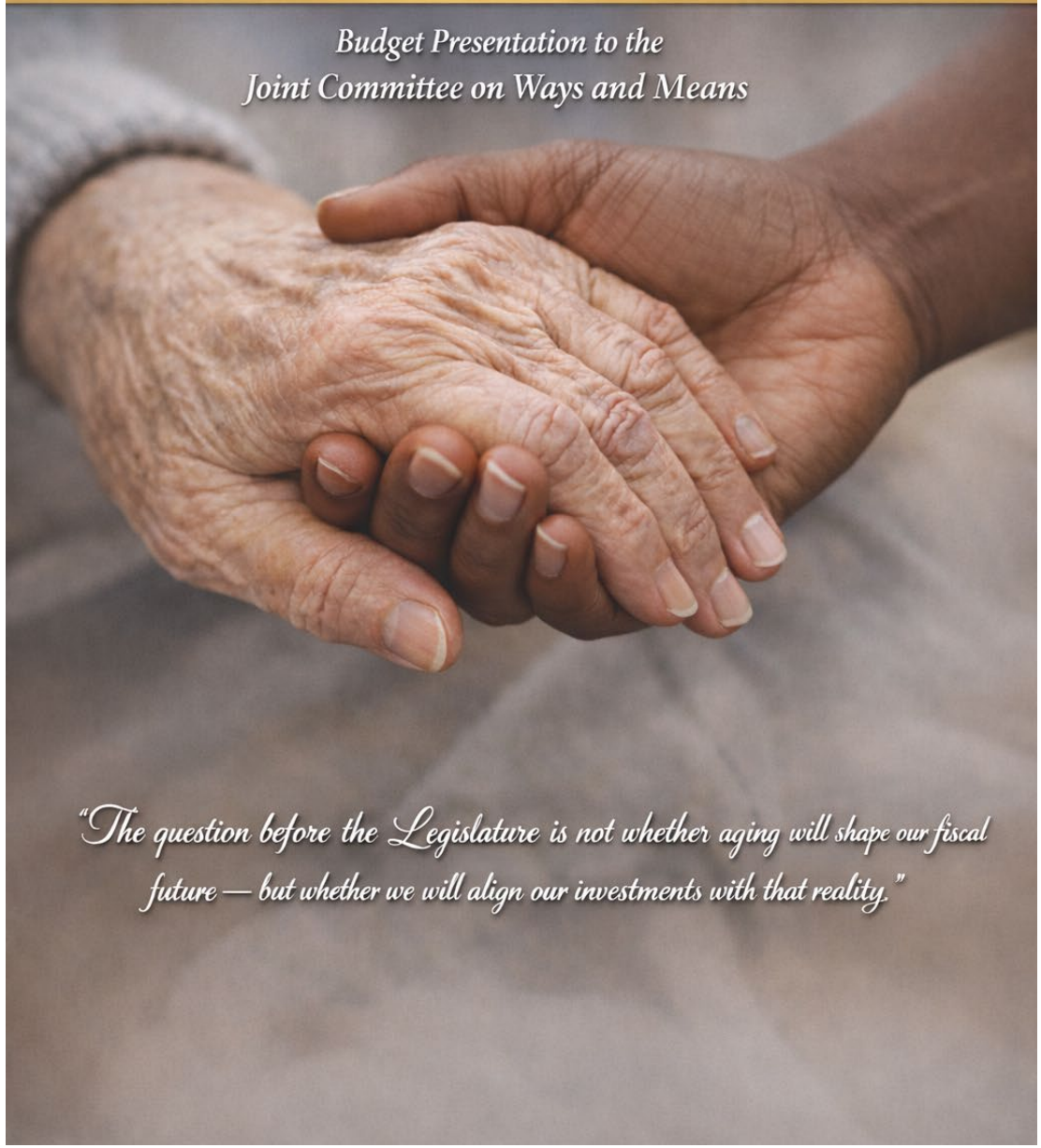


ALIGNING THE IMPACTS OF AGING AND CAREGIVING

WITH THE FY 2027 GENERAL
APPROPRIATIONS BILL (H.2)

*Budget Presentation to the
Joint Committee on Ways and Means*



"The question before the Legislature is not whether aging will shape our fiscal future — but whether we will align our investments with that reality."

FY2027 BUDGET AMENDMENT JUSTIFICATION MEMORANDUM

To: Joint Committee on Ways and Means

From: Dignity Alliance Massachusetts

Date: March 1, 2026

Re: The Dignity Dozen — FY2027 Budget Amendments Strengthening Long-Term Care, Assisted Living, and Community Aging Supports

Introduction

Re: Aligning the Impacts of Aging and Caregiving with the FY 2027 General Appropriations Bill (H.2)

Thank you for the opportunity to submit testimony on the FY 2027 House 2 budget and its alignment with the Commonwealth's responsibilities to older adults, people with disabilities, and family caregivers

This memorandum is offered in recognition of the Committee's central constitutional role: stewarding limited public resources in a manner that is fiscally disciplined, forward-looking, and consistent with legislative intent.

Massachusetts stands at a defining demographic moment. The Commonwealth is aging rapidly and permanently. More than 1.7 million residents are already over age 60, and within the coming decade one in four residents will be an older adult. Those over age 85 represent the fastest-growing segment of the population. Increasingly, residents are living longer with chronic illness, cognitive impairment, mobility limitations, behavioral health needs, and caregiving responsibilities that directly shape state expenditures in MassHealth, housing, public health, emergency services, and long-term care.

These are not temporary pressures. They are structural conditions that will increasingly define the Commonwealth's fiscal landscape.

The enactment of Chapter 197 of the Acts of 2024 appropriately acknowledged that long-term care oversight, transparency, and accountability must evolve alongside demographic change. It created a critical framework for resident protection and system integrity. But Chapter 197 is a foundation—not a finish line. Statutory reform alone does not alter fiscal trajectories. Implementation requires workforce stability, enforcement capacity, behavioral health access,

community-based alternatives, and measurable outcomes. The budget is where those commitments either take operational form—or remain aspirational.

The FY 2027 General Appropriations Bill therefore represents more than continuation funding. It is the Commonwealth's opportunity to align appropriations with predictable cost drivers and proven cost-avoidance strategies associated with aging and caregiving.

Overwhelmingly, older adults and people with disabilities want to remain in their homes and communities. This preference is about dignity, autonomy, safety, and connection—but it is also sound fiscal policy. Community-based services are consistently more cost-effective than institutional care, reduce avoidable hospitalizations, and mitigate long-term MassHealth exposure. When upstream systems are underfunded or unstable, the downstream costs appear in emergency departments, shelters, psychiatric boarding, nursing facilities, and other high-cost settings.

In a constrained fiscal environment marked by modest revenue growth and uncertainty in federal funding streams, disciplined prioritization is essential. Dignity Alliance Massachusetts has approached its FY 2027 recommendations with that reality in mind. We do not propose broad expansion. Rather, we recommend targeted investments that stabilize lower-cost community systems, prevent avoidable institutionalization, enforce statutory standards where institutional care remains necessary, and protect the integrity of public spending.

In that context, we underscore the importance of the Behavioral Health Older Adult Partnership (BEHOAP) funded through line item 9110-1640. Community-based older adult behavioral health services prevent or delay nursing home placement, reduce emergency department utilization, and address untreated depression, anxiety, substance use, and dementia-related behavioral challenges that destabilize individuals and caregivers alike. Behavioral health is not ancillary to aging policy, it is central to it.

While there is strong merit in expanding BEHOAP statewide to meet growing demand, we recognize the current fiscal climate. At a minimum, we strongly urge that line item 9110-1640 not be reduced below the Governor's recommendation of \$2,455,303. Reductions would undermine service continuity in regions currently served, increase institutional and acute care costs, and reverse progress made in keeping vulnerable older adults safely in their communities.

The choice before the Legislature is not whether to incur costs associated with aging and disability—but whether to incur them proactively and strategically, or reactively and at greater expense. Aligning the FY 2027 budget with the realities of longevity, disability, and caregiving is not special interest advocacy. It is sound fiscal governance in the Commonwealth that is aging by success.

The decisions made in this budget cycle will shape whether Massachusetts continues to lead as a state where people can age with dignity, live safely with disabilities, and remain connected to their communities while protecting the Commonwealth's long-term fiscal stability.

We respectfully submit the following recommendations for your consideration.

PART I — LINE ITEM AMENDMENTS

(Ordered Numerically)

4000-0600 — Personal Needs Allowance (PNA)

Amendment Language

In line item 4000-0600, by striking the figure and inserting in place thereof a figure sufficient to increase the personal needs allowance for residents of nursing facilities to not less than \$100 per month; and provided further, that beginning July 1, 2027, the personal needs allowance shall be adjusted annually based on the consumer price index for all urban consumers (CPI-U).

Explanation of the Amendment

This amendment increases the Personal Needs Allowance (PNA) for nursing facility residents from \$72.80 per month to not less than \$100 per month and permanently indexes the allowance to inflation beginning January 1, 2027.

The current PNA level of \$72.80 is inadequate to meet even minimal personal expenses for residents of nursing facilities. The state supplemental payment amount has not been increased since FY2008. Over the past seventeen years, the cost of living has increased significantly due to cumulative inflation. Residents must use the PNA to purchase clothing, toiletries, shoes, personal hygiene supplies, haircuts, telephone access, over-the-counter items, modest social participation costs, and other basic personal necessities not covered by Medicaid.

The failure to adjust the PNA since FY2008 has resulted in a substantial erosion of purchasing power. When adjusted for inflation since 2008, the current \$72.80 monthly allowance would need to be significantly higher simply to maintain equivalent value. This amendment does not fully compensate for nearly two decades of inflationary loss; however, increasing the allowance to \$100 per month provides meaningful relief and establishes a structure to prevent further erosion going forward through automatic CPI indexing.

In 2025 alone, twelve states increased their supplemental Personal Needs Allowance rates for nursing home residents. Massachusetts was once in the top tier of states supporting nursing home residents through an adequate PNA. Today, the Commonwealth ranks approximately 24th among states. Adoption of this amendment would restore Massachusetts to the top tier of states in supporting its most vulnerable residents.

This amendment represents a modest but critical step toward correcting years of inaction and reaffirming the Commonwealth's leadership in long-term care policy.

Fiscal Note

Estimated FY27 impact: approximately \$6.5 million gross.
No federal Medicaid match is available for the state supplemental increase.

While this amendment increases direct state expenditures, the amount is modest in comparison to the overall long-term care budget and represents a targeted investment in resident dignity.

Why It Matters

The Personal Needs Allowance is the only discretionary income available to most nursing home residents. After their required contribution toward care costs, residents are left with the PNA to meet all personal needs. At \$72.80 per month, residents are expected to survive on approximately \$2.40 per day.

This level of support is inconsistent with the Commonwealth's values and undermines resident dignity. Residents should not be forced to choose between basic hygiene products and telephone access to family members.

Massachusetts has historically been a leader in long-term care policy. The Commonwealth was once among the highest-ranking states in PNA support but now ranks approximately 24th. Increasing the allowance to \$100 per month and indexing it to inflation moves Massachusetts back toward the top tier of states that protect their most vulnerable citizens.

Although this amendment does not fully restore the lost purchasing power since FY2008, it establishes a forward-looking mechanism that prevents future erosion and signals a renewed commitment to dignity, fairness, and responsible policy.

4000-0601 — Personal Care Attendant (PCA) Program Protection

Amendment Language

Amend the bill in Section 2, in item 4000-0601, by striking the following words:-
“... provided further that, the executive office of health and human services shall convene and consult with the PCA working group established under item 4000-0601 of section 2 of chapter 140 of the acts of 2024 to identify savings in addition those identified in the November 28, 2025 report to effectuate a gross amount of spending consistent with the appropriation included herein; provided further that, not less than 30 days after the effective date of this act, after convening said group, the executive office shall provide an implementation plan to ensure spending

consistent with this appropriation to the secretary of administration and finance and the house and senate committees on ways and means...;”

And further amend said item by inserting after the words “MSP expanded program eligibility” the following words: -

“... provided further that the executive office of health and human services shall implement the consensus savings recommendations of the PCA working group established under item 4000-0601 of section 2 of chapter 140 of the acts of 2024 and as identified in the group’s November 28, 2025 report; provided further the executive office of health and human services shall convene and regularly consult with the PCA working group to develop additional savings recommendations; provided further that additional PCA program savings recommendations shall be implemented only upon the consensus recommendation of the PCA working group and that the personal care attendant program shall otherwise maintain the same eligibility criteria and level of services in fiscal year 2027 as were available in fiscal year 2026;...”

Explanation of the Amendment

This amendment rejects the Governor’s proposed \$68 million in additional unilateral cuts beyond the \$32 million in consensus savings already recommended by the PCA Working Group.

The amendment ensures that:

- Only consensus-based savings developed through the PCA Working Group process are implemented.
- The Executive Office of Health and Human Services continue to convene and consult with the PCA Working Group;
- Additional savings beyond those already identified may only be implemented upon consensus recommendation; and
- Eligibility criteria and service levels in FY2027 remain consistent with FY2026.

Fiscal Note

Avoids \$68 million in additional unilateral reductions.

Maintains \$32 million in consensus savings.

Preserves federal Medicaid matching revenue.

Prevents cost-shifting to more expensive institutional settings.

Why It Matters

The PCA program serves approximately 50,000 seniors and people with disabilities and employs more than 60,000 PCAs statewide. It is more cost-effective than nursing facility placement and prevents unnecessary hospitalization and institutionalization. Unilateral reductions risk destabilizing the workforce and increasing long-term MassHealth expenditures.

4510-0100 — High-Risk Nursing Facility Oversight Transparency

Amendment Language

In line item 4510-0100, by adding the following words: -

provided further, that not less than \$500,000 shall be expended for the establishment, implementation, and ongoing administration of a High-Risk Nursing Facility Oversight Watch List; provided further, that the department of public health shall establish and maintain a quarterly High-Risk Nursing Facility Oversight Watch List identifying nursing facilities licensed pursuant to section 71 of chapter 111 of the General Laws that demonstrate repeated serious deficiencies, patterns of noncompliance, substandard quality of care, enforcement actions, receivership, substantial civil monetary penalties, significant staffing instability, or other objective indicators of elevated risk to resident health and safety; provided further, that the watch list shall be updated not less than quarterly and published in a conspicuous location on the department's publicly accessible website; provided further, that any facility included on the watch list shall provide written disclosure of its status to any prospective resident or the resident's legal representative prior to admission and shall obtain written acknowledgment of such disclosure; provided further, that the department shall promulgate regulations establishing objective criteria for inclusion on and removal from the watch list; and provided further, that the department shall submit an annual report summarizing watch list activity, corrective actions, and outcomes to the house and senate committees on ways and means and the joint committee on public health not later than March 1 of each year.

Explanation of the Amendment

Massachusetts is experiencing increasing nursing facility closures, ownership transfers, and consolidation — often involving complex ownership structures and investor-driven entities. In financially distressed or aggressively leveraged facilities, staffing reductions are frequently the first cost-containment measure. Staffing instability is strongly correlated with substandard care, increased deficiency citations, preventable hospitalizations, and adverse resident outcomes.

Under the current regulatory framework, the Department of Public Health (DPH) primarily operates in a reactive posture. Intervention typically occurs after:

- Serious deficiencies are cited;
- Enforcement actions escalate;
- Ownership transfer is proposed; or
- Closure or receivership becomes imminent.

By the time these events occur, residents and staff may already face disruption or harm.

This amendment establishes a proactive oversight structure by directing DPH to create and maintain a High-Risk Nursing Facility Oversight Watch List supported by a dedicated minimum appropriation of \$500,000 within line item 4510-0100.

The Watch List would:

- Identify facilities demonstrating patterns of serious or repeated deficiencies;
- Incorporate objective risk indicators including staffing instability and enforcement history;
- Be updated quarterly;
- Be publicly accessible;
- Require disclosure to prospective residents and families prior to admission;
- Include annual legislative reporting on outcomes and corrective actions; and
- Be governed by objective regulatory criteria for inclusion and removal.

The Watch List is not punitive. It is an early-warning transparency and stabilization mechanism. Its purpose is to allow regulators, policymakers, residents, families, and local communities to identify facilities exhibiting patterns of elevated risk before crisis, closure, or receivership occurs.

By allocating a defined amount within the existing line item, this amendment ensures that DPH has sufficient dedicated resources to integrate inspection data, enforcement history, staffing reports, and ownership information into a structured, transparent oversight tool.

Fiscal Note

Minimum allocation within line item 4510-0100: **\$500,000.**

This funding supports:

- Data integration and analytics;
- Public reporting infrastructure;
- Regulatory development;
- Ongoing monitoring and quarterly updates;
- Annual reporting to the Legislature.

The administrative cost is modest relative to the overall long-term care budget and leverages existing inspection, staffing, and enforcement data systems.

Potential fiscal benefits include:

- Earlier intervention preventing facility collapse or emergency receivership;
- Reduced likelihood of abrupt closures requiring costly state-managed transitions;
- Decreased emergency relocation expenses;

- Reduced avoidable hospitalizations linked to deteriorating facility conditions;
- Stabilization planning before financial distress escalates.

The cost of a single extended receivership or emergency relocation event can exceed the annual administrative cost of this Watch List. Preventing even one major crisis event could offset multiple years of funding.

This amendment represents a modest but strategic investment in proactive oversight that may reduce long-term fiscal exposure.

Why It Matters

Residents of nursing facilities are among the Commonwealth's most medically fragile and vulnerable individuals. Many are cognitively impaired, mobility-limited, and entirely dependent on continuity of care.

When facilities experience financial instability, staffing reductions, or rapid ownership changes, residents face heightened risk. Sudden closures or deterioration in quality can result in:

- Forced relocations far from family and community;
- Disruption of established caregiver relationships;
- Increased hospitalization;
- Accelerated health decline;
- Workforce displacement.

Families often lack timely, accessible information about a facility's regulatory history or emerging risk patterns. A structured, publicly accessible Watch List improves transparency and strengthens informed decision-making.

This amendment shifts the Commonwealth from reactive crisis management to proactive risk identification.

It:

- Elevates transparency;
- Encourages corrective action before collapse;
- Signals regulatory attention early;
- Protects residents from preventable harm;
- Strengthens public confidence in long-term care oversight;
- Safeguards taxpayer investment in Medicaid-funded facilities.

In an environment of accelerating ownership change and financial stress within the nursing home sector, proactive oversight is essential.

The Commonwealth should not wait for crisis, receivership, or tragedy before acting. This amendment ensures that Massachusetts anticipates risk rather than merely responding to failure.

9110-0650 (*new line item*)—Limited Frail Elder Waiver

Line Amount: \$122,000,000 (note this is a maximization initiative. As a result of increased FFP Revenue, the new line item will yield a net gain of at least \$38,000,000 to the General Fund)

Amendment Language

For health care services provided to MassHealth members who are older adults eligible for community-based waiver services; provided, that such services shall be provided to members participating in a new MassHealth waiver established during calendar year 2026 and titled “Limited Frail Elder Waiver” and approved under 1915(c) of the Social Security Act; provided that the waiver shall serve as a pathway to, and operated in coordination with, the Frail Elder Waiver that is enabled in item 9110-0600; provided that no expenditures from this item shall be authorized until after a Frail Elder Waiver Limited program is approved; provided further that funds may be expended from this item for health care services provided to recipients in prior fiscal years; provided further, that the financial eligibility requirements shall be less restrictive than the Frail Elder Waiver and shall leverage state policy flexibilities clarified by CMS State Medicaid Director Letter SMD #21 004 which permit states to tailor financial eligibility rules for HCBS populations without altering institutional eligibility standards; provided further that the resource limit for the Frail Elder Waiver Limited program shall be no less than \$130,000; provided further, that the Frail Elder Waiver Limited program shall elect to implement an individual cost limit on combined waiver and state plan services; provided further, that for “waiver year one” of the Frail Elder Waiver Limited program the individual cost limit shall be established at no less than \$1,300 per month; provided further, that the target population of the Frail Elder Waiver limited program shall reserve capacity to first enroll individuals in the state home care program who are either participating in or waitlisted for the ECOP program; provided further, that in addition to the Frail Elder Waiver Limited program being constrained by a maximum number of unduplicated participants served throughout a waiver year, there shall be a point-in-time limitation of participants who may be served in a month; provided further, that the Secretary of Aging and Independence shall be granted substantial deference for establishing point-in-time participant limitations to ensure the limitation level allows for both the maximum transition of ECOP-eligible consumers and the reasonably expected demand for the waiver outyears; provided further, that the secretary of administration and finance shall reduce the amount available in item 9110-1630 by an amount equivalent to 75% of the net cost of services that are reimbursed from this item; provided further, that the secretary of administration and finance shall reduce the amount available in item 9110-1633 by an amount equivalent to 25% of the net cost of services that are reimbursed from this item.

Explanation of the Amendment

The Enhanced Community Options Program (ECOP) is presently a non-Medicaid State Home Care program operated by the Executive Office of Aging & Independence (AGE). ECOP serves low-income older adults who are clinically eligible for a nursing facility placement. Because consumers have a higher care complexity, the ECOP program offers a higher intensity of services than the traditional Basic home care program operated by AGE. Beginning in January 2025, AGE capped ECOP enrollment and began waitlisting clinically qualifying consumers. In January 2025, the program supported 9,283 consumers; in January 2026, program enrollment is capped at 5,374, a 42% reduction from the prior year level.

Relatively recent policy tools made available by CMS create an opportunity to convert most traditional ECOP utilization into Medicaid-reimbursable activity. Prudent application of these policy tools will result in qualifying health care expenditures generating Federal Financial Participation (FFP) revenue with a federal match rate of 50%.

Based on September 2025 AGE Home Care Program census and reported participant income levels, it is estimated that 6,919 ECOP-qualifying consumers can be converted to a new 1915(c) program, tentatively titled “Limited Frail Elder Waiver”. All clinically qualifying consumers will appropriately have access to an enhanced service plan. This includes income-eligible consumers from the September waitlist of 836 individuals.

The amendment language is admittedly complex, but it does prescribe how to successfully apply the CMS policy tools in a manner to generate an estimated \$54.6M per year in FFP revenue; yielding an estimated net savings to the General Fund of \$38.5M per year.

The amendment language does place significant restrictions on expenditure authority to ensure the initiative nets positive to the General Fund.

It is emphasized that this initiative will generate a \$38.5M net surplus to the General while eliminating the ECOP waitlist. This initiative is serving the same consumers that are assumed in the Governor’s FY27 Recommendation, while at the same time providing all qualifying consumers with access to appropriate service plans.

Dignity Alliance further advocates for the net savings to be re-invested into the elder care services portfolio to cure the waitlist of the Basic State Home Care program.

Interested readers are encouraged to review the Dignity Alliance Policy Memo prepared by Peter Tiernan titled “Optimizing the State Home Care Program and Eliminating Waitlists” (copy attached).

Fiscal Note

Gross State Investment: Relative to the Governor’s FY27 Recommendation, it is estimated that 6,919 average monthly ECOP consumers will be associated to +\$15.1M in additional outlay.

Of these 6,919 consumers, 6,227 are projected to qualify for a new 1915(c) Waiver, “Limited Frail Elder Waiver”. Eligible health care expenditures are estimated to generate \$53.6M in new FFP Revenue.

Estimated Net State Cost: Due to the new FFP revenue, this initiative will have a net positive effect on the General Fund. When expressed in terms of new cost, it is estimated at -\$38.5M. Alternatively stated, the item is a \$38.5 cost savings initiative.

Cost Avoidance Impact: In addition to the \$38.5M in cost savings, this initiative will generate cost avoidance in the form of both delayed nursing facility placement, and delayed enrollment in the traditional Frail Elder Waiver. Deference is given to AGE to suggest a cost avoidance estimate. Dignity Alliance does raise awareness of a 2/1/18 report from AGE to House & Senate Committees on Ways and Means that opines on most substantial cost avoidance attributable to the state home care program.

Why It Matters

Preserves Dignity and Independence

This initiative preserves the long-standing Massachusetts social contract as reflected in the ECOP program to offer low-income seniors with a nursing facility level-of-care need to be able to access service plans offering an appropriate level of service intensity. It cures the ECOP waitlist that has been steadily accruing ever since AGE announced it was waitlisting consumers in January 2025.

This initiative improves the proposition for low-income seniors to successfully age in place.

Reduces Institutional Pressure

Massachusetts nursing facilities are experiencing closures, staffing shortages, and financial instability. Preventing unnecessary admissions protects both residents and system capacity.

Aligns Fiscal Responsibility with Humane Policy

Community-based stabilization is significantly less expensive than hospital or long-term care placement.

This amendment reflects fiscally responsible Medicaid management while strengthening humane care policy.

Maximizes Federal Participation

Requiring EOHHS and AGE to maximize Medicaid reimbursement ensures that the Commonwealth draws down available federal dollars rather than relying solely on state funds.

Leveraging federal resources reduces net state exposure and increases return on investment.

Bottom Line

This amendment is both a sound Medicaid strategy and a reaffirmation of Massachusetts' commitment to community-based aging.

PART II — OUTSIDE SECTIONS

SECTION XX — Two-Resident Room Maximum

Amendment Language

SECTION XX. Section 72 of chapter 111 of the General Laws is hereby amended by inserting the following subsection:-

“No skilled nursing facility licensed under this section shall house more than two residents in a single bedroom; provided, however, that facilities shall comply with this requirement for any new construction, substantial renovation, or change of ownership occurring after July 1, 2027.”

Explanation of the Amendment

Establishes a statutory maximum of two residents per bedroom in skilled nursing facilities.

Fiscal Note

No direct state appropriation impact. Implementation costs borne by facilities during renovation or new construction.

Why It Matters

Multi-bed rooms contributed to rapid disease transmission during COVID-19. Limiting occupancy improves infection control, privacy, and dignity.

SECTION XX — Assisted Living Affordability Task Force

Amendment Language

SECTION XX. There shall be a special commission to study assisted living affordability in the commonwealth.

(a) The commission shall consist of: the secretary of elder affairs or designee, the executive director of the Center for Health Information and Analysis or designee, the house and senate chairs of the joint committee on aging and independence, one representative of assisted living operators, one representative of consumer advocacy organizations, one representative of housing advocates, and one member appointed by the governor with expertise in health care finance.

(b) The commission shall study affordability barriers, rate structures, public subsidy options, workforce costs, and resident financial protections.

(c) The commission shall file a report that shall not be limited only to consensus recommendations to the house and senate committees on ways and means and the clerks of the house and senate not later than December 31, 2027.

Explanation of the Amendment

Creates a structured policy commission to address rising assisted living costs and financial access barriers.

Fiscal Note

Minimal administrative cost. No new programmatic spending required.

Why It Matters

Assisted living is increasingly unaffordable for moderate-income seniors. Structured analysis ensures data-driven policy reform.

SECTION XX — Board of Assisted Living Residence Managers

Amendment Language

SECTION XX. Chapter 19D of the General Laws is hereby amended by inserting the following section:-

Section ____. Board of Assisted Living Residence Managers.

- (a) There shall be established within the executive office of aging and independence a board of assisted living residence managers.
- (b) The board shall establish licensure standards, professional qualifications, continuing education requirements, and disciplinary procedures for managers of certified assisted living residences.
- (c) The board shall consist of 7 members appointed by the governor for terms of five years, except that the first appointments shall be staggered so that only a portion shall expire in any one year. Member shall include one licensed assisted living manager, one geriatric health professional, one consumer representative, one housing specialist, and three public members not currently affiliated with the assisted living industry or for the past ten years.
- (d) The board shall be fee-supported through licensure and renewal fees sufficient to offset administrative costs.

Explanation of the Amendment

Creates a professional licensing structure for assisted living managers to ensure leadership accountability and competency.

Fiscal Note

Fee-supported. Net neutral to the General Fund.

Why It Matters

Assisted living managers oversee resident safety, medication management, and emergency response. Professional licensure elevates standards and strengthens accountability.

SECTION XX — Annual Long-Term Care Transparency Report

Amendment Language

SECTION XX. The executive office of health and human services shall annually submit to the house and senate committees on ways and means and publish publicly a consolidated long-term care transparency report with individual reports for each facility.

The report shall include:

- (a) Total expenditures by service category and individually for nursing facilities, assisted living subsidies, home- and community-based services, and supplemental payments.
- (b) Staffing levels, turnover rates, and hours per resident day for nursing facilities, provided, however, that no facility shall provide less than 3.58 hours per resident day unless increased by regulation, in order to maintain a valid license.
- (c) Enforcement actions, deficiency citations, receiverships, and civil monetary penalties.
- (d) Ownership structures, including parent entities and related party transactions.
- (e) Supplemental payment distributions and associated quality metrics.

The report shall be filed not later than March 1 of each year.

Explanation of the Amendment

Requires comprehensive annual reporting to ensure fiscal, quality, and ownership transparency across the long-term care continuum.

Fiscal Note

Minimal administrative cost using existing data systems.

Why It Matters

Legislative oversight requires clear, consolidated reporting. Transparency supports data-driven budgeting and improves public trust.

SECTION XX — Audit of Nursing Facility Direct Care Spending Compliance

Amendment Language

SECTION XX. Chapter 118E of the General Laws is hereby amended by inserting after section 70 the following section:-

Section 70A. Audit of Nursing Facility Direct Care Spending Compliance.

(a) The executive office of health and human services, in consultation with the office of the state auditor, shall conduct or cause to be conducted annual audits of nursing facilities participating in the MassHealth program to ensure compliance with all statutory and regulatory requirements governing direct care spending, staffing expenditures, and related-party financial transactions.

(b) Such audits shall examine, at a minimum:

- (i) Compliance with direct care spending requirements and percentage thresholds established by law;
- (ii) Expenditures for nursing, certified nurse aide staffing, and other resident care services;
- (iii) Administrative, management, and consulting fees;
- (iv) Related-party transactions, including payments to parent entities, real estate affiliates, management companies, staffing agencies, and other affiliated entities;
- (v) Allocation methodologies used to classify expenses as direct care or non-direct care; and
- (vi) Any distributions, dividends, or transfers to owners or affiliated entities.

(c) The executive office shall prioritize audits of facilities identified as high-risk based on patterns of deficiencies, enforcement actions, staffing instability, or inclusion on the High-Risk Nursing Facility Oversight Watch List.

(d) The executive office shall publish annually, not later than March 1, a public report summarizing audit findings, instances of noncompliance, corrective actions taken, enforcement measures imposed, and any recoupment of funds.

(e) The executive office shall promulgate regulations to implement this section, including standards for audit methodology, documentation requirements, and corrective action procedures.

Explanation of the Amendment

Massachusetts law requires that a defined percentage of nursing facility revenue be spent on direct resident care. These requirements were enacted to ensure that public Medicaid funding is used primarily for staffing and services that directly benefit residents.

However, enforcement of direct care spending requirements requires rigorous and transparent financial oversight.

Nursing facilities frequently operate within complex ownership and corporate structures. Payments may flow between related entities for:

- Real estate leases;
- Management fees;
- Consulting arrangements;
- Staffing agency contracts;
- Administrative services;
- Parent company distributions.

Without structured auditing, it can be difficult to determine whether expenditures classified as “direct care” reflect actual staffing and resident services or whether funds are being diverted to related-party arrangements that reduce staffing adequacy.

This amendment establishes a statutory requirement for annual audits of nursing facility direct care spending compliance. It strengthens financial accountability by:

- Requiring examination of related-party transactions;
- Reviewing classification of expenditures;
- Identifying misallocation of funds;
- Prioritizing high-risk facilities;
- Publishing findings for transparency;
- Enabling corrective action and potential recoupment.

The amendment does not create new spending requirements for facilities. Rather, it ensures that existing statutory spending mandates are verified and enforced.

The inclusion of coordination with the Office of the State Auditor strengthens independence and public credibility.

Fiscal Note

Administrative costs associated with annual audits will depend on scope and sampling methodology.

Estimated annual cost: approximately \$750,000–\$1,000,000, depending on audit intensity and use of contracted financial auditors.

These costs may be partially offset by:

- Recoupment of funds found to be improperly classified or spent in violation of statutory requirements;
- Reduction in future enforcement and receivership costs through earlier detection of financial instability;
- Improved compliance resulting in reduced need for corrective enforcement actions.

Potential fiscal benefits include:

- Greater assurance that Medicaid funds are directed toward resident care;
- Improved staffing stability;
- Reduction in avoidable hospitalizations linked to understaffing;
- Deterrence of improper financial structuring;
- Protection of taxpayer investment.

Even modest recoupment actions or prevention of misuse of funds could offset audit costs.

Why It Matters

MassHealth is one of the largest payors for nursing facility care in the Commonwealth. Taxpayer dollars fund the majority of resident days in many facilities.

When funds intended for direct resident care are diverted into excessive administrative fees, inflated related-party transactions, or owner distributions, the consequences are immediate:

- Lower staffing levels;
- Increased staff turnover;
- Higher rates of falls, infections, and pressure injuries;
- Increased hospitalization;
- Decline in resident safety and dignity.

Direct care spending laws were enacted to ensure that Medicaid funding translates into adequate staffing and resident care. Without structured auditing, those protections risk becoming symbolic rather than operational.

This amendment:

- Reinforces the integrity of direct care spending requirements;
- Protects residents from the consequences of financial misallocation;
- Protects staff from chronic understaffing;
- Protects taxpayers from misuse of public funds;
- Increases public confidence in long-term care oversight.

In an era of increasing ownership complexity, private equity involvement, and multi-layered corporate structures, financial transparency is essential.

Residents and families assume that public funding meant for care is actually spent on care. This amend ensures that assumption is verified through objective audit oversight.

It strengthens accountability, fiscal responsibility, and the Commonwealth's commitment to ensuring that public dollars produce measurable improvements in resident safety and quality of care.

SECTION XX. Veterans Connected Communities and Small-House Care Demonstration Program

Notwithstanding any general or special law to the contrary, there shall be established within the Executive Office of Veterans' Services a Veterans Connected Communities and Small-House Care Demonstration Program to develop and implement a regional program of small-house, non-institutional residential care and supportive housing models for veterans who are clinically eligible for nursing facility level of care.

The Executive Office of Veterans' Services, in cooperation with the Office of the Veterans' Advocate, shall develop a plan to identify regions of the Commonwealth with significant concentrations of aging veterans and assess projected long-term care needs. The program shall prioritize the development of small-home models in such regions to allow veterans to receive long-term services and supports in community-based, home-like settings rather than large institutional facilities.

Eligible uses of funds shall include predevelopment costs, capital construction and renovation, technical assistance, service coordination, and the braiding of federal, state, municipal, and private funding sources. Capital expenditures may be funded through previously authorized bond proceeds, including funds authorized by the Legislature in 2021, totaling \$200,000,000, for veterans' home redevelopment and related capital purposes, including but not limited to funds associated with the Holyoke Soldiers' Home redevelopment.

The Executive Office shall report to the Joint Committee on Ways and Means and the Joint Committee on Veterans and Federal Affairs not later than December 31, 2026 on program design, regional siting recommendations, capital financing strategies, projected operating costs,

anticipated MassHealth savings, and recommended statutory changes necessary to scale the model statewide.

Explanation of the Amendment

This amendment directs the Executive Office of Veterans' Services, in cooperation with the Office of the Veterans' Advocate, to develop and implement a regional demonstration program of small-house long-term care homes for veterans who meet nursing home level-of-care criteria.

Rather than concentrating veterans in large institutional settings, the program would establish smaller, home-like residences integrated within communities where large numbers of aging veterans already reside. The model would align housing, health services, behavioral health supports, and long-term services and supports in a coordinated, community-based environment.

The amendment leverages capital authority already authorized by the Legislature in 2021, including up to \$200,000,000 in bond funding, thereby enabling development without new borrowing authorization. It also requires a formal implementation and savings report to the Legislature to ensure accountability and scalability.

Fiscal Note

Capital Funding Source:

The program may utilize previously authorized bond proceeds, including funds within the \$200,000,000 capital authorization enacted in 2021 for veterans' home redevelopment and related projects. No new borrowing authorization is required.

Operating Impact:

While operating costs will depend on final design and siting, small-house models typically demonstrate lower per-resident operational instability and improved staffing retention compared to traditional large institutions.

MassHealth Savings Potential:

By creating community-based small homes for veterans who are currently or prospectively supported through MassHealth-funded nursing facility placements, the Commonwealth may reduce long-term Medicaid expenditures. Avoiding or shortening institutional placements can generate ongoing savings in MassHealth long-term care spending.

Net Fiscal Impact:

Primarily a capital reallocation strategy utilizing existing authorization; potential long-term MassHealth savings through reduced institutional utilization.

Why It Matters

Massachusetts has learned painful lessons about the vulnerability of large congregate veterans' facilities. Small-house models—typically housing 8–12 residents—consistently demonstrate:

- Stronger infection control outcomes
- Greater staffing stability and lower turnover
- Improved resident satisfaction and quality of life
- Reduced hospitalization and transfer rates

For veterans, the need is especially acute. Many aging veterans prefer to remain close to family and familiar communities. Yet access to veterans' long-term care options is often geographically limited, forcing relocation far from home or reliance on MassHealth-funded civilian nursing facilities.

Developing a regional network of small veterans' homes would:

- Allow veterans to age in place near their home communities.
- Reduce reliance on institutional nursing homes funded through MassHealth.
- Leverage existing capital authorization without new debt.
- Create a scalable model for future veterans' housing investments.
- Integrate housing, health care, and supportive services in a coordinated framework.

This amendment aligns fiscal prudence with moral responsibility. It builds on existing legislative authorization, advances community-based care, and ensures that those who served the Commonwealth and the nation can age with dignity, safety, and connection.

By investing strategically in small-house veterans' homes, Massachusetts can lead once again in veteran-centered innovation while protecting both public dollars and public trust.

SECTION XX. Department of Public Health — Public Hearing Transparency

Amendment Language

SECTION XX. Section 20 of chapter 30A of the General Laws, as most recently appearing in the 2024 Official Edition, is hereby amended by inserting after section 1D the following section:

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Section 1E. The Department of Public Health shall hold a public hearing at the request of one or more citizens relative to the application, sale, transfer, closure, or receivership of a licensee to operate a skilled nursing facility or nursing home licensed under section 71 of chapter 111.

The hearing shall be advertised on the website of the department and on the website of the facility or facilities not less than fourteen (14) days prior to the date set for the public hearing.

Every hearing conducted pursuant to this section shall be conducted in a hybrid manner, both in-person and through virtual means accessible to the public.

The licensee shall make a good faith effort to notify any current resident, the resident's authorized representative or caregiver, and family representative, if any, in advance of the hearing.

Explanation of the Amendment

This amendment strengthens transparency and public accountability in licensing actions involving skilled nursing facilities and nursing homes regulated by the Massachusetts Department of Public Health under section 71 of chapter 111.

Currently, a telephonic hearing is permitted at the discretion of the department after a request signed by ten registered voters.

significant transactions — including sales, transfers of ownership, closures, and receiverships — may proceed with limited public visibility and without a guaranteed opportunity for residents, families, staff, or community members to provide input.

This amendment:

- Requires a public hearing upon request of one or more citizens.
- Mandates at least 14 days' public notice on both the Department and facility websites.
- Requires hearings to be conducted in hybrid format (in-person and virtual).
- Ensures residents and their authorized representatives are notified in advance.

The amendment creates a clear statutory right to public engagement before major changes affecting resident care and facility operations occur.

Fiscal Note

Estimated Fiscal Impact: Minimal

- Administrative costs associated with scheduling and conducting hearings are expected to be modest and absorbable within existing departmental resources.
- Hybrid hearing platforms are already widely used by state agencies, limiting additional technology costs.
- Notice requirements rely on existing agency and facility websites.

No new programmatic spending or personnel line items are required.

Why It Matters

Nursing home residents are among the Commonwealth's most medically vulnerable citizens. Decisions involving facility ownership transfers, closures, or receivership can directly impact:

- Continuity of care
- Staffing levels
- Quality and safety outcomes
- Financial stability of the facility
- Resident displacement risks

Ownership changes, particularly involving private equity or complex corporate structures, can materially alter how facilities are operated. Without structured public input, residents and families often learn of changes after key decisions have already been made.

This amendment ensures:

- Transparency before irreversible decisions occur.
- Meaningful participation by residents and families
- Public accountability in transactions affecting publicly funded care
- Early identification of community concerns
- Greater trust in the regulatory process

By guaranteeing an accessible public forum, the Commonwealth affirms that nursing home residents are not passive occupants of licensed facilities, but individuals whose homes, health, and dignity are directly affected by these decisions.

This is a low-cost reform with high public value, reinforcing the Commonwealth's commitment to transparency, accountability, and resident-centered long-term care governance.