

NURSING FACILITY TASK FORCE

*Established by Chapter 41, Section 91
of the Acts of 2019*

Presented and Approved by the Task
Force January 31, 2020



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Nursing Facility Task Force Overview

- The Nursing Facility Task Force was established in July 2019 with Governor Baker's signing into law of Chapter 41, Section 91 of the Acts of 2019
- The Task Force is charged with considering:
 - Improvements to the MassHealth reimbursement system for skilled nursing facilities to promote financial stability;
 - Industry-wide workforce initiatives including, but not limited to, ways to improve recruitment, training, including transitional training opportunities for employment in rest homes, assisted living and other alternative senior housing options, retention, rates of pay and other methods of ensuring a sustainable workforce;
 - The role of external economic factors on the development and retention of the elder care services workforce such as the increases in the minimum wage and competition from other industries;
 - The feasibility of establishing a voluntary reconfiguration program for certain areas of elder care services, including the impact of a reduction in the number of currently licensed beds, while ensuring quality and maintaining access;
 - Recommended criteria for a voluntary reconfiguration program including, but not limited to, occupancy, co-location of services, care standards and regional geographic need;
 - Recommended incentives for elder care service operators to align the need for elder care services with current and future demand and conversion of underutilized beds or other resources to meet current and future demand; and
 - Any additional reforms to strengthen the public process for facility closures and sales or other recommendations necessary to address the issues referenced in this section.

Nursing Facility Task Force Members

Name	Title / Affiliation
Marylou Sudders (Chair)	Secretary, Executive Office of Health and Human Services (Chair)
Rosalin Acosta	Secretary, Executive Office of Labor and Workforce Development
Rebecca Annis	Pond Home & the Community at Pond Meadow
Ruth B. Balsler	Massachusetts State Representative, Chair of the Joint Committee on Elder Affairs
Richard Bane	Massachusetts Senior Care Association
Elizabeth Chen	Secretary, Executive Office of Elder Affairs
Tim Foley	Executive Vice President, 1199SEIU
Tara Gregorio	President, Massachusetts Senior Care Association
Patricia Jehlen	Massachusetts State Senator, Chair of the Joint Committee on Elder Affairs
Elizabeth Kelley	Director, Bureau of Health Care Safety and Quality, Department of Public Health
Barbara Mann	State President Emeritus, Massachusetts Senior Action Council
Mathew J. Muratore	Massachusetts State Representative
Naomi Prendergast	President/CEO, D'Youville Life and Wellness Community
Patrick Stapleton	Chief Executive Officer, Sherrill House, Inc.
Daniel Tsai	Assistant Secretary, MassHealth

Nursing Facility Task Force Meeting Schedule and Procedural Overview

Nursing Facility Task Force Meeting Schedule

Date	Topics Discussed
November 22, 2019	<ul style="list-style-type: none">• Discussion of the Commission’s charges, members’ goals, and proposed agenda for the Task Force
October 18, 2019	<ul style="list-style-type: none">• Current structure of MassHealth Rates and opportunities for reform• Overview of Massachusetts Healthcare Workforce Collaborative• MSCA presentation on workforce and nursing facility reimbursement
November 22, 2019	<ul style="list-style-type: none">• Overview of the CHIA Nursing Facility Industry Report
December 20, 2019	<ul style="list-style-type: none">• Quality in Nursing Facilities in Massachusetts• Possible Points of agreement, outline of a sensible sustainable rate structure, aligning payments with quality and member complexity• Letter to Secretary Sudders from Disability Advocates
January 10, 2020	<ul style="list-style-type: none">• Follow ups from December meeting: Nursing Home Satisfaction Survey and map of low quality and low occupancy facilities• Overview of the Rest Home Industry, and their role on the MA healthcare continuum• Task Force member “points of agreement”, policy goals and potential policy proposals
January 31, 2020	<ul style="list-style-type: none">• Discussion of the proposed final report and vote to send final report to the Legislature



- The Task Force members present unanimously voted to submit the final report to the Legislature at the January 31, 2020 meeting
- EOHHS will deliver a memo to the Legislature outlining the authorities (i.e., regulation, statute) that are required to implement the policy options considered by the Task Force
- All materials of the Task Force may be found on the [Nursing Facility Task Force](#) website.

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Nursing facilities are one service type of a continuum of Long Term Services and Supports (LTSS) as a covered MassHealth benefit

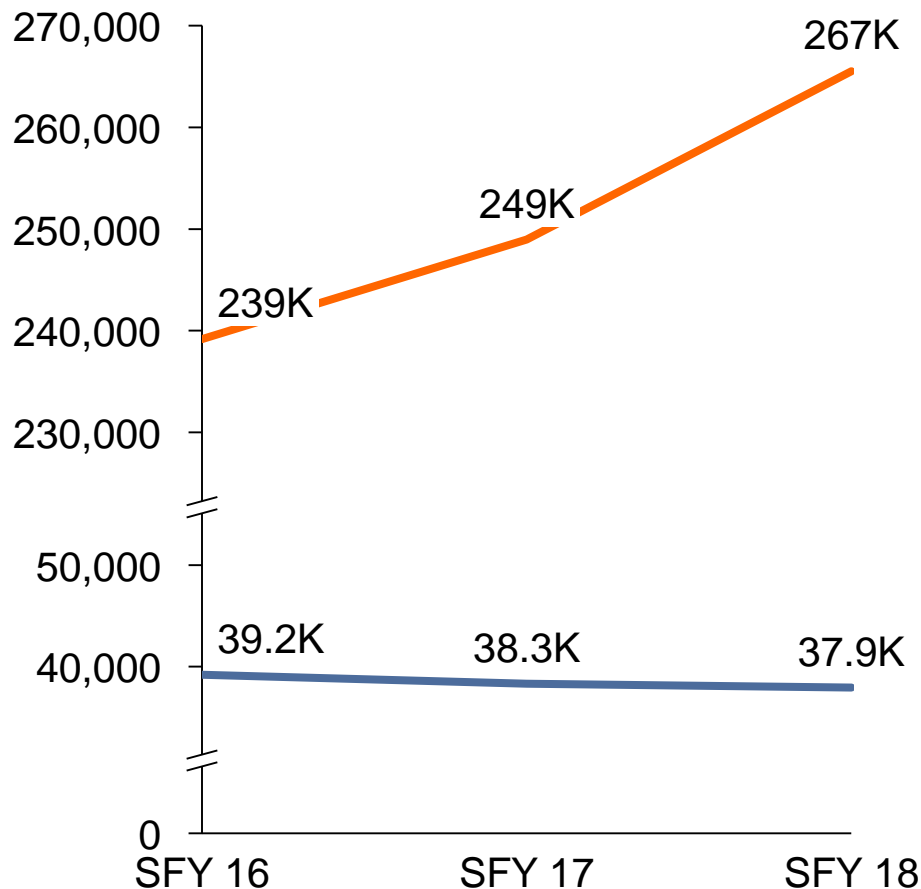
	Program	Eligibility Criteria	SFY18 Spend	SFY18 Utilizers
Institutional	Nursing Facility	<ul style="list-style-type: none"> Require skilled nursing services or assistance with 2+ Activities of Daily Living (ADLs) and nursing services 	\$1.279B	35K
Home and Community Based Services	Adult Day Health (ADH)	<ul style="list-style-type: none"> 1+ chronic or post-acute condition that requires active care by a nurse Skilled service or 1+ ADL with cueing and supervision; must occur at ADH 	\$105M	9K
	Adult Foster Care (AFC)	<ul style="list-style-type: none"> 3 ADLs with physical assistance or 2 ADLs with physical assistance and behavioral management 1-2 ADLs with physical assistance or cueing and supervision throughout entire task 	\$267M	13K
	Group Adult Foster Care (GAFC)	<ul style="list-style-type: none"> 1+ ADL with cueing and supervision or physical assistance throughout entire task 	\$79M	8K
	Day Habilitation (DH)	<ul style="list-style-type: none"> Intellectual Disability (ID) or Developmental Disability (DD) and need program to acquire, improve, or retain max skill level and independent functioning 	\$170M	11K
	Home Health – Nursing and Therapy Services	<ul style="list-style-type: none"> Nursing/therapy/Home Health aide based on physician certification of medical necessity 	\$337M	33K
	Home Health Aide Only	<ul style="list-style-type: none"> 2+ ADL needs and physician certification of medical necessity 	\$163M	
	Personal Care Attendants (PCA)	<ul style="list-style-type: none"> 2+ ADLs with physical assistance 	\$714M	36K
HCBS Waivers	Waiver Programs (DDS, EOE, MRC, TBI)	<ul style="list-style-type: none"> Eligibility criteria varies by program 	\$1.8B	31K

Note: Skilled service is skilled nursing and/or therapy (PT/OT/ST) and/or medication administration visit; Home Health includes Intermittent Skilled Nursing, CSN, Therapies, Med Admin); Rest Home is not included as a service on this slide because it is not a MassHealth covered service
 Source: MassHealth Program Regulations; MassHealth Program Data

The number of individuals served at home and in the community is growing (+11%), while the number residing in nursing homes is declining (-2%)

Annual MassHealth Members, SFY16-18

Growth



Home/community:
Personal care,
home care, and
other in-home &
community supports

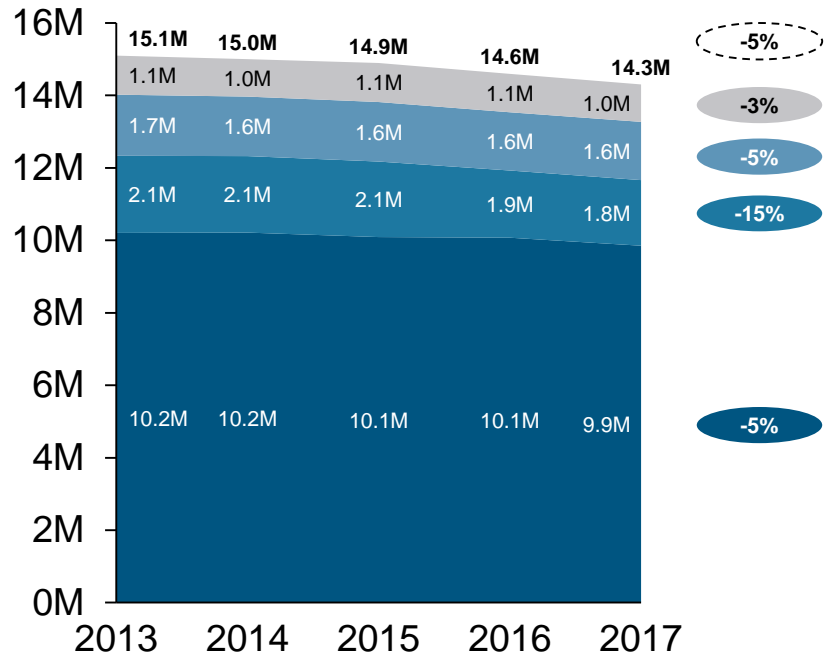
11%

Nursing Facility

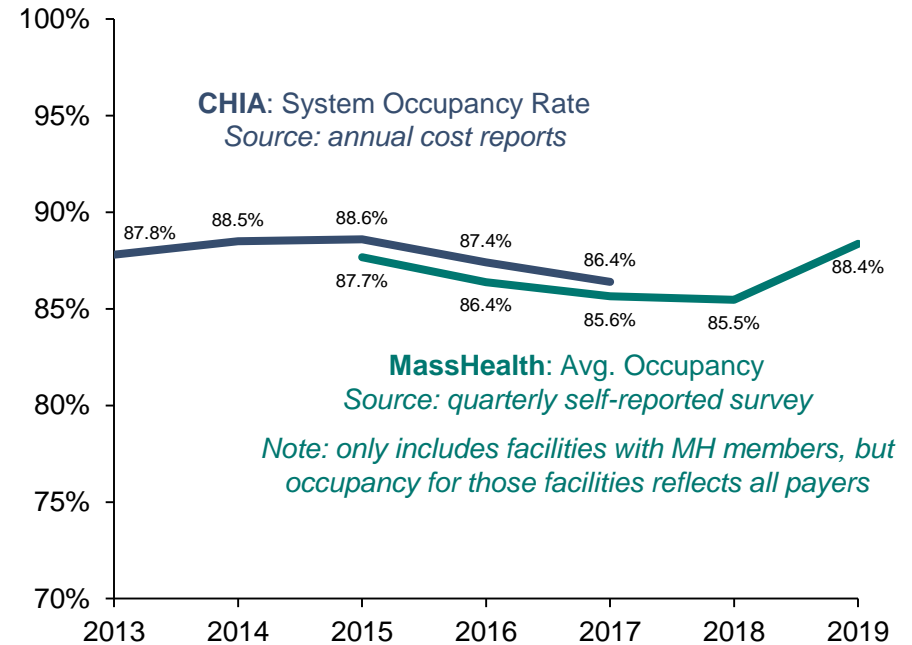
-2%

Nursing facility resident days and overall occupancy rates of facilities have declined

Resident Days by Payer Type CY2013-2017



System Occupancy Rates CY2013-2019



Medicaid
 Self Pay
 Medicare
 Other

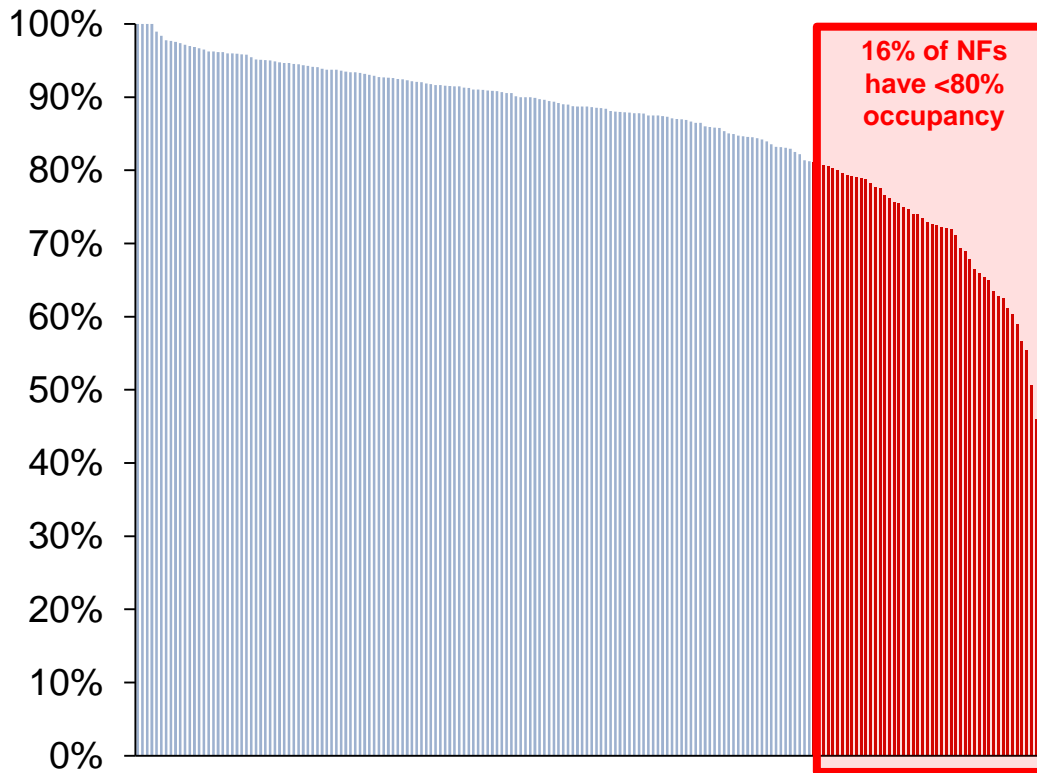
- Occupancy rate measures the share of filled beds across all nursing facilities for a given year
- Occupancy rates can be an indicator of financial stability; higher occupancy generates increased income to offset both fixed & variable expenses
- Occupancy rates increased from 2018 to 2019 due to closures and a reduction in total beds

Note: CHIA published an interactive dashboard available online at <http://www.chiamass.gov/massachusetts-nursing-facilities/>

Sources: Baseline Report on the Massachusetts Nursing Facility Industry: An Overview (2019); MassHealth Nursing Facility Occupancy Survey (January 2015 – July 2019)

One in six nursing homes now operates with occupancy under 80%; facilities with low occupancy rates are not sustainable

Nursing Home Occupancy Rate by home, April 2019 ¹



- There are 366 nursing facilities that contract with MassHealth
- Of those 366 facilities, the average industry occupancy rate is 87%²
- Facilities with low occupancy rates are not sustainable because they cannot independently generate sufficient income to offset fixed and variable costs

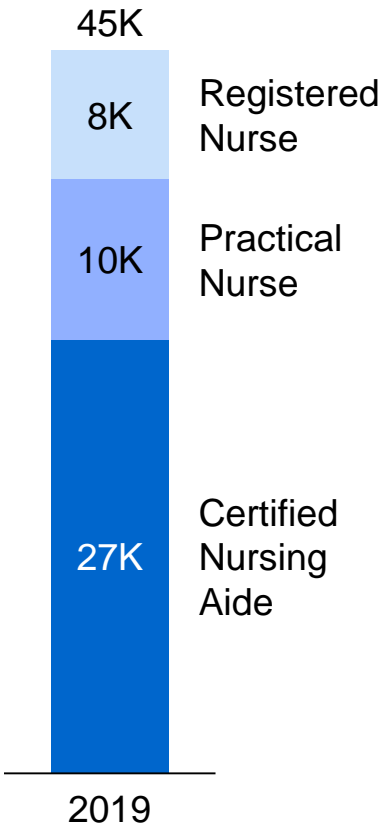
There are 383 total nursing facilities in Massachusetts, but only 366 contract with MassHealth

¹ SNF Census April 2019; Medicare Star Quality Score February 2019

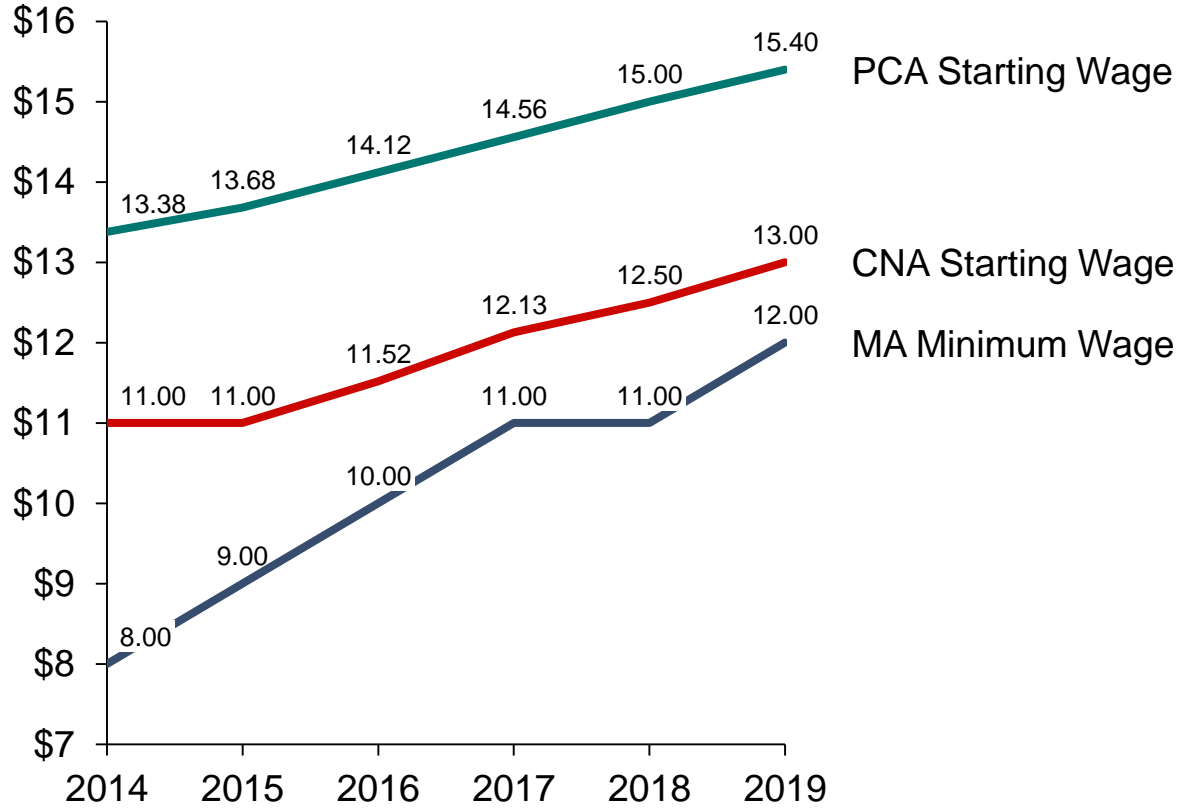
² Self reported beds out of service (BOOS) were included in calculation of occupancy rates

Overall, Massachusetts nursing facilities employ 45,000 direct care staff employees; labor costs continue to increase

Direct Care Staff ¹
2019



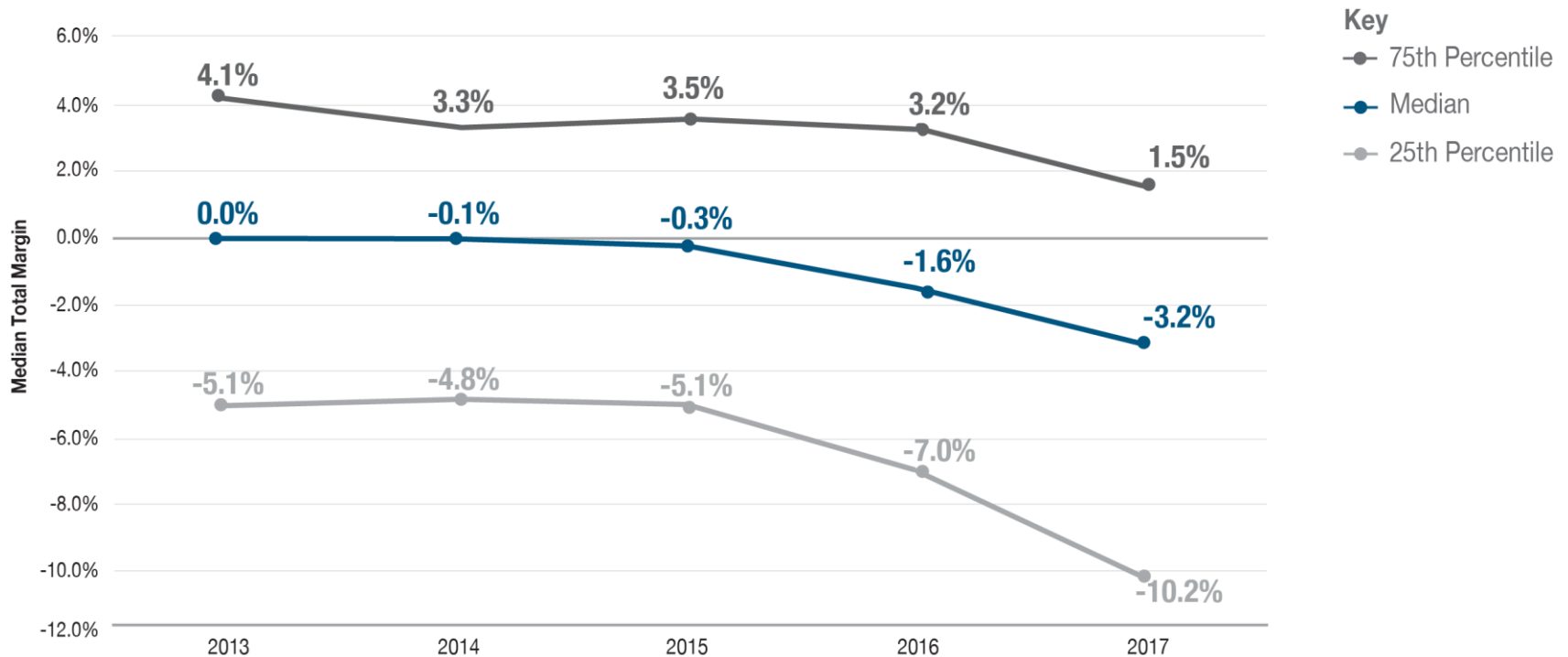
Starting Wages for CNAs and PCAs
CY2014-2019



Note: starting wage numbers are based on a snap shot in time and based on survey data
Sources: MSCA's [October Task Force Presentation](#); 2019 Mass Senior Care Employment Trends for total Direct Care Staff and starting wages; Federal Reserve Economic Data for Massachusetts Minimum Wage

Because of declining occupancy and rising labor costs, nursing facility margins have declined over the last few years

Nursing Facility Median Total Profit Margin, CY2013-2017



- Total margin evaluates the overall profitability of a nursing facility, reflecting income and expenses from both primary, patient care activities of the facility, as well as other unrelated business activities, such as investment income, sale of assets, among others.
- Total margin includes depreciation and amortization

For historical reasons, MassHealth nursing facility rates are complex and do not appropriately account for resident acuity or quality

- Complex, outdated (20+ year old) rate structure
 - \$80M+ in historical “add-ons” not included in the base rates
 - Structure is poorly understood
 - Based on state-specific MMQ assessment (vs. CMS MDS tool)
 - Administratively burdensome
- Rates are not well-aligned with certain policy goals
 - Despite rate add-ons for higher acuity and complexity, rates could be structured better to account for resident populations that have been identified to be of higher acuity and complexity
 - Rates have limited alignment to nursing facility quality
- Rates are regressive
 - High Medicaid occupancy facilities receive lower rates on average than low Medicaid occupancy facilities, mainly due to differences in capital payments
 - The \$5M add-on for High Medicaid facilities partially addresses this problem
 - The SFY20 rates reduced regressivity further by creating class-based rates for capital
 - However, more can be done to reduce regressivity


Nursing facility quality can be measured using DPH and CMS tools

DPH's Nursing Facility Survey Performance Tool

- Each facility receives a score up to 132 based on performance in the last three recertification surveys and any complaint surveys in the past year
- The score is based on 5 components:
 - Administration
 - Nursing
 - Resident Rights
 - Kitchen/Food Services
 - Environment
- Scores calculated for each facility do not depend on other facilities' scores (i.e., scores are not relative)

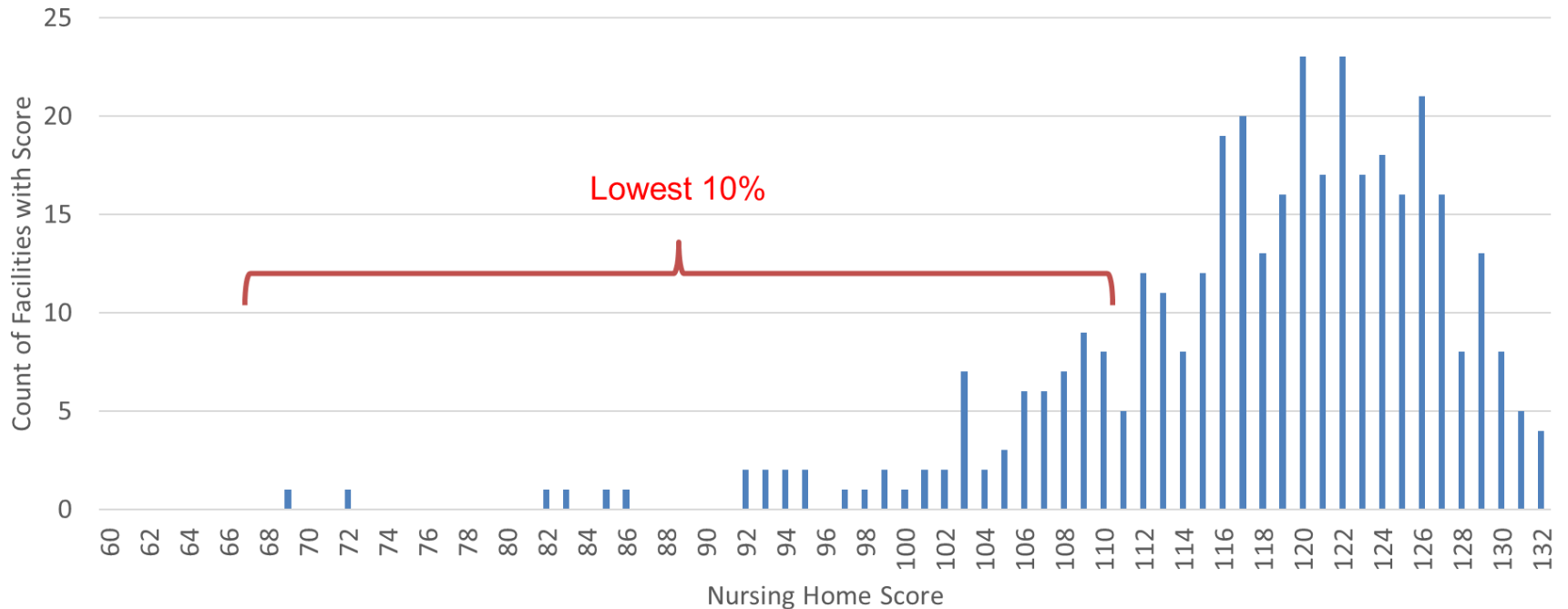
CMS's Nursing Home Compare 5-Star Quality Rating Tool

- Each facility receives a rating between 1 and 5 stars
- The overall rating is based on 3 components:
 - Health inspections: similar measures as in DPH's survey
 - Staffing: ratio of staff hours per resident day
 - Quality of resident care measures: clinical measures (e.g., re-hospitalizations rate)
- Ratings are *relative* (i.e., the distribution of scores is partially fixed)

- 
- Both measures of quality are currently used as inputs to calculate MassHealth rates
 - Task Force members said that they preferred DPH's score because ratings are not relative, but both quality measures are useful
 - Task Force members said that analysis of quality ratings should consider how scores trend over time (i.e., the chronicity)

DPH's survey tool helps identify low quality facilities; quality varies widely across facilities

DPH Nursing Home Survey Tool Score Distribution As of November 22, 2019

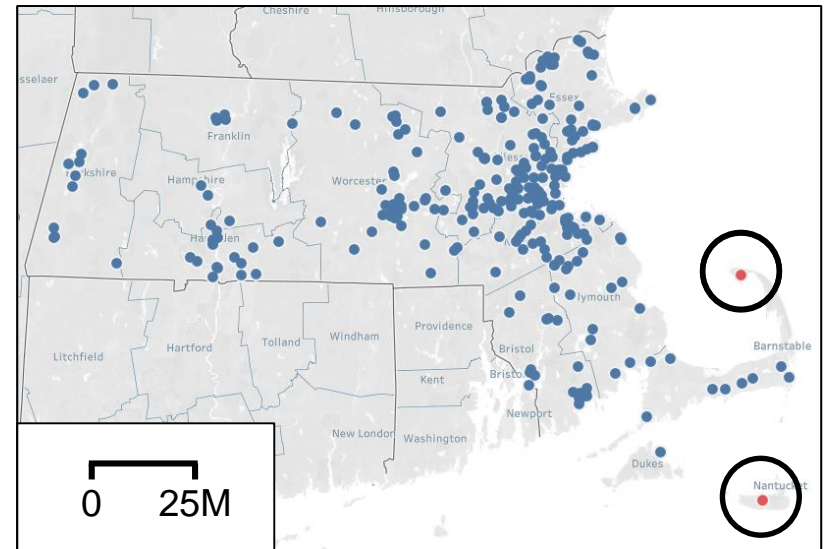


Nearly all nursing facilities have at least one CMS rated 3+ Star nursing facility with capacity within a reasonable radius

MA Nursing Facilities by Radius in Miles

Map at a 25 Mile Threshold

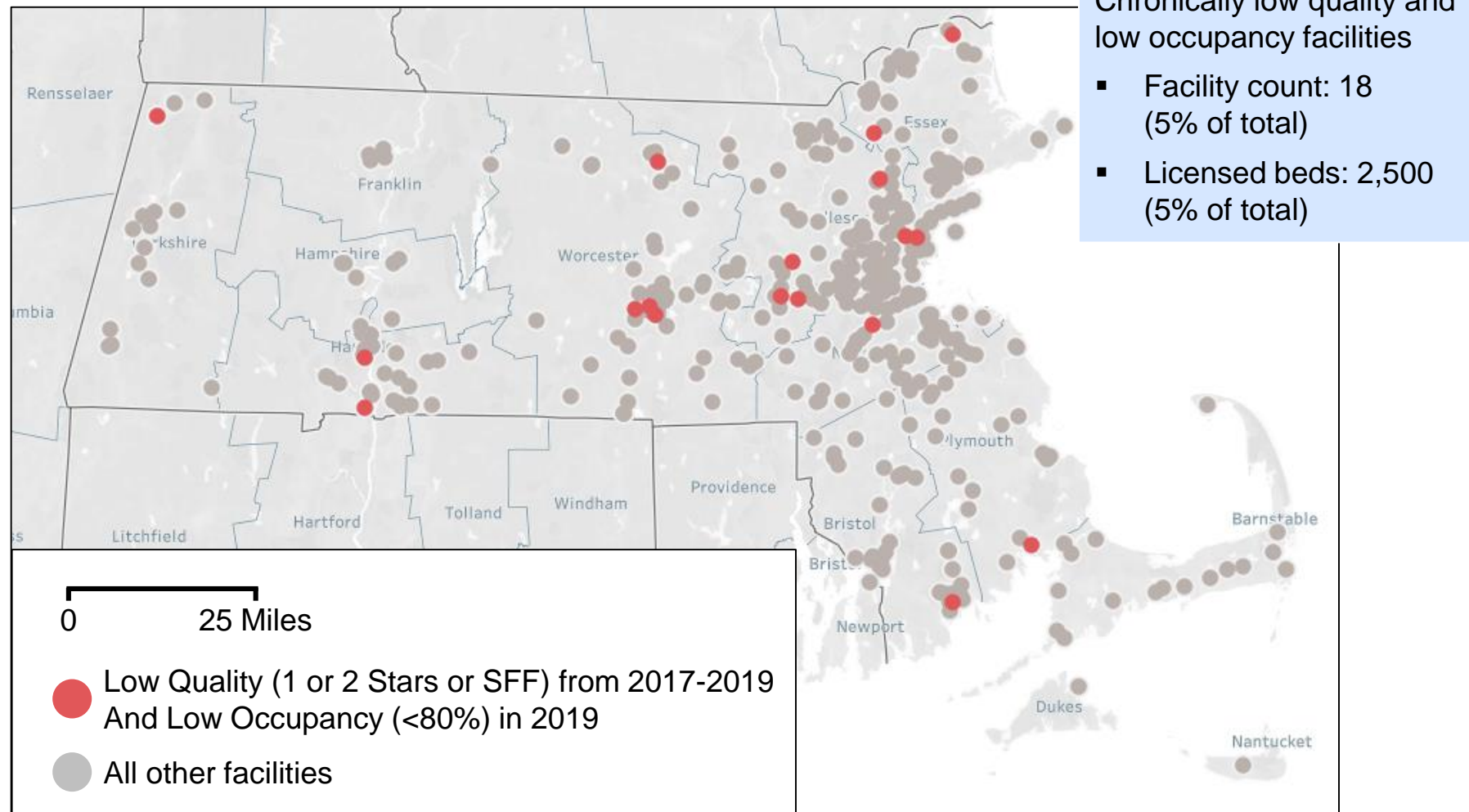
Distance Threshold	Number of Facilities within 25 Miles with at least 3+ Stars and Capacity
5 Miles	79
10 Miles	20
15 Miles	7
20 Miles	3
25 Miles	2
30 Miles	2



Note: The 2 facilities not within 25 miles are in Provincetown and Nantucket; “Capacity” is defined as <95% occupancy
 Source: MassHealth Occupancy Survey (April 2019), Medicare Star Quality Score (October 2019)

A small number of facilities across the State are chronically low quality and low occupancy

Map of chronically low quality and low occupancy facilities



List of chronically low quality and low occupancy facilities

Facility Name	Operating Company	Overall Occupancy (as of April 1, 2019)	MassHealth Share of Residents (as of April 1, 2019)	Medicare Score (as of Nov 2017) - Overall	Medicare Score (as of Oct 2019) - Overall	# of Licensed Beds (as of Dec 18, 2019)	Change of ownership within past year
AGAWAM HEALTHCARE	Next Step Healthcare	51%	84%	2	2	176	
BRANDON WOODS OF NEW BEDFORD	Essex Group Management Corp.	78%	90%	2	1	135	
DEDHAM HEALTHCARE	Next Step Healthcare	63%	87%	2	1	145	
DEXTER HOUSE HEALTHCARE	Next Step Healthcare	69%	84%	1	2	130	
ELIOT CENTER FOR HEALTH & REHABILITATION	National Health Care Associates, Inc.	71%	65%	2	1	114	
FITCHBURG GARDENS FOR NURSING AND REHABILITATION	Fusion Healthcare Services, Corp	80%	89%	1	2	87	X
HERMITAGE HEALTHCARE	Next Step Healthcare	78%	81%	2	2	101	X
CASA DE RAMANA REHABILITATION CENTER	Landmark Management Solutions	60%	80%	1	2	124	X
MAPLEWOOD REHAB AND NURSING	RegalCare Management Group	79%	49%	1	1	120	
REHABILITATION & NURSING CENTER AT EVERETT	Personal Healthcare LLC	80%	86%	2	1	183	
SWEET BROOK OF WILLIAMSTOWN REHABILITATION & N CTR	SB Operating Company LLC	65%	88%	1	*	146	
WAREHAM HEALTHCARE	Next Step Healthcare	59%	81%	1	1	175	
WEST SIDE HOUSE LTC FACILITY	Essex Group Management Corp.	67%	94%	2	2	91	
BEAR MOUNTAIN AT ANDOVER	Bear Mountain Healthcare	61%	80%	1	1	135	X
BEAR MOUNTAIN AT SUDBURY	Bear Mountain Healthcare	71%	72%	2	2	142	X
BEAR MOUNTAIN WEST SPRINGFIELD	Bear Mountain Healthcare	71%	77%	1	2	168	X
WOODBRIAR HEALTH CENTER	The Pointe Group	70%	80%	2	1	142	X
WORCESTER REHABILITATION & HEALTH CARE	Athena Health Care Systems	79%	87%	1	1	160	

Note: No Overall Medicare Score is reported for 2018 because the health inspection component of the survey was suspended from February 2018 to May 2019 in order for CMS for make updates to its survey methodology. However, overall scores were still reported based on the other 2 components of the overall score (staffing and quality measures) during this period but not included on this slide. *Special Focus Facility. CMS does not assign star ratings to Special Focus Facilities in this designation because they are not comparable to other facilities.

Source: MassHealth Nursing Facility Occupancy Survey April 2019; Medicare Star Quality Score

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The Task Force reached consensus on 19 Points of Agreement (1/2)

- It is important to have quality nursing facilities and rest homes available for those who need this level of care
- There is currently excess bed capacity in the system
- Structural changes to the industry are needed to ensure longer term financial sustainability
- A percentage of nursing facilities are low quality; chronically low quality facilities are especially troubling
- Most nursing facilities are struggling financially; margins have fallen over the last few years
- Nursing facilities in the top quartile of Medicaid mix operate with negative median total margins of -6.2% compared to the industry's median total margin of -3.2%; negative margins are not sustainable
- Need to reduce excess bed capacity in the system, directing funding spent on empty beds to support the direct care workforce in remaining facilities and the expansion of community based services
- There should be incentives to allow for the conversion of nursing facilities to alternative services such as affordable senior housing or assisted living units
- Oversight by the HPC/CHIA should be improved to allow all stakeholders' opportunities to monitor the industry's financial stability, to review the finances of nursing home licensed owners, and to ensure each home's staffing sufficiency and worker readiness

The Task Force reached consensus on 19 Points of Agreement (2/2)

- A new and simplified rate structure should be based on five reasonable and sustainable core components:
 - One integrated rate structure
 - Differentiated levels of payment based on complexity and acuity
 - Rate structure that incentivizes higher occupancy
 - Progressive rate structure
 - Material incentives for quality
- Consider how to apply the principles of a new and simplified rate structure to Rest Homes
- Payments should be based on utilization and quality
- The current payment system does not appropriately account for acuity or complex patient populations
- A new payment system should include a transition from the current MMQ system to the MDS
- Full compliance of the nursing home user fee should be enforced
- Rates and market forces are not enough to preserve quality nursing facilities and reduce low-quality beds; the state should consider other tools including, but not limited to, incentives, assistance and sanctions to achieve those goals
- The DPH licensing process for nursing facilities should be modified to strengthen suitability review
- The Nursing Facility Task Force should consider the voice of the resident in its policy discussions and recommend the implementation of a survey to recognize the resident experience
- It is important to adequately pay nursing facility and rest home direct care staff to improve retention, promote recruitment and ensure both quality of care and workplace standards

The Points of Agreement were distilled into 4 policy goals

Points of Agreement



Right size the Nursing Home industry in response to current and future demand

Establish a Reasonable and Sustainable Rate Structure for Nursing and Rest Homes

Promote High Quality Care in Nursing and Rest Homes

Ensure a Sustainable Workforce Serving the Care Needs of Individuals Across the Entire Long-Term Care Continuum

Right size the Nursing Home industry in response to current and future demand

- Establish incentives for high occupancy and high quality facilities that result in the closure or repurposing of chronically low occupancy and low quality nursing facilities
- Provide DPH with more explicit statutory authority to revoke the licenses of chronic underperformers in quality and occupancy
- Establish clear standards for defining “chronic underperformers” and “occupancy”
- Establish comprehensive projection of future demand across the long term care continuum as well as the estimated costs associated with this demand
- Rate investments should support structural change rather than funding broad based rate increases alone
- Support and facilitate structural changes to the nursing and rest homes industry that promote sustainability across the long term care continuum, through initiatives including:
 - Low-interest, capital programs to incentivize conversions or colocation of other services
 - Voluntary reconfiguration program
 - Technical assistance for NFs interested in conversion or closure
 - Development of affordable assisted living
 - Build on age-friendly efforts within cities and towns and improve the availability of affordable, supportive housing for older adults
- Support the workforce impacted by nursing facility closures and reconfiguration to ensure appropriate employment transitions

Establish a Reasonable and Sustainable Rate Structure for Nursing Homes and Rest Homes

- Establish one integrated rate structure based on building blocks of a sensible, sustainable rate structure. This includes:
 - Eliminating the MMQ and basing reimbursement on the MDS assessment
 - Incentives for higher occupancy and facilities with a high percentage of Medicaid residents
 - A rate structure and payments linked to quality achievement and improvement
 - Support for geographically isolated areas
- Review rest home rate structure and how best to apply these principles to rest home rates
- Update base year costs regularly so that rates are reflective of actual costs
- Structure rates to incentivize higher occupancy while maintaining quality, to invest in staff and not empty beds
- Increase compliance of the user fee assessment through additional payment and licensing enforcement tools
- Ensure capital component of the rate reflects ability of providers to invest in capital projects and improvements

Promote High Quality Care in Nursing Home and Rest Homes

- Strengthen and or expand targeted quality programs such as the DPH Supportive Planning and Operations Team (SPOT) program
- Enhance quality resident care by sharing best practices with the nursing facilities and rest homes industries to address identified resident and safety concerns
- Strengthen and streamline suitability review standards for nursing homes and rest homes
- Promote and incorporate the resident and family experience by implementing a resident quality of life and family experience survey into quality metrics
- Incorporate resident and family survey results as a measured component when determining quality incentives
- Mitigate the negative impact of involuntary transfers when a home is closed by developing a resident, family, and staff transition support program in addition to current communication standards
- Prioritize the DPH Nursing Home Survey Performance Tool over the CMS Nursing Home Compare 5-Star Quality Rating Tool as a measure of quality
- Quality measures should be considered over time; nursing facilities should have opportunities to implement quality performance improvement projects over a period of three years and/or survey cycles

Ensure a Sustainable Workforce Serving the Care Needs of Individuals Across the Long-Term Care Continuum

- Strengthen the quality of resident care by requiring that a certain percentage of facility expenditures are directed towards staff wages and other direct care costs
- Provide adequate wages to recruit, train and retain direct care staff across the continuum
- Support and provide resources to increase recruitment and retention initiatives, including:
 - Career ladder grants
 - Loan/tuition forgiveness programs
 - Increased availability of affordable classes and training opportunities
- Evaluate and identify opportunities to improve the CNA certification process such as reducing delays in certification
- Examine the utilization rate and impact of per diem wages on direct care staff
- Establish best practices relative to workforce and workplace standards that promote high-quality, safe patient care
- Encourage facilities to establish labor-management care planning committees to develop and monitor initiatives to ensure a safe working environment and the provision of quality care
- Improve HPC/CHIA reporting from the nursing home industry on employers' ongoing efforts that demonstrate planning and investment in worker readiness such as education and best practice training
- Conduct a workforce satisfaction survey on a regular basis

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- Appendix A: Nursing Facility Task Force Statute
- Appendix B: Meetings Materials Provided to the Task Force
- Appendix C: Conceptual outline of the building blocks of a sensible, sustainable Nursing Facility rate structure
- Appendix D: Comments received from individual Task Force members on policy proposals
- Appendix E: Letters received from advocates
- Appendix F: Letter providing clarifications on the January 10 discussion regarding Rest Homes

Appendix A – Nursing Facility Task Force Statute

Legal Authority: Chapter 41, Section 91 of the Acts of 2019

Purpose: The Task Force shall evaluate ways to ensure the financial stability of skilled nursing facilities; consider the role of skilled nursing facilities within the continuum of elder care services; and address current workforce challenges.

15 members:

- the Secretary of Health and Human Services, or their designee, who shall serve as chair;
- the Chairs of the Joint Committee on Elder Affairs, or their designees;
- the Secretary of Elder Affairs, or their designee;
- the Secretary of Labor and Workforce Development, or their designee;
- the Commissioner of Public Health, or their designee;
- the Assistant Secretary for MassHealth, or their designee;
- 1 person to be appointed by the Minority Leader of the House of Representatives;
- 1 person to be appointed by the Minority Leader of the Senate;
- 6 persons to be appointed by the Governor,
 - 1 of whom shall be a representative of the Massachusetts Senior Care Association, Inc.
 - 1 of whom shall be a representative of LeadingAge Massachusetts, Inc.
 - 1 of whom shall be a representative of 1199SEIU
 - 1 of whom shall be a representative of Massachusetts Association of Residential Care Homes, Inc.
 - 1 of whom shall be a representative of the Massachusetts Senior Action Council, Inc.
 - 1 of whom shall be an expert on long-term care and aging policy

Appendix A – Nursing Facility Task Force Statute (cont.)

The Task Force shall consider:

1. Improvements to the MassHealth reimbursement system for skilled nursing facilities to promote financial stability;
2. Industry-wide workforce initiatives including, but not limited to, ways to improve recruitment, training, including transitional training opportunities for employment in rest homes, assisted living and other alternative senior housing options, retention, rates of pay and other methods of ensuring a sustainable workforce;
3. The role of external economic factors on the development and retention of the elder care services workforce such as the increases in the minimum wage and competition from other industries;
4. The feasibility of establishing a voluntary reconfiguration program for certain areas of elder care services, including the impact of a reduction in the number of currently licensed beds, while ensuring quality and maintaining access;
5. Recommended criteria for a voluntary reconfiguration program including, but not limited to, occupancy, co-location of services, care standards and regional geographic need;
6. Recommended incentives for elder care service operators to align the need for elder care services with current and future demand and conversion of underutilized beds or other resources to meet current and future demand; and
7. Any additional reforms to strengthen the public process for facility closures and sales or other recommendations necessary to address the issues referenced in this section.

The task force shall submit its report, including any proposed legislation necessary to carry out its recommendations, by filing the same with the Clerks of the House of Representatives and Senate, the Joint Committee on Health Care Financing, the Joint Committee on Elder Affairs and the House and Senate Committees on Ways and Means not later than February 1, 2020.

Appendix B – Meetings Materials Provided to the Task Force (1/3)

Presenters	Topics Discussed	Resources and Supporting Documents
November 22nd, 2019		
Secretary Marylou Sudders <i>Task Force Chair</i>	Discussion of the Commission's charges, members' goals, and proposed agenda for the Task Force	<u>September 20th, 2019 Presentation</u>
October 18, 2019		
Assistant Secretary Daniel Tsai <i>MassHealth</i>	Current structure of MassHealth Rates and opportunities for reform	<u>Assistant Secretary Tsai's presentation, MassHealth</u>
Undersecretary Jennifer James <i>Executive Office of Labor and Workforce Development</i>	Overview of Massachusetts Healthcare Collaborative	<u>Undersecretary James's presentation, EOLWD</u>
Tara M. Ms. Gregorio <i>Massachusetts Senior Care Association</i>	MSCA presentation on workforce and nursing facility reimbursement	<u>Ms. Gregorio's presentation</u> <u>MSCA Handout</u>
November 22, 2019		
Caitlin Sullivan <i>Center for Health Information and Analysis (CHIA)</i>	Overview of the CHIA Nursing Facility Industry Report	<u>Ms. Sullivan's presentation, CHIA</u>

Appendix B – Meetings Materials Provided to the Task Force (2/3)

Presenters	Topics Discussed	Resources and Supporting Documents
December 20, 2019		
<p>Elizabeth Ms. Kelley <i>DPH, Bureau of Health Care Safety and Quality</i></p> <p>Kate Fillo <i>DPH, Bureau of Health Care Safety and Quality</i></p>	<p>Quality in Nursing Facilities in Massachusetts</p>	<ul style="list-style-type: none"> • Ms. Kelley's presentation, DPH
<p>Secretary Sudders <i>Task Force Chair</i></p>	<p>Possible Points of agreement, outline of a sensible sustainable rate structure, aligning payments with quality and member complexity</p>	<ul style="list-style-type: none"> • EOHHS presentation, December 20th, 2019
<p>Secretary Sudders <i>Task Force Chair</i></p>	<p>Letter to Secretary Sudders from Disability Advocates</p>	<ul style="list-style-type: none"> • Letter to Secretary Sudders from Disability Advocates
January 10, 2020		
<p>Elizabeth Ms. Kelley <i>DPH, Bureau of Health Care Safety and Quality</i></p> <p>Secretary Sudders <i>Commission Chair</i></p>	<p>Follow ups from December meeting: Nursing Home Satisfaction Survey and map of low quality and low occupancy facilities</p>	<ul style="list-style-type: none"> • Presentation of follow-ups from December Meeting

Appendix B –Meetings Materials Provided to the Task Force (3/3)

Presenters	Topics Discussed	Resources and Supporting Documents
January 10, 2020: <i>Continued</i>		
Rebecca Ms. Annis <i>Administrator, Pond Home</i>	Overview of the Rest Home Industry, and their role on the Massachusetts healthcare continuum	<ul style="list-style-type: none"> • Ms. Annis's presentation, Rest Home Industry • Handout-Rest Homes-Proposed Policy Changes • Handout-Rest Homes-Their Value on the Health Care Continuum • Summary of findings from Rest Home Visits, 2018 • Letter providing clarifications on the January 10 discussion regarding Rest Homes
Secretary Sudders <i>Commission Chair</i>	Task Force member “points of agreement”, policy goals and potential policy proposals	<ul style="list-style-type: none"> • EOHHS Possible Policy Proposals and Points of Agreement, EOHHS presentation • January 10, 2020 meeting handout, Policy Proposal and Points of Agreement Framework
January 31, 2020		
Secretary Sudders <i>Commission Chair</i>	Letters to Secretary Sudders from disability advocates	<ul style="list-style-type: none"> • Letter from Mr. Dennis Heaphy, Mr. Paul Spooner and Ms. Millie Hernandez • Letter from One Care Implementation Council • Letter from Aging Life Care Association-New England Chapter, Greater Boston Legal Services, and Massachusetts Advocates for Nursing Home Reform
	Discussion of the proposed final report and vote to send final report to the Legislature	

Appendix C: Conceptual outline of the building blocks of a sensible, sustainable Nursing Facility rate structure

1 **One integrated rate structure** (no hold harmless provisions, roll historic add-ons into the base, use a more recent cost year)

2 **Differentiated levels of payment based on complexity and acuity** of members

3 **Rate structure that incentivizes higher occupancy** – while maintaining quality and minimizing the use of funds to pay for empty beds

4 **Progressive rate structure** – facilities with a large percentage of MassHealth members should receive higher reimbursement

5 **Material incentives for quality** (achieving high quality or improving quality)

Appendix C: Conceptual outline of a sensible, sustainable rate structure

	Current System	New simplified rate structure
1 Integrated Rate Structure	<ul style="list-style-type: none"> Rate structure is NOT integrated \$80M+ in non-user fee add-ons (Direct Care Staff, PASRR Level II, Cape & Islands, Kosher Kitchen, etc.) Cost base year: 2014 Rate structure difficult for facilities and EOHHS to administer 	<ul style="list-style-type: none"> Integrated rate structure builds historic add-ons and capital into base rates Continue to disallow hold harmless rate structures All-in payments are equivalent to a more recent cost base year Rate structure substantially simpler to administer
2 Differentiated rates for member complexity and acuity	<ul style="list-style-type: none"> Acuity adjustment based on ADLs only; use state-specific MMQ assessment that does not appropriately account for acuity 	<ul style="list-style-type: none"> Acuity-adjust payments based on: (1) Medicare's MDS assessment, and (2) additional factors like SUD or behavioral complexity
3 Incentives for higher occupancy	<ul style="list-style-type: none"> Facilities with high and low occupancy are paid the same base rate 	<ul style="list-style-type: none"> Create rate structure that incentivizes higher occupancy while maintaining quality and minimizing the use of funds to pay for empty beds
4 Progressive rate structure	<ul style="list-style-type: none"> Current structure is regressive because of capital Partially offset: \$5M add-on for High Medicaid facilities 	<ul style="list-style-type: none"> All else equal, level of payment should be higher for high Medicaid facilities
5 Material Incentives for quality	<ul style="list-style-type: none"> ~1% of rate linked to quality (Quality Achievement and Improvement Add-on, 3+ Star Add-on) 	<ul style="list-style-type: none"> Significant payments (e.g., ~5-10% of rate) linked to quality achievement and improvement

Appendix D – Comments received from individual Task Force members on policy proposals - includes mark-ups (1/4)

Policy Goal: Right size the Nursing Home industry in response to current and future demand
Member Suggestions
<ul style="list-style-type: none"> ▪ Establish incentives for high occupancy and high quality that result in the closure of chronically low occupancy and low quality facilities (Ms. Kelley, Ms. Prendergast, Mr. Stapleton) ▪ Establish rate and other program incentives for high occupancy that may result in the voluntary closure or repurposing of chronically low occupancy and underperforming facilities (Ms. Gregorio)
<ul style="list-style-type: none"> ▪ Provide DPH the statutory authority to close revoke the licenses of chronic underperformers in quality and occupancy (Sec. Chen) ▪ Provide DPH the statutory authority to close chronic underperformers in quality and occupancy with consideration for geographic needs of the population (Ms. Annis) ▪ Provide DPH the statutory authority to close facilities with chronic poor performance and low occupancy underperformers in quality and occupancy (Mr. Stapleton) ▪ Provide DPH the statutory authority to involuntarily close chronic underperformers in quality and occupancy (Ms. Gregorio)
<ul style="list-style-type: none"> ▪ Build on age-friendly efforts within cities and towns to consider the LTSS and supportive housing needs within a given community (Mr. Stapleton)
<ul style="list-style-type: none"> ▪ Based on regional needed identified, provide supports, including needed capital to allow for conversions to other services/housing including affordable assisted living, affordable housing with services, rest homes (Mr. Stapleton)
<ul style="list-style-type: none"> ▪ Establish for future demand across the continuum, including levels of care and projected use of institutional and community based services and programs across the continuum as well as the cost associated with meeting this projected demand (Sen. Jehlen)
<ul style="list-style-type: none"> ▪ Rate investments should reflect current costs of resident care and direct care staffing, while supporting structural change that promotes quality, staffing, Medicaid utilization, overall occupancy, medical and behavioral acuity and other resident care priorities of EOHHS rather than funding broad based rate increases (Ms. Gregorio)
<ul style="list-style-type: none"> ▪ Support and facilitate structural changes to the industry that promote sustainability across the long term care continuum <ul style="list-style-type: none"> ○ Establishment of Low-interest, capital programs to incentivize conversions or colocation of other services (Ms. Gregorio) ○ Provide needed capital improvements to qualified NH and RH (Ms. Annis) ○ Voluntary reconfiguration program ○ Provide Technical assistance for NFs interested in conversion or closure (Ms. Gregorio) ○ Support the Rest Home industry, as this support is a lower cost alternative for individuals who may need to transition from AL to SNF (Ms. Prendergast) ○ Support the Rest Home industry, so that no Rest Home closes solely for financial reasons (Ms. Annis) ○ Waiver to allow development of affordable assisted living (Sen. Jehlen) ○ Provide financial support to facilities that opt to focus on SUD and Behavioral Health (Ms. Prendergast) ○ Review policies to eliminate systems that penalize Rest Homes pursuing change in ownership (Ms. Annis)

Appendix D – Comments received from individual Task Force members on policy proposals - includes mark-ups (2/4)

Policy Goal: Establish a Reasonable and Sustainable Rate Structure for Nursing and Rest Homes

Member Suggestions

- Establish one integrated rate structure based on building blocks of a sensible, sustainable rate structure **that is based on current cost of resident care and direct care staffing (Ms. Gregorio, Mr. Stapleton)**. This includes:
 - Eliminating the MMQ and basing reimbursement on the MDS assessment ~~with possible additional payments (e.g. SUD members and other resource intensive conditions) (Sec. Chen)~~
 - Eliminating the MMQ and basing reimbursement on the MDS assessment with possible additional payments (e.g. SUD members and other resource intensive conditions **including residents with significant cognitive impairments and behavioral health needs (Mr. Stapleton)**)
 - Incentives for higher occupancy ~~and high percentage of Medicaid facilities (Mr. Stapleton)~~
 - ~~A~~ **progressive** rate structure and payments linked to quality achievement and improvement **(Sec. Chen)** for nursing homes and Rest Homes **(Ms. Annis)**
 - **Revision of the existing procedures governing the reimbursement and establishment of rates for all DPH licensed long term care facilities & religious order homes (Ms. Annis)**
 - **Regional cost differences and need to support facilities in areas with high concentrations of poverty (Mr. Stapleton)**
- Update efficiency standards to reflect current utilization **and eliminate current occupancy penalties (Ms. Annis)**
- Update base year costs **to most recent available at CHIA (Sec. Chen)**
- Update base year costs **and apply CMS labor inflation rate to inflate labor costs from the base year to the rate year (Ms. Gregorio)**
- Update base year costs **annually (Ms. Annis)**
- **Recognize that the people being cared for are frail, and provide reimbursement for a short period of time after death to clear, clean, and prepare the room would be reasonable (Ms. Annis)**
- **Enforce** compliance of the user fee assessment through additional payment and licensing **enforcement** tools **(Sec. Chen)**
- Increase compliance of the user fee assessment through additional payment and licensing tools **as well as improve the funding of MassHealth's share of the user fee (Ms. Gregorio)**
- **Provide a defined process for homes to request & receive rate relief for increased staffing needs due to increased resident needs/aging in place populations, required cost increases for staffing such as increase in minimum wage, PFMLA, sick time; as well as DPH Survey compliance requirements (Ms. Annis)**
- **Ensure capital costs reflects ability of providers to invest in physical plant to best support residents including investments in innovative models such as "small house" nursing homes (Mr. Stapleton)**
- **A reformed rate structure should include a new "medical loss ratio" or "labor cost floor" requiring that a large proportion of MassHealth rate reimbursements are utilized for labor costs to improve wages and benefits, increase staffing levels, and ensure higher quality care (Mr. Foley)**
- **Along with these structural reforms, the state should fund a substantial MassHealth rate increase in the FY21 budget (Mr. Foley)**
- **Create a direct care add-on provision for both NH & RH (Ms. Annis)**

Appendix D – Comments received from individual Task Force members on policy proposals - includes mark-ups (3/4)

Policy Goal: Promote High Quality Care in Nursing and Rest Homes	
Member Suggestions	
<ul style="list-style-type: none"> Enhance quality resident care by convening government agencies, stakeholders, academia and content experts to conduct periodic nursing facility staff training programs that are based on the most frequently DPH cited deficient practices in nursing facilities (Ms. Gregorio) 	
<ul style="list-style-type: none"> Enhance DPH's licensing and 'suitability review' authority and processes to establish stronger review of new owners and to improve the transparency of DPH's licensing and suitability determination processes (Mr. Foley) Streamline suitability for fully compliant existing licenses (Mr. Bane) 	
<ul style="list-style-type: none"> Promote and incorporate the resident and family experience by implementing a resident and family survey (Sec. Chen, Ms. Gregorio) Promote and incorporate the resident experience by implementing a resident survey with strong survey results favorably impacting the Medicaid rate (Ms. Prendergast) 	
<ul style="list-style-type: none"> Establish a performance based grant program for specific quality initiatives related to most frequently cited DPH deficiencies (Ms. Gregorio) 	
<ul style="list-style-type: none"> Develop and strengthen and fund, state direct care staffing standards as a leading indicator of care quality (Ms. Gregorio) Fully reimburse for direct care staffing costs as a leading indicator of care quality (Mr. Stapleton) 	
<ul style="list-style-type: none"> Mitigate the impact of involuntary transfers when a home is closed by developing a resident, family, & staff preparatory program (Ms. Annis) 	
<ul style="list-style-type: none"> The state should utilize the DPH Nursing Home Survey Tool rather than the CMS star system as the primary measure of quality (Mr. Foley) 	
<ul style="list-style-type: none"> Quality should be measured over time, with real opportunities for nursing homes to implement quality performance improvement projects over a period of three years (Mr. Foley) 	
<ul style="list-style-type: none"> Look at using the fees collected from NBUF to supplement payments to homes that have high percentage of subsidized residents (Ms. Annis) 	

Appendix D – Comments received from individual Task Force members on policy proposals - includes mark-ups (4/4)

Policy Goal: Ensure a Sustainable Workforce Serving the Care Needs of Individuals Across the Entire Long-Term Care Continuum

Member Suggestions

- ~~Strengthen direct care staff by requiring wage requirements similar to the medical loss ratio requirements imposed on health plans (Mr. Bane, Sec. Chen)~~
 - Strengthen direct care staff by fully reimbursing for direct care staffing (Mr. Stapleton)
 - Examine the feasibility and design of a medical loss ratio for nursing facility sector (Ms. Gregorio)
 - Establish per diem rates for cost categories, and require payments for nursing, ancillary, support, and capital costs to be spent within those categories (Sen. Jehlen)
 - Strengthen direct care staff and promote responsible employers by requiring wage requirements similar to the medical loss ratio requirements imposed on health plans (Mr. Foley)
-
- Provide adequate wages to recruit, train, and retain direct care staff across the continuum (Sen. Jehlen)
 - Recognize the state’s share of any wage, payroll and training mandates through MassHealth nursing facility rates (Ms. Gregorio)
-
- Support and provide resources to provide opportunities for advancement and to increase recruitment and retention initiatives including continuing efforts to put CNAs on a path to a living wage via expansion of programs similar to the direct care add-on, supporting career ladder grants and tuition forgiveness programs (Ms. Gregorio)
-
- Make LPN programs more affordable (Ms. Annis)
 - Make Massachusetts the leader in the nation for valuing direct care workers as our population ages- this would include training, improved wages, marketing the jobs available as a direct care worker, and showing the value and honor of this chosen profession (Ms. Annis)
-
- Evaluate and identify opportunities to improve the CNA certification process for direct care workers across the long-term care continuum (Sec. Chen)
 - Evaluate and identify opportunities to improve and make more accessible CNA training programs and reduce unnecessary delays in the CNA certification process (Ms. Gregorio)
 - Evaluate and identify opportunities to improve the CNA certification process & make availability of classes, & affordability a priority (Ms. Annis)
-
- ~~Improve staffing by structuring~~ Structure the MassHealth reimbursement process to require sufficient and increased spending on labor costs by imposing requirements similar to a medical loss ratio imposed on health insurance plans (Sec. Chen)
 - Improve staffing by structuring the MassHealth reimbursement process to require sufficient and increased spending on labor costs by using CMS’ labor inflation forecast to set annual nursing facility rates and recognizing labor mandates (Ms. Gregorio)
 - Improve staffing by structuring the MassHealth reimbursement process to ~~require sufficient and reimburse~~ for increased spending on labor costs (Mr. Stapleton)

Appendix E – Letters received from advocates (1/3)

January 30, 2020

EOHHS Secretary Marylou Sudders
Chair, Nursing Facility Task Force
One Ashburton Place
Boston, MA 02108

Delivered by email to Marylou.sudders@state.ma.us

Dear Secretary Sudders:

We are writing as a follow-up to the presentation at the Nursing Facility Task Force's January 10 meeting by Paul Spooner of MWCIL, Millie Hernandez of ECIL, and Dennis Heaphy of the DPC. We wish to offer comments on overriding concerns we hope can be considered for the final report and any resulting next steps.

First, however, we wish to emphasize that while there are positive stories sometimes emanating from facilities, oftentimes the quality of life is desperate. Paul and Dennis expressed fear, as persons with significant disabilities, about needing to go in a facility. Millie, also with significant disabilities, detailed how her stay in a nursing home was marked by filth, neglect, harassment and inattentiveness to health.

Moving forward, points we believe must be considered include these:

- There's a need to review complaint and oversight mechanisms for facilities.
- The predominant model for nursing facilities must be seriously reconsidered. As able, people choose to remain at home or, if unable to remain at home for health reasons, to at least go to more homelike settings as exists in assisted living residences or in places exemplified by the Greenhouse model. Simply addressing the financial problems plaguing nursing homes by providing more resources but otherwise preserving the status quo is unacceptable.
- Quality measures built around what people would want if unable to stay at home—not shaped by what exists—are needed, as are risk adjustment policies supporting higher levels of care as needed.

- Any financial package must include support for the workforce directly caring for residents. We also strongly support an audit of MassHealth nursing home cost reports, as recommended by Massachusetts Advocates for Nursing Home Reform, to verify the amount of any MassHealth shortfall and to ensure MassHealth funds are being utilized in the best interests of nursing home residents.
- Commensurate examination of steps that can enhance alternatives to nursing facility placement are essential. These include support for LTSS and affordable, integrated and accessible housing; and a revamping of regulations and support for assisted living residences to allow them to serve people with a broader range of health needs and insurance coverage, including MassHealth.

As we have noted, 20% of those in nursing homes are under age 65. The future of facilities is very much a concern for the disability rights community and we look forward to future engagement.

Thank you for the opportunity to convey our concerns.

Sincerely,

Bill Henning, Boston Center for Independent Living/DAAHR
Paul Spooner, ~~Metrowest~~ Center for Independent Living
Marlene Sallo, Disability Law Center
Colin Killick, Disability Policy Consortium
Vicky ~~Pulos~~, Mass Law Reform Institute
Nancy Lorenz, Greater Boston Legal Services
Millie Hernandez, Boston Center for Independent Living
Arlene Germain, Massachusetts Advocates for Nursing Home Reform
Lisa Orgettas, Disability Resource Center (Salem)
Steve Higgins, Independence Associates (E. Bridgewater)
Lisa Pita, Southeast Center for Independent Living (Fall River)
Coreen Brinckerhoff, Cape Organization for Rights of the Disabled
Dennis Heaphy, DAAHR
Meg Coffin, Center for Living and Working (Worcester)
Joe Castellani, Ad Lib Center for Independent Living (Pittsfield)
June ~~Savageau~~, Northeast Independent Living Program (Lawrence/Lowell)

Appendix E – Letters received from advocates (2/3)

January 29, 2020

EOHHS Secretary Marylou Sudders
Chair, Nursing Facility Task Force
One Ashburton Place
Boston, MA 02108

Delivered by email to Marylou.sudders@state.ma.us

Dear Secretary Sudders,

As leaders of the One Care Implementation Council, we are writing to request that you include this letter in the official record of findings on the nursing home Task Force. The Council acknowledges the important role nursing homes play in the lives of persons who have medically complex needs and/or other confounding factors. At the same time, it is imperative that the Task Force recommendations and subsequent steps taken by Statehouse policy makers align with innovations being championed by the Executive Office of Health and Human Services (EOHHS).

It is important to point out that the Task Force lacks two elements necessary for successful innovations in person-centered care. First, improving quality of care is not listed among the Purposes of the Task Force. Second, despite comprising 20% of the nursing home population, the Task Force lacks representation from the disability community and/or their family members/guardians.

Additional considerations include:

- the current nursing home model is fiscally unsustainable;
- initiatives being undertaken by MassHealth, including One Care, were established to reduce institutionalization by rebalancing spending through better alignment of Medicare and Medicaid dollars;
- the current nursing home model is not aligned with needs and goals of many elders and persons with disabilities requiring nursing home level care;
- health inequities may lead to increased institutionalization and isolation of low income ethnic, minority and other underserved populations with complex care needs.

Over the past 20 years alternatives to the current nursing home model have emerged. Assisted living facilities are probably the most popular. However, current regulations do not permit persons with ADL and IADL needs to reside in assisted living facilities. There is also the greenhouse model. The Leonard Florence Center for Living stands is an example of the greenhouse model. In addition, the Veterans Administration is also advancing variations on the current nursing home model. All these models provide residents choice, control and dignity of risk not available in the standard nursing home model.

Attached is a list of recommendations for the Task Force's consideration. We thank you for your leadership and look forward to ongoing partnership with EOHHS in the development of One Care 2.0 and other initiatives that impact populations with complex care needs. Please contact us if you have any questions.

Dennis Heaphy, Chair
Crystal Evans, Co Vice-Chair
Paul Styczko, Co Vice-Chair

We ask that Task Force recommendations made to Statehouse policymakers provides a roadmap to sustainable whole person-centered nursing home level care:

1. Committed to advancing the dignity and human rights of elders, persons with disabilities, and their family members.
2. Requires ongoing engagement with and oversight by disability, elder and other advocacy groups in the development and implementation of systems transformation of the nursing home industry.
3. Aligned with the commitment by MassHealth to the State's Olmstead plan, community first, and rebalancing spending priorities.
4. Balances new investment dollars in institutional care with equitable increased investment in community based LTSS initiatives such as expansion of affordable housing availability in the Commonwealth.
5. Remedy health and wellness inequities across racial, ethnic and other populations.
6. Establish value-based and alternative payment methodologies that are adjusted by risk category along with quality adjustment criteria.
7. Researching best practices being developed in other states e.g. work done in Tennessee which has developed a Quality Improvement and Long-Term Service in Supports Initiative.¹
8. Providing consumers alternative models of care that advance consumer choice, control and dignity of risk that includes removal regulatory barriers preventing persons with disabilities from accessing options such as assisted-living communities.
9. Tying sustainability and quality to just working conditions and wages of nursing home employees, in particular direct staff e.g. nurses and Certified Nursing Assistants.
10. Strengthening incentives for One Care plans to rebalance spending in a manner that promotes person-centered LTSS to their members.

¹ <https://www.tn.gov/content/dam/tn/tenncare/documents/QuiltssFramwork.pdf> these alternative models.

Appendix E – Letters received from advocates (3/3)

Aging Life Care Association-New England Chapter
Greater Boston Legal Services
Massachusetts Advocates for Nursing Home Reform

January 30, 2020

Secretary Marylou Sudders
Delivered by email to Marylou.sudders@state.ma.us
Executive Office of Health and Human Services
Chair, Nursing Facility Task Force
One Ashburton Place, 11th Floor
Boston, MA 02108

Dear Secretary Sudders:

We are writing as advocates for Massachusetts nursing home residents to express our strong support for:

1. performing an independent audit of MassHealth nursing home cost reports; and
2. implementing an 80(care)/20(administration) medical loss ratio.

We urge you to include this audit and 80/20 medical loss ratio in Nursing Home Task Force recommendations based on our concerns with potential MassHealth rate revisions for Massachusetts nursing homes, the recent financial failures of Skyline nursing homes, and the additional information noted below. Just yesterday, we met with Undersecretary Lauren Peters, Assistant Secretary for MassHealth, Daniel Tsai, and his team to present our views, and we greatly appreciate their time and attention to our perspective.

Although it has been presented that the MassHealth reimbursement rates are inadequate to maintain the cost of operating a nursing home, a different picture is portrayed by the following sample of opposing views:

- 3/27/16 Boston Globe, *A Pattern of Profit and Subpar Care at Mass. Nursing Homes*, Kay Lazar: "...On forms they submit to the state, nursing homes frequently report they are losing money. But that's only part of the story. A review of records from companies affiliated with the homes shows they are directing cash to subsidiaries and to help pay executives' six-figure salaries..."
- Providers have wide latitude on how they utilize MassHealth funds and other revenue, since there are no limits on self-dealing transactions or contracts; no set minimum required to be spent on resident care; no set minimum on staffing levels; and no ceiling on administrative costs.

Our organizations support performing an audit of nursing home MassHealth cost reports for several reasons:

- to determine the degree of MassHealth rate shortfalls and how best to implement a rate increase;
- to ensure that a reasonable level of funds is consistently maintained through a medical loss ratio.
- to better allocate public funds between nursing homes and community-based services; and
- to ensure that MassHealth/other funds are being utilized in the best interests of nursing home residents.

January 30, 2020
Aging Life Care Association-New England Chapter, Greater Boston Legal Services, Massachusetts Advocates for Nursing Home Reform

We must take a close look at the true financial status of Massachusetts nursing homes to ensure that funds are being used to provide the highest practicable quality of care and quality of life for nursing home residents, the care facilities have pledged to provide in their licensure requirements. Therefore, to protect Massachusetts nursing home residents and provide the mandated care they deserve, we urge you to include in Task Force recommendations a transparent financial review of Massachusetts nursing homes and a meaningful medical loss ratio.

Thank you for considering our views.

Greater Boston Legal Services, on Behalf of Our Clients
Radhika Bhattacharya, Managing Attorney, Elder Health & Disability Unit

Massachusetts Advocates for Nursing Home Reform
Alison Weingartner, Executive Director
Arlene Germain, Policy Director

Aging Life Care Association – New England Chapter
Rebecca Wild-Wesley, Public Policy Chair

Cc: Daniel Tsai, Assistant Secretary of MassHealth Daniel.Tsai@MassMail.State.MA.US
Lauren Peters, Undersecretary for Health Policy Lauren.B.Peters@MassMail.State.MA.US
Susan Ciccariello Susan.Ciccariello@MassMail.State.MA.US
Jacqueline Fratus Jacqueline.Fratus@mass.gov
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Meera Ramamoorthy Meera.Ramamoorthy@MassMail.State.MA.US
Pavel Terpelets Pavel.Terpelets@MassMail.State.MA.US

Appendix F –Letter providing clarifications on the January 10 discussion regarding Rest Homes (1/2)

Nursing Facility Task Force
Clarification letter-January 10th Meeting
1/31/20

Dear Secretary Sudders

I would like to provide additional clarification and information related to questions posed during my presentation at the January 10th Nursing Facility Task Force meeting:

- In response to the question posed by Mr. Bane regarding the source of the annual cost of nursing facilities:
 - The source of the information, Dibbern.com, was contacted and said that their information, regarding the Cost of Long Term Care in Massachusetts, was from Met Life Reports.
- In response to Secretary Chen's question about the use of the survey prepared by Mary Bronski in 2015 as compared to the DPH survey conducted in 2018:
 - The Survey cited in my presentation was offered to all Rest Homes in in 2015. The response rate was 47% response rate. In total, 41 homes were surveyed and medical records were reviewed. A total of 1,217 residents were interviewed. My limited understanding of the DPH 2018 survey was that it was offered to 22 specific homes, and 17 agreed to participate. In total, 119 residents were interviewed. This is a much smaller statistical sample and I believe the DPH survey was targeting homes with a high level of Medicaid. My home was not asked to participate in that survey, so I cannot speak to the details of it.
- In response to the comment regarding the increase in number of nursing hours:
 - MARCH submitted a request to CHIA for them to provide the hours by home. MARCH has received from CHIA 2017 aggregate Rest Home information that is being analyzed. We will provide updated nursing hour information when it is available.

- In response to the question by Rep. Balsler about why more people receiving antipsychotic medication (38%) than the percent of individuals reported to have mental health issues (29%), I contacted Mary Bronski, the survey author, for clarification. She replied with:
 - "The questions as they appeared in the survey sent to RCF representatives. The questions are as follows:
 - As far as you know how many current residents have been diagnosed with serious mental health problems such as schizophrenia and psychosis?
 - As far as you know how many current residents receive antipsychotic medication?
 - In response to the observation that some residents who are on antipsychotics, do not carry a mental health diagnosis like schizophrenia or psychosis:
 - It is important to keep in mind that antipsychotic medications can be used "off-label" which means the drugs are given for other reasons. They may be on an antipsychotic for other reasons like depression, anxiety, ADHD, eating disorder. Antipsychotics can be prescribed for many reasons other than for schizophrenia or psychosis. My research team purposefully did not include other mental health diagnosis like depression in the survey question because the goal was to highlight more serious mental health problems.
 - An additional explanation is that the responding facility representatives were not aware that the resident on the antipsychotic had a diagnosis of schizophrenia or psychosis. When a resident with serious mental health problem such as schizophrenia and psychosis are well controlled on their medications over an extended period of time, it is difficult for staff to identify the problem or corresponding diagnoses as the clinical manifestations of the mental health problem is not present day to day. I believe this "out of sight out of mind" explains the omission of this information leading to the discrepancy between the data points."

Rest Home presentation presented to the Task Force on January 10th, can be found here:
[January 10, 2020 Presentation-Rest Homes](#)

Appendix F – Letter providing clarifications on the January 10 discussion regarding Rest Homes (2/2)

- Secretary Chen asked for clarification regarding the challenges of selling a privately owned Rest Home. Below is an example submitted to CHIA from MARCH for their review and comment.
 - “This is how the reimbursement works for a purchase of an existing facility with a new owner. The buyer (new owner) would inherit the adjusted cost basis of the previous owner or owners and would be reimbursed based upon their remaining available non depreciated adjusted basis.
 - Facility purchased originally in 1980 for \$400,000.00. depreciation reimbursed through cost report is \$300,000.00. Remaining non depreciated basis equals \$100,000.00.
 - A new buyer purchases facility for \$800,000.00 in 2020. The new buyer inherits the previous owner’s adjusted basis for reimbursement purposes of \$100,000.00. He will not get reimbursed, in this example, of the difference of \$700,000.00 for the fixed portion of reimbursement. Additionally, the debt service on this purchase would also be allocated for reimbursement to 1/8 of the debt service. The remaining 7/8 would not be reimbursed.
 - In summary, if the facility has been in existence for many years, and many have, the reimbursable basis to a new owner is minimal at best along with the debt service on this purchase. It can be virtually impossible to sustain a facility under these circumstances since much of the cost is non reimbursable” - It is not really comparable to stocks that have depreciated in value as was stated in the minutes.
- In response to the question regarding the split between private and public rates:
 - It is estimated that of the 2,900 Rest Home beds, 8% - 10% are private pay.
- In response to the question regarding the number of staff employed by Rest Homes:
 - MARCH surveyed its membership to determine staffing by facility. As of 1/18/2020, 30 homes reporting 1,033 staff members or an average of 34 employees per home.

In addition, I would like to respond to your comment, Secretary Sudders, that people who leave rest homes for community living receive greater access to private funds. I would like to request additional clarification on this comment. I believe that this is true for any person leaving a long-term care facility where they are subsidized by the state or federal government because of the limitations of the Personal Needs Allowance.

Finally, I would like to respectfully disagree with Representative Muratore’s comment that rest homes are more like assisted-living than nursing facilities. Rest homes are more like nursing facilities which is why they are part of this Task Force.

Thank you for allowing me to submit these clarifications into the record.

Sincerely,

Rebecca Annis