

Clark University

Clark Digital Commons

School of Professional Studies

Master's Papers

5-2020

Rest Homes: Their Value on Massachusetts Healthcare Continuum

Ronald Pawelski

Clark University, rpawelski@clarku.edu

Follow this and additional works at: https://commons.clarku.edu/sps_masters_papers



Part of the [Business and Corporate Communications Commons](#), [Family, Life Course, and Society Commons](#), [Health Policy Commons](#), [Human Resources Management Commons](#), [Information Security Commons](#), [Management Information Systems Commons](#), [Marketing Commons](#), [Nonprofit Administration and Management Commons](#), [Public Administration Commons](#), [Public Health Commons](#), [Social Media Commons](#), and the [Sociology of Culture Commons](#)

Recommended Citation

Pawelski, Ronald, "Rest Homes: Their Value on Massachusetts Healthcare Continuum" (2020). *School of Professional Studies*. 41.

https://commons.clarku.edu/sps_masters_papers/41

This Capstone is brought to you for free and open access by the Master's Papers at Clark Digital Commons. It has been accepted for inclusion in School of Professional Studies by an authorized administrator of Clark Digital Commons. For more information, please contact mkrikonis@clarku.edu, jodolan@clarku.edu, dltz@clarku.edu.

Rest Homes:

Their Value on the Massachusetts Healthcare Continuum

Ronald J. Pawelski, President

Massachusetts Association of Residential Care Homes

Abstract

In Massachusetts, rest homes provide cost effective care for elderly residents in a community setting. Rest homes, however, are not well-understood and the rest home industry itself suffers greatly, not only from a lack of understanding of the services they provide, but also from the strain on their financial resources due to both competition from other healthcare options and insufficient reimbursement rates for residents' care.

The paper explores the financial challenges facing the industry and outlines the data that speaks to the value of the rest home care option for both the residents themselves and Massachusetts state healthcare budget. It compares rest homes with other institutions, including assisted living and nursing homes, and demonstrates the financial advantages of rest homes for certain segments of the elderly population. It also outlines the Massachusetts state government role in funding rest homes, and underscores the importance that advocacy plays in the industry's survival. The paper highlights the issues of rate adequacy, the human impact of closures on elderly residents and provides a view of the possible road ahead for this challenged industry. In conclusion, it demonstrates the value of rest homes on the Massachusetts healthcare continuum in medical, financial and social terms.

Table of Contents

Introduction.....4

Rest Home Industry Profile: An Industry Struggling to Survive.....5

Rest Home Advocates.....6

Profile of Rest Home Services.....7

Discussion Points.....9

Payment Comparison.....11

Comparison of Rest Homes to Skilled Nursing Homes.....12

Rest Home: A Cost-Effective Healthcare Option.....13

Cost Avoidance Analysis Compared to Nursing Facility Care.....16

Resident Profile.....16

State and Federal Agencies Interface: the Need for a Cohesive Program Focus...19

Problems with the Lack of Agency Coordination.....24

Advocacy and Legislative Involvement, including Grassroots Efforts.....24

Financial Challenges Facing the Rest Home Industry.....28

The Human Cost of Closures.....33

The Future of Rest Homes in Massachusetts.....34

Summary: The Value of Rest Homes.....35

References.....36

Appendix.....38

Introduction

Residential care homes, licensed as rest homes in Massachusetts, play an important role in the care of over four thousand aged, infirm and indigent residents of the Commonwealth. There is a general lack of understanding about who they are, the services they provide and the population they care for. Often associated with nursing homes or the rapidly growing assisted living industry, they serve a different population of the elderly and have significant value over other residential options for elderly persons. They fill a distinctive and important role on the Massachusetts healthcare continuum.

Rest homes are also an industry in financial peril. According to the Massachusetts Department of Public Health, since 1998, one hundred and two rest homes in the state have closed, primarily due to financial reasons. The financial issues are a direct result of United States federal and Massachusetts state regulatory compliance requirements, increased costs related to an ever-increasing aging-in-place population and the lightning rod issue of rate adequacy. As a result, over 4,000 residents of closed facilities were displaced and subjected to the trauma associated with involuntary transfer.

Rest Home Industry Profile: An industry Struggling to Survive

Rest homes in Massachusetts have been in existence since the 1800's. Historically often known as boarding homes or houses, modern day homes were first licensed by the Massachusetts Department of Public Health in the 1940's. In the 1970's, the

Commonwealth saw an increase in the number of rest homes as wood framed structured nursing homes, known as Level III homes, converted to rest homes due to Life Safety Code Compliance issues and to avoid the costs of retrofitting sprinkler systems.

At its zenith, the rest home industry had a community presence across the Commonwealth with over 200 homes caring for more than 7,000 aged, infirm and indigent residents. Worcester, Fitchburg and Boston had the highest concentration of homes. However, since 1998, one hundred and two homes have closed, due primarily to financial problems, and more closures are looming.

Today, there are only seventy-two rest homes remaining in the Commonwealth. These homes are termed “Free Standing” as they are not part of a nursing facility wing.

The average home size is thirty-three beds, with the largest home having eighty-nine beds and the smallest home, five beds. Forty-nine homes are for-profit with eight of the forty-nine listed as private (not admitting publicly assisted residents). Eighteen homes are listed as not-for-profit, and five homes are listed as religious order homes that do not require licensing by the Department of Public Health. Worcester remains the area with the highest concentration of rest homes in Massachusetts.

Rest Home Advocates

Rest homes in Massachusetts are represented by two primary associations, the Massachusetts Association of Residential Care Homes (MARCH) representing the for-profit, not-for-profit and religious order homes; and Leading Age of Massachusetts (LeadingAgeMA) representing the not-for profit and selected religious order homes.

MARCH is a Massachusetts-based organization formed in 1991. It focuses exclusively on advocating and educating on behalf of rest homes in the Commonwealth; their owners/executive directors, their residents and their healthcare staff. As stated on their website, www.maresidentialcarehomes.org, its mission is to provide the public with key information about the value of rest homes as an elder care option and to work to enhance the financial viability of the industry.

Rest homes provide a cost-effective quality of care for their residents and their families in a community-based home-like environment. Legislative and advocacy efforts focus on ensuring that there are no further rest home closures due to financial reasons.

LeadingAge Massachusetts, <https://www.leadingagemass.org>, represents the full continuum of not-for-profit providers of healthcare, housing and services for older persons in Massachusetts. Their members provide housing and services to over 30,000 older adults and persons with disabilities in the Commonwealth. In addition to rest homes, they represent continuing care retirement communities, skilled nursing facilities, assisted living residences, senior housing, home health services, and adult day health and hospice programs.

LeadingAgeMA lists its mission as *“Expand the World of Possibilities for Aging” by leading in innovative practices that transform how we care for the aging population and lead initiatives to develop services that meet “older adult” needs*”.

Profile of Rest Home Services

Rest homes provide medical management, medication management, address psycho/social needs in addition to room and board for an average cost of \$97.00 per day.

(Note: See the *MARCH Residential Care Fact Sheet: Provided Services*, Appendix, Exhibit 1.)

Table 1

Comparison of Rest Home Services to Assisted Living Services

(Seaman, Kathy, Executive Director, Mount Pleasant Home, Jamaica Plain Massachusetts)

ASSISTED LIVING	RESIDENTIAL CARE (rest home)	SKILLED NURSING (nursing home)
Regulated by MA Executive Office of Elder Affairs	Licensed & Regulated by the MA Department of Public Health	Licensed & Regulated by the MA Department of Public Health
Provide up to 3 meals daily in dining room & social activities	Provide 3 meals daily, snacks, social activities & events	Provide 3 meals daily, snacks, activities
Housekeeping & laundry services (may require an extra fee)	Housekeeping & laundry included	Housekeeping & laundry included
Offer 24-hour security	24-hour supervision & security	24-hour skilled nursing, IV drugs, oxygen, injections, mechanical lift transfers
Onsite staff responds to emergencies call 911	Onsite staff respond to emergencies; gives first aid & calls 911	Onsite staff responds to emergencies
May provide oversight of a resident's self-administration of medication (extra fee)	Administers medications; maintains medical record, takes MD orders; coordinates medical care needs	Administers medications; maintains medical record, takes MD orders; coordinates medical care needs.
Supervision of bathing/dressing for a set number of hours. Additional hours by fee.	Provides assistance with bathing dressing	Assistance with all personal care needs; total care

Minor nursing services	Licensed nurse available at times	RN & LPN coverage 24/7; medical director available for consultation
Resident provides furniture	Encourage personal belongings; furniture provided	Furniture provided; may have special units for rehab, dementia etc.
Primarily private pay with limited state funding	Mostly subsidized by DTA, SSA, SSI & Pension and Limited private pay	Medicare, Medicaid, long term care insurance & private pay

Discussion Points

From a provided services standpoint, the key difference between assisted living centers and rest homes is the amount of direct care that they provide. Although rest homes are not required to have licensed nursing and aide staff at their facilities, (the DPH regulation calls for a responsible person and nursing consulting) most rest homes today have licensed nursing staff providing direct care.

Current Massachusetts assisted living regulations do not permit direct care staff to be employed on-site. Residents of assisted living centers may contract for services through a private agency for additional care. Given the provided care considerations, rest homes are able to provide care to residents with a higher acuity level, providing more support with Activities of Daily Living (ADL); including bathing, feeding, dressing, and grooming. This care differential is a competitive advantage for rest homes.

In recent years, per discussions with rest home owners and executive directors, rest homes have received placement referrals from assisted living centers for their residents who have experienced increased acuity levels and/or have experienced multiple falls. Several assisted living locations have established criteria related to falls prevention and the ability to ambulate to ensure resident safety and the appropriateness of the resident remaining in an assisted living facility.

Assisted living centers generally provide their residents with several apartment models to select from. Rest homes, many of which are old Victorian-style mansions updated to comply with state requirements, provide single, double and in some cases four-to-a-room living options.

As assisted living centers are decidedly newer construction, (as opposed to rest homes most of which were built prior to 1978), they have a clear competitive advantage in their choice of living arrangements. Their new construction, coupled with the option not to share living space, poses a significant threat to the continued existence of rest homes.

If assisted living centers are permitted to have licensed nursing staff on site, it will signal the end of the rest home industry. Recently, the Somerville Home in Somerville, Massachusetts, decided to cease operations due to the opening of a new assisted living center in the area. The rest home's board of directors carefully reviewed the financial implications and realized that the Somerville home would not be able to compete as a rest home and made the difficult decision to close. Approximately fifty residents of the Somerville home were sent to different healthcare institutions and were subjected to the trauma of involuntary transfer.

Payment Comparison

Residents of assisted living centers predominantly pay privately. There are few subsidies available to their residents at this time. Once the residents exhaust their funds, they may find that they need to make alternative living arrangements.

Residents of rest homes either pay privately or receive payment for their care from the Massachusetts Department of Transitional Assistance (DTA).

<https://www.mass.gov/lists/departments-of-transitional-assistance-regulations>

Each rest home has its own specific rate as established by the Commonwealth. For those residents receiving Social Security, Supplemental Security Income (SSI) or a pension, the rest home applies that monthly amount minus \$72.80 and uses the MassHealth claims payment system to bill the Commonwealth for the balance of the monthly bill. For those residents that have no income and qualify Emergency Aid to the Elderly, Disabled and Children (EAEDC), DTA will pay the members or the rest home directly for the resident's care.

Comparison of Rest Homes to Skilled Nursing Homes

From a care standpoint, the primary difference between a rest home and a nursing home is the amount and level of complexity of the care provided. Nursing facilities now provide an extensive range of services that include skilled nursing care, rehabilitation services; including physical therapy, occupational therapy and speech therapy and dementia care including Alzheimer's. Nursing facilities are equipped to care for residents with higher acuity levels, residents who are non-ambulatory and/or residents who are there for rehabilitation stays.

Per the Long-Term Care in Massachusetts Fact Sheet: (2008)

- Of those residents covered by MassHealth, 46% stay less than a year, 33% one to four years, and 21% more than four years.
- The average length of stay for MassHealth beneficiaries is 2.4 years. Note that these figures do not count the time the beneficiary may have spent in the facility prior to qualifying for MassHealth.

From a living arrangement standpoint, the model is institutionally - based with residents having the option of private or semi-private rooms.

Rest homes provide medical management in a community setting. Many of these homes are actively engaged in the community and their residents are active members of the community. Rest home residents typically do not require the higher level of care found in nursing homes. The acuity levels of rest home residents as high, although this is beginning to change based on an ever-increasing aging-in-place population. Most residents are ambulatory, although a small percentage are ambulatory with assistance of a cane or a walker. Complex medical services, if provided, are contracted services.

Residents in rest homes have a much longer length of stay as these places become the residents' **home**. While no exact data exist regarding length of stay, anecdotal information presented by owners and executive directors notes that the vast majority of the residents have been in their homes for decades. Residents generally remain in their rest home until they require more care than the rest home can provide or until they die.

Rest Homes: A Cost-Effective Health Care Option

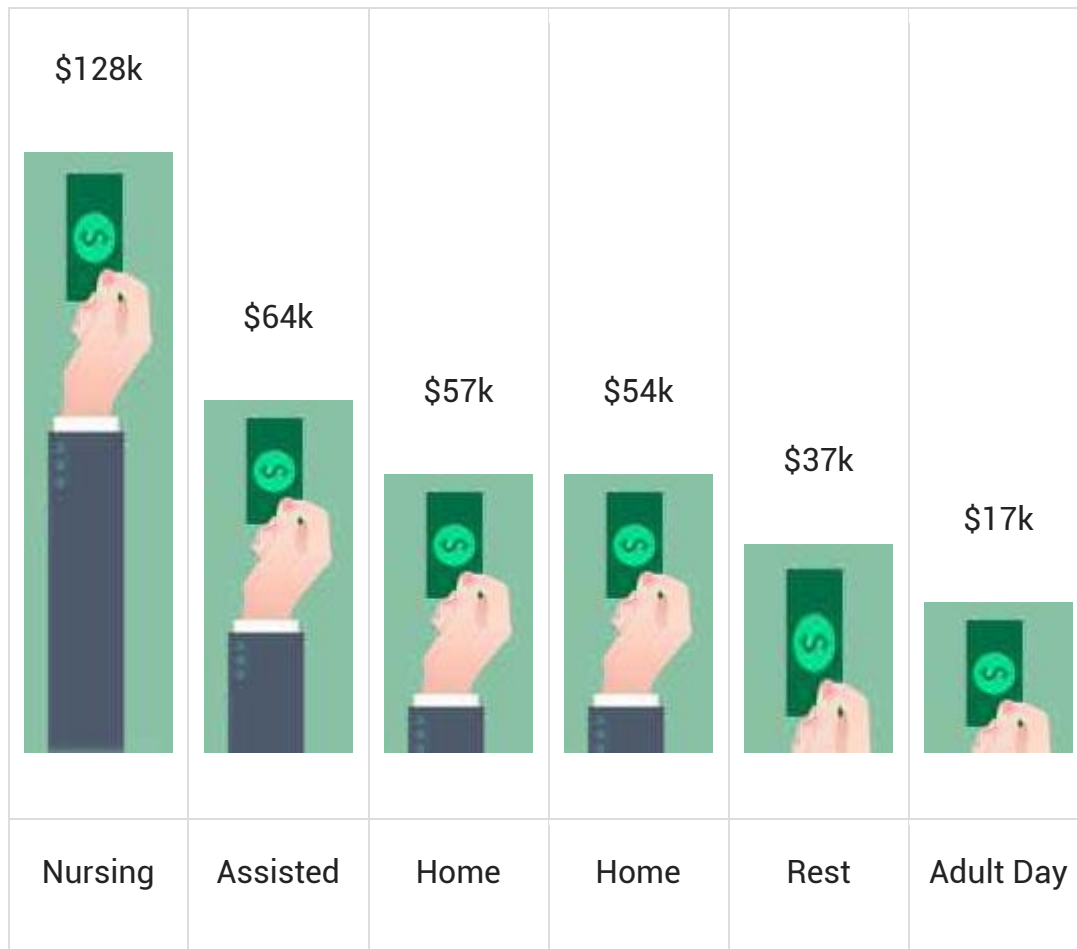
In Massachusetts, statewide averages for nursing homes costs totaled \$327 per day for a semi-private and \$350/day for private totaling over \$127,000 per year. Assisted living averaged \$4,645 per month or \$55,740 per year while providing fewer services than a nursing home. Note: Per Mass Senior Care for SFY 2019, the MassHealth average per diem payment rate is \$212 per day or \$77,380 per annum.

[Massachusetts Nursing Home Costs](#)

Table 2

Comparing Long Term Care in Massachusetts

Estimated Annual Cost (median rates)



Home	Living	Health	maker	Home	Care
		Aide	Non-Med		

Nursing Home data is based on a Semi-Private Room.

The nursing home trade association, Massachusetts Senior Care, makes the case that the MassHealth reimbursement rates on average trail actual costs by \$37 per day per patient.

Here are a few figures about overall MassHealth nursing home payments:

(Long-Term Care in Massachusetts Factsheet)

- In 2007, nursing facilities earned \$3.7 billion, of which 70% was covered by MassHealth, 14% by Medicare, and 16% out-of-pocket or other payers.
- Use of nursing homes has declined significantly in recent years, from more than 50,000 residents in 1995 to approximately 45,000 today.
- In 2003, 73% of MassHealth's long-term care expenditures went to nursing facilities; by 2008, this had dropped to 60%.

Compared to the other care options listed about, Rest Homes represent a cost-effective care option based on the following:

- The average cost of a one-year stay to the Commonwealth is \$37,000 per resident, assuming the member is completely dependent on state funding from the Department of Transitional Assistance.

- Approximately 50% of rest home residents have some form of Social Security, SSI or retirement income, meaning that the expenditure to the Commonwealth would be less than \$37,000 per resident per year.
- The annual expenditure for rest home care under DTA is approximately \$50 million annually. There is no federal financial participation or match as rest homes are not considered Medicaid providers.
- The per diem cost includes medical management, medication management, psycho-social support AND room and board.
- Occupancy rates have remained over 90% for most rest homes, due in large part to the number of closures.

Cost Avoidance Analysis Compared to Nursing Facility Care

If the rest home industry did not exist and the majority of the current resident population were placed in nursing homes, the Commonwealth would be facing an incremental charge to MassHealth of \$35 million per year. This assume 50% federal matching funds. If no additional funding comes from the federal government, the figure would be even higher; approximately \$70 million per year.

The “ballpark” analysis is as follows:

2000 residents (estimated) X (\$212.00 – (\$97.00) daily rate X 365 = \$70,809,788 per year.

In summary, rest homes represent over a \$35 million per year cost avoidance to the Commonwealth.

Resident Profile

To best understand who resides in rest homes, I relied on the following two approaches:

The first approach references the survey work completed by Mary Bronski, *Characteristics and Demographics of Residential Care Facility Residents in Massachusetts*. Dr. Bronski profiled the residents of Massachusetts residential care homes through the completion of a web-based survey of rest home owners and administrators. The study was groundbreaking as it was the first time that a demographic study was completed of rest home residents.

Here are key characteristics and demographics of the population surveyed:

- **Age:** Over 75% of the population is 65 or older with over 34% greater than 85 years of age. While this points to an aging-in-place population, it was surprising to learn that close to 8% of the population was between the ages of 22 and 54. It points to the need for a population that is need of both care and housing
- **Race:** The vast majority of the population is white with smaller percentages of black, Hispanic and Asian populations.
- **Sex:** 69% of the population is female and 31% male. This percentage is fairly consistent across long term care segments.
- **Care Need Profile:** The survey demonstrated that the care needs were more consistent with a medical model of care than a housing model. This issue has been an ongoing debate within the industry and state government regarding the need for licensed staff. An aging-in-place population will require additional care.

The following findings support the need for nursing and nurses aid services:

- From an Activities of Daily Living standpoint, 52% of the population required assistance with showering and bathing, 45% of the population, while ambulatory, required the assistance of a cane, walker or wheelchair, 31% needed assistance using the bathroom with 27% of the population having an episode of urinary incontinence.
- Mental health and medication management were essential components of a rest home care plan as 29% had a current diagnosis of mental issues, with 21% being diagnosed with Alzheimer's disease and early onset of dementia. Medication management is an essential part of the population care needs as one third of the population requires antipsychotic medications. Several rest homes have specialized in mental health management as some of the residents can be traced back to the deinstitutionalization of state hospitals.
- Visitation The number of residents never having received a visitor (29%) speaks to the number of residents that do not have family connections. Each home has examples of residents who were homeless with no family support prior to admission.

The second approach taken was to visit member rest homes and observe first hand, the resident population and assess the care needs of the resident. The personal observations closely track with the survey results. What did not become evident in the survey are the number of members, an aging in place population, some with no family support, who will require additional care as the years advance. The challenge for each

rest home will be their ability to address these needs without having to discharge the resident to a higher acuity care environment.

In summary, the current residents of rest homes represent the aged, infirm and indigent population of the Commonwealth. Many have come from homeless situations and many have no family connections. Not only do rest homes address their medical needs but they also provide a place for them to call home.

State and Federal Agencies Interface: The Need for a Cohesive Program Focus

Several state and federal agencies play prominent roles in the operations of rest homes including regulatory compliance, resident eligibility, payment, rate determinations and support:

Department of Public Health- (DPH), Division of HealthCare Facility Licensure and Certification
<https://www.mass.gov/orgs/division-of-health-care-facility-licensure-and-certification>

DPH serves as the regulatory and compliance arm of the Commonwealth. All rest homes with the exception of religious order homes, are licensed by DPH consistent with 105CMR 150.00 Standard for Long Term Care Facilities, 105 CMR 153 Licensure Procedure and Suitability Requirements and 105 CMR 155 Patient and Resident Abuse Prevention, Reporting, Investigation, Penalties and Registry. Renewal occurs every two years and is carried out by survey teams that monitor for compliance with physician and nursing services, patient care and care plans, pharmaceutical services and medications, social services, physical plant, safety and record keeping.

The rest home industry routinely testifies at public hearings on proposed regulatory changes. In recent years, the industry was successful in advocating for the retainment of a grandfather clause on building construction that, if not adopted, would have signaled the end of all rest homes in the Commonwealth.

Current advocacy efforts include creating a separate set of regulations specially for rest homes as the current regulations include all long-term care facilities

Where past years were marked with controversy and contention, the current relationship has markedly improved. DPH has provided the industry with insightful in-service and training. The industry and DPH have worked collaboratively to improve the quality of care standards in rest homes and to prevent unnecessary home closures.

Department of Transitional Assistance (DTA)

Per their website, the Department of Transitional Assistance assists and empowers low-income individuals and families to meet their basic needs, improve their quality of life and achieve long-term economic self-sufficiency. To recap, approximately 50% of the Rest Home population qualify for the Emergency Aid to the Elderly Disabled and Children (EAEDC) program and receive direct care payments for their rest home residency. The remaining 50% have their care provided thru and SSI account. All rest home care for the publicly-assisted residents of rest homes is provided by the DTA.

The rest home industry interfaces with DTA on issues of resident eligibility and billing. A separate unit has been established at DTA headquarters to field questions specific to rest homes and their residents.

Executive Office of Elder Affairs (EOEA)

<https://www.mass.gov/orgs/executive-office-of-elder-affairs>

The Executive Office of Elder Affairs mission is to promote the independence, empowerment and well-being of older adults, individuals and their caregivers.

Over the years, EOEA has served as the champion and had served as the de facto program manager for rest homes. They have commissioned Rest Homes studies to determine whether rest homes were a housing model or a medical model.

Their Office of Long-Term Services and Supports reports to both EOEA and MassHealth. This group has interfaced with the Rest Home Industry on Group Adult Foster Care as a potential payment vehicle and in researching waiver programs that would provide federal funding.

MassHealth & Maximus

Most rest home residents receiving EAEDC payments and SSI benefits qualify for the state Medicaid program. MassHealth provides a suite of ancillary medical services, including physician visits, prescription drugs, therapy services hospital stays, nursing facility coverage and transportation services. Many residents participate in coverage options that provide incremental service care to rest home residents including Adult Day Health, Group Adult Foster Care, Senior Care Options (SCO) and Program for All - inclusive Care for the Elderly (PACE).

While rest homes are not considered MassHealth Providers, they are required to enroll as providers to submit claims to the MassHealth Claims Payment system. Maximus, the

customer service arm of MassHealth, oversees provider enrollment and claims processing for those residents that have SSA, SSI and/or SSP income.

Massachusetts State Supplemental Program (SSP)

The Massachusetts SSP program is a state cash benefit program for qualified Supplemental Security Income (SSI) applicants. SSI provides monthly payments to certain eligible rest home residents. Massachusetts provides additional benefits for those residents that qualify. This program is a payment source for rest home residents that helps pay for their care.

Center for Health Information Analysis (CHIA)

<http://www.chiamass.gov>

CHIA is an independent agency that serves as the Commonwealth's primary hub for healthcare data and healthcare analytics that provide inputs to healthcare policy development. Previously known as the Rate Setting Commission, CHIA is responsible for establishing rest home per diem rates based on the submission of rest home cost reports.

Under an interagency agreement with EOHHS, CHIA in concert with EOHHS has established regulations 101CMR 204.00 that detail rules and regulations governing allowable costs and formulas used in setting rest home reimbursement rates.

The rest home industry routinely testifies at public hearings when new payment rates are established.

Executive Office of Health and Human Services (EOHHS)

<https://www.mass.gov/orgs/executive-office-of-health-and-human-services>

EOHHS is the organization that oversees operations of DPH, DTA, MassHealth, EOEA and manages the relationship with CHIA. Recent involvement with EOHHS has focused on the need to establish a coherent long-term strategy for rest homes.

A recent study is underway to determine what actions will be taken to stabilize the industry. EOHHS has recently invited MARCH to recommend changes to the Rate and Reimbursement regulations. A Rate and Reimbursement Committee has been formed by MARCH to provide essential feedback to EOHHS in August 2019 timeframe.

The United States Social Security Administration (SSA) <https://www.ssa.gov/>

Rest homes interface with local SSA offices for those residents that are eligible to receive SSA or SSI benefits. In many instances, the rest home becomes the representative payee for the resident and assists in the management of the resident's accounts with the SSA offices. Recent efforts with the NE Region SSA have seen an in-service provided to rest homes with a concentration on best practices in working with the Social Security Administration.

Problems with the Lack of Agency Coordination

The number of agencies rest home owners, executive directors and their staff need to interface with on a daily basis is daunting from an administrative overhead standpoint. While relations with each agency have been improving over recent years, the one area that remains unresolved is the development of a long-term strategy defining the future of rest homes in the Commonwealth. Rate adequacy and reimbursement for direct costs will be discussed in more detail later in the paper.

Advocacy and Legislative Involvement, including Grass Roots Efforts

Over the past few years, advocacy and lobbying have taken on a critical role in the continued survival of rest homes in the Commonwealth. Rate formulas endorsed by the Commonwealth did not provide rest homes with any ability to predict if and when they would receive increases to offset increased state and federal requirements that spiked operating costs. Years have passed without any increases.

The advocacy model previously employed was changed from advocating for increases with state agencies, to advocating directly to the state Executive Branch and the Legislative Branches.

MARCH followed the model that *Moses Mercado & Drew Maloney, Forbes Magazine, January 19, 2009 How to Influence Government*, described in the article as an old-school fixer model. This model combined developing a clear concise message with developing a grassroots organization.

We discovered that Massachusetts legislators (senators and representatives) did not even know they had rest homes in their district, let alone what rest homes did. In addition to working to cultivate relationships with the legislative branch, (MARCH was told that it was late to the game). MARCH needed to educate the legislative branch about what a rest home was, how rest homes were different from assisted living and Nursing Homes and the financial challenges the industry was facing.

MARCH tailored our message(s) to our audience and leaned to modify the message as needed. (Note, see Appendix, Exhibit 2 for 2019 Rest Home Talking Points and the message "Save Our Home" campaign.)

The second key piece of the MARCH advocacy involved developing a grass roots presence for the cause of saving rest homes. Owners, executive directors, their staff and their residents were recruited and asked to serve as volunteers in support of the campaign. The following details the advocacy approach taken:

1. You should know who your senators and representatives are- You can determine this by Googling "Find my Legislator" on www.malegislature.gov. Once you have determined this, you should make it a point to contact your senator and your representative and introduce yourself and your rest home. Provide a detailed profile about your Home: how long you have been in existence, how many residents you care for, their ages, how long have they lived there, how many healthcare professionals you employ, as examples.
2. Invite your senator and representative to visit your home (at least annually)- In MARCH's dealings with the legislature, many did not know they had a rest home in their district, let alone what a rest home does and where it sits on the healthcare continuum. Inviting your senator and representative to the rest home is a great way for them to see first-hand the good works carried out on a day-in, day-out basis. In addition, it is a great way for your residents to meet with legislators and for the legislators to meet their constituents. This approach is the best way to explain to your legislators the challenges that you, the residents and your staff face on a daily basis without adequate reimbursement. The MARCH president is available to attend these sessions and can help you prep to hold a Legislator's Day - an annual event for your Rest Home.

3. Establish a Resident Letter Writing Campaign- Handwritten letters from your residents describing in their own words what it means to be a resident of your Rest Home- their home- is more effective than any email that a senator or representative will receive. This statement is based on countless conversations with legislators that have Rest Homes in their respective districts.

4. Become Politically Active- You should notice that many of the legislators are running for re-election. A way to establish a relationship with them is to volunteer on their campaigns or contribute financially to their re-election bid.

MARCH is NOT able to make political contributions on behalf of any candidate but you as Rest Home owners and executive director are free to do so.

5. Establish Local Relationships - Grass roots advocacy is also effective at the local level. Form relationships with your respective town or city mayor, selectmen, trade associations, Council on Aging and Senior Centers. As Rest Homes are a community-based treasure, it is important that you are recognized as a community-based asset that plays an important role on the healthcare continuum.

Taking these advocacy steps listed are essential to survival and securing incremental funding for rest homes. Results over the past two years have proven the model to be successful in securing incremental funding from the legislature. In State Fiscal Year (SFY) 2019, faced with the closure of several rest homes, repeated meetings with the Executive Branch yielded positive results. The Governor interceded and working in concert with members from his EOHHS and DTA organizations, appropriated \$4M in emergency funding for rest homes.

In SFY 2020, MARCH has been able to secure language in the House budget that set a precedent for MARCH. As it stands today, the Senate, the House and the Governor have approved language that would provide another \$4M in incremental funding for rest homes.

A key segment that has gone untapped to this date is the use of media. The industry has embarked on a major upgrade of its website with the intent to use this and other forms of information to broadcast its message. The industry is also contacting members of promotional campaigns that have proven to be highly successful in the Commonwealth like the Marijuana Council to determine what additional approaches the rest home industry should take in promoting its name recognition in the state.

Financial Challenges Facing the Rest Home Industry

This section explores the myriad of financial challenges facing rest homes today. A recent Boston Globe article, *“Rest Homes in Massachusetts Keep Closing as Financial Pressures Mount”*, highlighted the case of a not-for-profit home closure. The per diem rates established by the Commonwealth are a lightning rod issue with the long term care industry and raises the question of whether the Commonwealth is meeting its commitments to healthcare for the elderly.

January of 2018 marked a groundbreaking event for rest homes. A rest home Open Forum was held in Worcester, Massachusetts attended by legislators, agency heads, rest home owners and executive directors and advocates for rest homes. At that meeting, MARCH and LeadingAge representatives presented the rest home financial

challenges from an operating and cash flow, a regulatory and capital improvements standpoint.

Based on the current rate and reimbursement regulations, rest homes rates are calculated based on expenditures in nursing/operations, administrative and capital expenditures. These established rates trail over time, they do not keep up with current costs, falling behind the actual rest home expenditures. This results in rest homes not receiving payment for their current costs.

As a result of the state's method of calculating rates, wherein reimbursement rates under state statute or budgetary language need not be increased for extended periods of time, rest homes are challenged on a daily basis to live within their operating budgets and provide the care residents require.

The operational challenges become exacerbated when the residents age in place and acuity levels rise. For these residents to remain in their "homes", rest home owners and executive directors are faced with either adding licensed nursing staff or transferring the residents to a nursing facility. Most rest homes choose to add staff even though they know they will not be immediately compensated by the Commonwealth for the incremental costs to their payroll. The same situation applies for those homes that have a resident population with cognitive impairments and related drug management issues; additional staffing is required to meet the residents' needs.

The other significant operational challenge rest homes face is one of staff recruitment and retainment. Rest homes are at a disadvantage compared to other healthcare

sectors that receive a direct care add-on increase to their rates to address recruitment and retainment challenges, for example in nursing homes.

From a regulatory standpoint, rest home licensure surveys translated into rest homes being required to address operational expenses and capital improvements to remain in compliance. In 2016, expenditures reached \$1.6 million and in 2017, expenditures exceeded \$3.0 million related to licensure surveys related to quality of care and safety. As part of their updated regulatory process, additional expenditures will be required to address safety concerns. While rest home administration is not opposed to making these improvements, not being reimbursed for these expenditures places them under an added financial burden.

Compliance with state and federal wage laws have a dramatic impact on rest homes operation. The minimum wage requirements added an incremental .5M to the industry's payroll expenses that carries over annually. Future increases will have an additive impact. The State Employer Medical Assistance Contribution (EMAC) program taxed rest homes for those employees that received their care from MassHealth or ConnectorCare. The tax resulted in rest homes paying up to an additional \$750 per healthcare worker per year.

Regulations currently prevent buyers (future purchasers) of rest homes to be reimbursed for their cost basis (purchase price) as opposed to being subject to reimbursement for the historically adjusted basis. These regulations impede the transfer and sale of owners that want to leave the industry and encourage closure rather than sale of homes.

Based on the industries' current financial state and bottom line performance, rest homes are not able to secure loans to make operating and capital improvements. These conditions have resulted in closures based primarily on financial reasons. Per public testimony, a rest home closed in Brimfield to become a doggie day care center. A home in Weymouth closed in 2018 because the owner could not secure a loan to make DPH-mandated capital improvements.

The Boston Globe article placed a spotlight on the issue of closures and was the first of its kind to link the closures to the adequacy of the reimbursement rates. It resurfaced all the old issues and discussions about the lightning rod issue in healthcare; "Are rates indeed adequate and is the Commonwealth not taking ownership and responsibility for the care of its aged and indigent population?".

Rate adequacy and its impact on long-term care in the Commonwealth has been a lightning-rod issue for decades. The nursing home trade association, Massachusetts Senior Care, makes the case that the MassHealth reimbursement rates, on average, trail actual costs by \$37 per patient per day. MARCH has completed its financial analysis and have concluded that reimbursement rates for rest homes for the indigent residents, on average, trail actual costs by \$17 per patient per day. A highly regulated business, with over 70% of its population eligible for MassHealth or DTA payments cannot continue to be a going concern while running at a loss. Based on the closures of rest homes and nursing homes in the Commonwealth, the result is that they cannot continue to operate for long.

The Boston Globe article served as a watershed for the industry because it featured the closing of the Somerville Home, a not-for-profit home and member of the Somerville Community. This closure, along with the closure of the home in Weymouth, sparked a renewed interest at the executive, legislative and state agency level resulting in the Governor authorizing \$4 million in incremental funding for Rest Homes. While the amount did not address all the financial concerns or address the issue of rate adequacy or the Commonwealth's responsibilities to its poor, it did stem the tide of additional mass closures. It also sparked discussion and research on other payment and subsidy options for rest homes.

Other states with rest homes have explored and implemented different payment models in support of their residents residing in rest homes. Vermont, Maine and Minnesota have pursued waiver programs. North Carolina has implemented a payment program that includes Personal Care Attendant payments. The common thread in all cases was to obtain a federal match for rest home care. Rest homes in Massachusetts are not considered Medicaid providers and as such the Commonwealth does not receive any federal money for rest home resident care. One hundred percent of the money for rest home reimbursement is state-funded through the Department of Transitional Assistance. The Massachusetts federal match for MassHealth is 50 cents for every dollar spent.

Current discussions center on allowing rest homes to become Group Adult Foster Care (GAFC) providers. A limited number of residents currently receive GAFC services provided by a third party. The Rest Home industry is proposing that allowing rest homes to become GAFC providers creates a win, win, win scenario. First, the residents

with higher acuity needs will receive the necessary care. Second, the rest home will receive an additional \$40+ dollars a day for those residents that qualify. This will provide much needed financial relief that would be a predictable source of revenue. Third, as GAFC is considered a Medicaid program, the Commonwealth would receive a federal match.

Other approaches the industry has advocated for are to reimburse based on current allowable costs thereby ensuring that monies spent on behalf of the Commonwealth's most needy are paid upfront. Providing for low interest loans would allow rest home owners and executive directors to address staffing needs and make much-needed capital improvements. Providing for a direct care add-on would allow Rest Homes to receive reimbursement up-front and address the financial challenges of an aging-in-place population and residents in need of dementia care.

The Human Cost of Closures

Often overlooked amidst the regulatory, financial and operational issues facing rest homes and the Commonwealth is the impact of closures and the associated human cost. Since 1998, over 4,000 aged, infirm and indigent residents, many who had previously been homeless, have lost their homes and faced the adverse effects of involuntary transfer in the form of "transfer trauma"

Terri D. Keville cites in her paper on transfer trauma that, *"...the term was coined in the early 1960s when gerontologists first became concerned that involuntary relocation of the elderly - either from private residences to institutions or from one institution to another - might have adverse health effects and possibly even hasten death."*

An early study by Adrich and Mendkoff cited by Terri Keville indicated that, “*This comparison indicated that the death rates for all transferred groups except those in the tenth decade of life were substantially and significantly higher than the rates that would have been anticipated (in the absence of the move) based on the historical data.*”.

In the early 1970’s, the Long-Term Care Division of the Massachusetts Welfare Department hired three teams comprised of Registered Nurses Masters of Science and Masters of Social Work experts to address a significant number of nursing home closures due to Life Safety Code regulations. Their role was to prepare the residents and family members for the impending closure of the home. These actions were taken in recognition of the transfer trauma that the residents would experience. One such study by Coffman concluded that “*In light of further, meta-analysis of the data, that the most lethal moves are those that involve closure of an institution and dispersal of its residents.*”.

While many court cases contested the existence of transfer trauma as witnessed in the Supreme Court Case of O'Bannon vs. Town Court Nursing Center, lower court rulings and the case literature support that transfer trauma is genuine and significant. MARCH takes the position that no rest homes should close in the future based solely for financial reasons.

The Future of Rest Homes in Massachusetts

What does the future hold for rest homes? Here is an industry that is small compared to assisted living and nursing facility care. Legislators in the House and Senate have opined that the number of rest homes in the state is just too small to warrant

consideration for incremental funding. It is an industry that is not expanding. Rest homes are perceived to be over regulated, lack a favorable return on investment and also lack sources of low interest loans. These factors make buying, expanding and building rest homes financially unfavorable.

The fact that over one hundred homes have closed since 1998, displacing over 4,000 residents, would indicate that the Commonwealth is content to let the industry die through attrition.

While the prognosis for the industry's future is poor and at best uncertain, these homes represent safe havens for over 2,000 elderly people, many of whom have experienced homelessness. They employ over 4,500 healthcare professionals. These homes are integral parts of the local communities they serve.

Over the past few years, a renewed education effort has been underway to inform and educate the Executive Branch, the Legislature and state agencies about the important role rest homes play on the healthcare continuum. The focus has been on the value of rest homes compared to other long-term care options, and how rest home services differ from assisted living and nursing homes. The education and advocacy efforts have started to resonate with state government resulting in incremental funding and the hope of long term financial stability. Rest homes are slowly losing their moniker of being an enigma.

Summary: The Value of Rest Homes

Rest homes play an important role on the healthcare continuum providing cost effective care to an elderly population in a community based setting that their residents call

home. Rest homes are endangered by rate inadequacy, over-regulation, balkanized agency oversight and competition from other healthcare options that provide different levels of care. The human cost associated with the transfer trauma that residents experience when rest homes close, is also a major concern. Recent advocacy efforts have had a significant impact in convincing the Massachusetts executive and legislative branches that rest homes have high monetary and social value. This seachange in the perception of rest homes offers a ray of hope for their future survival.

REFERENCES

Articles

Aldrich CK, Mendkoff E.(1963 March 11) Relocation of the Aged and Disabled: a Mortality Study. *Journal of the American Geriatric Society* pp.185 - pp.194
Retrieved from [PMID: 14011825 DOI: 10.1111/j.1532-5415.1963.tb00047.x](https://pubmed.ncbi.nlm.nih.gov/14011825/)

Bronski, M, Lawton, S. et al (2015 fall) A State-Wide Web Based Survey of the Characteristics and Demographics of Residential CareFacility Residents in Massachusetts, Northeastern University PhD thesis presentation, ppt slides

Coffman, T. (1981) Relocation and Survival of Institutionalized Aged: A Re-examination of the Evidence, *Gerontologist (Volume 21)* pp.483 - pp.485

Keville, T. (1993). Studies of Transfer Trauma in Nursing Home Patients: How the Legal System has Failed to See the Whole Picture. *Health Matrix: The Journal of Law-Medicine Volume 3 (Issue 2)* pp. 421-pp.458

Mercadao, M. And Maloney, D. (2009, January 19). How to Influence the Government. *Forbes*, Retrieved from https://www.forbes.com/2009/01/19/government-relations-lobbying-oped-cx_mm_dm_0119mercadomaloney.html#23dd7a0e594f

Seaman, K. (2018) What do Residential Care Homes (Rest Homes) Provide? Retrieved from <https://maresidentialcarehomes.org>

Weisman, R. (2018, November 18) Rest Homes in Mass. Keep Closing as Financial Pressures Mount, *Boston Globe*, Retrieved from <https://www.bostonglobe.com/metro/2018/11/18/rest-homes-closing-massachusetts-financial-pressures-mount/xMQ2LY7FcWJGEWuEeuZ8iO/story.html>

Government and Associations

Center for Health Information Analysis. Retrieved from <http://www.chiamass.gov>

Executive Office of Health and Human Services

Retrieved from <https://www.mass.gov/orgs/executive-office-of-health-and-human-services>

Massachusetts Legislature, Find my Legislator, Retrieved from www.malegislature.gov.

Leading Age Massachusetts, Retrieved from <https://www.leadingagemass.org>

Long-Term Care in Massachusetts: Facts at a Glance, Retrieved from <https://bluecrossmafoundation.org/sites/default/files/Long%20Term%20Care%20in%20MA%20Facts%20At%20a%20Glance.pdf>

Massachusetts Department of Public Health; Division of Health Care Facility Licensure
Retrieved from <https://www.mass.gov/orgs/division-of-health-care-facility-licensure-and-certification>

Massachusetts Department of Transitional Assistance (DTA). Retrieved from <https://www.mass.gov/lists/department-of-transitional-assistance-regulations>

Massachusetts Executive Office of Elder Affairs

Retrieved from <https://www.mass.gov/orgs/executive-office-of-elder-affairs>

MassHealth and Maximus, Retrieved from <https://www.masshealthchoices.com>

Massachusetts Legislature, Find my Legislator, Retrieved from www.malegislature.gov.

Massachusetts Department of Public Health; Division of Health Care Facility Licensure
Retrieved from <https://www.mass.gov/orgs/division-of-health-care-facility-licensure-and-certification> 34

Nursing Home Costs in Massachusetts, Retrieved from
<https://www.dibbern.com/nursing-homes/massachusetts/cost-for-massachusetts-nursing-homes.htm>

United States Social Security Administration, Retrieved from <https://www.ssa.gov/>

U.S. Supreme Court, (1980) O'Bannon v. Town Court Nursing Ctr., 447 U.S. 773,
O'Bannon v. Town Court Nursing Center No. 78-1318 Argued November 6, 1979
Decided June 23, 1980, 447 U.S. 773. Retrieved from Retrieved from
<https://supreme.justia.com/cases/federal/us/447/773/>

APPENDIX

Exhibit 1

Residential Care Fact Sheet 2019

Ronald Pawelski

Services:

Provide medical management, medication management, and address psycho/social needs;

Provide nursing, pharmacy, dietary and social service consultation;

Licensed nursing oversight has increased on average to 1.5 FTE's to care who those who age in place exceeding 0.02FTE's as required by the DPH regulations;

24-hours a day oversight for assistance, first aid and emergencies;

Medication administration & maintenance of a medical record;

3 meals and 3 snacks a day;

Personal care as needed;
5+day a week activity program;
Housekeeping and laundry services;
All services provided at a specific *single daily rate*.

Industry size & utilization:
90 facilities, 22 are part of a nursing home;
Only 55 homes are free standing facilities accepting publicly aided residents;
There are approximately 3000 subsidized beds for the general public;
Since 1998, 100 homes have closed displacing over 3,000 residents;
Average sized home is 28 beds, ranging from 5 to 158 beds;
Average occupancy is 95%;
Employs approximately 2750 people;
14 homes care for those who have a major mental illness, many had been *homeless*;
9 homes care exclusively for retired nuns or priests.

Financing:
Average daily rate is \$94.83/day, ranging from \$74-129/day for 24 hour care;
Adult day health rates \$59-75 per 6-8 hour day;
The last rate increase became effective December, 2018
Need immediate cost adjustment to meet wage increases, EMAC increase and FMLA and sick pay for part time employees;
Rates are based on budgetary restrictions not allowable costs contrary to State Statute;"
Almost ½ the funding for care is paid for by the resident's SSA/SSI/SSDI and pension checks;
Need State sponsored low interest program for needed capital improvements;
Federal matching waiver programs should be seriously explored.

ADVOCACY & EDUCATION FOR THE COMMUNITY SINCE 1991

M.A.R.C.H.

Massachusetts Association of Residential Care Homes
c/o Ronald J. Pawelski, President
Cell: 978.549.8739
E-mail: [HYPERLINK "mailto:rjpawelski@comcast.net"](mailto:rjpawelski@comcast.net) rjpawelski@comcast.net
Web: maresidentialcarehomes.org

Exhibit 2

2019 Rest Home Talking Points

Ronald Pawelski

- Rest homes care for over 3,000 Aged and Infirm (70+ in age) publicly assisted residents in a least restrictive setting. Rest Homes play an important role in Health Care Continuum providing housing and healthcare options

- Provide Licensed Medical Care, Medical and Medication Management and Room and Board in a Community Based Setting residents call their **HOME**
- At \$94.83/ day more cost effective than Nursing Facility (\$250.00), Assisted Living (\$140.00) or Adult Day Health (\$59-\$75 per 6-hour day)
- Rest Homes save an estimated \$30-40M annually to Commonwealth compared to NF care and provide more care than Assisted Living
- Prevent Homelessness. Since 1998 100 homes closed displacing over 4,000 residents. Closures result in increased morbidity and mortality rates. Only 75 free standing Rest Homes operate today
- Rest Homes are association of **Small Businesses** employing over 2,800 healthcare professionals.
- Industry dealing with an “Aging in Place Population” with high percentage with Mental Health issues. Over 40% would qualify for a Nursing Facility. Rest Home have added Licensed Nursing Staff to address this issue
- Current rates do not adequately reimburse business for their current operating expenses or address increased fiscal outlays due to adding staff, (\$2M) DPH compliance, (\$3M) minimum wage (1M) and unemployment supplement (\$.5M). FMLA cost is being determined. Loss of \$18.00/day for publicly assisted residents; Private Pay residents serves to subsidize
- Rest Homes are reimbursed with 100% state funds thru Department of Transitional Assistance. There is no Federal Match. Request has been made to State Agencies for several years to pursue Federal Waivers to obtain matching funds like California and Vermont

- Unlike Nursing Homes, Rest Homes do not receive a direct care add-on and developed the following campaign

“SAVE OUR HOME”

Campaign

Good Morning Legislator

Residential Care Homes, licensed as Rest Homes in Massachusetts, play an important role in the healthcare continuum, as they care for and are the HOMES to over 3,000 aged, infirm and indigent residents. Many of the residents of Residential Care Homes were previously homeless.

Each of you has a Residential Care/Rest Home(s) in your district. The residents, the healthcare staff and the owners and executive directors need your assistance. If they have not done so already, they will be contacting you to visit their HOMES to inform you about the important role they play, the valuable and cost-effective services they provide and discuss their concerns.

(Attached, for your review, is key information about Residential Care/Rest Homes.)

Due to a myriad of financial challenges including Federal and State compliance and the increased staffing costs for caring for an aging in place population, Residential Care Homes continue to be challenged to remain open. Current reimbursement rates do not keep pace with the increased cost requirements of operating a Residential Care Home. Since 1998, 100 Homes have closed, the majority due to financial issues, resulting in over 4,000 residents being displaced and subject to the trauma associated with involuntary transfer.

*MARCH, the Massachusetts Association of Residential Care Homes, the largest trade association for these Homes and their Residents in the Commonwealth is leading the effort on the SAVE OUR HOME campaign. We need your support in securing a \$4M increase in this year's budget that will directly benefit our residents and our healthcare staff. Simply stated our goal is to **SAVE OUR HOME.***

We ask that you make this \$4M incremental funding request (4408-1000 Emergency Aid to the Elderly Disabled and Children and 4405-2000 State Supplement to Supplemental Security Income) one of your top three priorities in your meetings with your House Ways and Means Chair Michlewitz. Your actions will help these residents save their homes.

On behalf of all the residents we collectively serve, thank you for your consideration.

Ronald J. Pawelski, President

Massachusetts Association of Residential Care Homes