LONG-TERM CARE FOR THE ELDERLY IN THE DISTRICT OF COLUMBIA

Issues and Prospects

JOSHUA M. WiENER AND DAVID G. STEVENSON
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Joshua M. Wiener
David G. Stevenson
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## Contents

**Background** ................................................................. 2

**Agencies** .............................................................................. 5
  - D.C. Office on Aging ......................................................... 5
  - Medical Assistance Administration of the Department of Health  7
  - State Health Planning and Development Agency of the
    Department of Health ...................................................... 8
  - Licensing Regulation Administration of the Department of Health 8
  - Adult Protective Services of the Department of Human Services 8

**Policy Development and Implementation** ............................... 9

**Home- and Community-Based Services.** ............................... 11
  - District-Funded Home Care Services .................................. 11
  - Home Health, Personal Care, and Adult Day Care .................. 12
  - Medicaid Home- and Community-Based Services Waiver ........ 14
  - Case Management/Level-of-Care Determination .................... 16
  - Nonmedical Residential Care Facilities .............................. 18

**Nursing Homes** ..................................................................... 20
  - Nursing Home Reimbursement ......................................... 20
  - Certificate of Need and the Supply of Long-Term Care Providers 23
  - Quality of Care in Community Residence Facilities and Nursing
    Homes ............................................................................. 25

**Other Issues** ......................................................................... 28
  - D.C. Office on Aging ......................................................... 28
  - Adult Protective Services .................................................. 29

**The Road Not Taken: Other Possible Initiatives** ...................... 30
  - Maximizing Private Contributions for Long-Term Care ........ 30
  - Medicare Maximization ...................................................... 31
  - Integrating Acute and Long-Term Care through Managed Care 31

**Challenges for the Future** .................................................. 31

**List of People Interviewed or Who Provided Information** ........ 39

**About the Authors** ............................................................ 41
Long-Term Care for the Elderly in the District of Columbia: Issues and Prospects

ike the rest of the United States, the District of Columbia spends a substantial portion—nearly a fifth—of its Medicaid budget on long-term care for the elderly. Compared with the 50 states, however, the District faces special challenges in meeting the needs of the disabled elderly. The District’s older population has a higher proportion of low-income people and African Americans than the older population of the 50 states. The District is not quite a state—it lacks the size, geographic diversity, and broad fiscal base characteristic of most states—and it is also distinct from other cities in the governmental responsibilities that it assumes. In addition, decisionmaking in the District, as the nation’s capital, has always been complicated, in part because of the involvement of Congress and the federal executive branch. The transfer of most government functions in 1995 from the mayor and the city council to a federally appointed control board has made policy development and implementation even more complex.

Although the context of long-term care policy in the District of Columbia is unique, local policymakers must address the same issues of cost containment and delivery system reform that shape reform efforts in the states. This paper presents an overview of long-term care for the elderly in the District and the major issues that policymakers are addressing in the late 1990s. This analysis is part of a larger study conducted by the Urban Institute to assess health care in the District. The information included in this paper was collected in 1998 from public documents and interviews with representatives of District agencies, long-term care providers, advocates for the elderly, and experts. To encourage candor in the interviews, respondents were told that no one would be quoted by name. Wiener, the senior author, was co-chair of the Long-Term Care, Elderly, and Adult Protective Services Subcommittee of the Human Services Action Group of Mayor Anthony Williams’ transition
effort. In that capacity, the senior author interviewed a number of knowledgeable individuals. He is also a member of the Long-Term Care Committee of the Mayor’s Health Policy Council, where he has been involved in home care and nursing home issues, especially certificate-of-need standards for nursing homes.

The first section of this paper presents background information on the elderly population, the supply of nursing homes and other providers, and Medicaid expenditures. The next section briefly describes the principal agencies involved with long-term care in the District. The next five sections of the paper analyze issues related to policy development and implementation, home- and community-based services, nursing homes, and other topics, including the D.C. Office on Aging and Adult Protective Services in the Department of Human Services. The paper concludes by examining the District of Columbia’s challenges for the future in organizing, financing, and assuring quality of care in long-term care for the elderly.

Background

The total population in the District was 528,964 in 1997, of which 73,375 were ages 65 or older (table 1). The District had a slightly higher proportion of elderly than the nation did (13.9 percent compared with 12.7 percent). Although the number of older people is expected to increase in virtually every state, the District’s elderly population is projected to fall by 12.4 percent between 1996 and 2002.

Reflecting its urban setting, the District of Columbia’s elderly population is quite different from those of the 50 states and the nation as a whole. In particular, minorities (especially African Americans) make up a much larger portion of the District’s elderly population than the national average—only one-third of the District’s elderly population is white, compared with nearly 90 percent nationwide. In addition, although the District has many upper-income residents, the older population in the District is much more likely to be low income than in the 50 states: Nearly 20 percent of the District’s elderly population is below the federal poverty level, almost twice the national average.
Characteristics of the long-term care market in the District are shown in table 2. In 1998, the District’s 23 nursing facilities (17 nonfederal, freestanding nursing facilities and 6 hospital-based or hospital-affiliated skilled nursing or sub-acute units) and 3,101 beds—123.1 beds per 1,000 elderly ages 75 and over—put the District below the national average of 131.3 beds per 1,000 elderly ages 75 and over. Moreover, approximately 15 percent of District Medicaid enrollees who use nursing home care live in facilities in Maryland and Virginia. The city is above the national average in its supply of licensed nonmedical residential care beds (known as community residence facilities in the District), with 62.4 beds per 1,000 elderly ages 75 and over compared with 54.8 beds per 1,000 elderly ages 75 and over nationwide. In addition, the city has several “naturally occurring retirement communities,” where individuals have aged in place, creating a substantial concentration of older residents. Finally, the District had 26 home health agencies in 1998.

TABLE 1  Demographic Characteristics and Potential Demand for Long-Term Care Services

<table>
<thead>
<tr>
<th>Total Elderly Population (000)</th>
<th>Elderly as Percentage of Total Population</th>
<th>Elderly Medicaid Enrollees (000)</th>
<th>Elderly Enrollees as Percentage of Total Enrollees</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>34,075</td>
<td>12.7</td>
<td>4,103</td>
</tr>
<tr>
<td>District of Columbia</td>
<td>73</td>
<td>13.9</td>
<td>10</td>
</tr>
</tbody>
</table>

Note: “Enrollees” include all individuals who sign up for Medicaid in the given fiscal year. Some enrollees may not use any services.

b. 1996. Urban Institute calculations based on Health Care Financing Administration 2082 Reports.


TABLE 2  Characteristics of the Long-Term Care System

<table>
<thead>
<tr>
<th>Licensed Nursing Facilities</th>
<th>Licensed Residential Care</th>
<th>Licensed Home Health Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Facilities</td>
<td>Total Beds</td>
<td>Beds/1000 75+</td>
</tr>
<tr>
<td>United States</td>
<td>17,806</td>
<td>1,819,901</td>
</tr>
<tr>
<td>District of Columbia</td>
<td>23</td>
<td>3,101</td>
</tr>
</tbody>
</table>

Because its population is lower income, a larger portion of the District of Columbia's population relies on Medicaid for health care than the national average. In 1996, an average of 10,000 elderly District residents were Medicaid eligibles (table 1). The proportion of elderly Medicare beneficiaries also eligible for Medicaid was nearly twice the national average in 1994 (23.9 percent compared with 12.5 percent). Still, in 1996, the proportion of Medicaid beneficiaries in the District who were elderly was below the national average (7.3 percent compared with 9.9 percent), which reflects the large number of nonelderly adults and children on the program. Even though a greater portion of elderly residents in the District are Medicaid enrollees than the national average, the high number of nonelderly enrollees in the District dwarfs the number of elderly enrollees.

Despite the lower proportion of Medicaid beneficiaries who are elderly, the proportion of overall Medicaid dollars for long-term care services was similar to the national average. This similarity results from the high long-term care spending per elderly enrollee in the District—$12,611 compared with $7,601 nationwide in 1996. Similarly, the District spends $1,800 per elderly resident on long-term care compared with $915 per elderly resident for the nation as a whole (table 3). Thus, spending levels are high.

In 1996, the District spent about $131 million for services for the elderly, about 21 percent of Medicaid expenditures. The vast majority of expenditures are for long-term care services. Almost all District Medicaid long-term care expenditures for the elderly were for institutional care in 1996; only 2.6 percent of Medicaid long-term care expenditures for the elderly were for home care, much less than the national average of 12.1 percent (table 3). In 1996,

<table>
<thead>
<tr>
<th>TABLE 3</th>
<th>Distribution of Medicaid Long-Term Care Expenditures for the Elderly, 1996</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total Long-Term Care for Elderly (000)</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>United States</td>
<td>31,189,168</td>
</tr>
<tr>
<td>District of Columbia</td>
<td>131,402</td>
</tr>
</tbody>
</table>

Source: Urban Institute calculations based on Health Care Financing Administration 64 and 2082 data.
Notes: Data do not include administrative costs, accounting adjustments, or the U.S. Territories. Totals may not add because of rounding. "ICF-MR" refers to intermediate care facilities for the mentally retarded. "Nursing Facility" refers to skilled nursing facilities/other intermediate care facilities.
about three-fourths of all Medicaid home care expenditures in the District were for home health, while personal care accounted for the remaining one-fourth. Medicaid long-term care expenditures for the elderly grew at an average rate of 3.4 percent annually in the District from 1990 to 1996—well below the national growth rate of 9.1 percent over the same period. Medicaid nursing home spending growth outpaced home care expenditures in the District during this same period (table 4).

### Agencies

Five main agencies address the long-term care and social needs of the elderly in the District of Columbia: the D.C. Office on Aging, the Medical Assistance Administration (Medicaid) of the Department of Health, the State Health Planning and Development Agency of the Department of Health, the Licensing Regulation Administration of the Department of Health, and Adult Protective Services of the Department of Human Services.

The Office on Aging is the District’s State and Area Agency on Aging as authorized by the federal Older Americans Act and D.C. Law 1-24. It is a small agency with a budget of about $18.2 million in fiscal year 1999, which has remained roughly constant in nominal terms over the past several years. The D.C. Office on Aging’s ability to effectively advocate for older persons depends heavily on the executive director’s position as a member of the mayor’s cabinet.

Most services it funds are delivered by private, nonprofit organizations, each of which provides private matching funds in the form of client contributions, fundraising, and donated space and services. Six lead agencies provide focal points throughout the city for assessing needs, targeting services, and responding to the public. The Office on Aging provides funding for the following programs:

- In-home and extended services for the homebound elderly, including visiting nurses, homemakers, home-delivered
### TABLE 4  Medicaid Long-Term Care Expenditures by Type of Service, 1990–1996

**Elderly Beneficiaries**

<table>
<thead>
<tr>
<th>UNITED STATES</th>
<th>Long-Term Care Expenditures (millions)</th>
<th>Average Annual Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SNF-ICF-Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ICF-MR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DISTRICT OF COLUMBIA</th>
<th>Long-Term Care Expenditures (millions)</th>
<th>Average Annual Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SNF-ICF-Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ICF-MR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Care</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Source:** Urban Institute calculations based on Health Care Financing Administration 1082 and HCAF 64 data.

**Note:** Data does not include disproportionate share hospital payments, administrative costs, accounting adjustments, or the U.S. Territories. Totals may not add because of rounding. "ICF-MR" refers to intermediate care facilities for the mentally retarded. "SNF-ICF" refers to skilled nursing facilities and other intermediate care facilities.
meals, telephone reassurance, heavy house cleaning, minor home repairs, geriatric day care, and respite aid.

- Transportation services for elderly to and from medical appointments, dialysis clinics, and personal business trips for public benefits.

- Community services, including senior wellness centers, congregate meals, counseling, health promotion, nutrition screening, socialization, literacy, transportation, a senior center for the homeless, and an emergency shelter.

- Supportive services, including case management and long-term care ombudsman advocacy.

- Special services, including special events during Older Americans month.

- Older workers employment and training programs.

The D.C. Office on Aging also oversees operation of the Washington Center for Aging Services nursing home and adult day center, although the funds for its operation do not appear in its budget.

The Medical Assistance Administration (also known as the Commission on Health Care Finance) operates the District’s Medicaid program, the federal-state health care program for the poor. Medicaid covers the following long-term care services that are used primarily by the elderly: nursing facilities, home health, personal care, and adult day health care. The District Medicaid program will begin operating a Medicaid home- and community-based services waiver for the elderly in 1999. In addition, Medicaid pays Medicare premiums and cost-sharing for the low-income elderly and covers certain acute care services (e.g., prescription drugs) that are not covered by Medicare. Elderly persons with incomes below the federal poverty level are eligible for Medicaid in the District. Despite a budget approaching $1 billion, Medicaid has only 68 staff members, including operations and auditing personnel.

*Medical Assistance Administration of the Department of Health*
The State Health Planning and Development Agency of the Department of Health is responsible for operation of the District’s certificate-of-need program and development of the state health plan. The State Health Coordinating Council, which is composed of government and nongovernment officials, advises the director. Until recently, the State Health Planning and Development Agency was an independent agency; even now, final decisions on certificate-of-need applications are made by the director of the agency rather than by the director of the Department of Health. Most new health providers must obtain a certificate of need before they can operate.

The Licensing Regulation Administration of the Department of Health licenses community residence facilities and nursing facilities and certifies nursing facilities and home health agencies for participation in Medicare and Medicaid. It is the primary quality-assurance authority for the District. Until 1998, these functions resided in the Department of Consumer and Regulatory Affairs rather than the Department of Health.

Funding for nursing facility quality assurance comes primarily from the federal government, while funding for community residence facilities comes from the District. Although understaffing for nursing home quality assurance is not a major problem, the Licensing Regulation Administration does not have adequate staff to license community residence facilities in a timely manner. Staff assigned to community residence facilities also must inspect child day care centers and adoption agencies.

Adult Protective Services is a branch of the Family Services Administration within the Department of Human Services. Its mission is to prevent or remedy neglect, abuse, and exploitation of vulnerable adults, as authorized by the Protective Services Act of 1984. The law requires that Adult Protective Services initiate investigations of life-threatening abuse within 24 hours of complaint receipt.

Over three-quarters of the population served are people over 60 years of age, although an increasing proportion of the caseload is made up of younger disabled adults, including those who are mentally ill or mentally retarded. Most of the older clientele are low-income females. The large majority of the clients live in the
community, although some complaints are received regarding nursing home and community residence facilities.

Policy Development and Implementation

The policy environment for long-term care is dominated by four factors. First, despite substantial spending on long-term care for the elderly and numerous problems in the organization and financing of services, long-term care for the elderly is not a high priority for District government, and this lack of attention has consequences for policy development. Policy issues relating to young children and their parents have a much higher profile, despite the fact that about two-thirds of Medicaid expenditures are for the elderly and younger persons with disabilities.

Second, responsibility for services for the elderly and long-term care is distributed across a substantial number of District agencies. Virtually every person interviewed noted that policy and implementation are highly fragmented and uncoordinated, and it is difficult to implement comprehensive solutions, which most parties believe is essential. Leadership on long-term care issues is lacking, and it is hard to hold anyone accountable. According to one observer, one consequence of the lack of coordinated action is that “no one really thinks about long-term care in a coordinated way—Medicaid thinks about its part, the Office on Aging thinks about its part, and so on.”

As with the rest of District government, the splintered political structure of the District has complicated the problems of accountability. Since 1995, the District of Columbia Financial Responsibility and Management Assistance Authority (the control board) has had the authority to make major fiscal and programmatic decisions regarding health and social service programs in the District. The control board is presidentially appointed and not directly accountable to the political process. In addition, informants agreed that the explicit objective of the control board is to make fiscal decisions in light of budgetary concerns rather than to promote any specific policy direction. While the control board is clearly powerful, the mayor and city
council have continued to be somewhat involved in health, income, and social services policy and implementation. Added to this complexity, of course, is the involvement of the U.S. Senate and House of Representatives and the federal executive branch. As a result, authority and accountability are remarkably diffuse, leaving individuals both inside and outside District government feeling uncertain about whom to lobby for change. A “policy vacuum” exists in long-term care as well as other issues. The election of Anthony Williams, former chief financial officer for the control board, as mayor is accelerating the return of authority to the mayor and city council, but the process is not yet complete.

Third, despite the involvement of the control board and many management consultant reports, problems with contracting, budgeting, personnel, and overall administrative capacity continue to make it difficult to develop and implement new initiatives. Certain decisions are made solely to avoid the contracting process; hiring additional personnel takes a very long time, even when they are fully budgeted. All the city agencies involved with long-term care report being understaffed. As a result, agencies often do not have the resources needed to solve problems. Reflecting on his initial entry into District government, the Medicaid director noted, “The District over the years had failed to invest in the staff or the information systems needed to run a big, complicated operation such as Medicaid. The District’s program covers 130,000 people, spends about $1 billion a year (one-fifth of the District’s budget), and processes more than 5 million medical and prescription claims. Yet the agency I inherited had no auditors, no reimbursement specialists, no computer experts, and an antiquated computer system. We were running Medicaid as if it were the corner grocery store.”

Fourth, in contrast to most states, where the nursing home industry is the dominant interest group on Medicaid issues, neither the District of Columbia Health Care Association (the nursing home association) nor the Capital Home Care Association (which recently merged with the Maryland National Capital Home Care Association) is viewed as particularly influential. Within long-term care, the nursing home association is more powerful than the home health association. Hospital interests play a much stronger role in setting the Medicaid agenda than they do in most states because many District hospitals are heavily dependent on Medicaid. Older people in the District are considered to be a
Home- and Community-Based Services

Despite the preference of disabled elderly to stay in their own homes and the large number of disabled older people in the community without services, long-term care spending for the elderly in the District is heavily tilted toward institutional care. In fact, a 1995 study ranked the District last after the 50 states in its progress toward home- and community-based services. There is broad consensus that attention must shift from institutional to home- and community-based care.

Complicating the movement to home- and community-based services is the demographic profile of the District’s elderly population. While home care might be a realistic care alternative for some nursing home residents, one nursing home administrator argued that many residents would have to establish a “home” first. In addition, several observers note that the District ranks first before the 50 states in the percentage of residents over the age of 65 who live alone and posit that these older persons might not have the informal supports necessary to make home care feasible. Moreover, the District’s nursing home residents tend to be more disabled than the national average, perhaps making home care a realistic option for a smaller proportion of District nursing home residents.

Until recently, the District of Columbia’s Department of Human Services operated a relatively large home care program, which provided homemaker and chore services to the disabled elderly. Financed by federal Social Services Block Grant and District government money, funding for the program has dwindled from more than $12 million (serving 2,600 individuals) in 1994 to less than $400,000 (serving fewer than 200 people with very minimal benefits) in 1998. Although advocates for the elderly say they tried...
“desperately” to save the program, their lobbying efforts met with “total failure.” District officials and home care representatives alike believe that the dramatic cutback in services occurred with almost no follow-up planning for individuals who lost services. Although a few clients were transferred to the Medicaid personal care program, most did not meet the program’s financial eligibility requirements.

Although it has only limited funds, the D.C. Office on Aging funds a variety of programs designed to expand the range and volume of home care services. Within its service network are 30 community-based, educational, and local government agencies operating more than 40 programs for seniors. But funding levels are low; the 1998 Office on Aging budget was below its 1991 budget. As a result, the quantity of almost all D.C. Office on Aging-supported services is projected to decline between FY 1997 and FY 1999.

The Office on Aging currently funds about $5.9 million in home care services, including the remains of the Department of Human Services In-Home Support Program, AL-CARE (for people with Alzheimer’s disease), and the Standing in the Gap project, which focuses on people with dementia who live alone. Crucial to the network are six “lead” agencies that act as community satellites and provide a wide range of social and health services throughout the eight wards of the city. The Office on Aging also funds agencies to do case management, providing assessment and care planning for people in need of services (see below).

As in most parts of the country, medically oriented home health care in the District is very heavily dominated by Medicare funding: 80 to 90 percent of home health revenues are from Medicare. Still, 1995 Medicare home health expenditures per beneficiary were lower than the national average—$288 per beneficiary compared with $395 per beneficiary nationally. The Department of Health is preparing new regulations to license home health agencies.

Despite coverage of personal care services (i.e., help with the activities of daily living, such as eating, bathing, and dressing), Medicaid expenditures for these services remain surprisingly low in the District of Columbia. Only about 300 (elderly and nonelderly) people receive services, even though beneficiaries are not required to have a nursing home level of disability and only a physician’s authorization is required. One government official speculated that
Medicaid personal care expenditures are not higher because services are limited to 20 hours per week (in contrast to New York, where individuals can receive personal care up to 24 hours a day in some instances). This limit will not apply to participants in the Medicaid home- and community-based services waiver (see below). Advocates for the elderly believe that the low expenditures reflect insufficient access to personal care services and contend that beneficiaries are unaware that the services are covered. Another barrier, which is not unique to the District, is Medicaid financial eligibility standards, which are believed to exclude a large percentage of people who need services but who have too much income or too many assets to qualify.

Over the past few years, the personal care program has been substantially restructured. Personal care aides, who contracted directly with Medicaid, sued to be considered District employees. They won their suit, which would have increased their wages substantially, but their victory was short-lived. Soon after the court decision, the District terminated all personal care aides and now relies solely on Medicare-certified home health agencies to serve clients. The medical orientation of home health agencies may limit use of this service.

According to the home care association and advocates for the elderly, the Medicaid personal care payment rate—$10.50 per hour—is inadequate to maintain a qualified workforce. District officials acknowledge that the rate is low and have proposed an increase to $11.50 per hour, but insist that finding providers of home care services has not been a problem, even though the number of suppliers has declined. One reason may be that some home health agencies accept low Medicaid payments to position themselves for Medicare patients, as they claim some hospitals and long-term care facilities will not provide home health referrals unless the provider is both Medicare and Medicaid certified. In addition to the potential effects of low provider payments on access for Medicaid patients, advocates for the elderly worry about the quality of services provided (“you get what you pay for”) and believe that rates should be at least $12.50 per hour.

A final issue related to personal care is whether services should continue to be supervised by a registered nurse, a requirement eliminated by the federal Health Care Financing Administration in 1997, but retained as a requirement in the District.Retention of
this regulation has meant that all personal care is provided by home health agencies. Although advocates of this supervision believe that the requirement helps assure quality of care, opponents argue that it results in higher costs and in a more medical model of care than is desirable.

Adult day health care in the District is a small but important element in the continuum of long-term care. Designed to provide medical and social services to seniors with functional impairments in a group setting on a nonresidential basis, Medicaid day health care requires all clients to be disabled enough to justify admission to a nursing home. Four Medicaid-participating, medically supervised centers serve the District, and one additional facility in Maryland is certified to provide care for District Medicaid residents. The four centers have a total capacity of 179 people, and average daily attendance was about 142 in 1997, of which a little more than half were Medicaid clients. Only one of the four adult day care centers has a waiting list. Most centers contend that their Medicaid payment rate, which averages $66 per day, is below their costs. Additional “social” day care centers, some funded by the D.C. Office on Aging, also operate in the District.

The District has only recently taken advantage of provisions of federal Medicaid law allowing states to cover a wide range of nonmedical long-term care services, including case management, home health aide services, personal care, respite care, rehabilitation, and adult day health care, through a home- and community-based services waiver. To qualify, states must target people at risk of institutionalization (e.g., in nursing homes or intermediate care facilities for the mentally retarded) and assure the federal Health Care Financing Administration that the average cost of providing Medicaid services with the waiver will not exceed the average cost of services without the waiver. Because of this cost-neutrality requirement, states must provide these services only to a preapproved number of people, thus limiting their potential financial liability. These waivers allow states to expand their commitment to home- and community-based services in a more controlled manner than the regular Medicaid program, which must provide services as open-ended entitlements to all who meet the eligibility standards.

Although all 50 states have operated home- and community-based services waiver programs for the elderly for some time, the
District did not gain approval of a waiver program for disabled older persons until 1998. The approved waiver is for a very small program, beginning with a maximum average daily census of 75 individuals and growing to a maximum average daily census of 225 individuals by the end of the third year (an additional 75 individuals each year). Participants must have a nursing home level of disability, but no further screen to assess risk of institutionalization is required. Financial eligibility is limited to people with incomes below the federal poverty level. District officials contend that while savings might not be realized initially, the nursing home census eventually can be reduced.

Several points of controversy arose in the development of the waiver proposal. Advocates for the elderly had hoped for a far larger program with broader financial eligibility, as is the case in many other states. They also wanted to include persons ages 18 and older and not limit eligibility to the elderly. Staying within the existing Medicaid budget, however, dictated a modest start. In addition, the Medicaid agency argues that an initially small program will allow it to put systems in place and to gain experience with case management before attempting a larger effort.

As a result of the start-small strategy, only a few differences exist between participating in the regular Medicaid program and participating in the waiver program. The principal differences are that the waiver program makes greater use of case management, personal care is not restricted to 20 hours per week, and chore services are covered. Waiver participants may not be served in existing nonmedical residential facilities (as they are in some other states) because licensure regulations prohibit these facilities from serving people with a nursing home level of disability.

Determining in a timely fashion whether an individual meets the financial criteria may present an administrative challenge for the home- and community-based services waiver program. The Income Maintenance Administration of the Department of Human Services reportedly takes 45 days to process a Medicaid application, which is far too long, for example, for a hospital trying to discharge a patient. The success of the waiver program in deterring institutionalization depends greatly on the prompt provision of home- and community-based services. Expansion of the waiver beyond the initial plans may require a redesign and simplification of the eligibility process, as is being done with the children’s health insurance program.
Over the past 20 years, all states and the District of Columbia have developed one or more case management systems for long-term care that assess client needs, help develop care plans, refer people to service providers or make service arrangements, monitor the provision of services on an ongoing basis, conduct regular assessments, and close cases when appropriate. In some states, case management agencies authorize public funding for home- and community-based services. In most systems, case management is limited to the noninstitutionalized population and the use of home- and community-based services. A related, but often separate, function is to assess whether Medicaid (and sometimes private-pay) nursing home applicants are disabled enough to need nursing home level of care.

The District currently has elements of a preadmission screening and case management system, but responsibility is fragmented among several organizations and participation is not required to receive most home- and community-based services. As a result, the amount of integration and coordination that the District achieves is modest.

Many stakeholders believe that strengthening case management is key to rationally allocating resources and changing the balance of care. In some states with strong home- and community-based services systems, there is a single point of entry for all publicly funded noninstitutional care.

Office on Aging Case Management Agencies
The D.C. Office on Aging contracts with five agencies to provide case management in specified catchment areas (with the exception of one site that operates citywide). The agencies use standardized assessment instruments and care planning formats and are responsible for coordinating and monitoring care and conducting periodic reassessments. The agencies have access to an interdisciplinary team consisting of a nurse practitioner and a gero-psychiatrist. In addition, the case management programs have priority access to other services funded by the D.C. Office on Aging, including transportation services, home-delivered meals, and legal services. However, case managers do not have power to directly authorize Medicaid or Office on Aging-funded services. The program serves over 1,700 clients per year and has no income eligibility requirements. There is no fee for the service, although clients are given an opportunity to contribute toward the cost of the service.
Case Management Under Medicaid Home- and Community-Based Services Waiver

Case management is critical to the success of the Medicaid home-and community-based services waiver because services must be provided in a cost-effective manner. Given staffing problems, neither Medicaid nor the D.C. Office on Aging wanted to directly provide the case management services under the waiver. Instead, District Medicaid chose to offer case management services as a covered service and to make vendor payments to agencies for these services. The care plans developed by the independent case managers will be reviewed and authorized by a nurse employed by Medicaid. One benefit of this strategy is that case management will be eligible for the 70 percent federal Medicaid match for services rather than the 50 percent match for administrative expenses.

This strategy has three risks. First, some observers worry that under this approach the system could become fragmented if there are a large number of case management providers. To minimize this potential problem, Medicaid has established provider participation standards that will require substantial operational experience (favoring existing Office on Aging case management agencies). Nonetheless, other agencies may possibly qualify, splintering the case management system. Second, some analysts are worried that the District will lose a key element of financial and programmatic control over the waiver if outside organizations provide care planning, especially if individuals can pick and choose their case managers based on how much service they recommend. Ultimately in this kind of system, the case managers will be accountable to their clients rather than to Medicaid, which has both positive and negative consequences. Third, while supporting the use of the D.C. Office on Aging-funded agencies as a way of developing an integrated case management system, some observers contend that the clients currently seen by these agencies are not severely disabled and that these agencies “will need a lot of upgrading in their skills” if they are to work with individuals who have a nursing home level of disability. In addition, most agencies rely on social workers rather than nurses, which could limit their ability to develop medical strategies to keep people out of institutions.

Nursing Home Level-of-Care Determination

Making sure that nursing home use is limited to individuals who are severely disabled enough to warrant admission to an institution is a...
LONG-TERM CARE FOR THE ELDERLY IN THE DISTRICT OF COLUMBIA

potentially important mechanism to control expenditures and is the first step in determining eligibility for the Medicaid home- and community-based services waiver and adult day health care. Until recently, ensuring that Medicaid applicants to nursing homes required that level of care was the responsibility of the city-run central referral bureau. As a budget-cutting measure, the bureau was eliminated and level-of-care determinations for adult day health care, nursing homes, and the home- and community-based services waiver are now done by Delmarva Foundation for Medical Care, Inc., the local peer review organization that does utilization review for Medicaid. (Level-of-care reviews for community residence facilities are done by the Department of Health and currently rely on the acting director of the Department of Health, who is a physician.)

Three problems arise from this arrangement for level-of-care assessment. First, determining level of care for nursing home admission is almost completely divorced from the case management and care planning systems. As a result, severely disabled individuals who might stay out of nursing homes if alternative care could be arranged are not referred to community-based case managers unless they do not meet the nursing home criteria. Second, the level-of-care examinations are paper reviews, rather than in-person assessments of the individuals, making it difficult to tell what is needed to keep a person at home. Nurse reviewers may focus on medical rather than social issues and may not be familiar with community services. As a result, the reviews may be biased toward institutionalization. Third, reviews are fragmented among several players. For example, if nursing home level of care is denied and the person seeks entrance to a community residence facility, the paperwork must be resubmitted to the Department of Health for appropriateness for that level of care, adding to the administrative burden and slowing the admission process.

Recognizing that group residential settings have certain economies of scale that are lacking in traditional home care where services must be provided to one person at a time, the District of Columbia, like many states, is exploring the potential role of nonmedical residential alternatives to nursing home care. The general hope in promoting residential alternatives is to provide a more homelike environment and greater personal autonomy at less cost than nursing homes.
At present, there is a significant supply of so-called “community residence facilities” in the District, which are generally (although not always) small facilities for residents who need 24-hour supervision, located mostly in Northeast and Southeast Washington. In 1996, the District had a greater supply of residential beds than the national average and had more than half as many residential care beds as nursing home beds. Indeed, including facilities for the mentally retarded and mentally ill, as well as those for the elderly, community residence facility beds outnumber nursing home beds. Some of the better known facilities are very expensive, costing $3,000 or more per month. Low-income people in community residence facilities have some financial support through the District’s addition to Supplemental Security Income benefits. As in most states, these residential beds are not subject to certificate-of-need requirements.

In theory, community residence facilities may serve only slightly disabled individuals. Regulations require that residents be “able to perform activities of daily living with minimal assistance,” “generally oriented to time and place,” “capable of acting for self-preservation in an emergency,” and not in need of professional nursing care. However, regulatory limits that would require involuntary transfers are not strictly enforced, in part because of legal challenges based on the federal Fair Housing Act and the Americans with Disabilities Act. As a result, some facilities serve a substantially more disabled population than District standards allow.

Because of the regulatory restrictions, many community residence facilities are not suitable for those who need more intensive assisted living services. In fall 1998, city council hearings were held on legislation developed by the District of Columbia Coalition on Long-Term Care—Bill 12-727—to establish an “assisted living facility” licensure category that would serve a population substantially more disabled than can be served in community residence facilities. Facilities would be licensed according to three levels of care. Under the proposed statute, an “individual service plan” would be developed for each person entering the assisted living facility and updated when a change in services was required. Residents who exceed the licensed level of care after admission would be able to remain in the facility if the resident and the home are granted a waiver allowing the provision of the additional care needed. Although drafters of the bill believe that most existing community residence facilities could be grandfathered under the lowest
level of care, opinions differ on how extensive the changes in staff training and operations will need to be. The bill also permits trained nonnursing personnel to dispense medications with scheduled supervision and monitoring. The question of how to regulate residential facilities in a flexible enough way to allow individuals to age in place, while at the same time preventing these facilities from becoming substandard nursing homes, is a major issue.

Like other interested parties, the nursing home association sees the expansion of residential facilities as a “natural extension” of the long-term care continuum that would provide a needed discharge option for District nursing home residents. In addition, according to the District’s nursing home association, several of its member facilities would like to develop assisted living facilities as an additional line of business.

**Nursing Homes**

Nursing homes are the dominant setting for long-term care for the elderly in the District and figure prominently in the long-term care policy agenda. Fully 84 percent of District nursing home residents are Medicaid beneficiaries, far above the national average of 68 percent. Not surprisingly, nursing homes are the focus for much of the District’s cost-control efforts in long-term care. Policy issues concerning nursing homes include Medicaid reimbursement, certificate of need, and quality of care.

The District of Columbia Medicaid program pays nursing homes prospectively determined rates based on each facility’s historical 1995 costs trended forward by inflation. Compared with the 50 states, Medicaid nursing home reimbursement rates in the District are very high, with an average daily rate of $210 in 1998, the second-highest average rate in the country, following Alaska. In answer to concerned District officials, the nursing home industry asserts that comparisons with states with substantial low-cost rural and suburban areas are misleading and that the District’s rates are comparable with other cities (although data on this point are not...
readily available). In the industry’s view, the rates simply reflect the relatively high proportion of hospital-based facilities and the cost of doing business in the District, with its more expensive labor, real estate, and worker’s compensation premiums. Moreover, the nursing home industry insists that providing Medicaid services is not profitable, a contention that seems inconsistent with certificate-of-need applications for new nursing facilities.

The city has focused some of its cost-control efforts on nursing home reimbursement. Whereas reforms such as expanding the availability of home- and community-based services offer uncertain savings, reimbursement cuts offer quick, predictable, and potentially large savings. The District has already moved to limit rates and would like to implement further payment methodology reforms in the near future. The latest effort by the District (adopted in October 1996) established cost limits based on 1995 median costs for patient care and for administrative expenses—125 percent of median costs for hospital-based facilities and 100 percent of median costs for freestanding facilities. Even before the repeal of federal minimum standards for nursing home reimbursement—the Boren amendment—Medicaid officials did not worry about substantive lawsuits because similar reimbursement systems consistently have been upheld by courts in other states.

Conflict over nursing home and other long-term care reimbursement has focused largely on the alleged administrative inadequacies of District government rather than on the substance of the reimbursement methodologies. In the past, the nursing home industry successfully has sued to force the District to adhere to its own written policies—for instance, to make timely payments or to perform the audits necessary to establish new base-year costs. While the current reimbursement system for nursing homes has made rate calculation much simpler, audits of costs for other providers (e.g., adult day health care) remain a problem.

Medicaid officials would like to implement a casemix-adjusted payment system for nursing homes and have hired a consultant to make recommendations. Officials hope that a reimbursement system more closely relating payments to resident needs will improve access for high-cost individuals and create an incentive to serve less disabled persons in the community rather than in nursing homes.
homes. However, a casemix reimbursement system has been under discussion for a number of years without much progress. The nursing home industry would welcome a patient-based acuity system for nursing home reimbursement but notes that casemix reimbursement would be difficult to implement in the District. In particular, the industry fears that the District would not commit the necessary resources to manage such a complicated, data-intensive system. Of particular concern is that the District government does not have the administrative capacity to audit patient assessments or to establish the sophisticated computer infrastructure required to operate a casemix reimbursement system. However, with the computerization of the federal nursing home Minimum Data Set, which provides information on resident disabilities and needs, and the movement by Medicare to casemix reimbursement, the District’s nursing home industry is eager to implement a comparable system for Medicaid. Most observers believe that the District needs the computer and administrative capacity required for casemix reimbursement in order to effectively manage other aspects of the Medicaid program.

Beyond concerns about administrative capacity, some stakeholders are ambivalent about casemix reimbursement for nursing homes. Advocates for the elderly are concerned that reimbursement change will be “done in a vacuum” and will ignore the needs of less disabled individuals who might be displaced from nursing homes without alternative services being available. Most observers believe that District nursing homes have a substantial number of “social placements”—individuals whose care needs do not require a nursing home level of care but who lack access to supports necessary to stay in the community. Given the current lack of publicly funded home- and community-based services, changing to a casemix reimbursement system could be detrimental for these individuals. In fact, earlier discussions of casemix payment systems foundered over this very issue.

An additional issue related to nursing home reimbursement is whether the current inclusion of prescription drugs in the prospectively determined rate discourages nursing homes from admitting severely disabled residents with expensive medical needs. This is particularly a concern with HIV and AIDS patients, who have extremely high prescription drug costs. The nursing home industry and Medicaid are discussing the exclusion of these costs from the rate.
Many states have responded to growing Medicaid long-term care expenditures by limiting the number of long-term care providers through certificate-of-need programs and moratoria on new construction or participation in Medicaid. Certificate-of-need programs require state regulatory approval before the establishment or expansion of health facilities or services. State supply controls have focused largely on nursing home beds, where the general premise is that any new beds are likely to be filled with Medicaid residents, but many states also have certificate-of-need requirements for home health agencies and assisted living facilities. The District of Columbia State Health Planning and Development Agency is responsible for developing a comprehensive state health plan and for operating the certificate-of-need program for nursing homes, home health agencies, adult day health care, and hospices. Budget cuts and the temporary termination of the certificate-of-need program in the mid-1990s have hampered the ability of the agency to function and have slowed the revision of the state health plan.

Some observers, including the Long-Term Care Committee of the Mayor’s Health Policy Council, have identified several problems in the state health plan as it pertains to long-term care and in the certificate-of-need standards for nursing home care. First, the state health plan is dominated by the narrow requirements of the certificate-of-need program rather than forming a blueprint for a broad range of health policy initiatives. Thus, the plan tends to ignore home- and community-based services not subject to certificate of need and does not provide an overall strategy to alter the balance of institutional and noninstitutional services. Moreover, instead of viewing long-term care as a whole, the state health plan is fragmented, treating each service separately from the others. For example, there are separate chapters on nursing facilities, home health, rehabilitation, hospice, and day treatment, but little that integrates the chapters in an overall vision.

Second, in evaluating nursing home applicants for certificates of need, the State Health Planning and Development Agency uses a methodology developed in 1989. Thus, the standards depend on data that are badly out of date. As part of revising the state health plan, the State Health Planning and Development Agency is updating the methodology with the help of the Long-Term Care Committee of the Mayor’s Health Policy Council. Both the existing and the revised methodologies of the committee and the State Health Planning and Development Agency are expected to provide a more comprehensive approach to assessing the need for long-term care facilities.
Health Planning and Development Agency project no additional need for nursing home beds through 2002, mostly because of the declining elderly population in the District.  

Third, some observers contend that too many small services not requiring substantial capital investment require certificate-of-need review, including home health, adult day health centers, and nursing home bedside dialysis. In their opinion, certificate-of-need review for these services only adds expense and does not significantly control health care expenditures.

As mentioned above, the city has 23 nursing facilities with 3,101 nursing home beds, putting it below the national average in its nursing home bed to elderly population ratio. Approved certificates of need for 245 nursing home beds will increase the bed supply in the near future. Medicaid officials strongly believe that additional nursing home beds would prevent them from expanding home- and community-based services. As one Medicaid official put it, “If 50 new beds were to be approved, we [Medicaid] would be likely to pay for 42 of them, at an annual new cost of approximately $50,000 per bed or $2.1 million in annual expenditures. The city needs to have these resources available for other, more diverse community-based services, including day treatment and personal care.” The nursing home industry is primarily concerned that any new bed-need formula be applied flexibly and that the standard adapt to rapidly changing conditions in the health care marketplace.

In the 1980s, access to nursing home care was a major problem in the District, especially for hospitalized patients. In 1989, the District of Columbia Hospital Association estimated that as many as 200 people awaited placement on an average day. These backlogs posed a major financial liability for local hospitals, especially following implementation of the Medicare prospective payment system for hospitals. In addition, in 1987 approximately 900 District of Columbia nursing home residents were placed in Maryland and Virginia nursing homes. In fact, the purchase of the to-be-closed National Lutheran home by the District Office on Aging was an explicit effort to maintain access to nursing home care, especially for Medicaid enrollees.

Even though the nursing home bed supply is lower than the national average, District government officials, home health providers, and advocates for the elderly believe that access to nursing home care in the District has improved considerably over the past decade and that institutional capacity is sufficient.
ing home care in the District has improved considerably over the past decade and that institutional capacity is sufficient. In a 1998 survey of District hospitals, the State Health Planning and Development Agency did not find significant backlogs of persons waiting for nursing home placements. Government officials and elderly advocates contend that District nursing homes currently work very hard to fill their beds. Moreover, nursing home representatives complain that 387 District Medicaid beneficiaries still resided in Maryland and Virginia nursing homes as of March 1998. While this is a big decline from a decade ago, the industry contends that out-of-District placements deprive city facilities of needed revenue. Medicaid officials note that payment rates in Maryland and Virginia appear to be lower than District reimbursement levels but do not actively promote out-of-District placements.

In part because home health providers in the District rely primarily on Medicare rather than Medicaid for their revenue, the certificate-of-need requirement does not seem to be a policy priority for District officials or home health providers. However, one District official contended that it does not make sense to maintain a certificate-of-need requirement for home health services because no effort is made to limit the supply of services that an individual agency provides. Since 1989, the State Health Planning and Development Agency has approved 60 home health agency applications for certificates of need. Most of these agencies never became operational, and others closed because they did not find the industry profitable.

A major responsibility of the Department of Health is quality assurance in community residence facilities, nursing homes, and home health agencies. Should an “assisted living facility” licensure category be established, the Department of Health would likely have responsibility for those facilities as well.

Regulation of community residence facilities has been a low priority for District government officials. Regulators are very understaffed and must also do child day care and adoption agency reviews. As a result, as many as 30 percent of facilities do not have current licenses simply because regulators cannot get to them in a timely fashion. In addition, community residence regulators rely on a badly out-of-date computer system that requires a great deal of manual activity for tracking licensure requirements. Moreover, some consumers and providers believe that enforcement is incon-
sistent and the regulations are out of date. Providers and consumers have also voiced opposition to efforts by regulators to force relocation of disabled residents to nursing homes. Successful implementation of the assisted living facility concept will require more staff and a new regulatory outlook that searches for ways to allow individuals to age in place.

Stakeholders disagree about the quality of care in nursing homes in the District. In the early 1990s, egregious quality-of-care problems at D.C. Village—a large, city-run nursing home in the District—led to a federal lawsuit alleging civil rights abuse at the home. The court-appointed monitor described the situation as one of “appalling and avoidable wrongs.”\(^{32}\) Unable to improve care despite high costs and substantial staffing, District officials finally closed D.C. Village in 1995 and placed residents in other settings. Most observers attributed problems at D.C. Village to the “awful” personnel and procurement system in the District, where everything takes “months and months,” a luxury that direct-service organizations rarely have.

Although few would deny that conditions at D.C. Village were unacceptable, District government officials tend to believe that quality of care in nursing homes is generally adequate and has improved in recent years. The nursing home association notes that federal nursing home certification survey results have been “quite good” recently and that, as in the rest of the country, the use of physical restraints—a key quality indicator—has declined. Surveyors contend that the prevalence of pressure sores has decreased and that sanitation has improved over the past five years. In addition, perhaps 40 percent of District beds are in facilities accredited by the Joint Commission on Accreditation of Healthcare Organizations. The nursing home association cites the survey process, strong leadership in District facilities, and an excellent relationship between operators and surveyors as reasons for the positive results.

Advocates for the elderly, however, expressed strong reservations about the quality of long-term care in the District and view the Medicare and Medicaid survey and certification process for nursing homes as “broken.” They point to the large increase in recent years in the number of complaints to the D.C. Long-Term Care Ombudsman (although the District of Columbia Health Care Association contends that the definition of “complaint” is too broad to make it a good indicator of quality trends). Moreover, a
recent federal Health Care Financing Administration survey of one District facility found 60 pages’ worth of deficiencies. Critics point to “regulatory discretion” and insufficient enforcement as contributors to the problem and believe that inspectors focus too much on “paperwork violations” rather than actual care. In addition, the Licensing Regulation Administration has not attempted to make public information about nursing home quality widely available to consumers, even when it has imposed a freeze on Medicaid and Medicare admissions at particular facilities.

In addition to the nationwide problem of improving quality of care in nursing homes, there are several District-specific issues. First, in 1994 a United States District Court ruled that the licensure categories previously in effect in the District were inconsistent with, and preempted by, federal changes enacted as part of the Omnibus Budget Reconciliation Act of 1987. In response, the District made its licensure rules the same as the federal conditions of participation for Medicare and Medicaid. The Department of Health is preparing licensing regulations for nursing facilities that are more detailed than federal rules. Advocates for the elderly contend that the proposed licensing standards, although designed to go beyond the federal requirements, require substantial revision to be tougher and more outcome-oriented. In contrast, the District Health Care Association has raised questions about the desirability of licensure standards separate from the federal rules.33

Second, in virtually every state, licensure and survey and certification for participation in Medicaid and Medicare are administratively located in the Department of Health. However, until 1998, these responsibilities were located in the District’s Department of Consumer and Regulatory Affairs. Previous Department of Health officials complained that the transfer was not “smooth” and that insufficient resources were provided.34 In addition, despite the transfer, some regulatory responsibilities remain in the Department of Consumer and Regulatory Affairs, including imposition of civil fines and penalties under the civil infractions act, transfer/discharge hearings for long-term care residents, and decisions on “reasonable accommodations” under the Americans with Disabilities Act. This separation fragments responsibility for quality enforcement.

Third, the District has not promulgated its schedule of civil fines and penalties for nursing facilities, making the city out of compliance with federal Medicaid requirements and its own civil
infractions law. A schedule of penalties does exist for community residence facilities. On the one hand, some observers believe that the fines should be used more often; on the other hand, some analysts believe that the fines are often arbitrary.

Other Issues

The District also faces a number of issues related to the D.C. Office on Aging and Adult Protective Services in the Department of Human Services.

**D.C. Office on Aging**

The D.C. Office on Aging has an importance far greater than its small budget would suggest. The senior service network reaches almost half of D.C.’s seniors, leverages substantial private resources, and has considerable influence over public and private service providers. In addition, it has the potential to mobilize significant numbers of older people as a resource for the city.

Providers and consumer advocates consistently call for the following:

- Additional funds for all services but especially for home care and transportation.

- Improved communication with the senior service network and encouragement of cooperative efforts to jointly determine service priorities, service outcomes, and performance measures.

- Increased automation for client service delivery and planning, as well as financial accountability.

- Attention to the concept of older people as a resource for the city, as well as a population needing and deserving support.

- Creation of a professional information and referral system with clear roles for the D.C. Office on Aging and the lead agencies.
- Flexible grants rather than a switch to rigid contracts.
- Improvement and upgrading of its outdated management information system.

Adult Protective Services is often the place of last resort for helping vulnerable adults. The referrals come from a wide range of sources, including social workers, hospitals, police, and neighbors. Workers have experienced increases in the caseload (from 1,271 in 1997 to about 1,500 in 1998) and are finding it difficult to provide quality care. The staff’s ability to meet the mandate to find the least restrictive arrangement has been compromised by the severe reduction in publicly funded homemaker services and by increasing difficulty in obtaining medical assessments.

Reduced budget is the major issue for the Adult Protective Services staff. Six positions have been eliminated, leaving 22 for 1999. Adult Protective Services also experienced a cut in the federal Social Services Block Grant, which helps fund the office and homemaker services for its clients. In 1998, the In-Home Support division of the Family Services Administration was abolished; remaining funds are managed by the D.C. Office on Aging under an interagency agreement, which in turn contracts for these services with Home Care Partners. This service is routinely limited to six hours per week.

Adult Protective Service workers and long-term care providers cited a lack of timely cooperation from other D.C. agencies. The most frequent problems occur in securing legal services from Corporation Counsel—which does not appear to give priority to at-risk elders—and psychiatric consultation and treatment from mental health services at St. Elizabeth’s Hospital. Adult Protective Services workers also report uneven cooperation from hospitals for screening clients, from fire and police for interventions and escort, and from the Income Maintenance Administration for determining Medicaid eligibility. On the plus side, the Elder Abuse Committee established by the D.C. Office on Aging was seen as a positive forum for creating working relationships.

A major barrier to improved management is the low level of automation and, consequently, the inadequate database. Adult Protective Services plans for 1999 include providing computers
and training for all caseworkers and making laptops available to workers in the field. Another barrier cited is the extreme delay in procurement and personnel, even for such small items as office supplies and emergency provisions.

An additional issue is that Adult Protective Services is mandated to cover clients who are at risk because of abuse, neglect, or exploitation by a third party but not clients at risk because of self-neglect. In practice, Adult Protective Services does respond to self-neglect cases and often provides continuing care for them. Adult Protective Services workers do not have the authority to intervene against the will of a person who is self-neglecting but considered mentally competent.

The Road Not Taken: Other Possible Initiatives

Some states have sought to control their long-term care expenditures by maximizing private spending and Medicare financing to substitute for state spending and by integrating acute and long-term care services through managed care. These types of initiatives are not being aggressively pursued in the District.

Maximizing Private Contributions for Long-Term Care

One broad strategy that states can use to control long-term care spending is to offset state spending with increased private spending by promoting private long-term care insurance, reducing transfer of assets to qualify for Medicaid, and expanding estate recovery. Each of these approaches builds on the premise that a substantial proportion of Medicaid long-term care beneficiaries were not always poor but were impoverished by the high costs of long-term care.

Increasing private contributions for long-term care is not considered a feasible cost-saving strategy in the District because much of the older population is relatively poor. One District official reported that most Medicaid beneficiaries in nursing homes were also eligible for Medicaid in the community. As a consequence, no policy attention is given to asset transfer or estate recovery. Similarly, the promotion of private long-term care insurance is
characterized as “hopeless,” and the District is the only jurisdiction not to have adopted specific regulations for private long-term care insurance. In fact, the District has one of the lowest market penetrations of private long-term care insurance in the country.36

States have long sought to shift Medicaid long-term care expenditures to Medicare but have been frustrated by the narrow range of Medicare coverage for nursing home and home health care. That situation has changed dramatically since the late 1980s, when Medicare post-acute coverage rules were liberalized, making the benefits more oriented toward long-term care. Although not a major focus, the growth in hospital-based sub-acute care units has spurred D.C. Medicaid to insist that facilities be certified to participate in Medicare and to require facilities to bill Medicare first.

Older persons with disabilities currently encounter a fragmented financing and delivery system. Some states have sought to end that fragmentation and save money by adding nursing home and home care services to the array of services provided through managed care organizations. So far, most of these initiatives have been small in scale and slow to be implemented. In the District, Medicaid is enrolling the non-Medicare population into managed care first.37 A Medicaid research and demonstration waiver that involves managed care exists for children receiving Supplemental Security Income but not for disabled nonelderly or elderly adults. As one official noted, “The city will deal with the Medicare population last in terms of managed care, but we will eventually get to them.” A problem for initiatives of this nature is that Medicare managed care penetration in the District is fairly low, not providing much of a base on which to build.

Challenges for the Future

Long-term care and other human services for the elderly are primarily the responsibility of the D.C. Office on Aging, Medicaid, the Licensing Regulation Administration, the State Health Planning and Development Agency, and Adult Protective Services. Long-term care policy has been dominated in recent years by fiscal crisis and budget cutting. Driven by the need
for savings, long-term care for the elderly has been under severe stress over the past few years, with termination of the large, mostly city-funded chore aide and homemaker programs, privatization of the personal care aide program under Medicaid, elimination of the agency responsible for screening admissions to licensed nursing and residential facilities, and reduction of the Office on Aging budget. In addition, despite management reforms and two years of control board involvement, all of the agencies interviewed reported that procurement and personnel actions still require a very long time to complete. Automated data systems and access to computers remain at low levels. On the positive side, there is broad consensus on the overall policy direction and several initiatives are being implemented or are at least under discussion, including a new Medicaid home- and community-based services waiver, new licensing rules for assisted living facilities, casemix reimbursement for nursing homes, and a new state health plan. The central dilemma is that spending per elderly resident for long-term care is very high, but the District’s system of long-term care is not meeting the needs of the elderly.

As the new mayor, city council, city administrators, and the control board plan for the future, they face many challenges in long-term care for the elderly. First, policy development and implementation are fragmented across a number of agencies, making it difficult to originate initiatives that require cooperation. No one agency or individual is accountable for long-term care policy. Moreover, despite large Medicaid expenditures and a major need for reform, long-term care for the elderly has not received the attention it deserves from high-level city officials. As a result, it is very difficult to make explicit policy tradeoffs, which will continue to be important in a tight budget environment.

Better coordination of long-term care policy and implementation could be accomplished by designating a long-term care staff person in the Office of the Mayor, establishing a lead agency on long-term care, creating a Department of Aging and Disability that would consolidate government responsibilities in one agency, or establishing a long-term care working group with existing agencies. Within the existing structure, progress will be difficult if the director of the Department of Health does not have an understanding of and interest in health care financing, including long-term care. A “pure public health” professional may be inconsistent with the needs of the Department and certainly of long-term care for the elderly. Using the state health plan to articulate District policy and
monitor its implementation could give relevant stakeholders a sense of where the city is going on long-term care policy. Currently, the state health plan is dominated by certificate-of-need concerns and does not function as a broad policy document for long-term care.

Second, the District of Columbia has lagged behind the 50 states in reforming its long-term care system for the elderly, especially the expansion of home- and community-based services. Home care services are a very small proportion of Medicaid expenditures for long-term care for the elderly, and budget cuts virtually have eliminated a large home care program financed by the District. The new Medicaid home- and community-based services waiver could set the stage for widening the range of services available to the severely disabled elderly in the District, but the initial program will be very small. Expanding resources for home- and community-based services could be accomplished by increasing funding for the D.C. Office on Aging, liberalizing regular Medicaid eligibility and removing some of the restrictions on use of personal care and other services, and increasing the size and eligibility for the Medicaid home- and community-based services waiver. These approaches are not mutually exclusive, and each targets a somewhat different population and requires different levels of District funding. For the Medicaid home- and community-based services waiver, shortening the processing time for Medicaid eligibility applications is critical because long delays can mean nursing home rather than community placement.

Expanding the continuum of home- and community-based services is key to meeting the needs of the disabled elderly. Nonmedical residential facilities could play an important role in long-term care in the District, especially for elderly individuals for whom home care might not be feasible. As structured currently, however, community residence facilities are limited in their ability to meet the needs of the disabled elderly. As a result, a new assisted living facility licensure category has been proposed but not yet enacted. A key issue is how to allow individuals to age in place without turning the facilities into substandard nursing homes.

Case management, another important part of a comprehensive long-term care system, is fragmented and not well integrated into the nursing home admission process. While the D.C. Office on Aging funds some case management and the Medicaid home- and community-based services waiver offers it as a covered benefit, individuals seeking long-term care do not have a single point of
entry that will give them access to a complete range of home- and community-based services. Thus, unlike many states, there is nobody responsible for managing the care of disabled older people.

Third, since such a large percentage of long-term care spending is for nursing home care, it is not surprising that many policy issues focus on these services. Although the nursing home industry contends that Medicaid payment levels are similar to other cities and reflect the high proportion of hospital-based facilities, District Medicaid rates appear to be high and have been a target for savings. The District would like to implement a casemix payment system for nursing homes as a way of improving access for severely disabled people and providing incentives for efficiency. But doing so will require a major new administrative and computer infrastructure that may be daunting to implement. In addition, casemix reimbursement presupposes the existence of home- and community-based services for persons with light care needs who will no longer be financially attractive to nursing homes.

Certificate-of-need reviews for nursing homes are based on a methodology and data that are a decade old. A new methodology that is close to being adopted by the State Health Planning and Development Agency will project a need for no new beds, primarily because of the declining elderly population. If additional institutional investment is constrained, funds will probably be available for home- and community-based services.

As is true across the country, there is increased concern in the District about quality of care in nursing homes and questions about whether the Medicare and Medicaid certification process is assuring high-quality care. Quality assurance in the District is complicated by the lack of licensure standards that go beyond the federal standards and the absence of a schedule of civil money penalties for quality infractions. Also, the effort to develop assisted living facilities will require creative and flexible regulatory oversight to make sure that these residences do not become substandard nursing homes but still allow older people to age in place. This proposed increase in regulatory responsibility is particularly problematic because of understaffing of personnel currently responsible for community residences.

Finally, other tests for the District involve improving the management and services funded by the D.C. Office on Aging and pro-
viding Adult Protective Services with the resources to address the needs of a growing elder abuse problem.

In sum, the principal question facing the District is whether it will be able to change the balance of the delivery system to finance a broad range of home- and community-based services and at the same time assure good quality of care and access for nursing home residents who require it.

Notes
4. Ibid.
8. Urban Institute calculations based on Health Care Financing Administration form 2082 and 64 data.
10. On the nursing home side, the Washington, D.C. Health Care Association is the youngest American Health Care Association affiliate and has been in existence for only 11 years. Virtually all District of Columbia nursing homes in the area are members, including the non-profit facilities. On the home health side, the Capital Home Care Association has served the District of Columbia for the past 14 years and has recently merged with Maryland’s Home Care Association to become the Maryland National Capital Home Care Association. The combined association will represent over 160 home care providers.
13. Ibid.
14. Ibid.
19. Many of these services, such as case management and personal care, can also be covered through the regular Medicaid program.
20. Medicaid considered contracting with the Office on Aging case management agencies, but the Health Care Financing Administration insisted that the procurement eventually be opened to competitive bidding, possibly resulting in an award to other organizations.
23. Ibid.
28. The Medicare prospective payment system reimburses hospitals on a per-episode basis, making long-stay patients potentially unprofitable.
30. Little information is available on why these residents were placed outside the District of Columbia. Medicaid has no restrictions on out-of-District placements. To some extent, these nursing home placements are in facilities relatively close to the District and may represent individual or family preferences. However, according to some observers, an important factor is the need of hospitals for rapid discharges, which leads them to rely on any nursing home they can, including out-of-District facilities. In other
cases, out-of-District placements may reflect difficulty in obtaining beds for “heavy care” residents within the city. According to District Medicaid data, 34 percent of the out-of-District placements are “special or heavy care” under Virginia or Maryland reimbursement categories. The nursing home bed planning methodology of the Long-Term Care Committee of the Mayor’s Health Policy Council recommends including the “special or heavy care” residents in the District’s need for beds. Long-Term Care Committee of the Mayor’s Health Policy Council. “Nursing Home Bed Planning Methodology for the District of Columbia: A Proposal by the Long-Term Care Committee of the Mayor’s Health Policy Council.” July 6, 1998.


35. Some middle-class and wealthy elderly persons transfer, shelter, or underreport their assets—so-called “Medicaid estate planning”—in order to appear poor enough to qualify for Medicaid nursing home care. In addition, the Omnibus Budget Reconciliation Act of 1993 requires states to recover the Medicaid cost of nursing home care from the estates (primarily the house) of deceased nursing home residents.


List of People Interviewed or Who Provided Information

D.C. Government Officials

Department of Health, Medical Assistance Administration
  Paul Offner, Director, Medical Assistance Administration
  Donna Folkemer, Chief, Medicaid Policy
  Marlene Kelly, Acting Director, Department of Health

Department of Health, Licensing Regulation Administration
  Judith McPherson, Health Facility Division Program Manager
  Ellen Yung Fatah, Human Services Facility Division Program Manager
  Carmen Johnson
  Helen Jordan
  Sharon Lewis
  Catherine Van Buren

Office on Aging
  E. Veronica Pace, Executive Director
  Karyn Barquin
  Wesley Cooke
  Sam Gawad

Department of Human Services, Family Services Administration,
Adult Protective Services Branch
  Ricardo Lyles, Chief, Family Services Administration
  Barbara Strother
  David Thomas
  Louise Wilson

Provider and Consumer Groups

David Beck, District of Columbia Health Care Association
Alethea Campbell, D.C. Commission on Aging
Elizabeth Stewart Fox, Williams Transition ’98
Diana Guinyard, Greater Southeast Center on Aging
Ann Hart, D.C. Legal Counsel for the Elderly
Gail Jernigan, D.C. Health Care Association
Joan Lewis, D.C. Hospital Association
Vera Mayer, D.C. Coalition on Long-Term Care
Rachel Roberts, Family and Child Services
Barbara Soniat, George Washington University-Iona Case Management
Margaret Terry, Home Care Partners
Solange Vivens, VMT and Washington Center for Aging Services
Sue Whitman, Long-Term Care Committee of the Health Policy Council
Joshua M. Wiener is a principal research associate at the Urban Institute’s Health Policy Center, where he specializes in research on Medicaid, long-term care, and health policy for the elderly. Before coming to the Urban Institute, he did research and policy analysis for the Brookings Institution, the Health Care Financing Administration, the Commonwealth of Massachusetts, the state of New York, and the city of New York.

David G. Stevenson is currently a graduate student at the University of Texas-Galveston. Previously, he was a research associate at the Urban Institute’s Health Policy Center. His research has centered on aging, disability, and long-term care. Mr. Stevenson’s previous research focused on access to health care for people with disabilities, the cost-effectiveness of clinical preventive services, and Medicaid managed care for people with disabilities.