Massachusetts Assisted Living Residence (ALR) Commission Report

Established by Section 32 of Chapter 197 of the Acts of 2024

Submitted to the Legislature: December 31, 2025
Commission Final Vote: January 12, 2026

Table of Contents

I. ALR Commission Overview

Overview

- The ALR Commission was established in 2024 with the enactment of Section 32 of Chapter 197 of the Acts of 2024, An Act to Improve Quality and Oversight of Long-term Care.
- The Commission was chaired by the Secretary of the Executive Office of Aging & Independence (AGE), Robin Lipson, and was comprised of a diverse panel of lawmakers, assisted living resident family members, elder law and aging advocates, public health and long-term care experts, and representatives from industry associations and consumer organizations (see full list in Appendix A).
- The Commission met 16 times from February 2025 to January 2026 and held two (2) public hearings; the first one on May 15, 2025, and the second on November 5, 2025.
- The Commission's meetings were held virtually on Zoom.
- The meetings were organized by topic. Commission members and other experts were invited to present on their areas of expertise. Appendix B outlines the meetings and input provided, including the individuals who presented.
- All meetings were subject to the Open Meeting Law and minutes were taken and approved for each meeting.
- All materials considered by the Commission as well as minutes of the Commission's meetings were posted on a publicly-available webpage: https://www.mass.gov/assisted-living-residences-alr-commission
- The Commission was originally required to submit its recommendations to the Clerks of the Senate and House of Representatives, the Joint Committee on Elder Affairs, and the Senate and House Committees on Ways and Means by August 1, 2025. The Commission's deadline was extended beyond August 1st, to incorporate additional discussion and development of recommendations in light of the tragic July fire at Gabriel House Assisted Living.
- On December 17, 2025, a motion was made "to vote to affirm or support the six recommendations included in the report as amended in this meeting through conversation." The motion was seconded and there was no further discussion on the motion. A vote was taken on the motion: 18 members voted to affirm or support; 2 members were absent from the vote; and 1 member stated "present" during the vote.
- To allow time for final copy edits and the submission of any additional letters for inclusion in the final report, and for an opportunity to meet quorum for a final vote on the report, the Commission extended its review period. On January 12, 2026, the Commission will take a final vote on the complete report, including all appendices, and a vote to formally conclude the Commission's work.

Legislative Language, Section 32 of Chapter 197 of the Acts of 2024

Goal: Study and recommend policies to ensure assisted living residences adequately meet the health and safety needs of residents

Charge: The Commission was charged with examining:

(i) the current statutory and regulatory oversight of assisted living residences;

(ii) assisted living best practices in other states;

(iii) the impacts of licensing or certifying such residences;

(iv) advertising practices of assisted living residences to potential residents and their families;

(v) regulatory procedures for opening, closing or changing ownership of a residence, including determination of need processes and clustering of facilities;

(vi) trends in incident reports made to the executive office of elder affairs and the long term care ombudsman's office and resolutions of such incidents;

(vii) methods to provide transparency of information for potential consumers and family members researching and comparing residences;

(viii) safety standards;

(ix) existing consumer protections for residents in statutes and regulations; and

(x) basic health services in residences.

Note: *See Comprehensive findings for each charge in slides 23 - 110.*

Deliverable: Submit a report and recommendations not later than August 1, 2025[1].

[1] *In light of the tragic fire that occurred on July 13, 2025, at Gabriel House Assisted Living, the Commission's deadline was extended to the end of the calendar year, with the report due no later than December 31, 2025.*

Legislative Language, Section 32 of Chapter 197 of the Acts of 2024 *(cont'd)*

Commission Members: The ALR Commission was required to include the following:

- the Secretary of Aging & Independence, who shall serve as chair;
- the Commissioner of Public Health or a designee;
- the Assistant Secretary of MassHealth or a designee;
- the Long-Term Care Ombudsman or a designee;
- the Chairs of the Joint Committee on Elder Affairs;
  - 1 member to be appointed by the Senate President;
  - 1 member to be appointed by the Speaker of the House of Representatives;
  - 1 member to be appointed by the Minority Leader of the Senate;
  - 1 member to be appointed by the Minority Leader of the House of Representatives;
- 3 members to be appointed by the Governor,
  - 2 of whom shall be residents or family members of residents at an assisted living residence;
- a representative of the Massachusetts chapter of the National Academy of Elder Law Attorneys;
- a representative of LeadingAge Massachusetts, Inc.;
- a representative of the Massachusetts Assisted Living Association,
- Inc.;
- a representative of AARP Massachusetts; a representative of the New England chapter of the Gerontological Advanced Practice Nurses Association;
- a representative of the Massachusetts chapter of the Alzheimer's Association;
- a representative of MassPACE, Inc.; and a representative of Greater Boston Legal Services, Inc.

II. Recommendations

Big Picture Impact

The ALR Commission has a unique opportunity to strengthen and transform assisted living in Massachusetts. By aligning on bold but achievable reforms, the Commission can help ensure that residents and their families are safer, more informed, and better protected.

The following recommendations, paired with SMART (specific, measurable, achievable, relevant, and time-bound) goals, would:

Protect consumers with clear disclosures, transparency on costs and compliance, and enforceable resident rights.

Ensure safety and preparedness through fire and emergency standards that account for resident acuity and strengthen coordination with public safety.

Strengthen staffing and clinical oversight in a realistic, market-sensitive way that preserves the residential model while strengthening requirements for nursing leadership to support residents with increasing acuity.

Build accountability and trust with public-facing data, penalties for noncompliance, and investment into oversight, safety and quality resources.

Advance affordability by creating an ALR affordability task force charged with assessing statewide supply and true service costs, identifying gaps in access, and recommending sustainable financing models.

Deliver measurable results with timelines and accountability so the Legislature and public can track progress.

The Commission's Key Findings

ALRs are an important part of Massachusetts' long-term services continuum and play a vital role in meeting the diverse needs and preferences of older adults by offering a supportive and flexible residential setting.

6 Key Findings:

1. Information about ALRs can be confusing. Disclosure statements vary significantly across ALRs, making it difficult for families to compare options and understand costs, services, and rights.
2. Residents and families are often unaware how costs increase as care needs evolve, or when an ALR can no longer safely meet a Resident's needs.
3. Families cannot easily access compliance or incident data; current reliance on public records requests limits accountability and informed choice.
4. Staffing and leadership is critical to ensuring resident safety, wellbeing, and quality of life. Staffing levels and practices vary widely across providers, creating inconsistencies in care and supports.
5. The Gabriel House fire underscored the urgent need for stronger fire and emergency preparedness standards.
6. ALRs remain unaffordable for many; pathways for lower-income residents are fragmented and difficult to navigate.

High-Level Recommendations Resulting from the Findings

6 Key Findings:

1. *Information about ALRs can be confusing. Disclosure statements vary significantly across ALRs, making it difficult for families to compare options and understand costs, services, and rights.*
2. *Residents and families are often unaware how costs increase as care needs evolve, or when an ALR can no longer safely meet a Resident's needs.*
3. *Families cannot easily access compliance or incident data; current reliance on public records requests limits accountability and informed choice.*
4. *Staffing and leadership is critical to ensuring resident safety, wellbeing, and quality of life. Staffing levels and practices vary widely across providers, creating inconsistencies in care and supports.*
5. *The Gabriel House fire underscored the urgent need for stronger fire and emergency preparedness standards.*
6. *ALRs remain unaffordable for many; pathways for lower-income residents are fragmented and difficult to navigate.*

6 Key Recommendations:

1. Standardize Disclosures to Improve Informed Decision-Making
2. Clarify Assessments, Services and Costs as Needs Change
3. Improve Accessibility of Public Information, Transparency & Accountability
4. Strengthen Staffing & Promote Resident Voice
5. Bolster Emergency Preparedness & Safety
6. Establish an ALR Affordability Task Force

Recommendation 1 | *Standardize Disclosures to Improve Informed Decision-Making*

KEY FINDINGS

Information about ALRs can be confusing. Disclosure statements vary significantly across ALRs, making it difficult for families to compare options and understand costs, services, and rights.

RECOMMENDATIONS

Agency/ Regulatory Actions

- ***Uniform disclosure form***. By **July 1, 2026**, require all ALRs to use a uniform disclosure form in plain language, meeting state accessibility standards and modeled after Minnesota's approach as appropriate and tailored to Massachusetts' assisted living model to allow residents and families to easily compare ALRs.
  - Require inclusion of key services and costs (base rates, add-ons, etc.), fee schedules, rate change and refund policies, key contract terms, resident rights, staffing (e.g., hours worked by staff, listed by title/ licensure, on duty during day and overnight, nurse availability and onsite hours, etc.), and any limits on services or staffing that may affect a resident's ability to age in place.
  - Mandate posting online (ALR and AGE websites) and update annually or within 30 days of a material change, in accessible formats, including Spanish and other translated languages upon request, with the availability of translated versions clearly indicated through a standardized language access ("Babel") notice.
  - Develop the form in consultation with providers, families and residents, and key stakeholders to ensure it clearly and concisely captures variations in services, charging practices, staffing models, and dementia-related care features, and aligns, where appropriate, with forthcoming consumer protection regulations issued by the Attorney General.

RESIDENT & FAMILY IMPACT

Transparency ensures older adults and their families can make informed, side-by-side comparisons of ALRs and understand their rights from the outset.

Recommendation 2 | *Clarify Assessments, Services and Costs as Needs Change*

KEY FINDINGS Residents and families are often unaware how costs increase as care needs evolve, or when an ALR can no longer safely meet a Resident's needs.

RECOMMENDATIONS

Agency/ Regulatory Actions

- ***Standardized assessment elements***. By **July 1, 2027**, require a standardized approach to resident assessment to capture each resident's social, physical, medical, cognitive impairment/dementia and emergency preparedness needs at admission, not less than every six months, and when there are changes in condition. This may be achieved through:
  - Use of a uniform assessment tool for all ALRs, or a set of core, standardized assessment elements incorporated into any ALR's chosen tool. Core elements should support person-centered practice and include resident and, as appropriate, family participation.
  - Develop core elements with providers, vendors, families, advocates and experts as appropriate to ensure feasibility and avoid duplicative assessments.
  - Link assessments to transparency by requiring the uniform disclosure form (Recommendation #1) to include how changes in care levels impact costs and provide timely written notice of cost or service changes based on assessment results, as well as impact staffing needs and how those needs do or do not align with ALR capabilities.
  - Assessment results and service plans should document when a resident's needs exceed what an ALR can safely provide and outline available options.
  - Assessments must include emergency contingency planning for each resident, and each facility must review its evacuation plan with each resident, in addition to staff, on a regular basis.
  - Assessments must focus exclusively on the resident's assessed needs and care requirements and may not be used to unfairly target, exclude, or disadvantage residents.
  - Consider process for ALRs to submit aggregated acuity data to AGE for policy development.

RESIDENT & FAMILY IMPACT Provides clear, upfront information on services, service limits and costs—helping to avoid unplanned moves or unexpected expenses. Consistent assessment practices also create a stronger foundation for future standards, ensuring greater transparency and predictability over time.

Recommendation 3 | *Improve Accessibility of Public Information, Transparency & Accountability*

KEY FINDINGS

Families cannot easily access compliance or incident data; current reliance on public records requests limits accountability and informed choice.

RECOMMENDATIONS

Agency/ Regulatory Actions

- ***Public database***. By **July 1, 2026,** launch an online, publicly accessible database of compliance reports, which focus on findings that meaningfully relate to resident care, safety and regulatory compliance, as well as applications, corrective actions plans, enforcement notices (i.e., final findings and any associated fines, modifications, suspensions, revocations), ownership information, and uniform disclosure forms.
- ***Financial accountability***. By **January 1, 2027,** introduce fines for violations, with higher penalties for repeat or serious violations. All fines must have clear parameters identifying when fines apply, and access to an appeals process for disputed findings or penalties.
- ***Long Term Care Ombudsman Program (LTCOP) Notification, and other Oversight Agencies***. **By April 1, 2026,** AGE will send notification to the LTCOP reporting ALR changes in ownership, serious findings, suspensions or revocations, and closures, and notify the Department of Public Health and/or MassHealth if the ALR operates programs under their oversight. Notifications are intended to support coordination, resident advocacy, and continuity of services.

Potential Legislative Actions

- Establish a dedicated and sustainable funding mechanism, such as an Assisted Living Residence Trust, supported by certification and recertification fees and fines[1] that are reinvested into the quality and oversight of ALRs by AGE to: expand certification staffing beyond the current level of four individuals, conduct more frequent certification compliance reviews[2], complaint and incident investigations, timely access to Ombudsman services, maintain public-facing data, strengthen reporting and accountability measures, support resources for managing appeals of findings/fines, and implement future oversight enhancements recommended in this report.

[1] Commission members unanimously supported reinvesting certification and recertification fees back to the AGE ALR Certification Unit, and there was majority support for also reinvesting fines associated with compliance findings.

[2] Mass. General Laws c. 19D, § 5 requires biennial review of all ALRS; some Commission members recommended additional funding to support certification reviews every 12–18 months.

RESIDENT & FAMILY IMPACT

Expands resources for state oversight, giving families greater confidence that complaints and incidents are fully investigated. Improves access to safety and compliance records so residents and families can make more informed choices when choosing or evaluating an ALR.

Recommendation 4 | *Strengthen Staffing & Promote Resident Voice*

KEY FINDINGS

Staffing and leadership is critical to ensuring resident safety, wellbeing, and quality of life. Staffing levels and practices vary widely across providers, creating inconsistencies in care and supports.

RECOMMENDATIONS

Agency/ Regulatory Actions

- ***Nurse capacity***. By **January 1, 2027**, require every ALR to designate at least one licensed nurse[1] employed by or under written agreement with the residence, to oversee the development of resident service plans that support the needs captured through a standardized assessment approach as described in Recommendation #2. The nurse must provide on-site services for a minimum number of hours each week, scaled to ALR size, resident acuity and needs, and be available on call 24 hours a day to support staff and respond to changes in resident condition.
- ***Leadership competency***. By **January 1, 2027**, require each ALR's Executive Director or Resident Care Director to annually complete state-recognized training to ensure consistency, quality, and continuing education.
- ***Acuity-based staffing model.*** AGE will work toward the completion of an acuity-informed staffing model **by July 1, 2027**, so that staffing reflects resident needs, care complexity, and ALR size—providing flexibility and avoiding one-size-fits-all ratios. This should be phased in and developed with providers and residents/families, establish clearly defined minimum staffing expectations, and require ALRs to regularly submit staffing reports on a schedule determined by AGE, to ensure feasibility and align with emerging best practices.
- ***Workforce development***. Ensure certified nursing assistants (CNA) are aware of and connected to state-supported CNA training and career ladder programs established under the long-term care legislation. Ensure dementia training adheres to current evidence-based standards and require ALRs to document competency of all staff, and provide families clear information on dementia training content.
- ***Self-governed resident & family councils***. Require ALRs to support resident and family council meetings. Self-governed councils should be supported whenever possible; at minimum, ALRs must hold regular (monthly or quarterly) resident and family meetings and maintain minutes, which may be reviewed by AGE during certification compliance reviews.
- ***Annual listening sessions***. **Starting in CY2026**, AGE will convene listening sessions with residents and families to gather regular and ongoing feedback and evaluate the impact of commission recommendations.

[1] *Final regulatory language should ensure alignment with nursing scope-of-practice requirements and clarify when responsibilities may be fulfilled by an LPN or require RN oversight, taking into account resident needs and safety.*

Potential Legislative Actions

- **Amend MGL Chapter 111, Section 72W½ to allow certified medication aides (CMAs)** to work in ALRs.
- **Require licensure and board of registration for ALR Executive Directors**.

RESIDENT & FAMILY IMPACT

Clear staffing standards help families set realistic expectations when choosing an ALR. Regular resident and family feedback ensures policies reflect lived experience.

Recommendation 5 | *Bolster Emergency Preparedness & Safety (1 of 2)*

KEY FINDINGS The Gabriel House fire underscored the urgent need for stronger fire and emergency preparedness standards.

RECOMMENDATIONS

Agency/ Regulatory Actions

- ***Annual inspection verification***. By **July 1, 2026,** AGE should consult with the Fire Chiefs Association of Massachusetts regarding additional requirements, including but not limited to requiring ALRs to provide annual sign-off and/or documentation from their local fire department, building inspector (where applicable), and board of health confirming inspection dates and no outstanding violations. Inspection documentation must be publicly posted in the ALR and verified by AGE during compliance reviews.
- ***Life safety requirements***. By **January 1, 2027**:
  - Amend AGE onsite compliance checklists to incorporate appropriate life-safety criteria aligned with Department of Public Health long-term care facility survey standards, where appropriate and applicable. These updates should be phased into the current certification processes, along with structured provider engagement.
- ***Emergency planning & hazard analysis***. By **January 1, 2027**, require ALRs to:
  - Annually update and review emergency plans with local fire department, provide annual emergency response training for staff, and maintain active, ongoing relationships with local fire departments.
  - Complete documented annual hazard vulnerability analyses that are developed, reviewed and approved by qualified emergency preparedness professionals (e.g., International Association of Emergency Managers (IAEM) certification, Federal Emergency Management Agency (FEMA), National Incident Management System (NIMS), or the Homeland Security Exercise and Evaluation Program (HSEEP) training, or relevant experience in emergency management, public health preparedness, or fire safety).
  - Designate at least one staff member per shift to serve as the Resident Safety Coordinator. Resident Safety Coordinator(s) must annually meet with the local Fire Chief and complete fire safety training—including extinguisher use and evacuation and shelter-in-place protocols. Coordinators must conduct and document at least annual, one-to-one reviews with each resident to confirm individualized evacuation or shelter-in-place plans.
  - ALRs must maintain appropriate evacuation equipment (e.g., evacuation chairs for residents not located on ground floors), clearly label resident rooms and critical areas, and ensure emergency personnel can readily identify resident locations, needs, and egress pathways.
- ***Training, drills & daily safety oversight***. By **January 1, 2027**, require ALR to:
  - Conduct quarterly emergency exercises of all staff and annual evacuation drills of all staff (direct and contracted), conducted in coordination with local fire department, with resident engagement in appropriate components of emergency preparedness, including initial and annual review of evacuation plans and education on fire, natural disasters, and other hazards.

Recommendation 5 | *Bolster Emergency Preparedness & Safety (2 of 2)*

RECOMMENDATIONS

Agency/ Regulatory Actions *(cont'd)*

- Designate at least one staff person, who may or may not be a Resident Safety Coordinator, with formal safety training, such as crowd management certification, who completes documented daily safety checks (fire alarms, emergency lighting, exits), identifies potential fire risks (smoking materials, space heaters, blocked egress), immediately corrects, and verifies emergency contact and resident-assistance information is current and accessible. Records must be retained and available upon request by AGE. This person, along with the Resident Safety Coordinator(s) must annually meet with the local Fire Chief and complete fire safety training.

- ***First responder coordination and communication***. By **January 1, 2027**:
  - Require ALRs to maintain a standard census document for immediate access by emergency services identifying residents, their location and their individualized emergency needs (e.g., hearing, vision, mobility, oxygen, vital medications, cognitive impairment/ dementia). Census documents should correspond with individualized emergency assistance plans documented in every resident service plan. ALRs must be able to produce this census even during power loss or system interruption.
  - Explore a data-sharing protocol to provide first responders with real-time emergency information, as well as consider conducting a statewide review with fire and emergency preparedness experts to evaluate additional risk mitigation strategies.
  - Require each Assisted Living Residence to maintain a code-compliant, continuously monitored fire alarm system with direct, reliable transmission to emergency services, using a Master Box connection when feasible and approved by the local fire department.

Potential Legislative Actions

- **Review ALR Building Classification Standards**. Evaluate whether Assisted Living Residences—particularly memory care units—should continue to be classified as Residential Group R-2 or whether an alternative classification (e.g., Institutional Group I-2, or a modified standard) is warranted based on resident vulnerability (e.g., mobility, disability, cognitive impairment/dementia , or executive functioning) and need for assisted evacuation.
- **Modernize Building Code Requirements for ALRs.** Consider updates to applicable building and life-safety codes for new ALR construction, and evaluate phased compliance pathways for existing facilities that account for feasibility, cost of upgrades, and resident disruption, while prioritizing effective egress, fire protection, and emergency response. Explore legislative or budgetary options to support targeted grant funding, financing, or other incentives—particularly for ALRs serving lower-income residents—and coordinate with EOHLC and other state partners to leverage existing housing or capital funding sources, where feasible, to reduce the risk of ALRs coming offline due to financial constraints for making building upgrades.

RESIDENT & FAMILY IMPACT

Stronger fire safety and emergency planning will provide greater clarity and peace of mind, as well as protect against future tragedies.

Recommendation 6 | *Establish an ALR Affordability Task Force*

KEY FINDINGS ALRs remain unaffordable for many; pathways for lower-income residents are fragmented and difficult to navigate.

RECOMMENDATIONS

Potential Legislative Actions

- ***Establish ALR Affordability Task Force***. By **July 1, 2026**, convene a task force to define "affordable ALR", create an inventory of qualifying residences, assess the service versus housing and operational costs, identify and evaluate any gaps in the continuum of care, estimate statewide need, and recommend sustainable "housing plus services" financing models. The task force should review financing and affordability models for the defined population in other settings, as well as other states, including Medicaid-supported options (e.g., CMS waivers, eligibility requirements) and subsidized housing options, and assess feasibility for Massachusetts. The task force should clearly define:
  - the targeted population and service needs; and
  - the income levels of those supported or subsidized in any future model.

  The task force should include representatives with expertise across housing, services, dementia care, aging services, financing, Medicaid, and consumer experience, including: Executive Office of Aging & Independence (AGE); MassHealth; Department of Public Health (DPH); Executive Office of Housing & Livable Communities (EOHLC); MassHousing; Community Economic Development Assistance Corporation (CEDAC); Aging Services Access Point (ASAP) / Area Agency on Aging (AAA); MassPACE; consumer advocates and residents/families with experience in housing, ALRs and low-income populations; and ALR industry.

  The task force should also obtain regular, meaningful feedback from consumers, family caregivers, Ombudsman representatives, and aging-services advocates to ensure recommendations remain resident-centered.
- Based on the recommendations that may come out of the ALR Affordability Task Force, the legislature may need to prepare certain statutory changes (e.g., create a capital fund for no-interest loans to assist "affordable" ALRs in upgrading facilities with best practice safety features).

RESIDENT & FAMILY IMPACT Greater clarity on the real cost of care versus housing and other costs, and possible opportunity for clearer pathways for lower-income older adults to access assisted living or equivalent "housing plus services" models.

Summary of Recommendations Requiring Legislative Action *(1 of 2)*

For ease of legislative review, the table below consolidates the specific actions across Recommendations 1 through 6 that would require statutory or budgetary action, as outlined on pages 11-17.

Recommendation	Legislative Actions
Recommendation 3 *Improve Accessibility of Public Information, Transparency & Accountability*	• **Establish a dedicated and sustainable funding mechanism, such as an Assisted Living Residence Trust, supported by certification and recertification fees and fines**[1] that are reinvested into the quality and oversight of ALRs by AGE to: expand certification staffing beyond the current level of four individuals, conduct more frequent certification compliance reviews[2], complaint and incident investigations, timely access to Ombudsman services, maintain public-facing data, strengthen reporting and accountability measures, support resources for managing appeals of findings/fines, and implement future oversight enhancements recommended in this report. [1] Commission members unanimously supported reinvesting certification and recertification fees back to the AGE ALR Certification Unit. There was general support for also reinvesting fines associated with compliance findings. [2] Mass. General Laws c. 19D, § 5 requires biennial review of all ALRS; some Commission members recommended funding to support certification reviews every 12–18 months.
Recommendation 4 *Strengthen Staffing & Promote Resident Voice*	• **Amend MGL Chapter 111, Section 72W½ to allow certified medication aides (CMAs**) to work in ALRs. • **Require licensure and board of registration for ALR Executive Directors**.
Recommendation 5 *Bolster Emergency Preparedness & Safety*	• **Review ALR Building Classification Standards**. Evaluate whether Assisted Living Residences—particularly memory care units—should continue to be classified as Residential Group R-2 or whether an alternative classification (e.g., Institutional Group I-2, or a modified standard) is warranted based on resident vulnerability (e.g., mobility, disability, cognitive impairment/dementia , or executive functioning) and need for assisted evacuation. • **Modernize Building Code Requirements for ALRs.** Consider updates to applicable building and life-safety codes for new ALR construction, and evaluate phased compliance pathways for existing facilities that account for feasibility, cost of upgrades, and resident disruption, while prioritizing effective egress, fire protection, and emergency response. Explore legislative or budgetary options to support targeted grant funding, financing, or other incentives—particularly for ALRs serving lower-income residents—and coordinate with Executive Office of Housing and Livable Communities (EOHLC) and other state partners to leverage existing housing or capital funding sources, where feasible, to reduce the risk of ALRs coming offline due to financial constraints for making building upgrades.

Summary of Recommendations Requiring Legislative Action *(2 of 2)*

Recommendation	Legislative Actions *(cont'd)*

Recommendation 6
Establish an ALR Affordability Task Force
	• **Establish ALR Affordability Task Force**. By **July 1, 2026,** convene a task force to define "affordable ALR", create an inventory of qualifying residences, assess the service versus housing and operational costs, identify and evaluate any gaps in the continuum of care, estimate statewide need, and recommend sustainable "housing plus services" financing models. The task force should review financing and affordability models for the defined population in other settings, as well as other states, including Medicaid-supported options (e.g., CMS waivers, eligibility requirements) and subsidized housing options, and assess feasibility for Massachusetts. The task force should clearly define:
	  ◦ the targeted population and service needs; and
	  ◦ the income levels of those supported or subsidized in any future model.
	  ◦ The task force should include representatives with expertise across housing, services, dementia care, aging services, financing, Medicaid, and consumer experience, including: Executive Office of Aging & Independence (AGE); MassHealth; Department of Public Health (DPH); Executive Office of Housing & Livable Communities (EOHLC); MassHousing; Community Economic Development Assistance Corporation (CEDAC); Aging Services Access Point (ASAP) / Area Agency on Aging (AAA); MassPACE; consumer advocates and residents/families with experience in housing, ALRs and low-income populations; and ALR industry.
	  ◦ The task force should also obtain regular, meaningful feedback from consumers, family caregivers, Ombudsman representatives, and aging-services advocates to ensure recommendations remain resident-centered.
	• Based on the recommendations that may come out of the ALR Affordability Task Force, the legislature may need to prepare certain statutory changes (e.g., create a capital fund for no-interest loans to assist "affordable" ALRs in upgrading facilities with best practice safety features).

III. Public Hearing Testimony & Findings

Public Hearing Testimony Summary

May 15, 2025

- **Attendance Overview**
  - **Total Registered Attendees:** 57
- **Written Testimony Participation**
  - **Total Oral Testimonies Provided:** 12
  - **Total Written Testimonies Provided:** 12
  - **Position Summary:**
    - Majority: Change needed
    - Some: Support status quo
- **Key Themes Raised**
  1. **Assessments** – Processes, transparency, and consistency across providers.
  2. **Basic Health Services** – Expansion and billing considerations.
  3. **Staffing Levels** – Adequacy and flexibility based on resident needs.
  4. **Family Involvement** – Importance of resident and family councils.
  5. **Resident Advocates** – Emphasis on preserving the resident-centered model.

November 5, 2025

- **Attendance Overview**
  - **Total Registered Attendees:** 160
- **Testimony Participation**
  - **Total Oral Testimonies Provided:** 21
  - **Total Written Testimonies Provided:** 22
  - **Position Summary:**
    - Majority: Change needed (staffing, affordability, safety, and scope-of-care reforms required)
    - Some: Support for preserving core ALR model while addressing gaps
- **Key Themes Raised**
  1. **Affordability crisis**
  2. **Workforce challenges harming resident care** –lack of adequate training in communication, dementia care, cultural competency, and supervision; inadequate staffing ratios; inconsistent leadership expectations.
  3. **Strong support for Basic Health Services** – currently many families filling gaps, sometimes visiting multiple times daily to provide care ALRs cannot.
  4. **Safety & emergency preparedness gaps** – delayed or improper emergency responses; lack of drills; staff confusion around protocols.
  5. **Transparency, accountability & quality concerns** – poor communication, insufficient documentation, and lack of family engagement; requests for routine assessments, clearer staffing and stronger oversight.
  6. **Positive recognition** – many noted that ALRs can provide meaningful community, dignity, and safety when well-staffed and well-managed.

Public Hearing Testimony Findings

May 15, 2025

- **12 individuals spoke at the public hearing**
- **What We Heard**
  - Valuable input from industry professionals, policy leaders, and advocates.
  - Recommendations to:
    - Enhance consumer protections;
    - Improve transparency in pricing and compliance reporting; and
    - Greater transparency in service option and costs.
- **What Was Missing**
  - Limited attendance and testimony from **residents and family members.**
  - Hearing format (virtual webinar) and **lack of broad public awareness** may have impacted participation.
- Opportunity remains to **proactively engage residents and families** through future outreach and targeted listening sessions.

November 5, 2025

- **21 individuals spoke at the public hearing**
- **What We Heard**
  - The ALR system is at a breaking point for middle-income families, who cannot afford care and do not qualify for subsidized assistance.
  - Staffing and training deficiencies directly affect resident dignity, safety, and quality of life.
  - Safety culture must be strengthened—including emergency readiness, overnight staffing, and incident response.
  - Standardization, transparency, and data-driven oversight were widely supported as paths toward improved quality.
  - There is broad agreement that meaningful change requires both regulatory reform and investment.
- **What Was Improved**
  - Second hearing was much better attended
  - Testimony was primarily provided by residents, families and advocates, as opposed to the first hearing which was primarily represented by ALR industry providers

IV. Commission's Findings by Legislative Charge

Important context: All content in Section IV reflects the current state of ALRs in Massachusetts and other states, and provides insight into Commission member discussions. The findings reflect the Commission's thinking and should not be considered recommendations—rather, they serve as background and context behind the final recommendations outlined in Section II.

(i) the current statutory and regulatory oversight of assisted living residences

Current Statutory and Regulatory Oversight

- **Statutory Framework**
  - **Governing Statute:** M.G.L. c. 19D (since 1994)
  - **Regulations:** 651 CMR 12.00 (established 1996)
  - **Model:** Residential housing with service supports, not medical facilities
  - **Key Consumer Protections:**
    - Oversight under landlord-tenant law
    - Biennial certification by AGE (Annual for ALRs offering Basic Health Services starting 2026)
    - Disclosure of ownership and operational transparency
- **Oversight Responsibilities**
  - **Executive Office of Aging & Independence (AGE),** formerly the Executive Office of Elder Affairs (EOEA)
    - Certification, inspection, and compliance monitoring
    - Unannounced inspections and enforcement authority
    - Mandated corrective plans for deficiencies
    - Emergency actions allowed to protect resident safety

Recent Reforms and Anticipated Regulatory Enhancements

- **Major Updates: Chapter 197 of the Acts of 2024**
  - **Basic Health Services Statutory Authorization:**
    - Authorizes ALRs to provide limited basic health services (e.g., injections, simple dressing changes, oxygen management, specimen collection, ointment application)
    - AGE will promulgate regulations to define scope, standards, and oversight requirements
  - **Enhanced Transparency:**
    - Ownership disclosure lowered from 25% to 5% threshold
  - **Strengthened Enforcement:**
    - Authority to impose fines (up to $500/day)
    - Whistleblower protections for employees and residents

- **Consumer Protections**
  - **Attorney General's Office (AGO)** developing consumer protection regulations applicable to ALRs
  - Expected to address resident rights, disclosures, and unfair or deceptive practices

- **Long-Term Care Ombudsman Program (LTCOP)**
  - Independent resident advocacy with direct access to resolve complaints
  - ALRs required to post Ombudsman contact information

Key Takeaways

Current Oversight

- Oversight anchored in M.G.L. c. 19D and 651 CMR 12.00
- Recent reforms (2024) significantly enhanced AGE authority
- Certification and inspections required for continued operation
- Ombudsman program supports resident protections

(ii) assisted living best practices in other states

Best Practices from Other States: Assisted Living Oversight and Service Models

- **Tailored Health Services (National Trend)**
  - Most states allow ALRs to choose which health services to offer.
  - Massachusetts' "all or none" Basic Health Services model is more rigid.

- **Certified Medication Aides (CMAs)**
  - Many states allow trained non-nurses to administer medications, freeing nurses for more complex care.
  - *Related Recommendation*: Introduce legislation to expand CMAs into ALRs via Limited Medication Administration (LMA) adjustments.

- **Acuity-Based Staffing Models**
  - States like Oregon require staffing based on resident acuity rather than static ratios.
  - *Related Recommendation*: Establish acuity-based staffing guidance where staffing is aligned to resident needs but is still flexible and not a one-size-fits-all approach.

Best Practices for Dementia Care and Consumer Protections

- **Dementia Care Innovations**
  - **Enhanced Dementia Training (Minnesota, Virginia, Maine)**
    - Higher training hours, skills assessments, and written disclosure of training to families.
    - *Related Recommendation:* Strengthen staffing and leadership requirements, as well as enhanced disclosure requirements.
  - **Dedicated Licensing for Dementia Units (Minnesota, Indiana, Oklahoma)**
    - Requires clear marketing, licensing, and service disclosure for memory care units.
    - *Related Recommendation:* Support transparency and disclosure.

- **Strengthened Resident Protections**
  - **Involuntary Discharge Safeguards (Colorado, Virginia)**
    - Written notices, clear appeal processes, and steps to resolve underlying issues.
    - *Related Recommendation:* Enhance discharge protections in revised regulations to better support residents' rights.
  - **Electronic Monitoring Standards**
    - Other states emphasize resident consent and control over monitoring.
    - *Related Recommendation:* Massachusetts may consider formalizing electronic monitoring policies.

Access, Affordability, and Transparency

- **Increasing Access for Low-Income Residents**
  - **Frail Elder Waivers in Other States (DC, Ohio, California)**
    - Medicaid waivers in other states specifically support assisted living access.
    - *Related Recommendation:* Establish task force to explore pathways for expanding ALR affordability
- **Transparency Tools**
  - **Uniform Disclosure Checklists (Minnesota)**
    - Required pre-contract disclosures to improve consumer decision-making.
    - *Related Recommendation:* Support standardized disclosure forms to promote clarity and comparability.

- **Connecticut's Managed Residential Model**
  - Separate licensure for building and services promotes flexibility.
  - Uses Medicaid to fund personal care, but residents still pay room and board.
  - Highlights affordability challenges similar to Massachusetts.

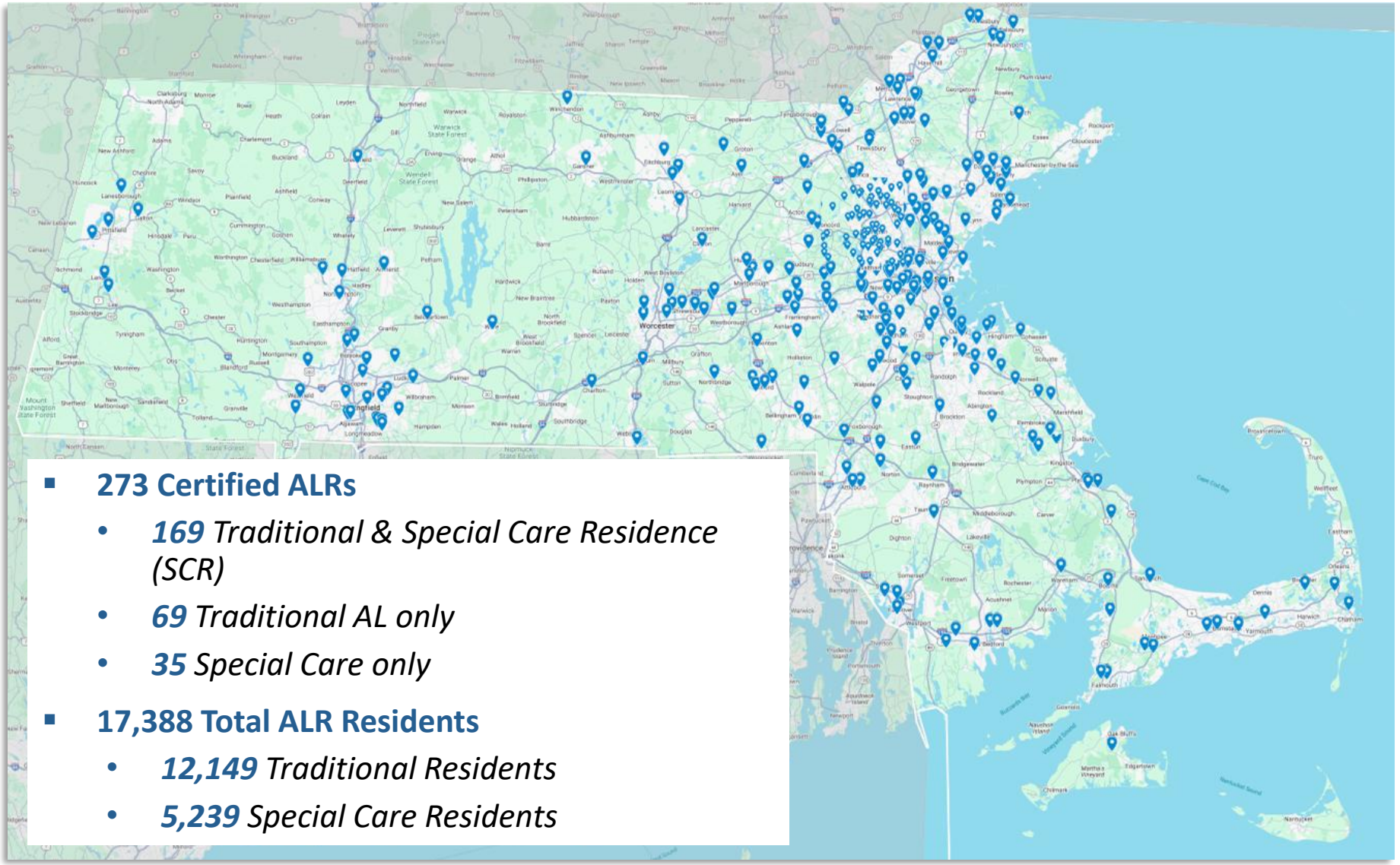
Key Takeaways for Best Practices in Other States

Best Practices in Other States

- Flexibility in offering Basic Health Services (i.e., do not require all ALRs to provide Basic Health Services)
- Certified Medication Assistants (CMAs) to support medication management
- Acuity-based staffing
- Uniform disclosures to improve consumer decision-making

(iii) the impacts of licensing or certifying such residences

Certified ALRs in Massachusetts



- **273 Certified ALRs**
  - ***169*** *Traditional & Special Care Residence (SCR)*
  - ***69*** *Traditional AL only*
  - ***35*** *Special Care only*
- **17,388 Total ALR Residents**
  - ***12,149*** *Traditional Residents*
  - ***5,239*** *Special Care Residents*

Impacts of Certifying ALRs in Massachusetts

- **Key Findings:**
  - **Certification Establishes Baseline Protections:**
    - No ALR can operate or advertise without certification by AGE (Executive Office of Aging & Independence).
    - Biennial (or annual for ALRs that become certified to provide Basic Health Services) inspections help ensure continued compliance with care, staffing, and resident rights standards.
  - **Strengthened Oversight Through Recent Reforms (2024 Legislation):**
    - New Basic Health Services (BHS) certification requires **annual review**.
    - Expanded enforcement authority: fines up to **$500/day** and **whistleblower protections**.
    - Increased transparency: mandatory disclosure of individuals with **5%+ ownership interest**.
  - **Specialized Dementia Care Standards:**
    - Enhanced staffing, service planning, and safety standards for Special Care Residences.
    - Ongoing, dementia-specific staff training requirements.
  - **Active Compliance Monitoring:**
    - Unannounced inspections, incident reporting, complaint tracking, public record requests, and operational change reviews.
    - AGE has authority to **modify, suspend, or revoke certifications**.

- **Ties to Recommendations:**
  - Stronger enforcement and transparency provisions directly support recommendations to improve **consumer protections** and **accountability** in ALRs.

Certification | *Important Considerations*

What Works Well

- **Assisted Living Residences actively enhance social interactions for residents.**
- **Statewide Certification Requirement:** All ALRs must be certified by AGE to operate or advertise, ensuring baseline regulatory oversight.
- **Biennial (or Annual) Compliance Reviews:** Regular on-site inspections and renewal processes promote accountability and ongoing quality monitoring.
- **Clear Regulatory Standards:** Certification sets expectations for service delivery, resident rights, staffing qualifications, and medication management.
- **Increased Transparency:** Recent reforms strengthen ownership disclosure requirements and improve public visibility into ALR operations.
- **Enforcement Tools:** Revoke or alter certifications, and respond swiftly to immediate threats to resident safety.
- **Ombudsman Access:** Residents have dedicated advocacy channels through the Long-Term Care Ombudsman program.

Areas to Explore for Future Consideration

- **Staffing Ratios:** Regulations do not prescribe minimum staff-to-resident ratios, creating variability in staffing models.
- **Resident Assessments:** ALRs are not required to use a standardized assessment tool to evaluate resident needs or appropriateness for assisted living.
- **Equity in Access:** ALRs are not required to accept residents using public subsidies (e.g., GAFC, SSI-G), which may limit access for low-income individuals.

Industry Perspective

- The ALR industry highlights that **increasing regulatory requirements often leads to higher operating costs.**
- These costs are typically **absorbed by residents, potentially impacting affordability** in an already expensive housing and care setting.
- Residents and families typically prefer to choose their preferred level of services and amenities rather than having to pay for a more institutionalized environment before they need it.
- Ongoing discussions focus on **balancing regulatory oversight with maintaining access and affordability,** and recognizing that ALRs are a non-clinical, residential model,

Key Takeaways for Impacts of Certification

Impacts of Certification

- **Benefits**: Accountability, transparency, stronger enforcement
- **Challenges**: No staffing ratios, no monetary fines, resident/ family affordability concerns
- **Industry view**: Increased regulation may drive up resident costs

(iv) advertising practices of assisted living residences to potential residents and their families

Current ALR Advertising Practices in Massachusetts

- **Certification Required:** ALRs must be certified by the Executive Office of Aging & Independence (AGE) to advertise as an assisted living residence.
- **Pre-Certification Advertising:** Permitted *only if* the certification process has been formally initiated **and** all materials clearly state that certification is pending.
- **Consumer Protection Aligned:** ALR advertising is subject to Massachusetts consumer protection laws (Chapter 93A), requiring accuracy, transparency, and fairness.
- **Massachusetts requires detailed upfront disclosures:**
  - Residency agreements must include:
    - Scope of services
    - Fees, payment schedules, and refund policies
    - Admission and discharge criteria
    - Resident rights
    - Staffing levels and emergency protocols
    - *Note: Disclosure format is not standardized making comparison across ALRs more challenging*
- **Residency agreement required before move-in:** Most residents sign their Residency Agreements without consulting an attorney although the documents have been drafted by attorneys.
- **ALR advertising**: Falls under the Massachusetts consumer protection statute (Chapter 93A). False or deceptive practices carry potential civil and administrative penalties.

What Works Well & Areas to Watch

What Works Well

- **Certification is Required**
  Only certified ALRs can advertise as assisted living residences, protecting consumers from misleading promotions.
- **Pre-Certification Advertising Allowed with Disclosure**
  ALRs can advertise before certification **if** they clearly state certification is pending.

Areas to Watch

Issue	Description
Fee Structure	Advertising "no hidden fees" while charging undisclosed community or service fees
Hidden Fees	Not specifying purpose or refundability of upfront charges
Promises	Overpromising resident experience (e.g., staff-to-resident ratio, care levels)

Key Takeaways for Advertising Practices

Advertising Practices

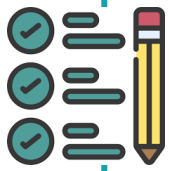
- Certification Required to Advertise as an ALR
- Pre-Certification Advertising Allowed with Disclosure
- Advertising Is Covered by Consumer Protection Laws
- Disclosure of Services and Fees Required—But Not Standardized
- Residency agreements must include key information (e.g., services offered, fees, refund policies), but formats vary across providers, limiting comparability for consumers.
- A uniform disclosure format—like those used in Minnesota—could improve clarity, comparability, and informed consumer decision-making.

(v) regulatory procedures for opening, closing or changing ownership of a residence, including determination of need processes and clustering of facilities

Opening an ALR | *Application Submission & Initial Certification*

Timing & Fees

- Submit AGE-prescribed forms (notarized, under penalty of perjury) ≥ 60 days before planned opening
- Pay non-refundable $200 fee
- One application per residence



Core Application Materials

- Names & addresses of officers, directors, trustees
- Names & addresses of limited partners/shareholders owning > 25% interest. NOTE, this is now 5% with An Act to Improve Quality and Oversight of Long-term Care
- For each individual named, list all multifamily housing or health care facilities or providers in the Commonwealth or in other states in which he or she has been or is an officer, director, trustee, or general partner
- For each individual, list the names and addressed of those who have, within the five years before the date of the application, directly or indirectly have an ownership interest in:
  - Hospitals, clinics, long-term care, rehab, lab, etc.
  - Medical provider licensed under other applicable state statutes
  - Home health agency in Mass. certified under Title XVIII of the Social Security Act
- For each individual listed above, list the names and addresses of applicable entities in which there was an ownership interest during the applicable period
- With respect to each licensed or certified entity, the Applicant shall furnish a written statement from DPH that such licensed or certified entity has:
  - Substantially met applicable criteria for licensure or certification:
  - If applicable, has corrected all cited deficiencies without de-licensure or decertification being imposed

Opening an ALR | *Post-Application Submission (1 of 2)*

AGE Review & On-Site Inspection

- AGE staff reviews operational plan & attachments for MA compliance (M.G.L. c. 19D; 651 CMR 12.00)
- After receipt of application, AGE will:
  - Conduct on-site compliance inspection (physical environment, staffing, policies)
  - Confirm all required documents are complete
- If approved:
  - AGE issues written notice of certification & associated fee request
  - Applicant submits fee within 10 days of notice
  - AGE issues a 2-year certificate (fee established by Secretary of Admin. & Finance, M.G.L. c. 7, § 3B)

Opening an ALR | *Post-Application Submission (2 of 2)*

Discretionary Denial Criteria | AGE may deny certification if applicant (or any owner) has:

- Applicants have a history of serious violations, patient abuse, or facility closures due to non-compliance.
- Entities failed to correct health and safety deficiencies at other facilities
- Been subject to a patient care receivership action
- Ceased to operate such an entity as a result of:
  - Suspension or revocation of license or certification
  - Receivership
  - A settlement agreement arising from suspension or revocation of a license or certification
  - Has a settlement agreement in lieu of or as a result of a receivership
  - Has been the subject of a substantiated case of patient abuse or neglect involving material failure to provide adequate protection or services for the resident in order to prevent such abuse or neglect; or
  - Has over the course of its operations been cited for repeated, serious and willful violations of rules and regulations governing the operation of said entity that indicate a disregard for resident safety and an inability to responsibly operate an assisted living residence.
  - Has been found in violation of any local, state or federal statute, regulation, ordinance or other law by reason of that individual's relationship to an Assisted Living Residence

Closing an ALR

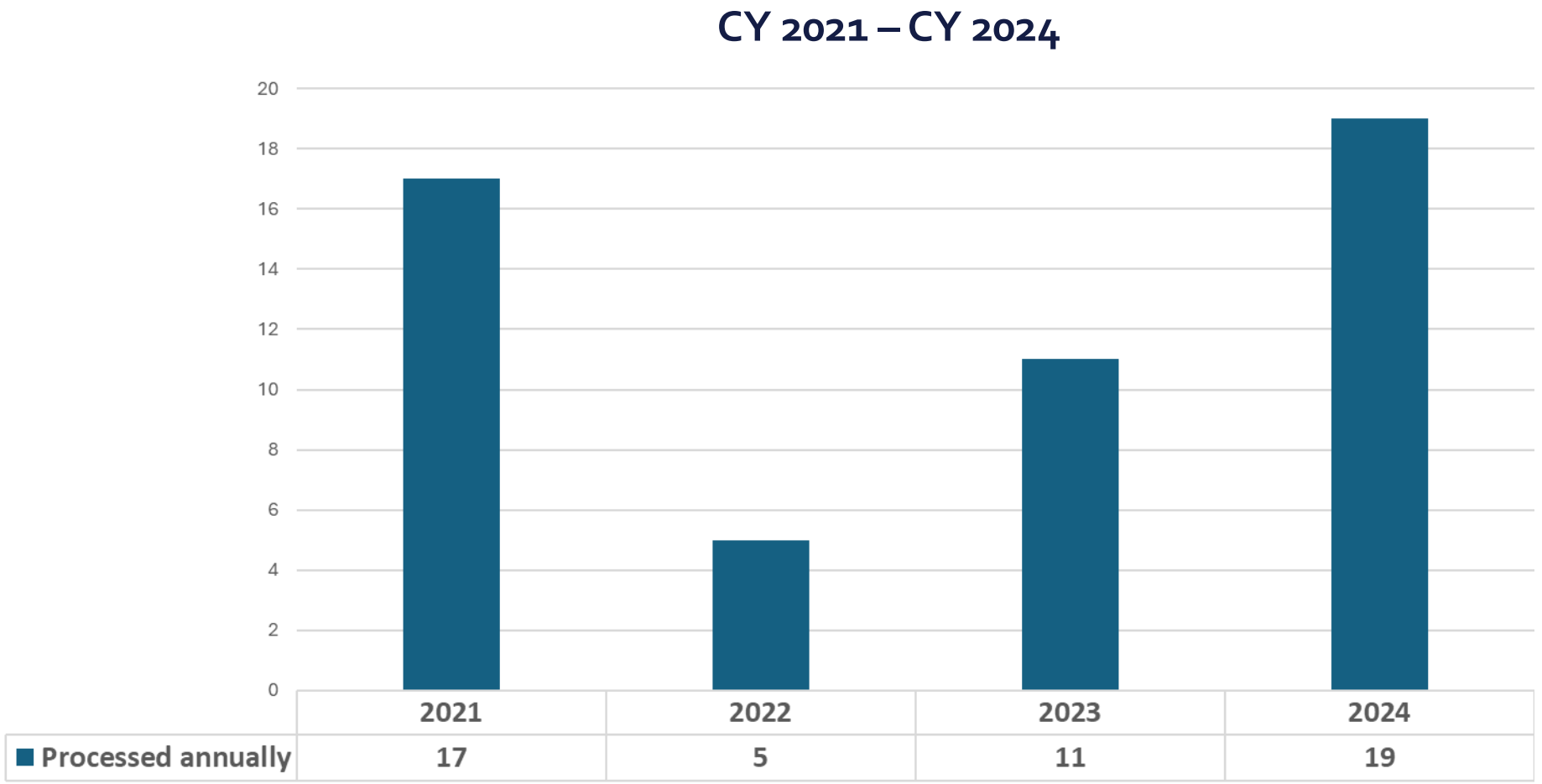
- **Sponsor Notification (≥ 120 days before closure)**
  - Written notice to:
    - Residents & legal representatives
    - Resident representatives (if applicable)
  - Notice must include:
    - Intended closure date
    - Sponsor's plan to assist Residents in securing comparable housing and services, if necessary; and
    - A reference to the rights of the Residents that may be exercised under landlord/tenant laws established under M.G.L. c. 186 or c. 239

- **AGE Notification**
  - Written notice to AGE containing:
    - Copy of resident notice
    - Proof of resident notifications
    - List of residents receiving additional services or subsidies (e.g., GAFC)

Transferring Ownership of an ALR

- **Notification & Pre-Transfer Requirements**
  - Applies when any party acquires ≥ 5% ownership interest in an existing ALR
  - Submit AGE application & supporting documentation 30 days before scheduled transfer
  - Required pre-transfer documents:
    - Completed AGE "Change in Ownership (CHOW)" application
    - Notarized buyer/seller forms confirming agreement to transfer interest
- **Post-Transfer Requirements (within 5 days of closing)**
  - Submit to AGE:
    - Notarized confirmation of completed transfer
    - Prior sponsor returns current certificate to AGE
  - If all documents are in order, AGE grants temporary certification (effective on transfer date)
  - Temporary certification remains valid until AGE approves or denies new-owner certification

Transfer / Change of Ownership Trends

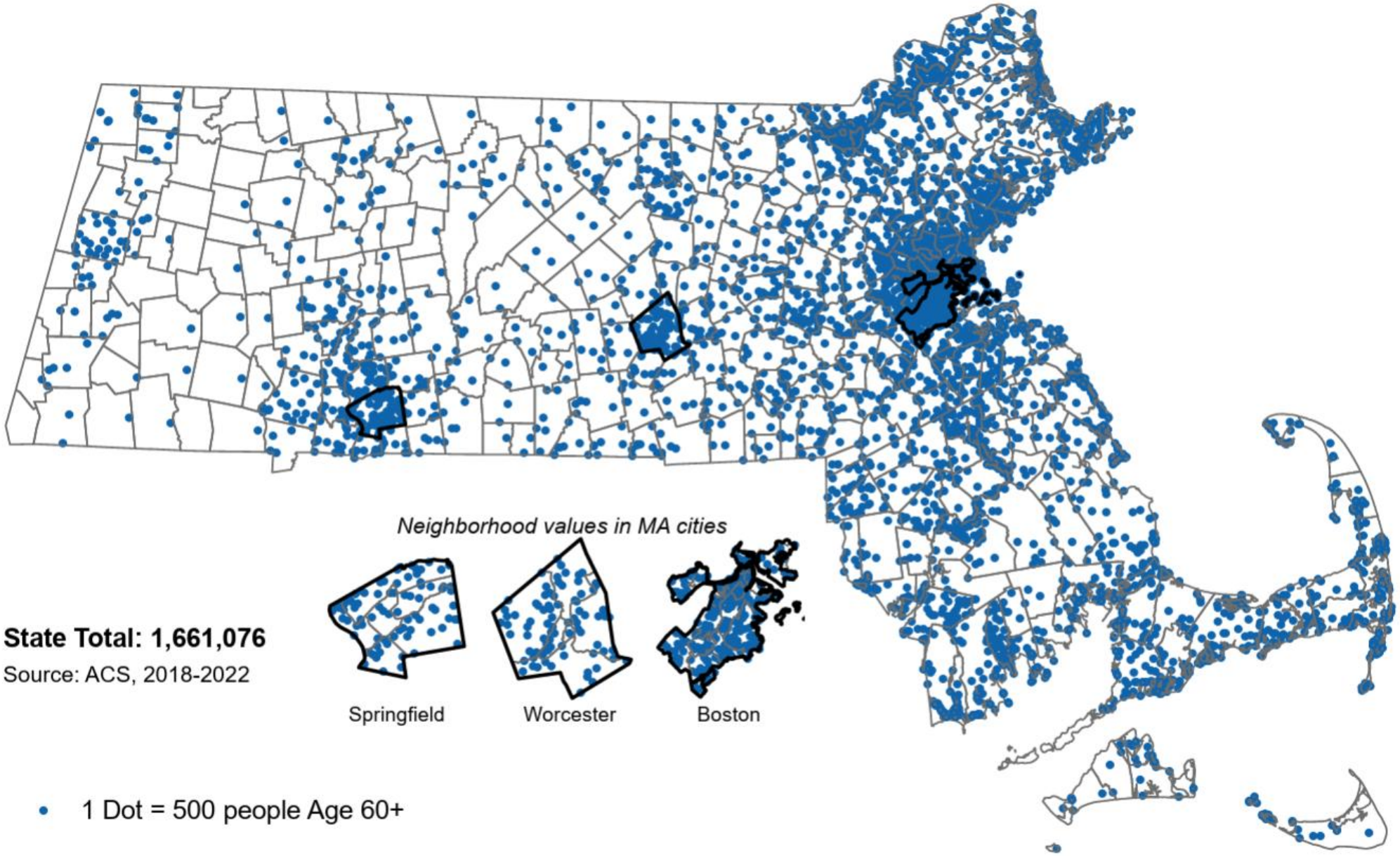


Clustering Considerations

Clustering of ALRs:

- No formal "determination of need" process (unlike hospitals or nursing homes)
- AGE monitors the **geographic distribution of ALRs** across Massachusetts.
- Clustering tends to occur in:
  - **Densely populated areas**
  - **Areas with aging population**

Density of Population Age 60+ Years

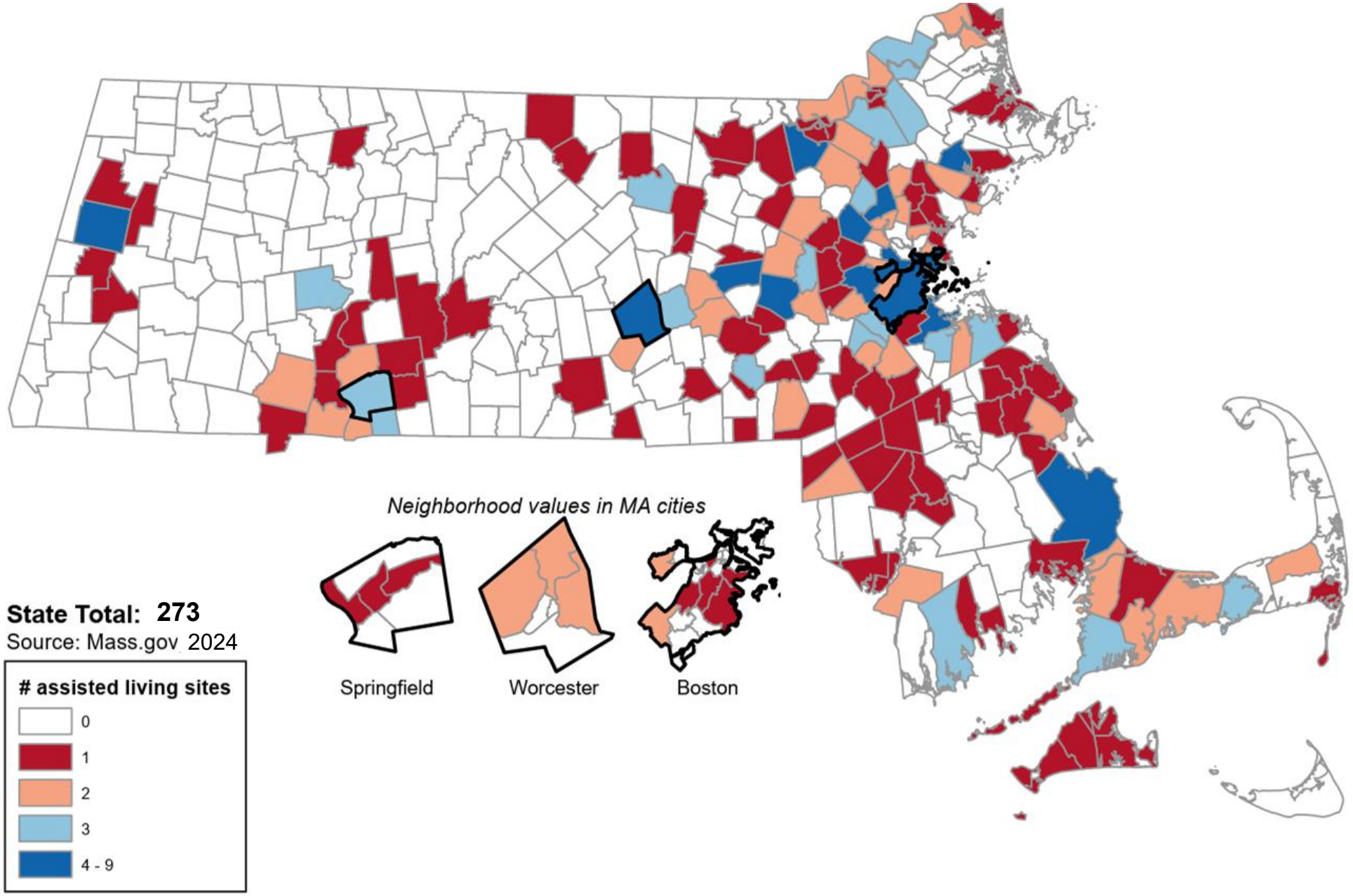


State Total: 1,661,076

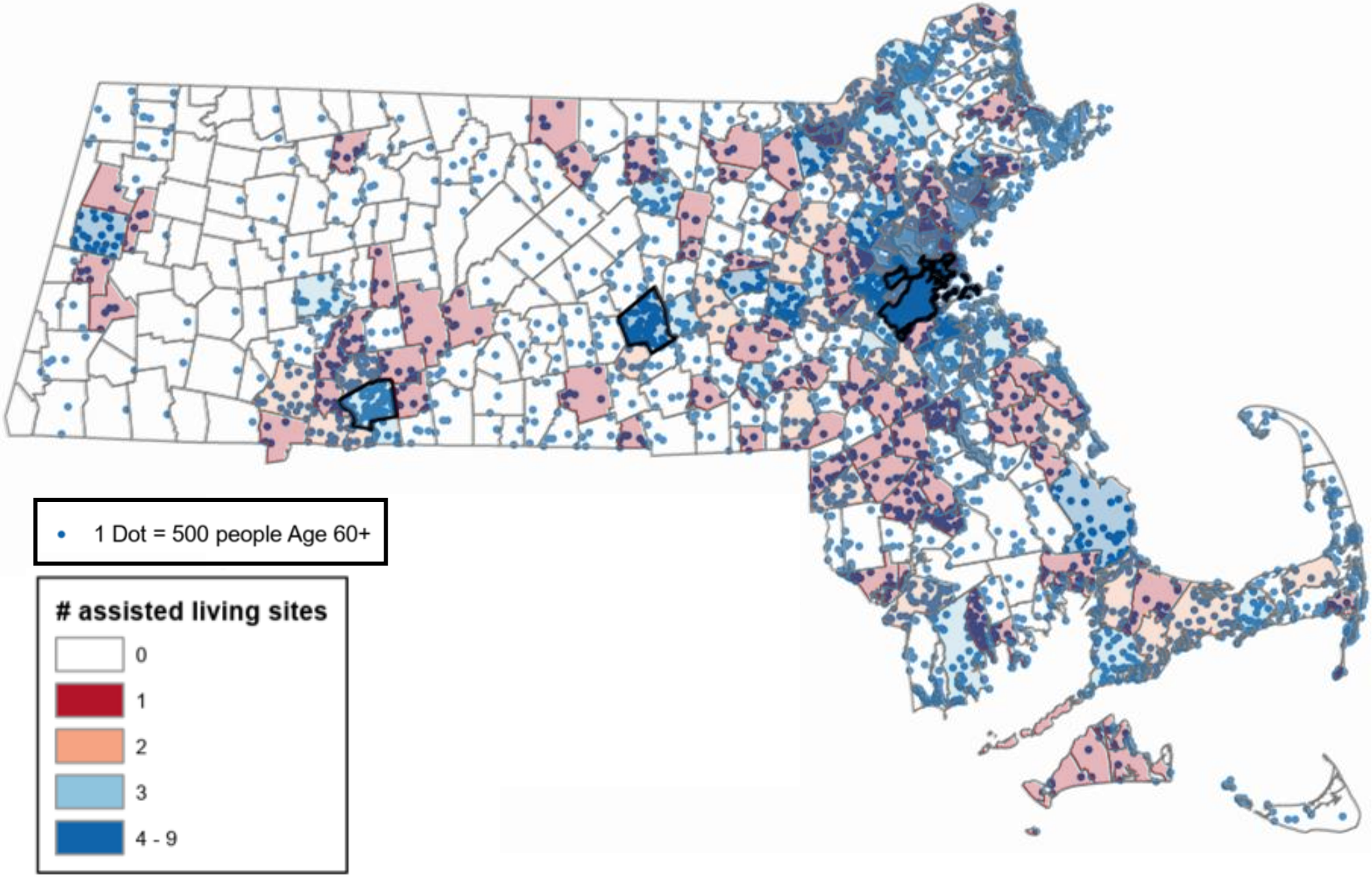
Source: ACS, 2018-2022

- 1 Dot = 500 people Age 60+

Number of Assisted Living Sites



Density of Population Age 60+ Years & Number of ALRs



Key Takeaways for Opening, Closing and ALR Ownership Changes

Opening, Closing and Ownership

- Certification process includes inspection, ownership disclosure, and compliance checks
- Closures and CHOWs require resident and AGE notification
- AGE has discretion to deny applications based on past violations, criminal records, sanctions associated with owners/principals, etc.
- No formal Determination of Need process

(vi) trends in incident reports made to the executive office of elder affairs and the long term care ombudsman's office and resolutions of such incidents

Understanding Incidents and Complaints in ALRs

What is an Incident?

- Reportable event that occurs within the residence.
- Must be reported by the ALR to the Executive Office of Aging & Independence (AGE) within required timeframes.
- Examples: falls with injury, medication errors, elopement, unexpected death.

What is a Complaint?

- Raised by a resident, family member, staff, or the public about concerns in the residence.
- Often reported to the Long-Term Care (LTC) Ombudsman's Office or to AGE.
- Examples: concerns about care quality, resident rights, billing practices.

Who Handles What?

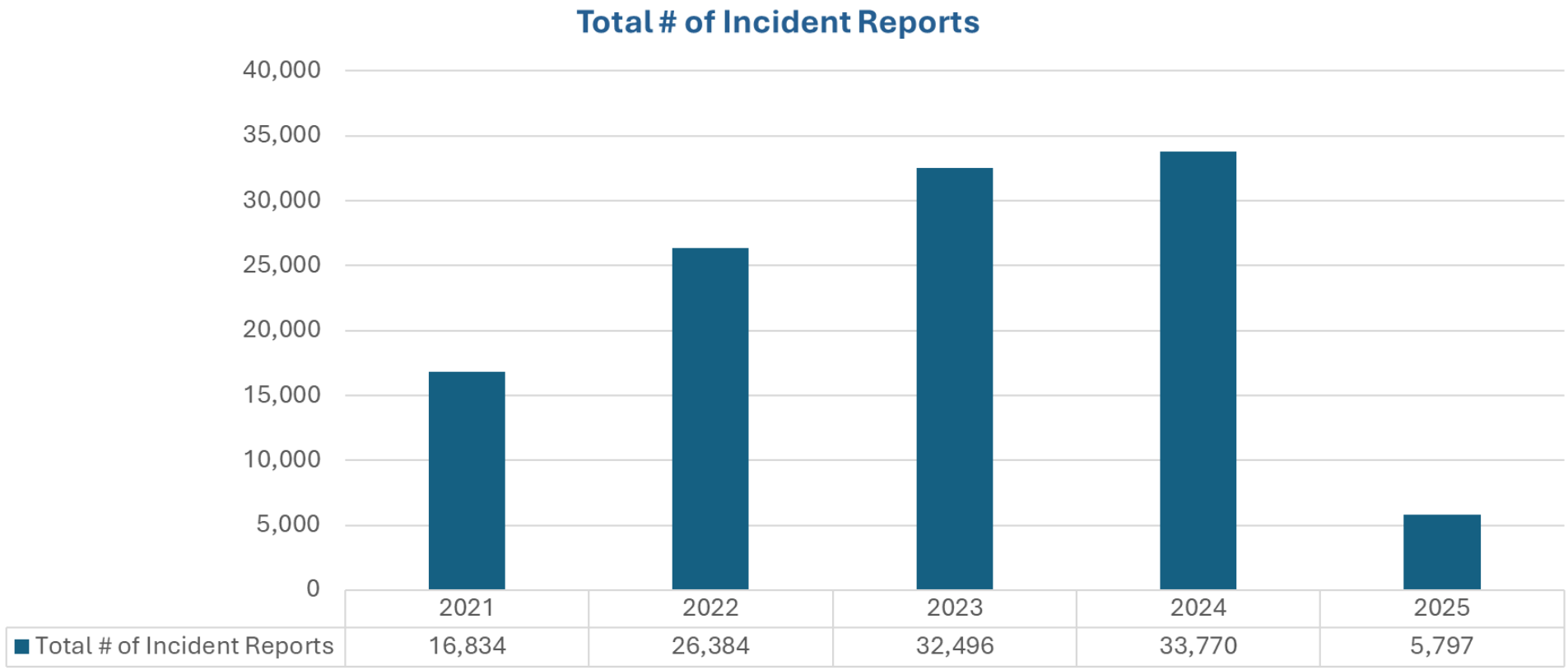
AGE ALR Certification Unit	LTC Ombudsman Program*
Oversees ALR certification and compliance.	Advocates for residents in ALRs, nursing homes, and rest homes.
Reviews incident reports.	Investigates and resolves resident complaints.
Conducts routine and unplanned compliance reviews.	Works directly with residents, families, and staff to address concerns.
Can issue enforcement actions.	Independent resident-focused advocacy.

**LTC Ombudsman Program only works with current residents of an ALR and cannot assist or advocate once a Resident has moved on from the ALR.*

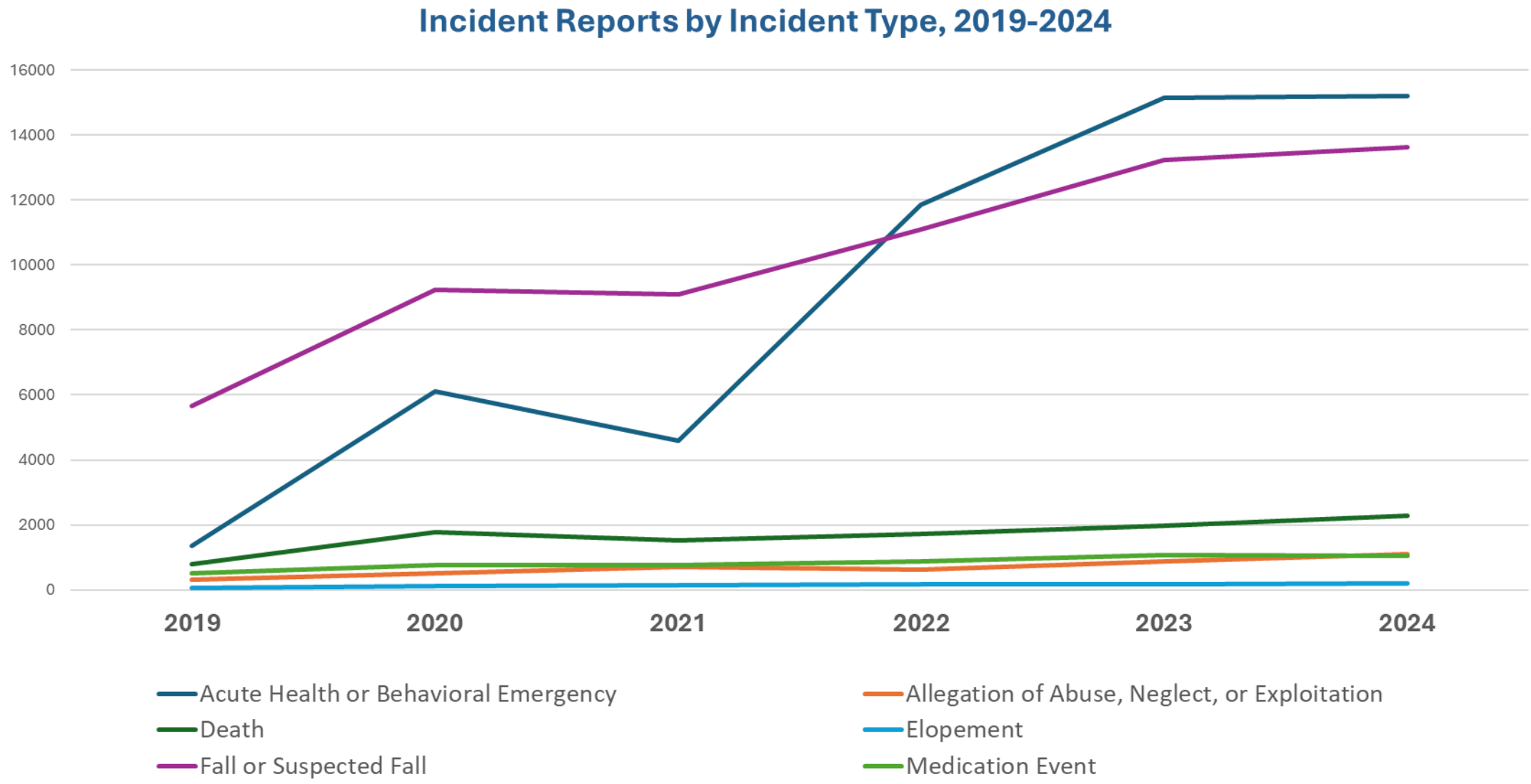
ALR Incident Report Trends | *Volume*

Key Trends:

- Steady increase in incident report submissions over time.
- Increase is partly due to enhanced training and guidance provided by AGE emphasizing the importance of transparent reporting.
- ALRs are encouraged to 'report when in doubt' to support proactive oversight.



ALR Incident Report Trends | *Types*



ALR Incident Report Trends | *Volume by Type*

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**

Long Term Care (LTC) Ombudsman Program

- **Purpose:** Provide free advocacy for residents living in **nursing homes, rest homes, and assisted living residences**
- **Funding:** Federal and state resources
- **Key Activities:**
  - Investigate & Resolve Complaints (e.g., care quality, resident rights, billing, discharges)
  - Advocate for Resident Rights (e.g., promote dignity, choice, and quality of life)
  - Educate Residents, Families & Staff (e.g., resident rights, care options, complaint process)
  - Visit Facilities Regularly (e.g., build relationships and identify issues early)
  - Support Resident & Family Councils (e.g., strengthen self-advocacy and community voice)
  - Collaborate with State Agencies (e.g., Coordinate with AGE, DPH, and others)
  - Promote System-Level Improvements (e.g., address trends and recommend policy changes)
- **Staff and Population Served:**
  - 41 paid Ombudsman staff and 206 Certified Volunteer Ombudsmen across all three settings of care, who last year donated 17,923 hours to the program (as of federal fiscal year 2024).
  - At least one ombudsperson is assigned to every ALR.
  - They provided advocacy to over 65,000 residents living in over 683 nursing homes, rest homes, and assisted living residences across the State.

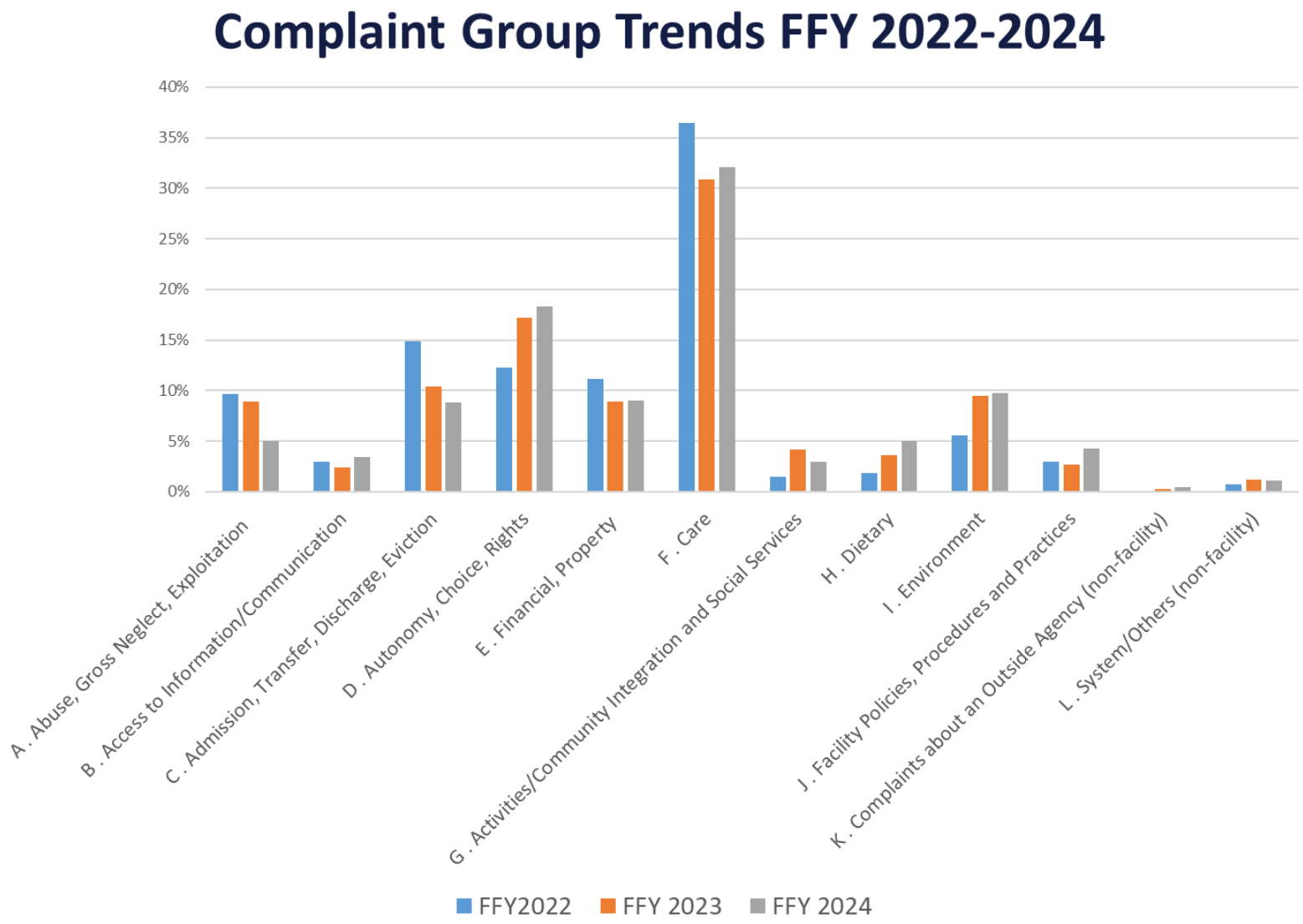
LTC Ombudsman Program | *FFY2024 Complaint Outcomes*

The program worked to resolve

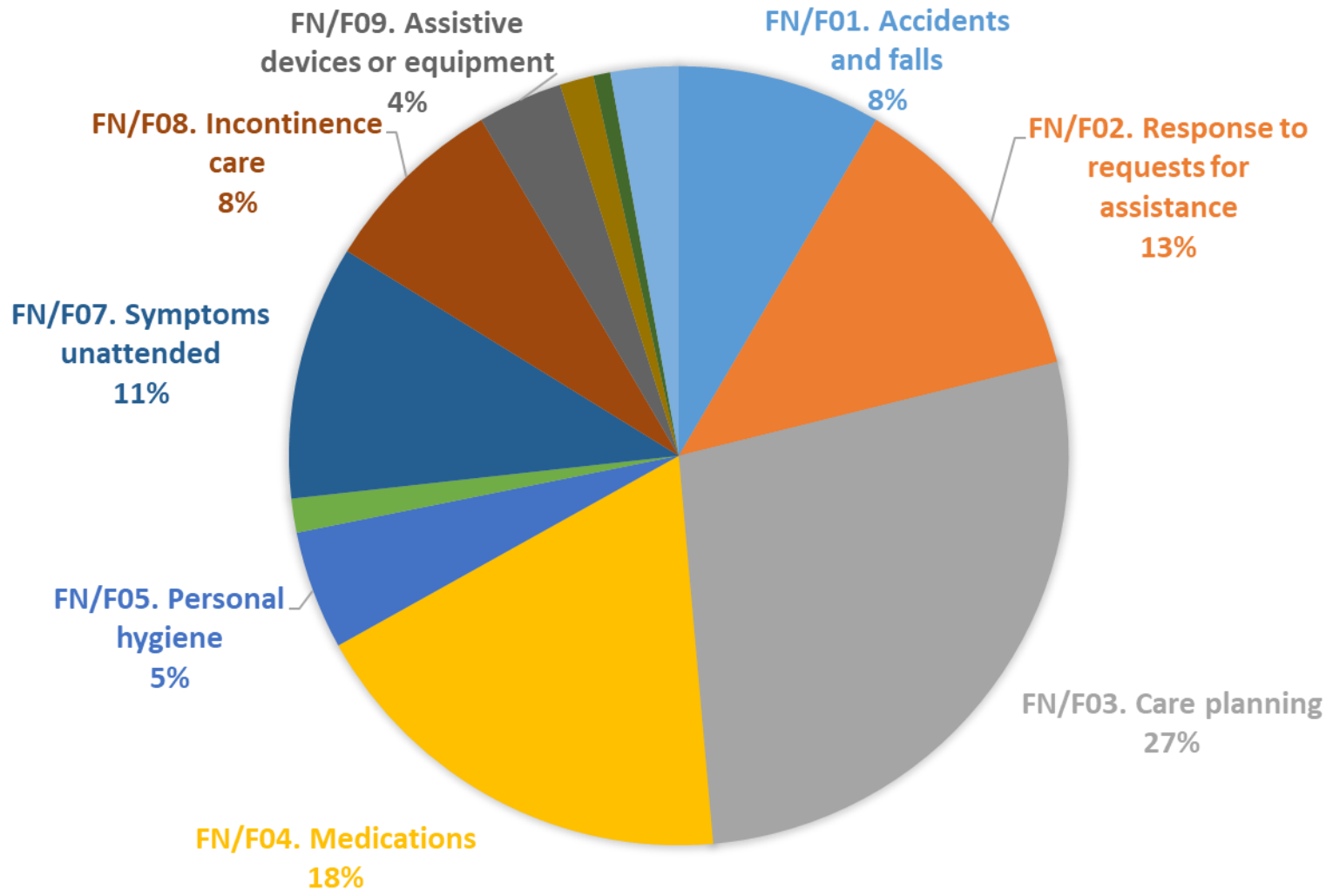
443

complaints initiated by residents, their families, and other concerned individuals.

LTC Ombudsman Program | *Distribution of Complaint Types*



LTC Ombudsman Program | *FFY 2024 Care Complaints Detail*



Key Takeaways for Trends

Trends

- Incident reports rising, in part due to improved training
- Increase in incidents due in part to improved reporting, but warrants further evaluation of events related to medical complexity to determine how those events might be reduced
- Most complaints resolved satisfactorily by LTC Ombudsman Program
- Still limited real-time, centralized public visibility
- Recommend strengthening reporting transparency

(vii) methods to provide transparency of information for potential consumers and family members researching and comparing residences

Why Transparency Matters in Assisted Living

- **Key Considerations for Families and Residents:**
  - Choosing an Assisted Living Residence (ALR) is a significant life decision.
  - Consumers need **clear, accessible, and comparable information** to make informed choices.
  - Transparency helps families:
    - Understand care offerings and limitations.
    - Compare costs and contract terms.
    - Evaluate safety and quality records.

Current Transparency Practices in Massachusetts

What's Available Today:

- ALR Directory: Basic contact information
- Mass-ALA Resource Guide
- Certification Status: Publicly available through the Executive Office of Aging & Independence (AGE)
- Incident Reports: Available upon request, but not centralized or user-friendly
- Documents that AGE makes or receives are subject to the Massachusetts Public Records Law.

Challenges:

- Information is fragmented across sources
- Limited standardization across facilities
- Consumers often rely on word-of-mouth or marketing materials

Opportunities for Improvement

Making ALR Information Easier to Find and Understand:

- **Online Consumer Portal:**
  - Searchable database with filters (e.g., location, pricing, services offered, safety records)
- **Standardized One-Page Summaries:**
  - Key details on costs, services, staff qualifications, and safety history
- **Public Posting of Key Reports:**
  - Inspection results, incident trends and ownership changes
- **Uniform Disclosure Form:**
  - Require all ALRs to use a standardized, consumer-friendly disclosure form (similar to Minnesota's model) that clearly presents:
    - Fee schedules and cost tiers
    - Services offered
    - Refund policies
    - Key resident rights and contract terms

Key Takeaways for Transparency

Transparency

- **Consumers Need Clear, Comparable Information.** Choosing an ALR is a major life decision—families need access to consistent data on services, safety, and costs.
- **Current Information is Fragmented.** While certification status and incident reports are available, they are spread across sources and not easily accessible or standardized.
- **Lack of Standardization Makes Comparisons Difficult.** Fee structures, service offerings, and contract terms vary widely, with no uniform disclosure format to aid decision-making.
- **The Commission recommends:**
  - A uniform disclosure statement outlining key cost and service information
  - An online portal with searchable compliance and service data
  - Public posting of inspection results, incident trends, and ownership changes

(viii) safety standards

Core Services Required at All ALRs

- **Assistance and supervision with Activities of Daily Living (ADLs):** bathing, toileting, dressing, eating/feeding, transferring and ambulation, as specified in each resident's individualized service plan.
- **Instrumental Activities of Daily Living (IADLs):** housekeeping, laundry, meal preparation (at least one meal per day with dietary options), and socialization opportunities.
- **24/7 on-site staff and personal emergency response systems** for urgent or emergency needs.
- **Private or semi-private apartments** with lockable doors, kitchenettes or access to a community kitchen, and private or shared bathrooms depending on the Residence.

Other Types of Support

- **Specialized Care / Memory Care:** Some ALRs offer specialized memory care programs for residents with dementia or Alzheimer's disease. This is not required at all ALRs and should be confirmed before move-in.
- **Social and Recreational Activities:** ALRs provide opportunities for socialization and engagement, tailored to resident interests and abilities.
- **Coordination with Outside Health Providers:** Skilled nursing services, such as injections or medical therapies, may be provided by certified home health agencies on a part-time or scheduled basis if needed.

Additional points to keep in mind:

- ALRs in Massachusetts manage support through individualized, regularly updated service plans.
- They provide required assistance with ADLs and mobility, including some transfer assistance.
- The ability to provide higher levels of physical support (like two-person assists or lifts) varies by Residence-always confirm with the ALR before moving in.
- If needs change, service plans are adjusted, but some residents may need to transition to a different care setting if their needs exceed what the ALR can provide

Safety Standards

- **Physical Environment**
  - Lockable single or double-occupancy Units with private bathrooms or half-baths and shared bathing facilities as specified
  - Compliance with all applicable state building, fire safety, sanitary, and disability-access codes

- **Evidence-Informed Falls Prevention**
  - Annual review of policies/procedures to ensure a safe environment, including a documented, evidence-informed falls prevention program

- **Emergency Preparedness & Response**
  - Comprehensive emergency management plan covering fire, flood, severe weather, utility loss, missing residents, etc., developed with local/state planners; includes evacuation strategies, mutual aid, supply continuity, EMS/public safety liaisons, HHAN and Silver Alert participation
  - Annual simulated evacuation drills for all shifts; written plans provided to each Resident; staff orientation and periodic training on the plan
  - 24-hour on-site staffing or personal emergency response systems to signal urgent needs

- **Incident Reporting**
  - Report to AGE within 24 hours any "Significant Negative Effect" incident (e.g., injury, elopement, communicable disease outbreak) or displacement of residents ≥ 8 hours .

Quality Assurance & Performance Improvement

- **Ongoing Quality Program**
  - Establish and maintain a continuous quality improvement and assurance program focused on Resident health, safety, and satisfaction
  - Quarterly data collection and analysis on services, outcomes, and care experience

- **Key Quality Assurance Activities**
  - Service Planning Review: Annual random sampling of Resident assessments, service plans, and progress notes to verify implementation and goal attainment
  - Medication Quality Plan:
    - Semi-annual evaluation of each Personal Care worker's SAMM/LMA compliance
    - Quarterly audit of medication documentation for SAMM/LMA adherence
  - Problem-Resolution System: Mechanism (e.g., surveys, suggestion boxes) for anonymous issue reporting, with documented follow-up actions

Key Takeaways for Safety Standards

Safety Standards

- **Core Safety Supports Are Required in All ALRs**. ALRs must provide assistance with ADLs and IADLs, 24/7 staff or emergency response systems, and secure, accessible private living spaces.
- **Environmental and Emergency Protocols.** Residences must comply with building and fire codes, maintain emergency plans, and conduct evacuation drills across all shifts.
- **Incident Reporting is Mandatory.** Significant negative events (e.g., falls, infections, elopements) must be reported to AGE within 24 hours.
- **Ongoing Quality Assurance is Required.** ALRs must maintain performance improvement programs, conduct service and medication audits, and have anonymous issue reporting systems.
- **Areas for Continued Attention:**
  - ALRs vary in their ability to support higher-acuity physical needs (e.g., lifts or two-person transfers);
  - Consumers should confirm capabilities before move-in.

(ix) existing consumer protections for residents in statutes and regulations

Consumer Protections for ALR Residents | *Current*

Certification & Oversight: AGE certifies ALRs, conducts biennial visits and enforces compliance

Resident Rights: Rights under Chapter 19D including refusal of services, participation in service plans, privacy protections, and landlord-tenant protections apply

Landlord-Tenant Law: ALRs subject to landlord-tenant law including security deposit rules (SJC ruling 2019)

Financial Protections: Prohibition on ALR control of resident funds; transparency on fees; Medicaid estate recovery limited to federal minimum

Consumer Service Quality & Safety Protections | *Current*

- Individualized service plans with resident involvement

- To prevent inappropriate placements:
  - ALRs must ensure residents receive proper assessments before and during their stay
  - ALRs cannot admit residents requiring 24-hour skilled nursing supervision unless the resident elects to receive Basic Health Services from residences that are certified to provide such services or from qualified third parties
  - Skilled nursing beyond Basic Health Services care can only be provided under specific conditions, such as through certified home health agencies

- 24/7 on-site staff and emergency response systems required

- Mandatory reporting of incidents affecting residents within 24 hours to AGE

- Elder abuse protections and mandatory reporting laws apply

Consumer Protections for ALR Residents | *Forthcoming Enhancements (1 of 2)*

Chapter 197 of the Acts of 2024, introduced significant reforms within ALRs to enhance transparency, expand service offerings, and strengthen enforcement.

Key Enhancements:

- **ALRs may become certified to directly provide Basic Health Services, which include:**
  - Injections,
  - Simple dressing changes,
  - Oxygen management,
  - Specimen collection with home diagnostic tests, and
  - Applying ointments or drops.

- **Enhanced Certification and Operating Plan Updates:**
  - Residences seeking basic health services certification must undergo an annual compliance review by AGE.

- **Increased Transparency Requirements:**
  - Disclose all officers, directors, trustees, and shareholders or partners with a 5% or greater interest (previously 25%)

- **Oversight and Enforcement:**
  - A dedicated Assisted Living Residences Commission to study the sector and recommend policy improvements.
  - AGE may impose fines of up to $500 per day for sponsors or applicants who fail to comply with assisted living requirements.
  - Includes whistleblower protections prohibiting residences from retaliating against employees or residents who, in good faith, report violations of law, rules, or regulations or raise concerns about public health, safety, or well-being.

Consumer Protections for ALR Residents | *Forthcoming Enhancements (2 of 2)*

Mass. Gen. Laws, Chapter 93A, Massachusetts' Attorney General's Office (AGO) is drafting consumer protection regulations for ALRs under the consumer protection statute (Mass. Gen. Laws, Chapter 93A)

Key Enhancements:

- Prohibit unfair and deceptive business practices
- Authorize the Attorney General to promulgate regulations requiring disclosures about contractual terms
- Allow for declaration of certain acts and practices as unlawful

Key Takeaways for Consumer Protections

Consumer Protections

- **Foundational Protections in Statute and Regulation**. M.G.L. c. 19D and 651 CMR 12.00 require individualized service planning, pre-admission assessments, and incident reporting.
- **Enhanced Protections through 2024 Reforms (Ch. 197).**
  - ALRs can now be certified to offer Basic Health Services (BHS)
  - AGE can impose fines and require greater transparency
  - Whistleblower protections prohibit retaliation against those reporting violations
- **Forthcoming Consumer Protection Regulations Under Ch. 93A**. The Attorney General is developing regulations to:
  - Ban unfair/deceptive practices
  - Mandate standardized disclosures
  - Declare specific violations unlawful
- **Ombudsman Program Provides Independent Advocacy**. Residents have access to LTC Ombudsman support for complaints, education, and rights advocacy.

(x) basic health services in residences

Basic Health Services

- Chapter 197 of the Acts of 2024 permanently authorizes ALRs to provide **five Basic Health Services** on-site:
  1. Injections
  2. Simple dressing changes
  3. Oxygen management
  4. Specimen collection with home diagnostic tests*
  5. Applying ointments or drops

- **Certification requirements for Residences seeking to provide Basic Health Services**:
  - Annual compliance review by AGE (vs. every two years requirement for ALRs without Basic Health Services)
  - Updated operating plans demonstrating staff competencies, equipment, and protocols

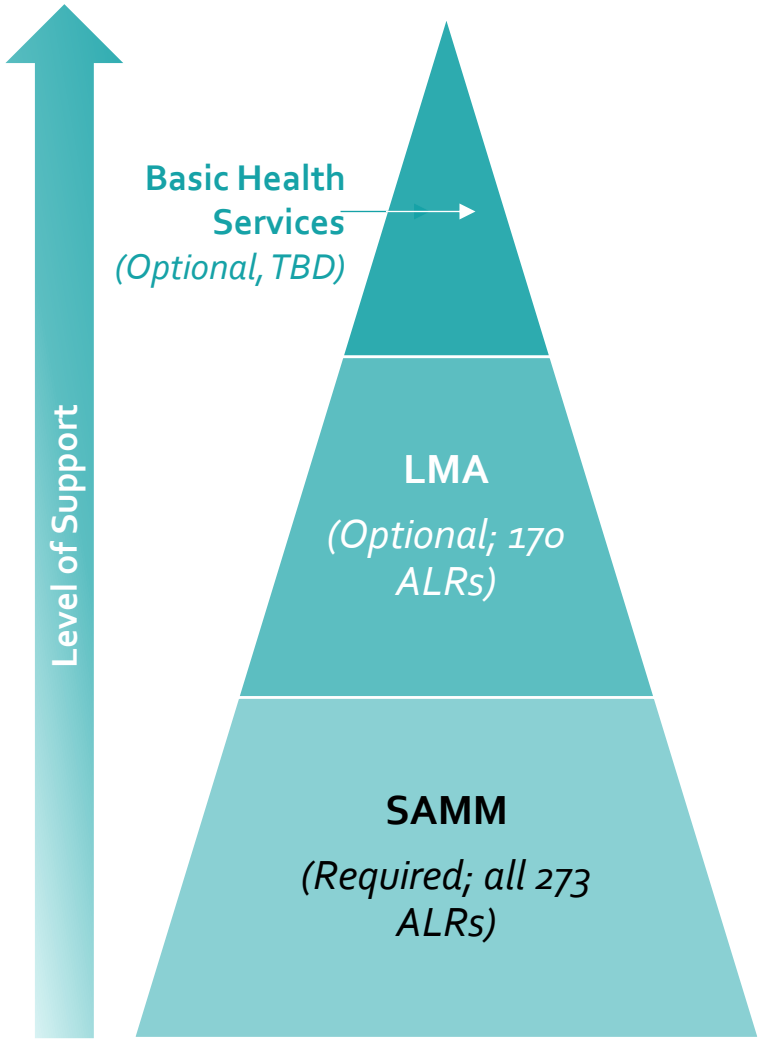
**Including but not limited to warfarin, prothrombin or International Normalized Ratio (INR) testing and glucose testing, provided such home diagnostic testing or monitoring is approved by the US FDA for home use*

Integrating Basic Health Services with Residential Model

- **Scope and limits of Basic Health Services relative to skilled nursing:**
  - BHS expands this scope slightly but still excludes 24/7 skilled nursing care

- **Training, staffing, and infrastructure needs:**
  - Ensuring staff competencies for injections, oxygen management, diagnostic testing
  - Staffing level needed to safely support Basic Health Services under review as proposed ALR regulations are being drafted

Medication Support Levels



Level	What It Entails	Staff Involved	Key Details
Basic Health Services	Administration of injections, simple dressings, oxygen management, home diagnostic tests, application of ointments/drops.	Licensed nurse (RN or LPN); must consult with resident's doctor/nurse	ALR must be certified for this level. Service plans require quarterly review and detailed protocols
Limited Medication Administration (LMA)	Direct administration of non-injectable medications (oral, topical, inhalers, eye/ear drops, etc.) from pharmacy-labeled containers.	Licensed nurse (RN or LPN)	Only a nurse may perform LMA. All administration must follow nursing standards and be documented
Self-Administered Medication Management (SAMM)	Reminding residents to take medications, opening containers, reading labels, observing residents while they self-administer. No direct administration of medication.	Trained ALR staff (not nurses)	All ALRs must offer SAMM. Staff cannot administer medication, only assist and remind

Key Takeaways for Basic Health Services

Basic Health Services (BHS)

- **New Authority for ALRs to Offer Basic Health Services On-Site,** which includes:
  - Injections
  - Simple dressing changes
  - Oxygen management
  - Specimen collection (e.g., glucose testing)
  - Ointment or drop application
- **Certification Requirements are Enhanced.** ALRs offering BHS must undergo annual reviews, maintain updated operating plans, and demonstrate staff competency and safety protocols.
- **BHS Do Not Replace Skilled Nursing Care.** ALRs offering BHS are still not licensed for 24/7 skilled nursing; higher-acuity care must be provided via home health agencies or transition to appropriate care settings.
- **Supports Aging in Place When Safely Delivered.** When implemented with appropriate staffing and training, BHS can reduce avoidable transitions and improve continuity of care.

V. Commission's Findings related to Special Focus Topics

(A) Lessons Learned from Gabriel House Fire

Gabriel House Fire | *What Happened & Immediate Response*

- Accidental fire at Gabriel House ALR in Fall River.
- Highlighted how quickly smoke and fire can spread in buildings with older construction and mixed resident needs.
- Displaced residents needed rapid relocation and coordinated support.
- **Immediate Administration response**:
  - **Cross-agency workgroup** immediately formed to help all displaced residents secure safe, permanent housing.
  - Launch of statewide **Fire and Life Safety Initiative** covering all 272 ALRs
    - Within 5 days of fire, ALRs required to:
      - Send letters to residents/families explaining fire safety protocols, evacuation procedures, and key contacts.
      - Post evacuation instructions and exit routes inside each resident unit and in common areas.
    - Within 35 days of fire, ALRs required to:
      - Complete and submit fire safety self-assessment survey (e.g., sprinklers, fire drills, evacuation protocols, fire doors/walls, building age and key systems).
      - Submit most current site-specific Disaster & Emergency Preparedness Plans from every ALR.

Lessons from First Responders & Local Officials in Fall River, MA

- **Building design & materials matter:**
  - Concerns about vinyl siding because of high burn rate and toxic smoke.
  - Recommendation for central heating, ventilation, and air conditioning (HVAC) in larger buildings to reduce reliance on window AC units, which can block or complicate window evacuations.

- **Resident information & evacuation support:**
  - Need for a digital, real-time census that includes mobility, behavioral health needs, and critical medications.
  - Blueprint/floor plan readily available to first responders, highlighting residents needing evacuation assistance.
  - Clear door signage distinguishing resident units, closets, vacant units; visual indicators of residents who are ambulatory, non-ambulatory, or need assistance.
  - Evacuation chairs/sleds mounted near exits and fire extinguishers on each floor.
  - Consider floor markings that guide residents to exits, even when crawling below smoke.

- **Fire/smoke response practices:**
  - Shift from a "fire safety" mindset to a "smoke safety" mindset (smoke as the primary life threat).
  - Drills and training that teach residents when to shelter in place vs. evacuate and explanation that opening doors can worsen smoke spread.
  - Requirement that temporary and contract staff also participate in emergency training drills.

Key Takeaways from Gabriel House Fire

Improvements in Emergency Preparedness and Response

- Need to verify that ALRs received annual inspection from local fire department (e.g., sign-off / documentation from local fire/building/health officials, posted in the ALR and verified by AGE), and ALRs should regularly consult with local fire department, local building inspector and local board of public health.
- Emergency planning must be resident-specific and operational in real time (e.g., standardize census documents that identify resident location and individualized emergency needs, and ensure clear unit signage, and updated blueprints).
- Emergency exercises must reflect real-world complexity and ALRs must regularly work to close any gaps between "paper" plans and actual performance.
- Quarterly exercises for all staff (including contracted/temporary) and resident-inclusive drills support a culture of readiness.
- Partnership with first responders is essential.
- Local officials' recommendations on building plans, equipment, and smoke-safety behaviors reinforce:
  - Hazard vulnerability analyses reviewed by experts with recognized emergency-management or life-safety qualifications.
  - Data-sharing mechanisms so first responders receive real-time information upon arrival.
- Overall: Gabriel House transformed the Commission's work from abstract policy to urgent, actionable change—directly informing Recommendation 5 and reinforcing the need for stronger regulations, consistent inspections, and practical, building-level protections for residents and responders.

(B) Life Safety & Emergency Preparedness

Current Landscape | *Strengths, Gaps, and Emerging Risks*

- ALRs statutorily classified as residential occupancies, even though many residents—especially in memory care—are not capable of self-preservation like typical apartment tenants.
- Large variation across ALRs and municipalities:
  - Different building ages, fire protection systems, and physical layouts.
  - Fire department capacity ranges from large urban departments to smaller or volunteer departments.
- Some of the State Fire Marshal's core messages include:
  - Building and life-safety systems are the "great equalizer"—we cannot put 100% of the burden on ALR staff behavior and local fire departments.
  - ALRs must foster and maintain strong ongoing relationships with their local fire departments.

Expert Perspectives | *What Works for Life Safety & Emergency Preparedness*

- Planning & risk assessment
  - Hazard Vulnerability Analyses tailored to the facility's physical plant, location (e.g., flood, storm, coastal risk), and resident mix (e.g., mobility, cognition/dementia, etc.).
  - Robust, written Emergency Operations Plans that are regularly reviewed, updated, and tested—not PDFs on a shelf.
  - Membership in MassMAP (or equivalent mutual aid network) to support evacuation, sheltering, and resource sharing.
- Design & systems
  - Integrated fire protection systems: alarms, sprinklers, smoke/heat/carbon monoxide detectors, fire-rated doors, elevator recall to the main floor, passive egress design, clear exit signage, and good lighting.
  - Consider master box alarms that transmit directly to local fire departments, reducing delay from third-party monitoring.
  - Policies that prohibit or tightly control high-risk items (space heaters, extension cords), and enforce smoking rules, clutter reduction, and maintenance of fire doors.
- Staff & resident training
  - Orientation for all staff—including temporary/contract staff—covers alarms, evacuation routes, shelter-in-place protocols, and extinguisher use.
  - Regular drills well beyond minimum ALR requirements (e.g., quarterly per shift, mirroring skilled nursing standards).
  - Resident and family orientation and drills that emphasize what to do, including when not to open doors or self-evacuate.
  - Daily or routine safety checks (Crowd Manager-style checklists) to keep exit paths clear, equipment functional, and policies alive in daily practice.
- Resident assessment & unit inspections
  - Integrate emergency-evacuation considerations into resident assessments and ALR appropriateness determinations.
  - Semi-annual unit inspections to identify safety hazards (cords, heaters, clutter), environmental issues (leaks, mold), and evolving mobility or cognitive needs that affect evacuation.

Key Takeaways for Life Safety & Emergency Preparedness

Life Safety & Emergency Preparedness

- Life safety must be built into the physical environment and occupancy model.
- **Emergency preparedness is a continuous cycle**—not a one-time plan.
  - Hazard vulnerability analyses, annual plan updates, and expert review ensure plans reflect real risks, resident acuity, and building conditions.
- **Training, drills, and culture change are non-negotiable.**
- **Real-time information saves lives**.
  - Standard census documents and data-sharing protocols with first responders translates into actionable information during an incident.
- **Coordinated oversight drives consistent safety statewide**.
- Overall: Expert input confirms and strengthens Recommendation 5—highlighting that robust life-safety systems, realistic emergency planning, and sustained training are essential to protecting ALR residents and preventing future tragedies like Gabriel House.

(C) Staffing

Why Staffing Matters | *Evolving the ALR Model*

- Assisted living today is no longer the mostly social model of 20–30 years ago.
  - Residents now present with higher acuity, dementia, mobility limitations, behavioral health needs, and complex chronic conditions.
  - ALRs increasingly function as hybrid residential–health environments, requiring staff with both clinical and non-clinical competencies.

- Regulatory oversight relies heavily on post-incident enforcement ("insufficient staffing" determinations after harm occurs), rather than proactive standards that prevent harm in the first place.

- Families assume that certification means ALRs can meet their needs—disclosure alone is insufficient to protect residents if minimum service standards and staffing expectations are not clearly defined.

- Workforce shortages, variable leadership competency, and wide differences across providers create inconsistencies in safety, quality, and resident experience.

Perspectives on Staffing from National Experts, Providers, and Advocates *(1 of 2)*

- **Staffing is both an art and a science**
  - Adequacy = **competency + sufficiency + the right mix of roles.**
  - **Too often flexibility = ambiguity**
  - Teams need not only personal care attendants (PCAs)/CNAs but also **nurses, activities staff, social workers, nutritionists, dining staff, environmental services**, and engaged leadership.

- **Nursing presence is essential**
  - Nursing staff are often the **only clinically trained individuals onsite** and are critical for assessments, care planning, responding to changes, and training others.
  - Debate focused on:
    - RN vs. LPN role in assessments and care planning.
    - Minimum onsite hours vs. flexible/on-call structures.
    - Feasibility in small and rural ALRs.

Perspectives on Staffing from National Experts, Providers, and Advocates *(2 of 2)*

- **Leadership competence drives quality**
  - Executive Directors have enormous influence on culture and safety.
  - High turnover and lack of standardized expectations create operational instability.
  - Panelists debated **certification vs. experience,** with strong support from legislators and advocates for **mandatory training and competencies,** not optional mentorship alone.

- **Acuity-based staffing is important—but challenging**
  - Providers worry about overly rigid ratios; advocates warn that "flexibility" often becomes **insufficient staffing**.
  - A shared belief emerged: staffing must **align with individualized service plans,** but the state must set **minimum expectations** to avoid race-to-the-bottom standards.

- **Transparency alone is not enough**
  - Disclosures do not replace quality or safety requirements.
  - Residents and families often **cannot negotiate** or compare dozens of variables; they assume ALRs meet baseline expectations.

Operational Realities & Opportunities for Improvement

- **Current tools are insufficient.** The AGE Quality Assurance/Performance Improvement (QAPI) forms are valuable, but they:
  - Are reviewed only during **biennial certification visits**.
  - Do **not function as real-time staffing sufficiency tools**.
  - Do not ensure competency or ongoing alignment with resident needs.

- **Workforce shortages undermine consistency**
  - PCAs, home health aides (HHAs), CNAs, and universal workers float across home care, nursing homes, and ALRs.
  - Low wages, burnout, and limited career ladders affect retention and quality.

- **Key staffing gaps identified by experts**
  - **Dementia-care training** is inconsistent across ALRs.
  - Insufficient schedules for **activities staff** and behavioral supports.
  - Lack of required **social work capacity** despite residents' psychosocial needs.
  - Inconsistent infection control practices tied to insufficient environmental services staffing.

- **Misalignment between ALR responsibilities and oversight capacity**
  - Nursing homes receive **4–7 surveyors for a week** every 12-15 months; ALRs receive **1–2 surveyors for ~5 hours every 2 years**, despite increasing resident acuity.
  - This oversight imbalance creates blind spots around staffing sufficiency, training, leadership, and execution of service plans.

Key Takeaways for Staffing

Staffing

- **Nurse Capacity Is Essential.** Licensed nurses are critical for safe assessments, service-plan oversight, early identification of decline, and staff training. Minimum statewide standards are necessary.
- **Leadership Competency Drives Safety and Quality.** Consistent, state-recognized training sets clear expectations for Executive Directors.
- **Staffing Must Match Acuity and ALR Size.** Ratios alone are insufficient; staffing must reflect resident needs, dementia supports, mobility requirements, and changing acuity. A phased, co-developed model provides flexibility with guardrails against understaffing.
- **Competency-Based Workforce Development Is Required.** CNA preparation, dementia skills, and documented competencies improve reliability and safety while reducing variation across ALRs.
- **Resident & Family Voice Must Inform Staffing Oversight.** Residents and families often identify staffing concerns first. Structured feedback from residents and families ensures the staffing model stays grounded in lived experience.
- **Staffing Underpins All Other Reforms.** Emergency preparedness, dementia safety, care quality, and resident rights depend on adequate, well-trained, stable staff and strong leadership. Without staffing reform, the Commission's broader recommendations cannot be fully realized.

(D) Affordability

Massachusetts Affordable Housing Options for Older Adults | *Key Terms*

Affordable Housing: Federal term reflecting the goal of spending **no more than 30% of gross household income on housing** — leaving enough to cover other expenses.

- Spending **>30%** = *Housing Cost Burdened*
- Spending **>50%** = *Severely Housing Cost Burdened*

Area Median Income (AMI): Middle income in your area based on federal data set updated annually providing figures by household size and geography

Low-Income Brackets:

- **Extremely Low Income (ELI):** <30% AMI→ most MassHealth members fall here
  - → Fee-For-Services (FFS), Senior Care Options (SCO) and One Care ~ 28% AMI
  - → Waivers and the Program of All-Inclusive Care for the Elderly (PACE) ~35% AMI
- **Very Low Income (VLI):** 30-50% AMI
- **Low Income (LI):** 50-80% AMI

Low Income Housing Tax Credit (LIHTC): Federal program awards tax credits to housing developers for reserving % of units as rent-restricted or low-income housing; LIHTC financed housing is targeted to people with incomes < 60% AMI.

Components of Affordable Housing

Most affordable housing contains one or more of the following 3 components

- Capital – "bricks and mortar"
  - One-time costs for acquiring land/buildings, renovations, construction
  - Funding comes from government loans/grants, banks, and philanthropy
- Operating
  - Maintenance, utilities, systems (e.g., HVAC), and upkeep (e.g., snow removal)
  - Ongoing costs
  - Operating funding:
    - Usually covered by rent payments from resident
    - Deeply affordable housing targeted to people with lower incomes requires operating/project based subsidies since resident rent payments are insufficient
- Supportive Services
  - Some buildings employ a Resident Service Coordinator to assist all residents in connecting to resources
  - Residents of affordable housing must pay and arrange for any support services they may want/need to address their individual needs
  - Some residents of affordable housing may be over income for MassHealth and other state service programs

Types of Affordable Housing

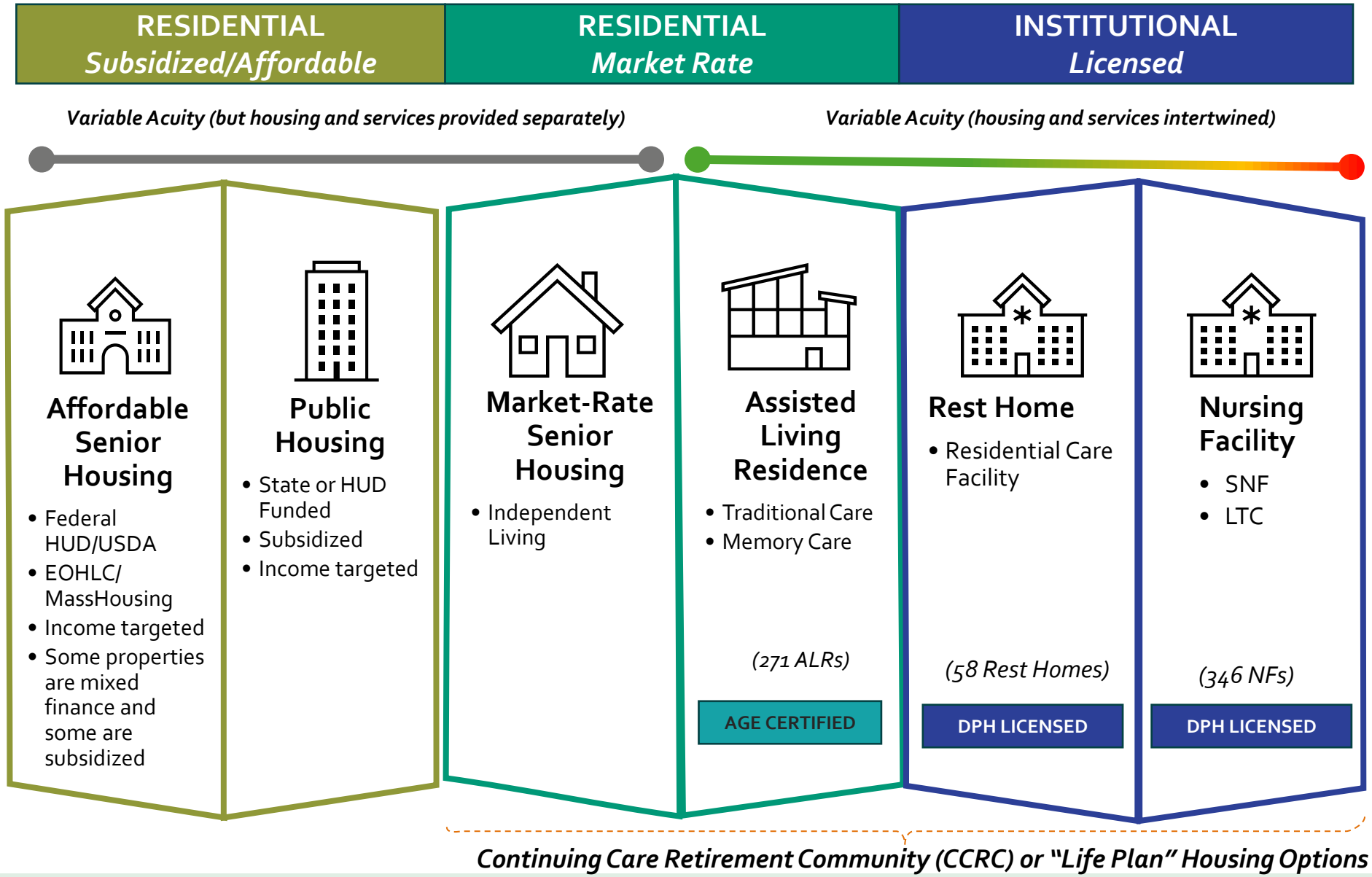
- **Private Subsidized Housing**
  - Owned by for-profit or non-profit orgs
  - Income-restricted; rent reduced via government capital funds
  - Often serves households <60% AMI
  - Can be age restricted

- **Public Housing**
  - Owned by local housing authorities
  - Ongoing federal/state rent subsidies
  - Serves households <80% AMI
  - Some properties targeted to older adults/people with disabilities

- Estimated 110,000 age restricted senior affordable housing units across the Commonwealth, split somewhat evenly between public housing and private assisted housing

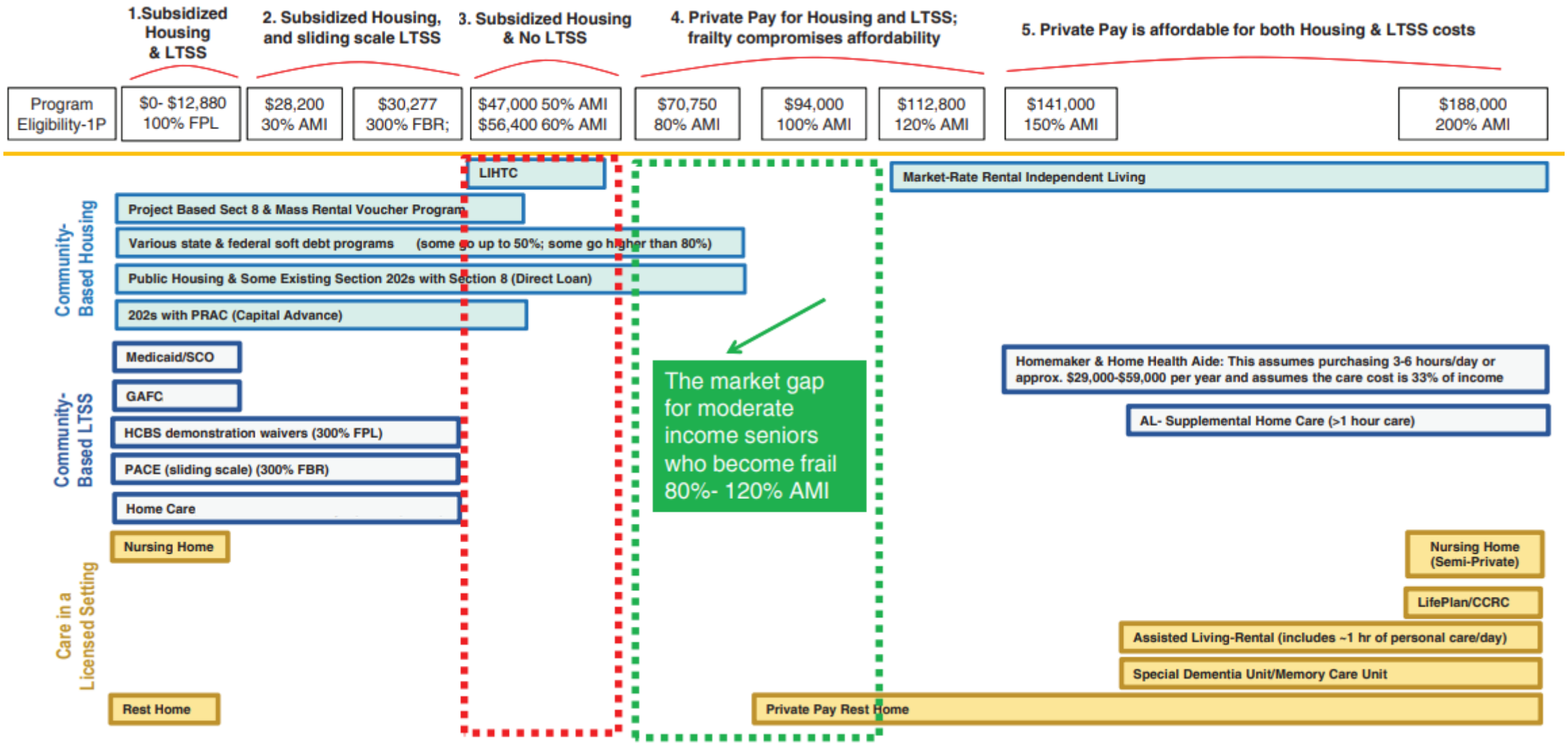
- There is a shortage of affordable housing across the state, and most properties have long waitlists.

Housing Options for Older Adults in Massachusetts



Eligibility for Senior Affordable Housing & Long-Term Services and Supports

Note: Graphic created by 2LifeCommunities and represents historic amounts (circa MA 2021)



The Affordability Problem: Why Massachusetts Faces a Structural Gap

- Massachusetts has ~272 ALRs, the vast majority private-pay, with median monthly costs $6,000–$8,000+—far out of reach for low- and moderate-income older adults.
- MassHealth cannot pay for room and board, and current service payments (e.g., Group Adult Foster Care (GAFC)) do not scale with rising acuity or the potential real cost of ALR service delivery (note: the real cost of ALR services requires further analysis).
- Housing and service systems were created separately and use different eligibility frameworks (AMI vs. MassHealth income/asset rules), creating misaligned thresholds and a fragmented pathway into ALRs.
- The result: ALRs increasingly serve high-income residents, while the population most in need—older adults on extremely low to moderate fixed incomes—has no viable path into assisted living.
- Public hearing testimony reinforced this: families rapidly deplete savings ("until death do us part, not until MassHealth do us part"), feel they have "no choice," and lack clarity on pricing and fee structures.

Perspectives on Affordability from Expert Panel

- **Housing affordability and service affordability operate under different rules.**
  - Housing uses Area Median Income (AMI) and rental subsidy frameworks (Section 8, Massachusetts Rental Voucher Program (MRVP), LIHTC).
  - Services rely on MassHealth medical necessity, not AMI—and MassHealth cannot pay for rent or meals.
  - These systems overlap poorly, leaving residents unable to afford rent or services even when eligible for one.
- **Affordable ALR models require rental subsidies.**
  - Serving households ≤50% AMI is not feasible without vouchers.
  - Providers noted: There is no way to make real estate costs work for extremely low-income seniors without rental subsidy.
- **Labor and operating costs outpace available funding.**
  - Workforce shortages raise wages and drive costs; construction and utility costs continue to climb.
  - More affordable ALRs that historically served low-income populations have exited the market or decertified because the model is not financially sustainable.
- **GAFC and SCO/PACE partnerships only partially solve the problem.**
  - GAFC payment is not calibrated to resident acuity and cannot cover the full service package that frailer residents need.
  - SCO/One Care/PACE contracts are often capitated, not individualized, and don't adjust quickly as needs rise.
- **Massachusetts' "missing middle" is stranded**
  - Older adults around 70%–120% AMI earn too much for deep subsidies yet too little for private-pay ALRs—an acute gap that neither housing nor health programs address.

What an Effective Affordability Strategy Must Confront

- In reality, ALRs are a setting of care, not just a housing type
  - Tenancies are short (22–23 months on average), and resident needs change rapidly.
  - This reality should shape financing models and eligibility criteria.
- Affordability requires clarity about who ALRs are for
  - Task force members emphasized the need to define:
    - Target income range (e.g., extremely low income? lower-middle income?)
    - Target service needs (What level of ADL/IADL need is realistic for a subsidized model?)
  - Without a defined population, policy solutions remain diffuse and unimplementable.
- One-size-fits-all "affordable ALR" is not the goal
  - Experts urged abandoning the idea of a separate low-income ALR "tier."
  - Instead: scalable, mixed-income or supportive housing + service integration models are more sustainable.
- Transparency and accountability are affordability tools
  - Public hearing themes emphasized:
    - Clear, predictable pricing
    - Honest disclosure of fee increases
    - Stronger consumer protections (incl. AG oversight)
- Any future solution requires interagency architecture that includes experts in housing (EOHLC), LTSS/services (MassHealth), and ALR regulation (AGE).

Key Takeaways for Affordability

Affordability

- **Define "Affordable Assisted Living" Through a Task Force.** Cross-agency leadership with providers, consumers, and housing experts must set a statewide definition, population focus, and core service package.
- **Affordability May Require New Financing Models.** Subsidies, service alignment, and transparent pricing must be evaluated together—including GAFC, supportive housing hybrids, and mixed-income models.
- **Pair Affordability with Strong Consumer Protections.** Greater oversight of fees, transparency, and rate increases is essential to avoid exposing low- and middle-income residents to risk.
- **Clarify or Create Pathways for Low- and Moderate-Income Residents.** Map who can be sustainably served in "housing + services" models and establish consistent eligibility and access pathways across housing and services.
- **Affordability Is Foundational to Equity and Aging in Place.** Without reform, ALRs will remain inaccessible to many, families will exhaust savings, and supportive housing will be delayed.

Recommendation: Use the Task Force to build a long-term, equitable affordability roadmap.

VI. Appendices

Appendix A - List of Commission Members

List of Commission Members *(1 of 2)*

Seat on Commission	Commission Member
Secretary of Aging & Independence and Commission Chair	Robin Lipson, Secretary, Executive Office of Aging & Independence
DPH Commissioner or designee	Dr. Jessica Zeidman, Deputy Commissioner/ Chief Medical Officer, DPH
MassHealth Assistant Secretary or designee	Pavel Terpelets, Director of Institutional Programs, Office of Long-Term Services and Supports (OLTSS), MassHealth
Long-term Care Ombudsman Program	Carolyn Fenn, State Ombudsman and Director of the Long-Term Care Ombudsman Program, EOHHS
House Chair of the Joint Committee on Elder Affairs, designee	Representative Tom Stanley
Senate Chair of the Joint Committee on Elder Affairs, designee	Senator Patricia Jehlen
Appointee of the Senate President	Senator Mark Montigny
Appointee of the House Speaker	Matthew Salmon
Appointee of the Senate Minority Leader	Tara Gregorio, President- Massachusetts Senior Care Association
Appointee of the House Minority Leader	Mathew Muratore
Resident or family member of a resident at an ALR # 1	Kathleen Lynch Moncata
Resident or family member of a resident at an ALR # 2	Rose-Marie Cervone
At-Large	Beth Anderson, EPOCH Senior Living, Treasurer, Mass-ALA
Representative of the MassNAELA	Liane Zeitz, Owner-Law Office of Liane Zeitz
Representative of Leading Age MA	Elissa Sherman, President – Leading Age MA

List of Commission Members *(2 of 2)*

Seat on Commission	Commission Member
Representative of MassALA	Brian Doherty, President & CEO - MassALA
Representative of AARP	Jen Benson, Executive Director – AARP MA
Representative of the New England Chapter of the Gerontological Advanced Practice Nurses Association	Katherine Ladetto, Assistant Professor, School of Nursing- Simmons University
Representative of the Alzheimer's Association	Lainey Titus Samant, Senior Advocacy Manager, Alzheimer's Association, MA/NH Chapter
Representative of MassPACE	Dr. Jennifer Maynard, Executive Director-MassPACE
Representative of Greater Boston Legal Services	Lindsay Mitnik, Staff Attorney, Elder Law-Greater Boston Legal Services

Appendix B - Commission Meetings & Presentations

Commission Meetings & Presentations *(1 of 2)*

Date	Topic	Key Focus	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	(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
7/15/2025	Recommendations & Report Drafting	Consolidate findings and recommendations, and review draft report	Commission Members	All topics (i)-(x) as outlined in SECTION 32(a) for final recommendations and report drafting
7/23/2025	Gabriel Housing Fire Situational Awareness & Report Review	Debrief on Situational Awareness & Lessons Learned from Secretary Meeting with Fall River Emergency Officials, and review revised report based on Commission feedback	Commission Members	All topics (i)-(x) as outlined in SECTION 32(a) for final recommendations and report drafting

Commission Meetings & Presentations *(2 of 2)*

Date	Topic	Key Focus	Speakers/Stakeholders	Exact Statute Language
9/4/2025	Life Safety & Emergency Preparedness	Life Safety & Emergency Preparedness Deep-Dive with Expert Panel	MassMAP, DPH, Legacy Lifecare, Northbridge Communities	(viii) safety standards
9/29/2025	Recommendation Review & Discussion	Revise Recommendations based on Emergency Preparedness	Commission Members	All topics (i)-(x) as outlined in SECTION 32(a) for final recommendations and report drafting
10/28/2025	Staffing	Staffing Deep-Dive with Expert Panel	Justice in Aging, Moving Forward Coalition, DPH, NewBridge on the Charles	(ii) assisted living best practices in other states
11/5/2025	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))
11/18/2025	Affordability	Affordability Deep-Dive with Expert Panel	HCBS Solutions LLC, Harborlight Homes, MassHealth, EHS Chief Housing Officer	(ii) assisted living best practices in other states
12/3/2025	Recommendation Review & Discussion	Review Revised Recommendations & Overall Consensus	Commission Members	All topics (i)-(x) as outlined in SECTION 32(a) for final recommendations and report drafting
12/12/2025	Fire Safety & Emergency Preparedness	Fire Safety & Emergency Preparedness Discussion with State Fire Marshal	State Fire Marshal, Department of Fire Services	(viii) safety standards
12/17/2025	Final Report Review	Key considerations related to opening/ closing/ ownership, and need determinations	Commission Members	All topics (i)-(x) as outlined in SECTION 32(a) for final recommendations and report drafting
1/12/2026	Final Report Vote	Vote on Final Report submission to the Legislature	Commission Members	All topics (i)-(x) as outlined in SECTION 32(a) for final recommendations and report drafting

Appendix C - Commission Member Letters

Letters submitted by Commission members for inclusion in the final report.