Executive Office of Aging & Independence

ALR Commission Meeting #3

Wednesday, April 2 | 10:00 AM

Your Partners in Aging.

Agenda

1. **Opening |** *Secretary Robin Lipson (15 mins)*
   - Welcome & Attendance
   - Approval of February 26th and March 5, 2025 Meeting Minutes
   - Refresher & Guidance for Discussion

2. **Presentations**
   - **ALR State Policy Comparison** | Jennifer Benson, AARP Massachusetts (10 mins)
   - **Best Practices for the Dementia Community in Assisted Living Residences** | Lainey Titus Samant, Alzheimer's Association (10 mins)
   - **The Connecticut Model of Assisted Living** | Elissa Sherman, LeadingAge Massachusetts (10 mins)
   - **Massachusetts ALR Industry Compared to Other States** | Brian Doherty, Massachusetts Assisted Living Association (Mass-ALA) & Beth Anderson, EPOCH Senior Living / Treasurer Mass-ALA (10 mins)

3. **General Discussion** *(30 mins)*

4. **Wrap-Up |** *Secretary Robin Lipson (5 mins)*
   - Roadmap and Proposed Topics & Presenters for April 17th Meeting

Refresher

Secretary Robin Lipson

ALR Commission Action Items

Focus of Today's Presentations

During today's discussion, keep in mind:

- **Previously discussed trends**
- Upcoming conversations about **resident transparency & protections**

- Review current statutory and regulatory oversight of assisted living residences for **improvement opportunities**.
- Evaluate how licensing and certification affect ALR **operations and care quality**.
- Assess incident reporting trends (using data from the Executive Office of Aging & Independence and the Long-Term Care Ombudsman's office) to identify **recurring issues and solutions**.
- Examine best practices from other states to **identify innovative, adaptable strategies**.
- Scrutinize advertising practices to **ensure clear, transparent information for prospective residents and families**.
- Explore methods to **enhance consumer transparency** by **improving information accessibility and comparability**.
- Review **safety standards** and **consumer protections** in existing statutes and regulations.
- Investigate the delivery of basic health services to **ensure safe and effective care**.
- Analyze regulatory procedures for opening, closing, or transferring residence ownership—including community need assessments and facility clustering—to better protect consumers.

Refresher | *ALR Incident Report Trends*

Year	Residents	Incidents	Incidents per Resident
2019	16,930	8,669	**0.5**
2020	14,835	18,518	**1.3**
2021	15,654	16,835	**1.1**
2022	16,304	26,375	**1.6**
2023	17,143	32,483	**1.9**
2024	17,943	33,466	**1.9**

INCIDENT TYPE	COUNT					
Year	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**
Acute Health or Behavioral Emergency	1,345	6,117	4,603	11,843	15,141	15,207
Allegation of Abuse, Neglect, or Exploitation	312	502	703	634	876	1,088
Death	783	1,765	1,513	1,726	1,982	2,289
Elopement	67	129	151	181	183	200
Fall or Suspected Fall	5,658	9,251	9,108	11,110	13,241	13,631
Medication Event	504	754	757	880	1,060	1,031
Grand Total	**8,669**	**18,518**	**16,835**	**26,375**	**32,483**	**33,446**

Table presented during March 5, 2025, ALR Commission Meeting #2 (slide 11)

- The total number of incidents is growing **faster** than the resident population.
  - By 2024, there are **nearly two incidents per resident** (1.9), compared to about **0.5** in 2019.
- Most significant increases
  - Falls or Suspected Falls
    - ***2019***: 5,658
    - ***2023***: 13,601
  - Acute Health or Behavioral Emergency
    - ***2019***: 1,345
    - ***2023***: 15,207
    - Numbers may reflect more acute medical needs among residents and/or better (or more frequent) reporting.
  - Allegation of Abuse, Neglect, or Exploitation
    - ***2019***: 312
    - ***2024***: 1,088
    - Although smaller in absolute numbers, these are **serious** concerns and have more than tripled since 2019.

Questions to Consider & Discuss

- Are there elements from other states' policies or practices we should consider in Massachusetts?
- What might help us address the rising incident rates and specialized care needs while maintaining an environment that encourages incident reporting?
- In what ways can we improve transparency for residents and families?

ALR State Policy Comparison

Jennifer Benson, AARP Massachusetts

State Comparison Overview

- States are responsible for licensing and regulatory oversight and enforcement in the assisted living context. Because the licensure, oversight and regulation are controlled by the states, assisted living varies greatly from state to state.
- Not all states license ALR's (ie: CT, MI, PR).
- Unfortunately, the absence of a single, universally accepted term for assisted living makes it difficult to compare or understand an assisted living framework across different states.

State Comparison Overview

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 than a nursing home but, that allows individuals who need assistance with Activities of Daily Living (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.

Massachusetts

Scope of Care: 1. For all Residents whose service plans so specify, supervision of and assistance with Activities of Daily Living, including at a minimum bathing, dressing, and ambulation and similar tasks; and supervision or assistance with Instrumental Activities of Daily Living including at a minimum laundry, housekeeping, socialization and similar tasks;

2. Self-administered Medication Management (SAMM) of prescription or over-the-counter medication, if specified by a Resident's service plan.

3. Timely assistance to Residents and prompt response to urgent or emergency needs.

4. Up to three regularly scheduled meals daily (minimum of one meal per day)

Massachusetts

Licensed: Yes. The Executive Office of Aging and Independence (AGE) certifies assisted living residences.

Can Residents Age In Place? No. Facilities do not have to retain any resident in need of skilled nursing unless the facility is licensed to provide hospice care.

Medicaid Coverage: The Medicaid state plan covers personal care services and case management oversight in an assisted living residence through Home- and Community-based Services Waivers (HCBS).

Minnesota

Scope of Care: A facility that provides assisted living services: Assisted living services. "Assisted living services" includes one or more of the following:
(1) assisting with dressing, self-feeding, oral hygiene, hair care, grooming, toileting, and bathing;
(2) providing standby assistance;
(3) providing verbal or visual reminders to the resident to take regularly scheduled medication, which includes bringing the resident previously set up medication, medication in original containers, or liquid or food to accompany the medication;
(4) providing verbal or visual reminders to the resident to perform regularly scheduled treatments and exercises;
(5) preparing specialized diets ordered by a licensed health professional;
(6) services of an advanced practice registered nurse, registered nurse, licensed practical nurse, physical therapist, respiratory therapist, occupational therapist, speech-language pathologist, dietitian or nutritionist, or social worker;
(7) tasks delegated to unlicensed personnel by a registered nurse or assigned by a licensed health professional within the person's scope of practice;
(8) medication management services;
(9) hands-on assistance with transfers and mobility;
(10) treatment and therapies;
(11) assisting residents with eating when the residents have complicated eating problems as identified in the resident record or through an assessment such as difficulty swallowing, recurrent lung aspirations, or requiring the use of a tube or parenteral or intravenous instruments to be fed;
(12) providing other complex or specialty health care services; and
(13) supportive services in addition to the provision of at least one of the services listed in clauses (1) to (12).

Minnesota

Can Residents Age In Place? No. A facility can discharge 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**.

Medicaid Coverage: Medicaid home and community-based services waivers cover Assisted Living.

Licensed: Yes. The Health Regulation Division of the Minnesota within the Minnesota Department of Health licenses assisted living.

Minnesota

4659.0090 UNIFORM CHECKLIST DISCLOSURE OF SERVICES.

§Subpart 1.

Definition.

- For purposes of this part "Uniform Checklist Disclosure of Services" or "checklist" means the checklist developed and posted by the commissioner under subpart 2 and Minnesota Statutes, section 144G.40, subdivision 2, that an assisted living facility must provide to prospective residents before a contract is executed to enhance understanding of policies and services that are provided and are not provided by the facility.

Subp. 2.

Uniform checklist disclosure of services.

- The commissioner shall post a Uniform Checklist Disclosure of Services template with a comprehensive list of assisted living services, developed according to Minnesota Statutes, section 144G.40, subdivision 2, paragraph (c), on the department's website for facility use. The commissioner shall update the checklist on an as-needed basis.

Wyoming

Scope of Care: The facility must provide, among other core services: (1) assistance with transportation; (2) assistance with obtaining medical, dental, and optometric care; and (3) assistance w/ ADLS.

Pennsylvania

Scope of Care: 1. For Assisted Living Facilities: all levels of care
2. For Residential Care Facilities: all levels of care

Utah

Scope of Care: Facilities must provide personal care, food service, housekeeping, laundry, maintenance, activity programs, administration, and assistance with self-administration of medication, and arrange for necessary medical and dental care

Wisconsin

Scope of Care:

1. Provides general services, client-specific services, and medication administration and assistance.
2. Provides services that are sufficient and qualified to meet the care needs identified in the tenant service agreements, meets unscheduled care needs of its tenants, and makes emergency services available 24 hours per day.

Citations

- COMPENDIUM OF RESIDENTIAL CARE AND ASSISTED LIVING REGULATIONS AND POLICY
- AARP Assisted Living Summary of State Statutes
- LTSS Choices Long-Term Services & Supports
- Minnesota HHS State Regulations
- AHCA/NCAL Assisted Living 2019 State Regulatory Review
- MassHealth for Long-Term-Care Services

Best Practices for the Dementia Community in Assisted Living Residences

Lainey Titus Samant
Senior Advocacy Manager
Alzheimer's Association | MA/NH Chapter

Considerations for Residents with Dementia

- Dementia Specific Training
- Adequate Staffing
- Licensing Standards
- Involuntary Discharge Process
- Electronic Monitoring

Current MA Dementia Specific Training Requirements

General Orientation

- At least **two hours** of general orientation training shall be devoted to the topic of dementia and cognitive impairments (out of 7 hours total).
- Both the Residence Manager and Service Coordinator shall receive an additional **two-hour** training devoted to dementia care topics.
- All new employees who work within a Special Care Residence and have direct contact with residents must receive **seven hours** of additional training on topics related to the specialized care needs of the resident population.

Current MA Dementia Specific Training Requirements

Ongoing In-service Education and Training

- A minimum of ten hours per year of ongoing education and training is required for all employees, with at least **two hours** on the specialized needs of residents with Alzheimer's disease and related dementia.
- Employees working in a Special Care Residence must receive an additional **four hours** of training per year related to the residents' specialized needs.
- All employees and providers shall receive ongoing in-service education and training to ensure orientation training is reinforced, on topics including Alzheimer's disease and cognitive impairments.

Dementia Specific Training Requirements

Virginia

Training in working with individuals who have cognitive impairment:

- Administrator: 12 hours
- Direct care staff: 6 hours
- All other staff: 2 hours
- Direct care staff in a special care residence: 10 hours

Maine

For all new employees assigned to dementia units, assisted living facilities must provide:

- 8 hours of classroom orientation
- 8 hours of clinical orientation

Dementia Specific Training Considerations

Minnesota

- Competency requirements, depending on role
  - Written or oral exam and practical skills assessment
  - ALR must have a method for determining and documenting each staff person's knowledge and understanding of the training provided
- Direct-care employees restricted from providing direct care until training complete, unless another trained employee is on site
- Written or electronic notice of dementia training to residents and families
- Training on the person-centered care approach

Massachusetts Staffing Requirements

- Sufficient staffing for scheduled and reasonably foreseeable unscheduled resident needs and to respond to individual resident emergencies

- A Special Care Residence shall have sufficient staff qualified by training and experience awake and on duty at all times to meet the 24-hour per day scheduled and reasonably foreseeable unscheduled resident needs

- It shall never be considered sufficient to have fewer than two staff members in a Special Care Residence
  - Exemptions are available in some situations that allow one staff member and one Floater to be on duty during an overnight shift

Adequate Staffing Considerations

- Appropriate staff ratio practices affect the quality of life for those in ALRs, especially those living with dementia.
- According to one study, residents showed lower verbal aggression scores when there was a higher staff-to-resident ratio.
- However, there is limited research identifying an optimal ratio of staffing.
- Therefore, states might look toward implementing acuity-based staffing models.
- In addition, staff ratios should be provided to families to inform their decision making when choosing an ALR

Staffing Tools & Requirements in Other States

Virginia

Day hours:

- 20 or fewer residents: at least two direct care staff members
- For every additional 10 residents (or portion of 10): at least one additional direct care staff member
- If no more than 5 residents are in the unit: one direct care staff member, provided there are at least two other direct care staff members in the building

Night hours:

- 22 or fewer residents: at least two direct care staff members
- 23 to 32 residents: at least three direct care staff members
- 33 to 40 residents: at least four direct care staff members
- More than 40 residents: at least four direct care staff members plus at least one more direct care staff member for every additional 10 residents, or portion of 10

Staffing Tools & Requirements in Other States

Georgia

At a minimum, a memory care center must have:

- 1 direct care worker for every 12 residents during all waking hours
- 1 direct care worker for every 15 residents during all non-waking hours
- 1 registered professional nurse, licensed practical nurse or certified medication aide, and two on-site direct care staff persons at all times
- 1 registered professional nurse or licensed practical nurse must be on-site or available in the building at all times as follows:
  - 1-12 residents: a minimum of eight (8) hours per week
  - 13-30 residents: a minimum of sixteen (16) hours per week
  - 31-40 residents: a minimum of twenty-four (24) hours per week
  - More than 40 residents: a minimum of forty (40) hours per week

Staffing Tools & Requirements in Other States

Oregon

- Assisted living residences must:
  - Implement and maintain an Oregon Department of Human Services (ODHS) approved proprietary Acuity Based Staffing Tool (ABST) or the ODHS ABST that is free of cost.
  - Review and update the posted staffing plan when reviewing the ABST

Indiana

- Written disclosure form, completed in conjunction with the long term care ombudsman's office
- Must include the staff-to-patient ratio for each shift
- Completed annually and made available to any individual seeking information on services for an individual with Alzheimer's or dementia

Licensing Standards for Memory Care Units

Massachusetts

- Certification approved by AGE for all Assisted Living facilities
- For a Special Care Residence, the facility must submit an operating plan that explains how the Special Care Residence or Residences will meet the specialized needs of its resident population, including those who may need assistance in directing their own care due to cognitive or other impairments.
    - This includes a description of the physical design of the structure and the units, physical environment, specialized safety features, enrichment activities, and the ongoing training of staff.

Licensing Standards for Memory Care Units

Minnesota

- Assisted living facilities that market themselves as providing dementia care, including those with specialized dementia or memory care unit, be licensed accordingly
- Therefore, there are two assisted living licensing programs, one dedicated for people with dementia, “Assisted living facility with dementia care”
- "Assisted living facility with dementia care" means a licensed assisted living facility that is advertised, marketed, or otherwise promoted as providing specialized care for individuals with Alzheimer's disease or other dementias.
- License granted by the State Commissioner of Health

Disclosures Required for Licensing

Indiana

- Requires that ALRs which provide memory care services disclose their dementia-specific care, staffing levels, and transfer/discharge policies.

Oklahoma

- Requires that any ALR with a memory care unit disclose the type of care provided that distinguishes it as being especially applicable to or suitable for those living with Alzheimer's or dementia.
- Disclosure form provided to the state Department of Health, any person seeking placement in the memory care unit and the State Long-Term Care Ombudsman.

Involuntary Discharge Process in Massachusetts

Residents' Rights

- To not be evicted from the assisted living residence except in accordance with the provisions of landlord tenant law

Involuntary Discharge Process in Other States

Colorado

- Written notice to the resident and other specified persons at least 30 days prior to the involuntary discharge
  - Exemption if needs a higher level of care or the resident poses a harm to the resident or to other residents
- If the involuntary discharge is due to a resident's nonpayment of monthly services and room and board, the residence may discharge the resident 31 days after the resident received the notice of discharge.
- Establishes a process to challenge an involuntary discharge

Involuntary Discharge Process in Other States

Virginia

- Requires that regulations be promulgated to provide certain safeguards for residents, including:
  - Description of the reasons for which a resident may be involuntarily discharged
  - Requirement that the facility make reasonable efforts to resolve any issues upon which the discharge is based
  - Information regarding the resident's right to appeal the facility's decision to discharge the resident.

Considerations for Electronic Monitoring

- Overall, resident autonomy and privacy should be protected
- Informed consent of resident being monitored
- Informed consent of roommates residing in shared living spaces
- Ability for the user (whether a resident or substitute decision maker) to turn the camera/device on and off as needed
- Allow resident to consent to video recording but not audio

The Connecticut Model of Assisted Living

Presentation to the Assisted Living Commission

April 2, 2025

Elissa Sherman
LeadingAge Massachusetts

Overview: Assisted Living in Connecticut

- 152 Assisted Living Buildings with a total of 9000 AL Apartment units
- 60% are part of national or regional chains
- Average cost in 2020 - $6300 per month
  (memory care 20 – 30% more)

Source: The Resident's Guide to Managed Residential Communities in Connecticut

For Assisted Living - Connecticut Regulates the Building Separate from the Services

Building: Managed Residential Community (MRC)

Services: Assisted Living Services Agency (ALSA)

Managed Residential Community (MRC)

- Registered with state of Connecticut
- Core services required:
  - 3 meals a day
  - Laundry service
  - Regularly scheduled transportation
  - Housekeeping
  - Maintenance
  - Social and recreational opportunities
  - 24 hour a day security
  - Emergency on-call system for each unit
  - On-site washers and dryers
  - Common space
  - Residential Service Coordinator
- Residential unit includes full bathroom within the unit and equipment for preparation and storage of food

Assisted Living Service Agencies

- Licensed by the Connecticut Department of Public Health (DPH)
- Provides nursing services, assistance with ADLs
- Those receiving service must be considered “chronic and stable.”

Connecticut Home Care Program for Elders

- Medicaid waiver program that pays for Assisted Living Services
- For individuals 65+
- Must meet functional and financial requirements
- Four service packages for assisted living services included in this funding program

Three Types of Affordable Assisted Living Sites in Connecticut where ALSA services can be provided

HUD Subsidized Housing/ Assisted Living Conversion Program

Not required to register as Managed Residential Community

Subsidized Assisted Living Demonstration Sites (four)

These sites are considered managed residential communities

State Congregate Housing

Not considered Managed Residential Communities

AL services funded through the Connecticut Home Care Program for Elders

Private Pay Assisted living Program

- 125 slots using Connecticut Home Care Program to pay for services for residents in private assisted living that have spent down assets
- Pays for services only (resident must still pay for room and board)
- Includes a cost share depending upon applicant’s income and assets

Challenges

- 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 of the expertise of affordable housing sites.
- 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

--*President & CEO,* Massachusetts Assisted Living Association

Beth Anderson

--*Vice President,* EPOCH Senior Living

-- *Treasurer*, Massachusetts Assisted Living Association Board of Directors

The Massachusetts Assisted Living Association (Mass-ALA) is a not-for-profit association, dedicated to professionally operated assisted living residences in Massachusetts that provide housing and services for individuals with varied needs and income levels.

Established in 1990 as a state affiliate of Argentum, Mass-ALA serves as the voice of assisted living in Massachusetts, providing information and education, and advocating on behalf of our members and the seniors they serve. Mass-ALA promotes a model of care which treats all residents with dignity, provides privacy and encourages independence and freedom of choice.

Continuum of Care for Older Adults in MA

Independent Living

- Residential apartment with services, including meals, housekeeping, and life enrichment activities.
- Private pay & third-party insurance.

Assisted Living

- Residential homelike and community living setting in individual apartments. Services provided include meals, housekeeping, life enrichment activities and programming, assistance with the activities of daily living (personal hygiene, dressing, toileting, mobility, medication management, and eating), providing support to individuals who have chronic but stable conditions.
- Also included under the assisted living umbrella are special care communities tailored to meet the needs of residents with dementia and related illnesses. Roughly 30% of assisted living residents in MA reside in special care units.
- Private pay and third-party insurance.

Skilled Nursing

- 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, with residents living in semi-private rooms (with some private rooms).
- Funding is primarily through Medicare and Medicaid.

Review Of Leading States' Policies: MA Has One Of The Strongest Disclosure Requirements

651 CMR 12.08(3) ensures residents and families fully understand the terms of their residency agreements by requiring a detailed written Residency Agreement and a Disclosure to be signed prior to move-in, including items such as:

- Scope of Services – Clear breakdown of services provided.
- Fees & Payments – Full disclosure of costs, rate changes, and refund policies.
- Admission & Discharge Criteria – Explicit guidelines to prevent unfair evictions and ensure proper placement.
- Resident Rights – Guaranteed legal protections and grievance procedures.
- Staffing & Emergencies – Transparency on staff levels and emergency plans.

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.

Basic Health Services in Other States

- **Flexibility** of which services to offer (the new Massachusetts law requires residences to offer all or none of the health services, while the majority of states do not).
- We intentionally pursued a more tailored model with the newly passed law; support offered in assisted living includes holistic support services for residents with chronic but stable conditions.
- Other states allow skilled services beyond those permitted under the new MA law to be delivered by nurses and other licensed/trained caregivers, including catheters, colostomy/ileostomy, wounds (stage 1 and above), and tracheotomy.

Best Practices from Other States on Workforce Specializations

- 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.
- The new MA Certified Medication Aid (CMA) should be introduced into assisted living by adjusting the Limited Medication Administration (LMA) regulation to give them 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.

Massachusetts ALR Regulations Working Well

- Current regulatory and statutory scheme supports the residential model of ALR services that delivers high-quality and cost-effective care in support of meeting residents' physical, mental, and behavioral health.

- Over the 30-year history of the assisted living model, AGE has made timely updates to regulations to meet changing circumstances amid an aging population, such as medication assistance and special care.

- Promotes resident independence, dignity, and values consumer choice.

- Consumers prefer the ability to choose the residential model (homelike setting)in a vibrant community.

MA Special Care Regulations Are More Advanced Than Many States

- **Environment:** Designed for **enhanced safety**, with secure features to minimize exits and **support residents with dementia-related wandering behaviors**.
- **Service Plans:** Tailored specifically for residents with evolving health needs and **cognitive impairments**, incorporating **dementia-specific strategies** beyond the standard ALR service planning process.
- **Resident Rights:** Upholds privacy, dignity, and autonomy, with **specialized protocols to balance independence and community living with cognitive support needs**.
- **Compliance:** Subject to **enhanced oversight**, including **SCU-specific biennial reviews** that assess dementia care standards, environmental safety, and staffing requirements—**beyond the standard ALR inspection process**.

Consumer Choice is Supported and Encouraged

- Multiple resources to support informed consumer choice:
  - AGE's Consumer Guide
  - Detailed Residency Agreement Requirements and AGE Residency Agreement Cover Sheet
  - Disclosure Statements
  - Recently Expanded Assisted Living Ombudsman Program
  - Mass-ALA Resource Guide

- Consumer choice is a critical issue, as each ALR is unique and able to tailor its services to the populations it serves.

- Prevents "institutionalization" to meet the needs of residents, unlike nursing homes with rigid rules governing how all aspects of services are delivered. The assisted living environment should retain its homelike atmosphere.

Staffing Based on Residents' Needs

- MA residential model has varied service levels and residents with differences in needs.
- Special Care Units must have no fewer than two staff members on duty at all times, as the waiver allowing flexibility ended on March 31, 2025, after four years of demonstrated success. Despite positive outcomes during the waiver period, the original staffing requirement is now reinstated.
- Minimal circumstances/citations based on lack of staffing.
- Resident needs = the most effective means of determining staffing. Consumers have the most options in terms of services and costs when some ALRs serve populations with higher staff needs than others.
- Unnecessary staffing increases costs to residents.

Strong Regulatory Oversight

- Evidence that the current statutes and regulations are working well is continuously demonstrated through the compliance survey process.
- Modifications, suspensions, financial penalties, and denial of admissions secures compliance in the limited situations where material noncompliance occurs.
- The plan of correction process achieves necessary changes in operations in response to noncompliance issues.
- The new law gives AGE authority to issue fines up to $500 per day. *It is important that the regulations further 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.*

Policy Changes to Increase Access to ALRs and Services Residents' Needs

Frail Elder Waiver:

Massachusetts needs ALR support programs that would permit low-income individuals improved access to assisted living services.

- Most states provide this assistance through the Medicaid Frail Elder Waiver.
- Amending Frail Elder Waiver to add service (similar to District of Columbia 1915(c)).
- Establishing a new stand-alone 1915(c) waiver (for example, "Senior Assisted Living Waiver") that only enables Assisted Living (similar to Ohio 1915(c)).
- Enabling only within the SCO program via "in lieu of service" authority (California, Pennsylvania).
- This Medicaid Waiver makes supports available to eligible frail elders 60 and older who meet the requirements for a nursing facility but prefer to remain in the community residing in an ALR.
- Commission members, Joint Committee on Elder Affairs Chairs Jehlen and Stanley have filed (SD.1319/HD.2385), to facilitate research and a report about making such Waiver available for those who desire to live in assisted living. Executive action could be taken without such legislation.

Conclusion

- Regulations are working as intended. The flexibility, consumer protections, and quality controls afforded by existing regulations allows ALRs to offer various staffing, services, acuity levels, and amenity models **to give consumers the choice** between different cost and service levels. As a result, assisted living is more popular and cost-effective than other settings and service models thanks to the value it provides.

- With respect to other regulatory components (e.g., documentation, incident reporting, penalties, etc.) **Massachusetts either exceeds or is consistent with regulatory standards** in other states.

- The scope of services that can be offered in Massachusetts is significantly more limited than in most other states, which makes ALRs less accessible to older adults and their families.

- As **consumers increasingly choose assisted living,** access must be available to residents of varying incomes. Improved access can be facilitated by:
  - **Maintaining flexibility of regulations** so that residents do not have to pay for services they do not need
  - **Basic Medicaid reimbursement** on the full cost of assisted living, preferably through the Frail Elder Waiver.

Questions & Discussion

Questions to Consider & Discuss

- Overall questions and/or thoughts?

- Are there elements from other states' policies or practices we should consider in Massachusetts?

- What might help us address the rising incident rates and specialized care needs, particularly in dementia care, while maintaining an environment that encourages incident reporting?

- In what ways can we improve transparency for residents and families?

Roadmap

April 17th Meeting Proposed Topics & Presenters

Secretary Robin Lipson

Roadmap | *Where We Are Going*

Date	Topic	Key Focus	Proposed Speakers/Stakeholders	Exact Statute Language
2/26/2025	Intro & ALRs Oversight	Overview of ALRs, ethics/compliance, legislative mandates	Secretary of Elder Affairs (Chair), AGE Director of ALRs	(i) the current statutory and regulatory oversight of assisted living residences;
3/5/2025	Key Trends	Trends in ALR certification, ownership changes, incident/complaint reporting	AGE Director of ALRs, LTC Ombudsman Director	(iii) the impacts of licensing or certifying such residences; (vi) trends in incident reports and resolutions
4/2/2025	State Comparisons, Best Practices & Advertising	Review of leading states' policies, licensing impacts, advertising practices	Mass-ALA, LeadingAge, Alzheimer's Association, AARP	(ii) assisted living best practices in other states; (iv) advertising practices of assisted living residences
4/17/2025	Transparency & Consumer Protections	Methods for transparency, consumer protections, resident safety	Greater Boston Legal Services, National Academy of Elder Law Attorneys, AGO Representative	(ix) existing consumer protections for residents; (vii) methods to provide transparency of information for potential consumers and families
5/7/2025	Safety Standards & Health Services	Safety standards and integration of basic health services	NE Chapter of Gerontological AP Nurses, DPH, AGE	(viii) safety standards; (x) basic health services in residences
5/15/2025	Public Hearing	Engage residents, families, advocacy groups, and industry stakeholders	Residents, family members, advocacy groups, industry representatives	Public Hearing (gathering public input, as required by SECTION 32(b))
6/4/2025	ALR Affordability & Regulatory Procedures	Key considerations related to opening/ closing/ ownership, and need determinations	MassPACE, MassHealth, AGE	(v) regulatory procedures for opening, closing or changing ownership, including determination of need processes and clustering of facilities
7/2/2025	Final Recommendations & Report Drafting	Consolidate findings and finalize recommendations	AGE Chair, Staff, Policy & Legal Team	All topics (i)-(x) as outlined in SECTION 32(a) for final recommendations and report drafting
8/1/2025	Submit Legislative Report			

THANK YOU!