

**STAFF REPORT TO THE PUBLIC HEALTH COUNCIL  
FOR A DETERMINATION OF NEED**

Applicant Name	Wellman Healthcare Group, Inc.
Applicant Address	250 Shearer Street Palmer, MA
Filing Date	November 17, 2021
Type of DoN Application	Long Term Care Substantial Capital Expenditure
Total Value	\$18,838,384.00
Project Number	PHC-21052014-LE
Ten Taxpayer Group (TTG)	None
Community Health Initiative (CHI)	\$565,151.52
Staff Recommendation	Approval
Public Health Council	February 9, 2022

Project Summary and Regulatory Review

Wellman Healthcare Group, Inc. (Applicant), submitted an application for a substantial capital expenditure to expand their long-term care facility through construction of a 46,225 gross square foot (gsf) replacement facility with 82 beds (of which 21 will be new beds). The replacement facility includes: two floors each with 41 beds including 20 semiprivate rooms and one private room. The second floor will be a locked memory care unit; plus, an enclosed exterior garden on the first floor and a roof patio. The capital expenditure for the Proposed Project is \$18,838,384.00; and the Community Health Initiatives (CHI) commitment is \$565,151.52.

This Application for Determination of Need (DoN) falls within the definition of Substantial Capital Expenditure, which are reviewed under the DoN regulation 105 CMR 100.000. The Department must determine that need exists for a Proposed Project, on the basis of material in the record, where the Applicant makes a clear and convincing demonstration that the Proposed Project meets each Determination of Need Factor set forth within 105 CMR 100.210. This staff report addresses each of the six factors set forth in the regulation.

The Department did not receive any written comments on this application, nor were any Ten Taxpayer Groups formed.

## **Application Overview**

Wellman Healthcare Group, Inc. (“Wellman” or the “Applicant”) is a healthcare system that operates Palmer Healthcare Center (“PHC” or the “Facility”), a 61-bed skilled nursing facility located on a 12.6-acre campus in Palmer, Massachusetts. The Facility has been serving the greater Palmer community for over 55 years. It is a high Medicaid provider, with approximately 80% of their patients enrolled in Medicaid as of August 2021. It is a CMS four-star rated facility.

## **Proposed Project**

The Facility was originally built in 1963 as a single story, 20,976 gross square feet (“GSF”) building with 20 rooms comprised of 61 beds, with five (5) 4-bedded rooms, eleven (11) 3-bedded rooms, and four (4) semiprivate rooms with two (2) beds each. The unit is a locked unit. The Facility is located in a rural area and serves a high volume of patients with government payers. It provides dementia care and geriatric services, although the current facility does not have a licensed Dementia Special Care Unit, largely due to the prohibitive cost to meet physical plant requirements in the current space.

As the Applicant was found to fit the criteria set forth in the DoN Memorandum “Applications for Determination of Need for Long-Term Care Facilities,”<sup>1</sup> it received approval to submit a DoN Application to add twenty-one (21) new Level II long-term care beds to its 61-bed skilled facility.

The Applicant must come into compliance with new Department of Public Health (“DPH” de-densification licensure requirements for long-term care facilities set out in 105 CMR 150.320(B) (the “De-Densification Requirements”). The Applicant has asserted that to meet the De-Densification Requirements in its current building would reduce the existing Facility to only 40 beds which would not be sufficient to serve the Applicant’s Patient Panel.

The Applicant proposes to build a replacement facility (the “Replacement Facility”) with 82 beds in order to both comply with the De-Densification Requirements and remain financially viable, while serving its patient panel. This Replacement Facility will be located adjacent to the current Facility on its campus located at 250 Shearer St., Palmer, Massachusetts.

A summary of changes proposed by the Applicant is presented in Table 1.

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<sup>1</sup> <https://www.mass.gov/doc/don-long-term-care-moratorium-memo-pdf/download>

**Table 1: Overview of the De-Densification Project**

	Pre-Project (#)	Post-Project (#)
<b>Rooms</b>		
4-bedded rooms	5	0
3-bedded rooms	11	0
2-bedded rooms	4	40*
Private rooms	0	2
<i>Total beds</i>	61	82
<b>Area</b>		
Floors	1	2
Dementia Special Care Units	0	1
Gross Sq Feet	20,976	46,225

\*The Replacement Facility will include 20 semi-private hybrid rooms which meet the licensure requirements for single room and can be used as a single or double as needed by the Applicant

Each of the two floors will have 21 rooms: one private room and 20 rooms that can be flexed to serve as either single- or double-bedded rooms. Only the second floor will be locked.

The Applicant states its Replacement Facility will prioritize infection control measures against COVID-19 and other transmittable disease by:

1. Having a separate entrance and exit vestibule to allow for enhanced screening and infection control measures
2. Having a handwashing sink near the replacement facility's entrance
3. Implementing a layered approach to maximizing outdoor air ventilation and/or reducing recirculation of air indoors, consistent with the layered approach described in the Centers for Disease Control and Prevention Guidelines.<sup>2</sup>
4. Installing a state-of-the-art variable refrigerant flow (VRF) forced air HVAC system which will include mechanical fresh air provided by a series of Energy Recovery Ventilators (ERV's) which pre-condition incoming outside air with heated or cooled air, thereby increasing energy efficiency and maximizing infection control by achieving the required level of air exchanges and filtering the fresh air with MERV-13 filtration throughout the building, which effectively targets airborne contaminants.
5. Having a localized air filtration and interior mechanical air exchange which has been shown to improve the indoor air quality (IAQ) and further mitigate air contamination.

The Replacement Facility will have the capacity to serve individuals with geriatric-psychiatric or dementia diagnosis who need access to skilled nursing care in a secure facility, individuals with COVID-19 (or other similar infectious, airborne diseases), and individuals with short-term skilled nursing care needs.

<sup>2</sup> <https://www.cdc.gov/coronavirus/2019-ncov/community/ventilation.html#:~:text=CDC%20recommends%20a%20layered%20approach,lower%20the%20risk%20of%20exposure.>

## OVERVIEW of PROPOSED PROJECT AND FACTOR REVIEW

Description	What's Needed to Meet Factor 1: Demonstration of need; improved health outcomes and quality of life; assurances of health equity; continuity and coordination of care; evidence of community engagement; and competition on recognized measures of health care spending.	What's Needed to Meet Factor 2: Demonstration of cost containment, improved public health outcomes, and delivery system transformation	Factors 3, 4 & 5 <sup>3</sup>	What's Needed to Meet Factor 6: Demonstration of plans for fulfilling ... responsibilities ... in the DPH Community-based Health Initiatives Guideline.
	<i>Staff Report finds</i>			
	MEETS	MEETS	MEETS	MEETS
The Applicant is proposing to replace their existing facility, increasing the number of beds from 61 to 82, in order to: 1) comply with the new Dedensification Requirements and 2) continue performing at their maximum efficiency level.	✓	✓	✓	✓

<sup>3</sup> 3: Sufficient evidence of compliance and good standing with federal, state, and local laws and regulations

4: Sufficient documentation of the availability of sufficient funds for capital and ongoing operating costs necessary to support the Project without negative impacts or consequences to the Applicant's existing Patient Panel 5: The ... Project, on balance, is superior to alternative and substitute methods for meeting ... Patient Panel needs.

## Patient Panel<sup>4</sup>

The Applicant provided a narrative summary of the Facility’s patient panel. Upon request from DoN Staff for additional Patient Panel information, the Applicant stated its previous record system only captured financial data and patient data were recorded on paper records and that racial and ethnic data were not recorded. Staff notes the following observations about the Applicant’s patient panel data below, summarized in Table 2:

- **Age** – The age of all patients in the Facility’s patient panel ranges from 50-99, with the majority in the 70-79 age range. As the Applicant did not provide specific breakdowns by each age group, this information is not presented in Table 2.
- **Race/Ethnicity** – As the facility has not collected race or ethnicity data consistently to date, it is limited. A new Electronic Medical Record (EMR) system was implemented in March 2021 and these data elements will be collected henceforth.
- **Primary Service Area** – 76 percent of patients came from within 20 miles of the facility, with 42 percent from within 10 miles.

**Table 2: Overview of Patient Panel (FY17-19)**

<b>Total Individual Patients (FY18-20)</b>	97
<b>Gender</b>	
Male	41%
Female	59%
<b>Race<sup>5</sup></b>	
Caucasian	55%
Black	2%
Hispanic	4%
Unknown/Not Specified	39%
<b>Patient Origin</b>	
Within 10 miles	42%
Within 20 miles	34%

Table 3 below presents payer mix data in two views: a sample of a typical monthly payer mix and the FY20 payer mix for Palmer Healthcare Center. The discrepancy between the rates of Medicaid and Medicare between the time periods results from patients’ long lengths of stay and the changes in long-term care coverage during a patient’s stay. According to the Applicant, patients are usually admitted to the Facility under the Medicare Part A scheme, but once they fall out of eligibility (the applicant reports this typically occurs within the first 50 days in the Facility), most patients transfer their coverage to MassHealth or self-pay. The monthly snapshot shows the individuals’ actual insurance in a given month which is more likely to reflect the

<sup>4</sup> As defined in 105 CMR 100.100, Patient Panel is the total of the individual patients regardless of payer, including those patients seen within an emergency department(s) if applicable, seen over the course of the most recent complete 36-month period by the Applicant or Holder.

<sup>5</sup> Self-identified

change to Medicaid, while the fiscal year average reflects payer at point of admission (when Medicare is more likely to be in effect). Of note, the Applicant’s average Medicare case-mix index of 1.34-1.38 which the Applicant states reflects that the Patient Panel has a high level of cognitive impairment and more behavioral than medical needs.

**Table 3: Payer Mix – August 2021 and FY2020**

<b>Payer type</b>	<b>Aug 2021</b>	<b>FY2020</b>
MEDICAID	80%	38%
MEDICARE	10%	52%
Self-Pay/ Commercial	10%	9%

**Factor 1: a) Patient Panel Need**

In addition to complying with De-Densification Requirements, the Applicant attributes Patient Panel needs for expanded capacity to the following:

1. Capacity constraints
  2. Inability to accommodate community needs
  3. Need for an unlocked unit
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1. The Facility operates at or near capacity most of the time. Typical lengths of stay in the facility are long, generally a result of many patients experiencing a high level of cognitive impairment and mid- to severe levels of dementia. Among the Patient Panel are residents who present or are at risk for declines in swallowing and nutritional intake, self-feeding, balance, muscle weakness and mobility and ADL performance. Patients may require increased pain management as well as occupational, physical, and speech therapy to aid the patient adapt to the Facility.

The Facility’s average length of stay is 3.2 years, which is greater than Massachusetts’ average of 2.41 years, which is consistent with the composition of their patient panel.<sup>6</sup> Evidence suggests that lengths of stay in long-term care facilities is significantly longer for patients with dementia compared to patients without dementia.<sup>7</sup> The Applicant provided their Level II Resident Days by Year for FY18 to FY20, as seen in Table 4.

Additionally, the Applicant’s patients are not generally discharged back into the community, due to the heightened risk of wandering when moved to a new environment. While efforts

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<sup>6</sup> Long-Term Care in Massachusetts: Facts at a Glance. Available at: <https://www.mass.gov/doc/ltc-factsheetpdf/download>

<sup>7</sup> Sabbagh MN, Silverberg N, Majeed B, Samant S, Sparks DL, Seward J, Connor DJ. Length of stay in skilled nursing facilities is longer for patients with dementia. *J Alzheimers Dis.* 2003 Feb;5(1):57-63. doi: 10.3233/jad-2003-5108. PMID: 12590167.

are made to discharge short-term patients with low-level dementia whose physical health improves after coming to the Facility, this is not enough to meet the demand of the larger patient population.

**Table 4: Resident Days per Year**

<b>Year (1/1-12/31)</b>	<b>Resident Days</b>
2018	19,231
2019	20,457
2020	20,097

2. In FY2021, the Facility turned away 31 referrals from neighboring hospitals because of lack of capacity. These referrals included patients with both short- and long-term care needs, and behavioral health diagnoses, some of whom could be cared for in unlocked environments while others require locked facilities. The Applicant cites the Baystate Health Community Needs Assessment, which found that the Palmer community has higher rates for the majority of health conditions identified as prioritized health needs, including a mental health hospitalization rate more than double that of the state. Specifically, around 30% of its older adults experiencing depression and 15% of people over the age of 65 in Palmer have some form of Alzheimer’s or dementia.<sup>8</sup>

The Applicant notes its close relationship with Baystate Wing Hospital, a 74-bed community hospital located within a mile of the Facility and provides inpatient and outpatient behavioral health, including geriatric psychiatry. Baystate Wing is a primary referral source for the Applicant, though it receives referrals from other skilled nursing facilities who are unable to accommodate the behavioral needs of residents. In addition, the Applicant states the modern state-of-the art build environment will be specifically designed to address the behavioral health needs of the Patient Panel where the role of the physical environment is crucial to supporting their care and providing an atmosphere of familiarity that can positively contribute to their health outcomes<sup>9</sup>

3. The Applicant’s Proposed Project includes a new, unlocked first floor of the Replacement Facility which it asserts will serve patients with short term needs to expand its ability to serve demonstrated unmet need for the short and long-term skilled nursing facility services in Palmer.

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<sup>8</sup> PUB. HEALTH INST. OF W. MASS., COMMUNITY NEEDS ASSESSMENT, 69 (2019) (Adopted by the Baystate Health Board of Trustees on Sept. 10, 2019) (available at <https://www.baystatehealth.org/-/media/files/aboutus/community-programs/community-benefits/2019-community-health-needs-assessments/baystate-wing-2019-chnareport-final-web.pdf?la=en>)

<sup>9</sup> Bram de Boer et al., The Physical Environment of Nursing Homes for People with Dementia: Traditional Nursing Homes, Small-Scale Living Facilities, and Green Care Farms, 6(4) HEALTHCARE (BASEL) 137 (Nov. 26, 2018), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6315793/>

- a) Through ongoing discussions with the Baystate Wing’s orthopedic team, the Applicant has identified a need for short-term rehabilitation beds in the community to allow patients to receive their short-term rehabilitation care locally. With the Facility’s current configuration of predominantly triples and quads on a locked floor, it cannot accommodate these residents.
- b) Additionally, when residents need to step down from a locked unit they have to be transferred to another facility. The Proposed Project would allow them to remain at PHC with their same caregivers and ensure continuity of care and reduction of transfer trauma. The Proposed Project will assist in meeting this need.

The Applicant asserts that the Facility’s approach to long-term care is to ensure as much independence and safety as possible and to focus on enhancing the quality of life of their aging Patient Panel. The Applicant reports that approximately 23% of their residents are on anti-psychotic medication.<sup>10</sup> The Applicant attributes their Patient Panel’s relatively high rate of anti-psychotic medication to the facility’s specialization in treating geriatric-psychiatric patients with Alzheimer’s in a locked environment specifically, many of its patients have a dual diagnosis of dementia and schizophrenia or bipolar disorder.

### ***Analysis***

Staff finds that the information provided by Applicant demonstrates sufficient Patient Panel need for the expansion of the Facility’s long-term care capacity. The Applicant serves a population with elevated cognitive impairment and mental health needs requiring a specialized care and often higher level of service. Staff recognizes that providing these services while complying with the De-Densification Requirements would be difficult with the current Facility’s layout and size. The Applicant has demonstrated the need for short-term beds in an unlocked setting to accommodate referrals from Baystate Wing Hospital and to allow residents to step down from the locked unit in the same facility.

Given the Applicant’s relatively high rate of patients on anti-psychotic medication, Staff recommend ongoing reporting on the percentage of anti-psychotic medication as well as the diagnoses of patients on these medications.

## **Factor 1: b) Public Health Value, Improved Health Outcomes And Quality Of Life; Assurances Of Health Equity**

The Applicant must demonstrate that the Proposed Project adds measurable public health value in terms of improved health outcomes and quality of life of the Applicant’s existing patient panel, while providing reasonable assurances of health equity.

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<sup>10</sup> The Centers for Medicare and Medicaid Services (CMS) reported trends for anti-psychotic medication use across all long-term care facilities has been down trending since 2012, and the average national rate in 2018 was reported to be around 15%. (Source: National Partnership to Improve Dementia Care in Nursing Homes: Antipsychotic Medication Use Data Report (April 2019). Available at: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Antipsychotic-Medication-Use-Data-Report.pdf> )



Palmer Healthcare Center is rated four out of five stars on CMS Nursing Home Compare, an assessment based on three major factors: 1) health inspections, 2) staffing, and 3) quality of resident care measures. The Applicant notes its population includes many patients with cognitive needs who require specialized care. Access to these services locally, particularly amongst a high public payer population adds public health value. In addition to providing care to the geriatric-psychiatric population, the addition of a first-floor unit in the Replacement Facility will allow care for short-term stay patients and those who do not require a locked unit. The expanded access to these and may contribute to improved health outcomes and quality of life of members of the Palmer community.

### **Equity**

The Applicant states it does not discriminate on the basis of socioeconomic status and accepts all appropriate residents in its service area, which has a high volume of MassHealth beneficiaries.

The socio-economic status (SES) of the patient population in Palmer Healthcare Center's service area tends to be lower than the rest of the state, and DoN Staff note that studies show long-term care outcomes differ by race and socioeconomic status.<sup>11, 12, 13</sup> Increasing service capacity for both short-term and long-term residents can improve patient outcomes and quality of life for these patients by ensuring access to appropriate care. The Applicant has demonstrated it serves a high proportion of public payer patients.

Race data on the region in Table 5 show a large white population. Given the Facility's lack of historical race data, Staff are unable to make any conclusions about the distribution of its population by race.

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<sup>11</sup>

<https://dls.gateway.dor.state.ma.us/reports/rdPage.aspx?rdRequestForwarding=Form&rdReport=Socioeconomic.MedHouseholdFamInc&rdPaging=&rdShowModes=&rdDataCache=9024611102&rdSort=tblMedHouseFamInc~Median+Household+Income~Number~~&tblMedHouseFamInc-PageNr=0&rdSortArrowTable=rdSortArrowKey-Socioeconomic-MedHouseholdFamInc-tblMedHouseFamInc-Median+Household+Income>

<sup>12</sup> <https://www.jstor.org/stable/4149069>

<sup>13</sup> <https://lpeproject.org/blog/medicare-for-all-how-to-reduce-inequality-in-the-long-term-care-market/>

**Table 5: Demographic comparison across local regions and Facility’s Patient Panel<sup>14</sup>**

Race	Hampden County	Palmer City	Palmer Healthcare Center
<i>Total population estimate</i>		12,232	97
White	83%	90%	55%
Black or African-American	11%	2%	2%
American Indian/ Alaskan Native	1%	0%	N/A
Asian	3%	2%	N/A
Hispanic or Latino	26%	5%	4%

All Determination of Need Holders will have to provide a plan for approval by the Office of Health Equity for the development and improvement of language access and assistive services provided to individuals with disabilities, non-English speaking, Limited English Proficiency (LEP), and American Sign Language (ASL) patients. To support any language needs, the Facility uses a third-party interpreter service, LanguageLine Solutions, which is a phone line available on-demand 24/7 for 240+ languages. The Applicant states that their patient panel consists mostly of primarily English-speaking patients.

Additionally, the Applicant has committed to implementing robust infection control practices to promote better health outcomes by protecting patients from COVID-19 and other respiratory diseases, as noted earlier in the report. The Applicant states that the Proposed Project is designed to meet industry-defined best practices for safety, quality, and efficiency.

### **Analysis**

Staff finds that the Proposed Project supports improved outcomes, improved quality of life and greater patient satisfaction. It is difficult to assess the race and ethnicity of the Applicant’s patient population, given the tracking issues noted earlier. The Applicant has stated that the Facility will capture race/ ethnicity data as reported by their patients going forward, using their EMR system (launched in March 2021), and predicts that this data gap will significantly be reduced or eliminated. Staff recommend ongoing reporting on race as the Applicant begins to collect these data more accurately.

### **Factor 1: c) Efficiency, Continuity of Care, Coordination of Care**

The Applicant asserts that the Replacement Facility will increase efficiency and continue to ensure linkages to appropriate external services such as primary care and social programs as necessary. The Facility currently has a service model in place that is used to refer patients to

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<sup>14</sup> Census.gov. 2019 QuickFacts: Palmer Town City, Massachusetts.  
<https://www.census.gov/quickfacts/fact/table/hampdencountymassachusetts/RHI525219#RHI525219>

community-based services. With the added capacity of the Replacement Facility, the Applicant predicts that referral activities to community services will increase in the future.

Upon admission, the patient is closely followed by their original primary care provider. The Facility's care team maintains regular communication with the patient's primary care provider. As the patient adapts to the Facility, the role of primary care gradually transitions to the Facility's medical director. The care team also coordinates closely with the patients' families to develop individual care plans to meet unique needs.

The Applicant states that a new EMR was launched in March 2021. It provides functionality and access to amalgamated patient health information that is regularly reviewed by long-term care staff, allows providers to coordinate patient care notes and instructions with external providers, and affords immediate patient access to provider notes and most diagnostic test results.

### ***Analysis***

Staff finds that the Facility demonstrates sufficient plans to maintain and improve on efficiency, coordination, and continuity of care with the Proposed Project. With the new EMR, the Facility will improve on continuity and coordination of care for its long-term care patients. There is evidence demonstrating that the benefits to U.S. nursing homes of having electronic record systems, such as better patient health outcomes (i.e. urinary tract infections and depressive symptoms), are likely driven by improved administrative thoroughness, including documentation, risk assessments and clinical decision support systems.<sup>15</sup>

### **Factor 1: d) Consultation**

The Applicant has provided evidence of consultation with all government agencies that have licensure, certification, or other regulatory oversight, which has been done and will not be addressed further in this report.

### **Factor 1: e) Evidence of Sound Community Engagement through the Patient Panel**

The Department's Guideline for community engagement defines "community" as the Patient Panel, and requires that at minimum, the Applicant must "consult" with groups representative of the Applicant's Patient Panel. Regulations state that efforts in such consultation should consist of engaging "community coalitions statistically representative of the Patient Panel."<sup>16</sup>

The Applicant asserts that a diverse team of stakeholders in the greater Palmer community were consulted regarding this Proposed Project. These consultations were with:

1. State and local officials

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<sup>15</sup> Bjarnadottir RI, Herzig CTA, Travers JL, Castle NG, Stone PW. Implementation of Electronic Health Records in US Nursing Homes. *Comput Inform Nurs.* 2017;35(8):417-424. doi:10.1097/CIN.0000000000000344

<sup>16</sup> DoN Regulation 100.210 (A)(1)(e). <https://www.mass.gov/files/documents/2018/12/31/jud-lib-105cmr100.pdf>

2. HealthDrive (the Facility’s provider for mental health and geriatric psychiatry)
3. Baystate Wing Hospital
4. Palmer’s own employees and staff.

The Applicant states that everyone consulted about the Proposed Project was supportive of its decision to expand and replace its existing capacity.

**Analysis**

Staff finds that the Applicant met the required community engagement standard of Consult in the planning phase of the Proposed Project.

**Factor 1: f) Competition on Price, Total Medical Expenses (TME), Costs And Other Measures Of Health Care Spending**

The Applicant states that the Proposed Project, which is being done to comply with the Department’s long-term care facility regulations and new requirements to de-densify rooms, will compete based on price, TME, costs, and other measures of healthcare spending based on the following:

- As is true for the existing Facility, the Replacement Facility will maintain full Medicaid certification.
- Palmer Healthcare Center is located in a high-need area, with high demand for its services

From the information provided by the Applicant (Table 6), it is noted that the Applicant reports a lower than median cost structure in its existing Facility and slightly above the median upon completion of the Replacement Facility.

**Table 6: Projected Operational Expenses 2019-2026**

	2019				Inflation Adjustment	2026			
	PALMER HEALTHCARE CENTER	Hampden, MA 25th percentile	Hampden, MA 50th percentile	Hampden, MA 75th percentile		PALMER HEALTHCARE CENTER	Hampden, MA 25th percentile	Hampden, MA 50th percentile	Hampden, MA 75th percentile
<b>Costs per Patient Day*</b>									
Administration	\$74	\$51	\$57	\$69	2.0%	\$84	\$59	\$65	\$79
Plant	\$14	\$12	\$13	\$18	2.0%	\$19	\$13	\$15	\$21
Dietary	\$17	\$18	\$21	\$24	2.0%	\$20	\$21	\$24	\$28
Laundry	\$5	\$4	\$5	\$5	2.0%	\$5	\$4	\$6	\$6
Housekeeping	\$6	\$6	\$6	\$8	2.0%	\$7	\$7	\$7	\$9
Nursing	\$66	\$88	\$110	\$122	2.0%	\$120	\$101	\$126	\$140
Social Services	\$3	\$3	\$4	\$4	2.0%	\$8	\$3	\$5	\$5
Other General Services	\$7	\$2	\$4	\$6	2.0%	\$4	\$3	\$5	\$7
<b>Total Costs</b>	<b>\$192</b>	<b>\$184</b>	<b>\$220</b>	<b>\$256</b>		<b>\$268</b>	<b>\$211</b>	<b>\$253</b>	<b>\$295</b>

\*Palmer numbers include benefits which are included in Administration. Benchmark data excludes benefits. Additionally, Ancillary expenditures are excluded for both Palmer and the Benchmark data.

**Analysis**

Staff examined the Applicant’s ability to compete based on price, costs and other measures of health spending and found that the Applicant sufficiently provides lower-cost services to a high-

needs community at a high public payer mix. Staff found evidence supporting costs savings from having de-densified nursing service beds, in addition to other benefits, such as lower risk of infection, operational efficiencies, higher quality time with visitors.<sup>17</sup>

## **FACTOR 1: SUMMARY**

As a result of information provided by the Applicant and additional analysis, staff finds that the Applicant has demonstrated that the Proposed Project has met Factor 1(a-f).

## **Factor 2: Cost containment, Improved Public Health Outcomes and Delivery System Transformation**

### **Cost Containment**

The new patient rooms in the Replacement Facility are designed to be adjustable between semiprivate and private rooms with no additional construction cost to allow for flexibility based on the needs of the patient panel over time. Staffing costs are projected to increase given the addition of 21 beds, but the Applicant asserts that these costs are warranted, given its potential to contribute to the improvement of health and well-being of its patient panel. The Applicant also states that it anticipates the overall operating costs of the Replacement Facility will be lower than that of the current Facility due to added efficiencies and modernizations in the Replacement Facility.

Finally, the Applicant asserts that the Replacement Facility will contribute to the Commonwealth's goals of cost containment by meeting or exceeding the "silver level" of the Leadership in Energy and Environmental Design- Health Care (LEED-HC), part of the U.S. Green Building initiative. The LEED rating system denotes that the Replacement Facility's building design and construction plans will meet standards for a sustainable building based on factors that is focused on providing a healthy space for people to live and work.<sup>18</sup>

The LEED-HC standard also assures that the Replacement facility will be energy efficient and modern in its mechanical design throughout the building, such as the air ventilation system. The Applicant states that the floor plan is designed to maximize resident care and workflow efficiency.

### ***Analysis: Cost Containment***

Cost containment on a statewide level is impacted through pricing, which is a function of what providers charge payers and what payers agree to pay. While payment contracts between individual providers and commercial payers are confidential, those among providers and Medicare and Medicaid are relatively transparent. While Staff cannot assess how the Applicant's contracts with payers that may incent more or less utilization of services are

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<sup>17</sup> M. Calkins and C. Cassella, "Exploring the Cost and Value of Private Versus Shared Bedrooms in Nursing Homes," *The Gerontologist*, April 2007 47:169–83.

<sup>18</sup> <https://www.usgbc.org/leed>

structured for the other project components. However, given the facility's high percentage of public payers, it is not anticipated that the project would result in significant cost changes.

The staff finds that the Proposed Project will achieve cost savings by increasing operational efficiencies and sustainability through modernization of mechanical systems throughout the Replacement Facility.

### **Improved Public Health Outcomes**

The Applicant states that the Proposed Project will improve public health outcomes by maximizing infection control and minimizing future disease outbreaks, such as COVID-19. The Applicant asserts that improved systems in the Replacement Facility will lower and prevent hospitalized readmissions and improve on their public health outcomes. The Applicant states that patients have had positive health outcomes during their stay at the Facility to date and expanding the number of beds will further allow the Facility to provide their skilled nursing services and contribute to positive health outcomes for those who otherwise could not access these services at home. In addition, the first-floor unit of the Replacement Facility will allow the accommodation of short-term stay patients and those who do not require a locked unit. This new capacity will contribute to improved public health outcomes for the Palmer community who has not had this level service available in the local community before.

#### ***Analysis: Public Health Outcomes***

The staff finds that the Applicant has provided context in which public health outcomes will be prioritized with the enhanced infection control measures set by the Replacement Facility. The improved efficiencies in infection control may lower preventable hospitalizations and readmissions. Most importantly, the addition of 21 beds and expansion of the first floor unit which could newly accommodate short-term patients would be a significant contribution to the long-term health of elders in the patient population who currently do not have access to appropriate skilled nursing services.

### **Delivery System Transformation**

The Applicant states that patients will be provided with linkages to address identified Social Determinants of Health (SDoH) needs and assigned a community health worker to assist with unanticipated challenges.

First, the Applicant states that all of its Patient Panel is diagnosed with cognitive disorders at varying levels. The Facility tailors daily activities for each patient for cognitive stimulation. The Facility also provides ample opportunities for patients to go outside, and sometimes hires external entertainment/ performers at the Facility. In the recent months, the Facility also has started to offer music therapy to patients as appropriate.

The Applicant asserts that the Facility and the community has always had a strong connection in terms of linkage to services for the elderly residents. The Facility has a discharge follow-up program in which patients and caregivers are given the direct telephone numbers for the Facility's Director of Nurses and Social Services and encouraged to call regarding any medical questions that they might have until home health services begin. Allowing patients and their

caregivers direct access to Facility staff can prevent delays a patient may experience going to a larger hospital as the external facility wouldn't have the patient's records and would not have familiarity with the patient's ailment.

This community linkage program will continue with the Replacement Facility and will allow for patients who have trouble post-discharge to directly be readmitted to the Facility without going through gatekeepers at external hospitals.

### ***Analysis: Delivery System Transformation***

Central to the goal of Delivery System Transformation is the integration of social services and community-based expertise. The Applicant described a focus on connecting discharged patients directly back to the Facility itself when there is an issue. Upon staff inquiry, the Applicant clarified that, in the post-discharge program, family members' primary question was about a medication or if the resident should be completing certain tasks upon their return home. Other frequent questions are about their aftercare, such as the scheduling of their home health, primary care, or therapy sessions.

Staff notes that having post-discharge access to direct phone calls with the Facility has the potential to save time and future costs of care. There is prior evidence that U.S.-based hospitals experience lower rates of 30-day readmission when there are post-discharge calls made to the patient.<sup>19</sup> Staff finds that delivery systems for patients with cognitive disorders and efficiency of post-discharge care coordination will likely be enhanced with the Proposed Project.

### **FACTOR 2: SUMMARY**

As a result of information provided by the Applicant and additional analysis, staff finds that the Applicant has demonstrated that the Proposed Project has met Factor 2.

### **Factor 3: Relevant Licensure/Oversight Compliance**

The Applicant has provided evidence of compliance and good standing with federal, state, and local laws and regulations and will not be addressed further in this report.

### **Factor 4: Demonstration of Sufficient Funds as Supported by an Independent CPA Analysis**

Under Factor 4, the Applicant must demonstrate that it has sufficient funds available for capital and operating costs necessary to support the Proposed Project without negative effects or consequences to the existing Patient Panel. Documentation sufficient to make such finding must be supported by an analysis by an independent CPA. CliftonLarsonAllen LLP ("the independent CPA") examined a range of documents and information in developing its report including five-year financial projection (Projections) for the Applicant (fiscal years ending 2021 through 2026), Audited Consolidated Financial Statements for the Applicant, various

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<sup>19</sup> Harrison JD, Auerbach AD, Quinn K, Kynoch E, Mourad M. Assessing the impact of nurse post-discharge telephone calls on 30-day hospital readmission rates. *J Gen Intern Med.* 2014;29(11):1519-1525. doi:10.1007/s11606-014-2954-2

presentations to Leadership on the Proposed Project, historical results, and third-party industry data. Additionally, it calculated Key Metrics (profitability, liquidity, and solvency) to assist in determining reasonableness of the Applicant's assumptions and feasibility of the Projections.

### **Revenue**

CPA reports that the Facility's revenue consists of revenue from operating the nursing home. The CPA derived predictions from interim financial data from the current period and historical experience of operating the facility. Future years were predicted utilizing assumptions for rate increases and operating expenses. To account for COVID-19, temporary impacts were implemented for 2021, including additional costs for emergency preparedness, disease control and containment, potential shortages of staff, wages, and reductions in certain revenue streams. The significant decline in revenue due to COVID-19 is majorly attributed to decline in census and occupancy decline. The Census impact is removed started in 2022 through the end of projection. Revenues were calculated to gradually increase until 2024, when the Replacement Facility with 21 additional beds is projected to go live, where the Applicant will experience a 39% jump in revenue.

Both Private and all types of public payers (Medicaid, Medicare, HMO) were predicted to rise every year of prediction. The CPA applied a 2% rate increase per year for the Projection Period 2023-2026. With the change in volume of the Replacement Facility, the CPA predicted a \$60 increase in the Medicare rate in 2022 and \$23 increase in public rates as current Medicaid regulations would allow upon completion of the Replacement Facility.

The CPA reviewed historical occupancy rates and predicted a maximum of 93.5% occupancy rate for the old Facility through 2023, and the Replacement Facility of 82 beds to start at a 83.1% occupancy rate in 2024 but gradually rise to 92.3% by 2026.

Regarding supplemental revenue, the CPA assumed that the Applicant received approximately \$419,000 in Federal and State stimulus payments due to COVID-19 in 2021. There were no such payments calculated for projections for 2022 – 2026.

Other operating revenues included were 1) Medicare Part B services and 2) Miscellaneous Revenue. The CPA applied a 2% inflationary increase to these items for the projection period.

### **Operating Expenses**

Operating expenses included in the analysis are salaries, employee benefits, supplies, professional fees and purchased services, state taxes, interest, and depreciation and amortization. The CPA adjusted 2021 baseline with projection for additional COVID-19 expenditures with an annualized impact of approximately \$293,000 added to the base year through the end of the projection period. Operating expenses are also set to increase 2% annually for inflation in major expense categories.

Annual employment expenses include wages for 2,080 hours of time, federal and state payroll taxes, health insurance, worker's compensation, pension costs, and other miscellaneous



benefits. The benefits account for approximately 20% of the wages. Upon the completion of the Replacement Facility, additional staffing needs are projected to be \$357,000 in 2024 and \$713,000 in 2025.

In non-salaried expenses, general and administrative costs include liability insurance, accounting and legal fees, computer expenses, professional fees, telephone and internet service, and marketing costs. Also included are dietary food serve costs, plan operations, housekeeping, laundry and linen costs. There is also nursing support, social services, recreation, and ancillaries. These also include any professional consultants used for healthcare. Above non-salaried cost categories are all assumed to experience a 2% annual inflationary increase throughout the projection period. Utilities, upon completion of the Replacement Facility, are assumed to add \$250,000 of expenses in 2024.

Depreciations are expected to occur gradually to break even throughout the projection period. The CPA reports the useful lives of property and equipment for computing depreciations are: 1) building – 40 years, 2) equipment – 5 to 10 years, and 3) leasehold improvements – 20 years.

### **Capital Expenditures and Cash Flows**

The CPA reviewed the project costs and cash flows. The Applicant's loan portfolio is comprised of unsecured related party loans receivable from the shareholder that bear interest at the applicable federal rate 0.36% with no fixed repayment terms for the projected period. The related Party Receivable is approximately \$338,000 which is assumed to remain consistent throughout the projected period.

For the Applicant's current status under the Internal Revenue Code, it is not subject to any federal taxes on its taxable income. However, stockholders are liable for income taxes on their share. The CPA assumed future tax rates for the state will approximate current tax rates 3% at the beginning. Amortization charged to operations for the projection period was approximately \$6,000 for the years 2021-2023 and \$15,000 for 2024-2026.

In regard to revenues from third party payors (Medicare, Medicaid, HMO, patient) from goods and services that transfer over to the customer over a period of time, they are projected to range from approximately \$5.0 million in 2021 to \$5.8 million in 2023, then with the completion of the Replacement Facility, starting at \$8.1 million in 2024 to \$9.5 million in 2026.

### **CPA's Conclusion of Feasibility**

The CPA predicts that the Replacement Facility will bring significant revenue starting in 2024. From the provided projected revenue for Palmer for FY2021-26, the CPA found the Proposed Project to be reasonable and feasible. Earnings before Interest, Depreciation and Amortization (EBIDA) margin for the Applicant was 17.3% in 2019 and projected to be 25.2% in 2026. This is well-above the top quartile which demonstrates the Applicant's ability to contain and control operating cost. The CPA determined that the Projections are reasonable and feasible and not

likely to have a negative impact on the Patient Panel or result in the liquidation of Palmer Healthcare Center.

***Analysis***

Staff finds that the Applicant has provided sufficient documentation of the availability of sufficient funds for capital and ongoing operating costs necessary to support the Proposed Project without negative impacts or consequences to the Applicant’s Patient Panel. As a result, Staff finds the CPA analysis to be acceptable and that the Applicant has met the requirements of Factor 4.

**Factor 5: Assessment of the Proposed Project’s Relative Merit**

The Applicant has provided sufficient evidence that the Proposed Project, on balance, is superior to alternative and substitute methods for meeting the existing Patient Panel needs identified by the Applicant pursuant to 105 CMR 100.210(A)(1). Evaluation of 105 CMR 100.210(A)(5) shall take into account, at a minimum, the quality, efficiency, and capital and operating costs of the Proposed Project relative to potential alternatives or substitutes, including alternative evidence-based strategies and public health interventions.

The Applicant considered and rejected the following alternatives to the Proposed Project because they were cost-prohibitive, shorter-term solutions, which did not provide the needed physical and fiscal efficiencies for best practice of care delivery and patient experience:

- 1) *Current Proposal*: *Constructing a new modern state-of-the art de-densified 82-bed replacement facility on the same campus as the Facility*  
*Quality*: *This would enable the Applicant to comply with the De-Densification Requirements and modernize its old facility so it can continue to care for the patient panel.*  
*Efficiency*: *The Proposed Project will allow the Facility to operate more efficiently and more cost-effectively.*
- 2) *Alternative Proposal*: *There is no alternative proposal to the Proposed Project. The Applicant is precluded from renovating the current facility due to zoning, abutting wetlands, and parking limitations which do not allow for compliance with the De-Densification Requirements.*

The Applicant asserts that the primary proposal above would be the only option to meet the needs of 1) new De-densification regulations 2) patients and 3) need for infection control based on lessons learned during the pandemic.

***Analysis***

Staff finds that the Applicant has appropriately considered the quality, efficiency, and capital and operating costs of the Proposed Project and recognizes that there are no feasible alternatives. As a result of information provided by the Applicant and additional analysis, staff finds the Applicant has reasonably met the standards of Factor 5.

## **Factor 6: Fulfillment of DPH Community-based Health Initiatives Guideline: Overall Application**

The Community Health Initiative (CHI) component of the DoN regulation requires Long-Term Care Facilities, which are not deemed Conservation Projects, to contribute 3% of the total value of the project to a CHI Healthy Aging Fund. Payment may be made in full at the time of project approval or in 2 equal installments with the first payment due at the time of receipt of a duly approved Notice of Determination of Need (or upon receipt of a payment letter from DPH), and the second, on the first anniversary of the Notice. The Applicant has chosen to pay in two equal installments. Any deviation to this payment schedule will require program approval. For this proposed Long-term Care Facility Project, the CHI contribution will be \$565,151.52. Based on the Applicant's compliance with the above requirement, the Applicant meets the terms of Factor 6

## **Findings and Recommendations**

Based upon a review of the materials submitted, Staff finds that the Applicant has met each DoN Factor for the Proposed Project and recommends that the Department approve this Determination of Need, subject to all applicable Standard Conditions.

## **Conditions to the DoN**

1. Of the total required CHI contribution of \$565,151.52 which will be directed to the Massachusetts Healthy Aging Fund
2. To comply with the Holder's obligation to contribute to the Massachusetts Healthy Aging Fund, the Holder must submit a check for \$282,575.76 to Health Resources in Action (the fiscal agent for the CHI Statewide Initiative).
  - i. The Holder must submit the funds to HRiA within 30 days from the date of the Notice of Approval.
  - ii. The Holder must promptly notify DPH (CHI contact staff) when the payment has been made.

Pursuant to 105 CMR 100.310(A)(12), ongoing reporting is required to DoN. In order to measure the impact of the Proposed Project, staff recommends the Applicant report annually the following metrics. The first full year will establish the baseline and the Applicant will then establish target measures for subsequent years:

**Anti-Psychotic Medication** –As the Applicant serves a large geriatric-psychiatric population, it will measure the percent of its patients on anti-psychotic medication.

Measure 1 : The Applicant will calculate and report on the number and percent of patients on anti-psychotic medication.

Denominator – Number of patients served in the reporting year.

Numerator – Number of patients served in the reporting year who were taking anti-psychotic medications during that year.

Measure 2: The Applicant will report on the diagnoses of every patient requiring antipsychotic medications during the reporting year.

**Racial/Ethnic Demographic Data** – The Applicant will provide racial and ethnic demographic data which it reports it will be capturing more robustly.

Measure: the percentage of the Patient Panel by reported racial/ethnic categories.

Denominator – Number of patients served in the reporting year.

Numerator – Percent of patients served in the reporting year by racial/ethnic categories as reported by patients.