Aid Pathway
DSW to LPN certificate program*	DDS	Provides tuition and expenses for direct care staff to become an LPN – DDS LPN Certificate Program
Pre-C.N.A. Training for Low-level of English speakers	ORI	Prepares clients with necessary language skills pertaining to the CNA certificate before enrolling them in the CNA course. This supports better comprehension and retention of the material, which will enable them to study for the final exam and enhance their chances of passing. Using the tentative curriculum of selected materials relevant to the CNA and Home Health Aid fields, a class started with clients interested in pursuing this career at the site of a community partner in Springfield.
Home Health Aide/Certified Nursing Assistance training	ORI	Partners with Spectrum Healthcare Training Center in Lynn and with Royal Health Care Institute in Salem to provide HHA and C.N.A training to non-native, medium-level English speakers.
Continuous Skilled Nursing (CSN) Loan Repayment Program	MassHealth	One time program administered by the Massachusetts League of Community Health Centers (the League) to provide student loan repayment for RNs and LPNs providing continuous skilled nursing services to MassHealth members in exchange for a 2 or 3 year service commitment.
CSN Nurse Training Initiative	MassHealth	Enhances the skills of LPNs and RNs providing CSN services to complex care members
CSN Retention Bonuses	MassHealth	Retaining current agency and independent nurses who are currently providing CSN services
HCBS 10% add on	MassHealth	SCO and One Care contracts require plans pay 10% add on for Home Health services to increase wages, benefits to direct care staff. Requirement through 12/31/2023

Workforce initiatives cont.

Project Name	Agency	Brief Project Description
Homecare Workforce Advanced Skills - Mental Health and Alzheimer's Supportive Home Care Aid and Substance Misuse and Social Isolation Training	AGE	The Mental Health Home Care Aide, Alzheimer's Supportive Home Care Aide, and Substance Misuse and Social Isolation training advances professionals up the career ladder from Home Health Aide to Supportive Home Care Aide. These training certificates allow for greater potential to provide specialized care to more consumers.
Transition PHCAST In-Person curriculum to online platform	AGE	The Personal and Home Care Aide State Training (PHCAST) curriculum serves as an entry level training opportunity for Homemakers (40 hrs) and Personal Care Homemakers (60 hr) that meet a portion of the training requirements for CNAs and Home Health Aides (https://mahomecaretraining.org/#resources)
Strengthening the Cultural Competency of PHCAST and Increasing Accessibility - Language Translation	AGE	The PHCAST curriculum will be translated into Spanish, Haitian Creole, Mandarin, Cantonese, Russian, Brazilian Portuguese, and Vietnamese to increase accessibility to Homemaker and Personal Care Homemaker jobs given the diverse linguistic backgrounds of direct care workers and aspiring professionals across the Commonwealth.
Broadening the "Reach": Awareness and Marketing Campaign - Online PHCAST	AGE	Many communities and people are unaware of the types of jobs available in the direct care industry especially in the home-based environment. This initiative broadened our reach by targeting digital, print, and radio marketing in English, Spanish, and Haitian Creole to raise awareness for Homemaking and Personal Care Homemaking as well as the availability of the free online PHCAST training in diverse (and growing) languages.
Broadening the "Reach": Awareness and Marketing Campaign - Online PHCAST	AGE	Digital, print, and radio marketing and awareness campaign in Mandarin, Cantonese, Brazilian Portuguese and Russian for the online PHCAST training curriculum
Professional Development and Opportunity - PHCAST Job Board	AGE	A free job board for PHCAST learners as well as other qualified individuals who are interested in working in homemaking or personal care homemaking
BU CADER Certificate Initiative	AGE	Boston University's (BU) Center for Aging and Disability Education and Research (CADER) facilitates web-based training on case management for staff in the aging and disability network including case managers, information and referral specialists, options counselors, SHINE, and Independent Living Centers and Councils on Aging (COAs). The goal of the program is to train new staff or staff without education or extensive experience, provide them with college level certificates, and bring them up in line with other professionals in the field.
BU CADER LGBT Aging in Massachusetts	AGE	Recovery coach trainings
Accessibility Enhancements - LGBT Aging in Massachusetts	AGE	Increasing accessibility for learners of diverse linguistic backgrounds by translating material into Spanish and Haitian Creole.
Initiative to Support Diverse Learners: PHCAST Train the Trainer	AGE	Train hiring and training staff at agencies, community colleges and other settings to teach PHCAST in person
Direct support certificate program	DDS	This program is a collaboration between DDS and the Massachusetts Association of Community Colleges. Upon completion of the program, participants have a Direct Support Certificate, 22-28 transferrable community college credits, and a better understanding of the human services field and their role in it. The program is currently being provided in 8 community colleges.

iv. Utilization of pharmacists and other health care providers in long term care

The Task Force discussed utilization of pharmacists and other health care providers in long term care.

The group highlighted that they did not currently have any concerns with the current utilization of pharmacists or any other health care providers in long term care facilities.

The group also did not identify any significant new or unexplored opportunities in this area.

v. Any policy reforms to strengthen long-term care in the commonwealth including, but not limited to, maintaining quality of care

Summary of data reviewed in producing recommendations

- The task force reviewed the data that MassHealth collects on spending on resident care in skilled nursing facilities and rest homes and how that data impacts payment. *Reports available here:* Direct Care Cost Quotient (DCC-Q) Reports | Mass.gov

- The task force reviewed the data that MassHealth collects related to staffing and how that data impacts payment.

- The task force reviewed DPH & CMS Quality Score Rate Adjustment data and how that data impacts payment.

MassHealth tracks spending on resident care, monitors staffing hours and adjusts rates based on quality scores

	Nursing Facilities	Rest Homes
Direct Care Cost Quotient *(DCC-Q)* **&** **Resident Care Cost Quotient** *(RCC-Q)*	▪ Nursing facilities must have a DCC-Q score of at least 75% during the prior fiscal year otherwise will receive a penalty of up to 5% in their rate for the next rate year ▪ The DCC-Q score is calculated by dividing their Total Direct Care Expenses (e.g., direct care workforce, food and dietary supplies, laundry and housekeeping supplies) by their Total Adjusted Nursing Revenues ▪ In FY24, 296 out of 335 facilities met the 75% requirement	▪ Rest Homes must have a RCC-Q score of at least 80% during the prior fiscal year otherwise will receive a penalty of up to 5% in their rate for the next rate year ▪ The RCC-Q score is calculated by dividing their Total Resident Care Expenses (e.g., administrator salary, direct care workforce, food and dietary supplies, laundry and housekeeping supplies) by their Total Revenues ▪ In FY24, 40 out of 51 rest homes met the 80% requirement
DPH & CMS Quality Score Rate Adjustments	▪ Nursing facility rates also take into account a nursing facility's DPH and CMS quality scores ▪ Nursing facilities qualify for bonuses and/or penalties to their rate based on their quality achievement and quality improvement scores	
Hours Per Patient Day *(HPPD)* **Penalties**	▪ MassHealth monitors nursing facility staffing levels and hold facilities to a standard of 3.58 hours per patient day ▪ For each federal fiscal quarter that a facility that did not meet this standard of 3.58 HPPD, it receives a 2% downward adjustment on its standard per diem rate for any claims paid for that quarter	

Details on rate adjustments based on quality & DCC-Q/RCC-Q scores

Nursing facilities and rest homes may receive up to a 5% penalty on their rate based on their DCC-Q / RCC-Q score. The penalty is determined based on their score as described below.

DCC-Q Score *(NFs)*	RCC-Q Score *(RHs)*	Rate adjustment
75% or higher	80% or higher	0%
74%	79%	-0.5%
73%	78%	-1%
72%	77%	-1.5%
71%	76%	-2.0%
70%	75%	-2.5%
69%	74%	-3.0%
68%	73%	-3.5%
67%	72%	-4.0%
66%	71%	-4.5%
65% or lower	70% or lower	-5%

Nursing facilities may also receive penalties or bonuses on their per diem rate based on their DPH and CMS quality scores. The penalties/bonuses are determined based on their scores as described below.

Quality Improvement	CMS	DPH	Bonus
Highest quality	5 stars	124+	+2%
QI (quality improvement) ++	+2 star change	+4 change	+1.5%
QI +	+1 star change	+1-3 change	+1%
QI flat	+0 star change	+0 change	0%
QI -- from High Quality	-1 star change from 5	-1-3 change from 124+	0%
QI -	-1 star change	-1-3 change	-2%
QI --	-2 star change	-4 change	-2.5%
Chronic low quality	Avg. (2018-2021) ≤1.5 stars	Avg. <100 for 3 years	-3%

Quality Achievement	CMS Star	DPH Score	Bonus
High quality	5	124+	+1%
Good quality	4	120 - 123	+0.75%
Average quality	3	116 - 119	0%
Poor quality	2	111 - 115	-0.75%
Low quality	1	110 or less	-1%

Comparing *for profit & non-profit, greenhouse and non-greenhouse, by County*

	FY24 DCC-Q Score				July 2024 Overall CMS Score						July 2024 DPH Score[1]					Q3 2024 HPPD Score			
	Less than 75%		Greater than 75%		1	2	3	4	5	Chronic Low Quality	110 or less	111-115	116-119	120-123	124+	Less than 3.58		Greater than 3.58	
All Nursing Facilities	**74**	*22%*	**257**	*78%*	**80**	**71**	**59**	**69**	**50**	**53**	**110**	**44**	**50**	**56**	**71**	**122**	*37%*	**207**	*63%*
For Profit	66	*20%*	179	*54%*	72	60	39	49	23	47	93	33	38	40	41	114	*34%*	130	*39%*
Non-Profit	8	*2%*	77	*23%*	8	11	20	19	27	5	19	11	11	16	30	8	*2%*	76	*23%*
Greenhouse Model[2]	1	*0%*	1	*0%*	0	0	0	0	2	0	0	1	0	0	1	0	*0%*	2	*1%*
Non-greenhouse	73	*22%*	255	*77%*	80	71	59	69	48	53	110	43	50	56	70	122	*37%*	205	*62%*
By County:																			
Barnstable	6	*2%*	9	*3%*	5	6	2	0	2	3	5	3	1	1	5	7	*2%*	8	*2%*
Berkshire	1	*0%*	11	*3%*	2	3	3	3	1	3	1	2	4	1	4	4	*1%*	8	*2%*
Bristol	9	*3%*	19	*6%*	10	3	7	7	0	6	6	7	5	5	5	12	*4%*	16	*5%*
Dukes	0	*0%*	1	*0%*	0	0	0	1	0	0	0	0	0	1	0	0	*0%*	1	*0%*
Essex	11	*3%*	34	*10%*	10	13	5	10	7	7	20	6	10	3	6	17	*5%*	27	*8%*
Franklin	1	*0%*	2	*1%*	2	0	1	0	0	0	1	1	0	0	1	2	*1%*	1	*0%*
Hampden	7	*2%*	17	*5%*	6	1	7	8	2	2	7	5	4	3	5	9	*3%*	15	*5%*
Hampshire	0	*0%*	6	*2%*	2	1	2	1	0	2	2	0	3	1	0	4	*1%*	2	*1%*
Middlesex	12	*4%*	55	*17%*	16	18	11	11	11	10	27	9	10	12	9	19	*6%*	48	*15%*
Nantucket	0	*0%*	1	*0%*	0	0	0	1	0	1	0	0	1	0	0	0	*0%*	1	*0%*
Norfolk	5	*2%*	27	*8%*	8	8	5	4	7	4	13	1	4	7	7	9	*3%*	23	*7%*
Plymouth	12	*4%*	15	*5%*	6	2	4	8	6	3	6	2	1	8	10	14	*4%*	13	*4%*
Suffolk	2	*1%*	19	*6%*	4	6	2	3	6	3	11	4	0	1	5	6	*2%*	14	*4%*
Worcester	8	*2%*	41	*12%*	9	10	10	12	8	9	11	4	7	13	14	19	*6%*	30	*9%*

1. The statewide average CMS Score is a 3 and the statewide average for DPH Scores is 113
2. Given the limited sample size for Greenhouse Model facilities, it is not statistically significant to compare the greenhouse model facilities with the non-greenhouse model facilities.

(vi) The adequacy of payor rates

Summary of data reviewed in producing recommendations

- The task force reviewed the Center for Health Information and Analytics (CHIA) Nursing Facility Performance Dashboard which includes data on individual facility characteristics, quality scores and financial data as well as industry level data on revenues, expenses, margins and utilization by payer
- As a CHIA dashboard is not currently available for Rest Homes, the task force did not conduct a deep dive into Rest Home cost reports.
- The task force reviewed data presented by CHIA on the distribution of payer mix by patient days across nursing facilities over the last three years
- CHIA presented an overview of how nursing facility rates are set based on nursing, operating and capital costs and then adjusted with further facility-based adjustments and an inflation factor

Dashboard Profiles

- Characteristics
- Quality rating
- Direct Care Cost Quotient
- Financial metrics
- Filter by region, management company, and facility name

2023 Nursing Facility Profiles

Filter by Region: (All)
Filter by Management Company: (All)
Select Facility: Aberjona Nursing Center, ...

Download PDF

Aberjona Nursing Center, Inc.

	01/01/2023 - 12/31/2023
City/Zip Code	Winchester, 01890
Licensed Beds	123
Payer Mix: Medicare/Medicaid/Self-Pay	48.2% / 32.4% / 19.2%
Average Daily Census	113.3
Total FTEs	174.9
Legal Status	Limited Liability Corporation (LLC)
Ownership	Aberjona Nursing Center, Inc.
Management Company	Stellar Health Management LLC
Realty Company	Swanton St. 184 LLC

Quality (as of June 2024)

CMS 5 Star Rating (link)	5/5

Component Ratings	
Health Inspection Rating	4/5
Staffing Rating	4/5
QM Rating	5/5

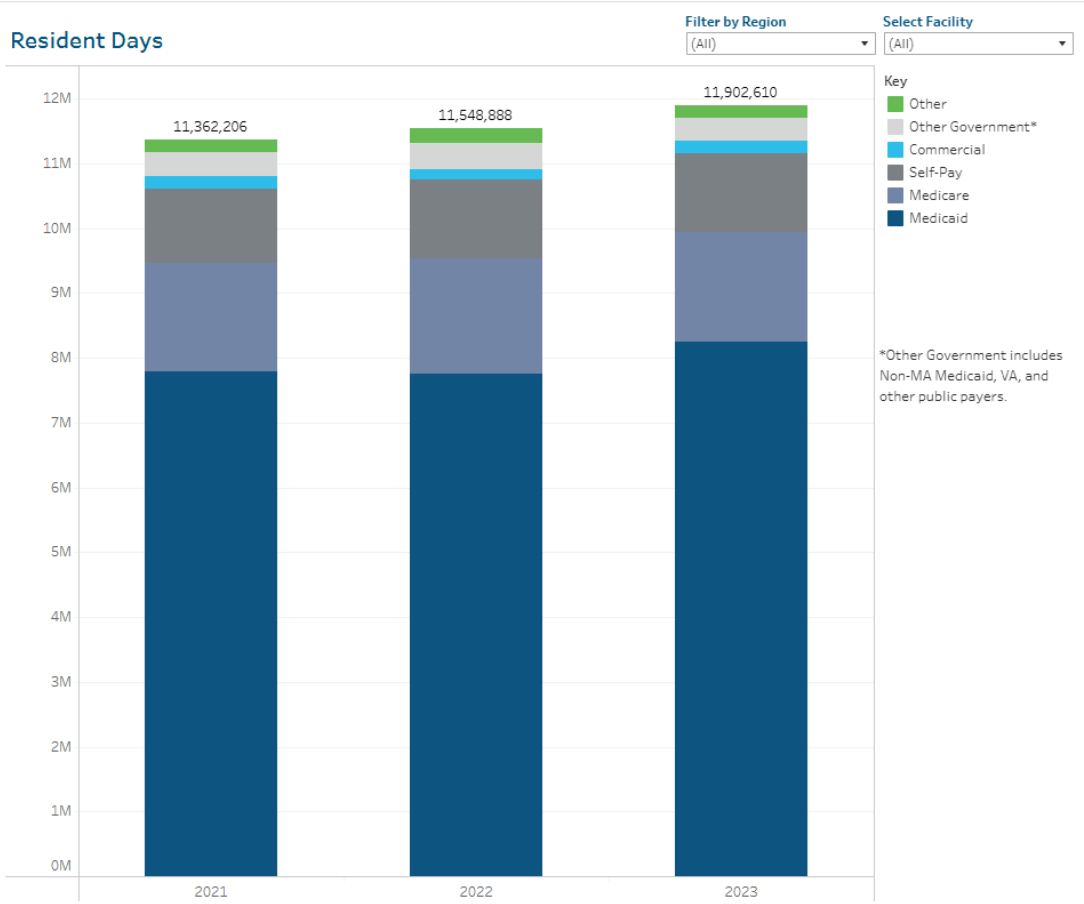
Reporting Period	10/01/2020 - 06/30/2021	07/01/2021 - 06/30/2022	07/01/2022 - 06/30/2023
Direct Care Cost Quotient (DCC-Q) (link)	68%	77%	75%

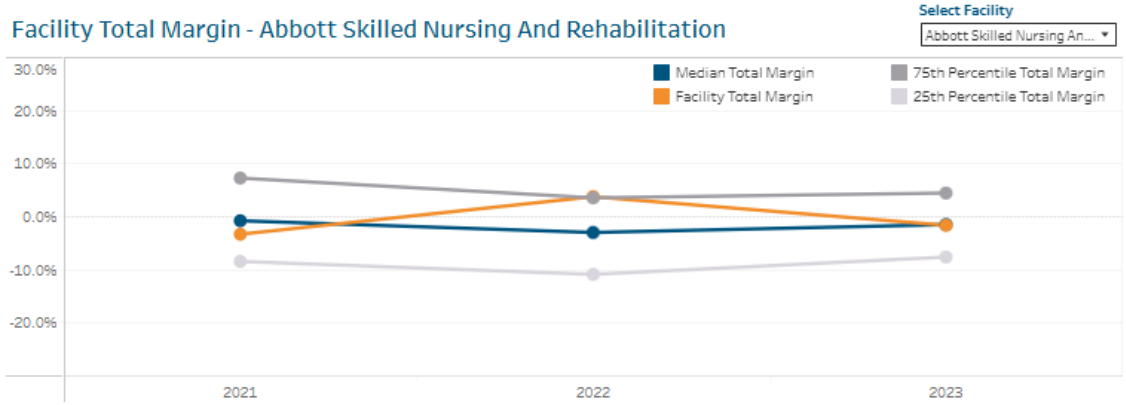
Financial Metrics

	01/01/2021 - 12/31/2021	01/01/2022 - 12/31/2022	01/01/2023 - 12/31/2023
Total Revenue	$19,630,876	$18,341,746	$21,716,836
Total Expenses	$16,147,842	$16,954,225	$18,720,152
Profit (Loss)	$3,483,034	$1,387,521	$2,996,684
Facility Total Margin	17.7%	7.6%	13.8%
Management Company Fees	$2,825,061	$0	$1,027,474
Realty Company Rent	$672,000	$2,100,000	$2,177,249
Current Ratio	4.0	13.3	3.4
Days Cash on Hand	-1.0	2.0	0.0
Days in Accounts Payable	28.9	22.5	30.5
Days in Accounts Receivable	51.2	77.0	70.4
Debt Service Coverage Ratio			
Equity Financing Ratio			
Long-Term Debt to Total Capitalization			
Total Net Assets	$4,031,371	$2,020,884	$4,347,942

Dashboard Industry Data

- Resident days by payer type, region, facility
- Aggregate revenue and expense figures
- Median profitability metrics





Industry Data by Year

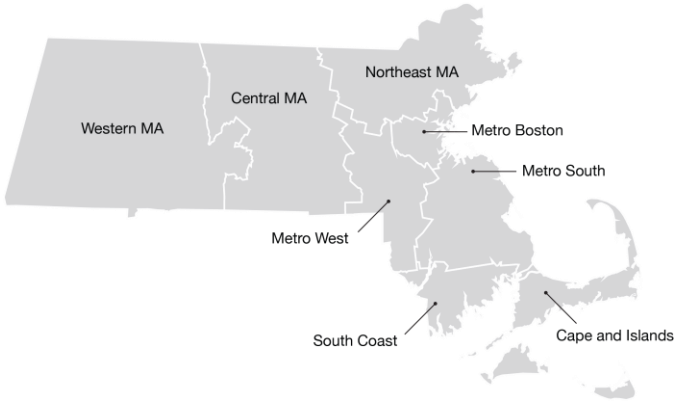
	2021	2022	2023
Number of Facilities	349	335	334
Total Operating Revenue	$ 4,529,227,833	$ 4,486,525,948	$ 4,909,832,996
Total Expenses	$ 4,506,168,740	$ 4,715,984,899	$ 4,948,174,280
Total Profit (Loss)	$ 23,059,093	$ (229,458,951)	$ (38,341,284)
% Facilities Reporting Loss	54.4%	60.0%	58.4%
Total Margin Median	-0.8%	-3.0%	-1.6%
Days Cash on Hand Median	8.7	6.2	5.0
Days in Accounts Payable Median	69.8	67.5	66.5
Days in Accounts Receivable Median	42.0	46.6	49.9
DCCQ Median	0.85	0.84	0.82

Industry Data by Region (2023)

	Cape and Islands	Central MA	Metro Boston	Metro South	Metro West	Northeastern MA	South Coast	Western MA	Statewide
Number of Facilities	18	46	50	44	32	76	22	46	**334**
% Reporting Loss	55.6%	41.3%	66.0%	70.5%	68.8%	51.3%	54.5%	63.0%	**58.4%**
Total Margin Median	-2.6%	0.7%	-4.8%	-2.5%	-3.8%	-0.4%	-0.4%	-2.1%	**-1.6%**
Days Cash on Hand Median	3.0	7.4	5.9	3.9	4.8	5.8	5.9	1.6	**5.0**
Days Accts Payable Median	79.0	89.4	58.6	64.1	59.5	62.5	71.9	79.8	**66.5**
Days Accts Rec. Median	53.3	48.0	51.9	47.6	45.5	51.8	49.7	52.4	**49.9**
DCCQ Median	0.82	0.82	0.85	0.80	0.85	0.83	0.83	0.83	**0.82**

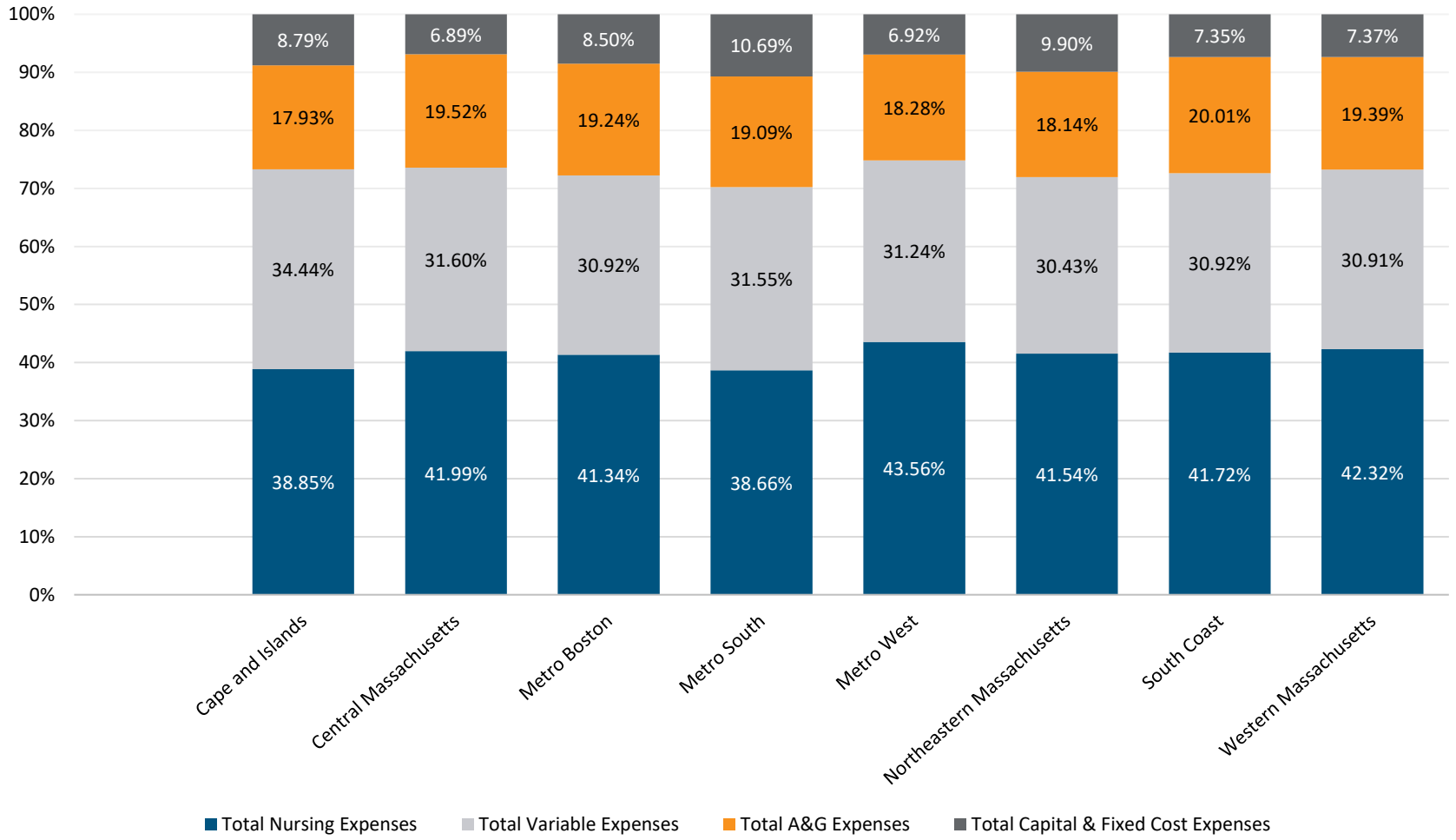
Overall financial performance varied modestly

- Central MA highest median total margin (0.7%)
- Metro Boston lowest median total margin (-4.8%)
- Relative performance varied over prior two years

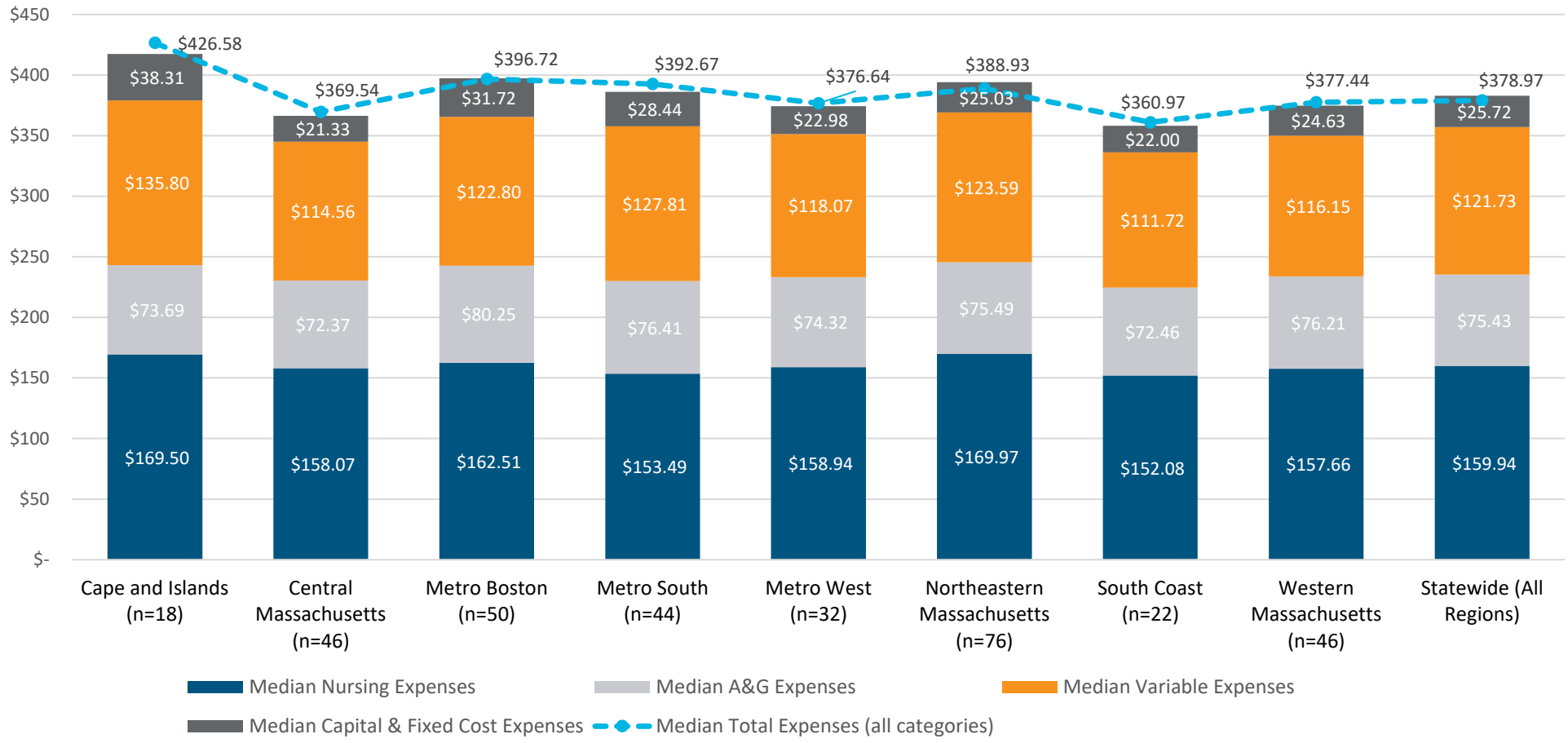


Expense Components by Region, CY 2023

Nursing expenses as a proportion of total expenses ranged from 38.6% to 43.5% across regions



Median Expenses by Region per Patient Day, CY 2023



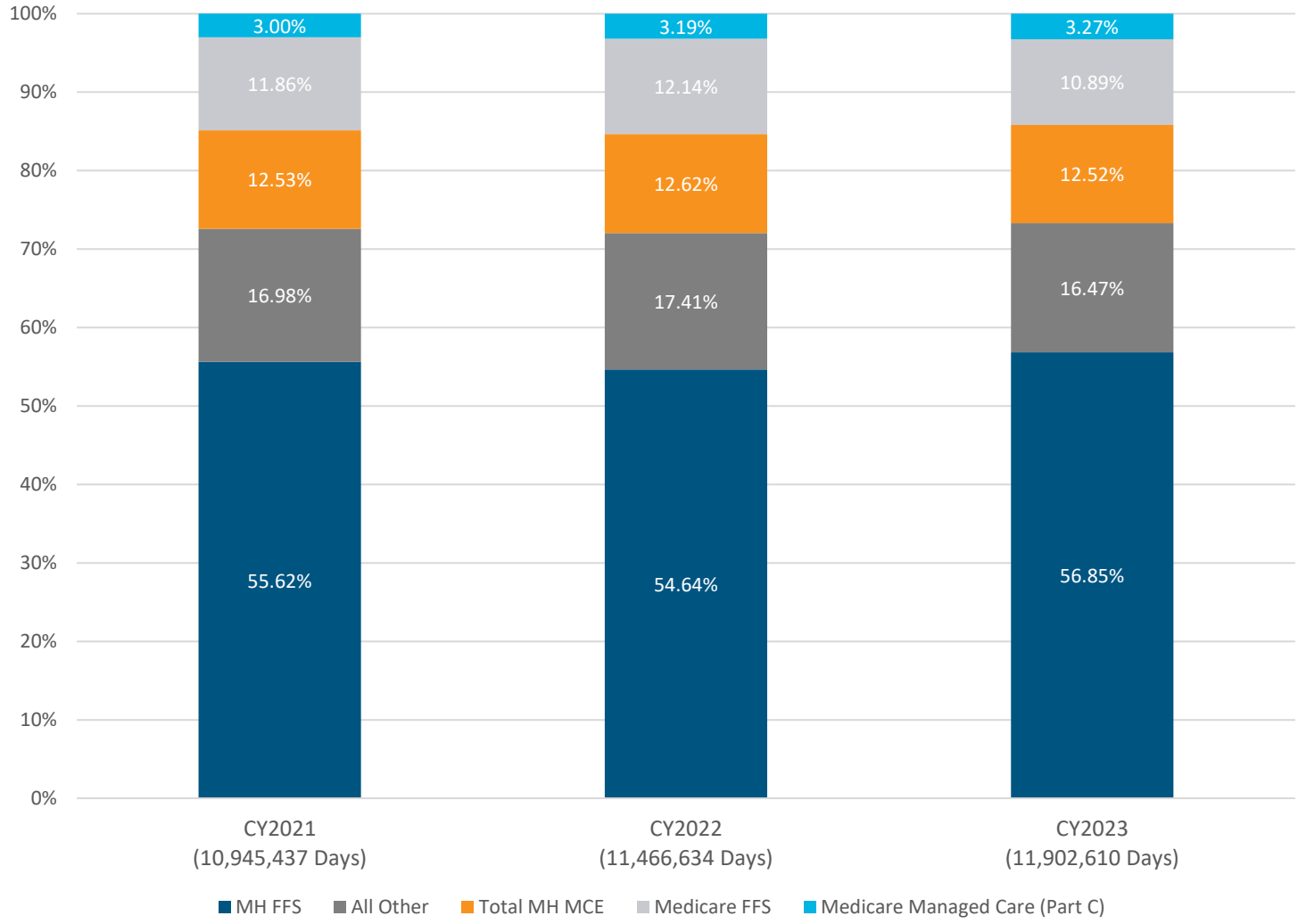
Summary Regional Median Total Expenses and Revenue per Patient Day, CY 2023

	# Facilities	Patient Days	Total Median Expenses	Total Median Revenue
Cape and Islands	18	519,834	$ 426.58	$ 392.86
Central Massachusetts	46	1,763,681	$ 369.54	$ 371.88
Metro Boston	50	1,862,997	$ 396.72	$ 380.02
Metro South	44	1,558,946	$ 392.67	$ 375.82
Metro West	32	970,049	$ 376.64	$ 356.71
Northeastern Massachusetts	76	2,563,179	$ 388.93	$ 379.61
South Coast	22	851,082	$ 360.97	$ 358.74
Western Massachusetts	46	1,536,480	$ 377.44	$ 364.95
Statewide (All Regions)	334	11,626,248	$ 378.97	$ 372.25

Payer Mix by Patient Days, CY 2021-2023

Payer mix composition has remained generally stable

- Slight decrease from CY 2021-2022 for MassHealth FFS
- Increase from CY 2022-2023 for MassHealth FFS



Payer Mix by Patient Days, CY 2021-2023

MassHealth Managed Care program resident days as proportion of total days have remained generally stable between 2021 and 2023

	CY 2021	CY 2022	CY 2023
Medicare FFS	11.86%	12.14%	10.89%
Medicare Managed Care (Part C)	3.00%	3.19%	3.27%
MassHealth FFS	55.62%	54.64%	56.85%
MassHealth Managed Care	2.53%	2.86%	3.71%
SCO	9.46%	9.32%	8.02%
OneCare	0.09%	0.03%	0.09%
PACE	0.44%	0.42%	0.70%
Total MassHealth MCE	12.53%	12.62%	12.52%
All Other	16.98%	17.41%	16.47%

NF Rate Setting Overview

- CHIA provides analytical support for MassHealth in setting payment rates
- Nursing, Operating, and Capital rates calculated with **recent cost report data**
  - **25** Nursing standard rates, **1** Operating standard rate
  - Capital rates **calculated individually** for each facility
  - Inflation factor (CAF) may be applied
- Per diem rates may also include additional components
  - Add-ons (direct care, MS)
  - Adjustments (kosher kitchen, high Medicaid, quality measures, DCC-Q, nursing payment)
  - Maximum change adjustments (caps on overall increases/decreases)

(vii) Costs and impacts of financing for facility construction and maintenance including, but not limited to, private equity and real estate investment trusts;

Summary of information discussed

- The task force discussed how difficult it is for nursing facilities and rest homes to access funding for capital and maintenance projects given the high expenses related to accessing financing in the current market

- Ron Pawelski, from MARCH, shared that cost of Capital rates are running as high as 9.2% for real estate development

- Ron Pawelski shared that based on discussions with contacts in the REIT area, the strategy that most companies are now following in the short term is to acquire distressed properties, make them more efficient and turn a profit. Bottom line, in private equity, no one will take the risk to build in long term care based on the cost of capital on new build.

(viii) Costs associated with transportation options to and from facilities for individuals

Summary of data reviewed in producing recommendations

- The task force reviewed cost report data reported by nursing facilities on transportation costs related to recreational/therapy activity transportation, motor vehicle depreciation expenses and motor vehicle operation expenses
- The task forced reviewed a transportation presentation on non-emergency medical transportation
- The task force discussed that while transportation can be a friction point, it is not a significant barrier to residents receiving care. To mitigate the issues:
  - Some rest home and skilled nursing facility providers report purchasing vans that can augment the PT-1 system
  - Some rest homes reported utilizing Uber or Lyft to support members
- The group noted that should the broader financial outlook improve a grant program to support LTC facilities' purchase of vans would be helpful.

Transportation Costs, CY 2023

	Definition	# Facilities Reporting Expense	Proportion of Expense of Total Reported Expenses
Recreational Therapy/ Activities: Transportation	Costs of transportation for recreational therapy/activities	30	0.01%
Motor Vehicles: Current Year Depreciation	Depreciation expenses for motor vehicles	40	0.02%
Travel: Motor Vehicle Expense	Costs associated with operation of a motor vehicle including insurance, excise tax, depreciation, and interest	241	0.06%

Specific Member Statements

Ron Pawelski, MARCH

Memorandum

To: Massachusetts Task Force to Review the Viability and Sustainability of Long-Term Care Facilities

From: Ronald J. Pawelski, President

Massachusetts Association of Residential Care Homes

Date: July 2, 2025

Re: Proposed Recommendations

Background:
THE single biggest challenge facing Rest Homes and other LTC facilities in the Commonwealth from a viability and sustainability standpoint is addressing the decades old issue of **rate adequacy.**

Since 1998, 107 Rest Homes have closed (over 60% of the total population) due to financial concerns directly related to rate adequacy in payments made by the Commonwealth for caring for their public assistance residents. Over 4,000 aged, infirm and indigents residents, many who had previously been homeless, lost their homes and were faced with the traumas associated with involuntary transfer.

In 2019 a Nursing Facility Task Force was convened to address critical issues challenging LTC facilities in the Commonwealth. Rest Homes cited Rate Adequacy as the number one priority and challenge to address, citing a series of proposed regulatory reforms.. Those proposed changes were never adopted. MARCH convened a Rate Committee comprised on owners, executive directors, CPA's and members of Clifton Larsen Allen to compile a set of recommendations. (See enclosed list of proposed regulatory reforms.)

Fast forward to today and we find, based on a survey of Rest Homes in the Commonwealth, that payments for public assistance residents lag actual Rest Home care costs by over $20 per day per resident. In Skilled Nursing Facilities that number approaches close to $40 per day per patient. This shortfall in the rates results in organizations go before the Massachusetts legislature annually seeking incremental funding directly competing for healthcare dollars that are in constant need by in short supply. Sadly, we have another MARCH member home that has declared their intent to close, citing inadequate reimbursement and the inability to address required capital improvements
Rate Adequacy/ Operational Definition- Owners and executive directors of LTC facilities view rate adequacy as receiving sufficient reimbursement from the Commonwealth for their public assisted residents where there is the ability to meet their operations responsibilities in caring for their residents, recruit and adequately pay staff to be retained, address administrative costs and have sufficient funds to make capital Improvements to the physical plant. When the current rate does not meet the stated requirements, it will have direct implications from an operational, procedural and regulatory standpoint in the operating of a LTC facility.

To address the issue of the rate adequacy MARCH is recommending the following regulatory, procedural and process changes.
Allocate funding (refer to the LTC insurance analysis where money was appropriated for the study) to hire an independent industry expert organization to review the existing reimbursement regulations 101 CMR 204.00 to determine what changes would require ensuring rates are adequately and accurately developed in the staffing, other expenses and capital areas. Regulations short of RCC-Q being enacted have not been updated in decades and do not address the issue of denied costs in rate determinations.

Ron Pawelski, MARCH

CHIA, dating back to the Rate Setting Commission is NOT an independent objective organization and is currently directed by the former Undersecretary of EOHHS, who in mandating RCC-Q implementation against industry requests, was no friend to Rest Homes. A company like Clifton Larsen Allen has more employees and CPA's with more knowledge and background (many employed by CLA today wrote the regulations) than the current staff at CHIA.
The reimbursement regulations concerning staffing should be updated to allocate and address staff recruitment and retainment

The core issue driving this shortage is the inadequate state reimbursement rate, which places rest homes at a significant disadvantage compared to nursing homes and private duty home health agencies.
While nursing homes receive substantially higher reimbursement and additional federal and state financial support, rest homes continue to operate under outdated and insufficient rates that no longer reflect the true cost of care. This has severely limited our ability to offer competitive wages to direct care staff, making it nearly impossible to attract and retain qualified caregivers in an already tight labor market.
Moreover, private duty home health agencies—many of which are unlicensed or minimally regulated—can charge premium rates for services while offering higher pay and flexible schedules to their staff. This further drains the pool of available workers and leaves rest homes struggling to provide consistent and reliable care for some of our most vulnerable residents.
The result is a critical staffing shortage that threatens the sustainability of the rest home model—a model that fills an essential gap in the continuum of elder care by providing safe, dignified, and cost-effective services for residents who do not meet the clinical threshold for nursing homes but are no longer able to live independently.
We urge the Commonwealth to immediately review and increase the reimbursement rates for rest homes to a level that allows us to remain viable and competitive in today's healthcare labor market. Without swift action, many rest homes will be forced to reduce services or close altogether, leading to displacement of residents and increased strain on other parts of the healthcare system.

Adding to the strain is the fact that hospitals are increasingly hiring "sitters" or one-on-one companions—often without requiring certification—for behavioral support and patient supervision. These positions offer caregivers substantially higher hourly rates than any rest homes can afford. As a result, the already limited pool of available caregivers is further depleted, leaving rest homes unable to staff appropriately and putting the quality of resident care at risk. Our facility lost few staff members in recent week for hospital sitter at a rate that we cannot touch.

Furthermore, to counter the ever -growing aging in place population in Rest Homes, the increases incurred to hire additional RN's LPN's and CNA's should be immediately reimbursable requiring immediate rate increases

- Capital Improvement:
  - Allow for immediate rate increases when DPH orders capital improvements per their surveys.
- Base Year Calculation:
  - Modify the cost report process to reimburse based on most current and actual costs as opposed to a two year + delay in promulgating new rates.
- Prospective vs. Retrospective Rate Determinations.
  - Review option of reverting back to a prospective vs retrospective rate process Refer to process prior to 2006.
- Incorporate recommendations presented to the NF Task Force – see below
- Suspend RCC-Q functions until independent auditor report weights in on fiscal impact and benefit.
- Rate Appeals
  - Incorporate DALA appeal process into mainstream where rate changes can be enacted in a timely fashion. (Timely defined as 6 months or less)

Ron Pawelski, MARCH

Proposed Policy Changes to Rest Home Rates and Reimbursement

Submitted by the Massachusetts Association of Residential Care Homes (MARCH) to the
Executive Office of Health and Human Services (EOHHS)

The purpose of this document is to propose changes to regulation 101CMR 204.00 that detail rules and regulations governing allowable costs and formulas used in setting rest home reimbursement rates. The submission is in response to an invitation by representatives of EOHHS and the Executive Office of Elder Affairs (EOEA) to submit proposed changes pursuant to a meeting held to discuss the future of Rest Homes in the Commonwealth. MARCH formed a Rate and Reimbursement Committee to develop the following response to EOHHS and EOEA:
Introduction: The overarching goals for the suggested changes are to ensure Rest Homes are compensated adequately by the Commonwealth for the care they provide to the aged, infirm and indigent population of Massachusetts and to preserve people's HOMES. MARCH's mandate is to ensure that no additional Rest Home is forced to close purely for financial reasons, resulting in residents losing their homes. Since 1998, 102 Rest Homes have closed displacing over 4,000 residents, subjecting them to the trauma associated with involuntary transfer.

Proposed Change #1 - Reimburse based on current and actual costs: MARCH advocates rolling the base year annually to ensure rates reflect a better determination of costs. Rolling the base year annually also provides the industry will a predictable revenue stream to more effectively manage their businesses. When reimbursement trails actual costs, Rest Homes are forced and expected to absorb these costs until the base year is rolled. The current process promotes instability in the industry. We are seeking a process that is predictable and promotes the reimbursement of current costs.

Proposed Change Number #2- Recognize financial impact of Federal and State Regulatory Changes: EMAC, Minimum wage, Family Leave Act: The introduction of mandated changes in the form of taxes and fees places an unfair and undue burden on these small businesses. Rest Homes are forced to comply with these mandated changes without any regard to the financial impact they will have with their operations. MARCH advocates that there be provisions in the regulations to apply for immediate rate increases to comply with these required changes. These unplanned taxes represent the single largest concern voiced by MARCH members.

Proposed Change Number #3- Reimburse for incremental staffing requirements to address the Aging-In-Place issues and homes with increasing dementia care populations: To address an ever - increasing aging-in-place population, Rest Homes hire licensed nursing staff to address the increased direct care needs of their residents. MARCH is requesting that these increased payroll costs are addressed as immediate adjustments to a rest home's rate, rather than wait to be compensated as part of a base year roll. The same case can be made for those homes that have a dementia population that require more direct care needs.

Ron Pawelski, MARCH

Proposed Change Number #4 Provide immediate rate relief for mandated changes per Department of Public Health Survey: Based on DPH licensure surveys, Rest Homes are required to submit plans of correction and implement said plans of correction within 90 days. Given the extent and nature of the required compliance actions, some homes have not been able to secure the finances to make the required changes. Several homes have been forced to close as a result. MARCH is proposing that immediate rate relief and rate adjustments be made to facilitate implementing required plans of correction and thereby ensuring rest homes are not forced to close.

Proposed Change #5 Create Direct Care Add-On Provision: Unlike the nursing facility industry, Rest Homes have not received a direct care add to their rates. However, like nursing facilities, Rest Homes have the same challenges with recruitment and retention. MARCH is requesting that provisions in the rate and reimbursement policies recognize this need and create a direct care add-on provision for Rest Homes

Proposed Change #6 Change Occupancy Requirement from 94% to actual patient days: The patient day utilization factor should be the actual patient days, not the 94% that is imputed for the rate calculations. Facilities that have a census that is lower than the 94% as indicated, are negatively impacted by this step-up in the use of this calculation. There are many reasons that a census could be low in any given year. This could happen by a large turnover possibly due to death and/or renovations that temporarily prevent admissions etc... which creates open census days. The result is that facilities are financially penalized by this variable cost divisor that has a major impact on the ability to successfully operate. The variable cost divisor should be the actual census days to determine the variable cost allowance per diem

Proposed Change #7 Change the reimbursable basis in the sale of a Rest Home: Another major issue for the survival of the industry is the ability to sell a facility to a non-related individual or entity and have these costs for the new owner reimbursable. The current regulation stipulates that the new owner inherits the adjusted basis from the previous owner. In most cases, there is minimal or no basis to be recognized for reimbursement by the new owner. There would be no reimbursement for the purchase price of the facility as well as the debt service related to this. This discourages the future continuation of many facilities as the real estate is sold as such and not for residential care.

Proposed Change #8 Increase rest home bed rate for SNFs with rest home Beds- When Skilled Nursing Facilities and free- standing Rest Homes receive rate increases, these 23+ facilities have not received rate increases. Provisions should be made to have this small group received adjusted rate increases.

Proposed Change #9 High Percentage of Publicly Assisted Residents- Provide a slightly higher rate increase for those Rest Homes with a high, (defined as greater than 95% of their resident population) public assistance census.

Other: Availability of no interest- low interest loans: While not regulatory based, a major financial concern is the ability to secure loans to make required capital improvements and/or hire additional staffing to care for the residents. MARCH can point to a series of homes that would still be operating if they were able to secure the needed capital.

MARCH would welcome the opportunity to review this document with all concerned parties. It is also our intent to bring these proposed changes to the Stabilization Task Force established by the legislature.

Ronald J. Pawelski, President
Massachusetts Association of Residential Care Homes

Ron Pawelski, MARCH

MARCH believes that monies should be allocated to complete a more detailed supply and demand analysis rather than relying on one data source.

Segment II: Current State vs. Future State This is the analytical segment designed to identify the current supply of Acute Hospital beds, SNF Beds, Rest Home Beds and Assisted Living and current utilization by HSA area. Suggested analysis would include number patients awaiting placement in acute settings current occupancy levels in the LTC settings and current demographics. The Future State would be an analysis and projections of where LTC services will be required and in what amount

For "Current State":

- For the HSA areas, suggest using the American Community Survey (ACS - gov't data; free) to understand the current population, incomes, etc. for demographic underpinnings. This data comes in at an extremely micro level geographic level - with ability I believe to roll it up to HSAs

- For AL + NC communities: NIC is for existing communities as well as the upcoming supply pipeline (https://www.nic.org/) While not full MA coverage - they have 10 out of 14 counties, the more rural ones tend to lack data. A suggested approach is to request a custom study from LivingPath (https://www.livingpath.com/) which would probably be pricey but should be considered.

NIC has County-level and MSA level data on occupancy and rate across the major groups - IL, AL, NC. They also have a time series of closures / unit reductions available in their data. (I don't think RH data shows up anywhere, but we have a listing by city/town geographic area that could be added)

The approach would be to do a baseline overlay by HSA that shows the Hospitals, SNF;s, Rest Homes and ALRs showing their current occupancy levels, the 2000 patients in hospitals awaiting placement, plotting out the locations, unit counts, year built, etc. Hospital data probably exist somewhere but not sure where.

Ron Pawelski, MARCH

For "Future State"

- Demographics: Companies like **Experian and Claritas** have 5 year forward looking estimates at the same ACS micro level. They may have population by age projections and incomes. Other sources could be **Moody's or Oxford Economics** if state/county level outlooks are suggested. Should have 65+ population

- New Supply**: NIC + Dodge Data & Analytics (fka McGraw-Hill Construction** -have the supply pipelines. Dodge is included in an NIC subscription, but I don't know if the state has a subscription. If not, this might be a suggested and required addition..

- Demand: Penetration Rate (80+ pop / occupied units)? usually 10-12% is the number. So, for every ten 80+ people, 1 new unit is required.

Would see these all as key indicators in trying to determine demand by HSA area by LTC discipline.

As it relates to Rest Homes, we know the occupancy level hovers around 90% and we know the total capacity of the industry. Our demographic information provided in the RH Task Force shows our average age is 75.

Note: Supply and Demand analysis that is presented for SNF's was NOT included in the Rest Home Task Force reporting. As such, time and attention should have been allocated to complete the same analysis that is provided for SNF's. It does not duplicate information. L

In listing the closure information for Rest Homes, I think it is important to show the % of the industry that has closed, over 60 % of the total, based on rate adequacy.

Christine Bishop, Brandeis University

Christine Bishop further recommended that the rate setting method and regulatory actions should avoid overly penalizing high-Medicaid facilities that are making a good-faith effort to respond to the incentives of the system, but face challenges due to long-term underfunding for capital projects and other infrastructure.

Appendix

Key Definitions

Rest Home: a residential care facility that provides 24-hour supervision and supportive services for aged, infirm, and at times indigent populations, who may have difficulty in caring for themselves, but do not routinely require nursing care. Rest homes provide housing, meals, activities, and arrange and coordinate medical services for individuals who need a supportive living arrangement. Rest homes are licensed by the Massachusetts Department of Public Health (DPH).

- Some rest home beds, classified as “Level IV” beds, are located within skilled nursing facilities (SNFs), which are considered “multi-level” or “hybrid” facilities.
- Per 105 CMR 150.00 Standards for Long Term Care Facilities, religious order homes do not require a license from DPH to operate. These homes must meet all local health and safety requirements.

Nursing Facility: alternatively known as “skilled nursing facilities” (SNFs), nursing facilities are supportive living environments for aged or infirm residents that provides a wide range of health and personal care services. Services at nursing facilities focus more on medical care than most rest home or assisted living facilities, and may include rehabilitation services, such as physical, occupational, and speech therapy. Similar to rest homes, nursing facilities are licensed by DPH.

Assisted Living Residence: private residences that offer housing, meals, and personal care services to aging adults who live independently. Assisted living residences (ALRs) are certified by the Executive Office of Aging & Independence (AGE) and are designed for adults who can live independently in a home-like environment but may need help with daily activities such as housekeeping, meal preparation, bathing, dressing, and/or medication assistance. ALRs do not provide medical or nursing services and are not designed for people who need serious medical care. Most assisted living residents pay fees privately, and the cost for each ALR can vary depending on the size, services, and location of the residence.

Key Definitions (cont.)

RCC-Q: the Resident Care Cost Quotient (RCC-Q) is a methodology for tracking spending across rest homes, including investments in direct care staff, infection control, and other resident care related expenditures that have a direct and meaningful impact on overall resident quality of life, health, and wellbeing. The RCC-Q serves as a mechanism to strengthen resident quality of care by holding rest homes financially accountable for managing their revenue and investing in resident care related costs, including direct care staffing.

DCC-Q: similar to the RCC-Q for rest homes, the Direct Care Cost Quotient (DCC-Q) is a methodology for tracking spending at nursing facilities, the key difference being that nursing facilities are not permitted to include the salaries for administrators, executive directors, and responsible parties (RPs) in their reporting as direct care staff.