

Council of the District of Columbia Committee on Health
Taskforce on Long-Term Care

TASKFORCE REPORT

To: David A. Catania, Chairperson, Committee on Health

From: Joshua Wiener, Ph.D.

Date: November 4, 2005

Re: Report of the Taskforce on Long-Term Care

The spectrum of long-term care services provided to people with chronic diseases, disabilities and seniors is wide. Long-term care services range from personal assistance with basic activities of daily living to skilled nursing home care. While some options for long-term care are available to District residents, utilization of non-institutional long-term care services is low. The Committee on Health convened the Long-Term Care (“LTC”) Taskforce in June 2005 to examine the factors that contribute to the over-reliance on institutional long-term care in the District and to identify measures that will produce wider accessibility to home and community-based services.

This report represents the recommendations of the LTC Taskforce. Although each recommendation was approved by a majority of the Taskforce, it should be noted that not all recommendations were approved unanimously. The LTC Taskforce will assist Council staff in crafting legislation based on the recommendations of this report.

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I. BACKGROUND OF THE TASKFORCE

The Long-Term Care Taskforce was created in the summer of 2005 by Councilmember David A. Catania, Chairperson of the Committee on Health, to identify obstacles and propose actions to improve access to a full spectrum of high quality and comprehensive long-term care services by seniors and persons with disabilities in the District of Columbia.

Many limitations within the current long-term care delivery system prompted Chairperson Catania to convene the taskforce. In the District of Columbia, the vast majority of Medicaid funds are spent on institutional care rather than home and community-based services. While institutional care is an essential component on the continuum of long-term care, consumers prefer to continue living in their homes rather than move to a nursing home. Increasing Medicaid options for supportive residential services will enable people to remain in the community and may delay entrance into nursing facilities.

Medicaid Home and Community-Based Services waivers provide states with a mechanism for delivering health and support services to targeted populations, such as seniors and persons with disabilities. The Department of Health's ("DOHs") Medical Assistance Administration ("MAA") obtained approval for two Medicaid home and community-based services waivers that offer supportive residential services for seniors and people with disabilities and for people with developmental disabilities. However, these options for supportive services in the District of Columbia have not been fully implemented or administered in a way that provides residents with a true choice in obtaining long-term care.

The LTC Taskforce was charged with making recommendations to minimize current obstacles to delivery of home and community-based health and personal care services, to enhance the quality of services and health care in institutional and non-institutional settings, and to expand long-term care options for seniors and disabled residents of the District. The recommendations are grouped into the following categories: access, quality, workforce and home and community-based services.

II. ACCESS

There are a number of barriers to accessing long-term care services in the District of Columbia that significantly impede the ability of seniors with disabilities to receive home and community-based services. As of September 2005, 781 individuals were receiving home and community-based services through the Elderly and Physically Disabled Waiver. Services consist of personal care aides, case management, personal emergency response services, and respite care. For Fiscal Year 2005, 920 slots were available; in Fiscal Year 2006, 1,220 slots will be available. These barriers account for some of the underutilization of the Medicaid home and community-based services waiver and may result in unnecessary placement of seniors and persons with disabilities in institutional care. These barriers include:

- The lack of an effective single point of entry for information, assessment, eligibility determination, and admission;
- The lack of a program and agency to assist residents of nursing homes in transitioning to home and community based services;
- A lack of uniformity in the level of care determination process. There is also inadequate information technology and other supportive infrastructures to facilitate the sharing of information and to avoid the need for duplicate information collection; and
- The failure of the District of Columbia to fully utilize federal dollars awarded to it or available to it for the purposes described above.

Unless individuals understand their options and receive timely notice of eligibility, they cannot have a real choice of services and settings. It is, therefore, crucial that the District of Columbia provide individuals with a coherent source of information about the range of long-term care services and how to access them, as well as a well-designed and effectively run single point of entry for assessment and admission to public programs. When these elements are combined and functioning effectively, residents of the District of Columbia will have a comprehensive system that offers genuine person-centered access to all aspects of long-term care services.

A. Management of the Aging and Disability Resource Center

The District of Columbia currently has an Aging and Disability Resource Center (“ADRC”) operated under contract by Chesapeake Consulting, Inc. However, few people know about the ADRC and its functions. There is little public outreach and few efforts to coordinate with case management agencies, hospital discharge planners and other health care professionals. In addition, it is not clear that the ADRC is well managed or achieving its mission. Another barrier to accessing care is the failure to identify

individuals at critical decision points, such as when persons are discharged from the hospital who could stay in the community with an appropriate package of services.

Recommendations:

- Public awareness of the ADRC should be greatly increased through a wide variety of promotional efforts, including through D.C. government websites (coordinating these efforts with the District's Chief Technology Officer), the creation and use of a consumer-friendly and easily remembered name and phone number, and special outreach efforts to professionals.
- The ADRC must be appropriately funded and run by professionals with significant long-term care expertise if it is to meet the needs of the citizens of the District of Columbia. While the contract for the ADRC mandates coordination, streamlining of eligibility determinations, the creation of a governing committee, and the flagging of people in nursing homes who may be more appropriately cared for in the community, it is not certain that any of these responsibilities are being met. Additional oversight of the operation of the ADRC is needed.
- The ADRC must promptly identify and aid persons at risk of permanent institutionalization before they lose housing and other community supports. A responsible governmental entity should be designated and held accountable for assisting individuals who wish to stay in the community or leave an institution.

B. Nursing Facility Transition Program

In addition to diverting persons from being admitted to nursing homes, some persons in nursing facilities wish to move to the community and need help doing so.

Recommendation:

- A nursing facility transition program should be created that would facilitate the movement of nursing home residents to less restrictive community settings. The District of Columbia should consider utilizing a system of nursing facility case management to ensure that nursing home residents know their options and get assistance in obtaining home and community based services. In order to aid the transition to the community, Medicaid financial eligibility rules should be altered to allow nursing home residents to maintain their home or to obtain and furnish a home after transition to the community.

C. Assessment and Communication

Information about a client's functional status, medical needs, Medicaid financial eligibility, family structure and preferences are spread over a large number of governmental and quasi-governmental entities, including DOH, the ADRC, and the

Delmarva Foundation. This fragmentation makes it difficult to put together a package of services to allow individuals to stay in the community.

Recommendation:

- The organizations involved with level of care assessments, functional and medical assessments, Medicaid financial eligibility determinations, care planning and case management should work to dramatically improve and speed communication and coordination among these organizations. Over the long run, the District should work toward consolidating these functions within the ADRC. The ADRC must have an effective information system that fully supports these functions and enables multiple entities to share information and avoid duplicate information collection.

D. Use of Federal Funds

The District of Columbia has not effectively utilized federal funds available for development of long-term care information systems and Resource Centers. For example, the Centers for Medicare and Medicaid Services' Systems Change grant was partly to be used for this function, but were not fully expended.

Recommendation:

- The District of Columbia should seek and use federal infrastructure development funds, especially for the ADRC.

III. QUALITY OF CARE

High quality of care in long-term care facilities and home and community-based services is vital to the safety, stability and quality of life for seniors and persons with disabilities in the District of Columbia. The current regulatory and reimbursement system does not guarantee high quality of care. In particular, few systems exist to monitor quality of care in settings outside of nursing facilities.

A. Residential Care and Supportive Community Services

A number of obstacles make challenging the expansion and maintenance of a long-term care system that provides residents with true choices and options for care in the District of Columbia. Limited affordable housing stock, an underdeveloped direct care workforce, reimbursement rates for services that are not adjusted for inflation or are based on old data, and varying standards of care within District agencies responsible for the delivery and regulation of long-term care potentially diminish access and quality of care to residents.

Recommendations:

- Establish a current cost base for long-term care provider reimbursement, especially assisted living residences. Currently, long-term care facilities are reimbursed at rates that do not automatically increase for inflation, potentially denying providers with the revenue they need to provide quality care. As assisted living facilities become a fully developed long-term care option in the District of Columbia, an entirely new Medicaid reimbursement system will need to be established.
- Increase funding for long-term care providers, including home care services, by raising the number of Medicaid home and community-based services waiver participants. Improved access to and administration of Medicaid waiver services will require the addition of Medicaid waiver slots. MAA should work with appropriate consumer, government and provider stakeholders to proactively obtain federal approval for additional waiver services.
- The District of Columbia government needs to maintain, improve, and link psychiatric, psycho-geriatric and other behavioral health programs with long-term care providers by funding services, increasing community mental health crisis placements and ensuring that emergency responses are available for behavioral problems that occur in long-term care facilities. Long-term care in institutional settings is provided twenty-four hours a day, seven days a week. Mental health crises and behavioral health problems in these settings may arise at any time. The District should create an integrated, interdisciplinary team comprised of mental and behavioral health care providers, long-term care providers, and advocates to develop guidelines and support systems to meet the psychiatric, substance abuse and psycho-social needs of residents in long-term care facilities and settings during times of crisis and on an ongoing basis.

B. Survey Oversight

The principal mechanism of quality assurance for nursing facilities is the federally mandated survey and inspection system, combined with the District of Columbia's licensure requirements. The District of Columbia enacted licensure requirements for assisted living facilities in 2000, which have yet to be implemented. DOH, the Health Regulation Administration ("HRA"), long-term care providers and advocates have struggled to ensure that the rights and dignity of residents in long-term care programs are preserved and that services are delivered in accordance with quality standards. A comprehensive approach to quality assurance is needed.

Recommendations:

- The following legislative, regulatory and policy amendments should be made to strengthen the current survey process and improve quality of long-term care services:
 - Amend Title 22 DCMR, Chapter 32, regarding restraints, to ensure compliance with federal law and regulations.
 - Create, finalize and implement the Assisted Living Residence licensure protocols, level of care criteria, schedule of fines, and surveyor training criteria.
 - Create and fund an Ombudsman Program to monitor and advocate on behalf of home care beneficiaries.
 - Amend current complaint protocols and create a 24 hour, 7 day per week rapid response system.
 - Ensure the transparency of the survey process and require the HRA to post all surveys on its website.
 - Grant the D.C. Board of Nursing the authority to oversee the training curriculum and certification of direct care workers.
 - Create a Civil Monetary Penalty Fund and have DOH (or other licensing agencies that monitor health care, such as the Department of Mental Health) collect monetary penalties that may be used for reimbursing residents for lost or stolen personal belongings, and increased training for surveyors, professionals and the general public.
 - Amend enforcement regulations to increase penalties against providers who are repeated poor performers. These funds would be allocated to a Civil Monetary Penalty Fund.

- Develop and implement training seminars and licensure protocols to provide training to HRA surveyors to ensure a consistent survey process.
- Expand the types of professionals who routinely participate in surveys of long-term care facilities.
- Create a taskforce to improve quality assurance, fiscal management, and to respond to complaints rapidly.
- Provide adequate funding to sustain continuous quality of care improvement, environmental improvements, and enhance training for paraprofessionals and professionals in the long-term care field.

C. Innovative Quality Assurance Programs

Alternative programs, such as Wellspring, the Eden Alternative, the Pioneer Project, and the Green House Project, are new approaches to quality improvement that focus on organizational culture change.

Recommendations:

- District government agencies and the D.C. Council should develop program grants and training programs through DOH, Delmarva Foundation and the D.C. Office on Aging to implement new approaches to quality improvement within long-term care facilities.
- DOH should develop training programs to educate surveyors on innovative quality assurance programs, such as the Eden Alternative, Wellspring, and the Green House project.

D. Non-reimbursable Services in Nursing Homes

Throughout the District, long-term care providers are challenged to maintain access for residents to critical dental care, psychological services, hearing aids and durable medical equipment due to Medicaid reimbursement rates that do not cover these services. As a result, some nursing facilities and long-term care providers in the District that provide Medicaid services also routinely provide uncompensated care to the indigent for these services.

Recommendations:

- Medicaid reimbursement should cover the costs of dental care and dentures, hearing aids, glasses, wheelchairs, psychosocial programming, and restorative therapy, all of which have a clear impact on quality of life and care.

- Creative solutions should be explored to respond to the unmet needs of nursing facility residents. For example, dental services could be provided by partnering with dental schools such as Howard University.

IV. WORKFORCE

Long-term care consists primarily of assistance with the activities of daily living (dressing, bathing, eating, moving about) and the instrumental activities of daily living (money management, medication administration, moving in the community). Direct care workers perform these services in client homes, nursing homes, assisted living residences and group homes. In this labor-intensive field, the quality of long-term care depends largely on the availability of workers and the ability of the direct care worker to meet the specific needs of clients.

The direct care workforce is the heart of long-term care services. Despite their fundamental role in caring for seniors and people with disabilities, the direct care worker is poorly cared for by our society. Direct care workers receive low wages and few, if any, health and other fringe benefits. They often work multiple jobs because of the low salaries.

The District, like the rest of the country, faces two major problems regarding its long-term care workforce.

- Workers are hard to recruit and to retain. This shortage of workers results in services not provided because there are not enough workers to provide them in both nursing homes and in the community. Limited availability of direct care workers results in short-staffed long-term care facilities and underutilized Medicaid home and community-based waiver services. High turnover rates affect the continuity and quality of care and means that workers do not know the needs and preferences of individual clients.
- The training curriculum of direct care workers does not adequately prepare them to serve persons with disabilities. In addition, varying training requirements for persons working in nursing homes and home and community-based services makes moving from nursing homes to home and community-based services difficult to accomplish.

A. Wages of Direct Care Workers

It is essential to raise the wages to attract and to retain direct care workers. Adequate Medicaid reimbursement to cover competitive wages is fundamental to the viability of quality long-term care options. In recent years, the low reimbursement rate paid by MAA to home care agencies exacerbated the shortage of workers.

Recommendations:

- Raise the Medicaid reimbursement rate for home care agencies and other long-term care providers in Fiscal Year 2006 sufficiently to enable them to pay direct care workers \$10.50 an hour. Preliminary information from District of Columbia home care agencies suggests that agencies will need to receive at least \$18.50 an hour to cover the cost of the wage increase and the associated taxes. The \$10.50 wage would

be specified in the agency's contracts with the District government or by a Living Wage statute.

- Enact a Living Wage law for \$10.50 an hour or better. This law would require that MAA and other District agencies budget sufficient funds to cover the designated hourly wage, the associated taxes and an annual cost of living increase.
- Set the same hourly wage requirement of \$10.50 an hour for the soon-to-be implemented consumer-directed personal care program.
- Provide higher reimbursements to home care agencies to cover overtime payments to direct care workers who work in excess of 40 hours per week with one client. Higher reimbursements should also be provided to allow for night and weekend pay differentials.
- Provide Medicaid reimbursement rates for skilled nursing assessments at a level comparable to our neighboring jurisdictions in order to recruit and retain skilled nursing personnel. At present, the reimbursement rates in neighboring jurisdictions are twice those of the District of Columbia.

B. Health Benefits for Direct Care Workers and their Families

The proposed increased wages do not permit the direct care workers to buy urgently needed health care insurance for themselves and their families. Without health insurance, direct care workers turn to costly hospital emergency rooms as primary health care providers.

Recommendations:

- Increase income eligibility for the Alliance to 350% of the federal poverty level, allowing direct care workers to qualify.
- Encourage providers to join together to negotiate beneficial industry-wide health insurance rates and other benefits for their workforce.
- Allow both agency and consumer-directed workers to join the health insurance pool used by District government workers.

C. Training for Direct Care Workers

Despite similarities in tasks performed by direct care workers across long-term care settings, training requirements differ greatly. In the District of Columbia, Certified Nursing Assistants ("CNAs") in nursing homes are required to have a minimum of 120 hours of training, while home health aides are required to have a minimum of 75 hours. While there is overlap, there is often very different training in the two sectors. Therefore, to move from home care to nursing home work, or vice versa, often requires workers to

complete the entire training as if they did not have any previous experience, which is inefficient and results in lost pay. This diminishes the ability of the workers to seek the best wages, benefits and working conditions and restricts the industry from attracting a wider range of workers. In addition, none of the training is specific to the needs of the individuals with disabilities for whom they will be caring.

Recommendations:

- Direct and fund the Board of Nursing to review, coordinate and update the didactic and clinical training of all long-term care workers to accomplish the following:
 - Establish a 75-hour universal core curriculum for all direct care workers (i.e., both institutional and non-institutional services). Direct care workers interested in employment in long-term care facilities as CNAs would be required to complete at least another 45 hours of training for a total of 120 hours of training.
 - For certified nurse assistants and others desiring additional training, the core curriculum should be supplemented by special modules (described below) which will provide state-of-the-art techniques and cultural sensitivity for: individual long-term care settings, including consumer-directed care; special populations; end-of-life and palliative care; coping skills; and readiness and life skills training.
 - Establish on-the-job training mentors for both agency and consumer-directed care workers.
 - Provide technical assistance to the licensed training schools for direct care workers in adopting the new curriculum.
 - Certify students in all settings who have passed the tests.
 - Develop a registry of all certified direct care workers so that employers will know who has completed the training.
- Explore ways to expand the delegation of specified nursing tasks to direct care workers with appropriate training.
- Develop a consistent means for payments from the Workforce Investment Council, the D.C. Department of Employment Services, or other agencies for tuition for all core and specialized module training.
- Expand funding of caregiver education for unpaid family caregivers modeled on the D.C. Office on Aging's program which utilizes a caregiver educator to provide individually tailored information on caregiving techniques, such as transfer from bed to chair and bathing in bed. The program should also explore the problem of young children providing care to parents and older relatives.

- Explore developing individualized modules for consumer-directed workers that provide one-on-one training on how to best meet the needs of the individuals they are supporting. For example, trainers could accompany the worker to their client's home for the first appointment. Best practice techniques used by consumer-directed programs in the other states should be investigated for possible implementation in the District of Columbia.

D. Home Care Agencies

Because of the large number of District Medicaid beneficiaries with disabilities, more home care agencies are needed to serve these clients. The planned consumer-directed program will not be large enough to reduce the number of home care agency clients. Consumer direction, as in other jurisdictions, will bring new workers into the long-term care industry, most of whom will serve only their family members. Reimbursement issues are the greatest deterrents to the entry of new home care agencies in the District of Columbia. However, additional barriers reduce access to home care services.

Recommendations:

- Mandate the prompt payment of claims by MAA.
- Amend Home Care Agency rules to allow agencies to provide only non-skilled, non-medical services, such as personal care. These constitute the bulk of Medicaid client needs. Currently, all home care agencies must provide skilled services with nurse directors, which is costly and unnecessary.
- Consistent with the previous recommendation, eliminate HRA policies and procedures requiring each home care agency to hold a certificate of need. D.C. Health Planning Agency requires a certificate of need only for skilled home health care agencies.
- Encourage consolidation and reduction of the paperwork required by MAA. The conversion to electronic record keeping and billing is also encouraged.

E. Other Enhancements of Working Conditions

Attracting direct care workers to enter and remain in the long-term care industry of the District at a time when other jobs offer more money, status and recognition requires creative initiatives.

Recommendations:

- Institute a residential parking permit program for home care and other direct care workers and supervisors to allow them to park in restricted zones when assisting

clients and supervising staff. This permit could be assigned to the person with disabilities who lives in the restricted zone. Currently, home care and other workers often receive parking tickets while assisting their clients.

- Develop incentives for all long-term care providers to have a member of their Human Resource Department trained, free of charge, in the use of The Benefit Bank, a software program developed by the National Council of Churches, which provides eligibility and application information for public programs. Direct care workers may be eligible for a number of public benefits and subsidies for which they have not applied.

V. HOME AND COMMUNITY-BASED SERVICES

A disproportionate amount of Medicaid's budget for long-term care services is spent on institutional services rather than home and community-based services for individuals with chronic disabilities. These high risk and high cost populations are characterized by medical complexity, dependence on family and social supports, and difficulty accessing services. These individuals require an interdisciplinary system that requires healthcare and social systems working in concert. Currently, there are numerous barriers to the creation of a more balanced long-term care delivery system in the District of Columbia.

A. Home and Community-Based Medicaid Waivers

1. Slot Availability of Elderly and Physically Disabled Medicaid Waiver

MAA has actively worked to increase the number of individuals who are enrolled in the Elderly and Physically Disabled ("EPD") Medicaid home and community-based services waiver. However, the waiver is underutilized. As of September 2005, 781 individuals were receiving home and community-based services through the waiver. Services consist of personal care aides ("PCAs"), case management, personal emergency response services ("PERS"), and respite care. For Fiscal Year 2005, 920 slots were available; in Fiscal Year 2006, 1,220 slots are available. The EPD Waiver provides a vital option to remain in the community to those who would otherwise be institutionalized. The EPD Waiver helps to preserve an individual's independence and dignity at a cost no higher than institutional care.

Recommendation:

- Continue outreach and education about EPD Waiver services and the enrollment process to providers serving disabled and senior populations. Providers include hospitals, sub-acute care facilities, senior and handicapped-accessible housing complexes, lead senior service agencies, and community agencies (e.g., Center for Independent Living, Columbia Lighthouse for the Blind, Bread for the City, etc.).

2. Paperwork Requirements

The EPD Medicaid Waiver is paperwork intensive, which is a disincentive for providers to participate in the program. Both case managers and direct care agencies are required to write individual service plans ("ISPs"), quarterly reviews, and, when changes are made, both agencies must make revisions. However, only the case management ISP is submitted to MAA for authorization. Direct care agencies are also required to submit a plan of treatment to Medicaid in addition to submitting the ISP to the case manager.

Recommendation:

- Build a long-term care information technology system to automate and streamline the assessment and reporting requirements for the EPD Waiver, as well as other LTC services. An intranet could be established as a means for authorization of services and communication among providers, minimizing the paper trail that is created within the current system. Medicaid should work to create buy-in across government agencies. In the interim, DOH should establish a working group of MAA representatives, waiver case managers and direct care providers to examine current paperwork requirements and make recommendations to reduce requirements.
- Create universal forms for all levels of care (i.e., waiver, assisted living, community residential facilities, nursing homes, personal care, etc.) and create a system of electronic submission.

3. Consumer-Directed Care

MAA obtained approval from the Centers for Medicare and Medicaid Services in 2002 to add consumer-directed care as a service under the EPD Waiver. In addition, MAA has contracted with Oregon Technical to implement the program and it is hoped consumers can begin to access this program by the end of 2005. Consumer-directed care will help to empower Medicaid Waiver beneficiaries and increase their control over services. It will allow consumers to hire an aide of their choosing without having to utilize a home care agency. Because consumer-directed clients often choose family members, consumer direction can help to ease the personal care aide shortage. It will also help to increase consumer choice, meet unmet needs, and add to consumers' quality of life. Issues of liability, quality assurance, workmen's compensation and other issues need to be addressed.

Recommendation:

- Implement consumer-directed care under the EPD Waiver.

4. Medically-Complex Medicaid Waiver

Medically-complex, chronically ill individuals require intensive care coordination integrating both medical and social services. Currently, services are delivered in a fragmented fashion with little communication among providers. Coordination between medical and social services that improves compliance with medical regimens, reduces costly medical events, prevents or delays nursing home placement and allows individuals to die at home if they choose is not currently funded.

Recommendations:

- MAA received a grant from the Robert Wood Johnson Foundation-funded Center for Health Care Strategies to test two chronic care delivery models that are being used within the EPD Waiver to see what may work best. If data supports a more intensive chronic care model, MAA plans to prepare a fiscal impact statement and pursue a

separate 1915(c), or research and demonstration waiver, for this high-risk population. MMA should continue work on this issue.

- MAA should apply to the Center for Medicare and Medicaid Services for a research and demonstration waiver to establish a chronic care coordination fee for selected, costly beneficiaries deemed at high risk (as opposed to eligible) for institutionalization. This would create a two-tiered system within the current EPD Waiver Program: the current system, which enhances social supports and a second system with enhanced services, which provides both social supports and medical coordination based on disease complexity. The second-tiered program would provide a higher *per member per month* payment to an organization that meets criteria as defined by MAA, which provides primary care and case management services, and an expanded array of services, to include at least the following:
 - A. Urgent care services to mitigate emergency room use. Criteria would include:
 - (1) Ability to provide an in-home visit by a clinician within 4 hours;
 - (2) Around-the-clock availability;
 - (3) Communication link to the attending or a covering physician;
 - (4) Ability to provide point-of-care diagnostics; and
 - (5) Availability of a portable drug box for onsite initiation of therapeutics.
 - B. Health education and nutritional counseling in the home, including hands-on training in medication compliance, meal preparation and healthy alternative selection of foodstuffs.
 - C. To optimize the drug benefit:
 - (1) Periodic updates by a clinical pharmacist for physicians and nurse practitioners regarding formulary changes; and
 - (2) An individualized annual review of patient charts for medications choices.

5. Assisted Living

Five years after the passage of the Assisted Living Regulatory Act of 2000, DOH has yet to issue its first assisted living license. When it is finally implemented, low-income clients may be eligible for the Medicaid Elderly and Physically Disabled Waiver as a partial source of funding for their care in assisted living facilities. As passed, the statute called for the eventual sunseting of DCMR Chapter 34 community residential facilities (“CRFs”) (facilities for seniors), but that provision was not included in the final bill because of a technical error. The populations served in assisted living (“AL”) and CRFs are the same or overlapping. However, CRF residents who meet Waiver eligibility criteria are not covered for EPD Waiver services. Public funding levels for low-income

clients in CRFs and AL are inadequate to cover basic operating costs, resulting in the closure of many small CRFs over the past few years; these are the facilities that serve the low-income population.

Recommendations:

- The Assisted Living Regulatory Act of 2000 should be implemented.
- Public funding for low-income AL and CRF clients through the EPD Waiver and Supplemental Security Income (“SSI”) State Optional Payment need to be available, adequate in amount, and reimbursable to the facility, to attract and retain AL facilities who admit low-income clients. SSI State Optional Payments are very low and should be increased by one-third. A technical amendment to reinstate the legislative provision in the Assisted Living Regulatory Act of 2000 terminating Chapter 34 CRFs as a regulatory category, as originally intended, was recently introduced. This amendment should be passed, thereby allowing the conversion of CRFs to assisted living licenses.
- During this transition period, DOH should conduct outreach to CRFs to educate them about the impact of the conversion and provide them with technical assistance to meet the standards and licensure requirements that govern AL facilities. In addition, EPD Waiver services should be available to CRF clients who meet the level-of-care eligibility criteria. Funding is needed for an adequate EPD Waiver rate and SSI State Optional Payment. Both the EPD Waiver rate and SSI State Optional Payment need to be available to CRFs and AL during the sunset transition period. To avoid unnecessary administrative costs and to provide an incentive for AL facilities to enroll in the EPD Waiver, AL providers should be reimbursed directly under the EPD Waiver to pay their own staff caregivers and case managers, rather than having to contract with a direct care or case management agency.

B. Medicaid State Plan Services

1. Medical Necessity Definition

The definition of medical necessity for all Medicaid services, including homecare, waiver, hospital, and nursing home, is undergoing review by MAA. The initial proposal by MAA for a new definition limited Medicaid-covered long-term care services to skilled services, effectively ending coverage for personal care aide services. The revised draft criteria remain problematic, appearing to adopt criteria for home care services that are tied to curing or ameliorating conditions, and disregarding the need for home care services based on consumers’ ongoing functional limitations. For the vast majority of older and younger people with disabilities in the District, Medicaid personal care aide services are essential to assist with their activities of daily living. In addition to curtailing the long-term attendant care, the proposed regulations are based on a set of proprietary standards that are unavailable to Medicaid clients and their advocates.

Recommendation:

- Eligibility for long-term care under Medicaid should focus on the need for assistance with performing the activities of daily living and instrumental activities of daily living. The current functional criteria for long-term care should be maintained.

2. Uncovered Medicaid Services**Physical and Occupational Therapy:**

Medicaid does not cover in-home physical therapy or occupational therapy (“PT/OT”) services for Medicaid-only beneficiaries. These individuals, some of whom are severely disabled, must attend an inconvenient outpatient center in order to receive physical and occupational therapy. For those who are able to travel, Medicaid incurs transportation charges when these individuals attend the outpatient center.

Recommendation:

- Amend the State Plan to include coverage of speech therapy and PT/OT services in institutional and community-based long-term care programs.

Hospice

Hospice care is not covered under Medicaid State Plan services. Patients have to choose between receiving personal care services and hospice care.

Recommendation:

- Cover hospice under Medicaid. Allow terminal patients to receive both PCA services and hospice care.

Durable Medical Equipment

Medicaid limits access to advanced support surfaces to beneficiaries residing in the community. Specifically, Group 2 mattresses, such as low air loss beds that are needed for the treatment of advanced pressure ulcers (Stage III and IV) and specialty foam mattresses for the prevention of pressure ulcers among high-risk individuals, are not covered services.

Recommendation:

- Medicaid beneficiaries who meet Medicare criteria for specialty support surfaces for the prevention and treatment of pressure ulcers should have access to Group 2 mattresses, as defined by Medicare. In addition, specialty support surfaces for wheelchairs should be available to all eligible Medicaid beneficiaries residing in the community, as defined by Medicare.

C. Money Follows the Person

The District does not utilize Money Follows the Person concepts in its budgeting. These budgeting approaches allow institutionalized persons to utilize the money that would be paid to a nursing home to fund home and community-based services. All Medicaid funded individuals currently in nursing homes and other institutions who choose to leave the facility should be served in the community by a District of Columbia home and community-based program. Money Follows the Person allows Medicaid funds to be redirected out of institutions and into home and community-based services for individuals who are discharged into the community. Housing is a barrier to persons returning to the community.

Recommendation:

- The District should endorse and implement Money Follows the Person concepts. All Medicaid funded individuals currently in nursing homes and other institutions who choose to leave the facility should be served in the community by a District of Columbia home and community-based program. When a person is discharged from a nursing home, the money should be transferred from the institutional budget line item to the home and community-based services budget line item.

D. Supportive Services in the Community

1. Coordination of Acute and Long-Term Care

There is limited access to primary care, preventive care and health maintenance for low-income seniors and persons with disabilities, particularly those who reside in medically-underserved areas of the District of Columbia.

Recommendations:

- Providers of long-term care and District agencies responsible for the delivery of services to seniors and persons with disabilities should collaborate with the District of Columbia Primary Care Association's Medical Home Initiative. This collaboration would provide seniors and younger people with disabilities with a medical home for primary health management and support.
- MAA should explore the possibility of helping to establish a Program of All-Inclusive Care for the Elderly ("PACE") in the District of Columbia. PACE programs provide a broad range of acute and long-term care services to persons who require a nursing home level of care on a capitated basis. They integrate acute and long-term care services.

2. Handicapped Home Accessibility

Accessibility of the home may make the difference between remaining in the community versus moving to a nursing home. The Handicapped Accessibility Improvement Program (“HAIP”), which provides home modifications, is funded through the D.C. Department of Housing and Community Development. The program has many burdensome requirements, which limits access to this program. For example, the housing modification application is lengthy and complicated. Most seniors and persons with disabilities cannot navigate this process independently. In order to qualify for HAIP, applicants must be the sole or primary owner of the home, have a low-income, and be unable to obtain home repair financing through a private lender. Individuals who rent their homes are not eligible for HAIP.

Application approval by HAIP can take 2 to 3 weeks. It can take an additional 6 to 7 weeks to determine the scope of work. Finally, homeowner applicants must access competitive bids from contractors and submit those bids to HAIP. An additional barrier in this process is that homeowners must adhere to Title X, which requires housing programs to abate lead based paint hazards, which can add an additional 6 weeks to the project. Thus, the HAIP process can take several months before renovations can be approved and work completed.

The home modification benefit under the EPD Waiver is underutilized. The benefit cannot be accessed unless the client first applies to HAIP and is denied. Even if a waiver client has been pre-screened by a case manager, who is knowledgeable about HAIP requirements, and does not meet the above requirements, the client still has to apply for the program and be denied before accessing the waiver benefit, which is a waste of time and resources.

Recommendations:

- Streamline the application process and revise the eligibility requirements, including limiting the income criteria solely to the applicant’s income (rather than the household). The ADRC should assist seniors and disabled consumers with completing the application and navigating the overall process. A realistic timeframe of when applications should be approved and construction started should be established.
- Alternatives to HAIP should be established for non-homeowners, including renters. Under the Americans with Disabilities Act, landlords must allow tenants to modify the home in order to make it handicapped-accessible; however, the tenant must remove the modification once he or she vacates the rented property. Funding, possibly through HAIP, should be made available to provide modifications for renters and removal of modifications when an individual vacates the rented property. The modification (i.e., ramps, grab bars, stair glides) may be able to be recycled for another consumer.
- Create a separate screening process for waiver participants who are ineligible for HAIP. Allow home and community-based services waiver participants, including

non-homeowners, to access the home modification benefit without first having to receive a denial from HAIP.

3. Home Maintenance Assistance

Seniors and persons with disabilities often require non-health care related assistance (e.g., housekeeping, painting, yard work, grocery shopping) to be able to function safely in their home environment and to delay or prevent a move to institutional care. There are limited programs and funding available to support these individuals as they age-in-place in their own homes or apartments. Living on fixed incomes, low-income seniors and persons with disabilities are often unable to afford basic maintenance and upkeep of their homes.

Recommendation:

- Establish funding for innovative programs that enable seniors and persons with disabilities to maintain their own homes. These programs could be volunteer-based and focus on assisting seniors *free of charge* with yard work, painting, light repair and maintenance projects. These programs should coordinate with existing community-based volunteer services. The District's Aging and Disability Resource Center should provide information about these services.

VI. BIOGRAPHY OF TASKFORCE MEMBERS

The LTC Taskforce was comprised of long-term care providers, advocates, long-term care clients, policymakers, and representatives from the Medical Assistance Administration and the Health Care Regulation and Licensing Administration.

Chairman: Joshua M. Wiener, Ph.D., is a Senior Fellow and Program Director for Aging, Disability and Long-Term Care at RTI International, a nonprofit research organization. He is the author or editor of eight books and over 100 articles on health care for seniors, people with disabilities, long-term care, Medicaid, health reform, health care rationing, and maternal and child health. Dr. Wiener was co-chair of the Long-Term Care Committee of the Mayor's Health Policy Council. Prior to coming to RTI International, he performed policy analysis and research for the Urban Institute, the Brookings Institution, the Health Care Financing Administration, the Massachusetts Department of Public Health, the Congressional Budget Office, the New York State Moreland Act Commission on Nursing Homes and Residential Facilities, and the New York City Department of Health.

Roxanne Ando is the Director of Christian Communities Group Homes, Inc. ("CCGH"), a service of Episcopal Senior Ministries, and has served in this capacity since 1989. As its principal operating and development official, she manages CCGH's three group homes and developed its Age-in-Place program, which assists seniors in the community using volunteer labor. Ms. Ando received her J.D. from Harvard Law School and is a member of the D.C. and Virginia bars.

Robert L. Cosby, Jr. Ph.D., serves as Chief of the Office of Disabilities and Aging at the D.C. Department of Health's Medical Assistance Administration ("MAA"). The Office of Disabilities and Aging works as Medicaid's primary Office involving Nursing Homes, Home and Community Based Services, Intermediate Care Facilities for the Mentally Retarded and Developmentally Disabled and some HIV related services. Dr. Cosby's duties include program management, oversight, administration and some policy development for the District's Medicaid Services for Older Persons and Persons with Disabilities. He and his staff are responsible for 4 Medicaid waiver programs and 13 programs and projects at the MAA. Dr. Cosby has worked in health and human service related work for over 25 years at the local, state, regional and national levels. He holds degrees in Social Science, Social Work, Religious Studies and Gerontology.

Robert "Bobby" Coward is the Executive Director of DIRECT Action (Disabled Individuals for Real Empowerment and Community Training) and a person living with a disability. The mission of DIRECT Action is to organize people with disabilities residing in the District of Columbia to actively promote access to community-based services and supports, accessible housing and employment programs to ensure full participation and economic success in D.C. community life rather than institutional segregation for people with disabilities.

Jennifer Crawley is a licensed clinical social worker with Washington Hospital Center's Medical House Call Program. In this position, she provides case management services to some of the District's most frail seniors under the Elderly and Physically Disabled Medicaid Waiver. Ms. Crawley also has extensive expertise in delivering family-centered services, crisis intervention, patient advocacy and education, and building and facilitating community collaborations.

Sandy Douglass is the Administrator/CEO at The Methodist Home of D.C. She has been at The Methodist Home for 13 years, and in the senior living and long-term care profession for more than 20 years. She is a board member of the District of Columbia Health Care Association and Chair of the Assisted Living Committee. Ms. Douglass also holds a Board position with LifeSpan/MANPHA, a senior service alliance representing both Maryland and D.C. member facilities. The Methodist Home is a member of the Mid-Atlantic Wellspring Alliance and is an active Wellspring facility.

Sue Hargreaves is the Director of Social Services at the Lisner-Louise-Dickson-Hurt Home and has been a member of the Long-term Health Care Community since 1990. She serves on the Board of Directors of Sarah's Circle and is an active member of policy committees such as The Continuum of Care Committee, focusing on concerns for the District's seniors. Ms. Hargreaves holds Bachelors' Degrees in Social Work and Psychology and completed her Master's Degree in Health Services Administration.

Ilene R. Henshaw serves as Senior Legislative Representative for Health and Long-term Care in AARP's Department of State Affairs. As such, she provides strategic guidance to AARP's state offices on long-term care, health, and prescription drug advocacy efforts. Prior to coming to AARP, Ms. Henshaw directed policy and legislative affairs for consumer and advocacy organizations working to ensure quality care for long-term care consumers. She received her J.D. from American University, Washington College of Law and her B.A. Summa Cum Laude from The University at Albany. She has served on the Board of Directors of the National Citizens' Coalition for Nursing Home Reform and on Fairfax County's Long-term Care Taskforce.

Helen R. Jordan, MSW, LGSW, CPM, is the Interim Chief of Staff of the Health Care Regulation and Licensing Administration ("HCRLA"). HCRLA was created July 27, 2004 and is divided into 2 sub-administrations: Health Professional Licensing Administration and Health Regulation Administration. HCRLA administers all District and federal laws and regulations governing the licensing, certification and registration of health professionals, health care and human services facilities and laboratories. In her capacity as Interim Chief of Staff, Ms. Jordan is responsible for day-to-day operation of the HCRLA and identifying, analyzing and coordinating the implementation of a variety of policy issues and decisions formulated by the Senior Deputy Director. Ms. Jordan received a B.S. in Social Welfare from Florida State University, and a Master of Social Work Degree from Boston University. Ms. Jordan also earned a certificate in public management at Georgetown University.

Gerald “Jerry” Kasunic is the Director of the D.C. Long-term Care Ombudsman Program. The D.C. Long-term Care Ombudsman is charged by D.C. statute to advocate for the rights of older persons and other persons who are residents of nursing facilities and community residence facilities, investigate and resolve complaints made by or on behalf of an older person or other person who is a resident of a nursing facility or a community residence facility, as well as monitor the quality of care, services provided, and quality of life experienced by older persons and residents to ensure that the care and services are in accordance with applicable District and federal laws.

Marla Lahat is the Executive Director of Home Care Partners, a non-profit, supportive home care agency that provides home care aide services to seniors and disabled individuals throughout the metropolitan area as well as training for individuals who wish to become home care aides. Ms. Lahat has a Master’s Degree in Social Work from Temple University and a Bachelor’s Degree in Science/Social Work from Cornell University. She is licensed as an Independent Clinical Social Worker and has published several articles related to her work with clients with Alzheimer’s disease and collaborated on a book entitled, Alone But Not Forgotten. Ms. Lahat currently serves on several committees throughout the metropolitan area, including the D.C. Long-Term Care Coalition, the Northern Virginia Network of Non-Profit Human Service Providers, and the National Association for Home Care’s accreditation committee.

Steven Lutzky, Ph.D., is the President of HCBS Strategies, Inc. Dr. Lutzky has conducted research on and development of home and community-based systems for individuals with disabilities and long-term illnesses for the federal government, state governments, and private sector clients. He served as the Director of Division for Community Systems Improvement within the Disabled and Elderly Health Program Group, Center for Medicaid and State Operations, Center for Medicare and Medicaid Services (“CMS”). Prior to joining CMS, he served as the Chief of the Office on Disabilities and Aging within the District of Columbia’s Department of Health Medical Assistance Administration. Dr. Lutzky has written and presented on long-term care and disability issues for the U.S. Senate Finance Committee, Senate and House professional staff, the U.S. Department of Health and Human Services and state governments, as well as interest groups (e.g., AARP and Families USA), and other private sector clients.

Vera Waltman Mayer, Esquire, is Coordinator of the D.C. Coalition on Long-term Care, whose members are consumers, advocates and providers united to help the District expand Medicaid services for District residents with chronic care needs. The Coalition has assisted in the development and implementation of extensive home care and assisted living regulations. Previously, she was IONA Senior Services’ Long-Term Care Ombudsman.

Denise S. Pope, RN, MSN, is the Administrator of the Health Regulation Administration (HRA) for the Health Care Regulation and Licensing Administration (HCRLA). HRA is the regulatory agency that administers District and federal laws and regulations relative to licensure and certification of health-care and social services facilities, including the inspection and surveying of provider facilities and the investigation of consumer and self-

reported facility incidents and complaints. Ms. Pope's duties include program management and oversight, general administration and policy development. Ms. Pope has over 25 years of experience in nursing, academia and health-related activities. She holds degrees in Nursing and Home Health Administration.

George A. Taler, M.D., graduated from the University of Maryland School of Medicine in 1975, completed a residency in Family Medicine in 1978, and a Geriatric Fellowship at the Jewish Institute for Geriatric Care (now the Parker Geriatric Institute) in New Hyde Park, New York. Dr. Taler joined the Family Medicine faculty at the University of Maryland, where he was an Associate Professor until he left in 1999 to join the Washington Hospital Center as Director of Long-term Care. His responsibilities include Co-Director of the Medical House Call Program, Vice-President for Medical Affairs of MedStar Home Health-VNA and Medical Director of Northwest Health Care Center, a 343-bed nursing home in Washington, D.C. Community leadership activities include Past-President of the Maryland Gerontological Association, 1991-1992; Founding President of the Maryland Geriatrics Society (State affiliate of the American Geriatrics Society), 1993; President of the American Academy of Home Care Physicians, 1998-2000. Dr. Taler has been a member of the Board of the National Pressure Ulcer Advisory Panel since 2002.

Eve Tetaz, a retired D.C. Public School teacher, is currently caring for her one hundred year old mother under the Medicaid Waiver Program in the Adams Morgan neighborhood of Washington, D.C. Since her involvement with the program, she has become an advocate for the home health care worker and is acutely aware of the importance of having fully trained health care professionals whose responsibility is to care for patients in the comfort and security of their homes.

Romaine B. Thomas is State President of AARP D.C. Ms. Thomas is the retired principal of Ketcham Elementary School. She has been honored by organizations such as the American Business Women's Association, National Capital Parks, Union Temple Baptist Church, Community Action Program and Washington Urban League for dedicated service to the District. Ms. Thomas received a B.S. from Miner Teachers College and an M.A. from The George Washington University.