**Assisted Living Residences (ALR) Commission**

Meeting Minutes

Wednesday, April 2, 2025

10:00 am - 11:30 am

Date of meeting: Wednesday, April 2, 2025

Start time: 10:00 am

End time: 11:30 am

Location: Virtual Meeting (Zoom)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Votes** | **Members** | **Present** | **Vote 1:****Approval of 2/26****Meeting Minutes** | **Vote II:****Approval of****3/5****Meeting Minutes** | **Vote III:****Motion to Adjourn** |
| **1** | **Secretary Robin Lipson** – Secretary, Executive Office of Aging & Independence (AGE) *(Chair)* | X | X | X | X |
| **2** | **Dr. Jessica Zeidman** – Deputy Commissioner/Chief Medical Officer, Department of Public Health | X | X | X | X |
| **3** | **Pavel Terpelets** – Director of Institutional Programs, Office of Long-Term Services and Supports (OLTSS), MassHealth | - | - | - | - |
| **4** | **Carolyn Fenn** – State Ombudsman and Director of the Long-Term Care Ombudsman Program, EOHHS | X | X | X | X |
| **5** | **Representative Thomas Stanley** – State Legislator, Mass. House of Representatives  | - | - | - | - |
| **6** | **Senator Patricia Jehlen** – State Legislator, Mass. Senate | X | X | X | X |
| **7** | **Senator Mark Montigny** – State Legislator, Mass. Senate | X | X | X | X |
| **8** | **Matt Salmon** – CEO, Salmon Health and Retirement | X | X | A | X |
| **9** | **Tara Gregorio** – President, Massachusetts Senior Care Association (MSCA) | X | - | X | X |
| **10** | **Mathew Muratore** – Appointee of the House Minority Leader | X | X | X | X |
| **11** | **Beth Anderson**– An Appointee of the Governor, Vice President at EPOCH Senior Living | X | A | A | X |
| **12** | **TBD** |  |  |  |  |
| **13** | **TBD** |  |  |  |  |
| **14** | **Liane Zeitz** – Owner, Law Office of Liane Zeitz, the representative of the Massachusetts chapter of the National Academy of Elder Law Attorneys | X | X | X | X |
| **15** | **Elissa Sherman,** President of LeadingAge Massachusetts, Inc. | X | X | X | X |
| **16** | **Brian Doherty,** President & CEO of Massachusetts Assisted Living Association, Inc. (Mass-ALA) | X | X | X | X |
| **17** | **Jennifer Benson** – State Director of AARP Massachusetts | X | X | X | X |
| **18** | **Katherine Ladetto** – Assistant Professor, School of Nursing, Simmons University, the representative of the New England chapter of the Gerontological Advanced Practice Nurses Association | - | - | - | - |
| **19** | **Lainey Titus Samant** – Senior Advocacy Manager, Alzheimer’s Association, MA/NH Chapter | X | X | A | X |
| **20** | **Dr. Jennifer Maynard** –Executive Director, Massachusetts Program of All-Inclusive Care for the Elderly (Mass. PACE) | X | X | X | X |
| **21** | **Lindsay Mitnik** –Staff Attorney, Elder Law- Greater Boston Legal Services | X | X | X | X |

**\*** (X) Voted in favor; (O) Opposed; (A) Abstained from vote; (-) Absent from meeting or during vote

**Proceedings**

Secretary Robin Lipson, of the Executive Office of Aging & Independence, welcomed everyone and noted that this meeting was subject to the Open Meeting Law and any votes the Commission takes will be subject to a roll call vote. This PowerPoint Presentation was used throughout the meeting: [download](https://www.mass.gov/doc/alr-commission-meeting-presentation-april-2-2025/download). Secretary Lipson welcomed Beth Anderson, the Commission’s newest member. Beth serves as the Vice President of Risk Management and Compliance at EPOCH Senior Living. She has been in the industry since 1995 and has a lot of experience. She manages legal affairs for EPOCH and is responsible for overseeing all their legal matters, managing legal risk, ensuring compliance with laws, etc. She previously had been on the business side working on acquisitions and permitting and zoning for construction of senior housing. Secretary Lipson took the prerogative as the Chair of the Commission to invite two guests to this meeting. This is to ensure that we have the voice of consumers and Residents. Secretary Lipson asked Kathleen Lynch Moncata and Rose-Marie Cervone to attend today’s meeting as guests. They will participate as asked, but are not allowed to take any votes. It is important to have a strong perspective from ALR Residents and their families.

Secretary Lipson asked if there were any proposed changes to the draft meeting minutes from the past two meetings—the February 26th and March 5th meetings. The Commission members had no proposed changes to the draft meeting minutes for both meetings. A motion to accept the minutes from the February 26th meeting was made. *See* Vote I Column in the Chart above. The meeting minutes for the February 26th meeting were approved. A motion to accept the minutes from the March 5th meeting was made. The meeting minutes for the March 5th meeting were approved. *See* Vote II Column in the Chart above.

At today’s meeting, the Commission will look at ALRs in other states to see if we can understand some of the innovative and more adaptable strategies. *See* Slide 2. Whitney Moyer, the Chief Operating Officer at the Executive Office of Aging & Independence (AGE), provided a refresher about incident report trends that were mentioned at the last meeting. *See* Slide 5. The top table in Slide 5 shows the ratio of incidents per Resident. The number of incidents has more than doubled from 2019 to 2024. However, AGE as an agency has told ALRs to submit more incident reports and to overreport in order for AGE to understand what is happening in ALRs. The total number of incidents is growing faster than the Resident population. The most significant increases include falls or suspected falls, acute health or behavioral emergencies, and allegations of abuse, neglect, or exploitation.

Secretary Lipson mentioned that there were three questions she wants people to consider during the presentation: (1) Are there elements from other states’ policies or practices we should consider in Massachusetts?; (2) What might help us address the rising incident rates and specialized care needs while maintaining an environment that encourages incident reporting?; and (3) In what ways can we improve transparency for Residents and families? *See* Slide 6.

Jennifer Benson from AARP Massachusetts presented first. *See* Slide 7. Ms. Benson noted that what constitutes an “Assisted Living” varies greatly from state to state. Additionally, not all states license ALRs. Generally speaking, Assisted Living refers to a residential care setting on the long-term care continuum that usually is more home-like, and often provides more privacy and autonomy that a nursing home but, that allows individuals who need assistance with Activities of Daily Livings (ADLs) or Instrumental Activities of Daily Living (IADLs) to receive some level of personal care services to assist with those ADL or IADL needs, while also receiving room and board.

In Massachusetts, ALRs are certified by the Executive Office of Aging & Independence. *See* Slide 11. ALRs in Massachusetts do not have to retain any Resident in need of skilled nursing care unless the facility is licensed to provide hospice care. The Medicaid state plan covers personal care services and case management oversight in an ALR through Home- and Community-based Services waivers (HCBS). Minnesota is very prescriptive in its regulations about what needs to be provided. *See* Slide 12. In Minnesota, a facility can discharge a Resident if the Resident’s assessed needs exceed the scope of services agreed upon in the assisted living contract and are not included in the services the facility disclosed in the uniform checklist.

Minnesota has a uniform checklist so every ALR must provide the same information in the same way so that comparisons can be made from one facility to another. *See* Slide 14. The uniform checklist disclosure of services is spelled out in regulation. The checklist has to be displayed on the ALR’s website as well as presented to the Residents and future Residents. This is all publicly available information in order to make comparisons easily. In Wyoming, for scope of care, the facility must provide assistance with obtaining medical, dental, and optometric care. *See* Slide 15. This means that there is a lot more case management required by the ALR. Utah is also prescriptive about what needs to be provided in ALRs.

Lainey Titus Samant, a Senior Advocacy Manager with the Alzheimer’s Association, presented next. *See* Slide 18. Ms. Samant discussed best practices for the dementia community in ALRs. Some considerations for Residents with dementia include dementia-specific training, adequate staffing, licensing standards, the involuntary discharge process, and electronic monitoring. She discussed the current Massachusetts dementia-specific training requirements, which include a general orientation and ongoing in-service education and training. She discussed the staffing tools and requirements in other states. *See* Slide 26. In Maine, the ALR must provide all new employees assigned to dementia units 8 hours of classroom orientation and 8 hours of clinical orientation. In Minnesota, there are competency requirements depending on the role.

In Massachusetts, there needs to be sufficient staffing for scheduled and reasonably foreseeable unscheduled Resident needs and to respond to individual Resident emergencies. In general, regarding adequate staffing considerations, appropriate staff ratio practices affect the quality of life for those in ALRs, especially those living with dementia. *See* Slide 25. There is limited research on what the optimal ratio of staffing is. Therefore, states might look toward implementing acuity-based staffing models. Staff ratios should be provided to families to inform their decision-making when choosing an ALR.

In Georgia, a memory care center must have one registered professional nurse, licensed practical nurse or certified medication aide, and two on-site direct care staff persons at all times. *See* Slide 27. Additionally, in Georgia, there is a requirement for the number of hours a registered professional nurse or a licensed practical nurse must be on-site at the facility based on the amount of Residents. Oregon has acuity-based staffing. The Oregon Department of Human Services (ODHS) has created an Acuity Based Staffing Tool (ABST) tool that ALRs can use, or ALRs can get a different tool approved by ODHS. *See* Slide 28. It is free of cost for ALRs to use the ABST. The ALRs are then required to review and update their staffing plan once it has been determined what the staffing level should be at the ALR using the ABST. In Indiana, the ALR must provide a written disclosure form that is completed in conjunction with the long-term care ombudsman’s office. The written disclosure form must include the staff-to-patient ratio for each shift. This form is completed annually and is made available to any individual seeking information on services for an individual with Alzheimer’s or dementia.

In Minnesota, there are two separate licensing programs—one is for ALRs and the other is for ALRs with dementia care. There are different requirements to be licensed as an ALR with dementia care. In Colorado, there is a requirement that a written notice be given to the Resident and other specific persons at least 30 days prior to the involuntary discharge. There is an exemption for that requirement—the exemption can be used if the Resident needs a higher level of care or if the Resident poses harm to the Resident or other Residents. *See* Slide 33. In regard to electronic monitoring, Resident autonomy and privacy should be protected.

Elissa Sherman, of LeadingAge Massachusetts, presented next. *See* Slide 36. Ms. Sherman discussed the Connecticut model of Assisted Living. In Connecticut, there are 152 Assisted Living buildings with a total of 9000 Assisted Living apartment units. 60% are part of a national or regional chain. The average cost in 2020 was $6,300 per month. Memory care costs 20% to 30% more. The Connecticut model is unique because the services are licensed separately from the building. Therefore, assisted living services can be provided in a range of different housing settings. The building is considered a Managed Residential Community (MRC). The services are licensed as Assisted Living Services Agencies (ALSA). MRCs are registered with the state of Connecticut, so the building themselves are not licensed. There are required services that must be provided such as three meals a day, laundry services, regularly scheduled transportation, etc. *See* Slide 38. The Residential unit includes a full bathroom within the unit and equipment for the preparation and storage of food. There is a Residential Service Coordinator who works with the ALSA and serves as a liaison to support Residents.

ALSAs are licensed by the Connecticut Department of Public Health. ALSAs provide nursing services and assistance with ADLs. It is a little more of a healthcare model in that there are more licensed nurses that are required. Those receiving services must be considered “chronic and stable.”

There is a Medicaid waiver program called the Connecticut Home Care Program for Elders which pays for assisted living services. *See* Slide 41. It is for Residents who are 65+ and they have to meet functional and financial requirements. For those who do qualify, the state has set up four different levels or packages of assisted living services included in this funding program.

There are three types of affordable assisted living sites in Connecticut where ALSA services can be provided. They are the HUD subsidized housing/assisted living conversion program, subsidized assisted living demonstration sites, and state congregate housing. In all these settings, there are assisted living services that are funded through the Connecticut Home Program for Elders. There is also a private pay assisted living program. *See* Slide 44.

There are 125 slots that use the Connecticut Home Care Program, which pays for services for Residents in private assisted living that have spent down assets. The program only pays for services—the Resident must still pay for room and board. There are some challenges with this model. The current licensure model of an ALSA requires a certain number of on-site nursing hours which may not be financially feasible for an affordable housing setting where the number of assisted living clients may be small. Some of the MRC requirements that emerged after COVID were outside the expertise of affordable housing sites. Additionally, the affordable models do not include memory care units and the options available for transitioning someone who needs a secured unit are very limited and it usually means a nursing home placement.

Brian Doherty of Massachusetts Assisted Living Association (Mass-ALA) and Beth Anderson of EPOCH Senior Living presented next. See Slide 45. In Massachusetts, there is a continuum of care for older adults, which include independent living, assisted living, and skilled nursing. *See* Slide 47. Roughly 30% of Assisted Living Residents in Massachusetts reside in Special Care Units. Skilled nursing provides 24/7 care in a clinical and institutional setting similar to a hospital for people with chronic complex medical needs associated with ongoing illnesses and post-surgical rehabilitation. The funding for skilled nursing is primarily through Medicare and Medicaid.

Massachusetts has one of the strongest disclosure requirements in the country. *See* Slide 48. The Assisted Living Advisory Council (ALAC) has worked on the residency agreement--the Resident or decision-maker now needs to initial at each line of the Residency Agreement. Massachusetts is a leader among the states in affording consumer protections and helping to ensure Residents are empowered to choose and make fully informed decisions by mandating greater detail and upfront transparency.

Regarding Basic Health Services, Mr. Doherty noted that the majority of other states have the flexibility of which services to offer. *See* Slide 49. The new Massachusetts law requires Residences to offer all or none of the Basic Health Services. Other states allow skilled services beyond those permitted under the new Massachusetts law to be delivered by nurses and other licensed/trained caregivers, including catheters, colostomy/ileostomy, wounds (stage 1 and above), and tracheotomy.

Mr. Doherty added that many states allow caregivers who are not nurses to receive training to administer medications, which allows nurses to focus on individualized service plans and overall wellness. *See* Slide 50. The new Massachusetts Certified Medication Aide (CMA) should be introduced into assisted living by adjusting the Limited Medication Administration (LMA) regulation to give Certified Medication Aides a role. This would benefit Residents by allowing more cost-effective, value-based, and specialized services, while also benefitting staff by opening up a new career ladder.

Ms. Anderson noted that over the 30-year history of the Assisted Living model, AGE has made timely updates to the regulations to meet the changing circumstances amid an aging population, such as medication assistance and special care. *See* Slide 51. There are multiple resources to support informed consumer choice, which include: (1) AGE’s Consumer Guide; (2) detailed Residency Agreement requirements and the AGE Residency Agreement cover sheet; (3) Disclosure Statements; (4) the recently expanded Assisted Living Ombudsman Program; and (5) the Mass-ALA Resource Guide.

Through the many iterations of AGE’s regulations, Ms. Anderson believes that ALRs are well-regulated. *See* Slide 55. She also added that the new law gives AGE that authority to issue fines of up to $500 per day. She mentioned that it is important that the regulations define a limit to the number of days for which these fines can be issued and clarify the categories of serious infractions that would warrant a fine.

Mr. Doherty mentioned the Frail Elder Waiver bill and that Massachusetts needs ALR support programs that would permit low-income individuals to have improved access to Assisted Living services. *See* Slide 56. Mr. Doherty noted that as consumers increasingly choose Assisted Living, access must be available to Residents of varying incomes. Improved access can be facilitated by maintaining the flexibility of regulations so that Residents do not have to pay for services they do not need, as well as having a Basic Medicaid reimbursement on the full cost of Assisted Living, preferably through the Frail Elder Waiver.

Secretary Lipson mentioned that ALR Residents may be receiving MassHealth support through Group Adult Foster Care and PACE if they are clinically and financially eligible. Rose-Marie Cervone noted that when a Resident becomes unstable in an ALR, sometimes the ALR staff cannot handle it. The ALR may not move to a more medical approach when they need to, which is required to assess the Resident to know that the ALR has to transfer the Resident.

Kathleen Lynch Moncata mentioned that she goes back to transparency and accountability. How do consumers know about one place and compare it to another—it is very difficult to find out that information. In terms of accountability, what actions have been taken by AGE regarding certification or the results of an inspection for these ALRs and is that something consumers can get access to? Secretary Lipson noted that we do have strong disclosure requirements—the issue might be whether they are uniform. The comparisons are hard to make.

Whitney Moyer mentioned that AGE is working on having information be more accessible on its mass.gov website. Interested individuals will have the ability to access and see the different types of actions that have been taken by AGE. The process for requesting insight currently is through a public records request.

Dr. Jessica Zeidman noted that currently the statute requires certified medication aides need to provide care at a long-term care facility. Tara Gregorio reiterated that there is a tug between a housing model and a medical model. When looking at other states and the models that we want to emulate, we need to know if they are based on a housing model or a medical model and who is the regulator. She believes it would be good if we could have a way where we are all equally accountable to some type of disclosure and transparency checklist. Families need to understand what ALRs perform medical services and what the costs are. Another opportunity may be to look at the training opportunities of our elder care workers, and how do we take an inventory and see where we are deficient and where we should be focusing more.

Beth Anderson noted that Mass-ALA has a resource guide, and AGE has a consumer guide. Both guides have checklists in them. With this checklist, you walk through an ALR and determine what is provided at the ALR. Jennifer Maynard mentioned that we have to be mindful of staffing. She also noted that Residents’ needs change and sometimes there is a disconnect between what the family is seeing, what the ALR is seeing, and what the Resident is seeing. Documentation about what the Resident is needing helps when a transition is necessary and it makes the process more collaborative.

Liane Zeitz wants to highlight the issue of staffing. The regulations require sufficient staffing, but there is no easy way for consumers or AGE to monitor that. She is interested in what other states require in terms of ratios or number of Residents and acuity levels. The term “sufficient” is not specific enough for people to assess.

Matt Salmon, of Salmon Health and Retirement, noted that one of the challenges now is that we are starting to provide services in ALRs that ALRs were not designed for. ALRs have different construction and building regulations than nursing homes and hospitals. ALRs are built for a social model and not a medical model. Nursing homes and hospitals are constructed based on a medical model.

Brian Doherty mentioned that in regard to the increase of incident reports submitted to AGE, clarifying and educating ALRs about what needs to actually be reported would be helpful and lessen the number of incident reports submitted to AGE.

Secretary Lipson mentioned the next meeting will be held on April 17th. The meeting will focus on transparency and consumer protections. Secretary Lipson noted that AGE is in the process of getting the ALR regulations involving Basic Health Services ready for public notice. Liane Zeitz asked if the next meeting should be rescheduled. The Attorney General’s Office is working on consumer protection regulations, and those regulations have not yet come out and we are waiting for the Governor’s appointments of consumer representatives. Secretary Lipson noted we are working with the Governor’s Office. We included strong Resident and family voices at this meeting, and they are welcome to attend the next meeting. The Attorney General’s staff will mention at the next meeting where they are with the regulations and the Attorney General’s Office wants to hear from all of you.

**Vote III to adjourn the meeting:** A motion to adjourn was made and seconded. The motion was approved by roll call vote (see detailed record of votes above).

The meeting was adjourned at 11:30 am.

**Meeting Materials**

1. PowerPoint Presentation: [download](https://www.mass.gov/doc/alr-commission-meeting-presentation-april-2-2025/download)